Child Marriage and Maternal Health Risks among Young Mothers in Gombi, Adamawa State, Nigeria: Implications for Mortality, Entitlements and Freedoms.

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Abstract

Efforts towards the liberation of the girl-child from the shackles of early marriage have continued to be resisted with tradition, culture and religion in parts of Nigeria. This study examines the maternal health implications of early marriage on young mothers in Gombi, using data obtained from 200 young mothers aged 15-24years. The study reveals that more than 60% had only primary education, 50% had been married for between 5-9years and more than 70% had experienced complications before or after childbirth. Age at first marriage, current age, level of education and household decision-making influence maternal health risks in the study area. Entitlements and freedoms that are highly relevant to reduction of maternal mortality, provided by international treaties are inaccessible to young women in the study area. Strategies to end child marriage in the study area should include mass and compulsory education of girls, provision of other options to early marriage and childbearing and involvement of fathers in preventing and ending the practice.

Key Concepts: Child Marriage, Maternal Health, Mortality, Entitlements

Introduction and Background

Child marriage, referring to a marriage of a young person less than 18 years is still widely practiced in many parts of the world but remains prevalent in countries of Africa, Latin America and the Caribbean as well as Southern Asia and predominantly affects girls. It is estimated that, if nothing changes, a 100 million young girls aged 15 years or less will be married within the present decade (ICRW 2007). Regional estimates of its occurrence for girls include 48% in Southern Asia, 42% in Africa and 29% in Latin America and the Caribbean (UNICEF, 2005; Nour, 2006) with wide differentials across the countries. In the West African sub-region, the proportions of girls affected vary from 28% - 43% (Ghana, Togo, Cote d'Ivoire, Senegal, Benin, Nigeria) to 60-80% (Burkina Faso, Guinea, Mali, Chad and Niger).

In Nigeria, the practice of child marriage is deeply entrenched in tradition, culture and religion and the country has one of the highest rates of child marriage in the world, with estimated 42% of girls married before 18 years; and while this is found among many ethnic groups across the country, its predominance is clearly in the northern part of the country (Population Council, 2005). While nationwide, 20% of girls are married by age 15 and 40% are married by age 18, child marriage is extremely prevalent in some regions such as among the predominantly Muslim Hausa-Fulani of the Northwest and North-East (of which Gombi is a part) where 48% of girls are married by age 15, and 78% are married by age 18 (Bamgbose, 2002; Nigeria, 2004; Population Council, 2005). While average age at first marriage is 17 years nationwide, average age of

marriage for girls is just over 11 years in Kebbi State and about15 years in most other parts of northern Nigeria. Among the Yorubas, made up of a mixture of Christians and Muslims in the South-West, child-marriages are no longer arranged and for the Igbo in the South-East that are predominantly Christians, the practice has declined considerably and restricted to few communities (Akpan, 2003), Nigeria, 2004) and situations where pregnant teenagers are forcefully married off, to prevent family shame or restore honour (IRBC, 2006). Child marriages are often arranged in two distinct ways, within a context of force and coercion, either by parents or other persons in positions of authority in the family arranging their young daughter's marriage to an adult, often a much older man or arranging the future marriage of two children. It is not uncommon to find girls of 7 -14 years already married off with the girls sent off to live with the families of the husbands. Generally, prospective husbands are selected based on social, religious and monetary factors and age is not considered an important factor, as husbands are on the average 12 years older than the child brides in monogamous unions and up to 15-20 years older in polygynous unions (Population Council, 2005) and in isolated cases, may be several decades older (UNICEF, 2005).

Occurrence and Perpetuation

The reasons for child marriage are based on a mix of cultural, social, economic and religious factors**.** Poverty is observed to be at the core of decisions and practices related to early marriage, more in low-income societies than in their high-income counterparts, as they lack resources to support healthy alternatives for girls, such as prolonged schooling and skill acquisition to secure their future. The girls in turn have higher chances of being poor and remaining poor and of facing serious social and health consequences inimical to their personal growth and development. Bunch (2005) makes it clear that the widespread practice of child marriage makes it increasingly difficult for families to escape poverty in the developing world, thereby undermining critical international efforts to fight poverty, HIV/AIDS and other development challenges, and making huge investments in development assistance less effective. It is therefore very costly in terms of the consequences for these societies.

Child marriage is predominantly practiced in the rural and poor communities where young girls are regarded as economic burden and quickly married off to alleviate household expenses. Oftentimes, in these communities, educational and economic opportunities available to girls are few and they are often married off quickly to protect them and the economic wellbeing of the family.

The continuing economic hardship in many developing countries is encouraging a rise in early and child-marriage, even among populations that do not normally practice it, as child marriage is often regarded as a family-building strategy, an economic strategy and the resulting transaction important for the financial and social survival of the child and her family. Where poverty is acute, also, parents may regard young girls as economic burden and their marriage to much older rich men becomes very attractive and beneficial to the girl and her family. A daughter may be treated as a commodity that the family has to be traded and sometimes girls are used as currency to settle debts or stabilize relationships between families (Forward, 2008).
In many parts of Africa, Nigeria inclusive, the bride price or wealth, paid in exchange for the bride's labour and fertility is an important resource for greater wealth and survival of the family and therefore may induce early arrangements of marriage by parents (Lloyd, 2005). Existing notions of morality and honour are important influences on decisions of parents to marry off

daughters very early to ensure that a girl's virginity is preserved at marriage, as culturally expected in order to purchase the highly valued virtue for the girl and honour for her family. In the absence of viable options, early marriage is seen as a way of protecting girls from unwanted pregnancies. When such marriages are to older men, they are also considered as necessary guardians against possible immoral and inappropriate behavior on the part of the young wives.

Some religious practices, such as Islam encourage early marriage and parents imbibe this for fear of their daughters being pregnant out of wedlock and the only available option could be marriage at an early age (Giyan, 2009). Early marriage has been defended in Nigeria as clearly permissible by the Islamic religion, but with the cautionary measure that such marriages can only be consummated when the bride is mature enough (Bamgbose, 2002). However, these decisions are often made without the consent of the child and with no recourse to the consequences of the actions.

The clarion call for the liberation of the girl- child from the shackles of early marriage and her attendant relegation to a vulnerable position has continued to be resisted with traditional customs and religious beliefs, despite the United Nations declarations (UNICEF, 2001) on the fundamental human rights of the girl-child. Child marriage is regarded as a global problem that undermines global development efforts towards achieving more educated, healthier and stable populations as it often involves discontinuance of education, early severance of family ties, separation of the child-bride from her peers, domestic violence, early sexual activity and child bearing associated with health complications. Significantly, the practice has received universal condemnation and has been identified as contributing greatly to the slow pace of achieving the Millennium Development Goals (MDGs) (eradicating extreme poverty and hunger, achieving universal primarily education, promoting gender equality and empowering women, reducing child mortality, improving maternal health and combating HIV/AIDS, cervical cancer, sexually transmitted diseases, VVF, malaria and other diseases) in many countries.

Consequences and Risks

The direct physical and health consequences of child marriage have been well articulated in literature (UNFPA, 2005;UNICEF 2005; Giyan, 2009; Lloyd, 2005). Child-brides are often likely to be forced into sexual activities and commence child bearing early, and are at higher risks of complications arising from these such as heavy bleeding, fistula, infections, anaemia, eclampsia, obstructed labour and obstetric fistula, all due to the physical and sexual immaturity.

World Health Organization (2006) revealed that the risk of death following pregnancy is twice as high for women between 15 and 19 years than those between the ages 20 and 24years. The mortality rate can be up to five times higher for married girls aged between 10 and 14 than for women of at least 20years. They are more susceptible to anemia than adults and this greatly increases the risk and complications linked to pregnancy, especially with the added pressure to prove their fertility in the first year of marriage. Available evidences show that infant mortality among children of very young mothers is higher, sometimes two times higher than among those of their older peers (UNICEF 2001). Girls between the ages of 10 and 14 years are 5 to 7 times more likely to die in childbirth and girls between the ages of 15 and 19 years are twice as likely. High death rates are secondary to eclampsia, postpartum hemorrhage, sepsis, HIV infection, malaria, and obstructed labor, conditions that are all closely associated with early childbearing (Nour , 2009). Advocates of safe motherhood have therefore turned attention to the issue of child marriage, emphasizing that pregnancies that occur 'too early' when a girl's body is not fully

mature and may constitute a major risk to the immediate survival and future health of both mother and child. Young brides often lack the freedom of movement and voice for negotiation for access to healthcare (prenatal, antenatal and postnatal care) needed to avoid childbirth complications, sometimes due to distance, costs and barriers created by spouses and in-laws.

The risks associated with marriages to older husbands are many and include increased vulnerability to HIV/AIDS and other sexually transmitted infections from older husbands who might have contacted these from previous sex partners, inability to negotiate sexual decisions and use of contraception and condoms for protection and helpless submission to a prevailing atmosphere of double sexual morality in favour of men. The link between Female Genital Mutilation (FGM) and child marriage has been highlighted as the two are more often than not likely to be found together and FGM may in fact be a requirement for marriage.

Girls who marry early are deprived of the opportunity for personal development, balanced wellbeing, participation in civic life and their reproductive health rights are infringed upon. Young married girls are robbed of their youth and are required to take on roles for which they are not psychologically or physically prepared. Overall, they are characterized by low level of education, poor health, lack of agency and personal autonomy. While girls in many developing countries are generally less likely to enroll in schools, traditional prescription of early marriage for them further discourages parents from investing in their education, leaving the girls, at marriage, without adequate knowledge about sexual relationships, their bodies, reproduction, contraception, family planning and confining them within the walls of cultural silence on the issues.
Girls who marry early are more likely to experience abuse and violence than others, with inevitable psychological as well as physical consequences. Studies indicate that women who marry at young ages are more likely to believe the justification for wife battering as a corrective measure and therefore acceptable for a husband to do so and are therefore more likely to experience and accept domestic violence themselves (Jenson and Thornton, 2003;ICRW,2008).Child marriage for girls often means a confinement to a helpless lifetime of domestic and sexual subservience.

Not well equipped for the union and poor, the age difference between the girl-bride with low economic status and her husband often makes it almost impossible for her to negotiate safe sex. The very young wives often lack adequate information on critical sexual relations, contraception, sexually transmitted diseases, pregnancy and childbirth. Clark (2004) in his study of Kenya revealed that the increase in the numbers of young females infected with HIV has led some policy makers and researchers to conclude that large age differences in sexual partners leave adolescent girls at particular risk of infection. Clark (2004) in his study in Kenya observed that 30 percent of male partners of married adolescent girls were infected with HIV, while only 11.5 percent of the partners of unmarried girls were HIV-positive.

The psycho-social requirements of marriage (family and wife-mates politics and diplomacy) are often beyond child brides who are largely unprepared for their roles in complex family settings. Young brides are more often than not subjected to forms of abuse such as psychological trauma, domestic violence, forced sexual acts, marital rape by the husband and in-laws and subjected to domestic slavery, given her position as the young wife. Evidences of the links of early marriage

with divorce, abandonment, separation, widowhood and denial of property rights abound in contemporary literature (UNICEF, 2001).

Nigeria is credited as the country with the second highest maternal mortality ratio in the world with an estimated 1000 for every 100,000 births, only after India (UNFPA, 2004; COMPASS, 2006). Significantly, the North East region of which Gombi, the study area is a part, accounts for about 75% of the country's maternal mortality. Within this region, the most common causes of maternal mortality is the pregnancy-related, life-threatening conditions of eclampsia, obstructed births, malaria, Female Genital Mutilation, hemorrhaging, and unsafe childbirth practices due to the large majority of women that deliver their babies at home (Zozulya, 2011) .

The social, psychological, health and developmental challenges posed by child marriage for the girl-child are many and are being addressed globally. However, regional and local variations in its occurrence necessitate the adaptation of global strategies as well as the development of local initiatives to address it. In addition, focus on adolescent sexuality within marriage by researchers is limited. To do this however, needed policy and programmatic actions must be based on a deep understanding of the real issues in every community where it child marriage is practiced. There is therefore a need to continue to research into it in communities that practice it. Underserved communities such as Gombi and others in North-East Nigeria with staggering statistics of a Total Fertility Rate of 7.2, median age at first marriage of 15 years, median age at first birth of 18.2 among women aged 20-49 and one of the highest levels of experience of Fistula in the world need to be studied to provide sufficient information needed to stimulate action against the practice. This study examines child marriage and maternal health risks in the study area, as well as its implications for mortality from a rights –based approach, through a small-scale study, in order to identify the real issues involved in the study area.

Challenges by the Nigerian Constitution and Human Rights Laws

Child marriage is widely and globally regarded as a surviving form of social discrimination and is challenged by the Nigerian constitution and several human rights laws. In the last Century, particularly, intense global opposition to child marriage has deepened and the concerns are expressed in various conventions and charters.

Under the Nigerian Law, the concept of the child is based exclusively on calendar age. The legal age at marriage is 21 years and anyone under this age is considered a minor and would require a parental consent before legally entering into a marriage in the country ((Effah, 1996). The rights of the girl-child in Nigeria are protected by a legal framework, including national laws and international and regional conventions which the country has ratified. The relevant International Human Rights Instruments and Child Marriage include the Universal Declaration of Human Rights (UDHR), 1948, the Convention on Consent to Marriage, Minimum Age for Marriage and Registration of Marriages, 1964, African Charter on the Rights and Welfare of the Child, 1990, and the Convention on the Rights of the Child. Others are the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW) and the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. All these are relevant to the issue of child marriage, emphasizing the issue of protection for the child against physical and mental violence, sexual and psychological abuse, maltreatment and exploitation by parents, guardians and members of the family. The instruments also emphasise the right to health, access to health care services and protection from harmful traditional practices. Of particular significance is the

Convention on the Rights of the Child that focuses strongly on several survival-related issues underscored by the practice of child marriage such as the right to education, protection from physical, psychological and mental violence, including sexual abuse, rape and exploitation. It also emphasizes, for the child, the right to the highest attainable standard of health, rest and leisure, employment and the right to be protected from separation from parents and peers.

Utilizing the human rights approach to achieve the Millenium Development Goal of reducing maternal mortality by 2015 has in the last decade provided new strategies for addressing child marriage. The rights to health in the context of maternal mortality emphasizes entitlements to goods and services such as reproductive healthcare, information and a breakdown of social, political, economic and cultural barriers that women face in accessing the interventions that can prevent maternal mortality. It is in this context that child marriage is strongly connected to other associated rights such as the rights to life and education that are important for addressing the issue of child marriage.

The persistence of the practice of child marriage has been linked to lack of sufficient political will to engage the problem. In many countries, and despite the ratification of the international treaties and agreements, existing laws against child marriage are not enforced or upheld and sanctions are either not clearly spelt out or enforced at all (Innocenti Digest, 2001). However, it is evident that the key national and international instruments that challenge child marriage focus on age, consent, equality within marriage, personal and property rights of women.

Data and Methods

The study was conducted in Gombi LGA in Adamawa State of Nigeria comprising of the following villages: Garkida, Guyaku, Balwhona, Wushipra, Gaanda, Lala, Bokki, Tsakuwa, Gudawi, Gombi, Ladiel, Fadchi, Kwallamba, Misamba and Ferwumarah. The unique characteristics of these villages include common language, religious beliefs and cultural practices which make the LGA homogeneous in nature.

Qualitative and quantitative methods were used for data gathering. For quantitative data, the Questionnaire Method was used while Focus Group Discussion (FGD) and In-depth interview methods were used for the collection of qualitative data.

Stratified sampling technique was employed to select the sample for the study. The study area was stratified with the listing of the villages and ten of the enlisted villages were randomly selected. From the selected villages, 20 houses were randomly selected using the National Population Commission (NPC) house numbering. From the selected houses young women aged 15-24 years who married before age 16 years and have had at least one child were interviewed using the specially designed questionnaire. In all 200 questionnaires were correctly filled and analyzed for the study. The information collected covered the socio-demographic characteristics, reproductive health issues, child bearing, sexual behaviour and the risks of early marriage and childbearing. Six (6) Focus Group Discussions were held to elicit information on traditional expectations regarding sexuality, impact of early marriage on well-being and consequences of early marriage. The FGDs were conducted by four trained research assistants from the localities. In-depth interviews were also conducted among the stakeholders (health workers, community leaders, religious leaders, market women and traditional health workers) in the study area.

Returned questionnaires were subjected to thorough screening for consistency and thereafter edited. The pre-coded nature of the questionnaire facilitated easy entry of the data and statistical analysis. The data were subjected to basic demographic analytical techniques using a combination of univariate, bivariate, and multivariate (logistic regression) analyses. Information collected were transcribed and organized under broad headings that depict different aspects of the discussions. The transcribed information were analyzed descriptively and utilized to highlight the relevant areas of the study.

Findings

Socio-Demographic Characteristics

Majority of the respondents ((72.5%) were in the 20-24yrs age cohort and had little exposure to formal education as 60% had attended a primary school while 30% had opportunities to attend and complete secondary school education. All the respondents were young mothers who married early at various ages before 16 years of age and had been married less than 5years (45.0%), 5-9 years (50.0%) and few (5.0%) for more than 10 years. Some of the respondents were engaged in farming (41%), trading (15.5%), salaried workers in the local administrative offices while about one in every three (35.0%) was a full-time housewife. They were more Muslims (59.0%) than Christians (41.0%). Estimated incomes of respondents reveal that more than half (55.0%) earned less than N15, 000.00 ($100) per month, about a third (35%) earned between N20, 000.00-N40, 000.00 ($250) per month while 20% of the respondents earned more than this per month (Table 1). The respondents were therefore young mothers characterized by little education, largely informal sector engagement, low income, early marriage and rural residences.

Family and Marriage

Transition from childhood to adulthood without distinct period of adolescence characterizes the lives of young women in the study area. Early marriage, followed closely by childbearing is generally perceived as the norm for girls in the study area, even among those that had some formal education. Information from FGDs reveal that culture, tradition and religion play very important roles in the lives of the people and decisions on marriage are primarily the responsibilities of fathers who rely on religious leaders and community elders for guidance. Early marriage for girls was still generally favored to protect the girl-child and chart a good future for her. Religious prescriptions were cited by male participants in the FGDs but there was a general agreement by female participants that poverty plays a major role in decisions to marry off girls early, particularly when they are withdrawn from schools for marriage, sometimes with the hope that they may continue after marriage and sponsored by the husband. This was corroborated by the quantitative data on the factors influencing the timing of marriage in the area, 47% of the respondents agreed that poverty was the major factor influencing child marriage in the area, while 21.5% and 12.5% respectively mentioned culture and religion. Gombi and surrounding communities are largely rural and there were expressions of anxiety over the spread of certain values from the nearby urban areas which may lead to the breakdown of long-held family and community values, the need to prevent prostitution, unwanted teenage pregnancies, childlessness and other unwholesome western values that allow what is considered unnecessary freedom for young girls. Majority (87%) of the respondents expressed the wish to experience schooling beyond the level they presently were and their admiration for well-educated women, in terms of appearance, confidence and material possession. The FGDs revealed that many of the respondents dropped out of school because the schools were far from home and there were fears of sexual harassment as they were growing up.

Religious leader in Lala:

A girl must be in her husband's house before or at puberty. This is why parents give their young girls' hands in marriage at their younger ages. Education is good for girls but they must be properly married----------if a good marriage arrangement that favours the girl and the family comes up, it is good for the girl to leave school and marry first, then continue later if the husband permits------"

Community elder, Wushipra:

"*The main reason why parents allow their daughters to marry very early is to avoid shame; they try to avoid promiscuity which may lead to unwanted pregnancy. They prefer early marriage to our young girls becoming prostitutes. Our culture does not permit misbehavior by girls, even boys must marry early to be responsible. It is the duty of a girls's father to marry her of appropriately".*

A 20 year old mother, Musamba

"I believe it is poverty that makes parents give out their young girls in marriage. There are some of my mates who are still in school. Those parents who could afford to send their children to higher institutions are not involved in this act. It is not religion but poverty as many girls would like to attend school but it is important to listen to the family."

Decision-Making

Decision –making on the choice and timing of marriage is the exclusive preserve of fathers in the study area as revealed by 79% of the respondents (Table 2) and more often than not, husbands arranged for young girls are older men within the society who can afford the bride price and other items demanded by the bride's parents. Polygyny is expected and respected, but monogamy is highly valued by majority of the women. On the women's economic status, 78% of the respondents depend on their husbands for all (Table 2) their daily needs and that of their children, even when involved in some employment, trade or farming.

The status of women in the study area is revealed in the generally low educational attainment, low income and the pattern of family and fertility decision-making that is highly patriarchal. Majority (82%) responded that husbands were the sole decision makers on issues of fertility and family size and use of contraception (Table 2). This is evident in the overwhelming 82.5% of the respondents that reported that husbands determined the decision to register for and timing of ante-natal care, as well as particular health facility to use, which may be heavily dependent on affordability. Since husbands were the main providers in the households, wives were generally very submissive as culturally expected. However, first and older wives were given some leverage on issues related to household purchases and some family matters. This was corroborated by the FGDs in which participants revealed that fertility decisions taken by husbands were sometimes injurious to the health and wellbeing of the wives and cited decisions to have another child to ensure a male child or more male children.

A 24 year old, *Gombi*

Since we depend on our husbands for the daily needs and they are the ones that can determine the number of children. If I have the resources (e.g. land) and I make a lot of money from it, I can say I want this number of children or this is the hospital I want to use. They are the ones that own the land and the crops, we are just assisting them to support our family.

A trader (18 years), Fadchi

It is our religion that allows husbands or the heads of the family to be the one to decide on the number of children. Even if the wife desires more children and the husband says no there is nothing she can do. Likewise if the husbands desire more children the wife can't say no to him. *Male children are favoured in our culture---*

A housewife, Guyaku:

It is not the fault of women not to go to the hospital, their husbands must approve of it because you can't take the decision on your own.

Only 25% of the respondents ever discussed the need for family planning and use of contraceptives with their husbands. Spousal communication on the use of contraceptives as previously revealed (NDHS, 2008) is therefore still very low. The data also revealed that spousal communication on fertility issues is very low as a result of the wide age differences between the young mothers and their husbands and this is likely to be associated with the capacity for interpersonal interactions that facilitate or impede sexual protective behavior (Frank, 1983). The FGDs revealed a general lack of confidence by respondents in articulating the issues around reproductive health issues and associated with childbearing.

Maternal Health Risks

The data revealed that respondents commenced childbearing between 14 and 18 years of age and 71% had experienced at least one serious pregnancy or birth-related health problem which include excessive bleeding during labour (19.0%), obstructed and/or prolonged labour (49.0%), frequent miscarriages (12.0%) and prolonged sickness after childbirth (20%) as shown in Table 3. In addition to these, of those that had experienced various health complications, 37 (26%) had been exposed to the risk of vesico-vagina and recto-vigina fistula and were at various stages of treatment. This and discussions in the FGDs revealed that maternal morbidity is very high among the young mothers. In-depth interviews conducted with healthcare personnel in the localities revealed that early commencement of childbearing is a problem in the study area. The uptake of opportunities for ante natal and post natal care was reportedly low among women due to distance from the facilities, cost, husband's attitude and ignorance. Birth-spacing is not deliberately practiced and contraceptive use is almost non-existent. While there were no locally collated figures, health personnel also confirmed a high and increasing frequency of maternal deaths involving young mothers, in and outside health facilities in the study area due to the various risks that they are exposed to. These evidences support previous evidences of very high maternal mortality characteristic of the North-East region of the country of which the study area is a part (COMPASS, 2006) and the well documented fact that pregnancy-related deaths are the leading cause of morbidity and mortality among 15-19 years-old girls (married and unmarried) worldwide (UNICEF Innocenti Research Centre,2001;COMPASS 2006).

A nurse, Gombi:

"Most of the cases we witness in the health facilities are prolonged labour, VVF and excessive bleeding. Some of these women are too young for childbearing but because of our culture and religion there is nothing we can do, we are educating them still we still have new cases every day. Sexually Transmitted Infections are very common around here but many are treated at the local chemists and herbal clinics rather than in the hospitals because of shame. We know that the most important issue is the immaturity of their bodies---that is the risk".

A civil servant, Gombi

"It is prolonged and obstructed labour that is more common in this area, with excessive bleeding. It has led to loss of many girls in our community. Some of these women are not well informed about the pregnancy complications. Some of them will not attend anti-natal clinic. They are too young and not yet ripe for childbearing but are married and expected to have children. They are also children"

A full housewife, Misamba:

Miscarriage and excessive bleeding are very common pregnancy complications in our community. Also prolonged labour mainly because pregnant women do not register early for ante natal care because the young ones don't have money they don't know when its appropriate to do so.

A nurse/midwife, Balwhona:

"We are used to complications in this health facilities, this was common among young girls, who married before age 18 years. Some of them will not come to the health facilities for anti-natal until it has resulted to complications – sometimes it might result to death. We have witnessed several deaths of young girls that are wives and too young to safely deliver their children"

A medical doctor, Gombi:

Majority of the complications we have handled were as a result of early marriage and their negligence of not attending anti-natal for proper medical advice. VVF cases are also common in this area, but we are trying our best to educate them.

The occurrence of Sexually Transmitted Infections (STI) is also very high in the sample, with 62.5% that reported ever to have contacted at least one type of STI. Treatment of STIs were more often than not outside government hospitals and clinics (77.5%) such as herbal homes, local chemists and pharmacies and private clinics and as pointed out in the FGDs, the treatments were not often followed up to completion. This is in agreement with an earlier study (Adeyemi, 2011) that revealed that women with sexually transmitted infections are more likely to be asymptomatic and therefore less likely to seek appropriate treatment in appropriate places. However, the consequences of undetected and untreated STIs are devastating and include increased vulnerability to HIV infections, infertility, ectopic pregnancy, miscarriages, social stigma and premature death. Only 28% of the respondents claimed to have good knowledge of HIV/AIDS but revealed in the FGDs that they mostly lack the will to negotiate safe sex with husbands whose HIV statuses were unknown to them. Majority of respondents were in polygynous unions, a situation that may potentially increase their exposure to the risks of STIs and HIV, within the context of their inability to exercise any control over the network of sexual practices due to the prevailing socio-cultural conditions and polygyny.

The sample of young early-married mothers was analysed for differentials in experiences of pregnancy-related complications across categories as shown in Table 5. Religious affiliation had minimal impact on the occurrence of pregnancy complications as slightly more Muslims (72%) than Christians (69%) had experienced complications. However, the FGDs and in-depth interviews with religious and community leaders revealed that early marriage of before 18 years is the norm in the study area but child marriages are conducted mostly among Muslims because the religion permits it, with caution. The experience of serious pregnancy-related complications decrease with increasing exposure to educational opportunities with more respondents with primary level (completed, 67.8%; not completed, 78.0%) education reporting complications, compared to those with secondary (61.6%) and post secondary (50%) levels of education. Similarly, respondents' husbands' level of education was found to be associated. Of the respondents that had experienced complications, more husbands had no formal education (84%) or primary level education, (68%) compared with those that had secondary (67.0%) and post secondary (50.0%) levels. The data (Table 5) also show that pregnancy–related complications were reported more among respondents aged 15-19 years (75%), low income (less N20,000.00 per month), full housewives ((79.0%) and farmers (62.0%) than among those aged 20-24 years (69.6%), high income (N40,000.00 + per month), traders (35.0%) and civil servants in salaried employment (29.0%). Significantly, experiences of pregnancy-related complications increase with increasing number of children of the respondents from one (54%) to at least four children (78%) in the study area. The data therefore reveal that level of education of respondents and their husbands, income of respondents, age of respondents, number of children ever born and to a lesser extent, religion influence exposure to maternal health risks of young mothers that married very early in the study area.

The outcome of logistic regression (Table 6) of selected variables and Ever Had Pregnancy Complications further corroborated the findings and revealed that respondents aged 15-19 years are 1.234 times more likely to experience pregnancy complications than those aged 20-24 years. With the level of education of the respondents, those with primary education (completed and non-completed) are 4.359 and 2.086 respectively more likely to experience complications than those in other categories. This is probably because those with little education before marriage may be unable or poorly equipped to take appropriate reproductive health decisions that are important in reducing pregnancy-related complications. Low empowerment, indicated by low income and low decision–making power is significantly associated with the likelihood of experiencing pregnancy complications in the study area as those with low empowerment are 4.2 times more likely to experience complications when compared with other categories. Number of children is also another significant factor identified in the analysis, it was revealed that ever-experienced complications may likely increase with the number of children. This is an interesting finding in this study, particularly with low contraceptive use.

Maternal Health-Seeking Behaviour

Place of delivery is one of the factors that influence maternal deaths and 28% of the respondents delivered their last baby at home while 23% delivered at the homes of Traditional Birth Attendant. Ogunlesi (2005) in her study of utilization of delivery services in Ilesa, Nigeria observed that high stillbirth and early neonatal mortality rate have been long associated with unattended deliveries compared with hospital-based deliveries. While various factors can influence the use of health facilities by women even when they know they are at risk, Esimai, Ojo and Fasubaa (2002) explained that the prominent reasons given for non-utilization of health facilities were time of occurrence of labour, difficulty with transportation, fear of surgical operation, husband/family influence and availability of alternative delivery assistance by TBA's and relatives. From the survey 33% of the respondents

indicated that the health facilities were far, more than 5kms from their homes and this may be one of the reasons for none use of the health facility. The distance to health facility can deny these married women of the use of the service even if the services provided are affordable. Stock (1987) found out that in Nigeria at a distance of 5 kilometers from a dispensary, per capital utilization fell to less than one-third of the 0-km rate and a related study in India showed that the proportion of a community attending a dispensary decreased by 50% for every additional half-mile between the community and the facility (Bunor, 2004). Respondents expressed confidence in nurses, midwives and Traditional Birth Attendants and preference for facilities that have many of them. The type of health personnel available at different facilities for delivery also influences the decision to use the facilities in the study area. Nurse/mid-wives and Traditional Birth Attendants were preferred (Table 4). Delay in seeking medical treatment is one of the factors mentioned among the FGDs participants as a cause of maternal death and complications in the study area. This may be as a result of the revelation that decision –making regarding medical treatment is the responsibility of husbands and only 17.5% of the respondents reported their ability to decide on their medical treatment. Since this involves money and majority of the respondents had limited means of livelihood, the ability to take decisions related to their health is limited.

A Medical personnel, Gombi

'We don't have enough hands in this hospital but most of these women, particularly the young ones will not report at the health facilities on time until their cases are getting out of hands. With no history of the pregnancies, delays are caused in diagnosis prior to treatment---Also many women are referred to this facility from surrounding villages and sometimes they are very young for childbearing and have not been to any facility for ante-natal care so it could be too late to save them and the babies"

Advancing Local Agenda in Gombi: Child Marriage and Maternal Mortality in the Context of Entitlements and Freedoms

Child marriage in Gombi can be described as a gross human rights violation that puts young girls at risk and keeps them in perpetual poverty**.** The practice is still widespread and is directly and strongly linked to maternal morbidity and maternal mortality characteristic of the entire North – East zone of the country. It thrives within the context of cultural and religious prescriptions and poverty; and is sustained within the context of very weak protection of the fundamental human and child rights in Nigeria. Girls in this locality therefore face significant cultural and social barriers to living wholesome and healthy lives that are often strengthened by religious prescriptions on marriage. These include the facts that their marriages were arranged without their consent, the opportunities for schooling were either disrupted or not utilized at all, they were made to commence sexual relations and subsequent childbearing early, they were exposed fully to various reproductive health risks as shown in this study. They were in various ways exposed to psychological experiences obtainable only within such settings and they had very low voice in family, fertility and reproductive health decision-making.

Increasing recognition that reducing maternal mortality is not just an issue of development but also an issue of human rights has recently become widespread. This is because preventable maternal mortality occurs where there is a failure to give effects to the rights of women to health and equality and where there are evidences of the violation of women's right to life. The close relationship between maternal mortality and the right to the highest attainable standard of health has been recognized in several international human rights treaties and adjudged to include entitlements to goods and services such as sexual and reproductive health care and information.

More significantly for this study, it is also recognized to include a necessary breakdown of cultural, social, political, economic and other barriers that women face in accessing interventions that may prevent maternal mortality.

Poverty has also been shown to be at the core of the way young girls are regarded as economic burden and quickly married off to alleviate household expenses in the study area. In these communities, educational and economic opportunities available to girls are few and girls are often quickly married off to protect them as well as improve the economic well- being of the family. Considerations for family honour also put pressure on families to marry off young daughters, to avoid embarrassment and shame that may come with loss of virginity and unwanted pregnancies as they grow up. Early marriage invariably confines young girls to a life of poverty, in a cycle that is often difficult to break and significantly deprive them of freedom and entitlements to life.

The notion of good reproductive health encompasses all aspects of the reproduction process including the right to engage in sexual relations and to decide when to have children and these are the rights not accessible to the young women in the study area. Reducing maternal morbidity by reducing complications arising from child bearing at young ages therefore would impact directly on maternal mortality but this may be difficult in the context of early marriage.

Behind the practice of child marriage is a failure to guarantee child and young people's rights, manifested by denial of education, low status, deep poverty and restricted mobility. While the Nigerian Child is supposed to be protected by a well articulated legal framework earlier outlined in this paper, it is evident that in practice this is not so and there is a need to engage social and cultural norms surrounding the practice of child marriage.

The issues of legal sanctions are desirable but complicated as the laws of the country exist alongside customary and religious laws on marriage. Country laws are also not applicable to customary marriages. Within the context of poor registration of marriage and failure to apply recommended sanctions to law breakers (parents, spouses, officials etc), child brides are generally left unprotected. It is for these that in Nigeria, inconsistencies exist between the legal minimum age at marriage, which is 21 years and actual practice, as marriages of children as young as 7 to 10 years were reported in the FGDs conducted in few communities in the study area.

Conclusion

Initial concerns about child marriage centred on its contributions to rapid population growth, as early childbearing, in the absence of contraception results in large family sizes. However, in the latter part of the 20th Century, advocates of safe motherhood and adolescent health turned attention to child marriage, emphasizing the vulnerability of young girls to HIV/AIDS, STIs and other serious health issues. Beyond this, however, and more recently, attention has further shifted to the need for widespread education for girls and its benefits, a situation that necessitated greater focus on child marriage and the exclusion of girls from schools within a rights-based approach. In the context of widespread HIV/AIDS, very high maternal mortality and growing sexual violence against girls within permissive traditional practices, the demographic and health implications of early marriage as practised in Gombi are grave for Nigeria.

This study has identified the negative impact of early marriage on young women in Gombi, expressed in form of high maternal morbidity through various pregnancy complications in the study area. Earlier

findings (UNFPA 2004) that child brides are likely to commence childbearing early and the strong correlation between the age of mother and maternal morbidity are supported in this study. With this, it is clear that the practice of child marriage in the study area and in other parts of Nigeria is directly impeding the ability of the country to achieve six (6) of the Millenium Development Goals, which are those of eradicating extreme poverty and hunger, achieving Universal Primary Education, promoting gender equality and empowering women, reducing child mortality, improving maternal mortality and combating HIV/AIDS, cervical cancer, sexually transmitted diseases, VVF, malaria and other communicable diseases by 2015.

Progress in health and gender matters towards the achievement of MDGs has been scored low in Nigeria. Strategic interventions planned for gender issues, infant and maternal health, HIV/AIDs, malaria, tuberculosis and primary health and implemented since 2000 have failed to yield any appreciable results and the government at all levels are being pressured to increase allocation of resources to the sectors to ensure an overall progress in the wellbeing of the population. While increase in commitment and funding are important, there is an urgent need to refocus the development lens in Nigeria to a critical and crosscutting issue as child marriage, the reduction of which can speed up the achievement of the MDGs, if not by 2015, in as short a time as possible. There is an urgent need to focus on the cultural traps to which the practice of child marriage has confined girls in Gombi and other parts of the country, through renewed commitment to compulsory education beyond primary school level for girls, enforcement of legislation and commitments to uphold the fundamental rights of the child. In particular, men, in their capacity as fathers, community and religious leaders must be targeted for change, given their roles as custodians of tradition and decision–makers on marriage and family matters. The several elements of marriage (choice, consent, timing, etc) and maternal health must be understood afresh as entitlements and the freedom associated with them must be granted to every citizen.

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TABLE 1: Percentage Distribution of Respondents' Socio-Demographic Characteristics

VARIABLES	FREQUENCY	PERCENTAGE (%)
AGE		
15-19	55	27.5
20-24	145	72.5
Total		**100.0**
OCCUPATION		
Farming	82	41.0
Trading	31	15.5
Civil Servant	17	13.5
House Wife	70	35.0
Total	**200**	100
Highest Level of Education Attained		
Primary Completed	64	32
Primary Non-completed	56	28
Secondary	60	30
Post secondary	20	10
Total	**200**	**100.0**
RELIGIOUS AFFILIATION		

Christians	82	41.0
Muslims	118	59.0
Total	**273**	**100.0**
ESTIMATED INCOME (N per month)		
10,000.00-19000.00	110	55.0
20000.00-40,000.00	70	35.0
Above 40,000.00	20	10
Total	200	100
DURATION OF MARRIAGE (yrs)		
Less than 5	90	45.0
5-9	100	50.0
10 & above	10	5.0
Total	**200**	**100.0**

Source: *Field Work, 2011.*

Table 2. Percentage Distribution of Respondents' Family and Marriage Characteristics

VARIABLES	**FREQUENCY**	**PERCENTAGE (%)**
DECISION TO MARRY TAKEN BY		
Both partners	11	5.5
Parents	159	79.5
Others	30	15.0
Total	**200**	**100.0**
HOUSEHOLD PROVISION BORNE BY?		
Husband	156	78.0
Wife	0	0.0

Parents	7	3.5
Others	37	18.5
Total	**200**	**100.0**
NO OF CHILDREN EVER BORN		
1	35	17.5
2	25	12.5
3	60	30
4+	80	40.0
Total	**200**	**100.0**
EVER EXPERIENCED DOMESTIC VIOLENCE?		
Yes	107	53.5
No	93	46.5
Total	**200**	**100.0**
INVOLVEMENT IN DECISIONS ON FAMILY SIZE		
Yes	56	27.8
No	144	72.2
Total	**200**	**100.0**
DISCUSSION ON FAMILY PLANNING WITH SPOUSE		
Yes	50	25.0
No	150	75.0
Total	**200**	**100.0**
FINAL DECISION ON FAMILY SIZE TAKEN BY		

Husband	165.0	82.5
Wife	0	0.0
Both	35	17.5
Total	**200**	**100.0**
FINAL DECISION ON TIMING OF NEXT BIRTH		
Husband	153	74.5
Wife	21	10.5
Both	26	13.0
Total	**200**	**100.0**

Table 3. Percentage Distribution of Respondents Experiences of Maternal Health-related Risks

Ever experienced pregnancy-related complications?		
Yes	142	71
No	58	29
Total	200	100
Type of complication experienced		
Excessive Bleeding	27	19.0
Frequent Miscarriages	17	12.0
Obstructed and/or prolonged labour	70	49.0
Prolonged Sickness after childbirth	28	100
Total	142	
Exposure to Fistula		
Yes	37	26.0
No	105	74.0
	142	

Total		
Ever Had STIs?		
Yes	125	62.5
No	75	37.5
Total	200	**100.0**
Place of treatment of the STI's		
Private clinic	35	17.5
Herbal Home	100	50.0
Government Health centre/clinic	45	22.5
Others (Local chemist, open	20	10.0
Total	**200**	**100.0**
Good Knowledge of HIV/AIDS		
Yes	56	28.0
No	144	72.0
Total	**200**	**100.0**

Table 4. Percentage Distribution of Respondents Reported Maternal Health-Seeking Behaviour

Variables	**FREQUENCY**	**PERCENTAGE**
Place of Delivery of last child		
Respondents' Home	56	28
Govt. Hospital	40	20
Govt. Health Centre	38	19
Private Hospital/clinic	20	10

TBA Home	46	23
Total	**200**	**100**
Type of Health Personnel for Delivery of last child		
Doctor	20	10.0
Nurse/midwife	50	25.0
Auxiliary midwife	30	15.0
CS health professional	34	17.0
Traditional Birth Attendant	60	30.0
Relative, Friend	6	3.0
Total	200	100
Capacity to decide on Medical treatment for self/children		
Yes	35	17.5
No	160	80.0
Depends	5	2.5
Total	200	100
Proximity of Health Facilities		
0-2 km (near)	46	23.0
3-4 km (far)	87	43.5
More than 5 km (very far)	67	33.5
Use of ante-natal care		
Never	20.0	10.0
Always	87	43.5

Sometimes	91	45.5
Total	**200**	**100**

Table 5. ANALYSIS OF SELECTED VARIABLES AND MATERNAL HEALTH RISKS (EVER HAD COMPLICATIONS?).

VARIABLES	EVER HAD COMPLICATION		NO COMPLICATION		Total	
Religion	No	%	No	%	NO	%
Christianity	57	69.5	22	30.5	82	100
Islam	82	72.0	36	28.0	118	100
Total	142	71.0	58	29.0	200	100
Age						
15-19	41	75.0	14	25.0	55	100
20-24	101	69.6	44	20.4	145	100
Total	142	71.0	58	29.0	200	100
Educational Level						
Primary (Not Completed)	50	78.0	14	22.0	64	100
Primary (Completed)	38	67.8	28	32.2	56	100
Secondary	34	61.6	26	38.4	60	100
Post Secondary	10	50.0	10	50.0	20	100
Total	142		58	29.0	200	100
Occupation						
Housewife	55	79.0	15 21.0		70 100	

Trading	11	35.0	20 65.0		31 100	
Civil servant/Public servant	5	29.0	12 71.0		17 100	
Farming	51	62.0	31 38.0		82	100
Total	142	71.0	58 29.0		200	100
Income						
Less than N20,000	82	75.0	28	25.0	110	100
21,000-40,000	50	71.0	20	29.0	70	100
Above 40,000	10	50.0	10	50.0	20	100
Total	142	71.0	58	29.0	200	100
Partner's Level of Education						
No formal education	52	84.0	10	26.0	62	100
Primary	47	68.0	22	32.0	69	100
Secondary	33	67.0	16	33.0	49	100
Postsecondary	10	50.0	10	50.0	20	100
Total	142	71.0	58	29.0	200	100
No of Children Ever Born						
1	19	54.0	16	46.0	35	100
2	15	60.0	10	40.0	25	100
3	45	75.0	15	25.0	60	100
4 and above	63	78.0	17	22.0	80	100
Total	142	71.0	58	29.0	200	100

Table 6. LOGISTIC REGRESSION OF SELECTED VARIABLES AND EVER HAD COMPLICATIONS?

Variables	Odd Ratio
Age	
15-19	1.234**
20-24	RC
Level of Education	
Primary Completed	4.359**
Primary Non Completed	2.086**
Secondary	1.951
Post secondary	RC
Level of Empowerment (Decision Making)	
High Empowerment	RC
Low Empowerment	4.231*
Occupation	
Farming	0.997
Trading	0.938
Civil/public servant	0.844
Housewife	RC
No of Children	
1	RC
2	0.984
3	0.223
4 and above	1.072
Years of Marriage	
Less than 5 years	2,367
5-9 Years	1,294
10 years and above	RC

Income	
Less than N20,000	2.56
21,000-40,000	2.48
Above 40,000	RC