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Irrational acts: Maternal death, women's agency, and the obligation to care in Uganda

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Abstract

Following the recommendation of the WHO in the mid-2000s, the Ugandan government banned traditional birth attendants (TBAs) and encouraged all women to give birth in biomedical clinics. Yet in rural Luuka district, about half of women still give birth at home or with the assistance of lay providers. This article examines women's healthcare behavior to better understand decisions that are characterized as irrational by officials, in particular women's choices to delay care, move between providers, and defer health decisions to others. Building on anthropological interest in the relationality of care, this article explores how women compel the care of others, especially under conditions of healthcare scarcity and in contexts outside clinical settings. A focus on the gendered nature of kin-based care provides insight into how acts often characterized as irrational can be modes of action for women in ways that exceed a policy focus on healthcare choice and autonomy.

KEYWORDS
care, maternal health, medical pluralism, Uganda

INTRODUCTION

News reached me of Esther's[1] death as I was packing up and preparing to leave for the airport outside Kampala, a few hours west of the rural community where I had been conducting research on the causes of maternal health complications in Uganda. The news of her death shocked me, despite the time I had spent listening to the women in her community describe their struggles to access reproductive healthcare. I had seen Esther just days before, laughing and joking at the offices of the community organization where she worked in Luuka district, her colleagues teasing her (with jokes that seemed ominous now) about her swollen ankles and expanding girth as she approached the final weeks of her pregnancy. Esther was jovial and quick to smile, despite what I knew to be a difficult domestic life. She had only one child in a community where having multiple children connotes status and security, and a husband whose support of the household was unpredictable. But despite these struggles, Esther held a stable job in an organization that ran a private clinic, and she was surrounded by supportive colleagues.

She received regular prenatal care and had been preparing to give birth at her organization's clinic, under the supervision of trained biomedical midwives. But Esther had died, much to the consternation of her co-workers, in her sister's village, where she had retreated days before to seek the help of an herbalist and spiritual healer to address her unresolved but troubling symptoms. How could a woman with such well-established ties to biomedical care, including care providers who knew her well, become another statistic in Uganda's long struggle to reduce maternal mortality rates?

Much of the policy and research focus directed toward the issue of maternal death in Africa has highlighted the importance of understanding how women or those around them navigate health decisions, especially decisions regarding when and where to seek care. In the early 2000s, the WHO reversed a decade of support for the training of lay midwives in rural communities in order to unilaterally promote delivery in biomedical clinics as the key determinant of a safer birth (Wendland, 2022, 246). Since that policy shift, efforts to reduce women's morbidity and mortality globally have focused intensely on the location of birth and supervision by "skilled birth attendants" as the most critical contributors to women's pregnancy risk. In the public policy and public health realm, where much attention has been focused on reducing the damning stigma of high national maternal mortality ratios, interventions have pointed to decision-making delays—delays in seeking care, delays in accessing care, and delays in receiving care once at a biomedical facility—as critical stress points that contribute to maternal death (cf. Ellis et al., 2011). Here the problem of maternal health is often characterized as a problem of choice, where poor decisions (to fail to plan, to wait, to seek care outside the clinic) are the leading drivers of health complications and death.

The consequence of this framing has been that women's behaviors have been highlighted as the root of many maternal health problems. Their choices, especially those that lead to care outside clinical settings, have often been characterized as irrational. Esther's death was so surprising in part because she was considered to be someone unlikely to make seemingly irrational choices. She was educated and had close ties to the clinic where she had been receiving prenatal care. But in the wake of her death, her supervisor told me that he believed she had died precisely because of the decisions she made regarding her treatment. After several attempts to address her symptoms at the clinic, Esther had given up on her regular providers and traveled an hour east to her sister's village home, where she sought care from non-biomedical practitioners. "It was belief in witchcraft that killed Esther," her supervisor explained succinctly to me. For her colleague, the cause of Esther's death was a clear case of making the wrong choice between two forms of care, one biomedical and capable of securing health, and the other cultural, traditional, and dangerous.

In Africa, the narrative that women behave irrationally in seeking out non-biomedical providers is as old as the practice of biomedicine itself. Clinical biomedicine was introduced at the behest of a colonial state that sought to deploy medical care as both an institution and an ideological tool that could help manage and subdue non-modern subjects (Thomas, 2003; Vaughan, 1991). The figure of the irrational healthcare subject continues to play a central, determining role in global health interventions to the present day (Brown & Chiavaroli, 2023; Denyer Willis et al., 2023). In an era of neoliberal reforms that have cut state funding for healthcare and other forms of state infrastructure, interventions that focus on reforming individual behavior have taken on a new valence, recasting problems of structural inequality as problems of individual will (Li, 2007). To avoid a health center during labor, overuse antibiotics (Dixon et al., 2021), or drink unsafe water during a cholera outbreak (Paley, 2001) is characterized as an action of individual choice, driven by a deficit of rationality and accountability, reformed by interventions that seek to modernize, or cultivate certain kinds of behavior.

In recent years, anthropologists have used a focus on caregiving relationships as a lens through which to both criticize the myopic focus on individual behavior at the center of such policies and examine the ways people manage the changes wrought by such political-economic shifts. The relational aspect of health has long been central to anthropological investigations of healing, in African ethnography especially (Evans-Pritchard, 1976; Feierman & Janzen, 1992), but relationality has come into focus in new ways through anthropological considerations of care. Key works such as those by Annemarie

Mol (2008) and Arthur Kleinman (2009) critically examine how the relationality of care complicates biomedicine's emphasis on autonomous choice as a singular moral good and mode of action. This focus on care has highlighted how health is shaped by relationships that are often morally fraught and affected by changing global political-economic conditions that constrain who cares and how care is meted out (McKay, 2018; Ticktin, 2011). Additional strands of research have revealed the moral and affective aspects of caregiving and the cultural variations in what constitutes "good care" (Buch, 2014; Bunkley et al., 2024). Such work has argued for understanding carework as an alternative way of being in the world, which may help to both reproduce and challenge the policy and economic frameworks giving shape to clinical medicine today (Yates-Doer, 2011).

In this article, I am similarly interested in how a focus on patient decision-making occludes the reality of a relational orientation to care: one whereby patients are economically, politically, and culturally dependent on others in order to access healthcare and make healthcare choices. But here I diverge from a sustained and fruitful focus on acts of caregiving, to understand better the ways patients themselves compel care from others, especially under circumstances in which the forms of relationality and social interdependence that structure relations of care are under stress. What forms of agency are available to women for whom few truly autonomous choices regarding care providers exist? I am particularly interested in how actions often perceived to be passive—waiting, deferral to others, failing to maintain clinical relationships—are in fact strategies utilized by women to activate forms of care that extend beyond the clinic, especially kin-based care.

In the context of this study, women navigate care-based relationships not through behaviors that seem agentive and active—such as gift-giving between patients and clinical staff, which has been the focus of studies of the transformation of post-socialist medicine (Andaya, 2009), or acts of sharing between community members that have been highlighted as behavior that strengthens claims to care in other parts of Africa (Scherz et al., 2024, 45)—but rather through behaviors that seem irrational and even lacking in agency (silence, deferral, waiting), but which nonetheless work to generate the attention and investment of others. For women, the most important resource in seeking out healthcare was not their ability to assert their preferences for care (making "better choices"), but rather their ability to compel the attention of others, often by ceding their control of health decisions to relations outside clinical settings. Under conditions where the choice of provider rarely guaranteed a safe birth, women relied instead on ideas about obligation, gendered interdependence, and moral action, which made others responsible for them, helping them navigate a health landscape that was anything but reliable.

Drawing on research that has highlighted diverse forms of moral action that shape persons and which may be contingent on passivity and subordination as much as action and autonomy (Mahmood, 2011; Scherz, 2013), I am interested in how acts of care can be drawn out and the diverse ways women may constitute themselves as cared-for. Perhaps especially under conditions of scarcity, where women struggle to acquire the resources necessary for a good birth, what they rely on most are their (often frayed) relations to kin. In this context, care is, as Johanna Cook and Catherine Trundle have described, "unsettled," both as a remedy for the insufficiency of healthcare infrastructure and as a reflection on the strained relations between community members (2020). This reading of care-based relationships builds on earlier medical anthropological work that highlighted the importance of kin-based groups in care decision-making in Africa (Janzen, 1978), but this study provides a window into the ways these relationships may be changing, shaped both by the limitations of state health infrastructure and a political-economic environment that has altered family and gender-based relationships.

Below I begin with a description of the healthcare landscape in Luuka, and the ways that healthcare scarcity helped to perpetuate women's use of both clinical and non-clinical providers. Under these conditions, a woman's preference for a certain kind of provider mattered less than the relations of support she had access to and the strength and reliability of such networks. Healthcare-seeking for women was characterized by behaviors driven less by questions of *what* would cure (technology, biomedicine) than it was about questions of *who* would help navigate care access. In the subsequent sections, I explore the nature of these relationships of support, in particular gendered relations of caregiving, and the ways that women sought to compel care from men and other kin, often by drawing on behaviors that public health officials condemn as irrational—delay, deferral, and inconsistency in the pursuit of clinical care. Men were rarely hands-on caregivers, but they played central, though often contested, roles in women's care-seeking behavior through their provision of financial support. In an environment of clinical scarcity, access to care was contingent on managing resources that were deeply relational and gendered.

NAVIGATING A FRACTURED HEALTHCARE LANDSCAPE IN LUUKA

For two months in 2022, six in 2023, and one month in 2024, I conducted research in Luuka district in eastern Uganda, interviewing pregnant women who lived in a group of villages near a trading center that lies in the southern half of the district, about a thirty-minute drive from Iganga town, the nearest urban area, situated across a district boundary to the south. This had followed a longer span of research on health, gender, and sexuality in Uganda, including two months in 2018 and 2019 that focused on reproductive health activism and which informed this current project. Over the two-year span between when I began and ended research in Luuka, I interviewed 106 pregnant women, re-interviewing eighty-eight of them following their deliveries. My interviews with women focused on how they prepared for labor and where they sought care during pregnancy, including the ways they perceived and addressed barriers to care. I also interviewed more than two dozen professional caregivers in a range of facilities, from biomedical midwives to traditional birth attendants (TBAs) to drug shop attendants, as well as other community members, including local council leaders, fathers, and older women. I spent time in clinics, homes, and at a local NGO that ran a private health facility and other health initiatives in the area. In all, I conducted over 300 recorded interviews with community members and engaged in many other informal conversations about birth, pregnancy, family, and the struggle to secure health.

Working outside a specific clinical setting provided a broad view of the healthcare landscape in Luuka and the ways that women navigated it. Luuka is a rural agricultural community, with most people living on either small rented plots or modest (five acres or less) family farms, which dot the landscape along the district's murram roads and dirt tracks. While 250 square miles in size, and with a population of about 300,000 people, Luuka does not have a hospital within the district, nor does it have any tarmac roads or major highways. It does have one level-IV government clinic (the level below a hospital) which has one doctor on staff. This facility is the only one in the district with an operating theater. (Many women in need of surgical delivery are referred outside the district for care.) In addition to the level-IV clinic, there are also nine level-III government clinics and two private level-III clinics that have biomedically trained midwives on staff (though no doctors) who are capable of attending to uncomplicated deliveries. Women also regularly receive care from TBAs and from drug shops, or small kiosks that sell pharmaceuticals by the dose and which provide care during labor and delivery (though they are unlicensed to do so).

I use the term *fractured* to describe healthcare in Luuka both because healthcare resources were shaped by conditions of scarcity that limited quality of care—availability of drugs, number of providers—and also because women freely moved between providers, receiving certain kinds of care from one place, and other forms of care from another, piecing together reproductive healthcare supports throughout pregnancy and often even during labor itself. These behaviors were driven in part by what Susan Reynolds Whyte has described as a "pragmatics of uncertainty," the product of an effort to seek out diagnosis and treatment from multiple providers after one fails to offer adequate explanation or treatment (1997). Movement between providers and the layering of different health epistemologies were far more common than were definitive assertions of caregiver preference, despite regular messages from government officials and local clinicians that the best form of care was in the clinic, and that TBAs and drug shops offered unsafe approaches to care.

For patients, the choice of provider was rarely viewed in terms of a clear-cut dichotomy, between the safe and un-safe, trained and un-trained, or modern and non-modern. As Harris Solomon has described in his study of pervasive food adulteration in India, when the options people are faced with are themselves unreliable—plastics may protect or contaminate food; doctors may heal or abandon you—people's behaviors to avoid risk are rarely motivated by a logic of choice, whereby one choice is framed as healthy and others not (2015). Women sought to move between different forms of care in an effort to piece together support in an environment where nothing was assured when it came to access and quality. Women "bounced" (traveling to and then being forced to leave) from clinics that were unstaffed upon their arrival, or were forced to transfer care because of escalating complications, or the lack of necessary supplies, drugs, or working equipment at a given clinic. It was not uncommon for women to seek out advice from a nearby TBA about the status of their labor (will I deliver today?) and then move elsewhere to give birth. Nearly all women used herbal medicine during pregnancy—to prepare and strengthen the body during gestation, or speed labor—while also seeking prenatal care at a clinic. Women also regularly moved between villages and homes, relocating to stay with different family members during pregnancy, and in doing so altering their access to new and old networks of providers and caregivers.

What I found significant about the effects of these conditions was not only that women were pragmatic, layering forms of care because no provider was altogether reliable, but also that the fractured nature of this healthcare landscape necessitated that women prioritize relationships of caregiving beyond clinical sites. Gaps in care required assistance and support, for transportation between providers, for sourcing missing medicine and supplies, and for dealing with emergencies that local providers could not manage. Women not only sought out different kinds of providers but also sought to mobilize broader networks of support beyond clinics, networks that ideally provided them with a degree of flexibility and improvisation necessary to navigate care that was uncertain.

What perhaps best demonstrated this dynamic was the persistent lack of certain medicines and technologies in clinical settings and the demand that women draw upon others to help bridge these gaps in care. The state healthcare system was supposed to provide government and some private facilities with essential medicines and supplies, but shipments often lacked promised drugs, and nearly always contained less than was necessary to last until the next delivery. Women who arrived without necessary medical supplies (latex gloves, exam table sheets), or who could not source stocked-out drugs, could face delays in care, or, if the case was non-emergent (such as a prenatal visit), be denied care. One midwife, Rachel, who worked at the district's level-IV clinic, explained the pressure created by drug and supply stock-outs and the role of relatives in dealing with the problem:

> We lack some essential, essential drugs. We get stock-outs. Like magnesium sulfate for convulsions of mothers during pregnancy, during preeclampsia. It is so essential. We should not miss [this] in our facility. There is also a drug, tranexamic acid, to control bleeding [that we often lack]. And these are expensive drugs. One amp [vial] of magnesium is sold at 30,000 Ush [$8]. And a mother needs three [vials]. A village husband cannot come up with 90,000Ush [to buy this himself]! It is not so easy to treat. It is a problem.

When such stock-outs occurred, it was family members—especially husbands— who were called upon to source the necessary drugs or supplies from nearby pharmacies before providers would attend to a patient.

During one prenatal home visit I attended with a biomedical midwife, she inquired about the preparations for birth the mother had undertaken. The discussion quickly turned to the role of the father in helping make necessary medical supply purchases:

> Midwife Patricia: Have you prepared for the baby?
> Aisha: Yes, I am prepared.
> Midwife Patricia: Where is your husband?
> Aisha: He's not here, but he does send everything I need for the baby.
> Midwife Patricia: Oh, thank your husband for taking care of you!

A healthcare landscape that was fractured and partial was navigated not by definitive choices that outlined the superiority of one kind of care (biomedical versus herbal), but rather by women's ability to piece together care, usually by relying on the help and support of kin who would transport them to different clinics, source supplies from drug shops, and respond quickly to medical emergencies. This was a layering of care resources, both of kinds of medicine (the use of both TBAs and clinics), but also of care-giving relations. Quality care in this environment was rarely ensured simply by the location for care one chose, but rather by the durability and flexibility of social ties that supported the patient during a time of need.

Esther's death was indicative of the unpredictability of clinical care, and women's prioritization of kin to help navigate this uncertainty. Even for a woman who had the resources to seek second opinions and who had strong connections to biomedical providers, multiple clinicians still failed to adequately diagnose her condition. She was seen initially at her workplace's clinic, where she complained of edema. There, her blood pressure was not high enough to alert midwives to her worsening condition. She traveled home that evening, becoming more unwell on the thirty-minute journey, and was seen at a second biomedical clinic, this time in Iganga town, where she lived. There she was given some kind of treatment (likely painkillers for her complaints of a headache), but her preeclampsia was again missed. Ultimately, frustrated by the lack of any resolution or diagnosis, she turned to her sister and the alternative of non-biomedical care, traveling an hour east to a more rural area. The herbalist and spiritualist she consulted offered alternative theories for her unease, ones related to the dangerous jealousy of a former employee at her workplace, but these care providers were also ill-equipped to diagnose and treat her preeclampsia. Ultimately Esther's condition worsened, and she suffered convulsions. She died on the back of a motorbike on the way to a different town's hospital, her sister's final effort to seek adequate care for her.

MAKING IRRATIONAL CHOICES: TO DEFER AND DELAY IS TO ACT

Rather than simply plan well and prepare for clinical births, as recommended by biomedical providers, women often demonstrated behaviors that seemed the opposite of responsible. Esther left an urban area in favor of a remote village and eschewed entreaties from co-workers to return to the workplace to be seen by the midwives again. She sought alternative interventions offered by non-biomedical healers after she failed to find relief in the clinic, a pragmatic approach to diagnostics and treatment that characterized how many women in this region approached the problem of illness. But she was also motivated to move specifically in order to be closer to her sister, whom she trusted to care for her. Esther and other women often prioritized relationships with close family, especially natal female kin and husbands, to help them navigate the uncertainty that defined medical care. By doing so they were often able to mobilize support that could be critical to their survival, but such tactics could also mean they demonstrated behaviors that medical professionals deemed non-ideal and which could put them at risk: delaying medical care, deferring medical planning to others, moving farther away from clinical facilities to prioritize proximity to kin.

While women were often told to plan for labor, when I talked with women about their preparations, they often expressed ambivalence about what they would do once the time for delivery came. One woman, Miriam, who was seven-and-a-half months pregnant with her first child, had been receiving prenatal care at the Busalamu level-II clinic, which did not deliver babies. I asked her where she planned to go instead to give birth:

> Miriam: There is a woman named Sylvia, in Busalamu [a TBA]. I hear that woman delivers. She delivers many women around here.
>
> Lydia: So will you go there to deliver?
>
> Miriam: I don't know.
>
> Lydia: You don't know where you wish to deliver?

> Miriam: No.
> Lydia: Who will help make these decisions?
> Miriam: My husband.

When I later asked her what she would consider good care during delivery, she answered:

> Miriam: I would hope to be looked after so well and have everything I need to use.
> Lydia: Will you have someone to be your caretaker?
> Miriam: Yes, my elder sister.
> Lydia: Your sister will come and stay with you at the end of pregnancy?
> Miriam: Yes, she is soon coming, even now.

On the one hand, Miriam's ambivalence about the location of birth could be read as a lack of sufficient planning. On the other hand, Miriam was expressing a deference to other's opinions: someone else (husband, sister) will decide for me because they will be here to help me. She emphasized women's priorities for delivery, namely that they be "looked after" and have help securing the material resources necessary for birth. Deference to a wider network of kin in healthcare decision-making is typical in the community and throughout much of sub-Saharan Africa. John Janzen has described the importance of the "therapy management group" in the southern Democratic Republic of Congo, emphasizing how the pursuit of health not only required navigating multiple kinds of health providers—clinical, spiritual—in a similarly diverse healthcare landscape, but also how patients were rarely at the center of critical decision-making regarding treatment, deferring instead to more senior family members (1978). Family members were key agents in women's health in Luuka as well, often providing hands-on care (washing, feeding) but also providing assistance in sourcing funds for care, and deciding where and when to seek it. Having a robust network of caregivers invested in your health was considered by women critical to the pursuit of a healthy birth, though the attention of others could not always be assured. Because of this, women sought to find ways to compel others to take part in the work of care-seeking. Women's delay in choosing a location for birth was a way for them to draw others into this decision, deferring to the opinions of those who were obligated to take care of them.

The act of deferring to others was shaped by conditions that largely sidelined women's ability to fully control their access to healthcare. Cost was perhaps the biggest hurdle to healthcare in Luuka. Most women did not hold regular wage-earning jobs and had limited ability to earn cash beyond doing day labor in neighbors' gardens for very low pay (typically less than $1.50 a day). This meant it was financially unfeasible for women to truly assert total autonomy over health decisions. Women needed a very minimum of 20–30,000Ush ($6–8) to pay for birth assistance for a simple delivery at a TBA or drug shop, with a c-section costing 500,000Ush ($135) or more (even at government facilities that promised free care). This did not account for other supports required during labor, especially the costs associated with additional medicines, supplies, and transportation.

Under conditions that limited women's financial autonomy, behaviors that compelled the action of kin provided women with the means to intervene in the terms of their care. One way that women sought to compel the care of others was to defer to kin members' decision-making, as Miriam has done. Another way to do this was to relocate to be close to natal kin, as Esther had done at the end of her pregnancy. Another mother, Aisha, had moved in her ninth month of pregnancy from her husband's home to her sister and mother's village, about a forty-five minute journey, to be closer to their care at the time of birth. This meant she had had to interrupt the continuity of the prenatal care she had been receiving from a government clinic and a TBA in her marital village to move to a place where the location of care providers was uncertain, and the decision about providers in the hands of others. Yet she expressed little concern about the need to plan for the location of the birth in this new village: "Wherever I will be taken, I will be fine. Maybe in Bukanga (HC III), or wherever, it will be fine. My mother will make the decision."

Patience, deferral, and relocation were some of the limited ways that women might co-opt support from husbands and other family, who were culturally obligated, but materially constrained, in their abilities to financially provide for kin. Anna Eisenstein (2021) has described the ways that urban women in Western Uganda use "willful waiting" as a means of managing their life course, purposefully delaying marriage and motherhood in order to best "pace" themselves with others with whom interconnections might be most valuable. Waiting and delay, she argues, offer women control over their lives by helping them better navigate their social relationships. Similarly, women in Luuka sought out connections to others in order to support their care, using tactics like the deferral of decisions to kin. Far from being passive, such actions were intended to draw others into relationships of care and support, to pace one's care with the actions of others.

If waiting and deferral were actions women took to compel care, movement from place to place, especially relocating to be closer to kin, was another. Movement within and between social spaces is a recognized and valued action in central Uganda because of the ways it is associated with opportunities to extend and strengthen social ties (Scherz et al., 2024, 45). As Sandra Calkins and Tyler Zoanni have argued in their essay on what they call an aesthetics of "bundling" in central Uganda, value, security, and opportunity arise from "social-material thickenings," or being able to layer and add on to one's social network (2023, 382). Moving from place to place, even in ways that disrupted or discontinued clinical care, was an action often driven by the desires of women to extend and strengthen social relations with those who were obligated to care for them. Aisha and Esther prioritized connection to kin over continuity or proximity to clinical providers, and relocated considerable distances in order to establish and assure such kin-based connections. Far from signs of women's lack of agency, actions that induced delay, deferral, or relocation were tactics that offered a degree of consideration and control for women under circumstances where healthcare access was otherwise uncertain.

CONTESTED OBLIGATIONS TO CARE: GENDERED RELATIONS OF CAREGIVING

If women deferred decisions and moved to be closer to kin in order to strengthen social ties, it was underlying expectations of moral and social obligation that animated the actions of others. While men were not hands-on caregivers, they were expected to play a key role in supporting women during pregnancy by providing financial resources, and men's relationships with women were at the center of questions of care and healthcare access in the community. I was not surprised when Patricia, the midwife whom I accompanied on the home outreach described earlier, inquired of the pregnant mother Aisha, "where is your husband?" and Aisha responded with a report of the material care her husband had provided. Such a question revealed the importance of men in healthcare access and preparation, even if men were often absent from provider visits.

Nearly every woman discussed with me the financial caregiving obligations of men and the ways these obligations could be a point of stress as often as they were a promise of support. While women sought to compel the care of men (and other kin) through tactics like those described above, the fulfillment of these obligations was not certain and was perhaps women's biggest complaint about care-seeking. Rebecca, who lived near a busy trading center and was pregnant with her third child, described how she had shifted from a private level-III clinic to a government clinic for prenatal care because government clinics were considered cheaper. "My husband now doesn't give me support [money], so I must go to Bukanga (HC III)….Even now, that it is almost time to deliver, he hasn't brought me anything."

Women's discussions of men's obligation to support their wives—and concerns about their failures to do so—drew on gendered expectations of behavior that positioned husbands as material providers within a household. Kato, a 45-year-old father to eight children who lived in a rented house near a trading center, told me that ideal models of masculinity in Busoga were directly tied to the provision of financial support, "A man should fulfill the responsibilities of the home. Educate the children…To see how to look for the money to keep the family going…For example, when a mother goes to health services, he should provide transport and provide the money she will need in the facility." Relationships between men and women were deeply shaped by expectations of material support on the part of male partners. A former LC1 chairman (the local government representative whose job is to resolve community conflicts) explained to me that a "responsible" man was someone who could "move hand in hand with his family" by provisioning for his wife and children.

Here both Kato and the chairman emphasize ideas about respectability (*ekitibwa*, Lusoga) and good manners (*empiisa*, Lusoga) which shaped expectations for moral behavior and social obligation in Luuka and throughout southern Uganda. Being a respectable member of society meant that a person helped maintain relationships of interdependence with others, especially through acts of marriage and reproduction. Today, many couples in Busoga delay formal bridewealth (*kwandhula*, Lusoga) ceremonies because of their expense, but the underlying meaning that the ceremony attributes to marriage, especially the importance of the patrilineal kin group and the inequality, as well as interdependence, between men and women, remains central to social life (Parikh, 2015, 76). When I asked Jackie, a mother to four children, what made a good marriage the first word of her response was "*empiisa*." To be well-mannered meant that you knew how to treat others in a way that would strengthen a larger kinship network: "Good manners. Respecting the people on the husband's side and giving respect to the husband himself. He must also respect me as a wife. And respect my side, my relatives."

Women drew upon these expectations of gendered obligation within marriage to try to compel the attention of care of husbands and kin. Marriage, especially when formalized with an initial meeting of families or a full bridewealth ceremony, incurred certain rights for both women and men. If problems arose, a marriage that had involved extended kin typically provided women with the grounds to complain about their husbands' behavior, either to local officials like the LC1 chairman, or to in-laws directly. Bernice, a young mother of a newborn, elaborated the importance of such rights when she told me that marriage made the husband and wife known to each other's families, "It's very important for the family you are joining to know where you are coming from. If there are problems, you know where to begin from."

For women, these ideas are critically important because they highlight the ways even dependent members of society have certain rights that can be demanded from those with access to more resources, a perspective that has shaped approaches to gender and reproductive rights movements in the region (Boyd, 2022; Wyrod, 2016). Rights and political agency in Uganda have long been understood to be experienced not through the assertion of individual will and equality, but in terms of the reinforcement of the moral obligation between often unequal members of society (Hanson, 2022). This is an orientation to political and social obligation that emphasizes the reciprocal nature of status and power and the interdependence of groups within a social hierarchy, providing dependent members of society the ability to make a moral claim on those with greater status.

In the context of the family, this meant that while women were not considered equal to men, they could expect men's support during pregnancy and labor, and they could use these expectations to compel the care and material investment of male partners.[2] Yet in Luuka, these ideas about gendered interdependence were under stress because of economic and social changes, especially increasing competition for land and higher costs of living, which made it hard for men to earn enough cash to support their families. Kato, the man with eight children, told me that being the head of a family was more complicated now than it had been for his parents. "It was different [before]. Because a long time ago things were not so expensive. We had land and food. This morning, I was [working] in the [neighbor's] garden. I made 10,000Ush [$2.70]. I used it, and it wasn't even enough for what we need today."

Economic challenges also meant that young men often traveled to find work, and family members could live over broad geographic areas (one reason why women so often moved during pregnancy). Young men usually had to leave home to seek out better jobs, often working as laborers in towns and the capital of Kampala, leaving their wives in Luuka for long periods of time. Even men who worked as sugarcane laborers, some of the most readily available wage-paying work in Luuka, left their homes for periods of time to sleep near the fields they were harvesting. Men's movement in and out of households for work, and women's more limited ability to earn cash (because wage-earning jobs were less available to them, and because of their higher burden of household work), meant that relationships were often strained by financial pressures. When I asked one 22-year-old father of a 5-month-old baby how such pressure affects relationships he stated simply, "Money rules everything at home." Cash was increasingly necessary for life in the village—extra food bought at markets, transportation, school fees for children, medical expenses—but men's and women's unequal access to cash meant that it functioned to both solidify and strain relationships. Cash was the way men showed support and care. Its scarcity undermined the forms of gendered interdependence that women relied upon.

UNSUPPORTIVE RELATIONSHIPS, CHALLENGING OBLIGATIONS TO CARE

In Luuka, women's efforts to compel care were modes of action that sought to mobilize relationships that would help them manage gaps in treatment access, but these modes of action were constrained by changing economic conditions that had simultaneously undermined women's claims on their kin's resources while providing few alternative avenues for their empowerment. The enduring importance of maintaining family ties even when doing so was challenging—moving to a different district to give birth near one's mother, or staying with a husband who was erratic in his support—revealed the necessity of such ties to women's ability to access healthcare.

Dorothy was twenty-six, had three children, and was five months pregnant with her fourth child (though only the last two children were with her current husband). She had left her first husband because of a lack of material support. "I was the second wife. But he wasn't taking care of me and the children. With my second child, when labor started, I called him, but he was with the other wife. He said, 'ok I'll come in the morning.' And he didn't come." She ended up giving birth alone in her home and had to call her landlord to assist her after the baby was delivered. She explained that her biggest concern for her current pregnancy was again the question of support, this time from her second husband. While he was sometimes hesitant to provide for her needs, she felt he was trying. "He has just brought me some bedsheets, which I was able to cut into baby blankets. And he complained (about me cutting the bedsheets)! But I told him, what am I to do? I will be patient with him. At least he is providing some things for me."

If Dorothy was trying to work things out with her husband because her relationship with him remained a key form of support, other women struggled because of the total absence of a socially approved relationship or other kin ties that could serve as alternatives. Women who lived apart from natal kin and whose husbands lived away from them tended to struggle the most with care-seeking. The lack of secure ties to others often translated into higher-risk deliveries and barriers to care. Rebecca, who was pregnant with her third child and who I had earlier described switching clinics because of cost, explained to me the risks associated with a lack of secure caregiving relationships. When I asked her about the biggest problem women face during pregnancy she answered, "Myself, as an example, when a child gets sick, I must look for all means to get treatment. Same when I give birth, I must look for the support I need. I worry a lot about that."

Rebecca's lack of direct financial support from kin was apparent in the struggles she ultimately faced during delivery. When I met her six weeks after giving birth, she told me that when she went into labor she had no cash or other resources prepared for the delivery. She also lacked the immediate presence of any family members. Her two young children were at home, but her husband had left the area for work. Her parents lived in the northern part of Luuka, far from where she lived. So, her immediate financial and relational resources were limited. She awoke the morning she went into labor and saw that she was bleeding (a worrying sign) but did not yet feel severe labor pains. So, she decided to take work digging in a neighbor's garden, to secure some small amount of cash and food for her children.

When she returned from the garden, she prepared food and then approached a neighbor, who was traveling to Kiyunga to visit a sick relative. Kiyunga is the location of the district's level-IV clinic, but it is about twenty-five minutes on a motorbike from Rebecca's home. It was not the nearest biomedical clinic, but as her neighbor was already traveling there, he offered to take her for free. When she arrived at Kiyunga she had no caretaker (relative) with her, no money, and no medical supplies. The midwives told her that she would probably deliver the baby that night, but she was not yet in the final stage of labor. She decided to leave the clinic, as her neighbor was then returning home and he was her only means of transport. Back at home, she labored alone, ultimately delivering by herself around midnight before she had time to call for help. I asked her why she decided to leave Kiyunga before delivering—a decision that most medical professionals would consider risky—and she said it was a calculation based on the resources she had. "In Kiyunga, they ask for gloves, a bar of soap, a bucket. I had nothing. When I arrived, there was another woman in labor, and I saw that after pushing [delivering], her family was told to go and buy these things."

When women lacked strong social relationships, and especially the presence of close family members, they were at higher risk of mistreatment from clinics and faced barriers to care driven by a lack of relational and, by extension, material resources. The same kinds of relationships that allowed women to compel care from others could, in their absence, place women in precarious positions that directly affected their access to care. For Rebecca, the presence of a friendly neighbor was a key resource that enabled her to travel to a relatively well-equipped government clinic, but the lack of caretakers for her children at home, her lack of any money or medical supplies, and the absence of a family member to accompany her meant that she feared she would not be well-treated there, and may not access care. Without those forms of support, she returned home to give birth, where she was at least in proximity to her other children and neighbors who knew her.

CONCLUSION: THE ROLE OF RELATIONS IN CARE-SEEKING AND PERCEPTIONS OF CARE CHOICE

What was the best strategy for a healthy birth? For women in Luuka, the message presented by the government had, for at least the last two decades, been clear: delivery at a biomedical clinic. Health policy has steadfastly emphasized women's choice and agency as key means of addressing maternal healthcare deficits. If women took action and chose the more technologically advanced form of healthcare, deliveries could be made safer. Yet few women I interviewed described choosing care providers based on the promise of biomedical standards of care.

Women were often ambivalent about their choices, and regularly moved between different kinds of providers during labor and other medical emergencies. I have argued here that such behaviors revealed how women prioritized kin-based care relationships as their biggest resource during pregnancy, providing them with the most flexible and safest path to a healthy birth under conditions where the provision of any healthcare was uncertain. While women had limited access to cash, they had a moral claim on the care of others in their kin group, especially their husbands. Because of this, many women sought to compel the care of husbands and other relatives, by deferring to the decisions of kin about the timing and location of care, or by moving to be closer to family members. Women's actions during pregnancy and labor, while often perceived to be irrational by providers and policy makers, were shaped by a different experience of personal agency and action, one enmeshed in ideas of gendered interdependence that both constrained women's perceived choices and provided for a moral claim on the actions of others.

This reading of women's care-seeking behavior builds on a broader critique of policies that have narrowly focused on patient choice as a key driver of health interventions. Perhaps especially in reproductive health, choice is a loaded concept, a signal of women's empowerment, but one which places the burden of good care on women alone. In Luuka, care was rarely experienced as an individual choice. Access to healthcare was always contingent upon one's relations to others. Care was also gendered, in ways that are perhaps surprising given the ways that women feature, both in our collective imagination and on the ground in places like Luuka, as primary caregivers. Men were key participants in acts of care, even if they were often physically absent from delivery and postpartum rooms, because of the way that they controlled access to the financial resources that enabled caregiving. Successful maternal health policies must feature the role of men more prominently in policy initiatives, recognizing the ways that access to care and care decision-making are deeply relational and gendered. Women and men both played roles in care decision-making, yet these roles were differentiated and contingent. The ways such relationships both support and constrain women's access to providers must be acknowledged to implement more effective interventions to reduce maternal death.

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ENDNOTES

[1] All names are pseudonyms to preserve confidentiality.

[2] Women have legal equality with men, enshrined in the language of the 1995 Ugandan constitution, but within families and households their status is effectively considered to be unequal but interdependent with men. Robert Wyrod (2016), Sylvia Tamale (2017), and Erin Moore (2020) are some of the scholars to explore the limits on, and moral experience of, gender-based rights in Uganda.

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