



Women on the Margin, Decision-making and the Unmet Need for Maternal Health in Rural Mbarara District Uganda

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Abstract - This paper presents research findings from a study that was conducted between September 2009 and December 2010 in Mbarara District, Southwestern Uganda. The study examined intra-household social determinants of demand for maternal health care including family planning practices. A wide range of questions were included in a household survey to assess maternal healthcare decision-making. Among most Ugandan communities, household resource allocation and decision-making follow a hierarchy whereby men/husbands direct the process for allocation of resources. 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 the maternal health services. It was found that more than half of all maternal healthcare decisions that women make are in many ways influenced by men/husbands.

Keywords - Women, Decision-Making, Family Planning, Rural, Uganda

1. Introduction

In Uganda, the prevalence of contraceptive use is estimated at 30% among married women, 52% among the sexually active unmarried women and 34% for both categories all together (UBOS 2006b; UBOS 2011). Uganda's fertility rate is estimated at 6.9 children per women (Simkhada, Teijlingen et al. 2008; WHO 2010). Mbarara District's total fertility rate is estimated at 7.0 children per woman and contraceptive prevalence rate is 30% (Mbarara District Health Report 2010).

According to Parkhurst et al. (2006), barriers to women's access to maternal health care in low-income settings are clearly defined and these barriers 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.

Evidence shows that majority of women in most developing countries like Uganda are faced with high unmet need for contraceptives that is worsened by women's limited bargaining power to allocate family resources (Blanc 2001; Kaye et al. 2006; Kabakyenga et al. 2011). In Uganda, women's limited decision-making autonomy at the household level have has been associated with poor maternal health behaviours (Kyomuhendo 2003; Parkhurst et al. 2006). 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, male

involvement is a key factor in community acceptance of prevention programmes such as condoms use and Prevention of Mother to Child Transmission of HIV/AIDS (PMTCT) programmes (Byamugisha et al. 2010). 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.

Additionally, the unmet need for family planning has multiple manifestations which are distinguishable from those directly affected by actual accessibility (Bankole & Singh 1998; Simkhada 2008) and those indirectly affected by women's decision-making inabilities (Ensor & Cooper 2004). Whereas evidence indicating women's limited decision-making ability has grown, there is still limited policy and research attention on how unmet family planning decision-making relates with women's lack of power to access and allocate household resources.

Aim of the Research: In particular, the paper is intended to explain the link between intra-household decision-making dynamics and women's ability to control being pregnant. It broadens the debate on access to contraception through examining women's intra-household decision-making margins i.e. what women can and cannot make a decision to do. The paper presents and discusses results from a study on gender trends in decision-making and allocation of resources among rural household of Mbarara District in Southwestern Uganda.

2. Subjects and Methods

The study was conducted in Mbarara District, southwestern Uganda. Fifty five percent (55%) of Mbarara District's population is under 18 years and only 5% are above 60 years old. The population of Mbarara district stands at 418,200 with 204,300 men and 213,900 women with an average population growth rate of 2.8% (UBOS 2009). For the last three decades, the total fertility rate of the district was 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 District Health Report 2010). Most of the district's communities are predominantly agricultural, and farm work is the major household activity on which men and women spend their time.

A household survey was conducted in December 2010 among 202 females, aged 20 to 49 years, and 66 males, ages 20 to 60+, who responded to questions on household division of labour, intra-household decision-making dynamics, land access and ownership, gender relations and use maternal healthcare. In addition, seven key informants were interviewed and seven focus group discussions were held, (4 with women and 3 with men), to gain an in depth understanding of role sharing in the community. Likert scales 1 – 4 were developed to study variance in agreement on who does most of the work and the gender differences in attitudes towards the selected categories of house work.

The statistical analyses included cross tabulations, bivariate correlations, and Analysis of Variance (ANOVA), which controlled for the effect of age, education, level of education, main source of income, use of alcohol and main source of information. All statistical tests were carried out against a bench mark level of significance of $\alpha = .005$. Level of education, age, main source of income, ownership of land, head of household were the main demographic variables. There was significant multi-co linearity for most of the independent variables. The main limitation of the study is that it was limited to how spouses share roles excluding the other members of the family and workers.

3. Results

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 land tenure 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.

Findings indicate gender differences in decision-making in allocation of family resources including controlling being pregnant. In this study it is indicated that the husband rather than the wife makes most of the contraception decisions and household social and economic decisions¹ (see table 2 and 6). It was found out that being a household head is an important factor in determining access to maternal healthcare intra-household decisionmaking dynamics; 95% of all households are head by men and less than 5% by women. Being a head of the household was found to be endowed with decision-making authority. It is also indicated that only 34% of women in rural Mbarara use contraceptives to prevent being pregnant. While 61% of people can control the number of children to have, more than 6 in every 10 people who cannot decide on the number of children to have are women.

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

Table 1. Use of Contraceptives

Use of Contraceptives 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%

Source: Nyakato, 2014

In this paper, inconsistency use of contraceptives is reflected by whether the recent pregnancy was intended or did not plan to be pregnant but when it happened they accepted they pregnancy. Results indicated that 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).

¹ For instance the research discovered that one the reason men dominate household decision-making is because land ownership is culturally reserved for men. Land is an important factor in Uganda since it is a basic source of livelihood for both men and women.

Another central question for determining unmet need for contraception was on who is the principle decision-maker in deciding the number of children one should have. Although the majority in Table 2 below - (45% N.128), believe that couple jointly decide the number of children, fathers/men (33% N. 94) have a much higher influence on the number of children a couple can have mothers/women (21% N.60). 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, with women depending on their

husbands for decisions, and men being solely responsible for household social, political and economic decisions. 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 contraceptive use without the husbands permission was one cause of domestic violence. Women who can make their own decisions regarding family planning have been found to be more likely to use contraceptives than those who cannot (Ensor & Cooper 2004).

Table 2. 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%

Source: Nyakato, 2014

Decisionmaking 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 to have the next child and combining men and women 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 2 above shows that husbands/fathers 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. Respon-

dents who said they did not decide on the number of children they had (16% N.46) were asked who then decided on the number of children to produce. 50% (N.141) of the respondents said it was God's plan that they had the children that they have, while 35% (N.101) said it was a husband's decision, only 9% (N.25) say that the women is in control, and 2% (N.6) cited the current number of children to the influence of 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; DeRose & Ezeh 2010) particularly Uganda, religion still determines people's fertility decisions (Homsy et al. 2009).

Table 3. Household Decision-Making for Use of antenatal care (ANC), Skilled Care at Birth and Number of Children

Questions	Husband	Wife	In-law
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)	46% (n=131)

Source: Nyakato, 2014

Note: the question on who decides the number of children a family should have provided an option for influence of decisions by in-laws and it was indicated that 46% (n=131), of the decisions on the number of children is influenced by in-laws.

Results from the question in Table 3 above 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). Studies have attempted to related the high rate of visiting health facilities to access ANC at least one to women's need to know the wellbeing of the pregnancy and fear of the health workers treatment in times of emergency (Kyomuhendo 2003), however, to increase ANC visits to the recommended four times during a pregnancy, there is need to mitigate other factors especially the rigidities in the health facility schedule and the influence of husbands and quality

couple relations. In the next section, there is a description of household factors and the way they affect women's access to maternal health services.

Determining the implications of basic socio-demographic characteristics on use of maternal services, Pearson χ^2 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. Majority of the study 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. The maximum number of children per household was 4 with a mean of 3.88 and a standard deviation of 2.44 children. 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.

Table 4. Determining the level of significance between respondents' socio-demographic characteristics and use of maternal services

Demographic Characteristic Variables		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 χ^2	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 χ^2	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 χ^2	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 χ^2	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 χ^2	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 χ^2	14.13	2.47	14.13	4.80	19.68
	Pr	.118	.481	.118	.570	.073
	N	283	283	283	283	283

Source: Nyakato, 2014 * Pearson Chi2 is significant at the 0.05 level.

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.

The above Table 4 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 whether 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 ultimately decide the number of children to have. Women (46%) than as opposed to men (62%) were also 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.

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). Previous studies from places where patriarchy is predominant have found that household head is a symbolic decision-making role of husbands (Jackson 2012; Rao and Hossain 2012). Similarly,

in this study it was found out that 95% of the households in rural Mbarara district are headed by men as they make and influence most of the household decisions. Findings also show that 93% of decisions to purchase and 78% to sale land are by men.

Table 5. 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%

Source: Nyakato, 2014

This study's findings on land decision-making dynamics are consistent with other studies, where land tenure is the ultimate source of livelihood for most of Uganda's population (Deininger et al. 2008). In addition, for men land ownership is associated with conception of identity and masculinity, and so it is also a man's responsibility to purchase land (Sen 1987). The sale of family land is legally protected by the requirement to secure 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 woman own land, does she know where I got it from,... it is unbelievable to 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 of land, 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)

On the contrary, 95% of decisions regarding gardening (preparing for planting, planting, weeding and harvesting), were made by women. In Uganda, farm work especially in rural areas is predominantly the work of women, they do most of the gardening role as men take on the selling of farm produce. In South-western Uganda where this study was conducted, farming contributes a monthly average income of 13 US Dollars, 73% of households' income comes from farm work, followed by casual labor 9% salaried job for spouse (5%) keeping and sale of animals (2%) (Nyakato, 2013a).

The reversed gender difference in decision-making (see table 5 above) for gardening verses sell and purchase of land could be associated with the findings from this research which revealed that 74% of people who spend more than 6 hours on farm work were women. Prior studies have indicated that women in Uganda provide more than 70% of farm labour, but with unequal access to land (Place & Otsuka 2002; World Bank 2011). Limitations on women decision-making, particularly on the sale of land could also be attributed to Uganda's customary land laws which restrict women's ownership of land and other household properties (Doss 2012). Land ownership also had a crosscutting significant relationship with decision-making on the number of children a couple can have (P value .010) and whether the last pregnancy was intended (P value.010). Ninety (97% n=264) of the people of Kashari County Mbarara District, Southwestern Uganda claim to own land.

The study found that while about 7 in every 10 women felt insecure on their family land, only 2 men in every 10 men shared such fears. This study's findings indicate that household land ownership significantly affects decision-making for the number of children in a family (p-value .001). Land use decision-making was found to significantly influence skilled birth attendance and use of antenatal care during the last pregnancy. It is evident that women lack the power to influence allocation of household resources a factor that cannot be ignored in the study of failures to mitigate unmet need for family planning among Uganda's women.

Table 6. 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 χ^2	.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	Pearson χ^2	.128	1.13	3.10	1.05	11.14

months	Pr	.938	.569	.542	.984	.517
	N	283	283	283	283	283
How often contraceptives were used during the last 12 months	Pearson χ^2	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 χ^2	.840	16.97(*)	1.64	9.77	20.97(*)
	Pr	.657	.000	.440	.135	.007
	N	283	283	283	283	283

Source: Nyakato, 2014 * Pearson Chi2 is significant at 0.05 level.

In Table 6 above, the Pearson χ^2 tests indicate a significant relationship between land ownership and decision-making dynamics with maternal health care decision making in a number of following:

While land ownership does not have a direct significant relationship with the use of maternal health services, consensus about whether a household has enough land to produce food for its family members and the security of land had 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% stated otherwise. 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 the majority of people feel secure on their land, the study indicates that 5 in every 10 respondents 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 casual farm labour. Land is the main economic resources for household and its gendered ownership affects maternal health seeking behaviours. Studies elsewhere have modeled the effect of land as an asset where its ownership is often used as a proxy for bargaining power (Deere et al 2012). Such an analysis neglects how male social dominance and the gendered allocation of land create the 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 paper measures the effect of land use decision-making on use of maternal healthcare in Kashari County Mbarara District.

4. Discussion

According to national level statistics, Ugandan married 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 2006a). This study found out that 93% of all decisions to purchase or and owner land decisions and 78% of sale of land decisions are made by husbands. On the contrary, women make 95% of decisions regarding gardening (physical working on the land). 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 trends and access to livelihoods assets (Ellis & Bahiigwa 2003).

This study found that a husband unlike 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 the allocation of resources affect reproductive decision-making. The balance of gendered power, in spousal relationships impact and condition women's health behaviours (Sen 1987). Poor family relations, and communication among couples in particular, make women vulnerable to unwanted and unplanned pregnancies (Wolff et al. 2000; Nyakato 2014).

Kabeer (1999) 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. For example, when women earn economically, they often face opposition in decision-making constituted in male authority. 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 Uganda, women's reproductive health decisions are limited by their reliance on their husband's control of household assets (Parkhurst, et al. 2006; Nyakato 2013b).

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. 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). Previous studies on health demand have concluded that most women's decisions to use maternal healthcare are predetermined by their spouses (Ensor & Cooper 2004).

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 based on differences on who makes decisions for land sale and purchase, and who does the gardening. Importantly for this paper, while women can influence 95% of decisions for gardening, they can only make 22% of the decisions for sale of land and only 7% of decisions for land purchase. On the reverse end, 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 & Tsikata 2003). In this paper, land use decision-making present a case for how household level material resource allocation can compromise maternal health.

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 comfortable with a woman who has land"* (individual interview – Local Council Secretary 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 convince her and we sell and buy another piece which I can control. You cannot do much if it is 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 & Kevane 1999). For women this is an insecure tenure with diverse implications on the nature of couple relations and use of maternal healthcare. Women's limited land rights make them submissive to their husbands decisions a finding that proves Sen's model on gender and cooperative conflict which analyses the effect of gendered intra-household inequalities and decision-making (Sen 1987). The gendered cultural restrictions on land ownership in Uganda, most certainly have impact on their choice to control being pregnant (Nyakato, 2013a)

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), Uganda's 1998 Land Act only provides protection for women and children against customary and community practices, though it denies the right of ownership to women and does not provide women with equal rights to land. Rather the Land Act rather provides two legal protections during marriage, one being spousal consent before their residence and surrounding before the sale of family land, and two the wife's right to occupy family land (Giovarelli 2006). However, studies show that Land Act has not reduced land conflict and land grabbing from women (Deininger & Castagnini 2006), and it is not uncommon that men sell off their land without the consent of their wives (Tripp, 2004).

Contradictory decision-making dynamics that compromise both women's livelihood and maternal health behaviours are imbedded in the land access customs and women's social status. 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 & Tsikata 2003). Restricted decision-making leave women no choice but to live and depend on men's decisions, which in many ways compromise their maternal health autonomy and choice. 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. In the study by Koenig et al. (2003), women's use of contraceptives has been associated with domestic violence, and women who insisted on use of condoms or were found to use contraceptives without their partners knowledge were at risk of being physically abused by their husbands.

5. Conclusion

In conclusion, in Uganda, unmet need for family planning is significantly affected by men's symbolic role of household head and the reserved right to own land. Women's decision-making is thus marginalised by the cultural restrictions

on land ownership and men's reserved role to allocate resources land inclusive. Until women can independently make decisions without open confrontation of their husbands/partners, use of maternal health services in rural Mbarara and Uganda in general will remain a challenge.

Most of the land ownership remains customary, passed to male children mainly at marriage. Irrespective of the type of ownership, land decision-making dynamics were found to significantly influence maternal health behaviours among women of Mbarara District south western Uganda. Household maternal healthcare decision-making is ultimately based on 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 little choice other than to partake the will of men. Further research should be carried out to determine the psychological barriers to women's access to health care resulting from uncertainties surrounding land security and ownership.

In addition household land is a source of identity and belonging of which women's claim is to marriage and production of family food. Women do not only lack economic power, they are socially dependant on their husbands, when women depend on men, their health is in the hands of someone who may not understand or care about what best suits their health needs. For women the value of land encompasses the fact that it is their source of employment and livelihood. The majority of the women in Kashari County, Mbarara District spend at least 6 hours of their work hours working on the farm and the rest of the time doing 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 important to conclude that women's limited land tenure affects maternal healthcare decision-making. This is because women's undefined land access status in a subsistent agricultural dependent community can be equated to an oppressed social status. That is to mean, women in Uganda do not have defined land tenure yet they solely depend on land for their labour.

While age and level of education were found to be significantly associated with maternal health behaviours, this paper indicates that men's symbolic decision-making role and ownership of land are other factors that cannot be ignored in maternal health debate in settings such as Uganda. In this context women land ownership status is not streamlined requiring that a subtle bargain. Promote women's autonomy. Land use decision-making procedures should be redefined by finding material resources equivalent to land for women's ownership.

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