CHAPTER 1

1. INTRODUCTION

1.1 BACKGROUND AND OVERVIEW

In rural areas, women carry the burden of preventing unplanned pregnancies alone (Shears, 2004). Most men rely on their partners to use contraceptives (Weston, Schipalius & Vollenhoven, 2002). When two people are in a relationship, it is important that they make decisions together about using contraceptives to prevent unwanted pregnancies. Men should, therefore be targeted for family planning services to encourage their participation in the use of contraceptives (Weston et al, 2002).

In South Africa, contraceptives are available free of charge at clinics and other public health establishments. Contraceptives improve the health and socioeconomic conditions of people (Baron & Byrne, 1994). They empower men and women to have control over their ability to have children. The aim of this study was to determine men's knowledge, attitudes and practices on the use of contraceptives.

1.2. DEFINITION OF CONCEPTS AND ABBREVIATIONS

1.2.1 Reproductive Health

"Reproductive health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functioning and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable method of family planning of their choice, as well as

other methods of their choice for regulation of fertility which are not against the law, and their right of access to health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant". This comprehensive definition was adopted at the International Conference of Population and Development (ICPD) held at Cairo in 1994 where 179 countries met to forge an international commitment to improving reproductive health and protecting reproductive rights (Chaya; Johnston; Engelmann; Ethelton & Green, 2001).

1.2.2 Reproductive Age

In men, the reproductive age is a period of forty years starting from the age of 15 up 45 years. During this period, almost all men have sexual intercourse for the first time, marry and become fathers and reach a point in their lives when they decide they do not need any more children (The Alan Guttmacher Institute, 2003).

1.2.3 Contraceptive

An agent or device intended to prevent conception or capable of preventing conception or impregnation. A contraceptive is also barrier method able to prevent STIs as well.

1.2.4 Contraception

This is the use of contraceptives to avoid pregnancy resulting from sexual intercourse.

1.2.5 Birth Control

It is the practice of preventing or reducing the probability of pregnancy without abstaining from sexual intercourse. It also includes sometimes the ending of unwanted pregnancy or abstinence.

1.2.6 Family Planning

The term family planning is used for thoughtful and premeditated selection and use of birth control technique or set of techniques.

1.2.7 Attitude

Allport (Variables, 2003) defined an attitude as a mental and neural state of readiness, organized through experience, exerting an influence upon an individual's response to an object and the situations with which it is related. It is a relatively enduring organization of beliefs, feelings and behavioural tendencies towards socially significant objects, groups, events or symbols (Burr, 2000).

1.2.8 Abbreviations

1.2.8.1 IUCD: Intrauterine contraceptive device

1.2.8.2 LAM: Lactational amenorrheal method

1.3 PROBLEM STATEMENT

Woman in rural areas often cannot negotiate for safer sex because men violate women's sexual rights. This undermines women's position in society and makes them vulnerable to unwanted pregnancies (Cullinan, 2003). Research has shown that throughout the world, the attitudes and behaviours of some men seriously jeopardise the health of women (The Alan Guttmacher Institute, 2003). Men are brought up to initiate sexual matters but they are not initiative when it comes to contraception. One study reported that most men do not worry about getting anybody pregnant (Stein, 2002). Women carry the burden of preventing unplanned and unwanted pregnancies alone (Shears, 2004).

About half of men in rural areas lack knowledge on the benefits of contraceptives. They are ignorant and have a negative attitude towards contraceptives. Only 54% of men use a contraceptive method, which indicates that measures still need to be put in place to promote change in behaviour towards contraceptives (Weston et al, 2002).

In my personal experience as a nurse working in a Primary Health Care (PHC) clinic, I heard women complaining that men are not cooperative when told about contraceptives. Many rural women confided in me that they used contraceptives secretly and always lived under fear of being discovered. They complained that their male partners destroyed

appointment cards used for follow-up on contraceptives at clinics, destroyed contraceptive pills that women kept for daily use, refused condoms that women brought home and some even beat them when they discovered that they used contraceptives secretly. Men beat their partners when they use contraceptives without the men's consent because these contraceptives, they allege, have a negative impact on men's reproductive health.

On the other hand, men confided in me that they experienced aches and pains, premature aging, early deaths, weak erections and other chronic diseases due to the effects of contraceptives used by their partners. Box 1 summarises complaints of men about women and women about men concerning the use of contraceptives. Little data exist regarding men's contraceptive knowledge, attitude and practices in South Africa and other parts of the world (Weston et al, 2002).

BOX 1. COMPLAINTS OF MEN AND WOMEN AGAINST EACH OTHER

Women About Men

- Men are not cooperative
- Men destroy our appointment cards
- Men destroy our contraceptive pills
- Men refuse to use condoms that we bring home
- Men beat, abandon and divorce us for initiating contraception

Men About Women

- Women's contraceptives causes us bodily aches and pains
- We have premature ejaculation from their contraceptives
- We experience premature aging from their contraception
- Women's contraceptives causes us all sorts of chronic illnesses
- We have diminished libido from their contraceptives

Box 1 shows complaints of men and women against each other.

1.4 RESEARCH FRAMEWORK

1.4.1 AIM OF THE STUDY

To study knowledge, practices and attitudes of rural men on the use of contraceptives in a village of Limpopo, South Africa.

1.4.2 OBJECTIVES

- To identify the benefits of contraceptives as perceived by men.
- To identify the various methods of contraceptives known to men.
- To identify the influence men have on women's decision to use contraceptives.
- To assess men's willingness to use the male pill when available.
- To identify contraceptive methods used by men.

1.4.3 RESEARCH QUESTIONS

The study aimed to answer the following questions pertaining to the knowledge, practices and attitudes of men towards the use of contraceptives:

- Which methods of contraceptive did men know?
- Were men taking responsibility with their partners in deciding on the use of contraceptives?
- Were men aware of the benefits of using contraceptives?
- What was the attitude of men towards the use of contraceptives?
- Were men willing to use male contraceptive pill when available?

1.4.4 SIGNIFICANCE OF THE STUDY

Findings from the study are available for use in planning for strategies to inform and educate men in the use and importance of contraceptives. Research indicated that it was possible to facilitate men's participation in contraception and family planning by introducing training programmes (Weston et al 2002). Those training programmes will sensitise men to participate in reproductive health matters as equal partners with women. Improving men's knowledge on reproductive health is essential to increasing the

likelihood that men will engage in protective behaviours to benefit their own health and that of their partners (The Alan Guttmacher Institute, 2003). Women will then be relieved of the burden of carrying alone the responsibility to prevent unwanted pregnancies. Active participation by men in sexuality and reproductive health would promote the concept of mutual respect and equality in sexual decision-making and relationship (Shears, 2004). The challenge facing reproductive health workers in South Africa is not to condemn men for their negative attitudes towards contraceptives, but to make the hidden cultural logic behind resistance to contraceptive use known and thereafter to find ways to work with or around them (van Dyk, 2001).

Contraceptives prevent unwanted pregnancies and some can protect partners against sexually transmitted infections (STIs) including infection with HIV. Men who understand contraceptives, who have developed a positive attitude towards them and who use them will also contribute towards prevention and control of STIs and HIV/Aids in the country (Bauni et al, 2003).

CHAPTER 2

2. LITERATURE REVIEW

2.1 INTRODUCTION

This chapter focuses on the empirical and theoretical literature review. The empirical literature review focuses on South Africa and some African countries (States). The theoretical literature review focuses on social learning theory.

2.2 Empirical Literature Review

2.2.1 Introduction

Family planning is a means for spacing or limiting births for the welfare of the mother and child (Bauni, Garimoi, Maharaj, Mushingeh, Neema, Ngirwamungu & Riwa, 2003; Baron and Byrne, 1994). Contraceptives are helpful in preventing unwanted pregnancy and some can protect against sexually transmitted infections (STIs) including HIV infection (Bauni et al, 2003; Evian, 2000).

A study by the Women's Health Project on South African women's experiences of contraception and contraceptive services has found that men are willing to use contraceptives including sterilization in the form of vasectomy if given information about them. Men are also willing to use condoms if they did not have to queue in order to acquire them from health workers at the clinics (Gready, Klugman, Xaba, Boikanyo & Rees, 1997). Condoms should be distributed in such a way that they are easily accessible and increase a sense of privacy while reducing embarrassment (van Dyk, 2001). Men are more interested in family planning than is usually assumed and today family planning programmes are increasingly focusing on involving men (Weston et al 2002). Men aged 35 to 64 are less likely to seek contraceptive advice than young ones (Hirschowitz and Segel, 2003). Rural Africans are less likely to seek advice on contraceptives compared to those living in urban or metropolitan areas. A previous study found that only 14% of African men living in rural areas use contraceptives as compared to 21% in urban and

metropolitan areas (Hirschowitz and Segel, 2003). The study also found that as the level of education increases so does the percentage of those seeking contraception.

Methods of contraception commonly available to men in many African countries include condoms, sterilization, withdrawal and periodic abstinence until a child is wanted (Hirschowitz and Segel, 2003). In South Africa, common contraceptive methods available to women are oral contraceptives, injectable, barrier methods, and the indigenous family planning methods such as the safe period and the (Stein, 2002). Box 2 presents methods that are easily available in South Africa according to sexes.

BOX 2.

EASILY AVAILABLE METHODS OF CONTRACEPTIVES

For Men

Withdrawal; Condoms

For Women

Diaphragm; Injectable; Lactational Amenorrhoea Method;

Oral contraceptives; Indigenous methods;

Intrauterine Contraceptive Device (IUCD)

For Both sexes

Sterilization; Periodic Abstinence until a child is wanted

Box 2 shows easily available methods of contraceptives in South Africa for men and women and for both sexes.

2.2.2 Contraceptives in Tanzania and Kenya

A study conducted in Tanzania indicated that contraceptives were acceptable amongst men but they rejected the use of condoms in marriage as they regarded a condom to be a means to prevent STIs and not as a contraceptive. In Kenya acceptability and use of contraceptives was very low (Buani et al, 2003). Conducted studies found that women

were vulnerable to STIs and unwanted pregnancies due to men's leading roles in the family and community. As a result, the women said:

- they could not refuse to have sex
- they could not ask their husband to use a condom
- they could not do anything to protect themselves from infections and unwanted pregnancies
- they could not talk about the problem with their husbands.

In certain situations married women used contraceptives secretly as their husbands were not cooperative (Hirschowitz and Segel, 2003). Gready et al (1997) found the following to be the main barriers to communication between partners on contraception:

- cultural beliefs;
- ignorance;
- religious teachings;
- men's lack of cooperation.

2.2.3 Contraceptives in Zambia

In Zambia, condoms were known as contraceptives but were mostly associated with:

- commercial sex workers;
- teenage sex;
- extramarital affairs;
- use during menstruation;
- casual relationships;
- early stages of a relationship.

Researchers found that men rejected the use of condoms in marriage as that indicated unfaithfulness. They accepted condom use in casual relationships or in early stages of a relationship but rarely in stable relationships. Communication between spouses on reproductive issues was limited at best, with most men disapproving of contraception. That lead to disagreement amongst couples which resulted in women being beaten, divorced or rejected (Bauni et al, 2003).

Communication and cooperation between partners is very important in the use of contraceptives. Such communication is more likely in happy monogamous marriages where the couples are young and more educated. Both parties in a relationship are responsible for making decisions around contraception (Shears, 2004).

In most African countries women reported that men were not cooperative in discussion on contraceptives. Some men considered family planning to be the responsibility of women while on the other hand women considered it the responsibility of both partners. Sixty seven percent of men in conducted studies said that decision should be made together with their partners and agreed to take responsibility together. However their behaviour of preferring oral contraceptives and intrauterine contraceptive device (IUCD) over other methods and their choice of tubal legation being twice that of vasectomy did not seem to support their declaration of taking responsibility together with their partners. The study further revealed that 63% of men would not take a male contraceptive pill when available (Weston et al, 2002). Reproductive health experts recognised that involving men in family planning would yield many benefits such as client satisfaction and the adoption, continuation and effectiveness of contraceptive use (Shears, 2004).

Hirschowitz and Segel (2003) found that 48% of men relied on their partners to use contraceptives while 15% cited lack of knowledge about contraception as some of the reasons they did not practice contraception. Weston et al (2002) found that cultural factors prevented most men from using contraceptives.

The factors were expressed as:

- fear that contraceptives would undermine their authority as head of the family;
- fear of harmful side effects;
- fear that contraceptives would encourage their wives to be unfaithful;
- opposition due to religious reasons;
- desire to have a large family.

Societal expectations about what it means to be a man may give men the power to influence and determine women's reproductive health choices, which may undermine women's ability to protect themselves form unintended pregnancy or HIV infection (Shears, 2004). Condoms were perceived by many Africans as blocking the gift of self and preventing the ripening of the foetus in pregnancy (van Dyk, 2001). The use of contraceptives was found to be surrounded by false beliefs shared by many people in most rural communities. Most common of such beliefs were (Bauni et al, 2003):

- condoms were contaminated with HIV;
- the possibility of a condom remaining inside the woman's womb;
- stomach pains;
- condoms lead to premature ageing.

Mass media in the form of radio and television are the main sources of information on contraceptives in South Africa but most men would like to get information from doctors and nurses in the clinics (Weston et al, 2002). The use of mass media together with training programs to reach both men and women would help significantly to promote the concept of mutual respect and equality in sexual decision-making and relationship (Weston et al, 2002; Shears, 2004).

2.3. THEORETICAL LITERATURE REVIEW

2.3.1 SOCIAL LEARNING THEORY

2.3.2 Introduction

Social learning theory has been used to how people learn by imitating others. According to this theory people form their thoughts, feelings and actions from observing what they perceive to be the thoughts, feelings and actions of others. Social learning theory sees a person as an active participant who perceives and evaluates stimuli, who strives towards goals and devises plans, to achieve them, who plans his or her future behaviour, judges his or her past behaviour and again plans his or her behaviour in the light of his or her

self-evaluation (Meyer, 1989). This therefore indicates that knowledge, practices and attitudes are learned behaviours and can change due to social influences.

The study was on the attitude of men towards the use of contraceptives. It was also based on attitude theory. An attitude is defined as a psychological tendency that is expressed by evaluating a particular entity with some degree of favour or disfavour (Eagley and Chaiken, 1993). It is an evaluation of various objects that are stored in memory. An attitude is a mental state of readiness, which direct and influence response to objects (Petty, 1995). It is a general evaluation that we hold of other people and objects. This mental state of readiness is primarily learned but genetics play a role as well (Baron and Byrne, 1994).

2.3.3 Attitude as having affective, behavioural, and cognitive components

Attitudes have affective, behavioural, and cognitive components. Attitudes predict guide and influence behaviour. Strong attitudes predict behaviour better than weak attitudes. Attitude formed because of direct personal experience with an attitude object predict behaviour better than those formed because of exposure to second hand information (Variables, 2003).

The attitude object activates attitudes automatically and once activated; they are present in the consciousness to guide behaviour and overt actions. They help a person to make sense of the world. The amount of knowledge one has about the attitude object greatly influences the consistency between attitude and behaviour. High consistency between attitude and belief leads to high consistency between attitude and behaviour. Important attitudes predict behaviour better than less important attitudes, as do those about which one expresses certainty. Attitudes that come to mind quickly are better predictors of behaviour than those that come to mind slowly. Attitudes are important determinants of one's actions but there are other factors that determine actions as well. Cultural factors influence many forms of behaviour including sexual behaviour. Attitudes are not permanent but can change through a process of persuasion. A person remains open to attitude change throughout his or her lifetime (Baron and Byrne, 1997).

The study was also based on social learning theory. According to this theory, people form their thoughts, feelings and actions from observing and imitating what they perceive to be the thoughts, feelings and actions of others. Social learning theory sees a person as an active participant who perceives and evaluates stimuli, who strives towards goals and devises plans, to achieve them, who plans his or her future behaviour, judges his or her past behaviour, and then replans his or her behaviour in the light of his or her self-evaluation (Meyer, 1989). This therefore indicates that knowledge, practices and attitudes are learned behaviours and can change due to social influences.

2.3.4 CONCLUSION

Knowledge, attitude, and practices of rural men towards the use of contraceptives looked at ambivalently by African men and this may be difficult to know various useful contraceptive devices.

CHAPTER 3

3. METHODOLOGY

3.1 Introduction

A focus group was used as the method of research. The method was suitable to the study as it enabled the researcher to get closer to participant's perceptions on sensitive issues. It also encouraged participants to analyse their own views more intensely than it would have been the case with individual interview. A focus group is a discussion-based interview, which is able to generate variety of opinions on a particular topic (Millward, 1995; Bowling, 2002). It allowed the researcher and the participants to pursue the study topic in greater depth by explaining cultural values and beliefs about contraception. The focus group enabled the researcher to gain insight into how participants represented contraception as a whole and on a collective rather than individual basis.

3.2. Study Site

The study was conducted in Ga-Sekororo, Maruleng Municipality in the Bohlabela District of Limpopo. Ga-Sekororo is a rural area about sixty kilometres Southeast of Tzaneen. There are ten villages in the area. Ga-Sekororo was chosen for the study because it was accessible to the researcher as he was involved with a development NGO in that area.

3.3 Study Design

A qualitative study was conducted to study the knowledge, practices and attitudes of men towards the use of contraceptives.

3.4 Sampling

Five villages from Ga-Sekororo were conveniently selected as the area of study. The sample was one focus group from each of the five villages. Focus group members were recruited from villages falling under the area of operation of a development NGO the researcher was involved with because of convenience. Each focus group was made of six to ten members. Table 3.1 lists the villages and number of members in each group. As focus groups are not intended to yield generalisable data (Millard, 1995), random sampling was not necessary. Convenience sampling method was used to include people who were near at hand, easy to recruit and were most likely to give the greatest insight into the study topic (Fife-Schaw, 1995; Bowling, 2002). Rosnow and Rosenthal (1996) argued that people are the same in terms of the psychological mechanisms that regulates behaviour. They conclude that it therefore makes little or no difference whether participants are selected randomly or theoretically. A convenience sample was suitable to explain these complex issues of knowledge, practices and the attitude of men towards the use contraceptives.

TABLE 3.1

VILLAGES AND NUMBER OF MEMBERS

Name of village	Number of members
Moshate	6
Makgaung	6
Madeira	8
Metz	10
Sofaya	7

Source: Fieldwork 2005

Table 3.1 Shows villages at Ga-Sekororo and number of members in a group

3.5. Ethical Consideration

The researcher observed relevant ethical and legal guidelines governing research with human participants. He obtained informed consent from participants. The researcher submitted the proposal to the Ethics Committee of the University of Limpopo before he collected data from participants. The results of the study will be available in the university library for students and other researchers to use. An attempt will be made to publish them in a journal to make the findings available to the wider research community. The researcher will give participants feedback through community meetings, which will be held once the study is concluded and findings documented.

3.6 Data Collection

The researcher used an audiotape to record what participants said during group session. The researcher also made observational notes during meetings to supplement the tape recordings. He obtained informed consent from participants to take notes and to make an audio recording of the proceedings.

3.7 Procedure

The researcher recruited men between the ages of twenty and fifty into five focus groups. Men between these ages are readily available and are likely to have had a relationship with a woman who is on contraceptives. Each participant signed a consent form once he had agreed to participate in the study (see Appendix 1). Group sessions were held at times and venues convenient to participants. In some cases, two sessions lasting for one to two hours were held while in others three sessions were held. Table 4.2 indicates venue and number of sessions held in each village. The researcher facilitated all group sessions using a topic guide. The topic guide is a checklist of issues the researcher wished to probe. It is a flexible tool used as a guide to topics to probe during meetings and it is not a fixed set of questions (see Appendix 2). The researcher translated the guide into Sepedi,

which is the first language of the participants but urged participants to use any language they felt most comfortable with.

TABLE 3.2

VENUE AND NUMBER OF SESSIONS IN EACH VILLAGE

Name of village	Venue for meetings	Number of sessions
Moshate	Local restaurant	1
Sofaya	Under a tree	1
Madeira	Local school	2
Metz	NGO offices	2
Makgaung	Local church	2

Source: Fieldwork 2005

Table 3.2 Shows venue and number of sessions in each village

CHAPTER 4

4.1 Data Analysis

The researcher transcribed the audiotape recordings into a textual form. He used qualitative content analysis to analyse the textual form where he put emphasis on meaning. Meaning was derived from:

- the research questions;
- the topic guide and
- a closer examination of the whole data

The researcher used qualitative content analysis not to put numbers to data but to derive meaning from the data.

4.2 Results

4.2.1 Questions about knowledge

The results of questions on knowledge of methods, awareness of benefits and consequences of unprotected sex are summarised in Box 4.1.

4.2.2 Questions about practices

The results in Figure 4.1 indicate the percentage of men in the focus groups who reported to be willing to use the male pill when available and those who take a decision with their partners to use contraceptives. Box 4.2 indicates the methods that individual men practice and the reasons for selecting such methods.

BOX 4.1

KNOWLEDGE, METHODS AND BENEFITS OF CONTRACEPTIVES

Known methods of contraceptives

- Loop; Abstinence; Sterilization;
- Condoms; Withdrawal;
- The pill; Injection;
- Breastfeeding; Traditional method

Benefits of using contraceptives

- Manageable family size
- Control pregnancies
- Children can grow well
- Some prevent STIs

Consequences of unprotected sex

- Unplanned pregnancy
- Frequent pregnancies
- STIs including HIV

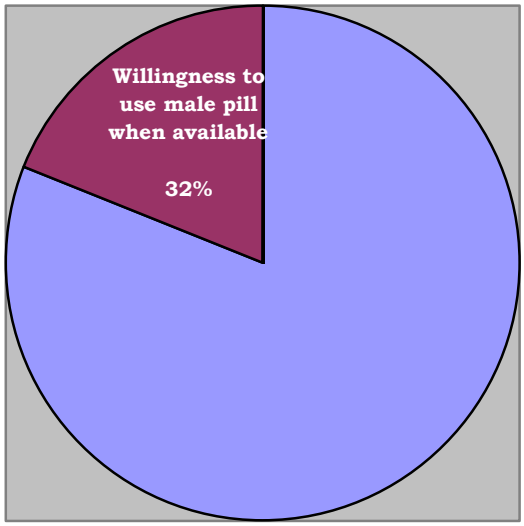
Box 4.1. Knowledge about methods and benefits of contraceptives

4.2.3 Questions about attitudes

Men responded that contraceptives have some few benefits but are generally bad for men's health. More men (80%) prefer a smaller family of up to three children while ninety-two percent prefer the first child to be a boy. The results are summarised in Figure 4.3 and 4.4.

FIGURE 4.1

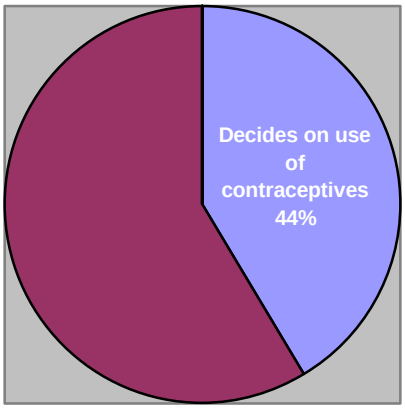
WILLINGNESS TO USE CONTRACEPTIVES



Source: Fieldwork 2005

Figure 4.1 shows willingness to use contraceptives

FIGURE 4.2
DECISION TO USE CONTRACEPTIVES



Source: Fieldwork 2005

Figure 4.2 shows decision to use contraceptives

BOX 4.2

METHODS USED AND REASON FOR USE.

Injection

- The appointment card is proof of use.
- I trust her to protect herself.
- She has to protect herself.

The Pill

- I can see her physically taking it.
- The appointment card is proof of use.

Condoms

- I have control over their use.
- There is a concrete proof that I am using it.
- I can physically inspect it for safety.
- Traditional Methods.

Reasons for use

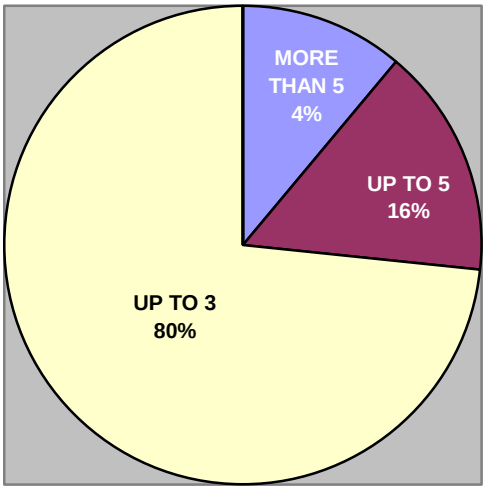
- I trust them to work.
- They will not affect my health negatively.

Source: Fieldwork 2005

Box 4.2 shows methods used and reasons for use of injection, the pill and condoms

FIGURE 4.3

NUMBER OF CHILDREN IN THE FAMILY

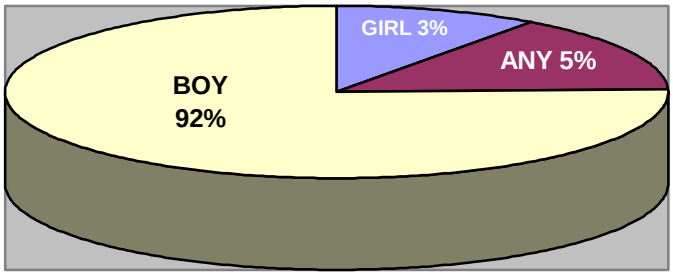


Source: Fieldwork 2005

Figure 4.3 shows number of children in the family

FIGURE 4.4

SEX OF FIRST CHILD IN THE FAMILY



Source: Fieldwork 2005

Figure 4.4 shows sex of first child in the family

CHAPTER 5

5. DISCUSSION AND CONCLUSION

5.1 Introduction

This chapter focuses on the discussion of major findings. Results presented in chapter 4 have been discussed in relation to literature review. This chapter also presents recommendations and conclusion.

5.1.1. Questions about knowledge

Men who participated in the focus groups discussions had knowledge of modern methods of contraceptives available in South Africa. They also mentioned traditional methods, which were indigenous to the area. Men mentioned breastfeeding as a method of contraceptive, which was not the same as Lactational Amenorrhoea Method (LAM). They explained that the smell of breast milk is not attractive to men; as such, breastfeeding women will not have sexual intercourse as men are repelled by the smell.

People in this area share the same believe with most African communities that if a breastfeeding woman engages in sexual intercourse, the nature of milk is negatively affected and the child who feeds on such milk will experience health problems (King; 2003). Men would also avoid impregnating a breastfeeding woman because they believe that pregnancy affect the nature of milk, making it unsuitable to the child. The practice in this area is that if the woman gets pregnant while still breastfeeding, she should immediately stop feeding her child from her breast to protect the child against diseases caused by unhealthy milk. As breastfeeding is valued in this area, men and women avoid sexual activities that would interfere with it. These then makes breastfeeding a method of contraceptives to those who hold such believes.

As a group, the men showed a limited awareness of the benefits as well as the consequences of unprotected sexual intercourse. Only few were able to indicate benefits and consequences listed above. Most men indicated that contraceptives are dangerous to men and women, and attributed multiple births, conjoined twins, congenital defects in children and increased poor health in men to the use of modern contraceptives by women. One man in the group said, *"there are no real men today, all are weak and look like old men and can not dig trenches like men used to do in the past."*

5.1.2. Questions about practices

The methods used in personal relationships did not include male sterilization and withdrawal but included traditional methods, condoms, injectable and the oral contraceptive pill. The types of method chosen indicate that the burden of using contraceptive is still on the women. Even older men did not mention male sterilization as the method they used in their relationships.

Less than half of the men decided with their partners on the use of contraceptives in their relationship. Fifty-six percent left the decision on the partner who had to ensure she was adequately protected against the consequences of unprotected sexual intercourse. Only thirty-two percent indicated a willingness to use a male pill when available which further indicated unwillingness amongst men to share the burden of contraception.

Even the reasons given by the 44%, which decided with their partners, and the 32%, which was willing to use the male pill when available, were selfish. The reasons were that men decided with the women to protect themselves against supporting a pregnant woman and men further indicated that they would use the male pill when available to be in control, as they do not trust women when they say they are using a contraceptive method.

5.1.3. Questions on attitudes

Men who participated in the study have as a group a negative attitude towards contraceptives. Some indicated that nature should be allowed to continue undisturbed by the use of modern contraceptives. They reasoned that nature has a way to ensure that women do not bear more children than they can afford to care for. They indicated that in those rare situations where the use of contraceptives in a relationship becomes necessary, the person should consult the elders who will recommend a suitable traditional method. One man said *"having sex with a condom is like vomiting and then eating the vomitus and that is why most men are just weak and aging early these days as many people use condoms".*

The results on the number of children in the family indicate that smaller families are preferred by the majority of men. However, the means to achieve a smaller family is left to nature and not to modern scientific methods of contraceptives.

Almost all men in the groups (93%) preferred a boy as the firstborn child in the family. The sexes of subsequent children were not important to these men as long as the first one was a boy. If the firstborn becomes a girl, the man becomes disappointed but would be happy if the subsequent one is a boy. This practice is common amongst Africans in South Africa. The danger of this practice is that if the firstborn happens to be a girl, the woman will continue to have pregnancies at short intervals with the hope that the next one will be a boy. This put many women under pressure to bear a boy by risking their lives though repeated and frequent pregnancies.

5.2. Recommendations

Programmes to involve men in reproductive health should be intensified by both government and nongovernmental organisation (NGOs).Young men should be targeted so that they will grow up with the knowledge that sexuality and reproductive health issues are the responsibility of both men and women. Innovative ways to reach men should be sought by the various NGOs and research institutions so that men's health can get the same attention as women's health in South Africa.

5.3. Conclusion

Women in Ga-Sekororo carry the burden of using contraceptives alone, as men are not sharing the responsibility with them. Men violate women's sexual and reproductive rights due to their position in society. Most men are ignorant about the benefits of contraceptives. Contraceptive methods as well as contraceptive information is freely available at most public health institution in South Africa but it is not accessible to men because provision of these services did not take into account the position of men in society.

Men and women blame each other on the lack of communication and cooperation on the use of contraceptives in a relationship. This study has indicated that men will develop a positive attitude towards contraceptives and then share the responsibility for their use if given sufficient information on their sexuality and reproductive health. Men reject the condom as a method of contraceptive and associate it with irresponsible sexual activities before and outside of marriage. A male child is more valued than a female child in this community and many couples will continue to bear children until a male child is born.

6. References

Baron,A.R. and Byrne,D. 1994. *Social Psychology. Understanding Human Interaction.* Massachusetts: Ally and Bacon.

Bauni, E, K., Garimoni, C. O., Maharaj, P., Mushingeh, A. C., Neema, S., Ngirwamungu. E. and Riwa, P. 2003. Attitudes to Sexuality and Family Planning. Progress in Reproductive Health Research. Retrieved August 6, 2003, from *The Reading Room* on World Wide Web: http//www.reproline.jhu.edu/english.htm.

Bowling, A. 2002. *Research Methods in Health: Investigating health and health services.* Philadelphia: Open University Press.

Burr, S. 2000. *Attitude Questionnaires.* Edinburgh: Scottish Council for Research in Education

Chaya, N.; Johnston, B.; Engelman, R.; Ethelston, S and Green, H.E. 2001. A World of Difference: Sexual and Reproductive Health and Risks. From Population Action CD-Rom, Publications and Fact Sheets.

Cullinan, K. 2001. Men get maternal. Retrieved May 1, 2004, from *Health-e news service* on World Wide Web:
http//www.health-e.org.za.

Cullinan, K. 2003. Teen mothers often forced into sex. Retrieved May 1, 2004, from *Health-e news service* on World Wide Web: http://www.health-e.org.za.

Early, A. H. & Chaiken. S. 1993. The nature of attitudes. In Mynhardt,J.C., Appelgryn. A.E.M., Moore, C. and Nieuwoundt, J.M. (Ed). *Readings in Social Psychology (pp 164-183).* Pretoria: University of South Africa.

Evian, C. 2000. *Primary AIDS Care*. Houghton: Jacana Education.

Fife-Schaw, C. 1995. Surveys and Sampling Issues. In Breakwell, G.M.,Hammond, S. and Fife-Schaw, C. (Ed). *Research Methods in Psychology* (pp 99-115). London: SAGE Publications Ltd

Gready, M., Klugman, B., Xaba, M., Boikanyo, M. and Rees, H. 1997 South African Women's Experiences of Contraception and Contraceptive Services. In *Beyond Acceptability: User's Perspectives on Contraception* (pp 23-34). New York: World Health Organisation.

Hirschowitz, R. and Segel, K. 2003. *Reproductive and Sexual Health: A National Household Survey of Inequalities in South Africa.* Retrieved February 22, 2003, from the World Wide Web: http//www.hst.org.za.htm.

King, S. 2003. *Helping Mothers to Breastfeed.* Nairobi: African Medical and Research Foundation.

Meyer, W.F. 1998. Bandura's Social Learning Theory. In Meyer, W.F.,Moore, C. and Disjoin, H.G. (Ed). *Personality Theories-from Freud to Frenkel* (pp 219-240). Johannesburg: Lexicon Publishers.

Milward, L. 1995. Focus Groups. In Breakwell, M.G., Hammond, S and Fife-Schaw, C. (Ed). *Research Methods in Psychology* (pp 274-292). London: SAGE Publications.

Petty, R.E. 1995. Attitude Change. In Tesser, A. (Ed). *Advanced Social Psychology* (pp 195-255). Boston:McGraw-Hill, Inc.

Rosnow, R.L. and Rosenthal, R. 1996. *Beginning Behavioral Research: A Conceptual Primer.* London:Prentice-Hall Internation.

Shears, K.H. Involving Men: Impact of integrated services depends on male cooperation. *Network 2004*;23(3):29-31. Research Triangle Park, USA:Family Health International

Stein, J. 2002. Fertility research confirms what most women know. Retrieved May 1, 2004 from *Health-e news service* on the World Wide Web:http//www.health-e.org.za.

Stein, J. 2000. Gender inequality- a costly imbalance. Retrieved May 1, 2004 from *Health-e news service* on the World Wide Web: http//www.health-e.org.za.

The Alan Guttmacher Institute. 2003. In Their Own Right: Addressing the Sexual and Reproductive Health Needs of Men Worldwide. Washington DC. The Allan Guttmacher Institute.

Van Dyk, A. 2001. *HIV/AIDS Care and Counselling: A Multidisciplinary Approach*. Cape Town: Pearson Education.

Variables: Attitude. Available at http://users.ipfw.edu/bordens/social/attit.htm. Accessed August 28, 2003

Weston, G.C., Schipalius, M.L. and Vollenhoven, B.J. Migrant fathers and their attitudes to potential male hormonal contraceptive. *Contraception* 2002 Nov 13,66(5):351-355

APPENDIX 1

LETTER OF CONSENT

I am conducting research in your community as part of my studies with the University of Limpopo. The research is about opinions and feelings of men towards the use of contraceptives. The results will be made available to other researchers and health workers who may use them to plan for interventions on men's sexuality and reproductive health services. Your participation is important and your name and identity will be kept confidential. If you agree to participate, please write your name and sign in the space provided

Name_____

Signature_____

Thank you

Sogo Matlala

APPENDIX 2

TOPIC GUIDE

This serves as a checklist to guide and focus discussions on the topic. The following types of questions will be asked to probe for responses: (Bowling, 2002)

1. Questions about knowledge:
    - Can we talk about contraceptive methods that u know of?
    - Can we talk about the benefits of using contraceptives?
    - Can we talk about the consequences of engaging in unprotected sexual intercourse?
2. Questions about practices:
    - Can we talk about the reasons for using contraceptives?
    - Which contraceptive methods do you use in your relationship?
    - Can we talk about who decides on the use of contraceptives between the partners in a relationship?
    - Let us talk about our willingness to use the male contraceptive pill when available.
3. Questions on attitudes:
    - Let us talk about our feelings towards the use of contraceptives.
    - Can we talk about our feelings on the size of the family (number of children)?
    - Can we talk about our feelings on the sex of the first child, and of the subsequent children?