Determinants of Adolescents Pregnancy and Access to Reproductive Health Services in Niger Delta, Nigeria

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Abstract

This study investigated the determinants of adolescents' pregnancy and access to reproductive health services in Niger Delta region, Nigeria. Two research questions and two research hypotheses were employed. Research design was descriptive survey design. Research instrument was a structured questionnaire. The population comprised of married female adolescents (3,027) in Rivers State. One thousand (1,000) participants were sample through purposive sampling technique. The reliability of the instrument yielded 0.87. The descriptive statistics of simple percentages and mean scores were used to analyze the data while the inferential statistics of simple regression and ANOVA were used to test the hypotheses at 0.05 alpha levels. The study revealed that all the independent variables (poverty and cultural beliefs) were significance correlates of adolescents' pregnancy and access to reproductive health services in Niger Delta region, Nigeria. It was therefore recommended that Ministry and parents must solve the problem of poverty on the access of female adolescents' pregnancy productive health services in Niger Delta, Nigeria. Traditional herbalist and parent should identify the effect of cultural belief on the access of female adolescents' pregnancy productive health services in Niger Delta, Nigeria.

Keywords: Determinants, Adolescents Pregnancy, Access, Reproductive Health, Services

1. Introduction

Adolescents constitute an important proportion of the population of Niger Delta region, Nigeria. According to the World Health Organization (WHO, 2022) this class of young people are within the ages of 10 to 19 years. Adolescent stage is a delicate stage that presents with challenges especially that of sexual and reproductive health due to the developmental changes (Mellesse et. al., 2020). While some may want to abstain from sex others that choose to be sexually active may want to explore and this act of exploration sometimes ends with negative consequences. . It is important that they experience safe and pleasurable sexual life, the absence of which may expose them to reproductive health challenges. Adolescent sexual behaviour is influenced by several factors (Mbachu et al., 2020). However, having access to the right sexual and reproductive health information and services is an important step in structuring and addressing their sexual and reproductive health needs.

Historically, adolescent marriage was common around the world. The practice began to be questioned in the 20th century, with the age of individuals' first marriage increasing in many countries and most countries increasing the minimum marriage age (Brown, 2013; Cormo et. al., 2020). Although early marriages affect both the sexes, however, females have been the major victims (Okiyi et al., 2020; Alawari, 2022). Its practice has inflicted harmful effects on the parties involved and also the overall society. Early marriage is everywhere considered a violation of the Human Rights and efforts are being made to educate people on its adverse effects. According to Burgess et al., (2022), marriage of girls below 18 years of age is common worldwide and affects millions. Adolescent marriage is a human rights violation that prevents girls from obtaining education, enjoying optimal health, bonding with peers and ultimately choosing their own life partners. (Ahmed et al., 2020). Adolescent marriage is driven by poverty and has many effects

on adolescents' health: increased risk for Sexually Transmitted Diseases (STDs), cervical cancer, malaria, death during childbirth, and obstetric fistulas (Beutel, 2010).

Adolescent marriage is an ancient worldwide custom. Other terms applied to adolescent marriage include "early marriage" and "child brides." Early marriage is vague and does not necessarily refer to children. Moreover, what is early for one person may be late for another. The legally-prescribed marriageable age in many jurisdictions is above 18 years, especially in the case of females; and even when the age is set at 18 years, many jurisdictions permit earlier marriage with parental consent; because Parents feel that marriage provides their daughter with a sense of protection from sexual promiscuity and safe from sexually transmitted infections and teenage pregnancy (Nour, 2006; Beredugo et al., 2020), Age of consent laws are intended to protect adolescents from exposure to sexualisation and sexual exploitation, and child trafficking is also, to some extent, associated with adolescent marriage. Adolescent marriage affects both boys and girls, though the overwhelming majority of those affected are girls, most of who are in poor socio economic situations (UNICEF, 2012).

Complications from pregnancy and childbirth are the main causes of death among adolescents below age 18 in developing countries. Pregnant adolescents aged 15 to 20 are twice as likely to die in childbirth as those in their 20s, and adolescents under the age of 15 are five times as likely to die (Dahl, 2010; Ezenwaka et al., 2020). These consequences are due largely to adolescents' physiological immaturity where the pelvis and birth canal are not fully developed. Adolescent pregnancy, particularly those that are below age 15, increases the risk of developing obstetric fistula, since their smaller pelvises make them prone to obstructed labour (Joseph et al., 2018). Fistula leaves its victims with urine or foecal incontinence that causes lifelong complications with infection, pain, and smell. Complications during pregnancy and birth are worsened in poor countries where adolescent marriage is prevalent (Human Rights Watch, 2013).

Poverty plays a central role in perpetuating adolescent marriage. Parents want to ensure their daughters' financial security; however, daughters are considered an economic burden (Maigari, 2018. Feeding, clothing, and educating girls is costly, and girls will eventually leave the household. A family's only way to recover its investment in a daughter may be early marriage in exchange for a dowry. In some countries, the dowry decreases as the girl gets older, this may tempt parents to have their daughters married at younger ages. These are not necessarily heartless parents but, rather, parents who are surviving under heartless conditions. Parents worry about ensuring their daughters' virginity and chastity. Adolescent marriage is also seen as a protective mechanism against premarital sexual activity, unintended pregnancies, and Sexually Transmitted Diseases (STDs) (Boyden, Pankhurst, & Tafere, 2012).

However, adolescents' marriage has far-reaching health, social, economic, and political implications for the girl and her community. It truncates a girl's childhood, creates grave physical and psychological health risks, and robs her of internationally recognized human rights. Ending adolescent marriage requires the consent of all those involved, including fathers and community leaders, and tribal leaders. To break the cycle of poverty, programmes are needed to educate and empower women. In 2000, eight Millennium Development Goals outlined a vision that committed member countries to eradicate extreme poverty and hunger, educate all children through primary school, improve mothers' health, combat HIV/AIDS and malaria, ensure environmental sustainability, and develop a global partnership for development by the year 2015 (Melhodo, 2007). Most of these goals directly affect adolescent marriage. The Health system in the state is in three levels, the tertiary health care, which is overseen by the Federal government, the secondary

level controlled by the state and the Primary Health care (PHC) level controlled by the LG. In addition, there are some faith based and privately own health facilities. The primary health care facilities are found in almost all the communities but faced with the challenge of limited resources and staff, so do not run a 24- hour service; while the secondary and the tertiary health facilities are concentrated at the urban areas Consequently, this study sought to investigate if poverty and culture/belief were correlates of early marriage and their perceived implications on the reproductive health service of female adolescents in the Niger Delta region, Nigeria.

1.2 Statement of the Problem

It has been projected that the population of young people in Niger Delta region will exceed 2 million by the year 2025, a large proportion of which are adolescents. Recent report shows that about 28% of adolescent in Niger Delta region are sexually active and the median age of sexual debut is about 15 years. Many adolescents in Niger Delta region lack the skills to negotiate safe sex and delay the unset of sexual activities. This is of concern considering that age at first sexual intercourse is an important indicator of the possibility of unintended pregnancy and STI. Inconsistent and incorrect condom use is a common practice among adolescents in Nigeria resulting in unintended pregnancy that ends in unsafe abortion and its complications. It is also exposing them to STI and HIV with a prevalence of 17% among adolescents in the southeastern part and 14% in the northern part of the country. Nigeria reports a yearly abortion rate of 25 abortions/1000 women more than a quarter of which are from adolescents resulting from unintended pregnancy. In the southern part of Niger Delta region, about 32% of the cases of unsafe abortion were among adolescents. Worst still is the fact that they are often missed identified by health care providers as children and considered not appropriate target for contraceptive information and services. The youth friendly health centers, which should meet the SRH needs of the adolescents, are also not in the capacity to do so, leaving them to resort to other means. Child marriage is a major problem in Nigeria; NDHS 2013 shows that 28.8% of females between ages 15 and 19 are currently married. The rate is as high as 76% in the North and 10% in the Niger Delta region part of the country. Adolescent fertility rate is 122 per 1000 women; amidst the low contraceptive rate among adolescents. To address the sexual and reproductive health problems of adolescent, the national adolescent reproductive health policy was developed with establishment of youth friendly health centers in some part of the Niger Delta region. Therefore, this study investigates if; poverty, culture/belief and perceived effects on the access of reproductive health were correlates of determinants of adolescents' pregnancy and access to reproductive health services in Niger Delta, Nigeria.

1.3 Aim and Objectives of the Study

The aim of this study is to investigate the determinants of adolescents' pregnancy and access to reproductive health services in Niger Delta, Nigeria. Specifically, the objectives of this study were to determine if:

1. Poverty has extent effects to access female adolescents' pregnancy productive health services in Niger Delta, Nigeria.
2. Cultural belief has extent effects to access female adolescents' pregnancy productive health services in Niger Delta, Nigeria.

1.4 Research Questions

The following research questions were formulated to guide this study:

1. To what extent do poverty affects the access of female adolescents' pregnancy productive health services in Niger Delta, Nigeria?
2. To what extent does cultural belief affect the access of female adolescents' pregnancy productive health services in Niger Delta, Nigeria?

1.5 Research Hypotheses

The following hypotheses were formulated to guide this study and were tested at .05 Alpha levels:

1. There is no significant relationship between poverty and the access of female adolescents' pregnancy productive health services in Niger Delta, Nigeria.

2. There is no significant relationship between cultural belief and the access of female adolescents' pregnancy productive health services in Niger Delta, Nigeria.

1.6 Significance of the Study

This study, which is a perception study (the participants are not all victims of adolescent marriage) aimed at contributing to knowledge that will inform and improve educational judgments and decisions, in order to further improve or promote educational actions on early marriages and sexual health of adolescents among legal parents and caregivers or custodians of adolescents in Rivers State. This study also aimed to have immediate relevance to all stakeholders and benefactors in adolescents' sexual health issues because of its intention to "inform' and to provide a better understanding to individuals on the effects of early marriages on the sexual and reproductive health of adolescents in Rivers State. The findings of this study may enable policymakers and programme planners to design legislation and services by the government, specifically for the adolescents who are most likely to experience these sexual and reproductive health problems associated with early marriages.

The findings and recommendations of this study may stimulate the interest of the health workers, government, parents, mass media, and teachers to embark on more extensive campaigns on the importance of sexuality and \ reproductive health education as well as the sexual health effects of early marriages. Furthermore, this study may also provide some information that will add to the existing body of knowledge in the field of health education in general and in the area of sexuality education in particular. This study may also provide a spring board to generate further studies on sexuality education, as well as act as a reference point for future research works in the area of adolescents' sexuality.

1.7 Attribution Theory

The theory was propounded by Ajzen (1988). Attribution theory attempts to account for the way in which people make attributions. Attributions are the ordinary explanations people give for the events that happen in their daily lives. However, health is partly determined by individual lifestyle factors, such as patterns of living, religious background, level of education/ignorance, level of poverty or standard of living, culture/belief and social/environmental factors (i.e. attention to relationships with family, friends and significant others within the local community, working and living conditions–housing, employment, access to healthcare services and so on). The theory of planned behaviour, which is an extension of the theory of reasoned action, explained virtually any behaviour over which the individual has volitional control (i.e, any action that the person could choose to engage in, such as having premarital sexual intercourse, premature pregnancy, having multiple sexual partners or total abstinence, giving out their adolescent girls to marriage).

A major assumption of the theory of reasoned action is that the intention to engage in a particular behaviour is the principal determinant of whether or not the person will actually engage in the behaviour. There are only two factors that determine behavioural intention: one's own attitude toward the behaviour itself, and one's impression of the social norms regarding the behaviour. In both the theory of reasoned action and the theory of planned behaviour, the person's own attitude toward the behaviour (i.e., whether or not one thinks the behaviour is "good" or "had") is determined by the person's belief that a given behaviour will lead to a given outcome* weighed by how positively or negatively the person evaluates the outcome. In addition, the theory of planned behaviour states that perceived behavioural control predicts behaviour independently. This means that there is a direct link from perceived behavioural control Alawari, M. B. (2022). Modern Day Slavery: A Case of the Girl Child in Nigeria. *Unizik Journal of Gender Research*, *1*(1). to the behaviour, a link that necessarily mediated by intentions. The more one perceives control over behaviour, the more likelihood to engage in that behaviour even when one does not intend to do so.

2. Research Design

The descriptive survey design was used for this study. According to Elley (1994), survey design is a method used to collect information by asking a set of pre-formulated questions in a pre- determined sequence in a structured questionnaire to form a sample size of individuals who are assumed to be representatives of a defined or larger population. The rationale for choosing this method was based on the fact that it usually concentrates on the description of events, recording, and analyzing and data interpretation.

2.1 Population for the Study

The population for this study comprised of all the married female adolescents (3,027) in Niger Delta Region.

2.2 Sample and Sampling Techniques

The participants for the study consisted of one thousand (1,000) participants and were drawn from the entire Niger Delta region, Nigeria. These participants were drawn using the purposive sampling technique. In order to provide avenue for generalization and justification for the population for the study, the researcher and the trained research assistants administered the questionnaire forms in (Stage 1: (Purposive)), to adolescent mothers in Primary Health Care Centres, (Stage 2 (Purposive)), in the Niger Delta region, Nigeria. However, since the questionnaire forms could not be administered to the entire study population, the researcher in (Stage 3: (Simple Random)) randomly drew participants

from three health centres in (Stage 4: (Simple Random)) randomly selected three States of Niger Delta region, Nigeria. In totality, 1,200 questionnaire forms were administered, while the valid and used forms were 1,000 copies (a return rate of 83%). The questionnaire forms were retrieved from the participants within a period of twelve weeks.

2.3 Research Instrument

The research instrument for this study was the structured questionnaire titled "Determinants of Adolescents Pregnancy and Access to Reproductive Health Services Questionnaire (DAPARHSQ)", which was designed by the researcher for the purpose of gathering information from the participants. The research instrument consisted of two sections "A and B". Section A, elicited information about the demographic data of the participants. While section B, collected information based on the independent variables under study. The self-designed questionnaire was the four-point Likert type with the following weight allotments: VHE = Very High Extent, HE = High Extent, LE = Low Extent and VLE = Very Low Extent.

2.4 Validity of the Instrument

In order to ensure that the research instrument had face and content validity, a draft of the self-developed questionnaire was presented to the researcher's supervisor and other experts in the Department of Health Education, Ignatius Ajuru University of Education,Nigeria, for content and construct validation. Comments, suggestions and recommendations made by these experts were carefully studied and used to improve the quality of the instrument as well as the entire study.

2.5 Reliability of the Instrument

To ensure the reliability and to know the strength and weaknesses of the research instrument, the corrected version of the instrument were administered to twenty adolescent mothers (who were not part of the study population) in Niger Delta region, as the researcher hoped to involve the whole of Niger Delta States. The collected data were collated and subjected to test-retest, which yielded 0.87.

2.7 Procedure for Data Collection

The researcher obtained a Letter of introduction from the Head, Department of Health Education, Ignatius Ajuru University of Education, which was delivered to the Chief Nursing Officers/Matrons of the selected Primary Health Care Centres to solicit for their support and co-operation, in order to facilitate easy access of the researcher to the research sites as well as the research participants required for the study. Also, the researcher solicited for the assistance of nine- trained research assistants (3 from each of the Niger Delta states), who were ancillary staff in the research sites that helped to administer the questionnaire to the adolescent mothers, who attend ante-natal clinics in the three senatorial districts. The questionnaire forms were retrieved from the participants within a period of twelve weeks.

2.8 Procedure for Data Analysis

The completed copies of the questionnaire were collated, coded and analysed using the descriptive statistics of simple percentages to analyse the demographic characteristics of the participants, the Criterion mean at 2.50 was

used to analyse the data concerning the research questions, while the inferential statistics of ANOVA (Analysis of Variance) was used to test the hypotheses under study. However, all hypotheses were tested at 0.05 alpha levels.

Results

Research Question 1: To what extent do poverty affects the access of female adolescents' pregnancy productive health services in Niger Delta region, Nigeria?

Table 1: Mean Score and standard deviation analysis on poverty as it affects the access of female adolescents pregnancy productive health services in Niger Delta region, Nigeria

S/N	Items	Responses				$\bar{x}$	SD	Decision
		VHE	HE	LE	VLE			
1	The dire need for settling some financial obligations force some girls into early marriage.	365	441	130	64	3.12	0.77	High Extent
2	Some adolescent girls are encouraged into early marriage by their parents in order for them to assist to train other children.	330	501	131	38	3.11	0.86	High Extent
3	Some girls are forced to marry early because their parents are poor	342	473	123	62	3.10	0.84	High Extent
4	In some traditional societies adolescent marriage is regarded as a family-building strategy.	259	357	258	126	2.75	0.98	High Extent
	Overall Mean					**3.02**	**0.86**	

*VHE = Very High Extent, HE = High Extent, LE = Low Extent, VLE = Very Low Extent *VLE= 1.00-1.49, LE = 1.50-2.49, HE = 2.50-3.49, VHE = 3.50-4.00.

The result in table 1 indicated that the dire need for settling some financial obligations forces some girls into early marriage as shown in the mean score 3.12± 0.77 was accepted. Secondly, some adolescent girls are encouraged into early marriage by their parents in order for them to assist to train other children with the mean score 3.11±0.86. Thirdly, some girls are forced to marry early because their parents are poor as the mean score 3.10±0.84 was accepted. Lastly, in some traditional societies adolescent marriage is regarded as a family-building strategy as illustrated by the mean score 2.75±0.98. The aggregate mean ($\bar{x}$) = 3.02 which is greater than the criterion mean =2.50, this indicate that to a high extent poverty constitutes a correlate of female adolescents pregnancy productive health services in Niger Delta region, Nigeria.

Research Question 2: To what extent does cultural belief affect the access of female adolescents' pregnancy productive health services in Niger Delta region, Nigeria?

Table 2: Mean Score and standard deviation analysis on cultural belief as it affect the access of female adolescents pregnancy productive health services in Niger Delta region, Nigeria

S/N	Items	Responses				$\bar{x}$	SD	Decision
		VHE	HE	LE	VLE			
1	Some cultures applaud virgins, so give their girls out to marriage at an early age.	308	437	169	86	3.14	0.89	High Extent
2	In some cultures, adolescent marriage is seen as a normal thing.	346	440	129	85	3.12	0.85	High Extent
3	In some cultures, abortion is forbidden and once a child is pregnant, she must get married.	380	406	150	64	3.10	0.88	High Extent
4	In some cultures, adolescent marriages are encouraged.	401	409	115	75	2.97	0.94	High Extent
	Overall Mean					**3.08**	**0.89**	

Table 2 showed shows that some cultures applaud virgins, so they give their girls out to pregnancy at an early age with mean scores (= 3.14±0.89 were accepted. In some cultures, adolescent marriage is seen as a normal thing as mean scores of ( ) = 3.12±0.85 illustrated. In some cultures, abortion is forbidden and once a child is pregnant, she must get married as mean scores of ( ) = 3.10±0.88, which is also accepted. Lastly, in some cultures, adolescent marriages are encouraged as mean scores of (= 2.97±0.94, which is also accepted. The aggregate mean ( ) = 3.08 which is greater than the criterion mean = 2.50, was accepted and hence to a high extent culture constitutes a correlate of female adolescents pregnancy productive health services in Niger Delta region, Nigeria.

Hypotheses

The hypotheses in this study were tested using the simple regression statistical tool at 0.05 level of significance. Decision rule stipulates that if the calculated critical value is greater than the table value, the hypothesis should be rejected.

Hypothesis 1: Is there any significant relationship between poverty and the access of female adolescents' pregnancy productive health services in Niger Delta region, Nigeria

Table 3: Summary of simple regression and correlation showing the contribution of poverty and the access of female adolescents' pregnancy productive health services in Niger Delta region, Nigeria

Sources	**R**	**R2**	**Adjusted R2**	**Standard Error**	**Fcal**	**SS**	**MS**	**df**	**p-value**	**Decision**
Regression	0.243	0.059	0.058	0.556	62.423	19.319	19.319	1	0.000*	Significant
Residual						308.862	0.309	998		
Total						328.181		999		
Model	Unstandardized Coefficients			Standardized Coefficients		t			p-value	
1	Beta (β)	Std. Error		Beta (β)						
(Constant)	2.386	0.076				31.214			0.000*	
Poverty	0.210	0.027		0.243		7.901			0.000*	

Asterisks shows significant relationship p<0.05

Table 3 revealed a positive relationship between poverty and female adolescents' pregnancy productive health services in Niger Delta region, Nigeria. It further shows a coefficient correlation (R) as 0.243, the correlation square (R_2) was 0.059 while the adjusted R_2 was 0.058. Considering the adjusted simple regression coefficient which is 0.058, it is implied that 5.8% of the variations on female adolescents pregnancy productive health services in Niger Delta region, Nigeria is accounted for by poverty. The significance of the composite contribution was tested at $p<0.05$. The table also showed that the analysis of variance for the regression yielded a calculated F-value of 62.423 was significant at 0.000 level which is lower than 0.05, the chosen level of probability. Therefore, poverty is a significant correlate of female adolescents' pregnancy productive health services in Niger Delta region, Nigeria. Furthermore, the table shows that in model 1 where poverty formed the model the Beta value was 0.243 and the significant t-value was 7.901 which is significant at 0.000 level and is lower than the 0.05, the chosen level of probability. That is poverty can independently relate significantly with female adolescents pregnancy since, it contributed to about 5.8% variations in early marriage

among adolescents. The regression equation for model 1 is $Y^1 = 2.386 + 0.210\ X_1$ where X_1 is the score on poverty and Y^1 = is the predicted early marriage score.

Hypothesis 2: Is there any significant relationship between cultural belief and the access of female adolescents' pregnancy productive health services in Niger Delta region, Nigeria.

Table 4: Summary of simple regression and correlation showing cultural belief and the access of female adolescents' pregnancy productive health services in Niger Delta region, Nigeria

Sources	**R**	**R2**	**Adjusted R2**	**Standard Error**	**Fcal**	**SS**	**MS**	**df**	**p-value**	**Decision**
Regression	0.327	0.107	0.106	0.542	119.574	35.113	35.113	1	0.000*	Significant
Residual						293.067	0.294	998		
Total						328.181		999		
Model	Unstandardized Coefficients			Standardized Coefficients		t			p-value	
1	Beta (β)	Std. Error		Beta (β)						
(Constant)	1.974	0.093				21.203			0.000*	
Poverty	0.325	0.030		0.327		10.935			0.000*	

Asterisks shows significant relationship p<0.05

Table 4 shows a positive correlation of cultural belief on female adolescents' pregnancy productive health services in Niger Delta region, Nigeria. It further revealed that the simple regression coefficient obtained from the influence of cultural belief (R) was 0.327, the regression coefficient square (R2) was 0.107 while the adjusted R2 was 0.106. Considering the adjusted simple regression coefficient which is 0.106, it is deduced that the influence of cultural belief can only contribute about 10.6% of the variations on adolescents' pregnancy in Nigeria Delta region. The table also showed that calculated F-value of 119.574 was significant at 0.000 level which is lower than 0.05, the chosen level of probability. Thus, cultural belief is a significant correlate of female adolescents' pregnancy productive health services in Niger Delta region, Nigeria. The result indicate that model 1 where cultural belief formed the model, the Beta value was 0.327 and the significant t-value was 10.935 which is significant at 0.000 level and is lower than the 0.05, the chosen level of probability. This implies that cultural belief can independently relate significantly with female adolescents pregnancy since, it contributed to about 10.6% variations in adolescents pregnancy. The regression equation for model 1 is $Y^1 = 1.974 + 0.325\ X_1$ where X_1 is the score on religious norm and Y^1 = is the predicted early marriage score.

3. Discussion of Findings

3.1 Poverty Relief

The finding reveals that poverty was a correlate of female adolescents marriage as some adolescents were forced into female early marriage by their parents in order to cater for some financial obligations, because adolescent girls are seen as family-building strategy, because of continuing economic hardship, to reduce or protect them from economic burden and because the earlier the female child goes legally into marriage, the higher the bride price. This finding also goes in line with the submission of Elis (2003), which stated that poverty plays a central role in perpetuating adolescent marriage, as parents want to ensure their daughters' financial security; however, daughters are considered

an economic burden as feeding, clothing, and educating girls is costly, and girls will eventually leave the household. A family's only way to recover its investment in a daughter may be to have her married in exchange for a dowry. In some countries, the dowry decreases as the girl gets older, this may tempt parents to have their daughters married at younger ages. These are not necessarily heartless parents but, rather, parents who are surviving under heartless conditions.

3.2 Cultural belief

This finding points out that some cultures applaud virgins, so they give out their girls to marriage at an early age, and some lack the knowledge of what is involved in marriage, so they encourage their adolescent girls into it. While in some cultures early marriage is a sign that the adolescent girls is attractive and the family is worthy to associate with, also in some cultures a girl child is an asset so they get them married out as quickly as possible, they have a longer period of fertility before them; and they are more likely to be obedient and docile. This finding corroborates that of Goody (1990), which highlighted a number of reasons why young brides are preferred in traditional societies: they have a longer period of fertility before them; and they are more likely to be obedient and docile and possess the necessary qualities to learn and accept the rules and ways of her new household. Relatedly, Dixon (1971), attributed the historic practice of adolescence marriage in China, India, Japan and Arabia to the prevalence of clans and lineages which gave economic and social support to newly married couples, as well as pressures to produce children for strengthening and sustaining the clan. By contrast, the traditional emphasis on individual responsibility in Western family systems meant that newly married couples were expected to be able to provide for themselves and their children, which necessarily causes marital delays while the potential bride and groom acquire the needed skills, resources and maturity to manage an independent household.

Conclusion

Based upon the findings as revealed in this study, it is however appropriate to conclude that poverty and cultural believe was a significant correlates of access female adolescents pregnancy productive health services in Niger Delta, Nigeria.

Recommendations

Consequent upon the findings and conclusions of this study, the following recommendations are made:

1. Ministry and parents must solve the problem of poverty on the access of female adolescents' pregnancy productive health services in Niger Delta, Nigeria.

2. Traditional herbalist and parent should identify the effect of cultural belief on the access of female adolescents' pregnancy productive health services in Niger Delta, Nigeria

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