Women Household Decision Making Power, its Determinants, and Maternal Mortality: A Conceptual Analysis

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Abstract
The high level of maternal mortality, particularly in developing countries, has attracted different studies aimed at identifying socioeconomic factors associated with maternal healthcare service utilization. Women status in the form of household decision making power and its determinants are one of these factors explored by various empirical studies. Though significant associations between women household decision making power, its socioeconomic determinants, and maternal healthcare service utilization were revealed, conceptual analysis of these relationships was given less attention in the studies. This study therefore analyzes the conceptual relationships between women household decision making power, its determinants, and how it consequently affect maternal healthcare service utilization and maternal mortality. The study brings to light the conceptual relationship between women household decision making power and maternal mortality for more policy attention, and provides supportive explanations to the findings of the previous empirical studies.

Keywords: *Maternal mortality, women status, maternal healthcare, conceptual analysis*

Introduction

The unacceptably high level of maternal mortality in the developing nations is a serious concern to global development. In 2015, at the end of the Millennium Development Goals (MDGs) which sought to reduce maternal deaths per 100,000 live birth by 75% between 1990 and 2015, the world recorded 303,000 maternal deaths (United Nations, 2015). The developing nations contributed 99% of these deaths. About 830 maternal deaths occur daily at global level today. Of this deaths, 180 and 550 occur in South Asia and sub-Saharan Africa respectively, compared to only 5 in the developed countries (World Health Organization, 2018). The global maternal mortality is therefore a developing nation's problem. However, married women in the developing nations, who are mostly the direct victims of maternal deaths, suffer low status in the households and the society in general (Khanna & Sri, 2016; United Nations, 2015b). The inadequate and lack of access to utilization of maternal healthcare service by women in the developing countries has been identified to be associated with their low status in the household.

Women status in the household is measured in different empirical studies in terms of their ability to take and participate in three household decision making dimensions – decision on health, decision on major household purchase, and decision on visits to family and relatives (Furuta & Salway, 2006; Ghose et al., 2017; Haider, Qureshi, & Khan, 2017; Hou & Ma, 2013). Having any of this decision making power has been identified to be significantly associated with increase in the utilization of maternal healthcare services such as antenatal care, postnatal care, birth in health facility, and use of contraception in some developing nations (Adhikari, 2016; Ameyaw, Tanle, Kissah-Korsah, & Amo-Adjei, 2016; Fawole & Adeoye, 2015; Ganle et al., 2015; Ghose et al., 2017; Hou & Ma, 2013; Tiruneh, Chuang, & Chuang, 2017; White, Dynes, Rubardt, Sissoko & Stephenson, 2013). Similarly, some socioeconomic factors have been identified to have great influence on women household decision making power. Acharya, Bell, Simkhada, van Teijlingen & Regmi (2010), Wiklander (2010), Sultana (2011), Assaad, Nazier & Ramadan (2014), Khan (2014), Dito (2015), Jahan, Hossain, & Mahmud (2015), and Duah & Adisah-Atta (2017) revealed that

woman's education, husband/partner's education, employment/wealth, Mass media, woman's age and age at marriage, social and cultural norms are significantly associated with women household decision making power.

However, most of these studies were majorly concerned with finding only the significant relationship, and gave less attention to the conceptual analysis of how the relationship works. Though there are studies that give frameworks for analyzing the determinants of maternal mortality, most of the frameworks are general and give more concentration on the health system factors (Filippi, Chou, Barreix, & Say, 2018). The famous and widely known framework of Mccarthy & Maine (1992) described the distal (socioeconomic and cultural factors) and intermediate (healthcare and health system factors) determinants of maternal mortality, of which women status falls under the distal determinants. Some other previous frameworks also highlighted the socioeconomic and cultural determinants of maternal mortality (Calvello, Skog, Tenner, & Wallis, 2015; Chera, Zlotkin, & Thind, 2015). In the previous studies on framework for the determinants of maternal mortality, no study have captured and described in specific form, how women status works to affect maternal mortality, and none have used women household decision making power in its conceptual framework, despite numerous empirical studies on the effect of women household decision making power on maternal mortality. This study therefore aim to add to the existing frameworks, the conceptual analysis of the determinants of women household decision making power and how its relationship with maternal healthcare service utilization works to influence maternal mortality. This would bring to light and provides supportive explanations to the findings of the empirical studies, as well as drawing more policy attention.

Conceptual Analysis

Figure 1 shows the schematic working process of women household decision making power, from its determinants to maternal healthcare service utilization, and consequently to reducing incidences of obstetric causes of maternal mortality and the ultimate maternal mortality.

Determinants of Women Household Decision Making Power

Married women in the households are surrounded by individual and family/cultural factors that influence their ability to take and participate in any of the three dimensions of household decision making. These factors are: woman's education, husband/partner's education, employment/wealth, Mass media, woman's age at marriage, social and cultural norms as shown in figure 1. These factors may likely increase or decrease women's ability to take and participate in the household decisions, depending on how they occur.

Educated women got exposed to different social life in the learning process. In this process, they acquire skills to press in for their right to participate in household decision making process. The influence of education on women household decision making power may increase with increase in the level of education because the level of exposure and skills could vary with education level. Husband/partner's education also have positive influence on a woman household decision making power. This is particularly more important in a patriarchal society, where women status in the society are based on the patriarchal ideology, which gives superiority to men simply by virtue of being male gender. The patriarchal ideology is more pervasive in the developing world, hence, the low level of women status in the region. In the similar way the woman's education exposes her to social life, the man's education does the same. Education could make a husband/partner more exposed and less patriarchal, which makes him to recognize the woman's position as partner in the household. Hence, he gives her the freedom to take and participate in the household decision making.

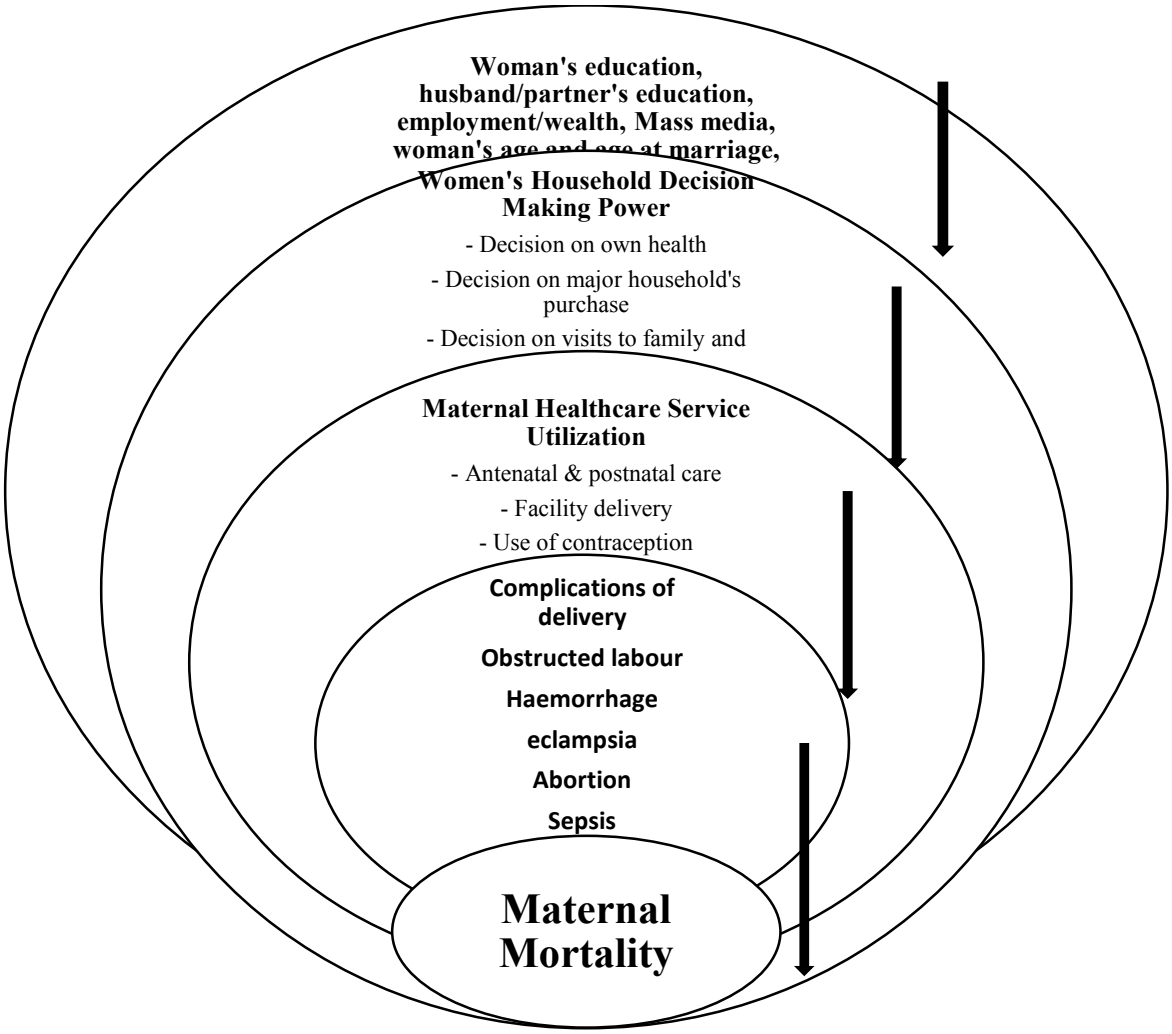

Figure 1: Conceptual Framework for the Relationship between Women Household Decision Making Power and Maternal Mortality

In addition to the exposure provided by education of both gender, exposure to mass media also create awareness and play important role in uplifting the status of women. Mass media exposure untamed the women from the psychology of male dominance as they are being exposed to different social setting in different places across the globe. This could similarly have the same effect on male as their patriarchal perspective of the women folk is reshaped by being exposed to what is obtainable in other society were women status are recognized, and the important role they could play as a result of such recognition.

The woman's employment status and wealth is another factor that influences her household decision making power in the household. If a woman is employed and has independent wealth or income, she does not need to depend on the man for her daily need and pursuance. This gives her financial autonomy to decide on what to purchase, both in terms of goods and healthcare services, as well as her mobility because she would not depend on the husband for transport. However, this may not be possible in patriarchal setting. In a patriarchal society, both the woman, her wealth, and even the decision to work for earnings and where to work are all under the control of the man. In this context, education again, particularly of the male, and probably the mass media, play vital role in reshaping the male-dominance perspective. Until this is achieved, the employment and wealth of the woman could hardly promote her household decision making power. The woman's age and her age at

marriage could be another probable factor. A woman who married at early age, for example below 18 years (Dickens, 2015), is very likely to be timid and tamed because of lack of exposure, probably due to low education level. At such an early age, she would not have acquired adequate level of education. However, as she grows in age, she becomes more exposed through the mass media, daily interaction, and probably acquire further education, her status in the household may improve.

Another important factor that could determine the woman household decision making power is the social and cultural norms in the society. While this might be patriarchal, it could take another dimension. Families in some developing countries, particularly in Africa, are by culture, mostly extended families. Male children are made to live with their spouses in the same household with their parents and other siblings. By this, the woman is not only answerable to the husband, but to the entire extended family. This culture grossly limit the woman household decision making ability as all decisions in the household are controlled and regulated by elders and parents in the family.

Woman Household Decision Making Power, Utilization of Maternal Healthcare Services, and Maternal Mortality

As earlier stated, woman household decision making power is basically measured in three categories – decision on her health, major household purchase, and visits to family and relatives; these affect the woman's health, authority over financial resources in the household, and her ability to move freely, respectively. The assumption is, these three decision making powers afford women the access and utilization of maternal healthcare services such as antenatal and postnatal care, giving birth in medical facility, and use of contraception to regulate fertility as shown in Figure 1. Each of these dimensions gives her a different route to the utilization of maternal healthcare services. If she takes and participates in decisions that affect her health, she takes prompt and appropriate actions towards her maternal healthcare needs without necessarily waiting for the husband's permission. In this, the first delay in seeking health care in the three delays model for seeking health is avoided (Bennouna et al., 2016; Maternity Worldwide, 2018). Similarly, taking and participating in decision on major household purchase and visits to family and relatives give her financial authority (free access to financial resources in the household) and freedom of movement, respectively, without necessarily being permitted by the husband. With this, she can purchase maternal healthcare and visit maternal healthcare center as the need arises. Hence, as shown by the arrow running from women's household decision making power to maternal healthcare service utilization in Figure 1, women household decision making power facilitates their access to and utilization of maternal healthcare services.

Prompt and adequate utilization of maternal healthcare services resulting from women household decision making power would further reduce the incidence of maternal mortality stemming from complications of delivery, obstructed labour, haemorrhage, eclampsia, abortion, and sepsis (an infection mostly after birth that leads to excessive bleeding). Regular antenatal care could help in early discovery of some pregnancy complications such as placenta praevia and malposition, which lead to antepartum and postpartum excessive bleeding (haemorrhage), and consequently lead to maternal mortality if not timely arrested. Similarly, facility delivery and postnatal care could aid the timely arrest of obstructed labour (example, shoulder dystocia), postpartum haemorrhage, and sepsis. Maternal deaths from abortion could be reduced by the use of contraception to prevent unwanted pregnancy. According toWorld Health Organization(2018) more than 75% of global maternal deaths result from haemorrhage, sepsis, eclampsia, complications from delivery, and unsafe abortion. Similarly, Say et al., (2014) revealed that 27.1% (19.9 – 36.2), 2.8% (1.6 – 4.9), 2.8% (1.4 – 5.5), 7.9% (4.7 – 13.2), 10.7% (5.9 – 18.6), and 14% (11.1 – 17.4) of global maternal deaths resulted from haemorrhage, complications of delivery, obstructed labour, abortion, sepsis, and hypertension (pre-eclampsia and eclampsia), respectively. Reduction in the incidences of complications from delivery, obstructed labour, haemorrhage, eclampsia, abortion, and sepsis through timely and adequate utilization of maternal healthcare services would therefore reduce maternal mortality in no small measure.

Conclusion

Women household decision making power plays important role in reducing maternal mortality through the ability to decide for timely and adequate use of maternal healthcare services. This consequently reduces incidence of complications during delivery, obstructed labour, haemorrhage, eclampsia, abortion, and sepsis, which were identified as major causes of maternal mortality. This conceptual analysis shows that women status depends on education of the women and the husbands, age and age at marriage, employment /wealth, exposure to mass media, and the prevailing social and cultural norms in the society. Women status, measured by three household decision making dimensions – decision on health, decision on major household purchase and decision on visits to family and relatives, influence maternal healthcare service utilization, reduces incidence of obstetric causes of maternal mortality, and consequently reduces maternal mortality. How this relationship works has been highlighted for policy direction and supportive explanation for previous empirical studies on the relationship between women household decision making and maternal mortality.

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