2020

The Lived Experience of Child Marriage and its Health Effects Among Young Mothers in Nigeria

Anastasia Iliwo Ashi
Walden University

Walden University

College of Health Sciences

This is to certify that the doctoral dissertation by

Anastasia Iliwho Ashi

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Mary Lou Gutierrez, Committee Chairperson, Public Health Faculty
Dr. Michael Schwab, Committee Member, Public Health Faculty
Dr. Kim Sanders, University Reviewer, Public Health Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2020

Abstract

The Lived Experience of Child Marriage and its Health Effects

Among Young Mothers in Nigeria

by

Anastasia Iliwho Ashi

Master of Education, University of Abuja, Nigeria, 2012

Bachelor of Science/Education, University of Port Harcourt, Nigeria, 1992

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health.

Walden University

August 2020

Abstract

Child marriage has life-threatening implications for the mental, physical, and psychological development of the girl-child. In Sub-Saharan Africa, and other resource poor settings, child brides and very young mothers undergo various negative experiences including economic hardship and health challenges such as obstetric fistulas, birth complications, and even death. The purpose of this phenomenological study was to describe the lived experiences of child marriage and its effect on maternal health among young mothers in Nigeria. The social ecological model provided the conceptual framework for this study. Ten young women ages 18-24 years who had been child brides when age 12-16 years were recruited through purposive sampling and interviewed using in-depth key informant interviews. Interviews were transcribed, entered, and coded using NVivo 12 software. Colaizzi's 7 steps of data analysis were employed to extract meanings from 9 themes that made up 20 sub themes. The 9 themes were low happiness indices, education denial, husband dominance, dehumanizing experience, poverty, lack of support/exposure to telling and doing, forced young matrimony, pregnancy complications, and pressure on and from parents. One remarkable finding from this study is that not all child brides are denied the right to education. Unfortunately, access to education may be at the cost of dehumanizing experiences such as being used as sex slaves by those paying for their education. Findings from the study may be used by governments and Non-Governmental Organizations to advocate for family and community support, increased knowledge, and awareness of the needs of young mothers, in addition to improving maternal health outcomes through advocacy for support that increases focus on access to maternity care for young mothers.

The Lived Experience of Child Marriage and its health Effects Among Young Mothers in Nigeria

by

Anastasia Iliwho Ashi

Master of Education, University of Abuja, Nigeria, 2012

Bachelor of Science/Education, University of Port Harcourt, Nigeria, 1992

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health.

Walden University

August 2020

Dedication

This study is dedicated to the memory of my beloved husband the Hon. Justice Valentine Bekeh Ashi. Val was a loving husband, my best friend, and my inspiration. He inspired me to undertake this doctoral program and committed resources to it. He was anxious to see me complete the program and lately he would fondly hail me with Hi Dr. Ashi, the great lady Ann! I miss him so much and will miss his presence at my graduation. May his gentle soul rest in Peace.

To the memory of my adorable sister, Mrs. Roseline Ogbene Oniah Ugbaka. Rosa was a motivator in most of my endeavors and always stood by me in whatever I did. She desired so much to see me complete my doctoral study and was looking forward to personally attend my graduation. Although she passed on at a critical stage of my study she has continued to urge me to carry on. I will miss her presence at my graduation. May God rest her soul. And to the memory of my beloved dad, Mr. Edward Ogah Oniah, who is now smiling in heaven because his dream of seeing me a doctor is now fulfilled. May he continue to rest in peace.

Acknowledgments

I wish to express my thanks to God almighty who provided this opportunity for me to fulfill my destiny of becoming a doctor. To the Blessed Virgin Mary, my mother for always being by my side and who taught me to keep my hope in Jesus and to do whatever he tells me because someday "All generations shall call me blessed." I sincerely thank my chair, Dr. Mary Lou Gutierrez, for her skilled guidance, patience, and relentless work to put me on track from the beginning to completion of this dissertation journey. My special thanks go to my committee member Dr. Michael Schwab, for his adept and tireless counseling and guidance to carry on with this dissertation process, and to my University Research Reviewer, Dr. Kim Sanders, for astutely reviewing this work.

I sincerely thank the following persons: Rev. Fr. Loius Duniya, who provided a smooth passage for me to collect my data, and for his untiring support throughout the period of my study. To Dr. Silas Ochejele for his role in coordinating the expert panel. I cannot complete this acknowledgment without mentioning Prof. Frederick Nwosu, and Dr. Mrs. Stella Onuoha-Obilor, who came in handy at a point I was confused and stuck. To my siblings especially my kid brother Reverend Father Jude Oniah for his untiring support, prayers, and encouragement, and to my elder sister Mrs Mercy Ejini who was always on hand to care for the children while I was away at residencies. I am eternally grateful to my beloved mother Mrs. Elizabeth Agianpe Oniah for her support and prayers, and for always believing that I could do whatever I set out to do. Finally, I give a special hug to my babies Maria-Gratia-Benedicta Akpana, Michelle-Gabriella, Raphaella-Christine, who I also call ‘my archangels' for their support and understanding from beginning to the end of this doctoral study. In spite of their age, they knew that mummy

needed to do her ‘schoolwork’ and should not be disturbed.” and to my sunshine, my dawn of a new day, the great John-Paul! My consoler who came in handy and became my strength to carry on in spite of the odds! And to all those whom I cannot mention here, I am eternally grateful, and I pray that the good Lord blesses and reward you richly.

Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction to The Study

Introduction

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

Background of the Study

The United Nation's Millennium Development Goals (MDGs), are a set of eight time bound goals, put together by the United Nations Assembly in 2000, to address issues of poverty, education, health, and the environment. The set of eight MDGs comprising 21 targets and 60 indicators were meant to enable effective tracking and monitoring of the progress towards the commitments by the United Nations countries, between 1990 and 2015, when the goals were expected to be met (UNICEF, 2018). The United Nation's MDGs targeted the reduction of maternal mortality rate by three-quarters between 1990 and 2015. Global progress towards the reduction of maternal mortality rates was disproportionate in Sub-Saharan Africa where young girls were at higher risk of dying during or after pregnancy compared to their counterparts in Europe (Global Development, 2014). The completion of the MDGs gave way to the Sustainable

Development Goals (SDGs) of 2016-2030. Both the retrospective MDGs and current SDGs advocate development centered on people and identified women and children as important segments of the population as well and a critical link between the present generation and the future. Therefore, investing in the health of women is of immense global benefit (United Nations, 2015). For this reason, the United Nations considered improving the health of mothers and children as an important aspect of the MDGs and included it as goal Number 5.

In some countries in Sub-Saharan Africa, including Ethiopia, Madagascar, and Uganda, satisfactory progress was made towards achieving the MDG No. 5 (improving maternal health) in large part because of increased use of antenatal care (Alam, Hajizadeh, Dumont, & Fournier, 2015). In contrast, other countries such as Cameroon, Zambia, and Zimbabwe have not achieved progress in reducing maternal mortality, due to lower use of antenatal care services. The maternal death rate in these areas was greater than 550 per 100,000, representing an annual reduction rate in 2010 of less than 1.5% (Alam et al. 2015). This trend indicated that increased support for young mothers and utilization of maternal care is directly related to a decline in maternal mortality. For example, some of the unpleasant experiences and poor maternal outcomes may be avoided by improving access to maternity care for young mothers.

Nigeria is the most populous country in Africa and in 2015 recorded the highest number of maternal deaths in the world. Rural poor teenage mothers and less educated women were the most vulnerable and at-risk populations (Okigbo et al. 2017). Approximately three-quarters of the rural women in Nigeria deliver their infants outside health facilities and without skilled birth attendants. Lack of maternity care by skilled

birth attendants, results in higher mortality rates and indicates a potential for progress (Oyibo, Watt & Weller, 2017).

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

Problem Statement

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

Nigeria is still not on track to achieve the MDG No. 5 on maternal morbidity and negative maternal outcomes (Zuber et al., 2018). Some of the factors underlying this

failure are early age of marriage, poverty, lack of education, and delay in seeking professional health care (Bruce et al. 2015). In Morocco and some parts of Sub-Saharan Africa, Sabbe et al. (2013) also identified male sexual desire and the patriarchal system as a major risk factor for child marriage, especially where a father's right over his daughter can be transferred to an older male in the community for economic gain, a practice that is believed to strengthen the family's social status and improve economic relationships. A report by Women Living Under Muslim Laws (WLUML) identified Nigeria as having some of the highest rates of child marriage in the world, with higher prevalence in the North, where an estimated 43% of girls get married by age 15 (UNOHCR, 2013).

While the reasons for the high maternal mortality rates and slow progress in achieving improved maternal health status in Nigeria are yet to be identified, researchers suggested that contextual issues such as gender (autonomy, inequality), socioeconomic status (education, poverty), and cultural factors (child marriage, patriarchy), are all associated with young and teenage motherhood (Bruce et al., 2015). According to Kalipeni et al. (2017), the extent to which these contextual issues contribute to the unacceptable rise in maternal mortality rates needs further exploration. Access to maternal health care across the country (Nigeria) has been minimal and inequitable. Zuber et al. (2018) suggested that timely access to care is necessary to reduce maternal risk in middle-income countries. In addition, Zuber et al. (2018) observed that the majority of teen mothers in Sub Sahara Africa have minimal access to quality health care and suffer from severe psychological trauma, obstetric complications, and even death.

Sociocultural factors such as culture, religion, and the level of education are independently correlated with the mortality of women in Nigeria (Ariyo, Ozodiegwu &

Doctor, 2017). Young mothers in Nigeria experience various psychological and sociocultural factors that make motherhood a painful experience. Some of the challenges faced by young mothers in underdeveloped communities include an inability to cope with increased responsibility of motherhood, lack of support from child's father and the wider society, coupled with lack of access to maternity care (Ngum Chi Watts et al. 2015; Okwaraji, Webb, & Edmond, 2015). Researchers such as Oyibo et al. (2017) have identified communication and education as essential factors necessary to reduce maternal mortality and improve access to quality healthcare.

Child marriage is widely practiced in Nigeria and is further encouraged by cultural factors and traditions in some parts of the country. Nigeria is a patriarchal society, where male relatives sometimes force young girls into marriage before the age of 15. Subsequently, many of these girls become pregnant as adolescents, thereby increasing the risks of complications related to pregnancy and childbirth (UNOCHR, 2013). These teenage mothers experience frustration, isolation, and lack of support from family members and the broader community. In most cases their health is permanently damaged, while some of them die in the process of childbirth, due to complications such as vesico-vaginal fistula (Mumtaz et al. 2014).

To improve maternal health in Nigeria, a concerted effort is needed to focus on this vulnerable population (Okigbo et al.2017). An in-depth understanding of the experiences of young mothers may improve the support of both family members and community expand knowledge and awareness of the needs of teen mothers in vulnerable populations (Ngum Chi Watts et al. 2015). Early age of marriage and inequities in accessing maternity care have been implicated as some of the factors responsible for poor

maternal outcomes. While child marriage is prevalent in Nigeria and results in significant negative consequences, there is a paucity of literature on the lived experiences of the girls themselves.

Purpose of the Study

The purpose of this phenomenological study was to describe the lived experiences of women who were child brides and mothers at ages 12-16 years, during their prenatal, natal, and postpartum periods. The interview included their perceptions of the psychological, social, cultural, and institutional factors that made up their experiences during their prenatal, natal, and postpartum periods. The participants included 10 young women ages 18-24 years who experienced child marriage when they were12-16 years old.

Research Question

What are the lived experiences of child marriage and maternal outcomes among young mothers aged 12-16 years during their prenatal, natal, and postpartum periods in Nigeria?

Theoretical Framework

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

organizational, community and public policy. The model allows for a deeper understanding of individual experiences in the social and ecological context (Glanz, Rimer &Viswanath, 2015).

Nature of the Study

This phenomenological study explored the psychological, socio-cultural, and institutional factors that formed the experiences of child mothers who were forced into marriage before the age of 16 years. The phenomenological approach was best suited for because it involves participants who are experiential experts of the phenomenon under review (Rudestam, & Newton, 2015). Phenomenology is concerned with the study of human existence and the perception and understanding of peoples' behavior. Some hidden features of people's lives that would not ordinarily emerge or that people would not reveal to people outside their cultural or social circles can be exposed through phenomenology (Carpenter, 2013a, In Liamputtong, 2013; Liamputtong, 2013).

Up to 10 participants ages 18-24 years were purposively selected. They were able to provide rich first-hand information about their experiences as child mothers, information that made meaningful contributions to learning about the main issues associated with the study (Rudestam & Newton, 2015). Given anonymity and confidentiality, the participants were interviewed using one-on-one, open ended in-depth interviews, and were thus able to speak confidently and freely about their experiences. The results were analyzed at the group level to minimize the risk of exposure to individual participants (Babbie, 2015).

Operational Definitions of Terms

Early marriage: Marriage among young girls ages 12-16 years (UNICEF, 2016).

Global Strategy (2016-2030): A roadmap to achieve the right to the highest attainable standard of health for all women, children, and adolescents –to transform the future and ensure every newborn, mother and child not only survives but thrives. (UNICEF, 2016).

Maternal mortality: Death of mothers as a result of complications from pregnancy and childbirth. (UNICEF, 2016).

Patriarchy: a system of male dominance and authority where women are oppressed through its social political and economic institutions (Godiya, 2013).

Teenage mothers: Traditionally, a teenager is considered to be a young person between ages 13-19 years old. In this study, a teenage mother will refer to a young mother between ages 13-19 (UNICEF, 2016).

Young mothers: In this study a young mother will refer to immature, inexperienced child mothers who are not necessarily teenagers, and adolescent mothers (UNICEF, 2016).

Assumptions

The assumption was that participants would respond to questions in all sincerity, depending on how much they understood. Child marriage, teenage pregnancy, and teenage motherhood at the age of 12-16 years come with frustrations, inadequacy, and deprivation. Therefore, it was assumed that even after several years, these young women might not forget the painful experiences, and might be able to relive their feelings and give detailed information about the events, and their perceptions of teenage motherhood.

Scope and Delimitations

The study was conducted with young mothers, ages 18- 24 years, in Igu community, Abuja, Nigeria, and focused on their lived experiences including the mental, social, cultural, and institutional factors that affected their experience of their childhood prenatal, natal, and postpartum experiences.

Limitations

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

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

Third, participants were wary of reliving their lived experiences, especially because they had traumatic memories of them. Because of the sensitive nature of the

study, participants became emotional during the course of the interviews. A lot of time was wasted repeating the interviews in order to guide against inconsistency and inadequate data. (Rudestam & Newton, 2015). I repeated interviews to collect enough data to establish consistency of themes, an understanding of the raw data by other researchers, as well as generalization and transferability of results to similar findings.

Fourth, cultural sensitivity prevented participants from giving appropriate responses to questions. Participants were aware that the researcher was from a different culture and may look down on them as primitive people because they feel that their culture is worse than other cultures. They were not willing to say some intimate things such as the one being violated by her father. The researcher counseled and assured participants that we are all one. This encouraged them to speak freely.

Significance

The results of this study may become the basis for educational programs in schools, on television, in clinics, and even social media, in order to increase knowledge and awareness of the needs of teen mothers and to improve support from family members as well as the entire community. The social change implications from this study potentially provided much-needed insights into the alarming rates of maternal morbidity and mortality, as well as the slow progress of achieving improved maternal health outcomes in Nigeria.

Summary and Transition

The United Nation's MDG No. 5 targeted a reduction in the maternal mortality rate by three-quarters between 1990 and 2015 (Zuber et al. 2018). Globally, there has been a 44% decrease in the maternal mortality from 385 deaths/100,000 live births to

216; however, this is less than the 5.5% annual rate required to achieve the three-quarters reduction in maternal mortality in the Goal No. 5 (UNICEF, 2016). Most regions experienced declines in the level of maternal mortality between 1990 and 2015, but rates in Sub-Saharan Africa remain intolerably high at 510 deaths/100,000 live births. Out of the estimated 289,000 global maternal deaths in 2013, 62% occurred in Sub-Saharan Africa (WHO et al. 2014). In Nigeria, maternal mortality rates continue to accelerate, especially among young teenage mothers. These are critical issues and cannot be overlooked because Nigeria's population is about 18% of the total population of Sub-Saharan Africa (Okigbo et al. 2017). If maternal health must be improved in Nigeria there is, therefore, the need for an increased response to maternal health care to focus on vulnerable people (Okigbo et al. 2017). An in-depth understanding of the experiences of young teenage mothers may provide a basis for helping to improve care and support and for reducing maternal deaths among this vulnerable group. This Chapter presented an overview of some of the contributing factors that formed the experiences of child mothers and inhibited access to maternity care. In chapter 2, the existing literature is reviewed, and an account of how this study addressed the gaps in the literature is described. In chapter 3, I

Chapter 2: Literature Review

Introduction

The purpose of this phenomenological study was to describe the lived experiences of women who were child brides and mothers at ages 12-16 years, during their prenatal, natal, and postpartum periods. This chapter covers the literature on the causes of teenage motherhood specifically child marriage, factors that contribute to child marriage, the effects of child marriage, and the actual experiences of child mothers. Also covered were studies that involved interviews to reveal the psychological, socio-cultural, and institutional factors that formed the lived experiences of young mothers in Nigeria.

Literature Search Strategy

A comprehensive literature search of studies published between 2013 and 2019 was carried out including earlier seminal studies that related to this research. The purpose was to enable an in-depth understanding of the relationship between teenage motherhood and the trend in maternal outcomes in Nigeria, the experiences of young mothers, and the psychological, socio-cultural, and institutional factors that formed these experiences. Searches were conducted in Google Scholar, Walden Med line and Pub Med, Pro Quest, other Medical literature online, and EBSCO Host using the following search terms: *social ecology model, child marriage, technical support for young mothers, access to maternity care, phenomenology, qualitative research, maternal mortality, maternal outcomes. Millennium Development Goals and Sustainable Development Goals* were also factors that made up the literature.

Theoretical Framework

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

The SEM enables researchers to explore a theoretical approach to comprehend the diverse effects people's behavior, as well as the interaction of these influences, to designing multiple interventions that are culturally competent to address public health issues. The numerous influences revealed by the SEM across levels have been used to develop multi-level interventions that focus on organizational policies, practices, and linkages, to address public health issues (Glanz et al. 2015). The primary focus of the SEM is to understand the multivariate nature of public health problems and use this understanding to develop multi-level interventions, by preventing a problem before it begins, through understanding the risk factors and the influence of potential prevention strategies. The multi-level controls of the SEM were utilized successfully to prevent violence by acting through the multiple levels at the same time (CDC, 2017). The SEM provided an excellent framework for examining the psychological, socio-cultural, and institutional factors that contribute to the experiences of child brides.

Global Trends in Maternal Mortality

The aim of the Millennium Development Goal No. 5 is to improve maternal health. The targets of this goal include (a) to reduce by three quarters, between 1990 and

2015, the maternal mortality ratio; and (b) to achieve by 2015, universal access to reproductive health. There was a 45% global decrease in maternal mortality ratio (MMR), between 1990 and 2003. This number seemed large but not enough to achieve the targeted 75% reduction by 2015 (WHS, 2015). According to the World Health statistics, 13 countries out of the 89 countries with the highest MMR, made little or no progress at all between 1990 and 2013. Leading causes of maternal deaths in these regions include pregnancy related complications such as direct obstetric causes namely, hemorrhage (27%), hypertensive disease of pregnancy (14%), as well as sepsis (11%) (WHO, 2015).

Access to the reproductive health care is also minimal as only 64% of pregnant women worldwide received the recommended minimum of four antenatal care visits. This implies that there is a need to expand global antenatal care coverage. In the World Health African region and low-income countries, coverage by skilled birth attendants is still only 51% (WHO, 2015).

In 2013, 62% of global maternal deaths occurred in Africa. Maternal mortality ratio (MMR) was also highest in this region, with 510 deaths per 100,000 live births (WHO, 2014). There was a 44% decline in global MMR from 385 to 216 deaths per 100,000 live births. This figure is impressive but did not meet the 5.5% target required to achieve the three-quarters reduction in the Millennium Development Goal No. 5 (UNICEF, 2016).

Most regions experienced considerable declines, including the Middle East and North America, but figures in sub-Sahara Africa remained unacceptably high. Interestingly, Alam et al. (2015) found that some countries in sub-Sahara Africa including Ethiopia, Madagascar, and Uganda, saw reasonable progress in reduction of

MMR. However, most regions failed to achieve this feat, including Nigeria. Nigeria is still one of the top 20 countries in the world with highest maternal deaths in 2015 (Atuoye et al., 2015). Table 1 below is a demonstration of different data sources on maternal mortality in Nigeria. The statistics represent estimates of MMR from different sources.

Table 1

Estimates of Nigeria Maternal Mortality Ratio Data 1990-2008

Source and Year	**1990**	**1995**	**2000**	**2003**	**2005**	**2008**	**2003-08**
WHO et al. 2008	1100	1100	980		900	840	
WHO et al. 2007					1000		
WHO et al. 2003			800				
UNICEF					1100	(840)	
DHS	1000		704	800		545	
UNHDR 2010							1100

Source. Global One 2015 (2018)

The lifetime risk of maternal deaths for teenage mothers in sub-Sahara Africa is higher than the figures reported above. For example, for a 15 years old girl in sub-Sahara Africa, the lifetime risk is 1 in 40, while in Europe the lifetime risk for a 15-year-old girl stands at 1 in 3,300. The clear disparity in lifetime risks across regions underscores the uneven progress around the world in achieving the Maternal Developmental Goal No. 5 (Global Development, 2014). These marked disparities in maternal health outcomes experienced globally can be attributed to complications related to pregnancy and childbirth. Global causes of maternal deaths include abortion 8%, hemorrhage 27%,

hypertention14%, sepsis 11%, embolism 3% indirect causes 28%, and other direct causes 10% (UNICEF, 2016).

The WHO report in 2013 showed MMRs for the United States and the United Kingdom were 21 and 12 respectively, with corresponding lifetime risks of 1 in 2,400 for the United States, and 1 in 4,600 deaths for the United Kingdom (Ezeonwu, 2014). In other high-income countries lifetime risks of maternal deaths range between 1 in 3,300, and in sub-Sahara Africa the value is 1 in 36 deaths (UNICEF, 2016). The WHO reported that the MMR is highest in sub-Sahara Africa, with 510 deaths per 100,000 live births (WHO et al. 2013). A study conducted by Ezeonwu (2014) revealed that Nigeria has the highest MMR in the world (630 deaths per 100,000 live births). Subsequent findings by Atuoye et al. (2015) indicated that Nigeria is still one of the top 20 countries in the world with highest maternal deaths in 2015.

The above data support the need to increase maternal healthcare response and advocacy campaign. Emphasis should be placed on public, NGO, and policy attention on maternal health issues in Nigeria (Global One 2015, 2018). The high rates of maternal deaths in Nigeria can be attributed to the high prevalence of child marriages and poverty (Okigbo et al., 2017). The poverty levels contribute to a large number of the rural women who deliver their babies outside health facilities without skilled birth attendants (Oyibo et al., 2017). The findings of both Okigbo et al. as well as Oyibo et al. gave credence to the works of Ezeonwu, (2014) and Atuoye et al. (2015).

These findings point to the fact that maternal outcomes in Nigeria are still unfinished business, and more effort is required to accelerate a reduction in maternal mortality rates and actualize the Sustainable Development Goals. Poverty is a significant

risk factor. The World Bank reported that 64.4% of Nigerians live in extreme poverty (Global One 2015, 2018). What this means is that most families will not be able to utilize healthcare facilities, including maternity care. Those who can pay for private facilities will be able to access care, while those who cannot pay will lack access. It is therefore evident that utilization of maternity care in Nigeria is dependent on socio-economic status. Another risk factor is the extremely low age of marriage, which compounds the situation of lack of access to maternity care by very young teenage girls below the age of 16 (Okwaraji et al., 2015).

Governmental Efforts and Maternal Mortality in Nigeria

The MMR in Nigeria seem to have reduced by half between 1995 and 2013, from 1,200 per 100,000 live births to 576 per 100,000 live births. Based on data from the Demographic and Health Survey no progress has been made, as this figure is insignificant and not enough to achieve the Millennium Development Goal No. 5 target of 300 per 100,000 live births. This implies that further investment is necessary to meet the target (UNICEF, 2016).

The government of Nigeria recognized the slow progress in reducing maternal deaths and introduced the maternal and child health week (MNCHW) amongst other measures to strategically accelerate the improvement of maternal health and reduction of child mortality. The main focus of this intervention is to deliver an integrated cost-effective maternal and child health package to strengthen the routine primary health care services (UNICEF, 2016). The evaluation report revealed that there was no significant contribution to improved maternal health outcomes. However, the program has a potential to increase coverage to a reasonable extent for improved outcomes through

mobilization, awareness creation and participation. This can be achieved by effectively partnering with NGOs, and other international organizations, as well as timely release of funds and complete commitment by state governments (UNICEF, 2016).

Context of Child Marriage

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

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

International Covenant on Civil and Political Rights 1966, child marriage is considered an issue of human rights, slavery, and social injustice, that needs to be stopped. (Nasrullah, et al., 2014).

Contributing Factors to Child Marriage

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

Poverty

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

The geographic locations in Nigeria play a very significant role on poverty and consumption. People who live in the northern zones fare worse than those living in other parts of the country. The high poverty level is affected by factors such as illiteracy, low

productivity, poor infrastructure, and unemployment (UNICEF, 2014). Thus, there is a high incidence of child marriage in the region, as many families give out their immature daughters for financial and economic gains.

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

Lack of Prenatal Education

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

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

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

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

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

Patriarchy

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

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

The patriarchal system in Nigeria creates a situation of male dominance, social stratification, and differentiation on the basis of gender, and places males in an advantageous position over females. Women are thought to be inferior to men, thus they are discriminated upon in all spheres of life, including acquiring formal education. They are relegated to the background, mistreated, and permanently kept as house-helps, and most times forced into early marriage or prostitution and trafficking (Godiya, 2013).

Women are also vulnerable to climate related problems because their activities are mostly centered on occupations such as small scale and rain-fed agriculture (Onwuluebe, 2019).

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

Access To Care

Young mothers lack access to healthcare both for themselves and for their babies, because of low socio-economic status, and lack of autonomy to make decisions. According to Sialubanje, van der Pijl, Kirch, Hamar, & Ruiter (2015), women ages 15-45 believe that factors such as lack of autonomy to make decisions, gender inequalities, low socioeconomic status, and socio-cultural norms, prevent them from utilizing access to maternity waiting homes, thereby exposing young mothers to life threatening health risks, including obstetric complications, and subsequent maternal mortality. Child mothers have been known to have limited access to maternal care because of poverty, lack of education, the high cost of accessing maternal care (Zuber et al. 2018).

Access to maternal health care is dependent on several other factors, including education, age, and distance to health centers. Uneducated women live further away from a health facility than educated women. (Okwaraji, Webb, & Edmond, 2015). Geographical factors such as roads and transport are also associated with lack of access to

healthcare facilities (Atuoye et al. 2015). Timely access to emergency obstetric care is an essential tool in the reduction of maternal risk in middle-income countries (Schmitz et al., 2019; Zuber et al. 2018)

While Sialubanje et al. (2015) identified gender inequalities, low socioeconomic status, socio-cultural norms, and lack of autonomy to make decisions concerning the health of young mothers, as some factors that prevent child mothers from utilizing access to maternity waiting homes. Scanneving et al. (2013) had earlier pinpointed economic standing, gender, and social status as predictors of access to maternal and reproductive care. These factors play a significant role in improving maternal health outcomes.

Cultural Norms

Child marriage in Nigeria is a result of cultural norms (Kalipeni et al., 2017). In Nigeria, child marriage is sustained by traditions and culture in some parts. The patriarchal system already discussed earlier is a structure set of material base which encourages male dominance, through a system of arrangement into groups based on gender, in order to provide material advantage to men, and at the same time, it places severe constraints on the roles and activities of women (Godiya, 2013; Onwuluebe, 2019).

Religion

In a comprehensive study to answer the question whether faith or religion actually plays a role in promoting child marriage in Africa, Gemignani and Wodon, (2015) provided an account of trends in child marriage in Africa, and the statistical association between child marriage and faith affiliation. The researchers found child marriage to be closely associated with religion. The higher prevalence is among the Muslim, animists,

and traditional belief populations. In addition, child marriage was found to be higher among people without a faith affiliation, as compared to Catholics and Protestants (Gemignani & Wodon, 2015).

The Muslim communities in some parts of Burkina Faso in Africa, believe that early marriage provides an opportunity for girls to have their parents' blessings for respecting their will. They also believe that early marriage provides a home for the woman. The Muslim religious requirement says that a woman without a home is not a true or devoted Muslim and her prayers will not be answered if she prays. They also believe that early marriage helps girls to imbibe values that will make them good wives and obey their men or spouses. There is a strong belief that school or education makes a woman rebellious and may delay her marriage (Gemignani & Wodon, 2015).

Nigeria has the highest number of child marriages in the world, with extreme prevalence in the North. About 48% of girls are given out in marriage by age 15 and below (UNOCHR, 2013). And the north is predominantly Muslim, with pockets of Christian and other traditional religion in some parts. This confirms reports of earlier studies which stated that child marriage is deeply rooted in ethnic values and religious beliefs. Therefore, to curb child marriage, it will be necessary to consider focusing more attention on ethnic values and religious beliefs in Africa.

Insecurity

Insecurity, conflicts, and displacements have been known to promote child marriage. In a qualitative study to gather data about the factors that promote child marriage among Syrian refugees in Lebanon, Mourtada, Schlecht, and DeJong (2017) found that child marriage was prevalent in pre-conflict Syria, as a result of the feeling of

insecurity, conflicts, and displacements related issues in the region. These factors worsen the economic situation and disrupt education for adolescent girls.

Earlier studies by Neal, Stone, and Ingham (2016) showed that young women in regions where conflict is prevalent are at risk of unfavorable outcomes resulting from violence, economic deterioration, and breakdown of community structures and services. In their systemic review of quantitative studies, Neal et al. (2016) revealed the effects of armed conflicts, including sexual debut, first marriage and first birth, among young adolescents under the age of 20 years. These have serious negative implications for public health.

Recently in some Northern parts of Nigeria, many young girls below the age of 18, are abducted and married off to terrorists in areas where armed conflict is prevalent. A recent report by Association for Reproductive and Family Health (ARFH), stated that the dreaded Islamists terrorist group kidnapped 275 young girls from a secondary school in Borno State, North East Nigeria. The girls were abused, raped, ill-treated, and forced into marriage to the terrorists. Many of the girls died in the process because they could not withstand the harsh conditions in which they were subjected to. A few years later the terrorists struck again, kidnapping 110 girls, and subjecting them to sexual abuse, torture, and forced marriage (ARFH, 2018). These series of abductions put the girl child at a disadvantage educationally because parents are afraid to send their daughters to school for fear of being abducted. They are given out in marriage at a tender age, just to avoid abductions (Abayomi, 2018). These reports confirm that insecurity promotes child marriage in large numbers, and very bizarre circumstances.

Effects of Child Marriage on Health

Child marriage refers to a marriage contracted below the age of 18. UNICEF considers girls who marry before the age of 18 as child brides. (Beattie et al. 2015). Child marriage has severe adverse implications on the mental, physical, and psychological health of the girl child. Child marriage destroys the mental, physical well-being and life chances of teenage girls. In a study focusing on sub-Saharan Africa as a region with the highest incidences of child marriage, researchers, explored the harmful effects of child marriage and found that child marriage had some negative impact on the health, education, and economic wellbeing of young girls. In this section, some main effects of child marriage and teen birth, such as physical illness, loss of dignity and social standing, as well as loss of educational opportunities, are outlined.

Physical Illness

Child brides suffer intense pressure from their older partners to become pregnant and have more frequent unprotected sex than their unmarried counterparts, and hence high risk of sexually transmitted diseases and numerous other health complications that may result in high rates of maternal mortality. The findings of Beattie et al. (2015) corroborate this fact when they noted that child brides have more frequent unprotected sex than their unmarried counterparts, and hence high risk of obstetric complications, maternal morbidity, and death. Other harmful effects of child marriage include female genital mutilation, hypertension, heart disease, diabetes, depression, and genetic conditions (Beattie, et al., 2015).

In sub-Saharan Africa, early child marriage has been implicated as a major cause of obstetric fistulas and many other gynecological complications in young women. More

than half of the girls in Niger are given out in marriage before the age of 15 and have their first and sometimes only pregnancy before the age of 16, in most cases as a result of poverty (Meurice, Genadry, Bradley, Majors & Ganda, 2016). Studies have shown that the combination of youth and malnutrition results in an underdeveloped pelvis, leading to complications such as cephalo-pelvic disproportion. This is a condition where the head of the pelvis becomes too large for successful vaginal delivery. As a result, the fetal head becomes stuck in the narrow pelvis, and since access to skilled birth attendants is limited or not readily available, the young mother suffers an abnormal tear into the bladder or rectum. This condition accounts for 76% to 97% of obstetric fistulas (Amoudu, Salami, & Richter, 2018; Shrivastava, Shrivastava, & Ramasamy, 2017).

Baker, Bellows, Bach, and Warren (2017) observed similar findings where most child brides have minimal access to maternity care, and suffer from severe obstetric complications, including obstetric fistulas (vesico-vaginal and rectal-vaginal fistula), psychological trauma, and even death. Other physical health risks are sexually transmitted diseases, Human immunodeficiency virus/Acquired immunodeficiency syndrome (HIV/AIDS), chronic pelvic infection, acute urinary retention, urethral damage, obstetric fistulas, (vesico-vaginal and rectal-vaginal fistula), vulval adhesions, dysmenorrhea, and death.

Loss of Dignity and Social Standing

Early marriage deprives the young girls of their youth and pushes them into the burden of responsibilities both as a mother and to her husband. She is forced to have sexual relations against her will and is deprived of education and playing with friends. The International Center for Research on women reported that young married girls lack

the negotiating power to get support for issues that are of interest to them, and they are frequently subjected to domestic sexual violence, abandonment, and threats of divorce. A review of qualitative studies by Fasha, Worku, and Mengistu (2018) reveal that the child brides feel a broad sense of loss of body control, loss of social role as a woman, loss of dignity, loss of integration in social life, and loss of self-worth. In general, this negative image among child brides is due to consequences of an obstetric fistula during birth (Mselle & Kohi, 2015).

Loss of Educational Opportunities

Child brides are denied the right to education and access to the school environment; hence the lack of development for themselves and the community. (Heller & Hannig, 2017). Child brides lack education and hence have low economic power. Because of lack of education, they lack the necessary purchasing power, and the ability to make decisions concerning their health, since they cannot fund it. The International Center for Research on women also reported that the common belief in many countries that child marriage is prevalent is that the education of the girl child is not a priority. Rather a woman's role is more of that of a wife mother and home maker. Most of the times poor families cannot afford to send their daughters to school. The only option left for the girls is just to be given out in marriage. When they are given out in marriage are adolescents, they lose the opportunity of schooling, thereby having limited chances to prosper jobs or entrepreneurs. The cycle continues because without support, child brides end up raising their children in poverty, who face the same challenges as their mothers (UNICEF, 2014).

In Nigeria, and other regions with armed conflicts, the abduction of girls from schools causes an abrupt end to their schooling or education, and others get scared of going to school for fear of being abducted (Abayomi, 2018). The study by Ngunen and Wodon (2014) confirms these findings that child marriage reduces the level of educational attainment.

Effects Of Child Motherhood

Child marriage is closely associated with child motherhood because most child brides become child/teenage mothers if they give birth within their teenage period. Effects of child motherhood are detrimental to the girl child and the entire community. Young mothers between ages 12 -16 years are predisposed to the harmful effects of young motherhood. At this age, a young girl is physiologically and psychologically underdeveloped and unprepared for the challenges of motherhood (Okigbo et al. 2017; Zuber et al. 2018). This age bracket is a critical developmental age of the life of a teenager, therefore, placing the burden of motherhood on a child of this age can have adverse social and health consequences (Ngum Chi Watts et al. 2015).

Child brides who become child mothers are exposed to multiple health risks and obstetric complications (Okigbo et al. 2017). Apart from the numerous health risks associated with child marriage, which have been mentioned earlier, there are myriads of detrimental effects of child motherhood which could be either psychological, physiological, caused by socio- cultural or institutional factors.

Psychological Effects

As earlier mentioned, child marriage is marriage contracted before the age of 18 years. A child-mother at this age is not physiologically and psychologically mature to

face the responsibilities of childbearing. Several psychological factors related to the mental and emotional state of young mothers, affect the child mother at this age, such as sexual difficulties with anorgasmia, psychological trauma, and death (Okigbo et al., 2017). The child mother experiences shame, depression, and other emotions of the child bride such as anxiety, fear, confusion, anger, and resentment. Adolescent pregnancies within resource poor settings put young mothers at risk of adverse mental and psychosocial disorders, including depression. A study conducted by Osok, Kigamwa, Vander Stoep, Huang, and Kumar (2018) revealed that depression is common among pregnant adolescents in areas deprived of resources, and a major contributor of years lived with disability.

Teenage motherhood has remarkable effects on antenatal and postnatal wellbeing. In a primary prospective mother-child cohort (Rhea Study) study, Koutra et al. (2013) evaluated the occurrence of postpartum depression during the antenatal and post-natal period and found that antenatal psychological well -being has a significant effect on postpartum depression.

Young mothers experience shame, embarrassment, pain, and lack of financial and technical support from the father of the child and the broader society, and they are isolated and frowned upon by their broader ethnic community. This feeling of isolation makes the young mother unable to access maternity care during her prenatal, natal, and postnatal period (Ngum Chi Watts et al., 2015). Other psychological effects of child motherhood include mental trauma, risky behaviors, unhealthy practices in pregnancy, inadequate nutrition, and unhealthy weight gain (Okigbo et al., 2017).

Physiological Effects

There are numerous physiological effects of child motherhood , remarkable among them are life threatening obstetric complications including fistula. Young mothers are vulnerable, and often victims of obstetric fistula. Obstetric fistula is an abnormal opening of the vagina into the bladder (vesico-vaginal fistula) or an abnormal opening of the vagina into the bowel (rectal-vaginal fistula), both resulting in urinary incontinence (Amodu et al. 2018). This medical condition which affects more than 2 million to 3.5 women under the age of 30 in Sub Saharan Africa, is caused by prolonged unattended obstructed labor due to physical constraints of a narrow pelvis, pressure, inhibition of circulation to vaginal tissues, and subsequent necrosis (Amodu et al. 2018).

Obstetric fistula is a major cause for public health concern in low-income countries and presents a major challenge to physicians in these regions. The condition results in high rates of maternal mortality, and social isolation. Nigeria records high rates of Obstetric fistula, accounting for half of the cases worldwide. In Nigeria, obstetric fistula is prevalent in the North Western region, due to the high population of child brides as well as subsequent child mothers, and it is a major cause of maternal and infant mortality (Amodu et al. 2018).

A typical example is given of a 15-year-old girl who was delivered of a stillborn baby after three days of labor. The prolonged parturition had created an injury, where the girl started leaking urine (due to a vesico-vaginal fistula). There are many such cases where the girl is unable to access cesarean section and therefore cannot deliver her baby safely (United Nations, 2017).

Socio-Cultural Effects

Child motherhood reduces the level of education attainment (Abayomi, 2018; Ngunen & Wodon, 2014). One major socio-cultural factor is the patriarchal system earlier mentioned, where a father's right over his daughter is transferred to an older male in the community for economic gains, to strengthen the family's social status and improve economic relationships (Sabbe et al. 2013). The patriarchy system encourages inhuman discrimination of women and children and promotes gender inequity. This culture restricts women's position in families by allowing differentiation in gender, where women and girls are placed as second citizens, and preferential treatment is given to men over women regarding education and inheritance. Domestic and sexual violence against women is allowed. The culture also encourages male dominance, and women are married out early to improve the family's socioeconomic status. The early marriage deprives young women of education and makes them lose self-esteem and self-confidence (Godiya, 2013). Child brides have more frequent unprotected sex than their unmarried counterparts because they do not have the right to say no. As a result, they are exposed to high risk of obstetric complications, including bleeding, obstetric fistulas, maternal morbidity, and mortality.

In a comprehensive study by region, Ariyo et al. (2017) conducted a retrospective analysis and evaluated the association between social and cultural issues concerning maternal mortality. Their analysis of these issues was based on the hypothesis that low socioeconomic status and gender inequality are associated with maternal mortality. The researchers identified cultural beliefs and attitudes, low educational attainment, inadequate antenatal, intra-partum, and post-partum care, as well as region, religion, and

the level of community women's education, as risk factors independently associated with maternal mortality across the sub-Saharan region. And the prevalence is high among Nigerian women. Women in Nigeria face inequities in education, income, and social standing, compared to men. The findings of Ariyo et al. (2017) also identified historical, religious, cultural, economic, and sociological factors, as issues that interact to keep the girl child at risk of child marriage.

The social and legal autonomy of women, education, income, and occupation affect women's access to health services, health-seeking behavior, reproductive status, and health status. The results of the study of Ariyo et al. (2017) confirmed that culture is a significant risk factor for child marriage and maternal mortality in this region. The researchers concluded that the status of women in their families and communities are risk factors for maternal mortality.

Institutional Effects

Access to maternity care is critical to improved maternal health status. Because of the negative experiences of teenage mothers earlier mentioned, young mothers find it challenging to access maternity care. In an in-depth study by Zuber et al. (2018) timely access to care was perceived as an essential factor to reduce maternal risk in middle-income countries. Most countries across the sub-Saharan region, including Chad, Niger, Mali, and Nigeria, have inequitable access to maternity care. In Nigeria, the alarming rate of maternal mortality was found to be associated with unequal access to maternity care, and the negative impacts of child marriage (United Nations, 2016).

To understand the relationship between access to maternity care and maternal mortality, Okwaraji et al. (2015) utilized Andersen's model of health services use and

found that child marriage and subsequently teenage motherhood has strong associations with access to maternity care and maternal mortality. Several issues including denial, poverty, lack of education, low socioeconomic status, are factors that may affect timely access to maternity care by young teenage mothers. The rural poor and less educated adolescent girls are the most vulnerable and at-risk populations for teenage motherhood and the associated complications. These young women do not deliver their babies in health facilities or the presence of skilled birth attendants. They do not have access to adequate antenatal or intra-partum care because they are not part of the decision-making process in their families (Ariyo et al. 2017). This absence of antenatal and intra-partum care can lead to delayed obstructed labor and other complications of childbirth, including fistula and death of the woman.

Experiences of Child Marriage Among Young Mothers

Motherhood is supposedly a joyful experience, but child mothers or teenage mothers undergo diverse harrowing experiences that make motherhood a painful encounter instead of the joyous feeling that should complement the birth of a child (Ngum Chi Watts et al. 2015). Because of the harmful effects of child marriage among young mothers during their prenatal, natal, postnatal, and postpartum period, earlier mentioned, young mothers find it difficult to cope with the challenges of motherhood. In a qualitative study to find out the lived experiences of African Australian refugee women who have experienced child motherhood in Australia, Ngum Chi Watts et al. (2015) found that the young mothers received good support from their mothers, siblings and close friends, but never got any support from the father of their baby and the wider community. The young mothers face resentment, shame, and embarrassment from the

community. This frustration affected their mental, physical wellbeing and life chances of teenage girls. This confirms the findings of Abayomi (2018) who noted that young mothers are denied the right to education and access to the school environment, thereby not being able to develop themselves and the community.

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

Positive Social Change

The implications for positive social change are to increase knowledge and awareness of the needs of young mothers and increase support from family members and the entire community. The results of this study may provide much-needed insights into the alarming rates of maternal morbidity and mortality, as well as the slow progress of achieving improved maternal health outcomes in Nigeria. Insight into this research arena will contribute to actualizing the development goals related to improved maternal health. By addressing the underestimated remote causes of maternal mortality such as the social and cultural factors (child marriage, extremely low age of marriage and subsequent early

pregnancy and early motherhood) that predispose the girl child to the multiple risk factors relating to pregnancy and childbirth, these goals can be met.

Summary and Conclusions

This literature review sought to describe the psychological, physiological, socio-cultural ,and institutional factors that contribute to the lived experiences of young mothers, as well as the effects of child marriage and teen pregnancy in young mothers ages 18-24 in Igu community in Abuja, Nigeria. The literature review showed that there are inequities in the progress of achieving the Millennium Development Goal No. 5, among countries in the sub-Saharan region. Most of the regions failed to make progress in reducing maternal mortality, while some nations made considerable progress. Young mothers are found to be mostly at risk. Several factors are responsible for this inequality of growth, such as early age of motherhood, inadequate access to maternity care, lack of utilization of maternal health care services, lack of social support, patriarchy, and poverty. Other factors were lack of financial and technical support from family and community members, low socio-economic status, social isolation of young mothers, which prevented them from seeking maternity care, and other health-seeking behaviors.

The literature also revealed myriads of effects of child motherhood and teen pregnancy, which include mental, psychological, and physiological disorders, such as frustration, inadequacy, depression, preventable diseases including HIV/AIDS, obstetric complications (fistulas, vulval adhesions), and death. In chapter 3, the methodology for the study is described, including role of the researcher, development of the instrument, data collection in Abuja, and issues of trustworthiness.

Chapter 3: Methods

Introduction

The purpose of this phenomenological study was to describe the lived experiences of women who were child brides and mothers at ages 12-16 years, during their prenatal, natal, and postpartum periods. This chapter also highlights the reasons for using a phenomenological design, as well as described the setting, sample size, the instrument of data collection, methods of data analysis, and protection of human participants and ethical concerns.

Research Design and Rationale

This phenomenological study used in-depth face-to-face interviews to explore the lived experiences of child brides and the maternal outcomes of young mothers in Nigeria. The study participants comprised up to 10 young mothers ages 18-24 years, who experienced life as child mothers between the ages of 12-16. The final sample size was determined by the point at which data were saturated. I repeated interviews to guide against inadequate data that could result in lack of saturation and inconsistency. Enough data was collected to establish consistency of themes, an understanding of the raw data by other researchers, as well as generalization and transferability of results to similar findings. Participants repeatedly said the same things. At that point I knew that data was saturated.

A phenomenological design with in-depth face-to-face interviews was meant to elicit information about the perceptions, attitudes, knowledge, and feelings of participants about their lived experiences. The interviews included open-ended and follow-up questions to enable young mothers to tell the story of their lives as child mothers. The interview questions were transcribed, and member checking was used to detect and

correct errors that may have occurred during transcription. Data was collected until all available participants were interviewed. I repeated interviews to guide against inadequate data that could result in lack of saturation and inconsistency. Enough data was collected to establish consistency of themes, an understanding of the raw data by other researchers, as well as generalization and transferability of results to similar findings. Participants repeatedly said the same things. At that point I knew that data was saturated. NVivo version 12 software (QSR International) was used to store data imported from audio transcripts, manage the data to identify nodes and themes, and to bring out rich and insightful descriptions of participants' views (Rudestam & Newton, 2015).

Research Question

What are the lived experiences of child marriage and maternal outcomes among young mothers ages 12-16 years during their prenatal, natal, and postpartum periods in Nigeria?

Role of The Researcher

As the researcher, I was responsible for all facets of recruiting participants, getting the research site, conducting interviews, and analyzing the data. Other responsibilities were to collate verbal responses and observe the nonverbal body language of participants. The interview process utilized the broken English that is commonly spoken by everybody including rural dwellers in Nigeria. This ensured the accuracy of data and understanding of questions by participants who could not understand the standard English language. As the researcher, I was solely responsible for the final interpretation and presentation of the results.

Methodology

Population and Setting

This study was conducted in Igu community of Abuja, Nigeria. The rationale for selecting this community was based on its proximity to the Federal capital of Nigeria where healthcare and maternity facilities are easily available, but the rate of death of young mothers is alarming. Igu community is a rural area where teenage motherhood is prevalent. The rate of poverty is extremely high and socio-economic status of women is low, with low levels of education.

Access to maternity care seems to be minimal. The paradoxical nature of this community, therefore, left a question in my mind, as to why the high rate of maternal deaths of young women in spite of the availability of healthcare services. Healthcare facilities are available but not easily accessible by young mothers. What factors are responsible for inaccessibility of healthcare facilities especially by young mothers? This study aimed to find answers to some of these questions.

The target participants included young girls ages 18-24 years at the time of the interview who experienced child marriage and were child mothers before age 16, in Igu community, Abuja, Nigeria. Purposive selection was used to select the participants, on the basis that they met both inclusionary and exclusionary criteria; and could provide rich information that made meaningful contributions to learning about the main issues associated with the study.

Sample Size

The planned sample was up to 20 participants. Although the recommended sample size for the phenomenological study is 10, up to 20 participants were recruited to

allow flexibility. Some participants failed to respond, while others declined participation in the course of the study. Participation was voluntary and flexible, and participants were allowed to decline at any point in the process (Rudestam & Newton, 2015). Eventually 10 participants were interviewed and the interviews were repeated until saturation was reached.

Several researchers have conducted qualitative and pilot studies with a varied number of participants. Atuoye et al. (2015) used eight focus group discussions involving 40 males and 45 females; Mumtaz et al. (2014) used 94 in-depth interviews, 11 focus group discussions, 134 observational sessions, and five maternal death case studies. This study utilized a sample size of 10 participants. This number accommodated a diverse and representative sample of the young women who themselves had experienced child marriage at age 12- 16 years.

Instrumentation

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

Data Collection

Data was collected through in-depth face-to-face interviews at a community center and a church. The church has a big hall as well as small rooms called the sacristy and confessional. These small rooms were utilized to enable participants have enough privacy and be able to speak freely about their experiences. The community center also houses an

external small room. This also was used to conduct the interview, to ensure privacy. Some participants were not allowed to come out to public places such as the Muslim women, and the researcher was not allowed entrance to their homes. These participants were excluded from the study.

Attention was given to the child mothers and open-ended questions were used, to enable an understanding of the psychological and socio-cultural factors that made up the lived experiences of young mothers (Appendix B). Open-ended questions allowed participants to tell their story without restrictions. In-depth interviews provided opportunity for participants to discuss their deep-rooted secrets whole-heartedly with all sincerity as much as possible (Ngum Chi Watts et al.,2015; Rudestam, 2015). The duration of the interview was meant to be between 45 minutes to one hour. However, some participants spent less than that time talking, and the rest of the time they were silent. NVivo 12 software was used to effectively manage and code the data.

Recruitment procedures. Participants were recruited through purposive selection. Researchers utilize purposive selection based on the research questions, to recruit experiential participants who can provide rich information to contribute meaningfully to the main issues associated with the study (Rudestam &Newton, 2015). Chain referral or snowballing was utilized to get participants whereby other participants referred their peers who meet the criteria. Eligibility for inclusion was based on whether they were between 18-24 years, were married at age 12-16, and gave birth at that age bracket. Participants who were above 24 years of age, were not included. In addition, those who were married between ages 12-16 years but were not mothers at that age were not included in the study. Gatekeepers of these communities including the community

heads, and church leaders, were contacted to grant permission and access to participants, as well as help distribute information to the community members about the study and identify participants for recruitment (Appendix D). Fliers were distributed in churches and community centers, while phone numbers were provided for contact.

Consent procedures. Each of the girls were asked to grant permission to be contacted again if necessary, to confirm some statements. The interview was recorded on tape with the consent of the participants. Probing questions were asked to allow participants to discuss important issues and accentuate their lived experiences as teen mothers, as well as to remove sentiments and any beliefs that I as the researcher held, to enable objectivity and meaningful data collection (Creswell, 2014).

Data Analysis

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

Validity and Trustworthiness

Validity in qualitative studies is the responsibility of the researcher to prove that the results of the study are based on a critical investigation, and the study is judged based on trustworthiness and credibility. One way to ensure validity is to provide credibility, transferability, dependability, and confirmability (Rudestam & Newton, 2015). In order to justify the claims of this study, the researcher ensured that the methods and conclusions could be trusted, and that the phenomenon under study was meaningful to further research.

There were no serious threats to the validity of the findings in the process of planning, data collection, and analysis, as well as interpretation. The researcher repeated interviews to guide against inadequate data that could result in lack of saturation and inconsistency (Rudestam & Newton, 2015). In order to forestall any issues relating to validity and trustworthiness of this study, enough data was collected to establish consistency of themes, an understanding of the raw data by other researcher, as well as generalization and transferability of results to similar findings. The entire process of the study was meticulously recorded so that future researchers can use it to recapture steps and reach new conclusions (Rudestam & Newton, 2015).

Issues of Trustworthiness. Qualitative research can be viewed from the standpoint of trustworthiness and credibility. Trustworthiness is one of the criteria for evaluating qualitative research. To develop trustworthiness, Lincoln & Guba proposed five criteria namely- credibility, dependability, confirmability, transferability, and authenticity (Cope, 2014). The technique of member checking was explored to improve

accuracy, credibility, validity, and transferability. This technique enabled the researcher to get feedback from participants.

Credibility. The researcher can enhance credibility by showing engagement, observation, methods, and audit trail. My experience as a researcher in this study is adequately described and findings verified with the participants.

Dependability. The researcher made certain that the data was constant under similar conditions. Other researchers can agree with the decision at every stage of the research process and replicate study findings with similar participants (Cope, 2014).

Confirmability. Quotes that represent emerging themes were provided from participants to demonstrate confirmability, and conclusions, and interpretations of data was drawn from these emerging themes (Cope, 2014).

Transferability. A qualitative study is said to have met the criteria of transferability if the results are meaningful to other persons not involved in the study and can be applied to their own experiences. As the researcher, I ensured that findings can be applied to other settings or groups (Cope, 2014).

Authenticity. Refers to the extent to which the researcher can demonstrate the ability to express feelings and emotions of participants' experiences in a dedicated manner (Cope, 2014). As the researcher, I faithfully expressed the experiences of participants to ensure the authenticity of this study.

In summary, trustworthiness in qualitative research can be achieved by demonstrating prolonged engagement with participants, observing persistently, ensuring triangulation or credibility (not manipulate data), establishing peer debriefing, member

checks, thick description, audit trail, negative case analysis, reflexive journalism and referential adequacy (Walden University, (n.d).

Ethical Procedures

It is imperative that researchers must act ethically when conducting a study. Any research involving human participants and vulnerable populations require strict compliance with the laid down ethical procedures, and researchers must adhere strictly to these steps to conduct a successful study. Ethical methods involve having an independent review committee to scrutinize the study to make sure that the ethical standards for the institution are strictly adhered to. The institutionalized procedures involve obtaining informed consent before starting all research (Rudestam, 2014). The necessary documentation was done before data collection, the researcher obtained a written authority from the Institutional Review Board, (IRB), and also from the site of the research. (Appendix G). The study conformed to the following norms and values, as proposed by Sieber and Tolich (2012), validity of the research, and competency of the researcher (Rudestam, 2014).

As the researcher, I made sure to get informed consent from participants, and that they come out of the research unharmed. It was anticipated that this study will carry some risks on participants, such as distress, upset and trauma, as a result of reliving unpleasant memories of their experiences. But the benefits of the study both for participants and the community far outweigh the risks. One of the most important roles as the researcher in this study was for me to ensure to provide some cushioning effect by introducing counseling on sensitive matters beforehand.

Summary and Conclusions

This qualitative study was conducted in Igu, community in Abuja, Nigeria. This community experiences poor maternal outcomes, in spite of the proximity to the Federal capital territory, and availability of healthcare facilities. The aim of the study is to explore the psychological, social, cultural, and institutional factors that constitute the lived experiences of child mothers during their prenatal, natal, and postpartum period in Nigeria. These experiences may pose barriers to access to maternity care, and subsequent negative maternal health outcomes. In-depth interviews were used as instruments of data collection to provide information from young women ages 18-24 years, who had experienced teenage motherhood. The results are presented in Chapter 4.

Chapter 4: Presentation of Results

Introduction

The central purpose of this phenomenological study was to explore the lived experiences of young mothers ages 12-16 years, during their prenatal, natal, and postpartum periods in the Igu community of the Federal Capital Territory, Nigeria. Purposive sampling was used to select 10 participants who were child mothers at ages 12-16 years. In this chapter, I describe the data analysis and present the results of the study. The study addressed the following research question:

Research Question. What are the lived experiences of child marriage and related maternal outcomes among young mothers aged 12-16 years during their prenatal, natal, and postpartum period in Nigeria?

Demographic Characteristics

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

This study was based on the need for a scientific inquiry into the world of young mothers who experienced motherhood through child marriage. The topic was so sensitive that several prospective participants changed their minds. Their immediate environment and society at large influenced their individual attitudes towards the study. The sensitivity level of the topic and study reduced the study's robustness. Member checking was used to validate findings and ensure the study's robustness. The qualitative data analysis software NVivo12 was deployed to conduct every facet of the analysis activity. Nodal classifications depended on the coding of text specificity to the contextual elements in the research question. Furthermore, participant responses to the individual interview questions provided an avenue to populate the nodes with conjunctive data pieces.

While answering the interview questions, the participants emphasized various phenomena to drive their points home. For instance, some participants demonstrated through body language, while others just remained silent amidst sobs, to show the magnitude of their emotions and feelings. Such instances were abundant, which seemed to point to their life-changing child-marriage experiences. NVivo12 was used to explore participant-by-participant presentations over the 10 questions. In the same vein NVivo12 was also used to explore question-by-question presentations. Table 2 presents the demographic characteristics of the 10 child mothers interviewed.

Table 2

Demographic Characteristics of 10 Child mothers interviewed

Participant ID	Age at marriage (years)	Current age (years)	Age at first motherhood (years)	Educational level	Number of children
CM01	12	20	12	Primary	4
CM02	14	24	15	Primary	3
CM03	13	24	13	No education	4
CM04	16	22	16	Primary	1
CM05	16	24	16	No education	4
CM06	16	24	16	Primary	3
CM07	14	24	14	Primary	3
CM08	14	24	14	Primary	2
CM09	15	24	15	Primary	2
CM010	16	24	16	Primary	3

Study participants

10 individuals participated in the study, and saturation was reached at this point. These 10 individuals served as participants because they experienced child marriage first-hand. The need and pledge to protect participant privacy helped to secure as much data as possible. This confirmation is important because of the apparent stigma with which the child marriage victims went about their daily lives. Therefore, every piece of data had meaning, especially also in the face of participants' emotional breakdown when the question for data was uppermost.

Data Analysis

Data were analyzed using the principles of phenomenology and Colaizzi's seven steps for data analysis, namely; (a) transcription of interviews; (b) extraction of

meaningful statements (c) articulating the meaning of each statement, creating codes and allowing themes to arise from the data; (d) aggregating the meanings into themes; (e) writing the description; (f) returning to participants to validate the description; (g) and incorporating new data into the final description (Colaizzi, 1978).

At the inception of my data collation, I listened to the audio recording several times, thereafter I transcribed all the interviews on word document. I read the transcripts many times to ensure that they corresponded with the audio recording.

Emergence of Themes

The analysis activity involved uploading data to NVivo12 data analysis software. The input-output sequence used the raw data arising from participant interviews. Figure 1 shows the NVivo12 pictorial output of the word frequencies of participant responses during the interview sessions. The word chart reveals words that were used most often.

Figure 1. Word chart of participants' response

The words that were frequently used by the participants appeared as words in large font sizes. The above word chart became a reference material to determine the veracity of emerging findings. Each time a clue emerged from the multiple input-output iterations, the clue is matched against the word chart to see which word and what font size represented that clue. The rigor engendered by this analysis activity was heightened by the sensitivity level of the topic and participant posture toward the release of sensitive private information.

A complete iteration specifically involved assembling, processing, dissembling, reassembling, reprocessing, and interpreting. Some of the small font size words turned out to be clues of larger phenomena in the psyche of the participant. Therefore, those small font-size words became objectives of several extra iterations during which the negligible word clues became clear as associated with some words in larger sized font. A confirmation of meanings constituted the completion of an iteration. After the software identified the frequently used words, I used Colaizzi's steps of data analysis to articulate the meaning of each category of statements, and created 9 themes, each with sub-themes. Later, I returned to participants to validate their descriptions, to confirm that that was what they meant. Based on the research question, the following nine themes were created; each is reported with their N-Vivo occurrence rate in Table 3.

Table 3

Themes and NVivo Assessing Scales

Order	Themes	Occurrences	
		N	%
1	Low Happiness Indices	65	2.69
2	Education Denial	62	2.57
3	Husband Dominance	61	2.52
4	Dehumanizing Confusing Experience	57	2.36
5	Poverty	45	1.86
6	Lack of support/Exposure to Telling and Doing	45	1.86
7	Forced Young Matrimony/Servitude	33	1.37
8	Complicated Pregnancies	31	1.28
9	Pressures on (and from) Parents	41	1.70

Evidence of Trustworthiness

In a qualitative study the researcher must prove the validity and integrity of the research. Evidence of trustworthiness is the ability of the researcher to demonstrate that the results of the study are accurate, based on a critical investigation, dependable, confirmable, and applicable to other settings (Rudestam & Newton, 2015). Lincoln & Guba (1985) proposed five criteria to demonstrate the trustworthiness of research and data findings, namely- credibility, dependability, confirmability, transferability, and authenticity (Cope, 2014). In order to ensure trustworthiness, I developed a 10 item interview guide with semi structured questions, followed up with probing questions, and then explored the technique of member checking to improve accuracy, credibility, validity, and transferability of my research findings. This technique enabled me to get feedback from participants, by engagement, observation, methods, and audit trail with participants.

Credibility. Using the conceptual framework as a model, I was able to gather credible in-depth information from participants, to further strengthen the quality of my findings. I engaged participants in one on one discussion and verified findings with them to ensure that they meant what they said.

Dependability. As the researcher, I made sure that the data was constant under the same conditions. The findings of this study can be replicated with similar participants, and subsequently, researchers can agree with the decision at every stage of the process.

Confirmability. Participants provided quotes that represented emerging themes, which led me to draw conclusions and interpretation. Thus, confirmability was ensured (Cope, 2014).

Transferability. In order to meet the criteria of transferability, I ensured that the findings can be applied to other settings. My data analysis revealed some unexpected results as some participants were happy to leave home and be child brides, not because child marriage is good in essence but because there were some factors that made them unhappy in their parents' homes. This implies that the situation of some child brides may vary depending on the circumstances in which they found themselves, and the demographic qualities. The probing questions generated answers that pointed to the fact that child marriage could be a better alternative in some other cultures and circumstances. This means that other persons not involved in the study may find the results meaningful and can apply the findings to their own circumstances (Cope, 2014).

Authenticity. This refers to the extent to which the researcher can demonstrate the ability to express feelings and emotions of participants' experiences in a dedicated

manner (Cope, 2014). As the researcher, I faithfully expressed the experiences of participants to ensure the authenticity of this study.

Thematic Analyses Results

Theme 1: Low Happiness Indices

Subtheme 1(a): All participants were unhappy. All the participants shared one thing in common: they were all unhappy with the situation in which they found themselves. The participants offered mostly varying explanations. Some participants skipped a question or two, but none of them missed the opportunity to reveal feelings of unhappiness. The pervasiveness of unhappiness among the participants created a need for a deeper understanding. That need found avenues in the exploration of feeling elements in the data across all interview questions. For example, Participant 1 said, “I was 12 years old. I was not happy.” In several instances, even questions that had nothing to do with feelings elicited the unhappiness theme. The plight of the child marriage victims stared them in the face every day, no matter what they were doing and how mature in age they had become. They had lost their dignity as women.

Subtheme 1(b): Some participants had feelings of regret and self chastisement. Child marriage affected their psychological and physical health.

Subtheme 1(c): For some, child marriage has redeeming features. In an unexpected twist, Participant 2 said, “I was happy”, which set a stage for extra probing. The participant explained, “My father is wicked. He does not talk to my husband. I am happy with my husband.” Therefore, the reason for a different twist to the ‘unhappiness’ theme became clear. When all stigmatized persons shared the same feelings (of unhappiness) hearing one claim to be happy was enough justification to probe, and the

result was that Participant 2 was fundamentally unhappy but found happiness in the unfortunate incident of early marriage. The now married participant said, “I was 14 years old. He (the husband) paid my dowry. I have support from him. I have 3 children now.” This drew a parallel between the participant’s father and the husband. Participant 2 reiterated, “I was happy.”

The situation of Participant 2 was unique as the only participant who held on to the one gladdening incident. The participant ensured to downgrade the pangs of child marriage and the wickedness of her father. In other words, she accepted it as the culture but jubilated that something changed her story – the rare occurrence of having a supportive husband when husbands in the child marriage world were mostly savage and exploitative of their victims. Accordingly, Participant 2 said regarding those who still lived in their parents’ homes unhappy, “If they are not happy it is better to go and marry.” When probed why she was happy, illiterate, when her age mates were in school, Participant 2 said, “My father was wicked to me. He refused to train me in school, and my mother was sick.” Explaining further she stated that she got married and her husband was supportive. She confessed, “He buys me clothes, and he buys for my children too.”

The participants did not miss any opportunity to touch on their unhappiness. Participant 3 said, “I was not happy.” They associated every facet of life with unhappiness. Participant 4 said, “I was not happy.” In fact, Participant 2 who confessed to being happy for a specific reason wound up at the situation that preceded her happiness. In other words, she was happy because something happened to her in the middle of her deep unhappiness. Participant 5 said, “I was not happy.” Without the experience of child marriage, these participants would probably not have known the kind of unhappiness they

faced. Therefore, their unhappiness was circumstantial. Participant 6 said, “I was not happy.” Happiness constituted a major theme, because of the way the participants uniformly talked about ‘unhappiness’. This consistency showed enough reason to recognize the ‘unhappiness’ theme. Participant 4 said, “I was happy,” which echoed Participant 2’s situation. Upon further probing, Participant 4 explained situations in her parents’ home that made her to feel happy when she first realized she was getting married. Even though her husband was beating her, she was still ‘happy away from home. In specificity, all participants but one made categorical condemnation of their plight by the way they projected the issue of lack of happiness. Participant 9 said, “Not happy.” Participant 10 said, “I was not happy.” Participant 7 said, “Not happy.” From data analysis outcomes, the participants chose the angle of lack of ‘happiness’ which is very close to ‘sadness’.

Subtheme 1(d): Delivering a baby brought happiness to a participant.

Participant 8 said that she had an accidental pregnancy. She expressed happiness that she delivered the baby with the help of a nurse. In other words, their plight constituted a clear harbinger of sadness, but delivering a baby brought her happiness. It was unclear if her happiness was limited to having a successful childbirth or extended to the fact that she received help from a nurse. Her unhappy situation was submerged in the birth of the baby.

Participant 7 said, “No support. No dowry. It was accidental pregnancy.” Participant 1 reported a critical health challenge for which her mother came to help her. Participant 2 said, “I was happy that I have my own home and my father will never come to disturb me again. My husband is supportive.” Again, this participant’s comments

showed that she became happy because she finally had her own home." Participant 3 said, "I was not happy." Participant 8 said, "Not happy. The nurse wanted to take me to the hospital, but my husband refused. Their choice of addressing their plight from the angle of lack of happiness was indicative of their desire for happiness. The participants elucidated the child wife predicament as characteristically saddening, and happiness only came from occurrences that were few and far between.

Theme 2: Education Denial

Subtheme 2(a): Child brides are denied the right to education. Participants were denied the right to education. Some child wives desired education while others were uninterested in the topic of education. Participant 2 said, "My father was wicked to me. He refused to train me in school, and my mother was sick." The norm is that education is not for a little-girl-turned-wife. Participant 1 said, "My friends are in school already. I only go to the farm and I carry load to the market to sell for my husband. Groundnut and Yams." According to the ruling authorities, a child wife who desires education is thinking 'evil' in the eyes of her owner. Participant 6 said, "I am an applicant. I did not finish my school and I did not learn any trade. So, I find it difficult to even feed myself and my children."

Child wives are deliberately denied education because it removes them from physical availability. Contrary to the child marriage custom, the girl child needs education to become free. Participant 6 said, "Marriage at young age is not beneficial because the husband will not support, and the wife need to finish her school or learn work so that she can feed her children and send them to school." The right to education does not exist in the world of child marriage. Participant 2 said, "My father was sleeping with

me. Because I refused, he stopped paying my school fees. So, I had to run away to get married." Some parents do not want to send any of their children to any school, how much more the girl child. In the case of Participant 2, a lender or benefactor had no hand in her exit from home. Participant 3 said, "School is good, but I left school." The world of child marriage is full of extenuating circumstances in which case a child who is already in school could leave school.

Subtheme 2(b): Some participants hate education because of past bad school experiences. Participant 2 said, "My father was violating me. And I hated him up till today. I hate school now because he was always sleeping with me before paying my school fees, so I do not want to go to school again." The culture of a people influences the things they do in different situations." Participant 5 said, "I did not go to school. So, I cannot work. No money only farm work." Denying a child wife education as she grows is a way to ensure she does not know how to respond to life and living.

Subtheme 2(c) :Uneducated child wives suffer physical and mental health challenges. Education is viewed as a Western phenomenon; hence the expression 'Boko Haram' (meaning Western education is forbidden). Participant 4 said, "They will suffer if they don't go to school. The people that went to school are working. Their husbands do not beat them. But if he 'give her belle' (meaning if he impregnates her), she will stop school." When a girl child becomes a wife, her chances of going to school disappear. Participant 5 said, "Not beneficial at all. School is good." If specific people group despises education, then, they would not allow their children to be educated; that mindset controls everything else the said people group would do. The outcome is backwardness. Participant 3 said, "I wanted to go to school but I made a mistake. Now no money. I want

to work." Child wives also suffer serious health challenges arising from lack of education on the part of their parents, new owners, and handlers (husbands).

Theme 3: Husband dominance

Subtheme 3(a): Child wives are either slaves or house helps. Societies have principles they subscribe to; some societies are husband-driven. Men must have wives and, sometimes, multiple wives without regard to exactly how many the wives are. Participant 5 said,

> I was not happy. Nobody is caring for me. My parents only told me that I was going to do house girl work. But when I went there, I found out that I was married. He has four wives. So, the senior wife is the one taking care of me. She was the one who came to carry me from our house.

Slaves and child wives do not receive any respect. Participant 6 said, "I did not deliver in the hospital." The child wife can be sent on any kind of errand. Child wives often become objects of ridicule in the new families they find themselves. Societies have principles they subscribe to; some societies are husband-driven. Men must have wives and, sometimes, multiple wives without regard to exactly how many the wives are. Because of the prevalence of child marriage in some cultures, every male wants to have a wife, and that is often for the wrong reasons. Participant 5 said, "I have four children now, but I am not working. I cannot feed them. Husband is not bringing money."

Participant 5 said, "Nobody is caring for me. My parents only told me that I was going to do house girl work. But When I went there, I found out that I was married. He has four wives".

Participant 2 got married and said of her husband, “He buys me clothes; and he buys for my children too.” Participant 4 said, “I received ante-natal care. My husband took me to the hospital. I delivered there.” Husbands are respected; and so, even some young men who have not yet attained adolescence sometimes aspire to have their own wives so as of show off their ascension to the class of men.

Subtheme 3(b): Child wives suffer untold hardship. Participant 6 said, “I suffered so much. I cannot event relate everything I passed through. My husband was hostile to me because he was not yet ready to marry, but I was forced to marry him because he impregnated me by accident.” Participant 6 said,

> I am an applicant. I did not finish my school and I did not learn any trade. So, I find it difficult to even feed myself and my children. Life is unbearable. No money no food, no clothes. My husband only comes to me when he wants another child. I have 3 children now.

Subtheme 3(c): Husband dominance leads to childbirth complications. Participant 8 said, “I had prolonged labor because my husband wanted a female Muslim Doctor to attend to me.” In the child marriage world, the husbands do not care about the issue of children or the health of the wives. Some of them might be merely interested in sex, child trafficking, or other ills associated with child marriage. Participant 2 said, “My father is wicked. He does not talk to my husband. I am happy with my husband.”

Theme 4. Dehumanizing/Confusing Experience

Subtheme 4(a): Most participants are deprived of positive human qualities by their spouses. Maltreatment, beating, incarcerating, punishing, and taunting are some of the ills that befall a child wife. Participant 4 said, “I have my own home. But my

husband is always beating me." The 'owners' of the child wives do anything they wish to the 'wife' with impunity. Participant 4 said, "But my husband is always beating me. He does not bring money for food. He always goes out to drink." Those children who become wives do not experience normal life, as their husbands view them as property. Participant 4 said, "You go to farm and come back. Husband is beating. He is carrying another girl who is going to school. Enslavement is common in the child marriage environment. Participant 1 said, "My friends are in school already. I only go to the farm and I carry loads to the market to sell for my husband." Participant 4 said, "They will suffer if they don't go to school. The people that went to school are working." Their husbands do not beat them. Dehumanization of a child wife can come in any form, expected or unexpected. The way husbands and their relatives treat their child wives show they have no regard for the human beings.

Subtheme 4(b): Every passing day has its surprises; victims of child wives face unexpected negative events. Child wives do not have the capacity to stand up for themselves. Passersby do not intervene when a girl child is being chastised or punished because they simply assume she is either a slave or wife. Participant 2 reported that her father was sleeping with her, and she had to run away. Child wives are castigated at the slighted opportunity, even without any provocation. Child wives are maltreated often for sport.

Subtheme 4(c): Child wives suffer rejection. Participant 8 reported that because of her extreme bad health, her husband does not want her anymore." Children who are sent away from their families suffer shameful fate in the hands of their new handlers. Participant 6 said, "I felt rejected by everybody. My parents rejected me that I

disappointed them, and they forced me to marry the boy that gave me pregnancy. The boy rejected me and denied that he was not the one responsible. He drove me away but later his mother brought me back. He did not show me love. He was always beating me so that I would go, but I had nowhere to go to since my parents drove me away. I wanted to kill myself."

Participant 3 was married off to a boy who had gotten her pregnant. When he ran away, she was blamed. "The boy ran away. He said he is not responsible for the pregnancy. My parents took me to his parents, but they sent me back. The boy rejected me. My parents have rejected me. But I am still living with them."

The culture of respect comes with the posture of the controllers and the controlled. Participant 3 said, "The boy's parents did not want to see me. They sent the boy away. Up till now I have not seen him. I don't know where he is. I am living with my parents."

Theme 5: Poverty

Subtheme 5(a): Child wives are used as collateral for loans and other goods.

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

sacrifice their female children to make sure the male children are sent to school. When girl child becomes a wife under the circumstances of parental poverty, the child-wife has little or no value to the lien-holder glorified as husband. Participant 5 said, "I was only 15 years old. My father said I should go and live with him because he does not have money to pay back the money he received from the man." In several instances, a girl child would not know that she was getting into marriage. Participant 9 had a similar story that she became pregnant. The man who impregnated her did not pay any dowry. **S**ome men want to have one or more wives in order to show off affluence – they lend money to poor families and receive their girl children.

Participant 2 said, "I was happy that I have my own home, and my father will never come to disturb me again. My husband is supportive." A husband may be merely satisfied that the neighborhood people know him as a husband with one or more wives, even though those wives are under-age children. Participant 8 said, "I almost died. The nurse wanted to take me to the hospital, but my husband refused."

The need for money was not abstract. The participants explained that money was needed for basic needs like food, clothing, and other critical items a female would need for daily living. When a girl child leaves her family to transition to the family of her father's friends or neighbors, the child already has a stigma, coming from a poor family.

When a girl child becomes a child wife, the poverty stigma often stays with the child because the new families often decide that there is no need to spend on the child wife; after all, the child did not experience money while with her parents. Therefore, it would be a waste to treat the child well. Consequently, many child wives continue in want and penury throughout their married lives. Child marriage in Nigeria is affected by

cultural norms, religion, and poverty (UNOHCHR, 2013). Participant 1 said, "I want to work and earn money. No work. I want to learn tailoring." Under money challenge circumstances, individuals often take regrettable decisions. Participant 5 said, "I did not receive any ante-natal care. My husband refused to provide money for maternity visit, and I delivered at home." Families taking in a child from a poor family often treat the child with spite and levity. Participant 7 also suffered the same fate as Participant 5 in ante-natal care. She was denied financial help. She was unable to utilize hospital services and ended up having her baby at home. Participant 1 said, "My parents supported me. My husband gave me money to register in the hospital, but he was disturbing me too much." While it appeared money was available, the attendant disturbance was undeniable.

Theme 6. Lack of Support and Exposure to Telling and Doing

Subtheme 6(a): Child wives do not receive support from spouse or community. Participant 6 said, "Marriage at a young age is not beneficial because the husband will not support, and the wife needs to finish her schooling or learn work so that she can feed her children and send them to school." Participant 10 said, "No support from husband or parents" that made marriage an easy respite, no matter how inconvenient and risky. Participant 6 further said: said,

> I did not receive any support. I suffered so much; I cannot even relate everything I passed through. My husband was hostile to me because he was not yet ready to marry, but I was forced to marry him because he impregnated me by accident. Nobody supported me. I went to do house-girl job for one woman, but when she discovered that I was pregnant, she sent me away. I suffered.

Participant 6 who already accepted the fate of being married addressed her healthcare challenges said, “I did not receive any support. My parents were not happy.” Her parents were unhappy that even after she had become someone’s wife, she was not receiving enough care. Participant 7 said, “No money. Only the Rev Father gives us food and clothes. No support from spouse or parents.” Participant 9 said, “I just got pregnant. No dowry. My parents are annoyed; so, they are not supporting me.”

Circumstances beyond the control of parents often compel them to send their little girl children into forced marriages. Participant 2 said, “My father did not support me. But my mother came to stay with me when I delivered. My husband gave me money to register in the hospital.”

Subtheme 6(b): Lack of support leads to feelings of confusion. Child wives experience a feeling of confusion, not understanding what is going on or why they have to leave home. Participant 3 said, “I was confused, and I did not understand why this was happening to me.” When a little girl moves into a strange home, she may not know that she is turning into a wife or sex tool. There might be instances where a man might begin to appreciate the child wife, but that is rather uncommon. Participant 3 said, “I was doing very well in school, but I lost my father and my mother could not pay my school fees.”

Subtheme 6 (c):Child wives are Exposed to Telling and Doing. The job of the girl child is to obey and do everything that is whispered, spoken, or screamed into her ears. The culture of respect comes with the posture of the controllers and the controlled. Participant 3 said, “The boy’s parents did not want to see me. They sent the boy away. Up till now I have not seen him. I don’t know where he is. I am living with my parents.” Participant 1 said, “I was crying. My parents sent me to him because he impregnated me.

I wanted to go to school but my mother said I have spoilt my school so I should follow him." Followers have only one thing to do – obey.

Participant 6 said, "It was an accidental pregnancy. I was only 14 years old, and I was forced to go and live with him because my parents were angry." The higher echelon individuals tell the lower ones what to do. Participant 7 said:

> I had no option. If they tell you to follow a husband you cannot argue. My parents had already collected money from him and paid my brother's school fees. If I ran away they would say I don't want my brother to go to school.
>
> The lower echelon people simply do what they are told to do.

Theme 7: Forced Young Matrimony/Servitude

Subtheme 7(a): Many girl-children are forced into becoming home-makers. Matrimony is desirable across the cultures within the demographic; however, the reasons are often different from culture to culture. Parents who are financially incapacitated often force their little girls to go and live with other families. Young girls become wives when they are not ripe for matrimony. Participant 5 continued, "Baba is not my father. He is my husband. His daughter comes to give me food for my children. Participant 1 said, "I was crying. My parents sent me to him because he impregnated me. I wanted to go to school but my mother said I have spoilt my school so I should follow him." Participant 1 said, "I did not fall in love with him. He got me pregnant then I was forced to marry him." In several instances, the girl child could become pregnant and would not know why her belly is shooting out. Girl children who are forced into marriage face double trouble in that their parents, in some cases, are behind the forced marriage; the receiving husband is the beneficiary.

Participant 8 said, “I had an accidental pregnancy. ” The pressure on the girl child arising from forced marriage is difficult to handle because of lack of supporters. Imposed matrimony continues to affect the health and wellbeing of the affected children. When accidental pregnancies occur among grown girls, the society considers the incident terrible. Participant 6 said, “It was an accidental pregnancy. I was only 14 years old, and I was forced to go and live with him because my parents were angry.”

Theme 8: Complicated Pregnancies and Birth

Subtheme 8(a): Many child wives develop health challenges that lead to complicated pregnancies and birth. Pregnancies occur among girl children mainly in specific cultures that practice child marriage; therefore, the pregnancy of a child does not draw much attention as a problem. However, these pregnancies often result in severe complications including obstetric fistulas and death. Participant 6 said,

> I am no longer healthy. A lot of things have changed**.** After having my third child they discovered that I was positive. And my husband drove me away again. I also have a big tear; (fistula), but I don’t have money to go the center for treatment. My husband has married a new wife. He does not care for me and my children.

This participant became HIV positive and also developed obstetric fistula.

Some extreme events occur in the lives of the girl children leading to (or caused by) early marriage; pregnancy is one of such events. Some child wives become pregnant at unbelievably tender ages, and their parents do not care because their children have become wives. Some child pregnancies lead to severe sicknesses. Participant 8 reported having such early pregnancy. Participant 7 also reported having an accidental pregnancy. Some child pregnancy victims suffer from severe sicknesses. Participant 6 said:

> I did not deliver in the hospital. I had a big tear and it has not gone because I got pregnant again two times and I have 3 children now. Although I started loving the child later even though I do not have money or food for them.

While girl children might be under-age and not ready for pregnancies, some of them have been biologically altered because of forced early sexual experience. Participant 9 said, "It was accidental pregnancy. He did not pay any dowry." These early pregnancies may not be rampant but each of the events spell extreme problems on all persons connected with the child. Participant 3 said, "The boy ran away. He said he is not responsible for the pregnancy. My parents took me to his parents, but they sent me back." When pregnancy occurs with a child wife, the situation is characteristically unusual and would require extra caution. Child marriage is, therefore, often a direct route to child pregnancy. Participant 9 said, "I just got pregnant. and my parents are not supporting me."

Theme 9: Pressures on and from Parents

Subtheme 9(a): Parents transfer pressure to their girl children. A family that is experiencing hard times would, in the context of this study, hand over its little girl to go and live with another family. Some girls become slaves. Others become wives. There is a lot of stress on all parties, caused by pressure on all sides- financial pressure on parents, psychological stress on men showing masculinity , and physical and emotional stress on the girl child, of being sold out into slavery, physical stress of giving birth at a tender age, and eventual health complications , STIs, HIV/AIDS, fistula, and death.

Subtheme 9(b): Many child wives are under pressure to marry and give birth. Participant 6 said, "I was only 14 years old, and I was forced to go and live with

him because my parents were angry." Pressure from friends and neighbors are often manageable, but when the parents begin to mount pressure on the girl children, the pressures are usually overbearing. The girl child suffers the dual effect of pressure – pressure on parents and pressure from parents. Some parents borrow money from friends or neighbors. The parents may give out their little girls as their first step.

Some participants explained that their parents were mounting severe pressure on them. In some instances, a girl is mortgaged over to a creditor, and since the debtor is unable to redeem the debt, the girl child becomes a wife or even a slave-wife. Participant 7 said, "I had no option. If they tell you to follow a husband you cannot argue. My parents had already collected money from him and paid my brother's school fees." Parents who are unable to withstand the pressures succumb to the mouth-watering loans or gifts whose main purposes would be to get hold of the girl child from the emasculated family. When the borrower fails to pay, and the lender is mounting severe pressure, the borrower gives something; usually in that culture within the demographic of this study, the collateral would be the girl child. Participant 1 said, "I was crying. My parents sent me to him because he impregnated me."

The parents may be facing financial and other possible pressures. Participant 1 said, "My parents supported me. My husband gave me money to register in the hospital, but he was disturbing me too much." Participants narrated the untold pressure on their parents.

The pressure parents face could sometimes be related to the need to send their boy child to school. Participant 10 said, "No support from husband or parents." When things

became difficult in the family, the parents exhibited a negative attitude toward the girl children as if the problem were caused by the girls.

Summary And Conclusion

In this chapter I presented the demographic information of participants, and the themes and sub themes that emerged from the analysis., including evidence of trustworthiness. The lived experience of child brides became clear from participants' comments. NVivo12 explorations helped to organize the data and develop codes as well as categories, while I used Colaizzi's steps of data analysis to express the meaning of each category of statements. The study results supported the study research question with 9 themes and several subthemes.

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

Chapter 5: Discussion, Conclusions and Recommendations

Introduction

The purpose of this phenomenological study was to describe the lived experiences of women who were child brides and mothers at ages 12-16 years, during their prenatal, natal, and postpartum periods. My goal of using a phenomenological approach was to examine the lived experiences of child marriage among young mothers, and to develop rich insightful descriptions of the perceptions, attitude, knowledge, and feelings of participants about the lived experiences that affect these young mothers .I collected data through in depth face-to-face interviews with 10 young mothers in Igu community in Abuja, Nigeria. I identified principal themes and sub themes relevant to experiences and feelings of these child mothers.

I designed open-ended interview questions and pliable follow-up questions to draw in depth responses from the young mothers as well as to talk about their deep-rooted secrets and experiences as child mothers as whole-heartedly as possible (Ngum Chi Watts et al., 2015; Rudestam, 2015).

The research question was as follows: What are the lived experiences of child marriage and maternal outcomes among young mothers aged 12-16 years during their prenatal, natal, and postpartum periods in Nigeria? I used the social-ecological model as the theoretical framework to guide the study to engender deeper comprehension of the life and times of the child brides in the context of the patrilineal society. NVivo12 was instrumental in identifying key indicators of the child marriage culture given that the phenomenon affects not just the child bride, but also the bride's husband, the bride's father, the bride's mother, and middlemen.

Interpretation of Findings

Based on the findings, the participants had one thing in common: the trauma of forced physical and locational move and psychological transition. These child mothers who are plagued with physical and psychological injuries, such as obstetric fistula, experience a broad sense of loss that damages their identity and quality of life (Zuber et al., 2018).

Among the myriad negative outcomes were loss of happiness among the victims, denial of educational opportunities, and loss of voice in a society that revolves around husband figures. Furthermore, Abayomi, (2018) observed that the utter disregard for girl children is extreme to the extent of dehumanization. Poverty, servitude, and subjugation are all a part of these girls' daily existence. Child marriage is mostly the only option in the demographic of this study.

Unexpected and complicated pregnancies are common among child brides who are not yet fully developed. Severe pressure affects all parties as husbands scramble to satisfy diverse obligations associated with trading on the girls.

Low happiness indices. The lived experiences of child marriage could become evident through comprehension of those diverse situations. Because of the visible maternal outcomes among young mothers, critical consideration became necessary (Msele & Kohi 2015). Victims of child marriage are characteristically unhappy. The victims experienced sudden loss of the happiness they knew while in their family homes, no matter how poor their families were.

The participants constantly referred to the trauma associated with sadness. They talked about how lonesome they were. The participant responses that dealt with

loneliness created impressions of hopelessness. The victims were afraid of the unknown. In other words, there was no telling in most cases who would come to harass the child bride; it could be her husband, father-in-law, mother-in-law, brother-in-law, or some random person in the vicinity. The child bride is prey to all forms of societal vulturine. Being unable to imagine what the next experience would be the child bride's life was filled with fear of the unknown. They were in no position to predict anything. Good and bad events would take place in quick succession. There was no way to know which one was going to occur. Evidence from the literature revealed that child brides are unable to predict the temperament of the husband or any other kinds of girl child owner (Ariyo et al. 2017). Also, Ngum Chi Watts et al. (2015), noted that the inability of child brides to predict their husbands' temperament created feelings of unhappiness, loss of dignity and psychological trauma in the girl brides. This study confirms the findings of earlier studies, as participants were not happy, and had feelings of regret and self-chastisement.

Victims of child marriage and all parties in the incidence do not show signs of happiness. In other words, the child-wife is unhappy; the parents of the child bride are unhappy; the husband of the child bride is unhappy; in certain situations, parents of the young husband are unhappy. This happiness element is contra-indicative in the sense that some of the individuals might be exhibiting behaviors seeming to be happy. The findings of this study also confirms the findings of Ariyo et. al. (2017). However, each party has an element in the episode that is internally concerning. That element is internal to the individual, and no other party may feel that concern.

Most child brides are unhappy to find themselves in the home of strangers where they experience changes in their bodies that they never knew anything about. Several

young husbands might beat their chests to have become husbands, but unhappy about a load of responsibility especially associated with pre-natal, birthing, and post-natal care. An example is seen in the response of one of the participants that her supposed husband absconded from home and the child bride does not know his where about up till the time this data was collected.

Okigbo et al. (2017), reviewed evidence from the literature that support the urgent need for an increased need for maternal health care to focus on vulnerable people if maternal health is to be improved in Nigeria.

Many parents of the child bride, while happy that care for the girl child has become the job of someone else, are unhappy that they were unable to raise their daughter at home. Many parents of the young husband are unhappy about raising another child in the name of a daughter-in-law.

The lived experience of child brides could be summarized as deeply unhappy and disempowered. Participants in this study felt a loss of dignity and social standing. These support findings of earlier studies by Fasha et al. (2018), who observed that child brides feel a broad sense of loss of body control, loss of social role as a woman, loss of dignity, loss of integration in social life, and loss of self-worth .All parties in the child marriage phenomenon are unhappy, each for his or her specific reasons. For instance, health risks facing the child brides contribute to their unhappiness and that of the people immediately around them. The child brides in this study expressed their unhappiness for different reasons. This finding supports the earlier findings by Okigbo et al. (2017).

However, contrary to findings of earlier studies that child brides are always unhappy, this study revealed that child marriage has some redeeming features. For

example, for some participants the feeling of unhappiness was engulfed by a sudden twist of happiness after the birth of a baby. One participant felt happy after leaving her parents' house because her father was 'wicked' and was violating her. In some instances, the birth of a child brings a turning point in the life of the young mother. That turning point is only known after the birth as the husband could react in either direction. If the husband feels happy that a child is born, then, the wife will begin to live a normal life. On the contrary, if the husband got disappointed because childbirth would disrupt whatever was his original agenda, then, the new mother and baby would begin a new journey into difficulties.

Education Denial. Participants in this study reported that they desired education but were denied by parents and husbands. Participant 2 said, "My father was wicked to me. He refused to train me in school, and my mother was sick." Denying a girl education renders that girl handicapped in several ways. This confirms the findings of Heller and Hannig, (2017), in the literature who noted that child brides are denied the right to education and access to the school environment, leading to the lack of development for themselves and the community. According to Heller and Hannig, (2017), denying young people education is a major error in human development. This error is evident in the perpetration of child marriage. This confirms earlier findings in a study by Shrivastava et al. (2017). These researchers found that a girl child that receives education will be able to identify choice options in life and make appropriate health decisions for herself. Therefore, denying a girl child an educational opportunity to learn how to read and write is a major dent to the child's future prospects. Education denial is, therefore, harmful to all children, especially those girl children herded into infant matrimony. Education denial

thus occurs like a sentence passed on them like they were offenders of sorts. The need to educate the girl child becomes even more important in the face of outcomes already recorded from forced child marriages. Wodon et al. (2017), in the literature reinforce this fact as they suggest that when young adolescent girls are equipped with information on life skills and knowledge, they are better prepared to make decisions concerning their health and future (Wodon et al. 2017).

This study reveals that uneducated child wives do not have any aspiration; they take life as it comes each day. The absence of education ran parallel to their plight obviously unknown to them. Participant 1 said, "My friends are in school already. I only go to the farm and I carry load to the market to sell for my husband."

However, there is a twist in the interest in education, contrary to the fact that child brides are denied the right to education. Some participants in this study expressed hatred for education because of what they have to pass through to go to school. Participant 2 said, "My father was sleeping with me. Because I refused, he stopped paying my school fees. So, I had to run away to get married." And I hated him up till today. I hate school now because he was always sleeping with me before paying my school fees, so I do not want to go to school again." This finding is in line with findings of earlier studies in the literature. Abayomi, (2018), mentioned that the abduction of girls from schools causes an abrupt end to their education in Nigeria and regions with armed conflict. Girl children in these regions develop hatred for school for fear of being abducted (Abayomi, 2018). Thus, while majority of child wives are denied the right to education, some others prefer to go into marriage and own their home and forget about education, because going to school will cause them more misery.

Husband Dominance. The culture of a people group goes a long way in setting expectations for such people. The child bride in this study is from a geographic region where child marriage is commonly accepted as the way of life. Child brides had no voice in a society that revolved around husband figures. In that culture, husband mentality rules. The male children are often expected to get married very early in life. Thus, adulthood often comes upon teenage boys who may not have been prepared for that role. This implies that both the girl child and the boy child are victims of child marriage. Participants in this study mentioned that they are sent to be house helps and later turn to wives. Participant 5 said, “I was not happy.” Nobody is caring for me. My parents only told me that I was going to do house girl work. But when I went there, I found out that I was married. He has four wives. So, the senior wife is the one taking care of me. Child wives are, at best, trainee wives and mothers. Participant 5 said, “The senior wife but I call her mama because she is the one who is taking care of me. Marriage experience is unpredictable in the life of a girl child.

The cultural ruler-ship of the male figure is, therefore, nothing short of male dominance. A husband thus begins from a tender age to rule over a wife. As they both grow, the man is traditionally influenced to marry more wives, especially if the man is growing economically. Poverty in the land would persist because the children who should become educated and contribute to the development of the land became wives while still children. With such poverty, more parents would continue to funnel their girl children to young men who appear to be financially blessed. The findings of this study confirms findings of earlier studies by Onwuluebe (2019), who noted that the patriarchal system encourages male dominance, through a system of arrangement into groups based on

gender, in order to provide material advantage to men, and at the same time, place severe constraints on the roles and activities of women. (Onwuluebe, 2019).

The male dominance culture creates a system of husband primacy. The importance of husbands continues to drive the actions of young men (who are, at best, boys) and their parents who support bringing in a child bride. This craze is not because of the desire for child brides but because of the belief that their girl child might also become a young bride to some young man (Amodu et al. 2018). Therefore, supporting their young boys to become husbands aptly consoles the families for the inevitable loss of their girl children to other young boys who are also becoming husbands (Amodu et al. 2018).

Child Wives Suffer untold Hardship. The participants reported that they suffered so much. Participant 6 said, "I suffered so much. I cannot event relate everything I passed through. My husband was hostile to me because he was not yet ready to marry, but I was forced to marry him because he impregnated me by accident. I find it difficult to even feed myself and my children. Life is unbearable." Husband have been extensively labeled in charge in the male-dominated cultures including the demographics of this study where child brides are rampant. When men are definitely in charge, females are often unhappy. The research question was as follows: What are the lived experiences of child marriage on maternal outcomes among young mothers aged 12-16 years during their prenatal, natal, and postpartum period in Nigeria? The lived experiences of child brides include submission to husbands. Considering that some husbands are kind while others are cruel, the plight of a cruel husband's wife is doubled by the fact that submission comes with a hard labor sentencing (Osok et al., 2018).

Osok et al. (2018) reviewed evidence in the literature that supports the untold hardship that child wives experience, sometimes due to the viciousness of husbands. Husband dominance leads to severe complications of childbirth, including prolonged labor, obstetric fistula and even death. One of my study participants reported that she had prolonged labor because her husband wanted a female Muslim doctor to attend to her. In the child marriage world, the husbands do not care about the issue of children or the health of the wives. The effect of cruelty on the part of husbands heightens the victim's plight.

Dehumanizing/Confusing Experience. Participants in this study experienced psychological trauma, shame, fear, anger, and resentment all through their prenatal, natal, and postpartum period. This confirms the findings of Okigbo et al. (2017), Osok et al. (2018) in the literature. Child wives are constantly dehumanized and exploited for sex or trafficking. Child labor, sexploitation, trafficking, and pledging make some of the girls to fall into the hands of multiple owners. This multiplicity often comes with harrowing sex experiences that sometimes cause weird illnesses on the part of the girl brides (Amoudu et al. 2018). These different conditions constitute the dehumanization of the girl bride. Interpreting the dehumanizing element involves combining the bitter with the sweet in the sense that some young boys want to brag that they have wives.

Some of such boys sometimes battle with the pains of caring for the outcomes of motherhood. Some mature adults also scheme to get child brides Some husbands have an insatiable appetite for wives and get new wives at the slightest opportunity, provocation, or borrower approach. Wives so acquired stand the chance of facing dehumanizing acts.

The meaning is that several girl brides are facing harsh living conditions in their different households and cannot complain because the culture mandates the matrimony.

Evidence from the literature reveal that while the culture dictates the acceptability of child brides, the dehumanizing experience facing the young brides remain inexplicable. Utter disregard for girl children to the extent of dehumanization became the way of life, even if the child was crying, pleading, or otherwise demonstrating her disagreement. The irony of embracing the culture of child marriage and making a child-bride's life unbearable remains a mystery (Fasha et al. 2018).

A child bride is often viewed as second-hand or secondary in all things. A person with the profile of secondary or second-hand is restive. The research question was as follows: What are the lived experiences of child marriage on maternal outcomes among young mothers aged 12-16 years during their prenatal, natal, and postpartum period in Nigeria? A secondary individual is relegated to the background in virtually everything. Degrading and dehumanizing words and deeds are hurled at the child bride because she hardly has anyone for plead her cause. Some participants in my study revealed that they were constantly beaten at the slightest opportunity and deprived of positive human qualities. They suffer rejection and face unexpected negative events. Participant 4 said, "I have my own home, but my husband is always beating me." This corroborates evidence in the literature by Amoudu et al. (2018). Considering that the child bride is living a life at the will of the owner, holder, or handler, she will be receiving inhuman or rough treatments (Amoudu et al. 2018).

Poverty. In this study, some participants reported that they were used as collateral to lend money from richer people, who later became spouses to them when the parents

could not pay back the loan. One of the participants in this study said, “I was only 15 years old. My father said I should go and live with him because he does not have money to pay back the money he received from the man.” This is in concurrence with previous studies and evidence from the literature by Godiya, (2013), which showed that a father can give out his daughter in exchange for money, farmlands, or other economic gains. And when the parents cannot pay back, the girl child becomes a wife to the older male in the community (Patriarchy). The patriarchal system earlier discussed in the literature allows girl children to be forced into marriage where they are regarded as chattels without any rights. They have more frequent unprotected sex because they do not have the right to say No (UNOHCHR, 2013).

Some parents believe that their girl children would be economically safe in the hands of a rich husband. Such poor parents approach the rich for small loans that might be difficult to pay back. In the event of such repayment failure, the girl child given as collateral becomes wife to the lender. In several instances, the lender presumes borrower incapacity to repay and immediately begins to treat the collateral as an acquired asset.

Poverty may be a result of money challenges. However, an individual may face money challenges and still not be poor. This concept is, however, dependent upon various factors that are outside the scope of this study. Money challenges are specific to the study and deserve specific attention. Poverty appeared to be the only lot apportioned to the girl child. Child marriages are traceable to different phenomena (Meurice et al. 2016). Poverty is one such phenomenon. Families facing money challenges may not be poor but unable to solve certain problems arising from money challenges.

Therefore, the issue of money challenges is interpretable as factors contributing to child marriages. When a family is unable to pay certain expenses, such a family may still live without any emergencies. However, when certain financial challenges occur that must receive due and urgent attention, giving out a girl child to a family with the requisite amount needed may become the only way out Meurice et al. 2016). When this kind of situation arises and the problem is solved through child marriage, the girl's family may be generally described as poor; however, the family's specific situation was not describable as poverty but an emergent money challenge.

If families were not money-challenged, their culture would still enslave them in child marriage. The attraction for child brides has, therefore, given rise to child trafficking in which case financially endowed individuals within the subject demographic had the choice between getting a child-bride or engaging in the arbitrage (Abayomi, 2018). The contextual interpretation of money challenges draws attention to the urge to exchange a girl-child for money (on the part of the have-nots), the urge to get married (on the part of child-bride seekers), or the urge to be middle-man trafficking in child-brides. All these scenarios may be ascribed to money-challenges.

Parts of Africa such as Mali, North West Africa, Cameroon, and Central Africa parade the child marriage phenomenon (Efevbera et al. 2019). With these countries bordering Nigeria, one would not look too far to see why pockets of demographic areas in the Islamic North of Nigeria also parade the phenomenon. While money challenge readily implies a lack of money, money challenge, on a higher thinking level, is also the challenge (on the part of a financially endowed individual) of pursuing child-bride

trafficking specifically because of the availability of money, which is the main factor preventing families within the demographic to send their girl-children to school.

Poverty is at the heart of the predicament of the child bride. The research question was as follows: What are the lived experiences of child marriage on maternal outcomes among young mothers aged 12-16 years during their prenatal, natal, and postpartum period in Nigeria? Poverty is one of the lived experiences of a child wife. Those who channeled the girl child into child marriage made no plans for the girl's life and living (Neal et al., 2016). Consequently, the child bride remains an epitome of poverty whether in the hands of a husband, transferred from holder to holder, or traded through the inventory of traffickers.

Lack of support/exposure to telling and doing. Because of the patrilineal nature of the demographic, all children are only used to receiving instructions and carrying them out. A boy-child who exhibits insubordination either runs away from home or is sent to a religious teacher where the boy will live and learn religious discipline. Child marriage was the only option available to the girl child. This exposure to telling and doing characterizes society as a male dominance culture. In this culture, parents tell the children what to do (Mourtada et al. 2017). The children simply do what they are instructed to do.

This telling and doing component is all-encompassing, and nonconforming children receive chastisement in the form of corporal punishments (Neal et al. 2016). The telling and doing culture is one that all the children are conversant with. Thus, religious leaders have such children most of whom are boys. Nonconforming girls run away, stay home under corporal punishment regimes, or are sent to a husband. In some of the instances of sending a girl child to a husband, the parents often lied to the children that

they are going to live with one of their uncles or aunts (Onwuluebe, 2019). They only realize they have become wives after some time at that new home.

The nonconforming girls who still do not like the submission required at the new home run away. When such girls run away, some of them become beggars in another city or town. Others move from home to home until they end up in the home of a person they love or who loves them (Oluwakemi et al. 2018). Considering that the children are still too young to know about love, they would simply like the new place where they do not receive corporal punishments. The child, though now a wife, realizes that telling and doing is pervasive in the culture. Possibilities are that a child bride may end up in a home where the husband is not high-handed.

A child bride is expected to be available at all times and to carry out all tasks assigned without questioning the assigner or nature of task, no matter how harmful the task might be to her. Servitude is slavery or bondage. That is the lot of a child wife (Kalipeni, et al. 2017). Subjugation is conquest or defeat, which is the yoke the child bride is bearing. The research question was as follows: What are the lived experiences of child marriage on maternal outcomes among young mothers aged 12-16 years during their prenatal, natal, and postpartum period in Nigeria? When a child bride suffers servitude and subjugation in the hands of adults or even young adults, such a child bride may be disoriented for as long as such situations persist in her life. This lived experience rids the child bride of every capacity to think or talk.

Forced Young Matrimony. Adults and children in the demographics are commonly confronted by a lifestyle that is opposite one's preferences. Forced young matrimony is thus an acceptable fate among the children thus endued. Forced young

matrimony became a phenomenon that adults and children live with. Within the culture, most first marriages are forced. Subsequent ones are either forced or arranged between parents. The forced ones are also mostly arranged, but the difference is that the forced version requires no input from the girl child.

The arranged version occurs with the knowledge of, and probably tacit, the involvement of the girl child. The cultural antecedents circumscribe the process of giving and taking the girl bride (Mourtada et al. 2017). In such a situation, whether the child agrees to go to a new home or is compelled to do so, the force element is inescapable. Because of this element, the demographic becomes known for forced marriages.

Many participants in my study reveal that they were forced into becoming home makers. The common occurrence of forced matrimony becomes a practice, even among mature adults. The older men often scout directly or through gopher for wives who could be 40 years younger than the intending husband. The cultural antecedents of the demographic make teenagers accept the hands of old men in marriage because the culture had closed the age gap between husbands and wives (Schmitz et al. 2019. Thus, a family may have five or more wives ranging from 18 to 40, depending on the whims and fancies of the man of the house.

It is also possible that the first wife was forced out by her parents into the hands of the husband. Therefore, she sees nothing wrong in receiving a new juvenile wife into the family to share the husband. While civilized societies would perceive members of the demographic as living a life different from the life one would like to live, the members of such society only see a generally accepted way of life.

Human beings characteristically dislike mandatory activities. When parents, for instance, force a child to relocate, the child would resist such compulsion. Forcing girl children into matrimonial obligations has remained the way out for parents who are either unable to raise their girl children or desirous of quick money (Zuber et al. 2018). The research question was as follows: What are the lived experiences of child marriage on maternal outcomes among young mothers aged 12-16 years during their prenatal, natal, and postpartum period in Nigeria? Children who are forced to marry a man may appropriate words to express their experiences. Living with a foisted husband was an experience some participants recalled with regrets. Forced matrimonial obligation is a negative lived experience.

Complicated Pregnancies and Births. Many child wives develop health challenges that lead to complicated pregnancies and birth. When girl children begin to live in homes other than their birth homes, they often become sex toys, which is also represents dehumanizing (Bako & Syed, 2018). Unexpected pregnancies in the children's immature biological systems did not cause adult concerns. Perhaps as a result, pregnancy and birth complications arise. Furthermore, such pregnancies occur without the actual or purported husbands expecting them.

Some girl brides in this study reported facing life-threatening health concerns including sexually transmitted diseases such as HIV/AIDS, and obstetric fistula. This confirms earlier studies in the literature which revealed that many child wives suffer pregnancy complications because their bodies are not yet able to process pregnancy; child mothers are plagued with physical and psychological injuries, and experience a broad sense of loss that negatively impacts their identity and quality of life (Msele& Kohi 2015;

Zuber et al. 2018).

When pregnancy is unwanted in the case of the young girls, their husbands are often inexperienced to even know that pregnancy was developing. For instance, pregnancy issues tend to be greater in a child-bride situation than in that of mature adult brides (Rahman et al. 2017). In several instances, things go wrong before the girl or her husband reports or ask for assistance.

Unconventional complicated pregnancies characterize most of the child marriage phenomenon. The experience associated with such pregnancies is, at best, dehumanizing and unwarranted, especially considering the tender ages of both husbands and wives. The unfortunate aspect of the problem is that all involved parties regard the happenings as normal. Instead of thinking about sending the girls to school to increase their awareness level, mature adults continue to bring teen wives into their households that already have several serving wives.

Rather than enjoy the feeling of pregnancy, child brides are ignorant regarding the development going on in their biological systems (Chari et al., 2017). Unconventional pregnancies are characteristically frowned upon. Child brides might become pregnant without expecting such experiences, since pregnancy is an unknown phenomenon to the children. Complicated and unexpected pregnancies are some of the lived experiences of child brides. When a child of 12 – 16 years old suddenly becomes pregnant the associated health risks disarray the child's lifestyle or the pattern of events in the girls' immediate family.

Pressure On and From Parents. Child marriage is usually a result of pressures. Intense pressure from multiple avenues, from parents, their older partners, parental

poverty, environmental exposures constitute negative factors that make up the experiences of teenage mothers (Beattie et al. 2015). Pressures on parents contribute immensely to the problem. Pressures from parents also contribute to child marriage. Several other pressures account for child marriages (Wodon et al. 2017). All pressures are ascribable to the parents. The situations are only general and may apply to one and not to the other.

Evidence from the literature reveals if a parent is financially down, that parent would be under financial pressure, and if a parent has friends and counterparts whose children were married, the parent will want to attain the same status (Rahman et al. 2017). If a parent has more girl children than boys, the parent will think more about using the girls to earn some money with which to train the boy child. Some participants in this study reported that they were forced into marriage so that the money could be used to send their brother to school.

Financially endowed parents would normally have no reason to be involved in child marriage, but seeing that the culture supports child marriage, some of the parents become middlemen in the tradition that has grown into a viable market. Individuals who have no personal connection with child brides or young husbands create business opportunities around the tradition (Oluwakemi et al. 2018). Such individuals state that they have a girl child ready to join a husband. Their unsuspecting prospective customers would not know that there was no girl child.

Potential husbands also understand that even if they were not ready to become husbands, they could transact and get the girl child. Some of such transactions have led to child marriages. The cultural antecedents of the demographic created an environment for

multiple players in child marriages that have become a market (Kalipeni et al. 2017). The lure of monetary returns has also led poor parents to act as agents or factors in an arbitrage process to convey a girl child to prospective requisitions. This burgeoning activity creates more pressure on the parents of girl children who need money.

The stimulus-response scenario leads to the constant giving and receiving monies, giving, and receiving girl children, buying, and selling girl children, and stocking girl children in the guise of having multiple wives. Those who marry multiple wives are sometimes found acquiring more wives, and observers may not know that they are stocking merchandise. When they let go of a supposed wife, observers would think that divorce occurred. Even when they see the exited 'wife' in the house of another husband, she would look like a divorcee who remarried (Okigbo et al. 2017). These pressures are on parents of the girl children and parents of the young husbands, all for varied personal reasons.

Child marriage has multiple facets. All persons representing the different facets of child marriage face unique pressures. The journey of a child bride normally begins when her father tells her to go and live with, say, an uncle, aunt, family friend, or neighbor. While most children dislike the idea, and some act in opposition, the children usually end up in that new family. The reason for one father might be different from the reason of another father. The research question was as follows: What are the lived experiences of child marriage on maternal outcomes among young mothers aged 12-16 years during their prenatal, natal, and postpartum period in Nigeria? The lived experiences of child brides are mostly filled with pressure on all sides. Her father was under financial pressure. Her new husband gets under pressure for shouldering responsibilities arising

from his wife's pregnancy. The child bride is under pressure from the beating she gets form the husband, from hunger and starvation, fear of the unknown, the husband's temperament, or any other element (Ariyo et al. 2017). The arbitrage operators are under pressure to meet the demand of their customers such as traffickers or intending husbands. Each functionary is under severe pressure.

Limitations of The Study

The highly sensitive nature of this study created a limitation in the area of willing participants. While most participants were ready and willing to participate in the study, the researcher was not allowed access to Muslim child brides therefore the data collection was limited to non-Muslim participants. However, the study had 10 participants, who gave in-depth information to answer the research question, and saturation was reached at this point.

This research study was designed to investigate the lived experiences of women who were child brides and mothers at ages 12-16 years, during their prenatal, natal, and postpartum period. Other researchers could extend the study to child brides.

The lived experiences of the child brides fall within a closed system, which made it researchable without extraneous elements or paradigms. Furthermore, the boundaries of the subject made for easy reflection on the part of the participants and the interviewer. The behavioral patterns constituent in the culture of this demographic were easily identifiable during the interviews. Consequently, the emergence of themes was in consonance with participant-indicated patterns.

Child brides could serve as a specific or discrete demographic for a study such as this. Limiting this study to this participant classification enabled the capture of extensive

classification-specific data. Child brides appear to be in a world of their own because of the specificity of child bride circumstances. Early teenagers who are within 12 and 16 years of age are just slightly older than infants and younger than reckonable teenagers.

When children within the bracket constitute a demographic, the limitation would not be only of age, but also of social implication. Prenatal care patients constitute a bracket that could be endangered when they are minors such as 12 to 16-year old girls. The dangers associated with initial pregnancy experience are elevated when the pregnant person is of the demographic in this study (Zuber et al. 2018). Circumscribing this category of participants involved a conscious focus on the problem statement for this research study. Natal stage patients are at the middle of the care continuum, which means that the patients are supposed to have confirmed progress or otherwise in their pregnancy experiences.

This demographic is qualified to undergo scholarly investigation. However, the nature of this substantive study unavoidably warranted an inclusion of this stage in pregnancy care. Postpartum stage patients might be critical to the conclusions required in this study because the evidence of child marriage includes the experiences women have in their postpartum stages. The different sub-stages of postpartum could, in diverse circumstances, necessitate limitation variations.

Limitations include the culture of the demographic, the possibility that a participant might withhold information due to stigma and sensitivity issues. The issues of self-reporting often face legitimacy when a research respondent or interviewee invests intense emotion in the subject of the study. Because of the intense nature of this research topic, limitations may occur through the acceptance of responses provided under intense

emotion. Participants' parents were not part of the study to enable the interviewer to verify some participant comments that appeared to be complaints and confessions.

While the culture of the demographic was fully identified, the specific activities of individuals taking advantage of the child marriage environment were not controlled, as these former child brides elucidated (Schmitz et al. 2019). This limitation remains a task for future researchers. Private issues prevented the use of interpreters who would have confirmed understanding while the interviewers were in process. The participants were adults, even though they were minors at the child bride stages of their lives. Being mature adults at the time of the interviews makes their responses believable as valid data. The limitation still exists in that sensitivity issues precluded the involvement or engagement of other parties. In spite of these limitations, the output addressed the research problem, thus the research purpose was met.

Recommendations

The issue of child marriage commands attention among the educated members of the Nigerian society. Child brides often constitute discussion topics in places where victims may not perceive discussants as stigmatizing them. Future researchers should consider a deeper and more incisive inquiry into the life and times of child brides. An investigation of this phenomenon could be separated from other elements of child marriage. Understanding child brides could help other researches to put the phenomenon in perspective. A need exists to develop a curriculum for training child brides to increase their awareness and worth in their immediate communities, and the girl child should have free access to education, to avert the problem of being turned into sex slaves as a condition for giving them education.

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

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

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

1. The perceptions of former child brides, young adults who are still in the marriage that started when they were minors.

2. The perceptions of parents of child brides.

3. The perceptions of parents of young husbands.

4. The perceptions of old or mature adults still bringing in teenage brides. With the approval or permission of Institutional Review Boards, researchers could interview child brides whose stages in the marriage excludes them from any harm in answering interview questions.

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

Implications For Positive Social Change

The findings from my study have potentials for positive social change. Many child brides expressed a feeling of unhappiness, confusion, frustration, and loss of dignity. Some participants also demonstrated the desire to go to school but were denied education by their parents and spouses. Some child wives develop life threatening health challenges including complicated pregnancies and childbirth, STIs and obstetric fistulas. Based on the findings, there are no policies to control the perpetuation of child marriage (Onwuluebe, 2019). The need exists for government bodies at the local, state, and federal levels to show interest in the abolition of child marriage. Different levels of chastisement would be needed to match the types and magnitudes of abuse girl children receive from their parents and spouses. However, the empowerment of whistle-blowers could produce success in eliminating child marriage ills.

When people engage in activities, they perfect their art in such activities. Child marriage and the attendant ills are standardized by the perpetrators. The adoption of

techniques by the abusers must have helped them to maintain their foothold in the child marriage market (Wodon et al. 2017). This is impliedly a source of strength to both the market and its operators. Based on the different faces of this malaise, government departments exist that may already be operating in the segment of society related to child marriage. Activating such departments or agencies to identify, recognize, and dismantle the rackets will solve most of that problem, if not all of it.

Conclusion

Child marriage is a practice commonly found in specific demographic pockets of Nigerian society. The practice often represents people's traditions. At other times, it reflects the Islamic faith or belief system. For instance, the people of Syria practiced child marriage, and the Muslim faith helps them to sustain the practice (Mourtada et al. 2017). The peoples of the child marriage culture tend to hold fast to the practice. The cultural angle widely sustains the practice, and Nigerians within the demographics appear to revere the child marriage culture. In other words, child marriage practice is one phenomenon that represents culture, tradition, religion, commerce, and social expression. Nigeria is a male-dominated society. Hence, anything wrapped up in the garb of tradition, culture, and faith stays in the custody of the male while the womenfolk submit to their authority in everything.

Poverty-stricken parents borrow money from rich people in exchange for their little girls who will move in with the lender for the duration of the debt. The understanding is that once the debt is paid, the girl returns to her family. Unfortunately, those transactions do not end in line with this narrative. More often than not, the children become wives, sex objects, sex slaves, moveable merchandise at the whims and caprices

of the holder. This study reveals the extent to which child marriage is of interest to members of the demographic. The practice strengthens the resolve of all stakeholders in the child marriage activities to perpetuate the practice.

Until education is entrenched within the demographic, the pervasive lack of awareness will drive the child marriage agenda for probably much longer than it has been in existence. This is because individuals who are in authority, including government policymakers, are still acquiring teenage wives. The mature adults, some of whom are already old and of retirement ages, believe that marrying a very young girl is safe because such young girls learn, assimilate, and live by religious values and serve their husbands or slave masters with loyalty (Gemignani & Wodon, 2015). Under such circumstances, child marriage may have become a perpetual and eternal practice within the subject demographic.

Young girls becoming brides before age 15 often face risks such as pregnancy (for that age). Furthermore, complications associated with pregnancy and childbirth could cause instability in the life of the girl bride. Child marriage is predominant in the Northern parts of Nigeria where the Islamic religion holds sway. The practice is therefore, strengthened by the religious and cultural leaning of the demographic. When pregnancies occur at such tender age, the child brides, their hosting families, and their birth families are usually unable to handle some harmful effects of pregnancy in a little child (Godha et al. 2013).

The prenatal, natal, postnatal ,and postpartum periods usually constitute challenges to all the parties. Child marriage middlemen and arbitrage operators often try to unload their ‘stock’ before the health deterioration stage. When young mothers are

unable to cope with health care challenges, several things happen. Some husbands do not bother about the problem. Some girls run away to unknown destinations. Daring traffickers take on the merchandise with the intention to unload before the health issues become public knowledge.

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

Of paramount importance is the need to isolate for change of narrative the general Muslim religious belief that a woman without a home is not a true or devoted Muslim. The modification should focus on excluding little girl children and to define a woman based on universal adult suffrage. When that understanding becomes pervasive, frustrations, inadequacies, and lopsided deprivations associated with child marriage will disappear, ensuring that giving a girl out at an early age for marriage is destructive. Such practices engender inequities against girl children.

References

AFRH, (2018). Child marriage, an unending abomination in Nigeria. Retrieved from https://arfh-ng.org/child-marriage-an-unending-abomination-in-Nigeria/

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

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

Amoudu, O.C., Salami, B.O., Richter, M.S. (2018). Obstetric fistula policy in Nigeria: a critical discourse analysis. *BMC Pregnancy and Childbirth, 18*, 269. Doi.org/10.1186/s12884-018-1907-x.

Ariyo, O., Ozodiegwu, I. D., Doctor, H. V., (2017). The influence of the social and cultural environment on maternal mortality in Nigeria: Evidence from the 2013 demographic and health survey. *PLoS ONE,* 12(12*). R*etrieved from https://doi.org.10.137/journal.pone.0190285

Asonye, P.N., (2014). Experiences and Perceptions of Pregnant Unmarried Adolescent Girls in Nigeria. *Walden University Dissertation* Retrieved from http://www.scholarworks.waldenu.edu/dissertations.

Atuoye, K. N., Amoyaw, J. A., Kuuire, V. Z., Kangmennaang, J., Boamah, S.V., (2015). Utilisation of skilled birth attendants over time in Nigeria and Malawi. Global

Public Health, 12(6). Retrieved from https://doi-org.ezp.waldenulibrary.org/10.1080/17441692.2017.1315441

Atuoye, K.N., Dixon, J., Rishworth, A., Galaa, S. Z., Boamah, S. A., & Luginaah, I. (2015). Can She make it? Transportation barriers to accessing maternal and child health care services in rural Ghana. *BMC Health Services Research,* 15333. doi:10.1186/s12913-015-1005-y

Baker, Z., Bellows, B., Bach, R., Warren, C. (2017). Barriers to obstetric fistula treatment in low‐income countries: a systematic review. *Tropical Medicine & International Health,* 22(8), 938-959. doi.org/10.1111/tmi.12893|

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

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

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

Bruce, S. G., Blanchard, A. K., Gurav, K., Roy, A., Jayanna, K., Mohan, H. L., &.Avery, L. (2015). Preferences for infant delivery site among pregnant women and new mothers in Northern Karnataka, India. *BMC Pregnancy and Childbirth,* 1549. doi:10.1186/s12884-015-0481-8

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

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

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

Cope, D., 2014). Methods and Meanings: Credibility and Trustworthiness of Qualitative Research. *Oncology Nursing Forum,* 41(1), 89-91. Retrieved from doi: 10.1188/14.ONF.89-91.

Crawford, L. M., (2016). Qualitative Research Designs. In Burkholder, G. J., Cox, K. A., & Crawford, L. M. (2016). *The Scholar-Practitioner's Guide to Research Design.* Baltimore MD: Laureate Publishing.

Creswell, J. W. (2014). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). Thousand Oaks, CA: Sage.

Creswell, J. W., (2014). *Research design: Qualitative, Quantitative, and Mixed Methods Approaches.* (4th ed.). Thousand Oaks, CA: Sage.

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

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

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

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

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

Global-One, (2015). Maternal Health in Nigeria -statistical overview. Retrieved from: http://www.globalone2015.org/wp-contentuploads/2011/11/mat…..

Godha, D., Hotchkiss, D., & Gage, A. J., (2013). Association between child marriage and reproductive health outcomes and service utilization: A multi-country study from south Asia. *Adolescent Health,* 52(5), 552-5588 Retrieved from: https://doi.org/10.1016/j.jadohealth.2013.01.021

Godiya, A. M, (2013). Patriarchy and gender inequality in Nigeria: the way forward. *European Scientific Journal, 9(17), ISSN:7881* Retrieved *,* 9(17) 2*5* Retrieved from https://doi.org/10.19044/esj.2013.v9n17p%p

Heller, A. & Hannig, A. (2017) Unsettling the fistula narrative: cultural pathology, biomedical redemption, and inequities of health access in Niger and Ethiopia. *Anthropology & Medicine,* 24, 1, 81-95. doi:10.1080/13648470.2016.1249252

Jones, E., Lattof, S., Coast, E., &Lattof, R., (2017). Interventions to provide culturally-appropriate maternity care services: factors affecting implementation*. BMC Pregnancy &Childbirth,* 17(1), 1-10. doi:10.1186/s12884-017-1449-7

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

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

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

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

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

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

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

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

Mumtaz, Z., Salway, S., Bhatti, A., Shannar, L., Zaman, S., Laing, L., & Ellison, G. H., (2014). Improving maternal health in Pakistan: towards a deeper understanding of the social determinants of poor women's access to maternal health services. *American Journal of Public Health, 104 Suppl, IS17-S24.* doi:10.2105/AJPH.2013.301377

Nasrullah, M., Muazzam, S., Bhutta, A., and Raj, A., (2014). Girl Child marriage and Its Effects on Fertility in Pakistan: Findings from Pakistan Demographic and Health

Survey, 2006-2007. *Maternal and Child Health Journal,* 18(3), 534-543. Retrieved from: https://www.ingenioushealthsciences.com/publications

Neal, S., Stone, N., & Ingham, R. (2016). The impact of armed conflict on adolescent transitions: a systemic review of quantitative research on age of sexual debut, first marriage and first birth in young women under the age of 20 years. *BMC Public Health,* 16(1). Retrieved from https://doi.org/10.1186/s12889-016-2868-5

Ngum Chi Watts, M. Liaputtong, P., and Mcmichael, C., (2015). Early motherhood: a qualitative study exploring the experiences of African Australian teenage mothers in greater Melbourne, Australia. *BMC Public Health,* 15, 873. doi:10.1186/s12889-2215-2

Ngunen, M. C. & Wodon, Q., (2014). Impact of Child Marriage on Literacy and Education Attainment in Africa. *UNICEF and UNESCO Statistics. Washington, DC: The World Bank.* Retrieved from http://allinschool.org/wp-coontent/uploads/2015/OOSC-2014-QW-Child-Marriage-final.pdf

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

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

Oladapo, T. O., Souza, J. P., Bohren, M. A., Tuncap, O., Vogel., J. P., Fawole, B., Mugerwa, K., & Gulmezoglu, M., (2015). WHO Better Outcomes in Labour Difficulty (BOLD) project: innovating to improve quality care around the time of

childbirth. *Reproductive Health,* 12(48). Retrieved from: http://dx.doi.org/10.1186/s12978-015-0029-4

Onwuluebe, C. J., (2019). Patriarchy and women vulnerability to adverse climate change in Nigeria. *Journals SAGEPub .Co.* Retrieved from: https://doi.org/10.1177/2158244019825914

Osok, J., Kigamwa, P., Vander Stoep, Huang, Keng-Yen, & Kumar, M., (2018). Depression and its psychosocial risk factors in pregnant Kenyan adolescents: a cross-sectional study in a community health center in Nairobi. *BMC Psychiatry,* 18(136). Retrieved from https://doi.org/10/1186/s 12888-018-1706-y

Oyibo, N., Watt, J., & Weller, G. (2017). Evaluating lay perceptions of maternal mortality to improve risk communication: A case study in Rivers State, Nigeria. *Global Public Health,* 12(6). doi:10.1080/17441692.2016.1211165

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

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

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

Sabbe A., Oulami, H., Zekraoui W., Hikmat, H., Temmerman M., Leye, E., (2013). Determinants of child and forced marriage in Morocco: stakeholder perspectives on health, policies and human rights *BMC International Health and Human*

Rights, 13(43). doi: 10.1186/1472-698X-13-43

Shrivastava SR, Shrivastava PS, Ramasamy J. (2017). Responding to the public health challenge of obstetric fistula in developing nations: A preventable cause of physical and social disability. *Annals of Tropical Medicine, Public Health, 10*, 797-798. Retrieved from http://www.atmph.org/text.asp?2017/10/4/797/196515

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

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

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

Tukur, I., Ijaiya, M.A., Tin Su, T., Chan, C.K., Muhammed-Baba, T.A., Karuthan, C. (2015). Analysis of 137 Obstetric fistula cases seen at three fistula centers in Northwest Nigeria. *East African Medical Journal,* 92(8), 408-414 https://www.ajol.info/index.php/eamj/article/view/126645

UNICEF, (2014). Child marriage tied to poverty and lack of education. Retrieved from https://www. buildon.org/2014/07/unicef-report-child-marriage

UNICEF, (2016). Maternal mortality fell by almost half between 1990 and 2015. Retrieved from https://data.unicef.org/maternal-health/maternal-mortality.html.

UNICEF, (2016). 2016 Nigeria: Evaluation of the Maternal, Newborn and Child health Week in Nigeria. *Liverpool School of Tropical Medicine Centre for Maternal and Newborn Health.* Retrieved from https://www.unicef.org/evaldatabase/index_95507.html

United Nations OHCHR, (2013). Child, Early and Forced Marriage: A Multi-Country Study of Women Living Under Muslim Laws *A Submission to the UN Office of the High Commissioner on Human Rights (OHCHR)* Retrieved from http://www.wluml.org/sites/wluml.org/files/UN%20report%20final.pdf

United Nations, (2015). UN General Assembly, Transforming Our world: The 20130 Agenda for Sustainable Development. Retrieved from http:www. A/RES/70/1

Walden University (n.d). Sampling and Sampling Size Considerations. Retrieved from www. Walden university database.

WHO. (2015). World Health Statistics. The health-related Millennium Development Goals. Retrieved from http://www.EN_WHS2015_Part1.pdf

WHO. 2015. Millennium Developmental Goals: Gender Chart, 2015. (Trends in Maternal Mortality: 1990 to 2015. Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Retrieved from http://mdgs.un.org/unsd/mdg/Resources/Static/Products/Progress2015/Gender_Chart_Web.pdf

WHO, UNICEF,UNPFPA, World Bank Group and UNPD (NMEG). (2015). Trends in estimates of maternal mortality ratio (MMR, Maternal deaths per 100,000 live births) 1990-2015. Retrieved from http://www.EN_WHS2015_Part1.pdf

Wodon, Q., Male, C., Onagoruwa, A., Savadogo, A., and Yedan, A., (2017). The Cost of Not Investing in Girls in Uganda: Child Marriage, Early Childbearing, Low Educational Attainment for Girls and Their Impacts. Washington, DC. *The World Bank.* doi:10.1596/29039 Corpus ID: 49403503

Zuber PLF, Moran AC, Chou D, et al. (2018). Mapping the landscape of global programs to evaluate health interventions in pregnancy: the need for harmonized approaches, standards, and tools. *BMJ Glob Health 3*, e001053. doi:10.1136/bmjgh-2018-001053

Appendix A: Interview Protocol

Time of Interview:……Hour/Minutes AM/PM

Date……

Place……

Interviewee (pseudonym): P001-P010

Introduction: Hello,

Welcome to this interview session, and thanks for accepting to participate. I appreciate your time. As you already know, the purpose of this interview is to help me to develop an in-depth understanding of the impact of child marriage on maternal outcomes among young mothers in Nigeria, including the experiences of child marriage among young mothers. This interview is estimated to last for about 45 minutes to an hour, and I wish to inform you that I will be audio taping this interview. Is that okay by you? When we finish the interview, I will be giving you the transcripts, and I will also share my notes with you so that you can review them and make necessary corrections on your responses. This will help me to improve accuracy, credibility, validity, and transferability. This study may be published, and in publication, your name will not be mentioned. Pseudonyms will be used in case we decide to use direct quotes. Is that okay by you? Okay let's start then.

Ice breaker: Do you know any girl in your family or community who was stopped from going to school and given out in marriage? (Please do not tell me their names). What do you say about that?

Interview Questions

1. Tell me about your marriage. Did you fall in love with your husband or it was your family's choice for you to marry him?
2. How did you feel when you first realized that you were married and going to be living with a man?
3. Could you explain to me how you felt when you were first separated from your parents?
4. Did you receive ante-natal care during your pregnancy? And did you deliver in the hospital or at home? [Follow-up if they did not have access]
5. How did you feel at the birth of your baby? Tell me more about your experience at that time?
6. Tell me about your experience during the period of your pregnancy. What kind of support did you receive from family and husband and how long ago?
7. Did you receive support financially? What about other kind of support? Can you tell me more about the behavior of people around you?
8. What aspect of the experience was most remarkable? Can you narrate your feelings?
9. How has this experience affected you? What challenges did you face and are you still facing?
10. What has changed in your life since the experience? Do you think it is beneficial for young girls to marry without going to school?

    Is there any other thing you wish to tell me? Anything special about your

experience as a young mother that you think we should know?

Thank you so much for accepting to participate in this study. If you have any questions or if you remember something and you want to tell me, you can contact me by phone at

_____

Appendix B: Expert Panel Form

The qualitative reviews of interview questions to be used in this study were examined in detail by a Panel of experts. The Panel was comprised of three Doctors/lecturers in the field of obstetrics and gynecology, nursing, and public health. They provided critical appraisal of each survey domain and make changes as appropriate.

The panel members were:

1. Mercy Oniah-Ejini (RN/Midwife)

2. Dr. Hasana Umar

3. Dr. Silas Ochejele

Panel Expert #1

Form for Review and Evaluation of Validity and Reliability by a Panel of Experts for Qualitative Instrumentation of *"The Lived Experiences of Child Marriage and Its Health Effects Among Young Mothers in Nigeria."*

Instructions: Please review the attached Qualitative Instrumentation of research topic: *"The Lived Experiences of Child Marriage and its Health Effects Among Young Mothers in Nigeria"* and respond to the following questions regarding the construction, validity and potential reliability for the Qualitative research study, *"The Lived Experiences t of Child Marriage and Its Health Effects Among Young Mothers in Nigeria,"* in light of the phenomenon being researched, examined, assessed, evaluated or measured.

Section I. VALIDITY EVALUATION

A test, survey, questionnaire, evaluation, or assessment instrument is valid to the extent that the instrument measures the construct(s) that the instrument purports to measure.

1. Instrument Construction:

1. (a). Are the instructions for completing the instrument clear?

[X] Yes

[ ] No (if no, please explain)

[ ] Yes, provided the following actions are taken:

1.(b). Is the application and results of the Qualitative Instrumentation of "The Lived Experiences of Child Marriage and its Health Effects Among Young Mothers in Nigeria", adequately reflected in this instrument?

[X] Yes

[ ] No (if no, please explain)

[ ] Yes, provided the following actions are taken:

1. (c). What items would you add? None

1. (d). What items would you delete? None

2. Content Validity:

Will the scores yielded by Qualitative Instrumentation of "*The Lived Experiences of Child Marriage and its Health Effects Among Young Mothers in Nigeria"*, adequately represent the content or conceptual domain of the construct being measured? In other words, does the instrument have adequate and appropriate items that constitute a representative sample of the complete domain of items used to generalize the construct being measured?

[x] Yes

[ ] No (if no, please explain)

[ ] Yes, provided the following actions are taken:

3. Construct Validity:

Qualitative Instrumentation *"The Lived Experiences of Child Marriage and its Health Effects Among Young Mothers in Nigeria"*, is designed to measure "The Lived experiences of Child Marriage Among Young Mothers in Nigeria". Please see constructs definition:

Please find constructs definition inserted here:

Psychological, physiological, cultural, and institutional experiences that young mothers go through, during their prenatal, natal, and post-natal period. These include treatment of young mothers by spouses, family members and the community, regarding behavior of people towards them, and financial, moral, as well as psychological support that these young mothers get from their families and the entire community.

3. (a) Does the Qualitative Instrumentation of *"The Lived Experiences of Child Marriage and its Health Effects Among Young Mothers in Nigeria"*, represent concepts or constructs it should represent and does not represent concepts it should not represent? In other words, does the Qualitative Instrumentation of "*The Lived Experiences of Child Marriage and its Health Effects Among Young Mothers in Nigeria"*, adequately represent the constructs it purports to represent?

[ ] Yes

[ ] No (if no, please explain)

[x] Yes, provided the following actions are taken:

The questions should be reduced to 8 or 10 and should be more of a friendly conversation between the researcher and the participants. Not too rigid, but a casual or informal discussion, to enable participants open up and provide as much information as they can give.

3. (b) Is the Qualitative Instrumentation of *"The Lived Experiences of Child Marriage and its Health Effects Among Young Mothers in Nigeria",* inclusive of the important dimensions or facets of the constructs it purports to measure.

[X] Yes

[ ] No (if no, please explain)

[ ] Yes, provided the following actions are taken:

3. (c) Does the Qualitative Instrumentation of *"The Lived experiences of Child Marriage and its Health Effects Among Young Mothers in Nigeria"*, avoid excess reliable variance, ensuring no items are easier or harder for some respondents in a manner relevant to the interpreted construct?

[X] Yes

[ ] No (if no, please explain)

[ ] Yes, provided the following actions are taken:

D. Face Validity

Does the Qualitative Instrumentation *of "The Lived experiences of Child Marriage and its Health Effects Among Young Mothers in Nigeria"*, look valid? Does it appear to represent a measure of the construct it purports to measure?

[X] Yes

[ ] No (if no, please explain)

[ ] Yes, provided the following actions are taken:

E. Item Bias

Does the wording or placement of an item avoid affecting someone's response?

(This includes the avoidance of double-barreled items, words, or phrases, which raise emotional red flags, ambiguous wording, gender bias, racial/ethnic bias, and the manipulative placement of an item or wording of an item)

[X] Yes

[ ] No (if no, please explain)

[ ] Yes, provided the following actions are taken:

F. Consequential Validity

Does the Qualitative Instrumentation of *"The Live Experiences of Child Marriage and its Health Effects Among Young Mothers in Nigeria,"* instrument embody desirable values and have potentially positive consequences for the discipline or field it reflects?

[X] Yes

[ ] No (if no, please explain)

[ ] Yes, provided the following actions are taken:

Section II. RELIABILITY EVALUATION

A test, survey, questionnaire, evaluation, or assessment instrument is reliable to the extent that whatever construct(s) the instrument measures, it measures the construct(s) consistently.

A. Internal Consistency

Are the items that make up the Qualitative Instrumentation of *"The Live Experiences of Child Marriage and its Health Effects Among Young Mothers in Nigeria",* internally consistent with each component and/or the constructs being examined, assessed, evaluated, or measured?

[X] Yes

[ ] No (if no, please explain)

[ ] Yes, provided the following actions are taken:

B. Potential for Reliability (Potential for Consistent Responses)

Understanding that research participants completing this instrument will vary in their understanding and experience with the *"The Lived Experiences of Child and its Health Effects Among Young Mothers in Nigeria"*, and thus vary in their responses, is

there anything about this instrument that would lead you to believe that this instrument would not consistently measure *"The Lived Experiences of Child Marriage and its Health Effects Among Young Mothers in Nigeria"*.

[ ] Yes

[X] No (if no, please explain) *I believe that this instrument would consistently measure the constructs even with the understanding that the research participants may vary in their understanding and experience.*

[ ] Yes, provided the following actions are taken:

Please provide any additional comments, suggestions for improvement, and/or any other thoughts regarding the construction, how the survey to be easier to complete, validity and/or reliability of the Qualitative Instrumentation of "*The Lived Experiences of Child Marriage and its Health Effects Among Young Mothers in Nigeria"*.

Panel Member

Printed or typed Name: Mercy Oniah-Ejini

Title: Director of Nursing and Public Health

Signature: ____M. E. Oniah-Ejini_____Date: _26th September, 2018.

Panel Member #2

Section I. VALIDITY EVALUATION

A test, survey, questionnaire, evaluation, or assessment instrument is valid to the extent that the instrument measures the construct(s) that the instrument purports to measure.

1. Instrument Construction:

1. (a). Are the instructions for completing the instrument clear?

[X] Yes

[ ] No (if no, please explain)

[ ] Yes, provided the following actions are taken:

1.(b). Is the application and results of the Qualitative Instrumentation of "The Lived experiences of Child Marriage Among Young Mothers in Nigeria", adequately reflected in this instrument?

[X] Yes

[ ] No (if no, please explain)

[ ] Yes, provided the following actions are taken:

1. (c). What items would you add?

None

1. (d). What items would you delete?

None

2. Content Validity:

Will the scores yielded by Qualitative Instrumentation of *"The Impact of Child Marriage on Maternal Outcomes Among Young Mothers in Nigeria",* adequately represent the content or conceptual domain of the construct being measured? In other words, does the instrument have adequate and appropriate items that constitute a representative sample of the complete domain of items used to generalize the construct being measured?

[x] Yes

[ ] No (if no, please explain)

[ ] Yes, provided the following actions are taken:

3. Construct Validity:

Qualitative Instrumentation "The Impact of Child Marriage on Maternal Outcomes Among Young Mothers in Nigeria", is designed to *measure "The Lived Experiences of Child Marriage and its Health Effects Among Young Mothers in Nigeria"*. Please see constructs definition:

Please find constructs definition inserted here:

Psychological, physiological, cultural, and institutional experiences that young mothers go through, during their prenatal, natal, and post-natal period. These include treatment of young mothers by spouses, family members and the community, regarding behavior of people towards them, and financial, moral, as well as psychological support that these young mothers get from their families and the entire community.

3. (a) Does the Qualitative Instrumentation of *"The Lived Experiences of Child Marriage and its Health Effects Among Young Mothers in Nigeria"*, represent concepts or constructs it should represent and does not represent concepts it should not represent? In other words, does the Qualitative Instrumentation of *"The Lived Experiences of Child Marriage and its Health Effects Among Young Mothers in Nigeria",* adequately represent the constructs it purports to represent?

[x] Yes

[ ] No (if no, please explain)

[ ] Yes, provided the following actions are taken:

3. (b) Is the Qualitative Instrumentation of *"The Lived Experiences of Child Marriage and its Health Effects Outcomes Among Young Mothers in Nigeria",* inclusive of the important dimensions or facets of the constructs it purports to measure.

[X] Yes

[ ] No (if no, please explain)

[ ] Yes, provided the following actions are taken:

3. (c) Does the Qualitative Instrumentation of *"The Lived Experiences of Child Marriage and its Health Effects Among Young Mothers in Nigeria.*" avoid excess reliable variance, ensuring no items are easier or harder for some respondents in a manner relevant to the interpreted construct?

[X] Yes

[ ] No (if no, please explain)

[ ] Yes, provided the following actions are taken:

D. Face Validity

Does the Qualitative Instrumentation of "The Lived Experiences of Child Marriage and its Health Effects Among Young Mothers in Nigeria," look valid? Does it appear to represent a measure of the construct it purports to measure?

[X] Yes

[ ] No (if no, please explain)

[ ] Yes, provided the following actions are taken:

E. Item Bias

Does the wording or placement of an item avoid affecting someone's response? (This includes the avoidance of double-barreled items, words, or phrases, which raise emotional red flags, ambiguous wording, gender bias, racial/ethnic bias, and the manipulative placement of an item or wording of an item)

[X] Yes

[ ] No (if no, please explain)

[ ] Yes, provided the following actions are taken:

F. Consequential Validity

Does the Qualitative Instrumentation of *"The Lived Experiences of Child Marriage its Health Effects Among Young Mothers in Nigeria,"* instrument embody desirable values and have potentially positive consequences for the discipline or field it reflects?

[X] Yes

[ ] No (if no, please explain)

[ ] Yes, provided the following actions are taken:

Section II. RELIABILITY EVALUATION

A test, survey, questionnaire, evaluation, or assessment instrument is reliable to the extent that whatever construct(s) the instrument measures, it measures the construct(s) consistently.

A. Internal Consistency

Are the items that make up the Qualitative Instrumentation of "The Lived Experiences of Child Marriage and its Health Effects Among Young Mothers in Nigeria", internally consistent with each component and/or the constructs being examined, assessed, evaluated, or measured?

[X] Yes

[ ] No (if no, please explain)

[ ] Yes, provided the following actions are taken:

B. Potential for Reliability (Potential for Consistent Responses)

Understanding that research participants completing this instrument will vary in their understanding and experience with the "The Lived Experiences of Child Marriage and its Health Effects Among Young Mothers in Nigeria", and thus vary in their responses, is there anything about this instrument that would lead you to believe that this instrument would not consistently measure "The Lived Experiences of Child Marriage and its Health Effects Among Young Mothers in Nigeria".

[ ] Yes

[ ] No (if no, please explain) I believe that this instrument would consistently measure the constructs even with the understanding that the research participants may vary in their understanding and experience.

[x] Yes, provided the following actions are taken: Since research participants vary in their experiences of child marriage, questions should be modified to reflect these discrepancies. Questions should be reduced to the barest minimum, and more generalized to enable participants answer freely, instead of the researcher having an idea of what their responses should look like. Individual responses can lead the researcher to the next type of question.

Please provide any additional comments, suggestions for improvement, and/or any other thoughts regarding the construction, how the survey to be easier to complete, validity and/or reliability of the Qualitative Instrumentation of "The Lived Experiences of Child Marriage and its Health Effects Among Young Mothers in Nigeria".

Panel Member

Printed or typed Name: Dr. Hasana Umar

Title: Consultant Gynecologist

Signature: __HEUmar____Date: _28th September, 2018.

Appendix C: Letter to Federal Capital Department of Health

Letter to Federal Capital Development Authority Department of Health

My name is Anastasia Ashi. I am a Ph.D. student at Walden University, and I have selected Igu community in Abuja Federal Capital Territory, to conduct my dissertation research on 'The Lived Experiences of child marriage and its Health Effects among young mothers in Nigeria'. The progress of achieving the Millennium Development Goals, in Nigeria has been very slow. With the time target of achieving the Millennium Development Goals passed (2015), and the advent of the Sustainable Development Goals, it is worrisome that Nigeria is still not on track to fully achieve the Millennium Development Goals. There has been considerable progress in achieving other Millennium Development Goals, except Number 5, which specifically aims at achieving improved maternal health is still far from being actualized in Nigeria. Many contextual issues including child marriage, and access to maternity care, have been implicated as factors that retard the progress of achieving improved maternal outcomes. The rate of maternal mortality is higher in Nigeria, compared to other countries in sub Saharan Africa. Teenage mothers are mostly at risk of dying from complications associated with pregnancy. These young women go through very harrowing experiences as a result of early marriage, lack of access to maternity care, and poor socioeconomic status.

In this study, I will be trying to identify some of the lived experiences of young mothers during their prenatal, natal, and postnatal period. I also plan to review the extent of maternity care available to young mothers, and how they can access quality maternity care. My research is intended to create awareness on the needs of young mothers and to

advocate for more humane treatment and support for young pregnant girls in order to enhance access to quality maternity care.

Participation in this study will be strictly voluntary and participant responses and identity will be protected and kept confidential. When I complete the study, I will share my research findings and recommendations with the Society of gynecologists of Nigeria, the Federal Ministry of Health, and other stake-holders, including non- governmental organizations and the United Nations agencies.

I respectfully request your approval for me to conduct this proposed public health research within Igu community in the Federal Capital Territory, Abuja. If you have any questions or concerns on this project, kindly contact me at [redacted] or my Ph. D committee Chairperson, Dr. Mary-Lou Gutierrez [redacted]

Thank you for your consideration of this request. I look forward to hearing from you.

Sincerely,

Anastasia Ashi

Appendix D: Letter Of Cooperation To Partner

Dear Parish Priest,

Catholic Church Igu

My name is Anastasia Ashi. I am a PhD student at Walden University. I have selected Igu community in the Federal Capital Territory, Abuja, to conduct my dissertation research on 'The Lived Experiences of child marriage and its Health Effects among young mothers in Nigeria'.

The United Nation's Millennium Development Goals identified the health of mothers as a significant global concern that requires urgent attention to ensure sustainable development. However, Nigeria failed to achieve the Millennium Development Goals even after the time target of 2015. Early age of marriage and poor treatment of young indigent mothers have been implicated as a major reason for the slow progress of achieving improved maternal outcomes, (MDG Number 5). In this study, I will be trying to identify the factors that contribute to the lived experiences of child mothers in Igu community of the FCT. My goal is to create awareness and advocate for more humane treatment and support for girls in Nigeria as well as to improve the experiences of teenage mothers in vulnerable populations.

I am therefore soliciting your kind permission to enable me make use of your church as a point of contact and information for the participants. If possible and convenient, I will also I will also use the church facilities as a meeting point for participants, and data collection venue. Participation in this study will be strictly voluntary and participant responses and identity will be protected as confidential. I will share my research findings

and recommendations with the Federal Capital Territory Ministry of Health and the Office of the Senior Special Assistant To the President on Millennium Development Goals, as well as other interested stakeholders in the region, including non-governmental organizations and United Nations agencies.

I respectfully request your approval for me to conduct this proposed public health research within Igu community of the FCT. If you have any questions or concerns of this project, please contact me by email. Also, you may contact my PhD Committee Chairperson, Dr. Mary-Lou Gutierrez.

Thank you for your consideration of this request. I look forward to hearing from you.

Sincerely,

Anastasia Ashi

Appendix E: Recruitment Flyer

Young Mothers in Our Society Need Support to help them Enjoy The benefits of Motherhood! You Can help make a difference in Your Community!

You can help if you:

- · □are between the ages of 18 to 24,
- · □live in Igu community Abuja,
- · □got married between ages 12 -16 years,
- · □had a child or became pregnant between ages 12 to 16 years.

- You can help by

· Sharing with a female researcher your experiences about being a mother at ages 12-16 years,

How will this help?

· Sharing your experiences will help the researcher better understand how to help other young mothers have support from their spouses and family, to live a healthy happy life.

What are the details of the study? • The study details are described on the consent forms available

Who do I contact? Anastasia Ashi

Phone Number: XXXXXXXXXX

Date: XX.XX.XXXX

Appendix F: Letter of Cooperation From Partner

Thy Will Be Done

Catholic Archdiocese of Abuja

ST. MULUMBA'S CATHOLIC CHURCH, IGU

P. O. Box 126 Garki, Abuja.
email: stmulumbaparish@yahoo.com

8th October, 2019

Lady Anastasia Ashi,
Ph.D Student, Walden University,
Baltimore,
USA.

Dear Ma,

RE: Request To Conduct Your Ph. D Research In Our Parish And Community

We received with delight the request letter from you showing that our Igu community and Parish has been chosen for the conduct of your Ph. D dissertation on the **"Impact of Child Marriage on Maternal Outcomes in Nigeria."**

After the receipt of your letter of request, we met as a community to consider your proposal. It is therefore my privilege to inform you that the entire Igu community of Bwari Area Council FCT agrees with your choice of its community for the conduct of this research.

The community promises to offer her cooperation in the conduct of this research as she strongly believes in the expansion of the frontiers of knowledge through scholarly research, and the positive impact of the results of research.

We promise to make available the church premises/hall for your use as data collection site. There will also be some rooms available to ensure you have privacy with your participants. We also wish to inform you that the church offers relief services to the community, which includes free counselling services and provision of relief materials to distressed and internally displaced persons. You may also wish to avail yourself of this opportunity if the need arises.

We look forward to having you for the said research on a date that we anticipate shall be communicated to us shortly.

Thank you and best wishes.

Yours Faithfully,

Rev. Fr. Louis Shebayan Duniya
Parish Priest

ST. MULUMBA'S CATHOLIC CHURCH
Sign.....
Date 8/10/19
IGU, ABUJA

Appendix G: Millennium Developmental Goals

The Millennium Development Goals	
Goal 1	Eradicate Extreme Poverty and hunger
Goal 2	Achieve Universal primary Education
Goal 3	Promote Gender Equality And Empower women
Goal 4	To Reduce Child Mortality
Goal 5	To Improve Maternal Health
Goal 6	Combat HIV/AIDS, Malaria and Other Diseases
Goal 7	To Ensure Environmental Sustainability
Goal 8	To Develop a Global Partnership for Development

Source: UNDP (2000) Millennium Development Goals

Appendix H: Sustainable Development Goals

Goal 1: End poverty in all its forms everywhere
Goal 2: End hunger, achieve food security and improved nutrition and promote sustainable agriculture
Goal 3: Ensure healthy lives and promote well-being for all at all ages
Goal 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all
Goal 5: Achieve gender equality and empower all women and girls
Goal 6: Ensure availability and sustainable management of water and sanitation for All
Goal 7: Ensure access to affordable, reliable, sustainable, and modern energy for all
Goal 8: Promote sustained, inclusive, and sustainable economic growth, full and productive employment, and decent work for all
Goal 9: Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation
Goal 10: Reduce inequality within and among countries
Goal 11: Make cities and human settlements inclusive, safe, resilient, and sustainable
Goal 13: Take urgent action to combat climate change and its impacts*
Goal 14: Conserve and sustainably use the oceans, seas, and marine resources for sustainable development
Goal 15: Protect, restore, and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss
Goal 16: Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable, and inclusive institutions at all levels
Goal 17: Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development

Source: United Nations General Assembly, (2015).