PERSPECTIVES IN WOMEN REPRODUCTIVE HEALTH DECISION MAKING AMONG MOTHERS DELIVERED IN KENYATTA NATIONAL HOSPITAL AND PUMWANI MATERNITY HOSPITAL

BY

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DECLARATION

I, Everlyne Chepkemoi Nyangwaria hereby declare that all the work submitted is original and it has never been presented to any university for the award of any degree.

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DEDICATION

To my beloved husband, Richard

To our dear children Lynne, Laura and Dan

To my parents Mr. John Chemursoi Nyangwaria

And Mrs. Leah Kalyasoi Nyangwaria.

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I appreciate the invaluable guidance from my academic supervisors. I also recognize the guidance given to me by Dr. Anna Karani and the rest of the nursing staff in the school of nursing sciences.

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Finally to my classmates and any other person that played an important role in the compilation of this book and has not been mentioned.

LIST OF ABBREVIATIONS

ART	- ANTIRETROVIRAL THERAPY
KNH	- KENYATTA NATIONAL HOSPITAL
WHO	- WORLD HEALTH ORGANIZATION
KDHS	- KENYA DEMOGRAPHIC AND HEALTH SURVEY
ANC	- ANTENATAL CLINIC
FGD	- FOCUS GROUP DISCUSSION
FP	-FAMILY PLANNING
HIV	- HUMAN IMMUNODEFICIENCY VIRUS
AIDS	-ACQUIRED IMMUNE DEFICIENCY SYNDROME
STI	- SEXUALLY TRANSMITTED INFECTION
MTCT	- MOTHER TO CHILD TRANSMISSION OF HIV/AIDS
HPM	-HEALTH PROMOTION MODEL
NSFG	-NATIONAL SURVEY ON FAMILY GROWTH
ICPD	-INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT
UNFPA	-UNITED NATIONS POPULATION FUND
IUCD	-INTRAUTERINE CONTRACEPTIVE DEVICE

OPERATIONAL DEFINITIONS

Antenatal care: routine check-ups offered to pregnant women at a health facility prior to birth.[45]

Decision-making: the ability of a woman to make choices or decisions on her reproductive health.[2]

Empowering: to enable, make one understand, attain the knowledge about an issue/concept so as to be able to utilize the same in solving issues.[46]

Health care facility: organization that provides health care services based on societal and client demands. [46]

Health seeking behavior: any activity undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy. [45]

Labor and delivery: pertain to the birthing process that includes complete dilation of cervix, the baby moving down the cervix from the uterus to being born, and the placenta being delivered.[32]

Maternal death: the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. [47]

Physical characteristics: refers to the actual environment the woman leaves in. The kind of housing, the neighborhood, and how it affects her.[14]

Reproductive Health: a condition in which the reproductive process is accomplished in a state of complete physical, mental and social well-being and is not merely the absence of disorders of reproductive process. It therefore implies that people have the ability to reproduce, to regulate fertility and to practice and enjoy sexual relationships. [39]

Sexuality: ongoing process of recognizing, accepting, and expressing oneself as a sexual being. [46]

Service environment: the place where mothers receive services like churches, availability of water, transport to the hospital and other facilities like shops.[14]

Social environment: the environment or situation in which an event takes place.[45]

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABSTRACT

AIM OF STUDY: To establish the perspectives in women's reproductive health decision making among mothers delivered in Kenyatta National Hospital and Pumwani Maternity Hospital.

PERIOD OF STUDY: May 30th, 2006 – July 3rd 2006.

STUDY SITE: Kenyatta National Hospital and Pumwani Maternity Hospital

METHODOLOGY: The study adopted a descriptive cross sectional research design. Three hundred and eighty four women presenting to the study facilities for delivery were recruited. Mothers who had delivered were interviewed using a semi-structured questionnaire that collected information on socio-demographic and cultural characteristics, women's role in reproductive health decision making including prevention of HIV/AIDS transmission, health care factors influencing women's reproductive health decision making, and perception of men's role in women's reproductive health decision making.

Systematic random sampling was used to select the study subjects. There being 20 deliveries in KNH and 60 deliveries in Pumwani per day, a ratio of 1:3 were obtained. The sample for KNH was 96 mothers while that of Pumwani maternity hospital were 288. On the first day, all mothers who had been admitted were serialized using the admission book and their numbers subjected to the table of random numbers to select the first subject. There after, every fourth consenting mother was administered to a questionnaire till the required sample size was achieved.

Three focus group discussions were conducted one in KNH and two in Pumwani maternity hospital to stimulate richer responses thus obtaining in-depth information. Data obtained was processed and analyzed using SPSS. Chi-square was used to test the results at 0.05 level of significance.

RESULTS: the study revealed that age, marital status, level of education and employment status plays a major role in women reproductive health decision making. Some cultural factors found to influence decision making include polygamy, FGM, wife inheritance, sex of baby (preference for boys) and dowry. Female circumcision is a practice that is done forcefully. Some women were in agreement with wife inheritance because some widows do not have any source of income and the only way for her to earn a living is through inheritance. Decision on sexual practice was influenced by many factors. There was significant statistical association between age, marital status, and level of education, income range and planning of pregnancy. Some women initiate sexual intercourse at an early age. Women do not have a chance to choose a marriage partner due to financial constraints. The choice of hospital for delivery depends on services offered and financial capability. Decision on family size is done by the man on many occasions even though some women left decision to super power. Family planning utilization is still low among women. Health services entail service provision and educating women thus influencing their reproductive health decision making. Male partners were found to have a negative influence even though some men were already participating positively in women reproductive health decision making. Women were found not to be able to make decisions on HIV/AIDS preventive measures.

CONCLUSION AND RECOMMENDATION: There is evidence that women are increasingly making decisions influencing their reproductive health, though much needs to be done to empower them. There is need for policies favoring women to be put in place and the government needs to put more effort in educating women on their rights.

CHAPTER ONE: INTRODUCTION

1.1 Background

According to the Kenya Demographic and Health Survey (2003), [1] the amount of control women have towards their sexual practices have important implications for demographic and health outcomes. This includes pregnancy, Human immunodeficiency virus (HIV)/ acquired immunodeficiency syndrome (AIDS) and other sexually transmitted infections.

In a study done in India, four main issues affecting women's decision-making were identified. These include: knowledge, tradition, stigma and accessibility of health services.[2]

In a secondary analysis of a large nationwide survey of women in Pakistan, the study found that, in addition to a range of socio-demographic variables, women's decision autonomy was significantly associated with contraceptive use. The data suggested, however, that autonomy did not mediate the association between women's education and contraceptive use[3]. The ability of women to take decisions on the method and timing of family planning may not only enhance their bargaining power but also reduce their vulnerability to sexually transmitted infections (STIs) including acquired immunodeficiency syndrome (AIDS) from diseased or high-risk partners.[4]

According to the Family Planning International Assistance, women in Kenya often forge their partners' signatures rather than risk violence or abandonment for requesting permission to use family planning services. Similarly, focus group discussions on sexuality in Mexico and Peru confirm that women feared violence, desertion, or accusations of infidelity if they proposed using contraception. When family planning providers in Ethiopia stopped requiring spousal consent, use of the clinics' services increased by 26 per cent in a short period of time.[5]

Many HIV/AIDS-prevention strategies are based on negotiated condom use between partners. This relies on the gravely mistaken assumption that there is equality of

negotiating power between men and women. Even in consensual unions, women may lack full control over their sexual lives. Available studies from Latin America and Asia confirm that women's bargaining power in married life is weakest when it comes to sex and reproduction. [5] *"Of all the health challenges that countries face, those posed in relation to sexual and reproductive health are perhaps the most daunting because they involve not only diseases, but also normal components of life such as sexual maturation and pregnancy, surrounded by cultural, social, ethical and religious considerations. In no other aspect of health is the need for broad community involvement, alongside focused and effective interventions, so necessary."*[5]

The international reproductive health community has acknowledged the importance of addressing gender disparities in sexual relations and reproductive health decision making as fundamental to improving the reproductive health rights of both women and men. [6]

This study looked at factors affecting women's decision making on reproductive health care.

1.2 Statement of the Problem

Globally, about half a million maternal deaths take place each year partly because women are having more pregnancies than they want. If all women were able to avoid unwanted pregnancy, at the very least a quarter of the maternal deaths would be avoided.[7]

There is also evidence in Kenya that maternal mortality is on the increase due to the fact that women are having more children than they desire, leading some to seeking unsafe abortions. Although abortion is illegal in Kenya, the complications of unsafe abortions account for much of the maternal morbidity and mortality. In a study conducted by the Population Council in 1997 on admission to gynecological wards in five Kenyan Ministry of Health hospitals (i.e. Eldoret, Kisumu, Mombasa, Nakuru and Nyeri) on average, 35% of gynecological ward admissions were due to incomplete abortion. Estimates of Nairobi hospitals gynecological admissions attributable to complications of unsafe abortions have been as high as 50% to 60%. [8] Available data on maternal mortality in Kenya indicate an

increase from 395 per 100,000 births in 1994 to 590 in 1998. Estimates from the 2003 KDHS show little improvement. The proportion of medically assisted delivery has been on a gradual decline over time. [9]

According to Cook (1994) [10] evidence confirms the dangers to health presented by pregnancies that come too early, too late, too often and at intervals that are too closely spaced in women's reproductive lives. She also states that women may be disadvantaged in protecting themselves against HIV infection not only through lack of information, but also through lack of power to deny partners intercourse, to insist that partners use condoms or to obtain supplies of new female condom.

Gender roles also influence maternity care. When complications of pregnancy and childbirth develop, women are often not able to make decisions about their care. As a result this places male family members and community members in decision-making roles. However, men often make poor decisions about seeking care during pregnancy and childbirth, in part because they do not understand the dangers involved.[11]

Some communities in Kenya like the cattle-keeping Kuria marry off female children some of whom are as young as 12 years old. It is unfortunate that while other communities are discarding traditions that drag down their socio-economic development, the Kuria community still embraces the custom of marrying off their children. Teenage marriages burden the young girls with responsibilities that they are ill prepared for. This includes child bearing and the concomitant hustles of taking care of children. [12]

Lack of women reproductive health decision-making has a large impact on the society at large. Unplanned pregnancies lead to a tremendous increase in the country's population growth. Kenya has an estimated quarter a million street children as a result of these unplanned pregnancies. The issue of street children has become a major social problem.[9]

It has been noted in Kenya that the relative helplessness of girls and female adolescents to negotiate sexual matters and resist sexual coercion within their marriage raises their risk of HIV infection. Forced sex with older, HIV-infected husbands may explain in part

why married adolescent girls have some of the highest HIV rates. Data from Zambia also show that young married girls are more likely to be HIV-positive than are their unmarried peers because they have sex more often, use condoms less often, are unable to refuse sex, and have partners who are more likely to be HIV-positive. [13]

Among women seen at the KNH postnatal clinic, it is estimated that about 15% do not make their own decisions regarding family planning and instead would prefer their husbands being the decision makers. It has also been noted that countrywide, although a large percentage of women attend antenatal clinic during pregnancy, early antenatal clinic attendance is low. One reason that makes women not to seek early prenatal care is that they do not wish to be pregnant.[14]

In many African countries, most women die in pregnancy and during labour because of the following three major delays: the delay in ***deciding*** to seek care; the delay in ***reaching*** the health facility; and the delay in ***receiving appropriate care*** after arrival at the facility. These are the main obstacles to safe-motherhood.[15] In a study done by Rani and Lule (2004), in Kenya, unequal distribution and access to health services were factors found to influence women's decision making in reproductive health care. [16]

From the above, it is evident that the ability of a woman to make any decision on reproductive health has a major influence to society in general.

1.3 Research Question

1) What are the perspectives in women's reproductive health decision-making?

1.4 Research Objectives

The broad objective of the study was to establish the perspectives in women's reproductive health decision-making among mothers delivered in Kenyatta National Hospital and Pumwani maternity hospital. To achieve this objective, the study was guided by the following specific objectives:

i. To establish the role of women in decision-making with regard to their reproductive health care.

ii. To determine the socio-economic and cultural factors that influence women's decision making in reproductive health.

iii. To determine whether accessibility of health services influence women's decision-making in reproductive health care utility.

iv. To explore women's perceptions with respect to male involvement in reproductive health decision-making.

v. To establish whether women are able to make decisions on protective measures in relation to STI and HIV/AIDS.

1.5 Hypothesis

Women's reproductive health decision making is not influenced by socio-demographic characteristics.

1.6 Justification of the Study

About half of maternal deaths occurring globally are due to women having more pregnancies than they want. [7] From a study done in KNH on contraceptive acceptance and continuation in women managed for incomplete abortion, it was found that the high abortion rates were due to lack of contraceptive use. The majority of the abortions resulted from unwanted pregnancies, which were more in adolescents.

The population continues to explode causing strain on medical, social and economic progress in the country. According to the National Council for population and development, Kenya's population is growing because many children are born. Most parents have five children on the average and yet most of them really want three or four children. This has resulted into overcrowding. In 1970, Nairobi had only 700,000 people. The population has continued to grow. By 1996 Nairobi had more than 1,500,000 people. This crowding creates problems of water, schools, housing, jobs and security.[17]
Among women seen in KNH postnatal clinic, approximately 15% do not want to commit themselves on issues regarding family planning and instead would want their husbands to make decisions on their reproductive health practice. In a study done on contraceptive acceptance and continuation in women managed for incomplete abortion at KNH, advice

against use of contraceptives mostly by husbands and to a less extent by relatives, accounted for 12.9% and 6.8% non use of contraceptives prior to and after counseling respectively. After counseling, 14.1% wished to use contraceptives after discussion with somebody else, 12.1% of whom wanted to discuss with the husband. These and many other situations in Reproductive health decision-making and its impact need to be investigated.[21]

1.6 Expected Benefits of Study

The study findings will be used to improve implementation programmes related to women's reproductive health care in the two hospitals. It will enhance understanding of maternal risk factors and their relationship to adverse pregnancy outcomes. This will aid in the development and assessment of programs designed to identify high-risk pregnancy and reduce adverse outcomes which include preterm births, low birth weight, infant mortality, poor child spacing and low postpartum contraception.

The study findings can also be replicated to other health facilities of the country.

Lastly, the study findings will be used for publication to promote reproductive health education and stimulate further research on related issues.

1.7 THEORITICAL FRAMEWORK

Pender's Health Promotion Model

The Health Promotion Model (HPM) was used to guide the study. The (HPM) was operationalized in line with the study's specific objectives, based on the following assumptions and theoretical statements derived from the model.

The HPM emphasizes that persons seek to create conditions of living through which they can express their unique human health potential and have the capacity for reflective self-awareness, including assessment of their own competencies. Persons value growth in directions viewed as positive and attempt to achieve a personally acceptable balance

between change and stability and individuals seek to actively regulate their own behavior. Prior behavior inherited and acquired characteristics influence beliefs, affect and enactment of health-promoting behavior. Persons commit to engaging in behaviors from which they anticipate deriving personally valued benefits.[43] Women would therefore engage in reproductive health decisions to promote their own health.

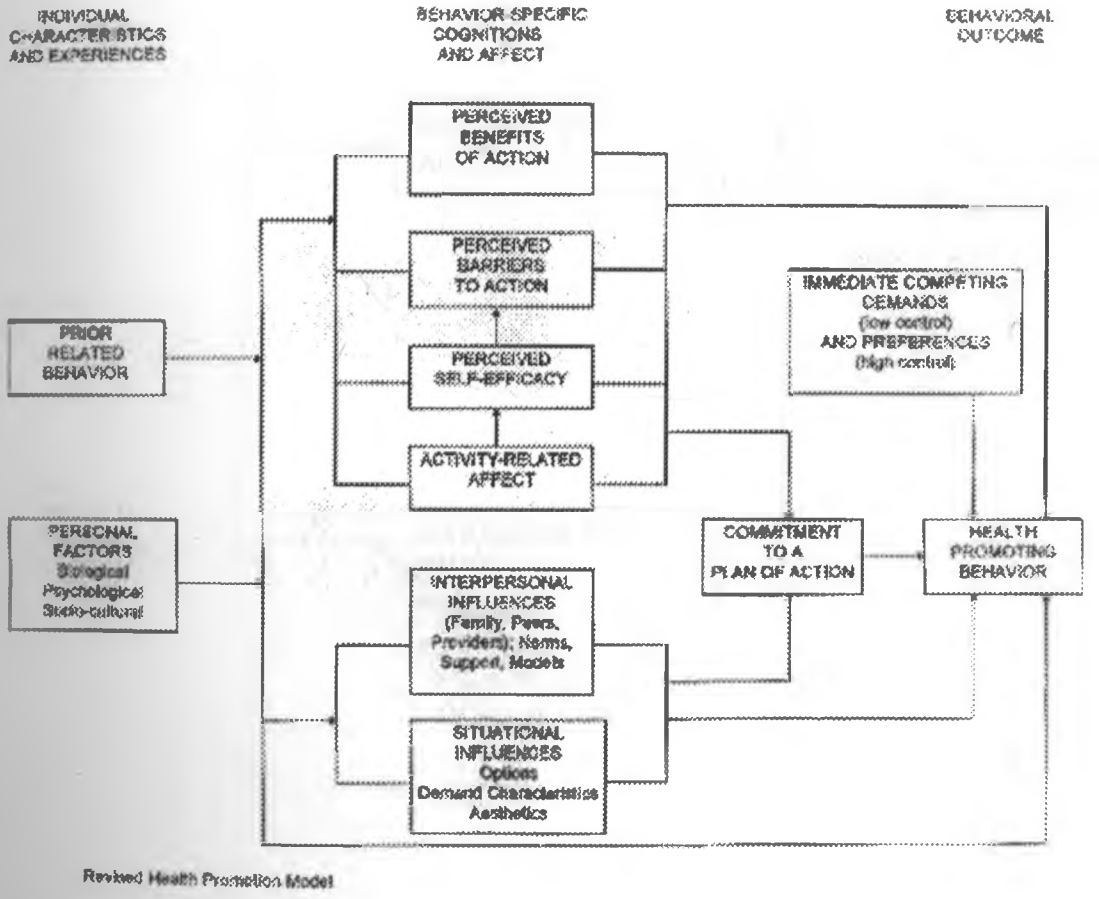
The HPM emphasizes that individuals in all their biopsychosocial complexity interact with the environment, progressively transforming the environment and are being transformed over time. Health professionals constitute a part of the interpersonal environment, which exerts influence on persons throughout their lifespan. Self-initiated reconfiguration of person-environment interactive patterns is essential to behavior change. The influence of socio-economic, cultural and health service factors affecting women decision-making contribute to health promotion behavior. Perceived barriers can constrain commitment to action, a mediator of behavior as well as actual behavior. Perceived competence or self-efficacy to execute a given behavior increases the likelihood of commitment to action and actual performance of the behavior. Greater perceived self-efficacy results in fewer perceived barriers to a specific health behavior. Positive affect toward a behavior results in greater perceived self-efficacy, which can in turn, result in increased positive affect.[43]

When positive emotions or affect are associated with a behavior, the probability of commitment and action is increased. Persons are more likely to commit to and engage in health-promoting behaviors when significant others model the behavior, expect the behavior to occur, and provide assistance and support to enable the behavior. Male involvement in women reproductive health decision-making will be looked at in line with the models assumptions. Families, peers and health care providers are important sources of interpersonal influence that can increase or decrease commitment to and engagement in health-promoting behavior.

In establishing the role of women in decisions on protective measures in relation to prevention of STIs and HIV/AIDS, the HPM emphasizes that situational influences in the

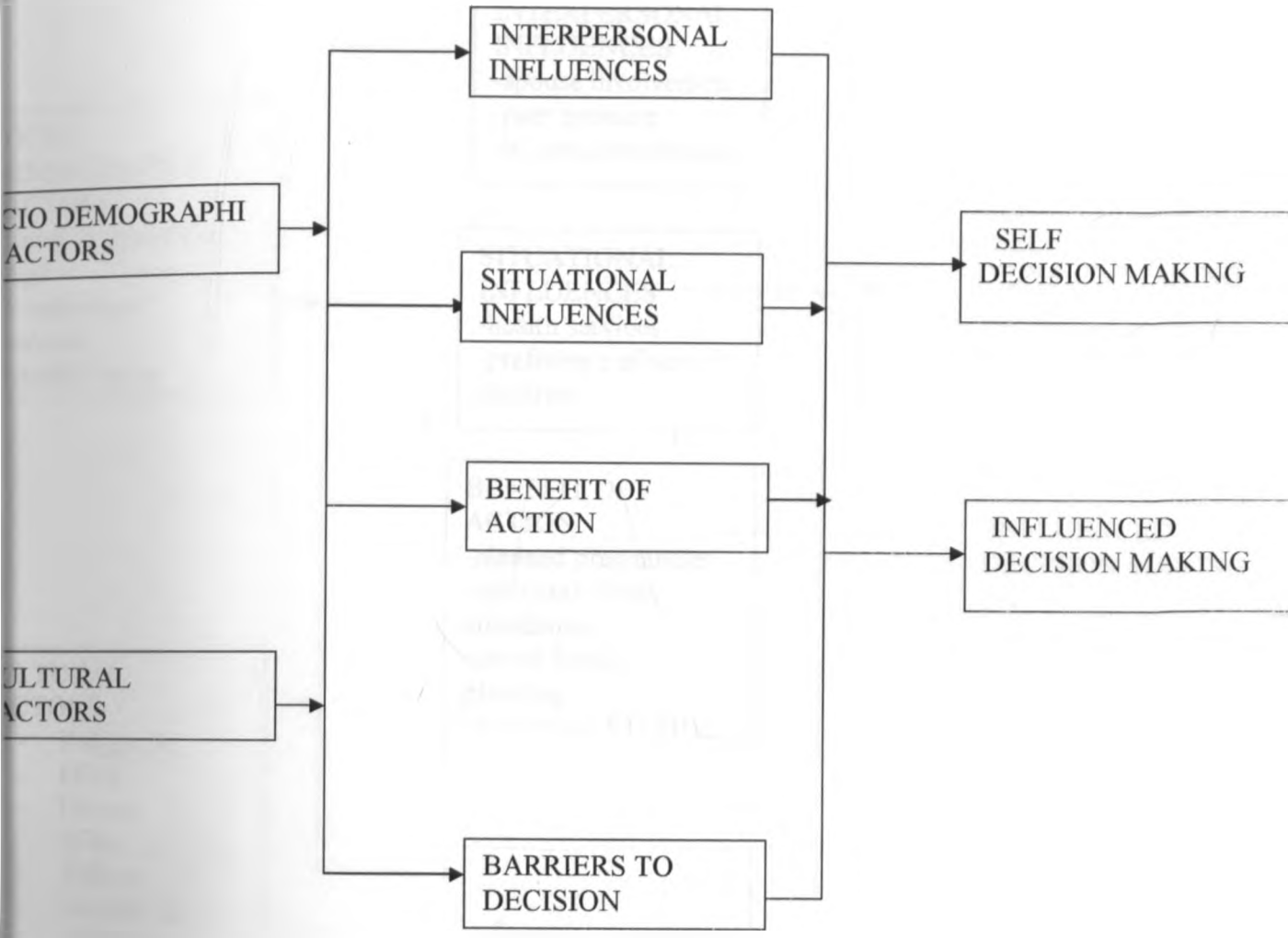
external environment can increase or decrease commitment to or participation in health-promoting behavior. The greater the commitments to a specific plan of action, the more likely health-promoting behaviors are to be maintained over time. Commitment to a plan of action is less likely to result in the desired behavior when competing demands over which persons have little control require immediate attention. When other actions are more attractive and thus preferred over the target behavior, persons can modify cognitions, affect and the interpersonal and physical environment to create incentives for health actions.

Figure 1: Pender's Health Promotion Model



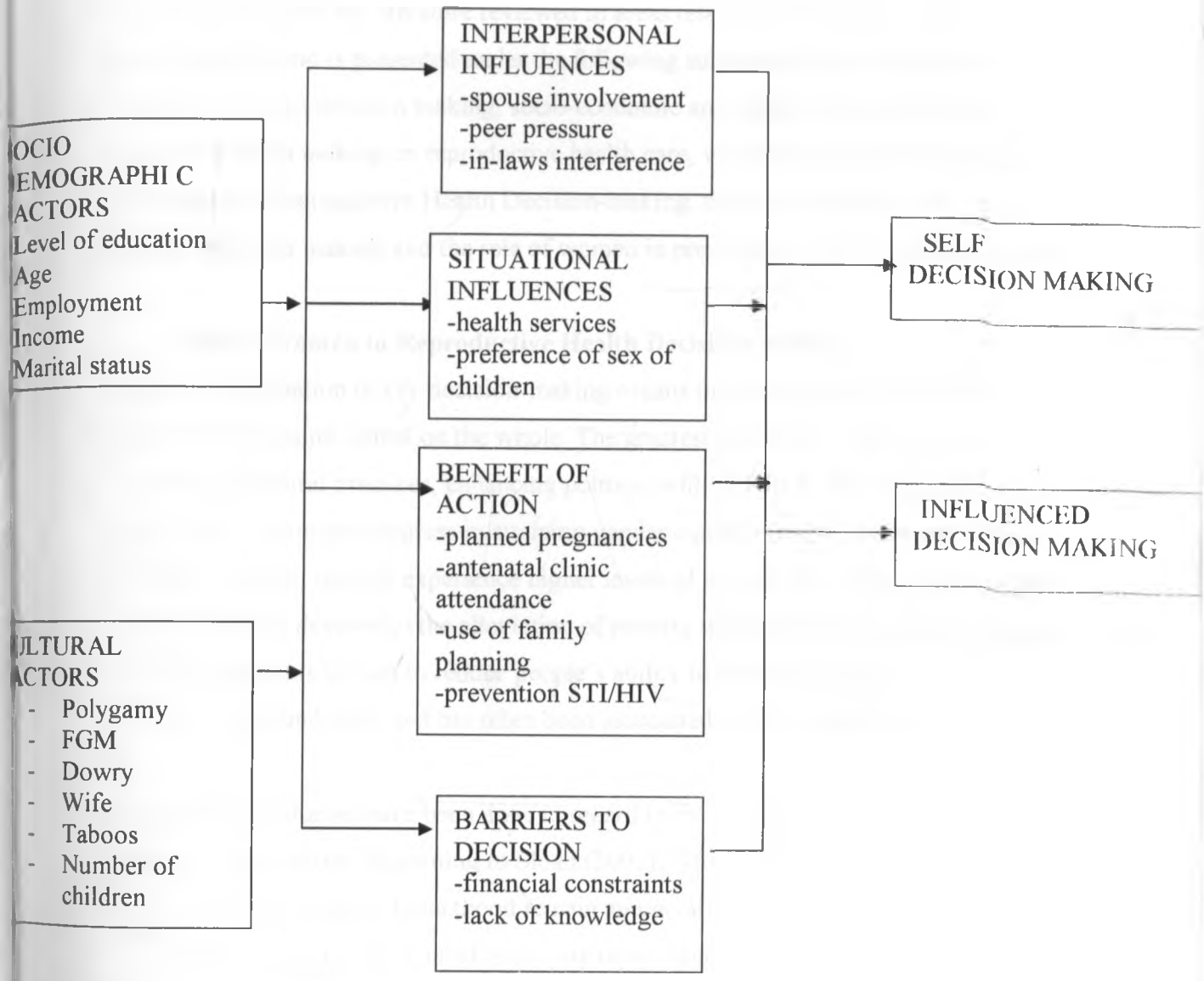
1.8 CONCEPTUAL FRAMEWORK

Figure 2: conceptual Framework on perspectives on decision making on reproductive health issues



1.9 OPERATIONAL FRAMEWORK

Figure 3: Operational Framework on perspectives on decision making on reproductive health issues



CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

This section presents the literature reviewed in areas related to the study in line with the study objectives and is presented under the following sub-topics: Role of women in reproductive health decision making, socio-economic and cultural factors affecting women's decision making on reproductive health care, women's perceptions to male involvement in Reproductive Health Decision-making, the link of health services to women's decision-making and the role of women in prevention of STIs and HIV/AIDS.

2.1 Role of Women in Reproductive Health Decision-Making

Women's participation in key decision-making organs of government in Kenya has increased but remains dismal on the whole. The greatest challenges include tackling retrogressive cultural practices, enhancing political will, and strengthening institutional mechanisms to promote progress in attaining gender equality, equity and empowerment of women. Overall, women experience higher levels of poverty than men, therefore more resources need be devoted to the alleviation of poverty within female-headed households. Lack of education is known to reduce people's ability to take advantage of the opportunities around them and has often been associated with increased poverty.[17]

Several research studies have been done in regard to the role of women in reproductive health decision-making. According to Sloan (2002), [18] for many women, successful contraception and Planned Parenthood remain an unrealized dream. Approximately half of all the pregnancies in the United States are unintended, with the highest rates occurring among adolescents, lower-income women and African-American women. Because of the high rate of unintended pregnancy and abortion, large numbers of women do not complete their education and become single parents who bear the burden of financial and psychological stress.

The national survey on Family Growth (NSFG) uses specific definitions to classify pregnancies:

a) Intended- wanted at time of conception or sooner.
b) Unintended- not wanted at the time conception occurred.
c) Mistimed- wanted by the woman some time but occurring sooner than desired.
d) Unwanted- occurring when the woman did not want any pregnancy. [18]

Women's ability to control their fertility could by itself, reduce the number of maternal deaths by as much as 20-35% simply by reducing pregnancies to the number desired. Birth spacing has a substantial effect on child mortality, potentially reducing child deaths by as much as 20% in some cases. With the full complement of sexual and reproductive health services, including particular attention to the one billion adolescents now transitioning to adulthood, the effect on health (including HIV prevention), well being and poverty-reduction would be far greater than with the level of coverage and selected interventions that currently exist. [19]
According to a study in Europe, the number of HIV-infected women who have subsequent live births has increased. Reproductive decision-making is a difficult issue. Aspects such as socio-cultural background, past reproductive history, maternal disease progression status and concerns about the risk of Mother to child transmission complicates the decision making process.[20]

Gennavo (2005), [14] states that improvements in maternal child health have occurred in part because of improvement in social factors. For example, pregnancy desire has been found to be related to birth weight. Women who did not want to be pregnant had higher rates of low birth weight. Also those women who do not want to be pregnant do not seek early prenatal care. They may likely smoke, drink, have unsafe sex, eat poorly, get inadequate folic acid and thus have poorer birth outcomes.

In some cases, husbands do not approve their wives using family planning. As a result, women may sacrifice their own wishes to those of their partners or perception of their partners' wishes. Alternatively, women may practice contraception covertly, potentially exposing themselves to financial vulnerability or emotional or physical violence if discovered. [6]

In a study done on contraceptive acceptance and continuation in women managed for incomplete abortion at KNH, it was evident that the high abortion rates seen in the hospital were due to lack of contraceptive use.[21] The study realized that immediate post-abortion counseling positively influenced contraceptive use. After counseling, 14.1% of the patients said they wished to use contraceptives, but they had to discuss with the husband. Only a few of the husbands who had refused their wives to use contraceptives came to the clinic when requested. Some of the husbands expressed different fears, either that the contraceptives will interfere with sexual pleasure, or cause complications such as frigidity and infertility in their wives. Others felt contraception would encourage promiscuity among their wives.[21]

According to Wataka, [22] the project of family life and adolescent Reproductive health at the Egerton University was conceived as a result of the increasing concern of the university about the alarming rate of female students' dropping out due to unplanned or unwanted pregnancy. Also, unknown numbers were suspected to be illegally terminating their pregnancies.

Better access to emergency contraception, for example, could lead to a reduction in unintended pregnancy, a decrease in the national abortion rate and, on the individual level, a decline in the number of women confronted with the difficult decision of how to resolve an unwanted pregnancy. [23]

In a study done in Nairobi, Kenya, results showed that despite low levels of awareness and widespread misinformation, the participants expressed considerable interest in emergency contraception.[24]

The fact that an increasing proportion of women having abortions are poor underscores the importance of public assistance for family planning programs as an effective means of reducing the incidence of both unintended pregnancy and abortion. The decision to have an abortion is typically motivated by diverse, interrelated reasons. [23]

Some women engage in sex believing that having sex will bring them the affection, love and purpose in life that they lack. But instead of happiness and contentment, it often results in decreased self-esteem, pain, rejection and sometimes tragedy. [25]

The trauma of sexual coercion and assault at different stages of the life cycle of many women and girls leave them with severe loss of self-esteem and autonomy. This in turn means that they do not always make the best sexual and reproductive health decisions for themselves. Many accept victimization as "part of being female". Early traumatic sexual experiences can result in among other things unprotected sex with multiple partners, prostitution and teenage pregnancy. Findings of a community-based study showed that 49 per cent of childhood sexual abuse victims reported being battered in adult relationships. As many as 68 per cent of incest victims reported being the victims of rape or attempted rape later in their lives .[2]

2.2 Socio-Economic and Cultural Factors Affecting Women's Decision Making

In many societies, a woman's status and prestige within the community is determined by the degree to which she meets some culturally defined concept of fertility. In some cases, the definition may be a function of the number of children she bears. In others, it may relate to the sex of the children or the age at which she first becomes pregnant. Whatever the definition, whenever women's compliance with these ideals places their health at risk, it is important to understand precisely what the risks are and identify how best they can be overcome either through the provision of appropriate health care services, through efforts to modify the existing cultural norms or through activities that help women respond to them in a manner that satisfies their own reproductive health intentions. [2]

The major socio-economic and cultural factors that influence women's decision-making include the following:

2.2.1 Bride wealth

While there is no reason to doubt that practices such as bride wealth influence the reproductive health status of areas where it is prevalent, much still remains to be learned

about how that influence is exerted and how best to address the needs of those women most directly affected by it. In those parts of the country where this practice exists, it is believed that women are under considerable pressure to continue bearing children, particularly girl children, since they represent such an important source of wealth to the family. In Gambela, for example, many health care providers singled out bride wealth, as the principal reason the demand for permanent contraceptive methods is so low among the native populations. The low demand for short-term methods, on the other hand, was attributed to other cultural factors, particularly the tradition of post-partum sexual abstinence.[6]

In Kenya, the bride wealth is common among many communities. For example, among the Kuria community marriages necessitate a hefty bride price (also called bride wealth or dowry) paid for in head of cattle from the groom and his family to the family of the bride. As cattle-rusting has increased in recent years, the impetus for parents to 'sell off' their daughters has grown, making forced marriages an easy way to compensate for stolen herds. The other contributing factor is that the husbands, those able to afford the bride wealth, are mostly old men. This therefore encourages polygamy. The situation among the Kisii community of Kenya is that bride wealth is very important and some people consider level of education in deciding on how many the parents should be given in terms of bride price.[12]

Child marriage in South Africa is also facilitated by the tradition of Lobola, also called bride wealth. A mans family gives goods or property to his prospective wife's family as compensation for her obligation to bear children and the loss of her labor. A young girls high productive and reproductive potential makes her especially valuable in such marital arrangements. Once married, a young woman may have little control over sexual matters. Three- quarter to some 1,000 South African women who responded to a survey said that the prevailing view in their culture was that a man who had paid Lobola owned his wife and could have sex with her whenever he chose. [13]

Devaluation of women of all ages moves beyond matters of status and spiritual concerns into the area of material interests. Daughters in this respect cost dowry payments so that

they may marry into other families. Money spent on education earns no return for the family when women leave the family on marriage or become outcasts through pregnancy before marriage. Daughters in-law warrant no investment when they die through pregnancy, become infertile or suffer infections or disgrace that lead to divorce or abandonment by their husbands.[10]

2.2.2 Infertility

Where childbearing is important for woman's status and prestige, infertility can also represent a serious problem. [15]Infertility is a growing problem in Africa and affects the lives of many couples. As a health problem, it is largely culturally and socially constructed in such a way that even though it affects a couple it is the woman who bears the burden. This perspective has major implications for women whose status hinges on fertility performance. In Kenya, infertility not only erodes the status of infertile women but also threatens their source of livelihood. The burden of infertility is compounded by the fact that at the national programme level it is underplayed as a problem, the main focus being on fertility control. [26]

There is evidence suggesting that women who engage in sexual activity in their early and mid-teens are particularly likely to suffer from infertility. The prevalence of infertility is very strongly associated with a woman's age at first sexual exposure in both Cameroon and Nigeria. The majority of women initiate sexual relations in their early teens. For instance, according to data from the Nigeria DHS, at ages 20–24, the proportion of those infertile is 15% among women who had intercourse before age 13, but only 4% among those who postponed sexual activity until after their 19th birthday. In the two countries, about one-third of women aged 20–44 are unable to have a live birth. Even though infertility has declined in these two populations, there remains major challenges and impediments to reaching the bare minimum of reproductive health described as "the absence of disease or infirmity."[27]

It is therefore evident that women with no children would be the most likely to have male-centered decision-making attitudes. As they have more children, and thus gain more

control over household resources, their attitudes may change. These attitudinal patterns could also reflect women's growing ability and desire to control their procreative lives as they have more children and gain greater exposure and access to reproductive health services.[19]

2.2.3 Early Marriage and Virginity testing

Explanations for the persistence of early marriage are diverse and range from the desire to ensure a daughter's virginity to secure a child's future at an early age or simply to conform to tradition. By remaining in subservient roles, whether as daughters within the parental household or as early brides, opportunities to develop the psychological and social skills necessary to make decisions and life choices remain severely restricted. These restrictions are compounded further by the fact that young women are denied educational opportunities, even at the primary level. [15]

Despite setting a legal minimum age for marriage in Kenya, the age at which marriage is allowed with parental consent is often much lower. The practice of early marriage is increasing rather than declining. In some Kenyan communities, fear of HIV/AIDS has lead to a demand for younger brides. Older men seek under-age girls as brides or sexual partners in the mistaken belief that sex with a virgin will cure them of AIDS. Young girls, relatively powerless in unions with older men are rarely able to insist upon safe sexual practices such as condom or contraceptive use. [28]

Young women often begin childbearing at an early age, long before they have matured either physically or psychologically. As a result, their risk of obstetric complications is significantly increased. They are, for example, more likely to develop nutritional anemia, increasing the risks associated with pregnancy, including post-partum hemorrhage. Adolescent childbearing is also associated with a higher risk of hypertension that can lead to maternal and/or fetal death. The most widely described consequence of adolescent pregnancy is obstructed labour, leading to vesico-vaginal fistulas. These are widespread not only in Ethiopia, but also in other African countries where early marriage and early pregnancy are common [15]

Cultural customs and gender norms can lock girls and women into relationships in which nonconsensual sex is inescapable. Child Marriage, for example is a custom that often results in girls experiencing forced and traumatic first sex with their husbands, as well as subsequent forced sex within their marriages.[13]

As with early marriage, the rationale and even consequences of abduction vary with the circumstances under which it is employed. In some cases, abduction entails the forced seizure and rape of a young woman against her will. But as studies have pointed out, the practice of abduction is also "part of a complex social relationship related to family formation and the sustainability of ethnic groups" (National Committee, 1998). In some situations, it has been known that the girl arranges abduction herself, ostensibly to circumvent her family's disapproval of the proposed partner. In other cases, it is the girl's family that arranges the abduction, particularly in situations where the family finds itself unable to finance the costs of a formal marriage.[15]

Loss of virginity is a greater stigma and barrier to marriage in women than in men. Men bear no health risks for premarital preservation of their virginity. While men and women may rank equally as initiators of auchastity and adultery this may be equally condemned.[10]

In Zimbabwe, Virginity testing is a practice in which a young girls mother, aunt, neighbor or even prospective husband inserts a finger into her vagina to verify her virginity. This may take place in ceremonies sanctioned by rural chiefs as well as in churches and the home.[13]

2.2.4 Male Dominance

Gender inequality in reproductive decision-making is a key element of the social context of reproductive health. Research shows that couples often disagree about the desirability of pregnancy and the use of contraceptives.[29] When this discordance occurs in a situation of male authority, men's opinions about these issues may overrule women's even though the woman often must implement the decisions made on these matters. Conversely,

women who have some decision-making power and autonomy often are better able than other women to meet their reproductive health goals. [6]

In a study done on adopting the female condom in Kenya and Brazil, in the partner dialogue, whether or not a woman was to continue use of the female condom depended to an important degree upon the reaction of the male partner. Kenya is typically a patriarchal society where women are not expected to express love or desire for sex. Cultural norms in Kenya dictate that sex is for the man's pleasure and not the woman's. [30]

In some areas, such as Gambela, male dominance is further reinforced by cultural traditions such as bride wealth by which men effectively purchase, and therefore own, the reproductive rights of their wives. One impact of such dominance was evident in the degree to which women feel able to utilize their knowledge of reproductive health services or even to seek further information about it. Even among women with a fairly broad knowledge of family planning methods, many refused to use them out of fear their husbands would not approve. "He would divorce me immediately" was a common response. [6]

Few countries have applied domestically the international conventions laws that keep women subservient to men and thus put them at increased risk of HIV infection. In Botswana, tribal courts treat adultery as a female crime only. In Lesotho and Swaziland, if a woman is married in a community of property she is considered a legal minor and cannot sign a contract without her husband's permission. In Mozambique, a man is the traditional head of the household and the wife is subordinate. Her property is given to her husband who has authority to allow her to enter into a commercial transaction. In Swaziland, a woman cannot have access to land without her husband, or male relative nor can she inherit from her deceased husband. [31]

2.2.5 Level of Education

Women living in urban areas that tend to be more educated and of higher socioeconomic status have increased access to FP information and services. According to the KDHS

(2003), [1] educated women are more likely to delay marriage, use modern contraceptives, seek antenatal care, have fewer children, ensure their children are vaccinated, and to experience lower infant and child mortality rates.

As levels of education rise among rural women, their decision-making attitudes and behavior may change. Among men, education appears to be the most important factor. The least educated men had elevated odds of supporting and practicing male-centered decision-making. [6]

In a study done on causes and prevention of maternal mortality in three districts in Kenya, due to socio-cultural taboos against pregnancy out of wedlock, 50% of the adolescents had never been to school.[33] Illiteracy among women is a major contributing factor to maternal mortality. Girls who do not go to school, are likely to marry at a very early age and as a result, they are exposed to various complications, particularly obstructed labour due to a small pelvis, with a few of them developing subsequent (vesico-vaginal and recto-vaginal fistulas.) [33]

Due to lack of education, most women have no chance of securing a salaried employment and are therefore forced to remain as peasant farmers with little or no income. They, therefore have to totally depend on their husbands. Without economic power, they are likely to have no power over their own bodies. [33]

According to Alves B and Sheikh Aziz (2005), [34]women from affluent backgrounds are more likely to deliver by elective caesarian sections than those from deprived backgrounds while much of this variation is likely to be explained by biological factors including increased maternal age and infant birth weight in the more affluent, the association persists even after adjustment for these factors suggesting that social factors may also play an important role.

2.2.6 Female Genital Mutilation

According to Cook (1994), [10] FGM reflects a stereotypical perception that women may legitimately be exposed to non-therapeutic surgery in order to comply with the gender-specific norms of their community.

In a survey done by PATH in association with the Maendeleo Ya Wanawake in Kenya, it was found that FGM is most common in Meru, Narok, Samburu, Kisii, and North Eastern. Excision is the most predominant type in most of the practicing tribes of Kenya, while infibullation, the most severe form, is practiced in the North Eastern part of the country. [35]

Former president Daniel Arap Moi realizing the negative effects of FGM was one of the first African leaders to condemn the practice in 1989. However, at that time in Kenya, many people were not yet aware of the dangers of FGM and thousands of girls were circumcised immediately following his condemnation.[35]

In a study done in Kenya on efforts to eradicate FGM, the cultural meaning and significance attached to the practice were cultural and tribal identity. Circumcision was a requirement for one to be identified as a full member of the ethnic group. This is strongly held among the Abagusii who hold circumcision as a mark that distinguishes them from their uncircumcised neighbors such as the Luo. [36]

In other communities of Kenya, FGM confers social and spiritual authority to marry and procreate. The adult status gained through having been circumcised allowed the young woman to participate in adult privileges, duties and responsibilities. Among the Meru of Tharaka, the Kalenjin and the Maasai, a child born of or conceived by an uncircumcised girl was considered ritually unclean and she/he cannot participate in some cultural events and activities. Among the Maasai, such a child was stigmatized through out his/her life and treated as an outcast even in his/her family.[36]

Another reason given by other communities is that FGM is done to control women's sexuality. There exists a belief that the clitoris makes a woman easily sexually excited,

since she cannot control her sexual desires, she becomes sexually immoral and cannot stick to one man. Control of sexual desire is a definition of the true womanhood in these ethnic groups. [36]

In some communities, FGM is considered to be the most significant rite of passage to adulthood, enhancing tribal cohesion, providing girls with respect and important recognition from their peers, and increasing girl's chances of marriage. The practice is also perceived as a means of preventing promiscuity and is believed to promote easy childbirth. Women have emerged as the group most attached to the practice. [35]

Many general community enforcement mechanisms has allowed the FGM practice to continue including multitudes of myths regarding FGM, e.g. the husband of an uncircumcised girl will die, the midwife delivering uncircumcised women will go blind, the baby will be abnormal, the genitals will grow uncontrollably; uncircumcised girls will be immature, and dirty.[35]

Views of the uncircumcised women and those who do not circumcise their daughters are considered irresponsible, bad and imitators of western culture, others consider them as strong and liberated.[35]

In conclusion, FGM has been noted to have socioeconomic, health and psychological impacts upon the girl child. The Socio-economic impacts include the effects on the girls education (since many girls are married off immediately after circumcision), loss of opportunity for self development and achievement of self ideals, psychological effects include the dilemma between identity, sense of belonging and pain which may cause internal conflict within a young girl resulting to psychological trauma and loss of self-esteem. Other impacts include serious health problems associated with trauma and the irreversible loss of body parts as a result of the practice.[37]

2.2.7 Wife Inheritance

This practice can take different forms. Commonly, however, a man may inherit his brother's widow. In Zimbabwe, a widow passes to her deceased husband's brother in a

traditional practice called "kugara nhaka," which could fuel HIV transmission if the woman's deceased husband was HIV-infected she has become HIV-infected and she transmits the virus to her Husband's brother.[13]

In Kenya, the custom persists among the Luo, although widows have been reported to resist being inherited and may attempt to protect their sexual health by insisting that their partners use condoms or permanently abstain from sexual intercourse.[13]

In western Kenya, the custom known as wife inheritance once held an honorable promise. A community would take care of a widow and her children. She did not remarry. Her husband's family simply took responsibility for her. If a brother-in-law could not care for her, then a cousin or a respected outsider would. The inheritor made sure that the widow and her children were fed, clothed, sheltered, educated, protected, and kept. A man could only take on a widow if he had a family. His first wife would accept the arrangement because tradition frowned on his having sexual relations with his inherited one. The system worked until the inheritors began to shun that taboo. They had sex with the widows and that helped HIV explode throughout central and East Africa.[38]

A group of 29 Kenyan women all HIV positive formed a club to fight the culture of wife inheritance, named "The Obwanda Distress Relief Club" in the small village of Obwanda in the western Kenyan district of Homa Bay. Members of the Obwanda Distress Relief Club meet every week to campaign against wife inheritance and the need for voluntary Aids testing. The chairperson of the club says the biggest challenge facing them is ignorance. "Many people think we are pretending we have HIV/AIDS. They say we want to encourage young women to become big-headed and that it is fashionable not to be inherited". The African Medical Research Foundation in Homa Bay says that although many people are much more aware of Aids, it is still difficult to convince people to discard deep-rooted practices. [38]

Pervasive as it has been, however, HIV/AIDS did not kill the tradition of widow inheritance. Men, often seeking to cheat widows out of land, have continued to inherit

them. Widows, shackled by poverty, have continued to rely on inheritors to take care of them. [38]

A number of the Kenya's 40-plus tribes embrace the tradition, but it is especially popular among groups that dominate western Kenya. The region has the highest rate of HIV and AIDS in Kenya in part because wife inheritance allows the disease to grow exponentially. An inheritor has his own family. He infects his first wife and the widow he has inherited. Then he dies, and two other men inherit the women he leaves behind. Those men die, and then their widows are inherited. "It's a terrible cycle." [38]

Most widows in places like Busia possess little education, have no property, do not hold jobs and do not have the skills to easily find one. They must choose, one AIDS activist says, "to [be inherited] and be infected and have food, or you starve." [38]

From the above discussions, it is clearly evident that socio-economic and cultural factors have a big role in women decision-making. It has both positive and negative impacts. The following statement was made by Thoraya Obaid, the Executive director of UNFPA at the African Summit on HIV/AIDS, 2001: "We often invoke cultural values to justify our inaction. But our cultures are full of values that support women and young people, that promotes knowledge and dialogue that builds on community solidarity and mutual support among its members. Let us all call on these cultural values to move us forward in the fight against HIV/AIDS"[28]

2.3 Women's Perceptions on Male Involvement in Reproductive Health Decision-Making

The ICPD programme of action repeatedly emphasizes the importance of achieving greater male involvement in reproductive health. Such involvement is needed in order to improve and protect the sexual and reproductive well being of both men and women. Achieving this means that men have greater participation in roles traditionally assigned by society to women; childcare and socialization, prenatal and postpartum care, contraception and disease prevention especially sexually transmitted infections.[39]

It is not well known what women want with respect to male involvement and what their perceptions are of the extent they would like their partners involved. In many instances, women's groups are still not quite sure what the right approach to male involvement should be, what coalitions or alliances should be formed so that agreements can be reached that do not hinder women's power or status. [29]

The international reproductive health community has acknowledged the importance of addressing gender disparities in sexual relations and reproductive health decision making as fundamental to improving the reproductive health and rights of both women and men. Gender based power inequalities can contribute to poor health outcomes for example, by hindering communication between partners about reproductive health decisions, by preventing women's and men's attainment of sexual health and pleasure, and by increasing their risk of contracting HIV infection and other sexually transmitted infections (STIs). [6]

According to a study done in Honduras, women who lived in less urban areas, had less than a secondary education or were of medium or low socio-economic status, had elevated odds both of believing that men alone should make reproductive decisions and of living in a household in which the man made these decisions. [6]

In an accessibility and feasibility study done in integrating men into the reproductive health equation, it was noted that men in Kenya already participate in women-centered reproductive health services. [40] For the majority of women interviewed, the man's financial responsibility for her care was their primary concern. Many men accompanied their partners to the facilities in order to pay fees. On the other hand, both the women and men interviewed thought that men should and could be more involved, especially in consultations and counseling. The benefit of partners knowing about and understanding women's health status was seen as highly valuable.[40]

The structural and attitudinal constraints at the health facilities were seen as playing a major role in keeping men away. The idea that men regard reproductive health as a woman's affair resonated in the discussions across the groups as well as in the findings of

the quantitative survey. Overall the institutional barriers seemed to be more overwhelming than the cultural barriers, given that one of the reasons frequently given for nonparticipation was fear of non-acceptance by the health providers. Service providers in general were supportive of the idea of greater participation by men in the interviewing and counseling stages, but not during physical examinations or in the wards. [40]

Most harmful sexual practices have their origin in patriarchal societies that promote the superiority of men over women, gender insensitive and gender biased laws which are passed in male dominated parliaments. In a study on human rights and gender issues in Botswana, Lesotho, Mozambique, South Africa, Swaziland and Zimbabwe, it was observed that while these countries have acceded to the convention of the elimination of all forms of discrimination against women, there was evidence of common and customary laws that encourage gender discrimination against women.

2.4 The Link of Health Services to Women's Decision Making

In a retrospective descriptive study conducted in Kakamega, Kirinyaga, and Kilifi districts, the reasons for utilization of any health facility were reported to be nearness, free services, availability of medicines and other facilities. Correspondingly, reasons for non-utilization of services were unavailability of drugs, unavailability of facilities, services not free and unpleasant health worker-patient relationship. Most of the women having maternal deaths (80%) in Kilifi were illiterate. The national literacy rate for women is 47% and 69% for men. In Kakamega and Kirinyaga, educated groups seemed to be at greater risk. This shows that there are other factors besides primary and secondary education involved. [33]

In Honduras, most women have access to FP services at a health post, a health clinic or a hospital. Although women in rural areas often have ready access only to health posts, the lowest tier of service, the care provided at these facilities is free. However, they have to cater for their transport and food at the facility where they spend long hours waiting for services. Whether these service barriers affect rural women's attitudes on who should make reproductive decisions or the reality of who makes those decisions in their

household is unclear. These women may have traditional lifestyles in which men usually still make decisions. [6]

The role of information is to contribute to the individuals' liberty to choose whether or not to accept a proposed form of management. It's not to persuade or condition a person to decide in a particular way, even if that way may appear to the health professional who gives the information to serve the person's best interests. In other words, the right to informed choice includes the right to make choices that health professionals may consider to be poor choices. Paternalistic medicine has been prone to conclude that women's choices are incompletely made if they do not follow health professionals' recommendations and that therefore women can be displaced as decision-makers concerning their medical management .[10]

Friedman et al (2005) [19] in an article transforming health systems to improve the lives of women and children, for the United Nations millennium project task force on child health and maternal health, the potential breakthrough lies in putting health systems at the centre of millennium development goals (MDGS) strategies and in addressing these systems, not only as delivery mechanisms for technical interventions but also as core social institutions as part of the very fabric of social and civic life.

In high mortality countries today, especially for the poorest populations, health systems are frequently the source of catastrophic costs, humiliating treatment and deepening social exclusion. Health systems can be a vehicle for fulfilling rights, for active citizenship and for democratic development and poverty reduction in its fullest sense. Sexual and reproductive health services and rights, if genuinely fulfilled, would have substantial effects on both women and children. [19]

Clinic-based approaches to contraceptive service delivery have not equalized contraceptive use across socioeconomic groups. Poor women still lag behind their better-off counterparts, in part because they have less money at their disposal with which to pay for care and may encounter geographic barriers in reaching clinic sites. Alternative service delivery strategies that have been implemented in Bangladesh, such as the use of

female outreach workers and community-based distribution of contraceptives to young newlyweds, may explain this country's relatively high levels of contraceptive use, even among the poorest women. Delivering services to disadvantaged youth may require community-based outreach projects that are more expensive than traditional approaches and may not be justified by conventional cost-effectiveness analyses. [16]

In order for women to exercise choice freely, they must act according to their own preferences. They should not be conditioned to comply with other's preferences by being dependent on current or future assistance for themselves or their families. They should not feel obliged to undertake acts of self-sacrifice in order to pay for help they have received. [10]

Unequal distribution of the benefits of development and unequal access to various health services may lead to even broader gaps in reproductive health needs and outcomes among rich and poor adolescents. The risk of further "epidemiological polarization" has clear implications for health systems, which must seek to address the specific health needs of young people from different socioeconomic backgrounds. [16]

An article in the Lancet by Barlett (2005) [41] where giving birth is a forecast of death, the high mortality of Afghan women could have many causes including limited availability and accessibility of health services, high fertility, poor health, including anemia from chronic under nutrition and infectious diseases, poverty, low rates of literacy, lack of knowledge about maternal health and safe delivery and cultural practices. Widespread restrictions on education and employment limit the number of trained female health providers and reduce women's resources to access care.

2.5 Role of Women in Prevention of STIs and HIV/AIDS

Women's vulnerability to HIV/AIDS must be examined in the context of the social and economic factors that shape our world. Globally, the feminization of AIDS is linked to poverty and is "at its heart . . . a crisis of gender inequality, with women less able than men to exercise control over their bodies and lives."[20]

Women tend to become infected with HIV at younger ages than men do, reflecting that the risk they face is partly related to the vulnerability intrinsic to being young. Globally, young women (i.e., those aged 15 to 24) are 1.6 times more likely to be living with HIV/AIDS than their male counterparts. Women may be disadvantaged in protecting themselves against HIV infection not only through lack of information, but also through lack of power to deny partners intercourse, to insist that partners use condoms or to obtain supplies of new female condoms. [10]

Worldwide, women tend to know less than men about HIV and its transmission.[2] In fact, in many cultures, ignorance about sexuality itself—let alone HIV disease—is considered a defining element of femininity. According to recent data compiled by the United Nations, more than 80 percent of young women lack "sufficient knowledge" about HIV disease. Many have "no idea how HIV/AIDS is transmitted and little or no information on protection methods."[2] In the United States, many young women, even in areas of high seroprevalence, believe that they are not at risk for HIV infection. [20]

Around the world, most women face barriers to health care services. Access to care, however, is no guarantee that women will receive the information they need to prevent HIV or secure appropriate diagnosis and treatment. In the United States, a study by the Kaiser Family Foundation found that only about one-third of the women surveyed had talked to a health care provider about HIV/AIDS, a serious issue for women who may not understand that they are at risk for HIV infection. [42]

According to Shishana and David's Alicia (2004), [31]sub-Saharan Africa is the only part of the world where HIV prevalence and AIDS deaths are higher for women than for men. In every society, males and females who by nature are biologically different are expected to behave in prescribed ways. In some cultures in southern Africa, men are expected to have multiple partners, while women are expected to be monogamous, the age of marriage is often lower for females than for males, and men are expected to have younger sexual partners. Women must be protected if AIDS epidemic is to be checked. It's important for government to implement gender-sensitive policies. Women should not remain subservient to men.[31]

Refusing sex is simply not an option for many women, particularly for sex workers, victims of sex trafficking, women forced into marriage, and young women who have relationships with much older men. But the problem is not limited to those situations. Research suggests that at least 1 in 5 women worldwide have been physically or sexually abused as either adults or children. An estimated 10 to 15 percent of all females, many of who are younger than 15, report being forced to have sex.[20]

Several studies have found that women commonly cite their partner's unwillingness as the primary reason for infrequent condom use.[16] Moreover, unprotected sex is often considered a sign of intimacy, commitment, and trust between a couple.[17] Maintaining intimacy and securing male approval may be especially important to adolescent girls, who also may lack the communication skills to negotiate condom use. [20]

Royston (1989),[7] thus emphasizes that maternal mortality should not be viewed as a chance event so much as a chronic disease developing over a long period, for the outcome of a pregnancy is profoundly influenced by the circumstances of a woman's life, by the economic and environmental conditions in which she lives, as well as by her social status.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Study Design

This was a cross-sectional study aimed at describing the perspectives in women's reproductive health decision making. Both qualitative and quantitative methods were used.

3.2 Study Area

The study was conducted at Kenyatta National Hospital and Pumwani Maternity Hospital.

3.3 Study Population

A sample was obtained from all consenting mothers presenting to KNH and Pumwani postnatal wards. According to KNH records, twenty (20) deliveries are conducted daily on average. In Pumwani, there is an average of eighty (80) deliveries per day.[44]

Three focus group discussions, each comprising of six consenting mothers were conducted. One was in KNH and the remaining two in Pumwani maternity hospital. Those mothers who did not participate in completing the questionnaires were purposively selected for the FGD.

3.4 Inclusion/Exclusion Criteria

3.4.1 Inclusion Criteria

All consenting mothers who delivered at the KNH and Pumwani maternity Hospital during the study period were considered for the study.

3.4.2 Exclusion Criteria

1) Mothers delivered who were unconscious or in a very sick condition and were unable to respond.
2) All non- consenting mothers delivered at the KNH and Pumwani maternity Hospital.

3.5 Sample Size

The sample size was determined using the following formula: Fisher et.al. (1998)

$$n = \frac{Z^2 p(1-p)}{d^2}$$

Where,

n = desired sample size

Z = the standard normal deviate at 95% confidence interval = 1.96

p = estimated proportion of women who make own decisions on reproductive health. (p = 50 %) was used since there was no estimate available in literature. Use of this figure of 50% is recommended by Fisher et.al. (1998)

d = the degree of precision (set at ± 5%)

Substituting in the above formula:

$$n = \frac{(1.96)^2 * 0.5 * 0.5}{(0.05)^2} = \frac{0.5 * 0.5 * 3.84}{0.0025} = 384.$$

Therefore, a total of 384 subjects were recruited for this study.

3.6 Study Tools

Both quantitative and qualitative methods were used in the collection of data.

3.6.1 Questionnaire

Semi structured questionnaire with both closed-ended and open-ended questions was used to generate quantitative data. The questionnaire was found to be the most ideal for its efficiency and cost effectiveness to obtain socio-demographic, economic and cultural factors, role of women in reproductive health decision making, link of health services to women decision making, role of women in reducing spread of STDs and HIV/Aids, and women's perceptions of male involvement in reproductive health decision-making. To ensure reliability and validity, the questionnaire was pre-tested one week prior to the study and results were used to refine the instrument.

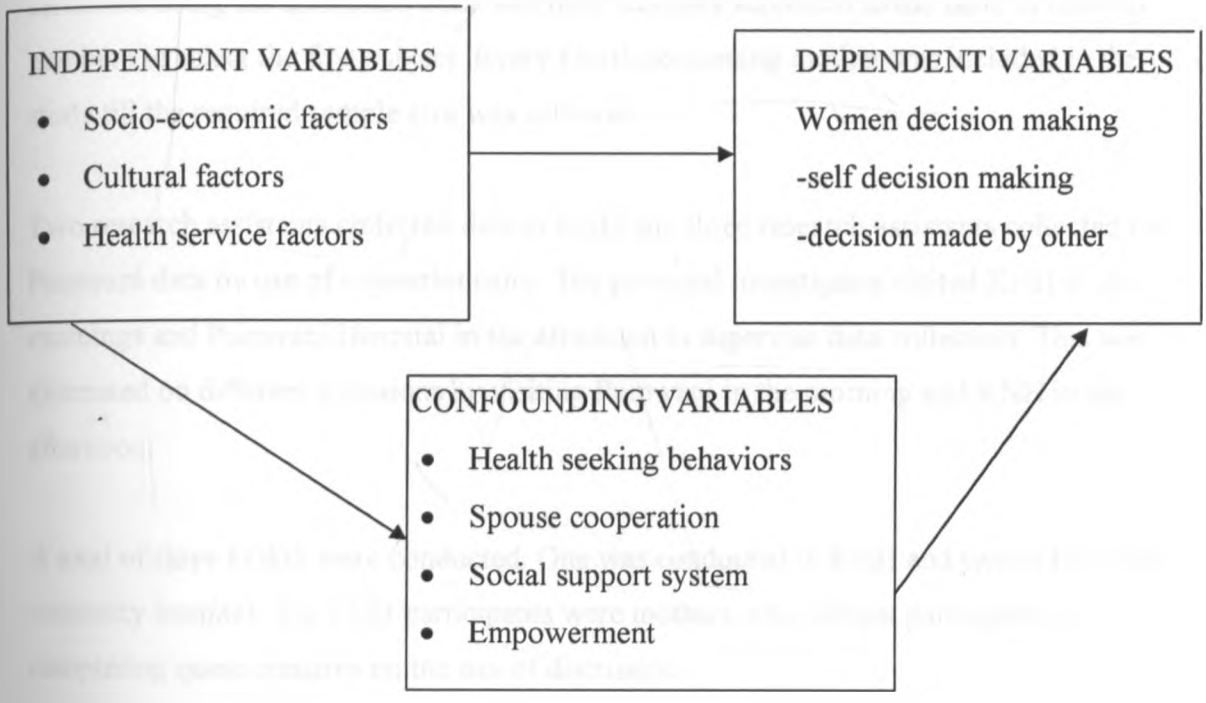
3.6.2 Focus Group Discussions

FGD was designed to elicit responses through conversation. It provided in-depth information that could not be achieved by use of a questionnaire alone. This complemented the data collected through the questionnaire.

Three research assistants carried out each FGD; one as the moderator, one as an observer and the other taking notes based on the interview schedule during the interview process. The moderator guided the FGDs by asking questions following a predesigned FGD guide (see Appendix II). Each FGD lasted for one to one and half hours and were composed of 6 participants. The FGD discussions were tape-recorded.

3.7 Variables

Fig 4: Interacting variables in women decision making on reproductive health



The independent variables affecting the study are socio-economic factors, cultural factors and accessibility of health services. The confounding factors considered include the health seeking behaviors, spouse cooperation, and the social support system. These factors would then influence the women's decision making of spacing of children, attending antenatal clinics, use of modern contraceptives and having their deliveries in the hospital. These then are the dependent variables.

3.8 Research Assistants

Six research assistants were selected from registered nurses with reproductive health background. A two day workshop was conducted for the research assistants prior to the onset of the study.

3.9 Procedure

In both institutions systematic random sampling method was used to select the study subjects. Proportionate sampling was used to determine the number of respondents from each hospital to correspond to the number of deliveries per day to ensure the sample was representative. There being 20 deliveries in KNH and 60 deliveries in Pumwani per day, a ratio of 1:3 were obtained. The sample for KNH was 96 mothers while that of Pumwani maternity hospital were 288. On the first day, all mothers who had been admitted were serialized using the admission book and their numbers subjected to the table of random numbers to select the first subject. Every fourth consenting mother was included in the study till the required sample size was achieved.

Two research assistants collected data in KNH and three research assistants collected the Pumwani data by use of a questionnaire. The principal investigator visited KNH in the mornings and Pumwani Hospital in the afternoon to supervise data collection. This was alternated on different occasions by visiting Pumwani in the morning and KNH in the afternoon.

A total of three FGDS were conducted. One was conducted in KNH and two in Pumwani maternity hospital. The FGD participants were mothers who did not participate in completing questionnaires on the day of discussion.

3.10 Data Management

The completed questionnaires were examined daily for completeness and properly completed questionnaires were entered into a computer and analyzed using SPSS. Frequencies of various parameters were obtained. These included socio-economic and demographic factors, cultural factors, role of women in reproductive health decision making, link of health services to women decision making, and women's perceptions on male involvement in reproductive health decision making. Tests of significance were done using Student-t-test, chi-square and multiple logistic regressions as appropriate. Results are presented pie charts, tables and graphs.

Qualitative data generated from FGDs was used to generate themes.

3.11 Minimizing Of Errors and Biases

Subjects were selected randomly; the questionnaire was pretested in one of the KNH postnatal ward excluded in the main study. The research assistants were trained before the study commenced and the principal investigator supervised the collection of data. Coding of data was done accurately.

3.12 Ethical Issues

Informed consent was obtained from the participants before recruiting them into the study. Approval to carry out the study was obtained from the Kenyatta National Hospital Research and Ethical Committee, and the Pumwani Maternity Hospital Research and Ethics Committee.

Confidentiality was observed and no names indicated in the questionnaires. Clinical management of the patients was the responsibility of the attending clinician. Findings of the study will be availed to the participating institutions.

3.13 Study Limitations

The study was confined to women delivered in KNH and Pumwani maternity Hospital. Findings therefore need not necessarily reflect the true situation in other parts of the country since these are referral urban-based institutions.

Most of the history was based on recall. Recall bias was therefore difficult to eliminate completely.

Some of the questions asked were personal. One had therefore to be patient and be able to counsel the respondents to give the information needed.

CHAPTER FOUR: RESULTS

Introduction

This chapter gives the socio-demographic and cultural characteristics of the women, followed by other findings of the study, presented as follows: women's role in their reproductive health decision making; health facility factors influencing women's reproductive health decision making, role of women in prevention of the spread of STIs and HIV/AIDS and finally, the women's perceptions of the men's role in women's reproductive health decision making.

4.1 Socio-Economic and Demographic Factors

A total of 384 women were recruited into the study of which 25% were interviewed in KNH and 75% in Pumwani Maternity Hospital.

The socio-demographic data analyzed are presented in table 1. The findings indicate the average age of the respondents was 25.4 years, youngest 15 years and oldest 42 years. Majority of the women (57.1%) were aged between 21-30 years.
Among the 384 women, 297 (77.3%) were married while 87 (22.7%) unmarried.
Most of the women were Christians 368 (95.9%) and 16 (4.1%) were Muslims.

Few 1.6% of the participants did not have any education at all, 38% had primary education; 45.3% secondary education and 1.6% had tertiary education (college, university).

It was elicited that 51% of them had no employment, 34.4% were on salaried employment and 14.6% were self-employed.

More than half (51 %) of the subjects did not have a monthly income. Below Kshs. 2000 were 10.9 %, 25% were earning between Kshs. 3,000-10,000 per month, 8.4 % Kshs.11, 000-20,000 and 4.7% earned over Kshs. 20,000.

Table 1: Socio demographic characteristics of the women (n=384)

Characteristic	Frequency	Percent (n=384)
Age group		
Below 15 years	2	0.5
16-20years	85	22.1
21-25 years	123	32.0
26-30 years	104	27.1
31-35 years	53	13.8
36-40 years	16	4.2
Above 40 years	1	0.3
Marital status		
Married	297	77.3
Unmarried	87	22.7
Religion		
Christians	36	95.9
Muslims	16	4.1
Level of education		
Nil	6	1.6
Primary	146	38.0
Secondary	174	45.3
Tertiary	58	15.1
Occupation		
Unemployed	196	51.0
Formal employment	132	34.4
Self employed	56	14.6
Salary income range		
None	196	51.0
Below 2000	42	10.9
3000-5000	53	13.8
6000-10000	43	11.2
11000-20000	32	8.4
21000-30000	12	3.1
31000-40000	2	0.5
Above 40000	4	1.1

The women interviewed were from the following ethnic groups: Kikuyu 35.7%; Kamba 20.6%; Luhya 14.6% ; Luo 11.4%; Meru 5.5%; Kisii 3.1% and others (Kalenjin, Somali, Nubia, Giriama, Teso, Embu, Maasai, Kuria) 9.1%. The distribution by tribe is presented in table 2.

Table 2: Distribution of women studied by tribe (n=384)

Tribe	Frequencies	Percent
Kikuyu	137	35.7
Kamba	79	20.6
Luhya	56	14.6
Luo	44	11.4
Meru	21	5.5
Kisii	12	3.1
Others	35	9.1

Table 3 presents the distribution of respondents from Nairobi by division. It was evident that many mothers travelled from far to get services from the two hospitals putting in mind the proximity of the residential areas to the two health facilities. This could be explained by the fact that the two hospitals are the largest referral hospitals in Kenya, Pumwani being specifically for maternal services.

Table 3: Residential area of the women studied by division (n=384)

Division	Frequencies	Percent
Central	10	2.6
Dagoretti	31	8.1
Embakasi	112	29.2
Kasarani	47	12.2
Kibera	35	9.1
Makadara	32	8.3
Parklands	2	.5
Pumwani	29	7.6
Outside Nairobi	86	22.5

Social demographic characteristics of spouses

The spouses' socio-demographic characteristics of the 297 married women were taken and they are presented in table 4. The mean age was 30.96 years and this is higher than the women's which was 25.41years. The spouses' ages ranged between 15-58 years. Majority were aged between 26 - 40 years.

It was found that 78.2% of the men had secondary education and above. 19.8% had primary education while 1.7% had no education. 0.3% of the women did not know their spouses level of education.

Men who were on salaried employment accounted for 68.1%, the self employed were 22.9% and 9.1% of the spouses were unemployed. The spouses' monthly income also presented in table 4 is: 44.4% of the spouses earned below Kshs. 10,000, while 17.5% earned between Kshs. 11,000 and 20,000. Only 9.8% of the spouses earned over Kshs. 21,000. It was interesting to note that 28.3% of the women did not have an idea of their spouses approximate monthly income range.

Table 4: Socio-demographic characteristics of spouses (n=297)

Husbands details	Frequency	Percent
Age		
Below 20	4	1.3
21-25	48	16.2
26-30	112	37.6
31-40	108	36.4
41-50	16	5.4
Above 51	2	0.7
Don't know	7	2.4
Level of education		
Nil	5	1.7
Primary	59	19.8
Secondary	157	52.9
Tertiary	75	25.3
Don't know	1	0.3
Occupation		
Unemployed	27	9.1
Salaried employment	202	68.0
Self employed	68	22.9
Monthly income		
Below 2000	19	6.4
3000-10000	113	38.0
11000-20000	52	17.5
21000-30000	18	6.1
Above 30000	11	3.7
Don't know	84	28.3

More than 80% of the spouses were from the Kikuyu, Luhya, Kamba and Luo ethnic groups. The Kikuyu were 36.4%, 17.2 % were Luhya, 14.8 % Kamba, 13.8 % Luo, Kisii 4.2%, Kalenjin 4.2% and 9.4% were from other (Somali, Nubia, Meru, Embu, Taita, Chaga, Teso, Kuria, Maasai and Giriama) ethnic groups as presented in table 5.

Table 5: Distribution of spouses by tribe n=297

Spouses tribe	Frequencies	Percent
Kikuyu	108	36.4
Luhya	51	17.2
Kamba	44	14.8
Luo	41	13.8
Kisii	16	4.2
Kalenjin	16	4.2
Others	21	9.4

4.2 Cultural Factors influencing Women Reproductive Health Decision Making

Cultural factors influenced women decision making in different ways. There was an element of urbanization because most of the women did not understand well cultural factors. Two hundred and seventy seven (72%) had no cultural factors influencing their reproductive health decision making. Others had different opinions: 37 (9.6%) felt polygamy was practiced in their communities and a woman had no say when the spouse wanted to marry another wife. Some communities still practiced female circumcision and 40 (10.4%) felt that this was done forcefully. Others 30 (7.8 %) thought cultural influences included dowry payment, wife inheritance, arranged marriages, sex of the baby (preference for boys), number of children, naming children after the relatives and the dead and women must be married before they have children.

Dowry was said to have different influences once a woman was married. Two hundred and nine (54%) woman said it earned more respect and that women had more say once dowry had been paid. Others had different views. Twenty six (6.8 %) said a woman had no say once dowry had been paid. Twenty three (6%) said a woman is not considered legally married if dowry had not been paid. Eighteen (4.7 %) said if dowry is paid, wife must bear children. Sixteen (4.2 %) thought that men mistreat women once dowry had

been paid, 8 (2.1%) said dowry benefits girls parents , 7(1.8%) said men dictate number of children once dowry is paid, 7(1.8%) said woman cannot leave husband once dowry had been paid and other 19 (4.9%) said that if a woman dies before dowry is paid, she cannot be buried where she is married and that if a woman has not had her dowry paid will not receive her daughters dowry. Instead it will be taken to her parents. Findings are tabulated in table 6 below.

Table 6: Influence of dowry on women reproductive health decision making. (n=384)

Dowry influence	Frequency	Percent
No influence	209	54.4
Woman earned respect	51	13.3
Woman has no say once dowry has been paid	26	6.8
Woman not considered legally married if not paid	23	6
Wife must bear children if dowry has been paid	18	4.7
Men mistreat women when he pays dowry	16	4.2
Dowry benefits parents	8	2.1
Woman cannot leave husband if dowry is paid	7	1.8
Once paid, men dictate number of children to be born	7	1.8
others	19	4.9

Table 7 presents cultural factors that influence women reproductive health decision making. Polygamy was noted to be a common practice in many cultures. Of the 384

women interviewed, 284 (74.0%) said it is practiced in their culture, 89 (23.1%) said it is not practiced, while 11 (2.9%) did not know whether it was practiced or not.

Wife inheritance is practiced in some cultures. One hundred and fifteen (30%) women said it was still practiced in their culture, while 261 (68%) said it did not exist and 8 (2 %) did not know whether it was practiced or not.

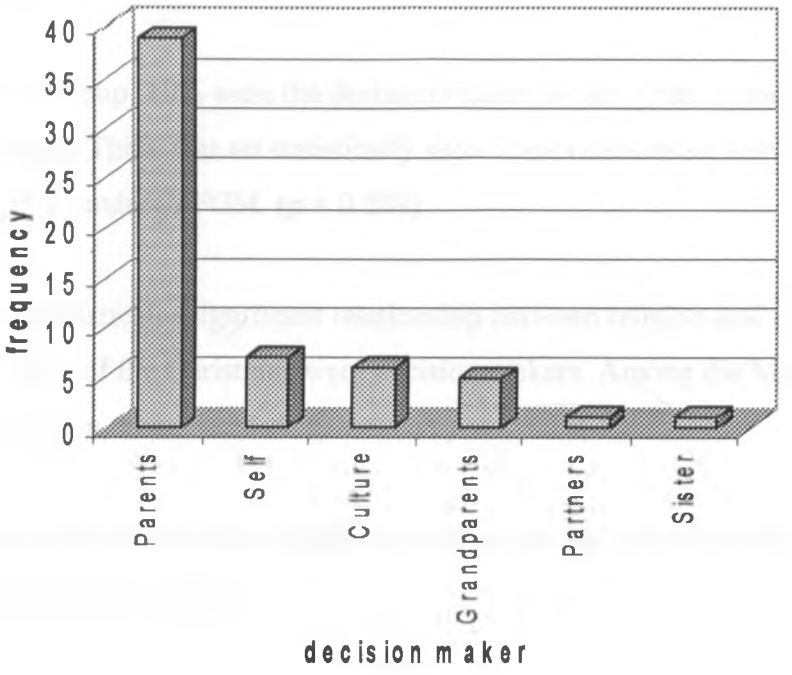
Female genital mutilation is practiced in some communities. Ninety three (24.2 %) said it is still practiced in their culture, while 291 (75.8%) said it is not practiced. Those who had undergone FGM were 59 (15.4%).

Table 7: Presents cultural practices (n=384)

Cultural factors	Frequency	Percent
Polygamy		
Yes	284	74
No	89	23.1
Don't know	11	2.9
Wife inheritance		
Yes	115	30
No	261	68
Don't know	8	2
FGM	93	24.2
Yes	291	75.8
No		
Women who underwent FGM		
Yes	59	15.4
No	325	84.6

The women who underwent FGM were further interviewed to elicit who made the decision. Decisions were made by the parents for 39 (66.1 %), 7 (11.8%) made the decision on their own, 6 (10.2 %) said it is their cultural practice and had to be done, 5 (8.5 %), grandparents' decision, 1 (3.4%) partners' decision and 1 (3.4%) sisters' decision (Fig. 5).

Figure 5: On who made decision on FGM



Women had different views regarding FGM. One hundred and eighty one (47%) were of the opinion that it is not a good practice, 81 (21.1%) said it should be stopped, 27 (7 %) said it is a good practice and its part of culture should continue, 22 (5.7%) said it affects a woman during childbirth, 20 (5.2%) said it is good, it hardens women , 18 (4.7%) said it is not necessary, it is an outdated practice, 12 (3.1%) thought FGM transmits diseases like HIV and tetanus. The 'others' category included: it is an abuse and traumatizing to women, unbiblical, spoils woman body, it is good and gives woman status of a grown up, should continue it is part of culture, no desire for sex and it is individual decision and women should not be forced.

Further analysis was done to elicit relationship between socio-demographic factors and practice of FGM as illustrated in Table 8. Only 59 (15.4%) of all the respondents had undergone FGM.

Women aged below 20 years who made the decision on FGM were 10% of the women who underwent FGM. In the 21-30 years category, 12.8 % were the decision makers and

in above 30 years category, 10 % were the decision makers. There was no statistically significant relationship between age and decision to undergo FGM. ($p = 0.995$)

Among the married group, 10% were the decision makers while in the unmarried 18.8% were decision makers. There was no statistically significant relationship between marital status and decision to undergo FGM. ($p = 0.209$)

There was also no statistically significant relationship between religion and decision to undergo FGM. 13.8% of the Christians were decision makers. Among the Muslims who underwent circumcision, none decided. ($p = 0.268$.)

Level of education and income range neither contributed to decision to undergo FGM, ($p = 0.906$ and $p = 0.784$ respectively.)

Table 8: Relationship between socio-demographic characteristics of sample population and decision on circumcision (n= 59)

Characteristics(factors)		Decision on circumcision		Total (%)	Chi- square (χ^2)	SIGN (P value)
		Self	other			
Age	Below 20	1 (10)	9 (90)	10(100)	0.010	0.995
	21-30	5 (12.8)	34 (87.2)	39(100)		
	> 30	1 (10)	9 (90)	10(100)		
Marital status	Married	4(10)	36(90)	40(100)	0.323	0.209
	Unmarried	3(18.8)	16(81.2)	19(100)		
Religion	Christian	7(13.5)	45 (86.5)	52(100)	1.227	0.268
	Muslim	0	7 (77.8)	7(100)		
Income range	None	3(9.7)	28 (92.3)	31(100)	0.487	0.784
	< 10 000	4(16.7)	20(83.3)	24(100)		
	> 11,000	0	4(100)	4(100)		
Level of education	None	0	2(100)	2(100)	0.559	0.906
	Primary	3(11.1)	24(89.9)	27(100)		
	Secondary	3(13)	20(87)	23(100)		
	Tertiary	1(14.3)	6 (85.7)	7(100)		

P = probability Figures in parenthesis indicate percentages

Cultural taboos are still observed during pregnancy. Among the women 84 (21.9%) admitted to the existence of cultural taboos being observed during pregnancy. Majority 300 (78.1 %) said there were no taboos observed in their culture during pregnancy.

Some cultures do not allow women to eat eggs while pregnant, otherwise the child will be big, was a response from 23.8 % of the 84 women who said there are cultural taboos observed in their culture. Other 17.9 % said women should not be unfaithful during pregnancy; 16.7 % said a woman should not eat slaughtered animal, pork/ rabbit while pregnant; 10.7 % that a pregnant woman should not attend funerals, 8.3 % said a pregnant woman is not allowed to go and see a woman whose child has died, and others 8.3 % don't eat with a pregnant sister; 6.0 % do not sleep with parents in-law in the same house when pregnant, don't eat fatty foods, and others 9.5%(must respect mother in-law, avoid

carrying heavy loads, avoid being rude, don't eat with younger brother if he married before you, avoid sex when pregnant, and don't look at a grave when pregnant). This is presented in Table 9.

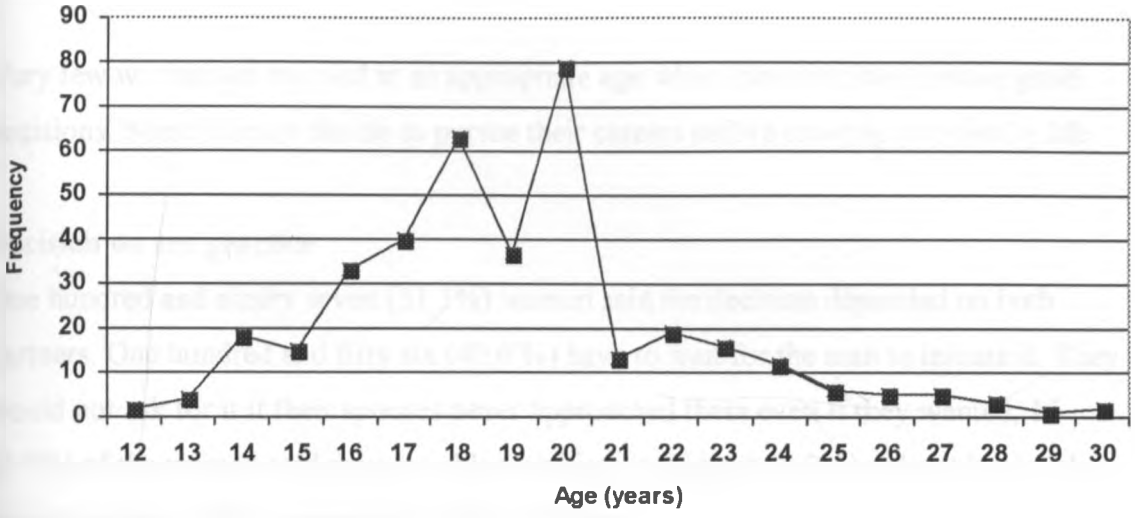
Table 9: Cultural taboos observed during pregnancy (n=84)

Cultural taboos	Frequency	Percent
Do not eat eggs	20	23.8
Woman should not be unfaithful during pregnancy	15	17.9
Woman not allowed to eat slaughtered animal	14	16.7
Pregnant woman should not attend funeral	8	10.7
Pregnant woman not allowed to visit woman whose child has died	7	8.3
Pregnant woman cannot eat with a pregnant sister	7	8.3
Pregnant woman cannot sleep with parents in-law in same house	5	6.0
Others	8	9.5

Other cultures require a girl to be a virgin until marriage. One hundred and seventy seven (46.1%) of the women said that this was their cultural expectation. Two hundred and seven (53.9%) said it was not the case any more.

Age of beginning sex was also considered. The mean age at first sexual intercourse was 19 years. The youngest age for beginning sexual intercourse was 12 years and others began at 30 years. Distribution of age at first sexual intercourse is presented in figure 6.

Figure 6: Age at first sexual intercourse



The women had different reasons for beginning sex. Those who made the decision on their own were 49%. Boyfriends influenced 25% of the women. Some 11.5% were forced into it, 8.3% were due to peer influence, and 6.3 % were married at the time of first sexual intercourse.

Table 10: Decision to begin sex (n=384)

Reason for beginning sex	Frequency	Percent
Self	188	48.9
Influenced by boyfriend	96	25
Forced	44	11.5
Peer influence	32	8.3
Married	24	6.3

Participants in the FGDs were in agreement that girls engage in sexual activity at a tender age exposing them to risk of diseases and pregnancy. This in turn leads them to getting married. Some girls get married early due to problems. Some would want to continue with education, but due to financial problems, they opt to marry any available man rather than staying at home or doing odd jobs. Some girls are just stubborn. Some start sexual

activity early, predisposing them to pregnancy, sexually transmitted infections and HIV/AIDS.

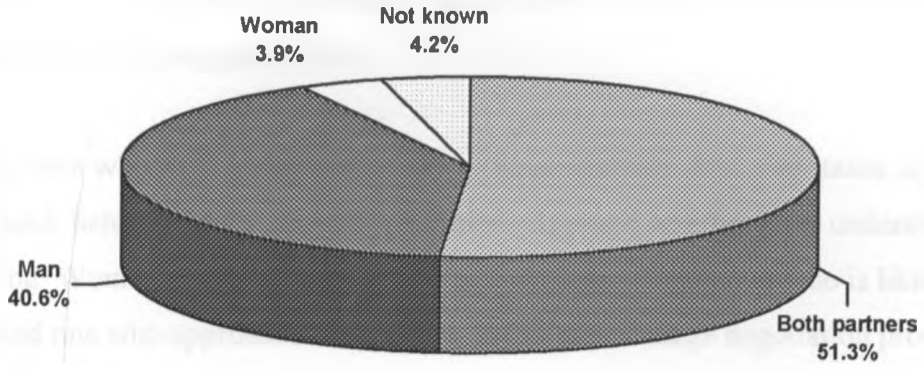
Very few women get married at an appropriate age when they are able to make good decisions. Some women decide to pursue their careers before entering into family life.

Decision on sex practice

One hundred and ninety seven (51.3%) women said the decision depended on both partners. One hundred and fifty six (40.6 %) have to wait for the man to initiate it. They would not ask for it if their spouses never approached them even if they wanted, 15 (3.9%) of the women said they are able to initiate it. Sixteen (4.2%) did not know who should initiate. This is presented in figure 7 below.

The FGDS stated that a woman cannot initiate sex because she will be thought of as loose. It's also culturally unacceptable in some communities for a woman to ask a man for sex. Some women feel shy to approach their spouses for sex because they fear the spouse will think of them as being prostitutes. Some verbal responses spouses have given have been discouraging. One of the women said in Kiswahili "hiyo tu ndiyo umeshinda ukiwaza mchana yote?"(That is all that you have been thinking of the whole day?). The cultural expectations is that a man is the head and so should be the decision maker on all matters. Some women can initiate it depending on relationship with husband.

Figure 7: On who makes decision on sex practice



Women do not have much control over their bodies. If a man wants sex and a woman declines, he forces her to have sex claiming it is their right. Even if the woman is not prepared or is not on a method of FP, it does not matter. If she gets a pregnancy that is unintended, men are quick in advocating for abortion. Women are not however for the idea of killing. Women are raped on many occasions in marriage but are shy and afraid of coming up freely with it. The recently passed sexual offences bill hopefully will be of help to these women.

4.3 Role of Women in Reproductive Health Decision Making

Characteristics women consider in a man to make a marital commitment

Asked what characteristic they would consider while choosing a spouse, different responses were given. The four main characteristic women would consider are the man's character, love, physical looks and financial stability {112 (29.2%), 107 (27.9%), 85 (22.1%), and 66 (17.2%) respectively}. Others 14 (3.6%) would consider whether he is faithful, responsible, hardworking. Level of education and tribe also matter for others. The characteristics women consider in a man to marry are presented in Table 11.

Hardships as stated in the FGDS do not allow a woman to make decision on a choice of a man. This makes women to go for any available and willing man. Women think by

getting married they will be solving their problems. They don't realize they are giving themselves more problems. Some FGD participants also said that some girls engage in sex for pleasure. When they accidentally get pregnant they are forced to get married to the man who has impregnated them.

Those women who have a chance to make a choice consider financial status, age, background, behavior, tribe, level of education, class and whether he is understanding and loving. Women would also consider a man with good character who is liked by people and one who approaches the parents to initiate marriage negotiation procedures.

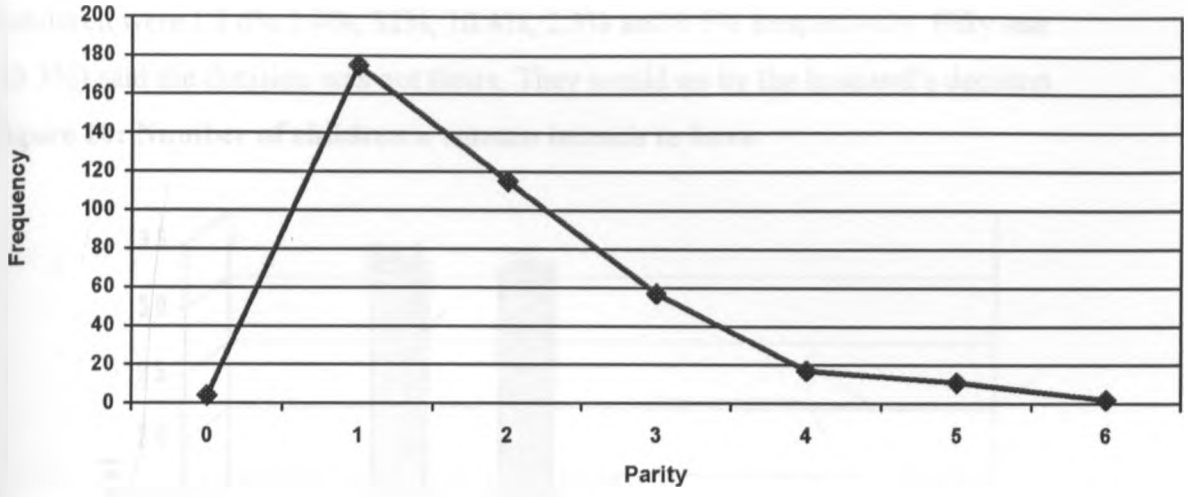
Table 11: Characteristic women consider in a man to make decision to marry him (n=384)

Characteristic	Frequency	Percent
Character	112	29.2
Love	107	27.9
Physical looks	85	22.1
Financial status	66	17.2

Number of children each woman had

First time mothers were majority of women who delivered in the hospitals. The average number of children a woman delivered was 1.87. One hundred and eighty two (47.4%) had delivered their first child, 115 (29.9%) the second child, 57 (14.9%) the third child, 17 (4.4%) the fourth child, 11(2.9%) the fifth child, and 2 (0.5%) sixth child. This is presented in Figure 8.

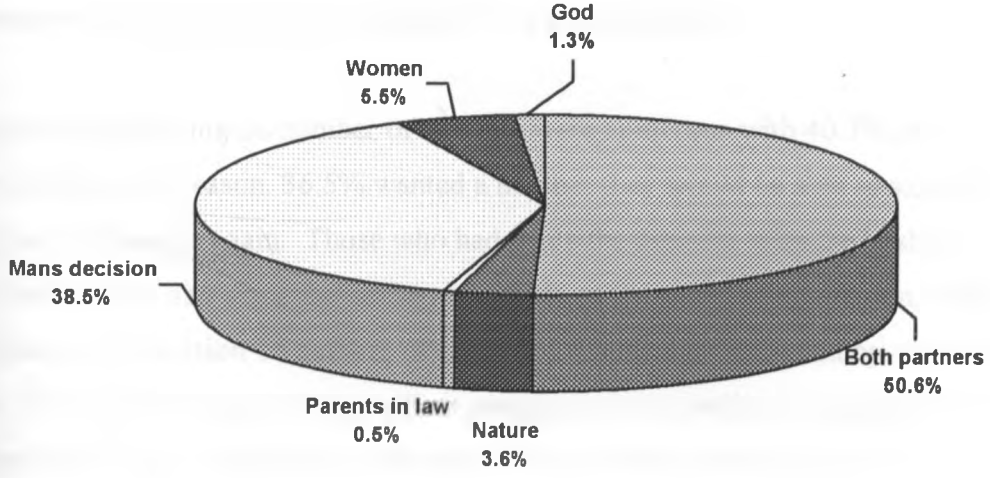
Figure 8: Parity of women delivered



Decision making on family size

Decision on number of children to be born is made by both partners among 194 (50.6%). One hundred and forty eight (38.5%) said it was solely the man's decision, 21 (5.5%) said it was a woman's decision. Fourteen (3.6%) said nature determines the number of children one has, 5 (1.3%) said decision is made by God. Two (0.5%) said decision is made by parents in-law. (Figure 9)

Figure 9: on who decides on number of children to born



The number of children each woman intended to have is presented in figure 10. The women wanted between one to six children each. Those who wanted 1, 2, 3, 4, 5 and 6 children were (8.6%,2.8%, 32%, 10.4%, 2.3% and 0.5%)respectively. Fifty one (13.3%) said the decision was not theirs. They would go by the husband's decision.

Figure 10: Number of children a woman intends to have

Decision on number of children according to the FGD participants is discussed with spouse due to issues related to finances and health factors. From FGDS, it was no longer convenient to have many children because of the poor economy.

The reasons for deciding on number of children were numerous with 40.7% of the women not having a reason. 36.5% wanted a number they would be able to support, 3.4% did not want to deliver again. Those who had made the decision with the husband were 3.4%. The husband had made the decision on 2.3% of the sampled population. Other (2.1%) had made decision on number of children because they delivered by caesarean section. Some made decision because their pregnancy is normally problematic. One point eight percent said it will depend on whether the next child is girl/boy, and 1.8% will have children she can handle alone even if spouse disowns. The remaining 6.2% had different

reasons (God's wish, anything can happen, people are advised to have 4 children, does not intend to get married and career does not allow her to have many children).

Table 12: Reason for deciding on number of children to bear (n=384)

Reason	Frequency	Percent
No reason	156	40.7
Able to support	140	36.5
Does not want to deliver again	13	3.4
Had decide with husband	13	3.4
Husbands decision	9	2.3
Delivered by caesarean section	8	2.1
Pregnancy normally problematic	7	1.8
Will depend on sex of next child	7	1.8
Can handle alone even if spouse leaves her	7	1.8
Others	24	6.2

Birth spacing was viewed differently by different women. Those who thought the ideal birth spacing was 1 year were 2 (0.5%). Forty six (12%) of women thought it is two years, 95(24.7%) three years and 56(14.6%) four years. The majority 113 (29.4%) said the ideal birth spacing is five years, some 43 (11.2%) did not know the ideal birth spacing. Twenty nine (7.2%) said the ideal birth spacing is 6-10 years.

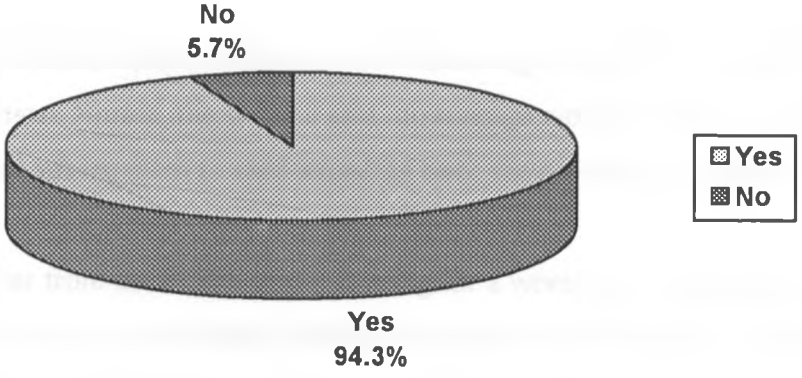
Table 13: Recommended birth spacing according to sample population (n=384)

Years	Frequency	Percent
1	2	0.5
2	46	12
3	95	24.7
4	56	14.6
5	113	29.4
6-10	29	7.6
Don't know	43	11.2

Antenatal clinic attendance

More than 90% of the women attended antenatal clinic at least once in their pregnancy. Only 22 (5.7 %) of the 384 women did not attend ANC clinic during their current pregnancy (presented in figure 11).They had different reasons for not attending. Even though the majority of women attended ANC during the pregnancy, they began attending in different months and had different reasons for attending at that time.

Figure 11: Antenatal clinic attendance



With regard to the different reasons for attending ANC, 99(27.3%) of 362 who attended thought it was good and it was the right time for them to start attending ANC, 72(19.9 %) were unwell seeking treatment, 58 (16.0%) wanted to know the progress of the baby and their own health and 31(8.6%) did not have a reason and just went because people normally go for ANC services. One hundred and two (28.2%) gave different reasons like not having time, money being available at that time, being forced by spouse, being at the village, needed to get card for easy admission during labor, avoiding being scolded if you go late, not being attended to when you go early and wanting to know HIV status.

On antenatal clinic attendance, the FGD participants stated that the decision on time to start attending antenatal clinic depends mostly on the woman. Some women delay in starting antenatal clinic attendance because they don't want to go to the government institutions. Private hospitals require money and most women are not financially able. Other women would like to attend clinic as soon as they realize they are pregnant, but lack finances.

Some women don't know importance of antenatal clinic but just go because others have been going and are still going.

In some unions, the man is the one deciding the right time for the woman to start ANC, depending on availability of money.

Health care workers in some occasions have discouraged women from attending ANC at an early gestation. Nurses, the women said, discourage women from attending antenatal clinic early and advice them to start attending once the pregnancy is visible.

It was also clear from the FGDS that it is tiring for a woman to start attending ANC early since they will have to attend many times as required which they did not think is necessary. Instead of starting early, they would rather wait until when they are almost delivering so that they also get a card. This will avoid complicating admission process

when in labor. Attending antenatal clinic on very many occasions mean they will wait for the baby for long.

Of the 22 who did not attend antenatal clinic in their pregnancy, 4 (18%) had no reason, 3 (13.6%) did not know the importance, 3 (13.6%) were well (had no problems), 3 (13.6%) did not want the pregnancy, 2 (9.1%) had no money, 2 (9.1%) feared vaginal examinations, 2 (9.1%) did not get time, 1(4.5%) had traveled, 1(4.5%) was unwell, and 1(4.5%) did not want people to know she was pregnant.

Table 14: Reason for not attending ANC (n=22)

Reason for not attending ANC	Frequency	Percent
No reason	4	18.2
Did not know its important	3	13.6
Had no problem	3	13.6
Was not prepared for pregnancy	3	13.6
Had no money	2	9.1
Feared vaginal examination	2	9.1
Did not get time	2	9.1
Was on safari	1	4.5
Was unwell	1	4.5
Did not want people to know was pregnant	1	4.5

Results for the relationship between socio-demographic factors and antenatal clinic attendance are presented in table 11. There is statistically significant association between marital status and antenatal clinic attendance. 3.7% of married women did not attend antenatal clinic while 12.6% of the unmarried women did not attend antenatal clinic. ($p = 0.002$).

There was no statistically significant association between age, religion, income range and level of education to antenatal clinic attendance ($p > 0.05$).

Table 15: Relationship between socio-demographic characteristics of the sample population and antenatal clinic attendance. (n=384)

Characteristics(factors)		Antenatal clinic attendance		Total (%)	Chi square(χ^2)	(P value)
		Yes	No			
Age	Below 20	80(92)	7(8)	87(100)	3.279	0.194
	21-30	213(94)	14(6)	227(100)		
	> 30	69(98.6)	1(1.4)	70(100)		
Marital status	Married	286(96.3)	11(3.7)	297(100)	**9.838**	**0.002**
	Unmarried	77(87.4)	11(12.6)	87 (100)		
Religion	Christian	346(94)	22 (6.0)	368(100)	1.021	0.312
	Muslim	16(100)	0	16(100)		
Income range	None	197(95.2)	10(4.8)	207(100)	2.355	0.308
	< 10 000	122(93.1)	9(6.9)	131(100)		
	> 11,000	43(93.5)	3(6.5)	46(100)		
Level of education	Nil	6(100)	0	6(100)	2.937	0.401
	primary	134(91.8)	12(8.2)	146(100)		
	secondary	166((95.4)	8(4.6)	174(100)		
	tertiary	56(96.5)	2(3.5)	58(100)		

P = probability Figures in parenthesis indicate percentages

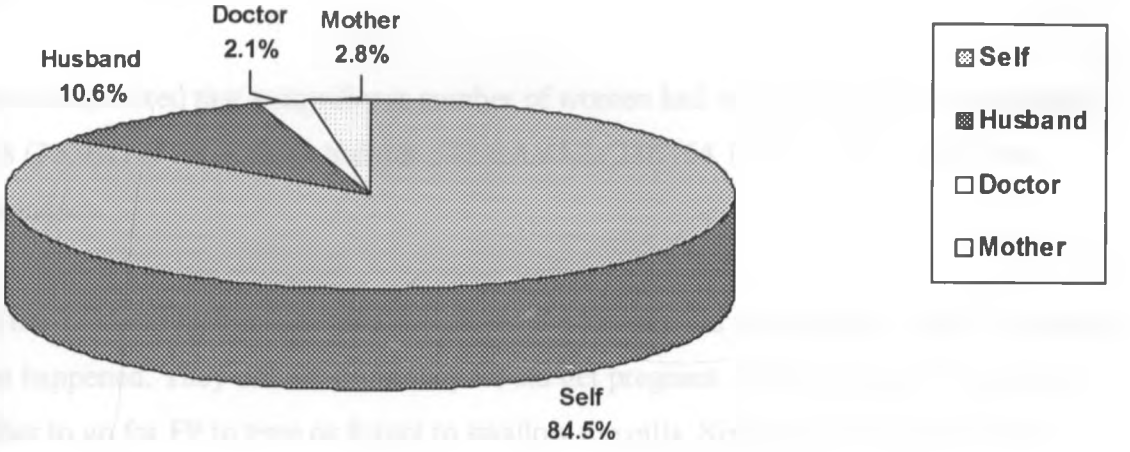
Mode of delivery

In the study 243 (63.3%) women had a spontaneous vertex delivery in their current pregnancy while 141 (36.7 %) delivered by caesarian section.

The doctor made decision for caesarian section in 116 (82.3%) of the cases. Women who made the decision were 17 (12.1 %%) (Some made decision due to their HIV status and others due to their previous birth by CS). Four (2.8%) husband made the decision. In 4 (2.8%) the decision was made by both partners.

The majority 119 (84.4%) of the women who delivered by caesarian section signed the theatre consent, 15 (10.6%) were signed for by their husband. Four (2.8%) by the mother and 3 (2.1%) by the doctor. This is shown in figure 12 below.

Figure 12: On who signed theatre consent form



The study also sought to know how many hours the woman labored at home before coming to hospital. Different responses were elicited for waiting at home after labor began. Distribution of hours labored at home is given by the following table.

Table 16: Hours labored at home. (n=384)

Hours labored at home	Frequency	Percent
None	5	1.3
1-12	259	67.4
13-24	31	8.1
25-36	3	0.8
37-48	6	1.6
Don't know	80	20.8

The women who delivered in the different hospitals had various reasons for choosing the place of delivery. Two hundred and thirty nine (62.2%) women said it was their decision (well staffed, equipped, services and cost good, only hospital she knows, popular and proximity to residence), 78 (20.3%) were referrals from other hospitals due to labor complications, 21 (5.5%) were brought by neighbor/friend, 20 (5.2%) had their spouses deciding, 13 (3.4%) had their condition dictated by circumstances, 5 (1.3%) were staff in the hospitals and 8 (2.1%) just came,(did not have a reason).

Money plays a key role in decision on place of delivery. This was elicited from the FGDS. Most women don't have their own money so they cannot make a decision on place of delivery.

It was also noted that a significant number of women had not planned for the pregnancy. 138 (35.9%) of the women had not planned while 246 (64.1%) had planned for the pregnancy.

Of the 138 who had not planned, when asked why they did not prevent, 54 (39.1%) said it just happened. They did not think they would get pregnant. Thirty eight (27.5%) forgot either to go for FP in time or forgot to swallow the pills. Sixteen (11.6%) were on a method of FP which backfired. Nine (6.5%) admitted to have been careless. Seven (5.1%) did not use FP because they were on medication. Five (3.6%) did not know how to prevent. Four (2.9%) their partner had been on safari. Four (2.9%) said it was God's plan and 1 (0.7%) said spouse does not allow FP use.

Table 17: Reason for not preventing pregnancy (n=138)

Reason for not preventing	Frequency	Percent
Just happened Didn't expect to get pregnant	54	39.1
Forgot to use FP	38	27.5
FP Method failure	16	11.6
Carelessness	9	6.5
On medication could not use FP	7	5.1
Did not know how to prevent	4	2.9
Gods plan	4	2.9
Partner refused to use condom	2	1.4
Was drunk	2	1.4
Spouse declined FP	1	0.7
Pills were over and husband insisted	1	0.7

Participants in the FGDS stated that women on many occasions found themselves pregnant accidentally due to low FP utilization. The decision on when to get pregnant was done mainly by the spouse.

Further analysis was done using the socio-demographic characteristics in relation to pregnancy planning.

Out of the 384 respondents, 246 (64%) of the women had planned for the pregnancy. The findings from the study presented in table 14 indicate that there was significant statistical association between age and plan for pregnancy. Among the under 20 years, 50.6% had not planned for the pregnancy, the 21-30, 30.2% were caught unaware, and among the over 31 years, 33.35 had not planned for the pregnancy. ($p < 0.003$)
The study findings indicate that married women were more likely to plan for the pregnancy as compared to unmarried women (73.1% versus 33.3%). The difference was statistically significant ($p = 0.000$).

Level of education was also noted to influence planning of pregnancy. 86% of the women with tertiary education planned for their pregnancy, 64.15 with secondary education, 58.6% with primary education and 16.7% of those who did not have any education planned their pregnancy. The relationship between level of education and decision on pregnancy was statistically significant ($p = 0.000$)

Income range was found to be associated with planning pregnancy. Among the women who earn >10,000 shillings, 91.3% had planned for the pregnancy, 65.4% of those earning < 10,000 planned for their pregnancy. Among those who did not have any income, 57.2 % had planned for the pregnancy. The relationship between income and planning for pregnancy was statistically significant ($p < 0.001$).

There was no statistically significant association between religion and planning for pregnancy. 64.1% Christians had planned for the pregnancy, while 62.5%of the Muslims had also planned for the pregnancy ($p < 0.860$).

Table 18: Relationship between socio-demographic characteristics with pregnancy planning

Characteristics(factors)		Pregnancy planned		Total (%)	Chi square(χ^2)	(P value)
		Yes	No			
Age	Below 20	43(49.4)	45(50.6)	88(100)	**11.522**	**0.003**
	21-30	157(69.8)	69(30.2)	226(100)		
	> 30	46(66.7)	24(33.3)	70(100)		
Marital status	Married	217(73.1)	80 (26.9)	297(100)	**48.075**	**0.000**
	Unmarried	29(33.3)	58(66.7)	87(100)		
Religion	Christian	236(64.1)	132(35.9)	368(100)	0.031	0.860
	Muslim	10(62.5)	6(37.5)	16(100)		
Income range	None	119(57.2)	89(42.8)	208(100)	**11.363**	**0.001**
	< 10 000	85(65.4)	45(34.6)	130(100)		
	> 11,000	42(91.3)	4(8.7)	46(100)		
Level of education	none	1(16.7)	5(83.3)	6(100)	**19.679**	**0.000**
	primary	85(58.6)	61(41.4)	146(100)		
	secondary	111(64.1)	63(35.9)	174(100)		
	tertiary	49(86)	9(14)	58(100)		

P = probability Figures in parenthesis indicate percentages

Opinion on unwanted pregnancies

The women were also asked their opinion in regard to unwanted pregnancies; different responses were elicited as presented in Table 19

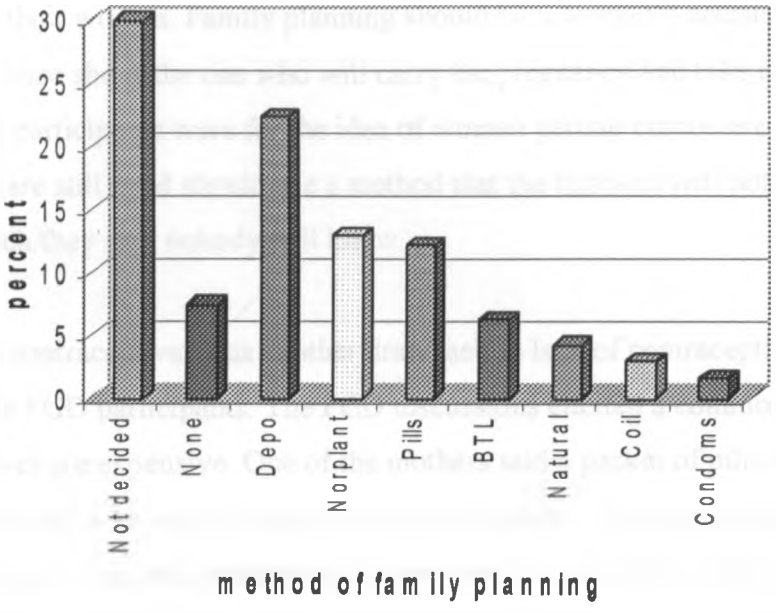
Table 19: Women's opinions on unwanted pregnancy (n=384)

Opinion on unwanted pregnancy	Frequency	Percent
No opinion	30	7.9
Not good	42	10.9
Carry to term	117	30.4
Should be prevented	91	23.7
Causes problems	55	14.3
Will know what to do when it happens to me	24	6.3
Terminate	16	4.2
Others (God's plan, leads to outcasts in society, its okay)	9	2.3

The study also elicited the recommended time to resume sexual intercourse after delivery and the period ranges from one week to 52 weeks.

The study findings on intention of method of family planning to use found out that 115 (29.9%) of the 384 had not decided whether to use FP (responses like; not discussed with husband, husband will decide for me, don't know the right one). Twenty nine (7.6%) were not to use any method. Eighty six (22.4%) opted for depo injection, 50 (13%) Norplant, 47 (12.2%) pills, 24 (6.3%) BTL, 16 (4.2%) natural FP, 11 (2.9%) would use IUCD "coil" and 6 (1.6%) for condoms as shown in figure 13.

Figure 13: Methods of FP women intended to use



Further analysis was done in relation to women's educational level and decision on family planning use. 16.7% of women who had no education were not intending to use any method of family planning, 10.9% of women with primary education were also not intending to use any method of FP. The women with secondary level of education that did not intend to use a method of FP were 9.4%. Surprisingly, 11.4% of women who had tertiary education did not intend to use any method of FP. It was noted that there was statistically significant association between modern contraceptive use and level of education (x^2 =38.467, d.f =24, p<0.031).

Different women in the different FGDS had different views regarding contraceptive use. Some women had very little knowledge on modern contraceptive methods available. The women mentioned adverse effects expected with FP use as a major hindrance. The women felt that more education on methods of contraception and their side effects is needed.

Some women mentioned that their spouses do not like their women using contraceptives. The women were in agreement that men need to be educated on family planning to be able to support their women. Family planning should be a woman's decision if spouse is uncooperative since she is the one who will carry the pregnancy and take care of the baby born. The FGD participants were for the idea of women getting empowered. Those whose spouses are still rigid should use a method that the husband will not know like injectables which they said nobody will know.

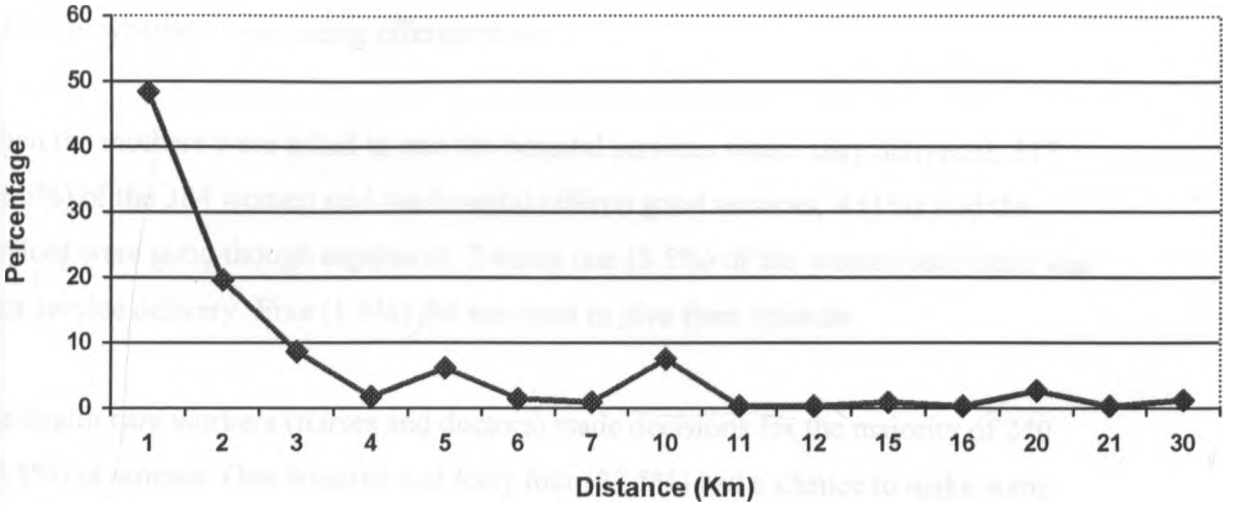
The cost of the contraceptives was another drawback to lack of contraceptive use according to the FGD participants. The FGD discussions elicited a common response that the contraceptives are expensive. One of the mothers said a packet of pills cost kshs. 20. Instead of using that in buying pills and your children starve, it would be better to buy sukuma for the day. This was interesting because she does not think of the consequences of having another unplanned pregnancy which is worse than saving twenty shillings and buying pills.

The women's opinions on the preferred methods of FP were that majority of women preferred to use injectable (Depo provera). Others preferred Norplant, pills and BTL (once a woman had enough children and if spouse is not in agreement a woman to do it secretly).

4.4 Influences of Health Services to Women Decision Making

The average distance to the nearest health facility was 3.5 Kms. One hundred and sixty eight (43.8%) said the nearest facility was less than a kilometer from their residence. Sixty eight (17.7%) of them said it was about 2kms far, 30(7.8%) said 3kms, 6 (1.6%) said 4kms and 21 (5.5%) 5kms. For 54(14.1%) ranged from 6-20 kms. Thirty seven (9.6%) did not know the nearest facility from their residence. This is presented in figure 14 below.

Figure 14: on distance to nearest health facility.



The services offered at the nearest facility included: ANC services, maternity services, immunization of children, family planning and consultation services. Women who said ANC services were available were 187 (48.7%), 128 (33.3%) said maternity services were available, 104 (27.1%) said immunization services were available. One hundred and eighty six (48.4%) said FP services were being offered there.

Of the 384 women, 246 (64.1%) said services in their nearest facility was good. Twenty one (5.5%) said the services were poor. Seventy five (19.5%) said it was fair. Forty two (10.9%) did not know.

Table 20: Quality of services of nearest health facility as rated by women (n=384)

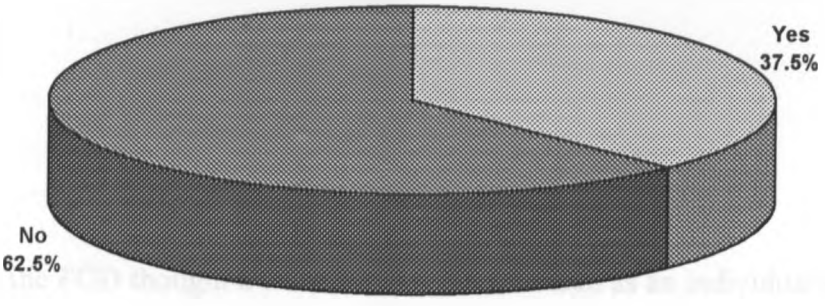
Quality of services	Frequency	Percent
Good	246	64.1
Poor	21	5.5
Fair	75	19.5
Don't know	42	10.9

Overall, 314 (81.8%) of the 384 women said family planning services was being offered in the nearest facility. Thirteen (3.4%) said it was not being offered and 57 (14.8%) did not know whether it was being offered or not.

When the mothers were asked to rate the hospital services where they delivered, 317 (82.6%) of the 384 women said the hospital offered good services, 4 (1%) said the services were good though expensive. Twenty one (5.5%) of the women said there was poor service delivery. Five (1.8%) did not want to give their opinion.

The health care workers (nurses and doctors) made decisions for the majority of 240 (62.5%) of women. One hundred and forty four (37.5%) had a chance to make some decisions.

Figure 15: women who had a chance to make decisions in the hospitals

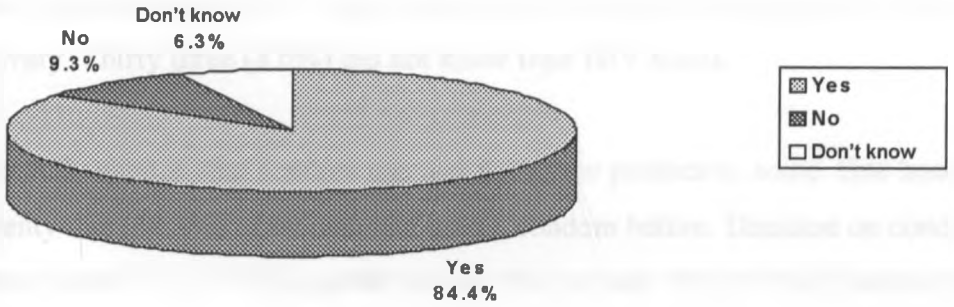


Health facilities were found to influence women's decision making in various ways. 85 (22.1%) said it did not influence them in any way. One hundred (26%) said the health facilities provide services for women to utilize. Sixty seven (17.4%) thought the health facilities provided both services and educated women. One hundred and thirty one (34.1%) of the women said the health facilities educated women and gave them advice.

4.5 Role of Women in Prevention of STIs and HIV/AIDS

Decisions on preventive measures of STIs and HIV/AIDS brought controversial information. Majority (84.4%) of the women said they were able to prevent the spread of the diseases, though it is not possible for a woman to do it single handedly without the spouses commitment. Some even said "you as a woman know yourself, but do you know your partners moves?" About 9.3% of the women said out rightly they were not able to do it. Those who did not know how to do it were 6.3%.

Figure 16: women able to make decision on HIV/AIDS preventive measures



Women in the FGD thought a woman could not do much as an individual since they are not able to deny their spouse sex even if they were suspecting the spouse of being unfaithful. Most men have girlfriends outside marriage. Even if the women refuse, the partners go to their girlfriends. Some men even beat there wives if they refuse sex. This makes women to give in and avoid being beaten. "Women can have self control, what about the husband? The other woman is interested only in money. You cannot control your husband's movements". Women have financial difficulties forcing them to stick to unfaithful partners.

The women in the FGDs also said that those women who have been tested to be HIV positive should stop self condemnation accept the situation and move on with life. Nowadays there are ARVs that can keep one going. Some people infected with HIV have irresponsible behavior of wanting to spread HIV.

Some FGD participants thought women should be going for check ups frequently and when they have a funny discharge, they should always seek medical attention as early as possible. Women ought to take control of their lives. They can live without unfaithful partners. They don't have to stick to them lest they bring diseases.

Over 90% of the women knew their HIV status. Some knew through VCT, others knew their status through PMTCT and others were tested in the hospitals when they came in for delivery. Thirty three (8.6%) did not know their HIV status.

The study elicited that condom use was not a new practice to some. One hundred and seventy one (44.5%) of women had used a condom before. Decision on condom use was either by self, 67 (39.2%), partner 45 (26.3%), or both 59 (34.5%) (Table 21).

Table 21: Shows on who made decision on condom use. (n=171)

Decision on condom use	Frequency	Percent
Self	67	39.2
Partner's decision	45	26.3
Both partner's	59	34.5

Further analysis was done using the socio-demographic characteristics in relation to condom use decision. Condom use decision among the under 20 years old was made by the women themselves in 28.6% of subjects among the 42 who had used condoms. Among the aged 21-30 years, 38.7% were the decision makers. The over 30, 52.8% were the decision makers on condom use. The relationship between age and condom use decision making was statistically significant ($p = 0.032$).

With respect to marital status, it was noted that among the married women, 34.5% made decision on condom use while 48.3% of the unmarried were the decision makers. The relationship was not statistically significant (p =0.165)

The relationship between level of education and condom use decision was statistically significant. Among 41.9% of women who had tertiary education, condom use decision making was a self decision. 34.6% of those who had secondary education were condom use decision makers. 41.7%who had primary education decided on condom use. Two or 100% of women, who had no education, had made decision on condom use. The relationship between condom use decision and level of education was statistically significant (p =0.000).

Relationship between religion and condom use decision was found to have no statistically significant association (p=0.948). 39.3% Christians who had used condoms was due to self decision. The 33.3% of Muslims who had used condoms was due to self decision.

Income earned was found to have a relationship with condom use decision making. Among women who did not have any income per month, 38.5% made decision on condom use. Those who had an income ranging to 10,000 shillings per month, 40% of them were condom use decision makers. 39.4% of women who had monthly income of over 11,000 shillings were condom use decision makers. There was statistically significant association between condom use decision making and the income earned per month (p=0.011).

Table 22: Relationship between women's reproductive health decision making and decision on condom use

Characteristics(factors)		Decision on condom use		Total (%)	Chi square(χ^2)	SIGN (P value)
		Self	other			
Age	Below 20	12(28.6)	30(71.4)	42(100)	10.538	0.032
	21-30	36(38.7)	57(61.3)	93(100)		
	> 30	19(52.8)	17(47.2)	36(100)		
Marital status	Married	39(34.5)	74(65.5)	113 (100)	3.603	0.165
	Unmarried	28(48.3)	30(51.7)	58(100)		
Religion	Christian	63(39.6)	96(60.4)	159(100)	0.107	0.948
	Muslim	4(33.3)	8(66.7)	12(100)		
Income range	None	30(38.5)	48(61.5)	78(100)	8.934	0.011
	< 10 000	24(40)	36(60)	60(100)		
	> 11,000	13(39.4)	20(60.6)	33(100)		
Level of education	None	2(100)	0	2(100)	31.746	0.000
	Primary	20(41.7)	28(58.3)	48(100)		
	Secondary	27(34.6)	51(65.4)	78(100)		
	Tertiary	18(41.9)	25(58.1)	43(100)		

P = probability Figures in parenthesis indicate percentages

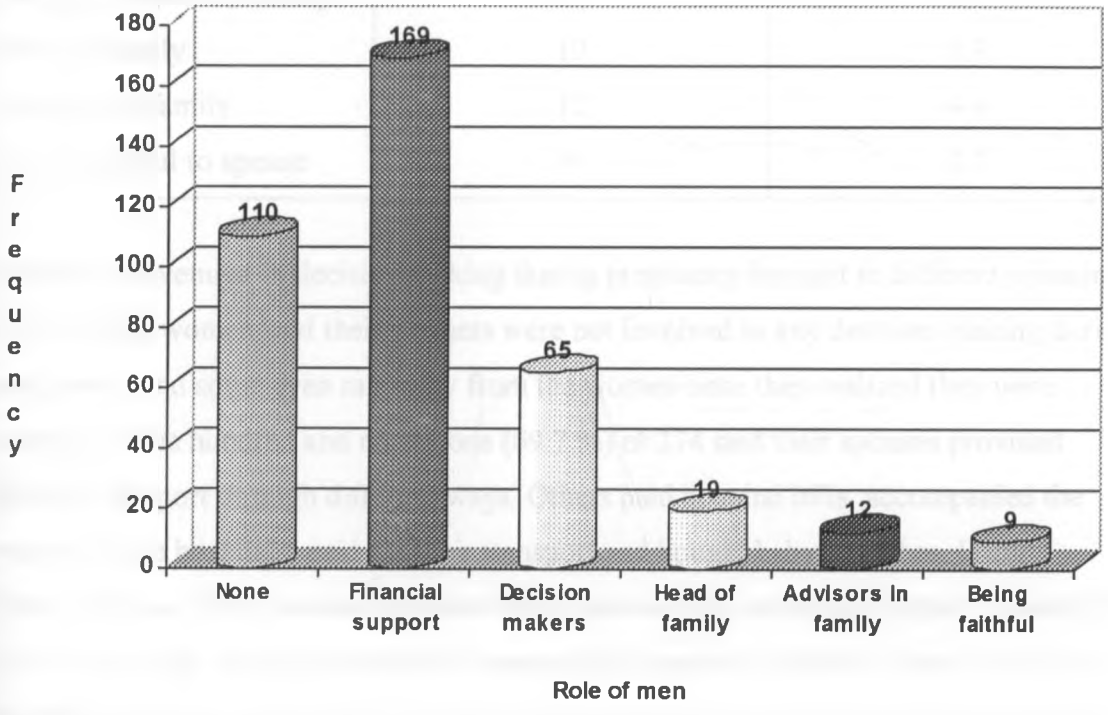
93.4% of the women interviewed knew one correct way of preventing the spread of HIV/AIDS. This included abstinence, being faithful, condom use, avoiding blood transfusions and avoiding sharing sharp instruments.5.2% of the women said they did not know of a method of preventing the spread. 1.4% said that the spread of HIV/AIDS could be prevented by use of ARVs, by choosing men carefully, through testing and by believing in God/getting saved.

When asked whether an HIV positive mother can infect the fetus/infant, 85.1% said yes and gave further explanations on how mother to child transmission can occur. 7.3% said no and 7.6% did not know.

4.6 Role of Men in women's reproductive health decision making

When interviewed on the role of men, 110 (28.6%) of 384 women said men did not have a role to play in women's decisions, 274 (71.4%) said men had different roles to play. Men's roles are presented in figure 17 below.

Figure 17: role of men in women's reproductive health decision making



It was very clear from the three FGDs that women did not receive required support from their spouses. Instead most of them wanted to dictate to their wives what should be done. Some responses were "once a woman becomes pregnant they leave you to make decisions on your own some don't even provide money for hospital, some men come home late, and leave very early and give very little attention to their wives and children. Men also don't want to come when children are playing; they come when they have slept and some even don't provide food for the children."

The main role of men is financial support. They take care of the family, provide food, clothing and daily basic needs. This was mentioned by 61.7% of the participants. 23.7 %

said the man was the decision maker in the family, 6.9% said the man was the head of the family. 4.4% said their role was advisory, and 3.3% said their role was to be faithful.

Table 23: Role of men in women decision making (n=274)

Role of men	Frequency	Percent
Financial support	169	61.7
Decision makers in family	65	23.7
Head of family	19	6.9
Advisors in family	12	4.4
Being faithful to spouse	9	3.3

Spouse involvement in decision making during pregnancy brought in different opinions. 110 (28.6%) women said their partners were not involved in any decision making during pregnancy, and some even ran away from the women once they realized they were pregnant. One hundred and ninety one (69.7 %) of 274 said their spouses provided financial support through different ways. Others paid hospital bills, accompanied the women to the hospitals, paid for their transport and bought baby's clothes. Forty three(16%) said their spouses provided both financial and emotional support. Twenty five (9.1%) said their spouses decided for them which hospital to deliver in and 15 (5.5%) said their spouses participated in healthy discussions and ensured good communication.

Finally the study sought to find out the challenges women faced in their decision making. Twenty five (6.5%) said there were none. One hundred and twelve (29.2%) said women were not able to make decisions regarding their own health since men are always the final decision makers. Forty six (12%) said financial constraints was a major drawback since a woman who is not financially independent has to rely on someone to make, livelihood would otherwise be threatened. Thirty three women (8.6%) said husbands were uncooperative, 30 (7.8%) said women lacked courage and confidence in making decisions, 18 (4.7%) said many women were ignorant, disagreement in decision making 15 (3.9%), men dislike FP 12 (3.1%), 9 (2.3%) had irresponsible spouses, 35 (9.1%) said there was lack of communication between spouses, spouses were unfaithful, women

lack of education/ needed education, and that there was influence from in-laws. Forty nine (12.8%) said they did not know the challenges women faced.

Table 24: challenges women faced in decision making

Challenges faced	Frequency	Percent
None	25	6.5
Men final decision makers	119	29.2
Financial constraints	46	12
Uncooperative husbands	33	8.6
Lack of courage and confidence	30	7.8
Ignorance	18	4.7
Disagreement in decision making	15	3.9
Men dislike FP	12	3.1
Irresponsible spouse	9	2.3
Others	35	9.1
Don't know	49	12.8

The conclusion from FGDS was that women are not able to make decisions since they lack support from their spouses. When unmarried women are able to make decisions since their decision is theirs. Once married, they have to depend on their husbands to make decisions for them. Some men are approachable some are not. So it is important for a woman to know which kind of man she has married or intends to marry.

CHAPTER 5: DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 DISCUSSION

This study considered different areas that women were involved in decision making in their reproductive lives. It presents descriptive findings only and does not examine the causes of differential findings between the different groups of women which may in part be explained by variations in social norms, disparities in the status of women from different socioeconomic groups, cultural and health services factors.

The study subjects were young mothers with the mean age being 25.41 years ranging from 15-42 years while that of their spouses was 30.96 years ranging from 15-58 years meaning the spouses were older. Studies have shown that women who tend to be younger than their partners depend on them to make decisions.[50] Young girls, relatively powerless in unions with older men are rarely able to insist upon safe sexual practices such as condom or contraceptive use. [2]

Majority of the women were married with 60.4% having secondary education and above, with 78.2% of the spouses having secondary education and above. The relatively low level of education implies that getting employment would be rare in women evidenced by 51% of unemployed women. Only 9.1% of the spouses were unemployed. According to the KDHS (2003), [1] educated women are more likely to delay marriage, use modern contraceptives, seek antenatal care, have fewer children, and ensure their children are vaccinated and to experience lower infant and child mortality rates.

Educated and economically empowered women are in a position of making own reproductive health decisions. Due to lack of education, most women have no chance of securing a salaried employment and are therefore forced to remain as housewives with no income. They, therefore have to totally depend on their husbands. Without economic power, they are likely to have no power over their own bodies. [33, 50]

Different cultural factors were found to influence women's reproductive health decision making. Polygamy, wife inheritance, female circumcision, dowry payment, arranged marriages, sex of the baby (preference for boys), number of children, naming after the dead and women must be married before getting a baby were some of the cultural factors that were mentioned. This is in line with different studies done in India, Ethiopia, Zimbabwe, and Nigeria ([6, 13, 15, 38, and 35])

Discrimination against girls, often resulting from son preference, endangers their current and future health and well-being. Some conditions force girls into early marriage, pregnancy and child-bearing and subject them to harmful practices, such as female genital mutilation, posing grave health risks.[8] Overall 15.8% of the women underwent FGM indicating a decrease from 32% according to the 2003 KDHS. Majority of women who underwent female genital mutilation said that the decision was made by somebody else. Parents were the sole decision makers in 66.1% of the cases while 11% made the decision to undergo FGM. There was no significant statistical association between socio-demographic factors and women's decision making to undergo FGM. Some cultures still practice FGM despite the campaigns began in the 1940s against it. Other studies have confirmed that women and female children endure traditional traumas inflicted by barbaric cultural practices such as genital mutilation that increase potential exposure to AIDS.[51]

Cultural taboos exist in some communities. Among the women interviewed, 21.9% said there were still cultural taboos observed in their communities. The cultural taboos observed were: a pregnant woman is not allowed to eat eggs, otherwise child will be big; women should not be unfaithful during pregnancy; a pregnant woman should not eat pork, rabbit or any slaughtered animal.

Other cultures require a girl to be a virgin until marriage, and this was the expectation in 46.1% of the women. Loss of virginity is a greater stigma and barrier to marriage in women than in men. Men bear no health risks for premarital preservation of their

virginity. While men and women may rank equally as initiators of auchastity and adultery this may be equally condemned. [10]

It was evident that some women engaged in sexual intercourse at a tender age. Others began at the age of 12, with the mean age being 19 years. According to the 2003 KDHS, median age at first sex was 17.8 years. Focus group discussion participants admitted that girls engage in sexual activity young due to financial problems and its related factors. The trend towards early sexual experience combined with a lack of information and services increases the risk of unwanted and too early pregnancy, HIV infection, other sexually transmitted diseases and unsafe abortions. Early child-bearing continues to be an impediment to improvements in the educational, economic and social status of women in all parts of the world.[8, 50]

Decision on sex practice varied between the women. Both partners were decision makers among 51.3% of the study participants. Men are expected to be the decision makers in many of the occasions. The women who had to wait for spouse were over 40%. Women in the FGD clarified that most women were not able to make decisions on sex practice because some women are shy, and are not able to approach their spouses for sex, some have fears that when they do it, they will be thought of as being loose with high libido. Others, in an attempt to ask the spouse had received shocking responses from them. It was also clear that most women do not have control over their own bodies and would not deny spouse sex at any given time for any reason. Some women have even been forced by their husbands to have sex.

Decision on number of children a woman is to bear is predominantly made by the man. Some women left decision to super powers. Different factors were found to influence decision on number of children with other women waiting for their spouses to make the decision. Delivering a number that one would be able to support was another factor women put into consideration. The sex of the baby was also found to delay decision on number of children one is to bear with women having only girls delivering more children until they get a boy.

Women rarely have a chance to make a choice on marriage partner since majority get married at a tender age due to problems especially when they drop out of school due to fee problem. The women prefer getting married to any available man, than languish in abject poverty. Those who make a choice consider the man's character, loving character, physical looks and financial stability.

First time mothers were the majority of women delivered at the hospitals. This represented 47.4% of the total population. This is in accordance with the KDHS (2003) which indicated women seeking hospital deliveries are women having their first babies.[1]

More than 90% of the women attended antenatal clinic at least once in their pregnancy. This is in line with the 2003 Kenya Demographic and Health Survey. Only 5.7% of the women did not attend antenatal clinic mainly due to ignorance and others because the pregnancy was not intended.

The study elicited that 67.4% of the women labored at home for less than 12 hours before going to hospital. Women cited different reasons for laboring at home for the hours they waited. Accessibility in terms of transport and lack of money for hospital were the main reasons given. Some of the women were waiting for their spouses to go and take them. Other studies have also confirmed that some women lack transport especially when labor begins at night and the hospitals cannot be accessed easily during those hours. Insecurity also contributes to making accessibility in the night difficult.

Decision on choice of hospital for delivery depends on many factors. Others consider whether facility is well staffed, equipped, whether services are good and affordable. Others did not know any other hospital. Others chose because of its popularity and proximity to residence. Referrals from other health facilities are also many due to labor complications and anticipation of complications. Sometimes decision is made by neighbors/friends, spouse and for some their condition dictates. In a study conducted in Kakamega, Kirinyaga, and Kilifi districts, the reasons for utilization of any health facility

were reported to be nearness, free services, availability of medicines and other facilities. Correspondingly, reasons for non-utilization of services were unavailability of drugs, unavailability of facilities, services not free and unpleasant health worker-patient relationship.[33]

Unplanned pregnancies accounted for 35.9% of the sample population. Women had different reasons for not preventing the pregnancies. Unplanned pregnancies are common in Kenya, 20% being unwanted, 25% mistimed or wanted later according to the 2003 KDHS. Approximately half of all the pregnancies in the United States are unintended with the highest rates occurring among adolescents, lower-income women and African-American women. Because of the high rate of unintended pregnancy and abortion, large numbers of women do not complete their education and become single parents who bear the burden of financial and psychological stress.[18]

Decision on family planning after delivery by women was noted to be influenced by other factors. Those who had not decided or not having an intention to use were 30% and 7.5% respectively citing different reasons. Depo injection was noted to be the commonest method of family planning the women were intending to use, followed by Norplant then oral pills. Women are prevented from using contraception or seeking family planning advice. They are also not allowed to make decisions on the number of children to bear, spacing, and when to have children by controlling husbands or partners, family and society.[48]

The nearest health facility from women's residential area was less than 2 kilometers away among 61.5% of the women. Over 95% of the health facilities offered maternal child health services to include ANC, family planning and immunizations. Consultation services for other health problems were also available in the facilities.

Health facilities were found to influence women's decision making in various ways. They provide services for women to utilize educate and give advice. Access to and use of

Sexual and reproductive health services- such as contraception, family planning, and skilled birth attendants- plays a central role in determining maternal and child mortality.[48]

The women rated the health facility services as good, fair and poor (64.1%, 19.5%, 5.5%) respectively. Women are not given a chance of making any decisions in the hospitals. The nurses and doctors made all the decisions and the women would follow them. Paternalistic medicine has been prone to conclude that women's choices are incompletely made if they do not follow health professionals' recommendations. Women can therefore be displaced as decision-makers concerning their medical management. The right to informed choice however includes the right to make choices that health professionals may consider to be poor choices.[10]

Decision on preventive measures on STIs and HIV/AIDS was felt to be a responsibility of both partners. An opinion of 84.4% of the women was that women were able to make decisions on preventive measures if the spouse was also committed to the same. 91.4% of women knew their HIV status. The government has been advocating for people to know their HIV status. In the FGDS, the women also wanted ways for getting men tested because its like most programmes only targeted women and children.

The trend on knowledge of prevention of HIV/AIDS was similar with the trends noted in the KDHS. 93.4% of the women knew one correct way of preventing HIV/AIDS transmission. Further 85% of the women said a fetus /infant can get HIV infection through the mother.

Men have major roles to play in women reproductive health decision making. Financial support was noted to be the main role of the men. Other roles include decision making in the home, being the head of the family, advisory roles and also responsibility of being faithful to the spouse.

Spouses participated in different ways in decision making during the time the women were pregnant. Some spouses provided financial support through different ways, others

paid hospital bills, accompanied the women to the hospitals and paid for their transport, and bought food and baby's clothes. Others provided emotional support and decided on the hospital for delivery. Others participated in healthy discussions and ensured good communication. Some women said that their spouses did not participate in any way. This comprised 28.6% of the sample population.

More women are able to make decisions than not, though there are challenges they face. Society has dictated to them on many occasions, financial constraints being a major drawback, others are lack of education, lack of courage and confidence and ignorance. Some husbands are uncooperative. Others are not supportive, are irresponsible, dislike FP and are unfaithful. Men have been known to be the final decision makers. Cultural factors and influence from in-laws are among other challenges women face.

5.2 CONCLUSIONS

This study demonstrates that women's reproductive health decision making is a complex issue. It is influenced by many confounding factors and in many circumstances involves an element of negotiation.

The most important factors affecting women's decision making are socio demographic and cultural in nature. However, this does not detract from the relevance of service-related factors. The socio demographic and cultural factors identified include maternal low education status, marital status, maternal age, religion, income, parity and religion, therefore rejecting the hypothesis. These are similar to those documented in many settings throughout Africa and other developing countries.

Many women believe that they can take decisions on family size, when to have a baby and choice of spacing period. There is a discrepancy though with the current situation on utilization of FP and intention of many women willing to use a method of family planning.

Most women take part in decisions on when to seek health treatment. The majority of women believed in their right of control over their sexual activity. Even though others are forced even in marriage to have sex. Hopefully the sexual offences bill (Njoki Ndung'u bill) that was recently passed should do a lot for these women who do not know their rights.

Women are willing to take decisions on HIV/AIDS preventive measures. If the spouses cooperate, with them then the spread would reduce.

The male negative role, especially during pregnancy and sexual dominance affects women's decision making. Though some men are very supportive and already participate in women reproductive health decision making.

5.3 RECOMMENDATIONS

The study findings can be used as the basis for a number of policy recommendations.

- Education was found to have an important impact on women's reproductive health decision making. This suggests that:
  - Improving educational opportunity for women may have a large impact on improving women's reproductive health decision making. This is, however, a long-term goal.
  - Women should be educated on their reproductive health rights. Several copies of the new sexual offences bill should be translated to other languages of Kenya, printed and disseminated to areas where women can access it. The government should be on the forefront in educating women on their rights.
  - Health programmes already existing should target women with little or no education. The already existing programmes need to be evaluated to determine whether they meet the reproductive health needs of women.
  - Assist women and their formal and informal organizations to establish and expand effective peer education and outreach programmes. They should also participate in the design, implementation and monitoring of these programmes.
- The study findings also revealed that women who were economically empowered were able to make their own decisions. Unemployed women should therefore be educated on engaging in micro businesses to enable them have a source of income and stop depending wholly on the spouse.
- It was also evident that women who are not married or in union are less likely to use the health services. It is imperative to also target this group during education campaigns
- Some cultural practices were found to impact negatively on women's reproductive health decision making. This should be completely eliminated.
- Health services were found to influence women reproductive health decision making thus there is need for the government to support health service systems and operations research to strengthen access and improve the quality of service

delivery. This will ensure appropriate support for women in provision and utilization of the services.

- It was also noted that majority of women had little knowledge on different methods of family planning. Hospitals should allow informed decision making when women come for services, for example in case of FP they should give explanations to women and let them make informed choice.
- Give all women and health workers the relevant information and education about sexually transmitted diseases including HIV/AIDS and pregnancy. They should also know the implications for the baby, including breast- feeding.
- It was also evident in the study that men are the main reproductive health decision makers.
  - Men should also be targeted so that they can support women in their reproductive health decision making. This should be through intensive information, education and communication activities.
  - Designing specific programmes for men of all ages and male adolescents, aimed at providing complete and accurate information on safe and responsible sexual and reproductive health behavior is necessary. This includes voluntary, appropriate and effective male methods for the prevention of HIV/AIDS and other sexually transmitted diseases through interaction abstinence and condom use and importance of respecting women's decisions in reproductive health care.
  - Health facilities should incorporate male partners in reproductive health care.
- On issues of preventing HIV transmission, it was clearly evident that both partners need to be involved. Most HIV/AIDS screening programmes have been targeting women. Programmes also targeting men need to be incorporated.
- The study did not look into the men's perspectives in reproductive health decision making and other studies need to be done to enable to come up with broader perspectives.
- Study only done in Nairobi, there is need to replicate the same in other parts of the country to come up with a more generalized view.

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APPENDICES

APPENDIX I: PREVIEW OF THE STUDY AREA

1. KENYATTA NATIONAL HOSPITAL

Kenyatta National Hospital is the largest National Teaching and Referral Hospital in Kenya. It is the apex of the referral system in the Health sector in Kenya. It covers an area of 45.7 Hectares and within the KNH complex are the college of Health Sciences (University of Nairobi) and the Kenya Medical Training College. It has a long-standing history for excellence and Research performance.

The hospital has out-patient, ICU, Casualty, Laboratory, administrative, medical records, theatre, pharmacy and many other support units and has a tower block housing many wards of different specialties. It has a complex management structure divided into administrative, nursing and clinical units with many divisions and sections of management.

In the hospital are different departments with specialties of medicine and nursing. Among this is the department of Obstetrics and Gynecology that handles any issue related to women reproductive health care. Averagely, 20 mothers deliver daily in the labor ward. It is in this area that research will be conducted.

2. PUMWANI MATERNITY HOSPITAL

This is an obstetric hospital for delivering expectant mothers. It also provides other services related to women's health such as antenatal and post-natal clinic services. It offers Family Planning services to clients requiring the services. Pumwani houses a school of Midwifery within the Hospital, which trains Kenya Registered Midwifery as well as Kenya Enrolled Midwives in accordance with the syllabus, laid down by the Nursing Council of Kenya. Averages of 80 babies are delivered daily.

APPENDIX II: INFORMED CONSENT EXPLANATION FORM

TITLE OF STUDY: perspectives in women reproductive health decision making among mothers delivered in KNH and Pumwani maternity hospital.

My name is Evelyn Nyangwaria. I am under-taking a postgraduate study at the University of Nairobi, School of Nursing Sciences. I would like you to participate in a medical research study. The objective of this study is to establish the **factors affecting women's decision making in reproductive health care**. You will be required to respond to questions in a given questionnaire or participate in a focus group discussion. Before you fill the questionnaire, it is very important that you understand the following principles that apply to all participants in the study.

Participation plus filling of this questionnaire is entirely voluntary; your confidentiality will be safeguarded; your identity and records relating to your participation will remain confidential. Names of participants will not appear in any final reports or publications resulting from this study; there are no risks to be incurred for participating in this study. If there is any part of this consent explanation sheet that you do not understand, you are free to ask the investigator before signing below.

In case of any problem or concern, you may either contact my supervisors or myself through the following number: 0722-358834 or the KNH Research and Ethics committee, P.o Box. 20723, NAIROBI.

PARTICIPANT

I ----------have fully understood the objectives of the research and hereby sign as a show of willingness to participate.

Signature----------date----------

WITNESS BY

Signature----------date----------

APPENDIX III: RESEARCH QUESTIONNAIRE

Questionnaire No.....

(Please answer the following. Write in the spaces provided and tick the appropriate option in the boxes provided. Answer all the questions.)

SECTION A: SOCIO-ECONOMIC AND DEMOGRAPHIC FACTORS

1. Age of respondent: ----------
2. Marital status----------
3. Religion----------
4. Level of education----------
5. Occupation----------
6. Residence----------
7. Tribe----------
8. Husbands age----------
9. Husbands level of education----------
10. Husbands occupation----------
11. Husbands tribe----------
12. What is your salary/income range per month?

    1 = Below 2000/= ☐

    2 = 3000/= - 5000/= ☐

    3 = 6000/= - 10,000/= ☐

    4 = 11,000/= -20,000/= ☐

    5 = 21,000/= -30,000/= ☐

    6 = 31,000/= -40,000/= ☐

    7 = Above 40,000/= please specify----------

13. What is your spouse's approximate income level per month?

    1 = Below 2000/= ☐

2 = 3000/= - 5000/= ☐

3 = 6000/= - 10,000/= ☐

4 = 11,000/= -20,000/= ☐

5 = 21,000/= -30,000/= ☐

6 = 31,000/= -40,000/= ☐

7 = Above 40,000/= please indicate----------

14. List three characteristics you think women consider in a man in order to make a decision to marry him.

1 ----------
2 ----------
3 ----------

SECTION C: CULTURAL FACTORS

15. List three cultural factors which influence your reproductive health decision-making and how it influences.
    1. ----------
    2. ----------
    3. ----------
16. Are there cultural taboos observed during pregnancy in your community? ----------
    ----
    ----

17. What influence does dowry have in regard to women reproductive health decision-making in your culture? ----------
    ----
    ----

18. Is FGM a common practice in your culture?
    ☐ YES ☐ NO

19. What is your opinion on FGM? ----------

    ----

20. Did you undergo FGM?

    ☐ YES ☐ NO

21. If yes who made the decision? ----------
    ----

22. In your culture are women suppose to be virgins until marriage? ----------
---
23. In your culture who decides on the number of children to be born? ----------
---
24. Is polygamy practiced in your culture? ----------

---
25. In your culture, is wife inheritance practiced? ----------
---

---

26. According to your culture, who negotiates and makes decision on sex?

1	=Woman	☐
2	=Man	☐
3	=Both partners	☐
4	= Don't know	☐

SECTION D: ROLE OF WOMEN IN DECISION MAKING IN REPRODUCTIVE HEALTH ISSUES

27. Parity------

28. Mode of delivery in current birth----------

29. Did you have any complications during or after delivery? ----------
---

30. If C/S who made the decision? ----------
---

31. Who signed the consent form for theatre? ----------
---

32. How many hours did you labor at home before coming to hospital? ----------
---

33. Why did you choose to come and deliver in this hospital? ----------
---

34. If you have been pregnant before, please fill in the table below.

Year of birth	Place of delivery	Who made decision on place of delivery at that time?	Did you attend ANC clinic during that pregnancy	Have you used any method of FP	Reason for using method of FP	Reason for not using FP

35. Was the current pregnancy planned for?

1 =Yes ☐ (if yes, go to question 29)

2 =No ☐

3 =Don't know ☐

4 =Other (specify)----------

36. If No in number 35, who made the decision and why were you unable to prevent it? ----------
---

37. How did you confirm that you were pregnant? ----------
---

38. Age at first sexual intercourse----------

39. Was it your decision to begin sex at that time or are there factors that influenced you to start? ----------
---
---

40. Did you attend antenatal clinic during your pregnancy?

☐ YES ☐ NO

41. If yes, at what month of the pregnancy did you start attending ANC clinic? --------
---

42. Why did you decide to attend at that time? ----------

---

43. How many times did you attend antenatal clinic in your pregnancy and why did you decide on those times? ----------
---

44. If NO in 40, why didn't you attend antenatal clinic? ----------
---
---

45. What method of family planning do you intend to use? ----------
---

46. How many children do you intend to have in total and why that number? ---------
---
---

47. What is your opinion in regard to unwanted pregnancies? ----------
---

48. What is the recommended time for a woman to resume sexual intercourse after delivery? Please specify in weeks----------

49. In your opinion, what is the recommended birth spacing? ----------
---

SECTION E: THE LINK OF HEALTH SERVICES TO WOMEN DECISION MAKING

50. How far is the nearest health facility from your home? (Approximate in kilometers)----------
51. Name the services offered in the facility?
    1 ----------
    2 ----------
    3 ----------
    4 ----------
    5 ----------
52. In your view, how do you rate the quality of services offered in your nearest health facility?

    1 =Good ☐
    2 =Poor ☐
    3 =Fair ☐
    4 =Don't know ☐
    5 =Other (specify)----------

53. Are family planning services available at the facility?

1 =Yes ☐

2 = No ☐

3 = Don't know ☐

54. What advice/s have you been given after delivery regarding your care and the care of your baby? ----------
---

55. What is your opinion on maternity services offered in the hospital? ----------
---

---

56. In your experience at the hospital, did you have a chance to make your own reproductive health decisions? ----------
---
---

57. How do the health facilities influence your reproductive health decision-making?

SECTION F: ROLE OF WOMEN IN REDUCING SPREAD OF STDS AND HIV/AIDS

58. In your opinion, are women able to make decisions on preventive measures of STIs and HIV/AIDS?

1 =Yes ☐

2 =No ☐

3 =Don't know ☐

4 =Other (specify)----------

59. Are their community projects focusing on women and HIV/AIDS in your community?

1 =Yes ☐

2 = No ☐

3 =Don't know ☐

4 =Other (specify) ----------

60. Do you know your HIV status?

1 =Yes ☐

2 = No ☐

61. If yes in 62, how did you know about your HIV status?----------

62. Can HIV infected mothers transmit the infection to their infants?
    1 =Yes ☐
    2 = No ☐
    3 =Don't know ☐
    4 =Other (specify) ----------

63. Have you ever used a condom before?
    ☐ YES ☐ NO

64. If yes who made the decision to use the condom? ----------
    ----

65. Name any two ways you know for preventing the spread of HIV/AIDS.
    1. ----------
    2. ----------

SECTION G: WOMENS PERCEPTIONS OF MALE INVOLVEMENT IN REPRODUCTIVE HEALTH DECISION-MAKING

66. In your opinion, what is the role of men in women reproductive health decision-making?
    1. ----------
    2. ----------
    3. ----------
    4. ----------

67. In what way was your spouse involved in decisions during your pregnancy---------
    ----

68. In general what do you think are the problems women face in reproductive health decision-making? ----------
    ----

Thank you for your cooperation.

APPENDIX IV: FOCUS GROUP DISCUSSION GUIDE

1) Views of age at marriage
   -are women younger or older and why
2) Socio-economic and cultural factors influencing women reproductive health decision-making.
3) Factors women consider in a man before marrying
   -Education status
   -Economic status
   -Other factors.
4) Role women play in decisions regarding reproductive health.
   -decision on number and spacing of children
   -decision on family planning
   -decision on ANC and place of delivery
5) Ways of improving women's reproductive health decision-making
6) Views on health facilities.
   -accessibility
   -relationship with health care workers
   -services offered at the facility. Are they adequate?
7) What role men play in women reproductive health issues.
8) Role of women in prevention of STIs and HIV/AIDS
   -condom use
   -when and who to have sex with
9) General knowledge of women on reproductive health care
   -Routine check ups like self breast examination, yearly Pap smear
   -Complications during pregnancy like anemia in pregnancy, Diabetes, pregnancy induced hypertension, ante partum hemorrhage?

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REPUBLIC OF KENYA

JOGOO HOUSE "B"
HARAMBEE AVENUE
P.O. Box 60209-00200
NAIROBI
KENYA

17th June 2006

Everlyne Chepkemoi Rotich
Moi University
P.O. Box 3900
ELDORET

Dear Madam

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***'Perspectives on Women Reproductive Health Decision making among Mothers delivered in Kenyatta National Hospital and Pumwani Maternity Hospital'***

I am pleased to inform you that you have been authorized to carry out research for a period ending 30th August 2006.

You are advised to report to the Director – Kenyatta National Hospital and the Medical Officer in charge of Pumwani Maternity Hospital before commencing your research project.

On completion of your research, you are expected to submit two copies of your research report to this office.

Yours faithfully

M. O. ONDIEKI
FOR: PERMANENT SECRETARY

Copy to:

The Director, Kenyatta National Hospital – **Nairobi**
The Medical Officer in charge, Pumwani Hospital - **Nairobi**

Research Permit No. MOST 13/001/36C 463

Date of issue 18.7.2006

Fee received SHS.500.00

THIS IS TO CERTIFY THAT:

Prof./Dr./Mr./Mrs./Miss EVERLYNE CHEPKEMOI ROTICH

of (Address) MOI UNIVERSITY P.O.BOX 3900 ELDORET

has been permitted to conduct research in KENYATTA NATIONAL HOSPITAL AND PUMWANI HOSPITAL Location,

NAIROBI District,

NAIROBI Province,

on the topic PERSPECTIVES IN WOMEN REPRODUCTIVE HEALTH DECISION MAKING AMONG MOTHERS DELIVERED IN KENYATTA NATIONAL HOSPITAL AND PUMWANI MATERNITY HOSPITAL

for a period ending 31ST AUGUST, 2006

For PERMANENT SECRETARY
MINISTRY OF EDUCATION
SCIENCE AND TECHNOLOGY

M.O.ONDIEKI

Applicant's Signature

for *Permanent Secretary Ministry of Science and Technology*

CONDITIONS

1. You must report to the District Commissioner and the District Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit.
2. Government Officers will not be interviewed without prior appointment.
3. No questionnaire will be used unless it has been approved.
4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.
5. You are required to submit at least two(2)/four(4) bound copies of your final report for Kenyans and non-Kenyans respectively.
6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice

HARAMBEE

REPUBLIC OF KENYA

RESEARCH CLEARANCE PERMIT

(CONDITIONS ... see back page)

PUMWANI MATERNITY HOSPITAL

Tel: 02/6763291– 4
Fax: 02/6762965

P.O. Box 42849
Code: 00100- GPO
Nairobi.

INSTITUTIONAL RESEARCH AND ETHICAL REVIEV COMMITTEE (IRERC)

PROPOSAL APPROVAL

Dear Ms. Everlyne C.R. Nyangwaria,

It is our pleasure to inform you that your approval entitled, "**Perspectives in Women Reproductive Health Decision Making among Mothers Delivered in Kenyatta National Hospital and Pumwani Maternity Hospital"**, has been reviewed by the Institutional Research Committee.

The IRERC held a meeting on 4th April 2006. The proposal has been reviewed on the research merit, ethical consideration, sampling, methodology and relevance to the care of patients for research purposes.

The committee is guided by the institutional guidelines as well as International Technology for Scientific purpose.

The proposal has been approved unconditionally by the above named committee and further to that please refer to the guidelines from the institutional Medical Superintendent.

DR C. WANYONYI
AG. MEDICAL SUPERINTENDENT

C.C. File

KENYATTA NATIONAL HOSPITAL
Hospital Rd. along, Ngong Rd.
P.O. Box 20723, Nairobi.
Tel: 726300-9
Fax: 725272
Telegrams: "MEDSUP", Nairobi.
Email: **KNHplan@Ken.Healthnet.org**

Ref: KNH-ERC/ 01/ 3552 **Date: 30 May 2006**

Nyangwaria Everlyn Rotich
School of Nursing Sciences
College of Health Sciences
University of Nairobi

Dear Rotich

RESEARCH PROPOSAL: "PERSPECTIVES IN WOMEN REPRODUCTIVE HEALTH DECISION MAKING AMONG MOTHERS DELIVERED IN K.N.H. AND PUMWANI MATERNITY HOSPITAL' (P14/1/2006)

This is to inform you that the Kenyatta National Hospital Ethics and Research Committee has reviewed and **approved** revised version of your above cited research proposal for the period 31st May 2006 – 30th May 2007.

You will be required to request for a renewal of the approval if you intend to continue with the study beyond the deadline given.

On behalf of the Committee, I wish you fruitful research and look forward to receiving a summary of the research findings upon completion of the study.

This information will form part of database that will be consulted in future when processing related research study so as to minimize chances of study duplication.

Yours sincerely

PROF A N GUANTAI
SECRETARY, KNH-ERC

c.c. Prof. K.M.Bhatt, Chairperson, KNH-ERC
The Deputy Director CS, KNH
The HOD, Medical Records, KNH
Supervisors: Mrs j. Oyieke
Mrs Shereen Penny
Dr Blasio Osogo

ROBI	CENTRAL	NGARA	NGARA EAST
ROBI	CENTRAL	NGARA	NGARA WEST
IROBI	CENTRAL	STAREHE	CITY SQUARE
IROBI	CENTRAL	STAREHE	NAIROBI CENTRAL
IROBI	CENTRAL	STAREHE	PANGANI
IROBI	CENTRAL	STAREHE	ZIWANI/STAREHE/K
IROBI	DAGORETTI	KANGEMI	KANGEMI
IROBI	DAGORETTI	KANGEMI	UTHIRU/RUTHIMITU
IROBI	DAGORETTI	KAWANGWARE	KAWANGWARE
IROBI	DAGORETTI	MUTUINI	MUTUINI
IROBI	DAGORETTI	RIRUTA	RIRUTA
IROBI	DAGORETTI	WAITHAKA	WAITHAKA
IROBI	EMBAKASI	DANDORA	DANDORA
IROBI	EMBAKASI	DANDORA	KARIOBANGI SOUT
IROBI	EMBAKASI	EMBAKASI	EMBAKASI
IROBI	EMBAKASI	EMBAKASI	MIHANGO
IROBI	EMBAKASI	NJIRU	KOMA ROCK
IROBI	EMBAKASI	NJIRU	RUAI
IROBI	EMBAKASI	NJIRU	UMOJA
IROBI	KASARANI	KAHAWA	KAHAWA NORTH
IROBI	KASARANI	KAHAWA	KAHAWA SOUTH
IROBI	KASARANI	KARIOBANGI	KARIOBANGI NORT
IROBI	KASARANI	KARIOBANGI	KOROGOCHO
IROBI	KASARANI	KASARANI(RUARAKA	KASARANI
IROBI	KASARANI	KASARANI(RUARAKA	RUARAKA
IROBI	KASARANI	MATHARE	HURUMA
IROBI	KASARANI	MATHARE	MATHARE
IROBI	KASARANI	ROYSAMBU	ROYSAMBU
IROBI	KIBERA	KAREN/LANGATA	KAREN
IROBI	KIBERA	KAREN/LANGATA	LANGATA
IROBI	KIBERA	KENYATTA/GOLF CO	GOLF COURSE
IROBI	KIBERA	KENYATTA/GOLF CO	KENYATTA HOSP
IROBI	KIBERA	KIBERA/WOODLEY	KIBERA
IROBI	KIBERA	KIBERA/WOODLEY	WOODLEY
IROBI	KIBERA	MUGUMOINI	MUGUMOINI
IROBI	KIBERA	MUGUMOINI	NAIROBI WEST
IROBI	MAKADARA	KALOLENI/MAKONGE	KALOLENI
IROBI	MAKADARA	KALOLENI/MAKONGE	MAKONGENI
IROBI	MAKADARA	MAKADARA	HAMZA
IROBI	MAKADARA	MAKADARA	HARAMBEE
IROBI	MAKADARA	MAKADARA	LUMUMBA
IROBI	MAKADARA	MARINGO/MBOTELA	MBOTELA
IROBI	MAKADARA	MARINGO/MBOTELA	OFAFA
IROBI	MAKADARA	VIWANDA	NAIROBI SOUTH
IROBI	MAKADARA	VIWANDA	VIWANDANIIINDU A
IROBI	PARKLANDS/WESTL	KILIMANI	KILELESHWA
IROBI	PARKLANDS/WESTL	KILIMANI	KILIMANI
IROBI	PARKLANDS/WESTL	KILIMANI	MASIWA
IROBI	PARKLANDS/WESTL	KILIMANI	MUTHANGARI
IROBI	PARKLANDS/WESTL	PARKLANDS	HIGHRIDGE
IROBI	PARKLANDS/WESTL	PARKLANDS	KARURA
IROBI	PARKLANDS/WESTL	PARKLANDS	KITISURU
IROBI	PARKLANDS/WESTL	PARKLANDS	LORESHO/KYUNA
IROBI	PARKLANDS/WESTL	PARKLANDS	MUTHAIGA
IROBI	PARKLANDS/WESTL	PARKLANDS	SP. VALLEY/U.PARK
IROBI	PUMWANI	BAHATI	KIMATHI

STRICT	DIVISION	LOCATION	SUBLOC
AIROBI	PUMWANI	BAHATI	UHURU
AIROBI	PUMWANI	EASTLEIGH	EASTLEIGH NORTH
AIROBI	PUMWANI	EASTLEIGH	EASTLEIGH SOUTH
AIROBI	PUMWANI	KAMUKUNJI	MUTHURWA
AIROBI	PUMWANI	KAMUKUNJI	SHAURI MOYO/KAM
AIROBI	PUMWANI	PUMWANI	MAJENGO