# DECISION MAKING AND REPRODUCTIVE ISSUES: A CASE STUDY OF EXPECTANT MARRIED MOTHERS AT CHAINAMA ANTE-NATAL CLINIC IN LUSAKA.

By

Mungaila Stellah



A Dissertation Submitted to the University of Zambia in Partial fulfilment of the Requirements for the degree of Master of Arts in Gender Studies


University of Zambia

Lusaka

2007

## DECLARATION

I, **Stellah Mungaila** hereby declare that this dissertation represents my own work. The sources of all materials have specifically been acknowledged and the dissertation has not previously been submitted for a degree at this or any other university.

Signature of Researcher: ----------

Date: ----------

## APPROVAL

This dissertation by **Stellah Mungaila** is approved as fulfilling part of the requirements for the award of the degree of Master of Arts in Gender Studies of the University of Zambia.

Examiners' Signature

1:---------- DATE: 31-10-07

2:---------- DATE: 31-10-07

3:---------- DATE: 07-11-07

4:---------- DATE: ----------

## DEDICATION

In loving memory of my beloved Mother

**DORCUS TABITHA NAMFUKWE**

Mother I now feel the same heat you felt in your love life. I now understand why you vowed never to get married again. While nursing your broken heart, you made sure each one of us (six) got the needed education and now we can read, write and analyse issues. You will always remain a great Mother and Father never to be forgotten.

**MAY YOUR SOUL REST IN PEACE.**

## ACKNOWLEDGEMENTS

I would like to give thanks to the most Gracious and Almighty Father in heaven for the guidance, peace and strength provided throughout the time I was writing my dissertation.

I wish to express my utmost gratitude to the persons without whom this mammoth task could not have been accomplished. My heartfelt thanks go to my supervisor, Dr. Fay Gadsden for the guidance, support, encouragement and patience she rendered to me during my dissertation writing. Doctor, I greatly appreciate your efforts and may the good Lord richly bless you as you continue helping others as well. My heartfelt thanks go to Mr. Mwanza Jason a lecturer at the University of Zambia for his constant encouragements, suggestions from the time I started thinking about the topic on which to study to the end of my dissertation writing. Most of all for having taught me how to use a Software I never knew I would use for my Data analysis. I truly appreciate your help Mr. Mwanza. I wish to thank my current employers Technical Education Vocational and Entrepreneurship Training Authority (TEVETA) and my former employers the Ministry of Education for having provided financial support and granting me study leave respectively. I also thank the Nurse-in-charge and all Nurses together with the support staff at Chainama Ante-natal Clinic in Lusaka for their support during data collection.

Last but not the least, I wish to thank all the lecturers and staff of the Gender Studies Department for their support.

Lastly, I wish to thank my beloved sons Denny Khuzwayo, Norman Kashi and Rashid Gondwe for supporting and caring for each other whilst all my attention shifted to this enduring task.

## Table of Contents

**List of Tables**

## List of Figures

**List of Appendices**

**Abstract**

The aspect of who makes decisions on reproductive issues in marriages has been overlooked by the many organisations that are advocating for the promotion of reproductive rights and gender equality as a whole. The effects of male decision making on reproductive issues have adverse consequences on women and the whole of humankind.

The overall objective of this study was to give an insight on decision making and reproductive issues as they exist in marriages of those who attended antenatal at Chainama clinic in Lusaka, highlighting the general pattern of decision making on reproductive issues and the reasons for the types of decision making. The study also sought to examine the effects of male decision making on the wives.

The study was undertaken between June and August 2005. Data was collected using both qualitative and quantitative methods and involved the structured open and closed interview for 39 respondents and 2 Focus Group Discussions for 14 respondents.

The study revealed that husbands have a greater decision making power than their wives. The study further revealed that shared decision making between wives and husbands is very low.

The study has also revealed that wives perceived that there are seven determinants for the decision making patterns that exist between wives and husbands and these are: cultural norms, religious promulgations and teachings, negotiating skills, marriage counsellors, the 'go- between', families and husbands' socio-economic positions.

The study has also demonstrated that the wives' socio-economic status contributed negligibly to decision making behaviour regarding reproductive issues especially when to have sex and on the number of children.

This study revealed the effects of unshared decision making on wives and these are gender based violence which can either be psychological, physical or emotional. It can also lead to wives' ill health caused by taking contraceptives such as pills, threat of divorce, marital rape and the contraction of HIV/AIDS.

In conclusion, shared decision making on reproductive issues especially is an aspect that needs to be addressed with the urgency it deserves. Reproductive issues affect a woman directly and as such it is only fair that wives' concerns are adequately addressed.

# CHAPTER ONE- INTRODUCTION

## 1.0 Introduction

Salper (1972) points out that throughout history, marriage has been viewed as an institution of unequal relations hence the genesis of women's rebellion. Decision making on reproductive issues in Zambia has been characterised by the power relations that occur in hierarchically structured marriages. In Zambia regarding reproductive issues and decision making there is an indication that decision making within marriage rests upon the husband. This has been attributed to various religious beliefs, traditions and customs governing societies.

There are efforts being made by the Government and Non-Governmental Organizations in attempting to encourage women's full participation in political decision making as seen from the many workshops and seminars that are conducted in the domain of gendered decision making. Despite the efforts being made by the Government of Zambia and Non-Governmental Organizations in putting forth the affirmative action to accelerate women's involvement in various sectors of national development regarding empowerment in public life, addressing power relations in marriages remains a nightmare. O'Connell (1994) argues that marriage without inequality is possible but unlikely to become widespread until gender inequalities within the wider society are removed. In my own opinion, a strong and healthy marriage means a strong and healthy family, and a strong and healthy family means a strong and healthy nation, therefore a strong and healthy nation to some extent will depend on an egalitarian marriage which in this case becomes a foundation of any nation's social, economic and political egalitarian success. In this regard, issues of equality at any level become a success flow.

## 1.1 Statement of the Problem

The ideal situation for any society advocating for gender equality is that both wife and husband must be equal partners in making major and challenging decisions which include those dealing with reproductive issues. Despite Zambia being a signatory to basic human rights principles guaranteed by the international law and coming up with the Gender Policy that acknowledges the importance of the agreed upon reproductive rights, the continued fight for these rights seems to remain a challenge to date. The resolutions made during the

International Conference on Population and Development (ICPD) in 1994 and repeated at the Beijing conference of 1995 to which Zambia is a signatory stated that;

> 'Reproduction rights rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health (...) the right to freedom from interference in reproductive decision making.' (p.13)

The National Gender policy (2000), aims to ensure equal opportunities for both women and men and women's full participation at all levels for sustainable development. Gender issues addressed by the policy are; the power relations between women and men in both public and domestic domains, cultural and traditional practices that systematically subject women to male authority and women and girls' limited access to and use of basic health services, inadequate reproductive health facilities, maternal and child health care.

However, the authority of the husband over the wife is often claimed to be an aspect of the Zambian culture and sanctioned by Christian teaching. There are unsubstantiated claims from some women in everyday talk that there are inequalities in decision making regarding reproductive issues in marriages in Zambia. The fact that these claims are unsupported by much empirical evidence means that we are not able to say what the actual situation is. In workshops and seminars, organisations such as Young Women Christian Association (YWCA), Women in Law Association (WLA) and the Zambia police's Victim Support Unit (VSU) have argued that they have constantly received cases of marital violence and divorce that are caused by unshared decision making on reproductive issues in marriages. Sandra Miwanda Bagenda, a volunteer at Young Women Christian Association Kitwe branch during an interview reviewed that 'out of 20 cases the branch receives in a week, 17 are on marriage rape and almost all cases on the average are on marital violence.' In the midst of such non-scientific claims there still is a continuous call for women's empowerment by most Non-Governmental Organization dealing with gender equality without necessarily looking at decision making regarding reproductive issues in marriages. There was a need therefore to conduct a study to show the current scenario regarding decision making and reproductive issues and advance research driven solutions.

## 1.2 Research Questions

. This study sought to answer the following research questions:

1. On what reproductive issues is there shared decision-making between wives and husbands?
2. On what reproductive issues is there unshared decision-making between wives and husbands?
3. Why are decision making patterns on reproductive issues between wives and husbands the way they are?
4. What are the effects of male decision making on wives?

## 1.3. Objectives of the Study

In order to ground the study and answer the research questions, the following objectives provided the framework of the form of data that was required, the methodological format of data collection, the analytic processes and the manner of presentation of the findings.

1. Using descriptive analysis and narrative accounts show issues where there is shared and unshared decision-making in marriage. (This objective is directed to how research questions number 1 and 2 were to be answered and in what form the data was to be shown)
2. To explore the real life situation of married women with a view to finding out the typology of decision-making in marriage of both husbands and wives. (This objective is directed to how research question number 3 was to be answered and in what form the data was to be presented)
3. To provide a descriptive account and analysis of the effects on wives of the male decision making on reproductive issues .This objective is directed to how research question number 4 was to be answered and in what form the data was to be shown).
4. To suggest interventional strategies using insights drawn from the descriptive accounts.

## 1.4. Significance of the Study

This study is significant for a number of reasons and these are set out below:

1. The outcome of the study is important to the Zambian Government, Non-Government Organization and the Department of Gender Studies in their continued quest for gender equality in the nation in the sense that it will:

- Augment advocacy on women's issues which include the fight against HIV/AIDS and the reduction of maternal mortality rate.
- Facilitate strategic planning in mitigating the negative impacts of unshared decision-making on reproductive health issues.

2. The outcome of the study is important to the field of knowledge in the sense that this is a pioneering study that is looking at decision making and reproductive issues and as such, the study will provide:
   - An enrichment of practical information to researchers, lecturers and students.
   - Typologies of gendered decision making on reproductive matters involving wives.

## 1.5 The Limitations of the Study

The first limitation has to do with the nature of a qualitative inquiry. Like all qualitative inquires, this study was associated with a small and non probability sample and as such we cannot generalize beyond the sample but only to the population of wives where the sample was drawn from and these were only married women who were pregnant and attending antenatal clinic at Chainama in the City of Lusaka.

The second limitation was the inadequate time and financial resources which limited the possibilities of interviewing more people.

## 1.7 Structure of Dissertation

This dissertation is divided into five chapters. Chapter One introduces the study and the problem, the objectives and the significance of the study. Chapter Two reviews the literature related to the study. Chapter Three provides the research methodology which indicates sources of data, sampling procedures, sample size and characteristic of the respondents utilized in the study. Chapter Four represents an analysis and discussion of the findings of the study. Finally, Chapter Five provides the conclusions and suggestions for future actions in the form of recommendations.

# CHAPTER TWO - LITERATURE REVIEW

## 2.0 Introduction

This chapter will review the literature related to the patterns of decision making in marriages. These studies have been included because they are relevant to my study. Definitions of key words are done within the text.

## 2.1 Marriage

Statutory and customary marriages are based on a mixture of customs and laws and differ widely on matters such as the rights and duties of each spouse in relation to children, the name to be used by women and children as well as the use of property and inheritance rules. O'Connell (1994) indicates that marriage signifies some mutual commitment by each partner. Harris (1969) defines marriage as an institution where tasks concerning procreation, rearing and transmission of values are performed.

Marriage, then, according to Harris marks the re-ordering of domestic relationships and the establishment of decent and economic relationship. The relationship in marriage must satisfy not only sexual needs but also emotional and intellectual needs while at the same time not interfering too much with each individual's personal freedom and development. Marriage as a term has no clear-cut definition and most researchers use attributes and characteristics accepted in their culture in defining it.

### 2.1.1 Types of Marriage

Mace and Mace (1978) argue that traditional marriage is hierarchically structured where a man's role is that of a leader, one in charge who issues orders and makes decisions while a woman's role is that of submissiveness treating her husband with respect even if she did not agree with him, one able to suppress her feeling of hostility and resentment in order to keep peace. In this type of relationship spouses have very conventional approaches to male and female roles in which they see their personalities as matching with the highly accepted cultural stereotype.

Mace and Mace argue that in companionship marriage wives and husbands are equal partners as they both have the desire for intimacy, closeness and the deep sharing of life experience.

According to Dreikurs (1972) putting this type of marriage into practice has landed most people into trouble. One obvious reason could be the non-availability of models to demonstrate just how this can be done.

In Zambia, according to Geisler et al. (1985) among matrilineal groups such as the Bemba of Northern Province, married women are surrounded by the supportive kin who have access to economic resources such as land and labour. In this regard husbands appear to be in subordinate position in terms of resource allocation and decision making within the home. In patrilineal societies like the Chewa of Eastern Province women are dependent on their husbands and in-laws. Geisler notes that traditionally patrilineal marriages are said to be more stable than the matrilineal ones. This is because in patrilineal system, men work at accumulating estates to be inherited by their sons. This is not the case under the matrilineal system where there are conflicting demands of one's nuclear family and those of one's matrikin. It must be noted, however, that even when a husband is seen to be in a subordinate position in the matrilineal societies, the woman's authority over children and reproductive rights is problematic as there is the conflict of authority between the brother and husband.

## 2.2 Gender

According to Haslanger (2000), the culturally accepted sexual differences and the roles assigned to a man and woman is what is called gender. Gender thus has several dimensions. Holmes (1997:203) defines gender as 'a complex continuum which interacts with other social dimensions such as social status, ethnicity, age and power.' Oakley (1972, 1990) contends that sex needs to be understood, not as some objective variable, but as part of the process of social construction. Oakley distinguishes clearly between sex (as basic physiological differences between males and females) and gender as patterns of behaviour which are culturally specific and are attached to the sexes of being male and female.

## 2.3 Gender Stereotypes

Street *et al.* (1995) state that gender stereotypes are among the meanings used by society in the construction of gender roles, and are socially constructed characteristics that society accepts to be typically for women and men. There is a very high agreement in society about what are considered to be typically feminine and typically masculine characteristics. Kimmel, (1986) states that the typically feminine and typically masculine characteristics are called stereotypes. He purports that stereotypes provide collective, organised and

dichotomous meanings of gender and often become widely shared beliefs about what women and men innately are.

### 2.4 Authority

According to O'Connell (1994) as a group, women are at a distinct disadvantage when considering both power and authority in marriage. O'Connell (1994) argues that authority is viewed as having two dimensions: 'relative and shared authority.' He states that relative authority also referred to as a marital authority is one where one spouse dominates. Attributes to this kind of authority are the concentration of power which is usually in the hands of husbands allowing them to dominate sexual, economic and psychological relations. Studies conducted in Zambia on decision making have indicated that in public a wife must be modest and asexual while readily available to her husband in private. Dover (2001) revealed that women in Chiawa and Chilanga districts of Lusaka were expected to observe modesty. This has resulted in society's acceptance of the idea that sex is a man's right and a woman's obligation. In this regard man's sexual actions are accepted at a woman's expense. Such ideas were tested against the findings of this study.

Shared authority on the other hand according to Komarovsky (1963) is where the activities in a home are controlled by both partners. In other words, the control of most activities in a home is shared. According to Hardill et al. (1995), studies on decision making in dual-career households conducted in Britain have shown that the rate of joint decision making is highest in the middle economic category and lowest in the highest and lowest economic categories. They further argue that a wife who has a paid job is less likely to be controlled by her husband and that shared activities and decision making is joint when the wife works. These ideas were tested against the findings of this study in relation to reproductive issues. According to Harris (1969), the distribution of authority can either be syncretic or autonomic. Where relative authority is at its maximum, there can be little shared authority, hence the existence of two polar types where a wife or husband dominates. Where relative authority of one over the partner lies between these extremes and the amount of shared authority is high then the distribution of authority is syncrentic which means each spouse has relatively few activities in which he or she is the boss and control of most activities is shared. Harris (1969) further states that where the amount of relative authority is low, family activities between the spouses are divided into two (autonomic authority). In this case the wife will have authority over the husband in one set of activities and the husband over the wife in the other set.

## 2.5 Marital Roles

Harris (1969) argues that the conditions under which the activities are performed have an effect on defining roles. In this regard, both wife and husband are able to perform their roles within broad limits of the society in accordance with their personal needs. However, it is worth noting that these broad limits are laid down by the norms of society as a whole.

## 2.6 Economic Perspectives on Marriage, Fertility and Gender

Hotz et al. (1997) argue that it is a commonly held but not universal view among economists working in the demographic area that fertility can be analyzed within the choice-theoretic framework of neoclassical economics. The assumptions of that framework are (i) that the actors in marriage have a well-defined set of preferences, (ii) that they face limited resources or, more generally, face a well-defined opportunity set, and (iii) that they make optimal decisions in the sense that there are no other decisions given their current state of knowledge that would make them better off (from their own perspective).

Hotz further states that at the most fundamental level, economic models of fertility can be viewed as a standard application of the theory of the consumer. The economic modelling of fertility has been an active area of research, incorporating advances in economic theory more generally. Thus, static lifetime formulations have given way to life cycle dynamic models. According to Hotz more recently there has been increasing concern about applying individualistic models of behaviour to the household as if the household was the elementary decision making unit. This concern has given rise to new approaches to modelling household decision making that recognize the saliency of the individual decision makers who comprise the household .These developments are being incorporated into the modelling of fertility. It is best to view economic modelling of fertility behaviour as work in progress.

### *2.6.1 The Standard Static Lifetime Model*

Becker and Lewis (1973) indicate that the standard static lifetime model focuses on decision making that is related to children and has been used in studying family sizes. The first serious attempts at modelling fertility behaviour incorporated two important extensions; allowing for parental choice about the "quality" (which can be purchased at some fixed cost per unit) as well as the quantity of children

### *2.6.2 Life Cycle Dynamic Models*

According to Hotz and Miller (1988) the static lifetime model provided the foundation for studying features of the fertility process that go beyond the choice of the lifetime quantity (and quality) of children. In itself, the static formulation is silent about the timing and spacing of children and the relationship of childbearing to other life cycle household decisions. Life cycle dynamic models pose the decision problem in a sequential framework in which the household responds to the evolution of events that are unknown *ex ante*, allowing for sequential decisions to be made about contraception, time allocation (to work and childrearing); and consumption.

### *2.6.3 The Willis Model*

Willis (1997) assumes a static model in which men and women each have preferences over the number and quality of their children. For generality, their preferences may differ, but there is no need that they do or that one sex systematically cares more about the quality of their children. What distinguishes men from women is that women can bear only a limited number of children while men can father an indefinitely large number and that men do not always know the identity of their children. Child quality is a collective good, i.e., one parent's enjoyment does not diminish that of the other parent.

### *2.6.4 Social-Demographic Perspectives on Fertility and Gender*

The paper by Nathanson and Schoen (1993) questions why Americans (or members of industrialized societies generally) continue to have children given their direct and indirect (opportunity) costs. They argue that couples have strong interests in social integration with family and friends. The support that this social integration brings is highly supported by couples. Gender differences in the resource value of children as social capital were not addressed theoretically in this paper.

Among the only detailed pieces of empirical research (of which I am aware) that lends itself to analysis of gender differences in the forgoing terms is the chapter in Elijah Anderson's book, Streetwise, titled "Sex codes and family life among Northton's youth" (1990:112-137). Streetwise is an ethnographic study of two adjacent inner-cities communities, one ethnically and racially mixed and the other black and poor.

Anderson (1990) argues that among young men, family-sustaining jobs are critical in the formation of an economically self-reliant family. Without viable alternatives in the job market, young men seek status in the recognition and support of their male peer group. To many inner-city black youths, the most important people in life are members of their peer groups. They set the standards for conduct, and it is important to live up to those standards. According to Anderson, some of the peer group standards are their use of sexual prowess and fathering as a proof of manhood. While sexual conquests are a status symbol, emotional commitment to the young woman may, on the other hand, be taken by peers as a sign of weakness. Anderson argues that young women's goals are quite different as they want to be like middle class housewives as seen on television.

Anderson (1990) has portrayed one end of a spectrum, in which sexuality is men's only social resource deployed to gain status in the eyes of peers rather than partners or kin, and children are "social capital" only for women. An obvious prediction from Anderson's data--he makes this prediction himself--is that as men acquire a job, and perhaps most of all, a persistent sense of hope for an economic future ,the most wretched elements of the portrait presented here begin to lose their force, slowly becoming neutralized. In other words, a conventional family life depends on the availability of economic resources to men. It is not clear where this leaves women. Anderson states that insofar as women perceive themselves as having "something to lose" by becoming pregnant, they are more likely to take precautions against it, hardly a new idea.

### 2.7 Decision Making

Decision making is the ability to utilise all available information and to weigh situations, analyse the advantages and disadvantages and be able to make choices whose consequences one is aware of.

Edgell (1980) states that decision making studies in dual-career households demonstrate how marital decisions are placed along a continuum. The continuum is such that there are decisions which are perceived as important but infrequent at one end of the scale and those seen as unimportant but frequent at the other. Even though Edgell was not dealing with decision making and reproductive health issues, he pointed out some form of gendered decision making patterns whereby the former was the responsibility of the male and the latter of the female.

According to Finch and Mason (1993) family negotiation is the process through which individualism in the family or marital relationship is mutually maintained. In this regard, one may deduce that mutual understanding in marriage lies to some extent in the family negotiations.

A study on gender relations and reproductive decision making in Honduras conducted by Speizer et al. (2005) revealed that husbands feared to approve of family planning and allowing their wives to use it because they may lose their role as the head of the family and their wives may be unfaithful. Watkins and Wilkinson (1997) argue that in instances where husbands approved of family planning in theory, they are unwilling to use male condoms in practice and disapproved their wives' practicing contraception.

According to Djamba (1994) conjugal relationships are to a large extent defined in cultural terms and that 'there is evidence that many African men and women believe that husbands are the primary decision makers regarding contraceptive use and their marital sexual activity'. This was revealed from the 1991 surveys that were conducted in Nigeria and Zaire.

Other findings by Oni and McCarthy (1991) on decision making on contraceptive use and family size in Nigeria among the Ilorin revealed that most men said they should decide and those numbers were the highest among men who have no education or who have only primary education.

Caldwell and Caldwell (1978) argue that men and their lineages rule over reproduction and decide on matters of family size in Nigeria and elsewhere in Africa. These findings were tested in this study.

The study on family planning and decision making conducted in George compound in Lusaka Zambia by Pia Johansson and Therese Brolin (2006) showed that husbands decide over their wives' bodies through family planning. Women were found to have less self esteem and had little to say in the decision making process as they were not considered to be responsible for the household economy. In George compound the findings revealed that the husband's permission to start using contraceptives was sought by the wives.

Crompton (1993) states that men are crucial actors in the formation of new households, the maintenance, reproduction and identities of households through their position as heads of households. Chizororo et al.(1999) for instance in a study of family influences on Zimbabwean women's reproductive decisions and their participation in the wider society did show from interviews and focus groups that participants consistently emphasized that husbands are the primary decision-makers regarding family size and contraceptive use. A majority of the women in this study said they discuss issues of family size with their husbands and that they tended to agree with their husbands. It was also interesting to note that when some women were asked how as couples they made decisions about family planning, these women generally agreed that since husbands work to provide for the family, they have the right to make the final decisions. Women's comments on this topic often pointed to the disadvantage they feel in family planning decisions if they are not contributing to household income. While there was agreement among all respondents that women should consult their husbands on family planning decisions, there was a lack of consensus on how to resolve conflicts when husbands and wives disagree. Men were generally supportive of child spacing after proof of fertility, but most concurred that in cases of disagreement over the use of family planning, the husband's decision should prevail. The embarrassment of being overridden by a wife who would seek family planning without consulting her husband was viewed with indignation by men, and some said that such a woman should even be divorced, since clandestine use of contraceptives is evidence of promiscuous activity. Urban men in a focus group agreed that 'in the home a man should have the final say. If the woman uses contraception when the husband doesn't want (her to) it ruins the marriage, because many women do it for prostitution during (their husbands') absence.'

Chizororo et al. (1999) further reveal that multiple factors intervene during decision making on the reproductive issues making the process dynamic and situation-specific. According to Chizororo et al. studies on decision making regarding abortion reveal that the findings make out a strong case for encouraging a dialogue between the couple through counselling services before and after the abortion, providing health education related to safe, effective, reversible and user-controlled contraceptives, reaching safe abortion services to women as close to the village as possible and increasing women's decision making capacity in all areas of life, including those related to reproduction and sexuality.

The right to reproductive health care according to the International Conference on Population and Development (1994) resolutions include taking measures to promote safe motherhood, care for those with HIV/AIDS and other sexually transmitted infections, abortion, infertility treatments and access to a full range of quality contraception. The Zambia National Gender Policy (2000) reveals that women seeking the termination of pregnancy face difficult authorisation procedures. Other than Zimbabwean studies that assert that the family is integral in decision making, there have been very few studies that have looked at male decision making and abortion. Shostak et al. (1984) state that a study of the partners of women obtaining abortions found that the majority agreed with their partner's decision. Almost 60 percent had positive feelings about the abortion, 13 percent had negative feelings and the remainder had mixed feeling. Among married couples, men were found to have more liberal attitudes towards abortion than women.

According to Miller et al. (1991) during the last two decades sterilization has become the most widely used contraceptive method used among married couples in the United States In 1995, the National Survey of Family Growth reported that 41 percent of married women ages 15-44 or their partners had a sterilizing operation. While the incidence of male sterilization has grown from the early 1970s, its increase has not been nearly as rapid as the increase in female sterilization. Indeed in 1973 rates of male and female sterilization were comparable. Chandra et al. (1997) argue that there has been some research on motivation of both males and females towards sterilization, most of them focussing on married couples and that almost one quarter (24 percent) reported a tubal ligation and one-seventh (15 percent) said their male partners had been sterilized. Most of this work has also examined couple dynamics. Nevertheless decisions about who will be sterilized according to Miller (1991) appear to result in the partner who is most motivated to end childbearing having the operation. Thus the fact that more women undergo sterilization may not necessarily reflect male's negative views of vasectomy so much as their female partners' positive motivation to end their childbearing.

Reproductive decision making process is one of the key elements of the social context of the reproductive health. If good reproductive health is to be achieved in any nation this aspect must be addressed with the urgency it deserves. There are limited studies on decision making and reproductive issues in Zambia, but African countries like Nigeria have seen an increase in researches on reproductive decision making since 1960s.

# CHAPTER THREE - RESEARCH DESIGN

## 3.0 Introduction

This study was conducted in the reproductive wing of Chainama College Clinic in the City of Lusaka. In designing the study, the researcher chose to use both the qualitative and quantitative approach since it was considered to be the most appropriate in answering the research questions and fulfilling the enunciated aims set out earlier.

## 3.1 The Research Setting

The study was specifically carried out in the antenatal section of the clinic and this section of the clinic was chosen because this study was about reproductive issues only and such a setting provided the sought reality. The section is located in the outpatient section of the department where expectant mothers came for routine checkups.

The researcher gained entry into this department through a letter of permission granted by the University of Zambia. Upon approval of the study, the researcher went to the antenatal section and met with the nursing officer who was the head of department. After discussing with her the objectives and how the research was to be conducted, the head of department facilitated the study by introducing the researcher to all the health workers in the various departments (namely the outpatient department, laboratory, wards and the pharmacy) as a student from The University of Zambian who was conducting a research for her master's thesis.

## 3.2 Description of the Outpatient Setting

The antenatal section where the research was conducted runs three types of clinics, which are the antenatal, family planning and child health. The antenatal clinics are conducted twice in a week and operate from about 8 a.m to about 12 p.m. According to the nursing officer, about 300 expectant mothers visit the antenatal clinic per week. In order to be attended to, women usually come early in the morning to get their numbers and they sit in the waiting area outside the consulting room waiting to be called in by the nurse. The women who come to these clinics are either first attendees or re-attendees who have

come for routine check-ups as a review or for continued treatment because they have chronic illnesses. Others who are attended to are those who have acute illnesses and these are referred to this hospital from the local clinics in their communities, although there are self-referral women too. When women come, all of them are given numbers by the nursing administration and they are attended to on a first come first serve basis. Only when there is an emergency or an acutely ill woman is she seen at once.

Nurses screen all patients who come to the hospital from the reception area and it is from this area that numbers are assigned to them. When a woman's turn comes, the nurse calls out the number and the woman responds by answering or standing up and walking forward to the nurse. The woman then follows the nurse into a room to be examined. The waiting time averages 2-3 hours.

### 3.3 Data Sources for this Study

The data for this study were drawn from Focus Group Discussions and structured open and closed ended questions that guided the interviews. Initially, the data collection technique that was to be used was in-depth one to one interviews. Looking at the busy schedule the nurses had and the longer waiting time, it was not possible to use this technique. It was then thought to vary the data collection methods to a structured open and closed ended interview schedule and Focus Group Discussions.

### 3.4 Sampling Process

Purposive sampling was the chosen method of sampling. The justification for selecting purposive sampling was predicated on the logic of selecting only those respondents that would provide specific data necessary to answer the research questions and these were pregnant, married women who attended ante-natal clinic on the set days in a week. The process took more that one visit. The selection of respondents, particularly for the Focus Group Discussions was guided by the need to fulfill theoretical saturation (Glaser and Strauss, 1967: 61; Lincoln and Guba, 1985: 34 Miles and Huberman, 1994:27).

### 3.5 Sample size

This study was based on 39 respondents who were interviewed using a structured open and closed ended interview schedule and 14 respondents who participated in 2 Focus Group Discussions of 7 participants in each group.

### 3.6 Data Collection Process

Data was obtained using 'open and closed ended' interviews and 2 Focus Group Discussions. The researcher documented and recorded what was said by the participants.

### 3.7 Data Analysis

The researcher personally transcribed all the Focus Group Discussions to produce verbatim text. In analysing these texts, the researcher paid attention to the manifest content. According to Downe-Wamboldt (1992) and Koch (1995) manifest content analysis involves looking at what the text says, thus dealing largely on giving description of the visible and obvious components of the text. Manifest content analysis is shown in this study by presenting reality in verbatim (quotations of parts of speech or the whole speech)

Qualitative data analysis was assisted by the Non numerical Unstructured Data Indexing Searching and Theorizing (NUD*IST Vivo or N Vivo) software version 1.1. This is a computer software package designed by Qualitative Research and Solutions (Q.S.R., 1997; Fraser, 1999). N Vivo software was used for the following analytic procedures:

- Storing and categorizing of interview transcripts, memos, and other documents.
- Creating of categories through computer-assisted coding.
- Conducting searches relevant to analysis in order to generate reports.
- Moving and linking data as higher order themes emerged.
- Creating basic hierarchical models of codes.

The memos generated in N Vivo formed the basis for much of the final writing of the study. While N Vivo assisted with the storage and categorizing of data, the analysis was conducted in accordance with grounded theory methodology. Quantitative data was analysed using SPSS.

## 3.8 Ethical Matters

Since this study involves human participants, it was paramount to obtain consent to undertake this study. Therefore informed consent was obtained from all relevant parties, the board and respondents prior to data collection. In this vein, letters expressing purposes, benefits and risks were given to all eligible respondents (see appendix I).

# CHAPTER IV – FINDINGS AND DISCUSSIONS

## 4.0 Introduction

The statement of the problem raised five main pertinent issues and these were clustered around three research questions. In order to present the findings succinctly, we provide the answers to the research questions around five main themes-each theme standing for a research question as argued by De Vaus' (2001) This chapter therefore, discusses the findings of the study. Section 4.1 gives a description of the sample in terms of its social background. Section 4.2 discusses the general pattern of decision making on reproductive issues between wives and husbands. Section 4.3 highlights the pattern of shared decision making on reproductive issues between wives and husbands. Section 4.4 gives the reasons for the types of decision making. In section 4.5 the researcher discusses the effects of unshared decision making.

## 4.1 Description of the Sample

This study is based on 39 respondents who were interviewed using structured 'open and closed ended' interview schedule (Appendix II) and 14 respondents who participated in 2 Focus Group Discussions. (Appendix III)

### *4.1.1Age*

The women under study who were interviewed were relatively young. The youngest was 18 and the oldest was 36. The majority n= 23 (59%) were aged between 27 and 36 the minority of them $n$ = 16 (41%) were aged between 17 and 26. The mean mode and median were centred around 27 and 29 years. The husbands to the women under study were relatively older than the women. The youngest was 21 and the oldest was 73. The greater majority n= 28 (71%) were aged between 27 and 36 just like there wives. The mean mode and median was 32. The oldest husband was married to a wife half his age (36) whereas the youngest husband (21) was married to a younger wife (19). Unlike the wives' who had two bands of age ranges, the husbands' age range was in five bands. This is because of the continued fertility of men which goes beyond the age 44 or less as menopause for women.

### *4.1.2 Wives and Husbands' Tribe*

The majority of the respondents belonged to one tribal group of Bemba with others being other tribes and non Zambians. The data shows that there were more intertribal marriages than intra tribal marriages. According to 2000 census of population, the Bemba language was the most predominant and widely spoken language cluster as 30.1 percent of the population. Therefore, the reason for the high number of Bemba speakers could be that it is a widely spoken language around Chainama clinic and this population is aware of the importance of attending antenatal clinic.

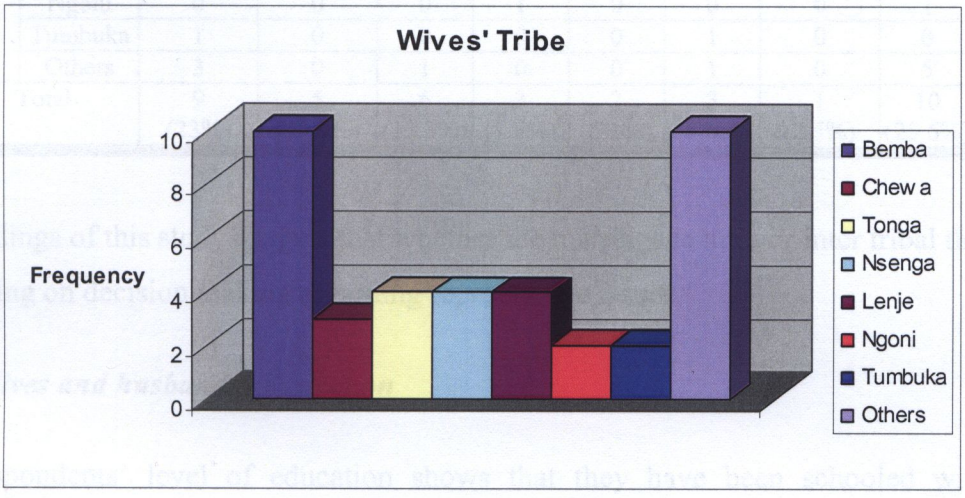


Figure 4.1 Wives' Tribe

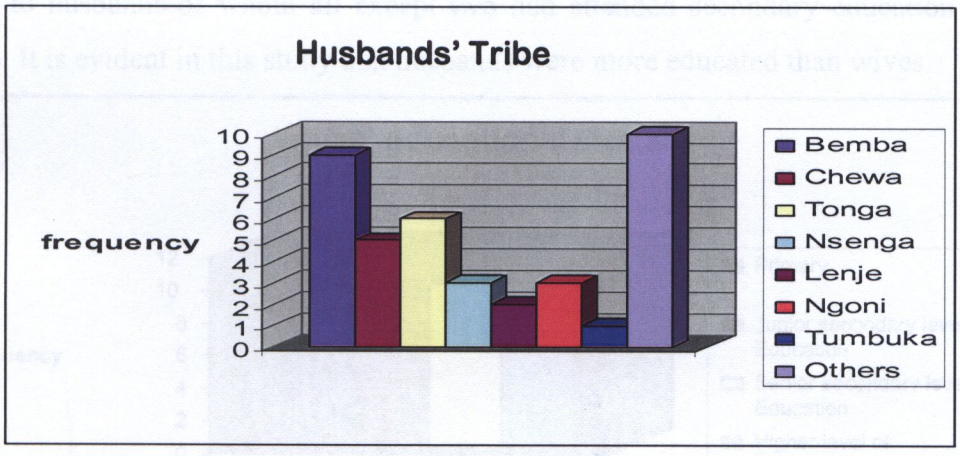


Figure 4.2 Husbands' Tribe

The table below shows the profile of marriage by tribe. The points of intersection between the rows and columns indicate the frequency of marriage between couples by tribe.

**Table 4.1 A cross tabulation of marriage by Tribe**

| | | What tribe is your husband? | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Bemba | Chewa | Tonga | Nsenga | Lenje | Ngoni | Tumbuka | Others | Total |
| What tribe are you? | Bemba | 4 | 2 | 2 | 0 | 0 | 0 | 0 | 2 | 10(25.6%) |
| | Chewa | 0 | 2 | | 0 | 0 | 1 | 0 | 0 | 3(7.6%) |
| | Tonga | 0 | 1 | 1 | 0 | 1 | 0 | 0 | 1 | 4(10.2%) |
| | Nsenga | 0 | 0 | 0 | 2 | 0 | 0 | 1 | 1 | 4(10.2%) |
| | Lenje | 1 | 0 | 2 | 0 | 1 | 0 | 0 | 0 | 4(10.2%) |
| | Ngoni | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 2(5.1%) |
| | Tumbuka | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 2(5.1%) |
| | Others | 3 | 0 | 1 | 0 | 0 | 1 | 0 | 5 | 10(25.6%) |
| Total | | 9 (23%) | 5 (12.8%) | 6 (13.3%) | 3 (7.6%) | 2 (5.1%) | 3 (7.6%) | 1 (2.5%) | 10 (25.6%) | 39(100%) |

The findings of this study suggest that whether the marriage is intra or inter tribal there is no bearing on decision making regarding reproductive issues.

### *4.1.3 Wives and husbands' Education*

The respondents' level of education shows that they have been schooled with the majority n = 27 (69.2%) at least having been to secondary school. The respondents were married to husbands of whom all except two had attended secondary education n= 37 (94.8%). It is evident in this study that husbands were more educated than wives.

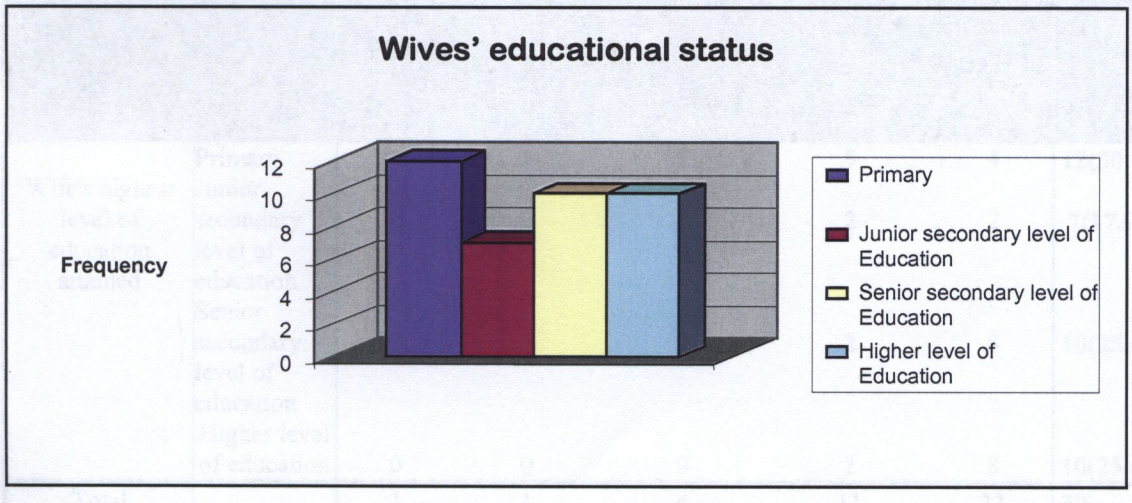


**Figure 4.3Wives' educational status**

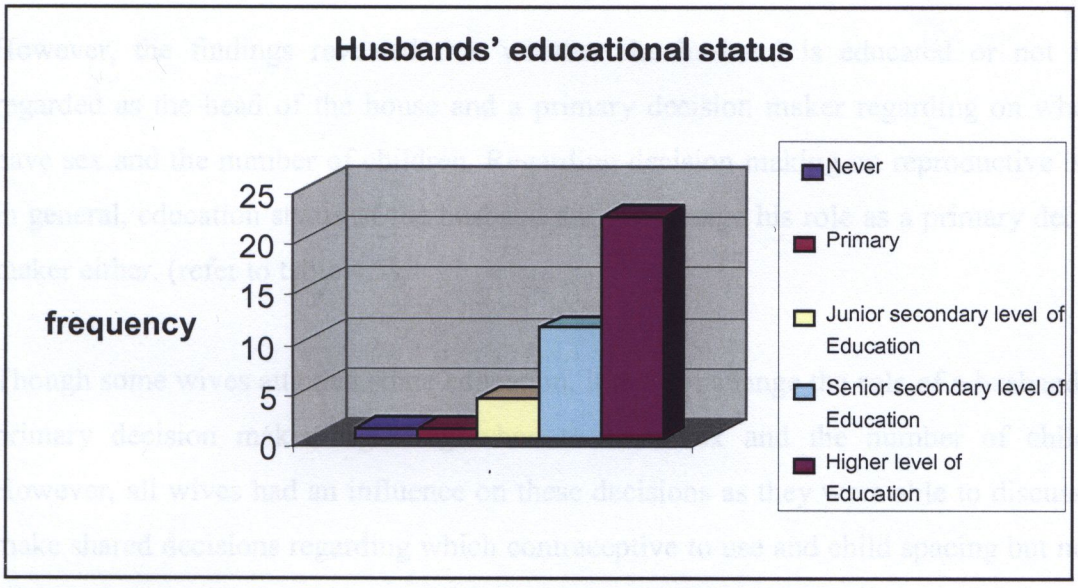


**Figure 4.4 Husbands' educational status**

The table below shows the profile of marriage by level of educational status. The points of intersection between the roles and columns indicate the frequency of marriage between couples by level of education.

**Table 4.2 A cross tabulation of the profile of couples' education status**

| | | Husband's highest level of education attained | | | | | Total |
|---|---|---|---|---|---|---|---|
| | | Never been to School | Primary level of education | Junior secondary level of education | Senior secondary level of education | Higher level of education | |
| Wife's highest level of education attained | Primary | 1 | 1 | 1 | 5 | 4 | **12(30.7%)** |
| | Junior secondary level of education | 0 | 0 | 3 | 2 | 2 | **7(17.9%)** |
| | Senior secondary level of education | 0 | 0 | 0 | 2 | 8 | **10(25.6%)** |
| | Higher level of education | 0 | 0 | 0 | 2 | 8 | **10(25.6%)** |
| Total | | **1 (2.5%)** | **1 (2.5%)** | **4 (10.2%)** | **11 (28.2%)** | **22 (56.4%)** | **39 (100%)** |

The husbands' high education status has some implications on decision making regarding reproductive issues. The findings revealed that the husbands' high education status is an added advantage regarding the authority to make decisions in a home.

However, the findings revealed that whether the husband is educated or not he is regarded as the head of the house and a primary decision maker regarding on when to have sex and the number of children. Regarding decision making on reproductive issues in general, education status of the husband did not change his role as a primary decision maker either. (refer to table 4.5).

Though some wives attained some education, it did not change the role of a husband as a primary decision maker regarding when to have sex and the number of children. However, all wives had an influence on these decisions as they were able to discuss and make shared decisions regarding which contraceptive to use and child spacing but not on when to have sex and number of children.

### *4.1.4 Families' Source of Income*

A look at how the families earned a living shows that a majority of women n=21 (53.8%) were housewives who depended on their husbands economically as compared to n= 14 (46.2%) who were engaged in some economic activity which took the form of some business or professional job.

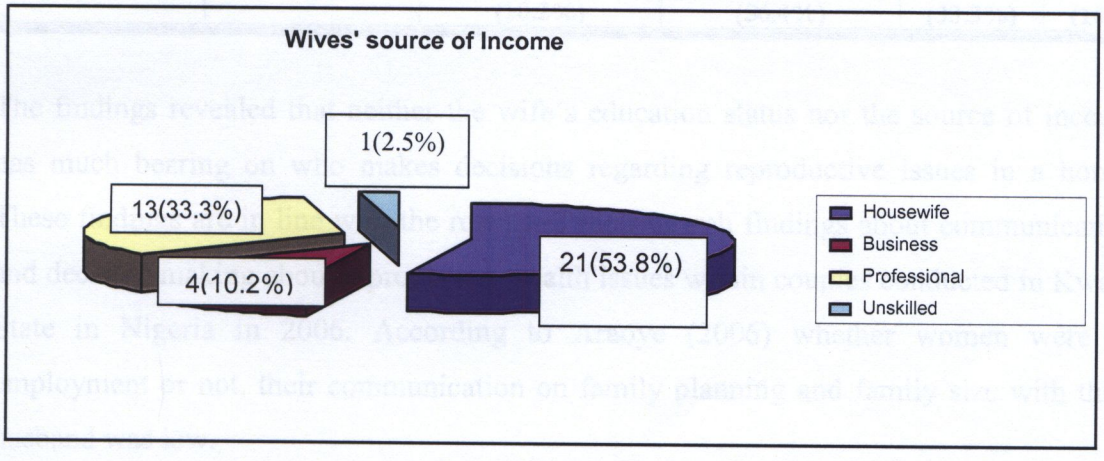


Figure 4.5 Wives' source of income

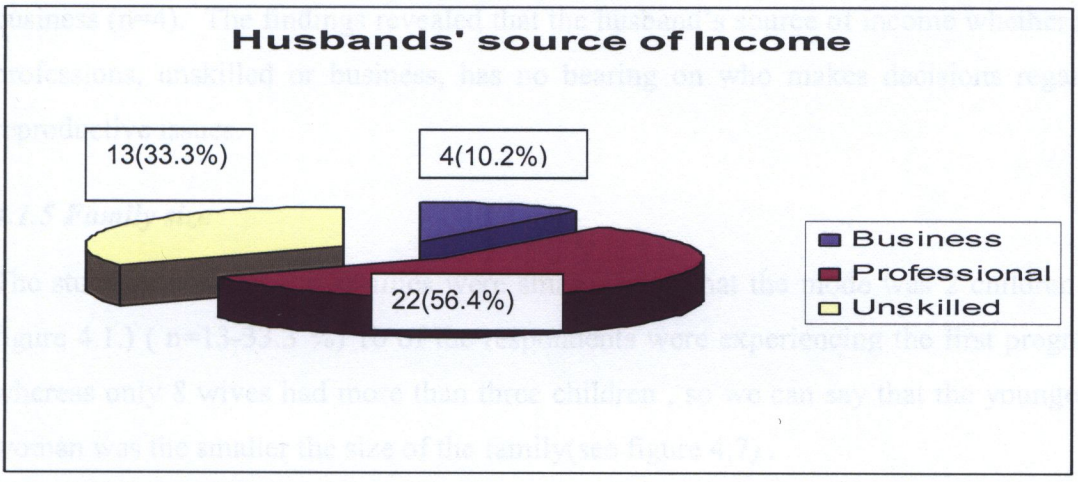


Figure 4.6 Husbands' source of income

The table below shows the profile of marriage by level of source of income. The points of intersection between the roles and columns indicate the frequency of marriage between couples by level of source of income.

**Table 4.3 A cross tabulation of the profile of Couples' source of Income**

| | | What does your husband do for a living? | | | Total |
|---|---|---|---|---|---|
| | | Business | Professional | Unskilled | |
| What do you do for a living? | Housewife | 1 | 10 | 10 | **21(53.8%)** |
| | Business | 1 | 1 | 2 | **4(10.2%)** |
| | Professional | 1 | 11 | 1 | **13(33.3%)** |
| | Unskilled | 1 | 0 | 0 | **1(2.5%)** |
| **Total** | | **4 (10.2%)** | **22 (56.4%)** | **13 (33.3%)** | **39 (100%)** |

The findings revealed that neither the wife's education status nor the source of income has much bearing on who makes decisions regarding reproductive issues in a home. These findings are in line with the results of the research findings about communication and decision making about reproductive health issues within couples conducted in Kwara State in Nigeria in 2006. According to Araoye (2006) whether women were in employment or not, their communication on family planning and family size with their husband was low.

All husbands had an income from a profession or business or some other unskilled undertaking. The majority were professionals (n=22) followed by unskilled (=13) and

business (n=4). The findings revealed that the husband's source of income whether from professions, unskilled or business, has no bearing on who makes decisions regarding reproductive issues.

### *4.1.5 Family size*

The study shows that the families were small noting that the mode was 2 children (see figure 4.1.) ( n=13-33.3 %) 10 of the respondents were experiencing the first pregnancy whereas only 8 wives had more than three children , so we can say that the younger the woman was the smaller the size of the family(see figure 4.7) .

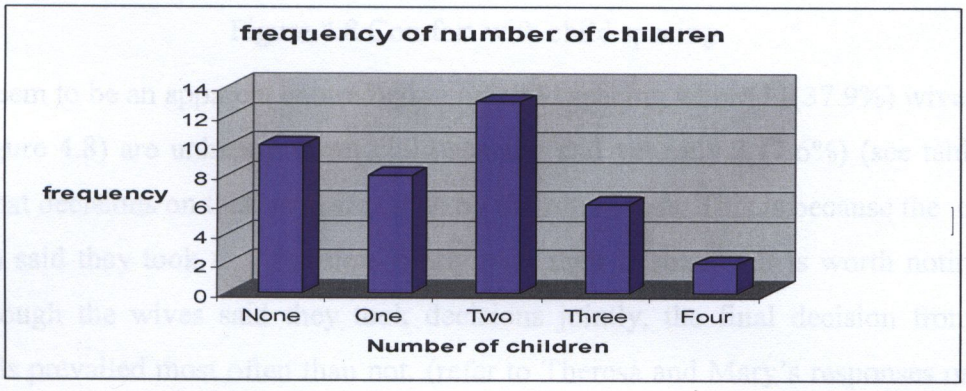


Figure 4.7 Frequency of number of children n=39

**Table 4.4 Distribution of number of children according to age range.**

| | | How many children do you have? | | | | | Total |
|---|---|---|---|---|---|---|---|
| | | None | One | Two | Three | Four | |
| wife's age range | 27-36 years | 2 | 4 | 12 | 3 | 2 | **23(58.9%)** |
| | 17-26 years | 8 | 4 | 1 | 3 | 0 | **16(41%)** |
| **Total** | | **10 (25.6%)** | **8 (20.5%)** | **13 933.3%)** | **6 (13.3%)** | **2 95.1%)** | **39 (100%)** |

The study showed that of the 29 (74.3%) who had at least one child, when they were asked if they were comfortable with the child spacing, the majority said they were. (figure 4.8.)

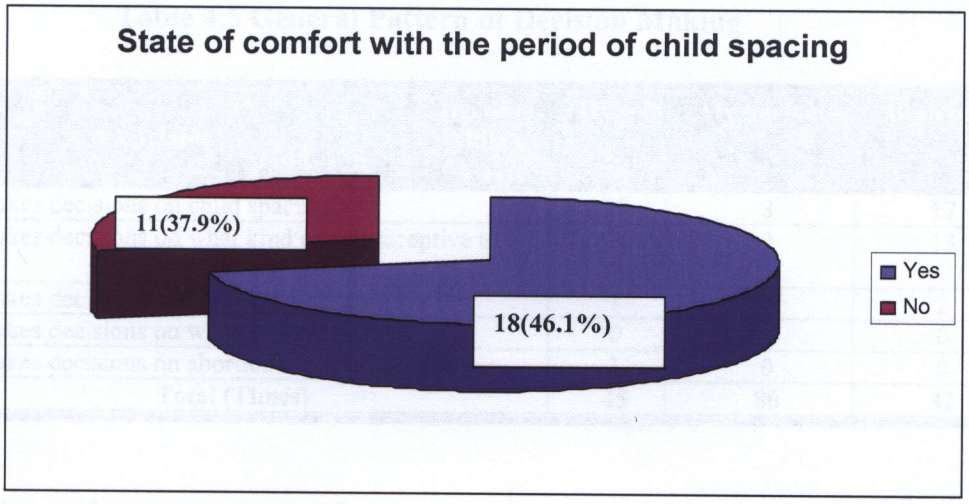


Figure 4.8 Comfort with child spacing

There seem to be an apparent contradiction on child spacing where 11(37.9%) wives (see figure 4.8) are unhappy about child spacing and yet only 3 (7.6%) (see table 4.5) stated that decisions on this issue are taken by their husbands. This is because the other 8 (20.5%) said they took this decision jointly with their husbands .It is worth noting that even though the wives said they took decisions jointly, the final decision from their husbands prevailed most often than not. (refer to Theresa and Mary's responses on page 28).

## 4.2 General patterns of decision-making on reproductive issues between wives and husbands.

Wives were asked questions on who made decisions on five reproductive issues. According to the profile below, it is evident that husbands generally have a greater say on reproductive issue as compared to wives. In addition, cooperative decision making is very low as compared to solitary decision making. According to this study, making decisions regarding when to have sex, and number of children are a preserve of husbands whereas wives are confined to issues of child spacing and contraceptive use. Table 4.5 shows this pattern at a general level.

**Table 4.5 General Pattern of Decision Making**

| Variable / Decision Maker | My self | My husband | Both of us |
|---|---|---|---|
| Who makes decisions on child spacing? | 19 | 3 | 17 |
| Who makes decisions on what kind of contraceptive to use? | 24 | 2 | 13 |
| Who makes decisions on number of children? | 1 | 36 | 2 |
| Who makes decisions on when to have sex? | 0 | 39 | 0 |
| Who makes decisions on abortion? | 1 | 0 | 0 |
| **Total (Times)** | **45** | **80** | **32** |

### *4.2.1 Decision making on child spacing*

The findings on decision making regarding child spacing revealed that all the wives felt that their husbands never minded in seeing them making a decision (table 4.7). However, the women had varying positions on how they would feel if their husbands made the decisions on child spacing with an almost equal distribution among those who were comfortable, uncomfortable and borderline (table 4.6).

**Table 4.6 Comfort with decision making on child spacing**

| | | |
|---|---|---|
| How would you feel if your husband decided on child spacing? | Very uncomfortable | 4(10.2%) |
| | Uncomfortable | 8((20.5%) |
| | just okay | 17(43.5%) |
| | Comfortable | 8(20.5%) |
| | Very comfortable | 2(5.1%) |
| **Total** | | **39(100%)** |

**Table 4.7 Comfort with decision making on child spacing**

| How would your husband feel if you decided on child spacing? | |
|---|---|
| Comfortable | 39(100%) |

A cross tabulation of comforts and discomforts shows that while the wives believed that their husbands were not worried with their wives making decisions on child spacing, their wives had varying positions if husbands were to make decisions ( table 4.6)

These findings can be attributed to the perception by the husbands that child spacing which is closely related to contraceptive use is a wife's business. Most wives said that

though their husbands supported the use of contraceptives as a way to space the children, they (husbands) were not ready to use any form of contraceptives such as a condom. Wives in the Focus Group Discussion said that though they discussed child spacing in their homes, they ended up with what their husbands wanted. According to the wives, the fact that they were able to discuss child spacing and contraceptive use with their husbands was a milestone in terms of shared decision making on reproductive issues.

### *4.2.2 Decision making on contraception*

A look at decision making on contraception showed that all the wives said that they believed that their husbands were uncomfortable with their wives making decisions on contraceptive use (Table 4.8).

**Table 4.8 Perception of husbands' comfort regarding decision making on contraception**

| Very uncomfortable | Uncomfortable |
|---|---|
| **18(46.1%)** | **21(53.8%)** |

**Table 4.9 Perception of wives' comfort regarding decision making on contraception**

| Very uncomfortable | Uncomfortable | Just okay | Comfortable |
|---|---|---|---|
| **2(5.1%)** | **21(53.8%)** | **15(38.45)** | **2(5.1%)** |

Though wives had an upper hand in making decisions on contraception, this left husbands uncomfortable and this is supported by the cross tabulation below.

**Table 4.10 Cross tabulation of both husband and wives comfort regarding decision making on contraception**

| | | Very uncomfortable | Uncomfortable | |
|---|---|---|---|---|
| How would you feel if your husband decided on what kind of contraceptive to use? | Very uncomfortable | 0 | 1 | **1(2.5%)** |
| | Uncomfortable | 9 | 12 | **21(53.85)** |
| | just okay | 7 | 8 | **15(38.45)** |
| | Comfortable | 2 | 0 | **2(5.1%)** |
| **Total** | | **18 (46.1%)** | **21 (53.85)** | **39 (1005)** |

Table 4.10 indicates that all the wives perceived that their husbands' consent was to be sought even if they claimed they made decisions on what kind of contraceptive to use.

In the focus groups, varying positions were advanced for the feelings on contraceptive use. Below we show some examples of what the women testified as to what symbolized variations in comfort.

Irene, a 24 year old housewife with two children attested to her negotiating skills when her husband was indignant. This was on account of the belief that contraceptives lead to infertility and she had to negotiate to continue to be on Noristerat, (an injectable contraception)

> I was allowed by my husband to be on Noristerat only after I had proved to him by lobbying that I was fertile by giving him at least two children even after taking it for three years. I am sure that after this pregnancy, I will continue for a long time.

Chilufya, a 30 year old housewife with three children stated:

> The pill I take makes me sick. It has deformed my looks. I just have to use the pill because there is nothing I can do since my husband does not accept even to use condoms.

Theresa, a 28 year old teacher with two children stated:

> My husband can not agree to use any form of contraceptive so I have to decide which one to use...though I have to discuss this with him. He must know, otherwise there will be trouble at home if I use it without his consent.

Mary, a 33 year old accountant with three children stated:

> It is a woman's duty to see to it that she does not fall pregnant at a wrong time. Therefore I have to decide which contraceptive to take and I will be very uncomfortable if my husband did that... But... my husband must know...

### *4.2.3 Decision making on the number of children*

Regarding decision making on the number of children a couple should have, wives claimed that husbands had a position of extreme discomfort (n =39) if they (wives) took a decision.

**Table 4.11 Perception of husbands' comfort regarding the wives' decision making on the number of children**

| Very uncomfortable | Uncomfortable |
|---|---|
| **26(66.65)** | **13(33.35)** |

**Table 4.12 Perception of wives' comfort regarding the husbands' decision making on the number of children**

| Very uncomfortable | Uncomfortable | Just okay | Comfortable |
|---|---|---|---|
| **7(17.9%0** | **9(23%)** | **22(56.4%)** | **1(2.5%)** |

**Table 4.13 Cross tabulations regarding comfort on decision making on number of children of husbands and wives**

| | | Very uncomfortable | Uncomfortable | |
|---|---|---|---|---|
| How would you feel if your husband decided on number of children? | Very uncomfortable | 4 | 3 | **7(17.9%)** |
| | Uncomfortable | 9 | 0 | **9(23%)** |
| | just okay | 12 | 10 | **22(56.4%)** |
| | Comfortable | 1 | 0 | **1(2.5%)** |
| Total | | **26 (66.65)** | **13 (33.35)** | **39 (100%)** |

A majority of the women in the Focus Group Discussions said they discuss issues of number of children with their husbands and that they tended to agree with their husbands decisions citing finance as a principal determinant. When housewives were asked how as couples they made decisions about family size, they generally agreed that since husbands worked to provide for the family, they have the right to make the final decisions. There were, however, different circumstances that determined decision making other than the financial reasons. Below we show some extracts in support of the findings.

Faith, a 28 year old secondary school teacher with three children, surprised the researcher when she remarked:

> For young women, I feel I should have more children before I start to use family planning. It is good to have a big family – you might get one good child or one bad child. But this has an economic cost too and your husband may not be too happy to discover that you are expecting without his say.

Regina, a 29 year old housewife with three children stated:

> I do not think that I have power to make decisions on the number of children I should have. As you know I do not work and I depend on my husband. Husbands are able to read the future more than we can as women. They know how much it will cost to look after the children, things like school, clothing, food and health care.

Irene, a 27 year old housewife with three children said:

> Any way the number of children cannot be determined by me and even my husband. God is the provider. This does not mean that we cannot decide on the number, not at all. This being a very sensitive case, I take a low profile and let my husband decide. My role is to see that I have a child when I am healthy and strong.

Chibwe, a 29 year housewife and grade 12 school leaver with four children remarked:

> I will have to press on to ask my husband to have a child as long as I do not have a daughter. My husband is very understanding and he tries to accommodate my proposals. If the scan will show that I have another son, I will go for another pregnancy.

Georgina, a 34 year old court clerk with five children said:

> My husband does not fuss about when I say I just want to have two children. But my mother has been encouraging me to have another child arguing that I will be more secure with three or four and even five. I think just three is okay for me. I have been thinking of having a tubal ligation after this child. I am yet to discuss with my husband.

The findings suggest that being a provider of a home (as husbands in this study were), gives husbands extra authority to make decisions on family size. The two working wives' Faith and Georgina's comments appear to show some amount of independence and at face value one is tempted to assume that working wives have to some extent a little amount of decision making power regarding the number of children. However, findings of this study indicate that the majority of working wives' husbands made decisions regarding the number of children.

### *4.2.4 Decision making on when to have sex*

Decision making on when to have sex showed that nearly all the women n= 34 (87.17%) had a position of extreme discomfort regarding their husbands' decision on when to have sex. They also perceived that their husbands would be in extreme discomfort if they (wives) decided on when to have sex. Despite such a scenario, wives resented their

husbands' decision making power regarding when to have sex because they felt used, humiliated, devalued and lost their self esteem.( Focus Group Discussions)

**Table 4.14 Cross tabulation regarding comfort on decision making on when to have sex**

| | | Very uncomfortable | Uncomfortable | just okay | |
|---|---|---|---|---|---|
| How do you feel if your husband decided on when to have sex? | Very comfortable | 13 | 21 | 5 | **39(100%)** |
| **Total** | | **13 (33.35)** | **21 (53.8%)** | **5 (12.850** | **39 (100%)** |

This was the liveliest part of the focus groups in the sense that sex was considered to be important in marriage. Some wives stated that they wanted sex all the time as long as they were not ill while others said it was not all the time that they felt like having sex. In the focus groups, it came out very strongly that the husbands needed to make an advance to their wives and it was mandatory for the wives to respond. These findings were in line with those of Dover that sex is a man's right and a woman's duty. This showed that women were invisible in decision making regarding when to have sex.

Women's invisibility and silence within the home is reinforced through gender stereotypes. This invisibility and silence leads a woman to accept her secondary status, even in relation to her own health and well being. The respondents revealed that there is lack of initiation to dialogue or when dialogue has been initiated, there is poor dialogue between the wife and her spouse. Even the extended family's or the church's utilitarian attitude towards its female members makes it difficult for a wife to discuss sexuality issues. There were a number of reasons the wives' advanced for letting the husbands be in the forefront in making decisions. The following extracts present issues that were advanced by many wives during the focus group discussions.

*Religious promulgations and teachings*

Johannah, secretary said:

> The Bible says wives should be submissive to their husbands because they are the heads of the house.

Grace, an accountant said:

> As a Christian the bible tells me that my husband is the head of the house...So I need to obey him and consult him in anything that I do....He must make the final decision...

*Cultural norms*

Idah, a form five school leaver who was pregnant for the first time said:

> In the event that your husband complained to *bashi bukombe* (the go between) or *bana chimbusa* (marriage counselors) about any abominable sexual conduct, you will be castigated. This is because sex is a sacred act in marriage and a wife must fulfill it when the husband demands.

Mutale, a teacher with stated that:

> During my marriage ceremony I was taught several ways of satisfying my husband sexually. I was instructed that I must obey my husband each time he demands for sex. But you know these husbands they may have a girl friend and even though you know you cannot refuse him sex. Now there is AIDS..... as married women we are not safe even from contracting HIV/AIDS.

*Power of men*

Caroline, a counselor observed:

> There is male dominance in sexual relationships and this inherent of the economic base that they wield. Women are nobodies when it comes to deciding to have sex. Men demand sex all the time even when the woman is sick. You refuse oh oh oh you will face the wrath. They will deny you money, insult you or even beat you up.

Faith, a secondary school teacher lamented:

> There is a lot of forced sex like rape in marriage. When a woman decides not to have sex, the husband will force himself upon her. There are no feelings about the other partner. What is surprising is that men want it all times and they have no rest. You wonder what moves in them any way. You try to speak even with humility; you will be threatened with divorce or to share a husband with a new rival. This seems to be welcome in our modern society once it gets to the ears of elders.

These findings regarding husbands being primary decision makers on when to have sex can be attributed to the traditional marriage teachings that women go through before marriage regardless of the tribe to which one belongs. The findings also show that Christianity and the Bible teachings that emphasise on husbands being the head of the house and the aspect of women submitting to their husbands contribute to wives having less decision making powers in a marriage.

### 4.3 Shared decision making

This study found that couples shared decision making on only three variables.

Table 4.15 Shared Decision Making

| Variable | Both of us |
|---|---|
| Who makes decisions on child spacing? | 17(43.5%) |
| Who makes decisions on what contraceptive to use? | 13(33.35) |
| Who makes decisions on number of children? | 2(5.1%) |
| Who makes decisions on when to have sex? | 0 |
| Who makes decisions on abortion? | 0 |
| **Total** | 32(82%) |

### 4.4 Reasons for the Types of Decision making

In view of the responses that were advanced in answering the earlier research questions, the patterns of decision making we have seen can be diagrammed as follows:

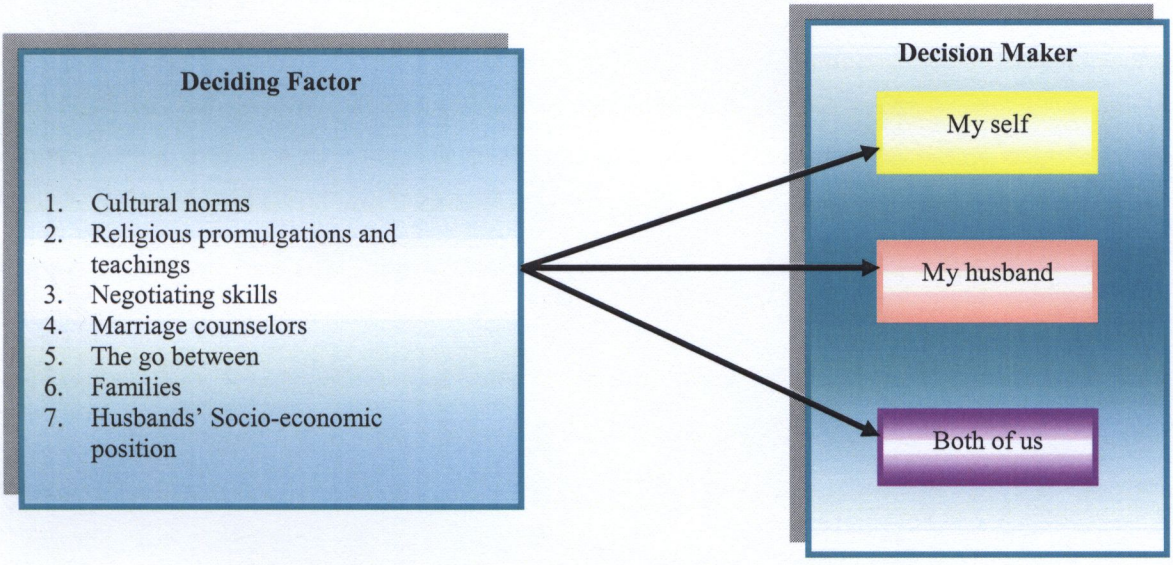


Figure 4.9 Deciding factor and Decision maker model

While there was agreement among all respondents that men are dominant in decision making most wives irrespective of education or economic status did not find it embarrassing to be overruled by their husbands. The study has revealed that though there are areas of agreements, there are seven important factors that shape the decision making processes in the home (figure4.9). These factors are; cultural norms, religious promulgations and teachings, negotiation skills, marriage councilors, the 'go-between', families and husbands' socio-economic position.

### 4.5 Effects of unshared decision making

We have shown that men are more dominant in making decisions on when to have sex and the number of children and on the average putting all the five reproductive issues together, husbands are primary decision makers on reproductive issues. (table 4.5) The aspect of husbands being primary decision makers in reproductive issues was visible even in homes where wives were educated or had a good economic status. It was observed that when the wives opposed their husbands' decisions, they were likely to face sanctions which led to divorce and domestic violence. Husbands' authority regarding reproductive issues, apart from leading to wives' ill health caused by taking contraceptives such as pills, can lead to wives' contracting HIV /AIDS.

# CHAPTER FIVE - CONCLUSION AND RECOMMENDATIONS

## 5.0 Conclusion

In this chapter, the researcher will discuss the conclusions of the study following the findings of the research questions. The researcher will also give recommendations based on this study.

The conclusions of this study are based on the four research questions which this study set to answer. The research questions were to find out on what reproductive issues there is shared decision making between wives and husbands, on what reproductive issues there is unshared decision making between wives and husbands, why decision making patterns on reproductive issues between wives and husbands were the way they were and the effects of male decision making regarding reproductive issued on wives.

This study has shown that generally husbands have a greater reproductive decision making power than their wives. Notably husbands dominate in making decisions regarding when to have sex and on the number of children. This study has further shown that shared decision making between husbands and wives is low.

This study has further shown that there are seven determinants for the decision making patterns that exist between the studied husbands and wives and these are: cultural norms, religious promulgations and teachings, negotiating skills, marriage counselors, the 'go-between', families and husbands socio-economic position.

Regarding shared decision making on reproductive issues, this study revealed that husbands and wives discuss issues of contraceptive use and child spacing. These two aspects were seen as exclusively being for women as husbands expected their wives to use contraceptives and not them.

This study has discussed the effects of unshared decision making on wives and these are gender based violence which can either be psychological, physical and emotional. It can also

lead to wives' ill health caused by taking contraceptives such as pills, threat of divorce, marital rape and the contraction of HIV/AIDS.

This study has shown that socio-economic status contributes negligibly to a wife's decision making behaviour regarding reproductive issues and this relates to the George compound study of women that revealed that husband's permission to start using contraceptives needed to be sought. These findings correlate with other African studies like the Zaire and Nigeria survey by Djamba (1994). Djamba submitted that conjugal relationships are to a larger extent defined in cultural terms and that 'there is evidence that many African men and women believe that husbands are the primary decision makers regarding their marital sexual activity. However, when we tested Hardill and others' hypothesis (Hardill et al. 1995), following their Meta analytic studies on decision making in dual-career households conducted in Britain, it did not apply to the Zambian situation. They submitted that studies on decision making in dual-career households conducted in Britain have shown that the working wife is less likely to be dominated by her husband and that shared activities and decision making is joint when the wife has a paid job. In this study the general decision making pattern on reproductive issues show that husbands had maximum authority, hence the existence of one polar decision type where a husband dominates.

Contrary to what other studies have asserted and particularly Willis (1997 that almost all extant economic models of fertility, static or dynamic, treat the household as having a single set of preferences and that no one person has the monopoly in decision making, this study has shown that there are no single house hold sets of preferential of models but solitary preferences and these point to husband's domination. We can then deduce that men are crucial actors in making decisions on reproductive issues, through their position as heads of households and this is supported by the American position (Crompton, 1993) and the African positions as evidenced by Djamba (1994) in Nigeria and Zaire as well as the Zimbabwean position (Chizororo et al., 1999).

The reproductive issues raised in this study directly affect the woman's body and as such it is only fair that women themselves take lead in taking decisions that affect them more. Unless women have a greater say on decision making regarding reproductive issues, the fight for gender equality is far from being won.

## 5.1 Recommendations

1. NGOs and Governmental organisations that are advocating for gender equality must develop strategies which will address power relations that exist in the institution of marriage.
2. Community sensitization on the effects of unshared decision making regarding reproductive issues must be encouraged.
3. Traditional, cultural and religious teachings must encourage shared decision making regarding reproductive issues.
4. Health practitioners must make a follow up on the effects of contraceptives on women's health.
5. Husbands and wives must be encouraged to attend under-five clinics/antenatal talks together.
6. Husbands must be encouraged through media programmes and Government to use contraceptives and also to realise that contraceptive use is for both husbands and wives.
7. Traditional marriage counsellors must redesign their teachings on sex in marriage to empower women to participate in the reproductive decision making process.
8. There is need to have more Non-Governmental Organisations that will dedicate themselves to gender sensitive reproductive issues only and advocate for legislation to support women.
9. Couples should extensively be sensitized by different NGOs and Government organisation on whom to see should they face gender based violence in a home.

## BIBLIOGRAPHY


Anderson, E. (1990), *Streetwise: Race, class, and change in an urban community*, Chicago:University of Chicago Press.

Araoye,M.O.(2006), 'Communication and Decision Making About reproductive Health Issues Within Couples in Kwara State ,In Trop J. Obstet Gynaecol, 23 (1) April, 2006.

Bebel,A. (1988), *Women in the past, present and future.* London: Wan Publications.

Becker, G. and Lewis, H. G. (1973). "On the Interaction between the Quantity and Quality of Children". *The Journal of Political Economy* **81**: S279-S288.

Blaikie, N. (2000), *Designing Social Research.* Oxford. Polity Press.

Caldwell,J.C. and Caldwell, P. ( 1978), 'The achieved small family: Early fertility transition in an African city,' *Studies in family Planning*, 9,1 (January):2) 18.

Chandra, A. (1997), 'His or Hers: Choice of Contraceptive Method among Married Couples' In The U.S. Paper presented at the Annual Meeting of the Population Association of America, Baltimore.

Chizororo, F. M, Wekwete N, Matshaka M. (1999), *Family Influences on Zimbabwean Women's Reproductive Decisions and the Wider Society.* Harare: University of Zimbabwe.

Crompton, R. (1993), *Class and Stratification: an Introduction to current debates.* Cambridge: Polity

CSO (2000), *Census of Population Analytical Report*, Volume 10 Lusaka, Zambia

De Vaus, D.A. (2001), *Research Design in Social Research*, London: Sage publications

Djamba, Yanki K. (1994), Spouses' Differential Roles in Control of Fertility: Evidence from Kinshasa.' Study Report prepared for the World Health Organisation, Zaire: Department of Demography, University of Kinshasa.

Dover, P. (2001) 'A man of Power: Gender and HIV/AIDS in Zambia'. Unpublished Ph.D Thesis Uppsala University, Department of Cultural Anthropology and Ethnology.

Downe-Wamboldt, D. (1992), 'Content Analysis: Method, Applications and Issues', *Health Care for Women International*, **13** (3): 313-321.

Dreikurs, R. (1972), *The Marriage Relationship: Psychoanalytic perspective.* Salo Rosenbaum and Anglo, Eds. New York: Basic Books

Drew, P, Heritage, J. (1998), 'Analyzing talk at work: an introduction.' In: Drew P, Heritage J, editors. *Talk at work. Interaction In Institutional Settings.* London. Cambridge University Press, p. 3–65.

Drew, P. and Heritage, J. (1992), *Talk at Work: Interaction in Institutional Settings.* Cambridge: Cambridge University Press.

Edgel, S. (1980), *Middle Class Couples.* London: Allen and Unwin.

Finch, J. and Mason, J. (1993), *Negotiating family responsibilities.* Routledge, London.

Fraser, D. (1999), QSR *NUD*IST Vivo: Reference Guide.* Melbourne: Qualitative Solutions and Research Pty.

Geisler, G.G., Keller B.B, Chuzu P.M. (1985), 'The needs of Rural women in Northern Province: Analysis and Recommendations.' National Commission for Development Planning (NCDP) and NORAD. Lusaka.

Glaser, A.L. and Corbin, J. (1990), *Basics of Qualitative Research: Grounded Theory Procedures and Techniques.* Newbury Park: Sage.

Glaser, B.C. (1978), *Theoretical Sensitivity.* Mill Valley: The Sociology Press.

Glaser, B.C., and Strauss, A. (1967), *The Discovery Of Grounded Theory.* New York. Aldine Publishing Company.

Hardill, I., Dudleston, A.C., Linacre, R., Green, A.E. and Owen, D.W. (1995), *The Location and Mobility Decisions of Dual career households in Great Britain: Research Methods.* Department of Economics and Public Administration Occasional Paper Series 95/3. Nottingham: Nottingham Trent University.

Harris, C.C ( 1969), *The Family: Studies of Sociology.* London: Pergamon.

Haslanger, S (2000), 'Gender and Race: (What) Are They? (What) Do We Want Them To Be?', *Nous*, **34** (1).

Heidegger, M. (1996), Being *and Time.* Albany: State University of New York Press.

Holmes, J. (1997), 'Women, Language and Identity', *Social Linguistics*, **1** (2): 195-223.

Hotz, V.J. and Miller, R. (1988). 'An empirical analysis of life cycle labor supply and fertility'. *Econometrica,* **56,** 91-118.

Hotz, V.J., Klerman, J.A., and Willis, R.J. (1997), 'The economics of fertility in developed countries.' In Rosenzweig, M.R. and Stark, O. (Eds.), *Handbook of Population and Family Economics.* New York : Elsevier.

Johansson, P and Brolin,T ( 2006), *Family Planning And Decision Making- Cases from George Compound Lusaka,* Zambia. Masters Thesis in Africa and International development Cooperation, Centre for African Studies, University of Goteborg.

Kaler, A. (1998), 'A Threat to the Nation and a Threat to the Men: the Banning of Depo-Provera in Zimbabwe, 1981.' *Journal of Southern African Studies*, 24:2, pp. 347-376.

Kimmel, M.S. (1986), 'Introduction: toward men's studies.' *American Behavioural Scientist.* 29. (5): pp. 517–529.

Koch, T. (1995), 'Interpretive Approaches in Nursing Research: The Influence of Husserl and Heidegger', *Advanced Nursing.* **21** (5); 827-836.

Komarovsky, ( 1963), 'Class differences in family decision-making experience' In Sussman. M. Source book in *Marriage and the family.* Boston: Houghton Mittlin.

Kondracki, N.L., Wellman, N.S. and Amundson, D.R. (2002), 'Content Analysis: Review of Methods and Their Applications in Nutrition Education', *Nutrition Education Behaviour*, **34** (4): 224-230.

Layder, D. (1998), *Sociological Practice: Linking Theory and Social Research.* London: Sage.

Lincoln, Y.S. and Guba, E.G. (1985), *Naturalistic Enquiry.* Newbury Park: Sage.

Mace and Mace (1978) , *We Can Have Better Marriages.* Nashville: Abingdon

Miles, M.B. and Huberman, A.M. (1994), *Qualitative Data Analysis: A Sourcebook of New Methods.* Newbury Park: Sage.

Miller, W.B., Shain, R.N., and Pasta, D.J. (1991), 'Tubal Sterilization or Vasectomy: How Do Married Couples Make the Choice.' Fertility *and Sterility.* **56** (2): 278-284.

Morgan, A.L. (1991), *After Marriage Ends Economic consequences for Midlife Women.* London: Sage Publications Ltd

Nathanson, C. and Schoen, R. (1977), Sex *roles as variables in preventive health behaviour. Community Health* **3** 2, pp. 142–155.

Neuman L.W. (2000), *Social Research Methods.* Boston. Allyn & Bacon.

Oakley , A. (1972), *Sex, Gender and Society.* London: Temple Smith.

Oakley, A. (1990), *House wife.* London: Penguin Books

Ocholla-Ayaya, A.B.C. (1997), 'The African Family between Tradition and Modernity' in Aderanti Adepoju (ed.) *Family, Population and Development in Africa*, Zed Books.

O'Connell, H. (1994), *Women and the Family.* London: Zed Books Ltd.

Oni, G.A and McCarthy, J. ( 1991), 'Family Planning knowledge, attitudes and practices of males in Ilorin, Nigeria.' *International Family planning Perspectives*, 17,2-June):50-55

Parsons, T. (1964), *The Social System.* Cambridge: The Free Press.

Pleck, J.H., Sonenstein, F.L. and Ku, L.C., (1994), 'Problem behaviours and masculinity ideology in adolescent males.' In: Ketterlinus, R.D. and Lamb, M.E. (Eds.). *Adolescent Problem Behaviours:* Issues and Research. Hillsdale, NJ. Lawrence Erlbaum: pp. 165–186.

Q.S.R. (1997), *Qualitative Solutions and Research. NUD*IST.4 User's Guide.* Victoria: Sage.
Rakow, L. (1986), 'Rethinking Gender Research in Communication', *Communication,* 36 (4): 11-26.

Rosenwasser, S.M., Wright, L.S., Barber, R.B. (1987), 'The Rights and Responsibilities of Men in Abortion Situations.' *Journal of Sex Research.* **23** (1): 97-105.

Salper, R. (1972) , *Female Liberation: History and Current Politics.* New York; Alfred A. Knopf

Shostak, A.B., McLouth, G. And Seng, L. (1984), Men *and Abortion: Lessons, Losses and Love.* New York: Praeger, 299-304.

Speizer,I.S.,Whittle, L.,Carter,M. ( 2005), 'Gender Realtions and Reproductive Decision Making In Honduras' In *International family Planning Perspectives* Volume 31, number 3, spetember, 2005

Strauss, A., and Corbin, J. (1990), *Basics Of Qualitative Research: Grounded Theory Procedures And Techniques.* Newbury Park, CA: Sage.

Street, S., Kimmel, E.B. and Kromrey, J.D. (1995), 'Revisiting university student gender role perceptions.' *Sex Roles.* **33.** (3/4): pp. 183–201.

United Nations, (1994), *International Conference on Population and Developmen*t Cairo, Egypt, Sept.5-13.

....., (1995), *Beijing Platform for Action,* Beijing.

Von Neuman, J., and Morgenstein, O. (1947), *Theory of Games and Economic Behaviour*, 2 nd ed. Princeton, N.J.: Prince town University Press .

Wallston, B.S., DeVellis B.M., and Wallston, K. (1983), 'Licensed practical nurses' sex role stereotypes.' *Psych. Women Quart.* **3** : pp. 199–208.

Watkins, S.R.N. and Wilkinson, D. (1997),Orderly Theories, disorderly women, In Jones G.W et al., The continuing Demographic transition, New York: Oxford University Press.

# APPENDICES

## APPENDIX I- INFORMED CONSENT FORM

**Topic: Decision – making and its effect on reproductive issues: A case Study of expectant married mothers at Chainama antenatal clinic in Lusaka.**

Dear Respondent,

My name is Stellah Mungaila, a postgraduate student attached to the department of Gender Studies at the University of Zambian in the School of Humanities and Social Sciences conducting a study on the above topic.

You have been purposively selected to take part in the study by way of providing information through interviews and Focus group Discussions. Your participation is purely voluntary and you reserve the right to withdraw any time without any explanations. Even when you agree to participate, you are free to refuse to answer certain questions you are not comfortable with.

**Purpose of the Study**

The purpose of the study is to establish the effects of decision – making on reproductive issues among the expectant married mothers attending antenatal at Chainama clinic in Lusaka. This is in order to provide research driven recommendations that takes care of the concerns of decision-making in marriages regarding reproductive issues.

**Procedures**

You will be asked questions on issues regarding decision-making and its effect on reproductive issues. The information provided will be kept confidential

Should you agree to participate in this study ,you will be requested to sign the informant consent form below. Responses you provide will be recorded and you are assured that identification will not be possible since your name will not be recorded anywhere at all

**Possible benefit to participants**

Though there are no benefits to you as an individual, you will have an opportunity to discuss your experiences and offer suggestions on how decision making in marriages can best be tackled without having regrettable effects. Your participation will yield findings that will be used for advocacy as well as informing relevant stakeholders that are instrumental in their quest for gender equality

**Risks and/ or discomforts**

Apart from the some questions being sensitive there is no risk to you as a respondent. If you are uncomfortable with some of the questions asked you are free to refuse to answer and you hereby assured that your refusal to participate or answer any questions carries no risk at all.

**Reasons why you may withdraw from the project**

Participation is voluntary and can be withdrawn any time without any explanation

**Costs to you**

You will not incur any material and or financial costs for participating in this study.

**Confidentiality**

The information obtained from you is confidential and will be treated as such to the extent permitted by law.

If you have understood the nature of this study please put your initials or thumb print where indicated. If you need any clarification or help please feel free to call Dr. Kunsanthan at cell 097-794730, Dr, Ndubani at cell 097-783728 or Dr. Gadsden at cell 097-841643 or visit us at the following address:

School of Humanities and Social Sciences,
Gender Studies Department
University of Zambia/
Box 32379
Lusaka.

I.....having fully understood the nature and implications of the study, agree to participate.

Respondent's Signature or thumbprint .....

Date.....

Witness 'Signature or thumbprint.....

Date.....

## APPENDIX II - INTERVIEW SCHEDULE

### SECTION A: BACKGROUND INFORMATION

Q.1 When were you born?

Month.....Year.....

Q2.When was your husband born?

Month.....Year.....

Q3. What tribe are you?

.....

Q4. What tribe is your husband?

.....

Q5. What is your highest level of education attainment?

.....

Q6. What is your husband's highest level of education attainment?

.....

Q7. What do you do for your living?

.....

Q8. What does your husband do for a living?

.....

Q9. What is your marital status?

.....

### SECTION B DECISION - MAKING ON CHILD SPACING

Q.10.How many years are in between your last child and the one you are expecting?

.....

.....

Q.11. Are you comfortable with the period in between your last child and the one you are carrying?

.....

.....

Q.12. If yes/No, Give reasons to your answer.

.....

.....

Q.13. Do you approve of family planning?

.....

.....

Q.14. If answer is Yes/No to Q. 13 give reasons

.....

.....

.....

Q. 15. How would you feel if your husband decided on child spacing? (Very comfortable, Uncomfortable, Comfortable, just okay)

.....

.....

Q 16. How would your husband feel if you decided on child spacing? (Very comfortable, Uncomfortable, Comfortable, just okay)

Q.17. Does you husband support the use of any family planning?

.....

.....

Q.18. If answer is yes say how /No give reasons (that he gives)

.....

.....

**SECTION C: DECISION – WHAT KIND OF CONTRACEPTIVE USE**

Q19. How many children do you have?

.....

.....

Q.20. Did you plan to have those children?

.....

.....

Q.21. If your answer is No, why did you have them/him/her?

.....

.....

Q.22. Do you discuss issues of contraceptives with your husband?

.....

.....

Q.23. Who decides what kind of contraceptive to use between you and your husband?

.....

.....

Q.24. Give reasons to your answer in Q 23.

.....

.....

Q. 25. How would you feel if your husband decided on what kind of contraceptive to use? (Very comfortable, Uncomfortable, Comfortable, just okay)

.....

.....

Q. 26. How would your husband feel you decided on what kind of contraceptive to use? (Very comfortable, Uncomfortable, Comfortable, just okay)

.....

.....

**SECTION D: DECISION – MAKING ON NUMBER OF CHILDREN**

Q.27. Who decided when to have children?

.....

.....

Q.28. Give reasons to answer given in Q27

.....

.....

Q. 29. How would you feel if your husband decided on number of children? (Very comfortable, Uncomfortable, Comfortable, just okay)

.....

.....

Q.30. How would your husband feel if you decided on number of children? (Very comfortable, Uncomfortable, Comfortable, just okay)

.....

.....

Q.31. Does having a lot of children worry you?

.....

.....

Q.32. Give reasons to your answer in Q31

.....

.....

Q.33. If yes to Q 31, what do you think can be done?

.....

.....

**SECTION E DECISION - MAKING ON WHEN TO HAVE SEX**

Q.34. Who decides when to have sex?

.....

.....

Q.35. Give reasons to your answer in Q 34.

.....

.....

Q .36. How would you feel if your husband decided on when to have sex? (Very comfortable, Uncomfortable, Comfortable, just okay)

.....

.....

Q .37. How would your husband feel if you decided on when to have sex? (Very comfortable, Uncomfortable, Comfortable, just okay)

.....

.....

Q.38.Have you ever been forced to have sex by your husband?

.....

.....

Q.39. If your answer is yes, what was your reaction?

.....

.....

Q.40. what do you think are the results of forced sex in marriage?

.....

.....

Q.41. Have you at any time made a decision to have or not to have sex?

.....

.....

Q.42. what was your husband's reaction?

.....

.....

Q.43. Does the way these decisions are made have any effects on you?

.....

.....

Q.44. Give reasons to your answer to question 43.

.....

.....

**END OF INTERVIEW**

**THANK YOU!**

**APPENDIX III- FOCUS GROUP DISCUSSION GUIDING QUESTIONS**

DATE.....

TIME.....

NO. OF PARTICIPANTS.....

CHARACTERISTICS OF PARTICIPANTS:

.....

**INSTRUCTION TO GROUP FACILITATOR**

- Greet the participants
- Introduce yourself and the note taker to the group
- Introduce the topic and the purpose of the study
- Facilitate the discussion without being involved in it
- Keep all information confidential

There are two main issues of concern in my study and I would like to get your views on them

1. **The first one is about mother hood (meaning reproductive issues) and they relate to five matters and these are;**
   - Family size
   - Contraceptive use
   - Child spacing
   - Abortion
   - Sex with your husband

**2. The second one is related to decision-making on these matters**

**BACKGROUND INFORMATION**

1. What is your experience of your motherhood on the following matters?
   - Family size
   - Contraceptive use
   - Child spacing
   - Abortion
   - Sex with your husband

**PERSONAL EXPERIENCE**

2. Describe as completely, clearly as you can an experience of your mother hood on the following matters;

(a) Family size

(b) Contraceptive use

(c) Child spacing

(d) Abortion

(e) Sex with your husband

**DECISION – MAKING REPRODUCTIVE ISSUES**

3. How do you and your husband go about making decisions in terms of what you want on these matters? (Family size, Contraceptive use, Child spacing, Abortion, conception and Sex of the child).
4. On what issues from the mentioned do you as a wife make decisions?
5. Give reasons to your answer.
6. Concerning the mentioned reproductive matters, on what does your husband make decisions?
7. Give reasons to your answer.
8. So whom can we say makes most decisions regarding the mentioned reproductive matters in your home?
9. Give reasons to your answer.
10 What can you say about some of the decisions made by your husband?
11. Are there some decisions that make you uncomfortable?
12. Give reasons to your answer.
13 Does your husband feel uncomfortable by some decisions you make?
14. Give reasons to your answer
15 What are those decisions that make him uncomfortable?
16. Do you reach a compromise?
17. If answer to Q 23 is yes, how do you reach a compromise? (give situations)
18. How do you go about making decisions on;

(a) Family size

(b) Contraceptive use

(c) Child spacing

(d) Abortion

(e) Sex with your husband

19. Does the way these decisions are made have an effect on you?

20. What should actually happen in making decisions in matters concerning

(a) Family size

(b) Contraceptive use

(c) Child spacing

(d) Abortion

(e) Sex with your husband

**THE END**

**THANK YOU!**