Child Marriage Health Issues among Adolescent Tribal Girls in Nigeria
DOI: 10.13140/RG.2.2.26923.26402

Child Marriage Health Issues among Adolescent Tribal Girls in Nigeria. Anastasia Ashi, Ph.D., M.Ed; Grace Nwosu, Ph.D., MS, FIIAS. Journal of Functional Education; Fall 2020, Volume 4, No 5, 111-126.

RESEARCH ARTICLE

Child marriage health Issues in Nigeria

Anastasia Ashi, Ph.D., M.Ed

Research Associate

Center for Academic Research and Educational Sustainability

Abuja, Nigeria

Grace Nwosu, Ph.D., MS, FIIAS

Faculty

Emmanuel University

Fayetteville, North Carolina, U.S.A.

Abstract

Child marriage has life-threatening implications for the mental, physical, and psychological development of the girl-child. In Sub-Saharan Africa, and other resource poor settings, child brides and very young mothers undergo various negative experiences including economic hardship and health challenges such as obstetric fistulas, birth complications, and even death. The purpose of this phenomenological study was to describe the lived experiences of child marriage and its effect on maternal health among young mothers in Nigeria. The social ecological model provided the conceptual framework for this study. Ten young women ages 18-24 years who had been child brides when age 12-16 years were recruited through purposive sampling and interviewed using in-depth key informant interviews. Global progress towards the reduction of maternal mortality rates was disproportionate in Sub-Saharan Africa where young girls were at higher risk of dying during or after pregnancy compared to their counterparts in Europe (Global Development, 2014). The completion of the MDGsgave way to the Sustainable Development Goals (SDGs) of 2016-2030. Both the retrospective MDGsand current SDGsadvocate development centered on people and identified women and children as important segments of the population as well and a critical link between the present generation and the future. Therefore, investing in the health of women is of immense global benefit (United Nations, 2015).

Introduction

Despite global efforts to improve maternal outcomes in Nigeria progress is slow (Okigbo, Adegoke, & Olurunsaiye, 2017). While reasons for the slow pace have not been identified, contextual issues - such as gender (autonomy, inequality), socioeconomic status (education, poverty), and cultural factors (child marriage, patriarchy), are all associated with young and teenage motherhood (Bruce et al., 2015). In this chapter, apreview of the study is provided, with highlights on how background issues of developmental goals have affected maternal outcomes in Nigeria.In addition, the statement of the public health problem, research questions, limitations, nature of the study, theoretical framework, and the significance of the study are presented.

While the global maternal death rate is estimated at 350per 100,000 women each year, these deaths are due to preventable complications related to pregnancy and childbirth (United Nations, 2015).In 2008, six countries including Nigeria accounted for over 50% of maternal mortality (WHO, 2014). Global statistics as of 2017 indicated that Nigeria ranks second behind India, and eighth behind Angola, Liberia, Niger, Rwanda, Sierra-Leone, and Somalia, in maternal mortality rates in Sub-Saharan Africa (Kalipeni, Iwelunmor, & Grigsby-Toussaint, 2017). In addition, the high frequency of teen pregnancies in Nigeria is associated with a high rate of sexually transmitted diseases and negative social reactions towards affected girls thus placing their health at increased risk (Asonye, 2014). Achieving improved maternal outcomes in resource poor settings, including many parts of Sub-Saharan Africa, is still a significant challenge to the healthcare system (Okigbo et al., 2017).

The MDG No. 5 aimed at improving maternal health. Its major objective was to reduce the maternal mortality ratio by three-quarters between 1990 and 2015, as well as achieve universal access to reproductive health (UNICEF, 2018). The global maternal mortality ratio among women ages 15-49 dropped nearly 44%, not 75% as projected (WHO, 2015). In Sub-Sahara Africa, the unmet need for family planning declined from 28% to 24% (WHO, 2015).

Nigeria is still not on track to achieve the MDG No. 5 on maternal morbidity and negative maternal outcomes (Zuber et al., 2018). Some of the factors underlying this failure are early age of marriage, poverty, lack of education, and delay in seeking professional health care (Bruce et al. 2015). In Morocco and some parts of Sub-Saharan Africa, Sabbe et al. (2013) also identified male sexual desire and the patriarchal system as a major risk factor for child marriage, especially where a father's right over his daughter can be transferred to an older male in the community for economic gain, a practice that is believed to strengthen the family's social status and improve economic relationships. A report by Women Living Under Muslim Laws (WLUML) identified Nigeria as having some of the highest rates of child marriage in the world, with higher prevalence in the North, where an estimated 43% of girls get married by age 15 (UNOHCR, 2013).

Background

The United Nation's MDGNo.5 targeted a reduction in the maternal mortality rate by three-quarters between 1990 and 2015 (Zuber et al. 2018).Globally, there has been a 44% decrease in the maternal mortality from 385 deaths/100,000 live births to 216; however, this is less than the 5.5% annual rate required to achieve the three-quarters reduction in maternal mortality in the Goal No. 5 (UNICEF, 2016). Most regions experienced declines in the level of maternal

mortality between 1990 and 2015, but rates in Sub-Saharan Africa remain intolerably high at 510 deaths/100,000 live births. Out of the estimated 289,000 global maternal deaths in 2013, 62% occurred in Sub-Saharan Africa (WHO et al., 2014). In Nigeria, maternal mortality rates continue to accelerate, especially among young teenage mothers. These are critical issues and cannot be overlooked because Nigeria's population is about 18% of the total population of Sub-Saharan Africa (Okigbo et al., 2017). If maternal health must be improved in Nigeria there is, therefore, the need for an increased response to maternal health care to focus on vulnerable people (Okigbo et al., 2017). An in-depth understanding of the experiences of young teenage mothers may provide a basis for helping to improve care and support andfor reducing maternal deaths among this vulnerable group. An overview of some of the contributing factors that formed the experiences of child mothers andinhibited access to maternity care. The existing literature is reviewed, and an account of how this study addressed the gaps in the literature is described.

The factors that contribute to the lived experiences of young mothers ages 12-16 years during their prenatal, natal, and postpartum periods,have multifaceted implications and adverse outcomes for maternal health. Due to time limitations, Ifocused on understanding and describing the experiences of young mothers ages 18 to 24 years at time of the study, who were forced to marry and became mothers between ages of 12 and 16years. Limiting this study to this participant classification enabled the capture of extensive classification-specific data.

Responses were influenced by the bias of family members, who resisted any form of an interview and did not want their children to be exposed or to subject them to talk about unpleasant experiences. Husbands or in-laws did not readily grant permission for these young mothers to be interviewed, for fear of indictment. One way this limitation was addressed was counseling and awareness creation to enlighten participants' family that the study was meant to benefit the community and not to harm anyone irrespective of their religious affiliations. This helped in convincing some family members to allow their children participate in the study.

Theoretical Considerations

The socio-ecological model (SEM) was the conceptual framework that guided this study. The model is a multi-level theoretical approach that stems from Bronfenbrenner's ecological perspective (1979). It posits that health-related behavior affects and is affected by multiple influences, including intrapersonal, interpersonal, organizational, community and public policy (Glanz et al., 2015). Researchers can formulate multi-level interventions through the different levels of the SEM.

The social-ecological model was used to guide the study, contributed to the understanding of the multifactorial nature of the experiences of child marriage among young mothers in Nigeria, including psychological, socio-cultural, and institutional factors. This model developed by McLeroy et al. (1988) proposes that individual, interpersonal, community, organizational, and societal factors affect lifestyle, behavior choices, and health, whether directly or indirectly. In other words, the health-related behavior is a result of multiple levels of influence: intrapersonal, interpersonal, organizational, community and public policy. The model allows for a deeper understanding of individual experiences in the social and ecological context (Glanz, Rimer & Viswanath, 2015).

Literature Review

Context of Child Marriage

Child marriage refers to young, adolescent, juvenile or teenage marriage, often before the age of 18. UNICEF considers girls who marry before the age of 18 as child brides (Beattie et al., 2015). Child marriage involves young, adolescent, juvenile or teenage girls often before the age of 18. Child marriage could culminate into child motherhood. Not all girls who get pregnant are marry, and not all child brides end up as child mothers, but many adolescent mothers are child brides who were given out in marriage between ages 12-16 years, and many of the child brides end up as teenage mothers. This study focused on girls who became pregnant under 16 years rather than under 18, because this group of persons is most vulnerable, considered as minors and cannot give informed consent to the marriage (UNOHCR, 2013).

Child marriage, child motherhood, and poverty have been identified as barriers to improved maternal health outcomes (Bruce et al., 2015). Achieving enhanced maternal results in Nigeria is still a great challenge to the healthcare system and a significant issue in context. The practice of child marriage is thought to play a significant role in the slow rate of achieving improved maternal outcomes (Bruce et al., 2015). The United Nations Millennium Development Goals reports over the years, have continued to implicate child marriage as a significant factor that impedes the improvement of maternal health in Nigeria. Child marriage has been condemned as one of the most intolerable crimes in the world. A clear violation of the Universal declaration of human rights 1984, and International Covenant on Civil and Political Rights 1966, child marriage is considered an issue of human rights, slavery, and social injustice, that needs to be stopped (Nasrullah et al., 2014).

Contributing Factors to Child Marriage

Child marriage is prevalent in most parts of Africa including Mali, North West Africa, Cameroon, and Central Africa (Efevbera, Bhabha, Farmer & Fink, 2019; Oluwakemi, Amodu, Salami, & Richter, 2018). The regions that have a high incidence of child marriages are similar regarding culture and religion and characterized by high poverty rates, insecurity, and lack of education. Child marriage in Nigeria is affected by cultural norms, religion, and poverty (UNOHCHR, 2013). I have included factors that contribute to child marriage in this section as poverty, lack of prenatal education, patriarchy, access to care, cultural norms, religion, and insecurity.

Poverty

Nigeria is a country of paradoxes, richly blessed with human, material, and natural resources. The country is the eighth largest oil exporter in the world and the second largest economy in Africa, but over half of the population live below the poverty level. Poverty is higher in rural areas, and therefore these people have lower access to services (UNICEF, 2014). The case of Nigeria is critical to the rest of sub-Saharan Africa because Nigeria's population is highest in this region-about 180 million (National Population Commission, 2016).

The geographic locations in Nigeria play a very significant role on poverty and consumption. People who live in the northern zones fare worse than those living in other parts of the country. The high poverty level is affected by factors such as illiteracy, low productivity, poor infrastructure, and unemployment (UNICEF, 2014). Thus, there is a high incidence of child

marriage in the region, as many families give out their immature daughters for financial and economic gains.

A multi-country study on the prevalence and cultural causes of forced child marriage was conducted by an international non-governmental organization (NGO), Women Living Under Moslem Laws (WLUML). The study emphasized the role of poverty in child marriage and confirmed that child marriage in Africa takes place in a context of poverty, vulnerability, exploitation, and slavery and a cultural context in which exploitation and slavery are accepted, even though they infringe on the rights of the girl child (UNOHCHR, 2013).

Lack of Prenatal Education

Studies have shown that prenatal education is important in the life of women. Prenatal education affords girls the opportunity to understand proper nutrition during pregnancy, learn about the physiology of birth, and helps to heal past emotional scars, thereby enabling women have the best experience of childbirth.

Exposure to contaminated drinking water, child marriage and low maternal weight gain during pregnancy, have been found to contribute to preterm birth. In a study to examine the individual and interactive effects of prenatal arsenic exposure, child marriage and pregnancy weight gain on preterm birth in Bangladesh, Rahman, et al. (2017), found an inverse association between weight gain during pregnancy and preterm birth among women with a history of child marriage. The authors therefore concluded that the risk of preterm birth could be drastically reduced by reducing arsenic exposure and ending child marriage.

Lack of prenatal education promotes child and early marriage and places the girl and her entire family in an uninformed position about what to expect in marriage, pregnancy, and childbirth. Child marriage is significantly associated with several factors including lower age at first birth, fertility, increased risk of child mortality, decreased risk of contraceptive–use before any childbirth,higher risk of giving births multiple times, high risks of unplanned pregnancies, and increased risks of termination of pregnancies,as compared to adult marriage (Zuber et al., 2018).

Wodon, Male, Onagoruwa, Savadogo, and Yedan (2017) reinforce this fact as they suggest that when young adolescent girls are equipped with information on life skills and knowledge, they are better prepared to make decisions concerning their health and future. This means that prenatal education can help young adolescent girls to understand the dangers of early/child marriagesuch as bad headaches, obstetric complications, feelings of numbness and depression, as well as other myriads of health issues associated with child marriage, including death. Lack of prenatal education will rather expose young girls to ignorance of these facts.

Godha, Hotchkiss, and Gage (2013) evaluated the relationship between child marriage, fertility control, and maternal health care use outcomes in some South Asian countries. The researchers found that women who marry in early adolescence or childhood are predisposed to most of the negative outcomes than older women. Further, Chari et al. (2017) found that delayed marriage results in better health and educational outcomes and age at marriage is a significant determinant of a women’s educational attainment as well as her marriage market outcome.

Patriarchy

Patriarchy is defined as a system of male dominance and authority where women are oppressed through its social political and economic institutions.The patriarchal system allows a father to transfer his right over his daughter to the older male in the community for money, farmland, or crops, to enhance the family's social status and improve economic relationships. The patriarchal system creates opportunity for older men who selfishly desire young girls, to buy them off their parents for economic gains (Godiya, 2013). Furthermore, the patriarchal system is culturally justified and perceives women as commodities, not able to make decisions for themselves regarding when and who to marry. They are easily forced into marriage because by law they are regarded as chattels, without rights (UNOHCHR, 2013).

Nigeria is a patriarchal society where 40% of the girls marry before age 18, and 18.5% of girls marry before their 15th birthday (Godiya, 2013). While this system is prevalent in the northern parts of Nigeria, there are pockets of the patriarchal system in some parts of Southern Nigeria, specifically, the Utanga area of Cross River State. Here child marriage is practiced as money marriage. A girl of 10 years is given out in marriage in return for money and other material gains.

The patriarchal system in Nigeria creates a situation of male dominance, social stratification, and differentiation on the basis of gender, and places males in an advantageous position over females. Women are thought to be inferior to men, thus they are discriminated upon in all spheres of life, including acquiring formal education. They are relegated to the background, mistreated, and permanently kept as house-helps, and most times forced into early marriage or prostitution and trafficking (Godiya, 2013). Women are also vulnerable to climate related problems because their activities are mostly centered on occupations such as small scale and rain-fed agriculture (Onwuluebe, 2019).

The patriarchal system in Nigeria further places the female child at risk of early marriage and the subsequent complicationsof child marriage. With better educational opportunities, and other perquisites, men always see themselves as superior to women, while the women suffer severe constraints on their roles and activities. Women are marginalized in education and economic development, as well as social and political space (Bako & Syed, 2018). Thus, the patriarchal system limits the position of women and condones domestic and sexual violence.

The child mothers who are plagued with physical and psychological injuries such as obstetric fistula, experience a broad sense of loss that negatively impacts on their identity and quality of life (Msele & Kohi2015; Zuber et al., 2018). The study of Okigbo et al. (2017) validated the findings of earlier studies and show that child brides are exposed to multiple forms of obstetric complications such as hypertension, female genital mutilation, diabetes, HIV/AIDS, vesico-vaginal fistula resulting from prolonged obstructed labor, and death. In addition, Beattie et al. (2015) identified lack of education, intense pressure from their older partners to become pregnant, and high rates of maternal mortality, as some of the negative factors that make up the experiences of teenage mothers.

Methodology and Design

A phenomenological design with in-depth face-to-face interviews was meant to elicit information about the perceptions, attitudes, knowledge, and feelings of participants about their

lived experiences.The interviews included open-ended and follow-up questionsto enable young mothers to tell the story of their lives as child mothers. The interview questions were transcribed, and member checking was used to detect and correct errors that may have occurred during transcription. Data was collected until all available participantswere interviewed. I repeated interviews to guide against inadequate data that could result in lack of saturation and inconsistency. The research question was: *What are the lived experiences of child marriage andmaternal outcomes among young mothers ages 12-16 years during their prenatal, natal, and postpartum periods in Nigeria?*

This study was conducted in Igu community of Abuja, Nigeria. The rationale for selecting this community was based on its proximity to the Federal capital of Nigeria where healthcare and maternity facilities are easily available, but the rate of death of young mothers is alarming. Igu community is a rural area where teenage motherhood is prevalent. The rate of poverty is extremely high and socio-economic status of women is low, with low levels of education. The planned sample was up to 20 participants. Although the recommended sample size for the phenomenological study is 10, up to 20 participants were recruited toallow flexibility. Some participants failed to respond, while others declined participation in the course of the study. Participation was voluntary and flexible, and participants were allowed to decline at any point in the process (Rudestam & Newton, 2015). Eventually 10 participants were interviewed and the interviews were repeated until saturation was reached.

The interview guide was the instrument for data collection. Questions were framed to reflect the psychological, physiological, socio-cultural and institutionalexperiencesof participants. For example, participants wereasked to focus on describing their lived experiences as child mothers,what these experiences meant for themand how these experiences have affected them.

Enough data was collected to establish consistency of themes, an understanding of the raw data by other researchers, as well as generalization and transferability of results to similar findings. Participants repeatedly said the same things. At that point I knew that data was saturated. NVivo version 12 software (QSR International) was used to store data imported from audio transcripts, manage the data to identify nodes and themes, and to bring out rich and insightful descriptions of participants' views (Rudestam & Newton, 2015).

Findings

Data were collected until all available participants were interviewed. The principles of phenomenology and Colaizzi's seven steps for data analysis were employed to guide the study. Colaizzi (1978) outlined the following steps to analyze phenomenological data: (a) Transcription of interviews- each participants' interview is transcribed from the digital recording, then read the transcript several times to ensure the phenomenon of interest is critically explored; (b) Extraction of meaningful statements relating to child marriage and its effect on maternal outcomes; (c) Articulating the meaning of each statement, creating codes and allowing themes to arise from the data; (d) Aggregating the meanings into themes; (e) Writing the description, (f) Returning to participants to validate the descriptions; and, (g) Incorporating new data into the final description (Colaizzi, 1978).

The child marriage phenomenon is common in the Igu community of Abuja in Nigeria. The rationale for selecting this community was based on its proximity to the Federal capital of Nigeria where healthcare and maternity facilities are easily available, but the rate of death of young mothers is alarming. Igu community is a rural area where teenage motherhood is prevalent. The rate of poverty is extremely high and socio-economic status of women is low, with low levels of education. The participants were mainly young women ages 18-24 years who experienced child marriage while they were ages 12-16. The child marriage phenomenon was found to be higher among the rural poor and less educated adolescent girls, those without a faith affiliation, those who were vulnerable, and those who faced teenage motherhood risks and associated complications.

Data were analyzed using the principles of phenomenology and Colaizzi's seven steps for data analysis, namely; (a) transcription of interviews; (b) extraction of meaningful statements (c) articulating the meaning of each statement, creating codes and allowing themes to arise from the data; (d) aggregating the meanings into themes; (e) writing the description; (f) returning to participants tovalidate the description; (g) and incorporating new data into the final description (Colaizzi, 1978).

At the inception of data collation, listening to the audio recording several times and transcribing all the interviews on word document occurred as many times as interviews took place. Multiple re-reads ensured the transcripts corresponded with the audio recording.

All participants were unhappy. All the participants shared one thing in common: they were all unhappy with the situation in which they found themselves. The participants offered mostly varying explanations. Some participants skipped a question or two, but none of them missed the opportunity to reveal feelings of unhappiness. **Child brides are denied the right to education.** Participants were denied the right to education. Some child wives desired education while others were uninterested in the topic of education. Child wives are deliberately denied education because it removes them from physical availability. Contrary to the child marriage custom, the girl child needs education to become free.

Child wives are either slaves or house helps. Societies have principles they subscribe to; some societies are husband-driven. Men must have wives and, sometimes, multiple wives without regard to exactly how many the wives are. **Most participants are deprived of positive human qualities by their spouses.**Maltreatment, beating, incarcerating, punishing, and taunting are some of the ills that befall a child wife. **Every passing day has its surprises; victims of child wives face unexpected negative events.**Child wives do not have the capacity to stand up for themselves. Passersby do not intervene when a girl child is being chastised or punished because they simply assume she is either a slave or wife.

Child wives are used as collateral for loans and other goods. Collateralization is a situation where a man gives out his young daughter in exchange for money, or other goods. Most child marriages are contracted on the basis of imposition by parents, conscription by men, collateralization by lenders, subtle acquiescence, and other contingencies. When a man has money in a culture that practices child marriage, that man will begin to look for a poor family that he can lend some money to and take their girl child as a collateral. This is the process of indirect marriage, and the local community refer to it "money" marriage.A few parents who want to send their sons to school rent out, sell, or mortgage their daughters, no matter the age of such daughters. The inability of a family to pay the school fees for their children would sometimes cause them to sacrifice their female children to make sure the male children are sent to

school.When girl child becomes a wife under the circumstances of parental poverty, the child-wife has little or no value to the lien-holder glorified as husband.

Circumstances beyond the control of parents often compel them to send their little girl children into forced marriages. Child wives experience a feeling of confusion, not understanding what is going on or why they have to leave home The job of the girl child is to obey and do everything that is whispered,spoken, or screamed into her ears. The culture of respect comes with the posture of the controllers and the controlled. **Many girl-children are forced into becoming home-makers.**Matrimony is desirable across the cultures within the demographic; however, the reasons are often different from culture to culture. Parents who are financially incapacitated often force their little girls to go and live with other families. Young girls become wives when they are not ripe for matrimony. Pregnancies occur among girl children mainly in specific cultures that practice child marriage; therefore, the pregnancy of a child does not draw much attention as a problem. **Parents transfer pressure to their girl children.**A family that is experiencing hard times would, in the context of this study, hand over its little girl to go and live with another family. Some girls become slaves. Others become wives. There is a lot of stress on all parties, caused by pressure on all sides- financial pressure on parents, psychological stress on men showing masculinity, and physical and emotional stress on the girl child, of being sold out into slavery, physical stress of giving birth at a tender age, and eventual health complications , STIs, HIV/AIDS, fistula, and death.

Recommendations

Prenatal education can help young adolescent girls to understand the dangers of early/child marriage such as bad headaches, obstetric complications, feelings of numbness and depression, as well as other myriads of health issues associated with child marriage, including death. Lack of prenatal education will rather expose young girls to ignorance of these facts.

The essential attributes of child brides should be investigated to enable trainers and influencers to know what to convey to policymakers. The mindset of the traditionalists in the demographic would also be of interest. This is because researchers would like to know why even a man who does not have a girl child would enter the child marriage market. The research findings would be helpful for educating not only the victims and perpetrators but also to raise awareness among members of the public who have been indifferent. While conducting such research, the investigators should consider finding ways and means to achieve solutions without creating counter-productive interest (Bako & Syed, 2018). In other words, individuals who have no knowledge of the existence of the child marriage market should not rely on the findings to become aware of the existence and decide to become traders in that market.

Future researchers using the qualitative methodology should also consider exploring perceptions in separate studies. For example, a researcher could use the qualitative method to capture the following:

1. The perceptions of former child brides, young adults who are still in the marriage that started when they were minors;
2. The perceptions of parents of child brides;
3. The perceptions of parents of young husbands;
4. The perceptions of old or mature adults still bringing in teenage brides. With the approval or permission of Institutional Review Boards, researchers could interview child brides whose stages in the marriage preclude them from any harm in answering interview questions.

I recommend that future researchers use quantitative methods to examine the demographics within which child marriage thrives, to capture potential correlations between pertinent variables. Furthermore, such researchers could use hypotheses to query any associations among runaway child wives, ego-driven young husbands, money-driven parents, the presence of child-bride rackets, and the role of non-governmental entities.

Conclusion

This study took place within a demographic that practices child marriage. The participants were decisive in presenting their responses; even though some of them were still under the weight of emotions, which encapsulates their lived experience and reality. Some of those emotional moments appeared to have prevented them from saying everything they could say. Considering the touchy nature of the subject of this research study, the participants demonstrated a commitment to the research topic. The need to vehemently pursue solutions to the plight of child wives is in the will of the survivors, and the findings will be instrumental to charting the course of rescuing the victims.In this concluding chapter I discussed the themes that emerged from the analysis, and I made recommendations and conclusions based on the findings from the study.

The problems requiring solutions are low age of marriage, lack of access to maternity care, nonexistence of women's health education, pervasive young teenage girls illiteracy, involvement and patronage of mature adult men, inability of the government to categorize child brides as vulnerable, and the insecurity of young girls, even from their birth families. Researchers, readers, and research users could rely on this study to investigate ways or solution models to eliminate the danger posed by child marriage.

References

Abayomi, A. A., (2018). Gender and behavior-Implications of Boko Haram operations on girl-child education in North Eastern Nigeria.*Gender and Behavior* 16 (1) *p 11085-11098. Retrieved from* https://hdl.handle.net/10520/EJC-fe1f16b84

Alam, N., Hajizadeh, M., Dumont, A., & Fournier, P. (2015). Inequalities in Maternal Health Care Utilization in Sub-Saharan African Countries: A Multiyear and Multi-Country Analysis. *PLoS ONE* 10(4), e0120922. doi:10.1371/journal.pone.0120922

Amoudu, O.C., Salami, B.O., & Richter, M.S. (2018). Obstetric fistula policy in Nigeria: a

Bako, M. J., & Syed, J. (2018) Women's marginalization in Nigeria and the way forward, *Human Resource Development International*, 21(5), 425-443. doi:10.1080/13678868.2018.1458567

Bashah, D.T., Worku, A.G. & Mengistu, M.Y. (2018). Consequences of obstetric fistula in sub Sahara African countries, from patients' perspective: a systematic review of qualitative studies. *BMC Women's Health,* 18, 106. doi:10.1186/s12905-018-0605-1.

Beattie, T. S., Bhattacharjee, P., Isac, S., Davey, C., Javalker, P., Nair, S., & …Heise, L. (2015). Supporting adolescent girls to stay in school, reduce child marriage and reduce entry into sex work as HIV risk prevention in north Karnataka, India: protocol for a cluster randomized controlled trial. *BMC Public Health,* 15292. doi:10.1186/s12889-015-1623-7

Carpenter, C., (2013).Phenomenology and rehabilitation research. In: Liamputtong, P. (2013). *Research methods in health: Foundations for evidenced-based practice*.2nd ed. Melbourne: *Oxford University Press.* p.123-40.

CDC, (2017). The Social Ecological Model: A framework for prevention. Violence, Prevention/Injury Center.*Centersfor Disease Control and Prevention.* Retrieved from http/www.cdc.gov/violence/prevention.o

Chari, A.V., Heath, R., Maertens, A., & Freeha, F., (2017). The causal effect of maternal age at marriage on child wellbeing: Evidence from India. *Journal of Development Economics 127*(42-55). doi:10/1016/j.jdeveco.2017.02.002

Efevbera, Y., Bhabha, J., Farmer, P. & Fink, G. (2019). Girl child marriage, socioeconomic status, and undernutrition: evidence from 35 countries in Sub-Saharan Africa. *BMC Medicine, 17,* 55. doi:10.1186/s12916-019-1279-8

Ezeonwu, M. (2014). Policy strategies to improve maternal health services delivery and outcomes in Anambra State, Nigeria.*Health Care for Women International,* 35(7-9), 828-844. doi:10.1080/07399332.2014.925454

Gemignani, R., & Wodon, Q. (2015). Child marriage and faith affiliation in Sub Saharan Africa: stylized facts and heterogeneity.*The Review of Faith & International Affairs*,13(3), 41-47. doi:10.1080/15570274.2015.1075752

Glanz, K., Rimer, B. K., & Viswanath, K. (Eds.). (2015). *Health behavior: Theory, research, and practice* (5th ed.). San Francisco, CA: Jossey-Bass/Wiley

Global Development. (2014). Maternal mortality down 45% globally, but 33 women an hour are still dying. Retrieved from: https://www.the guardian.com/news/datablog/2014/may/07/maternal-mortality-rate-drops-half-report-whochildbirth-pregnancy

Kalipeni, E., Iwelunmor, J., & Grigsby-Toussaint, D. (2017). Maternal and child health in Africa for sustainable development goals beyond 2015.*Global Public Health*,12(6), 643-647. doi:10.1080/17441692.2017.1304622

Kikuchi, K, Ansah, E., Okawa, S., Shibanuma, A., Gyapong, M., Owusu-Agyei, S., Oduro, A….& Jimba, M. (2015). Ghana's Ensure Mothers and Babies Regular Access to Care (EMBRACE) program: study protocol for a cluster randomized controlled trial and the Ghana EMBRACE Implementation Research Project. doi:10:1186/s13063-0140538

Liamputtong, P. (2013). *Qualitative research methods* 4th ed. Melbourne: *Oxford University press*.

Lukoye, D., Ssengooba, W., Musisi, K., Kasule, G. W., Cobelens, F. J., Joloba, M., & Barolia, R. (2016).An ethnographic investigation of the maternity healthcare experience of Immigrants in rural and urban Alberta, Canada.*BMC Pregnancy and Childbirth,* 1620. doi:10.1186/s12884-015-0773-z

Meurice, M.E., Genadry, R.R., Bradley, C.S., Majors, B., & Ganda, S.O. (2016). Identifying barriers to accessing information and treatment for obstetric fistula in Niamey, Niger. *Proceedings in Obstetrics and Gynecology*, 6(2), 1-13. doi:10.17077/2154-4751.1304

Meyer, E., Hennink, M., Rochat, R., Julian, Z., Pinto, M., Zertuche, A., & Cota, P., (2016). Working towards safe motherhood delays and barriers to prenatal care for women in rural and peri-urban areas of Georgia. *Maternal and Child Health Journal.* 20 (7), 1358-1365. doi:10.1007/s10995-016-1997x

Mourtada, R., Schlect, J., & DeJong, J. (2017). A qualitative study exploring child marriage practices among Syrian conflict-affected populations in Lebanon. *Conflict and health,* 11(Suppl1), 27. doi:101186/s13031-017-0131-z

Mselle, L.T. & Kohi, T.W. (2015). Living with constant leaking of urine and odour: thematic analysis of socio-cultural experiences of women affected by obstetric fistula in rural Tanzania. *BMC Women's Health*, *15,* 107. doi:10.1186/s12905-015-0267-1

Okigbo, C. C., Adegoke, K. K., & Olorunsaiye, C. Z., (2017). Trends in reproductive health indicators in Nigeria using demographic and health surveys. *Global Public Health,* 12(6*).* doi:10.1080/17441692.2016.1245350

Okwaraji, Y. B., Webb, E. L., & Edmond, K. M. (2015). Barriers to physical access to maternal health services in rural Ethiopia*BMC Health Services Research*, 1549. doi:10.1186/s12913-015-1161-0

Oladapo, T. O., Souza, J. P., Bohren, M. A., Tuncap, O., Vogel., J. P., Fawole, B., Mugerwa, K., & Gulmezoglu, M., (2015). WHO Better Outcomes in Labour Difficulty (BOLD) project: innovating to improve quality care around the time of childbirth. *Reproductive Health,* 12(48). doi:10.1186/s12978-015-0029-4

Rahman, M.L.,Kile, L., M., Rodriguez, G.E., Valeri, L., Raj, A., Mazumdar, M., & Christiani, D. C. (2017). Prenatal arsenic exposure, child marriage, and pregnancy weight gain: Associations with preterm birth in Bangladesh. doi:10.1016/j.envint.2017.12.004

Ravitch, S. M., & Carl, N. M. (2016). *Qualitative research: Bridging the conceptual, theoretical, and methodological*. Thousand Oaks, CA: Sage Publications.

Rudestam, K. E., & Newton, R. R., (2015). *Surviving your dissertation: A comprehensive guide to content and process* (4th ed.).Thousand Oaks, CA: Sage Publications.

Sabbe, A., Oulami, H., Zekraoui, W., Hikmat, H., Temmerman, M., & Leye, E., (2013).

Sialubanje, C., Massar, K., van der Pijl, M., Kirch, E., Hunter, D., & Ruiter, R., (2015). Improving Access to Skilled Facility-Based Delivery Services: Women's Beliefs on Facilitators and Barriers to The Utilization of Maternity Waiting Homes in Rural Zambia. *Reproductive Health*, 12(61). doi:10.1186/s12978-0051-6

Schmitz, M., M., Serbanescu, F., Kamara, V., Kraft, J. M., Cunningham, M., Opio, G., Komakech, P., Conlon, C. M., & Mary M. Goodwin, M. M. (2019). Did saving mothers, giving life expand timely access to life saving care in Uganda? A spatial district -level analysis of travel time to emergency obstetric and newborn care.*Global Health: Science and Practice.* 7(S151-S167. doi:10.9745/GHSP-D-18-00366

Solomon S., (2017). Creating Protocols for Trustworthiness in Qualitative Research. *Journal of Cultural Diversity, 23(3),* 121-127 Retrieved from https://www.ncbi.nlm.nih.gov/labs/journals/j-cult-divers/

Dr. Anastasia Ashi is a Research Associate at the Center for Academic Research and Educational Sustainability in Abuja, Nigeria. She is also a Member of the Africa Governance Index Committee in Ghana, West Africa.

Dr. Grace Nwosu is a Faculty Member at Emmanuel University. She is also a Fellow of the International Institute for African Scholars in Fayetteville, North Carolina in the United States.

Key words: child marriage, teenagers, child abuse, poverty, domination