Article

'I Am on a Family Planning Program, but I Have Not Told My Husband': Contraceptive Decision-Making of Child Brides in Ghana

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Abstract

This study explores the factors that influence child bride's decision making, either independently or jointly on modern contraceptive use in Ghana. The findings of this study are based on qualitative data collected through in-depth interviews with 15 child brides aged 15–24 years from four administrative regions in Ghana. It was observed that knowing about contraceptives, quality of the knowledge, attitude and sociocultural influences affected child brides' decision to use contraception. Thus, autonomy in decision making requires first, making the decision to access contraceptives and secondly, whether the decision can be implemented alone or with permission or in consultation with their spouses. It can be concluded from this study that child brides are not always as vulnerable and unable to exercise agency as is sometimes suggested because they sometimes used contraceptives without informing their partners although there is the possibility of a negative backlash from their partners when it is known.

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Introduction

Child marriage, defined as marriage before the age of eighteen years is prevalent in almost all African countries although the incidence varies across them (UNICEF, 2014). The prevalence rate ranges from a high of 76% in Niger to 2% in Algeria. In Ghana, the practice of child marriage is prevalent in all the ten administrative regions with a national incidence rate of 23.6% of child marriage among women aged 15–49 years (Domfe & Oduro, 2018). Furthermore, 20% of married women between ages 20–24 married before the age of 18 years (Domfe & Oduro, 2018). It is, however, more prevalent in some regions than others (Domfe & Oduro, 2018; Ghana Statistical Service, Ghana Health Service, & ICF International, 2015). The Northern Region has the highest incidence of 38.0% and Greater Accra Region has the lowest incidence of 17.8% (Domfe & Oduro, 2018).

In the past, child marriage in Ghana was predominantly due to religious and cultural factors. Some cultural practices that promote child marriage are child betrothal, bride exchange and 'trokosi'. Bride exchange is the practice of marrying a groom's sister into his bride's family. 'Trokosi' a traditional practice, where virgin girls are given off to priests to pacify the gods for the sins of their parents or a family member (Bilyeu, 1999) also encourages child marriage in some parts of the Volta Region. Girls who are sent to the shrines in most cases end up as wives of the priest. However, in recent times economic factors and teenage pregnancy are important causes of child marriage, contributing to its persistence in the country (Domfe & Oduro, 2018).

The practice of child marriage persists in although Ghana has signed on to agreements, conventions and laws initiated at the global and national levels to curb the practice of child marriage. For instance, the 1990 African Charter on the Rights and Welfare of the Child (ACRWC) entreats member states to take actions to end the practice of child marriage. In Ghana, both the 1992 Constitution and the 1998 Children's Act set the legal age for marriage for both boys and girls at 18 years in line with the ACRWC (1990).

Most studies on child marriage have argued that marriage before the age of 18 could have negative health and social outcomes on women's reproductive health (Godha, Hotchkiss, & Gage, 2013; Raj, Saggurti, Balaiah, & Silverman, 2009). Marrying before the age of 18 years expose young women to early sexual and reproductive health risks (Callaghan, Gambo, & Fellin, 2015; Erulkar, 2013; Nour, 2006; Walker, 2012; Wodon, Nguyen, & Tsimpo,

2016). Chief among these risks is early childbearing which has the tendency to increase fertility rates (Maswikwa, Richter, Kaufman, & Nandi, 2015). For instance, in their study Godha et al. (2013) observed that in the South Asian context, child marriage was significantly associated with outcomes such as poor fertility control and lower contraceptive use which they attributed to women's limited knowledge on modern contraceptives, limited decision-making power as well as social norms for child bearing.

Marrying early or being in a consensual union can affect a woman's decision-making on her reproductive health. Studies on developing countries indicate that women who marry early have less decision-making power (DeRose & Ezeh, 2010; Jensen & Thornton, 2003; Sano et al., 2018) due to patriarchal norms that tend to dominate most societies. Women's status in their social context informs how much they can contribute to decision-making in the household including decisions about their reproductive health (Osamor & Grady, 2018b). In most low- and middle-income countries, especially sub-Saharan African countries, where patriarchal norms and values are predominant, women's contraceptive decision making may be influenced by several factors including their age, marital status, educational level, income and even geographical residence (DeRose & Ezeh, 2010; Duah & Adisah-Atta, 2017; Oheneba-Sakyi & Takyi, 1997).

Modern contraceptives are widely known to be a reliable resource that help women plan their reproductive health. Knowledge and use of contraceptives play a critical role in the sexual and reproductive health outcomes of women in general. Women's knowledge and use of contraceptives have the potential to help them manage their reproductive lives to reduce fertility rates, decrease risk of maternal mortality as well as sexually transmitted infections (STIs). Approximately 97% and 99% of currently married women or sexually active women in Ghana have knowledge on contraceptives (Ghana Statistical Service et al., 2015). Whereas there is widespread knowledge of contraceptives (99%) among women (15–49 years) in Ghana, only 18.2% use any modern method of contraceptive (Ghana Statistical Service et al., 2015). Among women aged 15–19 and 20–24, 96.5% and 99.1% had knowledge on any contraceptive method, respectively, with only 6.3% and 21.1%, respectively, having used a modern method (Ghana Statistical Service et al., 2015).

Indeed, several studies have examined contraceptive use among women in Ghana (Aviisah et al., 2018; Beson, Appiah, & Adomah-Afari, 2018; Nketiah-Amponsah, Arthur, & Abuosi, 2012; Nonvignon & Novignon, 2014) and most of these studies suggest that contraceptive demand and prevalence are higher for sexually active unmarried adolescents than for adolescents who are married or in consensual unions. Explaining married women's use or

non-use of modern contraceptives requires a nuanced approach that identifies the peculiarity of the marriage, which in this study is the age at marriage or consensual union. Such an approach will provide in-depth knowledge on the experience of child brides and their fertility control. In this paper, we explore the factors influencing contraceptive use among young women who married or entered consensual unions before the age of 18. These women and girls are described in this paper as child brides.

Women's Decision-Making on Contraceptive Use

Decision-making on one's health can be a complex venture. To decide to use any healthcare intervention requires knowledge about the risk one is exposed to and the benefits of using the intervention. It is expected that child brides' decision on whether to use contraceptives will be based on their knowledge of their existence. In the likelihood of lack of knowledge about contraceptives, child brides may have no bases to initiate or make decisions on contraceptive use. Being aware and informed about the risks and solutions in one's health is an important step in the decision-making processes (Rapley, 2008). This could be achieved by interacting with and interrelating with members of the society at different levels since such interactions could be a source of obtaining knowledge and information about the existence and use of contraceptives. Knowledge on the existence of contraceptives influences the decision a woman takes either alone or with her spouse (Mackenzie, 2008; Walter & Ross, 2014).

Women's decisions on their health are not usually made in isolation but are based on the outcome of their interactions with members of the society at various levels [individual, family, community and institutional] (Rapley, 2008; Walter & Ross, 2014). In most societies, there are norms and values embedded in the various social structures that influence the roles of women and men in decision making. In developing countries, these norms and values are often rooted in religious beliefs as well as the customary practices of the society (Callaghan et al., 2015; Cislaghi, Mackie, Nkwi, & Shakya, 2019; Dean et al., 2019). These could constrain or enable women's ability to have autonomy to make decisions concerning their own reproductive health. These cultural norms support women's submission to men and this intend influence women's participation in decision-making in their marital homes. A woman's autonomy in decision-making is influenced by several factors ranging from marital status, educational attainment, living arrangements as well as wealth status (Rammohan & Johar, 2009; Sano et al., 2018). In the Democratic Republic of Congo, Sano et al. (2018) observed that healthcare decision making autonomy is independently influenced by women's control over earnings

among other factors such as partners' educational level and women's educational level.

The concept of autonomy in decision-making with regard to one's healthcare has been defined in different ways by different researchers (Brunson, Shell-Duncan, & Steele, 2009; Osamor & Grady, 2018a). Most definitions of women's autonomy include women's participation either independently or jointly in decision-making on their own health care. Brunson et al. (2009, p. 9) define women's autonomy as 'the ability to make decisions on one's own, to control one's own body, and to determine how resources will be used, without needing to consult with or ask permission from another person'. This definition identifies the independent decision making of women without external control. Other definitions of autonomy suggest that autonomy is not always about independent decision-making and that women may still have autonomy in decision-making when they make decisions jointly with their spouses (Mullany, Hindin, & Becker, 2005; Osamor & Grady, 2018a, 2018b). According to Mullany et al. (2005), couples' joint decision-making should be considered as a husband's respect for a wife's autonomy. They concluded that it was important to involve husbands and encourage couple's joint decision-making in reproductive health matters to improve women's reproductive health. Their study on women in Bangladesh, found that women who took joint decisions with their spouses concerning their health were supported by their spouses which resulted in improved health practices.

Studies suggest that the use of modern contraceptives in sub-Saharan Africa are based on women's autonomy, either through independent decision or joint decision making (Duah & Adisah-Atta, 2017; Osamor & Grady, 2018a, 2018b; Sano et al., 2018; Walter & Ross, 2014). However, compared to women in developed countries, not may women in Africa have independent decision-making autonomy over their health (Duah & Adisah-Atta, 2017; Sano et al., 2018). Most women make decisions about their healthcare jointly with their spouses; however, the final decisions may not be in the interest of the women (Duah & Adisah-Atta, 2017; Sano et al., 2018). In their study on Ghana, Duah and Adisah-Atta (2017) observed that women in Ghana exercise healthcare decision making autonomy either alone (22%) or jointly with their partners (53%). Sano et al. (2018) in a study on married women (15–49 years) in the Democratic Republic of Congo observed that limited decision -making autonomy of some women created barriers preventing women's use of modern contraceptives. Such studies do not provide a clear picture of the experiences of married women below the age of 18. The evidence suggests that child brides are a unique group of married women who have less opportunity and power compared to women who married after age eighteen. With most studies examining the topic from mainly a

quantitative point of view and the fact that studies from South Asia seem to dominate the literature, this study seeks to provide a qualitative perspective of contraceptive decision making among women who married as children from an African context, specifically, Ghana. A qualitative perspective is adopted because it will provide more insight into the nuances of women's decision-making with respect to their reproductive health.

Data and Methodology

Study Sites. The study was conducted in 2016 in eight communities in four of the ten administrative regions of Ghana[1]. These are the Brong Ahafo Region, Volta Region, Northern Region and Upper East Region. These are communities in which World Vision Ghana has programmes. Data on child marriage in Ghana suggests that these are among the regions with high prevalence rates (Domfe & Oduro, 2018). Data collection in each of the four regions were carried out in one rural and one urban community.

The communities selected for the study have diverse religious beliefs. In the Northern Region, the predominant religion is Islam, whereas in the Brong Ahafo Region, Christianity is dominant. African traditional belief is dominant in one of the communities in the Volta Region and the Upper East Region, respectively. The communities in this study were characterized by high rates of school dropouts especially among girls. The high rate of dropouts was attributed to low levels of interest in education, poverty, teenage pregnancy and child marriage. Child marriage, according to the community members, had declined and the practice of forcing young girls into marriage has stopped. However, from some community profiling interviews, it was observed that the practice of child marriage was prevalent due to teenage pregnancy and poverty. When girls become pregnant out of wedlock parents considered they had no option than to give them out into marriage. In the communities in the Upper West Region and Northern Region, cultural practices such as bride exchange and betrothal featured more prominently as causes of child marriage among girls.

Participants' Selection, Data Collection Procedure and Data Analysis

The data used in this paper is part of a broader study on child marriage in Ghana commissioned by World Vision Ghana. Qualitative data was collected from women who got married before the age of 18 (child brides), parents of child brides, community members as well as key informants. Data collection

began with a community profile exercise that was conducted in each of the communities to provide insight into the context of child marriage. Eight community profiles involving 3–4 well informed members of the community across the four selected regions were carried out. The main issues sought were a brief history about the community, norms about education/schooling, educational services, and child marriage.

Focus group discussions were carried out with groups of men and women in each community in the four regions. The participants in the focus group discussions were purposively selected from each community. The selection criteria included; being a native of the community and having resided in the community consistently for more than 10 years. The main topics discussed during the focus groups were the changes or lack thereof around child marriage norms and practices in the community as well as the community's views on these changes/non-changes – positive/negative and why. The main aim of the focus group discussion was to gain insight into the perspective of community members on the practice of child marriage in their community.

The child brides were selected through the purposive and snowball sampling techniques and the data were collected through in-depth interviews. Women who self-acclaimed that they were married or cohabiting with a man before they turned 18 years were contacted in their homes and permission was sought from a guardian in the home of child brides who were less than 18 years before their own assent was sought. Consent from participants was obtained prior to the start of the interviews. For the interviews with the child brides below 18, consent was sought from the guardian, usually the father in-law with whom they lived with. A face-to-face interview in a private space was conducted using a semi-structured interview guide. Each interview spanned 45 minutes on average. Some of the questions the interview guide sought to explore included child bride's perspective on marriage, reasons why they got married and their life experiences since they got married (including reproductive health and fertility control).

For this paper, 15 interviews from child brides, aged 15–24 were purposively selected from the bigger study and analysed. Women who had married or entered consensual unions as child brides but were 25 years and above were excluded from this analysis, because they may not recall vividly their reproductive experiences at the time of their union which forms the core part and strength of this paper.

The audio recorded tapes were transcribed and translated verbatim into English from the local languages in which the interviews were conducted (Attride-Stirling, 2001; Guest, MacQueen, & Namey, 2012). Given the exploratory nature of the study, the data were analysed without an existing framework using the inductive-thematic analysis method. The transcripts

were thoroughly read to gain a perspective of the entire interview and to ensure accuracy of transcription. The interviews were analysed based on themes around individual and social factors that influence contraceptive use decision-making among child brides. Direct quotes were used to support the various themes discussed in the analysis. To ensure the anonymity of the study participants, pseudonyms are used instead of their actual names.

Socio-Demographic Characteristics of Participants

The socio-demographic characteristics of the study participants are described in Table 1. Six of the participants are less than 18 years and seven are between 18 and 20 years. Ten are Christians and four are Muslim. The highest level of education attained by the respondents is junior high school (JHS). Most (9) of the respondents had completed between four and six years of primary school education with one respondent each reporting having completed between one and three years of primary education or having no formal education. Most of the participants had just started their reproductive lives which is reflected in the number of live child births they have had. Twelve out of the fifteen child brides reported having one child. However, a twenty-four-year-old woman who got married at the age of fourteen indicated that she had five children. Six out of the fifteen respondents were employed. These girls and women were mainly employed in the informal sector where little or no formal education is required. Most of them indicated that they were engaged in petty trading, gathering of sheanut fruits, farming as well as rearing of livestock. The main reasons why they got married or were currently in consensual unions were teenage pregnancy (7) and personal decision (5). Most child brides are given into marriage or settle to marry when they become pregnant. Those who enter marriage by choice did so because they wanted to marry their partners. One of the participants got married as a result of an arranged marriage. Of the remaining two, one was betrothed and the other got married through the cultural practice of bride exchange. Table 2 provides a summary of the major themes, sub-themes and sample quotes.

Results

Child Brides' Knowledge of Reproductive Health Issues

Child brides' knowledge of contraception influences their decision on whether to use it or not. From the data, it was observed that women's and girls' knowledge about their susceptibility to pregnancy was not universal. Not all child brides were knowledgeable about sexual and reproductive health matters. In the study, it was observed that most child brides did not understand

Table 1. Socio-Demographic Background of Respondents.

Socio-Demographic characteristics	Frequency N= (15)
Age of respondents	
15–17	6
18–20	7
23–24	2
Religious background	
Christian	10
Muslim	4
African traditional religion	1
Highest level of education	
Junior high school	4
Upper primary (Class 4–6)	9
Lower primary (Class 1–3)	1
None	1
Number of children living	
No child	1
One child	12
More than one child	2
Employment status	
Employed	6
Unemployed	9
Bases of marriage	
Personal choice	5
Betrothal	1
Bride exchange	1
Teenage pregnancy	7
Arranged marriage	1
Knowledge/Practice of family planning	
Practicing family planning	3
Not practicing family planning	10
Not aware of family planning	2

the consequences of unprotected sex. Three categories of child brides are identified based on their knowledge of contraceptives: those who did not know about it until after they got married, those who knew about contraception before they got married, and those who at the time of the interview still did not know about contraception.

Some child brides explained that they were ignorant that their sexual activities would lead to pregnancy.

> I did not know I was going to get pregnant when I had sex with him . . . my stomach was becoming big and I told my mother about it and she saw it and confirmed that I was pregnant. So, we went to the hospital and there too it was confirmed. (In-depth Interview, Ama [15 years], Upper East Region)

Not knowing they are susceptible to pregnancy despite having unprotected sex reveals the lack of knowledge of some child brides of the use of contraceptives. The narrative above depicts most child brides' sexual and reproductive health knowledge in the study areas and provides one of the explanations why most girls ended up with unplanned pregnancy and therefore having to get married before they turned 18. When child brides become pregnant, they conclude that 'It [pregnancy] always comes by mistake we do not plan for it'. (In-depth Interview, Alberta [24 years], Volta Region). Child brides usually got introduced to family planning programmes when they went to the hospital or clinic to deliver or seek healthcare after childbirth. Most child brides who got to know about contraception after marriage, often acquired it after childbirth and this influenced their decision on the use of contraceptives. 'When I gave birth to my second child, they told me at the hospital about family planning'. (In-depth Interview, Stella [17 years], Volta Region). Antenatal care (ANC) clinics were identified as the main sources of information on contraceptives by child brides in this study. Through their interactions with health professionals at the clinics, child brides are advised and educated on the importance of enrolling onto family planning programs.

> It was when I went for weighing at the clinic that the nurses told us. One of the nurses told me that after delivery if I want to go back to school, I should come for the family planning injection. (In-depth interview, Linda [18 years], Upper East Region)

> The nurses who do the weighing of our children do educate us about family planning. (In-depth Interview, Mansa [23 years], Upper East Region)

> . . .When I gave birth to my second child, they told me at the hospital about family planning. (In-depth Interview, Stella [17 years], Volta Region)

Some child brides are not on any family planning program because they are not aware of the existence of such programs. When a child bride in the Northern Region was asked if she was on any family planning program, she explained: 'I don't know what that is, I have never heard about it before' (In-depth Interview, Adiza [19 years], Northern Region).

Having access to information on contraceptives informed women's decision on available options for planning their reproductive health and lives in general.

Quality of Information on Contraception

The quality of information available on the benefits and risks associated with contraceptive use also informs the decision to use contraceptives. Decisions on contraceptive use were influenced by the child brides' perceptions on the side effects of contraceptives on women's reproductive health. Child brides' decision not to use contraceptives were based on their fears of the side effects of contraceptives.

> They (other women) say if you do it, it may be over for you, and you can never give birth again (In-depth interview, Zakia [23 years], Northern Region)

Child Brides Assertiveness Towards Contraception Use

Although child brides did not want to have more children immediately after having a baby, the behaviour of some towards taking reliable measures to avoid an unintended pregnancy predisposed them to the risk of an unplanned pregnancy. The following conversation with Farida illustrates the attitude of most of the child brides in the study:

> Interviewer: Have you protected yourself against another pregnancy?
>
> Respondent: No.
>
> Interviewer: What will you do when your husband asks for sex?
>
> Respondent: I won't allow him.
>
> Interviewer: You're sleeping with him in the same room how are you able to refuse him sex?
>
> Respondent: I have told him that our child is too young.
>
> Interviewer: Does he agree to it that your child is too young?
>
> Respondent: Yes.
>
> Interviewer: How long are you going to wait to have another child?
>
> Respondent: It will be between three to four years. (In-depth Interviews, Farida [16 years], Volta Region)

When a child bride who was nursing a baby and had no intention of having another child until her baby turned 3 years was asked if she was on any family planning program, she responded: 'I am not on any family planning program now, I will do it later'. (In-depth Interviews, Gloria [20 years], Upper East Region). Similarly, Alberta a twenty-four-year-old nursing mother, when asked if she was on any family planning program, responded: 'No [not using contraceptive] but I am now thinking of going to do it (family planning)'. Although studies have suggested that knowledge on contraceptives did not always inform use of contraceptives, having knowledge may lead to future use of contraceptives.

Sociocultural practices

In most Ghanaian societies especially in the rural communities, there are norms and values that influence women's behaviour, with respect to their sexual and reproductive health. The traditional method of contraception employed by some child brides is informed by their societies' norms and values regarding childbirth. For instance, according to Zakia, a Dagomba,

> I am currently staying in my father's house because of childbirth, down here that is what happens. You must stay with your parents up to two years after having a baby, you must give birth two times before you can stop going to your father's house anytime you deliver (In-depth Interview, Zakia [23 years], Northern Region)

Zakia, who had moved to her parents' home after childbirth explained that she had no plans of enrolling on a family planning program. Although moving to her parents' home after childbirth is a cultural practice, Zakia had to go through with this because her husband would not permit her to use modern contraceptives. This is not unexpected because, Zakia comes from a society where abstinence is used to plan one's first and second childbirth. Such customary practices are believed to help plan a woman's reproductive health. A similar explanation is given by Adiza, a 19-year-old Dagomba child bride who has a child who is a year and some months old and was staying in her father's house because she had moved in after giving birth and would return to her husband's house when her child turns 2 years. Staying away from one's matrimonial home according to the women kept them away from having sexual relationships with their husbands during that period which in the long run prevents pregnancy whilst they nurse their babies. Women only returned to their husbands' houses after the child turns 2 years, which is a natural way of spacing childbirth. Some child brides relied on this traditional method (abstinence) to meet their contraceptive needs.

Child Brides' Autonomy or Lack of it and Contraceptive Use Decision-Making

Two out of the three child brides who asserted that they were on a family planning program explained that they took such decisions on their own.

> I am on a family planning program, . . . I have not told my husband . . . because he won't agree. I went to the hospital. . . . I went for the family planning injection. (In-depth Interview, Mansa [23 years], Upper East Region)

> I will not let him know I am doing family planning. I will go to the hospital and do it secretly (In-depth Interview, Lucy [16 years], Upper East Region)

Child brides independently took decisions on contraceptive use especially when to use modern contraceptives and get it done. When child brides envisioned that their spouses would not support their decision to use contraceptives, they did not inform their husbands because they opined that their spouses would not permit it. Most child brides said that they had to make such decisions without informing their spouses because they harboured fears of not receiving support from them. In a few instances, some child brides on their own, enrolled on family planning programs, after which, they informed their spouses. In her case, Mary said:

> Yes, I told him I have done it [family planning] for two months and he did not complain about it. But what I have done is for three years. (In-depth Interviews, Mary [18 years], Upper East Region)

Although some child brides felt the need to inform their spouses about their decision to use contraceptives, they still had some reservations about their spouses' response to their decision and therefore resorted to deception as illustrated by Mary's quote. Mary informed her husband after she had accessed family planning. She went on further to explain how she had deceived her husband on the span of the family planning program she had enrolled on based on her perceptions about her husband's response.

Seeking husband's permission was influenced by patriarchal and religious norms that require women submit to their husbands. Some child brides held the view that they needed the permission of their husbands to access any of the family planning programmes. A 19-year-old child bride explained; 'No, I cannot do it (access family planning) unless I tell him (husband)' (In-depth Interview, Amina [19 years] Northern Region). Similarly, another child bride from the Northern Region also corroborated this: 'If I must access family

planning, I have to tell my husband'. (In-depth Interview, Binta [17 years], Northern Region).

Often, women who sought the permission of their husbands in order to access family planning programs were not granted permission. For Zakia, she will respect her husband's decision because women must respect their husbands, whereas Lucy on her part explained that she will go ahead with her decision without her husband's knowledge.

> If I discuss family planning with my husband, he will not allow me to do it, . . . when you marry you have to respect your husband's decisions besides, he is older than me (In-depth Interviews, Zakia [23 years], Northern Region)

> I told him I wanted to enrol on a family planning program after my first child, he said no and that I should give birth again before I do it. . . . I will not let him know when enrol on a family planning program. (In-depth Interview, Lucy [16 years], Upper East Region)

Husbands' reasons for not allowing their wives to access family planning are sometimes based on their perceptions and fears about side effects.

> He (husband) doesn't like it (family planning) because his sister did it, and she is now having challenges with it in her marriage. She went to the hospital, and she was told that it is the family planning that is preventing her from having children. Sometimes she even vomits blood. That is why he said he will never allow his wife to have family planning (In-depth Interview, Sally [19 years], Upper East Region)

> My husband advised me not do family planning, he said there are diseases attached to family planning. (In-depth Interview, Stella [17 years], Volta Region)

Family planning in Ghana comes with a cost and this may influence women's decisions on when to seek family planning services and whether they have autonomy in decision-making. Most child brides in the study are not working mainly because of their low educational attainment, lack of skills and the fact that they have young children. Some of them are financially dependent on their spouses and therefore their husbands' decision on family planning takes precedence. Under such circumstances, child brides without the financial support of their husbands may not be able to access family planning programs when they want to. It takes women who can support themselves financially to seek family planning services on their own. Mary who engaged in petty trading and Abigail a farm hand explained:

> My son is too young. I have done family planning (Norplant). I told him (husband) to give me money to go and do it after the birth of our son, but he did not, so I went there to do it myself. I sought his consent to do it, but he did not want me to do it. So, I did it myself. (In-depth Interview, Mary [18 years], Upper East region)

> I will go for the family planning injectable in the hospital. I am carrying cassava as a labourer and hope to save some of the money to go to the hospital. (In-depth Interview, Abigail [15 years], Upper East Region)

In such cases, women who can sometimes find work to raise some money or those who have financial resources go for family planning using their own funds.

Discussion

Qualitative studies on young unmarried women's non-use of contraceptives in sub-Saharan Africa identified lack of access to family planning education (Chandra-Mouli, McCarraher, Phillips, Williamson, & Hainsworth, 2014). Similar observation was made in this study among child brides, most child brides did not know about family planning before their first birth and this influenced their ability to negotiate or use any modern contraceptive. This finding provides explanations for why most child brides are characterized by lack of contraceptive use before their first childbirth (Godha et al., (2013); Raj et al., 2009). There is an important link between knowledge of contraceptives and decision-making because it is impossible for child brides to negotiate about contraceptive use when they do not know about it. Deciding whether or not to use contraceptives is based on whether one is aware of its existence and availability. It was obvious from the three categories of child brides (those who knew about contraception before they got married, those who did not know about it until after they got married and those who still do not know) identified from the study that those who had knowledge on contraceptives after marriage did so after childbirth and gained this information from the health facility. When they get to know about contraceptives and reproduction there is the challenge of the kind of information they have. This will then affect whether they want to use modern contraceptives. The health facility was identified by the three child brides who were on a family planning program as their source of information on family planning. These three child brides who accessed family planning programs normally go to the hospital for the procedure to be done, an indication that they were using methods (insertion and injectable contraceptive methods) that required the assistance

Table 2. Summary of Main Theme, Sub-Themes and Sample Quotes.

Main theme	Sub-themes	Sample quotes
Factors influencing child bride's decision on contraceptive use	Child brides' knowledge of reproductive health issues	'It was when I went for weighing at the clinic that the nurses told us. One of the nurses told me that after delivery if I want to go back to school, I should come for the family planning injection'. (In-depth interview, Linda [18 years], Upper East Region)
	Quality of information on contraception	'They (other women) say if you do it, it may be over for you, and you can never give birth again'. (In-depth interview, Zakia [23 years], Northern Region)
	Child brides assertiveness towards contraception use	'I am not on any family planning program now, I will do it later'. (In-depth Interviews, Gloria [20 years], Upper East Region)
	Sociocultural practices	'I am currently staying in my father's house because of childbirth, down here that is what happens. You must stay with your parents up to two years after having a baby, you must give birth two times before you can stop going to your father's house anytime you deliver'. (In-depth Interview, Zakia [23 years], Northern Region)
	Child brides' autonomy or lack of it and contraceptive use decision-making	'I am on a family planning program, . . . I have not told my husband . . . because he won't agree. I went to the hospital. . . . I went for the family planning injection'. (In-depth Interview, Mansa [23 years], Upper East Region)

of health professionals. More importantly, they were using methods that were not visible to their husbands. This practice of child brides seeking for family planning services at a hospital or a clinic may limit women's access to the wide range of methods that could be accessed from other sources other than the hospital or clinic (Hindin, McGough, & Adanu, 2014). Although, Ghana has made substantial strides in contraceptive knowledge and awareness among women (Ghana Statistical Service et al., 2015), child brides who are often characterized by low educational attainment and may reside in rural areas may not have access to information on contraceptives.

Brunson et al. (2009, p. 9) define women's autonomy as 'the ability to make decisions on one's own, to control one's own body, and to determine how resources will be used, without needing to consult with or ask permission from another person'. This definition identifies the independent decision making of women without external control. Although studies have identified education, wealth status and number of children as predicting women's autonomy in family planning decision (Alabi, Odimegwu, De-Wet, & Akinyemi, 2019; Wodon et al., 2016). This study observed that for child brides, it was mainly their wealth status. Women's wealth status played a major role in their ability to take decisions on family planning without their husbands consent or support. Decisions on the use of contraceptives were sometimes taken by the child brides alone without the knowledge of their spouses. The practice of deliberately using contraceptives without informing one's spouse is a common practice among women who live in societies where patriarchal norms allow men to make decisions with or without their spouses (Biddlecom, Munthali, Singh, & Woog, 2007; DeRose & Ezeh, 2010; Kibira et al., 2020). These studies suggest that such practices have been successfully used by women to control their fertility. In this study, child brides had to use deceit to enrol on family planning programs. In as much as they had autonomy, there could be consequences should their spouses find out about the deception. In other instances, husbands were informed about the decision after it had been made. This suggests that despite their young age, they were exercising agency.

Husbands' attitudes also played an important role in young women's decision to use contraceptives. In the current study, it was observed that women who discussed or informed their spouses about their decisions on family planning did not receive the necessary support. This contributed to young women's non-use of contraceptives. Similar findings were observed in a study on Zambia in a population survey of married women and their husbands. In the Zambian case, it was observed that many women who used contraceptives did so without the knowledge of their husbands (Biddlecom & Fapohunda, 1998). Similar explanations were found in both the Zambian and the Ghanaian case, where women explained that they did not involve their husbands in their decision because they found it difficult to bring up the subject of family planning with them. The child brides in Ghana further noted that they did not inform their husbands because they believed their husbands would not support their decision. This explains the extent to which traditional norms and values that supports men having more power in the decision-making process influence women's inability to bring up reproductive health issues for discussion in the marital homes.

Fears about side effects of contraceptives have been identified by several studies as deterring women from using them (Adanu, Seffah, Anarfi, Lince, & Blanchard, 2012; Hindin et al., 2014). The fear of not being able to have more children in future informed child brides' personal decisions on the use of contraceptives. Since most child brides are in their reproductive ages and the sustainability of marriage in most societies in Ghana is dependent on a woman's reproductive ability, young women tend to be more concerned about their fertility and being able to have more children. Aside young women's own fears, a partner/spouse's fear also influenced husbands support for women's use of contraceptive. To encourage the use of contraceptive, adequate information as well as proper counselling, detailing all the side effects of contraceptives should be the focus of interventions (Adanu et al., 2012; Hindin et al., 2014).

Cultural beliefs and practices also play a role in child brides use or non-use of contraceptives (Wilkinson & Callister, 2010). This study observed that traditional contraceptive methods influenced child brides' use or non-use of modern contraceptives to control their fertility. The decision of some child brides not to use modern contraceptive was influenced by the sociocultural practices of their ethnic background. Some ethnic groups have norms and values that support the traditional method of contraceptive, which some child brides subscribed to, sometimes after their first choice of using a modern method are denied. Thus, some child brides used the traditional method of abstinence from sex after childbirth. For child brides who turned to this method because it was part of their cultural practice, they were supported by their family, hence they moved in to stay with their in-laws or their own parents for a stipulated number of years. In communities where the cultural practices are strictly adhered to, the decision to use a family planning method may be influenced by the cultural norms and values of the society. The traditional method of child brides leaving their marital home to stay with their family after childbirth served the same purpose of modern contraceptives because it helped women to control childbirth in terms of child spacing. It is crucial for intervention programs to always consider existing cultural practices in a given social context and analyse how they can influence women's decision on sexual and reproductive health behaviour, especially concerning the uptake of contraceptives.

Going to the hospital to access family planning comes with a cost, which tends to limit women's access. Given the circumstances under which some child brides marry as well as the socio-economic background of some child brides, they tend not to be employed and therefore are often not financially empowered to meet their health needs and for that matter their contraceptive needs independently. Respondents who had the financial means were able to

access family planning with or without the consent of their spouses. This supports the findings made by Do and Kurimoto (2010) that the use of contraceptives in Ghana by women was associated with economic empowerment. When women are economically empowered, they can have autonomy on decisions about health with or without the support of their spouses.

Limitations

A limitation of this study is that the sample comprises only married or partnered women aged 15–24 years. Thus, the findings cannot be compared with women who married after 18 years. However, the focus of the paper is to find out whether any negotiation regarding contraceptive use occurs between child brides and their partners and to investigate how child brides navigate the terrain. Thus, not having a comparator group, though limiting, does not undermine the value of the paper's findings. However, one advantage of this study is the age range that is used to determine the inclusion and exclusion criteria for the selection of the sample for this study. Child brides aged 15 to 24 have the advantage of easily recalling their experiences as well as sharing their current sexual and reproductive health experiences because they are still in their reproductive age.

Conclusion

This paper set out to explore decision-making on contraceptive use among girls and young women in the social context of Ghana who are currently married or in consensual unions or entered into these unions before they turned 18 years. Not having knowledge about contraceptives prevented these women from using contraceptives. As part of its school curricula, the Ghana Education Service (GES) has included sexual and reproductive health education at the basic level of education to inform and educate girls on their sexual and reproductive health. To drum this education home, traditional leaders should be empowered to work together with members of their communities especially parents to encourage and ensure that girls stay in school at least to complete their basic level education before marriage, since most child brides drop out of school after marriage or are school dropouts.

Having knowledge on contraceptives did not always lead to contraception use. The few child brides who used contraceptives did so under the shroud of deception and of those who did not use contraceptives, it was a combination of fear, husband's refusal and societal norms. Family planning decisions are influenced by the child brides own wish, their spouses wish, the cost of the contraception method as well as the norms and values of their society's

cultural practices and beliefs. Given the social context in which marriage is embedded in relationships with spouses and the family, child brides did not have much autonomy in decision making on their reproductive health, hence often preventing them from using modern contraceptives. Husband's wish has an influence on child bride's decision, but sometimes, child brides navigated through this by being assertive, taking decisions on their own and accessing family planning programs without the knowledge of their spouse. Husbands' attitudes towards women's decision to use contraceptives, sometimes pushed women to be deceptive. And when they did use contraceptives in these circumstances, they did not use the pill, the use of which can be detected, but rather measures that are less visible. Under such circumstances, contraceptive methods that are not visible become handy for women who are denied support to use contraceptives. Programs and interventions that aim to increase women's uptake of modern contraception should always look at women's social context and educate them on the various options that would be suitable for them with or without the knowledge and consent of their spouses. Child brides, who are economically empowered, are the ones who took such decisions without their husbands support or knowledge. This is indicative of the importance of child brides being economically empowered and their use of contraception.

It can be concluded from this study that child brides continue to be vulnerable in their marriage and consensual unions, since only a few are able to exercise agency in taking part in family planning programs. The fact that only a few, who may be financially capable, are able to access family planning programs without informing their partners illustrates this point. Moreover, there is the possibility of a negative backlash from their partners if they are found out. Since most child brides rely on the information, they receive from the hospitals and clinics, such centres should be used to inform child brides and their spouses about other sources such as pharmacy or licensed chemical shops where they could access family planning without necessarily going to the health centre, so that women who live in communities with no health centres may not be hindered by lack of access or proximity issues. Women should be informed about other family planning programs that are more discrete and these should be made easily accessible for women regardless of their location.

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Note

1. Six additional administrative regions were created in 2018 bringing the total number of administrative regions to 16.

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