

Women's Autonomy on Healthcare Decision Making in Sub-Saharan African Countries: A Synthesis

Victoria Matatio Elia Guli¹ and Nigatu Regassa Geda^{2*}

¹Victoria Matatio Elia Guli; University of Juba,

Institute of Peace Development and Security Studies Juba, South Sudan

^{2*}Center for Population Studies, College of Development Studies, Addis Ababa University, Sidist

Kilo Campus, Ethiopia, P.O. Box 1176

E-mail: ¹<elia_vicky@yahoo.com>, ²<negyon@yahoo.com>

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ABSTRACT Over the last few decades, despite progress made in improving female's decision-making autonomy, the challenges posed by female's low status in Sub-Saharan African countries (SSA) are still influential research agenda. The aim of this scoping review is to assess the effects of women's autonomy on healthcare decision-making. The researchers did the study based on 15 articles selected from PubMed and Google Scholar. The selection deliberated only those published in the last 15 years, primarily based on nationally representative findings from Sub-Saharan African countries. The selected studies focused on decision-making autonomy on healthcare parameters. All studies reported significant positive impacts of female's decision-making autonomy on children's health, and women's well-being, such as improved children's nutrition, maternal and children's well-being, reduced mortality rate, and health service utilization. However, the impacts were more substantial or visible at the community level than at individual or household levels. The study recommended strengthening women's involvement in education, promoting peer education, improving husband-wife communication, promoting rural women's participation in economic activities, and owning assets. More importantly, any intervention should focus more on community norms than only individual decision-making per se.

INTRODUCTION

The issue of women's autonomy is extensively discussed in several fields and attracted the attention of a number of scholars. However, none of the previous studies used a single most accepted definition representing the multiple dimensions of autonomy (Osamor and Grady 2016). As a result, the use of the term varies from one setting to another. In some instances, the term is used interchangeably with empowerment (Mistry et al. 2009). In most research settings, women's autonomy takes three different forms, namely, decision-making autonomy, physical autonomy and economic autonomy (Ebot 2014; Becker et al. 2006). Autonomy in decision-making refers to the ability of women to participate in making significant decisions about themselves and their households. Physical autonomy represents women's autonomy of movement outside their homes. Finally, economic autonomy entails women's access to strategic financial assets (Dancer and Rammohan 2009).

Previous studies reported that uneven power levels between women and men in intimate relationships are crucial in determining women's decision-making autonomy (Yaya et al. 2018;

Upadhyay et al. 2014). Moreover, it seems to have significantly affected women's livelihood in middle-income and low countries (Ebot 2014). As a result, during the last three decades, considerable attention has been given to improve women's decision-making and autonomy at all phases. For instance, Sustainable Development Goal-5 emphasised the significance of promoting women's autonomy to address welfare in emerging countries (Osborn 2015).

Previous studies conducted around the world reported significant and positive impacts of women's autonomy on declining rate of early mortality (Doan and Bisharat 1990), improved access and usage of healthcare services (Woldemichael and Tenkorang 2010; Woldemichael 2010), and better child nutritional outcomes (Dancer and Rammohan 2009; Brunson et al. 2009). In addition, some studies reported significant positive impacts of women's decision-making and autonomy on child immunization (Ebot 2014; Singh et al. 2012) and household nutrition (Brunson et al. 2009). The benefits of empowerment reported by various studies are not essentially restricted to women themselves, as the impact may perhaps extend to those around them (Yaya et al. 2018).

Most of the study on this subject has been carried out in the context of South Asia (Upadhyay et al. 2014). Studies conducted in the Sub-Saharan African context are both scarce and are limited in scope. Thus, to the best of our understanding, this review could be one of the few attempts to compile and synthesize women's domestic level autonomy in the Sub-Saharan African context.

Objective

The main aim of this scoping review is to examine the role of women's decision-making autonomy on healthcare in Sub-Saharan African countries based on a synthesis of selected studies.

METHODOLOGY

Sources of Information, Search Strategy and Data Extraction

The studies included in this scoping review were collected by searching from the electronic database (Google scholar and PubMed).

Three keywords were used to simplify searching and locating studies from SSA countries; namely, women's autonomy, decision-making autonomy, and sub-Saharan Africa. The selection and extraction strategies used are presented in the flow chart in Figure 1. In the first round of searching, the researchers found 45 publications from PubMed and 25 from Google Scholar. Thus, the total number of publications retained after removing duplicates was 59. The second stage of selection and withdrawal involved screening titles and abstracts for significance, scope, and study approaches employed by individual studies. At

this stage, 44 published materials were excluded. Finally, the researchers included 15 full texts for review. As the core objective was not estimating prevalence, the researchers did not assess the quality of the included studies. The final set of publications was selected using the following three criteria:

- Articles published in the last 15 years.
- Studies conducted on nationally representative data from SSA.
- Primarily addressing female's decision-making autonomy on various healthcare parameters.

Summary of Study Designs

As indicated above, the review included studies conducted based on large sample size data from SSA countries. Nearly all the studies used respondents in the age group 15-49 and particularly those who were married. Nearly all studies used one of the probability sampling methods. Most studies used a survey questionnaire as their primary data collection instrument. Issues included were socio-demographic characteristics, maternal characteristics, autonomy, decision parameters, and other specific subjects related to their respective outcome variables.

In all the reviewed studies, the researchers used quantitative approaches. Except for two articles, 13 of them had a cross-sectional design. Most of the studies had drawn data from a specific country, and five employed multi-country analyses (Table 1).

Strategy for the Synthesis

The present analysis focused on assessing the effects of women's autonomy on themselves, their children, and overall household well-being. The researchers undertook both quantitative and narrative synthesis.

RESULTS

Table 2 presents a list of definitions and descriptions for women's autonomy in decision-making used by each author. It is noted that the definitions vary from context to context, and most of them did not use a comprehensive description to exemplify the multidimensional setting of women's decision-making power.

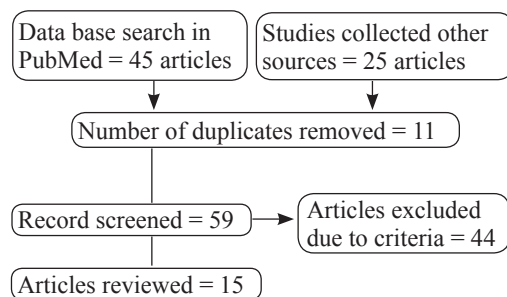


Fig. 1. Schema for article search
Source: Authors

Table 1: Summary of sampling and study designs for each selected study

<i>Study</i>	<i>Country</i>	<i>Approaches</i>	<i>Design</i>	<i>Sample (n)</i>	<i>Data and year</i>
Ebot 2014	Ethiopia	Quantitative	Cross-sectional	2,941 mothers of children under 24 months	EDHS 2011
Gabrysch et al. 2016	Zambia	Quantitative	Cross-sectional	2012 married women (aged 15–49)	ZDHS 2007
Sougou et al. 2020	Senegal	Quantitative	Cross-sectional	8865 women aged 15–49	SDHS, 2017
Awoley et al. 2018	Nigeria	Quantitative	Cross-sectional	4,996 young married women aged 15 to 24	NDHS 2013
Akinyemi et al. 2017	Nigeria	Quantitative	Cross-sectional	31, 482 women aged 15 - 49 years	NDHS 2013
Chol et al., 2019	31 Sub-Saharan African countries	Quantitative	Cross-sectional	NA	National data
Upadhyay and Karasek 2010	Guinea, Mali, Namibia, and Zambia	Quantitative	Cross-sectional	Guinea (1,997), Mali (2,665), Namibia (867), Zambia (3,129) married women	DHS 2005-2007
Darteh et al. 2019	27 sub-Sahara Africa countries	Quantitative	Cross-sectional	210,536 women	DHS conducted in 2010-2016
Yaya et al. 2018	32 SSA countries	Quantitative	Cross-seccional	474,622 women respondent of reproductive age (15–49 years)	DHS 2008-2016
Tiruneh et al. 2017	Ethiopia	Quantitative	Cross-sectional	6058 and 7043 women for 2005 and 2011 data, respectively	EDHS 2005 and 2011
Singh et al. 2012	Nigeria	Quantitative	Cross-sectional	3,454 currently married women	NDHS 2008
Speizer et al. 2014	Ghana	Quantitative	Cross-sectional	1,606 women	National data
Samari and Pebley 2018	Egypt		Longitudinal	4,655 married wome (age 15-49)	Egyptian Labor Market Panel Survey (ELMPS)
Atake and Ali 2019	Burkina Faso, Chad, Mali, and Niger	Quantitative	Cross-sectional	NA	DHS 2010-2014
Amugsi et al. 2016	Ghana	Quantitative	Cross-sectional	2262 women respondents in the agee group 15–49.	GDHS 2008

The definitions and descriptions given for autonomy (see Table 2) are translated to a simple conceptual model presented in Figure 2. The framework bears a resemblance close to Social-Ecological Model (SEM), which has been used as analytical framework since the 1970s. The model identified the basic assumptions that underpin the SEM, such as the influences individuals have on their environment, the impact of others, and the individual's environment. These theories have evolved into the current SEM mainly used to address population health through more modifications and adaptations. However, socio-economic challenges

are far too complex to understand from a single analysis point (Golden and Earp 2012).

As shown in Figure 2, the middle column of boxes contains the critical components of women's autonomy. Knowledge attainment necessitates women and men's awareness of their rights, resources, and skills. Participation involves women's ability to take an active part in household and community-level decisions. Community-level involvement would increase women's voices in household decision-making because of improved support from group members. These would also enhance thier access to household resources (such as food and other basic

Table 2: Conceptualization of women's decision-making autonomy by individual studies

<i>Study</i>	<i>Conceptualization of women's autonomy and decision making</i>
Ebot 2014	Abilities of women in obtaining health care purchasing household goods, visiting relatives/family and spending money in their own will (Ebot 2014: 3)
Gabrysch et al. 2016	Women's decision-making/autonomy concerns with financial, movement, health care, violence and relationship (Gabrysch et al. 2016: 2)
Sougou et al. 2020	Women's decision making power on her well-being (Sougou et al. 2020: 4)
Awoley et al. 2018	Women's decision making power is measured by women's decision on large household purchase, healthcare and visits to family/relatives (Awoley et al. 2018: 2)
Akinyemi et al. 2017	Women can decide on issues concerning their well-being, large domestic purchases, and visits to relatives/friends. The authors categorized the variable into low, medium, or high (Akinyemi et al. 2017: 28)
Chol et al. 2019	Women's capability to make autonomous decision, including manipulation of the control assets and environment, engage and hold them an accountable institution (Chol et al. 2019: 2)
Upadhyay and Karasek 2010	Used three indicators of female's empowerment: a) women's family decision-making role such as respondent's well-being, family purchases; and visits to relatives/family. b) Attitudes about gender responsibilities; and c) Additional gender-related variables such as inter-spousal education difference, woman's age at first marriage, inter-spousal age variance (Upadhyay and Karasek 2010: 14-15)
Darteh et al. 2019	Darteh et al. (2019) conceptualized decision-making power as "decision-making on sexual intercourse, condom use, and reproductive health" (Darteh et al. 2019: 3)
Yaya et al. 2018	The mechanisms of women's empowerment comprised: 1) Labor force participation (existing occupation situation), 2) Divergence with aims to support wife-beating 3) Decision-making power (measured by respondent's well-being, family purchases and house earning and visiting family members) 4) Awareness level (Yaya et al. 2018: 3-4)
Tiruneh et al. 2017	Women's ability to make decisions on matters about (a) the woman's well-being (personal decision-making authority), (b) essential acquirements (economic decision-making authority), and (c) make visits to family or friends (movement decision-making power)? Greater decision-making power was defined as a woman who made more than one choice, either together with her partner or alone, (Tiruneh et al. 2017: 3)
Singh et al. 2012	Women can decide on health care, purchase primary household goods, visit friends/family and buying of daily goods (Singh et al. 2012: 839)
Speizer et al. 2014	Autonomy refer to women's ability to decide on her well-being (Speizer et al. 2014: 3)
Samari and Pebley 2018	Understood individual autonomy as flexibility for financial or economic independence and physical autonomy (Samari and Pebley 2018: 3)
Atake and Ali 2019	Measured autonomy using an index, drawn from three dimensions of empowerment of women: socio-cultural, economic and family/relational (Atake and Ali 2019: 3-4)
Amugsi et al. 2016	Amugsi et al. (2016: 5) defined autonomy as women's ability to have the final say on: spending money, making family buyings, their well-being, and their views on capacity to reject husband sex on reasonable grounds and wife-beating.

needs) and opens up the opportunities for engendering much-needed income in securing other family needs. Access to a credit or capital and control over land and other household resources is another crucial pillar of autonomy.

Table 3 presents a short description of the explanatory and outcome variables used by the reviewed studies. It is noted that the findings vary from context to context and individual researcher's goals and objectives. In 12 of the 15 reviewed articles, decision-making autonomy appeared to be the primary explanatory variable in the regression analysis. In contrast, other individual and group level factors were used as

confounders in the studies. Outcome variables used by the studies include immunization of children, delivery at health institutions, family planning utilisation, fertility, decision-making in child survival and ultimate number of children.

Table 4 presents a list of women's decision-making autonomy reported using different studies. In most studies, women's contribution in health care decision-making was found very low. In a number of the studies, the participation rate is as low as five percent. However, a substantial proportion of the studies confirmed significant positive effects of autonomy in healthcare-seeking and practices.

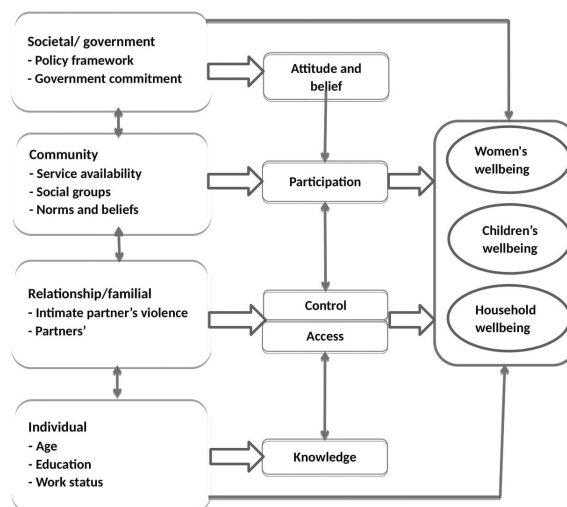


Fig. 2. Framework for conceptualizing woman's autonomy and decision making

Source: Authors

DISCUSSION

The study has mainly aimed at reviewing recent studies carried out in SSA on impacts of women's decision-making and/or autonomy on a range of parameters. The synthesis of the 15 articles that studied women's decision-making autonomy in SSA generally differs in conceptualisation, focus areas, and depth depending on each study's context.

It is noted that the studies significantly vary in terms of conceptualising or defining women's decision-making autonomy. Some are more comprehensive than others. For instance, the definition used by Upadhyay and Karasek (2010) equates autonomy with 'empowerment.' On the other hand, the description used by Sougou et al. (2020) is precisely about making healthcare decisions. The disparities in defining autonomy seem to have emanated from the outcome variables each study has primarily wished to address. In classical studies of the 1980s and 1990s, researchers used the term autonomy merely in association with access to information (Dyson and Moore 1983) or the ability to act independently (Basu 1992) or decision-making about meaningful private or family life (Mason 1995).

There are wide variations in reporting the prevalence of decision-making autonomy depending on the study setting and methodology (such as sample

size and measurements). For instance, in the study of family planning in Senegal (comprising 8,865 women aged 15-49 years), only 6.26 percent of women were found to make their own decisions while husbands or partners made such decisions for more than eighty percent of them (Sougou et al. 2020). Similarly, in the study of Nigerian women's decision-making (n=4996), Awoley et al. (2018) reported that only three percent of the sampled women made decisions alone on large household purchases and their own healthcare. Close to two-thirds of them (62%) said their husbands were making decisions concerning visits to family or relatives (Awoley et al. 2018).

Most of the studies reviewed reported the significant role of autonomy, especially in promoting children's well-being and increasing women's power. More than two-thirds of the reviewed articles examined the impacts of decision-making autonomy on health-seeking behaviour. Thus, the outcome variable takes different forms, such as immunization of children, delivery at health institutions, family planning utilization, fertility, decision-making in child survival and an ideal number of children. The article search process witnessed that studies conducted at national levels on the effects of autonomy on other livelihood dimensions (such as decision-making on asset ownership, financial utilisation, significant purchases, etc.) are rare.

Table 3: Summary of findings by the individual studies, SSA

<i>Study</i>	<i>Outcome variable</i>	<i>Explanatory variables</i>	<i>Reported findings/ conclusion made</i>
Ebot 2014	Child immunizations	Decision-making autonomy index, which ranged from 0-4 Control variable: religion, rural/urban housing location, women's age, polygamous marriage, age at first marriage, child's sex, child's age and number of children under five living in the family	A one-unit increase in women's individual-level independence is related with a 5 percent unit improvement in children's immunizations. One unit increase in a community's autonomy level are linked with a 31 percent improvement in children's immunizations (Ebot 2014: 1210-1212)
Gabrysch et al. 2016	Facility delivery	Explanatory variables comprises of five dimensions: health care, financial, relationship, movement and violence.	Power relations and gender norms may supersede an individual's autonomous decisions at the community level, as well as behaviors or preferences connected to care-seeking for childbearing (Gabrysch et al. 2016: 5).
Sougou et al. 2020	Family planning	Women's decision-making/autonomy over their well-being; other socio-economic variables, including marital status, age, wealth and residence were used as control variables.	The study reported that older women who are educated, ones, women who have educated husbands, and living in wealthier households increase the possibility of decision-making on family planning use. Yet, women's autonomy did not significantly affect family planning (Sougou et al. 2020: 5).
Awoley et al. 2018	Place of Birth and antenatal care visits.	The primary explanatory variable was women's power. Other socio-economic variables (such as the highest level of education, wealth index, work status, place of residence and religion,) were also encompassed.	The study establish substantial associations between women's independence, health facility delivery and antenatal care visits (Awoley et al. 2018: 9).
Akinyemi et al. 2017	Child survival-mortality	Women's autonomy was the primary variable, but other individuals and household variables were included. It also constituted community norms about women's decision making.	The likelihood of childhood mortality was greater among women with low decision making power. However, the study revealed that the effects were more potent at the community than individual level, i.e., an individually empowered woman may have limited DMI if she lives in a society where women have limited decision-making authority (Akinyemi et al. 2017: 32).
Chol et al. 2019	Antenatal care, skilled delivery care and service utilization	Women's autonomy plus education attainment, family wealth, employed status place of residence and age at birth of the last child.	The study established weak connections at regional and national levels. The exclusion was the Southern Africa region, where links between women's freedom and maternal healthcare services utilization were practically robust (Chol et al. 2019: 6).
Upadhyay and Karasek 2010	Perfect number of children, the achievement of their desired fertility	Women's autonomy adjusted for other socio-economic variables	Women's autonomy was related with women's ideal number of children in only one country. The variable for decision-making was not significant for the other nations (Upadhyay and Karasek 2010: 29).
Darteh et al. 2019	Decision-making autonomy	Residence, education, wealth status, religion, occupation, religion, age and partner's level of education	Generally, about five out of ten (half) women requested their husbands to use a condom during sex; six out of ten women rejected their partner's sex, and seven out of ten women could make at least one decision. Again, residence, education level, religion, age, occupation, partner's education and occupation were linked with women's decision-making (Darteh et al. 2019: 7).

Table 3: Contd.....

<i>Study</i>	<i>Outcome variable</i>	<i>Explanatory variables</i>	<i>Reported findings/ conclusion made</i>
Yaya et al. 2018	Contraceptive use	Women's empowerment plus other socio-economic characteristics	This study revealed that contraceptive use is linked with women's empowerment and other proximate determinants, including maternal age, husband's education, wealth, neighborhood-level and country-level factors (Yaya et al. 2018: 10).
Tiruneh et al. 2017	Health service utilization (antenatal care, delivery, and post-natal care)	Women's autonomy plus selected background characteristics	Women's autonomy and other proximate variables (such as women's and their husbands' educational level, employment status, and wealth index) were positively linked with maternal healthcare service utilization (Tiruneh et al., 2017: 10).
Singh et al. 2012	Child immunization	Women's autonomy plus selected individual and community level variables	Women with greater household decision-making were more likely to have their child fully immunized than women with poor decision-making (Singh et al., 2012: 842).
Speizer et al. 2014	Institutional delivery	The prime independent variables for this analysis were decision-making autonomy and attitudes toward institutional delivery.	Women with lower decision-making autonomy regarding their healthcare had lower likelihood of facility delivery contrasted to women who took active part in health care decisions (Speizer et al. 2014: 10)
Samari and Pebley 2018	Autonomy	Individual, household, and community characteristics	Age, education, wealth status, residence, social position, community link, and marital form have become key determinants of women's autonomy (Samari and Pebley 2018: 14).
Atake and Ali 2019	Ideal number of children	Individual, household, and community characteristics	Women's empowerment is considerably associated with a desire for fewer children in all countries studied (Atake and Ali 2019: 12).
Amugsi et al. 2016	Women's dietary diversity	Individual, household, and community characteristics	Women's participation in decision-making regarding household purchases was significantly associated with higher diet diversity after adjusting for individual and household level covariates (Amugsi et al., 2016: 6).

One striking feature of the findings drawn from most reviewed articles is that the effects of women's autonomy on the various livelihood dimensions are stronger at the society level than at household or individual levels. For example, in Akinyemi et al.'s (2017) study, the effects of women's decision-making index on key child healthcare domains were more potent at the society level than at the individual level (Akinyemi et al. 2017). The finding entails that a separate women's decision-making power may perhaps be compromised significantly if a woman exists in a community where they generally have low decision-making autonomy (Akinyemi et al. 2017). Such a finding implies that community norms and attitudes play a vital role in shaping behaviour and positively affect individual decision-making authority (Kabeer 2005).

Nearly all the reviewed studies implied that women's decision-making autonomy is affected

by various background variables, including the women's age, education of the couple, household wealth, and household size. For instance, Sougou et al. (2020) found that women's influence to make their health-related decisions rises with their age (Sougou et al. 2020). Other studies also confirmed that the women's position in society changes according to their role in society and generation, implicating those older women to have more decision-making autonomy at the household level (Alemayehun and Meskele 2017; Osamor and Grady 2016; Amadiume 2015). In the study by Sougou et al. (2020), women in the richest quintiles appeared to have more power. Several studies consistently reported that women in equitable socio-economic households had healthier decision-making power over their health and other domains (Sougou et al. 2020; Darteh et al. 2019; Samari and Pebley 2018; Nigatu et al. 2014).

Table 4: Key findings on women's autonomy in decision-making, SSA

<i>Study</i>	<i>Women's autonomy in decision making reported by different studies</i>
Ebot 2014	Based on the individual-level autonomy index used in this study a mean of 3.1 signifies that most women made about 3 out of 4 decisions alone or jointly on average. Across all societies, the average autonomy achieved was 3.7 (Ebot 2014: 7).
Sougou et al. 2020	Eighty percent of women respondents reported that their spouses or husbands make decisions on their wellbeing, including health care. The study also showed that women's independence in decision-making develops with age (Sougou et al. 2020: 3).
Awoley et al. 2018	More than 70 percent of the women indicated that their spouses alone decide on their well-being and large family financing/purchases. In comparison, less than 25 percent claimed that these decisions are made together. Only 3 percent of stated making decisions alone on their well-being and large family buying. Close to two thirds of the women said that their partners make decision alone on a visit to relatives or family while a small percentage (4%) indicated that they alone decide on visits to relatives or family(Awoley et al. 2018: 3).
Akinyemi et al. 2017	The percentage of children whose mothers involved in decision-making on large family purchases, visits to /friends/relatives and their health care were 33.9, 34.5 and 43.1 percent, in that order. Generally, 27.3 percent of 31482 children had mothers who jointly make decision-making(Akinyemi et al. 2017: 30)
Chol et al. 2019	The proportion of surveyed women with no schooling was topmost in Burkina Faso (83%) and lowest in Lesotho and Zimbabwe (1%). The surveyed women who were jobless were primary in Niger 77 percent and least in Rwanda 14 percent. The three nations with the topmost proportion of survey women having at least basic learning happened all in the Southern African region: Namibia 92 percent, Lesotho 99 percent, and Zimbabwe 99 percent (Chol et al. 2019: 5).
Upadhyay and Karasek 2010	Considerable variability was found among the four countries in the women's empowerment indicators. Namibia had the most empowered women, with the most reporting any say in all four family decisions (67.7%), most reporting that not any of the five motives justified beating of wife (68.5%), and the most reporting that all three reasons were justification for refusing sex (74.5%). Mali had the fewest women reporting any say in all four household decisions (10.6%) and the fewest reporting that all three reasons justified refusing sex (9.5%). Guinea had the most irregular women reporting none of the five causes explained beating(11.8%) (Upadhyay & Karasek 2010: 19).
Darteh et al. 2019	Among 27 SSA countries the percentage of women who could ask their spouse to use a condom during sexual contact varied from 16.6 percent to 93.4 percent in Mali and Namibia. Women who could reject sex varied from 18.3 percent in Mali to 92.4 percent in Namibia. The percentage of women who could make at least one reproductive health decision varied from 25.5 percent in Mali and 97.2 percent in Namibia (Darteh et al., 2019: 1).
Yaya et al. 2018	Results showed significant disparities in women who reportedly ever use contraceptive techniques; ranging from as low as (6.7%) in Chad and 72 percent in Namibia. Contraceptive use was considerably more mutual among respondents from the wealthiest families (28.5% against 18.9%) even after adjusting for socio-economic and demographic factors (Yaya et al. 2018: 6)
Tiruneh et al.2017	The proportion of women with contrasting approaches toward high decision-making authority, wife beating and at least basic learning in societies enlarged from 22.3 percent , 36.3 percent, 70.8 percent in 2005 to 32.1 percent ,48.5 percent, 75.3 percent in 2011 respectively (Tiruneh et al. 2017: 4)
Singh et al. 2012	Thirty five percent of women respondents had high family decision-making, and twenty seven percent had high financial decision-making. In terms of assertiveness towards gender norms, a little more than half (52%) reported that wife-beating is under no circumstances acceptable, and forty six percent designated that a wife has the right to reject sex (Singh et al. 2012: 840)
Speizer et al. 2014	Virtually half of the women reported that they alone can decide about their health care with their partner. Forty-seven percent of women account that their spouse alone makes these well-being decisions, and only four percent say that someone else makes these decisions (Speizer et al. 2014: 6)

Table 4: Contd.....

<i>Study</i>	<i>Women's autonomy in decision making reported by different studies</i>
Samari and Pebley 2018	Women's right to use financial resources meaningfully changed over the period of six years, with sixty five percent of women being financially self-sufficient in 2006 and Sixty percent of married women in 2012 (Samari and Pebley 2018: 10)
Atake and Ali 2019	The study reported the relationship between women's status and an ideal number of children. The desired number of children was considerably higher: more than fifty percent of partners had the same ideal number of children as their wives. Also, the percentage of women testified having more children than their desired number was established in Mali (40%), Burkina Faso(30%), Chad (16%), and Niger (13%), (Atake and Ali 2019: 10).

The researchers reported that both the woman's and her partner's educational status are critical determinants of decision-making autonomy (Sougou et al., 2020; Samari and Pebley 2018; Ahmed et al. 2010). Interestingly, some of the reviewed studies strongly argued that partners' education has a significant role in women's decision-making autonomy, as more educated partners provide more room for women's role in the household (Sougou et al. 2020; Speizer et al. 2014). These are ordinary men with basic education. Studies have revealed that well-educated men incline to have less sexist beliefs (Sultana 2011). Thus, educating men is vital, as assistance from the partner and household environment have positively influenced women's decision-making autonomy (Speizer et al. 2014). Generally, the findings of the effects of education on decision-making autonomy are usually consistent across studies regardless of study areas, methodology, and analysis level (Nigatu et al. 2014).

Most studies conducted in developing regions reached nearly a similar conclusion regarding the role of socio-economic variables. For instance, a study in Nepal found that being older, having paid employment, having many alive children and having improved education were positively linked to women's power in decision-making (Acharya et al. 2010). Other studies also reached a similar conclusion (Ahmed et al. 2010). There are two lines of argument regarding the impacts of decision-making autonomy on women and households' well-being. First, most studies reported the positive role of increased women's autonomy, while very few pinpointed its adverse impacts.

This relationship could emanate from differences in how researchers measure autonomy, definitions used, and use of other outcome variables of interest. Some studies, claiming adverse effects, argued that enhancements in women's autonomy may sometimes result in increased domestic violence degrees (d'Oliveira et al. 2009; Koenig et

al. 2003). Higher women's autonomy in decision-making decreases intimate partner violence (Sabarwal et al. 2012). Some studies associated women's better decision-making autonomy with increased depression and blood pressure, on the ground that having more independence could lead to increased violence between spouses (Hadley et al. 2010). Others argue that decision-making could empower women towards avoiding domestic violence (Hindin et al. 2008). Joint decision-making decreases the rate domestic violence (Kishor and Johnson 2004; Heaton and Forste 2008), and educating and involving males in health-related decisions may increase women's autonomy and well-being whereas reducing fight and difference between partners (Mullany et al. 2005; Feyisetan 2000).

On the contrary, some of the reviewed studies reported weaker results of impacts of autonomy on livelihood. For example, the studies conducted in Ethiopia and Eritrea establish that most autonomy indices were not meaningfully related with facility-based birth, even after controlling for other variables (Woldemichael 2010). Furthermore, in a joint analysis across 33 locations (comprising 21 African locations), Ahmed et al. (2010) found female autonomy as the least important determinant of women's access and utilization of maternal health services across all nations, especially among African countries (Ahmed et al. 2010). One plausible reason for weaker autonomy impacts in different dimensions is that women cannot transform their individual decision-making authority into their benefits (Awoley et al. 2018).

Studies on development and gender have made it possible to emphasise access to empowerment or autonomy, which is at the center of resolving social disparities related to gender. In Senegal, women's independence over decision-making for their health is fragile (Sougou et al. 2020). Other studies have revealed that only 6.26 percent of women have the right to decide their health. For most women

80.33 percent, of their spouses or husbands decide for them. In different places studies have revealed how certain traditional customs shape women's autonomy in making decisions concerning women's health (Singh et al., 2019). It is mainly about the partner or husband's domination when making important decisions for women on issues of health (Sultana et al. 2011).

The studies demonstrated that women's power to make decisions regarding their health increases with their age. Sado et al. (2014) has demonstrated the effect of women's age on empowerment. In most African countries, a small number of women are permitted to decide on their health (Alemayehun and Meskele 2017). In many traditional communities, older women may be necessary, significant, or even independent. Still, in contrast to male of the same age, their positions usually suffer from absence of value and recognition. Moreover, the studies demonstrated that women in the richest quintiles have increased power over decision-making.

Overall, the studies have concluded a significant relationship between women's autonomy and a range of healthcare-seeking behaviours, comprising health services, child's diet, and nutrition (Atake and Gnakou 2019; Darteh et al. 2019; Tiruneh et al. 2017; Amugsi et al. 2016). These outcomes are consistent with other findings conducted worldwide (Obonyo et al. 2014; Baral et al. 2010; Fawole and Adeoye 2015; Woldemichael 2007). Data analysis using the DHS conducted in 32 nations in sub-Saharan Africa has reported a significant link between health-seeking behaviours and women's autonomy at the family level (Yaya et al. 2018). Sharma et al. (2007) reported that women with greater freedom could manage their children's healthcare and make fertility decisions regardless of their financial and physical assets. Other studies conducted in Africa also confirmed this (Kamiya 2010). Speizer et al. (2014) emphasised community traditions and customs in institutional delivery and indicated that women's autonomy played a significant role in safeguarding these requirements are facility-based.

These scooping review is not without limitations. First, the synthesis made in the above few paragraphs was based on a small number of Sub-Saharan African countries where studies were carried out based on nationally representative data. Second, this review does not include several local studies, as they were based on a small sample size. Thus, the review is not representative of the

entire region. Third, the selected have focused on women's autonomy regarding healthcare decision-making and did not cover other livelihood dimensions, such as access to other economic services, income, employment, and other household domains.

CONCLUSION

Three vital conclusions can be drawn from the present scooping review. First, no single study conducted in Sub-Saharan Africa has provided a comprehensive measure of women's decision-making autonomy, and indeed, the conceptualisation of the term varies significantly from context to context. Due to such variations, it is usually difficult to compare findings across studies. Second, as an outcome variable, women's decision-making autonomy is determined by specific background characteristics, most importantly, the women's age, education of the couple, household wealth, and household size. Third, nearly all studies witnessed significant positive impacts of women's decision-making autonomy on women's well-being, such as improved childhood nutrition, reduced mortality, maternal and children's health, and health services utilisation. However, the impacts are more substantial or visible at the community level than at the individual or household level.

RECOMMENDATIONS

The overall findings from the reviewed articles suggest that program designers and local administrators in SSA should work towards developing females' involvement in formal education, promoting peer education, improving communication between husband-wife, as it is central to women's autonomy in decision-making, and increasing rural women's participation in income generation activities and rights to access/control economic resources.

LIST OF ABBREVIATIONS

DHS: Demographic and Health Surveys
SES: Socioeconomic Status
SDGs: Sustainable Development Goals
WHO: World Health Organisation

REFERENCES

- Acharya DR, Bell JS, Simkhada P 2010. Women's autonomy in household decision-making: A demographic study in Nepal. *Reprod Health*, 7: 15. <https://doi.org/10.1186/1742-4755-7-15>.

- Ahmed S, Creanga AA, Gillespie DG, Tsui AO 2010. Economic status, education, and empowerment: Implications for maternal health service utilization in developing countries. *PLoS One*, 5(6): e11190. Doi: 10.1371/journal.pone.0011190. PMID: 20585646; PMCID: PMC2890410.
- Akinyemi J, Odimegwu CO, Banjo OO 2017. Dynamics of maternal union dissolution and childhood mortality in sub-Saharan Africa. *Development Southern Africa*, 34(6): 752-770. DOI: 10.1080/0376835X.2017.1351871.
- Alemayehun M, Meskele M 2017. Health care decision-making autonomy of women from rural districts of Southern Ethiopia: A community-based cross-sectional study. *Int J Women's Health*, 9: 213-221. Doi: 10.2147/IJWH.S131139. PMID: 28458582; PMCID: PMC5402916.
- Amadiume PI 2015. *Male Daughters, Female Husbands: Gender and Sex in an African Society*. Londres E.T. New Jersey: Zed Books Ltd
- Amugsi D, Lartey A, Kimani-Murage E, Mberu B 2016. Women's participation in household decision-making and higher dietary diversity: Findings from nationally representative data from Ghana. *Journal of Health, Population, and Nutrition*, 35. <https://doi.org/10.1186/s41043-016-0053-1>.
- Atake EH, Gnakou AP 2019. Women's empowerment and fertility preferences in high fertility countries in Sub-Saharan Africa. *BMC Women's Health*, 19(54): 1-14. <https://doi.org/10.1186/s12905-019-0747-9>
- Baral YR, Lyons K, Skinner J, van Teijlingen ER 2010. Determinants of skilled birth attendants for delivery in Nepal. *Kathmandu Univ Med J (KUMJ)*, 8(31): 325-332. doi: 10.3126/kumj.v8i3.6223. PMID: 22610739.
- Basu AM 1992. *Culture, the Status of Women and Demographic Behavior*. Oxford: Clarendon.
- Becker S, Fonseca-Becker F, Schenck-Yglesias C 2006. Husbands' and wives' reports of women's decision-making power in Western Guatemala and their effects on preventive health behaviors. *Soc Sci Med*, 62(9): 2313-2326. doi: 10.1016/j.socscimed.2005.10.006. Epub 2005 Nov 22. PMID: 16307836.
- Brunson EK, Shell-Duncan B, Steele M 2009. Women's autonomy and its relationship to children's nutrition among the Rendille of northern Kenya. *Am J Hum Biol*, 21(1): 55-64. DOI:10.1002/ajhb.20815. PMID: 18792063; PMCID: PMC3962675.
- Dancer D, Rammohan A 2009. Maternal autonomy and child nutrition: Evidence from rural Nepal. *Indian Growth and Development Review*, 2(1): 18-38. <https://doi.org/10.1108/17538250910953444>
- Darteh EK, Dickson KS, Doku DT 2019. Women's reproductive health decision-making: A multi-country analysis of demographic and health surveys in sub-Saharan Africa. *PLoS ONE*, 14(1): e0209985. <https://doi.org/10.1371/journal.pone.0209985>
- Doan RM, Bisharat L 1990. Female autonomy and child nutritional status: The extended family residential unit in Amman, Jordan. *Soc Sci Med*, 31(7): 783-789. DOI: 10.1016/0277-9536(90)90173-p. PMID: 2244220.
- D'Oliveira A, Schraiber L, Junior I, Ludermit A, Portella A, Diniz S, Couto M, Valença O 2009. Factors associated with intimate partner violence against Brazilian women. *Revista de saúde pública*, 43: 299-311.
- Dyson T, Mick M 1983. On Kinship Structure, Female Autonomy, And Demographic Behavior In India. *Population And Development Review*, 9(1): 35-60. From <JSTOR, www.jstor.org/stable/1972894.> (Retrieved on 27 March 2021).
- Ebot J 2014. Place matters: Community-level effects of women's autonomy on Ethiopian children's immunization status. *African Population Studies*, 28: 1202-1215. Doi: <https://doi.org/10.11564/28-0-568>.
- Fawole OI, Adeoye IA 2015. Women's status within the household as a determinant of maternal health care use in Nigeria. *Afr Health Sci*, 15(1): 217-225. DOI: 10.4314/ahs.v15i1.28. PMID: 25834551; PMCID: PMC4370136.
- Feyisetan BJ 2000. Spousal communication and contraceptive use among the Yoruba of Nigeria. *Population Research and Policy Review*, 19: 29-45. <http://dx.doi.org/10.1023/A:1006388011947>
- Gabrysch S, McMahon SA, Siling K, Kenward MG, Campbell OM 2016. Autonomy dimensions and care-seeking for delivery in Zambia: The prevailing importance of cluster-level measurement. *Sci Rep*, 6: 22578. DOI: 10.1038/srep22578. PMID: 26931301; PMCID: PMC4773858.
- Golden SD, Earp JA. 2012. Social-ecological approaches to individuals and their contexts: twenty years of health education and behavior health promotion interventions. *Health Educ Behav*, 39(3): 364-372. DOI: 10.1177/1090198111418634.
- Hadley C, Brewis A, Pike I 2010. Does less autonomy erode women's health? Yes. No. Maybe. *Am J Hum Biol*, 22(1): 103-110. doi: 10.1002/ajhb.20959. PMID: 19533612.
- Heaton TB, Forste R 2008. Domestic Violence, Couple Interaction, and Children's Health in Latin-American countries (Bolivia, Peru, Colombia, Haiti, and Nicaragua): Faculty Publications, 2786. From <<https://scholarsarchive.byu.edu/facpub/2786/>> (Retrieved on 12 January 2020).
- Hindin M, Kishor S, Ansara DL, Nilsson J, Brown C, Russell EB, Khamphakdy BS, Btoush R, Haj-Yahia MM, Serbanescu F 2008. Intimate partner violence among couples in 10 DHS countries: Predictors and health outcomes. *J Interpers Violence*, 23: 1654-1663.
- Kabeer N 2005. Gender equality and women's empowerment: A critical analysis of the third-millennium development goal 1. *Gender and Development*, 13(1): 13-24. DOI: 10.1080/13552070512331332273.
- Kishor S, Johnson K 2004. Profiling domestic violence: A multi-country study. *Studies in Family Planning*, 36(3): 259.
- Kamiya Y 2010. Endogenous Women's Autonomy and the Use of Reproductive Health Services: Empirical Evidence from Tajikistan, *OSIPP Discussion Paper* DP-2010-E-010: Osaka School of International Public Policy, Osaka University, Japan.
- Koenig MA, Ahmed S, Hossain MB 2003. Women's status and domestic violence in rural Bangladesh: Individual- and community-level effects. *Demography*, 40: 269-288. <https://doi.org/10.1353/dem.2003.0014>.
- Mason KO 1995. Gender and Demographic Change: What Do We Know? *IUSSP Paper*. Liège, Belgium.
- Mistry R, Galal O, Lu M 2009. Women's autonomy and pregnancy care in rural India: a contextual analysis. *Soc Sci Med*, 69(6): 926-933. DOI: 10.1016/j.socscimed.2009.07.008.
- Mullany BC, Hindin MJ, Becker S 2005. Can women's autonomy impede male involvement in pregnancy health in Katmandu, Nepal? *Soc Sci Med*, 61(9): 1993-2006. DOI: 10.1016/j.socscimed.2005.04.006. PMID: 15922498.
- Nigatu D, Gebremariam A, Abera M 2014. Factors associated with women's autonomy regarding maternal and child health care utilization in Bale Zone: A community-based cross-sectional study. *BMC Women's Health*, 14: 79. <https://doi.org/10.1186/1472-6874-14-79>.

- Obonyo CO, Asweto C, Ouma J, Aluo JR 2014. Women empowerment and skilled attendance/facility delivery in a rural community of Western Kenya. *IOSR Journal of Nursing and Health Science*, 3: 48-53. 10.9790/1959-03224853.
- Osamor PE, Grady C 2016. Women's autonomy in health care decision-making in developing countries: A synthesis of the literature. *Int J Women's Health*, 8: 191-202. DOI: 10.2147/IJWH.S105483. PMID: 27354830; PMCID: PMC4908934.
- Osborn D, Cutter A, Ullah F 2015. Universal Sustainable Development Goals: Understanding the Transformational Challenges for Develop Countries. Report of a Study By Stakeholder's Forum. From <https://sustainabledevelopment.un.org/content/documents/1684SF_-_SDG_Universality_Report_-_May_2015.pdf> (Retrieved on 12 January 2020).
- Sabarwal S, McCormick MC, Silverman JG, Subramanian SV 2012. Association between maternal intimate partner violence victimization and childhood immunization in India. *Journal of Tropical Paediatrics*, 58(2): 107-113.
- Sado L, Spaho A, Hotchkiss DR 2014. The influence of women's empowerment on maternal health care utilization: Evidence from Albania. *Soc Sci Med*, 114: 169-177. doi:10.1016/j.socscimed.2014.05.047. Epub 2014 May 28. PMID: 24929918.
- Samari G, Pebley RP 2018. Longitudinal determinants of married women's autonomy in Egypt. *Gender, Place and Culture*, 25(6): 799-820. DOI: 10.1080/0966369X.2018.1473346.
- Sharma SK, Sawangde Y, Sirirassamee B 2007. Access to health: Women's status and utilization of maternal health services in Nepal. *Journal of Biosocial Science*, 39(5): 67.
- Singh SK, Sharma B, Vishwakarma D, Yadav G, Srivastava S, Maharana B 2019. Women's empowerment and use of contraception in India: Macro and micro perspectives emerging from NFHS-4 (2015-16). *Sex Reprod Health Off J Swed Assoc Midwives*, 19: 15-23.
- Singh K, Erica H, Comfort O 2012. Maternal autonomy and attitudes towards gender norms: Associations with childhood immunization in Nigeria. *Maternal and Child Health Journal*, 1-5.
- Sougou NM, Bassoum O, Faye A et al. 2020. Women's autonomy in health decision-making and its effect on access to family planning services in Senegal in 2017: A propensity score analysis. *BMC Public Health*, 20: 872. <https://doi.org/10.1186/s12889-020-09003-x>
- Speizer IS, Story WT, Singh K 2014. Factors associated with institutional delivery in Ghana of the role of decision-making autonomy and community norms. *BMC Pregnancy and Childbirth*, 14(398): 1-13. <https://doi.org/10.1186/s12884-014-0398-7>.
- Sultana AM 2011. Factors affect women's autonomy and decision-making power within the household in rural communities. *J Appl Sci Res*, 7(1): 18-22.
- Tiruneh FN, Chuang KY 2017. Women's autonomy and maternal healthcare service utilization in Ethiopia. *BMC Health Services*, 17(718): 1-12.
- Upadhyay Ushma D, Karasek D 2010. Women's Empowerment and Achievement of Desired DHS. *Working Papers No. 80*. Calverton, Maryland, USA: ICF Macro.
- Upadhyay UD, Gipson JD, Withers M 2014. Women's empowerment and fertility: A Review of the literature. *Social Science and Medicine*, 115: 111-120.
- Woldemichael G 2007. Women's Status and Reproductive Preferences in Eritrea. *MPIDR Working Paper*, WP 2007-023. Max Planck Institute for Demographic Research Konrad-Zuse-Strasse 1D-18057 Rostock: Germany.
- Woldemichael G, Tenkorang EY 2010. Women's autonomy and maternal health-seeking behavior in Ethiopia. *Maternal Child Health J*, 14(6): 988-998. DOI: 10.1007/s10995-009-0535-5. PMID: 19882240.
- Woldemichael G 2010. Do women with higher autonomy seek more maternal health care? Evidence from Eritrea and Ethiopia. *Health Care Women Int*, 31(7): 599-620. DOI: 10.1080/07399331003599555. PMID: 20526926
- Yaya S, Uthman OA, Ekholuenetale M. 2018. Women empowerment as an enabling factor of contraceptive use in sub-Saharan Africa: A multilevel analysis of cross-sectional surveys of 32 countries. *Reprod Health*, 15: 214. <https://doi.org/10.1186/s12978-018-0658-5>.

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