

**“It has come to destroy me.”**

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*An exploratory study to understand the well-being of married girls in rural  
Eastern Region, Ghana*



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## **Abstract**

Creating child marriage-free communities and giving girls complete agency in deciding if, when, and whom to marry are now common goals and philosophies of the development agendas of international organizations and nations. Given the variety of negative physical health consequences that are linked to child marriage, previous academic and programmatic research has primarily focused on that area of girls' overall well-being and neglected other areas, including mental and social well-being. It is critical to gain this missing information and this study does so for Ghana's Eastern Region, where the increasing population numbers would lead to an overall increase in the number of girls married as children if the practice is not curbed. Hence, this study aims to fill a knowledge gap around the perspectives child brides in this area have on their overall well-being and the ways in which they navigate the structures that impact their ability to exercise agency to better their own well-being.

Data was gathered in the Boti and Akpo-Akpamu communities using in-depth interviews, focus group discussions, and participant observation. Results show that most girls find their general well-being to worsen after being married, with girls prioritizing certain areas of well-being more than others. However, the extent to which well-being suffers has more to do with the economic standing of a girl and her husband than anything else. Moreover, girls also made clear that the main driver to their being married was adolescent pregnancy, rather than early marriage leading them to become pregnant. Finally, the research finds that girls' decision-making (or exercising of agency) related to marriage takes place in restrictive contexts. These findings problematize assumptions that underlie much of the development community's actions for intervening in the practice of child marriage and demand a more local understanding of what leads girls to marriage and poor well-being outcomes. Having this contextual understanding can be used by the development community to better intervene in an effort to end the harmful practice of child marriage.

**Keywords:** child marriage; early marriage; adolescent pregnancy; health; well-being; agency; structure; Ghana

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### **Acronyms**

FGD: Focus group discussion

HBM: Health Belief Model

IDI: In-depth interview

IUD: Intrauterine device

N/DHIS: National/District Health Insurance Scheme

TBA: Traditional birth attendant

THP-Ghana: The Hunger Project-Ghana

UNFPA: United Nations Population Fund

UNICEF: United Nations Children's Fund

WHO: World Health Organization



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# 1 Introduction

*“I did not have anybody to support me, and then I met him. He was so enticing. When he persuaded me to give my consent to marry him, I thought things would move on well. After entering marriage, I realized things were not going well and it became something... As I was, so I am now.”<sup>1</sup> – Piper (22-years-old, married)*

Piper was 16 or 17-years-old when a 23-year-old man asked her to marry him. Both of her parents had died and her older sister often did not have enough food to share with her. Believing his promises that he could offer her a better future, she entered into child marriage. It was not long before she told him she was pregnant. Furious, he said that he was leaving to go to the market and would return.

Five years later, I sat outside Piper’s pink home with her. Laundry hung from the ceiling and the sounds of chickens and goats surrounded us. Her husband went to the market five years ago and, irate about her pregnancy, never returned. She is expecting another baby in the next few months. This baby she shares with her second husband. Caring for her first child made her economic situation direr, which is to say nothing of the persistent, debilitating headaches she has suffered with since giving birth. Reflecting on her pre-marriage condition, she explained her post-marriage and motherhood reality: *“As I was, so I am now.”*

## 1.1 Problem statement

Within the international development aid community, child marriage is defined as “any legal or customary union involving a boy or girl below the age of 18...” and is considered a human rights violation (Stevanovic Fenn et al., 2015: 12). While multiple international human rights agreements, including the Universal Declaration of Human Rights, the Convention on the Rights of the Child, and the African Charter on the Rights and Welfare of the Child, condemn child marriage and call for young people to be protected from marriage, the practice continues

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<sup>1</sup> Quotations delivered by research participants and used within this thesis have been edited to make the subject first person rather than third person as the interpreter delivered them. The content of the quotation has not been altered.

in numerous countries around the world (Hampton, 2010; Stevanovic Fenn et al., 2015). Child marriage can and does negatively impact important development indicators for girls and women, including their education, employment, and empowerment. Such experiences often also negatively impact the development indicators of a girl's child(ren), which, given the intergenerational impact, make these serious issues for the international development community to address (Delprato, Akyeampong, & Dunne, 2017; Gage, 2013b). While the impacts child marriage has on the physical health of girls are well documented, its impacts on mental, physical, and social well-being are not. Having a more holistic view of the general well-being of child brides would lead to a more complete picture of the needs of girls and women living in child marriage. The primary aim of this research was to collect qualitative data to understand how and the ways in which the practice of child marriage influences the well-being of girls – like Piper - in Ghana's Eastern Region.

## **1.2 Literature review**

The following sub-sections provide an overview of the available academic and programmatic literature related to the ill-being consequences of child marriage and its prevalence in Ghana and more broadly.

### **1.2.1 Ill-being effects of child marriage and adolescent pregnancy**

Child marriage and adolescent pregnancy can have or correlate with negative impacts on a girl's overall well-being (Jensen & Thornton, 2003; Stevanovic Fenn et al., 2015; Loaiza & Liang, 2013). There is no international operating definition of well-being, and a variety of definitions and measurements for well-being have been proposed as research of the concept has increased over the past few decades (Dodge et. al, 2012; Hartwell, 2013: 230). Even so, the multidimensional concept is included in the World Health Organization's (WHO) definition of health as "... a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, n.d.). Using this as a launching point, this research will look into how married girls in Ghana's Eastern Region experience physical, mental, and social well-being and 'ill-being,' that is poor experiences of well-being. Whereas health is the absence of injury or malady, well-being incorporates both health and a person's own assessment of their

quality of life in both a particular area (physical, mental, or social) and overall. Thus overall well-being is measured, in this research, by the subjective perceptions and experiences of individuals.

### ***Adolescent pregnancy***

Chief among the well-being concerns for child brides is adolescent pregnancy, which leads to physical, social, and mental well-being issues for girls. Organizations such as the WHO and United Nations Population Fund (UNFPA) refer to adolescent pregnancy as pregnancy in girls and women age 19 and younger (Blum & Gates, 2015; WHO, 2018). Like child marriage, adolescent pregnancy is also widely acknowledged to be a condition with long-lasting negative impacts that transcend physical health, including curtailing economic opportunities, education, and emotional health (Raj & Boehmer, 2013; Stevanovic Fenn et al., 2015: 43; LeGrand & Mbacké, 1993). In addition to often being considered a violation of the human rights of girls, adolescent pregnancy “poses high development costs for communities, particularly in perpetuating the cycle of poverty” (Loaiza & Liang, 2013: 3). However, it is important to note that this conceptualization of adolescent pregnancy as a human rights issue implies that pregnancy is something that happens *to* girls rather than something in which they might willingly play a part.

Adolescent pregnancy in Ghana is common and more prevalent in rural areas, like those in which this research occurred, than in urban areas (Ghana Statistical Service, Ghana Health Service, and ICF International, 2015: 69-70). One-fifth of women aged 25-49 report having given birth before the age of 18 (Ghana Statistical Service, Ghana Health Service, and ICF International, 2015: 59), which measures adolescent pregnancy differently from the WHO and UNFPA. However, this measurement, which considers pregnancy in girls under 18-years-old, is useful when looking at adolescent pregnancy in comparison to child marriage. Most of the adolescent pregnancies in Ghana happen at age 15 or older. In contrast to other countries in the region, including Guinea, Mali, and Niger, Ghana has a relatively low number of girls giving birth before the age of 15, a practice which leads to an even more elevated level of health consequences when compared with girls giving birth later. Seventeen percent of Ghanaian women aged 20-24 who had a birth before the age of 18 reported their first birth



as taking place before the age of 15, while the other 83% of first births happened at age 15 or later (Stevanovic Fenn et. al., 2015: 44).

The Ministry of Health and Ghana Health Service has adopted several initiatives in an effort to reduce girls' vulnerability to adolescent pregnancy. Among others they include: comprehensive sexuality educations in schools, encouraging traditional community leaders and parents to take care of the basic needs of adolescents, beginning outreach activities in places where adolescents tend to gather (such as markets) related to pregnancy prevention, and providing reproductive health services and family planning to sexually active teens (Republic of Ghana Ministry of Gender, Children and Social Protection, 2016: 13-14).

### ***Physical ill-being***

Girls who are married as children and/or have children at a young age are often exposed to maternal health and well-being consequences related to marriage and adolescent pregnancy (Raj & Boehmer, 2013; Hampton, 2010; Gage, 2013b). When compared to women who marry later in life, child brides around the world are more susceptible to poor sexual and reproductive health outcomes, higher rates of maternal mortality and morbidity, gender-based and domestic violence and malnutrition (Gage, 2013a; Nour, 2006). As for physical health consequences of bearing a child at an early age, girls giving birth experience higher risks of obstetric fistulae, obstruction during delivery, placental tears, eclampsia, and infection. The WHO notes that complications due to pregnancy and childbirth are the leading cause of death globally for girls aged 15 to 19-years-old (WHO, 2018).

### ***Emotional and social ill-being***

In addition to physical ill-being, child marriage also frequently presents girls with mental and social ill-being over the course of their lives. Such issues include limited educational and employment opportunities, financial dependence on a husband, increased stress and poor mental health, limited opportunity to interact with peers and develop support systems outside of the marriage, and a lack of agency (Segal-Engelchin et al., 2016; Stevanovic Fenn et al., 2015: 43; Gage, 2013a).

All of these well-being concerns have led the international community to make eliminating the practice of child marriage a key piece of accomplishing health and development goals (Greene, 2014: 1). In fact, ending child marriage is included as target 5.3 of Sustainable Development Goal 5: Achieve gender equality and empower women and girls (United Nations, n.d.). That, however, assumes that simply marrying at a later age would lead girls in the developing world to experience better well-being, thereby, increasing development. This research will illustrate how only aiming to address child marriage might be too simplistic in that it looks to marriage as the starting point for intervention rather than as an effect of other development issues.

### **1.2.2 Child marriage<sup>2</sup> in Ghana**

Nationally, the rate<sup>3</sup> of child marriage in Ghana stands at 21%, with 1 in 5 girls being married before they turn 18 years old. Comparatively, Republic of Congo, Senegal, Nigeria, and Niger see rates of child marriage at 32.55%, 32.89%, 42.82%, and 76.27%, respectively (Stevanovic Fenn et al., 2015: 36). However, child marriage rates in Ghana differ across regions and socio-economic status: Rural areas, particularly in the North of the country, see higher rates, and girls from rural areas are twice as likely to be married before their 18<sup>th</sup> birthday when compared to girls from urban areas. Further, girls living in poverty or with lower levels of education are more likely to be married than their peers (Republic of Ghana Ministry of Gender, Children and Social Protection, 2016: 4-5; Stevanovic Fenn et al., 2015). The Ghana 2014 Demographic and Health Survey found that 27.2% of women aged 20-49 reported first being married by age 18 (Ghana Statistical Service, Ghana Health Service, and ICF International, 2015: 53). Within the Eastern Region, 18.7% of women aged 18-22 reported being married by 18 years of age, while 4.47% reported being married by 15 years of age (Malé and Wodon, 2016: 3).

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<sup>2</sup> The terms 'early marriage' and 'child marriage' will be used interchangeably throughout this study to refer to a practice in which at least one person is less than 18 years of age. While these terms are often distinguishable within the literature, the participants in this research were no longer considered 'children' when they married.

<sup>3</sup> The practice of measuring child marriage varies depending on the source, which can sometimes make analysis and comparison difficult. Most studies measure incidence or the share of girls within a population who marry early (Nguyen & Wodon, 2015).

With a growing population that would lead to larger numbers of married girls, and thereby more girls facing marriage-related consequences, should prevalence rates of child marriage not decrease, the Ghanaian government, in 2016, unveiled a national strategy for addressing child marriage between 2017 and 2026 (Republic of Ghana Ministry of Gender, Children and Social Protection, 2016: 6). After meeting with girls and communities across the country, the government, alongside the United Nations Children's Fund (UNICEF), identified a variety of factors as contributing to the high prevalence of child marriage. Factors include gender inequality, traditional practices including girls marrying to pay off family debts, and adolescents looking for a way out of unfavorable circumstances (Republic of Ghana Ministry of Gender, Children and Social Protection, 2016). The latter factor links closely with the findings by the Her Choice program and other authors that some (Ghanaian) girls view marriage as beneficial and a way out of poverty and to escape violence in their family homes (Koster et al., 2017: 29; Segal-Engelchin et al., 2016).

### **1.3 Role of Her Choice and The Hunger Project**

The Her Choice program is an initiative working to create child marriage free communities and improve the position of women and girls. The program is developed by four Netherlands-based organizations (Stichting Kinderpostzegels Nederland, The Hunger Project, International Child Development Initiatives, and the University of Amsterdam), and implemented by their 32 partner organizations in 11 countries around the world with the aim being to foster child marriage-free communities (Koster, et al., 2017: 1). The baseline study of the Her Choice program informed the early stages of this research proposal.

It is through Her Choice and my supervisor, Dr. Winny Koster from the Amsterdam Institute for Social Science Research, that I was put in contact with The Hunger Project-Ghana (THP-Ghana) about this research. The Hunger Project utilizes their Epicenter Strategy to bring together "10,000 to 15,000 people in a cluster of villages to create an 'epicenter...'" (The Hunger Project, 2015: 2). THP-Ghana works to implement the Her Choice program across several of their epicenters. Per the agreed upon terms, THP-Ghana permitted me access to two



epicenters, Boti and Akpo-Akpamu, in Ghana's Eastern Region for the fieldwork portion of this research.

#### **1.4 Research aim and relevance of study**

This research adds to the scarce literature on broader experiences of well-being, rather than solely physical health, of girls married as children and the influence of local context. In order for development programs to combat negative health and well-being outcomes for girls and women, it is critical to fill the context- and location-specific knowledge gap that currently exists related to how married girls experience and attempt to improve their overall well-being and who supports or counters those efforts.

This research has social relevance because though there is significant (though repetitive) literature on child marriage, there is less literature available on the specific context in which child marriage occurs in Ghana and in the country's Eastern Region. There is also an overall lack of information and understanding regarding married girls' priorities related to their well-being. By gaining this missing data, enhanced programming can be designed to better meet the needs and desires of these girls. Additionally, collecting this missing data could also help to inform single girls of what the implications might be of being married at a young age, which is particularly useful within this context as some Ghanaian girls desire to be married because they see it as a better way to secure a livelihood than in their parental home (Koster et al., 2017: 29).

The findings of this research contribute to the discussion of well-being rather than health as a proper development indicator by which to design development programming so as to best meet the needs of girls and women in these communities. Further academic relevance of this study lies in the exploration of the agency girls do or do not exert and the structural factors that help and/or hinder them with regard to early marriage and their well-being or ill-being experiences. Given that much of the development discourse frames child brides as victims, it is important to explore the ways in which this is or is not correct so as to both have respect for their roles in their marriages and achieve the best development outcomes for these girls.

## **1.5 Thesis outline**

This thesis is organized into seven chapters, including this introduction. This chapter introduced the problem statement, literature review, and relevance of the study. Following this is a chapter concerning the theoretical framework, which will provide an overview of the concepts that this research draws upon. The third chapter explains the research methodology, including the research questions and sub questions, conceptual scheme, data collection and analysis methods, and ethics and limitations of the study. Following are three chapters related to the empirical findings of the research. Chapter Four will examine the motivations for early marriage of both girls and support individuals in their lives. The well-being experiences of girls both before and after early marriage are explored in Chapter Five, while Chapter Six looks at the actions through which girls and women attempt to promote their own well-being and who they see as being supportive or destructive to that. Chapter Seven discusses the research and provides a conclusion, as well as recommendations for further research, policy, and practice.

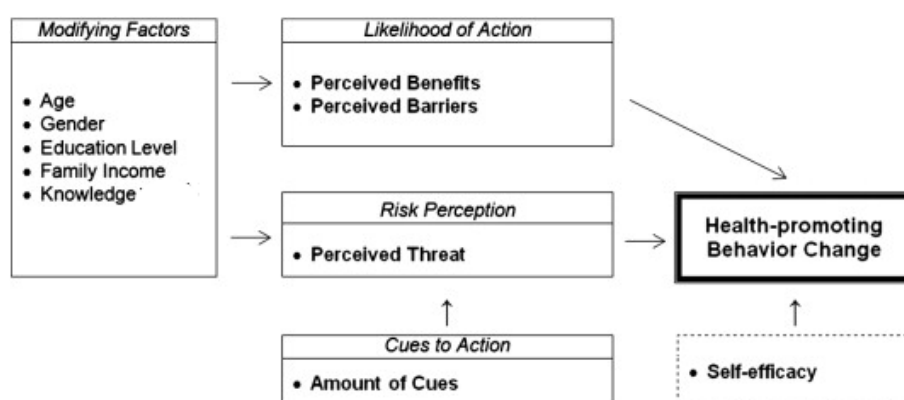
## **2 Theoretical framework**

This research engages with theoretical concepts and models drawn from themes presented in the literature that was examined in the previous chapter.

### **2.1 Health Belief Model**

The Health Belief Model (HBM), popular within public and global health since its inception in the 1950s, is a psychological model that works to predict health behaviors. It has four main components: (1) perceived risk or susceptibility, which is concerned with a person's thoughts on their chances of having a particular condition; (2) perceived severity, which reflects a person's concern with the seriousness and consequences of a particular condition; (3) perceived benefits and perceived barriers, which illustrate a person's belief in the success of and then costs of taking action; and (4) cues to action, which represent awareness or reminders about addressing a health concern (Menon and Szalacha, 2008). Later designs of the HBM also include the concept of self-efficacy (Menon and Szalacha, 2008), which Bandura defines as "concerned with

judgments of how well one can execute courses of action required to deal with prospective situations” (1982: 122). Self-efficacy and other components of the HBM will be critical to understanding the action or inaction married Ghanaian girls and women take related to their health or well-being. Per the Model, a girl’s belief in her control (i.e. self-efficacy) over a behavior change (in combination with perceived barriers or threats or other modifying factors within which she finds herself) would result in her taking or not taking action to better her health and well-being.



**Figure 1: Health Belief Model (adapted from: Lo et al., 2015: 198).**

This model is particularly useful within the context of the work that The Hunger Project and Her Choice program are doing as they are working, among other things, to provide both better knowledge of sexual and reproductive health as well as access to health services for girls and women. Within the context of this research, applying the Health Belief Model could assist with understanding at which point in the model intervention is needed to yield better health outcomes for married girls and women.

## 2.2 Agency and structure

Within the context of child marriage and the related experiences of ill-being, girls are often framed as being non-consenting actors or victims to their marriages and the associated well-being consequences in two ways: first, because they are physically forced to marry by their families or second, because they are so disadvantaged by the context within which they live that they have no choice but to marry. However, the framing by development actors of girls as passive actors and, thereby, early marriage as something that happens *to* them rather than a



decision they also play a part in, has proven to be controversial. As was mentioned in sub-section 1.2.2, some girls may view marriage as something that could improve their well-being by removing them from the poverty they experience in their familial homes.

It is because of this frequent framing of girls and women as non-consenting actors within much of the literature on child marriage that the concepts of agency and structure will be employed in this research as a framework for understanding first, how married girls make decisions about their well-being and, second, how a girl's ability to better her well-being is influenced, be it positively or negatively, by her marriage, the context within which she lives, and the support individuals in her life. The agency and structure framework has also long been used to understand health behaviors within the social sciences, which makes these concepts an ideal vantage point from which to understand the realities found in this research (Veenstra & Burnett, 2014).

Choby and Clark define the term "agency" as "an individual's positioning within a network of power relations, which defines a set of limits and freedoms shaping action" (2014: 90). Similarly, Ahearn describes agency as "the socioculturally mediated capacity to act" (2001: 112). In other words, the exercising of agency is concerned with decision-making and the ability to act. Further, these definitions make clear that rather than acting completely freely, individuals can have their agency shaped by external constraints and facilitators. Perceived self-efficacy corresponds closely to the concept of agency in that they both relate to an individual making a decision and shape what action that individual sees as possible in a given situation. Within this research, a girl's agency could evolve over time and may differ depending on the contextual situation, marriage, for example, she finds herself in.

These contextual changes and the shaping of the level of agency a girl might have are known as "structure." Choby and Clark define this concept as "the network of relations through which society, its institutions, and power relations are produced and reproduced" (2014: 91). Structural factors that influence, constrain, or facilitate agency can include cultural, economic, political, and social norms. Specifically, this research will inquire about how economic status, marital status, gender norms, and availability and types (whether traditional or

Western) of health services might influence the agency of girls and women in these communities. I expect that girls will find their decision-making influenced by several of these structural factors at perhaps different times in their lives. As such, I will inquire into their agency related to their well-being behaviors both before and after marriage to gain an understanding of whether and how well-being priorities and decision-making evolve after marriage.

Given the nature of the relationship between structure and agency and the fact that they can both evolve over different times and spaces, agency can be understood as part of a continuum rather than a duality of have or have not. For example, Klocker describes agency in terms of “thickness” and “thinness.” “...‘Thin’ agency refers to decisions and everyday actions that are carried out within highly restrictive contexts, characterized by few viable alternatives. ‘Thick’ agency is having the latitude to act within a broad range of options...” (Klocker, 2007: 85). This idea of thin agency might be used to understand why girls may seek marriage at an early age or choose to address or ignore a well-being issue.

Further, Klocker understands that structure, including community and cultural contexts and personal relationships “...can act as ‘thinners’ or ‘thickeners’ of individual’s agency, by constraining or expanding their range of viable choices” (2007: 85). The influence structure has on the thinning or thickening of agency may be used to understand and explain how a certain girl’s well-being might be at a greater disadvantage than others due to her positioning within the power relationships and social structures she finds herself in. More broadly, the thinning or thickening of agency will be important for understanding and interpreting the actions related to well-being that girls do or do not take and how they negotiate structural components, such as power relations, norms, and contexts, which may vary over time and space.

### **3 Research methodology**

This chapter describes the research design and methods by first explaining the research questions and then considering the conceptual scheme, epistemology, research location, units of analysis, and data collection methods. Following that

is an explanation of the quality criteria, limitations of the research, ethics, and reflexive positioning.

### **3.1 Research question and sub-questions**

Based on the conceptual framework presented in chapter two, this research aimed to gain an understanding of how child marriage influences the well-being of girls and their related agency. Taking that as well as the context and location-specific knowledge gap into account, the following research question was formulated:

- How does child marriage influence experiences of and agency related to well-being amongst girls in rural Eastern Region, Ghana?

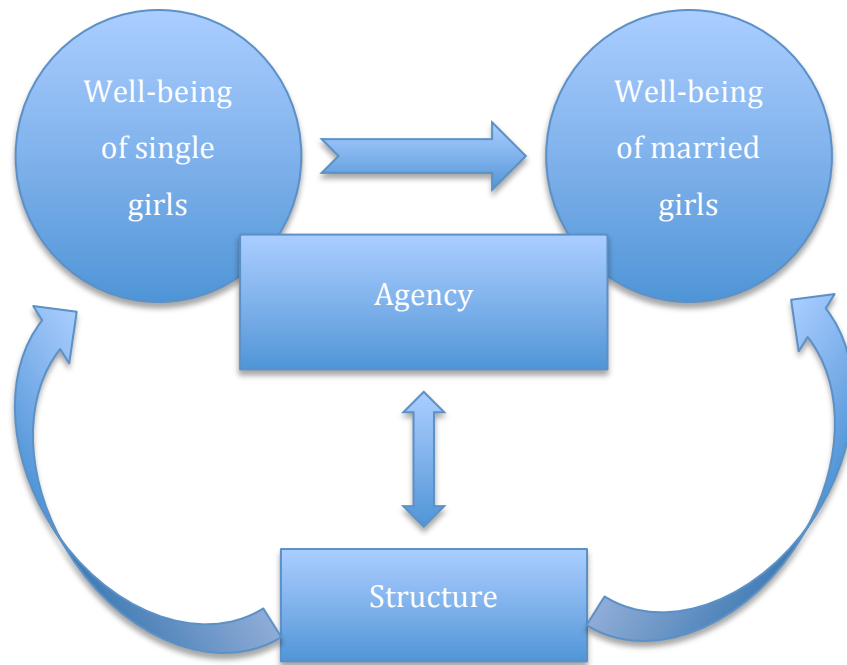
To help explore the main research question, the following sub-questions were prepared and will be answered in Chapters Five, Six, and Seven:

- For what reasons are girls and significant individuals in their lives motivated to pursue child marriage?
- How is well-being experienced by girls and women both before and after marriage?
- Which significant others and/or institutions and/or circumstances in girls' lives are perceived by girls to support or undermine their well-being?
- What actions do married girls take to promote their well-being?

### **3.2 Conceptual scheme**

This conceptual framework highlights the main concepts that contributed to this research and their relation to one another. Central to the research is the well-being of married girls, with the understanding that an individual's well-being might evolve as a girl goes from being single to being married. Influencing a girl's well-being (be it positively or negatively) is the local structural context in which she exists, which includes the sociocultural norms and practices related to child marriage and well-being, the various intersections that make up her life, including socioeconomic status, education level, (dis)ability, etc., and the support from individuals and institutions that is present in her life. Also taken into account in this conceptual scheme is a girl's opportunity to exercise agency (or self-efficacy within the HBM) both within and outside of marriage, which can

positively or negatively affect her well-being. Further, it is understood that both structure and girls' agency influence each other. The particular ways in which the concepts were operationalized can be found in the appendix.



**Figure 2: Conceptual scheme**

### **3.3 Epistemology**

The purpose of this qualitative study is to understand the experiences and agency related to well-being of young women and girls. Further, this study works to understand the intrinsic differences in the experiences of young women and girls as a result of their own personal circumstances and the community norms present within their local context. As such, an interpretivist epistemological position that recognizes knowledge to be relative rather than absolute, even between individuals in the same social setting that influences it, was taken in this research (Bryman, 2012: 28-32).

### **3.4 Research location**

Koforidua, the capital of Ghana's Eastern Region and home to one of The Hunger Project's regional offices, was the research base for this project. The city is located within the New Juaben Municipal district, which has an estimated population of 183,727 people (Ghana Statistical Service, 2012: 4). Some informal data collection occurred in Koforidua, but the majority of data collection took

place at and around two Hunger Project epicenters located in the rural areas of Boti and Akpo-Akpamu. THP-Ghana chose these two epicenters for the research prior to my arrival because the locations are in fairly close proximity to Koforidua and are two of the communities in which the Her Choice project is being conducted. These locations fall approximately 23-27 kilometers northeast of Koforidua. Both the Boti and Akpo-Akpamu epicenters bring together eight rural communities to create and carryout programming. The map below highlights Ghana's Eastern Region and the town of Koforidua.



**Map 1: Map of Ghana's Eastern Region**

**Source:** [www.bbc.co.uk/worldservice/Africa/2008/11/081126\\_ghana08\\_koforidua.shtml](http://www.bbc.co.uk/worldservice/Africa/2008/11/081126_ghana08_koforidua.shtml)

The communities that these epicenters service are remote and poor road conditions make travel challenging, particularly in the rainy season. Though for this research I traveled from village to village via car, the vast majority of the population who are served by these epicenters walk to them with some villages being quite nearby (perhaps 15 minutes walking) and others much farther away. Among these villages, nearly all have electricity though some received it rather recently. Economic statuses and, thereby, living standards are similar across the different villages and families. The majority of families farm vegetables, including cabbages, yams, and maize, both for sustenance and as a way to make an income. Further entrepreneurial activity like bead making and selling of foodstuffs at local markets is also common. Nearly everyone who I spoke with mentioned that they suffered, sometimes seasonally due to farming, with

poverty. However, there are clearly levels to this poverty based on observation of home types and other observable characteristics.



The types of building materials used for homes seem to correlate to a person's economic situation. Many of the IDI participants lived in mud homes, which were often in poor condition. Francis, on the other hand, who spoke to me of her good economic fortune, lives in a concrete home with windows, doors, and fencing around the house. Similarly, her chickens and goats are kept separate from her home. This differs significantly from other IDI participants whose livestock are not kept separate from the family's living quarters.

**Photo 1: Photo of THP-Ghana Akpo-Akpamu Epicenter**



**Photo 2: Photo of THP-Ghana Boti Epicenter**

### 3.5 Units of analysis and sampling methods

The primary units of analysis were married girls (ages 12-17) and women who were married as children (currently aged 18-24). Data was also collected from support individuals and community members, including husbands, parents, and healthcare workers, who play significant roles in the lives of girls and women. These primary units of analysis were carefully selected to cover a variety of demographics, including current age, age at marriage, age at first childbirth, hometown, school attendance, and socio-economic class.

After arriving in Koforidua, leaders in the community were asked by THP-Ghana staff to inform girls and women with the desired demographic background that focus group discussions (FGDs) related to child marriage and well-being would be taking place and to come to the epicenters on particular days at particular times if they were interested in participating. From that larger population sample (see Figure 3), purposive sampling was used to select girls who met the desired demographic factors (age, marital status, age at first childbirth, etc.) for participating in the research.

<i><b>FGDs</b></i>		<b>Boti Epicenter (n=24)</b>	<b>Akpo-Akpamu Epicenter (n=17)</b>
Age group	12-17 years	5	1
	18-24 years	19	16
Total		24	17

**Figure 3: Summary of larger FGD populations, including individuals who were not selected for FGDs**

Bryman defines the goal of purposive sampling as, “to sample cases/participants in a strategic way, so that those sampled are relevant to the research questions that are posed” (2016: 408). Purposive sampling was useful in this research to ensure that a wide variety of life experiences were explored with married girls and women and single mothers. Toward the end of the research period, snowball sampling was also employed to locate married girls and women and single mothers. Convenience sampling was used for the FGD with community support individuals and health workers. For the FGD with community support individuals, THP-Ghana had already scheduled a community meeting in Bosotwi. I used that previously scheduled opportunity to purposively sample community members to participate in the FGD. Early in the fieldwork



period, I asked a THP-Ghana staff member to introduce me to a healthcare worker in the community to discuss with her findings that had come out of FGDs with girls and women. Toward the end of the fieldwork period, I again asked another THP-Ghana staff member to introduce me to a second healthcare worker in the community. This second interview allowed me to explore further topics that had come up during the entire research period.

### **3.6 Data collection methods**

Different qualitative data collection methods were employed in this research project. Data collection started with focus group discussions, after which individual semi-structured interviews were conducted. Informal conversations occurred throughout the fieldwork period.

#### ***Focus group discussions***

In order to gain a general understanding of the lived realities of girls in the communities in which I would be conducting research, I began the fieldwork period with FGDs. The intention was to hold two FGDs at both the Boti and Akpo-Akpamu epicenters, one being with married girls aged 12-17 and the second being with women aged 18-24 who married before the age of 18. FGDs are an effective data collection tool for gathering information related to community norms and expectations for girls and assisted in gaining an initial understanding of the context within which child marriage takes place and the actions girls feel they can take to improve their well-being. Hosting the FGDs at THP-Ghana epicenters provided a safe and familiar space to the girls in which to discuss these sensitive topics, as well as to introduce myself. This familiarity would prove critical for those girls who also participated in in-depth interviews, in the hope that they would feel comfortable opening up about their personal experiences.

Following the guidance of Bryman (2016), the intent was to keep FGDs to small groups of participants (i.e. 5-8 individuals) with the aim being to understand the potentially different perspectives of the individuals within the group. However, occasions did occur in which a desired informant arrived late and joined a group that did not match with her age and/or increased the group size. In total, 17 girls and women participated in two FGDs at the Boti epicenter,

with one group consisting of five 17-year-old girls, two 18-year-olds, and one 20-year-old woman. The second FGD included five 18-year-olds and four women aged 20 to 23-years old. At the Akpo-Akpamu epicenter, 11 girls and women participated in two FGDs. The first group consisted of six women aged 18 to 23-years-old. The second FGD included one 17-year-old girl and four women aged 19 to 22-years-old (see Figure 4).



**Photo 3: FGD  
with girls at  
the Boti  
Epicenter**

It became clear upon arrival at the Boti epicenter that a number of girls in the larger pool of possible participants were single mothers who had given birth before the age of 18. Believing that their perspectives might add additional layers to the research regarding the choice to marry early and/or how well-being of single mothers might differ from married girls, the decision was made to include them as a unit of analysis. As such, single mothers currently aged 12-17 and 18-24 (but who had given birth before the age of 18) also participated in FGDs and in-depth interviews.

The same FGD guide (see appendix 9.4) was used to steer the conversations, but freedom was given to participants to speak about the topics they found to be most relevant to them. Conversations began by asking girls and women to define what marriage meant to them, what they saw as motivations for child marriage, and if there were specific characteristics about a girl that made her more likely to marry young. The discussions then moved on to explore their awareness of general well-being issues related to child marriage and how a

girl (whether married or a single mother) might act to improve her well-being as well as what services and support are available for doing so. These FGDs lasted between one and one-and-a-half hours.

Additionally, one FGD took place with seven community support individuals in the community of Bosotwi, which is serviced by the Boti epicenter. Individuals in this FGD included a religious leader, chief, queen mother, and other community elders. The purpose of this discussion was to understand how community members and leaders perceive child marriage, girls who marry or become mothers before 18 years of age, and the related well-being issues. Furthermore, this FGD was used to gain insight into the role that community members play in supporting married girls and single mothers (see appendix 9.5).

THP-Ghana employees speaking Twi and/or Krobo acted as interpreters during all FGDs to address language barrier issues, though some participants did occasionally communicate in English. To facilitate the FGDs, I led the conversations as the moderator with the interpreter then relaying the questions to the FGD participants. The interpreter would then relay the participants' answers to me, which allowed for follow-up questions or clarification if necessary. The FGDs were recorded after receiving informed oral consent from all of the participants.

<i><b>FGDs</b></i>		<b>Boti Epicenter (n=17)</b>	<b>Akpo-Akpamu Epicenter (n=11)</b>
Age group	12-17 years	5	1
	18-24 years	12	10
Marital status	Single mothers	13	5
	Married	4	6

**Figure 4: Summary of FGDs with married girls and single mothers**

### ***In-depth interviews***

After the completion of the FGDs, 14 in-depth interviews (IDIs) were conducted with married girls, women who were married as children, and single mothers (see Figure 5). Each interview lasted between 30 minutes and one-and-a-half hours. These IDIs were used to capture life stories and to gain an understanding of the well-being experiences that girls in the research location live with. The majority of the IDIs occurred at the home of the participant (or a relative's

home) in an effort to ensure she was in a location that she was familiar and hopefully comfortable with. One interview with a single mother took place at the Boti epicenter, while two other interviews with single mothers took place at a local school.



**Photo 4: IDIs with women near Boti**

Bryman describes semi-structured interviews as those that begin with topics to be covered, though not necessarily to be asked in any particular order, but that give interviewees space in how they reply (2016: 468). As such, an interview guide (see appendix 9.3) was prepared to steer the interview and address topics related to the research question(s), but participants were free to speak about the topics they found to be most pertinent to their health and well-being experiences as well as ignore topics they were less comfortable speaking about. If certain topics seemed more pertinent to a particular research participant, more time was spent discussing those. For example, girls and women had a lot to share about their mental well-being and significant time was spent discussing that, whereas they were less concerned with social well-being which then was generally discussed very briefly. Further, girls who were married to a second partner sometimes seemed, based on physical mannerisms including the wringing of hands, to be uncomfortable discussing their first partners. In general, topics for discussion included experiences of well-being and how these (may) have changed since being married, motivations for early marriage, who/what girls and women believe support or undermine their well-being, and actions girls and women take to better their well-being.

In addition to the IDIs conducted with girls and women, two interviews took place with nurses who are currently or were previously employed at either the Boti and Akpo-Akpamu THP-Ghana epicenters. The first interview took place shortly after the completion of the FGDs with girls and women. Themes that arose in the FGDs could be discussed from the healthcare provider's perspective which then informed the in-depth interview guide for use with girls and women. The second interview with a nurse came at the end of the fieldwork period allowing for further clarification and insights.

The majority of IDIs with girls and women were recorded after having received informed oral consent. Due to time constraints related to their schooling, two of the IDIs with single mothers were not recorded; instead, detailed notes were taken during the brief interviews. While informed consent was received from the nurses who were interviewed, the discussions were not recorded. Instead, detailed notes were taken. All of the IDIs were conducted through an interpreter with me leading the discussion.

<i><b>IDIs</b></i>		<b>Boti (n=7)</b>	<b>Akpo-Akpamu (n=7)</b>
Age group	12-17 years	2	2
	18-24 years	5	5
Marital status	Single mothers	2	2
	Married	5	5

**Figure 5: Summary of IDIs with married girls and single mothers**

### ***Informal conversations***

Throughout the research period, I was able to interact with a variety of members, including adult men and women, of the Boti, Akpo, and Koforidua communities. These interactions and conversations informed the general context of the research, particularly related to community norms and expectations for girls. Individuals with whom these conversations occurred also provided insight into the different perspectives of individuals living in suburban and rural communities. For example, several individuals with whom informal conversations occurred in Koforidua, a more suburban community, were unaware of the extent to which child marriage occurred in rural areas of Ghana whereas those individuals living in the rural communities recognized it as a

frequent occurrence. While these conversations were not recorded, notes were taken afterward to document specifics of the discussion.

### ***Field notes***

Throughout the fieldwork period, both jotted and full field notes, including observations and reflections related to the research, were taken during interviews and FGDs and at the end of each day (Bryman, 2012). Notes included descriptions of physical surroundings, participant body language, interactions between participants and family members, and personal reflections on the interviews and research process. These notes have been useful in being reflexive on my place as a researcher in the research process and in being reflective in identifying themes that frequently emerged from informal conversations, interviews, and FGDs.

### **3.7 Data analysis**

Recorded IDIs and FGDs were transcribed in the field, from which major topics and themes were identified. Additionally, having travel time to and from the field allowed for the discussion of findings and themes with my interpreters. This was particularly useful because they could elaborate and provide further cultural context on issues that were raised in the interviews. The identified themes were then applied as topics of discussion to successive IDIs and FGDs in the hope of having saturated categories of discussion at the end of the data collection period.

Upon return to the Netherlands, I embarked on the task of manual coding with the already established preliminary codes and themes that emerged from the research in the back of my mind. Given the exploratory nature of the research, open coding was employed with the transcriptions to add more substance to the preliminary codes and themes. By reading through each transcript, I highlighted passages that girls expressed as being and/or I felt were important to the experiences of well-being and agency. The transcribed interviews and FGDs were coded within Microsoft Word to allow for easy access and continued security. After arranging the codes under broader themes, they were positioned under sub-questions that would be addressed in empirical chapters. Field notes and my fieldwork diary, along with the two interview methods, were used to triangulate the data.

### 3.8 Reflections on quality

Bryman, based on Lincoln and Guba, outlines the means through which to verify the reliability and validity of qualitative research. These criteria consist of *trustworthiness*, including *credibility*, *transferability*, *dependability*, and *confirmability*, and *authenticity* (2012: 390). *Credibility* is concerned with how the research understands social reality. Being introduced to the communities and accompanied on interviews by THP-Ghana staff members who are already well-acquainted with local individuals aided in increasing the credibility of this research. Furthermore, significant time was spent building rapport with individual interview research participants so as to ensure their comfort with the research process. In spite of this, there were instances in which girls were uncomfortable with the line of questioning and hesitant to respond. When it felt like confusion, rather than discomfort with the question, might be the issue, questions were rephrased to make sure they were being properly understood. If issues persisted, girls were reminded that they could skip a question. For FGDs, less time was available to devote to getting to know the participants and allow them to get to know me. The days of these discussions were my first time meeting the participants. Still, the interpreters and I took care to speak casually with participants before the FGDs and thoroughly explain the purpose of the discussion to them in an effort to ensure their comfort. It was also beneficial to be accompanied by a THP-Ghana interpreter, whom research participants already know well. Additionally, as was previously mentioned, triangulation of data collection methods was used in an effort to reduce bias that could emerge from using only one data collection method. Finally, throughout and at the end of the fieldwork period, significant discussion time was spent with THP-Ghana staff members asking for their opinions on my interpretations of the data collection. This allowed me to compare their professional opinions and experiences with the content that was being provided by the research subjects.

Like other qualitative research, this project focused on gaining specific, in-depth contextual information, which can make *transferability* to other contexts difficult (Bryman, 2012:392). However, being that this research focused on well-being experiences within child marriage (something that is practiced around the world), some of the experiences that were shared could be familiar to

girls and women in comparable situations in other areas of Ghana and other countries. The richness of the data collected will help the reader to assess whether my interpretation of and arguments related to the findings of the research can be transferred to other contexts.

*Dependability* refers to the reliability of qualitative research and asserts that detailed records should be kept of the entire research process so as to maintain transparency (Bryman, 2012: 392). From the beginning of the research process, detailed records and field notes related to the data collection process were kept that could be used for a peer audit (Bryman, 2012: 392).

Bryman refers to *confirmability* as being “concerned with ensuring that, while recognizing that complete objectivity is impossible in social research, the researcher can be shown to have acted in good faith...” (2012: 392). My position as a white Western woman and how that might be interpreted within the context of the research and research location was seriously reflected on both before, during, and after the fieldwork period in an effort to ensure that my personal background did not unduly influence the research or research participants. Throughout the research period, my interpreters and I took care to ensure that research participants felt comfortable to express themselves. Further, I sought clarification related to statements made by research participants numerous times throughout the data collection period to confirm that the interpreters and I correctly understood their views. This ensured that those views could, eventually, be portrayed appropriately throughout this thesis.

Finally, *authenticity* is concerned with fairness during the research process and how the research could have a larger impact to benefit the lives of the informants (Bryman, 2012: 393). This thesis will be shared with THP-Ghana in an effort to help them better understand the lived realities of the girls and women they are working with in the Her Choice initiative. Hopefully these findings will assist them in addressing issues that girls and women in the Boti and Akpo-Akpamu communities consider important. Further, the variety of research participants contributes to a more holistic view and a fair representation of the communities and community members.



### **3.9 Reflexive positioning and ethical considerations**

Child marriage by itself is a complex and deeply personal practice. When combined with well-being and ill-being, the sensitivity of the topic being explored by this research was magnified because it explored several facets of a girl's personal life. As such, ethical considerations were taken into account before, during, and after the period of research.

#### ***Informed consent***

Before the beginning of any interview or FGD, participants were educated on the nature and purpose of the research, that though I was working alongside THP-Ghana (an organization with which they were familiar) they were not under any obligation to speak with me because of a prior allegiance to the organization, and that they were free to leave the discussion or not answer any question they were uncomfortable with.

Initially, the intention was to receive signed consent forms from participants before interviews or FGDs began. After arriving in Ghana and discussing this intent with my local supervisor, I was advised that receiving verbal consent was likely a better option. THP-Ghana staff members had previously experienced rural community members, like those with whom I would be working, being uncomfortable with signing forms. As such, this advice was taken and verbal consent was received from all research participants before data collection began.

While the majority of the research informants were above the age of majority and no longer considered children, several informants were either 17 years old or unsure of their age, which could potentially put them below the age of majority and brings up ethical considerations related to conducting research with children. Upon arrival in Ghana, local consultation was done with THP-Ghana staff members to determine who other than the girls themselves should give consent for their participation in the research (Graham et al., 2013). THP-Ghana staff explained that while the girls being asked to participate in this research may be legally considered children, they live in such a way (i.e. being mothers and/or being married) that they are viewed in their communities as adults. As such, THP-Ghana advised that no consent from parents, husbands, or anyone else would be needed or expected for this research.

Still, consent was taken very seriously especially considering the sensitive nature of the topics of discussion. Following guidance from a UNICEF publication regarding conducting ethical research with children, consent was informed, given voluntarily, and renegotiable (Graham et al., 2013: 57-59). At the beginning of a FGD or IDI, a pre-drafted script regarding the research and collection of data was read to research participants. This script included information about the nature of the research and intentions for how the captured data would be used. Furthermore, it explained to participants that their responses would be kept as password-protected digital files in an effort to ensure confidentiality. Participants were also informed that their name and other identifying information would not be included in the written work in an effort to ensure their privacy.

### ***Confidentiality***

As was previously mentioned, to ensure the anonymity of participants, all collected data, including participant names and other identifying information, responses, field notes, and interview transcripts, are kept secure as password-protected digital files. Further, pseudonyms have been assigned to respondents for use in this thesis to safeguard a response from being traced back to a particular person.

### ***Reflexive positioning***

As authors Guillemin and Gillam suggest, the researcher's reflexivity both ahead of the research (in thinking of the impact it might have on participants) and during it (in planning for uncomfortable or "ethically important moments") are critical to maintaining an ethical period of research (2004: 277). In terms of positionality, being a white, Western woman conducting research in Ghana had the potential to bring a variety of challenges to this project. In particular, research subjects might have been hesitant to discuss their experiences with child marriage and well-being with me because of their perceptions of what my biases might be. Fortunately, THP-Ghana staff members were present as a gatekeeper and introduced me to the communities, which hopefully reduced some of the participants' fear or apprehension of speaking to an outsider of the community. I tried to assure potential research participants and the larger communities that my presence was aimed at understanding the experiences and

expectations of the people living within the community. Further, I informed participants that the information they provided could potentially positively impact THP-Ghana programming to help the organization better address the issues being experienced in these communities.

Additionally, given the variety of research subjects involved in this project and the THP-Ghana staff members acting as gatekeepers and interpreters, my positionality within power relations changed depending on the research participant. As such, power relations were reflected on as the research went on, and I adjusted myself accordingly and as much as possible for the comfort of the research subject. Positionality and reflexivity within research evolve constantly and were reviewed frequently before, during, and after the research period to better engage with the research in a meaningful way, as suggested by Sultana (2007).

### **3.10 Limitations of the research**

In an effort to maintain transparency of the research project and thereby increase its reliability, limitations of the research are discussed below.

#### ***Use of interpreters***

While English is the official language of Ghana, it became clear upon arrival in Koforidua and after discussions with THP-Ghana that I would have to employ an interpreter. Given the rural setting of the research and that much of the research population received limited formal education, English language skills were sparser than I had anticipated. While significant literature exists on the drawbacks of having an interpreter, whether because of the increased time involved in data collection, issues with meaning being translated properly, or having a negative impact on the pace of interviews, the positives far outweighed the negatives from my perspective as a researcher (Skjelsbaek, 2016: 505; Squires, 2008).

Patricia Osei Amponsah, the Her Choice Project Coordinator for THP-Ghana, acted as my first interpreter. Further on in the data collection period, two more interpreters, Thomas Danquah and Mustapha Shaibu, from THP-Ghana were provided to me. Before engaging them in interviews or FGDs, I expressed concern that their being male may negatively impact the comfort of the female

participants in speaking about their personal health and well-being. However, Ms. Osei Amponsah informed me that the other interpreters worked on the Her Choice program with THP-Ghana and that girls and women in the community would be comfortable speaking about these issues in their presence.

In an effort to limit the influence they could have on the research, interpreters were thoroughly briefed on the aim of the research project before their involvement. This meant to ensure that the statements made by research participants and the meaning behind those statements were captured and interpreted properly for my use and analysis.

### ***Limited time in the research communities***

The initial intention was for me to stay in either the Boti or Akpo-Akpamu communities with a host family or at a THP-Ghana epicenter during the fieldwork period. Upon arrival in the field, I discovered that this had not been arranged and that the intention of THP-Ghana was to have me stay in a hotel in Koforidua, more than an hour away from the primary research locations. Though I requested assistance in finding alternative accommodation to give me more time in either the Boti and/or Akpo-Akpamu communities, this never manifested. As such, my time in the field was limited to daily trips to the communities a few times each week. Having stayed in the communities may have given me a closer association with community members.

Being largely absent from the epicenters and surrounding communities also had an impact on the potential participants I came into contact with. One of the demographic categories that this research aimed to be informed by was married girls currently between the ages of 12 and 17. However, the youngest married girls that I came into contact with through various sampling methods were 17 years old. Given that some of the married girls and women reported being married or having children before the age of 17, one could infer that married girls below the age of 17 are present in the communities but were unable to be contacted during this research project. This issue was further complicated by the fact that many individuals are uncertain about their age, which makes contacting them either directly or through snowball sampling difficult.

### ***Privacy***

Unfortunately, I could not always ensure the privacy of participants during the data collection process. During the research period, every effort was taken to ensure the privacy and confidentiality of research participants. However, this sometimes proved challenging because individual interviews took place at girls' homes and FGDs took place at THP-Ghana epicenters. Family members, neighbors, and community members dropping by frequently interrupted conversations. They were politely asked to leave if it appeared that they intended to remain nearby to listen to the conversations.

## **4 Child marriage in rural Eastern Region**

### **4.1 Introduction**

This chapter uses the views and experiences of married girls and women and community members in the Boti and Akpo-Akpamu communities to shed light on what motivates girls or significant individuals in their lives to either desire, encourage, or accept child marriage. Firstly, this chapter will explain the norms and traditions of child marriage within these communities, including the definition and process of the custom and the preferences of girls and their families either for or against marriage. Secondly, this chapter will discuss what encourages girls to engage in sexual relationships at early ages. Finally, specific personal situations that drive girls to seek out marriage will be described.

### **4.2 Practice of marriage**

Within these communities, the practice of marriage is ceremonial with none of the girls interviewed having completed a legal marriage through the state. Residents in the Boti and Akpo communities explained that a boy or man generally first proposes to the girl before the involvement of their families in the completion of certain marital rites. The ceremonial marriage rites include the couple's families first agreeing to the marriage. The groom's family then has to give the bride's family a dowry or bride price in the form of money, clothes, cloth, and alcohol. Penny (22-years-old, married, IDI) further explained that the alcohol is used as a libation *"to call the Gods, to tell them they [the parents] have*

*taken care of both children and now they are coming together as husband and wife.”*

Within FGDs, the majority of girls and women were very clear that relationships in which these rites had not been performed were not considered marriage. Another type of ceremonial bond between a man and a woman, a pregnancy rite, was mentioned in the Akpo communities, but this was not regarded as marriage. If a woman falls pregnant before being married, her partner can perform pregnancy rites that allow her to then move in with him. These rites include bringing the woman's family similar, but far fewer, items to those that are brought for marriage rites. Girls in a FGD explained that as a boyfriend-girlfriend relationship rather than husband-wife, though the man had the option of returning later to perform the full marriage rites. Residents of Boti communities were also asked about pregnancy rites but said that it is not common, illustrating a difference in traditions between the two areas.

Conversely, another woman in a FGD in the Akpo Epicenter explained marriage differently and in a way that relates closely to the precarious economic reality facing the girls and women living in these communities. She explained, *“I don't have a mother. I don't have a father. So anyone I see and think can help me, as a man, that's how I understand it to be married. I will be with the person because I think he can help me.”* This explanation is important for understanding what it often means to be married in these communities. Because in spite of the majority of girls participating in FGDs explaining that the rites need to be completed for a relationship to be considered marriage, these norms did not usually match the lived realities of self-declared married women who participated in IDIs. In fact, only one of the 10 girls interviewed individually who consider themselves to be married actually completed the marriage rites.

All of the girls participating in this study who consider themselves to be married intend or hope to eventually perform the traditional rites which they see as important an important part of marriage. For most of the grooms and their families, though, poverty is keeping them from being able to complete the marriage rites. Several of the girls and women interviewed have been married for five or more years and given birth to multiple children, but the formal marriage rites have still not been performed. In two cases, two grooms and their

families brought alcohol to the brides' families in an effort to show that they recognize and claim the pregnancy as the responsibility of their son. While not a complete marriage rite, this practice is done as a sign of respect to the bride and her family and makes the marriage arrangement more formal.

One of the women interviewed, for whom marriage rites have not been performed, indicated that she did not consider herself to be married. Moreover, she is living in an unhappy marriage and intends to leave her husband when she can afford to. It is my assumption that the idea of leaving her husband feels more culturally appropriate to her if she never considered herself to be married at all.

### **4.3 Premarital sexual relationships**

As was mentioned in sub-section 3.4, most families in these areas mention struggling with poverty either year-round or as it relates to their seasonal farming. Given that, most married girls and women, both in FGDs and individual interviews, report some type of economic need, be it school fees, food scarcity, or a health concern, as a reality for them when they were single girls living with their families. It seems that these economic needs and desires, more so or perhaps rather than sexual desire or genuine affection, often motivate girls to seek out or engage in premarital sexual relationships with men and boys who offer to provide them with funds or provisions. Joanna, who had her child at 14-years-old, shared that economic hardship, including starvation and finding transportation to school, led her to accepting an offer of money from a 20-year-old man and eventually engaging in a sexual relationship with him:

*"Sometimes feeding and transportation [were an issue]. So one day I was walking to school and met a guy who proposed and said he will assist me in schooling. From time to time, he was giving me money... I was going to visit him and pregnancy resulted out of it."* – Joanna (17-years-old, single mother, IDI)

Joanna's story illustrates a reality that was brought up time and time again: girls in need often find or are approached by boys their own age or older men who offer to provide them with something they feel they are lacking.

Sexual relationships between girls and their partners who offer them economic assistance are a condition of these arrangements. During a FGD in the Akpo-Akpamu Epicenter, one respondent, when discussing the onset of sexual

relationships for young girls, noted, *“Some of them [girls], too, they don’t have anyone taking care of them and they find themselves in a situation whereby they will need the help. Before the man will help you, he has to sleep with you...”* Girls participating in FGDs explained that the majority of girls in their communities engage in sexual relationships, sometimes as early as 11- or 12-years-old, with the goal being to receive economic assistance for their various needs. Further, participants find that a majority of girls in the communities become pregnant as a result of these premarital sexual relationships.

#### **4.4 Adolescent pregnancy**

##### **4.4.1 Awareness of the risk of pregnancy and use of family planning**

With the onset of sexual relationships that was discussed in the previous section, the risk of adolescent pregnancy and its aforementioned ill-being side effects becomes a concern for girls. The majority of girls report being aware of pregnancy as a possible result of sexual relationships with men. In fact, only one woman, Gillian (22-years-old, married mother of three, IDI), said she did not realize it was a possibility until she herself became pregnant; she believed at the time (when she was around 16-years-old) that she was too young to become pregnant in spite of being regularly engaged in a sexual relationship.

However, for the majority of the girls and women I interviewed, the economic hardship they were experiencing was severe enough for them to risk pregnancy for the economic support their partners offered. As Nell, now a married woman between the ages of 17- and 20-years-old (it is not uncommon for people to be uncertain of their age) who gave birth to her first child at age 12, explained, *“I knew I could get pregnant, but because there was no help I was just going [to my boyfriend].”* For some, that awareness of the risk of pregnancy came from discussions with family members, while those who had more schooling received sexual and reproductive health information in school.

In spite of the awareness of the risk of pregnancy, the vast majority of girls who are now mothers report that they did not use any family planning method prior to becoming pregnant but did not desire to conceive a child. They gave various reasons for non-use of family planning methods:



Sally, who became pregnant at 15, said that while she knew having sex could cause pregnancy, she was too young when first having sex to know of family planning methods and, as such, did not use any. She was the sole research participant to indicate that she was ignorant about family planning.

Another reason for non-use is the pervasive fear of family planning methods. Most of the girls and women interviewed individually explained that they were not using family planning before their first pregnancies because of stories they had heard about other girls and women getting sick, bleeding, having heart attacks, or even dying from the use of hormonal birth control. Ingrid, who had her first child at age 17, told me, *"I was scared because I heard when you used it you could get heart attack."*

Joanna, a single mother who became pregnant at 14, was the only participant to attempt to use family planning methods before becoming pregnant with her first child. Her partner, a 20-year-old man, informed her that he was using condoms to prevent pregnancy. It was unclear whether condoms were actually in use during every sexual encounter in this relationship or if a condom failed to prevent Joanna's pregnancy.

The type of birth control that was most frequently brought up during my discussions with research participants was a hormonal implant that is effective for a five-year period. A few participants discussed the use of condoms or the birth control injection. At government-sponsored clinics, which are present in both the Boti and Akpo-Akpamu Epicenters, an implant costs 25 Ghana Cedis, which equates to less than five Euros. Nurses in the epicenter clinics told me that it was not uncommon to provide birth control to single girls and girls as young as 12- or 13-years-old seek it out themselves without being accompanied by a parent.

While most girls and women told me that they would be able to access birth control if they chose to, the precarious economic situations in which young girls in these communities find themselves make it hard to imagine that, financially, it could be accessed year-round (given the importance of seasonal farming) or that a young girl would prioritize spending the money she receives from her partner on family planning rather than on her other needs.

#### **4.5 Pregnancy as a driver of early marriage**

Given the number of young people engaged in sexual relationships (which girls in FGDs asserted to be the majority of their peers) and the low usage of family planning, it is no surprise that adolescent pregnancy is a frequent reality. FGD participants informed me that they believed the majority of girls in their communities become pregnant before the age of 18 with many then marrying their partner and father of their child. One FGD participant at the Akpo-Akpamu Epicenter told me, *"You get pregnant before you start considering marriage. [Those] who come and get married before pregnancy is just a few."*

##### ***Role of parents***

In speaking with individuals who play supportive roles in the lives of girls and women, it is clear that parents have a key role to play in whether or not a girl marries her partner after becoming pregnant. In the FGD with support individuals in the community of Bosotwi, the motivations for parents to encourage their daughters to marry early after becoming pregnant were discussed.

While nearly all girls, women, and support individuals interviewed for this research were careful to say that parents do not "force" girls to marry, it was evident that parents generally do not intervene to prevent their daughter from marrying after she becomes pregnant. Firstly, parents often believe that their daughters are "wicked" or "bad" for engaging in sexual relationships when they should have known better or had been warned against it by their parents. That frustration with their daughter is often enough for parents to acquiesce to the idea of her leaving their home to either become married or live with the father of her child. Secondly, motherhood within these communities is often seen as a step into adulthood, giving parents the freedom from having to care for their child any longer. One community elder said in a FGD, *"If you have given birth, you can't stay with me because you're an adult. So you have to go."* Similarly, parents would face the added economic burden of having another mouth to feed if they allowed their daughter and grandchild to live with them.

Interestingly, the participants in the Bosotwi FGD (which did not include married girls or women or single mothers) asserted that the majority of girls stay with their parents after becoming pregnant rather than marrying, which

counters the argument made by girls and women in FGDs. In my experience in the communities, I found it far more difficult to locate these single mothers rather than married girls. This may indicate a difference in customs in the Bosotwi community versus the other communities or an unawareness of the living situations of girls on the parts of these community leaders.

### ***Girls' decision-making related to marriage***

Apart from the influence parents' motivations likely have over whether a girl marries early, girls assert that they choose whether or not they marry. However, upon further scrutiny, it is apparent that there are limited options for girls who find themselves pregnant outside of marriage making the definition and understanding of the concept of 'choice' a narrow one. This is evidenced by the situation Phoebe, a 17-year-old married mother of one, found herself in after becoming pregnant. In our conversation outside the home she shares with her husband, she was clear when telling me that she did not feel pushed or forced into marriage by anyone. At the same time, though, she did not want to get married:

***Facilitator:*** *Do you feel like you had a say in getting married? Or was something else pushing you to get married?*

***Phoebe:*** *Nobody pushed me.*

***Facilitator:*** *You wanted to get married?*

***Phoebe:*** *No. I wanted not to marry, but no one also pushed me to marry.*

***Facilitator:*** *So if you didn't want to marry, why did you?*

***Phoebe:*** *Because of my child. If I had gotten someone to help me [economically], I wouldn't have ended up marrying. But no one was there to help.*

Given that her parents refused to provide financial support for her or to allow her to remain in their home, Phoebe did not see another option for survival if she did not marry her partner. Phoebe's story reflects those of many other girls in the communities who assert that they themselves chose to marry, but whose economic and social situations gave them few alternatives when their parents refused to continue to support them.

Alternatively, some girls and women reported the desire or willingness to marry either because they continued to believe it was a way out of the poverty they experienced in their familial homes or because they were resigned to

marriage being the next step after having become pregnant. When asked if she wanted to marry her husband after finding out she was pregnant, Penny (22-years-old, married, IDI), who was 14-years-old when she married, replied: *“Yes, because I also thought he would be able to assist me and I would also be a partner. So I was looking forward to that.”* For Penny, marriage represented economic and social independence from her parents, which she craved. Her parents did not attempt to deter her from the idea of marrying the father of her child. In fact, parental intervention in a situation in which a girl desires to be married is limited. Several girls and women reported telling their parents that they were pregnant and intended to move in with their partners. When their parents *“didn’t say anything,”* the girls proceeded to move in with the fathers of their children. For most of them, this constituted as a marriage in spite of the marriage rites generally not having been performed.

So while marriage is not the goal for most girls when they begin to engage in sexual relationships, it is almost an inevitable result given the perfect storm of factors at play—frequent sexual encounters, low usage of family planning, and pregnancy. In fact, only one IDI participant, Penny, said she desired to be married after finding out she was pregnant.

#### **4.6 Being orphaned as a driver of marriage**

Five of the 14 girls and women in IDIs recounted how they experienced the serious illness or death of at least one parent before they became pregnant or were married. For these girls, the poverty that is experienced by the communities more generally is worsened by the loss of one parent or both. As such, being orphaned is itself a motivation for early marriage within these communities even outside of adolescent pregnancy. During a FGD with married girls and single mothers at the Epicenter in Akpo, one participant explained:

*“...maybe someone growing up and the person doesn’t have any mother, no father, nobody is taking care of the person and the person cannot take care of herself. So if she finds someone who can take care of those things for her, she’s ready to go into that marriage because she thinks that person can help her since she doesn’t have nobody—no father, no brother—to take care of her needs for her.”*

This quote is similar to the experiences of Piper, whose story was first discussed at the beginning of this thesis. Within this research, only girls who were orphaned reported having been married before becoming pregnant.

#### **4.7 Concluding remarks**

The goal of this chapter was to give insight into the practice of marriage and the respondents' understanding of it along with their motivations for early marriage. Participants generally understand marriage to be a very formal process with specific rites that need to be performed. However, marriage rites have not been completed for the majority of the participants in this research and the girls and women still consider themselves to be married. Economic hardship makes the completion of these formal rites challenging, and it appears to be socially acceptable to have children and live together if the intention to eventually complete the rites is there.

Based on the literature review that had been completed prior to the fieldwork period, I anticipated finding cultural norms, including traditional practices, to be the primary driver of early marriage in these communities and to then explore the related well-being concerns from there. Instead, it was apparent from the first FGDs that pregnancy, rather than cultural or religious norms, is the primary driver of child marriage in these communities. Girls largely report being able to choose whether or not to marry after finding out they are pregnant, but this chapter underlined that they truly have limited options—particularly if their parents will not step in to care for them.

The following chapter will examine girls' experiences and expectations of well-being both before and after marriage and motherhood.

## **5 Experiences and expectations of well-being before and after marriage and motherhood**

### **5.1 Introduction**

Literature included in sub-section 1.2.1 shows that sexual relationships and/or early marriages come with a variety of negative well-being consequences for girls. This chapter presents findings related to how, prior to marriage and

motherhood, girls experienced various aspects of well-being and how they expected those to change when they became mothers and wives. Participants were asked to reflect back on when they were single and without children to explain their perceptions and experiences. The experiences of well-being by married girls and single mothers will also be discussed. Further, this chapter will highlight the actions girls and women take to advance their own well-being.

## **5.2 Well-being of single girls**

### **5.2.1 Physical well-being**

This research operationalizes physical well-being to include the absence of general illness or disease, aspects of maternal and sexual health issues, intimate partner violence, and girls' interpretations of their quality of life as it relates to their physical bodies. Overall, girls and women largely reported experiencing good physical health as single girls living with their families. When discussing this aspect of their general well-being, girls and women, including Francis, Nell, and Gillian, commonly described themselves as physically "*strong*" prior to giving birth and being married. Definitions of strength often corresponded to the kind of manual labor girls are capable of doing, such as farming or hauling water.

Occasionally minor illnesses, including fever, stomachache, and headache, were experienced. Sally, who at 15-years-old had a baby with her husband who is eight years her senior, told me:

*"During that time, I really did not have any health issues. Sometimes, occasionally, I would have some stomach upset. Then sometimes, too, I would go to farm or if I work for some time I would feel some body pains. I get some... over the counter drug, so I get it from the drug store."* – Sally (20-years-old, married, IDI)

Those participants, like Sally, who do describe experiencing minor physical ill-being while single found them to be inconsequential and easy to address at a nearby clinic, through a traditional healer, or using home remedies with herbs and plants growing nearby often with the assistance of a parent or relative.

### **5.2.2 Mental well-being**

Mental well-being is discussed in terms of absence of stress, life satisfaction, and happiness. Most girls, like Ingrid (20-years-old, considers herself unmarried,

IDI), found their levels of happiness were better before they had children. Girls and women primarily reported feeling emotional distress when they were single due to their economic situations and their parents being unable to meet their needs, as was discussed in section 5.2.1. Penny (22-years-old, married, IDI), who had her first child at age 14, described worrying for her future and experiencing stress because of her parents' economic struggles: *"I [saw] the struggles my parents were going through to cater for us [Penny and her siblings]. So I was like, 'am I going to toil the same way or will mine be better?'"* Similarly, Diana (22-years-old, married, IDI), who became pregnant at 17-years-old, said that she, as a single girl, experienced stress due to the idea of what might happen to her economically should she become pregnant. Believing that a potential pregnancy could cause her to suffer because she *"was not well-established... not well-matured... does not have any income,"* Diana explained that she was *"worried"* about getting pregnant. However, for her, this mental concern was not enough to encourage her to use family planning to prevent pregnancy. While mental ill-being, like that stated above, is present in the lives of single girls, it is not something that girls reported seeking help, even informally, for. As an example, girls did not describe speaking to peers or someone else about the stress they felt.

These findings fit with a broader finding of this research: economic statuses can seriously bolster or undermine other aspects of well-being.

### **5.2.3 Expectations of well-being issues**

Girls appear to have been ill prepared for what well-being effects they can expect as a result of being married early or having a baby at an early age. In school, sexual and reproductive health education is included as curriculum in subjects like social studies, integrated science, and biology. Teaching of these subjects begins in the later stages of primary school and continues through senior high school. Research on the curriculum shows that the content of this curriculum ranges *"from definitions and explanations of adolescence, sexual and reproductive health and rights, and biological changes in the body to gender relations and contributions of youth, but there is a strong emphasis on negative and irresponsible behaviors of adolescents, as well as a focus on the benefits of*

abstinence” (Awusabo-Asare et al., 2017:18). Further, community nurses told me that they educate pregnant girls about the potential birth consequences they may face because of their young age.

In spite of the training they are supposed to have had, girls generally report being largely unaware of the ill-being issues related to early pregnancy and child marriage. Francis (23-years-old, married, IDI), who completed primary school, was taught about pregnancy in school, but said that she did not receive any information about health issues related to pregnancy. Ingrid (20-years-old, considers herself unmarried, IDI) nearly completed junior high school but never received sexual and reproductive health classes in school; she also said that no one, whether at school or a relative, ever spoke with her about the ill-being effects of having a baby at an early age. In total, 10 of the 14 girls and women who participated in IDIs reported not having received any education related to the well-being consequences of early pregnancy and/or marriage. Three other girls did not respond to the question.

Joanna (17-years-old, single mother, IDI) was informed by her grandfather of economic consequences, particularly related to education, which can come from having a baby or being married at an early age. Interestingly, Phoebe’s 20-year-old husband told me in an informal conversation that he knew prior to being married and having a baby with his wife that girls and women might experience ill-being as a result of marriage and childbirth: *“Maybe sometimes... when going to give birth she will even die. That is what I was thinking about.”* Phoebe (17-years-old) herself said that she had no such knowledge.

With most girls in this study having completed at least part of junior high school, they should have been exposed to some sexual and reproductive health classes. Those that had a negligible or primary-level education may not have been exposed to such an education in school. In spite of sexual and reproductive health education being a planned part of classes, a headmaster of a junior and senior high school in an Akpo-Akpamu community told me that sexual and reproductive health education is actually rarely given in schools, including the one he oversees. His reasoning for this was the discomfort teachers might have with giving students this information.



### **5.3 Well-being experiences of married girls and single mothers**

This section explores the physical, mental, and social well-being of married girls and women. Because single mothers describe similar ill-being issues to those of married girls and women, their experiences are also examined in this section. Single mothers do not attribute their ill-being experiences to their being unmarried or feel that their experiences are different from those of their married counterparts. Rather, single mothers find factors other than marital status to result in ill-being.

#### **5.3.1 Physical ill-being**

In this section I describe experiences with physical ill-being and how women attempt to exercise agency to deal with such issues. Based on the literature, I expected to interact with married girls and single mothers experiencing a variety of physical ill-being concerns related to their pregnancies and childbirths. In addition to those, this research aims to understand other aspects of physical well-being, including domestic violence and general physical health, of married girls and women and how they might perceive marriage and motherhood as having affected that.

#### ***Birth and labor-related complications***

Four out of 14 of the girls participating in IDIs gave birth before the age of 15, making the likelihood of them having experienced labor-related complications even greater. Overall, many participants, regardless of the age at which they first gave birth, did and do still experience labor and birth-related physical ill-being. These complaints include significant bleeding during pregnancy or labor, child mortality, stomach pain after delivery, and prolonged labor.

At 17-years-old, Ingrid experienced bleeding for three days during her seventh month of pregnancy with her first child. After visiting the traditional birth attendant (TBA) who was attending her pregnancy, she was referred to the THP-Ghana Epicenter clinic, which then referred her to the hospital in Koforidua because the complication was too severe for them to handle:

*"I was having some complications at the seven months, so I was taken to the... regional hospital. They did D&C [dilation and curettage] on me. I was operated on... They said they have to operate [on] me and remove the baby. So they did at the seventh month. Even my second child, too, the seventh*

*month, but I delivered in the house.” – Ingrid (20-years-old, considers herself unmarried, IDI)*

Ingrid’s baby survived, but she was left feeling weak and exhausted after the birth and procedure. Ingrid’s story is exceptional because she had the means, and thereby thicker agency, to seek further healthcare at a more advanced hospital in a larger city. Other girls and women who live in less financially sound households would experience thinner agency and be unable to seek further treatment or treatment at all because of financial constraints.

This brings us to the story of Nell, who had her first child at age 12. She experienced the death of a child during her third and most recent pregnancy. She now continues to experience stomach pains, but has not sought healthcare because she and her husband cannot afford to:

*“Somebody was taking care of me, like a TBA. The person told me they [the babies] were twins and one is dead in the womb... So I went to another woman; the woman said there is no problem... But since then, it is the stomach that I have been having a problem with... When I got to seven months... I had [a] miscarriage. One [baby] came out and one remained.” – Nell (between 17- and 20-years-old, married, IDI),*

Nell was pregnant with twins and experienced the miscarriage of one of the babies during her seventh month of pregnancy. The second twin later delivered safely. The structure within which Nell now lives has evolved from before she was married. Whereas prior to marriage she received economic support from her husband (who was then her sexual partner) and was also supported by her parents, the nature of their relationship changed after marriage. She now relies on her husband completely, and his refusal to give her money for healthcare unless an issue is “very serious” negatively impacts her agency and self-efficacy capabilities.

Bonnie (19-years-old, single, IDI) also experienced the loss of a child. She gave birth at 17-years-old and her baby died shortly after delivery. She told me that the birth attendant did not tell her why her baby did not survive. After the loss of her child, Bonnie was able to remain living with her mother and return to school. Bonnie’s story shows that the loss of a child, though heartbreaking, completely changes the direction a girl’s life might take. Had Bonnie’s child lived, she, like the other participants, would likely have never returned to school and

instead stayed home with her child. Further, the context change she experienced from being a soon-to-be-mother to losing her child changed the likely course her agency took. Not being a mother will exclude Bonnie from experiencing the thinning of agency related to well-being that many mothers do due to marriage and motherhood. Unlike mothers her age, Bonnie was able to return to school and continue her education.

These three stories are illustrative of some of the more serious labor and birth-related complications that girls experience. The stories also demonstrate the range of girls' agency and self-efficacy within the structures in which they live. However, physical ill-being that girls attribute to marriage and motherhood does not only relate to labor and giving birth.

### ***Loss of strength***

One of the most frequently repeated physical ill-being complaints heard from girls was a general loss of strength as compared to when they were single girls, which they attribute to marriage and motherhood. Phoebe, who recently gave birth to her first child, described her postnatal physical ill-being as:

*"Before I got pregnant I was very active, you know, can do whatever I wanted to. But [that] strength is no more there. I am not [as] active as I used to [be]. What I can do before, I cannot do it now. They are all part. The pregnancy is part. The marriage is part. Everything is part. That's why the strength is not like that."* – Phoebe (17-years-old, married, IDI)

Diana (22-years-old, married, IDI) experienced a similar loss of strength and explained: *"I am not as I used to be... in my physical health. Like something I could do previously, now I could not do. At first, I was very strong, but now I easily fall sick. Compared to previously when I was very healthy and could go about my daily activity... now I am sick."* Phoebe, Diana, and other girls as well, consider marriage and motherhood to be responsible for an overall feeling of weakness and loss of physical ability. Participants describe being unable to do manual labor to the extent that they had as single girls, which, particularly as it relates to farming, must be detrimental for their economic livelihoods and well-being.

### ***Domestic violence***

Another contributing factor to the increasing physical ill-being of married girls is intimate partner violence, which is commonly experienced among the research

participants. Ingrid (20-years-old, considers herself unmarried, IDI) informed me that she experiences domestic violence from her husband and that it leaves her with injuries which she treats herself in her home. In addition to Ingrid's experiences, Sally, Gillian, and Penny all expressed that they either had or were experiencing reoccurring instances of domestic violence within their marriages. However, this violence is not necessarily perceived as problematic in these communities. When Gillian (22-years-old, married, IDI) described the violence she experienced, she stated, *"It was just a slap,"* implying that the violence happening to her (or perhaps domestic violence more generally) is nothing to complain about. Similarly a THP-Ghana staff member explained, *"Oh, as for every marriage, it happens. But this we are talking about the extent of even beating."* Her statement makes clear that there are levels of acceptability when it comes to domestic violence in these communities. Perhaps, as Gillian and the THP-Ghana staff member implied, a slap is inconsequential, whereas a beating that results in serious injury is more cause for concern. So long as single mothers are not experiencing domestic violence from someone in their familial home, this may be an area in which single mothers are better off physically than married girls and women because they are not exposed to the same level of risk within their structure.

### **5.3.2 Mental well-being**

Overall, mental well-being is a major concern among the participants and an area in which they notice significant changes after marriage and motherhood. When asking married girls and women as well as single mothers about this aspect of their lives a common phenomenon is described time and time again: *"thinking."* This is the term they use to describe the effect the emotional weight of marriage and motherhood has on them. In the words of one young woman in a Boti FGD:

*"...It [marriage and children] comes with emotional stress because now you are married. When your daughter or your son is not feeling well and you yourself do not have money, your husband also does not have money, [and] then... it leaves you in a state of thinking. You will be thinking and you also feel regret. If I knew, I should have waited until I get something to do or waited until I finished my school before I entered into marriage. So when it happens like that, then you become so stressed and you think and think and think."*

This response highlights the ways in which physical ill-being and economic situations contribute to mental ill-being, including stress and feelings of regret. It further explains the disappointment that is felt in being unable to complete their education. Through this we can see the ways in which ill-being is influenced by the structural implications of marriage for many of the girls in these communities.

Similarly, Piper expounded on the ways in which her “thinking” impacts the social aspect of her overall well-being:

*“It is because I am thinking. Thinking about how to even cater for the children. It is like getting to evening and as of now you do not even know what is there for you to prepare and give to your son or your daughter when she comes from school. Will you have the funds to go and visit somebody? ... When it is even difficult to even get something to eat, I do not think I will even get the courage to go and say, ‘I am going to visit.’” – Piper (22-years-old, married, IDI)*

In cases such as this, girls and women feel so burdened by the weight of their situations that they are hesitant to socialize with friends and peers, which in and of itself might help ease the burdens they feel as so many other girls and women in the communities are experiencing similar feelings.

Occasionally, participants find that their mental well-being improves at different times in their lives as the structure they operate in changes. For a period of time between giving birth to her first child and then marrying another man, Nell lived with her mother. She explained:

*“I was not feeling fine, especially my auntie was not treating me well. I was thinking when I come to my mother [she and] my siblings as well will not treat me well. But when I came, the treatment was OK, so that made me reduce the thinking or anxiety, kind of ... when I came to my mother, at least the emotional feelings or thinking was reduced.” – Nell (between 17-and 20-years-old, married, IDI)*

Similarly, Francis, who had been orphaned, finds emotional comfort in her husband and believes that her mental well-being is bolstered while her stress is lessened because of his emotional and economic support and their partnership. Stories like these illustrate the ways in which different types of married relationships influence the mental well-being of girls.

Emotional pain like the experiences above emphasized is common, and some women consider their mental well-being to be paramount—even more so than physical well-being: *“In anything, it is the mind that should be very sound to make decisions and everything. So if emotionally I am down, I cannot do anything ... I need to be emotionally sound to do anything.”* Gillian (22-years-old, married, IDI) relayed this message to underscore that she sees having good mental well-being to be critical because of the ways in which it can influence a person’s overall sense of well-being.

### **5.3.3 Social well-being**

The participating girls and women describe a variety of social well-being realities that mothers and wives experience, though overall it is not a major area of concern for them. In this sub-section, I will detail these various experiences. For the purposes of this research, social well-being was operationalized to consist of a feeling of independence and having the ability to interact with peers, family members, or other individuals.

#### ***More limited social network***

In comparison to when they were single, some married girls and women and single mothers interact with a more limited network of people. Instead of going to school and spending time with friends and relatives, participants explain that they stay at home with their child(ren), work if they are employed or have a business, and do little else. Gillian (22-years-old, married, IDI) compared her life as a single girl to her current reality as a married mother of three children by saying, *“Before [marriage], I was visiting friends and would play. But when I got married, my social life changed... I am OK about that—not seeing the friends. I am OK.”* In spite of the change in her social reality, she is satisfied with the arrangement and does not feel like her social well-being has suffered.

#### ***Similar social situation***

Other girls and women experience less of a change in their social lives after marrying or becoming mothers. As a single girl, Joanna (17-years-old, single mother, IDI) was not interested in going out in the evenings with friends and her grandmother would not allow it. Now being a single mother, she finds that she occasionally meets friends but finds it difficult to make time for such an activity:

*“Now because I am working, I do not have that luxury of time to just sit and chat. [However,] when I am going to buy something and meet a person, I spend some time with them.”* Still, though, she is content with this social arrangement because she sees herself to be working hard and believes that this sacrifice will benefit her in the future.

### ***Increased social freedom***

Sally (20-years-old, married, IDI) actually finds more social freedom after having a child and marrying. When she was a single girl, her mother was very strict and would only allow her to visit her siblings, though she clearly worked around this rule because she was able to spend time with her boyfriend and become pregnant. Still, now that she is married and a mother, she finds that she is able to go where she likes and visit friends and family: *“I tell my husband I want to go and visit; he does not say anything. I have the liberty to go.”* In this instance, a changing structure also changes and thickens the agency Sally experiences in that she has more freedom to visit friends as she pleases and, thereby, enjoys better social well-being.

What is striking about the three different social scenarios, though, is that girls appear to be content with whatever their situations are. In general, they do not express the desire to spend more or less time with individuals outside of their marriages or immediate family members. When asked directly about their well-being priorities and what they desire to see bettered, none of the girls or women interviewed indicated that their social well-being is a priority for them.

## **5.4 Concluding remarks**

Marriage and motherhood change the living situations girls and women find themselves in, which then influences different aspects of their well-being (see Figure 6). The majority of the participants in this research made clear to me that for their overall sense of well-being, mental and physical well-being are most important with social well-being being of little consequence to their overall sense of well-being.

Rather a surprising find of this research was just how bothered girls and women were by the unanticipated emotional side effects of marriage and motherhood—even more so than the physical side effects. They were very open

in speaking about their emotions and mental state with me. In fact, some girls occasionally shied away from answering questions related to physical well-being. By comparison, they seemed more eager to discuss their mental well-being. Dishearteningly, there seems to be little option for addressing mental ill-being as mental health professionals are not present in these communities, and, culturally or personally, some girls report being hesitant to discuss these issues with peers or family members.

In closing, I want to try to give further insight into another idea, perhaps a cultural norm, that came up time and time again in this research: trust in a better future and endurance. Many girls and women, along with the community nurses who treat them, explained that they understood they lived challenging lives but they believed things would improve in the future and they had to endure until then. Joanna (17-years-old, single mother, IDI) told me about her fellow young mothers: *“I think fine, there may be a lot of stress [or] emotional challenges that they are going through. But I know at some time they will become use[d] to it.”* In spite of what these girls have lived through and experience daily, they are not only resigned as the previous quote would suggest but often optimistic about their futures provided they can get the necessary support, both emotionally and financially, to improve their situations.

This concept of support leads into the third and final empirical chapter, which will explore positive and negative influences on the well-being of married girls and single mothers.

Participants	Economic Situation	Emotional Well-Being	Physical Well-Being	Social Well-Being	Overall Impact	Advice for Others
Piper	±	X	≈	X	X	Against
Sally	+	X	X	+	X	Against
Gillian	±	X	X	±	X	Against
Diana	±	≈	≈	≈	X	Against
Nell	X	X	X		X	Against
Phoebe	X		X		X	Against
Mia	X	+	X		X	Against
Penny	±	±	X	≈	+	Against
Ingrid	X	X	X		±	
Francis	+	+	X	≈	+	Against



Joanna	±	X	±	≈	+	Against
Lena	X		≈			
Bonnie	+					
Lily	+		X			

**Figure 6: Table to show the impact child marriage and motherhood has had on girls who participated in IDIs and whether they would advise other girls to pursue pregnancy and marriage at the ages they did. Positive impacts are marked with +. Negative impacts are marked with X. Experiences of both positive and negative impacts are marked with ±. Negligible impacts are marked with ≈. Cells that are marked grey indicate that the respondent did not answer or was not asked directly how a particular area was impacted by child marriage or adolescent pregnancy.**

## 6 Influences on the well-being of girls and women

### 6.1 Introduction

As was discussed in the previous chapter, girls and women generally experience increased and/or new ill-being after marriage and childbearing. Given that, this chapter will examine the variety of actors who and contexts that single girls see as supportive or detrimental to their mental, physical, and social well-being and how that evolves for married girls and single mothers after marriage and/or motherhood. To provide further context as to how the treatment of physical health issues can be handled, section 6.5.1 will describe the government-sponsored health insurance program that some of the participants (or their family members) in this research subscribe to.

### 6.2 Influences on the well-being of single girls

Participants reflecting back on when they were single describe being largely dependent on their parents and, sometimes, other family members to address any typically minor physical health issues they experienced. As was mentioned in the previous chapter, most girls and women describe headaches and stomachaches as their primary health concerns when they were single. Parents, older siblings and grandparents are reported by participants as helping them, firstly, financially with getting healthcare they needed and, secondly, by

encouraging them to visit either a traditional medicine practitioner or the nearest clinic. Joanna recalled two health scares she experienced as a child that her grandmother and parents took the initiative to have examined:

*“I hardly fell sick, but I recall when being about six years or so having a problem in my breast. My grandma thought it was breast cancer, so she took me to the hospital. After examination, it wasn’t. They [health providers at hospital] gave me some drug and it went [away]. There was a time too when I was having pains around my side. They [parents and grandparents] took me to the hospital and I was also OK.”* –Joanna (17-years-old, single mother, IDI)

Mirroring what other women say they would do when they were still single and living with their parents, Joanna conveyed that she would wait for her family to recognize that she had a health issue and get it treated, rather than telling a family member about the problem herself and then getting help with treatment. This seeming cultural norm influences the agency of girls in that they do not act to better their own physical well-being and instead wait for a family member to intervene on their behalf.

Mental and social ill-being are not presented as being experienced by single girls and, therefore, are not areas in which support individuals are seen to be helpful or detrimental. However, some of the issues girls frame as economic, such as starvation, must also be emotionally worrisome or stressful and thereby another area in which families contribute to the ill-being of their daughters.

Economic realities are also a frequent issue for single girls. With parents often failing to provide girls with their basic needs, including healthcare, they are, thereby, causing their single daughters’ to experience ill-being. In such situations, girls find their boyfriends or sexual partners to be supportive of their overall well-being.

### **6.3 Influences on the well-being of married girls**

#### **6.3.1 Role of husbands**

Once married, one expects influence on the well-being of girls from their husbands. Opinions as to whether or not husbands are helpful or harmful to the well-being of their wives are mixed. Focus group discussions led girls and women to express that husbands are generally seen to undermine the well-being

of their wives. According to the participants in the FGDs, husbands are sometimes seen as harmful because they do not care for their wives emotionally, do not encourage them to have better physical health, bring home sexually-transmitted diseases from extra-marital partners, and contribute to their increasing stress levels. Similarly, within IDIs, several girls and women explained that their well-being was impacted by their husbands withholding financial support for physical ill-being issues. These behaviors by husbands lead to constrictive structures for wives, leaving them with thinner agency through which to address their well-being issues.

Still, there are other girls and women whose husbands are willing to support their wives in seeking help for a physical health concern— mainly as it relates to when they have the necessary funds. When discussing the use of family planning with Francis, a married mother of three children who has experienced physical health issues since becoming a mother, she explained that she and her husband both made the decision to begin using family planning. In this instance, both Francis and her husband were conscious of the fact that bearing children is an economic burden and that any further physical ill-being Francis experiences as a result of another pregnancy might further compound the economic troubles they face. For them, family planning is the best option for the prevention of further economic woes, and Francis's husband is both emotionally and economically supportive of her using birth control. This story illustrates a common finding in this research: different aspects of well-being are interconnected and the addressing of one can also positively impact another. It further shows the critical role that economics play in ensuring the well-being of girls and women.

In response to a question about how husbands contribute to a woman's well-being or ill-being, three girls and women in an Akpo-Akpamu FGD explained:

**Participant 1:** *Me and my husband do a farm. So when the money comes and I am sick, he gives me money to take care of me.*

**Participant 2:** *I do not know whether he has money or does not have money. So if you do not have money to take care of yourself, then he does not, it is not his problem. You have to look for your own money to take care of yourself.*

**Participant 3:** *My husband does not give me money, nothing. But he takes care of the kids.*

The three quotes illustrate different levels of support girls and women might receive from their husbands. Further, the quotes demonstrate the variety of ways in which women depend on their husbands, due to structural realities, including economic and social norms, which give men primary decision-making power. For example, the first respondent shares farm work with her husband. In spite of this, she is still reliant on him to give her a portion of the money they earn together for her healthcare needs. In other instances, as the second and third quotes illustrate, girls and women live with husbands who do not discuss or share family finances with them. Such cases would require the woman to either generate her own funds or seek monetary assistance from another party; this will be discussed further in sub-section 6.5. These three situations were not dissimilar from those of other research participants.

Interestingly, the third quote also gives insight into how children are valued in these communities as potential future providers for their parents. Whereas women and their ill-being issues (even those related to childbearing) can be seen as an economic burden, the costs of raising healthy children to adulthood is seen as investment for the parents themselves. Ingrid (20-years-old, considers herself unmarried, IDI) views motherhood to be a positive influence on her life in spite of the negative impact it (as well as marriage) has had on her overall well-being: *“In a way I see it to be positive because though there are certain things I cannot do [because of the ill-being that comes from marriage and motherhood], I think when the kids grow they can come and do it [provide] for me.”* Planned future economic dependence on their children is a common response from participants and gives insight into why girls and their husbands, like that of the third respondent above, might prioritize the well-being needs of their children over themselves and their wives, respectively.

In addition to being reliant on the financial support of their husbands to address physical ill-being, girls sometimes find that healthcare providers, including clinic nurses and TBAs, request a husband's presence and approval before treating them. Mia (18-years-old, widowed, IDI) visited a TBA during one of her pregnancies. Before seeing her for prenatal treatment, the TBA requested

Mia bring her husband to the appointment. Similarly, Mia later visited an Epicenter clinic nurse for the removal of an intrauterine device (IUD). Like the TBA, the nurse required Mia's husband to be at the clinic to consent to the removal of the IUD. These cultural norms that see girls needing approval from their husbands before receiving healthcare are indicative of a constrictive structure in which girls do not have complete control over their own physical well-being.

Women also find that their husbands influence their mental well-being for better or worse depending on the inner workings of their relationships. Mia (18-years-old, widowed, IDI), whose husband recently died, found that her husband helped her get through the emotional ups and downs she experienced during her four pregnancies. However, Gillian (22-years-old, married, IDI) finds that her relationship with her husband contributes to mental ill-being in that it causes her to be unhappy: *"It is as if [my] husband is being authoritative, pushing everything on me. But if we [were] together, planning, doing everything together, I would be happy."*

### **6.3.2 Role of parents and other family members**

When girls find their husbands or partners to be unreliable providers of support, there are other individuals they turn to for help with physical ill-being concerns. Whereas prior to marriage and childbearing girls see parents as negligent for not providing them with all of their necessary material needs and sometimes even healthcare, parents often play a critical role in advocating for the well-being of their daughters after marriage. Often in contrast to the role that husbands play, married girls and women find their parents to be supportive of different aspects of their well-being.

Diana (22-years-old, married, IDI), found her mother to be the most supportive person, in terms of her physical and mental well-being, to her during her pregnancy. But familial support is not limited to a girl's mother and father. Gillian, (22-years-old, married, IDI) a mother of three children, explained that she goes to her brother for help when she is struggling emotionally with the pressures of marriage and motherhood. She also indicated that her sister-in-law was the most supportive person for her during her pregnancy with her first child

when she was 17-years-old. When Sally (20-years-old, married, IDI) had her child and married her husband at age 15, she felt immense sorrow and frequently cried after giving birth. She found support in some of her aunties who would come to her house to comfort and encourage her.

According to a community elder who participated in a FGD, parents of married girls often keep a watchful eye on and advocate for the health of their daughters who have married and had children: *“If the parents are concerned, you just monitor and tell her to go to the clinic because you will pay for her. Sometimes if you are free with the man, you encourage the man to help her to also access healthcare.”* Being that their daughters have left their home and they are relieved of the burden of the everyday costs of their child and grandchild, parents may feel an obligation to look after the health of their daughters when the issue is serious. Alternatively, as the quote above illustrates, parents sometimes have good relationships with their sons-in-law, allowing them the opportunity to advocate for physical healthcare for their daughters. Knowing that husbands often withhold the funds necessary for seeking treatment from their wives (discussed in section 6.3.1), parents can leverage their relationships with their sons-in-law to get their assistance for their daughters’ physical ill-being issues.

#### **6.4 Influences on the well-being of single mothers**

At the end of the research period, a THP-Ghana employee told me that there is a stigma that comes with being a parent to a daughter who became pregnant outside of marriage: other people in the community consider people with pregnant daughters to be bad parents who failed to control their daughters. When the parents or broader family members of a single mother allow her to remain living with them, they are choosing to endure that stigma so that their daughter or relative does not have to enter into an early marriage. While THP-Ghana is working with the Her Choice program to transform these social norms and normalize the idea of a young mother delaying marriage and instead staying with her family, these parents and family members are, in the meantime, making sacrifices, both socially (due to the stigma) and financially, for the broader well-being of their daughters and grandchild.

In the FGD with community leaders, a village chief regarded adolescent pregnancy as regressing the progress of families, particularly for those who allow their daughter and grandchild to live with them:

*“She [the daughter] did not take the advice and she has now gotten herself married or she has gotten pregnant, now his [the girl’s father’s] duty and then the wife’s duty is to also cater for them. Because you went in [and got pregnant], the money I will use to cater for the daughter and then the child could have been channeled into a different area that will move the family forward. But because I am now catering to the baby and then the daughter, it will regress our progress.”*

This quote illustrates the continued economic hardship that parents in the community expect to experience when they allow their pregnant daughters, and eventually grandchildren, to remain living with them rather than go into child marriage. Being that it is unusual to find single mothers living with their parents, it seems that the economic hardship and stigma discussed in this chapter is generally too much for parents to handle—which then leads girls to usually be married at an early age after finding themselves to be pregnant.

## **6.5 Economics and well-being connection**

Underlying all aspects of a girl’s well-being, both before and after marriage and motherhood, is her economic situation which can dictate whether she is able to address any ill-being issues. Married girls and single mothers perceive their overall well-being to be connected to their economic situations, including financial security, the possession of basic needs, and receiving a complete education. This sub-section will explore the ways in which economic situations act as structural influences on the overall well-being of girls. It will also discuss how economics act as thinners or thickeners of girls’ choices and agency. Finally, this sub-section will explain Ghana’s health insurance scheme, which was widely discussed by participants, and how it influences the well-being of girls.

### **6.5.1 Financial security and physical well-being**

Many girls and women report a connection between their financial security and their ability to seek or prioritize seeking their physical well-being and healthcare, be it traditional or Western. As was discussed in section 3.4, there are certain seasons during the year in which farming is more fruitful and others

when it is not. As such, girls, whether single or married, and other individuals in the communities tend to go without healthcare if they become physically ill, whether inconsequentially or seriously, outside of the harvest season in which their family has a regular income. When asked whether there is someone or something that helps or hinders girls from getting the healthcare they need or desire, a married girl participating in a FGD in Boti stated, *“Nobody forces or encourages you. Because you do not have money, you cannot take [care] of our health needs.”*

On the day I was interviewing Nell (17-20-years-old, married, IDI), she came limping out of her home. Her left foot was swollen and dark black. After inquiring about the cause of her injury, she explained that she did not know what happened; she woke up one day and her foot was enflamed. Very concerned for her health, I asked what she planned to do for treatment. She was doing her best to treat the presumed infection with herbs that she had gathered, but stated, *“I am not seeking any medical attention because I am not having money to go.”*

This same idea of being unable to seek healthcare because of financial constraints was conveyed by a number of participants in this research across a wide variety of intersections, including married and single girls and women, those in happy or unhappy marriages, and those with parents and without. For many girls and women participating in this research, their economic status, rather than a person or institution in their lives, was the main catalyst for whether they sought out healthcare or not, and, thereby, majorly influences their well-being.

### ***Health insurance in Ghana***

Acknowledging the struggles that many Ghanaians face with affording healthcare, the Ghanaian government, in 2003, introduced a national health care system, the National/District Health Insurance Scheme (N/DHIS) (Ghana Statistical Service, Ghana Health Service, and ICF International, 2015: 272). Under the N/DHIS, several services relevant for girls and women are provided for free, including “antenatal and maternity services, emergency obstetric and neonatal care, home visits by community health nurses, immunization of children under 5, and adolescent health care...” (Ghana Statistical Service, Ghana Health Service, and ICF International, 2015: 285). According to participants,



enrollment in the N/DHIS costs 25 Cedis per year, which is equivalent to less than five Euros. A parent can then get coverage for their child for an additional five Cedis per year, which is equivalent to less than one Euro. A nurse at the Boti Epicenter clinic explained that it is not uncommon for girls or women without health insurance to still come to the clinic seeking prenatal care. She explained that she does not provide prescriptions or medicines to women if they do not have health insurance but that she will measure their abdomens throughout the pregnancy to monitor the baby's growth.

Though a 2014 government survey found that 67.7% of women age 15-49 in Ghana's Eastern Region were covered by N/DHIS (Ghana Statistical Service, Ghana Health Service, and ICF International, 2015: 273), it was rare to find among the girls I interviewed. In fact, only one girl, Joanna, stated that she was actively enrolled in the insurance program. Nell, on the other hand, had been enrolled in N/DHIS at one point, but let the coverage lapse when she did not have the funds to pay for it. Interestingly, that same 2014 study found that "awareness about programmes that help pregnant women and children under 18 to access health services is lowest among respondents age 15-19, among the less educated, and among the poorest respondents" (Ghana Statistical Service, Ghana Health Service, and ICF International, 2015: 286), all of which are demographics that relate closely to the participants in this research. Were health insurance more accessible economically, it would likely thicken the agency of girls and women because it does away with the financial burden they face in treating physical ill-being without insurance.

### **6.5.2 Basic needs and well-being**

As was mentioned in Chapter Four, girls frequently report experiencing economic issues while living with their parents. While girls rely on their parents and families for money and goods, they and other individuals in the communities find that parents do not or cannot always provide their daughters with their basic needs. The reality of going without what they see to be basic needs often leads girls to make decisions and take actions they might not have taken otherwise, thereby influencing their agency:

A male community elder in the Bosotwi community described a situation in which he knew of a girl experiencing financial hardship, which then led her to seek out a sexual relationship with a man who would provide her with what she needed. Speaking from the girl's perspective during a FGD he said, *"Now I am in my adolescent stage. I have started menstruating. You do not buy me pads. You do not even buy panties for me. I cannot also go to school with my soiled dresses, so I will also look for alternatives to get money."*

Lena (17-years-old, single mother, IDI), who had her first child at 16-years-old with a 30-year-old man, explained that her own widowed mother could not provide her with books or pencils to take to school. Further, Piper and Joanna explained that they experienced starvation when living with their families due to poor economic conditions.

The stories told by these participants illustrate that single girls and their families are experiencing persistent poverty that prevents them from meeting basic needs for consumption, education, and sanitation. Single girls experiencing such structural economic issues find themselves seeking financial assistance from other parties and making decisions they might not have had their basic needs been met.

### **6.5.3 Education and well-being**

Education is an aspect of the economic situations of girls that they consider essential to a prosperous future and desire to make a priority. In fact, as was mentioned in sub-section 6.5.2, some research participants engaged in premarital sexual relationships so as to have their basic school needs met by their partners. As a single girl, Ingrid, who is now married with two children, saw a different future for herself than what came to pass: *"Before I gave birth, I wanted to finish school and get a job."* Similarly, Francis (23-years-old, married, IDI) dropped out of school when she first became pregnant, but returned to school after she miscarried her child because she saw education to be a way for her to better her economic circumstances: *"If you go to school and complete the school or even you are working before you get married, it is far better."* Piper (22-years-old, married) was the only IDI participant who felt she was not a successful student and expressed the desire to leave school when she was a

single girl. The findings outlined here are illustrative of larger findings in this research: girls generally put a high value on education and desire to complete their education before entering into motherhood and marriage. Doing so, they believe, will help them to provide for themselves and their families financially and increase their feelings of well-being.

That being said however, girls generally leave school either because of economic need or after becoming pregnant because they have been married. Out of the 14 girls and women selected for IDIs, only Diana received an education beyond junior high school. Lily (18-years-old, single mother, IDI) found herself able to return to school after giving birth because her parents agreed to care for her child. Bonnie, whose child died after birth, also returned to school.

The significance that many girls put on their education is evident in stories like those of Joanna (17-years-old, single mother, IDI) who resisted marriage after becoming pregnant because she hoped to return to school. Asked if she had considered marrying her baby's father, she told me, *"No, because I wanted to still further my education. So I was thinking I would still be with my parents and after giving birth I would go back to school. So I did not want to go to the marriage home."* Joanna's child is three-years-old and, due to financial constraints, she has not yet returned to school as she had wished. The majority of the IDI participants had similar stories as Joanna, which must be disappointing knowing how highly most of them regard education.

Girls appear to be stuck in a cycle in which they desire to go to school but face economic hardship so they engage in premarital sexual relationships to have their basic needs met. These relationships often lead to pregnancy, which leads to marriage and them abandoning the very education for which they entered into a relationship for. Further, they believe schooling would result in them having a more secure financial future, which would lead to better experiences of well-being. These findings are representative of the way in which a lack of education is a condition that influences the ill-being of girls in these communities.

## **6.6 Concluding remarks**

The aim of this third empirical chapter was to explore how different actors in different contexts and situations can influence married girls and women and

single mothers to experience well-being and ill-being. Given the different people, motivations, and situations involved in the decision-making, it is challenging to assign overall blame for the ill-being that many participants in this research find themselves experiencing. That being said, however, girls and women in these contexts generally assert that husbands contribute to their ill-being whereas their parents, whom they accused prior to marriage of being neglectful, are supportive of well-being. Further, participants overwhelmingly face some type of economic hardship that exacerbates ill-being, be it lack of financial security or education. Finally, with mental ill-being widely experienced, some girls and women find encouragement from family members; however, most girls report rarely speaking with someone about these struggles.

Whereas the past three chapters presented the empirical findings of this research, the following chapter will place them within a broader theoretical framework.

## **7 Discussion and conclusion**

This qualitative research adds to the body of literature around broad well-being of child brides. Specifically, the purpose of this study is to gain an understanding of the sense of general well-being of single mothers and women married as children and compare this with their well-being as single girls without children. The study also looks into which aspects of well-being women deem most important for their overall sense of well-being, including mental, physical, and social. Structural factors, including economic situations, community norms around pregnancy and marriage, and actors influencing the well-being of married and single girls are also examined. Finally, women's agency to better their own well-being is explored.

This chapter will engage the empirical data presented in Chapters Four through Six with the theoretical and conceptual framework described in Chapter Two. Provisional policy recommendations concerning interventions for bettering well-being outcomes for girls will also be provided. Lastly, the chapter will conclude with recommendations for further research. As this research was exploratory in nature, it is important to consider that the data described here is

not comprehensive. Instead, it explores the motivations and experiences as the participants in this research explained them.

### **7.1 Agency, structure, and the Health Belief Model**

Child marriage and its physical health outcomes for girls are frequently researched topics, but this research has shown that there is still much to learn about (1) how child marriage comes to be in various locations and contexts and (2) the well-being priorities of those living it. This sub-section will provide answers to the four sub-questions of the main research question by discussing the empirical data in relation to the concepts and model that informed this research: agency, structure, and the HBM.

#### ***Pregnancy and poverty as reasons to choose child marriage***

Single girls who cannot secure help with a well-being issue, such as healthcare or the procurement of clothing or school supplies, from their parents or another relative often seek out a sexual partner for economic assistance. In so doing, they exercise thin agency within a structure that is constrictive because of dire economic situations (Klocker, 2007), but these relationships can lead girls to adolescent pregnancy and thereby expose them to the many ill-being issues that come from being young mothers (Gage, 2013a; Gage, 2013b; Hampton, 2010; Nour, 2006; Raj & Boehmer, 2013; WHO, 2018).

The literature often presents adolescent pregnancy as a result of or even secondary driver to child marriage after structural elements, including traditional practices or discriminatory gender norms (Republic of Ghana Ministry of Gender, Children and Social Protection, 2016; Loaiza & Liang, 2013). Conversely, this research found pregnancy to be the primary driver of child marriage in these communities. That being said, however, social norms that shame single mothers and their parents do underlie pregnancy as a motivation to child marriage and probably encourage early marriage as the solution to adolescent pregnancy. In this regard, it is more culturally appropriate to be married after becoming pregnant. In spite of the literature that frequently portrays girls as non-consenting actors in relation to child marriage (Greene, 2014), the data demonstrates that girls believe they participate in the decision-making process that leads them to marriage. That being said, though, the data also shows that girls execute thin agency (Klocker, 2007) as a result of the

overall constraining structure (Choby and Clark, 2014) within which they live. Structures such as the poor economic situation of girls' parents and cultural prejudices against parents with pregnant daughters might embolden parents to encourage or force their daughters to pursue marriage after becoming pregnant. Without parental support in caring for themselves and their child, girls have no option but to marry the man responsible for their pregnancy, thereby illustrating thin agency.

Given the significant finding that adolescent pregnancy is the primary driver for child marriage within these communities, it is nonsensical to only think of adolescent pregnancy as an ill-being effect of child marriage, as much of the literature does. Adolescent pregnancy evidently, at least in these communities, plays a role in what leads girls to child marriage and should be addressed accordingly. Sub-section 7.4 includes recommendations on how to address adolescent pregnancy in these communities.

***Marriage and motherhood have negative effects on the physical and mental well-being of girls***

The data shows that single girls went into marriage and/or motherhood largely unprepared for the well-being realities they would face. Being educated on the consequences of early marriage and adolescent pregnancy is important because it shapes how girls see their future and the issues they might anticipate themselves having. Receiving this education could lead to them being more aware of the potential risks and either making different decisions to mitigate those risks or, alternatively, paying close attention to problems they experience to ensure that problems do not escalate into something more serious. This lack of knowledge is indicative of a structural issue that impacts girls in that they have less available knowledge from which to make decisions that relate to their well-being.

Physical ill-being is prevalent among this study's participants, more so after marriage and childbearing than before when girls largely report only experiencing minor health concerns, such as headaches and stomachaches. These post-marriage findings correspond with what literature and development organizations promulgate about the effects of child marriage and adolescent pregnancy (Gage, 2013b; Gage, 2013a; Hampton, 2010; Jensen & Thornton,

2003; Loaiza & Liang, 2013; Nour, 2006; Raj & Boehmer, 2013; Stevanovic Fenn et al., 2015). Participants describe experiencing loss of strength, pregnancy and childbirth complications, miscarriage, and injuries from domestic violence after being married.

Such physical ill-being is compounded by the vast majority of girls refusing to use family planning to prevent unwanted pregnancy. Many rumors regarding hormonal birth control exist in these communities, including that it causes heart attacks, deafness, and general loss of mindfulness. These beliefs have serious implications for the future health of girls in these communities as each new pregnancy, particularly if the girl is still young, comes with significant physical risks both to her and her child. Further, the cultural tendency to not use birth control acts as a barrier within the HBM to the addressing of the prevention of unwanted pregnancies.

Literature also discusses the impact that early marriage and pregnancy can have on the mental well-being of girls (LeGrand & Mbacké, 1993; Segal-Engelchin et al., 2016; Stevanovic Fenn et al., 2015), but the prevalence with which this topic is covered in the literature is miniscule when compared to how prevalent the problem was in this research location. Rather than presenting mental ill-being, including sadness and stress, as something they wish to be treated, girls often discuss this information to be reflective on the choices that led them to child marriage and motherhood. They further use it to illustrate how their economic experiences, be they financial insecurity and/or lack of education, influence other areas of their lives in that they would be happier if their financial burden was lighter and they had received more education.

Social well-being experiences both before and after marriage are mixed. Literature presents child marriage as detrimental to social well-being in that girls are kept from support individuals in their lives by their wifely duties (Segal-Engelchin et al., 2016). However in this research, some girls report having significant independence being single and/or married, whereas others experience the opposite. What is interesting is that girls, whatever their social well-being circumstance may be, do not generally indicate being unhappy with their social well-being like they do mental or physical well-being. In fact, none of the participants indicated that they found social well-being to be a major

contributor to their overall feelings of well-being. While it might be assumed that girls having the social freedom to spend time with friends would also be beneficial to their mental well-being, girls instead do not actively express the desire to unload their emotional burdens on support individuals in their lives, which is perhaps due to cultural norms.

***Evolving support and contexts influence girls' action to promote well-being***

Whether a girl is married or a single mother, the data presents that she will go out of her way, believing in her self-efficacy (Bandura, 1982) and asserting what thin agency (Klocker, 2007) she has, to get the money she needs for the physical healthcare she desires. While girls' first stop is usually their husbands (if married) or parents (if single), they often know and take advantage of other individuals in their lives that they can look to for financial support to access healthcare. Generally, though, this only happens in situations in which the girl believes the threat of illness to be very severe. She is more likely to either ignore or self-treat a health issue that she views to be minor, including headaches or fevers. This indicates an intersection between self-efficacy and perceived threat or severity within the HBM. Such actions illustrate the ways in which girls and women navigate their personal and community structures to exercise what agency they can in such limiting circumstances.

Whereas single girls regard their parents as harmful to their experiences of overall well-being, because of parents' financial insecurity, married girls and women generally find their parents to be helpful in assisting them to have good physical well-being. Married girls often seek assistance from their parents or other family members because they generally find their husbands to cause them to experience ill-being. While in the end getting help from someone outside the marriage might address a physical ill-being concern, it simultaneously helps with an underlying financial security issue given that the two are intertwined: poor economic situations contribute to the worsening of well-being. However, options for seeking support for an ill-being issue are not unlimited. It was not uncommon to meet girls and women who had experienced physical ill-being that could not be addressed due to barriers (as in the HBM), including poor financial situations and their being unable to find someone in their lives to provide them with the necessary finances.



In Figure Six, the findings of this research are input into the HBM to illustrate the considerations at play when girls desire to address a physical ill-being issue. Participants consider, first, the prevention of more serious illnesses and, second, having the physical ability to continue to care for their children as perceived benefits to seeking assistance with physical ill-being issues. Contrarily, financial hardship and power dynamics within their relationships with their husbands are seen as barriers to promoting their well-being. Risk perception is also a key factor in whether or not girls and women in these communities act to promote their well-being, as they are more likely to address something they view to be serious and ignore or self-treat an illness that they view as minor. As was discussed in Chapter Six, some girls and women do report receiving prompting, or what the HBM calls “cues to action,” from support individuals in their lives, including parents and husbands (Bandura, 1982; Menon and Szalacha, 2008). Interestingly, nurses share that they proactively speak to married and/or pregnant girls about ill-being issues, but nurses were not brought up by girls as individuals who were supportive of their well-being. These cues to action combined with economic assistance from parents, husbands, or other family members often prove critical to girls seeking healthcare because they generally desire to reserve healthcare for their children, who they feel will provide for them economically later in life.

While much of the data supports the different pieces of the HBM, the sticking point in the model that prevents most girls and women from seeking physical healthcare is financial hardship. Were the individuals in these communities living in more sound economic situations, their overall well-being and, particularly, physical well-being would be better.

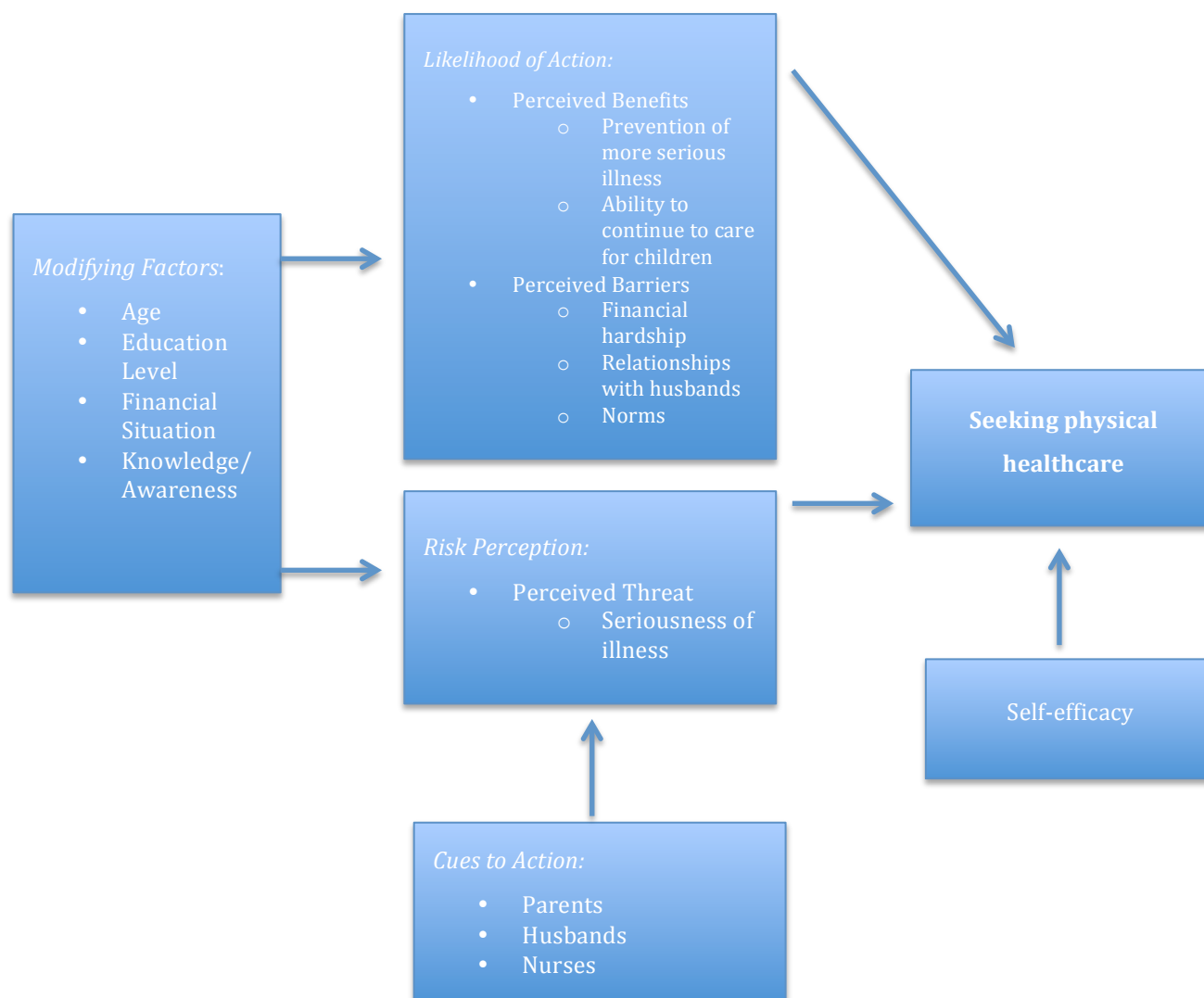
Poor financial security in combination with other limiting components of structure, like girls and women needing to bring their husbands or fathers along with them to healthcare providers, makes acting to advance their own needs very challenging. Such requests for male supervision over reproductive health needs are indicative of a norm that dictates women should not have total autonomy over their reproductive health, and should, instead, bring their husband with them to an appointment for him to give his consent to any related

procedure. This limiting structure that girls and women are operating within impacts their ability to exercise even thin agency in relation to their well-being.

While some girls do report noticing changes in their social well-being since being married or becoming mothers, it is of little consequence to them. None of this study's participants expressed a desire to prioritize or address their social well-being.

As was discussed earlier, girls also frequently report experiencing mental ill-being after marriage and motherhood. Unfortunately, any professional psychological counseling is impossible due to a seeming lack of available services in the communities. Further, girls do not generally report sharing their mental ill-being issues with support individuals in their lives. However, even if such professional services were available, it is unclear whether girls and women would exercise agency to engage in them given the importance they put on '*enduring*.'

The principle of '*enduring*' was demonstrated by the choices girls make whether or not to address ill-being, which are also informed by structural components such as relationships and economic situations acting as barriers to benefits to seeking care. In many ways and particularly when it comes to mental well-being, girls believe that they must endure their suffering because they made choices (i.e. engaging in premarital sexual relationships and becoming pregnant) that led them to where they are. However, the idea of enduring is also present in their outlook. In spite of their awareness of their circumstances, many girls expressed a positive outlook and hope for the future if they have the patience to wait for better days. Being mothers make girls optimistic that their economic situations (and thereby other aspects of well-being) will be bolstered in the future by their children's successes. Girls hope that their children will experience good fortune and then share that with them.

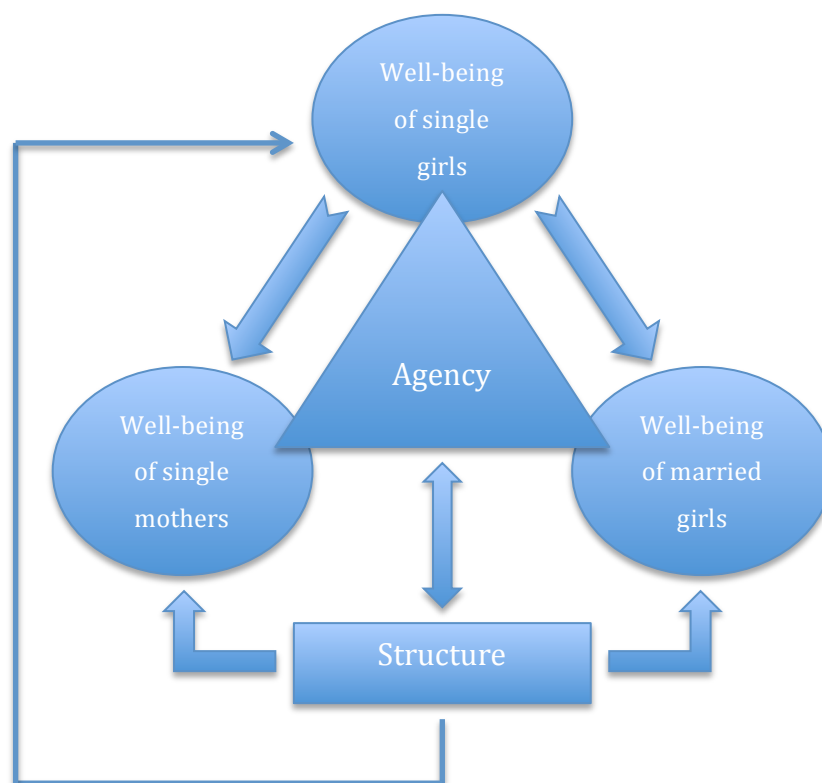


**Figure 6: Illustrating a completed Health Belief Model related to physical well-being using the data collected.**

## 7.2 Adapted conceptual scheme

Figure 5 illustrates an adaptation of the conceptual scheme, presented in subsection 3.2, that is based on the key concepts of this research according to the data and discussion. While largely similar to the original conceptual scheme, this new model also takes into account the well-being of single mothers, which was not an intended unit of analysis prior to arrival in Ghana, and understands that well-being might evolve as a girl goes from being single to being a single mother. As it did in the preliminary conceptual scheme, the adapted scheme shows the influence that structure, operating through various norms, actors, and contexts, has on both the well-being experiences and the agency of girls. This scheme also

illustrates how a girl's agency, no matter what marital state she is in, can influence structure.



**Figure 7: Adapted conceptual scheme**

### **7.3 Answer to main research question:**

#### ***How does child marriage influence experiences of and agency related to well-being amongst girls in rural Eastern Region, Ghana?***

Girls and other members of their communities overwhelmingly perceive child marriage as negatively influencing girls' overall well-being, be it mental, physical, or social, with social well-being the area of least concern for girls and women. Adolescent pregnancy and child marriage change girls' well-being experiences overall in that they generally cause a shift in concerns and priorities because of the exposure to new risks and realities. For example, single girls rarely report experiencing any significant well-being issues, but they frequently enter into premarital sexual relationships due to economic needs that are not being addressed by their parents. However, early marriage and childbearing bring about major physical and mental well-being issues, thereby changing how girls experience their own well-being.

Participants in this study corroborated the notion that their decision-making is influenced by structure, including sociocultural norms, relationships, and financial insecurity, both before and after marriage and/or motherhood. Given this, girls' agency toward their own well-being can be seen as thin, complex, opportunistic, and dependent on social structures and power relations. The study has illustrated that girls themselves feel they participate in decision-making related to their well-being, but that their options are limited. That being said however, agency is generally improved for girls living in better economic situations.

#### **7.4 Policy and practice recommendations**

Given the findings from this study, I endorse the following policy and practice recommendations:

- In order to eliminate child marriage in these communities, adolescent pregnancy needs to be addressed first.
  - Both policymakers and development practitioners should work to improve sexual and reproductive health education so that girls are aware of the ill-being consequences of adolescent pregnancy and child marriage and know how to prevent unwanted pregnancy. Further education on how to avoid or handle the ill-being associated with early marriage and adolescent pregnancy is also critical and allows girls to make more informed decisions related to their overall well-being.
  - Work needs to be done to address well-being needs of girls to prevent them from engaging in premarital sexual relationships without using family planning. As such, the economic standing of families must be addressed. Projects by the development community or Ghanaian government could provide school supplies for girls or compensate families for keeping their daughters in school and unwed.
- The prevalence of mental well-being issues among the participants was a surprising find. Given the dearth of mental health services in the communities, there is a need for development actors and the government

to identify innovative solutions for providing the emotional and psychological support to married girls and women and single mothers.

- Promote education and employment opportunities for girls to improve economic well-being and financial security, as finances were generally seen as an issue to addressing well-being issues more broadly. The promotion of employment opportunities, including bead and soap making, is currently being worked on by THP-Ghana, but resources are limited. Further, girls having the financial capacity to stay in school both before and after marriage and/or motherhood could help them in the long run economically.
- Development actors, including THP-Ghana and Her Choice, should continue to create and encourage dialogue in the communities around changing norms and traditional practices related to premarital sexual relations, use of contraception, child marriage and the well-being of girls more broadly.

## **7.5 Recommendations for future research**

Firstly, I would recommend focusing research into finding ways to optimize the sexual and reproductive health education that students receive in schools. While it is a delicate task to balance the moral conservatism that exists in these communities with exposing young children to sexual education, it is necessary considering the age at which young people in these communities engage in sexual relationships. Adding to this issue is the fact that at least some schools and/or teachers are not adhering to the sexual health curriculum as mandated by the government, which might contribute to increasing awareness and knowledge of pregnancy among girls. Knowing that adolescent pregnancy is both a cause and an effect of child marriage makes addressing it an important area for research.

Secondly, I recommend conducting research into the role that parents play in driving the early sexual relationships and marriages of their daughters. Because it is a failure on the parents' part (as seen by girls) that drive girls to engage in sexual relationships and because of the role they play in early marriage, it is critical to understand their perspectives on this issues. Doing so

could help to highlight how to intervene to prevent both adolescent pregnancy and child marriage.

Finally, I would also recommend carrying out research to gain insight into the motivations for men and boys to engage in sexual relationships with young girls in which they provide for girls' basic needs. Men and boys play active roles in both adolescent pregnancy and child marriage (with some of them being children themselves). It is therefore critical to incorporate their understandings and perspectives on relationships and marriage into the discourse to have a more robust understanding of the situation in Eastern Region.

## **7.6 Final remarks**

For Piper, whose story was first discussed at the beginning of this thesis, marriage did not provide her with the stability she sought. Instead the difference she notices now, as a married mother with another baby on the way, is increased pressure and stress for caring for her children, rather than just herself. This research allowed me, and the broader development community, to endeavor to understand the path that led her (and leads other girls in similar situations) here: to this pink house, in this village, with her new husband, her child, and another baby on the way.

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## 9 Appendices

### 9.1 List of respondents<sup>4</sup>

Type of Interview	Participant #	Pseudonym or role	Age	Age at Marriage	Number of Children	Community	Age at 1st Childbirth
IDI	1	Piper	22	17	1 and pregnant	Boti	17
IDI	2	Sally	20	15	1	Boti	15
IDI	3	Gillian	22	17	3	Akpo	17
IDI	4	Diana	22	17	2	Akpo	17
IDI	5	Nell	17-20	17	3	Akpo-Sru	12
IDI	6	Phoebe	17	17	1	Suta	17
IDI	7	Mia	18	12	4	Boti	11
IDI	8	Penny	22	14	2	Poupouse	14
IDI	9	Ingrid	20	Does not consider herself married	2	Terpoursi	17
IDI	10	Francis	23	13	3	Plau	15
IDI	11	Joanna	17	Single mother	1	Bosotwi	14
IDI	12	Lena	17	16	1	Boti	16
IDI	13	Bonnie	19	Single mother	child died	Akpo	16
IDI	14	Lily	18	Single mother	1	Akpo	17
FGD 1	15	Female	18	-	1	Boti	16

<sup>4</sup> This table provides transparency as to the IDI and FGD respondents. It further illustrates how many girls, particularly in the Boti communities, initially said that they were not married. When following up with them privately, the majority responded that they were married and/or living with their partners. However, some respondents were indeed single mothers.

		respondent					
FGD 1	16	Female respondent	18	-	Pregnant	Osubio No 2	-
FGD 1	17	Female respondent	17	-	1	Boti	16
FGD 1	18	Female respondent	17	-	Pregnant	Bosotwi	-
FGD 1	19	Female respondent	17	-	1	Bosotwi	14
FGD 1	20	Female respondent	17	-	1	Boti	15
FGD 1	21	Female respondent	17	-	2	Boti	12
FGD 1	22	Female respondent	20	15	1	Boti	15
FGD 2	23	Female respondent	21	-	1	Osubio No 1	17
FGD 2	24	Female respondent	18	-	1	Bosotwi	17
FGD 2	25	Female respondent	23	-	3	Boti	18
FGD 2	26	Female respondent	18	-	1	Boti	16
FGD 2	27	Female respondent	18	17	1	Boti	17
FGD 2	28	Female respondent	18	-	1	Osubio No 1	17
FGD 2	29	Female respondent	22	-	2	Poupouse	14
FGD 2	30	Female respondent	18	12	4	Boti	11
FGD 2	31	Female respondent	20	19	2	Boti	13
FGD 3	32	Female	23	15	3	Plau	15

		respondent					
FGD 3	33	Female respondent	20	17	2	Terpoursi	17
FGD 3	34	Female respondent	22	17	3	Akpo	17
FGD 3	35	Female respondent	22	17	2	Akpo	17
FGD 3	36	Female respondent	18	-	1	Bunase	17
FGD 3	37	Female respondent	18	-	1	Bunase	17
FGD 4	38	Female respondent	17	17	1	Suta	17
FGD 4	39	Female respondent	22	-	2	Akpo	17
FGD 4	40	Female respondent	22	-	2	Akpo	18
FGD 4	41	Female respondent	20	-	2	Plau-sra	17
FGD 4	42	Female respondent	19	-	1	Plau	16
FGD 5	43	Elder- (Chief's brother)				Bosotwi	
FGD 5	44	Chief				Bosotwi	
FGD 5	45	Elder				Bosotwi	
FGD 5	46	Mid-20s male				Bosotwi	
FGD 5	47	Pastor (female)				Bosotwi	
FGD 5	48	Elder (female)				Bosotwi	
FGD 5	49	Queen				Bosotwi	

		Mother					
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## 9.2 Operationalization of concepts

Concept	Dimension	Variable	Indicator
Support	Care	Health care providers	Would intervene to support better health and well-being of married girls
		Other care providers	Supportive of married girls
		Institutions	Favorable outlook on child marriage
		Other significant persons (husbands, parents)	Discuss family planning
			Access to health clinics and services
			Ramifications on health and well-being because of marriage
	Social views	Age	Appropriateness of child marriage
		Knowledge and perceptions	Who girls perceive as supporting/undermining their health and well-being
Well-Being	Physical health	Maternal and sexual health	Age at first birth
			Intervals between births



			Proportion of births that are wanted
			Unmet family planning/barriers to this
			Desiring pregnancy
			Using available health services
		Partner violence	Exposure
		Knowledge and perceptions	Knowledge of health risks related to marriage
			Changes in health after marriage
	Health Belief Model	Perceived risk	Knowledge of and feelings toward marriage-related health and well-being risks
			Knowledge of and feelings toward severity of marriage-related health and well-being risks
		Perceived benefits/barriers	Knowledge of and feelings toward benefits of/barriers to addressing marriage-related health and well-being risks

		Cues to action	Experience with Her Choice & THP-Ghana or other programming
	Economic well-being	Education	Satisfaction with schooling experience
		Financial independence/security	Employment
			Access to and joint control of finances
		Knowledge and perceptions	Changes in economic well-being after marriage
		Attitudes	Positive/negative outlook
	Social well-being	Independence	Interactions with peers/support systems outside marriage
		Knowledge and perceptions	Changes in social well-being after marriage
		Attitudes	Positive/negative outlook
	Physical well-being	Knowledge and perceptions	Changes in physical well-being after marriage
		Attitudes	Positive/negative outlook
	Mental well-being	Knowledge and perceptions	Changes in emotional and psychological well-being after

Agency			marriage
		Attitudes	Positive/negative outlook
			Life satisfaction
			Stress levels
	Practical	Feelings and perceptions of agency	Influence over whether or not to marry
			When girls want to marry, why/why not
			Ability to access family planning on their own (modern methods)
			Ability to go to another person for family planning
			Sole say in their healthcare
			Contraceptive user and non-user characteristics
			Evolution of agency with age, or contextual change
			Drivers of health behavior changes
	Relational	Feelings and perceptions of agency	Joint say in their healthcare (parents or husband)

			Changes in health behavior after/because of marriage
			Girls have more agency in health decisions before or after marriage. Why?

### 9.3 IDI guide

Name:_____	Husband's age:_____
Respondent No.:_____	Education:_____
Date:_____	Occupation:_____
Village:_____	Number of children:_____
Respondent's current age:_____	Age at first childbirth:_____
Respondent's age at marriage:_____	Languages spoken:_____

#### **I would like to ask some questions about your personal situation at the moment and what led to this situation**

1. What is your current living situation? (Probe: living with parents, living with husband or partner, etc.)
2. *For married girls / living with a partner:*
  - a. Why were you married? (Probe: poverty, love match, bride price, pregnancy, etc.) Was there a combination of factors that led you to marriage?
  - b. How much say did you have in marrying? Did your parents want you to marry? Your husband?
  - c. What was the process for you being married?
    - i. Were the marriage rites completed before you began living with your partner? What was done during the rites? If not, how did that process happen or where are you at in the process?
    - ii. Were pregnancy rites performed before you moved in with your partner? What was done?
3. *For single mothers*
  - a. What were the circumstances that led to you living with your parents rather than with the baby's father? (Probe: abandonment, choice, had parental support, etc.)
  - b. Were any marriage or pregnancy rites performed or completed?
4. What are some of the positive or negative well-being consequences of being married at a young age or having an early pregnancy?
5. *If applicable:* Looking back on it, how do you feel now about having been married at a young age?

#### **I would now like to talk about experiences of well-being before and after being married / having a baby. And also how you dealt /deal with any health problems**

##### **Well-being before pregnancy and/or marriage**

1. Before being married or becoming pregnant, what kind of well-being issues (problems) did you have as a single girl without children? (Probe: general physical sickness, family planning needs, violence, etc.)

2. When those problems arose, how did you handle it or see to it that they were addressed, if at all?
  - a. (probe: who did you ask for help, who listened, who paid?)
  - b. Were you responsible for making health-related decisions (i.e. going to see a health service provider, doing some home treatment) or was someone else?
  - c. If a parent didn't take your health concerns seriously, what would you do?

I want to ask some questions related to whether you were concerned about falling pregnant

3. As you got older and started having intimate relationships with boys, did you become concerned about becoming pregnant or other sexual health issues?
  - a. Did you understand when you began having sex that pregnancy could be a result?
  - b. Were you intentionally trying to get pregnant?
  - c. Why did you engage in a sexual relationship when you did? (Probe: love, desire, wanting a husband, etc.)
4. At this time, were you using or had you ever used family planning? Why or why not?
5. Before becoming pregnant, were you aware of any health and well-being consequences of early pregnancy? How did you feel about those? (Probe: concerned, unconcerned, perceived risk, perceived severity)
6. Before marriage, were you aware of any health and well-being consequences of early marriage? How did you feel about those? (Probe: concerned, unconcerned, perceived risk, perceived severity)

### **Mental well-being**

1. Before being married and/or having a baby, how did you imagine motherhood and marriage to be? Has that been what you've experienced?
  - a. If not, how do you wish it were different?
  - b. How would you like to your partner to care for you?
2. Since being married and/or having a baby, has your stress and stress levels changed? How so?
3. How has being married and/or having a baby early, impacted you emotionally?
  - a. Did you expect marriage and motherhood to be emotionally difficult?
4. What options are there for dealing with some of the emotional issues that come from marriage and motherhood?
5. Do you have a positive, neutral, or negative outlook on this facet of your life? Why?
6. Are you satisfied with your life so far? (Probe: would have rather waited for marriage/pregnancy)

### **Physical well-being after pregnancy and/or marriage**

1. Please tell me about how you found out you were pregnant and the actions you took afterwards.
2. During pregnancy, how did you feel about your health and well-being?  
How did those feelings change from before you were pregnant?
  - a. Did you experience any issues that you wanted to be addressed by a nurse, doctor, or traditional healer? What were they?
  - b. Were those issues addressed? How did that come about? (Probe: agency.)
3. During pregnancy, what did healthcare workers tell you about having a child at an early age? (Probe: made aware of possible labor/delivery complications?)
  - a. How did you feel about that information? Did it concern you?
  - b. Were you aware of such issues before becoming pregnant?
4. During pregnancy, did you feel like you had the support you needed to ensure your good health and well-being?
  - a. Who provided that support?
  - b. Did anyone make it difficult for you to have good health and well-being during your pregnancy?
5. Did you experience any complications with labor and delivery? What were those?
6. Where did you deliver (clinic, home)?
  - a. Why did you choose that location?
  - b. Did you make that decision yourself? (Probe: agency.)
7. After delivering your baby, did you experience any health issues because of the delivery? (Probe: obstetric fistulas or other common side effects of long labors in young mothers.)
8. Since being married or living with your partner, have you experienced any unwanted pregnancies?
  - a. How did you feel about those pregnancies?
  - b. Were you using family planning to try to avoid pregnancy?
9. *If respondent has more than one child:* How far apart are your children in age?
10. Do you and your husband/partner agree on how many children you want to have? Who decides how many children you want to have in your family? (Probe: agency.)
11. If family planning something that you are currently using? Why or why not?
  - a. If you wanted to use family planning, could you access it by yourself? (Probe: Need husband/partner or parents to access.)
12. Has your partner ever threatened, attempted, or committed violence against you in any way? This could include (threatening or actually)

hitting, pushing, slapping, or physically hurting you in any way. What were the circumstances that led to that?

13. Since being married or having a baby, has your physical health suffered in any way? (Probe: lack of food, as a result of violence, complications from childbirth, etc.)
14. How has your physical health and well-being changed since you were married or had a baby?
15. Who makes the decisions about your health?
  - a. *If applicable:* Has this changed over the course of your life and marriage? (Probe: whether or not age has any impact on agency)
16. Do you have a positive, neutral, or negative outlook on this facet of your life? Why?

### **Economic issues**

1. Are you happy with the level of education you received? Or would you have like to be in school for a longer or shorter time?
2. Are you employed?
3. Do you and your partner [parents if not married] share control over your family's money?
4. How has your economic status changed since being married or having a baby? Are you more or less financially stable than before being married and having a baby?
5. How do you feel today about your economic well-being, including your education, employment status, and financial security?
6. Do you have a positive, neutral, or negative outlook on this facet of your life? Why?

### **Social well-being**

1. Apart from your marriage, whom do you see or visit with regularly (friends, parents, other)?
2. Are you able to see or visit the people that you want to as often as you would like? Why or why not?
3. Have your interactions with friends, family, or the broader community changed since you were married or had a baby?
4. Do you have a positive, neutral, or negative outlook on this facet of your life? Why?

### **Health Belief Model**

1. Now that you are married and a mother, are there any health and well-being issues that you yourself experience that you ignore rather than have addressed by a health professional? Why do you ignore it rather than have it addressed? (Probe: perceived severity)
2. Now that you are married and a mother, are there any health and well-being issues that you yourself experience or may experience that you would be more likely to have addressed? Why? (Probe: perceived severity)



3. Are there certain positives or negatives to addressing your own health issues? (Probe: perceived benefits/barriers)
4. When experiencing a health or well-being concern, was there someone or something that encouraged you to address it (perhaps someone in your life, information you received from a reproductive health class)? (Probe: cues to action)

**Closing**

1. Would you say that marriage and motherhood has had more of a positive or negative impact on your health and well-being?
2. What would your advice be to other girls who have not yet been married or had a baby? Would you encourage them to do it? Why or why not?

## 9.4 FGD interview guide for girls

**Welcome** and thank you for volunteering to take part in this focus group discussion. I have asked you to participate in this discussion, as your point of view is important to this study project. I understand that you are very busy, so I appreciate your time.

My name is Brittany Haga. I am a student working towards my master's degree at the University of Amsterdam in the Netherlands. I am originally from America. I am here with [interpreter's name], who you may know at the 'Her Choice' project coordinator for The Hunger Project-Ghana.

### Introduction

For my study project, I'm hoping to understand how being married at a young age or having a child at a young age influences experiences of well-being. I would also like to learn about the actions that girls/young women take to improve their well-being. With this understanding, I can give recommendations to organizations like THP-Ghana on how to design their program activities targeted at young married girls or girls who have a child at an early age.

Thus, in this focus group discussion I hope to talk with you about child marriage in your communities and generally how girls' well-being is influenced by being married early or having a child at a young age. In this discussion you are asked to **talk generally about girls and women like you**. You do not have to share your personal experiences, feelings, or actions.

This discussion should not last more than two hours.

**Anonymity:** In the discussion I will not ask your real name and in the report I will make sure that nobody can trace who you are.

I want to ask your permission to audio record the discussion. This is because it is difficult to write down all that you say without interrupting you. I will later transcribe the tapes. This will help me to not miss anything that you have said in this discussion. The transcriptions will not include any identifying information that would allow specific statements to be linked to specific individuals.

In a discussion like this, there are no right or wrong answers. Everything any of you says is important. We can agree to disagree about some points.

Please note that if there are any questions or discussions that you do not wish to answer or participate in, you do not have to do so.

Do you have any questions at this point?

Do you all consent to being part of this discussion?

Do you all consent to the recording of this discussion?

Do I have your permission to proceed?

**I want us to start with setting some general rules.**

**Can you think of some rules for the discussion, such as the first:**

- Only one person should speak at a time. Please wait until a speaker is done with their statement before adding your own opinion.
- LET THEM ADD: (use of telephone, respect for other people's views, etc.)

### **Child Marriage**

- Please explain what marriage is considered to be in this community.  
Probe: Informal and formal arrangements
- What makes a girl ready for marriage? Probe: Is it her age (or something else - circumstances)?
- Do many girls in your community marry early? Probe: minority, half, majority.
- What or who motivates girls to marry early in your community? Do girls seek early marriage or does another person (parent, community member, men etc.) push them to do it?
- Is there something about a girl (how rich she is, where she comes from, who her parents are, etc.) that makes her have more say in whether or not she gets married?

### **Well-Being**

*Explain the meanings of well-being in this study.*

- Before girls in your community are married, what are generally their main well-being concerns?
- What types of actions do unmarried girls generally take to better their well-being? Or is someone else making the decisions for them?
- What kind of access to health clinics and health services do adolescent girls in these communities have? Can they make the decision to seek healthcare or does someone else (a parent or husband) make that decision?
- After marriage, what are generally some well-being concerns of girls and women?
- Generally, does a woman's well-being improve or worsen after marriage?
  - How/in what ways (worsen or improve)?
  - What are the reasons well-being improve/worsen?
  - Is there something or someone that would prevent a married girl from taking action to better her well-being?
- After a girl is married, what actions does she take (whether in changing her own behavior, seeking health treatment, etc.) to better her well-being?
- How might a single mother (a girl who is not married) experience well-being? Would it be different than how a married young mother experiences her well-being? Please explain why this would be so.

- Are there people in your community (parents, husbands, chiefs, NGO workers, etc.) who make it more difficult for girls to have good well-being?
- Are there people in your community (parents, husbands, chiefs, NGO workers, etc.) who help girls to have better well-being?
- If a girl had a well-being issue, who would she go to for support (if anyone)?
  - Would that person change after marriage?

## 9.5 FGD interview guide for support individuals

**Welcome** and thank you for volunteering to take part in this focus group discussion. I have asked you to participate as your point of view is important to this study project. I understand that you are very busy, so I appreciate your time. My name is Brittany Haga. I am a student working toward my master's degree at the University of Amsterdam in the Netherlands. I am originally from America. I am here with Patricia Osei Amponsah, who you may know as the 'Her Choice' project coordinator for The Hunger Project-Ghana.

### Introduction

For my study project, I'm hoping to understand how being married at a young age or having a child at a young age influences experiences of health and feelings of wellbeing. I would also like to learn about the actions that girls/young women take to improve their health and well-being. With this understanding, I can give recommendations to organizations like THP-Ghana on how to design their program activities targeted at young married girls or girls who have a child at an early age.

Thus, in this focus group discussion I hope to talk with you about child marriage in your communities and generally how girls' health and well-being is influenced by being married early or having a child at a young age. In this discussion you are asked to **talk generally about girls and women in your communities**. You do not have to share your personal experiences, feelings, or actions.

The discussion should not last more than one and a half hours.

**Anonymity:** In the discussion I will not ask your real name and in the report I will make sure that nobody can trace who you are.

I want to ask your permission to audio record the discussion. This is because it is difficult to write down all that you say without interrupting you. I will later transcribe the tapes. This will help me to not miss anything that you have said in this discussion. The transcriptions will not include any identifying information that would allow specific statements to be linked to specific individuals.

In a discussion like this, there are no right or wrong answers. Everything any of you says is important. We can agree to disagree about some points.

Please note that if there are any questions or discussions that you do not wish to answer or participate in, you do not have to do so.

Do you have any questions at this point?

Do you all consent to being part of this discussion?

Do you all consent to the recording of this discussion?

Do I have your permission to proceed?

**I want us to start with setting some general rules.**

- Only one person should speak at a time. Please wait until a speaker is done with their statement before adding your own opinion.
- If you have a telephone with you, please silence it now.
- In a group discussion such as this, it is not uncommon for people to disagree. If someone says something that you disagree with, please wait for him or her to finish before respectfully sharing your experience. It is important to remain respectful of everyone's views.

**Reasons and Attitudes Toward Child Marriage**

- Introductory Question: Please tell me about your current outlook on child marriage. Has that changed at all over time? How so?
- What makes a girl ready for marriage? Is it her age (or something else)? In what circumstances is early marriage appropriate?
- Is there something about a girl's situation that would make her more or less likely to marry before the age of 18?
- Are there circumstances in which a girl would be encouraged by someone in the community (parents, elders, friends, etc.) to marry before age 18? What would those be?
- What steps do you or would someone in your position (either as an elder, parent, community member, etc.) take to be supportive of married girls?
- What are the general community's attitudes toward girls who become pregnant or marry early? Is it looked down on?
- What happens to girls who fall pregnant when not married? What do parents do? (Probe: Are the girls allowed to remain with their families or are parents trying to let her marry the man that made her pregnant? And who makes the decision?)
- Do most girls who become pregnant end up getting married? Why or why not?

**Well-Being of Girls**

*Explain the meaning of well-being in this study*

- What are some of the main problems with wellbeing of single girls in this community?
- What kind of access to health clinics and health services do adolescent girls have? Can they make the decision to seek healthcare or does someone else (a parent or husband if they are married) make that decision?
- What do you view as some of the effects (both positive and negative) of marriage or early pregnancy on a girl's well-being? What are some of the main problems with well-being of married girls in this community?

- Considering their different living situations, do you see any differences in the well-being of married mothers and single mothers? What are those?
- Would someone in your position (either as an elder, parent, community member, etc.) intervene to support better well-being of married girls?
  - Are there certain instances in which it is more appropriate for you to intervene to support better well-being of married girls?  
(Probing for whether pregnancy/birth-related health is more appropriate to intervene in than physical violence, etc.)
- What do you consider to be solutions to ill-being concerns for married girls or young mothers?