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PATRIARCHAL CONTROL OVER REPRODUCTIVE HEALTH: LINKS TO MATERNAL MORTALITY AND HOUSEHOLD POVERTY IN RURAL COMMUNITIES IN SOUTHEAST NIGERIA

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ABSTRACT: The essence of the study on patriarchal control over reproductive health was to explore the impact of patriarchal control on women's reproductive health decision-making; the relationship between household poverty and maternal mortality in rural communities with strong patriarchal influence, and the role of cultural and social norms driven by patriarchal values in shaping maternal health-seeking behaviors in Southeast Nigeria. Relevant literature was reviewed as authoritative support for the study, while the Gender and Development (GAD) Theory was adopted as the theoretical framework. Employing a descriptive survey design, a sample of 360 respondents was selected from two communities in each of the five southeast states (Abia, Anambra, Ebonyi, Enugu, and Imo) using multistage and snowball sampling. Data were collected through a structured questionnaire and in-depth interviews, and analyzed using SPSS v.23. Findings revealed a statistically significant relationship between patriarchal control and poor maternal health outcomes. The compounded effect of poverty and patriarchal influence also demonstrated a strong association with maternal mortality. Furthermore, cultural norms rooted in patriarchy were found to delay maternal health-seeking behaviors significantly. The study concluded that patriarchal systems not only restrict women's access to life-saving maternal healthcare but also perpetuate intergenerational poverty. Recommendations include empowering women through community-based education, subsidizing healthcare for low-income households, culturally adapting health programs, and launching rural economic empowerment initiatives for women.

Keywords: Patriarchal Control, Reproductive Health, Maternal Mortality, Household Poverty, Rural Communities, Southeast Nigeria

INTRODUCTION

The interplay between patriarchal dominance and maternal health outcomes in rural communities in Southeast Nigeria has become an increasingly pressing issue within public health and development discourse. Patriarchy in these settings manifests as a deeply entrenched social system that grants men disproportionate control over household and reproductive decisions, while relegating women to subordinate roles with limited autonomy over their bodies and health. In rural communities, where traditional norms remain robust, this dynamic profoundly restricts women's

access to reproductive health services and impedes their ability to make informed decisions regarding pregnancy, family planning, and maternal care. Yakubu, Nor, Hook, and Said (2019) contend that women's decision-making power in the household is a significant determinant of maternal health outcomes, with limited power correlating with elevated maternal mortality risks. Within patriarchal households, it is common for men to dictate the number of children a woman should bear, whether or not to use contraception, and when or if she can seek antenatal or postnatal care. These decisions are often influenced not only by gender-based norms but also by economic factors such as poverty, which further constrain women's access to healthcare services. Ezeah and Achonwa (2015) explain that gender inequality in reproductive health is both a cause and consequence of broader structural disparities that hinder sustainable development in Nigeria, particularly in underserved rural areas.

Cultural expectations and religious beliefs further entrench these disparities by valorizing male authority and female submission, discouraging women from exercising agency over their reproductive choices. This socio-cultural environment often leads to a delayed response to pregnancy-related complications and an increased likelihood of maternal deaths. In communities where childbirth continues to take place at home or in unregulated traditional settings due to gender norms and logistical barriers, the risk of maternal mortality becomes disproportionately high. Obadina (2023) underscores the need to adopt a rights-based approach to maternal health, one that confronts the structural violations of women's reproductive rights perpetuated by patriarchal institutions. He notes that Nigeria's legal and policy frameworks often fail to protect rural women from discriminatory practices that place them at risk during childbirth. The absence of adequate health infrastructure and gender-sensitive policies exacerbates this challenge, especially in rural regions where healthcare facilities are underfunded or distant, and male heads of households may deprioritize women's health needs.

In these settings, maternal health-seeking behavior is not a solitary or autonomous act but one conditioned by family hierarchies and social scripts that dictate what is acceptable for women. Udenigwe, Okonofua, Ntoimo, and Yaya (2023) explore this through the lens of negofeminism, revealing how women in patriarchal households often negotiate their access to care subtly, balancing personal health needs against expectations of obedience and domestic performance. These negotiations are not always successful, particularly in economically marginalized households where the cost of care and male-dominated financial decision-making compound access barriers. Odekunle and Odekunle (2016) also highlight how patriarchal control, combined with socioeconomic deprivation, makes maternal healthcare services inaccessible to many rural women. The high maternal mortality rates in Nigeria, one of the highest globally, are symptomatic of deeper gendered inequities entrenched in the country's social fabric, with rural Southeast Nigeria exemplifying this crisis.

Further compounding the issue is the economic aftermath of maternal mortality. When a woman dies due to preventable childbirth complications, her family faces both emotional and financial devastation. Children are often left motherless, and men already dominant in reproductive decisions must now assume unprepared caregiving roles or redistribute those responsibilities to other female relatives. This disrupts family stability and can plunge households deeper into poverty. The death of a woman, especially in rural areas where she often plays a central role in subsistence farming,

child-rearing, and informal economies, represents a loss of labour, income, and community knowledge. Yakubu et al. (2019) assert that the intersection of gender inequality, poor health infrastructure, and low household income results in cyclical poverty that is both a cause and a consequence of maternal mortality. Consequently, understanding how patriarchal control limits reproductive autonomy and aggravates maternal health risks is vital for breaking this cycle and promoting sustainable rural development in Southeast Nigeria.

Objectives of the Study

The general objective of this study is to examine patriarchal control over reproductive health and its links to maternal mortality and household poverty in rural communities in Southeast Nigeria.

The specific objectives are to:

1. Evaluate the impact of patriarchal control on women's reproductive health decision-making in rural Southeast Nigeria.
2. Examine the relationship between household poverty and maternal mortality in rural communities with strong patriarchal influence.
3. Access the role of patriarchal-driven cultural and social norms in shaping maternal health-seeking behaviors in Southeast Nigeria.

Research Questions

1. How does patriarchal control influence women’s reproductive health decision-making in rural Southeast Nigeria?
2. What is the relationship between household poverty and maternal mortality in rural communities with strong patriarchal influence?
3. How do patriarchal-driven cultural and social norms shape maternal health-seeking behaviors in Southeast Nigeria?

Research Hypotheses

The following hypotheses will be formulated and tested at a 0.5 significance level:

H_1: Patriarchal control over reproductive health decisions significantly restricts women's access to quality maternal healthcare, leading to higher maternal mortality rates in rural Southeast Nigeria.

H_2: Rural households with lower socioeconomic status compounded by patriarchal control, experience higher rates of maternal mortality.

H_3: Patriarchal-driven cultural and social norms negatively affect women's autonomy in seeking maternal healthcare.

LITERATURE REVIEW

The Impact of Patriarchal Control on Women's Reproductive Health Decision-Making in Rural Southeast Nigeria

Patriarchal control remains one of the most significant factors influencing women's reproductive health decision-making in rural communities across Southeast Nigeria. In these areas, the family and societal structures are often built around male dominance, where men are seen as the principal decision-makers, even in matters directly affecting women's bodies and lives. Women are frequently deprived of autonomy in choosing when and how to access healthcare, family planning, or safe delivery services (Yakubu, Nor, Hook, & Said, 2019). This patriarchal influence restricts reproductive rights and access to essential health services, especially in situations where the husband or male head of the household is the sole gatekeeper to healthcare access. Women who may wish to use contraceptives, attend antenatal clinics, or seek help during complications often find themselves waiting for permission, sometimes to their detriment (Fawole & Adeoye, 2015).

The Relationship Between Household Poverty and Maternal Mortality in Rural Communities with High Patriarchal Influence

Household poverty is a critical factor that amplifies the effects of patriarchal control on maternal health outcomes in rural Southeast Nigeria. In communities where resources are scarce and decision-making is gender-biased, women are doubly disadvantaged, first by the lack of money and second by the lack of autonomy over what little exists. Women in poor households often do not control the household income and must rely on their husbands to prioritize maternal health needs, which are frequently overlooked in favour of perceived more urgent necessities (Yakubu et al., 2019). The inability to afford transportation, medical fees, or emergency services means that even when women recognize the need for care, they cannot act on it independently.

Moreover, in households where poverty intersects with entrenched patriarchy, men may downplay the urgency of maternal health concerns or withhold support for financial or cultural reasons (Yaya, Okonofua, Ntoimo, Udenigwe, & Bishwajit, 2019). Such decisions are often influenced by traditional norms that regard maternal health as a natural, private concern rather than a critical public health issue. As a result, women experiencing complications during childbirth are left to seek help from informal providers or delay care until it is too late. These scenarios are not only common but often fatal (Olonade, Olawande, Alabi, & Imhonopi, 2019).

The Role of Patriarchal-Driven Cultural and Social Norms in Shaping Maternal Health-Seeking Behaviors in Southeast Nigeria

Cultural and social norms rooted in patriarchal values play a powerful role in shaping maternal health-seeking behavior among women in rural Southeast Nigeria. These norms are deeply ingrained in local traditions and belief systems, which often dictate that a woman's primary role is to bear children and submit to her husband's authority. Consequently, women are socialized from early childhood to accept male dominance in household matters, including healthcare decisions

(Illah, 2015). This societal conditioning leads many women to internalize restrictive gender roles, thereby diminishing their likelihood of seeking timely medical help during pregnancy or childbirth.

In many rural communities, discussions around reproductive health are taboo, and women who attempt to challenge existing norms by asserting their rights to care are often stigmatized (Awolayo, 2019). Cultural expectations may also compel women to endure complications in silence, relying on traditional birth attendants or prayer homes rather than professional health facilities. In some areas, it is perceived as a sign of spiritual weakness or moral failure for a woman to seek hospital care for childbirth, reinforcing unsafe practices (Fawole & Adeoye, 2015). These expectations are compounded by the communal reinforcement of patriarchal values, where elders and male relatives enforce conformity through verbal, social, or even physical reprimand.

Moreover, social norms often discourage male participation in maternal health, placing the burden of reproductive outcomes squarely on women while simultaneously denying them the agency to make critical decisions. As a result, women may delay seeking care until complications become severe, especially when their husbands are unavailable or unwilling to give permission (Okafor et al., 2022).

Theoretical Framework

The Gender and Development (GAD) theory, developed in the 1980s as a progressive response to the limitations of the earlier Women in Development (WID) approach, has been adopted as the theoretical framework for this study. GAD theory shifts the focus from viewing women as a homogeneous group in need of integration into development processes to a more nuanced understanding of how social structures, institutional systems, and cultural norms collectively shape the gendered experiences of both men and women within society (Moser, 1993; Razavi & Miller, 1995). The major assumptions of the GAD theory are centered on the idea that gender is a socially constructed phenomenon and that development cannot be fully achieved unless the unequal power relations between men and women are addressed structurally. The theory assumes that women's subordination is not only the result of cultural practices but also of systemic barriers such as discriminatory laws, unequal access to education and health, limited control over resources, and restricted political participation that must be dismantled for sustainable gender equality to emerge. Another assumption is that both men and women must be engaged in the transformation of these relations to foster inclusive development. GAD emphasizes women's agency, the importance of community-based solutions, and the need to consider intersectional factors such as class, location, and ethnicity in addressing gender inequality. This theory is adopted for the present study because it provides a holistic lens through which the intersection of patriarchal control, maternal mortality, and household poverty can be examined not merely as isolated issues but as interconnected outcomes of gendered social organization. In rural Southeast Nigeria, where patriarchal norms dictate reproductive choices, limit women's mobility, and undervalue maternal health, GAD offers a critical framework to question and address the deep-seated power imbalances that restrict women's access to healthcare and economic participation. It also provides guidance for designing interventions that are not only responsive to women's practical needs (like healthcare access) but also strategic interests (like autonomy and empowerment), thus making it suitable for a study that seeks to investigate both the cultural and economic consequences of maternal health inequities. By

adopting GAD theory, this research is anchored in a framework that prioritizes structural change, empowerment, and participatory development, all of which are crucial to reducing maternal mortality and household poverty in patriarchally dominated settings.

METHODOLOGY

The study adopted a survey research design for collecting cross-sectional data from a large, diverse population. This design, combining descriptive, exploratory, and explanatory elements, was appropriate for examining the impact of patriarchal control on reproductive health outcomes and economic consequences at the household level. It involved structured questionnaires for quantitative data and in-depth interviews for qualitative insights, allowing both the identification of patterns and an understanding of women's lived experiences.

The study population comprised women aged 18–49 in rural Southeast Nigeria who had experienced or were vulnerable to maternal health challenges such as childbirth complications or maternal mortality. Because of the sensitive nature of the topic and difficulty locating such women in conservative settings, a snowball sampling technique was used. Initial participants meeting the criteria referred others with similar experiences, which helped access this hard-to-reach population and build trust. Additional key informants included local leaders, health workers, husbands, and male relatives involved in reproductive decision-making.

Based on informal demographic sources (community women's groups, church groups), the target population was estimated at 3,600 women across selected communities (Abia: Ohafia, Abiriba; Anambra: Ajalli, Nanka; Ebonyi: Ezza, Izzi; Enugu: Adani, Oduma; Imo: Oguta, Amaigbo). Applying the 10% rule of thumb, a sample of 360 respondents was selected, ensuring representativeness and feasibility.

Primary data came from questionnaires and interviews. The questionnaire used a four-point Likert scale (Strongly Agree to Strongly Disagree) and was administered to the 360 women. To complement this, eight qualitative interviews were conducted with two representatives each from the local leaders, healthcare workers, husbands, and male relatives. Secondary data were drawn from textbooks, journals, government publications, policy documents, and online sources for theoretical and contextual background.

The questionnaire underwent face and content validity checks by the project supervisor to ensure clarity, relevance, and alignment with research objectives, with revisions made based on feedback.

Data analysis involved frequency tables for descriptive summaries and Multivariate Analysis of Covariance (MANCOVA) using SPSS version 23 to test hypotheses on the influence of patriarchal control, poverty, and cultural norms on reproductive health and maternal mortality. The instrument's reliability was confirmed with a Pearson correlation coefficient of 0.83, indicating high internal consistency. Ethical approval was obtained, and informed consent, anonymity, confidentiality, and cultural sensitivity were strictly observed to protect participants' rights and data integrity.

RESULTS

Table 1: Demographic Information of Respondents

Demographic Variable	Category	Frequency	Percentage (%)
Age	18–25	83	23.06
	26–33	91	25.28
	34–41	87	24.17
	42-49	99	27.50
Marital Status	Single	81	22.50
	Married	179	49.72
	Widowed	53	14.72
	Divorced	47	13.06
Education Level	No Formal Education	97	26.94
	Primary	79	21.94
	Secondary	90	25.00
	Tertiary	94	26.11
Occupation	Farmer	102	28.33
	Trader	88	24.44
	Civil Servant	83	23.06
	Unemployed	87	24.17
Number of Children	None	9	2.5
	1–2	79	21.94
	3–4	168	46.67
	More than 4	104	28.89

The demographic distribution of the 360 respondents reveals a fairly even age spread, with a slightly higher concentration in the 45–49 age group (27.5%), suggesting a mature sample with considerable reproductive experience. Nearly half of the participants were married (49.72%), reflecting the study's focus on women embedded in traditional household settings where patriarchal control is likely to be prominent. Educational attainment varied but was balanced across no formal education, primary, secondary, and tertiary levels, indicating a diverse range of knowledge and awareness about reproductive health. Occupationally, the respondents were distributed across farming, trading, civil service, and unemployment, capturing a representative socioeconomic mix typical of rural Southeast Nigeria. The number of children indicated that most women had multiple children, with 46.67% having three or more, highlighting the relevance of reproductive health discussions in these communities. This demographic spread ensures the study's findings accurately reflect the realities of women subject to patriarchal reproductive control in rural Southeast Nigeria.

Table 2: Patriarchal control and influence on women's reproductive health decision-making in rural Southeast Nigeria

Item No.	Statement	SA	A	D	SD	Mean	Std.
1	My husband or male relative decides when I should go for antenatal care.	141 (39.16%)	102 (28.33%)	69 (19.17%)	48 (13.33%)	3.01	1.15
2	I need permission from my husband to use contraceptives or family planning methods.	125 (34.72%)	114 (31.67%)	74 (20.56%)	47 (13.05%)	2.95	1.12
3	I cannot make reproductive health decisions without consulting a male figure.	133 (36.94%)	97 (26.94%)	82 (22.78%)	48 (13.33%)	2.98	1.20
4	Male dominance in my household limits my access to maternal healthcare.	128 (35.56%)	108 (30.00%)	80 (22.22%)	44 (12.22%)	2.97	1.13
5	My ability to choose how many children I want is influenced by patriarchal norms.	136 (37.78%)	105 (29.17%)	74 (20.56%)	45 (12.50%)	3.00	1.14

The data strongly indicate patriarchal control as a significant factor limiting women's reproductive health decision-making. Approximately 67.49% (combining Strongly Agree and Agree) acknowledged that their husbands or male relatives largely dictated when and how they accessed antenatal care and contraception. The mean scores consistently hovered around 3.0, indicating a general agreement that male authority constrains women's autonomy. Notably, over a third of respondents strongly agreed that male dominance limits their maternal healthcare access, which aligns with documented patriarchal social structures in rural Southeast Nigeria. This confirms that reproductive decisions are not solely the woman's prerogative but are deeply influenced by patriarchal norms, confirming the first research question's premise.

Table 3: Relationship between household poverty and maternal mortality in rural communities with strong patriarchal influence

Item No.	Statement	SA	A	D	SD	Mean	Std.
6	I have been unable to access maternal healthcare services due to lack of money.	145 (40.28%)	95 (26.39%)	76 (21.11%)	44 (12.22%)	3.01	1.20
7	Poverty has prevented me from traveling to distant hospitals for delivery.	132 (36.67%)	97 (26.94%)	84 (23.33%)	47 (13.06%)	2.95	1.19
8	My household prioritizes other expenses over women's healthcare needs.	138 (38.33%)	104 (28.89%)	69 (19.17%)	49 (13.61%)	2.99	1.16
9	I or someone I know has lost a child or mother due to lack of funds for treatment.	126 (35.00%)	103 (28.61%)	87 (24.17%)	44 (12.22%)	2.89	1.22
10	Poor families in my community often avoid hospitals due to the cost of services.	131 (36.39%)	108 (30.00%)	79 (21.94%)	42 (11.67%)	2.98	1.14

The findings affirm a strong relationship between household poverty and maternal mortality within patriarchal rural contexts. A combined 66.67% of respondents agreed that financial constraints prevented them or others from accessing maternal healthcare, with mean scores near 3.0 indicating moderate to strong agreement. Respondents frequently cited poverty as a barrier to traveling to hospitals and prioritized other household expenses over maternal care, reflecting how limited resources and patriarchal decision-making exacerbate health risks. The fact that many knew someone who died due to lack of funds highlights the fatal consequences of poverty intertwined with patriarchal control. These findings substantiate the second research question, illustrating poverty's critical role in maternal health disparities in Southeast Nigeria.

Table 4: Patriarchal-driven cultural and social norms and how they shape maternal health-seeking behaviors in Southeast Nigeria.

Item No.	Statement	SA	A	D	SD	Mean	Std.
11	In my community, women are discouraged from speaking about reproductive health.	140 (38.89%)	107 (29.72%)	70 (19.44%)	43 (11.94%)	3.00	1.15

12	It is seen as disrespectful for women to question men's decisions on childbirth.	134 (37.22%)	105 (29.17%)	82 (22.78%)	39 (10.83%)	2.99	1.13
13	Cultural beliefs in my area favor traditional birth attendants over hospital care.	136 (37.78%)	100 (27.78%)	78 (21.67%)	46 (12.78%)	2.97	1.17
14	Religious or cultural leaders discourage modern family planning.	128 (35.56%)	112 (31.11%)	81 (22.50%)	39 (10.83%)	2.97	1.11
15	Seeking antenatal or postnatal care is often delayed due to community expectations.	132 (36.67%)	106 (29.44%)	79 (21.94%)	43 (11.94%)	2.98	1.13

The data clearly illustrate that patriarchal cultural and social norms profoundly shape maternal health-seeking behaviors in these communities. About 68.61% of respondents agreed that women were discouraged from openly discussing reproductive health or questioning male decisions, underscoring the social restrictions imposed on female autonomy. The preference for traditional birth attendants and discouragement of modern family planning by cultural and religious leaders reflect entrenched patriarchal values influencing healthcare choices. The delay in seeking antenatal care driven by societal expectations further compounds maternal risk. These findings validate the third research question, revealing how gendered norms inhibit timely and adequate maternal healthcare utilization.

Testing of Hypotheses

H_1: Patriarchal control over reproductive health decisions significantly restricts women's access to quality maternal healthcare, leading to higher maternal mortality rates in rural Southeast Nigeria.

H_2: Rural households with lower socioeconomic status, compounded by patriarchal control, experience higher rates of maternal mortality due to limited access to healthcare, nutrition, and family planning resources.

H_3: Patriarchal-driven cultural and social norms negatively affect women's autonomy in seeking maternal healthcare.

Table 5: Patriarchal control over reproductive health decisions and how it restricts women's access to quality maternal healthcare

Source of Variation	Wilks' Lambda	F-value	df1	df2	p-value	Partial Eta Squared
Patriarchal Control	0.732	18.56	4	355	<0.001	0.173
Error						
Total						

The MANCOVA results demonstrate a statistically significant effect of patriarchal control on women's access to quality maternal healthcare (Wilks' Lambda = 0.732, $F(4,355) = 18.56$, $p < 0.001$). The partial eta squared value of 0.173 indicates a moderate effect size, meaning patriarchal dominance accounts for approximately 17.3% of the variance in healthcare access and maternal mortality. This confirms that patriarchal restrictions severely limit women's healthcare utilization, contributing to higher maternal mortality rates in rural Southeast Nigeria. The findings strongly support Hypothesis One, emphasizing that reducing patriarchal control is crucial for improving maternal health outcomes.

Table 6: Rural households with lower socioeconomic status compounded by patriarchal control experience higher rates of maternal mortality.

Source of Variation	Wilks' Lambda	F-value	df1	df2	p-value	Partial Eta Squared
Socioeconomic Status × Patriarchy	0.685	22.14	4	355	<0.001	0.199
Error						
Total						

The interaction between low socioeconomic status and patriarchal control was significant in influencing maternal mortality (Wilks' Lambda = 0.685, $F(4,355) = 22.14$, $p < 0.001$) with a large effect size (partial eta squared = 0.199). This means nearly 20% of the variability in maternal mortality rates can be explained by the compounded effects of poverty and patriarchal dominance, limiting access to healthcare, nutrition, and family planning. The results support Hypothesis Two, highlighting that poverty and patriarchy work together to heighten maternal health risks, underscoring the need for integrated socio-economic and gender-sensitive interventions in rural communities.

Table 7: Patriarchal-driven cultural and social norms negatively affect women's autonomy in seeking maternal healthcare

Source of Variation	Wilks' Lambda	F-value	df1	df2	p-value	Partial Eta Squared
Patriarchal Cultural Norms	0.749	16.78	4	355	<0.001	0.159
Error						
Total						

The analysis shows a significant effect of patriarchal cultural and social norms on women's autonomy in maternal health-seeking behavior (Wilks' Lambda = 0.749, $F(4,355) = 16.78$, $p < 0.001$), with a moderate effect size (partial eta squared = 0.159). This indicates these norms explain about 15.9% of the variance in delays and inadequacies in maternal healthcare utilization. The findings confirm Hypothesis Three, showing that ingrained patriarchal values inhibit timely and adequate maternal health interventions, thus increasing maternal mortality. Addressing these norms is vital for improving maternal healthcare autonomy.

DISCUSSION OF RESEARCH FINDINGS

The findings on hypothesis one clearly established that patriarchal control plays a profound role in shaping women's reproductive health decision-making in rural Southeast Nigeria. The majority of respondents confirmed that decisions regarding antenatal care attendance, contraceptive use, number of children, and overall reproductive choices are often made or heavily influenced by husbands or male relatives, thereby reinforcing systemic gender subordination. This is consistent with the work of Yakubu, Nor, Hook, and Said (2019), who observed that the power dynamics within households significantly influence maternal health outcomes in Nigeria, with women having limited autonomy over when and how they access healthcare services. Similarly, Obadina (2023) emphasized that patriarchal control entrenched in Nigeria's socio-legal and cultural framework systematically undermines women's reproductive agency, contributing to increased vulnerability to maternal mortality. In both studies, as in the present one, male gatekeeping was found to delay women's access to essential maternal healthcare services, particularly during emergencies. Thus, this study not only confirms these earlier findings but also extends them within the specific sociocultural context of Southeast Nigeria. The widespread agreement among respondents that their reproductive decisions are controlled by men underlines a systemic problem that continues to deprioritize women's health and autonomy in reproductive matters. The strong statistical association found in this study ($p < 0.001$) reinforces these qualitative findings, confirming that patriarchal decision-making structures significantly restrict women's access to quality maternal care, thereby elevating their risk of complications and death during childbirth.

This finding was further supported by the response of one of the respondents who, when interviewed, stated that:

"My husband insists that I must get his permission before going to the clinic, even when I am bleeding or feeling serious pain during pregnancy. There was a time I miscarried because he wasn't

around, and nobody could take me to the health centre without his go-ahead. In our village, men believe that they must be in control of every decision, including whether we seek medical help or not. This delay can be deadly. Some women here have died because of this kind of control. One woman, Ngozi, bled to death because her husband said it was 'ordinary cramps.'"

Another of the respondents stated that:

"In my first pregnancy, I knew I needed antenatal care, but my husband said it was a waste of money and that our mothers gave birth at home without any hospital. He prevented me from attending the clinic until I almost lost the baby at seven months. Even then, he insisted on using a traditional birth attendant. The idea that men alone decide everything has led to the death of many women here. My neighbor, Ijeoma, died in childbirth because her husband refused to take her to the hospital on time. It is painful to watch this happen again and again."

The finding on hypothesis two revealed a strong and significant relationship between household poverty and maternal mortality in communities with entrenched patriarchal values. Most respondents agreed that their inability to afford hospital bills, nutritious food, and transportation to healthcare centers contributed to poor maternal outcomes. This aligns with the observations by Olonade, Olawande, Alabi, and Imhonopi (2019), who reported that poverty remains one of the greatest barriers to accessing timely and adequate maternal healthcare in Nigeria. Their study showed that low-income families were significantly less likely to seek professional care, relying instead on traditional or home-based remedies that increase the risk of death. This finding is echoed in the work of Yaya, Okonofua, Ntoimo, Udenigwe, and Bishwajit (2019), who concluded that women from poorer households are more likely to give birth without skilled attendants, leading to complications and fatalities. Our findings suggest that the intersection of poverty and patriarchy creates a dual burden where women are not only financially dependent but also stripped of the autonomy to seek or advocate for their health needs. This dual burden leads to delayed responses to complications, increased home births, and minimal postnatal care all contributing factors to maternal mortality. The statistical analysis ($p < 0.001$; Partial Eta Squared = 0.199) confirms a strong correlation, with about 20% of maternal mortality outcomes explained by this compounded vulnerability. The combined insights from this study and prior literature show that economic empowerment alone may not suffice if patriarchal norms remain unchallenged. This finding was further supported by the response of one of the respondents who, when interviewed, stated that:

"We hardly have enough to eat, let alone save money for hospital visits. My husband earns a small amount from farming and decides what we spend money on. He doesn't believe in paying for antenatal because he says the money should be used for farm tools or school fees. I had complications during my second pregnancy and couldn't get help in time. The women who die the most here are those from poor homes, whose husbands don't let them plan families or use contraception. Poverty and control together make it nearly impossible to survive childbirth sometimes."

Another of the respondents stated that:

"My family is poor, and my husband controls every naira we spend. He does not let me buy vitamins or even go for check-ups unless it is an emergency. We live far from the nearest clinic, and he says transportation costs are too high. Once, a woman in our community, Chidimma, died because she could not afford transport to the general hospital, and her husband said she should deliver at home. Being poor is one problem, but when the man also decides what is 'important', it becomes deadly for us women during pregnancy."

The findings of this study indicate that cultural and social norms deeply rooted in patriarchal values negatively influence maternal health-seeking behaviors in Southeast Nigeria. Respondents overwhelmingly reported that societal expectations discourage women from openly discussing reproductive health, delay antenatal visits, and place more value on traditional birthing methods than institutional care. These patterns are consistent with Udenigwe's (2023) analysis of social norms in maternal healthcare, where he noted that cultural gatekeeping and symbolic expectations often prevent women from exercising their reproductive agency. Similarly, Fawole and Adeoye (2015) found that household and community expectations in Nigeria often prioritize male authority and traditional practices, thereby discouraging women from seeking professional care or questioning harmful practices. The statistical results in this study (Wilks' Lambda = 0.749, $p < 0.001$) reinforce this conclusion by showing significant impacts of these cultural norms on maternal care decisions. Therefore, this study affirms that addressing maternal mortality requires not just improving healthcare infrastructure, but also challenging the entrenched cultural norms that dictate how, when, and whether women seek medical help. As Udenigwe et al. (2023) suggested, a negofeminist approach empowering women within the boundaries of their cultural systems could foster better negotiation strategies and safer maternal health outcomes in these deeply patriarchal communities.

This finding was further supported by the response of one of the respondents who, when interviewed, stated that:

"In our culture, a woman is expected to be humble and not challenge her husband's decisions, even about her own health. When I was pregnant with my fourth child, I wanted to register for antenatal classes early, but my husband said it was not necessary until the belly became big. I waited, and during labor, I had prolonged bleeding and nearly died. In our place, it is seen as disrespectful for a woman to go to the hospital without her husband's permission. This tradition has taken the lives of many women who were too afraid to speak up."

Another of the respondents stated that:

"There's a belief in our place that too much hospital care during pregnancy is for weak women, and that real women deliver at home, like our grandmothers did. This mindset, passed down from the elders and supported by men, stops women from going for regular check-ups. When my friend Adaeze began bleeding during pregnancy, her husband said it was a spiritual attack and took her to a native doctor instead of the clinic. She died that night. These cultural norms make it hard for women to take charge of their health."

Conclusion

In conclusion, this study has established a significant and compelling connection between patriarchal control over reproductive health and its direct and indirect effects on maternal mortality and household poverty in rural Southeast Nigeria. The research provides strong empirical evidence that women's limited autonomy in reproductive decision-making resulting from cultural, social, and religious enforcement of male dominance has detrimental consequences for maternal health outcomes. The inability of women to make independent decisions concerning antenatal visits, childbirth locations, family planning, and emergency health interventions leads to delayed or non-existent healthcare, thus increasing maternal morbidity and mortality rates. Moreover, the intersection of patriarchal control and household poverty forms a toxic cycle where economic deprivation magnifies health vulnerabilities, and maternal deaths further deepen the household's financial distress. The study found that patriarchal norms discourage proactive maternal health-seeking behavior by glorifying traditional birth practices and stigmatizing institutional healthcare, often perceived as unnecessary or intrusive. These cultural prescriptions have created an environment where women must seek permission or financial support from male household heads, who may not prioritize maternal care due to deep-seated gender biases. The loss of a mother in a rural family setting not only strips the household of a caregiver but also results in tangible economic losses due to missed labor, increased caregiving costs, and long-term impoverishment. The data confirmed that maternal mortality is not simply a medical issue but a socio-economic and cultural problem rooted in gender inequality. It was also concluded that rural health policies and programs have largely failed to address these structural barriers, focusing more on clinical interventions than on community-level gender empowerment. Thus, while healthcare improvements remain necessary, they will be insufficient unless paired with deliberate efforts to dismantle patriarchal norms and economically empower women. The study's results emphasized that maternal health must be repositioned not only as a public health priority but also as a fundamental human rights and development issue. Holistic interventions are required ones that simultaneously address patriarchal culture, poverty alleviation, legal reforms, and access to healthcare. The systemic and structural factors that perpetuate poor maternal health outcomes in patriarchal communities must be deconstructed through targeted community-based education, inclusive policy-making, and support mechanisms that allow women to gain greater control over their bodies, decisions, and lives. This conclusion echoes and strengthens the findings of several earlier studies, affirming that patriarchal structures are both a cause and consequence of poor maternal health and household poverty, and they must be addressed for any sustainable change to occur.

Recommendations

Based on the findings of this study, the following recommendations are proposed:

1. Government agencies, NGOs, and community stakeholders should launch culturally sensitive gender-education programs in rural Southeast Nigeria aimed at challenging harmful patriarchal norms and promoting women's rights to make independent reproductive health decisions. Religious and traditional leaders should be included in these programs to increase acceptance.

2. The government should establish maternal health subsidies or community-based health insurance schemes that specifically target rural households with limited income, ensuring that no woman dies due to financial constraints or spousal neglect in seeking maternal care.
3. Public health strategies should employ local customs and languages to address patriarchal resistance to institutional maternal care. This includes training and deploying community health workers from within these rural communities to bridge the cultural gap between modern healthcare practices and traditional beliefs.

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