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*Original Article*

# Determinants of Informed Decision-Making on Sexual Relations, Contraceptive Use, and Reproductive Health among Women of Reproductive Age: A Case of Married Women in Tanzania

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*Women's Autonomy, Informed Decision-Making, Sexual Relations, Reproductive Health, Contraceptive Use.*

## ABSTRACT

**Background:** The percentage of women aged 15-49 who have the autonomy to make informed decisions about sexual and reproductive health varies globally. According to recent data, approximately 57% of women in this age group can make decisions independently. However, regional disparities exist, with lower rates in many developing countries, particularly in Sub-Saharan Africa. **Objective:** Our goal was to ascertain the determinants of informed decision-making on sexual relations, contraceptive use, and reproductive health among women of reproductive in Tanzania. **Methods:** This cross-sectional study used secondary data from the Tanzania Demographic and Health Survey and Malaria Indicator Survey of 2022. The study population included married women aged 15-49 years. A multinomial regression model was used to identify determinants associated with making informed decisions on Sexual Relations, Contraceptive Use, and Reproductive Health. **Results:** A total of 6730 married women were included in the analysis. the majority resided in rural areas, had completed primary education, reported never hearing about family planning on the radio, not encountered family planning information on popular social media platforms like Facebook, Twitter, or Instagram, perceived distance to a health facility as a non-issue, were employed, and had 1-5 living children. On the other hand, Age, employment, husband employment, wealth index, distance to a health facility, and having living children were associated with higher odds of making all three informed decisions while hearing about family planning on the radio had lower odds. **Conclusion:** The study identifies factors influencing decision-making in married Tanzanian women of reproductive age. Older women and those with stable economic environments and financial independence are more likely to make informed choices. Access to healthcare facilities and good parenting experiences also improve women's decision-making autonomy**.** Targeted education and empowerment programs should be introduced to enhance informed decision-making among married women in Tanzania.

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## INTRODUCTION

The percentage of women aged 15-49 who make informed decisions about having sexual relations, contraceptive use, and reproductive health care varies significantly around the globe. Based on the most recent data from the World Health Organization (WHO) and Our World in Data (2023a), about 57% of women in a certain age group have the autonomy to make decisions independently. This statistic, which is part of the Sustainable Development Goals (SDG 5.6.1), reflects women's independence in crucial areas that impact their health and rights (United Nations, 2022). However, there are significant regional disparities in women's autonomy. While some developed regions show higher rates of autonomy, many developing countries have lower rates (Our World in Data, 2023a; United Nations Population Fund, 2020). This is particularly challenging in Sub-Saharan Africa, where only approximately 44% of females can make informed decisions about their sexual and reproductive health, as per World Bank data (2023). This lack of autonomy is attributed to economic barriers, limited access to healthcare and education, and cultural norms (Our World in Data, 2023a; United Nations Population Fund, 2020).

Even with efforts to improve women's rights and health outcomes, Sub-Saharan Africa still faces significant obstacles, including high rates of early marriage and gender-based violence, which hinder girls' autonomy (UN SDG Indicators, 2023a). Tanzania, specifically, has a lower-than-average percentage of women who can make informed decisions about sexual relations, contraceptive use, and reproductive health, with only 41% reported to have this capability (World Health Organization, 2023; Our World in Data, 2023). women aged 15-49 are capable of making those decisions on their own (UNICEF, 2021). There are continuous initiatives in Tanzania aimed at enhancing women's autonomy in making decisions. These initiatives focus on removing social barriers and expanding women's access to healthcare and education. However, obstacles like poverty, limited healthcare infrastructure, and strongly ingrained gender conventions continue to impede development (UN SDG Indicators, 2023a).

In order to improve the impacts of informed decision-making on sexual relations, contraceptive use, and reproductive health, the examined literature collectively highlights the critical need to resolve regional inequities, promote women's empowerment, and guarantee access to first-rate healthcare facilities. According to Adedini et al. (2014), maternal education and access to healthcare are important factors that influence the wide regional disparities in infant and maternal mortality in Nigeria. In a similar vein, Fagbamigbe et al. (2020) found that women's autonomy in making healthcare decisions significantly lowers maternal mortality. The role that education plays in postponing

 

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reproductive transitions, which leads to decreased fertility rates and improved fitness for mothers and infants, is highlighted by Bongaarts (2020). The ongoing challenge of unfulfilled aspirations for contraception, driven by cultural norms and insufficient verbal communication, is highlighted by Cleland et al. (2014) and Tumlinson et al. (2015a).

To further achieve the Sustainable Development Goals, Kruk et al. (2016) emphasise that improving access to healthcare alone would not suffice if quality treatment is not also provided. They thus urge for a revolution in health systems. According to Pratley (2016) and Upadhyay et al. (2014), there is a stronger correlation between women's empowerment and the benefits of improved health, highlighting the necessity of policies that support women's choices. Studies employing data from the UN SDG Indicators (2023b) and Our World in Data (2023b), as well as global data from Mosha et al. (2016), highlight the significance of gender dynamics and fair decision-making on reproductive health. All of these results highlight the need to invest in a strong healthcare infrastructure in addition to empowering women via education, employment opportunities, and legal rights in order to achieve long-term improvements.

The autonomy of women in making informed decisions about sexual encounters, using contraceptives, and reproductive health varies significantly by region, according to available facts and literature. Globally, approximately 57% of women have the authority to make these choices, but there are substantial regional differences, especially in Sub-Saharan Africa, where only about 44% of women have this level of autonomy. In Tanzania, the percentage is even lower at 41%, highlighting the significant obstacles to increasing women's ability to make decisions about their reproductive health (UNICEF, 2021). Various factors, such as geographical differences, women's autonomy, and the quality of healthcare systems, affect reproductive health outcomes. However, there may be a discrepancy in the ability of Tanzanian women of reproductive age to make informed decisions about their sexual relationships, contraceptive use, and reproductive health.

The efforts to improve women's autonomy in Tanzania by providing increased access to healthcare and education are ongoing. However, there is still a significant lack of knowledge regarding the specific factors that influence Tanzanian married women to make well-informed decisions. Factors such as high rates of early marriage and gender-based violence, deeply ingrained cultural norms, limitations in healthcare infrastructure, and economic constraints all play a role (UN SDG Indicators, 2023a). This study aims to examine these factors and their precise effects in the Tanzanian context. Identifying and addressing these obstacles and enablers to informed decision-making around sexual and reproductive health is crucial for improving Tanzanian women's autonomy and health outcomes through targeted policies and interventions.

## THEORETICAL FRAMEWORK

The Theory of Planned Behaviour (TPB) is integrated with particular demographic, social, and economic variables to create a theoretical framework for explaining informed decision-making about sexual encounters, usage of contraceptives, and reproductive health among women of reproductive age (Ajzen, 1991; Yzer, 2012). As per TPB, an individual's conduct is determined by their purpose in carrying out the behaviour, which is molded by their attitudes, subjective norms, and perceived control over their behaviour (Ajzen, 1991). Based on this theory, a woman's education level, her exposure to family planning material on the radio, and her usage of social media sites like Facebook, Instagram, and Twitter greatly influence her views on the use of contraceptives and other sexual and reproductive practices.

Subjective norms impact the social constraints a woman experiences regarding these health behaviours based on the husband's age and education, the number of live children, and the location (rural vs. urban) (Ajzen, 1991; Yzer, 2012). The woman's present employment

 

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position, her husband's employment status, the family wealth index, and the distance to the closest health facility all influence how easy or difficult it is for her to obtain contraceptives and other healthcare services (Ajzen, 1991; Yzer, 2012). These factors all have an impact on how the woman perceives her ability to regulate her behaviour (Ajzen, 1991). Furthermore, due to differing reproductive objectives and health demands among age groups, a woman's age affects her intentions about sexual encounters, the use of contraceptives, and her reproductive health (Yzer, 2012).

## MATERIALS AND METHODS

### Study Data and Design

The research employed data from the Tanzania Demographic Health Survey and Malaria Indicator Survey (TDHS-MIS) of 2022, marking the seventh DHS survey carried out in Tanzania as part of the DHS initiative. From February to July of 2022, data were gathered. Two stages of stratified sampling were used in the survey's sampling design to collect estimates for the entire nation, which is made up of Zanzibar and the Tanzanian mainland. The first stage involved choosing sample points, or clusters, which were made up of enumeration areas (EAs) drawn out for the 2012 Tanzania Population and Housing Census (PHC). Sixty-two clusters were chosen in all. Of the 629 EAs, 211 were located in cities, while 418 were found in rural regions. In the subsequent phase, a systematic selection of 26 families were made from every cluster, resulting in an estimated sample size of 16,354 households for the 2022 TDHS-MIS. The 2022 TDHS-MIS covered all women aged 15–49 who were either regular residents or guests in the household the night before the survey interview and were therefore eligible for an interview. The Household Questionnaire, the Questionnaire, the Man's Questionnaire, the Biomarker Questionnaire, and the Micronutrient Questionnaire were the five questionnaires utilised for the 2022 TDHS-MIS. In this study, using the IR File, data of all 15,254 women aged 15-49 who were interviewed were considered. A sample of 6370 married women aged 15-49 was drawn as an inclusion criterion in this study.

### Outcome variable

The dependent variable was generated from three questions, the first one, if a woman can say no to her husband if she does not want to have sexual intercourse (recoded as ”1” for yes and “0” for no ), second if a woman can make a decision about the use of family planning alone or jointly with her husband (recoded “1” for alone or jointly and “0” for otherwise), and lastly if a woman can decide on her health care alone or jointly husband (recoded “1” for alone or jointly and “0” for otherwise). These three variables were then added to generate the outcome variable “three informed decisions” after being added result scores (discrete) ranging from 0 to 3.

Where by

0=implies that a married woman did not make any of the three decisions

1= implies that a married woman made any one of the three decisions

2=implies that a married woman made any two of the three decisions

3=implies ‘that a married woman made all three informed decisions.

Therefore, for those married women who made a single decision, any two of the three decisions and three decisions were added and considered that they participated in making informed decisions on sexual relations, contraceptive use, and reproductive health**.**

### Independent variables

Several independent variables were found in the literature, and it was verified if the 2022 TDHS-MIS dataset contained them. These included age (15-24,25-34,35-49), Husband’s age (15-24, 25-34, 35-54, 55+), Education level (no education, primary, secondary, higher), Husband’s education level (no education, primary, secondary, higher, don't know), place of residence (urban, rural), working (no, yes ), husband/partner working (no,

 

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yes), wealth index (poor, middle, rich), heard family planning on the radio (no, yes), seen family planning on Facebook, Twitter Instagram (no, yes), distance to a health facility (big problem, It is not a big problem), number of living children (0, 1-5, 6+)

**Empirical Estimation Strategy**

A multinomial regression model was run to identify the factors associated with making three informed decision measurements (sexual relations, contraceptive use, and reproductive health) among married women between 15-49 years.

**Model Specification**

Let $Y_i$ be the categorical outcome variable representing the decision status, taking value in the set (sexual relations, contraceptive use, and reproductive health). The examined model is shown below:

$$P(Y_i = j) = \frac{e^{\beta_{0j}+\beta_{1j}X_{1i}+\beta_{2j}X_{2i}+\beta_{3j}X_{3i}}}{\sum_{k=1}^{3} e^{\beta_{0k}+\beta_{1k}X_{1i}+\beta_{2k}X_{2i}+\beta_{3k}X_{3i}}}$$

Here:

- $P(Y_i = j)$ is the probability of observation I belong to category j.
- $\beta_{0j}$, $\beta_{1j}$, $\beta_{2j}$, $\beta_{3j}$ are the parameters specific to category j.
- $X_{1i}$, $X_{2i}$. $X_{3i}$ are the values of the dimensions (sexual relations, contraceptive use, and reproductive health) for observation i.
- $K$ is the total number of categories (in this case, 3)

**Data analysis**

The study began with descriptive statistics to summarize participants' characteristics, followed by bivariate analysis where we performed cross-tabulation. Lastly, inferential analysis, specifically Multinomial Regression analysis was performed to assess independent variables associated with making informed decisions. Relative Risk Ratio (RRRs) with their corresponding 95% confidence intervals are presented and a p-value less 5% was considered to be statistically significant. The study used STATA software Version 16 for both processing and analysis.

**RESULTS**

Out of 6730 married women, a significant majority (n= 4608, 68.5%) resided in rural areas. Furthermore, over half (n= 3470, 51.6%) of these women had completed primary education. Interestingly, 3562 (52.9%) reported never hearing about family planning on the radio, and a substantial 6119 (90.9%) had not encountered family planning information on popular social media platforms like Facebook, Twitter, or Instagram. In terms of accessibility to healthcare, a majority (n=4834, 71.8%) of the married women perceived distance to a health facility as a non-issue. The education levels of partners were diverse, with 3746 (55.7%) having partners who attained primary education. Additionally, almost two-thirds (n=4268, 63.4%) of the women were employed. Economically, 3150 (46.8%) of the women fell into the "rich" category. Demographically, 2929 (43.5%) of the women were aged between 35 and 49 years. Notably, 6138 (91.2%) of the women's husbands were employed. The husbands' ages were spread, with more than half (n=3855, 57.3%) falling between 35 and 54 years old. Family size varied, with nearly three-quarters (n=4947, 73.5%) of the women having between 1 and 5 living children (shown in **Table 1**).

 

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**Figure 1. Distribution of informed decisions among married women**

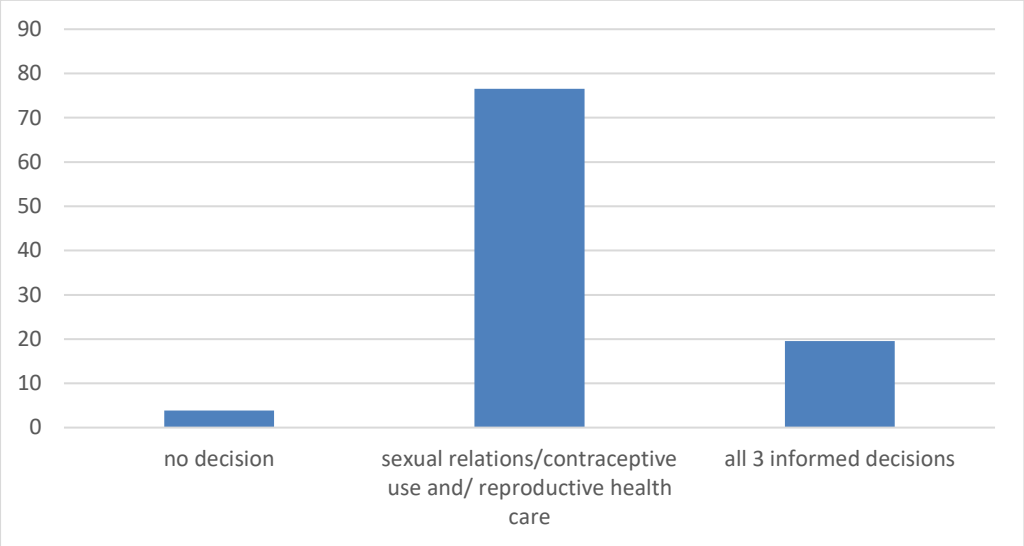


**Table 1: Distribution of the Study Participants and their Decision(s)**

| Variable | Single decision made n (%) | Two decisions made n (%) | All three decisions made n (%) | Total n (%) |
|---|---|---|---|---|
| **Age** | | | | |
| 15-24 | 96 (1.4) | 1009 (15.0) | 229 (3.4) | 1334 (19.8) |
| 25-34 | 90 (1.3) | 1899 (28.2) | 478 (7.1) | 2467 (36.7) |
| 35-49 | 73 (1.1) | 2248 (33.4) | 608 (9.0) | 2929 (43.5) |
| **Husband's age** | | | | |
| 15-24 | 40 (0.6) | 251 (3.7) | 64 (1.0) | 355 (5.3) |
| 25-34 | 85 (1.3) | 1485 (22.1) | 345 (5.1) | 1915 (28.5) |
| 35-54 | 119 (1.8) | 2946 (43.8) | 790 (11.7) | 3855 (57.3) |
| 55+ | 15 (0.2) | 474 (7.0) | 116 (1.7) | 605 (9.0) |
| **Education level** | | | | |
| no education | 84 (1.2) | 968 (14.4) | 282 (4.2) | 1334 (19.8) |
| Primary | 134 (2.0) | 2634 (39.1) | 702 (10.4) | 3470 (51.6) |
| Secondary | 41 (0.6) | 1470 (21.8) | 321 (4.8) | 1832 (27.2) |
| Higher | 0 (0) | 84 (1.2) | 10 (0.1) | 94 (1.4) |
| **Husband's education level** | | | | |
| no education | 57 (0.7) | 639 (9.8) | 174 (2.6) | 870 (12.9) |
| Primary | 158 (2.3) | 2812 (41.8) | 776 (11.5) | 3746 (55.7) |
| Secondary | 42 (0.6) | 1399 (20.8) | 317 (4.7) | 1758 (26.1) |
| Higher | 1 (0.01) | 185 (2.7) | 31 (0.5) | 217 (3.2) |
| don't know | 1 (0.01) | 121 (1.8) | 17 (0.3) | 139 (2.1) |
| **place of residence** | | | | |
| Urban | 45 (0.7) | 1705 (25.3) | 372 (5.5) | 2122 (31.5) |
| Rural | 214 (3.2) | 3451(51.3) | 943 (14.0) | 4608 (68.5) |
| **Working** | | | | |
| No | 140 (2.1) | 1907 (28.3) | 415 (6.2) | 2462 (36.6) |
| Yes | 119 (1.8) | 3249 (48.3) | 900 (13.4) | 4268 (63.4) |
| **husband/partner working** | | | | |
| No | 56 (0.8) | 460 (6.8) | 76 (1.1) | 592 (8.8) |
| Yes | 203 (3.0) | 4696 (69.9) | 1239 (18.4) | 6138 (91.2) |
| **wealth index** | | | | |
| Poor | 143 (2.1) | 1632 (24.2) | 455 (6.8) | 2230 (33.1) |
| Middle | 48 (0.7) | 1010 (15.0) | 292 (4.3) | 1350 (20.1) |

 

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| | | | | |
|---|---|---|---|---|
| Rich | 68 (1.0) | 2514 (37.4) | 568 (8.4) | 3150 (46.8) |
| **heard family planning on the radio** | | | | |
| No | 112 (1.7) | 251037 | 546 (8.1) | 3168 (47.1) |
| Yes | 147 (2.2) | 2646 (49.3) | 769 (11.4) | 3562 (52.9) |
| **seen family planning on Facebook, Twitter Instagram** | | | | |
| No | 247 (3.7) | 4633 (68.8) | 1239 (18.4) | 6119 (90.9) |
| Yes | 12 (0.2) | 523 (7.8) | 76 (1.1) | 611 (9.1) |
| **distance to a health facility** | | | | |
| big problem | 99 (1.5) | 1438 (21.4) | 359 (5.3) | 1896 (28.2) |
| It is not a big problem | 160 (2.4) | 3718 (55.2) | 956 (14.2) | 4834 (71.8) |
| **number of living children** | | | | |
| 0 | 41 (0.6) | 363 (5.4) | 83 (1.2) | 487 (7.2) |
| 1-5 | 173 (2.6) | 3828 (56.9) | 946 (14.1) | 4947 (73.5) |
| 6+ | 45 (0.7) | 965 (14.3) | 286 (4.2) | 1296 (19.3) |

**Source:** TDHS-MIS, 2022

Married women between the ages of 35-49 exhibited significantly higher odds (RRR=2.2, 95% CI: 1.29-3.75, P=0.0) of making all three informed decisions compared to their counterparts aged 15-24. Similarly, employed married women had 1.49 times higher odds (RRR=1.49, 95% CI: 1.33 -2.43, P=0.0) of making informed decisions compared to those who were not working. Additionally, married women whose husbands or partners were employed demonstrated substantially higher odds (RRR=2.98, 95% CI: 1.95 -4.53, P=0.0) of making all three informed decisions compared to those whose spouses were not working. On the wealth index, middle-class married women had slightly higher odds (RRR=1.43, 95% CI: 0.98 -2.1, P=0.047) of making all three informed decisions than their economically disadvantaged counterparts. Interestingly, married women who had heard about family planning on the radio were 33% less likely (RRR=0.67, 95% CI: 0.51-0.9, P=0.01) to make all three informed decisions than those without such information. On the perception of distance to a health facility, married women who did not consider it a significant issue had 38% higher odds (RRR=1.38, 95% CI: 1.02-1.86, P=0.03) of making all three informed decisions compared to their counterparts who perceived it as a significant concern. Furthermore, married women with 1 to 5 children had 72% higher odds (RRR=1.72, 95% CI: 1.1- 0.47, P=0.02) of making all three informed decisions than those without children. (See **Table 2**)

**Table 2 Multinomial regression showing factors of making informed decisions on sexual relations, contraceptive use, and reproductive health among married women**

| | **Base outcome (no decision)** | | | | | |
|---|---|---|---|---|---|---|
| | **single/two decision(s) made** | | | **all three decisions** | | |
| **Variable** | **RRR** | **95% CI** | **p-value** | **RRR** | **95% CI** | **p-value** |
| **Age** | | | | | | |
| 15-24 | **Reference** | | | | | |
| 25-34 | 1.22 | 0.84 - 1.78 | 0.3 | 1.41 | 0.94 - 2.14 | 0.1 |
| 35-49 | 1.9 | 1.16 - 3.13 | **0.01*** | 2.2 | 1.29 - 3.75 | **<0.001*** |
| | | | | | | |
| **Husband's age** | | | | | | |
| 15-24 | **Reference** | | | | | |
| 25-34 | 1.61 | 1.02 - 2.52 | **0.04*** | 1.48 | 0.88 - 2.48 | 0.14 |
| 35-54 | 1.71 | 1.01 - 2.91 | **0.05*** | 1.63 | 0.9 - 2.96 | 0.11 |
| 55+ | 2.4 | 1.14 - 5.06 | **0.02*** | 2 | 0.89 - 4.51 | 0.1 |
| | | | | | | |
| **Education level** | | | | | | |

 

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| | | | | | | |
|---|---|---|---|---|---|---|
| no education | **Reference** | | | | | |
| Primary | 1.3 | 0.95 - 1.78 | 0.1 | 1.26 | -0.11- 0.57 | 0.18 |
| Secondary | 1.68 | 1.04 - 2.71 | **0.03*** | 1.5 | -0.1- 0.91 | 0.12 |
| Higher | 1.05 | 0.77 - 1.43 | 0.746 | 4.10 | 0.79 - 21.12 | 0.09 |
| | | | | | | |
| **Husband's education level** | | | | | | |
| no education | **Reference** | | | | | |
| Primary | 1.09 | 0.77 - 1.54 | 0.63 | 1.16 | 0.79 - 1.7 | 0.44 |
| Secondary | 1.52 | 0.92 - 2.5 | 0.1 | 1.51 | 0.88 -2 .59 | 0.13 |
| Higher | 4.52 | 0.6 - 34.19 | 0.14 | 4.24 | 0.54 - 33.24 | 0.17 |
| don't know | 5.21 | 0.7 - 38.66 | 0.11 | 2.75 | 0.35 - 21.57 | 0.34 |
| | | | | | | |
| **place of residence** | | | | | | |
| Urban | **Reference** | | | | | |
| Rural | 0.81 | 0.54 -1.22 | 0.32 | 0.9 | 0.59 -1.39 | 0.65 |
| | | | | | | |
| **Working** | | | | | | |
| No | **Reference** | | | | | |
| Yes | 1.49 | 1.12 - 1.98 | **0.01*** | 1.79 | 1.33 - 2.43 | **<0.001*** |
| | | | | | | |
| **husband/partner working** | | | | | | |
| No | **Reference** | | | | | |
| Yes | 1.8 | 1.26 - 2.57 | **<0.001*** | 2.98 | 1.95 - 4.53 | **<0.001*** |
| | | | | | | |
| **wealth index** | | | | | | |
| Poor | **Reference** | | | | | |
| Middle | 1.35 | 0.94 -1.93 | 0.1 | 1.43 | 0.98 -2.1 | **0.047*** |
| Rich | 1.52 | 0.99 -2.33 | 0.06 | 1.46 | 0.93 -2.29 | 0.1 |
| | | | | | | |
| **heard family planning on the radio** | | | | | | |
| No | **Reference** | | | | | |
| Yes | 0.87 | 0.67 -1.14 | 0.32 | 0.67 | 0.51 -0.9 | **0.01*** |
| | | | | | | |
| **seen family planning on Facebook, Twitter Instagram** | | | | | | |
| No | **Reference** | | | | | |
| Yes | 1.04 | 0.55 -1.96 | 0.9 | 0.68 | 0.35 -1.32 | 0.25 |
| | | | | | | |
| **distance to a health facility** | | | | | | |
| big problem | **Reference** | | | | | |
| It is not a big problem | 1.18 | 0.89 -1.55 | 0.25 | 1.38 | 1.02 -1.86 | **0.03*** |
| | | | | | | |
| **number of living children** | | | | | | |
| 0 | **Reference** | | | | | |
| 1-5 | 1.73 | 1.16 -2.58 | **0.01*** | 1.72 | 1.1 -2.69 | **0.02*** |
| 6+ | 1.49 | 0.86 -2.55 | 0.15 | 1.58 | 0.88 -2.86 | 0.13 |
| | | | | | | |
| _cons | 1.59 | 0.8 -3.18 | 0.19 | 0.21 | 0.1 -0.47 | **<0.001** |

**Source:** Author's Computations

 

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## DISCUSSION

Married women aged 35-49 demonstrate significantly higher odds of participating in making all three informed decisions (on sexual relations, contraceptive use, and reproductive health) compared to those aged 15-24. This finding is steady with studies that suggest older women generally tend to have greater experience, confidence, and social capital, which can enhance their decision-making autonomy (Adedini et al., 2014; Fagbamigbe et al., 2020). This can explain why older age groups (35-49) may have accumulated more life experiences, exposure, and knowledge, contributing to enhanced decision-making capabilities.

The study also observed that employed married women had higher odds of participating in making informed decisions on sexual relations, contraceptive use, and reproductive health compared to those who were not working. Working empowers women and provides them with financial independence. This empowerment may translate into more freedom to choose their schedules and exercise regimens. (Motley, 2016; Mosha et al., 2016).

Moreover, married women whose husbands or partners were employed demonstrated substantially higher odds of making all three informed decisions than those whose spouses were not working. This finding may reflect the broader socioeconomic equilibrium of dual-earner households, providing an even more encouraging environment for women's independence (Tumlinson et al., 2015b). An employed spouse might correlate with a more stable economic environment, creating a conducive atmosphere for informed decision-making.

On the wealth index, middle-class married women had slightly higher chances of making all three informed decisions than their economically disadvantaged counterparts. This is consistent with research showing that women's empowerment and autonomy depend heavily on a healthy financial balance (Bongaarts, 2020). This could be attributed to improved access to resources, education, and healthcare, factors that influence decision-making positively.

The current study revealed that married women who had heard about family planning on the radio had lower odds of making all three informed decisions than those who had not received such information. This counterintuitive finding could suggest that learning about family planning alone is insufficient without comprehensive training and direction to implement those numbers (Cleland et al., 2014). Women who have heard about family planning may face societal pressures or biases that impact their decision-making in ways not captured by the available data.

On the perception of distance to a health facility, married women who did not consider it a significant issue had higher odds of making all three informed decisions than their counterparts who perceived it as a significant concern. Physical proximity can influence how easily women search for and get care, therefore accessibility to healthcare facilities is crucial (Kruk et al., 2016). Perceiving distance to a health facility as a non-issue may indicate better access to healthcare services. This improved accessibility can empower women to make informed decisions regarding their health and well-being.

Lastly, the study also found that married women with 1 - 5 children were likelier to make all three informed decisions than those with no children. According to Upadhyay et al. (2014), women who are parents may also possess more practical experience and a stronger interest in decisions related to health, which may enhance their autonomy. This may be because having experience with child-rearing can enhance a woman's confidence and decision-making abilities, allowing her to consider the well-being of herself and her children.

## CONCLUSION

The study reveals several factors that are among the primary influences on married Tanzanian women of reproductive age to make informed decisions about using contraceptives, having sexual encounters, and reproductive health

 

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concerns. Compared to younger married women (15–24), older married women (35–49) are more likely to make informed judgments, "Perhaps due to their enhanced social connections and life experience,". A stable economic environment and financial independence are important, as demonstrated by the increased likelihood of informed decision-making displayed by both employed women and those whose spouses are employed. Additionally, middle-class women make very well-informed decisions, which is a sign of consistent financial security. For a fair period, their children behave better and do better academically as a result. Fascinatingly, the study discovered that women who got their family planning information from the radio were less likely to make well-informed choices, suggesting that knowledge on its own is inadequate without thorough counseling. Having children and being able to access healthcare facilities were also found to be major determinants, with better parenting experience and access improving women's autonomy in making decisions.

**Recommendation**

Targeted education and empowerment programs should be introduced to improve informed decision-making among married women in Tanzania. Economic empowerment efforts are critical for creating supportive decision-making settings by expanding employment possibilities for women. Improving healthcare accessibility requires investments in infrastructure and mobile health services. Community-based support groups should be expanded to provide practical information and address social constraints. Further research is needed to understand the mismatch between radio-based family planning information and real decision-making. Addressing these areas can enable women to make educated decisions, boosting their overall well-being and autonomy.

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