



Couple Relations, Decision-making Hierarchy and Use of Maternal Health Care in Rural Uganda

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Abstract:

Although social relations are often cited as important in improving maternal health, in Uganda, little attention has been directed at understanding how couple relations influence maternal health decision-making. The article presents results on the influence of men's superior role in the allocation of family resources on maternal health care decision-making. Through a survey both men and women responded to questions on who makes and influences the decisions that affect women's maternal health care. There were significant gender differences in decision making for purchase and sale of land, purchase of household items and gardening. Gender biased decision-making significantly affected the choice for number of children, skilled care at childbirth and women's movement to visit family and friends. The study concludes that for positive maternal health behaviours, women need good relations with their spouses not only to gain support but as well access the resources which are controlled by men.

Key words: Hierarchy, Couple Relations, Social Relations, Maternal Health, Household, Decision-Making and Uganda

Background

This article is discussed basing of existing evidence on the effect of social relations and health (Berkman 1995). By

definition, social relationships refer to the character of ties that individuals have with others in society. According to Berkman (1995), social relations are often defined as one or two strong connections with a spouse, other family members or a very close friend. It could be neighbourhood ties, informal community networks, or civic engagements. These are standard features of social capital. The effect of social relations on health can be contradictory, especially when embedded opportunity is controlled (Hall and Taylor 2006). It all depends on the nature of relations and the status of the individual in the community ((Berkman et al. 2000).

Social relations are part of factors that enhance individuals' and communities' capabilities to cooperate and advance efforts to improve their health (Ibrahim 2006). However, most literature that refers to developing countries on social relations and maternal health is predominately on individuals and others, rather than the close ties at the family level (Beegle et al. 2001; Blanc 2001; Allendorf 2010). In this research, family relations in particular couple relations are assessed to determine their impact on household level maternal health seeking behaviours. In the context of maternal healthcare access in Uganda, family relations play a key role and need not be generalised, women after marriage depend on their marital families for their wellbeing and access to resources (Doss et al. 2012). In this research it is discussed that women's healthcare decisions depend on their husbands mainly because of the hierarchical control of family social and economic resources.

According to Hall and Taylor (2006), social relations in health follow two important traditions of study of society – the first category is that of Emile Durkheim who saw societies as interconnected wholes joined by personal relations and collective consciousness from which people derive emotional substance and a sense of self. The second perspective of Karl Marx put more emphasis on relations of domination where

individual relations are affected by differences class, status and power. This a foundation for analysing social resources embedded in social relations and the attached economic resources. The two dimensions, social connectedness and social hierarchy give a basis for promotion of maternal health through analysing of the nature of social relations that women experience during pregnancy. In this case the need for quality couple relations follows both aspects; there are benefits in couple connectedness because men will care for the maternal needs of their partners and difficulties because gender inequalities puts men and women in different positions that make it difficult for understanding and considering women health needs during pregnancy.

Quality of family and couple relations are common concepts in the areas of maternal healthcare access that are unfortunately not well explored in developing countries (Allendorf 2010). The strength of a marital relationship is associated with better health including better self-rated health and less depression. Allendorf 2010, article on the quality of family relationships and use of maternal healthcare in India, gives a distinction between the differences in attachment on family relationships for the developed world settling such as in the United States and United Kingdom where individual marital relations are more important and for developing countries in the south where marital relations extend to the entire family relations. At an individual level, good marital relations have been associated with odds of timely and adequate antenatal care, improvement of emotional well-being during and after pregnancy and reduces high risk of smoking and drinking during pregnancy. On the other hand women who experience domestic violence are more likely to have poor self-reported health and suicide thoughts and experience other health problems.

The other aspect of couple relations is women's decision-making. Women in most developing countries have restricted

decision making abilities that are as a result of differences in gender roles and family social hierarchy (Bankole and Singh 1998; Ashraf 2009). Evidence shows that communities where women's decision making and movement is restricted, experience higher maternal mortality rates (Wilkinson 2005; Navarro 2009). Also, women's lack of decision making power affects efforts to improving overall maternal healthcare access (Derose et al. 2002). The restrictions result from both social and economic status of women (Alaba and Koch 2007).

The factors that undermine women's decision to access healthcare include: women's low education, lack of control over household assets and overall lack of autonomy and low social position at both household and community levels (Ensor and Cooper 2004; Furuta and Salway 2006; Parkhurst et al. 2006). Other studies have associated women's delays in making decisions to use healthcare to long distances to health facilities, lack of money, sudden onset of labour, lack of awareness and self-motivation among women who have always delivered, and lack of motivation derived from bad previous experience at health facilities (Ndomugenyi et al. 1998). It is also evident that women's relations are responsible for different forms of delay and barriers to accessing maternal healthcare (Allendorf 2010). In Uganda, women's reproductive health decisions are limited by their reliance on their husband's control of household assets (Parkhurst, et al. 2006).

According to Eswaran (2002), women who have no stake in household assets are at a disadvantage and cannot make independent reproductive healthcare decisions. A small increase in women's assets has potential effects on decision making to use reproductive health services. For example, in Indonesia, a wife's higher share of assets is also associated with higher chances of giving birth in a hospital, at a private clinic or at home with a midwife in attendance (Beegle et al. 2001). Therefore, women's decision making determinants are diverse and complex and are not only social but economic, political and

psychological. They are about women's living conditions including their ability to control and influence their own life. Even in societies where the extended and nuclear family structures are rigid like India, the quality of a woman's relationship with a husband was found to significantly determine if a woman will use ANC. The relationship with in-laws was not significant (Allendorf 2010). Despite all of this evidence, the tendency, such as in the work of Thorlindsson (2011), is to ignore how individual social relations with the immediate social environment and the broader social structure of societies are connected to population health (Berkman 1995). Individual relations are important and according to Wilkinson (2006), within these relations, people become sensitive to pride and shame, acceptance and rejection. Social wellbeing is not a matter of stronger social networks alone, it is low control, insecurity, and loss of self-esteem which predispose psychosocial risks to poor health and economic circumstances (Wilkinson 1997). These aspects of people's relations with family and friends determine health behaviours and outcomes. It is therefore this social world dominated by marginalisation and inequality that affect health. To Wilkinson (2009), the up and down of the social hierarchy makes social interaction almost impossible. In an unequal relationship, domination and subordination, superiority and inferiority and respect and disrespect affect the quality of relations. The quality of family relations has been found to be linked to women's ability to make decisions about their own mobility and healthcare choices. Physical abuse and relationship conflicts predispose to poor prenatal health behaviours like alcohol abuse and smoking (Kimbrow 2008).

Decision making hierarchy on the other hand is a description of how decisions within a household are based on one position. Within households decision making in respect to acquisition, allocation and use of household and personal resources follow a hierarchy. It is socially determined among

communities that men are the sole decision makers including when to have sex (Wolff et al. 2000). Hierarchical social structures in which men have a higher status create expectations about male and female behaviour of which females are expected to be submissive to males (Eagly 1983). Unlike connectedness, social hierarchies such as gender inequality impinge on health in a number of ways; they expose individuals to less control of work plans and thus experience stress and anxiety (Wilkinson 2005). Differences in social roles command prestige in one group of people who are left to determine the distribution of status. Gender and ethnic groups are the two major forms of informal hierarchies that are known for their powerful stereotypes that affect self-esteem and the person's capacity to care for their health (Wilkinson 2005; Whitehead Margaret 2006; Cornwall et al. 2007).

Most of Uganda's culture and community practices do not provide for couples' public intimate relations, making it difficult for policymakers to determine the need to regulate and monitor relationships. For creating a linkage with society and policy, conclusions are made to establish a linkage between maternal health and domestic relations laws. Uganda is among African countries that have had the Domestic Relations Bill that is not being translated into policy for quite some time now (Nakitto 2009). The Domestic Relations Bill addresses women's property rights and equal sexual rights, but has been met with a lot of controversy that is largely cultural (Giovarelli 2006). For incorporating the community values and norms attention needs to be paid to the role of community-based participatory approaches of understanding and improving family relations and women's empowerment as a whole (Kreuter et al. 2003). Although most of the available literature is in the areas of domestic violence and women land access (Kreuter et al. 2003), evidence shows that, to promote justice and equality at the micro level, family relations are institutional and should be regulated (Nakitto 2009).

Family Structure in Rural Mbarara, South-western Uganda

According to Kimbro (2008), a family structure is an important determinant of health disparities. Social and economic inequalities at the community level have been found to determine family structure trends towards single motherhood, divorce and gender based domestic violence (Wilkinson 2005; McLanahan and Percheski 2008). In Uganda, marriage is a fundamental relationship in all societies, linking not only the husband and wife but also their families (Caldwell et al. 1992). Before marriage parents and other relatives organise ceremonies that include payment of bride-wealth by the man's family to signify acceptance of union into marriage by the two families (Kreuter et al. 2003). Marriage shapes sexual practices, childbearing and rearing as well as economic opportunities and the nature of individual and family relations. Like in most of Ugandan communities, rural Mbarara families are predominately patriarchal whereby when women get married they move to the family of a man who controls the allocation of family resources. Like among most communities around the country, women marry at a much younger age as compared to men. Many women marry before their age of 18, according to the 2006 DHS data, the median age of first marriage was 17.8 for women ages between 20 and 49 years (Green and Mukuria 2009).

Rural Mbarara is mainly inhabited by the Banyankole tribe and people practice both agriculture and animal husbandry as major economic activities. In most of rural Mbarara, the family is a mix of nuclear and joint/extended families. Being a patriarchal community, when a woman gets married, she moves to the family of her husband where, in most cases, there is daily contact with in-laws. The nature of these family contacts determines the couple relations. In most cases, it is the duty of the woman who is married to maintain the

relationship with her in-laws. In the case that a marriage does not work, at whatever age, a woman is expected to move back to her parent's home. This is the pattern that influences the nature of the couple relations.

Methods

The data used in this paper are from a field survey that was carried out in December, 2010 in 4 sub-counties of Mbarara District, Uganda. These communities are predominantly agricultural, and farm work is the major household activity on which men and women spend their time. A household survey was conducted among 202 females, aged 20 to 49 years, and 66 males, ages 20 to 60+, who responded to questions on use of division of labour, maternal healthcare, decision making, role sharing, and gender relations. In addition, seven key informants were interviewed and seven focus group discussions were held, (4 with women and 3 with men), to gain an in depth understanding of role sharing in the community. Likert scales were developed to study variance in agreement on who does most of the work and the gender differences in attitudes towards the selected categories of house work. The 2006 National DHS supplied overall national statistics on the subject matter.

The statistical analyses included cross tabulations, bivariate correlations, and Analysis of Variance (ANOVA), which controlled for the effect of age, education, level of education, main source of income, use of alcohol and main source of information. All statistical tests were carried out against a bench mark level of significance of $\alpha = .005$. Level of education for the respondent and the, spouse, main source of income, alcohol consumption and source of information were controlled for. There was significant multi-co linearity for most of the independent variable. The main limitation of the study is

that it was limited to how spouses share roles excluding the other members of the family and workers.

Presentation and Discussion of Findings

The results in this chapter only focus on household level decision-making process indicating that there are differences made by men and those made by women. The results also include data on couple relations and discussion of the impact on use maternal healthcare. To measure quality of couple relations, the study asked questions that looked out for fear and experience of partner violence, helping with work around home, having open discussions with a partner and having time to plan for family needs. The other part of the finding in this chapter is about the correlations between and quality of couple relations and decision-making for use of maternal health care.

Maternal health Care Variables

As it is with the rest of the thesis, this chapter looks at household-level factors that determine use of ANC during the last pregnancy, family planning and use of skilled delivery care by asking about the place of last childbirth. For most of the respondents (67%) the community health centre, which in this case is a health centre IV is their first place that they seek medical advice. While 98% attended ANC, at least once, most of the respondents had their first ANC visit between 4 & 7 months (51%), only 36% had their first ANC visit in the first 3 months of the last pregnancy. The findings are related with the national figures which indicate that 94% of pregnant women attend ANC at least once. The average age at the national level is also estimated at 5.5months. The higher percentages in this study could be attributed to the fact that the study was carried

out within a radius of about 15kms from the government health centre IV¹.

This study found that a significant number of women do not deliver with assistance of skilled personal or in a health facility. Thirty three percent (33% - N.93) had their last childbirth at home, 26% (N.73) at a private clinic and 40% (N.113) in a Government aided health facility. These statistics show that access to skilled care at birth is still very low. At the national level, the 2006 DHS data reported that only 42% of the deliveries were assisted by a skilled personal and 23% delivered with assistance of a traditional birth attendant (UBOS 2006)a. In 2009 the deliveries in a health facility were estimated at 34% (UBOS 2010). Another related study has rated delivery with assistance of a skilled person at 39% (Parkhurst et al. 2006).

This study found that by the time of the survey, only 48% (N.136) are using a modern contraceptive to control for pregnancy and 52% (N.147) were not using any method. When asked if the last pregnancy was intended, 62% (N.176) said yes, 25% (N.71) said no but did not mind being pregnant and 13% (N.36) did not at all intend to be pregnant. The common family planning method used is Depo-Provera. This is a three months hormonal shot given to prevent pregnancy. The other methods were used by one or two people (Baird 2000). The percentages show that there is an obvious unmet need for family planning with a mixed picture of having no choice. Results indicate that 25% of people would not mind being pregnant, a finding that could be interpreted as a lack of choice on fertility decisions. The study data shows that 88% (N.249) are aged between 20 and 39 years, an indication that the study participants were largely young. In relation with the national figures, the 2011 DHS report show Uganda's unmet need for family planning stands at 34% of currently married women. The contraceptive

¹ A Health Centre IV is a mini hospital which serves a county or a parliamentary constituency. It is a lower level from the district hospital and is planned to offer inpatient maternity services including cesarean section.

prevalence rate among married women stands at 30% and 52% for sexually active unmarried women (UBOS 2012).

Maternal Health Care and Household-level Decision-Making

The study found out the differences among husbands and wives in decision-making on family resources and use of maternal healthcare. At the time of the survey, it was reported that 95% of the households are headed by husbands/men. Husbands make 93% of the decisions regarding purchase of land and 78% of sale of land of which only 22% of women can make decisions to sale land. On the reverse, women make 95% of decisions regarding gardening and men only make 5%. The difference could be attributed to the other finding in this research which indicated that 74% people who spend more than 6 hours of their normal day on farm work were women. Also women in Uganda, women provide more than 70% of farm labour but with unequal access to land (World Bank 2011). The 22% of women who can make land sale decision making could also be attributed to Uganda's law on spousal consent on sale of land. Other studies have found a degree of land co-ownership between husband and wife (Doss et al. 2012). However, the influence women on allocation of household resources leaves a lot to desired if women are to influence what they need for maternal healthcare need.

Regarding decision making and access to maternal health services, the study participants were asked questions such as “*who decides among a husband and wife the number of children a family should have, who decides if a woman should deliver in a hospital and who decides when to go for ANC?*” Study participants were also asked who decides on family expenditure, if a child has to go to school, about the wife's visit to friends and relatives and gardening. They were also asked on a scale to determine how influential they feel their decisions are

both at home and in the entire community. Twenty one percent say decisions on the number of children a family should have are made by the wife, 33% by the husband, 45% both and only less than 1% said others. The other was recorded as a mother in-law. It is men who influence majority of the decisions on family property and resources, this quotation from one of the individual interviews confirms men's sole influence on household decision making *....when a man is not at home a woman cannot sell a goat to take a sick child to hospital. She has to wait for the husband to ask for permission although when a woman is not at home the man makes decisions on family property without her consent (Chairperson Local Council I – Rubindi Kashari Mbarara)*

While 61% say they can decide on the number of children to have, 37% of them cannot. However, all the 37% of the respondents who cannot decide on the number of children were women. Another question was asked to women alone: *“can you decide on the number of children to have?”* 61% of them said yes and 38% said no. During the qualitative interviews, the main reason that women gave for not deciding on the number of child was that when a women refuses to have children, the man gets them from other women and brings them home under their care. The following is the expression showing why men are the most decisive: *“....if you refuse to have children the man will marry another women and you will be the one to care for them in one way or another”* (Women Group Discussion, Rubindi April 2011).

It was found that men make 62% of the decisions to attend ANC and 71% of the decisions about where to deliver. Of all factors, majority of women in the study reported to make most (95%) of the decisions regarding gardening. The reason behind this discrepancy is that women are the ones who do most of digging and women were found to spend at least 6 hours per day on farm work. The rest of the decisions which were investigated were made by men. On average, women make

less than 20% of family decisions. While the majority of the decisions on the number of children a family should have were said to be joint (45%), men (45%) are believed to be responsible for more decisions on family size than women (33%). The following expression quoted out of one the discussions gives further evidence on the effluence of men in the reproductive health decision making: *Women are not decisive in their homes what men decide is what is right (mixed gender FGD Rwebishekye May 2011)*

Other related decision making questions were about the woman's movement and her freedom to use the household resources, particularly land and income. 73% say a husband makes most decisions regarding a wife's movement including visiting friends and 79% of income decisions. These finding are in agreement with national data, according to the 2006 DHS data, women make only 15% of decisions on purchase of large household items and 35% for daily household purchase. Twenty two percent of women can make decisions that affect their own health, only 20% of women can make independent decisions to visit friends or family and 36% of these decisions are by husbands (UBOS 2006).

In related studies it has been found that couples in Uganda are not certain of the partner's choices for the number of children because of poor couple communication and relations. According to Hollander (1997), couples in Uganda seldom openly discuss about use of contraceptives and in many instances both partners claim to have been to suggest that they use them. Some women use a method without their partner's knowledge. A later study by Wolff et al. (2000), found that 27% of women did not know their partner's wish with respect to contraceptive use and future child bearing choices. While men were more confident that they know their partners' desires, 10% did not know their partners fertility intensions. With this analysis, the next section of this chapter, discusses the state of couple relations with data partner violence and communication.

Another study had found that women's use of contraceptives is another case of domestic violence, in the study by Koenig et al. (2003), women who insisted on use of condoms or were found to use contraceptives without their partners knowledge were reasons for being physically abused by their husbands.

Quality of Relations Variables

On the other hand, to determine the quality of relations, respondents were asked questions on how husbands and wives relate with each other. The study also examined fear of partner being violent and if ever experienced domestic violence. Unlike in most studies where the focus is on physical and psychological violence against women, which is an indicator of negative couple relations (Kaye et al. 2006; Cook and Bewley 2008), this study also includes positive indicators of the relations. This was to comprehensive analysis household relations since maternal healthcare access is already complex in nature. For example, while social support from family and friends has been associated with access to maternal health (McCaw and Binns), according to Allendorf (2010), restrictions on women movements and poor quality of family relations resulting from gender hierarchy, lead to negative health outcomes (Wolff et al. 2000). Negative relations such as physical violence lead to foetal mortality and failure to access ANC and skilled delivery (Kearney et al. 2004).

However, comprehensive analysis of couple relations lack examples since most literature mainly focuses on domestic violence. In this study, domestic violence is examined as well as positive couple relations such as health with work at home and planning together which also may improve couple communication. Whereas domestic violence has been found to create fear and anxiety among women and thus limit access to maternal healthcare (Kearney et al. (2004), in this study, the couple's willingness to work together around the home, helping

with housework and feeling of respect for each other is argues that it builds self esteem, sense of control and sense of security which then promotes positive prospects for maternal healthcare. Examining both the negative and positive factors has helped to provide a measure of the quality of family relations and the respective affects on women's access to ANC, skilled delivery and use of modern family planning methods. The relevance of positive relations in maternal health is in agreement with a statement by Kearney et al. (2004) which states that:

Good quality marital relations benefit maternal health increasing the odds of timely and adequate antenatal care, improved emotional wellbeing during and after pregnancy and reduce high risk behaviours like smoking and drinking.

Therefore, for the purposes of contributing to knowledge on strategies to promote good maternal health practices, this research extends the analysis to positive relations like working together around the home, willingness to help with work at home and planning for family needs together. Planning is important especially during pregnancy and has been found to contribute to increased chance of using skilled birth care during childbirth. A recent study in rural Mbarara has found significant results between birth planning and skilled birth attendance with increased likelihood when a husband is involved (Kabakyenga et al. 2011). Helping with housework around the home is also known to reduce women's housework burdens and in this research it has been found to enhance couple cooperation and planning for maternal health (Mannino and Deutsch 2007).

This study found out that domestic violence is prevalent among rural household of Kashari County, Mbarara District. While the findings of this study revealed that only 3% (N.8) of married people fear that their spouses can be violent, 39% (N.110) have ever experienced physical violence by their

spouses. On exploring further about the most recent experience of physical violence (the last 6 months before the survey), it was found out that 47% (N.133) said they never experience violence in the last 6 months, 23% (N.65) said violence by the partner occasionally happened, 21% (N.59) said sometimes and 9% (26), were found to experience frequent physical abuse by their partners. It can therefore be estimated that about 5 in every 10 partners in Kahari County, Mbarara District experience physical violence within the last 6 months at the time of the survey. This figure is close to another study which rated intimate partner violence at 54% (Karamagi et al. 2006). Nationally experience of domestic physical and sexual violence is rated at 70% (UBOS 2006).

While these statistics show high level of domestic violence, when respondents were asked if they felt that their spouses treat them with respect, 80% (N.226) say they extremely feel that their spouses respect them. This finding could be related with the widely accepted belief that it is okay for a man to beat his partner/wife and the widely accepted reasons being neglect of children and a wife going out of home without informing the husband (UBOS 2012). However, the question on violence was answered by only a half of those who answered the question on respect for each other. This may be an indication that some people did not want to disclose in they do not feel respected by their spouses.

The other questions that were used to measure the quality of relations were about willingness to help with housework and if they feel they can have open discussions with their spouses: only 29% (N.83) say their spouses are willing to help with work around the home, 46% (106) say they frequently help and 13% (39) said their spouses never help with work around home.

Table 1: Relationship Status Based Upon the Spouses' Willingness to Help with Housework

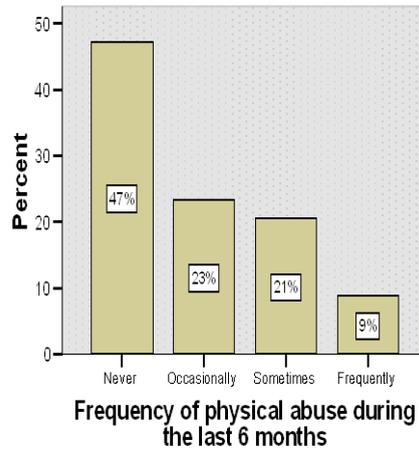
Question	Response			
	1. Never	2. Occasionally	3. Sometimes	4. Frequently
Spouse willing to help with work around the home	14% (39)	19% (54)	38% (107)	29% (83)
Having open discussions with a partner	15% (43)	13% (36)	26% (74)	46% (130)
Spouses working together	27% (76)	27% (76)	29% (83)	17% (48)

The implication of these findings is that spouses can be defined and understood with other indicators, it should mostly be about communication. According to Kimbro (2008), the relationship status of a pregnant woman with the father of the child is a source of emotional and social resources that determine pregnancy outcome.

Table 2: Rating the Quality of a Relationship with a Spouse

Factor	Responses			
	1. not at all	2. a little bit	3. quite a bit	4. extremely
Feeling of being treated with respect by the partner	3% (N.9)	6% (N.17)	11% (N.31)	80% (N.226)
Feeling of being treated unfairly	50% (N.142)	23% (N.65)	17% (N.48)	10% (N.28)
Fear of spouse becoming violent	38% (N.108)	45% (N.128)	14% (N.40)	3% (N.9)

Figure 1: Frequency of Physical abuse by a Partner during the Six Months



Couple relations and culture are linked together. Traditionally men are away from home and women keep the homes most of the time. This figure is a graph showing frequency of physical abuse by a partner. 47% say they have never been physically abused by their partners, 23% say it is occasionally, 21% sometimes and 9% experience frequent physical abuse by the partner.

In total 53% of married people in Kashari Mbarara district, have experienced or are experiencing physical violence by their spouses. The community experiences poor maternal health behaviours. For example, the study found that 39% of deliveries were not attended by skilled personnel and there is 64% unmet need for family planning. Studies have found that women who experience physical abuse are less likely to use maternal health services (Kaye et al. 2006). Also good quality marital relations influence a husband's understanding of the needs of a pregnant wife (Allendorf 2010). However, most couple relations in Uganda and most of sub-Saharan Africa are dependent on informal social structures dominated by dominance and power relations that propagate violent and unequal couple relations (Kaye et al. 2005). In the following

Table is a presentation of statistics on how people felt about their influence in the immediate environment and then within the community. The data in the table reveals a general feeling of being secure at both community and household levels a finding that contradicts with women’s lack of powers to influence intra-household resource allocation bargaining (Angwal 1997) but at the same time confirms strong social ties within the community.

Table 3: Individual Opinion about their Position in the Community and at Home

Factor	Responses			
	1. Not influential at all	2. Occasionally Influential	3. Sometimes Influential	4. Very Influential
Rating the position of a household in the community	9% (N.24)	21% (N.60)	30%(N.86)	40% (N.113)
Rating one’s position in his/her home	0.4% (N.1)	5% (N.14)	30%(N.85)	64% (N.183)

Determining the Effect of the Quality of Couple relations on Household-level Reproductive Health Decision-making

This study does not disregard effect of other maternal health care access barriers such as quality of health service, lack of information, income, education levels and long distances to the health facilities reported by other studies in the same field of study. The following statement that was made in one of the focus group meetings shows that people still to be informed about family planning methods and their effect on hormonal changes. *I fear family planning methods, they made my wife bleed and I ended up paying about 500,000/- on her medical care, this is not equivalent to caring for a sick child which costs 10,000/- (mixed gender FGD Omukabaale May 2011)*

Although women’s lack of decision making power is often linked to their low social economic status (Shen and Williamson

1999), social factors, especially social position, is as important for women’s reproductive health (Furuta and Salway 2006). This section of the study findings is about how intra-household factors affect the quality of relations and eventually the maternal health outcomes. The qualities of relations were measured using the questions on how men and women perceived their spousal relationships. To test for significance, the responses were correlated with decisions for family planning (P-value 0.003), ANC (P-value 0.001) and skilled birth attendance (P-value 0.023). The correlation tests were all significant at the P-value ≤ 0.05 . In the next Table are the details of the bi-variate correlations between decision-making to use ANC, skilled attendance and family planning with variable for quality of couple relations.

Frequency of open discussion with a partner was found to significantly determine use of ANC, skilled birth and family planning. Since communication enhances trust, partners who have honest discussions with each other have positive reproductive health behaviours. This finding is also in agreement with a study by Dudgeon and Inhorn (2004) on men’s influence over women’s health that presents men as important actors in women’s health, specifically because of their role in the social hierarchy.

Table 4: Measuring the Effect of Quality of Relations and Decision-making for use ANC, Skilled Delivery Care and Family Planning

Independent Variables (quality of relations)	Who decides the number of children the family should have?	Can you decide the number of children you would like to have?	Who makes most of the decision regarding wife going for antenatal care	Who makes most of the decision regarding wife going to hospital to deliver
Considered head of household	Pearson Correlation	-.141*	-.040	-.100
	Sig. (2-tailed)	.019	.563	.094
	N	283	283	283
Position of your household in your community	Pearson Correlation	.093	-.008	.436**
	Sig. (2-tailed)	.120	.912	.000
	N	283	283	283

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I feel my spouse treats me with respect	Pearson Correlation	.154*	.058	.024	.090
	Sig. (2-tailed)	.010	.405	.695	.132
	N	283	283	283	283
I feel my spouse treats me unfairly	Pearson Correlation	-.138*	-.144*	.029	-.018
	Sig. (2-tailed)	.022	.037	.631	.760
	N	283	283	283	283
I fear my spouse may be violent	Pearson Correlation	-.118	.056	.081	.047
	Sig. (2-tailed)	.052	.423	.180	.436
	N	283	283	283	283
Frequency of willingness to help with work around home	Pearson Correlation	.099	.072	.215**	.177**
	Sig. (2-tailed)	.101	.293	.000	.003
	N	283	283	283	283
Frequency of doing work together around home	Pearson Correlation	.026	.031	.177**	.109
	Sig. (2-tailed)	.661	.658	.003	.068
	N	283	283	283	283
Frequency of open discussion with partner	Pearson Correlation	.177**	.102	.193**	.136*
	Sig. (2-tailed)	.003	.136	.001	.023
	N	283	283	283	283
Have had time with partner in the last 6 months to plan for the family needs	Pearson Correlation	-.138*	.015	-.059	.011
	Sig. (2-tailed)	.022	.832	.327	.856
	N	283	283	283	283

** Correlation significant at the 0.01, * significant at .005 (2 tailed).

The study by Blanc (2001) suggests that equal power relations and the quality of couple communications are important in improving access to sexual and reproductive health services. Frequency and willingness of partners to help with work at home affects ANC and skilled delivery. However, more than 90% of housework is done by women with no help from their spouses. The individual perception of their household status in the community also determines ANC and skilled care. Unlike family planning, ANC and delivery in the hospital/skilled delivery were often significantly associated with almost the same factors. At the same time, the factors that were significantly associated with family planning were not associated with ANC and skilled delivery.

Family planning was significantly associated with the head of the household, partners' openness during discussions (P-value - .003), and planning together (P-value - .022). The feeling that one is being treated with respect (P-value - .010) and if a spouse feels treated unfairly (P-value - .022) were associated with decisions on the number of children. Frequency and willingness of a spouse to help with work around home (P-value - .003) and the position of the household in the community (P-value - .000) were associated with the decision to use ANC and hospital delivery. Open discussions with a partner had a crosscutting effect.

It shows in the above bi-variate correlations that decision making power lies with the head of the household – the husband. It is the husband who determines the number of children the couple should have and so with the family planning choices. The quality of relationship in terms of working together around home, respect for each other and planning together are important for decision making regarding use of maternal health services. Therefore, couple relations are a significant factor in improving maternal healthcare access.

Although the percentage of women who attend ANC is higher than that of skilled care, the two were found to be affected by almost the same quality of relations factors, open discussions among couples, frequency of helping with work at home and other factors. The reason for this discrepancy is that while ANC and skilled delivery are based at health facilities, ANC has a lower cost as compared with skilled delivery (Nahar and Costello 1998). Other studies have associated low use of skilled delivery. ANC is used by most women to find out the safety of the pregnancy (Kruk et al. 2007).

This study found that a husband more than a wife makes most of the social and economic decisions in the household. Men's authority extends to women's mobility and decisions to spend money and to take children to school. According to Allendorf (2010), husbands' restrictions on wives'

movements affect their use of maternal healthcare. Also, intra-household male-female decision making dynamics on allocation of resources affect reproductive decision making. The balance of power, fairness and justice of gender relationships, impact and condition women's health behaviours (Moss 2003). Poor family relations, and communication among couples in particular, make women vulnerable to unwanted and unplanned pregnancies (Wolff et al. 2000).

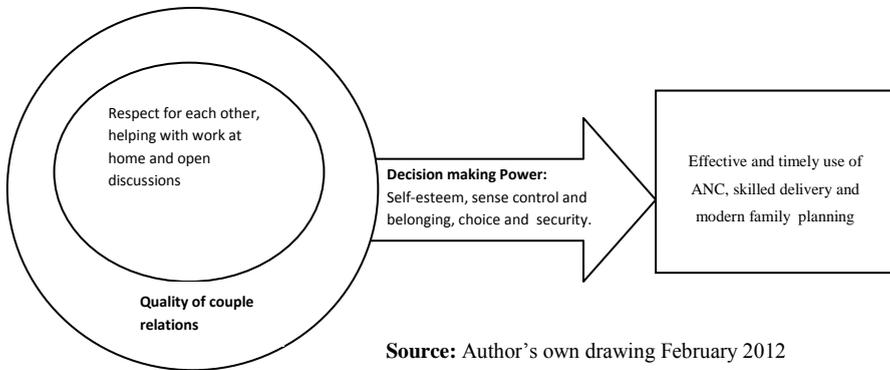
Examining the effect of the quality of couple relations, the study also found that respect for each other, willingness to help with housework and open discussions significantly influenced women's use of maternal health services. Decision making power to access maternal healthcare, especially ANC and skilled delivery depends on the quality of relations between husband and wife. This study found that it is willingness to help with work at home, respect for each other and lack of physical violence that are important for women's health prospects. Quality of relations improves couple communication and consensus in decision making that is needed for responsible maternal health. The couple relations are also tested because of the controlling behaviour of men supported by patriarchal authority. The following statements show the control women have on their wives: *It is becoming difficult every day, in fact I always advise men not to make a mistake and have all their children from one wife, the women will be difficult to manage. This could be why our grandparents had many wives.* (60 year old man – opinion leader, Kashare April 2011). *It is true that women who live in fear of their husbands are vulnerable to producing many children. Women in many cases use children to compensate for their lost relationship with their husbands* (LC II Chairperson Rwebishekye May 2011).

Since household relations are important in determining household decision making for resource allocation (Bolt and Bird 2003), from this perspective, the quality of relations with husbands is a resource for women's maternal healthcare needs.

Men are in control of most of family resources needed by women to access healthcare, 95% of households were found to be headed by men. It is the quality relations through communication, planning and helping with work that will help men understand the reproductive health needs of women. The double benefit with relieving women of housework hour during pregnancy, it improves couple relations and could reduce the opportunity cost time barrier presented by Parkhurst et al. (2006).

The following framework is an illustration of the decision making power embedded in the quality of couple relations. The framework is intended to illustrate how maternal healthcare decision making power depends on women's self-esteem and sense of control which are dependent on the sense of belonging. It is also argued that the choice to seek maternal healthcare results from a feeling of respect for each other, helping with work around the home and open discussions. Also, the framework shows that women who feel treated unfairly by their spouses, and fear or have experienced domestic violence are less likely to decide on their own when and whether to use maternal health services. This argument is in agreement with other studies which have found that women who experience partner violence experience poor maternal health (Moore 1999; Lawoko et al. 2007)), and that good self-care during pregnancy depends on good quality marital relations (Kimbrow 2008). The illustration below shows that women gain their self-esteem from the quality relations with their spouses and will feel secure to make healthy reproductive health choices. Therefore, components of maternal healthcare decision making power are self esteem, sense of control and belonging, choice and security.

Figure 2: Determining the Implications of Decision-Making Power and Quality of Couple Relations on Maternal Healthcare Access



Source: Author's own drawing February 2012

Better social relations are known to benefit health (Kawachi et al. 1999). The above framework is illustrating the components of quality couple relations which are characterized by respect for each other, helping with housework and couples having open and regular communication with each other promote use of maternal healthcare. In the previous sections of this chapter it was indicated that women after marriage depend on their husbands for decision making and so Figure 11 above illustrates that women experience of supportive relations within their homes will give self-esteem, and sense of control and belonging and so will effectively care for their reproductive health needs. Therefore, women with good couple relations have a sense of security in their relationships and are able to make independent choices. The resultant effect of good couple relations is women's high prospects for healthy maternal health practices.

Conclusions

The quality of couple relations is determined by the nature of communication. Commonly, a husband directs the

nature of couple relations mainly because of his socially constructed role of being a head of the household. Violence is also another significant factor determining the nature of couple relations in Kashari County Mbarara District. This study found out that more than 5 in every 10 women have experienced physical violence by their marital partner. This study found that positive aspect of marital relations helping with work at home and planning together enhance positive maternal health behaviours. Household couple relations uphold emotional, physical and social resources needed to attain effective maternal healthcare demand. Women have limited control over allocation of household resources and a sense of control improves their confidence and security in making positive maternal health decisions. Open discussions with a partner have a crosscutting effect on women's decision making to use family planning, ANC and skilled care at child birth. However, couple relations in most of Kashari County are characterised by domestic violence and gender inequalities in the position on men and women. Women are expected to respect their husband/partners which in many ways may limit ability to communicate at the same level.

A balanced decision-making process where husbands and wives mutually communicate with each other improves couples knowledge and understands of each other's reproductive health needs. Respect for each other, helping with work at home and open discussions among couple are resourceful for maternal health because they are a source of self esteem, sense of control and belonging and enhance for timely use of antenatal care, skilled delivery and family planning. On the contrary unequal gender relations can tension and insecurity and thus promote negative effects on maternal health.

Open discussions also build women's confidence regarding the support of their spouses and men's cooperation in maternal healthcare. Family resources are controlled by

husbands and so couples need to openly discuss and plan for family needs including maternal healthcare. Also helping with housework together was significantly associated with decision to go for antenatal care. This is confirmation that women's labour burdens are important in access to skilled care at childbirth.

Culturally women are expected to be submissive to their husbands and men are expected to be heads and leaders of the family. This hierarchy puts a husband and wife in different positions making it difficult for spouses to relate as partners but instead as superiors and subordinates. When a woman does not submit she may miss out on the opportunities of being part of the family and benefiting from her husband's decisions. Women are always required to meet the needs of the husbands and if not, they may be abandoned for other women.

There is an underlying fear which makes women succumb to producing many children to fill the relationship gap with their husband. The fear of divorce has been found to significantly determine women's change of fertility plans and choices. Women's decision-making authority and self esteem is negatively affected by the superior-inferior relationship between husbands and wives. Respect for each other and helping with work at home creates a decision-making environment conducive to women's access to maternal healthcare whereby there are chances for improving couple communication.

Three factors have been associated with the social hierarchy on maternal health. The first factor is that society assigns men and women different responsibilities which have attributes to their social economic position at both family and community levels. Secondary, unlike women, men's positions give them powers to make decisions that in many cases are not favourable for women's health. Thirdly women with quality relations with their spouses have better maternal health seeking behaviours because can better communicate their

healthcare needs. Therefore, in a setting such as rural Mbarara where women depend on their spouses for almost all household decision, quality of the relationship with a husband is a resource for women's reproductive health.

Although the passing of Uganda's Domestic Relations Bill into law remains controversial, the policy challenge remains how to improve couple relations. This study's findings indicate that couple relations are important for maternal health and require that they are regulated by the Domestic Relations Laws. For purposes of being accepted within the cultural settings, attention needs to be paid to the role of community-based participatory approaches to improve family relations and women empowerment.

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