



Women Empowerment and Maternal Health Seeking Behavior. A Case of Bagamoyo District, Tanzania.

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ABSTRACT

An essential component of empowerment is a woman's capacity to make choices that affect her own particular situation. A cross-sectional research approach was utilised, in which 250 women were chosen at random, to evaluate the degree of women's empowerment and their decision-making on health-related issues. Information was gathered about their involvement in various household decision-making processes, including the use of household income, decisions regarding significant purchases, decisions regarding food purchases, decisions regarding the pursuit of healthcare for children and other household members, and decisions regarding visiting families or relatives. A Composite Empowerment Index (CEI) was created using these data to gauge the degree of empowerment among them. The results indicated that women in the research area had a medium level of empowerment. Low personal autonomy in maternal health was found by descriptive analysis, which was exhibited in low decision-making about the use of family planning and decision on becoming pregnant. Results of an Ordinal Logistic Regression analysis showed that experiences with forced sexual contact, female genital mutilation (FGM), and decisions about using family planning, seeking medical care, choosing child care practices, and marital status all have an impact on women's empowerment and, consequently, how they seek out health care. Of these factors, it was determined that violence against women and the encouragement of FGM posed the biggest obstacles to women's empowerment and hence had a detrimental effect on women's health-seeking behaviour. Thus; in order to achieve a better degree of empowerment, it is essential to continue educating women about their rights and harmful cultural practises; hence influence positive maternal health-seeking behaviour.

Key words: Women Empowerment, Decision-Making, Maternal Health Seeking Behaviour, Bagamoyo, Tanzania

1. INTRODUCTION

Maternal death ratio has decreased by 44% globally since 1990, which represents a significant improvement in the general population health. Despite this development, some 830 women still die everyday from causes associated with pregnancy or childbirth. Tanzania's mortality rate is still one of the highest in the world, with most deaths occurring from the onset of true labor until the birth of the infant and the expulsion of the placenta (World Bank, 2020). According to the 2015–16 Tanzania Demographic and Health Survey, maternal mortality rates have remained high, at 556 deaths per 100,000 live births, due to many challenges including inadequate quality services and women's restricted ability to independently access health service (MoHCDGEC, 2016).

The focus of studies and initiatives around the world has shifted to women's autonomy¹ and its links to reproductive health and health-seeking behaviour especially in light of the 1994 Cairo International Conference on Population and Development (ICPD) (United Nations, 1994). A broad agreement was made at the ICPD to change the position of women, with the linked objectives of enhancing women's reproductive health and guaranteeing their reproductive rights. This constitutes a paradigm shift that emphasises the individual's choice to choose their own reproductive path (United Nations, 1994). The Sustainable Development Goals (SDGs) have also prioritised improving the health of women's reproductive systems, with a goal of bringing down the worldwide maternal death rate to less than 70% by 2030. Among the commitments of the SDG's goals is to guarantee everyone has access to family planning, information, and education, as well as the inclusion of reproductive health into national policies and initiatives (WHO, 2016). As a result, it may be inferred that the SDGs recognise the need for women to have more access to opportunities and a voice in order to manage their own and their children's health.

In low- and middle-income countries, most women still lack the ability to assert their rights and make decisions regarding their health. In some instances, even women's right to access healthcare for both themselves and their children is occasionally restricted (WHO, 2015). This low empowerment has led to an adverse effect on overall and well-being of women and the growth of their offspring. Additionally, inadequate access to maternal and child care services has been shown to cause persistence of maternity and child mortality (World Vision, 2015).

¹ Women's ability to act independently and execute decisions pertaining to personal matters important to their lives and their families (Basu, 1992 and Mason, 1994).

Empowering women is an important subject in today's world. While there have been many attempts to develop a consensus concept of empowerment, this concept has considerable variation in its conceptualization. In the field of women's empowerment alone, authors have used the term such as "gender equality", "women status" and "female autonomy" somewhat interchangeably. Most of cited definitions link empowerment with power or freedom used to achieve desired outcomes. Kabeer (2001) describes it as the expansion of women's ability to make strategic life choices in a context where this ability was previously denied to them; a definition which most of developing countries has been adopting, including the present study.

Various studies from different parts of the world have reported that increased women's empowerment is likely to increase their ability to seek and use health services to meet their own reproductive health goals, including safe motherhood and better child care practices (Kishori, 2000). A study in Bangladesh concluded that lower fertility desire was observed among women with a higher level of autonomy (Balk 1994), and lower fertility was found to be associated with women's greater autonomy in Malaysia, the Philippines, and Thailand (Tfaily 2004). While women's reproductive health seeking behavior was also found to be positively associated with freedom of movement and decision-making power in South India (Bhatia and Cleland, 1995), Another study by Kishori (2000) found women's autonomy to be an important explanatory factor in child survival and child health in Egypt. Using DHS data from Zimbabwe, Becker (1997) found a strong relationship between women's role in household decision-making and the extent of prenatal care and contraceptive use.

Apprehensively, the situation of women's empowerment and maternal health seeking behaviour is not well established in Tanzania. Available empirical evidence has examined other dimensions related to maternal health care. For example, a study conducted in Mkuranga and Bagamoyo (Kabula *et al.*, 2021) indicated the significant contribution of community health workers (CHW) in delivering maternal health interventions. Another qualitative and quantitative study by Tukay *et al.* (2021) evaluated the Direct Health Facility Financing (DHFF) program for improving Maternal Health Services in Pangani District. The overall results of this study found a positive impact of DHFF on maternal health service delivery in the district. Although a study in Mpwapa concluded that access to relevant and reliable maternal health information is essential to creating awareness and empowering women to make informed decisions about their reproductive health (Kassim, 2020), However, the relationship between women's empowerment and health-seeking behaviour is multi-dimensional and complex. Thus, better understanding and escalating this complex relationship between women's empowerment and maternal health seeking behavior is necessary for developing effective health strategies for a country like Tanzania. This study therefore filled this knowledge gap with specific objectives which are; to establish the status of women's empowerment in the study area and examine the influence of women's empowerment on maternal health seeking behaviour.

Women's empowerment and the ability to make decisions about reproductive health and sexual relations are pivotal to universal access to sexual and reproductive health. In Tanzania, the need to improve maternal healthcare is reflected in a number of national and international policies and programs. The 2030 Sustainable Development Goals (SDG) Agenda and the long-term 2063 Agenda both include commitments to gender equality and women's empowerment. The National Health Policy by the Ministry of Health, Community Development, Gender, Elderly, and Children (MoHCDGEC), in which the government has expressed its commitment to provide free maternal and child health care services to increase access for pregnant women (MoHCDGEC, 2016). In fact, the adoption of the SDGs is in line with the commitment to reduce maternal mortality to less than 70 per 100,000 live births by 2030. However, the current national plans and strategies do not fully capture the components of women's empowerment and health-seeking behavior, especially among rural women. Findings from this paper provide feedback to stakeholders, researchers, and policymakers aimed at improving maternal healthcare at all levels.

2. MATERIALS AND METHODS

2.1 Study Area

This paper is based on research conducted in Bagamoyo District, Tanzania, covering two wards, namely Bagamoyo and Kerege. The district is located in the Pwani Region of Tanzania, along the eastern coast of the country. It has a rich historical and cultural background and is known for its significant role in the Eastern African slave trade. Culturally, Bagamoyo is home to various ethnic groups, including Digo, Zaramo, Bondei, and other ethnic groups such as Masai, who migrated from neighboring districts like Handeni and Morogoro (URT, 2020/2021). The cultural diversity of the area contributes to a vibrant mix of languages, traditions, and customs. This diversity is likely to have an impact on the level of women's empowerment and hence influence health-seeking behavior among women in Bagamoyo district.

2.2 Study Design and Data Collection

The study was cross-sectional, descriptive, and analytical. It was considered suitable for the study since it enables the examination of the role of women's empowerment on maternal health seeking behavior. The design also allows more than one method to be used at a time and is suitable for descriptive analysis. Data was collected from women of reproductive ages between 15 and 49 years. With the assistance of ward officials, purposive sampling was used to obtain six villages: three villages from Bagamoyo and three from Kerege. Hence, a total of 250 respondents were involved in the study.

The focus of this study was at the community level, whereas a household-based analysis of socio-demographic and health-seeking behavior was considered. Household interviews were conducted using a self-administered questionnaire, which they filled out in the presence of the researcher. Ethical consideration was observed as all participants were informed before being interviewed of the purpose of the study, what participation involved, confidentiality in the research, and their rights to ask questions and withdraw from participation.

2.3 Data Analysis

Descriptive analysis was the main method of data analysis. Data collected from respondents were analyzed using the Statistical Package for Social Sciences (SPSS). Women's reproductive empowerment was the main explanatory variable. The common reproductive empowerment measures used in different studies focused on examining self-efficacy to express, negotiate, and carry out one's sexual and reproductive desires and outcomes (Edmeades, 2018), whereas sexual and reproductive decision-making and freedom from violence are commonly used indices.

For the purpose of this paper, four indices are adapted, including the Personal Autonomy Index (PAI), whereby seven variables related to women's decision-making on issues related to health were used. This dimension was computed on 1/7 variables in three responses: husband/partner '0', jointly '0.072, and respondent alone '0.143'. The Decision Making Index (DMI) on issues related to health care decisions was calculated on 1/8 variables in three responses: husband/partner '0', jointly '0.063, and respondent alone '0.125'. The Freedom from Violence Index (FVI) has six variables that assess whether a woman has been a victim of violence or not. FVI was computed in variables 1/6 in dummy '0' if not and 0.166 if yes. Freedom of movement index (FMI) was calculated on 1/5 variables in three responses: never '0', accompanied '0.1, and always alone '0.2'. Then, all four indices were combined into a single index, the Composite Empowerment Index (CEI), to measure women's empowerment. The CEI is the average of four indices, as indicated in equation (i). The use of CEI to measure women's empowerment is widely recognized by other researchers, such as Alam *et al.* (2015) and Sheikh *et al.* (2016).

$$CEI = 1/4 \text{ indices (PAI + DMI + FVI + FMI)Equation (i)}$$

The final cut-off empowerment levels were measures based on human development achievement as introduced in the Human Development Report 2014 (UNDP, 2014). Based on this report, human achievement is classified into four levels ranging from 0 to 1: low human development (0–0.549), medium (0.0550–0.699), high (0.7–0.799), and very high (0.8–1). Therefore, this study adapted a similar classification and classified empowerment into four levels. Since none of the women scores 0 on the CEI, the final empowerment was classified into three levels: low, medium, and high.

Ordinal logistic regression (OLR) was performed in order to determine the influence of women's empowerment on access to health services and maternal health-seeking behavior. The model was used because the dependent variable had three ordered categories of empowerment levels: low, medium, and high. The analysis is appropriate when the outcome variable is measured in more than two different categories (Agrest and Finlay, 2009; Nyange *et al.*, 2016). The relationship between women's empowerment and health-seeking behavior was determined by using the following equation:

$$P(Y) = \frac{e^{a+b_1X_1+\dots+b_kX_k}}{1+e^{a+b_1X_1+\dots+b_kX_k}}$$

Where: P(Y) = Outcome variable (probability of being grouped in the category of high level of empowerment), e = the natural log, a = interpretation of the equation, b₁ to b_k = coefficient of predictor variables, and X₁ to X_k = independent variables entered in the regression model. In this study, X₁ = marital status, X₂ = age of the mother at the birth of the first child, X₃ = decision on family planning use, X₄ = decision on getting pregnant, X₅ = decision on getting medical treatment, X₆ = decision on child care practices, X₇ = experience of sexual violence, and X₈ = victim of FGM. Analysis of the results focused on interpretation p-values for testing the significance of the relationship, b-coefficients measuring the direction of the relationship from higher to lower categories, and Wald statistics for measuring the strength of the influence on women's empowerment as explained in Pallant (2007).

3. RESULTS AND DISCUSSION

3.1 Background information of respondents

A total of 250 women were included in this analysis, as indicated in Table 1. The majority were aged 15–29 years (62.4%), followed by those who were aged between 30 and 40 years. The age of the mother at the time of delivering the first child showed that 49.8% had their first child at an age below 18 years, indicating early childbearing in the study area. Similar findings have also been reported by TDHS (2015). Tanzania has the 17th highest adolescent fertility rate in Africa, and teenage pregnancy has also increased by 4 percent since 2010. An awesome result indicated that the majority of participants had some years of basic education (76.4). Access to basic education has been recognized as a fundamental human right (UN, 1949). Also, education has been mentioned as an important key to empowering women to participate in decision-making in society (UN, 1995). Moreover, it is well documented that education enhances women's well-being as it gives them more autonomy in shaping their lives and gives them a greater voice in household decision-making (United Nations Children's Fund (UNICEF), 2005). Of the participants, only 6.8 percent had some sort of formal work, and 93.2% were engaged in diverse economic activities, which included agriculture, fishing activities, and small businesses. Women's economic status in the household is likely to increase their status power and may reinforce their decision-making behavior.

Table 1: Socio-demographic information of the respondents (n=250)

Variable	f	%
Place of Residence		
Bagamoyo	80	32.0
Kerege	170	68.0
Age (years) of the Mothers		
15 - 29	156	62.4

30 - 40	94	37.6
45+	4	1.6
Age (years) of the mothers at First Child	174	49.0
Below 18	103	41.2
19 and above	147	58.2
Marital Status		
Married	150	60.0
Otherwise	100	40.0
Education Level		
Basic education	191	76.4
No formal education	59	23.6
Occupation	44	12.4
Formal employment	17	6.8
Otherwise	233	93.2

Note: f = Frequency, % = percent

Furthermore, the findings in Table 1 show that more than half (60%) of the respondents were married, and 40% of respondents fell into the category of those who indicated that they were either single, divorced, separated, or widowed. Marital status is an important component of women's empowerment and has important role in women's life. In some culture, marriage is considered as an important social event and is supposed to transmit social value across generations. In these culture, lone women (unmarried/widow/divorcee/separated) are subjected to disrespect, have low empowerment and are not allowed to take part in the family decision making (Biswas, 2018).

3.2 Statuses of Women Empowerment

Before establishing the status of women's empowerment and examining the influence of women's empowerment on access to health care and health-seeking behavior, it is instructive to first look at the reliability of the research instruments used to construct levels of women's empowerment. The reliability of instruments is presented by Alpha Cronbach. Pallant (2001) states that Alpha Cronbach's values above 0.6 are considered high reliability and an acceptable index. whereas the value of Alpha Cronbach is less than 0.6, considered low. Alpha Cronbach of 0.8 and up to 1 is considered very good. Results presented in Table 2 indicate the degree of reliability of the instruments used in measuring the level of empowerment in the study area.

Table 2: Reliability statistics of decision-making construct.

Study Indicator	No. of Statements	Cronbach alpha value
Personal Autonomy on Health issues	7	0.851
Household Decision Making	8	0.706
Freedom From Violence	6	0.627
Freedom of Movement	5	0.783

The overall decision-making index has a value of 0.66 (Table 3), which denotes a medium level of empowerment status with respect to decision-making on different parameters. The parameter that performed most poorly is household decision-making on various matters (0.590). Further analysis indicated that women still express low exhibition in decision-making and prefer the company of their spouses or partners. The indices concerning personal autonomy in decision-making for women's health and the health of their children (0.639) are also not encouraging. Based on CEI, women in Bagamoyo district were classified as having a medium level of empowerment; that is, more than half (61.6%) of women in Bagamoyo district have attained a medium level of empowerment.

Table 3: Decision-Making Index

Study Indicator	Total Decision-Making Index
Personal Autonomy on Health issues	0.639
Household Decision Making	0.59
Freedom From Violence	0.759
Freedom of Movement	0.652
Overall Decision-Making Index	0.66

Analysis based on area of residence (Fig. 1) shows that there is a nearly equal low level of empowerment in both Kerege and Bagamoyo, while a higher level of empowerment is exhibited in Kerege. This may be contributed to by the multiple cultural norms and attitudes of the study areas, which hinder women's participation in various activities and hence impact their level of empowerment.

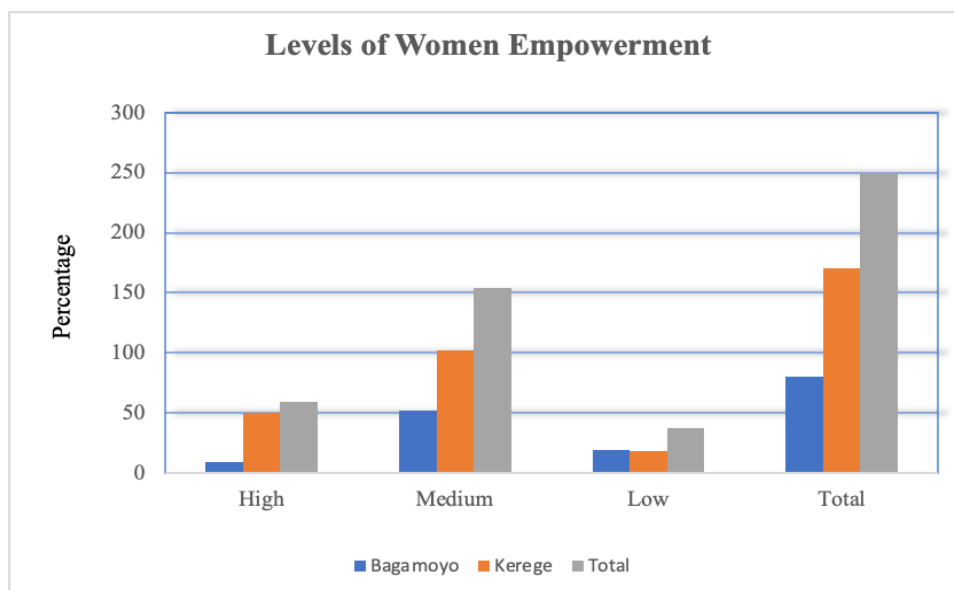


Figure 1: Levels of Empowerment among women in Bagamoyo District

Further analysis on individual parameters indicates that more than half of respondents (65.2%) have attained a higher level of empowerment on freedom from violence, while they have exhibited a medium level on the household decision-making index (54%), and a low level on the personal autonomy index (46.6%). This result was expected because of the nature of the Bagamoyo area, where male dominance in decision-making dominates. The importance of increasing women's empowerment in decision-making at various levels is widely acknowledged by Kebeer (1999) as a key to increasing women's agency in various spheres. Findings presented here suggest that women in the study area are not well involved in decision-making on various parameters. Pennington (2018) acknowledged that low empowerment has an adverse effect on the overall health and wellbeing of women and on the development of children. They are finally affecting the overall economic, political, and social development of the country.

3.3 Health Seeking Behaviour among Women

About 87.6% of women in Bagamoyo reported having visited antenatal clinics while they were pregnant (Table 4). More than half (66.6%) of them had four routine check-ups during the last pregnancy, while 33.1% had less than three routine check-ups. The majority of women prefer health facilities during the delivery of their children (87.5%), followed by home delivery (21.1%), where they receive assistance from traditional birth attendants (TBAs).

Table 4: Health care seeking behaviour among women in Bagamoyo District

Health care seeking behaviour	No. of participants answered Yes (%)
Did you attend ANC clinic during your last pregnancy	220 (87.6)
Preferred Health Facility for child delivery	197 (87.5)
Preferred Home Delivery Services	53 (21.1)
Preferred Health professional for child delivery assistance	171 (68.1)
Preferred Traditional Birth Attendance for child delivery assistance	79 (31.5)
Do you make your own decision regarding use of family planning.	118 (47%)
Do you make your own decision of getting pregnant.	106 (42.2)
Do you make your own decision for seeking medical treatment.	133 (53%)

It was observed in the present study that only 47% of women had the freedom to make decisions on using family planning, while more than half of respondents had to make decisions jointly with their spouses or partners. This result is also reflected in the decision-making process on getting pregnant, where the majority (42.4%) have to decide with their partners, indicating that personal decision-making on getting pregnant is minimal. The current findings portray that women's autonomy over decision-making for their health is still minimal and that decision-making power is less likely to be with women and mostly rests with partners or other relatives. This finding is in line with what is reported in Masawe *et al.* (2019), namely that the majority (81%) of married women in Tanzania depend on their husbands and/or partners or someone else to make the final decision about their health care. Similarly, Mainuddin *et al.* (2015) reported that only 12% of rural women in Bangladesh were empowered to make their own decision about seeking health care. Likewise, in several developing countries, studies have shown how certain cultural norms affect women's autonomy in making decisions about their health (Singh *et al.*, 2019).

3.4 Factors Influencing Women Empowerment and Health Seeking Behaviour

Ordinal Logistic Regression (OLR) was considered appropriate to determine the nature of the association because women's empowerment was measured at three ordered categories of low, medium, and high levels. The model gave better predictions and showed a statistically significant chi-squared statistic ($p < 0.05$). This indicates the presence of an association between the dependent variable (women's empowerment) and a combination of independent variables. The pseudo-R-square of Cox and Snell was 0.461, while Nagelkerke was 0.548, implying that predictor variables entered in the model explained 46.1 and 54.8 percent of the variance of women's empowerment, respectively.

The explanation of the overall output from the model focused on: p-values for testing the significance of the effect; coefficients for measuring the directions of women's empowerment to higher or lower categories; the value of each individual coefficient is indicated by a positive or negative sign. A positive sign associated with an indication of a coefficient variable increases the probability of being grouped in the category of high level of empowerment, and vice versa; Wald statistics are allied with measuring the strength of the influence on women's empowerment.

The findings in Table 4 show the most significant ($p < 0.05$) variables on the influence of women's empowerment were: Marital status, decision on family planning use, decision on getting medical treatment, decision on child care practices, experience of forced sexual intercourse, and victims of female genital Women who are married are 1.43 times more likely to have a higher empowerment level, controlling for other factors.

Table 4: The influence women empowerment on health seeking behaviour (n=250)

Variables	Coefficient	SE	Wald	Sig.
Marital Status	1.423	0.424	28.291	0.001
Age at first child birth	-0.176	0.308	0.326	0.568
Decision on family planning use	-1.450	0.551	6.911	0.009
Decision on getting pregnant	0.746	0.465	2.575	0.109
Decision on getting medical treatment	-1.763	0.398	19.615	0.000
Decision on child care practices	0.926	0.420	4.850	0.028
Experience sexual violence	1.844	0.446	17.109	0.000
Victim of FGM	2.064	0.442	21.822	0.000

$p = 0.000$; Goodness of-Fit =1; Cox and Snell = 0.461, Nagelkerke = 0.548; Test of Parallel line = 0.238

This means that the chances of single or unmarried mothers being groups with a higher level of empowerment decreased. The result concurs with findings by Nyange *et al.* (2016), who reported that married women are likely to experience more empowerment because of the opportunity to access family resources compared to unmarried and single women, who depend on parents and other family members on different matters.

Women's level of empowerment is strongly associated with their experience of FGM, suggesting that more empowered women voiced less support for the practice. A women's attitude about the practice as an independent adult who has been socialized into supporting it is strongly correlated with her having undergone FGM. The practice of FGM is rooted in social norms, cultural beliefs, and economic incentives. In most societies that embrace FGM, the senior generation is held responsible for continuing the culture, including FGM practice (Mkuwa *et al.*, 2023). A report from the NFPA (2023), states that FGM is less practiced in Bagamoyo. However, due to local migration from regions where FGM is widely practiced, it is inevitable that the population in Bagamoyo will conform to outside social standards. An immigrant women's leader who used to practice FGM made the following statement about its significance: "It was in our cultural belief that a woman could not become pregnant without being circumcised, and if it happened, the baby would die or be cursed." An influential Masai woman who migrated from Morogoro Rural where FGM is highly practiced".

Similarly, the variable accounting for the respondent's experience with violence was significant, indicating a higher level of acceptance of violence corresponds with less women's empowerment. This study found that women's reproductive choices was influence by the experience of violence from their spouses. That is the spouses with attitude of violence had more influences on women's reproductive choices. The study findings concur with results reported by Ahinkorah (2018), who found that in Sub Saharan Africa, women's decision-making was negatively influenced by violence from intimate partner. According to Ameyaw *et al.* (2021) empowerment enlightens women, liberates them to exercise their rights, strengthens their values, and give them the tools they need to be useful in all facets of life. In order to change how women view FGM and violence against women in society, information, education, and communication initiatives are necessary.

The Wald statistic value showed how strongly the decision to seek medical care was strongly correlated with women's empowerment. The negative correlation ($b = -1.763$) indicated that women with less power are less likely to determine whether to seek medical treatment. Similar associations can be seen for other factors as well, such as choices regarding family planning and child care. The results are in line with descriptive analysis (Table 4), which discovered that less than 50% of women decisions on utilizing family planning or getting pregnant. This implies that the authority to make these decisions lies with male partners or other family members. This finding showed that women still lack a lot of autonomy in making decisions in the area under study. Previous studies, including Singh *et al.* (2019), discovered that in a number of developing nations, specific cultural norms affect women's autonomy in making decisions about their health. It is mainly about the dominance of the husband or partners, who often make decisions for women on health issues (Sultana, 2011). It is clear from this finding that a low level of empowerment among women limits their ability to make decisions about certain health issues.

4. CONCLUSIONS AND RECOMMENDATIONS

The results of this study showed a link between indices of decision-making and women's empowerment. Bagamoyo's total score for women's decision-making empowerment is 0.66, which is considered to be a medium degree of empowerment status. Household decision-making on multiple issues (0.590), which is included in decision-making indices related to maternal health seeking behavior, was the metric that fared the worst. Women's decisions about seeking treatment were very important and were linked to a poor level of female empowerment. Therefore, women's empowerment should be taken into account while designing the health care system because it influences how they behave in terms of seeking out health care.

The promotion of FGM and the act of violence against women are seen as significant barriers to women's empowerment, which has a negative impact on how women seek out health care. In order to empower women to take charge of their own health, cultural beliefs and societal conventions that support these practices ought to be dismantled. Women should be encouraged to join self-help organizations and NGOs to fight against cultural norms that limit their capacity for decision-making.

Acknowledgements

The author declares no competing interests. This study was carried out as an individual study for knowledge creation. The author is grateful to the interviewers who provided valuable information for this study.

Conflicts of Interest

The authors declare no conflict of interest.

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