Intra-household Social Determinants of Demand for Maternal Health Services in Mbarara District, Uganda

Viola Nilah Nyakato

A Thesis Submitted to the Institute of Interdisciplinary Training and Research (IITR) as a Fulfilment for the Requirements of the Award of Doctor of Philosophy in Development Studies of Mbarara University of Science and Technology

October 2013

Declaration

I Viola Nilah Nyakato, declare that this thesis is my original work and has not been previously presented by me or any other person to this university or any higher institution of learning for any academic award.

Signature:

Date: 07/November 2014

This thesis has been supervised and is being submitted with my approval as a supervisor.

Name: Prof. Charles B Rwabukwali

Signature:

Date: 07/November 2014

Dedication

To my elder sister Barungi Criscence who has continued to sacrifice all that she has in the spirit of care for her siblings, and to my children Titus Ndekezi Rukundo and Erinah Mutuuzo Ninsiima.

Acknowledgements

It would not have been possible to write this doctoral thesis without help and support of kind of people around me, to only some of whom it is possible to give particular mention here.

First and foremost, I am grateful to my supervisor Prof. Charles B Rwabukwali of the Department of Sociology and Anthropology, School of Humanities and Social Sciences, Makerere University, Kampala Uganda. Prof. Charles B Rwabukwali's scrutiny and encouragement from the beginning enabled me to go through all the obstacles in the completion of this thesis. It is his continued academic guidance and support that enabled me produce this piece of scholarly work.

I acknowledge the support of the Vice Chancellor of Mbarara University of Science and Technology, Prof. Frederic I.B. Kayanja. I am grateful for his inspirational leadership and trust in my ability. I am indebted to the encouraging parental guidance of Prof. Kayanja.

I am grateful to the Deputy Vice Chancellor, Assoc. Prof. Pamela Mbabazi, for her continued moral, academic and financial support towards my PhD Studies. My family and I shall forever remember her generous financial support towards the July 2009 open heart surgery of our daughter Ninsiima Erinah Mutuuzo. Without Assoc. Prof. Mbabazi's support towards our daughter's open heart surgery at the Escorts Heart Institute in New Delhi, India, my dream for this PhD would have taken a different path.

I would also like to thank the Academic Registrar, Mr. Stephen Bazirake, for his steadfast encouragement to complete this thesis. I would like to thank Mr. Bazirake for being available to give me counsel whenever I was faced with obstacle.

I also acknowledge the support of Prof. Wim Pelupessy, of the Institute of Development Research (IVO), University of Tilburg, Netherlands. I thank him for the insights he shared during the initial years that formed this thesis. I am grateful for the support of the Dean, Assoc. Prof. Muriisa Roberts.

Besides academics and work, I have had a supportive family. My husband, Mr. Gad Ndaruhutse Ruzaaza, and my children, Titus Rukundo and Erinah Ninsiima, have made me what I am today. I thank them all for their patience regarding the busy schedule of a too-often unavailable wife and mother. My mother, Mrs. Nalongo Mfasoni Mugarura, and my father, Mr. Salongo Pony Mugarura, have been wonderful and loving parents. My Mummy and Daddy would always come to my house at a moment's

notice, to check on my children whenever I would busy with my studies. Furthermore, I thank my brothers and sisters, Chris, Clare, Colleta, Leonard (RIP), Adrian, Monica and Nicholas, for their support. In a special way I want to thank Ms. Susan Asasira, who has been caring for my children since 2010; every time I was away.

Furthermore, I am grateful for the financial support and skills development opportunities provided by the following institutions: Mbarara University of Science and Technology (MUST), The Netherlands International Agency for Higher Education (NUFFIC), the Population Reference Bureau (PRB) in Washington DC, the Organization of Social Science Research in East Africa (OSSREA), and the Centre for International Governance Innovation (CIGI), University of Tilburg and Dalhousie University, Association of Commonwealth Universities UK and School of International Development, University of East Anglia (UEA), UK. I would like to extend sincere gratitude to Dr. Karin Ringeim of PRB, Dr. Owen Willis from Dalhousie University, Prof. Nitya Roa and Prof. Ben Jones of UEA for their mentorship during my academic fellowships at the respective institutions. I am grateful to Ms. Ruth Makoff and Dr. Charles Lugo for their assistance with proof reading and language editing.

Finally, I thank God for His blessings. I thank God for my family and for all people and organizations that gave me support throughout my study period. May the Good Lord continue to bless all of you.

Table of Contents

Acknowledgements iv
List of Figures ix
List of Tables x
Map of Uganda xi
Map of Mbarara District Showing Counties and Sub-Counties xii
List of Acronyms xiii
Definition of Terms xiv
Abstract 1
CHAPTER ONE 2
Introduction 2
1.0 Introduction 2
1.2 Intra-Household Gender Relations and Maternal Health Decision-Making 5
1.2 The Social Determinants of Health Perspective 9
1.3 Maternal Health and Care in Uganda 12
1.4 Problem Statement 15
1.5 Study Justification 17
1.6 Study Aims 18
1.6. 1. Specific objectives 18
1.6.2 Hypothesis 18
1.6.3 Research questions 19
1.7 Thesis Structure 20
CHAPTER TWO 22
Theoretical Framework and Literature Review 22
2.0 Introduction 22
2.1 Maternal Health Care as a System 23
2.1.1 Social Determinants of Health and Maternal Health Care 25
2.1.2The Theory of the Social Determinants of Health 27
2.1.3 Understanding Social Determinants of Health from the Household Level Perspective 30
2.1.4 Contextualisation: Household Determinants of Maternal Health Care Demand 33
2.2 Addressing Intra-Household Inequalities to Improve Demand for Maternal Health Care 38
2.2.0 Introduction 38
2.2.1 Perspectives on Household Inequalities 38
2.2.2 Intra-household Decision-Making and Maternal Health Care 42
2.2.3 Gender Relations and Women's Property Rights in Uganda 43
2.2.4 Gender Dimensions of Access to Maternal Health Care 45
2.2.5 Initiatives on Gender Equality and Maternal Health Promotion 49
2.2.6 Primary Health Care Aspects of Social Determinants of Health 52
CHAPTER THREE 57
Study Setting and Methodology 57
3.0 Introduction 57
3.1 Description of the Study Area 57
3.2 Study Design and Data Collection Methods 60
3.2.1 Sampling Procedure 63
3.2.2 Validity and Reliability of Instruments 65
3.2.2.1 Validity of Instruments 66

3.2.3 Data Collection Methods 66
3.2.4 Qualitative Methods 68
3.3 Overall Ethical Consideration 70
3.4 Study Limitations 70
CHAPTER FOUR 72
Gender Inequality in Household Labour: Implications on Demand for Maternal Healthcare in Uganda 72
4.0 Introduction 72
4.1 General Socio-demographic Characteristics of the Study Participants 72
4.1.1 Sample Socio-demographic Characteristics for the Household Survey 73
4.1.2 Socio-demographic Characteristics of the Household Survey 74
4.1.4 General Information on Household Health and Access to Health Care 78
4.1.5 Presentation and Discussion of the General Descriptive Data on the Maternal Health Services 80
4.1.7 Cross tabulations for maternal services and selected household socio-demographic characteristics 85
4.1.8 Measuring the effect of general health status of household members and use of antenatal care, family planning and skilled care during child birth 87
4.2 Gender Inequality in Household Labour: Implications on Demand for Maternal Health Care in Uganda 94
4.2.0 Introduction 94
4.2.1 Gender Relations and Demand-Side Health Care Barriers 94
4.2.2 Status of Maternal Health and Healthcare in Uganda 96
4.2.3 Disparities in Gender Roles at the Household Level 97
4.2. 4 Presentation and Discussion of Findings 98
4.2.5 Household Division of Labour and Demand for Maternal Healthcare 103
4.2.6 Gender Differences in Attitudes towards House and Farm Work 106
4.2.7 Conclusions 109
CHAPTER FIVE 111
Women, Land and Maternal Healthcare Demand in Rural Uganda 111
5.0 Introduction 111
5.1 Customs and Women land Ownership 112
5.1.1 Women and Land Access in Uganda 114
5.2 Presentation and Discussion of Findings 115
5.2.1 General Land Ownership Variables 115
5.2.2 Descriptive statistics on Decision-making and Control of Land 117
5.2.4 Bivariate Correlation Coefficients for Land Ownership and Use of Maternal Health Care 121
5.2.5 Determining the Level of Significance between Land Ownership, Decision-making and Maternal Health Care 122
5.2.6 Intra-household Land Decision-making Dynamics and Use of Maternal Healthcare 124
5.3 Land Decision-Making and Prospects for Improvement of Maternal Health Care Outcomes 129
5.4 Conclusions 131
CHAPTER SIX 133
Couple Relations, Decision-making Hierarchy and Use of Maternal Health Care in Rural Uganda 133
6.0 Introduction 133
6.1 Social Relations and Health 134
6.1.1 Family Structure in Rural Mbarara, South-western Uganda 137

6.2 Presentation and Discussion of Findings 138
6.2.1 Maternal health Care Variables 138
6.2.2 Maternal Health Care and Household-level Decision-Making 140
6.2.3 Quality of Relations Variables 142
6.2.4 Determining the Effect of the Quality of Couple relations on Household-level Reproductive Health Decision-making 146
6.3 Conclusions 151
CHAPTER SEVEN 154
Integrating Intra-Household Social Determinants of Health into the Delivery of Mbarara District Lower Primary Health Care 154
7.0 Introduction 154
7.1 Primary Health Care and Decentralisation of Uganda's Health Care System 155
7.2 Understanding the Performance of Kashari Health Sub-District Primary Health Care Structures 159
7.2.1 Integrating Intra-Household Determinants of Use of Maternal Health Care in the Lower District Primary Health Care Centres. 165
7.3 Conclusions 169
CHAPTER EIGHT 171
CONCLUSIONS AND RECOMMENDATIONS 171
8.0 Introduction 171
8.1 The Research Aim, Thesis Problem and Literature Gaps 172
8.2 The Research Methodology and the State of Maternal Health Care in Kashari County, Mbarara District 173
8.3 Explaining the Impact of Gender Division of Household Labour on the Use of Maternal Health Care among Rural Populations of Kashari, Mbarara 174
8.4 Intra-Household Income and Land Decision-Making Dynamics in Kashari, Mbarara 176
8.5 Intra-Household Couple Relations and the Decision-Making Hierarchy in Kashari, Mbarara 178
8.6 Primary Health Care Integration of Intra-Household Maternal Health Determinants 179
8.7 Overall Conclusions 180
09. References 186
Annex A: Question Guide for Lower District Health Services Assessment 209
Annex B: Household Survey Questionnaire 211
Annex C: Interview guide for Individual and Group Discussions in Communities on Social Determinants of Demand for Maternal Health Services in Kashari, Mbarara, Uganda 223

List of Figures

Figure 1: CSDH Conceptual Framework and Entry Points for Intervention 29

Figure 2: Bullseye's Model of Social Determinants of Health 32

Figure 3: An illustration of the effect of intra-household factors on demand for maternal health care– *'going beyond institutional and community factors'* 35

Figure 4: Interplay between Household Factors; Possible Ways for Getting Out of a Health Poverty-Trap 41

Figure 5: Survey Variables 63

Figure 6: Household Main Source of Income 76

Figure 7: The Household Head 77

Figure 8: Daily roles of men and women 99

Figure 9: Household Division of Labour Determinants of Use of Maternal Health Care 108

Figure 10: Bar Graph on Gender Differences on Decision-making Regarding Sale and Use of Family Land 120

Figure 11: Frequency of Physical abuse by a Partner during the Six Months 145

Figure 12: Determining the Implications of Decision-Making Power and Quality of Couple Relations on Maternal Healthcare Access 151

Figure 13: Differences in Opinion about Health Priorities among Health Workers and Community Leaders 167

Figure 14: Household Factors Associated With Use of ANC, Skilled Delivery and Family Planning Services .. 183

List of Tables

Table 1: Selected Socio-demographic Characteristics of the Household Survey 75

Table 2: General Information on Household Health and Access to Health Care 79

Table 3: Use of Contraceptives 81

Table 4: Decision-making on the Number of Children 82

Table 5: Use of antenatal Care during the Last Pregnancy 82

Table 6: Assisted in during the Last Childbirth 83

Table 7: Number of Times a Husband has been Present during Childbirth 84

Table 8: Household Decision-Making for Use of ANC, Skilled Care at Birth and Number of Children 85

Table 9: Determining the level of significance between respondents' socio-demographic characteristics and use of maternal services 86

Table 10: Measuring the effect of general healthcare access information and use of antenatal care, family planning and skilled care during child birth 89

Table 11: Descriptive Percentages on the Attitudes towards Division of household/farm work 100

Table 12: Descriptive Statistics (Standard Deviation) about household-level attitudes towards division of house and farm work 102

Table 13: Intra-household Time Use and Access to Maternal Health Services 104

Table 14: Gender Differences in Time Spent on Child-care 105

Table 15: Ranking of Selected House and Farm-work Related Activities by Gender 106

Table 16: Intra-household Land Use Decision-making Dynamics 118

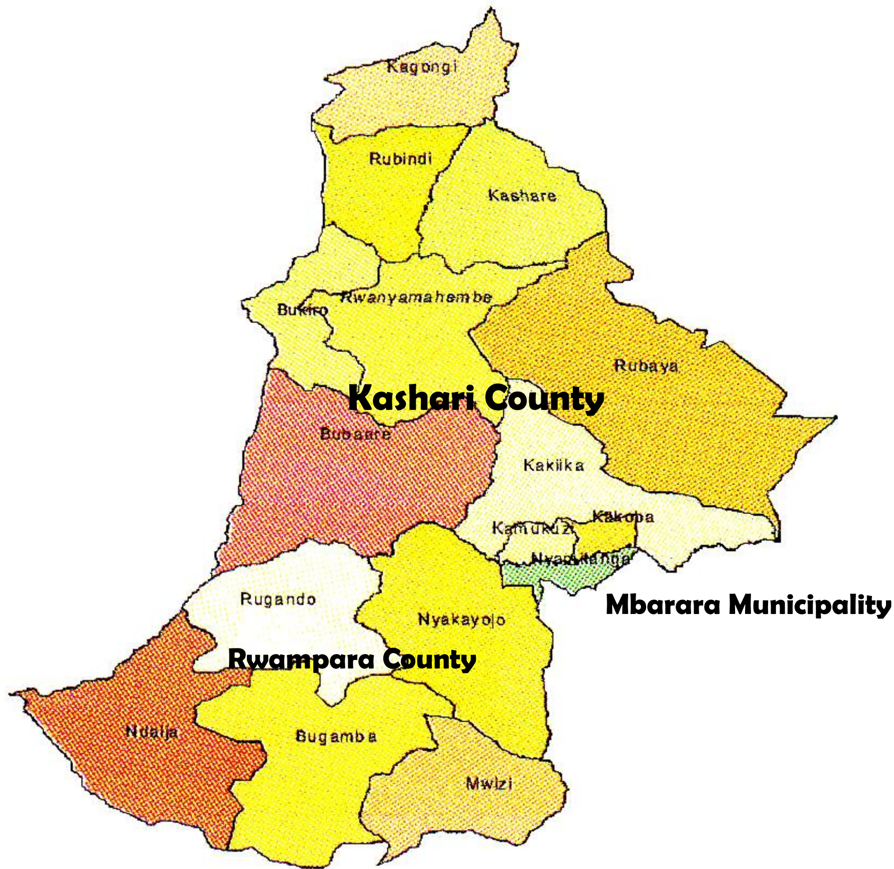
Table 17: Land Ownership, Decision-Making and Maternal Health Behaviours 123

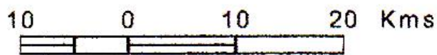
Table 18: Land Use Decision-making Dynamics and women's Access to Maternal Health Services 126

Table 19: Relationship Status Based Upon the Spouses' Willingness to Help with Housework 144
Table 20: Rating the Quality if a Relationship with a Spouse 144
Table 21: Individual Opinion about their Position in the Community and at Home 146
Table 22: Measuring the Effect of Quality of Relations and Decision-making for use ANC, Skilled Delivery Care and Family Planning 147
Table 23: The 2009 Priority Budget Areas for Kashari Health Centre IV –Bwizibwera 161
Table 24: Top contributors to burden of disease in Kashari Health Centre IV –Bwizibwera 162

Map of Uganda

Map of Mbarara District Showing Counties and Sub-Counties





List of Acronyms

AFFORD	AFFORD Health Marketing Initiative
ANC	Antenatal Care
ANOVA	Analysis of Variance
BOD	Burden of Disease
DHO	District Health Officer
EGPAF	Elizabeth Glaser Paediatric Aids Foundation
FGD	Focus Group Discussions
HC	Health Centre
HSSP	Health Sector Strategic Plan
LC	Local Council
MDGs	Millennium Development Goals
MJAP	Mulago-Mbarara Teaching Hospitals Joint AIDS Program
PHC	Primary Healthcare
PNFP	Private Not for Profit
PFP	Private for Profit
SDH	Social Determinants of Health
SPSS	Special Package for Social Scientists
TB	Tuberculosis
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
UGX	Uganda Shillings
UMHCP	Uganda Minimum Healthcare Package
WHO	World Health Organization

Definition of Terms

Antenatal Care (ANC): a branch of medicine that deals with prenatal and postnatal care for women during and after pregnancy and childbirth. ANC is an indication of access and utilisation of care during pregnancy (WHO 2012).

Division of household labour: the way in which housework, including labour on a farm, is distributed by gender. In most Ugandan households, division of labour is gendered in such a way that women and girls do most of the domestic roles and men and boys do most of the work outside of the home. As women and girls spend more time on domestic tasks, they have less time than their male counterparts for leisure, career development and earning income[i]. In Uganda, more young girls than boys drop out of school because of these gender expectations. Fewer young women than men enrol in secondary education.

Family planning: is a program to regulate the number and spacing of children in a family through the practice of contraception or other methods of birth control (WHO 2012).

Healthcare demand: in healthcare, utilisation of health services is an indicator of demand. When healthcare demand exceeds utilisation, it means consumers are unable to receive care due to factors such as insurance coverage, affordability and accessibility. Psychological (fear and pride) and demographic (age, gender, income and occupation) factors are the two major influences of healthcare demand (Vickery and Lynch 1995). In this study, the terms demand, use and utilisation are used concurrently.

Household: For the proposes of this study, the terms household and family are consistently used to mean a group of people who live together in one house, or separate houses, but share a compound, and cook and eat together on a daily basis. Only households in which the couple stays together for at least six months a year, and has a child aged 5 years or younger, were included in the survey for this research.

Intra-household Cooperative Conflict: because a household is composed of various individuals, conflicts of interest arise. These conflicts of interest have potential to create a spectrum of intra-household dynamics, ranging from non-cooperative to cooperative households (Sen 1987). Unequal access to strong fallback positions creates a situation in which individuals within the household have more or less bargaining power, and therefore have more or else influence over household decision-making (Agarwal 1997).

Skilled birth attendance: A skilled birth attendant is an accredited health professional, such as a midwife, doctor or nurse, who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns. Traditional birth attendants, whether trained or not, are excluded from the category of skilled attendant at delivery. In developed countries and in many urban areas in developing countries, skilled care at delivery is usually provided in a health facility (WHO 2012).

Social Determinants of Health: these are the ways in which economic and social conditions are distributed among population(s). They are factors that influence individual and group differences in health status. They are risk factors found in one's living and working conditions, such as distribution of income, wealth, influence and power (Marmot 2005).

Social gradient of health: a concept used in the measurement of the impacts of health inequality, that measures an individual's or group's position in society. It correlates one health to one's socioeconomic position, whether measured by income, occupational grade, or educational attainment (Kawachi, Subramanian et al. 2002).

Women's decision-making: for the purposes of this study, women's decision-making is the ability of a woman to autonomously make and influence decisions that affect her maternal health needs. It includes freedom of movement to visit friends, relatives, health facility and markets and to have sex. Women's decision-making also includes the ability to make choices on how to spend family income and the use of resources like land to cultivate (Wolff, Blanc et al. 2000).

Resources/land ownership: for the purposes of this study, this is about whether a household owns land, whatever the size or location. Most importantly, the study looks at who makes the decisions regarding the usage and sale of land. For this area of Mbarara District, land is the predominant source of livelihood.

Social relations: social relations, also commonly referred to as social interactions, refer to a relationship between two or more individuals (Berkman 1995). In this study, the focus is placed upon the manner in which men and women, particularly husbands and wives relate to one another.

Abstract

This thesis examines intra-household social determinants of the use of maternal healthcare among in Mbarara District, Uganda. Effective use of antenatal care, skilled delivery and family planning are essential components of the Safe Motherhood Initiative and crucial for decreasing maternal mortality, yet many women in Uganda still find difficulties in accessing these services. Nationally, less than 6 in every 10 births are attended by skilled personnel and less than 5 in every 10 women attend the recommended four antenatal visits. In Uganda, the fertility rate is estimated at 6.2 children per women. Evidence shows that poor use of maternal healthcare has multiple manifestations which can be distinguished between those directly affected by actual accessibility and those indirectly affected through the indirect effects of household decision-making. This thesis examines the indirect determinants of use of maternal health care with a specific analysis of the effects of household division of labour, land decision-making and couple relations among households in Kashari County, Mbarara District.

A cross sectional mixed methodology research design was used and data was collected using a survey questionnaire from 283 households, 7 individual interviews and 10 focus group discussions. In 2009, data was collected to assess how lower district level primary healthcare programmes integrate household level factors; 4 health workers and 6 community leaders were interviewed. In 2010, data was collected on household characteristics and use of maternal health services.

The 2009/2010 study found significant gender inequalities in the division of labour, household labour, use and ownership of land and couple relations. A statistical analysis indicated that household labour is inversely associated with maternal healthcare use. Although land was found to be largely owned and controlled by men, it is an economic resource and a source of women's daily occupation; it is on land that women spend more than 6 hours of their daily work. The study found that whereas at least 7 in every 10 women felt insecure on their family land, only 2 men in every 10 men shared such fears. Land use decision-making was found to significantly influence skilled birth attendance and ANC.

The quality of couple relations was found to determine decision-making for the use of family planning and skilled care at birth, which was associated with men's symbolic role as household heads. Husbands made 79% of income-related decisions and 73% of women said their husbands decide on their movements such as visiting friends. There was a significant level of poor couple communication whereby 15% of the respondents felt that they had never had open discussions with their spouses. In this study it was found that about 62% of women used skilled care during the last delivery and only 34% of women used contraceptives all the time. The study also found that family hierarchy limited women's decision making and socially constrained maternal healthcare decision-making.

Whereas the lower district health facilities are Primary Health Centres established to be sensitive to the social and economic needs of the community, the study hardly found any practices that were directed towards dealing with household factors. Uganda's lower district level healthcare system structures, though designed to support community engagement, follow Local Government administrative devolutions that do not deal effectively with intra-household living conditions.

In conclusion, the first step to address household level determinants of maternal health care use is to improve women's ability to exercise choice and mitigate the consequences of their decision-making. Women in Kashari County, Mbarara District were found to have limited claims on allocation of household resources, a factor that largely determines the significant gender inequalities in maternal health decision-making among husbands and wives. This thesis discusses gaps in dealing with intra-household factors within Uganda's PHC Strategy and recommends reorientation towards integration of intra-household decision-making.

Key words: Uganda, maternal healthcare, social determinants of health, healthcare demand, inequality, household labour, couple relations, land, policy, women and gender.

CHAPTER ONE

Introduction

1.0 Introduction

Globally, an estimated 287,000 maternal deaths occurred in 2010 of which, Sub-Saharan Africa accounted for 56% of the deaths followed by South Asia at 29%. Sub-Saharan Africa had the highest maternal mortality rate of 500 maternal deaths per 100,000 live births. A total of 40 countries, Uganda inclusive, had the highest MMR (defined as MMR ≥300 deaths per 100,000 live births) (WHO 2010). Specifically for Uganda, maternal mortality stands at 435 deaths per 100,000 live births (UBOS 2006; Hogan et al. 2010). Sub-Sahara's large proportion of maternal deaths has been attributed to poor quality healthcare, malaria, HIV/AIDS and restricted use of maternal healthcare linked to women education and empowerment (Bhutta et al. 2010). In addition, poor access to basic maternal health services – unmet needs for family planning (40.6%), skilled care during child birth (65%) and antenatal care at 4+ visits (51%), was responsible for the high MMR (WHO 2010).

While the debate to improve maternal healthcare through improvement of service delivery has remained dominant (Campbell and Graham 2006), the utilisation of maternal health services is a complex behavioural phenomenon (Chakraborty et al. 2003). Studies of determinants of healthcare confirm that the use of maternal healthcare is affected by a range of factors related to availability, quality and cost of services, as well as to the social structure, health beliefs and personal socioeconomic characteristics of the users (Ensor and Cooper 2004; Ajakaiye and Mwabu 2007; Ahmed and Khan 2011). Vickery and Lynch (1995) point out that utilisation of health services is an indicator of demand that depends on a combination of availability, quality and cost of healthcare.

In relation to the use of maternal healthcare in poor countries like Uganda, studies show that differences in education, income, women's status, and place of residence have a role to play in the use and non-use of services (Kyomuhendo 2003; Ensor and Cooper 2004; Ahmed and Khan 2011). In Uganda, women's lack of access to maternal healthcare is a result of a combination of factors that are related to the quality of health services, long distances to health facilities, women's lack of information and awareness, low

levels of education and income, domestic violence and women's lack of independence in deciding on their own healthcare (Kyomuhendo 2003; Kaye, Mirembe et al. 2006; Liljestrand 2006). With only about 2 in every 10 women deciding independently on their own healthcare (UBOS 2006), the importance of this thesis is that it examines this study is justified in pointing out the household level factors that limit women's maternal healthcare decision-making.

The 2011 Uganda Demographic and Health Survey (UDHS) asserts that, for the last five years, the country has registered no improvement in reduction of maternal deaths. The Maternal Mortality Rate (MMR) was estimated at 438 in 2011 as compared to 435 women who died in 2005 for every 100,000 live births (ibid.). According to the survey, the national fertility rate is among the highest in the world; approximately 6.2 children per woman. Women die as a result of complications such as severe bleeding, unsafe abortions and obstructed labour (source). These are mostly related to poor access to maternal healthcare. Only 58% of births are attended by skilled personnel and 47% of women attend the recommended 4 antenatal visits. In addition it has been observed that the contraceptive prevalence rate is 30% and the unmet need for family planning is 34% (UBOS 2006; UBOS 2012).

Whereas evidence indicating the household as a basis for delays in seeking maternal healthcare among developing countries is growing (Thaddeus and Maine 1994; Barnes-Josiah, Myntti et al. 1998; 2010), there is still limited analysis of the effect of women's daily living conditions. This thesis examines intra-household gender determinants of demand for maternal healthcare among rural households in Mbarara District, Uganda. It is premised on the understanding that inequity in gender roles and allocation of household resources influence access to the household social and economic resources needed to utilise maternal healthcare. It adopts Sen's model on gender and cooperative conflict to analyse the effect of gendered intra-household inequalities and decision-making (Sen 1987), and the Social Demands of Healthcare (SDH) approach as a theory concerned with how inequalities determine the health outcomes of populations and of individuals (Wilkinson 1997; Marmot 2005; Irwin and Scali 2007).

Gendered division of household labour, allocation of household resources and submissive behaviour cannot be isolated from women's living conditions. Evidence shows that most countries with poor maternal health outcomes are concurrently characterised by women's burdens in unpaid household and farm labour work and limited bargaining power in the allocation of household resources (Filippi et al. 2006). Therefore, this thesis examines the effects of division of household labour, couple relations and land use decision-making as determinants of demand for utilisation of family maternal health services –

antenatal care, skilled delivery and family planning among rural households in Mbarara District, Uganda. For purposes of relevancy and application of the research findings, the thesis further discusses integration of intra-household determinants of health into lower district health centres' Primary Health Care programmes. However, this study does not disregard the other health demand determinants such as household income level, women's education and the quality and availability of health services. The reason for focussing on household factors is to draw a broader analysis of factors that shape and delay decision-making in seeking care, from the perspective of women's social position within a household.

The thesis explores household determinants of demand for maternal healthcare by establishing a link between women's daily living conditions and maternal health behaviours. Further analyses integrate intra-household factors into the delivery of district lower health services – Health Centre IV downwards. Three basic maternal health services – family planning, antenatal care (ANC) and skilled care at birth have been used to investigate the intra-household determinants of maternal healthcare demand.

Marmot et al. 2008 point out that the health care system in itself is a determinant of health care decision-making, influenced by other social determinants. What determines decision-making to use maternal healthcare within a family demands examination. Sen (1987) in his cooperative conflict approach highlights two simultaneous problems faced by households in resource allocation decision-making. One involves cooperation (adding to the total resource availabilities) and the other conflict (dividing the total resource availabilities among the household). Household decision-making has also been explained using two factors; that women as mothers will perceive their welfare in relation to that of the entire family (Kabeer 1999) but at the same time perceive it as subordinate, since the social arrangements sustain gender gaps in control and ownership of household property (Agarwal 1997).

Whereas SDH theory gives a broader understanding of gender inequalities and maternal health (Marmot et al. 2006), it does not analyse the causes of gender differences in decision-making within the household. The original aspect of this thesis is the discussion of intra-household determinants of the use of maternal healthcare based on women's decision-making status as explained within the gender and cooperative conflict. The thesis integrates the broader view of household level inequalities by SDH with the specific analysis of the passive and dominant gender roles in the allocation and control of resources. The thesis argues that the control of women's reproductive decision-making by men undermines positive maternal healthcare. In this thesis, the words demand, utilisation and use are used concurrently.

The rest of this chapter proceeds as follow: Firstly is an outline of the Social Determinants of Health approach to introduce the main theoretical dimension for understanding the association between people's living conditions and health outcomes. Secondly is an examination of the gender dimension of living conditions to set out a more specific analysis of the factors underpinning the study. Thirdly is a brief synopsis of maternal health and healthcare in Uganda. This leads into discussion of research problems, justification, research aims and hypothesis and the research questions. At the end of the chapter is the thesis structure.

1.2 Intra-Household Gender Relations and Maternal Health Decision-Making

The 1980s was the advent of developing country literature on household decision-making dynamics and resource allocation (Doss et al. 2012). Sen's work on intra-household relations did not only lay the grounds for the capability approach but also influenced discussions on gender inequality in household resource allocation and bargaining (Sen 1987). His notion of family allocation captures the co-existence of conflict and perceived cooperation in the household arrangement and bargaining (Kabeer 1997; Rao 2012). In Sen's view, looking at households as aggregate entities without gender classification is misleading; men and women in the same family may well have divergent predicaments and women's inferior position within and outside the household is a problem of both female deprivation and poverty (Sen 1987). Low domestic power imbalances often with a gender connotation generate inequality and mediate opportunities to achieve well-being among household members (Iversen 2003).

The new reproductive health paradigms pay attention to gender relations, which influence both positively and negatively and directly and indirectly the reproductive outcomes of women (Dudgeon and Inhorn 2004). Maternal healthcare demand factors are often embedded in women's day-to-day social economic living conditions and culture (Magadi et al. 2000). Gender inequalities and women's roles are important determinants of women's access to healthcare (Oladeji 2008). For example, cultural preference for sons often characterises countries with poor maternal health indicators, mainly because of the limitations on women's fertility choices and eventually the use of family planning (Dodoo and Frost 2008). Marmot (2007) asserts that:

> Gender affects equal participation of women in political institutions from village to international level; unequal access to and control over property, economic assets and inheritance; unequal restrictions on physical mobility, reproduction and sexuality; sanctioned violence against women and girls' bodily integrity; and accepted codes of social conduct that condone violence and even reward sexual violence against women (Marmot 2007 p. 1155).

Women's lack of access to material living standards and lower social status within the social hierarchy has overwhelming powerful consequences on their health outcomes (Wilkinson 1997). Women do not only bear both social and economic deprivation but also lack economic assets and income due to their inferior positions at both community and household levels (Furuta and Salway 2006). Therefore, when discussing inequality selectively for women's health, there is a need to go beyond economic deprivations. For example, only developing countries which have comprehensively considered women's social and economic living conditions in the delivery of maternal healthcare programs are reported to be on track to reduce Maternal Mortality Rate and attaining the MDG goal for improving maternal health (Freedman 2005; Bryce 2008).

Hierarchies based upon gender determine the course of decision-making in many societies and constrain women's physical mobility (Furuta and Salway 2006). Women, like most poor communities, are a vulnerable group. They do not only fail to influence decisions that affect their lives but are also not in control of household income. In developing countries, women are victims of domestic violence and are faced with high levels of unpaid household and farm labour, as well as unemployment (Kyomuhendo 2003).

Cultural ideas about gender continue to represent women as subordinate; their rights and obligations are shaped by marriage and kinship rather than production (Kaye et al. 2005; Rao 2012). Their status depends on their roles as mothers and wives confined to domestic roles with less ability to speak out and make decisions pertaining to their health and well-being (Rao 2012). Understanding women's status and position in a household ultimately serves to improve strategies that promote utilisation of maternal health care. Women do not only struggle to access poor and long distance health services but are met with a need to negotiate for use of both household resources and services (Nanda 2002; Cottingham et al. 2008)

Whereas the role of women's status tends to form part of discussions on improving maternal health (Shen and Williamson 1999; Koenen et al. 2006), it is still a complex issue, especially when women remain a marginalised group in most communities (Selin, Stone et al. 2009). Their socioeconomic living conditions and status determines women's willingness to demand healthcare and influence the accessibility, acceptability and availability of healthcare (Whitehead 1991). While it is a fact that the high maternal mortality rates experienced in most developing countries can be attributed to poor

functional healthcare systems (Jitta et al. 2003), much could be achieved if women's social and economic status were to become a priority (Ensor and Cooper 2004).

Social and economic factors such as education, social networks, level of income, age, and rural or urban residence compose a health gradient (Becker et al. 1993; Celik and Hotchkiss 2000; Bloom et al. 2001; Penn-Kekana et al. 2007). Socioeconomic characteristics such as level of education, type of employment, level of income and residence affect utilisation of maternal health services and maternal health (Becker et al. 1993; Celik and Hotchkiss 2000; Dobrow et al. 2004). In Uganda, women are less educated than men such that 80% of females aged 60 and over, who often serve as cultural role-models for younger women, are illiterate and thus cannot read or write meaningfully in any language (UBOS 2006). The low socioeconomic status of women causes poor maternal health behaviours to perpetuate through generations (Kyomuhendo 2003). Because most women in Uganda belong to a lower socioeconomic class, they have limited power to influence whether, when and where to seek healthcare (Tebekaw et al. 2011). Most women's decisions to use maternal healthcare are predetermined by their spouses (Ensor and Cooper 2004).

It is women's economic status, gender relations, empowerment, and decision-making, inequalities in education, income and gender roles that constrain women's ability to access healthcare (Matthews et al. 1999; Marmot 2005). Male involvement in reproductive health is one aspect of approaches that acknowledge the predominant role of women's socioeconomic status in improving maternal health outcomes (Barker et al. 2011). In most communities in sub-Saharan Africa, male partners/husbands are key decision makers in questions of reproductive health (Watts and Mayhew 2004). In many societies in Uganda men's decisions have been found to have a potential impact on pregnant women's health behaviours (Wolff et al. 2000). In HIV/AIDS control programmes, the male role has been considered as a major player and contributor to community acceptance of prevention programmes such as use of condoms and community acceptance of Prevention of Mother to Child Transmission of HIV/AIDS (PMTCT) programmes (Byamugisha et al. 2010).

Hence, this thesis is a further analysis of the effect of women status and intra-household relations on use of maternal healthcare that specifically focuses on the gender dimensions of household labour, household resources decision-making and couple relations in Mbarara District, Uganda. Women's household labour burdens in Uganda are elaborated in the 2005 World Bank County Assessment, which reported a gender gap in time spent on household activities. The report found that males spent 8 hours of

the day on economic activities outside the home and only 1 hour on household activities such as fetching water, cooking, caring for children and the sick, and cleaning. Compared to women, men spent less time on farm work. Women spent 9 hours of a normal day on economic activities such as farm work and 6 hours on household activities (World Bank 2005). This is the 'double burden of women'(Hervey and Shaw 1998; Marshall 1998): women spend more time than men on both economic and unpaid household activities.

The other two study variables are quality of couple relations and land access, specifically land use decision-making. Couple relations are important since, according to the 2006 Uganda DHS data, at least 60% of women of reproductive age (15 to 49 years) have experienced domestic violence and 16% of them during pregnancy. Furthermore, women need to seek their spouse's permission to visit a health facility (Kyomuhendo 2003). In Uganda, land use and access is an important aspect of women's livelihoods. Whereas about 7% of women own land, 42% of women's labour is in agriculture and 90% of it is unpaid labour (UBOS 2010). Culturally, when a woman is divorced or her husband dies, land is taken back to the husband or the husband's family (Deininger and Castagnini 2006). On the other hand, women's access to land does not only boost agricultural production, but extends beyond economic benefits and plays a critical role in social status, well-being and basic female empowerment (Kabeer 1999; Tripp 2004). In many ways, land access is an important livelihood aspect that cannot not be ignored in the analysis of women's maternal health decision-making.

Therefore, this thesis examines how addressing factors such as couple relations, household labour burdens and women's access to land is a hidden pathway for improvement of maternal health in general and maternal healthcare utilisation in particular. Studies which have attempted to link this poor use of Uganda's maternal health services to basic demographic characteristics have found that factors such as education and income levels, women's social position and relationships contribute greatly to the health practices and attitudes towards healthcare of the entire family (Ndyomugyenyi et al. 1998; Wagstaff et al. 2004; Pakhurst et al. 2005; Xu, Evans et al. 2006; Kiwuwa and Mufubenga 2008).

These studies allude to two related factors that might explain the stagnating levels of maternal healthcare utilisation in Uganda. Firstly, reluctance to use maternity healthcare cannot only be attributed to high costs, poverty, or the long distances to the nearest health facility, but rather also to women's failure to be in control of decisions and family resources which directly affect their capacity to meet user fees and

transportation costs associated with seeking maternal healthcare services (Nanda 2002). Secondly, the evidence pertaining to location and residence indicates that unlike women living in urban areas, rural women are more likely to fail to use healthcare because of the distance and the quality of healthcare (Thaddeus and Maine 1994; Gabrysch and Campbell 2009).

Women's willingness and capacity to use maternal healthcare continues to be a challenge that can be improved through addressing social and economic factors embedded in intra-household living conditions. The importance of studying the household as a variable is its status as the primary producer and consumer of health and healthcare (Alaba and Koch 2007).

Factors such women's education, income, social relations, gender roles and empowerment have been found to play a significant role in the education sector regarding school enrolment and retention of the girl child (Bridges and Lawson 2008; Okumu et al. 2008). The unequally distributed household material and non-material resources, which vary by gender and decision making hierarchy, determine the use of health services (Becker et al. 1993; MacIntyre and Hunt 1997). Resources such as income and access to education are distributed according to hierarchies in which women tend to occupy the lower strata (Shelah et al. 2001). Globally, but particularly among poor nations, women are often not only restricted in their ability to make decisions about family resources, but also may not be in a position to decide whether or not to use available health services (Sandari 1992; Alaba and Koch 2007). Nevertheless, patterns of mortality and morbidity also follow these trends, making women the most vulnerable group (Coll-Black et al. 2007). Despite available evidence about the multi-faceted nature of maternal health and its determinants, Gabrysch and Campbell (2009) affirm that studies still concentrate on direct factors such as costs of services and distance barriers, quality of health care, medical personal and infrastructure development neglecting women's social determinants of maternal healthcare which are largely about socioeconomic barriers to accessibility.

1.2 The Social Determinants of Health Perspective

The study of SDH is about the social conditions in which people live and work and their relationship with individual health. SDH has three main theoretical dimensions. First is the psychosocial approach which is about the association between people's perception and experience of personal status in unequal environments. According to the theories of psychosocial approaches, the experience of living in social settings of inequality forces people to constantly compare their status, possessions and other life

circumstances, which leads to feelings of worthlessness and shame (Martikainen et al. 2002; Blane 2006). Second is the social production of disease, also known as political economy of health framework, which is about the political and economic determinants of health. This is approach argues that interpretation of income inequality and health must begin with the structural causes of inequality (Kawachi et al. 1999). The third category is the eco-social approach, which is about a multilevel framework that integrates determinates of population, distribution of disease and social inequalities. In this sense, disease patterns follow a social hierarchy whereby the rich tend to be healthier than those in middle class and the poor are the most unhealthy (Wilkinson 2006).

Krieger (2001) points out that the three frameworks highlight how social conditions are pathways for health. She observes that the socioeconomic status of women, availability of birth control technology and age of marriage have been linked to differences in women's health outcomes and exposure to diseases such as breast cancer (Krieger 1989). In addition, Ronsmans and Graham assert that deaths of over 500,000 women in developing countries are due to complications in pregnancy and childbirth (Ronsmans and Graham 2006). Women's level of education, place of residence, decision-making power and religious and cultural beliefs have an impact on the use of maternal health care (Kyomuhendo 2003; Say and Raine 2007). Women with higher levels of education and incomes tend to have a better ability to make decisions regarding use of contraceptives and skilled care during delivery than poor and less educated women (Filippi et al. 2006). Therefore, inequalities in power and control of women's decisions are important aspects of SDH and thus justify this thesis's application of SDH theory in assessing the household level determinants of demand for maternal health care by women in rural Mbarara, Uganda.

It is the social and gender inequality in control and allocation of household resources that makes it important to analyse barriers to accessing maternal health care within the SDH framework. If the healthcare systems are to achieve and sustain improvement of utilisation of maternal health care, there is a need to integrate household factors into women's health programmes. The concept of Primary Healthcare (PHC) promotes the idea of a universal minimum level of access to healthcare service to achieve some semblance of health equality (Bhutta et al. 2008). The focus of SDH upon inequality and health, combined with the focus of PHC upon equality in health, essentially makes these two concepts synonymous. The principle of universal access to healthcare requires that everyone within a country can access the same range of services according to needs and preferences, regardless of income, social status or residence and that people are empowered to use services (Marmot et al. 2008).

The SDH literature examines the negative impact of poverty and socioeconomic inequalities on health outcomes, including lack of access to services (Wilkinson 1997; Phelan et al. 2004; Marmot et al. 2008). However, the SDH literature is dominated by inequality and differences in disease patterns, mortality and morbidity (Leon and Walt 2001; Marmot 2005; Blane 2006), and does not necessarily address the public health concerns of health-seeking behaviours of the marginalised. Gender inequality is an important aspect of women's health across poor countries (Filippi et al. 2006) that needs to be mainstreamed in the SDH literature.

In the context of SDH theory, health inequalities are caused by differentials in power and control of resources, age, sex, neighbourhood, housing, education, income and employment (Navarro 2009). The explicit advantage of grounding this thesis in this approach is that the SDH literature distinguishes between health outcomes that are as a result of biological markers, and those that are due to social factors (Ichiro and Bruce 1997; Marmot 2005; Wilkinson 2006). Accumulating evidence demonstrates that poor social and economic living circumstances affect health throughout life (Macinko and Starfield 2001; Wilkinson and Marmot 2003; Wilkinson 2005). Material disadvantage, combined with the effects of insecurity, anxiety and lack of social integration affects the health of those at progressively lower levels of socioeconomic status (Dixon 2000). Evidence shows that individual health behaviour follows a social pattern. For example, the mortality rate among married people tends to be lower than that of the unmarried, of which men tend to have more benefits than women (Umberson 1992).

Other studies have found that marriage disruption through divorce affects women in terms of stress and loss of health-enhancing resources such as insurance (Lavelle and Smock 2012). Women's higher level of education has been associated with better maternal health behaviours (Simkhada et al. 2008). Other areas where social patterns are significant for health behaviours are smoking, substance abuse and nutrition (obesity and malnutrition) (Wilkinson 1999). While there is significant evidence about how social patterns make an important contribution to health, SDH literature remains much more about populations in developed countries than it is about those in developing countries, thereby limiting the identification of key issues that need to be considered (Harpham et al. 2002; Szreter and Woolcock 2004).

The 1980 Great Britain Black Report on inequalities in health is one piece used in the SDH literature to highlight the need for urgency to examine health gaps between privileged and disadvantaged social

groups (Macintyre 1997). Subsequently, much of Europe has extensively embraced and clarified health inequality and SDH. Sweden, Norway, the Netherlands and many other European countries spearheaded determinants-oriented public health strategies (Whitehead Margaret 2006). Developing countries including those in Sub-Saharan Africa, Asia, Latin America and Eastern Europe likewise have had movements geared towards critiquing market-oriented, neoliberal healthcare models calling for action to tackle the social and economic roots of ill health (WHO 2008). In Chile, healthcare system reform is based upon an integrative Primary Healthcare approach using a family-centred model (Vega Jeanette 2004). More recently, the healthcare reforms in the East African region, particularly in Rwanda, are following this trend (Basinga et al. 2011).

The reforms towards reducing social and economic inequalities have made Rwanda emerge as one of developing countries making substantial improvements in maternal health and progress towards achieving health-related Millennium Development Goals (MDGs) (Logie et al. 2008). Despite all of these achievements in healthcare in Rwanda, the most recent model handling health inequalities at the household level, it is still faced with glaring with gaps in how to achieve timely prenatal care visits, full child immunisation and enrolment on family planning programmes (Basinga et al. 2011) . These challenges in achieving sustainable improvements in women's health are an indicator that there remains a lot to do at both the demand and supply sides of healthcare (Ensor and Cooper 2004; Houweling et al. 2007).

1.3 Maternal Health and Care in Uganda

Uganda is among the countries that have registered insufficient progress to meet the 2015 MDG targets (Bryce 2008). The Millennium Development Goal 5 target is to reduce maternal mortality rate by ¾ between 1990 and 2015 and improve universal access to reproductive healthcare. As of 2010, Uganda's Maternal Mortality Ratio (MMR) had declined by just 21%. The Maternal Mortality Ratio decreased from 550 in 1990 to 435 deaths per 100,000 live births in 2010 (Uganda 2011). According to the 2010 WHO report, Uganda is among the countries whose women have the highest birth rates in Africa, and the lowest rates of modern contraceptive use (WHO 2010). Only 42% of pregnant women attend antenatal care for the recommended 4 times (UBOS 2006). Most of the causes of death are due to improper utilisation of maternal healthcare, particularly antenatal care (ANC), unskilled birth attendance at birth and use of family planning (Breslin 1998; Chao et al. 2005).

In Uganda, maternal healthcare is comprised of a number of players ranging from public to private healthcare services – hospitals, health centres and private clinics, to Private Not for Profit (PNFP) health facilities that are mainly under the established by religious institutions and non-government organisations (NGOs). Public health services are offered through a structure that begins with Village Health Teams (VHTs), Health Centres II, III, IV and general Hospitals. VHTs are a community level strategy through training a team of community members in increasing health awareness and thus promoting community participation in healthcare delivery and utilisation of health services (Uganda 2010). Another significant source of maternal healthcare is the traditional care offered by Traditional Birth Attendants (TBAs) (Kyomuhendo 2003; Kironde, Lukwago et al. 2004). In rural areas, pregnant women seek help from TBAs because of difficulty in accessing formal health services due to distance and high transportation, poor previous experience with formal health care, but also due to the traditional beliefs and customs (UBOS 2012). However TBAs' lack of knowledge and training and use of traditional practices have led to risky medical procedures that may result in high maternal mortalities (Amooti-Kaguna and Nuwaha 2000).

Improvement of maternal healthcare is a national development strategy. The 2010/2015 National Development Plan aims at delivering Uganda's National Minimum Healthcare Package (MHCP) to all Ugandan households. The MHCP is a guide for both the national and local government maternal health improvement strategies. Uganda's MHCP consists of the most cost-effective priority healthcare interventions and services addressing the high disease burden that are acceptable and affordable within the total resource portfolio of the health sector. Maternal and child health is one of the five priority components in the package, which also includes health promotion, disease prevention and community health initiatives, nutrition, prevention, control and management of communicable diseases and finally prevention, management and control of non-communicable diseases (Uganda 2010).

The Minimum Healthcare Package also focuses on policy issues that deal with increasing resource allocation for primary healthcare, abolition of user fees in public facilities, expansion of rural lower health facilities, provision of subsidies for the PNFP sub-sector, introduction of health sub-district structure, recruitment of qualified health workers, improvement of maternal and child health and increase in the volume of essential drugs purchased for health centres (Gwatkin et al. 2004; Pakhurst et al. 2005; Yates et al. 2006). Utilisation of population-based preventive services, particularly health education campaigns, promotion and distribution of insecticide-treated bed nets and condoms, supply of

safe drinking water and sanitation services are part of Uganda's Minimum Healthcare Package (Uganda 2010). While the 2010/2015 Health Sector Strategic Plan highlights for the first time the need to consider the SDH framework in the health sector (Uganda 2011), it is not elaborative and lacks specific information on factors that may compose the determinants.

Under-utilisation of maternal health services, particularly antenatal care, skilled birth attendance and family planning services, has been associated with high maternal mortality rates ((Penn-Kekana et al. 2007). A study by Deininger and Mpuga, comparing Uganda and other African countries, shows that Uganda ranked close to the bottom in the utilisation rate of these health services (Deininger and Mpuga 2005). While most women in Uganda (94%) attend antenatal care (ANC), the majority only initiate ANC late in pregnancy (on average, at 5.5 months). They often attend ANC only once, rather than the recommended four visits. Only 50% of childbirths are supervised or attended by skilled personnel and only 2 in every 10 Ugandan women use contraceptives to prevent unintended pregnancies (Ndomugyenyi et al. 1998; Waiswa et al. 2008).

The 2006 Uganda Demographic Health Survey (UDHS) data points out that only 4 in every 10 births in Uganda occur in a health facility. Of the remaining births, 23% are assisted by a traditional birth attendant, one quarter by a relative and 10% of births are born without any type of assistance. The proportion of childbirths in health facilities declined from 25% in 1999 to 23% in 2002/3 and maternity services are still consumed primarily by richer and urban communities (UBOS 2006). The 2008 Mbarara District[1] health report shows that rural Mbarara is affected by poor utilisation of maternity services estimated at less than 40%. The rural areas of Mbarara District are affected by child malnutrition, respiratory tract infections, malaria, low use of bed nets by pregnant women and under five children, only 31% of pregnant women and 28% of child sleep under mosquito nets to prevent malaria (Mbarara 2010).

Maternal health remains poor; the 2006 National Demographic Household Survey reported that more than 6000 women die every year due to pregnancy-related causes (UBOS 2006). In Uganda, like most sub-Saharan African countries, most maternal mortality causes are avoidable and embedded in people's attitudes towards health services and overall health practices (Ensor and Cooper 2004; Pakhurst et al. 2005). The 1995/96 burden of disease (BOD) study, using the discounted life years (DLYs) measure,

[1] Mbarara District is a the area of study located in the south western part of Uganda (*see map on page iv*)

found that 75% of all DLYs are due to preventable diseases, with the majority of them affecting women (Accorsi et al. 2005). Within the total burden of disease, prenatal and maternity-related conditions contribute 20.4%, malaria 15.4%, acute lower respiratory tract infections 10.5%, HIV/AIDS 9.1%, and diarrhoea 8.4%, accounting for approximately 60% of the total burden (Jeppsson et al. 2004).

These poor health indicators particular to unimproved maternal health outcomes continue to prompt the government of Uganda and the development partners to embark on efforts to improve health systems performance (Yates et al. 2006). These government efforts have included, among other things, putting in place a National Health Policy and a Health Sector Strategic Plan. The government of Uganda produced its three year national health plan in 1993. Since then, there have been three more strategic plans, the most recent being that of 2010-2015. One of the major focuses that cuts across these plans is the agenda to reduce maternal mortality through provision of emergency obstetrics care closer to rural women, further development of prevention and treatment services for malaria and HIV/AIDS and respective increase of financial resources for the sector (Jeppsson 2001; Sabik and Lie 2008). Improvements in maternal health have also continued to feature in the subsequent Uganda Poverty Eradication Action Plan (PEAP) which has now become the 2010-2016 National Development Plan (Uganda 2010) .

1.4 Problem Statement

Social determinants of health are often cited as a barrier to improving maternal health (Blanc and Wolf 2001; Nanda 2002; Marmot 2005; Wyrod 2008). Marmot (2005) refers to Social Determinants of Health (SDH) as risk factors found in one's living and working conditions, such as distribution of income, wealth, decision-making, influence and power. Gender inequality is a widely known SDH which damages the health of millions of women through, among other routes, discriminatory feeding patterns, violence against women, lack of access to resources and opportunities and lack of decision-making power over one's own health (WHO 2008).

Decision-making at the household level has long been recognised as an important factor in the 'delays' between onset of an obstetric complication completion and its adequate treatment and outcome (Thaddeus and Maine 1994). The Three Delays framework explains the interplay between factors related to distance, women's autonomy and medical assistance during an obstetric emergency (Pacagnella et al 2012). The problems of delay in making decisions to seek maternal health care are multilevel and they begin at home even before being faced with poor transportation and health services (Barnes-Josiah et al.

1998). Maternal health care decision-making at the household level in particular is affected by a woman's social position in the household and as a dependent of a man's allocation of household resources.

The 2010 – 2015 Government of Uganda Health Sector Strategic Plan III indicates that access to health facilities and healthcare for women in general is influenced by decision-making processes in families. The plan further reports that 22% of married women independently make decisions about their own healthcare while 40% depend on husbands to make such decisions. However, the Health Sector Strategic Plan points to the slow progress in addressing maternal health problems in Uganda as being due to lack of human resources, medicinal supplies, and appropriate buildings and equipment, including transport and communication equipment for referral (HSSP III p. 10 -11). Whereas research and policy attention has been directed towards understanding how intra-household dynamics influence the use of maternal health care, there remains limited exploration into how to bring about sustainable change in maternal health behaviour and attitudes (Penn-Kekana et al. 2007; Ashraf 2009; Barker et al 2011) through tackling gender dimensions of intra-household maternal health care decision-making (Cottinhham 2008).

In almost all African cultures, Uganda inclusive, intra-household relations are largely gender stratified (Rugadya 2004), characterised by hierarchical relations in which men and other patrilineal relatives have authority over women (Otiso 2006). In most of rural Uganda women depend on land for their livelihoods but only acquire land through marriage, the majority of which is customary land (Tripp 2004). In Uganda, 60% of women of reproductive age experience domestic violence and 16% of them during pregnancy (Koenig, Lutalo et al. 2003; UBOS 2006). Poor household power relations have been associated with unequal control over physical and financial resources (UBOS 2010). Worse still, women in most rural households are faced with housework labour burdens which consume most of their time, 42% of the female labour force is unpaid and 90% of it is agricultural labour (UBOS 2010).

Drawing from the above conceptual insights into intra-household maternal health care decision-making, this thesis examines how intra-household gender relations generate determinants of use of antenatal care, skilled care at childbirth and family planning. The thesis draws from the Social Determinants of Health theory (WHO 2008) and Amartya Sen's Intra-Household Gender and Cooperative Conflict theory to understand maternal health care decision-making in Mbarara District, Uganda. The thesis uses data from a household survey, individual interviews and focus group discussions to explain ways in which

women's land rights, couple relations and division of household labour determine maternal health care decision-making. The findings fill policy and research gaps on social restrictions surrounding maternal health decision-making in Uganda. Overall this thesis investigates the intra-household social determinants of demand for maternal health care in Mbarara District, Uganda based on the following study justification, research aim and research questions:

1.5 Study Justification

Maternal health services are a good determinant of maternal mortality and morbidity. Accessibility and availability of preventive and curative services are important in determining mortality and morbidity rates in a given context. This is an academic research project aimed at contributing to the existing body of knowledge on improvement of maternal health by analysing household level factors that limit women's access to maternal healthcare in rural Mbarara, Uganda. The study examines how household level factors in particular women's household labour burdens, couple relations and land use decision-making determine women's use of maternal health services. The uses of maternal health services being examined in this study are antenatal care, family planning and use of skilled care during childbirth. The significance of this research is that unlike other studies which focus on health care financing, human resources, transportation and user fees, this study examines and discusses household level living conditions that limit women's use of maternal healthcare.

According to the Three Delays Model by Thaddues and Maine (1994), utilisation of maternal healthcare is affected by factors that can be categorised in three phases: phase 1, the delay in deciding to seek care at an individual family level; phase 2, the delay in reaching an adequate health care facility; and phase 3, the delay in receiving adequate care at the facility. This study therefore examines the factors that are responsible for phase 1 delay by examining intra-household living conditions and how they limit women's capacity to decide effectively to seek maternal healthcare.

Therefore, this thesis is a source of literature on intra-household gender inequalities and women's access to maternal healthcare. The thesis also contributes literature on household level social determinates of health that can be integrated in the National Health Strategy to mainstream social determinants of health as is required by the National Health Sector Strategic Plan III, which for the first time alludes to the need to address the social determinates of health (Uganda 2010).

This thesis examines the significance of gender roles within a household, couple relations and land use dynamics in promoting maternal health. The inequalities related to these factors affect women's capacity and willingness to use antenatal care, skilled birth attendance and family planning offered at lower health facilities of Mbarara District, Uganda. These factors limit women's access to information, resources and time needed to access healthcare. This research has examined the impact of relations between husband and wife, the gendered division of household labour and access to family resources and land on the decision-making hierarchy concerning use of antenatal care, skilled delivery and family planning/modern contraception. The effects of basic demographic factors, particularly education, income and marital status, were controlled for.

1.6 Study Aims

The overall aim of this thesis is to examine the intra-household determinants of demand for maternal healthcare in Kashari, Mbarara District, Uganda. Underlying it is an attempt to establish intra-household determinants of maternal healthcare that can be applied to effective improvements of household-based maternal healthcare delays by Ugandan's lower district primary health care system.

1.6. 1. Specific objectives

Specifically, the thesis is guided by the following objectives:

a. To examine intra-household gender roles as determinants of maternal healthcare in Kashari, Mbarara District, Uganda
b. To determine the effects of land decision-making on the use of healthcare among rural communities in Kashari, Mbarara District, Uganda
c. To examine couple relations as determinants of use of maternal health services among households in Kashari, Mbarara District, Uganda
d. To explore the extent to which intra-household social determinants are integrated in Uganda's Primary Healthcare (PHC) programs and demonstrate how they can be integrated in the lower district health centres PHC programs

1.6.2 Hypothesis

The null hypothesis for this study assumes that there is no relationship between men and women's household socioeconomic inequalities (household labour, land use decision-making and couple

relations) and demand for maternal healthcare (antenatal care, family planning and skilled birth attendance).

1.6.3 Research questions

1. Do intra-household gender roles determine use of maternal healthcare in Kashari, Mbarara District, Uganda?
2. What are the effects of household land decision-making on use of maternal healthcare among the rural communities of Kashari, Mbarara District, Uganda?
3. Do couple relations determine use of maternal health services among households in Kashari, Mbarara District, Uganda?
4. How can intra-household social determinants of health be integrated into the delivery of Primary Healthcare (PHC) programmes of lower district health centres?

With respect to Question 1, the thesis describes the division of labour and how it influences intra-household determinants related to gender roles socialisation. Dealing with Question 1 helps to shed light on how gender role constructs impacts on differences in household division of labour for males and females. Data on men and women's daily engagement in different roles provides a description of attitudes towards the household division of labour and cross-tabulations indicate how gendered division of labour and stereotyping impacts on use of maternal healthcare. Analysing gender roles in this study is aimed at extending the discussion beyond the division of household labour, to determine the implications for the use of maternal healthcare. By examining household division of labour, the thesis examines the disadvantages of inequality in household gender roles for maternal health-seeking behaviours. The chapter examines the division of labour and attitudes towards gender specific roles that define the daily living conditions of women.

Question 2 analyses allocation and ownership of household resources, with a particular focus on land. The question examines land as the main household social and economic resource and a source of household livelihood for the majority of rural populations in Uganda. The study, under this objective, examines the determinants for use of maternal healthcare at the household level in decision-making for ownership, purchase, use and sale of land.

With respect to Question 3, the thesis sheds light on the quality of couple relations as a determinant of use of maternal healthcare. Good relations with a spouse/partner have been associated with positive

maternal behaviours such as use of antenatal care and postnatal care and lack of substance abuse. Therefore, this objective is aimed at demonstrating the effects of improvements in couple relations through helping with work around home and engagement of women in planning for allocation of family resources.

Finally, regarding Question 4, after determining intra-household determinants of maternal healthcare, the question offers an analysis of how primary healthcare systems understand household factors and their impacts on use of maternal healthcare. The question builds on the three delays maternal healthcare access model by Thaddeus and Maine (1994), which categorises maternal access factors across three levels. The first delay in seeking healthcare during an obstetric emergency is at the household level and has been attributed to lack of understanding of complications, acceptance of maternal death, low status of women and socio-cultural barriers. This objective of the study in this thesis indicates that lower district health facilities (IV, III and II) are the key entry point for integrating household factors into healthcare systems. These health facilities are based in communities and are strategically important for addressing household based barriers to utilisation of maternal healthcare.

1.7 Thesis Structure

This thesis is divided into eight chapters. Chapter one consists of the overall introduction, the background and the research problem statement. The chapter gives a situational analysis of the health status of women in the world, Sub-Saharan Africa and Uganda in particular.

Chapter two describes the theoretical framework and literature review. The literature review is arranged according to the major themes of the study – social determinants of health, gender inequalities, intra-household decision-making and maternal healthcare. The SDH theory is concurrently discussed with household gender relations so as to analyse the influence of women's living conditions and relations on utilisation of health services. A conceptual framework then illustrates and discusses intra-household factors that constrain women's capacity and willingness to use maternal health services. This framework illustrates the interconnectedness between household division of labour and women's deprivation of time for seeking care, and how women's lack of decision-making freedoms and poor or violent relations impact on maternal health behaviours. This study does not disregard the contribution of other maternal health utilisation barriers and so the conceptual framework also shows that the significance of the effects

of prevailing health system factors such distance, cost and quality of health services can keep women away from using healthcare (*see figure 2*).

In the third chapter is the description of the study setting/area of the thesis and presentation and discussion of the research methods that were used to obtain and analyse field data. Chapters four, five, six and seven are results chapters that are arranged according to the following subthemes informed by the study's specific objectives:

Chapter 2: Theoretical Framework and Literature Review

Chapter 3: Study Setting and Research Methods

Chapter 4: Intra-household Gender Roles Inequality; Implications for Demand for Maternal Health Care in Kashari County, Mbarara District, Uganda.

Chapter 5: Women, Land and Use of Maternal Health Care- among the Rural Communities of Kashari, Mbarara District, Uganda

Chapter 6: Couple Relations Determinants of use of Maternal Health Services among Households of Kashari, Mbarara District, Uganda

Chapter 7: Integrating Intra-Household Social determinants of Health into the Delivery of Primary Health Care (PHC) Programmes of Lower District Health Centres

Chapter 8: Conclusions, Recommendations and Policy Implications of the study for intra-household determinants demand of antenatal care, skilled maternal health care and family planning in Kashari County Mbarara District.

CHAPTER TWO

Theoretical Framework and Literature Review

2.0 Introduction

As per the World Health Organisation (WHO) definition, maternal health refers to the health of women during pregnancy, childbirth and the postpartum period . While motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill health and even death (Akanda and Salam 2012). The common direct and indirect causes of maternal morbidity and mortality experienced in most of sub-Saharan Africa include obstetric haemorrhage, infection, high blood pressure, unsafe abortion, obstructed labour, HIV/AIDS, malaria during pregnancy and immediately after childbirth and related problems (Bhutta et al. 2010; WHO 2010). The majority of maternal deaths occur during or immediately after childbirth. Poor maternal, newborn and child health remains a significant problem in developing countries. In 2008, it was estimated that more than 220,000 women in developing countries died during pregnancy (Hogan et al. 2010). The highest maternal mortality rates are in sub-Saharan Africa accounting for 56% of all deaths (WHO 2010). Evidence shows that early and regular checkups by health professionals are essential in assessing the physical status of women during pregnancy and ensuring appropriate interventions during delivery (Simkhada et al. 2008). High fertility rates add extra an burden to the already overstretched maternity services and potentially increase the obstetric risk, thereby increasing the number of maternal deaths (WHO 2010).

Although there is substantial progress made towards achieving the Millennium Development Goal (MDG) 5, aimed at reducing the maternal mortality rate between 1990 and 2015 by 75%, and universal reproductive health care, the rates of decline in maternal mortality remain insufficient to achieve these goals by 2015 (Bryce 2008; Bhutta et al. 2010). Interventions and strategies of improving reproductive, maternal, newborn and child health and survival are closely related and must be provided through a continuum of care approach (Kerber et al. 2007). When linked together and included as integrated programmes, these interventions can lower costs, promote greater efficiencies and reduce duplication of resources. However, efforts have been made to identify synergies and integrate these interventions across the continuum of care (Kerber et al. 2007). Despite the existing plethora of knowledge, there is lack of consensus on how best to move forward in a coordinated manner so as to achieve progress

towards sustainable improvement of maternal health care, especially among poor populations such as in Uganda. Further consensus is also needed about the level of evidence on household decision-making processes and the allocation of health resources (Kerber et al. 2007; Akanda and Salam 2012). As stated in the introduction, this thesis aims at examining factors at the household level which form a basis for the social determinants of health.

Therefore, in this literature review, a further analysis of the social determinants of health is conducted to provide the basis for household-based factors that constrain women's access to maternal health care services. The literature review specifically situates intra-household determinants of women's utilisation of maternal health care in south-western Uganda under the Social Determinants of Health paradigm. The Social Determinants of Health (SDH) theory is employed to analyse household level theoretical and empirical factors that hinder women's use of maternal health care. Whereas the SDH framework is largely used to assess the impact of inequality at macro levels – state, community and groups of people, this thesis examines the effect of gender inequalities at a micro level – intra-household relations. It is at this point that this review merges SDH and the gender cooperative conflict model to discuss aspects of intra-household decision-making about use of maternal health care.

The literature review is divided into two sections: the first section considers the theoretical and conceptual framework which provides the theoretical underpinnings of the thesis; the second section analyses the gaps in the SDH literature in dealing with household level inequalities and specifically expounds on the inclusion of household level gender differences. It explores intra-household decision-making, gender dimensions of access to maternal health care and the policy of mainstream gender equality in improvement of women's health, as well as health systems strategies to address health determinants. This arrangement of the literature review aims to contextualise the determinants of health stemming from intra-household inequalities. The end of the chapter examines the progress of primary healthcare in dealing with social determinants of health and barriers to accessing maternal health care among poor countries.

2.1 Maternal Health Care as a System

In responding to the foreseen failure of not meeting the MDG of reducing maternal mortality by 75% by 2015, there has been a considerable number of studies and reports published that suggest what needs to be done to address this lack of progress (Freedman et al. 2005; Campbell and Graham 2006; Filippi et al.

2006; Ronsmans and Graham 2006). Whereas access to contraceptive services to prevent unwanted pregnancies, delayed first pregnancy, access to safe abortion and post abortion care, targeted ANC care and post-partum care have all been widely acknowledged as important (WHO 2005; Filippi et al, 2006), attempts to substantially reduce maternal morbidity have involved a focus on prevention and treatment of life-threatening maternal complications (Campbell et al. 2006). The delivery of maternal health care should focus on a functional health system that is comprehensive in nature, in order to deal with direct causes and indirect factors that mainly relate to women's living conditions (Magnussen et al. 2004). Unlike some other health interventions, maternal health services are dependent on the functioning of the entire "health system" (Graham 2001; Bell et al. 2010). A functional maternal health system provides for systematic efforts to integrate family and community health packages (Kerber, de Graft-Johnson et al. 2007) on top of effective and efficient health care delivery, generation of useful information on health determinants, access to medicines, staff training, financing, regulation and accountability (WHO 2010)

Campbell and Graham (2006) used the work of Remer to highlight the importance of various larger health system components, such as resources, organisation, management and economic support for the delivery of services. Others have looked at the impact of various sector reforms on maternal health services, with user fees being a key issue that a number of authors have engaged with (Schneider and Gilson 2000; Goodburn and Campbell 2001; Borghi et al 2006). Freedman (2005) emphasised the need to transform health systems to improve the lives of women. The main argument is that health systems should be seen as key social institutions and that the concern for equity and human rights should be guiding principles when attempting to improve health systems. Whereas the UN millennium Report suggests an approach to improving health systems starting with an integrated primary health care approach with a focus on the district level, i.e. community up through the first referral facility level approach (Freedman 2005), I claim that this is not sufficient.

A maternal health services situation analysis study was undertaken in South Africa, Uganda, Bangladesh and Russia in 2001-2002: in Russia and South Africa the focus was predominantly on health care workers and their practices, while in Bangladesh and Uganda follow up-studies focused on issues of user's perceptions and utilisation of services (Parkhurst et al. 2006). This study is premised on the SDH approach, an approach that examines the relationship between social economic inequalities and health outcomes. From this perspective, this chapter discusses SDH literature, how it has developed over time, and its application to household level inequalities and women's status. The theoretical framework

incorporates gender dimensions of maternal health to provide a basis for household factors, which mainly relate to gender roles. The SDH gaps in dealing with household-level factors in improvement of maternal health care access are discussed under section 2.1.4, which discusses the conceptual framework that analyses bargaining aspects of gender inequalities within a household. Through the conceptual framework, the root causes of gender inequalities as centralised to pin down the limitations of women's bargaining for control and ownership of the resources needed for maternal health care, and thus discusses the intra-household compromise on maternal health care.

2.1.1 Social Determinants of Health and Maternal Health Care

Traditionally, the determinants of health are the social, economic, political and power inequalities among populations, they are the living conditions in which people live (Marmot 2005). The central health determinants are poor social and economic circumstances that affect health (CSDH 2008). In the same way, maternal health care access is affected by a wide range of social, economic and political factors that combine a lack of maternity service, shortage of health personnel, delivery by untrained persons, poor environmental sanitation, poor transport, and combination, restrictive and discriminatory social customs. Access to maternal health services is faced with the double edge of being both a problem of women and the poor.

SDH theory is a concept that has evolved since the 1940s and is well explained in the 2007 World Health Organization (WHO) Commission on Social Determinants of Health (CSDH) (WHO 2005; Hay 2007). The works of Evans and Wilkinson laid the foundations of SDH, which include income and social status, social support networks, education and literacy, employment and working conditions, social environments, physical environments, personal health practices and coping skills, child health development, biological and genetic endowment, health services, gender and culture, influence and power (Evans et al. 2001). The following is a description of the role of the WHO CSDH:

> The Commission's work is built around the health and equity approach and analyses the importance of social and economic policies. It unpacks the role of the health sector to include tackling unfair economic arrangements and bad policies. Broadly the action on Social Determinants of Health must involve the whole government, civil society, and local communities, business and global fora and international agencies. Policies and programs must embrace all key sectors of society not just the health sector. The Commission was established to support countries and global health partners to address social factors leading to ill health (WHO 2008:1).

SDH scholars discuss the effects of income inequality on the risk to disease or vulnerability to disease and injury (Wilkinson and Marmot 2003; Wilkinson and Pickett 2010). Their discussions are based on national statistics and on groups of people on the basis of race, ethnicity, income and education. They focus on the role of public policy and its effects upon shaping social environment (Hall and Taylor 2006). They have categorised social determinants into individual and structural inequalities. The individual factors include quality of parenting, nutrition, exercise and substance abuse, and the structural factors include unemployment, poverty, work experience and access to health care. There are two identifiable types of inequality that are discussed. The first is health inequalities, which are the observable differences in health indicators across groups of people from different social and economic backgrounds (Navarro 2009). Secondly is the differences in quality of health and health care that may include health outcomes or access to health care (Wagstaff and Doorslaer 2000).

According to the WHO CSDH, the unequal distribution of health damaging experience is not in any sense a natural phenomena but results from poor social policies, unfair economic arrangements and bad politics (WHO 2008). For example, women from poor countries statistically tend to have higher maternal mortality and fertility rates than those from rich countries (Ronsmans and Graham 2006). Secondly, social inequalities produce differences in health behaviours. The generic example is that people from lower social positions live risky lifestyles which may include poor diet, smoking, drug abuse and violence (Wilkinson 2005).

Health inequalities vary over time and between countries and have causes that underlie them (Graham 2001). In the case of the high maternal mortality rates among most developing countries, causes of poor access to health services have been associated with women's lack of material resources and social control, and their thus being stigmatised by the fact that they lack control over resources, affecting their ability to pay for health services (Nanda 2002). Poor women are less likely to use modern family planning and other maternal health services (Houweling et al. 2007). This thesis discusses the process through which household level inequalities produce unhealthy maternal health care practices by specifically examining the social position of women within a household.

Whilst data on women's education and income is included in the study, it is used to further understand women's social status within the household. Dealing with health inequalities specifically may call for strategies that make access to health care more equitable, such as bringing health services nearer to

people by establishing lower district health centres and investing in attracting health workers. The studies show that at a certain point, if health inequalities alone are dealt with, independently from social inequalities, health services may continue to be more accessible to those in better social positions than those in lower social positions (Penn-Kekana et al. 2007). Therefore, a strategy that balances both health and social inequalities is necessary.

It is evident that gender inequities are characteristic of households which sustain structure of authority with direct prescription of the roles of a husband and wife, whereby a husband makes decisions on behalf of the wife (Angel and Tienda 1982; Bolt and Bird 2003). The household division of labour and the decision-making hierarchy limits women's ownership and allocation of resources, and bargaining for resources has been found to have mixed levels of either conflict or cooperation (Agarwal 1997). In most developing countries poor maternal health outcomes are coupled with women's cultural obligation to cooperate and allow their husband's decisions to prevail. Women have less freedom to act, less personal autonomy and less access to information than their husbands/partners (Filippi et al. 2006). According to Backer (1981) when a household head (husband), places conditions on income transfers to his partner (wife), then her choices are controlled and limited to what is appropriate to the head of household (Becker and Becker 1991). This gives men/husbands considerable power over their wives (Iversen 2003). The gender inequalities in intra-household ownership control and allocation of resources preconditions women's bargaining for household resources. Therefore, without incorporating literature that analyse intra-household bargaining, the SDH framework is not sufficient to determine the intra-household inequalities that affect women health-seeking behaviour. This guides us towards the conceptual framework of this study that identifies social, emotional and economic barriers as rooted in women's lack of land use decision-making capacity, poor couple relations and house and farm labour burdens.

2.1.2The Theory of the Social Determinants of Health

This section presents the theoretical underpinnings of the study. SDH theory is a field concerned with how people's lifestyles and their living and working conditions determine differences in health outcomes (Marmot 2005). It is a field concerned with the conditions in which people are born, grow, live, work and age, including the systems put in place to prevent disease and treat illness when it occurs and the structural drivers of those conditions, and the distribution of power, money and resources shaped by social, economic and political forces (Bell, Taylor et al. 2010). It highlights is about the health

disadvantages arising from social and economic inequalities, and explains why societies with smaller income differences between the rich and poor experience more favourable health indicators such as life expectancy or infant and maternal mortality. For example, even among affluent nations, Japan, which has a comparatively low income inequality, has an average life expectancy of over 80 years, whereas the United States of America, which has a comparatively higher income inequality, has an average life expectancy of less than 75 years (Wilkinson and Marmot 2003). Other factors commonly associated with inequality are violence, obesity, limited trust and social capital (Wilkinson 2005; Wilkinson and Pickett 2010).

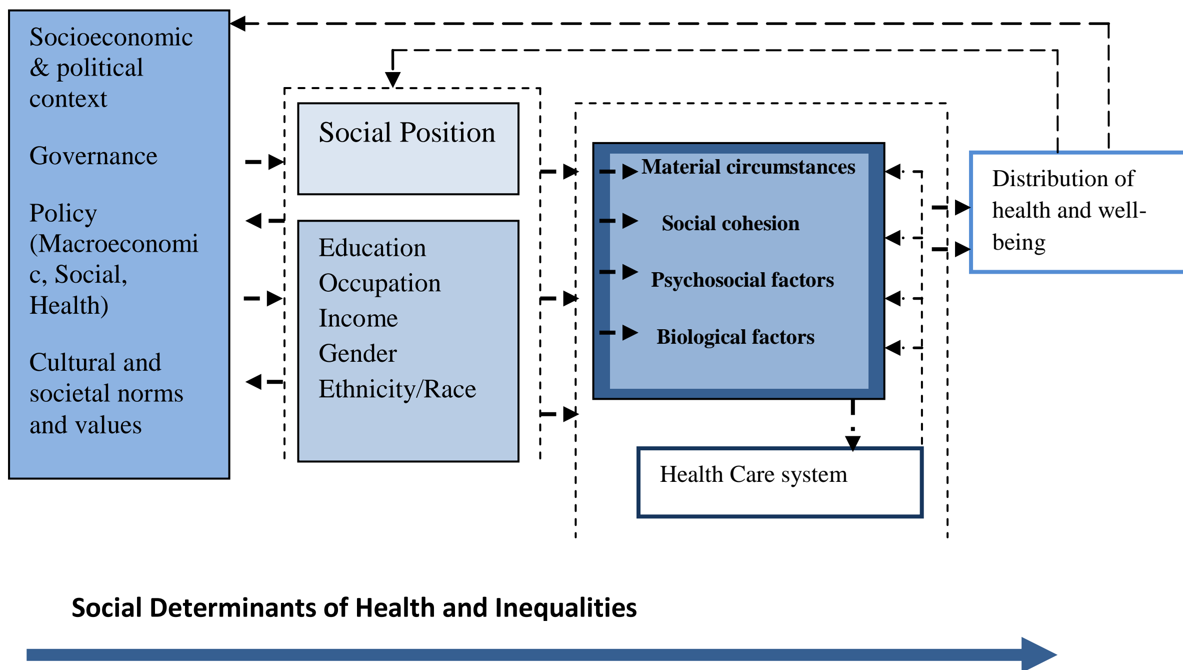
The SDH concept, though not new, only gained attention after the first edition of *Social Determinants of Health: The Solid Facts* by Wilkinson and M Marmot in 1998. However, by the middle of the 19th century, there were already careful, detailed enquiries on social factors in developed nations. As reported by Mechanic, in Chadwick's report of 1842 on the sanitary conditions of the labouring population of Great Britain, labourers and their families died at an average age of 16 years, and gentlemen and professionals died at an average age of 45 (Mechanic 2000). According to Tarlov, it is these social and economic conditions in which people live and work that determine their longevity (Tarlov 1996). In 1978, the WHO captured the concept in the definition of health as not a mere absence of disease, but as a complete state of physical, social and mental well-being (Nutbeam 1998).

Subsequently, although the 1980 Black Report, laid the conceptual foundations for a health equity agenda, SDH language did not achieve wide dissemination until the late 1990s, which later saw the establishment of the CSDH in 2005 (Navarro 2009). In 2003, the WHO Director-General, Lee Jong-wook, announced the intention to create a Commission on Social Determinants of Health, which the 2004 World Health Assembly tabled, and which was later launched in March 2005 in Chile (Solar and Irwin 2007). The works of Evans and Wilkinson and Canada's Federal Department of Health are some of the key foundations of SDH literature (Bryant, Richmond et al. 2008). It in this work that we find a collection of examples and case studies that show that health is determined by variables such as income and social status, social support networks, education and literacy, employment and working conditions, social environments, physical environments, personal health practices and coping skills, child health development, biological and genetic endowment, health services, gender and culture (Evans et al. 2001). The CSDH agenda to close gaps in health inequalities is guided by the following three principles:

> ....improve the conditions of daily life (i.e., the circumstances in which people are born, grow, live, work and age); tackle the inequitable distribution of power, money and resources (the structural drivers of those conditions of daily life) globally, nationally and locally; measure the problem, evaluate action, expand knowledge base, develop a work force that is trained in the social determinants of health, and raise public awareness about these determinants (Marmot et al. 2008 pg. 1661).

The Commission's principles are also illustrated in a conceptual framework that demonstrates areas of interdependence and action.

Figure 1: CSDH Conceptual Framework and Entry Points for Intervention



Source: WHO (2008), CSDH Final Report Page 43

Figure1 above, suggests that interventions to reduce inequalities can be aimed at the socioeconomic and political context, the social position that is determined by education, income, occupation, gender and ethnicity or race and the resultant psychosocial, material and biological conditions. An accessible health care system is one that brings into consideration this wide range of factors.

Therefore, the choice of SDH as a theoretical base for this study allows one to consider social and economic factors that determine maternal health outcomes by going beyond the current policy concerns

that are only dealing with improving medical supplies and setting up health facilities, with a lesser focus on socioeconomic living conditions. Examining intra-household social relations will show how differentiation in people's socioeconomic conditions, such as internal decision-making processes, can lead to differences in health access outcomes. According to Irwin and Scali (2007), social inequalities arise from individual social positions and unequal access to basic needs and opportunities due to failed governance. Factors such as women's social positions have been found to condition their freedoms and capability to function, and so could be used to explain the underutilisation of maternal health services (Sousan 1996; Nutbeam 1998).

Since women are one group of people affected by these inequalities, improvement in their health outcomes requires an understanding of how the socioeconomic inequalities arising from gendered power relations at the household level affect health service utilisation. There is recognition that in many cultures, men make decisions that affect women's reproductive health as well as their own (Blanc and Wolff 2001). Women experience household-level power inequalities, they have less access to resources and often cannot make decisions regarding the allocation of resources (Moss 2002).

Responding to the increasing concern for integrating SDH into the health care system, for the first time in 2010, Uganda's Health Strategic Plan mentioned the need to pay attention to health determinants (Uganda 2010). It is such developments that make it relevant to do research that identify local examples to apply to the processes needed to use the SDH approach. This study examines household level inequalities in distribution of resources and decisions-making power among couples and their likely effect on women's access to maternal health services. The study specifically links women's household level social status to their exposure to poor use of antennal care, skilled birth care and family planning in Mbarara District, Uganda.

2.1.3 Understanding Social Determinants of Health from the Household Level Perspective

As already presented in the previous section of this chapter, the effects of social and economic inequalities on health can be determined at global, regional, national and household levels (Kawachi et al. 2002). The description by Siddiqi et al. (2009) of SDH suggest three levels of analysis. The first of these is the global and national level which gives the aggregate effect of income and wealth inequalities created by market forces. The second is the institutional level which is about the organisations and institutional responsiveness towards trust, social cohesion and access to social services such as health

care and education. Thirdly, the ‘micro level’ is about the ways in which a family’s socioeconomic circumstances and personal support network determine health outcomes. Significant literature is available at a global level and much more on developed countries, for which some countries have succeed in implementing health promotion strategies that provide for those who cannot afford education, housing and health care (Sabik and Lie 2008).

In general, the macro inequalities trickle down to the micro levels of society and the macro-level social structures can depict the inequality patterns in micro situations (Collins 2000). As with the national level, household inequalities in income, education and gender have extremely similar impacts on the health of individuals at the household level (Wilkinson 2009). For example, communities with strict gender inequalities experience poor women’s health outcomes (Moss 2002). The health outcomes are compromised by gender inequalities in the distribution of household material and non-material resources (Kahn et al. 2000). Considerable maternal mortality in developing countries is attributed to their position within a household and lack of decision-making capacity (Christiana E.E 1994; Dodoo and Frost 2008).

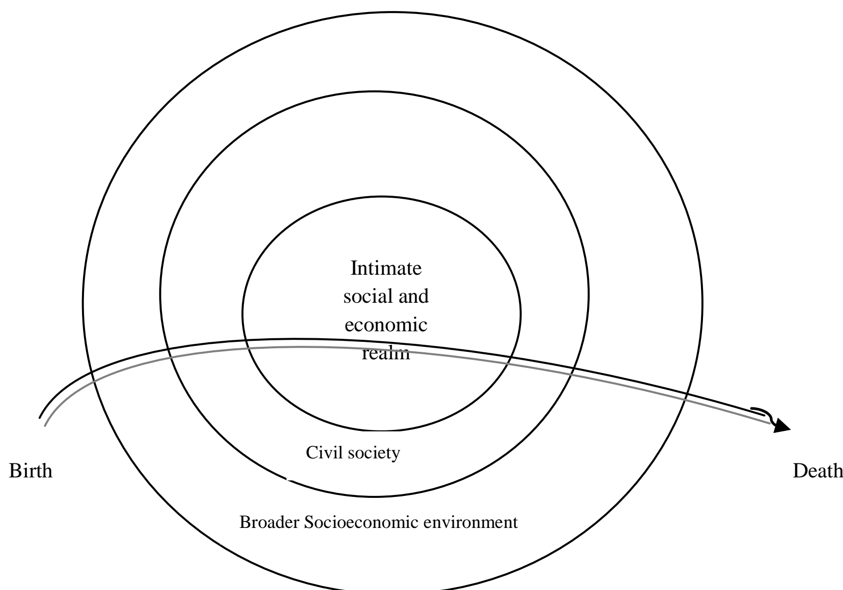
According to Wilkinson (2009), increases in social hierarchy and inequality within a household raise the stakes and anxieties about personal worth and feelings of inferiority, which can lead to anti-social behaviour. Living in an inferior position can then compromise a women’s prospects for better health behaviours (Sen, George et al. 2002). Women living in severely unequal social environments are driven by feelings of worthlessness (Alaba and Koch 2007). The traditional view of being a woman in most developing countries is to be submissive to men (Kyomuhendo 2003). Within a household, women are considered dependents of the household head who can always dictate a woman’s decisions, including about access to health care (Mwaka 1993; Agarwal 1997).

According to Parkhurst et al. (2006), barriers to women’s access to maternal health care in low-income settings are clear and they include: distance from health facilities, transportation problems, costs of services including informal charges and expenses, opportunity costs from time lost, perceived low-quality care in facilities including stigma and fear, and ability of women to travel alone. In Uganda, lack of women’s decision-making in the household and general community biases dictate that only abnormal pregnancies are handled in health facilities (Kyomuhendo 2003; Parkhurst et al. 2006). In a study by Nanda (2002), it was found that women’s lack of control over household resources and inequitable

decision-making power are important gender dimensions of user health fees that delay women's access to professional care.

In Uganda, like in the most of sub-Saharan Africa, land is the major household resource which its members depend on for their livelihood (Cooper 2010). In addition, land is a source of women's daily occupation; 72% of all employed women and 90% rural of women work in agriculture (Garcia 2006). However, the customary land tenure system limits women's ownership and control of land (Cooper 2010). Women's claims on land are weak, socially embedded and restricted to production of food for their families (Whitehead and Tsikata 2003), women do not often benefit from sale of farm produce (Garcia 2006). Studies have found that death of a spouse and end of marriage are the two major causes of women's insecurity on family land (Deininger and Castagnini 2006; Doss et al. 2012). It is such complex living conditions that make it relevant to study and assess women's living condition. The Bullseye model of SDH by Siddiqi et al. (2009) is an analysis of determinants at three levels of aggregation in society and this thesis is used to locate the position of a household within this as a social structure.

Figure 2: Bullseye's Model of Social Determinants of Health



Adopted from Siddiqi et al 2009.

In the Bullseye model, the highest level describes the socioeconomic characteristics of a nation, such as the level and distribution of income and wealth and the degree of inequality. The intermediate level of

aggregation is the civil society or social organisations that focus on increasing access to social goods, particularly health and education. The lower level is the 'micro' level, which focuses on the intimate realm of the family and the personal support network. The Bullseye model of SDH shows an individual's life (the arrow piercing through a bullseye) and the different levels of socioeconomic and psychosocial conditions that determine health outcomes. The model is meant to imply that everyone in society responds equally to each determinant (Siddiqi et al. 2009).

The model hypothesises that the inclusion of gender differences in the analysis of social determinants of health is a response to social to the comprehensive nature of health promotion (Siddiqi et al. 2009). The concern for gender roles and individual opportunities to access socioeconomic opportunities is opposed to the traditional determinants of health frameworks that stop at aggregate levels. The important issue of the Bullseye model is that it describes the aggregate function of different societal levels. Therefore, health systems should be able to capture multilevel influences on health and health care. This model gives a basis for promoting comprehensive health care through tackling micro and macro factors. The multilevel analysis of the determinants of health make the Bullseye model relevant in the analysis of micro factors such as decision-making for resource allocation within a household and the gender inequalities which can be both macro and micro.

2.1.4 Contextualisation: Household Determinants of Maternal Health Care Demand

This conceptual framework is intended to generate an explanation that captures important ways in which a household keeps custody of inequalities that negatively affect women's access to maternal health care. The household, unlike other levels of society, is an important producer of health and often controls health outcomes, notwithstanding the availability of health services (Lindelow 2008). This conceptual framework illustrates how factors such as gender roles, couple relations and land use decision-making dynamics create a linkage between supply and demand concerns surrounding improvement of women's health care demands.

Figure 3, is a conceptual framework which shows the linkages between intra-household inequalities and use of maternal health services. The framework positions household factors to explain the women's daily living conditions and the embedded barriers to maternal health. In this thesis household-level decision-making processes, gendered division of household labour, gendered land ownership and couple relations are discussed as fundamental causes of women's insecurities and fears which underlie failed

used of maternal health care. Previous studies have found that despite availability of health care, women always need permission for their husbands or senior in-laws to decide when to seek care, even in an emergency (Wolff et al. 2000; Kyomuhendo 2003).

It is therefore important to note that, women's inability to seek care during pregnancy is due to lack of a wide range of social, material and human resources (Bloom et al. 2001; Currie and Wiesenberg 2003). Lack of resources determines women's capacity to negotiate for their needs and empowerment in general (Kabeer 1999). In the case of social resources, studies have found differences in women health outcomes based on marital status of which married women tend to be more likely to take up preventive care such as cancer screening (Berkman 1995; Berkman et al. 2000). Therefore, this thesis adopts the view that social and economic resources enhance women health care decision-making but also identifies underlying factors that hinder women access to other material and human resources. Among other factors for example, the thesis describes how social resources like the perceived couple relations can provide a base on which women draw and advance their own social support for maternal health. The conceptual framework in figure 3 shows that women's daily living conditions, including how they use their time, determine their maternal health behaviours.

Figure 3: An illustration of the effect of intra-household factors on demand for maternal health care– *'going beyond institutional and community factors'*

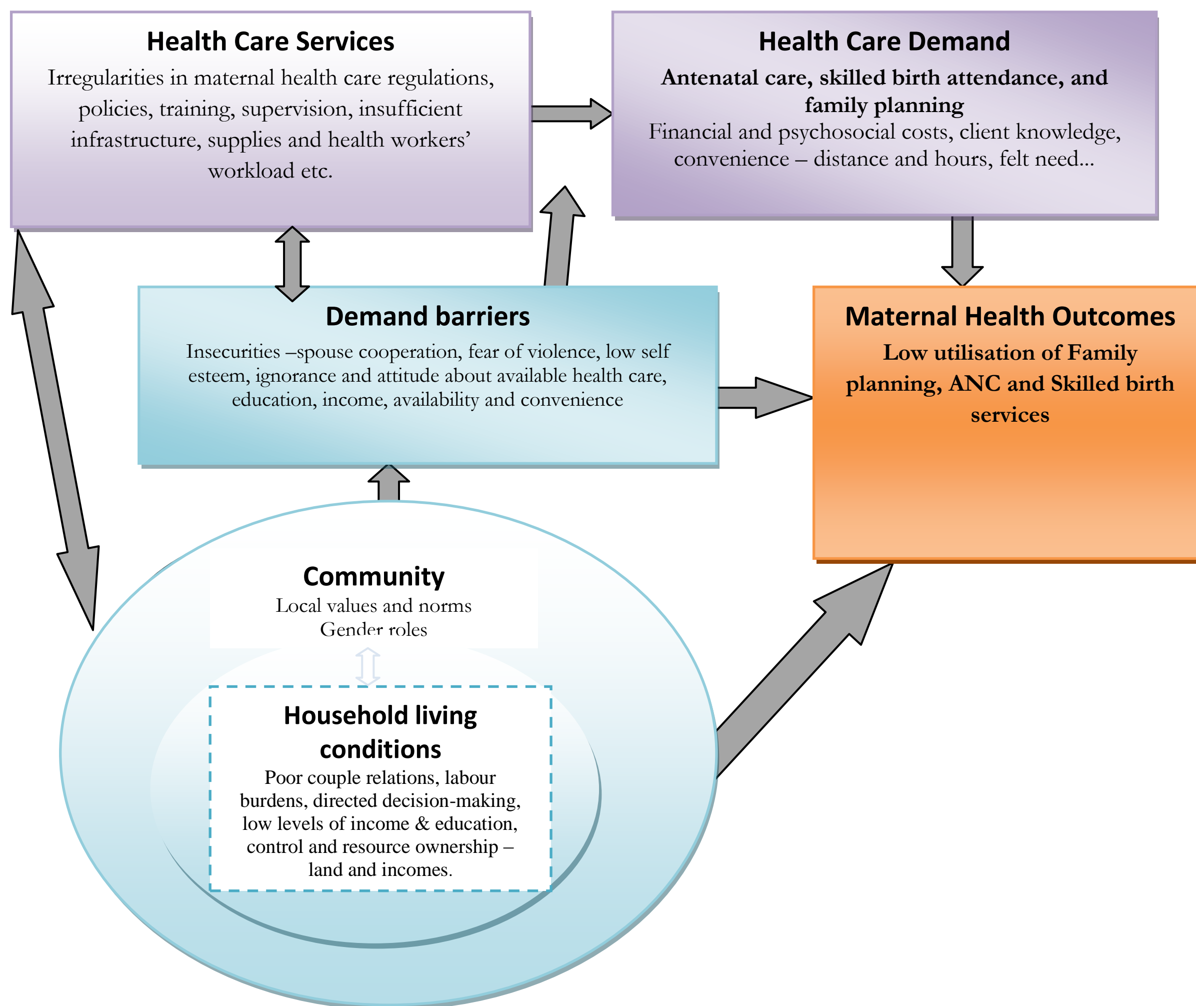


Figure 3 illustrates that the determinants of poor accessibility to health care for women not only have to do with supply factors such as the quality and availability of health care but are also demand related and include women's lack of decision-making autonomy, insecurity on family land and fear of violence or abandonment by their spouse and a chronic lack of time brought about by the overwhelming burden of household labour. Women's living conditions also limit their access to health care information, so they are often ignorant of the availability and accessibility of maternal health services. This conceptual framework illustrates that the ultimate effects of women's socioeconomic status are demand barriers such as insecurity due to fear of violence and lack of time, information and the financial resources necessary to access maternal health care. Women lack the physical and emotional resources needed to access care with confidence.

This thesis's conceptual framework recognises the influence of policy and service delivery structures. The circular part of the framework illustrates the household and the community as integrated levels that continuously influence one another. Utilisation of maternal health services involves weighing up social and economic costs, and it has been indicated in this thesis and other previous studies that women's maternal health care access depends on a number of factors that are not all related to the availability and quality of health services.

However, Uganda's health care delivery strategies are currently predominately focussing on the improvement of health care delivery through attracting health workers to public hospitals through salary increments, increasing medical supplies and equipping lower district health centres to reduce the distances travelled and related health care problems (Kiwanuka et al. 2008). As such, little focus is placed on community and household barriers, even in academic literature. To be able to undertake an analysis of both strategies (demand and supply), this study reviewed policy documents and carried out policy audits, i.e. assessments of policy priorities, as well as conducting facility base interviews and examining data on service delivery and its status.

For data on household factors that limit women's use of maternal services, relevant scientific literature was reviewed and interviews were carried out with community opinion leaders, elders, health workers and policy makers at the community, district and national levels to determine and assess the effects of household social and economic factors that are relevant to the accessibility of maternal health care services. The community factors, also known as living conditions or social determinants of health, have been divided into two categories: the community factors which constitute the overall norms and values that sustain interactions and behaviours. The framework illustrates how gender roles within a household generate social inequalities and are the underlying determinants of differences in exposure and vulnerability to health compromising conditions.

The framework above demonstrates a complete picture of a functional health system, and focuses on the demand and supply factors by looking at community, household and individual demand levels. The diagram showing how factors relate to each other is supported by studies which include evidence that maternal health care problems are multifaceted and so require multidisciplinary strategies; the strategies which will deal with both supply and demand factors (Ndomugyenyi et al. 1998; Ensor and Cooper 2004). This framework is intended to show how factors of the entire health system determine health

outcomes and that until we disintegrate the household level bottlenecks that are mainly concerned with upholding cultural norms from the rest of the determinates, maternal health improvement remains a dream.

Figure 3 explains the role of household inequalities within health care systems. However, this is not to say that this research disregards other inequalities but rather that it puts the household into context. Within a household there is a defined relationship of resources allocation and the influence over which resources are allocated to particular activities has implications for health behaviours (Thomas 1990; Furuta and Salway 2006). For maternal health, gender inequalities are a source of insecurity which determines women's maternal health outcomes. This thesis builds on and develops issues raised in the intra-household decision-making literature to present a line of argument on how gender roles interact to produce women's inability to take control of their health and how positive relations with their husbands are needed to enhance their physical and emotional capacity to seek pregnancy related care. The thesis explains how inequalities in division of household labour, couple relations and land use decision-making dynamics contribute toward a lack of maternal health care.

2.2 Addressing Intra-Household Inequalities to Improve Demand for Maternal Health Care

2.2.0 Introduction

This section of the literature review examines household level factors that determine maternal health care. The household is therefore the central unit of analysis for this thesis, with a focus on how differences in gender roles shape allocation and control of household resources, couple relations and eventually maternal health-seeking behaviours. This section concentrates on discussing relevant literature on household level inequalities with a specific focus on access to maternal health care. In the first part is an analysis of the household as a level of society at which the effects of social and economic inequality among its members are relevant. The thesis agrees and contributes to previous literature which has analysed the household as an institution in which its members unequally access its resources. The literature review is presented to examine household factors that limit equal access to household resources among its members.

This second section is organised into five sub-sections. The first sub-section analyses the concept of household inequalities and how it has been applied to health. Secondly is an analysis of household decision-making, to assess household resources bargaining and the disadvantages for maternal health care resources. The third sub-section looks at the gender dimensions of maternal health care by reviewing literature on gender as a dimension of social inequality and the effects of gender inequalities on women's health-seeking behaviour. The fourth and fifth sub-sections analyse household inequality by examining strategies that have focussed on gender equality and primary health care structures.

2.2.1 Perspectives on Household Inequalities

Inequality is a central concept in the SDH literature (Dixon 2000; Irwin and Scali 2007). Social, political and economic inequalities are the key causes of the differences in death rates and overall health outcomes experienced by the poor and the rich (Wilkinson 2005). However, when it comes to intra-household inequalities in developing countries, there are still significant gaps in the key SDH literature (Wilkinson and Pickett 2006). Most determinants of health studies concentrate on macro analysis with rich evidence on differences at subgroup and state levels (Subramanian and Kawachi 2004). As a result, data from aggregate levels is largely insufficient and inefficient in assessing the effect of relative positions at micro levels (Wagstaff and Doorslaer 2000).

A household can have a wide range of definitions and these depend on the definition's purpose. The first is of the household as the basic social institution where people live. In health and health care, a household has been referred to as a producer and consumer of health (Schumann and Mosley 1994). The growing literature on intra-household social inequalities and implications for maternal health requires a detailed definition of the household and its respective inequalities. Within the discipline of sociology, a household is a place where relationships are defined and norms constructed (Angel and Tienda 1982). The economist, on the other hand, emphasises the household's role in consumption, production, investment and allocation of labour and resources (Agarwal 2003). According to Holvoet (2005), a household is not necessarily a homogenous, neutral intermediary between economic policy and individual needs. It is not necessarily true that the allocation of resources within the household is in line with the needs and the policies for those in need of extra help (Alderman et al. 1995). The ways in which household resources are distributed is a measure of inequality, and age, gender and relation to the household head influence the nature of resource distribution (Alderman et al. 1995). Evidence shows that income inequality affects family structure and has been correlated with increasing single motherhood and decline in marriage among black women in the United States (Thomson et al. 1994).

It should not be assumed that a household is a complete institution in which members can exercises their preferences and choices (Agarwal 1997; Kabeer 1997). Often there are significant power and resource allocation inequalities that arise (Thomas 1990). Like other institutions, a household experiences inequalities, and women are victims because they largely belong to the household's lower socioeconomic sub-group (Shen and Williamson 1999). Common household inequalities are due to gender differences in education, occupation and income, work and gender roles, the social and physical environment and coping skills (Bolt and Bird 2003). These inequalities are specific features of the social context and are the pathways by which social conditions such as socioeconomic status translate into health outcomes, in which women are always at a disadvantage (Kawachi and Kennedy 1997). The household structure allocates power to different members which translate into significant inequalities. Women's health consumption behaviour is influenced by these power inequalities within a household (Berman et al. 1994).

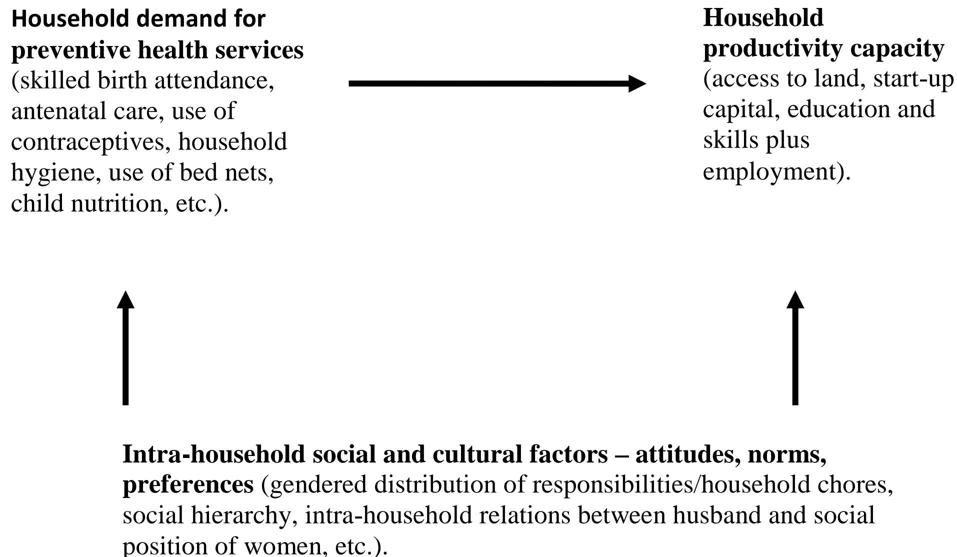
The critique by Navarro (2009) of the WHO SDH framework arises from its failure to consider power relations and living conditions at local levels. Navarro's criticism emphasises power categories of socioeconomic class, gender, race, and national power but lacks context on the importance of these

dynamics at the household level. Wilkinson's theory of social position assesses how socioeconomic differences caused by socioeconomic hierarchy limits power which causes material insecurity and social exclusion and other direct and indirect psychosocial effects (Wilkinson 1997) that might limit demand for health care. According to Solar and Scali (2007), social inequalities arise from individual social positions and unequal access to basic needs and opportunities due to failed governance at macro levels. Similarly, micro-level dynamics are likely to have the same effect. Lack of power conditions people's freedoms and capability to function (Nussbaum 2003) and so could be used to explain determinants of demand for maternal health care.

Women and children are victims of household level power inequalities, have less access to resources and cannot fully make decisions on the allocation of resources. Kabira et al. (1997) discuss the paradox of entrusting a woman with the responsibility of household and community health at the same time as denying her the opportunity to influence policies. In traditional Africa, the role of nurturing and ensuring a healthy family is given to women and they are customarily socialised as custodians of health (Mabsout 2011). However, a woman's performance in this role is restricted by her lower social status and, as a result, the woman's health cannot improve (Kyomuhendo 2003; Tebekaw et al. 2011). In most of rural Uganda, access to land is important to both men and women and relevant when one is discussing women's decision-making power in relation to their social status in a household. It is upon land that most rural households depend for their livelihoods, and lack of land has a strong association with poverty (Ellis and Bahiigwa 2003).

Household decision-making and resource allocation are affected by multiple factors including power and social relations, and these affect the health outcomes of the individuals. The household is a site of negotiation, bargaining and conflict with individuals having differential access to, and control over, resources and benefits (Bolt and Bird 2003). Household dynamics and women's decision-making need to be incorporated into health care service delivery. For example, it is difficult to understand opportunity costs from time lost leaving the home to seek care, without examining the time it takes and the permission required to leave the home. Whereas women engage in general care of family welfare, they still need to be permitted by their spouses to leave the house in order to seek medical care.

Figure 4: Interplay between Household Factors; Possible Ways for Getting Out of a Health Poverty-Trap



Adapted from Nyakato and Pelupessy 2011

While improved access to quality reproductive health services is key in reducing the maternal mortality rates experienced in most developing countries like Uganda (Ssengooba et al. 2004), a large number of women fail to access care because of other factors like long travel distances and the inability to make decisions at a household level (Donnay 2000). The above framework explains a possible health poverty trap that is a result of household social and economic factors. The factors are intra-household relations that connect together in a complex web and have a commonality that can cause a vicious cycle of low productivity and stagnant maternal and child health indicators in rural communities in South-western Uganda (Nyakato and Pelupessy 2011).

Within a household, therefore, there are social and economic inequalities that contribute to women's intra-household disadvantaged positions. The household inequalities are the result of cultural and community practices which assign roles based upon gender. Unfortunately, women's roles are disadvantaging and have negative implications for maternal health behaviours. This research updates the known factors such as household decision-making dynamics and control of resources and unpacks them into women's household labour burdens and quality of couple relations to create a basis for

understanding women's prospects for better health. This also helps to explore how to promote couple cooperation and male involvement in reproductive health. It is known that an important lack of progress in improving maternal health is linked to cultural norms that promote domestic violence and women's labour burdens.

2.2.2 Intra-household Decision-Making and Maternal Health Care

In most of traditional Africa, the responsibility of nurturing and ensuring the health of a family and the entire community is entrusted to women (Kabira et al. 1997). The contradiction is that women are denied the opportunities to control and influence not only the resources needed for family health, but also the material and non-material resources needed for their own health (Nanda 2002). Household health care resources are typically controlled by men, who dictate what should be done even if they do not understand the needs (Mwaka 1993). Additionally, in some cases women's attempts to influence decisions have been linked to domestic violence (Blanc 2001). Such domestic violence has been linked to fears of men that women's empowerment programs are a strategy to wrest from men their traditional powers and authorities within the household (Koenig et al. 2003).

Violence is commonly accompanied by emotional abuse, economic restrictions and controlling behaviours (Watts and Mayhew 2004). Despite the relevance of intra-household dynamics, research is limited and quite recent, with more research in Asia than the rest of the developing regions like sub-Saharan Africa (Agarwal 1997; Allendorf 2010). It is from this background that this chapter presents an analysis of intra-household inequalities in decision-making to analyse factors that affect women's household level status.

The intra-household decision-making process is one factor that delays women's accessing of care at the times when it is most needed. Difficulties in household decision-making have been related both to women's lack of decision-making capacity and the general status of a household. According to Berman et al. (1994), while a household is often the smallest form of social institution, its dynamics of production, consumption and social production ultimately determine the health outcomes of its individual members. Household level health is determined through a dynamic behaviour process which is as a result of a combination of internal factors related with knowledge about health services, resources, and behavioural norms and patterns – and external factors such as technologies, services, information, and skills – to restore, maintain and promote the health of members.

However, the socioeconomic differences in access to consumption and production resources among household members affect access to care, by which women and children are the most affected (Beegle et al. 2001). Women's lack of bargaining power within the household does not only impact on their own health, but that of children and other members of the household, including men. One of the other consequences of unequal power within the household is gender based violence, and the physical and psychological impacts of violence on reproductive health (Blanc 2001).

A wide range of factors determine intra-household decision-making and resource allocation. Women's bargaining power within the household is largely determined by income, asset ownership, education, age and kinship and type of marriage, quality of relations and their overall social status (Ashraf 2009; Allendorf 2010; Tebekaw et al. 2011). Different models have been used to assess women's bargaining power, with initial models depicting a household as a single production and consumption unit, but later analyses of bargaining advancing other models of household decision-making, including cooperative, collective and non-cooperative approaches (Rao 2012).

Given that the household is the main producer of health and that individuals in the household are the main consumers of health care, it is logical that inequalities within a household should be investigated. It is the household and the power embedded in household systems that control decisions with regards to health and health-seeking behaviours (Alaba and Koch 2007). Inequalities in gender roles, decision-making, income, influence and power indicate a need to apply SDH theory to the household level. Household inequalities have gender connotations and power struggles embedded in hierarchy, and eventually compromise women's capacity to access maternal health care (Woldemicael 2007). This study assesses the effect of household inequalities on housework labour, decision-making and land ownership. Whereas women are burdened by house and farm work labour, men keep control of decisions to allocate income generated from farm work and to purchase and sell land. Women depend on their husbands for land access and so are compelled to cooperate. I show that the fear of losing land rights and dependence on men's decision-making affects women's maternal health-seeking behaviours.

2.2.3 Gender Relations and Women's Property Rights in Uganda

Before analysing the gender dimensions of maternal health care, this section specifically puts into context aspects household level gender relations and women's property rights. Ugandan society has cultural rules that determine the gender identities, expression and roles of its members. In many

communities, roles of men and women vary, and gender role definition is entrenched and begins with family formation at marriage. Men and women have specific roles that contribute to the formation of Uganda culture. In this section of the literature review is an explanation of the marriage process and its linkage to gender role, intra-household relations and access and control of household resources, particularly land. The review also takes into account policy developments on family relations and women's control of over family assets.

According to Otiso (2006), marriage is traditionally one of the most important social customs in Uganda; being unmarried for both men and women has historically been considered being incomplete. Traditionally, polygamous men were more highly esteemed than those in monogamous marriages (Struensee and Vanessa 2004). Marriage is a means of unifying families, lineages and clans. The extended families of both the bride and the groom have historically played an important role in ensuring survival of the marriage (Asiimwe 2001). In many Ugandan communities marriage confers high social status on both men and women (Otiso 2006; Doss et al. 2012).

In addition, Ugandan society is patriarchal and males have greater access to the country's socioeconomic resources and privileges than do females (Rugadya et al. 2004). Because Uganda is a patriarchal society, at marriage women move to their husband's family to live and be integrated into the extended family (Otiso 2006). It is the extended family that ensures payment of dowry/bride wealth and survival of the marriage. The extended family is comprised of the men's kin who trace their lineage to a single ancestral patriarch. The other essential feature of marriage is that it entrenches the social norms and customary laws related to land ownership and other property inheritance (Doss et al. 2012). Uganda's Marriage Act of 2000 provides for civil marriages of all religions and gives recognition to customary marriage (Hunt 2004).

However, marriage in modern Uganda is undergoing profound changes because of socioeconomic and cultural changes. Religion, rising urbanisation, changing opportunities in the modern economy and the increasing pressure on land resources have lead to significant increases in monogamous marriage. Nevertheless, it remains the case that only through marriage do women secure land and other property rights. Land and livestock are important sources of livelihood for the Ugandan agrarian society, of which the majority of people, especially women depend on and work in agriculture (Garcia 2006).

In recent years, Uganda has taken important steps towards improving women's property rights. Much literature considers Uganda's Constitution to be one of the most gender neutral with regards to property in sub-Saharan Africa, including land rights that accord both men and women the same status and rights (Rugadya et al. 2004). However, it is also important to note that the erosion of customary land ownership in women's land rights through formal and informal relationships has weakened in the face of increased land commercialisation and scarcity (Tripp 2004). Other problems have been linked to shortcomings in the law and increased pressure on family relations (Asiimwe 2001).

In the 1998 Land Act, spousal consent requires that before sale of family land by a husband or wife the partner must consent (Joireman 2007). While there are shortcomings in the laws, in particular the Marriage Act 2000 and Customary Marriage Registration Act, issues of divorce, property rights and inheritance were addressed in the Domestic Relations Bill which was introduced in 1965 but has remained in contentious debate for decades and has never been passed into law (Doss et al. 2012). As a result, Uganda does not have a law set to directly regulate marriage and family relations. Therefore, the laws should be extended to regulate marriage and family relations and determine the legal status of men and women in the family. It should also provide legal recognition of joint property rights and a consensual union.

From this literature it can be concluded that the family is an important factor in the definition of gender roles, individual socioeconomic status and gender differences in access to resources in Uganda. The marriage process and maintenance of family relations play a key role in sustaining gender relations at the family and community levels. It can also be concluded that maintaining the gender relations status quo could be preventing enactment of laws such as the Domestic Relations Bill, which advocate for gender equality at the household level. Intra-household relations and allocation of resources are controlled and regulated by culture, which at the same time perpetuates household level gender inequalities.

2.2.4 Gender Dimensions of Access to Maternal Health Care

There are many factors that limit women's access to health care including low levels of education and income that are rooted in women's social vulnerability. Social factors, including women empowerment, need to be paid attention to and much more directly (Filippi et al. 2006). Women's empowerment through enhancement of choice and freedom needs to be at the forefront of maternal health promotion

programmes. However, resource allocation and policy concerns remain rooted in the model of health that sees health as the absence of disease (Ensor and Cooper 2004; Rosato et al. 2008).

According to SDH theory, good health involves reducing levels of educational failure, insecurity and unemployment and improvement of housing standards, as well as health policies that address all aspects of inequality (Wilkinson 1997). However, income poverty in itself, has been found to provide an incomplete explanation of differences in mortality rates between countries or among sub-groups within countries (Wagstaff 2002). Successful strategies are those that ensure that a public health strategy incorporates relevant social conditions (Wilkinson 2006; Bhutta et al. 2008). Social living conditions and community practices that marginalise the autonomy of certain groups of people create severe health inequalities. Gender is one of the major known non-income determinants of health (Wilkinson 1997).

According to Marmot (2005), because major determinants of health are social, so must be the remedies; the health differences between population groups are due to characteristics of society and when people change their social and economic environments their disease risks change. Marmot also argues that the health gradient is not a function of poverty alone but also causes inequality across the socioeconomic spectrum; as one move down the social hierarchy, life expectancy gets shorter and maternal mortality rates are higher. For maternal health, gender inequalities have been found to comprise all-important characteristics of social deprivations (Doyal 2000). Although women's empowerment has been found to create substantial improvements it is not always a priority for maternal health care strategies in developing countries (Kerber et al. 2007). Successful maternal health improvement strategies are those that have dealt with gender inequalities at all levels, including within a household (Penn-Kekana et al. 2007; Ahmed and Khan 2011).

Women's social and economic empowerment positively influences their likelihood to attend antenatal and post natal care, skilled delivery care and family planning (Currie and Wiesenberg 2003; Filippi et al. 2006; UBOS 2006). Gender inequalities at all levels discriminate against women and create the reverse effects (Ahmed and Khan 2011). An understanding of gender is necessary in order to effectively analyse the intra-household social determinants of women's access to maternal health care.

Sociologists distinguish between large scale gender inequalities such as labour force, educational and political trends and small scale gender roles that are directed by the details of gender interaction that occurs, for example, between couples, in families and among peers (Lueptow et al. 2001). To a large

extent family has continued to inform current sociological thinking on gender roles and emphasises that socialisation play a key role in gender development, resulting from parents' differential treatment of boys and girls (McHale et al. 2003).

In addition, economists' perspective recognises gender as relations that are both constituted by and help constitute the division of labour and resources between men and women in an interaction within structures of social hierarchy such as age, class, caste and race (Agarwal 1997). Both disciplines tend to agree that gender relations are neither uniform nor historically static and are largely socially constructed (Agarwal 2003; Kabeer 2005). However, the process of social construction of gender relations is inadequately understood and maintains gender inequalities. One factor that maintains status quo is family and its stability, which hinges on maintenance of unequal resource positions between men and women (Molyneux et al. 2002). Through socialisation, the family promotes and maintains gender inequalities (McHale et al. 2003).

Despite this perspective, gender inequality has a greater impact on women than on men. Domestic patriarchy is strong, whereby men regard women as their property because they pay bride wealth before marriage (Mason and Smith 2000). The outcomes of socialisation and related gender relations such as the marriage process predetermine that men are decision-makers and women play a care role. In most communities it is more likely that men have more opportunities to have an income and more political and social rights than women (Wilkinson 2005). Women experience more poverty than men due to gender discrimination (UBOS 2006; Lawson 2008). Gender conflict arises from access to critical forms of household property such as land. Typically, the decision-making process within a household is hierarchical and must be initiated by husbands. In most African households decision-making is primarily a male prerogative and women carry a more supportive care role (Molyneux et al. 2002).

Therefore, gender roles dictate women's social, political and economic status and thus account for a significant dimension of their health. Women's socioeconomic status in itself causes ill health because of differences in lifestyle in relation to other factors such as poverty, unpaid work, lack of education, domestic violence and low social status. There is also evidence that women in many relationships have a minimal role in negotiating sex and as a result, most of Africa is faced with a high burden of unplanned pregnancies (Blanc and Way 1998). Each year an estimated 775,000 women have an unintended pregnancy of which 85,000 of them end up in unsafe abortions. The unmet need for family

planning is estimated at 41%. While health workers advise young women to keep their pregnancy, 30% end in induced abortions (Kagumire 2010). Pregnancy before marriage is not socially accepted and leads to social discrimination. Studies have found that young girls who practice abortion mostly use non-medical methods and many lead to death. In the case of Uganda, unsafe abortion accounts for 9% of all maternal deaths.

Women's lack of decision-making is an aspect of gender relations that impacts on women's health and remains complex. It is a combination of a wide range of factors that determine women's status (Bloom, Wypij et al. 2001). The trend is such that decision-making for household resources and the choice of number of children/fertility is commonly a designated role of men; women avoid open confrontation and cooperate (Sen 1987; Blanc 2001). Although some studies have shown that women in their later life gain independence and make certain decisions (Beegle et al. 2001; Bloom et al. 2001), this is at the time beyond when women most need control of their life – control of their reproductive decisions.

According to the 2005 Uganda Demographic and Health Survey (DHS) data on participation in decision-making, the percentage of women who make major decisions in their household varies from 15% for decisions about large household purchases to 35% for daily household purchases. Major decisions are made by husbands or partners. Only 22% of married women say they mainly make decisions about their own health. Almost two-thirds say their husbands/partners make the health decisions. 20% of women can make independent decisions to visits friends and relatives. 36% say their decisions to visit are made by husbands/partners. However, men's limited involvement and lack of awareness about reproductive health has been associated with poor maternal health mainly because maternal health has remained a matter for women, regardless of their lack of decision-making power over the use of family resources (Mason and Smith 2000).

Gender-based violence, in particular, domestic violence, is an extreme phenomenon of gender inequality affecting millions of women in the world (Ostlin et al. 2006). Gender-based domestic violence takes different forms: physical, sexual, emotional and economic (Karamagi et al. 2006). In many cases, domestic violence goes unnoticed mainly because it is culturally accepted and sustained (Johnson and Ferraro 2000). Domestic violence is highly prevalent in sub-Saharan Africa, ranging from 13% to 49% of women having experienced violence at some point; physical violence against women ranges from 7% to 10% in Zimbabwe and South Africa to 77% in Ethiopia (Watts and Mayhew 2004). In Uganda, many

more women than men experience physical violence (60% of compared to 53% of men) (Kaye et al. 2006). Violence takes different forms and is justified for different reasons; in 2003, Koenig et al. found that use of contraceptives without the consent of a husband is a growing cause of wife beating. In Uganda, 70% of women have experienced physical or sexual violence, 60% of women have experienced violence during pregnancy (Kaye et al. 2006; UBOS 2006). Women are also more likely to experience sexual violence; more than 1 in every 5 as compared to men with 1 in every 10 (UBOS 2006).

This section of the literature review has indicated that the gender dimensions of women's access to health care are rooted in the household social and economic resources allocation, decision-making and male domination or patriarchy. The inequalities in resource allocation by gender make gender analysis an important aspect of social determinants of health. Household inequalities in decision-making and division of labour determine women's health due to the related restrictions on women's social and economic freedom. The distribution of gender roles strains women's attempts to take charge of their own health, especially because change of role can be a source of gender conflict that manifests in gender-based violence. Therefore, challenging gender roles which limit women's access to health care requires a multilevel analysis of social and economic policies. Thus the gender dimensions within this literature review have illustrated the intra-household barriers to women's access to health care that are largely embedded in gender roles which determine decision-making.

2.2.5 Initiatives on Gender Equality and Maternal Health Promotion

Gender is an essential factor with the SDH literature (Marmot et al. 2008). The social construction of gender creates both differences and inequalities between men and women's access to education, income, occupation and other related opportunities. Gender is a critical dimension according to which household, community and national resources are allocated (Sen 1987; Agarwal 1997), and in the process the gender inequalities in access to resources greatly impact on women's health (Doyal 2000). It is because of problems resulting from injustices and linked to women's low societal status that efforts have been geared towards improvement of women's status. In the majority of poor countries, women are a marginalised group, have less or no education, are affected by poor health, and live in poverty, discrimination and deprivation (Agarwal 1989; Bunch and Fried 1996).

More than thirty years ago, the 1978 Alma Ata Declaration promoted a comprehensive approach to improving health, with an emphasis upon building health systems from the bottom up through primary

health care and promotion of health equity (Travis, Bennett et al. 2004; Bryant, Richmond et al. 2008). Subsequently, a wide range of global initiatives have for decades directed efforts towards integrating gender equality, improvement of women's status and maternal health promotion. The 1994 International Conference on Population and Development (ICPD) that took place in Cairo and the 1995 fourth World Conference of Women in Beijing outlined a broader plan to combined reproductive health services with education, economic development, and job creation and training to meet defined health and women's empowerment goals (Yanda et al. 2003).

Another important highlight of the ICPD is the promotion of the right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have information about the means to do so and the right to enjoy the highest obtainable standard of sexual and reproductive health. It also includes the right to make decisions concerning reproductive health free from discrimination, coercion, and violence as expressed in the human rights documents (DeJong 2000). It is a shift from an emphasis on population to reproductive health, which introduced a comprehensive approach to women health's and well-being. It includes a wide range of issues from fertility to infertility, contraception, abortion, child health, maternal morbidity and mortality, sexuality and sexually transmitted diseases (Lane 1994). Empowerment of women was the central policy goal of both ICPD and the 1995 Beijing conference. The Beijing conference demanded economic and political empowerment of women and called for more active intervention of governments on behalf of women's equality (Moghadam and Senftova 2005). The ICDP on the other hand integrates health, human rights and development (Barton 2005).

The global concern around high maternal mortality, particularly in developing countries, led to the Safe Motherhood Conference in Nairobi in 1987 and the subsequent introduction of the Safe Motherhood Initiative (SMI) (Starrs 2006). The Safe Motherhood Campaign targets were to achieve universal access to antenatal and skilled care during childbirth to prevent women from dying of pregnancy-related causes (Maine and Rosenfield 1999; Jowett 2000). The SMI broader target was to reduce the 1990 maternal mortality rate by half by 2000, and further reductions by 2015. In line with arguments for addressing women's status, the SMI also aims at addressing men's support and commitment to women's health. The initiative acknowledges that the trends of high rates of maternal morbidity and mortality relate to regions where women have low literacy and limited rights. It reflects on two important issues: 1) men's

lack of understanding of the risks of pregnancy and 2) limited access to life-saving treatment due to societal gender inequality and the low value placed on women's lives (Jowett 2000).

According to AbouZahr (2003), the Safe Motherhood Campaign is a rights-based approach that defines maternal heath as a social injustice and a health advantage that obligates governments to address the causes of poor maternal health through political, health and legal systems. Since the SMI, the problem of maternal mortality and morbidity among poor countries has become an important development agenda. Since the campaign was initiated, maternal mortality has gained more attention than it had previously, but maternal mortality has remained quite high. In sub-Saharan Africa, about one woman dies for every 100 live births compared with every 1 in 5000 births in developed countries (Tita et al. 2007).

In 2001, the African States committed themselves to the Abuja Declaration to increase health care expenditure to 15% of the National GDP (Agaba 2009). The recent global initiative to improve maternal health is captured by the Millennium Development Goals (MDGs). In 2000, the United Nations during the Millennium Summit adopted eight MDGs that more or less tackle issues that affect women's status – education, poverty, income, child health, gender equality, HIV/AIDS and environmental sustainability. Similarly to the previous debates, the third MDG aims at promoting gender equality and empowerment of women. The goal aimed to eliminate the gender disparity in primary and secondary education preferably by 2005, and at all levels by 2015. In addition the fifth goal aimed at reducing the maternal mortality rate by three quarters between 1990 and 2015, and achieving universal access to reproductive health (Freedman 2005).

Whereas the MDGs adopted in 2000 have been seen to be the next generation of promoting 'health for all, the Count Down to 2015 indicates insufficient progress in the attainment of MDG 5 by most countries (Bryce 2008; Bhutta et al. 2010). It was estimated by the WHO that 302,000 to 394,300 maternal deaths occurred in 2008 and more than 50% of them occurred in 6 countries (India, Nigeria, Pakistan, Afghanistan, Ethiopia and Democratic Republic of Congo) (Bhutta et al. 2010). Estimates suggested that global progress between 1990 and 2005 was a reduction of 0.8% per year less than the required 5.5% (Hill, Thomas et al. 2007). As Bhutta et al. argue, access to maternal health services remains important:

> Reduction of maternal mortality and the estimated 20 million pregnancy related disabilities per year will required concerted efforts to improve coverage of comprehensive family planning programmes and antenatal care and skilled attendance at delivery, emergency obstetric and post natal care (Bhutta et al. 2010 pg.2037-238).

Despite the subsequent slow progress in improvement of women's health, especially among poor countries, the concern and debate for improvement of maternal health and the status of women has continued. Ranging from women's empowerment at the Cairo ICPD in 1994 to the 1995 Beinjing conference and then the Safe Motherhood Campaign and now MDGs, improvement in and women's access to maternal health services remains a challenge. In summary, although there is still difficulty in improving maternal health and promotion of gender equality, attempts have been made at all levels. There is wide acknowledgement and effort towards integrating improvements in women's socioeconomic status with improvements in maternal health. Regions and countries which have improved women's status through education and access to income offer good evidence. The improvement of women's status needs to be addressed at all levels, including from the household level. The social and cultural settings need to allow women's decision-making and men's involvement in reproductive health.

2.2.6 Primary Health Care Aspects of Social Determinants of Health

The 2010/2016 Uganda's Health Sector Strategic Plan (UHSSP) acknowledges the need to address social determinants of health for effective service delivery and improved health care access (Uganda 2010). In relation to the concept of social determinants of health, the 1990's establishment of Uganda's Primary Health Care structures was aimed at attaining and establishing universal access to health care (Okello et al. 1998).

It is on the basis of improving access to health care that this section of the literature review identifies the merging aspects SDH and intra-household inequalities. Sections 2.1.1-2.1.3 of the literature review discussed SDH theory and further explored the extent to which the theory addresses intra-household inequalities. While rising awareness about SDH is one of the three principles of the WHO CSDH (Marmot et al. 2008), this thesis explores the health system structures that support the application of the SDH framework. The integration of primary health care (PHC) and SDH is supported by the 2008 CSDH report, which has been seen to champion primary health care as a model for health systems that acts on underlying social, economic and political factors for health (Chan 2008).

In this section of the literature review is a critical analysis of the primary health care strategy and its relevance to SDH. The section discusses the potentiality of improving primary health care through integration of SDH, which is further analysed in Chapter 7, giving a specific discussion of Uganda's primary health care structures. The discussion is based on research finding on intra-household dynamics and use of maternal health care in Mbarara District, presented in Chapters 4, 5 and 6. In Chapter 7, the thesis specifically discusses the avenues for improving use of maternal health care through having PHC structures that address intra-household determinants of women's decision-making.

In 1978, the Alma-Ata Declaration articulated PHC as a set of guiding values for health development articulated in a range of approaches for addressing priority health needs and the fundamental determinants of health. The declaration affirmed access to health services as a fundamental human right. The approach formally adopted providing health services as PHC, which involved universal, community-based preventive and curative services with substantial community involvement (WHO 1978). Frenk (2009), in analysing the need to integrate PHC in health systems, asserts that the origins of the idea of PHC could date to as far back as 1920, when in the UK there existed three levels health care structures – primary centres, secondary health centres, and teaching hospitals that are still the basis of the pyramidal regionalisation of health services that prevail even today. Other inspirations for the PHC model have been linked to the former Soviet Union Feldshers and Polyclinics, the South African Pholela Health Centre Model, the Barefoot Doctors in China and the 1960's Christian Medical Commission.

By 1940, the Pholela Health Centre had pioneered community oriented PHC in rural Kwazulu-Natal South Africa. The centre provided comprehensive preventive and curative services that utilised community-based investigations to inform provision of health services and incorporated health education and health promotion as essential components of health delivery. The model emphasised holistic health care rather than simply medical care (Kautzky and Tollman 2008). Barefoot Doctors in China was a programme introduced in 1968 by the journal *Red Flag* as a national policy focused on quickly training paramedics to meet rural health care needs (Zhang and Unschuld 2008). The Barefoot Doctors programme was assessed to have effectively reduced costs and provided timely treatment to rural people (Cueto 2004).

It is important to note that the PHC setting has retained a framework that is inclusive of interventions delivered at first level health facilities (Bhutta et al. 2008). The major principles that guided the

establishment of PHC approaches were guided and strongly affirmed by the WHO's definition of health which states that:

> health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, …is a fundamental human right and … the attainment of the highest possible level of health is a most important world-wide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector (WHO 1978).

In reality, however, after more than three decades since the Alma-Ata Declaration, universal access to health and the health for all movement remains unfulfilled (De Maeseneer et al. 2007). The achievements of PHC have fallen short of attaining universal access to health care among the poorest populations of world, women inclusive. Several reasons have been provided to explain these failures: among developed countries experts and politicians refused to accept that communities should plan and implement their own health care services; among poor countries, the health sector reforms of the 1980s and 1990s, rooted in market forces and the economic benefits of better health, led to trading-off comprehensive for selective PHC (Hall and Taylor 2003).

The other important barrier identified has been the advancement of selective PHC under the pretext of cost-effectiveness (Magnussen et al. 2004). Advocates for selective PHC have argued that comprehensive PHC was too idealistic, expensive and unachievable in its goals of achieving total population coverage (Cueto 2004). Selective approaches are credited for substantial progress in many countries with immunisation coverage, measles reduction, control of the guinea worm, polio eradication, elimination of iron deficiency, breastfeeding and provision of safe water and sanitation (Beaglehole and Bonita 2004). However, evidence shows that interventions that can be routinely scheduled and delivered such as immunisation and antenatal care tend to have higher coverage than those that rely on full-time availability of clinical services such as skilled or emergency care at birth and care of sick newborn babies and children (Bhutta et al. 2008).

Therefore, it is still important that all the comprehensive aspects of PHC – infrastructure, services, skilled personnel, community attitudes and perception – are take care of (Bhutta et al. 2008; Bryant et al. 2008). Selective programmes have been found to lack the potential to challenge people's values and they tend to depend on professional hands-on services giving high credence to the importance of medical technology (Bhutta et al. 2008). This is quite a big challenge for poor countries faced with insufficient health sector funding, poor infrastructure and low retention of health personnel.

However, challenges to the improvement of maternal health care have been associated with factors that range from those associated with healthcare delivery to those related to women's status at both community and household levels. For example, maternal health programmes have become increasingly aware of the role household that decision-making plays in women's care-seeking behaviour (Bolt and Bird 2003; Furuta and Salway 2006). The following is a set of selected examples presented to create a basis for discussing how addressing women's status translates into positive results that can be associated with the need for reinventing comprehensive PHC in the delivery of maternal health services: Between 1988 and '89, the Zimbabwe Family Planning Council conducted a national education project targeting men, the first of its kind for sub-Saharan Africa. By the end of the campaign, men who took part in the programme were two times more likely than others to state that the husband alone should not decide whether to practice family planning (Kim et al. 1996). Male involvement in health has since attracted more attention in many aspects of maternal health, especially in HIV/AIDS control programmes (Dudgeon and Inhorn 2004).

A related example is from Indonesia's Suami SIAGA Campaign of 1998, which was implemented by the Ministry for Women's Empowerment. The major intervention was a large scale multi-media entertainment education intervention that targeted husbands with messages about birth preparedness and creating community-level awareness about the three delays that can prevent pregnant women from receiving appropriate care during an emergency. The campaign among other things led to a significant increase of men accompanying their wives to checkups/deliveries (Shefner-Rogers and Sood 2004).

Another example from Uganda is the 1996 RESCUER Project supported by the UNFPA under the Ministry of Health. The project extended services to rural communities through an effective referral system to handle emergency obstetric cases, through: equipping health referral facilities with minimum quality obstetric equipment; training and posting nurses and mid-wives; establishing feasible and cost-effective communication systems between traditional birth attendants and referral facilities in the catchment areas; and devising effective means of transport using three-wheeled motorised vehicles. The project evaluation indicated a dramatic increase in the number of obstetric referrals and Caesarean sections (Musoke 2002; Nanda et al. 2005). Between 2000 and 2003, Rwanda implemented a project aimed at the delegation of life saving skills from doctors to mid-level providers for obstetric complications in Nyanza District Hospital. The end of project evaluation indicated that under adequate

supervision and with immediate caesarean section back-up, vacuum deliveries conducted by competent mid-level providers are safe (Nanda et al. 2005).

The above examples are from a wide range of settings which is an indication that maternal health care remains complex and require comprehensive interventions that are based on local examples. Therefore, for maternal health care in poor countries with diverse gender inequalities, programmes should be designed in ways that adequately deal with the comprehensive nature of women's burdens of holding a lower status at both household and community levels. It is important to note that if PHC structures are to be effective in delivery of maternal health care, they should reach the poorest households and reduce the existing inequalities in utilisation of services. Where local projects have successful, they should be scaled up to national and regional programmes (Donnay 2000).

To briefly summarise the discussion here, Chapter 2 has been presented in two sections: Firstly, the chapter presented the theoretical and conceptual framework which discussed the theoretical underpinnings of the thesis and intra-household perspectives of maternal health care among poor countries, with a particular reference to Uganda. In that section the chapter began with a discussion on the foreseen failure of not meeting the MDG of reducing maternal mortality by 75% by 2015. It then explored SDH theory in relation to maternal health care access by indicating the wide range of social, economic and political factors that combine with a lack of maternity service, shortage of health personnel, delivery by untrained persons and poor environmental sanitation and which thus sustain poor maternal health outcomes. The chapter also conceptualised the ways in which a household keeps custody of inequalities that negatively affect women's access to maternal health care.

Secondly, the chapter presented discussions on intra-household gender relations, decision-making and resource allocation. It is here that the chapter looked at the different gender dimensions of maternal health care, with a specific analysis of intra-household gender relations and property rights in Uganda. This second section of the literature review also presented an analysis of the different local, national and international initiatives on gender equality and maternal health promotion. Finally, the chapter gave an analysis of the maternal health care systems by refocusing on social determinants of health and primary health care strategies to improve access to health care.

CHAPTER THREE

Study Setting and Methodology

3.0 Introduction

The chapter presents a detailed description of the study area, data collection and analysis methods. The first section of the chapter presents the socioeconomic demographic characteristics of Mbarara District with a specific reference to Kashari County where the empirical data was collected. The second section of the chapter is the description of the study design, data collection methods and sampling methods and procedures. Lastly in the chapter are the study's limitations.

3.1 Description of the Study Area

The study data was collected from Kashari County in Mbarara District, Uganda. Administratively, Mbarara District has three administrative sub-divisions and these are Kashari County, Rwampara County and Mbarara Municipality. Rwampara and Kashari Counties are the rural areas of the district and Mbarara Municipality is the urban sub-division of Mbarara District.

Data was collected from Kashari County which is divided into eight different sub-Counties which are Bubaare, Bukiro, Kashare, Kagongi, Kakiika, Rubaya, Rubindi and Rwanyamahembe. The sub-counties are divided into parishes and on average each sub-County has eight parishes. Each parish has up to 800 households and each household has an average of 5 people. 55% of Mbarara District's population is under 18 years and only 5% are above 60 years old. The majority of the district's population is indigenous. According to the 2002 census, 84% of the population was found to have been born in the district (UBOS 2009; Mbarara 2010).

The population of Mbarara district stands at 418,200 with 204,300 men and 213,900 women. Kashari hosts 44.3% of the district's total population, Rwampara 36.5% and the Municipality has 19.1%. The average population growth rate is 2.8%, which is lower than the national figure (3.2%). Mbarara Municipality has the highest population growth rate of 6.1%, followed by Kashari 3.17% and Rwampara has the lowest at 1.08%. The population growth rate of females is higher than that of males. The Municipality has the highest growth rate of females of 6.89% (UBOS 2009).

Mbarara District Health overall health status and services: The district health infrastructure follows the National Policy guidelines and is categorised into: (i) curative/clinical services, (ii) preventive services (school health, environmental health and sanitation, child immunisations, growth monitoring, HIV counselling, prevention of STI/HIV, epidemics and disaster prevention, nutrition, adolescent counselling), (iii) maternal and child health (maternity services, antenatal care, intermittent presumptive treatment, infant feeding, family planning and PMTCT – Prevention of Mother to Child Transmission of HIV/AIDS), (iv) surveillance for special diseases, (v) health education and promotion and (vi) in-patient services and rehabilitation services. The district health department also carries out outreach services and support and management functions (Mbarara 2010).

The District has 53 functioning health units which are either operated by the district local government or private or non-governmental organizations. These include 4 hospitals, 4 health centres at level IV/sub county health centre (level IV health centres are planned to offer obstetric care, inpatient services and minor surgeries), 13 health centres at level III (which offer outpatient services and inpatient for normal delivery attendance) and 29 health centres at level II (which offer outpatient care). All health centres are planned to offer routine antenatal care, family planning services and childhood immunisations. FM radio stations programs and other media health promotion and education have been intensified to create awareness in the community towards better preventive and curative health, to improve behaviour and utilisation of existing health services. The District offers community-based services through mobilising people towards social, economic and political development (Mbarara 2010).

Mbarara District registers almost 100% coverage of immunisation of the recommended childhood diseases, 60% safe drinking water and 74% latrine coverage. Eighty percent (80%) of mothers receive antenatal care and only 50% of deliveries are supervised or attended by skilled personnel. For the last three decades, the total fertility rate of the district is 7.0 children per woman, slightly higher than the national figure (6.9 children per woman). Mbarara District's contraceptive prevalence rate is 30%. Access to emergency obstetric care is still poor (Mbarara 2010).

Malaria is the common illness contributing 60% of the disease burden. Relating to maternal and prenatal diseases, the 2008/09 health report ranks malaria first (61%), followed by miscarriage and abortion-related complications (30%), high blood pressure (4.9%) and obstructed labour (4.5%). Comparatively, HIV/AIDS prevalence rate is 6.8% for the general population(Mbarara 2010).

The main sources of water for rural areas are boreholes, protected springs, and rain water and gravity flow. In the urban areas, tap/piped water is the main source. Sanitation and poor hygiene practices remain key causal factors of most childhood diseases. Only 19% of the population has a hand-washing facility after using the latrine, 65% of the households have a kitchen and 69% have a bath shelter. Malnutrition is another problem affecting children with over 206 cases reported in the 2008/09 district health report. Respiratory tract infections also contribute significantly to childhood illness and deaths in the District. People's cultures, attitudes towards healthcare and the inferior position of women in these communities determine the overall maternal health behaviours and outcomes (Mbarara 2010).

Development and other social and economic indicators: Regarding most developmental indicators, the district can be compared with other districts of the country. Within the western region, Mbarara district is rated as a relatively wealthy district with poverty incidence below 20%. Over the last few years, Mbarara district has enjoyed a steady annual economic growth rate of about 6.5%. The overall poverty trends between 1992 and 2005 show that the district has experienced considerable reductions in all poverty measures (40% to 21.4%). However, the rural areas' poverty levels are still high with increasing economic inequalities (ranging between 30% and 60%). The poverty inequality trends in the district can be explained based on people's social and economic activities. People involved in animal farming, particularly cattle keeping, tend to be richer than those involved in subsistence agriculture. Like in most regions, female-headed households experience more poverty risks (UBOS 2009).

With regards to education, the district has a relatively high adult literacy rate at 52.6% (compared with the national average of 50%). Primary school enrolment has maintained a positive trend of around 5.1%. However, the district has a high primary school dropout rate whereby almost half of those who enrol in P1 do not complete P7. Functional Adult Literacy (FAL), a program targeting adult learning attendance, increased to 79%. FAL learners have steadily increased and in 2009 the figure stood at 5,336. It is mainly the females who attend the FAL classes as opposed to males (of every 10 learners, only 2 are male) (UBOS 2009).

Social Structures and Income-Generating Activities: Most people in the district are farmers and earn most of their living through farming. The farming, in most cases, is subsistence whereby families sell off the surplus to be able to buy what they do not produce on their farms. More than 2/3 of the population

depends on banana as their staple food. The sales from bananas to urban areas provide income for the rural population (UBOS 2009).

A few community members own cows, goats, pigs and poultry. Almost all families have a piece of land where they have a banana plantation and a few have extra land for planting beans, maize, millet and potatoes. The pattern of farm labour throughout most of Uganda it is that women work in the gardens and on rare occasions are allowed to take farm produce to the market. It is men/husbands that make most decisions regarding income and expenditure (Mwaka 1993). In many cases, when there is need to do work outside the family farm for income, it is men who work as labourers on other people's farms, whereas the women are restricted to subsistence family food production. When the land is not enough to produce enough food for the family, they rent out land where they either pay off in kind or cash depending on the negotiations with the landlord (UBOS 2009).

Each village (about 100 households) has access to a small trading centre/small scale shops where they can buy what they do not directly produce from the farm. Each family buys posh (maize flour) for making maize porridge for children's breakfast once in a while. Also, in the trading centres, there are drug shops and small bars. Almost every man from the villages drinks some form of alcohol on a daily basis. Although selling of alcohol is often done by women, few women drink on a daily basis (UBOS 2009).

Most houses are made out of mud and roofed with iron sheets, and a few homes have houses built with clay bricks. The predominant religion is Christianity (Catholic, Anglican and Pentecostal church). Decision making is hierarchical and is patriarchal. Other than families where a man/husband is dead, decision making is solely done by husbands. Decisions attributed to women/a wife only made after consultations with a husband or a mother in-law. Some men have more than one wife. Like in almost all communities in the country, the responsibility of caring for children (feeding, sanitation and care when they are sick) is entrusted to women. When a man loses/divorces or separates with a wife, he is expected to remarry for the purposes of filling the caregiver role (UBOS 2009).

3.2 Study Design and Data Collection Methods

The study used a cross-sectional mixed methodology, whereby both qualitative and quantitative data collection and analysis methods were used. The study used of both qualitative and quantitative methods

and so a mixed methods framework, was helpful because of the crosscutting nature of the research problem which involved investigating the impact of household level factor on women use of household factor. In addition, a review of key policy documents was conducted to provide background information on Uganda's maternal health care and status. The document review covered the National Health Policy (2009), Health Sector Strategic Plan III (2010/11 – 2014/15), Demographic Health Surveys (2006&2012) and Mbarara District Health Report (2010).

Maternal healthcare demand consists of social cultural concerns which are difficult to provide quantifiable evidence and measurable factors (Ensor and Cooper 2004). According Creswell and Clark 2011, the use of mixed methods is intended to neutralise or cancel the biases of the other method and as well data from either of the methods can be used to triangulate and thus allow comprehensive analysis of the problem. Mixed methods also helped in collecting comprehensive data for generalization, validation of data and drawing of relevant conclusions (Gable 1994). In this study mixing both the qualitative and quantitative methods helped in validation and complementation of the data by the either methods.

The cross-sectional survey was specifically used because the study was aimed at understanding the prevalence of the problem during the time of the study. Data was collected using a questionnaire from households that met the study criteria (married and have a child or children aged 5 years and below). For this study, being married included all couples who stay together and regard themselves as married. The use of qualitative methods (open ended interviews and group discussions) allowed collection of detailed information about the research questions and problem. Although was not a health facility-based study, in September 2009, a lower district health centre level study was first carried out at Kashari health centre IV – Bwizibwera to provide insights into health facility primary health care priority setting and structures of service delivery. The main household survey was carried out in December 2010, covering four sub-counties in Kashari County. Qualitative interviews were conducted during and after the household survey and during data analysis to be able to fill any data gaps that emerged. The used of mixed methods helped in triangulating data collected by each of the methods and this allowed comprehensive analysis of the problem.

The survey questions were mainly about household social and economics characteristics, relations and use of selected maternal health services. Reference was made to services offered by government-aided health centres within Kashari Health Sub-District, Mbarara, in south-western Uganda. People were

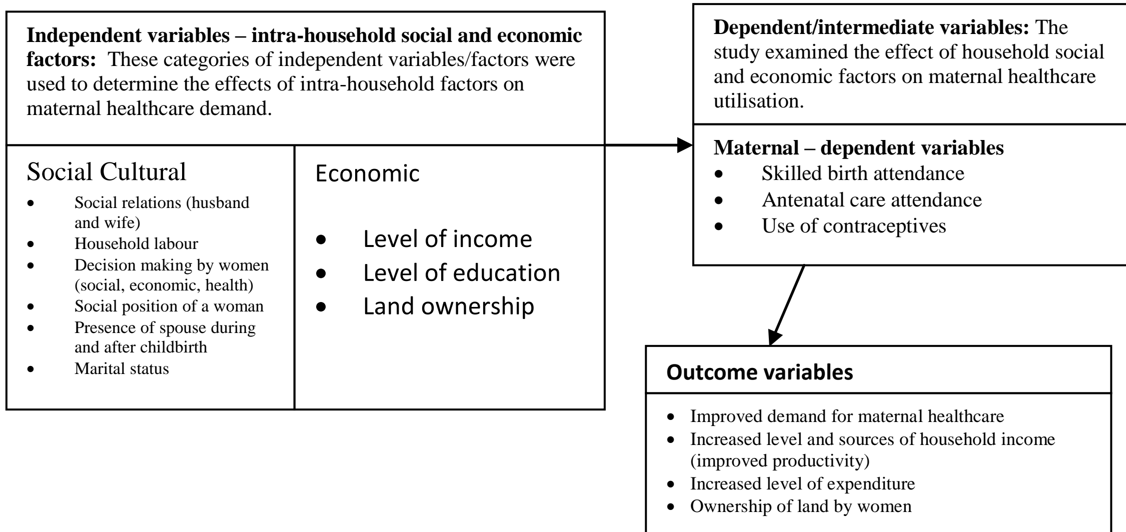
asked about their most recent maternal health practices with reference to the most recent pregnancy. To reduce recall biases, only households whose youngest child was aged 5 years and below participated in the household survey. For example, women were asked about where they last gave birth, if they attended antenatal care during the last pregnancy and how many times. They were asked if they were using any modern contraceptives at the time of interview. Men were asked the same questions in relation to their wives/partners. This also helped to examine men's knowledge of maternal healthcare needs. Men and women were asked about their relations with their spouses. The survey only recruited adults that were married and living with their partners. This was important for the quality relationship questions.

To minimize the errors resulting from specific time analysis, questions were administered to all people that fell into the described category of respondents. Individual and group interviews were carried out to assess cultural and traditional attitudes towards maternal health practices, family life and relationships. Opinion leaders were purposefully selected and participants for the group discussions were all adults that had not filled out the individual surveys. To be able to further validate the data, the research concurrently reviewed and referred to relevant literature. The study also drew discussions and conclusions upon existing secondary data.

A pretested survey questionnaire and discussion questions were translated in the local language to enable understanding of the questions by participants. The questions were translated by two independent persons who are fluent in both English and the local language i.e. Runyankole and checked by the third person for correctness. To be able to collect data at almost the same time, research assistants were recruited. Research assistants were trained on both the Runyankole/local language and the English questionnaires. The local language questionnaire was used as a guide for asking questions and the English questionnaires was filled out.

Figure 5: Survey Variables

A pre-coded quantitative survey questionnaire was designed and pre-tested to gather information on the following variables from a random sample.



Source: Author's drawing December 2009

3.2.1 Sampling Procedure

Being a mixed methodology design that combines qualitative and quantitative data collection methods, two sampling methods were used to select representative population. Kashari Health Sub-district was selected because it is one of the rural health sub-districts within Mbarara District. Working in both Rwampara and Kashari would not give different results since both counties have almost similar social and economic characteristics. Mbarara Municipality was left out mainly because it is urban.

A stratified sample was obtained to determine a random sample based on gender. Since this study assesses gender-related attitudes, both married men and women of reproductive age (18 - 49) for women and all men above 18 years were selected to respond to the household survey questionnaire. It was more difficult finding men than women, so the research purposely looked for men to cater for the including in the household survey. Men were only 25% of the sample. A representative population sample for the household survey was determined at the County level using Krejcie and Morgan (1970) table for determining sample size. The overall sample size for the survey was 268 respondents. 202 females, aged between 20 and 49 years of which 3% (N.9) were below 19 years, and 66 males, aged between 20 and 60 years, participated in the survey. For the qualitative discussions and interviews and discussions, there

were 7 key informants from the community and 10 focus group discussions including 2 mixed group interviews. Also prior to the field study, preliminary interviews were conducted with one district health office (District Medical Officer), 4 health workers (1 clinical officer, 2 midwives and one registered nurse) and 6 local council leaders on the health management committee for Bwizibwera Health Centre IV. The selection for key informants and focus group discussions participants was purposive which allowed selection of interviewees according to their characteristics. For the health works, the selection was biased towards those who are directed engaged on maternal health care such as midwives, registered nurse and health facility in-charge. At the community level, group discussions participants and key informants where purposely selected and they included married men and women, local council leaders and traditional birth attendants.

According to the national health sector plan, a Sub-district is expected to offer health services to an estimated number of 100,000 people (Uganda 2010). The 2002 national census, estimates the total population of Kashari County at 160,152 people. The national annual population growth rate is estimated at 3.2%. Kashari sub-district is comprised of 8 sub-counties with a total number of 52 parishes (UBOS 2009). Gender was considered as an independent stratum to determine the effect of gender relations and sharing of roles.

3.2.1.1 Sample Size

Kashari County has 8 sub-counties and only 4 were randomly selected and were included in the study. Using Krejcie and Morgan tables for determining samples where a given population (N = 160,152 people according to the 2002 Uganda Housing and Population census), the representative respondents/population sample size for the survey was approximately 310 people (Krejcie and Morgan D 1970) and only 283 could be interviewed during the time in the survey. The final sample is therefore approximately 92% of the expected representative sample size.

3.2.1.2 Determining the Stratum

In Mbarara like the national figures, the female population is estimated to be 51% of the total population. At the Sub-county level, the respondents were selected purposefully by indicators. The selection of respondents was determined based upon gender and reproductive age. To reduce recall biases in the study, the questions were based on the maternal health practices with the youngest child. Households with children aged 5 years and below were selected for participation in the survey. Men and

women beyond the age of 50 were selected based on their role in society for in-depth interviews and group discussions, and people were considered as elders/opinion leaders. The group and individual interview sessions were planned to assess the social context, attitudes and opinions towards the study of socioeconomic variables.

3.2.2 Validity and Reliability of Instruments

The survey questions, particularly those on the use of health services were considered valid and reliable since they were adapted from the 2002 WHO individual health structured survey questionnaire[2]. The questions on social and economic factors were revised to be applicable to local situations. These revisions were made based on literature, national demographic health surveys, research and previous work. Reliability of these questions was established by calculating Cronbach's Reliability Coefficient Alpha (α) as per the formula below:

$$\frac{K}{K-1}\left[1-\frac{\sum SD_i^2}{SD_t^2}\right]$$

Where,

α = Cronbach's reliability coefficient

K = Number of items in the questionnaire

SD_i^2 = Standard Deviation squared (Variance) for each in individual item i

SD_t^2 =Variance for total items in the questionnaire

The Cronbach's reliability coefficient alpha (α) of the questionnaire were calculated from the above formula and items in the questionnaire which were to be found ≤ 0.70, were considered reliable and so were used in data collection for this study.

Capacity and willingness to use health services were measured by the Likert scale. To increase the reliability of responses, 4 instead of 5 responses were put on the scale. The respondents were asked their level of agreement (strongly disagree, disagree, agree and strongly agree) with what stops the use of a service offered freely at government-aided health facilities. The reliability was α=0.70 (Tood and Heather 1998). The survey data was collected in a period of one month and conclusions were made

[2] http://www.who.int/responsiveness/surveys/individual.pdf

according to the maternal health practices of that time of the survey and the other unstructured interviews that were carried out between September 2009 and March 2012.

The reliability and validity of the qualitative research instruments were established by Content Related Evidence (CRE). The research instruments were peer reviewed through various presentations of research progress and activities to Faculty of Development Studies (now Institute of Interdisciplinary Training and Research) academics, after which, necessary adjustments would be made to remove ambiguity. The interview and group discussion data collection questions were tested in a pilot study in an effort to ascertain their validity and reliability. The results of the pilot study were used to review and come up with data collection tools – the pre-coded survey questionnaire and interview and group discussion guides. The researcher conducted face-to-face interviews with the respondents which further established the validity of the instruments. During individual and group interviews, clarification was sought by both the subjects and the researcher in cases where either party had not understood the questions and answers. This was helpful in eliminating ambiguity from the questions and answers.

3.2.2.1 Validity of Instruments

The strength of content validity of an instrument was calculated using the following formula:

$$CVI = \frac{n}{N}$$

Where, CVI = Content Validity Index

n = Number of items indicated relevant

N = Total number of items in the questionnaire

All the survey questions had a CVI value ≥ 0.05 and were considered valid for data collection.

3.2.3 Data Collection Methods

In order to achieve an adequate triangulation and generalisation, both pre-tested structured survey questionnaires and open ended data collection tools were used and integrated throughout the study investigative period. This study covers social and economic factors that influence use of selected maternal healthcare services. The aggregate effect on household economic levels was examined. The following are the different data collection methods and why and how they were used:

3.2.3.1 Quantitative Methods

Data on health services utilisation were collected by using a cross sectional household survey. A validated pre-coded questionnaire was used with questions on selected maternal health services and social relations, gender distribution of household labour, decision making by women, ownership and authority over land, source of income and level of education.

3.2.3.2 Quantitative Data Analysis Procedures

At the end of everyday of data collection and before the data entry process, data/filled questionnaires were edited by the researcher checking for possible errors, incompleteness, misclassification and gaps in the information obtained. The researcher randomly selected questionnaires filled in by research assistants and repeated them to check consistency. Data were coded and a database was created using the Special Package for Social Scientists (SPSS version 16) a computer program used to customise data entry process and analysis. The codes were designed based on a pretested standardised questionnaire.

Primary analysis: Multiple linear regressions were carried out to determine the relationship between household demographic factors and utilisation of selected maternal health services.

Bivariate analysis: A correlation with the household demographic characteristics in terms of land ownership, education, gender, multiple sources of income and levels of expenditure were determined to show the outcome effect of utilisation of maternal health services. Frequency distribution and cross-tabulation were used to properly test and identify social determinants and how they affect the use of maternal health services. Subsequently, data were quantified and interpreted in terms of health practices, attitudes, and behaviours. The significance of the relationships was tested using multivariate regressions.

The statistical analyses are based on cross-tabulations, bivariate correlations and Analysis of Variance (ANOVA). Both Analysis of Variance and Chi squared test $\chi 2$ were used to determine the significance of the relationships between the intra-household relations and willingness to utilise selected maternal health services. All statistical tests were carried out against a benchmark level of significance of $\alpha = .05$. During analysis, the effect of age, education, main source of income, use of alcohol and main source of information were controlled for. All variables apart from level of education for skilled birth attendance did not need to be controlled for. There was significant multicollinearity for most of the independent variables (see appendix II).

3.2.4 Qualitative Methods

Qualitative/unstructured modes of inquiry (interviews, group discussions, review of policy documents and observations) were used to find and explore in-depth explanations of the factors that hinder improvement of maternal health conditions, attitudes and practices at the levels of policy, service delivery, community and household. This is a multilevel assessment that helped in determining the roles of each of the levels in the health service delivery system. At the policy level, documents were reviewed and policymakers interviewed to find out priority issues regarding improving access to maternal healthcare. Health workers were interviewed to assess the delivery of the National Minimum Healthcare Package. The healthcare delivery level of this study was carried out as a baseline for the study to provide information that was used to design survey variables. This was referred to as a policy and service delivery analysis. Health workers, health management committee leaders, local councils and district health official were involved in the analysis.

Also at policy level, key reproductive health policy documents were reviewed. One district health official was interviewed at the district level, 4 health workers and 6 local leaders in the Kashari Health sub-district management committee were interviewed in September 2009. The researcher looked to examine the extent to which policies and regulations consider household-level factors in improvement of maternal health. At the health centre level, priority primary healthcare activities were assessed in relation to delivery of maternal healthcare. Unstructured questions were used to find out the policy and operational indicators used to determine the effect of household social and economic and factors on utilisation of the selected maternal health services. Other than the health policy documents, the domestic relations bill and poverty action plans of 2005-2010 were also part of the study policy documents because of their focus on gender and overall intra-household relations and resources.

The individual and group interviews at the community level were carried out with the aim of finding out shared and individual experiences and explanations of the relationship between household use of health facility maternal health services and intra-household dynamics. The qualitative part of the study at the community level was participatory in nature and rural appraisal procedures by Chambers were used to design guidelines and procedures for the qualitative inquiry. The procedures helped in finding the suitable respondents in the problem analysis process (Chambers 1997).

3.2.2.1 Selection of Discussion and Interview Respondents

Policymakers at the district level, local leaders and elders at the village level were purposively selected to participate in the interviews. Participants for focus group discussions and interviews at the community level were categorised into young married (18 to 25) years of partnership/marriage) and old married (more than 26 years in marriage/partnership). This helped to avoid domination of discussions by senior members of the community. Here the selection was not only based on households with a child of 5 years and below. Both men and women group discussions were equally represented and the discussions lasted until all issues of discussion were saturated. Data saturation from the focus group discussions and individual interviews was determined after realising that I was not obtaining significant new information on the research questions. For the health facility based interviews, information was collected from the selected key informants which may not necessarily mean that interviews were stopped at saturation level. However, the review of health reports provided back up evidence. The study covered 10 respondents for in-depth interviews and 8 discussion groups, 4 for women, 3 for men and 1 mixed-gender group discussion. In the pre-survey health services and policy analysis, 6 health workers and 2 local leaders participated in the study (local chairperson and health management committee chair).

3.2.2.2 Qualitative Data Management and Analysis Procedures

For adequate recording, coding, analysis and interpretation of the descriptive unstructured data, I formulated explicit recoding and coding instructions and trained research assistants until the set reliability requirements were met, following the guidelines of (Krippendorff 1980). An audio recording cassette was used to record data direct from respondents during interviews and discussions. The qualitative descriptive data were analysed progressively using thematic content analysis (Weber 1990). Emergent coding was used to establish themes/codes relating to health, social and economic factors and the respective determinants. Statements by respondents were quoted directly to show the verbatim expression. Anonymous names were used to refer to the respondents.

To achieve adequate validity in the coding and data interpretation process, the following steps recommended by Stemler (2001) were followed. Firstly, thematic content analysis was used to analyse field notes in relation with the research questions and emerging themes to create meaning. Secondly, people's expressions were quoted directly to add to the strength of the generalised findings. Thirdly, themes for categorising and creating meaning out of the data were predetermined by the researcher as

derived from the research questions. Other themes emerged through searching for recurrent patterns in the discussions and the collected data. Using the research questions as part of the data themes helped in the description and verification of the data categories.

3.3 Overall Ethical Consideration

The study procedures consider issues of confidentiality and consent throughout the research process. Respondents' consent to participate in the study was sought before administering any questions or beginning any other data collection procedure. People's names were not used in reporting data. A consent letter was signed for individual interviews and group consent was sought verbally before beginning any groups' discussions. Study participants were recruited on a voluntary basis and only adults/ household heads (above the age of 18) participated in the study.

The study abides by research ethical expectations and standards of the Republic of Uganda. The research protocol was reviewed and approved to be following research ethical procedures of the National Council of Science and Technology by Mbarara University of Science and Technology (MUST) Institutional Research Ethical Review Board. The research is for academic purposes and findings will be disseminated accordingly. The research finding shall be used to design strategies to disseminate to the Ministry of Health and related line ministries on how to incorporate social determinants in development and health improvement plans. Mbarara University of Science and Technology, Uganda, is responsible for the research quality, PhD thesis and the award of the degree.

3.4 Study Limitations

The study was limited to analysing the effect of intra-household determinants on the use of facility-based maternal healthcare. The study was limited to households with children aged 5 years and below excluding couples who had pregnancies with adverse outcomes such as discourage, abortion or death of the child during the same period (pregnancy during the last 5 years). Questions were only about use and non-use of family planning, skilled care at birth and antenatal care. All survey and open-ended interview questions were limited to the health practices at the time of the study. To complement a household level analysis, a policy and service delivery analysis was carried out to increase the scope of the study analysis. The other limitation is that the study did not cover indigenous/traditional maternal health practices. Questions were asked on alternative practices to help eliminate confounders by traditional

practices, during analysis and ‘medical pluralism’. The research design was cross-sectional and all data was collected in reference to the time of study, making the results for a case study. However, the tools of data collection were pretested and standardised and can be replicated in other study settings. To increase reliability of the data, all households who met the criteria of the study population were recruited in the study. Only one person (male) refused to participate in the study and the reason was that he was busy and did not have time to complete the survey. The use of mixed methods helped with validation and triangulation of both the qualitative and quantitative data.

CHAPTER FOUR

Gender Inequality in Household Labour: Implications on Demand for Maternal Healthcare in Uganda

4.0 Introduction

This is the first results' chapter of this thesis. It is comprised of two sections; the first section the chapter discusses the socio-demographics characteristics of the study participants. The second section of the chapter presents results on the first objective of the thesis which is discusses the effects of women's household labour burdens on demand for maternal health services in Kashari County Mbarara District. The overall aim of this study was to examine intra-household determinants of demand for maternal healthcare among rural communities in south-western Uganda by assessing the effect of household-level inequalities in division of household labour, control and resource allocation decision making and social relations. The study rejects the null hypothesis which stated that there is no relationship between the household social and economic inequalities (role sharing, decision making, resource allocation and social relations) on demand for maternal healthcare (antenatal care, family planning and skilled birth attendance). Household and farm work are an essential part of women's household level living conditions, it is a source of daily occupation and identity. The findings indicate that household gender roles are an important part maternal healthcare suggesting the need to examine household level time use and gendered attitudes towards household division of labour.

4.1 General Socio-demographic Characteristics of the Study Participants

The data used in this thesis was collected from a field study that was carried out between September 2009 and December, 2010 in Mbarara District, Uganda. In September 2009, interviews were conducted at the Mbarara District Health offices and a health assessment was conducted at Bwizibwera Health Centre IV to collect information about Primary Healthcare programs of Mbarara District. The aim of this preliminary study was to provide insights into maternal health services delivery at a lower government health facility such as Bwizibwera Health Centre IV. The second main purpose was to assess how social determinants of health are integrated into district health facilities which are the Primary Health Care Centres. For this part of the field study interviews were conducted with one district health office (District Medical Officer), 4 health workers (1 clinical officer, 2 midwives and one registered nurse) and

6 local council leaders on the health management committee for Bwizibwera Health Centre IV. The results from these interviews are presented in Chapter Seven.

A household survey was later conducted in October 2010 in 4 sub-counties of Kashari County, Mbarara District where 212 females aged 20 to 49 years and 70 males ages 20 to 60, responded to questions on use of maternal healthcare, decision making, role sharing, and gender relations. Seven key informants were interviewed and eight focus group discussions were held with women and men (4 groups and 3 groups for each sex respectively plus one that was of mixed gender). Likert scales were developed and used to get a variance in agreement on the differences in the decisions made by husband and wife (s) in a family. The qualitative data from individual interviews and group discussions of men and women alone, and mixed groups, gave detailed in-depth data on women's decision making power and where it is derived.

The statistical analyses are based on cross-tabulated bivariate correlations, and Analysis of Variance (ANOVA). All statistical tests were carried out against a benchmark level of significance of $\alpha = .05$. Cross-tabulations were made to determine the differences in independent and dependent variables.

4.1.1 Sample Socio-demographic Characteristics for the Household Survey

Because the survey was intended to investigate maternal health practices, only households with children aged 5 years and below were selected to respond to the survey questions. For the purposes of looking at daily household relations, the researcher purposively interviewed household heads who were married and currently staying with their partners. By currently staying together in this research means that, neither of the spouses worked or stayed outside of home for a period of more than six months. All households as long as they met the selection criteria and the household heads voluntarily accepted to participate in the survey were recruited in the survey. Only people who did not meet the criteria of being married and currently have a child aged 5 years and below were excluded. Ninety nine prevent of the survey respondents were married.

The household survey sample for the structured interviews was comprised of 75% (N.212) women and 25% (N.71) were men. However, it was found out that 95% of the households are headed by men; that is, men are the sole decision makers. The majority of the respondents, 89%, were aged between 20 and 39 years. 77% of the respondents attributed their failure to access health to cost and low household

income. The median estimated income per month was 30.000 Uganda shillings and equivalent to 13 US Dollars at the exchange rate of February 2011. At the time of the study, the median number of biological children per household was 3 children with a median age of 2 years. The interpretation is that this was a young category of the population. On average, each household has a total membership of 6 people.

Kashari is predominantly agricultural, and farm work is a major household activity on which men and women spend their time. 67% of the households say they depend on farm work and sale of farm produce for their income and other household needs. Farming contributes a monthly average income of 13 US Dollars. 73%of households' income comes from farm work, followed by causal labour (9%), salaried job for spouse (5%) and keeping and sale of animals (2%). Sale of farm produce was included in the survey because it is an activity that is concurrently done with farm labour and most of the farm produce is sold right from the garden. Women's time is not only for care but they too contribute significantly to household income as well. Three out of four people who spend 6 hours of the day on farm work are women. In the following Table 1, Figure 3 and 4 are demographic characteristics of the study population.

4.1.2 Socio-demographic Characteristics of the Household Survey

The following Table 1 is a presentation of the socio-demographic characteristics of the survey participants. Seventy five percent of the people who responded to the survey questionnaire were female and 25% were males. Majority of the respondents (88% N.250) are aged between 20 and 39 years. Ninety nine percent (N.282) were married/live with a partner and 62% had completed primary education. The maximum number of children per household was 4 with a mean of 3.88 and a standard deviation of 2.44 children. Majority were Christians 40% Catholics, 49% protestants/Anglicans and 9% Pentecostal Christians). Land ownership was mainly customary (97% N.274) and only 3% say their land is owned by registration. Majority of the land use and sale decision-making is by a husband (69% N. 180) and 20% say decision-making is joint between a husband and a wife. Eighty percent of the houses were semi-permanent (iron roof and brick walls). The common source of water is from an open well (68% N. 192), the other sources are community tap, protected spring, borehole and only 5% (N. 13) have a tap in their compound. The common source of information is through listening to a radio (89% N.251).

Table 1: Selected Socio-demographic Characteristics of the Household Survey

Category and Total number of people who responded	Total Number	Percentage
Sex (N=283)		
Male	71	25%
Female	212	75%
Age (283)		
Less than 19 Year (00 Males 09Female)	09	3%
20 – 29years (28 Males 100 Females)	128	45%
30 – 39years (30 Males 92 Females)	122	43%
40 – 49years (08 Males 11 Females)	19	7%
50 – 59years (04Males 00 Females)	04	1%
60+ (01 Males 00Females)	01	0.4%
Marital status (N=283)		
Married	283	100%
Widowed	0	0%
Divorced/Separated	0	0%
Education (N=283)		
Never attended school	41	14%
Attended up to lower primary	65	23%
Completed primary seven	130	46%
Attended college (1to 3years)	19	7%
Other (including attended Adult Literacy Classes)	28	10%
Religion (N=283)		
Catholic	112	40%
Protestant	138	49%
Pentecostal	26	9%
Muslim	7	3%
Total number of wives/partners (N=282)		
One	257	91%
Two	25	9%
Form of land ownership(N=264)		
Customary	257	97%
Registered/has land title	7	3%
Names of registration of land title (N=7)		
Husband	6	86%
Wife	1	14%
Is land is enough for household food production (N=283)		
Yes	108	38%
No	175	62%%

Table 1: Continued

Category and Total number of people who responded	Total Number	Percentage
Who has full say over use and sale of land in the home(N=283)		
Husband	195	69%
Wife	14	5%
Both husband and wife	57	20%
Other	17	6%
Type of housing (N=283)		
Permanent (Bricks and Iron roof)	41	15%
Semi-permanent (Bricks and Iron roof)	228	80%
Temporary (mud and grass/leaves thatch)	14	5%
Main Source of water(n=283)		
Tap in the compound	12	5%
Community tap	71	25%
Spring	2	0.7%
Open well	192	68%
Borehole	6	2%
Main Source of Information(N=283)		
Radio	253	89%
Newspapers	4	0.7%
Community meeting	2	1%
Friends	24	9%

Figure 6: Household Main Source of Income

Figure 6 below is a graph showing the main source of household income. The main source of income for most people in Rural Kashari, Mbarara is through sale of farm produce followed by farm work. Farm work includes those people who work on their gardens; they may be selling the surplus of their farm produce around home and those who work on other people's gardens for pay. About 18% keep and sell animals, 9% of depend on causal labour for their income and 2% of the people have a salaried job.

Household Main Source of Income

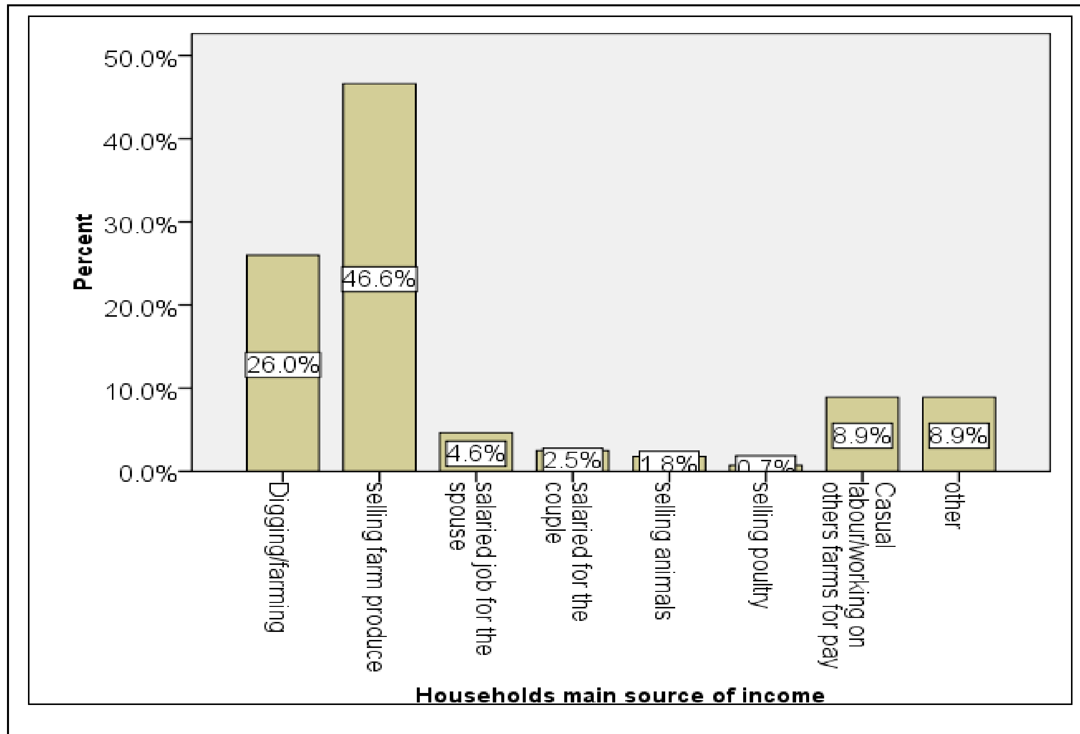
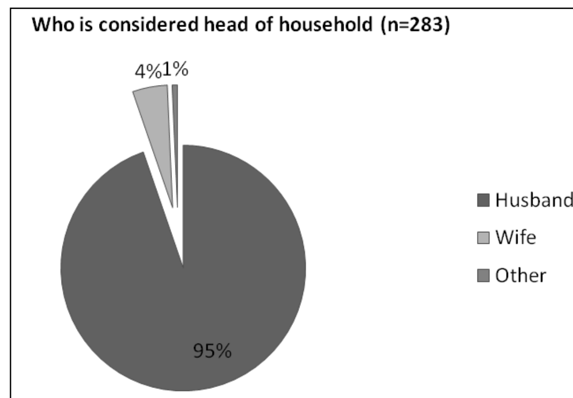


Figure 7: The Household Head

The figure below shows that 95% of all households are head by men and less than 5% by women. In this study being a household head was found to be an important factor in determining access to maternal healthcare intra-household decision making dynamics. Kabeer (1997) in her study on intra-household power relations in urban Bangladesh asserts that the symbolic idea of a head of the household denies mutuality and promotes hierarchy and dependence mainly because even when women earn they often face opposition in decision making constituted in male authority. In the context of rural Mbarara, the findings add to this evidence to declare that being a head of the household is endowed with decision making of authority. Findings also indicate that men/husband as heads of the household control the allocation and use of household resources.

Head of the Household



4.1.4 General Information on Household Health and Access to Health Care

In table 4 it is indicated that generally people expressed that their health and that of the children below the age of five years was good. It was also expressed that it is not very difficult to access health facilities. The cost of health care was said to be the main reason for household-level inability to use healthcare. The main place to first seek healthcare was said to be a community health centre and the main source of health information was through radio programmes. There was less health information from health workers although by the time of the survey, majority of the people had at least heard information about child immunization, antenatal care, family planning, skilled delivery and HIV/AIDS. The main source of health related information was through a radio programme. According to the 2011 World Bank report on Demography and Economic Growth in Uganda, the radio is the most accessible means of mass communication for both rural and urban areas. In rural areas radio covers 44.7% as compared to print media and television which are accessible by less than 1% of the population.

Table 2: General Information on Household Health and Access to Health Care

Category and total number of people who responded		Total number (N) of responses per category	Total percentage per category
General feelings about health (N.283)			
Very good		197	69%
Good		70	25%
Fair		13	5%
Bad		3	1%
Feelings the health of the children below 5 years with the household (N.283)			
Very good		197	69%
Good		70	25%
Fair		13	5%
Bad		3	1%
How easy it is to use the nearest health facility in case of emergency or severe illness (N.283)			
Not easy at all		14	5%
Somewhat easy		114	40%
Easy		76	27%
Very easy		79	28%
Factors that most describe inability to use health care (N.283)			
Cost of health care		219	78%
Family size		23	8%
Busy with work around home		26	9%
Alcoholism		6	2%
Household nutrition		9	3%
First place where health advice is sought (N.282)			
Private doctor/clinic		46	16%
Community Health Centre (lower HCs)		190	67%
Hospital		40	14%
Alternative		6	2%
Main source of health information (N.283)			
Health worker		71	25%
Community leader		6	2%
Friend		8	3%
Community health worker		28	10%
Radio programme		170	60%
If in the last 6 months any health worker came to the community to talking about any health issues (N.283)			
Yes		61	22%
No		222	78%
If in the last one month, heard about the following health issues (N.283)			
Antenatal care	Yes	252	89%

	No	31	11%
Family planning	Yes No	261 22	92% 8%
Skilled birth attendance	Yes No	206 77	73% 27%
Immunization of children	Yes No	269 14	95% 5%
HIV/AIDS	Yes No	273 10	97% 3%

4.1.5 Presentation and Discussion of the General Descriptive Data on the Maternal Health Services Using Frequency Tables

The general objective for this thesis was to examine intra-household determinants of demand for maternal healthcare in Kashari sub-County, Mbarara District, Uganda. In this study, maternal healthcare includes use of modern family planning methods, antenatal care attendance and skill care at birth. The intra-household determinants that were investigated are decision making, couple relations, division of household labour and women's control of household resources with specific reference to land use and control. The study also investigated the extent to which the primary healthcare programs at health centre level IV incorporate household level factors. In the following paragraphs there is a presentation of the descriptive statistics for each of the maternal health services and household factors.

Use of modern family planning methods: the questions on use of use contraceptives inquired whether a couple was using any modern family planning methods in the last 12 months at the time of the survey and if the last pregnancy was intended. Generally, the findings indicate that use of contraceptives is not consistent, it is on and off. At one time, someone is using contraceptive and then they stop. Only 34% (N.96) of the respondents said they use contraceptives all the time.

Table 3: Use of Contraceptives

Use of Contraceptives used in the last 12 months	Total Number	Percent
All the time	96	34%
Most of the time	88	31%
Sometimes	37	13%
Rarely	62	22%
Total	**283**	**100%**

Inconsistencies in the use of contraceptives are reflective of whether pregnancies are intended. 13% (N.37) said that their last pregnancy was not intended at all, 25% (N.71) said that it was not, but did not mind being pregnant, and 62% (N.175) say the pregnancy was intended. By definition, unmet need refers to women in their reproductive age and are sexually active (married or unmarried) who do not want to give birth in the future but are not practicing contraception (Becker 1999). Although a bigger percentage, 62%, said pregnancies were intended, there is still 38% of unmet need for contraceptives (a combination of those who totally did not want to get pregnant 13%, but became pregnant, and those who had no choice 25%). The findings of this study on unmet need are close to the national figure which is estimated at 41% (WHO 2010).

Another central question for determining unmet need for contraception was on *who decides on the number of children one should have.* Although the majority in table 3 below (45% N.127), believe that there is a joint effort in deciding the number of children, the number who responded "father" (33%) is still much higher than the number who responded "mother". Therefore, the factor of hierarchy and patriarchy must be examined. In this research, it was found that 95% of households are headed by a man, women depend on their husbands for decisions and men are responsible for household sole social, political and economic decisions. The "both" option could have been found more conformable and thus a limitation. The findings on use of contraceptives are consistent with other studies which found that husbands influence the decision to use contraceptives. A study by Koenig et al. (2003), found that use contraceptives without the husbands permission was one cause of domestic violence. Women who can make their own decisions have been found to be more likely to use contraceptives than those who cannot(Ensor and Cooper 2004).

Table 4: Decision-making on the Number of Children

Decision-making on the number of children the family can have	Total Number	Percent
Mother	60	21%
Father	94	33%
Both mother and father	128	45%
Others (in laws)	1	0.4%
Total	**283**	**100%**

Decision making on the number of children to have was used to measure access to family planning. According to Bankole and Singh (1998), desire to have children by husbands tends to influence women's decision of have the next child and combining fertility intentions predicts use of modern family planning. While this study found that there could be couple agreement on the number of children to have, the above Table 4 shows that husbands have a higher influence in deciding on the number of children to have than wives. This study's further triangulation of data of fertility choices was achieved by asking related questions. Respondents who said they did not decide on the number of children that they had (16% N.46), were asked who then decided on the number of children that they had. 50% (N.23) said it was God's plan that they had the children that they have, 35% (N.16) say it was a husband's decision, only 9% (N.4) said the women is in control and 2% (N.2), linked the decisions for the current number of children to in-laws. This study's finding are consistent with previous studies which found that husbands control their wives' fertility decisions (Blanc 2001; Derose et al. 2002; Crane 2010) and that in Uganda, religion still determines people's fertility decisions (Homsy et al. 2009).

Use of antenatal care (ANC): Almost everyone attended ANC (98% N. 279), although interestingly a man said he did not know if his wife had attended ANC. The median months for first ANC visit were 3 months which is consistent with the work of (Kiwuwa and Mufubenga 2008).

Table 5: Use of antenatal Care during the Last Pregnancy

If attended antenatal care during the last pregnancy	Total Number	Percent
Yes	279	98%
No	3	1%
Don't Know	1	0.4%
Total	**283**	**100%**

During ANC, 89% (N.252) were attended by a nurse or a midwife and only 7% (N.19) by a doctor. Three percent (8 pregnant women) sought care of an untrained/traditional birth attendant (TBA). The majority of pregnant women (76% N.215) reported to have received medicine to prevent malaria. 80% (N. 226) said they were tested for HIV/AIDS. Only 43% (N.31) of men had ever attended ANC with their spouses and 57% (N. 41) had not. Like family use planning, husbands were found to influence 71% (N.201) of the decisions related to use of ANC during the last pregnancy. It was found that only 29% (N.83) of women can decide by themselves if they will attend ANC.

Skilled care at birth: The majority of the respondent (63% N.178) lived less than 5kms from the nearest government aided health facility, a factor that was controlled for in examining the factors that determine access to skilled care at birth. However, only 40% (N.113) gave birth at a government-aided health facility/hospital, 26% (N.73) in private clinics, 33% (N.92) at home. As shown in the table below, only one person said she delivered out in the field. The findings of this study regarding skilled care during childbirth are consistent with the national figure estimated at slightly above 40% (UBOS 2006) and the recent related study by Kiwuwa and Mufubenga (2008) that put it at 59.2% after including women who deliver in private maternity homes. The 2010/2015 National Health Sector Strategic Plan estimated that only 34% of women deliver in health faculties (Uganda 2010).

Table 6: Assisted in during the Last Childbirth

Assistance During the Last Childbirth	Total Number	Valid Percent
Doctor (including specialists)	22	8%
Nurse/Midwife	152	54%
Auxiliary nurse (including student nurses, nurse aides etc)	17	6%
TBA	9	3%
Relative/friend with no medical training	82	29%
Other (in the feild)	1	0.4%
Total	283	100%

Presence of husband during childbirth: Male involvement in health is an important factor in the safe motherhood literature (Tita et al. 2007), however, in this study only 4% (N.11) of childbirths had a husband present, for the rest 96% (N. 272), it was reported that the husband was not present. However,

only 30% (N.85) feel it is necessary for a husband to be present and 37% (N.105) feel the presence of a husband during child birth is not necessary at all. In other related studies, the presence of a husband during childbirth has been found to be culturally restricted as men are expected to be doing other things related with looking after funds to meet related bills (McGrath et al. 1993; Waiswa et al. 2008). In the following table, when asked about all childbirths, the study results indicate that 49% (N. 138) of men in Kashari, Mbarara have never been present during child birth.

Findings also indicate that 13% (N.38) of men had been present during the birth of the first born, 18% (N.52) for all of their children and 19% (N.55) not all the time. These finding show that there is space for men being allowed to be present during childbirth. The key argument here is quality of relationship which will be defined in this study by working together around the home, planning for family needs and absence of domestic violence. At the time of the first born, the husband and wife have a good quality relationship and the husband felt obliged to be present. In this study, it is indicated that there are no substantial differences and so public health programs should as well as culture and family economic status focus on quality of relations to promote male involvement in maternal health. There is an effort by men to be present in maternal health which could be enhanced by a strategic program that is comprehensive in nature. Many programs such as the voucher program only address the economic issues (Ahmed and Khan 2011) and in many cases, in the way it is done, men can be excluded.

Table 7: Number of Times a Husband has been Present during Childbirth

Number of times a husband has been present during childbirth	Total Number	Percent
Not at all	138	49%
Only for the first born	38	13%
All the children	52	18%
Sometimes	55	20%
Total	**283**	**100%**

Intra-household Decision-Making Dynamics and Use Maternal Health Services: Table 7 below shows that for every one decision that wives have to make on maternal health needs, husbands have double the influence. The greater influence is on antenatal care visits, which is a finding that links to studies that have shown the link between women’s health and restrictions on their movements. Antenatal

care is a health facility-based service that requires women to travel at a specified time of the week to access medical check up during pregnancy. In many cases, ANC schedules are rigidly set and women are obliged to follow or else they miss the services. This was expressed in the following qualitative quote during one of the unstructured interviews: "*The ANC schedules at the health centre are rigid, they say that the clinic will be open between 4.00am and 01.00pm and by the time one goes around the home trying to finish up with work, they have left and you need to prepare to go there next week.....,"* ***(31 year old mother- Nchune April 2011)***

Table 8: Household Decision-Making for Use of ANC, Skilled Care at Birth and Number of Children

Questions	Husband	Wife
In your home, who makes most of the decisions regarding the *wife going for antenatal care?*	**71%** (n=200)	**29%** (n=83)
In your home, who makes most of the decisions regarding the *wife going to hospital to deliver?*	**62%** (n=175)	**38%** (n=108)
Who decides the number of children the family should have?	**33%** (n=93)	**21%** (n=59)

Note: the question on who decides the number of should a family can have captured capture the influence attributed to in-laws 46% (n=131) was attributed to in-laws.

Results from this question also indicate that the decision for the number of children a couple can have is influenced by other family members such as in-laws (46% n=131). Although studies have attempted to linked the almost 100% rate of accessing at least one ANC visit to pregnant women's need to know the wellbeing of the pregnancy and fear of the health workers treatment in times of emergency (Kyomuhendo 2003), steps to increase the recommended four ANC visits need to consider other factors especially the rigidities in the health facility schedule and re-examining the influence of husbands and overall couple relations. In the next section, there is a description of household factors and how they affect women's access to maternal health services.

4.1.7 Cross tabulations for maternal services and selected household socio-demographic characteristics

Pearson Ch2 was used to determine the level of significance between household socioeconomic characteristics and use of maternal health services. The variables which were tested were age, level of

education, source of income, household head and ownership of land. In Table 1 it was indicated that majority of the respondents were aged between 20 and 39 years (88% n=250), the median number of years in school were 3.77; 46% (n=130) of the study respondents had completed primary seven, 23% (n=65) had attended lower primary and 14% (n=41) have never attended school. Most of the land ownership is customary, that is, land is passed on to family member through male lineage. Regarding land decision-making, husbands have the highest say on use and sale of land.

The main source of income is sale of farm produce. Ninety five of men claim the symbolic role of head of household. Regarding use of maternal health services, only 34% of women use contraceptives all the time, 98% of the respondents attended ANC during the last pregnancy and only 40% delivered their youngest child in the hospital.

Table 9: Determining the level of significance between respondents' socio-demographic characteristics and use of maternal services

		Who decides the number of children the family should have?	How often contraceptives were used during the last 12 months	The last Pregnancy was intended	Attended antenatal care during the last pregnancy	Who assisted in delivery during last birth?
Age	Pearson Chi2	10.63	8.63	10.63	19.08	57.51(*)
	Pr	.561	.125	.561	.580	.000
	N	283	283	283	283	283
Head of household	Pearson Chi2	14.22(*)	6.06	14.22(*)	5.80	1.80
	Pr	.027	.048	.027	.446	.773
	N	283	283	283	283	283
Level of Education	Pearson Chi2	14.22(*)	5.31	23.48	6.83	8.12
	Pr	.027	.505	.172	.843	.422
	N	283	279	283	283	283
Households main source of income	Pearson Chi2	24.21	17.17	24.21	19.08	41.36(*)
	Pr	.283	.016	.283	.580	.050
	N	283	280	283	283	278
Does your household own any land	Pearson Chi2	11.29(*)	.0496	11.29(*)	14.86(*)	.501
	Pr	.010	.481	.010	.002	.909
	N	283	283	283	280	283
Who has full say over sale and use of land in the home	Pearson Chi2	14.13	2.47	14.13	4.80	19.68
	Pr	.118	.481	.118	.570	.073
	N	283	283	283	283	283

* Pearson Chi2 is significant at the 0.05 level.

The above Table 9 indicates significant relationships between socio-demographic characteristic of the respondents such as age, level of education, household headship, land ownership and decision-making

with use of maternal health service. Age was significantly associated with the type of assistance during the last delivery (P value .000). Majority of the respondents were aged between 20 and 39 years (88% n=250). While 54% of the last deliveries were reported to have been assisted by a nurse/midwife, people aged between 20 and 29 years were more likely to seek assistance of a midwife (58%) than those aged 40 to 49 years (42%).

Level of education was significantly associated with who makes decisions on the number of children a couple can have (P value .027). Of the people who attended lower primary education, men (28%) were more likely to decide the number of children a couple can have than women (14%). However, of the people who reported to have attended adult literacy education, both men (25%) and women (25%) expressed equality in decision-making on the number of children a couple can have.

Head of a household was significantly associated with if the last pregnancy was intended (P value .027) and who makes decisions on the number of children a couple can have (P value .027). Husbands claim 95% of the symbolic role of head-of-household; while 45% (n=128) of decisions on the number of children were reported to be joint, men (33% n=94) more than women (21% n=60) can decide the number children can have. Women (46%) than men (62%) were less likely to report that their last pregnancy was planned.

Source of income was significantly associated with type of assistance during the last delivery (P value .050). People who reported to have a salaried job (77%) as their main source of income were more likely to deliver with assistance of a midwife/nurse than those who depended on farming for their income (57%). In addition land ownership had a crosscutting significant relationship with decision-making on number of children a couple can have (P value .010), if the last pregnancy was intended ANC (P value.010) and attendance (P value .050). Ninety (97% n=264) of people claim to own land.

In this study, therefore key household factors that impact on maternal health seeking behaviours are age, level of education, men's symbolic decision-making role and ownership of land.

4.1.8 Measuring the effect of general health status of household members and use of antenatal care, family planning and skilled care during child birth

To obtain information about the household's health status, this study collected data on how people generally felt about their health and that of their children, source information about health and where

they go first in case they need healthcare. Pearson Chi2 was used to test if there is a significance relationship between these factors and use of family planning, antenatal care and skilled care during birth. The results of this study indicate that at the time of the survey, 98% of women attended antenatal care during their last pregnancy, 40% delivered in a government aided health facility and only 48% were using a modern mother of family planning.

This study found out that how people feel about their health and that of their children was significantly related with use of modern family planning methods (p-value .024, P-value .000) and planned pregnancy (P-value .000, P-value .016). Easy access to a health facility in case of an emergency was significantly associated with use of skilled care during the last childbirth (P-value .018) and ability to use health services was associated with use of antenatal care (P-value .028).

Access to health information had a cross-cutting significant relationship with use of antenatal care, family planning and skilled delivery at birth. These findings reflect that use of maternal services also depend on how easy people feel services are accessible, the findings can be used to conclude that in attempts to improve access to maternal healthcare, attitudes towards health and health care needs to be addressed. The following quotation from one of the focus group discussions illustrates the attitude people have about the available health care. *...services at the health centre are poor, there are no beds, people sleep in the open and mosquitoes bit their children when they have mosquito bed nets back home.....some people have delivered from home up to their seventh child, then why should they go to the hospital* ***(Rwebishekye mixed group Discussion, May 2011)***

Table 10: Measuring the effect of general healthcare access information and use of antenatal care, family planning and skilled care during child birth

		Use of Contraceptives to stop or control becoming pregnant	How often contraceptives were used during the last 12 months	Was the last Pregnancy was intended?	Who decides the number of children the family should have?	Attended antenatal care	Who assisted in delivery during last birth?	Place of birth of youngest child
Respondent's feeling about their health	Pearson Chi2	5.28	7.72	14.57(*)	5.84	8.80	14.09	12.37
	Pr	.152	.806	.024	.755	.456	.295	.416
	N	283	283	283	283	283	283	280
Feeling about the health of children	Pearson Chi2	16.37(*)	23.11(*)	9.70	7.51	3.86	13.77	12.37
	Pr	.001	.027	.138	.585	.921	.316	.416
	N	283	283	283	283	283	283	283
In case of emergency, how easy can you use of healthcare from nearest health facility?	Pearson Chi2	3.98	17.52	45.12(*)	7.78	15.44	15.44	15.45
	Pr	.264	.131	.000	.557	.218	.218	.218
	N	283	283	283	283	283	283	283
Access to health information by health workers	Pearson Chi2	7.82(*)	2.53	.933	5.96	4.18	11.49(*)	3.19
	Pr	.005	.640	.627	.113	.243	.022	.526
	N	283	283	283	283	283	283	283
Have attended any public talks on health in the last 6 months	Pearson Chi2	.069	3.92	.022	12.56(*)	.886	9.97(*)	4.62
	Pr	.793	.417	.989	.006	.829	.041	.329
	N	283	283	283	283	283	283	283
First place of consultation in case of need for advice about health	Pearson Chi2	3.05	31.11(*)	22.68(*)	12.30	7.78	27.80	31.19(*)
	Pr	.551	.013	.004	.369	.802	.033	.013
	N	283	283	283	283	283	283	283

Table 10 continued

		Use of Contraceptives to stop or control becoming pregnant	How often contraceptives were used during the last 12 months	Was the last Pregnancy was intended?	Who decides the number of children the family should have?	Attended antenatal care	Who assisted in delivery during last birth?	Place of birth of youngest child
Have received information on antenatal care in the last six months	Pearson Chi2	1.18	7.32	5.36	4.93	.626	15.19(*)	13.52(*)
	Pr	.276	.120	.068	.177	.890	.004	.009
	N	283	283	283	283	283	283	283
Have received information on skilled birth attendance in the last six months	Pearson Chi2	5.05	2.17	17.68(*)	5.01	1.92	15.09(*)	10.31(*)
	Pr	.025	.705	.000	.171	.589	.005	.036
	N	283	283	283	283	283	283	283
Have received information on immunization of children in the last six months	Pearson Chi2	.543	3.54	8.55(*)	.219	.265	13.25(*)	10.04(*)
	Pr	.461	.471	.014	.974	.966	.010	.040
	N	283	280	283	280	283	281	283
Have received information on HIV/AIDs in the last six months	Pearson Chi2	.644	8.48	.767	2.78	.186	5.49	3.61
	Pr	.422	.076	.682	.427	.980	.241	.0461
	N	283	283	283	280	283	281	280
Main source of health information	Pearson Chi2	1.61	11.80	25.14(*)	17.61	1.95	9.51	9.51
	Pr	.807	.757	.001	.128	.999	.891	.891
	N	283	283	283	283	283	283	283

* Pearson Chi2 is significant at 0.05 level.

The Pearson Chi2 statistical correlations in Table 10 reveal that access to information is a significant factor in improving access to maternal healthcare:

The results indicate a significant relationship between how people feel about their health and planning for pregnancy (p-value .024). The significant relationship could be on results indicating that 69% (n=197) of the people felt that their health is very good and only 1% felt their health is bad. For example, 50% of the people who felt very good about their health reported to have planned for the last pregnancy than those who felt bad about their health (25%).

A significant relationship was also found between how people feel about the health of their children aged 5 years, and current use of contraceptive (P-value .001) and use contraceptive in the last 12 months (P-value .027). Descriptively, only 34% (n=96) of people reported to be currently using contraceptives and 44% (n=113) used contraceptive in the last 12 months but may not currently using them.

The results also indicate that how people feel their ability to use the nearest health facility was significantly related with if the last pregnancy was planned (P-value .000). Only 28% of people felt that it was easy to use health services at the nearest health facility. Cost of health care (78% n=219) was one of the factors that was most associated with inability to use health care. Considering people who reported to find it very easy to use the nearest health care services (28% n.79), 78% of them planned for the last pregnancy and only 9% of them did not plan for the last pregnancy.

Current use of contraceptives (34% n=96) was significantly associated with if someone attended a health talk by health workers in the last 6 months. Only 22% (n=61) of the people had attended health talks by health workers in the last 6 months. Descriptively, 92% of people who reported to have attended a health talk in the last 6 months were currently using contraceptives and 99% of those who did not attend a health talk were not currently using contraceptives.

Access to ANC information 89% (n=252) in the last 6 months was significance associated with the nature of assistance during child birth (P-value .004) and place of birth (P-value .009). This study found out that 8% (n=22) delivered with assistance of a doctor, 54% (n=152) by a nurse or midwife and 32% (N.91) by untrained person such as a relative or TBA. While the area of study was close to a health centre IV i.e. government aided health facility, only 40% (n=113) used such a facility during the last delivery.

Cross tabulations indicated that only 25% of people who accessed information on ANC delivered without assistance of trained personnel as compared to 58% who claimed to have not accessed information on ANC. In addition, of the people who accessed information on ANC, 42% of them delivered in a health centre and only 29% delivered at home.

The kind of assistance during the last child birth and place of birth were significantly associated with if someone received accessed information on skilled delivery care during the last 6 months (P-value .010 and .040 respectively). The study indicates that 73% (n=206) received information about skilled delivery care. Of the people who claimed to have accessed information on skilled child birth during the last pregnancy, 41% (n= 83) of them delivered in a health facility and only 28% (n=56) delivered at home.

The main source of health was significantly associated with if the last pregnancy was planned (P value .001). The main source of health information was a radio (60% n=170) followed by health workers (25% n=71).

For this study descriptive factors on access to maternal health care include how people feel about their health and that of their children, cost of health care and access to information on maternal health care i.e. family planning, ANC and skilled care during child delivery. The findings however indicate while there is significant association between access to maternal healthcare information and utilisation of services, use of healthcare remains low. This is a basis for further analysis of the implications of women's socioeconomic status on maternal health behaviours as presented and discussed in the subsequent chapters.

These findings demonstrate that access to information about health and health services remain an important factor in improving access to maternal health services. The main source of information remains the radio and village health workers. The role of health workers in passing on information about maternal health services is said to be limited. The perceived limited role of health workers in health education could also be associated with limited resources that are put in health education programmes at lower health facilities. A study that was conducted in 2004 analysing funding for the health and education sectors found that government funding for primary health care centres remain low as compared to funding for hospitals (Ablo and Reinikka 2004). Provision of primary health care rests

with districts and urban councils, because of weak revenue, few districts allocate locally generated funds to services. Table 25 of Chapter 7 presents the situation at Bwizibwera Health Centre IV; the Primary Health Care centre responsible for the study area. Primary Health Care budget allocation for 2009 was 8.1% of the total budget for the Health Centre.

It should be noted that use of skilled care during childbirth and family planning remain low among women of Kashari County, Mbarara. Use of antenatal care also remains insufficient since a small percentage of women do their antenatal care visit at the recommended time and the recommended number of times. Household ownership of land, head of the family, source of income and level of education were the three individual socio-demographic characteristics that significantly affect use of these maternal health services. The importance of land in access to care is that it is the main household resource. The households' main sources of income are farm work and sale of farm produce. The husband/man is the head of the family and a sole decision maker. The radio programmes are the main source of information and having heard about health issues influences the use of the services. While the number of people who will have heard about child immunization, family planning and antenatal care and HIV/AIDS range from 8 to 9 in every 10 people, only 7 in every 10 people will have heard about skilled care during child birth. Therefore information about skilled delivery is still limited.

4.2 Gender Inequality in Household Labour: Implications on Demand for Maternal Health Care in Uganda

4.2.0 Introduction

This chapter presents results on women's household labour burdens and the effects on demand for maternal health services. Women's predominant role in household labour was found to have significant associations with skilled birth attendance and family planning. Time spent on child care negatively affects use of family planning and antenatal care. This chapter argues that addressing access to maternal healthcare, more attention needs to be given to the work load of women at home. At the same time the chapter shows that men's increased participation in childcare, house and farm work increases their cooperation of men with their spouses and their understanding of the importance of maternal health. The main argument of this chapter is that addressing household inequalities in division of house and farm work is an essential aspect of beginning to understanding women's living conditions and how they impact on use of maternal healthcare. It should be noted that whereas women's majority of work is mainly through engaging in household and farm work, they offer unpaid labour, neither control or own the land used for faming and hence have limited influence on household income decision-making. The aspects of access to land in decision making are addressed in chapters 5 and 6 respectively.

4.2.1 Gender Relations and Demand-Side Health Care Barriers

There is increasing evidence about the importance of demand side financing and access to maternal healthcare with evidence of reducing socioeconomic inequalities in utilisation of healthcare (Shakil and Mahmud 2011). Central to this discussion are factors that influence healthcare demand such as information on healthcare choices and providers, education, indirect consumer costs (distance and opportunity cost), household, community and preferences, attitudes and norms and prices and availability of substitute products and services (Ensor and Cooper 2004). Other factors in the discussion are women's decision making ability and overall gender relations (Standing 1999; Shelah et al. 2001). Although literature continues to point out gender relations in particular decision making as a core issue in women's healthcare access (Barnes-Josiah et al. 1998; Wolff et al. 2000; Dasai and Kierstern 2005), less attention has been given to the impact of productive roles of women restraining them to access healthcare.

Traditionally, women, more than men are known to spend most of their time doing unpaid farm and home and so could lack time and opportunities to access healthcare (Parkhurst et al. 2006). This chapter present an argument showing how attaining gender equality in house and farm labour increases women's free time to access health information and income generating opportunities that women need to influence their decisions to access healthcare. This chapter specifically analyses division of household labour by gender in rural south-western Uganda and the implications on maternal health outcomes. The data used in this chapter is from a field survey that was carried out in December 2010 in Rural Mbarara Uganda. The data is about gender differences in time spent on care for children and the sick, cleaning, watching, fetching water and firewood and digging/farm work by men and women. Farm work has been included in the list of house work related activities because it is most done around home and consumes most of the community's time. The chapter is about the impact of women's burden of household labour on access to antenatal care, skilled birth attendance and family planning. It was found out that there is a significant inequality (as indicated in Table 14) in the division of labour and role sharing among households in the community.

Seventy percent of all study participants strongly agreed that women do all household and farm activities much more than men at community level. 62% of women's time is spent on farm work and an average of 2 hours is spent on care for the children and the sick. For example time spent on caring for children was found to significantly affect family planning (Pvalue 0.041) and number of times a partner was present during child birth (Pvalue 0.000).

There is an inverse relationship between use of healthcare and the number of hours a woman works per day. Women who have a bigger burden of housework are less likely to use health services because their movements are restricted; they lack information and opportunities to earn income needed for access healthcare. Therefore, greater gender equality in childcare, house and farm work creates free time for women's care for their own health. Most important is that more attention needs to be given to the work load of women in addressing access to maternal healthcare.

4.2.2 Status of Maternal Health and Healthcare in Uganda

The estimated maternal mortality rate for Uganda is 435 deaths per 100,000 live births. As 16 women are reported to die every day from preventable maternal conditions only 42% deliver with skilled care. According to the 2006 Uganda Demographic and Health Survey (UDHS), of the 94% women who attended skilled antenatal care (ANC), only 42% attended the recommended 4 times. Worse still, only four in ten of births occur in a health facility, 23% with assistance of a traditional birth attendant, one-quarter by a relative and 10% without any type of assistance (Uganda 2006). Despite the Millennium Development Goal 5's target to reduce the 1990 ratio maternal mortality 75%, Uganda's maternal mortality ratio has only declined by just 21% in the last four decades, from 550 in 1990 to 435 deaths per 100,000 live births in 2010. The progress is partly due to under-utilization of maternal healthcare, particularly antenatal care (ANC), skilled birth attendance at birth and use of family planning (Breslin 1998; Chao et al. 2005)

However, for the last two decades Uganda has been seen to attempt to improve women's healthcare. Since the 1990s, health facility user fees were exempted for the poor and vulnerable groups, between 1995 and 2002 a health insurance scheme was tested in some parts of the country, in 2001 user fees were abolished for all health services and services were decentralised to the district level (Jeppsson et al. 2003). By 2004, up to 151 health centres were upgraded to Health Centre IV with approximately 18 of them having a functional operating theatre and in-patient maternity care services. The healthcare budget increased from 6% in 1999 to 10% in 2009 (Agaba 2009). However, these national priorities are enough to show that Uganda's healthcare system is predominantly supply and are not enough to promote effective demand for healthcare. According to Ensor and Cooper (2004), a comprehensive healthcare system should deal with demand barriers by combining price, quality, income, household social and cultural characteristics, and knowledge about the availability of services and education in general. The quality of social relations, sense of control, social status and involvement in community life are material foundations for health outcomes (Wilkinson 2005).

Whereas price, distance, knowledge and quality are important demand factors, women's social political and economic status affects their capacity to benefit from direct demand factors (Nanda 2002). In the next paragraphs of this chapter is further discussion of how an understanding gender relations in particular division of household labour is gainful strategy that can improve women's access to healthcare. The findings have provided significant linkages between household level time use trends

and women's demand for maternal care. The women's burden of household labour deprives them of free time needed to access healthcare and the disintegrated data on gender attitudes towards work around home including farm work.

4.2.3 Disparities in Gender Roles at the Household Level

The inequalities in gender roles are discussed from the intra-household gender inequalities in resources bargain, a perspective used by this study indicate the basis for explaining social norms around household tasks and household resources bargain. In order to put into context gendered division of household labour, this section also gives a brief explanation of gender roles as per the existing literature. The social expectations about the regarded appropriate behaviour for members of each sex (male and female) gives men and women different levels of authority where by women hold a degree of authority second to the husband. The gender differences create diversity in expectations of what is ideal for each of me members of the family, men and women thus hold different aspect of life. A study by Harris (2006) in Mali found distinct differences between men and women created by hold differences in attitudes towards the ideal number of children, helping with housework and couple communication. Women's overwhelming burdens of housework limit their opportunity to get income generating work outside the home (Sen 1987). In terms of determinants of health, gender is one of the well known forms of social inequality of societies with less economic and social inequalities are known for having better health outcomes for both women and the rest of the population (Wilkinson 2005). Economically, women are the majority of the world's poor and socially they hold the lowest social status. Gender inequalities have been widely explained to be responsible for women's less education, income, and restricted decision making and property ownership (Wilkinson and Pickett 2010).

Women's sole responsibility for household and farm labour is a barrier to their access to resources, information and freedom and movement (Medeiros et al. 2007). Disparities in gender roles at the household level are well known for restricting women's employment and career prospects. Women's burden of household labour keeps them away from productive activities in the market and opportunities for career development (Pablo 2010). Furthermore, the productive and reproduction role has also been discussed as a gender dimension of poverty and empowerment (Braunholtz-Speight Rim and Nicola 2008). Therefore, though limited in the maternal healthcare demand literature, the effect women's lack of free time due to household labour burden should not be under estimated.

According to the 2011 International Centre for research on Women (ICRW) report, there are more gender differences on performing housework among developing nations in South East Asia and Africa. The 2005 World Bank County Assessment reported a gender gap in time spent on household activities; males were found to spend 8 hours of the day on economic activities outside home and only 1 hour on household activities such as fetching water, cooking, care for children and the sick, and cleaning. As compared to women, men spend less time on farm work. Women spend 9 hours of a normal day on economic activities such as farm work and 6 hours on household activities (World Bank 2005). Women thus bear a 'double burden' (Hervey and Shaw 1998; Marshall 1998) whereby they spend more time doing both economic and non paid housework activities. Women bear a heavier work load due to accumulation of paid and unpaid activities (Medeiros et al. 2007).

Consequently, the effect women's burden of housework on healthcare access cannot be ignored since it is responsible for the key demand factors. Household labour burdens deny women freedom of movement and work opportunities to gain economic autonomy. As a result women's capacity to make appropriate decisions about their healthcare needs is affected. Women's busy schedule deprives them of time and freedom to seek healthcare information and take part in activities that can earn them income needed to pay for the health related needs like transport and user fees. The study results in the next section show that women are most of the day busy with housework to the extent that they lack time for self care including seeking maternity and antenatal care and family planning. Equitable distribution of household labour will contribute to increasing demand for maternal healthcare and improving health outcomes by giving women time to access information and income generating opportunities.

4.2. 4 Presentation and Discussion of Findings

The study specifically examines how women and men spent their time in and around the home with specific focus on division of domestic work such as cooking, cleaning, fetching water and firewood, caring for the sick and the children and washing. The study also examined the gender division of farm labour i.e. farm work/digging, selling of farm produce and care for animals.

The results show significant inequality in how much men and women contribute to household labour. Women are responsible for fetching water and firewood, cooking, washing and cleanliness around home. Women also spend an average of 2 hours on caring for the sick and children. On average women were found to work for 14 hours a day. Women are responsible for most of the work around the home

to the extent that it is taken for granted. It was found out that there are gender differences in attitudes towards household related activities, men tend to despise the care work women do around home. Eight in every 10 community members consider and take it as a norm that house and farm work are a woman's responsibility. Seven in every 10 respondents strongly agreed that women do much more of this work than men. In most cases, men do not share equitably in child care, house and farm work. Seventy three percent say a husband makes most decisions regarding a wives movement including visiting friends and 79% of income decisions. Contrary, women make 62% of gardening decisions. Men make 62% of decisions to visit ANC and 70% of where to deliver. In the following Figure 9 is a presentation of the daily roles of men and women which was generated from group discussions from men and women. Men and women differently were asked to make a list of what they do during a typical/normal day and they presented back to the group for group consensus.

Figure 8: Daily roles of men and women

Roles of Women	Roles of Men
• Wake up at around 6.00am • Prepare for children to go to school • Cleaning the house and the compound • Clean the house and make beds • Prepare and serve breakfast to the husband • Go to the gardens • Preparing lunch • Washing/do laundry • Prepared and serve lunch • Fetch water • Collect firewood • Check on the farm • Prepare super • Care for domestic animals and make sure they properly locked up in the kraal • Bath the children • Serving super • Taking children to sleep • Bathing • Wait for the husband to come back • Prepare bathing water for the husband • Opening for husband when he comes back • Serving the husband • Wash the man's feet • Sleep at around 11.00pm	• Wake up and wash his face • Take breakfast • Go to the gardens or farm or go to work • Come back and have lunch • Go for a walk or to the trading centre to drink alcohol, have a chat with friends or go to play a game • Comes back home at night; when drunk, start quarreling and fighting the wife and children • Ask for water and then take a shower • Sleep

The above Figure 8 indicates that men and women have a different daily work schedule. This study found an association between gender gap in household labour and demand for antenatal care, skilled birth attendance and contraceptive use. The relationship with women's access to reproductive health services was determined based on its association with time spent child care, house and farm work.

Attitudes towards Division of Labour at both Household and Community Levels

To gain more insight into the division of labour at the household level, the study inquired into people's attitudes on what men and women do at the house hold and community level. Using a scale of five values, men and women were asked to tell the sex differences in who they think does the work always, most of the time, share work equally, less often and never. In the following Tables 12,it is indicates that both at the household and community level, everybody agrees that cooking, cleaning around a home, fetching water and washing clothes is work that is always done by women. The findings agree with other studies which have found distinct gender differences in the division of household labour. Housework remains substantially the work of women.

Table 11: Descriptive Percentages on the Attitudes towards Division of household/farm work

In your home/community, the woman does the following work more often than the man.	Yes, always (1)	Yes, most of the time (2)	No, they do the work about equally (3)	No, they do the work less often than men (4)	No, women never do this activity (5)
Digging (N.283)					
At home	77%	9%	8%	6%	0.4%
In the community	79%	16%	5%	1%	
Caring for children (N.283)					
At home	75%	16%	5%	4%	
In the community	74%	20%	5%	1%	
Cooking (N.283)					
At home	98%	1%	0.7%		
In the community	95%	4%	0.7%		
Collecting firewood (N.283)					
At home	82%	7%	2%	5%	4%
In the community	76%	16%	4%	3%	1%

Table 11 Continued

In your home/community, the woman does the following work more often than the man.	Yes, always (1)	Yes, most of the time (2)	No, they do the work about equally (3)	No, they do the work less often than men (4)	No, women never do this activity (5)
Caring for the sick (N.283)					
At home	72%	12%	13%	3%	
In the community	67%	20%	11%	0.7%	
Selling farm produce (N.283)					
At home	46%	9%	16%	27%	2%
In the community	32%	14%	19%	34%	1%
Cleaning the home (N.283)					
At home	96%	3%	0.7%	0.4%	
In the community	94%	5%	0.4%	0.4%	
Fetching water (N.283)					
At home	87%	7%	2%	1%	3%
In the community	81%	16%	2%	0.4%	0.7%
Washing clothes (N.283)					
At home	95%	4%	0.4%	1%	
In the community	94%	5%	0.4%	0.4%	
Caring for animals (N.283)					
At home	41%	19%	7%	27%	6%
In the community	25%	9%	16%	45%	4%

There were slight differences in what people thought division of work by gender is within the household and the community level; while 87% of people believed that fetching water at the household level is always done by women, at the community level it was rated 81%. The differences were also with collecting firewood (82% versus 76%), caring for the sick (72% versus 67%). However, the trend was that percentage for the community level was always slightly lower than for household level. Seventy five believe that it is always women who care for the children within the household, at the community level it was rated at 74%. The study found reverse attitudes towards who cares for animals and sale of farm produce. The percentage of women who always do this kind of work dropped to 41% and 46% respectively.

Table 12: Descriptive Statistics (Standard Deviation) about household-level attitudes towards division of house and farm work

	N	Mean	Std. Deviation
Digging			
In your home, a woman often digs more often than the man	283	1.44	.902
In this community, women often do more digging than men	283	1.28	.599
Caring for children			
In your home, a woman often cares for children more often than man	283	1.39	.777
In this community, women often do more caring for children more often than the men	283	1.34	.641
Cooking			
In your home, a woman often cooks more often than the man	283	1.03	.213
In this community, women often do more cooking more often than the men	283	1.05	.248
Collecting firewood			
In your home, a woman often fetches firewood more often than the man	283	1.42	1.017
In this community, women often do more fetching fire wood more often than the men	283	1.37	.820
Caring for the sick			
In your home, a woman often care for the sick more often than the man	283	1.48	.840
In this community, women often do more caring for the sick more often than the men	283	1.43	.709
Selling of farm produce			
In your home, a woman often sells farm produce more often than the man	283	2.39	1.348
In this community, women often do more selling of farm produce more often than the men	283	2.57	1.278
Cleaning the home			
In your home, a woman often cleans the home more often than the man	283	1.05	.288
In this community, women do cleaning the house more often than the men	283	1.07	.308
Fetching water			
In your home, a woman often fetches the water more often than the man	283	1.27	.826
In this community, women often do more fetching water more often than the men	283	1.24	.576
Washing clothes			
In your home, a woman often washes clothes more often than the man	283	1.07	.375
In this community, women often do more washing clothes more often than the men	283	1.07	.308
Caring for animals			
In a home, a woman often cares for animals	283	2.40	1.415
In this community, women often do more care for animals more often than the men	283	2.96	1.314
Valid N (listwise)	283		

The standard deviations in Table 13 above indicate that there are gender differences in division of house and farm work that are accepted at household and community levels. Whereas with rest of the housework, the standard deviations were less than 1 and that of care for animals and sale of farm produce was greater than 1. The differences can be attributed to traditional division of labour where by caring and keeping animals was the of men and it involved moving with animals especially cows, goats and sheep away from home searching for pasture and water (see table 11). Also sale of farm produce involves moving away from home to take produce to the markets. The two activities are also where exchange of money is involved. Since men are the in charge of allocation and control household resources, the findings on division of labour in this study provide a further understanding of women's lack of access to financial resources within the household.

4.2.5 Household Division of Labour and Demand for Maternal Healthcare

The time women spend on housework-related activities is associated with use maternal healthcare; significant associations were with access to skilled birth attendance and contraceptives. Table 1 shows certainly that the more time spend on farm and house work the less the use of maternal health services.

Although men and women spend relatively the same time on farm work (58% and 62%), women tend to spend more time on care for the children and the sick, cleaning, fetching water and fire wood and sale of farm produce. The time spent on household work is not uniformly associated with use of antenatal care, skilled birth attendance and family planning services. Significant relationship was found between time spent on farm work and skilled birth attendance. Care for the children and the sick were associated with use of contraceptives. Antenatal care attendance did not have any direct relationship with time spent on household activities.

Women comprise 74.38% of the people who spend more than 6 hours of their normal day on farm work. On average both men and women spend a maximum of 2 hours on sale of farm produce with women being more involved (77.06%) and men least (22.94%). The negative relationship between skilled birth attendance and farm work (-0.105) and sale of farm produce (-0.068) suggests that women's lack of time limits access to healthcare. This means that the more time women spend on household related work, the less likely to use skilled birth attendance i.e. delivery from health facility. One reason to explain this outcome is that women spend most of their time doing unpaid household and farm work which deprives them free time to seek healthcare. Also they lack time to participate in income generating activities to

earn income needed to pay for services that need direct payments such as transport and out of pocket. The study also found out that women also make limited income-related decisions. For example 79% of decisions regarding money to spend on home items like food and clothing are by men/husbands.

Although farming generates income, lack of control over this income continues to affect women's ability to use healthcare. This is reflected in the negative correlation between skilled birth attendance and sale of farm produce. 7 in every 10 as compared to 3 in every 10 respondents believe that it is husbands who decide if a wife is to deliver in a health facility.

Table 13: Intra-household Time Use and Access to Maternal Health Services

Time spent on household activity	Health service	Type of relationship (Sig.2tailed)
Caring for children	Use of contraceptives	-0.038
Care for the sick	Use of contraceptives	-0.124
Farm work	Skilled birth attendance	-0.105
Selling farm produce	Skilled birth attendance	-0.068

The time one spends on child care (were negatively related (-0.038 and -0.124, respectively) to use of contraceptives and antenatal care. This is because care for the sick and the children are almost entirely provided by women, and this takes at least two hours a day. A better understanding of the differences in attitudes towards this work could be used to explain why the more time women spend on caring the less they are likely to control their birth or use contraceptives.

The time spent on care for children, fetching fire wood and washing was found to have a significant relationship with the possibility of a spouse being present during child birth. The Analysis of Varience in Table 3 below shows the significance of the relationships. This implies that men who participate in activities which are taken as women's work greatly embraced the need to be involved in maternal healthcare.

Table 14: Gender Differences in Time Spent on Child-care

Number of time a spouse was present during child birth (ANOVA)		Sum of squares	Df	Mean square	F	Sig.
Time spent of caring for children	Between groups	36.509	3	12.170	9.112	.000
	Within Groups	368.602	276	1.336		
Time Spend on washing	Between groups	22.948	2	11.474	8.371	.000
	Within Groups	368.725	269	1.371		
Time Spend on Fetching fire wood	Between groups	31.514	2	15.757	11.778	.000
	Within Groups	363.882	272	1.338		

The following are some of the qualitative quotations that express women's reasons for not delivering in a health facility with qualified health personnel and attending antenatal care. The information is specific to women who at the time of the interview had not delivered their youngest child in the health facility: *"….sometime you are busy with a lot of work around the home and this makes labour easy and you do not need to be in the hospital…* ***(25 year old mother – Kashare – April 2011)***

As I tried to prepare and look for someone to leave with my other young children, I realized it was too late and I decided to call on a TBA in my neighbourhood and I had my baby at home" ***(35 year old mother – Rubindi - April 2011)***

"I delivered my last baby at home because as I was in the garden, labour started and so I could not easily prepare, I called on my neighbour for assistance and all went well: ***(29 year old mother - Kashare- April 2011 ….)***

"The ANC schedules at the health centre are rigid, they say that clinic will be on between 4.00am and 01.00pm and by the time one goes around the home trying to finish up with work, they have left and you need to prepare to go they next week…..," ***(31 year old mother- Nchune April 2011)***

With these expressions, the effect of time deprivation on the side of women cannot be under estimated. It is obvious that housework in some way limits women's opportunities to plan and be ready for access healthcare.

4.2.6 Gender Differences in Attitudes towards House and Farm Work

Respondents were asked about how they valued the work done by themselves and others. The following Table 11 shows the responses for the two end of the scale –very important and less important. The table shows that unlike women, men rank cooking, care for children and cleaning to be less important. Farm work, sale of farm produce and care for animals are more or less equally rated by men and women. 30% of men as compared to 80% of women ranked child care as very important. Unlike the typical care work, men ranked farm work, sell of farm produce and care for animal at 74%, 67% and 26% respectively. However, compared with other care activities, men seem to value childcare slightly high as compared to other care activities – 32% followed by care for the sick at 15%. Child care therefore is one area where men's involvement in housework can be improved. Although women value cleaning a home, washing and fetching water men rank these activities as least important. This could be one of the reasons men are spending less time on doing housework.

Table 15: Ranking of Selected House and Farm-work Related Activities by Gender

Household Activity	Rank 1/very Important		Rank 4/less important	
	Male	Female	Male	Female
Caring for children	32%	77%	6%	1%
Caring for the sick	15%	28%	46%	16%
Cooking	11%	57%	56%	3%
Fetching fire wood	9%	33%	57%	30%
Cleaning the home	8 %	61%	58%	7%
Washing	8%	41%	49%	8%
Fetching water	6%	39%	52%	13%
Farm work	74%	80%	2%	2%
Selling farm produce	67%	48%	14%	10%
Caring for animals	26%	21%	51%	52%

The following quotes from interviews can help to explain the community justifications for the differences in the way work is divided in a home:

> *"Ooh God help women to continue to know their responsibilities in a home, men are the 'head' and women are the 'shoulders'. They can never be equal"* ***(Religious Leader – Kashari – Mbarara – December 2010)***

"A man can help out with housework when he is sure no one will see him" ***(Local Council leader – Rubindi Mbarara – December 2010)***

With these differences, women are not only overburdened but they also lack cooperation and support from their male partners. Research and policy should focus on how to improve men's attitudes towards 'women's work' and how men will be involved in housework. Men can contribute to improved women's health by taking over some household tasks so that women have time to access the needed reproductive health services and other related opportunities like education and income generation.

This study brings out two accounts for explaining the contribution of gender division of household labour on access to maternal health services. Through shared roles there care be improved couple cooperation and overall relations and women's opportunity to make decisions that affect their health through analyzing the household labour burden and time use.

Housework is predominantly the role of women and consumes most of their time. Women's time spent is largely spent on housework which can be linked to their being deprived of time to seek maternal health care. Studies have shown that time deprivation is as a results of the housework burden that affects women's social and economic autonomy since they cannot trade-off between domestic and market work (Medeiros et al. 2007).

The absolute time women spend on house and farm work is a major obstacle to their access to healthcare. Mainly because women's burden of household labour deprives them of free time to access not only health related information but opportunities to earn income needed to pay for healthcare. There is therefore, little or no doubt that time allocation affects women's health behaviours. One important factor is that housework is unpaid and their economic contributions remains unrecognized (Langsten and Salem 2008). Time spend on housework by women limits their economic opportunities to earn income needed to pay for healthcare needs. Also women are involved in farm work which is the main source of income; they have least influence on how to spend proceeds from the farm.

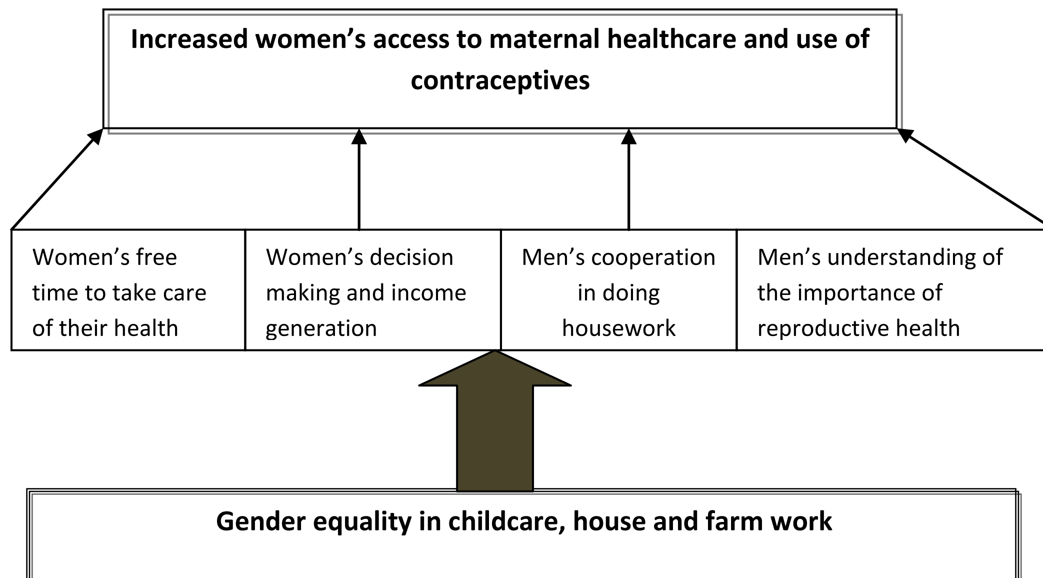
Understanding the components of gender inequality in house work and the related activities will remain complex without considering inequalities in the division of household labour. Reducing inequalities in household labour is not only an opportunity for reducing women's burden but also for increasing women's access to healthcare. Gender equality in household labour also increases opportunities for attaining greater involvement of men in reproductive and maternal health. Related studies argue for

responsible parenthood and male involvement in child care to promote women's participation in labour force outside home (Coverman and Sheley 1986; Connelly 1992; Deutsch et al. 2001). Recent studies focus on male involvement in antennal and maternity care (Simkhada et al. 2008).

Therefore, it is with this background that I argue that when men do more work at home, they will gain a greater understanding of reproductive health. When men are involved in housework they will come closer to realities of women's health. In the same way, women will have more free time to care for their health and carry out income generating activities. Figure 9 is an illustration of the benefits of increasing access to maternal health through reducing gender inequality in house and farm labour. Reducing women's housework burden is important since it helps women gain free time to access healthcare and gainfully opportunities earn income. Men will also understand and appreciate a women role at home which eventually enhances couple cooperation and overall improvement in reproductive health. Studies show that societies with less gender inequalities in housework record better maternal health outcomes. It is therefore reasonable to assume that reducing women's household labour burden promotes positive maternal health behaviours in particular use of family planning, institutional delivery and antenatal care.

Household division of labour determinants of use of maternal health care

Figure 9: Household Division of Labour Determinants of Use of Maternal Health Care



Source: Author's drawing July 2010.

Relieving women the burden of household labour burden promotes their decision making and autonomy. This argument is based on the 'three delays model'. Thadeus and Maine in 1990's argued that getting adequate care in time is an overwhelming factor leading to death of women in most developing countries. They presented a 'three delays model' (1) delay in making decisions to seek care when experiencing an obstetrics emergency; (2) the delay to reach an appropriate obstetric care facility; and (3) the delay in receiving adequate and appropriate care once the facility has been reached (Thaddeus and Deborah Maine 1994).

By critically reviewing the three delays model, the 3rd and partly the 2nd delays are obstacles that are much more related with issues of healthcare supply such as distance, structures, supply and healthcare personnel. The 1st obstacle however, is much more of demand; it is about household decision making dynamics that are related with hierarchy and income. It is that decisions are affected by both the levels of income and the overall social position of a woman. This study contributes to further understanding decision making barriers by describing the overwhelming burden of housework on women's time. If women are working for 14 hours a day, worse still on unpaid housework work, they are expected to be in a better situation to access healthcare. Time deprivation is an important delay that increases the understanding of household level delays.

4.2.7 Conclusions

Although housework is predominantly a responsibility of women in most communities, the inequalities in division of labour at home for are extreme and unbearable. Women than men do both house and farm work and are denied alternative use of time for self care including getting healthcare. House and farm work consumes most of women's time denying them freedom to access healthcare information and services. Adequate utilisation of maternal health services cannot be achieved by merely establishing health services, women's overall status needs to be considered.

Therefore equitable distribution of housework by gender is a necessary factor for improving maternal healthcare. As housework keeps women at home, shared responsibilities promote couple cooperation as women get free time to access other opportunities outside their home. Therefore, achieving significant improvements in women's health requires promoting gender equality right from the home i.e. how housework is divided by gender. Big gaps in household division of labour are of disadvantage for both men and women. For example, when women are overwhelmed with work they may not have choices but

to take up their burden which in most cases is taken for granted. For both men and women there is general agreement that housework related activities is for women. In situations a man is unemployment or has no alternative work outside a home setting, he rendered redundant.

To reduce gender inequalities in housework, communities need to know the advantages in shared responsibility. Campaigns promoting gender equality in household labour need to start from the lowest level i.e. the household by teaching both young men and women to appreciate the advantages of shared roles. Shared roles promote responsible parenthood and have been found to improve couple relations (Keith and Schafer 1980).

CHAPTER FIVE

Women, Land and Maternal Healthcare Demand in Rural Uganda

5.0 Introduction

In most communities in Uganda majority of women's land ownership status remains obscure amidst them being the main source of farm labour for household food production and income generation. While land has remained an important socioeconomic resource, the customary land tenure limits majority of Ugandan women's land rights. In this chapter, an attempt is made to show the effect of intra-household land access dynamics on use of antenatal care (ANC) and skilled care during child birth. The chapter's main discussion is presented around the statistical findings which did not indicate direct significant relationship between land ownership and use of maternal healthcare but indicated a significant effect with household level land related decision-making. The results have been explained by analysing land ownership as intermediary factor for use of women healthcare. In Kashari like it is in most of Ugandan communities, work on land provides the major source on household income, employment and production.

This chapter's analyses land as a household factor that shapes women's maternal healthcare decision-making by not merely looking land ownership but other factors that surround use decision-making, its role as source of identity and the allocation of resources that accruing from work on land. The discussion is drawn from the fact that women can make 95% gardening decisions and only 8% of decisions regarding allocation of household income. On the other hand men influence 92% of decisions regarding allocation of income resources of the household and only 5% of gardening decisions. As a result the study found that land decision-making significantly affected planned pregnancy, contraceptive use and antenatal care. The study also found that women are more likely to express land insecurity than men. Therefore, it can be concluded that women's lived experience of land insecurity undermines their prospects for positive maternal health. For policy relevancy, the study recommends that efforts to redress the customary land tenure impediments considerations should be extended to maternal health implications.

5.1 Customs and Women land Ownership

Since the 1970, which saw the advent of literature on Women in Development, many researchers have continued to show a close link between women's empowerment and the health outcomes of their families and communities (Visaria 1993; Jackson 1999; Mosedale 2005). Whereas land is a prime economic resource and a determinant of one's status in Uganda (Wamani et al. 2004), women are faced with social and economic barriers to accessing and owning land (Asiimwe 2001). Traditionally land rights and ownership are embedded deeply in social norms and customary law, including those related to marriage and inheritance (Doss et al. 2012). Traditionally in most of south western Uganda, land is passed on to males through customary land practices which culturally define women land ownership to be under the control and regulation of men (Deininger and Castagnini 2006).

The 1995 Constitution of Uganda and the 1998 Land Act recognise four tenure systems – Customary, Mailo Land (introduced as a result of the 1900 Buganda Agreement where land was divided between the Kabaka (king) of Buganda and the British Protectorate Government), Freehold and Leasehold land tenure systems. The customary land tenure is the most dominant in Uganda (Kawamara-Mishambi and Ovonji-Odida 2003). It is a system whereby land is owned and disposed off in accordance with customary regulations. However, the customary land ownership tenure system upholds male domination over women property rights. For example, under Customary Land Tenure, land ownership is through inheritance following a patriarchal system (Asiimwe 2001). The customary land tenure system makes women's land ownership protection depend on marriage and kin relations (Doss et al. 2012). It is the men and family members that define women land ownership, which makes women's land claims weaker (Whitehead and Tsikata 2003).

While it is prohibited to deny land access to women, children and persons with disability, the land laws provide for respect of tradition, customs and practices of concerned communities (Hunt 2004). The customary land tenure provides and inefficient land laws limit women land use and decision making choices, left at the mercy of patriarchal land customs which allow land ownership to only males. Customary land customs do not allow women to own land unless it is through a male kin (Hunt 2004; Giovarelli 2006). Since the 1990's land reforms, efforts to provide for joint ownership by women of their husbands property land inclusive has remained controversial (Hunt 2004). The benefits of ownership/control of land at the household level are increased economic strength and ability to bargain

(Giovarelli 2006). According to Kabeer (1999), the ability to exercise choice incorporates access to resources and claims to material, social and human resources.

Basing on the above analysis, it is important to note that women face land ownership and access which certainly could have a wide range of causes and effects. Many factors limit and cause women's limited land rights; according to Agarwal (2003), it is inequality in accessing family resources that limit women's choices in accessing land. In her earlier analysis of gender bargaining in Asia, Agarwal (1997) further asserts that women's land rights can over time help women negotiate less restrictive norms and better treatment from husbands. In addition, land is the most important economic resource and most a significant cause of gender inequalities (Jackson 2003). However, women land rights guarantee through marriage remains a challenge; in most Sub-Saharan Africa Uganda inclusive, cultural recognition as spouse is the major way to secure right to marital property (Cooper 2012). On the contrary, informal customary marriages have been found to increase vulnerability for land ownership and inheritance rights (Whitehead and Tsikata 2003; Tripp 2004). While majority of marriages are customary and so not registered, the attempts to pass the laws to regulate property ownership have been met with significant cultural and religious opposition (Cooper 2010).

Women's lack of land rights, coupled with unfavourable marriage customs cripples their ability to benefit from household resources (Giovarelli 2006). Although several studies have provided evidence on household level decision making hierarchy and male restrictions women's on movement outside home (Beegle et al. 2001; Derose et al. 2002), no study has directly examined intra-household land decision making dynamics and use of maternal health services. There is significant lack of analysis into the effect of women's access to land on maternal health behaviours, especially considering the fact that, for most communities, land remains the only livelihood resource. This chapter investigates the association between household land decision making dynamics and women's maternal health practices based on three factors: First the communities' definitions of land ownership by women. Secondly the chapter presents a discussion of the effect of women's access to household land on reproductive health decision making. Lastly, the chapter attempts to identifying the relevance of women's access to family resources to reproductive health policies and planning.

5.1.1 Women and Land Access in Uganda

Land is a physical asset on which almost all of Ugandan rural populations depend for their livelihood. Land is both a source of income and food of which the ownership, especially in south-western Uganda, ownership is predominantly customary (Deininger et al. 2008). In Uganda, land ownership provides ultimate security for ones socio-economic status (Jackson 2003). Land is also a measure of income security and people who do not own land ranked in the lower income quintile (Canagarajah et al. 2001; UBOS 2010). Land is owned through inheritance and the common practice is that land is passed on to the boy child commonly after he is married. In some societies land ownership by women is a taboo; women's only accepted form of land ownership is when they are married (Giovarelli 2006). Women's land tenure rights are fragile, customarily women land ownership is for other purposes, not necessary to give then property rights (Deininger and Castagnini 2006). Women's claims to land are justified solely through the recognition of their obligation in food production (Whitehead and Tsikata 2003), the use of land for a woman is to produce food for the family. Women provide most of the labour for agricultural and food production. According to the 2006 DHS, women provide more than 80% of agricultural labour, yet own less than 10% of land (UBOS 2006).

Therefore, land reform in order to protect women's access is not only about economic security and property rights, but it is also an issue of constitutional and human rights debates (Deininger et al. 2008). Whereas, the 1998 Land Act provides for spousal co-ownership of land, protection of land rights is largely through family (Giovarelli 2006). The land act is a state legal strand which states that a wife is entitled to 15% of the spouse's estate after death. However, in practice, all arrangements of land inheritance by women depends of intra-household family dynamics (Deininger and Castagnini 2006). Most widows lose their property to their husband's family through grabbing (Derose et al. 2002). In practice, customary law and written modern law conflict, with the customary taking precedence (Tripp 2004). Defence of tradition and custom as opposed to co-ownership of land has continued to frustrate activities geared towards promoting women land rights (Tripp 2000). Women access to land through their husbands does not gain them full ownership (Deere and Doss 2006), evidence shows women land access insecurity increases with divorce or death of a husband (Deininger et al. 2008).

It is important to note is that customary land tenure and male dominance restricts women's land ownership (Asiimwe 2001), less than 10% of Ugandan women formally own land and majority of women are not in control of land which is their means of production (UBOS 2006). In Uganda, though

customary land is recognized, formal ownership of land is largely by land registration (titles) which is rare in rural areas (Obaikol 2009). The customary terms of land ownership favour men, create a social economic divide between husbands and wives and makes women depend on their husbands for decision making (Giovarelli 2006). As a result, women depend on their male counterparts for use, ownership and sale of land (Obaikol 2009). However, land gives women access and control of household resources; it is their source of livelihood and identity (Hunt 2004). Being that most communities depend on land for their livelihood, it considered prime resource for individual and family well-being. Therefore, this study adds evidence to the debate agreeing that women ownership of resources such as land ensures a wide range of positive outcomes in maternal health. This chapter discusses empirical data indicating evidence on how uncertainties surrounding women's land access does not support prospects for positive maternal healthcare.

5.2 Presentation and Discussion of Findings

To determine land ownership dynamics within household, questions were asked to find out land ownership, types of land ownership, gender differences in land related decision-making in particular, gardening, work on farm, producing food, sale and purchase of land. Respondents were also asked if they felt secure on their land. During unstructured interviews and focus group discussions, community members were asked to define and describe their understanding of a women's ownership of land in the community. During analysis the survey data from the land related questions was then used to create correlations with women's use of maternal healthcare. As in the rest of the study, only family planning, ANC and skilled care at child birth were examined. The qualitative data was grouped in order to create key themes on the community definition of land ownership and the used to back up quantitative statistics. All questions and answers related to practices at the time of the survey.

5.2.1 General Land Ownership Variables

When both men and women were asked if their household owned land, the general perception 94% (N.266) is that households own land. Only 6% (N.17) said they did not own land at all. In relation with national figures, while 75% of Ugandans claim to own land, only 10% have land titles (UBOS 2012). However, more than ¾ of the people who said their households did not own land were women as compared to less than ¼ who were men. Also when asked if they had enough land for producing food for their families, only 38% (N.106) said they had enough land and 62% (N.175) felt their land was not

enough for their family food production. Another value attached to land is that for rural areas land is required income, as a source of identity and space to construct a house to live in.

The high percentages of land ownership may not necessarily refer to having a legal title or registration, with the predominance of customary land tenure, by agreeing to own land does not necessarily grant legal rights. When asked about the form of ownership, 97% (N.275) of land tenure was said to be customary and only 3% (N.8) is registered land of which all were men. The implication is that almost all land which people depend on has been acquired through family i.e. passed through a patriarchal lineage, i.e. from a father to a son especially after marriage. It has been presented in literature that the common way land is acquired is through customary tenure (Deininger et al. 2008). It has also been discussed that while women, gain access to land through their husbands, they do not gain ownership of it (Deere and Doss 2006).

The following quotations from the open ended discussions and interviews show how contagious women land ownership is: *....women have no authority on our land because it is reserved for our sons, when she goes to her home she gets her share....I paid dowry, she cannot share on my land....the government has given women authority, ...but the land which I got from my parents is mine alone...* ***(Individual interview – 44 years Old man from Kashare May 2011)****. ....even when they do not have enough land, some men go ahead and sell land without asking their wives, women fear to talk and just sign the agreement...otherwise she is beaten ....women fear to be divorced* ***(Women Group Discussion Omukatoma May 2011)***

These results could be explained by the fact that traditional customs do not yet give space to women ownership of land (Rugadya, Obaikol et al. 2004), despite their marital status, women traditionally not expected to claim ownership. The 2011 Uganda Demographic and Household Survey (UDHS) assets that tradition more than socioeconomic status play a big role in women asset ownership. For example it was reported that 70% of women in the highest quintile have no land as compared with 50% of women in the lowest quintile (UBOS 2012). This study indicates that even when land is acquired from parents, after marriage husband can use his authority to determine how the land shall be utilised. It is important to note that whether acquire land may not make any substantial differences since marriage traditions require a woman to abide by her husband's authority. In the literature review section it has been shown that after marriage women's decisions are largely dependent on their husbands (Otiso 2006).

In Uganda only 38% of currently married women participate in decisions pertaining to their own health, major household purchases and visits to their family or relative (UBOS 2012). This study found that less than 3 in every 10 women can make decisions to visit friends and relatives without the husbands' permission. Therefore even when there are arguments that women can inherit land only from their parents, women have limited freedom of movement may make it difficult to benefit from the acquired land. During one of the focus group discussion, when the discussion suggesting women land ownership came up it was met with contention *....in case my wife has land that she inherited from her father, ...I make sure she sells it and we buy another one on which I can have control* ***(Men Group Discussion – Rwebishekye April 2011).*** This assertion could be interpreted that the community is still restrictive of women land ownership. This could be evidenced by another findings which indicated significant gender difference in fear of land insecurity, although most people said they felt secure on their land (87%, N.237), five in every seven women were insecure on their family land as compared to two in every seven men. Having majority of people feeling that their land tenure is secure could be linked with the fact that land in rural south-western Uganda, generally family land is governed by customary or a set of family based regulations (Deininger et al. 2008).

Furthermore, the implications of women's land ownership can analysed at from two perspectives: first the generation of intra-household gender inequality and secondary mediation of opportunities to achieve well-being. Land is a basic socioeconomic resource for which men are intermediaries for women's access. Referring to the theoretical framework of this thesis which integrates the Social Determinants of Health theory and Amartya Sen's analysis of intra-household gender cooperative conflict, it is important to conclude that women's lack of land rights obliges them to cooperate with their spouses decisions and in the process forego responsible maternal healthcare.

5.2.2 Descriptive statistics on Decision-making and Control of Land

To be able to determine the decision making dynamics over land control, data was collected distinguishing between the husband and wife's land related decision-making limits over land use particularly gardening, purchase/ownership and sale. In the following table, the findings show that men make over 93% of all decisions regarding the purchase of land, 78% decisions regarding sale of land and only 5% of gardening decisions. Gardening/agriculture is major land activity for most people. In this study it was found that 73% of households depend on agriculture and sale of farm produce as their main sources of income.

In relation with other studies, food production and gardening are the only conditions allowed for women land claims (Whitehead and Tsikata 2003). The sudden less involvement of men influencing gardening decisions is an indication of the strict division of labour within the household. It has been literature section that farming is a major activity for women. This study found that although men and women are likely to spend relatively the same time on farm work – 62% of women time is spent on gardening as compared to 58%; women have an added responsibility of housework. However, this study also found that husbands influence 92% of family income and resource decisions but only 5% of gardening. The implication for this finding is that whereas women contribute highly to farm labour which is the major source of income, men control the incomes.

Table 16: Intra-household Land Use Decision-making Dynamics

Question	Husband	Wife
Decision regarding the purchase of land (N.283)	93%	7%
Decision regarding sale of land (N.283)	78 %	22%
Decision regarding gardening (N.283)	5%	95%
Decision regarding family income resources in your home (N.283)	92%	8%

This study's findings on land decision making dynamics are consistent with other studies which found related social and economic land decision making dynamics and is the ultimate source of livelihood for most of Uganda's population (Deininger et al. 2008). The studies also found that for men land is both owned for identity and masculinity purposes, and so it is their responsibility to purchase land (Jackson 2003). The sale of family land although protected by the requirement of spousal consent, men are often not culturally obliged to inform their wives about their decision to sell land (Tripp 2004). The following quotations also show that land ownership by men and women at the household level is surrounded by a lot of contention:

> *"…why should a women own land, does she know where I got it from,…. it is unbelievable let the women go and share on their father's property"* ***(Individual Interview 60 year oldman, Kashare April 2011)***

"…women own family land and apart from sell, they can do anything with it. The only problem comes when a man wants or marries another women...land is divided or even lost to the newly married" ***(Mixed focus group Discussion – Omukatoma May 2011)***

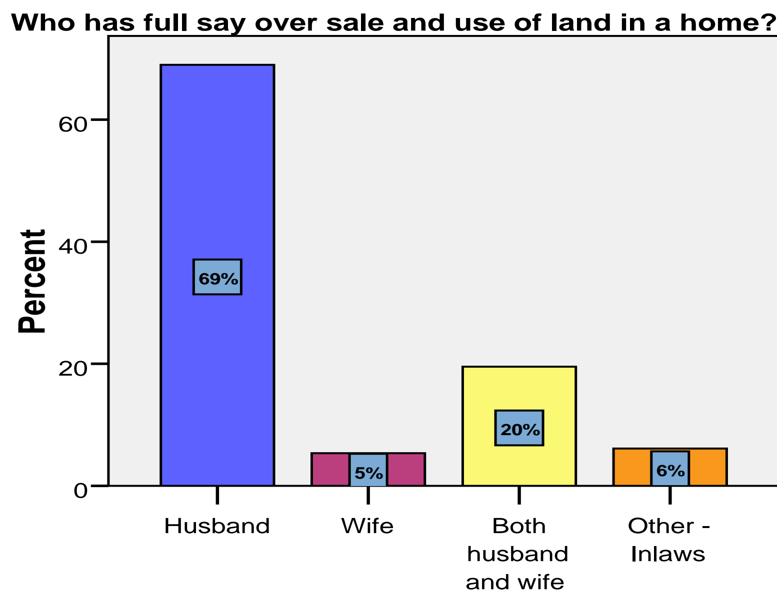
This study shows that land ownership is surrounded by a number of fears whereby men are worried about losing their authority when women begin to own land, women fear to lose the relationships on which land ownership is determined. While the 1998 land reforms require spousal consent over sale of land (Tripp 2004), Figure 9 on the next page shows that men/husband, still hold have definite authority over use and sale of land. The land is owned by men, because in most cultures and communities, women do not inherit land from their fathers or husbands. Therefore, the Spouse Consent Clause of the 1998 Land Reform Act without the co-ownership act does not provide legislation for women own and control land (Deininger and Castagnini 2006). Kawamara-Mishambi and Ovonji-Odida (2003) in their analysis of the co-ownership clause assert that the 1998 Land Act missed the opportunity to provide for women legal rights to own land when final Land Act contentiously lost the clause on men and women 'co-own' land.

Evidence shows that the Spouse Consent Clause has not achieved the intentions to provide security of women land tenure (Hunt 2004; Obaikol 2009). For instance this study Figure 9 shows that land decision making dynamics are still dependent on men who are responsible for 69% (N.195) of land related decisions. The findings show joint decision making only account for 20% (57). For that matter, women land legislations require that they provide for customary and community practices. There is still need for protection of women's land rights both as members of the household and people with interests and perception of benefit from land. As expressed below, apart from gardening, women have limited claims and land rights especially over land that has been inherited or passed on to her husband by his parents. *"…it is okay for a women to have equal rights on land, but it only has to be that which she has bought with her husband and not that which has been passed on from her husbands parents"* ***(Women Group Dicussion – Rubindi December 2010).***

"...some parents have started to give land to their daughters, but when they girls get married the find it convinient to sell the land because they will not be allowed to keep moving back and forth…some women sell land and but things like a cow to give them income and security" ***(Women group discussion interview – Mishenyi May 2011).***

The above expressions indicate that land which is inherited or passed on the man's parents cannot be claimed by a woman. Women's inheritance of land from her parents is also difficult because when she is married she moves to another family with limited opportunities to move back and forth to her home. Also land protects the status of a man and as it has been presented in the above sections of this chapter; men are not comfortable with women land ownership since this may threaten their status and limit men's control of over the women's decisions. Wyrod (2008), study on masculinity and shifting discourses of gender inequality in Uganda argues that patriarchal powers remain prevalent amidst promotion of women rights and so retain cultural notions of innate male authority. As Amartya Sen (1987) observed, intra-household allocation of resources coexists with extensive conflict and pervasive cooperation. Sen further argues that domestic power imbalances owing to property rights gender inequalities generate pervasive cooperation, shading light on why women do not use maternal health care (Beegle et al. 2001).

Figure 10: Bar Graph on Gender Differences on Decision-making Regarding Sale and Use of Family Land



Although women customary land rights are protected though the Spousal Consent clause of the 1998 Land Act, the above graph show that they still do not influence the decision to sale land. The following quotations from the open ended interviews show how difficult it remains: *...although the NRM government has given women authority over land, the land I got from my parents is mine and my wife cannot have authority over it"* ***(Individual Interview 60 year oldman, Kashare April 2011)***

"…I give land to my sons, if my wife wants land let her go to her parents ….for her, I paid dowry and she has nothing to do with my land" ***(Local Council Leader, Rubindi Mbarara – December 2010).***

The cross-cutting theme in the above expressions is that women do not own land because the custom of land inheritance favours males. Another finding is that, laws protecting women's land rights are known but the men's cultural rights prevail. Whereas, there is an epressed general feeling that a woman can have a share of her father's land, in practice it is different, as has been reported in literature, land is only given to boys because girls get married and move to another family (Giovarelli 2006). Apart from land ownerhip by marriage, the emerging form of land ownership is when a husband and wife buy land out out their savings and when a women decides to buy land as an individual. Some parents are also starting to pass on land to their daughters.

5.2.4 Bivariate Correlation Coefficients for Land Ownership and Use of Maternal Health Care

Decision-making: The study tested for use of ANC during the last pregnancy, place of birth for the youngest child and the current use of modern family planning. The unmet need for family planning was determined by finding out if the last pregnancy was intended; findings indicate that 98% (N. 278) had attended ANC at least once during the last pregnacy, about 62% (N.173) had delivered with assistance of trained person. 34% (N.44) those who responded to the question on use family planning are currently using contraceptives and and 21% (N.28) were not using any form of modern contraceptives. About 50% (135) of the respondents declianed to answer if they are using or not using contraceptives a response that could also be linked to women's unmet need for family planning due to lack of control of fertility decisons. Studies in Uganda have found that gender inequalities play a key role in decsion-making about fertility and sex (Wolff et al. 2000; Blanc 2001). Men tend to report a higher contraceptive prevalence than women (Blanc 2001).

Significance tests were performed using bivariate logistical regressions for both land ownership and decision making dynamics within the household. The Tables 19 and 20 show that when correlated with use of ANC and skilled delivery and family planning, land ownerhip and land related decison making affect use of the maternal services differently. While there were no direct correlations between land ownership and use maternal health service (see Table 19), maternal health behaviours were significantly

related with land related decision-making (see Table 20), going for antenatal care and place of delivery had crosscutting signficant relations with land use decison making. As was found in the study by Wamani, Tylleskär1 et al. (2004), women's autonomy on land had significant effects on child nuitrition. Land is the sole source of livelihood for most rural Ugandans and contributes to the social economic determinant of health outcomes. Family hierarchies based on gender overrule decision making processes in many societies and constraint women's education, health and physical mobility as a whole (Bloom et al. 2001). Increasing women's access to education, income, material resources such as land, and political rights have also been found to be important predictors for family health (Wamani et al. 2004).

5.2.5 Determining the Level of Significance between Land Ownership, Decision-making and Maternal Health Care

Five variables were used to determine ownership and control of lands which included household has land, the form of land ownership, if the land is enough for family food production and feeling sure on the land. It was indicated that 93% of the households own land and 97% of it is under customary land tenure. Whereas Majority, 87% of the people feel secure on their land, only 69% of the household feel they have enough land for family food production. The question on having enough land was used add to the details of land security since women are the major producers of food and evidence shows that food production is the major accepted claim for women's land ownership (Tripp 2004).

The following assertions from qualitative data also indicate the depth of the challenge: *....land is becoming scare, some families do not have any land left to pass on to their children....some have resorted to selling their small plots of land to be able to move where there is still room for expansion and food production* ***(LC II Chairperson Rwebishekye May 2011).*** *....women do not have land ownership at all,.... there are cases where women even hide their harvest if not the husband will sale and she will never know what the money from the harvest has been used for* ***(Women Group Discussion, Rubindi April 2011).*** *...when women own land they tend to become stubborn....the wise man is one who convinces her to sell it and then buy something like a cow...this you know that it will be easy to sell off* ***(Individual Interview, LC chair person – Rwembabi April 2011)***

From the above statement it can be noted that land ownership is faced with a number of challenges which include increase population pressure and community perceptions that only men should own land. The study indicates that women land ownership is as well important for maternal healthcare decision

making. The following Table 19 shows cross tabulations that were run to determine if there are significant relationships between household level land decision making variables and maternal health care decision-making.

Table 17: Land Ownership, Decision-Making and Maternal Health Behaviours

		If the household owns land	Enough to produce food enough for the family	Form of land ownership	Say over sale and use of land in the home	Feeling secure on family land
Uses any form of Contraceptives to stop or control becoming pregnant	Pearson Chi2	.501	8.64(*)	.019	2.48	5.47
	Pr	.481	.003	.889	.481	.242
	N	283	283	283	283	283
Use none of the contraceptives in the last 6 months	Pearson Chi2	.128	1.13	3.10	1.05	11.14
	Pr	.938	.569	.542	.984	.517
	N	283	283	283	283	283
How often contraceptives were used during the last 12 months	Pearson Chi2	4.23	6.20	.026	19.41	11.11
	Pr	.481	.185	.987	.079	.196
	N	283	283	283	283	283
The last Pregnancy was intended	Pearson Chi2	.840	16.97(*)	1.64	9.77	20.97(*)
	Pr	.657	.000	.440	.135	.007
	N	283	283	283	283	283
Attended antenatal care during the last pregnancy	Pearson Chi2	.841	16.97(*)	1.64	9.77	20.97(*)
	Pr	.657	.000	.440	.135	.007
	N	283	283	283	283	283
Who assisted in delivery during last birth?	Pearson Chi2	1.80	2.78	2.17	19.68	9.20
	Pr	.773	.595	.705	.073	.905
	N	283	283	283	283	283
Place of birth of youngest child	Pearson Chi2	1.94	1.28	3.151	6.81	4.60
	Pr	.746	.864	.533	.870	.997
	N	283	283	283	283	283
Type of hospital where youngest child was delivered	Pearson Chi2	1.489	.071	.935	2.26	1.52
	Pr	.222	.791	.334	.521	.823
	N	283	283	283	283	283

* Pearson Chi2 is significant at 0.05 level.

In Table 17 above, the Pearson Chi2 tests indicate a significant relationship between land ownership and decision-making dynamics with maternal health care decision making in the following ways:

While land ownership did not have a direct significant relationship with use of maternal health services, questions on if a household has enough land to produce food for its family members and security of land indicated significant relationships with use of ANC and planned pregnancy. Having enough land for family food production was significantly associated with use of contraceptives in the last 12 months (P-value .003), pregnancy planning (P value .000) and ANC attendance (P value .000). The study findings indicate that, while (n=266) of household claimed to own land, only 62% (n=175) feel they have enough land to produce enough food for the family.

Cross tabulations show that, of the respondents who felt they have enough land (62% n=175), 61% of them claim to have planned they last pregnancy and only 3% did not. Compared with people who feel they do not have enough land, 19% reported they had unplanned pregnancy. In addition, feeling insecure on land was significantly associated with if the last pregnancy was intended (P value .007) and ANC attendance (P value .007). While majority of people feel secure on their land, the study indicates that 5 in every 10 people who feel insecure are women as compared to 2 in every 5 men.

The study results also show that more than 72% of the people of Kashari County Mbarara District depend on land for their income in terms of farming, sale of farm produce and causal farm labour. Land is the main economic resources for household and its ownership which is gendered affects maternal health seeking behaviours. Studies elsewhere have modeled the effect of land and as an asset and its ownership is often used as a proxy for bargaining power (Deere and Leon 2003). Such an analysis neglects how male power to control and allocation land creates perception of women as dependants. It is therefore challenging to improve maternal healthcare decision-making without considering land decision making dynamics. To better examine the implications of land decision making, the following section of this chapter measures the effect of land use decision-making on use of maternal healthcare in Kashari County Mbarara District.

5.2.6 Intra-household Land Decision-making Dynamics and Use of Maternal Healthcare

This study differentiates between husbands and wives intra-household decision-making in order to determine the effects of social positions and family relations on maternal health behaviours. For this study, gender differences in land use decision-making was determined basing on differences on who makes decisions for land sale and purchase and then gardening. Impressively, while women can influence 95% of decisions for gardening, they can only make 22% of the decisions for sale of land and

only 7% for land purchase. On the reverse therefore, men influence 93% of decisions for purchase of land 78% for sale of land. This trend of the findings is in agreement with studies which found that women claims over land in most Uganda and the rest of the region are limited to food production (Whitehead and Tsikata 2003). In this chapter, results on land related decisions are discussed to present a discussion on household level material resources that determine use of maternal healthcare.

Table 18: Land Use Decision-making Dynamics and women's Access to Maternal Health Services

		Who makes most of the decision regarding gardening	Deciding on purchase of land	Deciding on family income resources	Deciding over use of land in the home
Currently uses any method to stop or control becoming pregnant	Pearson Chi2	.209	.918	.106	2.47
	Pr	.648	.338	.086	.481
	N	283	283	283	2483
How often contraceptives were used during the last 12 months	Pearson Chi2	2.22	1.71	-.119	19.42
	Pr	.696	.788	.179	.079
	N	283	283	283	283
The last Pregnancy was intended	Pearson Chi2	2.92	5.82(*)	-.006	9.77
	Pr	.232	.054	.915	.135
	N	283	283	283	283
Who decides the number of children the family should have?	Pearson Chi2	.702	13.01(*)	.036	14.12
	Pr	.873	.005	.552	.118
	N	283	282	283	283
Attended antenatal care	Pearson Chi2	2.92	5.05(*)	-.057	9.77
	Pr	.232	.054	.340	.135
	N	283	283	283	283
Who assisted in delivery during last birth?	Pearson Chi2	10.32(*)	2.34	.020	19.68
	Pr	.035	.673	.738	.073
	N	283	283	283	283
Place of birth of youngest child	Pearson Chi2	.034	1.59	-.014	6.81
	Pr	.853	.811	.815	.870
	N	283	283	283	283

Table 18 continued

		Who makes most of the decision regarding gardening	Deciding on purchase of land	Deciding on family income resources	Deciding over use of land in the home
Type of hospital where youngest child was delivered	Pearson Chi2	.034	.061	7.83(*)	2.26
	Pr	.853	.805	.050	.521
	N	283	283	283	283
Who makes most of the decision regarding wife going for antenatal care	Pearson Chi2	501	26.04(*)	32.84(*)	28.03(*)
	Pr	.479	.000	.000	.000
	N	283	283	283	283
Who makes most of the decision regarding wife going to hospital to deliver	Pearson Chi2	.007	33.73 (**)	49.34(*)	24.66(*)
	Pr	.935	.000	.000	.000
	N	283	283	283	283
Can you decide the number of children you would like to have?	Pearson Chi2	3.26	24.02(*)	22.12(*)	9.15
	Pr	.516	.000	.036	.690
	N	283	283	283	283
Did you decide on the current number of children you have?	Pearson Chi2	3.26	24.02(*)	22.12(*)	9.15
	Pr	.516	.000	.036	.690
	N	283	283	283	283

* Pearson Chi2 is significant at 0.05 level.

Land related decision-making was found to significantly influence women's use of maternal healthcare in Kashari County Mbarara District. Table 18 above, indicates that decision-making for purchase and use of land and allocation of household income resources significantly relate with maternal health care decision-making. Decision-making for purchase of land (Husband 93% and Wife 7%) was significantly associated with decision-making for place of delivery, use of ANC (P value .000), use of hospital during child birth (P value .000) and decision-making for the number of children a couple can have (P value .000). Overall, the study found that husband influenced more than 7 in every 10 decisions related with use of maternal health care.

People's perception on who allocates household resources had a crosscutting significant association with decision-making for type of hospital where the last child was delivered (P value .050), use of ANC (P value .000) and couple's decision-making on the number of children to have (P value .000). In addition, the study found out that Land use decision-making was significantly associated with decisions to attend antenatal care (P value .000) wife going to hospital to deliver (P value .000). Descriptively, husbands were found to influence 77% n= 167 of decisions to allocate household income resources and women are believed to influence only 23% n= 51 of the same decisions.

However, in table 18 above, Pearson Chi2 indicates that decision-making for gardening did not have any significant association with decisions to use maternal health care as compared other household decisions related with allocation of resources. This could be because majority of household gardening decision-making (95%) is by women.

The results indicate that, apart from decisons for gardening, the rest of the land related decisons have significant correlation with use of ANC and skilled care during child birth. The decisions for gardenning as it had already been presented in the previous sections was mostly (95%) influenced by women. The reason behind this discrepancy is that women are the ones who do most of cultivating and this study found that women spend at least 6 hours of a normal work day on farm work. Women's decision-making on land is important factor in improvement of use of maternal healthcare. Land decision making provides for their maternal health care choice because it drives women access to financial resources, it is an indicator for social status and a tool for accessing other resources (Rao 2012).

5.3 Land Decision-Making and Prospects for Improvement of Maternal Health Care Outcomes

In Uganda use of skilled care at birth and family planning remains low and among the lowest in the world, 34% of women deliver in health facilities and less than 45% of women have the recommended antenatal care visits. The maternal mortality rate is estimated at 435/100,000 and is largely attributed to poor access to maternal health services (UBOS 2010). A number of studies have examined the healthcare related challenges in terms of human resources, financing and availability and quality of health services (ten Hoope-Bender et al. 2006; Kruk et al. 2007; Mbonye et al. 2007). However, other studies have found considerable impact as a result of women's social and economic status (Kyomuhendo 2003; Ensor and Cooper 2004; Furuta and Salway 2006; Frost and Dodoo 2009).

While this research does not disregard the importance of the quality of healthcare in improving maternal healthcare, it contributes to the social and economic analysis of barriers to women's health. Factors that which affect utilisation of maternal health care can be categorised in demand and supply factors. (Ensor and Cooper 2004) distinguish these factors, they assert that demand factors are those that influence demand and operate at the individual, household and community levels. They include lack of knowledge about emergency problems and availability of services, poor communication to facilities, poverty, cultural and religious barriers and personal challenges including need for permission from husband. On the other hand supply factors are largely about the effectiveness of healthcare services which include quality and availability of healthcare. The major justification of this study is that it contributes to a deeper analysis of demand factors more particularly at the household level.

Therefore, land use and ownership decision making is central to the household's well being and constrains women's prospects for better maternal healthcare because it affects women decisions making and access to resources. This study present land decision making dynamics as an aspect which has underlying effect especially since land of land rights put women in a lower social carder and must depend on men for their land rights. It is therefore relevant that this chapter has discussed that household level land decision making dynamics latently affects maternal healthcare. Land decision making is important was studies continue to explore into the causes of household level maternal healthcare delays. This means that whereas women's earning power has been found to give then greater ability to

renegotiate the patriarchal bargain (Kabeer 1997), the customary land tenure and marriage customs seem intermediate women's decision making power and independence.

This study shows that intra-household land use decision-making dynamics is not only a measure of a women's status, but also a key maternal health determinant. Intra-household decision-making dynamics, in particular the use and ownership of land, has significant effect on women's access to ANC and skilled care at birth. It is therefore not surprising that this study found no direct significant relations between use of maternal healthcare and women's land ownership. The significant correlations were with intra-household land use decision making dynamics indicate an underlying effect of women's property insecurity at the household level. Therefore, to improve women's healthcare access, the value and governance of land as a source of livelihood is a central determining factor. Whereas, studies have shown that land ownership confers direct economic benefits as a key input in agricultural production, a source of income from rent and sale and also collateral for credit that may be used for consumption and investment (Giovarelli 2006), but very little attention has been paid to the intermediary effect of land ownership on women's healthcare.

Women will only benefit from the social and economic value of land when there is an efficient household level land governance strategy. This study found that the discussion of land ownership can raise contentions and conflict among men and women. This is evinced by these direct quotations: *"...some women are starting to own land but actually hide from their husbands, there is no man who can feel comfirtable with a woman who has land"* ***(individual interview – Local council secreary for Women Rubindi April 2011).***

"....i can not allow my wife to own land, it is that that she has inherited from her parents, I try as much as possible to convice her and we sell and buy aonther piece which I can control. You cannot do much if it ancestral, but I try and we sell the land" ***(Individual Interview – 44 year old Man Mishenyi Parish May 2011)***

Unequal gender access to land has consequences on women since they depend on it for cultivation and hence livelihood (Tripp 2004). Customarily, women gain land ownership at marriage and risk losing it when they divorce or are widowed (Gray and Kevane 1999). For women this is an insecure tenure, in the next chapter, the thesis presents an analysis of couple relations and use of maternal healthcare to create and inter linkage with women submission and pervasive cooperation.

With increasing knowledge on the negative effects of unclear terms of women land ownership embedded in the customary tenure, a greater account of what can be done to improve women land status cannot be ignored. According to Giovarelli (2006), the 1998 Land Act only provides protection for women and children against customary and community practices deny the right of ownership and do not provide women with equal rights to land. The Land Act rather provides two legal protections during marriage, that is spousal consent before their residence and surrounding before sell of land and the wife's right to occupy family land (Giovarelli 2006). However, studies show that Land Act has not reduced land conflict and grabbing from women (Deininger and Castagnini 2006), it is not uncommon that men sell off their land without the consent of their wives (Tripp 2004).

This study shows that 93% of all purchase and ownership of land decisions and 78% of sale of land decisions are by husbands. On the contrary, women make 95% of decisions regarding gardening. These are contradictory decision making dynamics that do not only compromise their livelihood but maternal health behaviours. Under these conditions, women are left with no choice but to live and depend on men's decisions that may result in compromising their maternal health choices. A study in Ghana found that conflict over land influences women to change their fertility goal (Derose, Dodoo et al. 2002). In this study, significant correlations were found between decision-making dynamics and use of antenatal care and health facility based childbirth. It was also found that 71% of women's decisions to attend antenatal care are made by husbands and 62% of husbands decide if their wives will deliver in a health facility.

5.4 Conclusions

This study concluded that lack of clear definition of women land ownership shape household decisions to seek women's maternal healthcare in Mbarara Uganda. Most of the land ownership remains customary, passed to male children mainly at marriage. In addition household land is a source of identity and belonging of which women's claim is to marriage and production of family food. For women the value of land encompasses the fact that it is their source of employment and livelihood. Majority of the women in Kashari County, Mbarara District spend at least 6 hours of their work hours working on farm and the rest of the time doing on domestic work. Therefore, land defines women's living conditions and thus carries meaning in the promotion of maternal health. However, while women can use the land to produce agricultural products for both food and income, they must dependent on men for ownership. It

is therefore apparent to say that women's limited ownership of land affects maternal healthcare decision making. In this context women land ownership status is not streamlined requiring that a subtle bargain.

Irrespective of the ownership, land decision-making dynamics were found to significantly influence antenatal (ANC) and use of skilled maternity care. Household maternal healthcare decision-making is ultimately affected women's dependence on male choices and desires. Fear of losing land rights, the risk of divorce and the ever present threat of domestic violence leaves women with minimum choices but to partake with what they perceive are the choices of men. Further research should be carried out to determine the psychological barriers to women's health resulting from uncertainties surrounding land security and ownership.

From a policy perspective, legislation to protect women's land rights need to consider the social and cultural complexities of the position of a woman in a household. This chapter's debates are relevant to the 1998 Land Act on Spousal Consent and Co-ownership Bill. Obaikol (2009) Uganda Alliance Report on Women Land Rights asserts that the Land Act is intended to provide for the protection of women's land rights through the seeking of consent by a spouse transacting in family land but to date there has been no clear demonstration of the effectiveness of this provision in protecting the rights of women.

Therefore this thesis recommends that such laws should be carried out in consideration of the importance of land access to women's and their social position on the whole. The land governance strategies need to regulate gender relations and work towards a secure land ownership status for both men and women. It is also necessary to assert that as long as land is a sole source of household livelihood, it should not only be secured through marriage, women land opportunities need to expand beyond marriage customs and relations. Hence, formal and culturally accepted means to enhance women's control and ownership of land should be researched, tested for cultural, religious and social efficacy and then institutionalized.

CHAPTER SIX

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

6.0 Introduction

Among most Ugandan communities, household resource allocation and decision-making follow a hierarchy whereby men/husbands direct the process for allocation of resources. This chapter examines the effect of the quality of couple relations on the maternal healthcare access and concludes that since men control household resources, women benefit from quality relations with their husbands partners. The chapter presents results on the influence of men on allocation of family resources on wife movement and use of maternal health related care. Through a survey both men and women were asked to determine who makes and influences the decisions that affect women's access to maternal healthcare. There were significant gender differences in making decisions for purchase and sale of land, purchase of household items, gardening, decision-making on number of children a family can have and where to deliver from, and wife's movement to visit family and friends.

Three factors, specifically, doing housework together, planning for family needs and fear or experience of domestic violence, were used as a measure for the quality of couple relations. The latter was used as a measure for poor marital relationship, and planning together and helping with housework were used to determined good couple relations. The study findings agree with other findings which have found that, in Uganda a big number of married women have experienced physical violence or fear that their husbands/patners may be violent. Poor communication among spouces make it difficult for women to execute their maternal healthcare plans. Most couple relations are often characterised by subordination of the wife and superiority of the husband.

This study found that there is unequal distribution of power and resources among couples and that it is husbands who are the primary heads of the family. Husbands control most of the family resources required for accessing maternal healthcare. This study also found that gendered household decision-making authority and the husbands' head of household role determine use of family planning, antenatal care and skilled care during childbirth. Thus making women dependant of on their husbands for thier healthcare decision-making. The study concludes that for postive maternal, women need good relations with their spouses not only to gain support but as well access the resources which are controlled by men.

6.1 Social Relations and Health

This chapter 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 (Ndomugyenyi 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 (Kimbro 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).

This section of the results chapter discusses how household-level decision making follows a gender hierarchy limit women's capacity to improve maternal health behaviours. 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).

6.1.1 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, 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 was 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.

6.2 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.

6.2.1 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 IV[3].

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

[3] 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.

6.2.2 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 male 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.

6.2.3 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 19: Relationship Status Based Upon the Spouses' Willingness to Help with Housework

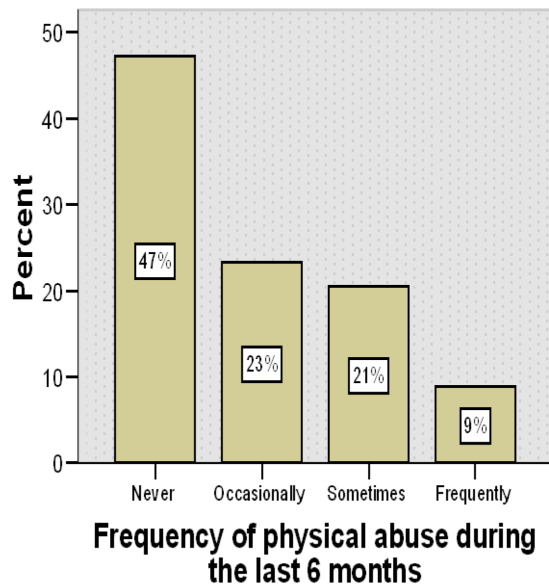
Question	Response			
	1. Never	**2. Occasionally**	**3. Sometimes**	**4. Frequently**
Spouse willing to help with work around the home	14% (39)	19% (54)	38% (107)	29% (83)
Having open discussions with a partner	15% (43)	13% (36)	26% (74)	46% (130)
Spouses working together	27% (76)	27% (76)	29% (83)	17% (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 20: Rating the Quality if 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 11: 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 21: 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)

6.2.4 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 22: 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 Chi2	1.14	2.73	3.52	4.78
	Pr	.888	.950	.172	.092
	N	283	283	283	283
Position of your household in your community	Pearson Chi2	19.57(*)	23.18(*)	61.38(*)	35.66(*)
	Pr	.003	.026	.000	.000
	N	283	283	283	283
I feel my spouse treats me with respect	Pearson Chi2	1.47	18.17	3.18	3.82
	Pr	.962	.111	.365	.281
	N	283	283	283	283
I feel my spouse treats me unfairly	Pearson Chi2	14.23(*)	21.10(*)	6.22	7.23
	Pr	.027	.049	.101	.065
	N	283	283	283	283
I fear my spouse may be violent	Pearson Chi2	2.46	.056	8.11	6.62
	Pr	.873	.423	.777	.085
	N	283	283	283	283
Frequency of willingness to help with work around home	Pearson Chi2	5.53	.072	17.01(*)	12.54(*)
	Pr	.477	.293	.001	.006
	N	283	283	283	283
Frequency of doing work together around home	Pearson Chi2	1.88	24.02(*)	8.75(*)	3.50
	Pr	.930	.020	.033	.321
	N	283	283	283	283
Frequency of open discussion with partner	Pearson Chi2	7.37	13.92	11.25(*)	5.37
	Pr	.288	.306	.010	.147
	N	283	283	283	283
Have had time with partner in the last 6 months to plan for the family needs	Pearson Chi2	.437	3.77	.968	.033
	Pr	.804	.438	.325	.855
	N	283	283	283	283

* Pearson Chi2 is significant at 0.05 level.

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. The study

used factors as such as position of a household in the community, fear and experience of partner violence, helping with housework, being able to treat each other with respect and planning together as measures of couple relations.

In Table 22 above, it is indicates a significant crosscutting relationship between one's opinion towards their household level of influence at the community level and decision-making for number of children a couple can have (P value .003), if one can make decisions on the number of children (P value .000) and decision-making to deliver in a hospital (P value .000). Statistically, the study found that women more than men tend to have a low opinion on the much influential their households are at a community level.

Another significant relationship was related with one's opinion on how they feel their spouses treat them. This had significant association with who decides on number of children a couple can have (P value .027) and if one can decide on the number of children they want to have (P value .049). Only 21% (n=59) of women say can decide on the number of children they want to have. Results indicate that majority of decision-making on the number of children a couple can have is by men (33% n=93) and in-laws (46% n=131.

One's attitude towards his/her spouse's willingness to help with work around home had a significant relationship with decisions to deliver in the hospital (P value .006). Of the people who felt that their spouses are willing to help with work at home (29% n=83), 80% say the decisions to use skilled care is by men and only 20% women. However, those who feel their spouses are never willing help with work around home did not have a significant deference in opinion. This could be interpreted to indicate that couple's with a close relationship are able to tell their differences in decision-making.

Doing work together was significantly associated with one's ability to decide on the number of children a couple can have (P value .020) and decision-making to attend ANC (P value .033). Results from cross tabulations show that all the 39% n= 80 respondents who claim they cannot decide on number of children they can have were women. None of the male respondents felt they cannot decide on the number of children they can have. Also one's opinion on whether their discussions with a spouse are honest was significantly associated with ANC decision-making (P value .010).

It shows in the above table 22, significant correlations indicate 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).

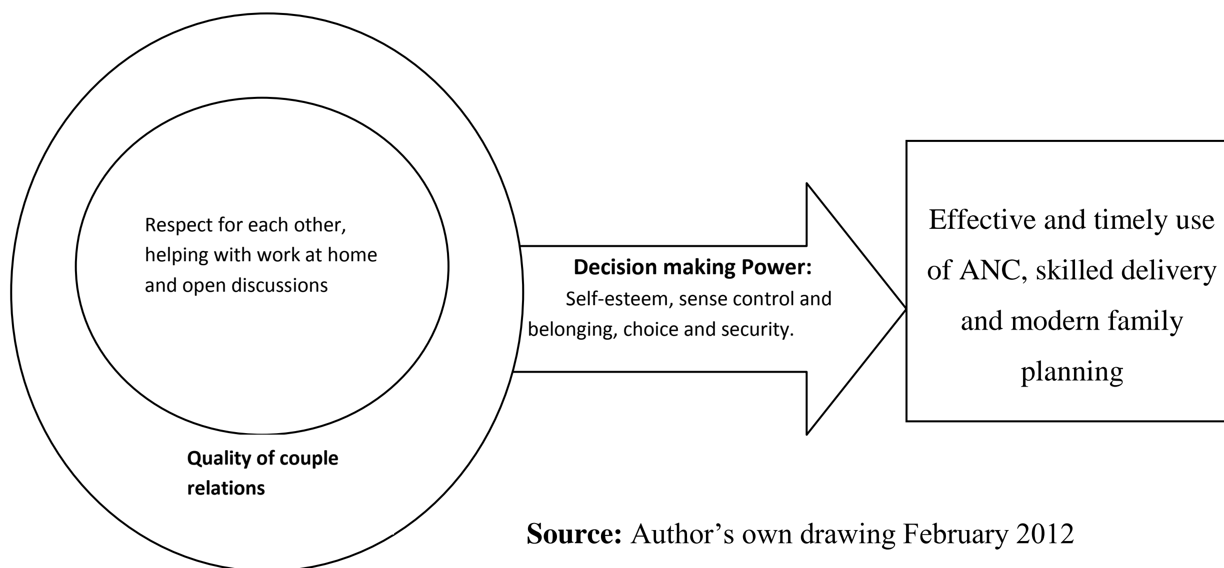
Examining the effect of the quality of couple relations, the study also found that respect for each other, willingness to help with housework and open discussions significantly influenced women's use of maternal health services. Decision making power to access maternal healthcare, especially ANC and 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 lour 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 (Kimbro 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 12: 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 componests 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 allustrates that women experience of supportive relations within their homes will gave self-esteem, and sense of control and belonging and so will effectively care for their reporductive 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.

6.3 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 divorse 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 puroses 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.

CHAPTER SEVEN

Integrating Intra-Household Social Determinants of Health into the Delivery of Mbarara District Lower Primary Health Care

7.0 Introduction

This chapter examines the Primary Health Care (PHC) structure, which is a component of the decentralised health care system in Uganda (Hutchinson et al. 2006). Its function is to bring services nearer to the people and achieve community participation and empowerment (Walley et al. 2008). The main aim of this chapter is to put into context the nature of the health care system within which maternal health care services are offered. Uganda's PHC structural arrangement follows a cascade of steps from the district hospital to the lower district health centres at the county (a health centre IV or a health sub-district), sub-county (a health centre III), parish (a health centre II) and village level (Village Health Teams -VHTs). This chapter focuses on Bwizibwera Health Centre IV, which is a sub-district health centre for Kashari County, located 20kms from Mbarara town.

According to the National Health Policy (2009), a health sub-district basic function is to facilitate the delivery of the minimum health care package. The main government strategy to implement a functional health sub-district is strengthening the planning, supervision, coordination and resource mobilisation capacity of the district health office for health development in the district. It involves devolving health services delivery to the health sub-district level and enhancing community responsibility for its own healthcare. The policy establishes minimum staffing for a sub-district health centre that includes: a resident doctor, a clinical officer, a midwife, an anaesthetic assistant, a laboratory assistant and a community health assistant (Uganda 2009).

A health centre IV structure is also planned to offer maternity services that include managing a plan for community participation and mobilisation through coordinating the lower health centres. Therefore, including a chapter on the healthcare delivery structure is intended to provide for a discussion of role of the household in the primary health care structure. It discusses a link between intra-household factors and the healthcare structure as derived from the empirical data in chapters' four, five and six. Its role is to present how health care can be improved though a comprehensive integration of women's socioeconomic living conditions. It explains the process and avenues for integrating intra-household social determinants of health in the delivery of PHC maternal programmes. Its major role is to show how

a health sub-district acts as the basis for the National Primary Health Care Strategy that ensures universal access to health through integrating community and household factors.

The chapter provides insights into how lower-level health facilities can integrate intra-household factors into their Primary Health care Strategy through interviews with Mbarara District health officials, health workers at Bwizibwera health centre IV and community leaders on the Health Centre Management Committee. It also uses documentary evidence from the 2010 Mbarara District Health Reports and the 2009 Bwizibwera Health Centre Reports. The findings suggest that there are challenges with implementing a comprehensive primary health care package, including inadequacies in monitoring and evaluation of health centre activities with regard to the roles of different parties and community needs, insufficient resources and weak relationships with the community leadership that hamper community participation.

This chapter proceeds as follows: First, it examines the background history of assenting to global PHC declarations and the adoption of PHC as an official health policy in Uganda. Secondly, it analyses the Ugandan health sub-district primary health care structures, base on the case of Kashari County, Mbarara District. Thirdly, the chapter analyses the gaps in operationalising a functional primary health care structure to provide a basis for discussing integration of intra-household determinants of maternal health care. It is at this point that the chapter examines the intra-household factors generated in previous chapters in relation to primary health care

7.1 Primary Health Care and Decentralisation of Uganda's Health Care System

Following the signing of the 1978 Alma Ata Declaration on PHC, in 1987 the Government of Uganda adopted PHC as an official health policy for making essential health care accessible to households (Okello, Lubanga et al. 1998). The core principles of PHC initiatives emphasise service provision based at lower levels of health care and within the community, through decentralisation of decision-making, universal access to healthcare, empowerment and the promotion of women and children's health (McPake, Hanson et al. 1993). In 1987, the Government of Uganda's Health Review Commission recommended the health centre (HC) as the lowest level of health care (Okello, Lubanga et al. 1998). The influence of the PHC approach on community participation in planning and providing health services has been viewed as one of the big forces behind the 1990's decentralisation of the public sector in both Africa and Latin America (Akin, Hutchinson et al. 2005).

Within the health sector, the process of decentralisation generally involved transferring responsibility for service delivery from central governments to districts and local provinces (Hutchinson et al. 2006). In the case of Uganda, as in many other African countries, decentralisation was undertaken in addition to a variety of other reforms, including introduction (and subsequent abandonment) of user fees, experimentation with the autonomy of local governments, district hospitals and prepayment schemes (Jeppsson 2001). At that time, Uganda was going through reforms and the 1997 Local Government Act's establishment of local governments (currently referred to as local councils) provided the structure for the subdivisions' primary health care centres (Hutchinson et al. 2006).

As a result, the establishment of PHC centres in Uganda followed the local government structure, a system of five tier governance linked through complex political and administrative arrangements. Starting from the lowest governance levels, the first tier involves creating contact between the community and health workers through the VHTs located at the village level. This is followed by the second tier, which is health centre level II (parish level), an equivalent of an outpatient dispensary. A health centre II provides the first level of interaction between the formal health sector and communities. It also provides for community outreach services and linkages with VHTs. The third tier is health centre level III (sub-County level), and is structured to provide basic preventive, promotive and curative care. They are also required to provide supervision of the community and health centres at level II that fall under their jurisdiction. The fourth tier is health centre level IV (county or sub-district level), which is designed to offer inpatient and outpatient health services, including obstetric emergency care. A health centre IV facility is mandated with planning, organisation, budgeting and management at this and lower level health centres, including private-not-for-profit (PNFP) and private for profit (PFP) health facilities under their jurisdiction. However, only 28% of the 145 of these facilities in Uganda are fully operational (Uganda 2009). Finally, the fifth tier consists of the district hospitals that, under normal circumstances, link all the other health centres (Uganda 2010).

VHTs and health management committees form the support structures for community participation in decision-making and planning for health services provision (Uganda 2009). The other strategy for community participation is through extension of the Ministry of Health engagement to PNFP hospitals and health centres (Bossert and Beauvais 2002; Uganda 2010). As such, involving communities in defining health priorities has been taken on as a principle that helps in mitigating the formidable

challenges of effective delivery of PHC programs at lower level health facilities within districts (Kapiriri et al. 2003).

As opposed to implementing the comprehensive requirements of a PHC system[4], in reality there remains considerable domination of medical approaches and selective approaches to PHC (Bhutta et al. 2008). Operational health care plans and budgets are focussed on the availability of medicine at PHC centres as a key determinant of the quality of health services (Nazerali et al. 2006). This undermines the other components of comprehensive PHC (prevention, promotion, rehabilitation and community participation) (Rohde et al. 2008), and some studies have indicated that this is a result of failed consideration of community-based health care programmes in the delivery of health services (Bhutta et al. 2008).

Subsequently, a number of factors are associated with the limited uptake of comprehensive PHC. Firstly, Rohde et al. (2008) assert that during the past 30 years since the 1978 Alma Ata declaration many countries have instead implemented selective PHC focused on child survival interventions (growth monitoring, oral rehydration, breastfeeding, immunisation, community health workers and case management of pneumonia supervised by district hospitals), and found that skilled birth attendance remained low even when they improved child health. However, countries such as Rwanda and Bangladesh that systematically implemented comprehensive PHC (immunisation, family planning, nutrition promotion, recruitment of health and application of national drug lists), were found to reduce child mortality as well as improve use of family planning (Bhutta et al. 2008).

Secondly, failures in implementing comprehensive PHC have been associated with countries' colonial history. In the case of Uganda, Okuonzi and Mactrae (1995) assert that the country has historically been dependent on health policies influenced by colonial administration, donors and NGOs/missionaries, whose bias has been towards selective PHC. Uganda has a history of having a health care system dominated by medical approaches, which often undermine the national capacity to implement comprehensive PHC. While Uganda's Minimum Health Care Package (MHCP) core interventions could be seen as an attempt to deal with the comprehensive approach, there are significant biases towards selective PHC, and towards attracting human resources to fill gaps in health care providers (Kapiriri and Norheim 2004). In addition, there has been a persistent bias in research towards increasing cost-

[4] Comprehensive health systems take into account all phases of life from infancy to old age and integrate all aspects of being, including physical, psychological, mental, social, environmental, political and so on Yamamoto, M. (1986). "The place of primary health care in a comprehensive health system." Social Science & Medicine **22**(11): 1229-1234.

effective health care through improving health care financing, human resources, supervision, management and collaboration.

Thirdly, the capacity to pursue a comprehensive PHC approach has been diverted by the shifting attention of donors towards the challenges posed by HIV/AIDS and related vertical programmes on malaria and tuberculosis (Travis et al. 2004). Evidence shows that HIV/AIDS aid levels in sub-Saharan Africa exceed the entire sum of national budgets (Shiffman 2008). As a result, while Uganda is credited for its comprehensive approach to treatment and management of HIV/AIDS (Agaba 2009), the comprehensive primary health care practices used in HIV/AIDS programmes have not practices have not been transmitted to other health sectors. On the other hand, the health plans reflect a strategy to implement comprehensive programmes that combine major health challenges such as mobilisation of resources with a focus on the major burden of disease determinants like treating malaria, elimination of user fees in public health centres, dispensing HIV/AIDS antiretroviral drugs, treating respiratory and sexually transmitted infections and maternal and child health (Uganda 2010).

In practice, Uganda's limited health care resources are mainly prioritised in financing tertiary health care facilities like district hospital and health centres (Jeppsson et al. 2003; Kapiriri et al. 2003). This focus of funding is ignores the massive burden of preventable diseases that result from diminished productivity and increased poverty (Okidi and Mckay 2003). This contradiction shows the health care system's underestimation of other factors that cause poor health and the inaccessibility of health care to individuals and communities (Okuonzi and Macrae 1995).

Generally, selective PHC is as a result of the failure of government to fully fund their health care budget and the dependency on donor and international funding community. In Uganda, 50% of the health sector budget is allocated to services in secondary and tertiary health institutions, and less than a third of the health care budget goes to PHC for which most of the activities have been recentralised to meet gaps in other health sector resources (Ahmad et al. 2006). The focus on HIV/AIDS programmes has also diminished the possibility of having a comprehensive package, as most HIV/AIDS programmes are donor-driven (Shiffman 2008; Agaba 2009).

7.2 Understanding the Performance of Kashari Health Sub-District Primary Health Care Structures

Data on the Kashari Health Sub-district provides an overview of PHC performance in the Mbarara District. Analysing the performance of PHC structures gives a basis for examining the integration of PHC and SDH presented in the next section of this chapter. The data on the performance of PHC structures was collected from both health workers and community leaders who were also represented on the VHTs. Health workers provided information on health services offered by the health centre, common health problems and the challenges faced in service delivery and community leaders shared views on the health programmes in general. The community leaders were asked related questions but also invited to give their opinion on their role in the improvement of health service delivery. This section thus presents an analysis of the structure and management of a health sub-district. At the district level, the interview with the District Health Office was aimed at finding information about resource allocation and the overall district health sector performance. The findings are presented in two sections. The first section explores the health care delivery system from the perception of both the health workers and community leaders and the second section examines the implications of these perceptions to determine a point of integration.

The Mbarara District health structure is based on the district local government administrative units which were established during the 1990 decentralisation process. The district is composed of three health sub-divisions which make up the health sub-districts: Rwampara (Kinoni Health Centre IV), Kashari (Bwizibwera Health Centre IV) and Municipality (Mbarara Municipal Council Health Centre IV). The study data was only collected from the district officers, Bwizibwera Health Centre IV staff and the Health Centre Management Committee who included 1 district health officer, 4 health workers and 2 local council leaders. Bwizibwera Health Centre offers all health services on a daily basis and these are categorised as inpatient, outpatient, immunisation, antenatal care, deliveries.

Bwizibwera Health Centre was among the first local health centres that were upgraded during the national restructuring exercise and by 2002 it had an operating theatre. It has a small capacity operating theatre planned to provide for emergencies, especially those related to pregnancy and childbirth, acute life-threatening childhood illnesses and accidents. However, at the time of the study the theatre was not operational, a situation that was attributed to the fact that the health centre did not have a medical doctor.

The health centres' establishment is planned to foster community involvement in the planning, management and delivery of health care (Uganda 2010).

Bwizibwera Health Centre, as a health sub-district, oversees six health centre IIIs – Bubare, Bikiro, Kagongi, Kakiika, Rubaya and Rubindi and eight health centre IIs. During the interviews with health workers at Bwizibwera Health Centre IV, it was found that a number of external partners are participating in health care delivery. However, three out of four partners involved in health care services delivery (MJAB, EGPAF, AFFORD, Healthy Child Uganda) are dealing with HIV/AIDS health care services, and only one of them is a child health improvement project.

The health centre implements PHC programmes with a particular focus on child immunisation, health education for women during antenatal care and family planning. They reported that they have specific days and times when these services are offered to the community. On the other hand, when asked about other programmes on community engagement, there were no records on health education or of how decisions about health education topics are determined. The study revealed that education follows the national guidelines from the Ministry of Health, which may indicate that health education is not tailored to the community that the health centre serves. The following quotation from one of the interviews with a health worker illustrates the process of health education during antenatal care: '*...when women come we first gather them for a health talk by the health worker, particularly the midwife, then do routine checks and they leave one by one...'* However, when asked about the minimum health care package, which is one of the documents with guidelines on community participation, the health worker expressed ignorance until I explained. This is what they were then able to say: *"I don't know about NMHCP and I am sure most health workers at this facility have not heard about it"* (**Midwife at Bwizibwera 16th September 2009**).

The study also found out that most PHC activities of the health centre are centred on child immunisation, a finding that concurs with other studies which have indicated child immunisation to be one of the most performing PHC programmes. The successes in child immunisation under the primary care programmes has been associated with the successes in the control of childhood immunisable diseases (Khaleghian 2004). As a result, PHC activities could have been ignored in the shadow of the progressive immunisation programme. In Kashari, only child immunisation outreach work is reported as PHC community engagement activity where health workers visit communities and conduct health

education. While other PHC activities were not talked about during the health workers' interviews, the Bwizibwera Health Centre PHC 2009/2010 report indicated a much more comprehensive list which included family support groups and home visits, Tuberculosis (TB) community-based dots monitoring, child health days integrated in school heath programs and school health education. Another finding was related to the limited allocation of funds to PHC activities; in table 19 it is indicated that 59.2% of the total budget of 2009/ 2010 for the Bwizibwera Health Centre IV was allocated to medical goods and supplies and only 8.1% to PHC.

Table 23: The 2009 Priority Budget Areas for Kashari Health Centre IV –Bwizibwera

Category	Budget allocation in Ugandan Shillings (UGX)
Management costs	2,59,6000
Administration costs	1,59,2000
Property costs	8,496069
Transport and machinery	3,730000
Supplies and services	330,000
Medical goods and services	30,331,317
PHC	4,160,000
Total	51,235,386

Source: 2009 Bwizibwera Health Centre work plan

The 2009/10 Annual District Health Centre Report indicated that malaria, child and maternal-related illness and HIV/AIDS were ranked as the top contributors to the burden of disease for Kashari County (Mbarara 2010). As quoted from the Health Centre In-charge, malaria contributes highest to the district disease burden, and HIV/AIDS is also a challenge. In this quote, the health centre in-charge summarised Kashari County's BOD as follows: *'malaria is a big burden and HIV/AIDS prevention remains a challenge, people are not using condoms and in cases of discordant couples, especially when it is a woman who is HIV/AIDS positive, their husbands are not always cooperative."*

This was confirmed by the health centre report of 2009; HIV/AIDS is captured in the report. The following Table 26 is documentary evidence showing the burden of disease for Kashari Health sub-district (accessed 16th September 2009); malaria and respiratory tract infections are the most common health problems followed by HIV/AIDS and sexually transmitted infections (STIs).

Table 24: Top contributors to burden of disease in Kashari Health Centre IV –Bwizibwera

Disease	Percentage
Malaria	53.2%
Respiratory Tract Infections (RTI)	22.7%
Helminthiasis/Tapeworm	0.2%
Urinary Tract Infections (UTI)	5.1%
STI (HIV)	10.2%
Pneumonia	1.0%
Skin diseases	3.1%
Diarrhoea	0.9%
Tuberculosis	0.01%
Trauma	0.2%
Dental conditions	1.1%

Source: Bwizibwera Health Centre IV 2009 Annual Report

The other problem encountered by the health centre was that health workers were often absent, a problem associated with understaffing. The reason was that either a worker was absent from duty or away attending to duties outside the health centre. This was evidenced by the fact that at the time of the study, the in-charge was not present at the health centre and I later met him on another day. The health centre reports and work plans were obtained from the notice board since the in-charge was said to have been away with the office keys. In addition, it was reported that out of the recruited 21 members of staff, at the time of the study 13 of them were either on study leave or annual leave and only 8 were present for duty. As such, this study can conclude that the health care system is faced with challenges related to limited supervision and understaffing. The following qualitative quotations confirm the extent of the problem of understaffing in the lower tier health facilities:

"Health workers are there but they are always away for training, meetings, and workshops." **(Health Management Committee Chairperson- 16th September 2009).** *"When health workers are transferred, they are not quickly replaced."* (**Health worker at Bwizibwera Health Centre – September 2009).** *"Presently, two health facilities in Bwengule and Kongoro are closed because of lack of staff. Mbarara District Health sector is only 32% staffed."* **(District Health Officer 23 September 09)**

The other challenge expressed in the following quotes is that the health units and their respective communities still have weak collaboration. Despite the existence of health management committees that are comprised of community members and health workers, communication between the health centre and the community still needs to be enhanced. Whereas local leaders expressed awareness of health

centre activities and its operations, they argued that they had limited powers to influence the performance of the entire system and called for the integration of community needs. Other studies have indicated that local governments have limited autonomy and are unable to adjust services even when they perceive demand (Khaleghian 2004; Kruk et al. 2007). In the case of this study, the following quotations can be interpreted to allude to similar a argument, which indicates a disjunction between policy plans and the actual situation on the ground: *"The village chairpersons are involved, when they're needed for community mobilisation, community leaders are given health information which they deliver through community gatherings."* **(Bwizibwera Local Council Chairperson 16th September 2009).** *"Health unit management meetings are irregular, they are supposed to be three per financial year but we sometimes have only one."* **(Bwizibwera Health Management Committee Member 16th September 2009).** *"When you go to the health centre, you may be there for two hours before anyone has bothered to know what you want. This is discouraging".* (**Chairperson LC1 Bwizibwera –B 17/9/2009)**

Although the decentralised PHC structure is designed to promote community participation (Magnussen et al. 2004), the findings indicate that the relationship between health workers and community leadership is still weak and could affect the expected community contribution to improving service delivery and utilisation. This finding concurs with Kyaddondo and Whyte's (2003) work on decentralisation, which concluded that health workers hold negative attitudes towards decentralisation because community engagement through health centre management committees diminished the respect that health workers enjoyed in communities. The study argues that in instances of conflict health workers have interpreted it as political interference. This can also be inferred from the following quotations from some of the interviews: *"Health workers think that politicians, like us, interfere with their work"* **(Chairperson Health Management Committee 16th Sept 2009).** *"The health workers are rude, they come late, they absent themselves from duty, they do not care about patients which discourages patients from coming back and it makes the health workers who cover for them not provide quality care"* (**Midwife at Bwizibwera Health Centre IV 16th September 2009).** *"People say that health workers are rude and they do not come"* **(Health worker, Bwizibwera Health Centre IV 16th September 2009).**

However, the above findings can also be a sign of poor communication among the two parties. While the health workers are concerned with the stress of insufficient supplies, staffing and funds, the community demands inclusion in the delivery of health services. Therefore, more effort should be put

into efforts that bring about a common understanding. Until communities and health workers understand each other's role, participation will continue to be difficult to achieve.

The other related finding is the conflicting needs and expectations of different actors in the system. The findings of this study indicate that the problem for health workers is that they are overstretched, with a large turnout of patients that their capacity cannot accommodate. On the other side, patients complain of not being attended to. The following quotations from different perspectives – of clients/community leaders and health workers – show the differences in opinions: *"We get 100 patients a day…. utilisation is 100%. Lower health units close early so the health workers are not there and all patients come here."* **(Health worker at Bwizibwera health centre 17th Sept 2009).** *"People have hope in the healthcare system, but when they continue to come and don't get treatment or they are not attended to in time, they cannot find a reason to come back to the health centre* **(Chairperson, LC1 Bwizibwera –B 17/9/2009).** *'Patients are required to buy books for their records and when they do not have them, they do not come. The book is 300 UGX which not all people can manage'* **(Chairperson, Health Management Committee 16th Sept 2009).** *"…… when people are sick they all go to the hospital. There is no reason that can stop them as long as they are sick."* **(Chairperson, Health Management Committee 16th Sept 2009).**

The demands and needs of health workers and the community which they service are therefore diversely different. For meaningful service delivery the two need to be harmonised to create an understanding of each other.

The other findings indicate that, due to insufficient funds, health centres are understaffed and there are cases of lower health facilities at the third and second levels being closed. Therefore, the entire support system needs to be improved. The following quotations show both the community and the health workers' expressions of what they feel about health services at their level: *"There is a challenge of delayed release of funds and political interference. Politicians have reached a level of looking at prescriptions, which is outside of their role of resource mobilisation."* **(District Health Officer 23 September 09)** *"We are understaffed. One health worker covers different departments despite their specialty, dispensing, clerking, community outreaches, midwifery, in-charge, health education."* **(Midwife at Bwizibwera Health Centre IV 16th September 2009).**

The above findings from the Kashari health sub-district reveal limited community participation in the implementation of the PHC strategy. It is indicated that health workers and community leaders are still grappling with understanding their roles as stakeholders and being expected to bridge the gaps between service providers and users. The health workers and health management committees expressed divergent interests – staffing and supplies vis-à-vis quality of health care and health workers' relationships with patients. This is reflected in the differences in opinions among the leadership (health workers and the community leaders) on what should be taken as priority in health planning and delivering health services. In addition, the health centre is still resource constrained, a finding that is in keeping with recent evidence which confirms that lowest tier health centres and government hospitals in Uganda are in a sorry state, with many of them faced with a lack of staff, electricity and drug stock (UBOS 2010; Nabyonga et al. 2011).

7.2.1 Integrating Intra-Household Determinants of Use of Maternal Health Care in the Lower District Primary Health Care Centres.

To integrate intra-household determinants of the use of maternal health care in Uganda's lower primary health facilities, this section discusses conditions at two levels – the health facility, from the above data on Kashari health sub-district, and the intra-household factors discussed in chapters' four, five and six.

This thesis has presented and discussed women's decision-making as the core intra-household determinant of use of maternal health care among the people of the Kashari health sub-district. While the findings about women's household level decision-making concur which other studies which have investigated women's determinants of health in terms of low levels of education and income, this thesis brings to the debate the decision-making determinants embedded in household labour, land decision-making and couple relations. Thus, by integrating intra-household factors into the PHC structures, the thesis provides systematic evidence to support the ways in which household socioeconomic factors impact on the use of maternal health care.

Findings in chapters 4, 5 and 6 reveal significant gender inequalities in the division of household labour, use and ownership of land and couple relations. In chapter 4, it was revealed that there is significant gender inequality in household labour. Statistical analysis indicated that household labour is inversely associated with maternal health care use. Chapter 5 shows that while land was found to be largely owned and controlled by men, it remains a significant source of women's economic resources and a main

source of their livelihood; it is on land that women spend more than 6 hours of their daily work. Apart from gardening, men make most of the land use decision-making, which was found to significantly affect skilled delivery and use of antenatal care. In addition, chapter 6 indicates that the quality of couple relations was found to determine decision-making for use of family planning and skilled delivery. Couple relations were associated with symbolic role of men as household heads and decision-makers.

The literature not only fails to provide sufficient evidence of the relevance of household level factors in the health care system but is not specific about the conflicting roles of the different stakeholders – health care service providers and users. The findings about the performance of the lower district primary health care structures discussed in the previous section of this chapter, show that the health care system and its clients have different and diverse needs that must find areas of agreement and common interest. For example, when health workers are asked about the challenges that affect service delivery and utilisation they mention issues such as poor funding, stock outs, low salaries and understaffing, which demonstrate their perspective on the problems facing health care. On the other hand, the community still feels that health workers need to improve their attitudes if they are to be able to provide services that are accessible. The concern of the community is how to improve communication with health workers. Yet both the community and health care providers agree on the need for inclusive health care leadership, timely stocking of medical supplies and tailoring health care funding to the community's health needs. The following figure contains an illustration of the common interest of the two parties – health workers and community leaders:

Figure 13: Differences in Opinion about Health Priorities among Health Workers and Community Leaders

Health facility-related challenges – health workers' opinions	Common areas of concern	Client-related challenges – community leaders' opinions
Delayed release of PHC funds Health workers' absenteeism Poor pay of health workers Non-functional structures Stockouts Understaffing Health workers' multiple roles Insufficient staff accommodation	Streamlining leadership and management of health units (coordination and control of healthcare delivery process) Monitoring and evaluation of PHC activities; finding relevancy to community needs Community and health workers' attitudinal change Timely stocking of medical supplies Community health education agenda spontaneous for as long as the community is available. Health workers' welfare HIV/AIDS programs are predominant	Health workers are not receptive Community mobilisation Irregular meetings of the Health Management Committee Long waiting hours at the health facility Distance to the nearest health facility Income level of clients

Source: Author's analysis output, November 2009

While findings of this study indicates that both sides are still grappling with quite different priorities, Bryant, Richmond et al.'s (2008) report on the progress of PHC in developing countries affirms that there remain gaps in achieving an integrated health care system that follow the demands of the 1998 Alma Ata Declaration. Essentially, an integrated PHC system involves universal community-based preventive and curative services, with substantial community involvement. In the case of Bwizibwera Health Centre, the two parties are concerned with quite different things – for example, while health care workers are concerned with challenges of service delivery and the disease burden, the community requires an understanding of their role as a link between the population and health centres which can be achieved through streamed lined communication system. In this example the findings of this analysis are in agreement with other studies which have concluded that Uganda's PHC strategy is well developed and planned but lacks only systematic implementation.

A related study that was conducted by Golooba-Mutebi in the central region in 2005 analysed the post-decentralisation of the health care system and found that whereas there have been achievements in rebuilding the physical infrastructure and delivering medical supplies there are still gaps in attaining community participation and engagement. Other studies have concluded that the implementation of the PHC strategy in Uganda is challenged by insufficient funding from both the central and respective local governments (Ablo and Reinikka 2004). The tendency is to focus on the curative function of the lower tier health care facilities and less interest in providing for community engagement programmes (Mbonye et al. 2007).

Therefore, to deal with the challenges of reorienting the health care systems towards prioritising the other arm of the PHC Strategy – community engagement and participation – requires a complete paradigm shift. This thesis presents the health care system gaps for dealing with dealing with household factors. The overall results of this thesis indicate that the household status of a woman has a lot to do with the division of household labour and ownership and access to resources. The thesis's main argument is that these are household factors which cannot be effectively dealt with in a system that largely focuses on improving the quality and availability of health care. It thus proposes an integrated system that is based on evidence about the context within which these conditions can be incorporated into service delivery and create favourable conditions for improving the use of maternal health care.

Figure 14 above contains an analysis of the differences in opinion among health workers and community leaders to show areas of common interest. According to Bhutta et al. (2008), the main factors that contribute to failure to deliver effective maternal PHC can be summarised into four factors: firstly the lack of a universally agreed minimum set of interventions that should be delivered to all women, children and newborns; secondly, the lack of attention to demand creation and community-level intervention and strategies to promote changes in care-seeking behaviour; thirdly, the shortage of well-trained staff, and reservations about task-shifting from more highly trained community health workers to those with less training; and fourthly, failure to allocate the resources needed to ensure strategies change. This study's findings about the Kashari Health Sub-District are in agreement with Bhutta, Ali et al.'s (2008) analysis of the challenges facing uptake of comprehensive PHC strategies by poor countries such as Uganda.

7.3 Conclusions

Evidence from this and other studies continue to show that the challenge for Uganda's PHC is that it faces both insufficient resources to fulfil its existing functions and lack of resources and effort to change its service delivery systems from the conventional curative system.

Although PHC is a key policy strategy for health and health care, it is still only partially implemented, with limited or no attention to the preventive function which allows for community participation. At Kashari Health Centre IV, a lower district level health centre, work plans and health centre activities overlook the clear evidence on the practices that support primary care. Community health promotion programmes need to be based on local examples, which require prioritising a health care practice based on continuous interaction between the health workers and the community. The village health teams, health management committees and the community engagement structures are not fully utilised by the PHC centres within the lower health sub-district. However, these are local government administrative devolutions that do not deal effectively with intra-household living conditions.

While income level is an important factor for health care access and utilisation, it should not be treated in isolation from other related factors such as education, level of income and gender relations. At the household level, factors that influence decision-making, household hierarchy, overall health behaviour and the economic role of children combined with education, gender and income are the key individual factors that determine health care demand.

Furthermore, it is difficult for health workers to implement community participation and engagement strategies without being knowledgeable about the community and its diverse social and economic characteristics. The PHC strategy provides for an integrated approach which is only limited by the curatively biased health care system. Regarding women's access to maternal health care, success will largely depend on the extent to which care at the lower health care facilities integrate community and more specifically intra-household factors.

The limited resources from both central and local governments have been used as a justification for abandoning the comprehensive PHC approach among most poor counties such as Uganda. But evidence shows that universal health care access remains relevant (Bryant, Richmond et al. 2008), and even after 30 years of failing to implement comprehensive PHC across poor countries, experts have found no

alternative strategy but to call for the rebirth of the idea of promoting universal access (Bhutta et al. 2008). In the case of maternal health care, the thesis brings to light the need to put into context daily living conditions and their impact on promoting universal access. The findings indicate that the PHC structures lack strategies to integrate intra-household factors, which are linked to the social arrangements of society.

CHAPTER EIGHT

CONCLUSIONS AND RECOMMENDATIONS

8.0 Introduction

This chapter presents the thesis's general conclusions and recommendations. The study was set out to examine the intra-household determinants of demand for maternal health care among households of Kashari, Mbarara District, Uganda. The general conclusions of this thesis reject the null hypothesis for this study, which assumed that there was no relationship between men and women's household socioeconomic inequalities (household labour, land use decision-making and couple relations) and demand for maternal healthcare (ANC, family planning and skilled birth attendance). The recommendations were developed through analysing selected relevant policy statements and formulating policy implications of the findings. The purpose of conducting a policy implications analysis is to be able to make recommendations that inform a specific policy framework.

Linking research to policy is becoming increasingly common and takes precedence over the research agenda, especially for the purposes of increasing knowledge and the capacity for research to influence policy and decision-making (Lavis et al. 2003). Part of the challenge of translating research into policy has been how to determine which research results can be applied to policy, and the timing and communication of research results (Walt 1994). Additionally, policy processes in Uganda are faced with limited policy frameworks that deal power relations which underpin the long term structural marginalisation of vulnerable groups (Hickey 2005). This makes it more appropriate to link these thesis findings to a policy. The recommendations are thus presented in relation to the policy implications of women's intra-household inequality for maternal health outcomes. Based on the theoretical framework and findings, three policy frameworks informed the conclusions and recommendations: The 1998 Land Act on Spouse Consent, 2003 Domestic Relations Bill (first drafted in 1965 and currently being discussed under the Marriage and Divorce Bill) and the Primary Health Care Strategy. These have been reviewed and considered important for providing a basis for the policy recommendations of this research.

The chapter proceeds as follows: Firstly, it stipulates the problem identified the research aim and specific objectives. Secondly, it states the literature gap as identified through the literature review in chapter 2. Thirdly, it outlines the research methodology used to address the research aim. It then states

the conclusions on the impact of intra-household gender roles on the use of maternal health care. Fifthly, the chapter discusses the findings and conclusions about the impacts of household resources decision-making on health care access, with particular focus on land and how it was related to maternal health behaviours. Sixthly, it stipulates the findings regarding the relevance of couple relations for maternal health care demand in Kashari, Uganda. These findings can inform the process of decision-making in relation to the availability of maternal health care. Lastly the chapter states how maternal health care can be integrated into the main PHC structures in the country as a whole, and provides recommendations on policy.

8.1 The Research Aim, Thesis Problem and Literature Gaps

Overall the thesis examined the intra-household determinants of demand for maternal health care in Kashari, Mbarara District, Uganda. The thesis has attempted to establish the intra-household determinants of maternal healthcare and indicate how they can be applied to improve the household level maternal health care delays that currently challenge the effectiveness of Ugandan's lower district PHC system. Similarly to other literature on barriers to women's health care access, this study confirms that maternal health care in Kashari County in Mbarara District is also faced with problems relating to the quality and availability of services, poor transport systems and the costs of services which contribute to household delays in seeking care at times of obstetric emergency.

The introduction and literature review chapters of this thesis have indicated that Uganda is among countries facing high maternal mortality rates whose circumstances are complicated by poor quality maternal health care and problematic maternal health-seeking behaviours. A significant number of women still deliver outside health facilities under the care of unskilled personnel. Worse still, the country registers the highest fertility rate and unmet need for family planning. Uganda's high maternal mortality rate has been attributed to women's poor access and use of maternal health services, inaccessible health services related to long distances, poor quality health care and low medical supplies. Literature has also indicated that most maternity services operate in poor conditions and health services lack water, power, equipment and supplies. Other factors have been related to women's insufficient knowledge of obstetric danger signs and lack of birth preparedness through saving money in order to facilitate referral. Whereas the literature provides a comprehensive analysis of the problems challenging maternal health care, there remains limited literature that specifically addresses women's living

conditions within households in relation to health care systems. This thesis therefore contributes to evidence on the socioeconomic determinants of the use of maternal health care, with a specific analysis of intra-household relations. The thesis further discusses the possibilities for integration of intra-household health determinants into Uganda's district lower tier health care systems.

To be able to examine the effect of women's socioeconomic conditions on the use of maternal health care, this thesis's investigation was undertaken by using SDH theory and intra-household gender and cooperative conflict theories. Social determinants of health are the ways in which economic and social conditions are distributed among population(s) (Marmot 2005). The SDH perspective helped to analyse the complex and broad intra-household living conditions grounded in socioeconomic inequalities. This theory was found to assist in explaining how women's limited decision-making powers affected their ability to use maternal health services. Additionally, Amartya Sen's intra-household gender and cooperative conflict theory was used to explain women's subordinate position in the household decision-making process and its influence on who takes cooperative or non-cooperative positions (Sen 1987).

The study has used empirical findings to show that current PHC structures do not make the anticipated efforts to integrate household level determinants of health. Combining the two theories' perspectives on living conditions and the causes of intra-household inequality, this thesis reveals that household labour burdens and social cultural restrictions on women's ownership of land placed women in subordinate rather than complementary relations. In this regard, women's insecurity over land weakened their bargaining power, and men's power over land, over other household decisions on income and their wives' movements outside the home restricted use of maternal health care. Thus this study does not only unpack men's symbolic superior role as household heads and decision-makers and give evidence on the factors which compound women's lower social status, but also presents a challenge to the health care system to address the intra-household barriers to maternal health care access.

8.2 The Research Methodology and the State of Maternal Health Care in Kashari County, Mbarara District

A case study research design was used and data was collected using a survey questionnaire from 283 households, 7 individual interviews and 10 focus group discussions. In 2009, data was collected to assess how district level PHC programmes integrate household level factors; 4 health workers and 6

community leaders were interviewed. In 2010, data was collected on household characteristics and the use of maternal health services.

The study was conducted in Kashari County, Mbarara District, South-Western Uganda. Administratively, Mbarara District has three administrative sub-divisions – Kashari County, Rwampara County and Mbarara Municipality. Kashari County is divided into eight different sub-counties (UBOS 2009; Mbarara 2010). Kashari hosts 44.3% of the district's total population, Rwampara 36.5% and the Municipality has 19.1% (UBOS 2009).

Regarding use of maternal health care, this study found that in Kashari County, 33% of the last deliveries were at home, 26% of women had delivered in private clinics and only 40% delivered in a government-aided health facility. While 98% of women attended antenatal care at least once during their last pregnancy, 51% of them has their first ANC visit between 4 and 7 months. Although 48% of women were using some form of modern contraception to control being pregnant, only 34% use contraceptives unremittingly. The common contraceptive was Depo-Provera. The unmet need for contraceptives was estimated at 38%. The study found that 62% of decisions to visit ANC and 70% decisions about where to deliver are influenced by husbands. While almost every woman attended ANC during at least the last pregnancy, the results concur with other studies which have found that women do not attend the recommended four ANC visits. Less than 50% of women in Kashari use skilled care at birth and a much smaller number use contraceptives to prevent unwanted pregnancies.

8.3 Explaining the Impact of Gender Division of Household Labour on the Use of Maternal Health Care among Rural Populations of Kashari, Mbarara

In Chapter 4, statistical analysis indicated that household labour is inversely associated with maternal health care use, a relationship that indicates that the higher the burden of labour, the less likely it is that women will use maternal health services. However, there was significant gender inequality in household labour and attitudes towards the kind of housework that one is expected to do. Women were found to be mainly responsible for fetching water and firewood, cooking, washing and cleanliness around the home. Women also spend an average of 2 hours caring for the sick and children.

Women were found to bear a significant burden of household labour, working for about 14 hours a day. Women were found to comprise 74% of members of the household who spend more than 6 hours of a

typical work day on farm work. There were gender differences in attitudes towards housework, less than a third (30%) of men as compared to more than three quarters of women (80%) ranked child care as an important household task. On average both men and women spend a maximum of 2 hours on sale of farm produce, with women being more involved (77%) and men far less (22%). The negative relationship between skilled birth attendance and farm work (-0.105) and sale of farm produce (-0.068) suggests that women's lack of time limits access to health care. The study found a negative relationship between skilled birth attendance and farm work and sale of farm produce, a finding that was used to suggest that women's intra-household use of time affects their use of maternal health care.

In this thesis, the investigation of gender roles was undertaken through an analysis of the gender division of household labour. The study considered household labour to include work around home, such as cooking, laundry, cleaning, fetching water and firewood, caring for the children and the sick. Because it is difficult to make a distinction between household labour and farm work among rural households, the analysis included work on the farm and care for animals. The study found significant gender differences in division of both household and farm labour – whereby more women than men were found to do most of the housework, including farm work. In contrast, men engaged more in care for animals than women. Also, the findings indicate that division of household labour is arranged in such a way that women may end up concentrating on only domestic work and farm labour, since men have a dominant influence on the allocation of household income and resources such as land. Based on these trends, the study concludes that the division of household labour puts men and women in separate spheres of life which eventually shape the extent to which men and women understand each other's needs, such as those related to maternal health care.

Another important difference in gender roles is men's decision-making role in maternal health care (family planning, ANC and skilled birth attendance) decision-making. In Chapter 4, the study revealed that women could not independently decide the number of children that they had. More than 7 in every 10 decisions on the place of birth for the last child and 6 in every 10 decisions for ANC were made by husbands. There were significant gender differences in decisions for the allocation of family income related resources. Generally, the intra-household role definition was found to be gender based and followed a hierarchy, a trend that did not only deny women autonomy in decision-making but was linked to limited couple interaction.

Moreover, the intra-household division of labour was found to promote gender inequality and constrain efforts to promote gender equality and women's empowerment. This is mainly because women's roles tend to limit their opportunities to improve their socioeconomic status – they are restricted to household care roles with limited or no chance of influencing allocations of household resources. On the contrary, as the heads of households, men are destined to control resources. Thus, the results revealed that intra-household gender roles result in dependent couple relations. Gender equality policies must therefore consider strategies to reduce the dependency outcomes of intra-household social inequalities. Furthermore, considering intra-household barriers to maternal health care access could be seen as an opportunity for mobilising communities about the advantages of gender equality and women's empowerment.

8.4 Intra-Household Income and Land Decision-Making Dynamics in Kashari, Mbarara

Chapter 5 shows that while land was found to be largely owned and controlled by men, it remains a significant source of women's economic resources and a main source of their livelihood; it is on land that women spend more than 6 hours of their daily work. In Mbarara district, like among most Ugandan communities, women's land ownership is challenged by the restrictions of customs set by patriarchal inheritance. Women can only claim land rights at marriage and production of food for household consumption. Even with the Spousal Consent Clause under the 1998 Uganda Land Act, women's land ownership rights culturally have remained limited.

Whereas about 7 in every 10 women feel insecure on family land, only 2 men in every 10 expressed land insecurity. Apart from gardening, men make most land use decisions, which was found to significantly affect use of skilled delivery and ANC. In addition, this study shows that 93% of all purchase and ownership of land decisions and 78% of land sale decisions are made by husbands. In contrast, women make 95% of decisions regarding gardening. Women's dominance in gardening-related decision-making and their limited influence on household resources decision-making provides evidence on how women's contributions to household labour do not translate into control of resources. Most households were found to depend on land in terms of farm work and sale of farm produce for both income and employment.

Analogous to the division of labour, intra-household decision-making is gender biased. In Chapter 5, the study findings indicate that 95% of household heads are men, a symbolic definition of men's role as

decision makers. More than 9 in every 10 intra-household decisions to own land are made by men. Women's land related decision-making is restricted to gardening, where they influence 95% of the decisions. While it is not clear whether it is the household division of labour or decision-making that constitutes the cause or effect, the two factors are interconnected. In this regard, women engage in unpaid household labour, and decision-making traditionally follows a patriarchal hierarchy. This is reflected in the gender differences in labour and income decision-making; whereas women were found to contribute more than 70% of farm labour and 67% of households depend on farm work and sale of farm produce for their income, men influence at least 92% of intra-household decisions regarding the allocation of income. It is therefore justified to conclude that the traditional customs that surround intra-household decision-making, the allocation of resources and division of labour deny women opportunities to control and access the resources needed to access healthcare.

The main argument for this assertion is that women's engagement in unpaid household labour denies them opportunities to own and control resources. The thesis findings and literature review have consistently indicated that women's decisions are restricted to only domestic work and gardening, which eventually limits their access to the physical, emotional and social resources needed for maternal health care. For example, whereas 6 hours of the woman's daily labour is on the farm, they only claim land for gardening to produce food for the family, and the allocation of income from farm produce is controlled by men. The study found significant differences in maternal health care decision-making; 2 in every 6 decisions on the number of children a couple can have are made by men, as compared to 1 in every 5 which are made by women. Only 2 in every 5 maternal healthcare related decisions were found to be made jointly by a couple. More than 7 in every 10 and 6 in every 10 decisions to use ANC are made by men.

Women's health is controlled as much as the household resources that they contribute to family wellbeing. These findings therefore reveal that intra-household resource decision-making is a determinant of the use of maternal health care. Statistically, while land ownership did not show a significant direct relationship with the use of maternal health care, land decision-making was significantly associated with use of ANC and decision-making for where the child was born.

8.5 Intra-Household Couple Relations and the Decision-Making Hierarchy in Kashari, Mbarara

In addition, Chapter 6 indicates that the quality of couple relations was found to determine decision-making for the use of family planning and skilled delivery. Couple relations were associated with the symbolic role of men as household heads and decision makers. Men make 79% of income-related decisions and 73% decide and control women's movements such as visiting a health facility or friends. There was a significant level of poor couple communication, whereby 15% of couples felt they had never had open discussions with their partners.

Furthermore, from the analysis of the implications of intra-household division of labour and decision-making dynamics on the use of maternal health care in Kashari, Mbarara, the connection with couple relations became apparent. In Chapter 6, the findings showed that couple relations follow traditions surrounding gender roles and are predominately based on the wife's submission and husband's domination in decision-making. This study indicates that couple relations are not only vertical – the subordination of women and superiority of husbands as heads of households – but are they are also faced with significant levels of domestic violence. Results revealed that more than 5 in every 10 married people in Kashari, Mbarara district have experienced physical partner violence. Despite the women's household labour burden, only about 2 in every 5 husbands were found to be willing to help with work around the home and about 1 in every 5 husbands never helped with work around home. These findings reveal the prevalence of poor domestic relations and a strict gender division of labour in Kashari.

Although studies of social relations have concentrated on the extent to which strong and supportive relationships are related to health, little attention has been paid to the effects of bargaining relationships. This study reveals that intra-household relations in Kashari, Mbarara district are dominated by bargaining relationships among couples, of which the husband's domination does not necessarily favour women's maternal health care needs. In most cases decision-making places husbands and wives within a top-down decision-making relationship structure as superiors and subordinates, making the relationships centred around bargaining than support. The study thus concludes that the superior-subordinate relations among men and women compromise the potential for supportive relationships, which is not commonly attended to in the health and social relations literature.

This thesis therefore concludes that women's dependence on husbands for their health care decisions is rooted in the social definition of men as decision-makers and women as dependants. In this context, good couple relations are valuable for women's health and should facilitate bargaining for the household allocation of resources. Since husbands/men control household resources, they need to understand maternal health care needs, which can be achieved through improved couple communication. It is important to note that positive good intra-household relations improve maternal health care bargaining ability – for example, the study indicates that the ability to hold open discussions with a partner was found to significantly determine use of ANC, skilled birth and family planning. However, findings indicated that couple relations are socially constructed within defined gender roles, marriage and land ownership customs. Men and women are expected to socially adhere to their roles, which unfortunately may limit partners' understanding of each other's needs, maternal health care inclusive.

8.6 Primary Health Care Integration of Intra-Household Maternal Health Determinants

In Chapter 7, the thesis further argues that although the lower district health facilities are primary health centres, established to be sensitive to the social and economic needs of the community, the study found hardly any practices that were directed towards dealing with household factors. Uganda's lower district health care structures, though designed to support community engagement, have remained largely administrative devolutions that do not embrace the intra-household factors that shape decisions to seek health care.

The main contribution of this research is a justification for a maternal health policy that mainstreams intra-household determinants of health into health care delivery. The study concludes that Uganda's PHC structure was merely a political decentralisation that failed to pay attention to households as a core health system structure. The findings in chapter 7 revealed that an enabling lower district PHC structure should be inclusive of household factors. In conclusion, a health system that addresses the improvements needed to meet maternal health care demand should consider women's intra-household decision-making constraints. In this case, women decision-making constraints require that district PHC programming re-emphasise the efforts for community participation, mobilisation and women's empowerment.

8.7 Overall Conclusions

Overall, the thesis concludes that women's household level decision-making still remains an important household determinant of maternal health care utilisation. Whereas debates to improve maternal health tend to focus on improving quality of health care, there remains a great deal of barriers embedded in household decision-making autonomy and resource allocation. In general terms, the capacity to register sustainable progress in Uganda's maternal health shall remain inadequate as long as women's decision-making autonomy remains restricted. Therefore, to effectively support the demand for maternal health care, Uganda's PHC system must deal with demand barriers by combining price, quality, income, household social and cultural characteristics, and knowledge about the availability of services and education in general. The quality of social relations, sense of control, social status and involvement in community life are material foundations for healthy maternal outcomes.

Findings in Chapters 4, 5 and 6 reveal significant gender inequalities in the division of household labour, use and ownership of land and couple relations. Apart from gardening, men make most of land-use decision-making, which was found to significantly affect use of skilled delivery and ANC. In addition, couple relations were associated with the symbolic role of men as household heads and decision makers.

The study found significant intra-household gender inequalities in household labour and decision-making over resource allocation. The point of departure for this study was the hypothesis that women's low socioeconomic status affects their decision-making abilities. The study further established that women's lack of control of household resources is associated with the poor use of maternal health care in Kashari, Mbarara District. Women's decision-making is compromised by their low status, burdens of unpaid labour and dependence on their husbands' authority and control of family assets, particularly land. Women's lack of autonomy in accessing maternal health care is entrenched in household level gender inequalities, particularly long hours of work, women's low social position, their subordination to husbands and land security uncertainty.

Lastly, household level inequalities in the control and allocation of social and material resources such as land determine women's maternal health care because women are placed in a situation where they become dependants of their husbands. Men's authority to control their wives is sustained by the traditional land tenure and marriage customs. Consequently, women have limited claims on household resources; the study found significant gender inequalities among couples in decision-making, division of

household labour and access to household land. The fact that women are engaged in domestic work with no direct financial benefits and fear of losing land rights, and that men have the upper hand on household income, means that women are dependants of men. Until women can independently make decisions without open confrontation of their husbands/partners, use of maternal health services in rural Mbarara will remain challenged.

8.8 Recommendations and Policy Implications

The formulation of the thesis recommendations has been based on a review of three strategic policies that were identified for their commonality and focus on household dynamics. The polices being analysed include: the Domestic Relations Bill, currently referred to as the Marriage and Divorce Bill; the Spousal Consent clause of the 1998 Land Act; and the Lower Health Sub-district PHC Strategy. The first two policies have been considered because of their social and cultural connotations for intra-household gender relations (Giovarelli 2006) and the latter is important in promoting community participation and health demand creation (Bhutta et al. 2008).

To begin with, Uganda's Domestic Relations Bill (DRB), currently being discussed under the Marriage and Divorce Bill, was introduced in 1965 and is still under debate, faced with stiff social, economic and religious contentions over divorce, property rights and inheritance (Doss, Truong et al. 2012). Briefly, the DRB combines all laws related to marriage, divorce, separation, inheritance and property rights in Uganda. If passed into law the DRB would regulate marriage and family relations and determine the legal status of men and women in the family. The 2005 version of the bill is reported to have been rejected on the grounds that it did not meet the marriage expectations of Islam on polygamy, and was rejected by Christians because of the proposed right for cohabiting couple to be declared married after ten years of living together.

Secondly, the 1998 Land Act was adopted in response to the need to provide tenure security to long term marginalised groups of people, including women (Deininger and Castagnini 2006). Section 40 of the 1998 Land Act provides for spousal consent during transactions over and registration of family land. It can be considered a subset of the DRB because of its provision for a spouse's written consent to sell land that provides the family both shelter and substance (Kawamara-Mishambi and Ovonji-Odida 2003). The section on spousal consent also assigns rights to children and spouses to stop a transaction or registration of customary land on which they depend for shelter and sustenance.

Thirdly, the Uganda Health Sector Strategic Plan III defines the PHC Strategy as"...the major strategy for delivery of health services in Uganda based on the district healthcare system." The major components of the strategy are "health promotion, enforcement and prevention interventions as defined in the UMHCP and empowerment of individuals and communities for a more active and meaningful participation in health development through VHTs and HUMCs" (Uganda 2010 P 40).

The 2010-2015 Health Sector Strategic Plan (HSSP) III expands on the PHC Strategy for reproductive health, targeting the improvement of high fertility rates, the unmet need for family planning, and poor obstetric care and access. The plan also incorporates sexual and gender-based violence and its impacts on maternal mortality and morbidity. According to Uganda's HSSP III, the right to sexual reproductive health services is important for reducing MMR and TFR (Uganda 2011). The following are the HSSP III priority strategies and interventions:

a. Strengthen information, education and communication activities on sexual and reproductive health.
b. Build institutional and technical capacity at national, district and community levels for reproductive health.
c. Expand the provision of sexual and reproductive health services.
d. Strengthen adolescent sexual and reproductive health services.
e. Strengthen the legal and policy environment to promote delivery of sexual and reproductive health services.

The above priorities indicate that PHC policy strategy acknowledges the need to deal with factors that motivate positive maternal health care utilisation through empowerment of individuals and the communities. Considering the effects of women's limited control of household resources on the use of maternal health care, this thesis recommends that additional maternal health promotion efforts integrate policies which deal with indirect factors, such as those within the household. By concurrently discussing the three policies, the study has explored and recommends an intra-household SDH agenda operationalised through the district PHC programmess. Through such an analysis the study recommends a multidisciplinary approach to maternal health promotion which is in agreement with PHC strategy.

The areas of entry for a multidisciplinary maternal health care promotion strategy should begin with creating a partnership between the advocates of the DRB. This study begins by recognising that the factors which have prevented the passing of the DRB are directly related to those affecting the

promotion of maternal health. The study thus recommends the passing of the DRB with direct clauses on maternal health, such as family planning and access to maternal health care. The bill already has clauses on domestic violence, thus providing a starting point.

In the following Figure 15 is a summary of intra-household living conditions and the relevant policy areas. The table is intended to show the linkage between household factors, maternal health and policy. Also in the table is a presentation of the respective policy actions that are aligned to different determinants.

Figure 14: Household Factors Associated With Use of ANC, Skilled Delivery and Family Planning Services

Determinant	Description of the Factors	Empirical Status	Policy Implications
Intra-household division of labour	Gender differences in time spent on housework and attitudes towards house and farm work.	Women's labour burdens, time deprivation, severity of division of labour by gender.	Integrate intra-household time on house work into PHC maternal health strategies.
Quality of couple relations	Having time to work together, helping with housework, couple communication and partner violence.	Couple relations are social resources for maternal health, unequal power relations, marginalised women's positions undermine couple communication.	Advocate a domestic relations bill that considers laws on reproductive and maternal health. Design and implement laws on responsible parenthood.
Land use dynamics	Gender based hierarchy, intra-household material and resources decision–making.	Land is a major economic resource and is customarily owned by men.	Promote women's autonomy. Land use decision-making procedures should be redefined by finding material resources equivalent to land for women's ownership.

Source: Author's own summary, March 2012

The following are specific actions and recommendations that link PHC strategies with women living conditions:

1) Use community education programmes through the VHTs to challenge gender roles, expectations and behaviours that compromise a woman's capacity to sustain decision-making.

2) Mainstream community participation by focusing on educating community members about the norms that shape women's behaviours, particularly those that limit education access and movements. The lack of control over resources like land is the primary concern.

    a. For a long time women have remained custodians of health, for which they lack control of the resources required for care. Gendered allocation of resources particularly land determines women's status and underpins their health behaviours. Therefore, land governance should be integrated in women health promotion strategies.

3) Increase consideration of people's living conditions that might hinder demand for health care within health care delivery. This could be achieved through the establishment of community research within health care delivery programmes to periodically assess community and household health behaviours.

4) Strategies to reduce gender inequalities and improve use of maternal health care should address the inequalities in household labour. Activities to reduce inequalities should include educating and involving men in housework and childcare as a route to improve women's reproductive health.

5) All civil, government and non government institutions targeting male involvement in health must deal with norms and social behaviors that promote gender inequality in household labour, resource allocation and couple relations.

6) Through community education, leaders must encourage men and women to share housework by highlighting the health benefits of sharing responsibilities at the household level. The economic and social value of housework could be defined by respective communities. Women's power to make decisions over farm proceeds does not improve their economic status but their overall health behaviors.

8.9 Further Research and Questions Raised by the Thesis

The thesis has examined the intra-household social determinants of the use of maternal health care among rural communities of Mbarara District in Uganda. It contributes to the body of knowledge on the intra-household factors that shape decisions to seek maternal health care within developing countries like Uganda. However, in this section of the concluding chapter, the thesis recognises certain aspects of the intra-household determinants of maternal health behaviours that may not have been fully dealt with and thus recommends that they are considered as areas for further research:

1) The study used a case study research design which investigated current maternal health practices among the people of Kashari County, Mbarara District. Through the study's findings, the thesis identified maternal health behaviours with the complex nature of women's household socioeconomic positions. Since women's health behaviours were found to be culturally sensitive and bound, further research could be carried out by undertaking anthropological approaches.
2) Regarding household labour and women's ownership of land, the thesis raises two fundamental questions: firstly, how does men's involvement in maternal health care relate to the household division of labour? What are the most viable options for women's land ownership?
3) This thesis has discussed the dynamics of couple relations and their inter-relationship with the customs that surround men and women's behaviours as husbands and wives. Since the study focused on couple relations, it did not examine relations between other members of the household, such as relatives and friends. Further research could also be undertaken to distinguish between intra-household supportive and bargaining relationships.
4) The thesis revealed gaps in the capacity of Mbarara District PHC structures to deal with household level maternal health care barriers. Further research could therefore focus on redefining the roles of the PHC structures, particularly of HUMCs and VHTs and how they can prioritise and incorporate the household into health care systems.

09. References

Ablo, E. and R. Reinikka (2004). "Do budgets really matter? Evidence from public spending on education and health in Uganda." Evidence from Public Spending on Education and Health in Uganda (June 1998). World Bank Policy Research Working Paper (1926).

AbouZahr, C. (2003). "Safe Motherhood: a brief history of the global movement 1947-2002." British Medical Bulletin **67**(1): 13-25.

Accorsi, S,. M.Fabiani,. B. Nattabi,. B.Corrado,. R.Iriso,. E. O. Ayella,. B.Pido,. P. A.Onek,. M. Ogwang and S. Declich (2005). "The disease profile of poverty: morbidity and mortality in northern Uganda in the context of war, population displacement and HIV/AIDS." Transactions of the Royal Society of Tropical Medicine and Hygiene **99**(3): 226-233.

Agaba, E. (2009). "Funding the promise: monitoring Uganda's health sector financing from an HIV/AIDS perspective." Africa Health Sciences **9**(s2): s81-s85.

Agarwal, B. (1989). "Rural women, poverty and natural resources: sustenance, sustainability and struggle for change." Economic and Political Weekly.

Agarwal, B. (1997). ""Bargaining" and Gender Relations: Within and Beyond the Household." Feminist Economics **3**(1): 1-51.

Agarwal, B. (2003). "Gender and Land Rights Revisited: Exploring New Prospects via the State, Family and Market." Journal of Agrarian Change **3**(1-2): 184-224.

Ahmad, E,. G. Brosio and M. González (2006). "Uganda: Managing More Effective Decentralization." IMF Working Paper **WP/06/279**.

Ahmed, S. and M. M. Khan (2011). "Is demand-side financing equity enhancing? Lessons from a maternal health voucher scheme in Bangladesh." Social Science & Medicine **72**(10): 1704-1710.

Ahmed, S. and M. M. Khan (2011). "A maternal health voucher scheme: what have we learned from the demand-side financing scheme in Bangladesh?" Health Policy and Planning **26**(1): 25-32.

Ajakaiye, O. and G. Mwabu (2007). "The Demand for Reproductive Health Services: An Application of Control Function Approach." AERC **Working Paper Series.** .

Akanda, M. and A. Salam (2012). "Demand for Institutional Delivery in Bangladesh: An Application of Household Production Function." Dhaka Univ. J. Sci **60**(1): 53-59.

Akin, J., P. Hutchinson and K. Strumpf (2005). "Decentralisation and government provision of public goods: The public health sector in Uganda." The Journal of Development Studies **41**(8): 1417-1443.

Alaba, O., A and S. Koch (2007). 'Household structure, social protection and health seeking behaviour in South Africa'. 1st Annual Conference: Charlotte Manye Maxeke Collaboration in Research and

Capacity Building in Economics of Social Protection, Ivory Tree Lodge, Pilansberg, South Africa, UPSpace at the University of Pretoria.

Alderman, H,. P. Chiappori,. L. Haddad,. J. Hoddinott and R. Kanbur (1995). "Unitary versus collective models of the household: is it time to shift the burden of proof? " The World Bank Research Observer **10**(1): 1-19.

Allendorf, K. (2010). "The quality of family relationships and use of maternal health-care services in India." Studies in Family Planning **41**(4): 363-275.

Amooti-Kaguna, B. and F. Nuwaha (2000). "Factors influencing choice of delivery sites in Rakai district of Uganda." Social Science & Medicine **50**(2): 203-213.

Angel, R. and M. Tienda (1982). "Determinants of Extended Household Structure: Cultural Pattern or Economic Need?" American Journal of Sociology **87**(6): 1360-1383.

Ashraf, N. (2009). "Spousal Control and Intra-Household Decision Making: An Experimental Study in the Philippines." The American Economic Review **99**(4): 1245-1277.

Asiimwe, J. (2001). "Making Women's Land Rights a Reality in Uganda: Advocacy for Co-Ownership by Spouses." Yale Hum. Rts. & Dev. LJ **4**: 171.

Baird, D. T. (2000). "Overview of advances in contraception." British Medical Bulletin **56**(3): 704-716.

Bankole, A. and S. Singh (1998). "Couples' Fertility and Contraceptive Decision-Making in Developing Countries: Hearing the Man's Voice." International Family Planning Perspectives **24**(1): 15-24.

Barker, G. J. Contreras,. B.Heilman,. A.K Singh,. R. Verma and M. Nascimento (2011). Evolving Men: Initial Results from the International Men and Gender Equality Survey (IMAGES). Washington, D.C, International Centre for Research on Women (ICRW) and Rio de Janeiro: Instituto Promundo.

Barnes-Josiah, D,. C. Myntti and A. Augustin (1998). "The 'Three Delays' as a Framework for Examining Maternal Mortality i Haiti." Social Science & Medicine **46**(8): 981-993.

Barton, C. (2005). "Women debate the MDGs." Development **48**(1): 101-106.

Basinga, P,. P. Gertler., A. Binagwaho,. A. Soucat,. J. Sturdy and C. Vermeersch (2011). "Effect on maternal and child health services in Rwanda of payment to primary health-care providers for performance: an impact evaluation." The Lancet **377**(9775): 1421-1428.

Beaglehole, R. and R. Bonita (2004). Public health at the crossroads: achievements and prospects, Cambridge University Press.

Becker, G. S. and G. S. Becker (1991). A Treatise on the Family, Harvard university press.

Becker, S. (1999). "Measuring Unmet Need: Wives, Husbands or Couples?" International Family Planning Perspectives **25**(4): 172-180.

Beegle, K,. E. Frankenberg and D. Thomas (2001). "Bargaining Power Within Couples and Use of Prenatal and Delivery Care in Indonesia." Studies in Family Planning **32**(2): 130-146.

Bell, R., S. Taylor, et al. (2010). "Global Health Governance: Commission on Social Determinants of Health and the Imperative for Change." The Journal of Law, Medicine & Ethics **38**(3): 470-485.

Berkman, L. F. (1995). "The role of social relations in health promotion." Psychosomatic Medicine **57**(3): 245-54.

Berkman, L., T. Glass,. I. Brissette and T. Seeman (2000). "From social integration to health: Durkheim in the new millennium." Social Science & Medicine **51**(6): 843-857.

Berman, P,. C. Kendall and K. Bhattacharyya (1994). "The household production of health: Integrating social science perspectives on micro-level health determinants." Social Science & Medicine **38**(2): 205-215.

Bhutta, Z., M. Chopra,. H. Axelson,. P. Berman,. T. Boerma,. J. Bryce,. F. Bustreo,. E. Cavagnero,. G. Cometto,. B. Daelmans,. A. Francisco,. H. Fogstad,. N. Gupta,. L. Laski,. J. Lawn,. B. Maliqi,. E. Mason,. C. Pitt,. J. Requejo,.A Starrs,. C. Victora and T. Wardlaw (2010). "Countdown to 2015 decade report (2000-10): taking stock of maternal, newborn, and child survival." The Lancet **375**(9730): 2032-2044.

Bhutta, Z., S. Ali,. S. Cousens,. T. M. Ali,. B. A. Haider,. A. Rizvi,. P. Okong,. S. Z. Bhutta and R.E. Black (2008). "Alma-Ata: Rebirth and Revision 6 Interventions to address maternal, newborn, and child survival: what difference can integrated primary health care strategies make?" Lancet **372**: 972-89.

Blanc, A. K. (2001). "The Effect of Power in Sexual Relationships on Sexual and Reproductive Health: An Examination of the Evidence." Studies in Family Planning **32**(3): 189-213.

Blanc, A. K. and A. A. Way (1998). "Sexual Behaviour and Contraceptive Knowledge and Use among Adolescents in Developing Countries." Studies in Family Planning **29**(2): 106-116.

Blanc, A. K. and B. Wolff (2001). "Gender and Decision-Making over Condom Use in Two Districts in Uganda." African Journal of Reproductive Health / La Revue Africaine de la Sant Reproductive **5**(3): 15-28.

Blane, D. (2006). The life course, the social gradient, and health. Social Determinants of Health. M. Marmot and R. G. Wilkinson. New York, Oxford University Press.

Bloom, S., D. Wypij and M. Das Gupta (2001). "Dimensions of women’s autonomy and the influence on maternal health care utilization in a north Indian city." Demography **38**(1): 67-78.

Bolt, J., Vincent and K. Bird (2003). The intra-household disadvantages framework: a framework for the analysis of intra-household difference and inequality. CPRC Working Papers no. 32. UK, Chronic Poverty Research Centre. **32**.

Bolt, V. J. and K. Bird (2003). "The Intra-household Disadvantages Framework: A Framework for the Analysis of Intra-Household Difference and Inequality." Chronic Poverty Research Centre **Working Paper No. 32.**

Bossert, T. J. and J. C. Beauvais (2002). "Decentralization of health systems in Ghana, Zambia, Uganda and the Philippines: a comparative analysis of decision space." Health Policy and Planning **17**(1): 14-31.

Braunholtz-Speight Rim, C., Harper and J. Nicola (2008). "Progressive social change – women's empowerment." Chronic Poverty Research Centre. Uganda. **Policy Brief no. 12**.

Breslin, M. (1998). "Almost one in three Ugandan births are unwanted or mistimed, but few women practice contraception." International Family Planning Perspectives **24**(1): 64 - 47.

Bryant, J. H., J. B. Richmond and K. Heggenhougen (2008). Alma-Ata and Primary Health Care: An Evolving Story. International Encyclopaedia of Public Health. Oxford, Academic Press**:** 152-174.

Bryce, J. (2008). "Countdown to 2015 for maternal, new born and child survival; The 2008 report on tracking coverage of interventions." The Lancet **371**: 1247 - 58.

Bunch, C. and S. Fried (1996). "Beijing '95: Moving Women's Human Rights from Margin to Center." Signs **22**(1): 200-204.

Byamugisha. R., J.K. Tumwine,. N. Semiyaga and T. Tylleskar (2010). "Research Determinants of male involvement in the prevention of mother-to-child transmission of HIV programme in Eastern Uganda: a cross-sectional survey."

Caldwell, J. C., P. Caldwell and I.O. Orubuloye (1992). "The Family and Sexual Networking in Sub-Saharan Africa: Historical Regional Differences and Present-Day Implications." Population Studies **46**(3): 385-410.

Campbell, O. M. R. and W. J. Graham (2006). "Strategies for reducing maternal mortality: getting on with what works." The Lancet **368**(9543): 1284-1299.

Chakraborty, N., A.M Islam., R.I. Chowdhury. W. Bari and H.H Akhter (2003). "Determinants of the use of maternal health services in rural Bangladesh." Health Promotion International **18**(4): 327-337.

Chambers, R. (1997). Whose Reality Counts? Putting the First Last. London, Intermediate Technology Publications.

Chan, M. (2008). "Return to Alma-Ata." Lancet (London, England) **372**(9642): 865-866.

Christiana E.E, O. (1994). "Gender inequalities of health in the third world." Social Science & Medicine **39**(9): 1237-1247.

Coll-Black, S., A. Bhushan and K. Fritsch (2007). "Integrating poverty and gender into health programs: A Sourcebook for health professionals." Nursing & Health Sciences **9**(4): 246-253.

Collins, R. (2000). "Situational Stratification: A Micro-Macro Theory of Inequality." Sociological Theory **18**(1): 17-43.

Cooper, E. (2010). "Inheritance and the intergenerational transmission of poverty in sub-Saharan Africa: policy considerations." Chronic Poverty Research Centre Working Paper (159).

Cooper, E. (2012). "Women and Inheritance in Sub-Saharan Africa: What Can Change?" Development Policy Review **30**(5): 641-657.

Creswell, J. W. and V. L. P. Clark (2011). Designing and conducting mixed methods Thousand Oals, Sage Publications.

CSDH (2008). Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health. . Geneva, World Health Organization.

Cueto, M. (2004). "The origins of primary health care and selective primary health care." American Journal of Public Health **94**(11): 1864.

De Maeseneer, J., S. Willems,. A. De Sutter,. I.Van de Geuchte and M. Billings (2007). "Primary health care as a strategy for achieving equitable care." Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Deere, C. D. and C. R. Doss (2006). Gender and the distribution of wealth in developing countries, Research Paper, UNU-WIDER, United Nations University (UNU).

Deere, C. D. and M. Leon (2003). "The Gender Asset Gap: Land in Latin America." World Development **31**(6): 925-947.

Deininger, K., D. A. Ali and T. Yamano (2008). "Legal Knowledge and Economic Development: The Case of Land Rights in Uganda." Land Economics **84**(4): 593-619.

Deininger, K. and R. Castagnini (2006). "Incidence and impact of land conflict in Uganda." Journal of Economic Behavior & Organization **60**(3): 321-345.

Deininger, K. and P. Mpuga (2005). "Economic and welfare impact of abolition of health user fees: Evidence from Uganda." Journal of African Economies **14**(1): 55 - 91.

DeJong, J. (2000). "The role and limitations of the Cairo International Conference on Population and Development." Social Science & Medicine **51**(6): 941-953.

Derose, L. F., F.N Dodoo and V. Vrushali (2002). "Fertility Desires and Perceptions of Power in Reproductive Conflict in Ghana." Gender & Society **16**(1): 53-73.

Dixon, J. (2000). "Social Determinants of Health." Health Promotion International **15**(1): 87-89.

Dodoo, F.N. and A.E. Frost (2008). "Gender in African Population Research: The Fertility/Reproductive Health Example." Annual Review of Sociology **34**(1): 431-452.

Donnay, F. (2000). "Maternal survival in developing countries: what has been done, what can be achieved in the next decade." International Journal of Gynaecology & Obstetrics **70**(1): 89-97.

Doss, C., M. Truong,. G. Nabanoga and J. Namaalwa (2012). "Women, Marriage and Asset Inheritance in Uganda." Development Policy Review **30**(5): 597-616.

Doyal, L. (2000). "Gender equity in health: debates and dilemmas." Social Science & Medicine **51**(6): 931-939.

Dudgeon, M. R. and M. C. Inhorn (2004). "Men's influences on women's reproductive health: medical anthropological perspectives." social Science & Medicine **59** (7): 1379-1395.

Eagly, A. H. (1983). "Gender and social influence: A social psychological analysis." American Psychologist **38**(9): 971.

Ellis, F. and G. Bahiigwa (2003). "Livelihoods and Rural Poverty Reduction in Uganda." World Development **31**(6): 997-1013.

Ensor, T. and S. Cooper (2004). "Overcoming barriers to health service access: influencing the demand side." Health Policy Plan. **19**(2): 69-79.

Ensor, T. and S. Cooper (2004). "Overcoming barriers to health service access: influencing the demand side." Health Policy Plan. **19**(2): 69 - 79.

Eswaran, M. (2002). "The empowerment of women, fertility, and child mortality: Towards a theoretical analysis." Journal of Population Economics **15**(3): 433-454.

Evans, T., M. Whitehead, et al. (2001). Changing inequalities in health. New York, Oxford UP.

Filippi, V., C. Ronsmans,. O.M.R Campbell,. W.J. Graham,. A. Mills,. J. Borghi,. M. Koblinsky and D. Osrin (2006). "Maternal health in poor countries: the broader context and a call for action." The Lancet **368**(9546): 1535-1541.

Freedman, L. P. (2005). "Achieving the MDGs: Health systems as core social institutions." Development: The millennium development goals **48**(1): 19-24.

Freedman, L. P., R.J. Waldman,. H. Pinho,. M.E Wirth,. A.M.RChowdhury and A. Rosenfield (2005). UN Millennium Project 2005. Who's got the power? transforming health systems for women and children. Task force on child health and maternal health, Earthscan.

Frenk, J. (2009). "Reinventing primary health care: the need for systems integration." Lancet (London, England) **374**(9684): 170-173.

Frost, A. E. and N.A. F. Dodoo (2009). "Men are Missing from African Family Planning." Contexts **8**(1): 44-49.

Furuta, M. and S. Salway (2006). "Women's position within the household as a determinant of Maternal Health Care Use in Nepal." International Family Planning Perspectives **32**(1): 17-27.

Gable, G., Guy (1994). "Integrating case study and survey research methods: an example in information systems." European Journal of Information Systems **3**(2): 112-126. .

Gabrysch, S. and O. Campbell (2009). "Still too far to walk: Literature review of the determinants of delivery service use." BMC Pregnancy and Childbirth **9**(1): 34.

Garcia, Z. (2006). "Agriculture, trade negotiations and gender." Food and Agriculture Organization (FAO).

Giovarelli, R. (2006). "Customary Law, Household Distribution of Wealth, and Women's Rights to Land and Property." Seattle Journal for Social Justice **4**(2).

Golooba-Mutebi, F. (2005). "When Popular Participation Won't Improve Service Provision: Primary Health Care in Uganda." Development Policy Review **23**(2): 165-182.

Graham, H. (2001). From science to policy: options for reducing health inequalities. Poverty inequality and health. D. Leon and G. Walt. New York, Oxford University Press.

Gray, L. and M. Kevane (1999). "Diminished Access, Diverted Exclusion: Women and Land Tenure in Sub-Saharan Africa." African Studies Review **42**(2): 15-39.

Green, C. P. and A. Mukuria (2009). Addressing Early Marriage in Uganda. Washington DC, USAID, Futures Group, Health Policy Initiative, Task Order I.

Hall, J. H. and R. Taylor (2003). "Health for all beyond 2000: the demise of the Alma-Ata Declaration and primary health care in developing countries." MJA **178**: 17-20.

Hall, P. A. and R. C. Taylor (2006). Health, Social Relations, and Public Policy Successful Societies: Institutions, Cultural Repertoires and Health, . P. A. H. a. M. Lamont.

Hardon, A. P., D. Akurut,. C. Comoro,. C. Ekezie,. H.F. Irunde,. T.Gerrits,. J. Kglatwane,. J. Kinsman,. R. Kwasa,. J. Maridadi,. T.M. Moroka,. S. Moyo,. A. Nakiyemba,. S. Nsimba,. R. Ogenyi,. T. Oyabba,.

F. Temu and R. Laing (2007). "Hunger, waiting time and transport costs: Time to confront challenges to ART adherence in Africa." AIDS Care **19**(5): 658-665.

Harris, C. (2006). "Doing Development with Men: Some Reflections on a Case Study from Mali." IDS Bulletin **37**(6): 47-56.

Hay, D. I. (2007). "Developing a Canadian Economic Case for Financing the Social Determinants of Health." Canadian Policy Research Networks (CPRN).

Hervey, T. and J. Shaw (1998). "Women, Work and Care: Women's Dual Role and Double Burden in Ec Sex Equality Law." Journal of European Social Policy **8**(1): 43-63.

Hickey, S. (2005). "The politics of staying poor: exploring the political space for poverty reduction in Uganda." World Development **33**(6): 995-1009.

Hill, K., K. Thomas, et al. (2007). "Estimates of maternal mortality worldwide between 1990 and 2005: an assessment of available data." The Lancet **370**(9595): 1311-1319.

Hogan, M. C,. K.J. Foreman,. M. Naghavi,. S.Y. Ahn,. M. Wang,. S.M Makela,. A.L. Lopez,. R. Lozano and C.J.L Murray (2010). "Maternal mortality for 181 countries, 1980- 2008: a systematic analysis of progress towards Millennium Development Goal 5." The Lancet **375**(9726): 1609-1623.

Hollander, D. (1997). "Ugandan Couples May Discuss Reproductive Issues, But Do Not Always Understand Each Other's Desires." International Family Planning Perspectives **23**(2): 90-92.

Holvoet, N. (2005). "Credit and women's group membership in South India: testing models of Intra-household allocative behaviour. ." Feminist Economics **11**(3): 20-62.

Homsy, J., R. Bunnell, et al. (2009). "Reproductive Intentions and Outcomes among Women on Antiretroviral Therapy in Rural Uganda: A Prospective Cohort Study." PLoS ONE **4**(1): e4149.

Houweling, T. A. J,. C. Ronsmans,. O.M.R.Campbell and A.E. Kunst (2007). "Huge poor-rich inequalities in maternity care: an international comparative study of maternity and child care in developing countries." Bulletin of the World Health Organization **85**: 745-754.

Hunt, D. (2004). "Unintended Consequences of Land Rights Reform: The Case of the 1998 Uganda Land Act." Development Policy Review **22**(2): 173-191.

Hutchinson, P., J. Akin and F. Ssengooba (2006). "The impacts of decentralization on health care seeking behaviours in Uganda." The International Journal of Health Planning and Management **21**(3): 239-270.

Ibrahim, S. S. (2006). "From individual to collective capabilities: the Capability Approach as a conceptual framework for self-help." Journal of Human Development **7**(3): 397-416.

Irwin, A. and E.Scali (2007). "Action on the social determinants of health: A historical perspective." Global Public Health **2**(3): 235-256.

Iversen, V. (2003). "Intra-household inequality: a challenge for the capability approach?" Feminist Economics **9**(2-3): 93-115.

Jackson, C. (1999). "Men's work, masculinities and gender divisions of labour." Journal of Development Studies **36**(1): 89-108.

Jackson, C. (2003). "Gender Analysis of Land: Beyond Land Rights for Women?" Journal of Agrarian Change **3**(4): 453-480.

Jeppsson, A. (2001). "Financial Priorities under decentralization in Uganda " Health Policy and Planning **16**(2): 187 - 192.

Jeppsson, A., S.A Okuonzi,. P. Ostergren and B. Hagstrom (2004). "Using burden of disease/cost effectiveness as an instrument for district health planning: experience from Uganda." Health policy.

Jeppsson, A., P. Ostergren and B. Hagstrom (2003). "Restructuring a ministry of health - an issue of structure and process: a case study from Uganda." health Policy and Planning **18**(1): 68 - 73.

Jitta, J., S.R. Whyte and N. Nshakira (2003). "The availability of drugs: what does it mean in Ugandan primary care." Health policy **65**(2): 167-179.

Johnson, M. P. and K. J. Ferraro (2000). "Research on Domestic Violence in the 1990s: Making Distinctions." Journal of Marriage and Family **62**(4): 948-963.

Joireman, S. F. (2007). "Enforcing New Property Rights in Sub-Saharan Africa: The Ugandan Constitution and the 1998 Land Act." Comparative Politics **39**(4): 463-480.

Jowett, M. (2000). "Safe motherhood interventions in low-income countries: an economic justification and evidence of cost effectiveness." Health Policy **53**(3): 201-228.

Kabakyenga, J. K,. P. Östergren., E. Turyakira and K.O Pettersson (2011). "Knowledge of obstetric danger signs and birth preparedness practices among women in rural Uganda." Reproductive Health **33**(8).

Kabeer, N. (1997)."Women, Wages and Intra-household Power Relations in Urban Bangladesh." Development and Change **28**(2): 261-302.

Kabeer, N. (1999). "Reources, Agency, Achievements: Reflections on the Measurements of Women Empowerment." Development and Change **30**(3): 435-464.

Kabeer, N. (1999). "Resources, Agency, Achievements: Reflections on the Measurement of Women's Empowerment." Development and Change **30**(3): 435-464.

Kabeer, N. (2005). "Gender equality and women's empowerment: A critical analysis of the third millennium development goal 1." Gender & Development **13**(1): 13-24.

Kabira, W.M., E. W.Gachukia and F.O. Matiangi (1997). "The effect of women's role on health: the paradox." International Journal of Gynaecology & Obstetrics **58**(1): 23-34.

Kagumire, R. (2010). "Pregnant and alone in Uganda." Canadian Medical Association Journal **182**(14): E685-E686.

Kahn, R.S., P.H. Wise,. B. P. Kennedy and I. Kawachi (2000). "State income inequality, household income, and maternal mental and physical health: cross sectional national survey." BMJ **321**(7272): 1311-1315.

Kapiriri, L., F.O. Norheim and K. Geggenhougen (2003). "Public participation in health planning and priority setting at the district level in Uganda." Health Policy and Planning **18**(2): 205 - 213.

Kapiriri, L. and O. F. Norheim (2004). "Criteria for priority-setting in health care in Uganda: exploration of stakeholders' values." Bulletin of the World Health Organization **82**: 172-179.

Kapiriri, L., F.O Norheim and D.K Martin (2007). "Priority setting at the micro-, meso- and macro-levels in Canada, Norway and Uganda." Health Policy **82**(1): 78-94.

Karamagi, C., J. Tumwine, et al. (2006). "Intimate partner violence against women in eastern Uganda: implications for HIV prevention." BMC Public Health **6**(1): 284.

Kautzky, K. and S. Tollman (2008). "A perspective on primary health care in South Africa." South African health review **20**.

Kawachi, I., B.P. Kennedy,. V. Gupta and D. Prothrow-Stith (1999). "Women's status and the health of women and men: a view from the States." Social Science & Medicine **48**(1): 21-32.

Kawachi, I. and P. Kennedy, Bruce (1997). "Socioeconomic determinants of health : Health and social cohesion: why care about income inequality? ." BMJ **314**(1037).

Kawachi, I., S.V Subramanian and N. Almeida-Filho (2002). "A glossary for health inequalities." Journal of Epidemiology and Community Health **56**(9): 647-652.

Kawamara-Mishambi, S. and I. Ovonji-Odida (2003). "The 'Lost Clause': The Campaign to Advance Women's Property Rights in the Uganda 1998 Land Act." No shortcuts to power: African women in politics and policy making **3**: 160.

Kaye, D. K., F. Mirembe,. A. M. Ekstrom,. G. Bantebya and A. Johansson (2005). "The Social Construction and Context of Domestic Violence in Wakiso District, Uganda." Culture, Health & Sexuality **7**(6): 625-635.

Kaye, Dan. K., F. Mirembe,. G. Bantebya,. A. Johansson and A.M. Ekstrom (2006). "Domestic violence during pregnancy and risk of low birth-weight and maternal complications: a prospective cohort study at Mulago Hospital, Uganda." Tropical Medicine & International Health **11**(10): 1576-1584.

Kearney, M.H., B.H. Munro,. U. Kelly and J.W. Hawkins (2004). "Health Behaviours as Mediators for the Effect of Partner Abuse on Infant Birth Weight." Nursing Research **53**(1): 36-45.

Keith, P. M. and R. B. Schafer (1980). "Role Strain and Depression in Two-Job Families." Family Relations **29**(4): 483-488

Kerber, K.J., J.E. de-Graft-Johnson,. Z.A. Bhutta,. P. Okong,. A. Starrs and J.E. Lawn (2007). "Continuum of care for maternal, newborn, and child health: from slogan to service delivery." The Lancet **370**(9595): 1358-1369.

Khaleghian, P. (2004). "Decentralization and public services: the case of immunization." Social Science & Medicine **59**(1): 163-183.

Kim, Y. M., C. Marangwanda, et al. (1996). Involving Men in Family Planning: The Zimbabwe Male Motivation and Family Planning Method Expansion Project, 1993-1994, Johns Hopkins School of Public Health, Centre for Communication Programs, Population Communication Services-Population Information Program.

Kimbro, R. T. (2008). "Together Forever? Romantic Relationship Characteristics and Prenatal Health Behaviors." Journal of Marriage and Family **70**(3): 745-757.

Kipp, W., J. Kamugisha, et al. (2001). "User fees, health staff incentives, and service utilisation in Kabarole District, Uganda." Bulletin of the World Health Organisation **79**(1).

Kironde, S,. J.Lukwago and R. Ssenyonga (2004). "Scaling the frontier-should traditional birth attendants also be used to provide nevirapine for PMTCT in Uganda?" African Health Sciences **3**(2): 102-103.

Kiwanuka, S. N., E. K.Ekirapa,. S. Peterson,. O. Okui,. M.H. Rahman,. D. Peters and G. W. Pariyo (2008). "Access to and utilisation of health services for the poor in Uganda: a systematic review of available evidence." Transactions of the Royal Society of Tropical Medicine and Hygiene **102**(11): 1067-1074.

Kiwuwa, M. and P. Mufubenga (2008). "Use of antenatal care, maternity services, intermittent presumptive treatment and insecticide treated bed nets by pregnant women in Luwero district, Uganda." Malaria Journal **7**(1): 44.

Kiwuwa, S., Mpungu and P. Mufubenga (2008). "Use of antenatal care, maternity services, intermittent presumptive treatment and insecticide treated bed nets by pregnant women in Luwero, district, Uganda." Malaria Journal **44**(7).

Koenig, K. C., Lincoln, A and A. Appleton (2003). "Women's status and domestic violence in rural Bangladesh: Individual- and community-level effects." Demography **40**(2): 269-288.

Koenig, M A., T. Lutalo,. F. Zhao,. F. Nalugoda,. F. Wabwire-Mangen,. N. Kiwanuka,. J. Wagman,. D. Serwadda,. M. Wawer and R. Gray (2003). "Domestic violence in rural Uganda: evidence from a community-based study." Bulletin of the World Health Organization **81**: 53-60.

Krejcie, R., V and W. Morgan D (1970). Determining sample size for research activities, education and psychological measurements. UK, Sage Publications.

Kreuter, M.W., S.N Lukwago,. D.C Bucholtz,. E.M Clark and V. Sanders-Thompson (2003). "Achieving Cultural Appropriateness in Health Promotion Programs: Targeted and Tailored Approaches." Health Education & Behavior **30**(2): 133-146.

Krieger, N. (1989). "Exposure, susceptibility, and breast cancer risk: A hypothesis regarding exogenous carcinogens, breast tissue development, and social gradients, including black/white differences, in breast cancer incidence." Breast Cancer Research and Treatment **13**(3): 205-223.

Krippendorff, K. (1980). Content Analysis: An Introduction to Its Methodology. Newbury Park, CA, Sage Publications.

Kruk, M. E., S. Galea,. M. Prescott and L.P. Freedman (2007). "Health care financing and utilization of maternal health services in developing countries." Health Policy Plan.: czm027.

Kyaddondo, D. and S. R. Whyte (2003). "Working in a decentralized system: a threat to health workers' respect and survival in Uganda." The International Journal of Health Planning and Management **18**(4): 329-342.

Kyomuhendo, G. B. (2003). "Low Use of Rural Maternity Services in Uganda: Impact of Women's Status, Traditional Beliefs and Limited Resources." Reproductive Health Matters **11**(21): 16-26.

Lane, S. D. (1994). "From population control to reproductive health: An emerging policy agenda." Social Science & Medicine **39**(9): 1303-1314.

Langsten, R. and R. Salem (2008). "Two Approaches to Measuring Women's Work in Developing Countries: A Comparison of Survey Data from Egypt." Population and Development Review **34**(2): 283-305

Lavelle, B. and P. J. Smock (2012). "Divorce and Women Risk of Health Insurance Loss." Journal of Health and Social Behavior **53**(4): 413-431.

Lavis, J. N., D. Robertson, et al. (2003). "How Can Research Organizations More Effectively Transfer Research Knowledge to Decision Makers?" Milbank Quarterly **81**(2): 221-248.

Lawson, D, A. McKay and J. Okidi (2006). "Poverty persistence and transitions in Uganda: a combined qualitative and quantitative analysis." The Journal of Development Studies **42, (7)** 1225-1251.

Leon, D. A. and G. Walt (2001). Poverty, inequality, and health in an international perspective: a divided world? Poverty, inequality, and health in an international perspective: a divided world? D. A. Leon and G. Walt. Oxford, Oxford Press.

Liljestrand, J. (2006). "Trends in maternal health/healthcare in low-income countries and the implications on neonatal health." Seminars in Fetal and Neonatal Medicine **11**(1): 3-6.

Lindelow, M. (2008). "Health as a family matter: Do intra - household education externalities matter for maternal and child health? ." Journal of Development Studies **44**(4): 562 - 585.

Logie, D.E., M. Rowson and F. Ndagije (2008). "Innovations in Rwanda's health system: looking to the future." The Lancet **372**(9634): 256-261.

Lueptow, L.B., L. Garovich-Szabo and M.B Lueptow (2001). "Social Change and the Persistence of Sex Typing: 1974-1997." Social Forces **80**(1): 1-36.

Mabsout, R. (2011). "Capability and Health Functioning in Ethiopian Households." Social Indicators Research **101**(3): 359-389.

Macinko, J. and B. Starfield (2001). "The Utility of Social Capital in Research on Health Determinants." Milbank Quarterly **79**(3): 387-427.

Macintyre, S. (1997). "The Black Report and beyond: what are the issues?" Social Science Medicine **44**: 723 - 745.

Magadi, M.A., N.J. Madise and R.N. Rodrigues (2000). "Frequency and timing of antenatal care in Kenya: explaining the variations between women of different communities." Social Science & Medicine **51**(4): 551-561.

Magnussen, L., J. Ehiri and P. Jolly (2004). "Comprehensive versus Selective Primary Health Care: Lessons For Global Health Policy." Health Affairs **23**(3): 167-176.

Maine, D. and A. Rosenfield (1999). "The Safe Motherhood Initiative: why has it stalled?" American Journal of Public Health **89**(4): 480-482.

Mannino, C. and F. Deutsch (2007). "Changing the Division of Household Labour: A Negotiated Process Between Partners." Sex Roles **56**(5): 309-324.

Marmot, M. (2005). "Social determinants of health inequalities " Lancet **365**: 1099 - 1104.

Marmot, M. (2007). "Achieving health equity: from root causes to fair outcomes." The Lancet **370**(9593): 1153-1163.

Marmot, M., S. Friel., R. Bell., T. A. J. Houweling and S. Taylor (2008). "Closing the gap in a generation: health equity through action on the social determinants of health." The Lancet **372**(9650): 1661-1669.

Marshall, G. (1998). A Dictionary of Sociology: Domestic division of labour. Oxford, Oxford University Press.

Mason, K. and H. Smith (2000). "Husbands' versus wives' fertility goals and use of contraception: The influence of gender context in five Asian countries." Demography **37**(3): 299-311.

Mbarara (2010). 2008/09 Mbarara District Status Health Report Mbarara, District Health Officer, Mbarara District Local Government.

Mbonye, A.K., M. G. Mutabazi,. J. B. Asimwe,. O.Sentumbwe,. J.Kabarangira,. G. Nanda and V. Orinda (2007). "Declining maternal mortality ratio in Uganda: Priority interventions to achieve the Millennium Development Goal." International Journal of Gynaecology & Obstetrics **98**(3): 285-290.

McHale, S.M., A.C. Crouter and S.D. Whiteman (2003). "The Family Contexts of Gender Development in Childhood and Adolescence." Social Development **12**(1): 125-148.

McLanahan, S. and C. Percheski (2008). "Family structure and the reproduction of inequalities." Annual Review of Sociology **34**: 256-276.

McPake, B., K. Hanson and A. Mills (1993). "Community financing of health care in Africa: An evaluation of the Bamako initiative." Social Science & Medicine **36**(11): 1383-1395.

Mechanic, D. (2000). "Rediscovering the Social Determinants of Health." Book Review Essay; Health Affairs **19**(3): 269.

Medeiros, M., R. Osorio and J. Costa (2007). "Gender Inequalities in Allocating Time to Paid and Unpaid Work: Evidence from Bolivia" The Levy Economics Institute of Bard College **Working Paper No. 495** (SSRN eLibrary).

Mehra, D., A. Agardh., K.O. Petterson and P. Ostergren (2012). Non-use of contraception: determinants among Ugandan university students.

Moghadam, V. M. and L. Senftova (2005). "Measuring women's empowerment: participation and rights in civil, political, social, economic, and cultural domains." International Social Science Journal **57**(184): 389-412.

Molyneux, C. S., G.Murira., J.Masha and R. W. Snow (2002). "Intra-household relations and treatment decision-making for childhood illnesses: a case of a Kenyan Study." Journal of Biosocial Science **34**(01): 109-131.

Mosedale, S. (2005). "Assessing women's empowerment: towards a conceptual framework." Journal of International Development **17**(2): 243-257.

Moss, N. E. (2002). "Gender equity and socioeconomic inequality: a framework for the patterning of women's health." Social Science & Medicine **54**(5): 649-661.

Moss, N. E. (2003). "Gender equity and Socioeconomic inequality: a Framework for the patterning of women's health." Social Science & Medicine **54**(5): 649-661.

Mwaka, V. M. (1993). Agricultural Production and women's time budget in Uganda. Different places, different voices; Gender and Development in Asia, Africa and Latin America. V. Momsen and V. Knnnaird. London, Routledge.

Nahar, S. and A. Costello (1998). "The hidden cost of 'free' maternity care in Dhaka Bangladesh." Health Policy and Planning **13**(4): 417-422.

Nakitto, S. (2009). Polygamy in the Domestic Relations Bill 2003: A Barrier to the Women's Human Rights in Uganda? Nottingham, University of Nottingham **LLM**.

Nanda, P. (2002). "Gender Dimensions of User Fees: Implications for Women's Utilization of Health Care." Reproductive Health Matters **10**(20): 127-134.

Nanda, P. (2002). "Gender Dimensions of User Fees: Implications for Women Utilization of Health Care." Reproductive Health Matters **10**(20): 127-134.

Nanda, P. (2002). "Gender Dimensions of User Fees: Implications for Women's Utilization of Health Care." Reproductive Health Matters **10**(20): 127-134.

Navarro, V. (2009). "What we mean by Social Determinants of Health." International Journal of Health Services **39**(3): 432-441.

Nazerali, H., M. O. Ofeba., J. Mwonga and S. Zaramba (2006). Medicines - driving demand for health services in Uganda. Health Systems Reforms in Uganda; the process and the outputs. C. K. Tashobya, F. Ssengoba and V. O. Cruz. London, Health Systems and Development Programme, London School of Hygiene and Tropical Medicine.

Ndomugyenyi R., S. Neema and P. Magnussen (1998). "The use of formal and informal services for antenatal care and malaria treatment in Rural Uganda." Health Policy and Planning **13**(1): 94-102.

Neema, S. (2005). The impact of health policies and health sector reform on the readiness of health systems to respond to women's health needs, with special focus on reproductive health, reproductive rights and HIV/AIDS. UN Division for Advancement of Women (DAW) Experts Group Meeting.

Nussbaum, M. (2003). "Capabilities as Fundamental Entitlement: Sen and Social Justice." Feminist Economics **9**(2-3): 33-59.

Nutbeam, D. (1998). "Evaluating health promotion – progress, problems and solutions." Health Promotion Int **13**: 27 – 44.

Nutbeam, D. (1998). "Health Promotion Glossary." Health Promotion. Int. **13**(4): 349-364.

Nyakato, V. N. and W. Pelupessy (2011). Not by money alone: the health poverty trap in rural Uganda. L'Afrique Des Grands Lacs: Annuaire 2010-2011. F. Reyntjens. Paris, L'Harmattan**:** 319-336.

Nyanzi, S., R. Pool and J. Kinsman (2001). "The negotiation of sexual relationships among school pupils in south-western Uganda." AIDS Care **13**(1): 83-98.

Obaikol, E. (2009). Women’s Land Rights and the Law: the Legislative Framework Governing Women's Land Rights in Uganda. Kampala, Uganda Land Alliance.

Okello, D. O., R. Lubanga., D. Guwatudde and A. Sebina-Zziwa (1998). "The challenge to restoring basic health care in Uganda." Social Science & Medicine **46**(1): 13-21.

Okidi, J. and A. Mckay (2003). "Poverty Dynamics in Uganda: 1992 - 2000." Chronic Poverty Research Centre CPRC Working Paper **27**.

Okuonzi, S. A. and J. Macrae (1995). "Whose policy is it anyway? International and national influences on health policy development in Uganda." Health Policy and Planning **10**(2): 122-132.

Oladeji, D. (2008). "Gender Roles and Norms Factors Influencing Reproductive Behaviour Among Couples in Ibadan, Nigeria." Anthropologist **10**(2): 133-138.

Ostlin, P., E. Eckermann., U. S. Mishra., M. Nkowane and E. Wallstam (2006). "Gender and health promotion: A multi-sectoral policy approach." Health Promotion International **21**(suppl 1): 25-35.

Otiso, K. M. (2006). Culture and customs of Uganda, Greenwood Publishing Group.

Pablo, R. S. (2010). "Gender disparities in time allocation, time poverty and labour allocation across employment sectors in Ethiopia." GDALM: 297-332.

Pacagnella, R.C., Cecatti, J.G., Osis, M.J. and Souza, J. P. (2012). "The role of delays in severe maternal morbidity and mortality: expanding the conceptual framework." Reproductive Health Matters **20**(39): 155-163

Parkhurst, J. O., S. A. Rahman and F. Ssengoba (2006). "Overcoming access barriers for facility based delivery in low income settings: insights from Bangladesh and Uganda." J Health Popul Nutri **24**(4): 438-445.

Penn-Kekana, L., B. McPake and J. Parkhurst (2007). "Improving Maternal Health: Getting What Works To Happen." Reproductive Health Matters **15**(30): 28-37.

Rao, N. (2012). "Male ‘Providers’ and Female ‘Housewives’: A Gendered Co-performance in Rural North India." Development and Change **43**(5): 1025-1048.

Rohde, J. S. Cousens., M. Chopra., V. Tangcharoensathien., R. Black., Z. A. Bhutta and J. E. Lawn (2008). "30 years after Alma-Ata: has primary health care worked in countries?" The Lancet **372**(9642): 950-961.

Ronsmans, C. and W. J. Graham (2006). "Maternal mortality: who, when, where, and why." The Lancet **368**(9542): 1189-1200.

Rugadya, M., E. Obaikol and H. Kamusiime (2004). "Gender and the land reform process in Uganda." Associates for Development. Online. Available HTTP:<http://www. oxfam. org. uk/resources/learning/landrights/downloads/afd_gender_land_reform_process. pdf>(accessed 2 February 2009).

Sabik, L. and R. Lie (2008). "Priority setting in health care: Lessons from the experiences of eight countries." International Journal for Equity in Health **7**(1): 4.

Sandari, T. (1992). "The untold story: how the health care systems in developing countries contribute to maternal mortality." Int J Health Serv **22**(3): 513-528.

Say, L. and R. Raine (2007). "A systematic review of inequalities in the use of maternal health care in developing countries: examining the scale of the problem and the importance of context." Bulletin of the World Health Organization **85**: 812-819.

Schumann, D. A. and W. H. Mosley (1994). "The household production of health: Introduction." Social Science & Medicine **38**(2): 201-204.

Selin, H., P. K. Stone, et al. (2009). Culture, Pregnancy and Childbirth in Uganda: Surviving the Women's Battle Childbirth Across Cultures, Springer Netherlands. **5:** 229-234.

Sen, A. (1987). Gender and cooperative conflicts, World Institute for Development Economics Research Helsinki.

Sen, G., A. George and P. Ostlin (2002). "The Case for Gender Equity in Health Research." Journal of Health Management **4**(2): 99-117.

Shakil, A. and K. M. Mahmud (2011). "Is demand-side financing equity enhancing? Lessons from maternal health voucher scheme in Bangladesh." Soc Sci Med **72**: 1704-1710.

Shefner-Rogers, C. L. and S. Sood (2004). "Involving husbands in safe motherhood: effects of the SUAMI SIAGA campaign in Indonesia." Journal of Health Communication **9**: 233-258.

Shen, C. and J. B. Williamson (1999). "Maternal mortality, women's status, and economic dependency in less developed countries: a cross-national analysis." Social Science & Medicine **49**(2): 197-214.

Shiffman, J. (2008). "Has donor prioritization of HIV/AIDS displaced aid for other health issues?" Health Policy and Planning **23**(2): 95-100.

Siddiqi, A., M. Bobak, et al. (2009). The social epidemiology of population health during the time of transition from communism in Central and Eastern Europe Social Inequality and Public Health. S. J. Babones. Bristol, The Polity Press.

Simkhada, B., E.Teijlingen., M. Porter and P. Simkhada (2008). "Factors affecting the utilization of antenatal care in developing countries: systematic review of the literature." Journal of Advanced Nursing **61**(3): 244-260.

Solar, O. and A. Irwin (2007). A conceptual Framework for Action on the Social Determinants of Health Draft Discussion paper for the Commission on Social Determinants of Health. O. Solar and A. Irwin. Geneva, WHO.

Sousan, A. (1996). "Women's autonomy and its impact on fertility." World Development **24**(12): 1793-1809.

Starrs, A. M. (2006). "Safe motherhood initiative: 20 years and counting." The Lancet **368**(9542): 1130-1132.

Stemler, S. (2001). "An overview of content analysis." Practical Assessment and Research Evaluation **10**.

Struensee, V. and S. Vanessa (2004). "The Domestic Relations Bill in Uganda: Potentially Addressing Polygamy, Bride Price, Cohabitation, Marital Rape, Widow Inheritance and Female Genital Mutilation." Retrieved 6th August 2012, 2012, from SSRN: http://ssrn.com/abstract=623501 or http://dx.doi.org/10.2139/ssrn.623501.

Subramanian, S. V. and I. Kawachi (2004). "Income Inequality and Health: What Have We Learned So Far?" Epidemiologic Reviews **26**(1): 78-91.

Tarlov, A. (1996). Social Determinants of health: the sociological transition. Health and social Organisation D. Blane, E. Brunner and G. Wilkinson, Richard. New York, Routledge**:** 71 - 93.

Tebekaw, Y., C. Teller and A. Hailemariam (2011). Women’s Decision-Making Autonomy and Their Nutritional Status in Ethiopia: Socio-Cultural Linking of Two MDGs The Demographic Transition and Development in Africa, Springer Netherlands**:** 105-124.

ten Hoope-Bender, P., J. Liljestrand and S. MacDonagh (2006). "Human resources and access to maternal health care." International Journal of Gynaecology & Obstetrics **94**(3): 226-233.

Thaddeus, S. and Deborah Maine (1994). "Too far to walk : maternal mortality in context " Social Science & Medicine **38**(1091-1110).

Thaddeus, S. and D. Maine (1994). "Too far to walk: Maternal mortality in context." Social Science & Medicine **38**(8): 1091-1110.

Thomas, D. (1990). "Intra-Household Resource Allocation: An Inferential Approach." The Journal of Human Resources **25**(4): 635-664.

Thomson, E., T. L. Hanson and S. S. McLanahan (1994). "Family Structure and Child Well-Being: Economic Resources vs. Parental Behaviours." Social Forces **73**(1): 221-242.

Thorlindsson, T. (2011). "Bring in the social context: Towards an integrated approach to health promotion and prevention." Scandinavian Journal of Public Health **39**(6 suppl): 19-25.

Tita, A.T.N., J.S.A. Stringer., R. L.Goldenberg and D. J. Rouse (2007). "Two Decades of the Safe Motherhood Initiative: Time for Another Wooden Spoon Award?" Obstetrics & Gynaecology **110**(5): 972-976 10.1097/01.AOG.0000281668.71111.ea.

Tood, j., Maurer and R. H. Pierce (1998). "A comparison of Likert scale and traditional measures of self-efficacy " Applied Psychology **83**(2): 1998-329.

Travis, P., S. Bennett., A. Haines., T. Pang., Z. Bhutta., A. A. Hyder., N. Pielemeier., A. Mills and T. Evans (2004). "Overcoming health-systems constraints to achieve the Millennium Development Goals." The Lancet **364**(9437): 900-906.

Tripp, A. M. (2000). The politics of women's tights and cultural diversity in Uganda. Geneva, United Nations Research Institute for Social Development

Tripp, A. M. (2004). "Women's Movements, Customary Law, and Land Rights in Africa: The Case of Uganda." African Studies Quarterly **7**(4a).

UBOS (2006). Demographic and Health Survey. UBOS, Macro International Inc. Calverton, Maryland, USA.

UBOS (2009). 2009 Mbarara District Local Government Statistical Abstract. Kampala, Uganda Bureau of Statistics

UBOS (2010). 2010 Statistical Abstract. Kampala, Uganda Bureau of Statistics.

UBOS (2010). Uganda National Household Survey 2009/2010. Socio-economic Module. Kampala, Uganda Bureau of Statistics.

UBOS (2012). Uganda Demographic and Health Survey 2011. Kampala, Uganda Bureau of Statistics and ICF International.

Uganda (2006). Uganda National Household Survey 2005/2006: Report on the social economic module. UBOS, Uganda Bureau of Statistics, Kampala.

Uganda (2009). National Health Policy: Reducing poverty through promoting people’s health. M. o. Health. Kampala, Government of Uganda. II.

Uganda (2010). Health Sector Strategic Plan III 2010/11-2014/15. Ministry of Health, Kampala, Government of Uganda, Ministry Of Health.

Uganda (2010). National Development Plan 2010/2015. Ministry of Planning and Economic Development. Kampala, Republic of Uganda.

Uganda (2010). Uganda National Development Plan (2010/11 - 2014/15) Ministry of Planning and Economic Development, Kampala, The Republic of Uganda.

Uganda (2011). Health Sector Strategic Plan III 2010/11-2014/15. Ministry of Health, Kampala, Government of Uganda-Ministry of Health.

Umberson, D. (1992). "Gender, marital status and the social control of health behaviour." Social Science & Medicine **34**(8): 907-917.

Vega Jeanette, A. I. (2004). "Tackling health inequalities: new approaches in public policy " Bulletin of the World Health Organisation **82**(7).

Vickery, D. M. and W. D. Lynch (1995). "Demand Management: Enabling Patients to Use Medical Care Appropriately." Journal of Occupational and Environmental Medicine **37**(5): 551-557.

Visaria, L. (1993). Female autonomy and fertility behaviour: an exploration of Gujarat data. international Population Conference of Union for scientific study of Population, Liege, Beligum, IUSSP.

Wagstaff, A. (2002). "Poverty and health sector inequalities." Bulletin of the World Health Organisation **80**(2).

Wagstaff, A and E. V. Doorslaer (2000). "Income inequality and health: what does the literature tell us?" Annu. Rev. Public Health **21**: 542-67.

Waiswa, P., K. Kallander., S.Peterson., G. Tomson and G. W. Pariyo. (2010). "Using the three delays model to understand why newborn babies die in eastern Uganda." Tropical Medicine & International Health **15**(8): 964-972.

Walt, G. (1994). "How far does research influence policy?" The European Journal of Public Health **4**(4): 233-235.

Wamani, H., T. Tylleskar., A. Astrom., J. Tumwine and S. Peterson (2004). "Mothers' education but not fathers' education, household assets or land ownership is the best predictor of child health inequalities in rural Uganda." International Journal for Equity in Health **3**(1): 9.

Watts, C. and S. Mayhew (2004). "Reproductive Health Services and Intimate Partner Violence: Shaping a Pragmatic Response in Sub-Saharan Africa." International Family Planning Perspectives **30**(4): 207-213.

Watts, C. and S. Mayhew (2004). "Reproductive health services and intimate partner violence: shaping a pragmatic response in Sub-Saharan Africa." International Family Planning Perspectives: 207-213.

Weber, R., P (1990). Basic content analysis. Newbury Park Canada Sage Publications.

Whitehead, A. and D. Tsikata (2003). "Policy Discourses on Women's Land Rights in Sub–Saharan Africa: The Implications of the Re–turn to the Customary." Journal of Agrarian Change **3**(1-2): 67-112.

Whitehead, M. (1991). "The concepts and principles of equity and health." Health Promot. Int. **6**(3): 217-228.

Whitehead Margaret, G. D. (2006). Concepts and principles for tackling social inequalities in health: levelling up part I. Copenhagen, World Health Organisation.

WHO (1978). Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR. Washington DC, WHO.

WHO (2005). Action on the social determinants of health: learning from previous experiences A background paper prepared for the commission of Social Determinants of Health, Secretariat of the Commission of Social Determinants of Health, WHO.

WHO (2008). Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health. . Geneva, World Health Organization.

WHO (2010). Trends in Maternal Mortality: 1990 to 2008: Estimates Developed by WHO, UNICEF, UNFPA and The World Bank. Geneva, World Health Organisation.

WHO (2012). "Health statistics and health information systems." Retrieved 18 July 2012, 2012, from http://www.who.int/healthinfo/statistics/indbirthswithskilledhealthpersonnel/en/.

Wilkinson, G., Richard (2005). The impact of inequality: How to make sick societies healthier. New York, The New Press.

Wilkinson, G., Richard and M. Marmot (2003). Social Determinants of Health: The Solid Facts. Copenhagen, WHO.

Wilkinson, G., Richard and K. Pickett (2010). The spirit level: why equality is better for everyone. London, Penguin Books.

Wilkinson, R. (2005). The impact of inequality: How to make sick societies healthier. New York, The New Press.

Wilkinson, R. and M. Marmot (2003). Social Determinants of Health: The solid Facts. Copenhagen, The World Health Organisation.

Wilkinson, R. G. (1997). "Socioeconomic Determinants of Health: health inequalities: relative or absolute material standards?" BMJ: 314-591.

Wilkinson, R. G. (1997). "Socioeconomic determinants of health: Health inequalities: relative or absolute material standards?" BMJ **314**(7080): 591.

Wilkinson, R. G. (1997). "Socioeconomic determinants of health: Health inequalities: relative or absolute material standards?" BMJ **314**(7080): 591-.

Wilkinson, R. G. (1999). "Health, Hierarchy, and Social Anxiety." Annals of the New York Academy of Sciences **896**(1): 48-63.

Wilkinson, R. G. (2005). The impact of inequality: How to make sick societies healthier. New York, The New Press.

Wilkinson, R. G. (2006). Ourselves and others - for better or worse: social vulnerability Social Determinants of Health. M. Marmot and R. G. Wilkinson. New York, Oxford University Press.

Wilkinson, R. G. (2009). The impact of inequality: empirical evidence. Social Inequality and Public Health. S. J. Babones. Bristol, The Policy Press.

Wilkinson, R. G. and M. Marmot (2003). Social Determinants of Health: The solid Facts. Copenhagen, WHO.

Wilkinson, R. G. and K. E. Pickett (2006). "Income inequality and population health: A review and explanation of the evidence." Social Science & Medicine **62**(7): 1768-1784.

Wilkinson, R. W., Ed. (2006). Ourselves and others - for better or worse: social vulnerability and inequality. Social Determinants of Health. New York, Oxford University Press.

Woldemicael, G. (2007). Do Women with Higher Autonomy Seek More Maternal and Child Health-Care? Evidence from Ethiopia and Eritrea. Rostock, Max Planck Institute for Demographic Research. **MPIDR Working Paper WP 2007-035**.

Woldemicael, G. and E. Tenkorang (2009). "Women's Autonomy and Maternal Health-Seeking Behavior in Ethiopia." Maternal and Child Health Journal **14**(6): 988-998.

Wolff, B., A. K. Blanc and A. J. Gage (2000). "Who decides? Women's status and negotiation of sex in Uganda." Culture, Health & Sexuality **2**(3): 303-322.

Wolff, B. A. K.Blanc and J. Ssekamatte-Ssebuliba (2000). "The role if couple negotiation in unmet need for contraception and the decision to stop childbearing in Uganda." Studies in Family Planning **31**(2): 124-137.

World Bank (2005). Uganda: From Periphery to Centre; A Strategic Country Gender Assessment. Washington, World Bank - Poverty Reduction and Economic Management, African Region.

World Bank (2011). Demography and Economic Growth in Uganda. Washington DC, World Bank - Poverty Reduction and Economic Management Unit, African Region.

World Bank (2011). Uganda - Reproductive health at a glance. . Washington D.C, The World Bank.

Wyrod, R. (2008). "Between Women's Rights and Men's Authority: Masculinity and Shifting Discourses of Gender Difference in Urban Uganda." Gender & Society **22**(6): 799-823.

Yamamoto, M. (1986). "The place of primary health care in a comprehensive health system." Social Science & Medicine **22**(11): 1229-1234.

Yanda, K., S. V. Smith, et al. (2003). "Reproductive health and human rights." International Journal of Gynecology & Obstetrics **82**(3): 275-283.

Yates, R. C. K. Tashobya., V. O. Cruz., B. McPake., F. Ssengooba., G. Murindwa., P. Lochoro., J. Bataringaya., H. Nazerali and F. Omaswa (2006). The Ugandan Health system reforms: miracle or mirage. London, Kampala, Institute of Public Health, Makerere University, Uganda, Health Systems Development Programme, London School of Hygiene and Tropical Medicine, UK and Ministry of Health Uganda.

Zhang, D. and P. U. Unschuld (2008). "China's barefoot doctor: past, present, and future." The Lancet **372**(9653): 1865-1867.

Annex A: Question Guide for Lower District Health Services Assessment

Uganda's MHCP is composed of health facility based services and Primary Health Care (PHC) strategies such as intensifying health awareness, community participation in promotion and improvement of services, interface between service providers and consumers, monitoring and evaluation. The purpose of carrying out the health assessment in this study was to examine Mbarara District's Lower Health Centres strategies and practices for implementing primary healthcare programs.

Questions for Health Workers (Mbarara District Health Officer, In-charge Bwizibwera Health Centre IV and other selected Health Workers)

1. What are the components of the Uganda National Minimum Health care Package (NMHCP)?

2. How would you describe your progress in implementing the PHC programs?

(What do you do to deliver the NMHCP? How have you managed to deliver the UNMHCP? What are challenges for delivering the minimum health care package in your health facilities?)

3. How do you determine your priorities and how do you monitor PHC activities? (ask for budget allocations get it as per record)

4. How would you rate the Services being provided? (On a scale of 1 to 10)

5. How do you rate service provision at your Health Centre in general? (On a scale of 1 to 10)

6. How do you rate PHC services provision by your health facility? (On a scale of 1 to 10)

7. How important are community factors (social relations, social capital, gender…) to effective access and utilization of health care?

8. What in your view can be done to improve your access and utilization of these services?

10. How important is integrating facility based services and PHC strategies in attaining an effective health services delivery and utilization outcome?

Questions for the Local Community (local council leaders and Health Management Committee Members)

1. What does Primary Health Care mean to you?

2. What are some of the factors that determine utilisation of health care services by your community?

3. How important is integrating curative/facility based services and preventive/PHC strategies (community involvement in determining health agendas, health education …) in attaining an effective health services delivery and utilisation outcome?

4. Any related concerns?

Annex B: Household Survey Questionnaire

SURVEY QUESTIONNARE ON SOCIAL DETERMINANTS OF DEMAND FOR MATERNAL HEALTHCARE IN KASHARI, MBARARA, UGANDA

Informed consent

Dear Participant, You have been randomly selected to be part of this survey and we would, therefore, like to interview you.

This research is by Viola Nyakato of Mbarara University of Science and Technology, Faculty of Development Studies. The study is on Social Determinants of Demand for Maternal healthcare among the people of Kashari Sub County, Mbarara District. The questions will be mainly about factors such as women's social status, decision making hierarchy, distribution of household resources and chores and resource ownership and allocation particularly land ownership by women. Specific questions will be asked on use of selected maternal healthcare services (Family planning, Antenatal care and skilled care at birth).

The study is carried out for only academic purposes and your responses to questions will be treated with full anonymity. Your participation in the study is of high value and confidentiality in regard to your response is guaranteed. Your participation is voluntary and you can withdraw from the survey after having agreed to participate. You are free to refuse to answer any question that you do not feel confirtable with.

The interview will take approximately 40 minutes. I will ask you questions about:

The information you provide is totally confidential and will not be disclosed to anyone. Your name, address, and other personal information will be removed from the questionnaire, and only a code will be used to connect your name and your answers without identifying you. The Survey Team may contact you again only if it is necessary to complete the information on the survey. We are interested in only interviewing family heads of households or their spouses with children aged 5 years and below. *(ask if the household has a child aged 5 years and below and then continue with the interview after consent)*

Your participation is voluntary and you can withdraw from the survey after having agreed to participate. You are free to refuse to answer any question that is asked in the questionnaire.

If you have any questions about this survey you may ask me or contact (the Principal Investigator on 0772982535).

Signing this consent indicates that you understand what will be expected of you and are willing to participate in this survey.

Respondent______________________________

Interviewer_______________________________

Date _________/____________/_____________ Questionnaire ID No. ______________________

Section A: Respondent's Demographic Characteristics							
	Date of interview _______dd________mm_______yy Name of the village______________________ Parish ___________________sub-county_____________ Respondent's identification code___________________ Questionnaire number_________________						
1	Record sex as observed	1. Male		2. Female			
2	What is your age?	1. 18 - 19	2. 20 - 29	3. 30 – 39	4. 40 - 49	5. 50 - 59	6. 60+
3	Marital status	1. Married	2. Widowed	3. Divorced /Separated	4. Never married	5.Other specify	
4	How many wives do you have/does your husband have? ***(if ever /is married)***	1. One	2. Two	3. More than two			
5	What is your religion?	1. Catholic					
		2. Protestant					
		3. Pentecostal					
		4. Moslem					
		5. Others *Specify*					
6	What is the total number of your biological children *(all children one has had in life including the dead)*						
7	Total number of other family dependants/children other than bio-children (*aged 18 years and below*)						
8	What is the age of your youngest Child						
9	What is the total number of						

	people in your household? *(including parents and other adults)*				
10	In your opinion what do you think is the ideal number of biological children for a single family/couple in this community?	1. one to two	2. Three to Four	3. More than four	
11	Whom do you consider the head of this household?	1. Husband	2. Wife	3. Other (*specify*)	
12	What is your highest level of education?	1. Never attended formal school			
		2 Attended adult literacy classes			
		3. Attended primary education stopped in lower primary			
		4. Attended primary Education and completed primary 7			
		5. Secondary education less than four years			
		6. college 1 year to 3 years			
		7. Others (*specify*)			
13	What is your spouse's highest level of education?	1. Never attended formal school			
		2 Attended adult literacy classes			
		3. Attended primary education stopped in lower primary			
		4. Attended primary Education and completed primary 7			
		5. Secondary education less than four years			
		6. college 1 year to 3 years			
		7. Others (*Specify)*			
14	What is the household's main source of income? *(choose one answer)*				
		1. Digging/farming			
		2. Selling farm produce			
		3. Salaried job for the spouse			
		4. Salaried for the couple			
		5. Keeping animals			
		6. Keeping Poultry			
		7. Causal labour/working on others farms for pay			
		8. Other (*specify)*			
			1. Yes	2. No	15b If ***Yes***, how much
15	How much money did you receive in the last month from the following activities/work? *(Read out the responses for the respondent to tell you what they earned from the options given. Mark Yes if there was earning and No for no earning during the previous month)*	1. Digging/farming			
		2. Selling farm produce			
		3. Salaried job for the spouse			
		4. Salaried for the couple			
		5. Selling animals			
		6. Selling Poultry			
		7. Causal labour/working on others farms for pay			

16	Do you keep any of the following animals and how many? *(read out the options for the respondent and ask for)*		1. Yes	2. No	16b. If ***Yes***, How many
		Poultry			
		Goat/Sheep			
		Cattle			
		Pigs			
		None of the above			
		Others specify			
17	Does your household own any land?	1. Yes	2. No *(If **No** go to 22)*		
18	**If yes**, what form of ownership?	1. Customary 2. Registered/has a land title			
		3. Others (*specify*)			
19	**If has Land Title,** in whose name is the land registered?	1. Husband			
		2. Wife			
		3. Both husband and wife			
		4. Others (*specify*)			
20	**If Owns Land,** In your opinion, do you feel you have enough land for producing enough food for your family?	1. Yes	2. No		
21	**If Owns Land,** who has full say over sale and use of land in your home?	1. Husband	2. Wife	3. Both husband and wife	4. Other (*specify*)
22	Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 or more drinks on an occasion?	1. __ ___Number of drinks	2. Does not drink alcohol		
23	**Observe** and indicate the interviewees' type of housing	1. Permanent (bricks and iron roof)			
		2. semi-permanent (mad and iron roof)			
		3. Temporary (mad and grass/leaves thatch)			
		1. Other (*specify*)			
24	What is your household's main source of water?	1. tap in the compound			
		2. community tap			
		3. spring			
		4. Open well			
		6. borehole			
		5. water tank in the compound			
		7. Other (*specify*)			
25	What is your household main source of information?				
		1. Radio	4. community meeting		
		2. News papers	5. friends		
		3. Television	6. Others (*specify*)		
26	Do you have a toilet? (*ask to see)*	1. Yes	2. No		

Section B: Now I am going to ask general questions on health and use of healthcare			

No.	Question	Response			
27	Overall how do you feel about your health? (*at the moment)*	1. Very good			
		2. Good			
		3. Fair			
		4. bad			
		5. Very Bad			
28	How do you feel about the health of the children in your home *(aged 5 years and below)?* - ***observe and make relevant notes***	1. Very good			
		2. Good			
		3. Fair			
		4. bad			
		5. Very Bad			
29	In case of an emergency e.g. severe illness how easy can you use healthcare from the nearest health facility OR get care?	1. not easy at all	2. Somewhat easy	3. easy ***Go to 31***	2. very easy ***Go to 31***
30	***If answers 1 and 2 above***, which of these factors MOST describes your inability to use health care? *(choose only one factors that MOST applies to your daily life – read out the options)*	1. Cost of health care/low family income			
		2. Family Size			
		3. Being busy with household work and do not have time to seek health care			
		3. Alcoholism			
		4. Household food security and nutrition			
		5. My relationship with my spouse			
		8. Others (*specify*)			
31	When you are sick or need advice about your health, where/who do you consult first? (*select one that applies to the respondents answers, ask their first option every time they feel sick*)	1. A private doctor			
		2. Community health centre			
		3. A hospital outpatient clinic			
		4. A hospital emergency room or urgent care centre			
		5. An alternative health care provider (such as acupuncturist, chiropractor, traditional healer, or herbalist)			
		6. Other (*specify*)			
32	In the last 6 months, have you seen any health worker coming to your community to talk about health issues?	1 Yes	2 No		
33	In the last 6 months, have you attended any public talks on health?	1 Yes	2 No		
34	Have you in the last one month heard information about the following issues?		1 Yes	2 No	
		Antenatal care			
		Family planning			
		Skilled birth attendance			
		Immunisation of children			
		HIV/AIDS			

35	*If Yes for any of the above*, what has been the main source of health related information?	1. Health worker		
		2. Community leader		
		3. Friend		
		4. Community Health Worker		
		5.Radio program		
		6. Other (*specify*)		

Section C: Maternal healthcare access

I will now ask you about antenatal care, family planning, child birth and other related maternal health practices.

Note: use the name of the youngest child for some of the following questions

36	Do you/your spouse use anything to stop or control becoming pregnant?	1. Yes	2. No	3. Don't Know	
37	Which of the following modern contraceptives have you used before? (*multiple question, tick all that apply)* *Read out the options and tick responses*	1. Birth control pills			
		2. Shots (Depo-Provera)			
		3.Withdrawal			
		4. Rhythm method			
		5. Foam, Jelly, Cream			
		6. IUD			
		7. Norplant			
		8. Condoms			
		9. Tubes tied/Vasectomy (sterilization)			
		10. Other (*specify*			
		11. None			
36	***IF Using any Method:*** During the past 12 months, how often did you use birth control methods?	1. all the time			
		2. most of the time			
		3. Sometimes			
		4. Rarely			
		5. Others (*Specify*)			
39	The last time you were pregnant, did you intend to get pregnant/get your partner pregnant?	1. Yes			
		2. No, but wouldn't have minded			
		3. No			
40	Who decides the number of children the family should have?	1. Mother	2. Father	3. Both mother and father	4. Others (*specify*)
41	**Only Women:** Can you decide how many children you would like to have?	1. Yes		2. No	
42	Did you decide on the current number of children that you have?	1. Yes	2. Not sure	3. No	4. still producing

No.	Question	Response		
43	*If No/not sure:* Who decided on the current number of children that you have?	1. Husband		
		2. Wife		
		3. In-laws		
		4. God's plan		
		5. Other (*Specify)*		
44	During your/spouse pregnancy with (NAME), did you/your spouse attend ANC?	1. Yes	2. No	3. Don't Know
45	*If Yes*, were you/spouse given any information or counselled about HIV, the virus that causes AIDS?	1. Yes	2. No	3. Don't Know
46	Was HIV testing offered to you/spouse at any time during visits? (*please remember that whatever you say is confidential and will only be used for research purposes*)	1. Yes	2. No	3. Don't Know
47	*If **Yes** attended ANC:* After how many weeks/months of pregnancy with (NAME), did you/your spouse first visit/attend ANC? (*at how many months of your pregnancy was your first visit*)	1. Less than 4 weeks (*less than 1 month*)		
		2. 4-12 weeks *(1 to 3 months)*		
		3. 16-28 weeks *(4 to 7 months)*		
		4. >28 weeks *(above seven months)*		
		5. Don't Know		
48	*If **Yes** attended ANC:* During the pregnancy with (Name), who did you/spouse see most?	1. Doctor (including specialists		
		2. Nurse/Midwife		
		3. Auxiliary nurse of midwife (including student nurses, nurse aides etc		
		4. TBA or other untrained person/relative		
		5. Others *(specify)*		
49	During your/spouse pregnancy with (NAME), did you suffer from malaria?	1. Yes	2. No	3. Don't Know
50	If Yes, did you seek medical care?	1. Yes	2. No	3. Don't Know
51	If Yes, where did you seek medical care?			
		1. at a health centre operated by Government		
		2. at a private clinic/facility		
		3. drug shop/pharmacy		
		4. outreach services/community health work		
		5. at home, gave drugs/self medication		
		6. at an alternative practitioner/used herbs		
		7. others *specify*		
52	If No, Why? *(tick only one answer that most applies to the response given)*			
		1. I got fine and did not need treatment		
		2. I lacked money for Transport		
		3. I lack money for treatment		
		4. I lacked time		
		5. I used traditional medicine/herbs		
		6. I thought it was not a medical case		
		7. others *specify*		
53	*If attended ANC*, did you receive medicine to prevent Malaria?	1. Yes	2. No	3. Don't Know

54	When you/spouse gave birth to (NAME), who assisted you in delivery?	1. Doctor (including specialists			
		2. Nurse/Midwife			
		3. Auxiliary nurse of midwife (including student nurses, nurse aides etc			
		4. TBA			
		5. Relative/friend with no medical training			
		6. Other (*specify)*			
55	Where did you/spouse give birth to the youngest child (NAME)?	1. Hospital or Health centre (level IV)			
		2. Private clinic/NGO health facility			
		3. at home			
		4. outside (such as field, transport, street, market etc)			
		5. Other (*specify*)			
56	*If delivered in hospital or any other health facility*; Was it government operated or private	1. Government aided	2. private (including private not for profit/NGOs)		
57	*If delivered in hospital or any other health facility*; What is the distance to the health facility?	______________Kms			
58	*If delivered in hospital or any other health facility*; Approximately how much money did you spend during the time when you were at the health facility?	______________Shillings			
59	For all your children's births, how many times has your spouse (have you) been present? *Ask for the presence of men during delivery*	1. Not at all	2. The first born	3. All the children	4. Sometimes
60	When you delivered from the hospital/health centre, has (your spouse/you) been allowed to be present during child birth?	1. Yes	2. No		
61	How do you feel about the presence of your spouse/your presence during child birth?	1. Not Necessary at all	2. Somewhat necessary	3. Necessar y	4. Very Necessary
62	**Only Men**: have you ever attended ANC with your wife?	1. Yes	2. No		
63	**Only Men**: have you ever taken your child for immunization?	1. Yes	2. No		

Section D: Socioeconomic and Cultural inequalities – attitudes, practices and behaviours:

I will now ask you questions on community relations, decision making and domestic relations

64	What do you think about the position of your household in your community?	1. Not influential at all	2. Occasionally Influential	3. Sometimes Influential	4. Very Influential
65	In the last 12 months, have you attended any community meeting?	1. Yes	2. No		
66	If yes, did you contribute to the discussion?	1. Yes	2. No		
		1. I was not invited to any community meeting			

		2. I did not feel confident to be part of any meeting			
		3. I lacked time to attend a meeting			
		4. Others *Specify*			
67	What do you think about your position in your home?	1. Not influential at all	2. Occasionally Influential	3. Sometimes Influential	4. Very Influential
To what extent do you agree with the following statements?					
68	I feel my spouse treats me with respect	1. not at all	2. a little bit	3. quite a bit	4. extremely
69	I feel my spouse treats me unfairly	1. not at all	2. a little bit	3. quite a bit	4. extremely
70	I fear my spouse may be violent	1. not at all	2. a little bit	3. quite a bit	4. extremely
71	**If owns land,** I feel insecure on my land?	1. not at all	2. a little bit	3. quite a bit	4. extremely

			Wife	Husband
72	In your home, who makes most of the decisions regarding the following:		Wife	Husband
		1. How much money to spend on home items like food and clothing		
		2. Wife visiting friends and relatives		
		3. Wife going anywhere outside home like going to market		
		4. Gardening		
		5. Taking children to hospital/clinic/health centre		
		6. Wife going for antenatal care		
		7. Wife going to hospital to deliver		
		8.Child going to school		
		9. Purchase of land		
		10. Sale of land		

73	Who makes most of the decisions regarding family income resources in your home?				
		1. Husband			
		2. Wife			
		3. Any of us available at the time of need			
		4. Consultative			
		5. Others (*specify*):-			
74	When a child is in a mistake, who is to blame?	1. Mother	2. Father	3. Other (*specify*)	
		Any comments ;-			
75	Have you ever been physically abused by your spouse?	1. Yes	2. No		
76	If Yes, in the last 6 months how often has your spouse physically abused you?	1. Never	2. Occasionally	3. Sometimes	4. Frequently
77	How often is your spouse willing to help you with work around home?	1. Never	2. Occasionally	3. Sometimes	4. Frequently
78	How often do you do things together with your spouse?	1. Never	2. Occasionally	3. Sometimes	4. Frequently
79	How open are your discussions with your	1. Not open	2.	3. Sometimes	4. Always

	partner?		Occasionally	open	
80	Have you and your spouse in the last 6 months had time together planning for your family needs such as food, health care and income sources?	1. Yes		2. No	

Attitude towards household work and division of housework according to sex

81	In the last 24 hours, between 9 a.m. and 5 p.m. weekdays, how did you spend most of your time?	1. Doing housework or home making
		2. In the garden digging
		3. At my work location outside my home
		4. Visiting friends
		5. At the trading centre taking alcohol
		6. Others (*specify*);-

82	In the last 24 hours, how much time did you spend on the following activities?	**A.** *(<2 hours)* **B.** *(3 to 5 hours)* **C.** *(6 to 8 hours)* **D.***(>8 hours)*	
		1. Digging	
		2. Caring for children	
		3. Cooking	
	(read out the options one at a time for respondents to tell you the time and make sure the estimated time is realistic and indicate using the above options)	4. Fetching fire wood	
		5. Caring for the sick	
		6. Selling farm produce	
		7. Cleaning the home	
		8. Fetching water	
		9. Washing	
		10. Caring for animals	

83	In order of importance, rate the following activities on the scale of 1, 2, 3 and 4 (**1** meaning very important and **4** least important)		**1.**	**2.**	**3.**	**4**
		1. Digging				
		2. Caring for children				
		3. Cooking				
	(tick given rank)	4. Fetching fire wood				
		5. Caring for the sick				
		6. selling farm produce				
		7. Cleaning the home				
		8. fetching water				
		9. Washing				
		10. Caring for animals				

84	Of your parents or guardians (man and woman) when you grew up, how often did you see your (1.mother/woman, 2.father/man) do the following tasks?		1. Mother/woman	2. Father/man
		1. Digging		
	a) Always	2. Caring for children		
	b) Often	3. Cooking		
	c) Sometimes	4. Fetching fire wood		
		5. Caring for the sick		

	d) Never ***indicate the response in the left columns to show how often mother/woman or father/man did the tasks***	6. Selling farm produce		
		7. Cleaning the home		
		8. fetching water		
		9. Washing Clothes		
		10. Caring for animals		
		11. Providing money for family needs		

I will now ask you to express how often women as compared to men do each of the following work:

85	In your home, the woman does the following work more often than the man. 1.Yes, Always 2. Yes, Most of the time 3. No, they do the work about equally 4. No, they do the work less often than men 5. No, women never do this activity ***indicate the response in the left columns to show how often women than men do the tasks***	1. Digging	
		2. Caring for children	
		3. Cooking	
		4. Fetching fire wood	
		5. Caring for the sick	
		6. Selling farm produce	
		7. Cleaning the home	
		8. Fetching water	
		9. Washing Clothes	
		10. Caring for animals	
86	In this community, women do the following work more often than men. 1.Yes, Always 2. Yes, Most of the time 3. No, they do the work about equally 4. No, they do the work less often than me 5. No, women never do this activity ***Indicate the responses in the left column***	1. Digging	
		2. Caring for children	
		3. Cooking	
		4. Fetching fire wood	
		5. Caring for the sick	
		6. selling of farm produce	
		7. Cleaning the home	
		8. fetching water	
		9. Washing Clothes	
		10. Caring for animals	

87. *To what extent do you agree with the following statements?*

A	In this community, women can have control over family resources even when their husbands are absent	1. Strongly Disagree	2. Disagre e	3. Agree	3. Strongly agree

B	In this community in the last one year, women have carried out activities that bring income to the family than men have been able to do.	1. Strongly Disagree	2. Disagre e	3. Agree	4. Strongly Agree
C	In most cases when a woman is absent from the home, most men in this community can fail to know what to do with family chores such as care for children, cooking, cleaning around the home, etc ……..	1. Strongly Disagree	2. Disagre e	3. Agree	4. Strongly Agree
D	It is okay in this community for young boys when they feel or t have nothing to do, they can go away from home ***e.g. play with fellow boys, visit friends but girls should remain at home and help with household chores***	1. Strongly Disagree	2. Disagree	3. Agree	4. Strongly Agree

8 9	Have you in the **last one month** felt like carrying out a task you take to be of the opposite sex but feared what others would think about your ? *If yes mention some of those activities (make notes)*	1. Yes	2. No

90. **Community suggestions on how to improve use of maternal health services offered at government aided health facilities:** In your opinion how can the use maternal healthcare improve? (In order of priority mention at least **4** major factors which can improve use of maternal healthcare)

Annex C: Interview guide for Individual and Group Discussions in Communities on Social Determinants of Demand for Maternal Health Services in Kashari, Mbarara, Uganda

Introduction: I am Viola Nyakato from Mbarara University of Science and Technology, Faculty of Development Studies. I am carrying of a study as part of my PhD studies at Mbarara University of Science and Technology on Social Determinants of demand for maternal healthcare among the people of Kashari Sub County, Mbarara District. The questions will be mainly about factors such as women's social status, decision making hierarchy, distribution of household resources and chores and resource ownership and allocation particularly land ownership by women.

The study is carried out for only academic purposes and your responses to questions will be treated with full anonymity. Your participation in the study is of high value and confidentiality in regard to your response is guaranteed. Your participation is voluntary and you can withdraw from the survey after having agreed to participate. You are free to refuse to answer any question that you do not feel comfartable with.

Do you agree to participate in the study? Yes No

Section A: General information on maternal health

1. In your opinion how do you describe the health of women during pregnancy and after birth? (What are the main health problems and practices towards preventing disease and improving health during this period?)
2. In your opinion, what do you think affects the use of health services targeting to prevent disease that affects women of reproductive age? How is the use of ANC, family planning and skilled birth attendance in this community? What hinders use of these services? ***Probe for:*** *the main factors that hinder timely use of modern health services provided by government aided health facilities.*

The responses will help answer the following questions:

a. It has been found out by some studies that most women attend antennal care only one time and in most cases when they are about 5 months pregnant and very few go at least 4 times and earlier than 4 months as recommended in health care. Why do you think this is so?
b. Where do most women in this community deliver from? Assuming that in your community you have equal access to a traditional midwife and a modern health unit with qualified doctors and nurses, there is an expecting mother, where is she likely to deliver from and why? (***probe for*** *the more likely choice not what they think is the ideal)*

Section B: Women's social status, decision making, power relations and couple/family relations

3. How would you describe the relations among married people in this community? *(probe for domestic violence and overall couple relations)*
   a. What do you define a good relationship with a spouse to be? /what are the components of a good marital relationship? *(**Probe:** do relationships make any differences difference in use of maternal healthcare?) How do the husband and wife relations affect use of healthcare access by women?*
4. How are decisions made in most families? (Of the husband and wife who make what decisions to do with health care, shopping, family planning, faming and child education, what decisions do women make and what decisions do men make?)
   a. For example, who decides the when a child has to be taken for treatment, sell of family properties, where to deliver from and why? When a child is in a mistake who is to blame and why?
   b. How does the decision making process look like? How does decision making affect women's autonomy over their health needs? (***Probe:*** *are women having any autonomy on allocation and utilisation of family resources? E.g. can a woman sell a family goat, cow, chicken, land if she needs money for any form of health care without the consent of her husband in case he is not around?)*
5. How would you describe the status of women in this community?
6. How does the status of women affect willingness and ability to use health services for women of reproductive age?

Section C: Division of household labour and women's health outcomes

7. What do you consider to be the main work done around home? How is the work shared at the household level? /who does what and why?
8. Does the way work is shared at home affect health behaviours? How does the current share/distribution of work/division of labour affect the overall family health behaviours?/ How does the current sharing of work affect the overall wellbeing of the family? *(Timely use of health services?)*
9. Do you think the distribution of work by gender affects the health of women? If yes how and if no why do you think so?
10. Are there any benefits when a husband and wife share/help each other in household work? What are the benefits? What some of the cultural beliefs and attitudes, do you think can affect sharing of house work?

Section D: ownership of land and other resources by women

11. Are women allowed to own any resources in this community? What resources are they allowed to own traditionally and which ones are they not allowed to own and why? In this community, *what resources are to be exclusively owned by men and why?*
12. Do women own land? If yes how do you define women ownership of land and if no why? (***Probe:*** *how does this community define women's ownership of land? if women do no own land, how secure are they?)*
13. **Women,** to what extent do you feel secure on your family land? (Do you fear that your spouse may sell off land or any other family without your consent?)

Section E: Interview guide for health workers

1. What do you consider to be the major health problems affecting women in this community?
2. What are your health care priories for women? How do you determine the priorities?
3. What do you do to improve use/demand for healthcare targeting women? How do you capture people's interest to use health care?
4. Do you have any health programs that involve the community? Which ones and how do you involve the community? What has worked and what has not worked and why?
5. How do you think use/demand for health care can be improved?