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Effects of Male Engagement Interventions[1] on Women's Autonomy in Decision Making in Iringa Region, Tanzania

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Abstract

Maternal and neonatal mortality are largely caused by delays in attending to obstetric complications and this is attributed to limited women's power in making decisions regarding household resources and utilisation of health care services. This requires effective implementation of male engagement interventions to improve women's autonomy in making decisions and hence reduce delays in attending to obstetric complications. This study examines the contribution of male engagement interventions in promoting women's autonomy in decision making within households and society. A structured questionnaire was used to collect data on socio-demographic and household characteristics, women's practices concerning prenatal care, childbirth, postnatal care, and related decision-making power. Descriptive statistics and inferential analysis were used to analyse the data. The findings show a significant difference in decision making autonomy regarding family planning methods among respondents who had received male engagement education versus those who had not received such education (p-0.001<1%). Again, there was significant participation of women in household purchases for daily needs (p-0.057<10%) and in decisions to work out of homes (p-0.015<5%). This trend was noted among respondents who had received male engagement education as compared to those who had not received such education. There was also greater engagement of women in decision making concerning major household purchases and their health care, although their engagement was not statistically significant (p-0.397>10% and p-0.293>10% respectively). Effective implementation of male engagement interventions may leverage men's power within households and promote women's autonomy in decision making, thereby improving healthcare-seeking behaviour.

Key Words: *male engagement, maternal and child health, obstetric complications, women's autonomy.*

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Background Information

Maternal and neonatal mortality is a global problem with more overwhelming effects in low and middle-income countries (LMICs). Globally, Maternal Mortality Ratio (MMR) stands at 216 per 100,000 live births and the Under-Five Mortality Ratio (U5MR) is 59.1 per 1,000 live births (WHO et al., 2015). LMICs account for approximately 99% of the global maternal and child mortality (Alkema et al., 2016). Obstetric complications are the most frequently reported causes of maternal and neonatal mortality (Bhutta et al., 2013; Lassi et al., 2014). This occurs when a pregnant woman delays to attend to such complications. The delay might be caused by inability to recognize the complications (Gandhi et al., 2004; Okong et al., 2006), lack of birth preparation (Oladapo et al., 2007), and delay of or inadequate services offered in health facilities (Filippi et al., 2007). Delays may also be caused by low autonomy of women to influence decisions within households regarding family resources (Sikder et al., 2011). Since household resources are mainly controlled by men, the influence of men significantly contributes to delays in seeking health care, reaching healthcare facilities and receiving appropriate care in health facilities (Wai et al., 2015). In addition, delays in attending to obstetric complications are caused by poor engagement of male partners in maternal and child-related matters. Engagement of male partners is worse when the situation involves the need for money and decision making (Singh et al., 2014).

Also, cultural practices and gender norms and roles have been found to be among the key barriers to the engagement of men in Maternal and Child Health (MCH). In most LMICs, particularly in the patriarchal societies, it is inappropriate for men to actively engage in MCH services. For example, men who accompany their wives or female partners to antenatal clinics (ANC) are considered weak people (Craymah et al., 2017) or bewitched (Nkuoh et al., 2010). Moreover, it is shameful for a man to attend women's gatherings (Byamugisha et al., 2010; Msuya et al., 2006). In this regard, MCH services are considered exclusively women's affairs (Ganle & Dery, 2015). As women have limited space to influence decisions regarding their health, male partners always decide on the use of MCH services regardless of the little knowledge they have regarding the services. This may lead to uninformed decisions that may ultimately affect utilisation of MCH services for women during pregnancy and after delivery (Gill et al., 2007; UNFPA et al., 2010).

Available evidence shows that effective implementation of male engagement interventions may promote women's autonomy in health care decisions and control of family resources (Mandal et al., 2017). It may also promote changes in attitudes and perceptions among men in the society regarding MCH services and also promote gender-equitable norms, roles and power relations (Dworkin et al., 2013). Distinctively, effective implementation of male engagement interventions may improve couple relations and communications within households. This may facilitate reduction of HIV and STDs risks, reduce inter-generational violence

against women, and promote men's advocacy for MCH services (Doyle et al., 2013).

Over the past two decades, there has been a growing impetus in engaging men in MCH services. In LMICs, Prevention of Mother to Child Transmission (PMTCT) guidelines and interventions promote male engagement specifically in HIV counselling and testing rather than in promoting their engagement in ANC services (Aluisio et al., 2011). Again, reproductive health services like family planning, prevention of unplanned pregnancy, unsafe abortion and promotion of safe motherhood are traditions viewed as women's affairs with limited concern for male partners (Onyango et al., 2010). In addition, most of the interventions that have engaged men in MCH services have focused on providing direct support to pregnant women during ANC, delivery and PNC period (Doyle et al., 2013; 2014). Men have been engaged differently like in making birth preparedness, transport arrangements, meeting delivery cost and others (Muheirwe & Nuhu, 2019b). Likewise, men have been engaged in child health services for prestigious reasons as fathers and not in maternal health (Muheirwe & Nuhu, 2019a; 2019b). This kind of engagement fails to challenge existing gender inequity norms, roles and power relations which limit women's autonomy (Comrie-Thomson et al., 2015; Mumtaz & Salway, 2009).

The Innovating for Maternal and Child Health in Africa (IMCHA) project implemented male engagement interventions in Iringa Region from 2016. The project was implemented in 20 Villages in Kilolo and Mufindi districts. In each Village, women chosen to represent their community were given the opportunity to define the problems, strategize locally and culturally contextualized solutions and then implement their plans. The specific interventions which were implemented were: engaging women groups in providing health education; working with community and religious leaders to sensitize community members on maternal and child health matters; strengthening the capacity of health committees to improve the quality of health care services and sensitizing health care workers to provide friendly and timely care to children and pregnant women (Maluka et al., 2020). Against this background, this study examined the contribution of male engagement interventions in promoting women's autonomy in decision making within households and societies.

Methods

Study Area, design and population

This study was conducted in Kilolo and Mufindi districts in Iringa Region in the Southern Highlands of Tanzania. These districts are predominantly rural, and majority of the residents rely on subsistence agriculture. The districts implemented male engagement interventions under the IMCHA project, which was implemented by the Institute of Development Studies (IDS) of the University of Dar es Salaam, in collaboration with regional and district health managers from Iringa Region and the Health Bridge Foundation of Canada. This study adopted

a case study design to examine the contribution of male engagement interventions in promoting women's autonomy in decision making regarding their health. The study assessed variations in perspectives between respondents who had received male engagement education and those had not received such education from the IMCHA team between July 2018 and June 2019.The population of the study included all pregnant women and mothers with children aged below 12 months. The participants were aged 18 years and above and had lived in the study area for at least six months before the conduct of this study.

Sampling techniques and sample size

The study utilised a probability sampling technique to select the required sample. The selection of respondents was done in different phases; the first phase was to establish the study population living in the particular area. A list of prospective participants was obtained from the community health workers (CHWs) who usually worked as volunteers in the community in promoting utilization of MCH services. Then, the list was validated by reviewing registers for ANC; family planning; delivery; Neonatal and Postnatal child records available in health facilities in the study areas. This process yielded 652 eligible respondents; of which 264 were pregnant women and 388 were mothers with children aged below 12 months as shown in Table 1.

Table 1: Distribution of Study Population and Sample

Study Area		**Pregnant**	**Mothers**	**Sample size**
Wards in Kilolo District	Nguruhe	24	40	20
	Lugalo	30	50	20
	Ukumbi	23	29	19
	Mlafu	37	53	20
	Ibumu	24	43	19
Wards Mufindi District	Nyololo	22	37	18
	Igowole	22	33	19
	Kasanga	21	33	19
	Kibengu	24	35	19
	Itandula	37	35	17
Total		**264**	**388**	**190**

Source: Field Data, 2019

The second phase was estimation of sample size. This was achieved through the formula described by Daniel and Cross (Daniel & Cross, 2013). Hence,

$$ss = \frac{N * X}{X + N - 1}$$

Where,

$$X = Z\alpha/2^2 \frac{(p)(1-p)}{MoE^2}$$

ss = sample size
N = population size estimated at 652 households
$Z_{\alpha/2}$ = critical value of the normal distribution was 90% and the critical value was 1.64
MoE = margin of error (levels of precision) was estimated at 0.05
P = sample proportion was estimated at 0.5

Thus,

$$X = 1.96^2 \quad \frac{(0.5)(1-0.5)}{0.05^2} \quad = 268.96$$

X = 268.96
Substituting the values into the formula;

$$ss = \frac{N * X}{X + N - 1}$$

$ss = \frac{652*268.96}{268.96+652-1} = 190$

To obtain 190 respondents, the study set to select up to ten (10) respondents from each study village.

The third phase was to select respondents using a simple random sampling whereby entities in the population were assigned codes which were written on paper cards. The cards were then placed in a non-transparent container and well shaken to mix them. Then, the researcher picked ten (10) cards from the container randomly and then the cards were matched with the codes to identify the entities. The fourth phase was the actual data collection process, which was done by three data collectors assisted by CHWs who used to give directions on locations of respondents. The research team visited respondents at their home or work areas for interviews. This gave rise to 190 interviews. Interviews were conducted in absence of husbands or other women.

Measurement of Variables

The Independent categorical data were collected to measure the relationship between male engagement strategies and its effects on women's autonomy. Measurement of the effects of male engagement was based on whether the respondents had either or not received the education from the IMCHA implementation team between July 2018 and June 2019. Whereas, women's autonomy was measured based on who had the final say on the following items: own health care, methods of preventing pregnancy; significant household purchases; household purchases for daily needs; and whether or not to work out of their home environment. The responses were limited to either own decision, husband, joint, or other relatives. The socio-demographic data included in the

questions consisted of age, marital status of respondents, education level and occupation.

Data collection

A structured questionnaire was used to collect data from respondents. During the data collection process, individual interviews were conducted with pregnant women or mothers with children aged below 12 months of birth in their homes or workplaces at a convenient area and time. Data was collected between July and September 2019.

Data analysis

Data were analysed using a descriptive table that showed socio-demographic information. In addition, an inferential analysis was done by using contingency tables to produce chi-square and p-values. Then inferential analysis was used to examine the existing relationship between respondents who had received or had not received male engagement education and the level of autonomy in decision making. Stata software version 15.0 (StataCorp 1985-2017) was used to generate the outputs.

Table 2: Respondents' Socio-demographic Data

Variables	**N (%)**	**Variables**	**N (%)**
Age		**Educational**	
Between 18-24 years	75 (40)	Never attended school	10 (5)
Between 25-34 years	92 (48)	Primary, not completed	8 (4)
Above 34 years	23 (12)	Primary Education	131 (69)
Status		Secondary	39 (21)
Pregnant women	59(31)	College/University	1 (0.5)
Mother with children	131 (69)	Vocational/ adult education	1 (0.5)
Marital status		**Occupation**	
Single	38 (20)	Private sector employee	1 (0.5)
Married	138 (73)	Farmer	142 (75)
Cohabiting	10 (5)	Self-employed/small business	42 (22)
Divorced	2 (1)	Others	5 (2.5)
Widowed	2 (1)		

Findings

Socio-demographic information of respondents

The socio-demographic information of the respondents is summarised in Table 2 which shows that 131(69%) of the respondents were mothers with children aged below 12 months. Some 138 (73%) of the respondents were married while 20% of

them were single mothers, 5% were cohabiting, and 1% of them were widowed or divorced. In terms of age, 92(48%) of them were 25-34 years; 75 (40%) were 18-24 years and 23(12%) were above 34 years. As for levels of education, 131(69%) of the respondents were primary school leavers, 39(21%) had secondary education, 10(5%) never attended school while 8(4%) of them had nursery education or did not complete primary education. Another 2(1%) of them were either college or vocational education graduates. In terms of occupation, the agricultural sector accounted for 75% with 142 of the respondents employed in the sector. Only one respondent was reportedly employed in the private sector while the rest few, 42 (22%) engaged in small business, and 5 (2.5%) in other sectors.

Effects of Male Engagement Education on Women's Autonomy

Table 3 presents the findings on the association between male engagement education and women's autonomy in decision-making within households.

Table 3: Male Engagement Education and Women's Autonomy

Women's decision-making autonomy	Received male engagement education				Did not received male engagement education				P-value
	Wife	Husband	Joint	Others	Wife	Husband	Joint	Others	
Who has the final say regarding your health care?	18 (15)	35 (30)	53 (46)	10 (9)	11 (16)	21 (30)	25 (36)	12 (17)	0.293
Who has the most say about which method you would use to prevent pregnancy?	13 (15)	4 (5)	66 (78)	2 (2)	14 (29)	11 (23)	23 (48)	0 (0)	0.001
Who has the final say regarding significant household purchases, e.g. TV, farms, etc?	4 (4)	36 (31)	63 (54)	13 (11)	4 (6)	25 (36)	29 (42)	11 (16)	0.397
Who has the final say regarding household purchases for daily needs, e.g. clothes?	19 (16)	16 (14)	68 (59)	13 (11)	11 (15)	15 (22)	28 (41)	15 (22)	0.057
Who has the final say regarding working out of home?	3 (3)	48 (41)	52 (45)	13 (11)	8 (12)	25 (36)	22 (32)	14 (20)	0.015

Women's Autonomy on the Use of Health Care and Family Planning

The findings show that there was no significant difference in women's decision-making autonomy regarding health care of their own between respondents who had received male engagement education and those who had not received such education (p-0.293>10%). However, joint decision making was higher among respondents who had received male engagement education than among those had not received such education. This is respectively substantiated by 53(46%) and 25(36%) of the respondents. On the other hands, self-decision making was slightly low among those who had received male engagement education as represented by 18(15%) of the respondents as compared to 11(16%) of those who had not received such education. There was no difference in proportions between respondents who had received male engagement education and those who had not received such education in terms of husbands having final says regarding their health care.

The findings also revealed a significant difference in decision making autonomy regarding the use of family planning methods between respondents who had received male engagement education and those who had not received such education (p-0.001<1%). Some 66(78%) of respondents who had received male engagement education reported making joint decisions regarding the methods of preventing pregnancy as compared to 23(48%) of those who had not received such education. On the contrary, the autonomy of women in making unilateral decisions on the methods of preventing pregnancy seemed to decline among respondents who had received male engagement educations, as evidenced by only 13 (15%) of them against 14(29%) of those who had not received such education. Also, husbands seemed to have more influence on the choice of methods of preventing pregnancy among respondents who had not received male engagement education as shown by 11(23%) of them as compared to 4(5%) of those who had received male engagement education.

Women's autonomy regarding household purchases

Male engagement education did not demonstrate significant relationship with women's autonomy regarding significant household purchases (p-0.397>10%). The findings show that 63(54%) of those who had received male engagement education made joint decisions compared to 29(42%) of those who had not received such education. Similarly, women's autonomy in making unilateral decisions regarding significant household purchases was slightly low. This was reflected in the findings whereby 4(4%) of the respondents who had received male engagement education made such unilateral decisions as compared to 6% (4) of those who had not received such education. Likewise, husbands of the respondents who had received male engagement education seemed to have relatively low power in influencing significant household purchases as compared to husbands of those who had not received such education. Some 36 (31%) of female respondents who had received male engagement education reported that their husbands had final says regarding significant household purchase as compared to 25(36%) of those who had not received such education.

Findings also showed a significant relationship between women's decision – making autonomy on household purchases for daily needs and male engagement education (p-0.057<10%). Joint decision making was high among respondents who had received male engagement education. This was supported by 68(59%) of the respondents; against 41(28) of those who had not received such education. Likewise, a total of 19(16%) respondents who had received male engagement education could make unilateral decisions regarding daily need purchases at the household as compared to 11(15%) of those who had not received such education. Another 16(14%) of those who had received male engagement education reported their husbands having final says regarding daily need purchases at the household as compared to 15(22%) of those who had not received such education.

Women's autonomy to work out of home

Findings further suggested a significant relationship (p-0.015<5%) between male engagement education and women's autonomy to decide whether or not to work out of their home environment. This is supported by only 3 (3%) of respondents who had received male engagement education who reported having the final say on whether or not to work out their home environment. This was against 8(12%) of those who had not received such education. It was revealed by 48 (41%) of respondents who had received male engagement education that their husbands had final says on whether or not to work out their home environment. This was opposed to 25 (36%) of those who had not received such education. As for joint decision making, about 45% (52) of respondents who had received male engagement education reported making joint decisions on whether or not women could work out their home environment. This was contrary to 32% (22) of those who had not received such education.

Discussion of findings

The study findings have demonstrated that male engagement interventions have improved joint decision making within households. As reported in the findings, more women who had received male engagement education reported making joint decisions as compared to those who had not received such education. This signifies an increase in women's autonomy to influence decisions regarding their health care, methods of preventing pregnancy, purchases of daily needs, and whether or not to work out of home. The increased women's autonomy in making important decisions may facilitate their income generating capacity and consequently help them make decisions related to birth preparedness and improvement in nutrition. Likewise, these positive changes may enhance harmonious communication within households and couples. This may reduce delays in attending to obstetric complications caused by lack or limited power of women to influence decisions within households during pregnancy, delivery and post-delivery periods.

The findings of this study resonate with earlier studies which reported improved joint decisions among couples following implementation of male engagement interventions (Mullany et al., 2005; Vermeulen et al., 2016). Vermeulen and others argue that effective engagements of men in MCH services may encourage joint decisions and use of family planning methods within households (Vermeulen et al., 2016). Joint decisions are associated with more positive health outcomes like increased utilisation of contraceptive methods (Al Riyami et al., 2004; Bawah, 2002; Mullany et al., 2005); effective breastfeeding, immunisation, and care-seeking during illness (Barker, 2014; Gill et al., 2007); as well as reduced inter-partner violence cases (Hindin & Adair, 2002). Likewise, joint decision making allows husbands and wives to share blames in case of negative consequences (Mullany et al., 2005). In addition, joint decision making increases equal access to and use of family resources; which can increase the demand and use of MCH services (Maitra, 2004). Women who are more engaged in decision making over household resources are more likely to set money aside for birth preparedness and ensure good nutrition during pregnancy and childhood parenting (Adhikari, 2016). In addition, women's autonomy in making decisions on significant household purchases is associated with a higher likelihood of attending the required four or more ANC visits (Ghose et al., 2017).

The findings have further reported a decrease in the autonomy of some women to make unilateral decisions among those who had received male engagement education as compared to those who had not. For example, the wife's power to make unilateral decisions regarding seeking care for her health was lower by 1% among respondents who had received male engagement education as compared to those who had never received such education. Decision making regarding large household purchases was lower by 2% among respondents who had received male engagement education as compared to those who had not. Likewise, women's power to decide whether or not to work out of home was lower by 9% among women who had received male engagement education as compared to those who had not received such education. Similarly, only 15% of women who had received male engagement education reported making unilateral decisions regarding the type of contraceptive method to use as compared to 29% of those who had not received such education.

The decrease in women's autonomy to make unilateral decisions may be associated with prevailing gender norms in society. In particular terms, empowered women are viewed as threats to men's position as heads of households. This may create fears for some women to make decisions without consultations with their husbands. The unilateral decision making may be interpreted as jeopardising men's positions within households. Furthermore, unilateral decisions may be associated with fears of intimate partner violence in case of negative outcomes. Studies from other settings have reported that the decrease in women's autonomy among those who had received male engagement education might have been caused by the fear of blame and total answerability in

case of negative consequences (Mullany et al., 2005). Sole decision-making has been associated with other negative health outcomes like an increase in inter-partner violence (Hindin & Adair, 2002).

Conclusion

This study concludes that effective implementation of male engagement interventions may leverage men's power within households and promote women's autonomy in decision making. It has generally been shown that implementation of male engagement interventions has increased the autonomy of women to make decisions regarding their health care, household purchases and whether or not to work out of their home environment when they secure jobs. More women reported participating in decision making either as unilateral or joint decisions. This may result in reducing delays in attending to obstetric complications, which largely cause maternal and child mortality.

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