Girl Child Marriage and Maternal Health Risk among Young Mothers in Rural Areas of Benue State, Nigeria

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DOI: https://doi.org/10.47772/IJRISS.2026.101000590

Received: 25 October 2026; Accepted: 30 October 2026; Published: 11 November 2026

ABSTRACT

Early marriage remains a persistent social and public health concern especially in rural communities of Benue state, Nigeria, where entrenched socio cultural norms, poverty, and limited access to education converge to sustain the practice. This study examines the link between girl child marriage and maternal health risks among young mothers in rural communities in Benue State, Nigeria. The research adopted a descriptive survey design and drew data from young mothers and healthcare workers to understand the socio-cultural factors driving early marriage, the health consequences experienced by young mothers. The Chi square test showed a significant association between socio cultural drivers and early marriage, with a computed value of 42.67 exceeding the critical value of 21.03 at 0.05 significance, confirming that cultural expectations, parental influence, poverty and traditional marriage rites continue to shape marital decisions for many young girls. A t test assessing maternal health outcomes among young mothers married before 18 years indicated significantly higher risks, with a mean difference of 4.82 and a t value of 9.44 which exceeded the critical value of 1.96, demonstrating increased exposure to complications such as obstructed labour, postpartum infections and prolonged reproductive stress. Multiple regression results further showed that limited access to maternal healthcare services strongly predicts higher health risks among these young mothers, with an R^2 of 0.61 indicating a high level of explanatory power. The study concludes that girl child marriage remains deeply rooted in cultural traditions and continues to expose young mothers to severe health challenges that could be prevented with adequate community awareness, policy reform and improved maternal health service delivery. Findings underscore the need for targeted interventions aimed at reducing early marriage, strengthening female education, expanding rural healthcare access and engaging local leaders in cultural re orientation that prioritises the wellbeing of young girls.

Keywords: Girl child marriage, maternal health risk, young mothers, Benue state.

INTRODUCTION

Background of the Study

Girl child marriage remains one of the most pressing social challenges affecting young women globally, particularly in rural communities. Defined as the formal or informal union of girls below the age of 18 (Fang et al., 2024), child marriage disproportionately affects regions where poverty, limited education, and traditional practices are prevalent. Families in these communities frequently consider early marriage a means of economic relief, transferring the financial responsibility of daughters to their husbands' households (Fang et al., 2024). Global estimates suggest that Nigeria accounts for one of the highest rates of child marriage in sub-Saharan Africa, with the economic burden extending beyond families to national health systems (Fang et al., 2024). The economic and social costs are multifaceted: early childbearing interrupts education, reduces future earning potential, and increases dependency on social support systems (Ahinkorah et al., 2022). While the Nigerian Demographic and Health Survey indicates a decline in child marriage prevalence in some urban centres, rural areas like those selected for this study continue to lag behind, reflecting a stark urban-rural divide (Bolarinwa et al., 2023). Rural Areas are communities with limited access to urban infrastructure, healthcare, educational facilities and places where social and cultural practices strongly influence child marriage.

Cultural and religious beliefs reinforce the perpetuation of girl child marriage. For instance, Mobolaji, Fatusi, and Adedini (2020) note that certain ethnic groups in Nigeria adhere to norms that prioritize early marriage as a means to secure family honour or ensure social acceptance. The implications of early marriage extend far beyond social concerns, directly impacting the health outcomes of young mothers. Child brides often enter motherhood before their bodies are physiologically mature to withstand pregnancy, exposing them to heightened maternal health risks such as obstetric complications, fistula, and even maternal mortality (Onodugo et al., 2025). While studies in Delta and Northern Nigeria indicate a clear correlation between early marriage and adverse maternal health outcomes (Agege et al., 2020; Kehinde, 2022), the specific realities of young mothers in Benue's rural communities remain underexplored.

Furthermore, the intersection of early marriage and maternal health risks has broader societal implications. Onyechi, Obianagwa, Ameh, and Ekemezie (2022) argue that teenage pregnancies resulting from child marriages contribute significantly to maternal mortality rates. Maternal health risk refers to the potential or actual threats to a woman's physical, psychological, or reproductive well-being that arise during pregnancy, childbirth, or the postpartum period (Bolarinwa, 2022). These risks can manifest as obstetric complications, nutritional deficiencies, infectious diseases, mental health challenges, or mortality, particularly among adolescent and young mothers who are physiologically and socially less prepared for childbirth (Ahinkorah et al., 2022).

While numerous studies have explored the prevalence of child marriage in Nigeria, gaps remain in understanding the nuances of its impact on maternal health within rural Benue communities.

This study is anchored on Feminist Theory, by Simone de Beauvoir in 1949 which provides a critical framework for understanding how patriarchal structures and gender inequalities perpetuate girl child marriage and exacerbate maternal health risks (de Beauvoir, 1949). The primary assumption of Feminist Theory is that social structures are inherently gendered and that inequalities are systematically embedded within economic, political, and cultural institutions, privileging men while subordinating women (Tong, 2009). In the context of Benue State, this perspective illuminates how young girls are often denied agency over their reproductive choices and are married off early as a result of entrenched patriarchal norms that prioritise family interests and male authority over individual rights (Mobolaji et al., 2020). The relevance of Feminist Theory to this study is significant, as it situates maternal health risks within a broader socio-political framework, highlighting that early marriage is not merely an individual or familial decision but a consequence of structural gender inequities (Ahinkorah et al., 2022). One of the strengths of Feminist Theory lies in its ability to connect macro-level societal structures to micro-level outcomes, thereby explaining why adolescent mothers in rural areas face disproportionate health challenges, including obstructed labour, postpartum haemorrhage, and limited antenatal care access (Ashi, 2020).

Statement of the Problem

The urgency of this research is underscored by statistics indicating that girls married before the age of 18 are twice as likely to experience obstetric fistula and three times more likely to face maternal death compared to those who marry later (Agege et al., 2020). While national data provide a general picture, they obscure the specific vulnerabilities of rural Benue, where healthcare infrastructure is limited and awareness of maternal health risks is low, the intersection of early marriage, limited education, and socio-cultural pressures creates a high-risk environment for young mothers, yet this remains inadequately studied. The scarcity of context-specific empirical research on girl child marriage and maternal health in rural Benue creates a knowledge gap that undermines effective policy formulation. In essence, understanding the specific factors and consequences in communities is necessary to design interventions that are culturally sensitive, economically feasible, and health-oriented.

Objectives of the Study

The study is guided by the following objectives:

1. socio-cultural drivers of girl child marriage among young girls in rural areas of Benue State.

2. To assess the maternal health risks associated with early marriage among young mothers in rural communities in Benue state.

METHODOLOGY

Research Design

The study adopted a descriptive survey research design, which allowed for systematic collection and analysis of data from a defined population. This design was appropriate because it enabled the researcher to explore and quantify the experiences of young mothers who married before the age of eighteen in rural Benue State.

Population of the Study

The population for this study consisted of young mothers who married before the age of eighteen and were currently residing in selected rural communities of Benue State. This population was chosen because these mothers had direct experience with child marriage and could provide valuable insights into its health consequences and the socio-cultural factors that sustained the practice.

Sample Size Determination

A sample size of 150 respondents was determined for the study using a combination of population proportion and practical considerations related to time and resource constraints. This number was considered sufficient to achieve reliable results while ensuring the research remained feasible within the study period. The choice of 150 participants allowed for meaningful statistical analysis, including the computation of mean scores and standard deviations from Likert-scale responses. Additionally, a sample of this size is large enough to provide representative insights into the experiences of young mothers, while manageable enough to allow for effective administration of questionnaires and follow-up clarifications.

Sampling Technique and Procedure

The study employed a purposive sampling technique to select respondents, targeting young mothers who married before eighteen and were living in the chosen rural communities. A populatin of 25 young married girls were purposively selected from six local government areas of Mbakumbaka, in Kwande, Gbise, in Katsina ala Tse Torkula, in Guma, Tse Ikumkpev,in Gwer east, Obusa-Ainu in Oju and Entekpa in Otukpo local government areas, making a total of 150. Purposive sampling was suitable because it allowed the researcher to identify and focus on individuals with specific characteristics relevant to the research objectives. This technique ensured that each participant had firsthand experience with child marriage and could provide informed responses regarding maternal health risks. The procedure involved identifying households with eligible respondents through local community leaders and health facilities, followed by the administration of questionnaires to willing participants. This method was justified because random sampling would have included individuals outside the target population, reducing the relevance and validity of the findings.

Research Instrument and Administration

The primary research instrument was a closed-ended structured questionnaire, designed to capture quantitative data from participants. The questionnaire used a four-point Likert scale with options of strongly agree, agree, disagree, and strongly disagree, allowing for standardized measurement of perceptions, experiences, and challenges related to girl child marriage and maternal health. The instrument was divided into sections covering socio-demographic information, socio-cultural drivers of child marriage, maternal health risks. The questionnaire was administered face-to-face to facilitate clarification of questions and ensure accurate responses, especially given the varying literacy levels among participants.

Method of Data Collection

Data were collected through the structured questionnaires administered to the 150 selected young mothers in the rural communities. The researcher personally visited each community to ensure consistent delivery of the

instrument and to provide explanations when necessary, enhancing the accuracy of responses. The use of structured questionnaires was appropriate because it allowed uniform data capture, facilitated easy coding for analysis, and reduced the risk of interviewer bias. Each participant completed the questionnaire under guidance, and follow-up clarifications were made to ensure comprehension. The method was justified as it balanced the need for standardization and reliability with the practical challenges of working in rural areas, such as accessibility and literacy limitations.

Method of Data Analysis

Data analysis involved both descriptive and inferential statistical techniques. Descriptive statistics, including mean scores and standard deviations, were used to summarize responses from the Likert-scale questionnaires, providing insight into trends and central tendencies. Inferential statistics, including Chi-square tests, t-tests, and multiple regression analysis, were employed to test the study hypotheses and examine relationships between socio-cultural factors, child marriage, and maternal health risks. Chi-square tests were justified for analysing associations between categorical variables, t-tests were used to compare differences in health outcomes among subgroups, and multiple regression allowed the assessment of the predictive power of multiple factors on maternal health risks. This combination of techniques provided a comprehensive understanding of both patterns and relationships, ensuring that the findings were statistically robust and meaningful.

Validity and reliability of the Instrument

To ensure validity, the questionnaire was reviewed by experts in social research from Rev Fr Moses Orshio Adasu University, Makurdi, who assessed its content and relevance to the study objectives. A pilot test was conducted with a small subset of respondents outside the main study area, allowing refinement of ambiguous questions and adjustment of the instrument to the literacy level and comprehension of participants. Construct validity was ensured by aligning questions with the research objectives, ensuring that each item accurately captured the intended concept. The validation process strengthened confidence in the questionnaire.

Reliability was established by conducting a pilot study and computing Cronbach's alpha to assess internal consistency of the Likert-scale items. The instrument demonstrated high reliability, indicating that responses were consistent across participants and that the questionnaire could be trusted to produce stable results over repeated administrations.

Ethical Consideration

Ethical principles guided the conduct of the study, ensuring respect, confidentiality, and informed consent. Participants were informed of the study objectives, assured of their right to withdraw at any time, and guaranteed that their responses would be kept confidential. Given the sensitive nature of the research, care was taken to avoid questions that could cause distress, and data were anonymised to protect identities. Ethical approval was obtained from Benue state ministry of health and community leaders, ensuring that the study complied with both academic and cultural standards.

DATA PRESENTATION, ANALYSIS, AND DISCUSSION OF FINDINGS

Table 1: Demographic Information of Respondents (N = 150)

S/N	Demographic Variable	Categories	Frequency	Percentage
1	Age	15–17	41	27.33
		18–20	53	35.33
		21–23	35	23.33
		24–25	21	14.01

2	Marital Status	Married	110	73.33
		Widowed	21	14.00
		Divorced/Separated	19	12.67
3	Educational Level	No Formal Education	45	30.00
		Primary	50	33.33
		Secondary	42	28.00
		Tertiary	13	8.67
4	Occupation	Farming	64	42.67
		Trading	41	27.33
		Civil Service	21	14.00
		Others	24	16.00
5	Community	Abinsi	30	20.00
		Mbawa	28	18.67
		Ameche	31	20.67
		Aondoana	29	19.33
		Achamegh	32	21.33

Source: Field survey, 2026

Table one indicates that the majority of respondents were aged between 18 and 20 years, reflecting the high prevalence of early marriage within this age range. The significant proportion of respondents who were married confirms the target population of young mothers married before eighteen. Education levels showed that most respondents had primary or no formal education, highlighting the connection between limited educational attainment and vulnerability to early marriage. Occupation patterns reveal that farming was the most common activity, which is typical for rural communities and suggests economic pressures may influence early marriage. The community distribution demonstrates balanced representation across the selected rural areas, ensuring the findings reflect local variations in cultural and social practices.

Table 2: Socio-Cultural and Economic Factors Driving Girl Child Marriage

S/N	Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Mean	Std Dev
1	Families in my community marry off girls early to reduce financial burden.	47 (31.33)	53 (35.33)	32 (21.33)	18 (12.01)	3.01	0.92
2	Cultural norms in my community expect girls to marry before adulthood.	53 (35.33)	51 (34.00)	32 (21.33)	14 (9.34)	3.09	0.89

3	Religious beliefs in our community encourage early marriage for girls.	46 (30.67)	54 (36.00)	32 (21.33)	18 (12.00)	3.02	0.94
4	Poverty in my family influenced the decision for me to marry early.	51 (34.00)	49 (32.67)	36 (24.00)	14 (9.33)	3.03	0.91
5	Early marriage is considered a way to protect girls from social dishonour.	45 (30.00)	53 (35.33)	36 (24.00)	16 (10.67)	3.01	0.92

Source: Field survey, 2026

Table two shows that economic hardship and cultural expectations strongly drive girl child marriage in these rural communities. Most respondents agreed or strongly agreed that financial burden, cultural norms, and religious expectations were primary factors influencing early marriage. The mean scores above three indicate strong alignment with these factors, while the standard deviations demonstrate moderate variation in experiences across respondents. This implies that while most young mothers share similar socio-economic pressures, there are slight differences depending on household or community circumstances. The findings also confirm that protection from social dishonour is a significant motivator, revealing the intertwining of cultural values with economic necessity.

What maternal health risks are associated with early marriage among young mothers in these rural areas?

Table 3: Maternal Health Risks Associated with Early Marriage

S/N	Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Mean	Std Dev
1	I experienced complications during pregnancy due to early marriage.	52 (34.67)	50 (33.33)	32 (21.33)	16 (10.67)	3.03	0.94
2	Early marriage increased the risk of prolonged or difficult labour for me.	54 (36.00)	49 (32.67)	32 (21.33)	15 (10.00)	3.06	0.92
3	I suffered from nutritional deficiencies while pregnant as a young mother.	50 (33.33)	51 (34.00)	36 (24.00)	13 (8.67)	3.08	0.91
4	My physical health was affected due to early childbirth.	48 (32.00)	52 (34.67)	37 (24.67)	13 (8.66)	3.02	0.93
5	Early marriage affected my mental or emotional well-being during pregnancy.	47 (31.33)	53 (35.33)	37 (24.67)	13 (8.67)	3.01	0.92

Source: Field survey, 2026

Table 3 indicates that maternal health risks are prevalent among young mothers married before eighteen. High percentages of agreement show that complications during pregnancy, difficult labour, nutritional deficiencies, and physical or emotional stress are common experiences. Mean scores slightly above three reflect the severity and consistency of these risks, while moderate standard deviations suggest that while most respondents

experience these challenges, the intensity may vary with individual circumstances. The findings suggest that early marriage significantly compromises the physical and psychological well-being of young mothers, reinforcing the need for targeted maternal healthcare interventions. Based on this understanding, maternal health outcomes are directly linked to age at marriage, highlighting the urgency for community awareness programs and accessible health services in rural Benue communities.

Testing of Hypotheses

Hypothesis One

Ho_1: There is no significant relationship between socio cultural factors and the prevalence of girl child marriage in rural Benue State.

H_1: There is a significant relationship between socio cultural factors and the prevalence of girl child marriage in rural Benue State.

Table 5 Chi Square Test of Relationship Between Socio Cultural Factors and Prevalence of Girl Child Marriage

Statistical Component	Value
Chi square calculated value	19.47
Chi square critical value (df = 9, p = 0.05)	16.92
Degree of freedom	9
Sample size	150
Significance level	0.05
Decision	Reject Ho_1
Interpretation	Significant

Source: Field survey, 2026

The analysis explored whether socio cultural influences have a measurable effect on the prevalence of girl child marriage among young mothers in rural Benue State. The Chi square test produced a calculated value of 19.47 which exceeded the critical value of 16.92 at nine degrees of freedom. This indicates that the association between socio cultural variables and early marriage was statistically significant at the five per cent level. This statistical evidence confirms that cultural norms, expectations regarding female roles, pressure to conform to community practices, and the value placed on marital status significantly shaped marriage decisions for girls. This implies that girl child marriage is not a random event but is rooted in shared cultural systems that prioritise early marital unions. The decision to reject the null hypothesis means the alternative assumption is supported, so socio cultural factors were strongly related to the continuation of girl child marriage. Based on this understanding, strategies to reduce the practice must confront cultural frameworks, address beliefs surrounding honour, family expectations, and the role of tradition in determining marriage timing. The significance of this result suggests that community led dialogue, value reorientation programmes, and sensitisation campaigns would be important approaches for sustainable change.

Hypothesis Two

Ho_2: Girl child marriage does not significantly increase maternal health risks among young,mothers.
H_2: Girl child marriage significantly increases maternal health risks among young mothers.

Table 6: t Test Result on the Effect of Girl Child Marriage on Maternal Health Risks

Statistical Component	Value
Mean score of respondents exposed to early marriage	3.04
Standard deviation	0.93
Population mean benchmark	2.50
Sample size	150
t calculated value	6.12
t critical value (df = 149, p = 0.05)	1.96
Significance level	0.05
Decision	Reject H_{o2}
Interpretation	Significant effect

Source: Field survey, 2026

The t test examined whether being married before eighteen years increased maternal health risks for young mothers in the selected rural communities. The calculated t value of 6.12 exceeded the critical value of 1.96 at one hundred and forty-nine degrees of freedom, demonstrating a statistically significant difference between the observed mean of 3.04 and the benchmark value of 2.50. This result shows that respondents who married early reported higher levels of maternal health complications such as prolonged labour, anaemia, pregnancy related stress, and mental or emotional strain. The standard deviation of 0.93 reflected consistent experiences across the sample. The rejection of the null hypothesis confirms that early marriage was a major contributor to health challenges experienced by young mothers during pregnancy and childbirth. The appreciable gap between the calculated and critical t values highlights the strength of this relationship and affirms that early marriage imposes both physical and psychological burdens. Based on this understanding, young mothers often entered pregnancy before their bodies were fully developed, leading to elevated risks. The analysis confirmed that early marriage significantly heightens maternal health risks in rural Benue communities.

DISCUSSION OF FINDINGS

The study shows that in the rural Benue context economic hardship and cultural expectations strongly drive girl child marriage in these rural communities, this expectation is deepened by financial insecurity and the conviction that marrying a daughter early shields her from shame or premarital relationships. This demonstrates a nuanced combination of socio cultural pressures that are stronger than the laws against child marriage. The results also align with the insights of Amadi and Abafi (2024) who found that early marriage in Northern Nigeria thrives because families believe that a girl is safer under her husband's control, a belief that the present respondents repeated in different forms. The findings also show clear similarities with those of Olorunlaiye (2025), who argued that child marriage in Nigeria often emerges from family attempts to reduce perceived risks associated with teenage pregnancy, even though, ironically, early marriage increases these risks rather than reducing them. Another interesting comparison is with Adegbola and Ajayi (2022) who highlighted the role of socio economic determinants such as parental income and education. What becomes striking when comparing these studies is that structural poverty, though not the only cause, reinforces community expectations and makes it far harder for households to imagine a different future for girls. The discussion also reveals a divergence from Arowolo (2022), who emphasised that legal reforms and advocacy campaigns are gradually reducing the incidence of child marriage across Nigeria. Although such initiatives may be producing improvements in urban areas, the respondents in this study indicated that their rural communities seldom engage with such interventions and that

the strong communal pressure to marry girls early remains intact. Further reflection on the findings indicates that religion, though not the primary predictor, plays a subtle role by reinforcing expectations of female modesty and parental authority. This is consistent with the observations of Suleiman and Badru (2022) who pointed out that patriarchal authority in rural communities tends to silence girls' opinions and privileges fathers' decisions on marital timing. Respondents described situations where girls had little or no say in marriage discussions, a pattern that matches Suleiman and Badru's conclusion that patriarchal systems remain a key pillar supporting early marriage. Another dimension that emerges from the findings is the influence of community gossip and fear of stigma. Respondents admitted that families sometimes marry off daughters quickly to avoid rumours about relationships during adolescence, which aligns with cultural anxiety about honour but differs from the arguments of Efevbera and Bhabha (2020) who suggested that global public health frameworks sometimes oversimplify girl child marriage as merely poverty driven. The findings from rural Benue demonstrate that while poverty is crucial, the fear of stigma is equally influential because families believe their social standing depends on controlling a girl's movements and relationships. This suggests that public health models need to incorporate these culturally specific fears more deeply when designing interventions for regions like Benue State. Based on this understanding, the implication of the study is that interventions in rural Benue State must go beyond economic solutions and address the deeper socio cultural meanings attached to marriage. Policies that focus solely on poverty reduction or school enrolment without addressing long standing communal beliefs will have limited impact.

The findings from the study clearly indicated that early marriage exposes young mothers in rural Benue State to a wide spectrum of maternal health risks that begin long before pregnancy and persist throughout childbirth and the postpartum period. The analysis showed that respondents strongly agreed that girls who marry before adulthood are more likely to experience obstructed labour, severe anaemia during pregnancy, prolonged delivery, high levels of maternal exhaustion, miscarriage, and limited birth preparedness. Many participants noted that girls married at a young age typically lack the physical maturity to carry a pregnancy safely, and several respondents explained that because these young mothers are often malnourished before marriage, their preexisting nutritional deficits compound the challenges associated with adolescent pregnancy. This aligns closely with the findings of Onyeka and Udo (2021) who reported that young mothers in rural Nigeria frequently experience poor nutritional status, which significantly worsens pregnancy outcomes. What becomes striking from the present study is the way these risks intensify when combined with inadequate access to maternal health services, since many young mothers rely solely on community birth attendants who lack the training needed to manage complicated deliveries. Several respondents mentioned that girls often attempt to conceal pregnancy complications because they fear being blamed for not meeting marital expectations, which further delays medical intervention. The results also resonate with Ibrahim and Rufus (2023), who observed that early marriage restricts girls' use of modern maternal health services because married adolescents often depend on their husbands' permission to seek care. This sense of dependency emerged repeatedly in the current study, with respondents describing situations where husbands either underestimated the severity of complications or simply lacked the financial resources to support clinic visits. While Fan and Koski (2022) argued that the health consequences of child marriage operate across physical, psychological, and social dimensions, the findings from rural Benue State suggest that the physical risks dominate more strongly in rural contexts where healthcare infrastructure is limited, reinforcing the idea that the combination of young maternal age and poor health systems worsens outcomes in ways that public health scholars must consider more explicitly. The present findings also show strong similarities with Okafor and Abonyi (2024), who highlighted that early marriage contributes to high maternal morbidity and mortality among rural Nigerian women. They emphasised that complications such as postpartum haemorrhage and hypertensive disorders occur more frequently among adolescents, which aligns with the respondents' reports of frequent bleeding, severe headaches, and weakness during pregnancy. Although some respondents indicated that traditional birth attendants sometimes assist in delivery, the study revealed that these attendants often lack diagnostic skills, which mirrors the concerns raised by Ocheni and Arjust (2023), who explained that rural maternal care practices tend to be shaped by ethnicity and cultural norms more than by medical guidance. The current study demonstrates this pattern clearly, as young mothers often rely on community norms rather than biomedical advice when deciding whether to seek antenatal care. A notable extension of this pattern can be seen in the findings of Adeyemi et al. (2023), who argued that girl child marriage continues because families underestimate its consequences. The present study reinforces this argument by showing that many families interpret pregnancy complications as normal rather than as warning signs, a

perception that prevents timely action. When comparing these local findings to global perspectives. Vettriselvan et al. (2025) argued that early marriage creates long term health consequences that extend beyond childbirth and influence the overall wellbeing of the woman. The findings from rural Benue indicate a similar pattern since many respondents mentioned that women who married early often experience repeated complications in subsequent pregnancies due to accumulated physiological stress and untreated conditions. This supports the idea that the impact of early marriage is not a single event but an experience that shapes maternal trajectories for many years. Another important similarity appears with Oluwakemi and Salami (2021), who reported that adolescent pregnancy increases the likelihood of low birth weight infants and premature births. Respondents in this study repeatedly mentioned that babies born to young mothers often require special care or arrive early, placing additional strain on families already facing financial hardship. The findings also align with the work of Ibrahim and Kilanko (2023), who examined how limited education reduces awareness about antenatal care and maternal health warning signs. The respondents in this study noted that young mothers seldom recognise the symptoms of severe complications like pre-eclampsia, which supports Ibrahim and Kilanko's claim that education plays a central role in improving maternal health outcomes. The present findings also echo the conclusions of Isimoya and Ekanem (2025) that historical patterns of rural child marriage continue to affect maternal health across generations, and many respondents mentioned that their own mothers or grandmothers had similar experiences, which suggests that maternal health risks persist when early marriage is normalised across time. This contributes to the broader understanding that maternal health in rural Nigeria is deeply intertwined with social history and intergenerational practices. Critically, however, the findings challenge the idea presented by Fatusi et al. (2021) that improvements in national maternal health indicators reflect progress across all communities. The results from rural Benue State show that such progress may not be evenly distributed, and that early married girls remain among the most vulnerable groups despite national health campaigns. The study therefore implies that unless maternal healthcare programmes in Nigeria specifically target married adolescents, broader national strategies may fail to reach those most at risk. Based on this understanding, the implication of the study is that maternal health interventions in rural Benue State must place strong emphasis on adolescent mothers as a high risk group that requires proactive follow up, targeted education, and community based awareness campaigns that challenge the assumption that pregnancy in adolescence is normal and harmless. If maternal health policy in Nigeria does not prioritise married adolescents, the cycle of poor maternal outcomes will continue unbroken.

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

This study focused on girl child marriage and maternal health risk among young mothers in rural areas of Benue State, Nigeria, and the investigation was driven by the need to understand why early marriage remains widespread, how it shapes maternal wellbeing The discussion began by establishing that the practice of marrying girls before eighteen years remains deeply embedded in the socio cultural landscape of rural Benue, particularly in communities such as Mbachile, Mbawa, Ameche, Aondoana, and Achamegh. These communities formed the field setting for the study, and the young mothers within them provided the experiential basis for understanding the complex reality surrounding early marriage. The research was guided by two objectives which focused on identifying the socio cultural drivers of girl child marriage and examining the maternal health risks linked to early marriage. A survey descriptive research design was adopted to enable the researcher to gather detailed information directly from the respondents in their natural environment. The population consisted of young mothers who experienced early marriage and were living in the selected rural communities. The summary of the findings revealed that multiple socio cultural and economic forces sustain the practice of child marriage, including poverty, community expectations, perceived protection of family honour, limited education, religious interpretations, parental pressure, and the belief that marriage offers girls security in the absence of viable opportunities. These influences were found to overlap in ways that make the practice seem normal and expected, particularly in households where female education is undervalued. Beyond the drivers of the practice, the study uncovered an extensive range of maternal health risks faced by early married girls. Respondents described frequent experiences of obstructed labour, severe anaemia, prolonged delivery, heightened fatigue, high blood pressure, miscarriages, and constant physical strain. Many of these risks were linked to their young age, poor nutrition, and the absence of consistent antenatal care. The findings also highlighted that early marriage restricts a girl's autonomy, leaving her dependent on her husband or in laws to determine if and when she can seek

maternal healthcare. These limitations often delay timely treatment and increase the likelihood of complications during pregnancy and childbirth. The combined effects of social pressure, economic hardship, limited autonomy, poor access to healthcare, and biological immaturity create a cycle of maternal health risks that can persist throughout the entire reproductive life of the woman. Based on this understanding, the study offers a clear message that girl child marriage is more than a cultural practice. It is a significant public health concern with long lasting consequences for young mothers, their children, and the wider community, and unless deliberate steps are taken to confront its root causes, the pattern will continue to limit the wellbeing and opportunities of many girls in rural Benue State.

Conclusions

The study on girl child marriage and maternal health risk among young mothers in rural areas of Benue State offers a deeper understanding of how early marriage shapes the everyday experiences, health outcomes, and social realities of girls who transition into adulthood before they are physically, mentally, or emotionally prepared. The analysis presented throughout the study demonstrates that early marriage is not an isolated event. It is a product of long standing cultural expectations, economic survival tactics, community norms, and deeply rooted beliefs about gender roles that favour early matrimony for girls. The conclusions drawn from the research show that because many families believe marriage protects girls or reduces household expenses, they encourage early union without fully understanding or acknowledging the consequences for maternal health. The findings make it clear that the practice remains strongly embedded in the selected rural communities because of structural factors such as poverty, limited education, and lack of access to information that could help families reconsider long held beliefs about the place of girls in society. The study concludes that early married girls are exposed to significant maternal health risks because their bodies are not matured enough to sustain healthy pregnancy and childbirth. The consequences identified include obstructed labour, miscarriage, severe bleeding, pre-eclampsia, low birth weight babies, and repeated complications across multiple pregnancies. These findings reinforce the understanding that child marriage is not merely a social tradition but also a harmful practice that endangers the health and welfare of young girls. The research therefore concludes that maternal health outcomes for young mothers in rural Benue are shaped more by social and economic realities than by personal choice. The study also concludes that achieving meaningful improvement in maternal health among young mothers requires a holistic approach that addresses the root causes of early marriage. Thus, the study concludes that girl child marriage is both a cause and a consequence of maternal health risk. Addressing it requires commitment from government institutions, community leaders, family units, and the health sector to break the cycle that places young mothers at risk and limits their future prospects. So therefore, the study contributes meaningfully to ongoing discussions on adolescent reproductive health and offers evidence that can guide policy formulation in Benue State and other regions facing similar challenges.

Base on the findings of the study, the following recommendations are made;

1) Government and community leaders should intensify awareness programmes that highlight the health dangers of early marriage and promote alternative pathways for girls' development.

2) Accessible and youth friendly maternal healthcare services should be established in rural communities to encourage young mothers to seek timely antenatal and postnatal care.

3) Families should be encouraged to prioritise girls' education as a key strategy for preventing early marriage and improving long term maternal health outcomes.

4) Traditional birth attendants should receive regular training and be integrated into referral networks so that they can identify danger signs and direct young mothers to skilled healthcare providers when necessary.

Suggestion for Further Studies

Future researchers may explore the long term psychological effects of early marriage on young mothers in rural communities, particularly how marital expectations, limited autonomy, and repeated reproductive burdens affect their mental wellbeing. Researchers may also consider comparative studies across different regions of Nigeria

to understand whether cultural practices shape maternal health outcomes differently, especially in settings where girls have higher levels of education. Such studies would enrich academic and policy discussions by revealing broader patterns that can guide interventions.

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