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Early Marriages and Healthcare Negligence in Sarki Women in Rural Nepal

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Abstract

Though early marriage is a problem in all communities in Nepal, few studies have looked specifically at very remote Dalit communities. This research explores the impact of early marriage on reproductive health and the use of healthcare services in the Sarki Dalit community of Baghchaur Municipality ward no. 2, Salyan District. Using an explanatory sequential design of mixed methods, we began with a census survey of every married woman with children, of which there were 167, and subsequently three additional qualitative in-depth interviews. The results showed that the problem is much more severe than anticipated: the median age of marriage is 16, and 42.5% of women were pregnant before age 15. Contact with the health system for maternal care was nearly nonexistent: 98.2% of women home-delivered their last baby, and 44.3% of women had no ANC. Binary logistic regression showed maternal literacy as the strongest predictor of receiving any ANC, with the odds of 4.6 (95% 2.15- 9.88, p<.001). The qualitative data showed that the active avoidance of maternal care was caused by a combination of deep-seated distrust in the health system, geographical remoteness, and poverty. As a result, the responding health system failed to meet its expected targets. The absence of national programs and the systemic abandonment that this community has received highlight the need for a multi-sectoral association.
Keywords: Early marriage, Women, Maternal healthcare, Reproductive health, Nepal

Introduction

Child marriage is a public health and social equality problem. It is a violation of the essential rights and health of girls. Although there is some progress in addressing the problem, South Asia is still a major holder of the problem, home to an estimated 40% of the world's child brides (UNFPA, 2023). Unlike neighboring countries, the legal age of marriage age in Nepal is 20 for both men and women, but this age is still not being respected. This is due to the connections of socialism, patriarchal norms, and social hierarchy (Acharya & Karki, 2019; Subedi & Karki, 2021). This appears to hide deep and extreme differences between diverse geographic and social groups (Ministry of Health and Population et al., 2023). Among ethnic and caste limits, remote and hilly areas show the major gaps.

Risks early marriage nearby, especially regarding reproductive health, is important. Adolescent girls are still too young and immature to handle the physical and emotional burdens of pregnancy and childbirth, putting them at great risk of developing life-threatening complications, such as obstetric fistula, hypertension, severe bleeding, and even death (Santhya, 2011; WHO, 2023). Teenage mothers are more likely to give birth to low-weight babies, have preterm children, and contribute to the high rate of neonatal deaths, thus perpetuating the cycle of poor health and socioeconomic disadvantage (Ganchimeg et al., 2014; Raj et al., 2019). Main challenges in maternal health are especially persistent public health worries in Nepal, which still faces 151 maternal deaths per 100,000 live births (MoHP et al., 2023).

Having been in the lower caste for generations, systemic exclusion of the Sarki has left them with very few educational, economic, and healthcare opportunities (Khatri et al., 2022). These challenges pay to the dilemma of Dalit girls who are most vulnerable to early marriage as a means to cope with economic burdens for the upholding of sociocultural traditions (Acharya & Karki, 2019; Subedi & Karki, 2021). This explains, in part, why Dalit women are among the worst off in the country in terms of maternal health and why they are so much less likely to receive antenatal care (ANC), deliver in an institution, and have a skilled attendant at their births (Malqyist et al., 2020). These issues are even more difficult in Salyan and other remote hilly districts, where challenging terrain, weak infrastructure, and a lack of health facilities are combined in ways that inhibit access to the most basic services (Gautam et al., 2021). Even though national surveys give us a general view, research focused on the needs of a community is imperative to learn the lived realities of certain marginalized groups. National-level data is also less likely to capture the magnitude of the problems faced by those communities that are socially and geographically isolated. Hence, this research aims to assess the scale and the reproductive health effects of early marriage on women within the Sarki community on the study site. This research is expected to fill a knowledge gap, given that there are fewer studies focused on geographically isolated, marginalized communities. This will help in the design of community-specific and culturally tailored programs to reach and uplift such communities. Specifically, this research aimed to capture the age at marriage and first childbearing, knowledge and causes of early marriage, utilization of maternal healthcare services, and the self-perceived reproductive health of the women and their children.

Methods and Procedures

This study adopted a rationalist paradigm in mixed-method research (Quan-Qual) to understand early marriage and reproductive health in the study community (Creswell & Plano Clark, 2018). For the multi-level analysis of the determinants of women's health, intersectionality

theory (Crenshaw, 1991) and the Socio-ecological model (Bronfenbrenner, 1979) guided the study. The research was in a remote part of Baghchaur Municipality Ward number 2, Salyan, Nepal, where a considerable Sarki Dalit community resides. For the quantitative section of the study, a census approach was adopted, and thus, all 167 married Sarki women, within the 15 to 45 years' age group, and who had at least one child, were interviewed to eliminate sampling error. For the qualitative part of the research, maximum variation purposive sampling was applied to identify three women who had been recorded in the survey and captured different dimensions of their experiences. The three were interviewed until thematic saturation was attained. For the qualitative part, I used an interview guide of semi-structured in-depth interviews, while for the quantitative part, I used a pre-tested structured questionnaire adapted from the NDHS. Ethics approval was obtained from the Baghchaur municipality. Data were analyzed using SPSS Statistics 26.0 for performing descriptive statistics, bivariate analysis (Chi-square test), and multivariate analysis (binary logistic regression). For qualitative data, thematic analysis (Braun & Clarke, 2006) was utilized in its six-phase process.

Results

This section approaches the findings of the census survey and the qualitative interviews to form a more comprehensive picture of the situation in the community.

Quantitative Findings

The socio-demographic and health situation issues are complicated and valued among all community individuals, and that is all 167 eligible women surveyed. Socio-Demographic Profile and Marriage Characteristics: There is a significant educational and economic disparity in that women and men were largely illiterate, at 55.7% and 59.3%, respectively. Mostly 70.7 percent of women were doing housework as unpaid, which proved to be a testament to a lack of economic independence.

Table 1

Socio-Demographic Characteristics of Respondents (N=167)

Characteristic	n	%
Education of the respondent		
Illiterate	93	55.7
Literate	74	44.3
Occupation of the respondent		
Housework	118	70.7
Wage labor	37	22.1
Agriculture	12	7.2
Education of husband		
Illiterate	99	59.3
Literate	68	40.7

As seen in Table 2, the age at which one had to marry was established at 16. Nearly 49 percent (n=81) were married off at an age earlier than 16. 42.5 percent (n=71) of the women had their first child at an age younger than 15, and childbearing began very soon after marriage.

Table 2
Age of Marriage and of First Pregnancy (N=167)

Variable and Category	*Frequency (n)*	*Percentage (%)*
Age at marriage		
10–12 years	*16*	*9.6*
13–15 years	*65*	*38.9*
16–18 years	*86*	*51.5*
Age at first pregnancy		
< 15 years	*71*	*42.5*
15–19 years	*96*	*57.5*

Table 3 presents some of the reasons why the survey participants entered into early marriages. The most common reason given by 55.7% of participants was 'tradition and parents' choice.' The second most common reason given by 26.9% of respondents was 'social pressure and fear of discrimination.'

Table 3
Perceived Causes of Own Early Marriage (N=167)

Perceived Cause	Frequency (n)	Percentage (%)
Tradition / parental decision	93	55.7
Social pressure/discrimination	45	26.9
Poverty	19	11.4
Love marriage / self-decision	10	6.0
Total	167	100.0

Lack of Use of Health Services and Health Outcomes: Family Planning: There was practically no use of formal maternal health care services (see Table 4). With 44.3% (n=74) of women reporting that they had no antenatal care visits, not much use of institutional delivery was found, as 98.2% (n=164) of the births occurred at home. For postnatal care, 100% (n=167) of women included in the study reported having no formal postnatal check-up.

Table 4
Practices of Maternal Healthcare Utilization (N=167)

Service and Category	Frequency (n)	Percentage (%)
Antenatal care (ANC) visits		
None	74	44.3
1–3 visits	84	50.3
4+ visits (Recommended)	9	5.4
Place of delivery		
At home	164	98.2
Health facility	3	1.8
Postnatal check-up (for mother)		

None	167	100.0

Lack of this type of care is connected to a high burden of self-reported health complications (Table 5). Almost half of the women reported having swelling (47.9%) and suffering from anemia (44.3%) post-delivery. Almost half (47.7%) of infants were reported to be low birth weight, which indicates that these maternal health complications were also linked to adverse outcomes for the newborn.

Table 5

Cases of Health Complications and Newborn

Complication Type and Category	Frequency (n)	Percentage (%)
During pregnancy (N=167)		
Swelling (edema)	80	47.9
Severe abdominal pain	46	27.5
Bleeding	34	20.4
After delivery (N=167)		
Anemia	74	44.3
Prolonged weakness	43	25.7
Newborn health status (n=65)		
Low birth weight	31	47.7
Healthy / Average weight	20	30.8

Use of family planning was also very low (see Table 6). Most of the respondents (70.7%) were not using any modern contraceptives, showing that there was a highly unmet need.

Table 6

Family Planning Practices Surveyed (N-167)

Method Used	Frequency (n)	Percentage (%)
None	118	70.7
Methods used	49	29.3
Oral pills	25	15.0
Depo-Provera (Injectable)	9	5.4
Female sterilization	9	5.4
Other (e.g., natural methods)	6	3.6
Total	167	100.0

The predictors of antenatal care utilization show that Table 7 consists of bivariate analysis, which indicates that there is a very strong relationship between receiving at least one ANC visit and mothers' education ($p < .001$).

Table 7
Mothers' Education/ANC attendance (N=167) Relationship

Health Indicator and Education Level	Received any ANC (≥1 visit)	Did not receive ANC	Total	Chi-square (χ^2)	p-value
Illiterate	37 (39.8%)	56 (60.2%)	93	16.63	< .001*
Literate	56 (75.7%)	18 (24.3%)	74		
Total	93	74	167		

**Statistically significant*

A binary logistic regression was completed to find the most important predictors while controlling for confounding factors (Table 8). The unique confounding predictor was maternal literacy. Literate women were more than 4.6 times attend at least one ANC visit (OR = 4.61, 95% CI: 2.15-9.88, p <.001).

Binary Logistic Regression Analysis Predicting Likelihood of Receiving Any Antenatal Care

Predictor Variable	B	SE	Wald χ^2	df	P	OR	95% CI for OR [Lower, Upper]
Maternal Literacy (Literate)	1.53	0.41	13.82	1	<.001***	4.61	[2.15, 9.88]
Husband's Literacy (Literate)	0.45	0.38	1.39	1	.238	1.57	[0.74, 3.32]
Age at Marriage (≥16 years)	-0.33	0.38	0.75	1	.386	0.72	[0.35, 1.50]

There were 167 total participants (N = 167), and the model explained between 10.3% (Cox & Snell R^2) and 14.2% (Nagelkerke R^2) variance for antenatal care. For the overall model (with df =3) for the time period tested (October 2023), the model explained variance relevance was statistically proven as the chi-square value was 18.25, which was statistically 'really significant' as the value was lower than 0.001. For the referenced groups, was the Maternal Literacy (Illiterate)? Husband's Literacy (Illiterate)? and Age at Marriage (<16 years) was 16 years for each of Ante-Natal Care (ANC) visits. Confidence Interval (CI), odds ratio (OR), and ante-natal care (ANC), meaning the care for mothers before childbirth, was statistically appreciated signified, as *** for p-value < .001.

Qualitative Findings

The interview with the three Sarki women served to include in the grim statistical facts of the survey a descriptive narrative. Thematic analysis revealed the way the disengagement of the community with the formal health system is the consequence of the lived experiences, but not a random decision of the members of the community. The statistical facts were underlined by the normalization of early marriage, which is complicated by geographical and financial limitations, and alienation and mistrust of the health system.

Early Marriage

The traditions that led to marrying young were first disclosed by the women who married young. The narratives of the research participants represented no true-life choice concerning marriages but rather an uncontrollable, culturally narrated life event, with no agency. There were no free decisions while marriages were framed as a duty, sourced respect by their parents, and no agency. Most participants framed the respect towards patriotism of family and community during

community marriages. One respondent (56 years old) explained, “My parents told me it was my time. I didn’t know the boy, but that is not our way. What could I say? A daughter’s job is to listen. It is our way.” Others felt that not getting married by the ages of 15 and 16 would lead to utter disgrace to them and their family. Most respondents had no knowledge of the legal marrying ages and the associated health risks; rather, community norms were marital expectations towards a social pathological order.

Barriers to Care

Not having births in institutions or ANC visits has to do with the combination of poverty and geography. Participants said a trip to the nearest health post took a long time and six hours of walking. Some walked on dangerous paths that were not only difficult but also dangerous and bogged down with mud during the rainy season. Financial difficulty worsened the situation. However, in a participant’s own words, “To walk the four hours to the health post means my husband loses a whole day's wage, and, in the end, we must pay for the medicine. And for what? For them to tell me I am not sick? We need to stay and sell the home." There was a cost involved in terms of lost income, Direct expense of a long trip and its costs, with the costs of rising transport being considered as a luxury not worth the expense. For these women, pregnancy was a normal life event, not a medical condition, and certainly not a situation that required the loss of scarce resources.

System of Distrust and Alienation

Some underestimate people's perception of their own situation, especially with regard to their own doubts about a formal system. Personal accounts uncovered issues because of the way Dalits are treated. Women recounted their feelings of being looked down upon by health workers. Feeling like the health workers were of a reputed class discouraged them from seeking care and made them feel like the health workers were there to control them and were watching them from a distance, and judged them. Preferring the risks of a home birth to the health care workers' condescending attitude discouraged them from seeking home care. A mother of four who never went to a health care facility during any of her pregnancies summed this feeling up very well: “At home, my mother-in-law knows what to do. She cares for me. It feels like we don’t belong. We are not welcome there.”

Discussion

This study brings to light certain community-specific information on the meeting of early marriage, social isolation, and healthcare negligence among the Sarki Dalit women of a remote district in Nepal. Sarki Dalit community women experience early marriages as the rule and are disengaged almost entirely from formal maternity healthcare. This withdrawal causes avoidable negative health consequences. This is only a small example of the scope of failures that national policies have avoided. Policies fail to design programs that meaningfully connect to the most distant communities along social and geographical lines. Early marriage is deeply rooted, even though the legal age of marriage age in a country is 20 years; the median age of women in which they get married is still 16 and almost fifty percent are married before they reach that age. The information we gathered revealed that the traditions and choices of parents are the most dominant ones, particularly those in authority. This echoes much earlier research that has shown the overwhelming influence of socio-cultural norms and the weak hand of the state in remote areas (Subedi & Karki, 2021). Other qualitative data has shed more light on the situation. Participants described marriage as an unavoidable event, driven entirely by parents, showing that national

health legal awareness campaigns about the risks of early marriage have not reached, much less influenced, the community in question.

The research showed that almost no contact was made with the formal maternity care healthcare services at all, and that figure is even more alarming in light of the national and provincial statistics. Looking at institutional deliveries of 1.8% and 44.3% of women not obtaining any antenatal care at all, and taking into account the averages from the 2022 NDHS, these numbers don't come close to the averages published (MoHP et al., 2023). This signifies a disservice in the public health infrastructure for this community. Such is the case with our mixed-methods design: the quantifiable data can represent the magnitude of the problem, and the qualitative interviews can describe the causes of the problem as a powerful combination of geographic inaccessibility (supply-side barrier), a deep mistrust in the health system, and financial hardships (demand-side barriers). While congruent with the barriers to healthcare in rural Nepal literature, this sheds light on the unique intensity with which these factors combine in a specific Dalit community (K.C. et al., 2022).

Maternal literacy was identified as the most singular and powerful factor from our regression analyses in determining whether the mother would utilize care or not, with literate women being 4.6 times more likely to attend at least one ANC visit ($p < .001$). This demonstrates the game-changing effect even minimal education can have in empowering women, most likely increasing their health literacy, autonomy, and their capacity to breach the complex barriers to obtaining care. Research indicates the connection between female schooling and better maternal health outcomes is strong/immutable/adaptable, while educational initiatives suggest the first step, health-seeking behaviors, to change. (Raj et al., 2019) The most negative outcomes from the lack of this care are easy to predict. Low weight of the newborns and the lack of control over the pregnant women in terms of under-nourishment and closely spaced pregnancies is a continued issue in poor, intergenerational health (Raj et al., 2019). Malnourished adolescent mothers create a weak infant, a disadvantage at birth, and death. The almost non-existent modern contraception uptake (29.3%) and lack of postnatal care point to a failure in all of reproductive health care. Women are exposed to illicit pregnancies and postpartum complications, which have long been ignored (Thapa et al., 2020).

Conclusion

Evidence indicates that early marriages (mean age being 16) are the direct cause of inadequate reproductive health among Sarki Dalit women in Nepal's remote areas, with 98% of all births at home and 44% of all births lacking prenatal care, and an almost complete lack of attachment to formal maternal healthcare. This distance is explainable due to the barriers that are logistical, geographic, and financial in nature, but it is also a result of mistrust in the health system that is rooted in caste. Its effects are maternal anemia and low birth weights, high rates, and the cyclic disadvantage of the generations. Maternal literacy is the most predictive of healthcare seeking, and the most effective intervention is female education, which can positively affect other variables in the system. This strategy will be able to disrupt the intergenerational disadvantage cycle and help to address the vulnerable points of the group that are unique and multifactorial

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