Reproductive health of the early married Muslim women in India: A study at Contai, Purba Medinipur, West Bengal

Bithika Adak[1] and Dipak K. Midya[2]

[1]Research Scholar, Department of Anthropology, Vidyasagar University, Midnapore 721 102, WB, India; [2]Professor, Department of Anthropology, Vidyasagar University, Midnapore 721 102, WB, India & Corresponding author's email: dkmidya@gmail.com

KEYWORDS	ABSTRACT
Early marriage, Muslim women, reproductive health, family planning, miscarriage	*The reproductive health of women has become one of the priority public health concerns since the Cairo conference in 1994. Early marriage of girls has serious implications not only on their own reproductive health but also on the health of the next generation. But till now, early marriage is probably the most significant health and rights concern for women in the developing countries. Surprisingly in India, research on reproductive health of the early married women, particularly among the Muslims, is a neglected area. In the present study we tried to examine the reproductive health behaviour of the early married Muslim women with particular reference to those in the Contai Municipality of West Bengal. The study finds highly significant association between the socioeconomic conditions (like education, poverty, awareness about family planning method) of the early married women and their different reproductive health constraints like abortion, miscarriage, under-weight of babies, etc.*

Introduction

Since the UN International Conference on Population and Development (ICPD), held at Cairo in1994, women's reproductive health has become one of the priority public health concerns (Harrison and Montgomery 2001). The conference highlighted the need for global monitoring of women's reproductive health and reproductive rights status and tried to redefine the discourse of reproduction aiming at empowering women and eliminating social inequalities and constraints for women. But till now early marriage is probably the most significant health and rights concern for women in the developing world, particularly in the lower and middle income countries (LMICs) (Jensen and Thomton 2003; Nour 2006; Rumble *et al.* 2018). Marriage practices and reproductive health behaviour are deeply embedded within the socio-cultural fabric of an ethnic group. Ethnographic study on socio-cultural perspectives of reproductive health behaviour is, therefore, very important to understand the reproductive behaviour of an ethnic group as every ethnic group has its own set of complex belief systems associated with puberty, menstruation, sexuality, marriage, pregnancy and childbearing (Kleinman 1980; Ngubane 1981; Martin 1989; Preston-Whyte 1993; Castaneda *et al.* 1996; Boyden *et al.* 2012). But, such study is very scanty excepting a few researches in Africa (M'bede 1985; Boyden *et al.* 2012; Woden *et al.* 2016), Mexico (Castaneda *et al.* 1996) and Indonesia (Rumble *et al.* 2018). There are only a few studies on women's perceptions about reproductive health in India (Gittlesohn *et al.* 1994; Sing and Sharma 1996; Raj *et al.* 2009). Surprisingly, such study is hardly available on the Muslim women, the largest ethnic minority in India. In India, early marriage of Muslim women is very frequent and such women are subjected to greater risks in connection with socioeconomic inequalities and health constraints.

Objectives

In this study, we have tried to examine the reproductive health behaviour of the Muslim women in India with particular reference to the early married women of the community in Contai Municipality of West Bengal in India and to highlight the effects of early marriage on the reproductive health of the women concerned.

Materials and Method

Study Area: For the present study, Contai Municipality under the Contai-I block of Purba Medinipur district in West Bengal was selected for the first author had social access to conduct fieldwork in the area. Contai is located about 160 km south of Kolkata, the State capital, and 31 km north of the beach town of Digha on the Bay of Bengal. The Contai municipality consists of 18 municipal wards. Out of these wards only five wards, *viz.*, ward Nos. 1 - 5 were purposively selected due to the high concentration of Muslim population in these wards.

Study group: Fifty Muslim households from each of the wards were selected through simple random sampling irrespective of the number of Muslim households in the wards. Thus, 250 households were selected. This gave a total population of 987 including 494 females and 493 males. The ward-wise distribution of population in the selected households is given in the Table-1. There are altogether 267 families living in these households. This is because some households consist of more than one family. The total female population was considered for socio-demographic analysis. For understanding reproductive health behavior of the early married women, all the women who were married at their early age were taken into consideration. There were altogether 265 early married women in the study population.

Table-1: Ward-wise age-sex distribution of the population

Ward No.	No. of household selected	Female N (%)	Male N (%)	Total N (%)
1	50	99 (10.03)	112 (11.35)	211 (21.38)
2	50	104 (10.54)	92 (09.32)	196 (19.86)
3	50	99 (10.03)	107 (10.84)	206 (20.87)
4	50	93 (09.42)	96 (09.73)	189 (19.15)
5	50	99 (10.03)	86 (08.71)	185 (18.74)
Total	250	494 (50.05)	493 (49.95)	987 (100.0)

Approach: The ethnographic approach has been the primary approach of understanding the reproductive health behavior of the study group (Castaneda *et al.* 1996; Boyden *et al.* 2012). This is because it provides the window onto social perception about practices of marriage and the belief pattern associated with menstruation, puberty, marriage, womanhood and pregnancy rites of women (Bernard 1988).

Conceptual dimensions: The reproductive health of women is generally viewed from social as opposed to biomedical perspectives to women's health as it is deeply oriented towards the socio-cultural practices of an ethnic group (WHO 1998; Kazanjian 1998). This usually refers to a state of complete physical, mental and social well-being and not merely the absence of illness or infirmity, in all matters relating to the reproductive system and its function and processes. This implies that women are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so (United Nations 2014). For the women's reproductive health, the focus is on their ability to survive the reproductive years and beyond with the

reproductive choice, dignity and successful childbearing, and to be free from gynecological diseases and risks (Zurayk *et al.* 1994). For the present case, early marriage means marriage before attaining the prescribed age for marriage, *i.e.*, 18 years.

Methods and techniques adopted: The primary methods of data collection were observation, interview and case study. Data on demographic aspects including age, sex, marital status, education, family income, etc. were obtained by using household survey schedules. Data on the reproductive health aspects, *i.e.*, age at first marriage, age at menarche and menopause, fertility preference, awareness and use of family-planning methods, breastfeeding practices, infant mortality, maternal and child health (for the first birth in particular), reproductive morbidity, etc. were obtained through the use of pretested questionnaires developed for the purpose. This was a cross-sectional study among the women in various age groups. Self-declared responses of the informants were recorded without any verification since there was no government record available on the issues. Symptoms and health problems were recorded as reported by the respondents. These were not verified by a doctor or through a doctor's prescription which was not available. Correlation of different variables was calculated through the SPSS 16.0. The fieldwork for the study was carried out in different phases within 2016-2019.

Findings and Analysis

Reproductive health and selection of reproductive strategies are different in women and men (Kilbourne-Brook 1998; Abadi Farahani *et al.* 2012; Ray *et al.* 2013). Girls' and women's health is, WHO observes, critically affected by socioeconomic factors like access to education, household wealth and place of residence (WHO 2009). Socioeconomic status of the present study group is demonstrated in various charts. Fig.1 shows that 34.62 per cent women are illiterate and 30.97 per cent of them left schooling in their primary level of education, who are now unable to read and write. Thus, about 62 per cent women are practically illiterate. The marital status of the women shows that about 62 per cent of them are married and 38 per cent are unmarried (Fig.2). Most families do not have any fixed monthly income. They are engaged as daily wage labourers and/or rickshaw pullers. The average monthly income of the families was calculated by adding up estimated income of earning members in the families for a period of three consecutive months. As per the Government of India estimation, a family with a monthly income up to INR 2250 falls under the Below Poverty Line (BPL) category (Balchand and Sunderarajan 2016). Though there was hardly any family under the BPL category, Fig.3 shows that about 48 per cent families have a monthly income of INR <5001 and 37.74 per cent families have that of INR 5001-7500. Only 1.50 per cent families have a monthly income of INR >10000. So, most families are in economically vulnerable situation.

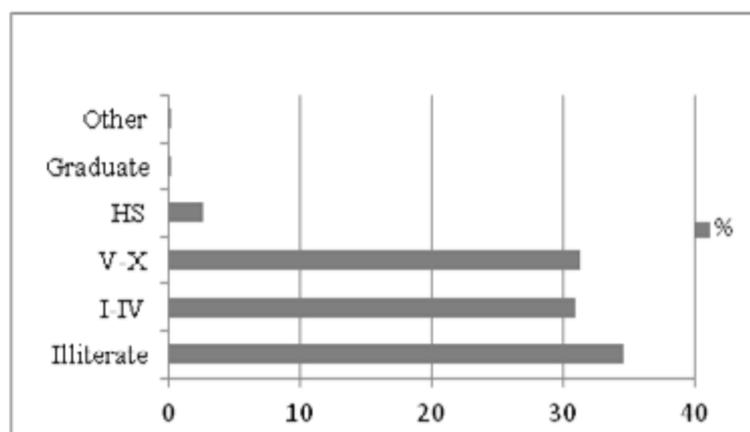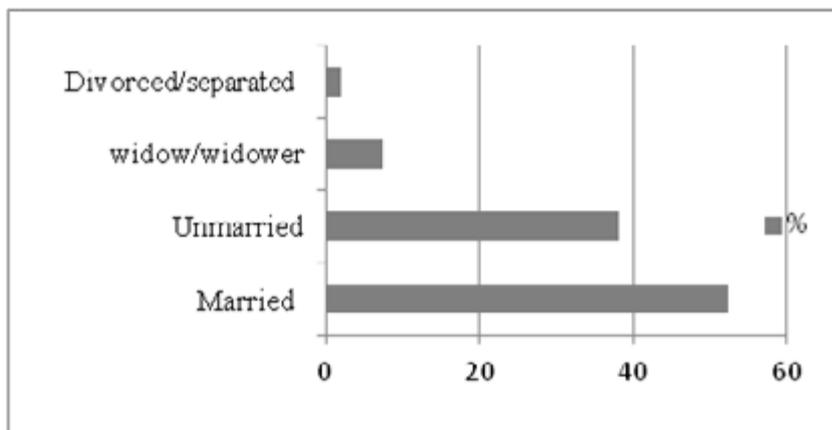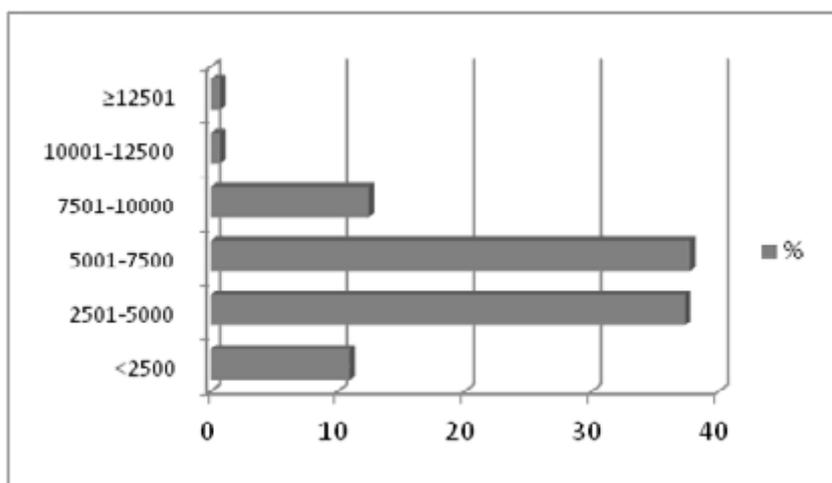*Fig.1: Educational status of the Muslim women (n_w = 494)*

Fig.2: Marital status of the Muslim women (n_w = 494)

Fig.3: Monthly family income (INR, n_f = 265)

WHO observes that women's health during the reproductive years (i.e., from 15 to 49 years) is not only important to women themselves but to the health and development of the next generation and that complications of pregnancy and childbirth are the leading cause of death in young women aged between 15 and 19 years in the developing countries (WHO 2009). In the study group, there are 265 women who were married in their early ages ranging from 7 to 17 years. So, the rate of early marriage in this Muslim group is 53.64 per cent. It was reported that 30.19 per cent of them were married at the age of 16 years, whereas 12.45, 24.53 and 16.61 per cent of them were married at the age of 14, 15 and 17 years respectively. Some of them were married as early as at the age of 7 (0.75%), 12 (6.79%) and 13 (8.68%) years. The most obvious social consequence of early marriage is drop out. The study shows that association between early marriage of girls and their education is highly significant (X^2 =49.19**, df=30, P<0.01) [Table-2].

Early marriage usually results in early pregnancy among most underprivileged communities. The Muslims under study are against adopting any family planning methods, since pregnancy is seen as the sign of fertility of woman and it completes womanhood. However, some women, mostly of the younger generation, were reportedly using contraceptive pills (43.77%), condom (3.40%) or adopting withdrawal technique (8.30%) in order to reduce the family burden. As practising contraceptive method by the females were not seen in good spirit, 61.21 per cent of the pill users were using this without their husband's knowledge. No family planning method was adopted by 44.53 per cent women. Most of them were not allowed to do that by their husbands and some thought that having a baby was the gift of the almighty Allah. The words of a woman aged 42 years reflect the belief against the use of family planning method:

> *I have given birth to five children, including two boys and three girls. I am not using any method because it is a sin to control the birth of a baby. Getting pregnant is a natural phenomenon which comes at the wills of Allah.*

It was also reported that 83.02 per cent women (including many young ones) were in habit of using old cloth. This was the traditional practice of the women in the study area. Only 16.98 per cent women were lucky to use napkins. A woman of 42 years at the Ward No. 3 revealed her preference in the following words:

> *I had menarche at the age of 13 years. When it happened for the first time, I leaned about this from my mother. She arranged some used cloth for me and guided me how to use it. Till now, I do use cloth. Now-a-days, sanitary napkins are available in market. But I never used napkins because I feel very uneasy to purchase napkins and my husband also feels uncomfortable to buy them.*

It is found that association between family planning awareness and the frequency of the act of conceiving is highly significant (X^2=63.91, df=10, P<0.0001) [Table-3]. The study further shows a highly significant association between women's education and family planning method adopted (X^2=44.38***, df=15, P<0.001) [Table-4]. A significant factor that contributed against the use of pills was the social learning about the side-effects from the user women. Out of 116 pill users, the problems of headache, weight gain, nausea, weakness, weight loss and even menstrual problem were reported by 28.45, 10.34, 10.34, 2.59, 6.03 and 12.07 per cent early married women respectively. Reported cases of anaemia were alarmingly high among the early married women. Whereas 46.42 per cent women had no idea about anaemia, 30.94 per cent women reported that they had anaemia. One of the serious health effects of early marriage is the low birth weight of the babies. In the present case, 56.23 per cent women had their first baby with a low birth weight. Only 30.94 per cent women reported that they had babies with a normal weight, whereas 12.83 per cent of them had no idea about their baby's weight. The poverty of the family is also an influencing factor. The early marriage of girls is a socioeconomic consequence of poverty. The study shows that the association between women's education and the monthly family income is highly significant (X^2=1.93***, df=25, P<0.001) [Table-5].

Among the early married women, 23.40 per cent experienced the trauma of abortion whereas 76.40 per cent did not. However, none of them had got multiple abortions. Fifty per cent of the women who experienced abortion opted for early termination of pregnancy as their previous babies were too young. Other causes of abortion included having many (usually 3-4) children (17.74%), overage of the mothers (14.52%), weakness of the mothers (8.06%), and other (including the cases like pressure from husband, etc.). The Muslim women did not like to disclose the incidence of abortion as their orthodox society was very sensitive about it. They, therefore, took the decision at a very early stage of pregnancy. The words of a woman aged 32 years expressed the compulsion and agony of such premature termination of pregnancy:

> *I have a very big family. There are my husband, children, father-in-law, mother-in-law and brother-in-laws. I have already two babies, and now have conceived again. We had no plan for another baby, but it happened. My husband told me that he was the only earning member in the family. If the baby was born the expenditure of family would go high and nurturing the baby would be very tough. Although my father-in-law was a rickshaw puller, his income was just nothing to say. All responsibilities in the family were on my husband's shoulder. That's why my husband asked me for the abortion. A world of fear surrounded me at once. Keeping aside all agonies and hesitation, we visited a doctor. Doctor gave me some medicines for abortion. I could not close my eyes that night. After taking the medicines my menstruation started. It was*

not right what we did. We did not disclose the incident to anybody till now.

One of the gravest consequences of early marriage is miscarriage. In the study group, 22.26 per cent early married women experienced miscarriage. About 49 per cent of them failed to identify the cause of miscarriage. However, 16.95 per cent of them attributed this to the fact that they felled down somehow and 33.9 per cent to the act of misdeed in past or may be in their previous birth. It is found that there is highly significant association between early marriage of women and miscarriage (X^2= 55.45***, df=24, P<0.0001) Table-6]. Thus, early marriage brings in various socioeconomic as well as reproductive health constraints in the life of women. But, among the Muslims the rate of early marriage is alarmingly high.

Table-2: Association between women's education and their early marriage (n_w=265)

Women's education	Age at first marriage (years)							X^2
	7	12	13	14	15	16	17	
Illiterate	0 (0.00)	9(23.68)	4(10.53)	6(15.79)	10(26.32)	6(15.79)	3(7.89)	
Only Can sign	2 (3.08)	5(7.68)	9(13.85)	6(9.23)	16(24.62)	21(32.31)	6(9.23)	
I-IV	0 (0.00)	2(3.08)	3(4.62)	9(13.85)	16(24.61)	19(29.23)	16(24.61)	49.19**
V-X	0 (0.00)	2(2.22)	7(7.78)	12(13.34)	22(24.44)	31(34.44)	16(17.78)	
H.S	0 (0.00)	0(0.00)	0(0.00)	0(0.00)	1(16.67)	3(50.00)	2(33.33)	
Graduate	0 (0.00)	0(0.00)	0(0.00)	0(0.00)	0(0.00)	0(0.00)	1(100.0)	

(**)=P<0.01, df=30   (Figure in parenthesis indicates per centage) Source: Fieldwork data, 2016-19.

Table-3: Association between family planning awareness and frequency of the act of conceiving.

Family planning awareness	Frequency of the act of conceiving										X^2
	1	2	3	4	5	6	7	8	9	15	
Yes	6 (14.63)	29 (70.73)	5 (12.20)	1 (2.44)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	60.61***
No	37 (16.52)	36 (16.07)	48 (21.43)	42 (18.75)	14 (6.25)	26 (11.60)	10 (4.46)	7 (3.13)	3 (1.34)	1 (0.45)	

(***)=P<0.0001, df=10 (Figure in parenthesis indicates per centage). Source: Fieldwork data, 2016-19.

Table-4: Association between women's education and adoption of family planning methods (n_w=265).

Women's education	Family planning method adopted				X^2
	Pill	Condom	Withdrawal	None	
Illiterate	6 (15.79)	1 (2.63)	2 (05.26)	29 (76.32)	
Only can sign	21(32.31)	0 (0.00)	4 (06.15)	40 (61.54)	
I-IV	33(50.77)	2 (3.08)	7 (10.77)	23 (35.40)	44.38***
V-X	52(57.78)	6 (6.67)	9 (10.00)	23 (25.56)	
H.S	4 (66.67)	0 (0.00)	0 (0.00)	2 (33.33)	
Graduate	0 (0.00)	0 (0.00)	0 (0.00)	1 (100.0)	

(***)=P<0.001, df=15; (Figure in parenthesis indicates per centage) Source: Fieldwork data, 2016-19.

Table-5: Association between women's education and monthly family income (n_f=167).

Women's education	Monthly family income (INR)						x^2
	≤2500	2501-5000	5001-7500	7501-10000	10001-12500	≥12501	
Illiterate	12 (31.58)	16 (42.11)	9 (23.68)	1 (2.63)	0 (0.00)	0 (0.00)	
Only can sign	7 (10.77)	26 (40.00)	26 (40.00)	5 (7.69)	1 (1.54)	0 (0.00)	
I-IV	7 (10.77)	29 (44.62)	21 (32.31)	8 (12.31)	0 (0.00)	0 (0.00)	1.93***
V-X	3 (3.33)	28 (31.11)	40 (44.44)	18 (20.00)	0 (0.00)	1 (1.11)	
H.S	0 (0.00)	0 (0.00)	4 (66.67)	1 (16.67)	0 (0.00)	1 (16.67)	
Graduate	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	1 (100)	0 (0.00)	

(***)=P<0.001, df=25   (Figure in parenthesis indicates per centage); Source: Fieldwork data, 2016-19.

Table-6: Association between early marriage of women and incidence of miscarriage (n_w=265)

Age at 1st marriage (yrs)	Causes of miscarriage				Not experienced miscarriage	X^2
	Result of misdeed	Falling down	Other#	Not known		
7	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	2 (100.0)	
12	8 (44.40)	1 (5.60)	0 (0.00)	0 (0.00)	9 (50.00)	
13	3 (13.04)	1 (4.35)	0 (0.00)	2 (8.70)	17(73.91)	
14	1 (3.03)	0 (0.00)	2 (6.06)	4 (12.12)	26(78.79)	55.45***
15	4 (6.15)	3 (4.62)	3 (4.62)	4 (6.15)	51(78.46)	
16	2 (2.50)	5 (6.20)	0 (0.00)	10 (12.5)	63 (78.80)	
17	2 (4.50)	0 (0.00)	1 (2.30)	3 (6.80)	38 (86.40)	

(***)=P<0.0001, df=24 ,(Figure in parenthesis indicates per centage),#The category includes the causes like overage of the woman, hard work, thyroid and asthma. Source: Fieldwork data, 2016-19.

Conclusion

In India since 1961, there is a declining trend of child sex ratio (CSR). It declined from 945 in 1991 to 927 in 2001 and then to 918 in 2011 (Govt. of India 2020). At the same time, the rate of illiterates among the females is almost double the rate among the males (34.54 and 17.86 per cent respectively) as per the Census report 2011(Census of India 2011). These are seen as major indicators of women disempowerment. In order to curb these menaces, the Government of India has introduced Beti bachao beti padhao (meaning save the girl educate the girl) scheme in 2019. The State Government in West Bengal also has come forward with the Kanyashree scheme in order to incentivize girls to continue education and disincentivize their early marriage (Govt. of West Bengal 2020). This has been very successful in reinforcing the positive impact of increased education and delayed marriage in West Bengal and earned international fame by winning the UNPSA Award 2017 of the United Nations. But it appears that these schemes have failed to cut the ice among the Muslims in the country as the findings of the present study suggest. This study shows that early marriage very high (53.64%) among the Muslims. It further shows that poverty and early marriage of the Muslim women has a highly significant association. Otoo-Oyortey and Pobi (2003) have also found the link between poverty and early marriage.

It was also found that there is a highly significant association between educational backwardness and early marriage of women. The very low literacy rate of the Muslim women (about 65 per cent) acts as a crucial factor toward social disempowerment. The Muslim women are traditionally not in favour of adopting any family planning measure. Sometimes husbands influence the decision. Similar evidence was also obtained in South Africa (Varga 2003). However, 55.47 per cent of them, mostly belonging to the younger generation, are using different family planning measures in order to reduce the economic burden. A highly significant association is found between family planning awareness and the frequency of the act of conceiving. The women under study are in general lacking the desirable awareness about hygienic health practices as 83.02 per cent of them are using old cloth as sanitary napkins.

The study further shows that early married women witnessed severe reproductive health hazards in the form of abortion and miscarriage. More than 23 per cent of such women had to opt for abortion for various causes. The level of correlation between women's early marriage and miscarriage is high (P<0.0001). Maternal mortality rate was not calculated as the data could not be verified with reliable records or the informants.

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