

Child marriage, well-being and health seeking behavior



A study among married adolescent girls in the Pokot tribe

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Institute of Health and Society

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A study among married adolescent girls from the Pokot tribe
Karamoja, Uganda

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Summary

Child marriage is a widely spread practice which happens across countries, cultures and religions. Child marriage is defined as any formal union or informal union where one or two of the parties are below the age of 18. This practice mainly affect girls. 15 million girls marry into child marriage every year. The girls commonly affected by this custom live in poor families in rural areas of South-East Asia and African countries. This study aims at understanding the process of child marriage, and examining health and well-being among child brides as well as their access to health care in the Pokot community of North-Eastern Uganda. The issues were explored by using a qualitative research design. Thirteen in-depth interviews were carried out with adolescent married girls. This was followed by ten key informant interviews and three focus group discussions, two with married adolescent girls and one with elders in the village.

The findings of this study highlights the complexity of child marriage, the intertwined issues of gender, poverty, “strong” traditional practices and norms that denies young girls to fulfill their potential in life. The married adolescent girls described their marriage as forced, however, they quickly adopted to their new role as wives. Fertility were seen to be extremely important and as a means to step into the adult world for girls. Hence, contraceptive methods were barely used, mainly due to men’s resistance. The majority of the young married girls participating in this study came from poor families, they had low levels of education. Further findings show that traditional medicine is important, however, the Pokot use Health care services from both traditional and biomedical health providers. Distance, cost of transport, health workers behavior and elders as decision-makers in married adolescent girls health seeking behavior were identified as the main barriers to health care utilization.

Interventions that challenge cultural practices like child marriage are unlikely to succeed without a comprehensive understanding of the causes and consequences of child marriage in a given setting. Findings from this study explains the causes and consequences of child marriage among the Pokot in Uganda. These findings can inform programs and projects in similar cultural context, with an aim to end child marriage.

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List of abbreviations

ACRWC: African Charter of the Rights and Welfare of the Child
AIDS: Auto Immunodeficiency Syndrome
AU: African Union
CO: Clinical officer
CBO: Community Based Organisation
CRC: Convention on the Rights of the Child
DHS: Demographic health survey (in Uganda)
ESA: East and Southern Africa
FGD: Focus Group Discussion
FGM: Female genital mutilation
GBV: Gender Based Violence
HBM: Health Belief Model
HC: Health Center
HIV: Human Immunodeficiency Virus
HW: Health worker
LMIC: Low to Middle Income Countries
MICS: Multiple Indicator Cluster Survey
MSI: Marie Stopes Clinic
MoH: Ministry of Health
MoGLSD: Ministry of Gender Labour Social Development
NGO: Non Governmental Organization
NSD: Norwegian Center for Research Data
REK: Regional Committees for Medical and Health Research Ethics
STI: Sexually Transmitted Infections
TBA: Traditional Birth Attendant
UBOS: Uganda Bureau of Statistics
UNFPA: United Nations Population Fund
UNICEF: United Nation Children's Fund
VHT: Village Health Team
WHO: World Health Organization

Institutional collaboration

The investigator is a student at UiO with a background from UiB. Joar Svanemyr is the main supervisor, currently working as a post doc researcher at Chr. Michelsen Institute (CMI). He is a former lecturer at UiO, Institute for Health and society. Joar Svanemyr established contact with Center for International Health (CIH), UiB. Ingunn Marie Engebretsen is one of the co-supervisors, she is a professor at CIH. The University of Bergen and Makerere University collaboration introduced me to Uganda by an exchange semester in 2013. Ingunn Marie Engebretsen have been working with projects in Uganda for years. She introduced Chris Olesen, a Phd student at faculty of Social Science, Department of Sociology and Anthropology, Makerere University. .

Structure of the thesis

The thesis is compromised of five different chapters. The first chapter introduces the concept of child marriage, the statement of the problem and theoretical framework. The second chapter aims at contextualizing child marriage and its causes and consequences. This is the the chapter where the literature and the demography of the study site is presented, in addition to the rationale and objectives. In the third chapter the research design and methodology are presented along with ethical considerations and quality of the research. The findings and analysis and their findings are presented in the fourth chapter. The fifth chapter is the discussion where findings are discussed in light of the theories and prior research. Lastly limitations of the study, conclusion and recommendations by the study participants follows.

1 Introduction

This introduction starts with an introduction to the problem of child marriage, followed by statement of the problem and the theoretical framework.

Globally 39.000 girls marry every year, and child marriage is commonly defined as any marriage or union before the age of 18. Very early marriage is defined as individuals who marry before the age of 16 (Boyden, Pankhurst, & Tafere, 2012). In most cases, the girl child is the one to be affected by child marriage (UNFPA, 2012b). Child marriage lies at the junction of a whole range of issues for the girl. The practice of child marriage is most common in rural, poor communities (ICRW, 2012) and in low-to middle income countries (LMIC). In LMIC one out of nine are married before the age of 15 and one-third of girls are married before the age of 18. UNICEF estimates that 720 million women living in the world today were married as children (UNICEF, 2015a). In 2012 the number of girls aged 20-24 who married before the age of 18 was 70 million globally (UNFPA, 2012b). If the trend continues with a yearly increase of 15 million, within the next decade 150 million child brides will be reached (ICRW, 2012). Child marriage persists despite widespread efforts to eliminate the practice (Kalamar, Lee-Rife, & Hindin, 2016). However there has been some progress in reducing the rates of child marriage, especially for the youngest girls (UNFPA, 2012b). There is a need to strengthen policy and programmed efforts, which should be informed by strong evidence (Svanemyr, Chandra-Mouli, Raj, Travers, & Sundaram, 2015).

Child marriage is most common in Asia and Sub-Saharan Africa. With the exception of Bangladesh, the 10 countries with the highest prevalence of child marriage are concentrated in western and Sub-Saharan Africa. The largest absolute number of child brides resides in South Asia (Girls not Brides, 2015). Seventeen percent, of child brides - 125 million - brides live in African countries (UNICEF, 2015a). In sub-Saharan Africa 12% are married before the age of 15 and 40% before the age of 18 (Girls not Brides, 2015). Niger is the country with the highest prevalence of child marriage, reaching 76% (Girls not Brides, 2015). Chad and the Central African Republic both have prevalences of 68% (Girls not Brides, 2015). Globally, the rates of child marriage is decreasing, especially in Asian countries. The prevalence across African countries is also decreasing, but the decrease is generally slower. In addition the decrease is unequal. Girls from the wealthiest families marry more seldom at young ages. For the poorest girls the practice of child marriage is continuing

at the same level (UNICEF, 2015a). The growing adolescent population in Africa is also contributing to the high numbers. If the current trend continues, approximately 50% of child brides will reside in Africa in 2050 (UNICEF, 2015a).

The legal framework in African countries shows that 33 countries have a legislation stating a minimum age of marriage at 18 for girls and boys and 4 countries have age limits above 18 years (Girls not Brides, 2015). Some of the countries which have a legislation stating a minimum age of marriage at 18 years allow exceptions if the boy or girl have the courts or parents' consent. Seventeen countries allows girls and boys to marry at different ages (Girls not Brides, 2015). In Uganda the legal age for marriage is the same for both boys and girls (Republic of Uganda, 1995).

For the first time, an all African campaign was launched to end early marriage in 2014 by the African Union (AU). This was followed by workshops and trainings on how to end early marriage and other harmful traditions. The government of Uganda has a strong emphasis on ending early marriage, teenage pregnancies and female genital mutilation (FGM). The government of Uganda and UNICEF Uganda launched *The National Strategy to End Child Marriage and Teenage Pregnancy 2014/2015 – 2019/2020* (Republic of Uganda, 2015).

In Uganda 10% marry before the age of 15, and 40% before the age of 18 (UBOS, 2011). The median age of marriage for men is 22,3 years while for women it is 17,9. Twenty-five percent of married women in Uganda lives in polygamous unions. African Charter on Rights and Welfare of the Child (ACRWC) and Article 1 of the Convention on the Rights of the Child (CRC), define a child as a person aged below the age of 18. ACRWC article 22 states that “*child marriage and the betrothal of girls and boys shall be prohibited and effective action, including legislation, shall be taken to specify the minimum age of marriage to be 18 years and make registration of all marriage in an official registry compulsory*”(ACRWC, 1990). Odala (2013) claims that marrying a young girl may be a mean towards sexually exploiting a girl as sex is presumed as a natural consequence of the marriage. Some countries allow underage marriage with authorization from parents or the court. Odala (2013) explains that this approach tends to violate the child's right to protection. Reasons for the parents to marry their girl off before she is 18 might be teenage pregnancy because the family might avoid the humiliation of having a pregnant, unmarried daughter. In other cases, economic reasons perpetuate marriage. Parents may want to avoid the responsibility of feeding one

more child, and the opportunity to gain from the bride wealth (Odala, 2013).

1.1 Statement of the problem

Child marriage is a global issue with varying rates between regions, countries and within countries. There is a significant amount of data on trends and child marriage around the world (Svanemyr et al., 2015), thus some issues require a better understanding of the causes and consequences of early marriage. There is a research gap on the differences in child marriage across religion, ethnicity, education and social class, among others (Green, 2014). There is a lack of qualitative studies on early marriage in African countries. The limited qualitative literature available is mostly produced by, or with, international charities and development agencies (Camfield & Tafere, 2011). The voice of the girls being married is absent in the literature (Callaghan, Gambo, & Fellin, 2015), where the girls are often portrayed as voiceless victims of a cultural practice imposed by their parents. The harmful consequences of child marriage have been documented, especially in Asia with an aim to examine determinants of child marriage (Steinhaus, Gregowski, Fenn, & Petroni, 2016). Thus the evidence from a Sub-sahara African context remains limited, despite its increased attention to child marriage in the recent years (Steinhaus et al., 2016).

The purpose of this study is to explore the process of child marriage among the Pokot, the transition from being a girl to a wife and what the life of a child bride is like. The study also aims to explore the health and well-being of young married girls, their health seeking behavior and what barriers they face when seeking health care. The field study was carried out in Amudat, a rural district in Karamoja sub-region in the Northern region of Uganda, on the border to Kenya. This study site is particularly interesting because early marriage is highly frequent in northern parts of Uganda, and a very common cultural practice among pastoralist societies like the Pokot. The girls marry young, often below the age of 15. Being married at such a young age usually also means having a teenage pregnancy, with the following health risks linked to pregnancy and birth. Investigating their health seeking behavior, the factors that interplay in their decision making process in seeking health care, and the barriers they face on their way to receiving quality health care, is especially interesting in a context where these girls have limited decision making power, poor health services and the traditional/herbal sector is commonly used.

1.2 Theoretical framework

The theoretical framework will be presented in this section. The theories of Social Norms and Health Belief Model will be used to analyze the findings from this study.

1.2.1 Norms

Social norms are explained by Bicchieri (2006) as a kind of grammar for social interactions. Like a grammar, a norm system defines what kind of behavior is acceptable and what is not in a society or a group (Bicchieri, 2006). Bicchieri further states that social norms are the unplanned, unexpected result caused by individuals interactions. An essential element in sustaining the norm is the conditional preference for conformity. The belief that other people will conform and the joint existence of a conditional preference for conformity will yield in an agreement between normative beliefs and behavior (Bicchieri, 2006).

What is a social norm?

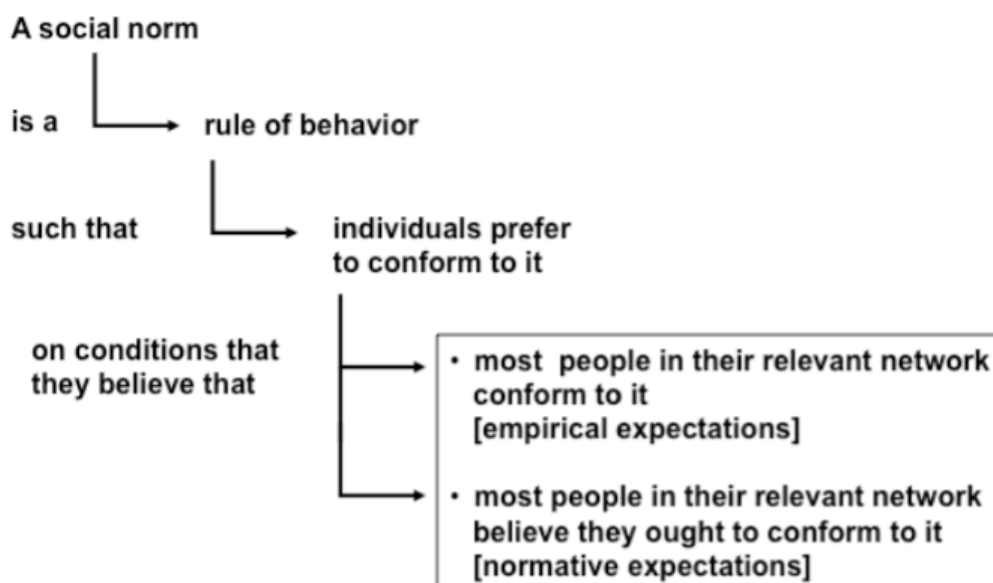


Illustration 1: The definition of a social norm

Source: Bicchieri et al (2014) Page: 11

Child marriage as a social norm

Bicchieri (2006) claims that the collective practice of child marriage is caused by individual behavior. If the aim is to understand child marriage, we have to understand why individuals behave

like they do (Bicchieri, Jiang, & Lindemans, 2014). She further states that people’s behavior is often influenced by what other people think you should do, and how other people behave. When behavior is influenced by these two factors, it is defined as a social norm by Bicchieri. Whether people are affected by social expectations or not is often determined by agency or autonomy. Someone who lacks autonomy and agency is often more sensitive to social expectations (Bicchieri et al., 2014). Autonomy is defined as the ability and desire to make one’s own choices, to reflect on what one might want (Bawetta & Navarra, 2012; Chirkov, Ryan & Sheldon, 2011) rather than having others decide for you. Bicchieri further states that autonomy is personal freedom and self-determination, whereby not everyone is equally autonomous. Social expectations are important because the existence of norms indicates that beliefs and behavior are interrelated. It is important to know what other parents are doing and thinking if the aim is to understand why parents are marrying off their daughters early. However, there are many actors who sustain child marriage. This is illustrated in the diagram below.

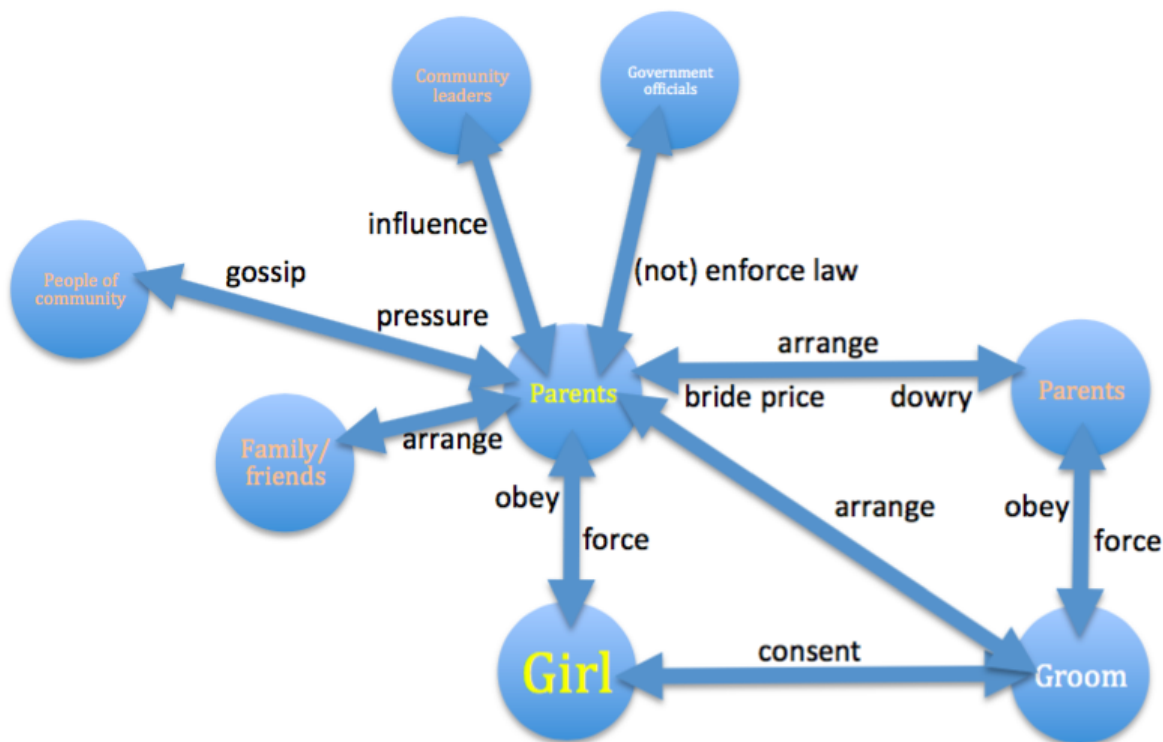


Illustration 2: Actors in the practice of child marriage

Different people ("actors") doing different things ("behaviors") that have an impact on child marriage ("the practice"). The actors in red constitute the reference group of the parents. Source: Bicchiero et al., (2014) page:12.

Whether child marriage is a descriptive norm, a social norm, a custom or a moral rule is determined by the different communities. Custom or moral rule is affected by personal beliefs, but descriptive norm and a social norm depends on social expectations for behavior (Bicchieri et al., 2014). This makes behavioral change complicated because when people’s behavior depends on what others think and do, they will only change if others change. Moreover, if child marriage is a social norm in the community, rather than a descriptive norm, the normative expectations will matter. As Bicchieri states, “in order to change the social norm of child marriage, one has to change people’s personal normative beliefs that child marriage is something good and the normative expectations that others also think that child marriage is good” Bicchieri et al, 2014 (p.15). This is illustrated in the model below.

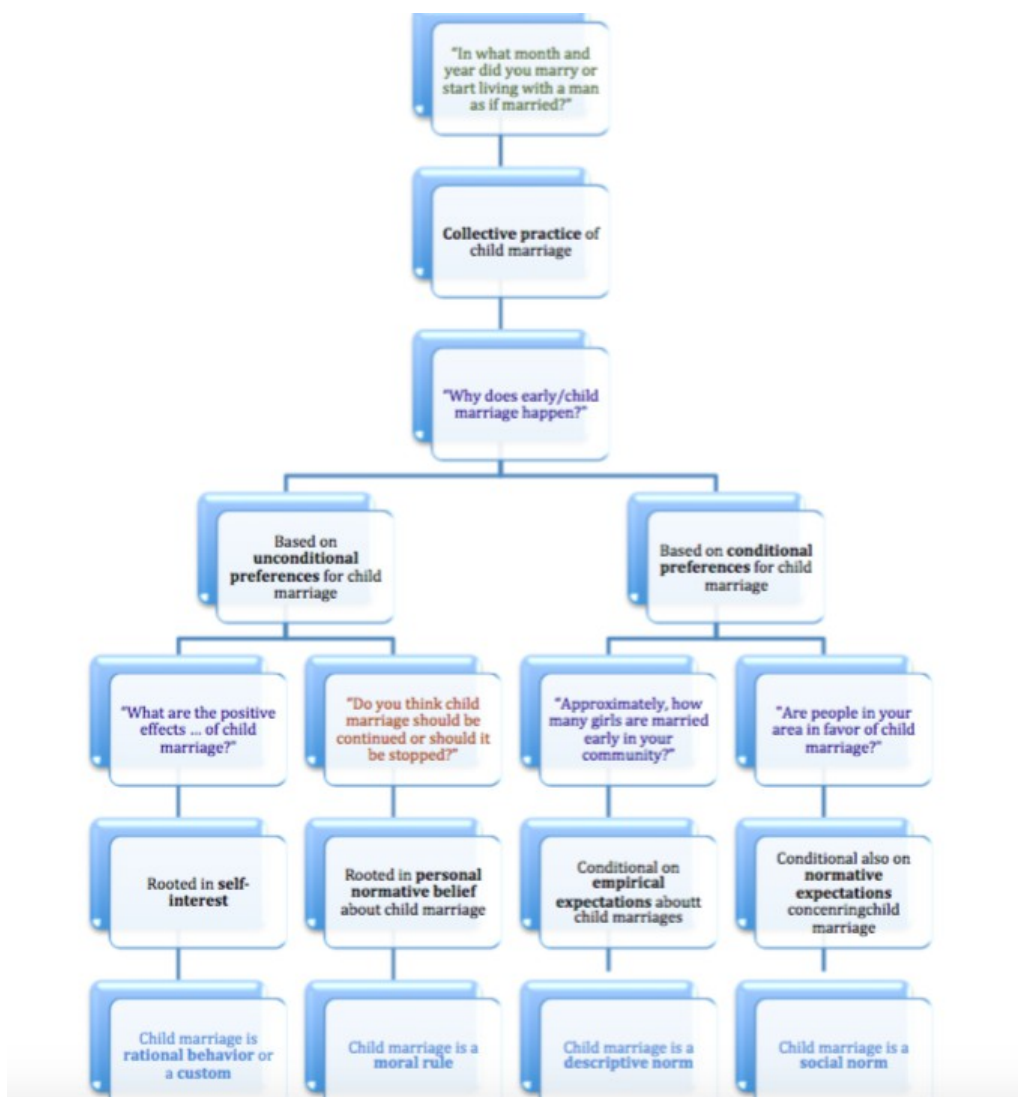


Illustration 3: Diagnostics for child marriage

This model is based on Bicchieri (2012). The green question is a MICS question by UNICEF, the blue question are Sood et al's (2007) and Maharjan et al's (2012) and the orange is Bicchieri et al (2014) page:18.

This model was developed by Bicchieri et al (2014) as a monitoring and evaluation tool for evaluating programs who aim to eliminate the practice of child marriage. As the model shows child marriage can either be a rational behavior or a custom, a moral rule, a descriptive norm or a social norm. Biccheri argues that in order to impose behavioral change in a community, it is vital to understand the role of child marriage in a given context or community (Bicchieri et al., 2014).

1.2.2 Health Belief Model

The health belief model (HBM) will be used to analyze the findings from this study. The HBM is one of the most commonly used and studied theories in public health (Jones et al., 2015). The HBM was developed by a group of social psychologists in the 1950s, working for the U.S public health service. Their aim was to understand why the utilization of preventive measures, such as screening and vaccination, were low (Janz & Becker, 1984). The HBM consists of several interacting factors. These are the individuals perceived susceptibility: perceived seriousness of the condition: perceived benefits of taking action and barriers to taking action (Rosenstock, 1974)

Rosenstock was one of the founders of the HBM. The original theory states that perceived susceptibility refers to the subjective risk of contracting a condition. The perceived susceptibility varies between individuals, some may deny the possibility of contracting the disease, while others may feel threatened by the condition (Rosenstock, 1974). The concept of perceived seriousness looks at how people perceive the seriousness of a given health problem, this also varies from person to person. According to Rosenstock (1974) the degree of seriousness is often based on the challenges and difficulties the condition will cause for a person, these can be both medical and social. Medical in ways of disability, death and illness and social in relation to how the condition can influence social relations, work and family life. Perceived susceptibility is partly dependent on the individual's knowledge (Rosenstock, 1974). Rosenstock explains the third factor: the perceived benefit of action. Action is influenced by the effectiveness of the alternatives available to treat the condition or disease. The individual's belief of the effectiveness and availability of services is subjective, as the individual's choice will be affected by the norms and pressure of his or her social group (Rosenstock, 1974). Lastly in the original model is the barriers to taking action. According to Rosenstock (1974) an individual may believe that a given treatment or action will reduce the threat of disease and be efficient. However, the action or treatment may be inconvenient, expensive, unpleasant or painful. These are seen as barriers to taking action. For action to happen, the perceived benefits of action must outweigh the barriers (Rosenstock, 1974). Cues for action is a part of the HBM, however, according to Jones et al (2015) it remains an underdeveloped part of the HBM (Jones et al., 2015). Individuals are thought to have internal and external cues, whereby internal cues are symptoms and external cues are advice from others or a promotional campaign (Janz & Becker, 1984). Acknowledgment by community members and enclosed endorsements from the government were seen as cues to action.

Janz and Becker (1984) state that normative behavior or social approval should also be considered as a factor in the HBM. Whether the behavior would be acceptable or not would affect the health seeking behavior and health care utilization. When undertaking a socially accepted behavior, for instance seeking health care when a pregnant women is bleeding. This is an expected and accepted behavior in certain communities. However, when performing a behavior that is not socially accepted, for instance an unmarried girl seeking contraceptive method or advice, such behavior would cause sanctions. Janz and Becker introduces the concept of self-efficacy, originally from Bandura's work. Self-efficacy is defined as "the conviction that one can successfully execute the behavior required to produce the outcomes" (Bandura, 1982). Both social approval and self-efficacy, according to Janz and Becker (1984), contribute to creating barriers. Barriers have proved to be the most powerful dimension of the HBM (Janz & Becker, 1984). According to the HBM, after the individual has perceived that the likelihood of having a condition is fairly high and has also perceived the condition as serious enough to act upon, the third step is to decide whether or not to seek treatment.

The Health Belief Model

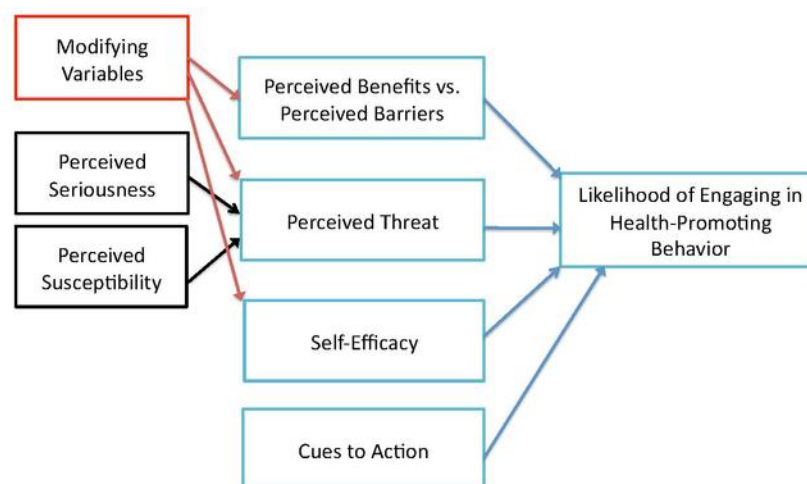


Illustration 4: The Health Belief Model

Source: https://en.wikipedia.org/wiki/File:The_Health_Belief_Model.pdf (01.02.2017)

1.3 Literature review, rationale and objectives

In this chapter the literature and demography of the study country and site will be presented. First the causes and consequences of child marriage and early pregnancies will be looked into, followed by understanding the context of Uganda and Karamoja and a presentation of the health system in Uganda and the reproductive health issues for adolescents. Then, the status of child marriage in Uganda and its causes and consequences will be discussed, as well as marital practices among the Pokot. Lastly the rationale and the objectives of this study will be presented.

1.3.1 Causes and consequences of child marriage

1.3.2 Gender inequality, autonomy and decision-making

Studies from Asian and African countries show that traditions and gender norms are often rooted in patriarchal values and ideologies. This, in combination with lack of economic and educational alternatives; instability; conflicts and humanitarian crises; have shown to be common causes of child marriage (Jain & Kurz, 2016; UNFPA, 2013). Marriage has a strong role in most communities; they can form new alliances between tribes, clans and reinforce social ties in villages (Nour, 2006). The background for child marriage varies widely. Parents tend to worry about ensuring their daughters' chastity and virginity. Child marriage serves as a protective mechanism against premarital sexual activity leading to unintended pregnancies and sexually transmitted infections (STI) (Nour, 2006). Findings from Steinhaus et al.'s (2016) study from Kenya and Zambia show two factors being a direct cause to child marriage; school dropout and pregnancy. These factors stem from the socioeconomic environment which the girls live in (Steinhaus et al., 2016). As Nour (2006) states; the parents are not necessarily heartless, but the conditions they live within are.

Child marriage can entrench and deepen poverty because it compromises girls' development in education, livelihood skills and personal growth (Otoo-Oyortey & Pobi, 2003). According to Otoo-Oyortey and Pobi this perpetuates the "feminization of poverty" by violating the girls' right to choose their own future. Findings by Raj (2010) show that the practice of early marriage tends to reproduce into the next generation because children of young uneducated mothers are less likely to continue beyond minimum schooling (Raj, 2010). According to Plan (2015), young married girls are likely to drop out of school and marry young like their mothers did (Plan, 2015). Nour (2006) explored factors affecting power relations in marriage and risk of STIs. Findings from Nour show

that men who marry young girls tend to be older because they have to work for some years to generate income for the dowry. Men are also expected to have had multiple sex partners and be sexually experienced when they marry. Polygamy is a common practice in Sub-Saharan Africa, and as the child brides are economically dependent on their husbands, they lack power to negotiate and to demand monogamy. Child brides cannot leave their husbands as the girls are most likely unable to repay the dowry (Nour, 2006).

Polygamy is the normative marriage system in many African societies (Lesthaeghe, 1989; Van de Walle, 2005). Polygamy is more prevalent in rural areas among men of older age and among people with low educational attainment (Bove & Vallengia, 2009). Polygamy increases the husbands reproduction and social ties through in-laws (Clingnet, 1970), and the productivity on the fields (Jacoby, 1995). The husband tends to give the first wife social respect, and they acquire the role of manager of the household (Madhavan, 2002).

Well-being and mental health

A few studies have looked at the association between well-being, mental health and early marriage, especially studies from African countries. Walker's findings show that child marriage reduces the physical wellbeing and hampers mental health, which leads to dramatic life changes for girls (Walker, 2012). A study from Ethiopia (Gage, 2013) found that child marriage had an association with increased odds of suicidal thoughts in girls. Results from a study in Asia and Africa showed that girls who married or engaged as minors have an increased risk of suicide and depression: this was explained primarily with the link of gender-based violence in various forms (Raj, 2010). Child brides tend to be affected by feelings of hopelessness, helplessness and severe depression: symptoms of sexual abuse and post-traumatic stress (IRCW, 2012).

According to Jankowiak et al (2005), women living in polygamous marriage in Sub-Saharan Africa appear to have less life satisfaction than women who live in monogamous marriage. This varies according to age and interpersonal factors, although the main reason for women's distress tends to be the latent aggression and hostility that may appear between co-wives (Jankowiak, Sudakov, & Wilreker, 2005). This aggression is often caused by competition for their husband's emotional fulfillment or access to his resources (Bove & Vallengia, 2009). The husband's behavior may also cause emotional distress for the wives. Women living in polygamous marriage are more likely to be exposed to domestic violence and sexual abuse (Jewes, lewin & Penn-Kekana, 2002). The reason

for this is unknown, but may be attributed to the socioeconomic status or age of the husband (Bove & Vallengia, 2009).

Fertility and reproductive health

According to Santhya's review (2011) early marriage compromises sexual and reproductive health of young women in numerous ways. Another consequence of early marriage is that it also affects the children of young wives. There are several indicators related to early marriage: unintended pregnancy, pregnancy related complications, delivery of babies with low birth weight, preterm delivery, fetal mortality and sexual and physical violence within marriage (Santhya, 2011).

Research on other indicators show a mixed picture: the risk of HIV and neonatal, infant and early childhood mortality call for a further examination for the health consequences of child marriage (Santhya, 2011). Girls married before 18 are less likely to use contraception and more likely to become pregnant. Child brides have limited spacing between pregnancies and are therefore likely to have a large number of children. These factors are linked to an increased risk of poor maternal, infant and child health outcomes (Raj, 2010).

Otoo-Oyorley and Pobi argues that the girls are exposed to an immense pressure to become a woman in a time when she is not prepared for these roles (Otoo-Oyorley & Pobi, 2003). The informants in Atuyanme et al's study discussed the dilemma of being physically able to become pregnant but not mentally ready to become a mother (Atuyambe, Mirembe, Annika, Kirumira, & Faxelid, 2009). The child bride has poor negotiation and decision-making skills, and lacks the ability to ensure the development and well-being of her children (Otoo-Oyorley & Pobi, 2003). In Sub-Saharan Africa there is a strong association between age of marriage and total fertility rates. Girls who marry early have been shown to be exposed to the risk of conception for a longer period of time than girls who delay marriage (Walker, 2012).

Studies from Niger and Tanzania shows that women in polygamous marriage are less willing than women in monogamous marriage to use contraceptive methods (Peterson, 1999; Hollos & Larsen, 2004). Women in polygamous marriage often compete to give birth to the most children, which makes them unwilling to limit their births unless their co-wives will do the same (Gage, 2000). A common natural way of spacing in Sub-Saharan Africa is the postpartum abstinence period. This can last up to 18 months (Caldwell & Caldwell, 1977), whereby the woman abstains from sex,

while her husband does not abstain (Blanc & Gage, 2000). Due to the low age for many girls who enter into marriage, their fertile period increases. Although this may be compensated for later as polygamous women aged 35 and above prolong their postpartum abstinence period (Lestaeghe et al, 1989).

1.3.3 Causes and consequences of early pregnancies

As mentioned above, women are expected to become pregnant soon after marriage. The purpose is to secure themselves in the marital home (Santhya, 2011). Nove et al's review (2014) found that maternal mortality and deliveries are often under-reported among adolescent girls, especially for girls with a poor socioeconomic background. The assumed higher maternal mortality among adolescents could be an indicator of adolescents' socioeconomic factors rather than their young age (Nove, Neal, & Camacho, 2014). However, in countries where adolescents have children when they are younger than 15-16 years old they have a greatly increased risk of maternal mortality compared with older adolescents (Conde-Agudelo et al., 2005; Gakidou & King., 2006). Countries where adolescents become mothers before the age of 16 have a higher maternal mortality rate by the age of 15-19 than for the age group of 20-24 (Neal et al., 2012)

The leading cause of death for girls aged 15-19 in developing countries is complications during pregnancy and childbearing (Dixon-Mueller & Lloyd, 2011; Loaiza & Liang, 2013). Preeclampsia and eclampsia were six times more likely to occur among adolescents. Pregnant adolescents are more likely to be infected by malaria than adults (Dixon-Mueller & Lloyd, 2011). Young women who begin childbearing early, are at a higher risk of obstetric fistula, often caused by obstetric labour (Dixon-Mueller & Lloyd, 2011) Obstetric labour tends to be a result of limited access or availability of services, whereby the child may die in labour (UBOS, 2011). Young girls aged 10-15 are especially vulnerable: their risk of fistula is as high as 88% (Cook, Dickens & Syed, 2004). Obstetric fistula is particularly prevalent in Sub-Saharan Africa and Uganda has the third highest rate of fistula in the world (UBOS, 2011). Although child brides are at a higher risk of pregnancy related complications, they tend to have poor pregnancy-related care seeking compared to older women (Raj, 2010; Reynolds, Wong, & Tucker, 2006).

1.3.4 Understanding the context in Uganda

The aim of this chapter is to provide a background description and to introduce factors influencing the lives and health seeking behavior of child brides in Uganda and Karamoja. The Ugandan health system will be presented alongside socioeconomic status, adolescents' health status and use of health services. Lastly, a description of child brides situation in Uganda and Karamoja will be presented. The cultural and traditional factors in Karamoja are also described

Uganda country information

Uganda borders the Democratic Republic of Congo (DRC) in the west, South Sudan in the north, Kenya in the east and Tanzania, Rwanda and Lake Victoria in the south. Uganda is a landlocked country with 112 districts across 241,039 square kilometers. The central and western parts of Uganda have fertile land, while the north and east are less fertile (UBOS, 2011). The climate is appropriate for agriculture with its two rainy seasons. See map below.



Illustration 5: Map of Uganda

Source: https://en.wikipedia.org/wiki/Template:Location_map_Uganda (accessed 20.07.2016)

The population of Uganda was 34,6 million in 2014. Demography shows that 29 million live in

rural areas and six million in the urban areas, primarily in the capital Kampala (UBOS, 2016). Annual population growth lies at three percent per year with a total fertility rate of 5,8 children per woman (UBOS, 2016). The population of Uganda has almost doubled in the last 20 years. Life expectancy at birth for Ugandans is 56 years for males and 58 years for females (UBOS, 2011).

Population density is high in the central and western regions, while population density declines in the north. Sixty-nine percent of the population relies on subsistence farming as their main income source, 80% of the households are involved in agriculture (UBOS, 2016). Sanitation and access to water has steadily improved, 72% access an improved water source while 8% have no access to toilet facilities. Ninety-four percent of Ugandans use firewood or charcoal for cooking, and 20% have access to electricity (UBOS, 2016). Uganda has 56 indigenous groups, with as many languages (Republic of Uganda, 1995). The groups vary in size and population and some are more dominant than others. Uganda is a republic with the President Yoweri Museveni ruling since 1986. He brought stability and economic growth to the nation after Milton Obote (1962-1971 and 1980-1985) and Idi Amin (1971-1979). However, even with relative peace in central regions, the lack of rotation in presidency should not be underestimated as the democratic development in Uganda appears to be stagnating (NORAD, 2017).

Socioeconomic factors

Uganda is considered a low-income country with a growth rate of 4,7 % and the gross national income per capita was in 2013 US\$ 1,570 (UNICEF, 2015b). Uganda is self-sufficient in food but distribution is uneven. Coffee is the main export commodity (UBOS, 2011). Distribution of wealth in Uganda is also uneven; according to the wealth quintiles, 79,2% of the population of Karamoja lies within the lowest wealth quintile. In general rural areas of the country 23,1% are within the lowest quintile, in the North 40% and in the West Nile 41%. Ninety-one percent of the persons within the highest wealth quintile live in Kampala (UBOS, 2011).

The majority of Ugandans have very little or no formal education; the literacy rate is 72,2%. Thirteen percent of children of primary school age (6-12 years) do not attend school (UBOS, 2016). Even though the Government of Uganda provides free universal education, 33% of girls and 34% of boys aged 6-9 have never attended school (UBOS, 2011). According to DHS, the long distances from school and the cost of education beyond tuition fees are reasons for why children are not in school. Some societies in Uganda view children aged 8 as too young for schooling (UBOS, 2011).

There is also a difference in urban and rural areas: 8% of girls in urban areas have never attained school while in the rural areas 22% of girls have never attained school. Poverty also plays its part; 7-8% of women and men in the wealthiest quintiles have no education whereas for the poorest quintiles 34% of women and 20% of men have never attended school (UBOS, 2011).

Uganda is one of the countries with the largest youth brackets in East Africa with 78% of the population below the age of 30, and 55% of the population below the age of 18 years old (UBOS, 2016). The youth cohort is growing, and it is the largest in Ugandan history. This same group is also the one with the highest unemployment (Youthmap, 2011). The current 80% unemployment rate for adolescents in Uganda is expected to worsen unless efforts to address this challenge are implemented (Banks & Sulaiman, 2012). Youth unemployment rates are not equally distributed between urban and the rural areas. In Kampala the rate of youth unemployment lies at 32,2% while in general the rate for urban parts of the country is 71% and 83% for rural youth. Gender is also a factor in the youth unemployment rates in Kampala: for females the rate is 27% compared to 9% for men (Banks & Sulaiman, 2012). The youth, here defined as people between 18-30 years old, represents 21% of the population, and 64% of the unemployment in Uganda (UBOS, 2016). Men end up in the informal economy due to unemployment: about 67% of employment outside agriculture is informal employment (Okidi, 2015). According to WHO, Uganda has one of the highest consumptions of alcohol in the East African region, with 23,7 liters as the annual per capita consumption (WHO, 2014). Kabwama et al (2016) found that 10% of Ugandans have disorders related to alcohol use, Ugandans drink more frequently in the countryside and men consume more than women (Kabwama et al., 2016).

In Northern Uganda many male youths engage in casual labour or as bodaboda drivers. Bodaboda is motorcycle taxis, and it is cited as the most common occupation by male youths (Youthmap, 2011). Female youths brew local alcohol as their economic activity. Local brewed alcohol stands for 80% of the consumed alcohol in Uganda. Among youth aged between 14 and 30, 70% engage in unpaid family work. Uganda strives to reach middle-income status. In order to achieve this goal, there is a need to invest in the youth (Ikomu, 2015).

Karamoja district information

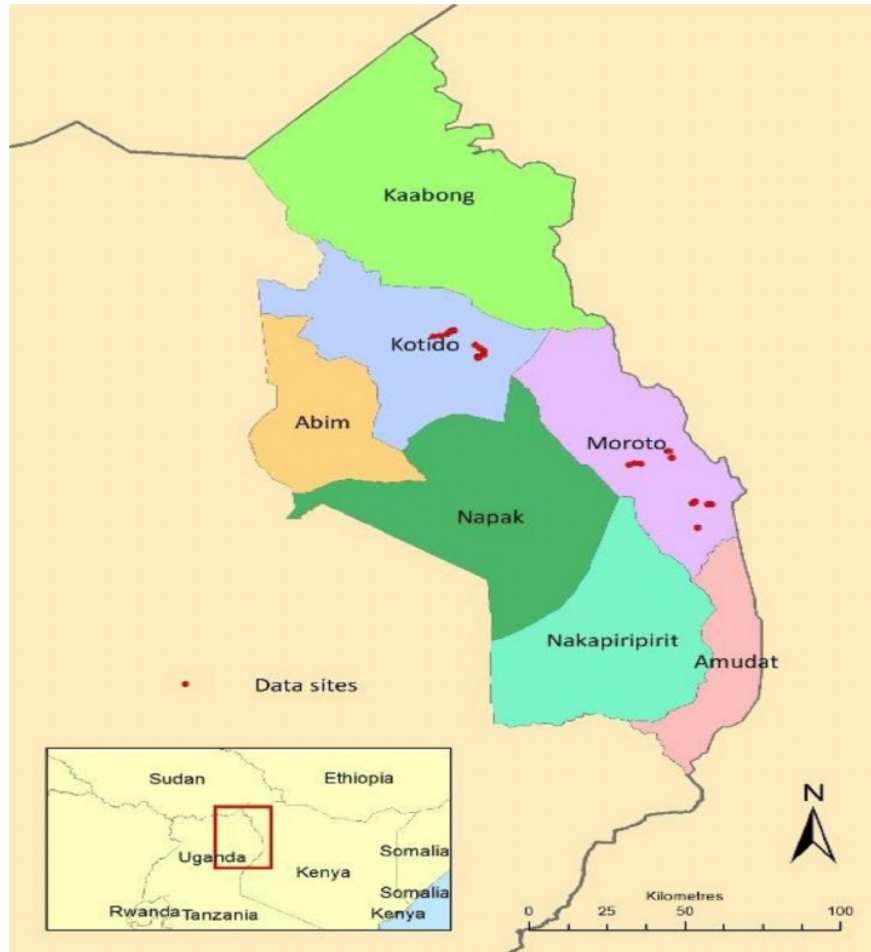


Illustration 6: Map of Karamoja

Source: https://www.researchgate.net/figure/283312919_fig1_Fig-1-Map-of-Karamoja-Region-showing-the-study-sites-in-the-districts-of-Moroto-and (accessed 20.07.2016)

According to the Ugandan Bureau of Statistics Karamoja is 1,640 square kilometers - approximately the same size as Belgium. Karamoja lies in the north east, bordering South Sudan and Kenya. Karamoja experiences cross border incursion from these two countries (Powell, 2010). The map in the preliminary pages shows where in Uganda the Karamoja region lies and what districts constitute Karamoja. The capital is the city of Moroto, which lies in the Moroto district. This fieldwork was conducted in the district of Amudat, which borders Moroto, Nakapiripirit and the West Pokot county of Kenya.

The total population of Karamoja is 1,1 million where 3% lives in urban areas and 97% in rural (UBOS, 2011). As with the rest of Uganda, 50% of the population is below 18 years old (Kanute & kagan, 2008). Findings from the OCHA report (2008) show that 82% of the population live in poverty. There is a global acute malnutrition in the region: 10,9% compared to 6% for the rest of the country. The international emergency threshold lies at 10%. The nutritional status is very poor, 50% of children below 5 years are stunted compared to the national average of 39,1% (UBOS, 2011). There is no access to open water (Powell, 2010) and the water and sanitation is very poor in the area with only 42,3% able to access safe water. Ninety-nine percent of the population can not access a toilet, the remaining 0,8% have pit latrines (UBOS, 2011). Due to poor sanitation diarrhea diseases and intestinal worms are a challenge. The most common diseases is malaria which 35% of all patients at health care services have it (UBOS, 2011).

The newest regional data on maternal mortality is from the demographic health survey of 2006. The Karamoja infant mortality rate was 178 per 1000 live births, and child mortality was 248 per 1000 live births and maternal mortality rate was 527 per 100,000 live births (UBOS, 2006). Fertility rates in Karamoja are 6,4, while the national average is 6,2. Nationally 30% are using family planning, while 7,8% are using family planning in Karamoja (UBOS, 2011). This might have a connection with the number of children desired by men, which is 7,2 in Karamoja while the rural average for the country is 5. Findings from the DHS show that women in Karamoja have one of the highest decision-making power in the country, with 81,6% compared to the national average of 60,2 (UBOS, 2011).

Karamoja has the poorest indicators for development in Uganda, the region suffers from chronic poverty. Karamoja has been exposed to instability caused by conflicts between clans over cattle and resources for decades. The socioeconomic development have to a great extent been negatively affected by the violence and small arms proliferation. Karamoja has the highest proportion of women and men with no education with 58,1% having none. The national average lies at 6,1 years in school for urban areas and 2,3 years in school for the rural areas (UBOS, 2011) Because of low levels of education, Karamoja has high levels of illiteracy. Among 23,000 children only 5,500 participated in primary education. At secondary level 221 students participated, whith only 61 of them female (UBOS, 2011). The human development index ranks Amudat district among the lowest in the country (UBOS, 2011).

Marginalization of Karamoja

Llamazares published a Northern Uganda conflict analysis report (2013). The report states that Karamoja is commonly considered distinct from the other regions in the north, as the only Sub-Saharan region with a dominant pastoralist and agro-pastoralist way of living. Karamoja has also suffered 40 years of food and general insecurity. The region is facing an increased interest in mineral and metal exploration, in addition to regional instability by the borders of Kenya and South Sudan (Llamazares, 2013). It is safe to say that Karamoja is distinctively less privileged than the rest of Uganda. The term “Karamoja cluster” is commonly used to describe a cross-border area of land which covers parts of South Eastern Sudan, South Western Ethiopia, and North Western Kenya in addition to the Karamoja area of North Eastern Uganda (Powell, 2010). The populations in the Karamoja cluster live similar pastoralist lifestyles. The map below shows the areas where people live a similar lifestyle to the Pokot. It also shows the border between Karamoja and West-Pokot, which is where Amudat borders Kenya, and where the cross-border interaction between the Pokot of Uganda and Kenya takes place.

The historic discourse of conflict and marginalization in Northern Uganda and the decisions and interventions from the government are often seen in a historic perspective of violence and exclusion. Asymmetrical power relations and marginalization is evident in the north, and the unequal level of development, access and distribution of power and natural resources remains as a key driver for conflict internally in Uganda (Llamazares, 2013). The report also identified gross disparities based on regions and ethnic groups in access to political appointment, military promotion, access to government scholarships and equal opportunities for skill enhancement (Llamazares, 2013). Despite specific development programs targeting Karamoja, the level of poverty has risen among pastoralist communities and the cattle rattling has become more violent. Kakande (2007) explains this with a lack of community involvement in the policy and programs, accusing the policy makers for being “top down”. They also attempted to reduce the mobility of the semi-nomadic Karimojongs by forcing them to settle down (Kakande, 2007).

This study was conducted in Amudat, one of the districts in Karamoja. Amudat borders the districts of Moroto, Nakapiripirit, Bukuro, Kween and Kenya. The Amudat district has 1610 square kilometers and an average altitude of 1280 meters above sea level. The population of Amudat is 111, 756 (UBOS, 2011). The majority of the population in Amudat belongs to the Pokot tribe. As

mentioned above, this area is a part of the Karamoja cluster. On the Kenyan side of the border the majority of the population belongs to the Pokot tribe. In the everyday life of the people living close to the Amudat – Kenya border, the border do not exist for them (Powell, 2010).

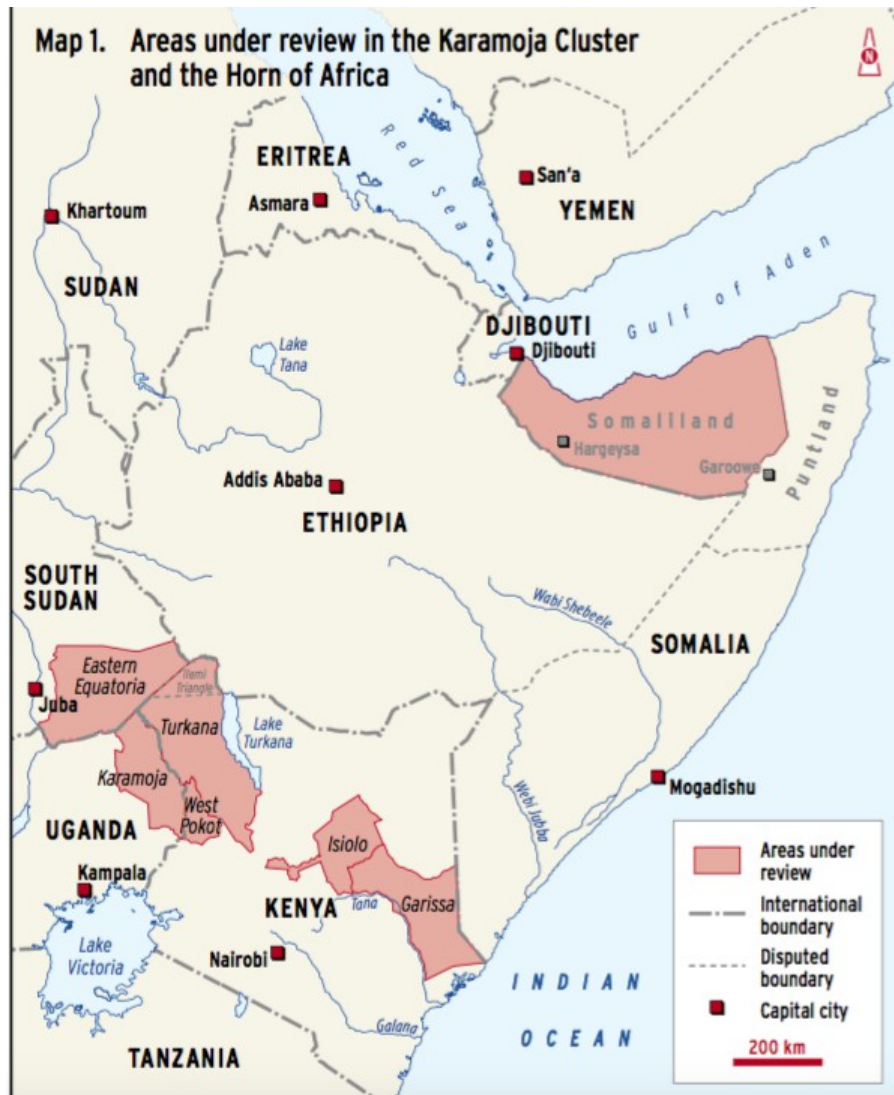


Illustration 7: Karamoja Cluster

Source: <http://www.smallarmssurvey.org/fileadmin/docs/G-Issue-briefs/SAS-AA-IB3-Traditional-Practices.pdf> (accessed: 20.09.2016)

1.3.5 Health system in Uganda

The health system in Uganda is decentralized, with several different actors within the public and private sector. Donors also play a major role in funding both private and public sector (Mukasa, 2012). The private side consists of traditional and complementary medicine practitioners, private practitioners and private not for profit organizations. The public health sector is constituted of the central government and the district health services which lies under local government authorities. The public health system is based on referrals, with the main hospital in the capital being the final referral point for health services (Mukasa, 2012).

There is an equity issue in the Ugandan health system, with many poor patients not accessing health services that are affordable to them. The patients have to pay a considerable expense for transport, user fees and drugs to access health services in the public sector, primarily for secondary and emergency care. Many health facilities often experience drug stock-outs and lack adequate staffing, a situation that tends to be more acute in rural areas. The government of Uganda continues to rely on donors in order for them to deliver health services, the structure of donor projects does not contribute to making the government self-sufficient. One of the downsides of donor driven health care is the short-term nature of projects, which leads to a disparity in services (UBOS, 2011).

Structure of the health system and performance

According to Mukasa the strengths of the Ugandan public health system are the decentralization and the will to extend services to the grassroots. Priority is given to further decentralization for better quality of care and to target the most important health problems of the rural population. Health Center 1 is a satellite health facility with no physical structure: The Village Health Team (VHT) travels to the communities to provide health education, vaccinations and supply drugs (Mukasa, 2012). Health Center 2 is the closest structural Health facility to the community, located at parish level. The Health Center 3 handles referrals from Health Center 2 and refers to Health Center 4, which is a mini-hospital. The staffing levels are low in Uganda, with only 63% filled in the public health sector. It is a challenge to fill the positions especially in hard to reach areas (Mukasa, 2012).

The private sector consists of many different providers. The majority of facility based providers are religious-based health care providers who exist under umbrella organizations. The non facility based providers consists of both international and national non-governmental organizations (NGO),

for instance Uganda Red Cross or OXFAM. Private health practitioners provide primary level services and limited secondary services in a range of health care services; pharmacy; nursing; midwifery; dental and clinical (Mukasa, 2012). Traditional and complementary medicine practitioners include all types of traditional healers, but it does not include people who engage in harmful practices. There are several associations with registered members coordinated by Cultural officers at sub-county and district levels. Thus, many of the traditional medicine actors remain unaffiliated with any association. In recent years several non-Ugandan traditional medicine systems have been introduced in Uganda, such as traditional Chinese medicine (Mukasa, 2012).

The annual health sector performance report (Ministry of Health, 2015) by the Ministries of Health shows a great disparity in quality of health care delivered in Uganda. Maternal mortality and morbidity are still at unacceptable rates nationally, these are highly preventable deaths (Ministry of health, 2015). The Ugandan government spends 13,7 US \$ per capita less than the target recommended by WHO. Of the bottom five performers, three are in Karamoja, with Amudat the poorest in health performance by 46,6% out of 100%. Gulu has the best health service performance by 89% followed by Kampala with 87,4%. The filling rate of health workers is 70% on a national level and 44% in Moroto. Amudat is considered the hardest to reach areas. The referral hospitals used by the Karamojongs are also the ones with the lowest scores; Mbale with 69,1% and Moroto with 61,4% (Ministry of Health, 2015).

1.3.6 Reproductive health challenges for adolescents

Adolescents in low- to mid income countries face the largest burden of sexual reproductive health challenges (Bearinger et al, 2007). Numbers from the World Bank show that the adolescent fertility rate, defined as birth per 1000 women aged 15-19, is 100 in Sub-Saharan Africa. Uganda lies at 109 (World Bank, 2016). HIV infection rates are also high among adolescents, 6000 are expected to transmit the virus each day. The majority of these youths live in Sub-Saharan Africa and 75% are female (UNFPA, 2014). Globally there is a growing recognition of the need to address and improve the sexual and reproductive health of adolescents. However, few goals have been reached yet (Sommer & Mmari, 2015).

Adolescent pregnancy lies at 25% in Uganda, the highest in Sub-Saharan Africa. Adolescents are at a higher risk of maternal deaths than older women: 33,3% of maternal deaths occur among adolescents, while the national average lies at 15% (UBOS, 2011). Ugandan girls are more likely

than their peers in Sub-Saharan Africa to become pregnant due to their low use of contraceptive (Gibson, Kabuchu, & Watkins, 2014).

In 2002 the WHO published “*Adolescent Friendly Health Services: An Agenda For Change*”. This describes how to communicate with youth, especially on issues concerning reproductive health. The government in Uganda aims at reducing teenage pregnancy and premarital sex by improving adolescent sexual and reproductive health services. Health workers have attained trainings on how to communicate with youth and to handle their issues (Ministry of Health, 2004).

Gender based violence

On a global level, married adolescent girls are more likely than their unmarried peers to be victims of sexual abuse, social isolation and domestic violence (ICRW, 2012). Gender based violence (GBV) is a challenge in Uganda and has been referred to as one of the worst in the world for GBV (Gibson et al, 2014). According to the Demographic Health Survey (DHS) in Uganda , fifty-six percent of women and fifty-five percent of men have experienced violence, while 28% of women and 9% of men have experienced sexual violence. Thirty-seven percent of women reported physical injuries, while twenty-six percent of men reported (UBOS, 2011). Perpetrators of physical violence tend to be family members and 50,4% of violence experienced by women is committed by their current partners or husbands (UBOS, 2011). Adolescent girls in Uganda are more likely to accept violence from their husbands than older women would (Wagman et al., 2009).

Female genital mutilation/cutting (FGM)

WHO defines female genital modification (FGM) as a procedure that causes injury to the female genitals for non-medical reason: it has no health benefits for girls and women. Globally, more than 200 million girls and women have been cut. These women primarily come from Africa, the Middle East and Asia. This cultural practice is widespread in 30 countries. The procedures are commonly carried out by traditional circumcisers, who often also have another important role in the community as traditional birth attendants (TBA) or midwives (WHO, 2017). FGM is seen as an initiation ritual for girls and as a required rite of passage before entering into marriage (Warner et al, 2013)

FGM is not a widespread traditional practice in Uganda. Nationally 1,4% of all women are circumcised. The Karamoja region holds the highest rates of FGM with 4,8% (UBOS, 2011). FGM

is a common practice among the Pokot and Kadamas (UBOS, 2011). FGM is classified into 4 types, the Pokot carry out the infibulation, classified as type 3. This is the most extreme version of FGM where the aim is to narrow the vaginal opening by creating a covering seal. This seal is formed by using the labia minor or labia major, and sometimes through stitching, with or without removing the clitoris (WHO, 2017). The Pokot remove the clitoris and the labia minor and major. They leave the wound to heal by tying the legs together.

Access, barriers and utilization of sexual and reproductive health services

In general there is poor access to health care services for adolescents (Green, Cardinal, & Goldstein-Siegel, 2010). African youths face barriers in health care service access such as age and marital status: fear for mistreatment: lack of confidentiality: inconvenient hours and locations of facilities: limited knowledge about available services and the high cost of services (Kabiru, Izugbara, & Beguy, 2013; Sommer & Mmari, 2015). Several studies show that young people lack knowledge of reproductive health and rights, HIV/AIDS and modern contraceptive methods (Kabiru et al., 2013; Råssjö & Kiwanuka, 2010). Adolescents in rural areas were especially thought to have poor information about family planning and reproductive health rights (Råssjö & Kiwanuka, 2010).

Ugandan women aged 18 or younger were less likely to use antenatal care, delivery care, or both, than women aged 19-23. They were also less likely to have their infants immunized (Reynolds, 2006; UDHS, 2006). Atyambe's study about health-seeking behavior in Uganda showed that reasons for not seeking health care when giving birth varied, from rumors about poor hygienic state to health care workers who treated them badly (Atuyambe et al, 2009). Mukasa's findings show the same picture: 60% of deliveries in rural areas are carried out at home, while nationally 50% deliver at a facility (Mukasa, 2012). Causes of home delivery are often related to means of transport to the health unit and lack of health facilities in the areas where people live (Mukasa, 2012; Rutakumwa & Krogman, 2007). In addition, cultural factors, economy and education may play a part in the health seeking behavior. Findings from Greene & Merrick's study (2005) show, young women and adolescents from the poorest households are less likely to use curative and preventative SRH services, compared to people from the wealthiest households (Greene & Merrick, 2005). Rutakumwa and Krogman identified several coping strategies for health concerns among participants of their study: they ignore it, do self-care/medication, secretly use contraceptives, use herbal/traditional medicine or seek advice in the female community (Rutakumwa & Krogman,

2007).

In Karamoja 25% of all deliveries occur in the public health sector, while 1,7% use the private sector. The majority do have assistance during delivery: 28,8% have a nurse attending, 18,4% have a traditional birth attendant and 47,3% have a friend or other to assist them during labour (UBOS, 2011). 87% of women living in Karamoja have at least one barrier to access health care. 86,3% said that money for treatment was the major challenge, while 41,9% said that distance to the health clinic was a challenge. 18% did not want to travel alone to the health clinic and 5,3% faced challenges with permission to go for treatment from their husband (UBOS, 2011).

Child marriage in Uganda and its causes and consequences

In Uganda 40% were married before the age of 18 and 10% before the age of 15. (UBOS, 2011). The prevalence of men married at 18 years old was 9% (UBOS, 2011). According to UNFPA Uganda has shown a significant decline in rates of child marriage in both rural and urban areas, the largest decline appears among girls who are 15 years and younger when married (UNFPA, 2012a). New estimates from UNICEF show a decrease to 40% as the national average married before the age of 18, and 10% married before the age of 15 (UNICEF, 2015b). The early marriage prevalence is higher in rural areas than urban. On average, Ugandan women tend to marry two years later in urban areas. The regional prevalence in Uganda was highest in the North by 59%, the second highest was the East with 58% percent. The prevalence in the East was 52%, while the lowest prevalence was in the Southwest region with a prevalence of 37%. These numbers are most likely high in the North and East due to them being post war areas and instability. This was the only data found that showed prevalence for the specific areas in Uganda (UNFPA, 2012a). According to Schlecht et al's study, the increase of early marriage in post conflict settings, war and instability is caused by the parents aim to protect their daughters from premarital sexual activity and secure economic stability (Schlecht, Rowley, & Babirye, 2013). Child marriage in Uganda is a significant contributor to the high levels of fertility, overall population growth and teenage pregnancies (UBOS, 2011).

In Ugandan communities poverty fuels the prevalence of child marriage. Parents can see their daughters as a potential to gain wealth. They can also be an intolerable economic burden where the parents are unable to meet their daughters' basic needs such as clothes, food and medication (Walker, 2012; Rubin et al, 2009; Bantebya et al, 2014, Schlecht et al, 2013; Bell & Aggleton,

2014). A study by Bantebya (2014) from Eastern Uganda shows that sexual maturation equals readiness for marriage. Once a girl has developed breasts she is considered ready for marriage. In some traditions girls are not supposed to start their menstruation in their parents' home. Poor hygiene management conditions for girls at school have been a driver for school drop out and early marriage (Bantebya, Muhanguzi, & Watson, 2014). Many teenage girls in Uganda find marriage the only practical solution to survive (Ochan, Nalugwa, & Apuuri, 2013), hence, several studies have shown that premarital pregnancy perpetuates early marriage (Bantebya et al., 2014). In many Ugandan communities pre-marital pregnancy remains stigmatized. It is looked upon as shameful, as a disgrace to the girls family and associated with disrespect and bad omens, embarrassment and curses. An unmarried teenage mother is considered a bad influence in the community. Bantebya et al (2014) suggest that premarital pregnancy or sexual relations have become more common, implying bending social norms about virginity and acceptance for premarital sexual relations (Bantebya et al., 2014).

Autonomy and participation in decision-making for girls is affected by age at marriage, decision-making power and autonomy tend to be lowest for the youngest girls. Using data from the national Demographic Health Survey (DHS), Rubin et al (2009) found that Ugandan girls who marry before the age of 14 were less likely to be part of the decision making process than girls who married at the age of 15 or above (Rubin, Green, & Mukuria, 2009). A Ugandan study (Hatcher et al., 2012) showed that women with a higher sexual relationship power had decreased symptoms for depression severity and were less likely to fulfill the criteria for depression. Low sexual relationship power is associated with intimate partner violence (Hatcher et al., 2012). They also had better mental health status compared to women with low sexual relationship power. Another Ugandan study by Atuyambe et al (2009) found that married women lacked decision making power, which made them feel exposed and powerless in their marriage (Atuyambe et al., 2009). Informal unions may deprive young girls' basic protection and social status. This can lead to social isolation in a new context whereby the child bride lacks support structures (Bantebya et al., 2014; Schlecht et al., 2013).

Marital practices among the Pokot

Few studies have looked at the Pokot tribe of East-Africa. The published research that exist is primarily conducted in Kenya. The Pokot tribes in Kenya are socially, culturally and geographically very close to the tribe in this study. A reason for the research gap might be the continuous instability

and hostility towards “foreigners” in Karamoja. Foreigners are defined as people from other tribes than the ones residing in Karamoja, both from Uganda and other countries.

In Bianco’s study (1991) she found that circumcision is an important rite of passage for Pokot women: it accompanies with social attractiveness and social status through marriage and motherhood. Pokot women carry their clan identification with them from one patrilineage to another, from her father to their husband. According to Bianco (1991), Pokot women are often named after her children - mother of so and so - and this can be seen as a symbol of their participation in the adult world of politics. In Conant’s ethnographic study from 1974, he found that the Pokot negotiate marriage and transaction of bride wealth. Those getting married are at times not included in the decision-making process, this is especially true for the girl.

Polygamy is common in Karamoja, the DHS data from 2011 show that polygamy has a strong role in Karamoja, with the highest national rate of 51%, while Central has 17% (UBOS, 2011). Conant (1974) found that in some cases friends, kin and co-wives are at times included when the man aims at selecting a new wife, however, such circumstances are rare. Conant (1974) concludes that marriage in Pokot traditions is not an individual affair based on love, but primarily an alliance between kin groups. This alliance is negotiated by the means of bride wealth (Conant, 1974). Edgerton and Conant (1964) state that the level of frustration and aggression between wife and husband is a notable feature of adult Pokot life.

Dean (1994) looked at child spacing, fertility and contraception among the Pokot in Kenya. The main reason for spacing was protection of the health of the mother. During warfare it was important to only have one child to carry. The way of spacing was the postpartum abstinence period. Dean (1994) also found that among the Pokot, high fertility was seen as a strong and important tradition, and as a mechanism for survival on farming. In Deans (1994) study, findings showed that spacing had decreased in recent years, most likely due to improved maternal health and less instability. Fertility tends to decrease when maternal mortality decrease. Among the Pokot, fertility seems to be rising. Dean (1994) explains this by stating that importance of fertility is persistent in the minds of men because they attach a great importance to clan power. Further Dean (1994) claim that the poor knowledge about how to limit fertility and how to talk about these issues are reasons to the high fertility (Dean, 1994).

Literature and demography from the study country and site provide a thick description on child marriage in the context where this study was conducted

1.4 Rationale

The rationale of this study is to add knowledge about married adolescent girls lives and their experience of marriage. As previously mentioned, there is a gap on child brides' experiences of their own life and situation and their health and well-being. This study can contribute to fill the research gap and inform programs who aim at eliminating the cultural practice of child marriage among the Pokot and in communities living similar lifestyles.

This study also seeks to understand the health seeking behavior of married adolescent girls and to understand their behavioral patterns, especially in relation to reproductive and maternal health. This knowledge can explain why adolescent married girls are more reluctant to deliver and to seek reproductive health care at the biomedical health clinics than their older peers. The study also seeks to find ways in which improvements of health care utilization can be done, and to understand the role of the traditional/herbal health sector. This added knowledge can inform programs aiming at reducing maternal mortality and increasing the use of maternal health services in Uganda.

1.5 Objectives of the study

General objectives

The study seeks to understand the process of child marriage and examine health and wellbeing among married adolescent girls as well as their access to health care in the Pokot community of North-eastern Uganda.

Specific objectives

1. To understand the process of child marriage
2. To explore the state of health and well-being among married adolescent girls
3. To explore the health seeking behavior of married adolescent girls
4. To identify possible approaches to improving health care delivery and health seeking among married adolescent girls

2 Methodology

2.1.1 Introduction

This chapter presents the methodology of the study. Chronologically, it includes a presentation of research methods, methods of data collection and the data construction process used during and after the fieldwork. Ethical considerations will also be discussed and quality control is included.

2.2 Research design

The research design in this study is a qualitative method. According to Creswell, qualitative research is a good methodology to apply when a problem or issue needs to be explored (Creswell, 2013). As for this study the aim was to explore life stories, the well-being of child brides and their utilization of health care. One of the major strengths of qualitative research is that the participants are free and encouraged to share personal experiences, feelings and thoughts. Such data is difficult to collect with any other method (Creswell, 2013). In-depth interviews, focus group discussions (FGD), observations and a meeting where the researcher's interpretations were checked against community members (a validation meeting) have been the main sources of data collection in the study.

Qualitative methods serve as an appropriate tool when exploring child brides' life stories, well-being and utilization of health care. They are also useful when exploring health workers practices, attitudes and knowledge about married adolescent girl's health and need of health care. In addition key informants were interviewed about their knowledge of child brides' experiences and the practice of marriage in Pokot culture. After collecting and transcribing data, a validation visit was carried out, both to include the participants in the analysis process and to confirm findings from the field work. According to Creswell the validation visit might have minimized the power structures between the researcher and the participants (Creswell, 2013).

2.3 Study area and population in the study area

The fieldwork for this study was conducted from September to November 2015 in the Amudat district, Northern Uganda. Amudat is considered to be a hard to reach area. This study was conducted in the rainy season, which made the field work challenging. Both reaching the field from Kampala, and reaching the villages in the field was a challenge. This was caused by little availability of public transport, petrol and rain on dirt roads.

The primary criteria for selecting this site was that it should be a rural area with a high prevalence of early marriage. When the aim is to investigate health seeking behavior and barriers to health care for married adolescent girls, this sub-county is also relevant as a study site. As described above, the delivery of health services in Amudat is the poorest in Uganda, and the nearest health facility was relatively far from most of the informants. The name of the sub-county where this study was conducted, is not revealed in this study. The health workers are few, and some of the stories of the child brides could possibly be recognized. The names of the informants are all pseudonyms or numbers.

Originally, the plan was to carry out the fieldwork in a different site. After one meeting in Uganda, the supervisor suggested to switch field to where he was conducting his study. This turned out to be a suitable site also for this study. It was an immense advantage for the investigator to have a supervisor who was well known to the field.

The main informants were girls married before the age of 18. Health workers and key informants were also included in this study. According to George and Bennet (2005) the primary selection criteria of informants should be relevant to the research objective (George & Bennet, 2005). The sub-county is densely populated compared to the areas around, however, it is still a rural area. The population mainly consists of people belonging to the Pokot tribe in which the majority of girls are married before 18.

2.4 Field entry procedure

The research protocol for this study was submitted to the Regional Committee for Medicine and Health Science Ethics (REK), who responded that this study was not relevant for their approval. The study was registered at the Norwegian Social Science Data Service (NSD). To protect the anonymity of the participants, NSD requested age specific questions of the husbands to be changed into brackets instead of actual age. The ethical board of the department of sociology and anthropology at Makerere University approved the protocol. They prepared an introduction letter, which was introduced to the local administrative representatives. Protocol clearance visits were carried out to the office of the chief administrative officer in Amudat, the district head officer and chairman of the local council in the sub-county. In addition to the formalities of approval, the

district police office in Amudat, the police station close by the site, and the hospital in Amudat were visited.

Interpreter/research assistant

In order to carry out this fieldwork, the assistance of a Pokot and English speaking interpreter was needed. The research team had preferences for a female worker, due to the sensitive nature of the study. Other selection criteria were prior experience in the field of reproductive health and good interpersonal skills. Due to the low education among the Pokot, especially for girls, it was a challenge to find a candidate within the criteria.

Thus, the interpreter who assisted with the field research was male. He had prior experience working as an interpreter as well as monitoring and reporting cases of FGM and child marriage. As a result of only two years of primary education, his English was limited. The interpreter is from the Pokot tribe, is a catechist in the local church and knows the cultural traditions and language well. He turned out to have good connections and interpersonal skills. Concerns were raised about his religious affiliations, his sex and for being a well-known person in the local community.

In general when using a translator, the message might be transformed while bypassing the interpreter, as he brings his own values, beliefs and assumptions to the research process (Leck, 2014). The expression of this influence might be implicit in the way the interpreter understands the information, or explicit in cases where the interpreter adds his own judgements or opinions to the expressions of the informants. Throughout the first interviews the latter was occurring. The issues were discussed, followed by improvements. Thus, it is challenging to know whether it could have affected the truthfulness of the information collected. Due to the relatively small study site, people seemed to be aware of each other and the interpreter was familiar with many of the informants. The interpreter thus advised the peer investigator on cultural sensitivity if some probing questions seemed inappropriate. Further, his role as an interpreter was carefully discussed prior to the first interviews and throughout the first week of the collaboration. According to Leck (2014), cultural sensitivity is a key ethical principle when conducting research in a different cultural context than your own (Leck, 2014).

2.5 Sample size and selection techniques

The informants proved to be relatively easy to access. They were purposely selected based on the predefined inclusion criteria of being married before the age of 18. The aim was to recruit ten to

fifteen married adolescents for the in-depth interviews and ten to sixteen for two different FGDs. Finally, 13 girls were recruited for the in-depth interviews, and 15 for the FGDs. The target number for participants in the in-depth interview was based on recommendations from the main supervisor and likelihood of reaching this number of participants within the timeframe of the fieldwork. A FGD commonly consists of 4-8 participants. This was the goal when recruiting participants for the FGDs.

Preferably four to six persons working within health care were to be interviewed. Recruiting health workers to the study was a challenge as they are few in the Amudat district. However, four health workers participated in the study. Elders turned out to have a significant role in health seeking behavior. Five to eight elderly people were to be invited for a focus group discussion. The interpreter made an appointment with a group of elders of a village for this discussion.

It is important to make a selection of informants that is well-reasoned with different characteristics to get variation of views and narratives (Hesselberg, 2014). To select a variety of participants, these characteristics were considered; childbearing, residency, age of husband and time married. Participants were identified through local knowledge and suggestions from the supervisor and the interpreter. The interpreter contacted and recruited participants by calling and visiting potential candidates and inviting them to participate in the study.

Key informants in this study were health workers, locally based organizations and people with knowledge of cultural traditions. The key informants were selected based on where they worked and what role they had at the clinic. Potential informants were contacted by phone or a visit, whereby they were asked whether they wanted to join or not.

During two of the interviews the informants revealed that they had left their husbands or that their husband had left them. These interviews were still included with an aim to understand the consequences of divorce in Pokot culture.

2.6 Data Collection and data collection techniques

This study aimed to collect rich, comprehensive and high quality data. To achieve this, triangulation of methods was used as a data collection method. Triangulation is defined by using more than one method to collect data (Dahlgren, Emmelin, & Winkvist, 2007), for instance by applying qualitative methods, or by using different methods within the two main methodological approaches. In this study only qualitative methods have been applied, where the main methods were semi-structural interviews and focus group discussions.

Throughout the fieldwork the investigator should aim to draw a precise picture of the context, a thick description (Dahlgren et al., 2007) Methods used to collect data to ensure a thick description were observation, field notes and informal conversations. The aim was to provide a reliable description for the reader, enabling an informed choice to decide whether the data can be transferred to another context or not (Dahlgren et al., 2007). With an aim to ensure the quality of the data, a validation visit in the field site was carried out after transcription.

To be attentive to the participants and able to ask follow up questions during the interviews and FGDs, all of the interviews and discussions were tape recorded in addition to being noted. Interview guides were prepared for in-depth interviews, key informant interviews and FGDs. For some of the informants the questions were not relevant so at times some questions were not asked. The interview guide was developed in the course of the field study. Throughout the interviews and FGDs, probing was used.

As a remuneration the informants of the study received half a kilo of sugar or soap to compensate them for their time and to thank them for their participation.

In-depth interviews

Throughout the field study 13 in-depth interviews were carried out with child brides and two follow-up interviews were also done. The interviews lasted between 20 minutes to one hour. The majority of the interviews with married young girls were carried out in their village in a private spot under a tree. Some interviews were carried out at the market day or in the trading center.

The interviews started with demographic questions, which were thought to be “easy questions” to “warm up” (Dunn, 2010) the informants and to make them comfortable with the situation.

Determination of age among the young girls and their husbands turned out to be a challenge, as some of the girls did not know their age, nor their husband’s age.

Probing was a challenge in the first interviews, but was improved after some experience and training in the interview situation. In the process of transcribing the investigator disclosed several responses where it would have been important to examine the replies. The two follow-up interviews were set up to further investigate information collected from the first round. Towards the end of the fieldwork, the investigator experienced a fairly good understanding of the research question. The last interviews did not bring out brand new ideas, even though when exploring life stories of people,

the stories will always bring something new to the table. The termination of the fieldwork was driven both by concerns of time limitation and data saturation.

Key informant interviews

The interviews with health workers were carried out at the health centers where they worked, and the interviews with the organizations took place at their offices. Key informant interviews with a TBA and a traditional cutter were carried out in their home village. The interview with the interpreter took place in the guesthouse compound. These interviews lasted between 20 minutes and one hour. Four health workers were interviewed for this study. They were recruited from health centers at second and third level. One participant was recruited from the hospital in Amudat.

The ongoing work to prevent early marriage is primarily carried out by the NGOs. To learn more about the work going on in Amudat, interviews were done with personnel attached to three locally based NGOs working to prevent early marriage and also collaborated with a school where girls who escaped early marriage and FGM could seek shelter. More than 200 girls had come to seek shelter since the beginning of the project in 2012.

Because traditional medicine is commonly used, especially in rural villages, a TBA, a traditional cutter and the translator were invited for an interview. The Ugandan supervisor attended some of the key informants interviews with these people.

Throughout the fieldwork some challenges occurred. The informants had preconceptions of what data the investigator wanted to collect, and replied what they thought we wanted to hear. Other participants covered up cultural practices by stating that in their village, no one would perform FGM or marry their daughter before the age of 18. The interviews with health workers were often disturbed, and it was a challenge to complete interviews due to their busy schedules.

Focus group discussions

FGD is a form of group interview with 5-8 participants with similar backgrounds or experiences. FGDs are ideal for studying behavior, understanding communication gaps, decision-making or how people negotiate norms and belief systems (Dahlgren et al., 2007). The FGDs were carried out in Pokot. The interpreter was the moderator and the investigator took notes, observed and probed. The discussions were tape recorded. Three focus group discussions were conducted. Two of the focus groups consisted of young married girls from two different villages: one FGD was conducted in a

rural village up in the mountains, another one in a trading center close to a gold mine. Female elders turned out to be the decision makers in relation to health seeking behavior. One FGD was carried out with a group of elders in the same village as for the first FGD.

It was challenging to make the FGD into a discussion rather than a group interview, especially for the FGD with young married girls in the rural village. It was easier to facilitate a discussion with the elders. The challenge in this FGD was to establish trust between the investigator and interpreter and the participants.

Field observations and conversations

Interviews were conducted at two health centers and a hospital. The health center at the study site neighbored the investigators' guesthouse. The investigators and interpreter visited the hospital several times throughout the course of the fieldwork. This enabled continuous observations in relation to health delivery, health seeking behavior and confidentiality. Throughout the fieldwork the investigator and interpreter had several conversations about traditional practices among the Pokot, and stories from the village. The interpreter gave oral consent to use information he shared in these informal conversations. Observations and notes relevant for the study were registered in a field diary. The diary was written in Norwegian, and later typed into a password secured computer.

2.7 Data capturing, processing and analysis

Prior to the fieldwork public health theories about health seeking behavior and psychological theories concerning coping and mental health were examined. In addition, studies on early marriage and related topics from Uganda and Sub-Saharan Africa were also reviewed. During fieldwork I aspired to be open to what issues of significance could appear among the informants.

After transcribing the interviews, the data was analyzed by a content analysis. Content analysis is a systematic analysis of text with identification, coding, classifying, developing categories and grouping of themes (Pope & Mays, 1995). Throughout the analysis a constant comparison was performed. This is a method of content analysis where each category is searched for in the data set, every section of the transcriptions is compared until we have reached the stage where no new categories can be identified (Pope & Mays, 1995). The computer software NVIVO was used as a tool in the content analysis.

The data was sorted in three categories according to topic and what research objective the findings were meant to inform. Information from the first group aimed at exploring the state and well-being of married adolescent girls. The second group is linked to the first objective, which aimed at understanding the process of child marriage. The third group was meant to inform the two last objectives; health seeking behavior and identify possible approaches to improve the health service.

- 1) in-depth interviews with child brides,
- 2) in-depth interviews with key informants and NGOs/CBOs
- 3) in-depth interviews with health workers and FGD with child brides and female elders

For the In-depth interviews with child brides, these codes/categories were used: *Barriers to Health Care, Health Seeking Behavior, Education, Food Security, Health and Wellbeing, Process of Marriage and Transition from Girl to Wife.*

When coding the information from the health workers and FGD the codes used were; *Health and Health Services, NGOs/CBOs Projects, Situation of Child Brides, Suggestions for Improvement of Services and Traditional Medicine.* For the last category these codes were used; *Cultural practices in Pokot, Health, Improvement of Health Care Services, Projects of NGOs/CBOs and Traditional Medicine.* Sub-categories were also created.

The analytical strategy is based on an inductive approach with an emphasis on the lived realities of the informant (Cloke et al., 2004). The approach was also influenced by abduction, which is based on the constant interplay between empirical realities and theoretical hypothesis. Abduction lies in the center of the inductive-deduction continuum (Ragin & Amoroso, 2011). The data interpretation process started with writing notes and diary entries in the field, followed by the process of transcription and preparation for the validation visit. This was followed by a content analysis using NVIVO. The course of these steps has enabled a solid knowledge of the data, which contributed to an analysis closely attached to the raw data.

Validation visit

An objective of qualitative research is to minimize the power relation between researcher and participants by sharing their stories and view of the situation, and to allow them to participate in the evaluation and analysis process of the research (Creswell, 2013). Informants from the study and people in the community were invited to the validation visit. The preliminary findings were presented with a power point presentation, and the participants were asked to confirm, correct and add information to the findings presented. The validation visit contributed some clarification, thus the majority of the findings were confirmed. The aim of this validation visit was to see whether the study had grasped the issues throughout the course of fieldwork or not. Both one of the Norwegian supervisors and the Ugandan supervisor attended.

2.8 Quality assurance strategy

The concepts in which quality assessment of the data follows; dependability, confirmability, transferability and credibility. The concept of *dependability* consists of two conditions. The first condition deals with the way the context may differ from the researchers pre understandings. The second condition within dependability is the principle of replication. The findings should be a literal analysis of the intended meaning of the informant (Jensen, 2008b; Yin, 2014).

The dependability of the study has been compromised at several stages of the study. For instance by using an interpreter to translate a language unknown to the investigator, and the investigators language barriers influencing how to interpret situations and conversations. This may have contributed to misunderstandings and misinterpretations during data collection. Throughout the interviews, when probing the questions turned out to be more leading than intended, which could have contributed to an exhortation of the informants replies, hence not in line with their intended meaning. It is possible that another researcher would get different results, which would compromise the principle of replication and can be viewed as a weakness of the study. However, in qualitative research knowledge is constructed in the interaction between research subject and researcher and it would be impossible to fully replicate the data by another researcher. Moreover, what is true to the participants may change over time.

Confirmability is partly connected to dependability, its aim is to verify the goals of qualitative research, which is to understand a phenomenon through the lens of the participant in the study. Confirmability deals with the evidence that the informants' expressions and the interpretation of the researcher is rooted in the informants truthful meanings (Jensen, 2008a). Informants may have answered what they thought I would like to hear rather than their truthful meanings. This may be due to power asymmetry, my outsider position and a lack of trust building over time. In some of the interview settings where husbands, or other people were around, their presence may have compromised what the informants communicated of their own thoughts. Additionally, my collaboration with the interpreter and my supervisor may have had a negative impact on the confirmability. I could have had several interviews with each participant to increase the confirmability, for two of the interviews this was done.

Transferability, or analytical generalization (Flyvbjerg, 2006) means that the research subjects should be relevant members of the community studied. To increase the transferability, the participants should be selected based on the principles of purposive sampling. Furthermore the researcher should be able to ensure that the research questions are responded to in an adequate manner (Baxter,

2010), in addition to obtain thick description. The sampling procedure is described in the methodology chapter. Thick description was not obtained from each interview and questions were not answered in an equally and detailed way in every interview. However, I believe that the information obtained from the study draws a good picture of the case.

Finally, how credible is the study? Credibility is associated with the accuracy of the research process, consistency in the written product and accuracy in the data analysis (Jensen, 2008). By using data triangulation and including participants with different characteristics, I have aspired to look into the research question from different angles. Moreover I have strived for transparency in research design, fieldwork and data analysis process, in addition to being self-reflexive.

Additionally, a validation meeting was held in the community, in accordance to consult the informants and the community and to check that the data corresponded with their meanings, which might also strengthen the credibility of the study (Bradshaw & Stratford, 2010).

2.9 Ethical considerations

Informed consent, confidentiality and anonymity

The majority of the participants of this study were illiterate. The interpreter translated the informed consent sheet to Pokot and read to the informants. The participants were informed about the use of tape recorder, anonymity and their right to withdraw from the study at any point. The informants used their fingerprints or signed to confirm their participation.

15 years is a commonly used age limit for inclusion in studies and research projects. Despite this, we decided to include participants at the age of 13. The aim of the study was to explore the lives of young married girls and the transition from girl to wife. Marriage occurs when girls are around 13 years old in the Pokot culture. It would be challenging to capture their experiences of the transition into marriage in retrospect. The translator and the investigator strived to ensure that the young girls were comfortable in the situation, and emphasized their right to terminate the interview or refuse to answer some of the questions. The interviews in the villages usually took place before or around mid-day, at a time when the husbands were out working.

After each interview the recordings were transcribed into a password secured computer. Backup copy was taken after each interview, and the transcript was electronically uploaded to a safe storage created by UiO. After the transcription the data was deleted from the tape recorder. Any names or personal characteristics, or identification markers of the participants were anonymized by the researcher. The notes from interviews, observations and FGD were typed and saved in a digital format on a password secured computer, and backup copies were uploaded to the safe storage. Although ideally the interviews should be transcribed the same day as the interview took place, due to inconvenience in the field, transcription was carried out in Kampala. The study site had poor access to internet, power and workspace.

Power relations and reflexivity

In a context of poor women, the investigator's position as a privileged and wealthy foreigner may have affected the data collection (Dowling, 2010). It was reflected upon how to approach the informants in a respectful manner. Even Ugandans from different tribes than the ones residing in Karamoja, were labeled as foreigners. Their prior experience with people from Europe and North-America is from World Food Programs projects and other international NGOs, supplying the

inhabitants with food or seeds, whereby many of the NGOs used payment as an incentive to have participants at their meetings.

It is not possible to tell whether the investigator's position has influenced any informants to participate in the study without intending to, or if some of the informants would not attend the interview if there were someone else conducting the study. This taken into consideration, the nature of the data in this study may have been affected. The investigator's outsider position may have served as an advantage, where some informants have perceived it as easier to talk to someone who is detached from the context, or it may have restrained my access to information. Perhaps the fact that the investigator is a young woman, not too far from the informants in age, might have made the informants less skeptical.

The interpreter occasionally gave some advices to the participants in Pokot. Several of the girls asked for advice, though the investigator's ability to give advice concerning their challenges was limited. Some of the participants in the study asked for solutions to their life situations, such as how to leave their husband and how to make their husbands accept the use of contraceptive methods. The lack of solutions may have contributed to the participants gaining less from participating than they expected. The investigator would want to give more back to the informant. According to Staddon (2014) it is common to experience feelings like this during an interview setting. The interpreter had solid knowledge about the practices and services of the NGOs. The investigator shared some information about reproductive health. However, the interpreter and the investigator's knowledge about the health services and their functions was limited at the time being.

Avoid causing harm

It is challenging to assess the consequences informants might face after participating in the study. For studies where the investigator comes from a different cultural setting, it is especially challenging to know. According to Godbole (2014) it is of vital importance to be sensitive to the consequences and participation among vulnerable informants with regard to safety, privacy and emotions (Godbole, 2014).

There may be a risk for the girls to participate in the study, possibly facing punishment from their husbands or families. GBV is a sensitive issue to discuss, it could cause harm in the form of violence from the informants' husbands. Despite this, investigating issues of violence and marital rape in marriage is crucial in order to understand and explore the life child brides live. These issues were carefully approached. In cases where the informants could have been harmed by the study, for

instance trauma, there would be no mental health service in the area to be referred to.

2.10 Limitations of the study

Because the field site changed at the last minute the investigator did not have time to do a literature study on the new site and adjust the proposal to the study context before entering the field. With a more solid background information, other questions might have been asked, and the study would perhaps have gained a deeper understanding of the complex issues around child marriage.

The relatively short time in the field is a limitation for the study. With a longer stay the investigator could have worked on the relations to the informants and perhaps gained thicker data. A longer stay would also contribute to increased observations, and hopefully, understandings of the context. The language barrier also served as a limitation of the study. Observations were merely based on body-language and interpretations. It would have been an advantage if the investigator could understand some of the conversations between the interpreter and the informants, and to understand conversations in the field. It would have been an advantage to know the local language.

It was a challenge for the participants in the study to estimate their own and their husbands' age. This can contribute to inaccuracy of the information, although this is a common issue when conducting research on illiterate participants.

Kerans (2010) claims that a limitation with observation as a method is the language barrier, which might increase the likelihood of misunderstandings. The researcher could also miss out on contextual meaning. For the case of this study, both the language and contextual meaning of what was observed or experienced might serve as bias for the data collected. Few people knew English, the majority used Pokot or Kiswahili. The investigator recognized some words in Kiswahili and Pokot, but the observations were mainly based on body language, interpretations of situations and assumptions based on observations.

3 Findings

This chapter contains the findings of the study. For contextualization of interpretations made, the chapter presents first the demographic characteristics of the respondents. Subsequently, findings are presented followed by key themes developed from the objectives of the study, notably; the process of child marriage; the state of health and well-being among married adolescent girls; the health seeking behavior of married adolescent girls and lastly, approaches to improving health care delivery and health seeking among child brides.

3.1 Demographic characteristics of the respondents

In this chapter, the informants of the study will be presented. Ten key informants participated. Three were working in a locally based organization, one was the research assistant, a TBA, a traditional cutter and 4 health workers. 3 FGDs were conducted, with child brides from two different villages, one semi-urban and one rural village and one with the elders in the rural village. A total of 15 persons participated in the FGDs. Lastly, 13 child brides participated in the in-depth interviews.

Key informants

Throughout the findings these informants will be named as in this table.

1	Interpreter	His profession is interpreting, he was also the interpreter in this study. Works with traditional practices such as FGM and child marriage. He is a Pokot.
2	Traditional Birth Attendant (TBA)	Also called traditional midwife. She is from the rural village 20km from the health center. A Pokot
3	Traditional cutter	Elderly woman performing circumcision, from a village close to the trading center. A Pokot
4	TPO	Local organization working with child marriage and FGM
5	Vision Care	Local organization working with child marriage and FGM
6	ZOA	Local organization working with child marriage and FGM

Table 1: Key informants

Key informants – health workers

These informants will be quoted by their role and work location. The Clinical Officer (CO) at the Health Center 2 will be named CO, HC 2.

1	Midwife at Health Center 3	Pokot, collaborates with ZOA and other NGOs for outreaches and health education. Female
2	Clinical Officer Health Center 3	Not Pokot. Been the clinical officer for One year. Male
3	Clinical Officer Amudat Hospital	Former clinical officer at health center 3. Clinical officer at Amudat Hospital, has her own pharmacy in Amudat. Female, not Pokot.
4	Clinical Officer Health Center 2	Female, Pokot. Working at the health center for 2 years.

Table 2: Key informants health workers

Focus group discussions

Information collected from the FGDs will be presented as FGD, urban/FGD, rural and FGD, elders in the findings.

1	FGD rural village, married adolescent girls	8 participants, inclusion criteria: married before the age of 18 and current age below 25 years. From the same village as the TBA and the FDG with elders. Users of health center 3. The village lies 20km from the Trading center where the health center lies.
2	FGD urban village, married adolescent girls.	7 participants, inclusion criteria: married before the age of 18 and current age below 25 years. Users of the health center 2. This trading center is relatively urban within this setting.
3	FGD rural village, elders	8 Participants of elderly women. They were all defined as “elders” in the village. Users of the health center 3. Same village as the first FGD.

Table 3: Focus group discussion

Informants for the In-depth interviews

The pseudonyms will be used in the findings to attach information to the informant.

Pseudonym	Age; current /when married	Years in School	Married for how long	Marital status	Age of husband	Total number of wives	Number of pregnancies	Number of Children
Chebidi	14/14	4	2 months	M	50-60	3	0	0
Chebiwot	16/14	0	2 years	M	50-60	2	0	0
Chebor	15/-	0	-	M	50-60	-	3	3
Chebuigou	15/10	0	5 years	M	50-60	2	2	1
Chamaio	18/17	8	1 year	M	50-60	4	1	0
Chemenjo	17/13	7	4 years	M	40-50	2	1	1
Chepmurgor	16/13	0	3 years	Left her husband	20-30	1	3	2
Chepmutai	19/?	3	-	M	20-30	1	3	2
Chepchirchir	20/18	6	2 years	M	20-30	1	1	1
Chepohonge	17/16	6	1 year	M	30-40	1	1	1
Chemchumba	18/15	0	2 years	Left her husband	30-40	3	2	2
Chepkeino	14/14	6	1 month	M	15-25	1	0	0
Cherop	13/13	4	1 month	M	30-40	2	0	0

Table 4: Informants for In-depth interviews

3.2 The process of child marriage in Amudat

In this section the beauty ideals of young women and girls will be highlighted, the culture of child marriage and its processes from a general descriptive view, the girls view and the official handling of the practice.

Process of marriage in Pokot culture

The translator and the traditional cutter shared the cultural practices of a Pokot marriage. The following findings were confirmed at the validation meeting.

The young girls were said to be aware of the process of marriage, they expect marriage after circumcision. Marriage in Pokot culture traditionally consists of five steps:

- 1) Test of courage
- 2) FGM
- 3) Bride wealth negotiation and selection of husband
- 4) Kidnap the girl to the marital home
- 5) Break the girl's virginity

The first step of marriage was to undergo tests of courage. This includes tattooing and removal of two teeth in the lower jaw. This was essential for initiation to womanhood through FGM. The midwife said that this evidence of courage, the tattoos and missing teeth, were signs of beauty.

The second stage is FGM. Traditionally in the Pokot culture the girls are circumcised when they start to develop breasts. The most desirable wife is a young virgin girl who has been through circumcision, with her breasts barely developed. These statements were repeated in several key informant interviews, and in informal conversations throughout the fieldwork. Key informants said that a man with a daughter with these qualities, is viewed as a rich man.

Bride wealth negotiation and selection of husband by the parents is the third stage. The TBA explained that traditionally the man is supposed to take the lead in the marriage process. The parents of the girl or the girl herself cannot initiate negotiation of bride wealth. During fieldwork several examples of this practice occurred. In the village close to the Kenyan border, the investigator met a girl who was waiting for someone to ask her to marry, she was 18 years old. The payment in Uganda was said to be three times higher than in Kenya: 30 cows in Uganda and 10 in Kenya. Cherop spent a year at home, waiting for someone to approach her parents and ask for

marriage. She was pulled out of school by her mother with the aim to get married. According to the key informants the first step for the groom-to-be, is to approach the parents of the girl. They discuss and after some days they meet again to agree on the payment and when the payment is due. They celebrate with drinks brought by the groom's family. The girl will be called when the decision is made. The following step is graduation from FGM. The girl goes through a healing process after the cutting and this is marked by a celebration called graduation. After she has been cut and gone through the ceremony of circumcision they can be married at any time. The graduation party is also a way for the parents to signal that their daughter is ready for marriage. When this is the case this will naturally happen as a step before the bride wealth negotiation.

The fifth step is when the husband kidnaps the girl into the marital home. The traditional cutter explained that the girls were usually not informed about the marriage, but they understand when the husband's family or friends come to pick her up. At times this happens by force because some of the girls try to escape. As a cultural practice the family of the bride and the groom sing songs about the young girl, praising her as a virgin with an untouched body. They start singing from the house of the father and continue until they reach the husband's home. The first night the newly-wed are not supposed to sleep together. The traditional cutter said "*they can postpone that kind of love with husband due to respect*" (traditional cutter). The respect mentioned here is directed towards the young girl, who often spends the first night with her mother in law. The sixth step is to break virginity the second night at the marital home. The man will report his first sexual encounter with his wife to the men in the village. They meet around the bonfire to discuss politics and to keep the village safe from wild animals. If the husband fails to penetrate his wife the first night, the mother in law would find a cow horn the size of a penis, smear it with butter and use it to enlarge the wife's vaginal opening.

The marital home is also the home of the other wives of the husband as polygamy is common in Pokot culture. The majority of the girls married into polygamous marriage with one or several co-wives. The exceptions were when the husband was young and just married his first wife, as for Chepkeino, Chepchonge, Chepchirchir, Chepmutai and Chepmurgur. These girls had husbands in their late teens, twenties or early 30s. The common perception that a child bride is married to a man three times her age is challenged by these findings. However, it can be a challenge to be the youngest wife: "*When a man marries a new wife, he tends to abandon the older women and they*

complain about it, giving the young girl a hard time”, (TPO).

Marriage is seen as very important in Pokot culture. The traditional cutter states that *“early marriage in the Pokot culture is very good because the girl is a virgin. But for the girl it’s painful, but there is no option for her, they don’t look at age”* (traditional cutter).

Based on interactions with people in the fieldwork it was stated that Pokot men prefer girls without education. When asking the midwife about this, the statement was confirmed and additional information that Pokot men prefer woman with low education because then they demand less of their husbands was given. It was further stated that even well-educated men also prefer uneducated women. Pokot women are also expected to be strong and hardworking.

An interesting finding in this study was that the norms for FGM seem to be changing. Four of the informants in this study did not go through FGM. Chemenjo, Cherop, Chepchonge and Chepkeinp. Chepchonge is Sabiny, a tribe where campaigns against FGM have lowered its incidence more than in Pokot from a universal level to 50% (UBOS, 2011). Chepkeino’s marriage was hasty. She got married due to an economic crisis in their family and she was not cut because she was supposed to be a school girl. In Cherop’s case, her mother did not want her to go through FGM. For Chemejo’s case, she was also a Sabiny and a Christian. She was working in the communities to prevent FGM with the church. These findings show that efforts for years to end the practice are giving results in the area. The practice has gone underground in Uganda. Key informants said that people traveled to Kenya or up in the mountains to carry out the procedure.

Religion has also played its part in the fight against FGM. The pastor in one village refused to marry girls who went through circumcision, because the bible did not say anything about circumcision for girls. In the first interview with Chemaio she said that she was cut, and in the second one that she was not cut due to her parents religious beliefs. Chepchonge experienced changing attitudes towards FGM throughout the last few years. The community was not aware of her not being cut. In an informal conversation with young girls they said that the bodies of women who were cut smell less than those who were not cut.

These perceptions occurred when the key informants explained why the Pokot decided to circumcise their women. They had two reasons; hygiene and control of female sexuality. The Pokot have been living in areas where water is scarce and women did not access enough water to keep

themselves clean. It was in their belief that a cut woman has a lower need for intimate hygienic maintenance. The second explanation was that the nomadic lifestyle of Pokot men separated them from their wives for up to 6 months. At times when they returned to their villages they found their wives pregnant with other men. There were also reported instances of wives who were accused of having sexual relations with their children. To avoid this, the elders decided to perform circumcision on their women to control their sexuality.

Female circumcision, the waiting of the girl or the girl's family and the initiative of the man, dowry and family negotiation were repeatedly mentioned by the informants as traces of the culture maintaining the dependency of the girl or woman and inability to negotiate her life-time choices. Although the cultural practice of FGM seems to be changing.

Transition from unmarried girl to wife: what is it like to be married?

What did the girls themselves think about the transition from being an unmarried girl to being a wife? What had changed and what did they think about their situation now compared to before they got married? Many of the girls talked about their life before marriage as comfortable and stable, with only a few chore tasks: fetching water and firewood, sweeping the compound and looking after cattle. Some enjoyed going to school and had time to play with their friends. For others, getting out of their primary house was a relief.

Several of the girls mentioned that they had adjusted to the new life and stated that they were now living good lives. They mentioned in particular a relief in terms of financial security. One replied: *"I'm financially stable, healthy and there is no shortage of food"*. Life was perceived as good, defined as a life without food shortage, beating and quarreling. For Chepchumba, Chepohnge and Chepmutai their life improved when settling in their husband's home. Chepchonge said that life is better after marriage. She was an orphan. Chepchonge stated that now life is good, stable and she felt like she was treated well. Chepchumba lost her mother and with a new woman in the home, life was challenging at her father's place. The case for Chepmutai was that her mother ran away and she was left alone with her father who was a «drunkard». *«I felt comfortable about going to stay with my husband»*, (Chepmutai).

Chepmutai and Chepkeino mentioned the freedom of being the woman of the household as an advantage of getting married. Cheokeino appreciated having her own house and being able to

«*decide everything*», with the example that she could choose what food she wanted to prepare. They felt this liberating and an advantage compared to when they stayed at their parents' home where they as girls were usually ordered around. Chebiwot talked about how she as the new woman was received and treated in a very respectful way, now being a woman and not a girl anymore.

Others were saying that they regretted getting married. Chepmutai felt that she was not being fairly treated when she was getting married. She said; «*I don't have any option, so I accepted*». Chebiwot said that if she had known what it was all about she would have wanted something else rather than being married. Cherop, Chebiwot and Chebidi said that they were primarily following orders from their husband. Chebor, comparing it to the life she was living now, said that she did not think about her father's home and her life there because it was too painful. Chepchirchir said she was uncomfortable at her husband's home. «*My husband is a drunkard, but what can I do? He is not quarreling*», Chepchirchir felt threatened by her husband, she was afraid that he would come at midnight to beat or kill her.

Chamaio expressed concerns for her future saying; «*I am the fourth wife, I am still young, is the rest of my life going to continue like this?*». The 13 year old newly wed Cherop stated that; «*I have not yet reached the age of becoming a woman, it was better staying at my father's home*» (Cherop).

The majority of the girls talked about an increase of workload. After marriage, the girls felt a huge responsibility, being the one to answer for everything: if the crops failed, when animals got lost, when there was no food or when the dinner was delayed. In addition, the girls were responsible for clearing the garden and building houses for themselves. “*It was better before*” said Chepchirchir, “*I was only carrying water, some firewood and relaxed*” (Chepchirchir).

From the interviews, it seems like the majority of the girls adjusted and accepted their new situation, even though the majority said that they preferred staying with their parents. The issues of threat, violence, heavy work load, large responsibility and alcohol abuse in the home were frequently mentioned. Alcohol was an issue both referring to the previous and recent homes with the description of the men as “drunkards”.

Child brides perceptions on the process of marriage

The married girls had the same explanation of the process of marriage as the translator, the TBA and the traditional cutter. Not all of the respondents went through FGM, but for those who were cut, they somehow expected to be married away. The bride-to-be was usually not informed or involved

in the decision making process of whether to accept the marriage or not. Seven out of 13 did not know their husband-to-be before marriage, missing reply from two informants. The remaining four could identify the husband by his name, as he was a neighbour or he had approached her for marriage before.

For five out of 13 cases the parents were the ones to decide to marry off their daughters. Two girls replied that the mother was the one that wanted them to get married, one mentioned only the father and another one said the father and the uncle. One named her representative family in Uganda, she was from Kenya. One accepted the marriage herself because she was an orphan. The question was not asked in three of the interviews.

Many of the girls were out working when the party and decision took place. They were not a part of the celebration at their parents' home. After the celebration, they were brought with their new husband back to his home. At times they had to search for the girl if she was out fetching water, firewood or doing other tasks. When they were brought from the bushes, they travelled straight to the husband's home.

The majority we talked to called their marriage a forced marriage, or they told us that they were taken by force the day they got married off. Chamaio had injuries from when she was taken to her husband's home. When trying to escape she was beaten up. Several of the girls said that they wanted to run away when their husband or his friends/family came to pick them, but they were held down too strongly to be able to escape. The girls were either carried, held, pulled, put on a motorcycle or transported in a vehicle. Chepchumba was threatened by her father if she refused to go with her husband. Chephonge said that she was happy about going to her husband's home, she was an orphan. Chebidi and Chepmurgor failed to tell their story about how the marriage happened, they did not give any reason, but it seemed to be too emotionally challenging to recap the situation.

Several NGOs are trying to eliminate cultural practices such as child marriage and FGM in the area. One of them is TPO. Their leader said that: "*Child marriage has been the most common violations happening in the Pokot community. After the girls are forced to marry, they just defend it as culture and accept it, but some don't and run away*" (TPO).

These stories from the girls together with the general description of cultural practices above supports the view of marginalization, violence and trauma of young women and girls under forced marriage in the Pokot tribe.

The State, child Marriage and State Subversion

Throughout the fieldwork we visited a court and several police stations to ask about reported cases of child marriage, frequency and how they were handled.

The police station at the site had no reported cases of child marriage. The child protection officer in the field site seemed to have an issue with alcohol and he was often absent. Although, they had a case reported whereby two wives of a husband had been fighting and one of the wives had injured the other one with a machete. The police view early marriage as a conflict between the families that are involved. Such cases are challenging to solve. At a visit to the court in Nakapiripirit they explained that in the region it is the traditional juridical system that people rely on. The court struggle to get people to come for testimonies. Without testimonies – no trial. They keep the charged person for as long as they can, before they have to release him or her. The birth certificate is needed to prove her age below 18 years. The police often release the accused because the birth certificate is not available. When the persecutor returns to the village, people think he did his time in prison. In their view, there is no need to show up for testimonies, and the case is shelved. Bribery is also an issue, the police is bribed to let the case be solved in the community. In many cases people solve their issues in the village, but in cases of FGM, early marriage and sexual assault of young girls, the girls' rights are not protected. The police may also fear reactions from the community.

Findings from this study show that the police and courts struggle to prosecute the practice of child marriage and that the traditional juridical system is strong. Almost every wife in the area is married as a child. It would be impossible to prosecute all men in the communities. Alcoholism and alcohol abuse were found to be an issue among police officers and the army.

3.3 The health and well-being and perceptions of health

Perceptions on Health and well-being among child brides

The meaning of health and well-being was discussed in the interviews. Health was associated with living a good life: being free and able to do your duties and to earn an income. Examples of the meaning of health was given by many of the married girls:

“It is good to be healthy and that health is when there is no stress” (Cherop).

For Chepkeino health meant enough food and to gain weight. Health was also related to

reproductive and relational abilities, giving birth safely, to have a safe pregnancy and being able to breastfeed. When the health is poor, the girls stated that they would fail to do this. Chebor said that health enabled her to stay together with her husband. According to Chebigut health also affects love. If the husband can see that his wife is healthy; *«he can love you so much»* (Chebigut).

Health was also associated with giving birth safely, to have a safe pregnancy and being able to breastfeed. When the health is poor, the girls stated that they would fail to do this. Additionally “being unhealthy” would mean that you would not be able to gain an income and carry out the daily chores. Forced labour and overwork could make you unhealthy.

Few talked about anything related to mental health or well-being, but Chemenjo said that *«if you have peace in your mind and doing your things, you can promote your health»* (Chemenjo). Feeling well and not feeling well was associated with whether you could manage your home and your daily work.

We had some challenges with questions about *«well-being»* as the term was not known to the informants. There is no word that translate directly to *«health»* in Pokot. Eventually the term *«stress»* came up, the informants were asked what made them stressed, and whether they were stressed in their current situation or not. Quarrels, food shortage and lack of training were perceived as stressful events.

A good health was equivalent with having a good life and as enabling the girls to carry out their daily tasks.

Health issues experienced by Child Brides

Common health issues experienced by child brides were caused by FGM, lack of access to health services, heavy work load, and stress caused by conflict within their polygamous marriage.

FGM proved to be a major cause of sexual and reproductive health complications. FGM can cause challenges during delivery, with the first labour being especially painful. The issue with painful urination was associated with clan inheritance, and had been following them for generations. They did not consider it related to FGM. One participant said that she had this issue even before she got circumcised. One girl said that if you have this condition of “bitter” when urinating in the final stage of pregnancy, it can lead to miscarriage. The health workers said that this was Urinary Tract Infection (UTI), which was very common among the child brides. UTI were caused by FGM and

deliveries, according to the health workers. FGM narrows the vaginal opening, the midwives have to perform episiotomies to deliver the child. *“They tell me that they have painful urination, and when they have sex with the husband it is painful, the thing is squeezed, so even for the man to pass is painful”* (Midwife).

Lack of access to health services increased the complications with pregnancy and labour. The pelvis of the girl might not be fully developed, this can result in an obstructed or prolonged labor. Caesarian section may be the only way to deliver the child. If the girl lives far from health facilities, she is likely to deliver with a TBA, with no possibility to perform a caesarian section.

The girls in this study said that they were expected to continue their heavy work load also when they were pregnant. The midwife confirmed this, and said that she had to convince the husbands to let their wives relax for the baby to survive the pregnancy. The participants in the FGDs said that their heavy workload during pregnancy caused bleedings and pain in the hips, abdomen and back. At times the informants were also disturbed with malaria when they were pregnant.

When interacting with the child brides, the midwife experienced that the girls also have a lot stress with delivery, due to prolonged labour and wounds to heal from the cutting and fatigue. However, stress was mainly associated with relations within the family; husband and other wives. One girl said that *«stress appears when he is harassing me in front of the other wives»* (Chemenjo). Several participants said that when there was a conflict between them and the husband it made them stressed, and also if there were some conflicts between the wives. Cherop and Chepmurgor got stressed when they were quarreling with their husbands. Chamaio said that she was stressed about her husband having another girlfriend because he was not satisfied with her. Even if stress was mostly related to relational issues, it was also referred to in terms of lack of resources, both physical and abstract: Chamaio said she was stressed about not having any education. Chepchumba was stressed because she is a single mother with no income to support her child, she said: *“To feel good about yourself means that there is no stress. Stress appears when there are some shortages of food”* (Chepchumba).

The majority of the issues mentioned were related to sexual and reproductive health, or related to their lifestyle as married adolescents living their lives within polygamous marriage and patriarchal communities.

Importance of fertility

Almost every single informant said that *«it's good to have children»*. The ability to reproduce is very important for a Pokot woman.

Chebiwot had been married for one year and Chamaio for two years, and they had not yet become pregnant, referred to as “failed to reproduce”. Chebiwot was struggling to get pregnant and claimed that you are not a woman or a wife until you have produced a child. *«You cannot refuse to be pregnant when married, it is the responsibility of a woman when married to reproduce»* (Chamaio). Chamaio wanted to leave her husband, she said that she did not view herself as a married woman, which also included that she was not ready to become a mother at this point in time. In the second interview with Chamaio, she claimed that she was praying every day to become pregnant. Chebiwot and Chamaio suffered from the absence of a child by not receiving the same amount of food and goods from their husbands as the producing co-wives. Chamaio claimed that she did not get anything from her husband, stating that *«if I have a child I get things»* (Chamaio).

Chebidi, Chepkeino and Cherop got married during the last three months, they had not conceived yet, as far as they knew, but were trying to become pregnant. They said that they were expecting babies soon and ready to become a mother, one of them being 13 years old, the other two 14 years old. When talking about the dangers of being young and pregnant, Chepkeino said that she did not hear about any risks, but was thinking that perhaps the passage could be too small for the baby to pass. She also said that in the beginning of the marriage she was fearing pregnancy and to deliver, but now she is confident that it will be okay. Cherop said that she was thinking about the risks of being pregnant: that the opening and hips are small and issues can happen. She added that she was afraid of being pregnant and giving birth, but ready to become a mother.

When talking about sex, Chepkeino said that she was having sex and she was enjoying it. Cherop said that in the beginning it was painful because she was small, but now it was getting better and she was starting to enjoy. Cherop and Chepkeino knew about family planning, they learned about it in school. They wanted to become pregnant so they were not interested in family planning.

The married adolescent girls were asked whether they had ever experienced to be forced into having sex. Seven out of 13 said that they had been coerced into having sex, one did not reply and five said that they had never experienced being coerced into having sex. So in other words, coercion varied from couple to couple.

Fertility is seen as vital for a woman in this community and as something necessary to become a respected woman in the community. Although some of the girls were aware of the dangers related to pregnancy and birth in a young age, they were ready to become mothers.

Access and use of contraceptive methods as a health issue

Some of the girls were not aware of contraceptives and some were curious about how to use it and its functionality. Others shared stories about diseases as a side effect of contraception. The majority of the girls interviewed said that their husbands would never accept contraception, and that some of them would be beaten up if the husband discovered that they were using contraception. A girl in one of the FGD said that if she used contraception, her husband's response would be this: *«I brought you here to multiply the generation, so you have now come here and done different things»* (urban, FGD).

Chamaio said that family planning is good because you can resist having many children. Chepmutai said that there is no need for contraceptives because her husband is providing financially and there is enough food. Chepchonge had the same opinions: if her husband becomes a drunkard and fails to earn an income, she would start using contraception. Chepchirchir had been using contraception for the last three months. She chose not to renew the dosage because she wanted to produce another child. She was pleased with the treatment and service she got at the health center. Her husband was not aware of her using contraception.

Family planning was one of the topics in the three FGDs. The girls in the rural village told us that the Pokot does not use family planning because when the man payed dowry, they do not want to limit reproduction. *“Now the child is crawling, and the husband is not giving me time for the child to grow, he wants another one straight away”*. *“When my husband is not waiting and he does not want her to use family planning, what can we do?”* (FGD, rural).

In the urban village they told us that the Pokot men were saying; *“I paid you, now you give birth to more children”*. The girls talked about side effects of contraception, they had heard that women using contraceptive methods were having their periods continuously. The majority of the informants have never received any training or information about the different types of contraception nor the side effects.

The health workers we talked to told us that the Pokot do not want contraception, especially the young girls. The ones who come for contraception are the mothers at 35-40 who were tired of

childbearing. The women usually seek contraception secretly and if the husbands discover the use, this can cause conflicts. Clinical officer at health center 3 told us that the midwife removed implants from two women last month because the husband realized that they were using contraception and chased her back to the health center. *“So the community will not embrace family planning so much, it scares the women”* (midwife). The midwife said that few men accept contraception, reasons for accepting might be that a man has too many children to feed, or the woman faces issues with deliveries. In some cases it is the women who refuses to use contraception. At the health center 2 they have a three month injection available, and staff from Marie Stopes come once a month with other methods. There is a Marie Stopes (MSI) clinic at the health center 3 run by the midwife. At the MSI clinic they had injections for three months and the implant for three years.

Throughout the study misconceptions about contraceptives were shared, the clinical officer at the health center 2 said that if they use contraception it could encourage the girls to become prostitutes. *“When the lady knows that she is protected, she will not get pregnant and will move with every man”* (CO, HC2). Two women in the village were known to behave as mentioned above. The health worker claimed that perhaps 1 out of 10 were using contraceptives below the age of 18.

It is apparent that the importance of fertility limits the girls autonomy in their use of contraceptive methods. Due to bride wealth the men are thought to have power over the female reproductive system.

Access to Social support as a determinat of health and well-being

The communities surrounding the girls gave various support and the support was frequently reported dependent on their behavior or reproductive ability. Within the household both the relationship to the co-wives and the husbands were referred to.

Some of the girls were living peacefully with the co-wives as a big family. For Chepkeino it felt like a big family. Others struggled with the older wives of the husband. Some of the girls were the only wife to their husband, mainly due to the young age of the husband. Chemenjo said that: *“there is a lot of conflict, it is difficult because he is a man of many wives”* (Chemenjo). Chebiwot said that there is conflict between her and the other wives as they are fighting over resources and food. Chebor said that if there is conflict between the wives the husband is there to protect them.

Some girls stated that they had a good relationship with their husbands. One of the girls said that

she could talk to her husband if something was bothering her. Chepchonge, the only wife of her husband, expected to be a part of the decision making process in choosing another wife for her husband. Chepkeino said that she was quarreling with her husband because there were some rumors about her not working and going around with “strange people”.

Several girls told us that they had friends in the village, someone to talk to and a place to seek advice when they were stressed. For one of the participants the case was somewhat different. Chepchirchir told us about her close relationship to the father of her husband. He was supporting her and guarding her from her drunk husband. She felt comfortable when the father of the husband was around.

Six of 13 girls said that they have experienced violence from their husband. Four said that they had never experienced violence from their husbands. One girl said that her husband was threatening to beat her. The reasons given for beatings were; if the food was burnt; or if the food was not ready when it should be; if they failed to do the daily tasks; if the crops failed; if their husbands were alcoholic, and if the wife tried to escape marriage. The girls avoided violence by managing their tasks. They were normally beaten with a stick if they were hit.

Regarding social support a complex pattern including marginalization, loneliness, poverty, violence and alcohol abuse were contrasting relative wealth, secure relations and negotiation power.

Education as a Determinant of health and Wellbeing

Among the participants in this study, five had never gone to school, one dropped out in Senior 2, the rest dropped out from Primary 3 to Primary 7 (check table 4 for details). The main reason given for school drop out was poverty: the family could not afford school, the parents wanted cows in return for them at marriage or the girls had to work at home.

Some schools were visited through the fieldwork period, the schools had few students in general, and especially few girls were enrolled in classes above Primary 3.

Three of the girls who never went to school said that they stayed at home because they were not allowed to go because the fathers wanted cows for them. Two of the respondents said that they did not go to school because they were responsible for looking after the cattle. Cherop dropped out of P4 because her mother wanted her to marry.

For some, economy was the reason for not sending girls to school or for their premature departure.

Chebor did not go to school because the nearby school was expensive; Chepchonge lost her parents and became an orphan and no one could pay her school fee. Chepkeino reached P6, dropped out of school and got married due to a financially unstable family. She said that the reason for her marriage was that when a girl is not in school she is supposed to be married.

Chepmutai had to drop out because her mother disappeared and she had to take the responsibility in their home. Chamaio said that malaria was the reason for her school drop out. She was sick for one year, causing delays in the progress of education.

These findings reflect the low educational level in this area.

3.4 Health seeking behavior and use of health care

The participants in the study were asked about their health seeking behavior. In this chapter findings about what kind of services they are using, elders as decision makers, barriers, behavior of health workers and suggested improvements of health services from the participants in the study will be presented.

Use of traditional medicine and traditional birth attendant

Traditional medicine holds a strong position in the site where this study was conducted.

“When a woman fails to become pregnant the elders prepare a drink of herbs”, the participants of the urban FGD said. Herbs are useful, there are herbs for any kind of treatment. An example they gave was that *“after delivering, you can have shortage of blood in the brain, the mother will be referred to an elderly woman to look for herbs. They usually take herbs first, if they fail, they proceed to the health center”* (FGD, urban)

Experiences with TBA were discussed in the FGD conducted in the rural village. They said that *“The TBA inserts her naked hands, sometimes with long fingernails that can damage their “private parts” The TBA is struggling and if she fails, she will refer to the health center.”* (FGD, rural). The participants of the urban FGD also had negative experiences with the TBA. *“The area has become very small and the TBA becomes tired of waiting and cuts to release space for the baby to come out.”* (FGD, urban). According to the informants the TBA use a dirty knife and no gloves. At times the TBA is drunk and *“can even cut another organ during labour. This results in urine all over”* (FGD, urban).

However, the TBA and elders are considered to have an important role in relation to pregnancy and evil spirits. The elders explained that the TBA smears a slippery fluid on the stomach of a pregnant girl to check if the baby position is right. The adolescent girls in the rural village said that *“when a woman is in her final stages of pregnancy, they believed that they must call an elderly woman to investigate whether the pregnant woman is cursed or not. If she is, they must sacrifice a male goat to exhort the evil spirits from her body”* (FGD, rural).

Herbs and sacrifice are also methods used when children become sick with malaria or when the cause of the illness is unknown. Malaria is cured by a herbal tea. If the treatment fails, the elders explained how to identify the illness: *“First they try herbs, and if it does not work they call an expert elderly lady to identify the issue by following the veins in the body”* (FGD, elders).

The interpreter confirmed this statement and further explained that *“if there is a need for a sacrifice, a definer must order the sacrifice, a male he goat. After sacrificing the goat, they fry the meat and eat it, and the intestines can be smeared on the body of the patient. If the child is still ill, they will bring her to the health center or hospital”*.

Traditional medicine was also discussed in the interview with the traditional cutter. She said that the elderly women would advise the young girls to use herbs because traveling to the health center could be costly and far away. *“But nowadays they have realized how helpful the medicine in the unit can be, so if the condition is critical, the elders will refer you to the unit. If the early marriage girl is seen at the unit, it is serious”* (traditional cutter)

The traditional cutter said that the elderly women were complaining because the VHT were stealing their customers by bringing drugs to the villages for free. For instance if the issue is Malaria, they would try to sell herbs to the patient in the village, and not advise them to seek health care at the clinic.

Young girls have poor experiences with the TBA so they prefer the biomedical health services. Although the elders are fighting to preserve cultural practices like herbal medicine.

Conflict between traditional and biomedical health services.

The clinical officer in Amudat said this about herbal medicine: *“I’m not sure what they do in the village, what those village people give to their children”* (CO, hospital). This statement illustrates the attitude of health workers towards traditional health services.

There seems to be a conflict between the different actors that provide health services, especially to

the young adolescent girls. According to the Midwife, the TBA has a strong position in the villages because they use herbal drugs and have enough time to council their clients. *“I think that because of FGM, most girls prefer the TBA”* (Midwife). The midwife said that the elders spread rumors that the nurse will handle you badly and stitch after they have delivered.

Patients were not allowed to bring herbal medicine in the unit, and the patients fear to tell the health workers what kind of herbal drugs they have been using. The Midwife explained that they do not accept other drugs in the unit because the consequence might be an overdose combining herbs and biomedical medicine. The midwife said; *“If you started with this medical drugs you continue with the drugs and leave traditional drugs in the village”* (Midwife). The elders from the FGD said that they could not tell the health worker about the herbs they had taken, because they fear that they would not get medication at the health clinic if the health worker knew about the herbs - *“You go! You have your own health unit, I can not add for you other drugs and you are still taking others”* (FGD, elders).

The TBA talked about her work: *“I am dealing with those simple cases of delivery. When I find that there is another one having complications, I refer her to the health center. We are doing it secretly in the villages, because we don't have gloves. If the health worker are seeing what we are doing without gloves it can be a different case, so we are assisting these labour pain secretly in the villages”* (TBA).

The challenging part of her job is that some of the circumcised women's vaginas are *“squeezed”*, as the midwife said. The tissue around the opening is stiff, not flexible as it is supposed to be. To enable the delivery, the TBA have to use a knife to widen the birth canal.

She escorts the girl to the unit when issues occur, for instance if the woman is underweight, she will have issues pushing the child. If the hip bones are not developed enough, the TBA would refer the girl to the health center immediately. During labor the TBA consider the energy of the mother, if she is weak or if the baby did not appear in the *“door”*, she would refer to the health center. The TBA told us that *we never learned the skill of stitching, so we do not perform it* (TBA).

At times the women are scared about going into labour, and being stitched after labour. The TBA shared with us their methods in these cases. *“To solve a coward women they call an elderly woman they tie the legs separate, another leg tied somewhere there, another one somewhere there. And the local midwife is at the middle to operate while the mother is tied. Pokot women fear the health unit*

because the health worker must stitch, repair, and the Pokot are cowards, she does not want to be touched again in that area” (TBA).

When the TBA escorts the women to the health center, the health workers are not aware of their position as a TBA. She is appreciated for escorting women in labour. The health workers fear that the TBA are using dirty knives to perform episiotomies, without wearing gloves and fear transmission of HIV.

The TBA wants a closer collaboration with the midwife at the health center, whereby the TBA could receive training and equipment for emergency situations in the villages. *“How can I be identified as a local midwife so that for me to have those clinical equipment; knives, cloths, gloves?” (TBA).*

Currently there is no collaboration between the biomedical health service and the traditional health service. The Pokot in this study use both health systems.

Use and experience of biomedical health services

According to the clinical officer at the hospital and health clinic 2 and 3, the girls sought treatment for malaria, diarrhea, respiratory tract infections, maternity health services and immunization of children. The girls participating in the FGDs were in general satisfied with the health services they received.

The girls in the two FGDs shared some of their experiences with the health center, health worker and VHT. They said that the medicine and immunization were useful. The girls would seek health care when they wanted to take HIV, typhoid or malaria tests. If a pregnant woman bled during pregnancy, they rushed to the health center immediately. The girls would not seek health care for UTIs, but would mention the issue while being at the health center for other reasons. The girls had positive experiences with delivery at the health center, because the health workers would wash them clean, which enabled them to walk shortly after delivery. They also appreciated the clothes they were given during labour. The participants in the FGD appreciate that the health center was able to carry out blood transfusions, fluid replacement and to check the position of the baby in the womb.

The girls emphasized in the in depth interviews and the FGD how important it is for them that the health workers were using gloves when they were examining and assisting them during labour. The majority of the girls seemed pleased with the health center and the health workers. One girl shared with us a different story; *“I came back without treatment, they just told me there is no drugs, go back and relax. She told me that no one was working at this hour, at IPM on a Friday. Sometimes*

these nurses are saying that today we are only doing this, you have to come back another day” (FGD, urban).

The girls would prefer a better supply of medication to the villages. The VHT are supposed to supply the villages with medication to the children. However, the girls said that the VHT were rarely seen in the village because they often had shortages of drugs. They would also want the VHT to expand their services by delivering medication for adults too.

The elders in the FGD said that when the health clinic have stock outages, the patients have to buy medication from the pharmacy. The elders expressed concerns of the practice of immediately referring a girl in labour to hospital when she had gone through FGM.

The girls are satisfied with the services they received at the health center, they appreciate the modern technology, the efficient medication and vaccines. On the other hand the elders expressed misbelief concerning the practices carried out at the biomedical health center.

Health seeking behavior

The key informants had different opinions about whether the child brides or the Pokot were good at seeking health care. By health care, we mean the health center 2, 3 or the hospital.

Observations from the field work disclosed a low number of patients. The health center 3 had four to five patients in their outdoor waiting room every day. On the market day or during the national vaccination campaign for measles, the health units were crowded. The hospital had few patients, at one visit, the hospital had one in-bed patient and at another visit, the investigator observed 7 patients at the clinical officer’s waiting room before lunch.

On one side the clinical officer at the hospital, claimed that the Pokot were very good at seeking health care and changing behaviors, she said; *“We have to appreciate with the Pokots that they are so good in health care seeking, they changed immediately after they get the information (..) if they hear something concerning health, they actually come, they are so positive! (..) there is no hindering, even the husbands are catching up”* (CO, Hospital).

On the other side the Clinical Officer at the health center 2 said that *“the girls tend to come in late, after facing some complications. Usually they have been seeing the TBA, who tell them to push. By the time they come to the health center, the opening is swollen. I would guess that 3 out of 10 come here to deliver when they are in their first pregnancy”* (CO, HC2). She also shared with us their

health seeking behavior; *“When they are sick, they just go to the pharmacies and buy drugs”* (CO, HC 2). This can lead to serious consequences for the girls. The health worker expressed concerns with the practice of going straight to the pharmacy without examining the patient at a professional health care provider. Some girls were unaware of their pregnancy and bought medication at the pharmacy to treat their morning sickness with medication that could cause involuntary miscarriages. The clinical officer said that these girls were following traditional patterns of health seeking behavior. *“When someone became sick, they would buy herbs, now they buy medication at the pharmacy. At times they become very sick and send someone to buy medication for them”* (CO, HC 2). These statements show that they are not particularly good at seeking health care, especially not at the Health clinic.

However, health seeking behavior has improved due to incentives from various programs. The clinical officer at health center 3 said that various incentives from organizations for women who deliver at health centers had improved the health seeking behavior. After some of the programs ended, women continued to seek maternal health services and immunization for their children. There are still some incentives, such as the mama kit and transport refund for maternal health services. The clinical officer estimated that women between 13 and 40 are filling up the unit. *“I would say that 80-90% seek maternity services due to the incentives, before only 10% would come. Thus they are delaying, they often wait until the market day to come, and often they are walking so they come late and they wait until their condition has developed into a severe case. When a woman decides to use a TBA, that's when she comes late to the unit. The women trust the elderly women, that she is an expert in herbal medicine”* (CO, HC3)

The midwife said that incentives had an impact on health seeking behavior. She said that the husbands used to refuse to let their wives seek health care. This had changed after the incentives were introduced. At health center 3 they used to have two or three deliveries per month, now they have 40-60.

According to the interpreter most young girls were using the service of a TBA, unless the condition was critical. He further stated that *“The girls are still under the care of the TBA, they advise the girls to stay with them, it is like a delaying tactic”*(interpreter). The representative from Vision Care said that *“People in Amudat have the kind of behavior that giving birth home is so normal. When you ask them why, they say that our mothers and grandmothers did so, and there is no problem”* (Vision Care).

Findings from the urban FGD described the health seeking behavior. If their child was sick, they would find painkillers, then travel to the unit. If the medical treatment failed, they buy herbs in the village. The participants felt free to choose what kind of health care provider they wish to use. In the rural FGD the participants would use the private clinic if the issue was critical.

The girls use the biomedical health services, pharmacies and traditional medicine. Severity of the condition seems to be an important factor in health seeking behavior whereby some would rush to the pharmacy, others to the health center. Health workers perceptions on the health seeking behavior of the Pokot were contradictory. However, incentives have improved the utilization of maternal health care to a great extent.

3.5 Barriers to health care service utilization

Elders as decision makers, cost, distance, drug stock outages and behavior of health workers were identified as barriers for health care service utilization.

Elders as decision makers in health seeking behavior

The role of elders as decision makers and advisors for the child brides turned out to be important in relation to the girls' health seeking behavior.

In the FGD conducted in the rural village the girls told us that they would first seek advice from an elderly woman in any case. If the condition was serious, the elderly woman would refer her to the health center, otherwise, the elderly woman would find a herbal treatment to the condition. The girls said that while they were waiting for herbs they would use paracetamol.

The elders role were increasingly important in relation to maternal and reproductive health. The participants in the urban FGD said: *“we cannot seek maternal health care from the health center on our own. We have to follow our strong culture. Our grandmothers used to be patient and wait for herbs. If you want to rush to the hospital, you will get some penalties. When you get another labour, they will tell you: you struggle for yourself. If the hospital is not available, who will assist you? If the herbs fail, the next step is to go to the health center“* (FGD, urban).

The elders in the FGD confirmed the behavioral pattern of health seeking. *“We first seek help of the herbs. We have the authority to handle the matter, we are the decision makers”*. The elders appreciated that we talked to them about their role as decision makers, it was important for them. The women in this group were all considered as elders who were the ones to seek advice from. Several of these women were also herbalists. They expressed skepticism towards the biomedical

health services. However, they emphasized that they did advise the girls to also use the biomedical health services, for instance when a girl is pregnant with her first child, they advise her to check the baby's position in the womb at the health center.

The clinical officer at the health center 2 confirmed the role of the elderly women as decision makers and providing herbal medicine to the girls. *"The effect of herbal medicine only last for some days"*. She added that *"They don't trust us, they say that we don't know"* (CO, HC2). The traditional cutter also confirmed the statements above, saying that *"if you see an early marriage girl in the health center, its serious"* (traditional cutter). She further states that if the issue is malaria, the elders would say: *"we have herbs, buy them"*. The traditional cutter said that the elders felt threatened by the VHT, and stated that; *"The elderly women are complaining that we used to treat small babies using herbs, but now the VHT is giving out services, drugs from the unit, so the elderly women are annoyed, they have killed our business"* (traditional cutter).

Elders as decision makers were identified as a barrier to health care utilization for married adolescent girls.

Cost, distance and drug stock out

Cost as a barrier to health care utilization was common among the participants of the study. Payment for the transport to the health center is the largest barrier to health care service utilization. The medication is supposed to be free, but when the health center has a stock outage, the patients have to buy the medication at the pharmacy. An NGO introduced an incentive to improve the use of maternal services with a transport refund. Participants in the study were using this service. However, some of the drivers of the taxis were unaware of the refund and refused to drive the girls for free.

Distance is also a barrier for child brides to utilize health care services. Some of the villages are as far as 20-30 kilometers away, in a mountainous area where the most common way of getting around is to walk. There is no public transportation besides the motorbikes, which are quite costly. The health center does not have any ambulances available, the closest one is at the hospital 60 km from the health center. *"If someone is very sick they cannot manage to come here"* the clinical officer at health center 2 told us. The girls in the rural FGD said *"it's very far to the health unit, and it is a steep hill!"* (FGD, rural).

The participants in the rural FGD said that they would seek health care at the health center if

finances were not available. They would use the pharmacy if finances were available. Finance in itself did not seem to be the main issue. As the clinical officer said: his patients would come for free treatment at the health center and seek health care at a traditional healer where they had to pay for the treatment.

Drug stock outage is also a common barrier to health care utilization. The whole of Karamoja was out of drugs for two months from June to August 2015. One of the reasons given as to why the participants in the rural FGD did not come to the clinic was drug stock outages. The clinical officer at the health center 2 said that *“people had been coming to the clinical officer and said; “why have you gone and sold the drugs?”, and we tell them that the government failed to supply, but they don't understand”* (CO, HC2). According to the midwife sometimes people stop by the clinic to inquire about VHT and drugs, then they go back to the village to report about the conditions and the stock outages.

Distance, cost and drug stock outages were repeatedly mentioned as barriers to health care utilization.

Unfriendly behavior of Health Workers

The behavior of health workers was discussed in the FDG's. The elders were especially critical of the behavior of health workers and their role as barriers in health care utilization.

The girls in the rural FGD had never experienced poor behavior from health workers. They had heard some rumors of poor treatment and corruption, however, they said that this was not common. For the girls in the urban FGD, the behavior of health workers was a big issue for them. They said that when they reached the health center in a critical condition, they were *“bugged aside”*, the health workers would tell them *“you wait, you did not come before, you should have come yesterday!”* (FGD, urban).

The elders confirmed the statement above, and said: *“No help there, its better to go and find an expert elderly woman to get herbs”* (FGD, elders). The translator also had this perception, according to him, people are complaining in the villages, he said that: *“how can a sick person be late?”* (translator). The translator also said that patients are treated differently according to their position in society, whereby the young girls were poorly treated. This perception also came up in the FGD with the elders.

In the interviews with health workers, we discussed the behavior of health workers. The clinical officer at the health center 2 said that some of the health workers could be harsh. The clinical officer at health center 3 said that the health workers were few and overworked. Since the patients came in late, so did the health workers. The health workers work at all hours so they might be out preparing food when the patients arrive at the health clinic. The midwife is the only one who delivers services for antenatal, delivery, immunization, health education, post natal and family planning.

“So you get confused and at the end of the day you are broken, tired, you even become harsh, that’s how it is. It’s a challenge. Maybe they will get you when you are tired, you want to go and eat something, you are not yourself.(...) It depends on the person and the right time, (...) that one that comes late, when you are very tired, she will leave when she is not very satisfied” (Midwife).

Ethnic background was also mentioned as a factor affecting health seeking behavior. The elders said that the young girls fear to deliver at the health center because the doctors would discover that they have gone through circumcision. The traditional cutter confirms this perception and said that the girls also fear being tested for HIV and to be reported to the police for FGM. She added that some girls fear health workers because they would state; *“eh you cut yourself and now you are bringing me your problems, you stay there and struggle with your problems!”* (traditional cutter).

The midwife’s experience with girls who had gone through FGM was that she had to perform episiotomies on them to enable the child to be delivered. Her challenges was that the girls did not want to be repaired after the episiotomies, *“they prefer their birth canal to remain large to the next delivery, but I always insist to repair and stitch the girls”* (Midwife).

The clinical officer at health center 2 confirmed that ethnic background used to affect the child brides health seeking behavior. However, she said that: *“things seems to be changing, before people feared to deliver at the health clinic because of FGM, especially for the first pregnancy. But these days, the patients come. Some are not coming, they ask me “do you know how to deliver someone that has been cut?” I tell them; yes”* (CO, HC2). The girls confirmed the clinical officer’s statement and said; *“we do not fear giving birth at the health clinic due to FGM because some of the health worker are Pokot or Sabine, they understand the culture”* (FGD, urban).

Observations made throughout the field work showed a lack of confidentiality in the health sector, the doors were often open, and people walk in during consultations and in the delivery room. One of the health workers started an interview with the investigator at the same time as she had a woman delivering a baby alone in the delivery room. After a while she returned to her work and the

interview was rescheduled. Another health worker had consultations whereby the whole waiting room could hear what she was saying to the patient. At times the health workers were away on courses, then the health center was left with one employee. One of the health workers had her own private clinic where she sold drugs in the evenings.

The young adolescent girls receive at times a very poor treatment at the health centers, although several of the informants had no complains about the service they receive. The health workers work inconvenient hours and there were few of them, however, the number of patients was not immense.

3.6 Suggested improvements of health service and utilization

The informants in the FGDs and the key informants were asked whether they had any suggestions for improvements of health service and utilization.

Salaries and human resources were a big problem, the clinical officer in Amudat told us.

“In these hard to reach places, we fail to give all the services we should because we are few. You are alone, overworked and you will do the basics and leave the others which you think is less important” (Midwife).

Understaffing was also an issue at health center 3. The clinical officer said that they lack 10 staff members. They are supposed to have thirteenth but they have only three. VHT in the area counts 48 members, with six leaders. Their challenge was that 90% of the members were illiterate, which makes it challenging to write reports of the child and count the drug supply.

According to the clinical officer at health center 3 there was a lack of youth friendly services because of issues with human resources. *“We cannot differentiate or separate them from other patients. The young girls who are married are considered as grown up women”* (CO, HC3).

He further said that it would be very good to have youth friendly services to prevent FGM, child marriage and STIs. Most of the health workers were trained to offer youth friendly services. At the hospital in Amudat the clinical officer told us that they have a youth corner where they discuss early pregnancy, marriage, HIV testing and prevention and how to abstain from sex. Organizations travel to the communities to carry out health education on these topics. We never saw the youth corner at the hospital. The interpreter requested for more health education and sensitization about the importance of maternal health service utilization, vaccination and to check their HIV-status.

Distance was identified as a major barrier to health seeking behavior. The participants in the rural

FGD said *“we want them to build a health center to be closer to the village”* (FGD, rural). The clinical officer also wants to increase the number of health centers in the area and upgrade the health center they have now. The TBA and the girls want the health center to collaborate with the TBA, with supplies of emergency equipment when it is too far to bring the girl to the clinic. The girls want the health center to learn how to cut their nails and use gloves.

Availability of medication came up as an important aspect of improving the health service. The girls in the urban FGD said that they wanted medication available, and medication for adults in the VHT. The elders wanted outreaches from the VHT to supply drugs to the village every week.

Behavior of health workers also came up as a barrier to health care utilization. The girls wished for sufficient health workers who were polite to help their patients. Elders asked for social and helpful health workers. Whereas the clinical officer at health center 3 aims at increasing the number of staff for improved services and reduced waiting time.

The participants in this study identified human resource, youth friendly service, accessibility of health care facility and medication, and friendliness and accessibility of health workers as potential for improvement.

3.7 Summary of the findings

The majority of the informants would define their marriage as a forced marriage. They experienced the transition into marriage as a traumatic rupture from their childhood. However, most of them were able to adapt to the expected role as mothers and wives. The findings describe their perception of health as being able to perform their duties, to live a good life and as absence of disease. Stress was mentioned in relation to well-being whereby the participants had worries about having enough food for their children and about their relations to co-wives and their husband. The most common health issues were malaria, urinary tract infections and reproductive health related issues. The importance of fertility among the Pokot was striking as necessary to become an adult in the community. Hence, they barely use family planning and contraception, mainly due to the men's resistance. The majority of the girls experienced improved food security after marriage. As rations often are based on number of children, their food security increased after the first child was born. The majority of these girls came from poor families. Education level among the participants was low, five of the informants never went to school, one finished primary school.

Traditional medicine proved to be important in these communities. The informants were using both

traditional medicine and biomedical medicine depending on the effect of treatments and what issue they experience. TBAs are important, especially in the villages far from the health center. However, the young girls prefer giving birth at the health center. The most frequent comment about the health center was that it was clean, and that they were washed clean there, and that they could get blood transfusions and fluid replacement there. Child brides' health seeking behavior was largely controlled by the elders in the village, especially in cases related to reproductive and maternal health. The barriers to seeking health care at the clinic are distance and cost of transport to the health center, poor behavior of health workers and the elders' role as decision makers. Lastly, the informants were asked to share their recommendations on how to improve health care utilization and quality of services. The informants requested increased number of health workers, frequent visits from the village health team and for the village health team to also supply the villages with medication for adults, not only for children. The TBA wished for collaboration and supplies from the health clinic that could be used in situations when women in labour failed to reach the health clinic.

4 Discussion

The discussion is divided into two sub-chapters. The first chapter looks at how the health and health seeking behavior of married adolescent girls is related to gender norms, gender roles, autonomy, the complexity of marriage, polygamy, fertility and conceptions of well-being.

4.1 Norms, gender roles and autonomy.

As mentioned in the theoretical framework, norms are meant to guide members of a group to control or regulate acceptable behavior. Norms are defined as ideals or standards of a behavior shared by a social group (Wight, 2006), or as Bicchieri states; as the grammar of social interaction (Bicchieri, 2006). These rules will not be perceived as entirely prescriptive but as a resource to legitimate behavior (Wight et al., 2006). If a member of the social group violates the norm, social disapproval and sanctions follow (Horne, Dodoo & Dodoo, 2013). Some norms are feminine and some are masculine. Autonomy is defined as being self-governed (Bicchieri, 2006).

Marriage

In this study the aim was to understand how child marriage affects young girls among the Pokot tribe in Amudat. The autonomy of the informants in this study was, as expected, constrained. Horne, Dodoo and Dodoo, (2013) claim that it is particularly important to understand the factors that are constraining the autonomy of married women to learn more about their situation, and to guide policies and programs that aim at supporting married women. Similarly, Bicchieri et al (2014) claims that it is important to examine the role of child marriage within a social norm framework in order to impose a behavioral change. In this chapter we seek to understand how these factors affect the married girl's life.

Among the Pokot, girls are married off early with the benefit of the household: to lower the household expenses and to gain bride wealth. Findings from this study and Conant's study (1974) confirm that Pokot women are often forced into marriage and they are rarely a part of the decision-making process. The household has traditionally been viewed as a unit making decisions for the benefit of all parts in the household. Although the benefit of married adolescent girls are more often not considered. Evidence shows that factors such as gender, age and social power affect an individuals ability to access key resources (Haddad, Hoddinott & Alderman, 1997). The autonomy of young girls in this community are in many ways sacrificed to gain wealth for the family.

Informants in this study were forced to marry and described their marriage as a dramatic change from their safe and predictable life at their father's home. However, their ultimate goal in life was to become a mother and a wife. The feeling of quandary was common among the informants: they wished to fill their roles as women while at the same time several of the participants wished that they could be children again, living back at their parents' home. However, after some time at their husband's home most of them adopted to their new role as wives and, for most of them, mothers. The norms proved to be much stronger than their personal autonomy.

Similar to the findings among the Pokot, Callaghan et al (2015) found that informants in her study experienced marriage as a traumatic rupture from childhood. Producing children was seen as inevitable, and something necessary for them to become happy (Callaghan et al., 2015)(Callagan et al, 2015). The informants in Callagan's study described marriage as repetitive domestic labour and respect and obedience of the husband (Callagan et al, 2015). Some of our informants similarly felt that they were merely following orders. The girls were stressed by the increase of workload and responsibility that followed their role as wives. However, the majority of the girls said that they were living good lives. This shows how strong the social norms are and how norms and expectations guide behavior and roles for women in these communities. When child brides violate norms and expectations, their husbands respond with sanctions: in most cases violence. Six informants experienced violence from their husbands. They were usually punished for not being able to manage their responsibilities. Some of the girls lived with alcoholic husbands, whereby they claimed this to be the reason for the violence. As noted above, it is common for wives to be coerced into sexual activities, this was also the reality for seven of the participants in this study.

Since most of these girls were following the norm, they experienced a new status in the community after marriage and especially after becoming mothers. They were finally treated with respect and considered as adults. The married adolescent girls enjoyed the freedom of being the woman of the household, deciding what to cook for dinner and how to organize the day. For the majority of the girls food security increased after marriage and they lived economically stable lives with enough food and animals. Most of the girls had a less fortunate situation at their parents' home, and for some their marriage caused significant improvement in living conditions.

In a community like the Pokot with a strong norm of marriage, one could assume that divorce was also a way of violating the norm of marriage by ending a marriage. Findings from this study show that divorce was found to be quite common among the Pokot, whereby remarriage turns out to be socially acceptable for Pokot women. Two of the informants had left their husbands and their hopes for the future was to find a good husband. Findings (Gage-Bardon, 1992) show that the proportion of unmarried women is low in polygamous societies because girls remarry quickly.

Polygamy and well-being

The informants in this study were all the youngest wife of their husband. Some of them described their relationship to their co-wives as if they were a big family living together. Others accused the first wife of taking advantage of her position as a distributor of resources. Husbands either delegated the responsibility to the first wife or divided the resources between the wives, sometimes according to number of children. It was evident in this study that the child brides struggling to reproduce had higher levels of conflict both between husband and wife, and in relation to co-wives. As also observed by Bove and Valeggia (2009), within polygamous marriage, a woman's ability to negotiate with the husband and collaborate with co-wives on the arenas of domestic responsibilities and reproduction, was seen as crucial to her own and her children's well-being (Bove & Valeggia, 2009). Jankowiak et al. (2005) outlines the woman's age rank, husbands behavior, local cultural factors and individual resources as determinants for competition and conflict between the co-wives (Jankowiak et al., 2005). Bledsoe (1993) states that the competition between wives increases when the women, to a greater extent, rely on their husband for access to resources or emotional fulfillment. This brings us to the next paragraph, fertility.

Fertility and contraception

As frequently mentioned, being a female adult means being a wife and a mother. The childless wives desired the respect and role in the community given to a mother and an adult woman. They also received less resources and goods compared to their fertile co-wives.

Infertility in Sub-Saharan Africa is a life-altering problem, regardless of country or community (Hollo et al, 2009). The importance of reproduction and as a part of becoming an adult can cause high levels of psychological distress, particularly for infertile women (Dyer et al, 2005). In many communities having children is an adult gender identification (Dyer, 2007) and this is also the case for the informants in this study. According to Bove and Valeggia (2009) fertility is an important

element of women's health and well-being in polygamous marriage, whereby coping with infertility appears to be more difficult for women living in polygamous marriage (Aghana, Dare & Ogunniyi, 1999). Similarly, findings from Dokor and Sandall (2007) found that higher rates of infertility-related stress were associated with polygamy. Two out of 13 participants struggled with infertility. They experienced high levels of stress and suffered from a low status in the community. Their relationships with their husbands were complicated and they received little emotional nor material support from their husbands. The two participants in the study who had failed to give their husband a child, feared that he would leave them. The rejection these girls feel, is most likely caused by a perceived violation of social norms. Evidence from literature and this study shows that there is a strong socio-cultural norm among the Pokot that prescribes childbearing.

Similar findings occurred in Jankowia et al's (2005) study. They found that married women fear that their husbands would leave them due to infertility. This would lead to losing their economic and social safety net in the community. Infertility can lead to stigmatization and exclusion (Gerritz, 1997; Sundby, 1997; Dyer et al., 2002) and childless marriage tend to result in extramarital affairs and divorce (Gerritz et al, 1999; Dyer et al, 2002,2004; Inhorn, 2003).

Evidence from the study shows that the husband gains control of his wife's reproduction when the bride wealth is paid. By paying bride wealth to the family of the girl, the husband compensates for the reproductive and domestic services of the woman. Consequently, if the wife tries to take autonomous action, she will experience social disapproval (Horne, Dodoo, & Dodoo, 2013). If a child bride decide to use contraception, this is seen as a violation of social norms. With this in mind, few participants were interested in using or talking about contraception. Some viewed it as something to use in case of an emergency, for example if the husband started to drink or he failed to gain income. The majority of the informants said that their husband would not allow them to use contraceptive methods. In the health centre the midwife had removed several implants because the husbands discovered them. According to the midwife, users of contraceptive methods were often women aged 35 and above who were tired of continuous pregnancies and deliveries.

Complexity of child marriage

Child brides are commonly constructed as voiceless victims of a harmful practice by the programs and projects that aim at eliminating child marriage. Achambault (2011) claims that they have a tendency to decontextualize child marriage and merely view it as a human rights issue. By victimizing and excluding child brides from the program design and implementation process, the

programs neglect the cultural, social and economic context these girls live within (Achaumbault, 2011), and the program may miss its target. In this study the aim was to understand the norms of the community and the causes and consequences behind child marriage.

According to the findings in this study, child marriage in this Pokot community is a social norm. Not only is the practice of child marriage widely spread in the community, there is also a common perception that child marriage is good for the Pokot. Marriage was mentioned as good by several of the key informants and married adolescent girls in the study. The ideal marriageable woman is a girl with the first signs of puberty and a father with a girl with these qualities is viewed as a wealthy man. Marriage among the Pokot is practically the same as child marriage, as almost every single woman in the communities is married before the age of 18. In a society where marriage and motherhood is the only way to enter into the adult world, child marriage is seen as a legitimate behavior and a natural part of growing up.

The social norms of child marriage and motherhood are far more important in guiding behavior in the community than the risks of maternal mortality and the complications that come with adolescent pregnancies. Dilger (2003) had similar findings in his study in Tanzania whereby norms for restricting sexual behavior had far greater importance than the threat of HIV infections (Dilger, 2003).

The findings in this study repeatedly illustrate that child marriage is a complex issue which is driven by socioeconomic factors and social norms. In their context, the participants in this study had few opportunities other than marriage. Violating the strong norm of marriage would cause sanctions from the community. Tradition seemed to be an important value to the participants in the study, which contributes to maintaining the social norm of marriage. The high bride price contributes to a significant wealth increase for the girl's family. The wealth is often used to secure marriage for her brothers. The Pokot girl, is, in other words, an important part of the economy. To understand why child marriage persists, it is important to draw attention to the benefits of marriage for the girl. Most of the informants in this study experienced respect, a higher status in the community and participation in politics. Further married adolescent girls experienced an increase in welfare and overall improved economic situation. Some of them were also appreciating the freedom of organizing their days and living in their own houses.

Factors influencing child marriage that were found in this study were poverty, strong gender norms, social norm of child marriage, poor educational opportunities, children as workforce, marriage as a source of income for the family and the traditional society the participants in this study live within.

4.2 Health and health seeking behavior

In this sub-chapter perception of health and illness among the participants and the health beliefs of the participants will be discussed while applying the conceptual framework of the health belief model.

Perceptions of health and illness

Findings from this study showed that the participants in this study had a holistic perception of health. They associated health with having a good life. Health included being able to fulfill their chores and task. Health was seen as enabling for the girl to be a mother. Health enabled them to look after their children, breastfeed and to earn an income. If a woman managed to go through pregnancy and labour without complications and to gain weight, she was considered to be healthy. Being unhealthy was associated with illness and disease, and to be unable to carry out the daily chores. Health is something that involved the community, as with many other aspects of human life in pluralistic societies like the Pokot. The recognized definition of health by WHO is «Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity» (WHO, 1948), which is also a holistic approach to health. Findings show that the Pokot's way of viewing health is similar to the recognized WHO definition. Several other studies from East Africa have found that the concept of health is translated into the local language of good life (Katahoire, 1998; Whyte, 1997). In Meintert's (2004) study from east Uganda, health was defined as a "good life", and as something people aimed at achieving. Meintert (2004,P.23) states; in a context like Uganda, most health care practices happen in their everyday life, and are performed by lay persons with an aim to achieve a good life. Meintert (2004) also found that in situations of illness, maintaining the social network turned out to have such importance because people need each other in cases of illness, especially people who live in rural areas.

Traditional medicine and biomedical health care

Findings from this study show that traditional medicine has a strong position in Pokot culture.

Traditional health services have a holistic perspective, whereby not only the physical health is addressed, but also the spiritual and social aspects of the individual (Sawers, 2016). The health centers and hospital in this study challenged cultural beliefs about health and illness. It is a difficult balancing act to impose ideas about western medicine when you risk undermining the practices of the respected elders (Sawers, 2016). The elders felt that their traditional and cultural heritage was threatened by the new medical practices by the biomedical health providers. This caused a mistrust between the elders and the health providers.

Some of these practices challenged their own ways in which illness and diseases have been treated for decades and this had economical implications for the herbalists. Their businesses were competing with the village health team and the health clinic. The elders and non-medical key informants shared rumors and stories where health workers were portrayed as the “bad guys”.

The midwife, clinical officers and nurses all condemned the use of herbal medicine, especially in the ward. Integration of TBAs in the joint effort to reduce maternal mortality has been promoted by WHO. However, a shift occurred and Uganda ended this project after advice from Safe Motherhood and WHO where TBAs were not allowed to be involved in deliveries (Turinawe et al., 2016). Findings from another study in northern Uganda show this shift as health administrators have denied TBAs in the facilities (Rudrum, 2016). Findings from this study showed that the TBA feared communicating her role to the midwife, and wished for training and equipment in the village. Rudrum (2016) claims that this rejection from the biomedical health services is violating women’s right to choice, autonomy and control while seeking maternal health care. This attitude may, in practice, reduce women’s access to safe care because women will continue to use TBAs out of wish and necessity until universal health coverage reaches rural parts of the world (Rudrum, 2016). TBAs are still an important source of health care in Uganda, especially in rural areas. It is estimated that 47-52% deliver with a TBA in Uganda today (Turinawe et al., 2016).

Evidence from Abubakar’s (2013) study showed that the strong role of elders as decision-makers and advisors may contribute to that people who do not believe in herbal medicine still use it to show respect to the elders in the community. These findings were also apparent in (Turinawe et al., 2016) and in this study. Girls preferred the health center, but they feared sanctions and listened to their elders. A possible advantage of a collaboration between biomedical midwives and TBAs is that it

might increase the number of deliveries with skilled birth attendant and build trust between the elders in the community and the health center. This is something the TBAs wish for.

4.3 Health Belief Model

The HBM will be used to analyze the findings in this study.

The concepts of the HBM was presented in the theoretical framework, they consist of these six concepts: perceived susceptibility, perceived seriousness, perceived benefit of action, barriers to taking action and lastly, added by Janz and Becker (1984), self-efficacy.

The concept of perceived susceptibility in the Health Belief Model helps us to understand how the study informants react to different kinds of conditions. The child brides mentioned malaria/fever, bleeding when pregnant, pain in their womb/abdomen, urinary tract infection and obstructed labour as common health issues. The child brides perceived immunization as important, efficient and vital for their children to be healthy. The majority of the mothers would bring their children for vaccination. Although these conditions were perceived as likely to contract, the perceived seriousness of the issue varies from condition to condition. Bleedings during pregnancy were perceived as a serious condition for which the child bride would rush to the health clinic immediately. If their children were sick with fever, their first action would be to discuss with an elderly woman. If the elderly woman considered the child to be in need of treatment from the health center, they would go to the health center.

Urinary tract infection seemed to be a constant problem for the participants in this study. The married adolescent girls claimed that their urinary tract infections were not caused by FGM or other issues, but by clan inheritance. This was also evident in the study of Vermandere et al's (2016). They further discovered that perceived susceptibility is often low in African countries. This may be attributed to a perception of illness and disease being inherited (Vermandere et al., 2016). The girls believe that they are highly likely to have urinary tract infection, thus their perceptions on the condition as being inherited affect their health seeking behavior. The participants in this study would not seek health care merely for a urinary tract infection, but they believed that the treatment was efficient and would request treatment while being at the health center for other reasons.

According to the HBM, after the individual has perceived that the likelihood of having a condition is fairly high and has also perceived the condition as serious enough to act upon, step 3 is to decide

whether to act upon the condition or not. What kind of health service they sought appears to vary in relation to what kind of issues the patient was facing and who the patient were. Findings from this study showed that the married adolescent girls were using both traditional medicine and biomedical medicine, depending on what kind of health issue they or their children experienced. The majority of the married adolescent girls would seek advice from an elderly woman or a traditional herbalist on how to respond to most conditions. While they were waiting for a diagnosis from the elders, the girls would look for painkillers. The girls would follow the advice from the elderly woman. Some of the participants in the urban FGD felt free to seek health care on their own, without guidance from elders, while participants from the rural FGD were not free to seek health care on their own. In cases of maternal health, pregnancy and delivery all informants said that they would follow the advice from the elders. The adolescent girls feared, and expected sanctions if they went straight to the health center thus indicating the lack of self-efficacy of adolescent girls in reproductive and maternal health seeking behavior.

These findings are similar to Abubakar et al's study on the socio cultural determinants of health-seeking behavior in Kenya. Abubakar found that most participants started with self medication or painkillers before traveling to the hospital. The participants went for traditional medicine or western medical treatment. For natural causes, such as fever or malaria they went to the medical doctors, but for other conditions, particularly those related to mental health they would seek the traditional healers (Abubakar et al., 2013). The participants in this study were using both traditional medicine and biomedical medicine, depending on what kind of health issue they or their children experienced. However, the role of the elders as decision makers was not mentioned in this study.

Among the Pokot, child brides would, in most cases, seek health advice from the elders of the village. The importance of maintaining the social networks occurred as a topic in this study when discussing the use of a TBA or the midwife at the health clinic. The girls said that they chose to seek assistance from the TBA in the village because, "who will help you the next time when you need help, and you are too far from the health clinic?". The majority of the informants would prefer to use the health center for delivery. However, the majority maintained the social network in the community by using TBAs.

The majority of the child brides would seek an elderly woman or a traditional herbalist for advice on how to respond to most conditions. Several of the interviewees said that normally they would

look for painkillers, while waiting for the response from the elderly woman. Depending on the condition and seriousness, the elderly woman would tell the girl how to act, and she would follow the advice given. Some of the informants felt free to seek biomedical health care on their own, others did not. Maternal health, pregnancy and delivery seemed to be the elders domain, whereby the informants in this study perceived it as important to seek advice from elders. As noted above, the child brides feared sanctions if they went straight to the health center. This indicates that the child brides themselves do not have self-efficacy in cases of reproductive health, for other conditions, this may vary.

When a person with a condition has decided to treat it there may be some barriers to the use of services. The main barriers mentioned in this study were cost of transport, medication stock outages, distance, elders as decision-makers and behavior of health workers. For some married adolescent girls, the elderly women in the villages might be a barrier to seeking health care from the health center. Cost of treatment was usually not the problem in Abubakar et al's (2013) study. This was evident also among the Pokot. They would seek health with traditional healers or buy medication that they could have gotten for free at the public health center. The clinician officer at the health center 3 said that the Pokot would come to him for free treatment, but would complement it with traditional medicine they had to pay for. Abukakar et al had the same finding in his study, and further explains that it was not merely about the money, but also the etiology of the disease. They would go to the hospital if it was for free, but not if they had to pay because they were not certain that the treatment would work (Abubakar et al., 2013).

The Pokot followed traditional paths of health seeking, as mentioned by Tinuande et al (2010). Findings show that a common way of seeking health care is to find an herbalist or a pharmacy to buy medication without consulting the doctor or other health personnel because few drugs demand prescription compared to other parts of the world (Tinuande et. al, 2010). The traditional way of seeking health among the Pokot was to identify the problem and pay for the treatment. The Pokot do have faith in biomedicine, but the behaviors of health workers, the role of elders as decision-makers and the traditional way of seeking health all serve as barriers to their health seeking behavior.

The HBM has been criticized for being based on an American or Western individualistic way of life.

It is difficult to design appropriate tests and to compare results. Other factors may heavily influence health behavior practices, such as special influences, cultural factors, socioeconomic factors and previous experience (Janz & Becker, 1984). In this study the limitation of the HBM is illustrated by the findings that in most cases, it is not the individual with the condition that determines whether to seek health care or not and what kind of services to seek. In pluralistic societies like the Pokot, there are many considerations to take into account. The child brides are at a low rank in the social system and most of them do not have the power to make their own decisions without facing social sanctions from their communities.

In the literature, the HBM has been used to analyze health seeking behavior in relation to one condition or disease, while in this study the aim was to look at health seeking behavior in relation to several conditions. Improved utilization of health care services could improve the maternal and reproductive health of married adolescent girls as they would be able to seek health care earlier, particularly in the process of labour. Seeking health care merely for UTI would increase their life quality, decrease pain and limit UTI related complications in times of pregnancy and labour. Findings from this study show that the major barrier to health care utilization, especially in cases of maternal and reproductive health, is the role of the elders as decision-makers. In relation to contraceptive methods, the barrier is men and the strong norm of fertility and this must be addressed in a different manner than other reproductive health matters. None of the informants mentioned the men's role in relation to health care utilization. Distance was also shown to be a huge barrier to health care utilization, however, there are incentives in the areas that offers refunds for transport to maternal health services. If the married adolescent girls reclaim their autonomy in health care utilization, perhaps distance would not have been such a great barrier to them.

4.4 Limitations of the study

The limitations to this study were limited time in the field and a limited selection of informants. Language barriers were also a limitation throughout the fieldwork. Further informants might have said what they thought the investigator wanted to hear and informants may have chosen to keep some information for themselves.

5 Conclusion with recommendations from the informants

The object of this thesis was to understand the process of child marriage and to examine health and wellbeing among married adolescent girls as well as their access to health care in the Pokot community of North-Eastern Uganda. The thesis shows in a detailed manner the processes of marriage among the Pokot in Amudat, the general perception of marriage and how the married adolescent girls experience the transition from girl to wife. Unless the features of marital culture are understood, behavioral change interventions are unlikely to succeed.

The health and well-being of the child brides was examined, although some challenges occurred whereby health and well-being were unknown concepts, and had no local translation. However, a “good life” was commonly used and had approximately the same meaning as health. Well-being relied primarily on the married adolescent girls’ relationship with their co-wives and husbands, food security and their ability to reproduce.

Another aim of the thesis was to explore the health seeking behavior of the married adolescent girls; the findings were discussed within the framework of the HBM. The findings show that traditional medicine is important in the community, especially for the elders. There seems to be a challenge for the biomedical health services and traditional or herbal health services to be complementary.

Lastly the recommendations from the participants in the study were that there is a need for health centers closer to the villages, with friendly health workers and with an increase in health worker staff. The young girls wished for an active VHT with medication also for adults. The TBA wished for a collaboration with the health center.

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7 Appendix

7.1 Interview guide

Interview guide married adolescent girls

Demography

How old are you?

Are you married? When did you marry? Did you live with your boyfriend/husband before you got married? Did you choose your husband or did your parents choose for you? Did you know him before you married him?

Have you ever been pregnant?

Do you have any children?

How old were you when getting married?

How old is your husband? 15-24, 25-34, 35-44, 45-54, 55-64, 65-74, 75-84

Does your husband have other wives than you? if yes, how many?

Education

Did you ever attend school? If yes, for how many years?

Are you still in school?

If not: Why are you not going to school? tell me about what happened when you stopped going to school

Well-being

What does being healthy/have a good health mean to you?

Probe: Do you feel healthy? If yes/no: can you tell me some more about that?

What does it mean to you to feel well, to feel good about yourself?

Probe: Do you feel well, can you tell me more about being well (or not well)

Marriage:

So, tell me about the time you got married. How did that happen?

Probe: Whose decision was it?

Did you know your spouse before getting married?

Tell me how your life was before you got married?

(Probe: What has changed in your life after you got married? is it a good or a bad change? explain why)

Tell me about your life living with your husband (and his family)

Probe: do they treat you well?

Have you ever been treated poorly?

Have you ever experience violence in your home?

Have you ever been coerced into having sex?

What do you think about having babies?

(Probe:So, who makes the decision of having babies?)

Have you used contraception/family planning?

(Probe: Explain more about this, Who decided it? when, where, efficacy)

Is there something you would like to add?

Interview guide NGOs/health workers/FGD elders

1. What is the state of health and well-being for girl children in marriage?

Probe: why?

2. Tell us about your experiences with health seeking behavior of girl children in marriage

Probe: where, why

3. What kind of services do they seek from these service providers respectively

Probe: family planning, reproductive health; antenatal care, vaccination/feeding for the child, malaria, stress, etc

4. What barriers to health care seeking in these facilities do they experience?

Probe: cost, distance to health care, time, husband/husbands family deciding whether to seek health care or not, health worker behavior, corruption, drug stock out

5. What gaps do you see in health care delivery for girl children in marriage in health care facilities?

6. What has been done to address these gaps?

7. What can be done to improve the quality of health care services you provide in this facility?

Probe: for what needs to be done to improve access and health care delivery

Is there something you would like to add?

Interview guide FGD with married adolescent girls

1. Tell us about your experiences with health care

Probe: where, why

2. What kind of services do you seek there (probe for each category of service provider)?

Probe: family planning, reproductive health; antenatal care, vaccination/feeding for the child, malaria, stress, why?

3. What are your barriers to health care seeking in health care facilities?

(Probe: cost, distance to health care, time, husband/husbands family deciding whether to seek health care or not, health worker behavior, corruption, drug stock out)

4. The last time you went to a health care facility, were satisfied with the service provided?

(probe:why? What about your earlier visit experiences?)

4. What can be done to improve the quality of health care services you receive in health care facilities? (Probe: for what needs to be done to improve access and health seeking behavior)

Is there something you would like to add?

If not, thank the respondent and close the discussion

Interview guide key informants

1. What is the process of girl child marriages in this area? (probe for prevalence, incidence, nature i.e. harmful or beneficial? etc)
2. How does it affect the wellbeing of a child in marriage?
3. Tell us about the health seeking behavior of girl children in marriage
Probe: where, why
4. What kind of services do they seek from these service providers respectively (probe for each category of service provider)?
Probe: family planning, reproductive health; antenatal care, vaccination/feeding for the child, malaria, stress, etc
5. What barriers to health care seeking in these facilities do they experience?
(Probe: cost, distance to health care, time, husband/husbands family deciding whether to seek health care or not, health worker behavior, corruption, drug stock out)
6. What gaps do you see in health care delivery for girl children in marriage in health care facilities?
7. What has been done to address these gaps?
8. What can be done to improve the quality of health care services you provide in this facility?
(Probe: for what needs to be done to improve access and health care delivery)

Is there something you would like to add?

7.2 Information letter

Informed consent form for young married girls in Amudat district

This informed consent form is for young married/in a union girls in Amudat district who are invited to participate in research on well-being and health care among young married girls in Amudat district.

Information Sheet

My name is Inga, I am a student at the University of Oslo. I am doing research on girls who marry early and their well-being and use of health care. I am going to give you information and invite you to be a part of this research. This consent form may contain words that you do not understand. Please ask me to stop as we go through the information and I will take time to explain. If you have questions later, you can ask them of me or of my interpreter/research assistant.

This research will involve your participation in an interview that will take about one hour. You are being invited to take part in this research because we feel that your experience as a married/in a union woman can contribute much to our understanding and knowledge of how early marriage can affect a girls life. Your participation in this research is entirely voluntary. It is your choice whether to participate or not. We will be asking you to share from your life story, questions that might be hard to answer. If you do not wish to answer any of the questions during the interview, you may say so and the interviewer will move on to the next question. No one else than the interviewer and an interpreter will be present unless you would like someone else to be there. The information recorded is confidential. The entire interview will be tape-recorded, but no one will be identified by name on the tape. The tape will be stored in a locked room, transferred to a computer and deleted after 3 weeks. The research takes place over 2 months in total.

There will be no direct benefit to you, but your participation is likely to help to learn more about young married girls lives. The knowledge that we get from this research will be shared with you in a meeting before it is widely available for the public. Following the meeting, we will publish the results so that other interested people may learn from the research.

If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact Inga Haaland/ingahaaland@gmail.com/0752540520 or Joseph 0783083331

This proposal has been reviewed and approved by Higher Degrees Committee in the School of Social sciences at Makerere University, which is a committee whose task it is to make sure that research participants are protected from harm. If you wish to find about more about the IRB, contact Chris Opesen, department of sociology and anthropology, +256 414540650. Do you have any questions?

Certificate of Consent

I have been invited to participate in research about early marriages and health care.

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Print Name of Participant _____

Signature of Participant _____

Date _____

Day/month/year

If illiterate

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness _____

Thumb print of participant

Signature of witness _____

Date _____

Day/month/year

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands what will be done.

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

Thumb print by participant:

Signature of Researcher /person taking the consent _____

Date _____

Day/month/year

7.3 Ethical approval

MAKERERE

P.O. Box 7062, Kampala, Uganda
Email: sociology@ss.mak.ac.ug
Website: www.mak.ac.ug



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Phone: +256-414-540650
Fax: +256-414-533396
Cables: "MAKUNIKA" Kampala

DEPARTMENT OF SOCIOLOGY AND ANTHROPOLOGY

05th August 2015

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

Re: Fieldwork for Miss Inga Haaland

Miss Inga Haaland is a graduate student of International Community Health in Oslo University, Norway. Her protocol on the theme: *"Health, well-being and barriers to health care among child brides: A case study of Amudat district in Uganda"* has satisfied conditions for fieldwork both in her mother University in Oslo and Makerere in Kampala (partner University) where it underwent an institutional review by the Higher Degrees Committee in the School of Social Sciences for ethical and technical issues.

As her country based supervisor in Makerere University therefore, I am glad to introduce Inga as my fieldwork student. Please accord her every support she may need while conducting her fieldwork in the community and with selected health workers without any reservations.

Thank you,

Chris C. Opesen

Co-Supervisor

Department of Sociology and Anthropology

Email: chrisopesen@chuss.mak.ac.ug

+256-783490 415/753680 777

CHIEF ADMINISTRATIVE OFFICER
21 SEP 2015
AMUDAT DISTRICT
Noted Dr. receive
& guide
J.M. CTO

Noted the student will be attached to
Blank Hest and the Yc Kavika is asked
to help her.



PRESIDENT'S OFFICE
DISTRICT INTERNAL SECURITY OFFICER
22 SEP 2015
AMUDAT DISTRICT

DIRECTOR HEALTH SERVICES
AMUDAT DISTRICT
LOCAL GOVERNMENT
Date: 21/09/2015

Forwarded to Giso
for further assistance.
JSTB OUELLO Jonathan
0776586465



Johanne Sundby
Institutt for helse og samfunn Universitetet i Oslo
Postboks 1130 Blindern
0318 OSLO

Vår dato: 26.06.2015

Vår ref: 43695 / 3 / MHM

Deres dato:

Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 08.06.2015. All nødvendig informasjon om prosjektet forelå i sin helhet 25.06.2015. Meldingen gjelder prosjektet:

43695	<i>Child marriages, well-being and health services in rural east Uganda. A qualitative study.</i>
Behandlingsansvarlig	Universitetet i Oslo, ved institusjonens øverste leder
Daglig ansvarlig	Johanne Sundby
Student	Inga Haaland

Etter gjennomgang av opplysninger gitt i meldeskjemaet og øvrig dokumentasjon, finner vi at prosjektet ikke medfører meldeplikt eller konsesjonsplikt etter personopplysningslovens §§ 31 og 33.

Dersom prosjektopplegget endres i forhold til de opplysninger som ligger til grunn for vår vurdering, skal prosjektet meldes på nytt. Endringsmeldinger gis via et eget skjema, <http://www.nsd.uib.no/personvern/meldeplikt/skjema.html>.

Vedlagt følger vår begrunnelse for hvorfor prosjektet ikke er meldepliktig.

Vennlig hilsen

Vigdis Namtvedt Kvalheim

Marianne Høgetveit Myhren

Kontaktperson: Marianne Høgetveit Myhren tlf: 55 58 25 29

Vedlegg: Prosjektvurdering

Kopi: Inga Haaland inga.haaland@studmed.uio.no

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

Avdelingskontorer / District Offices:

OSLO: NSD, Universitetet i Oslo, Postboks 1055 Blindern, 0316 Oslo. Tel: +47-22 85 52 11. nsd@uio.no

TRONDHEIM: NSD, Norges teknisk-naturvitenskapelige universitet, 7491 Trondheim. Tel: +47-73 59 19 07. kyrre.svarva@svt.ntnu.no

TROMSØ: NSD, SVF, Universitetet i Tromsø, 9037 Tromsø. Tel: +47-77 64 43 36. nsdmaa@svt.uit.no



VURDERING AV MELDEPLIKT

Etter dialog med personvernombudet vil student innhente opplysninger om ektemennenes alder i ti-årsintervaller. Vi kan derfor ikke se at det behandles direkte eller indirekte personopplysninger med elektroniske hjelpemidler, eller at det opprettes manuelt personregister som inneholder sensitive personopplysninger. Prosjektet vil dermed ikke omfattes av meldeplikten etter personopplysningsloven.

Det ligger til grunn for vår vurdering at alle opplysninger som behandles elektronisk i forbindelse med prosjektet er anonyme.

Med anonyme opplysninger forstås opplysninger som ikke på noe vis kan identifisere enkeltpersoner i et datamateriale, verken:

- direkte via personentydige kjennetegn (som navn, personnummer, epostadresse el.)
- indirekte via kombinasjon av bakgrunnsvariabler (som bosted/institusjon, kjønn, alder osv.)
- via kode og koblingsnøkkel som viser til personopplysninger (f.eks. en navneliste)
- eller via gjenkjennelige ansikter e.l. på bilde eller videoopptak.

Personvernombudet legger videre til grunn at navn/samtykkeerklæringer ikke knyttes til sensitive opplysninger.

FORSKNINGSETISKE HENSYN

Personvernombudet minner om at forskningsetiske retningslinjer vil gjelde selv om prosjektet ikke omfattes av meldeplikten. Opplysningene som innhentes er sensitive og det kan oppleves belastende å delta i forskning. Belastningen informantene utsettes for må stå i et rimelig forhold til den samfunnsmessige og vitenskapelige nytten av den aktuelle studien. I studentprosjekter må veileder ta et særskilt ansvar for dette, og sørge for at prosjektet gjennomføres i tråd med forskningsetiske retningslinjer.

Den som foretar datainnsamling bør ha kompetanse til å gjøre dette på en slik måte at belastningen på deltakerne blir minst mulig. Man bør være forberedt på å håndtere eventuelle problemer som kan oppstå, både underveis og etter datainnsamling. For eksempel kan enkelte informanter ha behov for oppfølging. Det er nyttig å ha erfaring med gruppen eller feltet det forskes på, eller være tilknyttet en forskningsgruppe med slik kompetanse. I studentprosjekter har veileder et særskilt ansvar for planlegging av datainnsamlingen og god oppfølging både av studenter og informanter.

Vi viser også til NESH og NEM sine forskningsetiske retningslinjer som dere finner her:

<https://www.etikkom.no/forskningsetiske-retningslinjer/Generelle-forskningsetiske-retningslinjer/>

FRA: post@helseforskning.etikkom.no
[mailto:post@helseforskning.etikkom.no]
SENDT: 8. mai 2015 13:45
TIL: joarsv@online.no
EMNE: Sv: REK sør-øst 2015/811 Gifte tenårings kunnskap og praksis relatert til helse og helsetjenester

VÅR REF.NR.: 2015/811 C

Hei.

Vi viser til innsendt skjema for fremleggingsvurdering av prosjektet _Gifte tenårings kunnskap og praksis relatert til helse og helsetjenester, _mottatt 06.05.2015.

Følgende angis som formålet med studien i skjemaet: _Målet med studien er å finne ut korleis unge gifte jenter har det i kvardagen, deira oppleving av velvære, mestring, autonomi, helsetilstand, og bruken av helsetjenester: Kvar søker dei helse/støtte, og kva behov har dei for helsetenester. Vi skal også sjå på haldningar og praksisar på helsesenter, korleis desse jentene vert tatt i mot, og på kva oppfatningar helsearbeidara har om unge gifte jenter sin situasjon og helsebehov._

Helseforskningsloven gjelder for medisinsk og helsefaglig forskning, forstått som _virksomhet som utføres med vitenskapelig metodikk for å skaffe til veie ny kunnskap om helse og sykdom_, jf. helseforskningslovens § 4.

I dette prosjektet er det unge kvinner i Ugandas egne erfaringer med å møte helsevesenet som er sentralt, ikke ny kunnskap om helse eller sykdom per se. Det er selve helsetjenesten som gjøres til gjenstand for undersøkelsen.

Prosjektet faller således ikke inn under bestemmelsene i helseforskningsloven, jf. helseforskningslovens §§ 2 og 4.

Prosjektet kan gjennomføres uten REK-godkjenning.

Vi antar for øvrig at prosjektet kommer inn under de interne regler for behandling av opplysninger som gjelder ved ansvarlig virksomhet. Søker bør derfor ta kontakt med enten forskerstøtteavdeling eller personvernombud for å avklare hvilke retningslinjer som er gjeldende.

Vi gjør videre oppmerksom på at konklusjonen er å anse som veiledende jfr. forvaltningsloven § 11.

Dersom dere likevel ønsker å søke REK, vil søknaden bli behandlet i komitémøte, og det vil bli fattet et enkeltvedtak etter forvaltningsloven.

Med vennlig hilsen
Tor Even Svanes

seniorrådgiver

post@helseforskning.etikkom.no

T: 22845521

REGIONAL KOMITÉ FOR MEDISINSK OG HELSEFAGLIG
FORSKNINGSETIKK REK SØR-ØST-NORGE (REK SØR-ØST)
[HTTP://HELSEFORSKNING.ETIKKOM.NO](http://helseforskning.etikkom.no) [1]

Links:

[1] <http://helseforskning.etikkom.no>