

ATTITUDES OF AFRICAN MALES

TO

CONTRACEPTION

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ATTITUDES OF AFRICAN MALES TO CONTRACEPTION

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THIS IS THE RESEARCHER'S ORIGINAL WORK.  
IT HAS NOT BEEN SUBMITTED IN ANY FORM TO ANOTHER  
UNIVERSITY.

ALL DATA SOURCES HAVE BEEN ACKNOWLEDGED.

<u>LIST OF CONTENTS</u>		<u>Page</u>
1.	SUMMARY	7
2.	INTRODUCTION	8
3.	OBJECTIVES	11
4.	DEFINITION OF CRITERIA	12
5.	SELECTION OF SAMPLE	12
6.	CONTROL GROUP	13
7.	METHOD OF DATA COLLECTION	13
8.	REDUCTION OF BIAS	14
9.1	RESULTS	15
9.2	KNOWLEDGE OF CONTRACEPTION	15
9.3	SOURCE OF INFORMATION ON CONTRACEPTION	18
9.4	AGE AND CONTRACEPTIVE USE	19
9.5	SOCIO-ECONOMIC STATUS AND CONTRACEPTIVE USE	22
9.6	DESIRED NUMBER OF CHILDREN	25
9.7	ATTITUDE OF THE RELATIVES TO CONTRACEPTION	25
9.8.1	TRADITIONAL METHOD OF CONTRACEPTION	26
9.8.2	FAMILY PLANNING AND AFRICAN TRADITION	27
9.8.3	AFRICAN MALE AND THE USE OF CONTRACEPTIVES	28
9.8.4	THE INFLUENCE OF THE AFRICAN MALE ON CONTRACEPTION	29
9.8.5	AFRICAN MALE'S BELIEFS ON EFFECTS OF CONTRACEPTION	29
9.9	RELIGION AND CONTRACEPTION	31
9.10	COMMUNITY TYPE AND CONTRACEPTIVE USE	33
10.	DISCUSSION	35
10.1	LIMITATION OF STUDY	35
10.2	KNOWLEDGE OF CONTRACEPTION	36
10.3	SOURCE OF CONTRACEPTIVE KNOWLEDGE	37
10.4	USE OF CONTRACEPTION	39
10.5	CONTRACEPTIVE USE AND AGE	40
10.6	SOCIO-ECONOMIC STATUS AND USE OF CONTRACEPTIVES	40
10.7	FAMILY SIZE	42

	<u>Page</u>	
10.8	TRADITIONAL METHODS OF CONTRACEPTION	43
10.9	AFRICAN MALE'S INFLUENCE ON CONTRACEPTION	44
10.10	SIDE EFFECTS OF CONTRACEPTIVES	46
10.11	RELIGION AND CONTRACEPTIVES	47
10.12	CONTRACEPTIVE USE AND COMMUNITY TYPE	49
11.	CONCLUSION	50
12.	RECOMMENDATIONS	51
13.	ACKNOWLEDGEMENTS	53
14.	REFERENCES	53

ANNEXURE 1 - TABLES

	<u>Page</u>
TABLE 1	56
TABLE 2	57
TABLE 3	58
TABLE 4	59
TABLE 5	60
TABLE 6	61
TABLE 7	62
TABLE 8	63
TABLE 9a and b	64
TABLE 10(a)	65
TABLE 10(b)	66
TABLE 11(a)	67
TABLE 11(b)	67
TABLE 12(a)	68
TABLE 12(b)	69
TABLE 13	70

ANNEXURE 2 - PROTOCOL

	<u>Page</u>
PROTOCOL	71
QUESTIONNAIRE	74
CHECKLIST	76

S U M M A R Y

The attitude of the African male to contraception and the role he plays in the acceptance of contraceptives by his racial group is presented.

Over a period of one month the researcher interviewed 220 African males at a primary care private practice. In this study 186 (85%) were aware of contraceptives and 34 (15%) had no knowledge of contraception; 111 (60%) were married and 75 (40%) were unmarried. The 26-35 year age group were the most familiar with contraception (57%). The unemployed were the least users of contraceptives (8%), whereas 69% of the professional group were using contraceptives.

The average ideal family size of the group was 4 children.

No significant cultural barriers to contraception were found. Religion was found to have little effect on contraceptive practice by the African male.

Fifty-three percent of the Urban dwellers were using contraceptives compared with only 30% of the Rural inhabitants.

Modern methods of contraception are not yet sufficiently known by the African male to be useful to him. Health workers should educate the African male in matters of contraception to achieve the desired objectives of family planning campaigns among this racial group.



I N T R O D U C T I O N

The attitude of the African male to contraception is not known. Attitudes of males for other racial groups in South Africa have been obtained through studies on the females. <sup>1,2</sup>

In the male dominated African way of life knowledge of the male attitude to contraception must be known if health workers involved in family planning are to achieve significant success in increasing patient compliance in the use of contraceptives.

African females, whether married or not, usually obey their consorts to the letter. The African female may possess superior knowledge on contraceptive matters compared with her consort, but she would respect whatever he says. That African females are more knowledgeable than the males in matters of contraception is due to the fact that health workers directed their educational strategies towards the female at the antenatal clinics, postnatal clinics and at baby care clinics. The "patriach" was completely overlooked. <sup>3</sup>

It is also not uncommon for the primary care practitioner to be told by a patient he is treating for sexually transmitted disease (STD) that the cause of his symptoms were due to the contraceptives used by the consort. It is however, not easy to differentiate between genuine mistaken belief that contraceptives are responsible for the STD's and the attempt of avoiding the label promiscuous on the part of the patient.

Many Africans believe that the taking of medication does create problems to the consort if she or he is not on the same medication. Traditionally some herbal medicines are thought to be less effective if coitus is not avoided during the treatment period. The consort is believed to be adversely affected.<sup>4</sup>

There is a general belief among the Africans that STD's are a result of "trapping" by the present or previous sexual contact.

Unfortunately the apparent increase incidence of STD's has paralleled the increased use of contraceptives. This association is readily thought of by Africans that contraception leads to STD's. The researcher has been asked by his patients on many occasions whether they may have coitus while on treatment. If this point is not cleared when medication is dispensed either the treatment will not be taken on the day that sexual contact is to occur or any problem that develops afterwards would be blamed on the taking of medication. In the researcher's experience purgatives and contraceptives are the commonly quoted drugs responsible for STD's.

Young ladies presenting unplanned pregnancies sometimes blame their predicament on the disapproval of their consorts to contraception. Even the unmarried who have had caesarean section deliveries would never use contraceptives unless their consorts approve. There are many, however, who use contraceptives surreptitiously.

In the traditional setting the mother-in-law was responsible for the spacing of children. It was her duty to see that the young bride did not resume sexual activity until the babies were at least two years old. This practice did not pose any problem for the males who could satisfy their sexual desires with their harems. There was so much social pressure against falling pregnant while breast feeding that such misfortunes were very rare. Unfortunately all the blame was placed on the female when pregnancy did occur, although it is the male who initiates sexual contact.

In view of this unexplored seemingly profound African male's influence on the use of contraception, the researcher decided upon undertaking this study.

O B J E C T I V E S

In undertaking this study the writer had the following objectives in mind:

1. To establish the percentage of African males who are aware of contraception and to ascertain how the knowledge was acquired.
2. To identify any association between age and the use of contraceptives.
3. To identify any association between contraception and socio-economic status.
4. To identify in respect of African males cultural factors, which are associated with actual or perceived ideal family size.
5. To determine the influence of the African male in the use of contraceptives by his consort.
6. To ascertain the influence of religion on contraceptive usage.
7. To establish the association between community type and contraceptive usage.
8. To make recommendations, directed to the education of the African male in respect of family spacing with due regard to his cultural background and religious convictions.

DEFINITION OF CRITERIA

- (a) African male = Any African over the age of eighteen years. The reported age was accepted.
- (b) Contraception = Any means of preventing pregnancy excluding celibacy..
- (c) Community type = Urban or Rural.
- (d) Partner = Constant consort. Casual sexual contacts were excluded.
- (e) Practice = The researcher is running a private general practice in Esikhawini township. This is in the Mtunzini Magesterial District.
- (f) Relatives = Any senior person related by blood to interviewee.
- (g) Knowledge of contraception = Being aware of the existence of a pregnancy preventing method.

SELECTION OF SAMPLE

All African males who attended the practice of the researcher during the study period who had not been seen before, were included in the sample. The study was conducted from 1 July 1985 to 31 July 1985. A pilot study was undertaken on 29 June 1985.

C O N T R O L   G R O U P

No control group was necessary for the purpose of this study. Comparisons were, however, made between the various sub-groups in the study population.

M E T H O D   O F   D A T A   C O L L E C T I O N

The writer interveiwed all African males who consulted him on 1 July 1985 to 31 July 1985. The purpose of the study was briefly explained and confidentiality was assured. The interviewees were shown the standard questionnaire which had no space for identification of the participants (annexure). The participants were assigned consecutive numbers 1 to 220. In respect of each participant, data was recorded on a standard precoded questionnaire (annexure). Repeat consultations during the study period were not included in the study.

A pilot study was undertaken on 29th June 1985. Since no major difficulties were encountered on that date, the collected data were added onto that of the study. The only adjustment that became necessary was the definition of phrase knowledge of contraception. For the purpose of the study, the participants were told that knowledge of contraceptives meant being aware of a method of preventing pregnancy.

R E D U C T I O N   O F   B I A S

The sample included all patients who met the requirements for admission to the study. The criteria defined in the protocol was adhered to. The standard questionnaire was used in interviewing all the patients and one observer, the researcher, collected all data.

R E S U L T S

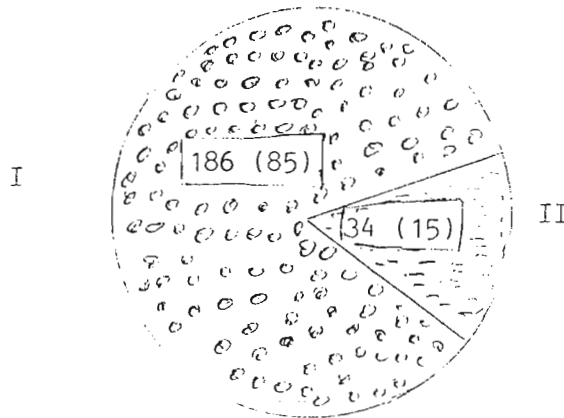
KNOWLEDGE OF CONTRACEPTION : OBJECTIVE 1(a).

Knowledge by whole sample : Of the whole population sample 186 (85%) were aware of contraception and 34 (15%) denied any knowledge of contraception.

Table 1.

Figure I (a)

Knowledge of contraception by African males seen at Esikhawini in July, 1985 : Number and Percentage (%).



I = Participants aware of contraception.

II = Participants not aware of contraception.

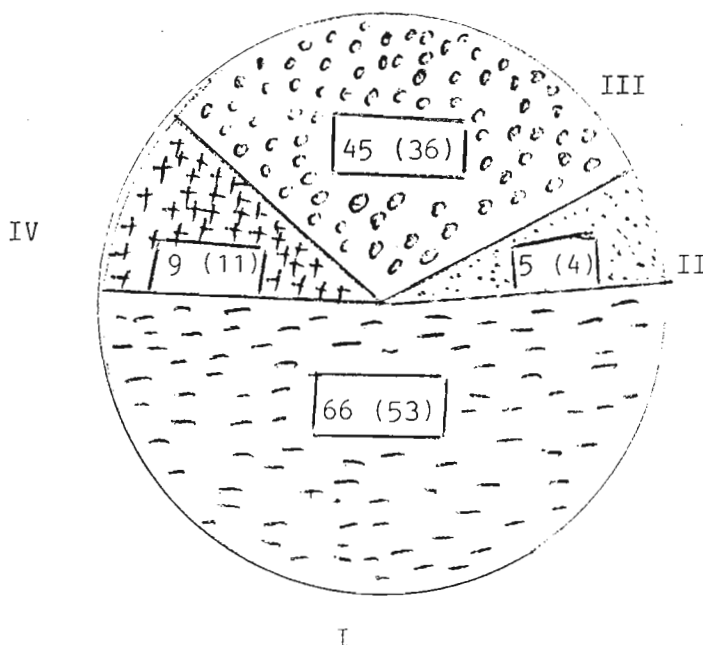
Knowledge by married men : There were 125 (57%) married men. Of these 125 participants, 111 (89%) professed knowledge of contraception and 14 (11%) denied any knowledge of contraception. Ten had more than one consort.



The difference in the knowledge of contraception between couples married by religious rites and those married by civil rites was not significant at the 0,05 level of probability ( $0,05 < P < 0,10$ ) Table 2.

Figure I(b)

Knowledge of contraception by married African males seen at Esikhawini during the month of July, 1985 :  
Number and Percent (%).

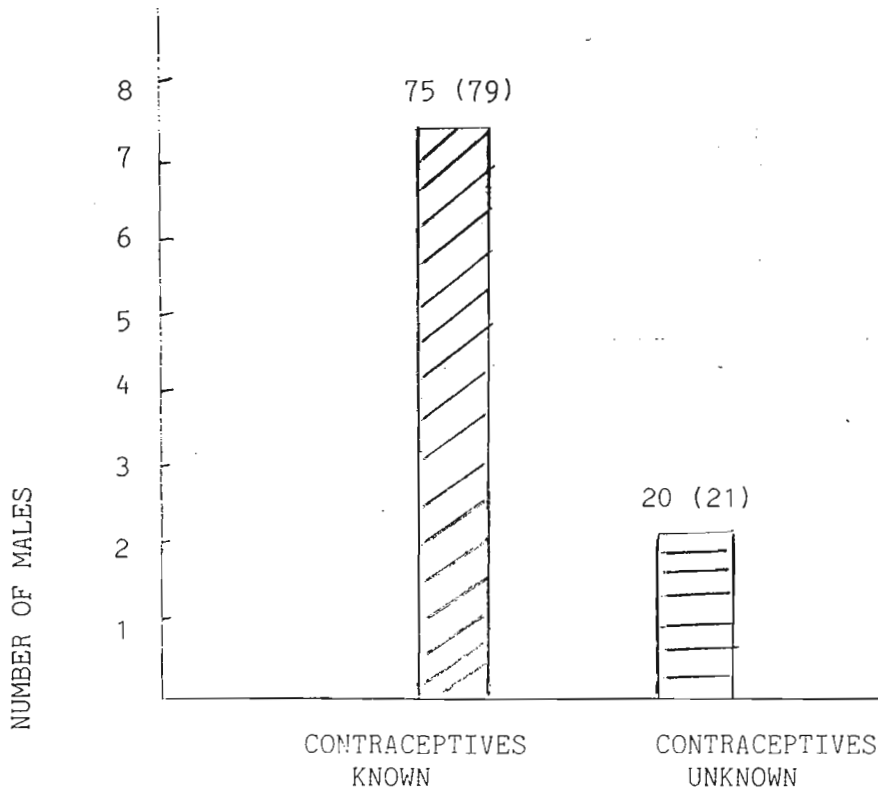


	I = Religious rites : aware of contraception.
	II = Religious rites : not aware of contraception.
	III = Civil rites : aware of contraception.
	IV = Civil rites : not aware of contraception.

Knowledge by unmarried men : There were 95 (43%) unmarried participants. Seventy-five (79%) of these professed knowledge of contraception and 20 (21%) had no knowledge whatsoever of contraception. This group consisted of single, widowed and divorced participants. Table 3.

Figure I(c)

Knowledge of contraception by unmarried African males seen at Esikhawini in July, 1985 : Number and Percent (%).



Eighty-nine percent of the married participants were aware of contraception compared to 79% of the unmarried. The difference in the knowledge of contraception between the married and unmarried participants was significant at 0.05 level of probability ( $0,02 < P < 0.05$ ).

SOURCE OF INFORMATION ON CONTRACEPTION : OBJECTIVE 1(b).

Many participants gave more than one source from which they obtained their information on contraception. Advertisement was quoted 150 times (51%) as a source of information on contraception out of a total of 297 episodes.

There were 71 (24%) episodes of friend/consort as a source of information; 42 (14%) of clinic/hospital; 18 (3%) of industry and the doctor was mentioned 10 times (3%). No participant gave either parent or the school as a source of information on contraception. Table 4.

Contraceptive Methods given : The most frequently quoted method of contraception by this sample was the pill. This was known to 57% of the participants; the injection was known to 42% of the sample; 40% knew no specific methods; 18% knew the condom and only 3% were aware of sterilization. Many participants knew more than one method of contraception and there were those whose knowledge was limited to the awareness of the availability of contraceptives. Table 5.

AGE AND CONTRACEPTIVE USE : OBJECTIVE 2.

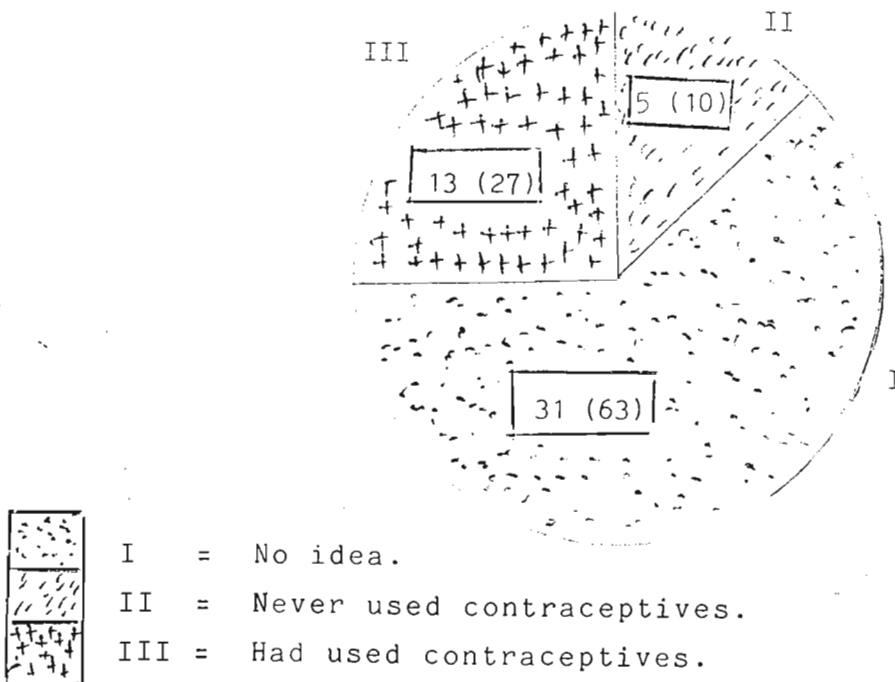
In this study contraception was found to be limited to the methods used by females. Less than 2% of the participants had used male methods of contraception.

The use of contraception by different age groups of the sample is shown in Table 6.

The 18 to 25 year age group : In this group 13 (27%) admitted having had coitus where contraceptives were used; 5 (10%) denied any experience with contraception and 31 (63%) had no idea as to whether they had had coitus where contraceptives were used or not.

Figure II(a)

Contraceptive use by 18-25 year age group of African males seen at Esikhawini in July, 1985 : Number and Percent (%).

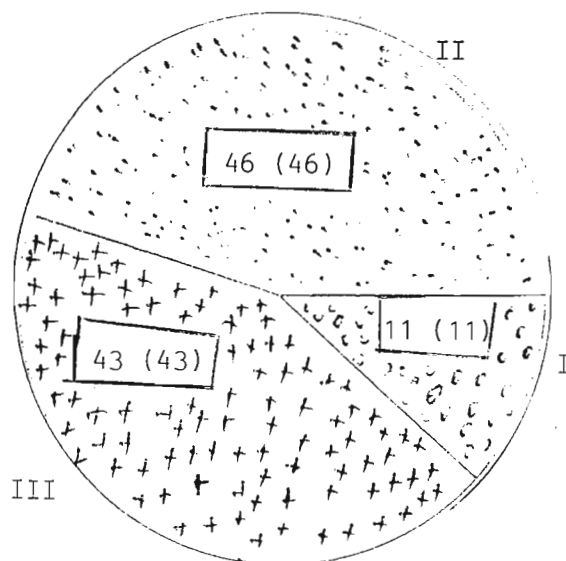


- I = No idea.
- II = Never used contraceptives.
- III = Had used contraceptives.

The 26-35 year age group : In this age group 46 (46%) had had coitus protected against pregnancy by contraception. Eleven (11%) had no experience with contraception and 43 (43%) had no idea whether they had been exposed to contraceptives.

Figure II(b)

Contraceptive use by 26-35 year age group of African males seen at Esikhawini in July 1985 : Number and Percent (%).

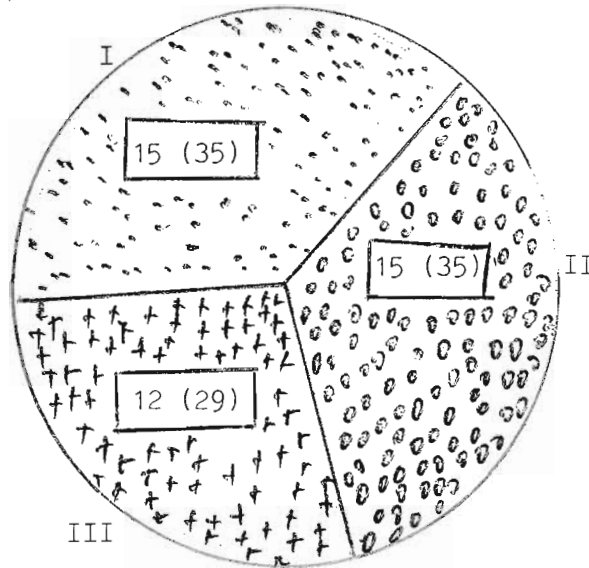


- I = Never used contraceptives.  
 II = Had used contraceptives.  
 III = Had no idea.

The 36-45 year age group : There were 42 participants in this age group. Fifteen (35%) had had coitus where contraceptives were used and 15 (35%) had no experience with contraceptives. Twelve (29%) had no idea whether they had been in contact with contraceptives.

Figure II (c)

Contraceptives used by 36-45 year age group of African males seen at Esikhawini in July, 1985 : Number and Percent (%).



- I = Had used contraceptives.  
 II = Had never used contraceptives.  
 III = Had no idea.

The 46 years and over : This was the smallest group made up of 28 participants. Six (21%) were aware of previous experience with contraceptives; 10 (36%) had had no experience with contraceptives and 12 (43%) had no idea whether they had had coitus where contraceptives were used. The age of one participant was not recorded in the questionnaire, hence the unspecific category in Table 6.

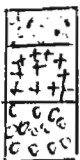
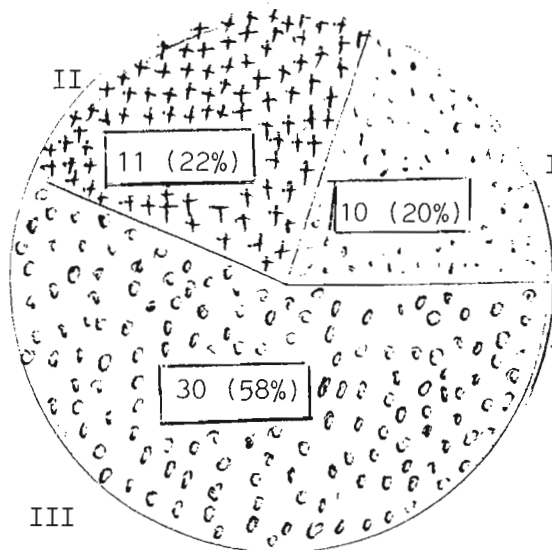
SOCIO-ECONOMIC STATUS AND CONTRACEPTIVE USE : OBJECTIVE 3.

Unemployed: There were 13 (6%) participants in the unemployed category which included students. Only one of these admitted having had coitus protected against pregnancy with contraceptives.

Manual unskilled: There were 51 participants in this category. Ten (20%) had used contraceptives. Eleven (22%) had never used contraceptives and 30 (58%) had no idea whether they had had coitus where contraceptives were used.

Figure III (a)

Use of contraceptives by manual unskilled African males seen at Esikhawini in July, 1985 :

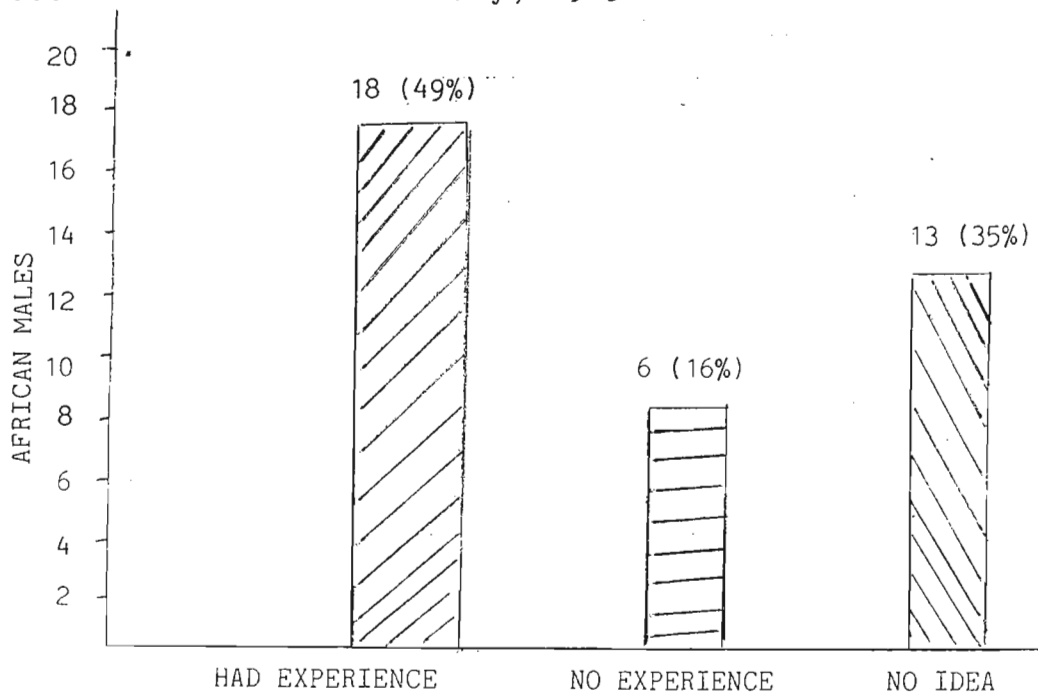


- I = Contraceptives used  
 II = Never used contraceptives.  
 III = No idea.

Manual skilled: There were 37 participants in this category. Eighteen (49%) had had coitus protected against pregnancy with contraceptives; 6 (16%) had had no experience with contraceptives and 13 (35%) had no idea whether they had been exposed to contraceptives.

Figure III (b)

Use of contraceptives by manual skilled African males seen at Esikhawini in July, 1985.

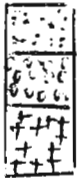
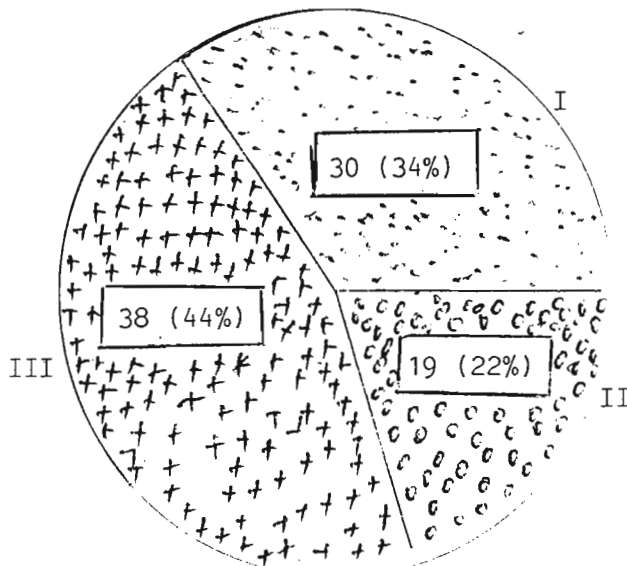


Non-manual: In this category there were 87 participants. Thirty (34%) had had experience with contraceptives; 19 (22%) had had no exposure to contraceptives and 38 (44%) were not aware of having used contraceptives.



Figure III (c)

Contraceptives used by non-manual African males seen at Esikhawini in July, 1985.

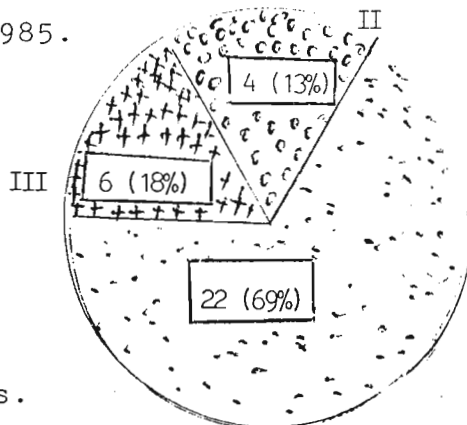


- I = Had used contraceptives.
- II = Had never used contraceptives.
- III = No idea.

Professional Group : There were 32 participants in the professional group. In this group 22(69%) had used contraceptives; 4 (13%) had had no experience with contraceptives and 6 (18%) had no idea whether they had had coitus where contraceptives were used. Table 7.

Figure III (d)

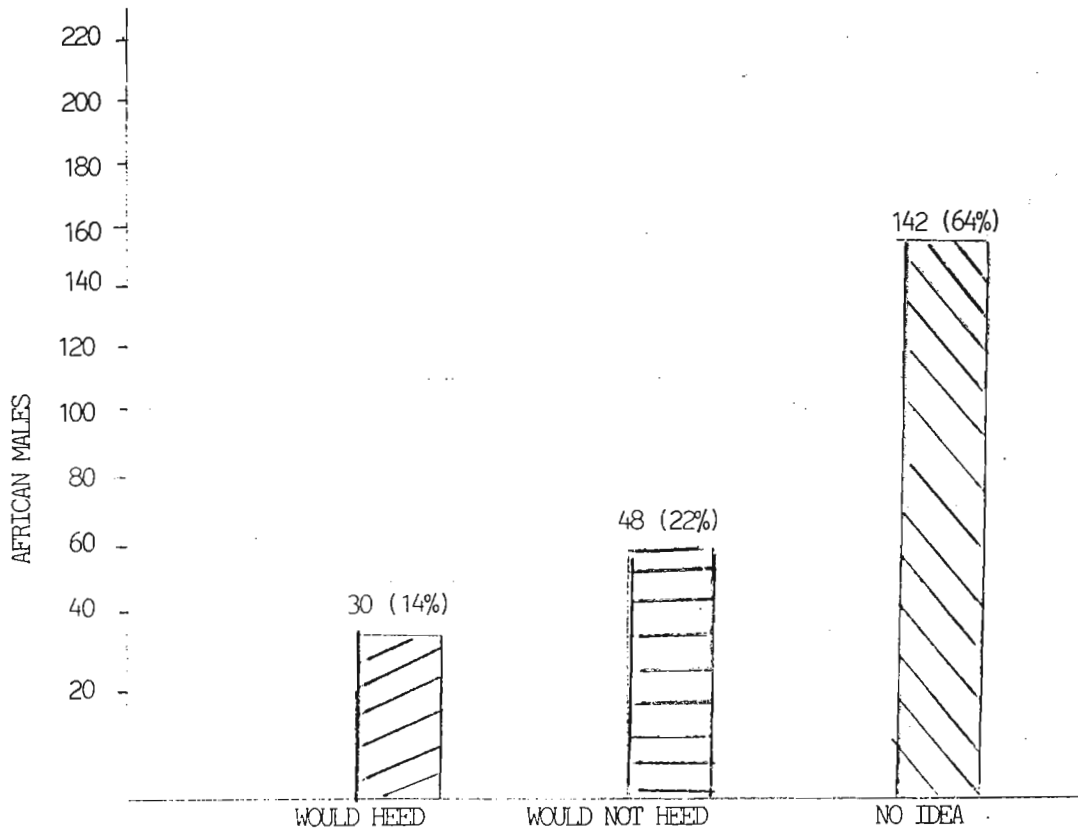
Use of contraceptives by professional African males seen at Esikhawini in July, 1985.



- I = Had used contraceptives.
- II = Had never used contraceptives.
- III = No idea.

Figure IV (a)

Expected reaction by African males to advice of relatives on family size.



(iii) Traditional Methods of Contraception

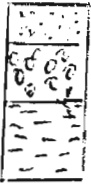
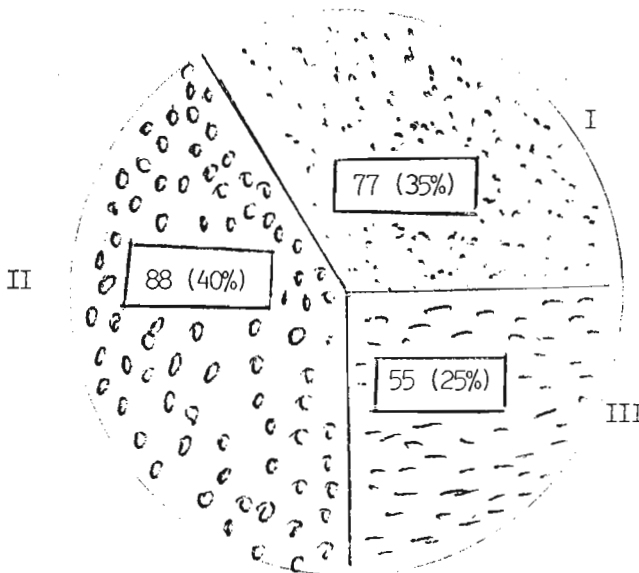
Knowledge of traditional methods of family spacing :  
 Of the total sample of 220 males, 77 (35%) were not aware of any traditional family spacing methods; 58 (26%) cited abstinence as a traditional method of family spacing; 35 (16%) mentioned coitus interfermora; 17 (8%) gave the performance of a ritual as one of the traditional methods of contraception. Fifteen (7%) participants gave coitus interruptus as one of the traditional methods of contraception. The less frequently given methods by 18 (8%) were passing urine by the female after coitus; lateral position during intercourse and breast feeding.  
 Table 10 (a).

(iv) Family Planning and African Tradition

Seventy-seven (35%) participants thought family planning was against African tradition; 88 (40%) thought it was not against African tradition and 55 (25%) had no idea whether contraception was against African tradition. Table 10 (b).

Figure IV (b)

Views on family planning and African tradition of males seen at Esikhawini in July, 1985.



- I = Family planning against African tradition.  
 II = Family planning not against African tradition.  
 III = No idea.

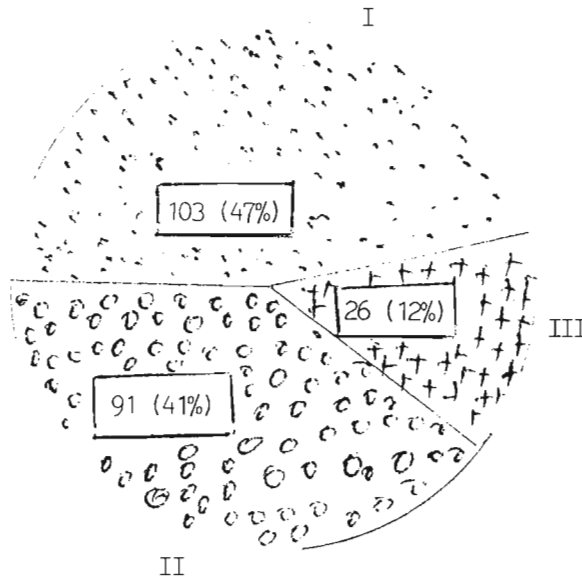
AFRICAN MALE AND THE USE OF CONTRACEPTIVES : OBJECTIVE 5

(i) Discussion of Family Planning with Partners.

One hundred and three (47%) participants stated that they had discussed contraception with their partners; 91 (41%) had never discussed contraception with their consorts and for 26 (12%) participants the question was not applicable. Those who had no stable partners and those whose partners were beyond the reproductive age fell into this category of "not applicable". This group also included those who stated that they had no idea about contraception. Table 11.

Figure V (a)

Discussion of Family Planning with consorts by African males seen at Esikhawini in July, 1985.

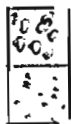
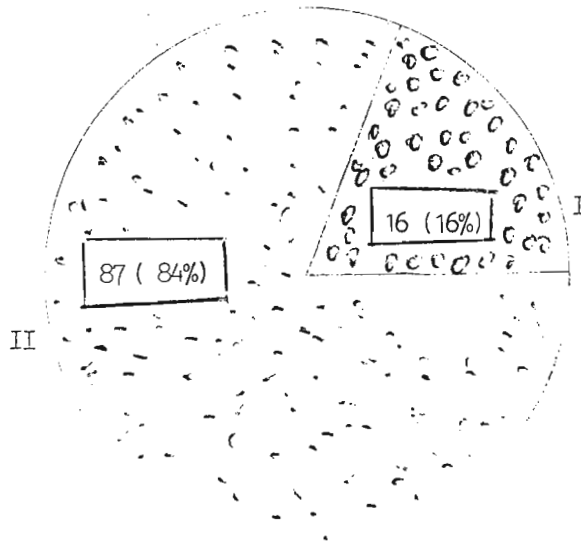


- |     |   |                |
|-----|---|----------------|
| I   | = | Had discussed. |
| II  | = | No discussion. |
| III | = | No idea.       |

Of the 103 participants who had discussed contraception with their partners 16 (16%) had discouraged the use of contraception and 87 (84%) did not discourage the use of contraceptives by their partners.

Figure V (b)

The influence on contraception of African males seen at Esikhawini in July, 1985.



- I = Contraception discouraged.  
 II = Contraception not discouraged.

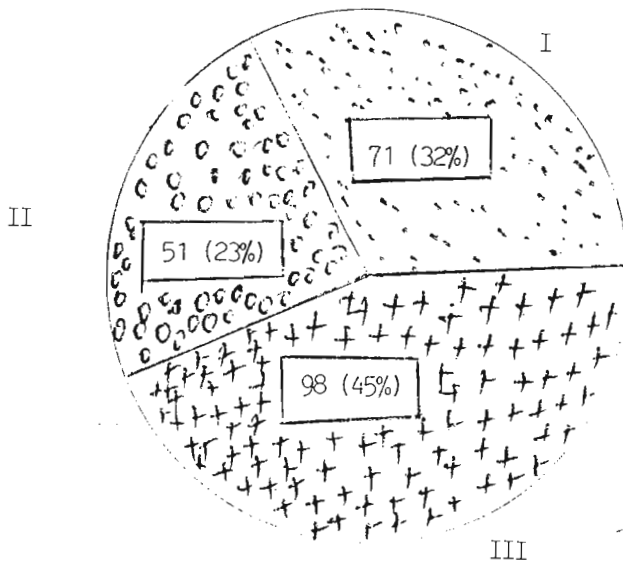
(ii) African Male's Beliefs on the Effects of Contraception

Seventy-one (32%) of the 220 participants thought that contraceptives were harmful to the male. The adverse effects they gave were impotence and sexually transmitted diseases. These were cited by all the 71 participants as being harmful.

Four participants said the pill and the injectable contraceptives were also harmful, but could not give specific adverse effects which they thought were associated with these methods. Fifty-one (23%) participants did not think that contraceptives were harmful to the male and 98 (45%) participants had no idea whether contraceptives were harmful or not. Table 11 (c).

Figure V (c)

Beliefs of African males on the effects of contraceptives on the male.



- I = Contraceptives are harmful to the male.
- II = Contraceptives are not harmful to the male.
- III = No idea.

RELIGION AND CONTRACEPTION : OBJECTIVE 6.

The participants belonged to many religious denominations, most of which did not constitute a group. The results were thus consolidated into Roman Catholics, Protestants, other and Heathen or Atheists.

Religious ruling on Contraception : There were 26 Catholics. Ten (39%) of them stated that their denomination does not approve of contraception; 6 (23%) indicated that Catholicism approves and 10 (39%) had no idea what the Church standpoint on contraception is.

There were 161 Protestants. Ten (6%) indicated that their denominations do not approve contraception; 96 (60%) stated that their denominations approve of contraception and 55 (34%) were not aware of any religious ruling on this matter.

Under the category "other" were the followers of Shembe (Church of Nazareth). This is a non Christian religion based on Zulu culture. Out of 19 participants in this category 4 (21%) stated that their religion is against contraception; 8 (42%) indicated that it was not against and 7 (37%) were not aware of any ruling on this matter. For the Heathen, religious opinion was not applicable. Table 12 (a).

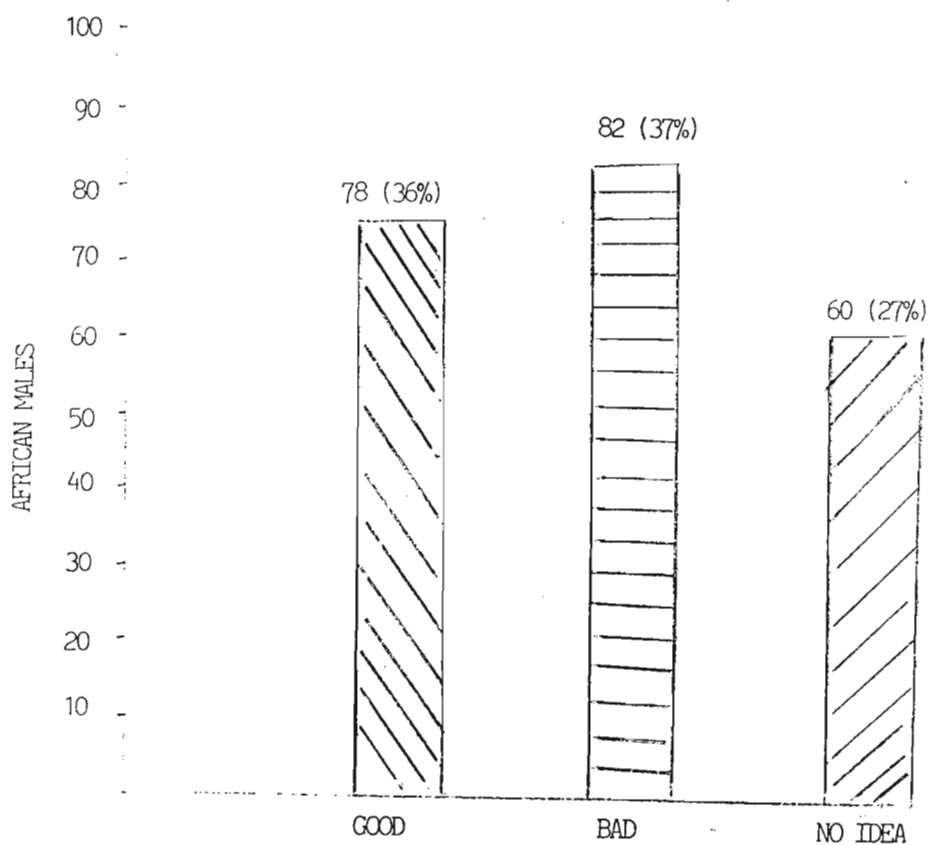
Opinion on religion and contraception : The opinion of the interviewees on whether contraception was for or against religious teaching were as follows:

Seventy-eight (36%) participants thought there was no barrier to contraception on the basis of religion; 82 (37%) thought that contraception was not compatible with religion and 60 (27%) did not want to commit themselves on this point.

Table 12 (b).

Figure VI

Opinion of African males on Religion and Contraception.



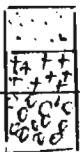
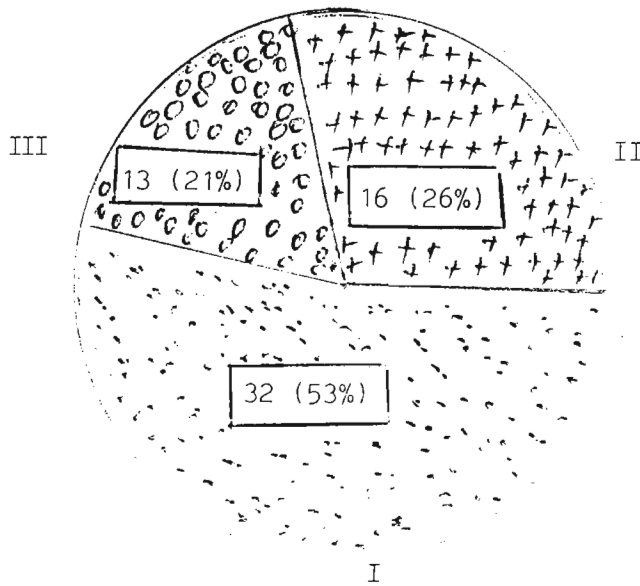


COMMUNITY TYPE AND CONTRACEPTIVE USE : OBJECTIVE 7.

URBAN : There were 61 (28%) participants who came from the Urban community. Thirty-two (53%) professed experience with contraceptives; 16 (26%) denied any experience with contraceptives and 13 (21%) had no idea whether they had been exposed to contraception or not. Table 13.

Figure VII (a)

Use of contraceptives by Urban African males seen at Esikhawini in July, 1985.

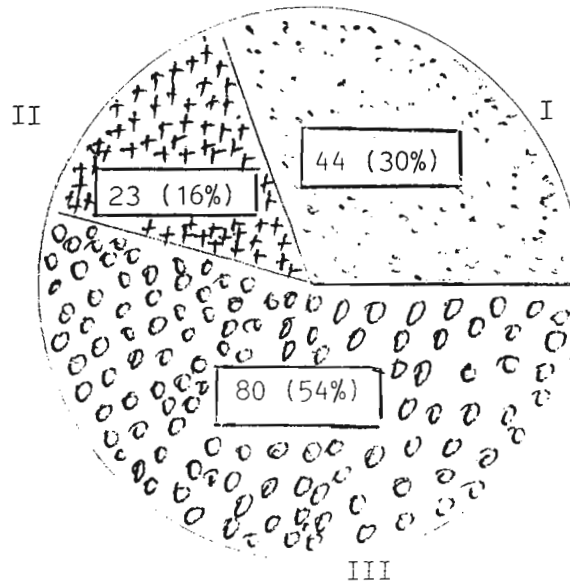



- I = Contraceptives used.
- II = Contraceptives never used.
- III = No idea.

RURAL : The Rural group consisted of 147 participants. Forty-four (30%) admitted having had experience with contraceptives; 23 (16%) denied any contact with contraceptives and 80 (54%) had no idea.

Figure VII (b)

Use of contraceptives by Rural African males seen at Esikhawini in July, 1985.



- 
 I = Contraceptives used.  
 II = Contraceptives never used.  
 III = No idea.

MIXED COMMUNITY : There were only 12 participants from the mixed community. Of this group 5 (42%) had had experience with contraceptives; 2 (16%) denied having had coitus where contraceptives were used and 5 (42%) had no idea.

The difference in the use of contraceptives between the three types of communities was found to be significant at 0,1% level ( $P > 0,001$ ).

D I S C U S S I O NLIMITATION OF STUDY

The author interviewed all the participants and filled in the questionnaire during the consultations. The collection of data was limited to one month to avoid prolonged disruption of the normal flow of patients. These factors resulted in the limited sample size. This was, however, advantageous in that ambiguous answers could be explored and observer variation was eliminated.

Almost all the interviewees had never been exposed to such seemingly inquisitive probing. They were initially afraid to give their opinion for fear of "annoying" their doctor. They did, however, relax and expressed their true knowledge and feelings after having been reassured.

After they had understood the nature and purpose of the research they were eager to give more information than was required in the questionnaire. They thought it was their golden opportunity to express their fears about contraception to a health care provider, but they were constantly directed to the questionnaire. It should be remembered that the introduction of contraception to the African people has been through the females at the clinics. The African male was never approached for his comments. Women and health workers alike simply presumed that the African male would oppose contraception. On most occasions he has not been consulted. The females who brought home contraceptive advise from the clinics could not answer questions put to them by their suspicious husbands.

The young and the unmarried tended to deny knowledge of contraception initially, for fear of being labeled promiscuous by their doctor. As the interview proceeded, however, they revealed at least some knowledge of contraception.

#### KNOWLEDGE OF CONTRACEPTION

The proportion of married participants that knew something about contraception was greater than that of the unmarried group. This shows that contraceptive campaigns have not spread enough to the young and unmarried for whom an unplanned pregnancy spells disaster. Church leaders are against contraceptive use by the unmarried because sex outside marriage is not permissible on the basis of the Ten Commandments. Medical personnel were generally not eager to counsel the unmarried on contraception. Such resistance can still be found in some practitioners at the infertility clinics where they refuse to investigate or "waste" time on the unmarried. It is only now that there is a general awareness of the runaway population growth that hard line attitudes in the medical profession are changing.

Because of the limited sample size, the results cannot be extrapolated to include the African male in general.

The study does, however, show the expected trend that married males who have to face the problem of looking after the families should concern themselves with the size of family they are able to support. Most probably, experience teaches them that it is easy to end up with an unplanned pregnancy where coitus is not protected with contraception.

The diminishing social pressures on those who are responsible for illegitimate offspring has not encouraged the unmarried to look for and to use modern contraceptive methods. Those that do not want to be known that they are having premarital sexual relations would not seek information on contraception.

In 1973 D.A. Davey and E.G. Robertson found that only 3,5% of women in their study were completely ignorant of all forms of contraception. <sup>5,6,7</sup>  
 In 1982 D.A. Whitelaw found that 24% of the women in his study were ignorant of contraception. <sup>8</sup> In this study 16% of the whole group denied any knowledge of contraception. No attempt was made in this study to find out whether the knowledge claimed by the rest of the group was sufficient to be utilized for the effective prevention of pregnancy. The general impression is that males do not know the minute details of contraception. There are very few contraceptive methods for males and these, except vasectomy, are used during the sexual act. The researcher has yet to see an African male who will accept a vasectomy.

#### SOURCE OF CONTRACEPTIVE KNOWLEDGE

As can be seen from the design of the protocol, the writer was aware of how the information on contraception was being disseminated among the Africans. One of the objectives was to establish the impact each method had on the African male and to find out what additional method, if any, was available to the African male.

Advertisement in the press and on the radio and television emerged as the major source of information. This accounted for 57% of the episodes given. Unfortunately this is a one-way traffic because individuals are unable to voice their queries. Advertisement was not meant for comprehensive information. Rightly the recipient is referred to the clinic to get the facts about contraception.

Medical and nursing personnel have made very little contribution in the dissemination of contraceptive knowledge among the African males as shown by the results of this study. Fortunately this aspect of preventative medicine is gaining momentum all the time. Pott and Diggory maintain that the family doctor is particularly well placed to give contraceptive advice.<sup>9</sup>

The family doctor is readily available to solve many problems on contraception even when his patients receive their contraceptives from the clinic. It is unfortunate that the designers of health policies in South Africa have not realised how important the family doctor is. They plan their health strategies to the exclusion of the person of first contact.

None of the participants had ever been informed by their parents or teachers on the availability and use of contraception. Discussion of sexual matters between parent and child is still rare among the Africans. Traditionally young men and women were taught sexual matters by senior unmarried men and women of the area. This was done during the initiation process which is found in many tribal customs.

The young lovers were instructed how they should behave themselves when they are together; the young man being instructed by a senior young man and the woman likewise by a senior young woman.

The classroom has not yet taken over this responsibility while rigid tribal customs are tumbling due to westernisation. The teacher, who also knows very little about contraceptives, cannot be expected to be effective in the dissemination of contraceptive knowledge among his students.

Industry is beginning to take part in educating the African male on matters of contraception. The contribution is, however, not yet significant, as shown by the results of this study.

The African male thus gets his contraceptive knowledge mainly from sources that are unable to give him comprehensive information and remove the unfounded fears that he might have. Table 4.

#### USE OF CONTRACEPTION BY AFRICAN MALES

Although 186 (85%) participants professed knowledge of contraceptives only 80 (36%) were using or had used contraceptives in the past. This shows that family planning campaigns have not yet achieved the desired effects on the African male. This is not surprising when his major source of contraceptive knowledge is advertisement. Davey in his paper refers to similar findings by Geraty in the discrepancy between knowledge of contraception and utilization. <sup>10</sup>

In her study, Amanda Roux found that 51% of her sample was using contraceptives. This was a very selected group because it was drawn from people attending either antenatal or postnatal clinic. It would be interesting to know what percentage of the population from which this sample was drawn, was actually using contraceptives.

#### CONTRACEPTIVE USE AND AGE

The splitting of contraceptive use according to age showed that the youngest age group has not yet had sufficient exposure to contraceptive campaign. <sup>12,13</sup> The majority of the youngest age group (63%), had no idea about contraception. It is not possible for a young man to have responsible sexual activity if he does not know how to prevent an unplanned pregnancy. His consort who must be conservative by tradition, relies on him in sexual matters with disastrous results. She cannot reveal her superior knowledge on sexual matters even when she has the knowledge. She relies on him to prevent pregnancy!

As has been stated earlier, westernization has demolished the African's strict moral code. In the traditional setting social pressures were so high that carnal knowledge of a woman by a young man was very rare.

#### SOCIO-ECONOMIC STATUS AND USE OF CONTRACEPTIVES

Although the sample size of this study is small, the results on economic status and use of contraceptives are in keeping with what has been found by other researchers.



Those with high income and education tend to be more receptive to contraceptive campaigns.<sup>16</sup> People who are studying tend to postpone starting families. Even those who pursue their studies after starting a family tend to delay the birth of another baby while they are studying. According to Pott and Diggory, family limitation in western societies began among the upper middle classes. Doctors and Clergymen, according to the 1911 census in Great Britain, were the earliest occupations to limit their families, followed by teachers.<sup>15</sup> This could be attributed to the fact that the educated can easily understand the advantages of a small family because of their broadened mental horizons. Their high standards of living would not be easy to maintain with large families.

In this study the unemployed and the manual unskilled groups were the least users of contraceptives, but ranked among the highest in the "no idea" category.

As far as the author knows, African teachers have no better knowledge of contraception than other professionals excluding doctors and nurses. Sex education including contraception cannot be delivered at African schools without the help of doctors, nurses or other health professionals. The school nurses are still concerned with the previously neglected field of pupil screening for medical conditions. Many pupils are being referred to clinics, hospitals and to general practitioners in private practice for medical conditions, but the author has yet to see a referral for contraception. There are many pupils at African schools who can boast of one or more unwanted pregnancy. Everybody in authority expects these little angels to behave themselves and avoid another pregnancy.

With the advancement in the provision of preventative and promotive aspects of medical care in South Africa, the area of inadequate sex education is hopefully going to disappear.

### FAMILY SIZE

The participants were aware of the advantages of a small family because the majority desired not more than four children. They had not acquired the knowledge on how not to exceed their desired family size. The modal ideal number of children was four. This is similar to what Amanda Roux found in her study. In her group the average ideal number was 3,3 children. <sup>16</sup>

In this study the desired family size was not correlated with the actual number of each participant's family. The author also did not correlate the desired family size and age of the participants. Francois de Villiers in his study found that older people desired larger families. <sup>17</sup> His study was, however, limited to rural Tswana people.

The tradition is that African males tend to desire large families compared to African women. The author's view is that with older African males, it is demanding a lot in a short time when health workers expect them to have fewer than four children. Many of these men grew up in large polygamous families where everybody lived for the other. The changes in attitudes towards family size are lagging behind the swift transformations that are taking place in the social and environmental spheres. It is not known whether the younger African males will also tend to desire more children as they grow older and as they accumulate wealth.

Another factor which determines the size of the African family is the number of boys among the offspring. It is generally known that every African male desires a preponderance of boys so that his name and that of the family could be perpetuated. The researcher did not ask the participants whether they would be satisfied with the number of children they had stated irrespective of the gender of the offspring. This was not the objective of this study.

#### TRADITIONAL METHODS OF CONTRACEPTION

Family spacing is not a new concept in the African way of life. This became evident when a number of traditional methods of contraception were given by many of the participants. What is new is the limited family size and the modern methods of contraception. The young unmarried lovers were limited to abstinence and coitus interruptus. These were 100% effective. Married people also observed a period of abstinence during lactation. Resumption of coitus post delivery was strictly regulated by social stipulations and enforced by old ladies.

Coitus interruptus which is never mentioned at family planning clinics is still widely used. The use of this method can also be found in the Bible. <sup>18</sup>

Methods such as lateral position at coitus and passing urine immediately after intercourse were obviously not effective.

Cultural factors were not found to influence the use of contraceptives by the African males. Only 14% of the participants thought they would heed the advice of their relatives on contraceptive matters. The apparent resistance among African males to contraceptive use is due to lack of sufficient motivation rather than to any cultural factors.

On direct questioning whether contraception was against the African customs, the writer found that 35% of the participants thought it was and 40% thought it was not. The 35% that stated that contraception is against African customs is a significant number when the fact that the African way of life is still dictated by customs is taken into consideration. This also demands that the health worker should be aware of this fact and should be ready to give unambiguous answers when counselling African males in family planning.

The author is thus of the opinion that the seemingly poor assimilation of contraceptive methods by the Africans is due to lack of the correct approach to the problem. Tribal customs play a minor role.

#### AFRICAN MALE'S INFLUENCE ON CONTRACEPTION

In African societies the woman is always a minor. She has to get permission from her husband for most of the things she wants to do and more-so on matters that affect the family. The researcher has seen many women with gynaecological and medical conditions that are not compatible with pregnancy who would not use contraceptives against the whims of their husbands. Ncayiyana found that 40% of his sample would use contraceptives "secretely" should the need arise. <sup>19</sup>

Family planning was introduced from the "wrong end" to the African in the researcher's opinion. Instead of approaching the policy makers, the males, health workers dealt with the African women at the clinics. The women were duty bound to approach their husbands for permission. It is thought that they could not answer all the questions put to them by the husbands. Anybody who introduces a topic of which he knows very little is not worth listening to.

Less than half of the participants had discussed family planning with their consorts. An equal number had had no discussion of family planning. The consorts of the latter group could be assumed to be either non-users or secret users of contraceptives.

It was surprising to find that the 103 participants that had discussed family planning only 16% had discouraged contraception. The author's impression is that African males are generally against modern contraceptive methods. In his opinion the low percentage of participants who disapproved of contraception were due to the fact that they did not want to antagonise their doctor. They knew that health workers in general encourage and advise contraception. To many people a personal matter of this nature could not be discussed with the doctor without themselves having introduced the topic. They could have just said what they thought would please the doctor.

Those males who disapprove contraception are likely to end up with large families. Long periods of abstinence are not possible in monogamous marriages unless the male works far away from home.

SIDE EFFECTS OF CONTRACEPTIVES : THE AFRICAN MALE'S POINT OF VIEW

The apparent resistance of the African male to contraception cannot be attributed to one factor. Contrary to the author's expectations, only 32% of the participants thought contraceptives have side effects in the male. Many females presenting with unplanned pregnancies tend to blame their consorts for not using contraceptives.

In African societies the woman's worth is measured by the number of babies she is able to bear. Inwardly she might not want to limit her family size but still would blame the consort should she fall pregnant. Sometimes the man might desire a small family, but the wife carries on producing more babies.

Ignorance on the part of the African male and poor health promotion on the part of the medical profession allow for free dissemination of unfounded rumours about contraception. The commonly quoted side effects of contraception are impotence and STD's. These could not have arisen had there been proper counselling of the clients.

None of those participants who feared harm from contraception had made an effort to verify their suspicions. It has been observed that the pill and injectable are protective against STD's.

More than 60% of the participants stated that they would like to be present when their consorts are given contraceptive advice. None of the participants would like their partners to use contraceptives secretly.

### RELIGION AND CONTRACEPTION

Religion seems to play a very small part in the African male's acceptance of contraception. Only 24 (11%) participants of different denominations thought contraception was against religious teaching. Even among the Catholics only 38% participants were aware that their Church was against contraception except for the periodic abstinence.

In Zaire Malonga Miatulda maintains that the Catholic Church has not hindered significantly the use of contraceptives, although 4 out of 10 Zairians are Catholics. The researcher has a number of Catholics who are on contraceptives among his patients. They obtain contraceptives from the local clinic free of charge.

Males are generally unwilling to practice prolonged periods of abstinence as advocated by the Catholic Church. Added to this is the fact that Catholic clergy practice celibacy and are thus regarded as ignorant of family life and the spontaneity of intercourse when health and environment are conducive. A study to establish the extent of contraceptive use among Catholics could be an eye opener to the bishops. The researcher has doubts whether the clergy would be willing to undertake such a study let alone publish it.

Only 6% of the Protestants thought contraception was against religion. The questionnaire of this study did not separate the views on contraception of the married from the unmarried. Some participants could have confused the church's view on contraception concerning the use by the unmarried.

No significance could be attached to the opinions of those who claimed to be Christians, but had more than one wife.

There is now a general trend among Africans which demands that the prospective bride should prove her fertility before marriage can take place. The Church is powerless in the face of this tendency.

Formerly, the birth of an illegitimate child used to cause embarrassment in both families, but now the infant increases the woman's chance of being taken as a wife.

Many participants thought that the church should have nothing to do with contraception. They felt that child spacing should be left entirely to individuals concerned.

Although the Catholic Church advocates periodic abstinence, this was the least quoted method of contraception. The few that claimed to be using the rhythm method had no proper knowledge of this. They used the terms "safe period" and being "careful" vaguely.

Periodic abstinence is mostly practised in Japan, which is not a Catholic dominated country. <sup>20</sup>

From the results of this study it can be concluded that religion has no appreciable influence on the use of contraceptives by African males.



CONTRACEPTIVE USE AND COMMUNITY TYPE

The general impression is that Urban communities tend to use contraceptives more than Rural ones because of the western influence and because of the availability and proximity of family planning clinics.

Communication is fast and efficient in Urban areas and the limited accommodation does not encourage large families. Those who dwell permanently in Urban areas are also free from the influences of the extended families. This study, however, has shown that cultural influence are not that significant in determining contraceptive use by the African male. In urban areas the women also work either to supplement the meagre incomes of their husbands or because they want to pursue their careers. The birth of a child would mean less income for the period during which the wife is on maternity leave.

It was not surprising to see in this study that urban dwellers tended to use contraceptives more than their rural counterparts.<sup>21</sup> There were also more contraceptive users than non-users in the mixed community category indicating the influence that Urbanisation has on family life. Added to this is the fact that education facilities are readily available in the urban areas. In his report of 11 countries, Rodriquez German has found that family size is inversely proportional to higher learning. He found that fewer rural inhabitants were familiar with contraception compared to town dwellers.<sup>22</sup> He also cited great distances to the available sources of contraceptives as one of the major reasons of non-contraceptive use by the rural communities. Health workers tend to concentrate on the education of the easily accessible and receptive town dwellers.

Ncayiyana and Margaret Ntlokwana found that 57% of antenatal clinic mothers had never been exposed to family planning education. <sup>23</sup>

The common feature of educational campaigns on family planning is the almost total disregard of the male sector of whatever community is being addressed. This attitude is, however, changing as seen by the involvement of men in the television and radio panel discussions. In one clinic in Soweto, Johannesburg men are also taught the rudiments of midwifery and they seem to take this very well.

#### C O N C L U S I O N

This study has shown that a large percentage (85%) of African males are aware of the existence of contraceptives. This knowledge is of benefit to a small percentage (37%) who practice contraception. The main source of knowledge is advertisement which is not expected to disseminate comprehensive information.

Health professionals have not yet significantly promoted good health through educating the African male on family planning. His position as a patriarch has not been taken into consideration when family planning campaigns are formulated, resulting in low returns.

There are no significant cultural factors that can prevent African males from accepting contraceptives. Fear of harm from the use of contraceptives is a minor problem that can be solved through proper counselling.

Religion has no significant effect on acceptance or rejection of family planning by the African male.

The general impression that Urban communities use contraceptives more than Rural dwellers has been confirmed by this study.

#### R E C O M M E N D A T I O N S

1. A study involving a larger sample of African males should be undertaken preferrably as a multicentre venture to minimise errors.
2. African males must be educated into the use and safety of modern methods of contraception.
3. The African male must be allowed to express his views on family spacing and contraception.
4. Any questions asked by those receiving family planning education should be answered by the health care workers sincerely and unambiguously.
5. The position of the African male as the head of the family should be taken into consideration when health promoting measures are introduced in the community.

6. Surreptitious dispensing of contraceptives to African women should be discouraged. Their consorts should be involved at the outset so that the women are not to blame should a problem such as delayed fertility occur.
7. Sex education should be introduced at home, at school and at any other social organization.
8. Health professionals should consult with religious and community leaders when introducing new health care measures in the community.
9. Health promotion in the community should be undertaken by health workers who are familiar with the culture and language of the community concerned.
10. There should be no politicization of health care promotion. Health care of the community should not be used by political organizations to gain votes.
11. Educational programmes on family spacing should be intensified in the young, the uneducated and rural dwellers.
12. Education on contraception should be taken upon by private general practitioners who are in close contact with the community.

A C K N O W L E D G E M E N T S

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TABLE 1

Knowledge of contraception by African males seen at Esikhawini during the month of July 1985, according to marital status: number and percent (%).

MARITAL STATUS	CONTRACEPTION KNOWN		CONTRACEPTION UNKNOWN		TOTAL	
MARRIED	111 (60)	(89)	14 (41)	(11)	125 (57)	(100)
UNMARRIED	75 (40)	(79)	20 (59)	(21)	95 (43)	(100)
TOTAL	186 (100)	(85)	34 (100)	(15)	220 (100)	(100)

$X^2_{0,05} > P > 0,02$



TABLE 2

Knowledge of contraception by married African males seen at Esikhawini during the month of July, 1985 : Number and Percentage (%).

TYPE OF MARRIAGE	CONTRACEPTION KNOWN		CONTRACEPTION UNKNOWN		TOTAL	
RELIGIOUS	66 (60)	(93)	5 (36)	(7)	71 (57)	(100)
CIVIL	45 (40)	(83)	9 (64)	(17)	54 (43)	(100)
TOTAL	111 (100)	(89)	14 (100)	(11)	125 (100)	(100)

DF  $X^2$  0,1 > P > 0,05

TABLE 3.

Knowledge of contraception by single African males seen at Esikhawini during the month of July 1985 : Number and Percent (%).

MARITAL STATUS	CONTRACEPTION KNOWN		CONTRACEPTION UNKNOWN		TOTAL	
SINGLE	71 (95)	(82)	16 (80)	(18)	87 (92)	(100)
DIVORCED	1 (1)	(50)	1 (5)	(50)	2 (2)	(100)
WIDOWED	3 (4)	(50)	3 (15)	(50)	6 (6)	(100)
TOTAL	75 (100)	(79)	20 (100)	(21)	95 (100)	(100)

TABLE 4

Source of information on contraception cited by African males seen at Esikhawini in July 1985 : Number and Percent (%).

SOURCE	NUMBER OF TIMES QUOTED	
1. ADVERTISEMENT	150	(51)
2. FRIEND/CONSORT	71	(24)
3. CLINIC/HOSPITAL	42	(14)
4. INDUSTRY	18	( 6)
5. DOCTOR	10	( 3)
6. OTHER	4	( 1)
7. NURSE*	2	( 1)
8. PARENT/SCHOOL	0	-
TOTAL	297	100

n = 220

\* NURSE - Other than the nurse in hospital, clinic or industry.

TABLE 5

METHODS OF CONTRACEPTION KNOWN TO AFRICAN MALES SEEN AT  
ESIKHAWINI DURING JULY 1985 AS PERCENTAGE (%).

METHOD OF CONTRACEPTION	PERCENTAGE OF PARTICIPANTS KNOWING
1. PILL	57%
2. INJECTION	42%
3. NIL	40%
4. CONDOM	18%
5. IUCD	15%
6. STERILIZATION	3%
7. SHIELDS	1%
8. SAFE PERIOD	LESS THAN 1%
9. SPERCIDAL AGENTS	LESS THAN 1%
10. COITUS INTERRUPTUS	0%
11. COITUS INTERFEMORA	0%

TABLE 6

USE OF CONTRACEPTION BY DIFFERENT AGE GROUPS OF AFRICAN  
 MALES SEEN AT ESIKHAWINI DURING THE MONTH OF JULY, 1985:  
 NUMBER AND PERCENT (%).

AGE GROUP (YEARS)	USE	NEVER USED	NO IDEA	TOTAL
18-25	13 (27) (16)	5 (10) (12)	31 (63) (32)	49 (100) (22)
26-35	46 (46) (57)	11 (11) (27)	43 (43) (44)	100 (100) (46)
36-45	15 (35) (19)	15 (35) (37)	12 (30) (12)	42 (100) (19)
46 +	6 (21) (8)	10 (36) (24)	12 (43) (12)	28 (100) (13)
UNSPECIFIED	-	-	-	1 (<1)
TOTAL	80 (36) (100)	41 (20) (100)	98 (44) (100)	220 (100) (100)

TABLE 7

CONTRACEPTIVE USE BY AFRICAN MALES OF DIFFERENT SOCIO-ECONOMIC STATUS SEEN AT ESIKHAWINI DURING THE MONTH OF JULY, 1985:  
NUMBER AND PERCENTAGE (%).

OCCUPATION	CONTRACEPTIVES USED	NEVER USED	NO IDEA	TOTAL
UNEMPLOYED	1 (8) (1)	1 (8) (2)	11 (84) (11)	13 (100) (6)
MANUAL UNSKILLED	10 (20) (13)	11 (22) (27)	30 (58) (31)	51 (100) (23)
MANUAL SKILLED	18 (49) (22)	6 (16) (15)	13 (35) (13)	37 (100) (17)
NON MANUAL	30 (34) (37)	19 (22) (46)	38 (44) (39)	87 (100) (39)
PROFESSIONAL	22 (69) (27)	4 (13) (10)	6 (18) (6)	32 (100) (15)
TOTAL	81 (37) (100)	41 (19) (100)	98 (44) (100)	220 (100) (100)

TABLE 8

DESIRED NUMBER OF CHILDREN BY AFRICAN MALES SEEN AT  
 ESIKHAWINI DURING THE MONTH OF JULY, 1985 : NUMBER  
 AND PERCENT (%).

DESIRED NUMBER OF CHILDREN	NUMBER OF PARTICIPANTS	
1	0	(0)
2	9	(4)
3	43	(19)
4	80	(36)
5	22	(10)
6	26	(12)
7 or more	10	(5)
Unlimited	26	(12)
No.ID.	4	(2)
TOTAL	220	(100)

TABLE 9(a)

CONSULTATION OF RELATIVES ON CONTRACEPTION BY AFRICAN MALES  
SEEN AT ESIKHAWINI IN JULY, 1985 : NUMBER AND PERCENT (%).

CONSULTED	NOT CONSULTED	NOT APPLICABLE	TOTAL
31 (14)	104 (47)	85 (39)	220 (100)

TABLE 9 (b)

ATTITUDES OF RELATIONS TO CONTRACEPTION : NUMBER AND PERCENT (%).

AGAINST	44	(20)
APPROVE	78	(36)
NOT CERTAIN	98	(44)
TOTAL	220	(100)



TABLE 10 (a)

TRADITIONAL METHODS OF CONTRACEPTION GIVEN BY AFRICAN  
 MALES SEEN AT ESIKHAWINI IN JULY, 1985: NUMBER AND  
 PERCENT (%).

CONTRACEPTIVE METHOD	NUMBER OF PARTICIPANTS AWARE	
NO. IDEA	77	(35)
ABSTINENCE	58	(26)
COITUS INTERFEMORA	35	(16)
RITUAL	17	(8)
COITUS INTERRUPTUS	15	(7)
OTHERS	18	(8)
TOTAL	220	(100)

TABLE 10 (b)

VIEWS ON FAMILY PLANNING AND AFRICAN TRADITION OF MALES  
SEEN AT ESIKHAWINI IN JULY, 1985: NUMBER AND PERCENT (%).

AGAINST TRADITION	77	(35)
NOT AGAINST TRADITION	88	(40)
NO IDEA	55	(25)
TOTAL	220	(100)

TABLE 11 (a)

DISCUSSION OF CONTRACEPTION WITH PARTNERS BY AFRICAN MALES  
SEEN AT ESIKHAWINI DURING THE MONTH OF JULY, 1985 :  
NUMBER AND PERCENT (%).

DISCUSSED	103	(47)
NO DISCUSSION	91	(41)
NOT APPLICABLE	26	(12)
TOTAL	220	(100)

TABLE 11 (b)

BELIEFS OF AFRICAN MALES ON THE EFFECTS OF CONTRACEPTIVES ON  
THE MALE.

HARMFUL	71	(32)
HARMLESS	51	(23)
NO IDEA	98	(45)
TOTAL	220	(100)

TABLE 12 (a)

RELIGIOUS STANDPOINT ON CONTRACEPTION AS UNDERSTOOD BY  
AFRICAN MALES SEEN AT ESIKHWINI DURING THE MONTH OF  
JULY, 1985 : NUMBER AND PERCENT (%).

RELIGION	DISAPPROVES OF CONTRACEPTION	APPROVES OF CONTRACEPTION	NO IDEA	TOTAL
R.C.C.	10 (38) (42)	6 (24) (6)	10 (38) (14)	26 (100) (12)
PROTESTANT	10 (6) (42)	96 (60) (87)	55 (34) (76)	161 (100) (73)
OTHER	4 (21) (16)	8 (42) (7)	7 (37) (10)	19 (100) (9)
HEATHEN	—	—	—	14 (100) (6)
TOTAL	24 (11) (100)	110 (50) (100)	72 (33) (100)	220 (100) (100)

TABLE 12 (b)

OPINION OF AFRICAN MALES ON RELIGION AND CONTRACEPTION :  
 NUMBER AND PERCENT (%).

CONTRACEPTIVES ARE GOOD	78	(36)
CONTRACEPTIVES ARE NOT GOOD	82	(37)
NO IDEA	60	(27)
TOTAL	220	(100)

TABLE 13

USE OF CONTRACEPTION BY AFRICAN MALES FROM DIFFERENT COMMUNITIES SEEN AT ESIKHAWINI DURING THE MONTH OF JULY, 1985 : NUMBER AND PERCENT (%).

COMMUNITY	USED	NEVER USED	NO IDEA	TOTAL
URBAN	32 (53) (40)	16 (26) (39)	13 (21) (13)	61 (100) (28)
RURAL	44 (30) (54)	23 (16) (56)	80 (54) (82)	147 (100) (66)
MIXED	5 (42) (6)	2 (16) (5)	5 (42) (5)	12 (100) (6)
TOTAL	81 (37) (100)	41 (19) (100)	98 (44) (100)	220 (100) (100)

1. ATTITUDES OF AFRICAN MALES TO CONTRACEPTION2. THE PROBLEM

The influence of the African male on the acceptance of contraception by his racial group is unknown.

3. OBJECTIVES

- 3.1 To establish the percentage of African males who are aware of contraception and to ascertain how the knowledge was acquired.
- 3.2 To identify any association between age and the use of contraceptives.
- 3.3 To identify any association between contraception and socio-economic status.
- 3.4 To identify in respect of African males cultural factors which are associated with actual or perceived ideal family size.
- 3.5 To determine the influence of the African male in the use of contraceptives by his consort.
- 3.6 To ascertain the influence of religion on contraceptive usage.
- 3.7 To establish the association between community type and contraceptive usage.
- 3.8 To make recommendations, directed to the education of the African male in respect of family spacing with due regard to his cultural background and religious convictions.

4. COLLECTION OF DATA

## 4.1 Definition of Criteria

- (a) African male = Any African over the age of eighteen years. The reported age will be accepted.
- (b) Contraception = Any means of preventing pregnancy excluding celibacy.
- (c) Community type = Urban or Rural.
- (d) Practice = The researcher is running a private general practice in Esikhawini Township. This is in the Mtunzini Magisterial District.
- (f) Relatives = Any senior person related by blood to interviewee.

#### 4.2 SELECTION OF SAMPLE AND CONTROL GROUP

##### Sample :

All African male patients attending the Practice of the researcher during the period 1 July 1985 to 31 July 1985 who have not previously attended the Practice during the study period.

A pilot study will be undertaken on 29 June 1985. If no major problem is encountered, data collected on that date will be added to that of the sample.

##### Control Group

No control group is necessary for the purpose of this study, however comparisons will be made between various sub-groups in the study population.

#### 4.3 METHOD OF DATA COLLECTION

All persons attending the practice during the study period who qualify for inclusion in the study will be requested to participate in the study. Interviewees will be assured of the confidentiality of the study. A structured standard Questionnaire will be used for the collection of data. Repeat consultations during the study period will be excluded (Annexure).

#### 4.4 ELIMINATION OF VARIABLES

- 4.4.1 The sample will include all patients meeting the requirements for admission to the study.
- 4.4.2 Criteria defined in the Protocol will be adhered to.
- 4.4.3 A standard questionnaire will be used in interviewing all patients.
- 4.4.4 One observer will collect all data, thereby eliminating interobserver variation.

#### 4.5 BARRIER DATES

- 4.5.1 Completion of Protocol and questionnaire : 12 May 1985.
- 4.5.2 Submission of Protocol to the Department of Community Health : 22 May 1985.
- 4.5.3 Finalization of Protocol : 6 June 1985.
- 4.5.4 Pilot Study : 29 June 1985.



4.5.6 Collation and Analysis of Data completed by 30 September 1985.

4.5.7 Submission of Report : 30 March 1986.

4.6 APPRAISAL OF LITERATURE

This will be ongoing throughout the study.

4.7 COLLATION OF COLLECTED DATA

All data will be collated onto a purpose designed collation sheet and analysed manually by the researcher.

5. PUBLICATION OF FINDINGS

A report will be submitted to the Department of Community Health in partial fulfilment of the requirement of Part II of the M. Prax. Med (Primary Care) degree of the University of Natal.

Q U E S T I O N N A I R E

OBJECTIVE 3.1

- (a) Marital Status \_\_\_\_\_  
\_\_\_\_\_
- (b) Type of marriage \_\_\_\_\_  
\_\_\_\_\_
- (c) Number of wives \_\_\_\_\_  
\_\_\_\_\_
- (d) Have you heard of contraception? \_\_\_\_\_  
\_\_\_\_\_
- (e) Where did you hear about  
contraception?  
\_\_\_\_\_  
\_\_\_\_\_
- (f) What contraceptive method do you know?  
\_\_\_\_\_  
\_\_\_\_\_

OBJECTIVE 3.2

- (a) Age \_\_\_\_\_  
\_\_\_\_\_
- (b) Have you had coitus where  
contraceptives were used? \_\_\_\_\_  
\_\_\_\_\_
- (c) Who used it? \_\_\_\_\_  
\_\_\_\_\_
- (d) What type?...specify... \_\_\_\_\_  
\_\_\_\_\_
- (e) Did you object when your partner  
used contraceptives? \_\_\_\_\_  
\_\_\_\_\_
- (f) Are you using contraceptives now? \_\_\_\_\_  
\_\_\_\_\_
- (g) Who is using it? \_\_\_\_\_  
\_\_\_\_\_

OBJECTIVE 3.3

- (a) How far did you go with schooling? \_\_\_\_\_  
\_\_\_\_\_
- (b) What is your occupation? \_\_\_\_\_  
\_\_\_\_\_
- (c) What is your partner's occupation? \_\_\_\_\_  
\_\_\_\_\_
- (d) How many children would you like to have? \_\_\_\_\_  
\_\_\_\_\_
- (e) Would you limit the number of children according to your income? \_\_\_\_\_  
\_\_\_\_\_

OBJECTIVE 3.4

- (a) How was family spacing achieved in the traditional African way of life?.....  
.....
- (b) What do the relatives say about family planning? \_\_\_\_\_  
\_\_\_\_\_
- (c) Do you consult your relative on matters of family planning? \_\_\_\_\_  
\_\_\_\_\_
- (d) Would you heed their advice concerning the number of children? \_\_\_\_\_  
\_\_\_\_\_
- (e) Is family planning against the traditional African way of life? \_\_\_\_\_  
\_\_\_\_\_

OBJECTIVE 3.5

- (a) Do you discuss family planning with your partner? \_\_\_\_\_  
\_\_\_\_\_
- (b) Have you ever discouraged your partner from using contraceptives? \_\_\_\_\_  
\_\_\_\_\_
- (c) Would you like to be involved when your partner consults a doctor/nurse for contraception? \_\_\_\_\_  
\_\_\_\_\_
- (d) If your partner were to use contraceptives without your knowledge, would you be angry? \_\_\_\_\_  
\_\_\_\_\_

(e) If your partner uses contraceptives, could you be affected?

\_\_\_\_\_  
\_\_\_\_\_

OBJECTIVE 3.6

(a) To which denomination do you belong?.....  
.....

(b) Is your church against contraception?

\_\_\_\_\_  
\_\_\_\_\_

(c) Does your church favour any particular contraceptive method?

\_\_\_\_\_  
\_\_\_\_\_

(d) Should the Church have a say in contraceptive matters?

\_\_\_\_\_  
\_\_\_\_\_

(e) In your opinion is contraception good from a religious point of view?

\_\_\_\_\_  
\_\_\_\_\_

OBJECTIVE 3.7

Community Type

\_\_\_\_\_  
\_\_\_\_\_

OBJECTIVE 3.1

## (a) Marital Status

Married = 1  
Single = 2

## (b) Type of Marriage

Religious = 1                      Civil = 2  
Common Law = 3                      Not Applicable = 4

## (c) Number of wives .....

(d) Have you heard of contraception?

Yes = 1                      No = 2

(e) Where did you hear about contraceptives?

Doctor = 1                      Nurse = 2  
Parents = 3                      School = 4  
Family  
Planning clinic = 5                      Industry = 6  
Friend = 7                      Advertisement = 8  
Other = 9                      Not Applicable = 0

(f) What contraceptive method do you know?

Safe Period = 1                      Coitus Interruptus = 2  
Coitus interfemora = 3                      Concom = 5  
Shield = 6                      I U C D = 7  
Pill = 8                      Injection = 9  
Sterilization = 10                      Nil = 0  
Other = (Specify)

OBJECTIVE 3.2

## (a) Completed years.

## (b) Have you had coitus where contraceptives were used?

Yes = 1    No = 2    No idea = 3    Not applicable = 4

## (c) Who used it?

Yourself = 1    Your partner = 2    Unknown = 3  
Not applicable = 4

## (d) What type : Specify ..... Not applicable = 4

## (e) Did you object when your partner used contraceptives?

Yes = 1    No = 2    Not Applicable = 4

## (f) Are you using contraceptives now?

Yes = 1    No = 2    Unknown = 3    Not Applicable = 4

## (g) Who uses?

OBJECTIVE 3.3

(a) Educational standard :

STD VI. = 1  
 STD VII = 2  
 STD X = 3

(b) Your occupation :

Unemployed = 0  
 Student = 1  
 Manual Skilled = 2  
 Manual Unskilled = 3  
 Non-manual = 5  
 Professional = 7

(c) Your partner's occupation :

To code as in (b) above. Plus Housewife = 9.

(d) Desired number of children : \_\_\_\_\_

(e) Would you limit the number of children according to your income?

Yes = 1 No = 2 Don't know = 3

OBJECTIVE 3.4(a) How was family spacing achieved in the traditional African way of life?  
(Code to follow)

(b) What do relatives say about family planning?

Approve = 1  
 Against = 2  
 No idea = 3  
 Not applicable = 4

(c) Do you consult your senior relatives on matters of family planning?

Yes = 1 No = 2 Not applicable = 4

(d) Would you heed their advice concerning the number of children?

Yes = 1 No = 2

(e) Is family planning against the traditional African way of life?

Yes = 1 No = 2 No idea = 3

OBJECTIVE 3.5

(a) Do you discuss family planning with your partner?

Yes = 1 No = 2 Not applicable = 4

(b) Have you ever discouraged your partner from using contraceptives?

Yes = 1 No = 2 Not applicable = 4

(c) Would you like to be involved when your partner consults a doctor/nurse for contraception?

Yes = 1 No = 2

(d) If your partner were to use contraceptives without your knowledge, would you be angry?

Yes = 1 No = 2

(e) If your partner uses contraceptives could you be affected?

Yes = 1 No = 2 No idea = 3

If Yes, how.....

OBJECTIVE 3.6

(a) To which denomination do you belong? (To code later)

(b) Is your church against contraception?

Yes = 1 No = 2 No idea = 3 Not applicable = 4

If Yes, specify.....

(c) Does your church favour any particular contraceptive method?

Yes = 1 No = 2 No idea = 3 Not applicable = 4

If Yes, specify .....

(d) Should the Church have a say in contraceptive matters?

Yes = 1 No = 2 Not applicable = 4

(e) In your opinion is contraception good from the religious point of view?

Yes = 1 No = 2 No idea = 3

OBJECTIVE 3.7

Community type : Urban = 1  
Rural = 2  
Mixed = 3