MEETING THE SEXUAL AND REPRODUCTIVE HEALTH NEEDS OF MARRIED ADOLESCENTS IN NORTHERN NIGERIA

By

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45th International Course in Health Development
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KIT (ROYAL TROPICAL INSTITUTE)
Development Policy & Practice/
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A thesis submitted in partial fulfillment of the requirement for the degree of Master of Public Health

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List of abbreviations

VVF	Vesico Vagina Fistula
RVF	Recto Vagina Fistula
ANC	Ante Natal Care
AHI	Action Health Incorporated
CILS	Center for Islamic and Legal Studies
YFS	Youth Friendly Services
FMOH	Federal Ministry of Health
WHO	World Health Organisation
UNICEF	United Nations Children Fund
UNFPA	United Nations Population
CRA	Child Rights Act
CRR	Center for Reproductive Rights
NARHS	National HIV/AIDS and Reproductive Health Survey
NDHS	National Demographic Health Survey
FHI	Family Health International
PRB	Population Reference Bureau
NBS	National Bureau of Statistics
DFID	United Kingdom Department for International Development
PRINN/MNCH	Partnership for Reviewing Routine Immunisation in Northern Nigeria; Maternal Newborn and Child Health Initiative
NPC	National Population Commission
IGWG	Inter-Agency Gender Working Group

Working Definitions

Reproductive health- is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes (ICPD, 1994)

Sexual health - Sexual health is the experience of the ongoing process of physical, psychological, and socio-cultural well being related to sexuality (PAHO and WHO, 2000)

Adolescents – persons between ages 10-19

Early/Child marriage - marriage of a person (girl) before the age of 18

Maternal mortality - the quality or state of being mortal

Maternal morbidity- the relative incidence of a particular disease

Northern Nigeria – specifically states in the North West and North East

Abstract

Background: Nigeria has one of the largest numbers of married adolescents in the world. In the predominantly Muslim Northern region of the country, about 70% of girls get married and start childbearing by the age of 18. Early marriage limits the social and development opportunities of married adolescents as well as exposes them to sexual and reproductive health problems which often result in grave consequences such as vesico vagina fistula, sexually transmitted diseases including HIV and death.

Methodology: Desk review of articles, reports and data from search engines like Google and pubmed on sexual and reproductive health of married adolescents was used. Grey literatures on unpublished and materials unavailable on line were also used.

Findings: The practise of early marriage is mainly fueled by cultural/traditional and religious factors as well as poverty, gender inequality and unfavourable marriage laws. Lack of education and social isolation hinders adolescents from utilizing of sexual and reproductive health services which leads to poor health outcomes for them. The shortcomings of the health system also contribute to poor management of SRH problems of married adolescents.

Conclusion: The minimum age of 18 for marriage should be enforced in Nigeria to allow girls to attain physical and mental maturity, complete secondary school education and be better prepared for the responsibilities of marriage. In the meantime, health workers, local midwives and key stakeholders in the community need resources and skills to address the sexual and reproductive health needs of adolescent girls who are already married. The government and development partners must be more committed in implementing programmes to improve the social and health conditions of married girls in Northern Nigeria.

Key words: "Early marriage", "Married adolescents", "Sexual and reproductive health", "Northern Nigeria", "Maternal mortality"

Word count: 13,702

Introduction

Universally, the legal age of marriage is 18 and any legal union which takes place below this age is termed "early or child marriage"(UNFPA, 2005). About 100 million girls will marry in the next ten years, if nothing is done globally (WHO & UNFPA, 2006). Nigeria is the most populous country in Africa and is credited to have one of the highest rates of child marriages in the world (Population Council, 2005). There are about 45 million young people aged 10-24 years comprising one third of the country's population (PRB, 2009). In the past few years, the country has witnessed a slight decline in early marriage from 39% to 33% however the proportion of teen girls marrying varies from 28% in the South to 89% in the North West (Singh et.al, 2004).

The sexual and reproductive health of adolescents (SRH) in Nigeria is generally poor (Advocates for Youth, 2001; AHI 2005). However, the SRH status of married adolescents is even more worrisome as their needs are often missed or overlooked in favour of their unmarried peers. Adolescents girls in the North marry early, give birth early and their cumulative fertility is high (Makinwa-Adebusoye, 2006). Moreover, these girls have little or no education compared to their peers in the South. The attainment of the Millennium Development Goals (1-6) by 2015 for Nigeria is certainly bleak with the continued practice of early marriage and its attendant health consequences on married adolescent girls.

I have worked with adolescents and young people for the past ten years as a communication specialist to create awareness on sexuality issues, conduct peer education trainings and implement activities to improve their sexual and reproductive health (SRH) in the South and North of Nigeria. All my work experiences targeted unmarried adolescents in and out of school hence my interest in this under-served group.

This thesis seeks to explore the various factors that lead to as well as continue to sustain early marriage practice in Northern Nigeria; the study shall highlight peculiar sexual and reproductive health problems and needs of married adolescent girls. Pertinent research questions include: What are the determinants of early marriage practice among adolescents in Northern Nigeria? What are the key SRH problems of married adolescents in Northern Nigeria? What has been the policy response to this social-health problem?

The findings of this study are geared towards providing recommendations to improve the situation. The target audience for this thesis are policymakers, religious and traditional leaders as well as health workers especially in Northern Nigeria who have their collective role to play in safeguarding the health and development of adolescent girls in the region.

Chapter One: Background on Nigeria

1.1. Demography and Population

Nigeria has the largest population in Africa of over 140 million people in Africa (NBS, 2006). The 48 years old nation covers a land mass of 923,768 square kilometres and shares borders with other countries such as Chad, Cameroun, Benin and Niger. The country is governed through 36 states and a Federal Capital Territory (FCT) and divided into six geo-political zones namely North-West, North-East, North-Central, South-West, South-East and South-South. (See map in Annex 1)

The largest ethnic group in Nigeria is the Hausa/Fulani (CIA, 2008) who are predominantly Muslim and reside mostly in the North East and North West regions. Twelve of the Northern states are governed by Islamic (sharia) law while the Southern states are ruled by the civil and customary laws.

1.2 Socio-economic indicators

Agriculture (food and cash crops) thrives in Nigeria and the country has abundant reserves of natural resources such as crude oil, iron ore, bitumen. However, in spite of its rich human and material resources, over 70 percent of the population lives in poverty (IMF, 2005). Nigeria is ranked 158 out of 177 countries with a Human Development Index (HDI) score of 0.470 (UNDP, 2008).

A little over half of the population in Nigeria is literate however there is inter-regional disparity in the level of education attained by sex, urban and rural area. As much as 62% to 66% of adults in the North East and North West have never attended school compared with 15% to 21% of those in the South east and South West (NPC, 2004). While 30% of urban residents have no education, about 48% of their rural counterparts are uneducated. Among women in the same region, 73-78% is illiterate.

1.3 Health indicators

Several social and health indicators in the country are comparable to the poorest in the world. Life expectancy in Nigeria is 47 years (UNDP, 2008). Total Fertility Rate (TFR) is about 6 children per woman (PRB, 2009). The country has the second highest number of maternal deaths in the world after India (WHO et al, 2005). The health indicators in the Northern region are worse than the South. Across the geo-political zones, Maternal Mortality Ratio (MMR) ranges from as low as 339/100,000 in the South-West to 1,716/100,000 in the North East (DFID, 2000). Use of modern method of family is 3% in the North East and North West compared with 23% and 14% of women in the South West and South South respectively (NPC, 2003a). This partially contributes to higher fertility rate of women (7 children) in the North than the South (4 children). Likewise, Infant Mortality Rate (IMR) is

125 and 114 per 1000 births in the North East and North West compared to 66 and 69 per 1000 births in the South East and South West (NPC, 2003a). The prevalence of HIV among women attending ANC rose from 1.8% in 1991 to 5.8% in 2001 and decreased to 4.4% in 2005 (FMOH, 2005).

1.4 Health system organisation

The performance of the health system in Nigeria is poor and this is reflected in the health status of the general population. The country's health system was ranked 187th among the 191 member states (WHO, 2000a).

Administratively, the provision of health care is undertaken by the three tiers of government at the national, state and local government level. States and local governments are responsible for secondary and primary health care services while the federal government funds the tertiary health services. The federal government also is in charge of setting national policies and guidelines, building capacity of the health system and coordinating national health programmes (DFID, 2000). There is a wide regional disparity in the health sector. There is more health services located in the South than in the North due to uneven human and material resources (NPC, 2003a).

Nigeria's GDP per capita is $1,128 (UNDP, 2008) and about 5% of this is spent on health (WHO, 2006). The government only meets 25% of the total health expenditure while the rest is covered by the private sector through direct out-of-pocket payment from consumers (WHO, 2006).

1.5 Married Adolescent's Sexual and Reproductive health

Median age at first marriage ranges from 21 years in the South-West to 14 years in the North West (FMOH, 2003). By the age of nineteen, more than 70% of girls in the North are married compared to 10% in the South (Sedgh et.al, 2009). Early childbearing is common as a quarter of Nigerian teenagers have stated having children by the age of 19 (NPC, 2003b). It is estimated that 60 percent of new HIV infections occur among young people under age 25 (Okonofua et.al, 1999) and HIV prevalence among 15-19 years old attending ante-natal services is 3.6% (FMOH, 2005).

With poor access to sexual and reproductive health services, many married adolescents remain vulnerable to health problems that are preventable in the first place. The peculiar SRH needs of married adolescents are often not addressed because there is an assumption that they are covered by services designed for older married women.

With an estimated population growth rate of over 3 percent per year, the Nigerian government is constantly faced with the challenge of improving the quality of life of its citizens. The enactment of the "National Health Policy" (1988) and "Adolescent Reproductive Health Policy (1999) are examples of good measures taken by the government to address development issues at the national level. However inadequate funding, poor governance and weak institutional capacity hinder the successful implementation of these policies.

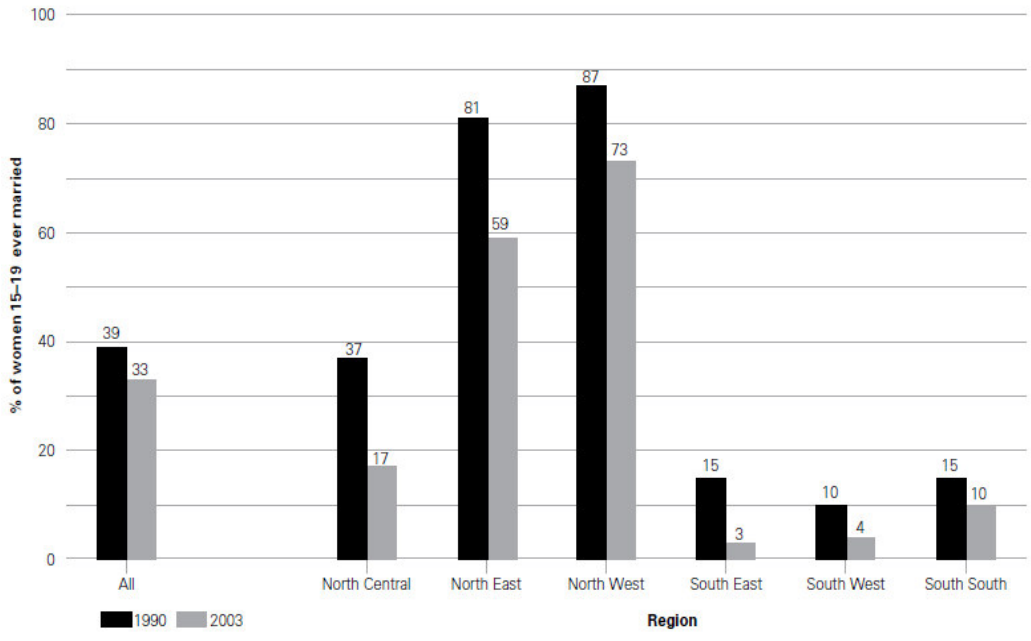
Chapter Two: Problem Statement, Objectives and Analytical Framework

This chapter briefly states the social and sexual and reproductive health problems of married adolescents. This section also includes the objectives of the thesis, methodology, analytical framework and limitations.

2.1 Statement of the problem

Early marriage is widely practiced among the Hausa/Fulani in the North West and North East region of Nigeria. In the past 20 years, the proportion of women marrying in their teens at the national level has reduced from 78% to 55% and drastically in the South-South region, from 70% to 28% (Singh et.al, 2004). However, in the North East and North West, the proportion remains high at 80-89%. From the National and Demographic Survey (2003) the prevalence of girls aged 15-19 who are married is as high as 73% in Northwest in contrast to 4% in the Southwest (NPC, 2003a). (see graph 1 below). This gap is even wider between girls in urban and rural (27% vs. 52%) areas in the Northern region (UNICEF, 2004) and highest among girls with no education or Qur'anic education only (FMOH, 2003). Early marriage in the region can also be termed forced marriage because the arrangement is almost always done without the consent of the girl. The choice and arrangement is made by the father in consultation with the grandmother and prospective husband and refusal to marry attracts grave punishment for the girl (Erulkar & Bello, 2005; Immigration & Refugee Board of Canada, 2006).

Graph 1. Prevalence of Adolescent Marriage across Nigerian Regions



Source: Sedgh et.al, (2009)

2.2 Problem Analysis

Adolescents girls in the North marry early, give birth early, have more children and have little or no education compared to their peers in the South (Makinwa-Adebusoye, 2006). Average age at first marriage for girls in the North West and North East is 15 years, and in some states like Kebbi (in the north), as low as 11 or 12 years; against the national average of 17 (NPC, 2003a; UNICEF 2001). The common reasons for this practice are deeply entrenched in cultural, traditional and religious beliefs. Some driving factors include poverty, protection of the girl's virginity, and prevention of bearing children outside wedlock (IPPF & UNFPA, 2006a).

Married adolescents are exposed to a higher risk of SRH problems. With little or no information on their sexuality, they get pregnant and face health risks that endanger their own lives and those of their unborn babies (UN, 2008). Common pregnancy related problems associated with adolescent girls include: eclampsia, anemia, obstructed labour and puerperal sepsis (WHO & UNFPA, 2003). Low contraceptive use (4%) among married adolescents (Singh et al, 2004) in the region is associated with high fertility. In a UNICEF study on maternal health in the North East of Nigeria, women on average had delivered their first child by age 19 and more than 50% had eight or more children in their forties (Galandanci et.al., 2007). Complications from pregnancy are a major cause of death among 15-19 year old girls (World Bank, 2006). The high rate of Vesico Vagina Fistula (VVF) and Recto-Vagina Fistula (RVF) in Northern Nigeria is strongly linked to the early marriage of the girls affected (Makinwa Adebusoye, 2006). There are about 200,000 cases of VVF in Nigeria and the North accounts for two third of the burden (Yusuf, 2005). In a hospital study conducted among VVF patients in a Northern state, 72% were between ages 10-20 and were married by the age of 15 years (Kabir, et.al, 2004).

Socially, nearly all married girls are denied education. While only 8% of unmarried girls are uneducated, up to 73% of married girls did not attend school in Nigeria (Population council, 2005). Early marriage is a violation of the girl's fundamental human rights and a defect of all the conventions Nigeria signed and promised to uphold. The attainment of the Millennium Development Goals (MDGs), specifically MDGs 1-6, for Nigeria by 2015 is certainly bleak with the continued practice of early marriage in the North (See Annex 2).

Clearly, married adolescent's sexual and reproductive health (SRH) status in Nigeria is poor and does not receive the deserved attention. They remain "invisible" and benefit less from the few interventions designed and implemented for adolescents in general. There is a need to understand the factors fuelling the practice of early marriage in the Northern Nigeria reveal its attendant social and health consequences on married girls and explore effective ways to address the problems.

2.3 Objectives

2.3.1 Overall objective

The general objective of this study is to determine factors contributing to the sustenance of early marriage and analyse the sexual and reproductive health implications among married adolescents in Northern.

2.3.2 Specific objectives

1. To identify the factors contributing to early marriage in Northern Nigeria
2. To describe the key SRH problems and needs and married adolescents in Northern Nigeria
3. To identify the determinants of poor SRH of married adolescents in Nigeria
4. To highlight good practices used by other countries that might be of policy relevance to improving the SRH of married adolescents
5. To provide recommendations on how to improve the SRH of married adolescents in Northern Nigeria

2.4 Methodology

Literature review of useful materials such as articles and reports on sexual and reproductive health of married adolescents were sourced from search engines like Google scholar, Scopus and Pubmed. Publications from international organisations working the area of adolescent health (especially married adolescents) such as Guttmacher Institute, Population Council, WHO and UNFPA were also used. Grey literatures from the Nigerian government and development partners which are unpublished or published and not available on line were also used.

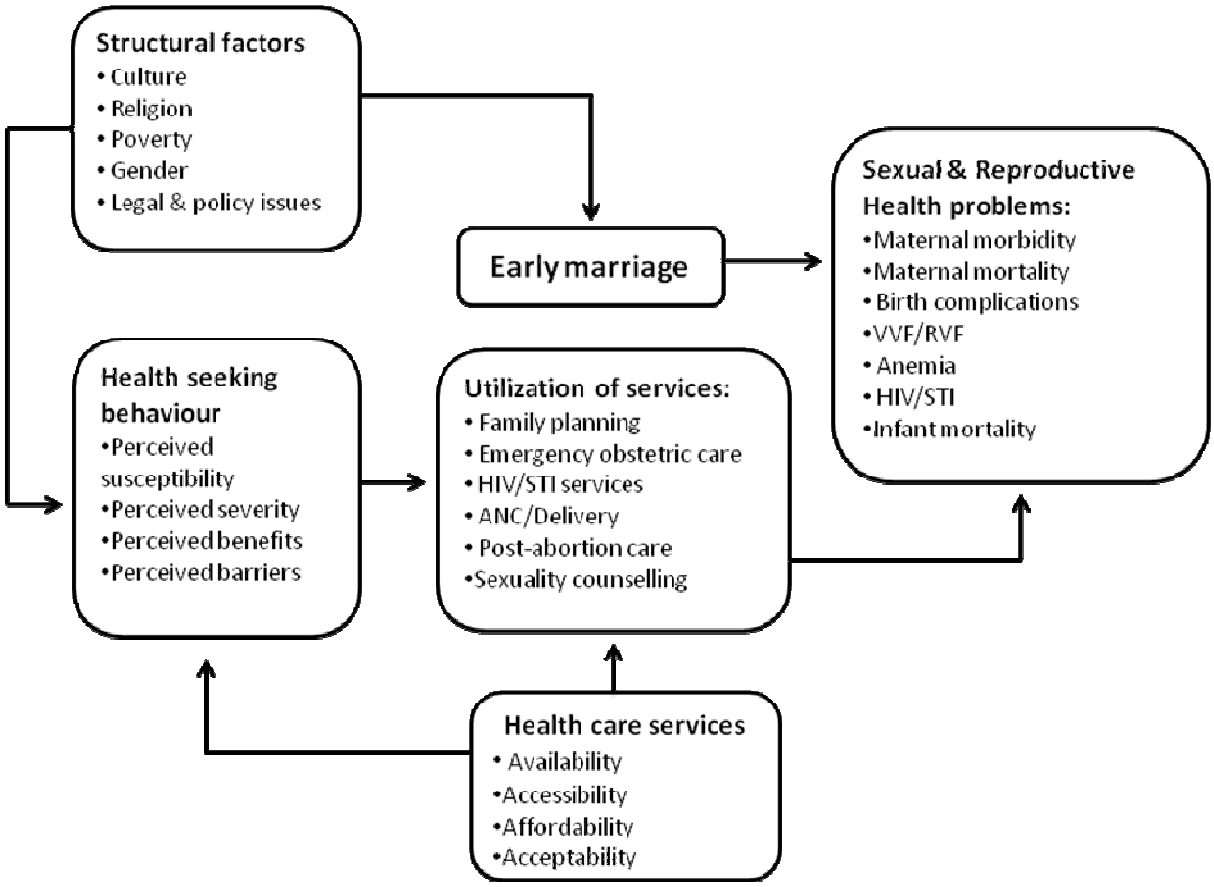
Key words include: Early marriage, Child marriage, Islam, Married adolescents, Married girls, Sexual health, Reproductive health, Nigeria, Northern Nigeria, Africa, Maternal health, Youth friendly services, Best practices, Maternal mortality, Maternal morbidity

2.5. Analytical Framework

There are no existing framework (on-line) specifically addressing SRH needs of married adolescents. I therefore developed a framework based on issues highlighted in my problem analysis tree (See Annex 3). Several key factors contribute to creating SRH problems for married adolescents. Structural factors such as religion, culture, and poverty contribute to the practise of early marriage. Low utilization of health care services such as family planning, Ante Natal Care (ANC) and delivery, as well as sexuality also predisposes them to SRH problems. The reasons services are not utilized by married adolescents is associated with their health seeking behavior as well as the characteristics of those services.

To analyse the health seeking behaviour factor I adopted the Health Belief Model by Sheeran and Abraham (1995) cited by (Hausman-Muela et.al, 2003). In many situations, married girls do not perceive themselves to be susceptible (perceived susceptibility) or at risk of complications (perceived severity). They are also poorly motivated to utilize health services because of perceived barriers and benefits. Structural factors also play a role in influencing the health seeking behaviour. The responsiveness of health care services also affects the SRH of married adolescents. To analyse this, I adopted the Access model by Penchansky and Thomas (1981) which examines how the health system meets the needs of clients through the "Four As" namely: Availability, Accessibility, Affordability and Acceptability (Wyszewianski, 2002). If these four components are not functioning well, it influences poor utilization and invariably contributes to the SRH problems of adolescent girls.

Figure 1. Analytical Framework on Sexual and Reproductive Health Problems of Married Adolescents



2.6. Limitations

This thesis is mainly a desk review of several literatures that exist on sexual and reproductive health of married adolescents. Limited time and resources hindered the author from getting primary data from the field on this topic. Majority of existing literature on SRH of adolescents in Nigeria are on the unmarried group so there is very limited material specifically on married adolescents in Northern Nigeria. As a result, sometimes inferences are made from available data on the 15-19 years age group to support the issues that married adolescents. Materials accessible on the topic from other countries with similar situations such as Ethiopia, Senegal, India, Nepal and Bangladesh were are also used.

Chapter Three: Factors Contributing to Early Marriage in Northern Nigeria

In this chapter, the factors contributing to and preventing reduction of the practice of early marriage in Northern Nigeria are discussed namely Culture, Religion, Gender, Poverty, Laws/Policies and Human rights factor.

3.1. Culture and Religion

Culture greatly influences what people believe, value, and practice as a people. While it can be inherited and it may be modified as it passes from generation to generation. UNESCO's Universal Declaration on Cultural Diversity (2001) defines culture as *"The set of distinctive spiritual, material, intellectual and emotional features of society or a social group. It encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs"(UNFPA, 2008).*

Among the Hausa/Fulani ethnic group of Northern Nigeria, their culture is mainly influenced by the doctrine of their religion which is Islam. Culture and religion are two distinctive factors; however, they have become integrated over the years in Hausa land and are the primary factors that influence early marriage in Northern Nigeria.

The adolescent Hausa girl is called a *budurwa* and is socialized to be modest, submissive and to desist from any acts or behaviour which may connote immorality or indecency (Wall, 1998, Doi, undated). From childhood, they are usually enrolled in Qur'anic schools alongside formal schools to ensure they get a balanced knowledge of formal and religious instructions. In some cases, girls are allowed to attend only Qur'anic schools.

The onset of puberty in girls and boys is marked by rapid growth and development which includes the appearance of secondary sexual characteristics. In girls, some of the major pubertal changes include secretion of hormones (oestrogen and progesterone), enlargement of the breast and hips, growth of pubic and auxiliary hair, onset of menarche (first menstruation), and sexual feelings and attraction to the opposite sex.

In Hausa land, the onset of menarche ie regarded as a sign of "maturity". A girl is not expected to start menstruating in her father's house so in many cases girls are married even before they experience their first menstruation. Girls are married off early to preserve their honour and ensure their sexuality and reproductive capacity is under the control of their husbands (Wall, 1998).

Muslims are guided by the principles in the Holy Qur'an and the Hadith which is a simplified form of the Qur'an (MSAwest, undated). There are four credited scholars of the Hadith one of which is Imam Malik whose jurisprudence was adopted to develop the Islamic laws of Northern Nigeria (CILS, 2005; CRR 2003). As a result, there are different

interpretations of what Islam prescribes as the appropriate age of marriage for girls.

Scholars unanimously agree there is no specified minimum age for girls to marry in Islam, however if a minor does get married, the union should not be consummated (sexually) until the girl is "physically and psychologically" mature (CILS, 2005; Yusuf, 2005). This is a critical point of contention as people diversely define a girl's "physical and psychological" maturity based on different subjective factors. Experts posit the period of adolescence is a transition from childhood to adulthood and not a onetime event marked by puberty. For instance, the onset of menstruation in a girl means pregnancy can occur if she has unprotected sex; however, it does not mean she is physically or emotionally ready to become sexually active or give birth. A girl's body is not fully developed until she reaches age 18-20 (Watson & Brazier, 2000). Additionally, adolescent development encompasses not just the physical but the cognitive and psychosocial development (Schutt-Aine & Maddaleno, 2003).

Islam places high value on virginity before marriage hence pre-marital sex and pregnancy out of wedlock are strictly forbidden in the North. Only 1% to 4% of girls 15-19 had premarital sex in the North East and North West (Sedge, et.al, 2009) and 2.4% and 3.5% had premarital births respectively (Erulkar & Bello, 2007). Early marriage is thus valued because it is regarded as a "safety net" to prevent sexual promiscuity and unwanted pregnancy (Ityavar & Jalingo, 2006). NDHS (2003) data shows that 85% of married girls are of the Islamic faith confirming a higher number of adolescent marriages among Muslim girls than those of other faiths. This practice is however low among Muslims in the Southwest mainly because of higher educational levels and different cultural principles.

3.2. Gender

Nigeria is a patriarchal society and as such regardless of the region, tribe or religion, men are generally dominant over women. However, religion and culture plays a critical role in widening the gap of inequality between men and women in the Northern region.

From childhood girls are less valued than boys. Investments in sons are believed to be a better asset because he will carry on the family name and become the head of his household. Invariably, less is invested in the education, nourishment and health of the girl (UNICEF, 2008). The respectable role of a Muslim woman in Hausa land is that of a wife and mother so girls are prepared from childhood to perform this role. Though, premarital sex is frowned on in the society, boys and girls are treated differently on matters relating to sexual behaviour. Girls are warned to preserve their virginity yet boys are allowed to go out and sow their "wild oats". This double social standard makes girls vulnerable to the STIs/HIV at the expense of the risky behaviour of men.

Once married girls are strictly under the authority of their husbands and secluded to avoid attention from other men. In the Northern states, the customary seclusion of married women-*Purdah system*- is still practiced to restrict women's movement outside of their homes and away from unrelated men even in emergency situations (CRR, 2003; U.S Dept of state, 2008). In this kind of environment, females are married to meet the needs of the husbands and fulfill societal expectations to procreate (Nnorom, 2006) thus limiting girls from attaining their full potential and making meaning contribution to their families and communities.

Economic empowerment of married girls is generally low. About 56% of them are not working and 42% are involved in low paying semi-skilled jobs compared with only 10% of men (Ityavar and Jalingo, 2006). As a result, men typically control the finances and make major household decisions including the reproductive health of women.

The low status associated with Muslim women has been argued to be baseless and not in line with what true Islam upholds. Osman (undated) says Muslim women have the right to work and be economically independent however, husbands are responsible for their family needs and if the wife wishes she can contribute to the family expenses. Another prominent advocate in the North, Mairo Bello, says, "*Religion has no gender bias; in Islam all people have their rights. There's nowhere where the religion recommends that the woman should be oppressed…"* (Frontline world, 2003). Islamic laws have therefore been grossly abused to suit the subjective beliefs of some ignorant groups (Ragab, 2009).

About 92% of women in the three northern regions do not make decisions on issues at the household level. Similarly, more women in the North East and North West agree their husbands can beat them for simple issues like burning the food or going out without permission (Makinwa Adebusoye, 2006) (See table on next page). The power imbalance between a married adolescent and her husband is even greater when she is several years younger, uneducated and economically dependent.

Table 1. Indicators of Women's participation in Decision making

Measure	Nigeria	Region					
		North Central	North East	North West	South East	South West	South South
% women who participated in Decision-making about							
Own healthcare	24.5	21.3	12.4	13.1	48.9	39.8	32.7
Making large purchases	20.3	12.7	11.4	11.7	42.9	28.0	31.2
Making daily purchases	30.2	26.1	15.3	16.8	59.0	43.8	44.4
Visits to family or relatives	35.5	23.2	39.8	28.0	57.1	42.3	36.7
What food to cook each day	39.9	39.5	38.8	26.4	57.6	47.2	47.6
All specified decisions	14.4	8.8	**6.8**	8.4	34.9	19.7	21.4
None of the specified decisions	46.4	50.6	**46.9**	57.5	30.9	35.4	41.2
%women who agree that husband is justified in beating wife if she							
Burns the food	30.7	27.4	65.7	29.8	8.8	10.5	25.9
Doesn't cook food on time	33.3	31.8	67.5	28.9	13.2	15.6	30.5
Argues with him	43.5	34.0	80.3	41.4	16.4	32.7	39.8
Goes out without telling him	52.8	39.7	83.2	71.8	17.4	23.4	43.5
Neglects the children	49.4	44.2	81.4	49.4	20.9	35.6	46.8
Refuses to have sex with him	37.5	28.8	73.5	47.7	9.3	12.0	26.1
% Agree with at least one reason	64.5	52.9	90.2	75.3	31.3	46.9	62.0

Source: (Makinwa-Adebusoye, 2006)

The significant differences (from the table above) between women in the North and South may be due to higher levels of education, social exposure and economic empowerment. The third goal of the Millennium development goals (MDG) which promotes gender equality and empowerment of women will be difficult to achieve by 2015 in Nigeria if the current situation persists.

3.3. Poverty

About 70% of Nigerians live in poverty and 1 in 3 adolescent girls live in poor households (Sedge et.al, 2009). Poverty rates in rural areas are about 1.5 times higher than the urban areas. Moreover, the poverty rate is much higher in the North than the South. Sixty seven percent of people in the North East are poor compared with 34% of those in the South East (UNICEF, 2009).

Poverty is also strongly associated with early marriage. Women in the lowest wealth quintile marry six years earlier (age 15 vs. 21) than those in the highest wealth quintile (NPC, 2003a). A very poor family is more likely to marry their daughter off early because her survival and that of her family may depend on it. This is even more common in the rural areas. Girls in rural areas were married by age 16 compared to age 19 for urban girls (NPC, 2003a). Countries with high rates of child marriage are synonymous with high rates of poverty and birth rates and low levels of development (UNFPA, 2005). The vicious cycle of poverty will continue at a high rate if more poor girls marry early and lack skills and competencies

to become economically empowered. This situation will lead to a poor performance for Nigeria in achieving the first MDG which targets eradication of extreme poverty and hunger.

3.4. Human Rights

In the past generation, it was common for marriages to be arranged by parents in the best interest of their children. As a custom, investigations are carried out on prospective family-in-laws to know their history, values, health condition and other requirements to ensure they are suitable for the union. Over the years, the influence of urbanization, education and adoption of western norms, values and ideas has significantly reduced the practice of arranged marriages particularly in the South. However, it seems the status quo remains unchanged in the Northern region of Nigeria.

The right to free and full consent to a marriage is recognized in the 1948 Universal Declaration of Human Rights (UDHR) and in many subsequent human rights instruments (UNICEF, 2001) yet it remains out of the reach of many adolescent girls in Northern Nigeria.

For social and financial benefits, many parents force their young daughters to marry men (sometimes) old enough to be their fathers (CILS, 2005) thereby depriving them of their rights to consent and choose their partner. Some girls are not just forced but also threatened into marriage. A 13 year old girl in Northern Nigeria was threatened by her father to get married. In her own words, she said, "*There was nothing I could have done because my father said if I refused, he will throw my mother out of the house unless I agree to marry"…* (Erulkar and Bello, 2007).

The consent of the woman is required as an important element of marriage in Islam and her parents should not force her to marry anyone against her wish (CILS 2005; Yusuf 2005; Doi, Osman, undated). However, arranged and/or forced marriages are still prevalent in the North and especially affect girls who are not enrolled in school or are very young (Immigration and Refugee Board of Canada, 2006). Under the Islamic law in Northern Nigeria, the father retains the "right" (*ijbar*) to arrange the marriage of his virgin daughter, regardless of her age and without her consent (CRR, 2003). This clause is based on the Imam Malik school of thought and is expected to be applied where the choice of the girl is clearly not in her best interest (Doi, undated). With the high rate of forced marriages in the North, it seems this clause has become an adopted norm rather than an exception to the rule.

Several rights of the girl prescribed in the Child Rights Act (CRA) are violated through the practice of early marriage as stated in the box below:

Figure 2. Child Rights Violated by Early Marriage

Child Rights Act
• The right to education (Article 28)
• The right to be protected from all forms of physical or mental violence, injury or abuse, including sexual abuse (Article 19) and from all forms of sexual exploitation (Article 34)
• The right to the enjoyment of the highest attainable standard of health (Article 24)
• The right to educational and vocational information and guidance (Article 28)
• The right to seek, receive and impart information and ideas (Article 13)
• The right to rest and leisure, and to participate freely in cultural life (Article 31)
• The right to not be separated from their parents against their will (Article 9)
• The right to protection against all forms of exploitation affecting any aspect of the child's welfare (Article 36)

Source: Adapted from UNFPA state of the world children 2003

3.5. Marriage Laws and Policies

There are three types of marriages recognised in Nigeria-the *Civil, Customary and Islamic*. The Civil law only permits marriage for and with the consent of people from 18 years on. On the other hand, the customary and Islamic laws have no defined age for marriage and the girl's consent is not required. Unclear definition of minimum age of marriage in these two laws legitimizes the practice of child marriage. In the two Northern regions where early marriage is most prevalent, the Islamic law is followed while the Civil law is mostly applied in the Southern region (CRR, 2003).

Nigeria is a signatory to several international conventions such as the Convention on Elimination of all forms of Discrimination against Women (CEDAW, 1979), Convention on the Right of the Child (CRC, 1989) and Plan of Action of International Conference on Population and Development (ICPD, 1994). Under the CRC, UNICEF (2008) defines a child as anyone below age 18 and article 16 (2) of CEDAW stipulates that "the betrothal and the marriage of a child shall have no legal effect, and all necessary action, including legislation, shall be taken to specify a minimum age for marriage". Unfortunately, this law is not being enforced in the Northern states and perhaps explains why Nigeria is yet to sign the Convention on Consent Marriage, Minimum Age of Marriage and Registration of Marriages (IPPF and UNFPA, 2006a).

In 1995, the first National Adolescent Health Policy was developed by the Federal Ministry of Health and followed by a strategic framework for its implementation in 1999 (FMOH, 2007b). This was done in recognition of the need to improve adolescent reproductive health in Nigeria. Some of the objectives which strive to provide Family life education in schools and establish Youth Friendly Services (YFS) centers address the general needs of young people (10-24) as a whole but are not sensitive to the peculiar needs of married adolescents.

Chapter Four: Sexual and Reproductive Health Problems and Needs of Married Adolescents in Northern Nigeria

4.1 Sexual and Reproductive Health Problems

4.1.1. Early and Frequent sex

Married adolescents often begin sexual relations earlier than their unmarried peers. More than half of the girls in the North-west had their first intercourse before age 15 compared to age 18 for their peers in the South West (FMOH, 2003). Naturally, frequency of unprotected sexual intercourse increases for married girls. This is confirmed with the data showing the highest percent of sexually active girls (80% and 72%) are in the North West and North East regions respectively (Erulkar and Bello, 2007). Early and frequent sexual relations expose married girls to pregnancy and childbirth when they are still physically and psychologically immature (IPPF and UNFPA, 2006a).

4.1.2. Early Birth and High Fertility

Nigeria is one of the seven countries with the highest adolescent birth rates in the world (WHO, 2008). One in five adolescent girls (15-19) is a mother and the annual Adolescent Birth Rate (ABR) is 124/1000 births. The regional ABR ranges from 221/1000 and 208/1000 in the North East and North West to 21/1000 and 40/1000 births in the South East and South West (Singh et.al, 2004). Over the years, there has been a general reduction of teenage births in Nigeria. National data reveals 59% of women in their forties had their first birth before age 20, compared to 46% of women in their twenties. However, there has been no improvement in North West and East regions where 70% of girls had their first delivery before age 20 (Singh et.al, 2004).

In most ethnic groups in Nigeria, procreation is expected immediately after marriage. Expectedly, adolescent girls are pressured by the family to prove their fertility as soon as they get married. Since girls in the North marry five years earlier than their peers in the South (Makinwa Adebusoye, 2006), they also end up with more children in their lifetime. A woman in the North has an average of 7 children compared with 4 children per woman in the South (NPC, 2003a). In a study conducted in ten Northern states, 50% of women in their forties had eight or more children (Galandanci et.al, 2007). Men have many children to enhance their social status and raise labour for farming while women do so to gain respect and honour and in polygamous unions, compete with co-wives to have the highest number of children (Wall, 1998; Pathfinder 2008).

4.1.3. Health Risks

Childbearing is one of the biggest health risks for women worldwide. A woman in Nigeria has a 1 in 18 chance of dying from pregnancy related causes compared with the risk of 1 in 4,800 for women in America. At the global level, 1 in 9 women who die from maternal complications is a Nigerian (UNICEF, 2009). Adolescent girls below age 19 in Nigeria are

twice at risk of dying from childbirth and those below age 15 are four to eight times at risk of dying compared with women above age 20 (Blum & Nelson-Nmari, 2004).

Nigeria has the second highest number of estimated maternal deaths in the world (WHO, 2000) and a Maternal Mortality Ratio (MMR) of 1100 per 100,000 live births (WHO et al, 2005).These figures suggest adolescent girls are disproportionately affected because they account for 46% of the national birth rates (Singh et al, 2004). MMR ranges from 1549/100,000 in the North East to 165/100,000 in the South-West (PRINN-MNCH, 2008). A hospital based study conducted in Kano (most populous northern state) showed a MMR of 2420 per 100,000 births. Teenage girls particularly those who were primiparae, rural dwellers and uneducated were mostly affected (Adamu et.al, 2003).

Married adolescents are more vulnerable to HIV due to "the young age at marriage, the wide spousal age gap, frequency of unprotected sexual activity, limited access to information and negotiation powers" (IPPF & UNFPA, 2006a). Teenage girls are more susceptible than mature women to sexually transmitted diseases (UNICEF, 2006a) because their genital tract is not fully developed and is less resistant to infection (Bankole et.al, 2004; Dennis and Jalingo, 2006).

Adolescent girls are prone to anemia because of their growth needs and regular loss of blood during menstruation (Senderowitz, 1998). Anaemia is often a result of malnutrition and manifests through deficiencies of Iron, Vitamin A and Folic acid (WHO and UNFPA, 2006). Adequate nutrition through iron rich foods and supplements is required by girls to function effectively. Malnutrition during adolescence is made worse for girls that begin early child bearing (IGWH & WHO, 2005). Pregnant adolescents are at risk of severe anemia because pregnancy normally requires more iron for blood production (Senderowitz, 1998). When a girl suffers from iron deficiency she competes with her fetus for nutrients (Leenstra et.al, 2004) which can result in grave health consequences for her and her baby. A survey among pregnant adolescents in Nigeria showed a reduced incidence of cephalopelvic disproportion among those who had received antimalarial drugs and iron and folic acid supplements during the second half of pregnancy (Senderowitz, 1997).

4.1.4. Health Consequences on girls

Complications from pregnancy are a major cause of death among 15-19 year old girls (World Bank, 2006) simply because their bodies are not fully developed and ready for childbirth. The top five causes of maternal deaths in Nigeria are eclampsia, ruptured uterus, anemia, post-partum hemorrhage and sepsis (Adamu et.al, 2003). Almost 60% of eclampsia patients in a semi-rural hospital in the North were adolescent girls below age 20 (Tukur, et.al, 2007). In another hospital based study in the North, case fatality rates were highest among teenage girls (Wall, 1998). Maternal deaths in the region are also strongly associated with age, number of pregnancies, lack of ANC and lack of education (Wall, 1998).

Nearly three quarters of maternal deaths in 2005 occurred among illiterate women in a related study in a Northern state (UNICEF, 2009).

Obstructed labour is another complication common among young girls delivering a baby. One of the outcomes of this complication is Vesico Vagina Fistulae (VVF) or Recto Vagina Fistulae (RVF), an incontinence of urine and faeces respectively. Prolonged obstructed labour occurs in young girls because their pelvis is too small for the baby to be delivered. As a result, too much pressure from the baby's head cause necrosis, leading to a tear between the vagina and bladder (VVF) or tear between the vagina and rectum (RVF). VVF results in leakage of urine while RVF causes leakage of faeces (WHO & UNFPA, 2006).

Nigeria accounts for 40% of the global burden of VVF (PRINN-MNCH, 2008) and the Federal Ministry of Health estimates there are up to 400,000 girls and women with VVF in Nigeria with an annual incidence of 10,000 cases (Population Council, 2005). The high rate of VVF and RVF in the north is strongly linked to the early marriage of among young girls affected (Makinwa Adebusoye, 2006). In a hospital study conducted among VVF patients in a northern state of Nigeria, 72% were between ages 10-20 and were married by the age of 15 (Kabir, et.al, 2004). Prolonged labour and delay in seeking help with a skilled birth provider are leading causes of the problem. Apart from the physical disability caused by VVF and RVF, the social consequences of fistula include isolation, abandonment or divorce, stigma, and lack of economic support (U.S Dept. of state, 2008). As a result, many fistula patients cannot access, afford or reach health facilities for surgery so they remain untreated and new cases occurs leading to a cumulative growth (Wall, 1998). Other injuries caused by obstructed labour include damage to the bladder and urethra, vaginal scarring and pelvic infections which leads to secondary infertility (Wall, 1998).

Similarly, HIV infection is 4.3% among young women aged 15-24 attending ante-natal clinics in Nigeria (FMOH, 2005). In Nigeria, young people account for over 30% of HIV cases, and girls aged 15-24 are nearly three times more at risk than boys (IPPF & UNFPA, 2006b). This situation correlates with studies from other African countries like Kenya and Zambia which showed married girls were more infected with HIV than their unmarried peers (ICRW, 2004).

4.1.5. Health Consequences on Infants

Infant Mortality Rate (IMR) in Nigeria is 100/1000 live births and 1.5 times higher in rural areas than in urban areas (NPC, 2003a). In 2004, WHO estimated 240,000 neonatal deaths in Nigeria (UNICEF, 2009). Stillbirths and death in the first week of life are 50% higher among babies born to mothers below age 20 than among babies born to mothers 20–29 years old (WHO, 2008). Babies of adolescent girls are more likely to suffer from low birth weight, under nutrition and late physical and cognitive development (UNICEF, 2009). IMR is also strongly linked to education of mothers. In Nigeria, IMR is higher at 124/1000 live births among uneducated mothers compared to 71/1000 among educated

mothers (NPC, 2003a). This gap widens further when compared with mothers with higher education.

4.2. Sexual and Reproductive Health Needs

The Right to Health is one of the universally acknowledged fundamental human rights, and Sexual and Reproductive health is an integral component of overall health. Reproductive health is defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes" (ICPD, 1994). It also includes sexual health, which is defined as the experience of the ongoing process of physical, psychological, and socio-cultural well being related to sexuality (PAHO and WHO, 2000). This universal concept recognizes that adolescents are therefore beneficiaries of sexual and reproductive rights which includes "the right to sexual integrity, safety of the sexual body, privacy, equality, love, expression, choice, education and access to care" (Schutt-Aine & Maddaleno, 2003). "Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so" (ICPD, 1994). Based on all the SRH problems affecting married adolescents, they are in dire need of information and services on their sexuality, family life, nutrition, STIS/HIV/AIDS prevention and treatment, safe motherhood and child care. These needs are identified based on findings in the literature but the specific SRH needs –generated from married girls in Northern Nigeria- is not yet available.

Chapter Five: Determinants of Poor SRH of Married Adolescents in Northern Nigeria

There are some factors which contribute to the poor health status of married adolescents. In this chapter, the social condition of married girls, their health seeking behaviour and the way the health care services respond to their needs will be discussed.

5.1 Social Condition of Married Adolescents

5.1.1 Low knowledge on SRH

Married adolescents have limited access to information about sex, pregnancy and parenthood and are often left to experience these events unprepared. A young girl from Northern Nigeria shared her experience below:

The first time I had sex with my husband; I felt serious pains and was bleeding. I had to tell my aunty and she gave me some medicine then I told her that I will never allow him to do that to me again. My aunty told me that if I stop after the first time, the wound will never heal. At that time my husband was a stubborn man and anytime he came to have sex with me, I just started crying. He would tell me that Allah is blessing and rewarding me so I should not be crying. (Married girl, age 14, married at 13, 2 co-wives, 2 pregnancies, 1st child died, 3 years education) (Erulkar and Bello, 2007)

Another young girl explained what she knew about motherhood below:
I didn't have anybody to talk to me about how to give birth until I had the experience... All I knew is that when a pregnant woman is about to give birth they bring her back to her parents or mother, otherwise the mother doesn't tell her anything. (Young woman, age 22, married at 16, never been to school) (Erulkar and Bello, 2007)

Adjusting to biological changes is a major challenge already for adolescents and in the case of young married girls, premature initiation into sexual activity and motherhood when they are unprepared can cause emotional stress and physical distress. Cultural norms and expectations which socialize girls to be passive and modest (Bankole et.al, 2004) may inhibit them from seeking information about their sexuality.

Interestingly, Islamic doctrine assures the right of women and men to sexual health information and practices (Ragab, 2009). Information covering a range of life issues including sexuality is contained in the *Fiqh.* The Fiqh is a detailed interpretation of the teachings in the Holy Qur'an which guides the Muslims way of life (World Federation of Muslim Communities, undated). Topics on sexuality covered in the Fiqh include puberty, hygiene, marriage and childbirth (Yusuf, 2005). Provisions have been made to provide Muslim children these teachings through Islamic and Religious Knowledge (IRK) taught in schools (primary, secondary and

tertiary), Qur'anic schools and the mosque. In reality, there is a gap between what is prescribed by Islam and what is being practiced as it is evidenced in the narration of the experiences of the two girls on the last page.

Married girls miss opportunities to learn from IRK classes when they are withdrawn or not allowed to attend school. The culture of silence on sexuality issues also hinders parents, guardians and teachers/tutors from providing accurate sexuality information to adolescents. As a result of this inaction, most young girls enter into marriage ill-informed about the SRH issues. It is not surprising that married girls are less informed about HIV/AIDS as well. Only half of married girls have heard of HIV and 38% know that HIV can be transmitted from mother to child (Population council, 2005). Just two in five adolescent girls know that condom use can prevent HIV transmission (Singh, et.al, 2004).

5.1.2 Older Spouse, Polygamy and Divorce

Marrying virgin girls to older men who are sexually experienced without confirming their HIV (or other STI) status puts young girls at higher risk of infection. Some adolescent girls are married off to older men, who are sexually experienced and (in some situations) in a polygamous union with other women. More than half (56%) of married girls aged 15-19 are ten or more years younger than their husbands (NPC, 2003a) and the age difference is up to 18 years or more when in polygamous unions (Erulkar & Bello, 2007).

Communication between married girls and their older spouses is poor thus making it difficult for girls to express concerns about their sexuality or reproductive health. Typically, young girls often lack the power, confidence and skills needed to negotiate condom use (Ityavar & Jalingo, 2006). Even when they suspect their husbands of infidelity, they may be powerless to raise the issue. Among married teenage women, only 24% and 13% have ever discussed HIV and family planning with their husbands (Singh et.al, 2004). Some factors that causes poor couple communication include the attitude and decision making power of men, shyness, and lack of access to the media and misinformation on RH issues (Pathfinder, 2008).

Polygyny-marriage between one man and two or more women-is practiced in Nigeria. Some men practice Polygyny to enhance their social status while others (i.e. in rural areas) do so to raise a large family for economic reasons (Nnorom, 2006). Polygyny is more prevalent in the North (44% in North East) than the South (10% in South East). It is also more common in rural than urban areas and among women with lower educational levels (NPC, 2003a). About 27% of married girls in Nigeria are in polygamous unions (IPPF & UNFPA, 2006). In a polygamous home, the co-wives are usually older and may treat the girl with hostility because she is perceived as a rival. Experiences shared by some young married girls in the North showed they are given less food and treated

poorly by their co-wives in the absence of the husband (Erulkar and Bello, 2007).

Divorce rates are also increasing in Hausa land. The average Hausa woman is estimated to experience four marriages in her lifetime (Last, 2006). This may be also due to remarriage after the death of a much older spouse. High rates of Polygyny, divorce and re-marriage increases the risk of STIs/HIV transmission among couples in the North (Yusuf, 2005). The risk becomes higher in polygamous unions where mutual fidelity is not practised among the husband and wives.

5.1.3 Education level

In 1999, the Nigerian government introduced the Universal Basic Education Programme (UBE) which provides tuition-free, compulsory schooling to children from primary to junior secondary school level (NPC, 2004). Early marriage denies adolescent girls their legal right to benefit from this programme. Research shows there is a higher chance for girls with little or no education to get married early. In a UNICEF study of 42 countries, women 20–24 years of age who had attended primary school were less likely to be married by age 18 than those who had not (UNICEF, 2005). Girls with no education or Qur'anic education only marry at an average age of 15 compared to girls with secondary school education (FMOH, 2007). This proves keeping girls in school longer delays the age at first marriage. Religion is also strongly associated with educational level in Nigeria. From 1990 to 2003, secondary education increased from 50% to 75% among Christian adolescent girls in contrast with 15% to 25% among Muslim adolescent girls (Agha, 2008).

Virtually all married adolescent girls in Nigeria are withdrawn from school. 3 out of 4 married girls cannot read at all; 73% of them did not go to school compared with 8% of their unmarried peers (Population council, 2005). With the difficult economic situation in Nigeria, many of these girls lack the pre-requisite skills and competencies needed to participate in gainful employment to attain a better quality of life. High rate of early marriage in the North is strongly associated with low levels of education and poverty (Erulkar & Bello, 2007).

In 2001, the National Council on Education approved the provision of Family Life and HIV/AIDS education for adolescents in schools. It is a greater challenge to implement this initiative in conservative Northern Nigeria because of resistance by Islamic clerics and misinterpretation of the benefits of the programme (Macarthur, 2007). Nonetheless, married girls miss this great opportunity to increase their knowledge on HIV/AIDS and other related sexuality issues when they are withdrawn from school. Education is one of the best investments that can make a difference in the lives of young girls and the benefits are felt by her family, community and society at large.

5.1.4 Social isolation

Early marriage disrupts the childhood of young girls. They are abruptly moved from their familiar home and environment to a new household where they are ostracized from their social network. The bond and support they share with their parents and friends may not be easily found in their new marital homes. The sudden change of status from a child to that of wife and mother, without adequate psycho-social support, can also affect their emotional well-being (Forward, 2002).

Unlike unmarried adolescents who socialize with friends in school or their communities and have access to information in the media, many married adolescents are denied the luxury of these interactions (FMOH, 2007b). Research has shown that access to peers, families, schools and communities play a significant role in determining adolescent health outcomes (WHO, 2007). Social contact and networks are widely recognised as essential for information sharing and support to adopt healthy behaviour. Many married girls describe marriage as lonely, restrictive, and limiting their access to information, schooling, and community participation (Bruce and Clark, 2003). The following rights of the child contained in the CRA are violated due to isolation. They are the rights to:

- seek, receive and impart information
- rest and leisure and to participate freely in cultural life
- not to be separated from parents against their will are assured in the CRC but unattainable for many married adolescents.

5.1.5 Harmful Traditional Practices

There are some traditional practices observed during pregnancy and childbirth that have negative effects on the SRH of adolescent girls. Hausa/Fulani girls are customarily expected to observe what is known as "kunya" (modesty) during pregnancy and delivery. Discussions on the state of pregnancy are frowned upon and girls are expected to bear the pain of labour and delivery in silence as an act of bravery and good character (Wall 1998; Yusuf, 2005). This social pressure to remain silent during pregnancy acts as a barrier for girls to raise questions or clarify concerns they may have about their condition (Wall, 1998). Moreover, when a girl is in labour and having complications, her "kunya" makes her delay seeking timely help until it is too late to prevent morbidity or mortality.

Another traditional practise which has been linked to VVF/RVF in the North is the "tsagar gishiri" cut (Last, 2006; Pathfinder 2008). This is a traditional episiotomy performed during obstructed labour by local midwives to aid the delivery of baby (Pathfinder 2008). With poor knowledge of the female anatomy, the midwife makes random cuts which often cause injury to the vagina, rectum, bladder and urethra (Wall, 1998). These five factors discussed all play a role to affects married adolescent's use of sexual and reproductive health services.

5.2 Utilization of SRH services

The social condition of married adolescents leads to low utilization of health services. Delaying first or subsequent births with family planning methods is often not a choice for married adolescents because of social pressures to start childbearing early. This influences low use of contraceptives (4%) including condoms (14%) among married girls (Singh et.al, 2004; FMOH 2007a). Children are regarded as gifts from God so people traditionally believe "family planning" obstructs the will of God (Pathfinder, 2008). Awareness of different types of contraceptives and its benefits is still low in the North especially among rural people (Wall, 1998). These beliefs compounded with the desire for a large family size hinders adolescents from utilizing family planning services.

An estimate of 760,000 abortions occurs annually in Nigeria and married women account for 37% of this burden. In Northern Nigeria, 29% of abortions are performed by a traditional healer or a friend and 20% of the women had an abortion to delay their birth (Bankole et.al, 2006). The incidence of abortion may be very low among married adolescents due to the pressure they face to bear children. However, for those who may have a miscarriage, there is no data on their utilization of post abortion care.

During pregnancy and delivery adolescent girls require more attention and care because of the higher risk they face. Only half of adolescent girls received ante natal care and 27% of them delivered with skilled attendants (FMOH, 2007a). This is similar with the general low demand for maternal health services among women of reproductive age in the region. In a study among eclampsia patients in a hospital in the North, majority (83%) did not attend ANC throughout their pregnancy and more than half delayed accessing the health facility for timely care (Tukur, et.al, 2007). Home delivery still seems to be the norm among women in the North. A UNICEF study in the Northern region showed 85% of the women delivered at home out of which only 5% had skilled care and only 11% sought post natal care (Galandanci et.al, 2007).

The government provides free HIV test in many public facilities but very few adolescents take advantage of this service. In 2003, only 2% of 15-19 year olds tested for HIV (IPPF and UNFPA, 2006b) with a slight increase to 7% in 2007 (FMOH, 2007a). The proportion of married girls accessing this service may be lower due to their peculiar social circumstance. Adolescents need prevention services that provide information and counselling on HIV and other sexuality issues to help them learn skills, assess their risks and make informed choices (WHO, 2004). Available data shows this is far from reality in Nigeria. Low utilization of SRH by married adolescents is affected by their health seeking behaviour.

5.3 Health Seeking Behaviour

The social condition of married adolescents – low literacy, knowledge and economic dependency- are factors which have a bearing on their health seeking behaviour. This lack of power and control over their health and lives makes them less motivated to seek care. The health belief model developed by Rosenstock, Strecher and Becker, (1994) has been used by several experts to examine the attitudes of individuals to see how it influences their behaviour (FHI, 2004).

I will examine the health seeking behaviour of married adolescents with the use of four elements of the health belief model which are: perceived susceptibility, perceived severity, perceived benefits and perceived barriers.

Perceived susceptibility is defined as one's subjective perception of the risk of contracting a health condition (FHI, 2004). This implies if a person does not feel he/she is at risk of a health problem, then they are not motivated to seek care. For instance, a health problem associated with adolescent girls is VVF but their perceived susceptibility to the problem is still low. The National HIV/AIDS and Reproductive Health Survey (FMOH, 2007) show only 50% and 37% of 15-19 year olds recognize VVF can be prevented by avoiding early marriage and childbirth respectively. Similarly, 64% of them feel they are at no risk of HIV infection (FMOH, 2007a) including almost half of those in polygamous unions (Erulkar and Bello, 2007). Once they don't see themselves at risk, they will not seek healthcare.

Perceived severity can be termed as feelings concerning the seriousness of contracting an illness or of leaving it untreated (including evaluations of both medical and social consequences) (FHI, 2004). Some young girls understand the social and health consequences of VVF because of the stigma associated with those living with the condition. However, some girls do not see the relevance of skilled care in preventing VVF due to low awareness about the dangers of home delivery (Erulkar and Bello, 2007a). However they may not perceive skilled care delivery as a measure to prevent VVF. Awareness about the dangers of home delivery especially for girls their age may also be low. In addition, only 49% of 15-19 year olds know STIs lead to infertility (FMOH, 2007a).

Perceived benefits are termed as the believed effectiveness of strategies designed to reduce the threat of illness (FHI, 2004). If a person does not appreciate or understand the benefits of the adopted health behaviour, he/she will not take action. The young married girl may not utilise family planning services to delay childbearing because proving her fertility to gain respect and acceptance in the family far outweigh delaying her first birth for better health status. Utilisation of maternal care services is also still low due to poor understanding of the value of skilled care over the popular local midwives (Pathfinder, 2008).

Perceived barriers are regarded as the potential negative consequences that may result from taking particular health actions, including physical, psychological, and financial demands (FHI, 2004).
This perception is more or less related with people's concern about being harmed when they take a health action. The popular myth about the adverse effect of contraceptives is still prominent among people. Three fourths of women still believe contraceptives can lead to infertility and only 41% of adolescent girls support contraceptive use (FMOH, 2007a). This misconception and personal bias ultimately acts as a barrier to utilise family planning services.

Poor perception of the quality of services also matter. Some people believe a hospital is a place for the sick to die (Last, 2006) because of rumoured or actual cases of maternal deaths. Some other reasons given by women for not delivering at health facilities include prohibition by their husbands (purdah system), cost, and hostile attitude of health workers (Pathfinder; 1998 and 2008). Seeking care without getting permission from the husband can lead to punishment and where there is little or no money available, health needs will not be a priority.

5.4 Health System Response

At the world children summit (2002) the UN General Assembly called for a reduction in maternal death rates of adolescent mothers through "ready and affordable access to essential obstetric care, well-equipped and adequately staffed maternal healthcare services, skilled attendance at delivery, emergency obstetric care, effective referral and transport to higher levels of care when necessary, post-partum care and family planning in order to, inter alia, promote safe motherhood" (UNFPA, 2003).

The health system in Nigeria has deteriorated over the years and is facing several challenges preventing it from coping with the needs of the general population (DFID, 2000; NPC, 2003a). With the aid of the Access model by Penchansky and Thomas (1981), the health system response to SRH needs of married girls is discussed below.

Availability measures the extent to which the provider has the requisite resources, such as personnel and technology, to meet the needs of the client (Wyszewianski, 2002). Available data from the Federal Ministry of Health in 1999 reveal there were 18,258 registered PHC facilities, 3,275 secondary facilities and 29 tertiary facilities across the country (PRINN-MNCH, 2008). Majority of these facilities are in dire need of rehabilitation. Dilapidated physical infrastructure, lack of equipments, power supply, drugs and water are common features of public health facilities (Last, 2006). Research reveals only about half of PHC facilities in Nigeria provide antenatal care services and about one fifth of maternal health care services meet the required standard for essential obstetric care (PRINN-MCH, 2008).

There is an appreciable stock of human resources for health Nigeria. There are 52,408 doctors, 128,918 nurses and 90,489 midwives registered in the country (FMOH, 2008). However, there is an uneven distribution as more than half of the skilled health workers are found in the South West. Only 4% and 8% of doctors work in the North East and North West translating to 35.5 doctors and 24 doctors per one million populations in each respective region (FMOH, 2008). There are several reasons for this uneven distribution the most important being financial and social, differences among the zones (PRINN-MCH, 2008).

Some health providers lack the skills and knowledge required to address the physical and emotional needs of married adolescents. Some are also reluctant to provide contraceptives to young married girls until they have had one or two children (Senderowitz, 1997). This shows health workers are not immune to social and cultural norms and perception that discourage regulation of fertility.

Existing Youth Friendly Service (YFS) centers are designed to meet the needs of unmarried adolescent girls and rarely accommodate the peculiar needs of married girls. A recent assessment of the national response to young people's SRH needs reveal a negligible number of public facilities are currently providing some element of YFS in Nigeria (FMOH, 2009). The very few YFS centers functioning are run by NGOs with funding from donors or international agencies. A few public health facilities in the North have been supported through staff training on Adolescent Reproductive Health, Information Education Communication (IEC) materials, and equipments to provide YFS to adolescents (Pathfinder 1998; AHI, 2004; Ku Saurara, 2005). However, sustainability of the intervention is weak due to regular transfer of staff, poor ownership, funding and management.

Information on sexual well-being, motherhood, ANC and delivery and other important needs of married girls are missing from YFS services (Bruce & Clark, 2003) in Nigeria. In 2002, an estimate of 8,953 maternity and primary health care centres, and teaching hospitals were providing some level of sexual and reproductive health services. Prevention of mother to child HIV transmission services were scaled up from 11 -200 operational sites 2002 (IPPF and UNFPA, 2006b). For a population of 140 million, these services are grossly inadequate to meet the needs of the people.

Accessibility refers to geographic accessibility, which is determined by how easily the client can physically reach the provider's location. Recently, it is documented that only 56.5 percent of Nigerians have access to health care. The proportion of households residing within 10 kilometres of a health centre, clinic or hospital is 73% in the Northeast and 67% in the Northwest regions (PRINN-MNCH, 2008). This distance is still too far for people to easily access health facilities especially in rural

areas where there are bad roads and inefficient public transport system. Nigeria was rated 43 (out of 100)* in providing access to safe motherhood services. Rural access was even lower at 29 while urban access scored 57 (Futures Group, undated). Ambulance services are rare (even in urban areas) so in emergency cases, people have to hire a vehicle to transport a woman in labour to the hospital (Last, 2006). In some cases, distance and poor condition of the roads to the health facility is a barrier. In a state wide study of maternal deaths in Kano state, mothers in rural areas and those living 20km away from facilities were four times more likely to die than other women (Adamu et.al 2003). Ironically, where geographic access is conducive, some women are either not permitted or are delayed to seek care (Wall, 1998).

Affordability is determined by how the provider's charges relate to the client's ability and willingness to pay for services. Most adolescents are economically dependent on their husbands and families-in-law so they personally cannot afford health care. Considering the high rate of poverty (70%), and lack of social security from the government (IMF, 2005; WHO, 2006) many families incur catastrophic cost on their income for health services. The private sector's total expenditure on health is 74.5% out of which 91% are out of pocket expenditure (WHO, 2006).

Some states in the North such as Bauchi, Gombe and the Federal Capital Territory have implemented free maternal care services to encourage mothers who are hindered because of cost to deliver in the hospitals. In other states where maternal care is not free, user fees, cost of drugs and cost of emergency obstetric care deters women from using the facilities. In cases where it is obvious a girl in labour may not survive, she is left to die at home rather than incur a double cost of transporting her to the hospital and returning her body back home to bury (Last, 2006). Private clinics provide good services but at a cost which is unaffordable to majority of families. In relation to family planning methods about 64% of 15-19 years old, feel condoms are affordable, but for emergency contraceptives and IUD, only 8% and 9% agree (FMOH, 2007a).

Acceptability captures the extent to which the client is comfortable with the more immutable characteristics of the provider. These characteristics include the age, sex, social class, and ethnicity of the provider (and of the client), as well as the diagnosis and type of coverage of the client. The sex of the provider has always been a hindrance for women in the North. In conservative areas where purdah is practised the women are uncomfortable with exposing their genitals to strangers or worse still male providers, so local female midwives are preferred (Wall, 1998). The position of delivery is also a known factor. Many women in the North prefer the squatting position when delivering (UNFPA and Engender health, 2003) than the standard lithotomy position preferred at health facilities. Understanding some of this traditional practice will enable health

* Composite figure based on an evaluation by health experts on maternal and neonatal services using a scale of 0–100, with 0 indicating a low score and 100 indicating a high score.

workers respond more sensitively to the needs of women. Poor quality of services caused by inadequate human and material resources in the health facilities also discourages people from using the services.

Chapter Six: Good Practices to Improve Sexual and Reproductive Health of Married Adolescents

Learning from the experiences of other countries with a high rate of married adolescents will help inform what can be adopted in the context of Nigeria. This chapter highlights examples of some interventions that have worked in other countries to improve the sexual and reproductive health of married girls.

6.1 Programmes targeting early marriage

Building alliances with key stakeholders such as Community members, government and local civil society has proven to help reduce the practice of early marriage. In Amhara region in Ethiopia, more than half of the girls are married by age 15. To address this practice, Population Council and the local government implemented a project to delay child marriage by using a combination of approaches such as female mentor groups, promotion of formal and informal education, participatory community discussions and economic incentives to reward girls who delay marriage. The greatest impact of the project delayed marriages of girls 10-14 years to their late teens. In comparison with a control group, the married girls had a better social network, an increased knowledge of RH issues and higher use of contraceptives (Erulkar and Muthengi, 2009).

In another part of the same region, the enforcement of the law worked as an added advantage to create change. Pathfinder International collaborated with key partners such as Women associations, Law enforcement agencies, Ethiopian Women Lawyers Association and Community groups to carry out extensive advocacy and legal intervention against early marriage and other harmful practices. Parents were discouraged from marrying off their daughters early and in cases where they refused were fined or legally prosecuted. Girls were also trained as peer educators in school and provided social support to girls at risk of being married or withdrawn. In addition influential people like religious and community leaders and local government officials formed a strong committee to campaign against early marriage. The combination of community activism and law enforcement worked to enforce the legal age of 18 for girls to be married in the region. In less than two years, 14,000 marriages were prevented or annulled successfully (Pathfinder 2006).

Another success story of using engaging communities to stop early marriage was shared by an NGO known as Tostan which worked with over 400 predominantly Muslim villages in Senegal and Guinea. The communities were empowered through activities on education, literacy and micro-credit projects which were all based on human rights principles. Religious leaders initially opposed the initiative but after more than 18 months of advocacy, religious and traditional leaders, village chiefs and representatives from several villages publicly renounced and made commitments to stop the practice of early marriage (WHO & UNFPA, 2006).

Life skills training for girls have also shown to have a positive impact on delaying marriage for girls. In Maharashtra, India, parents of young girls and community members were actively engaged by the Institute for Health Management, Pachod to allow their daughters participate in a one year Life skills programme. The course covered health issues like early marriage its negative consequences and other social skills. Girls who completed the course were more confident and empowered to make decisions such as refusing or convincing their parents to delay their marriage. Median age at marriage for girls in the target area increased from 14-17 at the end of project (ICRW, 2007a).

6.2 Programmes targeting Health care services

Experiences from other interventions focused on improving the social and health status of married girls through community empowerment and strengthening of the health care services.

The Population council implemented a project in two rural areas in India targeting adolescent girls who were newly married, pregnant for the first time or first time mothers. Some of the objectives of the project were to increase the girls' knowledge on RH, improve their maternal health practices and broaden their social support and network through young women's group and community activities. The project also served husbands of adolescent girls, mothers-in-law, health workers and the wider community. Home visits were paid to married girls and their husbands to provide them with SRH information on topics such as contraceptives, voluntary and safe sex, developing a delivery plan and care during and after pregnancy. Key effects of the project showed a significant improvement of social support for married girls, a 54% increase in knowledge of SRH issues and an improvement of partner communication and support on contraceptive use (Population Council 2008).

Similarly, the project improved the capacity of health providers to meet the needs of married adolescents. Traditional birth attendants were trained on safe delivery and provided with kits. Health workers from primary health centers and private facilities were also trained to improve the quality of their family planning, antenatal and delivery services. Health workers paid home visits to first time mothers six weeks after birth and bi-monthly thereafter for one year. Positive results include 11% increase in contraceptive use to delay first birth, 30% rise in early registration for antenatal and 26% rise in comprehensive ANC use among adolescent girls. Institutional delivery, post-partum care and breastfeeding practices were also significantly improved (Population Council, 2008).

In another part of Asia, a reproductive health project for married adolescents in Nepal used the same multi-level approach to provide SRH information and services by:

- Training married adolescent girls as peer educators to organize events to share RH information.
- Sensitizing influential family and community members like mothers and sisters-in-law, religious leaders and teachers to support married adolescent's access to SRH information and services.
- Strengthening the capacity of local health facilities to provide Youth Friendly Services to married adolescents through staff training, supply of essential equipments and technical support.

Project impact showed an increase in awareness on contraceptives and where to get them. ANC attendance by pregnant girls rose from 29% to 50% and home delivery dropped by 8% while post natal care increased from 20% to 30% (Acquire, 2008).

Providing health education to married girls on maternal health improves their health seeking behaviour. In a hospital based program in Mexico, 86% of pregnant adolescents who received family planning information and counseling during their prenatal sessions, returned for more ANC check–up and were more willing to space their children than 64% of those who did not receive the information (Senderowitz, 1997). In a related intervention in Bangladesh, adolescent girls were sensitized to seek ANC from trained birth attendants and educated on breastfeeding practices and nutrition. The evaluation showed 78% of young girls reached delivered with a skilled birth attendant compared to 41% of those not targeted and 89% fed their newborns with colostrum compared to 50% of other mothers (MacLaren, 1999).

Chapter Seven: Discussion, Conclusion and Recommendations

This chapter presents a discussion of the main findings of this thesis and proffers recommendations and a conclusion.

7.1 Discussion

The main objective of this thesis was to analyse the sexual and reproductive health problems and needs of married adolescents. The first part highlighted factors which contribute to early marriage; the second part showed the specific SRH problems and needs of married adolescents and the last part revealed the determinants of these problems.

The findings from this research reveal the key contributing factors to early marriage are culture and religion. Patriarchal norms have overtime become mixed with religious ideals to make people believe early marriage is a safety net for girls. The unclear or lack of a prescribed minimum age of marriage for girls in Islamic law leaves room for people to justify early marriage. Poverty and gender inequality further reduces girls to commodities that can be traded off into marriage. This finding is comparable to what is happening in other countries. A UNICEF study in six West African countries showed that the practice of early marriage continues because of the need to follow tradition, reinforce ties among or between communities, and protect girls from out-of-wedlock pregnancy (UNICEF, 2001). Half of the problem of early marriage in Northern Nigeria will be solved if efforts are made to define, adopt and enforce the universal minimum age of 18 in the Islamic laws operating in the Northern states.

Low literacy is quite common among married adolescents. Many girls start primary schools with the boys but are withdrawn or not allowed to proceed to secondary school because of early marriage. Parents need to be sensitized to give their daughters equal opportunities like their sons to complete their secondary school education. Education will not just benefit the girls but also give them better opportunities to develop their communities. The project in Amhara region rewarded girls who remained unmarried with a goat as an incentive (Erulkar and Muthengi, 2009). Poor families may need incentives to encourage them to retain their daughters in school. More research is needed to determine what incentive will be valued in Northern communities in Nigeria.

Culture is not static and with social mobilization, people can change their perception to adopt a new way of life. Many traditional and cultural practices contributing to the low status of women in Muslim societies are influenced more by the patriarchal system than Islamic injunctions (Ragab, undated; Yusuf, 2005). The positive teachings in Islam supporting education and sexual and reproductive health and rights of women must be shared with all Muslims especially through the religious clerics. Lessons can also be learnt from Muslims in Southern Nigeria whose women have higher levels of literacy and better sexual and

reproductive health status. Investments in girls and women's education and reproductive health can bring about progress in poverty reduction, sustainable development and peace (UNICEF, 2009).

Extensive and intensive community mobilization has proven to reduce the practice of child marriage in countries like Ethiopia and Senegal with predominant Muslim populations. Nigeria can borrow a leaf from these countries by mobilizing communities at the grassroots to build a strong movement against early marriage. More advocacy will be required with key religious stakeholders to record a similar success in Northern Nigeria. Influential Islamic groups such as the Jama'atil Nasril Islam (National Islamic Council), prominent Emirs, State governors and Federation of Muslim Women's Association of Nigeria (FOMWAN) in the North can play a key role in spearheading this process. Public declarations from these respected groups will have a positive multiple effects on adherents of Islam in the region.

Community initiatives should also engage men as partners to reduce the risk girls face in contracting STIs and HIV. Fathers need to be educated about the higher risks involved in marrying off their virgin daughters to older men with a long sexual history and unknown health status. In the Southern region of Nigeria, the norm of getting tested for HIV before marriage is fast spreading. In fact, some churches have institutionalized the policy of encouraging intending couples to know their HIV status before marriage. The same practice can be replicated in the North and targeted at fathers and religious leaders who conduct Islamic weddings. Similarly, better communication between husbands and adolescent wives should be encouraged.

Early childbearing is the biggest problem encountered by married adolescents in the North as 70% of them become mothers before age 20 (Singh et.al, 2004). Due to the higher risk associated with early births, higher rates of birth complications lead to VVF/RVF among married adolescents in the North. Communities must be sensitized to delay first births of very young married girls by delaying sexual initiation or allowing them to use contraceptives. Health workers within these communities should also play a key role in promoting this practice. The Population Council project in India successfully increased contraceptive use among married girls to delay their first births.

The social status of married girls must also be addressed as a matter of priority. Although none of the good practices specifically targeted keeping married girls in school, they did train single girls as peer educators in schools and provided life skills training as a strategy to retain them in schools. Special literacy programmes can be developed for married adolescents to continue their education. They can also gain from vocational skills trainings to learn how to become self-sufficient. Similarly, use of married adolescents as peers educators and women's group to conduct regular meetings and activities on SRH will improve young

married girls' access to information, social network and support. Another good way to reach many married girls in Northern Nigeria is with the Fiqh lessons taught in the Qur'anic schools. This medium will be widely accepted due to the high value placed on Religious knowledge.

Working with husbands and mothers-in-law of married girls is a good entry point to garner support for married girls to utilize SRH services. There are good examples of interventions in Nigeria and other countries which engaged communities to increase utilization of SRH services such as family planning, ANC attendance and delivery (COMPASS, 2008; Population Council, 2008). Married adolescents can also benefit from this initiative. However, the popular belief in the North that family planning leads to infertility, death or is equivalent to murder of the foetus must be dispelled to encourage contraceptive use. Recent findings have shown people in the North are more receptive to the concept of "child spacing" than "family planning" due to the belief that the latter is disrupting the will of God (Pathfinder, 2008). More health education is vital to promote the facts about contraceptive use and its benefits with the "child spacing" approach.

The three delays responsible for maternal morbidity and mortality are: delay in seeking care; delay in reaching a health facility; and delay in receiving care. Overcoming the first two delays in many Nigerian Northern homes is dependent on the husband or male relative giving permission to the women to seek skilled care and providing resources for transportation (U.S Dept. of state, 2008). Communities can play a key role to encourage men to avoid delay in seeking skilled care in cases of complications and assist those in need with timely transportation.

Health workers also need to be trained to recognize and treat married adolescents with the attention and care they deserve in a culturally sensitive manner. Married adolescents need accurate information on SRH to help them appreciate their sexuality and recognize when they are in danger (i.e. during pregnancy, RTI/STI infection). Health providers can win the trust of these girls by treating them in a friendly, respectful and non-judgmental manner. Opportunities abound through clinics providing ANC, family planning and STIs services to reach young married adolescents with information. Existing YFS centers can also be strengthened to meet the SRH needs of married adolescents. The health workers also have a duty to liaise with families, religious and community leaders to build stronger ties and solicit support to improve the SRH of married girls (WHO, 2004).

The Nigerian government has a responsibility to improve the general health system in the country. More attention must be paid to the Northern region especially in rural areas to improve people's access to health care. Good practices from other countries discussed have shown a responsive health system helps to increase contraceptive use, ANC/delivery/post partum attendance. The Federal Ministry of Health currently does not

recognize local midwives as part of the health system. If they are not recognized or supported to perform better, many more lives will be lost during home deliveries. Moreover, the midwives must also be discouraged to stop the practise of "tsagar gishiri" cut and rather be encouraged to refer girls with obstructed labour promptly for specialized care.

7.2 Conclusion

Early marriage is a social problem with dire public health consequences. Breaking the cycle of inequality, illiteracy, illness and poverty among married adolescents will go a long way in improving their sexual and reproductive health. The peculiar sexual and reproductive health needs of married adolescent girls in Northern Nigeria must be treated as a national priority. Improving the sexual and reproductive health of married adolescents in Northern Nigeria will not only bring great gains to the country's development but will help Nigeria achieve the MDGs 1-6. The recommendations stated below are provided to government, development partners and stakeholders to improve the social and health condition of married adolescents.

7.3 Recommendations

Policy

- The Nigerian government should define, adopt and enforce the universal minimum age of 18 into the Islamic and customary laws operating in the Northern states. A National forum with influential Islamic stakeholders should be convened to promote the agenda.
- The government should also engage influential Islamic bodies such as the Jama'atil Nasril Islam (National Islamic Council), prominent Emirs and the Federation of Muslim Women's Association of Nigeria (FOMWAN) to discourage the practise of early marriage

Research

- A research on specific SRH needs of married adolescents in Northern Nigeria is essential to determine effective ways to reach them with information and services
- A research should be conducted on incentives families in Northern Nigeria will value to retain their daughters in school
- An exploration study on factors that leading to higher literacy and better sexual and reproductive health status among Muslim girls and women in the South should be conducted

Education/Vocational skills training

- Promotion of girl child education must be intensified in the North and scholarships, books, uniforms and other incentives should be provided by government to support poor families
- The capacity of the Qur'anic instructors and schools must be strengthened to provide teachings on the Fiqh which covers sexual and reproductive health and family life issues.

- Economic empowerment should be provided to married adolescents through vocational skills training

Community

Intensive advocacy and community mobilization should be done to:

- Discourage early marriage
- Discourage practise of "Kunya"
- Increase SRH service utilization – Family planning, ANC, Delivery, Post partum, STIs and Sexuality
- Promote utilization of HIV Counselling and Testing services for young girls and their prospective husbands
- Create more public awareness on sexual and reproductive health and rights and economic and educational rights of women in Islam

Health services

Government at all levels (federal, state and local) must be committed to provide necessary human and material resources for health services to function and respond to the needs of married adolescents. Specifically government should:

- Strengthen the capacity of existing Youth Friendly Service centers to provide sexuality information and counseling to married adolescents and referral for further care
- Strengthen maternal health services in the North to be more responsive to the needs of married adolescents
- Train local midwives in Northern Nigeria on safe delivery, maternal and child care and supply them with delivery kits.
- Sensitize local midwives on the consequences of performing "tsagar gishiri" cuts to discourage the practise
- Establish stronger referral systems between local midwives, primary health centers and secondary health facilities to respond to cases of birth complications

References

Action Health Incorporated (AHI). (2005). *Meeting the Sexual and Reproductive Health Needs of Young People in Nigeria*. http://www.actionhealthinc.org/publications/downloads/srh_guide.pdf

Action Health Incorporated (2004). *Access Report. Bulletin on Promoting Access to Information and Services to Young People*. (Accessed 4 August 2009) http://www.actionhealthinc.org/publications/downloads/accessrep2.pdf

Acquire Project (2008). *Mobilizing Married Youth in Nepal to Improve Reproductive Health: The Reproductive Health for Married Adolescent Couples Project*, Nepal, 2005–2007 http://www.acquireproject.org/fileadmin/user_upload/ACQUIRE/Publications/RHMACP-Report-final.pdf

Adamu Yusuf, Hamisu Salihu, Nalini Sathiakumar and Greg Alexander. (2003). *Maternal Mortality in northern Nigeria: a Population based Study*. European Journal of Obstetrics and Gynaecology and Reproductive Biology 109; 153-159.

Advocates for Youth. 2001. *Adolescent Reproductive Health in Nigeria*. (Accessed 5 July 2009) http://www.advocatesforyouth.org/storage/advfy/documents/fsnigeria.pdf

Bankole Akinrinola, Singh Susheela, Woog Vanessa, Wulf Deirdre. (2004). *Risks and Protection- Youth and HIV/AIDS in Sub-Saharan Africa.* Guttmacher Institute. (Accessed 10 July 2009) http://www.guttmacher.org/pubs/riskandprotection.pdf

Bankole Akinrinola, Oye-Adeniran Boniface, Susheela Singh, Adewole Isaac et.al. (2006). Unwanted Pregnancy and Induced Abortion in Nigeria: Causes and Consequences. Guttmacher Institute and Campaign Against Unwanted Pregnancy.

Blum Robert and Nelson-Nmari Kristin. 2004. *The Health of Young People in a Global Context. Journal of Adolescent Health*. Volume 35, Issue 5. November 2004, Pages 402-418

Bruce Judith and Clark Shelley. (2003). *Including Married Adolescents in Adolescent Reproductive Health and HIV/AIDS*. Policy Paper prepared for the WHO/UNFPA/Population Council Technical Consultation on Married Adolescents, WHO, Geneva, 9–12 December 2003.

Central Intelligence Agency (CIA). (2008). *The CIA World Fact Book.*

Center for Reproductive Rights. (2003). *Women of the World-Laws and Policies Affecting their Reproductive Rights-Nigeria*.

Centre for Islamic Legal Studies (CILS), Ahmadu Bello University, Zaria. (2005). *Promoting Women's Rights through Sharia in Northern Nigeria*. (Accessed 8 August 2009) http://www.dfid.gov.uk/Documents/publications/promoting-women-sharia.pdf

Community Participation for Action in the Social Sector (COMPASS). 2008. *Success story- Unreceptive Muslim Religious Leaders Promote and Practice Family Planning in Nasarawa State*. (Accessed 14 August 2009) http://pf5.convio.net/site/PageServer?pagename=Success_Stories_2008_Muslim_Leaders_Promot_FP

Department for International Development (DFID), United Kingdom. (2000). *Country Health Briefing Paper-Nigeria. DFID Health Systems Resource Center*. (Accessed June 29 2009) http://www.dfidhealthrc.org/publications/Country_health/Nigeria.pdf

Doi Abdur Rahman I. (undated) Center for Islamic Legal Studies, Ahmadu Bello University, Zaira, Nigeria. (Accessed 1 August 2009) http://www.msawest.net/islam/humanrelations/womeninislam/womeninsociety.html

Erulkar A, Bello Mairo. 2007. The Experience of Married Adolescent Girls in Northern Nigeria. Population Council. http://www.popcouncil.org/pdfs/Nigeria_MarriedAdol.pdf (Accessed 2 June 2009)

Erulkar Annabel, Eunice Muthengi (2009) Evaluation of Berhane Hewan: A Program to Delay Child Marriage in Rural Ethiopia. International Perspectives on Sexual and Reproductive Health, 2009, 35(1):6–14. http://www.guttmacher.org/pubs/journals/3500609.pdf

Family Health International. (2004). Behavior Change -A Summary of Four Major Theories.

Forward (2002). Child and Forced Marriage. http://www.forwarduk.org.uk/key-issues/child-marriage (Accessed 5 August 2009)

Frontline World (2003). The Road North. Nigerian Women Speak Out. http://www.pbs.org/frontlineworld/stories/nigeria/voice03.html (Accessed 5 August 2009)

Federal Ministry of Health (FMOH), Nigeria. (2003). *National HIV/AIDS and Reproductive Health Survey (NARHS).*

Federal Ministry of Health, Nigeria (FMOH). (2005). *National HIV/Syphilis Sero-prevalence Sentinel Survey among Pregnant women attending Ante-natal clinic in Nigeria.*

Federal Ministry of Health (FMOH), Nigeria. (2007a). *National HIV/AIDS and Reproductive Health Survey (NARHS).*

Federal Ministry of Health (FMOH), Nigeria (2007b). *National Strategic Framework on the Health and Development of Adolescents and Young People in Nigeria.*

Federal Ministry of Health (FMOH), Nigeria. (2008). *Health workforce Country Profile for Nigeria.*

Federal Ministry of Health (FMOH), Nigeria. (2009). *Assessment Report of the National Response to Young People Sexual and Reproductive Health in Nigeria.*

Futures Group International (undated). *The Maternal and Neonatal Program Effort Index (MNPI).* (Accessed 17 August 2009) http://pdf.usaid.gov/pdf_docs/PNACR879.pdf

Galadanci HS, Ejembi CL, Iliyasu Z, Alagh B, Umar US (2007) *Maternal health in Northern Nigeria—a far cry from ideal*. BJOG114; 448-452.

Hausmann-Muela Susanna, Ribera Muela Joan and Nyamongo Isaac. (2003) *Health-seeking behaviour and the health system response.* DCPP Working Paper No. 14.

International Center for Research on Women. (2004). *When Marriage is No Haven-Child Marriage in developing countries*.

International Center for Research on Women (2007a). *Too Young to Wed-Education and Action to End Child Marriage.* http://www.icrw.org/docs/2006_cmtoolkit/cm_factsheets_success.pdf

International Center for Research on Women (2007b). *How to End Child Marriage-Action Strategies for Prevention and Protection*. http://www.icrw.org/docs/2006_cmtoolkit/cm_factsheets_success.pdf

International Conference on Population and Development (ICPD) Report (1994). United Nations Population Information Network.

International Monetary Fund (2005). Nigeria: Poverty Reduction Strategy Paper—National Economic Empowerment and Development Strategy. (Accessed 15 June) http://www.imf.org/external/pubs/ft/scr/2005/cr05433.pdf checked 7 February 2009

Interagency Gender Working Group and WHO. (2005). *A Summary of "So What?" Report. A Look at Whether Integrating a Gender Focus Into Programmes Makes a Difference to Outcomes*.

IPPF, UNFPA and the Global Coalition on Women and AIDS. (2006a). *Ending Child Marriage*. (Accessed 5 August) http://www.ippf.org/NR/rdonlyres/8415A7E9-0833-4500-AE53-9AA09F1A56D8/0/endchildmarriage.pdf

IPPF and UNFPA. (2006b).Report *Card-HIV Prevention for Girls and Young Women*. http://www.unfpa.org/hiv/docs/report-cards/nigeria.pdf

Ityavar Dennis and Jalingo Inuwa Bakari. (2006).*The State of Married Adolescents in Northern Nigeria.* Action Health Incorporated. (Accessed 14 July 2009) http://www.actionhealthinc.org/publications/downloads/married.pdf

Immigration and Refugee Board of Canada. (2006) *Nigeria: Forced marriage among the Yoruba, Igbo, and Hausa-Fulani; prevalence, consequences for a woman or minor who refuses to participate in the marriage; availability of state protection*, 3 March 2006, NGA101044.E

Kabir M. 2004. *Medico-Social Problems of Patients with Vesico-Vaginal Fistula in Murtala Mohammed Specialist Hospital, Kano*. Annals of African Medicine. Vol. 2, No. 2, 2004, pp. 54-57

Ku Saurara (Listen Up!) Project Nigeria. (2005) http://www.jhuccp.org/africa/nigeria/kusaurara_ph2.shtml (Accessed 16 August 2009)

Leenstra T., Kariuki S.T., Kurtis J.D., Oloo A.J., Kager P.A. and ter Kuile F.O. (2004) *Prevalence and severity of anemia and iron deficiency: cross-sectional studies in adolescent schoolgirls in western Kenya.* European Journal of Clinical Nutrition (2004) 58, 681–691. doi:10.1038/sj.ejcn.1601865.

Last, Murray. (2006). *Hausa-Encyclopedia of Medical Anthropology Health and Illness in the World's Cultures*. Volume I: Topics Volume II: Cultures. 10.1007/0-387-29905-X_74. Pg 718-729.
Macarthur Foundation Newsletter: Winter 2007 Population and Reproductive Health. Sexuality Education shows Results in Nigeria.

MacLaren, Alauddin. (1999) *Reaching Newlywed and Married Adolescents.* Youth lens. Family Health International.

Makinwa-Adebusoye Paulina. (2006). Hidden-The status of Married Adolescents in Northern Nigeria. Action Health Incorporated. http://www.actionhealthinc.org/publications/downloads/hidden.pdf (Accessed 20 June 2009)

MSAWEST. Undated. Sunna and Hadith. (Accessed 6 August 2009) http://www.msawest.net/islam/fundamentals/hadithsunnah/

National Bureau of Statistics (NBS), Federal Republic of Nigeria. 2006 Population Census. http://www.nigerianstat.gov.ng/Connections/Pop2006.pdf (Accessed May 3 2009)

National Population Commission [Nigeria] and ORC Macro. (2003a). Nigeria Demographic and Health Survey 2003: Key Findings.

National Population Commission [Nigeria] and ORC Macro. (2003b). Nigeria Demographic and Health Survey (NDHS). MEASURE DHS. Key Indicators for Youth aged 15-24.

National Population Commission [Nigeria] and ORC Macro. (2004). *Nigeria DHS Education Data Survey 2004: Education Data for Decision-Making*. Calverton, Maryland, USA: National Population Commission and ORC Macro.

Nnorom, Chinyere. (2006) *Forms and Dynamics of Marriage Relationships and the Sexual Health Needs of Married Partners.* Understanding Human Sexuality Seminar Series 4. Africa Regional Sexuality Resource Centre. http://www.arsrc.org/downloads/uhsss/nnorom.pdf

Okonofua, Friday, Ogonor, James, Omorodion, Franscisca, Temin, Miriam, Coplan, Paul, Kaufman, Joan, Heggenhougen, Kristian. (1999). *Assessment of Health Services for Treatment of Sexually Transmitted Infections among Nigerian Adolescents*. American Sexually Transmitted Diseases Association Journal. Volume 26(3), March 1999, Pp 184-190.

Osman Fathi. (Undated). *Muslim Women, the Family and the Society.* Omar Ibn Al Khattab Foundation. (accessed 1 August 2009) http://www.usc.edu/schools/college/crcc/private/cmje/issues/MUSLIM_WOMEN.pdf

Pan American Health Organisation (PAHO) and WHO. (2000). Promotion of Sexual Health Recommendations for Action. http://www.paho.org/english/hcp/hca/promotionsexualhealth.pdf (Accessed 12 August)

Partnership for Reviewing Routine Immunisation in Northern Nigeria; Maternal Newborn and Child Health Initiative (PRINN-MCH). *A Desk Review of Maternal, Neonatal and Child Health Issues in Northern Nigeria*. (2008). Save the children, Health Partners International and GRID Consulting Limited (unpublished).

Pathfinder International (1998) *Insights from Adolescent Project Experience.* http://www.pathfind.org/pf/pubs/insights.pdf (Accessed 12 August)

Pathfinder International (2006). *Creating Partnerships to Prevent Early Marriage in Amhara Region.* (Accessed 12 August) http://www.pathfind.org/site/DocServer/Pathfinder_Ethiopia_Report_FINAL.pdf?docID=6581

Pathfinder International. (2008) *Reproductive Health Knowledge and Practices in Northern Nigeria: Challenging Misconceptions*. http://www.pathfind.org/site/DocServer/Reproductive_Health_Knowledge_Northern_Nigeria.pdf?docID=10861 (Accessed 12 August)

Population council. 2005. *Child Marriage Briefing-Nigeria.* (Accessed June 1 2009) http://www.popcouncil.org/pdfs/briefingsheets/NIGERIA_2005.pdf

Population Council (2008). *Empowering Married Young Women and Improving their Sexual and Reproductive Health: Effects of the First-time Parents Project.* (Accessed 14 August 2009) http://www.popcouncil.org/pdfs/India_FirstTimeParents.pdf

Population Reference Bureau. 2009. (Accessed July 2 2009) http://www.prb.org/Datafinder/Geography/Summary.aspx?region=29&region_type=2

Ragab, Ahmed R. A. (2009) *Muslim's Perspectives on key Reproductive and Sexual Health Issues*. Africa Regional Sexuality Resource Centre. http://www.arsrc.org/features/issue006.htm (Accessed 12 August)

Senderowitz J. (1997) Do Youth-Friendly Services make a Difference. YouthNet. Family Health International.

Senderowitz J (1998). Young People and Anemia. YouthNet. Family Health International.

Sedgh Gilda, Akinrinola Bankole, Friday Okonofua, Collins Imarhiagbe, Rubina Hussain, Deirdre Wulf. (2009). Meeting Young Women's Sexual and Reproductive Health Needs in Nigeria. Guttmacher Institute.

Schutt-Aine Jessie and Maddaleno Matilde. (2003) Sexual Health and Development of Adolescents and Youth in the Americas-Program and Policy Implications. Pan American Health Organisation (PAHO). http://www.paho.org/English/HPP/HPF/ADOL/SRH.pdf (Accessed 2 July 2009)

Singh Susheela, Audam Suzette and Wulf Deirdre. (2004). *Early Childbearing in Nigeria: a Continuing Challenge.* Research in Brief, New York: The Guttmacher Institute: 2004 (No. 2).

Sohail Agha. (2008). *Changes in the Timing of Sexual Initiation among Young Muslim and Christian Women in Nigeria.* Archives of Sexual Behaviour- 1573-2800. Springer Netherlands.

Stanley K. Henshaw, Susheela Singh, Boniface A. Oye-Adeniran, Isaac F. Adewole, Ngozi Iwere and Yvette P. Cuca. (1998) *The Incidence of Induced Abortion in Nigeria*. Guttmacher Institute. International Family Planning Perspectives, Volume Number 4, December 1998.

Tukur J., Umar B.A, Rabi'u A. (2007). *Pattern of Eclampsia in a Tertiary Health Facility Situated in a Semi-Rural Town in Northern Nigeria.* Annals of African Medicine, Vol. 6, No. 4; 164-167.

UNDP. (2007/2008) Human Development Report.

UNFPA and Engender health. (2003). *Obstetric Fistula Needs Assessment Report: Nigeria*

UNFPA State of the World Population (2003).

UNFPA. 2005. *Child Marriage Fact Sheet*. State of the World Population 2005.

UNFPA. (2008). State of the World Population 2008-Youth Supplement. Generation of Change, Young People and Culture.

United Nations. (2008). Millennium Development Goal Report 2008.

UNICEF. (2001). Early marriage-Child Spouses. Innocenti Digest, No 7. http://www.unicef-irc.org/publications/pdf/digest7e.pdf

UNICEF. (2004). At A Glance-Nigeria Statistics.

UNICEF. (2006) State of the world children.

UNICEF. (2008). Child Marriage and the Law.

UNICEF. (2009). The State of the World's Children-Maternal and Newborn Health.

U.S Department of State. (2008). Human Rights Report: Nigeria. Bureau of Democracy, Human Rights, and Labor. (Accessed 18 July 2009) http://www.state.gov/g/drl/rls/hrrpt/2008/af/119018.htm

Watson Catherine and Brazier Ellen (2000). You, Your Life, Your Dreams: A Book for Adolescents. Family Care International and Straight Talk Foundation. (Accessed 22 July 2006) http://familycareintl.org/en/resources/publications/14

Wall Lewis. (1998) Dead Mothers and Injured Wives: The Social Context of Maternal Morbidity and Mortality among the Hausa of Northern Nigeria.

WHO. (2000). World Health Report. Health Systems: Improving Performance.

WHO and UNFPA. (2003) Pregnant Adolescents- Delivering on Global Promises of Hope.

WHO. (2004). Protecting young people from HIV and AIDS- the role of health services.

WHO, UNFPA, UNICEF and The World bank. (2005) Maternal Mortality in 2005.

WHO. (2006). Country Health System Fact Sheet Nigeria.

WHO and UNFPA. (2006). Married adolescents-No Place of Escape. http://whqlibdoc.who.int/publications/2006/9241593776_eng.pdf (Accessed May 30 2009)

WHO (2007). Helping Parents in Developing Countries Improve Adolescent's Health.

WHO. (2008) Why is Giving Special Attention to Adolescents Important for Achieving Millennium Development Goal 5? Factsheet.

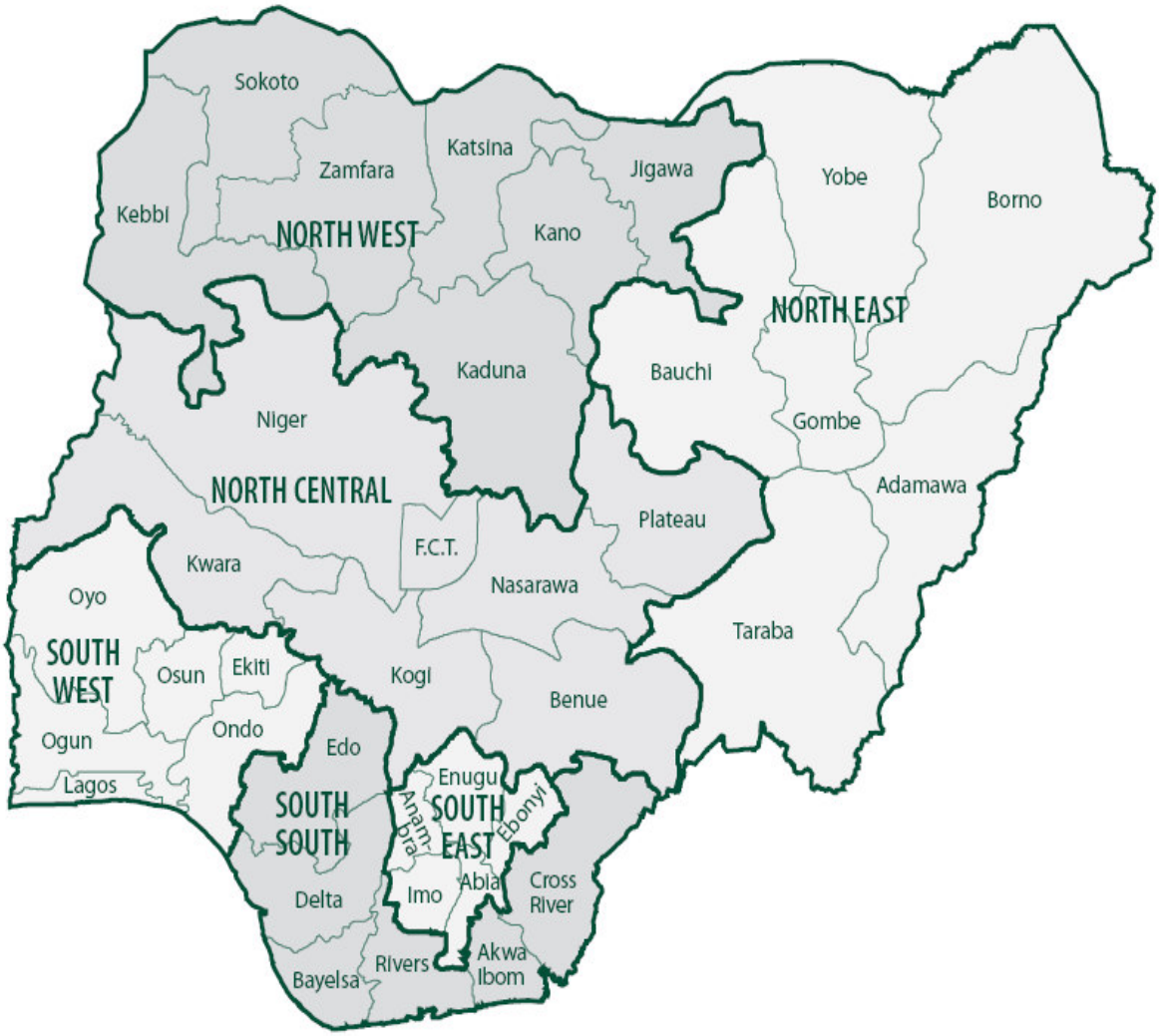
World Bank. (2006). Maternal Mortality. Public health at a Glance.

World Federation of Khoja Shia Ithna-Asheri Muslim Communities. (Undated). Fiqh and Fuqaha. (Accessed 10 August 2009) http://www.al-islam.org/fiqh/

Wyszewianski Leon. (2002). Access to Care: Remembering Old Lessons. Health Research and Education Trust. Volume 37(6): 1441–1443.

Yusuf Bilikisu. (2005) Sexuality and the Marriage Institution in Islam: An Appraisal. Understanding Human Sexuality Seminar Series 4. Africa Regional Sexuality Resource Centre. (Accessed 18 July 2009) http://www.arsrc.org/downloads/uhsss/bilkisu.pdf

Annexes
Annex 1: Map of Nigeria



Source: Nigerian Demographic and Health Survey (NDHS), 2003.

Annex 2: Effects of Early Marriage on the MDGs

Goal 1: Eradicate extreme poverty and hunger Young married girls are less likely to have the skills and training to be economically independent.
Goal 2: Achieve universal primary education Young girls below age 15 are unable to complete their primary school education when they get married.
Goal 3: Promote gender equality and empower women Girls are often denied their right to decide who and when to marry. Early marriage also makes them less empowered and confident to make informed decisions about their sexual and reproductive health.
Goal 4: Reduce child mortality Children of adolescent girls are more at risk of dying than women who are above the age of twenty.
Goal 5: Improve maternal health Adolescent girls contribute to maternal mortality because of the higher risk they face during and after childbirth. They are twice at risk of death below age 18 and five times more at risk below age 15.
Goal 6: Combat HIV/AIDS, malaria and other diseases Adolescent girls who marry older men with unknown sexual histories have a higher risk of contracting HIV and other sexually transmitted diseases.

Adapted from Married adolescents-No Place for Safety (WHO & UNFPA 2006)

Annex 3: Problem Analysis Tree