Research Article

Ghana Social Science Journal
2022, Vol.19 (1): 55–73

Publisher: School of Social Sciences UG

"Who am I to tell my husband the number of children we should have?": Sexual and reproductive health experiences of victims of child marriage in Ghana

Ummu Markwei [1*], Peace Mamle Tetteh [2] and Kwaku Osei-Hwedie [3]

Abstract

Child marriage remains relatively high in developing countries such as Ghana despite several legislations against it. This study explores the sexual and reproductive health of victims of child marriages in selected communities in the Upper East Region of Ghana. Employing the qualitative data collection methods of in-depth interviews, we examine how the web of culture, age and gender of children predisposes them to child marriages and subsequent negative reproductive health outcomes. Employing snowball and purposive sampling, fifteen victims of child marriages were selected from four districts in the Upper East Region of Ghana and interviewed. Transcribed data were analysed thematically. The findings indicate that most adolescent wives have no say regarding their choice of partner, the number of children to have, their use of contraceptives and their access to health facilities during pregnancy, delivery and after delivery, due to male authority. The findings of this study underscore the need to develop the capacity and negotiation skills of adolescents for and within marriage. Ultimately, multi-level community engagements with key stakeholders such as chiefs and religious leaders need to be deployed to provide knowledge and a re-orientation on reproductive and health rights and needs of adolescents to prevent child marriages.

Article History: Received 5 May 2022 Accepted 08 August 2022

Keyword: child marriage, reproductive health, rights, decision making, Ghana.

[1] Department of Business Administration, University of Professional Studies, Accra, Ghana.
[2] Department of Sociology, University of Ghana, Legon, Accra.
[3] Kofi Annan Peace Keeping Training Centre, Accra, Ghana.
***Corresponding author:** Department of Business Administration, University of Professional Studies, Accra, Ghana.
Email: ummulois@yahoo.com

Introduction

The Global Partnership to End Child Marriage (2018) states that child marriage is a serious problem that confronts nations worldwide. It is estimated that every year, about 12 million girls get married before the age of 18. The incidence of child marriage is prevalent in many parts of sub-Saharan Africa and mostly occurs among girls (Hertrich, 2017). There are about two million child brides in Ghana, out of which 600,000 married before age 15 (United Nations Children's Fund, 2020).

Child marriage is a human rights issue which prevents girls from making informed decisions about their health and sexuality (Ahonsi et al., 2019). Hence, The African Charter on the Rights and Welfare of the Child takes a firm stance against child marriage, stating in Article 21 (2) that 'child marriage and the betrothal of girls and boys shall be prohibited'. Article 16 (2) of the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) states that `the betrothal and marriage of a child should have no legal effect' – thus, considered null and void where it happens. Again, Article 14(2) of Ghana's Children's Act (560) of 1998 sets the minimum age for marriage at 18 years, and Article 14 (1) explicitly states that a child should not be forced to be betrothed or married.

The International Conference on Population and Development (ICPD, 1994) Programme of Action, Paragraph 7.2 defines reproductive health 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' (p. 59). 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. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases' (ICPD, 1994, p. 59).

It is obvious that child marriage denies children the rights espoused in the ICPD Programme of Action. Indeed, child marriage limits the extent to which girls can decide for "themselves when and with whom to have sex, when to marry and bear children, to negotiate safe sexual practices, to access appropriate and quality sexual and reproductive health services, and ultimately to enjoy better sexual and reproductive health" (The

Global Partnership to End Child marriage, 2018, pg. 1). As a result, the Convention on the Rights of the Child (UNCRC), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), Platform for Action of the International Conference of Women and the Programme of Action of the International Conference on Population and Development (ICPD) are all international legislations that seek to ensure girls and women enjoy their sexual and reproductive health rights.

Despite the plethora of legislation to ensure reproductive and health rights of children, and indeed the proscription of child marriage in Ghana, the practice persists in a number of communities, especially, in the Upper East Region. The power structure and patriarchal norms and practices in these societies make it difficult for women, especially adolescents, to freely make decisions concerning their reproductive and sexual rights. Victims of child marriage are less likely to have access to contraceptives. They are more prone to sexual violence and lack information and education on contraceptives. They are also unable to solely decide whether to use or not use contraceptives in the few instances where these are available because of the fear of their spouses (Nash et al., 2019; Kyilleh et al., 2018; Thatte et al., 2016; Plan International, 2018; Singh et al., 2018). Victims of child marriage are usually silenced in decisions concerning their sexuality and reproductive health (Nash et al., 2019). They are unable to negotiate safe sex and have unmet needs for contraceptives (United Nation Population Fund, 2015). Further, they are unable to decide when and how often to have children (UNFPA, 2015). As a result, victims of child marriage tend to have more children at an early age (World Bank and International Centre for Research on Women, 2017).

The failure to center gender in many national policies is seen as a major reason for the inadequate progress in the maternal health of women in Africa (Nash et al., 2019). However, there are limited studies that examine the extent to which the social position of adolescent girls in marriages affect their reproductive health in Ghana. Scholars in Ghana have mostly focused on barriers to accessing reproductive health services by adolescents in relation to HIV/ Sexually transmitted diseases (STIs), abortion and contraceptives as well as adolescents' reproductive health knowledge, choices and factors affecting reproductive health choices (Thatte et al, 2016; Kyilleh et al., 2018; Markwei, 2019). For instance, a study by Markwei (2019) on parental involvement in the sexuality education of their children and its role in sexual abuse showed that lack of knowledge on adolescent reproductive health and sexuality exposed adolescents to early pregnancy. Also, studies on child marriages in Ghana have largely focused on its prevalence, causes, perceptions, and consequences (Alhassan, 2013, Domfe, 2018; de Groot et al., 2018; Sarfo et al., 2020). Relatively little is known about the extent to which the social position of married adolescent girls affects their reproductive and sexual health rights and outcomes This paper, therefore, explores the sexual and reproductive health experiences of victims of child marriages. We examine how the relatively weak social position of adolescent girls, emanating from their age, gender, and the socio-cultural context, influence their

experiences in marriage. We envisage that the recommendations made herein will enhance the discourse on child rights and lead to tangible interventions that will ensure the laws prohibiting child marriage in Ghana are enforced.

Theoretical Framework

The social norms theory is used as a framework to explore the sexual and reproductive rights of adolescent girls in marriages in Ghana. This theory is adopted mainly because it explains how the social norms engendered by a cultural context, influence social institutions such as marriage, gender relations, adult-child relations and social status and position. The social norms theory posits that people's behaviours are largely influenced by what others do and think should be done (Bicchieri, 2006, 2014). This theory argues that behaviour is influenced "by inappropriate perceptions of how other members of our social groups think and act" (Mulumeoderhwa, 2016; pg. 1046).

The theory also posits that overestimations of unpleasant behaviors mostly encourage healthy behaviours whereas an underestimation of healthy behaviors prevents individuals from engaging in such acts (Berkowitz 2004). Similarly, Mulumeoderhwa (2016) asserts that social norms are encouraged through gendered power inequalities. These power inequalities can be examined by understanding people's ability to challenge norms (Marcus and Harper, 2014). Therefore, the social position of adolescent girls is critical in understanding their sexual and reproductive health situation. Gender inequalities and women's place in society can undermine the health of millions of girls and women (Sen & Ostlin, 2008). Male dominance in patriarchal societies increases the risk of maternal death among adolescent girls. This is because patriarchy determines whether girls have control over their health or not. These inequalities are socially governed and accepted as a norm (Sen and Ostin, 2008). Hence, in the incidence of family poverty, girls are forced into early marriages. Having relatively limited social position and power, because of their young ages and gender, these girls are doubly disempowered. In developing countries such as Ghana, it is documented that one in every three girls is married before reaching age 18 (United Nations Population Fund, 2016).

Victims of child marriage have little control over their reproductive and sexual health. These girls become pregnant at an early age, and this can increase childbirth complications (Kyilleh et al., 2018). Girls in this age bracket are also twice as likely to die during childbirth as compared to women 20 years and above (World Health Organisation, 2013). Thus, in understanding the sexual and reproductive health experiences of victims of child marriages in the Upper East region of Ghana and how the relatively weak social position of adolescent girls influences their experiences in marriage, it is appropriate to deliberate on how the social norms and beliefs influence gender relations and promote child marriage. This theory, thus, enabled the researchers to examine the extent to which social norms promote gender inequalities and how these affect the maternal health of adolescent girls.

Methods

Research design

We employed a qualitative design and used a semi-structured interview schedule for data collection. This approach is relevant for the study because it enabled the researchers to discover the subjective meanings that people construct and attach to their actions (Neuman, 2011). It also enabled the authors to capture an in-depth understanding of the lived experiences of the participants.

Study area

The Upper East Region of Ghana is in the Northern part of Ghana with Bolgatanga as its capital. It has a population of about 1,301,221 million and it is predominantly rural (Damfe & Oduro, 2018; Ghana Statistical Service, 2022). The orthodox health service in the region is organised in a four-tier system: regional, district, sub-district, and community levels. The majority of the population engage in agriculture. In terms of religion, three main religious groupings are found in the Upper East Region, namely: Christianity, Islam, and Traditional religion. Traditional religion is the most common form of worship in the region followed by Christianity and Islam. Child marriage is relatively common in this region of Ghana. For instance, the Catholic Health Service of the Navrongo-Bolgatanga Development Organization (NABOCADO) recorded 5,534 girls under 20 years getting pregnant in the first ten months of 2021 (Apubeo, 2021). Although it is not clear the number of girls who were married, the figure presented by NABOCADO, which was taken from the Ghana Health Service was discussed at a stakeholder engagement in the region on measures to curb child marriage in the region (Apubeo, 2021). The region is predominantly patriarchal and male dominance is seen in every aspect of life (Adongo et al., 1997).

Sampling, participants, and procedure for data collection

Given that victims of child marriages are a difficult to reach population, participants were recruited for the study through purposive and snowball sampling techniques. Purposive sampling enabled the researchers to select the specialized population of victims of child marriage. Participants were identified through pre-established networks who led the researchers to other participants (Ulin et al., 2002). The pre-established networks were gatekeepers who had information on happenings in the community and had connections with community members. These gatekeepers included men and women group leaders, and youth leaders. The gatekeepers led the research team to the families and victims of child marriages. The participants were conveniently selected based on their availability and willingness to be interviewed.

Fifteen participants were sampled from the Kasena/Nankana West District, Builsa District, Bolgatanga Municipal District and the Kasena/Nankana District. The sample size was reached through data saturation. Participants were selected on the basis that they married before age 18, have a child or children, and should have been married within the past five years; living within the selected community, and willing to participate in the study. The ages of the participants ranged from 14 to 21 years, with 11 of them falling within the 14-18 years age range. Five participants had primary education; seven of them practiced traditional religion; four were Muslims and four Christians. Seven were not employed, and the remaining eight were employed as farmers and as petty traders. The researchers gained access to an indigene who was well-known and respected in the community to lead them to the families of the participants. This indigene was recruited as a research assistant and trained on the purpose and ethics of the study and her role in the research.

The interviews were conducted in the preferred local languages of the participants; Kasena, Frafraha and Buli even though the interview guide was in English. The first author who has a Doctor of Philosophy Degree in Sociology and is fluent in Kasena together with the research assistant, who has a first degree in Social Work and speaks Kasena, Buli and Frafra conducted the interviews. Both interviewers had experiences in conducting interviews on such sensitive topics about children. The interview guide was developed from the literature reviewed on child marriages across the globe and Ghana. Some of the questions were: why did you get married? Do you think you have a voice regarding birth spacing and family size? Do you think you have a voice in the use of contraceptives? These questions were further probed to explore the views of the participants on the subject. With the permission of the participants, all the interviews were audio-recorded. Field notes were also used to take notes of observations that could not be captured through the audio-recording to support the analysis. The interviews lasted between 40 and 60 minutes. Data collection lasted for 10 weeks.

Referencing the British Sociological Associations (BSA) Ethics Guidelines, we ensured that all ethical guidelines were followed. Thus, specific ethical considerations related to obtaining informed consent and voluntary participation, confidentiality, anonymity, privacy and protection and prevention of harm to respondents were adhered to. We carefully explained the purpose of this study to participants in the language they understood to help them decide whether they wanted to participate or not. When they agreed, we made them thumbprint/sign a consent form. Participants were assured of the right to exit the study after they have given consent with no consequence to them. They were assured that the information they gave would be held in confidence and their input will not be traced to them. To ensure the latter, we used pseudonyms in the text to ensure anonymity. To ensure privacy and protection of participants from potential harm should the contents of the interviews be overheard by bystanders, we ensured that most of the interviews were conducted away from the homesteads and out of the hearing

of other persons. Participants were asked to suggest the places they deemed safe and convenient to express their views freely without any intimidation. Most of the interviews were conducted in the open, often under trees in the full glare of bystanders. This was to forestall any negative consequences for the girls should the interviews be held in closed spaces. When interviews had to be conducted in respondents' homes, husbands and parents who were present were politely asked to leave the premises before the interviews were conducted to ensure that their presence did not influence the outcome of the study.

Two language experts were engaged to translate the interviews into English. Researchers subsequently contacted some participants to validate and authenticate the information. For participants who were less than 18 years, parents and guardians consented, and these participants gave their assent to the study before the researchers proceeded to interview them. Taking a reflective stance as sociologists, we, as authors, appreciated the many ways in which we were (dis)similar with our respondents and how this helped us to interpret our findings. Just like these adolescents, the first and second authors are female; with the first author also from the Upper East Region and very familiar with the culture of the people. The other 2 authors, though not from this region, come from other regions in Ghana that have relatively similar socio-cultural patriarchal and gendered norms and expectations on marriage. Thus, through a sociological lens, we appreciated the disempowered position of these young girls because of their cultural environment, age, gender, poverty and indeed their levels of education. We took on an empathetic view to assert that these girls are like our own children, or like us as females and human, and should, therefore, also enjoy full sexual and reproductive health rights as we largely do. Our position, however, was not to impose what we think should be and we ensured this by bracketing off our views and sentiments to obtain participants own definition of the situation to determine workable solutions.

Data analysis

The data was organized and categorized according to the patterns and structures that connect the themes (Polit & Hunger,1997). The six phases of thematic analysis by Braun and Clarke (2006) were followed. This was done by first reading and re-reading the transcribed data for familiarization. The second phase identified and labeled the themes that were noted down in the first phase and then used to develop major themes. At the fourth phase, the researchers checked the themes according to the statements and coded the entire data, using the subsequent collated data to identify different themes (Pretorius & Morgan, 2011). The themes were defined and named next and finally summarized, and sub-themes derived. The themes identified were then compared to the relevant literature with supporting illustrative quotations before the final research report was produced. To validate the themes produced, we replayed and listened to the recorded interviews together, repeatedly, to ensure that what respondents sought to communicate is what had

been captured. We debated and compared our views and analyses of the interviews and agreed on the final themes to be included in the results.

Findings

Four major themes were derived from the interviews of this study, namely: marital decision making, birth spacing and family size, contraceptive use, and access to health services.

Marital decision making

Marital decision making describes participants' voice regarding who, when and how to marry as well as decisions within their marriage. The study found out that all the girls were forced into marriage and did not have a voice concerning when to get married and whom to get married to. Economic difficulty was the major factor that propelled parents to force their girls into marriage at an early age. Most of the victims interviewed stated that their families forced them into marriage due to their inability to meet their basic needs. Girls forced into such marriages did not have a voice in determining when to marry and whom to get married to, as illustrated here:

> My parents forced me into marriage at age 14 because they did not have enough money to further my education. Life was very difficult for us, and we had no help. Getting food to eat three times a day was even a problem. My dad called me one day and informed me about the man that wants to marry me. He explained to me that marrying was the best decision for me because they could not take care of me. I did not know the man but had to obey my parents because they said that was the best decision for me. I was very sad and cried that night (Zara, 16 years).

It can be deduced from the narration above that some parents forced their girls into marriage to ease their economic pressures. These parents mostly received bride prices in the form of cows, sheep, fowls, money and many more. These payments are used for investments to cushion the family against any economic difficulty. The cultural practice of the payment of bride price is a social norm which reinforces negative gender practices that tend to silence girls' voices in their choice of a partner. Having said this, however, it is important to note that this 'silence' in many cases may just be perceived. There are incidents where girls, employing some 'weapons of the weak' have escaped from their natal homes to avoid these marriages. The consequences, however, are often not pleasant, making this option the least preferred by many girls. One can also get a sense that some girls acquiesce to these marriages out of a 'sense of familial obligation', to support their parents.

It was also noticed from this study that the inability of parents to afford but most importantly value education for their daughters forced them into early marriage. For instance, in the words of Aliki, a 15-year-old girl:

> I never attended school because my parents did not have the money to pay for my fees, that is what I think. I also believe they did not see the importance of me attending school because someone will marry me in future. In this neigbourhood, almost all the girls are given out for marriage at an early age and hardly complete school.

It was realized from the study that the situation of girls dropping out of school was a common phenomenon in the communities studied because marriage and childbirth are considered as more important for girls. It can be gleaned from Aliki's statement that children are expected to be occupied somewhat-and if they are not in school, and are girls, then they are better off being married.

Birth spacing and family size

One of the questions we explored was whether girls could make an input regarding birth spacing and family size. Birth spacing and family size chronicle the interval from the participants childbirth until the next pregnancy and the number of children to have. The study found that all the participants, except two, did not have a say in determining the number of children they wanted to have. This, according to the participants, was because of their husband's being considered as the "heads of their families". This position mandated their partners to make all important decisions concerning their households including the size of family. For instance, Kaane, a 17-year-old, narrates her experience:

> I got married at the age of 15 years because I was pregnant. I was forced to marry him although I did not love him. I am not happy…I had to drop out of school to marry my husband. I did not plan to get married at the age I did. I have no control over decisions at home because I am very young. He will ask me to shut up if I want to share my thoughts with him. I get very depressed most times. My husband decides on the number of children we should have, and this is determined by his financial status. I have two children now, but I know he will insist I give birth to more children. When he realizes he does not have money, he does not talk about having more children but anytime he makes money, he insists I should give birth to another child. There is no mutual agreement on the number of children we should have because he is the head of the home.

This participant feels helpless given that she cannot contribute to the decision-making process in regulating fertility. She believes that being female and a child, it is virtually impossible to speak up and get her views heard by her spouse and respected regarding these matters. The participant believes her husband's authority cannot be disputed

because he is the head of the household. Other participants, believe that their sole purpose in marriage is to bear children according to the desire of their husbands. The following quotes are evidence of this:

> Why am I in this marriage? It is to give my husband children of course! In our culture, the children are the man's property and every decision regarding that is solely made by him. It is not proper to be telling your husband you want this number of children … after all the children are not considered yours so why do you worry about it? Not at all (Asiar, 17-years)

> It is my husband who decides on important issues concerning our marriage. I got married at the age of 17 years. It is a very bad feeling to marry at a tender age. I could have been an educationist if I had not married at an early age. My dreams have been shuttered. I feel like a prisoner because I do not have a say in anything that happens in my marriage. My husband says he paid for my bride price, so he has control over everything that concerns us. Who am I to tell my husband the number of children we should have? I dare not (Azara, 19 years).

The belief in women not having control over the number of children to have is seen in all the narratives of the participants. This lack of control is borne out of social expectations of the woman's role, the fear of husbands marrying second wives, and a sense of duty to please their husbands which aid in the expansion of the latter's lineage. Indeed, not only are the wives answerable, but also the families of the wives are, should a girl be unable to, or decide not to have the number of children her husband wants. Often, there is total disregard for healthy birth spacing which puts many of the mothers at risk of maternal mortality.

Contraceptives use

Access to and ability to make decisions regarding contraceptive use is one of the reproductive health rights of adolescents and women. We therefore sought to investigate whether at all, the adolescents in this study enjoyed this right in any form. Many of the adolescent girls interviewed in this study stated that they could not decide on their own to use contraceptives because it is considered an affront to the husband's authority and as a betrayal of him. Men in this cultural context seek to have many children as a sign of strength and social status. Hence, a woman's sole decision to use contraceptives is perceived as an effort by the woman to thwart the husband and his family's dreams of obtaining social status and perpetuating his lineage through having especially male children. Again, contraceptive use by women is linked to promiscuity and infidelity. To prevent a negative reaction from society, these young brides succumbed to the authority of their husbands who mostly did not permit them to use any contraceptives. For instance, according to Fuseina, a 19-year-old girl who got married at the age of 16:

> When I got married at the age of 16 years, I pleaded with my husband to allow me to use contraceptives in order to delay childbirth. I was not ready to give birth because I thought I was young. When I told my husband about my decision, he was very angry and asked me why he married me. I was afraid, so I kept quiet and complied with him. I gave birth the following year, but it was not easy for me at all… I went through some difficulty when giving birth.

Fuseina believed her decision to comply with her husband's choice of not using contraceptives was a sign of submission to her husband. Indeed, many women cannot dare suggest that they or their husbands use contraceptives. Thus, adolescents' inability to negotiate safe sex exposes them to several unwanted pregnancies, and risks of contracting sexually transmitted diseases where they were in polygynous marriages. According to Suleya, a 16-year-old girl:

> My husband has another wife apart from me. Even with that I sometimes feel that he has been having an affair outside our marriage. Sometimes, I want to ask him to use condoms when I am unsure of his sexual activities but who am I to tell him that? He might slap me and report me to his family for disrespecting him. I just pray and wish he does not infect me with any disease.

Married young girls' inability to negotiate safe sex is evident in the quote above. Although Suleya was aware of the potential consequences of the promiscuous life of her husband, she felt helpless about the situation. She felt there was not much she could do to prevent her husband from being with other women or wives, and possibly infecting her with sexually transmitted diseases. This is because some of the girls believed their role as wives was to always satisfy their husbands sexually. Aliyatu, a 19-year-old girl noted:

> I remember a very painful experience I encountered about a year ago… I got pregnant and was advised by the doctor to abstain from sex for the first three months (first trimester). I told my husband about it, but he was not bothered. One evening, he told me he wanted to have sex with me, I was afraid but had to allow him to because he is a man. I felt if I did not allow him to satisfy his sexual desire with me, he would look elsewhere. After I allowed him to have sex with me, I had severe abdominal pains and bled profusely. That was when he rushed me to the hospital. I lost the baby, but I thank God I was saved.

This story reflects the violence women must go through as their sexual rights are violated. The participants' right to safe sex and sexual pleasure is denied and reduced to a duty. This belief has been internalized by the participants and their rights for safer sex denied.

Access to sexual and reproductive health services

Another area where social norms undermine the sexual and reproductive rights of women is in relation to the decision concerning the utilization of health services. Some of

the participants revealed that they did not attend hospitals while pregnant because their husbands did not let them. Thus, patriarchy and weak social positions of women create a barrier to accessing health care which is the reason given for many maternal deaths (Ghana Health Service, 2016). Although health facilities, often in the form of community Health Posts (CHIPS Compounds), existed for use in most of the communities sampled, some of these participants did not and could not make use of them. Some of the responses showed that cultural myths influenced the decisions of partners in preventing their wives from receiving health care from health centres. This resulted in poor health outcomes for the participants. In the words of Zaara:

> When I got pregnant, I was powerless to go to the hospital because my husband said I should give birth at home. I did not have money to even go to the hospital in his absence… he said in his family, it is a taboo for first-borns to be born outside 'the family home'. Unfortunately, when I realized I was in labour and was sent to the family house, I waited for many hours and was in pain… I started screaming and thought something serious was going to happen. When they sensed danger, they rushed me to the hospital, and I was sent to the theatre (Zaara, 17 years).

Thus, the need to wait for a man to take a decision as to whether a woman should be sent to a hospital is one of the delays identified as responsible for maternal deaths in Ghana. Thus, by the time that families 'sense danger' and get to make the long journeys often on bad roads to health facilities, it may be too late to save a mother (GHS, 2016). The story by Zaara indicates how some adolescent wives can easily lose their lives because of their inability to utilize health facilities without their husband's approval. The participant's inability to visit antenatal and postnatal clinics was largely based on her vulnerability as an adolescent and her social position as a woman. Young wives had to adhere to the choices of their husbands irrespective of the health risks. Some of them had no option than to have their babies delivered by unskilled traditional birth attendants which exposed them to danger. The documentary, 'Women in Battle', which focused on maternal mortality in Ghana, explained that one of the reasons why husbands insist on home delivery by their wives was to assess whether their wives have been faithful to them (Boateng, 2018). The belief is that a woman who had been unfaithful would have difficulty giving birth and can only be delivered of her child if she confesses and asks for pardon for her infidelity. Thus, home deliveries allowed men to be present to witness the birthing process to make the determination of fidelity by their wives. Interestingly, given that these women are very young, they often tend to have difficulty with dilation and childbirth which really has nothing to do with fidelity.

Further, the loss of power and rights of these young wives emanated from their economic dependence on their husbands. Many of them have dropped out of school and mostly have no skill or employment and, thus, no income. The following is an example

in this regard:

> Where will I get the money to go to the hospital? I will definitely have to ask my husband for money to pay for my bills and everything. I am not working at the moment, and everything is being taken care of by my husband. I am thinking of starting a shea butter business when my husband supports me with the required capital. Due to my situation, when I got pregnant and my husband advised I use herbs and visit the herbalist when I had issues, I listened to him. It was only when I was about to deliver that I was sent to the hospital (Fatima, 17 years).

It can be gleaned from the foregoing that the factors that mitigate against the sexual and reproductive health rights of young wives are a myriad. It is a case of girls being caught up in a cultural, economic, gender, and age conundrum.

Discussion

The focus of this paper was to explore the extent to which social norms influenced the sexual and reproductive health rights of adolescents in child marriages in Ghana. The findings showed that adolescents did not have the cultural, social, and financial power to make decisions regarding when and whom to marry, childbirth spacing and the number of children to have, the use of contraceptives, and their access to pre- and post-natal health services.

The decision regarding when and who to marry was solely made by the parents or guardians of the adolescents. These decisions were largely undergirded by economic factors, and this has also been identified as a major reason for child marriages in some other regions in Ghana (Domfe, 2018; Ahonsi et al., 2019). Economic difficulty propels parents to force their daughters into marriage for financial security and for their daughters to escape poverty (Ahonsis, 2019). The victims of child marriage in this study revealed that the inability of their parents to provide their basic needs forced their parents to make them child brides. In view of this, Nour (2006) posits that parents who compel their children to marry at an early age cannot be accused of being heartless but are parents who believe their decisions will give their children a better life. Unfortunately, many of these child brides become victims of different forms of abuse.

Girl brides or wives' lack of agency and voice as evidenced herein also related to their inability to decide or make an input towards the decisions relating to birth spacing and family size. They also had no or little voice in decisions concerning the debut of childbirth once they got married. These situations occur because of the cultural belief that husbands are the heads of their households and responsible for major decisions concerning their households including fertility, whilst women's primary role is childbirth. Thus, gender inequalities determine the extent to which people have control over their health needs and shows whether they can realize their rights to good health (Nash et al., 2018). Furthermore, in patriarchal societies such as the Upper East Region of Ghana,

children birthed in marriages are regarded as properties of the man's family. Women's role as child bearers is predominant in such societies and tends to be an incentive for child marriage. Thus, in these communities, child marriages tend to be preferred because young girls are perceived to be more fertile than older women. Barrenness is, therefore, perceived of as a misfortune and women who are infertile are stigmatized. A woman's ability to produce children for her husband is seen as her pride. Adolescents who are forced into early marriages are, therefore, obligated to bear as many children as desired by their husbands and this can be detrimental to their health. As a result, adolescent girls are usually under pressure to be always sexually active and available to their partners (Hagman, 2013). Women who try to influence such decisions are seen as infringing on their husbands sexual and childbearing rights.

Another area where participants did not have much say was in relation to decisions concerning the use of contraceptives. The use of contraceptives is closely linked to fertility and women have little autonomy or control over such decisions. According to Adongo et al. (1997, pg. 1793), in patriarchal societies such as the Kassena Nankana District, men are mostly of the view that "fertility regulation is tantamount to conjugal refusal, depriving a man of his sense of sexual ownership of women and denying him children". Women who try to influence such decisions are seen as infringing on their husbands sexual and childbearing rights. Again, given the notion that women are the 'properties' of their husbands because of the latter's payment of their bride price, it is difficult for women to discuss issues regarding reproduction, such as the use of contraceptives with their spouses. Girls have a limited voice in the use of contraceptives because of their young ages and gender but more so because a girl's respectability is dependent on her being sexually available and allowing her partner sexual decision-making authority (Varga, 2003, pg.163).

Adolescent brides also had a challenge negotiating and obtaining their husbands consent to access pre- and post-natal health care. The gendered social structure and social stratification which tend to make children invisible, doubly disempowered these girls in child marriages. Thus, despite significant social changes over the years in the Upper East Region of Ghana, it seems the phenomenon observed in 1997 by Adongo et al. (1997) that about 90% of married women in this region require the permission of their spouses or other men in the household before leaving their husbands' compounds to seek health care persists. The findings of this current study also indicate that economic dependence on husbands was a key barrier to women accessing health facilities. This finding is similar to studies from other patriarchal societies like Pakistan where women's economic dependency on men affects their decision-making power in almost every area of their lives, including reproductive health (Bhutta & Haider, 2013). Child marriage worsens the health situation of girls as they are exposed to conditions by their husbands that make them vulnerable to sexual violence (Ahonsi et al., 2019). For instance, a study of 29 countries including Ghana showed that female adolescents were more vulnerable

to HIV as compared to older women (Ahonsi et al., 2019). This is because females who marry early usually find themselves in polygamous marriages with older partners. Hence, reducing gender inequalities in patriarchal societies such as the Upper East Region in Ghana will be a major step in curbing the high figures of maternal mortality and the incidence of child marriage.

Limitations of the study

This is one of the few studies to have examined the lived experiences of victims of child marriages in the Upper East Region of Ghana. To obtain a deeper appreciation of the issue of child marriage, a triangulated approach of mixed methods may be employed in the future to obtain some more detail regarding the prevalence and scope and, of course, the lived experiences of girls in other regions. A juxtaposition of the narratives obtained from other regions with this herein may well provide further insight and the impetus needed to engender the necessary social discourse and debate as well as the policy measures and interventions needed to ensure the implementation of the legislations that prohibit child marriages and the subsequent reduction in the incidence of the phenomenon.

Conclusion

This paper has explained the incidence and analysed the implications of child marriage for the sexual and reproductive health rights of girls. We argue that the practice of child marriage is engendered by three main factors, notably culture, gender inequalities and age, which act as a web to complicate the lives of girls within marriage, by denying them basic reproductive health rights. Girls who became victims of child marriage could not take decisions regarding their sexuality, fertility, use of contraceptives and utilization of health facilities. Being children, female and economically dependent on husbands places married adolescents in weak social positions with limited bargaining power in decisions concerning their sexual and reproductive health. The power relations created by patriarchy disempowers these young women and limits their sexual and reproductive autonomy. To forestall child marriages and to empower the many who are already in that situation as we found in the Upper East Region of Ghana, several measures are recommended. A three-pronged approach, targeting the societal, familial, and individual, is suggested as the wholistic way to combat this phenomenon. We argue that the interventions must be preventive as well as supportive of the existing victims. Measures to improve gender equality and address adolescents' sexuality and reproductive health is key to curbing child marriage in patriarchal societies such as the Upper East Region of Ghana. A combination of law enforcement and sustained community engagement to end child marriages is crucial. Free access to reproductive health facilities, education and job opportunities for women will enhance their social and economic positions and improve their bargaining power in marriage. The continued nation-wide implementation of the

National Adolescent Health and Development Programme (ADHD), which is in tandem with the Sustainable Development Goal (SDG) 3:7 that seeks to ensure that by 2030, all women of reproductive age will obtain universal access to sexual and reproductive health care services and promote healthy lives and wellbeing of all, is critical to ensure that the goals of making health services adolescent-friendly, and 'available, accessible, acceptable, equitable and affordable for every young person no matter their social or economic status' (GHS-FHD, 2016, pg.29) are realised. Community sensitization programs should be organised periodically, with a special focus on involving men, and peers (children in child marriages) as key actors in empowering women on their sexuality and reproductive rights. Men's involvement is critical in this respect given their dominant social position in the communities. Thus, to obtain their appreciation and buy-in of the relevant issues and interventions is a major step in working with them as partners to engender the desired changes (Kwapong, 2009). Thus, a combination of education and effective community engagement with stakeholders including particularly parents, religious leaders, traditional chiefs and queen mothers, NGOs, teachers, the media, and children themselves is important. The enforcement of legislations and, especially, monitoring and evaluation of interventions are critical to preventing child marriage and mitigating its dire effects on children's sexual and reproductive health rights and wellbeing.

Disclosure statement

No potential conflict of interest was reported by the author(s).

ORCID

Ummu Markwei https://orcid.org/0000-0002-7919-0323
Peace Mamle Tetteh https://orcid.org/0000-0002-8397-0461

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