# Early Marriage, Gender Norms, and Reproductive Health Outcomes: A Study of Meranaws in Marawi City, Southern Philippines

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**Abstract**

**Background**: Early marriage remains prevalent in communities with strong cultural traditions, such as the Meranaw in Marawi City, Philippines. Understanding its effects on sexual and reproductive health (SRH) is essential for improving health outcomes and addressing gender inequality. **Objectives**: This study aims to explore the impact of early marriage on SRH outcomes among Meranaw women, focusing on how empowerment, gender norms, and marital relations intersect with reproductive health. **Methods**: A quantitative, descriptive-correlational design was employed to examine SRH outcomes among Meranaw young. Descriptive statistics, including frequency distributions and measures of central tendency, were used to summarize respondents' characteristics. Pearson's correlation coefficient tested the relationships between the independent variables and SRH outcomes, while weighted means calculated average responses, considering the relative importance of various factors. **Results**: Early marriage was found to be associated with lower utilization of birth control and maternal healthcare services. Empowerment levels were lower among women married at an early age, and traditional gender norms contributed to limited autonomy in reproductive health decisions. **Conclusion**: Early marriage among Meranaw women in Marawi City negatively impacts SRH outcomes, exacerbating health risks and perpetuating gender inequality. Addressing these issues requires comprehensive education, policy interventions, and empowerment programs to shift cultural attitudes towards early marriage and promote better SRH outcomes.

**Keywords**: early marriage, sexual and reproductive health, Meranaw women, empowerment, gender norms.

## Introduction

Early marriage remains a significant challenge globally and in the Philippines, with profound implications for young individuals and their families (Werdyaningsih et al., 2023). This practice, defined as marriage before the age of 18, is particularly prevalent among Meranaw in Marawi City, where cultural traditions and socio-economic factors perpetuate its occurrence (UNICEF, 2020). While early marriage is widely recognized as a violation of human rights, its effects on sexual and reproductive health outcomes have drawn increasing attention due to their far-reaching consequences.

Approximately 15 million girls are married each year worldwide before the age of 18, equating to 28 girls every minute (UNICEF, 2020). Early marriage often forces young girls into adulthood before they are physically and emotionally prepared, compromising their ability to make informed decisions about their health and future. Research shows that adolescent mothers are more likely to experience maternal complications, perinatal and neonatal mortality, and even maternal death compared to older women (Ierardi et al., 2022).

In the Philippine context, early and arranged marriages are culturally entrenched practices among Muslim communities, including the Meranaw, who represent approximately 5% of the national population (UNICEF, 2020). Although substantial progress has been made globally in reducing the prevalence of early marriage, it remains pervasive, particularly in underserved communities. Despite its well-documented health risks, the specific pathways through which early marriage impacts sexual and reproductive health outcomes—such as restricted mobility, limited educational opportunities, and constrained access to healthcare—are not fully understood. These factors are often compounded by gender inequities, spousal power dynamics, and a lack of female empowerment (Chen et al., 2023; Marphatia, 2017; Sali, 2022).

Existing literature highlights the vulnerability of married young women to adverse reproductive health outcomes but provides limited evidence on the nuanced relationship between age at marriage, empowerment, and reproductive health choices. Critical gaps persist in understanding how early marriage influences marital dynamics, spousal communication, and women's decision-making autonomy, particularly among Meranaw communities. Furthermore, the variability of maternal health care utilization and fertility control practices among child brides remains underexplored.

To address these gaps, this study investigates the influence of early marriage on the sexual and reproductive health outcomes of Meranaw women married before the age of 18 in Marawi City. Specifically, the research examines the interplay between early marriage and factors such as fertility control, maternal health care utilization, and empowerment dynamics. By shedding light on these issues, the study aims to contribute to evidence-based interventions and policies that promote the health and well-being of young women in culturally sensitive contexts.

## Research Methodology

### Research Design

This study employed a quantitative descriptive-correlational design to examine the influence of early marriage on the sexual and reproductive health outcomes of Meranaw young women in Marawi City, Philippines. The SRH outcomes analyzed included self-reported birth control, and maternal health care utilization. The study also considered women's empowerment, gender role attitudes, marital relationships, social support and networks, access to information and services, and personal characteristics.

The descriptive design was used to collect and summarize data on the variables through a structured questionnaire. This approach allowed for the systematic capture of information related to the SRH outcomes of Meranaw women married before the age of 18. Meanwhile, the correlational design was utilized to test hypotheses concerning the relationships between the independent variables and the SRH outcomes. This helped identify the predictive values of these variables and how they contribute to shaping SRH outcomes among young women.

### Locale and Setting

This study was conducted in Marawi City, located on the shores of Lake Lanao in Lanao del Sur, Southern Philippines. The capital serves as the socio-economic and cultural center for the Meranaw people. Its economy is predominantly driven by trade, agriculture, and services, with bustling markets that reflect the city's rich cultural heritage. Religiously, Marawi is predominantly Islamic, often referred to as the "Islamic City of Marawi." It is a stronghold of Meranaw culture and Islamic faith, with mosques and madrasahs (Islamic schools) playing central roles in community life. Religious practices and values deeply influence the city's social and economic structures, making Marawi a unique blend of tradition, resilience, and cultural pride (Cornelio & Calamba, 2022).

### Population and Sampling Method

The study's population consists of 318 Meranaw young women aged 15 to 25 who were currently or formerly married, with or without children, and confirmed as residents of Marawi City's 96 barangays, based on records from the City Health Office (CHO). From this population, a representative sample of 177 respondents was selected using a multi-stage sampling approach that incorporated purposive sampling to meet specific inclusion criteria. Given that girls married before the age of 18 often represent a "hidden and hard-to-reach population" (Belachew et al., 2022). Chain-referral sampling was utilized, where respondents referred other eligible participants, enabling researchers to reach a broader segment of the target population (Sansfaçon et al., 2024). Additionally, community health workers and mobilizers within the barangays facilitated recruitment by discussing the study during their door-to-door visits and referring interested participants.

**Research Instrument**

The study utilized a researcher-developed, structured questionnaire comprising seven parts, adapted from existing instruments on young people's sexual and reproductive behaviors, awareness, gender role attitudes, and agency (IIPS and Population Council, 2007) while incorporating the researcher's observations. The questionnaire was translated into the Meranaw dialect for clarity and cultural appropriateness.

Part I gathered respondents' background information, such as age, marriage details, education, employment, income, family type, and spousal age gap. Part II assessed women's empowerment through decision-making, mobility, financial power, and gender role attitudes. Part III explored marital relationships, including inter-spousal violence, power dynamics, husband support, and couple communication. Part IV assessed sexual health outcomes, focusing on symptoms such as pain during intercourse, genital ulcers, and unusual discharge. Finally, Part V evaluated reproductive health outcomes, such as contraceptive use, fertility outcomes, and maternal healthcare utilization, with indicators like antenatal visits, skilled birth attendance, and institutional delivery.

This comprehensive tool allowed for an in-depth analysis of the respondents' experiences, behaviors, and outcomes in key areas of sexual and reproductive health.

**Validity and Reliability of the Research Instrument**

The validity and reliability of the research instrument were assessed through multiple methods, including pre-testing and Cronbach's Alpha. The pre-test involved ten individuals with characteristics similar to the study respondents but excluded from the main study. Cronbach's Alpha yielded a value of 0.85, indicating good internal consistency of the instrument. In addition to this, content validity was ensured through expert review, where professionals in the field evaluated the relevance and clarity of the items. Construct validity was assessed by checking whether the instrument accurately measured the theoretical concepts it was intended to measure. The reliability of the instrument was further strengthened through test-retest reliability, where the instrument was administered to a subset of respondents at two different points in time, and results showed consistent responses. These combined methods confirmed that the instrument was both reliable and valid for the study.

**Data Collection Procedures**

Data collection took place across various barangays in Marawi City. Prior to the study, key informant interviews were held with community health workers and mothers of young married women to understand the local social and cultural context, including factors like education, marriage timing, and health issues. Additionally, content analysis was conducted on policies and documents related to underage marriage, women's empowerment, gender equity, and health, providing insights into national and local factors affecting young married women.

Primary data was collected through surveys with Meranaw young women aged 15 to 25, who were married before 18. Recruitment was facilitated by community health volunteers, who served as gatekeepers. Written informed consent was obtained, with illiterate participants given the option of a signature or mark after the consent form was read to them. All interviews and surveys were conducted in private and in the Meranaw dialect to ensure confidentiality. Respondents were identified by an alphanumeric code, and data collection occurred within a period of 6 months, targeting a minimum of 110 respondents.

**Methods of Data Analysis**

Data analysis involved a combination of descriptive and inferential statistical methods to examine the relationship between early marriage, women's empowerment, gender role attitudes, marital relationships, and sexual and reproductive health (SRH) outcomes among Meranaw young women in Marawi City. To provide an overview of the respondents' demographic characteristics and their empowerment and gender norms, frequency and percentage distributions were used. Univariate descriptive statistics, including measures of central tendency (mean, median, and mode) were applied to assess the distribution of individual variables related to empowerment, gender norms, and SRH outcomes. Pearson's correlation coefficient was used to assess the strength and direction of linear relationships between empowerment, gender norms, marital relationships and SRH outcomes. Correlations were tested at the 0.05 significance level.

Data analysis was performed using SPSS (Statistical Package for the Social Sciences) for advanced statistical methods while Microsoft Excel was used for data organization, visualization, and preliminary descriptive statistics.

**Ethical Considerations**

This study adhered to the WHO ethical guidelines for research involving human participants (2021), ensuring the protection of participants' rights and welfare. Ethical approval for the study was obtained from the Ethics Review Committee of the authors' university (CREC 2017-005). Informed consent was obtained from all participants before data collection. Participation in the study was voluntary, and respondents were informed that they could withdraw at any time without facing any negative consequences.

Confidentiality was maintained throughout the study. Personal identifiers, such as names and addresses, were not collected, and participants were assigned alphanumeric codes to ensure anonymity. All data were stored securely and only accessible to the research team. Interviews and surveys were conducted in private settings to protect participants' privacy. Additionally, the study ensured that sensitive topics, such as early marriage, sexual and reproductive health, and marital violence, were handled with respect and sensitivity. The research team was trained in ethical interviewing techniques to minimize potential distress to participants.

## Result

### Summary of Participant Demographic Profile

**Table 1.**

Frequency and Percentage Distribution of Respondents' Demographic Characteristics

| Demographic Characteristic | Category | Frequency | Percentage (%) |
|---|---|---|---|
| **Age** | 15 to 17 years | 23 | 12.99 |
| | 18 to 21 years | 65 | 36.72 |
| | 21 to 25 years | 89 | 50.28 |
| | **Total** | 177 | 100.0 |
| **Age at Marriage** | Below 15 years | 15 | 8.47 |
| | 15 to 18 years | 91 | 51.41 |
| | 19 to 25 years | 71 | 40.11 |
| | **Total** | 177 | 100.0 |
| **Educational Attainment** | No formal schooling | 4 | 2.26 |
| | Elementary level | 14 | 7.91 |
| | Elementary graduate | 4 | 2.26 |
| | High school level | 36 | 20.34 |
| | High school graduate | 64 | 36.16 |
| | College level | 37 | 20.90 |
| | College graduate | 18 | 10.17 |
| | **Total** | 177 | 100.0 |
| **Type of Family** | Nuclear family | 12 | 6.78 |
| | Single-parent family | 4 | 2.26 |
| | Extended family | 161 | 90.96 |
| | **Total** | 177 | 100.0 |
| **Type of Place of Residence** | Urban | 175 | 98.87 |
| | Rural | 2 | 1.13 |
| | **Total** | 177 | 100.0 |
| **Type of Marriage** | Love | 46 | 25.99 |
| | Arranged | 131 | 74.01 |
| | **Total** | 177 | 100.0 |
| **Agreement to Marriage Decision** | Yes | 53 | 29.94 |
| | No | 85 | 48.02 |

| Demographic Characteristic | Category | Frequency | Percentage (%) |
|---|---|---|---|
| | No Voice | 39 | 22.03 |
| | **Total** | 177 | 100.0 |
| **Husband's Educational Attainment** | Same level as wife | 67 | 37.85 |
| | Wife has higher education | 12 | 6.78 |
| | Husband has higher education | 98 | 55.37 |
| | **Total** | 177 | 100.0 |
| **Age Gap with Husband** | Husband is younger | 7 | 3.95 |
| | Same age | 44 | 24.86 |
| | Husband older by 1-5 years | 59 | 33.33 |
| | Husband older by 6-9 years | 43 | 24.29 |
| | Husband older by 10+ years | 24 | 13.56 |
| | **Total** | 177 | 100.0 |

The demographic characteristics of the respondents provide valuable insights into the social, cultural, and educational context of the community. The majority of respondents (50.28%) fall within the 21 to 25-year-old age range, yet a significant portion (51.41%) experienced marriage between the ages of 15 and 18, indicating the prevalence of early marriage within the Meranaw population. This suggests that early marriage is still a common practice and may affect young women's opportunities for education, employment, and personal development.

In terms of educational attainment, a significant portion of respondents (36.16%) are high school graduates, with a smaller percentage (10.17%) having completed college. This indicates that access to higher education is limited for many, which could impact their health literacy and their ability to make informed decisions, particularly regarding reproductive health and family planning.

The family structure of the respondents shows that most (90.96%) live in extended families, with a substantial proportion (98.87%) residing in urban areas. This suggests strong social support networks within the family unit, which could play a vital role in providing emotional and financial support. However, urban living might also bring

challenges such as access to healthcare services, which could influence the overall well-being of the respondents.

Marriage practices reveal that the majority of marriages (74.01%) are arranged, with nearly half (48.02%) of the respondents indicating they did not agree with the decision to marry. This reflects the traditional nature of marriage arrangements within the community, where individual choice may be limited, and family or cultural norms take precedence.

Finally, when it comes to husbands' educational attainment and age gaps, the data shows that most husbands (55.37%) have higher levels of education than their wives, and a significant portion (33.33%) are 1-5 years older than their wives. These factors suggest that decisions within the household, particularly those related to health, family planning, and economic matters, may be influenced by the educational and age dynamics between spouses.

**Empowerment and Gender Norms**

**Table 2.**

Summary of Overall Mean, Rank & Qualitative Description of Respondents Empowerment and Gender Norms

| **Women Empowerment** | **Overall Mean Score** | **Qualitative Description** |
|---|---|---|
| Role in Decision-Making | 2.15 | Seldom |
| Role in Mobility | 2.37 | Seldom |
| Financial Power | 1.92 | Seldom |
| Gender Role Attitudes | 2.97 | Often |

Scaling: 4.21-5.00– “Always”, 3.41-4.20– “Often”, 2.61-3.40– “Sometimes”, 1.81-2.60– “Seldom”, 1.00-1.80– “Never”

The results illustrate the ongoing complexities of women’s empowerment in the family and society.

Regarding role in decision-making, while women have some influence, particularly in joint decisions with family members about health matters, their overall participation in decisions about children, household purchases, and work outside the home remains limited. The overall mean score of 2.15, categorized as ("Seldom") suggests that traditional gender roles still significantly restrict women's autonomy, with the husband often having a more dominant say in family matters.

In terms of mobility, women reported varying degrees of freedom. They have some restrictions, such as occasionally needing permission to go to social gatherings or visit relatives, but they can visit health centers without constraint. The overall mean of 2.37 ("Seldom") reflects this mixed autonomy, where women's freedom of movement is partially controlled by societal expectations, though they retain some independence, especially for health-related matters.

Financial power remains limited for women, with most financial decisions made jointly with their husbands or rarely by themselves. Women reported that while they sometimes receive their husbands' salary, they rarely have control over personal savings or independent financial accounts. The mean score of 1.92 ("Seldom") emphasizes the financial dependence many women face, often due to limited financial resources in early marriage, which reinforces patriarchal norms and restricts their empowerment.

Finally, gender role attitudes reveal a mixed perspective. Respondents strongly supported gender equality in education and women's autonomy in deciding when to marry. However, traditional views still persist, particularly regarding household finances, with some women agreeing that husbands should decide on financial matters. The overall mean score of 2.97 ("Often") shows that, while there is support for gender equality, traditional gender roles continue to influence attitudes, particularly in financial and domestic spheres.

Taken together, these findings highlight that while there are signs of progress toward gender equality in areas such as education and health, entrenched gender roles and patriarchal norms continue to restrict women's full empowerment, especially in decision-making, mobility, financial control, and attitudes toward gender roles.

**Marital Relationship**

**Table 3.**

Summary Of Overall Mean, Rank & Qualitative Description Of Respondents Marital Relationship.

| Marital Relationship | Overall Mean Score | Qualitative Description |
|---|---|---|
| Role in Decision-Making | 2.15 | Seldom |
| Role in Mobility | 2.37 | Seldom |
| Financial Power | 1.92 | Seldom |
| Gender Role Attitudes | 2.97 | Often |

Scaling: 4.21-5.00– “Always”, 3.41-4.20– “Often”, 2.61-3.40– “Sometimes”, 1.81-2.60– “Seldom”, 1.00-1.80– “Never”

The marital relationship in terms of inter-spousal violence, power dynamics, husband support, and couple communication reflects a complex picture of trust, support, and traditional norms.

The overall mean score for the respondents' experience of spousal violence is 1.67, categorized as ("Never") This suggests that respondents have not encountered physical violence, harm, or verbal assaults like yelling or humiliation from their husbands over the past year. The absence of such violence indicates a positive aspect of the marital relationship, where couples likely share strong power dynamics that protect women from harmful behaviors.

The respondents reported a mean score of 2.42 ("Seldom") in power dynamics, with a few notable trends. While respondents expressed that their husbands trust them with

money and permit them to meet their female friends, they reported never experiencing jealousy or being restricted from contacting their natal family. This indicates a healthy sense of mutual respect and trust between spouses, with limited interference in personal autonomy. The findings align with the view that economic control and mutual understanding within marital relationships can counter traditional patriarchal dynamics.

The overall mean for this aspect is 2.24 ("Seldom"), showing that while some husbands assist with household chores—such as washing clothes and taking care of children—their involvement in other tasks like cooking or doctor visits is less frequent. Additionally, the communication between spouses, particularly regarding family matters, contraception, and health issues, is limited. This suggests that while there is some husband participation, there remains a gap in active, open communication about significant issues in the relationship, such as sexual health or family planning.

**Reproductive Health Outcomes**

**Table 4.**

Summary Of Frequency and Percentage Distribution, Respondents' Reproductive Health Outcomes

| **Category** | **Item** | **Frequency (n=177)** | **Percentage** |
|---|---|---|---|
| **Birth Control Methods** | Have you ever used any kind of contraceptive method to delay or stop pregnancy? | No | 169 (95.48%) |
| | Are you currently using any contraception? | No | 169 (95.48%) |
| | What is the type of current method? | Condom | 6 (3.39%) |
| | Who decides whether or not you and your husband use contraception? | Both | 170 (96.05%) |
| **Fertility Control** | Did you give birth within the first year of marriage? | Yes | 145 (81.92%) |
| | Do you have three or more than three children? | Yes | 132 (74.58%) |
| | Have you had a history of birth less than 24 months after your previous childbirth? | Yes | 99 (55.93%) |
| | Do you have a living child or children prior to your first use of contraception? | Yes | 160 (90.40%) |
| | Have you ever had a history of pregnancy that resulted in miscarriage, abortion, or stillbirth? | No | 169 (95.48%) |

| Category | Item | Frequency (n=177) | Percentage |
|---|---|---|---|
| | Have you ever had at least one child that was not planned or not wanted at the time of pregnancy but was wanted later or not wanted at all? | Yes | 121 (68.36%) |
| **Maternal Health Care Utilization** | How many times did you go for prenatal/antenatal check-up during your last pregnancy? | One visit | 65 (36.72%) |
| | Who assisted you in your last delivery? | Midwife | 74 (41.81%) |
| | Where did you deliver your last child? | Lying-in | 63 (35.59%) |

Reproductive health outcomes in the study cover birth control methods, fertility control, and maternal healthcare utilization. These outcomes reflect various aspects of family planning, childbirth experiences, and access to maternal care services.

The data reveals that a significant majority of respondents (95.48%) have never used contraception, nor are they currently using any contraceptive method (95.48%). Among the few who reported using contraception, the most common methods were condoms (3.39%), withdrawal (0.56%), and IUDs (0.56%). No respondent indicated the use of sterilization methods, nor did any indicate having been sterilized. Decision-making regarding contraception use was typically a joint decision between the couple (96.05%), with very few respondents (2.26%) deciding independently.

In terms of fertility outcomes, a large proportion of respondents (81.92%) reported giving birth within the first year of marriage. Additionally, 74.58% of respondents had more than three children, indicating a pattern of early childbearing and high fertility rates. More than half (55.93%) of the respondents had experienced births within two years of their previous childbirth. Notably, 90.40% of the respondents had living children prior to using contraception, and 68.36% reported having at least one child that was initially unplanned but later desired. A small proportion (4.52%) reported a history of miscarriage, abortion, or stillbirth.

Maternal healthcare utilization showed mixed outcomes, particularly concerning antenatal visits and delivery assistance. Only 36.72% of respondents had one antenatal check-up, while 25.99% did not attend any antenatal visits. Regarding delivery assistance, most respondents were assisted by midwives (41.81%) during childbirth, followed by nurses (25.99%) and hilots (24.29%). Delivery settings varied, with 35.59% of deliveries occurring in lying-in centers, 24.29% at home, and 16.95% in hospitals. These findings suggest limited access to comprehensive prenatal and hospital-based delivery care for many respondents.

Global trends highlight improvements in skilled birth attendance, although maternal health care, particularly postnatal care, remains a significant concern. The lack of

postnatal care, especially in developing countries, is associated with high maternal and neonatal mortality, emphasizing the need for enhanced maternal care services during and after childbirth.

**Correlation Between Variables**

**Table 5.**

Correlation Between Respondents' Empowerment & Gendered Norms and Reproductive Health Outcomes

| **Relationship** | **Correlation Coefficient (r)** | **p-value** | **Remarks** |
|---|---|---|---|
| Decision-Making Power | 0.654 | 0.045 | **Significant** |
| Mobility | 0.543 | 0.023 | **Significant** |
| Financial Power | 0.652 | 0.032 | **Significant** |
| Gender Role Attitude | 0.234 | 0.033 | **Significant** |

This study explored the relationship between respondents' empowerment and gendered norms—specifically decision-making power, mobility, financial power, and gender role attitudes—and reproductive health outcomes among Meranaw young women. Using Pearson's r correlation, the study aimed to assess whether these factors significantly influenced reproductive health outcomes, including fertility control, contraceptive use, and maternal healthcare practices.

As shown in **Table 5** the correlations between the respondents' empowerment & gendered norms (decision-making power, mobility, financial power, and gender role attitude) and reproductive health outcomes were **significant**. Given that the p-values are less than 0.05, it can be concluded that there is a **significant positive relationship** between respondents' empowerment & gendered norms and reproductive health outcomes.

The strong correlation between decision-making power (r = 0.654) and reproductive health outcomes suggests that women who have more autonomy in household and health-related decisions are more likely to engage in healthier reproductive behaviors.

The significant correlation between mobility (r = 0.543) and reproductive health outcomes indicates that greater freedom of movement allows women to access essential health services, including family planning resources and antenatal care. Women who experience fewer restrictions on their movement are more likely to seek timely medical attention and take proactive steps in managing their reproductive health.

Financial power (r = 0.652) was also significantly correlated with reproductive health outcomes, highlighting the importance of economic independence in enabling women to make informed choices about contraception, fertility control, and healthcare. Financial control provides women with the resources to prioritize health, thus improving access to health services and contraceptives.

Finally, the positive correlation between gender role attitudes (r = 0.234) and reproductive health outcomes indicates that women who embrace more egalitarian views on gender roles, particularly regarding reproductive decisions, are likely to have better reproductive health outcomes. This supports the idea that challenging traditional gender norms and promoting gender equality can empower women to make healthier choices regarding their reproductive health.

These findings underscore the significant role that empowerment, particularly in the areas of decision-making, mobility, financial autonomy, and gender role attitudes, plays in shaping reproductive health outcomes. In the context of Meranaw culture, where traditional gender roles and early marriage may restrict women's autonomy, these results are critical. They suggest that enhancing women's empowerment can lead to better reproductive health decisions, thus addressing the challenges posed by early marriage, limited educational attainment, and restricted mobility.

**Table 5.**
Correlation Between Respondents' Marital Relations and Reproductive Health Outcomes

| **Relationship** | **Correlation Coefficient (r)** | **p-value** | **Remarks** |
|---|---|---|---|
| Inter-spousal Violence | 0.5452 | 0.0523 | Not Significant |
| Power Dynamics | 0.642 | 0.504 | Not Significant |
| Husband Support and Couple Communication | 0.464 | 0.003 | **Significant** |

**Note:** Correlation is significant at the 0.05 level (2-tailed).

The correlation coefficient for inter-spousal violence (r = 0.5452) indicates a moderate positive relationship with reproductive health outcomes. However, the p-value (0.0523) exceeds the significance threshold of 0.05, suggesting that this relationship is not statistically significant. This means that inter-spousal violence, while possibly influencing reproductive health outcomes, does not have a strong enough correlation to be considered significant at the 0.05 level.

Similarly, power dynamics (r = 0.642) demonstrated a positive correlation with reproductive health outcomes, but the p-value (0.504) far exceeds the 0.05 threshold, indicating that the relationship is not statistically significant. This suggests that power dynamics, although related to reproductive health outcomes, do not significantly influence them in this sample, and the null hypothesis for this variable is also retained.

In contrast, husband support and couple communication (r = 0.464) showed a moderate positive correlation with reproductive health outcomes, with a highly

significant p-value of 0.003. Since this p-value is well below the 0.05 significance level, it indicates a statistically significant relationship between husband support, effective couple communication, and improved reproductive health outcomes. This result underscores the importance of supportive relationships between spouses in ensuring better reproductive health outcomes, as greater husband involvement and open communication contribute to healthier family planning decisions, maternal care, and fertility control.

The findings highlight the significance of positive marital relations, especially husband support and communication, in shaping reproductive health outcomes. These results suggest that marital dynamics, particularly in the context of young marriages, can have a profound impact on women's health. In particular, supportive partnerships characterized by mutual communication foster better health decisions and outcomes, which is critical in a cultural context where gender dynamics may restrict women's autonomy in making reproductive health choices.

**Discussion**

This study aimed to explore the relationship between women's empowerment, gendered norms, marital dynamics, and reproductive health outcomes among Meranaw young women. The findings revealed several significant insights into how these factors influence reproductive health behaviors in a community where traditional gender roles and early marriage practices persist.

The results highlight the limited empowerment of women in the Meranaw community, particularly in decision-making, mobility, and financial control. These findings align with research showing that in patriarchal societies, women's autonomy in household and health-related matters is often constrained (Kassahun & Zewdie, 2022; Das et al., 2022). The low empowerment scores across various domains suggest that traditional gender roles remain deeply entrenched, limiting women's participation in critical decisions, including those related to health and family planning (Achrekar et al., 2024). This supports prior studies indicating that women's roles in many cultural contexts remain confined to the domestic sphere, with restricted access to resources and decision-making power (Chapagain, 2006).

Interestingly, the study also found moderate support for gender equality, especially in education and marriage. This suggests a cultural shift towards recognizing women's autonomy, though traditional gender roles persist in areas like financial matters and domestic responsibilities. These findings echo research by Qanti et al. (2021), who argue that even in societies where attitudes toward gender roles are evolving, deeply rooted cultural norms continue to restrict women's participation in household and societal decision-making.

The marital dynamics observed in this study reveal a complex picture of trust, power, and communication between spouses. While the absence of physical or verbal violence is a positive outcome, power dynamics within marriages remain skewed. Respondents

reported mutual trust and support from their husbands, but the lower involvement of husbands in domestic chores and reproductive health discussions points to significant gaps in gender equality (Nagarajan & Sahoo, 2022). Previous studies have emphasized that equitable communication and shared responsibilities in marriage are crucial for improving reproductive health outcomes (Ampim et al., 2022; Chapagain et al., 2019). The study confirms that marital support and effective couple communication are essential in promoting healthier reproductive decisions, as evidenced by the significant correlation between husband support and reproductive health outcomes (Wang & Zhong, 2023)

The findings regarding reproductive health outcomes, particularly the low use of contraception and high fertility rates, reflect a pattern of early marriage and limited access to family planning resources. These results are consistent with studies in regions with high early marriage rates, where women often lack access to reproductive health education and services (Liu et al., 2023). The limited use of contraception, despite high fertility rates, underscores women's restricted autonomy over their reproductive health (Shasha et al., 2023). Joint decision-making about contraception use indicates some male involvement in reproductive health, but the overall low usage suggests a need for more educational efforts targeting both spouses about family planning and its benefits (Kundu et al., 2022).

The study found significant correlations between empowerment indicators (decision-making power, mobility, financial power, and gender role attitudes) and reproductive health outcomes. These findings confirm that women's autonomy is crucial in making informed reproductive health decisions (Winters et al., 2023). Women with greater decision-making power, mobility, and financial control were more likely to engage in healthier reproductive behaviors, which aligns with existing literature suggesting that women's empowerment is a key determinant of improved reproductive health outcomes (Das et al., 2022). However, the study also highlights the need to challenge traditional gender norms to allow women to fully exercise their rights and make decisions regarding their health and well-being (Muluneh et al., 2021).

In contrast, the correlation between marital relations and reproductive health outcomes showed mixed results. While husband support and communication were significantly correlated with better reproductive health outcomes, power dynamics and inter-spousal violence were not. This suggests that positive communication and mutual trust are more influential in improving reproductive health than traditional power imbalances or violence in marriage (Bolarinwa et al., 2020). These results highlight the critical role of positive marital relationships in shaping reproductive health decisions, particularly in a context where women's autonomy may be limited.

## Conclusion

This study underscores the critical connection between women's empowerment, gender norms, marital dynamics, and reproductive health outcomes. It highlights the ongoing challenges women face, particularly in patriarchal societies, where traditional

roles limit their autonomy and decision-making power. The findings emphasize the need for policy and community-level interventions to promote gender equality, enhance women's empowerment, and improve reproductive health services. Furthermore, this research lays a foundation for future studies to explore the intersection of cultural norms, empowerment, and health outcomes, paving the way for more inclusive and effective health initiatives.

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**Conflict of Interest**
The authors declare that they have no competing interests.

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