FACTORS INFLUENCING EARLY MARRIAGE ON THE GIRL CHILD'S MATERNAL HEALTH PROJECTS: A CASE OF MARALAL TOWN, SAMBURU COUNTY, KENYA

BY

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DECLARATION

This research project report is my original work and has not been presented for any award in any other institution of higher learning.

..... 23/11/15 .....

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L50/82832/2012

This research project report has been submitted for examination with my approval as the university supervisor.

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DEDICATION

This work is dedicated to my parents, Mr. Charles Ikutwa and Mrs Jane Ikutwa for giving the opportunity to go to school and giving me the freedom to make my own decisions and choices in life.

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TABLE OF CONTENTS

LIST OF FIGURES

Figure……...PAGE

LIST OF TABLES

ABBREVIATIONS AND ACRONYMS

ANC	Antenatal Care
GOK:	Government of Kenya
HPV	Human Papilloma Virus
NGOs:	Non-Governmental Organizations
PNC	Prenatal Care
RAs:	Research Assistants
RH	Reproductive Health
SPSS:	Statistical Package for Social Sciences
STD	Sexual Transmitted Diseases
STI	Sexual Transmitted Infections
UNICEF:	United Nations International Children Education Fund
USAID:	United States Agency for International Development
WHO:	World Health Organization

ABSTRACT

The purpose of this study is to examine and assess factors that influence early marriage on the girl child's maternal health in Samburu County. Child marriage is a global problem affecting millions of girls across the world. It is considered a human rights violation because it deprives those involved of education and health services, the chance to learn skills and develop their personalities and leaves them vulnerable. Child marriage can have devastating consequences for a girl's health. It encourages the initiation of sexual activity at an age when girls' bodies are still developing and when they know little about their sexual and reproductive health. It destroys the health if the girl child at a very young age. In the course of this study, primary and secondary literature of related nature was reviewed including academic researches, journal papers, reports and books including online materials related to the area of study. Descriptive research design was adopted with purposive sampling method applied when analyzing the target population. Structured design questionnaires were developed and used for data collection. Questionnaires and reviewed by experts and pretested before implementation to ensure validity. The data gathered will be analyzed using the SPSS. After data analysis the descriptive statistics results were presented using percentage tables. A total of 86 questionnaires were used and had a high return rate from the target population. The quantitative information was collected through women in communities and key informants. Study findings clearly suggest that married girls are a distinct group that has experienced a wide range of risky behaviours; moreover, they face a number of obstacles that limit their ability to exercise safe choices in the area of sexual and reproductive health. Findings reiterate the need for programmatic attention to address the special needs and vulnerability of married young women There is a need to provide detailed information on sexual and reproductive health matters to young married girls, Findings underscore that access to maternal health services was far from universal, even at the time of the first—and often the most risky—pregnancy. Few women, particularly in Maralal, had accessed care during the antenatal, delivery and majority has no access or have choice in accessing antenatal services. These findings highlight that reproductive health programmes need to lay emphasis on increasing the demand for such services as well as improving the availability of such services In conclusion, findings of this study show that young married girls are a particularly vulnerable group that is in need of multi-pronged programmatic attention that addresses not only their own risk but also the likely factors contributing to these risks.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Birth, marriage and death are the standard trio of key events in most people's lives. But only one – marriage – is a matter of choice. The right to exercise that choice was recognized as a principle of law even in Roman times and has long been established in international human rights instruments. Yet many girls enter marriage without any chance of exercising their right to choose. USAID, (2012) descibes child marriage as a human rights violation and a practice that undermines efforts to promote sustainable development. In the last decade, child marriage affected 58 million girls, many of whom were married against their will and in violation of international laws and conventions.

Marriage before the age of 18 is a reality for many young women. In many parts of the world parents encourage the marriage of their daughters while they are still children in hopes that the marriage will benefit them both financially and socially, while also relieving financial burdens on the family. In actuality, child marriage is a violation of human rights, compromising the development of girls and often resulting in early pregnancy and social isolation, with little education and poor vocational training reinforcing the gendered nature of poverty (Nuruddin, 2005).

Globally, international and humanitarian organizations as well as some governments have recognized the dangers that forced and early marriage present to the lives of girls under the age of 18. Early marriage increases social isolation and launches girls into a cycle of poverty, gender inequities, and higher risk of dying from complications of pregnancy and childbirth. Early marriage forces young girls to assume responsibilities and handle situations for which they are often physically and psychologically unprepared. Furthermore, schooling—a critical pathway to a prosperous life—is often cut short by early marriage. (Sauti Yetu 2012)

According to UNFPA (2012) despite national laws and international agreements, child marriage remains a real and present threat to the human rights, lives and health of children, especially girls, in more than a hundred countries. One in three girls in low and middle-income countries (excluding China) will marry before the age of 18. One in nine girls will marry before their fifteenth birthday

According to Perczynska A. et al nd states that In Nepal there's a case study on early marriage that states there are numerous health risks that a girl is exposed to when she is married before she turns eighteen. She is expected to start being sexually active and bear children before her body has fully matured. One common problem amongst women in Nepal that is related to early child birth is uterine prolapse – a debilitating condition where the muscles and ligaments can no longer hold the uterus in place. While uterine prolapse can be caused by inadequate child spacing, lack of proper rest after childbirth and demanding labor during pregnancy, it has also been linked to early child birth.

In Africa, in the study by Isis – WICC, (2011), child marriage has become a common feature in most communities in Africa. This means that young girls who have not attained the minimum age for marriage of 18 years are married off; sometimes to men who are fit to be called their fathers or their grandfathers. In other situations and in some communities, a boy and a girl who are not 18 years old get married; thus forming a young couple, that itself becomes a social burden. In some communities, child marriage of children is regarded as a norm, the basic foundation of purity, of economic survival or even a basis for continuation of relationships and enhancement of family lineage

All African countries are faced with the challenge of child marriage, a harmful traditional practice that robs girls of their education, their health and their future. In Africa, high rates of child marriage combined with a rapidly growing population could have devastating human and development consequences (Girls not brides nd)

Traditionally initiation, circumcision and early marriage should not cause girls to drop – out of school. Wanyoike (2003) avows that some students who drop-out of school especially girls end up in early marriages and prostitution. However survey carried out among Samburu community indicates that girls are forced to early marriage at a tender age of 13 years. Threats of curses befalling those who refuse to get married make it difficult for girls to resist early marriages. Some continue with schooling after marriage but when they get pregnant they have to quit school (Wanyoike, 2003). This however disadvantages the girls as the boys are left to continue with their education.

UNICEF (2003) points out that child bride are common among the nomadic pastoralists of Kenya (The Samburu, Maasai, Turkana, Pokot, Somali, Rendile, Borana and Oromo. The religious and traditional norms dictate that marriage occurs or shortly after, puberty, especially for girls. Nomadic girls traditionally marry between the ages of 10-13 years. Further escalating

the pressure for early marriage is the reality that in these cultures women are traditionally valued on the basis of how many children they can produce for their husbands, not by how educated or economically successful they are(FAWE, 2000). The longer a girl stays in school, the less likely she is to be married before the age of 18 and have children during her teenage years. The issue of early marriages is still common in Samburu Central. Young girls are married off to old men at the expense of education and it's the main reason why gender disparity is high in the entire county. According to the daily nation Thursday January 28, 2010, a four year old Samburu girl was rescued from early marriage to a Moran that paid her parents 10 cows.

Wanjiku E et al. (2015) states that In Samburu shockingly, girls as young as seven years old are often married off to men way older. Even more astonishingly, the girls are circumcised on the morning of their wedding. They bleed into their new homes. Some men will wait for the girl to heal the wounds FGM inflicts on them, but others do not. These girls' education comes to a halt. They are expected to bear children, build houses, rear and manage domestic livestock in addition to providing food for the family. Female genital mutilation comes with stigma as the girls can get fistula, have difficult childbirth, infections, and anemia leading to death and experience reduced sexual pleasure. Indeed, this shows that the health of the girl child is adversely affected due to child marriage.

1.2 Statement of the problem

Studies have shown that there are serious health implications that come with child marriage. It leads to maternal mortality, sexually transmitted diseases, cervical cancer among others (International Center for Research on Women, 2007: UNICEF, 2001). According to the United Nations World Population Fund, in Africa 60% of women and girls give birth without a skilled medical professional present. Worldwide, 70,000 girls aged less than 18 years die each year during pregnancy and child birth (UNICEF, 2005).

UNICEF (2001) for example asserts that in many developing countries the transition from adolescence to adulthood is abruptly cut short by early marriage, a practice that has serious consequences for the health and development of female adolescents. Young girls are robbed of their youth and required to take on roles for which they are not psychologically or physically prepared. Many have no choice about the timing of marriage with their partner whilst some are coerced into marriage; others are too young to make an informed decision. Premature marriage deprives them of the opportunity from personal development as well as their rights to full

reproductive health (RH) and wellbeing, education, and participation in civic life (Saxena , 1999).

Furthermore, early marriage initiates a vicious cycle of poor health among adolescent females and their children. Early marriage is usually followed by early childbearing, a phenomenon that endangers the lives of both the adolescent girls and their children. For females under the age of 18, childbearing involves greater risks of maternal morbidity and mortality. Pregnancy-related complications are the primary cause of death for 15-19 year old girls worldwide (UNICEF 2001). Infants of adolescent mothers have greater likelihood of having low birth-weight with increased risk of death and illness (Somorset, 2000). When a child bride is married she is likely to be forced into sexual activity with her husband, and at an age where the bride is not physically and sexually mature this has severe health consequences. Child brides are likely to become pregnant at an early age and there is a strong correlation between the age of a mother and maternal mortality.

At a young age a girl has not developed fully and her body may strain under the effort of childbirth, which can result in obstructed labour and obstetric fistula. Obstetric fistula can also be caused by the early sexual relations associated with early marriage, which take place sometimes even before menarche. Good prenatal care reduces the risk of childbirth complications, but in many instances, due to the limited autonomy or freedom of movement, young wives are not able to negotiate access to health care. They may be unable to access health services because of distance, fear, expense or the need for permission from a spouse or in-laws. These barriers aggravate the risks of maternal complications and mortality for pregnant adolescents.

The risks of early pregnancy and childbirth are well documented: increased risk of dying, increased risk of premature labour, complications during delivery, low birth-weight, and a higher chance that the newborn will not survive. Pregnancy-related deaths are the leading cause of mortality for 15-19 year-old girls (married and unmarried) worldwide. Mothers in this age group face a 20 to 200 per cent greater chance of dying in pregnancy than women aged 20 to 24. Those under age 15 are five times as likely to die as women in their twenties. The main causes are haemorrhage, sepsis, preeclampsia/eclampsia and obstructed labour. (UNICEF 2001)

In Kenya, especially in Samburu County where child marriage is common has great health impact on the girl child. You find children delivering children who end up having

complications. Save the Children, (2013) pointed out that according to the most recent estimates, 35 percent of newborn deaths are caused by complications of premature birth. Babies born before 37 weeks of pregnancy are at risk due to loss of body heat, inability to take enough nutrition, breathing difficulties and infections. Almost half of all preterm babies are born at home, and even for those born in facilities, essential care is often lacking.

The Star newspaper Waweru N. (2015) points out that One of World Health Organisation's facts about maternal health is that most of maternal deaths can be prevented through skilled care at childbirth and access to emergency obstetric care. However, this is not always the case .In Samburu County, the statistics stand at 360 deaths for 1000 births, making it one of the worst counties in terms of maternal health. For most residents of Samburu, access to health care has been poor due to a variety of factors including extremely harsh weather conditions and in security. The lack of adequate staff to attend to such cases has also contributed to the increasing maternal mortality. Poor road network not only limits the community from accessing the health facilities but also obstructs the health workers from responding to emergency services.

The issue of early marriages is still common in Samburu Central. Young girls are married off to old men at the expense of education and it's the main reason why gender disparity is high in the entire county. According to the Daily Nation Thursday January 28, 2010, a four year old Samburu girl was rescued from early marriage to a Moran that paid her parents 10 cows.

1.3 The purpose of the study

The overall purpose of the study is to examine the influence of child marriages on the girl child's maternal health in Maralal in Samburu County.

1.4 Objectives of the study

The study is based on the following objectives:

1.1 To investigate factors that influence the marital age in early marriage on the girl child maternal health

1.2 To examine factors that influence early pregnancy health choices in early marriage on the girl child maternal health.

1.3 To establish factors that influence early pregnancy in early marriage on the girl child maternal health.

1.4 To examine factors that influence maternal education on the girl child's maternal health.

1.4 Research question

These were the research questions of this study.

1.1 What is the influence of marital age in early marriage on the girl child maternal health?

1.2 To what extent does pregnancy health choices in early marriage influence the maternal health of the girl child?

1.3 To what extent does early pregnancy in early marriage influence the girl child maternal health?

1.4 To what extent does maternal education in early marriage influence on the girl child's maternal health?

1.5 Significance of the study

Through this study, we will be able to extend proper education to the young girls, parents, local leaders on the disadvantages of early marriage; provide guidance and counseling to the young women, especially to the young marrying couples to be girls; their parents and the community; health workers; county and national policy makers and also researchers .

1.6 Assumption of the study

It was the assumption of this study that there will be maximum cooperation from respondents and all information sought will be availed and truthful.

1.7 Delimitation of the study

The study will be confined within Maralal, town in Samburu County Kenya, which is an underdeveloped and culture is a strong component of their way of life. The key people who will be targeted in this study are the local leaders in the communities, women groups, schools rescue centres, rescued girls in the centres and the health administrators.

1.8 Limitation of the study

This research would be limited by the finances as this may require a lot of costs in travelling and moving within the town.

1.9 Operational Definition of Significant Terms

Below are the definations of terms in this research.

Girl Child Maternal health: This are the Reproductive health complications and physical Body complications of young mothers during pregnancy, child delivery and after birth.

Early Pregnancy Health choices: It involves mentally making a decision: judging the merits of multiple options and selecting one or more of them. In this context it involves making early health choices over the girl child's body, having the power to make decision in regards to your well-being on when to get pregnant, which and when to use contraceptives, when to access the health services without having looking for permission.

Marital Age: This is the age a person is mean to marry either by right or subject to parental consent or arranged and decided by elders

Early pregnancy: This is where by young girls in Samburu aged between 9- 18years bear children at an early age. More or less it's like a nine year old giving birth to a baby. It's basically children having children.

Maternal education in this context it's the lack of schooling and lacking access to information on pregnancy, source of information on pregnancy and child health, family planning, child birth, intimate partner violence.

Early Marriage It is an informal union entered by young girls below 18 years of age

1.10 Organization of the study

This study is presented in five chapters; Chapter One of this study presents the statement of the problem, research objectives, research questions and definition of key terms. Chapter Two of the study presents the review of literature and the conceptual framework of the study. Chapter Three presents the research design and research methodology for this study. Chapter Four presents the research data analysis and interpretation. Chapter Five presents the findings, recommendations, conclusions and suggestions for further research.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter deals with the review of literature on the influence on early marriages on girl child's maternal health. The chapter also presents theoretical and conceptual frameworks on which the study is based.

2.2 Girl Child Maternal Health project

O. Ida (2014) article on addressing maternal health in Kenya, It is estimated that 7,700 women die each year in Kenya from pregnancy related complications. This translates to 21 women dying each day or one woman every hour from preventable causes, making the need to address safe motherhood a human rights imperative. The death of a woman, and especially that of a mother, has far reaching consequences. Women are the hearts and engines of their families, communities, and their country at large. Their health and survival has a huge impact on the economy and the environment as well as on peace and stability. The death of a mother shatters her family and threatens the family's wellbeing. We all have a role to play to save their lives by advocating, among other things, increased funding for programs to improve the health of mothers. Kenyan mothers must no longer die while giving life.

Too many women and children across the world still die unnecessarily from preventable illnesses or lack of adequate health care. Maternal, newborn and child health (MNCH) is now recognized as one of the most critical issues facing human development, requiring global solidarity and concerted urgent action. Maternal, newborn and child health depend on reproductive and sexual health. For example, access to safe and effective family planning methods allows women, and their partners, to choose if and when they would like a family. Delaying pregnancy and spacing pregnancy are important for women's physical health. Ensuring that every child who is born is wanted is also important for the emotional health of the woman and child. Women and men must know how to avoid – or seek early treatment for – sexually transmitted infections that can lead to infertility for the woman or to death or disability for the woman or child. (IPU 2015)

According to Sparrow A. (2014) article, Tens of thousands of Kenyan women and girls in Kenya suffer from obstetric fistula, a childbirth injury causing leakage of urine and faeces, a direct result of inadequate health services. While approximately 92 percent of women

giving birth received some antenatal care in 2010 only 47 percent had the recommended 4 or more visits and 56 percent of Kenyan women deliver their babies at home (more in rural areas). Only 44 percent of births were assisted by health care professionals, well below the target of 90 percent of deliveries by 2015, and these rates of antenatal care and skilled birth attendance have declined over the past 10 years, particularly among the poor. Traditional birth attendants assist with 28 percent of births, relatives and friends with 21 percent and in 7 percent of births, mothers receive no assistance at all.

2.3 Influence of marital age on the maternal health of the girl child project

Marriage is a union between a man and a woman such that the children born to the woman are recognized as legitimate offspring of both partners (Kottack, 2009). It is an important institution both for the individual and the society at large. For the individual, it is a significant and memorable event in one's life cycle as well as the most important foundation in the family formation process. It is also a rite of passage that marks the beginning of an individual's separation from the parental unit, even if generations continue to be socially and economically interdependent. For the society as a whole, it unites several individuals from different families and represents the creation of a production and consumption unit as well as one for the exchange of goods and services (Quisumbing and Hallman, 2003).

Age is an important factor for safe motherhood because it is related to sexual desires and fertility. It is also related to various risk factors of pregnancy, which affect health care seeking behavior of women. When we talk about the marital age of the girl child, this means once the girl is married she has no choice but to abide by the rules of marriage. This means she has to have an intimate relationship with her spouse and this in most cases mean forceful sexual intercourse. Usually the girl child is expected to show her fertility once she's married by bearing children which hence leads to early pregnancies.

Age at marriage is of particular interest because it marks the transition to adulthood in many Societies, the point at which certain options in education, employment, and participation in society are foreclosed, and the beginning of regular exposure to the risks of pregnancy and Childbearing. Women who marry early will have, on average, a longer period of exposure to the risk of pregnancy, often leading to higher completed fertility. Variation in age or entry in marriage helps explain differences in fertility across populations and also helps explain trends

infertility within individual populations over time (United Nations, 2005; Ezeh and Dodoo, 2007)

According to UNFPA (2012) despite national laws and international agreements, child marriage remains a real and present threat to the human rights, lives and health of children, especially girls, in more than a hundred countries. One in three girls in low and middle-income countries (excluding China) will marry before the age of 18. One in nine girls will marry before their fifteenth birthday.

Age at marriage varies with societies and at different times. In Africa, for example, age at marriage for females is relatively low. This is because marriage laws do not strictly spell out a minimum age. Uche (1976) and Khasiani (1995) also found that many Kenyan communities supported early marriages. It has, however, been observed that with educational opportunities, the median age at marriage is going up. In the industrialized countries, however, marriage before age eighteen was relatively uncommon among the older group of women and continues to remain so among young women (Alan Guttmacher Institute, 1998)..

Early marriages, sometimes referred to as child marriages, fall within the context of arranged marriages (Khasiani, 1995; Dolphyne, 1991). They are still practised by several communities in African countries including Kenya. Khasiani (1995) and Kihuha (1992), in their studies on fertility and population increase, found that the particular communities that have kept the practice alive are the Abakuria, the Maasai, Mijikenda and the pastoral communities in North Eastern Province, as well as the Rift Valley and Eastern Provinces. Early marriage is a problem that has been recognized by the Kenya government as being responsible for high female dropouts in primary and early secondary schooling (Kihuha,1992).

According to UNICEF (2005) marriage before the age of 18 is a reality for many young women. In many parts of the world parents encourage the marriage of their daughters while they are still children in hopes that the marriage will benefit them both financially and socially, while also relieving financial burdens on the family. In actuality, child marriage is a violation of human rights, compromising the development of girls and often resulting in early pregnancy and social isolation, with little education and poor vocational training reinforcing the gendered nature of poverty.

Gikenye (2001) asserts that in some cultures, providing education equally to both boys and girls clashes with traditional ways of life yet it is a recognized fact that when young people

acquire education, they develop skills and acquire more information that prepare them better to fit in a changing world especially in the changing job market. Further, they are more likely to gain practical knowledge that they can apply in areas of their lives. This increased knowledge for the woman can raise her status within her family and community and provide her with a sense of self-esteem that enables her to alter the situations that may affect her. For example, she can participate in decisions about when and whom to marry or to take her children to school, including girls (Alan Guttmacher Institute, 1998: Khasiani, 1995).

In the study by Isis – WICC, (2011), child marriage has become a common feature in most communities in Africa. This means that young girls who have not attained the minimum age for marriage of 18 years are married off; sometimes to men who are fit to be called their fathers or their grandfathers. In other situations and in some communities, a boy and a girl who are not 18 years old get married; thus forming a young couple, that itself becomes a social burden. In some communities, child marriage of children is regarded as a norm, the basic foundation of purity, of economic survival or even a basis for continuation of relationships and enhancement of family lineage

The differences in culture, religion and government intervention have, therefore, been shown to affect the age at first marriage. For most of the young girls who are married early, pubertal growth is still progressing and they have neither reached full mental nor physical maturity. They also have not had an opportunity to finish their primary education (Gikenye, 2001). Dolphyne (1991) has rightly observed that marriage arrangements or child betrothal and subsequent early marriage may have worked well in the past. In modern times, however, things have changed, and continue to change so that a girl may refuse to marry the man she has been chosen for when she was a child.

This may create problems if she cannot be persuaded to marry the chosen partner or suitor. The bride wealth that may have been already transferred to the girl's father has to be refunded which sometimes may not be possible as the parents, depending on their economic status, may have already used it. This may be followed by coercion or tricking the girl and sometimes outright force. At times the girls may try and succeed in running away and may be lucky to find rescue from outsiders since such girls do not expect any sympathy from their families as they are supposed to have let them down. The experiences the young brides and would-be brides who may be as young as 12 years go through can be quite traumatic. Due to the young girls' age and given the fact that their bodies are not yet fully developed to cope

with child bearing, young brides sometimes suffer permanent damage to their health in the process of child bearing (Gikenye, 2001).

Khasiani (1995), in her study on fertility, asserts that young age at marriage also relegates women to low status due to limited knowledge and experience as well as the few resources the woman brings into the union. Low age at marriage also exposes women to longer reproductive spans and increases their chances of higher fertility. This increases chances of poor health to women and reduces their opportunities to engage in higher education and employment activities outside the home as well as deciding on the number of children they can support (Kihuha,1992)

In Kenya, the minimum legal age at marriage is 18 for both sexes. Twenty-five percent of Kenyan adolescent girls are married before age 18, however, and 5 percent are married during early adolescence, that is, before age 15. Considerable variation in marriage rates occurs by region; girls in rural areas are significantly more likely than those living in urban areas to be married during adolescence (CBS 2004). A considerable proportion of Kenyan girls do not choose their husbands; their husbands are chosen for them, although rates of arranged marriages in Kenya are not as high as in South Asia, West Africa, and UNICEF

A considerable number of married adolescents and young women are in polygamous unions; nearly one in five married girls in Coast, Northeastern, and Rift Valley provinces are in such unions (CBS 2004). The younger a girl is when she marries, the larger the age difference between her and her spouse. Kenyan girls who married at age 14 or 15 were, on average, 11 years younger than their spouses. Girls who married at 16 or 17 were nine years younger, while those who married at 18 or 19 were seven years younger than their husbands. Age differences between spouses have important implications for the division of power and decision making in the household, especially when the wife is very young and her spouse is considerably older (CBS 2004)

Early marriage has been associated with earlier age at first birth, higher total fertility, lower utilization of maternal healthcare, and lower female education (Jensen and Thornton, 2003). Earlier physical maturation in women has been associated with earlier marriage and earlier fertility timing in previous studies (Field and Ambrus, 2008; Ghorry, 2012). The use of menarche as an IV relies on several assumptions. First, age of menarche needs to be correlated with age of marriage.

2.4 Influence of pregnancy Health Choices on the girl child's maternal health

DFID (2010) asserts that a woman's social, economic and other opportunities in life are enhanced by being able to make fertility and other health choices. They are increased further by her ability to live free from pregnancy- and childbirth-related disability and the stigma that can accompany it. Preventing pregnancy in young adolescents makes a particularly significant difference to girls' life chances. Gender equality and women's empowerment are both a means to and an end of improved reproductive, maternal and new born health.

Once married, girls are likely to feel, and in many cases are, powerless to refuse sex. They are likely to find it difficult to insist on condom use by their husbands, who commonly are older and more sexually experienced, making the girls especially vulnerable to HIV and other sexually transmitted infections. At its worst, child marriage can be tantamount to bonded labour or enslavement. It can be a sentence to regular exposure to domestic or sexual violence, and a pathway to commercial exploitation. (UNFPA 2012)

According to the research done by Pathfinder (2006), early marriage increases the span of a woman's reproductive period, and those who marry earlier are more likely to have a greater number of children than others. Due to age differences, economic dependency, lack of education, and many other associated factors, early-married women have and/or exercise lower sexual and reproductive rights than those who marry at appropriate ages. They have less ability to make decisions on matters related to reproductive health, such as the use of contraceptives and rights over sexuality (the ability to say "No" when asked for sex by husbands). Thus, early marrying women have less chance of spacing and/or avoiding unwanted pregnancy.

The life chances of children are in part determined by the health and nutrition of their mothers before and during pregnancy. Household poverty can be mitigated by improving women's health and survival; women are the sole income earners in up to a third of all households. Services and programmes that remove or reduce costs of commodities, care or referrals to poor women can prevent families spiralling into debt. Health care costs can be catastrophic and a major cause of deepening and persistent poverty. National economies benefit when mothers and babies are healthy and when high fertility rates fall. (DFID 2010)

The role that power and decision making play in a couple's transition to marriage is also critical. According to Blumstein and Schwartz (1983), the question of how power gets

distributed in a marriage used to be more clearly prescribed by society. Familial interactions, influences, and issues are significant in a couple's successful transition to marriage.

Child brides give birth at an age when it is highly dangerous for them to do so. Girls who give birth before the age of 15 are five times more likely to die in childbirth than women in their 20s (WHO, 2011). They are also at increased risk of pregnancy-related complications: 65% of all cases of obstetric fistula occur in girls under the age of 18. (WHO, 2008).Women's consent for childbearing is an important factor in the physiological and emotional wellbeing of both mother and child. However they don't have that choice to make as it is made by their husbands.

According to Girls not brides (2013), Child marriage is a major barrier to improving maternal health worldwide. Complications in pregnancy and childbirth are the leading cause of death in girls aged 15-19 in low- and middle-income countries (WHO, 2012). 95% of the world's births to adolescents occur in developing countries, and 90% of these are to girls who are already married (UNFPA, 2013).

Very few girls in early marriages in developing countries have access to contraception; nor would delayed pregnancy necessarily be acceptable to many husbands and in-laws.100 Indeed, in many societies, childbearing soon after marriage is integral to a woman's social status. In Yemen, 11 per cent of wives aged 15-29 stated that they did not use contraception because of their husbands' opposition. (UNICEF 2001). UNICEF also adds that In almost all Asian countries the family exerts strong pressure on the newly-married couple to begin childbearing quickly..

2.5 Influence of early Pregnancy on the girl child's maternal health

Child brides are likely to become pregnant at an early age and there is a strong correlation between the age of a mother and maternal mortality. Girl's age's l0-14 are five times more likely to die in pregnancy or childbirth than women aged 20-24 and girls aged 15-19 are twice as likely to die. Young mothers face higher risks during pregnancies including complications such as heavy bleeding, fistula, infection, anemia and eclampsia which contribute to higher mortality rates of both mother and child. At a young age a girl has not developed fully and her body may strain under the effort of child birth, which can result in obstructed labour and obstetric fistula. Obstetric fistula can also be caused by the early sexual relations associated with child marriage, which take place sometimes even before menarche.

UNICEF (2005) asserts that It is common sense to assume that girls who marry before 18 will usually have more children. Early child-bearing has long been seen as a risk to maternity, contributing significantly to large families. Since girls who are married young have a large number of child bearing years, they are more prone to miscarriage, infant death, malnutrition, cervical cancer, sterility, and maternal death. Even when girls are closer to the age of 18 but not yet that age, the risk remains. Girls between age 15 and 19 are twice as likely to die of pregnancy-related reasons as women between age 20 and 24. Child marriage is the leading cause of young women between the ages of 15 and 24 dying during pregnancy.

A large proportion of reproductive and sexual health concerns of adolescent girls and women root from early marriage and early pregnancy. In the context of reproductive health girl spouses face well-acknowledged risks. These include the problem of giving birth when the pelvis and birth canal are still under-developed which leads to an increased risk of complications during delivery including protracted labor. Mothers aged less than 15 are especially vulnerable to fistulae – relentless pressure from baby's skull can damage the birth canal causing breakages in the wall. A girl or a woman with this condition ─ irreversible without surgery ─ is not only in constant pain but will be socially ostracized and may well be divorced because of this. A long interval between marriage and conception of first child can be helpful for those girls who get married at an early age.(UNFPA 2004)

The perils of child marriage are not limited to only health complications during pregnancy and delivery period but in many cases during post-natal period as well. Because of the prolapsed uterus, they suffer from backaches, experience difficulties while walking, working and sitting for a long time. At times they had to give birth even after prolapsed uterus and this made the situation worse for them.

Good prenatal care reduces the risk of childbirth complications, but in many instances, due to the limited autonomy or freedom of movement, young wives are not able to negotiate access to health care. They may be unable to access health services because of distance, fear, expense or the need for permission from a spouse or in-laws. These barriers aggravate the risks of maternal complications and mortality for pregnant adolescents.

Maternal age the age of the mothers at which she deliveries her first child is very important since in most cases it influences the girl child health outcomes. Several studies (Simoes at al 2003; De Silva et al 2003) have pointed out that young mothers aged 18 years and below

were observed to have the highest proportions of low birth weight, pre-term deliveries and infant mortality rates due to their biological immaturity. Oboro et al (2003) have further argued that teenage mothers of 15 years and below were at higher risk of poor pregnancy outcomes, such as being anaemic, premature labour, low birth weight and operation deliveries than their counterparts who were aged 16 to 19 years.

However, there is a serious debate whether age per se is responsible for the poor pregnancy outcomes. Scholars such as Negussie and Obare (2003) in their study on pregnancy and child health outcomes among adolescents in Ethiopia have argued that studies that emphases maternal age in influencing teenage pregnancies are Hospital-based, which he refers to as employing less-rigorous analytical methods. Negussie and Obare also concurs with Oboro that the independent effect of maternal age on the frequency of preterm delivery, low birth weight and neonatal mortality was only significant as age if first childbirth falls below 16 years of age. Moore et al (1995) have concluded that early childbearing and poor health outcomes is due 16 not to age, but rather to the numerous risk factors associated with being young such as inadequate prenatal care and nutrition.

Married girls are often under pressure to become pregnant immediately or soon after marriage, although they are still children themselves and know little about sex or reproduction. A pregnancy too early in life before a girl's body is fully mature is a major risk to both mother and baby. Complications of pregnancy and childbirth are the main causes of death among adolescent girls ages 15-19 years old in developing countries. Among the disabilities associated with early childbirth is obstetric fistula, an injury which leaves girls in constant pain, vulnerable to infection, incontinent, and often shunned by their husbands, families and communities (UNFPA 2012)

According to WHO (2012) research, Developing countries, and 55% in West Africa, give birth by age 20; 90% of these births are within wedlock. Young age, coupled with limited access to health services, a lack of reproductive health information, cultural pressures, and little control or autonomy for decision-making, leads to high-risk pregnancies. These pregnancies, especially first-time pregnancies, are associated with high rates of maternal mortality, obstructed labour, pregnancy-induced hypertension, and fistula. Girls between the ages of 10 and 14 have five times the risk of dying during pregnancy and birth compared to women aged 20 to 24. Early onset of childbearing is also associated with negative maternal health outcomes due to frequent childbirth, unplanned pregnancy, and abortion. Adolescent

first time mothers have the accumulated risks of both age and parity, making these pregnancies extremely vulnerable.

Scholars like Gordon et al (2005) have further argued that first teenage births are not independently associated with an increased risk of adverse pregnancy outcomes but that it was the second teenage births that are associated with an almost threefold risk of preterm delivery, still birth and other STDs. There is scanty information on maternal age and teenage pregnancies and child birth in Uganda, however, it is indicated that children born to very young women suffer higher mortality rates than those born to older women (UBOS and ORC Marco, 2001) and infant mortality rates were observed to be higher at 105 deaths per 1,000 births under 20 years compared to 82 per 1,000 for births to women aged 20 to 29. Obstructed labor is the result of a girl's pelvis being too small to deliver a fetus. The fetus's head passes into the vagina, but its shoulders cannot fit through the mother's pelvic bones. Without a cesarean section, the neonate dies, and the mother is fortunate if she survives. If sepsis or hemorrhage does not occur and the girl does survive, the tissue and bones of the neonate will eventually soften and the remains will pass through the vagina.

World Health Organization (2006) revealed that the risk of death following pregnancy is twice as high for women between 15 and 19 years than those between the ages 20 and 24years. The mortality rate can be up to five times higher for married girls aged between 10 and 14 than for women of at least 20years. They are more susceptible to anemia than adults and this greatly increases the risk and complications linked to pregnancy, especially with the added pressure to prove their fertility in the first year of marriage

On the demand side, from the perspective of the groom, John R. et al (2003) argues that younger brides may be preferred for a number of reasons. First, women who are younger have longer 18 Gender and Development reproductive lives during which to have children. In regions where desired fertility is high, and/ or infant mortality rates or rates of miscarriage are high, there will be a stronger demand for younger brides. (John R et al 2003) adds that Men and their families may also view younger brides as more desirable because they are more easily controlled, and less assertive, because of their lack of physical, mental and emotional maturity. Younger brides may therefore be viewed as more 'trainable'. They may also be better able physically to perform household activities. Finally, younger brides are less likely to have had previous sexual contact, which, due to social norms and the prevalence of

sexually transmitted diseases, including HIV/AIDS, may be considered important or essential to the groom and/ or his family

One third of women in developing countries give birth before 20; as much as 55 percent of women give birth before 20 (Save the Children 2004). Women who bear children at a young age may face serious health consequences. Young mothers experience higher rates of maternal mortality and higher risk of obstructed labor and pregnancy-induced hypertension because their bodies are unprepared for childbirth (Save the Children 2004; Mathur, Greene and Malhotra 2003). Girls between 10 and 14 are five times more likely than women ages 20 to 24 to die in pregnancy and childbirth (UNFPA and the University of Aberdeen 2004). Girls ages 15 to 19 are twice as likely as older women to die from childbirth and pregnancy, making pregnancy the leading cause of death in poor countries for this age group (Save the Children 2004).

Girls who have babies also have a high risk of suffering from obstetric fistula, a condition in which the vagina, bladder and/or rectum tear during childbirth and, if left untreated, cause lifelong leakage of urine and feces (UNFPA and Engender Health 2003). Two million women suffer from obstetric fistula worldwide, and an additional 50,000 to 100,000 new cases develop annually among girls (Murray and Lopez 1998).

2.6 Influence of maternal Education on the girl child's maternal health

Education is an important issue in a woman's life because it helps her lead a better life. Through education, she can also acquire knowledge regarding health care for safe motherhood.

Women's education improves maternal health knowledge including that about child nutrition and hygiene. Education facilitates mother's learning about causation, prevention, recognition, and treatment of disease (Frost et al., 2005). In addition to basic health knowledge, education also is a factor of acculturation by breaking away from tradition and increasing acceptance of ideas and practices associated with modern medicine (Cleland and Van Ginneken, 1988; Kuate-Defo, 1997). Thus, children of educated women live in more hygienic environment, have higher prevalence of vaccination than their counterparts, receive appropriate care in case of disease, and therefore have better nutritional status than others.

Asrari, L. (2015) report avovs that Missing out on education means that child brides typically have less power and decision-making ability in their households, for example over family planning, and therefore less ability to make decisions about when to have children and how many to have, which can lead to higher maternal and infant mortality rates. In addition to that she asserts that research suggests that if all women completed primary education, the under-five mortality rate would fall by 15 per cent in low and lower middle income countries, saving almost a million lives annually. If all women completed secondary education, the under-five mortality rate would fall by 49 per cent, saving 3 million lives annually.

In the study done by Plan International (2015), a quality education is critical in helping children develop the skills, knowledge, confidence and abilities to make their own decisions, enjoy healthy and positive relationships, and make informed choices about their health and well-being, and their lives. However, girls forced to marry often drop out at the very point when education can guide them through the vulnerable period of adolescence2. Evidence shows that mothers with little education are less likely to keep their own children in school, because they themselves are less likely to be aware of benefits of school or to value education if they have not completed it themselves. They are also less likely to be able to support their children, due to their own low level of education, and their limited knowledge of the education system. Thus the children of child brides are unlikely to receive a full education and are in turn more likely to be child brides.

Child brides usually face intense social pressure to bear children, which makes them more likely to experience early and frequent pregnancies. It is often difficult for child brides to assert their wishes and needs to their husbands, particularly when it comes to negotiating safe sexual practices and the use of family planning methods. Child marriage encourages the initiation of sexual activity at an age when girls know little about their bodies, their sexual and reproductive health, or their right to access contraception. Married girls are hard to reach with family planning services and are often unaware that such services exist. This is especially the case for younger girls who are not in school and have virtually no access to sexuality education. (Girls not Brides 2013)

Maternal education has a strong positive effect on personal and child survival, especially during pregnancy and birth, because it indicates at least a basic understanding of modern health, improves the effectiveness of maternal behaviors involving the child‟s health, and changes the mother‟s role within a family to include greater attention to the use of modern

health services and sanitation. Educated women tend to better understand the importance of prenatal care, both for themselves and for the health of their child. These women are more likely to seek and obtain adequate care rather than, like in most developing countries, receive poor to no prenatal care. Maternal education also impacts the importance women place on prenatal care.(Gabriele L. 2010)

Maternal education is expected to provide mothers with the psychological, cognitive, and social capital resources that are important for positive parenting. Specifically, formal education fosters critical, analytical, and reflective thinking skills that are associated with more child-focused beliefs, goals, and behaviors (Grusec, 2006; Magnuson et al., 2009; Rosenblum, McDonoguh, Sameroof, & Muzik, 2008).

It is not coincidental that while female education increases, infant and maternal mortality decrease and a women's choice to seek prenatal care becomes increasingly common. Women who do not perceive prenatal care are poor, of high parity, low levels of education, and are unaware of the importance of prenatal care. Regardless of wealth, women who perceive prenatal care to be important are more likely to obtain adequate care, and women who perceive it to be important tend to be those who are educated. (Gabriele L. 2010)

Models on women's empowerment and autonomy argue that women's education promotes empowerment and influences participation in decisions that affect child nutrition and access to health services (Emina et al. 2009). Hobcraft (1993) argued that education permits women to exert greater control over health choices for their children. A series of studies have argued that maternal education affects child nutrition through health knowledge and attitudes, and in particular that maternal education improves the mother's knowledge about child health, including causes, prevention, and treatment of diseases (Frost et al. 2005). Further, maternal education promotes positive attitudes toward health-seeking behavior for their children, including awareness of the importance of immunization (Ruel et al. 1992). Caldwell (1979) argued that maternal education leads to "a shift from 'fatalistic' acceptance of health outcomes towards implementation of simple health knowledge." Emina et al. (2009) observed that children whose mothers are educated tend to live in more hygienic environments and are more likely to be vaccinated and have better nutritional outcomes.

According to Abuya, A., Kimani, K. et al.(2010), school attendance by women enables them to acquire formal education, which makes them knowledgeable on a whole range of health

issues about themselves and their children. This knowledge is imparted through a number of ways, including learning about the causes of diseases and illnesses, recognition, prevention and curative measures, the nutritional requirements for effective growth and development.

However, the evidence linking maternal education, health knowledge and child health is not conclusive. Glewwe (1999) found that health knowledge intervenes between maternal education and child health; whereas other research in the same area has found little and sometimes no association between maternal education and health knowledge.

Previous research links a mother's reproductive factors to child health. The argument is that better educated mothers have more control over their reproductive choices/decisions, including the number and the spacing of births. These factors ultimately influence child health (Gleww 1999). Research documents that in the developing countries women get married at early ages, and as a consequence, they enter the childbearing period when their bodies are still not mature enough to carry babies. The teenage mothers often do not use prenatal care even when these services are available. Consequently, these young mothers are exposed to a myriad of health risks, such as miscarriages and still births and low birth weight.

Glewwe (1999), in his study of Moroccan schools connects schooling of parents to child health through influencing and enhancing parental values, cognitive skills of parents (literacy, numeracy), raising household income, and parents' health knowledge. He posits that the linkage between mother's education and child health operate through mechanisms such as: health knowledge which is acquired through formal education—by directly teaching health related information; literacy and numeracy skills acquired through formal education, which help mothers in the diagnosis and treatment of children health problems. In addition, formal schooling exposes women to modern society, making them more receptive to modern medicine. Other studies have reported that education acts as a source of knowledge by providing literacy, information, and cognitive skills, as well as transforming people's attitudes by encourages the acceptance of modern ideas that enable people to relegate the traditional beliefs and authority.

2.7 Theoretic Framework

The centre for the theory of change (2013) defines Theory of Change is a specific and measurable description of a social change initiative that forms the basis for strategic planning, on-going decision-making and evaluation. The methodology used to create a Theory of

Change is also usually referred to a Theory of Change, or the Theory of Change approach or method. So, when you hear or say "Theory of Change", you may mean either the process or the result.

Every year 14 million girls are married before the age of 18. There is unprecedented recognition that child marriage infringes their rights and is a major setback to development. There is no single solution to ending this global problem, but thanks to the work of Girls Not Brides members, partners, governments and others, we are able to build an understanding of all that is necessary to achieve our ultimate vision: A world without child marriage where girls and women enjoy equal status with boys and men and are able to achieve their full potential in all aspects of their lives. Girls Not Brides has developed a 'Theory of Change on Child Marriage' to articulate what an effective response to child marriage entails.

The Theory of Change outlines the range of approaches needed, demonstrates how they intersect, and aims to provide a basis for identifying common indicators that could be used by diverse practitioners to monitor progress. The Theory of Change has been developed to facilitate greater partnership and collaboration among and across organisations, sectors and levels. It serves as a foundation to build consensus about actions needed to address child marriage and support married girls, in both the long and short term.

In this sense, the Theory of Change offers both a mirror and a target. Crucially, the Theory of Change demonstrates that there is no single solution to ending child marriage and that everyone has a role to play. Ultimately efforts to address child marriage must respond to local contexts and accordingly programmes and investments may take different forms. We hope that this Theory of Change will be a useful framework and tool for both governmental and non-governmental actors to draw from as they develop their own theories of change to respond to child marriage in their countries. It is intended both for those who are new to the issue, as well as those who work on it through one specific approach to see how their work forms part of a broader effort. The Theory of Change will remain an evolving document; feedback, updates and changes will be welcomed as the field evolves and we gain a better understanding of the effectiveness and interrelationship between different approaches. This brief outlines how the Theory of Change was developed and the insights that inform its structure and content (Girls not Brides nd,)

2.8 Conceptual Framework

The conceptual framework represents the relationship between independent variables, intervening and moderator variables, and dependent variable. Conceptual framework has therefore been developed from the reviewed literature and related theories.

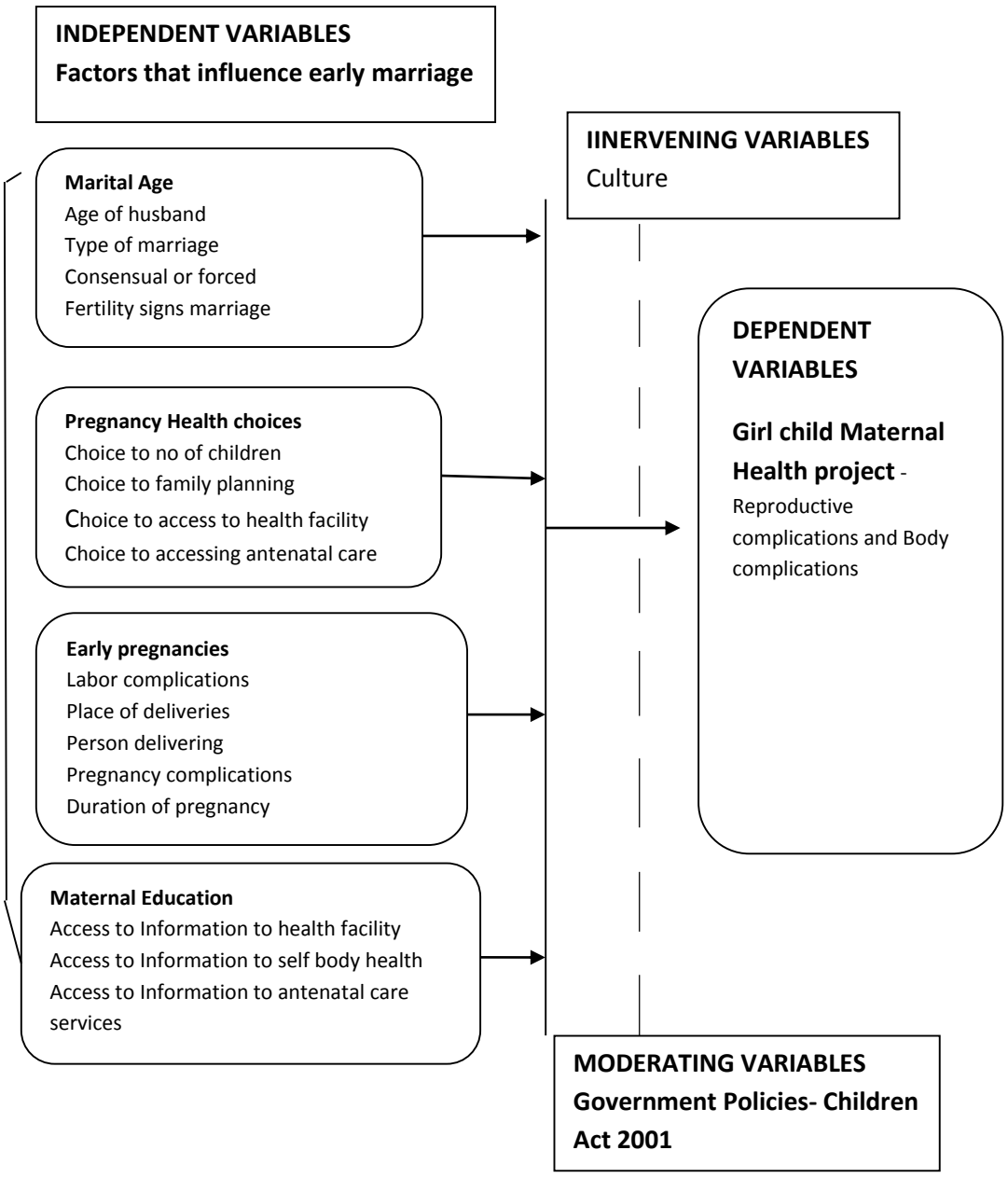

Fig. 2. Conceptual Framework

Conceptual framework has been developed from the reviewed literature and related theories. The independent variables include health choices, Age of marriage, health choices, early pregnancies and maternal education. The dependent variables examined is the outcome of the girl child maternal health.

2.9 Summary of literature review

This chapter dealt in length with the review of literature on child marriage and the influence it has on the girlchild's maternal health. The chapter also presents a conceptual framework that shows the relationship between early marriages in Maralal in Samburu County and its influence on the girl child's health.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter provides a discussion of the research methodology that was be used in this study. It gives detail to the research design used; the target population of interest; the sample size and technique; research instruments; data collection methods and analysis; and presentation techniques of the findings. It also explained the validity and reliability of the research instruments and ethical conditions that were considered.

3.2 Research Design

A research design is the plan aimed at fulfilling the objectives (Cooper and Schindler, 2000). This study aimed at examining the influence of child marriage on the girl chid's maternal health in Samburu County. Quantitative design will suffice in this situation..Quantitative research involves data collection, analysis and interpretation. It is mainly a statistical analysis method to solve the research problem, because data used in it, is mathematical and statistical form. Qualitative research is based on texts and images, pictures etc., Creswell (2003).

The researcher used descriptive survey as they describe characteristics associated with the subject population. According to Koul (1984) a descriptive study is useful in obtaining information concerning the current status of phenomena and describes what exists with respect to variables or conditions in a situation. The justification for using a descriptive design was that it enabled the researcher to collect in depth information about the population being studied. The descriptive design enabled the researcher to analytically explain findings based on the variables tested and hence enabled proper and succinct recommendations was provided.

3.3 Target Population

According to Mugenda & Mugenda (2003), the target population should have some observable characteristics, to which the study intends to generalize the results. Burns and Grove (2003) state that population includes all elements that meet certain criteria for inclusion in a study. Two types of population are target and accessible population. The targeted population of this study will be the women in the communities, schools administrators, health facilities, rescue centers and local leaders bringing a total of 125 repsondents. This is in accordance to Cooper

and Schindler (2000), where by a target population is the total collection of elements about which we wish to make inference.

3.4 Sample Size and Sample Technique

Sampling procedure is a systematic process of identifying individuals for a study to represent a larger group from which they are selected, Mugenda and Mugenda (2003).

3.4.1 Sample size

Kombo& Tromp (2006) defines sample as a finite part of a statistical population whose properties are studied to gain information about the whole population. A set of respondents selected from a large population of people for the purpose of survey can be called a sample. A reasonable sample, which can be dealt with effectively under the prevailing circumstances was selected. A sample of 69% of the targeted population was applied using purposive sampling. According to Gay (1983) as cited by Mugenda & Mugenda, (2003) suggests that for descriptive studies at least 10% -20% of the total population is adequate. Therefore 86 respondents formed the sample size of this study and has been calculated as shown in Table 3.1.

3.4.2 Sampling procedure

The research used purposive and simple random sampling in identifying respondents. Purposive sampling allows for handpicking of cases because they are informed or possess the required characteristics. Those identified named others with similar characteristics (Mugenda and Mugenda, 2003). These sampling methods were used in this study because the study focused on acquisition of in-depth information about early marriage in Maralal town. The town has schools, health centres, household, rescue centers and offices of local leaders.

Table 3.1 Sampling frame

Interviewers	**Target Population**	**Sample size**	**Percentage %**
Siguta Rescue centre administrators	10	5	50
Siguta rescue centre (rescued girls)	20	10	50
School administrators in 3 schools	20	15 (5 respondents per school)	75
3 Health centers Administrators	20	15 5 administrators per healthcentre	75
3 Women groups(individual women in the communities)	45	36 (12 women per group intervewed indivually)	80
Local leaders	10	5	50
Total	**125**	**86**	**69**

Source: Maralal Diocese Office

3.5 Research Instruments

The researcher used research instruments for both quantitative and qualitative collection of data. The data collection instruments consisted of questionnaires

Descriptive survey research design was used in this study which incorporated both qualitative and quantitative paradigms. Descriptive data will be collected and analyzed in order to provide answers to the research questions. Kothari (1985) recommends descriptive design as it allows the researcher to describe, record, analyze and report conditions that exist or existed. Quantitative research involves data collection, analysis and interpretation. It is mainly a statistical analysis method to solve the research problem, because data used in it, is mathematical and statistical form. Qualitative research is based on texts and images, pictures etc., Creswell (2003).

Both primary and secondary data was obtained from women, rescue centers, schools and health administrators as well as local leaders. The questionnaires consisted of both structured and unstructured questions. The secondary data was collected from reviews of books, magazines, websites and published reports. The questionnaire consisted of 4 sections; the first section had questions on the social demographic of the respondents, the marital age, pregnancy health choices, early pregnancies, maternal health and maternal education.The questionnaire addressed various respondents – women, rescue centers, schools and health administrators as well as local leaders.

3.5.1 Validity of the Instruments

Validity is concerned with the questions "Am I measuring what I intend to measure?" The problem of validity arises because measurement in the social sciences is, with very few exceptions, indirect (Nachmias and Nachmias, 1996). The researcher and the professionals checked how appropriate the content of the instrument is to the study; how comprehensive the content is in measuring all the constructs of the variable being measured.

3.5.2 Reliability of the Instruments

The researcher did a pre-test on the questionnaires to test reliability. Mugenda and Mugenda (1999) define reliability as a measure of the degree to which a research instrument yields consistent results or data after repeated trials. Split-half technique was used and aimed at determining the coefficient of internal consistency or reliability co-efficient. The research instrument was split into two subsets, one consisting of odd numbered questions and the other of even numbered questions. The score of all the odd and even numbered questions of responses in the pilot study was computed. According to Hunt, Tyrrell and Nicholson (2000), a correlation greater than 0.8 is described as strong, whereas a correlation less than 0.5 is described as weak.

3.6 Data Collection Procedure

Before collecting data, the researcher cleared with the University of Nairobi and then proceed to apply for a permit from the University. The researcher then proceeded to seek permission from Samburu Chief County for data collection in the sub villages. Quantitative data was collected at the sites using questionnaires within the sampled population.

Three research assistants (RAs) were recruited living within the area in case of language barriers and trained to assist in data collection. All research logistics needed by the RAs were the responsibility of the researcher during the course of the study

3.7 Data Analysis Technique

Data analysis entails categorizing, ordering, manipulating and summarizing of data to obtain answers to research questions. It is used to reduce raw data into intelligible and interpretable form using statistics. The data once collected was entered, checked, edited, cleaned, coded and put into back up data and organized accordingly. After editing the vital information was presented for analysis, categorization, ordering, manipulation and summarizing in view of the research questions using SPSS. After data analysis the descriptive statistics results was presented using percentage tables.

3.8 Ethical Considerations

Due consideration was accorded to ethical issues in the course of this study. Informed consent was sought from all the respondents after giving a detailed explanation of the study. The respondents were adequately made aware of voluntary participation and that the information collected was treated with utmost confidentiality and was only used for the purposes of this study. All the necessary authorization was obtained prior to conducting the study. The respondents were assured of anonymity of their identity.

3.9 Operationalization of variables

Operational definition is a description of a variable, term or object in terms of the specific process or set of validation tests used to determine its presence or quantity. Operational definition of a variable is the description of the operation that was used in measuring the variable.

Table 3.2 shows the operationalization of the independent and dependent variables that were used in the study

Objective	Independent variables	Indicators	Measurement	Scale	Data Collection Method	Approach of Data Analysis
To investigate the influence of marital age in early marriage on the girl child maternal health	Marital Age	Age when married Age of husband Type of marriage Consensual or forced Fertility signs marriage	9 -18years 13 – 22years (above) Concetual or forced Yes/ No	Norminal Norminal Nominal Nominal	Questionnaires	Correlational and descriptive statistics
To examine the influence of pregnancy health choices in early marriage on the girl child maternal health.	Health choices	Choice to no of children Choice to family planning Choice to reproctive health Choice to access health facility	Yes/No Yes/No Yes/No Yes/No Yes /No Yes/No	Norminal Norminal Norminal Norminal Norminal Norminal		

		Choice to accessing antenatal care				
To establish the influence of early pregnancy in early marriage on the girl child maternal health	Early pregnancy	Labor complications Place of deliveries Type of deilvery Pregnancy complications Duration of next pregnancy	Complicated/Induced / normal Hospital/ Home Natural/caecerean Yes/No 1-2 years	Norminal Nominal Norminal Nominal Nominal Ordinal	Questionnaires	Correlational and descriptive statistics
To examine the influence of maternal education in early marriage on the girl child's maternal health.	Maternal Education	Access to Information to health facility Access to Information to self body health Access to Information to	Yes/No Yes/No Yes/No Yes/No	Ordinal Norminal Norminal Nominal	Questionnaires	Correlational and descriptive statistics

		antenatal care services Information				

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1 Introduction

The focus of this chapter was to discuss the analysis and interpretation of the findings in line with the objectives of the study. The data that was obtained is presented in tabular form using percentages and frequencies. The chapter is further sub divided into sections that are pertinent to the subjects under study. The data was analyzed using quantitative means. The quantitative data was analysed by frequencies percentages and means using statistical package for social sciences (SPSS) while the. These were subsequently presented in tables.

4.2 Questionaire Return Rate

The data was collected from school, health, rescue centre administrators, local leaders and women in communities. Out of the 86 questionares all of them were filled and returned which was considered satisfactory for subsequent analysis. It was a reliable response rate for data analysis as Mugenda & Mugenda (2003) explain that any response above 60% is adequate for analysis. Based on the analysis, the response rate was high enough as shown in Table 4.2

Table 4.2. Presents rate of the respondents

Rate of Return	Frequency	Percentage
Returned by RA	86	100%
Not Returned	0	0%

4.3 Gender of the respondents

The study sought to determine the gender of the respondents amongs key informants. Women respondents were only interviewed as showon on table 4.3. The relevant results are presented in table 4.3

Table 4.3 Women in communities respondents

Variable	Frequency	Percent
Female	44	97.8
Invalid	1	2.2
Total	45	100

Table 4.3.1 Gender of the respondents amongst Key Informants

Variable	Frequency	Percent
Male	23	56.1
Female	18	43.9
Total	41	100

According to the findings, women respondents were 97.8% and we had one invalid questionnaire. Amongst key informants 56.1% of the respondents were male while 43.9% of the respondents were female. This was an indication that more men participated actively in responding to the issues of the girl child amongths the key informants targeted..

4.4 Age of respondents and education

Determining the age bracket of the respondents was important as it revealed their level of experience in dealing with the challenges of early marriage. Table 4.4 shows the age of respondents amongst the women in Maralal communities.

Table 4.4 Age of respondent among women in the communities

Variable	Frequency	Percent
<18 years	4	8.9
19-35 years	19	42.2
36-55 years	20	44.4
>56 years	2	4.4
Total	45	100

The findings revealed that 8.9% are below the age of 18 years, 42.2% are the ages between 19 – 35years, 44.4% of the women are between the ages 35 -55years years. Only 4.4% are above

56years. This shows the maturity and experience level of these women in regards to early marriages and that their response is subtsancial to this study.

Table 4.4.1 Education level of the respondents

The study indicated the education level of the respondents

Variable	Frequency	percent
None /didn't attend school	15	33
Primary level	24	53
Secondary level	5	11
Invalid	1	2
Total	**45**	**100**

The analysis indicated majority of the married young girls 53% have no education or stop their education at primary level. Those who did not attend school were 33% and those who reached secondary school were only 11%. There is need for alternative forms of education to enable girls acquire literacy and life skills necessary to enhance their capabilities to be able to support themselves and their children.

4.5 Marital age and it's influence on maternal health

The Tables shows the age the respondents got married and the normal age the women in Maralal communities get married.

4.5.1 Age respondents got married

The respondents were asked to state their age when they got married and this is shown on Table

Table 4.5.1. Age of women married in the communities

Variable	Frequency	Percent
9-12 years	9	20
13-15 years	15	33.3
16-18 years	5	11.1
18+ years	11	24.4
Not married	5	11.1
Total	45	88.9

Table 4.5.1.1 Key informants response on the age of married girls in the communities

Variable	Frequency	Percent
9-12 years	14	34.1
13-15years	16	39
16-18 years	6	14.6
18 years above	5	12.2
Total	41	100

The research shows the marital age of the responds.The women respondents between 9 – 12 years 20% were already married, 13- 15 years 33% were married, 16-18 years 11.1% were married and 24.4% were married above 18 years. Those who were not married were 11.1%. Key informants reaffirms that 34.1% of these young girls were married between 19 – 12 years of age, 39% were married between 13 – 15 years of age, 14.6 % were married betwwen 16 – 18 years of age and finally 12.2% were married above 18 years of age. Age is an important factor for safe motherhood because it is related to sexual desires and fertility. It is also related to various risk factors of pregnancy, which affect health care seeking behavior of women.(United Nations, 2005). When we talk about the marital age of the girl child, this means once the girl is married she has no choice but to abide by the rules of marriage. This means she has to have an intimate relationship with her spouse and this in most cases mean forceful sexual intercourse

4.5.2 Age of husband

The tables below shows the age of the men when married in Maralal community.

Table 4.5.2 Women in the communities. Age of husband when married

Variable	Frequency	Percent
18-21 years	4	8.9
22years+	36	80
Not married	5	11.1
Total	45	100

Table 4.5.2.1 Key informants; Age of husbands when married.

Variable	Frequency	Percent
18-21 years	3	7.3
22years+	38	92.7
Total	41	100

The findings showed that amongst the women respondents 8.9% were married to husbands were between 18 – 21 years of age and majority 80% were married to husbands above 22 years of age. Those not married were 11%. Key informants affirms that the young girls 7.3% were married to husbands aged between 18-21 years and 92.7% were married to husbands above 22 years. The research shows that young girls are married to older men at a very young age In the study by Isis – WICC, (2011), child marriage has become a common feature in most communities in Africa. This means that young girls who have not attained the minimum age for marriage of 18 years are married off; sometimes to men who are fit to be called their fathers or their grandfathers.

4.5.3 Consensual or planned marriage

The table below shows how girls are forced into marriage.

Table 4.5.3 Women in Communities- planned or consensual marriage

Variable	Frequency	Percent
Planned	25	55.6
Consensual	15	33.3
Not married	5	11.1
Total	45	100

Table 4.5.3.1 Key informants; planned or consensualmarriage?

Variable	Frequency	Percent
Planned	33	80.5
Consensual	8	19.5
Total	41	100

Acording to the women respondents above only 55.6% of marriages were planned and 33.3% were consentual. Key informants aasertify that 80.5% were planned marriages and 19.5% were concentual. The analysis shows that in Maralal communities most marriages are forced or planned without the girl child's consent. According to UNICEF (2001), Most young girls are are forced into marriage at a very early age. Others are simply too young to make an informed decision about their marriage partner or about the implications of marriage itself. They may have given what passes for 'consent' in the eyes of custom or the law, but in reality, consent to their binding union has been made by others on their behalf. Sometimes what the girl child wants is not of importance to the family.

4.6 Early Pregnancy Health choices and it's influence on maternal health

The study sought to understand the pregnancy health choice of a woman and young girls. A woman's social, economic and other opportunities in life are enhanced by being able to make fertility and other health choices.

4.6.1 Choice of number of children

The table showed whether the respondents had a choice in deciding on the number of children to have.

Table 4.6.1 Choice in the number of children women have in the community

Variable	Frequency	Percent
Yes	19	42.2
No	22	48.9
N/A	4	8.9
Total	45	100

Table 4.6.1.1 Concent to have children amongst the women in the communities

Variable	Frequency	Percent
Yes	31	68.1
No	10	25
N/A	4	8.9
Total	45	100

Table 4.6.1.2 Key Informants- choice in the number of children they have

Variable	Frequency	Percent
Yes	4	9.8
No	37	90.2
Total	41	100

The findings revealed that amongst women respondents show that 42.2% had a choice in the number of children to have and 48.9% had no choice at all. Those who had no childern were 8.9%. Key informants findings showes that 9.8% had a choice on the number of children to have and 90.2% had no choice. The results from the women in communities and key informants show that the lack of choice of the girl child in deciding on the number of children to have influences her maternal health. According to the research done by Pathfinder (2006), early marriage increases the span of a woman's reproductive period, and those who marry earlier are more likely to be forced to have a greater number of children than others.

4.6.3 Choice of family planning

The tables below presents how girls do not have a choice in using family planning methods.

Table 4.6.2 Women in communities; choice of using family planning

Variable	Frequency	Percent
Yes	19	42.2
No	22	48.9
N/A	4	8.9
Total	45	100

Table 4.6.2.1 Key Informants - choice of using family planning

Variable	Frequency	Percent
Yes	6	14.6
No	30	73.2
If yes must ask for permission	5	12.2
Total	41	100

The findings revealed that amongst women respondents show that 42.2% had a choice in using family planning and 48.9% had no choice at all. Those who did not respond were 8.9%. Key informants affirms that 14.6% had a choice of using family planning and 73.2% had no choice of using family planning.The results showed that once married, girls are likely to feel, and in many cases are, powerless to refuse sex. Pathfinder (2006) also asserts that these young girls have less ability to make decisions on matters related to reproductive health, such as the use of contraceptives and rights over sexuality (the ability to say "No" when asked for sex by husbands). Thus, early marrying women have less chance of spacing and/or avoiding unwanted pregnancy.

4.6.3 Choice to reproductive health

Table 4.6.3 shows choices of women over their reproductive health

Table 4.6.3 Women in communities- Do you have a choice on your reproductive health

Variable	Frequency	Percent
Yes	10	22.2
No	32	71.1
N/A	3	6.7
Total	45	93.3

Table. 4.6.3.1 Key informants; choice on your reproductive health

Variable	Frequency	Percent
Yes	6	14.6
No	30	73.2
If yes must ask for permission	5	12.2
Total	41	100

Women respondents findings showed that 22.2% had a choice over their reproductive health,71.1% had no choice over their bodies and 6.7% were invalid responses. The key informants findings showed that 14.6% had a choice ober their reproductive health and 73.2% had no choice.Early marriage increases the span of a woman's reproductive period, and those who marry earlier are more likely to have a greater number of children than others. The findings above clearly stipulates the girl child has no right to her reproductive health. (WHO, 2008) avows that women's consent for childbearing is an important factor in the physiological and emotional wellbeing of both mother and child. However they don't have that choice to make as it is made by their husbands.

4.6.4 Choice to health facility

Table 4.6.5 presents choice of the girl child in accessing health facilities.

Table 4.6.4 choice to health services

Variable	Frequency	Percent
No	16	35.6
Yes	29	64.4
Total	45	100

The analysis revealed that 64.4% has no choice to health services and 35.6% had a choice to health care.Most girls when they get married at an early age they do not have a choice or right to access to health facilities freely**.** According to Girls not brides (2012), Due to social isolation, poverty, and other pressures, many married girls have limited contact with formal health services before or after pregnancy.

4.6.5 Choice to antenatal services.

The table shows how pregnant young mothers have no information to antenatal care.

Table 4.6.6 Choice to antenatal care services

Variable	Frequency	Percent
Yes	25	55.6
No	16	35.6
N/A	3	6.7
Total	45	100

Table 4.6.5.1 Permission to access antenatal services

Variable	Frequency	Percent
Mother in law	2	4.4
Husband	27	60
N/A	16	35.6
Total	29	64.4

From the analysis only 55.6% have access to ANC services and 35.6% don't have that choice in accessing them. For those who are lucky enough to access the ANC they have to ask permission from their mother in law which is 4.4% or from their husband 60%. Those who did not respond to were 35.6%. Maralal is a rural town where access to antenatal services for young girls married early is very difficult. The girl child is not considered as in important asset in the community. She is seen as a property owned. To seek good antenatal care majority (60%) must ask for permission for their husbands. Lack of antenatal services influences their maternal health

4.6 Influence of early pregnancies on the maternal health of the girl child.

Child brides are likely to become pregnant at an early age and there is a strong correlation between the age of a mother and maternal mortality. Girl's age's l0-14 are five times more likely to die in pregnancy or childbirth than women aged 20-24 and girls aged 15-19 are twice as likely to die. The tables below shows how early pregnancies influences the maternal health of the girl child. Early Pregnancy was the major push factor leading to child marriage.

4.6.1 Age of pregnancy

The study clearly shows the age in which young married girls bear children. According to Facts for life global (fourth editon) every year over 500,000 women die from pregnancy and childbirth complications. For every woman who dies, approximately 20 more develop infections and severe disabling problems – adding up to more than 10 million women affected each year.

Table 4.6.1 Women in communities - Age when when pregnant

Variable	Frequency	Percent
9-12years	5	11.1
13-15years	19	42.2
16-18years	6	13.3
18+years	12	26.7
N/A	3	6.7
Total	45	100

Fact of life global also asserts that the younger the mother is, the greater the risk to her and her baby. The risk of maternal death related to pregnancy and childbirth for adolescent girls between 15 and 19 years of age accounts for some 70,000 deaths each year. For adolescents under 15 years of age these risks increase substantially. Girls who give birth before age 15 are five times more likely to die in childbirth than women in their twenties.

Table 4.7.1.1 Age when you had the second child

Variable	Frequency	Percent
9-12years	1	2.2
13-15years	8	17.8

16-18years	13	28.9
18+years	16	35.6
N/A	7	15.6

Table 4.7.1.2 Key informants – How old are girls in your communities when they get pregnant

Variable	Frequency	Percent
9-12years	6	14.6
13-15years	25	61
16-18years	8	19.5
18+ years	2	4.9
Total	41	100

Table 4.7.1.3 Key informants;Age of the girls when they have their second child

Variable	Frequency	Percent
9-12years	1	2.4
13-15years	13	31.7
16-18years	18	43.9
18+ years	9	22
Total	41	100

The findings indicate that majority of the respondents 66.6% got pregnant and had their first child below the age of 18 years and 60% had their second child still below 18years. Key informants re affirms that 95.1% of the women are pregnant when they are below 18 years of age, In addition to that, 78% of the women in the communities have their second born still

below the age of 18 years The spacing is very little and this clearly bring out health implications and thus influences their maternal health at a very young age. According to UNFPA (2012) Married girls are often under pressure to become pregnant immediately or soon after marriage, although they are still children themselves and know little about sex or reproduction. UNICEF (2005) adds that It is common sense to assume that girls who marry before 18 will usually have more children.

4.7.2 Nature of pregnancy

The table below presents the nature of their girl child nature of pregnancies

Table 4.7.2 Women in communities; Nature of pregnancy

Variable	Frequency	Percent
Complicated	27	65.9
To term	14	34.1
Total	41	100

The findings revealed that 65.9% of women experience complicated pregnancy and only 34.1% are able to have the normal pregnancy to term.In the analysis above most girls who are married early tend to not have problems with their pregnancy. Either they don't reach the full term of the pregnancy or some miscarry and others have complicated pregnancies.UNICEF (2005) avows that since girls who are married young have a large number of child bearing years, they are more prone to miscarriage, infant death, malnutrition, cervical cancer, sterility, and maternal death.

4.7.3 Labor

The table shows that the girl child have labor complications when they get pregnant at an early age which thus influences their maternal health

Table 4.7.3. Women in communities; Nature of labor

Normal	Frequency	Percent
Normal	9	20
Obstructed	14	31.1
Complicated	19	42.2
N/A	2	6.7
Total	45	100

Table 4.7.3.1 Key respondents – Nature of their labor.

Variable	Frequency	Percent
Normal	6	14.6
Obstructed	12	29.3
Complicated	23	56.1
Total	41	100

Women repondents findings indicated that 20% had normal labor, 31.1 % had obstructed labor and 42.2% had complicated labor. According to key informants finds above 14.6% had normal labor, 29.3% had obstructed labor and 56.1% had complicated labor. The findings show that at a young age below 16 years of age a girl's body has not developed fully and her body may strain under the effort of child birth, which can result in obstructed labor and obstetric fistula. A pregnancy too early in life before a girl's body is fully mature is a major risk to both mother and baby. Complications of pregnancy and childbirth are the main causes of death among adolescent girls ages 15-18 years old in developing countries. Among the disabilities associated with early childbirth is obstetric fistula, an injury which leaves girls in constant pain, vulnerable to infection, incontinent, and often shunned by their husbands, families and communities (UNFPA 2012)

4.7.4 Place and Nature of delivery

The tables indicates the nature place of delivery and the person who delivers. It also shows the people who helped with the delivery process,

Table 4.7.4 Women in communities; Place of delivery

Variable	Frequency	Percent
Hospital	19	42.2
At home	19	42.2
Outside homestead	2	4.4
Other	2	4.4
Total	42	93.3

Table 4.7.4.1 Nature of delivery

Variable	Frequency	Percent
Natural	34	75.6
Caesarean section	8	17.8
N/A	3	6.7
Total	45	100

Table 4.7.4.2 Who helps in the delivery process

Variable	Frequency	Percent
Doctor	8	17.8
Midwives	18	40
Traditionalbirth attendants	15	33.3
Relatives	1	2.2
N/A	3	6.7
Total	45	100

Table 4.7.4.3 Key Informants; Where do they deliver the baby in most cases?

Variable	Frequency	Percent
Hospital	1	2.4
At home	38	92.7
Outside homestead	2	4.9
Total	41	100

Table 4.7.4.4 Who helps in the delivery

Variable	Frequency	Percent
Midwives	5	12.2
Traditional birth attendants	33	80.5
Relative	3	7.3
Total	41	100

According to the analysis above 75.6% of women have natural deliveries and 17.8% have complicated deliveries.6.7% was in valid in this section. However only 17.8% were assisted by a doctor in the delivery process, 40% were assisted by midwives, 33.3% by traditional birth attendants and only 2.2% by relatives. There rest. 6.7% were invalid. From the analysis young mothers are especially vulnerable to fistulae – relentless pressure from baby's skull can damage the birth canal causing breakages in the wall. These include the problem of giving birth when the pelvis and birth canal are still under-developed which leads to an increased risk of complications during delivery including protracted labor. (UNFPA 2004). Not giving birth in the hospital also brings about maternal health problems. You may find Traditional birth attendants who are not knowledgeable about the birth process and of anything happens this may lead to various maternal health problems.

4.8 Influence of maternal Education on the girl child's health

Education is an important issue in a woman's life because it helps her lead a better life. Through education, she can also acquire knowledge regarding health care for safe motherhood. Most child brides in Maralal community are not educated of the general wellbeing of their maternal health because they have not attended school. The study below shows how these young girls lack access to basic maternal education in regards to their health.

4.8.1 Access to Information to health facility

The table below presents how young child brides lack information in relation to the health facilities

Table 4.8.1 Women in Communities; information on health services in your area

Variable	Frequency	Percent
Yes	9	20
No	36	80
Total	45	100

Table 4.8.1.1 Key informants; information on health care services in the area

Variable	Frequency	Percent
Yes	17	41.5
No	24	58.5
Total	41	100

From the findings 20% had education or knowledge on health and 80% had whatsoever no knowledge on health. Key respondents findings show that 41.5% had information on health and only 58.5% lacked information on health. WHO (2012), young age, coupled with limited access to health services, a lack of reproductive health information, cultural pressures, and little control or autonomy for decision-making, leads to high-risk pregnancies.

4.8.2 Access to information on family planning

Family planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility. A woman's ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy (WHO 2012). The tables below shows knowledge on family planning among these girls.

Table 4.8.2 Women in communities Access to family planning

Variable	Frequency	Percent
Yes	10	22.2
No	35	77.8
Total	45	100

Table 4.8.2.1 If yes which ones do you know

Variable	Frequency	Percent
Modern contaceptives	1	2.2
Traditional contaceptives	37	82.2
N/A	7	15.6
Total	45	100

From the findings, most girls especially married at a very young age don't have any information on family planning and those who have little knowledge on family planning only know the traditional method. Only 22.2% have information on family planning and 77.8% have no informantion on family planning. Those who have information only 2.2% know of modern contraceptives and 82.2% have knowledge on traditional contraceptives. 15.65 were invalid.Family planning is key factor in relation to their maternal health. Child marriage encourages the initiation of sexual activity at an age when girls know little about their bodies, their sexual and reproductive health, or their right to access contraception. Married girls are hard to reach with family planning services and are often unaware that such services exist. This is especially the case for younger girls who are not in school and have virtually no access to sexuality education. (Girls not Brides 2013)

4.8.3 Access to health information on girl child's body

The tables' presents how these girls are not aware or informed of the changes in their body.

Table 4.8.3 Women in communities: Educated about your body and the changes in the body

Variable	Frequency	Percent
Yes	9	20
No	36	80
Total	45	100

Table 4.8.3.1 Key Informants; educated about the change in their bodies.

Variable	Frequency	Percent
Yes	15	36.6
No	26	63.4
Total	41	100

The analysis showed that only 20% were educated about the changes in their body and 80% were not educated. Key informants findings showed that 36.6% of the women in their communities were educated about their body and only 63.4% have been educated on the changes in their bodies.The finding revealed that once these girls are married, they lose control of their body. Most girls are married off at a very young age when their bodies are not fully developed. They experience body changes which they should have been educated about. Premature marriage deprives them of the opportunity from personal development as well as their rights to full reproductive health (RH) and wellbeing, education, and participation in civic life (Saxena , 1999).

4.8.4 Access to Information on antenatal care services

The tables below shows the lack of education of teenage married girls on antenatal and prenatal care services

Table 4.8.3 Women in communities; Have you been educated or informed on the importance of antenatal and prenatal care

Variable	Frequency	Percent
Yes	12	26.7
No	33	73.3
Total	45	100

Table 4.8.3.1 Key Informants; Have they been educated or informed on the importance of antenatal and prenatal care

Variable	Frequency	Percent
Yes	21	51.2
No	20	48.8
Total	41	100

The results indicated that most pregnant women do not receive antenatal care. Only 26.7% were educated on ANC, and 73.3% had no education on ANC. Key informants findings above shows that only 51.2% had knowledge on ANC and 48.8% has no information on ANC.The study shows that the teenage mothers often do not use prenatal care even when these services are available. Consequently, these young mothers are exposed to a myriad of health risks, such as miscarriages and still births and low birth weight. Glewww (1999) avows that lack of access to modern health care services has great impact on increasing maternal death. Most pregnant women do not receive antenatal care; deliver without the assistance of trained health workers

4.9 Maternal Health of the girl child

It is estimated that 7,700 women die each year in Kenya from pregnancy related complications. This translates to 21 women dying each day or one woman every hour from preventable causes, making the need to address safe motherhood a human rights imperative. (O. Ida 2014). The tables below shows the influence of early marriages on the maternal health of the girl child.

4.9.1 Physical complications such as deformities

The table below shows the physical implications the girl child health.

Table 4.9.1 Develop of any deformities

Variable	Frequency	Percent
Yes	28	68.3
No	13	31.7
Total	41	100

The findings revealed that 68.3% have had deformities because of early marriage and child deliveries and 13% didn't have any deformities.When these young girls marry early, they get pregnant instantly and they give birth immediately at an early age. According to Nour (2009) Girls between the ages of 10 and 14 years are 5 to 7 times more likely to die in childbirth and girls between the ages of 15 and 19 years are twice as likely. High death rates are secondary to eclampsia, postpartum hemorrhage Since their bodies have not fully developed, due to forceful sexual relations and early child birth 68.3% end up having deformities. This influences their maternal health.

4.9.3 Bleeding during pregnancy and after birth

The respondents were asked whether they bled during pregnancy and after birth.

Table 4.9.3 bleeding during and after birth

Variable	Frequency	Percent
Yes	32	78
No	9	22
Total	41	100

Table 4.9.3.1 complications during pregnancy like walking, sitting back aches, bleeding

Variable	Frequency	Percent
Yes	37	90.2
No	4	9.8
Total	41	100

From the study it was established 90.2% of women in early marriages experience physical complicatiibs during pregnancy like walking, bleadding etc, and 9.8% only don't experience any problems. A large proportion of reproductive and sexual health concerns of adolescent girls and women root from early marriage and early pregnancy. In the context of reproductive health girl spouses face well-acknowledged risks. These include the problem of giving birth when the pelvis and birth canal are still under-developed which leads to an increased risk of complications during delivery including protracted labor. This may cause bleeding during pregnancy and after birth. (UNFPA 2004)

CHAPTER FIVE

SUMMARY OF FINDINGS, DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1. Introduction

This chapter summarizes the findings, discussions, conclusions and recommendations based on the analysis in chapter four. It also outlines the contribution to the body of knowledge and suggestions for further research.

5.2 Summary of Findings

This section provides a summary of the findings as presented in chapter four of the study. In reference to demographic characteristic, the study sought to establish the respondents' influence of early marriage on their maternal health. The findings indicated that 97.8% of the respondents were female and 2.2% were men which enabled the research to attain its objectives, among the key informants who were the health administrators, local leaders and school administrators 56.1% were men and 43.9% were women.

Majority of the Women respondents (97%) were between the ages of 13-18years years. The Key informants were between the ages above 18 years. The study shows that 64.5% of the women respondents were married below the age of 18years

5.2.1 influence of Marital Age on the girl child's maternal health

The first objective of the study to investigate the influence of marital age in early marriage on the girl child maternal health in Samburu County. The study shows that 64.5% of the women respondents were married below the age of 18years. 60% responded that the nature of teir marriage was in a polygamous set up. Further to that this young girls 80% responded to have been married to husbands who were much older than them. 45% were forced to have children immediately they got married. This clearly shows that marital age plays a key factor on the girl child's maternal health.

5.2.2 Influence of Early Pregnancy Health Choices on the girl child's maternal health

Based on objective two which sought to examine the influence of pregnancy health choices in early marriage on the girl child maternal health. 68.9% of the respondents had no choice of using family planning as well as the number of children to have.64.4% indicated that they had to ask for permission to go the health facilities from their husband. Key respondents strongly

validated that the young girls had no choice over the number of children they should have, when they should have them, they had no choice over their reproductive body. They had no free will to go to the health facilities whenever needed and they wish to go. Also they have no choice on if they can use family planning methods. Having no right to one's health influences the maternal health of the girl child.

5.2.3 Influence of Early pregnancies on the girl child's maternal health

In reference to objective three which sought to establish the influence of early pregnancy in early marriage on the girl child maternal health. 66.6% of the respondents indicated that they had their first child when they were below 18 years of age. Key informants respondents stated that 79% of the young married girls have their second child still below 18 years of age. They added that 65.9% of these young girls have complicated pregnancies which therefore leads to complicated labor and 95% give birth to children at home. These usually brings about health complications such as reproductive and physical issues later that affects the girl child maternal health.

5.2.4 Influence of Maternal Education on the girl child's maternal health

Finally, regarding objective four which sought to examine the influence of maternal education on the girl child's maternal health. 73.3 % have not been educated on antenatal care, 80% have not been educated about the changes that happen or occur in their bodies now that they are married and having children. 56.1 % have not been educated on what family planning is. Knowledge on family planning is very key to them as they will be able to control the number of children they give birth to as well the spread and infection of various diseases.

5.3 Discussions

For most women in the developing world the luck of regular access to modern health services greatly contributes to the increased morbidity and mortality. Most mothers receive insufficient family planning advice and ante natal care or none at all and deliver without access to skilled obstetrical care when complications develop.

The purpose of ANC is to care for pregnant mothers and to have all births attended by trained health workers, and to identify pregnancies where risk is high and provide special care for the mother and the infant. There is a large body of evidence from routine statistics and special to suggest that women who have received prenatal care experience lower rates of maternal mortality.

Ante natal care can also play a role in identifying danger signs or predicting complications around delivery by screening for risk factors and arranging for appropriate delivery care when indicated. Risk assessment has proven most useful in the prediction of obstructed or prolonged labour based on height and previous poor obstetric history (for example, caesarean section, still birth). A history of previous postpartum haemorrhage or retained placenta may be indicative of a woman at risk of postpartum haemorrhage.

It is, however, difficult to ensure cleanliness in all deliveries, particularly where access to clean water is limited. Educating trained birth attendants, women, their families, and community health workers to recognize the early signs of delivery problems including sepsis is a very important activity to save the life of the mother and the new born.Family planning can reduce maternal deaths from all causes, by reducing the fertility rate, and especially, unwanted pregnancies.

Minimizing vaginal examinations and ensuring clean delivery practices can prevent sepsis at delivery. The latter can be promoted through education of women, training of trained birth attendants and other health care staff and provision of adequate equipment and supplies. Early detection of puerperal sepsis depends on careful postpartum visit of women at home.

It is believed that maternal education enhances mothers‟ utilization of health Services, better hygienic practices and the ability to provide adequate health Care. It was however observed that the odds of developing complication at childbirth reduced by the level of education attainment. This is likely to be related to the knowledge and skills education imparts to the mother. This finding is supported by Gebremariam (2005) and Negussie et al (2003) who reported that education had strong and significant association with service utilization and hence favourable pregnancy outcomes.

5.4 Conclusions

From the results that we have seen above in chapter four, we can conclude that child marriage is a global issue that needs to be addressed and it requires support and attention from the government and government institutions, private sector, non- governmental institutions as well as the community as a whole. While the problem of child marriage is recognized globally, because it is so intricately connected with unique socio-cultural contexts, it requires complex and localized solutions. In Maralal town it was evident that almost every girl child had been married between the ages 12- 16 years (53.3%) , 75.6% had an early pregnancy

between the ages 9- 15 years.We need to take it into our hands to fight girl child marriages if we want to attain the recently refurbished sustainable development goals with special focus on goal number 3, 4 and 5.

It is without say that child marriages can not only have an impact on maternal health but its effects also has a negative impact on the psychological wellbeing of these girls who have been forced into marriages, denied the chance to go to school and have the freedom of making their own health and body choices. Further still, child marriage has negative implications on young mothers' psychological, reproductive and gynaecological health and exposes them to HIV infection. It is however unfortunate that this vice has been embraced by the community, parents and local leaders. Child marriage has been normalized under the disguise that it is an old traditional practice. Therefore the local and national government needs to form new strategies as well as support already in place efforts by individuals, organizations and institutions in cubing the vice. Child marriage is one of the worst forms of human rights violations of the girl child and a major detriment to the empowerment of women. In Maralal community it was evident that most of the young girls below 18 years of age had an early pregnancy, got married at an early age.

Child marriage has had devastating effects, not only to individual survivors but to whole communities. They include high levels of pregnancy complications. Lack of maternal education, lack of having one's own pregnancy choices which has greatly influenced their maternal health.

Further still, child marriage has negative implications on young mothers' psychological, reproductive and gynaecological health and exposes them to various health implications. It is however unfortunate that this vice has been embraced by the community, parents and local leaders. Child marriage has been normalized under the disguise that it is an old traditional practice.

From the development perspective, child marriage is a major public health concern and one of the underlying factors for underdevelopment.

Based on objective one, the study concluded that the marital age of the girl child , the younger the girl gets married the more complications her body faces. Once one is married the right to access many things is usually gone as one becomes a wife and a mother. This objective can be

concluded that women who marry early will have, on average, a longer period of exposure to the risk of pregnancy, often leading to higher completed fertility..

In reference to objective two, the study concluded that lack of not having choices in one's life especially when it comes to health and the girl child body may l make the girls especially vulnerable to HIV and other sexually transmitted infections. At its worst, child marriage can be tantamount to bonded labour or enslavement. It can be a sentence to regular exposure to domestic or sexual violence, and a pathway to commercial exploitation.

Regarding objective three, the study concluded that early pregnancies in most cases leads to complicated pregnancies, complicated labor, frequent bleeding, early deliveries and development of deformities and diseases such as fistula which influences the maternal health of the girl child.

On objective four, it was concluded that education is an important factor in a woman's life because it helps her lead a better life.Lack of maternal education affects the maternal health knowledge of the girl child, it affects the mother's ability to be able to learn about causation, prevention, recognition, and treatment of disease. It is through education we can break tradition and embrace modern practises.

5.5 Recommendations

The following recommendations were made in line with the findings of this study:

1. Influence partner governments to improve enforcement of international human rights instruments frameworks - in particular the African Charter on the Rights and Welfare of the Child.
2. Specialist services will be needed to address the health specific concerns of girls and women, for example specialist care for fistula sufferers
3. Advocate for dialogue around the issue of early and forced marriage in order to be understood in relation to gender inequality education and violence against women and girls, and come up with Interventions, which address complex and negative socio-cultural norms, attitudes and behaviors that will work to tackle early and forced marriage and this should be built on a foundation of support for girls' education.
4. Awareness-raising and education should be prioritized to inform communities on national laws on the legal minimum age of 18 years; marriage, the rights of women and children Invest in strengthening the evidence base on the relationship between early and forced marriage and girls' education and the achievement of the sustainable

Development Goals and the collection of age and sex disaggregated data. In particular, fund research into the role of education in preventing or delaying early and forced marriage. Ensure early and forced marriage interventions are included in planned piloting of new approaches to prevent violence against women and girls.

5. Leaders especially at community level should be availed specialized training to enable them appreciate their roles as change agents and prioritise service for development.

5.6 Suggestions for Further Research

The following directions for future research in Project Planning and Management were recommended:

1. Early marriages and social cultural practices.
2. Determinants of maternal health and child care in Arid and Semi-arid areas in Kenya.
3. Influence of policy formulation on legislation on violence against women and girls. Develop training for law enforcement Agencies on gender equality and human rights.

5.7 Contribution to the Body of Knowledge

This study contributes to the existing body of knowledge by offering a deeper insight to the challenges facing young girls, teenagers, child brides in Samburu County, Kenya. Most researchers argue that culture is the main obstacle facing the process of ending child marriage. In contrast, this study has established that the right of making one's choice in life, having a voice on what you want and what you don't want is a great hinder towards early marriages and maternal health.

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APPENDICES

Appendix I: specimen letter of introduction to the respondents

NIVEA LUCIA IKUTWA

DEPARTMENT OF EXTRA MURAL STUDIES

SCHOOL OF DISTANCE AND CONTINUING EDUCATION

UNIVERSITY OF NAIROBI

P.O BOX 30197-00100, G.P.O, NAIROBI

TEL: 0720853070; niv.ikutwa@yahoo.com

SUBJECT: MASTER OF ARTS IN PROJECT PLANNING AND MANAGEMENT RESEARCH PROJECT

Dear respondent,

THE INFLUENCE OF EARLY MARRIAGE ON THE GIRL CHILD'S MATERNAL HEALTH: A CASE OF MARALAL, SAMBURU KENYA

Dear Sir/Madam,

I am a final year MA Student carrying out an academic research for the purpose of examination leading to the award of a degree of Master of Arts in Project Planning and Management.

The purpose of this letter is to request you to provide the required information as per the questionnaires and interview guides provided. Kindly be as honest and as thorough as possible. The information you provide will be considered as confidential and will only be used for the purpose of my examination only.

Thanking you in advance for your cooperation.

Yours faithfully

Nivea Lucia Ikutwa

L50/82832/2012

Appendix II: Letter of Introduction to Diocese of Maralal.

18th September 2015

Director
Diocese of Maralal
P.O Box 350
Maralal, Samburu
Kenya

Dear Sir/Madam,

I am a Master of Arts in Project Planning and Management student at The University of Nairobi Kenya. I am currently undertaking a Research Project on: *'Factors influencing early marriage on the girl child's maternal health projects. A case in Maralal Town, Samburu Coutny, Kenya'* as a partial fulfillment for the requirement for an award of a Masters of Arts degree in Project Planning and Management.

A questionnaire will be used to gather relevant information to address the research objectives. The purpose of writing to you is to kindly request you to grant me permission to administer the research questionnaire to sampled respondents. Please note that the study will be conducted as an academic research and the information provided will be treated in strict confidence .Strict ethical principles will be observed to ensure confidentiality and the study outcomes and reports will not include reference to any individuals. Your acceptance will be highly appreciated.

Yours sincerely,

Nivea Lucia Ikutwa

Appendix III: Research Questionnaire

Kindly answer the following questions. The researcher would like to assure you that the information gathered will be kept confidential and used strictly for the purpose of this research only. Do not write your name anywhere in this paper. However, the usefulness of the information to the researcher will solely depend on your honesty.

INFLUENCE OF EARLY MARRIAGE ON THE GIRL CHILD'S MATERNAL HEALTH: A CASE OF MARALAL, SAMBURU KENYA

1. SOCIAL DEMOGRAPHIC INFORMATION

NO.	Questions & Filters	CODING CATEGORIES	Response
01	Sex of respondent	Male .....1 Female 2	
02	Age of respondent **[single response]**	≤ 18 years .....1 19 – 35 years .....2 36 – 55 years .....3 ≥ 56 years 4	
03	Education level of respondent? **[single response]**	None /didn't attend school .....1 Primary level .....2 Secondary level .....3 Tertiary level .....4 Above secondary level .....5 Other (specify _____6	
04	Occupation	School Administrator……..1 Health administrator…….2 Local leader/stakeholder……..…3 Rescue centre administrator…….4	

Women in communities, rescued girls

No.	A. Marriage Age			Response
1.	Are you married?	Yes……..	1	
		No……	2	
2.	If yes how old were you when you got married	9-12years……	1	
		13-15years…….	2	
		16-18 years……	3	
		18+ years……	4	
3.	How old was your husband when you got married?	13-15years……	1	
		16-18 years……	2	
		18- 21 years……..	3	
		22years+……..	4	
4.	Were you pressured to have children immediately after you got married?	Yes…….	1	
		No……..	2	
5.	Was your marriage planned or consensual?	Planned…….	1	
		Consensual……..	2	

	B. Pregnancy Health choices			Response
1.	Do you have the choice of deciding on the number of children?	Yes……..	1	
		No……..	2	
2.	Do you have a choice of using family planning?	Yes……	1	
		No……	2	
		If yes Must ask for permission..	3	

3.	Do you have a choice on your reproductive health?	Yes…… No……	1 2	
4.	Do you ask for permission in accessing the antenatal care services?	Yes …… No……	1 2	
5.	If yes from who do you ask permission from	Mother in law…… Husband…… Relatives…….. Other…….	1 2 3 4	
6.	a) Do you get consent on when to get pregnant?	Yes…… No……	1 2	
	b)If yes from who	Husband…… Mother in law…….. Relatives……..	1 2 3	
7.	Do you ask for permission to go to the health facility?	Yes…… No…….	1 2	

	C. Early Pregnancy			Responses
1.	a)Do you have children	Yes…… No……	1 2	
	b) If Yes how many	One …… Two……. Three+…….	1 2 3	
2.	How old were you when you got pregnant?	9-12years…… 13-15years……. 16-18 years …….. 18+years…….	1 2 3 4	

3.	Age when you had the second child	9-12years…… 13-15years……. 16-18 years …….. 18+ years…….	1 2 3 4	
4.	How was your pregnancy?	Complicated…… To term…….. Miscarried……..	1 2 3	
5.	Where did you deliver your baby?	Hospital…… At home…….. Outside homestead…… Other……	1 2 3 4	
6.	Nature of delivery	Natural..... Caesarean section.....	1 2	
7.	Who helped in the delivery process	Doctor…… Midwives…… Traditional birth attendants…… Relatives……	1 2 3 4	
8.	Did you have any complications during pregnancy like walking, sitting back aches, bleeding	Yes…… No……	1 2	
9.	How was your labor	Normal…… Obstructed…… Complicated……	1 2 3	

	D. Maternal Education			**Responses**
1.	Do you have any information on health services in your area?	Yes…… No……..	1 2	
2.	Have you been informed/educated on what family planning is?	Yes…….. No……	1 2	
3.	If yes which ones do you know	Modern Contraceptives…… Traditional contraceptives……	1 2	

4.	Have you been educated about your body and the changes in the body?	Yes…….. No……..	1 2	
5.	Have you been educated or informed on the importance of antenatal and prenatal care	Yes…….. No…….	1 2	

Key Informants: School, Health centers and rescue centre administrators, local leaders

No.	A. Marriage Age			Response
1.	How old are girls in your community married?	9-12years…… 13-15years…… 16-18 years…… 18+ years……	1 2 3 4	
2.	How old are their husbands when they get married?	13-15years…… 16-18 years…… 18- 21 years…….. 22years+……..	1 2 3 4	
3.	Are they pressured to have children immediately after marriage?	Yes……. No……..	1 2	
4.	Was their marriage planned or consensual?	Planned……. Consensual……..	1 2	
5.	Do you have cases where young girls	Yes…….. No……	1 2	

	runaway from marriage			

	B. Pregnancy Health choices			Response
1.	Do the young girls have the choice of deciding on the number of children they would like to have	Yes…….. No……..	1 2	
2.	Do they have a choice of using family planning?	Yes…… No…… If yes Must ask for permission..	1 2 3	
3.	Do they have a right to their bodies and can make decisions in regards to them?	Yes…… No……	1 2	
4.	a) Do they ask for permission in accessing the antenatal care services?	Yes …… No……	1 2	
	b) If yes from who do they ask permission from?	Mother in law…… Husband…… Relatives…….. Other…….	1 2 3 4	
5.	a) Do they have to get consent on when	Yes…… No……	1 2	
		Husband…… Mother in law…….. Relatives……..	1 2 3	

	to get pregnant? b) If yes from who			
6.	Do they ask for permission to go to the health facility?	Yes…… No…….	1 2	

	C. Early Pregnancy			Responses
1.	a)How old are the girls when they get pregnant	9-12years…… 13-15years…… 16-18 years …….. 18+ years…….	1 2 3 4	
	b) How many children do they usually have	One …… Two……. Three+……..	1 2 3	
2.	How old are they when they get their second child?	9-12years…… 13-15years…… 16-18 years …….. 18+ years…….	1 2 3 4	
3.	How is their pregnancy?	Complicated…… To term…….. Miscarried……..	1 2 3	
4.	Where do they deliver the baby in most cases?	Hospital…… At home…….. Outside homestead……..…… Other……	1 2 3 4	
5.	Who helps in the delivery?	Doctor…… Midwives…… Traditional birth attendants… Relative…….	1 2 3 4	

	D. Maternal Education			Responses
1.	Do they have any information on health care services in the area?	Yes…… No……..	1 2	
2.	Have they been informed/educated on what family planning is?	Yes…….. No……	1 2	
3.	If yes which methods do they know use?	Modern Contraceptives……. Traditional contraceptives……	1 2	
4.	Have they been you been educated about their body and the changes that comes with it?	Yes…….. No……..	1 2	
5.	Have they been educated or informed on the importance of antenatal and prenatal care	Yes…….. No…….	1 2	

	E. Maternal Health			Responses
1	Did they have any complications during pregnancy like walking, sitting back aches, bleeding	Yes…… No……	1 2	

2	How is their labor in most cases?	Normal…… Obstructed…… Complicated……	1 2 3	
3	Do they develop any deformities	Yes……. No……..	1 2	
4	Do they experience bleeding during pregnancy and after birth?	Yes…… No……..	1 2	

Thank you for your support

Appendix IV: Letter of authorization from the University of Nairobi

UNIVERSITY OF NAIROBI
COLLEGE OF EDUCATION AND EXTERNAL STUDIES
SCHOOL OF CONTINUING AND DISTANCE EDUCATION
DEPARTMENT OF EXTRA-MURAL STUDIES
NAIROBI EXTRA-MURAL CENTRE

Your Ref:

Our Ref:

Telephone: 318262 Ext. 120

Main Campus
Gandhi Wing, Ground Floor
P.O. Box 30197
NAIROBI

2nd November, 2015

REF: UON/CEES//NEMC/22/411

TO WHOM IT MAY CONCERN

RE: NIVEA LUCIA IKUTWA -REG NO-L50/82832/2012

This is to confirm that the above named is a student at the University of Nairobi, College of Education and External Studies, School of Continuing and Distance Education, Department of Extra- Mural Studies pursuing Master of Arts in Project Planning and Management.

She is proceeding for research entitled **"the influence of early marriage on the girl child's maternal health"**. A case of Maralal, Samburu Kenya.

Any assistance given to her will be appreciated.

UNIVERSITY OF NAIROBI CEES P.O. Box 30197 07 OCT 2015 NAIROBI NAIROBI EXTRA MURAL CENTRE

CAREN AWILLY
CENTRE ORGANIZER
NAIROBI EXTRA MURAL CENTRE

Appendix V: Letter of Authorization from NACOSTI

NACOSTI

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

Telephone: +254-20-2213471,
2241349, 310571, 2219420
Fax: +254-20-318245, 318249
Email: secretary@nacosti.go.ke
Website: www.nacosti.go.ke
When replying please quote

9th Floor, Utalii House
Uhuru Highway
P.O. Box 30623-00100
NAIROBI-KENYA

Ref: No. **NACOSTI/P/15/70695/8793**

Date: **23rd November, 2015**

Nivea Lucia Ikutwa
University of Nairobi
P.O. Box 30197-00100
NAIROBI.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"The influence of early marriage on the girl child's maternal health: A case of Maralal, Samburu Kenya,"*** I am pleased to inform you that you have been authorized to undertake research in **Samburu County** for a period ending **17th November, 2016.**

You are advised to report to **the County Commissioner and the County Director of Education, Samburu County** before embarking on the research project.

On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.

SAID HUSSEIN
FOR: DIRECTOR GENERAL/CEO

Copy to:

The County Commissioner
Samburu County.

The County Director of Education
Samburu County.