

FAMILY PLANNING

AN EVALUATIVE STUDY ON THE ATTITUDES AND
USE OF CONTRACEPTIVES BY BLACK
MALES IN UMTATA

BY

NOSINODI ALICIA MADIKIZELA

THESIS

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"Never before have so many people relied on drugs,
devices and Surgery to control their
fertility, a fact that warrants
careful monitoring of the
health aspects of
family planning
methods."

Akhter, H.H. - 1983.



IGNORANCE
SUSPICION
CONFIDENCE

Title and painting by Dr. F. S. Drewe, founder of the Holy Cross Hospital,
Pondoland. Painted in 1970 at the age of 83 years.

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SUMMARY

The purpose of this study is to identify, observe and record the attitudes and use of contraceptives by black males in Umtata and to investigate the effect of education, urbanisation and age on fertility control.

Data was gathered from a sample of adult males who were past the school going age and were employed or working in Umtata and its suburbs, which are Ngangelizwe, Ikwezi, Southernwood, Northcrest, Norwood, Ncambedlana, Nduli Crescent, Fortgale and Hill Crest. Information was also gathered from Nursing officers in charge of family planning service centres in the areas mentioned above.

Findings reveal that, although black urbanised educated males in Umtata seem to have accepted the use of contraceptives by themselves and their sexual partners, their patterns of behaviour in relation to fertility control and the value of children to families remains traditional. This contributes to the relatively high fertility rate in the country. Children are an investment for old age. They are also regarded as a security factor against divorce. It is the duty of legally married couples to raise a family with children who will continue to bear the family name.

It appears that men are either suspicious of modern contraception if not totally opposed to it. Many still prefer

the use of natural methods of contraception.

There is thus need for social workers and health planners to recognise and educate males on the use and benefits of modern contraceptives to limit the number of children borne and control periods when they would like to have children.

This study will be of value to social welfare services and to family planning nurses who are in direct contact with clients in hospitals and clinics, in their family planning campaigns, when they motivate couples and individuals on the importance of family planning, and also in mother-and-child health services. Educationists, sociologists, psychologists and persons in other fields of study will also benefit from information attained in this survey.

CHAPTER I

1. THE STUDY

It has been generally accepted world wide that a male and female have to be actively involved in making a child. Advanced embryo research and technology has made it possible for conception to take place by implantation of spermatozoa to the female with and sometimes without the knowledge and consent of the male partner.

The world's first test-tube baby, Louise Brown, was born in Northern England in July, 1978. Her birth was followed by a series of advances in reproductive technology on test tube babies/in vitro fertilisation, donor eggs, frozen embryos, surrogacy and multiple births. In 1987, a surrogate mother in Johannesburg gave birth to triplets after becoming pregnant through in-vitro fertilisation using her daughter's eggs and son in-laws sperms.

The 1000th test tube baby was born in 1988. The advances in reproductive technology heralded an era of hope for many infertile couples. Most Blacks, however, are not well informed about these reproductive advances and still believe and practise the conventional method of reproduction. For this reason, the above named modern reproductive

methods will not be referred to in this report. These advances, however, have given an indication of the importance of fertility world-wide.

In most societies emphasis has been placed on educating the woman in most aspects of child bearing including contraception and contraceptive use, ante-natal care and baby feedings. Women are sometimes blamed for falling pregnant at wrong times by some societal groups and it is sometimes bluntly stated that "she wanted the child" in cases of pre-marital pregnancies. This may be true in some cases, but may not be regarded as a norm. It has also been observed that family planning has, in some places, been too clinical in it's orientation to the total population of would be mothers, when the concept ought to affect the entire population (males and females). Black South African males according to a study by Lotter and Schmidt (1973), expressed more opposition to the use of contraception in hypothetical situations than is usually found among black women. Futher-more they expressed preferences for large families.

It would appear that the attitudes of black males towards modern contraception and their role in decision-making process in regard to family planning

are important factors influencing the fertility behaviour of a couple. The then United States Department of Health, Education and Welfare (1977) postulated that there was substantial ignorance regarding knowledge of reproduction and family planning methods, and that women did want fewer children.

It is against knowledge of this family planning background that attention is directed to Transkei. Little has been done in the country in the line of the study of human reproductive behaviour, fertility control and the associated norms and values. In the Republic of South Africa (Theron, 1987, p.12) the White population group is already applying family planning practices maximally, the Coloured and Indian groups are expected to reach full acceptance within the next decade, but Black people still need a great deal of motivation. The specific issue of the present study is a consideration of family planning patterns and values in the sample population (males) as most attention in the past has been directed to females on the subject of fertility control.

This investigation is the first in Transkei. Previous studies on the subject were undertaken in the Republic of South Africa by researchers

like Lötter J.M. in 1979; Du Plessis J.L. in 1974 and Groenewald, H.J. in 1978.

Black South African males in a study by Lötter, J.M. (1979) expressed more opposition to the use of contraception in hypothetical situations, than is usually found among black women. Furthermore they expressed preferences for large families. Somardjan (Stein and Sanders, 1971) stated that ideas about children also influence marital behaviour. Children, people argue, are an investment for old age. They are also a security factor against divorce. It is the duty of a legally married couple to raise a family with children who will continue to bear the family name.

The problem under study is attitudes of males towards family planning; factors which may be influencing them towards or against contraceptive usage, limitation of the number of children borne and spacing children. Their knowledge and use of available contraceptives will also be evaluated.

1.1 AIMS OF THE STUDY

The aim of this study is to investigate male attitudes towards contraception and contraceptive use. It is the intention of this report to indicate what in-roads family planning has made in an attempt to:

- i) limit population growth and
- ii) what problems are encountered in the field of family planning.
- iii) The approach to fertility control will be investigated and answers to questions as to why some black males prefer large families or are against the use of contraceptives themselves or by their partners will be sought.
- iv) Investigate the nature, and distribution and effects of family planning services in Umtata.
- v) To ascertain to what extent Westernisation and technology may be changing black people's practices and beliefs and their influence towards family planning practice.

1.2 ASSUMPTION AND PROPOSITIONS

The following factors seem to hinder the execution of family planning services;

1. Male opposition towards the use of contraceptives;
2. The tardiness of social norms to adjust to changing conditions;
3. Lack of motivation towards the use of contraceptives;
4. Lack of relevant knowledge on how contraceptives prevent a pregnancy from occurring or act in the body;
5. Unavailability of contraceptives;
6. Fear of change in the woman's behaviour when using contraceptives.

7. Fear of complications or problems caused by artificial contraceptives;
8. Preferences of larger families;

As a framework of this investigation, the following propositions have been developed for testing:-

1. Family planning practise is positively associated with peoples' socio-economic status and educational standard.
2. A couple's fecundity status has a vital bearing on it's family planning pattern irrespective of cultural factors.
3. Males fear that contraceptives used by their wives may lead to physical complications and ill-health.

An analysis of findings will be given and some recommendations will be suggested which may provide solutions to some problems.

It is hoped that this report will serve as a stimulus for future programming and operational research efforts to investigate a group which until now has been the focus of little attention and which could lead to new approaches in the field of male fertility.

CHAPTER 2

2. RESEARCH DESIGN AND METHODOLOGY

The quantitative - descriptive research design was used. This cross-sectional survey design was selected primarily to provide quantitative descriptive data which can be generalised to some designated population. The design is descriptive because the group investigated was already in existence and the researcher was not in a position to randomly assign subjects to either a control group or to an experiment group. This design stressed representativeness of all elements for the units under study and to accomplish the objective of representativeness in the design; seven steps are involved and have been followed in this study, (Grinnell, 1981, p.214). These are:-

- i) Developing research questions or specific hypotheses prior the survey;
- ii) Independent and dependent variables operationally defined in advance of survey.
- iii) Definition of population.
- iv) Choosing the paramaters of the study participants.
- v) Research instruments developed are pretested to establish validity and reliability.
- vi) Permission is sought from persons and/or organisations to participate in the study.
- vii) Individuals in the sample are contacted. Data are collected, coded, tabulated and analysed.

The researcher had planned to conduct interviews but eighty percent (80%) of the pre-test group indicated that time should be given to them to carefully read through the questions asked and to complete the questionnaires at their own pace. The pretest group was composed of twenty (20) males with similar qualities to the sample population. Respondents were given a free choice to decide on the method of answering questions i.e. the interview and/or completing the schedule.

Flexibility in gathering the data was maintained because twenty percent (20%) of the pretest group still preferred interviews and discussing the questions with the interviewer. The schedule of questionnaires used in the survey is reflected in Appendix 3.

2.1 RESEARCH SAMPLE

The segment of the population selected for the study was limited to one hundred and fifty (150) adult males (20 years and above), resident in Umtata and its suburbs. The sampling method used was interviewing the first male respondent who qualified with regard to age, education and occupation and then conducting interviews with every fifth adult male. This method was followed in offices and departments where respondents were employed as

well as in the residential areas. The marital status of respondents was not taken as a deciding factor since some unmarried males have children as well from unmarried mothers.

Selecting respondents of the stated age group and educational standard posed less problems because interviewers had acceptable communicating skills and were experienced in dealing with people. The question of whether they were employed or not posed no problems when respondents were contacted at work.

2.2 METHOD OF GATHERING DATA

Interviewers were distributed equally to cover the whole area. Two fieldworkers approached the townships from South and two from the North of Umtata. This was basically for security reasons (safety of interviewers) and for convenience of transport.

Each respondent was allowed to make a choice between the face-to-face interview, using the structured questionnaire or to complete the questionnaire in his own time.

Arrangements were made that completed questionnaires be delivered or collected by the interviewer when

completed. The researcher conducted forty-five (45) interviews. Of these seventeen (17) were interviews conducted with respondents who had stated that they preferred completing questionnaires independently. After reading through the schedule, there were some aspects they wanted to discuss with the interviewer. Questions in section "iii" of the schedule (Reproductive Patterns) apparently needed more clarification and some respondents needed reassurance about confidentiality and the purpose of the study.

The male interviewer conducted thirty three interviews (33) and of these seventeen were conducted with respondents who had indicated that they would not need assistance when completing the questionnaires. The other two female interviewers both conducted thirty nine (39) interviews and of these twenty one (21) were with respondents who had chosen to complete questionnaires independently. At the end of the study, it was noted that interviews had been conducted with eighty one percent (81%) of the study group. The high percentage of respondents who preferred to be interviewed (81%) is in contrast to the pre-test group, as only twenty percent (20%) selected to be interviewed and eighty percent completed the questionnaires independently.

Since respondents were given a free choice to decide on the method of answering questions, no problems were experienced in gathering data because interviewers had made provisions for both methods (conducting interviews and completing questionnaires). Information gathered was therefore relevant to the investigation under study irrespective of the method used for collecting it.

2.3 GEOGRAPHIC AREA OF THE STUDY

The study was conducted in Umtata (town) and its suburbs which are Ngangelizwe, Ikwezi, Southernwood, Northcrest, Norwood, Ncambedlana, Fortgale, Nduli Crescent and Hill Crest. The population in some townships like Ngangelizwe, Ikwezi, Ncambedlana, Northcrest, Nduli Crescent, Norwood and Hill Crest is predominantly black, (see Figure I: Map of Umtata). Occupants of houses in Fortgale, Southernwood and the main portion of the town of Umtata are mainly white. Coloureds, Indians and blacks are also resident in these areas.

Respondents were selected from both middle and lower income groups. Residential areas for the middle and lower income groups differ in some respects as stated below:

The area of residence, the type and size of the house. People who can afford to buy, build or rent a house in Umtata (town), Fortgale, Southernwood, Nduli Crescent, Norwood and Hill Crest are regarded as the middle

class, because the area of their plots or sites is relatively large, houses built are larger with garages and invariably most residents own cars. Vacant plots in some of these areas are sold at about twenty thousand rand (R20 000) and it is stipulated that the value of houses built in these areas should not be less than eighty thousand rand (Transkei to-day, 1984). The lower income group is mostly resident at Ngangelizwe, Ikwezi, Ncambedlana and Northcrest townships. Most houses in these areas are the traditional four or five roomed "match box" type of houses, typical of most houses in black urban townships, with marked overcrowding and an increased number of "shebeen" houses, selling all types of intoxicating drinks. Few people own cars in this group and most depend on public transport. Cases of assault, theft and other criminal offences are rife and are reported to occur in broad day-light at times.

Travelling at night, when compared to the middle class areas which are fairly quiet during the day and at night, can be dangerous and risky.

2.4 PROBLEMS ENCOUNTERED DURING THE INVESTIGATION

Progress in conducting interviews was slow because of the following reasons:

- i) Most males were at work during the day and could not be contacted at their residential places/homes.

- ii) It was difficult to contact them after work or in the early hours of the evening because most men did not go straight home after work. Some visited friends or entertained themselves on the sportfield while others attended part-time studies at the University of Transkei or at the local night schools. Appointments made were rarely honoured.

- iii) Conducting interviews in areas like Ngangelizwe townships was risky at times. The area is characterised by over crowding with a relatively high percentage of unemployed people. The number of "tsotsis" (thugs) is high in this area. Even police at times, especially at night, have to be fully armed when attending to complaints/problems in some areas like the "Back" and "Nomagazi" section/areas in Ngangelizwe township. For this reason, the researcher chose to conduct interviews with the male fieldworker, who was staying at Ngangelizwe and had a better understanding of peoples behaviour in this area.

- iv) Some males expressed their reluctance to be contacted at their homes because their wives or sexual partners might be interested in knowing their responses, which they regarded

as personal and confidential. Some men, for example, stated that they had children from women outside marriage and that it was never their intention to inform their wives of their private sexual affairs.

Interviews were, therefore, conducted at work during their tea or lunch break. Those who requested to complete questionnaires at their leisure time were permitted to do so. (More information on the project design is given in appendix 1 and 2).

2.5 PROEDURE

The coding of the data was done with the assistance of a computer from a nearby computer college (in town). Of the 150 respondents contacted, 6 questionnaires could not be analysed because the hand-writing on three questionnaires was illegible and the other three omitted to answer questions and/or misinterpreted some questions. These six questionnaires were discarded and only 144 could be processed. The researcher felt that the 6 questionnaires discarded were of little or no significance when 144 gathered the required data.

Eighty respondents were drawn from the lower income group and sixty four from the middle income group.

This is attributed to the fact that residential areas for the lower income group are densely populated with only Blacks, while the middle class regions are sparsely populated with Whites and other racial groups residing in these areas. It is felt that this will not affect the research findings because the criterion for selecting respondents was not based on residential areas but on education, occupation and age. It however, gives an indication of the ratio of population distribution in the sample studied and findings will give a global picture of all social strata in Umtata.

The investigator also conducted interviews with family planning clinic sisters about family planning services rendered to people. The family planning sisters contacted were at Elliot Road (Umtata Municipal Clinic), Ngangelizwe Clinic and Umtata Hospital.

The schedule of questions used to gather information from the family planning sisters is reflected in Appendix 4. The information requested was given freely and is contained in Chapter 4 of this report "Family Planning Strategy and Practice."

2.6 LIMITATIONS OF THE STUDY

1. It was difficult to conduct interviews on a wider scale because of transport problems and limited financial resources.

2. Some males were not free to discuss the topic of contraception with members of the opposite sex. Most, however, relaxed and responded freely and asked stimulating questions after the subject had been fully explained to them.
3. The survey group of 150 may be regarded as small and that generalisation of data may, therefore, be limited.
4. Contacting males at their homes posed problems and for this reason 89 percent of the survey group were contacted at work. They were sometimes very busy or delayed in completing the questionnaires. Those who were prepared to complete the questionnaires, finally did that after several reminders.
5. Although there are certain unique advantages to conduct a study on males, this group must be expected to have certain intrinsic biases on the subject under study. These will be reflected in this investigation.

Greer, G. (1985, p.35) in the "Politics of Human Fertility" stated that, how people explain their behaviour is simply generalisation, ideology and humbug produced to entertain the intruder, what they do may be observed and recorded.

In so far as sexual behaviour may not be observed, it may not be recorded and sexual fantasy, the component of sexual activity for many people, may not be observed under any circumstances. Responses, however, seem to be related to respondent's feelings and experiences. Some may have been given to please the interviewer, but it is felt that most respondents tried to be objective in their responses.

2.7 DEFINITION OF TERMS

Family Planning

A term descriptive of a decision by an individual or heterosexual couple to control their own fertility. The fertile couple decide how many children they would like to have and when they would like to have and when the births should take place (spacing).

Contraception

The prevention of conception and implantation.
Any method whatsoever of avoiding pregnancy.

Birth

All live births of respondent's wives/sexual partners.

Fecundity

The physiological capacity of a couple to participate in reproduction.

Demography

The statistical study of a population growth and

development.

Population Growth - can be positive or negative. A positive population growth means that the population size increases because of a high fertility rate and/or immigration. A negative growth rate means that the population size decreases because of a low fertility and/or emigration.

A Family Planning Programme

Aims at preventing undesired and unplanned pregnancies and thereby improving the health and living standards of the individuals, the family and the community. Families voluntarily decide whether to limit the number of children they will have.

Family Planning Services

- are essential programmes for preventing unwanted pregnancies. Such services include providing birth control information and contraceptives, pregnancy testing, infertility counselling, sex education, abortion counselling, sterilisation information and operations and helping couples to prepare for parenthood.

A Population Development Programme

- is instigated by the state and is aimed at lowering or increasing the population growth rate. The ultimate goal of the population development programme is to secure a balance between resources and population size.

Family Planning Governmental Programmes

- are National family planning programmes to lower the birth rate. They provide birth control information and services.

Population Control

- is deliberate regulation of the size of the population by society.

2.8 PRESENTATION OF DATA

The study is subdivided into ten chapters. The first chapter states the problem to be investigated and the significance of the study. Aims of the study and assumptions and propositions. An introduction to the subject of family planning and a brief review of relevant research and theory is given.

Chapter 2 is the exposition of the research design and methodology.

The research design and methods of investigation used are given as well as the research sample, method of gathering data, and geographical area of the study.

Chapters 3 to 7 give an in-depth study of the respondent's cultural background, their behavioural patterns and life experiences. Family planning services, history of contraception and criticisms of family planning and population control programmes have been included.

The aim is to give a situational analysis which will enable the reader to have a clear/better understanding of the sample population.

Chapter 3 gives a brief history of family planning, the importance of fertility, population growth, population policy and its criticisms.

Chapter 4 deals with the family planning strategy and practice, family planning programmes in the Republic of South Africa and Transkei.

Chapter 5 discusses population policy and social welfare policies and how these may influence peoples attitudes towards family planning programmes and contraceptive use.

Chapter 6 describes the characteristics of the sample population and their historical and cultural backgrounds.

Chapter 7 gives the information with regard to respondent's birth places, their educational standard and places of employment or occupation.

Chapter 8 discusses what respondents regarded as the ideal family size, the value of children to married couples and what respondents would do if they had no children.

Chapter 9 discusses contraceptives used by respondents and reasons for selecting them.

Chapter 10 gives the findings, conclusions and recommendations.

A final section contains appendices consisting of the interview schedules and information on the respondents involved in the study. A list of selected references is also tabulated at the end in the bibliography.

CHAPTER 3

3. HISTORY OF CONTRACEPTION

This chapter gives a brief history of contraception and family planning, the importance of fertility, population policy, methods and criticisms of family planning policies. Background information and some views of researchers who have studied this topic and other related subjects are referred to.

3.1 A SHORT HISTORY ON CONTRACEPTION

In the past, there was deep public hostility and opposition to family planning as well as a sharp controversy over the government's role in this sensitive area. Until a few years ago, family planning and population problems were considered "hush-hush" subjects. Public discussion was curtailed, not only in polite society, but in legislative and executive branches of the government as well (Greer, G, 1985, p.130).

3.2 ANCIENT CONTRACEPTIVE METHODS

Sexual abstinence has been practised for millennia. It was often associated to the so called unclean periods such as menstruation, pregnancy and lactation.

Coitus interruptus is probably the oldest method of contraception. The first description of this method is found in Genesis 38. It is also described, and often advertised in Greek writings and by Roman physicians. Vaginal

preparations were used long before the birth of Christ. The Petri Papyrus of 1850 B.C. describes a paste made from Crocodile dung which was placed in the vagina. Vaginal barrier methods such as the cervical diaphragm followed. the development of rubber items and in 1823, the first diaphragm was designed by Dr. F.A. Wilde.

Condoms were first described by the Italian gynaecologist Dr. Fallopius in 1654. They were meant to prevent pregnancy and venereal diseases.

Vaginal douching with soapy water and many other fluids were prescribed by Lucretius in 99 B.C. and by the famous Greek and Roman physicians such as Soranus and Aricessa.

Oral contraception was practised by the Chinese in 1200 B.C. The woman had to swallow six live tadpoles before coitus (Theron, F. 1987, p. 16).

3.3 MODERN METHODS

Sterilisation techniques were developed about 150 years ago, after the discovery of general anaesthesia.

Hormonal preparations were first suggested by Ludwig Haberlandt of Innsbruck in 1921. Rock, Garcia and Gegory Pincus demonstrated the ability of a progestogen, norethisterone to prevent ovulation in 1956.

In 1909 Dr. Richard Richter of Poland described an intrauterine device he had made on silkworm and used on 700 patients with no pregnancies occurring (Theron, F. 1987, p.17-18).

3.4 THE IMPORTANCE OF FERTILITY

The management of fertility is one of the most important functions of adulthood. In traditional societies, puberty rites dramatise this new responsibility. Often the passage through initiation which has never been encouraged or talked about among the sterile young. After the ritual, it is stressed that sex is not a form of infantile amusement, if it has ever been.

The importance of fertility cannot be gauged in the course of such a brief discussion, some suggestions, however, have been made.

The management of fertility is an essential aspect of maturity and a principal expression of people's altruism towards their groups.

The vitality of a continuing desire to reproduce even in technocratic societies is evidenced by people's reluctance to tolerate involuntary sterility. An ever growing number of doctors specialise in treating infertility, performing all kinds of interventions to correct blockages and abnormalities of the uterus,

often in circumstances which paediatricians might consider counter productive. Davis, A. (1982, p.17) has stated that during the days preceding the Civil war, Black women in the United States of America came to be increasingly appraised for their fertility (or the lack of it). She who was potentially a mother of ten, twelve, fourteen or more became a coveted treasure. This is true even to-day in some developing countries where a woman is respected only if she has managed to give birth to a number of children.

Questions on fertility and family planning are sometimes difficult to answer with certainty, because cultures change and norms and values change accordingly. It has been normal practise among some communities (e.g. Sotho) to ensure that a marriage will be productive by impregnating the woman before she is formally married. This was practised because even experienced gynaecologists could not be exact in their diagnosis and specify that a woman would reproduce when married.

The importance/value of children to a married couple and problems experienced by childless families and possible solutions arrived at is reflected in the following statement, told to the researcher by an elderly man from the Mount Frere district in Transkei, about their only sister in a family of three, who qualified as a teacher but disgraced the family by falling pregnant while still single and not married.

She gave birth to two sons and subsequently never got married as no man wanted to marry her after her pregnancies. It so happened that when the two brothers finally got married, the eldest had no children at all from his wife while the younger brother had three daughters and no sons. The two young boys belonging to their unmarried sister were both adopted by the elder brother and were regarded as heirs to the family. Their biological mother has since lost jurisdiction over them and the interpretation of family members was that "the Almighty (God) knew what he was planning for the family when everybody was still in darkness."

3.5 MOTIVES FOR INTRODUCING FAMILY PLANNING PROGRAMMES

The basic motives for the implementation of family planning programmes are varied and sometimes contradictory depending on the individual, the family or the community. Shlakman, V. (Stein and Sanders, 1971, p.45) pointed out the overlapping and sometimes apparently contradictory purposes advocated in family planning literature. She stated that the family planning policy is being urged to:

- 3.5.1 Ensure that every child is wanted;
- 3.5.2 Free women from the drudgery of chronic pregnancy and the requirement of bearing children against their will;
- 3.5.3 Reduce the social costs of child rearing;

- 3.5.4 Reduce child dependency, that is, to cut welfare costs;
- 3.5.5 Reduce poverty;
- 3.5.6 Prevent illegitimacy;
- 3.5.7 Foster the health and happiness of families by spacing children;
- 3.5.8 Encourage families not to have more children than they can afford;
- 3.5.9 Enhance family well being by reducing the size of families;
- 3.5.10 Protect maternal health;
- 3.5.11 Prevent defects through reduction of births to very young and older mothers and to others who are at risk;
- 3.5.12 Offer to every couple the opportunity to realise the size of the family to which it aspires and;
- 3.5.13 Control the total population.

The reasons given above give the impression that governments organise family planning services in order to moderate fertility and population growth, that all pregnancies should and in fact must be planned to ensure the comfort and security of individuals and groups.

The Department of National Health and Population Development has been commissioned to promote, implement, co-ordinate and monitor the Population Development Programme on National, regional, sub-regional and local level (R.S.A. PODDEV/3 1985). The most important factor to be concentrated on in the Population Development

Programme is:-

Socio economic development and family planning must be integrated in socio-economic programmes. The socio-economic components of the Population Development are:-

- i) Education - mass education and literacy programmes.
- ii) Primary health care - decreasing infant mortality rate and increasing life expectancy.
- iii) Training - man power training.
- iv) Improving the status of women-training women for labour markets and integrating/accommodating women in labour force.
- v) Economic development - job creation and decentralising economic activities.
- vi) Rural development - of general and agricultural services available in rural areas.
- vii) Community development - cultivate awareness, participation, and local level grass roots development involving local people and communities.
- viii) Family planning - contraception, breast-feeding, marriage postponement and encouraging spacing of births.
- ix) Information, education and communication action to create awareness and a climate of understanding and willingness to co-operate.

Family planning and population development programmes according to the motives specified above are an advantage to the individual, the family and the community.

The implication is that its practise should be encouraged by people irrespective of race, colour or creed. This might improve the physical, psychological and socio-economic status of citizens of any country, as long as people are allowed to decide on the number of children they want to have.

3.6 METHODS OF CONTRACEPTION

Contraception aims at preventing conception and pregnancy. To achieve this, various methods may be considered. Although abortion is included in the following classification, it is not really a contraceptive method but is regarded as a method of birth prevention.

3.6.1 CLASSIFICATION

A. Natural Methods:-

- a) Abstinence
- b) Coitus Interruptus
- c) Rhythm Methods :
 - Calender Method
 - Temperature Method
 - Cervical mucus-observation
 - Mittelschmerz
- d) Lactation

B. Barrier Methods:-

- a) Condoms
- b) Diaphragm and caps
- c) Sterilisation

- C. Spermicides:-
 - a) Foam preparations
 - b) Vaginal pessaries
 - c) Creams and jellies
 - d) Plastic film strips

- D. Systemic Contraception:
 - a) The injection
 - b) The pill

- E. Intra-uterine contraception

- F. Abortion.

3.6.2 POSSIBLE FUTURE METHODS

Theron, f. (1987), p.125) states that no new methods have been produced during the last two decades with the exception of laparoscopic sterilisation. A couple of hundred million rand (according to Theron) is spent annually on research and it is not expected that a revolutionary new method will be discovered in the next decade or more.

A. FEMALE METHODS

- a) Vaginal Contraceptive rings: these contain a synthetic progestogen and natural oestrogen which are slowly released and absorbed in the blood stream through the vaginal wall. clinical trials have already reached the stage where commercial availability is possible within 4 to 5 years.

- b) Cyclo - Provera : Administered monthly by means of an intra muscular injection.
- c) Norgestimate is a long acting progestogen, administered by intra-muscular injection. One dose gives protection for a period of 5 months.
- d) Subdermal implants - Silastic capsules containing a progestogen are introduced subdermally by means of a trochar and removed when used up or when the person wishes to conceive.
- e) Hysterotomy, transvaginal hysteroscopic and reversible sterilisation are also in the experimental stage (Theron, F. 1987 p. 125-131).

B. MALE METHODS

The development of new male contraceptive methods has not kept abreast with those intended for female users. Men have been using coitus interruptus for thousands of years and vasectomy for a number of decades. The following methods are still in the experimental stage:

- a) Reversible vasectomy: This is a difficult procedure, the resection of the vas deference sometimes leads to fibrosis and adhesions.

- b) Intravasal contraception: This can be done by occluding the vas deference i.e. reversible occlusion or by an intravasal device made of filaments of copper or zink. The copper and zink filaments affects the maturation of spermatozoa adversely.
- c) Hormonal methods : Androgens, oestrogens and progestogens either separately or in combination are administered orally or parenterally or by means of subdermal implants in males. Their disadvantage is that the return of fertility can take a long time as well as being uncertain.
- d) Immunisation: Experiments are being done on animals in an attempt to induce the production of sperm antibodies by means of immunisation with purified gonadotrophins, testicular tissue or spermatozoa.
- e) Gossypol is administered orally in tablet form. It reduces spermatogenesis. The side effects of gossypol are potassium deficiency which leads to tiredness and reduced interest in coitus. Hypokalaemia, irreversibility and testicular atrophy may develop (Theron, F. 1987. p. 132).

Greer, G. (1985, p.130) has quoted statements made at a Woman's meeting in Central Java in 1977 to the effect that women would gladly accept family planning provided it does:-

- not interfere with their working;
- not do them permanent harm;
- not go against their religion;
- be free or nearly so;
- have a woman to examine them and teach them what to do and how to do it;
- remain a secret between her and them.

The above statements are true and the new methods aim at providing reversible contraceptive methods which have no/minimal side effects/complications, are less expensive and morally acceptable to families and individuals. It is hoped that they will be reliable and safe. According to Theron, F. (1987, p.110) some male methods like vasectomy are easier, cheaper and safer from morbidity and mortality view point and also requires less man power and bed occupation than female sterilisation.

The new methods mentioned above are designed for both males and females. Most of these are long acting, reversible and easy to administer with less side effects and physical and psychological complications though some like the hormonal methods and vasectomy may be irreversible in some cases and may result in permanent sterility.

3.7 FAMILY PLANNING POLICY AND POPULATION POLICY

Family planning encompasses any medical, educational or information service designed to help couples limit or space the number of their children. Its objective is to help people to have the number of children they want. Population policy is concerned with the analysis and actions which embrace variables such as birth, deaths and migration. It is concerned with fertility rates for the "good:" of the nation. It's citizens may be having the required number of children or they may be having too many or too few. If a high birth rate or a low birth rate is endangering the nation, then the government's policy may be to encourage people to have more or fewer children. Couples can practise family planning without any kind of population policy.

The relation between family planning and population policy depends on how one defines the two terms. They may have the same effects such as increasing or decreasing the number of off-spring and therefore the population of a specific country or nation.

Many governments establish family planning services in order to moderate fertility and population growth, but it is also true that others have no demographic targets. Some even favour a larger population. Governments become involved in national population

programmes for different reason in the opinion of Alan Guttmacher (Stein and Sanders, 1971, p. 55), some of which are the following:-

Firstly there is the economic reason. Governments entertain hopes that a family planning programme curtails the population growth to the point of improving the economic situation, allowing greater industrialisation and reducing unemployment by cutting the annual inflow of youth into the labour pool.

Secondly there is the medical reason. Governments aim at reducing abortion, which is a world wide endemic disease and other health problems by introducing effective contraceptive programmes.

A third reason is that some Governments have become interested in popularising birth control as:-

a basic human right for their citizens. Freedom to have babies by choice rather than by chance should be a privilege shared by all.

In South Africa, the Government instituted a nation wide family planning programme in 1974, which is presently administered by the Department of Health and Population Development. The most important

factor to be concentrated on in the Population Development Programme is socio-economic development. Family planning is integrated in the socio-economic programmes. Prerequisites for the successful implementation of the Population Development Programme are:-

- Strong public support and education to create awareness of the issues.
- Services should be readily available - both geographically and economically.
- Far greater expenditure on family planning services (increase local clinics, trained personnel information and services).
- Intensive public education that promotes awareness and understanding of the consequences of a continued excessive population growth (RSA/wcs POPDDEV 3 (1985). The ultimate goal of the programme is the improvement of the quality of life of each population group in a specific area. It is apparent that most governments institute family planning programmes having the basic goal of achieving population policy objectives for the benefit of the nation, that is individuals, families and communities.

Theron, F. (1987, p. 14) states that the Department of National Health and Population Development already (1986) has 55000 service points where contraceptives can be obtained and, as stated in chapter 1, 'the White population group is already applying family

planning practices maximally; the Coloured and Indian groups are expected to reach full acceptance within the next decade, but Black people still need a great deal of motivation. Research directed at Black women reveals that the majority have some knowledge of modern contraceptive techniques and that the ideal and desired fertility levels are lower than the actual fertility on completion of the family building process (Lötter et al, 1975). This gives the impression that the family planning programmes reach all racial groups in South Africa and are widely accepted by Whites, Coloureds and Indians. These services have not diffused to blacks according to expectation. This large scale involvement in the field of family planning has only recently become a national priority and technologically and legally practicable. Higgins, E. (1981, p. 2) stated that the fact and incidence of contraception and family planning underscore an important sociological reality: culture patterns, although generally inclined to be conservative and resistant to change, are neither static nor cement - like, they do change. This may be the case with blacks. There are a number of possible problems which can inhibit the adoption of family planning and population policy programmes. Some of these will be discussed in the following section.

3.8 CRITICISMS OF POPULATION POLICY AND FAMILY PLANNING PROGRAMMES.

Consultants who have worked in programme development have observed the following:-

- a) Opposition by political, religious and professional societies because they consider it to represent Government invasion into a basically private matter;
- b) Population policy is less easy to accept for it can be equated with restriction of freedom.
- c) In tribal societies there is great reluctance on the part of any one tribe to accept family planning because of the fear of being supplanted by another group. The notion of a world-wide common good is far too nebulous and involves an exercise of altruism far beyond the range of the group protected by genetic identity, which can extend a little further, it seems than the family, the tribe, the race and occasionally the nationality (Greer, G, 1985, p. 43).

It seems obvious that fertility regulation can be effectively promoted by members of the culture, which is being urged to adopt it. It must be seen to be carried out in the service of that group in order to increase its survival capacity, and to be connected to visible consequences rather than demographer's projections. As long as family

planning consists entirely of pressure to accept sterility and is presented by people who are perceived as strangers, it will be suspect especially in tribal societies with a history of mutual antagonism.

Findings by Fred T. Sai (in the Draper Fund Report 1983, p. 26) reveal that family planning and population policy fields encompass many ethical issues which require careful consideration. The development and testing of contraceptives is an area which is often politicised as an unfortunate occurrence which makes genuine discussion difficult.

This chapter has given an overview of family planning, its meaning and problems experienced when rendering the services to people. The following chapter will briefly discuss the family planning strategy and practice in South Africa and Transkei. It will give a broad outline of family planning programmes and services available to individuals and groups and how the services are advertised in the country. The knowledge and understanding of services available and people's reaction and interpretation of the family planning policy may lead to a clear understanding of the respondent's reactions and responses to questions asked.

CHAPTER 4

4. FAMILY PLANNING STRATEGY AND PRACTICE

4.1 INTRODUCTION

Unterhalter, B (1977, p. 18) referred to findings by Soga (1930), Hunter (1936), Schapera (1937) and Ashton (1952) who came to conclusions that Black traditions encourage high fertility: that the status of the woman is measured largely by the number of children she has borne and that there is little incentive to limit the numbers as children have an economic utility in tribal society. According to Unterhalter (1977, p. 118) the practice of 'lobola' or bridal price makes girls and boys equally welcome in the family and polygamy ensures that almost every woman bears children. He further states that, while family limitation is not part of tribal tradition, family spacing has been adhered to and is promoted by abstinence from sex relations during prolonged periods of lactation (about two years). There have obviously been changes in these patterns as acculturation to the Western way of life has proceeded.

To-day large families are usually dysfunctional in urban environments, where they are regarded as an economic burden rather than an asset. Also since mortality is fairly low, provision does not

have to be made for it to compensate for high mortality.

4.2 FAMILY PLANNING PROGRAMMES IN SOUTH AFRICA

Hoogendoorn, Allan and Jawitz (1982, p. 5) state that the Government has instituted a "massive" family planning campaign with the aim of limiting the growth of poor classes. According to the writers, the greater the size of poorer classes, the greater the threat they pose on the privileged few of the country.

The success of the family planning campaign depends on everyone believing in it. In order to achieve this, the Government has launched a huge publicity drive. Family planning and contraceptive use is advertised in local and national magazines, family planning posters are displayed in clinics, hospitals, local shops and even in bus shelters. Each day on the radio and television, regular advertisements of family planning set on lively tunes and promises of a prosperous future. People are made to believe that they are poor because they have many children (Hoogendoorn et al, 1982, p. 10).

During the opening of Parliament in February, 1974, the State President made a statement concerning family planning policy. Whilst stressing that family

planning should form an integral part of development planning, as high socio-economic standard of living is irreconcilable with a high population growth rate, 'the rights' of the individual are underlined in the statement that, 'It is still the policy that all married couples should be allowed to decide on and to take the necessary action regarding the planning of their families----- that the government accepted the responsibility for developing a country - wide family planning programme and that population control was not its objective' (Department of Health Publication, 1977).

Family planning according to Hoogendoorn et al (1982 : 4) is given the highest priority by the State Health Department. The amount of money and people employed in promoting family planning has increased rapidly in recent years. Between 1977 and 1981, state spending on family planning increased by R10 million from R6,8 million to R17 million. Out of this 17 million, 6 million was spent on education, R1,3 million was spent on publicity e.g. in newspapers and magazines, display boards, radio and television. For purpose of personal education, full-time salaried advisors were appointed on a provisional basis of one per thirty thousand persons to the communities which they have to motivate. To-day there is one family planning advisor for every four thousand

women (Hoogendoorn et al., 1982, p. 4). Family planning services in Transkei were introduced at the same time with South Africa in 1974 because Transkei then, was part of South Africa. A detailed programme of family planning services in Transkei will be given in the following section because, even though services were introduced in 1974, it is felt that the manner in which programmes are conducted differ from South African Programmes because of a number of factors like availability of facilities, cultural factors and geographical factors. This background information will give more insight and understanding of experiences and services rendered to the sample population.

4.3 FAMILY PLANNING PROGRAMMES IN TRANSKEI

Family planning programmes in Transkei are conducted on the same lines as those in South Africa. The services are among the components of the comprehensive health scheme which is the policy of the Department of Health. The regional implementation of the programme is administered by all hospitals, by satellite clinics and mobile clinics have weekly programmes conducted on the same day as Child Health Care and Ante Natal Care Services. The programmes are conducted for convenience and to save on time and transport facilities for clients and officers responsible. Hospital family planning clinic services

are conducted on days that suit the specific hospitals and their communities. Some operate on a daily basis while others attend to clients once a week. The programmes are well advertised to the public (Family Planning Services - Department of Health Umtata) They are advertised in the media, over the radio, in hospitals and clinics. It is apparent that family planning services and programmes in Transkei have not reached the whole population because most people in rural areas do not own/posses radio and television sets and are unable to read family planning pamphlets with the relevant information. Some are far from towns, clinics and hospitals and only visit these (when it is possible) centres for some specific health problems and may not be contacted afterwards because of transport problems and poor/bad roads to transport workers who may wish to visit some clients and communities for the purpose of introducing the family planning programmes. These problems and other factors which encourage couples to have many children (to be discussed later) make the Transkei to have a high birth rate.

According to a report by Miss P. Madikizela (organiser of Nursing Services, 1981, p.1 = unpublished), the reaction of Transkeians to family planning programmes advertised in the country varies according to areas, for example, most people have been introduced to the concept of family planning and contraceptive

use in most urban areas, while in some rural areas, there are a number of people who have never heard of the modern concepts of family planning to limit and/or space children borne. Some have a shallow understanding, and good and strong motivation is needed because there is a social stigma which tends to make clients secretive about contraceptive use. She further stated that some males are against the use of condoms but encourage their wives and sexual partners to use contraceptives. It was finally stated that during the past five years, family planning as a service had progressed in the Transkei.

Though there are no statistics available, to validate the above statement, it is apparent that changes in family planning practice have occurred as changes have also taken place in other related fields. Figure 1 gives a statistical picture of family planning services in Transkei hospitals. It gives an impression that progress is uneven and that the concept, in some rural hospitals, does not seem to have taken root and much ambivalence and even rejection seems to exist.

4.4 FAMILY PLANNING EDUCATION

In all hospitals in Transkei, family planning motivators/advisors employed by the Department of Health, introduce couples and individuals to the concept of contraception and contraceptive use and help them to choose a method

they regard as most acceptable. There were no male family planning motivators at the time of the survey, female motivators approached both males and females in their efforts to introduce the subject of family planning and educate them on the advantages of family planning for the individual, the family as well as the community.

Special in-service education courses on family planning are conducted for a period of two weeks for registered nurses and for three weeks for enrolled staff nurses at Glen Grey, St Barnabas and St Patricks hospitals. The aim is to equip nursing officers working in family planning departments with the relevant, up to date, information on the subject. The Family Planning Section of the Department of Health and Population Development in the Republic of South Africa also conducts courses on family planning services in the Transkei. Family planning educators/motivators are updated and introduced to the modern trends of teaching and learning on the subject of family planning.

The fact that only females are employed as motivators and are educated on the subject may be a disadvantage as these female motivators have to approach and motivate males as well. In the neighbouring states for example in Venda and the Republic of South Africa, males are also employed as motivators to educate individuals and groups on the advantages of child spacing, getting

children by choice and not by chance as well as problems caused by unwanted pregnancies to the individual, the family as well as the community. Problems of population explosion, pre-marital pregnancies, early and conditional marriages (because of pregnancy) and special attention is also given to adolescents and high school students by giving lectures on sex education and preparing them for parenthood.

4.5 THE ROLE OF SOCIAL WORKERS

Social workers tend to be concerned about over-population and problems it may create. They come in contact with clients who want and need family planning information. They sometimes have to respond to controversial issues for example, possible racist implications when family planning services are directed at serving the poor, providing abortion information and making referrals, providing contraceptive information to teenagers and responding to those who advocate involuntary sterilisation of people who are seriously handicapped with hereditary conditions (Zastrow, C. 1986, p.514).

The number of social workers in Transkei is relatively small. According to information gathered from the Department of Welfare and Pensions, in Transkei, the total number of social workers in the whole country is less than one hundred (100).

There were about twenty six (26) vacant posts in 1984 which could not be filled because there were

no applicants (Transkei to-day, 1984). Social workers employed in the various districts in Transkei play a number of roles which are relevant to their training and expertise. They counsel couples who are sterile and desire children, offer sex education services, pregnancy counseling, abortion counseling, venereal disease counseling, and premarital counseling. They refer some clients to family planning motivators and educators as well as to clinics and hospitals for specialist care and attention and referrals to the social worker are also made by medical officers and members of the health and family planning team for counselling and guidance according to need. Social workers are also involved in the implementation of population development programmes for example:

- a) The promotion of self-help programmes, thus stimulating community responsibility and initiative.
- b) The acknowledgement and protection of human dignity of all people.
- c) The promotion of preventative and development programmes.
- d) The co-ordination of development actions on a local and regional level.
- e) The development of services and organisations to meet the needs of communities and to assure progress.
- f) The improvement of the basis of authority in the communities (RSA/WG/PODDEV/3 (1985)).

4.6 UMTATA CITY COUNCIL

Family planning services for the Umtata community are conducted at Umtata hospital and in the municipal clinics at Elliot Road (in town), at Ngangelizwe and the Civic Centre clinics. Family planning services at Umtata hospital are conducted daily from 07h00 to 16h00 except on week ends. Services at the municipal clinics are conducted on special days of the week because the officers employed at the Elliot Road Municipal clinic, which is the head office, also visit the other clinics at Ngangelizwe and the Civic Centre. They also visit factories for example:- Vusisizwe, Vulindlela, Intermagnetics, Fil-Africa and Elata Printers. Seven professional nurses who have studied a family planning course as a post-basic qualification are employed at the Umtata hospital family planning clinic and three professional nurses, with similar qualification are employed by the municipality. Other officers who may be assisting at the clinics are given orientation courses on the subject as well as in-service courses periodically. The above services were taken over at Independence from South Africa in 1976. The Government subsidises a certain percentage of the nurses salaries and issues some drugs to the municipality for distribution to people at no cost for example the T.B. drugs. The clinics are inspected periodically by officials from the Department of Health. The basic aim of the

inspections are assessing standards and giving some orientation and guidance according to need.

It has been reported that the number of people using the services is gradually increasing with the result that officers employed by the Municipality have requested for the quota of professional nurses employed to be increased because of the increased numbers and long queues which are specially marked when one officer is on leave and /or on sick leave.

4.7 FAMILY PLANNING STATISTICS

The statistical figures that follow reflect the number of persons using contraceptives at some hospitals and in the Umtata Municipal area:

STATISTICAL FIGURE 1

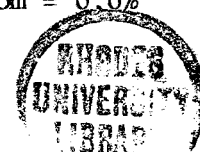
STATISTICAL PICTURE OF FAMILY PLANNING SERVICES IN TRANSKEI HOSPITALS

QUARTER ENDING: SEPTEMBER 1982 MARCH 1983 JUNE 1983 GRAND TOTAL

HOSPITAL	SEPTEMBER 1982				MARCH 1983				JUNE 1983				GRAND TOTAL			
	PILL	INJ	IUCD	COND	PILL	INJ	IUCD	COND	PILL	INJ	IUCD	COND	PILL	INJ	IUCD	COND
All Saints	-	-	-	-	531	179	NIL	NIL	778	150	16	10	1 309	392	16	1
Bambisani	65	21	NIL	NIL	67	26	2	NIL	56	20	3	NIL	188	67	5	-
Butterworth	-	-	-	-	507	392	3	NIL	-	-	-	-	507	392	3	-
Cala	-	-	-	-	756	241	NIL	NIL	772	NIL	NIL	NIL	1 528	241	-	-
Canzibe	-	-	-	-	145	67	NIL	NIL	170	114	NIL	NIL	315	181	-	-
Empilisweni	1 616	375	NIL	NIL	1 685	430	NIL	NIL	1 685	349	4	NIL	4 990	1 154	4	-
Glen Grey	3 542	691	NIL	NIL	2 675	801	NIL	NIL	2 541	825	NIL	NIL	8 758	2 317	-	-
Greenville	152	67	NIL	NIL	261	91	NIL	NIL	221	68	NIL	NIL	634	226	-	-
Holy Cross	477	325	NIL	NIL	583	318	NIL	NIL	601	326	4	NIL	1 616	969	4	-
Isilimela	206	91	NIL	NIL	106	33	NIL	NIL	300	146	NIL	NIL	612	270	-	-
Madwaleni	480	455	2	NIL	616	329	3	NIL	378	380	NIL	NIL	1 474	1 164	5	-
Mary Teresa	1 555	660	17	NIL	1 677	764	4	NIL	1 671	439	NIL	NIL	4 903	1 863	21	-
Mjanyane	173	95	NIL	NIL	120	43	NIL	NIL	124	58	NIL	NIL	417	196	-	-
Mt Ayliff	716	620	23	3	486	485	2	NIL	264	298	NIL	NIL	1 466	1 403	25	3
Nessie Knight	-	-	-	-	545	192	NIL	NIL	536	169	NIL	NIL	1 081	361	-	-
Rietvlei	669	561	2	73	691	454	11	7	691	454	4	7	2 051	1 469	17	87
Sipetu	122	59	NIL	NIL	39	64	NIL	NIL	61	51	NIL	NIL	222	174	NIL	NIL
St Barnabas	-	-	-	-	882	430	22	15	940	431	21	3	1 822	861	43	18
St Elizabeth	-	-	-	-	77	35	NIL	NIL	501	247	NIL	NIL	578	282	-	-
St Lucy's	480	280	NIL	NIL	1 100	613	NIL	NIL	-	-	-	-	1 580	893	-	-
St Margarets	-	-	-	-	144	88	NIL	NIL	-	-	-	-	144	88	-	-
St Patrick's	359	279	18	NIL	406	306	NIL	4	417	165	5	NIL	1 182	750	23	4
Tafalofefe	358	161	40	NIL	608	339	NIL	NIL	317	201	NIL	NIL	1 283	701	40	-
Taylor Beques	-	-	-	-	664	436	NIL	NIL	756	528	2	NIL	1 420	964	2	-
Umtata	-	-	-	-	7 494	180	557	205	2 849	1 438	3	150	10 343	5 618	560	355
Umzimkulu	-	-	-	-	316	78	NIL	NIL	-	-	-	-	316	78	-	-
Zitulele	-	-	-	-	128	119	NIL	NIL	138	119	NIL	NIL	266	238	-	-
TOTAL	10 970	4 740	102	76	23 264	11 533	604	231	16 771	6 976	62	170	51 005	23 249	768	468

Percentage: (Overall): Pill = 67,6% Injection = 30,8% IUCD = 1,08% Condom = 0,6%

Source : Family Planning Statistics : Department of Health : Transkei.



STATISTICAL FIGURE 2

STATISTICAL PICTURE OF FAMILY PLANNING SERVICES IN THE UMTATA-MUNICIPAL CLINIC

Statistics for Elliot Road, Ngangelizwe and Civic Centre Clinics.

<u>MONTH</u>		<u>METHOD</u>		
		PILL	INJECTION	CONDOM
JANUARY	1983	1 052	470	12
FEBRUARY	"	1 056	484	12
MARCH	"	1 056	488	18
APRIL	"	1 066	486	16
MAY	"	1 054	470	18
JUNE	"	1 058	474	22
JULY	"	1 062	472	22
AUGUST	"	1 064	475	24
SEPTEMBER	"	1 070	476	30
NOVEMBER	"	1 072	474	40
DECEMBER	"	1 068	478	32

TOTAL		12 740	5 721	268

PERCENTAGE		68%	30,6%	1,4%

<u>MONTH</u>		<u>PILL</u>	<u>INJECTION</u>	<u>CONDOM</u>
JANUARY	1984	1 060	474	34
FEBRUARY	"	1 069	484	36
MARCH	"	1 072	494	44
APRIL	"	1 062	480	40

TOTAL		4 263	1 932	154

PERCENTAGE		67%	30,5%	2,5%

<u>SOURCE:</u>	MUNICIPAL CLINIC STATISTICS - UMTATA			

STATISTICAL FIGURE 3

STATISTICAL PICTURE OF FAMILY PLANNING SERVICES IN UMTATA FACTORIES

<u>MONTH</u>		<u>METHOD</u>		
		<u>PILL</u>	<u>INJECTION</u>	<u>CONDOM</u>
JANUARY	1983	78	27	12
FEBRUARY	"	72	34	13
MARCH	"	60	26	18
APRIL	"	88	47	23
MAY	"	91	48	18
JUNE	"	29	25	4
JULY	"	85	23	5
AUGUST	"	51	16	3
SEPTEMBER	"	59	23	3
OCTOBER	"	72	32	4
NOVEMBER	"	76	37	5
DECEMBER	"	78	40	-

TOTAL		839	388	108

PERCENTAGE		62,8%	29,1%	8,1%

<u>MONTH</u>	<u>METHOD</u>		
	<u>PILL</u>	<u>INJECTION</u>	<u>CONDOM</u>
JANUARY 1984	105	30	3
FEBRUARY "	116	26	9
MARCH "	99	34	9
APRIL "	95	35	14

TOTAL	415	125	35

PERCENTAGE	72,2%	21,7%	6,1%

SOURCE : Municipal Clinic Statistics - Umtata

The above statistics indicate that the condom in Umtata is gradually accepted as compared to some hospitals where none were issued at all. It was reported that statistical figures were incomplete. Some hospitals failed to deliver these to the Department of Health for compilation.

Of the well known modern contraceptive techniques used in Transkei, the oral pill seems to be most popular. Umtata hospital, according to statistical figure 1, has the highest number of contraceptives distributed and it is also significant that more males visit the hospital to be issued with condoms.

Statistical figures, according to Van Regenmortel and Van Harte (1977, p.27), give the number of people who are supposed to be using contraceptives. It has proved to be extremely difficult to obtain an accurate assessment of the actual number of people using contraceptives through family planning clinic statistics because:-

1. Available figures were incomplete;
2. Figures indicated the number of attendances at clinics. Attendances are not people and therefore it is difficult to estimate the actual number of people using contraceptives.
3. A further difficulty in obtaining reliable figures is that if a client attends a clinic and then

switches over to another, she is recorded as a drop out at the first clinic and a new attender in the second clinic. It is also not known how many men and women are supplied with contraceptives by private doctors.

The Theron Commission findings were that some communities were not adequately motivated towards developing family planning services and that clinic facilities (particularly in rural areas) are either insufficient or non-existent (van Regenmortel and Van Harter, 1977, p.34). This may serve as a tentative explanation for the disparity in statistical figures of contraceptive users in Transkei hospitals (statistical figure 1). There may also be other factors involved like the shortage of properly trained family planning motivators of both sexes and of the modern audio-visual aids for family planning educators.

The lack of family planning services among the poor (as stated in the President's Committee on Population and Family Planning) is not a problem confined to one race, nor is it confined to the urban areas; the people needing services are found in all sections of the country. Excessive fertility can drive a family into poverty as well as reducing it's chances of escaping it. The mortality and the number of children who are chronically handicapped are all markedly greater among the poor than other members of the population.

This chapter has given an overview of family planning services in the country. The knowledge of available services and family planning programmes to which respondents might have been exposed will give a clear understanding of the sample population and may assist in the analysis and interpretation of data gathered.

5. POPULATION POLICY AND SOCIAL WELFARE

Population policies have typically grappled, with problems of population "quantity" as stated by Miningoff (1980), that is, what types of people are best suited to propagate and what types are not. The desire to improve population quality has often led theorists to advocate the "elimination" of the dependent populations. Where dependent populations exist, there must be some on going economic support to provide for their care, generally through taxation. Supporters of population policies have justified their demands for population limitation with promises of tax reduction. It is argued that the "tax burden" can be lessened if the pool of dependents and potential dependants can be decreased.

According to Miningoff (1980), where limitation is sought, the dependent population is typically characterised as a source of it's undoing. The blame for conditions of poverty and dependency is placed upon individuals rather than upon general social conditions. Social welfare institutions have been blamed for functioning to enfeeble the society through their artificial presentation of the "unfit" species. The establishment of social welfare institutions supported by taxation has been a controversial issue ever since English Poor Laws raised the question of whether the state

should or could tax the many to support the few. Kennedy (Miningoff, 1980) stated that, "if society applied to reproduction the same techniques of efficiency employed by stockbreeders, there would be no need for measures that supported the "good for nothings" at the expense of the good."

The above statements by Miningoff might lead to conclusions that the economic support of dependent populations is less than compelling, where population quality concerns are paramount, with a concurrent opportunity for economic gain.

The contradiction is, however, observed when improved technology seems to be directed towards population creation to the extent of encouraging and increasing the number of test-tube babies.

Social workers tend to be concerned about overpopulation and the problems now and the even greater problems it may create in the future. Problems associated with overpopulation and spoiling the environment seriously threaten to reduce the quality of human life throughout the world (Zastrow, 1986, p. 489)

Some problems of overpopulation are listed below (Zastrow, 1986, P. 489):-

- Large scale starvation and malnutrition.
- Rapid consumption of measurable fossil fuels and minerals.

- Food shortages, energy shortages, need to develop new energy sources assuring the safety of nuclear energy power plants, shortage of water reserves.
- Air pollution, solid waste disposal, radio-active wastes, nuclear wars spoiling the land, water pollution and general pollutants that cause slow subtle physiological changes.

Theron, f. (1987 p.12), in addition to the above stated problems of overpopulation states that:-

- The available water resources cannot support more than 80 million people. It is estimated that the population of the Republic of South Africa may reach 70 million by the year 2020 and could be 100 million in 2050 if the present growth rate is maintained.
- Only 12% of the total land is arable and this continually diminishes as cities expand.
- In less than 10 years, new employment needs may be as high as 500 000 per year, it will become increasingly difficult to reach and to maintain an economic growth rate to provide these.
- The housing shortage will become progressively worse with a deterioration in hygiene and living standards.
- The standard of education and health services and infra structure for public and social services

will be lowered and these sociological services will absorb such vast sums of money that no funds will be available for investment in economic development programmes.

- The result will be that all population groups will be poorer and eventually poverty stricken.
- On the socio-political front there will be an increase in unemployment, famine, water shortages, lack of sufficient housing, education and health services, agitation, riots and even anarchy.

If problems associated with overpopulation continue to intensify, a natural policy on population control may also need to be developed. A number of authorities are predicting dire consequences for the future of the world unless population measures are implemented immediately. Other authorities discount overpopulation concerns and predict that technological advances will prevent cataclysmic effects from rapid population growth.

Population problems experienced in South Africa and in other countries are similar to those experienced in Transkei. Conditions may be more pronounced in Transkei because economically it is dependent on that of South Africa. The then Minister of Finance, in his Policy Speech (1985/86) stated that the Transkei Government is unable to meet its recurrent expenditure

from current revenue, that it's economy is closely linked to that of South Africa and that Transkei therefore experiences the main economic problems currently experienced by South Africa. This is clearly explained in the next chapter.

This chapter has given a clear indication of social welfare and over-population problems and some reasons why some communities or racial groups may reject family planning and population policy programmes. Some factors that may influence respondent's attitudes towards family planning and contraceptive use are given and will be investigated in the study.

6. TRANSKEI: HISTORY AND BACKGROUND OF THE SAMPLE
POPULATION

This chapter gives the historical background and life style of the sample population. The information will give a clear understanding of some factors which might have influence on the respondent's attitudes towards family planning. Factors covered in this chapter can enhance or sometimes inhibit acceptance of family planning programmes in the country.

6.1 TRANSKEI BOUNDARIES

Transkei is situated in the South East of Southern Africa, south of South African Province of Natal and the independent kingdom of Lesotho. It's boundaries are the larger part of the Kei River in the west, mountain ranges including the Drakensburg to the North, the Umtamvuna River to the North West and the coastline of at least 270 kilometres. It has an area of about 45 000 square kilometres.

6.2 POLITICAL AND ADMINISTRATIVE STRUCTURE

Transkei was granted independence under South African Law in 1976. Constitutionally it forms a Republic with a nominal State President, a legislative assembly and an independent judiciary. Administratively Transkei has a dual system. The civil service is

organised into a number of state departments which are represented in the 28 magisterial districts of Transkei.

Alongside this structure, there are regional authorities and the various tribal authorities tend to control development at the local level or village level (Muller, N.D., 1985, p.1).

6.3 POPULATION

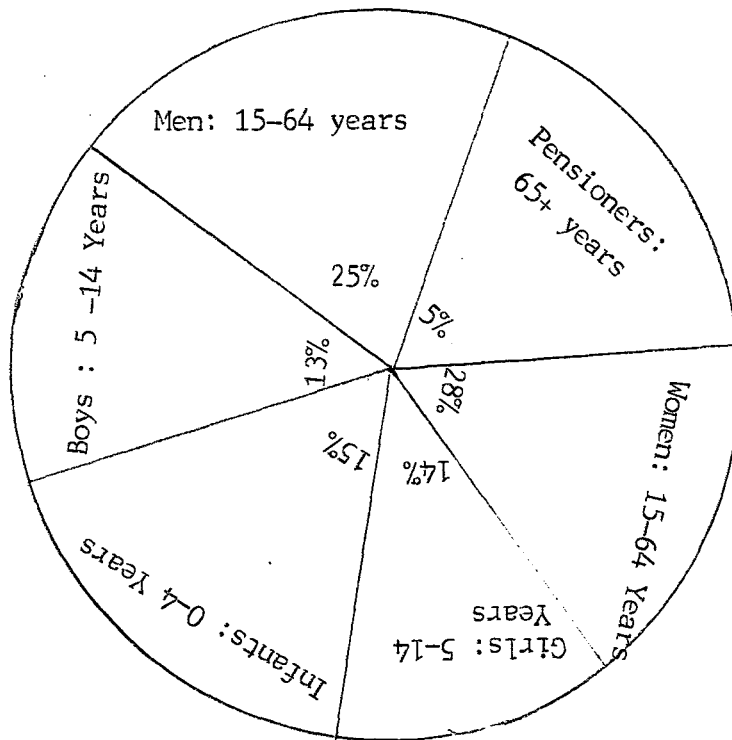
The people of Transkei comprise the Xhosa speaking members of the Cape Nguni group for the greater part and the Southern Sotho. In 1985, the de jure population was estimated at 3 609 962 and de facto population was 2 932 397. Information on vital statistics is scarce but indications are that the crude birth rate is about 38 per thousand and the crude mortality rate is 13 per thousand. This yields a natural rate of increase of 25 per thousand or 2,5 per cent.

Considerable difficulty is experienced in establishing the exact population of Transkei due to the widespread system of labour migration to the industrial areas in South Africa. The resident population in 1985 was 3,1 million. A further 500 000 Transkeians live and work in South Africa and may return home periodically when on holiday. Most of the population live in rural areas.

Between 1980 and the turn of the century, Transkei's population is projected to increase by 73,5 percent

to a total of 5,27 million (Muller, 1985, p.7). Muller further states that there seems to be a discrepancy in the natural rate of increase of 2,5 percent outlined and the projected rate of increase of 2,8 percent due to the different mortality assumptions.

1985 AGE DISTRIBUTION OF THE POPULATION



Source: Muller, 1985.

The percentage of women between 15 and 64 years as reflected above is relatively high as well as that of reproductive males (between 15 and 64 years). There is a sudden drop in the percentage of pensioners (above 65 years) which is only 5 percent while the percentage of infants (from 0 to 4 years) is high, being 15 percent.

6.4 ECONOMY

Transkei has the characteristics of most African economies which are said to be low per capita income, high incidence of mortality and low levels of expectancy, high fertility, low levels of schools' enrolment, quasi or non-existence of industry, the dominance of agriculture in the national economy and the low or complete lack of professional agricultural production.

Dependence on a single or narrow range of commodities both for internal consumption and for export, dualism between the traditional and the modern sectors of the economy, the predominance of expatriates in business enterprises both as owners and managers.

Transkei has a small highly dependent economy. The country's economy remains firmly rooted in the wider South African economy. For the past few years especially since 1983, the Transkei economy has been plagued by economic difficulties. The 1985/86 budget speech by the Minister of Finance, the Honourable S.M. Qaba, was in general a negative account of the performance of the economy in 1984/85, and a clear indication that, despite the tightening up process insituted in 1984, the economic situation continued to deteriorate. The Minister also pointed to the South African economic context in which the Transkei budget needs to be drawn up. That because the Transkei economy is closely linked and dependent on that of South Africa, the main economic problems currently faced by South Africa

and consequently Transkei can be catalogued as follows:

- The sluggish economic recovery in the United States and in other trade partner countries of Western Europe;
- The negative economic growth experienced by South Africa since 1982;
- The consequent drop in per capita income in real terms;
- Continued high level of unemployment and
- The currently mounting inflationary pressures. The economic problems seem to know no end despite efforts to overcome them (Second National Assembly. Ninth Session Appropriation Bill, 1985, 1st April 1985 to 31st March 1986.

Second Reading Speech by the Minister of Finance, The Honourable S.M. Qaba).

6.5 LABOUR AND EMPLOYMENT

Transkei's limited domestic resources are shown in the following tables:-

TABLE 1: THE STRUCTURE OF LABOUR FORCE IN 1982

<u>VARIABLE</u>	<u>NUMBER</u>	<u>% TOTAL</u>
Labour Supply	1 017 000	100%
Labour Demand:		
External	420 000	41,3%
Formal	195 000	19,2%
Informal	65 000	6,4%
Subsistence	150 000	14,7%
Unemployment	187 000	18,4%
GRAND TOTAL	<u>1 017 000</u>	<u>100%</u>

Source : Muller (1985)

In 1982 the Transkei labour force totalled about one million. Of this total, only 19,2 percent were employed in formal domestic employment. Less than 50 percent (41,3) were employed as migrants or commuters to the South African labour market and 18,4 percent were estimated to be unemployed in Transkei.

Incomes in Transkei are generally low and unequally distributed. Urban incomes are generally high and more evenly distributed than the rural incomes, although the gini index of 0,456 still represents a considerable degree of income concentration. Households derive some real income from agriculture and other informal activities. Maize yields plummeted during the 1983 draught. It is estimated that household agricultural activities contribute 25 percent of real incomes. Unskilled cash incomes are derived in roughly equal proportions from local wage employment, migrant's remittances and pensions and other public transfers.

6.6 PENSIONS

Pensions contributed 20 percent of incomes to the poorest in 1982. Between 1970 and 1983, the number of old age pensioners increased from an annual average of 47 767 to 92 843, and the average payment for pensions from R52 to R434 per annum. As a direct result, the annual total of old age pension payments increased from R2,5 to R40,3 million. Similar increases occurred

in the case of disability pensions where the annual average payment leapt from R53 to R651 per annum.

Although the significant increase in pensions occurred over the said period, even after inflation had been taken into account, payments remained inadequate because:-

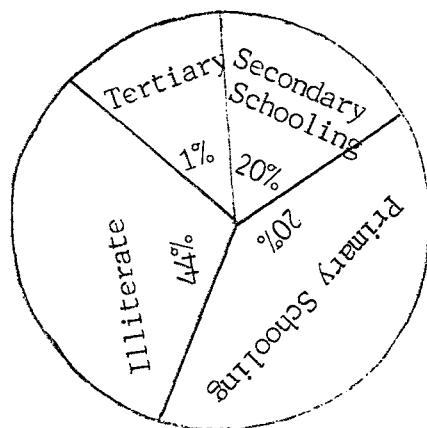
1. Pension form a major component of household incomes in some of the poorest Transkeians. They contributed nearly one fifth of the incomes of the poorest (23,9%) of rural households in 1982.
2. Not everyone who is eligible seems to obtain a pension. It was reported that some do not know their chronological age while others do not have their births or baptismal certificates to confirm their age when requested by officials and others do not know that they may apply for pension benefits at all. Problems of illiteracy and neglect/failure to attend community meetings with headmen and/or chiefs, who assist and recommend pensions to the needy, may also be the cause of some eligible people not to receive pension. According to the census, there were 175 000 pensioners. Of these, only 78 714 pensions were paid in that year (44,70%). It is assumed that some would have received incomes from other sources, but by far, the

majority of possible pensioners, who did not receive an income, probably were destitute or relied on young households who were struggling against increasing demands on their limited resources.

6.7 EDUCATION

The Transkei Department maintains operational control over the education system. It is regionally decentralised with headquarters at Butterworth, Engcobo, Mount Ayliff, Umzimkulu and Umtata, to stimulate the interest of citizens at the local level in matters of educational concern (Dept. of Education Annual Report, 1983). In Transkei, it is not compulsory to attend school.

1985 DISTRIBUTION OF EDUCATION FOR PERSONS OVER AGE 15



Source: Muller, 1985

The average number of year's schooling for rural adults is 3 and for urban adults, 6,5 years. Of all the school leavers, 2 percent obtain matric exemption

while 20 percent leave semi-literate.

Transkei education is at present in the difficult phase of "qualitative development". The education system has undergone such rapid expansion over the past 10 years that the "quantitative" increase in the school population and a broadening of the education and training structure has led to problems of a qualitative nature, entering crises proportions in some spheres (Muller, 1985, p.45).

6.8 HEALTH

Health services in the Republic of Transkei are comprehensive. They comprise both urban and rural hospitals and a vast network of clinics (residential and mobile). A three tiered system under the control of the Department of Health renders the following services to communities:-

1. Primary health care which involves residential and mobile clinics;
2. Secondary care which entails 28 general hospitals and
3. Tertiary care which involves 8 institutions for specialised health care (tuberculosis, orthopaedic, psychiatric and leprosy services).

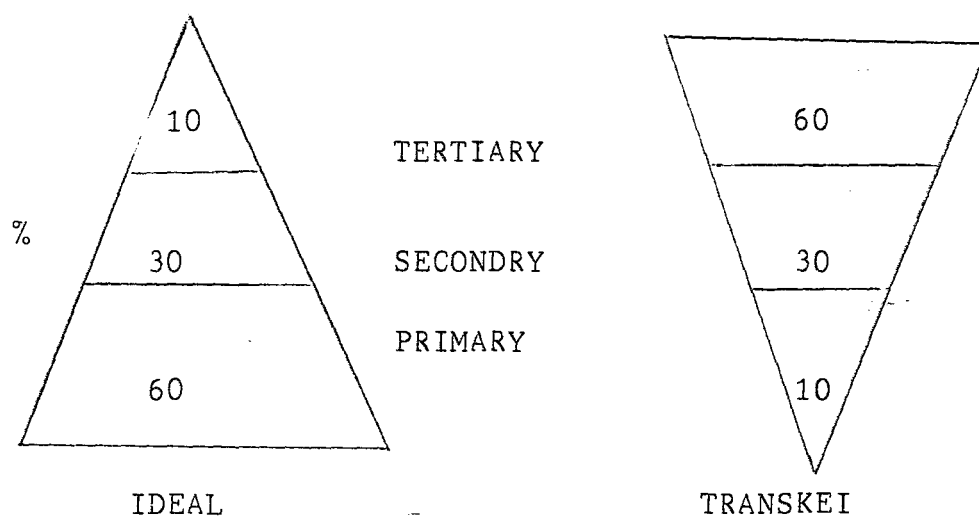
The national health service is supplemented by private practitioners, voluntary organisations for example the Red Cross and authentic traditional healers, supplied by traditional healers, who seem to be fairly

widely consulted. These other services fall outside the Department of Health.

6.8.1 RESOURCES

Ideally, a third world health service should allocate 5-10% of its resources to Tertiary care; 20-30% to secondary care and 60% or more to Primary Health Care. The present allocation of resources in Transkei is reversed, so that 60% of resources goes to Tertiary Care. This is reflected in figure 4 below = (Muller, 1985).

FIGURE: 4 THE STRUCTURE OF HEALTH EXPENDIDURE IN TRANSKEI



Source: Muller, 1985.

This, according to Muller (1985) results in the poor quality of rural clinic services and more sophisticated urban facilities receiving most of the financial assistance.

The Minister of Health in 1984 stated that, Transkei

health service is heavily weighted towards curative medicine and that this is not consistent with the patterns of disease found among the people.

The policy goals of the Transkei Department of Health are:-

"to promote the total health of the whole population by the intergrated provision of clinical care, preventive, health educative environmental and advisory services with the participation of the public and co-ordination between all governmental departments as well as non-governmental organisations at community, district and national levels" (Department of Health, Policy Speech 1984).

6.8.2 HEALTH SERVICES

In 1981 there were 137 doctors in Transkei, giving a ratio of 1 doctor per 19 000 people. The number of doctors in 1983, however, decreased by 20 to 117. There were 5 586 nurses in 1982 and 3 main hospitals of which 26 are general hospitals, 1 Orthopaedic, 1 Psychiatric, 1 Tuberculosis and 2 combined Leprosy and tuberculosis hospitals. Muller (1985) also stated that there is chronic manpower shortage, that only 124 of the 201 posts were filled in the Health Department in 1983 and some were filled by expatriates recruited from overseas's countries. In 1973 there were 4 974 hospital beds with a population of 385 per bed. In 1976 this figure rose to 6 312 beds with 330 per bed

and in 1981 there were 7 630 beds with 305 per bed and in 1983 the number of beds dropped to 7 113. There were 71 clinics in 1973 with a population of 27 000 per clinic. In 1976 there were 110 clinics with a population of 19 000 per clinic and in 1981, 171 clinics with a population of 14 000 per clinic. In 1983, the number of clinics had increased to 181 residential clinics and 51 mobile clinics.

Figures stated above indicate that, while there is still considerable room for quantitative improvement, there has been substantial expansion of health services over the past few years (Muller, N.D. 1985 p.39-40).

6.8.3 FERTILITY

Annual age specific fertility is defined as the number of children borne live to women in that age group (Irwig 1981, p.10). Overall annual fertility rates in 1981 were 86/1000 in 15-19 year olds, which increased to a maximum 260/1000 in 25-29 year olds and then decreased progressively to 55/1000 in the 15-49 year olds. The overall fertility rate in the 15-49 year olds was 178/1000 and 190/1000 in the 15-44 year olds. The annual crude birth rate was 48/1000. The number of pregnancies occurring in "at risk" groups were as follows:- 33 percent of pregnancies occur in "at risk" groups were as follows:- 11 percent of pregnancies occur in teenagers and 24 percent in women aged 35 years and older. In examining infertility, it has

been found that the population of women who have never had children from age 30 years upwards is relatively constant. Over the age range 30-60 years, it is 57/1000, that is, almost 6 percent of women who reach the end of their fertility period without ever having had live born children (Irwig, 1981).

6.8.4 INFANT MORTALITY

The Transkei infant mortality rate is six times higher than that of South African Whites. In a survey carried out in 1980, it was concluded that the Transkei rural infant mortality rate was estimated at 130/1000. The risk that a child dies before he is five years old is 190/1000. In other words 19 percent of live children borne die before they are five years old (Irwig, L.M. 1981). The infant mortality rate however is said to have decreased with the improvement of health standards in the country though no statistics are available yet.

6.8.5 FAMILY PLANNING

The advantages of family planning are discussed in health centres, as are the means of achieving planned parenthood. It has been reported that the birth rate is gradually declining though no clear findings are available in this field yet. The major problems faced by the Transkei populace vary in different parts of the country (urban and rural), but the most apparent are:-

Unemployment, non-availability of food and water during droughts, poor environmental sanitation, poverty and alcoholism. Malnutrition, tuberculosis, waterborne diseases such as enteric fever, typhoid, dysentery, gastro - enteritis and cholera plague may affect some rural communities during summer months.

The percentage of people suffering from diabetes, hypertension and peptic/gastric ulcers are said to be increasing in some urban areas like Umtata and Butterworth (Health statistics, 1985).

6.9 CULTURAL PATTERNS

The traditional way of life and customs are preserved by most people in rural communities and some urban areas. As a result of urbanisation and industrialisation over many decades, a substantial and ever growing proportion of the population has been absorbed into some form of Western life style.

Societal norms expect some duties to be performed by certain family members. Young men are expected to work and assist with the income of the home. The father is the dominant figure and a disciplinarian in the home. The mother in most rural homes accepts the father's /husband's word as final and has to accept his decisions in financial matters without any argument.

In urban areas, the state of affairs differs, because most wives are gainfully employed and therefore not financially dependent on their husbands.

Most families, especially in rural areas, are extended families. There is a gradual move towards the nuclear family in some urban families. It has been an accepted rule that a man gets married to one wife, but some prominent members like chiefs have often married two or more wives. This has also been practised by some traditional people in some rural areas, especially those who could afford to pay "lobola". Most christians and professional/educated people, however, are oriented towards monogamy and re-marry only if widowed or divorced.

The Transkei Marriage Act of 1978 legalised polygamy in Transkei with the one condition that men should be able to maintain their extended families. There is, however, no investigation done prior to the second or subsequent marriages to ensure that qualifying husbands have got the resources and nothing is done even if the families are not maintained or cared for after such marriages. The arrangement ensures that children are regarded as legitimate, thus eliminating the problems faced by unmarried mothers.

According to the Transkei Marriage Act No,21 of 1978:

Male persons may contract certain marriages during the existence of certain previous marriages with other parties.

It states that:

"Nothing in this Act or any other law contained shall be construed as prohibiting:

- a) Any male person from contracting:

(i) A Civil marriage which produces the legal consequences of property with any female person during the subsistence of any marriage between such male person or any other female person.

(ii) A Civil marriage which does not produce the legal consequences of a marriage out of community of property with any female person during the subsistence of any customary marriage.

Status and Rights of Wives and Children:

Whenever any male person becomes a party to more than one marriage, irrespective of whether anyone of his marriages;

- a) The status of every child borne of any such marriage;
- b) The status of every wife of such a person;
- c) The legal rights (including rights of succession) of every such child shall, subject to the provisions of the Act, be determined in accordance with the customary law applicable to the marriage concerned and a civil marriage contracted by such a person shall for that purpose be deemed to be a customary marriage which is subject to the customary law applicable in such a person.

This chapter has given a general view/idea of the background history and culture of the sample population.

It has been established that about 75 percent of all families fall below the household subsistence income level, two thirds of the adult population is illiterate and 22 percent live further than 8 kilometres from the nearest health facility and comprehensive mother-and-child health centres.

Information gathered in this chapter on the socio-economic status, education, health and cultural patterns, fertility and infant mortality rate affects the respondents life patterns and attitudes and obviously have a great influence on their attitudes towards contraceptive usage.

CHAPTER 7

7. THE SURVEY GROUP

Before analysing the family planning attitudes and contraceptives used by the sample population, it is necessary to obtain some data of their social and cultural backgrounds, their places of residence, their family histories, their occupation and educational standard. This information gives a background of some factors that may influence the respondent's behavioural patterns and responses to the subject under study.

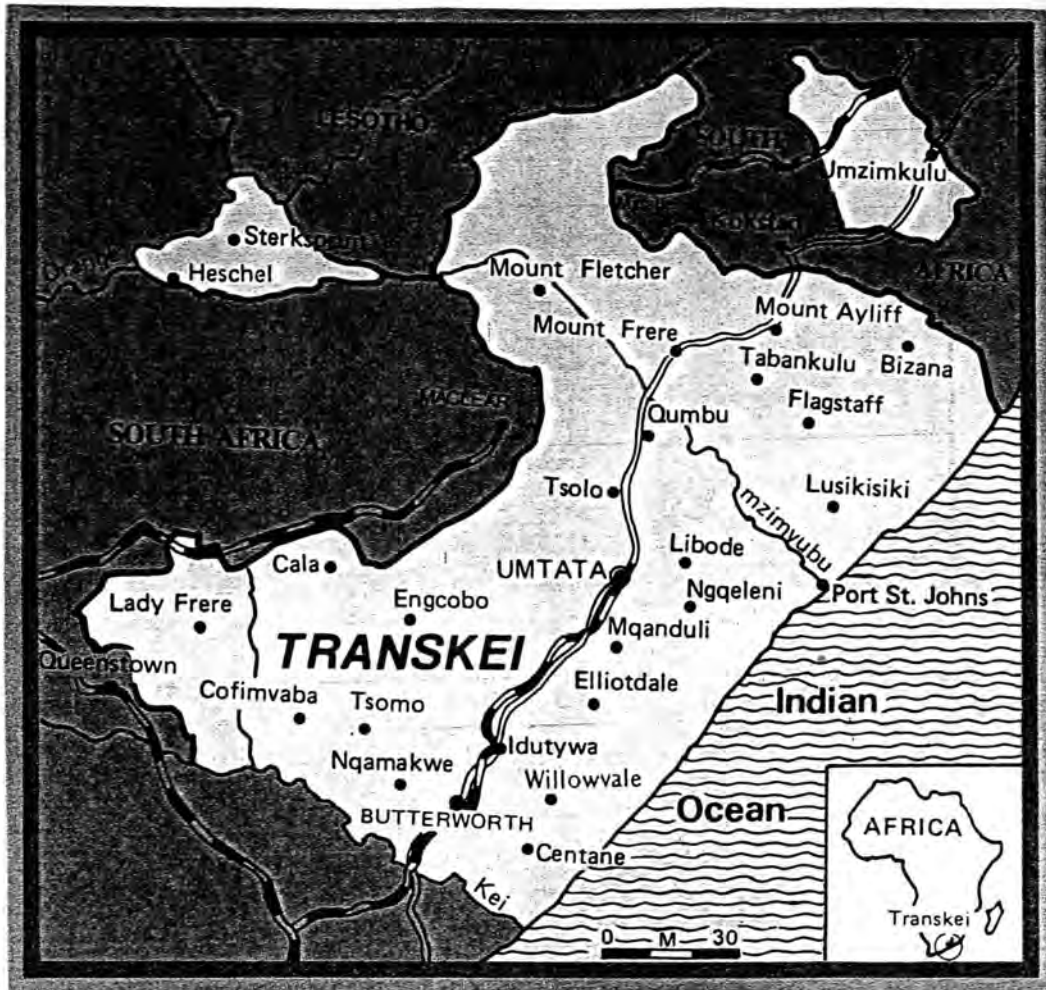
7.1 RESIDENTIAL AREAS OF THE SURVEY GROUP

The sample population was composed of males who were employed and resided in Umtata and its suburbs at the time of the survey. It was, however, apparent during interviews that most respondents were still attached to their families and relatives in rural areas. The following table gives respondent's birth places. It was noted that most respondents visited these places during week-ends and when on leave.

TABLE 2: RESPONDENT'S PLACES OF BIRTH

<u>BIRTH PLACE</u>	<u>NUMBER</u>	<u>BIRTH PLACE</u>	<u>NUMBER</u>
1. Bizana	6	8. Idutywa	2
2. Bytterworth	4	9. Johannesburg	2
3. Cape Town	4	10. Kentane	5
4. Cofimvaba	7	11. Kokstad	2
5. East London	2	12. Lady Frere	2
6. Engcobo	12	13. Libode	2
7. Flagstaff	6	14. Lusikisiki	4

MAP OF TRANSKEI





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<u>BIRTH PLACE</u>	<u>NUMBER</u>	<u>BIRHT PLACE</u>	<u>NUMBER</u>
15. Matatiele	4	23. Qumbu	4
16. Mt Fletcher	2	24. Tabankulu	7
17. Mt Frere	5	25. Tsolo	5
18. Mqanduli	1	26. Tsomo	3
19. Ngqeleni	5	27. Transkei (District	2
20. Nqamakwe	2	Not Mentioned)	
21. Port St. Johns	4	28. Umtata	11
22. Queenstown	2	29. Umzimkulu	2
		30. Willowvale	7

N = 144

Less than 10 percent of respondents (7,6%) as reflected in table 2 above were borne in Umtata. The majority (82%) came from rural areas all over Transkei and were believed to be making a transition to urban life. Of these, 8,3 percent were borne in cities and towns like Cape Town, Queenstown, Kokstad, Johannesburg and East London, outside the boundaries of Transkei. These could be classified as urbanites.

Respondents were asked to state the number of years they had been staying in Umtata. Responses listed in table 3 below were given.

TABLE 3 : PERIOD OF RESIDENCE IN UMTATA

<u>PERIOD IN YEARS</u>	<u>NUMBER</u>	<u>PERCENTAGE</u>
0 - 5 years	60	41,7
6 - 10 years	35	24,3
11 - 15 Years	18	12,5
16 and more	31	21,5
TOTAL	144	100

As indicated in table 3 above, 41,7 percent had been working or living in Umtata for a period of 5 years and less, while 21,5 percent had been in Umtata for more than fifteen years. As 66 percent of the sample population had worked or stayed in Umtata for a period of 10 years and less, the fact that most respondents were in the transitional phase between rural and urban life could be confirmed.

Respondents were asked if they were owning or renting the houses/rooms in which they stayed in Umtata.

They gave the following responses:

TABLE 4: HOUSES/ROOMS OCCUPIED BY RESPONDENTS

<u>RESPONSE</u>	<u>NUMBER</u>	<u>PERCENTAGE</u>
Renting	98	68,1
Owning	46	31,9
	<u>144</u>	<u>100</u>

It was established that 68 percent of the survey group rented the rooms/houses they occupied (table 4), and of these, some had stayed in the rented apartments for a period of more than 20 years or since birth. This information was gathered during interviews when some respondents decided to give more details at their own initiative, others had to be probed by the interviewer to get the information. It was also interesting to learn that some respondents, who had managed to buy houses in town preferred renting them out to people

<u>BIRTH PLACE</u>	<u>NUMBER</u>	<u>BIRHT PLACE</u>	<u>NUMBER</u>
15. Matatiele	4	23. Qumbu	4
16. Mt Fletcher	2	24. Tabankulu	7
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		30. Willowvale	7

N = 144

Less than 10 percent of respondents (7,6%) as reflected in table 2 above were borne in Umtata. The majority (82%) came from rural areas all over Transkei and were believed to be making a transition to urban life. Of these, 8,3 percent were borne in cities and towns like Cape Town, Queenstown, Kokstad, Johannesburg and East London, outside the boundaries of Transkei. These could be classified as urbanites.

Respondents were asked to state the number of years they had been staying in Umtata. Responses listed in table 3 below were given.

TABLE 3 : PERIOD OF RESIDENCE IN UMTATA

<u>PERIOD IN YEARS</u>	<u>NUMBER</u>	<u>PERCENTAGE</u>
0 - 5 years	60	41,7
6 - 10 years	35	24,3
11 - 15 Years	18	12,5
16 and more	31	21,5
TOTAL	144	100

As indicated in table 3 above, 41,7 percent had been working or living in Umtata for a period of 5 years and less, while 21,5 percent had been in Umtata for more than fifteen years. As 66 percent of the sample population had worked or stayed in Umtata for a period of 10 years and less, the fact that most respondents were in the transitional phase between rural and urban life could be confirmed.

Respondents were asked if they were owning or renting the houses/rooms in which they stayed in Umtata.

They gave the following responses:

TABLE 4: HOUSES/ROOMS OCCUPIED BY RESPONDENTS

<u>RESPONSE</u>	<u>NUMBER</u>	<u>PERCENTAGE</u>
Renting	98	68,1
Owning	46	31,9
	<u>144</u>	<u>100</u>

It was established that 68 percent of the survey group rented the rooms/houses they occupied (table 4), and of these, some had stayed in the rented apartments for a period of more than 20 years or since birth. This information was gathered during interviews when some respondents decided to give more details at their own initiative, others had to be probed by the interviewer to get the information. It was also interesting to learn that some respondents, who had managed to buy houses in town preferred renting them out to people

or firms desperately in need of accommodation at higher rentals. This helped to increase their source of income or the money was used to pay instalments for the same house if it was bought through a loan from a bank or building society. As individuals, respondents would rent a room or two at a relatively cheaper rental.

They gave the following responses when asked if they were married or single:

TABLE 5: MARITAL STATUS OF RESPONDENTS

<u>RESPONSE</u>	<u>NUMBER</u>	<u>PERCENTAGE</u>
Married	115	79,9
Single	29	20,1
	-----	-----
TOTAL	144	100
	-----	-----

Of the married respondents, 2,8 percent were married to second wives because they had divorced their first wives and 2,1 percent were married to more than one wife.

When asked if they were staying with other family members in Umtata, the survey group responded in the following manner:

TABLE 6: FAMILY MEMBERS STAYING WITH RESPONDENTS

<u>RESPONSE</u>	<u>NUMBER</u>	<u>PERCENTAGE</u>
- Staying with wife and children	82	56,9
- Staying with wife (children with relatives)	8	5,6

<u>RESPONSE</u>	<u>NUMBER</u>	<u>PERCENTAGE</u>
- Staying with children (wife working outside town)	4	2,8
- Staying alone (wife & children in rural home)	21	14,6
- Unmarried	29	20,1
TOTAL	144	100

N = 144

Respondents staying with wives alone believed that urban life and environment was not suitable for children and therefore not recommended for their upbringing. The number of children respondents had at the time of the survey is listed in table 7 below.

TABLE 7: NUMBER OF RESPONDENT'S CHILDREN

<u>NUMBER OF CHILDREN</u>	<u>RESPONDENTS</u>	<u>PERCENTAGE</u>
0	29	20,1
1 - 2	34	23,6
3 - 4	59	41,0
5 - 6	16	11,1
7 - 10	3	2,1
11 and more	3	2,1
TOTAL	144	100

It is apparent according to table 7 above that 3 to 4 children were favoured by most, since 41 percent had that number of children at the time of the survey. The percentage of respondents (20,1%) who had no children included both married and unmarried respondents.

The following cases have been singled out and presented individually because they did not follow the trend taken by the majority of respondents.

CASE 1

A fifty year old respondent employed as a clerk in the government offices, owned a seven - roomed house at Ncambedlana township. He stated that he was staying with the second wife in the house, who was a nursing sister in Umtata hospital. He had thirteen children from the two wives, that is, three from the first wife and ten from the second. He also had two more children from different women outside marriage. He stated that he was happy and proud that he had fifteen children and would welcome more children if the Almighty was willing to give him.

CASE 2

A fifty year old respondent also employed as a clerk by the Transkei Government had twelve children from his wife who was forty eight years old and was a house wife. He had three children from different women outside marriage. The family was renting a four-roomed house at Ngangelizwe Township. All twelve children were staying with their parents and the respondent was making arrangements that the other three children, who were staying with their mothers could join their brothers and sisters (according to the respondent's terminology).

The wife, apparently had accepted the arrangement and could not object though accommodation was limited in the house.

Twenty seven percent of married respondents stated that they had children from other women outside marriage, while 13,8 percent of the unmarried had children from unmarried mothers.

7.2 RESPONDENT'S SIBLINGS

In 1978, Groenewald (p.7) stated that a reduction in the number of children had taken place. This was in accordance with findings that fertility norms were changing and that the small family is becoming more common. To confirm these findings and to assess fertility norms in Transkei, respondents were asked the following question:

May you please state the number of your brothers and sisters?

Their responses are reflected in table 8 below:

TABLE 8 RESPONDENT'S SIBLINGS

<u>SIBLINGS</u>	<u>NUMBER</u>	<u>PERCENT</u>
0 - 2	29	20,1
3 - 4	40	27,8
5 - 6	45	31,3
7 - 10	24	16,7
11 and more	6	4,1
TOTAL	144	100

It is apparent, as reflected in table 8 above that a reduction in the number of children has taken place and that fertility norms are changing. The percentage of respondent's siblings between 3-6 children was 59,1% whereas that of their children of the same number was 51,1%. Respondents (table 7) favoured 3-4 children (41%) and only 2,1% had 7-10 children, when compared to 16,7% of respondent's siblings.

7.3 RESPONDENTS' AGE

According to Du Plessis (1974, p.11), age has an influence on attitudes with regard to males towards fertility. The young men set a lower ideal number of children than their elders.

TABLE 9: AGE OF RESPONDENTS

<u>AGE IN YEARS</u>	<u>NUMBER</u>	<u>PERCENTAGE</u>
20 - 25	27	18,8
26 - 30	16	11,1
31 - 35	21	14,6
36 - 40	22	15,3
40 and more	58	40,2
TOTAL	144	100

Since there were more respondents (40,2%) above the age of 40 years in the study, as shown in table 9, it would be fitting to assume that they would have desired to have more children than the younger generation.

This is still to be proved or disproved in this study.

7.4 RESPONDENT'S EDUCATIONAL STANDARD

The educational standard of respondents at the time of the survey is reflected in table 10 below.

TABLE 10: RESPONDENT'S EDUCATIONAL STANDARD

<u>EDUCATIONAL STANDARD</u>	<u>NUMBER</u>	<u>PERCENTAGE</u>
Std 7	5	3,5
Std 8	8	5,6
Std 9	5	3,5
Std 10	107	74,2
Graduates and Post Graduates	19	13,2
TOTAL	<u>144</u>	<u>100</u>

N = 144

Since Transkei is a developing country and is sometimes regarded as an under-developed country, the sample population in table 10 (above), is not a representative of the population in Transkei but a representative sample of the educated people in Umtata.

The study is based on the fact that educated men were interviewed on the topic of family planning in Umtata.

The findings will serve as a point of departure and serve as a starting point for more research topics in Transkei.

7.5 RESPONDENT'S OCCUPATION

The responses listed in table 11 were given when respondents were asked their places of employment.

TABLE 11 : RESPONDENT'S OCCUPATION

<u>OCCUPATION</u>	<u>NUMBER</u>	<u>PERCENTAGE</u>
Civil Service	128	88,8
Teaching	6	4,2
Labourers	8	5,6
Ministers of religion	2	1,4
<hr/>		
TOTAL	144	100
<hr/>		

N = 144

According to Du Plessis (1974, p.9, 11 and 24), research among both developed and under-developed populations show that a high level of education is an important indication of low fertility motivation. The educational level, age, marital status and occupation exert an influence on the orientation of men regarding family size. Differences between generations are closely connected with assimilated value orientations.

Older people have assimilated value orientations but, as a result of urbanisation, modernisation and continual contact with and influence of mainly modernised reference groups, modern value orientations with regard to fertility and family planning become assimilated and institutionalised in the social system.

Higgins (1981, p.61-65) states that couples in the

upper income groups reveal a relatively high percentage of contraceptive users than those in the lower income groups. That husbands and wives who were born on farms and/or villages have a lower proportion of users and that couples who do not use contraceptives are on the whole older than those who do. This comparison could not be made clearly in the study because respondents were not equally distributed according to age, educational standard, occupation and place of birth.

This chapter has introduced the reader to the sample population, comprised of men who appeared to be oriented to the concept of family planning because of the number of children they had at the time of the survey. The majority had 3-4 children (41% table 7). It is however, not known why the majority of respondents had 3-4 children, it is possible that they were using some form of contraception or that some children died at an earlier age or that some respondents and/or their partners were subfertile. This background information of respondents and their families will assist in the interpretation and analysis of data gathered.

It is however, worth reporting that some respondents i.e. 20 percent were unmarried and had not started their families yet, though some had children from unmarried mothers. There were some respondents who had not completed their families because they were still young or recently married as 44,5% were below

35 years old (table 9). Education and urbanization tends to lower fertility rates because the educated and urbanised/industrialised are more favourably disposed to contraceptive use. The next chapter deals with attitudes and ideals. Its aim is to discuss the ideal family size/value of children to a family and reactions to childlessness.

CHAPTER 8

8. ATTITUDES AND IDEALS

Attitudes refer to respondent's ways of thinking and behaving. Higgins (1981, p.144) states that favourable attitudes tend to result in specific actions and reasonably predicted behaviour. They shape and influence behaviour towards the achievement of a specific goal. Ideals generally mean ideas or objects regarded as standard to be aimed at. The question was aimed at assessing the respondent's general impressions of a widely applicable ideal or norm rather than their own particular, private or personal ideals. In the present study there is no median number of children considered as ideal. This will be established in this study. It is postulated that wives with higher educational qualifications favour a lower ideal family size than those with secondary school education and those who enjoyed only a primary school education (Higgins, 1981, p.124). Respondent's attitudes towards fertility and infertility are discussed in this chapter, what they regard as the ideal number of children for an average family and their reaction to childlessness.

8.1 DESIRED FAMILY SIZE

Respondents were asked what they regarded as the ideal number of children for an average family. Table 12 gives their responses to the question.

TABLE 12: IDEAL NUMBER OF CHILDREN

<u>IDEAL NUMBER</u>	<u>NUMBER</u>	<u>PERCENTAGE</u>
0 - 2	6	4,2
3 - 4	85	59,0
5 - 6	35	24,3
7 - 10	13	9,0
11 and more	3	2,1
As Many	2	1,4
TOTAL	144	100

N = 144

Most respondents (59% in table 12) regarded three to four children as the ideal number for an average family. This response, to some extent correlates with the number of children most respondents had at the time of the survey (41%, table 7). It is not clear whether they recommended 3-4 children, just because most had that number, which gave the impression that they could control their reproduction. The fact that some respondents were able to reach and maintain what they regarded as the ideal number of children makes one to believe that they had some reliable means of controlling fertility.

Few respondents (3,5%) regarded 11 children and more or as many children as ideal because they believed

that the Almighty who gave them everything (including children) could not be questioned but that they had to accept what they were given. These respondents, however, may be regarded as exceptional cases and their values may be regarded as having little significance.

8.2 VALUE OF CHILDREN TO A MARRIED COUPLE

Respondents, when asked what they regarded as the value of children to a married couple, gave reasons reflected in table 13.

TABLE 13: VALUE OF CHILDREN TO A MARRIED COUPLE

<u>RESPONSES</u>	<u>NUMBER</u>	<u>PERCENTAGE</u>
- Children keep marriage ties firm, contributing to making a happy family;	70	40,6
- They are parent's pride and strengthen marriage bonds;		
- Parenthood gives perfection to marriage life;		
- Children help with domestic duties and also build the home.	22	15,3%
- Children contribute towards the happiness of the family and they maintain the dignity of the home.	18	12,5%
- Children are God's blessing and therefore invaluable;	21	14,4%
- Children are born to inherit their parent's property and it is a		

- pleasure to have them as they are a replication of the self.	13	9,2%
TOTAL	144	100

It is clear from statements given by respondents that married couples are expected to have children and that a childless family is regarded as "empty" or incomplete. The above statement is reinforced by responses to the following question.

8.3 REACTIONS TO CHILDLESSNESS

In most societies, it is assumed that men are fertile unless they have been castrated. The reason why male sterility is seldom recognised is precisely because it's recognition would strike at the heart of morality, all order and coherence would be put to jeopardy (Greer, G. 1985, p.34). The woman has always been blamed in cases of childless marriages and, even if specialist treatment has to be sought, the male is rarely considered to be in need of such services. Education and modernisation, however, have influenced some males to realise that reproduction is a joint effort in human beings and that both parties involved may be lacking or may be in need of some specialist treatment if there is reproduction failure or difficulties.

Table 14 gives respondent's reactions when asked what they would do if they had no children.

TABLE 14: REACTION TO CHILDLESSNESS

<u>REACTION</u>	<u>NUMBER</u>	<u>PERCENTAGE</u>
Accept situation and do nothing	30	20,9
Seek medical advice	22	15,3
Adopt	42	29,1
Take care of relative's children	21	14,6
Adopt husbands children from children outside marriage	11	7,6
Pray to the Almighty	12	8,3
Dirvoce wife and remarry	6	4,2
TOTAL	<u>144</u>	<u>100</u>

Of respondent's interviewed, 20,9 percent stated that they would accept the situation and do nothing. This, however, does not mean that they were happy that they had no children, they might have arrived at that decision because they had realised that they were unable to solve their problem. There was not an acceptable alternative for them.

It was discovered during discussions with some respondents that, when they referred to adoption, they meant taking care of their brother's or relative's children who would assist them in attending to their domestic duties and finally inherit their properties after their death. Others recommended the maintenance and adoption of children borne from women outside marriage (7,6% in table 14).

It has been an acceptable practice that, with some

childless couples, the wife gives verbal consent (if she is sterile) that the husband may have a love affair with another woman outside marriage so that a child borne during that relationship may be adopted. The procedure, according to Xhosa custom, is that the man pays "damages" or whatever may be demanded by the parents of the unmarried mother, pay maintenance until the child is finally transferred to the fathers place of residence, after reaching a specific age, which is usually decided upon by the two families.

The practice of adopting children from unmarried mothers has been successfully done in the past, but of late, unmarried mothers are not always keen that their children are transferred to surrogate mothers. A number of factors have contributed to this change in attitudes. When unmarried mothers report that they are pregnant to their parents; they do not meet with negative reaction, as was the case before. - They maintain and keep their children with them and do not really care whether the child is maintained by the alleged father. This is noted in the educated and professional women, who are not keen to part with their off-spring.

The question of repondent's reaction to childlessness is difficult to explain because it is based on assumptions, values and ideals and not on what had actually been exper-

experienced by respondents. It has been reported that, it is sometimes not easy to come to decisions when faced with questions of this nature, because some things are easier stated than done. It is therefore not fair to conclude and believe that what respondents have suggested would be their action or behaviour, if actually faced with a problem of that nature. It is also apparent that even if the same problem might be experienced by the same individual on the same or different situation at a later period, their response might be different. This may be caused by a number of factors as stated in the following section.

8.4 REACTION TO NOT HAVING SONS

Respondents were asked if they preferred to have children of a specific sex and what they would do if children of the desired sex were not borne to the family.

This information would also give an idea of the value of children to the family. It has been reported that some clients at family planning clinics were reluctant or refused to use contraceptives before they gave birth to a specified number of girls or boys. Research may have to be done to confirm these reports from clinic sisters because there is no supporting research data.

TABLE 15: REACTION TO NOT HAVING SONS

<u>REACTION</u>	<u>NUMBER</u>	<u>PERCENTAGE</u>
Adopt sons	32	22,2

Do nothing, satisfied with what God has given me	52	40,2
Invite relative's sons	16	11,1
Get them from women outside marriage	14	9,7
Teach daughters masculine duties	8	5,6
Marry second or even third wife	6	4,2
Continue, try luck and pray	8	5,6
Won't allow girls to get married	2	1,4
TOTAL	144	100

TABLE 16: REACTION TO NOT HAVING DAUGHTERS

<u>REACTION</u>	<u>NUMBER</u>	<u>PERCENTAGE</u>
Adopt daughters	8	5,6
Accept what God has given me - Girls not important	108	74,9
Pray to God	5	3,5
Teach males female duties	5	3,5
Invite relatives daughters	8	5,6
Get them from women outside marriage	10	6,9
TOTAL	144	100

It is clear from tables 15 and 16 above that most males wish to have sons or boys in their families. When respondents were asked to state reasons for the sexual discrimination, they gave the following reasons:-

- Sons are an asset to the family because they remain at home with their parents. When they get married, the wife is brought home and stays with the whole family in the common home. Sons build and maintain

the home and care for their parents when old or disabled.

Girls on the contrary, leave their home after marriage. Parents, in the past, were rewarded by the herd of cattle payed as "lobola" or the bridal price when girls got married. Of late, most people do not have the cattle or money to buy these or have just lost interest in the practice. This makes parents to get little or no "lobola" when their daughters get married.

It also seems to be common practice these days that a relatively high percentage of girls fall pregnant before they actually get married. The chances of getting married if they are not married by the men who impregnated them are usually remote. These unmarried girls and their children usually end up being a financial burden to their parents who have to maintain them from their meager wages. Some parents have accepted this state of affairs though they don't regard it as a norm.

Changes in People's attitudes and beliefs are, however, evident especially among the educated and westernised families. Some families, for example, are content with only daughters in the family. They state that they have since realised that there is little difference between activities and responsibi-

lities of males and females in the home especially if they have been given equal educational opportunities and facilities. The percentage of Transkeians in Umtata who have accepted the above is relatively low as reflected in tables 15 and 16 above. It is evident that conflicting behaviours are sometimes observed because it is not easy for people to be completely divorced from the culture of their fathers and fore-fathers (of the value of sons in the family) within a short period of time. The importance of having children in some families is explained in an incident narrated to the researcher by one respondent, of a young bride or "Makoti", who stayed with her husband and in-laws. She was expected, according to tradition, to fall pregnant during their first year of marriage, but this was not the case with her. She did not fall pregnant as expected. She had reproductive difficulties. The in-laws after a year had elapsed, became impatient and were unsympathetic about their "Makoti's " problems which contributed to the delay in falling pregnant. They started blaming her for being infertile. She had been referred to some doctors and traditional healers for some investigations and gynaecological treatment, but the problem of the alleged sterility was not solved or treated. It so happened that one morning, when the makoti was preparing a meal in the kitchen, while some men were inspanning oxen in the yard in preparation for ploughing in the fields, a

comment was shouted by a woman from the extreme end of rondavels, stating that "the other ox with two legs in the kitchen should not be forgotten and left behind", it had to join the others in ploughing the fields, as it could not bear children for the family.

Such statements are not common among most families these days, but it is true that some members of the extended families accept and respect a woman who has brought children to the family.

These attitudes and values are gradually changing and women are being respected for other roles and contributions in family affairs. This is observed in 15,3 percent (table 14) of respondents who stated that they would seek medical advice if they had no children. The superior nature of men and the influence of extended family members seems to be weakening because of a number of factors for example education and westernisation.

It is apparent as reflected in table 12 that most respondents (59%) regarded 3 to 4 children as the ideal number of children for an average family. Their attitudes towards fertility and sterility gives the impression that sterility and childless families are regarded as incomplete. Most respondents (79%) stated that they would try all available means to ensure that they might have children in their families.

These are tabled in table 13. Only 21% stated that they might accept the situation, not because it was their choice but mainly because they had no alternative. Most respondents chose to have sons than daughters. This is reflected in their responses when their reaction towards not having sons and/or daughters was asked in tables 14 and 15.

The above information gives a clear indication of the respondent's attitudes towards children and these attitudes and ideals have an influence towards contraception and contraceptive use for example respondents may only use contraceptives if they have the desired number of children and/or sons in the family.

CHAPTER 9

9. ATTITUDES TOWARDS THE USE OF MODERN FAMILY PLANNING MEASURES

Family planning, according to Du Plessis (1974, p.17) is apparently accepted "in principle" by most Indian men. The acceptors are heavily concentrated in the younger age group, higher educational level categories, higher income groups and urban areas. The state of affairs with regard to black males seems to follow the same trend. Findings in this chapter will give an indication of attitudes of black males in Umtata towards the use of modern contraceptives.

9.1 ATTITUDES TOWARDS CONTRACEPTIVE USE

Respondents were asked to express their views with regard to the use of contraceptives by their families to limit the number of children or control periods when they would like to have children.

TABLE 17: ATTITUDES TOWARDS CONTRACEPTIVE USE

<u>RESPONSE</u>	<u>NUMBER</u>	<u>PERCENTAGE</u>
Contraceptives necessary	122	84,7
Contraceptives not necessary	22	15,3
TOTAL	144	100

N = 144

It is apparent according to table 17 above that most respondents (84,7%) accepted the family planning concept.

They gave the following reasons in support of their statements:

- Parents have to prepare for their children, clothe and feed them properly;
- Family members have to be proportional to their standard of living;
- The cost of living is very high these days;
- Couples should only have children when they are ready for them;
- Family planning is necessary so that couples can have time to work and earn a better living;
- To ensure that children are prepared for, physically and psychologically.

Relatively few respondents (15,3%, table 17) were against family limitation and spacing of children.

They stated that:-

- Everything depended on the wife, the mother of the children, who bears all the responsibility of pregnancy and child care; otherwise as individuals, they were against the family planning regime.
- Family planning and contraceptive use is a personal and confidential issue, discussed only by couples concerned and not with outsiders.
- According to their tradition, children are an asset to the family.

- It is against nature and God's will because in controlling and limiting the number of children borne, an abortion may be committed, which is criminal offence.

- There is no need as everything depends on the Almighty.

It is not necessary to interfere with God's natural ways of doing things.

- People must multiply without limitation.

It is not necessary to limit births because the numbers of blacks must remain high.

It is clear, according to findings that respondents had accepted the family planning concept (84,7% in table 17). They were gradually being converted from the traditional belief that nature cannot be controlled. The few (15,3) who were against the family planning practice adhered to their religions and/or traditional convictions which made them accept things as they were. They were not in a position to question or try to solve any of their problems because they expected their provider to be always with them to see to their needs.

9.2 ATTITUDES WITH REGARD TO FAMILY LIMITATION AND CHILD SPACING ANALYSED ACCORDING TO AGE AND EDUCATION LEVEL

TABLE 18: FAMILY PLANNING ATTITUDES ANALYSED ACCORDING TO AGE.

<u>AGE</u>	<u>CONTRACEPTIVES NECESSARY</u>	<u>PERCENTAGE</u>	<u>CONTRACEPTIVES NOT NECESSARY</u>	<u>PERCENTAGE</u>
20-25 Years	24	16,7	3	2,1
26-30 Years	16	11,1	0	0
31-35 Years	18	12,5	3	2,1
36-40 Years	17	11,8	5	3,5
41-50 Years	39	27,0	6	4,1
50 AND ABOVE	8	5,6	5	3,5
TOTAL	122	84,7	22	15,3

N = 144 = 100%

TABLE 19: FAMILY PLANNING ATTITUDES ANALYSED ACCORDING TO EDUCATIONAL STANDARD

<u>ED. STD</u>	<u>CONTRACEPTIVES NECESSARY</u>	<u>PERCENTAGE</u>	<u>CONTRACEPTIVES NOT NECESSARY</u>	<u>PERCENTAGE</u>
STD. 7	5	3,5	0	0
" 8	5	3,5	3	2,1
" 9	3	2,1	2	1,4
" 10	92	63,8	15	10,4
GRADUATES AND POST GRADUATES	17	11,8	2	1,4
TOTAL	122	84,7	22	15,3

N = 144 = 100%

One cannot conclude that age and education, according to tables 18 and 19 above have an influence on male

attitudes towards family spacing and limitation because the numbers of respondents were not equally distributed according to age and educational standard. There were more respondents above the age of 40 years (40,2% in table 9) and also 74,3 percent (table 10) were matriculants. It is, however, apparent that education and urbanisation have an influence on people towards family planning. This is based on the fact that 84,7 percent of the survey group accepted the family planning practice. Respondents were asked what couples should do to ensure that only wanted children were borne. Their responses are reflected in table 20 below.

TABLE 20: MEASURES TAKEN BY COUPLES TO ENSURE THAT ONLY WANTED CHILDREN WERE BORNE

<u>RESPONSE</u>	<u>NUMBER</u>	<u>PERCENTAGE</u>
Consult family planning clinics and/or doctors.	93	64,6
Couples Should control themselves and should not engage in sexual relations when they did not want children.	13	9,0
Do nothing, have as many children	22	15,3
No response	16	11,1
TOTAL	144	100

N = 144

Some couples, as reflected in table 20, believed that couples should have a strong will and not engage in sexual relations during periods when they did not

want to have children and that extra-marital love affairs should be discouraged. It is assumed that these respondents believe that couples engaged in sexual activities only when they wanted to reproduce.

Respondents who stated that nothing could be done (9,0%) believed that children are a natural gift from God and that nobody could entertain the idea that a gift from God is unwanted. They argued that nobody could be sure whether he has had a wanted or an unwanted child. Family planning, according to them, was against God's will because "somebody who could be of benefit to human kind might be killed." They also believed that God provides for all.

The non-response rate to this question was relatively high (11,1%). Respondents stated that the subject/topic of contraception and contraceptive use was strictly confidential and could only be discussed by the responsible couples and not with outsiders.

The following case illustrations give some views of respondents who did not seem to follow the same trend as others in responding to questions asked. They appeared to have some theoretical information about the aims and methods of contraceptives used and accepted the family planning regime, but could not allow their wives or sexual partners to use any form of contraception. The contradiction between theory and practice attracted the researchers attention. These attitudes and behaviours

may need further research at a later stage.

CASE 3

A forty year old respondent, staying in Ngangelizwe township for the past 19 years was employed as a messenger in the government offices. He had passed standard 9 and his wife was practising as a nurse at a hospital a few kilometres outside Umtata. They had four children.

He considered family limitation and spacing of children a necessity because of the high cost of living and the low salary scales for Blacks in the country. He was of the opinion that family planning, sex education and antenatal care were essential and that the public should be educated on these aspects.

Contrary to the above, the respondent stated that he was against or did not allow his wife to use contraceptives because they predisposed to health problems later in life. Apart from the fact that a woman who uses contraceptives is, according to him, a doctor's client/customer for the rest of her reproductive life, contraceptive use might also encourage prostitution and promiscuous activities. He stated that he was aware that his wife was using contraceptives, though he was against the practice, but was not sure of the method she was actually using. He finally commented that "women, these days, are untrustworthy and unreliable if they are not observed closely."

CASE 4

A twenty four year old unmarried respondent, who had been in Umtata for the past 15 years, was employed as a clerk in the government offices. He had 2 children, a boy and a girl, from different unmarried mothers.

He believed that family planning was necessary and that women should prevent a pregnancy from occurring using any of the available contraceptive methods. He emphasised the fact that the use of chemical and/or mechanical methods was "superb" as unwanted births of children could disrupt the couple's relationship and might also lead to frustrations, regrets and sometimes hostility among couples.

He stressed the point that he would not enjoy relationship with a woman who would allow herself to be pregnant against her husband's consent or knowledge as that would indicate that she was careless and in the least concerned about the future of other family members.

He further, stated that he allowed his girlfriends to use contraceptives, but was afraid that the chemical contraceptives might lead to health problems when used by the wife. As an individual, he used the condom and coitus interruptus methods of contraception but disliked these methods because they were uncomfortable and sometimes pleasure - robbing. He also recommended that abortions should be legalised in Transkei and that agencies and institutions for unwanted children

should be properly advertised to the public so that unwanted children could be made available for adoption to couples desparately in need of children.

It was apparent that some respondents regarded family planning as a woman's responsibility. The fear and uncertainty about the health of the contraceptive user was also noted. Some respondents were suspicious that their wives might be tempted to engage in extra-marital sexual activities freely should they be relieved of the fear of pregnancy.

9.3 CONTRACEPTIVES USED BY RESPONDENTS

Respondents were asked if they were using contraceptives to limit the number of children borne or to space periods when they would like to have them. They were also requested to state contraceptives used, if they were using any to prevent a pregnancy from occuring. The responses given are reflected in table 21.

TABLE 21: RESPONDENTS USING CONTRACEPTIVES

<u>RESPONSE</u>	<u>NUMBER</u>	<u>PERCENTAGE</u>
Respondents not using contraceptives	90	62,5
Respondents using contraceptives	32	22,2
No response	22	15,3
TOTAL	----- 144 -----	----- 100 -----

Contraceptives used by respondents were:

- The condom
- The rythme safe method and

- Foam tablets

Respondents commented that contraceptives designed for males were sometimes "uncomfortable, deprived them of sexual pleasure and were sometimes "dirty". They were referring to the withdrawal method, the condom and foam tablets.

9.4 CONTRACEPTIVES USED BY RESPONDENTS AND THEIR WIVES/
SEXUAL PARTNERS

Respondents were asked to mention the contraceptive methods they were using with their sexual partners. Table 22 gives a schedule of contraceptives used by respondents and their sexual partners during the survey period.

TABLE 22: CONTRACEPTIVE METHODS USED BY RESPONDENTS AND
THEIR PARTNERS

<u>CONTRACEPTIVE METHOD</u>	<u>NUMBER</u>	<u>PERCENTAGE</u>
Not using contraceptives	46	32,3
Withdrawal	27	18,9
Rubber condom	18	12,2
Rythme Method	13	8,9
Foam tablets	3	2,1
Anti-ovulatory pill	21	14,4
Loop	14	10,0
Douche	2	1,2
TOTAL	144	100

N = 144

According to table 22 above, it was obvious that men still preferred the withdrawal and rubber condom while women chose the anti-ovulatory pill (14,4%) . A higher percentage of respondents (32,2%) stated that they were not using any form of contraception. Some believed that nature should be allowed to take its course undisturbed while others stated that they were too old and had no reason to use contraceptives because their wives had already reached menopause. This statement is confirmed by the fact that 40,2 percent (table 9) of respondents were 40 years and above. This aspect definitely needs further research because it is not known how many respondents were not using contraceptives because of old age and what percentage relied on natural methods and adhered to God's planning.

It has been observed that the injection method of contraception was not mentioned by respondents, though it is widely advertised and prescribed in family planning clinics, according to reports given by family planning clinic sisters. It is possible that some respondents were not aware that their wives were using this method since the injection is administered at a clinic after a period of 2 or 3 months and cannot be taken home to be witnessed by her family members. More intensive research would have been required to investigate if the injection has been administered to sexual partners of respondents.

9.5 IDEAL LENGTH OF TIME BETWEEN MARRIAGE AND THE BIRTH OF THE FIRST CHILD

Respondents were requested to state the period they recommended as ideal between marriage and the birth of the first child. The question was asked to assess if respondents thought it necessary to space or limit the number of children borne; if they realised the value of contraceptives and were able to use them effectively. Responses are given in table 23 below.

TABLE 23: IDEAL LENGTH OF TIME BETWEEN MARRIAGE AND THE BIRTH OF THE FIRST CHILD

<u>IDEAL PERIOD</u>	<u>NUMBER</u>	<u>PERCENTAGE</u>
As soon or immediately after marriage	14	9,7
3 - 10 months	17	11,8
1 year	69	47,8
2 years	22	15,3
3 years	8	5,6
4 years	3	2,1
No formular	8	5,6
No response	3	2,1
TOTAL	144	100

N = 144

Most respondents (47,8%) as reflected in table 23 above, recommended that a period of one year should elapse between marriage and the birth of the first child. They gave the following reasons for their responses:

- It is necessary for a couple to prepare for the on coming child financially and psychologically;
- To get used to the wife first;
- To be able to recover from expenses payed for "lobola"
- To build a home first;
- To ensure that children are legitimate as it sometimes happens that the wife is pregnant from another boyfriend (man) when she get's married;
- To enjoy life freely for at least one year before being troubled by problems of pregnancy and children;
- Children should only be borne when marriage relationships are fully established.

Some respondents (11,8%) stated that couples should have children immediately after marriage. They believed that it was important for a couple to find out timeously if they were productive and to contact specialists if need arose, at an early stage. They stated that the presence of children improved marital relationships. Some wanted to have children earlier in marriage so that they could work and enjoy life fully afterwards.

It was noted that some respondents when they mentioned periods of, up to 10 months, considered the period of pregancy as a gap between marriage and the birth of the first child.

As an example, some respondents stated that there should be a period of 9 to 10 months before the first child is borne because social pressures from older family members, who did not expect them to wait for longer periods, compelled them to ensure that a child is borne soon, without any delay after marriage.

9.6 GOVERNMENT'S CONCERN ABOUT THE INCREASING POPULATION

The following question was finally posed to the survey group; "why do you think the government is so concerned about the increasing number of people in our country". They responded in the following manner.

TABLE 24: ATTITUDES TOWARDS GOVERNMENT CONCERN ABOUT THE INCREASING POPULATION

<u>REACTION</u>	<u>NUMBER</u>	<u>PERCENTAGE</u>
Approved	116	80,5
Disapproved	6	4,2
Neutral	22	15,3
TOTAL	144	100

N = 144

Respondents who did not approve of the family planning lobby comprised 4,2 percent of the survey group. In support of their negative attitudes, they stated that:

- There are many departments in the country that need large numbers of people like the defence and police force, which may have shortage of officers if the number of children borne is curtailed.
- Everything must be left to the Lord, the Creator, as factors like faction fights, accidents and natural disasters are the natural means of controlling over population.
- A large population serves as a source of manpower (labour force). Many countries are complaining

of shortage of manpower. China was given as an example, where food is produced in large quantities because labour force is in good supply and where no shortages have been reported.

The governments concern about the excessive increase in population figures was approved by the majority of respondents in the study (80,5%), because:

- The government has to ensure that all citizens in the country have accommodation facilities, are educated and have sufficient health services;
- Employment and job creation opportunities which have to be provided may not be enough if numbers are increased;
- Population growth should match the country's economic situation;
- To develop a healthy nation;
- There is not enough land and space to accommodate increased population figures in the country;
- Failure of crops due to droughts and other natural and unnatural disasters coupled with high cost of living has made it difficult to feed and maintain large numbers of people.

A relatively high percentage of the study group (15,3%) stated that they were not sure if the government was concerned about the increasing number of people in the country and did not know if the government was justified or not in taking such action.

It is apparent that a high percentage of respondents believed in the use of natural and mechanical contraception like the rythme, condom and withdrawal methods (40,0% table 22). It can however, be concluded that people are getting oriented to the use of chemical and/or mechanical contraceptives because a relatively high percentage of respondents were in favour of contraceptive use to limit and space children borne. Some actually took an active part and used some form of contraception with their sexual partners, though others were against the practice (32,3% table 22).

The next and final chapter is directed at the interpretation of findings, recommendations and conclusions.

CHAPTER 10

10. FINDINGS AND CONCLUSIONS

The major findings of the study are summarised in this chapter i.e. attitudes of males towards family planning and contraceptive use. Some general conclusions are drawn and recommendations given.

10.1 MAIN FINDINGS

The prevalence of family planning seems to be related significantly to the couple's sub-culture and the attitudes towards which family planning stems is largely from their cultural orientation.

Most respondents in the study group had lived and worked in Umtata for a period of ten years and less (66% in table 3), while 21 percent had been in Umtata for a period of more than sixteen years. Most respondents, though residing in Umtata, were still attached to their rural homes. They visited relatives and/or parents periodically and others, in fact, had set routines of going home (to rural homes), during week-ends or when on leave. Respondents were, therefore, exposed to the Western style of living in Umtata, which is regarded as an urban area, but were not completely divorced from their rural and traditional ways of living.

The Transkei Marriage Act No.21 of 1978 has also affected attitudes of some Transkeians towards family planning because polygamy is legalised and it's aim

is to ensure that children borne are legitimate.

This act does not seem to encourage family planning (limitation) practices; but, may instead lead to a decrease in contraceptive usage if most men and women accept the practice of polygamy because it is believed to remove the stigma of giving birth to illegitimate children.

Education and age have shown no direct significance to the couple's use of contraceptives because respondents were not selected with consideration of their age or educational levels. It was, however, noted that the majority believed that contraceptive use was an essential practice to enable couples to limit and space children borne. Of the respondents who accepted the family planning regimen, 63,7 percent were matriculants and 11,8 percent were graduates and post graduates (table 19). It was noted that only 22,2 percent (table 21) actually used contraceptives. Most relied on methods used by their sexual partners while others decided not to use them. Findings in this study have given an indication of the attitudes of male respondents in Umtata towards family planning. Men have some knowledge about contraception and the use of chemical and/or mechanical contraceptives. They seemed not to understand how chemical contraceptives prevented a pregnancy from occurring (the physiological action of the chemicals used) and this ignorance

led to some fears and non-acceptability by some.

The knowledge of contraceptive methods and acceptance of these does not automatically imply successful family planning. This is determined by the presence of some important intervening socio-economic variables.

Case illustrations in chapters 5 and 7 gave the impression that some respondents had knowledge of some family planning methods available and, infact, believed that these were necessary to control fertility but they did not use them and also did not allow their wives to use these because of the belief that contraceptives predispose to diseases like cancer or may also lead to infertility. Some believed that, should their sexual partners use contraceptives and be re-assured that they would not fall pregnant, they might freely engage in extra-marital love affairs, be prostitutes or might engage in promiscuous sexual relationships. It is apparent that more and appropriate education on the use and probable side effects of chemical contraceptives has to be given to people in general.

The question of couple's fecundity status is of vital importance and has to be considered when introducing contraceptives and other family planning methods. Fecund couples tend to use contraceptives as compared to the sub-fecund and sterile. The fact that 79,1 percent (table 14) of the survey group stated that they would take active steps if they had no children by seeking medical advice, adopt or even divorce

and re-marry another wife who (presumable) would reproduce, indicates the value of children to males. The sub-fecund and sterile are not keen on using chemical and/or mechanical contraceptives because they are still interested in having more children. They have no reason to prevent any pregnancy from occurring.

Family planning is to a degree, inversely related to family size. Families with few children or none at all are less inclined to use contraceptives than those who have more than the desired number.

It has also been observed that couples who use contraceptives tend to have less children than those who do not use contraceptives successfully and regularly.

Family planning is positively related to the user's attitude towards the use of contraceptives. This is more so that family planning is regarded as a woman's responsibility, men tend to be careless and sometimes have negative attitudes towards contraception. This was demonstrated by the low percent of actual users of contraceptives in the study (22,2% in table 21). It has, according to Greer (1985), been proved that most women have a positive attitude towards contraceptive use because of fear of pregnancy, child-bearing and of the inconveniences that follow when the man is, to a certain extent, free of all these problems.

10.2 ATTITUDES TOWARDS FAMILY PLANNING

It is apparent that contraceptives were not widely used by the sample population since only 22,2 percent were actually using them (table 21). They mainly relied on the mechanical and/or natural methods.

There seemed to be a difference in attitudes when respondents were asked contraceptives used by themselves as individuals and with their sexual partners. In table 21 it was observed that 62,5 percent of the survey group stated that they were not using contraceptives. It is, however, noted in table 22 that only 32,3 percent stated that they were not using them when asked contraceptive methods they used with their partners. This gives the impression that women motivated their partners and/or were actively involved as individuals or as partners in the practice of contraception.

The belief that couples engage in marriage for the purpose of reproduction was confined to some respondents. For this reason, 69,1 percent (table 23) suggested that children should be borne within a period of one year after marriage, so that couples could ascertain if they were fertile or not and to decide on steps to be taken to solve their reproductive problem, if sterile.

Women were sometimes blamed for reproductive failures or childless marriages and for giving birth to children

of a specific sex. Some respondents stated that they might divorce their wives and remarry or try to get children from women outside marriage if they had no children or there were children of an undesired/unacceptable sex in the family. This was mostly noted when there were no sons borne in the family (table 15).

It was also interesting to be informed that 15,3 percent (table 14) would seek medical advice if they had no children. They seemed to realise that both the husband and wife may have reproductive problems in cases of childless marriages and needed joint treatment.

Education and cultural diffusion with other social groups like Indians and Whites may have also facilitated a better understanding and respect of the woman. That women cannot be regarded as solely responsible for reproduction but are to be respected for their contributions by all family members and communities.

Children were regarded as a form of "insurance" by some respondents, as it was hoped that they would be responsible for maintaining and caring for their parents when old and disabled (table 13). It was also stated that children, especially boys, are needed as they would attend to family affairs and inherit their parent's property when they died. Some respondents (20,9% in table 14) stated that they would accept

the situation of not having children. This is an indication that people's values are gradually changing, though there may be other reasons for this attitude which may need further investigation.

The desire for a specific sex, according to family planning motivators, is sometimes responsible for the birth of more children than required, when the couple keeps on "trying", entertaining hopes that the child of the desired sex may be borne. This desire for children of a specific sex seems to be responsible for the disruption of plans made by couples and can only be solved by assisting couples and people in general to accept themselves and the sexes of their children and to learn to make productive use of what they have. It has been noted in this study that most respondents (tables 15 and 16) preferred having boys to having girls. As stated above, some even stated that they would divorce or re-marry a second wife, who it was hoped, would give birth to boys (table 14).

10.3 ATTITUDES OF MALES TOWARDS CONTRACEPTIVE USE

In many societies, men are often more literate than women, which makes them more accessible to new ideas and changing attitudes. According to Van Regen Mortel and Van Harte (1977), almost all males approve of family planning in principle and want to learn more about the subject if they are ill-informed. Many

men, as was the case with most respondents in the survey, accepted the family planning policy and the government's involvement in population control.

A high percentage of the survey group (64,4%) suggested that couples should contact family planning clinics and doctors to ensure that only wanted children were borne (table 20).

The contradiction was, however, observed when only 22,2 percent were actually using contraceptives to limit and space children borne (table 21).

Some respondents did not allow their sexual partners to use chemical and/or mechanical contraceptives because they feared that they might be unfaithful and/or engage in extra-marital sexual love affairs. Respondents believed that the possibility of a pregnancy was a stronger deterrent for a woman's potential adultery. Whether this does in fact deter women is difficult to establish, but it is strongly felt by many people (Van Harte and Van Regnmortel 1977). It can be argued that it is not so much that wife's possible adulterous behaviour which men fear, but rather the freedom of not having children, which contraception makes possible and gives a woman other alternatives of self-realisation, and have an equalising effect between a man and a woman. If a man is not sure about his masculinity and self-value, this change in her "natural"

role might threaten him and he would thus reject a change in her status within the family. It has also been observed that woman's liberation appears to be filtering to all levels of female behaviour, that is, in employment, education and also in the regulation and control of children borne. Women, to-day, are no longer regarded as sexual objects, to bear children and stay at home to care for the children.

Many people have a pantheistic view of the world and believe that everything that is natural is "correct" and therefore good and that chemo-mechanistic contraceptives which could interfere with natural sexual processes are "bad", and must have a detrimental effect on marriage life.

This was illustrated by responses from some respondents who stated that:

- Family planning is against nature and God's will, and that it was not necessary to interfere with God's natural way of doing things;
- Birth is a natural gift from God and that nobody can entertain ideas that a gift from God is unwanted (tables 17 and 20).

A relatively low percentage of respondents (22,2%) were using contraceptives. Some of the users stated that it was better to have a few healthy children than to have many children who posed more health

and other financial problems to the family, when the value of the rand was so low.

Though this was not a representative sample of the population in Umtata; the information received has given an indication that such attitudes existed and that a greater percentage of the population needed assistance and guidance to be able to accept and understand the effective use of modern contraception.

10.4 CONCLUSIONS

"There has been an increase in contraceptive prevalence over the past two decades." This statement was made by Akhter, H.H. (1983). In her discussions Akhter said; "Never before have so many people relied on drugs, devices and surgery to control fertility, a fact that warrants careful monitoring of the health aspects of family planning methods". This seems to be true even in Third World countries like Transkei. A number of mechanico-chemical contraceptive methods are available for use by both males and females to limit the number of children borne and space periods they would like to have children.

Family planning statistics as reflected in chapter 3 reveal that attendants at family planning clinics are gradually increasing. The percentage of male attendances, however, is relatively low when compared to that of females.

It has been reported that knowledge and use of contraceptives does not constitute proof of family planning. As stated by Higgins (1981), use of contraception might constitute evidence of favourable attitudes towards family planning and possibly also indicate a type of attempted planning.

As regards the number of children considered ideal and desired, there appears to be some evidence for suggesting that a shift in outlook has occurred over the past decades.

Many interviewers stated that their ideologies and beliefs had undergone some change over the course of time, that time and its concomitant experience had been made more realistic and rational as regards their fertility expectations. Precise data is, however, required to come to conclusions in this regard and not only to rely on inferences.

As regards the research questions which had to be answered by this study, it can be stated that:

1. Educated males in Umtata have not completely accepted contraceptive use to limit the number of children borne or space periods when they could be borne. The survey group consisted of the educated sector of the population and of these, only 22,2 percent were using contraceptives (table 21).

2. A couple's fecundity status has a vital bearing on their family planning pattern irrespective of culture patterns. Couples who had experienced problems in getting children and those who had no children at all were not using any form of contraception.
3. Males are not properly oriented on the different methods of contraceptives available, and their effect in the body of the user i.e. how they act when they prevent a pregnancy from occurring.
4. Some males entertain fears that contraceptive use by their wives or sexual partners might lead to health problems like cancer and sterility.
5. Fears that users might commit adultery or engage in promiscuous activities were also expressed by some.

A greater percentage of respondents were aware of and accepted family planning practices and principles. The contradictions observed in responses from some respondents and their reasons for allowing or not allowing their partners to use contraceptives suggests a need for further research.

Research questions that need further investigation are that:

1. Black males fear competition with their wives in the socio-economic field if they can be permitted to use contraceptives freely--the threat of "Woman's Liberation."

2. Failure in the use of contraceptives is due to faulty interspousal communication and
3. The effect of religion on the use of contraceptives among Blacks is inversely related to contraceptive use, family limitation and spacing of children.

Contraceptive users want fewer children than non-users in the same socio-economic and socio-cultural sub-groups. The sooner couples begin using contraceptives, the smaller their actual or expected family sizes. The sooner couples commence using contraceptives, the more successful is their family planning practice.

It was apparent that the use of chemo-mechanical contraceptives was not favoured by most respondents.

The majority of respondents relied on the natural methods of contraception which are the withdrawal (coitus interruptus) and the rythme methods (table 22). A relatively high percentage (12,2) relied on the condom.

It was reported that family planning services were not widely advertised in Transkei as was the case in countries like China, where over-population was greatly marked. As family planning services were conducted in most health centres in Transkei, it was mainly people who needed health care services who had access to them, except for the interested literate people, who might have an opportunity of

reading about the subject or listen with some meaningful interest and understanding in mass media.

Family planning can never be adequately investigated in a single, on the spot study due to the time perspective because it is possible that some of the non-users in the study, who were against contraceptive use might eventually be compelled to use some form of contraception, though the opposite is also true. Reference here is made to findings by Higgins (1981) who stated that "the present study could be more significant if it were allied to a follow up study."

10.5 RECOMMENDATIONS

It is true that people world-wide view contraception and contraceptive use in a medical context and thus the distribution of most contraceptives is often restricted to health delivery systems making them inaccessible to those persons outside the reach of the system.

This poses an ethical dilemma in a developing world where health coverage is small and may reach about one fourth of the population. Three quarters of the population thus may be denied of not only health services but of family planning services as well (Sai, F.T. 1983). Perhaps the best approach would be for contraceptive delivery system to play a leading role in introducing basic health care to the community where such care is

available. Alternative distributive channels are chemists and doctors, supermarkets and stores after the first assessment and prescription by a specialist in the field. Advisory centres are also necessary for counselling of adults with psycho-sexual problems.

The role of social welfare policy is interventive, to buffer individuals against the hardships of industrial societies and dependent populations such as the poor, the blind, the sick and the disabled (Miningoff, 1980).

Recommendations by Lonsdale (1974) will be referred to in this study. That social policy in the field of family planning should be improvement of socio-economic standards in the community in order to create a situation and provide a framework of values which a deprived group of people will find feasible to plan their families. Lonsdale stressed the following aspects:

1. Increase of social security benefits, for example, pensions and wages so that partners do not have to rely on their children for financial support.
2. Improvement of health services, specifically antenatal care and baby care to reduce foetal and infant mortality rates.
3. Education levels should be increased in addition to community education.

Institutions for child care facilities are necessary

so that mothers can be free to work.

Improvement of community and recreational resources for adults in order to provide other interests and goals rather than large families.

Unskilled people should be encouraged to organise their lives productively and in ways acceptable to the community.

Men should be reached through their places of employment.

Social workers should be more active in the field of family planning.

Some of the recommendations given above cannot be easily implemented because of some factors beyond the family planning nurse or social worker's control, for example, the increase of social security benefits. These may be possible in some countries but may not be easy to implement in some Third World countries like Transkei, because of the financial climate and other factors. These recommendations are regarded as ideal, so that, when circumstances permit, they may also be attended to.

Individuals, families and communities can be assisted and guided by social work practitioners in the following manner:

- a) Counselling of individuals and families who have problems in relation to family planning. This can be done through regular welfare programmes where

family planning is one facet of the total situation in which the client finds himself or counselling can be a built in feature of family planning programmes. The major problem is that counselling services are expensive, not enough case workers are available and few people can be reached quickly.

- b) Community support, client contact and motivation. The social worker helps to develop educational techniques and works with local leaders through the application of community development techniques. The aim is to provide a climate of opinion which legitimates and provides acceptance of population policies or family planning programmes.
- c) Documentation of programme activities, client activities and organisation obstacles encountered, without such documentation, evaluation and research are not possible. In such a role, social workers are able to provide feed-back and suggest changes to those guiding programmes and dispensing various kinds of services.
- d) Administering population development and family planning programmes at local, district and national level. Work with multi-professional staff and deal with extra-programme problems as well as

the internal operation of the programme.

- e) Training of existing staff (in-service) and trainees. The social work practitioner should impart the non-clinical aspects of the programme. He is also able to put the technical details into a much broader family education context.
- f) Supervision of fieldwork trainees and para-professional staff.
- g) Co-ordination of population programmes and family planning services with programmes of other agencies and developing better understanding of fertility control among all concerned.

The increase in number and quality of family planning and population programmes conducted in Transkei and ensuring that all communities are reached and programmes clearly explained in the language medium which is clearly understood by community members must be regarded as one of the priorities.

Family planning programmes must be introduced as indicators of population development programmes with the aim of improving the quality of life and resources for individuals, families and communities. The welfare burden may therefore, be reduced by lowering the birth rate, the illegitimacy rate and breaking the poverty

cycle by decreasing the transmission of poverty from one generation to another.

To achieve the desired goals social workers have to attend to the following aspects which influence people's attitudes towards child bearing and contraceptive usage.

These are :-

Premarital and pregnancy counselling, providing contraceptive information including the effectiveness and side effects of the various methods, sex education services at school, counselling couples who are sterile and desire children.

The number of family planning motivators needs to be increased and males should be employed to ensure that they give special attention to males and motivate and educate them towards using approaches that will be acceptable to them. It has to be stressed that contraception and family planning should be decided and agreed upon by couples jointly and not to be taken as the responsibility of an individual.

APPENDIX

PROJECT DESIGN

1. THE SAMPLE

The study was based on an investigation of black males who were employed and could read and write. Respondents selected had passed standard seven and higher standards and were living in Umtata and its suburbs.

Interviewers visited relevant males in offices and/or departments where they were employed during the day and contacted them in their residential places in the evenings or week-ends. Every fifth male of the specified category was contacted.

The interviewing process took a period of two months. Interviewers divided themselves into two groups when they visited the suburban areas. During week-days especially between 10h00 and 14h00, they visited respondents in their places of employment independently, ensuring that they contacted them during their tea or lunch breaks. Appointments were made with some and others allowed interviewers to conduct interviews

during working time. This depended on the type of employment and on the employer. The researcher and the field worker visited Ngangelizwe township, Ikwezi, Southernwood and Hillcrest. The other two female field-workers contacted respondents at Fortgale, Norwood, Northcrest and Ncambedlana.

The field-workers met twice a week between 08h00 and 10h00 to discuss their progress and any problems experienced and solutions were arrived at jointly. Field-workers were free to contact the researcher at all times if need arose and an itinerary, known by all, had been drawn, for easy contact when need arose.

The refusal rate could have been higher, were it not for the sensitivity, interest and dedication of field-workers. Their understanding of the language, culture and habits in general of interviewees, helped them in spotting areas where conflict of ideas might lead to negative reactions from respondents. Their experience and acceptable communication skills were an advantage in explaining and convincing respondents about some aspects of the questionnaire.

2. THE FIELD-WORKERS

Interviews were conducted by four field-workers, composed of the researcher, two middle aged females who were nursing sisters and a male, who was employed as a health educator in the Health Department. All

interviewers were past the age of forty years and were respected by community members. They understood the language of the interviewees, their background culture and beliefs as well as their childhood experiences. They were part of the community themselves.

- Interviewing techniques were discussed with field-workers and some specific areas which might lead to negative attitudes towards the subject of family planning and contraceptives use were attended to.

The positive approach to respondents was emphasised and the art of communication and the importance of confidentiality, respect and appropriate approach to interviewees was also discussed.

Each item of the schedule was clearly explained to the field-workers in detail to give them a better insight into the subject matter, to enable them to explain to respondents whatever was not clear.

The interviewing process posed less problems because interviewers understood the subject of family planning. They were also accepted and respected community members who were familiar with factors affecting behavioural patterns of interviewees in the country. All these factors made respondents to feel free and relax during interviews. It may be stated, however, that it is difficult to ascertain that respondents gave a true

reflection of their attitudes and feelings because of the nature of the subject.

Umtata, the capital city of Transkei, was chosen for this study because it employes a greater percentage of the country's citizens. Since most repondents (82% in table 2) were borne in villages outside Umtata and some were visiting their rural homes periodically, it may be stated that the sample population was a representation of the whole population in Transkei.

A sample population of 150 is relatively small and makes generalisation of findings difficult. Findings, however, will throw some light into the subject under study and may be used as a point of departure for programmes to be conducted in future.

SCHEDULE I

A standard schedule was used throughout the study. Some questions were completely structured while others were open-ended. Information gathered during the course of the interview which might qualify, clarify or enlarge upon the respondent's actual replies to specific questions were also recorded.

The schedule used follows below:-

RHODES UNIVERSITY : DEPARTMENT OF SOCIAL WORK FAMILY
PLANNING SURVEY.

"PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR
ABILITY. ALL INFORMATION WILL BE KEPT STRICTLY
CONFIDENTIAL."

DATE OF INTERVIEW _____

CODE NO:- _____

SECTION I : GENERAL SOCIOLOGICAL FACTORS.

1. May you please tell me where you were borne?

2. How long have you been staying in Umtata?

3. Are you owning or renting the house/room in
which you stay? (tick appropriate square.)

owning

renting

4. Are you single or married? -----
5. Do you stay alone, with your wife and/or children? -----
6. How many wives do you have? (if married)

7. May you please tell me the number of your children?

8. If your children are not from one wife, specify the number of children from the first and subsequent wives (woman) -----

9. Do you have children outside marriage?
- Yes NO
10. If yes, how many are they? -----
11. Are the children mentioned above (if any) from one wife?
- Yes No
12. If children mentioned above are not from one woman, please state how many there are from each woman? -----

13. How many brothers and sisters do you have?
Brothers -----
Sisters -----
14. May you please tell me how old you are?

15. What is your highest educational standard?

16. What type of job are you doing?

SECTION II : ATTITUDES AND IDEALS

17. What do you think is the ideal number of children for an average family? -----

18. What is the value of children to a married couple?

19. What would you do if you had no children?
(Either you or your wife does not reproduce)

20. What would you do if you had no sons in the family?

21. What would you do if you had no daughters?

SECTION III : REPRODUCTIVE PATTERNS

22. Do you think it is necessary that families/couples limit the number of children borne or control periods when they would like to have children?

Yes

No

23. Why? (If Yes or No in 22 above) -----

24. What should be done by couples to ensure that only wanted children are borne? -----

25. Some people use chemical and/or mechanical contraceptives to limit the size of their families and control periods when children should come. What is your reaction to that practice?

26. Why? (Reasons for reaction stated in 25 above)

27. Are you using contraceptives to limit your family size or control periods when children should come?

Yes

No

28. If yes (in 27 above), what type of contraceptives are you using?

29. What methods of contraception are you using with your wife or sexual partner to control or prevent a pregnancy from occurring?

30. What do you think is the ideal period between marriage and the birth of the first child?

31. Why? (To period given above)

32. Doctors, Nurses and Public Health Workers to-day are interested in learning about contraceptive methods people use these days; have you or your wife made use of the methods listed below?

SCHEDULE II

The following questions were asked from the family planning clinic sisters:-

- 1) The number of officers running the services and their qualifications.
- ii) Persons for whom the service is rendered.
- iii) Periods for attending clinic sessions
- iv) How services are advertised to the public.
- v) Fees payable by clients.
- vi) Types of contraceptives available.
- vii) Response from the public.
- ix) Problems experiences by males as well as females.
- x) Statistical figures of male attendance at clinics, advice given and contraceptives distributed.
- xi) Their observations and comments on male attitudes towards contraceptive use.

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