ATTITUDES TO FAMILY PLANNING IN THE TAUNG AREA OF BOPHUTHATSWANA: A SOCIAL WORK PERSPECTIVE

Thesis submitted in fulfilment of the requirements
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by

Geraldine Nomonde Thekisho

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Supervisor: Professor W.A. Mitchell

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ABSTRACT

Emphasis in the study is on the prevalence of poverty especially in the so called third world developing countries. Poverty as a social problem is caused by a number of factors, viz: Over population, unemployment, illiteracy, etc. In the case of the study the focus is placed on the rapid population growth or "population explosion" as it is commonly known. Family planning is seen as an important, but not the only strategy in combatting the interrelated problem of population growth and development. The relevance and importance of social workers, as members of a multidisciplinary team in the delivery of family planning programmes is emphasised.

There is evidence in the study to support the observation that Black African people in particular are reluctant to use family planning methods. Based on this evidence, the basic assumption arrived at is that there is a general unfavourable attitude to family planning in the Taung area.

The research design used is exploratory-descriptive. Of the 75 areas in the district, 10 areas were included in the investigation. A stratified random sample was used, with a sample size of 200 respondents. The interview schedule was used to collect data. It was structured and

consisted primarily of close-ended questions, and was analysed using the Biomedical Data Programme (B.M.D.P.).

The problem is formulated from literature concerned with population growth in the Republic of South Africa as well as Bophuthatswana. The following sub-problems were described: illegitimacy; health and economic problems associated with large families; abortion; malnutrition and malnourishment; and the absence of services of the National Family Planning Programme in the Taung area. Compatibility between social work and family planning is a central concern, with community development as a significant method of intervention.

The three important concepts in the study were broadly defined, viz: Overpopulation, family planning and attitude. It was established that

- the use of family planning follows rather than precedes the process of modernisation and rising economic standards;
- no family planning programme can be practised universally - because of factors such as culture, need and habit.

Attitudinal change is considered based on the basic assumption arrived at.

Little has been done on the subject of family planning in

South Africa. With regard to the role of social work in family planning, there have been impediments along the following lines: lack of firm tradition; emphasis on treatment rather than on preventive work; a view of family planning as a health measure and to be offered solely in the medical and health services. To be active in this field social workers need formal education and training.

Taung - the area of study is predominantly rural With almost all characteristics of rural areas, those of: Irregular transport services to and from remote areas; corrugated roads; primitive sanitary conditions; poor communication system; absence of electricity in villages; illiteracy and unemployment. On the other hand, development is evident especially in the health, education and welfare fields.

The central findings in the study are those arising from resistances to family planning usage - politically; culturally; morally and psychologically. The general conclusions are: The high rate of unemployment is present in the sample and there is financial dependence on partners (men); the importance of social workers in family planning is emphasised; there is a desire to have large number of children (children feature prominently in the area and are regarded as an asset in various ways); and lastly improved education does lead to an increase in motivation to adopt family planning practices.

Against the highlighted findings, recommendations were made, viz that: Community development be used as a strategy for change; social workers be involved as team members in family planning - in policy formulation and planning of population programmes at various levels, using different methods of intervention; paramedical aides be used - because of inter alia shortage of qualified manpower and lastly formal education and training to be granted to prospective change agents in family planning delivery programmes.

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CHAPTER 1

1. Introduction

The study focuses mainly on poverty as a social problem affecting the Taung area which is part of the Republic of Bophuthatswana. This problem is said to be common in almost all third world developing countries and is attributed to a number of factors, overpopulation, unemployment and illiteracy. However, the focus of this study is placed on rapid population growth, sometimes referred to as "population explosion".

Most people, the poor in particular, do not necessarily want large families. The concept large families will denote all those in the study who have families of five and more children. Apparently more poor families end up having more children than they expected or wanted than do other socio-economic groups. The poor tend to delay using family planning methods, the writer assumes, until they have three or more children and even when they use these methods, they are used less effectively. It is important to understand why this appears to be the case, since "the choice people make in their efforts to control conception has a fatefulness for their lives". (Christopher, 1980, p 136.) As early as 1798, Robert Thomas Malthus argued that population was growing in a geometric progression, whereas

sources of subsistence were growing in an arithmetic progression. (Perlman and Cozby, 1983, pp 250-251.)

Successful efforts have been made to decrease infant mortality rates worldwide without in turn decreasing the birth rate. Three solutions have been proposed to control a nation's population, viz increasing the death rate, promoting migration and decreasing the birthrate. (Hymovich and Barnard, 1979, p 3.)

Concentration in this study therefore, will be on the last mentioned factor and in particular the usage of family planning by the community, in order to try and reduce the birth rate. Family planning is seen as an important but not the only strategy in combatting the interrelated problems of population growth and development. From the individual's point of view it is his/her right to obtain the knowledge and means to plan and control his fertility. At the Bucharest conference on population (1974) the following resolution was accepted: that "all couples and individuals have the basic human right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so; the responsibility of couples and individuals in the exercise of this right takes into account the needs of their living and future children and their responsibility towards the community". (Groenewald, 1978, pp 1-2.)

To understand the population problem clearly cultural factors, it is suggested, should be considered against the background of historical beliefs, which affect the present views concerning family planning, for example the Blacks' preference for larger families and conversely the Whites' tendency of a two child family.

The relevance and importance of social workers, in the delivery of family planning is emphasised in the study. Social workers can help in diffusing information on family planning, not because they are technically more competent in the subject or more knowledgeable than others, but because "they are able to convey a sense of human warmth and build up the dignity of those whom they are dealing with". (Midgely, 1981, pp 134-137.)

To help in alleviating this population problem, a multi-disciplinary approach or team work is needed, i.e., for social workers to work in close collaboration with the medical team, specialist demographic research workers, administrators and statisticians. Team work implies that solutions to problems can be worked out as a group rather than by individuals and it is possible to arrive at a shared philosophy and to act as an organic entity.

1.1 Motivation For The Study

The motivation for this study came from the writer's

experience as a social worker for three years (i.e., from January 1980 to January 1983) in a rural area of Bophuthatswana, viz Taung. From statistics gathered by the writer during the specified periods as a social work practitioner in the Taung area, 80% of the total cases handled were those of family welfare services - specifically non-support cases. Of the women who presented the cases, 90% were said to be unemployed. They were relying economically either on their parents or their siblings, who had their own families as well to take care of. The women (85%) had more than five children to care for, mostly with different fathers, whose demands and needs could not be met because of their fathers not being able to financially support them. This, therefore, indicated a link between the size of the family and poverty.

Whilst applications were being handled for the biological fathers of the children in question to be requested to economically support their families, material assistance (i.e., relief supplies) had to be given out by the social worker because of the identified need. From what was then gathered, child bearing was used as a means to earn a living, which instead contributed in making these families poorer. Poverty and unemployment could then be attributed to over-population. From the total number of those cases handled, when advised by the social worker to use family planning methods to limit their families, 95% of the women

openly indicated their reluctance, on the basis of not having a liking for these methods.

It appeared, judging by the number of non-support cases handled of the said women, with the stipulated number of children, coming to the social worker for welfare (relief) supplies, and their responses on their attitudes to family planning, that there was widespread ignorance of and/or reluctance locally to use family planning methods. A literature search was made, concentrating on Black populations. Evidence was found to support the observation that Black African people in particular are reluctant to use family planning methods and the following reasons were cited by different researchers:

1.1.1 Many Blacks regard family planning advice as politically motivated. Blacks are afraid to be overwhelmed by Whites and eventually be swamped by them. Reinforcing this belief, it has been found that some of the birth control measures used on Blacks in South Africa are unsafe. Mabetoa (1982) citing Gordon (1981) reveals that "Depo provera" an injection prohibited for use in European countries and the United States of America is currently marketed in the third world countries. In South Africa the injection method is being used on Black and Coloured women only. It has been established that the injection is harmful to

breast fed babies because it can interfere with the production of antibodies. As a result of this irresponsible use of one contraceptive technique, many people refuse even to use the safest measures. (Mabetoa, 1982, pp 19-20).

1.1.2 Black tribal tradition encourages high fertility. The status of a woman is measured largely by the number of children she has born and there is little incentive to limit numbers as children have an economic utility in tribal societies. The practice of lobola or bride price makes girls and boys equally welcome in the family and polygamy ensures that almost every woman bears children. While family limitation is not part of tribal tradition, family spacing is strictly adhered to and is promoted by abstinence from sex relations during a prolonged period of lactation. (Unterhalter, 1977, p 178).

1.1.3 Fears among Blacks that contraceptive users become promiscuous thus contracting sexually transmitted diseases.

1.1.4 The existence of relatively high infant mortality rates among Blacks, makes high fertility necessary to replace children lost in the first years of life. Also, violence is common place in the Black

townships, so that parents must compensate not only for infant deaths, but deaths during adolescence and early adulthood. (Official Year Book of the R.S.A., 1984, p 29).

1.1.5 According to Shillington (1980) reluctance to use family planning methods is also attributable to the fact that there is "no best method". The reasons have been divided into two categories, viz physical and psychological factors.

a) Physical Reasons

Some women cannot tolerate an intra-uterine device, or they have had too many children for it to be effective. Others cannot take an oral contraceptive for medical reasons (high blood pressure, migrane etc). The diaphragm is also not suitable for all women due to anatomical differences.

b) Psychological Reasons

The oral contraceptive and the Depo provera injection are often thought to cause illness, which the woman may be experiencing. The lack of menstruation while using the injection method is also cause for concern among many

> Black women, as they feel they need proof (menses) that they are not pregnant. Many women feel that the cord from an intra-uterine device (I.U.D.) might damage their partner's penis - a fear which is shared by men also. The diaphragm needs some practice to insert and needs to be worn for eight hours after intercourse. The woman has to decide beforehand that she will have intercourse, or interrupts the proceedings to insert it, and this is distasteful to many women. (Shillington, 1980, p 4).

1.1.6 Despite recent advances, wages for Blacks are low and it is difficult for most parents to save for the time when they are no longer economically active. Parents as a result of this, have to rely on their children for financial support in their old age. Old age pensions are also generally inadequate in most Black countries.

1.2 Aims of the Study

Based on the writers own observation and perception of the problem and on the literature just referred to, the following aims for the study are constructed:

1.2.1 To identify the attitude of the sample population

towards family planning in the Taung area.

1.2.2 To investigate the feasibility of including social workers as members of an inter disciplinary team, in the delivery of family planning.

1.2.3 To inquire into the traditional beliefs of Blacks - the study population would be drawn from the local community which is predominantly Setswana speaking. To establish how these traditional beliefs might be having a bearing on their present attitudes to family planning.

1.2.4 To make a study regarding the relationship between attitude to family planning and existing socio-economic conditions in the area. Inter-alia the reasons which contributed to large South African families is the lack of material belongings and also the lack of sports and other facilities among poorer people makes the indulgence in sex more important than it is in more affluent homes. (Tiley, 1974, p 86).

1.2.5 To make an evaluation of facilities that exist for training personnel engaged in the field of family planning in Bophuthatswana.

1.2.6 Finally to try and find out which channels of

communication are most effective and should in future be used for disseminating information on family planning.

1.3 Assumptions for the Study

The basic assumption in this study is that there is a general unfavourable attitude to family planning in the Taung area. The term "unfavourable" as used in the study will mean negative, unsatisfactory and/or a disapproval.

Arising from this basic assumption it was proposed to test the following assumptions:

1.3.1 That the use of contraception is (or appears to be) the responsibility of the female. For example, all contraceptive devices or methods devolve on the woman, with only the exclusion of the withdrawal and the condom.

1.3.2 Since the investigation was restricted to women, it was assumed, that change in norms concerning fertility and the use of contraception as well as fertility will be reflected in changes in the woman's value orientation, change in contraceptive use in the case of the woman or her husband (as reported by the women) and eventually change in the fertility behaviour of the woman. (Lötter and

Van Tonder, 1976, p 4).

1.3.3 That success can be attributed to a family planning development programme, which attacks the causes of poverty and under-development rather than merely alleviating the symptoms.

1.4 Operational Definitions

1.4.1 Contraception

Any method whatsoever of avoiding conception except by means of sterilization and abortion. (Higgins, 1968, p.iv).

1.4.2 Family Size

The number of children a couple actually has, desires, expects to have or considers to be ideal. A further explanation of concepts from the definition follows:

1.4.2.1 Actual

The number of living children a couple has produced together, from the start of their relationship to the present time.

1.4.2.2 Desired

The number of children any particular couple initially had in mind but could not achieve because of certain unforeseen circumstances and reasons.

1.4.2.3 Expects

The number of children a couple expects to have in their completed family.

1.4.2.4 Ideal

This is the number of children that the couple/person feels the average couple of their particular ethnic group should have.

1.4.3 Family Planning Users

These are the women who, at the time of the study, were attending a family planning clinic for a second and subsequent visits and are presently using a family planning method.

1.4.4 Family Planning Never Users

These are women who, at the time of the study,

were not using any family planning method, and had not done so in the past and intend to remain so for good.

1.4.5 Family Planning Non Users

These are women who, at the time of the study, were not using any family planning method.

1.4.6 Family Planning Past Users

These are women who, at the time of the study, were no longer using contraception, but were once users at an earlier stage of their sexual life.

1.4.7 The Unmarried Mother

For the purpose of this study, the term "unmarried mother" refers to a woman who has conceived and given birth to a baby, without being married to the father of the child and who was not married to him at the time of the study.

1.4.8 Illegitimacy

Births resulting from sexual relations between a man and woman, who are not married to each other (Bezuidenhout, 1984, p.27).

1.4.9 Ethnic Group

The term ethnic group has come to mean any group within a traditional society that possesses elements of a distinctive culture, that are a source of solidarity among its members. In this study the Setswana speaking people will be considered as belonging to a separate group as compared to existing ethnic groups.

1.4.10 Rural and Urban

A typical rural setting is characterised by intimate relationships, and a prescribed status, and where the population density is relatively low. While an urban setting on the other hand is marked by contractual, impersonal and partial relationships, with a relatively high population density (Phillips and Williams, 1984, p.11).

Lastly, it must be remembered that all proclaimed towns in Bophuthatswana are regarded as urban and therefore government controlled, and all villages as rural and therefore privately or tribal owned and controlled.

CHAPTER 2

2. Research Design and Methodology

2.1 Introduction

This chapter outlines the type of the research design used in the study, orientation and planning, sampling, data collection, implementation of the study, interviewing procedures, results of the pilot study, the analysis of the data and limitations of the study.

2.2 The Research Design

The exploratory - descriptive design was used. This type of investigation becomes necessary when a poorly defined problem confronts the researcher. Often the researcher initially possesses little objective information about the nature of a problem and the possible factors influencing it. In such cases then, the researcher first must objectively describe the problem before studying its causation and prescribing treatment. (Arkava and Lane, 1983, p.190)

In one way or another, all research is connected with describing phenomena. In Social Work this descriptive function involves primarily the delineation of

characteristics of social systems, target problems and interventions. The descriptive function of research encompasses not only delineation of phenomena in a holistic fashion, (for example, 60% of the women in the Taung area are unmarried mothers) but also specification of how different parts are related (for example, the lower their income, the more likely they are to be single parents).

The logic of this function is to break wholes down into interconnected parts, to achieve a detailed picture. The researcher further tried to determine whether the presenting problem differed by ethnicity or marital status for instance. Although investigations of these relations might stimulate (or even be guided by) speculation about causality, the descriptive function delivers only information about the presence of association among factors. It does not determine causal connections. Thus, in the example given earlier we learn that income and single parenthood are related in a particular setting, but we do not know if low income was a cause or consequence of single parenthood.

2.3 Orientation And Planning

The orientation and planning of the study took approximately five months to complete. The main object was to get a clear idea of the family planning services in

both the Republic of South Africa and Bophuthatswana. During the orientation period, the study of literature was undertaken, including official statistical compilations, data released in annual reports of the various agencies and professionals from related fields were also consulted.

2.4 Sampling

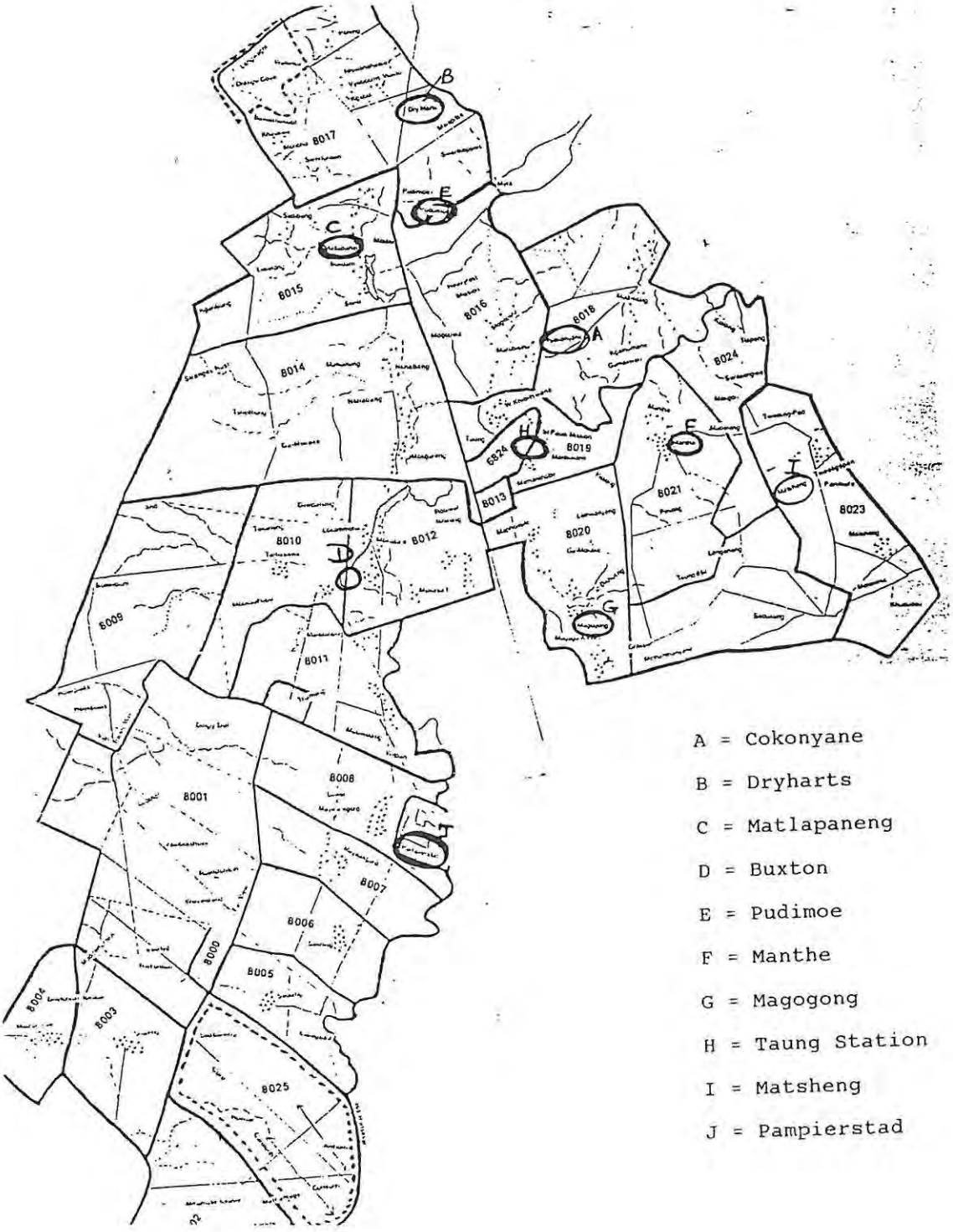
2.4.1 Choice of the Area

The interview was conducted in the Taung district, Republic of Bophuthatswana. (Figure 1 shows the Taung Map). Taung comprises approximately of 72 villages and 3 townships, viz Pampierstad, Pudimoe and Taung Station. The nearest village is approximately 1 kilometre away from the hospital which is Khibitswane village and the furthest village is approximately 60 kilometres away, which is Losasaneng village. The estimated number of house units in each village is approximately 120 with approximately 1000 households, while the estimated number of house units in each township is approximately 500 with approximately 2000 households.

Of the 75 areas in the district, 10 areas were included in the investigation, from both the tribal and the government controlled areas. The

Figure 1

Map Showing Location of Taung and the Selected Areas



selection included all three townships and seven villages which were chosen at random. All the households were listed and numbered and the Nth number was selected proportionally from all areas.

2.4.2 Subjects

A stratified random sample was used. Attention was focused on women in the study. This is in line with the assumption arrived at in 1.3.1. The woman also, is the one who ultimately bears the child and has to care for it, often without help. Women between the ages 14-45 years of age (these are regarded as child bearing ages in the Taung area) qualified for inclusion. The women, according to the study, were to be in the "high risk category" which included women who are in all probability particularly exposed to pregnancy. They could be married, or not married, but presently being involved in a cohabitation / courtship, not to have given birth to a child during the previous three months and not to have been pregnant at the time of the study.

2.4.3 Sampling Strategy

From the 1985 census report the total population of women in the Taung district within the age

range of between 14-45 years was given as approximately 50 000. The given figure yields a sample size of 200 which gives 95% confidence level and the expected rate of occurrence not to be over 5% or not less than 95%, with the accuracy level of ±3%. (Arkin and Colton, 1966, p.147).

2.5 Data Collection

To realise the aims of the study, an interview schedule was used. Several studies were consulted to aid in the design of this tool. The works of Connell (1985); Lötter (1977); Lötter and Van Tonder (1976); Fourie and Rall (1984) and Strydom (1983) were particularly useful. The objective of the interview schedule was to collect data from respondents on aspects of: Fertility norms, traditional and cultural beliefs, knowledge and use of family planning, the views of both the users and the non users of family planning.

The interview schedule used was structured. Both close-ended and open-ended questions were used. The interview schedule was used rather than the questionnaire technique, because it has the following important factors:

2.5.1 Advantages

2.5.1.1 Flexibility: Questions could be clarified and further information elicited through probing.

2.5.1.2 Response Rate: The interviewer was capable of eliciting information in large amounts and in greater depths. This type of instrument is particularly useful for obtaining data on topics that are complex, highly sensitive, emotive like family planning.

2.5.1.3 Question Order: It was ensured that there be control over question order, and that the respondents did not thwart the structure of the interview schedule.

2.5.1.4 Spontaneity: The interviewer recorded spontaneous answers. Spontaneous answers are more informative and less normative than answers about which the respondent has had time to think.

2.5.1.5 Respondent alone can answer: The respondent was unable to "cheat" by receiving prompting answers from others, or by having another complete the entire questionnaire, as often happens in mailed questionnaires.

2.5.1.6 Completeness: The interviewer ensured that all questions were answered.

2.5.1.7 The area under investigation is said to have a low literacy level, most selected respondents could

have experienced problems with a self administered questionnaire for example.

2.5.1.8 Postal services are very irregular in the area and are of extremely poor quality, hence the non reliance on mailed questionnaires. Against the advantages of the interview schedule there are, however, also disadvantages as well that need to be considered.

2.5.2 Disadvantages

2.5.2.1 Costs: Interviewing is expensive, either in terms of research time or research money.

2.5.2.2 Only a limited number of persons may be interviewed due to time and costs.

2.5.2.3 The interviewer may make subjective judgements about the responses, and thus bias the data.

2.5.2.4 The overall reliability of responses can be limited since respondents tend to answer truthfully those questions which are not embarrassing to them.

2.5.2.5 Interview responses are sometimes biased depending upon the age, sex, education, race, interview

experience, socio-economic level, and the religious background of the interviewer.

2.5.2.6 Finally, the question of anonymity: It is difficult to convince the respondent that his/her anonymity will be protected. The respondent knows that the interviewer knows who he/she is. If the interviewee is suspicious of the interviewer, or of the sponsoring institution, his/her answers will not be candid, especially when they touch upon matters the interviewee wishes to keep confidential.

2.6 Field Work

Field work was conducted during the months June and July 1987.

2.7 Interviewing Procedures

For purposes of interviewing people from different areas in the district, permission was granted by the local magistrate. Preliminary visits to the different areas were made by the writer. This was to acquaint the traditional leaders (chiefs and headmen) and the people from different areas about the purpose of the study and to get their cooperation. The major concern of the respondents was to be assured that confidentiality will be maintained.

Participation was wholly voluntary. With uncooperative selected subjects 30 minutes or less were spent by the writer establishing rapport and trying to explain in simple terms the purpose of the whole exercise and that there was no connection with the government whatsoever. Recording was done verbatim in the presence of the respondents.

2.8 The Pilot Study

A pilot study was undertaken with 20 respondents from two areas, viz one village (Cokonyane) and one township (Taung Station). The main aim was to check on any problems that might not have been anticipated concerning the respondents' understanding of the questions. The 20 respondents represented the two categories (i.e. family planning users and non users) of respondents to whom the interview schedule would be administered.

The pilot study helped the researcher to establish the time required to complete each interview schedule, which was 45 minutes or less. This made it possible to give the respondents in the sample an indication of how much time they would have to set aside for the interview. As a result of the pilot study, statements in the interview schedule (see Appendix, Section 3) in the main survey were rephrased to questions, because pilot respondents had tended to agree indiscriminately with all statements.

2.9 Data Analysis

For the analysis of the data, the B.M.D.P. Statistical Software was used. The B.M.D.P. (Biomedical Computer Programme) is designed to aid data analysis by providing methods ranging from simple data display and description to advanced statistical techniques. Data are usually analysed by an interactive "examine and modify" series of steps.

The B.M.D.P. programmes are organised so that problems to be analysed, the variables to be used in the analysis, and the layout of the data are specified in a uniform manner for all programmes. This permits different analysis of the same data with only minor changes in the instructions. The programme is arranged by the type of analysis appropriate to the data, for example, data description, frequency tables, analysis of variance, multivariate analysis, regression analysis etc. (Dixon et al, 1985, p.3). Variables presented were those most central to the goals of the study and were presented in tables. The contents of which were frequencies (raw scores) and percentages and measures of central tendency (averages) such as the mean. Univariate and bivariate or contingency tables were also used.

2.10 Limitations of the Study

While every effort was made to achieve the aims, (see 1.2) difficulties arose in the course of planning and of field work which limited the degree of success achieved:

2.10.1 It became apparent that to construct a statistically valid and reliable sample survey in order to ascertain the views of "the community" was desirable but impracticable. A limited probability sample was used. Only a selected group of women were interviewed. No attempt to explore male attitudes towards family planning is made in the study. This was inter alia because of the assumption arrived at, (see 1.3) as well as because of one of the disadvantages of the interview schedule mentioned in 2.5.2.1. No attempt is also made to explore the attitudes of social workers towards any aspect of family planning - this is mainly because during the time of the study, social workers in the Taung area were not actively involved in the delivery of family planning.

2.10.2 The researcher experienced lack of cooperation from some of the selected informants. There was lack of trust - as the informants were mistaking the interviewer for some government employee.

This, as a result, contributed in making the study expensive in terms of time used in creating rapport and explaining in simple terms the purpose of the research.

2.10.3 Some of the subjects selected could not be located easily because they were seasonally employed. Field work clashed with the harvesting period of mielies. This contributed in sample loss. It must lastly be remembered, that all research studies have limitations, usually for the reasons listed. Moreover, no author of a dissertation is without shortcomings.

CHAPTER 3

3. Formulation of the Problem

3.1 Introduction

The ability of a country to ensure an acceptable standard and quality of life for all its people is directly linked to the balance between its population size and the extent, replenishment and replacement of its available resources. When the population growth exceeds the availability of natural resources, the quality of life will inevitably become lower with a resulting detrimental effect on stability. (Schoeman et al, 1985, p.1).

The population of the world is currently expanding at the rate of 1,7% annually. Leon Tabah in (Faaland, 1982, p.199). The average expectation of life has risen, without a corresponding decline in fertility, which is responsible for the "population explosion" or simply stated overpopulation. Overpopulation may lead to malnutrition, under-nourishment and famine. This might lead to poverty, lack of educational facilities and concomitant ignorance and inability of greater achievement or of a greater contribution to economic growth and development. This in turn may further lead to diminishing opportunities for employment, unplanned urbanisation, uncontrolled pollution

of air and water, further deterioration and degeneration into slums, which again may lead to greater social decay, extra marital births, uncontrolled population and even greater poverty.

This vicious circle is the all important question which is at present forcing mankind to reflect, to come to its senses and to take urgent action. In the event of it becoming more difficult to give proper care to the growing population, and ever increasing number of human beings will, of necessity, be poorly fed, poorly clothed and equipped, as well as poorly housed. Under these conditions, uncertainty, confusion and revolution may occur, factors which will retard if not ultimately render impossible all human development and terrestrial life. (Van Rensburg, 1972, p.2).

Within a family context, the low socio-economic conditions caused in this case by overpopulation can also contribute to poverty which can form a vicious circle as well. Large poor families transmit in most cases behaviour patterns which create poverty, pathology and underdevelopment to their children. The part played by the process of socialization is central. Socialization in this study can be described as a process that leads to individuals acquiring ways of acting, thinking and feeling with other members of their culture or sub-culture. Socialization also involves the transmission of values, skills,

attitudes and pattern of behaviour from generation to generation.

The three major agents of socialization are considered to be the family, school and peers. Of these the family is held to be of crucial importance in that it deals with children in their earliest and most formative years. The child-rearing environment and practices are thought to shape their children's personalities. Indeed, it is often assumed that certain ways of adult functioning are related to particular child / parent experiences.

If the child-rearing practices are deficient, due to poverty caused in turn by large unplanned families, then the children will not develop into adults who can fit into the prevailing culture with all its opportunities for education and advancement. If one wishes to make any real changes, then the methods and environment of child bearing and rearing should be changed together with the prevailing poor socio-economic conditions.

It is not a high birth rate, the high population density or the rapid growth which causes concern, but their social and political consequences. A low birth rate is not a value in itself to which all other values should be subordinated, but merely one of the instruments through which a nation can achieve vital national ideals. A population policy must, therefore, be rooted in a nation's

ideals, in other spheres of its existence and must have a bearing on such values as peace, security, fairness, the standard of living, economic development, distribution of income, pollution, health and education. (Van Rensburg, 1972, p.90).

In this study the problem of the acceptance of family planning will be analysed, bearing in mind the following related problems: population growth in the Republic of South Africa and the independent state of Bophuthatswana.

3.2 Population Growth in South Africa

Reference is made to the Republic of South Africa because the Republic of Bophuthatswana, although said to be independent, is within the Republic of South Africa and still part of it. The South African population presently grows at a rate of 2,3% per annum (Whites 1,5%, Coloureds 1,8%, Indians 1,76% and Black 2,8%). If this growth rate were to continue, the present South African population of approximately 28 million would increase to 47 million in the year 2000, to 79 million in 2020 and 138 million in 2040. (Schoeman et al, 1985, p.1). Table 1 depicts this projection.

Table 1

PROJECTIONS FOR THE SOUTH AFRICAN POPULATION IF THE RATES OF POPULATION GROWTH ARE MAINTAINED (in millions)

	Present Growth per Year	1980	2000	2020	2040
Whites	1,55%	2,53	3,79	5,40	7,03
Coloureds	1,80%	4,40	5,81	6,64	7,57
Asians	1,76%	0,81	1,16	1,55	1,99
Blacks	2,80%	20,70	36,40	65,60	121,60
Total Population	2,3 %	28,44	47,16	79,19	138,19

(Schoeman et al, 1985, p.1)

3.2.1 Phases of Population Growth

The different population groups undergo different stages of demographic transition, i.e. phases of population growth.

3.2.1.1 Traditional Phase

The two most important characteristics of this phase are the high birth rate, but also a high mortality rate. Consequently the population growth remains relatively low. All population groups in South Africa have moved through this phase.

3.2.1.2 Pre-Modern Phase

While there is still an exceptionally high birth rate in this phase, the mortality rate has decreased. The difference between births and deaths widens with a resulting population explosion. The reason for a declining mortality rate can be attributed to various factors, such as improved health services and education. The White population has already reached the modern phase, Coloureds and Indians have progressed much further through the pre-modern phase than has the Black population. Table 2 shows the mortality rates of Blacks.

Table 2

THE MORTALITY RATES OF BLACKS

OPSOMMING VAN LEWENSTATISTIEKE: KOERSE EN VERHOUDINGS

- SUMMARY OF VITAL STATISTICS: RATES AND RATIOS

AAR EAR	Ru-koers - Crude rate			Sterfgevalle-Deaths		Kindermortaliteit Infant Mortality	
	T	M	V-F	Manneverhouding Masculinity	Betreklike verhouding Relative ratio	Persentasie van alle sterfgevalle Percentage of all deaths	Masculinity
1968	..	..	..	1 457	..	31,7	1 146
1969	..	..	..	1 447	..	31,2	1 118
1970	10,8	11,4	10,2	1 455	1 118	29,8	1 097
1971	..	..	..	1 501	..	29,7	1 079
1972	..	..	..	1 343	..	29,2	1 064
1973	..	..	..	1 474	..	27,9	1 101
1974	..	..	..	1 405	..	27,9	1 057
1975	..	..	..	1 591	..	24,7	1 129
1976	..	..	..	1 652	..	22,5	1 105
1977	..	..	..	1 607	..	23,5	1 118
1978	..	..	..	1 507	..	25,4	1 095
1979	..	..	..	1 454	..	24,7	1 106
1980	..	..	..	1 449	..	22,3	1 043
1981	..	..	..	1 497	..	19,8	1 071
1982	..	..	..	1 574	..	18,5	1 126
1983	..	..	..	1 577	..	17,4	1 083
1984	..	..	..	1 520	..	17,9	1 077

(GOVERNMENT PRINTER PRETORIA) : REPORT No. 07-05-07

3.2.1.3 Modern Phase

> This phase is said to be characterised by both a low birth and low mortality rate. Consequently the population growth remains low or becomes stationary. Most of the so-called first world countries have reached this phase and in South Africa the White population has moved into the modern phase. (Schoeman et al, 1985, p.2).

3.3 Population Growth in Bophuthatswana

With the Republic of Bophuthatswana, the focus of attention in this study, the entire nation according to the 1985 census was 1 740 600. From the total number of people living in the country, 1 170 300 are the Batswana people grouped into different autonomous tribes. The remainder are members of ten Black ethnic groups. The White population in the country comprises of 5 668 people. (Bophuthatswana, 1985, Statistics).

According to the 1985 census report, the population for the Taung area was given as 152 000 people. From the given figure 133 745 are the Batswana people; the Xhosas formed 8 641; South Sothos 4 604; Zulus 941; Swazis 141; North Sothos 1 273; Shangans 219; Vendas 32; other Blacks 270; Whites 111; Coloureds 1 272; Asians 10; those unspecified

345. (Bophuthatswana, 1985, Statistics). According to the report there are a total of 66 883 males and 85 117 females in the area.

From the given figures it is evident that women in the Taung area are in the majority, presumably because of the high rate of migration by men. The emigrating rate per year for example in the area during the year 1980 was calculated at 1,17%. The high rate of emigration is due in turn to the high rate of unemployment reported in the area. Migration to South Africa has been described by Hobart Houghton as quoted in Böhning (1981) as "an evil canker at the heart of the whole society, wasteful of labour, destructive of ambition, a wrecker of homes and a symptom of a fundamental failure to create a coherent and progressive economic society". (Böhning, 1981, p.74).

On the other hand migration can serve as a link between the wage sector and the rural homestead, providing the main source of cash income for approximately two thirds of the homesteads at any given time, yet it is much more complex a factor than a simple "push" to provide the necessary support for the dependent family. The migrant labour system separates husband and wife during their sexually active years. Most men visit their wives once a year for two weeks only. Thomas (1974) as quoted by Mabetoa (1982) describes the effects of such life as follows:

> Broken marriages, desertion and faithlessness are distressingly common and the reason is clear. It is fundamental to realise that African relationships, as in all cultures, depend on loyalty and affection. These bonds in turn depend upon mutual support and comfort, on shared experiences and responsibilities and companionships. All three must be sacrificed when the man goes away for long periods, becoming virtually a visitor to his own home. Many ties become undone. Human relationships are sensitive and separation makes them vulnerable, and provides a fertile ground for faithlessness, jealousies and suspicions, accusations, real and imagined. (Mabetoa, 1982, p.38).

The report further indicates that from the total number of people in the area, 139 108 were reported to be without work. The given figures from the Republic of South Africa and those of Bophuthatswana clearly indicate that there is a high population growth in the country. Much has been said about the results of the population explosion and it is clear that there are considerable differences of opinion with regard to its effects on individuals, the community and the environment.

3.4 The Rate of Illegitimacy

In the Republic of South Africa, exact figures of the extent of unplanned pregnancies and illegitimacy are not recorded and as a result not known, especially with regard to Blacks. In Bezuidenhout (1984) the extent of illegitimacy in South Africa is given according to the Whites, Coloureds and Asian people only. This will, however, be used, as an aid in giving a picture of the extent and nature of the problem. Table 3 shows the number

of White, Coloured and Asian illegitimate births out of the total live births in South Africa for the years 1970-1980.

Table 3

ILLEGITIMATE BIRTHS AS A PERCENTAGE OF TOTAL LIVE BIRTHS IN THE RESPECTIVE POPULATION GROUPS IN SOUTH AFRICA, 1970-1980

Year	White	Coloured	Asian
1970	3,0	43,1	6,7
1971	2,9	43,3	8,7
1972	3,0	43,5	6,7
1973	4,1	45,9	9,7
1974	4,2	47,0	14,2
1975	4,1	49,6	15,1
1976	4,5	51,0	15,7
1977	4,5	50,3	12,9
1978	4,6	49,2	11,3
1979	4,8	53,1	13,1
1980	5,0	51,7	14,8

(Bezuidenhout, 1984, p.41)

According to Table 3 when comparing the various population groups with each other, the percentage of illegitimate births among Whites is low, while the Coloureds' percentage of illegitimate births has exceeded the legitimate birth rate. From the table also, there is a general tendency for illegitimate births to form a gradual increasing percentage of all live births.

Table 4 shows the ages of White, Coloured and Asian mothers as a percentage of illegitimate children, in South Africa, 1980.

Table 4

AGES OF WHITE, COLOURED AND ASIAN MOTHERS OF ILLEGITIMATE CHILDREN IN SOUTH AFRICA, 1980

Age of Mother (years)	White	Coloured	Asian
Less than 15 years	0,6	0,5	1,0
15 - 19 years	37,9	37,9	22,8
20 - 24 years	38,9	41,3	34,2
25 - 29 years	12,3	17,7	22,7
30 - 34 years	6,9	7,9	11,9
35 years +	3,3	4,8	7,5
N	3711	37709	2922

(Bezuidenhout, 1984, p.42)

Table 4 shows that the age distribution of mothers of illegitimate children is very much the same for all population groups. There is, however, a difference regarding age below 19 years of age and younger in respect of the various population groups. There is also a significant increase in illegitimacy as regards the 20 - 24 year age group among the Coloureds, as compared with the White and Asian population groups.

Table 5

TEENAGE PREGNANCIES RESULTING IN ILLEGITIMATE BIRTHS IN THE WHITE, COLOURED AND ASIAN POPULATION GROUPS IN SOUTH AFRICA 1974 - 1980

Year	Coloured	White	Asian
1974	29,2	21,0	16,3
1975	29,8	21,0	16,4
1976	30,3	22,5	16,3
1977	28,3	22,0	15,4
1978	30,2	24,6	15,3
1979	38,4	29,8	27,3
1980	38,5	28,4	17,9

(Bezuidenhout, 1984, p.43)

As can be seen from Table 5, the illegitimacy among the Coloured population group is high and has also been steadily increasing. Illegitimacy according to Bezuidenhout (1984) is not only a deviation from family norms but it is also strongly associated with disorganised families, which again is associated with disorganised areas. The Whites live in more organised and Coloureds in less organised areas, because on the whole the Whites are found in the higher socio-economic scale. We would therefore expect Black family life to be more disorganised and because of this disorganisation a higher incidence of illegitimacy is expected than among other population groups. (Bezuidenhout, 1984, pp.41-43).

At the Taung Community Hospital it has been reported that during the year 1985, there was a total of 2 343 maternity deliveries. Forty five percent of these deliveries were first pregnancies. Of the women in their first pregnancy 60% admitted openly when interviewed by the hospital based social worker not to have planned their pregnancy. The average age of the women in their first pregnancy in the hospital was given as 19 years and six months, which points to a significant number of unwanted teenage pregnancies. (Taung Community Hospital Annual Report, 1986, p.12).

3.5 Problems associated with frequent and unplanned births within the context of a stable relationship

3.5.1 Health Problems

A father who must support a large family has, in most cases, more worries and will be more overworked than the father who needs only to support a smaller family. At times he may even have to take a part time job together with his normal job, just to keep things together. He may also not have enough of the necessary foods to keep him strong and healthy.

On the other hand the health of mothers with large families, especially when pregnancies are too frequent, is generally poorer than the health of mothers with well planned families. The chances of

miscarriages are greater if the mother has had babies year after year. At the Taung Community Hospital, it is reported that from the number of the total admissions, 40% are maternity cases. Thirty three percent of these cases, consisting mostly of third and subsequent deliveries, are complicated cases resulting in still births. (Taung Community Hospital Annual Report, 1986, p.13).

3.5.2 Economic Problems

Presently prices are rising almost daily and it is difficult even for a well to do couple to feed, clothe and even educate their children as they would have wished. The cost of living is becoming so high that people cannot afford large families.

As an illustration of the high cost of living, according to the official consumer price index, the cost of living increased throughout the 1960's at a relatively low rate of 2,6% a year. Since 1970, there has been an acceleration in the rate of inflation and during the ten year period (1971-1980) there was an average increase of 11,2% a year in the general price level of consumer goods and services. During the first three years of the 1980's the average annual rate of increase accelerated further to 14,6%. In 1983 it dropped to 12,3%. In explaining the

acceleration in inflation, cognisance has to be taken of factors such as unfavourable climatic conditions in agriculture which has had an adverse effect on food prices. (Official Year Book of the R.S.A., 1984, p.350).

The consumer price index (C.P.I.) rose steadily in 1984 to peak at a year on year increase of 13,25%. The food index rose by 11,6% in the same period. Price increase during 1984 included a 16,6% rise in the price of brown bread to 42 cents and an 11% rise in that of white bread to 60 cents in February 1984. Following the increase in the price of maize, African consumer bodies said that a price increase in "the most essential foodstuffs for people in the lower income bracket, would make African poverty unbearable". (Cooper et al, 1985, p.240).

3.6 The Rate of Back Street Abortion

Some people, especially those in the rural area like Taung, oppose sex education in schools and teenage contraception, lest they arouse sexual curiosity and stimulate premarital sexual intercourse. However, disclosure about school girls pregnancies and back street abortions in South Africa has come to light and lack of sex education at schools is blamed.

According to the Abortion and Sterilisation Act No 2 of 1975, abortion is defined as "the abortion of a live foetus of a woman with intent to kill such foetus" (Strauss, 1984, p.93). Abortion may be procured by a medical practitioner only. The act further gives the following six indications:

1. Where the continued pregnancy constitutes a serious threat to the woman's mental health, and is of such a nature as to create the danger of permanent damage to her health and the abortion is necessary to ensure her mental health.
2. Where the continued pregnancy endangers the life of a woman.
3. Where the continued pregnancy constitutes a serious threat to the woman's physical health.
4. Where there exists a serious risk that the child to be born will suffer from a physical or mental defect of such a nature that it will be irreparably seriously handicapped.
5. Where the foetus was conceived in consequence of rape.
6. Where the foetus was conceived in the incest.

An abortion not falling within these provisions, constitutes a criminal offence and is punishable by a fine not exceeding R 5000 or imprisonment not exceeding five years. (Strauss, 1984, p.93).

It is difficult to know exactly how many abortions are performed annually especially in the so called rural areas, where cases are mostly not reported and or recorded. However, some idea may be obtained by examining accessible statistics for the hospital treatment of septic or incomplete abortions in various parts of the country.

In the Johannesburg area, between 1959 and 1964, there were 302 deaths (on police records) from illegal abortions. Baragwanath Hospital in Johannesburg sets up two special wards during weekends for the handling of incomplete abortion patients. At Groote Schuur Hospital in Cape Town, 1820 septic abortion cases were admitted in 1970, and these represented almost 30% of all admission to the department of gynaecology which maintains a special septic abortion unit. This unit has the highest bed occupancy and the greatest patient turnover of all wards in the hospital. At the King Edward VIII Hospital in Durban, approximately 4000 septic abortions are treated annually and there is at least one death a month. Hospital records of course, only indicate the number of back street abortions which are unsuccessful and which result in sepsis or death, they reveal only the tip of the iceberg. (Oosthuizen et al, 1974, pp. 115-116).

According to a report released by the Department of Health and Welfare in May 1985, nearly 30 000 operations for the residue of pregnancies were performed, from December 1983

to October 1984. Back Street abortion then, by virtue of its high incidence and its danger, is responsible for an enormous amount of physical and psychological suffering amongst women. It has a high death rate; it results in sterility in one out of every four to five cases treated in hospital; it causes chronic ill health in a high proportion of cases; it is associated with psychological disturbance which may be severe and long lasting, these are mainly disturbances attributable to guilt or anxiety, but may take other forms, for example, the inability to form subsequent heterosexual love relationships. Of interest to be noted is that the psychological effects of legal abortion where they occur are relatively mild and of brief duration. (Oosthuizen et al, 1974, p.116).

Abortion whether legal or not, will not in this study be regarded as any form of family planning method (contraception), but instead as an effect or end result for not using, nor properly using any form of contraception.

3.7 The Rate of Malnutrition and Malnourishment

The cost of raising a child these days is extremely expensive. Not only do large families put a stress on the family budget, but one sees a health care problem increasing proportionately to family size. Poor physical growth is noted in siblings of large families because of lack of proper food.

Comprehensive data regarding the nutritional status of Southern Africa is basically non existent. The only indicator of the nutritional status one gets is from the isolated surveys that overseas agencies conduct and report on. In Griesel (1980), it was estimated for instance that on the average 3% of the population in South Africa, under the age of five years suffer from diseases like kwashiokor, pellagra and beri-beri. Although South Africa is said to have produced 25 000 kilojoules per capita per day and 147 grams of protein per capita per day during 1976, a too large proportion of the population still suffer from the various forms of malnutrition. According to Griesel (1980), by making use of different surveys a reasonable picture of the overall situation can be pieced together. In a survey done during 1971 and 1972 in a Black community in the Northern Transvaal, between 30% and 40% of diseases associated with vitamin deficiency was reported in pre-school and school children. Potgieter as cited in Griesel (1980) in his study at Kalafong Hospital with malnourished children admitted between the periods March 1977 to February 1979, reported the following as possible contributory factors: That the mothers may have been unmarried, unsupported, unemployed and uneducated; that the child may have been unplanned and unwanted and as a result conditions are unwarranted in the society. (Griesel, 1980, pp.1-15). It is reported at the Taung Hospital that 50% of all the children admitted, are suffering from kwashiokor and pellagra, which remain major health problems. These

diseases are also reported to be major causes of infant mortality rate at the hospital. The hospital based social worker revealed that 70% of these children are from large, mostly poor families. (Taung Community Hospital Annual Report, 1986, p.10).

3.8 The Absence of Services of the National Family Planning Programme in the Taung Area

A national family planning programme is important and the following principles are normally set down: That every child has a right to be wanted by parents and have a right to decide on the number of children that they want, all people have a right to obtain scientific information on the control of conception and the treatment of infertility, under professional direction; all children have the right to scientific sex education and later to adequate marriage preparation. Furthermore, many programmes urge that colleges and universities should train professional staff to help people in these matters and recognise that scientific research in the field of sex and human fertility and the development of reliable contraceptive measures, which can be universally accepted, is urgently necessary. Malcolm Potts in (Potts and Wood, 1972, p.24).

According to Rapoport (1970), family planning as a field of endeavour has many basic concepts built into it. One key concept is the regulation of fertility by preventing

unwanted pregnancies, by spacing the number of children desired. This gives families mastery over their reproductive functions and enlarges their capacity for choice and self-direction in individual and private family goals. Self-determination, choice and effectiveness in family planning are important ethical and behavioural considerations. Family planning is also embedded in the health matrix and seeks to make an impact on foetal wastage, prematurity, maternal mortality and morbidity and child health. It is also rooted in concepts of social and psychological well-being in its emphasis on strengthening the quality and stability of family life, thus, it becomes a measure for positive mental health. Family planning objectives include not only conception control but also help with problems of infertility. Thus, family planning deals with the promotion, postponement, and prevention of conception. In essence then, family planning deals with the vital concern of fertility control via individual and family behavioural acts which will help produce wanted and planned children. (Rapoport, 1970, p.28).

Family planning policy is being urged for the following reasons: To assure that every child is wanted; to free women from the drudgery of chronic pregnancy and the requirement of bearing a child against their wills; to reduce child dependency, i.e., to cut public welfare costs; to reduce the social costs of child rearing; to reduce poverty; to prevent illegitimacy; to foster the health and

happiness of families by spacing pregnancies; to encourage families not to have more children than they can afford; to enhance family well-being by reducing the size of families; to protect maternal health; to prevent defects through reduction of births to every young or older mother, and to others who are at risk, and through genetic counselling; to offer every couple the opportunity to realize the size of family to which it aspires; and to control total population. Irwin Sanders in (Kendall, 1971, p.45).

In 1952, India was the first developing country to start an organised national family planning programme. Other developing countries soon followed. The result is that today more than 80 developing countries have programmes, 26 of these with programmes are in Africa (this includes the Republic of South Africa). Only three of the 13 countries in the southern part of Africa do not have programmes. In the Republic of South Africa, a national family planning programme was implemented by the government in 1974, as a responsibility of the Department of Health, now the Department of National Health and Population Development. (The Nurse and Family Planning Modules, R.S.A., 1980, p.13).

In the Republic of Bophuthatswana the office of the national family planning association, a voluntary body, is in Mafikeng. Sub offices are established at the following

places: Moretele and Odi in the eastern region; Lehurutshe, Mankwe and Madikwe in the northern region. Offices of this nature are not yet established in Taung, Ganyesa, Kudumane and Thaba Nchu. The Association's services are definitely needed in the Taung area, because of the nature and extent of the problem already highlighted. Based on the broad policy guideline of "active community involvement", the Association utilises the readily available community resources of "Bathusi" (helpers), in distributing educational material and condoms, and in informing local people about family planning generally. Their policy makes the Association extremely important as part of a national birth control programme.

According to Rapoport (1970) there is a great compatibility between social work and family planning at a level of more instrumental values in regard to enhancing, strengthening, and preserving of family life, which are central concerns to social work. (Rapoport, 1970, p.34). The direct contribution the social worker can make to family planning is centered primarily on his attributes and skills as a practitioner. By virtue of their professions, social welfare personnel are human relations specialists and are involved in the daily lives of individuals, families, and communities at large. They are aware of the culture, mores, traditions, and taboos influencing family lives. They are familiar with family motivations, attitudes, reactions, and potentialities. They are qualified to advise on intimate

areas of social relationships, psychological problems, and cultural inhibitions and values that have a direct bearing on the success or failure of population planning programmes. (Kendall, 1971, p.87). The following have been listed in Kendall (1971) on the social work contribution to family planning services: Knowledge of social, emotional, and cultural characteristics of individuals and population as influencing social functioning - specifically translated into the human and social requirements of daily living; a systematic and practical approach to problem-solving that works equally well in identifying anticipated problems in programmes and services; a knowledge and art in communication with individuals and groups that permits a more effective transmission of information and the reduction of resistances to utilizing services; an ability to serve as coordinator, mediator, enabler, advocate, administrator, educator, and in several other roles for which the situation may call. (Kendall, 1971, p.45).

On the other hand, the social work profession provides the scholarly, scientific approach to decision making in family planning, not from the use of high pressure salesmanship and the use of scare tactics, but from sound choice among alternative behaviour patterns. Through the application of sound methodology the individual is helped to enlarge his capacities for life and experience, and to meet crisis situations, calling into play his capacities to cope with problems in other areas of life. Social workers also have

the skills to facilitate the implementation of family planning programmes through social action. They are concerned with women in the professions and in the labour market, so that they may find satisfying roles other than or in addition to child bearing and rearing. They should continue to work for general reforms that will provide medical care, job opportunities, and education in order to reduce poverty. Poverty should be viewed not only as a condition of economic insuffiency, but also as a matter of social and political exclusion, non participation in decision-making on matters that affect the individual, and eventually erosion of self-respect. (Florendo, 1973, p.33).

All methods employed in problem solving in social work are relevant to family planning enterprise. Community development is growing rapidly as a significant method of intervention used by social workers in family planning. Strategies for social change including political action receive major attention. (Rapoport, 1970, pp.34-35). The people at the grassroots level should experience an improvement both in their socio-economic and constitutional position and in their physical environment. The main aim of community development in family planning is to afford individuals and communities the opportunity to involve themselves in grassroots development aimed at the enhancement of the quality of life. The specific goals of the national community development strategy are the following: The promotion of community involvement and

community participation with a view to the upgrading of socio-economic conditions; the development of human potential and the mobilisation of resources in and around communities to the advantages of those communities; the promotion of self-help programmes that will encourage and stimulate community responsibility and community initiatives; the recognition and protection of the human dignity of all people; the promotion of preventive and development programmes; the coordination of all development actions at the local and regional levels; the establishment according to need, of services and organisations that will sustain and augment progress; and lastly the improvement of the basis of authority within communities.

However, to be noted is the fact that even if the national family planning programmes are said to be effective, it is not easy to measure scientifically to what extent they are successful. The National Health and Population Development Department (R.S.A.) with their programme, more advanced than that of the Republic of Bophuthatswana, reported that one way of measuring progress and success of the programme has been through the attainment of clinic attendance objectives. The objective is determined by assessing the actual average monthly clinic attendance of the previous year and adding a realistic expected percentage growth for the year. This additional growth expectation differs from region to region, depending on the expected extension of services in terms of both quantity and quality. A minimum

of 8% increase in recorded clinic attendance is expected per region per year. It is reported that in some regions a growth in excess of 15% has been achieved in monthly clinic attendance. (Privately communicated with the Director General, National Health and Population Development, on the 26th June, 1986). This clearly illustrates that progress is being achieved in having these programmes accepted.

CHAPTER 4

4. Broad Trends in Overpopulation, Family Planning and Attitudes

4.1 Introduction

The main purpose of this study is to look into the attitudes of the rural Setswana speaking people towards the usage of family planning. This is to be viewed against the people's cultural background. The writer aligns herself with the views of Horton and Hunt (1984) who pointed out that innovations are most readily accepted when they fit with the existing culture. However, it must be borne in mind that not all innovations mesh so well. Innovations may be incompatible with the existing culture in at least three ways:

4.1.1 First, the innovations may conflict with existing patterns. When this happens, there are at least three possible outcomes, viz, it may be rejected; it may be accepted and the conflicting cultural traits modified to fit it; it may be accepted and its conflict with the existing culture may be cancelled and evaded by rationalisation.

4.1.2 The innovations may call for new patterns not present in the culture.

4.1.3 Some innovations are substitutive, not additive and these are less readily accepted.

It is common practice that whenever the nature of the choice is such that one cannot have both the new and the old, the acceptance of the new is usually delayed. (Horton and Hunt, 1984, p.21).

The most important concepts to be dealt with briefly are overpopulation, family planning and attitude.

4.2 The Concept: Overpopulation

The concept overpopulation is regarded as a contributory factor to poverty, which is said to be prevalent in the Taung area, and also a motivation for the study as stated in the first chapter. A clear meaning of the term has to be known. As used in this study, the term "overpopulation" is defined as a state of society in which there are too many people for economic efficiency, in other words too many people for the society to live at the highest level that is possible with existing land and capital and existing technical skills. The definition implies that if the population had not grown so large its members would be individually better off, but it does not necessarily imply

that if the population were to become smaller, highest living standards would be immediately possible. (Political and Economic Planning, 1955, p.90).

4.3 The Concept: Family Planning

As stated also in chapter one, family planning is seen as an important but not the only strategy in combatting the interrelated problems of population growth and development. The concept has to be viewed broadly and not narrowly in terms of preventing conception only.

The modern term for the measures taken to achieve family size aspiration is family planning. For many, the earlier and better known phrase "birth control" (the two terms are synonymous) became associated only with preventing pregnancies. As now used, both, in general scientific discussion and in this study, family planning includes measures to delay and prevent pregnancies, to overcome infertility, to permit adequate intervals between births and to ensure that only wanted births take place. ((Hymovich and Barnard, 1965, p.169). A further explanation of concepts or elements from the definition of family planning is as follows:

4.3.1 Delaying: Of the first pregnancy for a young couple, that is postponing the first pregnancy until they are financially and psychologically ready for the baby.

4.3.2 Spacing: Of the children, this implies that a woman does not fall pregnant every year. She will also have a chance to regain her strength and get used to the new baby before she falls pregnant again.

4.3.3 Stopping: When the desired (wanted) number of children has been reached. The couple should decide together how many children they can afford to feed, clothe and educate. For many people a smaller family means a better, brighter future.

4.3.4 Helping: Couples who have difficulty in achieving pregnancy, by referral to infertility clinics or other places like the hospital where such people can get advise. Under "helping" three classes of those who need help are distinguished, viz, those with:

4.3.4.1 Primary Infertility: The woman who has never conceived despite cohabitation and exposure to pregnancy for a period of two years.

4.3.4.2 Secondary Infertility: The woman has previously conceived, but is subsequently unable to conceive.

4.3.4.3 Pregnancy Wastage: The woman is able to conceive, but unable to produce a live birth (The Nurse and Family Planning Modules, R.S.A., 1980, pp.44-45).

4.4 The Concept: Attitude

The basic assumption in this study as given in 1.3 is that there is a general unfavourable attitude to family planning in the Taung area. If the assumption is accepted at the end of the study, the aim will then be to try to come up with ways of changing the prevailing attitude to a more positive one. Thus, the importance of knowing what attitudes are, and how attitudes are formed is vital, to be able to work towards attitude change. Attitude may be defined as "... a well established mental set which predisposes a person to evaluate something favourably or unfavourably. Attitudes are composed both of emotional elements of liking or disliking and cognitive elements that identify the objects' qualities". (Silverman, 1978, p.501).

"Attitudes (are) enduring systems of positive or negative evaluations, emotional feelings and pro or con actions and tendencies with respect to social objects." Brehm in (Greenwald et al, 1968, p.362).

Most modern definitions of attitude have emphasised cognitive, affective and behavioural components. The cognitive part refers to what a person believes about something or a class of things. The affective part refers to how much one likes or dislikes the attitude object. The behaviour component refers to how one is inclined to act towards the attitude object. Clearly, the expectation is that there are consistent relationships among these components or they would not be part of the same construct.

4.4.1 Aspects of Acquiring Attitudes

There are four important aspects of acquiring attitudes, viz:

4.4.1.1 All attitudes are learned, they do not magically appear as a person matures physically. Attitudes are acquired through direct instruction, by taking on the attribute of someone a person loves or admires (identification), and by adopting social roles such as pupil-teacher, husband-wife, doctor or mechanic for example.

4.4.1.2 All attitudes are continually open to modification and change. Attitude change is

the acquisition, reversal, or intensification of an attitude. Once attitudes are learned, they are not written in concrete terms, but rather are continuously modified according to the persons' experiences.

4.4.1.3 The learning and modification of attitudes have their origins in the interaction with other people. The interaction can be direct or indirect. It is, however, always within systems of human relationships that attitudes are learned and modified.

4.4.1.4 Acquiring and modifying attitudes is a dynamic process in which other people confront the person with expectations as to what are appropriate attitudes, at the same time the person is struggling to increase his or her competence in dealing with the environment by seeking out attitudes that appear to be helpful. Goldstein in (Kanfer and Goldstein, 1980, pp.60-61).

From the assumption that there is in the study an unfavourable attitude to family planning in the Taung area, the concept "family planning" is the dependent variable, "attitude" the independent

variable and "unfavourable" the intervening variable. This assumption has its origin in the views of most people in third world developing countries, that normative and psychic costs of contraception affect or delay its acceptance or adoption. The normative and psychic costs of contraception comprise of beliefs or attitudes, learned or formed by communication and interaction with others or by first hand experience. These will be grouped into six major categories.

4.5 Normative and Psychic Costs of Contraception

4.5.1 Contraception as a threat to cultural values and norms: As non conforming with religious and moral beliefs and as socially illegitimate behaviour.

4.5.2 Contraception as a challenge to social institutions and group values and norms: As causing disharmony with the extended family system; as requiring communication about sex between spouses; as provoking discord between spouses and as undermining family security and status.

4.5.3 Contraception as foregoing perceived benefits of child bearing: As a threat to self-fulfillment and security in the family role; as a loss of enjoyment of children; as making the family vulnerable to infant mortality.

4.5.4 Contraception as behaviour inconsistent with personal values and norms: As implying "inner control" or "efficacy"; as a threat to sex roles and sexual adjustment and as violating modesty and privacy in sexual matters.

4.5.5 Anxiety costs of practising contraception: Anxiety about temporary side effects; fear of permanent damage to health and anxiety about contraceptive failure.

4.5.6 Psychologistics: Perceived inaccessibility of contraceptive services. (Bulatao et al, 1983, p.153).

Generally, and in this study, it is believed that the use of family planning follows rather than precedes the process of modernisation and rising socio-economic standards. The question normally asked by researchers of family planning is "whether family planning programmes can effect a change in fertility, without a corresponding change in social and economic institutions". (Lonsdale, 1974, p.231).

In other words, there is a close relationship and interaction between the environment and the individual. A cause-effect and an effect-cause relationship obtains

which forms a chain reaction. It therefore depends during intervention where one would like to break the chain. No universally acceptable standards can be arrived at or prescribed, as far as different fertility programmes are concerned in different societies. As a way of illustration, progress is said to be noted and evident in China in as far as their family planning programme is concerned.

4.6 Model for Progress: China People's Republic, 1957 - 1971 Malcolm Potts in (Potts and Wood, 1972)

Family Planning programme in China is said to be there for the following reasons, viz: The need to regulate family size in order to create a socialist country for socio-economic reasons - to create time for the mother to work and study; to ensure the best conditions under which to educate the coming generation and to regulate family size because of its impact on the domestic economy, medical indications (the need to plan birth, in order to have healthy children and mothers) do not dominate family planning thinking in the way they do in most other programmes or on the work of international agencies such as the "World Health Organisation". The following policies have been enacted:

4.6.1 Age of Marriage

The age of marriage for Chinese girls used to be in the mid-teens, as is the pattern in all communities with extended families. In 1950 the minimum legal age was raised to 18 years for girls and 20 years for men. In 1956 a further rise was discussed but not implemented. According to Potts and Wood (1972) a rise in the age of marriage in a developing country contributes to demographic goals, and is socially useful provided it is accompanied by premarital sexual restraint or the provision of effective contraception to young people. China appears to have opted for chastity.

4.6.2 Contraceptive Methods

The unique aspect of the Chinese programme is that it has encouraged all possible methods of fertility limitation, from endeavouring to raise the age of marriage, through the commercial distribution of contraceptives, to induced abortion. There also does not appear to have been emphasis on a particular method or groups of methods, that has so often marred family planning programmes in other countries. A once a month pill and an injection are said to be under trial. A pattern of injection in which later doses are spread out at greater

intervals than early ones has been used. This device may overcome the problem of amenorrhoea (probably due to an accumulation of hormone with successive injections) which has been noted in many western studies.

4.6.3 Legal Abortion

In May 1957 the abortion law in China was reformed to permit terminating of pregnancy in the first three months, provided that a woman had not had a legal termination in the preceding year. Simple, convenient and easy methods of performing abortions are used. It is further pointed out that this has got the additional advantage that it can be taught to lower level health personnel.

4.6.4 Personnel

A very important part of the medical services in China has been the training of one million paramedical health personnel (referred to as barefoot doctors), who receive six months training after completing secondary school. These barefoot doctors are said to be assisted by three million health workers and are trained in medical techniques such as immunisation, the treatment of traumatic injuries and in family planning. A barefoot doctor

> may not be fully employed in medical services and can be found working beside his neighbours in the fields. He or she plays an essential role in the family planning services and is responsible for the distribution of contraceptives and also can act as a motivator.

Careful studies by well qualified doctors have been on groups of oral contraceptive users who have used the method for four years or longer. China, like other countries, has to face the problem of how new methods of contraception should be introduced into the community in a way that will minimise the possibility of adverse effects and at the same time discover as much as possible about the drug in advance of the nationwide use. The procedure has been adopted, following annual tests, of trying new contraceptives on members of the medical profession. Currently a significant number of female doctors are using injectable contraceptives. If the method progresses and side effects are acceptable then they will be made available to the rest of the community. This unique approach to drug testing may be of great motivational significance. It means that the medical profession has an experience and confidence in the contraceptive they are using, which is often lacking in many countries outside China. It is an important principle of family planning that those who prescribe the methods should be prepared to use them themselves. Malcolm Potts in (Potts and Wood, 1972, pp.219-225).

The Chinese model is said to be the most rational and extensive experiment in any developing country to give community support to the whole spectrum of birth control. Although this national family planning programme can be termed successful, such programmes cannot be universally practised. Different fertility regulations are to consider factors like culture - which in this case includes factors such as perception and perspectives. The degree of rationality in the fertility decision making process may depend on whose perspective is being considered. Marital fertility decisions generally attempt to maximise the total reward to all members of the household. It may be the living standard of the older generation or the satisfaction of one member of the nuclear family, such as the husband, that dominates decision making. Need - whether it is a felt need to use family planning methods in a particular society. Under environments of high mortality, a decision to terminate child-bearing must be considered against the unknown possibilities of widowhood or child mortality. The use of fertility regulation itself may have unknown associated health risks (abortion for example). Habit - cultural differences have been noted in the probability parents attach to having a son or a daughter. These factors call for a pragmatic or rational approach to be considered when dealing with fertility regulation programmes. As a way of further elaborating on the terms pragmatism and rationality the following are

factors to be considered when attitude change is considered.

4.7 Factors to be considered in Attitude Change

The individual must first recognise a need and perceive its achievement as possible, that is, it must be realistic need; the individual must have information on how that need can be met, that is he must have access to whatever materials or services the achievement of his goal requires and at a cost that he can afford; his society must not impose excessive negative sanctions on him/her for innovating whatever objectives. (Foster, 1973, p.17).

The change, however, firstly calls for the understanding of the different types of fertility decisions.

4.8 Types of Fertility Decisions

According to Hollerback as cited in Bulatao et al (1983) there are different types of fertility decision and the following will briefly be discussed: Non-decision - is said to occur when a couple does not foresee that pregnancy results from particular actions, misperceives their fecundity, or lacks knowledge of fertility regulation. Passive decision - takes place when restricted perceptions and particular habits or customs, institutionalised within the culture, reinforce the child

bearing behaviour for group survival or growth and leave individuals with little perceived choice. Such a couple can be said to be in a pre-awareness stage of decision making - though they make decisions relating to marriage, sexual relations that indirectly affect fertility, decisions directly relating to fertility goals are precluded by lack of knowledge. For more active decision making to take place, a couple must be aware of a number of things, viz: The probability of pregnancy, the possibility of regulating fertility and that the costs and benefits are attached to the fertility outcome. Fertility may then be said to be salient to the couple. Active consideration of the consequences of fertility behaviour may result in a decision to regulate fertility or to have additional children; however, it may also result in an implicit decision to do nothing. In this case, through the process called behavioural drift, a series of small decisions may lead by default to an unintended major decision. For example, a series of decisions to have an unprotected sexual relation may eventually produce an unintended pregnancy. Such decisions are sometimes characterised as ambivalent. Ambivalence is most noted among the high proportions of women who state that they do not want additional children and are not practising contraception.

Decisions may also be non rational if individuals act against their interests, regret over previous decisions,

this may be seen as indicating irrationality. When one individual has the power to enforce a decision over another, decision making may be termed coercive. Also decision can be categorised as joint if reached by two or more individuals on the basis of accommodation, compromise, compliance, or mutual agreement; or unilateral if made by one or more individuals in conflict with the desires of another, either openly or surreptitiously. (Bulatao et al, 1983, pp.351-353).

For the purpose of this study the "psychological reactance" model of Brehm as given in Greenwald et al (1968), and the "influence of kin and non-kin" model by Hollerback in Bulatao et al (1983) will be used in determining the fertility decision making processes.

4.9 Brehm's "Psychological Reactance" Model of Attitude Change in (Greenwald et al, 1968)

The "psychological reactance" is said to be a motivational state that operates in opposition to inducing forces such as persuasive communications, whilst trying to bring about attitude change within the individual. In general terms, the theory asserts that when a person's freedom to engage in a particular behaviour is eliminated or threatened with elimination, the individual will experience psychological reactance, a motivation directed towards the re-establishment of the lost or threatened freedom. Where

attitudes are concerned, it is assumed that the individual normally feels free to adopt a position for himself and that any attempt to force him to adopt a particular position constitutes a threat to that freedom.

Based on the main assumption arrived at that there is in the study an unfavourable attitude to family planning in the Taung area - the theory or model clearly highlights certain factors to be considered when attitude change is anticipated. That attitude change, although desired, should not be coercive, failing which according to the model the person will be defensive and act counter to the desired behaviour. A review will then be made of the type of freedom threatened, regarding the model.

4.9.1 The Effect of High Competence

When a person has not yet had a chance to study all the relevant information on an issue, the more competent he feels to make a good judgement, the more important it is to be free to adopt his own position. Thus given a feeling of high competence, the greater is the threat to the individual's freedom to decide for himself/herself, the greater will be his reactance and the more he/she will consequently tend to act counter to that threat. Where felt competence is low, a threat to the individual's freedom to decide for himself/

herself should have relatively little effect on his tendency to act conversely.

4.9.2 Private and Public Commitment

Commitment to a particular position tends to eliminate one's freedom to adopt other positions. While it is almost always conceivable that a person may change his/her position on an issue, public commitment may, in connection with implied punishment, virtually eliminate this freedom. Whether this commitment is private, deriving from a decision or emotional response, or public deriving from one or more reward or punishment contingencies, the greater the degree of commitment, the greater is the threat to one's freedom to adopt a different position, (or reject the one to which the commitment is made) and with high degrees of commitment, freedom is virtually eliminated. Commitment, therefore, has the capacity to arouse reactance and the effects of this arousal should be observable.

4.9.3 Implied Pressure

In general, a threat to freedom may be defined as the perception by an individual that there is pressure on him to behave in a specific way, in

this case, to adopt or reject a position on an issue. Perceptions of pressure may arise in various ways, some of which will be listed. Among those factors which give rise to the perception that there is an intent to influence are the following: That the communicator has something to gain by having his/her position adopted; that the communication is more one sided than is warranted by what the communicant knows; that there are systematic errors in the communication which favours the position advocated; that the communicator tries too hard (by using emotional appeals, and that the communicator draws a conclusion unwarranted by his communication). Brehm in (Greenwald et al, 1968, pp.277-284).

The presence of any of these factors in a communication tends to arouse reactance and a consequent tendency to resist influence, or move away from the advocated position.

4.10 The "Influence of Kin and Non-Kin" in the Fertility Decision Making Processes

The part played by the biological parents especially by males seems to be very great in fertility decision, in male dominated societies such as in the rural areas. There is no doubt that in such settings the man has absolute

authority as head of the family and in certain circumstances of mystique, a spiritual leader of his household and the tribe and also in the case of a chief. The dominant man has often thwarted efforts for family planning on the misconception that the methods used may lead to female sterility, loose morals and prostitution. He has often rejected out of hand the use of the condom on the premise that it creates a barrier between the sex organs and therefore interferes with the enjoyment of sex. There are a large number of men who would not mind each sexual act to culminate in the birth of a child, especially if they have no final responsibility for the outcome. A further impediment thrown by men on the works of family planning is the belief that the woman must be either pregnant or lactating especially in the migrant labour system where a man may be away from home in the mines for three quarter part of a year. This is said to keep the women occupied and away from mischief.

On the other hand, there is a question of gender preference by men. Across developing countries, the desire for having a balance between sons and daughters is most common. A stronger desire for sons does appear in some countries, notably in the rural Setswana influenced cultures (preservation of the family name). Since a man cannot, as of now, control the sex of his offspring, his family composition may not be in line with his gender preference. The demand for children may then be affected,

depending on two factors: their perception of the likelihood of having sons as opposed to having daughters, and the value they assign to alternate family compositions. Perceptions are affected by child bearing experiences, but are not always veridical. Some men fall into the "gambler's fallacy", believing for instance that, after a sequence of daughters a son is more likely. The opposite expectation, that after several daughters another daughter is more probable, has also been observed. Where the man perceives a greater likelihood of a more favourable outcome, demand may be increased. The cost of an additional child not being of the sex desired must also be assessed.

Fertility decision making in pre-transition societies need not be the monopoly of the biological parents. Caldwell (1981) as cited in Bulatao et al (1983), argues that, in such societies the biological parents in most cases, have little to say; instead the older generation, who control patterns of production, the consumption of food, medical care and other items, also exchange of goods within and outside the household, also control fertility. If fertility is advantageous to these people, the interests of the biological parents may be over-ridden. The influence of the elderly, which may be assumed to be pronatalist, is mostly greater in rural areas, especially among the poor, where patrilocal rather than neolocal residence and patrilineality prevail and where the

surviving children are few.

Fertility decisions may also be influenced by other relatives, or by extra familiar sources, including neighbours, peers, community leaders etc. Three ways are noted which influence sources of such decisional style, viz: by social consensus transmitted to the individual through socialization; by shared value judgement on the propriety of fertility related behaviour and the imposition of sanctions; and by advice and counsel. (Bulatao et al, 1983, p.367).

On this aspect, Snyman and Botha (1985), suggested that there be a move away from a narrow concentration of family planning. In other words, that planning concerning the reproductive function of the family, not be separated from planning in respect of family functions. The writer aligns herself with Snyman and Botha (1985) who pointed out that since the family is not functioning in isolation, the ability then to control and plan one's own life instead be extended to the groups and communities within which families function. By far the best way in which this can be affected is by means of a process of development and involvement of the community as a whole.

CHAPTER 5

5. The Phenomenon of Family Planning

5.1 Introduction

The population explosion is universally recognised as one part of the most serious problems which threatens mankind. Many problems have to be faced in order to achieve lower fertility. For some people numbers of children are still synonymous with wealth and ensure security in old age. (Lötter and van Tonder, 1976, p.27). With the exception of work done by the Human Science Research Council, little has been done on the subject of family planning in South Africa. The following are some significant findings of different researchers which are relevant to this investigation.

5.2 The Role of Men in Family Planning

It is often said that male opposition is an important stumbling block in the way of general acceptance of family planning. Research by Lötter (1977) seemed to lend support to this view. As a result of a multipurpose survey among Blacks in South Africa in 1970, with a sample comprising of 2000 Black males and 2000 Black females, between the ages of 20 and 59 years, living outside the borders of the

Transkei and other independent states, the following findings were given: That more Black men are expressing a rejection of contraception than Black women. In male dominated societies such as rural societies many men consider children to be proof of virility and that there is corresponding fear that contraception might lead to the undermining of the male authority and the wife would be unfaithful. It is also thought that contraceptives can reduce the pleasure of the sexual act. Males could indeed prove to be a serious obstacle on the way to a more general acceptance of family planning. For this reason many Black women do not tell their husbands that they are using some form of contraception. (Lötter, 1977, pp.3-11). According to research done by Lötter and Van Tonder (1976) on the "Fertility and family planning among Blacks in South Africa:: 1974", with a sample comprising of 6000 Black females between the ages 15 and 44 years, the following as regards men and the use of contraception were the findings: The investigation tried to find out whether the woman had already discussed family planning with her husband. Only approximately 20% of the women reported that they had discussed contraception with their husbands. Subgroups in which high percentages of the women reported such discussions were especially those in the high educational categories. It was also asked: "Will your husband object if you use something to prevent getting pregnant?" ("If pregnant now: Will your husband object if you use something to avoid becoming pregnant again?")

Approximately half of the women replied that they did not know. This percentage is not particularly high if it is remembered that only approximately 20% indicated that the matter had ever been discussed with their husbands. The higher the level of education, the higher the percentage who indicated that their husbands will not object and that the lower the percentage who indicated that they did not know. In urban areas the majority of women who said "Yes" or "No" were convinced that their husbands would not object. The opposite was the case with those women from the rural areas. (Lötter and Van Tonder, 1976, pp.92-95).

According to other population groups, in Shillington (1980) the following were some findings as regards Coloured and White men: Although some Coloured men suggest to their wives that they get some contraceptive assistance, and others are prepared to allow their wives to use contraceptives or use contraceptives themselves, there are many men who are against contraception. This is because they fear that their wives may be unfaithful. They believe that the possibility of pregnancy is a strong deterrent to possible adultery. They go on to say that it is not so much that they fear the adulterous behaviour of the women, but rather the freedom of not having to have and rear children. Some of these men who are caught in a changing culture, Shillington (1980) points out, are insecure in their masculinity and believe that the production of children can give a feeling of virility and

self value. Many of the Coloured women like the Black women do not even discuss family planning with their menfolk. The family planning clinics in fact it was pointed out, keep many clinic cards for the women so that the husbands do not know that they are attending.

With White men it was reported that they were generally positive towards family planning. Mostert as cited in Shillington (1980) found that over three quarters of the White couples who were not expecting a baby at the time of the study were using contraceptive methods. Of those who were expecting babies, only 4,8% had used contraception. Of these women, 54,8% said that they would use contraception after the birth of the baby. Reasons given by the White couples for using contraception to delay birth of the first child were: Financial reasons (the largest group); wanting to buy a house; completion of studies (either man or woman); the completion of a woman's work contract; wanting to move or go overseas; wanting to enjoy and get to know each other or else being too young to have children. Reasons for starting a family immediately, and thus not using contraception, included: Being in a hurry to start a family because of age; can afford to start a family or want to start a family soon. According to Kruger (1970) as cited in Shillington in as far as Whites are concerned, there is a difference of reasons given for using contraception between Afrikaans speaking males and English speaking males. More Afrikaans

speaking males than English speaking males gave the wish to give their children higher education as a reason for limiting their families, while English speaking males outnumbered Afrikaans speaking males in giving the higher cost of living as a reason for contraception. (Shillington, 1980, pp.22-33).

The influence of the male in the contraceptive usage of women is still largely an unknown factor, but it is one which would seem to be of sufficient importance and significance to be further explored in future studies. The attitudes of men to family planning apparently are influenced according to the above discussion by factors such as culture, the rural and urban factor as well as the educational background of the man.

On the other hand, socio-economic conditions also play a part in men's views and attitudes to family planning. Ferreira (1984) interviewed a sample of 80 Black opinion leaders drawn from the following regions: Eastern Transvaal, Central Transvaal, Southern Orange Free State, Drakensberg, Northern Cape, Western Cape and Eastern Cape. The sample included church ministers, members of community council, businessmen, professionals, educationalists, senior officials of administration boards and persons from cultural spheres and the media. Basically the study concerned two aspects: The knowledge, attitudes and practical approach of the informants to family planning in

general and regarding their own communities in particular; and the perceptions and attitudes of the informants towards the National Family Planning Programme in terms of the role of the government in promoting birth control among Blacks, the specific mechanisms of the programmes, and the priority they assigned to family planning, relative to other developmental issues. Four broad issues emerged from the data, viz: That the attitudes to family planning were generally positive, although reservations, suspicion and criticism were expressed regarding the National Family Planning Programme and its mechanisms; the majority of informants did not relate family planning to socio-economic advantages and improved quality of life. Low priority was generally given to family planning in comparison to the importance assigned to other developmental issues and policies. The vast majority were in favour of sex education in schools. A dilemma was posed, however, in making contraceptives freely available to teenagers and encouraging licentious behaviour. Lastly, the perceived political connotations of the government's role in the National Family Planning Programme on the part of the leaders and their followers were inescapable. In so far as Black opinion leaders were not included in the initial structuring and establishment of the family planning programme, many of the leaders in the sample tended to be "cold", although not negative, towards the programme and the role that they could play in propagating family planning amongst their people. The investigation

showed that few opinion leaders in the sample actively work for the programme. This did not, however, appear to be due to lack of desire on their part. Among possible reasons were: "fear" of losing their status in the community in as much as family planning has not yet acquired the status of a positive community norm. It would further seem that although Black people probably individually have a desire to adopt family planning they hesitate to talk about it openly. (Ferreira, 1984, pp.4-13).

5.3 Cultural Factors and Family Planning

5.3.1 Religion

According to Christopher (1980) Catholicism is pronatalist and sex tends to be approved solely in reproductive terms. The papal encyclical (Humanae vitae) is opposed to all forms of contraception except for the rhythm or safe period. Catholicism, Christopher (1980) maintains is not opposed to family planning in the literal sense, but relies more on self control and abstinence to achieve this. The church's teaching regarding contraception together with its attitudes towards sex can make the continued use of contraception difficult. Thus, the ambivalence and conflict experienced by Catholic women may lead to frequent complaints about the

method of birth control. These complaints, it is suggested, should be explored and not accepted at face value. Reliance is often placed on withdrawal since this does not necessitate public admission of the use of birth control and interestingly it may not be regarded as such by the women. (Christopher, 1980, p.225).

According to Shillington (1980) the effect which religion has on contraception has been explored by various authors and their findings are said to be in conflict. Englebrecht as quoted in Shillington (1980) states that religion does not play a role in attitudes of Black women towards contraception. The sample population included Anglicans, Methodists and Roman Catholics. However, Cartwright as quoted in Shillington (1980) pointed out that Catholics are less likely to attend family planning clinics than Protestants. Instead, it was the interaction of social class with religion that increased or decreased the likelihood of a woman using contraception. Women of a low socio-economic class were unlikely to be contraceptive users. Because of the religion controversy, Shillington, in her sample of 120 subjects during a survey of "contraceptive using women from three ethnic groups" (Black, Coloured and White), decided not to control for religion, as it seemed that women who felt that

contraception is contrary to their religion were not likely to come to the clinic. (Shillington, 1980, p.16)

5.3.2 The Influence of Cultural Attitudes on Method

5.3.2.1 Blacks in South Africa

According to Unterhalter (1977) in her exploratory investigation into the use of family planning services in Johannesburg by a group of 3878 Black women who, during 1967-1970, were attending two large urban family planning clinics, reported the following findings in as far as the choice of method is concerned: That the pill was the most popular form of contraceptive. The injection was not in very great demand with only 30% of the women making use of it. The probable reason given is the disturbance the injection causes in the menstrual cycle.

The intra-uterine device (I.U.D.) is also, according to the results given, resisted by most Black women. The reason given for this resistance was that women cannot control their own reproductive behaviour once the I.U.D. is inserted. Should they wish to fall pregnant, they would have to return to the clinic for the removal of the I.U.D. and "publicly" indicate to the doctor and nurse their decision to

have another child. In addition, there are also a number of misconceptions about the I.U.D. and its side effects, so that many women will blame every minor or major illness on the invisible I.U.D. which in the words of one woman in Unterhalter's survey "eats your inside". According to Unterhalter, women attending the clinics in general request the pill probably because it is visible and accords with every day habits of medicine taking and above all gives the woman self control over her reproductive behaviour. (Unterhalter, 1977, pp.86-187). Lötter and Van Tonder (1976) found that the oral pill is the best known of all contraceptive techniques in the case of Black women. That almost 90% of the women with high education and approximately 60% of the women with low education, have knowledge of this method, i.e., the pill. It is also best known in urban as well as rural areas. However, as may be expected, the percentage of urban dwellers who have knowledge of this method is 20% higher than for rural dwellers. (Lötter and Van Tonder, 1976, pp.66-70).

5.3.2.2 Other Population Groups in South Africa

With the Coloured people, Mostert in Shillington (1980) found that the oral contraceptives were the most popular form of contraception, followed by the

I.U.D. and then the condom. Of the fecund women in his sample, Groenewald as quoted in Shillington (1980) found that 50,3% used either an oral contraceptive, an I.U.D. or the contraceptive injection. Of these, the I.U.D. was the most widely used followed by the contraceptive injection method.

According to Shillington (1980) with the White population it would thus appear that chemical or mechanical devices would be used more effectively. The oral contraceptive pill is the most popular means of contraception followed by coitus interruptus, rhythm, the condom, foam and the I.U.D.

As regards other population groups from the United Kingdom, the findings of Cartwright as quoted in Christopher (1980) were as follows:

5.3.2.3 Asian Couples

Withdrawal and sheath are used to a certain extent prior to professional advice. Reliance is also placed on prolonged lactation. After professional advice all methods may be tried, though vasectomy is not popular.

5.3.2.4 West Indian Couples

The choice is influenced by the age group and marital status. The older married couples will use the pill, coil, sheath or cap. West Indian women find the cap an acceptable method and do not have reservations or inhibitions about touching their own genital organs. The older fertile women may seek sterilisation. Young West Indian couples tend to rely on withdrawal prior to professional advice. The sheath is not popular. After professional advice reliance is placed on the pill and coil. (Christopher, 1980, p.228).

5.3.3 Criticism of Cultural Factors and Family Planning

The question of religion under cultural factors especially Catholicism implies that contraception is immoral and unnatural. Most of the Black people, especially those in the rural areas, have thus combined traditional and Christian religions and children are seen as a gift of God and their forefathers for which parents have to be grateful. According to Lötter (1977) many Blacks regard the number of children as a gift of God and the number of children that a parent has as something that was decided on by God alone. (Lötter, 1977, p.5). The critical discussion of the religious implication

will therefore be looked into. According to Chandrasekhar (1965) morality from the origins of the word itself is a matter of custom, and varies from age to age, and from one culture to another. The morals of any society rest on what that society, at some particular stage of its development, thought wise and for the benefit and welfare of its people. Morals are therefore man made and as such they can never be static or absolute. In all cultures, codes of morals change with the changing needs and outlook of the people. Many practices and institutions which have the moral sanction of Society behind them today were at one time or another considered immoral. On the other hand, any number of practices and institutions which were once considered proper and moral are considered today immoral, primitive or unhealthy. If a new approach, device or institution is found to be in opposition to our notion of good morals, it is not wise to reject the socially useful innovation but to alter our morals. As an American advocate of family planning once put it, in reply to the charge that it is immoral: "Of course it is immoral, but it is socially useful. Therefore, we propose to make it moral". (Chandrasekhar, 1965, p.39).

There are still many Christians who maintain that family planning promotes immorality. On the

contrary, it can raise the "moral level" of a society to a higher level, for it will reduce the great number of illegitimate births or rather illegitimate parents. Every socially necessary device is bound to be abused by a minority. The abuse of a socially useful device, however, is no argument against the device itself. For example, we do not condemn razor blades, useful for shaving, simply because a few use them to commit suicide or homicide. Some Christians contend that contraception is unnatural. The term "unnatural" as used in this customary objection means "interference with natural processes by an outside human agency". (Chandrasekhar, 1965, p.41). In this sense, the whole life of man, from the cradle to the grave is unnatural, e.g. there are different types of medication, cooking, clothes etc. Should we allow nature to take its course, we will have to undo thousands of years of human progress and revert to the most primitive level of existence. It will be admitted by all that there are circumstances in life which justify, and even demand, the limitation of the family by some means of contraception, either mechanical or chemical.

On the question of choice of method, there is an indication that certain methods seem to be followed more often than others in each culture. This

depends in part on which marital partner is regarded as dominant especially with the Blacks and Coloureds as opposed to the White population. Attitudes are also influenced by social class. More educated members of each culture will be more flexible in their choice of method. The area of residence (in this case South Africa and the United Kingdom) does not seem to have an influence on the choice of method used.

5.4 The Rural-Urban Dichotomy

Lötter and Van Tonder (1976) found that high fertility norms still occur generally but that modernisation in this connection, especially in urban areas, tends to incline couples to have smaller families. (Lötter and Van Tonder, 1976, p.16).

Lötter, et al (1975) undertook a study in a non-rural environment (Tlhabane) in Bophuthatswana in February 1974. A sample of more than 1000 Black women were interviewed with the aid of pre-coded schedules. Data from the survey suggests that many of the Tlhabane men are beginning to accept the small family ideal. Preferred and ideal family sizes are still higher than in most modernised societies, but appeared to have fallen below the level of actual fertility prevalent under traditional tribal conditions. There were also other indications that norms in respect of family size may be changing. Women were, for instance,

sharply divided on the question whether "God would prefer large to small families?", 49,4% saying "Yes" and 50,6% saying "No". In answer to a question "which woman is more respected?", 38,8% indicated the woman with many children and 62,0% the woman with few children. The data revealed that many Black women in Tlhabane are urban in approach. (Lötter, et al, 1975, pp.6-9).

Lötter (1977) in his rural urban fertility differentiation revealed that many Blacks in the cities have been socialised in the rural and tribal milieu and often succeeded in avoiding "mental urbanisation" even during prolonged residence in the cities. In short, when urban dwellers remain orientated towards traditional values and norms which are internalised under tribal conditions, a decline in fertility does not follow automatically or mechanically. Lötter (1977) said that, to typical rural people, children are still of value even after one's death, as the more descendants there were left behind to worship one, the more important one's spirit was considered to be. The inverse relationship between fertility, education, employment and all other factors present in an urban area and those either absent or minimal in rural areas, can be said to be valid for the South African population. (Lötter, 1977, pp.9-10). Education, to significant levels and especially in urban surroundings, apparently causes conditions which are regarded by Golscheider in Lötter and Van Tonder (1976) as

necessary and sufficient for the transition from high to low fertility. They are: "The shift from kinship and dominance to an emphasis on the nuclear family; improving living standards and rising aspirations and social mobility; changing emphasis from ascription to achievement, from traditionalism to secularism; general values and goals emphasising individualism and rationalism". (Lötter and Van Tonder, 1976, p.21).

5.5 Attitudes of the Nurses Towards Family Planning

According to Ferreira and Mostert (1984) a study was undertaken, using data from a representative random sample of 521 nurses working in family planning clinics in the Republic of South Africa. The aim of the study was to ascertain the attitudes of the nurses towards family planning and their jobs, and what their levels of work satisfaction are. A survey procedure was employed for the investigation. The main findings of the investigation are as follows: Broadly speaking, family planning nurses are positive in their attitudes towards nursing in general and less positive towards family planning nursing in particular. The work satisfaction that nurses gain from family planning nursing is also generally important. Multivariate analysis showed that variables, positively correlated to a high level of work satisfaction, are the health region in which the nurses work, whether they work in a residential clinic and whether they work with their

own race group. The findings also revealed that nurses generally prefer the intra-uterine device as a contraceptive method for their clients. This is followed by the pill and the injection as second and third preferences respectively. Female sterilisation is given a low fourth position. The main variables related to preference for choice of contraceptive methods for clients were: the region in which the nurses work and whether they themselves have personally used the specific method. (Ferreira and Mostert, 1984, pp.10-46).

The attitudes of the nurses towards family planning were explored because, for a family planning service to be carried out successfully, it is necessary for the personnel in the field to have the "right" attitudes towards their work. Negative attitudes or dissatisfaction with working conditions can be detrimental to the efficacy of the service. Nurses play a vital role in the provision of health services, and in the case of family planning, nurses have largely taken over many of the doctor's duties. Family planning nurses are required to adapt their basic general nursing knowledge in order to take an active part in the educational and service aspect of family planning. In many cases this is the natural development of the women in their child bearing years. However, it also calls for a new awareness of the relation of family planning to comprehensive health care for individuals and families. No other sector of the health profession has the

same opportunity for disseminating knowledge on family planning. (Ferreira, 1984, p.2)

5.6 Impediments to Social Work Practice in Family Planning

It would be expected that, since the present study is from "a social work perspective", the attitudes of social workers would be explored as well. This has not been the case because the profession of social work generally has not been active and at the forefront of leadership in regard to furthering the cause of family planning, neither in terms of broader social policy development nor in terms of programmatic development and service delivery. This whole human problem area has been seriously neglected by the social work profession. Haselkorn, as cited in Rapoport (1970) rightly notes the compatibility of the value base of family planning and social work in regard to the right of opportunity for self realization and the right of self determination regarding freedom of choice in decisions affecting one's own fate.

The concept of self determination interpreted literally, refers to that condition in which an agent's behaviour emanates from his own wishes, choices and decisions. This concept is also regarded as a form of freedom. To be self determining in this sense it is argued, is to be liberated from the bonds of ignorance and passion (the idealist

view) or from the crippling and distorting effects of a repressive economic and social system (the Marxist view). According to the concept self determination, human beings are viewed as rational, constructive and socially cooperative, Biestek in (McDermot, 1975, pp.3-4). The idealist view has dominated social work thought and the concept self determination in this study is used according to this interpretation. As a principle in case work, self determination is regarded as the practical recognition of clients to freedom in making their own choices and decisions in the case work process. Case workers equally have a corresponding duty to respect that right, recognise that need, stimulate and help to activate that potential for self direction by helping the client to see and use the available and appropriate resources of the community and of his own personality. The client's right to self determination, however, is limited by the client's capacity for positive and constructive decision making, by the framework of civil and moral law and by the function of the agency. (Biestek, 1967, p.103).

According to Rapoport (1970), several reasons which have contributed to this impediment to social work practice in family planning might be identified. One is the lack of a firm tradition in the country with some exceptions, for the profession to operate at a level of social policy development. A related reason is the often noted function of social work in the society which is designated as

residual in contrast to an institutional function. Basically, it is meant that the profession is largely concerned with problems of social breakdown and with social disorganization, dealing with residual problems caused by social and cultural lags in institutional development. Social work has not developed, Rapoport maintains, a strong role in prevention, both on the level of provision of services as institutionalized for the entire society and on the level of promotion of health and well being. In social work it is dealt with populations already identified as problematic or "sick" and less responsive to working with populations potentially identifiable as "at risk" or healthy populations in need of basic services. In contrast, family planning has a strong preventive perspective and institutional dimension. Therefore, according to Rapoport, social work, by its tradition, has not grasped the opportunity of making an impact in this field.

Another possible reason for the lack of high social work visibility and activity in family planning is due to the fact that family planning is generally conceptualized as a basic health measure and is offered in a spectrum of health and medical services. Furthermore, where social work has been in an "ancillary" position - in this case a paramedical profession - it has rarely been able to exert strong initiative and leadership. For years the enabling and facilitating function and role of social work in

so-called secondary settings has been conceptualized. This role suggests the image of smoothing over, filling in gaps, and raising the quality of service on an individualized basis - a not unimportant task. The potential then for social work to lead, develop, and promote institutional and service delivery change has been ignored.

There are other serious complex value issues which may have contributed to the relative professional passivity of social work in the family planning field. The most obvious issue concerns human sexuality and the changing mores in regard to pre-marital, extra-marital, and adolescent sexuality. Scientific knowledge in regard to the effects of such change on people and on the social fabric is lacking, this forces professional practitioners in all service fields to fall back on their personal beliefs, attitudes, and mores. Social workers, it is pointed out, cannot deal comfortably with this subject despite frequent denials to the contrary. It should be noted that other health professionals, including doctors and nurses, unless specially trained and prepared for family planning functions, also have observable difficulties. Much of the literature dealing with family planning by-passes human sexual feelings, needs and responses. Contraceptive behaviour is most often dealt with as separate from sexual behaviour. Other value issues that contribute to complexity and uncertainty, in addition to the discomfort

with the subject of human sexuality in all its more raw forms, have to do with dilemmas such as the invasion of privacy and the need to safeguard it, and individual freedom as opposed to the need for social responsibility and the professional's role in the exercise of social controls.

To keep up with these dynamics, Rapoport suggests that social work professional education must engage in a constant effort of curriculum design and revision, and must build into the learner and practitioner a concept of lifelong study for the profession, through various mechanisms of self development, and more formalistic continuing education. This implies that social work has to sell itself by demonstrating its competence and potential contribution. Lastly, work in family planning can become a viable career choice for the professionally trained social worker. (Rapoport, 1970, pp.30-33).

In conclusion, it is of interest to note that according to the different research done, this clearly shows how controversial the subject "family planning" is. The writer in this present study, would like to contribute to this debate.

CHAPTER 6

6. Analysis of the Taung Community

6.1 Introduction

The purpose of this chapter is to orientate the reader on the nature and aspects of the area of study. To understand the process of either adopting or rejecting an innovation in a particular area, (in this case family planning in the Taung area) three most important factors have to be described and known, viz:

6.1.1 Geographic Position

The location of the area, division of villages and major tribes in the different villages.

6.1.2 Leadership Position, Family Life and Community Involvement

Here emphasis will be on the type of local government, which includes the part played by the chiefs and headmen, as well as a discussion on the custom and culture of the people. The traditional and present family life will also be briefly explored and lastly the aspect of community

involvement/participation will also be discussed.

6.1.3 Resources Available

The following will briefly be discussed under resources:

- Human resources;
- Physical resources; and
- Economic resources.

6.2 Geographic Position

6.2.1 The Location of the Area

Bophuthatswana is a country of seven separate geographic blocks of territory (land areas). The country is situated in the central interior of Southern Africa, between 24°and 30° South and longitudes 22° and 29° East. The seven separate blocks of land areas are divided into 12 districts, viz: Kuruman and Ganyesa (western block); Taung (south western block); Ditsobotla, Molopo and Lehurutshe (western central block); Madikwe, Mankwe, Bafokeng and part of Odi district (eastern central block); Odi and Moretele (eastern block); and Thaba Nchu district, a separate block, 70 km east of Bloemfontein (South Africa), and about 250 km south east of Taung. (Jeppe, 1985, p.15). For the purpose

of this study, we will confine ourselves to the south western block, the district of Taung.

6.2.2 Population

The area of Taung is divided into government controlled land, which is 2010 square kilometres and tribal and private land which is 855 square kilometres. The north/south diameter is 130 km, while the west/east diameter is 60 km. (Bophuthatswana, 1985, Statistics, p.20).

The district is predominantly a rural one, with 72 villages. The inhabitants are mostly the Batswana people. Major tribes in this district are the Batlhaping ba ga Phuduhutswana and the Batlhaping ba ga maidi. There are three major townships, viz Pampierstad, Pudimoe and Taung Station. All villages are under tribal authorities - chiefs and headmen, whereas the townships are under managers and town councillors, with the regional office being the magistrate's office.

6.3 Leadership Position, Family Life and Community Involvement

6.3.1 Local Government

There exists in every tribe in each village a system of local government. The basic unit of local government is the tribal authority. The members are councillors who are recognised in accordance with the customs and laws of the particular tribe, with the chief or headman as chairman of the authority. The tribal authority concerns itself with the affairs of the tribe, land conservation, education (particularly the building of schools for which a tribal levy can be instituted), the registration of births and deaths, and the administration of justice. The chief is responsible for law and order and has the right to search and arrest, but must report serious crimes or unlawful activities to the magistrate/government. The power to designate chiefs vests in the President who considers recommendations from the National Assembly. The tribal authority assists and advises the Bophuthatswana government. Each tribal authority in all 12 districts is represented on a regional authority by its chairman and two other councillors, who are appointed for a period of five years. Because of the nature of the country and need therefore for decentralisation, the

regional authority is a most important link in the chain of government (Education for Popagano: Report of the National Education Commission, 1978, p.4).

6.3.2 Custom and Culture

Although people vary considerably in details of conduct, certain recognised or standardized patterns of behaviour are incumbent upon them, according to their age, sex, economic position and rank. All these patterns of behaviour or rules of conduct, as they may be named together constitute what is conventionally termed the "law and custom" of the people.

In the social, political life of the Batswana people, the tribe has always played a dominant role as the traditional unit of organisation and the centre of cultural development. The chief (kgosi) who heads the tribe is the political, social, religious and economic leader. The tribe is divided into various kraals, each headed by a headman. Leadership of the tribe and of the kraal is hereditary, the eldest son being next in line. The Batswana people, as do most African people, operate under a patriarchal system. (Bophuthatswana - Five Years of Independence, 1984, p.6). While the tribe continues to be of major importance there has,

however, been a shift of emphasis from tribalism to nationhood. This shift has been the results partly of the process of acculturation and also because of purposeful efforts by the government to promote modernisation and cultural standardisation on a national basis. The Batswana people on the whole believe in Modimo, the Almighty, creator of man and the universe. So reverend and important a personality is "God" that he cannot be approached by ordinary men. As a result of this factor, God is therefore prayed through the badimo (ancestors) - their dead forefathers. There is a belief in life after death and that the dead live together with Modimo. Presently however, more than 90% of the Batswana people are Christians. (Bophuthatswana - Five Years of Independence, 1984, p.6).

In the past, economic life was of a subsistence nature in which hunting, agriculture and animal husbandry on a limited scale, were the most important activities. There was a division of labour between sexes, men hunted and tended the livestock, while the women engaged in crop production. Cattle played an important role, but more for social and religious reasons than for their economic value or as a source of food. Changes have come as a result of inter-tribal marriages, involvement in the South African economic systems, migrant labour, the

influence of the churches, formal and non formal education and the modern mass media. Culture is said to be dynamic and in reacting to a new environment, the Batswana people, too, have taken over certain western forms and norms. This process, it must be remembered, has not been indiscriminate. It has been a selective process in which new ways are being adjusted to and incorporated into the basic patterns of the past. (Education for Popagano: Report of the National Education Commission, 1978, p.5).

6.3.3 The Traditional and Present Family Life

6.3.3.1 Marriage

According to the Setswana law, as given in Schapera (1984) when a young man marries, he has to pay bogadi which is not a buying price but a token of appreciation to his parents-in-law for having given him a wife. Marriage, according to the Batswana people, is designed primarily for bearing children. It is accordingly the first duty of the husband, or of the wife herself, if after a couple of years she has not become pregnant, to call a magician skilled in this work to "doctor" her so that she may be able to bear a child. If this does not help, the husband in former times

had the right to ask his wife's family, or she herself would request them, to provide him with another woman to bear children in her house. It was held to be the wife's duty, not the husband's to find this substitute (Seantlo), and he need pay no additional bogadi for this woman, nor were there any ceremonies when she came to live with him. This custom is still practised to some extent along the lines just indicated. But on the whole it appears to be dying out. Nowadays, if the wife is barren, the husband occasionally takes an additional wife, but more frequently resorts openly to concubines. Should the wife make any trouble about this, he will divorce her and afterwards marry someone else. (Schapera, 1984, pp.155-156).

6.3.3.2 Sex and Age Differentiation

In the Setswana custom, as given in Schapera (1984) there are social distinctions based on sex and age. Women are on the whole regarded as socially inferior to men, and in the Setswana law are always treated as minors. Before marriage, a woman must submit to the authority of her father or guardian, while after marriage she comes under the control of her husband, and on his death, of some other male member of his family. Women take

no public part in the government of the tribe, and all the political offices are kept exclusively in the hands of the men.

Contact with civilization has brought about another line of division between the sexes. The men have,on the whole, been more exposed to western influences, due mainly to labour migration. Because of factors like the absence of job opportunities in the Taung area, migratory labour is common. Migrancy, however, although it is for the sake of economic upliftment, has a disastrous effect on family relationships as well. Migrant fathers often never return home, or are unable or unwilling to send back enough money for the family to live on. The woman, as a result, is forced to go out to look for work, often leaving the children in the care of a physically weak and poverty stricken older person. The results have been escalating rates of illegitimacy and the collapse of the family structure without any alternative source of social support to replace it.

Hitherto, women on the other hand, have been the much more conservative sex, apart from religion and even those who have received some education generally fall back into the routine tribal life.

The cumulative effect of education, however, must almost inevitably make itself felt in a reorganisation of women's place in society. Women still play no recognised part in political life, and legally are still dependent upon their husbands or fathers. Some have attained a measure of economic independence likely to extend into other spheres as well, although so far this tendency has manifested itself only in a greater freedom from the domestic control of the men.

Age and seniority are of considerable importance in the Setswana life. The older members of a family expect and usually obtain great respect from their juniors. An older brother always takes precedence over his younger brother, whose services he can freely command. Children are taught to obey their parents and seniors without hesitation or question, and to submit to their authority, under penalty, if need be, or severe chastisement. This regard for one's elders is extended beyond the family and kin to the members of the tribe as a whole. People senior to oneself in age or rank should always be treated with deference or respect. Failure to show them the prescribed forms of etiquette, or to carry out their reasonable requests, is regarded as reprehensible and may be punished. (Schapera,

1984, pp.28-29).

6.3.3.3 Rank and Social Class

Hereditary rank in the Setswana social system is confined to members of the royal family and to the headmen of wards. The chief, as head of the tribe, is by far its most important member and occupies a position of outstanding privilege and authority. His relatives share to some extent in the prestige of his exalted position and have considerable political influence, but they do not enjoy anything like the same rights and privileges. The more remote their relationship, the less is the derivative prestige to it. Generally speaking, the more highly placed a man's family is in the tribal hierarchy, the more important a person is in tribal affairs. If in addition, he is personally capable, his influence will be correspondingly greater.

Nowadays teachers may also enjoy considerable prestige, both because of their superior educational attainments and because they are relatively well paid. But they have tended more readily than any other section of the tribe to discard old practices and to embrace the western practices. For this reason they are not always

regarded with favour by the older and more conservative members of the tribe, and so do not command as much political influence as some of them desire.

6.3.4 Community Participation

Community participation can be promoted through self help groups. Self help groups or mutual aid organisations as they are sometimes termed, can be defined as "groups of people who feel they have a common personal problem, typically concerned with a medical, social or behavioural condition, and have joined together to do something about it". (Richardson, 1984, p.1). Self help activities are by their very nature problem orientated and change directed in that they seek to improve intolerable relationships between their constituents and life situations. (Mkalipe, 1983, p.24). What these groups do, how many are involved and how long they survive, varies from area to area, from group to group and from the nature of the problems experienced. In the main, such groups arise from intolerable conditions of living and the individual's inability to control, adapt or alter such conditions except through shared involvement with others.

In the Taung area, community members are actively involved in tribal matters. The formation of committees in the villages is encouraged as are yielded self help projects like, for example: Feeding schemes; the establishment of small businesses (food and clothing); the introduction of adult learning centres, where adults are exposed to literacy, numeracy, academic and vocational education; vegetable garden projects have also been started.

6.4 Resources Available

6.4.1 Human Resources

6.4.1.1 Health Services

There is only one hospital in the area, called the Taung Community Hospital. Table 6 shows the health facilities in Bophuthatswana - Geographical Distribution, 1984. The local hospital is situated in the north of the middle part. Ten district clinics and 17 mobile points are scattered all over the area. Because of the poor corrugated roads, private and public transport facilities to and from remote areas are scarce. Procedurally, patients from different villages have to visit the hospital only when referred to by their local

Table 6

HEALTH FACILITIES IN BOPHUTHATSWANA

GEOGRAPHICAL DISTRIBUTION 1984

	ALL BOPHUTHA-TSWANA	BAFOKENG	DITSOBOTLA I	DITSOBOTLA II	GANYESA	LEHURUTSHE I	LEHURUTSHE II	MADIKWE	MANKWE	MOLOPO	MORETELE I	MORETELE II	ODI I	ODI II	TAUNG	THABA-NCHU	TLHAPENG-TLHARO
Hospitals	10	-	1	1	-	1	-	1	1	1	1	-	-	-	1	1	1
Clinics (Static)	145	7	7	3	7	7	5	12	9	13	19	3	18	2	10	9	14
Mobile clinics	122	3	7	7	-	6	7	2	10	19	7	2	7	-	9	26	10
Total clinics	267	10	14	10	7	13	12	14	19	32	26	5	25	2	19	35	24
Total treatment Centres	277	10	15	11	7	14	12	15	20	33	27	5	25	2	20	36	25
Population 1984	1535000	109000	70000	34100	40600	57300	1200	626000	90300	111800	220,400	54000	3813000	22700	129100	64000	86900
Population per Hospital	1535000	-	70600	34100	-	57300	-	626000	90300	111800	220,400	-	-	-	129100	64000	86900
Hospital/50,000 population	0,33	-	0,71	1,5	-	0,87	-	0,80	0,55	0,45	0,23	-	-	-	0,39	0,78	0,58
Population per static clinic	10000	15400	10100	11400	5800	8200	240	5200	10000	8600	11600	18000	21200	11400	12900	7100	6200
Static clinic/ 10,000 population	0,95	0,65	0,99	0,88	1,75	2,05		1,92	1,00	1,16	0,86	0,56	0,47	0,88	0,75	1,41	1,61
Population per Treatment Centre	5540	10800	4700	3100	5790	2250		4170	4500	3390	8200	10800	15300	11400	6500	1800	8500
Number of beds	6303	38	1168	312	14	34	14	166	522	1127	517	17	62	8	424	1521	359
Number of bed/250 population	1,03	0,09	4,14	2,29	0,09	0,15	2,92	0,66	1,45	2,52	0,59	0,08	0,04	0,09	0,82	5,94	1,0

clinics. This, however, is not yet fully practised. Various services are offered by the hospital including: child welfare clinics, post natal clinics, family planning and the ante natal clinics, to mention only a few. For the purpose of this study, concentration will be laid on family planning services.

6.4.1.2 The Educational System

The educational system in the Taung area is the same as in the whole of Bophuthatswana. With its formal independence received from South Africa in 1977, Bophuthatswana inherited a system of education which had suffered from the cumulative effects of 25 years of Bantu education, i.e., poor buildings and equipment, overcrowded classes, underqualified teachers and poor academic standards.

From 1970 onwards, the Bophuthatswana education infrastructure expanded rapidly. The pupil enrolment increased dramatically from a total of 250 690 in 1970 to 400 229 in 1977 to 496 021 in 1983. This represented nearly a 100% increase over a period of 14 years. The increase was particularly at secondary level, whereas there were 14 055 secondary pupils in 1970, but in 1977

the number had risen to 64 650 and reached a total of 133 759 in 1983. The Taung area also witnessed a dramatic schooling expansion. (de Clercq, 1986, pp.46-47). As Table 7 shows, over the period 1970-1984, the number of pupils, teachers and classrooms increased significantly.

Table 7

TAUNG SCHOOL CHARACTERISTICS 1970 - 1984

Year	Primary	Secon-dary	Total	% Increase	Teachers	Class-rooms
1970	17 266	725	17 991		263	234
1971	19 131	905	20 036	11,3	303	-
1972	20 274	939	21 186	5,7	330	-
1973	22 640	1 075	23 715	11,9	362	-
1974	23 359	1 512	24 871	4,8	364	-
1975	24 980	2 520	27 500	10,6	422	-
1976	25 859	3 125	28 984	5,3	486	-
1977	27 671	3 865	31 536	8,8	528	450
1978	-	4 643	4 643	-	-	-
1979	-	-	-	-	-	-
1980	29 814	6 353	36 167	-	683	555
1981	31 352	8 257	39 609	9,5	751	594
1982	34 569	8 694	42 899	8,3	818	670
1983	34 569	8 835	43 404	1,2	883	715
1984	35 362	9 675	45 037	3,8	1 025	779

(de Clercq, 1986, p.47)

Compared to the rest of Bophuthatswana, the Taung pupil explosion was just above average. As Table 8 shows, the share of Taung in the overall Bophuthatswana pupil population has slightly increased. Whereas, in 1973, Taung primary and

secondary pupils constituted 8% and 5% respectively of the total Bophuthatswana primary and secondary population. By 1983, the proportion had risen to 9,5% and 6,6%. (de Clercq, 1986, p.47).

Table 8

BOPHUTHATSWANA AND THE TAUNG STUDENT POPULATION

Year	Taung Primary	Bophutha-tswana	%	Taung Secondary	Bophutha-tswana	%
1973	22 640	281 235	8,0	1 075	21 435	5,0
1977	27 671	325 650	8,5	3 865	64 650	6,0
1980	29 814	343 482	8,6	6 353	91 372	6,9
1983	34 564	362 264	9,5	8 835	133 757	6,6

(de Clercq, 1986, p.48)

This fast pupil explosion in the Taung area it is said, is not just the product of its rapid population growth, but also of the accelerated large scale resettlement programme of the Batswana people in the Northern Cape by South Africa.

There are presently 31 middle schools in the area (i.e , from standards 5 to 7) and 5 high schools (i.e., from standards 8 to 10). The ages of

students from both middle and high schools range from 11 to 22 years.

Emphasis will be on middle and high schools because these are concerned with the adolescents and the young persons on the verge of adulthood. This is a stage of development during which the pupil is at his most impressionable and receptive - a stage of great dangers, but also great opportunities when directions in life are decided upon, talents and aptitudes brought to light, and careers for the future chosen. It is a period of seeking the understanding of the adult and the security of norms and values in which he can believe and which guide him. In personal terms he seeks the company of his peers and is very susceptible to leadership within his peer group, whether this leadership be positive or destructive. In the Setswana tradition and culture, this was the period of initiation into manhood and womanhood, of the Bogwera for boys and the Bojale for girls. This ended with an intensive period of about six months training in the duties, work and rituals of the particular peer group. The group was taught the laws and customs of the tribe - the duties of adulthood, thrift, creativity, and civic pride. It is during this period that the subject of contraception can be introduced as

well as a period within which the essence of humanity can be accepted for ever.

6.4.1.3 Private Community Resources

Voluntary organisations or private community resources as they are sometimes referred to are effective alternatives to government intervention. The basic aim of such organisations is to encourage community participation, which will curtail the power of the government, counter vested interest and prevent government corruption. The involvement of indigenous persons in programmed change will both accelerate the change and make it more enduring. Community participation in such organisations is further believed to increase gratification, to diffuse both skills and responsibilities, to encourage commitment and identification, and is self generating and self evaluating. Voluntary organisations are also said to be more effective and more economical ways of rendering social service.

In the traditional rural society like Taung, voluntary organisations provide a channel for incremental social reform. The following voluntary organisations are present in the area, viz: care of the aged; marriage guidance and counselling;

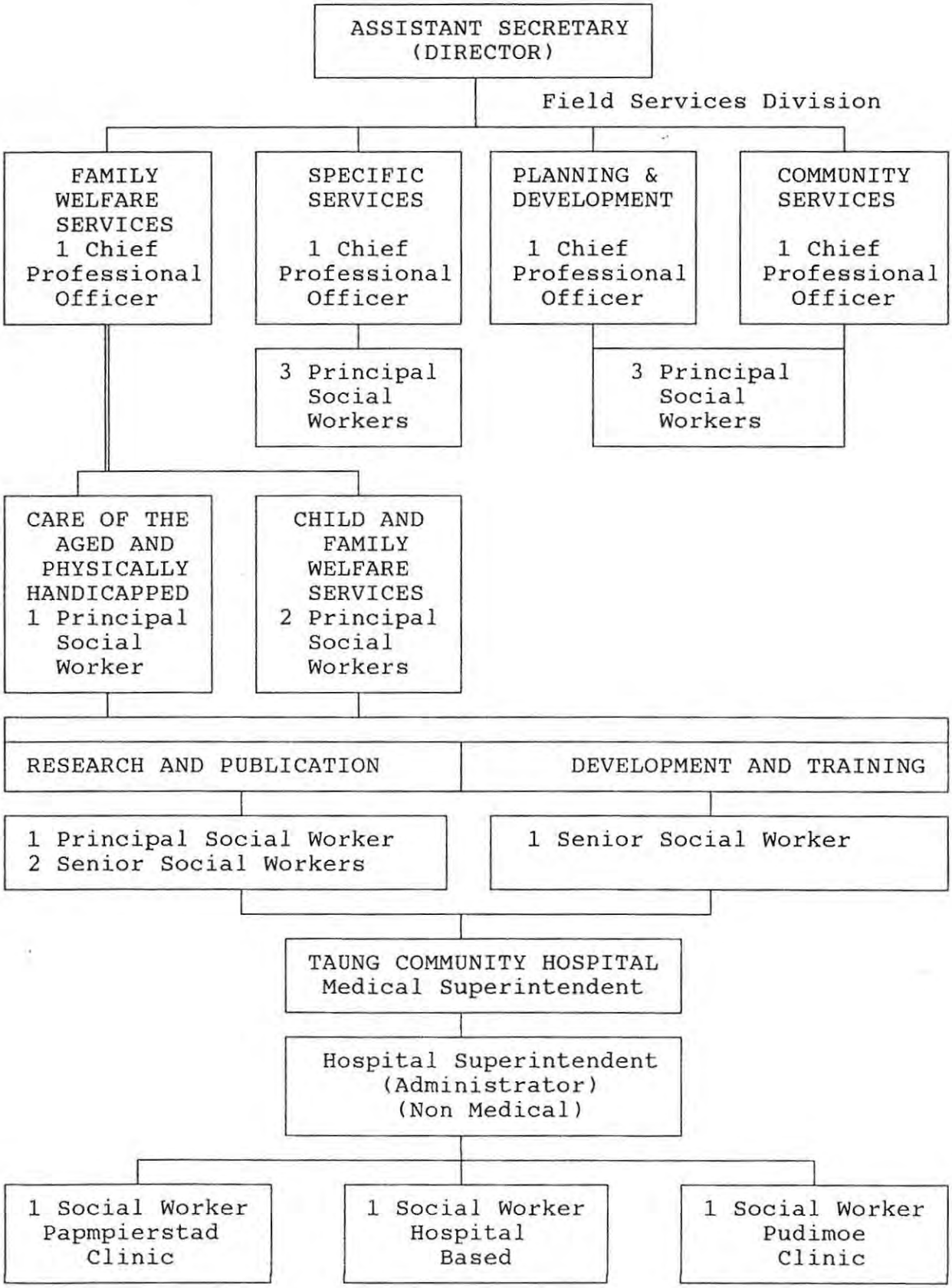
alcoholic prevention and care of the disabled.

6.4.1.4 Welfare Services

The Bophuthatswana Social Welfare Branch (Head Office, Mmabatho) is composed of five divisions, viz: The family welfare division; specific services; planning and development division; field services division and community services division. In the Taung area there are three social workers, who are responsible for covering the 72 villages and the three townships. Figure 2 shows the structure of the social welfare branch, i.e., from Head Office, Mmabatho, down to Taung district.

Figure 2

THE STRUCTURE OF THE SOCIAL WELFARE BRANCH



According to Figure 2 at the top of the structure at Head Office there is the Assistant Secretary, followed by the: chief professional officer, principal social workers and senior social workers. These senior personnel are responsible to the district social workers. In this case Taung Community Hospital, under the medical superintendent. There are only three social workers placed in the area, which points to a significant shortage of manpower.

6.4.1.4.1 Division of Areas among the three Social Workers

The three social workers operate from the following points: Taung Community Hospital, Pudimoe Clinic and Pampierstad Clinic. Areas have been divided as follows among the three social workers, viz: The hospital based social worker who renders services in Manthestad, Taung village and Cokonyane area. The social worker based at Pampierstad covers the southern zone of Taung which stretches as far as Madipelesa village. The third social worker stationed at Pudimoe clinic attends to the eastern zone which comprises of villages like Pudimoe, Dryharts, Myra etc.

6.4.1.4.2 Services Rendered

The case work method is used to carry out routine work which is broken down into categories. Categories with the high case loads are the following: Family welfare services, maintenance cases and those that need material assistance. Social workers do encounter problems of lack of resources for example, a follow up on cases is not done regularly due to the non availability of transport. To counter this problem of lack of manpower and transport, attention has been focused on community work, i.e., the establishment or formation of self help projects and voluntary organisations. As already highlighted previously social workers in the area are not directly active in the delivery of family planning programmes.

6.4.2 Physical Resources

6.4.2.1 Housing Conditions

In terms of housing standards and occupancy rates, conditions in the area have improved considerably. In the tribal villages some dwellings are still in physically poor condition, i.e. most are mud

houses with thatched roofs, poorly ventilated with primitive sanitary facilities and no electricity, while development is taking place in the so-called government controlled lands (urban). The main safeguard for the maintenance of minimum standards and regulations in the area are set by the Department of Local Government and Housing, supported by public health legislation, which is intended to ensure that no person should be allowed to live in a dwelling that is unfit for human habitation.

Factors which are considered in making the house reasonably suitable for occupation are the following: The state of repair, stability of foundations and freedom from dampness, also specific matters such as ventilation, waste disposal and sanitation. Unlike in the past, people in the area especially those in the urban areas, have the option of either renting or buying a house and eventually owning it at reasonable monthly instalments.

6.4.2.2 Transport

Transport availability and cost assume great importance in the area. Travel times and distances are usually greater and services and facilities

less conveniently situated. Some areas are often considered "inaccessible" not because of locational factors but because of poor transport facilities. To be noted is the fact that there are important differences in levels of mobility between the Taung residents. Some areas like Pampierstad, Taung Station, Pudimoe and Dryharts are situated near industrialised areas of the Republic of South Africa, and as a result most people are working in those areas. These people commute daily between their residences and places of work, hence regular transport in the mornings and at certain peak hours in the later afternoon. In some areas which lie away from the major transport networks people still have to walk long distances, use old and slow modes of transport, like donkey carts. This often makes travelling to and from remote areas difficult.

6.4.2.3 Recreational Organisation

In the rural areas like Taung, there is a marked absence of modern recreational facilities like tennis courts, theatres, football grounds or recreational centres where people could, for example, play indoor games, etc.

With the influence of urbanisation, practices of

the past are fast fading away, unfortunately with no substitute. In the past, although facilities such as these were absent, recreational functions of society were performed for the most part by the people themselves. Recreational organisations were therefore formalistic, as was only natural, considering that many of these activities were connected with religious ceremonies. Most forms of artistic and recreational activity were performed spontaneously without any special staging. An individual would often indulge in singing or in imaginative fights while doing his daily work. The outdoor life and the abundance of muscular exercise required in agricultural work made gymnasiums, stadiums and other athletic accommodation unnecessary. The body got enough exercise in the daily activities of rural life. The influence of western culture in some so called urban areas in Taung contributed to separating recreation from daily life. The role of the people is more passive. The country has been penetrated by a commercial type of urban recreation, for example, brass bands, dancing, sports and contests, radios and other forms of urban recreation. Recreation has been commercialised and people must pay to enjoy themselves and be entertained, since professional entertainers carry on their business for money and profit. This

poses as a problem, because most people in the rural areas cannot afford these costs. Their economic level is lower, compared to that of their urban counterparts. As a result of not knowing how to profitably utilise their leisure time many people in the area resort to love making (sex) which is often regarded as the poor man's recreation.

6.4.3 Economic Resources

Although Taung is an agricultural area, the agricultural sector is mostly geared to mere subsistence needs, is unable to absorb the large numbers that are added to the population every year. According to the 1985 census report, a total of 139 108 people were reported as registered work seekers in the area.

Of those employed 2 300 are said to be in the agriculture, hunting and forestry sector. Contrary to what people still believe, there is little land left in the area, that can still be used up for crop or animal husbandry without heavy capital investment, especially in the provision of water. Those who are not absorbed by the agricultural sector are working in the following available small industries in the area as given in the 1985 census report:

Electricity, gas and water industry = 100 people;
Construction industry = 800 people;
Transport, storage and accommodation = 458 people;
Financing, insurance, real estate and
bus service = 137 people;
Community, social and personal service =4933 people.

The following industries are not available in the area and instead are present in the neighbouring towns of the Republic of South Africa. According to the 1985 census, from the total number of migrant labourers and daily commuters, a total of 809 people are said to have been absorbed in the mining and quarrying industry, since these are not present in the area. From the manufacturing industry a total of 896 are employed and lastly 660 in the wholesale, retail, catering and accommodation industry.

In conclusion it must be mentioned that there is a marked degree of under-employment. Few small industries and businesses are in existence, and cannot absorb more work seekers in the area. The low literacy level of the people also inter alia accounts for their unskilledness if they are employed. As a result, the only alternative then becomes the mines (migrant labour) which are outside the borders of the Republic of Bophuthatswana.

CHAPTER 7

7. Findings of the Study

7.1 Introduction

This chapter outlines the personal characteristics of fertility norms and traditional beliefs of the target populations. Personal and socio-psychological characteristics can certainly not be divided into watertight compartments. Statistics are only an aid for bringing out a complex situation and should be looked upon as providing qualitative approximations, because figures have no emotional value. (Bembridge, 1984, p.39).

7.2 Personal Factors

The following will be discussed under personal factors, viz:

7.2.1 Tribal Affiliation of Respondents

All respondents in the sample were Setswana speaking, although they belonged to different tribal groups. To be noted is the fact that by speaking Setswana, does not necessarily mean Setswana is their mother tongue/language.

The word "Tswana" is derived from the concept bat itswana = Batswana, or as some people explain it, "the little ones who break away". This is a reflection of the tendency to fragment rather than amalgamate and form larger units. The Batswana people have always comprised of a conglomerate of various mutually dependent tribes, which, despite several temporary ad hoc alliances, were usually inclined to fragment rather than to integrate. The Batswana society, therefore, is intensely pluralistic. Each respondent in the sample was asked to state her tribal affiliation. Table 9 shows the tribal affiliation of respondents.

Table 9

TRIBAL AFFILIATION OF RESPONDENTS (N = 200)

TRIBAL AFFILIATION	N	%
Batlhaping	68	34,0
Barolong	54	27,0
Bakgatlha	9	4,5
Xhosa	18	9,0
Batswhweneng	7	3,5
Bafurutshe	12	6,0
Bakwena	13	6,5
Others	19	9,5
TOTAL	200	100,0

The Batlhaping (34%) and the Barolong (27%) are the two largest tribal groups represented in the sample.

7.2.2 Religious Affiliation of the Respondents

The most important factor in the higher rural birth rate is probably the familistic organisation of the rural society with the characteristic familistic religion and mores. The traditional attitude of the Christian religion towards the family has been expressed in the biblical phrase "Be fruitful and multiply, and fill the earth and subdue it". (Genesis 1:28). Birth control, therefore, and other means of the limitation of posterity, as well as sexual life outside legitimate marriage, have been condemned by the church. Table 10 shows the religious affiliation of respondents.

Table 10

RELIGIOUS AFFILIATION OF RESPONDENTS (N = 200)

RELIGIOUS AFFILIATION	N	%
Roman Catholic Church	48	24,0
Methodist Church	7	3,5
American Episcopal Church	15	7,5
Anglican Church	13	6,5
United Congregation Church	21	10,5
Zion Christian Church	17	8,5
Native Independence Church	9	4,5
Dutch Reformed Church	10	5,0
Apostolic Church	16	6,5
Seventh Day Adventist Church	11	5,5
New Apostle Church	6	3,0
Pentecostal Church	5	2,5
Five Mission Church	5	2,5
African Faith Mission	10	5,0
Others	10	5,0
TOTAL	200	100,0

Religious affiliation in the sample was considered on the basis of the Roman Catholic Church and Protestant Churches which were believed to be popular among the Batswana community. A distinction was made between Protestants and Roman Catholics, because of the Roman Catholic Church's known opposition to birth control. According to Table 10, the largest group with 24% respondents belonged to the Roman Catholic Church, followed numerically by the United Congregation Church (10,5%) and the Zion Christian Church (8,5%). The poorly represented denominations presented too few cases for a detailed presentation according to religious affiliation hence "others".

Since all respondents in the sample were Christians, they had to indicate their church attendance. From the total number of respondents, 61% said they were regular attenders, followed by 37% who said that they were attending only occasionally and the remaining 2% said they were not attending at all, that they were only Christians by name. Emphasis is on church services which are held once a week. The term "regular attendance" as used in the study means attending church services three and more times a month, whereas with "occasional attendance" church services are attended either once or twice a month.

7.2.3 Age of Respondents

According to Smith and Zopf, as quoted by Bembridge (1984), the age of an individual is one of the most important factors which determines his needs and the way in which he thinks and behaves. Although chronological age may have an impairing effect on physical abilities, which is important on family holdings, research studies have indicated little or no mental deterioration at least up to 60 years of age. (Bembridge, 1984, p.131).

Williams (1986) on the other hand points out that generally it can be expected that age is a factor which will have an influence on attitude and cultural change. Citing Watson (1978), Williams further indicates that research has shown that younger persons generally accept change and innovations more readily than those who with age, tend to become conservative and resist the adoption of innovations. (Williams, 1986, p.165). Table 11 shows the age distribution of the respondents.

Table 11

AGE DISTRIBUTION OF RESPONDENTS (N = 200)

AGE (years)	N	%
14 - 18	7	3,5
19 - 23	41	20,5
24 - 28	43	21,5
29 - 33	34	17,0
34 - 38	26	13,0
39 - 43	17	8,5
44 - 45	32	16,0
TOTAL	200	100,0

As is typical of women in their child bearing ages, it was found that the age distribution was skewed towards the younger groups. According to Table 11 the age structure of the women in the sample showed that 21,5% were between the ages 24-28 years, followed by those between the ages 19-23 years (20,5%). Contrary to our expectations, the figure for those between the ages 44-45 is high. The reason behind this was that concentration in the study was on those who were married. This age group met the demands of the sample, hence the high figure. According to the table, there are few respondents in the age group 39-43 years. This might be due to the fact that they were lactating during the time of the study and as a result did not qualify for inclusion.

7.2.4 Marital Status of the Respondents

There is a general belief that Blacks enter into marriage at an early age and as a result have children whilst still very young. Marriage according to the Setswana law is designed primarily for bearing children. Table 12 shows the marital status of the respondents.

Table 12

MARITAL STATUS OF THE RESPONDENTS (N = 200)

MARITAL STATUS	N	%
Legally Married	94	47,0
Traditionally Married	22	11,0
Living Together	13	6,5
Never Married	59	29,5
Widowed	5	2,5
Divorced	2	1,0
Separated	5	2,5
TOTAL	200	100,0

According to Table 12 those legally married were in the majority (47%) followed by those never married (29,5%). Other groups in the sample may not be well represented because concentration was mainly on those who were married or not married but involved in an affair or a cohabitation. This also indicates the importance attached to marriage according to

the Batswana people. In relation to their marital status, the respondents had to indicate their period of exposure to sexual relations. This was in response to the following question: (refer to Appendix) "For how long have you been staying (courting) together with partner?" The mean period of exposure was calculated at 8,7 years, which points to a significantly long period of exposure.

7.2.5 The Educational Level of the Respondents

According to Gupta (1983) as quoted by Williams (1986), education is the most effective tool for moulding the response of the agents of production to a common purpose. It can generate potent forces helpful in the transformation of a traditional society. Education training and manpower development can be regarded as prime factors which are essential for the development of a nation. (Williams, 1986, p.182). Educationalists have pointed out that people having less than 4 years of education are unlikely to attain an effective degree of literacy. Whereas those with 5 to 6 years schooling are likely to have a knowledge of written local language (which in this case is Setswana) and limited proficiency in foreign language (in this case it will be Afrikaans and English). (Bembridge and Penberthy, 1980, p.74). Table 13 shows the educational level of the respondents.

Table 13

EDUCATIONAL LEVEL OF THE RESPONDENTS (N = 200

EDUCATIONAL LEVEL	N	%
No Schooling or Standard Passed	23	11,5
Sub A - Standard 1	10	5,0
Standard 2 - Standard 4	50	25,0
Standard 5 - Standard 7	64	32,0
Standard 8 - Standard 10	49	24,5
Post Matric	4	2,0
TOTAL	200	100,0

The categories of education used in the sample, ranged from having no schooling to having attended a university, a technical college or technicon and/or any type of training after Standard 10. The category of primary school embraced all schooling up to Standard 4. The category of middle school means from Standard 5 to 7. The category of high school means from Standard 8 to 10, and that of post matric means having a degree or a diploma at any type of institution of higher learning. In general, there was an above average level of educational achievement throughout the sample population. The respondents (58,5%) had middle to post matric qualifications, while 30% had attained only primary education and 11% had no schooling or standard passed. The educational achievement of this group was higher than the figures given in the 1980 population census of the Taung area.

7.2.6 The Employment and Unemployment Level of the Respondents

It has been acknowledged that, for a family planning programme to succeed, it should be closely integrated into a programme directed at upgrading living standards of a community. That development should take precedence, whereupon birth control will take care of itself. (Ferreira and Mostert, 1984, p.3). Table 14 shows the employment level of the respondents.

Table 14

THE EMPLOYMENT AND THE UNEMPLOYMENT LEVEL OF THE RESPONDENTS (N = 200)

EMPLOYMENT/UNEMPLOYMENT LEVEL	N	%
Employed Unemployed	60 140	30 70
TOTAL	200	100

Seventy percent of respondents in the sample were unemployed while only a small portion of 30% were employed. This, therefore, signifies in the sample population a high rate of underemployment and unemployment.

Neither the employment status nor the income of husbands/partners of the respondents are presented in the study. As stated previously, in male dominated societies such as Taung there is virtually no communication on aspects such as place and nature of employment as well as income. On the other hand rural women when employed, keep a secret of their salary when asked about it, they seldom tell the truth when asked about their general family income, they lower it considerably to give an impression of struggling to make ends meet. Once you touch this aspect as an interviewer, they, the interviewees, only think of some financial or material gain.

7.2.7 Occupations Of Those Employed

Studies have shown that birth rates tend to decrease in periods of prosperity (employment) and to increase in periods of depression (unemployment). Heer as quoted in Potts and Selman (1979) has argued that in the process of economic development, rising per capita income would have exerted an upward pressure on fertility. However, this is countered by other factors associated with development such as increased education, the rising costs of children and the declining level of infant mortality. (Potts and Selman, 1979, p.207). While, on the other hand, the existence of large families in the poor

sections may be due to the following factors: For example, partly as being a reflection of the failure of family planning provision and difficulties over access to effective means of birth control. Table 15 shows the occupations of those employed.

Table 15

OCCUPATIONS OF THOSE EMPLOYED (N = 60)

OCCUPATIONS	N	%
UNSKILLED MANUAL WORKERS - Domestic Workers - Casual Workers	20	33
SEMI-SKILLED MANUAL WORKERS - Truck Drivers - Builders' Assistants	1	2
SKILLED MANUAL WORKERS - Dress Makers - Typists	1	2
CLERICAL WORKERS - Government Clerks - Bank Clerks - Shop Assistants	12	20
FARMERS - Self Employed in the Production or Distribution of Agricultural Produce	1	2
SMALL BUSINESS WOMEN - Food and Clothing	6	10
SEMI-PROFESSIONAL AND PROFESSIONAL WORKERS - Nurses - Social Workers - Teachers	19	31
TOTAL	60	100

Table 15 indicates that the largest category of those employed are unskilled manual workers (33%) who were mostly working in the Republic of South Africa and were commuting daily from their residential areas to the place of employment. These are followed numerically by the semi professional and professional workers (31%) who are mostly school teachers and nurses.

7.2.8 The Unemployeds' Reasons for being Unemployed

Many reasons were given by respondents as to why they were unemployed. A high proportion of women, about 40% said, that they were caring for their children; 24% said this was because of scarcity of work; 11% said that their partners refused to allow them work; 9% said they were still attending school; 8% said it was because of ill-health; 6% said they had no reasons for being unemployed and the remaining 2% said that they could not work because of physical disablement. This suggests that there is a lack of motivation on the part of women, since most said they were caring for their children. There is also a lack of employment opportunities in the area, particularly for unskilled manual workers. Table 16 shows their sources of income.

Table 16

SOURCES OF INCOME OF THE UNEMPLOYED
(N = 140)

SOURCES OF INCOME	N	%
Parent(s)	24	17,0
Welfare Grant(s)	10	7,3
Relative(s)	13	9,3
Partner(s)	93	66,4
TOTAL	140	100,0

Of the respondents, 66,4% in the sample were relying economically on their partners and this made the women dependent on and accountable to them. This category of respondents were mostly married women. These were followed by those dependent on their parents (17%). It could have been expected that, since the area in which the study took place is said to have poor socio-economic conditions, reliance on social security payments could have been considerable. This was not the case because such payments are not easily made, but strictly only with regulations including means test. Different types of social security payments are considered, viz: Maintenance and foster care grants. According to the Children's Act, No 33 of 1960, which is presently being revised in Bophuthatswana, (as against the Child Care Act, No 74 of 1983, which is used in the Republic of South Africa), to request a maintenance grant the woman applying must be able to proof that: The biological father of her children is unable to

financially support them, either because of being declared physically or mentally disabled or because of death; that she, the applicant, has been legally married to the man; that the children in question resulted from the union; and, if the children are of school-going age, proof that they are attending school but below the age of 16 years. The amounts for the maintenance grant are from R 6,05 per child per month, depending on circumstances which can make the applicant (parent) to either qualify on top of the maintenance grant for a parental grant or an additional grant. Foster care grants are from R 24,00 per child per month.

7.3 Fertility Norms

One cannot begin with the discussion of family planning without first considering the question of fertility and sterility. There are couples for whom the question of family planning is irrelevant simply because they cannot have children at all or produce a live birth. Most writers prefer to use the term fecundity to fertility. Fertility refers to the actual birth of children and fecundity refers to the ability or capacity to have children. (Lötter, 1977, p.40).

In this study, the term fertility shall be used to denote the number of live births and infertility to the inability to bear children and to bear a live birth (i.e., still births and morti-natal deaths). Infertility will be grouped according to primary and secondary infertility and to pregnancy wastage.

7.3.1 Total Number of Births

An attempt was made to obtain data from the women in the sample concerning the number of total births given. This was the total number of live births plus that of still births. The mean numbers were calculated and are as follows: The mean number of total live births in the sample was calculated as 3,73; that of still births as 0,23 and the total number of births as 3,97. Table 17 shows the period of exposure to sexual relations in correlation to the number of total births of the respondents.

Table 17

THE TOTAL NUMBER OF BIRTHS IN CORRELATION TO PERIOD OF EXPOSURE TO SEXUAL RELATIONS (N = 200)

YEARS OF EXPO-SURE	1	2	3	4	5	6	7	8	9	10+	TOTAL
1	74,1	14,8	0,0	3,7	3,7	0,0	0,0	0,0	0,0	3,7	100,0
2	63,2	21,1	5,3	3,3	5,3	5,3	0,0	0,0	0,0	0,0	100,0
3	40,0	20,0	30,0	0,0	0,0	10,0	0,0	0,0	0,0	0,0	100,0
4	56,2	18,7	6,3	12,5	0,0	6,3	0,0	0,0	0,0	0,0	100,0
5	7,7	23,1	30,8	23,1	0,0	15,4	0,0	0,0	0,0	0,0	100,0
6	30,0	50,0	10,0	10,0	0,0	0,0	0,0	0,0	0,0	0,0	100,0
7	7,7	15,4	30,8	23,1	15,4	0,0	7,7	0,0	0,0	0,0	100,0
8	0,0	16,7	50,0	16,7	16,7	0,0	0,0	0,0	0,0	0,0	100,0
9	0,0	25,0	25,0	50,0	0,0	0,0	0,0	0,0	0,0	0,0	100,0
10	11,1	0,0	0,0	11,1	33,3	11,1	0,0	11,1	11,1	1,1	100,0
11+	3,2	1,6	3,2	14,3	12,7	7,9	20,6	12,7	4,8	19,0	100,0
TOTAL%	28,5	14,0	11,5	12,0	8,0	5,5	7,0	4,5	2,0	7,0	100,0

According to Table 17 the longer the period of exposure the more the number of births given, The largest number of respondents had given birth to only one child (28,5%) and were exposed only for one year; followed by those with two births (14,0%) mostly exposed for 6 years. This may suggest that most respondents in the sample were young or rather entered into a sexual relationship at a very early age without even considering contraception. After giving birth to one child the space indicated before having the second child, might suggest the usage of contraceptives by young respondents, (because of having proved their womanhood) until before marriage where contraception might again be discontinued, (presumably because of the negative reaction to family planning, mostly of partners). Where the number of births given does not correlate with the exposure period, this clearly signifies that the respondent should have been involved with more than one partner from which relations children were born. The longer the period of exposure to sexual relations, the more the number of births given.

7.3.2 The Number of Live Births

The number of live births is not necessarily the number of living children. This helped in measuring

the fecundity level of the respondents. Table 18 indicates the number of live births in the various age groups. Emphasis is on the individual categories of the sample population.

Table 18

LIVE BIRTHS IN CORRELATION TO AGE OF RESPONDENTS (N = 200)

AGE YEARS	LIVE BIRTHS 0	1	2	3	4	5	6	7	8	9	10+	TOTAL
14-18	28,6	71,4	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	100,0
19-23	2,4	70,7	22,0	4,9	0,0	0,0	0,0	0,0	0,0	0,0	0,0	100,0
24-28	0,0	37,2	25,6	23,3	9,3	4,7	0,0	0,0	0,0	0,0	0,0	100,0
29-33	0,0	17,6	14,7	20,6	26,5	14,7	2,9	2,9	0,0	0,0	0,0	100,0
34-38	0,0	3,9	7,7	15,4	19,2	26,9	15,4	0,0	3,8	0,0	7,7	100,0
39-43	0,0	5,9	5,9	11,8	17,6	5,9	5,9	11,8	11,8	17,6	5,9	100,0
44-45	0,0	0,0	3,1	0,0	6,3	9,4	9,4	15,6	18,7	6,3	31,2	100,0
TOTAL %	1,5	29,0	14,5	12,5	11,5	9,0	4,5	4,0	4,5	2,5	6,5	100,0

The fecundity level of respondents in the sample is high. According to Table 18 the fecundity level increases with age and as a person becomes older it gradually decreases. Pregnancy wastage seems to be evident only among the very young respondents those between the ages 14-18 years. Apparently this is because of ignorance and underdevelopment of the body. The high fecundity level of all age groups on the other hand might also suggest to the usage of

accessible medical services in the area, by the respondents.

7.3.3 Live Births in Correlation to Educational Status

According to the theory of demographic transition, fertility control is first implemented by the top social status categories (presumably with higher educational qualifications) and only afterwards by the lower classes (presumably with poor educational qualifications). It may be expected that a general decline in Black fertility will be preceded by lower fertility among the high educational level categories. (Lötter, 1977, p.42). Table 19 shows the total number of live births in correlation to educational status of respondents.

Table 19

LIVE BIRTHS IN CORRELATION TO

EDUCATIONAL LEVEL OF RESPONDENTS

(N = 200)

EDUCATIONAL STATUS	LIVE BIRTHS 0	1	2	3	4	5	6	7	8	9	10+	TOTAL
No School	0,0	13,0	4,3	0,0	4,4	13,0	4,3	13,0	8,7	13,0	26,1	100,0
Sub A-Std 1	0,0	0,0	10,0	20,0	10,0	10,0	30,0	0,0	0,0	10,0	10,0	100,0
Std 2-Std 4	2,0	20,0	8,0	10,0	12,0	16,0	6,0	4,0	8,0	2,0	12,0	100,0
Std 5-Std 7	3,1	28,1	14,1	17,2	18,7	9,4	1,6	4,7	3,1	0,0	0,0	100,0
Std 8-Std10	0,0	49,0	26,5	14,8	6,1	0,0	2,0	0,0	2,0	0,0	0,0	100,0
Post Matric	0,0	75,0	25,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	100,0
TOTAL	1,5	29,0	14,5	12,5	11,5	9,0	4,5	4,0	4,5	2,5	6,5	100,0

Education according to Table 19 seems to be having an effect on the fecundity level of the respondents. Those with high school education and post matric had between 1 and 2 live births. They seem to be in total control of their fertility. Whereas those with middle school education only started controlling their conception after having well established families. Those with no schooling and with primary education have given birth to 10 and more children and feel it was too late to start controlling their conception (presumably because they are older and on the verge of completing their child bearing ages). There seems to be a correlation between educational standard and lowered fertility.

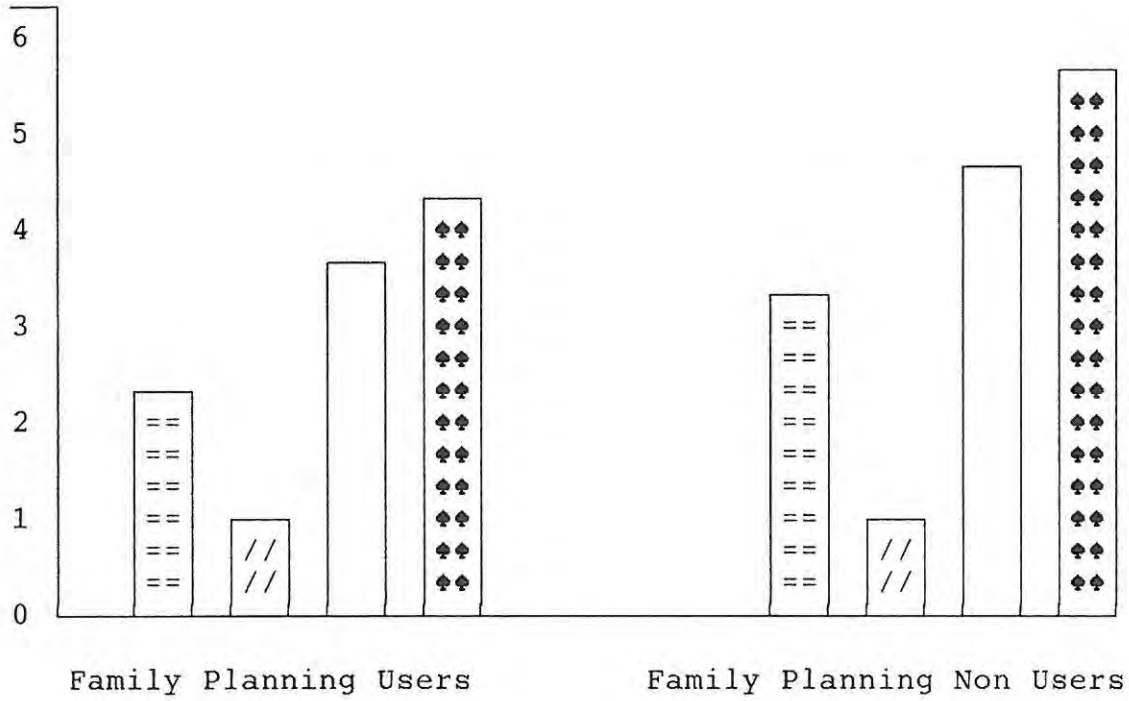
This can also on the other hand be referred to as a cultural phenomenon. Possibly then, the better educated have adopted a more western culture.

7.3.4 Attitudes Towards Family Size

An attempt was made to obtain accurate data from the respondents concerning the number of living children or actual number of children; expected (if the woman did not have living children) or still wished to have (in addition to the number she already had); desired - how many the woman wanted to have had, if everything could have been in her powers; and an ideal number of children - which is what the respondents had to regard as ideal for every woman of her ethnic group. Analysis according to the sample has been done in correlation to the respondent category, age of respondent, marital status and educational level of respondents. Different response numbers were added together and the mean number was calculated. These will be presented in figures by means of histograms. The mean numbers have been calculated and presented as follows: For actual number of living children in the sample population, the number was 3,1; expected 1,5; desired 4,4; and the ideal as 4,8 children. Figure 3 shows the mean number of actual living children according to the respondent category.

Figure 3

THE MEAN NUMBER OF ACTUAL LIVING CHILDREN
IN CORRELATION TO THE RESPONDENT CATEGORY (N = 200)



LEGEND

===== - Actual Number of Children

///// - Expected Number of Children

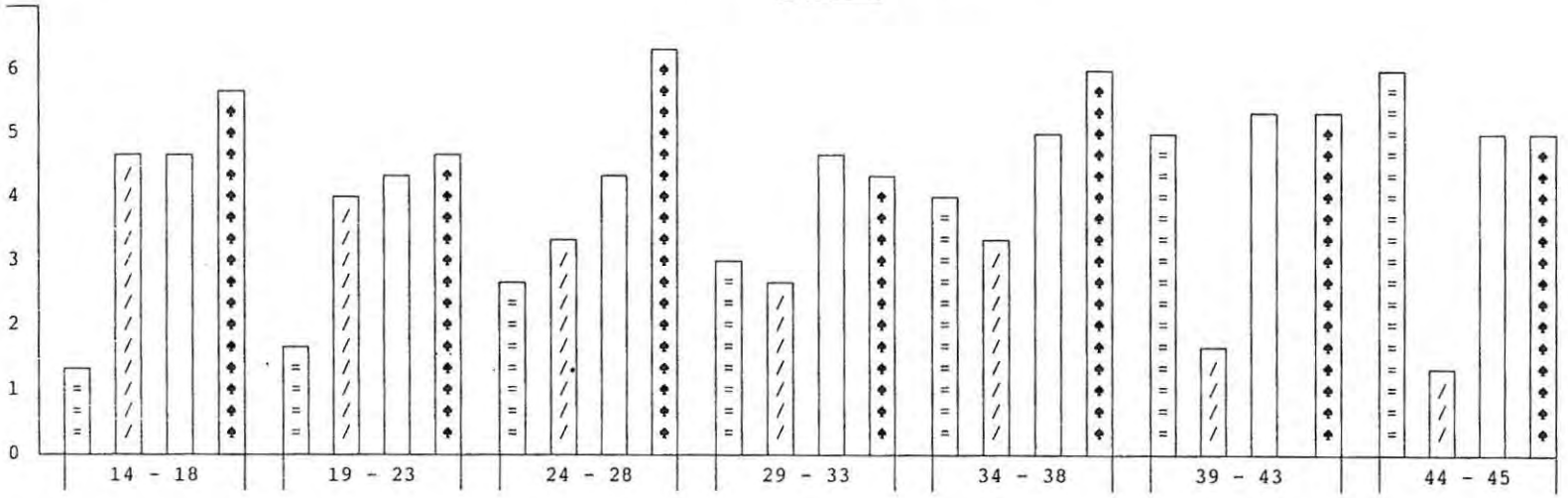
[ ] - Desired Number of Children

♠♠♠♠♠ - Ideal Number of Children

According to Figure 3, it is evident that most respondents in the sample do not come to the family planning clinic before child bearing has commenced. They attend only when their families are already well established. The implication of this finding for family life (including family planning) within the middle and high school settings, given the age range provided in chapter 6, i.e. from 11-22 years, suggest a place and the importance of preventive social work. The number indicated by the family planning users are low when compared to those given by their non user counterparts. Their expectations and desires are seemingly determined by their actual number of children. Respondents from both categories stated that they desired a larger number than their actual number and higher ideal numbers, 4,1 for the family planning users and 5,1 for the family planning non users. Figure 4 shows the number of children in correlation to age of respondent category.

Figure 4

MEAN NUMBER OF CHILDREN ACCORDING TO
AGE OF RESPONDENT CATEGORY
(N = 200)



LEGEND

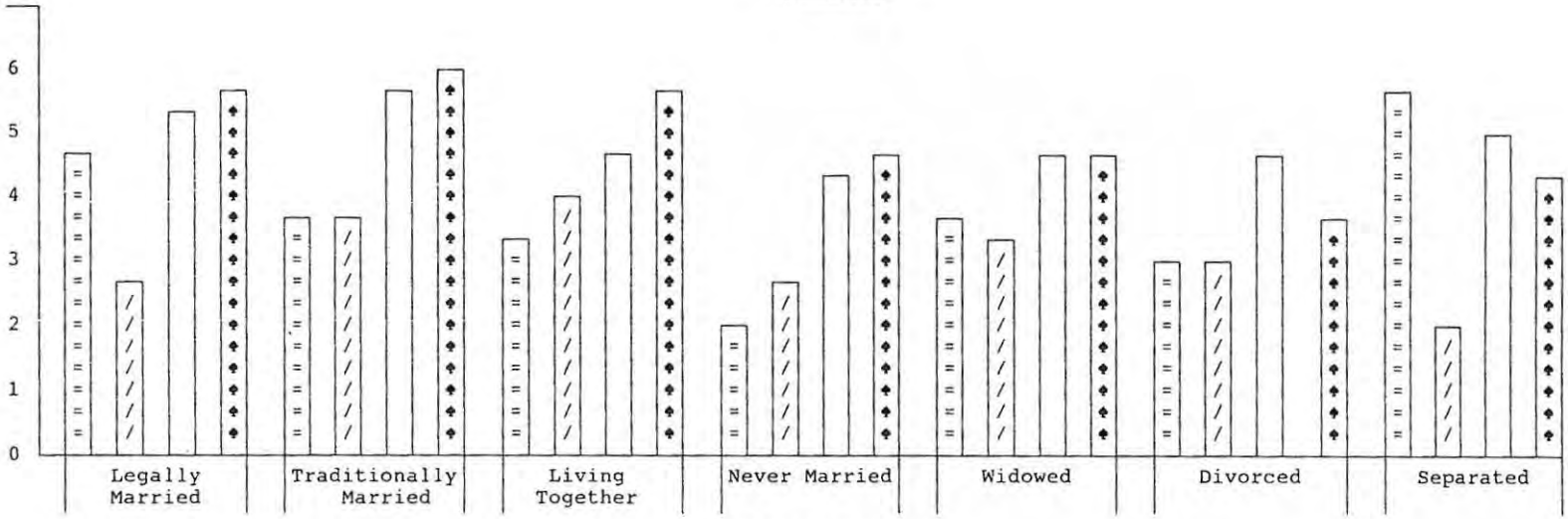
=====	- Actual Number of Children
/////	- Expected Number of Children
	- Desired Number of Children
♦♦♦♦♦	- Ideal Number of Children

According to Figure 4 the age of the respondent determines the number of children a person actually has, expects, desired and regard as ideal. The younger the woman, the fewer the actual number of children, their desired number is mostly similar to what they still expect, which is more futuristic in approach, unlike with their older counterparts whose desired number is wishful thinking, i.e. what could have been obtained in the past.

As previously pointed out, age seems to play a vital role as far as the fecundity and fertility level is concerned. The younger the women for example, the more fecund she is. Fecundity therefore decreases as one becomes older. The teenagers, i.e. those between the ages 14-18 years who are the "high risks" are most in need of knowledge of their physiological make up and functioning, which includes factors like contraception. Apparently most of these teenagers, because of lack of awareness and knowledge, prefer to control conception only after giving birth to at least one child, thus interrupting their schooling. The older respondents, those between the ages 39-45 years, were seemingly considering contraception because of already having well established families, while some are helped by the fact that child bearing automatically ceases or decreases.

Figure 5

THE MEAN NUMBER OF CHILDREN IN CORRELATION
TO THE MARITAL STATUS OF RESPONDENTS
(N = 200)



LEGEND

=====	- Actual Number of Children
/////	- Expected Number of Children
	- Desired Number of Children
♠♠♠♠♠	- Ideal Number of Children

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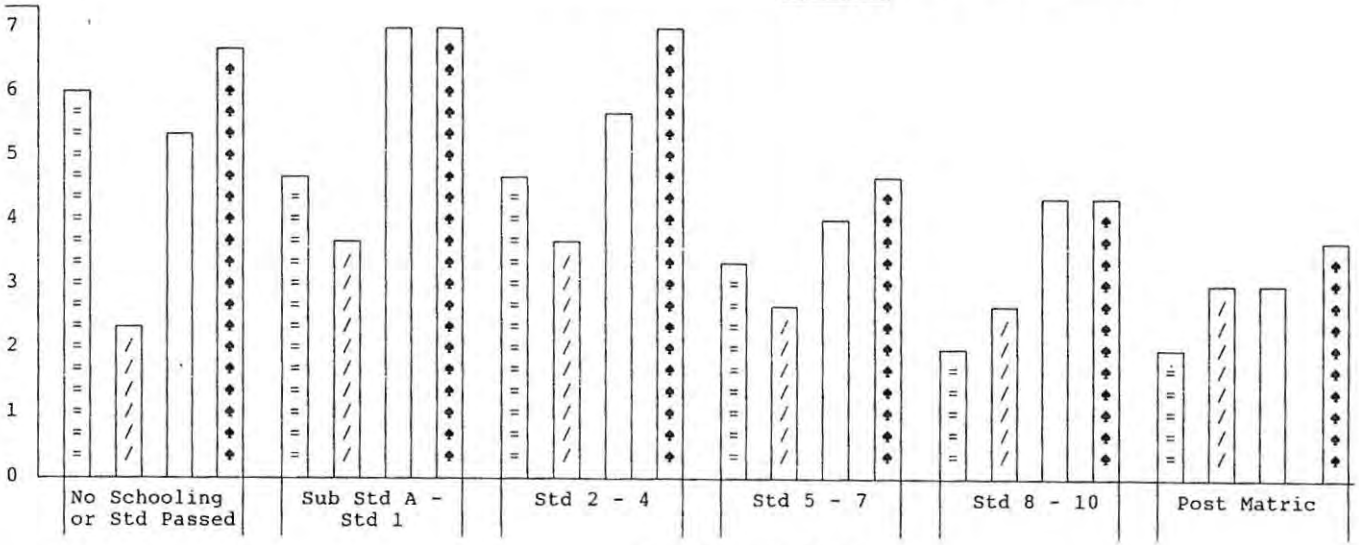
Figure 5 shows the mean number of children in correlation to the marital status of respondents. According to Figure 5 the legally married and those who said they had separated had well established families, partly it is assumed because of their marital statuses, that of being married, for both are. It might be observed that the value of children to married people is indisputable. The traditionally married, those living together and those never married had fewer living children with many expected numbers, seemingly because respondents in these categories said that they were promised marriage by their partners. The widowed and the divorced in this case, although not contemplating to get married, have extra marital affairs and since they, the women, do become economically dependent on these men, they are also willing to have their children. All women in the sample indicated more than three children as the ideal number.

Figure 6

THE MEAN NUMBER OF CHILDREN IN CORRELATION
TO THE EDUCATIONAL LEVEL OF THE RESPONDENTS - 1987
(N = 200)



LEGEND

=====	- Actual Number of Children
/////	- Expected Number of Children
	- Desired Number of Children
♠♠♠♠♠	- Ideal Number of Children

As expected education according to Figure 6 appears to have an effect on the fecundity level of the respondents. Those with middle school to post matric education had few children, which is an indication of having control over their conception. The respondents in these categories are either fully employed and/or are continuing with their formal education. Their expected numbers, it is assumed, might be fulfilled by their achievements, i.e. after completing their schooling. Their desires are similar to what they regard as ideal. Whereas those with primary education and with no schooling had a high number of living children and a high ideal number. In spite of the high actual number of children, they were still expecting more. Their desired number was higher than their actual number. It is assumed that the respondents from these categories are unemployed and to them bearing and rearing children becomes an occupation.

These respondents cannot read nor write and have never used or even considered using contraception because of inter alia, lack of trust and ignorance, peer group influence and societal pressures.

7.3.5 Age At First Birth

Communities in which women are exposed to pregnancy for "usually" long periods, often experience a high rate of reproduction, as in India where the average age of women at marriage is well below 20 years. However, age at entry into sexual unions may have little bearing on fertility in many communities, for instance where the use of contraceptives has become widespread In the case of Black South Africans, age at entry into sexual unions may still serve as an important factor in the study of fertility and fertility differentials. (Lötter, 1977, pp.2-7).

The mean numbers of age at first birth for all respondents were calculated. This helped in determining whether women in the Taung area do start child bearing during their youthful ages or not. Table 20 shows age at first birth in correlation to educational level of the respondents.

According to Table 20 the total mean number of age at first birth was 19,6 years. The respondents had between Standards 8-10 (39,7%) and Standards 5-7 (38,2%) educational qualifications. Education according to Table 20 seems to have no effect on age at first birth of the respondents in the sample.

Table 20

MEAN NUMBER OF AGE AT FIRST BIRTH
IN CORRELATION TO EDUCATIONAL LEVEL OF RESPONDENTS
(N = 200)

EDUCATIONAL	AGE AT FIRST BIRTH (years)	NUMBER OF RESPONDENTS (in %)
No Schooling or Standard Passed	14 - 18 years 19 - 23 years 24 - 28 years	0,0 1,5 0,0
TOTAL		1,5
Sub A - Std 1	14 - 18 years 19 - 23 years 24 - 28 years	2,9 0,0 0,0
TOTAL		2,9
Std 2 - Std 4	14 - 18 years 19 - 23 years 24 - 28 years	5,9 7,4 0,0
TOTAL		13,3
Std 5 - Std 7	14 - 18 years 19 - 23 years 24 - 28 years	14,7 17,6 5,9
TOTAL		38,2
Std 8 - Std 10	14 - 18 years 19 - 23 years 24 - 28 years	7,4 23,5 8,8
TOTAL		39,7
Post Matric	14 - 18 years 19 - 23 years 24 - 28 years	1,5 1,5 1,5
TOTAL		4,4

7.3.6 Period Between Births

The period between births can also be referred to as the "birth spacing" (parity). Mean numbers were calculated in correlation to the educational level of respondents. Table 21 shows the mean period between births in correlation to educational level of respondents.

Table 21

MEAN PERIOD BETWEEN BIRTHS IN CORRELATION

TO THE EDUCATIONAL LEVEL OF THE RESPONDENTS

(N = 200)

EDUCATIONAL LEVEL	MEAN PERIOD BETWEEN BIRTHS (in years)	NUMBER OF RESPONDENTS (in %)
No Schooling or Standard Passed	1 2 3 4 5 6	0,0 0,0 2,2 0,0 0,0 0,0
TOTAL		2,2
Sub A - Std 1	1 2 3 4 5 6	0,0 4,4 0,0 0,0 0,0 0,0
TOTAL		4,4
Std 2 - Std 4	1 2 3 4 5 6	0,0 11,1 4,4 0,0 0,0 0,0
TOTAL		15,5
Std 5 - Std 7	1 2 3 4 5 6	0,0 24,4 15,6 0,0 2,2 2,2
TOTAL		44,4

According to Table 21 the mean period between births of the respondents in the sample was 2,3 years. The educational levels were between Standards 5 to 7. (44,4%)

7.3.7 Last Birth

The period which has passed since the last birth is sometimes referred to as the "open interval". It offers a handy and possibly a more sensitive instrument for measuring change in fertility behaviour than the more customary "closed intervals" - the period between wedding or period of staying together. (Lötter et al, 1975, p.60). The mean number of last birth will be calculated according to the educational level of the respondents.

Table 22 shows the mean number of last birth in correlation to the educational level of the respondents.

Table 22

THE MEAN NUMBER OF LAST BIRTH IN CORRELATION TO THE EDUCATIONAL LEVEL OF THE RESPONDENTS (N = 200)

EDUCATIONAL LEVEL	MEAN NUMBER OF LAST BIRTH (in months)	NUMBER OF RESPONDENTS (in %)
No Schooling or Standard Passed	4 - 12	0,0
	13 - 24	0,0
	25 - 36	0,0
	37 - 48	0,0
	49 - 60	0,0
	61 +	1,5
TOTAL		1,5
Sub A - Std 1	4 - 12	0,0
	13 - 24	1,5
	25 - 36	1,5
	37 - 48	0,0
	49 - 60	0,0
	61 +	0,0
TOTAL		2,9
Std 2 - Std 4	4 - 12	7,4
	13 - 24	10,3
	25 - 36	1,5
	37 - 48	0,0
	49 - 60	1,5
	61 +	0,0
TOTAL		13,2
Std 5 - Std 7	4 - 12	13,2
	13 - 24	10,3
	25 - 36	5,9
	37 - 48	2,9
	49 - 60	1,5
	61 +	1,5
TOTAL		38,2
Std 8 - Std 10	4 - 12	11,8
	13 - 24	11,8
	25 - 36	4,4
	37 - 48	4,4
	49 - 60	4,4
	61 +	2,9
TOTAL		39,7
Post Matric	4 - 12	4,4
	13 - 24	0,0
	25 - 36	0,0
	37 - 48	0,0
	49 - 60	0,0
	61 +	0,0
TOTAL		4,4

According to Table 22 the mean number in the sample of the "open interval" was 4,1 years. The level of education seems to have no effect on the period which has passed since the last birth. Respondents in the sample apparently continued bearing children until nature intervened (Menopause).

7.4 Traditional And Cultural Beliefs

The culture of a society has been defined as "the common learned way of life, shared by the members of a society, consisting of the totality of tools, techniques, social institutions, attitudes, beliefs, motivations and systems of values, known to the group" (Foster, 1962, as cited by Bembridge, 1984, p.43).

In traditional communities, the child was seen as a valuable asset. He or she could labour on behalf of parents or the kinship group. The bride price (bogadi / lobola) a man received in exchange for the reproduction capacity of his daughters could enrich and a large family would ensure care in old age (LÖtter and Van Tonder, 1976, pp.23-25).

Against the background of the above paragraph, questions were presented to the women, with the main aim of exploring their traditional and cultural beliefs. Both

positive and negative questions to family limitation were presented. Llewellyn-Jones as quoted by Lötter (1977) for example suggests that in programmes aimed at lowering fertility, everyone should consistently be brought to a realisation of the dangers accompanying uncontrolled fertility and that new cultural norms which "prescribe" smaller families, should be established (Lötter, 1977, p.9).

The questions on traditional and cultural beliefs will be seen in correlation to age and educational level of the respondents. Table 23 shows responses to questions on traditional and cultural beliefs regarding family limitation in correlation to age of respondent.

Table 23

Responses to Questions on Traditional and Cultural Beliefs regarding Family Limitation in Correlation to Age of Respondent (N = 200)

QUESTIONS: DO YOU BELIEVE THAT ...	AGE	YES	NO	UN-CERTAIN	TOTAL
... a big family is a symbol of status ?	14-18	28,6	57,1	14,3	100,0
	19-23	26,8	73,2	0,0	100,0
	24-28	25,6	69,8	4,7	100,0
	29-33	20,6	76,5	2,9	100,0
	34-38	19,2	76,5	3,8	100,0
	39-43	17,6	76,5	5,9	100,0
	44-45	53,1	46,9	0,0	100,0
	TOTAL	28,0	69,0	3,0	100,0
... many countries in the world are poor because they have too many people ?	14-18	57,1	28,6	14,3	100,0
	19-23	68,3	26,8	4,9	100,0
	24-28	76,7	20,9	2,3	100,0
	29-33	82,4	8,8	8,8	100,0
	34-38	76,9	23,1	0,0	100,0
	39-43	76,5	17,6	5,9	100,0
	44-45	62,5	25,0	12,5	100,0
	TOTAL	73,0	21,0	6,0	100,0
... many children are an asset especially to parents who have reached old age ?	14-18	100,0	0,0	0,0	100,0
	19-23	63,4	34,1	2,4	100,0
	24-28	62,8	30,2	7,0	100,0
	29-33	38,2	50,0	11,8	100,0
	34-38	42,3	50,0	7,7	100,0
	39-43	17,6	76,5	5,9	100,0
	44-45	46,9	34,4	18,7	100,0
	TOTAL	51,0	40,5	8,5	100,0
... Blacks in South Africa will develop more quickly if they have fewer children ?	14-18	71,4	28,6	0,0	100,0
	19-23	85,4	14,6	0,0	100,0
	24-28	88,4	9,3	2,3	100,0
	29-33	85,3	8,8	5,9	100,0
	34-38	92,3	7,7	0,0	100,0
	39-43	82,4	11,8	5,9	100,0
	44-45	59,4	34,4	6,3	100,0
	TOTAL	82,0	15,0	3,0	100,0
... there will be too many people in the world in ten years time, if present trends continue ?	14-18	71,4	28,6	0,0	100,0
	19-23	51,2	43,9	4,9	100,0
	24-28	65,1	32,6	2,3	100,0
	29-33	61,8	32,4	5,9	100,0
	34-38	57,7	34,6	7,7	100,0
	39-43	35,3	47,1	17,6	100,0
	44-45	59,4	25,0	15,6	100,0
	TOTAL	57,5	35,0	7,5	100,0

According to Table 23 from the responses there seems to be a move from some traditional and cultural beliefs of the Batswana people in the sample. As already pointed out in the previous chapters, although the Batswana people are said to have taken and adopted certain western forms and norms, the process it must be remembered has not been indiscriminate, but selective. Sixty nine percent of the respondents disagreed that a big family (that of five and more children) is a status symbol; 73% could relate over-population with low socio-economic conditions. However, 51% regarded children as an asset (especially financially) to people who have reached old age (bearing in mind the low amounts in old age grants, with regard to Blacks); while 82% associated development and progress with family limitation; and lastly 57,5% of the respondents were aware of the present population problems and could give projections for the world population, if the present rates of population growth are maintained. Age seems not to have any effect in particular on people's responses to traditional and cultural beliefs. Table 24 shows the responses to questions on traditional and cultural beliefs, regarding family limitation in correlation to the educational level of the respondents.

Table 24 reveals that change is taking place. Modernised views have gained a considerable foothold among the educated respondents in the sample (especially those with high school and post matric qualifications).

Table 24

RESPONSES TO QUESTIONS ON TRADITIONAL AND CULTURAL BELIEFS REGARDING FAMILY LIMITATION IN CORRELATION TO EDUCATIONAL LEVEL OF RESPONDENTS (N = 200)

QUESTIONS: DO YOU BELIEVE THAT ...	EDUCATION	YES	NO	UN-CER-TAIN	TOTAL
... a big family is a symbol of status ?	No Schooling	56,5	39,1	4,3	100,0
	Sub A - Std 1	30,0	70,0	0,0	100,0
	Std 2 - Std 4	38,0	62,0	0,0	100,0
	Std 5 - Std 7	21,9	71,9	6,3	100,0
	Std 8 - Std10	14,3	83,7	2,0	100,0
	Post Matric	0,0	100,0	0,0	100,0
	TOTAL	28,0	69,0	3,0	100,0
... many countries in the world are poor because they have too many people ?	No Schooling	52,2	30,4	17,4	100,0
	Sub A - Std 1	50,4	40,0	10,0	100,0
	Std 2 - Std 4	60,0	40,0	0,0	100,0
	Std 5 - Std 7	82,8	15,0	1,6	100,0
	Std 8 - Std10	87,8	0,0	12,2	100,0
	Post Matric	75,0	25,0	0,0	100,0
	TOTAL	73,0	21,0	6,0	100,0
... many children are an asset especially to parents who have reached old age ?	No Schooling	60,9	26,1	13,0	100,0
	Sub A - Std 1	40,1	50,0	10,0	100,0
	Std 2 - Std 4	64,0	34,0	2,0	100,0
	Std 5 - Std 7	51,6	43,9	4,7	100,0
	Std 8 - Std10	36,7	49,0	14,3	100,0
	Post Matric	25,0	25,0	50,0	100,0
	TOTAL	51,0	40,5	8,5	100,0
... Black in South Africa will develop more quickly if they have fewer children?	No Schooling	65,2	17,4	17,4	100,0
	Sub A - Std 1	60,0	40,0	0,0	100,0
	Std 2 - Std 4	70,0	30,0	0,0	100,0
	Std 5 - Std 7	87,5	9,4	3,1	100,0
	Std 8 - Std10	98,0	2,0	0,0	100,0
	Post Matric	100,0	0,0	0,0	100,0
	TOTAL	82,0	15,0	3,0	100,0
... there will be too many people in the world in ten years time, if the present trend continues ?	No Schooling	60,9	21,7	17,4	100,0
	Sub A - Std 1	40,0	50,0	10,0	100,0
	Std 2 - Std 4	52,0	42,0	6,0	100,0
	Std 5 - Std 7	56,2	35,9	7,8	100,0
	Std 8 - Std10	63,3	32,7	4,1	100,0
	Post Matric	100,0	0,0	0,0	100,0
	TOTAL	57,5	35,0	7,5	100,0

7.5 Attitude, Knowledge and Use of Family Planning

There are many different methods of contraception some of which, if used efficiently, can give almost certain protection against pregnancy.

7.5.1 Attitude to Family Planning

In response to the question: "Are you in favour of family planning?" (See Appendix), 74% of the respondents in the sample answered in the affirmative and 26% responded negatively. Explanations were grouped according to similarity and the outcome was as follows for those who said they are in favour of family planning: 40% said it helps people to have fewer children; 28% said pregnancies can be delayed; 22% said family planning helps in preventing unplanned and unwanted pregnancies; while the remaining 10% said that it helps in spacing pregnancies. Those against family planning gave the following as reasons for their attitude: 42% said because of too many side effects from most methods, they fear that it will cause them ill-health; 27% said because of not being well informed about family planning methods they do not see the need for usage; 17% said they felt that it was morally wrong, i.e. it promotes promiscuity and is also against the teachings of "God" in the

bible; lastly 14% said they were against family planning simply because their partners disliked it. Inconveniences and especially perceived health hazards seem to be the main reasons for negativity.

7.5.2 Knowledge of Family Planning Methods

The extent of the women's knowledge of certain family planning methods will be shown in correlation to age and educational standard of respondents. Table 25 shows knowledge of family planning methods in correlation to age of respondents.

According to Table 25 of all the family planning methods available, three of these methods seem to be well known to the respondents in the sample, viz the oral pill (59,5%), injection (57%) and abstinence (100%), although the respondents did not in actual fact regard it as a method to prevent pregnancy. Those who indicated not to have known the popular family planning methods indicated to have heard of these. The other method such as the loop seems to be less well known although the respondents indicated to have heard of it (62%). From those that were not known and heard of are the douche, 98,5% said that they had never heard of the method; followed by spermicides (97%), diaphragm (94,5%), coitus-interruptus (91,5%), rhythm (85%) and the condom (49%).

Table 25

KNOWLEDGE OF FAMILY PLANNING
IN CORRELATION TO AGE OF RESPONDENT - 1987
(N = 200)

TYPE OF METHOD	AGE	KNOW	HAVE HEARD OF	HAVE NOT HEARD OF	TOTAL
Oral Pill	14 - 18	42,9	42,9	14,3	100,0
	19 - 23	68,3	31,7	0,0	100,0
	24 - 28	72,1	27,9	0,0	100,0
	29 - 33	70,6	26,5	2,9	100,0
	34 - 38	50,0	46,2	3,8	100,0
	39 - 43	47,1	41,2	11,8	100,0
	44 - 45	37,5	62,5	0,0	100,0
	TOTAL	59,5	38,0	2,5	100,0
Loop (IUD)	14 - 18	28,6	57,1	14,3	100,0
	19 - 23	29,3	63,4	7,3	100,0
	24 - 28	32,6	55,8	11,6	100,0
	29 - 33	47,1	47,1	5,9	100,0
	34 - 38	15,4	69,2	15,4	100,0
	39 - 43	11,8	82,4	5,9	100,0
	44 - 45	15,6	68,8	15,6	100,0
	TOTAL	27,5	62,0	10,5	100,0
Injection	14 - 18	28,8	71,4	0,0	100,0
	19 - 23	58,5	41,5	0,0	100,0
	24 - 28	67,4	32,6	0,0	100,0
	29 - 33	70,6	26,5	2,9	100,0
	34 - 38	57,7	38,5	3,8	100,0
	39 - 43	47,1	52,9	0,0	100,0
	44 - 45	37,5	59,4	3,1	100,0
	TOTAL	57,0	41,5	1,5	100,0
Condom	14 - 18	28,6	57,1	14,3	100,0
	19 - 23	29,3	36,6	34,1	100,0
	24 - 28	41,9	23,3	34,9	100,0
	29 - 33	41,2	26,5	32,4	100,0
	34 - 38	15,4	30,8	53,8	100,0
	39 - 43	0,0	23,5	76,5	100,0
	44 - 45	0,0	6,3	93,8	100,0
	TOTAL	25,0	26,0	49,0	100,0

Table 25 - continued

TYPE OF METHOD	AGE	KNOW	HAVE HEARD OF	HAVE NOT HEARD OF	TOTAL
Spermicides	14 - 18	0,0	0,0	100,0	100,0
	19 - 23	2,4	2,4	95,1	100,0
	24 - 28	4,7	2,3	93,0	100,0
	29 - 33	0,0	2,9	97,1	100,0
	34 - 38	0,0	0,0	100,0	100,0
	39 - 43	0,0	0,0	100,0	100,0
	44 - 45	0,0	0,0	100,0	100,0
	TOTAL	1,5	1,5	97,0	100,0
Douche	14 - 18	0,0	0,0	100,0	100,0
	19 - 23	2,4	2,4	95,1	100,0
	24 - 28	2,3	0,0	97,0	100,0
	29 - 33	0,0	0,0	100,0	100,0
	34 - 38	0,0	0,0	100,0	100,0
	39 - 43	0,0	0,0	100,0	100,0
	44 - 45	0,0	0,0	100,0	100,0
	TOTAL	1,0	0,5	98,5	100,0
Diaphragm	14 - 18	0,0	0,0	100,0	100,0
	19 - 23	4,9	4,9	90,2	100,0
	24 - 28	7,0	2,3	90,7	100,0
	29 - 33	0,0	5,9	94,1	100,0
	34 - 38	0,0	0,0	100,0	100,0
	39 - 43	0,0	0,0	100,0	100,0
	44 - 45	3,1	0,0	96,9	100,0
	TOTAL	3,0	2,5	94,5	100,0
Coitus Interruptus	14 - 18	0,0	0,0	100,0	100,0
	19 - 23	2,4	4,9	92,0	100,0
	24 - 28	7,0	2,3	90,7	100,0
	29 - 33	8,8	11,8	79,4	100,0
	34 - 38	3,8	3,8	92,3	100,0
	39 - 43	0,0	0,0	100,0	100,0
	44 - 45	3,1	0,0	96,9	100,0
	TOTAL	4,5	4,0	91,5	100,0

Table 25 - continued

TYPE OF METHOD	AGE	KNOW	HAVE HEARD OF	HAVE NOT HEARD OF	TOTAL
Abstinence	14 - 18	100,0	0,0	0,0	100,0
	19 - 23	100,0	0,0	0,0	100,0
	24 - 28	100,0	0,0	0,0	100,0
	29 - 33	100,0	0,0	0,0	100,0
	34 - 38	100,0	0,0	0,0	100,0
	39 - 43	100,0	0,0	0,0	100,0
	44 - 45	100,0	0,0	0,0	100,0
	TOTAL	100,0	0,0	0,0	100,0
Rhythm (Safe Period)	14 - 18	0,0	0,0	100,0	100,0
	19 - 23	7,3	2,4	90,2	100,0
	24 - 28	16,3	7,0	76,7	100,0
	29 - 33	17,6	11,8	70,6	100,0
	34 - 38	7,7	7,7	84,6	100,0
	39 - 43	0,0	0,0	100,0	100,0
	44 - 45	0,0	6,3	93,8	100,0
	TOTAL	9,0	6,0	85,0	100,0

Age seems to be playing a major role in as far as knowledge of family planning is concerned in the sample. The young respondents, those between the ages 14 to 18 years and the older ones between 39 and 43 years and 44 and 45 years, seem to have an awareness and knowledge problem regarding the availability of different kinds of methods. Those between the ages from 24 to 28 and 29 to 33 years seem to be conversant with family planning methods. It is assumed by the writer that the present state of affairs obtains due to the following factors: That most respondents came to be informed about family planning methods when already pregnant and attending the ante-natal clinic, especially on subsequent visits. With the very young respondents, they do not accept their first pregnancy and because of ignorance, embarrassment and refusal to face reality, either do not attend ante-natal clinics or wait until their due dates. The older respondents do not choose to attend such clinics, they rather prefer to give birth at their homes. Illiteracy also plays a major role. Table 26 shows the knowledge of family planning in relation to the educational level of the respondents.

Table 26

KNOWLEDGE OF FAMILY PLANNING METHODS
IN CORRELATION TO EDUCATIONAL LEVEL OF RESPONDENTS - 1987
(N = 200)

TYPE OF METHOD	EDUCATIONAL LEVEL	KNOW	HAVE HEARD OF	HAVE NOT HEARD OF	TOTAL
Oral Pill	No Schooling	21,7	69,6	8,7	100,0
	Sub A-Std 1	50,0	50,0	0,0	100,0
	Std 2-Std 4	40,0	54,0	6,0	100,0
	Std 5-Std 7	67,2	32,8	0,0	100,0
	Std 8-Std 10	85,7	14,3	0,0	100,0
	Post Matric	100,0	0,0	0,0	100,0
	TOTAL	59,5	38,0	2,5	100,0
Loop (IUD)	No Schooling	26,1	56,5	17,4	100,0
	Sub A-Std 1	10,0	60,0	30,0	100,0
	Std 2-Std 4	12,0	76,0	12,0	100,0
	Std 5-Std 7	23,4	64,1	12,5	100,0
	Std 8-Std 10	46,9	53,1	0,0	100,0
	Post Matric	100,0	0,0	0,0	100,0
	TOTAL	27,5	62,0	10,5	100,0
Injection	No Schooling	34,8	56,5	8,7	100,0
	Sub A-Std 1	30,0	70,0	0,0	100,0
	Std 2-Std 4	54,0	46,0	0,0	100,0
	Std 5-Std 7	57,8	40,6	1,6	100,0
	Std 8-Std 10	71,4	28,6	0,0	100,0
	Post Matric	100,0	0,0	0,0	100,0
	TOTAL	57,0	41,5	1,5	100,0
Condom	No Schooling	0,0	8,7	91,3	100,0
	Sub A-Std 1	0,0	10,0	90,0	100,0
	Std 2-Std 4	6,0	22,0	72,0	100,0
	Std 5-Std 7	23,4	31,2	45,3	100,0
	Std 8-Std 10	57,1	36,7	6,1	100,0
	Post Matric	100,0	0,0	0,0	100,0
	TOTAL	25,0	26,0	49,0	100,0
Spermi-cides	No Schooling	0,0	0,0	100,0	100,0
	Sub A-Std 1	0,0	0,0	100,0	100,0
	Std 2-Std 4	0,0	0,0	100,0	100,0
	Std 5-Std 7	1,6	0,0	98,4	100,0
	Std 8-Std 10	2,0	6,1	91,8	100,0
	Post Matric	25,0	0,0	75,0	100,0
	TOTAL	1,5	1,5	97,0	100,0

Table 26 - continued

TYPE OF METHOD	EDUCATIONAL LEVEL	KNOW	HAVE HEARD OF	HAVE NOT HEARD OF	TOTAL
Douche	No Schooling	0,0	0,0	100,0	100,0
	Sub A-Std 1	0,0	0,0	100,0	100,0
	Std 2-Std 4	0,0	0,0	100,0	100,0
	Std 5-Std 7	0,0	0,0	100,0	100,0
	Std 8-Std 10	2,0	2,0	95,9	100,0
	Post Matric	25,0	0,0	75,0	100,0
	TOTAL	1,0	0,5	98,5	100,0
Diaphragm	No Schooling	4,3	0,0	95,7	100,0
	Sub A-Std 1	0,0	0,0	100,0	100,0
	Std 2-Std 4	0,0	0,0	100,0	100,0
	Std 5-Std 7	0,0	0,0	100,0	100,0
	Std 8-Std 10	2,0	10,2	87,8	100,0
	Post Matric	100,0	0,0	0,0	100,0
	TOTAL	3,0	2,5	94,5	100,0
Coitus Inter-ruptus	No Schooling	8,7	0,0	92,3	100,0
	Sub A-Std 1	0,0	0,0	100,0	100,0
	Std 2-Std 4	0,0	0,0	100,0	100,0
	Std 5-Std 7	1,6	0,0	98,4	100,0
	Std 8-Std 10	10,2	16,3	73,5	100,0
	Post Matric	25,0	0,0	75,0	100,0
	TOTAL	4,5	4,0	91,5	100,0
Abstinence	No Schooling	100,0	0,0	0,0	100,0
	Sub A-Std 1	100,0	0,0	0,0	100,0
	Std 2-Std 4	100,0	0,0	0,0	100,0
	Std 5-Std 7	100,0	0,0	0,0	100,0
	Std 8-Std 10	100,0	0,0	0,0	100,0
	Post Matric	100,0	0,0	0,0	100,0
	TOTAL	100,0	0,0	0,0	100,0
Rhythm (Safe Period)	No Schooling	4,3	0,0	95,7	100,0
	Sub A-Std 1	0,0	0,0	100,0	100,0
	Std 2-Std 4	0,0	0,0	100,0	100,0
	Std 5-Std 7	3,1	3,1	93,8	100,0
	Std 8-Std 10	22,4	20,4	57,1	100,0
	Post Matric	100,0	0,0	0,0	100,0
	TOTAL	9,0	6,0	85,0	100,0

Table 26 indicates the importance of education in obtaining knowledge of family planning methods. Those with high educational levels especially with post matric qualifications have a knowledge of all family planning methods available except for spermicides and the douche, as compared to their counterparts with no schooling and those with less than four years of formal education. It is also those with high school and post matric qualifications that are employed as skilled workers. They have more secure jobs, are family planning users, and are aware of the effects of the high cost of living. This category of respondents can read for themselves, unlike those with low educational levels who have to be made aware by others.

7.5.3. Response to Statements in Respect of the Usage of Family Planning by Certain People, other than themselves (the Respondents)

The respondents were asked to indicate whether they agree or disagree to statements in respect of the use of family planning by certain categories of people. This will be presented in correlation to age and educational level of the respondents. Table 27 shows the responses to the statements in correlation to age of respondent.

Table 27

RESPONSES TO STATEMENTS REGARDING USAGE OF FAMILY PLANNING BY CERTAIN CATEGORIES OF PEOPLE (N = 200)

STATEMENT: Do you agree that the following persons should use contraceptives ?	AGE	AGREE	DIS-AGREE	TOTAL
Adolescent School Girls	14 - 18	71,4	28,6	100,0
	19 - 23	80,5	19,5	100,0
	24 - 28	79,1	20,9	100,0
	29 - 33	64,7	35,3	100,0
	34 - 38	69,2	30,8	100,0
	39 - 43	47,1	52,9	100,0
	44 - 45	56,2	43,7	100,0
	TOTAL	69,0	31,0	100,0
Unmarried Women no longer at School	14 - 18	71,4	28,6	100,0
	19 - 23	78,0	22,0	100,0
	24 - 28	76,7	23,3	100,0
	29 - 33	82,4	17,6	100,0
	34 - 38	84,6	15,4	100,0
	39 - 43	52,9	47,1	100,0
	44 - 45	65,6	34,4	100,0
	TOTAL	75,0	25,0	100,0
Newly Weds	14 - 18	57,1	42,9	100,0
	19 - 23	48,8	51,2	100,0
	24 - 28	55,8	44,2	100,0
	29 - 33	50,0	50,0	100,0
	34 - 38	26,9	73,1	100,0
	39 - 43	64,7	35,3	100,0
	44 - 45	37,5	62,5	100,0
	TOTAL	47,5	52,5	100,0
Married Couples with Small Families	14 - 18	57,1	42,9	100,0
	19 - 23	63,4	36,6	100,0
	24 - 28	65,1	34,9	100,0
	29 - 33	64,7	35,3	100,0
	34 - 38	69,2	30,8	100,0
	39 - 43	52,9	47,1	100,0
	44 - 45	43,7	56,3	100,0
	TOTAL	60,5	39,5	100,0

Table 27 - continued

STATEMENT: Do you agree that the following persons should use contraceptives ?	AGE	AGREE	DIS-AGREE	TOTAL
Married Couples with no Children	14 - 18	0,0	100,0	100,0
	19 - 23	4,9	95,1	100,0
	24 - 28	14,0	86,0	100,0
	29 - 33	0,0	100,0	100,0
	34 - 38	11,5	88,5	100,0
	39 - 43	11,8	88,2	100,0
	44 - 45	15,6	84,4	100,0
	TOTAL	9,0	91,0	100,0
Married Couples with Large Families	14 - 18	100,0	0,0	100,0
	19 - 23	95,1	4,9	100,0
	24 - 28	93,0	7,0	100,0
	29 - 33	97,1	2,9	100,0
	34 - 38	100,0	0,0	100,0
	39 - 43	93,8	6,3	100,0
	44 - 45	87,5	12,5	100,0
	TOTAL	94,5	5,5	100,0

Table 27 indicates that the respondents in the sample agreed to the usage of contraceptives by certain categories of people, especially the following: Married couples with large families (94,5%), unmarried women no longer at school (75%), adolescent school girls (69%) and married couples with small families (60,5%). The respondents disagreed completely that contraceptives should be used by married couples with no children (95%) and by the newly-weds (52,5%). All the age groups were apparently quite flexible in approach, with the lower age groups a little more so than the older ones. Those between the ages 14 to 18 and 19 to 23 years were in favour of family planning as long as it was after the birth of a child or two, for according to them (the respondents in these categories) one had then already proved one's fertility and womanhood. Whereas the older respondents, especially those between the ages 39 to 43 and 44 to 45 years, were reluctant that contraceptives be used by adolescent school girls. Their main argument was the question of morality. Although they agreed that adolescent school girls be allowed to use contraceptives, it was a question of being bound, and approach avoidance conflict (ambivalence). In fact the older respondents felt that before marriage the usage of contraceptives could cause damage which may lead to sterility.

After marriage the woman is supposed to be controlled by circumstances that will prevail in her marriage, for example, being under the authority of the husband. Marriage for all age groups was strictly for procreation.

Table 28 shows the responses to the statements in correlation to the educational level of the respondents.

According to Table 28 the level of education has an influence on the usage of contraceptives by the respondents. Both formal and informal education plays an important role, though emphasis is more on formal education, i.e. those with high school to post matric education. Although the respondents from these categories agreed to the usage of contraceptives, the term "family planning" for this group is not viewed or conceived narrowly only in the sense of prevention, but also in that of delaying until one gets married for example. The respondents from this category disagreed that contraceptives should be used by the newly weds and by married couples with no children. What comes out of these findings is that though the western culture is adopted due to factors like education, people are retaining some of their cultural identity, which they term valuable.

Table 28

RESPONSES TO STATEMENTS REGARDING USAGE OF CONTRACEPTIVES, BY CERTAIN CATEGORIES OF PEOPLE, IN CORRELATION TO THE EDUCATIONAL LEVEL OF THE RESPONDENTS (N = 200)

STATEMENT: Do you agree that the following persons should use contra-ceptives ?	LEVEL OF EDUCATION	AGREE	DIS-AGREE	TOTAL
Adolescent School Girls	No School	65,2	34,8	100,0
	Sub A-Std 1	60,0	40,0	100,0
	Std 2-Std 4	72,0	28,0	100,0
	Std 5-Std 7	67,2	32,8	100,0
	Std 8-Std10	69,4	30,6	100,0
	Post Matric	100,0	0,0	100,0
	TOTAL	69,0	31,0	100,0
Unmarried Women no longer at School	No School	65,2	34,8	100,0
	Sub A-Std 1	80,0	20,0	100,0
	Std 2-Std 4	72,0	28,0	100,0
	Std 5-Std 7	73,4	26,6	100,0
	Std 8-Std10	81,6	18,4	100,0
	Post Matric	100,0	0,0	100,0
	TOTAL	75,0	25,0	100,0
Newly Weds	No School	30,4	69,6	100,0
	Sub A-Std 1	40,0	60,0	100,0
	Std 2-Std 4	38,0	62,0	100,0
	Std 5-Std 7	45,3	54,7	100,0
	Std 8-Std10	71,4	28,6	100,0
	Post Matric	25,0	75,0	100,0
	TOTAL	47,5	52,5	100,0
Married Couples with small Families	No School	47,5	52,5	100,0
	Sub A-Std 1	70,0	30,0	100,0
	Std 2-Std 4	56,0	44,0	100,0
	Std 5-Std 7	59,4	40,6	100,0
	Std 8-Std10	67,3	32,7	100,0
	Post Matric	100,0	0,0	100,0
	TOTAL	60,5	39,5	100,0

Table 28 - continued

STATEMENT: Do you agree that the following persons should use contra-ceptives ?	LEVEL OF EDUCATION	AGREE	DIS-AGREE	TOTAL
Married Couples with no Children	No School	13,0	87,0	100,0
	Sub A-Std 1	0,0	100,0	100,0
	Std 2-Std 4	12,0	88,0	100,0
	Std 5-Std 7	8,0	92,0	100,0
	Std 8-Std10	8,2	91,8	100,0
	Post Matric	0,0	100,0	100,0
	TOTAL	9,0	91,0	100,0
Married Couples with large Families	No School	82,6	17,4	100,0
	Sub A-Std 1	100,0	0,0	100,0
	Std 2-Std 4	92,0	8,0	100,0
	Std 5-Std 7	96,8	3,2	100,0
	Std 8-Std10	98,0	2,0	100,0
	Post Matric	100,0	0,0	100,0
	TOTAL	94,5	5,5	100,0

7.6 Family Planning Users

It was assumed by the writer that all family planning users were attending a family planning clinic. Concentration therefore was focused on "repeats" and not first attenders. It is assumed in the study that a person who visits the family planning clinic for the first time, commonly has not accepted family planning yet, this person is only trying it out, The woman may have come out of curiosity, or because she was encouraged by her friends or relatives or motivated by a family planning advisor. A "repeat" in most cases has accepted family planning and is presently using contraceptives. Because of her experience regarding the subject matter, she is in a position to give her opinion, i.e. whether she is satisfied or not, in as far as a particular method is concerned. Family planning users will be seen in correlation to age and educational standard of the respondent category, religion and church attendance, marital status and employment level of the respondents.

Table 29

FAMILY PLANNING USERS IN CORRELATION TO AGE AND LEVEL OF EDUCATION OF THE RESPONDENTS (N = 68)

	AGE							
LEVEL OF EDUCATION	14-18	19-23	24-28	29-33	34-38	39-43	44-48	TOTAL
No School	0,0	0,0	0,0	0,0	0,0	0,0	1,5	1,5
Sub A - Std 1	0,0	0,0	0,0	1,5	0,0	1,5	0,0	2,9
Std 2 - Std 4	0,0	2,9	5,9	2,9	0,0	1,5	0,0	13,2
Std 5 - Std 7	0,0	10,3	10,3	8,8	7,4	1,5	0,0	38,2
Std 8 - Std 10	1,5	8,8	13,2	10,3	2,9	1,5	1,5	39,7
Post Matric	0,0	2,9	1,5	0,0	0,0	0,0	0,0	4,4
TOTAL	1,5	25,0	30,0	23,5	10,3	5,9	2,9	100,0

Table 29 indicates that from the total number of respondents in the sample 35% were users of family planning methods. The family planning users, according to the Table, had between high school education (39,7%) and middle school education (38,2%), were between the ages 24 to 28 years (30,9%) and 19 to 23 years (25%).

Table 30 shows family planning users in correlation to religion and church attendance.

Table 30

FAMILY PLANNING USERS IN CORRELATION TO RELIGION AND CHURCH ATTENDANCES (N = 68)

	CHURCH ATTENDANCE			
RELIGION	REGULAR	OCCA-SIONAL	NO ATTEN-DANCE	TOTAL
Roman Catholic	7,4	8,8	1,5	17,6
Methodist	4,4	1,5	0,0	5,9
American Episcopal	4,4	4,4	0,0	8,8
Anglican	5,9	1,5	0,0	7,4
United Congregation	7,4	5,9	0,0	13,2
Zion Christian	5,9	1,5	0,0	7,4
Native Independence	1,5	1,5	0,0	2,9
Dutch Reformed	1,5	2,9	0,0	4,4
Apostolic	4,4	0,0	0,0	4,4
New Apostolic	0,0	2,9	0,0	2,9
Seventh Day Adventist	4,4	5,9	0,0	10,3
Twelve Apostle	2,9	0,0	0,0	2,9
Pentecostal	0,0	1,5	0,0	1,5
Lutheran	1,5	0,0	0,0	1,5
Five Mission	4,4	0,0	0,0	4,4
African Faith Mission	1,5	0,0	0,0	1,5
Assemblies of God	2,9	0,0	0,0	2,9
TOTAL	60,3	38,2	1,5	100,0

According to Table 30, contrary to what people would expect, the regular church attenders are the frequent users of family planning clinics (60,3%) compared to those who said they attend only occasionally (38,2%) and those who do not attend at all (1,5%). Religion does not seem to have direct influence on the usage of contraceptives.

The two commonly known denominations in the area, viz the Roman Catholic Church and the Zion Christian Church, in spite of their open opposition to contraception, had

many family planning users. A fact which supports the statement that people decide against the background of their prevailing socio-economic conditions. Table 31 shows the family planning users in correlation to marital status and employment level of the respondent category.

Table 31

FAMILY PLANNING USERS IN CORRELATION TO MARITAL STATUS AND EMPLOYMENT LEVEL OF THE RESPONDENT CATEGORY (N = 68)

MARITAL STATUS	EMPLOYED	UNEMPLOYED	TOTAL
Legally Married	13,6	34,1	47,7
Traditionally Married	1,5	10,6	12,1
Living Together	0,8	4,5	5,3
Never Married	5,3	23,5	28,8
Widowed	1,5	1,5	3,0
Divorced	0,8	0,0	0,8
Separated	0,8	1,5	2,3
TOTAL	24,2	75,8	100,0

According to Table 31, the family planning users are unemployed (75,8%) and legally married (34,1%), followed numerically by those never married (23,5%). Family planning users who were employed only formed 24,2% as against 75,8% users who were unemployed.

7.6.1 Reasons given for using Family Planning Methods

In response to the question: "Why are you using family planning?" (see Appendix), 55,9% said that

they were using the methods to space their pregnancies, 29,4% said to have fewer children, while 14,7% said to prevent falling pregnant, that they wanted to have no more children.

7.6.2 Partner's Knowledge of Family Planning Usage

The overwhelming majority of respondents (82,4%) said that their partner knew that they were using family planning methods. Only 17,6% of the respondents said that their partners did not know and that the methods were secretly applied. Their reasons for not telling partners were because partners did not like these methods and various reasons were given, viz that: Contraception encourages promiscuity, causes ill-health and that it was morally wrong.

7.6.3 The Methods which were being used

All family planning users in the sample had to indicate the different kinds of family planning methods that they were presently using at the time of the study. The different methods will be shown in correlation to age of respondents. Table 32 shows the family planning methods used in correlation to age of respondents.

Table 32

THE FAMILY PLANNING METHODS BEING USED

IN CORRELATION TO AGE OF RESPONDENTS

(N = 68)

AGE	INJECTION	PILL	LOOP	CONDOM	TOTAL
14 - 18	1,5	0,0	0,0	0,0	1,5
19 - 23	11,8	8,8	2,9	0,0	23,5
24 - 28	19,1	10,3	1,5	0,0	30,9
29 - 33	11,8	7,4	2,9	1,5	23,5
34 - 38	2,9	4,4	2,9	1,5	11,8
39 - 43	2,9	0,0	1,5	0,0	4,4
44 - 45	2,9	1,5	0,0	0,0	4,4
TOTAL	52,9	32,4	11,8	2,9	100,0

Table 32 indicates that the injection was the most popularly used method (52,9%) followed by the pill (32,4%, the loop (11,8%) and the condom (2,9%). Most methods seem to be used by respondents between the ages 24 to 28 years (30,9%).

7.6.4 Sources of advice as regards the method used

The sources of advice were many and varied. What stands out clearly, however, is the extent to which women asked for the method they were using themselves (69,1%). This, in a way, indicates the extent to which women obtain information from their friends; 23,5% said that they were advised by the family planning nurses and only 7,4% indicated to have been advised by their parents. From those advised to use a particular type of method, 8% said that reasons were given for the encouragement to use a particular method, while only 14% said that no reasons whatsoever were given by advisors.

7.6.5 Tests for Suitability of Family Planning Methods

In response to the question: "Were you tested before you began to use this method?" (see Appendix), the majority of respondents in the sample indicated clearly the difficulty of answering the question. Their main argument was that they could not differentiate between routine tests and tests for suitability of method. However, 70,6% said tests were made, 26,5% said that such tests were not applied to them and 2,9% said that they did not remember at all.

7.6.6 Knowledge of the Disadvantages of the Method Used

Apart from the good points of the method used, 35,3% said that they had heard and knew of the adverse side effects as well; while 64,7% said they were only aware of the advantages of the methods they were using.

7.6.7 Knowledge and Need of other Family Planning Methods apart from the ones that were being used by individual Respondents

The majority of respondents (70,6% said that they were given information on other family planning methods, as against 29,4% who stated that they were given no information. However, 85% admitted that they still lacked knowledge on family planning methods and would like to be given more information.

7.6.8 Suppliers of Family Planning Methods

It must be remembered that most of the respondents were from poor socio-economic backgrounds. As a result, 78,5% said that they obtained their supplies and attention from the hospital and clinic, where these are issued free of charge. However, only a small number indicated to "others"

(21,5%), this was from private doctors. According to the respondents, the hospital and clinics in the area were within reasonable travelling distance (92,9%) and that working hours were suitable (96%). In actual fact the respondents pointed out that family planning clients at all clinics and the hospital are attended to every day for twenty four hours around the clock. None of the respondents were dissatisfied about the people delivering family planning services at the hospital and clinics (nurses); 100% said that their services (i.e. the nurses') were always rendered in a friendly manner and that most were helpful.

7.6.9 Suitable Media of Communication for the Dissemination of Information on Family Planning

Respondents had to indicate the media of information they regarded as suitable for the dissemination of information on family planning. The respondents in the sample said that the health workers were the best (38,3%); followed numerically by those who said the family planning clinic (25%); newsletters (19,1%); the radio (16,1%) and lastly television (1,5%).

7.7 Family Planning Non Users

These are the respondents who, at the time of the study, were not using any family planning method. Haselkorn as quoted in Shillington (1980) describes the non contraceptive user as the immature, dependent, self-punishing individual who has a feeling of low self esteem and self worth and who has little, if any, desire to control her life. Also the characteristics of such an individual would be the inability to assume responsibility, to control impulses, to appreciate long range goals and to develop a good sexual adjustment. (Shillington, 1980, p.5). This is of course, when other variables are excluded, for example religion.

7.7.1 Reasons given for not using Family Planning

From the total number of respondents in the sample, 62% were not using any family planning method at the time of the study. Different reasons were given which were grouped according to similarity and the outcome was as follows: 34% of the respondents from this category said that their main reasons were that they did not like the methods, because of too many unpleasant side effects; that family planning was promoting promiscuity (morally wrong); followed by those who said that the whole exercise was deliberate, they wanted to fall pregnant (12%);

another 12% said that they were experiencing difficulty in conceiving; 10% said that they did not want to use any method whilst breastfeeding, which they were still doing; 8% said that they were reluctant because of being ill-informed about the functioning of most methods; 7% said that it was because of having passed the child bearing age (menopause); while the other 6% said that they were unable to use methods, simply because their partners did not have any liking for these, and lastly the remaining 5% said they were once users, and were now taking a break.

7.7.2 Past Users and Never Users

Respondents in the sample had to indicate whether they were past users (those who once used a method and discontinued) or never users (those who have never used any type of family planning method). Table 33 shows the past and never users in correlation to religion and church attendance of the respondents.

Table 33

PAST AND NEVER USERS IN CORRELATION TO RELIGION AND CHURCH ATTENDANCE OF THE RESPONDENTS (N = 132)

RELIGION	PAST USERS				NEVER USERS				TOTAL
	RE-GU-LAR	OCCA SIO-NAL	NIL	TO-TAL	RE-GU-LAR	OCCA SIO-NAL	NIL	TO-TAL	
Roman Catholic	7,6	7,6	0,0	15,2	6,8	5,3	0,0	12,1	27,3
Methodist	0,0	0,0	0,0	0,0	0,8	0,8	0,8	2,4	2,4
American Episcopal	1,5	0,8	0,0	2,3	3,8	0,8	0,0	4,6	6,9
Anglican	1,5	1,5	0,0	3,0	0,0	2,3	0,8	3,1	6,1
United Congregation	1,5	1,5	0,0	3,0	5,3	0,8	0,0	6,1	9,1
Zion Christian	3,0	0,8	0,0	3,8	0,8	4,5	0,0	5,3	9,1
Native Independence	0,8	1,5	0,0	2,3	3,0	0,0	0,8	3,8	6,1
Dutch Reformed	1,5	2,3	0,0	3,8	0,8	0,8	0,0	1,6	5,4
Apostolic	3,0	0,0	0,0	3,0	4,5	0,0	0,0	4,5	7,5
Seventh Day Adventist	1,5	0,0	0,0	1,5	0,8	0,8	0,0	1,6	3,1
New Apostolic	0,8	0,0	0,0	0,8	1,5	0,0	0,0	1,5	2,3
Pentecostal	1,5	0,0	0,0	1,5	0,8	0,8	0,0	1,6	3,1
Five Mission	0,8	0,8	0,0	1,6	0,0	0,8	0,0	0,8	2,4
African Faith Mission	1,5	0,8	0,0	2,3	0,8	0,0	0,0	0,8	3,1
Others	0,8	0,8	0,0	1,6	3,8	0,8	0,0	4,6	6,2
TOTAL	28,0	18,2	0,0	46,2	33,3	18,2	2,3	53,8	100,0

According to Table 33, from those who were not using any family planning method, 53,8% said that they were never users, as against 46,2% who admitted to having once used family planning methods. The past users (15,2%) were from the Roman Catholic Church and were both regular (7,6%) and occasional church attenders (7,6%). On the other hand the very same Roman Catholic Church members said that they had never used any family planning method (12,1%). They were regular attenders (6,5%)

as against 5,3% who were occasional attenders. As with the family planning users, religion seemed not to have any direct influence on the non usage of family planning methods.

Table 34 shows the past and never users in correlation to the marital status of the respondents.

Table 34

PAST AND NEVER USERS IN CORRELATION TO MARITAL STATUS OF THE RESPONDENTS (N = 132)

MARITAL STATUS	AGE (years)	PAST USERS	NEVER USERS	TOTAL
Legally Married	14 - 18	0,0	0,0	0,0
	19 - 23	2,3	1,5	3,8
	24 - 28	3,0	3,0	6,1
	29 - 33	3,8	3,8	7,6
	34 - 38	5,3	3,0	8,3
	39 - 43	3,0	3,8	6,3
	44 - 45	7,6	7,6	15,2
	TOTAL	25,0	22,7	47,7
Traditionally Married	14 - 18	0,0	0,8	0,8
	19 - 23	0,8	0,8	1,5
	24 - 28	1,5	0,8	2,3
	29 - 33	1,5	0,8	2,3
	34 - 38	0,8	1,5	2,3
	39 - 43	0,0	0,8	0,8
	44 - 45	0,0	2,3	2,3
	TOTAL	4,5	7,6	12,1
Living Together	14 - 18	0,0	0,0	0,0
	19 - 23	0,8	1,5	2,3
	24 - 28	0,8	0,0	0,8
	29 - 33	0,8	0,0	0,8
	34 - 38	0,0	0,8	0,8
	39 - 43	0,0	0,0	0,0
	44 - 45	0,8	0,0	0,8
	TOTAL	3,0	2,3	5,3
Never Married	14 - 18	0,0	3,8	3,8
	19 - 23	3,8	6,8	10,6
	24 - 28	4,5	2,3	6,8
	29 - 33	2,3	0,0	2,3
	34 - 38	0,8	1,5	2,3
	39 - 43	0,0	1,5	1,5
	44 - 45	0,0	1,5	1,5
	TOTAL	11,4	17,4	28,8

Table 34 - continued

MARITAL STATUS	AGE (years)	PAST USERS	NEVER USERS	TOTAL
Widowed	14 - 18	0,0	0,0	0,0
	19 - 23	0,0	0,0	0,0
	24 - 28	0,0	0,8	0,8
	29 - 33	0,0	0,0	0,0
	34 - 38	0,8	0,0	0,0
	39 - 43	0,0	0,0	0,0
	44 - 45	0,0	1,5	2,3
	TOTAL	0,8	2,3	3,0
Divorced	14 - 18	0,0	0,0	0,0
	19 - 23	0,0	0,0	0,0
	24 - 28	0,0	0,0	0,0
	29 - 33	0,8	0,0	0,8
	34 - 38	0,0	0,0	0,0
	39 - 43	0,0	0,0	0,0
	44 - 45	0,0	0,0	0,0
	TOTAL	0,8	0,0	0,8
Separated	14 - 18	0,0	0,0	0,0
	19 - 23	0,0	0,0	0,0
	24 - 28	0,0	0,0	0,0
	29 - 33	0,0	0,0	0,0
	34 - 38	0,0	0,0	0,0
	39 - 43	0,8	0,0	0,8
	44 - 45	0,0	1,5	1,5
	TOTAL	0,8	1,5	2,3

According to Table 34, 47,7% of the respondents from the category of non users are legally married and between the ages 44 to 45 years; followed numerically by those never married (28,8%) between the ages 19 to 23 years (10,6%). From those who stated that they were once users, 25,0% were legally married and between the ages 44 to 45

years (7,6%). This implies that the legally married are not using any form of contraceptive because they cannot take decisions alone, but are accountable to their husbands who are not mostly in favour of these methods; while those never married do not want to "condemn themselves" (the term most commonly used) by taking contraceptives before marriage. The results in the past users category (44-45 years) from those legally married, imply also the past behaviour before presumably marriage and whilst still younger than the present age.

7.7.3 Method(s) Used by Past Users

The respondents who said they had once used a method(s), had to indicate the kind or type used. (The numbers given do not total a hundred percent because some respondents actually used more than one method). The majority of the respondents (66%) said that they had once used the injection; followed by those who said they had used pills (64%) and lastly 16,4% who said that they once tried the loop.

7.7.4 Reasons Given by the Never Users for not Having used any Method

The respondents who replied that they never used a family planning method were asked to give reasons, which were grouped. The majority (57%) said that this was due to ignorance, because they were not well informed about family planning, they had been relying on hearsay and what they heard scared them; 28% said their decision was deliberate, that they first wanted a well established family before considering usage of family planning methods. The respondents in this category pointed out that they wanted to use family planning to prevent having children; 80% said that they had never considered usage, on grounds that it was morally wrong, for God was the only one responsible for controlling conception. Their main argument was that conception be left to nature, with no human interference; and lastly 7 % said that they did not see the need to plan their families because they were experiencing difficulties in conceiving.

7.7.5 Reasons Given by the Past Users for Stopping Visits to the Family Planning Clinic

The respondents were required to give their reasons for no longer using a family planning method. The

respondents (59%) said that their main reason for stopping was due to too many side effects from the method used; 28% said that the whole exercise was purposeful and intentional, namely that they wanted to become pregnant; 9% said that they became pregnant in spite of the method; and lastly 4% said that their partner forbade them to attend the family planning clinic. From the category of the respondents, they did not discuss their intentions and/or resolutions with their partners. About 92% said that although their partners knew that contraceptives were being used, they were not told when it was discontinued. Only 8% of the partners encouraged sterilisation (tubaligation) to prevent future pregnancies.

7.7.6 The Extent to which Pregnancy was prevented by Family Planning Non Users

Since no family planning method was used by this category of respondents, they had to indicate what they were doing to prevent pregnancy from occurring. Table 35 shows the responses to the question on whether pregnancy was being prevented from occurring in relation to the educational level of the respondents.

Table 35

WHETHER PREGNANCY WAS BEING PREVENTED FROM OCCURRING IN RELATION TO THE EDUCATIONAL LEVEL OF THE RESPONDENTS (N = 132)

	EDUCATIONAL LEVEL						
PREVENTION OR NOT	NO SCHOOLING	SUB A-STD 1	STD 2-STD 4	STD 5-STD 7	STD 8-STD 10	POST MATRIC	TOTAL %
Doing Nothing	22,7	25,0	48,8	44,7	36,4	100,0	40,2
Change of Life	36,4	12,5	17,1	10,5	0,0	0,0	15,2
No Sex	9,1	0,0	2,4	15,8	27,3	0,0	11,4
Sterility	4,5	12,5	17,1	10,5	18,2	0,0	12,9
Other	27,3	50,0	14,6	18,4	18,2	0,0	20,5
TOTAL	100,0	100,0	100,0	100,0	100,0	100,0	100,0

According to Table 35, 40,2% of the respondents said that they were doing nothing to prevent pregnancy from occurring, yet they were not expecting to fall pregnant, their educational qualifications ranged from no schooling at all to post matric (100%), which does not signify much because the actual number was low; 20,5% gave "others" as a reason, and the main reasons under this heading was that breastfeeding was used as a preventative measure. People generally have a belief that since there is no menstruation whilst lactating, pregnancy is remote; 27,3% of those who

gave "others" as a reason had no schooling; 15,2% said that they had attained a change of life (menopause), they had no standard passed (36,4%); 12,9% said that they had difficulties in conceiving; these had an educational level of Standards 8 to 10 (18,2%); and lastly 11,2% said that they were doing nothing, that they were not sexually active, because their babies were still too small. Education does not seem to play a part in whether pregnancy was being prevented from occurring. Respondents in this category tended to be fatalistic in approach in that they were sexually active and did not associate it with the possibility of pregnancy.

7.7.7 Future Usage of Contraceptives

In response to the question: "Have you personally ever considered using a family planning method (again)?" (see Appendix), responses will be seen in correlation to age and marital status. Table 36 shows intended attendance of a family planning clinic according to age.

Table 36

INTENDED ATTENDANCE OF A FAMILY PLANNING CLINIC ACCORDING TO AGE (N = 132)

	RESPONSES			
AGE (years)	YES	NO	UNCERTAIN	TOTAL
14 - 18	5,7	0,0	16,7	4,5
19 - 23	26,4	6,6	33,3	18,2
24 - 28	28,3	8,2	11,1	16,7
29 - 33	15,1	11,5	16,7	13,6
34 - 38	20,8	8,2	16,7	14,4
39 - 43	3,8	16,4	5,6	9,8
44 - 45	0,0	49,2	0,0	22,7
TOTAL	100,0	100,0	100,0	100,0

According to Table 36, 49,2% of the respondents between the ages 44 to 48 years replied in the negative (presumably because they are nearing the end of their child bearing ages); followed by 33,3% between the ages 19 to 23 years who said that they were uncertain about their future intentions (presumably because they have small families and are not yet married); 28,3% between the ages 24 to 28 years replied in the affirmative (these presumably have completed their schooling, are employed, and know the value of family planning). Age appears to have played a role on the intentions of the respondents towards the usage of contraceptives.

Table 37 shows intended attendance of a family planning clinic according to marital status.

Table 37

INTENDED ATTENDANCE OF A FAMILY PLANNING CLINIC ACCORDING TO MARITAL STATUS (N = 132)

	RESPONSES			
MARITAL STATUS	YES	NO	UNCERTAIN	TOTAL
Legally Married	37,7	62,3	27,8	47,7
Traditionally Married	11,3	9,8	22,2	12,1
Living Together	5,7	4,9	5,6	5,3
Never Married	39,6	16,4	38,9	28,8
Widowed	3,8	3,3	0,0	3,0
Divorced	1,9	0,0	0,0	0,8
Separated	0,0	3,3	5,6	2,3
TOTAL	100,0	100,0	100,0	100,0

According to Table 37, the legally married respondents (62.3%) replied in the negative, that they do not intend using family planning methods in future and their main reason was the question of morality (it is assumed that they were under the control of their husbands who did not favour the use of contraceptives); this group was followed by those never married (39,6%) who said that they were intending to use contraception because they wanted to prevent having more children, the main reason was the high cost of living. Lastly from the category of those who were never married, 38,9% were uncertain about their future intentions.

Their main reasons was that they might get married and that the determining factor will be the future husband.

CHAPTER 8

8. DISCUSSION OF FINDINGS

8.1. Introduction

In this chapter, the major findings of the study will be discussed, against the background of the basic assumption arrived at that there is in the area an unfavourable attitude to family planning. From this discussion, certain recommendations will be made.

8.2 Tribal Affiliation

The two major tribes represented in the study are the Barolong (27%) and the Batlhaping (34%) tribes (Table 9). The Batlhaping tribe in actual fact originated from the Barolong tribe and was subdivided in later years. The most important of these divisions is the Batlhaping tribe which includes the Phuduhutswana and the Maidi clans. From what was gathered in the sample, tribalism is disappearing. The process of ethnic integration and tribal accumulations seems to be an indication of the emergence of a greater national awareness among the Batswana people as a whole. Tribal affiliation does not seem to be having any effect on attitude to family planning and the usage of contraception.

8.3 Religious Affiliation

The notion that the adherents of churches or religious groups are against the usage of contraceptives is not true according to the data collected in the sample (Table 30). Those religious groups which seem to be against the usage of contraceptives in the study, were the Roman Catholic Church and the Zion Christian Church. However, this seemed not to act as a deterrent, simply because family planning users (60,3%) are said to be regular church goers. Despite the high rate of non users of family planning methods in the sample (62%; see 7.7.1) this seems not to be from the influence mainly of the church's doctrines, although members chose to hide behind these. Individual members of the church seem to make up their own minds about what to do. All other churches do accept the idea of responsible parenthood which also includes that parents should decide how many children they are able to bring up properly - thus encouraging the responsible use of contraceptives.

According to Lonsdale (1974) in her findings it was also recognised that religions are changing constantly in that these very religions were having less influence over people's attitude to family planning than they used to have in the past. Lonsdale further maintains that there is often a time lag before changes are accepted and before the influence of religion, built into the culture over a

long period, can be set aside. Strong pressures may still prevail upon individuals to conform to standards which have already been set aside by the religious hierarchy (Lonsdale, 1974, p.249).

8.4 Age and Education

There seems to be in the study a close correlation between education and age. The highest percentage of women (21,5%) in the sample were between the ages 24 to 28 years (Table 11), and the educational standard most commonly attained was between Standards 5 and 7 (Table 13). The very young respondents, those between the ages 14 and 18 years, were still of school going ages, meaning that they had disrupted their schooling by becoming pregnant. The highest standard attained also indicated a high school drop out, because this did not correlate with their ages, presumably because of early pregnancy. Early pregnancy on the other hand may be related to an early period of exposure to sexual relationships. For example, the total mean number of age at first birth in the sample was 19,6 years (7.3.5). Under early exposure to sexual relations the following factors can be mentioned: Since most women in the study had large families (five and more children), this makes the mother unable to cope with the problems associated with child bearing and rearing. As a result the older daughter has to give a helping hand or sometimes is

compelled by circumstances to take over the responsibilities of caring for her siblings, thus performing parental roles frequently and from an early age. This can contribute to making her enter adulthood prematurely. Thus the desire to have a child herself, for she already knows how to effectively perform most of the household chores. This supports the statement arrived at in 3.1 that large, unmanageable and poverty stricken families create a vicious circle through the process of socialization. On the other hand again respondents, especially those from tribally owned villages, are living in houses of poor quality, for example, built from mud with thatched roofs, being extremely small and overcrowded. Approximately 55% of the Black population, about 13 million people, live on the 13% of the South African land area that makes up the ethnic independent states (homelands). Of these people, about 3 million have been forcibly removed from their traditional settlements in "White" South Africa and re-settled in the independent states. The total population of the independent states increased from 4 million in 1960 to more than 13 million in 1986. This led to overcrowding and impoverishment of rural areas (Sinclair, 1986, p.21). In these tribally owned villages, because of overcrowding, the older girls are exposed at an early age to their parents' sexual life, especially when sharing the same bedroom, which is usually what takes place. Lack of privacy can play a role, thus

promoting early pregnancy and child bearing especially when children are imitating the parents. This implies that the principal factor in Black impoverishment specifically in the Taung area is the inadequacy of basic community facilities and services such as housing, transport and recreational organisations (see Chapter Six). Because family planning is a politically and culturally sensitive issue for Blacks, who view it as a stratagem to perpetuate White political hegemony (1.1.1), it probably will not be possible to reduce the African birth rate until there is an improvement in the standard of living. This supports the statement in 1.2.4 that lack of material belongings among poorer people makes the indulgence in sex more important than it is in more affluent homes (Tiley, 1984, p.86).

A pattern, however, emerged from the analysis which suggests that generally subjects who are more educated and older respond more favourably to family planning. Those less educated and very young are, through lack of awareness and knowledge, fearful and sceptical of the motives of family planning. By education in this study, reference is made to both formal and informal education. Formal education creates a receptive atmosphere for planning because it promotes literacy and through this, gives access to literature on the subject. Education also promotes insight into the problems of every day life that

are essential to an understanding of the aims and methods of family planning. Informal education on the other hand can be referred to as experience acquired naturally through certain encounters. The older respondents have already proved their fertility and virility and have well established families. The respondents in this category are confronted with psychological stresses as well as socio-economic problems related to child rearing. This is unlike their younger counterparts who still want to prove their womanhood and are more resistant to family planning. Education, therefore, is considered to be important for effective family planning, for it encourages democratic participation and develops the person's ability to think rationally and independently. It also enables people to reach their potential for personal fulfilment and social contribution.

8.5 Marital Status and Unemployment

A high percentage of women (47%) in the sample were legally married (Table 12). The young unmarried women in the sample by virtue of already having had children, said that they were promised marriage by their partners. Pregnancy and child bearing can be intentional to hasten the process of marriage. This can be regarded as an unhealthy motive for entering matrimony. Unemployed women in the sample amounted to 70% (Table 14). Various reasons

were given for being unemployed, for example, they pointed to the fact that they were caring for their children; followed by those who said that their partners refused to give them permission to work and those who referred to the general scarcity of work in the area. The stated reasons emphasized lack of motivation to work, on the part of the women and the prevalence of under-employment and unemployment in the area, especially for the unskilled workers.

The majority (66,4%) were, as a result, largely financially dependent on their partners, who were migrant unskilled workers. This, as pointed out in Chapter Six, suggests that men in the study have absolute authority as heads of their families. They dominate the family in every area and see their power as lying in a high progeny. The men are accepted as law givers, providers and have the final word in the home.

This dominance, especially over the submissive female counterpart, often leads to large families which become unmanageable. As Byrne in Perlman and Cozby (1983) puts it, failure to use contraceptives in this case may be tied to traditional sex roles in which the male is the "sexual aggressor" and the female the "sexual victim". This role mitigates against contraceptive use, as the male does not wish to lose the "sexual conquest" by discussing

contraception with the partner. The woman in turn does not wish to be seen as "loose" or "easy" by being prepared for a sexual relation and thus not conforming to the role of a "sexual victim" (Perlman and Cozby, 1983, p.251).

Children in this case are seemingly used to fulfil the failed ambition of the mother, that of not being educated and employed. Being a mother, particularly in the lower socio-economic group like those in the Taung area, can be a reason for living. Children, by providing purpose and stimulation, can be a relief from boredom and loneliness and can also be an investment in and for the future or seen as a creative occupation. Some women only feel needed by their partners if they are nursing a baby, as soon as the baby becomes a toddler they have another baby to replace it. There is on the other hand also community and social pressure on the woman. For example, the woman without children is subject to derision, condemnation or pity, according to society's view. Often there can be no defence - the only escape is to become pregnant. According to the Setswana culture which to some extent still obtains, barrenness was attributed to sorcery, to some deficiency in the woman's blood, to some abnormality of her womb, to some former abortion, and above all, that she had led a promiscuous life. Hence the importance and necessity to bear children to prove all these wrong. This, therefore, makes the whole exercise a socio-economic and

cultural issue.

Of the employed women (30%), 31% were professionals (teachers and nurses; Table 15) presumably because of the availability of schools, a hospital and clinics in the area.

As previously mentioned in Chapter Six, the area caters mostly for skilled workers hence a high rate of migration, especially for the unskilled workers. Migrancy, as mentioned in Chapter Three, has a disastrous effect on the family relationships. On the other hand, migrancy also may have had its advantages on the family structure. Since it is evident that contraceptives were not effectively used in the sample (presumably because of the interference and refusal of partners), the absence of men from the home may then have helped in the spacing of children (presumably because family planning methods were used - especially by those who had more than one partner). Where family planning methods were not used, especially with the few faithful women (if there were any), the absence of partners from the home was then used as a natural method of abstaining from sexual relations. This was seen from the mean period of birth in the sample which was calculated at 2,3 years (Table 21).

8.6 Fertility Norms of the Respondents

From the data it is evident that high fertility norms still occur generally. The mean number of total births in the sample was 3,9 (7.3.1). This was analysed according to the period of staying together, courting and/or cohabitating (which will be referred to as 'period of sexual exposure') (Table 17). The higher the period of sexual exposure, the greater the number of births. The total number of births given was compared to the total number of live births and that of living children. From the analyses, there is a relationship existing between the number of total births, live births and living children. The relationship helped in measuring the high fecundity level of respondents present. This also suggests that a low level of infant and child mortality exists. This may be due to the effective utilisation of the existing health facilities by the respondents in the sample, for example, the attendance of ante-natal, post-natal and baby clinics. Unlike in the past, where emphasis was attached only to traditional healers and midwives, the trend seems to be one of moving towards modernisation, since hospital and clinic deliveries are on the increase. However, the high fecundity level among respondents in the sample may also serve as a good indicator of an absence of contraception.

Age and high educational qualification tend to promote

orientations towards smaller families. Difficulties were, however, encountered when respondents had to indicate their expected, desired and the ideal number of children (7.3.4). With the expected, although a number was suggested and given, the respondents said that when entering a relationship they had no preconceived ideas and left the birth of the children to chance. With the desired and ideal numbers, the older respondents in particular suggested the possibility of reincarnation, a process most saw as far fetched. This implies a low imaginary capacity.

The total mean number of living children was given as 3,1 which points to a high fecundity level in the sample. The expected number was low and was given as 1,5 children. With the desired as 4,4 children and the ideal as 4,8 children (7.3.4). According to the sample, there seems to be little change in fertility behaviour. This was measured by means of the "period which had passed since the last birth" (open interval). The mean number in the sample of the open interval was 4,1 years, which suggested that respondents in the sample apparently continued bearing children until nature intervened. The number of the desired and expected children were influenced by the number of children a person already had, as well as the marital status and nature of the relationship a person was involved in. For instance, whether the relationship was stable, casual and whether the woman was single, married

etc. Individually, the degree of stability was not high because the young unmarried women had fewer actual number of children, their desired numbers were based on the future unlike with their older married counterparts whose desired numbers were based on the past. The respondents indicated a low expected number of children. The validity of these responses cannot be accepted without questioning, because seemingly the respondents did not want to admit to their lack of planning, viz, that it was not purposeful but accidental.

Particularly noticeable is the consensus present concerning the desired and the ideal number of children, which probably indicates that high fertility norms still occur. It appears, however, that the inverse relationship between fertility, education and age is valid for the Blacks in the area.

8.7 Traditional and Cultural Beliefs

Although slow, there seems to be a change towards modernisation in as far as fertility and family planning is concerned in the area (7.4). There was an agreement that adolescent school girls and unmarried women no longer at school be granted the opportunity of using contraceptives. The respondents acknowledged the fact that unplanned pregnancies among teenagers, especially in the

case of school girls, was a problem. This was disrupting their schooling and later occupational opportunities, while the families of these girls were burdened with "fatherless" offspring that they could ill afford. There was also an agreement that married couples with small families (four and less children) and with large families be provided with family planning methods. Also, these people should have children by choice and not by chance. The respondents objected to the usage of family planning by couples with no children. Marriage, according to the Batswana people, is designed primarily for bearing children. Though the western culture is adopted, the process has not been indiscriminate but selective. Respondents for example, indicated that a large family was no longer regarded as a status symbol, especially with the present high cost of living. Respondents were also able to relate family planning to socio-economic advantages and improved quality of life. They could also associate social development especially concerning Blacks with the consistent usage of contraceptives. Contrary to what was expected respondents were aware of the present high population trends and were able to predict worse conditions, if present trends continued. The respondents, however, still regarded the usefulness of children especially during old age. It was ensured that parents with children are sure of security in old age. For example, "the cunning of the antelope (phala) comes from

its young" says the proverb. This means that a person with children cannot be lightly molested, for he is always sure of protection and support. Education according to what was gathered in the sample, has got an influence on the traditional and cultural beliefs of the respondent category (Table 24). As previously pointed out the better educated have adopted a more western culture.

8.8 Knowledge of Family Planning Methods

Respondents in the sample had to indicate their familiarity with different kinds of contraceptives, to assess the degree of awareness and/or ignorance regarding availability (7.5.2). Knowledge in this case included usage and/or having seen the method. The familiar methods in the sample were the injection, followed by the oral pill. All the other methods were less known except for abstinence which was known, although not as a method to prevent conception. The variable "knowledge of family planning" in the study is closely related to age (Table 25) and the educational level (Table 26) of the respondents. Contraception is a form of behaviour which traditional morality considered improper and which still in some instances carries a taboo. The older and very young respondents, even if they knew of the existence of a method, did not want or could not admit it openly. They want to keep silent about it. From those who said that

they had heard of the availability of the methods, the neighbours and friends were mentioned as sources of information. Those who said they knew about the method(s) mentioned the family planning nurses and the ante-natal clinic as the place where they came across this, i.e. when already pregnant. From the educational point of view the parents, teachers, social workers and all other formal leaders in the community would be expected to be the main sources of information about contraception. This implies a need for social work participation in family planning education, as a member of a team. An inter-professional teamwork approach emphasizes that a higher standard of living depends not only on family planning, but on social welfare changes; a more involved governmental role; continued economic and community development; more extensive and more appropriate education; and more careful, long-term planning and administration. When these professionals co-operate and integrate their programmes, the forces of social change are set into motion and family planning begins to be institutionalized in family, social and governmental systems. Ankrah and Radel in (Glasser et al, 1973, p.11-D-8).

In particular the role of a social worker as a team member in family planning education is an absolutely necessary intermediary between the professions and the users of professional services an interpreter; in addition to being the purveyor of information back and forth between

other professions and the service users; the social worker is in the best position to ascertain what services are needed and how they can be most effectively delivered (Kendall, 1971, p.56). In the sample the same familiar methods, i.e. the pill and the injection, were mentioned by both the users of family planning and non users (particularly the past users) - that they were once used. From what has been highlighted two factors are evident, viz: ignorance of the availability of family planning methods and how these methods function if known. This suggests the need for preventive social work. The mission of family planning impinges directly on preventive social work, viz: to bypass a measure of personal and community ills by eradicating some of the root causes of social pathology; and when it falls to the lot of the social worker to help families stabilize lives already disrupted by social and emotional stress; family planning can also be a means to augment the social work aim of rehabilitating the family; by offering the means for the control of fertility and, with it, some ordering of destiny, a third social goal is achieved; equal opportunity for all sectors of the population; helping those buffeted by fate to overcome their sense of helplessness has new meaning now that technological advances permit a growing variety of safe and effective methods acceptable for meeting individual differences (Kendall, 1971, pp.58-59).

Although the injection and pill are said to be effective and modern as compared to other existing methods, this narrowed the people's choice, especially when some wanted a method which did not interfere with their hormonal systems. Social workers on this aspect can serve in the advocacy role, that there be a swing towards the client centered approach in place of a clinic centered approach. This means that the stress is more upon the feelings, needs and desires of the people, than upon arguments on behalf of superiority of particular contraceptive techniques which may be adopted through a mass advertising campaign. What is needed, is the personal touch which social work can provide, one which fits family planning into the total life context of the family to be helped.

8.9 Suitable Communication Media, for the Dissemination of Information on Family Planning

Respondents (38,3%) said that health workers should be used to disseminate information on family planning (7.6.9). This is done on a personal basis, i.e. by means of face to face communication. Face to face or personal communication may be effective because of the following reasons: The person is seen in his/her own environment and the message therefore can be adopted to his/her needs and values; personal communication is not only one sided, i.e. questions can be asked and problems can be explained. In this way one can be sure that the message is clearly

understood; in the privacy of a house it is much easier to talk about and explain intimate matters than by means of mass media.

Though some suggested the family planning clinic (25,2%) as the appropriate place, the problem was that "the hard to reach", i.e. the non attenders will not benefit. With the newsletter, the illiterates will be left out. With the radio and television, the respondents (1,5%) were sceptical especially firstly because not everybody has access to these and secondly their main concern - especially the older respondents - was that the programmes might reach the so called "undesirable audience", i.e. the very young. In fact this kind of excuse is often given at many levels.

8.10 Family Planning Users

From the total number of respondents in the sample, the family planning users formed only about 38% (7.7). This clearly points to the reluctance of women in the study to effectively utilise family planning methods. What is of interest is the fact that respondents in this category started to attend a family planning clinic after bearing a child or after having a well established family. Various reasons were given for the prevailing state of affairs, that for example: children are used to prove one's

fertility and virility; others even pointed to the fact that there is a belief that contraceptives can make one sterile, so having a child already even if it is only one can make a person feel safe. Education and age play an important role in as far as the usage of contraceptives is concerned in the study (Table 29). Thus education, be it formal or informal, also contributed to encouraging communication between partners, because from this very category of respondents, 82,4% said that partners knew that methods were being used. This in a way indicates joint decision or approval thereof. About 68% of the respondents from the category said that they were using family planning to space their pregnancies. Though the users category was small, this clearly showed that family planning programmes are not conceived in the narrow sense of birth control or prevention of births only. Women (69,1%) from this group pointed out that they only requested the methods they were using, because they saw the effectiveness of the method with a neighbour, friend or relative (7.6.4). From what is then learned the nurses gave out these methods, at the request of the clients, which means that the principle of self determination was applied. Self determination on the other hand, although allowed in the practice of social work, must have limitations (it is presumed also in the nursing profession), for example, testing whether the method is suitable. It is believed that circumstances differ,

methods as well and that people belong to different groups which will make them react differently.

Although respondents (70,6%) said that they were tested (7.6.5), in actual fact they admitted openly not to have been able to differentiate between routine tests and tests for suitability of methods. This pointed to an impersonal approach adopted by family planning nurses. Nurses, it must be remembered, are trained in their profession and must maintain a certain authority in their relationship with patients in the curative services.

The same approach cannot be used in the preventative health services such as family planning. The woman who visits a family planning clinic is not ill, and she may not accept impersonal treatment, hence termed clients and not patients. The impersonal treatment on the other hand may be due to lack of motivation and knowledge on the part of the family planning nurses in the area. Family planning, like all other fields, is a specialised one and calls for additional training. Respondents (64,7%) indicated that they knew only the advantages and none of the disadvantages, and that they wanted more information on other family planning methods (7.6.7). On this aspect, there is some evidence that people who have been informed of the potential problems and side effects of a different contraceptive may experience them more frequently than

those not given this information. On the other hand, if left in ignorance, at the first hint of difficulty, users may be discouraged from continuing to use a particular contraceptive. If informed, the reaction of the people most probably will depend on how the information was imparted. Respondents (92,9%) had no problems pertaining to accessibility of the hospital and family planning clinic, as well as with the suitability of working hours at these places (7.6.8). The respondents (100%) also pointed out the friendliness and helpful nature of family planning nurses. This points to the improvement of health services in the area. Human motivation is therefore essential for the utilization of these services. Although it is complex at best, to motivate people, it is of much concern to the so called change agents whether they be social workers or any other professional group.

8.11 Family Planning Non Users

A high percentage of respondents (62%) from the sample were non users of family planning methods (7.7). This factor clearly shows how minimally family planning is being used in the area. On the other hand, this can be used to support the assumption that there is in the study an unfavourable attitude to family planning. Among the various reasons given for not using a family planning method, the respondents (34%) from this category said that

they were not well disposed largely because of having heard negative reports or were not well informed about particular methods (7.5.1). Ignorance, because of lack of interest and motivation, seemed to have prevailed. It has been recognised that the ignorance or embarrassment of many parents often makes them unsuitable as the main source of information or education about sex. In the western culture there is a belief that discussion on such topics be largely confined to the home. The young people on the other hand are willing to discuss sexual matters with close friends, instead of their parents, who also are equally ill informed.

Women seem to be having no realistic sense of their becoming pregnant and thus run great risks. For example, infrequent or first sexual relationship and breast feeding was often thought not to result in pregnancy. The reason for the behaviour of women not to use contraceptives whilst lactating is to be found in traditional tribal practice, where family spacing was achieved by means of prolonged lactation together with abstinence from sex relations. According to Unterhalter (1977) in this modern era these observances break down. It is firstly difficult to prolong breast feeding particularly when the mother works. Secondly, unlike in the past, many women are not legally married and it is possible that, without the social and familial pressures of marriage, men will not

consent to abstinence from sexual relationships (Unterhalter, 1977, pp.195-196). Since young women had sex infrequently, contraception was seen as unneccessary. Some of the reasons given for conceiving were the following: To deepen a relationship or to secure a faltering one; women also admitted that even though they realised that a pregnancy would not prevent the break up of a relationship, the baby was to be used as a precious reminder, almost a legacy, of someone they loved.

In response to the question "Are you at present trying to prevent pregnancy from occurring, what are you doing?" (See Appendix), the respondents (40,2%) said that they were doing nothing and gave no reasons for their action (Table 35). It is notable that, although no contraceptives were being used in this category, respondents though sexually active did not want to become pregnant. Since no precautionary measures were taken, the subjects were depending on fate and luck - hence were fatalistic in their approach. The attitude of fatalism is closely allied to the forces of tradition and constitutes a barrier, the existence of a low mastery over nature and social conditions. On this aspect, the belief in the capacity to affect one's destiny is a precondition, on an individual and collective basis, to utilize family planning, conception control and fertility control. In this respect, the reduction of fatalism as a view of one's relationship

to the world is part and parcel of a developmental function, particularly for countries which are moving towards modernisation. The social worker has a key role to play in this direction, to help harness the efforts towards instilling the will and the capacity to change this view, and, to help populations cope with the inevitable frustrations and strains attendant on developing a non fatalistic view of the world. Reference is again made to the necessity for the social worker to advocate necessary social change and to be constantly aware of the consequences of change. In effect, the utilisation of family planning is a consequence of economic and social development in a particular area. The change of view in man's capacity to affect his way of life and condition of life is a necessary component of such development.

As might be expected, views expressed on family planning usually in response to questions dealing with hypothetical situations, were generally favourable. In response to the question "Are you in favour of family planning?" (See Appendix) from the total number of all respondents in the sample, 74% said that they were in favour of family planning (7.5.1). From the number of positive respondents, 36% were from this very category of family planning non users. However, 40,2% respondents considered the idea of using a family planning method (7.7.7). A further 46,2% despite some with a favourable attitude, were negative

about ever using family planning themselves. From what is deducted then, being in favour of family planning in principle, does not necessarily mean acceptance of the innovation in practice. Furthermore, respondents could have provided misleading answers. A sizable number of respondents (13,2%) were uncertain regarding their future, of ever using a family planning method. The main reason given was that they had not yet discussed the matter with their partners on whom they were economically dependent and therefore accountable. Finally respondents from this category of family planning non users can be said to be in a pre-awareness stage of decision making.

CHAPTER 9

9. RECOMMENDATIONS AND CONCLUSIONS

9.1 Introduction

This chapter attempts to bring together the most important aspects of the findings to this study, and discusses implications for future areas concerning the subject matter of family planning. The central findings in the study are those arising from resistances in family planning and usage, viz: political - resistances in the sense, for example, of people wishing to expand their population for various purposes which they may consider to be entirely desirable (low socio-economic conditions in the area); Cultural - resistances such as those concerned with norms of behaviour in various groups, or those which result from cultural definitions of manhood or womanhood, or what is expected and reinforced through social and community pressure, or what gives people a sense of security; moral - resistances such as direct conflict with one's values, according to what one regards as socially acceptable (promiscuity, prostitution); psychological - resistances in the sense, for example, of evoking uncomfortable new ways of considering human sexuality and the difficulties on an individual basis in accepting these approaches whether related to cultural, religious norms,

or other factors.

The following general conclusions from the study can also be drawn:

9.1.1 A high proportion of the sample population were unemployed, and depended on their partners. Social security is largely unavailable except in cases in which a maintenance grant is payable. Due to strict regulations such payments are comparatively rare.

9.1.2 The role of the social worker in family planning is important and essential to assist in understanding and coping with change, and in adopting a problem-solving attitude to life and in promoting improved social functioning. Also human motivation is essential for the adoption of family planning practices. The social worker is one category of human service professional who is particularly suited to be a motivator in this regard.

9.1.3 Women in the sample indicated the desire to have more than three children (7.3.4). That is, there is a desire to have quite a large number of children. Children feature prominently in this community and are regarded as an asset in various ways. This, in fact, makes the task of those involved in family planning more difficult.

9.1.4 There is a high correlation between education and fecundity. It would seem as though improved education does lead to an increase in motivation to adopt family planning practices.

The recommendations that follow from the findings do not aim to solve the problem of over-population or family planning in the country. No comprehensive solution is yet in view. It is practicable however, to suggest an approach and a series of definite steps which, if taken, soon may create a basis for an eventual solution. There is no sovereign remedy, no short cut and above all no quick answer.

9.2 National Approaches to Family Planning

Knowledge of the population problem, especially in reference to its repercussions in the family and society, is reflected on the political level as a principal motivating force in decision-making, tending to modify an existing situation. The success of family planning programmes depends, however, on the joint decisions of government and citizens. This aspect emphasises community development as a strategy for change. The following are the aims of community development in family planning as outlined in Schoeman et al (1985):

9.2.1 To promote community involvement and community participation.

9.2.2 To encourage self-help programmes where community responsibility and initiative have to be stimulated.

9.2.3 To develop potential and mobilise existing resources to the advantage of the community.

9.2.4 To acknowledge and protect the human dignity of all people.

9.2.5 To promote development programmes.

9.2.6 To coordinate organisations and programmes at local and regional level.

9.2.7 To ensure a balance among social, economic and physical development at regional and local level.

It is the interchange of concepts between the policy planners and the consumer population - a product of knowledge of the problem and its repercussions, which permits decisions. On the governmental level, decision making must be preceded by enough ample and objective information in order to allow problem-solving in a given situation. The process therefore appears as a result of interaction between the government which understands the macro-economic situation, and the family, which feels particular needs.

Neither the governmental decision nor the needs felt by the population are enough by themselves. Besides this, it

is necessary to place information and means in the hands of the families in order to give them a choice (the possibility of choosing among various alternatives). There needs to be equality of opportunity to obtain quality services. This aspect suggests social policy change.

9.3 Social Policy Change

Social policy and family planning should be considered integral components of broader social and economic development policies and should foster a full expression of human rights so that the achievement of personal goals could be realised in harmony with societal needs. Developmental social welfare should play a key role in bringing about these conditions. Against the background of what has been highlighted it is suggested that the Bophuthatswana Family Planning Association liaise with the following governmental departments, for assistance and information:

- Economic Affairs: Statisticians;
- Agricultural Cooperation: Social and community planners and community development workers;
- Health and Social Welfare: Which should provide both the clinical and education subdirectorates of the family planning programme.

Figure 7

THE RECOMMENDED STRUCTURE OF THE BOPHUTHATSWANA FAMILY PLANNING ASSOCIATION

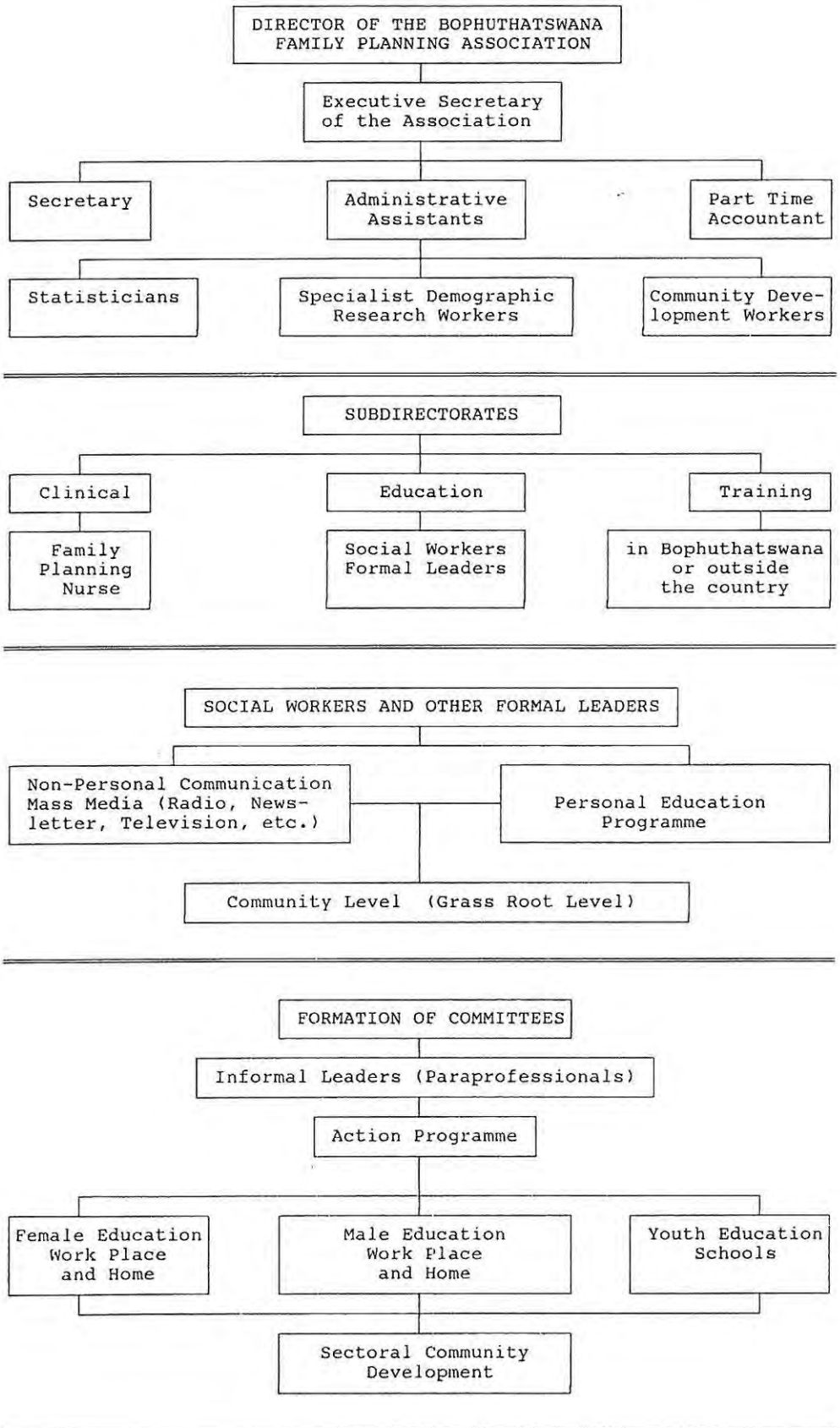


Figure 7 shows the recommended structure of the Bophuthatswana Family Planning Association. The process leading to decision making, it is suggested, opens important perspectives as to the efforts of social workers to collaborate on governmental population policies in such a way as to avoid conflicts. Based on the impediments of social work practice in the delivery of family planning as discussed in Chapter Five, as well as the professional value that social workers can offer in family planning, the following are roles suggested to be performed by these professionals to improve services in the area and country: Roles in policy formulation and planning as well as in family planning programme / organisation.

9.4 The Role of Social Work in Policy Formulation and Planning

In the formulation of policy, social work should projects its most basic principles and concerns which are considered essential for the development and protection of all members of society. Social work objectives are designed to enable individuals, families, groups and communities to participate more fully in development, viz, by:

9.4.1 Achieving changes in social, economic and cultural systems to promote equity through the greater distribution of the economic benefits of the

society;

9.4.2 Stimulating greater participation by all sectors of the society;

9.4.3 Serving the totality of the needs of the individual;

9.4.4 Strengthening the interrelationship between policy formulation at national and regional levels and social work participation at those levels;

9.4.5 Assisting in achieving the objectives of related sectors, such as health, education, housing; and

9.4.6 Providing for the minimum needs and rehabilitation for those in immediate need while assuring and enhancing self reliance.

9.5 The Role of Social Work in Family Planning Programme / Organisation

Direct family planning service in the area is usually provided in a clinic setting or a hospital. Social workers in Bophuthatswana normally operate from health centres (hospitals or clinics) because the Department of Health is closely integrated with that of Welfare. The major tasks of social work personnel in these settings in family planning will be those of interviewing; determination of eligibility; counselling and follow-up services. In particular the counselling function of social work is described as including the provision of information and of assistance to individuals for clarifying their own family

planning goals. The specified tasks should focus on the welfare of the individual and the family and should deal with cultural, religious and traditional aspects and aspirations as well as suspicions and fears. The basic objective of motivation activities should be to bring about change in personal and cultural values as an aspect of broader socio-economic change in order to cause a shift in attitudes, behaviour and more favourable to the acceptance of family planning.

The implementation of social welfare programmes related to family planning is considered to require among other things: An administrative and organisational system to operate at central, regional and local levels; follow up and evaluation as part of a continual review and adjustment process; a high degree of co-operation and co-ordination between the private and public sectors, as well as vertically through organisational levels and horizontally through different sectors; and a high degree of popular participation at all levels.

The importance of local administrative structure could be seen in the fact that they often constituted a principal linkage between local people and policy makers at a high level. The social welfare sector and its professionals have an important responsibility and a key role of the village people as a resource and in giving real meaning to their participation in national affairs.

Furthermore, while there should be a centralisation of communication, there should also be decentralisation of policy implementation and delivery of services. Social welfare administrators should be fully aware of and acquainted with legislation related to family planning, so as to guard against personal biases and denial of rights in offering family planning services. Social workers should therefore receive careful orientation and training in that area, and, when necessary, should work to bring about changes in the legal structure.

9.6 Manpower Development and Training

In order to be effective in the delivery of family planning, adequate levels of manpower should be available to carry out this function. In the Taung area, for example, there are only three social workers, who are required to serve all existing 72 villages. This signifies a shortage of qualified manpower. Against this shortage it is recommended that para-professional aides be utilised. The main advantage of para-professionals is that they are socially closer to the lower status members of the user system that they serve. In China for example, they are referred to as "barefoot doctors". It is important that services be directed towards the total development of the community, the family and the child, and not be focused solely on family limitation, thus providing broader opportunities and resources to help people achieve a

greater degree of self reliance. An important means to these ends is the co-operation between social work and other sectors, for example, health, education, agriculture and religion through an integrated service approach. The need for such integrated services is derived from several factors, viz: The scarcity of resources and the duplication which would result if each sector were individually to offer its own services; the scarcity of trained staff; and the increased effectiveness which results from the provision of multiple services in a single setting.

Social workers are expected to perform a number of specific tasks related to family planning at various levels such as: Education and information activities for motivation; community development, organisation and action; interviewing, counselling and general referral; follow up to provide a particular service and reduce drop-outs; mass communication activities; interagency co-ordination and referrals; training of social workers and those of other sectors; guidance and supervision of field staff; policy making, planning and administration; evaluation and survey work, including data collection; field demonstration / operation; and in some cases, distribution of contraceptives like condoms.

Social workers should have a general knowledge of the subject matter relating to family planning and populations

so that they could more effectively perform all social welfare tasks. Preparatory courses are offered at the University of Bophuthatswana for undergraduate social work students. These courses are the following:

Community work which includes the following models:

- community development, community organisation, social planning and social action;
- rural development;
- social policy; and
- social work administration.

While the university has a prime responsibility for the training of social workers at the professional level, special in-service training is needed for social workers, and para-professional workers. These training sessions should be decentralised for the sake of differences in various communities. The integrated and inter-disciplinary curriculum should be used.

The following objectives as set forth in the Report of Interregional Meeting of Experts on the Social Welfare Aspect of Family Planning - United Nations - for the training of professional and auxiliary workers (in Social Welfare and Family Planning, 1976, pp.18-19), will be adopted in the Taung area:

The training should impart:

a) A knowledge of population trends and problems;

b) A knowledge of social policy and social planning with specific reference to development and training;

c) An understanding of the knowledge base and action strategies for social change; and

d) An understanding of the value issues and cultural factors that affected behavioural change and impinge on population and family planning questions.

In addition, education and training programmes for all levels of social work personnel involved in family planning should encourage the development of certain common skills, including skills in:

i) Working with individuals in counselling roles with respect to changing attitudes and values regarding family size, family spacing, acceptability of family planning methods and effective usage and follow-through;

ii) Working with groups for educational purposes and in use of the group process in motivating and changing attitudes and practices with regard to family size and use of family planning measures;

iii) Social action, community development, community organisation, emphasizing popular participation;

iv) Intersectoral collaboration with related personnel

in delineation of appropriate roles and functions;

v) Administration of programmes and services, setting-up of clinics, formulation and implementation of policy;

vi) Supervision and consultation on the part of senior social work personnel in training and collaborative roles;

vii) Training of para-professional and auxiliary workers at all levels;

viii) Research methods relating to the systematic collection of relevant demographic data for programme planning, implementation and evaluation;

ix) Utilisation of effective communication channels and content, ranging from face to face encounters to use of mass media with differentiation of content according to different target groups; and

x) Handling and using community conflicts to achieve desired ends in family planning.

Finally it is recommended that the senior personnel in social work and related professions be responsible for the training programme which will differ according to different levels of the trainees.

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A P P E N D I X

THE INTERVIEW SCHEDULE

RHODES UNIVERSITY: DEPARTMENT OF SOCIAL WORK

FAMILY PLANNING SURVEY, 1987

SECTION 1

Respondents Number	1	2	3

Personal Data

Make Crosses in the Relevant Blocks

Tribal Affiliation	4	5
Religion	6	7

If belonging to some religious denomination, state attendance	8
Regular	1
Occasional	2
Do not attend at all	3

Age (years)	9
14 - 18	1
19 - 23	2
24 - 28	3
29 - 33	4
34 - 38	5
39 - 43	6
44 - 46	7

Present Marital Status	10
Legally Married	1
Traditionally Married	2
Living Together	3
Never Married	4
Widowed	5
Divorced	6
Separated	7

For how long have you been staying (courting) together with partner?	11	12

Highest School Standard Passed	13
No Schooling or standard passed	1
Sub Standard A - Standard 1	2
Standard 2 - Standard 4	3
Standard 5 - Standard 7	4
Standard 8 - Standard 10	5
Post Matric	6

Are you presently employed?	14
Yes	1
No	2

If yes, what is your present occupational status?	15

Occupational Classification

Unskilled Manual Worker (Domestic Workers, Casual Workers	1
Semi Skilled Manual Worker (Truck Drivers, Builders' Assistants	2
Skilled Manual Worker (Dress Makers, Typists)	3
Clerical Worker (Government Clerks, Bank Clerks, Shop Assistants)	4
Farmers (Self Employed in the production or distribution of agricultural produce)	5
Small Business Woman (Food and Clothing)	6
Semi Professional and Professional Worker (Nurses, Social Workers, School Teachers)	7

If not employed, explain why not?

If Unemployed, what is (are) your source(s) of Income?	16
Parent(s)	1
Friend(s)	2
Welfare grant(s)	3
Relative(s)	4
Partner(s)	5
Other(s)	7

SECTION 2

How many live births have you had?	17	18
How many still births have you had?		19
How many living children do you presently have?	20	21
How many children are you still expecting to have?	22	23
Suppose you had no children, how many children would you want to have?	24	25
What is the number of children you consider ideal for a family?	26	27
What was your age at first birth?	28	29
If you have more than one child, please state parity (period between births)		30
Please state period passed since last birth (in months)	31 32	33

SECTION 3

Traditional and Cultural Beliefs

Questions	1 Yes	2 No	3 Uncertain
Do you believe that:			
... a big family is a symbol of status?	34	1	
... many countries in the world are poor because they have too many people?	35	2	
... many children are an asset especially to parents who have reached old age?	36	3	
... Blacks in South Africa will develop more quickly if they have fewer children?	37	4	
... there will be too many people in the world in ten years time, if present trends continue?	38	5	

SECTION 4

Knowledge and Use of Family Planning

Are you in favour of family planning?	39
Yes	1
No	2

Explain your attitude:

_____

_____

Which method(s) of family planning do you know, have heard of, or have not heard of?

(Place a cross in the appropriate square)	2 Know	3 Have heard of	4 Have not heard of
Oral Pill	1		40
Loop (Intra-Uterine-Device)	2		41
Condom	3		42
Spermicides	5		44
Douche	6		45
Diaphragm	7		46
Coitus Interruptus	8		47
Abstinence	9		48
Rhythm (Safe Period)	10		49

Are you presently using a family planning method?	50
Yes	1
No	2

If no, why not?

If yes, does you partner know that you are using a family planning method?	51
Yes	1
No	2

Do you agree that the following persons should use contraceptives?	1 Agree	2 Disagree
Adolescent School Girls	1	52
Unmarried Women no longer at School	2	53
Newly Weds	3	54
Married Couples with small Families	4	55
Married Couples with no Children	5	56
Married Couples with large Families	6	57

SECTION 5

Family Planning Users Only

Why are you using family planning?	59
To stop having children	1
To have fewer children	2
To space pregnancies	3

What is the main method(s) you are using at present?	60

Who advised you to use the method(s) mentioned?	61
Self	1
Parent(s)	2
Friend(s)	3
Nurse	4
Doctor	5
Other(s) Specify	6

If advised, did the person or people who told you to use this method give you any reason?	62
Yes	1
No	2
Do not remember	3

Were you tested before you began to use this method?	63
Yes	1
No	2
Do not remember	3

Apart from the good points, have you heard of any bad effects of the method you are presently using?	64
Yes	1
No	2

Were you given information on other family planning methods?	65
Yes	1
No	2
Uncertain	3

Do you need more information on family planning methods?	66
Yes	1
No	2

Where do you go when you need attention or supplies?	67
Hospital	1
Clinic	2
Pharmacy	3
Friend (who is attending family planning clinic)	4
Other	5

Do you find it easy to reach the place/person mentioned?	68
Yes	1
No	2

Are the working hours at the place mentioned satisfactory, or would you like them to be changed?	69
Satisfactory	1
Change them	2
Uncertain	3

If not satisfied, which day and hours suit you best?	70

Day .....Hours from ..... till .....

Are people at the place mentioned, friendly and helpful?	71
Always	1
Most of the time	2
Sometimes	3
Seldom	4
Never	5

Which important media of communication do you regard as suitable for the dissemination of information on family planning?	72
Radio	1
Newsletter	2
Family planning clinic	3
Television	4
Health Workers (home visits)	5

SECTION 6

Family Planning Non Users Only

Have you ever used a family planning method?	73
Yes	1
No	2

If no, explain why not

_____

_____

If yes, which method(s)?	74	75	76

If you have stopped visiting the family planning clinic, why did you do so?	77
Became pregnant in spite of method	1
Wanted to become pregnant	2
Had to wait too long at the clinic	3
Unfriendly treatment at the clinic	4
Clinic too far from home	5
Too many side effects from the method	6
There is not enough privacy at the clinic	7
My partner forbade me to attend the clinic	8
Other reasons (specify)	9

What did your partner say when you stopped going to the family planning clinic?	78
Did not know that I was using something	1
Did not know that I had stopped	2
Was in favour of stopping	3
Any other reasons	4

Are you at present trying to prevent pregnancy from occuring? What are you doing?	79
Doing nothing, no reason	1
Have attained change of life	2
Doing nothing, no sex	3
Sterility	4
Any other reason	5

Have you personally ever considered using a family planning method (again)?	80
Yes	
No	1
Uncertain	2

Explain: