KNOWLEDGE, ATTITUDES, BELIEFS AND PRACTICES (KABP) CONCERNING FAMILY PLANNING AMONG URBAN MALE HIGH SCHOOL STUDENTS IN THE ZWELITSHA DISTRICT, CISKEI

WILLIAM BANGOTO KWAW

MARCH 1995

DECLARATION

I, William Bangoto Kwaw, hereby declare that the work on which this thesis is based is original (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, or is being or is to be submitted for another degree in this or any other university.

I empower the university to reproduce for the purpose of research either the whole or any portion of the contents in any manner whatsoever.

ACKNOWLEDGEMENTS

I am privileged to have had the support of many people who have made this study possible. It will be impossible to mention all their names.

Special thanks go to the Department of Education, Ciskei for granting me permission for the study in the high schools. The staff and students involved in the study were very co-operative.

Many thanks go to the Department of Health, Ciskei for granting permission for the school health team of Bisho Hospital to help in the translation of key words of the questionnaire into Xhosa and in the supervision of the answering of the questionnaire by students.

The course co-ordinator Prof Marian Jacobs and her able secretary Ms Dennis Brown have not lacked in their encouragement and guidance and to them I say thank you.

My sincere gratitude goes to Mr Rauf Sayed, a statistician at the Department of Community Health, University of Cape Town, for his statistical guidance.

DEDICATION

This dissertation is dedicated to my mother Yaba Ezoma for her maternal care.

SUBMISSION

Knowledge, attitudes, beliefs and Practices (KABP) concerning family planning among urban male high school students in the Zwelitsha District, Ciskei.

William Bangoto Kwaw M.B.Ch.B (GH) D.C.H. (SA)

This dissertation is submitted to the University of Cape Town in Partial fulfillment for the award of the Master of Philosophy in Maternal and Child Health Degree to Dr William Bangoto Kwaw.

Special thanks go to my thesis Supervisors Dr Ross Bailey of University of Cape Town (UCT) and MS Catherine Mathews (of the Medical Research Council, based at UCT) for their constructive criticisms and invaluable suggestions.

All sources which I have used in my references and annexures are hereby acknowledged. The author is particularly grateful to Ms Aletta Smidt for the typing and printing of this thesis.

W B KWAW
Bisho Hospital
Bisho, CISKEI

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

DEFINITION OF TERMS AND NOMENCLATURE

STD - Sexually Transmitted Diseases

DNPD - Department of National Health and Population Development

IPPF - International Planned Parenthood Federation

KABP - Knowledge, Attitudes, Beliefs and Practice

KNOWLEDGE - familiarity gained by experience, person's range of information

ATTITUDE - a disposition to respond favourably or unfavourably to an object, person, institution or event

BELIEF - the extent to which knowledge is applied to an individual's own life in the form of personal expectations or subjective opinions eg about health messages

PRACTICE - habitual action, custom or action as opposed to theory

CISKEI - Refers to the former independent homeland called Republic of Ciskei in South Africa. It is now part of the new Eastern Cape Province of South Africa.

FAMILY PLANNING- the voluntary use of methods and procedures in order to affect the number and timing of births. It includes all the proximate determinants of fertility including age of person at first sexual intercourse or marriage, contraception, sterilization, induced abortion and also the treatment of infertility. Its main theme is "Babies by choice and not by chance"

ZWELITSHA DISTRICT - One of the six magisterial districts of Ciskei - the others are Mdatsane, Peddie, Middledrift, Alice and Hewu.

RSA - Republic of South Africa
USA - United States of America
UK - United Kingdom
WHO - World Health Organisation
SRC - Students' Representative Council
XHOSA - One of the eleven official languages of South Africa and the predominant language spoken by the people in the Zwelitsha District (area of study).

SUMMARY

It takes two to tango! However family planning programmes in most countries especially in Sub-Saharan Africa have focused almost solely on one - the female-invariably with little impact. The few attempts which have been made to involve males have concentrated on the adult male. It was felt the time had come to involve the adolescent males most of whom are already sexually active and after all are the husbands and fathers of tomorrow. Male high school students (N=240) out of a total of 2101 male students were randomly selected from all the six urban high schools in the Zwelitsha District of Ciskei (now part of the new Eastern Cape Province of RSA) and were surveyed to obtain information on KABP concerning family planning. The study was undertaken to provide information for planning of a family planning health intervention programme by the school health team in an attempt to address the high unplanned teenage pregnancy rate and STDs in the schools. The response rate was 83,3%. Important findings included the following: 90% reported they had already had sexual intercourse; the mean age at first sexual intercourse was 15.4 years; the interval from first intercourse to first contraceptive use was 2 years; knowledge of contraceptives was at times scanty and there were several misconceptions and myths concerning fertility, contraceptives and STDs; majority (71,5%) felt the decision to use contraceptives should be the responsibility of both male and female; 86,4% expressed the desire to use contraceptives in the future and 73,0% felt sex education should start in primary school. The adolescent male is interested in family planning and wants to be an active participant in the programme. Recommendations for improved family planning services in schools are made.

INTRODUCTION

LITERATURE REVIEW

Family planning programmes are beginning to recognise that men, too, are vital and interested participants in family planning.[1] Throughout the world information on family planning activities and their provision has been almost exclusively focused on women. Former Ciskei, which has only recently begun to make family planning services available to its people both urban and rural is no exception.[2] However, the need for participation of Ciskeian men, whose authority in family decisions (like in most African societies) is paramount, should be recognised as a priority if family planning activities are to have the desired impact.[2]

In most traditional societies the husband is usually the dominant decision-maker, and his wife is expected to abide by his decision.[3,4] Cultural patterns vary, of course, but usually a wife's economic dependence on her husband gives him great influence in major household decisions. This dominant male role often extends to a couple's reproductive behaviour. Men have an important say in decisions about family size and the use of family planning services.[3,5-7] In places as varied as Hong Kong, Indonesia, Mexico, Nigeria, South Africa, Thailand and the United States of America (USA), studies have shown that her partner's attitude influences a women's decision whether to use family planning or not.[7-10] In both Mexican and South African studies, the husband's attitude was the reason that women gave most often for using or not using family planning.[8,9] Amongst married female students in Nigeria, one of every five who were not using a modern contraceptive method said her husband's objection was the reason. In Indonesia focus-group research suggests that the husband's influence on use of family planning is strong, especially early in

marriage.[10] Thus even if a woman favours family planning, she may not take the initiative to use a contraceptive without her husband's consent.[6,11] In many countries, law or programme policy prevents a woman from obtaining family planning services without her husband's consent.[12] One should not assume that the only family being discussed is the husband-wife long term relationship living in the same household. There are female headed households, short term transitory relationships and in cases of migrant labour, women do take on the mantle of important decision making.[13] Even in those cases men influence decisions regarding family planning.[13]

Men can also influence how long their partners continue to use family planning. Family planning projects in the late 1960's and 1970's that involved men as well as women showed that men can encourage longer use. [14-16] In a family planning education programme in Turkey, for example, when both husbands and wives received information the continuation rate after two years was 92 percent, compared with 86 percent when only wives received information.[15] In Iran in the late 1960's when women requesting oral contraceptives for the first time came to the clinic with their husbands, and their husbands were asked to make sure that their wives took the pill, the continuation rate at six months was 93 percent, In contrast, among women seen alone the continuation rate was only 12 percent.[16] Conversely in places as different as Jamaica, the Philippines and the U.S. State of Louisiana studies found that the husband's active disapproval led women to stop family planning.[17-19] In the Philippines, only half of women whose husbands tried to discourage them were still using contraception after one year compared with 72 percent of other women.[18]

School Health Teams in the Ciskei have been concentrating on female students as the main target of family planning programmes.(Personal Communication - Dr K Twumasi, Head of Zwelitsha District Health Services, Ciskei) Unwanted/unplanned pregnancies and sexually transmitted diseases (STDs), continue to be a big problem in high schools.[2,21,22] The reported rate of teenage pregnancy, excluding former Transkei, Bophutswana, Venda and Ciskei areas, is 330/1 000 women younger than 19 years.[23] In the Transkei, teenage pregnancies account for 25 percent of all births.[24] Teenagers get pregnant unintentionally, often as a result of complete ignorance about the process of conception, coupled with a low self image and little sense of control of the future.[21] Some land up unable to finish school, unemployable and locked into a situation of unwanted motherhood and poverty in which they are unlikely to develop to their full potential.[21] It has been stated repeatedly that early reproduction among teenagers is disadvantageous for medical economic, psychological and social reasons.[22] Yet studies investigating adolescent sexual behaviour show that more teenagers are engaging in sexual intercourse at young ages (<15 years), and that the proportion of teenage females who become pregnant has increased during the past decade.[25] STD and unplanned pregnancy resemble each other in that in both, sexual activity is involved and the high risk groups for both are people who are young, black and of low socio-economic status,[26] which applies to high school students in the Zwelitsha District.[2] It was felt the time has come to also target male high school students more actively in family planning activities. After all, they are the fathers and husbands of tomorrow (some are already fathers) who would invariably be the dominant decision makers and the partner is expected to abide by his decision. Many are already suspected to be sexually

active. In an early study to document empirically the sexual behaviour of the human male, Kinsey[27] discovered that when a total of 6 200 males of all ages were interviewed, those between 16-20 years of age were the most sexually active, and that those who reached maturity at early ages had on the average, about two times as much sexual activity per week as those who matured later. There is very little information on male adolescent sexual behaviour in South Africa. A British study found that nearly half the 16-year-olds had had sexual intercourse, rising to 89 percent by the age of 21 years.[28] The youth is an important target for fertility control.[29] Puberty and adolescence are important life stages during which values are formulated. It is during this time that many young people become sexually active and begin to establish patterns of sexual behaviour. Therefore they need information about family planning, STDs and decision-making at an appropriate age to enable them to make informed choices.[29]

Knowledge about family planning is necessary but the provision of knowledge alone is insufficient since it does not necessarily lead to the behaviour change required.[29] Attitudes, values and beliefs as well as cultural norms and the influence of family, peers and the media are all important determinants of whether or not appropriate behaviour is adopted.[29] Intervention programmes aimed at reducing unplanned pregnancies and STDs need to take all these factors into account to be successful.[30] In addition, health promotion publications acknowledge that approaches that actively involve the target group are more likely to be successful.[30]

There is currently a well motivated school health team in the Zwelitsha District who visit schools on a regular basis and offer a family planning service as part of a school health programme.

Students can also be referred for further follow-up in any of four urban and 22 rural clinics and to Bisho Hospital. Social workers also offer counselling services but at the moment that is limited to the base hospital Bisho and the four urban clinics . Counselling someone who comes for advice on family planning matters implies more than simply offering information and an expert professional opinion on what an appropriate course of action should be. While the client will quite properly expect expert advice, counselling also entails listening to his or her special needs and circumstances. It allows the person concerned to take on an active rather than a passive role in the decision-making process. In particular, it goes beyond mere questions of facts and includes a discussion and exploration of feelings and relationships.[31]

It would therefore be important for the current nurses in the School health team to be adequately trained in counselling which is a complicated and often subtle two-way relationship.

It is encouraging that after years of focusing attention on the female's ability and responsibility to manage her reproductive behaviour, the male is finally beginning to receive attention. However most studies have concentrated on the adult male.[32]

Literature search highlights the paucity of data on male adolescent sexual behaviour, contraceptive use and knowledge. The available research on the male's contraceptive behaviour, show that methods used by males (condoms and withdrawal) account for at least half of teenage contraceptive use.[33] In South Africa most studies on family planning have concentrated on the adolescent female or the male adult.[8,22,34,35] It is encouraging to note that local studies (though few) are beginning to look specifically at the adolescent male.[36-39]

There is a growing realisation that the adolescent male's knowledge of and active involvement in family planning is appropriate and desirable.[32] The growing consensus among researchers and planners is that it is now crucial to fill in the gap, that is, to research the forgotten partner - the adolescent male.[32]

PURPOSE OF STUDY

Family planning is a subject considered to be of extreme importance worldwide. Particularly in developing countries such as Ciskei, family planning programmes are not likely to have the desired impact without the support and involvement of men.

Getting the required information and hopefully the right attitudes to adolescent males especially during their school years will be a step in the right direction.

AIM OF STUDY

The aim of the study was to obtain comprehensive baseline information about knowledge, attitudes, beliefs and certain behavioural practices (KABP) concerning family planning among urban male high school students in Zwelitsha District so that appropriate health interventions could be planned by the School Health Team.

OBJECTIVES OF STUDY

1. To ascertain the extent of the urban male high school student knowledge about family planning in Zwelitsha District.
2. To assess the attitudes, beliefs and practices regarding family planning of these students.
3. To determine the main sources of information and education used by respondents for obtaining information on family planning.
4. To suggest ways of improving the family planning activities in those schools based on the appropriate data collected.

This study on family planning was the first of its kind in Ciskei schools.

DESCRIPTION OF AREA UNDER STUDY

The boundaries of the area under study coincide with the Zwelitsha Magisterial District which together with Mdantsane District to form the Bisho Planning Region (see attached locality plan from Manpower and Planning Division, Ciskei - Appendix A). It is part of Ciskei, a former bantustan of 8 000 - 9 000 km^2 on the coast of the Eastern Cape which the South African government pieced together by consolidating dozens of separate parcels of land, and "colonised" by removing 350 000 Xhosa speaking blacks from South Africa and resettling them in their "own group" area.[40] The Ciskei was made "independent" on 31 December 1981.[40] It is currently part of the newly created Eastern Cape Province.

Significant points in the physical and natural features are:- the region consists mainly of sandstone and mudstone (Beaufort-series) with a number of dolorite sheets.[41] Of note relating to geology, is the fact that there are no known minerals of economic importance within the region, and that little land in the region has been identified as being highly suitable for arable purposes.[41] It is estimated that only 13 percent of the land of Ciskei is suitable for that purpose. The region is characterised by river valleys and rolling hills with the altitude varying from sea level to approximately 1250m above sea level, in the vicinity of the Mount Kemp radio mast.[41] Rainfall within the region varies from 500mm per year to as high as 1200mm per year in the northern mountainous areas.[41] Minimum temperature for the region vary between 3°C to 9°C in winter maximum temperatures between of 25°C to 30°C in summer.[41]

It is estimated that the de-facto population of Ciskei is over one million, making Ciskei with perhaps 100 people per Km^2, one of the most densely populated parts of South Africa.[41]

The Zwelitsha district is largely rural in character with few urban settlements, Viz Zwelitsha, Bisho, Illitha, Dimbaza and Ndevana. The disparity between urban and rural living standards is great. The Surplus People Project estimated in 1980 that 50 percent of rural households and 20 percent of urban households earn less than R133 per month, well below the 1980 household subsistence level of R170 in rural and R196 in urban areas.[40] The exact statistics reflecting the current situation are not available.

The economic base is not strong and of note are the following:- There are a few industries such as textile manufacture and brick making, mostly in urban centres; for agriculture-livestock, fruit farming and arable farming are mostly subsistence in nature; for forestry there is the Ndakana Forest Project; for tourism there are hiking trails, Amatola Sun Hotel (Bisho), lake recreation (Maden, Rooikrans, Laing dams) for sailing and fishing. Other economic activities include government departments and limited commerce. However all the above activities offer few jobs. Most people in Ciskei depend on pensions, the income of commuters, the remittances of migrants and the daily earnings of those who find casual work.[42] In 1984, only 36 percent of income earned by Ciskei residents was generated inside the bantustan: 64 percent was earned outside by commuters and migrant workers.[42] Unemployment rates was put at 40% in 1984[42] - no reliable figures are available currently.

As regards transportation, the region is generally well served with roads.

It is, however, relevant to note that many of the major routes serving the region's population fall just outside the legal boundaries of Ciskei. Furthermore, the major regional roads all meet in King William's Town. This results in intra-regional traffic (e.g. from Bisho and Zwelitsha to Dimbaza, Berlin and Mdantsane) having to make use of roads which are outside the boundaries of Ciskei. The secondary roads which link the various settlements to urban centres are mostly gravel roads and in general, are in fairly good condition. Rail facilities within the region are limited to the East London - Dimbaza metropolitan corridor. From Berlin, the rail line runs in a northerly direction and except for a small portion in Peelton location (in Zwelitsha District), skirts along the "international" boundary between Ciskei and "Republic of South Africa" (see Appendix B). Though as from April 1993, Ciskei is said to be part of the new South Africa, the reality on the ground is that actual integration will take many years to materialise.

As regards culture, relevant issues are that customary law decrees that men take all the major decisions in the family.[43] In the eyes of South African law, even married African women were, until recently, minors.[43] For many women, the demand that custom be upheld, or the unwillingness to flout convention in a situation when most are dependent and alone for 11 months out of every 12, becomes highly oppressive.[13] The maintenance of male authority is entrenched in the tribal system.[43]

METHOD

STUDY POPULATION

The study population consisted of all urban male high school students in the Zwelitsha District, Ciskei with a total size of 2 101 students. High schools consist of standards 6 to 10. Table I shows the summary of male enrolment as at February 1993: The urban high schools in Zwelitsha District Ciskei standards 6-10. The study was conducted in August 1993.

TABLE I

Summary of Male Enrolment as at February 1993: Urban High Schools in Zwelitsha District, Ciskei Standards 6-10

School	STD 6	STD7	STD8	STD9	STD10
Hector Peterson	85	82	71	59	53
NonPendulo	83	72	70	70	69
Nonceba	90	89	75	75	64
Thembalabantu	102	88	72	71	62
Xolani	82	75	45	44	38
Nosizwe	86	84	57	48	40
Total	528	490	390	367	326
Grand Total 2 101					

SAMPLING

The EPI INFO COMPUTER Programme Version 5 was used in sample size calculation. In order to estimate sample size, an assumption was made that the prevalence rate of students' knowledge about family planning was 50 per cent. Although the minimum required sample size with 80% power and 95% confidence interval (CI) with a difference of 10% from the assumed true rate in the population is 92, a sample of 240 students was selected from he study population using a random table. This was done by using a sampling frame with a list of names of all students. Each student selected was informed by means of a letter distributed by the School Health Team and arrangements were made for

selected students to report to designated classrooms. Though a simple random sample was made from a single sample frame as indicated, for ease of administration of the questionnaire, a classroom was designated for each school. Out of this 240, 200 returned the questionnaires correctly filled in for analysis giving a response rate of 83,3%.

LOGISTICS

Much support for this study was obtained from the Department of Education and Culture, Ciskei; the School Health Team of the Zwelitsha District Health Services and the staff and students of the urban high schools involved in the study.

Written permission was asked for and granted by the Education and Culture Department (See Appendix C). However, the permission was negotiated with individual schools, principals, staff and school committees, student representative councils (SRCs) and parent-teacher associations. There was a lot of goodwill from all sides after the rationale of the study was explained and all schools agreed to participate. Members of the School Health Team were particularly helpful in these negotiations to get the message across in the local language Xhosa.

The other logistical support came from the Department of Health for providing drivers and cars and from the Head of the District Health Services for granting permission to the school Health Team to help in the study. The Medical Superintendent of Bisho Hospital readily granted me time off to conduct the study.

The nurses of the School Health Team also helped in designing, pretesting and supervision in the answering of questionnaires used in the study.

DATA COLLECTION

Data was collected by means of a questionnaire (See Appendix D) in the second week of August 1993. The questionnaire was written in English and then translated into Xhosa, the home language of the students by one of the school health nurses, a senior nursing personnel who have had a lot of experience in school health activities and also very proficient in the Xhosa language. It was then translated back into English by school students and nurses to check the translation and the appropriateness of the questions. Care was taken to ensure that the level of language used was appropriate for standard 6 to 10 high school students. Important key words or items still had their Xhosa equivalent retained in parentheses against the English version. It was pretested in a small group of students and the whole administration procedure was piloted in two classes not involved in the final study. The questionnaire was structured closely along the lines that used by the Jamaican National Family Planning Board - Young Adult Reproductive Survey - Male Questionnaire.[44]

The KABP Questionnaire concerning family planning among the urban male high school students had the following topics: (See Appendix D)

(a) Background characteristics (Questions about you)
(b) Family life (Questions on family)
(c) Sex education
(d) Contraceptive knowledge
(e) Sexual experience and contraceptive use
(f) Attitudes about family planning

ADMINISTRATION OF QUESTIONNAIRE

To ensure anonymity and confidentiality and to encourage honest responses, students were asked not to communicate with each other during administration of the questionnaire and to place completed questionnaires in sealed envelopes into a box. At the beginning of each session (i) the rationale for the study was explained; (ii) instructions were given as to how the questionnaire should be filled in. All this information was available on the front cover of the questionnaire booklet. The students were asked if they had questions before completing the questionnaire. The level of discipline maintained in the venues in which the questionnaire was completed was generally satisfactory. No student refused to complete the questionnaire. The questionnaire was self administered by students in a classroom under the supervision of school nurses. Those involved in the supervision were given training through a workshop.

It was decided not to involve the school principals or teachers in the administration of the questionnaires for the following reasons: (i) The possibility of gaining access to the schools was increased because minimal demands were being made on the resources of the school; (ii) the students were less likely to regard the whole exercise with suspicion because it was not directly associated with the education department; (iii) the validity of the responses was increased because there was no possibility of the school staff having access to the students' responses.

RESULTS AND ANALYSIS

Analysis of data was performed using the EPI INFO COMPUTER Programme version 5.

BACKGROUND CHARACTERISTICS OF RESPONDENTS

The results of the study of 200 respondents concerning background characteristics are presented. Table II shows the mean, median and range of ages in years and of family size (number of brothers and sisters) and also whether parents live together or not.

TABLE II#

AGE OF RESPONDENTS, FAMILY SIZE AND PERCENTAGE OF PARENTS STAYING TOGETHER

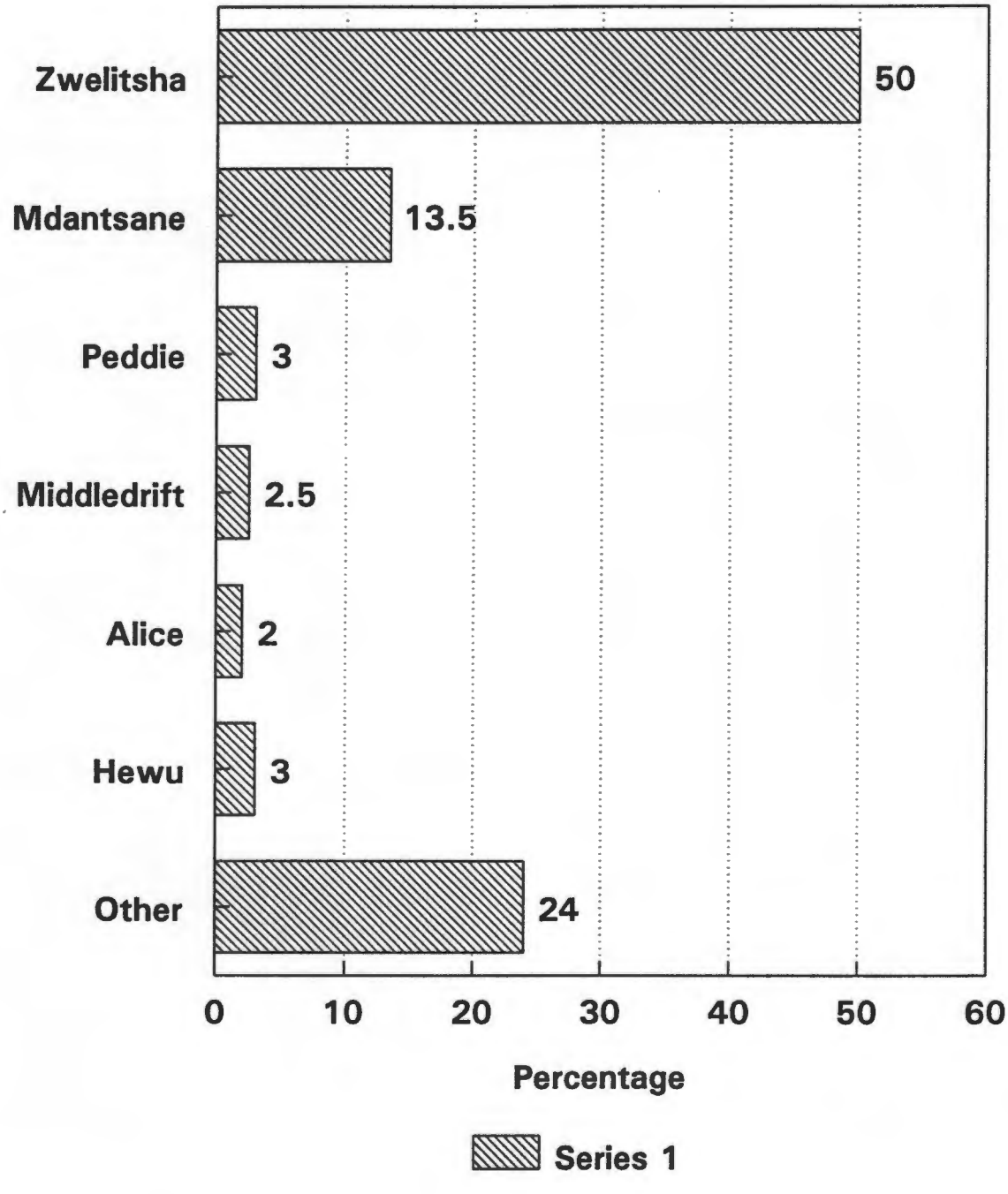
Respondent's Characteristic	N = 200 Mean	Median	Mode	Range
Age (years)	18.4	18	17.0	15 to 28
Family size (No. of brothers and sisters)	4.2	4	4	1 to 14
Parents staying together	Yes	No		Don't Know
	144(72%)	56(28%)		

 # See questionnaire (Appendix D) - Questions 1a, 2a and 2b.

The sample ranged from ages 15 to 28 with half of the respondents 18 years or younger. The average family size was 4 children with over two-thirds of parents staying together (72.0%).

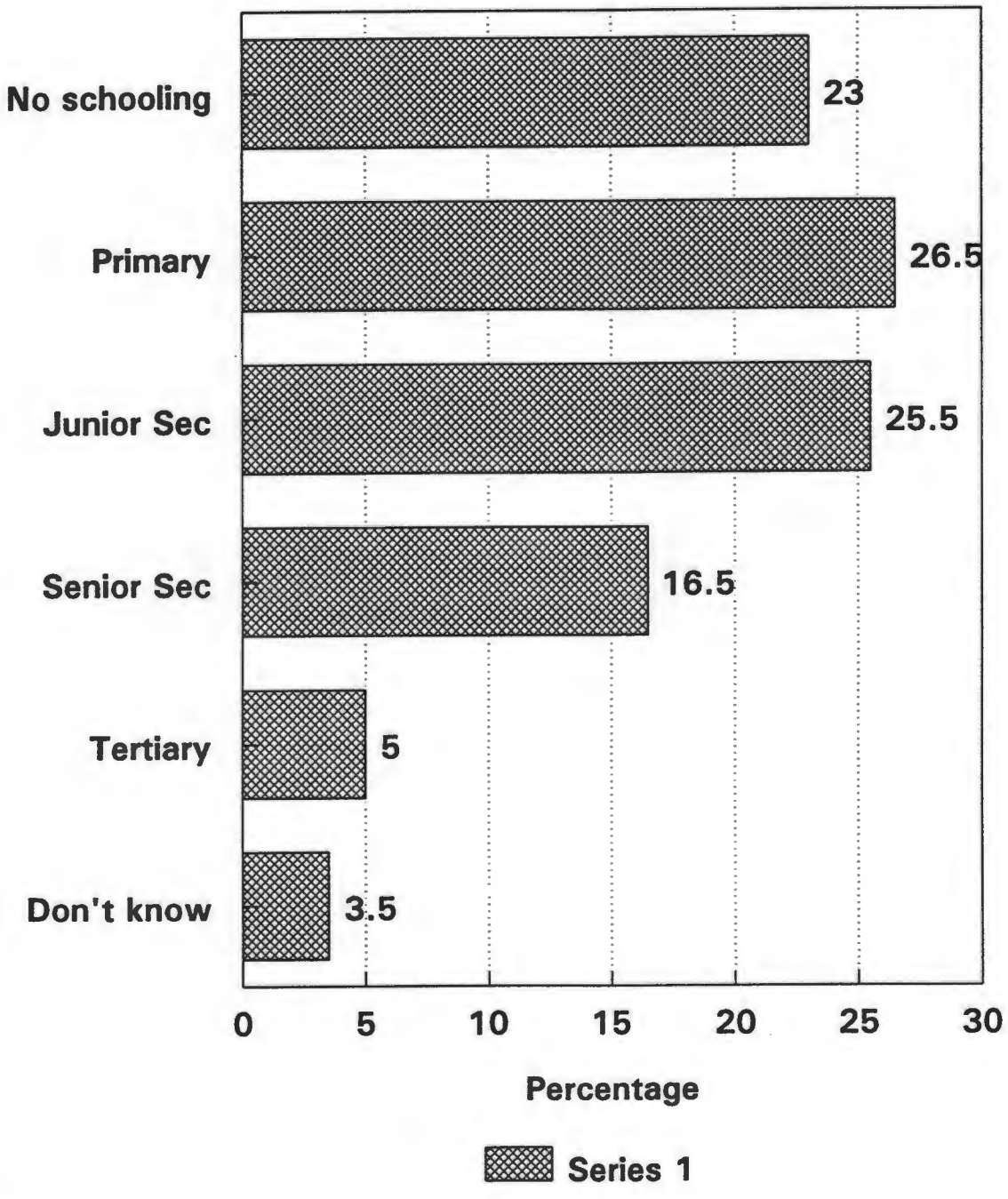
Figures 1 to 3 show respectively districts of origin, and respondents' mothers' and fathers' educational levels.

FIGURE 1: BACKGROUND CHARACTERISTICS - DISTRICTS OF ORIGIN OF RESPONDENTS



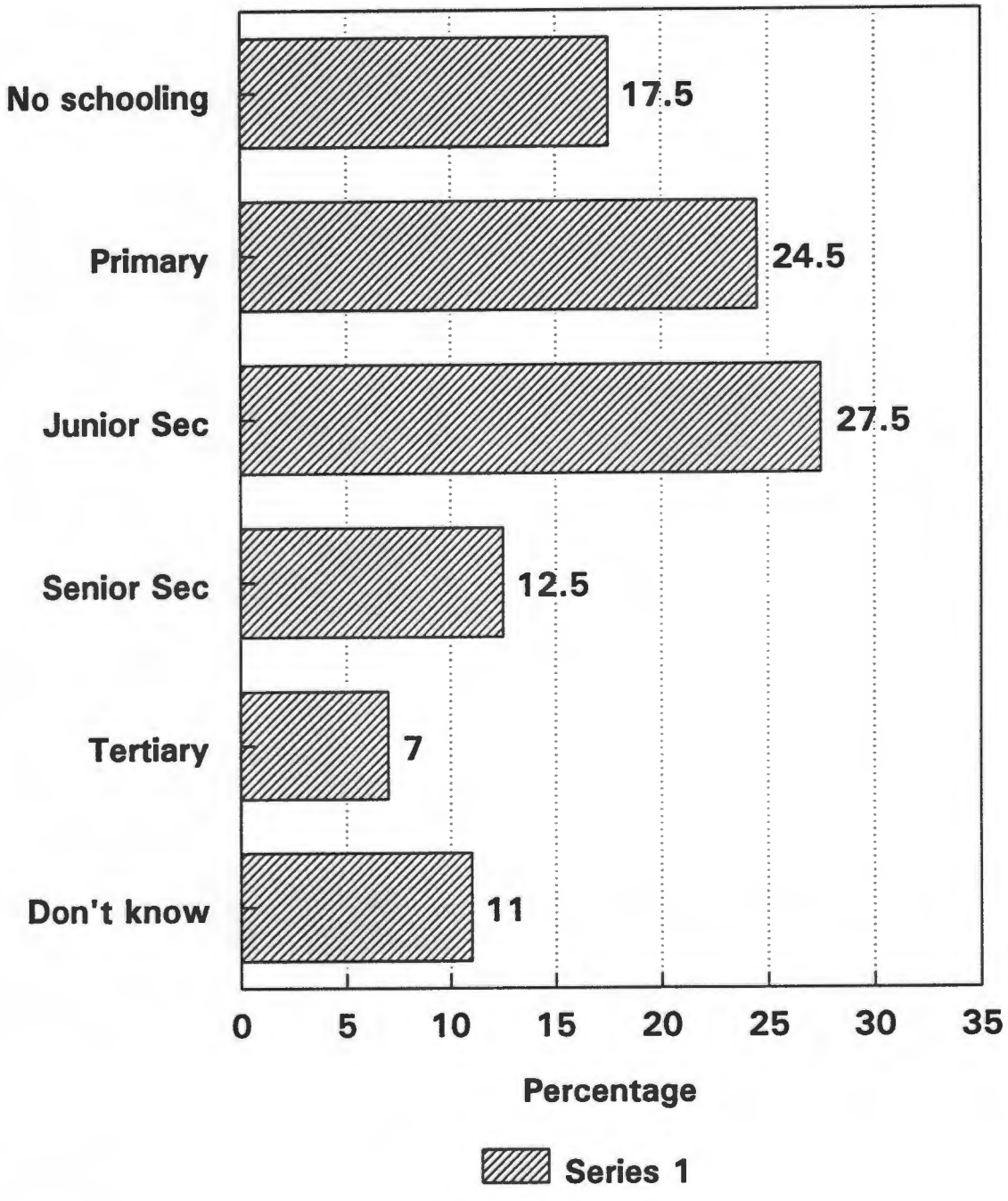
Response (n = 200)

FIGURE 2: BACKGROUND CHARACTERISTICS - EDUCATIONAL LEVEL OF RESPONDENTS' MOTHERS



Response (n = 200)

FIGURE 3: BACKGROUND CHARACTERISTICS - EDUCATIONAL LEVEL OF RESPONDENTS' FATHERS



Response (n = 200)

Half of the respondents (50%) were born in the Zwelitsha district. For mothers about a quarter had not had any formal education (23%) and a further quarter did not go beyond Primary School (26.5%). Only 5 percent had some tertiary education that is vocational, technical or university education. The corresponding figures for fathers were for no schooling (17.5%); primary (24.5%) and tertiary education (7%).

INFORMATION ON FAMILY LIFE

Table III shows results of responses to certain questions concerning family life.

TABLE III#

STUDENTS' RESPONSES TO QUESTIONS ON FAMILY LIFE

Questions	N = 200 Mean	Median	Mode	Range	Don't know*
Age (yr) when girl should start sex	17.6	17	16	10-25	2
Age (yr) when boy should start sex	17.4	17	18	9-25	1
Desired number of children	4.8	3	3	0-13	4
Age (yr) when woman should have first child	25.1	25	25	15-35	4
Age (yr) when man should have first child	25.2	25	25	16-36	2

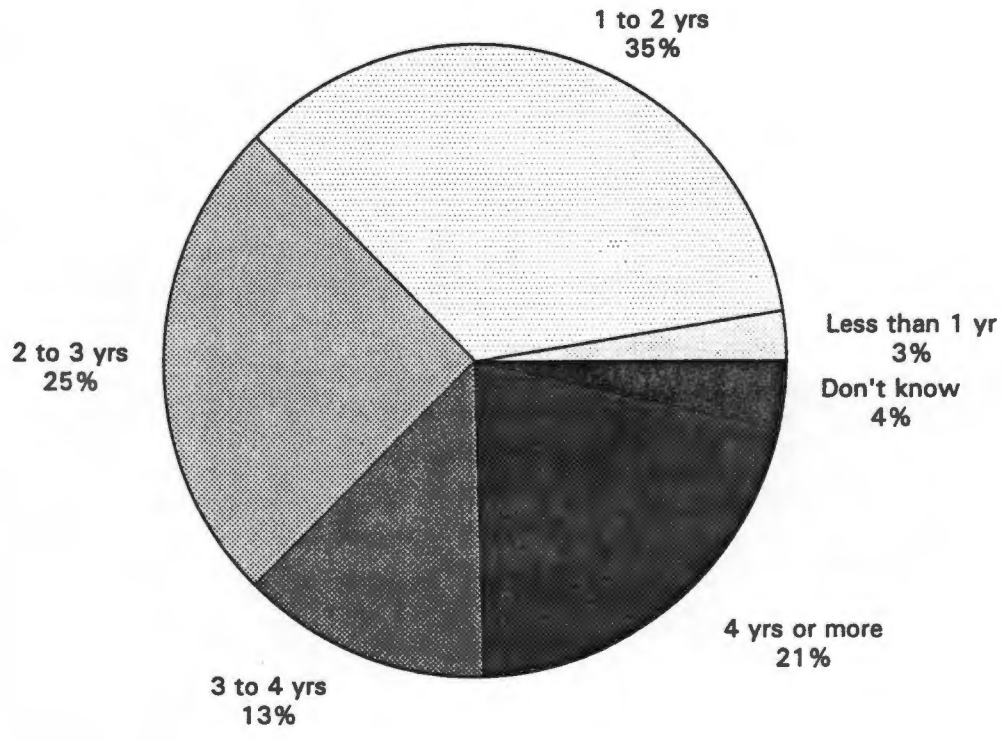
 # See questionnaire (Appendix D) - Question 3, 4, 5, 7 and 8.

***The corresponding figures in the "Don't know" column refer to number of respondents who ticked the "don't know" option on the questionnaire.**

The mean age at which both boys and girls should start sex according to respondents was around 17 years (17.6 for girls and 17.4 for boys). However the age at which a man or woman should have a child was put at about 25 years giving a period of about 8 years of sex without an intention of having children.

The mean desired family size was about 5 children (4.8) that is a large family with a range of 0-13 children. Figure 4 shows results of the "Desired inter-pregnancy interval".

FIGURE 4: INFORMATION ON FAMILY LIFE - DESIRED INTER-PREGNANCY INTERVALS AS REPORTED BY RESPONDENTS



Response (n = 200)

The most preferred inter-pregnancy interval is 1-2 years followed by 2-3 years.

INFORMATION ON SEX EDUCATION

Table IV Shows results of which people respondents consult when having doubts on sexual matters.

TABLE IV#

THE SOURCE RESPONDENTS CONSULT WHEN HAVING DOUBTS ON SEXUAL MATTERS

Person Consulted	Frequency	Percentage
God	13	6.5
Parents	26	13.0
Elder brother or sister	18	9.0
Books	14	7.0
Nurse	37	18.5
Partner/girlfriend	5	2.5
Social worker	13	6.5
Friend	59	29.5
Other relatives	1	0.5
No-one	14	7.0
TOTAL	200	100.0

 # See questionnaire (Appendix D) - Question 9.

Table V shows results of where respondents got their first information on sex outside school

TABLE V#

SOURCE (OUTSIDE OF SCHOOL) OF FIRST INFORMATION ON SEX

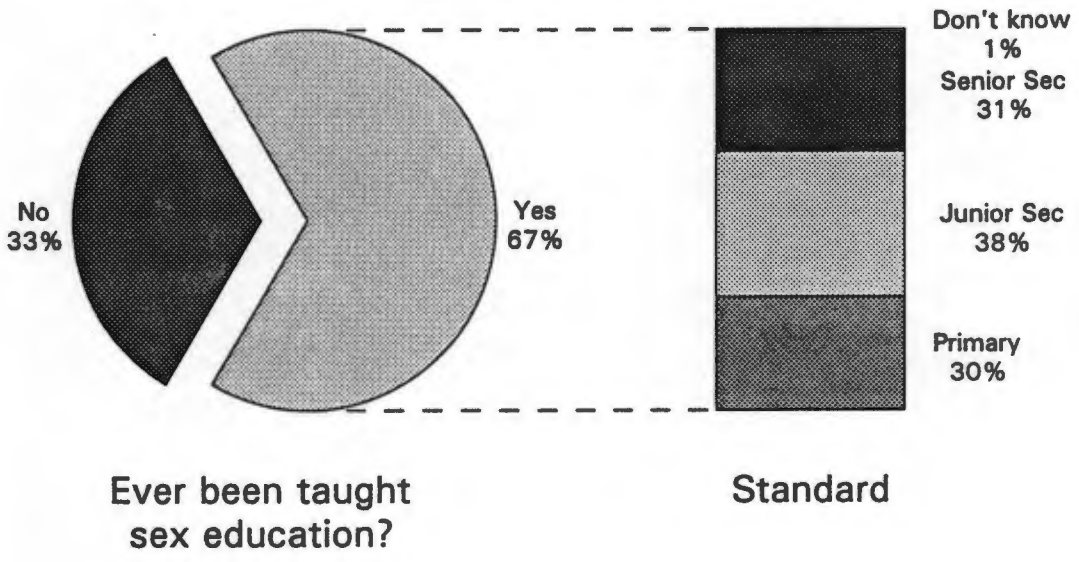
Source	Frequency	Percentage
Street/Taxi rank	9	4.5
Neighbourhood	7	3.5
Home	14	7.0
Grandmother's home	1	0.5
Other Relative's home	1	0.5
Library	13	6.5
Friend's house	64	32.0
Parties	17	8.5
Movies/Media	43	21.5
Clinic	18	9.0
Playfield	11	5.5
Other	1	0.5
TOTAL	200	100.0

 # See questionnaire (Appendix D) - Question 10.

Respondents prefer to consult friends (29.5%) and nurses (18.5%) rather than parents (13.0%) when they have doubts on sexual matters. A friend's house (32.0%) and movies/media (21.5%) account for more than half of their first time sources of information on sex.

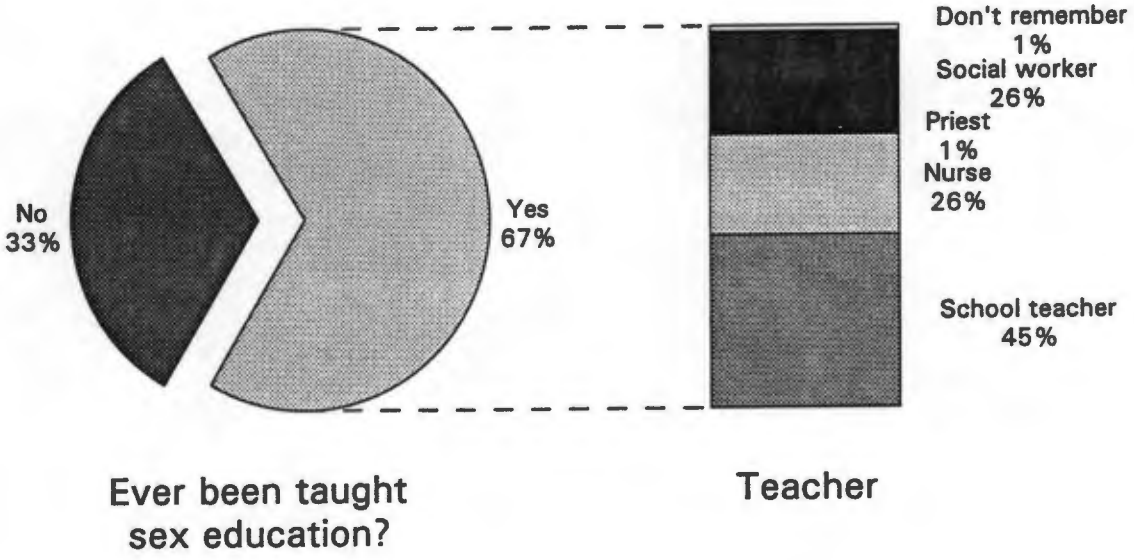
Figures 5 to 7 show results concerning previous sex education in schools: in what standard sex education began, who taught it and sex of the "teacher".

FIGURE 5: PERCENTAGE DISTRIBUTION OF RESPONDENTS WHO HAD RECEIVED SEX EDUCATION IN SCHOOLS AND STAGE AT WHICH SEX EDUCATION STARTED



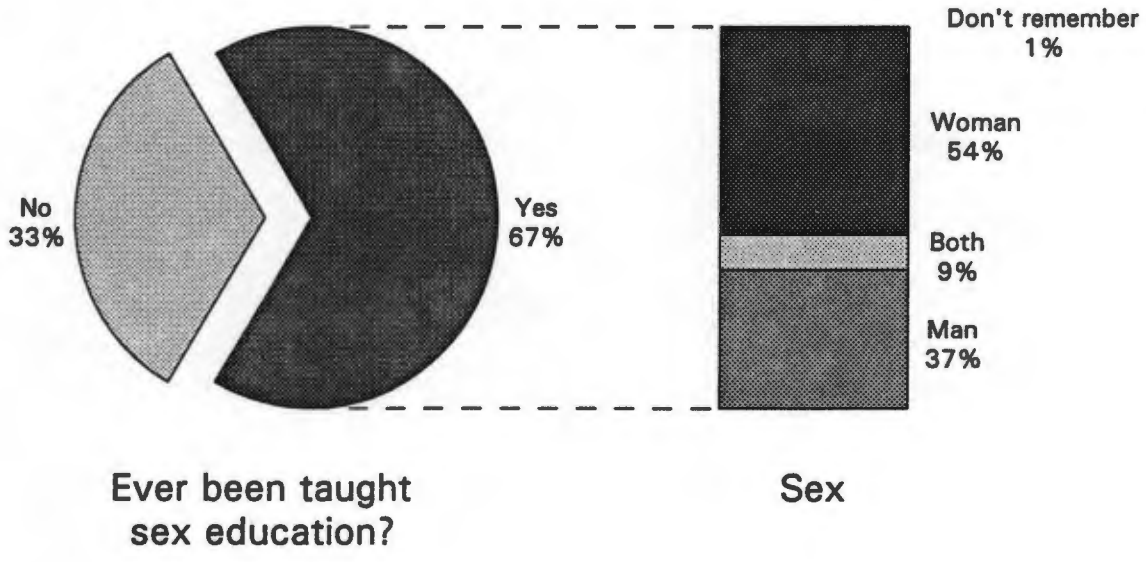
Response (n = 200)

FIGURE 6: PERCENTAGE DISTRIBUTION OF RESPONDENTS WHO HAD RECEIVED SEX EDUCATION IN SCHOOLS AND PROFESSION OF FIRST SEX EDUCATION TEACHER



Response (n = 200)

FIGURE 7: PERCENTAGE DISTRIBUTION OF RESPONDENTS WHO HAD RECEIVED SEX EDUCATION IN SCHOOLS AND GENDER OF FIRST SEX EDUCATION TEACHER



Response (n = 200)

Two thirds (67%) have had sex education in schools. Of these only 30.0% began in Primary schools. The school teacher ranked first followed by the nurse as the ones who introduced them to sex education in schools and the sex of the lecturer was given as female in over half of the cases (54.0%). Table VI shows results of responses to questions as regards content of sex education classes, knowledge on STDs and source of reading material on family life education.

TABLE VI#

STUDENTS' RESPONSES TO QUESTIONS ON SEX EDUCATION, STDS AND SOURCES OF READING MATERIAL ON FAMILY LIFE EDUCATION

Statement	Response Yes	No	Don't know
A. Content of sex education class included information on:			
1. Woman's menstrual period	134(67.0%)	66(33.0%)	
2. Modern contraceptive methods	54(40.3%)	77(57.7%)	3(2. %)
3. STDs	60(44.8%)	72(53.7%)	2(1.5%)
B. Knowledge of STDs - Name any STDs you know			
1. Syphilis	10(5.0%)	190(95.0%)	
2. Gonorrhoea	82(40.3%)	118(59.0%)	
3. AIDS	195(97.5%)	5(2.5%)	
4. Herpes	7(3.5%)	193(96.5%)	
5. Other	1(0.5%)	199(99.5%)	
C. Source(s) of reading material on family life education			
1. School (Min. of Education)	24(12.1%)	175(87.9%)	
2. Health Centre (Min. of Health)	52(26.0%)	148(74.0%)	
3. Social gathering/meeting	24(12.0%)	176(88.0%)	
4. Ciskei Family Planning	29(14.5%)	171(85.5%)	
5. Other	5(2.5%)	195(97.5%)	

 # See questionnaire (Appendix D) - Question 12e, 15 and 17.

As regards content of sex education classes women's menstrual periods were well covered (67.0%) followed by STDs (44.8%). Modern contraceptive methods were less covered (40.3%). Most respondents had heard about AIDS (97.5%) and a little under half of them knew about Gonorrhoea. Knowledge of other STDs was scanty. Generally reading material did not appear to be a good source of obtaining information on family life education.

Table VII shows results concerning responses about the female's most fertile time.

TABLE VII#

STUDENTS' BELIEFS ABOUT A FEMALE'S MOST FERTILE TIME DURING THE MENSTRUAL CYCLE

Time	Frequency	Percentage
A week before period	15	7.5
During her period	40	20.0
A week after period	51	25.5
Two weeks after period	5	2.5
Three weeks after period	13	6.5
All times are alike	17	8.5
Don't know	50	25.0
Not stated	9	4.5
TOTAL	200	100.0

 # See questionnaire (Appendix D) - Question 16.

Though the woman's menstrual period appeared to have featured a lot in the sex education classes, most respondents did not know the female's most fertile time - only 2.5% correctly knew that it was about two weeks after the period.

Tables VIII and IX respectively show results of responses as to when sex education should begin in schools and the best way of teaching it.

TABLE VIII#

RESPONDENTS' PREFERENCES FOR STAGE AT WHICH SEX EDUCATION SHOULD START IN SCHOOLS

Class	Frequency	%	Cumulative Frequency
Standard 1	7	3.5	3.5%
Standard 2	3	1.5	5.0%
Standard 3	22	11.0	16.0%
Standard 4	43	21.5	37.5%
Standard 5	37	18.5	56.0%
Standard 6	44	22.0	78.0%
Standard 7	28	14.0	92.0%
Standard 8	4	2.0	94.0%
Standard 9	3	1.5	95.5%
Standard 10	2	1.0	96.5%
Should not be taught	4	2.0	98.5%
Don't know	3	1.5	100.0%
TOTAL	200		

 # See questionnaire (Appendix D) - Question 13.

Whilst most of respondents do not favour starting in the lower two standards 1 and 2 (5%), the great majority favour beginning sometime between standards 3 to 6 (73.0%)

TABLE IX#

RESPONDENTS' SUGGESTIONS OF "BEST" WAY OF TEACHING SEX EDUCATION

Method	Frequency	Percentage
Boys and girls separately	36	18.0
Boys and girls together	133	66.5
One-to-one discussions	13	6.5
Doesn't matter method used	11	5.5
Doesn't have an opinion	7	3.5
TOTAL	200	100.0

 # See questionnaire (Appendix D) - Question 14.

Most favour teaching both boys and girls together (66.5%).

CONTRACEPTIVE KNOWLEDGE

Table X shows results of knowledge of contraceptive methods

TABLE X#

RESPONDENTS' KNOWLEDGE OF CONTRACEPTIVE METHODS

Student familiar with:	Response Yes	No	Tot no of response
Pill	87(43.5%)	113(56.5%)	200
Condom	188(94.0%)	12(6.0%)	200
Injection (Depo Provera, Nuristerate)	131(65.5%)	69(34.5%)	200
Diaphragm	7(3.5%)	191(96.5%)	198
Loop	12(6.1%)	186(93.9%)	198
Spermicides	20(10.0%)	180(90.0%)	200
Billings	1(0.5%)	199(99.5%)	200
Rhythm	49(24.5%)	151(75.5%)	200
Withdrawal	180(90.0%)	20(10.0%)	200
Bilateral tubal ligation	28(14.0%)	172(86.0%)	200
Vasectomy	19(9.5%)	181(90.5%)	200
After sex contraception	0(0%)	200(100%)	200
Other methods	60(30.0%)	140(70.0%)	200

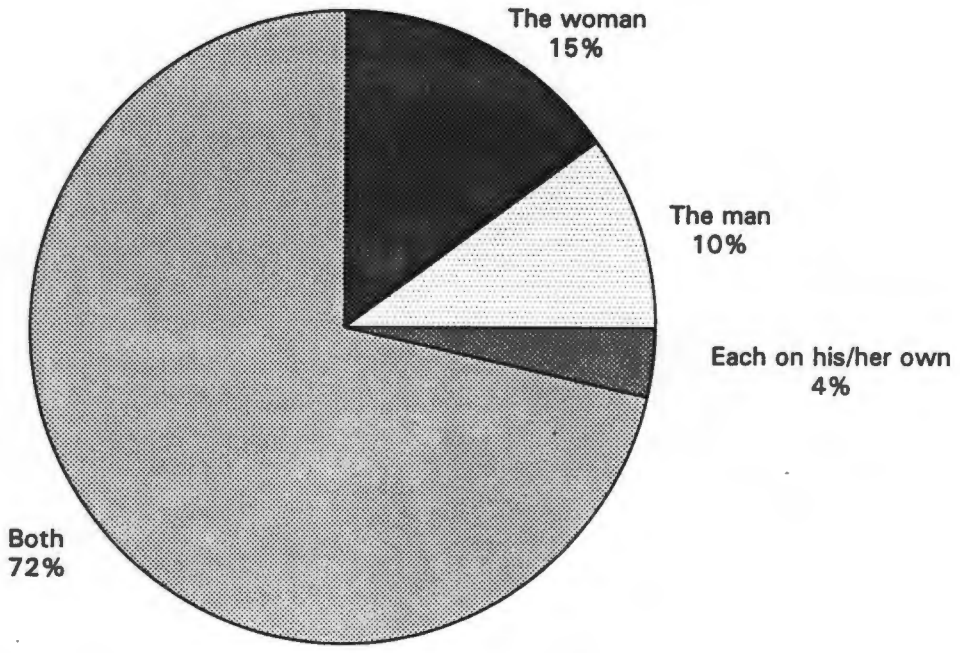
 # See questionnaire (Appendix D) - Question 18a.

Most respondents had good knowledge of the condom (94.0%) and withdrawal (90.0%) - two out of the four predominantly male contraceptive methods - the others being spermicides and vasectomy about which knowledge was very scanty - that is 10.0% and 9.5% respectively. Though 24.5% knew about the rhythm method, only 2,5% knew about the correct fertile time for the female (see Table VII). Other "methods" which 30.0% knew about included quinine, soapy douches and coitus intercrura known as "ukumetsha" in Xhosa. There was average knowledge of the Pill (43,5%) and injectable contraceptives - Depo Provera and Nuristreate (65,5%).

INFORMATION CONCERNING SEXUAL EXPERIENCE AND CONTRACEPTIVE USE

Figure 8 shows results of who must decide to use contraceptives

FIGURE 8: INFORMATION ON FAMILY LIFE - RESPONDENTS' SUGGESTIONS AS TO WHO SHOULD DECIDE TO USE CONTRACEPTIVES



Response (n = 200)

Majority of respondents (72.0%) believe the responsibility to use contraceptives should lie with both the man and woman. Table XI shows results about previous sexual experience and contraceptive use.

TABLE XI#

RESPONDENTS' PREVIOUS SEXUAL EXPERIENCE AND CONTRACEPTIVE USE

		Mean	Median	Mode	Range
Age (yr) at first sex act	(n=180)	15.4	14.0	14.0	9-20
Age (yr) of first lover	(n=180)	13.8	14.0	14.0	9-19

	Yes	No	Don't remember
Contraceptive used at first Sexual intercourse (n=180)	36(20%)	143(79.4%)	1(0.6%)

	Mean	Median	Mode	Range
Age (yr) at first contraceptive use (n=94)	17.4	18	18	14-21

	Yes	No	Don't remember
Ever talked to your girlfriend about family planning (n=104)	21(20.2%)	83(79.8%)	

 # See questionnaire (Appendix D) - Questions 19a, 19b, 20, 22 and 24.

At the time of the study the overwhelming majority of respondents had already had sexual intercourse - 180 out of 200 (90.0%). The mean age at first sexual experience was 15.4 yrs and that of the sexual partner 13.8 years. Only a handful used contraceptives at first sexual intercourse (20.0%). The mean age at first contraceptive use was 17.4 years. From the mean age of first sexual intercourse to first contraceptive use gives an average of two years of no contraceptive use. Few had ever had discussions concerning family planning with their girlfriends (20.2%). This last result should be interpreted with caution since a little under half of respondents did not answer the question.

Table XII shows reasons for not using any contraceptives at first sexual intercourse

TABLE XII#

RESPONDENTS' REASONS FOR NOT USING ANY CONTRACEPTIVES AT FIRST SEXUAL INTERCOURSE

Reason	Frequency	Percentage
Didn't know of any methods	98	68.5
Didn't expect sexual relations at that time	16	11.2
Partner against using something	10	7.0
Knew of methods but didn't know where to get them	9	6.3
Religion does not permit	2	1.4
Too shy to get method	2	1.4
Contraceptives are bad for one's health	1	0.7
TOTAL	143	100.0

 # See questionnaire (Appendix D) - Question 21.

The majority of respondents (68.5%) did not use any contraceptives at first sexual intercourse because they did not know of any methods. The next two important reasons for non-use were that they did not expect sexual relations at that time and that the partner was against using contraceptives.

Table XIII and figures 9 to 11 show results of sexual experience and contraceptive use in the recent past i.e. within the last 30 days.

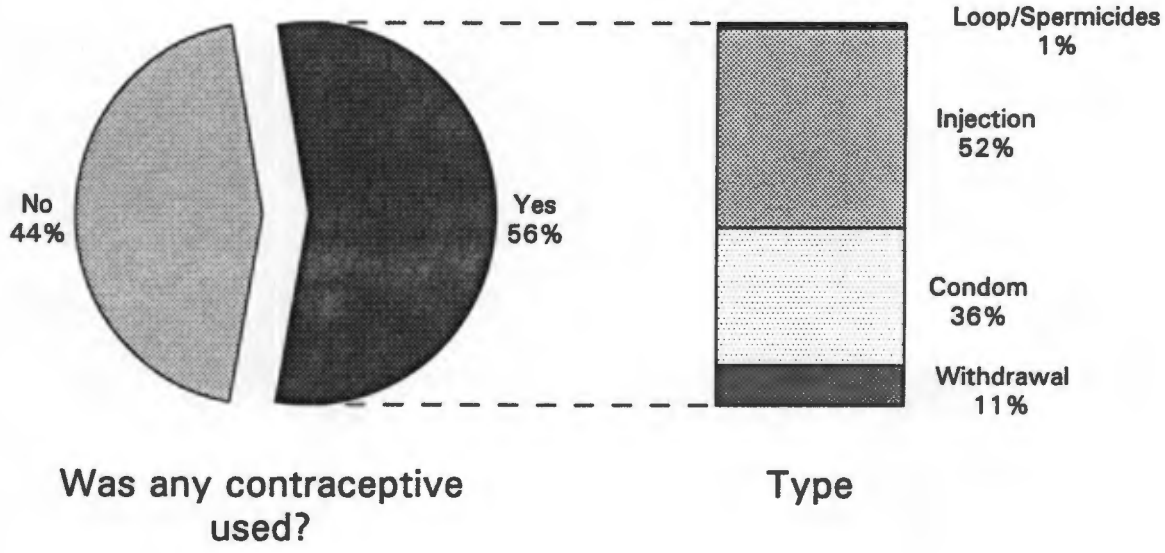
TABLE XIII#

RESPONDENTS' SEXUAL EXPERIENCE WITHIN LAST 30 DAYS

	Yes	No		
Any sex in last 30 days (n=180)	135 (75.0%)	45 (25.0%)		
	Mean	Median	Mode	Range
With how many girlfriends (n=135)	2	2	2	1-6
Number of episodes of sex in last 30 days (n=135)	6.6	6	4	2-12

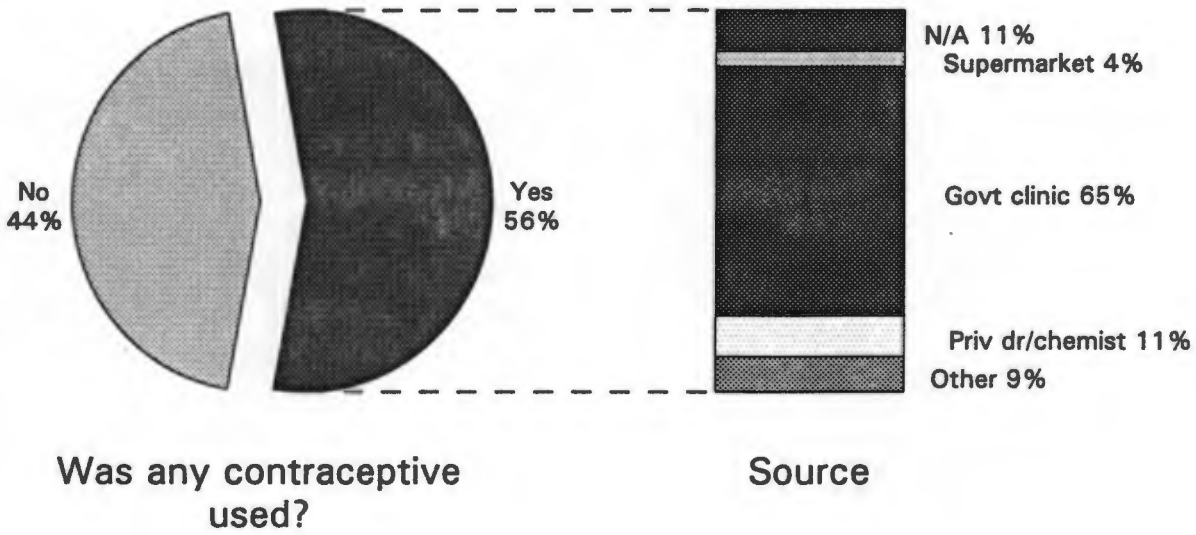
 # See questionnaire (Appendix D) - Questions 23a, 23b and 23c.

FIGURE 9: PERCENTAGE DISTRIBUTION OF RESPONDENTS WHO USED CONTRACEPTIVES AT LAST SEXUAL INTERCOURSE AND TYPE OF CONTRACEPTIVE USED



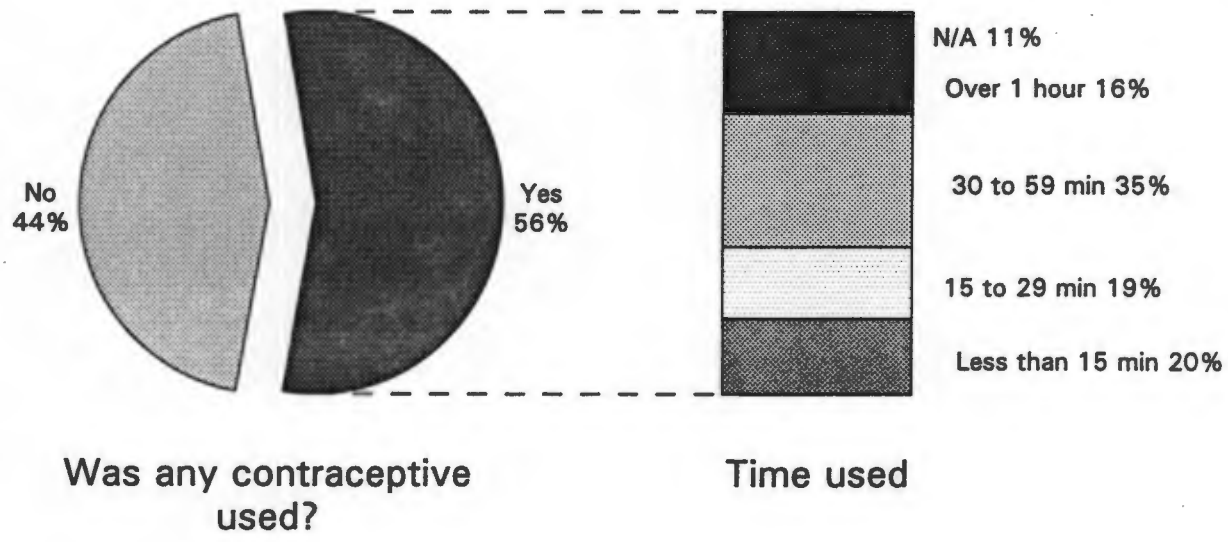
Response (n = 135)

FIGURE 10: PERCENTAGE DISTRIBUTION OF RESPONDENTS WHO USED CONTRACEPTIVES AT LAST SEXUAL INTERCOURSE AND SOURCE OF CONTRACEPTIVE



Response (n = 135)

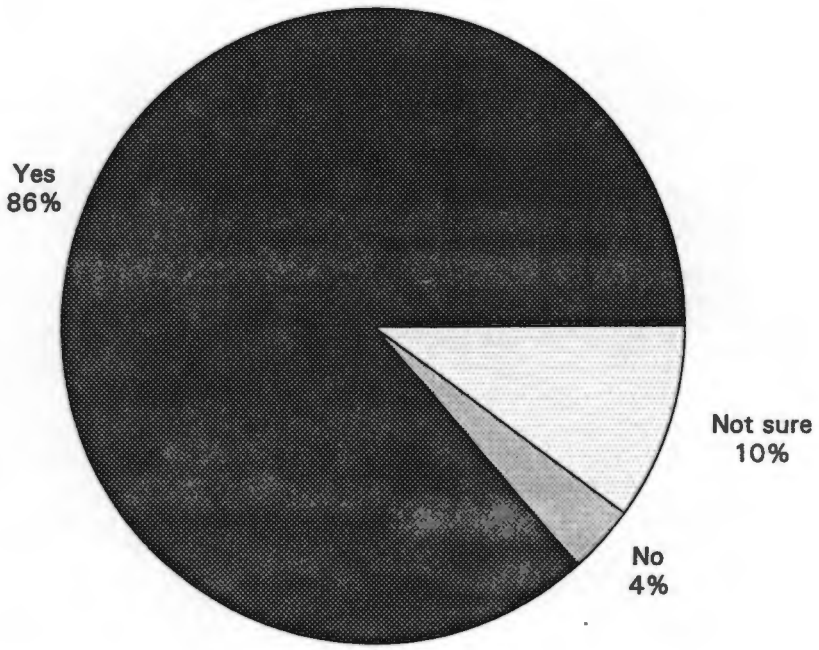
FIGURE 11: PERCENTAGE DISTRIBUTION OF RESPONDENTS WHO USED CONTRACEPTIVES AT LAST SEXUAL INTERCOURSE AN LENGTH OF TIME TAKEN TO OBTAIN CONTRACEPTIVE



Response (n = 135)

Of those who had had sexual intercourse before, three quarters (75.0%) has had sex within the previous month (135 out of 180 responses). Of those who were sexually active, each had on the average two girlfriends with a range of 1 to 6. The average number of sexual episodes was 6.6 over the previous month. Of the sexually active respondents, the most frequently used contraceptives were injections (Depo Provera and Nuristerate) - obviously by their partners (52.0%) followed by condoms (36.0%). The most frequently used site for obtaining contraceptives was the Government clinic (65,3%) and the most usual time taken to travel to that site was half to one hour. Figure 12 shows respondents' likely use of contraceptives in the future.

FIGURE 12: PERCENTAGE DISTRIBUTION OF RESPONDENTS' ANSWERS TO THE QUESTION "IN THE FUTURE, WOULD YOU (OR YOUR PARTNER) LIKE TO USE A METHOD TO PREVENT PREGNANCY?)



Response (n = 200)

The majority (86.4%) of respondents indicated that they would like to use contraceptives in the future. A tenth (10.1%) were not sure about the decision to use or not to use contraceptives in the future.

INFORMATION ABOUT ATTITUDES AND BELIEFS CONCERNING FAMILY PLANNING

Tables XIV to XVI show respectively responses to questions concerning attitudes and beliefs about family size, contraceptives and STDs.

TABLE XIV# STUDENTS' RESPONSES TO QUESTIONS CONCERNING ATTITUDES AND BELIEFS ABOUT FAMILY SIZE

Questions	Response (n=200) Yes	No	Uncertain
God to decide on number of children	86(43.0%)	91(45%)	23(11.5%)
Male to decide on number of children	134(67.0%)	58(29%)	8(4.0%)
Number of children shows a man's strength	77(38.5%)	117(58.5%)	6(3%)
Number of children shows a man's importance in community	77(38.5%)	108(54%)	15(7.5%)

 # See questionnaire (Appendix D) - Questions 27a, 27b, 27c and 27d.

TABLE XV# STUDENTS' RESPONSE TO QUESTIONS CONCERNING ATTITUDES AND BELIEFS ABOUT CONTRACEPTIVES

Questions	Response (n=200) Yes	No	Uncertain
Contraceptives should not be used	2(1.0%)	166(83.0%)	32(16.0%)
Nuristerate/Depo can divert menstruation to head	101(50.5%)	43(21.5%)	56(28.0%)
Nuristerate/Depo can cause nose bleeds	58(29.0%)	57(28.5%)	85(42.5%)
Condoms can cause scratches on penis	33(16.5%)	116(58.0%)	51(25.5)
Condoms can travel up partner's belly	111(55.5%)	63(31.5%)	26(13.0%)
Condoms can make vagina grow bigger	30(15.0%)	108(54.0%)	62(31.0%)
Condoms to be used only with prostitutes	105(52.5%)	79(39.5%)	16(8.0%)
Contraceptives encourage unfaithfulness	101(50.5%)	67(33.5%)	32(16.0%)

 # See questionnaire (Appendix D) - Questions 28a-28h

TABLE XVI[#] STUDENTS' RESPONSES TO QUESTIONS CONCERNING ATTITUDES AND BELIEFS ABOUT STDS

Statement	Response (n=200) Yes	No	Uncertain
Sex with a virgin can cure gonorrhoea	77(38.5%)	82(41%)	41(20.5%)
Sex can cure period pains	72(36%)	67(33.5%)	61(30.5%)

 # See questionnaire (Appendix D) - Questions 29a and 29b.

Other findings include the belief or attitude that the male is to decide on the number of children the family should have (67.0%); that injectable contraceptives - Nuristerate and Depo Provera can divert menstrual blood to the head (50.5%); that condoms can travel up the belly of partners (55.5%) and should only be used with prostitutes (52.5%). About half of respondents (50.5%) believe contraceptives encourage unfaithfulness in the partner. Other results include the idea that the number of children a family should have must be left to God (45.0%); that sex with a virgin can cure gonorrhoea (38.5%) or period pains (36.5%).

LIMITATIONS OF THE STUDY

A study of this nature is complex and a lot of resources are required. The fact that various role players were involved from design of questionnaires to obtaining results meant that problems were bound to arise.

1. **STUDY SITES** - Originally the idea was to involve all high school students in the whole of the Zwelitsha District - both urban and rural. The long distance from Bisho of certain rural areas coupled with the difficult terrain in certain places and non-availability of reliable transport and staff led to exclusion of students from rural high schools. Inclusion of rural areas would have given a better representation of the study population of all high school students and would have made it possible to make comparisons between urban and rural areas.

2. **CROSS-SECTIONAL APPROACH** - Implicit in many cross sectional studies is the problem that changes over time cannot be predicted. Without longitudinal data, caution should therefore be exercised in interpreting results of a cross-sectional study. This is particularly relevant when the study involves adolescent behaviour, much of which is of an experimental and thus transient in nature.[45]

3. **SAMPLING ISSUES** - A limitation of school-based studies is the exclusion of important sub-groups of adolescents. These include (a) adolescents who do not attend school at all, (b) adolescents who have left school prematurely; and (c) students who attend specialised schools. Prevalence rates for a variety of forms of risk-taking behaviour have been shown to be higher for these groups.[45] The behavioural profiles derived in this study may thus reflect a healthy student effect. It has been argued that individuals excluded in one of these ways constitute a small proportion of the adolescent population and their exclusion should not significantly influence overall findings.[45] However, in South Africa this may not be applicable because the rate of premature school-leaving is known to be high among specific sub-groups of the population.[46] A community based study with the aim of documenting KABP on family planning in male adolescents would help shed light on this issue.

4. **RELIABILITY OF SELF-REPORT MEASURES** - The issue in this regard is whether adolescents provide accurate and honest answers to questions. This was particularly pertinent in this study, since much of the information sought is considered to be sensitive and sometimes socially deviant.[47] Threats to reliability stem from two sources: (a) under-reporting, arising out of fear of being exposed and the subsequent embarrassment and (b) over-reporting. There were no items in the questionnaires to assess both under and over-reporting and biological markers[48] were not used.

DISCUSSION

This study provides much information needed to design appropriate family planning intervention programmes and it highlights a number of areas which need urgent attention.

KNOWLEDGE

Lack of knowledge or misinformation about contraceptives and fertility can lead to unwanted pregnancies. In this study, the most frequently cited reason for not using any contraceptive method at first sexual intercourse was that the respondents did not know of any methods. In a study in Nigeria, sexually active young men also cited the same reason for no using contraceptives.[7] What knowledge these young people have about sexual matters, they have picked mostly from friends and movies/media.[4] Among 700 secondary school students in the Ivory Coast, 53% reported their main source of information about contraceptives was the media/movies and 33% said friends.[4] Information from friends and the media is often incomplete, misleading or wrong. Mass media entertainment, for example, almost never mention contraceptives or even family planning in general. At the same time, however, the National Federation for Decency reported an average of 2,81 references to sex per hour on U.S. prime television.[49] Other studies estimate up to 4.3 references to prostitution and rape per hour of prime time television.[50] Many of these shows are rebroadcast in other countries. News reports tend to emphasize contraceptive failures and side effects.[50]

There is confusion as regards some aspects of knowledge of family planning. Most respondents who have had sex education previously in school had received information about the woman's menstrual period. However there are serious doubts about the acccuracy of these self-assesments in view of the low proportion of respondents who could identify the safe period in the woman's menstrual cycle. In a study among male black secondary school students in the U.S., only 10 percent knew that a woman's fertile period occurs roughly midway between menstrual periods.[31] In this study it was a mere 2,5%. Mistaken notions about modern contraceptives appear widespread among students. Fifty five and half percent of students think that condoms can travel up the partner's belly while 15,0% think they could make the vagina grow bigger. These findings are consistent with results in a study in Natal, South Africa.[38] About half of respondents think that the injectable contraceptives - Depo Provera and Nuristerate can divert menstrual blood to the head. All these show obvious lack of knowledge of basic anatomy of the female's reproductive tract. From the study the two most often used contraceptives for those engaging in sex in the recent past (over the past one month) were Nuristerate/Depo followed by condoms. In a study among township school students in Cape Town, injectable contraceptives were also the most frequently used method.[36] The belief among some respondents that sex can either cure period pains or gonorrhoea can constitute a barrier to education and needs to be corrected.

Most respondents think that the best inter-pregnancy interval is 1 to 2 years. This is far shorter than the recommended interval of 3 to 4 years in the WHO Safe motherhood Initiative plan of Action[51] which ensures to some extent the survival of children and the avoidance of the maternal depletion syndrome. Any family planning education

campaigns these students may have been exposed to have not yet conveyed accurate information about the issues raised above and need to be taken up in future health planning intervention. To ensure informed choices of family planning methods especially in later life, students knowledge base of contraceptives need to be broadened. In the study certain family planning methods such as the Billings method (natural family planning) - a favourite of the Roman Catholic Religion and "after sex" or "morning after" contraception have virtually not been heard off. Vasectomy - voluntary male sterilisation - a safe, effective and simple permanent family planning method was known to less than 10,0% of the respondents. As a permanent family planning method requiring "male participation"; it is well suited to couples who want no more children. Failure rates are low, and complications are rare. It is important to let students know that vasectomy is one of the contraceptive options that can be considered in the future.

ATTITUDES

Knowledge is necessary to achieve appropriate behaviour but knowledge alone is insufficient.[21] In order for information to be turned into action, people need to integrate it into their attitudinal and belief systems.[21] Most respondents believe in wanting large families - five children on the average - and that God or the Male should have the sole prerogative of deciding on the number of children the family should have. About 40,0% of respondents also felt that the number of children indicate the male's strength or importance in the community. This is consistent with a study in Senegal eliciting males attitude to family planning.[1] The above attitudes pose problems which need to be addressed. It is a healthy sign to note that most respondents felt that the need to use contraceptives should be the responsibility of both the male and female. The responsibility to use contraceptives has been found to be usually the female's with the male showing little concern.[1,7] The attitude held by half of respondents that contraceptives encourage unfaithfulness in partners and that condoms are to be used only with prostitutes are matters of concern. In a study among Xhosa speaking township scholars in Cape Town,[36] other attitudes found militating against the use of condoms were (i) that it interfered with sexual pleasure, (ii) that their use implied mistrust of the partner (iii) that it interfered with workings of the body and (iv) that though they knew how it looked, they did not know how to use it. Informal reports indicate students' preference of injectable contraceptives to condoms because of their belief in the concept of "NYAMA ENYAMENI" - a Xhosa term meaning

Body to **Body** **Co**ntact - captured in the local slang **BBC**. There is a need for education which would address this stigmatisation of contraceptives in general and bad attitudes towards condom use in particular in the light of the rapidly rising prevalence of the Human Immuno-Deficiency virus (HIV) infection in South Africa.[52]

SEXUAL BEHAVIOUR AND CONTRACEPTIVE USE

As young men struggle to acquire more education, as they move to cities to find jobs, the time that they spend between sexual maturity for boys and marriage is extended.[31] Where once childhood ended abruptly with marriage, now an intermediate period, past childhood but not yet adulthood now intervenes. Whether these young people are called teenagers, adolescents or youth, they face new problems because they reach sexual maturity before they have reached emotional, social or economic maturity. Sexual desires grow strong before they are able to support a family and opportunities to go to school, to hold a job may be jeopardized by sexual activity at an early age, leading most times to unwanted pregnancy, STDs, or infertility.[22] The majority of respondents have had sexual intercourse (90,0%) and the sexually active ones had 2 girlfriends on the average and seven sexual encounters over the previous 30 days. It is interesting to note the discrepancy between the mean age when respondents actually had their first sexual experience (15.4 years for themselves and 13.8 years for their partners) and when they think boys and girls should really start sex - 17.4 years for both. The students' interpretation of what constitutes sexual activity was not elicited. It is impossible to ascertain whether they reported on penetrative sexual intercourse or other sexual activities which places them at low risk. Coitus

intercrura known as "Ukumetsha" in Xhosa has been a culturally sanctioned and encouraged premarital sexual activity in the community.[53] One should always view reported sexual behaviour with caution as it is potentially both an over and an under estimate.[47] The interval from first coitus to first contraceptive use was two years. A school-based study in the U.S. found that the median delay to first contraceptive use, even among those who do attend clinics was almost a year while the median interval to first conception was only six months.[54] Respondents also thought that the appropriate time for a man or woman to have his or her first child was 25 years - thus giving a significant time lag between initiation of sexual activity and actually wanting a baby. Young people need information and guidance to help them through this difficult period but their access to such help is often limited. There is a trend towards sexual activity beginning at earlier ages.[31] While biological factors may play a part - age at menarche for girls gradually decreasing over the last half century to between 12 to 14 years, for most countries and for boys average age of emission of sperm 14 years,[31] other factors may play a part. Throughout the world, but especially where rapid urbanization and modernisation are occurring, young people are breaking away form constraints applied by their families and communities.[7] The mass media, peers and other sources of information compete with parents and traditional leaders for influence among the youth.[7] Mass media entertainment and advertising portray images of sex as glamorous, exciting and risk free,[50] a hobby with or no consequences, a pastime of the popular and the affluent.[49] Rock music and other youth oriented entertainment often seem designed to be sexually stimulating.[4] Most societies maintain a double standard about sexuality - condoning or even promoting premarital sex for males while condemning it for females.[33] In some cultures young men are

encouraged to have sex early to prove their manhood.[7] Many young men are very worried about homosexuality. They think that having intercourse and especially getting a girl pregnant are proof of heterosexuality.[31] Also, the stigma of unwed pregnancy and the responsibility for raising the child often fall entirely on the woman.[7] It must be noted that in this study most respondents felt that both the man and the woman should assume responsibility for using contraceptives. It is thus necessary to acknowledge all the above factors and try to provide students with the relevant information preferably before they become sexually active.

RECOMMENDATIONS

The peer group is an important influence on sexual behaviour and norms. Students themselves, therefore, need to be involved in family planning intervention programmes. Respondents singled out their friends (peers) as their most frequent confidantes regarding sexual matters. The most frequent place for obtaining contraceptives was from government clinics and the time taken to get there was rather long, ½ to 1 hour. It is encouraging to note that an overwhelming majority 86,4% expressed the desire to use contraceptives in the future. New avenues for contraceptive distribution need to be explored including use of established commercial channels, contraceptive social marketing programmes and community based distribution projects.[31] It is suggested that as an initially, school-based distribution be concentrated upon as the necessary logistics are already in place. Counselling services as already indicated need to be improved and expanded.

When school-based distribution of contraceptives takes place, the distributor (often a satisfied user himself) may make an ideal counsellor. That is where the current School Health Team could be expanded to include Youth programmes. One of the most persuasive forms of communication is person-to-person contact with peers. A number of programmes work with young leaders and counsellors often called "peer counsellors" or "Youth multipliers" or "Youth promoters" - to reach and teach other young people. Peer counsellors almost always volunteer to communicate with other young people. They have been used successfully in Latin America and the Carribbean.[31] In Asia peer counsellors play a large role in educational and community development projects in the Philippines, Thailand and Sri Lanka.[31] In

Africa peer counsellors do community outreach work in Ghana and Kenya.[31] Most commonly peer counsellors give talks and conduct group discussions on responsible parenthood, family values, human sexuality, STDs and family planning. Most programmes train peer counsellors in these areas and also in communication skills. There are some difficulties in using peer counsellors. However to be most effective, they need careful selection and preliminary training and regular supervision. Both activities require substantial time from programme staff. But young peoples' lives change frequently because of graduation, marriage and changing jobs - and thus many programmes report a rapid turnover among peer counsellors.[31]

Separate health and family planning programmes for young people are uncommon. For the most part, young people are not considered a distinct group needing special care. Yet young people often will not use existing health and family planning services that focus on older men and women.[30] Staff members usually are not trained to work with young people. The School Health Team will need to develop services especially for young people and their attitudes may limit access for youth. Innovative approaches could be multi-service youth programmes which offer a wide range of services to help young people in many facets of their development but here concentrating on family life education and family planning. School-based health and family planning clinics could be located either in the school or nearby. No new structures need be built-existing facilities could be used. These offer a wide range of services including general health, urological/gynaecological examination, treatment of minor illnesses, screening for STDs, counselling on sexuality and family planning and prescription/distribution of contraceptives and recreational activities. These types of clinics are operating in more than 35

schools in 18 communities in the United States and Sweden.[31] Other services for young people that need to be considered in the future when staff strength and resources permit include:

(1) A separate unit or centre associated with a family planning clinic for counselling young people; (2) certain hours or days of the week at the clinic set aside for young people; and (3) "hot lines" - telephone counselling services so that young people too shy to come to the clinic can still obtain information and advice. Maintaining hot lines can be difficult and expensive. Frequent advertising may be necessary to let young people know about the service. Training and paying counsellors is expensive, particularly since most hot lines operate ten or more lines per day. Costs can be minimized by using youth volunteers.[31]

A school based intervention should invariably involve the entire school community, including parents, teachers and students as part of an ongoing process of consultation with parent-teacher associations and students' representative councils.[36] It is essential to gain the support and trust of the youth and the rest of the school community. This is particularly important in the black school setting which is educationally disadvantaged and political volatile.[36] It would be important to start sex education in primary school (most respondents prefer starting from standard 3) and the method most favoured is teaching both boys and girls together. Since school teachers were

usually the first people to start sex education in schools, it would be important to train these "trainers"- that can be done in the short time through workshops and seminars designed in consultation with the school authorities. The long term solution will be to equip such teachers long before they graduate from the teacher training colleges - that is by incorporating such courses in the curricula of training colleges.

CONCLUSION

Family planning programmes have neglected men for too long and there is an urgent need to target them especially during their formative educational period. The study highlights certain key areas for intervention. It shows that male high school students are interested in family planning and want to receive more information about it. Some have mistaken notions about modern contraceptives; myths and misperceptions about fertility and STDs abound. Since the majority of these students are already sexually active, this places them at risk and makes health intervention programmes for these students a matter of urgency. These programmes should be developed in conjunction with all role players concerned - students themselves, parents, teachers and the community and should aim at the following objectives.

*To help students develop responsible attitudes towards sexual activity, pregnancy and parenthood and develop decision making skills and values of their own with respect to their sexual and social lives.

*To encourage conscientious use of contraceptive in those who are sexually active and to encourage attendance at the youth facility before the initiation of sexual activity.

*To provide early pregnancy and sexually transmitted disease detection and to refer patients for prompt and sound medical care.

*To train young people in an outreach programme to help one another develop responsible attitudes in the area of sexual relationships.

In the long term, however, the most effective family planning programmes will be those that serve the needs of both males and females, not only individually, but also together, as couples or partners, recognizing that family planning is a joint responsibility. Until and unless Maternal and Child Health (MCH) managers realize that, the goal of helping partners plan better families will remain elusive.

REFERENCES

1. **Ferry B.** (1981) The Senegalese Surveys. In Child spacing in Tropical Africa: Traditions and change, p. 265. Edited by Page H, Lesthaeghe. Academic Press, New York

2. **Roberts M, Rip M.** Black fertility patterns: Cape Town and the Ciskei. Second Carnegie Inquiry into Poverty and Development in Southern Africa paper 254, 1984.

3. **Nolasco AD.** Male Concepts: on masculinity, parenthood and family planning. Population Forum 7(1): 6-8, 1981

4. **Onyango-Omuodo D.** Promoting male responsibility in family planning in the Africa region. In: International Planned Parenthood Federation (IPPF). Male Involvement in family planning: programme initiatives, London IPPF, [1984], p. 9-12

5. **Mitchell RE.** Husband-wife relations and family planning practices in Hong Kong. Journal of marriage and the family 34(1): 139-145, February 1972

6. **Saraswarthi TS, Gupta R.** Fertility, family planning and the status of women. Journal of family welfare 32(1) 16-24, September 1985

7. **Ukaegbu AO.** Family planning attitudes and practices in Rural Eastern Nigeria. Studies in family planning 8(7): 177-183, July 1977

8. **Erasmus G.** Besluitneming met betrekking tot die gebruik van voorbehoedmiddels na bevalling: 'n Swart gemeenskap in Daveyton. (Decision making in relation to the use of contraception after delivery: a black community in Daveyton.) (Afr Summary in English) Pretoria, Suid-Afrika, Raad vir Geesteswetenskaplike Navorsing, 1983. (Navorsing bevinding SN - 243),

9. **Sedlin MG, Hollerbach P E.** Modern and traditional fertility regulation in a Mexican community: factors in the process of decision making. New York, Population Council, September 1978.

10. **Survey Research Indonesia (SRI).** Findings of a qualitative survey on attitudes towards, and knowledge of family planning: Jakarta 1985. Jakarta, SRI, April 26, 1985

11. **Figa-Talamanca I.** Inconsistences of attitudes and behaviour in family planning studies. Journal of Marriage and the family 34: 336-344, May 1972

12. **Cook RJ, Maine D.** Spousal Veto over Family Planning Services. American Journal of public Health 77(4) April 1987

13. **Gordon E.** An analysis of the impact of labour migration on the lives of women in Lesotho. In African women in the development process (edited by Nelson N.) p. 56-76. Frank Cass, London 1981

14. **Anonymous.** Ghana: Half the fertility reduction in a rural area is due to acceptance by men of family planning. International family Perspectives 5(1): 31-32, March 1979

15. **Fisek NH, Sumbuloglu K.** The effect of husband and wife education on family planning in rural Turkey. Studies in family planning 9(10-11): 280-285. October - November 1978

16. **Siassi I.** The psychiatrist's role in family planning. American Journal of Psychiatry 129(1): 80-85. July 1972

17. **Bracken MB.** The Jamaican family Planning Programme. Clinic Services and social support as factors in dropping out. International Journal of Health Education 20(2): 126-135. 1977

18. **Laing JE.** Differentials in Contraceptive use-effectiveness in the Philippines. Studies in family planning 5(10): 302-313

19. **McCalister D, Thiessen V.** Prediction in Family Planning: prediction of the adoption and continued use of contraception. American Journal of Public Health 60(8): 1372-1381. August 1970

20. **Bury JK.** Teenagers and Contraception. British Journal of Family Planning, 1986; 12: 11-14

21. **Brooks-Gunn J, Furstenberg F F.** Adolescent Sexual Behaviour AM Psychol 1989; 44: 249-257

22. **Nash E.** Teenage Pregnancy - Need a child bear a child? S Afr Med J 1990; 77: 47-151

23. **Department of National Health and Population (DNPD)**, 1990 Health Trends in South Africa. Pretoria: DNPD, February 1991

24. **Ncayiyana DJ, Ter Haar G.** Pregnant adolescents in rural Transkei. S Afr Med J 1989; 75: 231-232

25. **Alan Guttmacher Institute.** Teenage pregnancy: The problem that hasn't gone away. Alan Guttmacher Institute 1981

26. **Cates JW.** Sexually Transmitted Diseases and family Planning. Strange or Natural bedfellows? Journal of Reproductive Medicine V.29, 1984; p317-322

27. **Kinsey J et al.** Sexual Behaviour in the Human Male. Philadelphia, W B Sounders Co, 1948

28. **Bowie C, Ford N.** Sexual behaviour of young people and the risk of HIV infection. J Epidemiol Community Health, 1989; 43: 61-65

29. **Barlett EE.** The Contribution of school health Education to community Health Promotion: what can we reasonably expect? Am J Public Health 1981; 71: 1384-1391

30. **Van Coeverden de Groot HA, Greathead EE.** Adolescent sexuality education and contraception CME 1991; 9: 1369-1377

31. **International Planned Parenthood Federaton (IPPF).** Services for Adolescents: Some family planning association initiatives. London, IPPF. Programme development 1985

32. **Finkel ML, Finkel DJ.** Sexual and Contraceptive knowledge, attitudes, behaviour of male adolescents. Fam Plan Persp 7: 256-260, 1975

33. **Scales P.** Males and Morals: Teenage Contraceptive Behaviour amid the Double standard. The family co-ordinator 26: 211-222, 1977

34. **Preston-Whyte EA, Zondi M.** Adolescent sexuality and its implications for teenage pregnancy and AIDS CME 1991; 9: 1389-1394

35. **Amod Z, Shmukler D.** Sexual attitudes and behaviour of Indian South African adolescents. S Afr J Psychol 1986; 16: 21-26

36. **Matthews C, Kuhn L, Mercalf CA et al.** Knowledge, attitudes and beliefs about AIDS in township school students in Cape Town. S Afr Med J 1990; 78: 511-516

37. **Abdool Karim SS, Abdool Karim Q, Preston-Whyte E, Sanker N.** Reason for lack of Condom use among high school students. S Afr Med J 1992; 82: 107-110

38. **Abdool Karim Q, Preston-whyte E, Abdool Karim SS.** Teenagers seeking condoms at family planning services Part I. A user's perspective. S Afr Med J 1992; 82: 356-359

39. **Abdool Karim Q, Abdool Karim SS, Preston-Whyte E.** Teenagers seeking condoms at family planning services: Part II. A provider's perspective. S Afr Med J 1992; 82: 360-362

40. **Surplus People Project.** Forced Removals in South Africa Vol 2. The Eastern Cape, Cape Town, 1983

41. **Department of Manpower and Planning, Ciskei:** Annual Report 1991

42. **Turshen M.** Health and Human Rights in a South African Bantustan. Soc. Sci Med. Vol 22, No. 9, p887-892, 1986

43. **Yawitch J.** Apartheid and family life. Work Prog. 27, 40-42, 1983

44. **Jamaican National Family Planning Board** - Young Adult Reproductive Survey - Male Questionnaire Annual Report 1990

45. **World Health Orgnisation.** Young people's health - a challenge for society report of a WHO study on young people and "Health for all by the year 2 000". WHO Tech Rep Ser 1986; No. 731

46. **Flisher AJ.** Non-high school attending teenagers in Lotus River. Selected characteristics and risk taking behaviour. Urbanisation and Health Newsletter 1991, 10:20

47. **Rolinick SJ, Gross CK, Garrard J, Gibson KW.** A Comparison of response rate, data quality and cost in the collection of data on sexual history and personal behaviour. Am J. Epidemiol 1989: 129: 1052-1061

48. **Yach D.** Biological markers: Broadening or narrowing the scope of epidemiology. J Clin Epidemiol 1990, 43 : 309-310

49. **Libert Ray et al.** The early window: effects of television on children and youth. 2nd edition Oxford Pergamon, 1982

50. **Sprafkin J N and Silverman L T.** Update: Physically intimate and sexual behaviour on prime-time television 1978-79. Journal of Communication 31(1): 34-40 Winter 1981

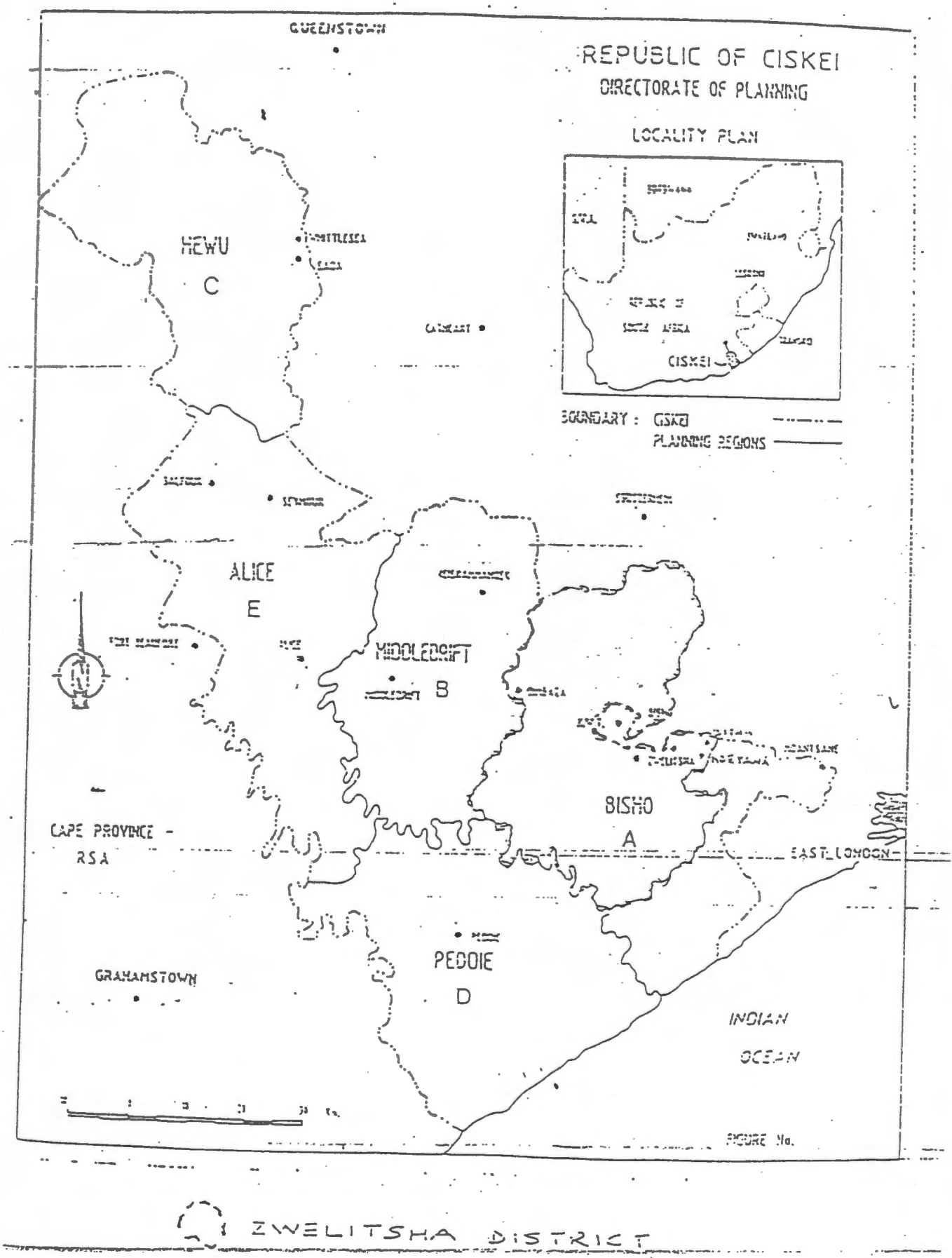
51. **Royston E, Armstrong S.** "Preventing Maternal Deaths", WHO 1989. Progress Report of the WHO Programme on Maternal Health and Safe Motherhood

52. **Padayachee GN, Schall R.** Short-term predictions of the prevalence of HIV infection among the black population in South Africa. SAfr Med J 1990; 77: 329-332

53. **Pauw BA.** The second generation. A study of the family among urbanised Bantu in East London, 1963, Oxford University Press, Cape Town

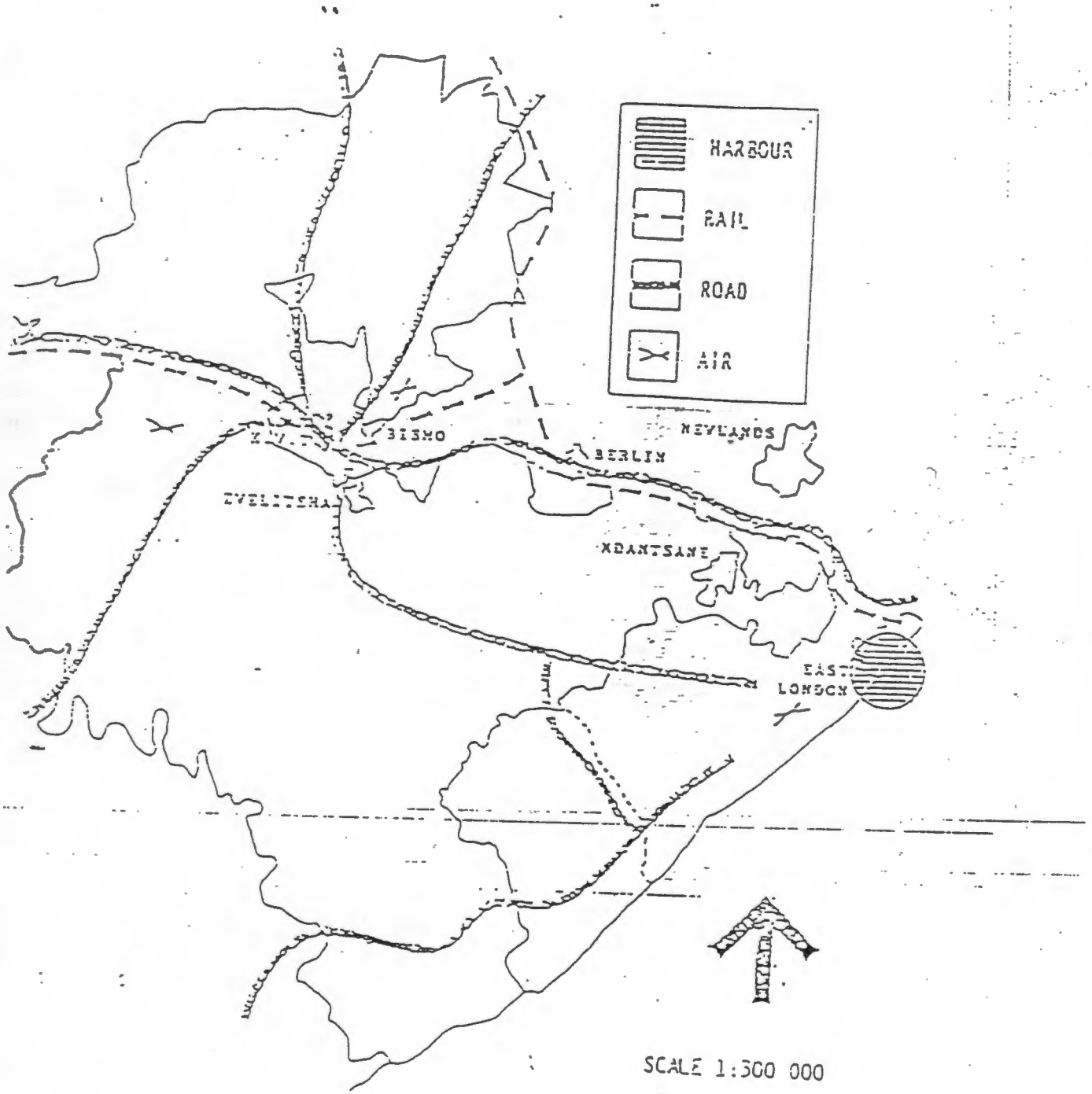
54. **Zabin LS, Kanter JF, Zelnik M.** The risk of adolescent pregnancy in the first months of intercourse. Fam Plann Perspect II: 215, 1979

APPENDIX A - MAP OF CISKEI SHOWING THE ZWELITSHA DISTRICT



ZWELITSHA DISTRICT

APPENDIX B - MAP OF CISKEI SHOWING MAJOR TRANSPORTATION NETWORK



PLAN 6. MDANTSANE/BISHO REGION : TRANSPORT NETWORK

APPENDIX C - PERMIT (LETTER OF AUTHORITY) FROM CISKEI DEPARTMENT OF EDUCATION AND CULTURE TO CONDUCT STUDY IN SCHOOLS

UMLAWULI JIKELELE WEMFUNDO
NENKCUBEKO
DIRECTOR-GENERAL FOR EDUCATION
AND CULTURE
10-2-1993
PRIVATE BAG X0032
BISHO

CISKEI GOVERNMENT SERVICE

DEPARTMENT OF EDUCATION AND CULTURE

LETTER OF AUTHORITY

N.I.N. A097603

Authority is hereby granted to DR WILLIAM KWAW
in his capacity as A STUDENT OF THE UNIVERSITY OF CAPE TOWN

To visit schools in the Republic of Ciskei for the purpose of CONDUCTING A STUDY AMONG MALE HIGH SCHOOL STUDENTS ON KNOWLEDGE; ATTITUDES; BELIEFS AND PRACTICE CONCERNING FAMILY PLANNING METHODS.

This letter of Authority is valid for the period 13-02-93 to 12-02-94 and is subject to the following conditions:-

1. Before visiting any school in a particular Directorate the representative must produce his letter of Authority to the Assistant Director and in the case he is not available to the next person in charge, who must endorse on the reverse side of the permit that he has taken notice of the intended visit and that it is in his opinion convenient for the schools.

2. The representative must endeavour to limit his stay at a school and must not exceed an hour, preferable during lunch/tea break, but not during tuition time.

3. Should a representative fail to comply with the above mentioned conditons, his permit will be cancelled immediately and no renewal of the permit will be granted.

Signed

DIRECTOR-GENERAL: DEPARTMENT OF EDUCATION AND CULTURE

DATE: 10/2/93

APPENDIX D - QUESTIONNAIRE

SCHOOL HEALTH SERVICES - ZWELITSHA DISTRICT FAMILY PLANNING SURVEY
MALE HIGH SCHOOL STUDENTS

Code | | | |

STUDENT QUESTIONNAIRE

Please fill in this questionnaire. The information will be used to help develop the school (Family Planning) education programme.

This questionnaire is anonymous, so

PLEASE DO NOT WRITE YOUR NAME ON IT.

For each question put a tick next to or circle the answer you choose. If there are no alternatives please write your answer out as fully as possible. You may answer in English or Xhosa. If you do not want to answer a question, please leave it out, rather than answering untruthfully. If you do not understand a question, please raise your hand and someone will help you.

YOUR TEACHERS WILL NOT SEE YOUR RESPONSES. When you have completed the questionnaire please put it in the envelope, seal it and leave it in the box provided.

A. QUESTIONS ABOUT YOU

1a. How old are you? _____ years

1b. Which District were you born in?

1. Zwelitsha District
2. Mdantsane District
3. Peddie District
4. Middledrift District
5. Hewu District
6. Alice District
7. Other Name _____

2a. Do your parents live together?

1. Yes
2. No
3. Doesn't know

2b. How many brothers and sisters do you have?

_____ brothers and sisters

2c. What was the last standard of schooling your mother completed?

1. No Schooling
2. Primary
3. Junior Secondary
4. Senior Secondary
5. Tertiary (Vocational, Technicon, University)
6. Doesn't know standard

2d. What was the last standard of schooling your father completed?

1. No schooling
2. Primary
3. Junior Secondary
4. Senior Secondary
5. Tertiary (vocational, Technicon, University standard)
6. Doesn't know

B. QUESTIONS ON FAMILY LIFE

3. In your opinion, at what age should a girl start having sex?

   Age _____
   88 Doesn't know

4. In your opinion, at what age should a boy start having sex?

   Age _____
   88 Doesn't know

5. How many children would you like to have? _____

6. In your opinion, how long after having a baby should a woman wait before having another baby?

   1. Less than 1 year
   2. 1 to 2 years
   3. 2 to 3 years
   4. 3 to 4 years
   5. 4 years or more
   6. Doesn't know

7. In your opinion, at what age is a woman responsible enough to have her first child? Age_____ (years)

8. And for the man? Age _____ (years)

C. QUESTIONS ON SEX EDUCATION

9. When you have doubts or problems about sexual matters, who helps you to solve them?

   1. God
   2. Parents
   3. Elder brothers or sisters
   4. Books
   5. Doctor/nurse
   6. Partner/Girlfriend
   7. Social worker (Nontlalontle)
   8. Friend
   9. Other relative
   10. No one
   11. Other (specify) _____
   12. Doesn't know

10. Where did you get your first information about sexual matters <u>that was not in school</u>?

1. The Street/Taxi Rank
2. Neighbourhood
3. Home
4. Grandmother's home
5. Relative's home
6. Library
7. Friend's house
8. Parties
9. Movies/Media
10. Clinic
11. Playfield
12. Other (specify) _____
13. Doesn't know

11. What does sex education mean to you? (Answer in English or Xhosa)

_____

_____

_____

12a. Have you ever been taught about sex education <u>in school</u>?

1. Yes
2. No (GO TO Question 13)

12b. At what standard were you first taught about sex?

1. Primary
2. Junior Secondary
3. Senior Secondary
4. Doesn't know

12c. Who taught this first class or course?

1. School teacher
2. Social worker (Nontlalontle)
3. Nurse
4. Priest
5. Other (specify) _____
6. Doesn't remember

12d. Was it a man or a woman?

1. Man
2. Woman
3. Both
4. Doesn't remember

12e. Did this first class (or course) or any later class (or course) in school include information about:

		Yes	No	Doesn't know
a.	The Woman's menstrual cycle or period (peyinta or ukuhlamba)	1	2	3
b.	Modern contraceptive methods (ukucwangcisa) such as the pill, loop, condom, foam tablets, Depo, Nuristerate	1	2	3
c.	Sexually transmitted diseases that can result from love making	1	2	3

13. At what standard do you think sex education should begin in schools?

77 Standard _____
88 It should not be taught
Doesn't know

14. What would be the best way of teaching sex education to young people?

1. Boys and girls separately
2. Boys and girls together
3. One to one discussions/individual attention
4. It doesn't matter
5. Other (specify): _____
6. Doesn't have an opinion about this

15. Can you remember if you ever received reading material (books, magazines, pamphlets, etc.) on family life education from any of the following places?

		Yes	No	Doesn't know
a.	School (Ministry of Education)	1	2	3
b.	Health centre (Ministry of Health)	1	2	3
c.	Social Gathering/meeting	1	2	3
d.	Ciskei Family Planning Services	1	2	3
e.	Other (specify) _____	1	2	3

16. When is it most likely that a girl can become pregnant?

1. A week before her period (peyinta) starts
2. During her period (peyinta)
3. A week after her period (peyinta) starts
4. Two weeks after her period (peyinta) starts
5. It doesn't matter; all times are alike
6. Doesn't know
7. Not stated

17. Name any sexually transmitted diseases you know of or have heard of?

		Yes	No
a.	Syphilis	1	2
b.	Gonorrhoea	1	2
c.	AIDS	1	2
d.	Herpes	1	2
e.	Other (specify) _____	1	2

D. CONTRACEPTIVE KNOWLEDGE (UKUCWANGCISA)

NOW LET'S LOOK AT CONTRACEPTIVE METHODS THAT PARTNERS USE IN ORDER TO DELAY THE NEXT PREGNANCY OR TO AVOID HAVING CHILDREN IF THEY DON'T WANT THEM

18a. Name any contraceptive methods you know.

		YES	NO
1.	Pill - ipilisi	1	2
2.	Condom - ikhondom/Ballon, isingxobo	1	2
3.	Injection (Dep, Nuristerate) - inaliti	1	2
4.	Diphragm - ifana nebhola eyohlulwe phakati ivala imlomo wesibeleko/okanye isiciko	1	2
5.	Loop - iLuphu	1	2
6.	Spermicides cream, jellies, Foam tablets ithi yakufakwa ngaphantsi izinyibilikele (incindi)	1	2
7.	Billings - incidindi yesibelako	1	2
8.	Rhythm - safe period, ikhalenda	1	2
9.	Withdrawal (pull out) - chamela ngaphandle	1	2
10.	Tubal Ligation (tie off) - ukuvala komfazi	1	2
11.	Vasectomy (tie off) - ukuvala kwendoda	1	2
12.	After-sex contraception (morning after)	1	2
13.	Other methods (specify) _____	1	2

18b. Who must decide to use something to avoid becoming pregnant, the man only, the woman only, or both?

1. The man
2. The woman
3. Both
4. Each one is on his or her own
5. Other (specify) _____

E. QUESTIONS ABOUT SEXUAL EXPERIENCE AND CONTRACEPTIVE USE

NOW I'D LIKE TO ASK YOU SOME VERY PERSONAL QUESTIONS: HOWEVER, THEY ARE VERY IMPORTANT FOR THE STUDY

19a. When did you first have sex/make love?

_____(years)
22 Has never had sex/made love (GO TO Question 24)
88 Doesn't remember

19b. How old was the person with whom you had sex for the first time?

_____(years)

20. Did you or your partner use a contraceptive method during this first sexual intercourse?

1. Yes
2. No (GO TO Question 21)
3. Doesn't remember/doesn't know (GO TO Question 22)

IF YOU USED CONTRACEPTIVES DURING FIRST SEXUAL INTERCOURSE GO TO QUESTION 23A

21. Why didn't you or your girlfriends use a contraceptive method during this first sexual intercourse/love making?

1. Didn't expect to have sexual relations at that time
2. Partner was against using something
3. Contraceptive methods are bad for one's health
4. Religion doesn't permit use
5. Didn't know of any methods
6. Knew of methods but didn't know where to get them
7. Intercourse is not satisfying when methods are used
8. Wanted to use something but couldn't get it at that moment
9. Too shy to get the method
10. Wanted partner to become pregnant
11. Other (Specify) _____
12. Doesn't know

22. At what age did you first have sexual intercourse using a contraceptive method?

_____ Years
77 Never used
88 Doesn't remember

23a. Have you had sex in the last 30 days?

1. Yes
2. No (GO TO Question 25)

23b. How many times? _____ Times

23c. With how many girlfriends? _____ Girlfriends

23d. Did you or your partner use a contraceptive method during the last time you had sexual intercourse?

1. Yes
2. No (GO TO Question 24)

23e. What was the method?

1. Pill - ipilisi
2. Condom - ikhondom/Ballon, isingxobo
3. Injection (Dep, Nuristerate) - inaliti
4. Diphragm - ifana nebhola eyohlulwe phakati ivala imlomo wesibeleko/okanye isiciko
5. Loop - iLuphu
6. Spermicides cream, jellies, Foam tablets ithi yakufakwa ngaphantsi izinyibilikele (incindi)
7. Billings - incidindi yesibelako
8. Rhythm - calendar method, safe period, (ikhalenda)
9. Withdrawal (pull out) - chamela ngaphandle
10. Tubal Ligation (tie off) - ukuvala komfazi
11. Vasectomy (tie off) - ukuvala kwendoda
12. After-sex contraception (morning after)
13. Other methods (specify) _____
14. Doesn't know (GO TO Question 24)

23f. Where did you or your partner obtain this method?

1. Government clinic/hospital
2. Private doctor
3. Chemist
4. Supermarket/shop
5. Circumcision school (Ebhomeni)
6. AIDS Educator
7. Other (specify): _____
8. Doesn't know/doesn't remember

23g. How long does it take to get to that place?

1. Less than 15 minutes
2. 15-29 minutes
3. 30-59 minutes
4. Over 1 hour

24. Have you ever talked with your partner/girlfriend about family planning or contraception?

1. Yes
2. No
3. Doesn't remember

25. In the future, would you (or your partner) like to use a method to prevent pregnancy?

1. Yes (GO TO Question 27a)
2. No
3. Not sure

26. Why not? (Answer in English or Xhosa)

_____

_____

_____

F. OTHER QUESTIONS ABOUT FAMILY PLANNING

PLEASE READ THESE STATEMENTS. INDICATE IF YOU AGREE OR NOT.

		Yes	No	Uncertain
27a.	God should decide how many children one should have	1	2	3
27b.	The male is the one to decide on how many children his wife/partner should have	1	2	3
27c.	A man needs many children in order to prove that he is very strong	1	2	3
27d.	A man needs many children to show one's importance in the community	1	2	3
28a.	Contraceptives should not be used	1	2	3
28b.	Injectable contraceptives (Nuristerate/Depo) cause blood to travel up back to the head	1	2	3
28c.	Nuristerate/Depo cause users to bleed from the nose	1	2	3
28d.	Condoms cause scratches on the penis	1	2	3
28e.	Condoms can get lost and travel up the partner/girlfriend's belly	1	2	3
28f.	Condoms make the vagina grow bigger	1	2	3
28g.	Contraceptives encourage girl-friends/partners to be unfaithful	1	2	3
28h.	Condoms should only be used with prostitutes (people selling bodies)	1	2	3
29a.	Sex with a virgin can cure gonorrhoea	1	2	3
29b.	Sex can cure period pains	1	2	3

THANK YOU FOR ANSWERING THIS QUESTIONNAIRE