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Being a Child Bride in Nigeria: A Feminist Narrative Inquiry

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ABSTRACT

This thesis draws on narratives of northern Hausa-Fulani Nigerian women married as child brides. The aim was to gain an in-depth understanding of Child Early Forced Marriage (CEFM) as experienced by these former child brides and identify the conditions that influence their decision-making autonomy on health care services utilization. A narrative inquiry approach within an intersectional feminist lens was used to analyze the structural, social, cultural, and religious realities that shape the experiences of former child brides in Nigeria. Fifteen former child brides from rural northern Nigeria who now reside in a southern urban setting of the country completed semi-structural interviews. Cladinin and Connelly's (2000) three-dimensional framework was used for analysis. Emergent themes were "young age at marriage and agency," "role of culture and religion," and "education too late for me but not for my daughter." The findings indicate that social constructs sustain CEFM to further gender inequality in Nigeria. Former child brides' past experiences helped shape future positive changes for their daughters, as they now value increased female education as a means to resist CEFM. The results could inform policymakers seeking to protect the rights of women in Nigeria and globally. Factors constraining women's decision-making authority and agency need to be addressed to enhance former child brides' advocacy for their daughters. Empowering former child brides through social and cultural initiatives can promote their agency to resist CEFM for future generations through quality education and the possible adoption of formal healthcare delivery in this ethnic group.

Keywords: Child and Early marriage, Child Brides, Intersectionality, Feminist, Narrative

Inquiry, Hausa-Fulani, Nigeria.

SUMMARY FOR LAY AUDIENCE

This thesis uses the stories of northern Hausa-Fulani Nigerian women married before 18 years, with the aim of gaining an understanding of Child Early Forced Marriage (CEFM), a practice of marrying off children before they come of age, common in the Hausa-Fulani of Nigeria. We studied the conditions that influence the ability of women who were married as children in Nigeria to make their own decisions regarding the use of health care services. Fifteen of these women from rural northern Nigeria who now live in the urban south completed interviews with the researcher. Cladinin and Connelly's (2000) three-dimensional framework was used for analysis. The main ideas, common to the women's stories, were "young age at marriage," "preference for home birth," and "education too late for me but not for my daughter." Our findings indicate that the practice of CEFM persists in Nigeria due to the culture and tradition that assumes men are superior to women in the family. The results further showed that the experiences of these women who married young is helping to shape future positive changes for their daughters, as these women now desire their daughters to have opportunities similar to the southern educated Nigerian women.

The results of our study could assist lawmakers in making laws to protect the rights of women in Nigeria and the world. The conditions that reduce women's decision-making authority need to be addressed to make the former child brides 'hopes of getting better education for their daughters and eradicate CEFM a reality. Programs to enable these women can increase their decision-making power to resist the practice for future

generations through better education and the use of formal health care in this ethnic group.

CO-AUTHORSHIP STATEMENT

Olubukola Sonibare conducted this research under the supervision of Dr. Marilyn Evans and with her doctoral committee advisors, Dr(s). Treena Orchard and Marilyn Ford- Gilboe. Dr(s). Marilyn Evans, Treena Orchard, and Marilyn Ford- Gilboe. will be co-authors with Olubukola Sonibare in publications arising from Chapters two, three, and four.

DEDICATION

He has done ALL things well and left nothing undone. He alone doeth WONDERS. This is the Lord’s doing, and it is marvelous!

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

INTRODUCTION

According to UNICEF (2020), 12 million girls globally are married before their18th birthday every year, and by 2030, 950 million girls would have been married before 18 years of age, the majority from developing countries. Child/Early Forced Marriage (CEFM) is recognized as a global human right issue ((UNICEF, 2020) and is associated with negative physical (Raj, 2018); mental (John et al., 2019); reproductive (Suarez, 2018); and educational outcomes for women and girls (Wodon et al., 2017). The practice of CEFM is gender-based, affecting females more than males (Raj et al., 2018), and negatively impacts the girl child's growth and development (Bartels et al., 2018).

In 2019, the United Nations Human Rights Council passed a resolution to strengthen and accelerate actions to prevent CEFM and support child brides. These interventions underscore the importance of achieving Sustainable Development Goal Five (SDG5), which speaks specifically to the elimination of CEFM by 2030 (United Nations, 2015). In Africa, although the practice of CEFM is declining, it remains widespread in parts of West African countries (Koski, Clark, & Nandi, 2017). Sub-Saharan Africa has the world's highest rates of CEFM, with two in every five girls reported as married before the age of 18 (Raj et al., 2019; Wodon et al., 2017).

High rates of CEFM occur in regions of Africa where poverty, gender, and educational disparity are widespread and religious beliefs and cultural norms that promote the practice predominate (Koski et al., 2017). Nigeria, an impoverished country, is reported to have the highest rate of child brides in Sub-Saharan Africa (High Commission of Canada in Nigeria, 2016), reporting a prevalence of 40% (UNICEF, 2018). Exploring the lived experiences of former child brides in Nigeria is essential to

understanding the sociocultural contextual factors that contribute to CEFM being considered a social norm and identifying strategies to address the practice and its associated adverse health outcomes for women.

Background and Significance

Early/child marriage is defined as a formal or informal union where one or both parties are married before the age of 18 years (World vision, 2020) and is described as a form of forced marriage (Sabbe et al., 2014). Forced marriage is not age-bound and constitutes a type of sexual slavery, where one or both parties are unable to give full consent to be married (Sabbe et al., 2014). CEFM is stated to be used by parents to protect a girl child from the negative influences of peers, modernization, urbanization, and technology, which could result in pre-marital sex and pregnancy (UNPF, 2020). The practice is recognized as a human right violation (UNICEF, 2020) used to control a girl child's sexuality and reproductive life by her family and the larger community (Tchoukou, 2020).

Nigeria has more than 380 ethnic groups (Odimegwu & Adewoyin, 2020). The Hausa-Fulani, Igbo, and Yoruba are the three dominant ones, with Hausa-Fulani being the largest (Demographic, 2019). CEFM is a common practice among the many ethnic groups in Nigeria but has remained persistent among Muslim communities in the northern part of the country (Allen & Adekola, 2017; Anozie et al., 2018; Hassan & Varshney, 2019; Mobolaji et al., 2020). Evidence shows that CEFM is 15-18 times higher in the Hausa-Fulani people, the major northern ethnic group, compared to Yoruba and Igbo, the major two southern ethnic groups (Mobolaji et al., 2020). Therefore, this study specifically focuses on women from the Hausa-Fulani ethnic group.

There are distinct cultural, social, religious, and economic differences between the

northern and southern regions of Nigeria that could account for the high prevalence of CEFM seen in the north. Factors such as poverty, low education, religious and cultural beliefs have been associated with high rates of CEFM, particularly in northern Nigeria (Amodu et al., 2017). The southern region of Nigeria represents the more urbanized, educated, and socioeconomically advanced part of the country in contrast to Northern Nigeria, which is impoverished, especially in the rural communities (Allen & Adekola, 2017; Babalola & Oyenubi, 2018). Further, CEFM is seen as acceptable primarily within Muslim rather than Christian communities in Nigeria (Iyabode, 2016). The Hausa-Fulani living in the northern rural part of Nigeria are mainly of the Islamic faith, while the vast majority of the ethnic groups in the south practice Christianity (Babalola & Oyenubi, 2018; Sabiu, 2018).

Within the northern Nigeria context, the practice of CEFM has been woven into the fabric of society as a social norm and subsequently transmitted across generations as a cultural tradition (Agege et al., 2018). CEFM is recognized as a manifestation of gender inequality and a reflection of deep-rooted social norms, which perpetuate the discrimination against girls (UNICEF, 2014). In regions where CEFM is a common practice, most girls' agency and decision-making capacity are limited, with little or no alternative options available to them (Zasha, 2018).

CEFM is sometimes used as a strategy for family survival to ease the economic burden of poor families (Allen & Adekola, 2017; Braimah, 2014). Girls living in poor households are approximately twice as likely to marry earlier than their counterparts living in wealthier households (Mathur et al., 2003). Poverty leads to limited access to formal education for a girl child (Raj et al., 2019), particularly for females living in rural regions. Hausa/Fulani women from northern Nigeria, many of whom were married as

child brides, typically migrate to urban cities in the south such as Lagos, with or without their partners due to extreme poverty, low income, and access to social and health services (Adekola et al., 2017). As a result of the interaction between poverty and their low educational background, these women are forced into petty trading and become part of the impoverished urban population (Izugbara & Ezeh, 2010). In contrast, the higher socioeconomic and educational status of their married counterparts from the south is protective against the dominant patriarchy and poverty in Nigeria (Adedini et al., 2017; Danjuma et al., 2015; Ebekue, 2017).

Cultural Disposition of Northern Nigerian Girls/Women

In northern Nigeria, CEFM remains a long-aged cultural belief associated with issues relating to gender inequality (Belhorma, 2016), including discrimination against girls and women within the family setting (Undelikwo et al., 2019). Families contribute to gender inequality by creating unequal opportunities for boys and girls through different parental attitudes. A girl child from patriarchal communities is socialized from birth to be calm, humble, and submissive to male figures (Undelikwo et al., 2019).

In such social contexts, the girl-child is confined to domestic activities, while the male child is socialized to be strong, adventurous, and enterprising (Undelikwo et al., 2019). Cultural norms in northern Nigeria promote male over female superiority, ascribe women to strictly segregated gender roles of wives and mothers, and encourage early child marriage and starting a family (Almu et al., 2019). In contrast, males are regarded as the head of the household and encouraged to achieve formal education or life skills.

Due to parental beliefs, societal norms, cultural norms, and religious beliefs regarding women's place in society, a girl child's agency is constrained and left with little or no choice but to conform to the practice of CEFM (Zasha, 2018). Bouilly et al.

(2016) point out that one's capacity to exercise autonomy is negatively impacted when someone with higher authority uses their power or coercion to override the agency of the subordinate. CEFM creates a double jeopardy situation for former child brides in characterizing their agency either as a single unmarried girl or a married woman. In both cases, their agencies are usually passive, constrained (Johnson, & Gilligan, 2021; Payne, 2012), and negative (Bouilly et al., 2016), as they cannot oppose the authority and decisions of the parent or spouse. Furthermore, Bouilly et al. (2016) argue that subordinate groups, such as former child brides, prioritize social values and norms over their own goals and act in ways that may be against their own desires.

Gender divide and power difference are created from birth socio-historically and infused into social fabric through which a male child is seen as dominant and a female child subordinate. In patriarchal societies, female education is not considered a priority, and parents place low value on girls' education because she is seen as the property of her future husband (Umeana, 2017; Undelikwo et al., 2019). Evidence indicates that educational marginalization in northern Nigeria results from male gender preference, where girls are more disadvantaged than boys in obtaining formal education (Onochie, 2010; UNICEF, 2018). According to UNICEF (2018), sociocultural norms and practices such as CEFM inhibit girls from attending school in northern Nigeria.

CEFM impacts schooling and educational opportunities as child brides are likely to drop out of formal school before or shortly after marriage (Mobolaji et al., 2020; Mlambo et al., 2019). Sinai et al. (2017) report that only 4% of northern Nigerian women complete secondary school due to being married as a young girl. CEFM contributes to northern Nigerian women's low social and economic status, which negatively impacts their decision-making autonomy (Mobolaji et al., 2020). Evidence suggests that

women's autonomous decision-making increases with higher educational attainment and socioeconomic conditions (Rizkianti et al., 2020). Further, evidence indicates that level of education is a determinant of the utilization of health service care (Adedokun, & Uthman, 2019). Studies have shown that women with lower levels of education utilize reproductive health services less than their counterparts with higher levels of education.

Health Services Utilization

In addition to poverty and low education, there is evidence to suggest religious laws that control the mobility of married women may compromise former child bride's use of formal health care services (Amodu et al., 2017). The practice of purdah, a religious and social practice of wife seclusion, widely practiced by members of the Hausa-Fulani community (Umaru Baba, & Van der Horst, 2018), constrain child brides' autonomy. For example, the practice restricts married women from going outside their homes without the permission of a male family member (Izugbara & Ezeh, 2010). Consequently, child brides' decision-making abilities are often limited due to factors such as being young Muslim girls, poor, uneducated, and subordinate; such vulnerabilities among Hausa-Fulani girls play a significant role in their low decision-making power and pose barriers to their accessing and using formal health services regardless of the geographical setting (Amodu et al., 2017).

Being young results in child brides being highly dependent on others for decisions regarding access and use of formal health care services. Their husbands, viewed as the head of the family, make most household decisions, impacting their health-seeking behavior. Women who are married as child brides grow up with limited decision-making power and are often non-users of formal health services because they need permission from their spouses (Fagbamigbe, & Idemudia, 2017).

Child brides give birth more frequently compared to their southern counterparts, who marry later. For example, the childbirth rate in Bauchi, a northern Nigerian state, is 41% compared to 1% in Lagos, a southern state (NDHS, 2018). Northern women are reported to use formal health providers far less than their southern counterparts during pregnancy and childbirth (Izugbara et al., 2016; Meh et al., 2019). According to Izugbara et al. (2016), 75-78% of women in the south compared to 11-20% in the north birthed their babies in the hospital.

Women who are married before the age of 18 years are particularly at increased risk of adverse pregnancy and birth outcomes. These underaged girls are expected to give birth within one year of marriage, have many children, and avoid the use of family planning and formal health services (Izugbara et al., 2016). Adolescence pregnancy is associated with high maternal morbidity and mortality (Anozie et al., 2018) and detrimental to the girl child's optimal health, especially for those who develop obstetric complications.

Maternal mortality rates in Nigeria are higher in the northern than southern regions (Amodu et al., 2017; Meh et al., 2019). According to Meh et al. (2019), maternal deaths in the north increased from 620 to 709 per 100,000 live births while slightly decreasing in the south from 401 to 365 per 100,000 live births between 2008 and 2013. Therefore, northern rural Nigerian women married as child brides have a higher risk of experiencing maternal mortality than their southern urban counterparts.

Culture of Home Birth

Religious edicts, cultural norms, and beliefs encourage home births under a family member's supervision (Abubakar et al., 2017; Ejembi, 1996), sometimes without traditional birth attendants (TBAs) (Izugbara, & Ezeh, 2010). Among many women from

northern regions of Nigeria, expressing labor pain is culturally frowned upon, and because they frequently do not recognize or acknowledge when there might be complications requiring medical interventions, seeking formal medical care can be delayed (Amodu et al., 2017). For example, women may not consider labor to be prolonged until it has lasted for more than two days (Amodu et al., 2017). In Northern Nigeria, the rate of having skilled birth attendants assisting women during labor and childbirth is reported to be as low as 5% (Fapohunda et al., 2017). Even when involved, TBAs usually only take part in the last stage of labor to cut the umbilical cord (Amodu et al., 2017; Ejembi, 1996).

In Nigeria, CEFM is widely prevalent in patriarchal, predominantly Muslim communities, rural areas and practiced primarily by people of lower socioeconomic status. Previous research has focused on the causes and the health consequences of CEFM for women living in rural and impoverished settings and preventive strategies (Amodu et al., 2017; Walker, 2012; Walker, 2019; Wodon et al., 2018). Most of the research that examines the effects of CEFM on married girls in Nigeria are quantitative (Allen & Adekola, 2017; Nasrullah et al., 2014).

Little to no research has been conducted to examine the lived experiences of former child brides in Nigeria and their access to and use of reproductive health services in urban areas. In addition, studies in Nigeria have reported that the utilization of services like antenatal and post-natal care and family planning among women is higher in those living in urban compared to rural areas due to factors such as cost of services, limited access, income, age at marriage, and level of education (Fagbamigbe & Idemudia, 2017, Maharjan et al., 2019).

Advocates for women’s reproductive rights use the high maternal and child

mortality figures to argue for the elimination of CEFM practice. However, consideration is also needed on supporting women who are former child brides by exploring their marital experiences and understanding why they do not utilize existing reproductive health services for care. Revealing the perspective of former child brides about their experiences and their decision-making regarding the use of formal health care services can increase our understanding of what supports they need as adult women to promote their health. Focusing on the early marital experiences of former child brides helps illuminate their past lives as young girls and how this previous experience shapes their transition from child brides into adult wives and mothers. The results will identify factors that influence their overall health and use of reproductive health services due to marrying early.

This research uses narrative inquiry to understand the storied experiences of Hausa-Fulani Nigerian women who were married as child brides in either northern or southern Nigeria but presently reside in the south. The research explores how gender intersects with other factors to contribute and shapes the experiences of these women, including their access to and use of health care services. The thesis serves as a platform to provide insight into the experiences of former child brides, illuminate their voices and their perspectives in an urban setting using a narrative, feminist qualitative design.

Purpose of the Study

The purpose of the narrative study is three-fold:

1) To gain an in-depth understanding of childhood marriage as experienced by Nigerian women of northern descent in southern Nigeria.

2) To identify the conditions and forces that influence the decisions of these women regarding their use of health services, including supports available to them, and

3) To examine how those conditions shaped and influenced their lives/experiences as social agents in southern Nigeria.

Research Questions

This study will address the following questions within the context of northern Nigerian women who were married before the age of 18 years and now reside in southern Nigeria.

1) How do former child brides married before 18 years describe their experience of marriage?

2) How did former child brides negotiate their transition from the role of a child to becoming a wife, mother, and caretaker married to older men?

3) What factors/conditions in southern Nigeria influenced or hindered access to and use of health services of former child brides?

For the purpose of this research study, early/child marriage is defined as a form of forced marriage given that children under the age of 18 are not matured enough to consent to a marriage., The focus is particularly on female children since they are more impacted than male children globally and within the study context.

Theoretical Underpinnings

This research adopted an intersectional feminist framework to understand the experience of being former child brides in Nigeria and their decision-making regarding the use of formal health facilities for reproductive care. Feminist-informed research is conducted to raise awareness and create change related to the multiple oppressions women and other marginalized populations encounter due to their gender, ethnicity, race, socioeconomic status, religion, and gender (Hall & Steven, 1991; Im 2013; Olsen 2011). It seeks to address the unequal power dynamics embedded in patriarchal structures that

place women in vulnerable positions.

Feminists researchers in nursing (e.g., Becker, 1999; Hall & Steven, 1991; Im, 2010; Olsen, 2011) have suggested that feminist-informed research in nursing should consider the following: a) make gender an analytical framework to examine how the social construction of gender gives power and authority to one sex and disadvantages another; b) center the experiences and stories of women as critical to knowledge production; c) promote social and transformative change in society which include acknowledging women as social change agents; and d) target the emancipation and empowerment of women and other marginalized populations from unequal power relations. Examining the experiences of former child brides and using their narratives as primary data is a conscious act of presenting Hausa-Fulani women as significant social actors who co-create knowledge and not only as passive victims of their CEFM circumstance (Mohantry, 2003). Involving and engaging former child brides as women who were affected by the issue of CEFM is empowering for them in the sense that it centers former child brides as social change agents in the history of changing early child marriage in Nigeria.

Feminist theory is relevant for exploring the experiences of former child brides because of its specific focus on gender and the lived experiences of women. However, a theoretical tenet of intersectionality asserts that no single factor should prioritize human experience and that experience cannot be accurately understood by a single characteristic such as gender (Crenshaw, 1989; Hankivsky, 2019). Therefore, combining intersectionality with feminist theory, both of which focused on social justice, will illuminate the multiple level dimensions of the women's experiences, and create knowledge that has an emancipatory and empowerment intent (Hankivsky, 2014; Yuval-

Davis, 2006).

Crenshaw coined the term ‘intersectionality’ in 1989 to describe how intersecting identities such as race, class, sexuality, and gender work together to oppress an individual (Crenshaw, 1989; Hankivsky, 2019). In other words, an intersectional approach to research would involve examining multiple and complex elements of structural inequalities and power dynamics (Rogers & Kelly, 2011). Since its coinage, the term has dominated the fields of feminist studies and social sciences research. In nursing and health research, intersectionality as a theory and framework has been used to study social justice and health disparities (Rogers & Kelly, 2011), race and caring practices (Raghuram, 2019), and power and privilege in nursing practice (Van Herk, 2011).

Given that intersectionality has been theorized to represent prevailing inequalities in the global north, the term can be contextualized to the multiple inequalities affecting women and other marginalized people in the global south. Although race may not directly affect the global south and Africa in particular, gender interacts with other multiple social factors to produce gender and power inequality. Social factors such as young age at marriage, low education, ethnicity, poverty, culture, and religion intertwining with gender have been identified to vary as a function of one another (Caiola et al., 2014) to predispose women to the practice of CEFM (Mobolaji et al., 2020). In other words, varied social locations matter in creating differences in the experiences of the women married as children in Nigeria.

But intersectionality also takes the position that it is the interactions of these varied positions that create these differences. According to (Crenshaw, 1989), these factors are multidimensional and relational in nature; they cannot be separated into distinct categories or hierarchical order. In order words, the factors vary in function as

they intersect; they can also exist simultaneously (Brisolara, 2003). Variation in these social constructs creates diverse marital experiences for women. For example, the marital experience of an uneducated poor (education level and poverty) northern Hausa-Fulani (ethnicity) woman (gender) living in an urban setting (geographical location) may be quite different than that of an educated southern woman who married at a later age (Mobolaji et al., 2020). Compared to women with a higher level of education, uneducated child brides are reported to be more predisposed and vulnerable to CEFM (Marphatia, et al., 2017). Although the social factors relate, they produce different and multi-dimensional experiences for the person in question.

The Researcher's Standpoint

When conducting qualitative feminist research, it is crucial for a researcher to identify her perspective and assumptions in order to locate herself within the research (Mehra, 2002). My perspective and assumptions as they relate to this study originated in my clinical experience as a nurse working in Nigeria. My background as a Nigerian by birth and professional experience as a bedside nurse in a developing patriarchal country gave me the opportunity to observe the effects of sexist attitudes such as prescribed gender roles. Working as a bedside nurse with women married from childhood, many still young girls, learning about their traditional, cultural, and religious beliefs, I began to question the meaning of early marriage as a lived experience from the perspectives of these women living in an urban setting.

Even from a professional standpoint, women nurses still get discriminated against. Nurses (mostly women) in Nigeria are rated second class in the healthcare industry by the other male-dominant cadres of medical practitioners, with some even reduced to running personal errands for physicians in private establishments. This inequality not only breeds

limited opportunities for the nurses but also has a snowball effect on their female patients. They sometimes get discouraged rather than motivated when seeing the treatment of nurses and the disparity between them and their male counterparts in the other medical professions. Through my experience as a nurse, I learned about the importance and necessity of being a strong and independent woman and the challenges of achieving this independence in a male-dominated world. As a nurse and woman, I seek to enable other women, such as former child brides, to reach their desired potential and achieve their aspirations, which I believe aligns with the principles of feminist research.

My assumptions are as follows: (a) men are advantaged and preferred over women by the society at large but more so in a developing society; (b) women are undervalued and disparaged; (c) women are important, their voices should be heard, and more opportunities should be provided to them; (d) women's knowledge, experiences, and beliefs are fundamental and vital for the achievement of gender equality; (e) women can and have brilliantly combined successfully balanced home management, motherhood and successful careers for which they typically receive little credit, and for which they deserve recognition.

Thesis Overview

This dissertation is written in an integrated article format with five chapters, three of which are independent unpublished articles: a systematic review, the primary research study, and one discussion paper. Chapter 1 is the introductory section, including the overview, the rationale behind exploring the experiences of former child brides in Nigeria, the purpose and research questions, the theoretical perspectives to guide the study, and the researcher's standpoint. Chapter 2 presents a systematic review of existing research to understand the experiences of women married before 18 in Nigeria and other

African countries. Chapter 3 is the narrative study about the experiences of Northern Hausa-Fulani women married as child brides and their health-seeking behaviors. Based on a key result, Chapter 4 is a discussion paper on the role of health care professionals in providing support to former child brides in Nigeria to promote their health. The Anderson Behavioral Model of Health Services Use (BM) was used as a guide. An overall summary of the study's findings, recommendations to address CEFM in Nigeria, and implications for nursing practice, further research, primary stakeholders, and public policies are outlined in Chapter 5.

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CHAPTER 2

LIVED EXPERIENCE OF CHILD BRIDES IN AFRICA: A QUALITATIVE SYSTEMATIC REVIEW

Introduction

Child/Early and Forced Marriage (CEFM) is largely practiced in Africa, Asia, parts of Latin America and Eastern Europe (Raj, 2010; Suarez, 2018) and defined as any formal or informal union where one or both parties are below the age of 18 (UNICEF, 2016). According to Raj et al. (2018), and corroborated by Suarez (2018), 720 million women were married under 18 years globally. Despite global intervention to address CEFM, girls from African countries are disproportionately affected compared to their counterparts from developed countries. In Africa, one in every two girls gets married before 18 years (UNICEF, 2014; Suarez, 2018).

Further highlighting the widespread practice of CEFM in Africa, evidence shows that 16 of the 20 countries with the highest rate of CEFM globally are in Africa (Efevbera, 2017; Girls Not Brides, 2015). According to country-specific data provided by the UNICEF report on ending child marriage, Bangladesh has the highest rate of CEFM of girls under the age of 15; however, Niger, a sub-Saharan African country, has the highest overall prevalence of CEFM in the world (UNICEF, 2014). Similarly, Nigeria has the highest rate of child brides in Sub-Saharan Africa (High Commission of Canada in Nigeria, 2016), accounting for 43% of child brides in the region (Girls Not Brides, 2020).

The occurrence of CEFM differs widely among regions within Nigeria, with a prevalence ranging from 10 % in the southern parts of the country to as high as 76 % in the north (Amodu et al., 2017). The minimum age of marriage is not fixed in the Nigerian constitution, but the Child Rights Act sets this age at 18. Currently, 24 of the 36 states in

Nigeria have adopted this act, only four of which are from the north: accounting for areas within the country (primarily northern) with the widespread practice of CEFM (Envuladu, 2016).

CEFM is a highly complex, controversial, and contextual issue in practicing countries, and there are different views of the practice depending on beliefs, values, and social norms. For example, CEFM has been viewed in some social groups as a mechanism to fulfill parents' desire to protect their girl child from idleness and promiscuity in the absence of viable alternatives such as education resulting from lack of economic resources (Stark, 2018; Zasha, 2018). Further, CEFM has been viewed as a product of gender inequality (Gatwiri & McLaren, 2017) sustained by socio-cultural norms and religious beliefs (Mobolaji et al., 2020), social values (Cislaghi et al., 2019), poverty (Envuladu, 2016), and weak legislation (Iyabode, 2016). Within patriarchal societies, girls are usually under the control of the male figure, usually the father or another male member in the extended family.

The practice of CEFM is categorized as a violation of human rights (Glover et al., 2018; Svanemyr et al., 2012; Wodon et al., 2017). Girls from impoverished families have limited agency due to their young age, and they are denied the right to choose who and when to marry because of limited viable alternatives. For example, education or skill acquisition is not considered a realistic option for girls because of cost. Child brides bear a disproportionately high burden of profound social marginalization and experience deleterious short- and long-term health outcomes (Raj et al., 2018). CEFM has a negative impact on gender equality/equity and women's health globally (Berkeley Public Health, 2013; Raj et al., 2018).

CEFM persists in a country such as Nigeria because it is rooted in patriarchal

power, embroidered through culture, religious practices, and poverty (Agege et al., 2017), making the practice a prevailing gender-related social norm. Within the family setting, a girl child is socialized to see the male figure as superior, a belief that persistently remains throughout her life cycle. For example, girls are trained to be good obedient housewives while boys are trained to be the potential head of the family. Boys are valued more than girls in patriarchal societies because a girl child is perceived as property for her future husband (Undelikwo et al., 2019).

This viewpoint discourages poor parents, usually the father, uncle, or elderly men in the community, from investing in formal education for girls. The male figure/authority would rather give out the girls in marriage in exchange for a dowry. (Undelikwo et al., 2019). The conventional arrangement played mainly by the men is used to control girls' sexuality in purporting of protection by placing a high value on the cultural norm of preserving the girl's virginity and prevent pre-marital sex, which is usually tied to the family honor (Sabbah-Karkaby & Stier, 2017). Consequently, these girls are given out in marriage as economic gain at a tender age, often to men much older than them (Belhorma, 2016; Gatwiri & McLaren, 2017).

Evidence indicates that CEFM negatively affects girls' physical health (Hamed et al., 2017), as well as their socioeconomic (Kenny et al., 2019), educational (Ganira et al., 2015), social and mental well-being (John et al., 2019). The practice is a key driver for poor maternal and child health outcomes in Nigeria. The cultural expectation and pressure on child brides to prove their fertility within the first year of marriage and have many children lead to high maternal-infant morbidity and mortality rates (Nnamuchi et al., 2015). Being married at a young age places young girls at increased risk for obstetric complications such as prolonged and obstructed labor, vesicovaginal fistula, stillbirths,

and postpartum hemorrhage because of their physical immaturity and underdeveloped reproductive system; infants born to child brides are at higher risk for neonatal death (Amodu et al., 2017; Envuladu, 2016). In addition, the mental and social wellbeing of child brides is adversely affected by experiencing pregnancy-related complications (Gatwiri & McLaren, 2017; Hamed et al., 2017), such as leaking urine and incontinence, which predisposes them to stigma and exclusion within their communities (Gatwiri & McLaren, 2017).

The existing research on CEFM is primarily quantitative and focused on adverse outcomes for child brides (Adedokun et al., 2016; Godha et al., 2013; Kamal & Hassan, 2015; Nguyen & Wodon, 2014) rather than on child brides' perceptions about their pre- and post-marital experiences. Although researchers increasingly recognize the significance of exploring child brides' perspectives on the practice (Adedokun et al., 2016), very few studies focus on the life that former child brides experience after marriage (Callaghan et al., 2015, Walker, 2019) and its impact on their health. Therefore, this systematic qualitative review of the literature aims to synthesize the best available evidence exploring the experiences of women who were married before the age of 18 years in African countries.

The findings of this review provide valuable insights on child brides' experiences, which may help government officials, policymakers, advocates, and health care providers to focus interventions on the needs of the child brides based on their experiences**.** In addition, having a description of the current state of the evidence on the experience of CEFM from the perspective of former child brides is essential in identifying the gaps in the evidence and guiding future research. The review's findings will provide evidence to inform health policy and health care practices in improving care for child brides locally,

nationally, and internationally. This review may also be used to increase efforts across the globe towards enhancing existing programs and supports available to former child brides.

Purpose of Review

This qualitative systematic review aims to identify and synthesize findings from qualitative studies on the experiences of women who were married as child brides in Nigeria and other African countries.

Research Question

The review aims to answer the following question: What are the similarities and differences in experiences of women who were married before the age of 18 years in Nigeria and other African countries?

Methods

Qualitative systematic reviews integrate findings from primary qualitative studies to inform and elicit new understanding about the experiences of participants in their own perspective and possibly influence the direction of future research (Seers, 2015).

Study Inclusion Criteria

The review questions and PICO (Participant, phenomenon of Interest, and Context) table for qualitative systematic review (Appendix A) defined the search strategy and criteria for the study. PICO is preferred over other tools such as SPIDER (Methley et al., 2014) for systematic reviews because it demonstrates a greater capacity for a fully comprehensive search. The review includes studies that use all types of qualitative methods. There was no publication time limit for the range of articles covered by this search in order to capture relevant studies and follow the trend of CEFM practice in African countries. The search for articles was carried out from April 2018 to April 2019.

Studies were included if: (1) they were peer-reviewed and published in English, (2) they focused on experiences of African women and girls who were married before 18 years in Africa, and (3) used qualitative or mixed methods design.

Search Strategy and Data Sources

The following electronic databases were searched: SCOPUS, Web of Science, CINAHL, Gender Studies, PROQUEST, and PUBMED. Search terms included “child bride*” OR” child marriage” OR “early marriage “OR “forced child marriage” OR “girl bride*” OR “girl marriage” OR “adolescent* childbearing” OR “teen* marriage” OR “young adult marriage” OR “arranged marriage” AND Nigeria OR Africa* OR “sub-Saharan”.

A literature database initial search was conducted to access all papers relevant to the topic with the help of a university librarian. Further screening of the literature was done using a more focused inclusion and exclusion criteria based on the PICo requirements (Curtin University Library, 2018). In addition to the databases mentioned above, the reference lists of relevant studies were hand-searched in order to identify additional references that were not found in the database. Finally, a manual search was done using Google scholar to access grey literature, albeit most of the eligible studies found there were already included in the previous search efforts.

Study Selection

Selection of the studies began after all the databases had been searched. To strengthen transparency as recommended by Tong, Flemming, McInnes, Oliver, and Craig (2012), in addition to the primary reviewer, an independent reviewer (TA) who is a graduate nursing student with previous experience in the research reviewed the search strategy and conducted the quality appraisal of included studies, using the same search

terms and eligibility criteria as the primary reviewer. After repeating the search strategy, the TA came up with five additional articles. One of these articles (Efevbera, 2017) was previously identified but not included because the full text was not available. It was added when a response for a full-text copy was received from the author. One other publication was included (John et al., 2019) after deliberations because it was a new publication and met the eligibility criteria. Three initially considered articles were excluded after reassessment because they did not meet the PICO criteria.

A total of 1680 studies were initially found: 1676 from the listed databases, and four through Google scholar. Only four articles were included from Google scholar because most of the articles found through Google scholar were already included in the other databases. After 31 duplicates were removed, 1649 studies remained for the first stage of screening, which was completed by reading the titles and abstracts of each article.

At the end of the first screening, 1541 articles were excluded for not meeting the eligibility criteria, leaving 108 going into the second stage of screening, which consisted of in-depth reading and evaluation of the full texts of the articles to select the most relevant that meet the inclusion criteria. At this stage, an additional 89 articles were excluded; one article was not published in English, seven were reports and discussion papers, four were quantitative, 32 did not fit PICO criteria, 11 were not conducted in Africa, 31 were duplicates, and the full text of three studies was not found. All 19 articles remaining after this stage were reassessed and approved by both primary and independent reviewers (see Figure 1).

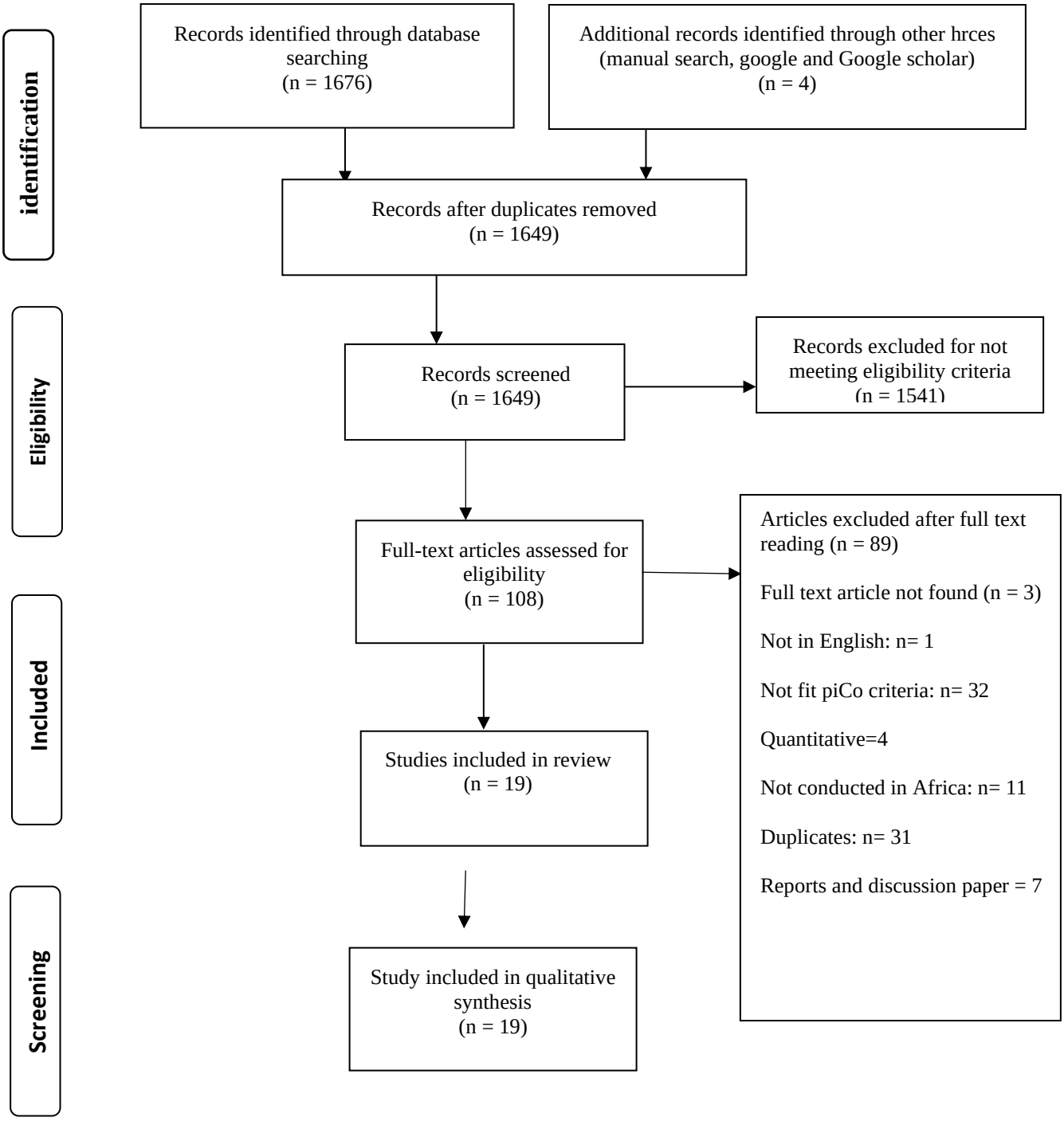

Figure 1. Selection of Articles Study Selection Process. Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) Flowchart

Moher, Liberati, Tetzlaff, and Altman DG (2009). The PRISMA Group. Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement.

Qualitative Assessment of Study

Assessing the quality of studies in a systematic review improves the rigor, validity, and trustworthiness of the results (Butler et al., 2016). Critical appraisal of the studies in this review was carried out using the Critical Appraisal Skills Programme [CASP] (2018). The CASP (2018) checklist is made up of 10 questions that addressed different parts of a study, namely the aims, methodology, study design, recruitment strategy, data collection, researcher/participant relationship, ethical concerns, data analysis, findings, and value of the research that can be used to test for rigor, relevance, and validity of studies (Appendix B). Questions one to nine focused on the value of the research and has the options of "yes", "can't tell," and "no," but no options exist for question 10. For this question, the options of high, medium, and low were adopted from Coates et al. (2018) for uniformity since they used the same tool in their qualitative systematic review.

Since the CASP checklist does not have a scoring system, a scoring system provided by Butler et al. (2016) was adapted to provide further appraisal and distinguish studies according to their scores to include the best quality papers, where "yes" = 1, "can't tell" = 0.5 and "no' = 0. According to the Butler et al. (2016) scoring system, a score of 9-10 shows high quality, 7.5-9 shows moderate quality, less than 7.5 shows low quality, and six or less shows poor quality. All articles scoring six or less were excluded.

Data Extraction and Synthesis

There must be a clear distinction as to what constitutes data before it is extracted (Butler et al., 2016)). For this qualitative systematic review, data comprises textual construct, which may include direct quotes or observations from the participants in the studies and the researcher's interpretation under "results" or "findings" in the

studies (Thomas & Harden, 2008). Munro et al.'s (2007) data extraction form was used for further meticulous review to improve validity. The data extraction table (see Appendix D) includes names of authors, year of publication, country/setting of the study, the objective of the study, research design, theoretical frameworks, sample size, participants characteristics, data collection methods, data analysis approach, and results of the studies.

Data Analysis

Thomas and Harden's (2008) thematic synthesis were used in this review as it goes beyond an in-depth understanding of the primary studies and helps to enhance transparency through generating new interpretative meanings, explanations, and constructs. Thematic synthesis was employed reflecting on the research questions for this review, which is to explore the experiences of African women married before the age of 18 years as child brides. Thematic synthesis involves recognizing similar and repetitive information in the studies and grouping them under various headings (Randolph, 2009).

The thematic synthesis in this review occurred in three stages: line by line text, creating descriptive themes, and developing analytical themes (Coates et al., 2018). NVivo 12 pro software for qualitative data analysis was used to manage the copious data during data synthesis. First, line by line coding of the quotations and text under findings or results describing the same meaning and concepts were copied verbatim into NVivo, and similar codes were grouped together to capture their meanings.

Second, nodes that seek to describe codes as recurrent within and across studies were used to synthesize themes from individual studies. Similar codes were combined to create descriptive themes. Direct quotes and the researcher's interpretations describing the experiences of women married before 18 years were used to reflect themes. The

categorized codes were then grouped to identify themes related to the women's experiences.

Lastly, analytical themes were inductively developed using word frequency query on NVivo to identify frequently used words and concepts. For this, a benchmark of 400 most frequently used words in all studies was used as a limit, with a minimum of at least four words to avoid excluding small relevant words. Stemmed terms (exact words and similar words) were enabled for a broader search. Final themes were compared across the studies through reading and re-reading each study to ensure the themes were reflective of African women who were married before the age of 18 years.

To explore the experiences of women married under the age of 18 in African countries, data were analyzed on the perceived knowledge and opinions of the women on marriage premaritally, at the point of marriage, and while transitioning to adulthood. Data on the predisposing factors and the consequences of the decision for child marriage helped to understand women's experiences as they transitioned from young child brides into women. The emerging themes not only described the marital experiences of African women who were married as child brides but also helped to gain insight into their previous experiences as young girls.

Results

Characteristics of Participants

A total of 833 participants who got married before 18 years of age were in the included studies (see Appendix C). The lowest age at marriage was eight years (Callaghan et al., 2015). The educational level of participants was low; few studies conducted had any participant with more than primary school education (Ketema & Erulkar, 2018; Luseno, et al., 2017). The majority of participants were Muslims;

however, two studies had a significant number of Christian participants. For example, 40 % of the participants in the study conducted in Kenya by Ganira et al. (2015) were Christians. In another study conducted in Zimbabwe, all participants were of the Christian faith (Luseno et al., 2017).

Characteristics of Study

The characteristics of the 19 studies are indicated in Appendix D. In terms of research design, 13 out of the 19 studies used a qualitative design, of which six were specific in the approach used as follows: a qualitative case study with phenomenology and feminist approach (Gatwiri & McLaren, 2017); one ethnographic qualitative study (Stark, 2018); one ethnographic case study (Archambault, 2011); grounded theory (Efevbera, 2017); exploratory qualitative study (Callaghan et al., 2015) and a cross-sectional qualitative study (McDougal et al., 2018). The other seven studies did not specify an approach, but their methodology indicated a qualitative research design (Akpan, 2003; Belhorma, 2016; Hamed et al., 2017; Ketema & Erulkar, 2018; Kenny et al., 2019; McClendon et al., 2018). Individual and focus group interviews and observations were most often methods used for data collection.

The remaining six studies used a mixed-methods approach (Adedokun et al., 2016; Allen & Adekola, 2017; Ganira et al., 2015; John et al., 2019; Luseno et al., 2017; Zhang et al., 2016). Out of the 19 studies, 12 studies were conducted in East Africa: Ethiopia (n=5), Tanzania (n=1), Zimbabwe (n=1), Kenya (n= 3), Somalia (n= 1), Sudan (n= 1), and Zimbabwe (n=1). One article was conducted in North Africa (n=1). The remaining five were conducted in West Africa: Nigeria (n=4) and Guinea (n-1).

The review revealed both similarities and differences in factors that make up the experiences of women married as children in different African settings. The thematic

synthesis generated two main themes and six sub-themes that described the experiences of African women married as children as primarily negative with some positive aspects. Although the two main themes and subthemes identified in the review are depicted as distinct entities (see Figure 2), many of them overlap. The two main themes are:

1. Predisposing factors to women's experience of CEFM
2. Consequential factors shaping women's marital experiences

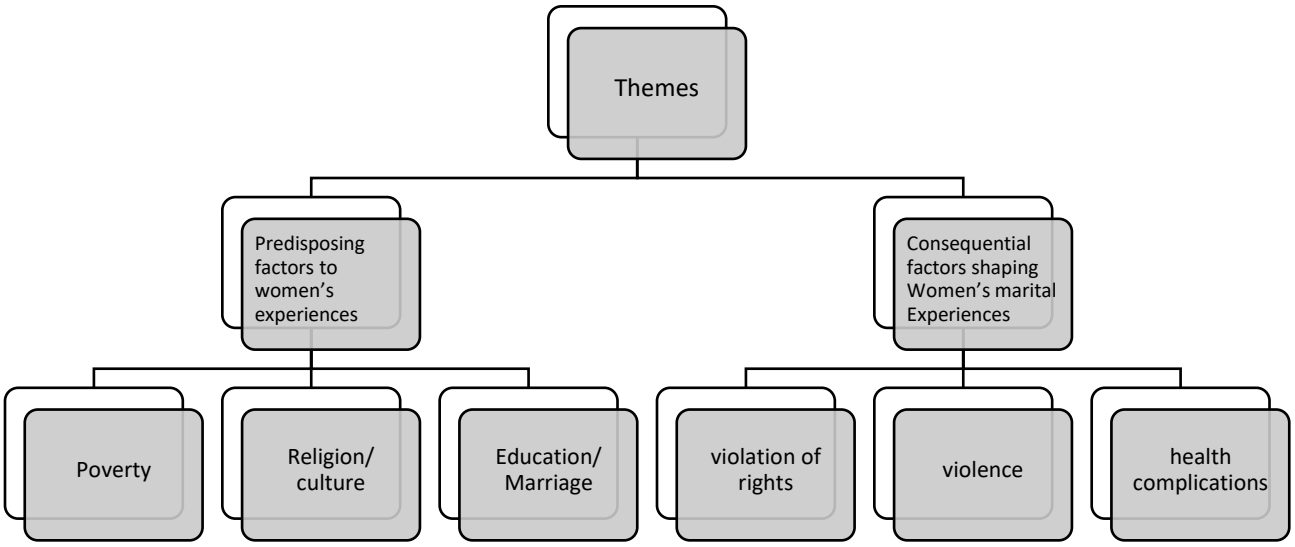

Figure 2. Themes. These themes and sub-themes reveal the factors and conditions that increase girls' vulnerability to the practice of CEFM and shape their pre-marital and marital experiences.

Theme 1: Predisposing Factors to Women's Experiences of CEFM

The sub-themes in this category are poverty; religious and cultural practices; education, and marriage.

Theme 1 Sub-theme (A): Poverty

In this review, poverty was identified as a significant cause of girls being married at a young age (Adedokun et al., 2016; Allen & Adekola, 2017; Akpan, 2003; Belhorma, 2016; Efevbera, 2017; Gatwiri, Stark, 2018). Poverty, as an experience, traversed the life

of child brides before marriage and continued as they transition into young wives, mothers, and adult women. Allen and Adekola (2017) highlighted that 60% of northern Nigerian girls experience CEFM because of poverty. Parents offer their young daughters out in marriage, as an economic survival tool, to older men who can pay their bride price and with the expectation that life will improve for them and their children after marriage (Adedokun et al., 2016; Allen & Adekola, 2017; Akpan, 2003; Efevbera, 2017; Gatwiri & McLaren, 2017; Stark, 2018). Likewise, in the context of severe poverty before marriage and due to limited alternatives, some girls report feeling obligated to relieve their parents/guidance of the burden of having to care for them by opting for early marriage. They viewed early marriage as an escape route with the expectations that their poverty experience will change after marriage (Stark, 2018).

In one study conducted in Tanzania, for instance, Stark, (2018), using an ethnographic approach, explored girl's perception of their alternatives in the context of constrained poverty. Stark (2018) concluded that extreme poverty, high cost of education, and unemployment motivate girls to marry early in aspiration for economic security. Two participants in Stark's study (2018, p. 14), Susan and Amira, stated how poverty pushed them to marry early. Susan explained that at that time, she felt that marrying at age 15 was the right thing to do because of the extreme poverty she was experiencing, having to live in one room with ten other people. Susan elaborated that she did not feel comfortable living in poverty, so she started a relationship with a man who could rent a room for her at that time.

Similarly, Amira stated that many girls marry before they are 17 years old because of poverty. Amira became pregnant at age 15 for a man who used to buy her food, who then left her after she gave birth. By age 17, Amira was married to her second

husband. For both girls, economic survival was a determinant for marrying at a young age, which could have made their alternatives, such as obtaining an education restricted or not viable.

The results revealed that childhood marriage does not always work out as expected, and the women's experience of poverty often continues after marriage, making them utterly dependent on their spouses. In a Nigerian study by Adedokun et al. (2016), women expressed their dependency on their spouse, resulting in low decision-making power. For example, a 24-year-old Nigerian woman stated that since they depend on their husbands for everything, their husbands have the right to determine everything, even the number of children they can have in the family and if they can use hospitals for health care (Adedokun, Adeyemi, Dauda, 2016).

Corroborating the identification of poverty as a significant factor for the cessation of education for girls in one study (Ganira et al., 2015), Stark (2018) elucidates that, in the context of extreme poverty, education opportunities were not often available as an option for young girls prior to marriage further impacting their economic status. In addition, lack of employment opportunities discourages parents and girls from considering obtaining an education. Stark (2018) described the reluctance of some parents to pay for their daughter's secondary education and how girls sometimes lack the motivation to continue school. The parents gave the reason that the high unemployment makes it difficult to earn an income after secondary education. In another study conducted in Ethiopia, Raj et al. (2019) stated that some girls explained how they were discouraged by their parents from attending school because parents believe education is not worth the cost of "pen and exercise book." One participant expressed her sadness when her parents arranged her marriage, as they felt education was not needed, and her

father thought female students are a burden to the family. (Raj et al., 2019).

Theme 1 Sub-theme (B): Religious and Cultural Practice

In Nigeria, like most other African countries, religion and culture drive the practice of CEFM, and both factors are perceived as a significant part of everyday life (Adedokun et al., 2016). Interestingly, religious differences in the practice of CEFM were noticed in the review. In Nigeria and other practicing countries, the practice of CEFM is associated mainly with Muslims, driven by Islamic laws governing the behaviour of women (Zasha, 2018). However, in studies from Kenya (Ganira et al., 2015) and Zimbabwe (Luseno et al., 2017), child brides were reported to be Christians rather than Muslims. Nevertheless, in most practicing communities, irrespective of religion, the intersection of customs, social norms/values, cultural and religious beliefs, and the need to uphold these socio-cultural beliefs were significant reasons why people still practice CEFM (Adedokun et al., 2016; Akpan, 2003; Efevbera, 2017; Gatwiri & Stark, 2018; Ganira et al., 2015; Zhang et al., 2016). Ganira et al.'s (2015) study conducted in Kenya with 30 young mothers asserted that cultural and religious adherence enhances the practice of CEFM. One woman stated that she got married as a sign of respect to her community and parents because early marriage is acknowledged as a custom in her society and religion.

Findings from the review revealed that childhood religious and cultural dictates/beliefs experienced by these women as a girl child continue into and are ongoing in marriage with their spouses. As mentioned above, women do not only depend on their spouse economically; culture and religion dictate that women rely on their spouses for every household decision, including reproductive health decisions. Results from one study indicated that some religious doctrines allow husbands as the head of the family to

decide the number of children their wives will have; the women have no say in the matter (Adedokun et al., 2016).

Similarly, a study by Ketema and Erulkar (2018) indicated that women needed their husband's approval to use family planning. The author reported that culture allows the husband to control his wife's choices as it relates to fertility and family planning. Gatwiri & McLaren (2017) indicated that most African religious and cultural practices are patriarchal and a legacy of pre-colonial traditions that perpetuates young girls being married at a young age. In their case study, Gatwiri and McLaren (2017) stated how one participant, "[Sasha] told her story about living in a patriarchal and oppressive culture that saw her being 'married off' at nine years of age" (p. 248). Other studies described how girls experience limited agency due to pressure from religious and cultural patriarchal practices and give in to marrying not of their own accord before the age of 18 (Gatwiri & McLaren, 2017; Ketema & Erulkar, 2018). There was a general consensus from the studies that religion and cultural practice in these patriarchal societies require girls to preserve their virginity before marriage, to which they are under continuous pressure to adhere and maintain the status quo.

Allen and Adekola (2017) reported that in the northern part of Nigeria where CEFM is prevalent, women would rather give in to early marriage than face the shame of pregnancy out of wedlock, considered one of the gravest offenses for a teenage girl. Likewise, in Zimbabwe, a girl narrated, "I had no one to buy me clothes. My boyfriend offered to buy some clothes for me, and I accepted. He asked me to go and fit the clothes in his room. He came and persuaded me to have sex. I then told him that I was no longer going home since I had lost my virginity" (Zhang et al., 2016, p. 9). This girl expressed fear of going home since she was involved in premarital sex. In Tanzania, Stark (2018)

reported that participants fear social condemnation and being viewed as promiscuous and tagged as unmarriageable if they delay marriage for too long. To sum it up, evidence indicates that the girls are either given out at an early age based on religion and cultural practices, or they accept early marriage based on the patriarchal, religious, and cultural practices they have experienced.

Theme 1 Sub-theme (C): Education and Marriage

While most women in the studies reported experiencing education cessation because of poverty or their parents viewing education as not valuable for their daughters (Archambault, 2011; McDougal et al., 2018; Raj et al., 2019; Stark, 2018), some women, through external influence on their parents had the opportunity to continue their education and to delay/cancel any early marriage plans. An external influence reported were the teachers who implemented the school-based and community outreach early marriage preventive program organized by the Oromia Development Association Comprehensive Adolescent/Youth Sexual and Reproductive Health Project (ODA) in Ethiopia (Rajat et.al., 2019).

An Ethiopian girl explained how she benefited from the preventive program, and she was able to continue her education because the external influence was able to convince her parents. Similarly, other youths were educated on family planning in another preventive program inclusive of sexual and reproductive health education (McClendon et al., 2018). Few other girls in Ethiopia were able to use family planning to delay pregnancy and continue their education after marriage. Zeyneb, an 18-year-old Ethiopian girl who got married as a minor (age not specified), explained that she got information about family planning from an extension care worker and was on injection contraception so she can continue her education.

Theme 2: Consequential Factors Shaping Women's Marital Experiences

The sub-themes in this category are violation of rights, violence, and health complications. As illustrated above, these arose from the notion that the premarital experiences shape the marital experiences.

Theme 2 Sub-theme (A): Violation of Rights

Many of the studies in this review identified CEFM as a violation of the fundamental human rights of a girl child (Adedokun et al., 2016; Allen & Adekola, 2017; Akpan, 2003; Archambault, 2011; Belhorma, 2016; Callaghan et al., 2015; Efevbera, 2017; Gatwiri et al., 2019; Stark, 2018; Zhang et al., 2016). For example, a Kenyan woman in the study by Ganira et al. (2015) said she got married not because she felt it was the right thing to do but because her father forced her. The Kenya woman lamented that she was not given any chance at all; her wish was to continue her education, but she got married because she could not refuse her father. The review indicated that the violation of their human rights continued as the girls became young wives and moved into adulthood with limited autonomy and agency. The majority of the studies in this review discussed the continuing subjugation of women married as child brides (Adedokun et al., 2016; Allen & Adekola 2017; Belhorma, 2016; Callaghan et al., 2015; Ganira et al., 2015; Ketema & Erulkar, 2018; Luseno et al., 2017; McClendon et al., 2019; Raj et al., 2019). Most women reported low autonomy, insufficient decision-making power, and total dependency on their partners with limited space for expression because they were very young, uneducated, and poor.

In the study by Ketema and Erulkar (2018), a 23-year-old woman from Ethiopia who married when she was 15 years stated that her in-laws told her she was not married to sit idle but to give birth to children. In the same study, another woman who was trying

to prevent getting pregnant said, “They [community] asked me why I took family planning as I am young. They asked me why I took it in the beginning [of the marriage]. They told me it is not good” (Ketema, & Erulkar, 2018 p. 5). Another housewife from Nigeria explained that women often do not go to the hospital for family planning because they cannot decide on their own; they need permission from their husbands. (Adedokun et al., 2016).

While the majority of the women participants in the review indicated being forced into marriage was a negative marital experience, a few expressed having positive marital outcomes. For example, some women saw themselves first as domestic assistants and mothers who should only care about the family rather than be equal sexual partners, which they interpreted as happiness (Callaghan et al., 2015). Their role as wives was described as being submissive and confined within their marital homes (Callaghan et al., 2015). For example, Halima, a Nigerian woman, expressed how being submissive, respecting her husband, and doing all the house chores expected of her made her happy (Callaghan et al., 2015), explaining that she was not a lady when she got married. Another Nigerian woman, Bilkisu, explained the few things she knew about marriage, which were to keep the house clean and respect her husband, helped her to stay at peace with her husband (Callaghan et al., 2015).

Theme 2 Sub-theme (B): Violence

Some women in the reviewed studies shared that their marital experiences included domestic violence. Some women verbalized the experience of different kinds of violence (Belhorma, 2016; Efevbera, 2017; John et al., 2019; McClendon et al., 2018; McDougal et al., 2018). In the study by John et al. (2019), an Ethiopian woman narrated the physical and sexual assault by her husband, “It used to be so painful for me when we

had intercourse. But I couldn't tell anyone. And when I refused, he used to beat me, splash water on me, put a rock on me and waited till I got tired and took me afterward" (p.5). Another Guinean woman stated that she tries not to provoke her husband because he hits her whenever he gets annoyed and has even injured her left eye. She narrated how her husband will lock her up in the house and leave for work. Her worst experience was when he plugged the heater on her and then hit her (Efevbera, 2017).

Belhorma (2016) reported Moroccan girls and women legitimize violence in marriage by describing it a result of cultural norms. According to Belhorma (2016), Moroccan society views any form of violence against women as legitimate and acceptable within the family setting. Moroccan women are not protected by law against any form of violence within the context of marriage. Authorities require them to provide a medical certificate and testimony of a witness to the violent act, which is usually challenging to obtain (Belhorma, 2016).

Theme 2 Sub-theme (C): Health Complications

Findings from some studies in this review revealed that women experienced health complications related to being child brides (Adedokun et al., 2016; Allen & Adekola, 2017; Akpan, 2003; Callaghan et al., 2015; Efevbera, 2017; Gatwiri et al., 2019; Zhang et al., 2016). The younger the women were at the time of marriage, the more likely they were to have health complications. Adedokun et al. (2016) highlighted that the majority (71%) of northern Nigerian women who commenced childbearing at a very young age had experienced at least one severe pregnancy or birth-related health complication. Akpan (2003) explained how Glory had developed a vesicovaginal fistula when she was 19 years but had been married much earlier in her life.

For some former child brides, their adverse health outcomes were not physical but

psychological. In John et al.'s study (2019), a woman responded to a question on how early forced marriage to someone she did not know had affected her psychological well-being. She answered by saying that she was depressed and cried all the time. For other women, their health complications led to an additional layer of the experience of abandonment by their spouses, in-laws, and even parents (Callaghan et al., 2015; Efevbera, 2017; Gatwiri & McLaren, (2017); Hamed et al., 2017: Luseno et al., 2017; Stark, 2018). A Kenyan woman participant from Gatwiri and McLaren's (2017) study was given away as a child bride at age nine; she developed vesicovaginal fistula when she was 11. She lamented how abandonment from her friends and family, including the stigma and shame, made her feel worthless and better off dead.

Many women in the reviewed studies described their transition from being a young girl to becoming an adult as stressful and full of regrets (Adedokun et al., 2016; Akpan, 2003; John et al., 2019). John et al. (2019) reported how one woman lamented when she was asked how different her life would have been if she had not married early. The woman explained that she would have been more mature in making her own choices and not suffering to raise a child that she cannot buy a birthday gift because she did not have the money. She regretted she did not know about family planning and suggested that government should teach girls about family planning to prevent unwanted pregnancies.

One common theme that cuts across all the women's experiences reported in the review is that they all expressed regret that they did not have enough time for their education. Ganira et al. (2015) reported one woman expressing regret that she was compelled to go away from school to get married and lamented that she would have been earning a salary to support her family if she finished school. She advised single girls that they should say no to untimely marriages and embrace education.

Strength and Limitations

To the best of this author's knowledge, this is the first systematic review of qualitative research on the experiences of women who were married as child brides in Nigeria and neighboring African countries. The comprehensive search and quality appraisal of studies were done by two independent reviewers. The review was limited to studies of experiences of women in Africa based on the individual study authors' analysis, and data were identified within women's quotes.

This review is limited by the fact that studies from all African countries were not captured. There is also the possibility that the themes identified do not reflect the original study authors' interpretation; however, the themes were inductively identified from the data. It is also important to note that although a comprehensive search strategy was carried out, only peer-reviewed articles found in electronic databases were accessed, which means that this review may not be representative of all studies in this study area.

Discussion

This qualitative systematic review provides the first synthesis of the evidence on the experiences of women married as child brides in Nigeria and neighboring African countries. The results from the 19 studies included in this review provide an increased understanding of the lived experiences of African women who were married before the age of 18 years. The two themes and six sub-themes presented in the review indicate that African women who were child brides share similar pre-marital experiences with some unique marital experiences along a spectrum. The results describe how African women's marital experiences were influenced by contextual factors such as extreme poverty, cultural and religious beliefs, which informed their premarital experiences that eventually shape their marital experiences as young African girls.

The experiences of women who were married early had a striking similarity across the African countries. For example, the marital experience of African former child brides is a result of interlinked cultural, social values, economic and religious factors. As revealed in this review, African women from different parts of Africa share the burden of similar patriarchal cultural, traditional, and religious norms that predisposed them to Child Early Forced Marriage (CEFM). For most of the girls, the predisposing contextual factors that make up their premarital experiences leading to CEFM intersect as ongoing marital experiences and, for some, produces or lead into other consequential factors such as further violation of rights, domestic violence, and health complications (Pepper & Wildy, 2009).

Identifying the predisposing factors to CEFM helps to understand the rationale for parents' decision for their daughters to marry young and the underlying values and conditions that continue to support the practice. The issue of CEFM is shown to be sustained and perpetuated by the same predisposing factors across the different parts of Africa (Gemignani & Wodon, 2015). In most countries where it is prevalent, CEFM has become a cultural and religious norm, which promotes patriarchal attitudes towards girls and women. The contextual factors, such as cultural values and religious beliefs attached to female virginity before marriage, intersect with extreme poverty to influence the decision of CEFM for parents. In countries like Nigeria, the cultural value of preservation of chastity in the context of extreme poverty give parents the justification to control their daughter's sexual behavior through CEFM. To these parents, a child's value is determined by their gender, making CEFM a part of life as they nurture girls from birth to take up the traditional role of wife and motherhood (Mlambo et al., 2019).

The review also revealed the restricted context in which some girls exercise their

agency by deciding to get married and adhering to the social norm of preserving virginity. According to the results of the systematic review, extreme poverty, high education cost, and unemployment contributed to girls choosing to leave school and get married early. Early marriage, many perceived, would improve their lives economically. A choice made within a limited or restive context is considered a thin agency, according to Klocker (2007), who conceptualized choices made within a broad range of alternative opinions as a thick agency. For child brides, the thin agency choice of early marriage fosters poverty, as the majority of the women reported remaining poor after marriage.

All the women in this review were married at a young age, uneducated and poor in their individual countries. Although most reported being forced to drop out of school and marry against their wishes or consent by their parents based on economic survival, few of them willingly gave up school for marriage. Their apparent willingness to marry young was not genuinely voluntary but rather in conformity with religious and cultural beliefs, including internalized gender norms that have made the practice of CEFM a social norm among these groups.

Ironically, most countries that practice CEFM have both local and international policies and laws in place to protect the rights of girls (Stark, 2018). However, weak legislation and poor implementation of existing laws promote the practice of CEFM (Ganira et al., 2015). Further, most countries acknowledge female education as a strategy to curb the practice of CEFM. Yet, retention of girls in primary schools remains an issue due to economic hardship experienced by many families (Ganira et al., 2015). Raj et al. (2019) asserted that the association between education and CEFM is bidirectional; girls not in school are vulnerable to CEFM, at the same time, CEFM leads to the cessation of child brides' education.

Positive experiences with being a child bride were not as frequently mentioned as the negative ones. However, the marital experiences were described as positive among a few women in the review when they do not have health complications and they remain submissive to their husbands. This finding is consistent with the studies of Callaghan et al. (2015) and Efevbera (2017), which both reported positive experiences of women married as child brides in Guinea and Nigeria, respectively.

Although predisposing factors to CEFM were found to be generally similar across all the African countries included in the review, religion as a predisposing factor for CEFM was found to differ. In contrast to the general trend of CEFM being more prominent in Muslim communities, this review showed that some countries had more Christians practicing CEFM. These exceptions were women from Kenya (Ganira et al., 2015) and Zimbabwe (Luseno et al., 2017) with high CEFM in Christians.

Although there are cultural and religious expectations for fathers in countries that practice CEFM to decide the timing and who his virgin daughter marries, girls in countries like Somalia are forcing their way into making marital choices by eloping (Kenny, Koshin, Sulaiman, & Cislaghi, 2019). In other words, some girls can exercise increased agency albeit within constrained choices resulting from limited viable alternatives. These girls conform to their internalized social norms, the unwritten rules that women must marry as virgins. Yet, they made socioculturally-mediated decisions (Zasha, 2018) to be married as child brides by eloping to avoid premarital sex. According to Kenny et al. (2019), parents are compelled to comply with adolescent-led marriages after their daughters elope to avoid the social consequences of unwanted and pregnancies out of wedlock.

While study participants generally described similar prior pre-marital experiences,

yet they each had unique marital experiences. Violation of rights as a subtheme in the second category can be considered a continuation of rights violations that commenced when the women were young girls. The constraints and limited agency these women experienced as young girls before marriage continues with the infringement of their rights as married women. For example, as young girls, they were powerless, voiceless, and could not refuse marriage (Kenny et al., 2019). As married women, the violation of their rights translates into low autonomy and insufficient decision-making rights in almost every aspect of their life. They were denied the freedom to make decisions on the use of health care services, family planning, delaying first birth, or pursuing post-marriage education due to religion or culture (Ketema & Erulkar, 2018). Thus, they are pressured to start having children immediately after marriage against their will, just as they were forced to get married early in the first place.

Their decision-making rights as women are continually violated by their spouses, in-laws, and even the larger community. Globally, every society experiences some form of violation of women's rights, making gender inequality a global reality. However, as highlighted in the review, patriarchy still operates in most African countries, with culture and tradition as the justification for these violations and inequities. Adherence to cultural beliefs and practices regarding women's sexuality and reproductive rights maintains the deep-rooted harmful practice of CEFM in Nigeria and other African countries, undermining women's rights and harbouring discrimination with an imbalance of power in the family.

Among the unique experiences, African women married as child brides faced, were health complications and violence. Some of the young wives were faced with childbirth complications due to their immature bodies. Complications related to

pregnancy and childbirth have been identified as the leading cause of death for girls ages 15 to 19 years in developing countries (Hervish & Feldman-Jacobs, 2011). A number of studies have focused on the relationship between CEFM and health complications leading to increased maternal and child mortality (Adedokun et al., 2016; Birech, 2013).

Furthermore, findings from this review highlight the role of CEFM in the perpetuation of violence against women in Africa. Due to cultural norms, men assume greater economic power creating unbalanced gender-based power dynamics that expose young wives to different forms of gender-based violence, leading to adverse physical and/or psychological health outcomes. A relationship between gender-based violence and mental health has been documented in Africa (Grose et al., 2019).

As revealed in this review, some of the African women who were married as child brides experienced heightened psychological trauma resulting from life events associated with CEFM. Some women expressed different forms of violence, including sexual, physical, and psychological. For women married as child brides in Nigeria and other African countries, CEFM-serves as a tool for enforcing prolonged entrapment, loss of autonomy, and domestic responsibilities. Social and gender norms are key pathways for perpetuating and sustaining gendered power inequality in Africa.

The review calls for more interventions to address the impact of CEFM on African former child brides' health and well-being. As indicated in this review, external influences such as schoolteachers were able to delay/cancel early marriage (McClendon et al., 2018; Raj et al., 2019), indicating that indeed concerted efforts can work in ameliorating the negative consequences of the practice. The results suggest the necessity of implementing ongoing child marriage prevention programs that will encourage parents to allow their daughters to stay in school in all African countries affected by the issue of

CEFM. Furthermore, indigenous community mobilization that focuses on behavioural change to discourage harmful practices such as CEFM should be continuous, knowing well that cultural change is difficult (Birech, 2013) and cannot be achieved without persistence.

Conclusion

This qualitative systematic review describes the experiences of African women who were married before the age of 18 years in Nigeria and neighboring countries in Africa. Although CEFM is prohibited by law in most African countries, the practice remains common because of interacting factors such as poverty, culture, and religious beliefs, enabled by weak legislation. The practice not only infringes on the rights and well-being of the girl child but is also a human right violation that continues to frustrate global efforts to promote gender equality and equity.

Despite the progress made on the global platform to advance human rights of the girl child and women, within the African continent, factors such as patriarchy, power imbalance, and the hierarchal relationship between men and women, including child brides, continue to impede progress to eradicating the practice. Thus, the social acceptance of CEFM and its intricate threads within the fabrics of societal norms and cultural practices has conditioned women into the uncontested acceptance of this injustice. Consequently, women suffer in silence under the burden of fate and the erroneous notion of fulfilling their assigned gender roles with a sense of compliance.

The result of this review points to the continuous need for interventions and preventive programs to serve as alternatives for CEFM in Africa. More human rights laws need to be upheld in every African country to support African women. Further, African leaders need to come together and develop poverty alleviation programs and

create more female employment opportunities that will effectively encourage parents and make their decisions against early marriage and support for female education an easier one. Finally, there is a need for a qualitative study to explore the experiences of former child brides and their health-seeking behavior to investigate the factors that influence their use of reproductive health services.

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CHAPTER 3

A NARRATIVE INQUIRY OF FORMER CHILD BRIDES' EXPERIENCES AND UTILIZATION OF HEALTH SERVICES IN NIGERIA

Introduction

Child/Early Forced Marriage (CEFM) is defined as offering a girl child for marriage before the age of 18 years, typically against the child's wishes, practiced in many parts of the world such as the Caribbean, Latin America, Eastern Europe, South Asia, and Sub-Sahara Africa (Raj et al., 2018; Svanemyr, Chandra-Mouli et al., 2015). CEFM is a common practice in patriarchal societies and is considered a human right violation rooted in issues relating to gender inequality. Consequently, in such societies, girls/women face discriminatory attitudes, limiting their agencies as girl children and decision-making autonomy as adult women. Further, the United Nations Commission for Human Rights indicates that CEFM is associated with potential health and reproductive health implications for child brides, including high maternal-child morbidity, mortality, gender-based violence, and low levels of autonomy (OHCHR, 2020).

Despite international, national, and local efforts to reduce the practice of CEFM, socio-cultural and religious factors remain key drivers of the phenomenon in the poorest regions of Africa (Wodon et al., 2018). UNICEF (2016) reported that 15 million girls are married as child brides annually and estimated that about 950 million girls would be married before 18 years by 2030, with the majority from developing countries, especially those in Africa, if the current trend remains the same. These figures reflect regions in Africa where poverty and gender inequality are widespread, including religious and cultural practices that promote CEFM.

Within the African continent, the practice is noted to be remarkably high in West

Africa (49%), with Nigeria standing out at 42.1% (Male & Wodon, 2016). Using data from a Demographic Health Survey of 31 Sub-Saharan countries, Koski et al. (2017) analyzed and reported changes in age at marriage over a 25- year period. The results showed that West African countries had the highest rates of CEFM, with differences in the trend among countries in the region. While Ghana and Togo showed a slow continuous decline in CEFM below 25%, Nigeria, Mali, and Ethiopia only had a slight difference drop over this period. Although the percentage in age at marriage reduction for Nigeria was not reported in this study, a recent study by Mobolaji et al. (2020) indicated that the CEFM rate in Nigeria has decreased by only 1% over the past three decades. While CEFM is less commonly practiced in East African countries like Rwanda, the decline noticed in West Africa is insignificant compared to the overall position Africa still holds in the practice globally.

Background & Significance

CEFM is practiced within many ethnic groups in Nigeria but is most predominantly seen in the northern rural part of the country, deeply rooted in poverty, religion, culture, and tradition. Evidence shows that CEFM is 15-18 times higher in the Hausa-Fulani, the major northern ethnic group, compared to Yoruba and Igbo, the major southern ethnic groups (Mobolaji et al., 2020). There are distinct cultural, social, religious, and economic differences between the northern and southern regions of Nigeria (Koziel, 2014), that could account for the high prevalence of CEFM in the north. For example, the Hausa-Fulani living in the northern rural part of Nigeria are primarily of the Islamic faith, while the vast majority of the ethnic groups in the south practice Christianity (Babalola, & Oyenubi, 2018; Sabiu, 2018). CEFM is considered acceptable within Muslim communities in Nigeria (Iyabode, 2016). For example, the 12 states with

the highest prevalence of CEFM in the country are all Muslim-dominated states (Mobolaji et al., 2020).

Social constructs, such as young age at marriage, low education, ethnicity, poverty, culture, and religion intertwining with gender have shown to vary in function but mutually inform one another (Caiola et al., 2014), to predispose women to CEFM (Mobolaji et al., 2020). These social constructs increase women's vulnerability; however, variations in the social constructs could create a situation for diverse marital experiences for women. For example, CEFM is associated with limitations of these social constructs, which usually place northern Nigerian girls at higher risk for early marriage.

The marital experience of an uneducated poor (education level and poverty) northern Hausa-Fulani (ethnicity) woman (gender) living in an urban setting (geographical location) may be quite different than that of an educated southern woman who married at a later age (Mobolaji et al., 2020). Compared with more educated women, uneducated child brides are reported to be more predisposed and vulnerable to CEFM (Marphatia et al., 2017). Although the social factors relate, they produce different and multidimensional experiences for the person in question.

Poverty has been identified as a significant factor associated with CEFM (Raj et al., 2019), intricately linked with impoverished households with limited resources in the world's poorest countries (Mathur et al., 2003). The poverty rate in northern Nigeria ranges between 45.9%-50.2% compared to 16% -28% in the south (World Bank, 2014). Research on child marriage in northern Nigeria indicates that many poor families give out their young daughters for marriage to older men for economic gains (Braimah, 2014; Mobolaji et al., 2020), further reinforcing the gendered nature of poverty (United Nations Children's Fund (UNICEF), 2005).

Religious beliefs and culture are tightly interwoven among the Hausa-Fulani of northern Nigeria, where Islamic religion is a complete way of life and governs people's behaviors, which are justified with values and beliefs (Sinai et al., 2017). Cultural and religious beliefs are used to create gendered norms and relations, which place insurmountable restraints of domestic gender roles on women and subordinate them to male figures, whereby they are socialized to view men as superior and authority figures (Ajala, 2016). Religious and cultural practices support fathers to betroth their daughters either from childhood or at puberty without seeking their wives' or daughters' consent (Mobolaji et al., 2020). Adherence to such discriminatory practices widens gender inequality within families, further promoting the practice of CEFM.

The educational disparity between northern and southern Nigeria is particularly pronounced among women and girls due to cultural practices such as CEFM (Odimegwu & Adewoyin 2020). Compared to their southern counterpart, Northern Nigerian women marry at an earlier age, contributing to their low level of education and economic status (Mobolaji et al., 2020). Nigerian women living in southern Nigeria are exposed to formal education, which is protective against the cultural patriarchal practices prominent in the north. (Adedini et al., 2017; Danjuma et al., 2015; Ebekue, 2017). According to Walker (2019), the few northern Nigerian women who attend formal schools are enrolled at a late age because parents want their children in Qur'anic schools first to acquire religious education. The education northern Nigerian women receive focuses more on religion rather than core academics which places them in a position to succumb to CEFM than their southern counterparts (Mobolaji et al., 2020).

Younger age at marriage results in lower education for females and fewer employment opportunities (Walker, 2019). Further, lack of formal education and limited

vocational or skills training places child brides in lower economic status and power inequality in relation to men. Such vulnerabilities play a significant role in their low decision-making power, influencing their autonomy as wives and mothers. Tchoukou (2020) argue that marriage is usually used to determine the degree of autonomy of northern Nigerian women, as the autonomy of these women is intricately woven into the religious and cultural milieu.

As a result of lower levels of education, cultural and religious beliefs, northern Nigerian women are less likely to use skilled healthcare providers and access formal health facilities for their reproductive health care needs compared to their southern Nigerian counterparts (Amodu et al., 2017). In their study, Amodu et al. (2017) discuss how northern women are less likely to access perinatal care services and use contraceptives than their southern counterparts. Similarly, Fapohunda et al. (2017) report that women with no one present (NOP) to assist during childbirth are likely to underutilize post-natal care services following delivery.

Among northern women, religious edict and cultural norms encourage home births under family member supervision (Abubakar et al., 2017; Ejembi, 1996), sometimes without traditional birth attendants (TBAs), even in settings with access to formal health care services (Izugbara, & Ezeh, 2010). For northern Nigerian women, in particular, expressing labor pain is culturally a taboo (Amodu et al., 2017), and they usually demonstrate a substantial pain threshold with no or negligible sign of labor pain (Sinai et al., 2017). As a result, they might not recognize or acknowledge when there might be complications requiring medical interventions and delay seeking formal medical care (Amodu, Salami, & Richter, 2017).

In northern Nigeria, the rate of having skilled birth attendants among child brides is reported to be as low as 5% (Fapohunda et al., 2017). Even when involved, TBAs usually only take part in the last stage of labor to cut the umbilical cord (Amodu et al., 2017; Ejembi, 1996). Many Nigerian women of northern origin and their families are enticed to migrate to Southern urban cities, such as Lagos (Adekola et al., 2017), to improve their lives and economic situation. The migration of former child brides can be with or without their partners due to extreme poverty, low income, or the prospect of receiving higher income and accessing better social and health services (Adekola et al., 2017).

There is limited qualitative research on the experiences of former child brides, including their health-seeking behaviors in urban settings. Much focus has been on quantitative research and preventive strategies of CEFM for unmarried girls with little understanding of CEFM from the perspective of former child brides. To gain an in-depth understanding of childhood marriage and the extent of participation of child brides in the use of reproductive health services, there is a need to explore the experiences of women who were married as children. Revealing the perspective of former child brides can help increase our understanding of what supports they need as adult women.

Focusing on former child brides' (pre) marital experiences helps to gain insight into their past lives as young girls and their transitioning from child brides into wives and mothers as adults. The findings will identify key factors that influence their use of reproductive health services. In recognition that former child brides have voices that need to be heard, their narratives in this study will serve as consciousness-raising and social critique of CEFM and associated adverse outcomes. Intersectional feminist lens can elucidate the social construct that shapes the experiences of former child brides in a

patriarchal community and generate health knowledge from their perspective. The results have implications for addressing educational inequality and gender differences in schooling for young girls within patriarchal communities. Also, the findings inform policy recommendations and programmatic efforts on the effects of women's education and empowerment on the use of reproductive health facilities, which could reduce maternal and child mortality in Nigeria and beyond.

Purpose of the Study

This thesis is guided by the following study objectives.

1) To gain an in-depth understanding of childhood marriage as experienced by rural northern women residing in southern urban Nigeria.

2) To identify the conditions that influence former child brides' decision-making process on access to and use of reproductive health services.

3) To examine how the conditions shaped and influenced the experiences of former child brides in southern Nigeria.

Research Questions

1**.** What is the experience of being a former child bride of northern Nigeria origin presently living in southern Nigeria?

2. How did former child brides negotiate the transition to becoming wives, mothers, and caretakers married to older men as children?

3. What are the experiences of former child brides' access to and use of reproductive services in Southern urban Nigerian setting

Theoretical Underpinnings

This study used intersectional feminist framework and principles to understand women's stories about being child brides and their use of reproductive health facilities. Feminist-informed research focuses on power dynamics embedded in patriarchal

structures that place women in vulnerable and subservient positions. Early and contemporary feminist researchers such as Becker (1999), Hall and Steven (1991), Im (2013), and Olsen (2011) purport feminist research principles as (a) is gender-focused and offers benefits to both women and men in their social context rather than biological construction; (b) uses women's experiences as primary data and focus of discussion to promote women's agency; (c) supports social and transformative change in society which includes acknowledging women as social change agents; (d) targets the emancipation and empowerment of women and other marginalized populations from unequal power relations.

Feminism is ideal for exploring the experiences of former child brides because gender is a major contributory factor related to CEFM. However, a theoretical tenet of intersectionality asserts that no single factor should prioritize human experience and that experience cannot be accurately understood by a single characteristic such as gender (Crenshaw, 1989; Hankivsky, 2019). The experiences of women who married as child brides in Nigeria cannot be studied in isolation without looking at how structural factors and power inequality contribute to it.

Exploring the lived experiences of former child brides is essential to understand how the socio-cultural context contributes to CEFM, particularly for northern Nigerian women. Therefore, intersectionality was incorporated to uncover the multiple social identities and forces that constitute the experience of women who were married as child brides in Nigeria. Intersectional feminist-informed research is conducted for and about women and acknowledges the multiple identities of the women's experiences by preventing gender mainstreaming (Brisolara, 2003).

The interrelationship of various social categories gave better comprehension in addressing how the relationship between two or more factors intersects to help shape the experiences of women married as children. For example, there was a broader understanding of how religious and cultural beliefs contribute to the low educational level of girls and women in Nigeria, which in turn limits their ability to gain higher economic status and sustain their position in society. Thus, girls encounter systemic constraints such as gendered societal norms (Sedziafa et al., 2019), increasing the delay in accessing and using formal health care facilities (Fagbamigbe & Idemudia, 2017).

Ethical & Safety Considerations

Research permission was granted by the Health Sciences Research Ethics Board at Western University, Lagos University Teaching Hospital (LUTH) Idi-araba, and Lagos State Health Service Commission. Eligible participants were given a letter of information and written informed consent was obtained after they agreed to be part of the study and prior to the interviews. I emphasized the voluntary nature of participation and discussed the risks and benefits of the study with participants. The study was considered low risk but with the potential of eliciting emotional distress for participants. Consequently, resources were made available for the women if they needed them. For instance, women's rights lawyers were informed about the study, and they offered to assist women who were experiencing abuse, and a clinical psychologist agreed to counsel women who may be in distress. Participants' confidentiality was maintained throughout the study. Research assistants (RAs) were trained on research ethics and required to sign a confidentiality agreement form. Pseudonyms were also used instead of participants' real names. The researcher made sure that there were no personal identifiers linking participants to data.

Design and Methodology

Narrative Inquiry

The design for this study was based on narrative inquiry, which is the study of stories told by people about themselves (Polkinghorne, 2007). Historically, narrative inquiry was said to have been formally first used by Connelly and Clandinin to describe the personal stories of teachers (Wang & Geale, 2015). Narratives have always been part of nursing practice, in which patients use stories to tell nurses about their health conditions. This study was guided by Connelly and Clandinin's (1988) approach of narrative inquiry to elicit a rich understanding of the marriage experience of Nigerian former child brides and identify the conditions that influence their use of formal health facilities as adult women.

Narrative inquiry offers more than re-storying participants' lived experiences; it also provides a means for social change (Daiute, 2013). As an art-based approach, it goes beyond storytelling to uncovering nuances by helping storytellers to reflect on things they have not contemplated before and bring out hidden things from their memories (Wang & Geale 2015). Exploring the experiences of former child brides and using narratives as primary data enhanced the collaboration between the participants and the researcher.

Methods

Settings

Two settings in an urban center in south Nigeria were selected for this study: Sabo West and Sabo East (Pseudonyms). These two settings are the main settlement communities for the Hausa-Fulani ethnic group. The settings are low-income neighborhoods with visibly overcrowded residential houses. They are surrounded by multiple public and private health facilities, several walk-in pharmacy stores, patents

medicine stores, and have Arabic schools, government-owned public schools, and private schools.

Sampling

The study used purposeful and snowball sampling techniques to recruit 15 – 20 former child brides of northern Nigeria origin presently living in a southern urban setting. Recruitment ended at 15 participants when there was no new information being shared by the participants (Fusch, & Ness, 2015). Purposeful sampling was used to ensure participants had the knowledge and experiences of CEFM. Snowball sampling was adapted to access potential participants through recommendations from study participants about other former child brides (Acharya et al., 2013). Women were eligible to participate in the study if they were of Nigerian nationality who self-identified; 1) as a child bride (i.e., married before 18 years in at least five to seven years), 2) woman of northern origin now living in southern Lagos, 3) currently married/divorced, 4) have at least one biological child, and 5) users or non-users of the health care services. Women who married as adults (i.e., above 18 years), did not have children at the time of the study, or lived outside the study sites in Nigeria were not eligible to participate.

Recruitment Strategy

I acknowledged my positionality and how I approached the recruitment of women for this study. I see myself as both an insider and an outsider; thus, I speak and relate to this research from both positions. My insider status stems from the fact that I am a Nigerian woman, a nurse, and a researcher investigating the lived experiences of former child brides. My citizenship, occupation, and gender status helped me gain some level of trust from my research participants, as well as the trust of gatekeepers during the recruitment stage. On the other hand, not being Hausa-Fulani ethnicity, Muslim, from

northern Nigeria, and not having experienced CEFM personally, I consider myself an outsider. To minimize the potential for outsider bias, I involved community men and women throughout the recruitment process. In particular, two native Hausa-speaking individuals were recruited as research assistants (RAs), male and female final year nursing students. The male student nurse was well-known and respected in the community, and he introduced me to the male community leaders, comprising the community chief, secretary, treasurer, and others. Most of these men are the husbands of potential participants.

Given that men are considered the household authority figure in Africa, to gain entry into the community and make the study participatory, I used the male community leaders as gatekeepers to set up initial meetings with the other community men and later the women leader (wife of community head). I sought the consent of the community men in both settings to conduct the study in the community and recruit participants. In all, three community meetings were held with 12-15 men, where I read the letter of information (see Appendix F), explaining the study, its relevance, and potential risks and benefits to them. After receiving the men's verbal consent to conduct the study, one of the men (the community secretary) introduced me to the women's community leader.

This process was similar for both settings; the men gave the women's leader permission to introduce me to potential participants after giving their verbal consent for the study to be conducted. I obtained access to potential participants for the study through the women's leader. While the women's leader identified participants, I screened the women for eligibility and explained the study to them. Women who met the inclusion criteria signed or thumbprint on the consent form (see Appendix F) and were part of the study. Obtaining the buy-in of the men and the use of a participant's home for the

interview helped to ensure privacy, build rapport, gain trust, and enhance the interaction with the women for them to tell their stories without fear of reprisal.

Data Collection

The data collection period lasted two months (July-August 2019). In-person interviews were conducted using an interview guide with semi-structured questions (see Appendix G). The interview guide consisted of twelve open-ended questions covering the following topics: being a child bride, motherhood, factors surrounding the use of antenatal services at health facilities, and their future expectation for themselves and their daughters. Probing questions were used to elicit more sharing from the participants. For example, I asked participants to provide examples of what they considered challenging or enjoyable.

Prior to data collection, a one-day training session was organized to familiarize the two RAs with the study, and they signed confidentiality agreement forms. The RAs assisted with data collection and served as interpreters/translators. The training primarily focused on eligibility criteria, ethical principles, anonymity/confidentiality of the participants, effective interpretation, and translation to produce accurate and truthful data (Temple, & Edwards, 2002). The RAs helped minimize the potential loss of meaning in translation from Hausa to English because they had knowledge in nursing and research. They also helped with transcribing the data.

Unlike Sabo East, where husbands allowed the interviews to be conducted at participants' homes, all interviews at Sabo West were conducted at the house of the community leader (community chief). The locations of the interviews were those preferred by and convenient for the men and participants, unlike the hospital environment the researcher previously proposed. An honorarium of a hygiene gift pack was proposed

to express gratitude, but cash of 2000 naira (5 CAD) was given as suggested by the women's leader.

All interviews were audio-recorded and lasted approximately 30 - 45 minutes. Participants were interviewed in either English or Hausa, and the RAs interpreted for interviews conducted in Hausa. I transcribed the six English interviews verbatim, and the RAs transcribed the remaining nine Hausa interviews verbatim into English. To ensure the accuracy of the transcriptions, I swapped audio recordings between RAs. In addition, I wrote down field notes to help capture the non-verbal behaviors of participants and context during the interviews (Khisa & Nyamongo, 2012). I also maintained a reflective journal of my thoughts and any ideas that emerged throughout the research process.

Finally, I ended each interview with a debriefing session by asking each participant if they wanted to share their feelings and/or mood after recounting their experiences and if they had any questions for me. One participant inquired about the possible benefits of sharing her story. In the end, I reemphasized the importance of the study, stressing how this study could inform policy on ending CEFM and enhance gender equality in Nigeria.

Data Analysis

This study adopted Cladinin and Connelly's three-dimensional framework technique to analyze the data (Cladinin and Connelly (2000). Using the Connelly and Clandinin (2000) framework helped to go beyond description and thematic development and introduced another step of re-storying the raw data with intersectional feminist principles in mind. According to Cladinin and Connelly (2000), thinking narratively during data analysis entails negotiation in relationships, purposes, and transactions, while keeping in mind the theoretical, methodological, and interpretive

considerations. Wiles et al. (2005) define narratives as meaningful final products from data or field text. In this study, full attention was given to field notes, which included non-verbal cues, silences, and context observed throughout data collection. -Data analyses for this study were informed by a four-step interactive process involving1) creating narratives, 2) broadening, 3) burrowing, and 4) storying and re-storying (Cladinin & Connelly 2000).

First, the participants' narratives were created using codes. Initial codes were generated from the interview transcripts. I started by assigning codes to recurring themes as I read through the transcripts several times. Interacting with the data this way allowed me to immerse myself in the narrative of each study participant. As suggested by Kim (2015), there is the need for the researcher to interact with the data several times to help assign meaning to participants' narratives. I compared transcripts to the identified initial codes to make amendments from the narratives. Mind mapping, which was used to illustrate the graphical format of main points and commonalities, made it easier to identify and connect codes (Burgess-Allen, & Owen-Smith, 2010; Johnston et al., 2016). For instance, I initially wrote my thoughts in long narratives, later replaced with phrases or short words. I then read through each transcript line by line and created a mind map for each transcript. I had listened to the audiotape at the start to ensure completeness and accuracy but listening to the audio recording repeatedly helped identify what is common in the narratives. Creating a mind map on paper for each transcript helped highlight emerging patterns. Initially, the patterns consisted of six themes and five sub-themes, which were later grouped into three broad themes to capture the past, present experiences, and future aspirations of former child brides.

Second, broadening emphasizes the broader context or expansion of the story

(Kim, 2015). Situating participants' narratives in history helps broaden and make sense of the actions in participants' experiences (McDonald et al., 2016). For instance, broadening the theme 'young age at marriage and agency' allowed me to make historical connections as the women reflected on their past experiences of becoming child brides. I used the first theme to expand the narrative threads that the women used to describe their past as child brides, thus, providing more information about the participants as it relates to the history, culture, and values from their narratives.

Third, burrowing was used to focus on more specific details leading to a thorough investigation of the data (Kim, 2015). For example, in the second theme, 'preference for home birth,' I further investigated if living in an urban setting influenced access and use of health care services in the past as child brides and presently as adult women. Fourth, storying and re-storying are completed after the researcher has broadened and burrowed into the data (Cladinin & Connelly 1990). The researcher finds ways of storying and re-storying the data in such a way that will bring to light the significance of the lived experience of the participant. The researcher wrote and re-wrote the women's stories as they unfolded throughout the analysis.

Rigor

I applied the principles of rigor espoused by Hall & Stevens (1991) to fit with the feminist lens of this study. Hall and Steven (1991) propose ten ways to ensure rigor in feminist research: reflexivity, credibility, rapport, coherence, complexity, consensus, relevance, naming, and relationality. The feminist researcher and study participants co-create knowledge such that the researcher takes self-reflexive measures to reduce potential bias (Hall & Steven, 1991). Reflexivity is explained as disciplined self-reflection (Wilkinson, 1988), where the researcher is expected to reflect on the research

process by acknowledging how personal interest and values can influence the research process from topic to conclusion of the study. I kept a reflective journal where I asked myself critical questions regarding how my positionality could affect the findings and ways, I could reduce bias.

To achieve credibility, I used member checking, i.e., following up with some participants to validate points they said during interviews. The first two transcripts were returned to the participants to approve of their narratives and correct any misconceptions. I presented as accurately as possible the participants' voices using their narratives to capture the complexity of their experiences and ensure the credibility of this study. To establish rapport, I asked participants to call me by my first name. Interviews were conducted as conversations held in places where the women felt most comfortable sharing their stories. I provided information about the study in a way that was understandable by asking open-ended questions to capture the participants' experiences. Telling their stories afforded the women agency through anonymity to speak privately, revealing elements of their experience that exposed the potential for change.

Findings

Participants

Fifteen women who self-identified as former child brides participated in this study (Table 1). The participants were between 19 to 50 years of age and were married between 12 years and 17 years old. Most participants (n=10) reported having attended Arabic school, two participants finished secondary school, two others had not completed primary school, and one woman had no form of education. On fertility, the highest number recorded was 14. The majority of women (n=11) had home births for all their children; two participants had hospital delivery. Another two participants had a mixture

of hospital and home birth, out of which one of them had nine home births out of 10, the other woman had three home births out of five. Four participants experienced the death of their children. One participant, who had only one living child, reported the loss of 11 children because she had home births with unskilled attendants.

Themes

Three broad themes resulted from the analysis of the women's narratives. Following Cladinin and Connelly's (2000) three-dimensional framework, former child bride's stories were situated across three-time frames; past, present, future to illuminate the research questions. The women's narratives revealed their lived experiences and transitioning of having been a child bride in the theme "young age at marriage and agency," the significance of culture and religion on women's health-seeking behavior in "preference for homebirth" and their future aspirations about their daughters' educational attainment, in "education is too late for me but not for my daughter." The themes brought visibility to the overlapping context of predisposing sociocultural constructs that shaped the lived experiences of former child brides, contribute to their current experiences, including their health-seeking behaviors, and inform their future expectations about their daughter's educational attainment. Further analysis revealed the striking observation of the tension former child brides experience in wanting to uphold and preserve the traditional practices of both home birth and CFEM to avoid promiscuity for their daughters. Yet, they desire formal education, which they were denied for their daughters.

Past Experiences of Former Child Brides

Theme 1: Young Age at Marriage and Agency

In describing their childhood (pre) marital experiences, former child brides shared memories that being of a young age made it possible for their parents to make marital

Table 1

Participants' Demographic Characteristics

Codes and Pseudonyms	Age	Age at marriage	No of children (living)	Gravida	State of origin	Language of interview	Education	Place of Birth
SWA-1 Bose	25	12	3	3	Nasarawa	Hausa	Arabic	Home
SWA-2 Buki	35	15	4	4	kano	Hausa	Arabic school	Home
SWA-3 Ope	50	17	1	12	Bauchi	Hausa	Arabic	Home
SWA-4 Bade	26	12	5	5	Katina	English	No school	Home
SWA-5 Ayo	24	14	2	2	Sokoto	Hausa	Arabic school	Home
SWI-6 Bola	43	14	7	7	Katsina	Hausa	Pry 3	Home
SWI-7 Tola	27	17	4	4	KADUNA	English	ss3	Hospital
SWI-8 Funmi	Can't tell	12	3	5	Jigawa	Hausa	Arabic	Hospital-2 Home - 3
SWI-9 Ade	19	12	1	1	Lagos	English	ss3	Hospital
SWI-10 Tolu	40	13	6	6	Maiduguri	Hausa	Arabic school	Home
SWI-11 Tosin	45	14	9	14	Sokoto	Hausa	Arabic school	Home
SWI-12 Toun	35	15	5	8	Kaduna	English	Arabic school	Home
SWI-13 Titi	25	13	6	6	Katsina	Hausa	Arabic school	Home

SWI-14 Nike	38	14	6	6	Zamfara	English	Pry 3	Home
SWI-15 Bami	48	15	10	10	Maiduguri	Hausa	Arabic school	Home 9 Hospital 1

choices and decisions for them. They explained that being so young, they had to obey their parents and could not refuse a marriage arrangement. For instance, 45-year-old Tosin, who married at age 14, said: "No, my parents wanted it; I was too young to refuse." Likewise, 40-year Tolu, who married at the age of 13, lamented she and her sister could not make marital choices and were forced into marriage by their parents.

> I did not choose to marry; I was forced; I could not do anything; we all went to Ghana for the marriage because that was where my father was. I did not even know I was getting married that day until they started dressing me up. Sadly, the same thing happened to my younger sister…she was forced to marry at 12. My father said it was good for us to marry before we start doing bad things with boys (IDI: Tolu, 40).

Participants reported the expectation that daughters obeying parents is a cultural norm and underpins why young girls cannot make autonomous marital choices. Here, Tolu indicated that CEFM is shaped by the cultural norm of preservation of virginity. Some participants shared they had never even met their future husbands before the wedding ceremony. Ayo, who married at 14 years describes how she first met her husband:

> I met him after the wedding, they took me to his house…No, I met him after the celebration. I wasn't the one that chose him; my father chose him for me to marry. I didn't feel any type of way because in my culture, anything your parents tell you to do, you must obey them regardless of the level of difficulty of the task, and you cannot say no to them.

Ayo described herself as an obedient young girl who must marry her parents' choice even though she had not met him before the wedding celebration. Parents, especially fathers, would arrange marriage with their friends, their friends' sons, or business partners.

Former child brides said they could not choose to marry people they loved and would have wanted to marry. Ope shared:

> I already had someone else in mind to marry, but they told me to marry my father's friend's son, and I accepted without argument.

Sometimes parents planned their daughters' marriage with members of extended families, but the girls were not informed until after the arrangement had been finalized. Bose described how she felt when she heard about the marriage her parents had arranged for her at age 12. "I could not do anything; I was just crying because at that time I was still young, and I did not know anything about marriage*."* Elaborating on life after her wedding, Bose described how she cried for two years:

> Anytime my husband came home from work and called me over, I used to run to his mother's room to cry. My mother-in-law used to beg me not to cry, but I cried for two years before I stopped.

Despite their limited agency to decide and make marital choices for themselves as young females, the women said they could not show their resentment out of respect for their parents. Ayo said she pretended to be happy to please her parents and accepted their choice even though she was sad that she never met her husband until her wedding day.

Overall, the women described themselves as young girls who were forced to marry at a young age without their consent and could not refuse or make their own marital choices. Most of the former child brides described feeling sad about their wedding. Their younger self would not have married so young, but they did it to show respect and please their parents. They expressed how their right to make decisions and choose who to marry was taken away from them, but they eventually accepted their parents' choices.

Present Experiences of Former Child Brides

Theme 2: Role of Culture and Religion

Religion and culture played significant roles in the women's health-seeking behaviors and how they presently went about their day-to-day married lives. Two sub-themes comprised this second theme: a) preference of home birth (b) acceptance and willingness to make the marriage work.

Preference of Home Birth

Research question two burrowed into the transitioning of the underaged married girls into child wives, mothers, and home caretakers. The women explained how they shifted from being an obedient child bride to becoming a pregnant wife and mother and being guided by their community's shared cultural norms and religious beliefs. In describing their experiences as non-users of formal health care services, participants mentioned that care during pregnancy and childbirth was expected to be provided to them by elderly women in their immediate household and the larger community.

Tosin explains:

> My senior wife helped me with my first child. Since then, I always give birth at home. I never attended any antenatal because nothing is wrong with me; I only go to the hospital [hospital close by, 200-300 meters] after I give birth at home and when my children are sick. There is one doctor that likes me; once I get there, he will quickly attend to me because he already knows that I usually give birth at home (IDI: Tosin, 45).

The former child brides described that their religious beliefs support birthing at home over going to a hospital. For example, most of the women associated a safe delivery at home to the supernatural or the work of God. Many women commented that they birthed their infants at home safely without the need for formal antenatal or labor and delivery care at a hospital. As Bose explains,

> I didn't go to any hospital when I was pregnant. I didn't go for any check-up; I had my baby at home God was with me, and I had the baby at home by myself.

The women indicated that they were socialized to view homebirth as the norm and consider the hospital an exception. The women explained that formal health facilities are only used for pregnancy-related complications or other illnesses. Tosin further explains:

> You know all this hospital thing; it's just the work of God; if you are not sick, why go to the hospital? You go to the hospital only when you are sick or the child is refusing to come out, but usually, the child comes out if you pray well. Do Hausa women do operation for delivery? We only go to the hospital when there is a problem; then the doctor can decide to do operation to bring the baby out. (IDI: Tosin, 45).

Likewise, Buki, who questioned the use of hospital care for childbirth, described professional health services as only being for when a person is ill. *"*Why deliver in hospital or use nurse at home when nothing is wrong with me? I take the children to the hospital only when they are sick, but nothing was wrong with them." Women who use health facilities for perinatal care were considered weak and perhaps not practicing their religion well. According to Tosin, "Hausa-Fulani women who struggle to give birth at home are weak; If I see a woman that is weak and cannot push out her baby, I get upset. Those kinds of women are weak, and it is possible they did not pray very well".

Elaborating on her motherhood experiences, Tosin explained how she prayed and used her knowledge acquired from older women and her experience of her first home delivery to aid her subsequent births.

> I don't use anything; I only pray very well daily. I gave birth to 14 children in this room; if you ask anybody in this community, they will tell you. I would cut the cord myself and bathe my child, take a shower after putting the baby to sleep before I call on the neighbors. I would have boiled water before the baby comes out. I only had help with the first pregnancy, and I was taught well by my senior wife. I usually don't breakwater, and I don't bleed much, so why go to the hospital? Once I have small abdominal pain, I will know its time, and then once I see small blood, the baby will follow (IDI: Tosin, 45).

Most of the women expressed their intention to pass on their experiential knowledge of pregnancy and childbirth to their daughters as they had learned from their mothers. Tolu explained; “I gave birth at home with the assistance of my mother-in-law, and I have now taught my daughters.” However, few of the women explained they would teach their daughters (in-laws) about home birthing, but they will also advise them to use formal health care. For example, Ope, who lost 11 children, had this to say when asked if she will advise the next generation to use hospital or home birth. “I will teach my daughter-in-law home birth, but my only living son is educated; he will not allow his wife give birth at home.” These women’s narratives indicate that they put faith in God for safe pregnancy and childbirth. They believe pregnancy is not a condition that needs to use formal health facilities, and they intend to preserve the cultural practice of unskilled home birth with the next generation.

Acceptance and Willingness to Make the Marriage Work

The women provided insight on how religious and cultural expectations of female submissiveness helped them to move from the experience of being an obedient sad child bride to becoming a mother and home career having an enjoyable marital experience. Many of the women discussed that submissiveness was helpful to accept their roles, and as long as they do what their husband wants, they will continue to have an enjoyable and successful marriage. Most participants reported their marriages were enjoyable by doing whatever their husbands wanted to show respect and make them happy. Nike reminisced: “I know I was always crying and sad at the start, but I didn’t suffer from getting married early; I actually enjoyed it, so I don’t see why I would need to choose differently. Everything is good as long as I respect and make my husband happy”.

Nike described what she did to make her husband happy and have an enjoyable marriage:

> First of all, one of the things I did to help me was to respect my husband completely. I tried to avoid the things my husband didn't like. Before he asks for food, make sure the food is available; try to understand your husband's likes and dislikes. Also, make sure to take care of the house very well and be clean. When you respect and do whatever your husband says, you don't get in any trouble with him.

As evident in Nike's words, to have a successful marriage, the wife needs to be submissive to her husband by doing whatever he says. Similarly, Bade described her current experience of marriage: *"*We are living happily, and I respect and obey my husband. I do everything he says without argument".

Though they initially felt sad being a child bride and married so young, the women indicated that they presently have an enjoyable marriage. However, they reported being fearful of having to comply with whatever decision their husbands make concerning their daughter's education. Most of the women expressed a desire for a better education for their daughters. Bose comments that her husband has plans for their eight-year-old daughter to marry when she is 13 years.

Although she doesn't want her daughter to marry at a young age, she has to follow her husband's wishes; "I have to do what my husband wants. I am just praying he will change his mind before then". Ayo corroborated Bose's narrative and mentioned that CEFM is to avoid pre-marital sex or pregnancy:

> My husband will arrange our daughter's marriage when she is 13 years because he believes girls are easily influenced, and it is our culture to protect girls like we were protected with marrying early. I am still suggesting age 15 to him; I do not know if he will agree. I want her to go to school and study hard until she completes her education before, she'll get married. But I have also told her she must remain a virgin even in school; if not, I will tell my husband to arrange her marriage.

Due to cultural and religious expectations regarding a woman's role in the family, the women feel compelled to protect their daughters from premarital sex amidst

educational attainment.

Future Aspirations

Theme 3: Education Too Late for Me but Not for My Daughter

All the women expressed their regrets of not being able to stay in school because of being married so young. Many mentioned that pursuing further education after marriage was not feasible or easy because of their ascribed gender roles in the family. However, they all valued formal education and consider having a good education as important for young girls. For example, when talking about her youth and education, Funmi described how not acquiring formal education, which she refers to as "proper," has limited her employment opportunities:

> I got married at 12 years; I was very young to know what was wrong or right; I did not know what was good for me. Before my wedding, I was in an Islamic school but dropped out after marriage. I did not attend government school. Today, I cannot do anything proper; I only sell small small things; I regret a lot. If only I had small proper education, I will be better off (IDI; Funmi, married at 12).

Similarly, Bade expressed that her Arabic religious education was a barrier from starting or continuing any formal education. Many women commented that it was *too late* and *no use* for them to go back to school after years of marriage. Nike described being a mother and attending school "as too difficult…, it will be really hard, I won't succeed, it's no use". Nike advised young girls to obtain an education before getting married.

> If I had a choice, I would have chosen to finish school before getting married; marriage does not allow a girl to finish school. My advice to any young girl is to finish school first before getting married because it is difficult to combine both at such a young age; you just can't.

When responding to questions around education for their daughters, most of the women considered education as a means for young girls to avoid CEFM by comparing

themselves with their counterparts who married late. Toun, 35 years old, married at 14 elaborated,

> We have seen the difference between women that marry early and those that marry late here in Lagos. I did not finish secondary school because of marriage; I would have not been married at 14 if I was going to finish secondary school; I would have been 17 or 18 years which I think is still better than 14years. We have girls who are going to university, but they are so few, we want more girls in university so they can also marry late.

Another participant, Bami, said her younger self would have wanted to be older before getting married and wants her three daughters to obtain an education first and not marry until they are over 20 years old. Tola was hopeful that her daughter would attain higher education before getting married: *"*I will only let my daughter get married after she has finished school." As resolute as Tola was about her daughter obtaining an education, she expressed her fear about her husband's refusal and insisted that she would involve his parents, and if his parents refuse, she will involve her own parents, if needed.

Conversely, women mentioned challenges with their daughter's education. Tosin described her husband as willing to allow their daughter to stay in school, but he's not able to pay the tuition.

> My husband now agrees our daughters stay in school. The only problem is the school fees; he cannot afford the school fees. Since I don't work, I ask my family members to help with my daughter's school fees, and they have been helping (IDI: Tosin, 45).

Furthermore, former child brides all spoke about their constrained agency and the authority of their husbands deciding about their daughters being educated or being married young. The women stated that children born from marriage are considered property of the father or male figurehead of the family; men have the final say about almost everything related to the family. Funmi explains.

Even now, I am regretting getting married early because it is the reason I did not

> go to proper school. I don't want my daughters to marry at such a young age because I want them to go to proper school to which I could not go. The only problem is that my husband might not want that, in that situation, there is nothing I can do because they are his children.

At the same time, former child brides expressed their fear of their daughters having pre-marital sex while in school, which is a taboo in Hausa-Fulani culture. They explained that although they favor education for females, they are not willing to tolerate any form of sexual misconduct from their daughters. Tosin, 45-year-old, explained the reason why their daughters cannot engage in pre-marital sex.

> Hausa men marry divorcees with children easily unlike other tribes. The only thing is that Hausa girl cannot lose her virginity or get pregnant before getting married; it is a taboo. If she does, she will never get any man to marry her.

The women explained that they are bargaining with their daughters to stay longer in school and not give in to the social norms of CEFM but remain as virgins until they finish school. At the same time, they are making efforts to get the buy-in of their spouses as the sole decision-maker by presenting it in a culturally appealing manner. Bola elaborated that although she desires her daughter will go all the way to university, however, it is her responsibility as a mother to protect her daughter as she was protected. She has therefore informed her daughter that her father will arrange her marriage if she is seen with a male company.

> I have told her she must choose one, school or marriage. She cannot mix marriage and school. I want her to go to university, and she wants to, but I have told her, if I see her with any man, I will tell her father to arrange her marriage.

Although most former child brides could not obtain further education for themselves, they all wanted their daughters to have access to quality education prior to being married. The women gained some level of agency and are making efforts to make positive educational choices for their daughters. As such, they are determined to see their

daughters achieve formal education before marriage amid challenges such as financial or a husband's refusal.

Discussion

This study conducted a retrospective exploration of the experiences of former child brides of northern Nigeria origin but who now reside in an urban setting in southern Nigeria. Guided by intersectional feminism framework and narrative inquiry, the research harnesses retrospective views that many factors such as young age at marriage, poverty, religion, culture, and low educational level with gender interact to place a girl child at risk of CEFM. The study contributes to existing knowledge on experiences of former child brides and stimulates changes in four ways: (a) it illuminates that, unlike young child brides, former child brides did not come through as victims, but as resilient women who survived the interaction of social constructs and developed some sense of agency (b) demonstrates that despite the close proximity to formal healthcare, utilization of formal health services is not high in urban settings among this population, (c) reveals specifically the future aspirations of former child brides following their past and current experiences, as having contrasting ideas of cultural retention of home birth practices and cultural resistance of CEFM, and (d) it elicits former child brides self-help strategies of communicating their displeasure towards the practice of CEFM as the cause of their low educational attainment, making them advocate for a longer stay in school for their daughters.

Contrary to existing studies, the findings reveal that Hausa-Fulani women who are now former child brides did not increase their use of formal health care services after moving to an urban setting, increasing their risk for poor health outcomes. Our findings also show that despite the close proximity to healthcare facilities, cultural and

religious intergenerational beliefs significantly contribute to the underutilization of formal health care services among these former child brides in an urban setting. Further, we discovered former child brides truly regret their low educational attainment due to having married so young. The former child brides wanted their daughters to spend more years in school to avoid CEFM.

The stories of the women illustrate how their childhood and current experiences as former child brides were formed through interactions of social factors and how these experiences are informing their future aspirations as it relates to their daughter's education. In Nigeria, most children are socialized early into gender roles with cultural and religious demands of submissiveness within the household for female children and authority/domineering role for male children (Ajala, 2016). This is, however, more prominent in the Hausa-Fulani ethnic group because of cultural practices such as CEFM, which restrict girls/women's opportunities and choices (Desmennu et al., 2018).

Our findings showed that, despite living in a southern urban setting with diverse ethnic groups, religion and cultural practices remain a strong influence on the northern Hausa-Fulani women's perception of their gender role in families, the community, and use of formal health services, in line with Mobolaji et al.,'s (2020) assertion that ethnic groups are distinct, and their characteristics will manifest mainly as it relates to culture and religious beliefs despite the geographical location. Migrant Hausa-Fulani communities are known to be associated with Islamic cultural practices (Desmennu et al., 2018).

The women's narratives can be explained in the context of inequitable gender norms and male dominance of parents and spouses, which relates the girl child's agency to power dynamics. For example, the women's narratives depict how girls were

transferred from obedient girls under their parents' authority to submissive dutiful wives under their spouses' authority. In articulating memories of their younger self, the former child brides emphasized how their parents within the interacting space of poverty, religion, and culture used coercive power to deny their agency to make marital choices for them without their consent. Abebe (2019) argues that children's personal agency is relational and can be regulated by many people in the familial context, making it mostly difficult and limited to the child. In this wise, former child brides' agency was denied by their parents at such a young age when they lack the agency to refuse parental authority.

Their stories of present-day life as married women reflect the continuation of cultural expectations of submissiveness. The agency of a former child bride, now an adult woman, can be described as remaining constrained (Johnson, & Gilligan, 2021; Payne, 2012) due to cultural demands and power inequality not to oppose spousal authorities. Former child brides are under traditional obligation and cultural norms to be submissive to be considered a good wife (Aluko, 2015; Ntoimo & Isiugo-Abanihe, 2014). Because former child brides are economically reliant on their husbands, submissiveness to them was a necessity.

According to the participants, the first few years of marriage were a huge transition; one participant explained that it took her two years to stop crying. However, Nike explained that remaining submissive and committed to gender roles helped her transitioning from sad early marriage experiences into having an enjoyable marital experience. Based on the narratives of former child brides in this study, women used submissiveness and prescribed gender roles to maintain a good relationship with their spouses.

These findings are consistent with an interpretive phenomenological analysis

used to explore the marital experiences of adult Northern Nigerian women (Callaghan et al., 2015). The authors reported how women were compelled to unwillingly conform to the normative cultural practices of CEFM, which the women described as a traumatic rupture of their childhood (Callaghan et al., 2015). Findings of the study revealed that women who find themselves being married as a young girl had been traditionally, culturally, and psychologically socialized with the traditional gender roles assigned to women, such that they want nothing more but to please their husband and with that, they are happy (Callaghan et al., 2015). Our findings revealed that most of the women made sense of their world by accepting their role as wives and mothers.

Our results further indicate that former child brides' use of formal health services, particularly reproductive care, was influenced by cultural norms, religious beliefs, and low educational levels. According to James (2013), religion is an important sociocultural factor that influences cultural and social beliefs, motivations, and human behavior. The interaction of cultural norms and religious beliefs with low educational levels resulted in adherence to and preference for the cultural norm of traditional health care of home birth in an urban setting. Accordingly, former child brides' low level of education contributed a role in their non-use of formal health care services. Although there is evidence that education estranges people from religious and cultural beliefs (James, 2013), the low education level of former child brides contributes to adherence to religious and cultural beliefs and their underutilization of formal health care service that is close to them.

Contrary to previous literature, our finding did not find distance as a barrier to using health care services among northern Nigerian women (Amodu et al., 2017; Awoyemi et al., 2011). Our results revealed that proximity to the health center of a distance of about 200-300 meters was not a facilitator of the use of formal health care by

the former child brides. The former brides considered going to the hospital only if they experience childbirth complications such as prolonged labor, the infant or mother was sick after a home birth, and when their faith in older women and home birth fail.

As mentioned previously, Hausa-Fulani married women are generally encouraged to have home birth under family member supervision based on religious seclusion. Abubakar et al. (2017) pointed out that some of the northern Nigerian women who were aware of the importance of antenatal care by attending still opted for unskilled home birth due to behavioral, socio-cultural, and religious preferences. Some of the reasons for the preference for unskilled home birth included custom, felt safer at home/privacy, more comfortable with family members, did not want male attendance, and dislike of staff attitude in hospital (Abubakar et al., (2017).

Although women in our study did not mention that they were restricted by seclusion, they described their reproductive experience as care provided by elderly women in the family or larger community. Former child brides repeatedly spoke of having a dependent child-wife experience where religious beliefs and intergenerational relationships enabled and socialized homebirth as a sign of strength when they can deliver their babies at home and alone. Instead of accessing and utilizing nearby health facilities, women talked about accessing older women in the community for their health needs. They gain religious knowledge about pregnancy and childbirth, and they associate safe delivery with the supernatural work of God. Based on their faith in God, these women do not see pregnancy and delivery as a need for the use of formal health care services, and in particular, they favored unskilled home birth. As a result, there is no motivation for them to access and use formal health facilities for antenatal, intrapartum, or postnatal care.

The study by Abubakar et al. (2017) reported unskilled home delivery among northern Nigerian women due to reliance on socio-cultural practices and religious beliefs. According to the authors, 73.4% of the women indicated a preference for unskilled home birth; most of the women did not receive antenatal care and would only seek formal care when sick. According to former child brides' narratives in our study, there is a misconception that considers home birth delivery a natural skill that must be learned and perfected without medical assistance. The whole idea is for the woman to get homebirth right the first time and subsequently give birth alone; those who use health providers are considered weak. The women associated the weakling perception with a need to be strong and religious. They mentioned how they used religion and faith to give birth at home to prove their strength. Faith, as mentioned by Tosin, does not only mean faith in God, but faith in a system that has been tested, tried and worked from generation to generation in their community.

The women in the study expressed how they tapped into the body of knowledge of generations of women and how they trusted in something that existed before them. In their description, the women tried to be systematic, hygienic (boiling of water) and scientific in their own crude way. Having this belief hinders the women seeking preventive care and their decision to use formal health care when needed, putting them at risk of pregnancy complications.

Ironically, the analysis revealed that former child brides consider the experience of home birth an inheritance norm that they intend to preserve by passing the knowledge to their next generation. Our findings reported that former child brides are already teaching their daughters unskilled birthing, which has implications for the health of the pregnant woman and her child. However, few of the women are seen to link the use of

health care to being educated. One participant mentioned that she would teach her daughter-in-law home birthing, but she was sure her educated son would not allow unskilled home birth.

In terms of urban-rural dichotomy, findings from this study contradict previous knowledge that the utilization of reproductive health services would be higher in urban settings compared to rural (Fagbamigbe & Idemudia, 2017, Maharjan et al., 2019) and that the choice of childbirth location is influenced by the geographical location, especially regarding access to qualitative health care or lack thereof (Gellis, 1991). Although the women in this narrative study were no longer residing in their birthplaces, living in an urban setting did not influence them as it relates to their use of reproductive health care. The women in this study depended on prayers and their faith in God to see them through pregnancy and childbirth and heeded the advice of older women rather than seeking medical care. Unskilled home delivery makes this group of women highly vulnerable to birth complications, maternal and child mortality (Fapohunda et al., 2017), as evident by the report from some of the women of loss of their children.

The finding that education level is a determinant of the use of formal health care services among women is corroborated with several previous research in Nigeria. One study conducted in Lagos, Nigeria, showed that educational attainment increases women's use of reproductive health care facilities to give birth (Wright et al., 2020). According to Wright et al. (2020), 91.6% of the participants in their study had received antenatal care because most participants have secondary school education and above. These findings are consistent with those of another Nigerian study by Ajayi and Akpan (2020), which found that the level of education is a strong indicator for the utilization of reproductive health care among women in Nigeria. According to their findings, although

the majority of births (85.6%) took place in health facilities, women with low educational levels remained non-users of formal health facilities.

There is evidence that planned home birth reduces adverse health outcomes (Ogbo et al., 2020). Narratives provided by former child brides point to the need for interventions focused on making homebirth safe since it is the preferred option among these women. As such, former child brides and the community at large will benefit from consistent health education to address the misconceptions about home birth delivery. In order to help channel the intergenerational cultural practice of home birth positively, there is a need to be more culturally sensitive by developing a community-based obstetric service to have only planned skilled home birth to make the experience safe for low-risk women.

Also, context-specific maternal health initiatives such as the Abiye initiative (safe motherhood) developed by the Ondo state government in Nigeria can be adopted in this community (Ajayi & Akpan, 2020). The Abiye initiative (safe motherhood) was reported to have a 29 percent increase in facility-based child delivery within three years from 56.5% (2013) to 85.6% (2016). Taking a cue from the Abiye initiative and based on the proximity of Hausa-Fulani communities to major hospitals, midwives should be assigned to each pregnant woman in the community for skilled home birth. Further, there should be a system in place for prompt referrals to nearby hospitals.

The former child brides had great aspirations for their daughters' future rather than for themselves. Telling their stories helped them uncover their past, illuminate the present and raise the consciousness of wanting their daughters to have access to quality education. Our findings revealed that some of the former child brides' attitudes about CEFM had shifted; they valued education and wanted their daughter to finish school

before being married. They related their low education to low socio-economic status, believing that they would have been better off with more education, as it could help improve their economic status. Most literature on CEFM has emphasized the importance of education in mitigating CEFM practice (Delprato et al., 2017; Walker, 2019; Wodon et al., 2018). Education is perceived as a means to improve one's economic status, and former child brides desire this for their daughters.

The findings of this study also revealed that despite their desire for their daughters to obtain an education before marriage, the former child brides said they would comply with their husband's decision if he decided on CEFM for their daughters. The women might continue to support CEFM for their daughters because of their low decision-making autonomy within the family and maintain their enjoyable marriage. In addition to their low education, religious and cultural demand on former child brides as the subordinate group to completely carry out their spouses' wishes further contributes to their low decision-making autonomy and agency as a mother.

According to Makama (2013), such an act where a spouse's decision precedes over the wife's to impede a woman's agency and decision-making autonomy is part of the social mechanism that sustains male dominance within the family. Although mothers are expected to naturally engage more with the majority of their daughter's education compared to fathers (Ahmad, 2013), Self (2014) argues that the mother's autonomy on her daughters' welfare in a patriarchal society cannot be effective since her husband can always override her decision.

As much as former child brides desired higher educational attainment for their daughters, they also feel obligated to protect them and do not want to encourage their daughters to engage in pre-marital sexual activities. They encouraged their daughters to

keep to the tradition of marrying as virgins while staying longer in school. One participant mentioned that it is their responsibility to protect girls from sexual activities or misconduct like they were protected by their parents. Premarital sexual activities are forbidden in the Islamic religion and are an act of immorality (Ishola & Mahsen, 2020). There is evidence that the high value attached to virginity contributes to the practice of CEFM in practicing countries. In conformity with Islamic law, parents use CEFM as a moral rule to prevent premarital sexual activities and preserve virginity before marriage (Delprato et al., 2015; Mobolaji et al., 2020). While asking their daughters to remain virgins while in school could indicate control over women's sexuality and reproductive rights, former child brides genuinely consider this a way of protecting their daughters from sexual immorality.

Our findings on former child brides' desire for their daughters to attain a quality education contradict previous research regarding CEFM. For example, (Ahmad 2013) found that, in Pakistan, mothers' illiteracy results in early marriage for their daughters. According to Ahmad (2013), female education remains undervalued; low educated mothers have low aspirations for their daughter's education attainment. Similarly, Delprato et al. (2017) explored transmission of education inequality in 25-32 sub-Saharan Africa countries and found that early married mothers (EMM)' aspiration for their daughter's education is often low, resulting from mother's low education. The results of these two studies suggest that female education is not highly valued in CEFM practicing communities and, as a result, becomes normalized.

In contrast, our findings showed that former child brides, despite their low education were wanting more girls in their community to have post-secondary education. As such, grounded within all the social constructs and life events, the only construct

former child brides seem unable to cope with is their low educational attainment. Therefore, while their self-agency may be constrained, the women showed determination and aspiration to advocate for their daughters. Abebe (2019) points out that agency increases with a child's maturity; it could be inferred that enduring life experiences of motherhood and home delivery have encouraged resilience, and the women have gradually developed some form of agency over the years (Alderson, & Yoshida, 2016). For example, advocating for their daughters demonstrates that they have enhanced their agency and wanting to make better educational choices for their daughters to stay longer in school. Thus, many of them desire to make better educational choices for their daughters than what their parents made for them.

Researchers have shown that a relationship exists between girls' education and age at marriage (Sabbah-Karkaby, & Stier, 2017). Staying longer in schooling translates to later marriage for girls with possible greater autonomy and economic power. Studies have also shown that northern states in Nigeria are undergoing some changes in support of girls 'education; however, there remains difficulty retaining the girls in school to prevent CEFM due to the socio-cultural acceptance of the practice (Walker, 2019). Similarly, previous research has shown that a high education level is protective against CEFM (Malhotra, Warner, McGonagle, & Lee-Rife, 2019) and is associated with a woman's high utilization of health services during pregnancy and childbirth (Undelikwo et al., 2019). The findings of this study add to the literature as they provide evidence that, given the opportunity, former child brides are willing to advocate for their daughters' education attainment.

International agencies such as UNICEF and the Department of International Development (DFID) have partnered with the federal government of Nigeria and have

been working on Girl' education project (GEP) from 2005 to 2019, especially in Northern Nigeria where CEFM is endemic (Agusiobo, 2018). This initiative is making efforts to promote and integrate secular and religious education in Qur'anic schools and has recorded success with increase enrolment in the GEP focus schools (Agusiobo, 2018; Federal Ministry of Education, 2020; Solomon, 2015). It is then imperative that all advocacy constituencies continue educating and mobilizing parents to create an enabling environment for establishing girl child formal education in this ethnic group. Investing more in formal rather than Arabic schooling for their daughters is more protective of all social constructs that put girls at risk of CEFM and subsequently address gender issues in a larger context.

Strengths & Limitations

A major strength of this study was having the support and buy-in of key community stakeholders, men, and female leaders to conduct this study, which made it easy for the women to participate freely in the interview with no restriction.

This population is not readily accessible; the men's involvement made it easy for the women to participate freely and openly in the interview with no restriction. The study also has a few limitations. The sample consisted of selected married child brides of a specific ethnic group, and their stories are not necessarily reflective of child brides from other ethnicities.

In addition, the geographical location might impact the applicability of the findings, as these migrant women may not be the same in characteristics as women who remain in the north. The study may also be limited by the fact that participants are being asked to recall past experiences, which might, in retrospect, differ from what exactly occurred. Finally, since the study was retrospective in nature, findings cannot be spread

across generations of women who have been married as child brides in this cohort.

Recommendations

This study highlights how former child brides demonstrated enhanced agency by advocating for the next generation, their daughters. However, socio-cultural norms and religion continue to impact women's rights. Although the results suggest that there has been some shift in views, CEFM still continues within this ethnic group. A sign of change was the fact that the men were willing to have the research conducted. However, the fact that the husbands needed to provide permission in the first place is an example of how entrenched these norms are in this particular ethnic group. Hence, negative parental attitudes towards female education that promote gender inequality and sustain CEFM needs to change. To support former child brides' efforts to advocate for their daughters' education attainment, the socio-cultural conditions constraining women's decision-making autonomy must be addressed. For example, girls' access to higher education should be strengthened to delay child marriage and support equitable gender norms in this ethnic group.

Former child brides expressed wanting a better life for their daughters, that they valued education for girls, which goes against the usual norm. Keeping girls in school has been identified as one of the best ways to delay marriage (Walker, 2019). Therefore, sustained prevention programs should focus on closing the education gap between northern girl-child and their male and female southern counterparts. Programs could include vulnerable women networks consisting of former child brides. Men specifically and the community at large should act as key actors to advocate and increase awareness about the importance of girls' education.

Also, it is vital to engage former child brides in income-generating skills such as

sewing and baking that will strengthen their financial security. As Malhotra et al. (2019) argued, empowering women to increase their self-value and contribution to the family. However, former child brides in this study were not given educational and economic opportunities; they are still subjected to low social status. Therefore, creating economic opportunities for them could help address this issue.

The study further demonstrated how socio-cultural norms and religion have far-reaching effects within an ethnic group to sustain the cultural practice of home birth. Programs to leverage existing structures within the health care system should be used to address this issue. There is a need for government, policymakers, and other stakeholders in the health sector to develop culturally sensitive health interventions tailored to the needs of former child brides as well as addressing the issue of CEFM intersectionally. Finally, our findings indicate the need for follow-up on future research to investigate fathers' interest in female education and when they intend to give out their daughters out in marriage to increase female education over time and increase uptake of formal reproductive health services based on female education.

Conclusion

The past experiences of former child brides are found to be historically grounded and socially constructed by the interactions of predisposing social constructs such as low education, cultural and religious beliefs. Their continued adherence to traditional norms and religion played a significant role in their everyday experiences and use of reproductive health services. While power inequality, cultural and religious beliefs challenge their decision-making autonomy, the women envisioned their daughters to have better education and more opportunities than they did. All other advocate constituencies, locally, nationally, and internationally should encourage former child brides through

ongoing long-term campaigns and ensure every girl child gets formal education, which will open their minds, create opportunities, and give them the power of choice.

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CHAPTER 4

APPLYING THE ANDERSON MODEL: THE ROLE OF INFORMAL AND FORMAL CARE PROVIDERS IN HEALTH-SEEKING BEHAVIOUR OF FORMER CHILD BRIDES IN NIGERIA

Introduction

Child Early Forced Marriage (CEFM) remains a long-standing global human rights issue and is associated with early fertility (Godha et al., 2013), as well as negative physical (Raj, 2018), mental (John et al., 2019), and reproductive outcomes (Rai et al., 2012; Suarez, 2018) for women. In Africa, the rate of CEFM is decreasing; however, the practice remains common in parts of West Africa (Koski, Clark, & Nandi, 2017), with Sub-Saharan Africa reporting the world's highest rates of CEFM (Raj et al., 2019; Wodon et al., 2017). Nigeria's high maternal mortality ratio of 630 per 100,000 live births is primarily related to the lack of adequate maternal health care for child brides, especially for those living in impoverished rural areas (Piane, 2019).

Child brides' young age and low utilization of formal perinatal health care services put them at greater risk of dying during pregnancy and childbirth (Piane, 2019). Although the determinants of these maternal deaths vary, the high maternal mortality rate in Nigeria has been attributed to inadequate use of formal health care services, especially among child-brides (Adedokun et al., 2016; Adewuyi et al., 2018; Fantaye et al., 2019; Izugbara et al., 2016; Sinai et al., 2017; Sonibare 2020, unpublished manuscript). The practice of CEFM in developing countries deserves more attention to help achieve the 2030 Sustainable Developmental Goal Five (SDG5), which speaks specifically to eliminating CEFM by 2030 and improving married adolescent girls' access to reproductive health services. (UN, 2015).

This chapter is based on the findings from the narrative study (see Chapter 3) conducted in Lagos, Nigeria, to explore the marital experiences of former child brides of Hausa-Fulani ethnicity and their health-seeking behavior as adult women. In-depth semi-structured interviews were conducted with 15 Hausa-Fulani women who married before 18 and now live in an urban setting. Following Cladinin and Connelly's (2000) three-dimensional framework with an intersectional feminist lens, three broad themes emerged from the analysis of the former child brides' narratives. The first theme, "Young age at marriage and agency," revealed the former child brides lived experiences transitioning from an obedient girl to a submissive wife. Theme 2, "Role of culture and religion," revealed how cultural norms and religious dogma influenced former child brides' health-seeking behaviors, particularly related to childbirth. The women reported a preference for home birth and acceptance of their ascribed role as wives in a happy marriage. Theme 3, "Education too late for me but not for my daughter," described the future aspirations of former child brides on their daughter's education attainment and how they used their voices to advocate for them.

One of the sub-themes of theme 2 indicated that former child brides preferred home births instead of accessing formal health care at a hospital for childbirth. Home births were often unassisted or with informal care providers, such as other women in the community. Child brides remain a vulnerable group who are more susceptible to adverse physical and reproductive health outcomes, primarily due to their reliance and primary use of informal health care services (Ogbo et al., 2020; Sinai et al., 2017) and experiencing unassisted home births. In terms of health-seeking behaviours, child brides require more support to attain optimal health care and the adoption of formal health care to reduce associated adverse health outcomes. Previous studies on CEFM have paid little

attention to former child brides and factors that facilitate their use of informal health care and discourage formal health care utilization.

In this paper, the Anderson Behavioral Model for Vulnerable Populations is used to assess and discuss factors identified in the narrative study that facilitate or impede the use of formal perinatal health care services by former child brides of Hausa-Fulani ethnicity in Nigeria. The Anderson Behavioral model includes elements relevant to understanding factors that influence the health-seeking behaviors of formal child brides and how to increase former child brides' uptake of formal health care in Nigeria (Babitsch, Gohl, & von Lengerke, 2012). Recommendations to enhance the integration of informal and formal perinatal health services for former child brides will be highlighted.

Background

The provision and utilization of skilled birth attendants have been identified by World Health Organization (WHO) as a critical initiative to decrease the high maternal and mortality rate in Nigeria. Many health programs have been implemented in Nigeria, such as the Midwives Services Scheme (MSS), Integrated Maternal, Newborn and Child Health program (IMNCH) (Izugbara et al., 2016), and the establishment of health facility committees (Oguntunde et al., 2018) to improve women's access to reproductive health care services. In addition, there has been community-based health programs to train community health workers and traditional birth attendants to provide primary health services in rural villages in Nigeria, with special attention to children and mothers (Davies-Adetugbo, & Adebawa, 1997, Prata et al., 2012; Uzondu et al., 2015). One community-led initiative requires every community in Nigeria to have a community health committee headed by the health worker in charge of the formal health facility in the community (Abimbola et al., 2016). Representatives from informal health care

providers and groups in the community, such as youth, women, men, teachers, and religious leaders comprise these community health committees. Abimbola et al. (2016) explain these community health committees are linked to public health facilities to govern and moderate the influence of informal health care providers and improve community members' access to existing formal health care services.

Despite all local and international efforts made to date to increase access to formal health care in Nigeria, the uptake and utilization of existing health care services by child brides remain exceptionally low, leaving them at high risk for pregnancy and childbirth complications. Accessing informal and unskilled healthcare providers are contributory factors to the low uptake of formal health services by former child brides (Sonibare 2020, unpublished manuscript). For example, traditional birth attendants (TBA); traditional healers (Amodu et al., 2017); patent and propriety medicine vendors (PPMVs) (Sieverding, & Beyeler, 2016) influence the low adoption of existing formal health care services of child brides (Adedokun et al., 2016; Amodu et al., 2017; Beyeler et al., 2015). A lack of insufficient support from formal healthcare providers, such as limited counseling about reproductive and sexual health (Olakunde et al., 2019), contributes to the low utilization of health services among child brides.

In healthcare-seeking behaviours, informal care providers are well-known as the first source of care in both rural and urban communities in Africa, Nigeria inclusive (Abimbola et al., 2016; Beyeler et al., 2015). While child brides are reported to delay seeking help from formal health care systems, they are more likely to access informal health care providers such as PPMVs as an alternative source of care (Amodu et al., 2017; Onyeonoro et al., 2016; Sonibare 2020, unpublished manuscript). Patent and propriety medicine vendors (PPMVs) are persons without formal training sanctioned by

the Nigeria Ministry of Health to legally sell over-the-counter medications but not prescription drugs (Beyeler et al., 2015; Sieverding, & Beyeler, 2016). In an attempt to promote the quality of maternal and child health services, the government of Nigeria included PPMV in national health interventions and approved a list of over-the-counter medicines that they can dispense (Beyeler et al., 2015). PPMVs also provide care for minor ailments, offer advice, and give follow-up care, while traditional birth attendants are used as a frontline of care during childbirth.

The primary reasons women in rural settings in developing countries use informal health care providers include proximity, ease of access, extended hospital wait time, flexible payment methods, and familiarity (Brieger et al., 2004; Sieverding, & Beyeler, 2016). Challenges to accessing formal health care services include poor road conditions to health facilities and high frequency of medication shortage (Sieverding, & Beyeler, 2016). According to Abimbola et al. (2016), informal health providers fill a huge gap in health services, particularly in underserved rural communities. They are close to the grassroots as they live within the communities and are trusted members. However, their lack of formal medical training poses a challenge for quality-of-service delivery to people in the community. The Nigerian government has attempted to reduce their demand in communities to ensure women receive safe care for childbirth (Abimbola et al., 2016). For example, community health committees sometimes insist that traditional birth attendants bring their clients to formal health facilities for delivery instead of having a home birth. They also are encouraged to bring the mother and newborn to formal health facilities for postpartum monitoring even when there is no complication**.**

Andersen Health Care Utilization Model

The Behavioral Model of Health Services Use (BM) was first developed in 1968

by the American medical sociologist Ronald Andersen (Andersen, 1968). In the model, Andersen (1968) outlined three components that identify conditions that facilitate or impede health service utilization: predisposing, enabling, and need factors in health service utilization. The original model emphasized individual-level factors; however, it has been broadened over the years to include social structures, demographics, environmental influence, and health outcomes (Bernard, 2011).

The model has been developed into different versions, tested extensively over time, and successfully applied in the study of health care utilization (Babitsch et al., 2012). For example, it has been revised to explore specific vulnerable populations; in children's (Adane et al., 2017) and adolescents' health-seeking behaviour (Berglas et al., 2016); to study women who experienced domestic abuse to determine their use of health services (Bradbury-Jones et al., 2015), and to examine factors in the utilization of maternal health care services among married adolescent girls in Nigeria (Azfredrick, 2016; Rai et al., 2012).

The revised and expanded Behavioral Model for Vulnerable Populations (Gelberg et al., 2000) posits that in addition to the three components described in the earlier version, there are characteristics reflecting problems peculiar to the individual and contextual levels for a vulnerable population, such as the child brides. However, the vulnerable factors are similar to general predisposing, enabling, and need elements. Predisposing factors refer to demographic characteristics and social structures, and health beliefs that make individuals more likely to use health services (Andersen, 1995; Babitsch et al., 2012). Vulnerable predisposing factors put individuals such as child brides in highly vulnerable health risk status (Gelberg et al., 2000; Oldfield, 2019). Vulnerable factors include low education level, no/low income, female, low marriage

age, ethnicity, religion and culture, poor sexual orientation (Bernard, 2011; Oldfield et al., 2019).

Enabling factors are those factors that facilitate an individual's use of health services. Enabling vulnerable domains includes social support, which could be generated from a person's social network, family, autonomy, available health personnel, and facilities (Oldfield et al., 2019). Other factors include the availability and utilization of information and community resources. Community enabling resources include a regular source of care, such as informal care providers, perception of care, user's satisfaction/preference, quality of care.

Need factors are divided into an individual's perceived need for health care (when individuals become aware of their need for health care) such as physical condition, illness, or disease conditions (Azfredrick, 2016), and externally assessed health needs (professional assessment, objective measurement of patients' health and need) (Babitsch et al., 2012). The health outcome component includes a person's perception of their health, which may or may not lead to the utilization of health care services. The domain of need includes evaluated and perceived need concerning illness that is particularly relevant to the vulnerable population. In the case of child brides, health outcomes could consist of adolescent pregnancies, obstetric and pregnancy complications, and sexually transmitted infections. Further, child brides are likely to experience domestic violence and contract a sexually transmitted infection from their spouses, who are usually much older and more sexually active with multiple sexual partners (Mobolaji et al., 2020).

Understanding Factors that Influence Former Child Bride's Health Care Utilization

Figure 3 represents an adaption of the Gelberg-Andersen behavioral model that

includes factors specifically relevant to influence child bride's utilization for health care services.

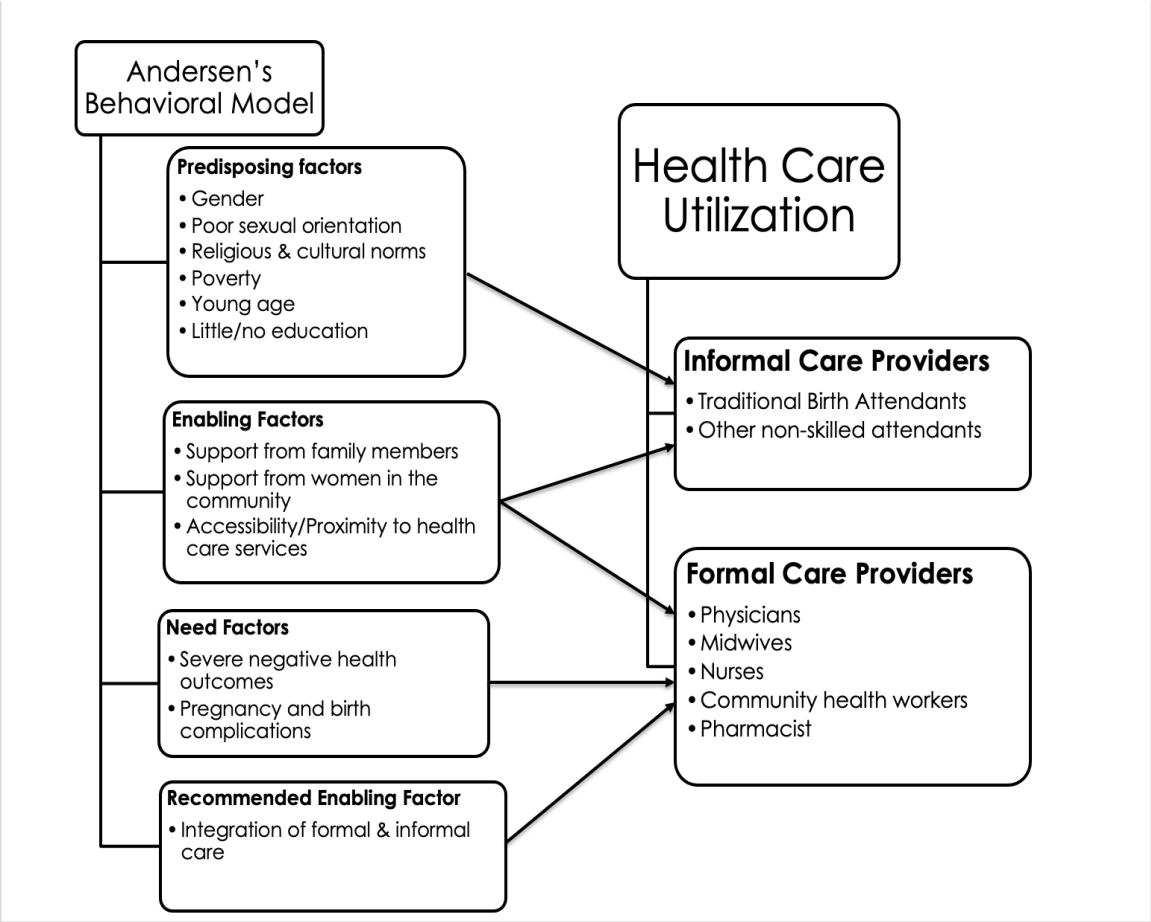

Figure 3. Application of Gelberg-Andersen Model for Vulnerable Population Specialized to Increase Health Care Services Utilization

Predisposing Factors

Analysis of the women's narratives revealed the various factors that predispose young girls to CEFM also interacted to facilitate their use, as child brides, of informal rather than formal health services. Cultural norms, religious beliefs, and low educational levels were shown to be vital influential factors on the health-seeking behaviors of the former child brides. Most of the women had unplanned home birth alone at home without

assistance from traditional or skilled birth attendants, increasing their risks for adverse health outcomes.

Findings from the narrative study indicated that the health-seeking behaviour of former child brides was also determined by the interplay of their distinctive cultural norms and religious beliefs with young age at marriage, poverty, gender, and low educational level. For example, some participants reported delays in seeking formal care when ill because they needed permission and funds from their husbands. One participant, Ayo explained: "…. I could not take the baby for vaccination, even when I was sick, he said I should go to the chemist (PPMV) not the hospital". Another participant Bami narrated her childbearing experience saying: "I just continued with home birth since my husband did not want hospital, and you know as a young girl and wife I could not argue with him. You see, it all depends on what your husband wants." Bami elaborated when asked how well she was prepared and educated as a young girl to give birth at home.

> I did not have any experience, I was young, and you are not supposed to know all these things until you get married. In my place, nobody will teach you how to give birth when you are still not married, even in school.

In their stories, the participants expressed how religiosity was embraced and played a significant role in their choice of health services. A strong faith in God with fervent prayers for safe delivery and birth played a significant role in how the women managed pregnancy and childbirth. One of the participants, Tosin, explained how religious beliefs and strong faith in God differentiated Hausa-Fulani women from their counterparts in other ethnic groups.

> Hausa women have more faith in God; we read more holy book. We put our total trust in God when we are pregnant and want to deliver our babies; that is the difference between us and the other women (35 married at 15 years).

The women explained how religiosity acts as a barrier to their reproductive health-seeking behavior as they prefer to put their faith in prayers rather than going to a hospital because prayers have worked with home birth for older women for many generations. The majority of the women explained that they did not receive antenatal care. Bose, like most of the women, explains, “I didn’t go to any hospital when I was pregnant. I didn’t go for any check-up, I just prayed”. Former child brides reminisced on their childbearing experiences as inexperienced young girls, and they relied on prayers and faith in God to help them with home birth. Additionally, former child brides explained how their young age made them depend on advice from laypeople, such as mother/in-law, senior wife, and older women in the community for support and perinatal care.

Enabling Factors

Support and trust in their mother/in-laws and other women in the community were critical enabling factors for the child brides to seek informal care during pregnancy, childbirth, and postpartum. Former child brides expressed how their young age and low education made them dependent on others such as their mother-in-law and older women in the community for pregnancy information. One participant, Bose, described connecting with other women in her community as a pregnant child bride:

> I did not have any reason to go to the hospital. There are always elderly women in the compound you can ask questions. They will even come to you if you don’t go to them; they know when you are pregnant.

Although they were aware of formal health facilities and services located close to them, the former child brides explained that they trust the older women's knowledge because home birth has worked for many generations before them. They explained that once they have given birth at home for the first time, they can continue to deliver on their

own as taught by the older women. They preferred to carry on the practice to deliver their babies at home alone without the need to access formal care providers (nurse, midwife, doctor). For example, Tosin explained how she relied on the knowledge she gained from her first home delivery with her senior wife to aid her subsequent births.

> I gave birth to 14 children in this room; if you ask anybody in this community, they will tell you. I would cut the cord myself and bathe my child, take a shower after putting the baby to sleep before I call on the neighbors. I would have boiled water before the baby comes out. I only had help with the first pregnancy, and I was taught well by my senior wife. I usually don't breakwater, and I don't bleed much, so why go to the hospital? Once I have small abdominal pain, I will know its time, and then once I see small blood, the baby will follow.

When asked if they were aware of any hospital within their proximity, Tosin said: "I know there's a hospital not too far from here, but I still wanted home birth." Although Andersen's model proposes that proximity to health care services should enable health care utilization, this was not the case for our participants.

Interestingly, some participants were teaching and encouraging their daughters to access informal care for future pregnancy and childbirth needs. These former child brides expressed they were also teaching their daughters the traditional practice of home birth because the practice is considered a heritage that needed to be passed down from generation to generation by women. Bami explained,

> All my daughters that are married have been taught how to give birth at home the way I did.

But despite remaining loyal to home birth, former child brides are nevertheless showing some effects of urbanization. Having resided in urban settings for a long time, they have had more exposure to the urbanized community and are changing their perspective on formal health care services. Hence, they are advising the younger female generation in the community/family to pursue formal care during childbirth. For example,

Bola highlighted how she advised her daughters and daughters-in-law when they got pregnant. "I usually tell them to go to the hospital; I told them not to call me; they should only call me when they are in the hospital." When asked why she does not want home birth for the younger women as she had during her time, she said, "Times have changed, even me if I get pregnant now, I won't stay at home. Things have changed, the environment has changed, so many diseases everywhere".

In summary, most of these women expressed wanting to uphold the tradition of home birth but recognizing the need for formal care; they reach a compromise by insisting on teaching home birth practices as well as encouraging hospital delivery for younger women. For example, Ope, who lost 11 children, had this to say when asked if she will advise the next generation to use hospital or home birth. "I will teach my daughter-in-law home birth, but my only living son is educated; he will not allow his wife give birth at home. So, I will advise her to go to the hospital."

Child Brides' Perceived Need for Health Care Utilization

The findings of the narrative study revealed a disconnect between the former child brides' perceived need for reproductive health care and evaluated needs, that is, professional assessment of reproductive health needs. The women considered pregnancy a common natural condition not deemed an illness. The former child brides explained that formal health services are only needed for an illness or if their newborn is sick after birth. They also shared that they did not attend any antenatal visits; they would only visit a nearby hospital to see a doctor when an urgent need arises after giving birth.

Although few of the women reported giving birth in the hospital, most of the participants echoed that; "You go to the hospital only when you are sick, or the child is refusing to come out, but usually the child comes out." Some women, like Buki,

specifically mentioned that there is no need to use skilled birth attendants for home delivery. “Why deliver in hospital or use nurse at home when nothing is wrong with me? I take the children to the hospital only when they are sick, but nothing was wrong with them”. Some of the women who gave birth in the hospital said they subsequently changed to home birth. Bami said she gave birth to only one of her ten children in the hospital.

> While I was in Nigeria, I did not go to any hospital for antenatal. However, I went to join my mum in Ghana when the pregnancy was eight months; it was my mum who now took me to the hospital in Ghana for delivery because I was feeling sick; that first one was the only pregnancy I delivered in the hospital.

Likewise, Tosin, who gave birth to 14 children, elaborated that one particular doctor who knew her to always have unskilled home birth attends to her quickly anytime she goes to the hospital.

> My senior wife helped me with my first child. I always give birth at home. I never attended any antenatal because nothing is wrong with me; I only go to the hospital [hospital close by, 200-300 meters] after I give birth at home and when my children are sick. There is one doctor that likes me; once I get there, he will quickly attend to me because he already knows that I usually give birth at home (IDI: Tosin, 45).

Home delivery is associated with high maternal and child mortality in this group of women and was seen in these women’s narratives. Ope experienced the loss of eleven children, many of whom she said died shortly after birth.

> A total of eleven of my children died. Most of them died when they were really young, some of them died shortly after birth. My only living son is my twelfth child.

Likewise, Tosin said she lost 5 out of her 14 children.

Discussion

The former child brides’ stories revealed formal health care services were being

under-utilized, including educational and preventive health care, as it relates to reproductive care in an urban setting. In line with Anderson's model (2000), the results of the narrative study showed that former child brides' health-seeking behaviour was shaped by the combination of predisposing, enabling, and perceived needs factors. In particular, our findings revealed that predisposing factors (gender, culture, religion, lack of education, poverty) and enabling factors (family members, women in the community, proximity to health care providers) influenced former child brides to seek care from informal providers during their childbearing years.

Generally, Hausa-Fulani girls lack sexual health education and access to reproductive health services because they are expected to be married before the onset of menarche and be safely guarded in sexual and reproductive health in their husband's home (James, 2013; Suarez, 2018). Due to the immaturity that comes with the young age of child brides, they naturally turn to mother figures such as their mother-in-law or older women in the community for support and counsel during pregnancy rather than formal health care providers. Girls/women are perceived as fragile and are expected to be under the protection and guidance of a male figure; (Goodhue, 2012), their father as girls, and their husband as child brides/women (Goodhue, 2012; Piane, 2019).

Therefore, as adult women, their spouse is in charge of all decisions, including their health care decisions, which impacts their health-seeking behavior and leads to delay in seeking quality care. They are culturally expected to ask for permission from their spouses regarding accessing health care (Fagbamigbe, & Idemudia, 2017). Consequently, the majority of former child brides end up as non-users of formal reproductive health services (Yurdakul, 2018).

The social support (enabling factor) former child brides receive from immediate

family members, older women, and laypersons in their community impedes them from seeking existing formal health care services but increases access to alternative sources of help, such as the use of traditional birth attendants (TBAs) and other non-skilled providers. The former child brides of Hausa-Fulani ethnicity in Nigeria are known to have retained faith and preference in self-treatment, traditional interventions, and alternative medicine rather than seeking out orthodox/western health care. (Amodu, Salami, & Richter, 2017). They considered the care formal health providers offered as only curative, negating the provision of primary prevention. The child brides utilized alternate sources of health care prescribed by their social support networks.

However, our findings also revealed that former child brides are enabling the younger generation of women currently in their childbearing years to accept formal health care services. Their change in perspective is a result of their increased exposure in an urbanized setting. The women migrated from the north with their internalized culture of home birth and low-level education for females. During their childbearing years, young age and lack of exposure resulted in their following the ideals of their culture, which is home birth. However, after years of exposure to diverse culture and southern educated women in urbanized communities, former child brides are trying to ensure their daughters are educated enough to thrive in an urban setting. Nevertheless, most of these former child brides are reluctant to lose the traditional practice of home birth procedures; hence, they achieve a compromise by insisting on training their daughters/daughters-in-law on home birth practices while recommending hospital delivery if needed.

Furthermore, findings from the narrative study were contrary to previous literature indicating that distance to a health facility acts as a barrier to the use of health care services among child brides (Amid, Salami, & Richter, 2017; Awoyemi, Obayelu,

& Opaluwa, 2011). Andersen's model proposed that proximity to health care services (an enabling factor) should encourage healthcare utilization. Yet, our findings demonstrated that although both formal and informal health care providers were within reach, only proximity to informal care enabled utilization. In short, proximity to formal health care providers did not influence health care utilization by the former child brides. Having formal health services within close proximity did not motivate the former child brides to use these services.

Evidence suggests that the utilization of reproductive health services is higher among women living in an urban setting compared to those in a rural setting (Fagbamigbe, & Idemudia, 2017, Maharjan et al., 2019). Existing literature also indicates that health-seeking behavior during childbirth is influenced by geographical location (Gellis, 1991) and the access to quality health care services in the urban compared to rural setting (Onyeonoro et al., 2016). However, our study's former child brides' use of formal health services was not influenced by living in an urban setting.

Generally, child brides are known to delay the utilization of formal health care services (Abubakar et al., 2017; Otu, 2018), only opting for help from skilled health providers, such as community health workers, midwives, pharmacist, and physician, as a last resort. Andersen's model suggests that the child brides' perceived need factors (such as birth complications and adverse health outcomes) would encourage them to seek formal care services. The former child brides only considered going to the hospital when they experienced childbirth complications, such as prolonged labor, poor health of the infant or mother, or loss of faith in the help provided by older women. We found that former child brides sought out formal care providers when they perceived that either themselves or their child was at risk of severe health complications. However, our

findings also indicated that among the former child brides, perceived need was becoming similar to evaluated need as they were advising younger wives to opt for hospital delivery.

According to the behavioral model for vulnerable populations, the value/worth of each component of the model depends on the degree of autonomy/discretion that an individual may exercise (Andersen, 1968; Gelberg et al., 2000). In other words, the degree of autonomy that a person has will determine the interplay of all components (Gelberg et al., 2000). Former child brides described their lack of autonomy as their inability to make health decisions as a young bride. According to the Andersen model, with low autonomy, need factors are increased and more important.

However, when autonomy is high, the predisposing and enabling factors are high and will be in use. With intermediate discretion, all three factors are expected to contribute to the use of health care services. In this context, child brides' autonomy is often low due to overlapping factors contributing to their vulnerability: being young, often poor, and undereducated (Parsons, Edmeades, Kes, Petroni, Sexton, & Wodon, 2015). In other words, discretion/autonomy for the child brides would mean their willingness to use formal health services, which is typically low as a result of their young age at marriage (predisposing) and reliance on others (enabling) to make health decisions for them. Therefore, their willingness to use formal health services is typically low compared to informal health care services utilization.

Findings from a study by Azfredrick (2016) revealed that age, as a predisposing factor, affects adolescents' health-seeking behavior in Nigeria. Although the adolescents in the study Azfredrick (2016) were not married, the findings indicate that their young age prevented them from utilizing reproductive health centers. Likewise, child brides as

young, uneducated girls/women need to be motivated to adopt reproductive health services to minimize their reliance on informal health care. The issue of reliance on informal providers needs to be addressed with educational intervention.

Former child brides need to be better informed on the importance of reproductive health services such as antenatal and post-natal care and family planning. However, education alone might not be able to change the practice of home birth among this population. Since having a home birth is the predominant approach for Hausa-Fulani women, the women should be encouraged to have skilled birth, allowing them to exercise their cultural inheritance without putting themselves and/or their infants at risk. Therefore, additional strategies, such as strengthening the existing relationship between informal and formal providers as an enabling factor for the population, are proposed. Increasing the collaboration between informal and formal providers will help improve their use of formal health services, which, in turn, will enhance the health and well-being of former child brides.

Integrating Informal and Formal Care as an Enabling Factor

Professional health care providers embrace and commit to their continual professional mandate in offering support and health care to child brides with the aim of the latter receiving optimal health. The negative health outcomes of child marriage can be reduced by strengthening the integration of both formal and informal health care providers' support as an enabling factor for the child brides, resulting in a positive impact and enhanced quality of life (Levine et al., 2015). Increased collaboration between the two types of providers will help to reduce pregnancy-related complications for the child brides and consequent reduction in maternal morbidity and mortality in Nigeria.

For the perceived health need component, the results show that experiencing

pregnancy/birth complications or an illness was a key influencing factor for the use of formal health services among the child brides. In addition, when informal health providers are no longer considered helpful, child brides also began to seek care from the formal health care services in their communities. The former child brides perceived the formal health care providers as only providing services that address their acute care needs, dismissing their preventive care services.

In a literature review, Baker (2007) defined social support as a range of interpersonal relationships or connections that impact the individual's functioning and includes support provided by individuals or social institutions. Baker (2007) offers more context in which to understand the benefits of integrating formal and informal health care support in the definition of health-seeking behavior. Further, Baker (2007) revealed how social support from skilled health care providers, such as pharmacists and physicians, increased the use of existing health care services of adolescents in different parts of the world, Nigeria inclusive. Baker (2007), implying that continued collaboration between informal and formal health providers would better meet the needs of, in this case, child brides by providing more effective and efficient health care services together rather than independently.

According to Sieverding and Beyeler (2016), there is evidence of bidirectional referrals being made between informal and formal health care services when patients' health conditions become severe. However, these referrals are often nonspecific and casual in nature (Sieverding et al., 2015). In addition, Sieverding et al. (2015) pointed out that the informational support informal providers receive from formal providers is limited, contributing to the fragmented service provided in the communities they serve. Abimbola et al. (2016) argue that the link between the informal and formal providers

should be more coordinated and better governed than what is presently available in Nigeria.

Formalizing the interaction between formal and informal care providers throughout the health care system by using formal providers as contacts will give informal providers more support, including education and other resources (Sieverding et al., 2015). The support informal providers receive from formal health providers could act as an enabling factor to encourage referrals of child brides to needed health services. Formal, comprehensive integration would reduce referral wait time because the formal health care providers will automatically take over the patient's management (Sieverding et al., 2016). The timely referrals could positively influence and empower the child bride's autonomy in accessing and utilizing health care services in Nigeria.

All healthcare providers should collaborate and complement each other's expertise to ensure a better understanding of their patients' experiences (Osaro & Charles, 2014; Orchard et al., 2017). Formal health providers employed in hospitals located near Hausa-Fulani communities can effectively use existing community healthcare workers programs to ensure contínuos health promotion activities targeting child brides. Since factors such as ease of access, trust, and familiarity encourage child brides to continue accessing informal care, formal care providers should work together and harmonize with informal providers for prompt referral and continuum of care.

For example, the existing community health committees in Nigeria should always use the mothers/in-laws and other elderly women in the community who are the usual point of first contact of child brides as gatekeepers to reach pregnant child brides. For child brides, health-seeking behavior basically included using mothers/in-laws, older women, TBAs, and PPVMs for health information and care. The community health

extension workers (CHEWs) or trained TBAs could work with these mothers/in-laws and community women to identify every pregnant child bride within the community.

In their study with pregnant women in western Nigeria, Ajayi and Akpan (2020) reported that trained CHEWs were used as health rangers to reach all pregnant women in their homes, workplaces, and meeting places such as markets. Their role was to monitor the pregnant women using a customized checklist to determine pregnant women who were at risk and in need of a timely referral to a health facility (Ajayi & Akpan, 2020). Although not mentioned by the former child brides in this study, Olaniran et al. (2019) reported that pregnant women most times delay prenatal care because of the cultural sensitivity of African women and their superstitious beliefs that they can lose their pregnancy to supernatural powers of jealous family members or senior wives. Therefore, pregnant child brides should be identified early by CHEWs. After identifying the pregnant child brides, CHEWs could provide health education that the mother/in-laws cannot provide.

According to Olaniran et al. (2019), CHEWs in Nigeria should be trained to identify pregnancy, provide related health education, screen for health conditions that may require referrals to formal health care services. However, not all CHEWs are trained to give therapeutic care, skilled antenatal, and birth attendants (Olaniran et al., 2019). Therefore, CHEWs need to expand their roles, especially during emergencies or if referrals are not feasible (Olaniran et al., 2019). Also, some CHEWs in Nigeria believe working alongside skilled birth attendants like midwives/nurses during delivery would be a sign of incompetence (Olaniran et al., 2019), although the World Health Organization recommends that all births should be with a skilled birth attendant (WHO, 2008; 2016).

In developed countries, the experience of home birth is comparable to that of

hospital-based births because it is well regulated with a midwife and strict standards of practice (Ashimi, & Amole, 2015). For example, this is equivalent to using a doula in countries like Canada, where skilled home birth is enforced. Doulas are trained to offer continuous emotional, non-medical maternal support during labor and home birth process with evidence to improve poor birth outcomes (Kozhimannil et al., 2016; Ashimi & Amole, 2015). Even in a developing country like Ghana, one of our participants explained that she had to visit a hospital during delivery when she was in Ghana but continued with an unskilled home birth in Nigeria. In Ghana, home births are safer because they are planned with skilled birth attendants (Adatara et al., 2020), while in Nigeria, many child brides continue to experience unskilled home births.

Further, as much as the predominant role and presence of PPMVs as informal providers have been identified in both rural and urban settings in Nigeria (Onyeonoro et al., 2016), their substandard care is also blamed on the weak regulatory enforcement (Sieverding et al., 2015). Therefore, the Pharmacist Council of Nigeria (PCN), the body in charge of regulating pharmacy practice in Nigeria, should enforce training, certifications, and accreditations of PPMVs in the country (Offu et al., 2015).

PPMVs have the potential to bridge the gap with a good referral network to ensure their clients are connected with primary, secondary, or tertiary institutions for continual and appropriate care for other health care providers to continue management. As already suggested in other studies (Onyeonoro et al., 2016), PPMVs can be trained on screening for blood pressure and glucose mentoring on identified child brides that visit them with timely referral to formal providers. PPMVs should be trained to document clients' profiles to help identify vulnerable populations (such as child brides) requiring urgent referrals to formal providers for continual care.

Hengelaar et al. (2018) described how utilization of formal care providers in the Netherlands was increased to provide care within communities. In the Netherlands, both formal and informal providers work together to create a care network that ensures support plans for patients (Hengelaar et al., 2018). Formal care providers see the collaboration as a partnership and a way of empowering informal providers with medical knowledge to handle minor cases and refer the complex cases (Hengelaar et al., 2018). A collaboration and seamless referral of child brides to formal health services by informal providers will encourage more involvement of formal health care providers and leverage the limited scope of practice of informal health care providers, thus, making possible the three components (predisposing, enabling, and need) of Andersen contribute to the timely utilization of existing health care services by child brides. Also, the comprehensive integration of both health services will prevent the fragmentation of care and foster continuity of care that is both culturally competent and conventional (Sieverding, & Beyeler, 2016).

Target Interventions

There is a need for target intervention that will promote the integration of services at various levels of care to enhance cooperation and communication between informal and formal health care providers. For prompt continuum of care, former child brides will benefit from a stronger collaboration between formal and informal care providers during antenatal, intrapartum, and postpartum periods, as well as family planning (Robb et al., 2013). Nevertheless, such efforts should not focus solely on the negative aspects of homebirth but should also communicate the benefits of skilled home birth to the target population and the entire community.

Education, Awareness, and Training

There is evidence that an individual's level of education determines their decision to access health services (Adedokun, & Uthman, 2019; Whitehead et al., 1997). Measures to increase health utilization could start at the individual and community levels with health education, advocacy, and mass education (Tayo, 2009), both in rural and urban settings. Health care providers should continue to work directly with communities to educate families, including single girls and child brides, about sexual and reproductive health in their native language to help increase their knowledge about women's health and rights (Leatt, Pink, & Guerriere, 2000; Walker, 2019). Strategies could include referring child brides to community resources such as adult learning centers, apprenticeship programs, and family health informational sessions. Also, CHEWs should engage directly with gatekeepers such as partners and in-laws, who are the main drivers of CEFM and health-seeking behaviors among child brides.

Additionally, community healthcare workers need to inform cultural and religious leaders and increase awareness about the benefits of integrating formal and informal healthcare services. Traditional and religious rulers have played a significant role in the past in public health interventions in Nigeria, including the fight against HIV/AIDS, female genital mutilation, and family planning improvement (Walker, 2015). Since members of the community trust and respect the ideals of traditional leaders, these leaders can introduce the benefits associated with integrating formal and informal providers to child brides and family members in the community.

Accessibility of informal health care is an effective health resource for child brides (Offu, Anetoh, Okonta, & Ekwunife, 2015). Thus, community engagement and awareness of the importance of having a skilled attendant during a home birth, especially for child brides who themselves are still children, is highly recommended (Desmennu et

al., 2018). Child brides would benefit from health education and accessibility to formal health care services, especially when their families and other community members better understand the benefits of the collaboration between informal and formal care providers. Continuous training and supervision of informal health providers ensure prompt referrals of patients to appropriate health institutions (Sieverding et al., 2015).

The role of all health care providers is to act in a manner that assists in enabling, mediating, and advocating for effective health services and adequate resources for child brides. Formal health providers must intervene in an effort to promote immediate and long-term health by providing health information, educating the community, and enhancing the people s' life skills ("The Ottawa Charter for Health Promotion," 2016). Both formal and informal health care providers need to collaborate and support the child brides by assisting them in developing their personal skills and self-awareness as well as helping them reflect on themselves and their health needs.

According to Ndukwe (2015), comprehensive, integrated health services include preventive and treatment care, collaboratively given by the healthcare providers with whom child brides interact when referred. Many developing countries are advancing towards an integrated health care system (Leatt et al., 2000), but currently, the Nigerian health care system has numerous barriers in providing comprehensive, integrated care (Welcome, 2011). Nigeria's primary health care plan, which was launched in 1978, needs to be amended to accommodate more skilled health care providers and propose a collaboration with informal care providers that provide essential services (Welcome, 2011).

Conclusion

Anderson Behavioral Model for Vulnerable Populations was used to understand

the interplay of factors contributing to inadequate utilization of formal healthcare services by former child brides in Nigeria. Findings from our narrative study indicated that child brides tend to avoid the use of formal health services even when these services were accessible. They seek out traditional, cultural, and religious-based practices that put them more at risk of adverse health outcomes. Creating a stronger collaboration between informal and formal healthcare providers would build trust between the child brides and those who work in hospitals, ultimately increasing child brides' awareness of the preventive services offered and decreasing the high maternal and newborn mortality rates in Nigeria.

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CHAPTER 5

DISCUSSION, CONCLUSION, AND IMPLICATIONS

This final chapter provides the overall conclusion of this study and offers implications for nursing practice and further research. The study used a narrative inquiry approach framed within a feminist intersectionality lens to further analyze structural, social, cultural, and political realities that co-construct former child brides in Nigeria storied experiences of managing their health and use of health services. A purposeful sample of 15 northern Nigerian women of Hausa-Fulani ethnicity, who were former child brides and residing in an urban setting, participated in audio-recorded semi-structured interviews. Data analysis was guided by the three-dimensional space (place, sociality, temporality) approach described by Cladinin and Connelly (2000).

The women's stories revealed three themes and sub-themes that described various factors that interacted to sustain the practice of CEFM in Nigeria. The study's results explain former child brides' experiences of marriage and health-seeking behavior in the context of extreme poverty, religion, culture, and patriarchy, which all interact to promotes gender inequalities. Findings indicated that the practice of CEFM is more than the interaction of the social constructs but is primarily associated with societal norms that support patriarchy and hegemony where men are still considered to have authority over women.

The qualitative systematic review of the literature on CFEM in African countries revealed a strong adherence to African traditions and customs with the endorsement of harmful cultural practices such as early forced marriages. The findings also displayed the presence of a patriarchal society that legitimizes social norms that assigns gender roles favoring male children and perpetuates gender inequality (Undelikwo et al., 2019). The

review's findings also revealed former child brides' marital experiences are shaped by factors that predispose them to CEFM, such as poverty, religion and cultural practices, education, patriarchy, and gender.

These factors influence parents' decisions to continue with the traditional cultural practice of CEFM in Nigeria and other African countries. Consequently, the practice has largely become normalized and sustained in some ethnic groups, such as Hausa-Fulani, in Nigeria. Although the high pervasiveness of CEFM is basically determined by different, though often similar domestic patriarchal cultures and traditions in African countries, the consequences are universal. For example, the findings from the narrative study and systematic review identified common consequential factors related to CEFM, such as health complications and various violations of women's rights.

Findings from both the systematic review and the narrative study revealed that CEFM is a cultural practice shaped by patriarchal principles and accepted as a social norm and is an infringement of the human rights of African women beginning in childhood. Their past experiences being married as a young girl shaped their present marital experience and is informing their future (Ketema & Erulkar, 2018; Undelikwo et al., 2019). Similarly, our findings revealed how gender inequality is maintained in Nigeria through patriarchal imposition and gender conformity of traditional cultural practices such as CEFM. Nigeria, like other Africa countries, is a highly patriarchal society where men, as authority figures, make all the household decisions with limited autonomy for the women.

The three main themes revealed in the women's stories describe the former child bride's life experiences over three timeframes: past, present, future (former child brides' reminiscence over the different stages of their transitioning; from being an obedient girl

forced into marriage without consent; to a child-wife who had to depend on others for health-seeking behaviour into becoming a mother). Former child brides described their early marital experiences as sad, but they gradually transitioned into adult women who are now experiencing an enjoyable marriage within the context of power relations. CEFM was shown to be a direct discrimination against the girl child in Nigeria; they are denied fundamental rights to agency, education, health, autonomy, and equality. The gender inequality and power imbalance begin at birth (Undelikwo et al., 2019) and continue through the woman's life. Women are perceived as objects and property owned by men and passed from the authority of one male, a father, to the authority of another male, a husband.

The participants 'narratives provide more insights regarding traditional gender roles in the Hausa-Fulani ethnic group. Gender roles were clearly defined and enforced from birth until girls were married as child brides. Most of the former child brides made sense of their world by accepting their role is to be a wife, mother, and home keeper. Consequently, because these women had a low level of education, they experienced low socio-economic status. Through the narrative of former child brides, their low socio-economic status interacted with the cultural/societal norm of gender roles, resulting in pronounced hierarchical decision-making in their homes.

Interestingly, this was a unique finding in that the women complied and accepted their ascribed gender roles, which informed their transition from child brides to child wives and adult women. The women negotiated their transitioning as a child bride from their past experience as a sad young bride to presently having an enjoyable marriage. Thus, in comparison to young child brides, former child brides did not present as victims but rather as of CEFM who complied with gender roles to navigate their past sad

experiences evidenced by their expression of having an enjoyable marriage. Although women are mandated by culture, religious beliefs, and social expectations, including traditional obligations to be obedient to men and to remain submissive (Aluko, 2015), former child brides reported that they leveraged this to maintain a good relationship with their partners in transitioning from a child bride to wife, mother, and caretaker of the home.

Following their experiences and interacting with their educated counterparts in urban settings, the former child brides were noted to be having conflicting ideas and desires. For example, their passion for their daughters to have an education conflicted with their adherence to cultural norms. The women now living in an urban setting saw the vast difference education made on their counterparts, and they desired that their daughters stay longer in school to prevent them from marrying as child brides.

Although the former child brides displayed courage, resilience, and agency at different points to advocate for their daughter's educational attainment, their ability to advocate for their daughters' education remained constrained. The women have to agree with whatever decision their husband made for their daughters, either to marry early or stay longer in school. Upholding absolute respect for their spouses and adhering to cultural norms, the former child brides suggested education to their daughters on one condition; the girls must remain virgins and not get involved in premarital sex while in school.

Nevertheless, even though the option of staying in school and maintaining one's virginity appears as a way of controlling the girls' sexuality, the women are presenting their request to their husbands in a culturally appealing way to obtain his approval. At the same time, they expressed genuine concern about their daughters' sexual activities while

in school. Although these women know they do not have the will to challenge their husbands' authority, they refuse to be passive in deciding their daughters' future. Their agency style is similar to what is found in anthropological literature as cultural agency (Beals & Wood, 2012; Butcholtz, 2002).

Cultural agency is explained as a means used to not challenge the social norm, but actors work towards a culture change through their actions (Zasha, 2018). The findings reflect that some of the women are becoming bold and resourceful to refuse the gender status quo and are already thinking of ways to influence decisions about their daughters' educational future. For example, suggesting education to their daughters on the condition that they remain virgins while in school, soliciting financial support, and suggesting involving family members to appeal to their spouses are ways former child brides are demonstrating their determination.

Another striking observation on the experiences of childbirth challenge evidence reported in the existing literature. Previous research indicates accessibility leads to higher use of reproductive health services in urban compared to rural settings in Nigeria (Singh et al., 2021) and comparative other African countries (Ekholuenetale et al., 2020). But our findings revealed living in an urban setting does not necessarily increase the uptake of formal health care services by former child brides. This is similar to other studies (Abubakar et al., 2017) that show that former child brides only go to hospitals when home birth fails or when sick from childbirth complications. Former child brides described how their religious beliefs, faith in God, and the system that has worked for generations contribute to their preference for home birth despite proximity to health facilities. Most of the women desired to keep the cultural heritage of home birth by teaching their daughters; however, they are beginning to have a change in perspective

towards the use of formal health care services.

In conclusion, CEFM remains prevalent in Nigeria, with continuing health impacts for young girls and women. The interaction of the contextual factors related to CEFM results in limited space for women in countries such as Nigeria to exercise their human rights and decision-making power. CEFM has a strong link to the cultural and religious beliefs upheld by those of the Hausa-Fulani ethnic group; former child brides continue to view the practice as a societal norm to which they and the next generation must adhere. Strategies are needed to respond to the local context with long-term sustainable efforts at national, regional, and international levels (Mlambo et al., 2019). The results have implications for nursing practice, nursing education, health care services, and health policy in Nigeria.

Implications

Community-Based Strategy

The findings in this study have identified the women in this group as high risk for adverse health outcomes based on their preference for unskilled home birth and poor utilization of formal health care services for their health needs. Actions must be taken to consistently strengthen the women in the community through implementing a capacity-building approach and reorienting their health care services by leveraging existing structures within the health care system. The health care services for this group need to include culturally competent care. For example, measures that will ensure safe homebirth, which is their delivery preference, need to be put in place.

All formal health care providers such as physicians, pharmacists, midwives, and nurses need to gain the trust of former child brides from the Hausa-Fulani ethnic group by strengthening the existing integration between informal and formal care services.

Collaboration between formal and informal care providers could influence the use of formal health care services by child brides. For example, since child brides are comfortable talking to older community women during pregnancy, the older women could be used as the link to reach child brides. The informal care providers, especially the older women in the Hausa-Fulani community, should be trained and together with the CHEWs to identify every pregnant child bride and prepare for skilled birth and prompt referral. Furthermore, the collaboration of formal health and informal care providers combined with national, international programmatic, and legislative efforts to eliminate the practice of CEFM will allow for active lobbying for cultural changes, which have the potential to reduce the health inequity to which these young women are currently subjected.

Evidence shows that home births in developed countries such as Canada are safe and associated with low maternal and infant mortality (Kozhimannil et al., 2016). Home births in Nigeria should be planned similar to what is practiced in other developing and developed countries. Because of the proximity of Hausa Fulani communities to hospitals, there should be a system in place that will allow the women to contact the hospital when in labor to deploy skilled birth attendants. There should be more training and deployment of skilled birth attendants (CHEWs, nurses, midwives) to work with informal care providers in achieving safe, skilled home birth.

The existing community health care workers' program needs to be more active and feasible in the Hausa-Fulani communities. CHEWs should work closely with the community women to identify every pregnant child bride. Further, CHEWs are trained to identify women at risk, and they need to be up to date in their role as health promoters, primary health care providers, community mobilizers, and treatment of common

childhood illness (Glenton, & Javadi, 2013). CHEWs need to go out more into these communities to educate individuals, families, and community members in particular behaviors such as family planning, nutrition during pregnancy, breastfeeding, immunization, as they are knowledgeable and designated for these tasks (Sotunsa et al., 2016; Olaniran et al., 2019).

Implication for Nursing Education

There is a need to increase training education for the informal care providers to provide culturally appropriate health services to pregnant child brides and increase their knowledge of maternal and child health conditions. Informal care providers such as CHEWs should be trained to identify pregnant women and give appropriate health education on family planning, antenatal and post-natal care. Also, nursing students will benefit from the inclusion of culturally competent care in the nursing curriculum to prepare them for taking care of this population. Women demonstrated a preference for home birth despite the proximity to different hospitals due to their cultural and religious beliefs. In this study, healthcare professionals were observed to be aware of women's home birth preference, as evidenced by participants saying that a particular doctor is always eager to attend to her knowing that she delivers at home.

Further, there is a need to integrate clinical skills on how southern student nurses and community health workers should relate with or communicate with northern Hausa-Fulani women living in the south who deliver at home, with appropriate cultural sensitivity. Nigerian nursing education needs to dedicate courses and increase curriculum content on the scope of various culturally competent care. The teaching of cultural competence needs to be taken beyond clinical experiential teaching to more practical strategies such as guest presentations from the Hausa-Fulani communities and visits of

nursing students for community health fairs (Harkess, & Kaddoura, 2016). Health fairs will help nursing students and community health workers to interact and connect with the women to understand how they view their health, particularly pregnancy, childbirth, and postpartum. Also, they will make the women build trust, become more comfortable to relate and accommodate skilled birth attendants during a home birth.

More emphasis should be placed on educating nursing students on managing a wide range of cultural concerns that makes these women unique in order to offer them the best evidence-based interventions during pregnancy and the labor process. For example, as seen in the findings from this study, Hausa women will show no sign of distress when experiencing labor pain because they believe they have to be strong. Nigeria's nursing body should have best practice guidelines and models that nursing educators can draw from with the goal of enhancing cultural competence learnings. Also, to improve cultural competence skills among nursing students, practicing nurses, and community health care workers, there is a need for continuous training to remain in the trend and up to date.

Implications for Future Research

With the suggestion of integrating formal and informal providers, future research is required to determine the impact on the utilization of health care services among these women in urban settings. There is also the need for more studies to investigate and assess the levels and rate of maternal morbidity and mortality among this ethnic group living in urban settings after the intervention. The Hausa-Fulani women in this study showed interest in their daughters' education if they were willing to honor the family by practicing abstinence. However, it is unknown if the girls are willing to stay in school as virgins to honor the family. As such, research is required to explore the daughters' perspective and explore what they really want for themselves. An in-depth

exploration of the Hausa-Fulani mother-daughter relationship regarding CEFM, and education would be valuable to further understand the dynamics of the practice.

It was noticed that the men were accommodating, allowing their wives to participate in this study and be interviewed in their homes. The women also reported that some of the men are encouraging their daughters to delay marriage and stay in school longer. More research is needed to explore the men's perspectives on CEFM and female education. Also, future researchers could conduct longitudinal studies to explore trends of the daughters of the women who were married as child brides received support from their parents to remain in school and not marry as child brides. It will be beneficial for future researchers to follow the trend of CEFM in this urban setting.

Implications for Policy Makers

Findings in the study revealed the father of the girl child determines marriageable age according to religious beliefs and cultural practices in the Hausa-Fulani population. The Child Right Act sets the marriageable age at 18 in Nigeria (Iyabode, 2016), but enforcement of the act is hampered by the religious, cultural, and traditional beliefs of the local rulers in most of the northern states of Nigeria. Presently, marriage laws in northern Nigeria are complicated because it exists alongside customary and religious laws (Adedokun et al., 2016), making sanctions difficult. These laws should be reviewed with civil marriage laws to reflect the standard of marriage and internationally agreed human rights (Ganira et al., 2015). In addition, the existing laws regarding marriageable age in Nigeria should be enforced. The Nigerian government needs to straighten the legislation and criminalize CEFM by adequately setting and enforcing the legal age of marriage, to address the issue of CEFM. This could eventually make a success of all the prevention programs, interventions, and international efforts for the

realizable goal of female education and ending the cultural practice.

Iyabode (2016) points out how England tackled the practice of child marriage by making consent an essential factor of marriage and introducing pre-marriage preventive factors to protect children who were threatened with forced marriage. One is the Emergency Protection Order (EPO) that could protect the girl child even if the parents are the threats, by neutralizing parental consent for marriage. In addition, there is a prohibited step order that can be obtained from local authorities to prevent the girl from being taken out of the country to be entered into a forced marriage. In England, there is also a post-marriage annulment if either of the party did not validly consent.

Walker (2015) advocated for legal support for married girls and economic empowerment programs to support child brides.
. The author suggested that child rights and social protection policies that are already in place should be enforced and translated into action to produce tangible results.
Iyabode (2016) highlighted how Egypt, an Islamic country like Nigeria, has been able to reform child marriage through religion using the Child Marriage Restraint Act of 1929 through Islamic law to prohibit underage marriage. Currently, Egypt has no record of child marriage (Iyabode, 2016; Koski et al., 2017).

Religious leaders in Nigeria should be continually engaged in policy development because they can play a significant role in curbing child marriage. They are leaders who operate between the people at the community level and policymakers in the government and whose opinion the people value and trust. While conducting a pilot project engaging religious leaders in northern Nigeria, Walker (2015) showed that traditional community rulers had played a major role in public health interventions in the past in Africa; in such efforts as the fight against HIV/AIDS, female genital mutilation, and family planning

improvement. Government leaders should come together and implement poverty alleviation programs that will be effective in addressing the practice of CEFM. With poverty alleviation, families will feel less pressured to marry their daughters early to reduce financial burdens.

Education remains one of the best platforms to reduce the cultural practice of CEFM among girls in this ethnic group. The benefits of education on the girl child, family, and society as a whole have long been recognized (Walker, 2012). Currently, there are many ongoing projects concerning CEFM and female education in Nigeria, especially in the northern part of the country (Walker, 2019). For example, the development Research and Projects Centre (dRPC), a Nigerian nonprofit organization, has two projects, the Conjugal Slavery in War (CSiW) and Partnership for Innovation and Practice in Secondary Education (PSIPSE) project (Phase 1, 2013-2015, and Phase 2, 2015-2019). The projects are skills acquisition programs that were integrated into dRPC existing interventions to help keep girls in secondary schools.

According to Walker (2019), both projects were not very successful because the girls still view marriage as their destiny. In secondary school educational projects, it was observed that girls were dropping out of government schools before completion of secondary school to marry or are forced to marry immediately after completion. At this point, consistent early marriage prevention programs that can give the girls targeted support with parental engagement (McClendon et al., 2018) are required to boost the girls' freedom of will. Similarly, prevention programs with integrated family planning support in the context of school to support the girls to stay longer in school before marriage or post marriage are required (McClendon et al., 2018). Post-marriage education should also be encouraged among this population.

Parents can change their views and allow their daughters to stay in school to prevent child marriage. Some of the former child brides reported that their spouses were already showing an interest in girl education. This interest in female education denotes that though this group of African men may embody patriarchy, it does not mean that they are not caring or capable of changing harmful cultural practices. This finding shows that concerted efforts can work in ameliorating the negative consequences of CEFM in this ethnic group.

The men in the Hausa-Fulani community need to be engaged to understand the importance of female education. For example, educational interventions should target families in these communities by using media campaigns to continue to increase the awareness of the importance of female education and gender equality. The community as a whole need to be educated on gender inequality and how to perceive and treat a girl child. The fight against gender inequality should start at the family level; how children are raised and socialized can be altered. Also, economic incentives can be provided to parents in these communities to encourage and promote female education.

For women who were married as child brides and can no longer benefit from formal education, feminists and women activists should ensure they are trained in different vocational skills to offer them a pathway to empowerment, agency, and poverty alleviation (Walker, 2019). This vulnerable group may not be aware of their rights because they always view the practice as a social norm and marriage as a way out. Women right activists need to ensure that girls' rights are not traded for early marriage and endeavor to restore strategic gender needs that girls have been denied in place of gender roles imposed on them by the patriarchal society as new brides with the responsibilities of caring for husband, children, and household. Such strategic gender

needs should include serving as a source of information and enlightening the girls to gain increased understanding and insight regarding their human and reproductive rights as well as facilitating their self-determination/identity.

With appropriate support, former child brides can be in an excellent position to engage and advocate for their daughters. Investing heavily in formal and informal education could help to promote more equitable gender relations. Former child brides should be trained in income-generating skills such as sewing and baking. The skills can be developed through organized training, initial setup funding, and provision of networking platforms among former child brides. Long-term investment in female formal and informal education will help to improve women's income and their level of autonomy in their families and communities.

Curbing of CEFM should be a shared responsibility that relies on the cooperation and communication between health care providers, all levels of government, and Non-Governmental Organizations (NGOs). Individuals, such as social advocates and women rights activists such as Iyabode (2016) and Walker (2019), should continue to address the practice of CEFM as gender inequality in the country, especially in prevalent regions. Consistently raising awareness about gender equality and working with NGOs, private and government organizations to curb this patriarchal cultural practice is highly recommended. Women's rights activists should continue to work with NGOs to campaign consistently and aggressively raise awareness about early marriage's harmful effects on women's well-being.

Walker (2019) explained that most interventions to curb CEFM are not very effective because there is no law enforcement; feminists/women activists need to call for stricter laws and law enforcement. Women groups and scholars need to be more vocal

and should continue to address and promote the rights of girls while they challenge parental control over girls' sexuality. They should continue to use every available human rights instrument and civil law to ensure that the existing law, such as Child Right Act (CRA), is implemented in all states and force the hands of the government to criminalize the practice of CEFM in the country.

Conclusion

This dissertation has attempted to focus on and facilitate understanding of childhood marriage as experienced by Nigerian women of northern descent in southern Nigeria, including factors that influence their health-seeking behaviors. Although CEFM is still being sustained as patriarchy and control over women's sexuality and reproductive rights, former child brides should be presented as survivors and not as victims. It can be concluded that exposure to urbanized settings in the south has impacted both Hausa Fulani men and women and is gradually influencing their perspectives on social issues like education and health care usage. In addition, the women still want to hold on to their strong cultural values such as chastity before marriage and home birth. Former child bride's attitude is beginning to change about female education in Nigeria. They desire educational attainment for their daughters before getting married but also demand that the girls keep their virginity until marriage.

Further, cultural norms are still strong influencers of former child brides' health-seeking behavior perpetuating health risks. These risks can be reduced by policies that promote homebirth under supervision. The women are willing to become advocates for their daughters, but they need support from policymakers, health care practitioners, and their spouses. There is an element of hope for continued change and enhanced health and well-being for young girls in Nigeria at risk for CEFM.

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Appendix A

Qualitative Systematic Review Inclusion and Exclusion Criteria Using PICo

PICo Elements*	**Inclusion Criteria**	**Exclusion Criteria**
Population	• Articles that include the experiences of child brides who were married before age 18 years in CEFM (child early forced marriage) in Africa • Studies that explored firsthand perspective of child brides' experiences in Africa who might or no longer be in the marriage • Articles that focus on women who were married as child brides and are still married • Articles that focus on women who were married as child brides and are no longer be in marriage • Studies that explore the experiences of child brides in developing countries	• Studies of African women or girls who experience CEFM but are not living in Africa. • Studies that explore CEFM experiences but not from the child brides' perspectives were excluded. • Studies that explore experiences of youth that got pregnant or explored the experiences of transition to adulthood and not explicitly child bride experiences • Studies that explore experiences on early marriage and not experiences of child brides • Quantitative studies. • Articles that explore experiences of non-African child brides. • Non- English publications due to lack of available resources for the translation of non-English papers.
Phenomenon of Interest	• Studies that explore experiences of child brides with a clear description of each participant's view • Studies that examine the needs, perceptions, and attitudes of African child brides • Studies that explore the experiences of child brides' transition to child wives	• Studies that do not explore African child brides' experiences

Context	• Studies that explore experiences of women that were married before they turned 18 years in Africa • Articles that discuss the child's rights in relation to CEFM practice	• Studies that explore experiences of women that were married before they turned 18 years in other developing countries • Articles that discuss the child's right outside CEFM and in a non-African context

*PICo elements coined from Curtin University Library (2018)

Appendix B

Search strategy and Results

Databases/ sources	Search terms	Number of articles
1. Cochrane Database of Systematic Reviews (CDSR)	"child bride*" OR "child marriage" OR "early marriage" OR "forced child marriage" OR "girl bride*" OR "girl marriage" OR "adolescent* childbearing" OR "teen* marriage" OR "arranged marriage" "young adult marriage" AND Nigeria OR Africa* O "sub-Saharan "AND feminist* OR "women* rights" OR "women* health" OR "human rights" OR "child* rights"	0
2. CINAHL	As above	51
3. PubMed	As above	840
4. Scopus	As above	490
5. ProQuest- Dissertations and Theses, Global	As above	103
6. Web of Science-MEDLINE	As above	95
7. Gender studies	As above	97
8. Manual search	As above	4
9. Total		1680
10. Duplicates removed	31	

11. Records after duplicates	1649	
12. Paper excluded	1541	
13. Full-text paper reviewed	108	
14. Full-text paper excluded with reasons	89	
15. Papers included	19	

Appendix C

Quality Appraisal Tool for Included Studies

CASP Qualitative criteria	**Yes**	**Can't Tell**	**No**	**Comments**
Section A: Are the results valid? 1. Was there a clear statement of the aims of the research?				
2. Is a qualitative methodology appropriate?				
Is it worth continuing? 3. Was the research design appropriate to address the aims of research?				
4. Was the recruitment strategy appropriate to the aims of the research?				
5. Was the data collected in a way that addressed the research issue?				
6. Has the relationship between the researcher and the participants been adequately considered?				
Section B: What are the results? 7. Have ethical issues been taken into consideration?				
8. Was the data analysis sufficiently rigorous?				
9. Is there a clear statement of findings?				

Section C: Will the results help locally? 10. How valuable is the research?				

Scoring system **Yes: 1 point** **Can't tell: 0.5 points** **No: 0 points**	**High quality paper: 9-10** **Moderate quality paper: 7.5-9** **Low quality paper: < 7.5** **Exclude: <6**

Quality assessment tool coined from CASP (2018)
Scoring tool for qualitative research by Butler, Copnell, and Hall (2016)

Appendix D

Characteristics of Included Studies

Author, year, country, journal	Purpose	Design	Participants	Country of origin of participants	Sampling technique	Data collection	Data analysis	Results
Adedokun, O., Adeyemi, O., & Dauda, C. (2016). Child marriage and maternal health risks among young mothers in Gombi, Adamawa	To examine the maternal health implications of early marriage on young mothers in Adamawa	Mixed methods	200 young mothers aged 15-24 years who married before 16 years old	Nigeria	Stratified sampling technique	Structured Questionnaire, Focus Group Discussion (FGD), and in-depth interview	Textual data analysis	The study established that girls in Gombi locality face significant cultural and social barriers strengthened by religious prescriptions on early marriage. Poverty plays a major role, which makes girls to be seen as economic burdens and given off early in marriage. Education was confirmed to help reduce pregnancy complication

Author, year, country, journal	Purpose	Design	Participants	Country of origin of participants	Sampling technique	Data collection	Data analysis	Results
								Participants described early marriage as problematic. They believe older women will make better wives because they will avoid health challenges

Author, year, country, journal	Purpose	Design	Participants	Country of origin of participants	Sampling technique	Data collection	Data analysis	Results
Callaghan, J. E., Gambo, Y., & Fellin, L. C. (2015). Hearing the silences: Adult Nigerian women's accounts of 'early marriages. *Feminism & Psychology*, *25*(4), 506-527.	To explore young women's lived experiences to early marriage	Exploratory Qualitative design	Six women (ages 25-35).	Nigeria	Convenience	In-depth interviews	Interpretive phenomenological analysis	

Author, year, country, journal	Purpose	Design	Participants	Country of origin of participants	Sampling technique	Data collection	Data analysis	Results
Ketema, H., & Erulkar, A. (2018). Married adolescents and family planning in rural Ethiopia: understanding barriers and opportunities. *African journal of reproductive health*, *22*(4), 26-34.	To explore married girls' knowledge and demand for Family Planning, as well as barriers and support	Qualitative design	16 young women (aged 16-24)	Ethiopia	Purposeful	Interviews	Thematic analysis	Respondents have an interest in the use of family planning. However, low decision-making power and families were barriers to the use of family planning

Author, year, country, journal	Purpose	Design	Participants	Country of origin of participants	Sampling technique	Data collection	Data analysis	Results
McDougal, L., Jackson, E. C., McClendon, K. A., Belayneh, Y., Sinha, A., & Raj, A. (2018). Beyond the statistic: exploring the process of early marriage decision-making using qualitative findings from Ethiopia and India. *BMC women's health*, *18*(1), 144.	To explore how girls and their marital de-cision-mak-ers initiate, negotiate, and finalize decisions on early marriage.	Cross-sectional qualitative study	43 girls in Ethiopia. Girls (aged 14-19)	Ethiopia and India	Convenience	Semi-structured interview	Latent content analysis approach	Early marriage is a process that is sustained by social pressure and cultural marital norms, which was further exacerbated by social inequities

McClendon, K. A., McDougal, L., Ayyaluru, S., Belayneh, Y., Sinha, A., Silverman, J. G., & Raj, A. (2018). Intersections of girl child marriage and family planning beliefs and use-qualitative findings from Ethiopia and India. Culture	To explore family planning use, including barriers, facilitators, and sources of services, among young women and girls, married as minors (younger than 18 years), including those able to cancel or postpone marriage as minors, and their decision-makers	Qualitative study design	39 (23 women and girls, married as minors and 16 women and girls able to cancel or postpone marriage as minors, in Ethiopia).	Ethiopia and India	Purposeful	In-depth interviews	Content analysis approach	Participants had general knowledge of family planning, but several barriers impede the access. Such include social pressure and expectations of childbearing after marriage. However, there was higher educational attainment for those who used family planning.

Author, year, country, journal	Purpose	Design	Participants	Country of origin of participants	Sampling technique	Data collection	Data analysis	Results
John, N. A., Edmeades, J., & Murithi, L. (2019). Child marriage and psychological well-being in Niger and Ethiopia. *BMC public health*, *19*(1), 1029.	To investigate the relationship between child marriage and mental health of child brides	Mixed method	Thirty-six women married aged 18–45 years. 32 in-depth interviews (16 aged 18-24 years and 25-45 years women)4 women in participatory focus groups	Niger and Ethiopia	Two-stage stratified sampling approach	In-depth interviews	Multivariate linear regressions and thematic analysis	Thematic analysis reported Ethiopian child brides reported suffering emotional distress and depression induced by the burden of handling marital responsibilities at an early age.

Author, year, country, journal	Purpose	Design	Participants	Country of origin of participants	Sampling technique	Data collection	Data analysis	Results
Kenny, L., Koshin, Sulaiman, & Cislaghi, (2019). Adolescent-led marriage in Somaliland and Putland: A surprising interaction of agency and social norms. *Journal of adolescence*, *72*, 101-111	To investigate norms and agency as facilitators and obstacles to adolescent girls' marriage in Somaliland and Puntland.	Qualitative design	Participants (n = 156) were men and women living in Somaliland and Puntland.	Somalia and Puntland	Non-probabilistic random route sampling	Focus group and semi-structured interview	Thematic analysis	Agency, social norms, poverty, and availability of and access to technology were found to interact to sustain child marriage.

Author, year, country, journal	Purpose	Design	Participants	Country of origin of participants	Sampling technique	Data collection	Data analysis	Results
Gatwiri, G. J., & McLaren, H. J. (2017). 'Better off Dead'-Sasha's Story of Living with Vaginal Fistula. Journal of International Women's Studies, 18(2), 247-259.	To explore the theoretical foundations of gender inequality,power, and patriarchy using a case study of a woman with vaginal fistula	Qualitative case study using phenomenological and feminist approach	One participant was used out of 30 participants from the larger study	Kenya	convenience	Interpretive feminist analysis	Phenomenological approach	The study revealed that women with fistula find alternative explanations in spirituality for their illness because scientific and medical explanations are confusing to them.

Author, year, country, journal	Purpose	Design	Participants	Country of origin of participants	Sampling technique	Data collection	Data analysis	Results
Efevbera, Y. (2017). Experiences of Early and Forced Marriage in Conakry, Guinea: An Exploratory Study. *Journal of Adolescent Health*, *60*(2), S107	To explore perceptions of the social construct of marriage, and its relationship to health and wellbeing, among ever-married women in Conakry, Guinea.	Grounded theory	Four women who identified as marrying early (aged 32-46)	Conakry, Guiney	Purposive sampling method	Semi-structured interview guides	Open coding using NVivo	Participants shared both negative and positive marital experiences

Author, year, country, journal	Purpose	Design	Participants	Country of origin of participants	Sampling technique	Data collection	Data analysis	Results
Akpan (2003), Early marriage in eastern Nigeria and the health consequences of vesico-vaginal fistulae (VVF) among young mothers.	To examine the challenges posed to early marriage by the Nigerian constitution and human rights law. Also, to focus on the health risk involved in early pregnancies and determine the fate of women affected by vesico-vagina fistula	Qualitative study design	Can't tell	Nigeria	convenience	interview	Can't tell	Human rights laws seeking to protect girl- children from early marriage are in place. But there is a need for implementation and enforcement of existing laws rather than new laws.

Author, year, country, journal	Purpose	Design	Participants	Country of origin of participants	Sampling technique	Data collection	Data analysis	Results
Zhang, L., Iritani, B. J., Luseno, W., Hartman, S., Rusakaniko, S., & Hallfors, D. D. (2016). Marital Age Disparity Among Orphaned Young Women and Their Husbands- A Mixed Methods Study in Rural Zimbabwe.	To compare age-similar (AS) marriages of orphaned young women to age-disparate (AD) marriages, defined as spousal age difference of 5 or more years.	Mixed methods	35 orphans married women (13-23 years)	Zimbabwe	Non-probability sampling	Randomized control trial and semi-structured interview	Thematic analysis	Majority of the young women married men older than them. Older husbands were found to provide better for their families than younger men. AD relationships, even in marriage, expose young women to a higher risk for STD

Author, year, country, journal	Purpose	Design	Participants	Country of origin of participants	Sampling technique	Data collection	Data analysis	Results
Raj, A., Salazar, M., Jackson, E. C., Wyss, N., McClendon, K. A., Khanna, A., ... & McDougal, L. (2019). Students and brides: a qualitative analysis of the relationship between girls' education and early marriage in Ethiopia and India. *BMC public health*, *19*(1), 19.	To assess how girls build resilience in the context of early marriage and education cessation	Qualitative study design	Forty-four girls aged 13-24 years. (21 women and girls married as minors and 23 women and girls able to cancel or postpone marriage as minors, in Ethiopia).	Ethiopia and India (aged 13-24) and up to three marital decision-makers	Purposeful/convenience	Semi-structured interview	Latent content analysis	The study highlighted social norms, traditional gender norms, and structural factors as risk context impending girls' education. Also, self-efficacy and family support were identified as resiliency factors that support girls' education.

Author, year, country, journal	Purpose	Design	Participants	Country of origin of participants	Sampling technique	Data collection	Data analysis	Results
Stark, L. (2018). "Poverty, Consent, and Choice in Early Marriage: Ethnographic Perspectives from Urban Tanzania." Marriage & Family Review **54**(6): 565-581.	To use ethnographic approach to access people's perceptions of their alternatives and to explore two concepts fundamental to notions of "child marriage": consent and agency	Ethnography-Qualitative design	130 women aged 13-70)	Dar es Salaam, Tanzania	Random selection	In-depth interviews	Thematic analysis	Some girls voluntarily got married before 18 years because of poverty, confirming that poverty is the main driver of early marriage.

Author, year, country, journal	Purpose	Design	Participants	Country of origin of participants	Sampling technique	Data collection	Data analysis	Results
Allen, A. A., & Adekola, P. O. (2017). Health implication of child marriage in north-east Nigeria. *Analele Universităţii din Oradea, Seria Geografie, 27*(1), 54-61.	To examine the factors inducing child marriage in the most endemic location in North-Eastern Nigeria and the health implications on victims.	Mixed methods	Eight child wives were interviewed	Nigeria	Simple random sampling	Focus group discussions	Simple percentage and correlation	Poverty and limited educational attainment are the two leading causes of child marriage in the study resulting in different health problems.

Author, year, country, journal	Purpose	Design	Participants	Country of origin of participants	Sampling technique	Data collection	Data analysis	Results
Hamed, S., Ahlberg, B. M., & Trenholm, J. (2017). Powerlessness, normalization, and resistance: A Foucauldian discourse analysis of women's narratives on obstetric fistula in Eastern Sudan. *Qualitative health research, 27*(12), 1828-1841.	To explore the perceptions and experiences of women suffering from obstetric fistula in Kassala to identify discourses that may contribute to its prevalence and on how women's behaviors are shaped.	Qualitative design	Nine women aged 12-16 years living with obstetric fistula	Kassala, Eastern Sudan		Individual interview and participant's observation using semi-structured interviews	Foucauldian discourse analysis	

Author, year, country, journal	Purpose	Design	Participants	Country of origin of participants	Sampling technique	Data collection	Data analysis	Results
Luseno, W. K., Zhang, L., Iritani, B. J., Hartman, S., Rusakaniko, S., & Hallfors, D. D. (2017). Influence of school support on early marriage experiences and health services utilization among young, orphaned women in Zimbabwe. *Health care for women international*, *38*(3), 283-299.	To use mixed-methods approach to examine whether and how school support affects pathways to marriage, experiences with marriage, and use of maternal and child health services among young orphaned women who participated in a randomized controlled trial (RCT) testing	Mixed methods	35 orphans Girls Eight girls married at or below age 15 years 18 girls married 16-17 years Nine girls married at 18 or above 18 years	Manicaland Province, Zimbabwe	Randomised control trial	Semi-structured interview	Thematic analysis	Most participants claimed to have used health care services; however, findings revealed a high number of child deaths, proving a high mortality rate among adolescents. Findings confirmed that school support reduces early marriage, pregnancy, and school dropout among young orphan women.

Author, year, country, journal	Purpose	Design	Participants	Country of origin of participants	Sampling technique	Data collection	Data analysis	Results
	school support as HIV prevention in Zimbabwe.							

Author, year, country, journal	Purpose	Design	Participants	Country of origin of participants	Sampling technique	Data collection	Data analysis	Results
Ganira, L. K., Inda, N. A., Odundo, P. A., Akondo, J. O., & Ngaruiya, B. (2015). Early and Forced Child Marriage on Girls' Education, in Migori County, Kenya: Constraints, Prospects, and Policy. *World Journal of Education*, *5*(4), 72-80	To assess the implication of early marriage on girls' education in Migori County.	Mixed method	30 women married before age 18 years	Kenya	Simple random sampling and purposive technique	Questionnaires and structured interviews	Systematic analysis	It was established that inadequate education attainment influences early marriages. It was recommended that the ministry of health and education should bar early and forced marriage.

Archambault, C. S. (2011). Ethnographic empathy and the social context of rights-"Rescuing" Maasai girls from early marriage. American Anthropologist, 113(4), 632-643	To get the stories of rescued child brides out so they can get sponsors to continue their education. Also, to illustrate how prevailing concepts of "tradition," "culture," "victimhood," and "collective rights" in human rights theory obscure critical structural factors that give rise to early marriage and	Ethnographic qualitative design	Case study of a girl out of 22 girls that were rescued from early marriage and took refuge in a center at Maasai, Kenya	Kenya	Random sampling	Interview	Can't tell	The study revealed how parents in Enkop hold education in high esteem and make a great investment in education. However, many obstacles stand in their way of educating their girl child, which forces them to turn to marriage in securing the girls' future

	deflect attention from effective policy initiatives							

Author, year, country, journal	Purpose	Design	Participants	Country of origin of participants	Sampling technique	Data collection	Data analysis	Results
Belhorma, S. (2016). 'Two months of marriage were sufficient to turn my life upside down'- early marriage as a form of gender-based violence. Gender & Development, 24(2), 219-230.	To gain insights into the attitudes and perceptions of young women themselves regarding the impact of early marriage on their lives.	Qualitative study design	Forty women who had been married before the age of 18 (aged 20-24).	Morocco	Convenience sampling	Focus group	Thematic analysis	Many of the participants declared that they had experienced one form of violence. There is a need for legal literacy and education on women's rights. There is a need for gender-sensitive education and joint work from all and sundry to combat the practice of early marriage.

Appendix E

Detailed Summary of Quality Appraisal of Included Studies from CASP 2018

Author, Year	Clear state-ment of researc h aims	Is qualitati ve method ology appropr iate?	Was the researc h design appropr iate to address the aims of the researc h?	Was the recruit-ment strategy appropr iate to the aims of the researc h?	Was the data collecte d in a wa y that address ed the researc h issue?	Researche r/ participan ts relationsh ip adequatel y considere d?	Ethic al issues consi dered	Was the data analysis sufficientl y rigorous?	Is there a clear state-ment of findings ?	How valuable is this research ?	Scor e
Adedokun, Adeyemi, & Dauda, (2016).	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	Yes	Yes	High	9.5
Allen, & Adekola, (2017).	Yes	Yes	Yes	Yes	Yes	Can't tell	Can't tell	Can't tell	Yes	High	8.5
Akpan, (2003).	Yes	Yes	Can't tell	Yes	Can't tell	Can't tell	No	Can't tell	Yes	Medium	7
Archambault, C. S. (2011).	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell	Can't tell	Yes	high	9
Belhorma, (2016).	Yes	Yes	Can't tell	Yes	Yes	Yes	No	Yes	Can't tell		

Author, Year	Clear state-ment of researc h aims	Is qualitati ve method ology appropr iate?	Was the researc h design appropr iate to address the aims of the researc h?	Was the recruit-ment strategy appropr iate to the aims of the researc h?	Was the data collecte d in a wa y that address ed the researc h issue?	Researche r/ participan ts relationsh ip adequatel y considere d?	Ethic al issues consi dered	Was the data analysis sufficientl y rigorous?	Is there a clear state-ment of findings ?	How valuable is this research ?	Scor e
Callaghan, Gambo, & Fellin, (2015)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	10
Efevbera, (2017).											
Ganira, Inda, Odundo, Akondo, & Ngaruiya, (2015).	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	High	8
Gatwiri, & McLaren, (2017).	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	High	9.5
Hamed, Ahlberg, & Trenholm, (2017).	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	High	10
John, Edmeades, & Murithi, (2019).	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	High	10

Author, Year	Clear state-ment of researc h aims	Is qualitati ve method ology appropr iate?	Was the researc h design appropr iate to address the aims of the researc h?	Was the recruit-ment strategy appropr iate to the aims of the researc h?	Was the data collecte d in a wa y that address ed the researc h issue?	Researche r/ participan ts relationsh ip adequatel y considere d?	Ethic al issues consi dered	Was the data analysis sufficientl y rigorous?	Is there a clear state-ment of findings ?	How valuable is this research ?	Scor e
Kenny, Koshin, Sulaiman, & Cislaghi, (2019).	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	High	10
Ketema, H., & Erulkar, A. (2018).	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	High	9.5
Luseno, Zhang, Iritani, Hartman, Rusakaniko, & Hallfors, (2017).	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	High	10
McClendon, McDougal , Ayyalur, Belayneh, Sinha, Silverman, & Raj, (2018).	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	yes	High	10

Author, Year	Clear state-ment of researc h aims	Is qualitati ve method ology appropr iate?	Was the researc h design appropr iate to address the aims of the researc h?	Was the recruit-ment strategy appropr iate to the aims of the researc h?	Was the data collecte d in a wa y that address ed the researc h issue?	Researche r/ participan ts relationsh ip adequatel y considere d?	Ethic al issues consi dered	Was the data analysis sufficientl y rigorous?	Is there a clear state-ment of findings ?	How valuable is this research ?	Scor e
McDougal, Jackson, McClendon, Belayneh, Sinha, & Raj, (2018).	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	High	10
Menon, Kusanthan, Mwaba, Juanola, Kok, (2018)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	High	10
Nkwemu, Jacobs, Mweemba, Sharma, & Zulu, (2019).	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	High	10

Author, Year	Clear state-ment of researc h aims	Is qualitati ve method ology appropr iate?	Was the researc h design appropr iate to address the aims of the researc h?	Was the recruit-ment strategy appropr iate to the aims of the researc h?	Was the data collecte d in a wa y that address ed the researc h issue?	Researche r/ participan ts relationsh ip adequatel y considere d?	Ethic al issues consi dered	Was the data analysis sufficientl y rigorous?	Is there a clear state-ment of findings ?	How valuable is this research ?	Scor e
Raj, Salazar, Jackson, Wyss, N., McClendon, Khann a, & McDougal, (2019).	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	High	10
Stark, (2018).	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	High	9.5
Zhang, Iritani, Luseno, Hartman, Rusakaniko, & Hallfors , (2016).	Yes	Yes	Yes	Yes	Can't tell	Can't tell	Can't tell	Yes	Yes	Medium	8

Appendix F

Letter of Information and Consent

Study Title: A Feminist Narrative Inquiry into Being a Child Bride in Nigeria: A proposal

"Qualitative Interviews"

Principal Investigator: Dr. Marilyn Evans, RN Ph.D., Associate Professor, Arthur Labatt Family School of Nursing, Faculty of Health Sciences, Western University, London, Ontario

Co-Investigators:

Marilyn Ford-Gilboe, Ph.D., RN, FAAN
Professor and Women's Health Research Chair in Rural Health Associate Director (Research) FNB 2302, Arthur Labatt Family School of Nursing
University of Western Ontario London, Ontario.

Treena Orchard, Ph.D., Associate Professor, 216 Labatt Health Sciences Bldg., School of Health Studies, Western University, London, Ontario.

Dr. Ishola Ajiferuke, Faculty of Information and Media Studies, FIMS & Nursing Building, Room 4025, Western University, London, Ontario

Olubukola Sonibare, RN, PhD-Student, Arthur Labatt Family School of Nursing, Faculty of Health Sciences, Western University, London, Ontario.

Name of Funder:
This research project is funded by the Africa Institute Graduate Student Research Fund

Conflict of Interest:
None to declare.

Letter of Information

1. *Introduction:*

I am Olubukola Sonibare, a Ph.D. student working under the supervision of Dr. Marilyn Evans, an Associate Professor in the Arthur Labatt School of Nursing at the University of Western Ontario in Canada. We invite you to participate in a research study to explore your experiences of being married before the age of 18 years in Nigeria and understand your use of health care services. We plan to interview 10 to 20 women who were child brides but now adult women.

2. *Background:*

Child brides are girls who were married before their 18th birthday. Child Early Forced Marriage (CEFM) has been practiced for a very long time in Nigeria and some other parts of the world. It usually affects more females than males. CEFM eventually results in poor health outcomes for the child bride and her baby.

3. Purpose of the Letter:

This letter is to give you information to help you decide if you would like to take part in this study.

4. *Purpose of the Study:*

The purpose of this study is to understand what it was like for women to be married before they were 18 years old in Nigeria. Also, we want to find out about your use of health care services and how helpful these services are for you.

5. *Who is Eligible to Take Part?*

You can take part if you:

- Are above 18 years old
- Are Nigerian citizen
- Were married before you turned 18 years in northern or southern part of Nigeria but now live in southern part of Nigeria
- You must have been married at least 5 to 7 years, but it does not matter if you are no longer married
- You have at least a child
- Used health care services or did not use when you were pregnant

6. *What Taking Part Means:*

If you agree to participate, you will meet with the researcher; an interpreter will be available if needed. The researcher will describe the study in more detail and answer any questions you might have. If you still are interested in taking part and understand what the study is about and what is expected, you will need to sign a consent form. You will be interviewed by the researcher with an interpreter if required. The interview will take 45 minutes to 1 hour. The interviewer will ask you about your childhood marriage experience, how you coped as a child at the same time as a married woman, what and who was your support. She will also ask if you used health care services or not. If you don't mind, we would like to audio-tape the interview so as to capture everything you say. However, the interviewer will take notes if you don't want audio-tape; this will not contain your name or any other thing that will make anyone know you. For safety reasons, we want to use health care centers for the interview as they are a safe and private

place, but you can decide on any other place that you think will be safe for the interview.

7. *Voluntary Participation/Withdrawal from Study:*

Taking part in this study is voluntary. You may refuse to answer specific questions. You may decide not to be in this study. At any time, you may leave the study or ask to have your information removed by contacting the researchers using the study email or phone number. It will not be possible to remove your information after the analysis has started. Taking part in this research study or dropping out will not affect your care in a health center, hospital, or community.

8. *Possible Risks:*

The risk in this study is that during or after an interview, depending on what you are talking about, there may be pleasant or painful memories of your childhood marriage experience. If you become upset, we will stop the interview. You can decide whether you want to continue to answer these questions or not. The interview will continue if you verbalize that you could go on, but you can take a break if you feel too upset. If needed, we will refer you to a counsellor in the hospital or other support services. The community health extension worker (CHEW), who often does your home visits, will be informed if needed and can also come to check on you during this time if required. I will call you the next day if you were distressed and unable to continue the interviews to see if you are doing well.

We will try not to increase any risk to you in taking part in this study. The interview will take place where and when it is convenient, private, and safe for you. To further reduce any risk to you, we have informed the community leaders about the study and the community women group for their support. These community women include women such as female market leaders, female leaders in church and mosque. We are aware they have a great influence on the decision-making process and understanding of your societal issues. Therefore, informing them ahead will help educate, sensitize, and mobilize other participants like you, including your partners.

9. *Possible Benefits:*

You may not directly benefit personally from participating in this study but may understand more about women's rights, health, and the use of health services in Nigeria. Also, you might become more aware of actions you can take to get health services. Your views may help to influence and also serve as a source of inspiration, hope, and support for other female children in the future. Also, what we learn from this study could help to identify what supports are needed for child brides. Also, it could help to inform public policymakers with the potential of improving the delivery of health services to women in Nigeria.

10. *Confidentiality of the Information You Provide:*

Confidentiality will be fully protected in this study. While in Nigeria, paper copies of the study, such as the consent form, will be stored in locked cabinets in the researcher's room. All the soft copy information will be kept on a personal password-protected computer, accessible only by the researcher. This information will be stored at the

researcher's home for the purposes of data analysis only. The participants' information will be stored in an encrypted file on this computer. The encryption type used is the Encrypted File System (EFS). The EFS is an in-built Windows software. A password only known to the researcher will be used in encryption. Data will be securely transported to Canada in soft copy using electronic (online) data collection, secure file transfer, encrypted and password email known only to the researcher. In Canada, the information you provide will be accessible only to the research team members (including the research committee members and the project supervisor). You can choose another name, or I can give you another name (pseudonyms) for the purpose of this research. Your personal identity or real name will not be released in any publications or presentations of this study or be present on the transcript. However, per legal requirements, any information on child abuse and neglect will be reported to the Ministry of Social Affairs and Social Development of Nigeria. When the researcher returns to Canada, your name and other identifying information will be saved on a secure server at Western University and kept separate from your transcript. Direct quotes from participants may be included in publications and presentations, but no personal identifiers will be included.

All personal and confidential information such as consent forms, tapes, and transcripts will be locked separately in a filing cabinet in a securely locked office at Western University, only accessible by the research team. Audio-recording will be destroyed after a written copy (transcript) has been made. The transcript and any written notes will be kept for at least seven years per Western University policy. After that time, they will all be deleted and shredded. Representatives of the University of Western Ontario Health Science Research Ethics Board may require access to this study-related records to monitor the conduct of this research.
We will use what we learn in this study to talk to other people in Nigeria and outside Nigeria; we will not mention your name. We will also write what we learn in research journals, magazines, newspapers, television, and radio.

11. *Costs and Compensation:*

There is no cost to taking part in this study. To thank you for your time, we will give you a hygiene package that will contain female items you can use, such as, sponge, bathing soap, sanitary towel, deodorant, lip gloss, and hand sanitizer. We will also give you NGN 1,450
(CAD 5) to cover any transportation costs.

12. *Consent:*

If you agree to take part in this study, please tell the researcher. She will record your consent on a form which we will keep in our office.

Consent Form

Project Title: A Feminist Narrative Inquiry into Being a Child Bride in Nigeria

Primary Investigator's Name: Marilyn Evans
Co-investigator's Name: Olubukola Sonibare

- I have read the letter of information; the nature of the study has been explained to me, and I agree to participate. All questions have been answered to my satisfaction.
- I agree to be audio-recorded
- I agree with the use of quotes provided by me, but that does not identify me in sharing the results of this research
- I agree not to discuss the terms of the interview outside the study setting with other participants known or unknown.

Participant's Name (Please Print): ….....

Participant's Signature: ….....

Date: Month: ..... Day: ..... Year: ….....

Person Obtaining Informed Consent (Please Print): ….....
Signature: ….....

Appendix G

Interview Questions

Demographic Data

1) Kindly give me information about yourself:

a) Age

b) Where you were born

c) Your educational level

d) The age you got married

e) Who else got married before the age of 18 years in your family?

f) How many children do you have? What are their ages?

Questions About Being Child Bride

2) Tell me about the planning of your marriage; when did you know you will be getting married?

3) What are your thoughts about being married at a young age?

4) How did you take the information you were given about your marriage?

5) What was it like for you to be married at a young age?

6) Tell me what you knew about marriage before you got married?

7) During your pregnancy, what health services did you use for your pregnancy(ies) and after giving birth? (a health facility or a Traditional Birth Attendant)?

8) Tell me about any challenges you experienced after you got married?

9) What are some of the things you did to cope with these challenges? Probes: helpful, not helpful, supports

10) What are some of the things you did not cope with very well?

11) What are your thoughts about the health services available for women similar to you? Probes: Any changes recommended in health services? What kinds of changes?

12) What are some of the things you enjoyed being married so young?

13) What more would you like to tell me?

Debriefing

1) Tell me how you feel now after talking to me about your experience?

2) What do you think can be done to make you more comfortable?

CURRICULUM VITAE

Olubukola Foluke Sonibare

CAREER SUMMARY

Dedicated and patient focused graduate Nurse with Proven expertise in acute patient care, family advocacy, leadership, management and research.

- ➢ Exceptional capacity to multi-task: managing competing priorities with ease while fostering delivery of superior patient care.
- ➢ Solid administrative and referral experience including admissions, assessment, treatment, referral, and education for a broad range of patients.
- ➢ Demonstrated ability to forge, lead, and motivate outstanding healthcare teams that provide top quality patient care.
- ➢ Outstanding interpersonal and communication skills.

Sept 2016 - Present

Research Assistant- Western University

- Instruction, lecturing or supervision in classes, tutorials or laboratories.
- Preparation of materials or set-up of required displays or apparatus for classes,
- Grading of essays, assignments, tutorials and term tests, proctoring of exams and conducting of field trips.
- Reading and corresponding electronically with students relevant to the assigned course, and other teaching related duties.

Jan 2010- Dec 2014

Principal Nursing Officer- Surgical Ward (Female) – Lagos University Teaching Hospital

- Giving holistic and individualized nursing care to patients using the nursing care plan to meet the physiological, psychological, sociological and cultural needs with the available resources.
- Health educating patients and relatives on their disease conditions and assisting the with patient's rehabilitation.
- Initiating ideas, ensuring continuity and delivery of quality patient care by assisting ward leaders with organization, administration and management.
- Assisting to organize ward nursing conferences, teaching the officers and ancillary staff.
- Supporting and interpreting hospital policy to patients, other staff and members of the public.
- Observing and correcting appropriately the auxiliary staff as well as supervising the job of subordinates to develop their capability for effective responsibilities.

JANUARY 2007 – December 2009

Nursing Officer- Surgical ward (Male)- Lagos University teaching Hospital

- Care for patients with life threatening surgical cases like hemothorax, pneumothorax, aneurysm, tracheal obstruction following intubation and so on.
- Planned, implemented and evaluated patient using a range of recognized nursing procedures.
- Managed the ward's stock control system.
- Supervised, taught and assess the learning of pre- registration students.
- Administered medication- IM, SC, PO, transdermal and topical
- Daily Wound assessment and prevention of infections by doing sterile dressing, taking wound swab for culture and sensitivity testing.

Volunteer Experience
London Food Bank
Let's Talk Science

ACADEMIC
Western University-Nursing in view
London ON, Canada.

Professional Training
Planned Parenthood and Family Planning – 2000

Hobbies
Traveling, Reading.

Professional membership

Member, Sigma Theta Thau, Walden USA Chapter.

Papers
Orchard, C.A., Sonibare, O., Morse, A., Collins, J., & Al-Hamad, A. (2017). Collaborative leadership, Part 1: The nurse leader's role within interprofessional teams. Canadian Journal of Nursing Leadership, 30(2), 14-25. doi: 10.12927/cjnl.2017.25258

Orchard, C.A., Sonibare, O., Morse, A., Collins, J., & Al-Hamad, A. (2017). Collaborative leadership, Part 2: The role of the nurse leader in interprofessional team-based practice – Shifting from task- to collaborative patient-/family-focused care. Canadian Journal of Nursing Leadership, 30(2), 26-38. doi: 10.12927/cjnl.2017.25257