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Yashua Alkali Hamza

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Walden University
2021

Abstract

Experiences of Married, First-Time Pregnant Adolescents

When Seeking Care in Kano State

by

Yashua Alkali Hamza

MBBS, University of Maiduguri, Nigeria 1998

MPH, University of Liverpool, UK, 2010

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health

Walden University

August 2021

Abstract

Kano State in Northern Nigeria has very high maternal mortality rates. Early marriage and early pregnancies between 15 to 18 years of age are two of the most significant factors in the high maternal mortality rates in Kano State. This phenomenological qualitative research study focused on young first-time mothers' experiences of seeking care between the ages of 15 and 18. The study's theoretical framework was the feminist theory of intersectionality. Colaizzi's seven-step method was the means used for data analysis. This study found that young adolescent first-time pregnant women in Kano City faced significant barriers at home and in health facilities when seeking care during their pregnancies. The barriers to care included harmful gender norms, stigma, discrimination, and increased abuse and disrespect for women perceived as younger, less educated, or less wealthy. Ultimately, the findings showed that the young women could not access health care due to these negative experiences. The implications for positive change included an increased understanding of the health care experiences of young women and the various intersecting factors that cause these experiences. Highlighting these experiences could be a way to start conversations on young, married, pregnant adolescents to remove barriers to their health.

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Dedication

Dedicated to my father, Professor Nur Alkali, who passed away in 2014 and taught me everything that I know.

Acknowledgments

I would like to start by thanking my committee chair, Dr. Jacquie Fraser, who patiently guided me and diligently worked to ensure that I became a successful research scholar. Thank you also to my committee members, Dr. Hadi Danawi and URR, for their guidance a support throughout the process.

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Chapter 1: Introduction to the Study

Introduction

Adolescence is a significant time in the life of any woman. Adolescence spans 10 to 19 years of age and consists of rapid changes in physical, social, and mental functions (Furstenberg, 2016). Although global rates of adolescent pregnancy have fallen, Sub-Saharan Africa still has very high pregnancy rates among adolescents aged 15 to 18 (Kassa et al., 2018). Adolescent pregnancy correlates with high rates of maternal mortality and morbidity and is a significant public health problem, particularly in developing countries with already high maternal death rates. Adolescent mothers in low-income countries suffer more complications of anemia, postpartum depression, pregnancy-induced hypertension, and postpartum hemorrhage (Azevedo et al., 2015; Shahabuddin et al., 2017). Also, babies born to adolescent mothers are 50% more susceptible to perinatal death than those born to mothers above the age of 20 (World Health Organization [WHO], 2014). Young girls who get pregnant not only face an increased risk of maternal death but are often unable to get an education and contribute meaningfully to society, which has an effect on community growth and development (Poudel et al., 2018).

Nigeria has some of the highest maternal mortality rates (MMRs) in the world, and adolescent pregnancies are major contributing factors to those mortality rates (Ayyuba et al., 2016). Regional variations exist in these figures, as Northern Nigeria has disproportionately higher rates of maternal deaths than other parts of the country because of social and cultural practices with adverse effects on women (Aradeon & Doctor,

2016). Globally and within the country, there has been a focus on adolescent pregnancies outside of marriage due to the stigma of extramarital relations, especially within conservative societies. However, in large suburban conservative cities with some of the highest mortality rates in the country, such as Kano State in Northern Nigeria, more than 97% of pregnant adolescents are married (Garba et al., 2016).

Married and pregnant adolescents are an understudied topic of interest. The perception is that married, pregnant adolescents are safe and have the same access to health care as older married women. However, studies have found higher maternal morbidity and mortality risks among adolescents than any other age group (Garba et al., 2016). Kano is a conservative state with high rates of early marriages. Married adolescents in Kano, particularly first-time mothers, have several influences in their lives that obstruct their agency, including husbands, mothers-in-law, and societies with strict gender laws, norms, and relationships (Fawole & Adeoye, 2015). Researchers in the region have indicated that a delay in seeking care correlates with increased mortality among young, pregnant women (Garba et al., 2016). Exploring the experiences of married adolescents and the effect of various external influences on their decisions when seeking care for their first pregnancies could provide valuable insights into the best health promotion approach from the individual to the community and the policy level. Reduced maternal mortality and morbidity rates for one of the most vulnerable groups in a country with some of the highest MMRs in the world could have a significant impact on communities and the entire country.

Background of the Study

Maternal health in Nigeria has long been a subject of interest. Researchers such as Ishola et al. (2017) and Yar'zever (2014) have studied maternal health and its various contributory factors, particularly in Northern Nigeria. According to Yakubu and Salisu (2018), Africa has the highest rates of adolescent pregnancies; however, there is a gap in research on the factors inherent in this phenomenon. Many of the studies reviewed for this research were on older women and the scale of the problem of maternal mortality in Northern Nigeria. A few scholars, such as Ntoimo et al. (2018), focused on older married women and examined the social and cultural context of maternal morbidity and mortality in the region.

Causes of Maternal Mortality and Morbidity in Northern Nigeria

Ariyo et al. (2017) examined data from the 2013 Nigerian Demographic Health Survey (NDHS) to determine the sociocultural determinants of maternal deaths. Ariyo et al. found twice as many maternal deaths in Northwestern Nigeria than other regions, with Muslim-dominated areas having the highest MMRs. In a multicenter study conducted in Northern Nigeria, Ntoimo et al. (2018) found that the most maternal deaths occurred in conservative areas with restrictive cultural and gender norms, a preference for traditional birth attendants, and systemic abuse and disrespect by hospital staff members. Ishola et al. (2017) examined the effect of disrespect and abuse of women during childbirth in Northern Nigeria and their relationships to maternal health outcomes. Ishola et al. found that the women giving birth suffered various abuses, including physical abuse, neglect, undignified care, and confidentiality breaches. They also found that the nature of the

disrespect had direct effects on the women's reduced attendance at health care facilities. The authors suggested conducting more in-depth qualitative research to explore the perspectives of providers, women, and family members to find ways to translate these experiences into evidence for future action or intervention. Yar'zever (2014) also explored the various cultural practices in Kano State and their relation to maternal deaths and found the highest MMRs among women living in rural areas. The most frequent underlying causes of death in those regions resulted from complications due to delaying care-seeking during pregnancy, delivery, or immediately postpartum.

Cultural Practices and First-Time Mothers

Early marriage is a practice rooted in the culture and tradition of the people of Kano. The region has traditional birthing practices for young, first-time mothers that could present danger to their health and contribute to high death rates before, during, or immediately after childbirth (Sripad et al., 2017). The traditional practice includes staying in dark rooms in hot conditions and drinking and bathing with boiling water for 60 days postpartum; this is a practice referred to as *wankan jego*. Wankan jego is a tradition practiced with the mistaken belief that it will cause a woman to resume her natural form and marital duties, including more childbearing, quickly. However, wankan jego associates with peripartum cardiomyopathy, a potentially fatal cardiac condition first described in the early 1970s when scholars discovered that Hausa/Fulani women had the highest incidence of peripartum cardiomyopathy in the world (Isezuo & Abubakar, 2007).

Another practice associated with maternal morbidity and mortality in Kano State is the gishiri cut. When a first-time mother cannot give birth after laboring for a long time, a traditional, often unskilled birth attendant may administer a deep gishiri cut to her genital area. According to Sripad et al. (2017), the gishiri cut is a significant contributor to obstetric fistula in underaged first-time mothers in Northern Nigeria. Obstetric fistula causes uncontrollable dribbling of urine. In most cases, obstetric fistula requires surgical repair and correlates with societal stigma and ostracization. Alkema et al. (2016) stated that although the Hausa/Fulani society shares some practices among different age groups, the gishiri cut has the most significant impact on adolescents.

Utilization of Health Care

Women in Sub-Saharan Africa have very low rates of using health care services throughout the entire continuum of care for pregnancy, childbirth, and labor (WHO, 2014). WHO (2014) suggests that pregnant women require a minimum of four antenatal care (ANC) visits to detect and treat complications early. ANC visits are critical in a continuum of care correlated with favorable maternal and child health outcomes. ANC is a free service in many states in Northern Nigeria. However, according to WHO, 61% of pregnant women in Nigeria attended ANC once, and only 57% made the recommended four visits, compared to a global average of 81% and 96%, respectively, in the neighboring country of Ghana. Fawole and Adeoye (2015) found regional variations in these percentages: less than 5% of women in Northern Nigeria attended full ANC and opted to deliver in health facilities. Giving birth at home without skilled birth attendants leaves pregnant women vulnerable during life-threatening emergencies. Ishola et al.

(2017) cited a lack of trained attendants at birth as the most critical underlying factor in maternal health in the region. Less than 25% of the population of women giving birth in the area did so with skilled birth attendants.

Family Dynamics, Patriarchy, and Control

Northern Nigeria has a majority Sunni Muslim population. Religious and cultural leaders significantly influence how people in the community use health care services. According to Al-Mujtaba et al. (2016), cultural interference is a barrier to health care use in communities. Power and control in African households are significant predictors of maternal morbidity and mortality. Thwala et al. (2019) noted that women in African households lacked the power to decide their pregnancy choices.

In most African societies, a male relative, generally a husband, father, male sibling, or uncle who is the head of the family, takes charge of basic decisions. Morgan et al. (2017) explored the factors in a lack of access to health care services for women. Morgan et al. found that unequal gender roles were a significant factor in family decisions for women to access health care services. A failure to address underlying gender norms could result in a regression in the progress in increasing access to regional health care services. Another issue found by Morgan et al. was the control of funds and resources. Married adolescents often lack control over resources in the house as they are least likely to be fully educated, literate, or gainfully employed, which causes them to be powerless. Alkema et al. (2016) noted that even when women make money, men decide how they use it. Alkema et al. noted that many African men view pregnancy as a natural

process and may feel reluctant to spend money sending their wives to hospitals or paying for extra expenses when complications occur.

The death of women in any community is a tragedy not only for families but for communities as a whole. According to the World Health Organization (2015), the health and well-being of women and children are some of the most sensitive indicators of the overall health and health care services of an area or region. Adolescent first-time mothers are disproportionately affected, and preventing avoidable deaths requires immediate social change. According to de la Sablonnière (2017), many definitions of social change exist; however, one definition is when the actions of individuals or a group of people in their societies, communities, or personal lives produce change with positive effects on people's lives. Lafreniere et al. (2012) noted that such positive changes can occur for social norms, structures, or community values. Exploring adolescent maternal health could produce the evidence needed to challenge long-held, detrimental societal and cultural norms that have caused the deaths of many young women. The findings of this study could contribute to ongoing discussions on how to strengthen communities to find innovative solutions to problems (Ravera et al., 2016). Engaging women in maternal health discussions could be a way to strengthen communities and save lives. Saving the lives of women and children is a significant aspiration in a society with unacceptably high maternal death numbers.

Problem Statement

MMRs in Nigeria have significant regional variations, with figures ranging from 165/100,000 live births in the south of the country to 1,700/100,000 in the north of the

country (Yar'zever, 2014). According to data from the United Nations maternal mortality interagency group, the average global MMR is 216/100,000; however, this rate is 546/100,000 in Sub-Saharan Africa (Alkema et al., 2016). Several reasons exist for regional variations in maternal death in Nigeria; according to Aradeon and Doctor, 2016), compared to the South, Northern Nigeria has low female literacy rates, high poverty rates, and high rates of practicing harmful cultural and gender activities with adverse effects on women.

Kano State in Northwestern Nigeria is the most populated state in the region and the second most populous in the country; it is also predominantly Muslim. Ariyo et al. (2017) noted that conservative areas with high Muslim populations have the highest MMRs. Kano State also has many hard-to-reach areas due to its landmass and vast arid topography, and women in most rural communities face challenges accessing health care. The local ethnic or cultural group is Hausa-Fulani. The Hausa-Fulani has the tribal practice of forced seclusion known as kulle, where women cannot leave the house without consent from their husbands. Kulle is a prevalent practice with significant effects on women's freedoms and rights. Adolescent girls comprise a considerable number of the women in forced seclusion. The mean age of marriage for women in the region is 15 years, and, by 18 years of age, 65% of adolescent girls are married (Aradeon & Doctor, 2016). Thus, adolescent girls face a significant risk for childbirth because many do not have fully developed pelvises and lack the emotional maturity to care for themselves and their babies (Mangeli et al., 2017). Studies in other regions of Africa have shown that adolescent mothers are more likely to have mental health issues and suffer from

emotional and domestic abuse from spouses and extended family members (Kassa et al., 2018).

Several research studies are available on maternal mortality and childbirth experiences among women in Northern Nigeria. However, few scholars have focused on adolescent, first-time mothers in Kano State. Mangeli et al. (2017) found that married adolescents were vulnerable to adverse maternal health outcomes because of their degree of education, agency (the ability to make decisions for themselves), access to sex education, young age, contraceptive use, peer pressure, social taboos against sexual discourse, and emotional fragility. A need exists to focus on married, first-time pregnant adolescents seeking care in Kano State because delays in care when pregnant or during delivery are among the most common causes of maternal death (Garba et al., 2016). A focus on the health of married, pregnant adolescents is the key to the achievement of numerous public health and health promotion programs and goals.

Purpose of the Study

This study focused on the care-seeking experiences of first-time pregnant adolescents aged 15 to 18 years. The goal was to explore how pregnant adolescents viewed the effects of religion, age, and culture on their care-seeking decisions. An examination commenced of the impact of the adolescents’ decision-making, influential societal structures or people, and their societal positions on how they sought care when pregnant. This study included an approach focused on gender and its intersection with various sociocultural determinants to address the effects of gender and sociocultural factors on maternal health.

According to Batist (2019), adequately addressing maternal mortality in Sub-Saharan Africa requires framing the deaths of women as a human rights issue and not just a health issue. Thus, a goal of this study was to focus on the issues of gender, age, poverty, education, and inequalities to contextualize and study maternal health. Such an approach has implications for rural communities in Northern Nigeria, where researchers, such as Ishola et al. (2017), have stated that cultural factors have a greater influence than the availability of health care on the choices women make while pregnant.

Research Questions

The study had the following guiding research questions:

RQ1: What are the experiences of first-time pregnant adolescents in Kano State when deciding to seek care while pregnant?

RQ2: How do first-time pregnant adolescents in Kano State view sociocultural and demographic influences as factors that affect their decision to seek care?

Theoretical Framework

The study had an underlying framework of the theory of intersectionality, which focuses on how systems of power in societies intersect and produce unique, characteristic experiences for those involved (Bright et al., 2015). Intersectionality theory is a branch of feminist theory, which indicates that women's health and experiences are not merely a total of their parts. For instance, being a woman and experiencing childbirth could mean different things to people of different ethnic groups, races, or religions (Hancock, 2007). The socially constructed categories of the theory include race, gender, social class, age, ethnicity, religion, and sexual orientation (Bauer, 2014). The theory originated from

recognizing that women have different experiences based on demographic characteristics and that their experiences transcend gender (Bright et al., 2015). The intersectionality theory, first described by Crenshaw in 1989, indicates that human beings occupy various societal roles that influence their experiences; these roles include age, gender, ethnicity, religion, geography, and social status (Crenshaw, 1994).

Intersectionality theory is a critique of forms of feminism that present all women as a homogenous group. The theory resulted from the discontent of Black women in the United States, who faced oppression uniquely different from their White counterparts and Black women in other cultures (Davis, 2008). Since its origin, the theory has steadily grown in popularity with feminist researchers, who have called for better ways to apply the theory to women's research (Bright et al., 2015). Although the theory originated from the experiences of Black American women in the Southern United States, Sylvain (2001) identified intersectionality as a theory used across the globe as a framework to study the struggles of women against various forces of power and oppression within local contexts.

Figure 1

The Various Constructs of the Intersectionality Theory

Note. From "What Does Intersectional Feminism Really Mean?" by International Women's Development Agency, May 11, 2018, https://iwda.org.au/what-does-intersectional-feminism-actually-mean/. Copyright 2018 by International Women's Development Agency. Used with permission.

Applying Intersectionality to This Research

Researchers in Western cultures have used intersectionality as a lens to study race, class, gender, and sexuality; however, its use in African cultures has come under increasing focus (Walker et al., 2017). Walker et al. (2017) stated that a theory such as intersectionality is an ideal choice to study an environment with pronounced social structure, patriarchy, and privilege. Kano State has a patriarchal society with differences between men's and women's experiences, constructs, expectations, and perceptions (Davis et al., 2013). In addition to the harmful cultural and gender norms experienced by women, the high levels of poverty and illiteracy of adolescent girls could directly affect

their social status and ability to make decisions. The intersectionality theory was the tool used in this study to ask questions, study, analyze, and elicit various sociocultural and demographic influences and how they affected the participants' experiences through their first pregnancies as adolescents. Intersectionality is a feminist theory; therefore, this study focused on the voices of the women and how they told their stories. Ravera et al. (2016) suggested that projects including women should have the input of women; hence, the gender approach was the means used to inform the methods of this qualitative research.

Nature of the Study

In this study, interviews occurred with 12 married, first-time pregnant adolescents under 18 years of age. The research occurred via interpretive phenomenology inquiry, enabling the participants to tell their stories in their own ways and learn from their experiences (Neubauer et al., 2019). Scholars mainly use interpretive phenomenology to explore the meaning of people's experiences; therefore, the participants in this study could narrate their experiences as they saw them (Muylaert et al., 2014). Hearing the participants tell their stories provided the opportunity to make sense of those stories. In-depth interviews with unstructured and semistructured interview questions were the means used to stimulate discussion.

In this study, purposeful sampling and selection commenced with the help of the faith-based women's group Federation of Muslim Women Association of Nigeria (FOMWAN) in the communities of Kano Municipal. The members of FOMWAN helped spread information about the study and recruit the initial participants. Snowball sampling

then occurred to continue recruitment as needed. The community-based women's groups included older women engaged in activities such as trading or sewing; they knew the community well and introduced me to the target group of young women.

I gained permission from the husbands and the participants for their safety and mine. The interviews occurred either remotely via telephone or in person, depending on the strict COVID-19 protocols in place at the time. Telephone interviews for data collection is an increasingly common and acceptable practice in qualitative research (Ward et al., 2015). According to Ward et al. (2015), qualitative researchers conduct interviews via telephone or email only when they cannot conduct face-to-face interviews. Telephone interviews are as valid as in-person interviews and could even be a preferred method in some cases, for instance, when discussing a sensitive topic.

Definition of Terms

Adolescent sexual and reproductive health: The sexual, physical, and emotional well-being of adolescents. Chandra-Mouli et al. (2013) stated that the reproductive health of adolescents focuses on preventing unsafe abortions, unwanted pregnancies, STDs, and sexual violence, as well as the emotional and mental health issues associated with the age group.

Adolescents: According to the WHO (2013), an adolescent is an individual between the ages of 10 and 19. The early adolescent period occurs between 10 and 14 years of age, with late adolescence spanning 15 to 19 years.

Agency: The ability of humans to make their own decisions and choices. Agency is a term often used within the context of gender, where it indicates the ability of women to make choices about their reproductive health and rights (Evans & Strauss, 2010).

Gender empowerment: A social process of giving people of any gender the right to control their lives (WHO, 2011). Gender empowerment broadly focuses on people of both genders; however, in conventional terms, it centers around the genders often marginalized (United Nations Development Programme [UNDP], 2015). According to UNDP (2015), men in most societies have more opportunities to control resources and more advantageous and favorable policies, cultural ideologies, and practices than women.

Gender norms: Gender is a social construct that any given society presents as the appropriate attributes, behaviors, and roles for men or women (WHO, 2011). Significant variability exists across various cultures as to what constitutes gender. According to WHO (2011), several factors influence society and present gender roles, including history, culture, religion, and gender relations in society. Such factors affect how people learn to behave or interact with the world in their societies.

Gender relations: How various genders relate with each other based on their societal roles and norms (WHO, 2011). According to Cerrato and Cifre (2018), people behave according to their ascribed societal roles. However, ascribed societal roles can produce hierarchies of unequal power that present particular disadvantages to women.

Health-seeking behavior: Any activity taken by individuals to find appropriate remedies when they perceive themselves to have health problems or be ill (Latunji &

Akinyemi, 2018). Health-seeking behaviors include seeking care from other sources apart from conventional health systems.

Reproductive health services: As defined by WHO (2011), reproductive health services include prevention, diagnosis, and treatment for sexually transmitted diseases, contraceptive services and counseling, prenatal and postnatal care, delivery care, safe abortions, and postabortion care and access to information and education to the above issues.

Skilled birth attendants: The health care professionals trained to have the needed skills to provide basic care during pregnancy and childbirth (Utz et al., 2013).

Social stigma: Social stigma occurs when an individual or a group of individuals within a society have characteristics or attributes perceived as different and therefore get rejected or mistreated (Ahmedani, 2011)

Assumptions

Researchers make assumptions about how they will conduct their studies. Qualitative research is an immersive experience, and experts have advised that researchers should have more than a passing interest in their subjects. A researcher's knowledge and beliefs have an essential bearing on the entire conduct of the research, particularly when conducting interviews with collaborative interactions (Muylaert et al., 2014). According to Teherani et al. (2015), qualitative researchers must always consider the effects of their views on the research process and ensure proper alignment between the research questions, the approach, and the underpinning belief systems of the research process. Howell (2013) laid out the essential steps for researchers to take before

embarking on any project. Essential questions include asking what is the particular phenomenon to explore or how well understood the context and background of the topic are.

Qualitative work requires a high degree of involvement from both participants and researchers; thus, context matters. Therefore, qualitative researchers must thoroughly understand the subject matter, the population, the population's practices, and any other background information before conducting studies (Howarth et al., 2016). The research assumptions were that the study was an inductive process and that I, as the researcher, remained open to how my worldview could affect the process, from recruitment to analysis. Another assumption was the participants would speak their truth openly and without any reservations or feelings of coercion.

Scope and Delimitations

The scope of research consists of its parameters and what to cover in the study. Typically, the scope includes a study's purpose, population, duration, topics, and geographical location (Simon & Goes, 2013). This study focused on the experiences of married pregnant adolescents and the factors in their care-seeking decisions in Kano City in Northwestern Nigeria. The study focused on the various intersecting factors in the adolescents' decisions to seek care and the various cultural, religious, and environmental factors affecting those decisions.

According to Simon and Goes (2013), delimitations are the boundaries a researcher sets for a study. The most critical step in outlining delimitations is the researcher's choice of the problem and the rationalization for excluding other problems.

For this study, the research problem was the participants' care-seeking experiences rather than their overall childbirth experiences. The study focused on health-seeking behaviors because researchers, such as Garba et al. (2016), have found that most maternal deaths occur from delaying seeking health care when complications occur during pregnancy, labor, or immediately peripartum. The second delimitation was the decision to focus on adolescents between the ages of 15 and 18. This age range was appropriate because Garba et al. found that most pregnant adolescents in Kano State fall in this age group.

Limitations

A qualitative study conducted during the COVID-19 pandemic is expensive and time-consuming due to the various restrictions. As a result of the restrictions, I had to settle for interviewing about a quarter of the participants by phone, even though my preference was to speak face-to-face. Phone interviews are an acceptable means of data gathering in qualitative studies and can be used when face-to-face interviews are not possible or when it is the preference of the interviewees (Ward et al., 2015). However, in this case, I believe that the face-to-face interactions would provide me with additional insights and enable me to pick up on non-verbal cues that would be useful for the study. Many adolescent girls who participated in this study lived in forced seclusion; therefore, gaining access to them required obtaining permission from their husbands. The forced seclusion and their husbands may have affected the participants' ability to speak freely. I took care to respect the women's wishes and ensure the women were not forced to participate. For those interviewed in person, I additionally looked out for any signs of discomfort during the interviews. Before the fieldwork commenced, I educated myself

thoroughly on working with minors to understand the dynamics of navigating interviews with that particular group. I also remained aware of and acted on verbal or nonverbal expressions of emotional distress from the women, taking appropriate measures to protect them. The protective measures included ensuring absolute confidentiality in the conversations, stopping any interviews that appeared to cause undue distress, and remaining aware of the participants' states of mind before, during, and after the interviews. These measures enabled me to know when I should conduct, pause, or stop the interviews. For those I interviewed via phone, all these measures were more challenging to carry out. I made sure to ask them repeatedly if they were comfortable talking with me and tried to listen for any signs of discomfort; this was not easy to do over the phone.

Other limitations of qualitative research are related to the reliability and the validity of the study process. According to Leung (2015), in qualitative studies, it is critical that researchers can make meaning from the data without compromising their quality and should strive to measure the various nuances and dimensions of the data as accurately as possible. As with any study, it is necessary to consider the potential for researcher bias and positionality. As a woman living and working in the same community as the participants, I experience the same patriarchal environment and some of the same experiences. This situation could have resulted in biases and preconceived notions that could have affected the quality of the research. Another relationship I had with the study subjects is that I am a female physician well-known in the community; with few women in medicine, this role has its issues. McNair et al. (2008) highlighted the various issues

associated with clinicians as qualitative researchers, including solid assumptions, the tendency to want to control interviews due to excessive training, and the inability to explore the feelings of the research subjects in depth. Davis et al. (2013) suggested some techniques for overcoming these potential issues, including that the researchers engage in reciprocity, open up and tell their own stories, and consciously strive to avoid assumptions. I used the techniques by Davis et al. during the interviews in this study.

Insider status could have been an advantage that provided me with the right amount of empathy. Additionally, having shared experiences could have given me a more in-depth understanding of the topic. According to Leung (2015), human emotions are integral parts of any interaction, and in qualitative research, they could even be a treasure. However, improving validity requires acknowledging human emotions.

Another issue related to the validity of qualitative research is how generalizable the findings are; this study was conducted in a Kano city with a specific group of participants who narrated experiences that were unique to them and their environment; therefore, the findings might not apply to a broader group of adolescent women in other settings. In addition, the participants themselves were diverse and at various stages in their pregnancies, and therefore, their experiences differed from each other. To ensure the accuracy of the findings, I used Colaizzi’s steps for data analysis; this analytical framework has an in-built validity that ensures the researcher’s analysis presents an accurate and multidimensional view of the phenomenon.

Significance

This research provided knowledge for a better understanding of the issues associated with pregnant adolescent girls, what they experience, and how they feel about their circumstances. Gender was a critical focus in this study. African authors, such as Bougangue and Ling (2017) in Ghana and Doyle et al. (2018) in Rwanda, have highlighted the transformative power of focusing on gender while discussing maternal health issues. The scholars indicated that gender-focused research on maternal health could indicate ways to transform societies for the better and change harmful societal norms. The goal of this study was to promote positive social change by producing evidence that community leaders, husbands, policymakers, and women can use to educate themselves and confront harmful gender norms. Positive social changes in the community could result in the increased agency of women, better care decision-making at the family level, and more lives saved. Saving lives is a particularly crucial component in Northern Nigeria, which has many married, pregnant adolescents and high maternal morbidity and mortality rates.

Summary

Chapter 1 focused on the research paradigm and the scale of the problem of maternal morbidity and mortality in Kano State of Northern Nigeria, especially for young women between the ages of 15 and 18. The chapter presented the region’s various cultural practices and gender norms for young adolescent mothers, particularly those giving birth for the first time. The chapter also included the nature of the study, scope, limitations, delimitations, and theoretical foundation for the study’s parameters. There

was a discussion of the relevance and significance of the study, the guiding research questions, and the theory.

Chapter 2 is a review of the literature related to the research topic, Chapter 3 presents the methodology, Chapter 4 includes the study's data and findings, and Chapter 5 has an analysis and interpretation of the findings, the implications of the findings, recommendations for future studies, and a conclusion.

Chapter 2: Literature Review

Introduction

Researchers have reported over a 44% decline in maternal mortality from 1990 to 2015 worldwide. However, women in Nigeria continue to die from maternal health causes at higher than average rates (Olonade et al., 2019). With just over 2.5% of the world population, Nigeria has more than 20% of the entire global maternal death burden (Souza, 2019). The number of women dying during childbirth in Nigeria has been a significant public health concern and the subject of many studies.

The MMR in Nigeria is 800 per 100,000 live births, a stark contrast to the 46 most-developed countries with a combined average of 12 per 100,000 maternal deaths (WHO, 2019). Nigeria does not have a homogenous MMR across all regions of the country. Southwestern Nigeria has 166 maternal deaths per 100,000 live births, compared to 1,549 in Northeastern Nigeria (Meh et al., 2019). Nigeria has a predominantly Muslim north and predominantly Christian south with vastly different cultural and religious practices (Ariyo et al., 2017).

Early marriage is a common practice of the Hausa-Fulani ethnic group of Northwestern Nigeria and those of the Muslim faith (Ariyo et al., 2017). In Northern Nigeria, about 40% of young women get married before 19 years of age. However, if young women get pregnant early, they have higher maternal health risks than their older counterparts (UNICEF, 2019). Adedokun et al. (2016), WHO (2016), and Oguntunde et al. (2019) found early marriages and adolescent pregnancies linked to high death rates in Northern Nigeria. Adolescents are more likely to die during childbirth than women older

than 19 (Nwobodo & Panti, 2012). In addition to maternal deaths, adolescent pregnancies can have complications with life-altering consequences, such as obstetric fistulas due to undeveloped pelvic regions or secondary infertilities due to labor complications (UNICEF, 2019). Young women married off early also have decreased educational opportunities (Kunnuji et al., 2018).

Kano State in Northern Nigeria is a deeply conservative and patriarchal region; men are often the sole decision-makers for how or when their wives access care during pregnancy (Ariyo et al., 2017). Married pregnant adolescents are frequently overlooked in studies focused on maternal deaths despite the risks to their health. Many scholars of MMR in Nigeria have used the DHS data, which present women of childbearing age as between 15 and 49 years (National Population Commission, 2013). Researchers who have included adolescents in this age range have failed to recognize that young women have unique risks, experiences, and constructs that require further exploration.

The purpose of this review is to present the literature available on the study's subject and theoretical framework. The literature review includes research on pregnant married adolescents, the problems they encounter, and the various experiences and influences affecting their care-seeking decisions for first pregnancies. The following sections present the literature on the intersectionality theory, its constructs, and its application to the study based on past research on the topic. The chapter also includes literature on adolescents' reproductive health care and use of health care services and the social and cultural factors in early marriage and adolescent birth experiences.

Literature Search Strategy

The initial search for primary sources commenced via an electronic database. The search included the Walden Library EBSCO database, Google Scholar, Medline, CINAHL Plus with Full Text, PubMed, ProQuest Central, the WHO Reproductive Health Library, and UNICEF country reports. The keywords used included *married adolescents, birthing practices, adolescent pregnancies, reproductive health or married adolescents, adolescent sexual and reproductive health, maternal mortality, intersectionality AND maternal health, birthing cultural practices in adolescent girls, first-time mothers, teenage mother, birth experiences, gender norms,* and *births*. I used the search terms independently, in combination, and sometimes with the truncation wild card * for clarity. The searches were in titles, full texts, abstracts, and subject headings.

Gray Literature

Gray literature consists of government agency reports, nongovernmental organization (NGO) publications, evaluation reports, and ongoing studies in print or electronic forms not usually controlled by conventional or commercial publishers (Paez, 2017). This review required the use of gray literature. Although many research and publications exist on maternal health in Kano State, there are few peer-reviewed or published international journal articles. Tarkang and Bain (2019) stated that African researchers, more than any other group, struggle for publication by reputable journals because of high rejection rates from publishers, financial constraints, and long turnaround times. Many organizational researchers of maternal health in Northern Nigeria conduct and publish research reports on their websites. According to Paez (2017), gray literature

is an essential means of balancing the available evidence, disseminating unpublished reports, and reducing the likelihood of publication bias. The gray literature search for this study included maternal, adolescent, and gender-related health articles from government websites, public health institutes, and global health organizations, such as WHO and UNICEF.

Selection and Inclusion Criteria

The literature search commenced for studies conducted between 2014 and the current date published in English or with associated English translations. While conducting the search, I had a particular interest in qualitative studies on the birthing experiences of young women in African communities. I sought to study how researchers navigated sensitive discussions about adolescent pregnancies and gender norms, particularly in conservative communities. In addition, I included quantitative research to compare studies or highlight the scale and the magnitude of the phenomenon of interest.

I conducted a search for studies on maternal mortality, sociocultural determinants, intersectionality theory and its constructs, adolescent health, and cultural birthing practices in Nigeria and other African countries. The search included studies from other nations to compare or highlight existing gaps. The search also incorporated articles with feminist perspectives or the intersectionality theory to address maternal health and adolescent health issues.

Literature Review on the Intersectionality Theory

Black feminist Crenshaw developed the intersectionality theory 30 years ago to study the unique circumstances and factors that contributed to the experiences of Black

women living in the United States (Rice et al., 2019). Crenshaw (1989) coined the term *intersectionality* and discussed the exclusion of Black women from policies targeted for addressing racism because they encountered discrimination not adequately understood. Crenshaw argued that the discrimination that Black women experienced in U.S. society has various overlapping factors different from women of other races. Additionally, Crenshaw stated that any policy or study that suggests the oppression of Black women is just the result of racism and sexism could not sufficiently address the problem. Intersecting factors, such as social class, poverty, and ethnicity, contribute to the discrimination experienced by Black women; therefore, Black women have different experiences from their White female counterparts and even their Black male counterparts.

Bright et al. (2015) discussed intersectionality, noting that power systems in societies that contribute to the oppression of minorities should not be taken in isolation. Instead, scholars must look at how these powers intersect and elicit the disadvantaged experiences of those involved. Bright et al. also stated that gender is not the sole reason for the subordination of an individual or a group; instead, socially constructed markers, experiences, and positions together produce these disadvantaged positions. Scholars should acknowledge these intersections in all studies related to gender and oppression.

Scholars have expanded and adapted the application of the intersectionality theory to include the constructs of age, class, religion, ethnicity, and socioeconomic status based on the context of each group (Rice et al., 2019). Bilge (2013), Bailey (2010), and Lewis (2013) found that the theory enabled individuals or groups to address their societal positions and disadvantages in relation to each other. Using intersectionality to

understand minorities' oppression could be a way to reveal the various levels of inequalities they experience. Rice et al. (2019) also noted that the rightful application of the theory requires accounting for the voices of those involved, including individuals at the lower end of privilege.

Constructs of Intersectionality

Intersectionality theory has many diverse and often context-specific constructs (Bauer, 2014), including gender and patriarchy (sexism), age (ageism), sexual orientation (homophobia), and ethnicity/race (racism). Other constructs of the theory focus on social standing or positions, including social status, legal status (e.g., rights of minorities or immigrants), educational background, or age cohort. Rice et al. (2019) stated that scholars could apply intersectionality on the microlevel and macrolevel, depending on their effects on the individuals or groups involved. Microlevel constructs include experiences specific to individuals; in contrast, macrolevel constructs incorporate systemic issues affecting a group of people in a community. The theory has expansive and diverse constructs. However, Rice et al. indicated that it is neither useful nor expedient to attempt to study every construct and level and their intersections in every detail. Bright et al. (2015) suggested that applying the constructs requires properly understanding the context and the lived experiences of the target group; however, this context could vary between individuals or groups of people from the same sociodemographic categories. In this study, I sought to determine which constructs or dimensions to use for this research by examining the literature by relevant researchers of the phenomenon of interest.

Age

In many societies, women experience more age-based discrimination than men. Age-based discrimination could have significant effects on women's reproductive health and rights (Harnois, 2015). Adolescents are disproportionately affected by such discrimination; in addition, adolescents have double the risk of maternal death than older women (Piane, 2019).

Some scholars have examined the intersection of age with gender. Hall et al. (2018) used a scale to investigate the types and effects of the stigma for young women seeking reproductive health information and services in Ghana. The scholars studied 1,063 women between 15 to 24 years, 15% of whom were married. Hall et al. conducted descriptive and bivariate statistics to analyze the findings on the stigma scale and found the highest stigma among the youngest age group. They also found high levels of stigma among those of the Muslim faith, unemployed individuals, and people who dropped out of school. Based on the findings, Hall et al. suggested more in-depth research on how these various factors intertwine.

Dunlop et al. (2018) carried out a similar study using DHS data from 34 countries in Sub-Saharan Africa to examine the link between age, facility births, and first-order pregnancies. They analyzed the data of 72,772 women who had their first births in the 5 years before the surveys. Using descriptive and crude analysis for both country-level and regional-level data, the researchers found that 59% of births occurred at a hospital facility. A comparison of women aged 15 to 29 showed that older women (>25 years of age) had almost double the odds of hospital delivery (95% CI, 1.6 to 2.2, $p < 0.0001$).

The researchers concluded that facility deliveries are associated with increased maternal age.

Socioeconomic Class and Poverty

Primary maternal health care in Nigeria is mostly a free service. However, the lack of health facilities and infrastructure in many rural areas could result in substantial out-of-pocket expenses for many individuals seeking care. Further difficulties occur if an individual has complications that require higher levels of care (Aregbeshola & Khan, 2018). Many studies on maternal health have indicated the intersection of social class and health-seeking behaviors. For example, Akeju et al. (2016) examined the health-seeking behavior of women in Ogun State of Southwestern Nigeria. The researchers conducted focus groups with women of childbearing age, health care providers, stakeholders, and opinion leaders. They found that the inability to pay for health care was associated with the decision not to seek care at health facilities during labor. The women referred to higher-level facilities due to complications had higher default rates due to the associated costs.

Doctor et al. (2018) analyzed 58 demographic and health surveys from 29 countries in Sub-Saharan Africa to determine the enablers of health facility deliveries in those regions. Using descriptive statistics, the researchers matched the social and demographic characteristics of women with their places of delivery. They found that the women of higher socioeconomic classes were 68% more likely to give birth in hospital facilities. Additionally, women who had at least a primary education were twice as likely to give birth in hospitals than the women who had not received an education.

Similarly, Iacoella and Tirivayi (2019) used DHS data from 13 countries with the highest adolescent marriage rates in Sub-Saharan Africa to determine the predictors of health care use among married adolescents. They found that adolescent women were likely to attend ANC and deliver safely in hospital facilities when they were educated and employed and had the autonomy to make financial decisions within the households. Both Doctor et al. (2018) and Iacoella and Tirivayi (2019) highlighted how economic status and education indicate where and how safely married adolescent women give birth in Sub-Saharan African countries. However, both studies included quantitative surveys and secondary data from the DHS; therefore, the researchers did not gain insight into the reasons behind the participants' choices and did not explore age, patriarchy, and other external influences in the decisions.

Adedokun and Uthman (2019) also showed the link between low socioeconomic status and a lack of use of health care facilities. The researchers surveyed secondary data from the 2013 Nigerian Demographic and Health Survey to determine the individual, community, and state-level factors associated with the nonuse of health care services for delivery by women. The findings showed that women from poor households who lacked an education had increased chances of not using health care facilities during delivery. Like many other studies on maternal health in Nigeria, Adedokun and Uthman used NDHS data and focused on women between the ages of 15 and 49 years.

Intersectional Stigma and Bias

Intersectional stigma addresses how various types of stigmatized identities intersect within a person or a group of people to produce adverse health and social

outcomes (Turan et al., 2019). The stereotyping of particular classes of people as lazy or unintelligent or based on appearance or how they dress could contribute to the discrimination or oppression experienced by those people (Lei & Bodenhausen, 2017). Young adolescent mothers are particularly vulnerable to such stereotyping. Chambers and Erausquin (2015) examined the persistently high rates of adolescent pregnancies and adverse health outcomes of young women living in underserved communities in the United States. The findings showed that, in addition to race, ethnicity, and social status, the young women also faced the stigma of their young age and inexperience for their reproductive health. The scholars found that young women experienced this stigma at schools, health care facilities, and public systems.

Little evidence indicates that married adolescents experience the same type of stigma as unmarried adolescents. However, a study on the intersecting stigma and the unique circumstances of married adolescents could provide insight into their experiences at home or with health institutions and their effects on their care-seeking decisions. Yakubu and Salisu (2018) conducted a review of 24 qualitative articles to study the factors associated with adolescent pregnancies in Sub-Saharan Africa. The scholars found that many health care providers lacked the skill needed to provide adolescent-friendly services and felt that the young women did not have the maturity to understand basic health instructions or make decisions on their own. As a result, Yakubu and Salisu indicated increased chances of unintended pregnancies due to unmet contraceptive needs and the reluctance to attend ANC because of health care providers' attitudes.

Patriarchy and Sexism

Gender and power relations are essential issues to consider when researching the health-making decisions of women in Africa. Osamor and Grady (2018) noted the few studies conducted in Africa on the effects of autonomy in decision-making on women's health. However, Osamor and Grady found that the women who made their own decisions had better health outcomes. Similarly, Ganle et al. (2014) explored the concepts of autonomy, agency, and patriarchy among families in Ghana. Ganle et al. conducted 12 focus group discussions and 81 key informant interviews with pregnant or breastfeeding women to explore the factors in maternal health decision-making among households and the influence of power and dynamics. The findings showed that the husbands were the sole decision-makers in most homes and that the opinions and knowledge of the husbands and mothers-in-laws had an influence on the decisions made. Anecdotally, it appeared that younger women were disproportionately affected. However, I did not find any studies focused on the influences in the decision-making of young married adolescents.

Patriarchy as a concept or part of the intersectionality construct is a little-studied topic. Therefore, scholars have the opportunity to research the effects of the patriarchy on women at the individual and the systemic levels without contending with competing influences (Bose, 2012). Patriarchy has importance within the African context. Therefore, a study on the patriarchy in Africa with the intersectionality theory could be a way to highlight its impact on the lives and health of young women. Oguntunde et al. (2019) conducted a qualitative study in two Northwestern Nigeria states to understand how men felt about an intervention focused on improving access to health care services for

pregnant women in their regions. The researchers interviewed 12 men married to women between the ages of 15 and 35 with at least one living child. Ninety percent of the participants were Muslim men. All the men agreed that they were the sole decision-makers in their households and determined when or if their wives attended ANC or went to the hospital while in labor. Furthermore, the participating men believed that their wives were not ready to be empowered.

Oguntunde et al.'s (2019) findings aligned with Sinai et al. (2017), who conducted a literature review on the barriers to seeking reproductive health care for women in Northern Nigeria. Sinai et al. analyzed 62 articles and concluded that men were the ultimate decision-makers for women's reproductive health care in most cases. However, unlike Oguntunde et al., Sinai et al. did not find that the women preferred to hand over their autonomy to the men. Instead, they noted that providing the women with blanket permission to decide when to go to the hospital if they felt their lives were in danger was associated with a higher likelihood that the women would seek care when needed.

Patriarchy and its role in the perpetuation of restrictive gender norms is a prevalent issue in conservative societies. Researchers have studied these dynamics over time. Levy et al. (2020) conducted a comprehensive review of programs with the goal of transforming harmful gender roles for those under the age of 24. From a review of 120 programs in Africa and South Asia, Levy et al. noted that many of the programs presented the opportunities to be gender transformative and improve the health and well-being of young adolescent women. However, the programs were deeply embedded in the

societal norms challenging to transform. Additionally, the young women who were both victims and part of a system believed these norms to be unwritten rules that they must follow.

Intersectionality Theory and Maternal Health Research

The theory of intersectionality is gaining in popularity; therefore, researchers must contend how to apply the theory in research (Rice et al., 2019). Applying the theory to research is a challenge in the absence of clear directions. Instead, the theory indicates several methods and approaches. According to Rice et al. (2019), some researchers have used intersectionality as a theory in their studies, while others have used it as a resource to understand the complexities of race and gender. Windsong (2018) also found that the application of intersectionality, particularly in qualitative research, enabled an understanding of how one factor affected the other rather than how they combined to create a single disadvantage.

In this study, I used a specially designed interview guide (see Appendix A) to enable the young women to tell their stories. The participants and I explored their experiences by listening and learning together. Scholars (e.g., Ore, 2019; Wharton, 2012) have studied the relationship between intersectionality and this form of knowledge generation through interaction. Researchers have found the intersectionality theory useful in understanding how people view themselves within particular social settings. In the present study, there was a critical need to understand how participants viewed themselves as women, adolescents, or as parts of social classes or categories in their social settings.

Maternal Adolescent Health Studies Using the Intersectionality Theory

I did not find any studies with the intersectionality theory and maternal health decision-making of adolescents in Nigeria. Only a few scholars worldwide have used the intersectionality theory to study the maternal health decision-making of adolescents. In a qualitative phenomenological study, Ngum Chi Watts et al. (2015) interviewed 16 women who had migrated from Sub-Saharan Africa to Australia and experienced pregnancies as teenagers while in Australia. The researchers sought to explore and understand the women's lived experiences during pregnancy. The scholars used intersectionality as a theoretical framework to understand the various influences in the participants' lives and how these influences transcended race and gender. Ngum Chi Watts et al. employed intersectionality to consider the multiple effects of their participants' diverse backgrounds and their effects on their experiences.

Batist (2019) indicated that studying maternal mortality and morbidity in Sub-Saharan Africa requires understanding the various influences in the lives of the women involved and how the intersections of those influences produce unique experiences. However, Batist did not focus on young women and only broadly addressed maternal mortality for all age groups. Chambers and Erausquin (2015) identified the gap in the literature of using intersectionality to study fundamental health-related issues; this could have resulted from a poor understanding of the application of the theory by researchers. They noted that using intersectionality to conduct studies for a wide range of topics and target groups could be a way to improve its acceptability in research.

Similarly, Rao et al. (2018) noted the shortage of studies with the intersectionality theory despite the many discussions around the usefulness of intersectionality research. They suggested using the theory for studies of disadvantaged or oppressed groups. Such research could be a way to find the right approaches for uplifting the status of those experiencing oppression and reducing biases and inequalities.

Early Marriage and Adolescent Pregnancies in West Africa

Early marriage, also referred to as child marriage, is the wedding of a couple, one or both under 18 years of age. In Africa, many early marriages occur between older men and younger women (UNICEF, 2018). Koski et al. (2017) conducted a survey to examine the trend of child marriages using DHS data from 31 Sub-Saharan African countries. They found declining rates of early marriage globally but increasing rates of early marriage in many African countries, such as Nigeria. African government officials have engaged in sustained efforts have to address the issue of early marriage. In 1990, officials from 41 African countries ratified the African Charter on the Rights and Welfare of the Child to hold governments accountable for ending cultural practices, such as early marriage, with adverse effects on children (African Union, 2016). Despite this treaty and the promises made by African delegates, early marriage in the region has remained an issue. Additionally, Sub-Saharan Africa is poised to become the region with the highest number of married female adolescents in the world (UNICEF, 2018). According to Koski et al., some legislative efforts in many African countries have occurred to set the age of marriage at 18 years. However, many pervasive traditional and cultural practices continue to present barriers to these reforms.

Studies of pregnant married adolescents have shown the link between adolescent pregnancies and increased maternal mortality, as well as the scale of the social and economic implications of the practice. Three qualitative studies occurred in four countries in Sub-Saharan Africa to find the trends, consequences, and prevention strategies of early/child marriages in those regions. Scholars in Kenya, Senegal, and Zambia used only qualitative methods, and mixed methods research occurred in Uganda (Petroni et al., 2019). The researchers found that young women with limited educational opportunities often married at young ages and that early marriage closely correlated with high school dropout rates. The scholars also found that a significant number of the young women interviewed wanted alternatives to marriage and preferred to either return to school or engage in meaningful trades. The researchers used primary data sources. Although the scholars focused on the social and economic issues of child marriage, they did not explicitly explore the health implications, health consequences, and health-seeking behaviors of married adolescents.

Piane (2019) reviewed 43 articles published from 2000 to 2016 in a literature review of the MMR in Nigeria. Many studies have shown that social determinants of health, such as poverty, illiteracy, harmful cultural practices, and gender norms, often occur together, leading to increased maternal morbidity and mortality in communities across the country. Yakubu and Salisu (2018) studied the determinants of early marriages and early pregnancies in Sub-Saharan Africa by reviewing 40 articles. The scholars found that, unlike other regions, adolescent pregnancies in Sub-Saharan Africa were strongly associated with early marriages, religion/culture, poverty, and a lack of proper health care

service delivery for adolescents. The researchers relied on data from qualitative research on adolescent pregnancies. However, Yakubu and Salisu researched a large geographical area; each study lacked context and did not focus on married adolescents.

Researchers have also examined the factors affecting the utilization of health care facilities of young married women in Nigeria. Chima (2018) examined the effects of the autonomy levels of young, ever-married adolescents on their utilization of health care facilities. The researcher looked at data from the last demographic and health survey conducted in Nigeria. Using a binary logistic regression model, the researcher examined the data from 4,996 ever-married adolescents between the ages of 15 and 24 and found that only 30% of the women delivered in health facilities. Chima also observed that younger women with less autonomy were more likely to miss the minimum number of ANC visits required and less likely to deliver in health facilities.

Health Implications

There is an expectation for young women in most West African communities to immediately start bearing children as part of their marital responsibilities (Avogo & Somefun, 2019). According to UNICEF (2018a) data, the leading global cause of mortality among young women aged 15 to 18 is maternal health-related conditions. Studies have shown that young women are not as likely as their older counterparts to attend ANC. Adolescent girls, particularly those pregnant for the first time, require close and careful monitoring. However, there is a 10% point statistically significant difference in ANC attendance among women between the ages of 15 to 18 compared to women older than 20 years. According to UNICEF, failure to receive ANC, especially among

young pregnant adolescents, correlates with an increased risk of not recognizing life-threatening complications early enough for intervention.

Neal et al. (2012) studied the various causes of maternal mortality among pregnant adolescents between 15 and 19. The scholars analyzed 15 papers and concluded that the most common causes of death for pregnant adolescents are hemorrhage, hypertensive disorders, sepsis, and obstructed labor. Nwobodo and Panti (2012) conducted a descriptive study with hospital data of maternal deaths at a tertiary hospital in Northwestern Nigeria. The scholars found that of the 20,729 live births that occurred, 15% of the pregnancies occurred in girls younger than 19. They also identified a hospital-based MMR for adolescents of 5,415 per 100,000 live births compared to older women of 2,398 per 100,000. The data from the research were hospital-based figures only and did not indicate any deaths that occurred in the community. Adedokun et al. (2016) looked at community-based data in the Gombi Adamawa state of Northeastern Nigeria, finding that over 70% of young women reported complications during pregnancy or while giving birth.

Earlier researchers have also examined the risks of HIV/AIDS for underaged women. Clark (2004) highlighted why married female adolescents in urban cities in Kenya and Zambia have higher rates of HIV than unmarried female adolescents. Clark found that the married adolescents faced greater HIV risk because of increased sexual activity without protection due to their married status. These adolescents were also unable to negotiate safe sex with their partners, who were often much older and more exposed to the disease due to previous sexual encounters and promiscuity.

More recent studies on the same topic have aligned with Clark (2004). An analysis of UNICEF's (2018) database of population-based surveys from 2010 to 2017 indicated that over two thirds of new HIV infections occurred in adolescents between the ages of 15 to 19. The analysis also showed that adolescent girls had the least information about HIV/AIDS. Petroni et al. (2019) acknowledged the link between early marriage, HIV/AIDS, and the maternal health outcomes of married adolescents. Petroni et al. took a more holistic view, arguing that previous approaches to looking at child marriage focused on preventing early marriages separate from the health risks to young women. They noted that any study or health intervention for married adolescents must address the multiple influences and consequences in adolescent girls' lives.

Few studies have holistic views of adolescent pregnancy. Instead, most scholars have focused on the overall MMRs of single disease entities. For instance, Ganchimeg et al. (2014) analyzed secondary data from the WHO for 23 low- to middle-income countries in Africa, Asia, and Latin America to study the link between young maternal age and adverse pregnancy outcomes among adolescent mothers. They found that young women between 16 and 19 years of age had a higher risk of preterm births, low birth weights, and higher overall adverse pregnancy outcomes than those between 20 to 24 years of age.

Yussif et al. (2017) conducted a cross-sectional survey to examine the adverse effects of first-time pregnancies on subsequent deliveries. Yussif et al. analyzed a sample of women from one community in Northern Ghana with demographics similar to Northern Nigeria. They interviewed 143 purposively selected women to establish a link

between their first pregnancies and future pregnancy complications. The researchers found that adolescent mothers had higher chances of adverse health outcomes in their first pregnancies; these outcomes also affected subsequent pregnancies. The health outcomes included elevated risks of cesarean section, low birth weights, fetal mortality, and MMR among this group of women.

Adedokun et al. (2016) conducted a mixed methods study of 200 women between 15 and 24 married before the age of 16 in Northern Nigeria. They found that those between the ages of 15 and 24 were 1.2 times more likely to suffer from pregnancy complications than those between ages 20 and 24. Many pregnancy complications occurred due to immature pelvis development, which correlated with an increased risk of obstructed labor. Further complications occurred due to delayed health-seeking behaviors and a lack of agency because of their young age. As with all the studies found on this topic, questions remained about the health-seeking behavior of young women and how they make care-seeking decisions when pregnant.

Sociocultural Determinants

Many studies on the maternal health outcomes of young adolescents have shown a significant social and cultural element, particularly in conservative communities. Envuladu et al. (2016) found that early marriage inextricably correlated with poverty, a lack of education, gender inequality, and the mistaken belief that early marriage was a barrier to promiscuity for girls. Avogo and Somefun (2019) analyzed the last round of DHS in Nigeria, Burkina Faso, and Niger, countries in West Africa with the highest numbers of married adolescents who have given birth. The survey included 6,653 married

adolescents between the ages of 15 and 18. In Nigeria, the researchers found that a higher level of education, higher family income, and belonging to the Christian faith significantly increased the marriage age of women.

According to UNICEF (2017), gender and social norms are strong influences in the lives of married adolescents in West Africa. Regions with the most significant gender gaps and inequalities have the highest rates of married adolescents. Northern Nigeria has mainly patriarchal communities, with husbands typically the primary decision-makers in the household (Shamaki & Buang, 2015). The region has a well-defined traditional family structure: Women do chores and bear and rear children while men farm, fish, and conduct other outdoor economic activities. The men must give permission for their wives to leave the house. Many men lack awareness of the link between maternal mortality and a lack of skilled attendants at birth. Early marriage has a significant effect on young women's agency, which is their ability to speak freely and make decisions in their best interest (McCleary-Sills et al., 2015).

Olonade et al. (2019) analyzed collaged data on maternal mortality in Nigeria by international organizations, such as WHO, UNICEF, and NDHS. The researchers examined the data using the functionalist theory, in which they considered maternal health a continuum of care from the prepregnancy to the postnatal stages. They found that traditional practices deeply embedded in religion and culture had adverse effects on women's reproductive health in the northern part of the country. The traditional practices affected the women's ability to have normal, healthy pregnancies and childbirth. The

taboo of male hospital staff was a barrier to many women in Northern Nigeria going to health care facilities for basic health needs.

Similarly, Aluko-Arowolo and Ademiluyi (2015) highlighted how several traditional beliefs in various parts of Nigeria could cause direct or indirect harm to the health of a mother or her child. For example, a traditional belief in some Northern Nigerian communities is that a woman who loses her life while giving birth is a “martyr” who goes straight to paradise. This traditional belief could result in complacency and delayed decision-making at home for some women.

Delays in decision-making do not only occur at home. Traditional beliefs could also affect the family choices made while at hospitals. Ugwu and de Kok (2015) carried out a mixed methods study to examine the social and cultural factors in family decisions to accept cesarean sections when required. The scholars found that 90% of the cases presenting in the hospitals were emergencies that occurred because of significant delays in seeking care from home. They also noted that 22% of those offered cesarean sections refused because of firmly held beliefs by family members that women should give birth in a “natural” way.

Alomair et al. (2020) reviewed 59 studies from 22 countries with predominantly Muslim populations to identify the various barriers to sexual and reproductive health services. The researchers found that negative attitudes against sexual and reproductive health services, the influence of community members, and the opposition of husbands were barriers to Muslim women in these countries from getting quality reproductive and sexual health services. Alomair et al. studied various countries all over the world.

However, they did not focus on the two key elements necessary for this study: cultural context and young and married adolescent women.

Not every researcher has found that social or religious factors are barriers to women accessing health care. Al-Mujitaba et al. (2016) conducted a qualitative study to determine if any religious influences were barriers to using hospital facilities by pregnant women in Northern Nigeria. After conducting focus group discussions with 68 women, the researchers found no significant religious barriers to hospital utilization by the women. However, the study included a higher number of Christian women (72%) compared to the general population, which consists predominantly of Muslims. Other researchers (Aluko-Arowolo & Ademiluyi, 2015) have stated that religious and traditional beliefs present more barriers to women accessing health care services for the Muslim population than the Christian population of the region.

Traditional and cultural practices have disproportionate effects on adolescent mothers experiencing pregnancy for the first time. Rabiu et al. (2016) conducted a cross-sectional survey of 199 pregnant women in Kano State to determine the frequency of wankan jego, a traditional practice prevalent among the Hausa-Fulani Muslim population in that area. Wankan jego consists of bathing a newly delivered mother with leaves immersed in boiling water, after which she receives continuous nursing in a room heated by glowing charcoal. The goal of wankan jego, a practice often enforced by older adults, is to enable a newly delivered mother to go back to her prepregnancy body quickly. However, the practice correlates with increased rates of the fatal heart disease of postpartum cardiomyopathy among Hausa-Fulani women (Sharma & Kumar, 2017). In a

cross-sectional survey, Rabiu et al. found that over 58% of the respondents still practiced wankan jego for anywhere from 4 to 40 days, with first-time mothers (primigravidae) having, on average, longer days than mothers with multiple children.

In a review of 63 published studies on the utilization of women's health services in Northern Nigeria, Sinai et al. (2017) found that women could not leave home without their husbands' permission, even for emergencies. Sinai et al. also stated that 83% of women preferred to deliver in hospitals if given a choice. Secluding and segregating women at home (*purdah*) is a common practice in many Muslim communities worldwide. Sinai et al. found that many cultural influences adversely affected the ability of women in Northern Nigeria to seek care, including elderly relatives and religious leaders, and the inability to understand the importance of effective reproductive health care.

Some scholars have found that the purdah system practiced in many rural communities of Northern Nigeria resulted in adverse maternal health events. Using data from two rounds of DHS in Nigeria, Adeyanju et al. (2017) conducted a decomposition analysis with both outcome and regressor variables to examine the effect of social and economic inequalities on access to maternal and child health care services. They found that the purdah that occurred in many parts of Northern Nigeria had a detrimental effect on pregnant women's access to health care, preventing them from seeking care when needed.

Decision-Making and Education

The education of married adolescents significantly impacts how they seek care (UNICEF, 2017). Early marriage and pregnancy not only occur because of a lack of education; they are also the cause of it. The existing literature indicated the influence of education on adolescents' care-seeking decisions. Shahabuddin et al. (2019) used qualitative methods to conduct in-depth interviews with 27 married female adolescents, family members, government officials, and health care providers in Nepal. The researchers found that a lack of education among married adolescent women prevented them from understanding reproductive health messages and the importance of having skilled attendants at birth. Similarly, McCleary-Sills et al. (2015) asserted that educating women enables them to question and challenge harmful gender norms.

Few studies of Nigeria have focused on the correlation of the education of girls to health care decision-making. In one cross-sectional study, Umar (2017) analyzed data from the DHS in Nigeria to determine the relationship between women's level of education and utilization of health care facilities. Umar studied data from 33,385 women between the ages of 19 and 49. Using the Chi-square test and multiple logistic regressions, Umar found a statistically significant association between level of education and the number of ANC visits and places of delivery. Older women had a higher likelihood of completing the four recommended ANC visits for each pregnancy.

Social Class

Some scholars have linked social class to the decision-making of married adolescents. Olakunde et al. (2019) examined the various factors in the decisions of

married adolescents between 15 and years of age to have skilled attendants during the births of their children. They analyzed secondary data from the fifth round of a multi-indicator cluster survey conducted in Nigeria between September 2016 and January 2017. Specifically, Olakunde et al. examined the data from married adolescent girls between the ages of 15 and 19 who had deliveries within the 2 years preceding the study and found that only 27% of the participants had skilled attendants at birth. The researchers also noted that those of the lowest social class were less likely to attend hospitals for deliveries or have skilled attendants during labor or after delivery.

Adewemimo et al. (2014) also researched what caused young women to decide to use skilled attendants at birth in Northern Nigeria. They conducted a population-based survey to collect data from 400 women between the ages of 15 and 49. Using logistic regression analysis, Adewemimo et al. found that only 13% of the participants had births assisted by skilled personnel members. The occupation of the husband and the presence of affordable services were also significant predictors of the decision to deliver in a hospital and to have skilled attendants at delivery. The data included women between the ages of 15 and 49; therefore, the findings and conclusions did not focus on adolescent girls.

Fagbamigbe and Idemudia (2015) used quantitative methods to analyze the data collected during the 2012 National HIV/AIDS and Reproductive Health Survey. The researchers found that over 56% of the respondents did not attend ANC because they lacked the financial resources. The respondents also reported not having a way to transport themselves to or pay the fees at hospital facilities.

Experiences of Married Adolescents and Health-Seeking Behaviors

Some studies have focused on the health outcomes and health implications of marriage, adolescent pregnancies, and maternal mortality. However, little research exists on the health-seeking experiences of adolescent mothers in relation to their social and demographic status and within the context of the African setting (Gyesaw & Ankomah, 2013). Hendrick and Marteleto (2017) stated that low- to middle-income countries and communities with restrictive gender norms against women have better maternal health outcomes when young women are autonomous to decide about their health. Pregnant married adolescents in Nigeria go through various decision-making processes and experiences when making decisions to seek health care. Religious beliefs, cultural beliefs, gender relations, and prior experiences with health facility staff influence many of their decisions. A need exists to explore these experiences in detail to understand their effects on overall maternal health.

Fatalism

The religious belief of predestined death that no one can prevent is a deciding factor for many families with women with complicated pregnancies or labor (Aradeon, & Doctor, 2016). Sharma et al. (2017) conducted a qualitative study in Jigawa State of Northern Nigeria to determine the decision-making processes behind 40 reported cases of maternal illness, neonatal illness, and maternal mortality cases among women between the ages of 15 and 49. The scholars conducted a combination of case studies, focus group discussions, illness narratives, key informant interviews, and verbal autopsies with witnesses, health care providers, and key decision-makers. The findings showed that

although all family members, including the women themselves, recognized dangerous symptoms that could result in maternal death, most women were not vocal about asking for help, leaving others to advocate for them.

Additionally, Sharma et al. (2017) found that the husbands were the key decision-makers who determined the type of care their wives received. The husbands made decisions based on their knowledge, beliefs, or past adverse experiences. The researchers also found that for the women who had died during childbirth, the husbands chose first to seek care with local traditional healers or to present late at the facility. The relatives who lost women during childbirth or while pregnant also overwhelmingly believed their deaths were preordained and that they could not have done anything to prevent their deaths.

Some researchers have also explored fatalism and its relationship to decision-making in maternal health. Lawan et al. (2015) used a cross-sectional design to randomly select 250 women between 15 and 49 years of age attending ANC in one of the busiest hospitals in Kano State. The objective of the study was to determine if the participants knew about eclampsia, a hypertensive disorder that could result in seizure and even death in pregnancy or labor, and their preparation for complications during childbirth. Fifty-one percent of the respondents believed that eclampsia was an affliction from God, and 18% purported it to be an affliction from evil spirits. The researchers found that those who believed eclampsia was a preventable and easily treated issue were more likely to have birth preparedness plans and standing permission from their husbands to go to the

hospitals on their own in case of emergency. In both studies, the focus was women between the ages of 14 and 49.

Fantaye et al. (2019) also explored beliefs of fatalism and predestination by conducting community conversations with elders and gatekeepers in Edo State of rural Nigeria. Some elders stated that God was the solution to maternal deaths and considered Him in charge of health regardless of health facilities. This particular study presented the importance of the belief in predestination in many Nigerian communities. However, the participants were from the southern part of the country, which has completely different cultural and religious practices from the north.

Sharma et al. (2019) also studied religious and cultural beliefs on predestination. They conducted narrative interviews with 40 family members who had experienced maternal health complications or deaths in their families in the Jigawa State of Northern Nigeria. A few of the respondents felt that pregnancy was a dangerous time for women. Sharma et al. reported that the individuals in their community greatly feared that women experiencing pregnancy might not survive and that only God determined if they lived or died. Despite these beliefs, some participants felt their belief in God meant they should seek care from competent others when women in their community had complications; however, others perceived seeking out spiritual and traditional treatments as solutions to pregnancy complications.

Experiences of Married Adolescents in Health Care Facilities

Researchers have also explored young adolescents' experiences when they eventually get to health facilities and the impact of these experiences on their health-

seeking behaviors. Challenges in health care infrastructure and service provision are factors in why and how women use maternal care services in Nigeria. Adeoye et al. (2017) stated that such challenges have the greatest effect on maternal health care services. According to the WHO (2016), adolescent girls require unique, readily available, and understandable services for their sexual and reproductive health.

In Nigeria, government facilities and some private facilities are the leading service providers for maternal health; however, these services remain suboptimal for women's needs (Odo et al., 2018). Odo et al. (2018) conducted a mixed methods study in Enugu, Southeastern Nigeria, to examine the sexual and reproductive health services available for young people between 12 and 24. The scholars researched 192 health facilities and randomly selected 1,447 adolescent boys and girls. They also conducted 27 in-depth interviews and 18 focus group discussions. Odo et al. found that most hospitals had sexual and reproductive health services (e.g., HIV, family planning, postabortion care); however, they lacked services tailored to adolescents' needs. The researchers also found that many young people could not pay the fees for services.

Other researchers discovered a lack of knowledge of basic reproductive health among young people. Atchison et al. (2019) conducted a baseline cross-sectional survey and qualitative interviews with married female adolescents aged 15 to 18 years in Northcentral Nigeria. They surveyed 4,600 married female adolescents and 250 husbands. The results showed that the participating adolescent girls had insufficient knowledge of family planning methods (30.1%) and a low contraceptive prevalence rate (8.7%).

Abuse and Disrespect by Hospital Staff

In addition to the lack of adequate services for young people in hospital facilities, Ishola et al. (2017) found one of the most impactful barriers to the utilization of health care facilities by pregnant women in Nigeria: abuse and disrespect from hospital staff during ANC, labor, and delivery. Widespread abuse and neglect in hospital facilities across Nigeria are barriers to young women utilizing health care facilities. Ishola et al. sought to determine the scale and effect of abuse by hospital staff members in facilities. The scholars conducted a systematic review of the literature published between January 2004 and July 2014 using several electronic databases. They selected 11 cross-sectional studies, one qualitative study, and two mixed methods studies based on the inclusion criteria. The researchers then used the Bowser and Hill landscape qualitative analytical tool as a framework for classifying abuse and disrespect in childbirth. Ishola et al. found that women in Nigeria suffered a wide variety of abuses during childbirth, including instances of physical abuse, neglect, undignified care, and breaches of confidentiality. They also uncovered that the nature of the disrespect directly affected reduced attendance to health care facilities. Ishola et al. (2017) suggested the need for more in-depth qualitative research to explore the perspectives of providers, women, and family members and translate these experiences into future actions or interventions. However, the scholars did not segregate the data according to age group; therefore, the findings did not show if mistreatment had disproportionate effects on women.

Ntoimo et al. (2019) researched the Edo State in Southern Nigeria to determine why women do not attend public health care facilities in rural Nigeria. The researchers

conducted 20 focus group discussions with married men and women in several key local government areas. The findings showed that in addition to lack of accessibility, bad roads, and long wait times at the facility, women encountered providers they perceived as inadequate. They also reported providers screaming and shouting for minor offenses. According to Ntoimo et al., health care providers' attitudes are a reason for the poor utilization of health facilities. This research provided deep insight into the issues of abuse and disrespect in hospital facilities. However, the study occurred in Southern Nigeria and did not focus on the experiences of adolescent women.

Not every researcher found that disrespect and abuse negatively impacted hospital utilization. Orpin et al. (2018) carried out a qualitative study of two hospital facilities in Central Nigeria to examine abuse and disrespect during maternal health services. They interviewed 32 women between the ages of 18 and 37 who had negative experiences during their last childbirth in hospital facilities. All the women interviewed reported experiencing abuse from hospital staff members and feeling belittled and dehumanized; however, they still would choose the hospitals for future pregnancies because they had little choice. Still, most of those interviewed stated that they would not return to the facilities for postpartum care. Orpin et al. noted that although the women who felt disrespected chose to go to the hospital for ANC and delivery, their experiences could have caused them to mistrust the system, as evident in their decisions not to return for postpartum care. As with most of the research reviewed, this study did not focus on the experiences of married adolescents, although it had at least three participants under the age of 20.

Maya et al. (2018) explored the experiences of adolescents in Ghana, West Africa. The researchers conducted 39 interviews and 10 focus group discussions with 110 women in two public health facilities in the country's eastern region. Twenty-nine of those interviewed were married adolescents between 15 and 19 years. Most participants reported encountering verbal and physical abuse while giving birth. Many stated that the maltreatment they endured affected their enthusiasm to use hospital facilities for subsequent births. One of the study's strengths was that Maya et al. separated the adolescents from the adults to express themselves freely without others overshadowing them. Few studies of maternal health have focused on adolescents in this context.

Conclusion and Transition

This literature review showed the large scale of the problem and the justification for focusing on married adolescents in this study. The literature indicated a lack of focus on married adolescents as a distinct group despite studies showing that they are a more vulnerable and at-risk population than their older counterparts. Many of the researchers who included the experiences of married pregnant women did not focus on those between the ages of 15 and 18 as a specific subgroup. Additionally, many of the studies included secondary data from the NDHS, which last occurred in 2013. A need exists for in-depth research on the members of this vulnerable group to explore their perceptions of their experiences of deciding to seek care in health facilities. The next chapter presents this study's methodology, setting, and approach to addressing the phenomenon of interest.

Chapter 3: Research Method

Introduction

Early marriages and adolescent pregnancies cause significant public health problems in Northern Nigeria (Kassa et al., 2018). Despite high death rates among women of childbearing age, Kano State in Northern Nigeria continues to have high numbers of adolescent pregnancies that significantly contribute to the city's maternal death rates (Adedokun et al., 2016). Married pregnant adolescents are a group often overlooked in studies on maternal mortality and morbidity. Scholars have often grouped adolescents with other women of childbearing age despite several studies showing that girls face the most risk and contribute more to maternal mortality and morbidity than older women (Garba et al., 2016).

The purpose of this study was to explore and understand the care-seeking experiences of first-time pregnant adolescents of 15 to 18 years of age. This study addressed how the participants viewed the effects of socioeconomic status, education, age, and culture on care-seeking decisions with a focus on gender and its intersection with various sociocultural determinants. This approach provided an understanding of the influence of gender and sociocultural factors on maternal health. Studying how gender, age, poverty, and education intersected was a way to contextualize and understand maternal health. Every study is unique; therefore, this chapter presents the present study's design, setting, population, sampling strategy, data analysis methods, and trustworthiness issues.

Research Design and Rationale

The research design is one of the most integral parts of a study. A well-articulated study plan presents the framework and the procedures and methods used for data collection, analysis, and interpretation (Ranganathan & Aggarwal, 2018). According to Ranganathan and Aggarwal (2018), a study's design can affect its validity. Therefore, researchers must choose the best design to answer their research questions. Wright et al. (2016) stated that the philosophical underpinnings of the researcher, the nature of what is known, and the alignment of those factors with the methods of data collection and analysis are critical components in conducting a rigorous qualitative study.

This study had the interpretive phenomenology approach. Interpretive phenomenology is a powerful qualitative research design for learning from the experiences of others (Neubauer et al., 2019). This study focused on understanding adolescent first-time mothers' decision-making processes and experiences, making phenomenology the most appropriate approach. Neubauer et al. (2019) stated that researchers can use phenomenology to learn about their study subjects' experiences and how they experience them. This study included an exploration of the participants' various experiences and the multiple influences and reasoning in their decisions to seek care, as well as the factors influencing their experiences and decisions.

Research Paradigm

The qualitative research approach is predicated on several paradigms that are the beliefs underpinning the entire research process (Teherani et al., 2015). Sale et al. (2002) pointed out that qualitative research has two main paradigms—interpretivism and

constructivism—which comprise the various social constructs of reality. The paradigms indicate the absence of fixed realities; instead, multiple realities can change according to context. As a result, qualitative researchers intertwine with their topics in a process where they must understand realities within their contexts (Sale et al., 2002). In this study, interpretive phenomenology was the design used to view the world through the participants' eyes. Interpretive phenomenology was an appropriate approach because it provided the opportunity to understand the participants' various experiences (Thanh & Thanh, 2015). The use of this paradigm occurred via free, unrestricted interactions between the participants and me. Creswell (2014) noted that such interactions focus on the thick descriptions of the experiences and the meanings that participants give to those experiences.

Research Questions

RQ1: What are the experiences of first-time pregnant adolescents in Kano State when deciding to seek care while pregnant?

RQ2: How do first-time pregnant adolescents in Kano State view sociocultural and demographic influences as factors that affect their decision to seek care?

Role of the Researcher

A researcher's knowledge and beliefs are critical components in the qualitative research process. Qualitative researchers must always consider their world views and the effects on their studies (Teherani et al., 2015). According to Teherani et al. (2015), a researcher must also ensure a proper alignment between the study's research question, approach, and the belief system underpinning the process. Researchers must consider

essential questions at the beginning of the process. According to Howell (2013), scholars explore the particular phenomena under study, how well they understand the phenomena, and the relationships between the researchers, topics, and participants. As the researcher, my role was to explore the phenomenon of interest by clarifying my position. Therefore, I reflected on my worldview and found alignment between all the aspects of the study topic. I then gathered, organized, and analyzed the data using the established ethical guidelines and codes of conduct of international and local ethical committees.

I have multiple backgrounds and identities, leading to biases before and during the study. As a health care provider, I know the rigors and challenges of delivering health care services in low-income settings. As a result, I approached the research with some understanding of what occurs in the health care setting and its implications for the participants. As a woman, I had a gendered approach to studying the phenomenon and looked at it from a feminine perspective. Recognizing these biases enabled me to situate myself properly. My gendered approach contributed to rather than obstructed my work. Using a feminist lens to focus on this topic provided me with new perspectives about the impacts of gender, patriarchy, and stereotypes on the phenomenon of interest.

Another identity I have is that of a Muslim woman who grew up in Northern Nigeria and later became one of the few indigenous female medical doctors in the area. My position enabled the participants and their family members to trust me with their information. I have been a part of the community that I studied; that role presented both unique challenges and a great opportunity. I have developed biases over my many years of interacting with young pregnant women and witnessing the number of maternal deaths.

I addressed these biases by remaining honest about my feelings and opinions regarding the responses I got while conducting the research. I continually reflected on my interactions with the participants, asking myself and noting questions about my feelings throughout the process. According to Austin and Sutton (2014), stepping back and examining underlying assumptions is an essential first step in addressing biases in research.

My insider status was also a unique advantage, as it provided me with the context needed to understand certain experiences. My insider status gave me more empathy and the shared experience needed for in-depth understanding than those who have not been in similar situations. Gair (2011) highlighted the role of shared experiences in improving the qualitative research process, noting that sharing experiences with participants is a way to enrich the research experience for both parties. I acknowledged partiality throughout the research to overcome the biases resulting from shared experiences.

Finally, I acknowledged my issues as a clinician. According to McNair et al. (2008), clinicians as qualitative researchers might encounter some challenges, mostly as a direct result of their training. Such challenges include insider assumptions, excessive control of the interview, and inadequate exploration of feelings. To overcome these risks, Dodgson (2019) recommended engaging in reflexivity and acknowledging and reflecting on biases and assumptions. Another suggestion was practicing reciprocity, which is the willingness to open up and share stories with participants. According to Davis et al. (2013), researchers can understand a phenomenon better if they approach participants

without assumptions. I approached the study with an open mind while drawing on my knowledge of the phenomenon to understand the participants' responses.

Methodology

The qualitative research methodology focuses on the in-depth experiences of the participants and the researchers' ability to understand and explain what the participants said, observed, and experienced (Austin & Sutton, 2014). Qualitative research has several underpinning concepts and paradigms, many of which have origins in philosophy and epistemology. Any inquiry requires a framework; however, qualitative research can have a fluid framework. Beginning with formulating the research questions, Erickson (2011) described the qualitative process as iterative, with each step as a precursor for the next. The back-and-forth and gradual build-up and melding of the concepts to build upon the next is a recursive process. Qualitative research requires purposeful participant selection; therefore, it is an inductive approach (Al-Busaidi, 2008). According to Al-Busaidi (2008), the objective of purposeful selection is to recruit individuals who can provide rich, descriptive depth and nuance to the interview questions.

There are four main qualitative research designs: phenomenology, ethnography, case studies, and grounded theory. Phenomenology was the method of choice for this study to elicit an in-depth understanding of the experiences of others. Phenomenology is an appropriate approach for learning about new and unexplored experiences (Neubauer et al., 2019). According to Neubauer et al. (2019), a phenomenological researcher explores a phenomenon through the experiences of those who have lived it. Researchers can also use phenomenology to investigate how people experience the world and why they

experience it in those ways. The participants in this study had similar characteristics: pregnant, married, and between 15 and 18 years of age. However, the participants had different experiences and actions. Phenomenology was the means used in this study to learn and understand the participants' different experiences, the reasons behind their decisions, and the influences on their decision-making processes.

The commonly known phenomenological traditions are transcendental, hermeneutic, and existential. However, broader and more contemporary phenomenological approaches include a mix of the philosophies of the transcendental and hermeneutic traditions (Neubauer et al., 2019): lifeworld research, postintentional, and interpretive phenomenological analysis (IPA). This research had the IPA approach. Researchers use IPA to uncover the meaning of a phenomenon through deep, rich inquiry (Peat et al., 2019). According to Peat et al. (2019), scholars use IPA in the field of public health to explore sensitive and complex topics. Neubauer et al. (2019) identified IPA as a way to explore how people make sense of and perceive the world and the influences on their experiences.

IPA researchers do not just rely on the revealed; they also play active roles in the process of engaging and understanding participants' experiences and worldviews. IPA researchers should encourage participants to explain their experiences and what they mean for them. I used my experience as a member of the community to explore the meanings behind the participants' decisions and in my interactions with the participants. According to Peat et al. (2019), the role of an IPA researcher requires more than

encouraging the participants to reveal their lived experiences. IPA researchers must also understand and interpret what their participants have revealed.

Justification for Using Qualitative Research

Researchers might have more familiarity with the quantitative method, which consists of collating large amounts of data to show the scale and scope of the topics of interest (Noyes et al., 2019). However, qualitative research has begun to receive widespread acceptance for public health research, particularly for maternal health care decisions (Martínez-García et al., 2019).

The shift away from the positivist theory of one reality is critical. According to Lange et al. (2019), researchers should conduct qualitative research for low- to middle-income countries where sociocultural factors contribute to maternal health decisions. Scholars can use qualitative research to explain the various biomedical factors in MMR statistics in such countries and discover multiple realities. Another benefit of using qualitative research to explore maternal health is presenting the missing voices beneath the figures and statistics. According to Lange et al., discussing the results of a qualitative study does not include generalizations. Qualitative researchers must contextualize each case, thus minimizing the chances of erroneous conclusions about unique circumstances.

Maternal mortality in northern Nigeria consists of more than health care services. Meh et al. (2019) stated that the significant differences between the MMR in the northern and southern parts of the country are partly due to the vastly different cultural practices in the north. Meh et al. highlighted the role of sociocultural context in maternal health. Understanding the reasons and the factors behind the behaviors of the women who live in

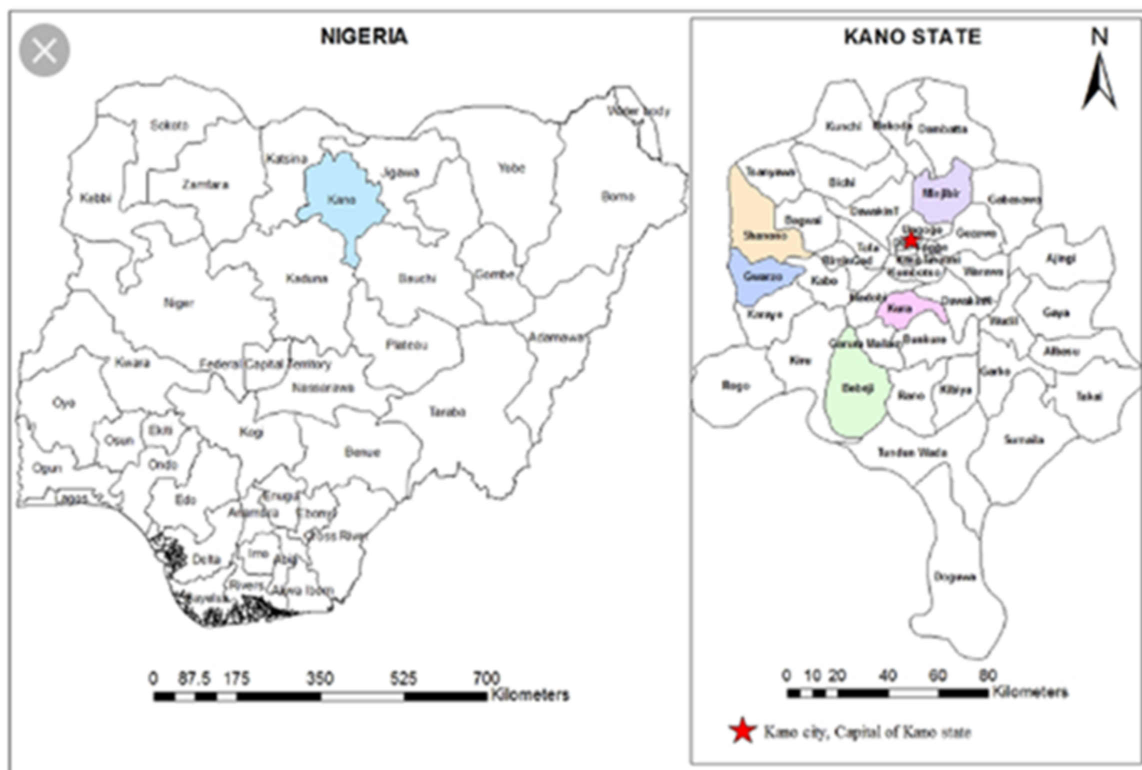
these regions requires a thorough exploration of the intersecting factors affecting how adolescent women in these environments view their health and seek care. Another advantage was that I know and understand the environment, and this knowledge provided an appropriate amount of depth to the investigation.

Study Area

The creation of Kano State from surrounding northern states in Nigeria occurred on May 27, 1967. The most recent population census in Nigeria showed Kano State's population as 9,401,288 in 2016, making Kano the most populated state in the country. However, in the absence of a government census since 2006, mathematical modeling has shown an exponentially growing state population density through the years (Weber et al., 2018). Figure 2 shows Kano State and Kano Metropolis (or Kano City), the state capital consisting mostly of urban and semirural areas. According to Ayila et al. (2014), massive urban expansion has occurred in Kano State due to increasing commercial activities in the capital.

Figure 2

Map of Nigeria Showing Kano State and Map of Kano State Showing All the Local Government Areas, Including Kano Municipal, the Study Area



Note. From https://www.researchgate.net/figure/A-geographic-map-showing-the-location-of-Kano-State-and-the-districts-involved

Kano State is an ancient city and center for Islamic thought and theology (Yar'Zever & Said, 2013). Thus, culture and religion are integral components affecting every aspect of life in this area. For instance, society determines social standing based on family size. The desire to get married and bear children has a significant influence on women's social status, contributing to the large family sizes in the region. The population consists primarily of Muslims, with a predominance of the Hausa-Fulani tribe.

Agriculture is the most dominant commercial activity in the state. The capital, which is the seat of government, has a large number of politicians and government workers (The World Bank in Nigeria, 2020). Although the commercial activity occurs in the capital, over 62% of the population live on less than a dollar a day.

The Multi-Indicator Cluster Survey (MICS) of the National Bureau of Statistics in Nigeria, supported by several national and international NGOs and funded by the UNICEF, provides internationally recognized comparable data with several indicators of the state of women and children in various parts of Nigeria (Ayede et al., 2018). The MICS for Kano State showed individuals under 15 years of age comprise about 51% of the Kano State population (UNICEF/National Bureau of Statistics, 2018), indicating a mostly young population with a high dependency ratio. According to the MICS survey data for Kano State, three in four women are between 15 and 18 years old and married.

Kano State's official language is English, although Hausa is the most predominantly spoken language. Participant interviews occurred in Hausa, as I speak, read, and understand Hausa fluently. I translated the interviews into English for data analysis and conclusions.

Participant Selection Logic

Sampling Strategy

Purposeful recruitment of participants occurred in this study. Purposeful sampling is a widely used strategy in qualitative research for recruiting the participants best suited to speak about the phenomenon of interest (Sargeant, 2012). This study focused on the health care decisions and experiences of adolescent first-time mothers. Therefore,

purposeful recruitment occurred for married and pregnant adolescents between 15 and 18 years of age. I chose this age group because studies have shown that the mean age of marriage in the region is 15 years, as 65% of adolescents get married before 18 (Aradeon & Doctor, 2016).

Sample Size

According to Creswell (2014), there is no definitive sample size for a qualitative study. Many researchers have different sample sizes based on their study designs. Unlike quantitative research, no gold standard exists for determining sample size for qualitative inquiry (Kirchherr & Charles, 2018). Kirchherr and Charles (2018) noted that most social science research requires a sample size of between 12 to 20 for data saturation; however, 20 participants could be too large in some instances. Other considerations for determining sample size include location, time, and resources.

I decided on a sample of 12 interviewees for context-rich information based on research I had conducted. For example, Guest et al. (2006) found 12 interviews sufficient for a study conducted in two West African countries among 66 women. Baker and Edwards (2012) and Nisar et al. (2016), who conducted studies with similar parameters, had sample sizes of 12. Twelve is not a required choice for sample size; researchers can increase or decrease their sample as needed. According to Vasileiou et al. (2018), researchers who have not achieved data saturation can recruit additional participants until they can no longer obtain new information.

Data Saturation

Researchers decide to discontinue data collection based on whether they have achieved data saturation (Saunders et al., 2018). Data saturation is one of the essential principles for attaining rigor in qualitative inquiry. Determining when saturation occurs requires consideration of factors, such as sample size and emerging themes (Saunders et al., 2018). Jackson et al. (2015) stated that researchers could determine saturation when they start to hear the participants say the same things during interviews. Still, Jackson et al. pointed out some challenges in determining when saturation has occurred. A robust discussion exists within scientific circles about whether saturation is an event or a process. Saunders et al. (2018) explained that qualitative researchers have achieved data saturation when new information does not provide anything new to the study and when they have explored all the constructs of the study without discovering anything further.

I started with a sample size of 12 and explored all the themes and constructs with this initial sample. I did not get any new information from the participants by the 12th interview. Saunders et al. (2018) suggested that researchers gain more insight by probing emerging themes rather than data saturation by incrementally increasing sample size. Therefore, I focused on going in-depth during the interviews. I documented this process in detail and justified at every step why I decided to remain with the initial sample size or add participants to the study.

Inclusion and Exclusion Criteria

Inclusion and exclusion criteria are essential parts of recruiting participants. According to Garg (2016), meticulous inclusion and exclusion criteria enable researchers

to recruit participants knowledgeable about the phenomenon of interest. Researchers can also use inclusion and exclusion criteria to reduce the chances of choosing participants unable to contribute to the study adequately. I based the study's criteria on the population of interest, topic, comparison, outcomes, and study design. The inclusion criteria were adolescent women between the ages of 15 and 18 who were married, were pregnant with a first child, were living in Kano City, and had husbands who gave permission to participate. The exclusion criteria were married pregnant adolescents who were younger than 15 years, did not consent to participate, or did not receive permission from their husbands to participate.

Conducting Research With Minors

The WHO (2018) provided a set of guidelines for researchers to use while working on sexual and reproductive health studies with adolescents, including emancipated minors. Emancipated minors are those under the legal age of consent (18 years of age in Nigeria) who have received the status of adulthood due to exceptional circumstances, such as marriage. The guidelines indicate that minors married, pregnant, or with children have the authority to make their own decisions to seek care or participate in any research or study (WHO, 2018).

I used the WHO guidelines to recruit participants between 15 and 18 years who could give consent due to their emancipated status. Therefore, even after obtaining permission from their husbands, the participants went through the informed consent process and consented to engage in the interviews. If any participants had experienced pressure to participate, I would have taken adequate steps to exclude them from the study

safely and respectfully; however, this did not occur. I obtained verbal consent from both the participants and their husbands.

Data Collection

Data collection from 12 adolescent women who fit the inclusion criteria occurred over 12 weeks, from recruitment to interviews. I interviewed the participants after obtaining all the necessary permissions and determining the safety of the interviews based on strict COVID-19 guidelines. Each interview lasted between 45 minutes to 1 hour. Four interviews occurred via telephone, and eight interviews occurred face to face. The interviews were in the Hausa language, recorded with a digital recorder. I maintained social distancing by conducting the interviews at the women's homes or private open spaces within the compounds, resorting to telephone interviews if social distancing was not possible. At the homes, as is the custom, most of the hosts provided mats. I brought mats in case I needed extra; however, there was little use for them. I brought a tape recorder, notepad, and pen to each interview. I listened intently while the participants responded to my questions, interjecting minimally with only probes and encouragement. After each interview, I went home, transcribed the interview, translated it into English, and compared the transcription and translation to ensure accuracy.

The permission to use a digital recorder was part of the informed consent process at the start of the discussions. I designed open-ended questions for the semi structured interviews (see Appendix A). After the interviews, I asked the participants if they had questions. I then provided them with my telephone number to reach me at any time and asked for their permission to call and request follow-up meetings for further information

or clarification. I called a few participants back when I required clarity or context for specific points in the interviews. I wrote my observations and reflections on the interview process in a notebook, which became part of the data used during analysis. I thanked the participants for their time by providing those who conducted face-to-face interviews with washing soap or detergent.

Instrumentation

I used open-ended questions to carry out one-on-one semi structured interviews with all the participants. The interview protocol enabled me to probe for details while maintaining a structure that fit the study's constructs. In-depth interviews with open-ended questions provide researchers and participants with the opportunity to engage in a dialogue and jointly explore the topic of interest. Open-ended questions also provide the flexibility to probe into personal and sensitive issues (DeJonckheere & Vaughn, 2019). Weller et al. (2018) stated that open-ended questionnaires give researchers the best chance of probing for information and enabling themes to emerge. Investigating the topic with a phenomenological approach in this study required exploring the participants' lived experiences with questions to develop major constructs and themes.

Developing the Interview Questions

I considered the various concepts I planned to explore in this study while developing the interview questions. The interview protocol addressed the participants' health care decision-making, maternal care needs, experiences, participation in decision-making, agency, and gender roles. The questions in the interview protocol also aligned with the intersectionality theory and the issues of gender intersecting with age,

educational background, and socioeconomic status for perspectives to enable the women to construct their stories.

I framed the open-ended questions to stimulate discussion and enable the participants to share their experiences. I encouraged the participants to tell their stories with limited interruptions. My gentle, follow-up probes gave them further opportunities to tell their stories in rich layers.

Introductions were an essential part of the interviews. I asked the first few questions to ease the interviewees into the process. The conclusion was another vital part of the interviews because it enabled the participants to fill in any perceived gaps related to the interview questions. In the beginning, I introduced the study to the participants so that they could tell their stories about the phenomenon of interest. The interview protocol included broad overarching questions tailored to produce the answers to the specific questions. Gentle probing occurred for more information. I ascertained content validity after conducting a pilot study.

Field Notes and Observation

Field notes and observations are also essential data tools. According to Phillippi and Lauderdale (2018), field notes provide contextual information and a more thorough understanding of the data gathered by the researcher from the interviews with the participants. After each interview, I reflected on the entire process and wrote notes about my observations in the field. I used the notes to capture information relevant for understanding the participants' responses. I also used the notes for data analysis, as they provided additional depth to the findings.

Field notes are essential tools for capturing the data collector's observations in qualitative research. Field notes should contain detailed descriptions of people, events, and dialogues; if done well, they also indicate the feelings and reactions of the researcher (Malacrida, 2007). Field notes are an increasingly valuable data collection resource because they provide rich and informative information (Friedemann et al., 2011). Field notes have several strong points. Researchers can use field notes for needed introspection, particularly when dealing with sensitive or complex issues. Field notes are also a way to minimize subjectivity and reduce bias with reflection and introspection (Hellesø et al., 2015).

Recruitment Strategy

To recruit the participants, I collaborated with FOMWAN, a faith-based women's group. Religious women's groups in Kano City have unfettered access to women who live in the community. For years, members of groups such as FOMWAN have worked closely with local communities for maternal health issues, particularly early marriages and maternal mortality (Wallace, 2014). FOMWAN is an organization present in every city in the state with an extensive database of each woman in the community. FOMWAN members also benefit from the widespread trust and acceptance of community members gained over decades of working on women's rights issues. FOMWAN are community gatekeepers trusted by the members of the religious establishment. Adedini et al. (2018) highlighted the importance of religious groups as gatekeepers in Northern Nigeria. They stated that religious leaders have wide acceptance because religion is a guide for people's lives. An additional benefit of such a group is the degree of access it has to women in

seclusion, particularly those not allowed to interact with the outside world, and especially with men who are not close relatives.

At the start of the outreach process, I discussed the research and purpose of the study through a series of phone calls with the Amira; leader of FOMWAN in Kano State. Amira gave me a contact in the city who served as a liaison between the community members and me. I spoke with the contact via telephone and explained the study's purpose and benefits for the community. We discussed her knowledge of the environment and FOMWAN's database to identify women who fit the criteria. I asked my contact to approach the women and their husbands to ask for permission to engage in interviews. Getting the husbands' permission was critical because the traditional sharia law in Kano State indicates that a husband has sole authority over his wife. Therefore, the husbands had to grant permission to ask the women to participate in the study. I emphasized to my contact that while the husbands' permission was the first step, the women must not feel pressured to participate in any way, even if the husbands permitted her to contact their wives. I ascertained this step before starting the interviews. I only approached the women after their husbands agreed I could recruit them. I verified that the participants met the inclusion criteria by asking them to confirm their age, marriage, and pregnancy status. I recruited the women after conducting this screening process.

Pilot Study

I conducted a pilot study before commencing the fieldwork. The pilot study was a critical step in establishing the suitability of the data collection tool and identifying and correcting issues with field entry, interview style, and the interview guide. Interviews

commenced with two adolescent women who fit the inclusion criteria when I approached the FOMWAN contact with the developed criteria. One of the interviews was via telephone, and one was face to face after establishing COVID-19 protocols.

I asked the questions developed for the pilot study and looked for ambiguous or difficult-to-answer questions or questions that caused the participants discomfort. I also took notes of the ease of the recruitment process and any issues that could impact the fieldwork. At the end of the pilot study, I determined that no adjustments were required. I included the pilot study participants from the main study.

Ethical Procedures

Research on human subjects requires considering the rights and well-being of the participants at every step. This study included pregnant adolescents younger than 18 who lived under mandatory seclusion; thus, there was a need for additional ethical considerations because the participants were members of a vulnerable population. I took extra precautions to protect the participants' rights and privacy. I gained informed consent from the women after obtaining the husbands' permission to contact the participants without jeopardizing their safety.

In addition, I ensured that all of the women interviewed understood that they had full autonomy to decide to participate in the research and that I respected their decision regardless of their choices. I also obtained IRB approval (Approval number 09-25-20-0644735). In addition, I obtained ethical clearance from the National Health Research Ethics Committee of Nigeria, the members of whom oversee the conduct of research in the country (NHREC Approval Number NHREC/01/01/2007-24/11/2020).

Minimizing Harm With Vulnerable Populations

Reducing harm is a crucial step in sensitive subjects or issues, particularly for research with minors. Researching children requires having an advocate present and preventing distress from any questions asked or issues raised. According to Hoeyer et al. (2005), a researcher should have a clear protocol for dealing with emotional distress, especially when working with vulnerable populations. Therefore, I was responsible for conducting research according to the highest ethical principles. Researchers dealing with potentially emotionally challenging subjects should develop strategies to avoid becoming overly emotionally involved. Researchers must have a considerable degree of self-reflection, emotional awareness, and the ability to assess relationships objectively. As a researcher, I sought to make sure that I was not so emotionally distant that I missed the chance to get truthful insights and knowledge into the research questions.

Community Entry

The main ethical concern related to recruitment was the possibility of the women getting rebuked, in trouble, or punished for discussing their reproductive health, especially if community members, leaders, and husbands viewed the interactions with suspicion. Punishment could result in emotional distress, a lack of privileges, or a trip back home for insubordination. Thus, gaining community entry was vital to conduct research and engage with community members in acceptable ways. I facilitated acceptance and protected the participants' rights and well-being by engaging with respected, knowledgeable community members trusted by the community patriarchs.

Using community-based and civil society organizations to gain acceptance from community leaders and husbands is a well-used strategy by researchers and policymakers in Northern Nigeria (Williamson & Rodd, 2016). Wallace (2016) stated that Muslim women's groups in the north of Nigeria, such as FOMWAN, are critical means of fostering connections between community members and policymakers and facilitating the institution of acceptable and sustainable policies in the community. FOMWAN's participation enabled me to gain the trust of the husbands and community gatekeepers and maintain the participants' and my safety.

Another concern was that the combined influence of FOMWAN and the potential participants' husbands could cause the young women to feel coerced into joining the study. I addressed this concern by clearly indicating to my FOMWAN community contact that no one should force the women to participate. While talking with the husbands before the interviews, I asked if they used any coercion to get their wives to participate, to which they all responded that they had not. Finally, before obtaining informed consent, I asked the women if they experienced coercion. None of the participants said or showed any indication through their tone or body language that they felt uncomfortable in the process.

Privacy and Confidentiality

According to the World Medical Association (2013), Declaration of Helsinki, researchers must ensure the confidentiality of their participants. Confidentiality was a critical component in this study due to the sensitivity of the collected data. I informed the women of the voluntary nature of their participation and their right to withdraw at any

time. The participants could decline to answer any questions if they felt uncomfortable. I did not include identifying information in the field notes or transcripts and identified the participants via codes that only I could access. At the start of each interview, I informed each participant of the steps taken to ensure the privacy of their information. I also let them know that they could withdraw consent at any time and decline the inclusion of their participation in the research. I remained observant for any signs of discomfort or distress at any time during the process. The interview discussions remained cordial and open without signs of emotional distress.

Informed Consent

I started the process by obtaining verbal consent from the participants' husbands with the husband assent form. After receiving permission from their husbands, the women consented to have me contact them to schedule interviews. I called the participants and described the study, its goals, and what I would do with the results. The women learned about the voluntary nature of participation and that they could withdraw at any time. I made it clear to the participants from the beginning that they could decide not to answer any questions they found uncomfortable. Communication of the information occurred in simple terms in the Hausa language. The participants also provided their permission to tape the interviews. I obtained and audio-recorded verbal consent due to the participants' literacy levels.

Storage of Data

Data storage is integral to ensuring participant confidentiality and privacy. As the researcher, I organized and stored data adequately and communicated the means of data

storage to the participants. The interview recordings occurred via a digital recorder. I uploaded the audio files to Google Cloud, and only I was the one with the password. The names on the tapes underwent coding without identifiers that linked the data to the participants. The recorder, all field notes, and any raw data remained locked in a home office drawer to which only I had the key. I stored the transcripts on my password-protected personal computer, to which only I had access. Per the Walden University Institutional Review Board (IRB) protocol and best practices, I will store the data for 5 years and then destroy them.

Data Analysis Plan

Data analysis is the process in which a researcher examines the data in detail for similarities, differences, and patterns for enhanced understanding of the phenomenon of interest (Tolley et al., 2005). According to Tolley et al. (2005), researchers should consider five guiding principles when analyzing data:

- Remaining aware of personal perspectives and assumptions that could affect the process.
- Understanding the context behind the participants' responses.
- Allowing the theory to emerge from the analysis.
- Remaining aware of exceptional cases, particularly when dealing with sensitive topics, as these could be representations of the voices of an overlooked population
- Understanding the iterative nature of qualitative research to enable the nonlinear emergence of patterns of human behavior.

Data Analysis Process Using Colaizzi’s Steps

Data analysis commenced with the steps outlined by Colaizzi to uncover, understand, and interpret the participants’ experiences. According to Colaizzi (1973), researchers should allow the subjects of their studies to reveal themselves. However, this might not occur all at once; each step could result in another. Colaizzi’s method is a useful way to understand people’s lived experiences (Wirihana et al., 2018). In this study, Colaizzi’s method of data analysis allowed me to identify meaningful information via extraction from the raw data, themes, and categories (Shosha, 2012). Shosha (2012) and Morrow et al. (2015) stated that Colaizzi’s method has an added element of rigor because each of the seven steps produces detailed descriptions of the phenomenon of interest. The process includes validating the findings of the research participants.

In addition to the raw data obtained from participant interviews, researchers could use other data sources, such as field notes, analytical memos, and blogs, for analysis using Colaizzi’s method (Morrow et al., 2015). Understanding and interpreting lived experiences in phenomenological research require a researcher to enable themes and relationships to emerge (Neubauer et al., 2019). Colaizzi’s method has clear steps in a logical sequence to provide structure to the findings, enabling the researcher to understand what the data show (Wirihana et al., 2018). The data analysis in this study occurred with Colaizzi’s method to identify the themes, understand the participants’ experiences, and recognize the influence of the intersections of various constructs on these experiences. Shosha (2012) outlined the following steps of Colaizzi’s method.

1. Studying the transcripts: Qualitative interviews produce stories; therefore, analyzing interviews is usually a meticulous and laborious process (Tolley et al., 2005). In this study, data collection from the interviews occurred on tape with participants' permission. I performed translation and transcription by hand to check for accuracy. I am fluent in the written and spoken Hausa language. Translating and transcribing the interviews provided the opportunity to fully immerse in the data to identify themes for reflection and understanding.
2. Extracting statements and themes: After transcribing and translating the interviews, I reviewed the transcripts and identified patterns and emerging themes related to the study's theoretical constructs. In this step, identification and coding of significant statements occurred on a separate sheet. I developed a coding system to locate these statements based on the transcript, page, and line numbers for unique identification numbers to locate and identify comments in the transcripts.
3. Formulating meanings from the statements: After carefully studying the statements and looking at the reflexivity journal, I aggregated the statements and looked for the meanings aligned with the phenomenon. I then grouped and coded these statements. According to the Colaizzi method, the third step is a detailed and exhaustive process that requires identifying the meanings as close to the phenomenon of interest as possible (Shosha, 2012).

4. Gathering ideas or categories from across transcripts: In Step 4, I identified the ideas common across all the transcripts and grouped them into themes for the emergent themes.
5. Writing a description based on the themes and clusters identified: I wrote an exhaustive description of the phenomenon and brought together the themes identified in Step 4. I provided detailed and thorough descriptions to capture all the major themes and clusters produced during coding.
6. Producing a structure: I summarized the descriptions and identified a fundamental structure to the phenomenon. Then, I trimmed down the entire structure by removing redundancies, repetitions, and weak connections. Creating a storyline commenced with the data for how each of the major themes fit into the general picture. The presentation of the results included rich quotes representative of the study's significant findings.
7. Ensuring credibility: In this final step, I ensured the credibility of the data by sharing my findings with the participants. I called the women via telephone to share the results and ask if the findings were an accurate picture of their situations.

Treatment of Discrepant Cases

Data analysis involving sensitive topics, such as in this study, requires awareness of exceptional circumstances. Exceptional cases, also known as discrepant cases, are findings during analysis that do not fit the emerging patterns and are at odds with most of the data (McPherson & Thorne, 2006). According to McPherson and Thorne (2006),

researchers must pay attention to discrepant cases to enhance their understanding of what is happening and amplify the voices of those marginalized. In this study, I interrogated the discrepant cases. I explored the data further in-depth to understand the underlying reasons behind the discrepant case. Chapter 4 presents the findings and the explanations.

Issues of Trustworthiness

Qualitative researchers must ensure the quality of their work. According to Leung (2015), no consensus exists on how to assess qualitative work thoroughly. For instance, some schools of thought focus on methodology (Dixon-Woods et al., 2004), while others focus on rigor during the interpretations of the results (Lincoln et al., 2011). Other researchers have a more holistic approach. For instance, Kitto et al. (2008) described the six criteria for assessing the quality of qualitative research: clarification and justification, procedural rigor, sample representativeness, interpretative rigor, reflexive and evaluative rigor, and transferability.

Credibility is one of the most critical aspects of ensuring the quality of qualitative research. Credibility is also a vital prerequisite for establishing trustworthiness in the process (Shenton, 2004). I ensured the study's credibility by measuring the phenomenon as precisely as possible; the findings were close to reality. Member checks are one way to ensure credibility. Also known as respondent validation, member checks occur when a researcher shares findings with the participants to check for accuracy. In this study, after conducting the analysis, I shared the results with the participants and asked if they accurately reflected our discussions.

I also used my analytical memos and reflective summaries to examine and apply previous findings for context. I also provided a detailed description of the phenomenon. A researcher's thoughts and beliefs are essential parts of the research process (Jeanfreu & Jack, 2010). A researcher should leave an audit trail of thoughts and actions during the research. During this study, I kept a journal to take reflexive memos and document my thoughts. I used the journal during the analysis process to contextualize and clarify my biases and reasoning for some of the study's conclusions.

Transition

This phenomenological inquiry story included narrative interviews on the health care decision-making of married adolescents between the ages of 15 and 18 and pregnant for the first time. This chapter presented the methods used for this research, including the participant recruitment, rationale for a sample size of 12, and the formulation of the study guide. This chapter also included the steps taken to ensure the participants' privacy and confidentiality. The chapter offered the data analysis and the means to ensure the credibility, dependability, and transferability of the findings.

Chapter 4: Results

The purpose of this phenomenological qualitative inquiry study was to explore the care-seeking experiences of first-time pregnant adolescents during their pregnancies. This study addressed how the participants viewed the effects of gender, age, social class, and education on their decisions to seek care. I investigated how the participants made their choices, the societal structures or people influential in their decisions, and the influence of various factors on those decisions. I used a theoretical construct focused on gender, social justice, and the intersection of various social and demographic determinants. This chapter presents the findings from 12 in-depth interviews with first-time pregnant adolescent girls. A semistructured interview allowed me to engage in in-depth discussions with the participants, explore their lived experiences, and understand the phenomenon under study.

The chapter has several sections. The first section presents the processes taken during the pilot study. The second section includes the participants' demographic characteristics, including their age, pregnancy status, educational level, and what they did for income. The third section presents the process of collecting, managing, storing, and protecting the data. There is evidence of the trustworthiness of the data through reliability, confirmability, transferability, and credibility. The data analysis included Colaizzi's steps for identifying, coding, and categorizing the keywords and themes. The fourth section of this chapter presents the findings and their relation to the intersectionality theory. I discuss the various constructs and how their intersections produced different participant outcomes.

Setting

At the time of the interviews, the community had just lifted the COVID-19 lockdown restrictions. Home visits could occur with an effective COVID-19 protocol. Based on the Nigerian Centers for Disease Control recommendations, I had to sit at least 2 meters away from the participants. Additionally, the participants had to be willing and able to wear face masks. Based on the study protocol, I interviewed the participants in private locations, away from family members who could hear us. Eight of the participants met these criteria and engaged in face-to-face interviews. The remaining four participants engaged in interviews remotely via telephone.

All home interviews occurred in an open, spacious, and secluded space called *zaure* or in the young women's private living rooms. After establishing the sufficient size and ventilation of the space, I provided the participants with masks and hand sanitizer. For the telephone interviews, I asked the participants to talk in quiet rooms away from interruptions and potential eavesdropping; all the participants assured me that they had done so. The interview recordings did not indicate apparent instances of outside interruptions. Two of the interviewed participants had poor network connections that kept breaking up. I had to postpone the interview with one participant until the individual could establish a clearer connection.

None of the participants appeared under any form of duress or coercion during the interviews. No family members, religious or traditional leaders, or women's group members influenced the interviews or data analysis outcomes. All the interviews proceeded as planned without adverse or unexpected events.

Demographics

Twelve participants who lived in different parts of Kano City engaged in interviews. The participants were adolescent women between 15 and 18 years of age. Five of the participants were 17, three were 16, two were 18, and two were 15. Six of the participants were in the third trimester of their pregnancies, five were in the second trimester, and one was in the first trimester. Each participant received a number based on the order of interviewing to maintain confidentiality and anonymity.

Pilot Study

A pilot study commenced to test the study design before the fieldwork. The goal of the pilot study was to test the processes of identifying and recruiting participants to determine the accuracy, appropriateness, and understanding of the study guide. The pilot study had the same inclusion and exclusion criteria as the main study. I selected two first-time married pregnant adolescents from the same study location. The two pilot study participants were 16 and 18 years of age and were 4 and 7 months pregnant, respectively. One interview occurred by telephone, and the other interview took place in the participant's home.

The pilot study results showed the appropriateness of the interview questions and that the participants could answer the question. Forty-five minutes was an adequate length of time for the interview. Both the telephone and face-to-face interviews were practical and effective means of engaging with the participants. Thus, I did not need to revise the data collection instrument, interview setting, interview time limit, or participant

choice. There was no need to make further adjustments or adaptations. The final study included the data collected from the pilot interviews.

Data Collection

Purposeful sampling commenced to recruit the participants. The primary contact and guide to the participants in the community was a FOMWAN representative who identified the adolescents in the community who met the inclusion criteria. The data collection commenced with an initial meeting with the FOMWAN guide to discuss the eligibility criteria (see Chapter 3). The FOMWAN representative made initial contact with the potential participants, letting them know she would share their telephone numbers with me and I would call them. The representative asked and received the participants' husbands for permission before approaching the wives. At this point, the representative requested to share the participants' telephone numbers only with me. I clarified with the guide that no coercion should occur to get the adolescents to participate and that I would only contact the women whose husbands provided permission.

In the first round of contacts, the FOMWAN guide identified 16 young women in the community who fit the criteria. The guide contacted the husbands first, and three declined the invitation to share their information with me. I contacted the 13 young women whose husbands had agreed and who shared their contact details with me. After I asked the wives for their permission to interview them, two declined to participate. At this point, I had 11 potential participants. The FOMWAN guide returned to the community and recruited one younger woman whose husband provided permission to contact. This potential participant agreed to be contacted as well.

An initial telephone call occurred with each participant to discuss the study's requirements, read the consent forms aloud, decide on participation, and confirm interest in participation. I emphasized that they had no obligation to participate and that they would not experience coercion from outside influences. Three adolescents agreed to participate right away, and the rest agreed to participate within 4 days of contact. After receiving permission and consent, I called the participants back to schedule either in-person or telephone interviews. At the time of the interviews, Nigeria had just lifted its COVID-19 restrictions, and people could meet face-to-face while wearing face masks and maintaining a distance of at least 2 meters. I confirmed face-to-face interviews with proper COVID-19 protocols with eight participants. Four participants scheduled telephone interviews.

The face-to-face interviews commenced with the usual, customary greetings. The in-person interviews occurred in quiet, secluded household areas with minimal chances of intrusion or eavesdropping. The interviews took place in the mornings between 8 a.m. and 12 noon because the husbands were out of the house. This was also a convenient time for the women because it occurred before the afternoon meal preparation and after the morning housework. After settling down, I read the consent forms aloud to each participant and asked for her verbal consent.

For the telephone interviews, I asked the participants for assurance that they were in safe and comfortable environments where they could speak freely without others overhearing. I read the consent forms aloud to the participants and gave them the chance to ask questions or request clarification before starting.

The interviews occurred in the Hausa language. I recorded the interviews with a Panasonic digital audio recorder and a phone audio recorder as a backup. I asked each participant for permission before recording the interview. I watched and listened for signs of discomfort or coercion from the participants; I did not find any in all the interviews. The participants all appeared comfortable with the process. In two instances (Participants 4 and 7), the interviews lasted less than 45 minutes. Participants 4 and 7 answered their questions quickly and stated when they did not know the answer to the questions. Participant 9 spoke for over an hour and was knowledgeable and enthusiastic about the questions. Translation of each interview into English occurred after each interview.

Data Saturation

Guest et al. (2006) noted that data saturation occurs when additional interviews do not yield new information. The interviews produced rich data from the participants. However, by the 12th interview, I noticed a lot of repeated information, with little new data or insights. At this point, data saturation had occurred. At the 15th week of data collection and after interviewing all 12 participants, I did not receive further information. Therefore, I discerned that the study did not need additional interviews.

Data Management

Data analysis commenced with the 12 translated transcripts and observational notes and reflections of the participants and interviews. I ensured confidentiality by coding the participants from P1 to P12 based on the interview sequence. Therefore, P1 was the first participant interviewed and P12 the last. I used these codes in the transcripts and the audio files. While gathering data in the field, I kept all consent forms and digital

recorders locked in a bag that I carried with me at all times, with the keys always in my custody. I stored the raw data in a cupboard in my home office every day after fieldwork. No one else had access to the study data and codes. Destruction of the data will occur 5 years after study completion.

Data Analysis

Data analysis is an essential yet complex part of any qualitative research study. The data analysis phase consisted of breaking down the extensive amount of rich data collected during the study into specific outcomes to address the study's research questions. According to Raskind et al. (2019), researchers must consider many factors when analyzing qualitative data, including the complexity of human behavior and the difficulty of adequately capturing a diverse population's lived experiences. There is no one way to analyze qualitative data (Saldaña & Omasta, 2018). Researchers must carefully consider the diversity of the participants, study framework, contextual information, and type of data collected when deciding on an analysis method.

Colaizzi's seven-step descriptive method (see Chapter 3) was the approach used to analyze the data. Colaizzi's method is a robust, seven-step process of examining detailed, thick descriptions from interviews and other data collection methods. Researchers use the rigorous, iterative process with overlapping steps to avoid missing significant understanding or insight from the data. According to Morrow et al. (2015), Colaizzi's data analysis approach is a way to remain close to the data and the participants' experiences. Colaizzi's method also has an inbuilt validity plan that

contributes to the trustworthiness of the process. The following sections present the steps of the data process.

Step 1: Familiarization

I translated the audio recording of each interview from Hausa to English after transcription. I read the English translations several times to familiarize myself with the interview content. As I conducted more interviews, I reread the previous interviews for additional understanding of what the participants said, what they meant, and the relevance of their data to the study.

Step 2: Extracting Significant Statements

The next step consisted of extracting statements from the transcripts that directly related to the phenomenon of study. I identified relevant words and phrases and recorded them in a notebook. I looked at the frequency of statements and how they related to each other. I documented the statements in my notebook, noting where they occurred in the transcripts and audio recordings to look for recurrences and patterns. This process occurred for each transcript.

I looked at the occurrence of the ideas across all the transcripts and noted their frequency, from most to least. Extraction occurred of 156 statements significant to the phenomenon of study. I also identified any divergent statements or quotes and labeled them as discrepant cases. Further study commenced of the discrepant cases for additional context and insight.

Step 3: Giving Meanings to Statements

Next, I gave meanings to the statements extracted from the transcripts. Examination of the statements commenced by reading them repeatedly and linking them with their specific contexts in the transcripts. I then grouped the statements with the same meanings into one category and looked for patterns in those groupings. Further grouping of the statements occurred into 61 central ideas, which produced the 35 code words used to extract the study's themes.

Step 4: Extracting Themes

I then looked for groupings of similar ideas, concepts, and statements for five themes from the transcripts' central ideas. I kept returning to the transcripts and observations to ensure I had captured the essence of what the participants said. I added to the richness of the data with additional notes from the transcripts and reflections. I put the observations and reflections in brackets to avoid influencing the theory's emergence. The data presented themselves. The reflections and observations in the brackets provided more context to the emergent findings. (See Appendix C for the theme extraction process.)

Step 5: Developing Rich, Thick Description From the Data

Development of detailed descriptions of the themes occurred using the data from the observations of the fieldwork and transcripts. I provided rich descriptions of the five themes showing the essence of the findings and participants' descriptions. This process resulted in over 10 pages of descriptions essential for understanding participants' care-seeking experiences.

Step 6: Producing the Fundamental Structure

The next step entailed condensing the thick, rich descriptions of the themes into short statements that presented the participants' experiences. The statements were an important step in the final write-up and for validating the findings. The statements focused on the themes found and their relationships to the theory used in the study. The statements included issues of gender, age, social class, education, and family relationships.

Step 7: Seeking Verification

In this final step, I went back to the participants with the short, dense statements from the analysis of the interviews. I asked them via telephone if the statements were accurate representations of their experiences. Their observations enabled me to create more context for the statements and for the final discussions. This final step occurred to verify that the statements were accurate reflections of the participants' thoughts and actions.

Using Field Notes From Observations and Reflections

I recorded my experiences each time I visited or called the participants to understand the discussions and context better. Although I live and work in the community, I approached the research with a healthy dose of curiosity. I remained open to learning new things and observing the various happenings and changes in the community to more deeply understand the topic and gain data for the research.

The first interviewee was very close to her due date. She appeared shy at first but later opened up and talked freely. At the end of the interview, she indicated the

seriousness of the situation of pregnant women dying in her community. The community members knew they had problems in the community. Almost every interview contained tragic reminders of the toll of maternal deaths in the community. During one of the interviews, the participant and I heard the announcement of the death of a pregnant woman nearby, and we paused to say a prayer for her. Hearing announcements of the deaths of pregnant women was a common occurrence.

A proverb in the community is that a pregnant woman already has one foot in the grave and that God determines if the other foot follows. Almost all the participants knew women who had died during pregnancy or delivery or shortly afterward. These accounts were tragic reminders of the burden of maternal deaths in the community. Living through them during the fieldwork provided me with insight and empathy into how the women viewed these events.

In my memos, I noted that the participants deeply rooted their experiences and in their faith. They silently accepted whatever they were going through as predestined. In moments when they complained, they expressed some guilt about sharing their sentiments, almost as if they felt that they were questioning God’s will. Despite their beliefs, they mostly expressed that they did not want to suffer and would prefer to do all that they could to avoid the fate of others. I was struck by the women’s stoicism; despite their age and circumstances, they carried themselves with quiet dignity. I met pregnant women who had endured so many hardships, illnesses, and poverty but who still expressed their thankfulness for the little things.

As each day went by, I captured my experiences in my notebook. I also wrote descriptions of the community to understand the areas and landmarks mentioned in the interviews. In the end, the memos from my observations and experiences were an integral part of understanding the data during analysis.

Evidence of Trustworthiness

Qualitative researchers must remain mindful of the quality of their work and ensure their studies' trustworthiness with methodical documentation of the process. Lincoln and Guba (1994) described four significant principles for establishing trust in a study's findings: credibility, transferability, dependability, and confirmability. I incorporated these principles into every step of this study and detailed them here as part of the trustworthiness process.

Credibility

Credibility is a critical aspect of ensuring trustworthiness, as it is a measure of how precisely a study presents the participants' experiences (Korstjens & Moser, 2018). Colaizzi's seven-step data analysis method provided several processes for ensuring the credibility of this study. The first step was reading the transcripts several times to familiarize myself with the data. After reading the transcripts, extracting themes, and writing out statements during the final stage of the data analysis, I called the participants and read them the summaries of the findings. The participants verified that the statements reflected their experiences and what they said during the interviews. They also cleared up any misconceptions. I asked follow-up questions to clarify certain statements and encourage the participants to give examples.

Transferability

Transferability indicates that other researchers can replicate the findings of a study in a different environment or context (Korstjens & Moser, 2018). The goal of transferability is to ensure that other researchers exploring the same topic in other environments can engage in the same process and get accurate results. Therefore, I provided step-by-step methodological details about participant recruitment, data collection, analysis, and criteria. I also provided descriptions of the setting, its peculiarities, and steps taken to protect the confidentiality and safety of the participants in such a unique environment. Purposefully sampling occurred to recruit the subjects most eligible to provide insight into the phenomenon under study.

Dependability and Confirmability

According to Lincoln and Guba (1994), dependability pertains to the consistency of the findings. A researcher ensures dependability by making sure the study design aligns with the established best practices. Confirmability addresses the neutrality of the research. A researcher ensures confirmability by basing the study's findings on the actual findings and grounded them in data.

A researcher can ensure dependability and confirmability by maintaining an audit trail (Forero et al., 2018). In this study, I kept a journal to document the entire process and record personal reflections. Jeanfreu and Jack (2010) stated that a researcher's thoughts and beliefs are essential parts of the research process. In this study, the journal was part of the data that provided additional context and insight during data analysis.

Results

Open-ended questions and probes from the interview protocol (see Appendix A) allowed me to collect data from 12 participants to address the two research questions.

RQ1: What are the experiences of first-time pregnant adolescents in Kano State when deciding to seek care while pregnant?

RQ2: How do first-time pregnant adolescents in Kano State view sociocultural and demographic influences as factors that affect their decisions to seek care?

Theme 1: Family and Relationships

In the first theme of family and relationships, the participants explored the impact of family issues and relationships in their care-seeking experiences during their pregnancies. The participants explored the intricate and sometimes complex relationships and how they intersected with age, gender, and social class. Almost all the participants said that knew the importance of giving birth in a hospital. Most preferred to seek care in hospital facilities when they felt unwell. However, a majority of the women stated that they could not make decisions for themselves, identifying their husbands as the most critical factor in their care-seeking decisions. P3 said,

> It is my desire to give birth in a hospital. During my early pregnancy, I had a lot of problems, [and] I did not know what to do. I turned to my husband because I know nothing, [and] he helped me by buying drugs [from a pharmacy]. If he says I cannot deliver in a hospital, I have no choice but to obey him.

P7 discussed her preferred birthing center and why she believed that she would not get her wish:

> I would like to give birth in the [primary health center], but my husband has informed me that this is not where I will give birth. I think he prefers a bigger hospital. I do not know why he prefers a bigger hospital [afraid/shy to ask]. As for me, I like the way they treat me in Kabuga. It is a small hospital, but they are kind. I hope that if he sees how I like Kabuga, maybe he will eventually agree. But as for now, I will do whatever he says.

P3 said,

> Sometimes, when I am not feeling well, I prefer to go to a hospital [for treatment], but it depends on my husband's mood. If he is happy, then he will allow me [to go]. If he is not, and I see that he is putting up a big attitude, I just keep quiet.

The participants also mentioned the role of extended family members and how they can also influence care-seeking decisions. The participants sometimes regarded these influences as positive. For example, P5 discussed her fear of going against her husband's wishes:

> I would like to deliver in the hospital because I was told [by relatives] that it is cleaner, and I [would] not have to mess up my home [during the birth process]. However, my husband says that he wants me to deliver at home because the hospital staff does not treat people well. I was afraid [to go contrary to his instruction], so I approached his mother, and she instructed [forced] him to agree for me to go to the hospital. I have been going for antenatal [there], and Insha Allah (God willing), I will deliver in the hospital.

P9 said,

> At the start of the pregnancy, I was not feeling too well. I did not tell anyone. It was my brother-in-law. When he came to visit us, he saw that my face was not okay. My husband is his younger brother [so he was able to talk to him] and told him to make sure that I am not with child. My husband took me for a test, and that is how I knew I was pregnant. Because of my brother-in-law, my husband does not joke about my condition. Anytime I tell him I am not okay, he takes me seriously. I am now going to the hospital regularly, and I believe I will deliver at the hospital, Insha Allah.

P1 said,

> My brothers have money, and so I am lucky with that. If a problem arises [with the pregnancy], I usually decide to go to the hospital, but only if my brothers agree to pay for the treatment. As long as they pay, my husband allows me to do whatever I need to do. But if [my husband] is the one paying, then you will hear his voice get very loud. I do not even try to approach him. I just ask my brothers, and they talk to him to allow me [to go to the hospital].

P5 said,

> When I am sick, I call my parents, and they beg my husband to allow them to take me to the hospital. Praise God, he always agrees, but if he is the one [taking care of the bills], I think it will be too much for him. We are three [wives], and he is not very rich, but he is trying [to provide food].

A few participants described negative experiences with extended relatives who tried to make them do what they did not want. P8 said,

> My mother-in-law's sister is a *ngorzoma* [traditional birth attendant]. Because of that, [my husband's family] do not allow me to say what I want when this pregnancy bothers me. Whatever my family or I say, they will say it is not so. Last week, I had stomach pain. They gave me herbs, which made me purge [diarrhea]. I was so sick, but Alhamdulillah [thank God], I recovered. Now they want me to deliver in the [ngorzoma's] hand because I am inexperienced. But I do not like it. I do not think she knows what she is doing, but I cannot say anything to the contrary. Whatever God wills, it is so.

P11 said,

> My husband's brothers will never allow him to let me go to the hospital. Every day I hear [on the radio] that we should go to the hospital. Every day, I tell my husband, and if he agrees, I go. Once the brothers complained that he is wasting money, [and] he listened to them all the time.

Some of the participants mentioned other relatives' and friends' experiences and how they decided on the care that they wanted for their pregnancies. P9 said,

> My sister always has difficult pregnancies. She usually suffers at home for many days [in labor] before they rush her to the hospital, and then she delivers successfully. It has happened about three times. The fourth time, my parents paid for the hospital expenses, and she did not have to suffer again. I am trying to save a little money [from gifts by people]. If God touches my husband's heart and he sees the way my sister has suffered, and I show him the money I [have] saved, I will be lucky myself to deliver in the hospital.

P11 said,

> I went to [primary] school with a girl who died last year. She was on her knees [in labor] for 3 days. For 3 days at home, her family refused to take her to the hospital. Her husband traveled, and there was no one to give permission or foot the bill. The [family] kept telling her to push and push. She got tired and kept asking for water, but the ngorzoma refused to give her water, saying it will harm her and the baby. The girl died with the baby inside her. I pray to Allah to save me from what happened to [her]. She really suffered.

P12 said,

> Initially, I thought that I should only go to the hospital when there is a problem because I do not like medicine and do not like injections, but a younger sister of my husband who was pregnant went to the hospital because she was sick. They found out that the baby was lying the wrong way. The baby was upside down [breech], so they had to cut her stomach to bring out the baby. When I heard that, I was scared that my baby will also be breech, so I went to the hospital [to check], and praise God, my baby is fine.

The family and relationships theme addressed the various interactions the participants had with husbands and other family members and their impact on the women's experiences. Most of the participants stated that their husbands were the most important influence in how they decided to seek care. Others mentioned family members, including mothers, mothers-in-law, and siblings. Some of the women reported beneficial influences, while others discussed detrimental influences. However, all the participants

indicated that the family members who made decisions on their behalf considered factors such as money and prior experiences in hospital facilities or with traditional birth attendants. The participants also reported that when others made decisions on their behalf, they did not like that they had little agency or power to change those decisions.

P2 said,

> When it comes to deciding [where to seek care for a problem], as a woman, I can only suggest what I would prefer to do. My husband is the final decider, and there are many things that can make a man say yes or no. In my case, if he has money, he says I can go to a hospital. If he has no money, he asks me to take traditional herbs, which I do not like.

Theme 2: Religious and Traditional Beliefs

The dominant religion in Kano City is Islam. All the participants were Muslim. In all 12 interviews, faith was a prominent factor in the participants' experiences and decision-making. The interviews were the means of exploring issues of religious beliefs and their influence on the participants' experiences, including faith, predestination, conservative values, and traditional birth attendants.

In almost every sentence, the participants invoked God or God's blessings in the outcomes of their pregnancies. All the participants believed that prayers were the most crucial factor in their pregnancy outcomes. The participants believed that God had predetermined the outcomes of their pregnancies and that they could do little to change that. Despite these beliefs, most women considered it wrong to do nothing when they fell ill because they did not want to suffer or lose their babies.

P7 said, “If God says the baby and I will be okay, then he will use the doctors or midwives to help us.” P1 said, “God can work his miracles any way he wants, sometimes you think that something is not good, but you do not know that maybe God is taking you away from something worse.” P3 discussed how religious leaders now advise women to go to hospitals:

> Religious leaders try to advise us. They tell us that when we are sick, we should look for help. They tell us on the radio that if we are sick, we should not keep quiet about it, that we should open up about it. Our husbands listen to the radio, and if God wills, then they will listen to the religious leaders and do what is proper.

When asked if the religious leaders had always advised women to go to the hospitals, P3 said, “Before, the religious leaders used to be very much against hospitals, but now there is a lot of *ra’ayi* [differences of opinion]. The majority now say that we should go.” P7 noted how religious leaders had changed over the years:

> According to my mother, we are lucky that things have changed because now religious leaders are on the side of the hospital. Before, they used to advise against going to the hospital [to deliver]. But now they are more enlightened, and they advise our husbands. It is up to the husbands to listen.

P5 said, “I have been healthy throughout this pregnancy. It is only to God that this glory goes. He alone did this for me.”

Some participants mentioned that religious leaders sometimes acted as health providers by offering prayer during sickness. For example, P5 said,

> Religious leaders sometimes do *rubutu and tofi* [incantations in water], and they sometimes help a lot when one is ill. However, sometimes when it is serious, the religious leaders themselves say that we should go to the hospital. Everything is in God's hands.

In all the interviews, no participants relied solely on prayers for their pregnancies. However, a few preferred to visit traditional healers and give birth with traditional birth attendants. For example, P11 said,

> My husband dislikes the hospital because there are male doctors that see our most secret parts. Even I am not okay with [seeing a male doctor]. If it is a male doctor there [in the hospital], I will not want to go. At least the traditional male healers do not have to touch you to give you medicine. I can even send a small child to go and collect the herbs without me going.

P9 said,

> Medicines from hospitals did not work for me when I was sick earlier in my pregnancy, so I took herbs, and they worked. Therefore, I prefer to take herbs throughout [my pregnancy], but I will deliver in the hospital, God willing. I go to the hospital during antenatal, but I do not tell them about the herbs because they always say we should not mix.

P2 said,

> I heard that giving birth in a hospital is better because they can help you to prevent issues [in labor and delivery] from becoming too complicated, but I

> would like to deliver at home with a traditional birth attendant because that is how my mother and grandmother gave birth, and they had no problem.

The participants mentioned taboos and practices associated with a first-time pregnancy. All the women stated that they had heard about or witnessed traditional practices, such as hot water birth and the gishiri cut. While some participants stated that they did not like some of the more difficult traditions, they still believed the traditional birth attendants conducted them for their well-being. However, a few participants said they would try to avoid some of the practices because of what their doctors had told them. P5 said, "Times are changing now, and the doctors have said that some of these practices are bad. I will try and convince my husband to avoid it." P11 said, "I hope that I can avoid these practices [hot water birth and forced seclusions]. However, I do not know if my parents and my husband's parents will agree."

Most participants discussed their various experiences with traditional and religious practices and how they contributed to their care-seeking decisions. Although most participants said that religion and tradition were essential factors in their lives, they still wanted to give birth in the hospital. Some participants trusted the hospital more than others. Other participants preferred the hospital due to negative experiences with traditional healers or recommendations from religious leaders about the importance of delivering in a hospital. The participants noted the gender of a male doctor in a hospital, the preference for traditional delivery by family members, and the belief of pregnancy outcomes as predestined while seeking care.

P3 said,

> Religious leaders try to advise us. They tell us that when we are sick, we should look for help. They tell us on the radio that if we are sick, we should not keep quiet about it, that we should open up about it. Our husbands listen to the radio, and if God wills, then they will listen to the religious leaders and do what is proper. Before, the religious leaders used to be very much against hospitals. Now there is a lot of *ra'ayi* [differences of opinion]. The majority now say that we should go.

Theme 3: Age, Gender, and Decision-Making

In the age, gender, and decision-making theme, the participants explored the effects of gender and age in their decision-making processes. All the women agreed that gender and age were significant factors in their experiences, decision-making processes, the treatment that they received, and how others saw and listened to them. Despite agreeing that they knew what was best for themselves, they stated that it was right for them to receive such treatment. P3 said,

> Whenever I want to make a decision, I always listen to what my elders tell me. You see, what an older person foresees, a little girl like me will not be able to foresee, no matter what I feel about my situation. An older person's reasoning is always better because they have experienced everything. For me, it is the first time. Will I now argue with someone who has [given birth] many times?

P5 talked about her experience as a young woman going to the hospital for the first time:

> When I first went to the hospital, I was confused. First of all, I did not know anything, [and] I had to ask my relatives and the people sitting next to me to guide

me because I know nothing. I did not even know what to tell the doctor or even where to go if I wanted to see a doctor.

Some participants described their experiences with others. P5 discussed her experience as one of several wives:

> My co-wives are older than me, so they have no problem [when seeking care]. Our husband often does not argue with them when they suggest where to go [if they feel unwell]. For me, it is different. They look at me like a small girl. Sometimes, our husband asks them to take care of me, and they tell me to do this or do that. The first co-wife is very caring—she is older like my mother—but my immediate senior co-wife is not very nice. Anything I want to do, she tells my husband to stop me, and he listens to her.

P7 talked about her much older neighbors:

> There is our neighbor, who is a mature [older] woman, just like you [points to me and laughs]. There is also [another neighbor] who is an older person. They make all their decisions by themselves, and they also advise others on what to do.

Some participants noted their different experiences when they went alone to the hospital and when they went with men or older individuals. P9 said,

> The [hospital] treatment is very different if we go alone. If we are alone, the [nurses] ignore us, and if we try to talk to them, they shout at us. With our husbands, they are very polite because they respect men and older women; maybe because they are advanced in age, they do not treat them the way they treat us.

> When we go with husbands, the treatment is very different from when we go alone, but the husbands do not like to go. They say they are too busy.

P9 described the separation of older women from the younger women in the hospital and how they received different treatment:

> We who have never given birth are not mixed with those who have given birth, and even our antenatal days are different. We are separated and treated like we do not know anything. We are always separate from the older women.

P3 also discussed receiving different treatment in the hospital:

> I believe that there should be a difference in the way we are cared for in the hospital. [For] a young woman carrying her first pregnancy, they should give you more tests and check you more because of the age, but that is not the case.

When asked if younger women received better treatment, P3 said, “We are not treated as kindly as the older ones.”

All the participants agreed that they received poor treatment at home or the hospital due to their young age and gender. They reported not having the chance to make decisions about their health, getting directed in the hospitals, or not receiving attention unless accompanied by older people or male relatives. In most instances, the young women expressed the desire for better treatment. However, many participants said they had no power to change people’s attitudes toward them. Some accepted such treatment as justified, while a few resigned themselves to their fate.

P8 said, “How can I make decisions? I can never be allowed to make decisions. I am a woman, and I am not even old enough. There are many others before me.” Similarly, P7 said,

> I am a small child, and I do not know much. We young people have much innocence about the world. Our people say that what an elder can see sitting down, a young person will not see even if they are on someone’s shoulder [famous Hausa proverb].

Theme 4: Wealth, Education, and Social Class

Big cities, such as Kano City, provide a wide variety of health care services. Pregnant women can choose from several secondary and tertiary hospitals, which could require a significant amount of money. Most families in Kano City do not have insurance and must pay out of pocket for health services. Instead of visiting costly private hospitals with slightly better services, some individuals decide to go to patent and proprietary medical vendors (PPMV). PPMVs are small pharmaceutical shop owners who sell drugs in communities. PPMVs are vendors, usually without formal training, who provide various services, ranging from drug prescriptions for minor ailments, malaria injections, and ANC. PPMVs, in most instances, provide cheaper services than hospitals, and community members can easily access them (Oyeyemi et al., 2020).

In all the interviews in this study, wealth, social class, and education were closely intertwined. Most of the participants regarded an educated woman as having finished at least senior and secondary school. P6 said, “In this community, if you see a woman who has her own money, it is likely that she is educated or her parents are educated.”

P6 discussed her desire to get an education:

> I was forced out of school to get married. My parents promised me that my husband would allow me to finish [school], but there is no sign. I wish I could go back [to school]. I want to make my own money. Without a NECO [secondary school certificate], you cannot even get a job as a cleaner nowadays.

The participants went to government hospitals, cheaper low-cost hospitals, or PPMVs based on their financial situations or families. For example, P1 said,

> My financial situation is worrisome. Sometimes, I wish I could go to a hospital, but I don't have the money to do so, so I just go to the chemist [pharmacist]. Assuming I had money, I would go to [a bigger hospital].

P3 said,

> I was told that I needed money to go to the hospital. I was able to do that because I had some money on me. My husband was okay about it since he did not have to pay any money.

P7 said, "If I had my own money, I would be able to go to a private hospital and not have to join long queues just to get cheap medicines." P7 also discussed why women needed money to receive good treatment:

> To be treated well, I have to save money. Sometimes, you have to give the attendants something [a tip]. Without money, they will not pay attention to you. They will say the card is finished, [and] we should go back and come another day. Sometimes, they ask us to pay for something, and if we do not, they ask us to go

> home. Whenever I want to go to the hospital, I try and raise some money, but it is not easy.

P7 also talked about the benefits of education and said, “If I were more educated and had my own money, I would have been able to buy my drugs without relying on my husband.”

Most of the participants agreed that they needed their husbands’ permission; however, they noted that having money provided them with increased chances of getting their way. P9 said,

> By God, some of these women in our community who are educated and wealthy are very lucky. They have the freedom to do anything they want. The husbands do not scold them—it is like they are bribing the husbands also [*laughs*]. Some of these women do not have to wait for their husbands for anything they need.

P4 talked about why having her own money was an important factor in seeking care:

> I make my own money. I am fortunate that my husband never asks me to give him my money, but I never spend the money without asking him. When I want to spend it on drugs, I ask him first, and Alhamdulillah, he always says yes.

When asked what she would do if her husband prevented her from using her money to seek care for her pregnancy, P4 said, “Then I have no choice but to obey him, but he won’t say no.”

Many of the participants who regularly went to the hospital discussed the differences in how women received treatment based on perceived social status. For

example, P9 spoke about how health care workers view women with wealth in the hospital, what she did to ensure that she received proper treatment, and why her method did not always have success:

> A more educated person is more knowledgeable; they know what to do to get money for themselves. I think it has to do with the way a person looks. Educated women dress well [and] wear clean clothes, so when they arrive at the hospital, they treat them well. I am not wealthy, but I try to look good when I go to the hospital so that they treat me well. Sometimes they treat me well, and sometimes they do not.

P8 said,

> If the doctors see that you look needy, they do not treat you well. In the hospital, they give you documents [sometimes in English] to fill, [and] only the educated ones understand what to write. Many of us are left [without help]. If we are lucky, someone will help us, but we are left like that if everyone is busy. If you do not fill the forms, they will not allow you to see a doctor.

P11 said, “Every time I go to the hospital, I am asked if I have been to school. It makes me uncomfortable because I haven’t been to school.”

Theme 5: Hospital Experience

The theme of hospital experience emerged because of how often the participants mentioned their hospital experiences and their impact on their decision-making. Eight of the 12 women either had experiences in the hospital during their pregnancies or had heard others’ experiences, which influenced their care-seeking decisions. Most of the

participants described having negative hospital experiences; however, they also said they preferred hospitals. P1 said,

> Many people have told me that giving birth at home is better because I heard that if you give birth in the hospital, they mistreat you and are revolted by you, especially if you are poor. But giving birth at home is dangerous, so many just bear the insults.

P5 considered a home delivery because of what she had heard about the treatment at hospitals. She said, "I have heard that people get mistreated in hospitals during delivery, so I will use them only for drugs and injections. When I hear things like this, I am considering that maybe I should deliver at home." Similarly, P7 said,

> We endure a lot of yelling and insults, but we have no choice. There is nowhere to go, and the doctors themselves, sometimes the work is too much for them. That is why I will deliver in the hospital if I have money.

Despite the disrespect she received at the hospital, she said that she would consider returning:

> I went through this *wulakanchi* [awful treatment] yesterday. Just yesterday, I was among the first to be at the hospital. Immediately after morning prayer (at sunrise), I trekked to the hospital and waited in line. Then so many women came later, some with their cars even, and they were attended to first. We waited for hours until they finished seeing all their "friends" [*said with scorn*]. Many young women sitting with me were angry. Some cursed the nurses and doctors for their bad treatment toward us. As for me, I have forgiven [the nurses and doctors], and

> this experience will not prevent me from coming to the hospital even if I am the last to be seen. However, many young women with me said [that] they would not come back.

P9 believed that the harsh treatment might be justified:

> The way I see it, when [the nurses and doctors] maltreat us, it is our fault, sometimes. I do not think that they want to treat us this way deliberately. The nurses told us the last time we went that they heard we have been saying bad things about them. They explained to us that it is only those who are untidy who will get maltreated. When coming to the hospital, they said [that] we should make sure our clothes are neat and that we do not smell. They said that if we look [unkempt], we should not come to the hospital, even if we are having contractions.

All the participants described having experiences at hospitals that influenced how they thought about their delivery choices. Many participants reported that they would rather endure insults, disrespect, and abuse than deliver at home. A few participants reported that the negative hospital experiences caused them to consider not delivering in the hospital. For example, P9 said, “When we go, we are maltreated [and] sometimes insulted. We undergo a lot. Sometimes, I tell myself I do not think I want to deliver in the hospital, but I am scared to deliver at home.“

Discrepant Cases

The first discrepant case emerged during the data analysis. Most participants stated that they wanted to give birth in the hospital; however, several narrated instances

when they had heard that women their age did not receive good treatment in the hospitals. Some also said they had heard stories of bad treatment. As a result of these discrepancies, I decided to look further into this phenomenon. In subsequent interviews and callbacks, I asked some of the participants why they wanted to give birth in hospitals despite the poor treatment. At least three participants said they feared giving birth at home because they worried about having complicated pregnancies. Two more participants mentioned that giving birth at home would create messes that were difficult to clean. Hospital births would enable them to come back to clean homes. A clean home appeared to be an essential consideration for these participants. A new theme emerged during the analysis on the participants' experiences in hospitals and their influence on their decision-making.

The second discrepant case occurred for P4, one of the youngest participants, who, unlike the rest of the women, said she had no restrictions on what she could do or ask for from her husband. She did not consider herself or her husband well-educated or wealthy, but she appeared to have a freedom not evident among the other participants. P4 said, "When I was sick, it was I who made the decision to go to the hospital. I always tell [my husband] to do things, and he doesn't challenge it. Whatever I say, he does." When asked why she had a different experience from most other women, she said, "[My husband is] easygoing and has placed no restrictions on me."

I investigated P4's background further to find out why her experiences differed from the other women's. I discovered that although she was from Kano City and had lived there all her life, her husband came from a nearby state with less conservative men

than Kano City. Her husband's origins appeared to be the reason for the distinct freedom that she enjoyed.

Theoretical Constructs and Narratives

Research with intersectionality as a theoretical construct focuses on the oppression of women that has resulted from intersecting factors. The intersectionality theory indicates that many things together produce different outcomes for different people, even if they have the same background (Rice et al., 2019). This study focused on the participants' experiences and how various social and demographic factors, such as gender, age, education, and social class, produce different outcomes for young women when deciding to seek care. The study included data focused on the core principles of intersectionality to address the research questions. The age and gender of the participants were sampling criteria. I designed the questions so that the participants could address the intersecting factors together.

When confronted with the intersectionality questions, many participants wanted more clarity. In several instances, it was a challenge to get the participants to explore all the factors together to explore intersectionality. I used probes to dive deeper into the issues. For instance, I asked questions, including, "As a young woman, do you think you would be listened to if you were more educated? What if you had more money? What if you were older? Would your experiences be different?" I also asked the participants to imagine someone else or talk about others' experiences without revealing identities; this approach appeared easier for the participants and produced more nuanced responses.

The questions about age and gender enabled the participants to explore their identities and the effects on their decision-making process. On these bases, the participants saw themselves as inferior and accepted that as part of their realities. As a result, most of them justified the unpleasant treatment they received at home and in hospitals. Most participants believed in their inferiority to men and that men made the best decisions on their behalf even if they did not like those decisions. Regarding their age, the participants still saw themselves as children. Despite their marital status, they felt that they had no right to decide about their health, even if they knew from other people's experiences, doctors, nurses, and other professionals what was the right choice for them.

P1 said,

> Obviously, as a woman, my husband's decision will always be better than mine. He is a man, and I am just a child. That is the reason why whatever decision he makes, I cannot go against it. He knows better than me.

P5 said, "God has put the man as the head of the family. [Men's] wisdom is from God. We cannot question God. He knows best."

P9 described her experience as one of three wives:

> When it comes to decision-making, our husband will always take the lead. However, when he allows [the women] to have our say, he always goes to the first wife. She is the eldest, and her opinion can be considered if our husband thinks she is saying the right thing. Our husband always has the final say, but he usually consults with his first wife because she is older than all of us and knows more

> than us. She decides what to do on our behalf, and if she is not on good terms with you, then she makes our husbands do things that are against us.

P4 said,

> I know many elderly women in this community. When you pass a certain age, no one bothers about you. [The older women] do what they like. They don't even cover properly [wear the hijab], but no one is worried about them. They only look at us, the young ones.

The questions about age and gender enabled the participants to explore their identities and lived experiences. In themselves, the questions did not provide the opportunity to explore the intersectionality of all the other sociodemographic factors; this was a challenge based on the theory's complexity. However, some of the questions in the study guide focused on how factors such as social class and education intersected with age and gender for certain outcomes. This elicited responses that suggested that the younger, poorer, and less-educated women who required the most care received the worst treatment.

There was an agreement among the participants that educated women had more wealth. No matter the age, wealth indicates better treatment for women both at home and in the hospital. P3 said,

> If a woman is educated, she is able to work and have more money. She dresses well, and she also smells good. The doctors and the nurses do not like to maltreat a woman like that. If a woman is educated, not only the doctors, [but] even her husband treats her differently [better] than if she is not educated.

P10 was a domestic worker who earned money that she saved for her delivery date. She stated, "As I have my own money, my husband hardly says no [when asked about a hospital visit]. I still have to ask him, but if he is not giving any money, he says I can go anytime."

Many participants described the experiences of uneducated and young women. P1 said, "The [hospital staff members] treat us differently when they find out that we are poor and uneducated." Most of the participants viewed their young age and female gender as their identity, which indicated that they lacked agency when confronted with other power dynamics. They believed that educated women had different experiences and received better treatment at home and in hospitals. The participants suggested that women with more wealth and education were more likely to have good experiences and choose to give birth in hospitals.

In the end, the additional questions on intersecting factors were essential components for understanding how the participants saw themselves and their place in society. The questions elicited additional perspectives on how women have different experiences based on wealth or education; such experiences influenced whether women had favorable outcomes. The participants' responses indicated that young women with less education and money are less likely to believe they know what is best for them. Women of the same age in the same community under the same conservative rule may receive better treatment if they have some money or education, earn money, or are older. The participants reported differences in treatment both at home among relatives and

husbands and in the hospital among hospital staff members; such treatment may significantly affect young women's access to quality and timely care.

Summary

This study focused on the care-seeking experiences of first-time pregnant adolescents in Kano Metropolis, Nigeria. The purpose of the study was to explore how participants viewed the effects of gender, age, and social class on their care-seeking decisions. This chapter provided the results of the analysis of the data collected from 12 young women. The data collection, data management, and analysis occurred via Colaizzi's seven steps. The chapter also presented the participants' demographics and the trustworthiness of the study.

The study showed the issues that young women face when deciding how or where to seek care and the various intersecting sociocultural factors that prevent them from articulating what they want. The chapter also presented the application of the intersectionality theory to the study. The findings indicate how various sociocultural factors intersect and contribute to the oppression of women in different ways. The final chapter includes an interpretation of the study's findings, reflections, recommendations, and implications for social change.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this phenomenological inquiry was to explore the health care decision-making experiences of first-time pregnant adolescent women in Kano City in Northern Nigeria and how these women viewed the influences of various social and demographic factors on their decisions to seek care. The social and demographic factors included age, gender, social class, and education and their intersections and outcomes. The literature review in Chapter 2 indicated the gap in exploring and understanding the experiences and factors in the maternal health care decision-making of married, pregnant adolescents younger than 18 years of age in Kano City in Northern Nigeria. Understanding the circumstances and experiences of adolescent women could provide essential insight into how to improve maternal health outcomes for this vulnerable group.

This study consisted of semi structured interviews with 12 married adolescents pregnant for the first time. Data collection and analysis commenced with Colaizzi's seven steps. Phenomenological inquiries are critical means of studying, understanding, and experiencing the lives of others, which are the foundational principles of qualitative research (Neubauer et al., 2019). Using phenomenological inquiry provided the opportunity to learn about the participants' experiences, thoughts, and perceptions of their unique situations and circumstances.

The theoretical framework of intersectionality was the lens used to view the lives of the young women. The intersectionality theory guided this study of the intersections of social and cultural determinants that produced outcomes for the participants. The participants' young age, lack of ability to negotiate their wants or needs, limited agency,

and economic dependence intersected to produce an oppressive environment with barriers to accessing the health care services they needed during their pregnancies.

Five themes emerged from data analysis: (a) family and relationships; (b) religious and traditional beliefs; (c) age, gender, and decision-making; (d) wealth, education, and social class; and (e) hospital experiences. This chapter presents the interpretation of the findings based on the study's emergent themes, theoretical constructs, and alignment with the literature presented in Chapter 2. Chapter 5 also includes the study's recommendations, limitations, implications for social change, and conclusions.

Interpretation Related to Literature Review

The study found that the participants experienced challenges and barriers when deciding to seek care for their pregnancies, including a lack of autonomy, abuse, and disrespect at their homes and the health facilities. The unpleasant experiences led them to struggle to articulate their wants and needs and get the health care required for their pregnancies. The younger participants with less money and education had the worst experiences. The net effect of the lack of autonomy was that the women did not want to or could not visit health care facilities when needed; instead, they sought care from alternative, unskilled providers.

This study's findings on young women's low use of health care facilities aligned with the existing research. Researchers of maternal health care service use in conservative communities have shown similar results. Chima (2018) found that married young women between 15 and 24 were less likely to give birth in hospitals and more

likely to miss ANC visits due to low autonomy, which presented risks of maternal health complications. However, I found that the young women lacked autonomy at home, in hospital facilities, and at the hands of health care providers. Another finding in this study that differed from Chima was that the intersection of age, female gender, and social class produced deeper levels of stigma and biases that affected the participants' ability to choose how and when they required health care services for their pregnancies.

Data analysis also showed that the participants knew and understood the importance of seeking care in health facilities and giving birth in hospitals. This finding aligned with Sinai et al. (2017), who observed that 83% of the women in Northwestern Nigeria (the location of Kano State) preferred to give birth in hospitals. Similarly, researchers in Nepal noted that most married adolescent women preferred to give birth in hospitals but faced the barriers of harsh treatment from health care providers, shyness, and embarrassment (Maharjan et al., 2019).

Most of the participants discussed encountering deeply embedded gender and cultural norms from their family members and others. Husbands and other relatives, particularly mothers-in-law, parents, and other extended family members, impacted the participants' ability to use health care services and decisions of where to seek help, when to access care, and where to give birth. Oguntunde et al. (2019) identified similar factors in the decision-making processes of young pregnant women in Kano State. Oguntunde et al. found that one of the most prevalent barriers to accessing health care for married adolescent women in Kano State was a profoundly patriarchal system where women often cannot control their reproductive health. Also, I found additional factors that

contributed to the oppression of the participants. For example, most of the participants in this study had a lower societal status because they did not finish school and lacked gainful employment. The low status resulted in additional discrimination at home and in health facilities. The findings indicate the widespread bias and stigma against young women with less education and wealth.

The findings in this study showed that other factors not directly related to the participants' age, gender, social class, or poverty levels influenced key decision-makers. The most prevalent factor was the financial resources available to the participants' families. In this study, the husbands were more likely to allow their wives to visit health facilities if they had their own money. Without money, the women had to visit PPMVs or traditional healers or could not seek care at all when needed.

The connection between hospital use and the disposable income available to a family was also the focus of researchers working in communities similar to that of the study. Doctor et al. (2018) and Iacoella and Tirivayi (2019) highlighted the importance of family-level income in the use of health care facilities among married women in Sub-Saharan African countries. Both studies showed that women with high family income were more likely to deliver safely in health facilities. My study further showed the care-seeking decision-making of young women in Kano State when sociodemographic factors such as gender, age, and education intersect.

Restrictive gender norms and their impact on maternal health decisions were significant study findings. The participants did not see anything wrong with allowing others to make decisions on their behalf, even if they did not like it. Most of the

participants perceived themselves as too young and incapable of making decisions due to societal norms. Some of the participants in this study acknowledged that their husbands forced them to accept their decisions.

Levy et al. (2020) and Hendrick and Marteleto (2017) found that people were valued differently in cultures with restrictive gender norms according to their perceived places in society. The gender norms and patterns of behavior deeply embedded in society have adverse effects on women from childhood. However, many women hold these views themselves. McCleary-Sills et al. (2015) noted that even when women perceived something as in their best interest, they could not articulate this view to their caregivers.

Similarly, this study showed that participants believed that they should accept whatever treatment they got, even when they experienced disrespect and abuse at hospital facilities. The findings also suggested that younger women with less money and education had more negative experiences, and uneducated women were the least likely to complain about their treatment. However, a consequence of these negative experiences in hospital settings was that women chose not to return to those health facilities unless forced to do so by their decision-makers.

Theme 1: Family and Relationships

For this study's first theme, the participants explored the role of family and relationships in their decision-making processes. The participants discussed who made decisions for them, dominance, fear and control, and their ability to communicate and negotiate effectively with family members for health care needs. Decision-making is a critical component of maternal health outcomes. Researchers studying the use of health

care services among women in Nigeria found that a woman's autonomy was a strong determinant of ANC usage (Obasohan et al., 2019). Although the findings of my study showed that the participants did not have autonomy, they also indicated that the husbands were the most critical decision-makers in the participants' lives. Most of the women interviewed had views about ANC attendance and health facility preferences for giving birth. However, they did not believe they had the power to make decisions for themselves. If their husbands were not around, unavailable, or unwilling to help, older relatives, including mothers-in-law, parents, and occasionally co-wives, made decisions for the participants.

Other relatives sometimes intervened for the young women as well. For instance, sometimes, the participants' husbands did not know of their wives' situations or had no money, and the wives could not raise some. In such situations, a mother-in-law was a decisive and powerful decision-maker. Most times, the mothers-in-law took the role of their sons in their absence. The participants' parents and other relatives also intervened when needed. However, despite who made decisions for the participants, the participants themselves could never decide what they wanted.

A lack of mobility was another issue the participants encountered during their care-seeking experiences that directly related to their roles within the family structure. In traditional Hausa societies, women cannot leave home without their husbands' permission (Sinai et al., 2017). This lack of mobility occurred not only due to the patriarchy and restrictive gender practices in the region, but was associated with access to

finances and other resources. Men who had money or access to money were more likely to permit their wives to visit hospitals, traditional healers, or PPMVs.

Dominance and control within family systems were also significant findings associated with families and relationships. Families in patriarchal societies are often profoundly complex systems with conflicting wants or needs. UNICEF (2018b) found that in addition to existing patriarchal structures, other household dynamics indicated the position of a married woman in a family.

One important household dynamic is the order of a wife within a polygamous household. This study showed that younger women were the least considered when making decisions in the home for health matters or issues. For example, in situations with scarce resources and the need to pay for health care services and medication, a husband may have more consideration for a senior wife and her children than the more junior wife.

The participants discussed their fear of asking for permission to access care when their husbands were in a bad mood. Some indicated that their husbands shouted at them when they asked for money, while others expressed a reluctance to approach their husbands if they needed anything. Some participants also described how senior wives sometimes made decisions often not in their best interest.

Women’s ability to communicate and negotiate reproductive health care needs with their partners is an essential part of a safe and effective reproductive health strategy, particularly in conservative communities. According to Hardee et al. (2017), couples who can discuss and negotiate essential aspects of women’s reproductive health have better

uptake of hospital services. While the participants in this study expressed the desire for a safe delivery, preferably in a hospital setting, they struggled to articulate these needs to their husbands. The age difference, economic dependency, and lack of agency caused the participants to struggle to communicate with their spouses. In the absence of their ability to communicate with husbands, the participants talked about discussing issues freely with other family members, particularly parents and siblings. Their other family members effectively acted as proxies, especially during urgent needs for health care services. No one, including the participants themselves, seemed aware that they had riskier pregnancies as underaged women and required different care in hospitals than older women who had experienced more pregnancies.

Theme 2: Religious and Traditional Beliefs

Religious and traditional beliefs are integral factors deeply intertwined and widely practiced by community members in Kano City. The participants of this study were all practicing Muslims who considered themselves deeply religious. They believed they had the moral obligation to obey their husbands and that, as Muslims, God decided their fate. The participants' beliefs had significant implications for how they experienced their pregnancies and ultimately decided to seek care. This finding aligned with Alomair et al. (2020), who found that Muslim women's religious and cultural beliefs intertwined and presented barriers to their access to sexual and reproductive health services. Alomair et al. found that the women believed that their religious practices provided them with protection against adverse health outcomes. They also believed that when a man or husband opposed specific health care practices, even those advised by health care

providers, women must obey. In my study, the participants believed that they had the religious and moral duty to obey their husbands, regardless of the circumstances.

Another religious belief found in this study was the significance of the participants' beliefs in predestination, a view closely related to fatalism. According to predestination, the women believed that those who die during childbirth could not have done anything to change the outcome. In Jigawa, a neighboring state to Kano with a similar cultural context, Sharma et al. (2019) studied the religious beliefs of men's involvement in reproductive health. They found that many men and women believed pregnancy was a dangerous time and that only God knew who would live or die during the process. The researchers noted that these beliefs resulted in complacency and delays in seeking needed care among some community members.

Similarly, the participants in my study strongly believed in predestination and viewed other beliefs as contrary to God and his commands, regardless of age and social status. The participants expressed a tacit acceptance of their situations as part of the grand plans for their lives. A frequent refrain during the interviews was "God knows best." The participants even discussed their oppression and lack of agency within the context of their religious beliefs. However, belief in predestination among the participants did not always result in complacency. Some participants stated that they wanted to give birth in a hospital because they believed that God could use health care providers to save their patients' lives. Sharma et al. (2019) reported a similar view, noting that some participants viewed their belief in God as an incentive rather than an impediment to seeking care.

This study also addressed the role of religious leaders in the maternal health of young women. Religious leaders have always been influential individuals in the community. Community members see religious leaders as the moral fabric of the society, and they often highly attend to and respect their words, directives, and advice. In this study, the participants mostly agreed that the religious leaders recognized the importance of allowing women to seek care when pregnant and sometimes encouraged husbands and relatives to take pregnant wives to the hospital.

The participants in this study also stated that the religious leaders in their community had begun preaching about allowing young women to attend ANC and deliver in hospital facilities. Some studies (e.g., Adenini et al., 2018; Sinai et al., 2017) have indicated that religious leaders perpetuated harmful maternal health practices, such as forced seclusion. For example, Sinai et al. (2017) showed that religious leaders were critical promotors of practices such as forced seclusion. The change in the tone and focus of the religious leaders found in my study could have occurred due to an increased focus on religious leaders as change agents by NGOs and government agencies. Governmental and nongovernmental agencies have focused on prominent religious leaders in Kano State as change agents for promoting safe maternal health practices among community members (Adedini, 2018).

The participants in this study also discussed religious leaders as alternatives to health care providers. The participants whose husbands had little money or disapproved of male hospital staff members attending their wives were more likely to turn to religious leaders for health services. Similarly, Sharma et al. (2019) found that spiritual and

cultural alternatives to health care were sometimes impediments to the utilization of maternal health services.

The participants in this study also discussed practices of traditional birth attendants and traditional healers. Alternative health care providers are familiar faces in the Kano City community who are deeply embedded in the culture and have the trust of the people in the community. This research indicates that traditional practices remain prevalent in the community, although women might prefer hospital deliveries. Young women may still engage in practices, such as delivering with a birth attendant or taking herbs and concoctions from traditional healers while pregnant. However, the participants in this study indicated that husbands or family members forced them to engage in such practices.

In this study, visiting traditional birthing attendants and healers was a practice mainly seen among the young women who lacked the money to attend health care facilities or whose husbands or family members insisted on particular healers. The participants with traditional healers among their family members or family members who approved of traditional practices were more likely to experience coercion to engage in traditional medical practices even if they did not personally approve.

This study also showed that traditional practices, such as hot water birth and forced seclusion after birth, remain in practice. However, the participants expressed a general dislike for these practices. Despite their distaste, however, the young women said it was not their decision to make. They indicated that after they gave birth, their decision-makers would likely force them to engage in these practices.

The findings also showed that religious leaders sometimes provided medicine or prayers for the young women who needed care and could not visit a hospital. The findings also showed that some participants opted to receive care remotely from traditional healers because it did not require mobility. Some participants also chose remote care because they would not have to physically attend the clinic and receive services from male providers.

Theme 3: Age, Gender, and Decision-Making

Age and gender, the most prominent identities of the participants, had an impact on the young women's experiences and how they accessed care. The two identities influenced each participant's experience and decision-making process, sometimes as direct impediments. The participants experienced discrimination at home and hospital facilities because of their age. They also faced significant barriers when making decisions about their bodies, health, birthing place, and birthing method. As a result of this discrimination, the participants had mainly negative decision-making processes and experiences. The last Demographic and Health Survey (National Population Commission, 2013) in Nigeria showed several factors behind women's autonomy: access to finances in the home, participation in health care decision-making, and the freedom to leave home without permission. Obasohan et al. (2019) stated that autonomy in Nigerian society is closely correlated with age and was a significant determinant of using ANC services in health facilities. Women without autonomy, particularly those young and vulnerable, continue to face adverse reproductive health outcomes. Obasohan et al. noted a close

connection between women's ability to make decisions on behalf of their health and positive maternal health outcomes.

In this study, the participants' preferred birthing choice was the hospital facility. A few of the women planned to give birth at home or with traditional birth attendants. However, they made these decisions due to family pressure or bad experiences in health facilities.

The choices for health facilities ranged from small primary health centers to larger, more equipped health centers. Most of the participants had strong opinions about where they wanted to give birth, causing them to be at odds with the primary decision-makers in their lives. Relatives or others' experiences convinced some participants to believe giving birth in a hospital was better. In contrast, others stated that they wanted to give birth in a hospital because they preferred clean homes after the birthing process.

However, nearly all young women said that they would likely not get their exact wishes, as they had to follow the decisions of their husbands, family members, and co-wives. This finding aligned with Solanke (2015), who observed that age closely correlated with women's decision-making autonomy. Solanke (2015) found that older women had more power to make decisions based on their needs and what was best for them.

Theme 4: Wealth, Education, and Social Class

Most of the participants in the study did not finish their education due to getting married at a very young age. However, their lack of education also caused them to lack gainful employment. Lacking an education had a significant impact on the participants'

experiences and decision-making. The findings indicate community perceptions of educated women as wealthier and of a higher social class. The participants had entirely different experiences at home and in hospital facilities. They described well-dressed women with expensive-looking clothing who were cleaner and driving cars received more respect and better treatment from health facility staff members. The participants reported that such women also garnered more respect and autonomy in the community, having more power to make decisions and better chances of receiving good treatment in hospital facilities.

Most of the participants discussed their experiences in primary health care centers used mainly by people considered destitute. However, even within that context, anyone perceived to have more money or more education received more respect. Research has shown that women with the worst maternal health outcomes have less money and education (Adedokun & Uthman, 2019; Nuamah et al., 2019; Shahabuddin et al., 2019). The findings of my study showed that the lack of autonomy at home and the disrespect experienced at health facilities made the participants less likely to seek care in health facilities. The findings suggested that having an education and money provides women with more autonomy in deciding care; such women can afford the services associated with good maternal health outcomes.

The participants also indicated that without money at their disposal, they had no other means of paying for care except for their husbands and relatives. A lack of money produced the additional burden of being at the mercy of husbands and other family members who paid for their health care. The findings also showed that visiting a proper

health facility (a private hospital versus a smaller health care center or PPMVs) directly correlated to the money available for families. The participants' husbands were the most likely to allow their wives to visit the hospital if they had the money or if others paid for treatment.

Theme 5: Hospital Experiences

Almost all participants had visited health facilities for multiple reasons during their pregnancies. Some attended ANC, and some visited because they felt unwell. Most of the facilities were small primary health care centers. Some of the participants who could afford it also went to private hospitals. The participants' experiences during these visits impacted their decision-making, particularly about where to give birth.

Most of the young women reported negative experiences of long wait lines; hospital workers who abused, disrespected, and ignored them; the inability to understand some hospital processes; and confusion about some of the health information passed on to them. The participants also felt that the long wait times resulted from the providers' uncaring attitudes, particularly toward younger women with less experience. Some participants narrated incidents when older women or women with money for the attendants' tips received preference over those waiting in line for a long time. One participant found this a particularly distressing experience, as she had to wake up early and travel a long distance to secure a place in line. This finding aligns with Ntoimo et al. (2019), who identified long wait times as a foremost reason why some women did not attend primary health facilities for pregnancy care in rural areas of Southern Nigeria. However, the strength of my study was that it addressed the experiences of younger

women and focused on the various factors in why they had longer wait times than older women with more education and money.

Most participants reported experiencing abuse and disrespect during facility visits, including being looked down on, yelled at, insulted, and ignored. In some facilities, young, first-time pregnant women got separated from older women. The younger women had to wait in long lines and received the worst treatment. Some participants felt that the hospital staff provided harsher treatment when they noticed individuals poorly dressed or not very clean.

Similarly, Ishola et al. (2017) found that abuse and disrespect by hospital staff members were impactful barriers to women accessing health care services. My study aligned with Ishola et al. and showed that the abuse and mistreatment of younger women caused them or their relatives to consider alternatives to hospital care. However, the participants reported that they received better treatment if their husbands or older relatives, especially male relatives, accompanied them on their visits. Some of the participants expressed the desire to give birth in a hospital facility but felt discouraged by their or others' experiences. Some participants stated that they experienced worse abuse in small primary health care centers because individuals with less money frequented that facility. Little or no abuse occurred in more expensive private hospitals. However, most participants found the larger facilities inaccessible because of distance and the private facilities too expensive.

The facilities participants visited did not have health information tailored for young adolescent women. Thus, the participants often felt unsure and confused about

what the health facility staff told them. The young women often struggled to understand the processes, procedures, and information provided at the clinics. This finding aligned with Odo et al. (2018), who surveyed over 197 facilities in Southern Nigeria and found a lack of sexual and reproductive health information targeted to adolescent women.

The participants in my study described instances when they had to ask other women, often older women, for help in understanding clinic processes. The participants who lacked the literacy needed to fill out the forms frequently went without help and felt frustrated and confused. As a result of the problems in the health care facilities, the participants stated that they turned to their mothers-in-law, co-wives, or more experienced mothers. However, these alternative sources did not always provide information in the participants' best interests or gave them misleading information.

Some participants, especially those with husbands who disapproved, expressed a reluctance to receive health services from male hospital staff members. Alqufly et al. (2019) highlighted the preference for female health care providers in Muslim societies in Saudi Arabia. Hassan et al. (2020) studied this preference among Muslim populations in the United Kingdom. In my study, some of the participants' husbands did not permit them to use health care facilities because of the concern that male staff members would examine them. Most of the doctors practicing in rural areas in Northern Nigeria are men. Therefore, the husbands' preference for female health care providers was a barrier to women's access to care in Hausa communities.

Findings Related to Intersectionality

The study's guiding theoretical framework was intersectionality. Intersectionality focuses on how various social and demographic constructs intersect to produce different forms of oppression for women. This study addressed the most common social constructs of intersectionality and their contributions to the participants' experiences. The participants faced unique experiences due to the intersections of age, gender, education, and social class. Their intersecting experiences caused them to have limited access to quality health care while pregnant and when making decisions about how to seek care. At home, the intersection of age and gender produced an oppressive outcome when deciding to seek care, as major decision-makers limited the participants' mobility, economic empowerment, and agency. In health facilities, the intersection of age and poverty resulted in stigma and biases from health care personnel, producing an oppressive and discriminatory environment.

The Intersection of Age With Gender, Social Class, and Education

One of the study's findings was that the community contained deeply entrenched gender roles. The participants in this study had clear beliefs about their roles as women. They believed that they were to stay at home, look after their families, and bear children. They believed that they had the responsibility for all the functions associated with carrying and bearing children. The participants indicated that it was their husbands' responsibility to decide when and how they should seek care; in turn, they had the wifely duty to accept whatever their husbands decided.

The participants also saw themselves as children despite their marital status. They felt that they lacked experience and required guidance from older adults who knew what was best for them. The participants' recognition of their identities as those from poor backgrounds was less clear; they considered their financial status more important for issues of who pays for health care and the facilities to attend. Several of the participants recognized that their uneducated status created disadvantages, especially in hospital facilities where the providers appeared to care about their clients' educational status. This study addressed these identities together in relation to the participants' age. The participants' intersecting identities as women and children resulted in social hierarchies and unequal power relations that influenced every aspect of the participants' experiences and health care decision-making processes.

Intersectionality suggests that social identities intersect and that different social groups have different experiences (Bright et al., 2015; Calasanti, 2019). Intersectionality is a means of studying how individual inequalities produce injustices and oppression. In this study, the women's husbands and family members were the significant decision-makers in their lives. In a patriarchal and conservative society, such power relations can cause harm. In many instances, the participants could not properly articulate their needs and wants. They sometimes chose not to say when they felt unwell or needed to see a doctor for fear of rejection or anger. They often had to accept situations unfair, oppressive, and detrimental to their health. Unequal power relations also occurred in health care facilities where the health care providers perpetuated the same gender norms and stereotypes by treating the younger women more harshly than older women.

Another power imbalance evident in the findings emerged from the intersection of age, gender, and social class. The participants saw themselves as inferior to women with more education or money. In some instances, the participants justified receiving inadequate treatment in hospitals by juxtapositioning themselves against their more affluent counterparts. Additionally, most participants lacked opportunities to engage in activities that could result in economic empowerment and critical resources. The young women needed resources to get good quality maternal care and the opportunity to participate in a social sphere where they could have value and respect. The lack of economic empowerment also resulted in a gender and power imbalance that produced oppressive outcomes. As shown by the findings, the health facility workers tended to give more attention and respect to women perceived as wealthier or of a higher social class.

Limitations of the Study

This study provided valuable insights into adolescent women's health care decision-making processes in Kano City. However, there were some limitations. The study had results limited to 12 participants interviewed within a particular social and cultural context. I focused on experiences unique to the participants and their geographical regions. Therefore, the findings might not be representative of women's experiences in a larger geographical area. The inclusion criteria also required adolescents between 15 to 18 years of age, as these individuals comprise the majority of adolescent pregnancies in the region. However, I did not solicit the experiences of married and pregnant adolescents between the ages of 13 and 15 years. It could have been a limitation that the data did not include the experiences of a younger adolescent population.

Researchers can have preconceptions and biases. I am a medical doctor known in the community, and I am familiar with the regional norms and culture. Thus, there was a chance that I brought my preconceptions and biases into my interactions with the participants and during data analysis. I mitigated my preconceptions and biases via continuous self-reflection throughout the study. Awareness of biases enabled me to remain mindful of their potential impact on data interpretation.

Implications for Social Change

Promoting positive social change requires identifying and outlining barriers that cause oppression. Batist (2019) pointed out that addressing issues of female empowerment could be a way to reduce the burden of maternal mortality in Sub-Saharan Africa. Women should be able to make decisions about their sexual and reproductive rights, even as adolescents.

This study focused on the conditions of the young adolescent women usually overlooked in studies on maternal mortality in Northern Nigeria. I found that young married adolescents in Kano City had little agency to make decisions. Their husbands and older relatives ruled them, and they received poor treatment in hospital facilities. The findings indicated that the intersection of vital sociodemographic determinants remains a significant barrier to quality maternal health care. The intersection of sociodemographic determinants contributes to oppressive gender roles in homes and communities for pregnant, married adolescents and produces biases and stigma at health care facilities.

The findings of this study also showed the seeming lack of awareness of the women, their husbands, and health care providers about the specific health needs and

vulnerabilities of young women. The lack of awareness of young adolescents' health led the individuals around these women to disregard their health status in favor of deeply entrenched, long-standing norms and beliefs. The findings also indicated that addressing the oppressive conditions and power relations with adverse effects on women's health and lives requires challenging the status quo. However, challenging the status quo takes significant effort. For example, in conservative societies, such as the study area, gatekeepers with positions of authority may not want to give up their power. However, research has also shown that they do not want to see their women die during childbirth and may be open to bringing about solutions if fully informed and engaged (Fantaye et al., 2019).

The knowledge produced by this research could contribute to small shifts in traditional patterns that have resulted in the subjugation and lack of access to care for women, with devastating results for centuries. The first change must occur at the family level. Families have a critical role in social change, and researchers have long stated that the most effective and enduring change occurs at the family level (Michaelson et al., 2021). Engaging families effectively requires experts to identify the most influential family member responsible for decision-making (Jazieh et al., 2018).

My study's findings indicate that husbands are the most influential decision-makers; therefore, they must be the first targets. I will share the findings of this research with husbands via the several avenues available for dissemination. One such avenue is the various community committees comprised primarily of men with families. Farmers, traders, and road transport workers have regular meetings to discuss issues in their

communities and trades. I will ask to speak at some of these meetings as a health professional, sharing the findings to show them the impact of their behaviors on their wives' lives and well-being.

Addressing men in the community could lead them to be health promoters who can help disseminate the message to other men. Engaging men in maternal health care is a successful strategy. For example, in Ghana, Bougangue and Ling (2017) found men made aware of studies that showed the importance of their engagement early in maternal health issues completely transformed their behavior and supported pregnant women in their communities. Similarly, Doyle et al. (2018) researched the successful effects of a gender-transformative intervention among a Rwandan tribe. They found that interventions targeted to men for activities such as ANC lessons and being birth companions if the women desired could be a way to completely change societal norms that obstruct women's rights to their bodies.

I will share with the men in the study site's community how young women feel about their access to care and how certain beliefs and attitudes of their husbands are barriers to getting the care they need. I will discuss the importance of allowing their first-time pregnant adolescent wives to receive care in a proper hospital by health care professionals. Additionally, I will advise the men to prioritize their wives' health care and avoid unorthodox practitioners, such as PPMVs, traditional healers, and medicine men.

The research findings also indicate that mothers and mothers-in-law have a role in the oppression of adolescent women. I will work with faith-based female organizations that have existed in the community for many years. I will share my findings with several

of these organizations, such as FOMWAN, which have successfully addressed many sensitive issues, including reproductive health and rights,

Focusing on creating awareness among men about the need for improved access to health care facilities for women is a well-known and effective strategy for gaining support for change at the microlevel. However, addressing maternal health care for adolescents requires more than creating awareness among family members. A need exists to address the cultural structures at the community level that contribute to and enable some of these injustices. Oppressive community structures include the long-held norms, cultures, and beliefs about young women, particularly the strict gender roles demanding that women must raise children without the involvement of men, predestination, the martyrdom of women who die during pregnancy, and fears of male doctors attending wives at hospitals. Change can occur in such community beliefs if people in positions of power learn from this research that young women have different health requirements than their older counterparts. People in positions of power must also learn that these societal structures and norms are barriers to women's decision-making, mobility, and finances that contribute to continued subjugation and detrimental health effects.

The literature has shown that many community gatekeepers and stakeholders have yet to link how gender norms have harmful effects on women (Fantaye et al., 2019). The justification for using a community-based approach to achieve positive social change is that individuals should be integral parts of their societies. However, interventions must address more than the individual; impactful change often occurs via collaborative extension into society (Merzel & Afflitti, 2003). People are likely to change their

behaviors if they are involved in making decisions. Community involvement enables community members to be continuous advocates. Sustainability has better chances of success when people in the community get involved. Involvement also correlates with the increased likelihood of community members contributing their time and money.

I will work with community members by helping some influential clerics to understand the effects of some of these cultural norms on young women; in turn, the clerics can disseminate these findings in their weekly Friday sermons, which are traditional means of sharing information. Hearing the sermons could enable community members to address these issues and understand the harm caused by traditional norms and beliefs. Little research has shown the link between female subjugation and oppression and poor health; my study addressed this missing link. An example of how direct engagement could result in change is the finding in this study that religious leaders have begun preaching the importance of allowing young women to visit health care facilities. While such a change might have resulted from many years of intervention, this finding suggests that change can occur, even among societies with deeply entrenched belief systems.

A need also exists for institutional-level change. This study showed how disrespect and abuse at the hospital level hindered the participants and their family members from accessing care. This research suggests the need for an inclusive health care intervention targeted to all family members instead of leaving the burden of childbearing to women. The strategy of using the same family members involved in oppressing young women may sound like a counterintuitive tactic, as this study showed

that family members were often the leading causes of injustice. However, research has also shown that engaging and informing family members in maternal health care could be a way to reduce the oppression faced by women at the family level. Depending on the content of the health promotion messages, educating family members could be a way to address issues of injustice and oppression (Fantaye et al., 2019).

Researchers and experts have long indicated that health care service delivery should address the cultural preferences of individuals (Jones et al., 2017). Similarly, the findings from this research indicate that husbands and other community decision-makers must learn the importance of providing women, even young women, with the financial, social, and physical autonomy they need to take care of their health. A need exists to advocate for young women to receive an education and gain the skills they need for financial independence. Researchers have also shown that family members well-informed and engaged with health systems are more likely to seek care, understand the importance of skilled attendants at birth, and hold health providers accountable, therefore reducing incidents of abuse and disrespect at facilities (Cofie et al., 2015).

A need also exists to address the institutional-level issue of the attitude of health care providers. The findings of this research showed the significant repercussions of health care providers' attitudes on young women's access to care. I will share my findings with the chief nursing officers and chief medical officers of select primary health care centers in the study location to show them the link between the attitudes of nurses and doctors and the quality of maternal health care. I will reach a wider audience within the health care community by publishing my findings in prominent medical journals,

such as the *Nigerian Journal of Medicine*, *African Journals Online*, *Tropical Journal of Obstetrics and Gynaecology*, and *Africa Journal of Nursing and Midwifery*. I will also speak at relevant conferences in Nigeria. The goal of the journal publications and conference presentations will be to increase general awareness and target the policymakers able to influence critical policy within the country to introduce and enforce respectful maternity care in school curricula and at health institutions.

I will also use the conference presentations and paper publications to advocate for using intersectionality as a theoretical construct to examine the maternal health care issues of young women of childbearing age to expose layers of oppression in conservative communities. Researchers can use intersectionality to better understand the experiences of different groups of women and make recommendations tailored to their specific needs. The policymakers who attend conferences can also learn why female empowerment, education, and financial independence are critical to maternal health care and health outcomes.

Recommendations

The findings of this study provide the opportunity for further research on young, married adolescent women. A need exists for further research to enhance health care providers' knowledge and awareness of the intersecting factors affecting pregnant adolescent girls and how to mitigate these factors. There is also a need for continued research on the reproductive health knowledge of married adolescent girls in seclusion. Understanding and exploring what young women in seclusion know about their

reproductive health could provide profound insights into creating interventions specific to their needs and building on their existing knowledge.

There has been little research on the maternal health of women between the ages of 15 and 18 in Northern Nigeria; even more limited are in-depth studies on the effects of multiple sociocultural factors on young women's decision-making powers and the impacts on their health. Scholars looking at women's maternal health should recognize that married, pregnant adolescents have markedly different experiences and social circumstances from older women. For example, this study showed that married adolescents experienced different oppression and subjugation than older women with more wealth and education.

This study included data from young adolescent women only. I believe the inclusion of health care providers and husbands could have provided more depth to the discussion. The inclusion of married adolescents younger than 15 years of age in future studies could also lend more depth and scope to understanding the phenomenon.

Researchers of maternal health working in places such as Kano City should also attend to the subset of married, pregnant adolescents, as they have entirely different experiences and outcomes from other groups of women. Individuals researching maternal health in this context should consider not grouping together all women of reproductive age. This suggestion includes the population-level surveys and epidemiological studies widely used to influence policy at the state and federal levels.

Conclusion

Based on the data analysis, I determined that young adolescent women in Kano City who are pregnant for the first time encounter significant barriers when deciding to seek care during their pregnancies. The study's findings also indicated that the intersection of several sociocultural determinants produced different levels of discrimination, bias, and oppression, posing barriers to seeking quality maternal health care.

The first research question focused on the experiences of married pregnant adolescents when seeking care. The findings showed that the individuals around the young women overrode them when making decisions about their health. The participants could not articulate their needs and wants to the decision-makers in their lives. The findings also indicated that although the women knew and understood the need to seek care in a health facility, they suffered from a lack of autonomy in decision-making, a lack of economic empowerment to pay for hospital bills, and poor mobility to access the required care. The study also showed that the young women faced different biases, stigma, and discrimination in health facilities than older women with more education and wealth. The second research question focused on the various sociocultural determinants that influence young women's ability to seek care. Age, gender, social status, and educational levels all have significant effects on the experience of young women, both at home and in hospital facilities.

The feminist theory of intersectionality was this study's theoretical framework. The intersectionality theory focuses on the various factors that intersect to produce

different disadvantages for a person or group of people. I used the intersectionality theory and found that young women in Kano City did not experience oppression and discrimination in the same way. Younger women with less education and wealth suffered the worst oppression. The younger women experienced this level of discrimination at home with family members and in health facilities with hospital staff.

This study has findings critical for understanding the maternal health-care-seeking and decision-making behaviors of adolescent women in Kano City. Using the intersectionality lens enabled the critical study of the various factors that intersect to produce challenges for the participants. Examining and understanding these structures could provide the opportunity to initiate genuine reforms to dismantle the barriers faced by women. The findings of this research could be a starting point for discussions with a more in-depth focus on young married women and their reproductive health in Hausa society.

Many adolescent women in Kano City are married and have disproportionately high rates of maternal morbidity and mortality. Therefore, a need exists for discussions to finding lasting solutions to the problems of high rates of maternal morbidity and mortality for this group. A recommendation is for further research on the knowledge and awareness of providers, family members, and young women of the effects of harmful cultural norms on young women's reproductive health. A need exists for more studies focused on young pregnant adolescent women's specific circumstances.

Chapter 5 presented the interpretation of the findings, recommendations for further research, implications of the research for positive social change, and a summary

of the findings. In light of the significant maternal health burden in Kano City, particularly among adolescent women, this study is a small part of what should be an overall and more holistic effort to tackle the problem. There is a need for additional studies focused on married adolescents to close the gap in understanding and address their unique problems.

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Appendix A

Interview guide

Greetings and introductions

Hello, my name is Yashua Hamza, a Ph.D. Student working on my dissertation (get signed informed consent and permission to record the interaction.

Constructs	Questions
Experience seeking/not seeking care	**General questions** **If the participant had any health care needs during this pregnancy:** • When seeking care, where did you go and why? Probe for hospitals, pharmacies, traditional birth attendants, advice from relatives • What was your experience? How were you treated? How did you feel about your treatment? Probes: Why do you think you were treated like that? How would you have wanted to be treated **If the participant did not have any health care needs during this pregnancy** • If you were to need any care during this pregnancy, where would you go and why: Probe for hospitals, pharmacies, traditional birth attendants, advice from relatives. • What do you think your experience would be like? How do you think you would have been treated? Why do you feel you would be treated like that? How would you want to be treated? **Age** Would you have been treated differently if you were older? How do older women get treated in the health facility compared to younger women? **Education** How would your treatment have been if you were more/less educated? **Social class**

	How would your treatment have been if you had more/less money? **Gender** How are women treated when they go alone versus when they go with their husbands?
Health care needs	• Regarding your health during this current pregnancy, how has this pregnancy been for you? What did you need during this pregnancy? probe for specific health care needs, illness, antenatal care, confirmation of pregnancy • If you had any reason to seek medical health, what did you decide to do, and why did you take that decision? Probe for specifics, what was your role in making that decision? **Age** If you were older, how would your decision have been different? **Education** • If you were more educated, how would your decision have been different? **Social class** • If you had more money, how would your decision have ben different? **Gender** • In your community, who in the household makes decisions about seeking care when pregnant? Why is that so? How does it affect you? • If a woman is sick while pregnant, who decides if she goes to the hospital? What is your role in the decision-making process? • What would you like to do when it comes time to deliver the baby, where would you like to give birth? Why did you make that choice? Will you get your choice? Probe: Please help me understand your answer.
Agency of women in decision making	• In your household, how is money spent? Who decides how money is spent, and for what purpose? Does this change if a woman is sick and needs to go to the health facility? Does it change if women were older/younger, more educated/less educated?

	• Who makes other significant decisions in the house and why? • If you need any health care urgently, who decides where to go, and how are those decisions made? How do your age, educational status, and presence and absence of money affect how these decisions are made? • How would things change if you were to make the decisions in your house? probe for how these decisions are affected by age, money, educational level, and gender
Gender relations in homes and communities	• What are the roles of community members in the decision-making process regarding your health? probe for if family members, community and religious leaders are part of the decision-making process and in what way • When making decisions about health, does the household decision-maker take notice of your advice? Do you have examples you can share about when your opinion was used? What were the circumstances? How did you feel about the outcome? • How would things change for you as a woman in this community if you were the one in charge of your health, making the decisions? Help me understand your responses.

Conclusion

- Is there anything else you would like to add that would help me understand your responses today?

Interviewer comments and reflections (journaling)

Include where the interview was conducted. During the meeting note the demeanor and comportment of the interviewee. If any unanticipated or interesting events occurred, record observations. Reflect on each conversation at the end, record everything in a journal.