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TOO YOUNG TO MARRY: A QUALITATIVE INQUIRY INTO THE PHYSICAL AND MENTAL HEALTH OUTCOMES OF CHILD MARRIAGE IN RURAL PAKISTAN

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Abstract

Child marriage remains a critical public health and human rights challenge in Pakistan, disproportionately affecting rural adolescent girls. This qualitative study explored the physical and psychological health consequences of child marriage in rural Khyber Pakhtunkhwa, with a focus on Nowshera district. Data were collected through focus group discussions with married women, in-depth interviews with survivors, and key informant interviews with healthcare providers and community stakeholders. Thematic analysis revealed five overarching patterns: early pregnancy-related maternal risks, chronic nutritional deficiencies, and obstetric complications; psychological distress including depression, anxiety, trauma-related symptoms, and social isolation; intergenerational impacts on children's physical and emotional well-being; barriers to healthcare access due to stigma, gender norms, and economic dependence; and long-term consequences such as chronic illness and diminished self-worth. The findings underscore the intersection of socio-cultural practices, economic precarity, and weak service infrastructure in perpetuating cycles of harm. The study highlights the urgent need for integrated interventions addressing both maternal and mental health outcomes of child marriage, community-based prevention strategies, and effective enforcement of legal frameworks. By situating these findings within Pakistan's socio-legal and global development agenda, the study contributes context-specific evidence to advance progress towards Sustainable Development Goals 3 and 5.

INTRODUCTION

Child marriage remains a pervasive public health and human rights challenge globally, with significant implications for women's physical and psychological well-being. An estimated 12 million girls are married before the age of 18 each year, primarily in low- and middle-income countries where intersecting vulnerabilities: poverty, gender inequality, and limited access to healthcare compound the adverse outcomes (UNICEF, 2023). The practice is closely linked with increased maternal morbidity and mortality, adverse neonatal outcomes, and long-term psychological

distress, including depression, anxiety, and post-traumatic stress symptoms (Raj et al., 2018; Nour, 2019; Trevillion et al., 2012). Recognizing these impacts, the global agenda situates child marriage within Sustainable Development Goal (SDG) 3, which emphasizes ensuring healthy lives and well-being, and SDG 5, which seeks to eliminate all harmful practices against women and girls (United Nations, 2023).

In Pakistan, child marriage persists as a deeply entrenched socio-cultural practice despite legal reforms and advocacy efforts. National estimates suggest that approximately 18–21% of girls are married before the age of 18, with prevalence significantly higher in rural areas (UNICEF, 2023; NIPS & ICF, 2019). The Pakistan Demographic and Health Survey (PDHS 2017–18) highlights that adolescent pregnancies are disproportionately concentrated in rural regions and are associated with increased maternal complications and neonatal mortality. In Khyber Pakhtunkhwa (KP), structural and cultural determinants—including *purdah* (female seclusion), low female literacy, and restricted mobility—intersect with poverty to perpetuate early marriage (Naz, Aslam, Azra, & Karim, 2022; Sarfraz, Tariq, Hamid, & Iqbal, 2016). District-level data further underscore the vulnerability of rural girls: female literacy in Nowshera is approximately 34.8%, reflecting systemic gender disparities that limit autonomy and increase susceptibility to early marriage (Pakistan Bureau of Statistics [PBS], 2023).

The legal framework in Pakistan reflects a fragmented approach to child marriage prevention. The federal Child Marriage Restraint Act (1929) sets the minimum marriage age for girls at 16, while Sindh's Child Marriage Restraint Act (2013) remains the only provincial legislation raising the age to 18. Punjab's 2015 amendment increased penalties but retained the minimum age of 16. In Khyber Pakhtunkhwa, the Child Marriage Restraint Act (2021) sets the age at 18 for girls; however, enforcement remains weak due to cultural resistance and limited community-level monitoring (Government of Khyber Pakhtunkhwa, 2021; Mukhtar, 2023; Webb & Renzaho, 2023). Studies suggest that without localized engagement and culturally grounded strategies, legal reforms alone have limited effectiveness in rural settings (Ali, et al., 2021).

Beyond the physical consequences, the psychological impacts of child marriage are often underexplored in Pakistan. Evidence indicates that adolescent brides face elevated risks of depression, anxiety, social isolation, and trauma-related symptoms, especially where intimate partner violence co-occurs (Soggiu, Luppi, & Simoni, 2022; Naz et al., 2024a). In rural KP, the lack of trauma-informed mental health services exacerbates these outcomes, leaving adolescent mothers with untreated psychological distress (Naz et al., 2023). Previous research by Naz et al., (2023) in rural KP revealed that early pregnancies combined with low autonomy create a compounded burden of maternal risk and emotional harm among young brides.

Despite growing literature on child marriage in Pakistan, there remains a critical gap in qualitative, context-specific evidence from rural Khyber Pakhtunkhwa. Most studies rely on national surveys or examine single determinants in isolation, leaving the intersection of physical, maternal, and psychological outcomes insufficiently understood (Naz et al., 2022; Sarfraz et al., 2016). Districts like Nowshera, where socio-cultural norms, economic deprivation, and weak service infrastructure converge, remain under-researched despite being high-burden contexts.

Addressing this gap, the present study explores the physical and psychological health impacts of child marriage among rural women in Khyber Pakhtunkhwa, centering the lived experiences of adolescent brides and triangulating insights from healthcare providers and community stakeholders. By situating these narratives within Pakistan's socio-legal framework and global development agenda, the study contributes original evidence to inform culturally sensitive, multi-sectoral interventions aimed at eliminating child marriage and mitigating its health consequences, thereby supporting national and global commitments under SDG 3 and SDG 5.

Literature Review

Global Context of Child Marriage and Health Impacts

Child marriage is internationally recognized as both a human rights violation and a major public health concern, with profound physical and psychological consequences for adolescent girls. Globally, approximately 12 million girls are married before the age of 18 each year, disproportionately in low- and middle-income countries (UNICEF, 2023). Evidence consistently links early marriage to adverse maternal and neonatal outcomes, including increased risk of obstetric complications, maternal mortality, and low-birth-weight infants due to biological immaturity and lack of access to skilled care (Raj et al., 2018; Nour, 2019). The psychological sequelae are equally significant: depression, anxiety, PTSD-like symptoms, and social isolation are widely reported among child brides, exacerbated in contexts where gender-based violence accompanies early marriage (Trevillion et al., 2012; Sardinha et al., 2022). These realities place child marriage squarely within the targets of Sustainable Development Goal (SDG) 3 on health and well-being and SDG 5 on gender equality, which explicitly call for ending child, early, and forced marriage (United Nations, 2023).

Child Marriage in Pakistan: Prevalence and Trends

Pakistan ranks among the countries with the highest absolute number of child brides, with an estimated 18–21% of girls married before the age of 18 (UNICEF, 2023; NIPS & ICF, 2019). The Pakistan Demographic and Health Survey (PDHS 2017–18) shows that adolescent pregnancies remain disproportionately high in rural areas, with significant links to maternal morbidity and neonatal mortality (NIPS & ICF, 2019). Drivers of early marriage include poverty, lack of educational opportunities, patriarchal norms, and the use of marriage to settle social or tribal obligations (Sarfraz et al., 2016; Ali, Mansoor, & Mansoor, 2021). In Khyber Pakhtunkhwa, cultural practices such as *purdah* (female seclusion) and gendered decision-making exacerbate the practice, while rural districts face added constraints due to poor infrastructure and limited healthcare services (Naz, Aslam, Azra, & Karim, 2022).

Legal and Policy Framework

Pakistan's legal landscape on child marriage is fragmented. The federal Child Marriage Restraint Act (1929) sets the minimum marriage age at 16 for girls and 18 for boys, with limited enforcement mechanisms. Sindh's Child Marriage Restraint Act (2013) is the only provincial legislation to raise the minimum age for girls to 18 and criminalize violations. Punjab amended the federal law in 2015, increasing penalties but retaining 16 as the minimum age for girls. In Khyber Pakhtunkhwa, the Child Marriage Restraint Act (2021) set the minimum age at 18 for girls; however, weak implementation, limited awareness, and strong cultural resistance have constrained its effectiveness. Studies highlight that without community engagement and localized monitoring, legal reforms alone have limited impact in reducing child marriage prevalence in rural areas (Webb & Renzaho, 2023; Mukhtar, 2023).

Maternal and Child Health Impacts in Khyber Pakhtunkhwa

Adolescent motherhood is associated with increased maternal mortality and adverse birth outcomes in Pakistan. The Pakistan Maternal Mortality Survey (PMMS 2019) estimated a maternal mortality ratio of 165 per 100,000 live births in Khyber Pakhtunkhwa, with rural adolescent mothers among the most vulnerable groups (NIPS, 2020). Nutritional deficiencies and early pregnancy compound these risks, as young brides often enter marriage malnourished and face pregnancies before their bodies are physiologically prepared. Prior studies in rural KP have documented the convergence of poverty, limited female autonomy, and restricted healthcare access as major determinants of maternal health outcomes (Naz, Khan, & Azam, 2023; Naz, Ayub, & Afridi, 2023).

Mental Health and Psychosocial Dimensions

While physical health consequences are well documented, fewer studies have explored the psychological effects of child marriage in Pakistan.

International evidence shows strong associations between early marriage, intimate partner violence, and common mental disorders such as depression and PTSD (Trevillion et al., 2012; Soggiu, Luppi, & Simoni, 2022). In rural Pakistan, stigma, lack of trauma-informed services, and absence of safe spaces exacerbate mental health impacts. Naz, Aslam, Amin, and Sayed (2024) emphasize that mental healthcare access in Pakistan is critically limited, particularly in rural areas where gender-sensitive services are lacking. This gap leaves adolescent brides with untreated psychological trauma, reinforcing cycles of silence and isolation.

Gaps in Existing Research

Most existing studies on child marriage in Pakistan rely on national-level survey data or focus narrowly on prevalence and socio-economic determinants. Few have undertaken in-depth qualitative analyses that capture the lived experiences and intersecting physical and psychological effects of child marriage in rural Khyber Pakhtunkhwa. District-level evidence, especially from areas like Nowshera, remains scarce. This study addresses that gap by using a multi-perspective qualitative approach to explore both maternal and mental health consequences of child marriage, providing context-specific insights essential for policy and program design.

The reviewed literature underscores the severe physical and psychological consequences of child marriage globally and in Pakistan, while highlighting persistent gaps in localized, context-specific evidence from rural Khyber Pakhtunkhwa. Despite legal reforms and growing advocacy, early marriage remains entrenched in districts such as Nowshera, where cultural norms, economic precarity, and weak health infrastructure intersect to produce multi-dimensional harm. Existing studies have largely concentrated on national prevalence estimates or single determinants, leaving the lived experiences and combined maternal and mental health outcomes of adolescent brides underexplored.

This study responds to that gap by using a qualitative approach to capture the voices of women married as children, alongside perspectives from healthcare providers and key community actors. By situating these narratives within the broader socio-legal and health context of Khyber Pakhtunkhwa, the research generates nuanced, actionable insights to inform policy and community-based interventions. Importantly, the findings aim to contribute to Pakistan's progress toward Sustainable Development Goal 3 (ensure healthy lives and well-being) and Sustainable Development Goal 5 (achieve gender equality and eliminate all harmful practices), both of which explicitly prioritize ending child, early, and forced marriage and mitigating its health impacts.

Methodology

Study Design

A qualitative research design was employed to explore the health impacts of child marriages among women in rural Khyber Pakhtunkhwa (KPK), Pakistan. This approach was selected to capture the lived experiences of women and contextualize the physical, psychological, and intergenerational health outcomes associated with early marriage within socio-cultural and structural dynamics (Creswell & Poth, 2018; Braun & Clarke, 2022). This approach has been largely used in literature (Riaz et al., 2024a; Riaz et al., 2024b; Naz et al., 2024b; Naz et al., 2024c) **Study Setting**

The study was conducted in rural communities of Nowshera District, KPK, an area with persistently high rates of early marriage and limited access to reproductive and mental health services (Pakistan Bureau of Statistics [PBS], 2023). These communities are characterized by patriarchal household structures, purdah (female seclusion), and economic precarity, which shape women's health-seeking behavior and exposure to gender-based violence.

Sampling and Participants

Purposive sampling was used to recruit participants with direct or professional experience of child marriage. The sample included three groups:

- **Survivors of child marriage** (n = 12) who had married before the age of 18 and were currently residing in the district.
- **Community women** (n = 32) who participated in four focus group

discussions (FGDs), offering collective insights into community norms and health impacts.

- **Key stakeholders** (n = 6) including healthcare providers, Lady Health Workers, and social workers, who were interviewed as key informants (KIIs) to contextualize service delivery challenges.

Eligibility criteria included being female, over 18 at the time of interview, and willing to provide informed consent. Key informants were selected based on their direct involvement in maternal, reproductive, or community health services in the area.

Data Collection

Data were collected between March and June 2025 using three qualitative methods to enable triangulation:

- **In-depth Interviews (IDIs)** with survivors (n = 12) captured personal narratives on physical, psychological, and reproductive health consequences of early marriage.
- **Focus Group Discussions (FGDs)** (n = 4) explored collective perceptions, community norms, and intergenerational impacts.
- **Key Informant Interviews (KIIs)** (n = 6) provided professional perspectives on healthcare barriers and service gaps for child brides.

A semi-structured guide was developed based on existing literature on child marriage and health outcomes (Raj et al., 2018; Nour, 2019) and contextualized to KPK's socio-cultural setting. Interviews and FGDs were conducted in Pashto, audio-recorded with permission, and supplemented by field notes.

Ethical Considerations

All participants provided informed consent, and pseudonyms were used to ensure confidentiality. Given the sensitivity of the topic, WHO ethical and safety guidelines for research on gender-based violence were strictly followed, including referral pathways for participants requiring psychosocial support (WHO, 2016).

Data Analysis

Audio recordings were transcribed verbatim and translated into English. Thematic analysis following Braun and Clarke's (2022) six-step framework was applied to identify patterns and themes related to health impacts. NVivo 12 software was used to organize and code the data. Codes were developed inductively from the transcripts and refined through iterative comparison across IDIs, FGDs, and KIIs to ensure credibility and confirmability (Nowell et al., 2017). Themes were validated through peer debriefing and triangulation of data sources.

Results

Participant Profile and Data Sources

The analysis was based on data collected through 12 in-depth interviews (IDIs) with survivors of child marriage, four FGDs with a total of 32 community women, and six KIIs with healthcare providers and social workers. Participants ranged in age from 18 to 45 years, with most having been married between the ages of 13 and 17. All women were from rural communities of Nowshera District, Khyber Pakhtunkhwa, characterized by high rates of early marriage, low female literacy, and limited healthcare infrastructure (PBS, 2023). This combination of perspectives allowed for a triangulated understanding of the physical, psychological, and intergenerational health impacts of child marriage.

Table 1. Health Impacts of Child Marriages:

Themes	Sub-Themes	Illustrative Quotes
Physical Health Complications	Early Pregnancy & Maternal Risk	"We were married at 14… my first child came before I turned 16. My body was too weak; I lost so much blood."
	Injuries from Domestic Violence	"He hit me with whatever was in his hand… my bones still hurt. I never went to the doctor; what would people say?"
	Nutritional Deficiencies	"Most of these girls are malnourished when they conceive. Their children are born underweight, and the mothers remain weak for years."
Mental and Emotional Health	Depression & Anxiety	"I cry at night and pray to die… I was a child myself when they married me. My heart is never at peace."
	Trauma from Sexual Violence	"I was scared every night; I didn't even understand what marriage was. Those nights still come back in my dreams."
	Social Isolation	"After marriage, they stopped my school and friends. I don't talk to anyone now; it feels like I live in a cage."
Impact on Children's Health	Poor Birth Outcomes	"Children born to these young mothers are often premature and sick. Many don't survive the first year."
	Intergenerational Trauma	"My daughter sees the beatings; she hides in the corner. I fear she will think this is normal life."
Barriers to Healthcare Access	Stigma & Shame	"We cannot go to the hospital; people will say bad things. Better to suffer quietly."
	Economic Dependence	"If the husband says no, you can't go. You are dependent on him for even medicine."
Long-Term Health Consequences	Chronic Illness	"From the day I married, my body

Physical Health Complications

Early Pregnancy and Maternal Risk. A dominant sub-theme across all IDIs and FGDs was the toll of adolescent pregnancies on women's health. Participants described life-threatening complications during childbirth, prolonged recovery periods, and feelings of physical immaturity when thrust into motherhood.

One woman recounted: *"We were married at 14… my first child came before I turned 16. My body was too weak; I lost so much blood."*

These accounts highlighted the biological vulnerability of adolescent girls, consistent with evidence linking early pregnancy to increased maternal morbidity and mortality (Nour, 2019; Raj et al., 2018). Key informants observed that many young mothers were malnourished prior to conception, exacerbating risks of hemorrhage and obstructing labor.

Injuries from Domestic Violence. Another recurring sub-theme was the physical harm resulting from intimate partner violence. Women spoke of untreated fractures, chronic pain, and permanent disabilities.

One survivor said, *"He hit me with whatever was in his hand… my bones still hurt. I never went to the doctor; what would people say?"*

The silence surrounding these injuries underscored the intersection of violence, stigma, and limited healthcare access, a pattern

documented in rural GBV research (Naz et al., 2022; Webb & Renzaho, 2023).

Nutritional Deficiencies. Healthcare providers highlighted that most child brides entered marriage with poor nutritional status, leading to underweight infants and long-term maternal weakness.

As one midwife explained: *"Most of these girls are malnourished when they conceive. Their children are born underweight, and the mothers remain weak for years."*

This finding underscores the compounding effect of poverty and early marriage on maternal and child health.

Mental and Emotional Health

Depression and Anxiety. Psychological distress emerged as one of the most pervasive themes. Women described persistent sadness, hopelessness, and a sense of being "trapped."

One participant shared: *"I cry at night and pray to die… I was a child myself when they married me. My heart is never at peace."*

These narratives reflect classic symptoms of depression and anxiety associated with early marriage and intimate partner violence (Trevillion et al., 2012; Soggiu et al., 2022). The lack of psychosocial and trauma-informed services in rural Khyber Pakhtunkhwa further intensified these experiences, leaving women untreated and isolated, a pattern consistent with national evidence on limited mental health access in Pakistan (Naz et al., 2024a).

Trauma from Sexual Violence. Many participants revealed traumatic memories of being forced into sexual relations at an age when they lacked understanding of marriage or intimacy.

Several described recurring nightmares and flashbacks: *"I was scared every night; I didn't even understand what marriage was. Those nights still come back in my dreams."*

These PTSD-like symptoms align with global evidence on the psychological sequelae of child marriage (Sardinha et al., 2022). The absence of rural mental health infrastructure to address gender-based trauma exacerbates the long-term impact (Naz et al., 2024a).

Social Isolation. Another critical sub-theme was the loss of social networks and abrupt transition from adolescence to isolation. Many women spoke of being withdrawn from school and restricted from visiting friends or natal families.

One woman expressed: *"After marriage, they stopped my school and friends. I don't talk to anyone now; it feels like I live in a cage."*

This loss of peer support eroded resilience and contributed to emotional numbness, echoing findings from South Asian studies on early marriage and mental health (Raj et al., 2018).

Impact on Children's Health

Poor Birth Outcomes. Participants and healthcare workers consistently linked child marriage with adverse neonatal outcomes. Many underage mothers reported premature births and infant mortality.

A key informant stated: *"Children born to these young mothers are often premature and sick. Many don't survive the first year."*

This reflects PDHS findings associating adolescent pregnancy with higher neonatal and infant mortality rates (NIPS & ICF, 2019; Aftab et al., 2023).

Intergenerational Trauma. Survivors frequently voiced fear for their children's psychological well-being.

Witnessing violence created long-term emotional scars, as one woman said: *"My daughter sees the beatings; she hides in the corner. I fear she will think this is normal life."*

These accounts emphasize how cycles of trauma can perpetuate across generations in the absence of intervention (Evans et al., 2020).

Barriers to Healthcare Access

Stigma and Shame. Cultural stigma was a major deterrent to seeking care. Women described avoiding hospitals to prevent gossip or accusations of immorality:

"We cannot go to the hospital; people will say bad things. Better to suffer quietly."

Such stigma reinforces secrecy around both reproductive and mental health issues, reducing the likelihood of timely care.

Economic Dependence. Financial control by husbands and in-laws compounded healthcare barriers. Several participants highlighted their lack of agency:

"If the husband says no, you can't go. You are dependent on him for even medicine."

This reflects structural gender inequities that limit women's health autonomy in rural Pakistan (Naz et al., 2023; Sarfraz et al., 2016).

Long-Term Health Consequences

Chronic Illness. Years of repeated pregnancies, untreated injuries, and sustained stress led to cumulative physical and psychosomatic illness.

One participant shared: *"From the day I married, my body has been sick. Now I have twenty illnesses, all from those years."*

These narratives underscore the enduring nature of early marriage's health consequences, persisting well into adulthood (Nour, 2019).

Reproductive Health Loss. Healthcare providers noted early onset of infertility and reproductive complications among child brides due to unspaced pregnancies and lack of postnatal care. This finding reflects the long-term reproductive toll of early marriage in resource-limited settings.

Discussion

This study explored the physical and psychological health consequences of child marriage among rural women in Khyber Pakhtunkhwa, highlighting how early marriage interacts with gender-based violence, poverty, and limited healthcare infrastructure to produce multi-layered and enduring health outcomes. The findings demonstrate that child marriage is not only a violation of girls' rights but also a public health issue with long-term consequences for women and their children, consistent with global evidence linking early marriage to adverse maternal and mental health outcomes (Raj et al., 2018; Nour, 2019).

The results revealed that early pregnancy was almost universal among participants and frequently accompanied by life-threatening complications such as hemorrhage, obstructed labor, and severe anemia. These findings align with the Pakistan Demographic and Health Survey (PDHS 2017–18), which reported significantly higher maternal morbidity and mortality among adolescent mothers compared to women aged 20–24 (NIPS & ICF, 2019). Similar patterns have been documented across South Asia, where child marriage increases the risk of maternal death by 70–80% due to biological immaturity and limited access to skilled obstetric care (Raj et al., 2018; Nour, 2019). In this study, key informants underscored how malnutrition and early childbearing intersect, leaving girls physiologically unprepared for pregnancy and contributing to adverse neonatal outcomes. These findings echo previous research from rural Pakistan demonstrating the compounded effect of poverty, nutritional deprivation, and early marriage on maternal and infant survival (Naz et al., 2023).

Beyond physical risks, this study documented profound psychological consequences of child marriage. Women's narratives revealed high prevalence of depression, anxiety, and trauma-related symptoms, including nightmares and hypervigilance. These findings are consistent with international evidence linking early marriage and intimate partner violence to common mental disorders and PTSD (Trevillion et al., 2012; Soggiu et al., 2022). Importantly, the results resonate with national studies indicating that mental health remains one of the most neglected dimensions of women's health in Pakistan. Naz et al., (2024a) highlight that rural areas, particularly Khyber Pakhtunkhwa, suffer from a lack of trauma-informed and gender-sensitive mental health services, leaving survivors of violence without appropriate psychosocial support. This gap was evident in participants' accounts of enduring psychological pain in isolation and the absence of safe spaces for disclosure or treatment.

A critical contribution of this study is its illumination of the intergenerational dimension

of child marriage. Participants expressed concern for their children's physical and mental well-being, with healthcare providers corroborating the high prevalence of low-birthweight and premature infants among adolescent mothers. These findings are in line with PDHS data showing a strong association between maternal age under 18 and neonatal mortality (NIPS & ICF, 2019). The accounts of children witnessing domestic violence and internalizing fear point to the transmission of trauma across generations, a phenomenon documented in global research on adverse childhood experiences (Evans et al., 2020) and confirmed in rural Pakistani contexts (Naz et al., 2023).

The findings also underscore the structural and cultural barriers that sustain child marriage and exacerbate its health impacts. Women's dependence on husbands and in-laws for healthcare decisions, combined with pervasive stigma, mirrors patterns identified in previous studies on maternal and reproductive healthcare access in rural Pakistan (Sarfraz et al., 2016; Naz, Aslam, Azra, & Karim, 2022). Social norms prioritizing family honor over women's safety created an environment where seeking help was perceived as dishonor, perpetuating cycles of silence and learned helplessness. This is consistent with Walker's (2017) conceptualization of "battered woman syndrome" and reinforces the need to address community-level attitudes alongside individual support.

Importantly, the study highlights how child marriage acts as a structural determinant of both SDG 3 (good health and well-being) and SDG 5 (gender equality) outcomes. Pakistan's slow progress on reducing maternal mortality and addressing gender-based violence is unlikely to accelerate without targeted interventions to prevent early marriage and mitigate its health consequences. The narratives from Nowshera underscore the urgency of integrating maternal health, mental health, and GBV response services at the community level, particularly through primary healthcare and Lady Health Worker (LHW) programs. Evidence from other low- and middle-income countries suggests that community-based psychosocial interventions and empowerment programs can reduce depression and PTSD among GBV survivors and delay early marriage rates (Abramsky et al., 2018; Sardinha et al., 2022).

This study contributes new insights by focusing on an under-researched district in rural Khyber Pakhtunkhwa and by centering survivors' voices alongside provider perspectives. While previous research has examined the prevalence of child marriage in Pakistan, few studies have captured the lived experiences of women to illustrate the intersecting physical and psychological burdens. By using qualitative methods, this study adds depth to national survey data and highlights the necessity of culturally sensitive, multi-sectoral approaches. Integrating findings with existing evidence (Naz et al., 2023; Naz et al., 2022) underscores the systemic nature of these issues and the need for policy interventions that combine legal enforcement, education, and health system strengthening.

Conclusion

This study highlighted the profound physical and psychological health consequences of child marriage among rural women in Khyber Pakhtunkhwa, Pakistan. The findings demonstrated that early marriage exposes adolescent girls to heightened maternal morbidity, adverse neonatal outcomes, and enduring mental health sequelae, including depression, anxiety, and trauma-related symptoms. These outcomes were amplified by structural barriers such as poverty, gendered power dynamics, and limited access to maternal and mental healthcare services. Importantly, the study underscored the intergenerational impact of child marriage, with children bearing the consequences of premature motherhood and exposure to domestic violence.

By centering survivors' narratives alongside healthcare providers' perspectives, the study provided a nuanced understanding of how socio-cultural norms, economic dependency, and institutional gaps intersect to sustain cycles of harm. These insights reaffirm that child marriage is not only a violation of human rights but also a major public health challenge hindering Pakistan's progress toward Sustainable Development Goals

(SDG) 3 on health and well-being and SDG 5 on gender equality.

Recommendations

The following recommendations are made in accordance with the findings of the study.

1. **Early Intervention to Prevent Adolescent Pregnancy**: The study found that most participants experienced early pregnancies soon after marriage, resulting in maternal complications and poor neonatal outcomes. Interventions should focus on delaying first pregnancies through community education, access to reproductive health information, and promoting spacing methods for adolescent brides.
2. **Strengthening Maternal Nutrition and Health Services**: Nutritional deficiencies were repeatedly highlighted, with young mothers reporting chronic weakness and healthcare providers observing underweight infants. Nutrition supplementation programs tailored for adolescent mothers and integration of nutritional counseling into maternal health services are essential.
3. **Integrating Mental Health Support into Rural Healthcare**: The findings revealed pervasive depression, anxiety, and trauma-related symptoms among women married as children. Rural healthcare systems must incorporate trauma-informed mental health screening and counseling services. Training Lady Health Workers to provide basic psychosocial support and referrals would address the identified gaps.
4. **Community-Based GBV Response Mechanisms**: Participants reported physical abuse, verbal humiliation, and lack of safe reporting avenues, leading to learned helplessness. Establishing confidential, community-level GBV response mechanisms and survivor-friendly referral pathways within primary healthcare centers is crucial to break cycles of violence.
5. **Addressing Social Isolation and Rebuilding Support Networks**: Many women described isolation from family and peers after marriage, exacerbating psychological distress. Programs fostering community support groups for adolescent brides and creating safe spaces for peer interaction could mitigate these effects and provide emotional resilience.
6. **Intergenerational Trauma Prevention**: Concerns about children witnessing violence and experiencing fear highlight the need for family-centered interventions. Counseling services should include young mothers and their children to reduce intergenerational transmission of trauma and promote healthier parenting practices.
7. **Strengthening Implementation of Child Marriage Laws**: The persistence of early marriage despite legal frameworks underscores weak enforcement. Local-level monitoring, involvement of religious and community leaders, and awareness campaigns are needed to bridge the gap between legislation and practice.
8. **Targeted Awareness Campaigns in Rural Khyber Pakhtunkhwa**: The study revealed strong cultural norms perpetuating early marriage and discouraging healthcare seeking. Tailored awareness campaigns using culturally appropriate messaging in districts like Nowshera can help shift attitudes and empower communities to protect adolescent girls.

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