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Child Marriage: Parents' Lived Experience of Decision-Making Processes and Consequential Health Effects

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Author Note

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Abstract

Child or early marriage is increasingly recognized as a public health concern that poses significant health challenges for young brides. This qualitative research explored child marriage among Hausa-Fulani ethnolinguistic communities in northeastern Nigeria. Qualitative interviews were conducted with parents who had arranged marriages for their underage children. The study relied on a theoretical foundation of social values theory and interpretative phenomenological analysis. The results provided an in-depth understanding of the child marriage phenomenon, by exploring parents' lived experiences and the role of the child bride's health in the decision-making process, and illustrated how social values and norms drive child marriage in the community. The roles of shame and honor were particularly significant, and these feelings drove the practice of child marriage in these communities. Contrary to the prevailing narrative in the literature, no direct evidence indicated that poverty was a factor in the parental decision-making process. The decision to marry off their children was the purview of male parents in Hausa-Fulani communities, and social values were a key symbol of community identity preserved by common sociocultural practices. The child bride's good health was a necessary condition for the marriage, and minimal considerations were given to the girl's abilities to bear marital responsibility or children. Effective reproductive health education and promotion interventions are required to curb and prevent child marriage. Community-based collaborative projects are key to creating the desired changes in these communities to end this practice.

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Introduction to the Study

Child marriage is a global public health problem and a widespread harmful practice that affects many adolescent girls (Raj, 2018; Chandra-Mouli et al., 2013), with dire consequences, including a high prevalence of maternal and infant morbidity and mortality (Petroni et al., 2019; Raj & Boehmer, 2013; Raj et al.,, 2018; Tenkorang, 2019). The practice of child marriage is internationally recognized as pervasive abuse and a violation of child and human rights that significantly compromises maternal and child health (Raj et al., 2018; UNICEF, 2017). Researchers have made substantial efforts to understand child marriage, with a focus on curbing and preventing it (Bicchieri et al., 2014; Raj et al., 2018).

Previous work regarding child marriage in sub-Saharan Africa, including Nigeria, has focused on the harmful effects of this practice on young girls, their families, and society, as well as issues of economic survival, including poverty and inequality. However, the harmful effects extend beyond economics and include physical, psychological, and mental effects on these children (Association for Reproductive & Family Health, 2018; Raj, 2010; Walker, 2012). Currently, it is unclear what factors motivate and influence parents to marry off their underage children and to ignore the immense harm child marriage may cause. Further, the role of the bride's health in the decision-making process is unknown. These factors may, in part, be the reasons why child marriage remains prevalent despite numerous social and health interventions.

This research aimed to develop an in-depth understanding of the child marriage phenomenon by exploring the parents' lived experiences and the role of the child bride's health in the parental decision-making process. Phenomenological qualitative research inquiry, namely interpretative phenomenology analysis (IPA), was used to explore in depth the lived experiences of the parents involved in child marriage, to gain a nuanced understanding of the role of the child bride's health in the parental decision-making process leading to the marriage of their minor children. Understanding the decision-making

process and how and why parents make these decisions is critical to a deeper understanding of the reported health implications of child marriage (Parsons et al., 2015; Raj & Boehmer, 2013; Walker, 2012). Such information can form vital resources for the successful implementation of social and health intervention programs intended to curb and prevent the harmful practice of child marriage and provide viable alternatives to this community to achieve social change.

Theoretical and Conceptual Framework

A theoretical and conceptual framework guided the research and provided the necessary connection between research parameters and key theoretical concepts. The framework related to the perceived value of child marriage within social norms and described how these influenced the parental decision-making mechanism. It sought to explain how and why parents decide to marry off their underage daughters by establishing the relationship between injunctive norm(s) and the decision-making process associated with child marriage. Parental decision-making can be analogous to everyday decisions made on behalf of others, or surrogate decision-making, and the risk preferences involved. Tunney and Ziegler (2015) explained the surrogate decision-making process as one that produces an outcome that will affect another person. Surrogate decision-making is often used in situations when individuals are unable to make informed decisions for themselves, as in the case of child marriage. The constructs of social value theory (SVT) explain parental decision-making in terms of individual preferences for adopting community social norms regardless of the associated health risks of child marriage. The parents believed they needed to follow their group of reference or behavioral rules to conform to a socially acceptable norm (Bicchieri et al., 2014). SVT suggests that decision-making for others is driven by social values, leading to acceptable, or reference group–sanctioned, behavior, in contrast to personal decisions that are influenced by other determinants (Dore et al., 2014).

Figure 1 illustrates the mechanism of decision-making proposed by SVT (Dore et al., 2014): the social values underline the process, or the norm referred to as an injunctive norm, and the decision-making process. The surrogate decision-making process for self and others, or self–other after Tunney and Ziegler (2015), was used to explain the parental risk preferences.

Figure 1. Mechanism for decision-making in social values theory (Dore et al., 2014).

The other elements of SVT are the perceived social norms and the decision-making processes that combine with the perceived social value to determine parental decision-making. First, SVT expediently explains the immediate question of whether decisions people make for others are different from the decisions they would make for themselves in cases involving risk aversion, such as those involved with child marriage. SVT further explains why parental decision-making relies on the dominant factors when making marital decisions underscoring the significance of the perceived value of child marriage in the community. These factors are interrelated with injunctive norms that are socially sanctioned by society and consistent with established explanations for the causes of child marriage.

Based on these assertions, parental decisions to marry off their underage children can be modeled into four main categories based on intent. (1) Benevolent, where parental decision-making can be selfless or other-regarding. This type of decision results in one based on what the parents think is best for the child, irrespective of the aspirations, goals, or desires of the child. The focus here is on *what the parent should do*. (2) Egocentric, in which the parents can be perceived as selfish and egocentric when they fail to meet the child's expected aspirations and goals of well-being. The focus here is on *what is wanted by the parent*. (3) Simulated, where

parents attempt to model the goals and aspirations of the child, or what is best for the child, by targeting the decision outcomes to match those of the child. The focus here is on *what would the child do*. (4) Projected, when the parental decision is based on what the parents would do or prefer if they were in the child's position. The focus here is on *what would the parent do*. Although the surrogate's intentions might be good concerning the normative expectation, their judgment is based on their utility functions or goals. The outcomes of the decisions are determined by the differences in the intention and ability of the parents to meet the perceived wishes and aspirations of the child. Examples of wishes and aspirations of girls may include avoiding the risks associated with child marriage, marrying at an older age, and preventing the associated health consequences. Figure 2 shows the model drawn to qualitatively predict the parental decision-making process. Parents can attempt to model the goals and aspirations desired by the child, or what is best for the child, by targeting the decision outcomes to match those of the child. The focus here is on *what would the child do*.

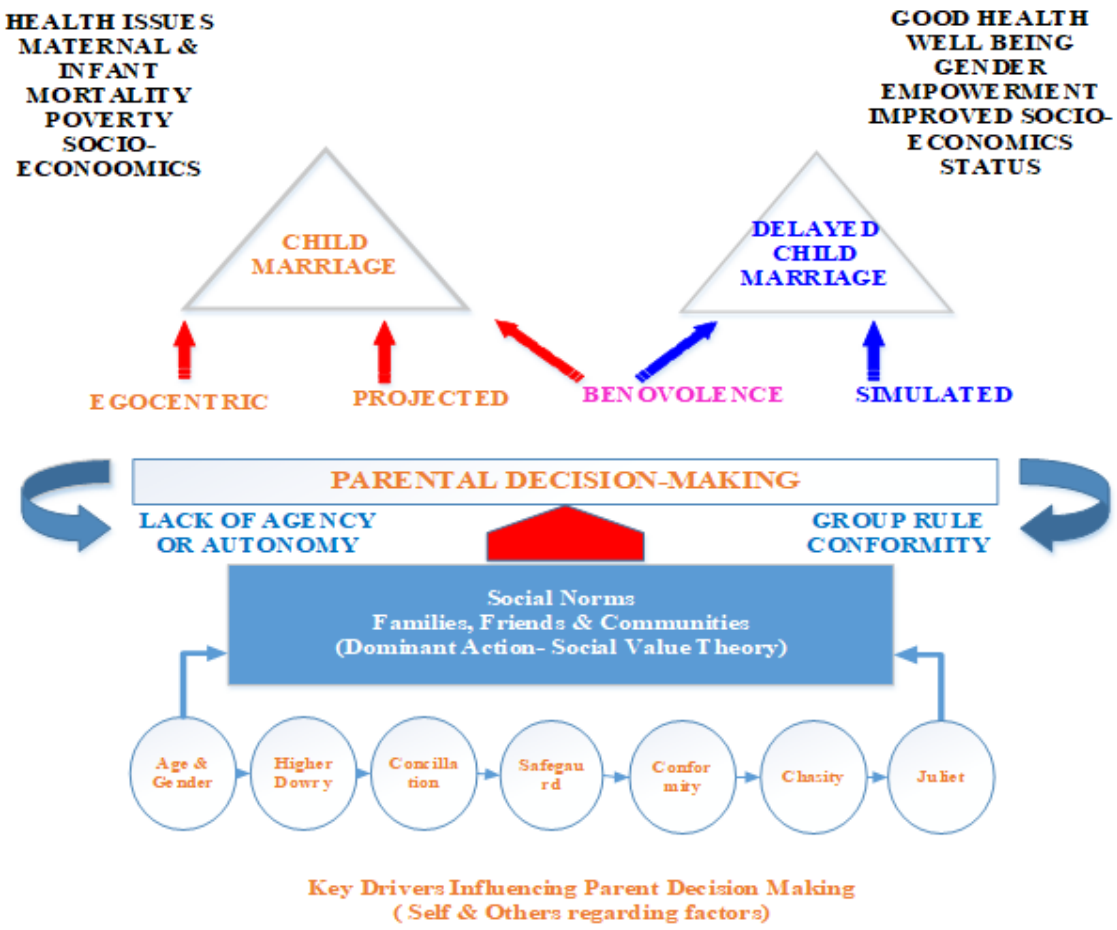

Figure 2. Conceptual framework for parental decision-making process for child marriage. Associations between the elements are indicated.

The egocentric or projected decision will almost certainly lead to child marriage, unlike the simulated decision, which favors the child bride's goals and aspirations. The benevolent decision-making option can go either way, resulting in child marriage or accidentally aligning with the girl's perceived goals and aspirations. This is accidental or coincidental because it is not intended to meet the desires of the young girl.

Figure 2 shows how families, friends, and the community can influence the injunctive norm, depicted as a blue shaded rectangle, which is driven by various determinants or causes of

child marriage—age, gender, dowry, conciliation, safeguard, conformity, chastity, and Juliet (Bicchieri et al., 2014; Perlman & Adamu, 2017; Walker, 2017). The model predicts that child marriage relies on egocentric, projected, or benevolent behaviors of the parents and is only delayed in simulated behaviors. The resulting harmful effects of child marriage and potential benefits are listed in Figure 2. The framework derived from this research can serve as a tool to provide a qualitative assessment of the parental options and choices concerning child marriage and may have practical use in the design of health and social interventions required to curb and prevent child marriage.

Methodology

Research Questions

The following research questions guided the study and were informed by the identified gaps in the literature, designed to explore parents' lived experiences of the role of the bride's health in the broader process of permitting child marriage. The objectives were to achieve a nuanced understanding of the role of the bride's health in parental decision-making in child marriage.

RQ1: What are the lived experiences of parents who married off their children under 18 years of age?

RQ2: What role does a bride's health play in her parents' decision-making for early marriage?

Data Collection

This research was a qualitative study based on in-depth IPA methodology. IPA is based on three primary theoretical underpinnings and draws from fundamental principles of phenomenology, hermeneutics, and idiography. IPA's primary constructs relate to the interpretation of reality and participants' lived experiences (Smith & Osborn, 2015). The

approach aimed to examine the personal experiences to produce an account of decision-making through lived experiences, understandings, perceptions, and personal views rather than as prescribed by preexisting theoretical preconceptions. IPA is particularly relevant for examining complex phenomena, such as child marriage, for which data is collected in the form of personal accounts in a natural setting and individuals make sense and meaning of their life experiences.

The research setting was among the patriarchal societies of Hausa-Fulani ethnic communities in northeastern Nigeria. Most of the population of interest comprised individuals with low incomes, education, and health literacy and who were entirely dependent on subsistence farming and cattle rearing. The Hausa-Fulani people represent the largest ethnic community in sub-Saharan Africa (Walker, 2012) have one of the highest child marriage rates in the world, at up to 76% (UNICEF, 2017, 2019). Early marriage is a feature of girls' adolescent life in this region and a pivotal experience of their well-being. The chosen sites were culturally homogeneous communities located between 300 and 500 kilometers apart, namely Yola, Bauchi, and Maiduguri in northeastern Nigeria.

The study participants were selected using purposive sampling. All participants were required to be from the Hausa-Fulani ethnolinguistic group residing in northeastern Nigeria. The sample included male or female parents identified from the designated study locations. The research plan generated a purposive sample that captured parents' life experiences from the three selected towns. Parents who had married off their daughters as minors during the past 5 years (i.e., 2014 to 2019) were prescreened and selected. Participant recruitment focused on parents from the bride's side in the identified sites.

The interview questionnaire was designed to be consistent with the research questions that explored the practice of child marriage, the parental decision-making process, and whether consideration was given to health consequences. The interview outline was structured and defined based on IPA, which enabled the achievement of a nuanced understanding of child marriage (Appendix A). The interview was conducted in the Hausa language and translated using a web-based Google Hausa language translator application.

Table 1

Summary of participants based on location

Participants	Bauchi	Maiduguri	Yola
Number of participants at the start of the study	7	7	7
Pseudonyms of interviewed participants	RP1, RP2, RP3, RP4, RP5, RP6	RP8, RP9, RP10, RP11, RP13	RP15, RP16, RP17, RP18, RP19, RP20, RP21
Pseudonyms of participants who dropped out of the study	RP5	0	RP17
Pseudonyms of participants who could not be interviewed*	RP7	RP12, RP14	0

*These participants could not be interviewed because of the COVID-19 emergency. Alternative methods approved by Walden University could not be used because of poor internet services in northeastern Nigeria.

Recruitment was conducted in person by approaching unknown participants in strategically selected public locations in various areas in each city. The interview was a one-on-one, face-to-face meeting involving a direct verbal conversation that positively conveyed the

research's aims and objectives. Short, focused, open-ended, semi-structured questions were used for the interview, which lasted between 1 and 1.5 hours, including the follow-up question. Twenty-one main interviewees were purposely selected, along with five backup participants, consistent with the defined sampling plan. However, only 18 participants could be interviewed, because two participants (RP5 and RP17) dropped out for personal reasons, three others (RP7, RP12, and RP14) could not be interviewed because of time constraints due to the COVID-19 emergency evacuation, and time did not permit approaching the backup participants.

Data Analysis

Qualitative content analysis was used to provide a subjective interpretation of the content of the participants' interviews through a systematic coding process of sorting and identifying themes or categories that articulate a broad and condensed description of the phenomenon. The data analysis was reduced to six thematic focuses, drawn from 33 major categories, 22 subcategories, and 44 codes that emerged from the raw interview data. Qualitative text analysis software package QDA Miner version 5 and Microsoft Excel 2016 edition were used to repeatedly scan and sort each transcript by indexing the words and repeated expressions.

The six thematic focuses were (a) social values, (b) social norms, (c) parental decision-making, (d) sanctions, (e) perceptions and aspirations, and (f) the child bride's health. Direct quotes from the participants were captured to ensure an accurate presentation of the views expressed. The thematic focuses, codes, and research questions are shown in Table 2.

The results are presented by thematic focus, citing participants' responses and providing explanations to describe the context of the input relative to the research questions. The personal narratives were drawn from responses to the questionnaire and distilled from the identified codes to develop thematic categories. The analysis identified six themes that described the participants'

lived experiences of early marriage decision-making and the role of the bride's health in this process.

Table 2

Thematic focuses, codes, and research questions derived from the data

Thematic focus	Codes	Research questions
Social values	Early marriage values	RQ1 & RQ2
	Honor and shame	RQ1
	Purity and chastity	RQ2
	Bearing children	RQ1 & RQ2
	Behavioral expectations	RQ1 & RQ2
	Marriage preparations	RQ1
	Family and friends	RQ1
	Readiness for marital responsibilities	RQ1 & RQ2
Social norms	Marriage age	RQ1 & RQ2
	Dowry—bridewealth	RQ1
	Negotiations and transaction	RQ1
	Marriage contract	RQ1
	Wedding ceremony	RQ1
	Arranged marriage	RQ1 & RQ2
Parental decision-making	Parental decision-making	RQ1
	Guardian of the marriage or *wali*	RQ1
	Love arranged marriage	RQ1
	Forced marriage (no consent)	RQ1
Sanctions	Community leaders	RQ1
	Refusing an early marriage	RQ1
	Social consequences for the girl for late marriage	RQ1
	Social consequences for the family for late marriage	RQ1

	Sanctions for premarital sex	RQ1 & RQ2
Perception and aspirations	Girl's voice	RQ1 & RQ2
	Alternative options to early marriage	RQ1 & RQ2
	Social consequences for the family for late marriage	RQ1 & RQ2
	Love marriage	RQ1 RQ2
Bride health	Obstetric fistula, vesicovaginal fistula	RQ2
	Infant and maternal mortality	RQ2 RQ2
	Mental illness, intimate partner violence	RQ2
	Rejection due to ill health	RQ2
	Marital responsibilities	RQ2

Limitations

This research's limitations include confining recruitment to three towns in a specific geographic region of northeastern Nigeria and a relatively small population of interest and sample size. Other limitations faced during the research included difficulty with acceptability or obtaining permission from community leaders and having COVID-19 affect data collection because of travel restrictions in Nigeria and returning to the United States. Nevertheless, the findings may apply to other Hausa-Fulani ethnolinguistic communities in the region and sub-Saharan Africa.

Results

Thematic Focus 1: Social Values

This thematic focus is integral to the perceived early marriage values in the community. The thematic focus on social values appeared consistently in every participant's response. Each participant

described a set of perceived social values attributable to the practice of early child marriage. For example, when asked questions regarding the exact age at which they married off their daughter and their personal views on the appropriateness of the marital age, 13 participants directly related early marriage to specific individual and community values derived from their traditional and cultural beliefs. Two participants' perceptions extended beyond the individual and community in associating these with belief systems as part of the tradition. Participant RP3 eloquently stated:

> My daughters were married on the same day. The younger one was 12 years of age; her sister was married at 14 years. These days, the girls grow up more quickly and mature faster. They all started their menses in their marital homes, so it is the right age as defined by our beliefs and traditions. This is the right time, as girls should not start menstruation while still at her parent's home. We decided to combine the ceremonies; it was a blessing for everyone and the community.
>
> This makes obvious that the trigger for marriage is the onset of maturity that comes with a girl's commencement of menstrual periods, determined as the right marital age.

Shame and Honor

A resonating response was heard from all participants regarding the protection and perceived aspiration of child brides by the parents. Shame and honor were associated with protection and the perceived well-being and aspiration of these girls. Participants from the three towns emotionally connected the perceived values derived from early marriage to honor, chastity, and protection offered to the adolescent girls from the evils of society. The participants' responses to the questions on shame and honor were mixed: a few were more enthusiastic, whereas others were dampened because of specific

incidents. I perceived the question was poignant as it touched on some of the underlying reasons parents married off their underage children. For example, RP21 stated:

> We married our daughter at age 12 years to protect her honor and the long-established respectability and pride of our family, without which there will be only shame that comes with promiscuity and prostitution, leading to increased chances of unwanted pregnancy. That is unacceptable and will bring disrepute and shame to my household… This is every parent's God-given responsibility to look after his daughter and marry his daughter at the appropriate age, as everyone is concerned about the shame that needed to be avoided, else the penalties transcend generations, damaging the long-established reputation, dignity, and respectability of the entire family.

Thematic Focus 2: Social Norms

The participants' responses associated with social norms were methodologically broken down without diminishing or misrepresenting their core meanings. A summary is presented in Table 3. For example, the marriage age consideration was one of the most important norms in the community. All 18 participants stated 11 to 15 years as the appropriate marital age according to community social norms, consistent with their traditions passed unchanged through generations. All participants agreed that social expectations and norms in marital age were dictated by the community. In these cases, no specific age was set for the marriage. The onset of menstruation was seen as the most appropriate time. All participants directly or indirectly mentioned their fear of older daughters not having a husband. RP11 mentioned:

The commonly observed ritual of marrying off daughters at the onset of their menstrual period as an accepted practice has remained strong throughout the community and over time. The payment of a dowry or bridewealth was another norm emphasized during the interviews;

participants highlighted the criticality of dowry payment as a prerequisite for marriage, which upholds the marriage contract.

Table 3

Codes, research questions, and quotes for the thematic focus 'social values'

Thematic focus	Categorized codes	Research question	Significant statements shared by the participants	Exploratory comments
Social values	Marriage age	RQ1 & RQ2	In our culture and belief of marriage, girls are married just before they start menses; this can be either 11 or 12 years of age or sometimes even up to 15 years old. My daughter was due for marriage at age 12; she was ready to marry.	The commonly observed ritual of marrying off daughters at the onset of their menstrual period.
	Dowry–bridewealth	RQ1	Dowry payment is compulsory, without which there is no marriage. The husband could not assume full rights until it has been paid. In my daughter's case, the groom's family made the payment in cash and seven cows. This is sanctioned by our religion; these are wealth given in full to the bride.	Importance of the dowry or bridewealth in the institution of marriage in the community.
	Negotiations and transaction	RQ1	There were very extended negotiations in my daughter's marriage. There were issues with the dowry amount of marriage, selection, and agreement of the marriage representatives, the dates of the marriage, including the bride delivery location; the house was too small, there was simply no space.	Recognition of the transactional part of the marriage contract.
	Marriage contract	RQ1	In our culture, the marriage contract is witnessed; its formal and verbal proclamation is made under oath and is administered by a religious community leader. The bridegroom's representative and parents made a request and indicated our daughter join their son, and my daughter's representative, her senior uncle, accepted on behalf of our family. The Imam recited some portion of the Quran and teaching of the Prophet, alerted the witnesses, and declared my daughter married	Detailing the practice includes public declaration and witness, underpinned by religious beliefs.

			according to Islamic teachings by a public announcement with hundreds of invitees from both the bride's and groom's families and friends.	
	Wedding ceremony	RQ1	The ceremony started 3 days before the formal wedding contract or *Fatiha* when the bride is delivered to her husband's house. The first day was the application of henna to be delivered by the groom's family. This is a ritual indicating that she is now formally engaged and cannot leave home. The next day, the bride was bathed by her family in the presence of the groom's family and a *walima* or dinner was held to honor the bride, friends, and extended families to ready the marriage contract sign-off. There has never been as much crowd in this town as we have seen. She was blessed. We did not even have enough space to accommodate our relations. We thank God, everyone stayed after the Friday prayer. It was joyous for all families and friends. Her uncle slaughtered a goat and distributed food.	Describing the practice of wedding ceremony, a necessary ritual followed marking the importance of the institution of marriage.
	Arranged marriage	RQ1 & RQ2	At times what happens is that the man wants to marry a girl who doesn't want him. But, if the man's family finds an agreement with the girl's family, they force the girl to marry him.	The indication that the marriages may not be with the girl's consent, as parental decision overrides a girl's resistance to her parents' choice of a husband.

Thematic Focus 3: Parental Decision-Making Process

The thematic focus on parental decision-making is relevant to both RQ1 and RQ2. At least 17 participants mentioned that the bride's father made the final decision to marry off their daughter. For example, participant RP20 indicated:

> My husband decided after consultation with his extended family relatives. Her most senior uncle had the final say. He was assigned as the *wali* or bride representative and he

> was elected to present her during the wedding to the groom's family and serve as the negotiator in all issues related to the marriage.

Six participants described a significant influence on the father from an extended member of the family. For example, participant RP17 stated:

> Her senior uncle planned to marry off his daughter, and he decided to have them married altogether. Both of us [father and mother] could not refuse, as she is equally his daughter. We only pray and wish her well in her matrimonial home, even as we did not think she was ready or matured enough to bear marital responsibilities.

Thematic Focus 4: Bride's Health

All the participants mentioned directly or indirectly that the bridegroom would not marry their underage daughter if she were unhealthy or sick with any illness. The child bride's health was determined by her general well-being before the marriage, and no formal medical examination was conducted as part of the marriage process. This section is divided into five subsections highlighting the consequential effects of child marriage in the population of interest as shown in Table 4.

Participant RP15 indicated that his daughter was perfectly healthy before marriage, but afterward, she became sick with mental illness and was thought to have been infected by jinns or witchcraft. The participant described the situation:

> She was a very healthy girl and never been ill. All it takes is 3 months to get sick and she's been ill. Thank God she is getting better. My daughter will never go back, never– God forbid and protect her from these evils.

From the narration given by RP15, it appeared that his daughter was experiencing psychological or mental illness caused by a lack of care and physical and mental abuse in the form of intimate partner violence. The parents-in-law explained to the parent that his daughter

misunderstood others and repeatedly complained about the older wives treating her badly. Participant RP5 described a similar situation in which a bride was returned by her husband due to health complications:

> My daughter has urination problems [obstetric fistula]. The husband distanced himself and returned her back to us; he says it is the influence of witchcraft after failing to get treatment. The doctor [nurse's medical record] said she wasn't matured enough for childbearing. It's very hard for us as there are no medicines in the hospital; she is sick, and we were planning to send her to her uncle in Kano after selling this year's bean harvest.

As the participant explained what his family was going through, he could hardly conceal his anger toward his daughter's husband for abandoning her and returning her home after she sustained injuries during childbirth. Due to her injuries, she had been rejected by her husband and his family who associated the health problem with witchcraft.

Health issues related to urination are prevalent among child brides and lead to rejection and social stigmatization in the community. Urination problems linked to child marriage, similar to psychological or mental health illnesses, are always thought to be caused by either jinns or witchcraft. Witchcraft and jinns were echoed repeatedly in the interviews because the former is an essential source of traditional medicine that predates modern medicine in the community.

A grieving participant (RP18) recounted what had happened to his family in a very emotional tone, sometimes breaking into tears during the interview. I tried to suspend the interview, but the participant insisted on completing it.

> My daughter lost her son during delivery, she was hurt; it was an act of God, she wasn't strong, she wasn't well, and she was not eating well during the pregnancy. She has been

working very hard in her parents-in-law's home, and it's a large house. We are praying for her to get well.

For RP10, the situation was tragic and unbearable as he conceded to losing his only daughter and grandchild:

In summary, for the theme of the child bride's health, there was no indication that specific considerations were given to the underage girls. Although it is also clear that only healthy girls can be married in the community, underage girls are not ready to bear the responsibilities of marriage and childbearing. None of the participants acknowledged the health consequences associated with marrying off their young daughters.

Table 4

Codes, research questions, and quotes for the thematic focus 'bride's health'

Thematic focus	Categorized codes	Research question	Significant statements shared by the participants	Exploratory comments
Bride's health	Obstetric fistula	RQ2	My daughter has urination problems [obstetric fistula]. The husband distanced himself and returned her back to us. He says it is the influence of witchcraft after failing to get treatment; the doctor [nurse's medical record] said she wasn't matured enough for childbearing. It's very hard for us as there are no medicines in the hospital, she is sick, and we were planning to send her to her uncle in Kano after selling this year's bean harvest.	Consequential health effects of underage marriage, the girl sustaining Vt, unable to hold urine, facing rejection, and associating health problems with witchcraft.
	Maternal and infant mortality	RQ2	My daughter lost her son during delivery, she was hurt; it was an act of God, she wasn't strong, she wasn't well, and she was not eating well during the pregnancy. She has been working very hard in her parents-in-law's home, and it's a large house. We are praying for her to get well.	The girl was too young for marital responsibilities and childbearing. Parents-in-law made her perform household duties. Unwell, she lost the baby after a difficult pregnancy.

		RQ2	She lost the baby, and we lost her. This is a tragedy, an act of God. This was her fate. Everyone liked her; her husband has been in shock and wasn't talking. He and his father did everything; she had the best nurses and midwives around in the city hospital.	The girl was unable to carry through the pregnancy and childbearing; the baby died during delivery and she died due to injuries sustained during birth. Her parents attributed this outcome to her fate and an act of God.
	HIV/AIDS	RQ2	The husband died; she followed him and died. He infected all his three wives with a mysterious illness [HIV/AIDS]. They never recovered, they could not afford medicines [crying]… all we could do is to bury our child and leave the judgment to God. We have her son, a good boy.	The parents forced their underage daughter to marry an older man with HIV/AIDS. She died along with other wives from the polygamous marriage.
	Mental health, psychological	RQ2	She was a very healthy girl and never been ill. All it takes is 3 months to get sick and she's been ill. Thank God she is getting better. My daughter will never go back, never—God forbid and protect her from these evils.	The girl had malaria, which led to mental illness caused by physical and mental abuse, lack of care, and intimate partner violence.

	Marital responsibility	RQ2	Thank God. My daughter is overworked and never respected, there is so much witchcraft, so much harm is done to her. The Imam says jinns infected her. She was chained in the hospital for months. She is better now, quite; thank God, she will soon be herself. The husband and his parents couldn't care less, there are even rumors of dowry return when they didn't spend a penny on her medicines. It's a shame.	The girl was experiencing mental illness caused by physical and mental abuse from her husband and parents-in-law, isolation, and rejection.

Discussion

The role of shame and honor indicates that Hausa-Fulani parents marry off their underage daughters as insurance against the shame and lack of respect that comes with premarital sex and illegal pregnancy. Shame and honor are substantial and underpin the Hausa-Fulani communities' reasons for practicing child marriage with the objectives of preventing promiscuity, prostitution, and increased chances of unwanted pregnancies. The community insists on doing everything possible to avoid shame and sustain the family's honor and respectability and the associated pride. The findings from this research highlighted specific social values driving the practice of child marriage in Hausa-Fulani communities. The perception was that shame comes with social stigmatization and a loss of respectability, pride, and honor, all of which are profoundly cherished by Hausa-Fulani ethnolinguistic communities. This finding is an extension of previous knowledge about Hausa-Fulani and is consistent with the current literature (Perlman et al., 2016; Adetokunbo et al., 2016).

The shared perception in Hausa-Fulani communities of social values centered around early marriages as beneficial to the child, parents, and community. This perspective is an extension of knowledge on child marriage because children were never perceived as beneficiaries within the practice. This finding validated the theoretical and conceptual model, which showed that parents might marry off their underage children for unselfish and benevolent reasons that align with the children's goals and aspirations. This finding contrasts with literature that has presumed parents are selfish and egocentric in failing to meet the child's expected aspirations and goals of well-being (Nour, 2009; Adedokun et al., 2016). Further, it stresses the significance of social values derived from child marriage, confirming the work of Bicchieri et al. (2014) and Cislaghi, Mackie, Nkwi, and Shakya (2019).

Participants' narratives highlighted that social norms are deeply rooted in guiding the practice of child marriage in Hausa-Fulani communities, confirming the findings reported by Perlman (2017). These norms are long-standing and particularly crucial because social life within Hausa-Fulani communities is organized around the family unit in a communal home system. The data also showed that social norms concerning the appropriate age of marriage, the amount of a dowry or bridewealth, and acceptance of arranged marriages are deeply rooted in the community. In a comparative analysis for the same geographical setting, Amodu et al. (2017) argued that Hausa-Fulani ethnolinguistic social norms had been preserved and the communities were resisting modernity.

Data from participants' responses in this study suggested no rule existed regarding at what age a girl should be married, and the onset of menstruation was the definition of maturity for these girls. The social norm was for parents, particularly mothers, to be tasked with observing

their daughter's readiness for marriage at the onset of menstruation. SVT's theoretical and conceptual model supported the analysis of child marriage as a social norm.

Exploring the parental lived experiences of Hausa-Fulani communities in the decision-making process on the practice of child marriage provided greater insight and contributed previously unavailable knowledge on the subject. The study established that fathers had made the final decision to marry off their underage daughters, although this decision was often influenced by family, friends, and the community. The current study indicated that in 80% of cases, the father made the final decision to marry off an underage child. The study further clarified the father's responsibility for choosing the suitor and managing marriage transactions, including deciding on marriage timing. This confirms the findings of Perlman et al. (2017), who studied child marriage among the Hausa residing in the wider geographical region of northern Nigeria and the Republic of Niger.

This study did not find direct evidence to support the argument that poverty influences the practice of child marriage; however, it must be noted that the study was based on a small sample. In the studied communities, parents explained that child marriage practices cut across affluent and low-income families alike, and the phenomenon is driven by social norms informed by traditional customs and religious beliefs. The research findings indicated that most of the parents were content and comfortable in feeding, clothing, and sheltering their children, and they perceived this as a sacred responsibility. Therefore, participants rarely discussed poverty as a factor in child marriage decisions in the study community. Notably, the research design ensured the inclusion of both low-income and affluent participants from the communities. Parents spoke of the necessity of protecting these children from society's evils and difficulties in getting a husband for older girls having higher significance than any adverse effects. In contrast to this

study, the importance of poverty as a factor and driver of parental decision-making in marrying off underage children has been reported (Adedokun et al., 2016; Bhat et al., 2005; Raj & Bhoehmer, 2013; Walker, 2012). Although poverty can be rationally understood and accepted as an essential driver of child marriage in communities where the population is predominantly poor with low socioeconomic and literacy statuses, this relation was not observed in this study.

The findings concerning the theme of the child bride's health, a central focus of this research, revealed the unanimity of the participants' view of the health and well-being of their children as an essential prerequisite for marriage. The health consequences and the rejection of the adolescent girls who became sick after their marriage exposed in this study are inconceivable. The results reaffirm that the practice of child marriage has detrimental effects on the health of these children and demands an urgency to curb and prevent child marriage practices. The current study revealed that the child bride's health is given significant consideration before the marriage contract is drawn. Participants overwhelmingly narrated that the bridegroom and his family would never consider their daughter if she were unhealthy or sick with any illness. However, little or no consideration was given to the consequential health effects after the marriage, characterized by neglect, abuse, and rejection of child brides due to ill health.

Recommendations

This study prescribes an expanded research initiative focusing on child marriage's health effects, with increased sample sizes and broader geographical coverage. Such an effort is needed to develop appropriate interventions to end or change behaviors and attitudes related to child marriage practice. It is clear from this study that the social norms and values within Hausa-Fulani communities are limiting girls' voices and their opportunities to challenge decisions concerning

their aspirations, such as delaying marriage to attend school or acquiring skills to improve their social and economic well-being.

Implications for Positive Social Change

This research project originated from my passion for instituting positive social change in the population of interest. My parents and generations of grandparents are products of child marriage, and I come from the population of interest area. Child marriage is deeply rooted and institutionalized in tradition and culture in the community (Adedokun et al., 2016; Perlman et al., 2017; Walker, 2012), and this research was initiated to qualitatively explore in depth the lived experiences of the active participants and the health effects on the child brides, who are the silent victims. The primary objectives were to bring about positive social change that would curb and eventually end the practice of underage marriage in the region and elsewhere in the world. The health consequences revealed in this study and validated by prior research need to be prevented through behavioral and attitudinal changes in the community using public health education awareness campaigns.

Conclusion

This study reported on a qualitative research exploration of child marriage among Hausa-Fulani ethnolinguistic communities in northeastern Nigeria. Hausa-Fulani people are a profoundly socially conservative and patriarchal society. The decision to marry off these children is the preserve of male parents in Hausa-Fulani communities, and this finding is consistent with what has been observed in male-dominated patriarchal societies. The health consequences have been determined to cause the prevailing high rates of infant and maternal mortality, obstetric fistula, and psychological and mental illness in the interest population. The parental lived experience data provided insight into the core driving factors that sustain the practice of child

marriage through social value expectations and social norms handed down through generations. Social values emerged as critical factors in determining the communities' identities, bounded by common sociocultural practices. These factors were sustained and preserved in the community by the community religious leaders, who serve as guardians of the customary traditions.

The child bride's health was a necessary condition for marriage, and the marriage would not proceed if she were sick or affected by ill health. However, such consideration ended at the time of marriage. No consideration was given to whether the girl was mature enough to bear marital responsibility and childbearing. A model was drawn based on the theoretical and conceptual framework that qualitatively explained and predicted the potential outcomes of parental decision-making in child marriage and the associated harmful consequences of the practice.

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Appendix A: Interview Guide (Questionnaire)

Participating parents who married off their daughters under age 18 years within the last 5 years.

Step 1: Obtain consent from all respondents before beginning the interview.

Step 2: Interview the parents who consented to the marriage of their children at an early age (under 18 years old).

Interview Data

Date of the interview_____Start time_____End time _____

Pseudonym: _____

Prelude

The thematic focus of the in-depth interview is on exploring the lived experiences of parents in marrying their underage daughter, the decision-making process, and the role of the bride's health. It is intended that parent and religious leader participants respond with their own words.

Main Research Questions

RQ1: What are the lived experiences of parents who married off their children who were under 18 years of age?

RQ2: What role does a bride's health play in her parents' decision-making for early marriage?

PART 1: Parents' Lived Experiences of Early Marriage

First, thank you for volunteering to participate in this research. I would like to talk with you about your personal lived experience marrying your daughter under 18 years of

age, how you came to the decision, and what considerations you may have given regarding the bride girl's health.

Warm-Up Questions

Parents

(a) Please tell me a little about your married life in this community?

(b) Do you think your experience within your married household is common?

(c) What would you say about the prevailing health issues in young brides in this community?

Interview Questions

1. What do you think about the age at which your daughter was married? What is your view and What does it mean to have your daughter married at this age and why?
2. At what age do you think girls should get married? And why?
3. Do you think there are benefits/disadvantages to marriage before 18 years of age?
4. Can you tell me any social, economic, or health benefits of delaying marriage and first birth?
5. What do you think are the benefits/disadvantages of delaying marriage and first birth? (In terms of health, social, economic, and education aspects.)
6. What sorts of norms and practices are there in this community around early marriage and have they shifted over time? If so, how and why?
7. What preparations (economic, guidance, skills training, etc.) were entailed in the marriage transaction? What did you think about this?
8. Did the preparation go as expected? How is this similar or different to your day?

6. What are the incentives for parents to marry their girls at an early or later age? Why

are the incentives for girls to marry at an early or later age?

7. Is the bride price given at marriage in this community? Why/why not? What does it consist of? How do you feel about it? What if it is not given?
8. What are some of the disadvantages (practical/economic and social) of marrying at an early age? Remaining single? • For you as a parent; for your daughter girls; or other family members (e.g., brothers, sisters, uncles, aunts, cousins)? [Some themes being explored include the values of virginity vs. experience; marrying for love vs. marrying for money, etc.; children or marriage.]
9. What are your experiences in these issues?
10. How was the marriage proposal made, and by whom?
11. Why did this individual propose?
12. Was the marriage proposal presented to you directly or did you hear about it through somebody else?
13. What was the age of the person who proposed marriage to your daughter?
14. How was your daughter's husband selected, and what criteria led to the acceptance of the choice?
15. Did you and your child agree on this? Why/why not?
16. Did you and your spouse agree? Why/why not?
17. Do girls get to choose their husbands? Why/why not?
18. Are there particular groups of girls who have greater agency/flexibility in the process?
19. Has this been changing over time? Why?
20. What happens if girls don't follow arranged marriages?
21. What are your expectations of your daughter?

22. What are girls expected to do and how are they expected to behave?
23. What are her alternative options?
24. Do girls feel under pressure to live up to those expectations? If yes, where do you think the pressure comes from?
25. What were your feelings about that? Are you satisfied with the marriage?
26. Do you have any regrets marrying your daughter at this age?
27. What are your personal experiences of marriage at an early age?
28. Did you go through a similar process? Marrying at an early age.
29. What is was the differences and why?
30. If you must go through the marriage process, would you do it all over again?

Decision-making

31. How did you come to the decision to marry off your daughter?
32. What are the transaction processes?
33. Did you consult anyone–spouse, family friend, imams?
34. Who has the greatest influence on your decision-making process and why?
35. What motivates this decision-making process?
36. What happens if a girl gets married or cohabits early without informing her family?
37. What factors did you consider before making the decision? Why are they important?
38. What are some values/customs/attitudes that promote/discourage girls' marriage at a certain age? [To be separate during questioning.] Have these changed over time? Why and in what ways?
39. What other options do you have besides marrying her off under 18 years old? If she wasn't married what would she have been doing?

40. What do you think about girls' education? Do you think girls should go to school like boys do?
41. Who made the final decision on your marriage?
42. Please briefly tell me the chain of events that eventually led to the decision. Was there agreement among all family members? How easy or difficult were these decisions?
43. Who was most influential in the decision and why?

Sanction and values

44. What are the consequences economically, socially, and legally of child marriage?
45. If a girl's parents want her to get married early and she refuses, what happens?
46. What happens to you and your family in the community if you do not want to marry your daughter?
47. What happens if your daughter expresses dislike about your proposed husband for her?
48. How do you react? What do you do next?
49. Where do the values come from (e.g., religious leaders; better-off families; based on own experience)?
50. Who advocates/articulates/gives voice to this ideal?
51. Can you tell me about the community support you received regarding the decision to marry your daughter? For example, how supportive other families were, law enforcement bodies, government, health service workers?

PART 2: Parents' Lived Experience of the Role of Bride Girl's Health

Next, I would like to talk with you about the causes and consequences of early marriage, particularly the role of the bride's health during and after the marriage.

52. What role do the bride's health and well-being play in the decision-making process?
53. What is the state of health and well-being for the bride during the marriage and afterward in her husband's house? Who follows up on this? When and how do they do so?
54. What are the key roles and responsibilities of girls and the people in the family? At what age you think girls should have their first baby? Can you tell me what you know about first births?
55. How did you determine your daughter's readiness in being able to handle marriage and childbearing responsibilities?
56. What are the values of being a girl/wife in the community? What types of things are girls told they shouldn't do? Do you think they are capable of taking on marital responsibilities and that of childbearing?
57. How do you react to/behave toward other families/parents who can't attain these values (tolerate, look down on them, shun them, etc.)? What happens if you can't attain this?
58. What are their positive/negative expectations from marriage [including probes around children, family honor, economic security, emotional well-being, fear of gender-based violence, concerns about care work burden, etc.]?
59. Do girls feel under pressure to live up to those expectations? If yes, where do you think the pressure comes from? What were your feelings about that?

60. How does the marriage affect the bride's health afterward? Is there something you would like to add?