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Male modern contraceptive methods: It's Knowledge, usage, perceptions, attitudes and beliefs- in the North West Province, a case study of the Madibeng Local Municipality in the Bojanala district.

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Contents

EXECUTIVE SUMMARY

The population policy of South Africa aims at improving the quality, accessibility, availability of primary health care services which include reproductive health and rights services to all. It has been the norm that responsibilities of the sexual and reproductive needs and services are taken care of by women in both developing and developed countries. It has therefore turn out to be the concerns of the South African government to involve the South African men and boys in Sexual and Reproductive Health and Rights as it is important to both men and women. Men are known to influence contraceptive choices, there is however drought of research on men's contraceptive knowledge, perceptions, attitudes, usage and beliefs. Majority of studies mainly focused on involvement of men into family planning decisions, nothing has been done in the usage, awareness and perceptions. The aim of this study is to examine factors influencing the knowledge, usage, perceptions, attitudes and beliefs about male contraceptive methods in the North West Province, a case study of the Madibeng local municipality in the Bojanala district in South Africa.

The study made use of a questionnaire to collect primary information in order to assess the knowledge, perceptions, attitudes, beliefs and usage of male modern contraceptive methods among 473 men aged 15 and 64 years in Madibeng Local municipality in the Bojanala District municipality in the North West Province. With the application of descriptive analytical techniques, the study highlighted that majority of males aged between 15 and 64 years were found in wards 17 and 12 and were in the middle ages; with secondary as the highest level of educations; with higher proportion single; higher unemployment rate; and mostly were earning lower income. Knowledge of both family planning issues and male modern contraceptives exists among the Madibeng male population. Though the commonly known method came out to be condom, other methods which emerged recently came out to be unknown and if known is to a lesser extent. Men were positively involved in decision making regarding contraceptive use with the beliefs and attitudes being positive too.

The current fertility pattern and desires resembles the modernized pattern indicating that if men were to be actively involved in family planning issues and were actively using the male contraceptives in complimenting women, universal coverage will easily be recognized.

In summary, the study accentuates that integrating men in reproductive health issues will lead to a greater uptake of contraceptives. Thereby recommending that in order to promote male contraceptive use generally, family planning could focus on increasing support of contraceptives, improve partner communication and joint family planning decision making. In that note, the government need to invest in access to reproductive health services generally as a tool for improving lives of South African men and the North West province in particular.

ACKNOWLEDMENT

The study collected data from the male population in Madibeng local municipality. The study consumed huge amount of time, work and dedication. Execution of this study would not have been possible if the directorate did not have been supported by many individuals, other directorates and other institution. The study will therefore like to thank each and every individual who participated in this study in any way. First and foremost, the study would like to express the heartfelt appreciation to the participants of this study because there has never been a study without respondents. Over and above, the study would also like to thank those who participated in data collection, editing, coding, capturing, cleaning, analysis and report writing. This include among others the Population Policy Promotion directorate, Research Unit in the Department of Social Development, the Management and community development team from Madibeng Service point. The study would also like to acknowledge support from the Department of Social Development, the Chief Directorate of Community Development, the PPP directorate, the Research Unit, the office of the Speaker in the Madibeng Local Municipality, ward councilors and tribal authorities. And lastly, it goes without saying, the presence, and guidance and support the study got from the management of the Population Policy Promotion since from the planning to final stage, it is highly appreciated.

LIST OF ABBREVIATION

ICPD: international Conference on Population and Development

POA: Program of Action

SDT: Second Demographic Transition

UNAIDS: United Nations Programme on HIV/AIDS

LIST OF FIGURES

LIST OF TABLES

1. CHAPTER 1: INTRODUCTION

1.1. INTRODUCTION

This chapter serves as an introductory section which includes introduction, background of the study, objectives of the study, statement of the problem, Hypothesis, Justification, organization of the study as well as definition of concepts. The population policy of South Africa aims at improving the quality, accessibility, availability of primary health care services which include reproductive health and rights services to all. It has been the norm that responsibilities of the sexual and reproductive needs and services are taken care of by women in both developing and developed countries. This however made male reproductive health services to be absent in the public services. It has come to the concerns of the South African government to involve the South African men and boys in Sexual and Reproductive Health and Rights as it is important to both men and women. Men have been seen to play a greater role in decisions to use or not to use contraceptive.

1.2. BACKGROUND OF THE STUDY

Around 2010/2011, Medical male Circumcision was launched as one of the strategy to reduce the risk of STI and HIV infections as a starting point. This is of course not enough as it does not reduce the risk of unwanted and unplanned pregnancies which is one of the population concerns outlined in the 1998 population policy of South Africa. The fifteen year progress review of the 1998 population policy of South Africa and the 1994 International Conference on Population and Development Programme of Action @ 20 recommended the promotion and encouragement of male involvement and responsibility in family planning and contraception usage. It is important to acknowledge the importance of both men and women in sexual and reproductive health issues, but more focus has to be on men (Department of Social Development, 2015; Green & Biddlecom, 2000).

According to Sigalla and Charles (2013), most males lack knowledge about male contraceptive methods and family planning in general. They further found male condom to be the most knowledgeable male method of contraceptive among males. In a study done in Uganda, men reported their knowledge of modern contraceptive methods through their partners 'knowledge from health providers and as media campaigns (Thummalachetty et al, 2017). Studies have found contraceptive knowledge among men to be more than 80% (Stewart, 2017) though varies in some instances. For example, in the study done by Sigalla and Charles (2013) youth and nurses were found to be more knowledgeable. Usage also varies, older men were less likely to use condom in the study done by Stewart et al, (2018). Men have been seen to play a greater role in decisions to use or not to use contraceptive. Studies have shown that contraceptive use is likely to be more effective for women when men are actively engaged in family planning matters (Ochako et al, 2017).

The South African government has committed to achieving the Sustainable Development Goals (SDGs) around family planning and the Family Planning (FP) 2020 goals, which align with the country's laws and policies that support sexual and reproductive health and rights. The 2001 National Contraceptive Policy Guidelines (updated in 2012), the National Health Act as well as the National Adolescent Sexual and Reproductive Health and Rights Framework Strategy (2014 - 2019) recognise the challenges and health needs of women, adolescents, including men, particularly family planning needs (Adeagbo et al, 2017).

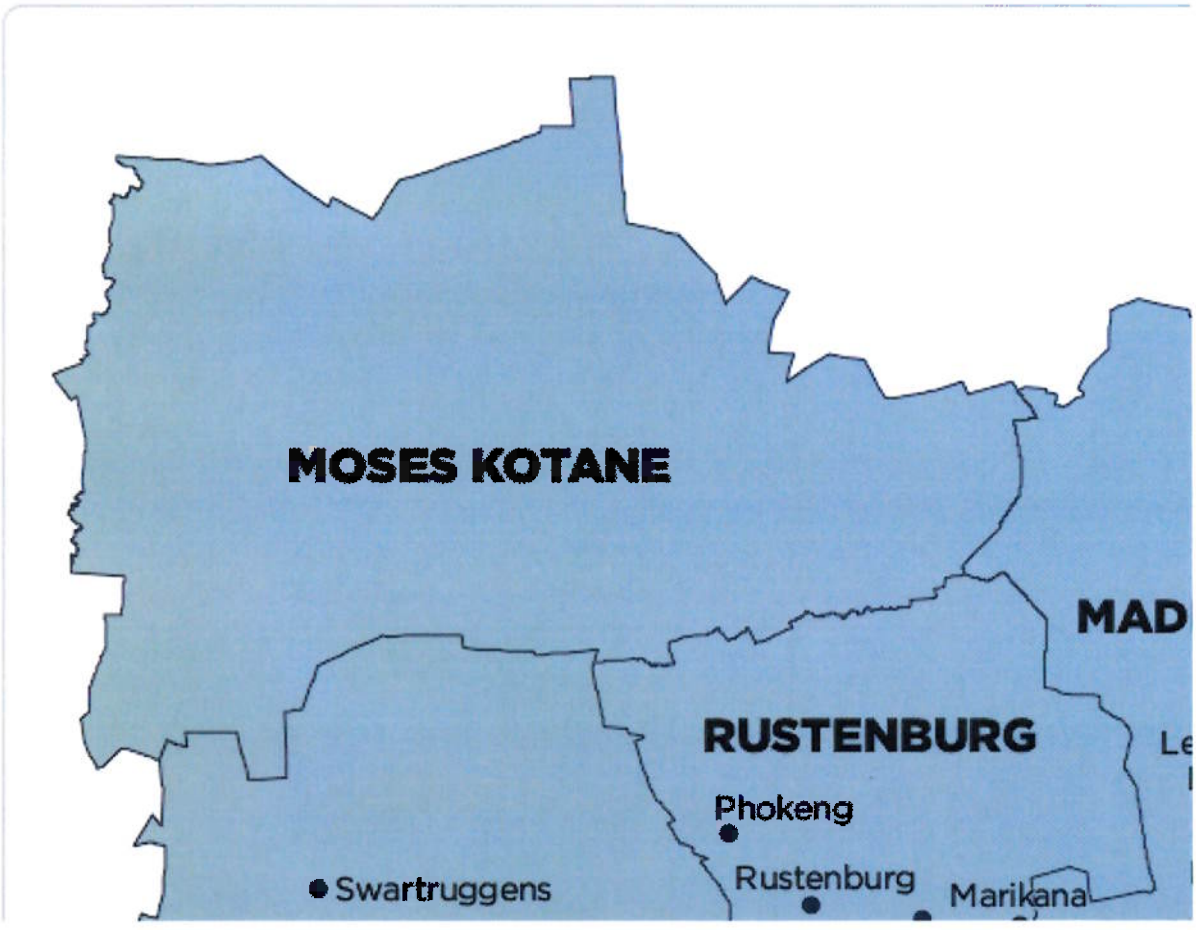
According to Wright et al (2017) both men and women are given a number of options with regard to methods of contraceptives in developed countries with specific reference to the United States of America. They further stated that selection of method is influenced by a number of factors including personal preference, access, cost, and the impact of sexual partners. Thus however affect the consistency of use of contraceptive methods in general. Additionally, barriers are likely to affect the consistent use of method of contraception, this take account of 'dislike of

method side effects, lack of information, and the high cost of contraceptive methods. In this instance, couples might end up facing risks such as unprotected intercourse and unintended pregnancy in times of method discontinuation.

1.3. GEOGRAPHICAL BACKGROUND OF THE STUDY AREA

Bojanala Platinum District Municipality (BPDM) is one of the four district municipalities in the North West Province. BPDM is situated on the eastern part of the North West province and it shares provincial boundaries with Limpopo, Mpumalanga and Gauteng Provinces and a national boundary with Botswana in the northern side. Its geographic size is covers 18 333km², with a population of 1 657 148 (Statistics South Africa, 2016) and this makes it the most populous of the four districts of the North West Province.

Fig. 1.1: Map for Bojanala District Municipality



The local municipalities which make up Bojanala Platinum District Municipality are Kgetleng Rivier Local Municipality; Madibeng local Municipality; Moretele Local Municipality; Moses Kotane Local Municipality and Rustenburg Local. As indicated above, the population of Bojanala Platinum district was standing at 1 657 148 in 2016, this represent 44% of the total population of the North West province.

1.4. Madibeng Local Municipality

Madibeng Local municipality is one of the local municipalities in the Bojanala District municipality which occupies the eastern part of District Municipality and is demarcated into 41 wards. The municipality's major settlements include Brits, Hartebeespoortdam and Mothotlung. The main economic drivers in Madibeng Local Municipality are tourism, manufacturing, agriculture and mining. Madibeng's economy also benefits from its location along the N4 Toll Road, and its proximity to the country's economic hub of Johannesburg. However, currently, mining is reported to be the predominant economic activity in the area.

Figure 1.2: Madibeng Local Municipality Map

The municipality has seen a growth in population from 475 796 in 2011 to an estimated 536 110 in 2016.This figure is more than the average annual increase of the district of 2% which sits at 2.71% currently. The number of households in the Local municipality was estimated to be 193 364 with an average household size of 2.8 person per household. Majority of people in the local municipality were found to be males at 53% as compared to 47% of females with a sex ratio of 115.4%. Majority of the persons aged between 15 and 64 years were employed at 65.9% while unemployed accounted for 30.30% with youth unemployment Rate of 38.20%. Majority of people age 20 and above had some primary level of education at 57.30% and 90% being Black/African ethnic group. Dependency ratio for the local municipality was estimated to be 51.8% meaning more than half of the population are dependent on the economically active population for survival.

1.5. STATEMENT OF THE PROBLEM

Even though men are known to influence contraceptive choices, there is dearth of research on men's contraceptive knowledge, perceptions, attitudes, usage and beliefs. Majority of studies mainly focused on involvement of men into family planning decisions, nothing has been done in the usage, awareness and perceptions. The misconception and low awareness of some contraceptive methods clearly highlights the need for promotion and encouragement of usage among males through training of awareness campaigns. Condom is the mainly known method of contraceptive known by men. There has been another modern methods of contraceptives which has been introduced globally and in the country recently. What has been observed during the Sexual and Reproductive Health and Rights advocacies conducted by the Population Policy Promotion Directorate is that almost all men are not aware of any male modern method of contraceptive except the condom.

This study therefore aims at examining factors influencing the knowledge, usage, perceptions, attitudes and beliefs about male contraceptive methods in the North

West Province, a case study of the Madibeng local municipality in the Bojanala district in South Africa. The study further finds out determinants of modern contraceptive use among sexually active men. Lastly the study also explored the correlates of modern contraceptive use. There is also inadequate research done on men's sources of knowledge regarding modern contraception. As a result study intend to fill literature gaps in knowledge, usage and sources from which men gain knowledge about contraception (Thummalachetty et al, 2017; Health System Trust, 2012).

1.6. OBJECTIVES

- To explore factors which influences men's perceptions, beliefs and attitude towards male contraceptive usage.
- To examine factors influencing knowledge and usage of male contraceptives.
- To find out sources of knowledge about contraceptives.
- Determine the prevalence of contraceptive use among males.

1.7. JUSTIFICATION/MOTIVATION

The Bojanala district has been selected as the study area as it is characterised as an industrialised and rapidly growing district. It has also been reported to contribute largely to the economic growth of the province due to the mining industry which attract more males with different background and culture. Furthermore, the district is characterised by lower sex ratio indicating that there are more males than females. Men migrating temporarily for job purposes are likely to leave their families at home. This exposes them to the risk of multiple partnerships, unprotected sex, etc. This will lead to the higher rate of HIV and AIDS and related sexual infections incidents, higher rate of unwanted pregnancies and unwanted births, higher rate of children born outside marriage and higher rates of fertility in general in the district.

As one of the recommendations of the 20 plus reviews on Sexual and Reproductive Health, men should play a very important role in reproductive issues as individuals rather than being only considered women's partners. Their reproductive desires should also be considered. This study therefore serves to increase awareness, understanding and knowledge about modern contraceptives in the North West Province.

1.8. DEFINITION OF CONCEPTS

1.8.1. Knowledge: according to the Oxford Dictionary, knowledge is defined as facts, information and skills acquired through experience or education or the theoretical or practical understanding of a subject.

1.8.2. Modern contraceptive methods: A product or medical procedure that interferes with reproduction from acts of sexual intercourse (Hubacher & Trussel, 2015).

1.8.3. Contraceptive Prevalence: is the percentage of people who are currently using at least one method of contraception regardless of the method used (Hubacher & Trussel, 2015).

1.8.4. Family planning: refers to a program which enables couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so, and to have informed choice and access to a full range of safe and effective modern methods of preventing pregnancy.

1.8.5. Modern Family Planning methods: refers to safe, effective and legal methods to prevent pregnancy such as the pill, intra-uterine device (IUD), injectable, condom, ligation, vasectomy, and modern natural family planning methods include mucus/billing/ovulation, lactation amenorrhea, basal body temperature and standard days method.

1.8.6. Reproductive rights:- the rights of individuals and couples, subject to applicable laws, to decide freely and responsibly the number, spacing and timing of their children; to make other decisions concerning reproduction free of discrimination, coercion and violence; to have the information and means to do so; and to attain the highest standard of sexual and reproductive health.

1.9. DIVISION OF THE REPORT

1.9.1. CHAPTER ONE: GENERAL ORIENTATION OF THE STUDY

This will be an introductory chapter which will cover the background and introduction of the study, the problem statement, the aim and objectives of the study, the rationale/significance of the study, and definition of concepts.

1.9.2. CHAPTER: TWO: LITERATURE REVIEW AND THEORETICAL/CONCEPTUAL FRAMEWORKS

The main focus of this chapter will be on literature related to the male modern contraceptive. The chapter will also develop conceptual and/or theoretical framework related to male modern contraceptives.

1.9.3. CHAPTER THREE: REASERCH METHODOLOGY

The crux of this chapter will mainly be on the research methods used in the study which covers research approach, data sources and data analysis.

1.9.4. CHAPTER FOUR: DATA ANALYSIS AND INTERPRETATION

This chapter will be based on the analysis and interpretation of the results.

1.9.5. CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

This chapter will seek to provide discussion of main findings conclusions and recommendations drawn from the study.

2. CHAPTER 2: LITERATURE REVIEW

2.1. INTRODUCTION

The preceding chapter introduced the study by giving an overview of the study, objectives, study problem, justification and a guideline on how the study is organized, as well as definition of concepts. It has been identified in this study that there is a gap of knowledge on male contraceptives, this guided the structure of the literature in this study. Therefore, the study firstly looked at knowledge usage and attitudes of contraceptives in general with a global view and then narrow it to the country. Then focuses on the male contraceptive and its determinants with regard to knowledge, accessibility, attitude and practice. Theories related to male contraceptives and behavioral change are also discussed. It has been realized that achieving the universal access to reproduction health as one of the Sustainable Development Goals 2030 target is challenging. Accordingly, the need for joint sexual and reproductive health responsibility between men and women in order to achieve gender equality and to reduce health inequalities has been receiving more and more attention since the democratic year.

In developed countries, oral contraceptives and condoms have been predominant methods (Sudha et al, 2018). Organised family planning efforts are seen to be focusing primarily on women, with less attention being given to men. Efforts to expand the so – called vision in order to realise constructive male engagement evolve first encouraging men to be supportive partners of women's reproductive health and to also focus on meeting men's own reproductive health needs and engaging men as contraceptive users and gets of change in families and communities (USAID, 2016).

2.2. INVOLVEMENT OF MEN IN FAMILY PLANNING

It has been recommended by ICPD that in order to increase the uptake of contraceptives among women, men must be included in family planning programming. Men have since been reported to be involved in family planning decision making. For example, more than half of men who participated in a study

which was conducted in Ethiopia reported joint decision – making on family planning matters. Men are further found to have a considerable influence in family planning decisions. Knowledge of and involvement of method of contraceptives by men is seen as a factor influencing the uptake of contraceptives by women. Additionally, ease and frequency of communication about family planning within couples significantly predicts contraceptive uptake, which is an indication that men influence contraceptive use and choice and use of contraception is derived from joint decision-making (Pereira, 2017).

As stated earlier in this study, in the past family planning/ programmes were mainly focused on women than men. This has led to the myth that family planning is women's business, this however changed after the 1994 Cairo International Conference on Population and Development (ICPD) where this was resolved and focus was then posed to both men and women. The ICPD endorsed a Program of Action (POA), and emphasized the need for gender equity with special focus on male's involvement in sexual and reproductive health. Gender-based inequities were, for the first time, recognized as barriers to reproductive health. And the reproductive health community began to focus on men's responsibility in population and reproductive health policies and programs (Pereira, 2017).

As stated by UNAIDS in 2014, involving men in family planning programs could promote gender equity and thus decreasing HIV/AIDS and STI's prevalence's. Men's involvement in contraceptive use and/or reproductive health issues is a significant or a pressing issue to achieve Development Goals in relation with reductions in deaths caused by pregnancy outcome also known as maternal mortality. It is important to understand what male involvement means, before assessing their involvement. Many terminologies are used to refer to male involvement in reproductive health services and programmes. For instance other perceive male involvement in reproductive health as setting a room to educate men about their health and those of women; setting a bowl of condoms for men to pick, accompanying their wives to clinics. Yet

other programmes to involve men in reproductive health use terms such as, including men's participation, men's responsibility, male motivation, male involvement, men and partners as well as men and reproductive health. In this premise, there seem to be no consensus on which terms best define male involvement in reproductive. However, this study consider male involvement as participation in order to influence both social and behavioural changes in reproductive health. Such changes include roles in relation to couple's decision-making about sex, contraception and raring/ energetic children. In relation to this definition, factors which seems to influence men's involvement in contraceptives are discussed below (Pereira, 2017).

2.2.1. Factors associated with the involvement of men family planning

There are number of factors which act to influence male involvement towards family planning and this include cultural belief, religious, educational level economic and social influences to mention a few. The fact that as a norm family planning and contraceptive use were associated with women, men found themselves left out and got the idea that it is the women's responsibility. No attention was paid on educating men on family planning and their role in pregnancy prevention. It has been argued that decision to adopt family planning is mainly influenced by and individuals' attitude towards it. Furthermore, men are more likely to contribute to family planning if they are told that their involvement would make family planning effective. Recent studies have reported that the effectiveness of family planning is likely to be influenced by active participation of their male partners. Beliefs and myths around family planning methods are also reported to reduce the usage, for examples there is a belief that when using family planning methods women are likely to experience complications such as weight gain and problems associated with cancer. South African men are reported to be actively involved in family planning programs as compared to other countries in the Sub-Saharan Africa region (UNFPA, 2012). It has also been reported that the use of female contraceptives is highly dependent on spouse communication, that is, the more the communication the higher the usage.

The other factor is the living standards of men living in rural areas as compared to men living in urban areas. This puts males in urban areas in a better position to access knowledge around family planning matters hence the higher the usage and positive attitudes towards them. Therefore, men in urban areas are able to look at the opportunity cost of children than rural men. Unemployment is of the issues which can inhibit involvement of men in family planning methods as it is associated with extreme poverty conditions and unaffordability family planning programs since they are expensive which lead to little knowledge or not knowing anything at all about family planning. Accordingly, husbands with higher levels of education are more likely to go for joint family planning decisions. Joint decision making among couples, especially on family planning use, is a critical component in reaching desired family size. Therefore education is an important factor, educated men understands the importance of limited family size basing their decision on economic rationality of fertility (Pereira, 2017).

2.3. GLOBAL TRENDS IN MALE CONTRACEPTIVE USAGE

According to Pereira (2017), men have in the past involved partially or not at all in sexual and reproductive health issues, and vast of focus has been on men as partners and supporters in literature. As reported by WHO (2017) report, the use of contraceptives has increased in the past two decades from 54% in the years 1990s to 57% in 2015. Literature suggests an increase in male-controlled methods globally (Pereira, 2017; WHO, 2017). Other than male condom and male vasectomy, there are a number of modern male contraceptives such as male pill, implant and injection. The challenge is they are not widely known nor accepted. Modernization played a bigger role in change in behavior for both men and women. Through, the recognition of women's rights and the improvement as well as an increased availability of family planning programmes and services, and this has significantly contributed towards the involvement of men in family planning. Women empowerment gave women rights and opened doors to easy access of contraceptives for women. This has however influenced and encouraged their partners to support them and make joint family planning decisions.

Furthermore, educational level for both men and women played a bigger role as a determinant of use of modern method of contraceptives. Similarly, social changes that includes area of residence, adoption of urban lifestyles influenced by economic status both men and women and the development of new technologies led to the use of modern contraceptives. Evidence suggest that men in developed countries have been having much better knowledge about contraceptives and are very open to the idea of family planning. Trends in Europe and other developed countries are different as compared to trends in Africa and other developing countries. Trends in Europe reflects that men are involved in effort to control fertility and this has happened from a long time, methods like withdrawal, abstinence and prolonged breastfeeding has been practiced for a very long time. European males have been reported supportive to their partners in terms of encouraging the use of contraceptive and family planning from the start. Condoms and vasectomy originated from Europe, this advocates the effort of including men to be involved in or towards family planning.

However, men in developing countries are becoming visible in making important decision in the family including family size, the use of contraceptives. Previously men were greatly influenced by culture and beliefs, women were defined by the number of children she had and men gained the status as number of children grew (preferably boys). Both men and women opposed contraceptive use due to the fear of being sterilized and also due to misconceptions about contraceptives. Male participation in Reproductive Health services operation includes the way men agree and designate sustenance to their partners' needs, choices and rights together with using contraception and their own reproductive and sexual behaviour to endorse adherence of human rights and the need to implement equity. Subsequently, it is predominantly applicable in male-dominant cultures where men previously obligated an all-inclusive participation in resolutions concerning to family and society.

Many sub-Saharan Africa countries have high rates of unmet need for family planning (FP) and low rates of contraceptive use. Yet, regardless of increasing indication on the benefits of appealing men in reproductive health supervisory, fertility rates and unmet need for family planning remain high in many sub-Saharan African countries. Despite the fact that there are many significant factors, low contraceptive prevalence has been endorsed in part to men's hostility to or non-involvement in family planning. Male commitment has traditionally been portrayed as hindering by obstructing women's decision-making on use of family planning, or non-existent among male partners who are vague completely in line for absence of awareness in difficulties associated with reproductive health.

2.4. MODERN CONTRACEPTIVE METHODS DEFINED.

According to Singh et al. (2018), modern contraceptive methods were invented in order for couples to act on natural impulses and desires with diminished risks of pregnancy. Modern contraceptive methods are regarded as technological advances designed to overcome biology thereby enabling couples to have sexual intercourse at any mutually-desired time. Sigh et al, (2018) proposed that modern contraceptive be defined as a product or medical procedure that interferes with reproduction from acts of sexual intercourse. This definition of modern contraception methods allows for an easy way of categorization of methods. For instance, methods that do not fit under the definition of modern can alternatively be labeled as "Non-Modern Methods".

2.4.1. MALE CONTRACEPTIVES

Male contraceptives, also known as male birth control are described as methods of preventing pregnancy that primarily involve the male physiology. The most common kinds of male contraception include condoms, withdrawal or pulling out, outer course, and vasectomy. Male contraception, or birth control, keeps sperm from coming into contact with an egg to avoid pregnancy.

2.5. DIFFERENT TYPES OF MALE CONTRACEPTIVES

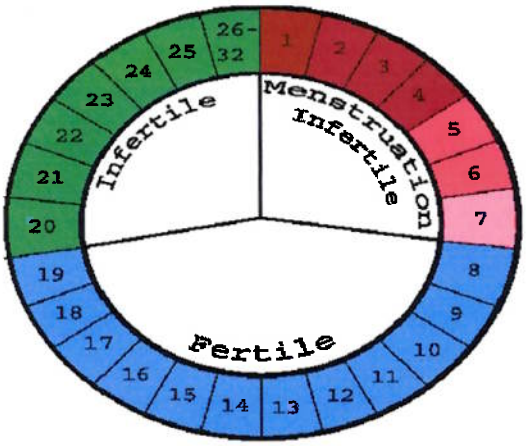
2.5.1. COMMONLY USED MALE CONTRACEPTIVES

2.5.1.1. TRADITIONAL METHODS

2.5.1.1.1. **Coitus interruptus**: This is the oldest model of contraceptives which can be reliable unless the male partner is not corporative. Coitus interruptus also known as withdrawal or the pull out, involves withdrawal of penis from the vagina just before ejaculation, thus preventing semen from entering the woman. It is reported that with this method, men needs good self – control in both emotional and physical being in order to succeed.

2.5.1.1.2. **Lactational Amenorrhoea Method:** This referrers to breastfeeding women, it is believed that during this period women secrete hormones that prevent conception for six months. During this time there is no menstruation and full breastfeeding is maintain day and night. It is however not regarded as a reliable method as breastfeeding is irregular.

2.5.1.1.3. **Rhythm Method:** It is a traditional method where the ovulation of a woman is used to predict a period when a woman is expected to be fertile thereby avoiding intercourse during those days. This also not reliable as it requires careful record keeping for calculating safe period. Furthermore, this cannot be used by women with irregular circles, or after childbirth or during menopause years.



2.5.1.2. MODERN METHODS

2.5.1.2.1. **Male condom**: The male condom is reported as one of the most popular and affordable forms of birth control (Sudha et al, 2018). A male condom is a thin sheath that covers the penis during intercourse and is made of one of either rubber (latex), or plastic (polyurethane: the best alternative for people allergic to latex, and lambskin. Male condoms can vary greatly in color, size, and amount of lubrication and spermicide. The male condom protects against sexually transmitted infection (STI) and pregnancy by covering the penis and preventing direct contact between the penis and vagina, as well as collecting the semen and preventing it from entering the vagina. The male condom is rolled over the erect or hardened penis and prevents against direct contact between the penis and vagina. The condom must be removed before the erection ends or the sperm can leak out. Use the condom once only, then throw it in the garbage. Do not flush it down the toilet (Brown, 2013).

2.5.1.2.2. **Male sterilization (vasectomy):** It is referred to a permanent surgical method in which the vasa differentia which carries the sperms from the testes to the penis are blocked.

This prevents the sperms from being released into the semen at the time of ejaculation.

It is believed to be the simplest and reliable method. It is not known to affect health or sexual vigor, not even reported to interfere with intercourse. This is achieved by cutting and tying off the tubes – vas deferens – through which sperm pass

2.5.2. NEW MODERN METHODS OF CONTRACEPTIVES

Historically, the burden of contraception has always been assumed to lies with women. Researchers have conducted studies on two types of systemic birth control for men: hormonal male contraception and immune-contraception. Hormonal male contraception uses hormones (injected, implanted, or taken orally) to stop sperm production, but this would reverse when the contraception is no longer used. Immuno-contraception is a birth control method that uses the body's immune system response to prevent pregnancy. Although this is a viable option for many animal species, scientific interest in use by human subjects has recently declined

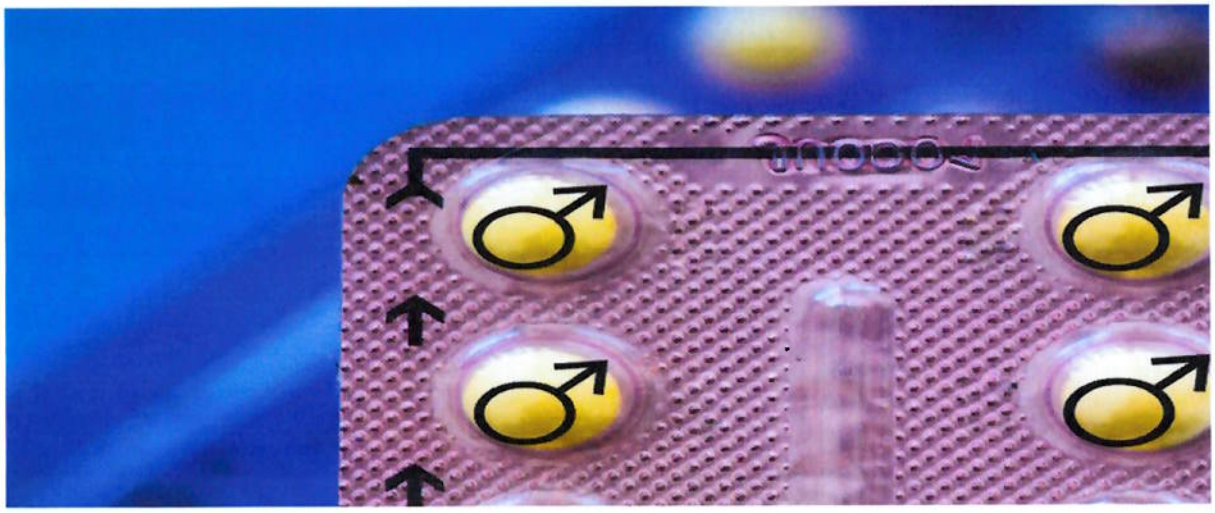
because research does not show a reliable decrease in fertility among male subjects (Khourdaji et al, 2018).

Choices of male contraception methods have been for a long time limited to coitus interruptus, periodic abstinence, condom use or vasectomy. However, the above mentioned methods have been criticized to be irreversible and being inadequate. Furthermore, condoms are typically used in casual sexual encounters or the early stages of a relationship, and are often abandoned once a relationship becomes serious (van Wersch et al, 2012; Schneiderman, 2018). According to the Times Live newspaper released on the 25 of May 2018 by Admas Watkins, the idea of creating a male contraceptive has been around almost as long as the female contraceptive was adopted. Watkins further argued that from the study which was conducted in 2016, pregnancy rates fell (declined) for female partners of men who received the injections (Plana, 2017; Murdoc and Goldberg, 2014).

There are a number of new methods of male birth control namely, a pill, a gel, and a nonsurgical vasectomy. Men are being encouraged to control birth, but they are currently having limited options mentioned above which are vasectomy, use condoms, or try the dubious "pullout" method. This methods goes with disadvantages and limitations which can reduce usage. Condoms can be cumbersome, vasectomies require more surgery to reverse, and pulling out is, well, not exactly a reliable form of birth control. This has encouraged men to go for hormonal birth control pill. It has been reported that, male modern contraceptive search for the reliable method without or with minimal side-effects. A number of experts have been searching for a new male contraceptive for instance the recent stories about a sperm-suppressing pill out of the University of Washington. It has further been reported that there are a number of more promising products which are going through clinical trials. These are, a topical gel that blocks sperm production, followed by a hormonal pill contraceptive and a nonsurgical vasectomy (Plana, 2017; Murdoc and Goldberg, 2014).

2.5.2.1. THE MALE PILL

An oversee study has shown that a new birth control pill for men appears to be safe when used daily for a month, with hormone responses consistent with effective contraception. In the study conducted by the University of Washington early in 2018 by Professor Stephannie Page, many men reported to prefer a daily pill as a reversible contraception as opposed to injections or topical gel which are also emerging. It is likely that the uptake among men will at an initial stage be slow but seen to improve as it is normalized going forward. As Prof Page put "A change in the mindset will not occur overnight and as we know contraception has been as primarily the responsibility of the females for a very long time" (Schneiderman, 2018; Khourdaji et al 2018). The male pill which is taken once – daily, has been found to be safe in men, with hormone responses consistent with effective contraception. The new pill – dimethandrolone undecaroate or DMAU - appears to be safe when used daily for a month (Oberholzer, 2016). The pill suppresses the sperm production (Belluz, 2018; Dorman et al, 2018).

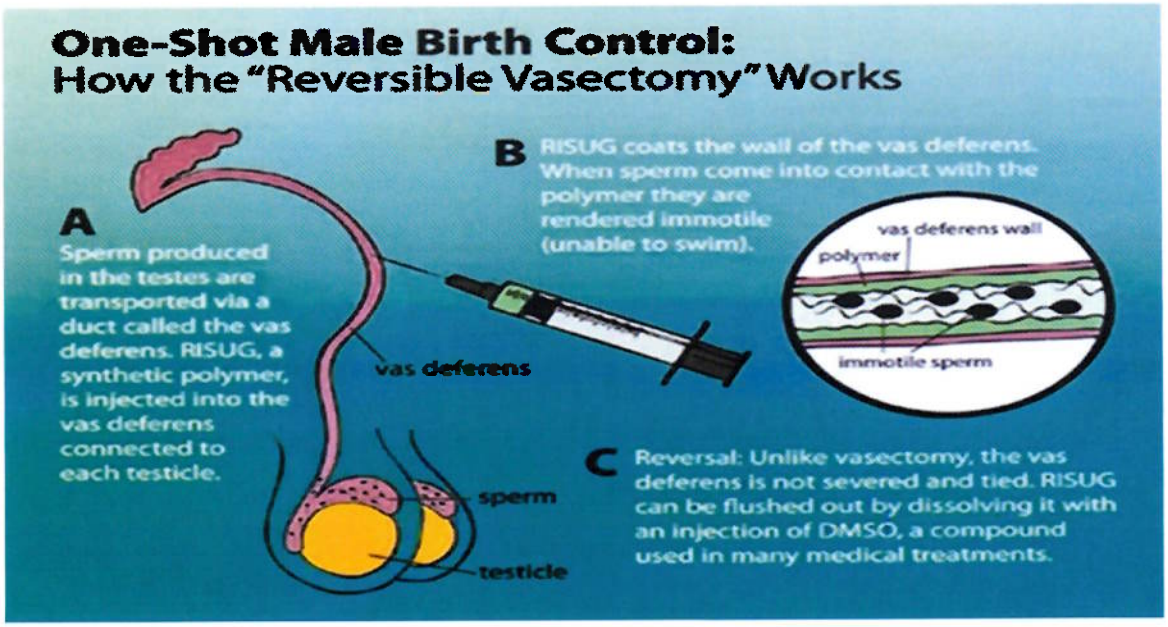


2.5.2.2. NONSURGICAL VASECTOMY

The nonsurgical vasectomy comes in a form of a gel which can be used in a number of ways that is a single –short or injection of a gel into the penis, and a gel applied in some parts of the body.

2.5.2.2.1. THE GEL

Another birth control type is Vasalge, it is a single – short non – hormonal male birth control. As reported by Elaine Lissner, the executive director of the Parsemus Foundation which is the organization which developed Vasalgel, they were planning to make the vasalgel to be available to men by the year 2018. According to College Candy, Vaslgel is a gel that is injected into the penis and blocks sperm from leaving the vas deferens. The gel is almost like a vasectomy but is only temporary and can be reversed unlike vasectomy (Oberholzer, 2016; Peloo, 2018; Belluz, 2018). The India institute of technology they developed the similar product which is a Non – surgical vasectomy named RISUG (Reversible Inhibition of Sperm Under Guidance).This gel involves injecting a polymer gel into the vas deferens to block sperm, rather than cutting or tying the vas. The treatment can be reversed with a shot that breaks down the gel. The procedure is 98% effective at preventing pregnancy (Plana, 2017; Murdoc and Goldberg, 2014).



There is also Nestorone – testosterone gel. This gel contains testerones and a progestin which is synthetic form of female sex hormone progesterone. The progestin in the gel which is meant to be applied to the arms and shoulders every day, works to shut down the gonadoteopin hormones responsible for stimulating testosterone production in the testes. And since sperm production is dependent on very high testosterone levels in the testes which is much higher than the

testosterone levels in the blood, shutting down the gonado lowers sperm production (Belluz, 2018; Dorman et al, 2018).

2.6. PSYCHOSOCIAL AND CULTURAL FACTORS DETERMINING THE USE ON NEW MALE CONTRACEPTIVES

2.6.1. ACCEPTABILITY

In a study conducted with specific focus of Scotland, China and South Africa by Anderson and Baird in van Wersch et al (2012), majority of females across the cultures generally expressed acceptance of male pill. The study further reported that males also agreed with and accepted the usefulness of a new method of male contraceptive. As reported further by van Wersch et al, (2012), in studies done in England, males in stable relationships were more than willing to accept the male pill than those in unstable or casual sexual relationships. Moreover, in a study done in Sweden, men were generally positive about the new male contraceptive pill. Young and single men are reported to be interested in controlling their own fertility too (Schneiderman, 2018).

2.6.2. TRUST

Trust has been reported as another psychosocial variable. The question is 'would women trust their partners to use a male pill efficiently, and would men trust themselves'. A smaller portion of women reported not to trust their partners in study done in Scotland, China and South Africa. However, in another study done by Eberhardt et al, (2000) in England, women reported less trust than men with

regards to the effective use of the male pill. The study further reported that men in stable relationships were more than likely to have high self – efficiency and more positive attitude towards the male pill.

2.6.3. FEAR OF SIDE EFFECTS

The possible side – effects of the male contraceptive pill has been found to potentially affect the acceptability and willingness to use (van Wersch, 2012). In another study by Brooks (1998), majority of men reported that they would not tolerate any side – effects around male pill. Van Wersch et al, (2012) further reported that mostly men who were unwilling or undecided regarding MHC were more likely to be concerned about potential effects of the male pill on future fertility (Khourdaji et al 2018).

2.6.4. PERCEPTIONS OF CONTRACEPTIVE RESPONSIBILITY

Accordingly, research into the use of the male contraceptive pill has been carried out since the 1970s, and hundreds of trials have been conducted in order to augment the pill's performance in terms of side – effects and risk factors, however there is still no commercially available male contraceptive pill. Though there is an increasing awareness that men should share contraceptive responsibility. Majority of men believe that they should be more responsible for contraception than they were before. It has also shown that a high proportion of men in both developed and developing countries are prepared to use a hormonal method once it is made available. As reported by van Wersch et al, (2012), in a study conducted by Galsier et al (2000) with a sample from Edinburgh, Shanghai, Hong Kong and Cape Town, the male pill may serve a significant purpose in Africa.

2.6.5. FEAR OF LOSING CONNOTATIONS OF MASCUILINITY

It is believed that men may not be enthusiastic about the use of male contraceptive pill because of its feminine association. Men feel that using a form of male contraceptive would threaten their masculinity (van Wersch et al, 2012).

2.7. THEORETICAL FRAMEWORK

The study under investigation is based on the Malthus theory of population growth. As argued by Agarwal (2018), the Malthusian theory of population is a theory of exponential population growth and arithmetic food supply growth. He wrote an essay on principles of population where he examined the relationship between population growth and resources and came up with the Malthusian theory. This theory will be supported with the neo-Malthusian theory. Neo – Malthusianism generally refers to people with the same basic concerns as Malthus. They advocate for population control programs to ensure resources for current and future populations. They however differ mainly in their enthusiasm for contraceptive techniques. The relevance of this theories is further be supported with the Second Demographic Transition and Gender revolution which both propose equal participation of both men and women in sexual and reproductive health. They are in favor of modern and postmodern health behavioral change. The framework is discussed below in relating the South African situation with specific focus of the North West Province.

2.7.1. MALTHUSIAN THEORY OF POPULATION GROWTH

His population is based on principles of population. Thomas Malthus theorized that population grew in geometric progression while food grew in arithmetic progression. This simply means population will grow faster than food production, which will lead to shortage of food supply if not controlled. The theory argued that because there will be higher population than the availability of food, many people will die from the shortage of food. Malthus based his theory first on the fact that food is necessary to the existence of man. And secondly to the fact that the passion between sexes is necessary and will remain nearly in its present state, hence population control. The reality about Malthusian theory/ trap is that as population increases, the world would not be able to sustain crop production to feed the ever – growing population. That is population in such a way that it overtakes the development of adequate land for crops.

The Malthusian trap also states that income gains per person through advancing technologies are lost through increased growth in population. Malthus observed that

the increase in population is first triggered by gains in food production which is referred to as catastrophe or crisis. However, as population rises it exceeds the limit where food production can support the entire population which is beyond its carrying capacity, resulting in food shortages. According to the theory, after the population increases exceeds food supplies, the result is a crisis. The crisis is called Malthusian crisis were famine, disease and low resistance to diseases occur which halt the population growth (Woodling, 2017).

Furthermore, it has been argued that the population trap is still relevant today. In industrialized countries the population growth have been stabilized or tapered off as a result of decreasing birth and death rates brought about by modern medicine. The condition is, if the development lifts poor people out of poverty, the least and less developed countries will see the largest consumer base growth in the world which has the potential to bring growth to economy everywhere. The fact is, they must escape the population trap first through provision of support to organizations, policies, programmes which build community wealth such as family planning programmes (Woodling, 2017).

According to Malthus there are two types of 'checks' that can reduce population growth rate. Preventive checks which are one of the checks talks about the voluntary actions which people can take in order to avoid contribution to the growth of population. In this Malthus included the moral restraint where people resist for instance the marriage and birth postponement until one is capable of supporting a family. Malthus also suggested positive checks which are referred to things which may shorten the average lifespan such as disease, warfare, famine, and poor living and working environments. As postulated these factors would eventually result in a Malthusian catastrophe, which is forced return of a population to basic survival (Woodling, 2017).

That being the case about Malthus, there are a number of criticism around His Principles of population growth. First it argued that Malthus did not foresee changes in the economy that changed the role of children in the industrialized societies. The argument further stated that, Malthus failed to account for improvements in technology which will in turn:

- Enable food production to increase at rates greater than arithmetic, often at rates exceeding those of population growth;
- Enable to access larger amounts of resources; and
- Enables different forms of production.

The challenge will be, being technologically advanced will affect the sustainability of the resources, the world we end up degraded as the land cannot be expanded or enlarged in order to accommodate the incontrollable growing population (Neumayer, 2006).

According to Neo – Malthusian theory of fertility change, some developing have grown beyond their carrying capacity due to high fertility which led to overpopulation. The challenge will then be, would these overpopulated countries be saved? The fact is, if they were to be saved the whole world will be affected. Even if they are to be rescued, it appears to be temporary. Tragically, provision of food of food to poor countries may lead to catastrophe of scarcely imaginable proportions, this can be broken by teaching people how to keep their fertility in check through advocating best family practices or control measures (Neumayer, 2006).

2.7.2. North West Province Today

Malthus relates population growth with food production. The questions which arise are that does this apply to the North West Province? Did we not take this into consideration in our development plans as a province? Why does it look like we are experiencing high population growth and unbalanced food production and provision of service delivery in general? It was reported by Merten in 2017 August in Daily

Maverick that more South Africans are slumping back into poverty as previous gains have been reversed since the year 2011. For South Africa in general, in 2015 there were about 30.4 million people living in poverty which is reported to be three million more than what was reported in 2011, and North West is no exceptional. Merten however raised a concern to government and policy makers about policies which are continuing to fail to bring about change in governance. It was reported by the NWDC (2017) that the percentage of people living in poverty was marginally higher than the national average at 44.5% in the last quarter of 2016/17. Furthermore, as reported by City Press in 2017 in analyzing the then Premier Supra Mahumapelo, there were about 1.66 million or estimated 475 000 households living in poverty in the province at the beginning of the year 2017.

The ideal situation is the balance between population and resources, which is optimum population. According to the justification of an optimum population, immediately when a geographical area finds itself having population which is more than the resources, the situation is overpopulation. Do we find ourselves as the province facing Malthusian Trap or have we been trapped, have we ever experienced the Malthusian crisis? In responding, this should be taken into consideration:

- Do we have enough agricultural space for food production?
- Are we technologically advanced (in terms of machinery, irrigation, fertilizers, and new types of crops) in order to enhance production for both consumption and profit making.

If this is not the case we are likely to be overpopulated. Malthus predicted outcomes such as food shortage, famines (starvation), war and epidemics as crises. This is likely to be the situation in the province. The society is fighting for poor service delivery; as mentioned earlier in this study there is still high number of people living under poverty line in the province; unemployment rate is still high; inequalities in opportunities and income in household remains high; the government budget deficit is overshooting due to significant shortfalls in tax revenue and high spending,

particularly in areas of debt costs, infrastructure, education, health and other core social programmes that benefit poor South Africans (Department of Finance, 2018). The population need to be fixed in accordance with available resources, this necessitate moral restraint on reproduction.

The point is that the population grew more than it is expected since the 1960s. In order to sustain that, agricultural resources had to be doubled if not tripled. Consumption demand also grew abnormally, this however coupled with high unemployment rate and high dependency ratio (58%) in the province, led to high demand in supply from government in terms of financial and social support for the poor. The province is challenged with demand for housing as a result of high population growth, with limited financial and land resources in this regard. The most difficult question is since the province seems to be trapped, how will it exit this trap? Are we missing the point? Over and above what the province has prioritized in order to realize better life for all through development plans which are aligned with the Sustainable Development Goals (SDGs) and National Development Plan 2030, there is a need to find the root cause. The main problem sit with the manner in which the population is growing in the province, are we putting effective measures to put the population growth under control? One of the starting point is to exit the trap through modernized ways of checking the population growth as recommended by Neo – Malthusian theory.

As Malthus pointed out, the passion between sexes will forever exist, the fact is if not checked we will experience high fertility since union and family formations are no longer for procreation but the other way round. That is marriage has lost its value therefore, age at sex is early with late age at marriage, high proportion single and single parenting outside formal unions. The neo – Malthusians asked whether reproduction is a right or privileged. They believed population growth to have impacts on the environment; they therefore supported family planning, contraception and abortion. They also believed that numbers should be linked with

level of consumption, hence optimization. This means we will have to abandon some free access to certain services. The only way freedom can be saved is by relinquishing the freedom to breed because it will ruin all the resources eventually. Therefore promotion and full access to family planning programmes becomes vital with equitable share of responsibility for both men and women.

As highlighted earlier in this study, the burden of contraceptives has been on women however the need for men to start taking a share has been acknowledge with no luck to find the relevant and suitable method for men. As emphasized, achieving universal coverage of contraceptive use becomes a challenge if men are excluded. Modern use of contraceptive by both men and women will lower fertility and stabilize population at the end. According to the Second Demographic Transition (SDT), lower fertility can be achieved through sustained sub – replacement fertility. It will take us decades to achieve sub – replacement fertility as a province, but we have to keep our house in order with the primary driver being shift from cultural towards postmodern attitudes and norms. The second revolution promoted the change in contraceptive practice. Besides, the SDT encourages change in decision making regarding family planning matters.

Change in family behavior therefore is key, that is, retreat from marriage which is increasing numbers of adult disrupts, delay, or avoid formal ties, either entering cohabiting relationships or living outside a partnership. Furthermore, childbearing and childrearing has been separated from marriage as alluded to earlier in this study. However, there is still high number of children born outside marriage. The use of contraceptives was high among women during gender revolution when women emerged out of the home and entered the public sphere due to commitment in labour force participation. (Zaidi and Morgan, 2017). Most importantly, the second half of the gender revolution talks about increased involvement of men in the private sphere of home and family which include taking a responsibility of preventing birth (Goldschider et al, 2015).

2.8. CONCLUSION

The study discussed knowledge usage and attitudes of contraceptives in general with a global view and then narrow it to the country. Then male contraceptive and its determinants with regard to knowledge, accessibility, attitude and practice. Theories related to male contraceptives and behavioral change are also discussed. Achieving universal coverage of contraceptives is very important, it has been discovered in the literature that it is still a challenge. The upcoming chapter therefore analyses the collected data in order to respond to the study research question.

3. CHAPTER 3: RESEARCH METHODS

3.1. INTRODUCTION

Literature and theories related to male contraceptives has been reviewed in the previous chapter. The current chapter present research methods applied in this study. These include the research approach, sample size and sampling design, data analysis and ethical considerations.

3.2. DATA SOURCE AND METHODS

The study employed triangulation research approach which incorporates both using both quantitative and Qualitative method of research. Both methods are important in this study as the area seems to have been overlooked hence the existence of gap in literature which needs to be closed. Quantitative part of the research approach addresses quantifiable part which is needed for measureable indicators, while qualitative approach has been used to collect awareness, knowledge and attitudes with regard to male modern contraceptives in the Bojanala district in the North West province (De Vos et al, 2005; Goddard and Melville, 2001).

3.3. TARGET POPULATION

The study focused on the sexually active men aged between 15 and 64 years residing in the Madibeng local municipality in the Bojanala District Municipality.

3.4. THE SAMPLE SIZE DETERMINATION

Sampling frame was drawn from the latest data set administered by the statistics South Africa which in this case is Census 2011 (De Vos et al, 2005). As per the 2011 Census, Bojanala has a total of 560 683 males 15 to 64 years while Madibeng local municipality has a total of 181 016 male population aged 15 to 64 years. A sample determination table was used to determine the sample size for this study. According to the sample determination table for simple random sampling, a population comprising of a total of 100 000 and above afford a sample size of 400 at 95% confidence interval of margin of error. (Krejcie and Morgan, 1970; Bartlett et al, 2001). However, in cluster sampling it is a requirement to multiply the sample size further with the design effect. In statistics, the design effect or the estimates of unit of variance, is an adjustment which is used in some studies. In this study the design effect is used since the study used cluster sampling when selecting the wards and

the sample was later distributed proportionally into those wards. It is used to allow for the design structure. The respondents in the same cluster are likely to be somewhat similar to one another. The adjustment inflates the variance of parameter estimates, and therefore their standard errors, which is necessary to allow for correlations among clusters of observations. This accounts for the loss of information inherent in the clustered design (Bartlett et al, 2001). The design effect for this study was calculated with the use of the following method:

DEFF = $1 + \delta(n - 1)$ (Shackman, 2001) *where*

DEFF is the design effect

δ is the interclass correlation for static in question, for this study it is 1,and

n is the average size of the cluster, for the purpose of this study the average size was estimated to be 0.18

Therefore, DEFF = 1 + 1 (0.18 – 1)

DEFF = 0.18

Then sample size was further multiplied by DEFF = 400 X 0.18 = 72 and then added to 400= 472. Therefore the sample size was estimated to be 472.

3.5. SAMPLING DESIGN

The study applied probability sampling techniques in order to identify males aged between 15 and 64 years. There are 41 wards in the Madibeng local municipality in total. There was a need to take a number of stages in sampling due to a number of geographical levels the country has, thereby using a multistage sampling technique. At the first stage, the study sampled wards. Statistically, a 10% sample is statistically relevant, however, for this study a 20% sample of the wards was randomly selected making a total of 8 wards. Selected wards are wards 33, 38, 02, 07,12,17,22, and 27. A systematic random sampling was applied to identify the above listed wards where the interval was calculated. The systematic random sampling technique uses the intervals (K^{th} letter) which uses the total population and the determined sample size to calculate the interval. At ward level, 41 (total wards)/ 8 (sample size - 8 wards) = 5 wards. This means from the starting point each and

every 5th ward was selected. Ward 33 was therefore selected as the starting point with the use of lottery method which is one of the commonly used simple random sampling technique.

The sample size was then proportionally distributed to the selected wards. That is, they were equitably shared whereby the sample was distributed in correspondence with the weight in which wards share to the total population. However, there are wards which are comprised of more than one sub – area or village, in this case the ward sample was equitably shared among those sub – areas. Sub – frames were thereby determined in this regard. After allocation in the wards has been done, the households were randomly selected with the use of systematic random sampling technique. Sampling frames of households in each ward was then developed. This was only applied in those wards were using the total population of each selected ward with the sample size allocated to them. At household level, in cases where there are more than one male aged between 15 and 64 years, a simple random sampling technique complemented with the discretion of a data collector was employed to identify eligible candidates with this regard (Bless and Higson-Smith, 2000; De Vos et al, 2005; Bellhouse, 2014).

Table 3.1: Sample distribution.

WARD	TOTAL MALES	MALES 15 – 64 YRS	SAMPLE ALLOCATION
Ward 33	4812	3033	47
Ward 38	5160	3606	32
Ward 02	5414	3558	42
Ward 07	7422	5368	73
Ward 12	5942	4345	90
Ward 17	7806	6269	96
Ward 22	4740	3616	38
Ward 27	7038	4415	55
Total	48333	34211	473

3.6. METHOD OF DATA COLLECTION

3.6.1. Data Collection Procedure

The study was based on the primary source of data which allows the researcher to collect data specifically for the current study. The study used face to face interview as a data collection instrument. A pre – coded structured questionnaire was then applied to collect both qualitative and quantitative data for the study. The structured questionnaire is the commonly used method of data collection in cross- sectional studies. The questionnaire covered both open – ended and closed – ended questions. The open – ended questions collected qualitative information with respect to the attitudes, perceptions and views about male contraceptives while the closed ended collected quantitative data (Bless and Higson-Smith, 2000; De Vos et al, 2005).

3.7. DATA ANALYSIS

3.7.1. Selection of Study Variables

3.7.1.1. Dependent Variables

There are two depended variables, the first is beliefs, perceptions, attitudes and knowledge of male modern contraceptive and second one is usage of male modern contraceptives.

3.7.1.2. Independent Variables

Independent variables include the demographic and socioeconomic characteristics of respondents.

3.7.2. Analytical techniques

Analysis in this study was mainly descriptive, done at two levels of analysis which are univariate and bivariate levels. At univariate level, the study described the demographic and socio - economic attributes of participants. Secondly, the bivariate analysis in which the dependent variable and independent variables were compared, with the use of cross tabulation and chi – square techniques. This was done in order to test the relationship between dependent and independent variables and their level of significant. Data is presented in a tabular and graphical format.

3.8. ETHICAL CONSIDERATION

Data in this study was collected from human beings who required the application of ethical principles during the process of data collection. In this regard, respondents were well informed about their voluntary participation and were assured of their confidentiality. Prior to the interview, participants read, understood and signed the informed consent agreement. In the consent forms, the study aimed at ensuring that every respondents has confidentiality guaranteed, permission to have him or her participating in the study is granted, voluntary withdraw during and before the interviews is understood, data protection assurance and non-disclosure agreement that the information is to be solely used for the research is also cleared (Saunders, 2009; De Vos et al, 2005).

3.9. DATA QUALITY

3.9.1. Validity and Reliability

The study insured that data quality is maintained by ensuring that data was collected by experienced data collectors and close supervision is provided during data collection. The questionnaire was pre – tested in order to test the appropriateness, the duration of the questionnaire, and also to identify any potential problems with the questionnaire design. With that being done, the results were used to improve the quality, internal consistency, its reliability and validity (Saunders, 2009; De Vos et al, 2005; Creswell, 1994).

3.10. LIMITATIONS OF THE STUDY

One of the limitations is the fact that the study used the 2011 census data to sample based on the fact that it is the latest census conducted in the country. The study could have used the most recent data sets such as the 2016 Community Survey, statistically a sample cannot be designed from a sampled data.

4. CHAPTER 4: FINDINGS

4.1. INTRODUCTION

The previous chapter focused on the methods of research applied in the current study. The current chapter present the findings of the study. As indicated in the previous chapter, analysis in this study was done at both univariate and bivariate level of analysis. The first part of the study discusses the socio – demographic characteristics of the respondents. The second part looks at knowledge and involvement of men in family planning. The third part discusses knowledge, access, usage, belief of male modern contraceptives. The fourth part then discusses the reproductive characteristics of males. The last part examine the relationship between knowledge, usage, attitudes, beliefs and access against the socio – demographic characteristics of male males aged 15 and 64 years residing in Madibeng Local Municipality. The study analyses a sample of 473 males aged between 15 and 64 years residing in Madibeng Local municipality in the Bojanala District municipality in the North West Province.

4.2. SOCIO DEMOGRAPHIC CHARACTERISTICS OF MALES AGED 15 – 64 IN MADIBENG LOCAL MUNICIPALITY.

Table 4.1 below present socio – demographic characteristics of men aged 15 – 64 in Madibeng by socio – demographic characteristics. As outlined in chapter 3, sample size was distribution proportionally to the selected wards. Based on those proportions, majority of respondents were found to be in Ward 17 (Mmakau) and Ward 12 (Letlhabile) accounting for 20.3% and 19.0% respectively. This was followed by Ward 7 (Majakaneng) with 15.4% and then ward 27 (Mamba) with 11.6%. The least were found to be Wards 38, 22, 2 and 33 accounting for 6.8%, 8.0%, 8.9% and 9.9% respectively. This means most of males aged between 15 and 64 years are found in wards 17 and 12.

4.2.1. AGE

Table 4.1 below also present distribution of respondents by age groups. Accordingly, majoring of respondents were aged between 20 and 39 years, with 19.1% from age group 25 – 29, followed by 18.0% of age group 20 – 24, 16.7% of age group 30 –

34 and 10.8% from age group 35 – 39. As expected the higher age groups were less represented in the study with age group 50 – 54 being the least at 3.2.

4.2.2. HIGHEST EDUCATIONAL LEVEL

Respondents were also asked to indicate their level of education which is very important in assessing one's knowledge and awareness and it has been used as one of the indicators in many studies with regards to knowledge and usage of contraceptives globally. That is, the higher the education the more the chances of knowledge and usage. As shown in table 4.1 below, majority of respondents reported secondary level with grade ranging between 9 and 12 as their highest level of education accounting for 58.1% followed by grades 6 – 8 with 15.9%. The least being other qualification, post graduate qualification and bachelor's degree with 0.4%, 0.6% and 1.7% respectively.

4.2.3. MARITAL STATUS

Presented in table 4.1 is also marital status of study population. Most respondents where single that is never married accounting for 53.8% followed by those single but living with their partners with 22.0%. Those married and living with their partners reported 15.5% while married and separated from partners was 3.6%. The lower numbers of married respondents is a true reflection of the country and the province. This might be due to the number of single and living with partners has been increasing lately due to the fact that marriage has lost its value.

Table 4.1: Demographic characteristics of males aged 15 – 64 in Madibeng Local Municipality.

SOCIO DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS		
VARIABLE	FREQUENCY	PERCENTAGES
WARD		
Ward 02 - Jericho	42	8.9
Ward 17 – Mmakau	96	20.3
Ward 33 - Zandfontein	47	9.9
Ward 22 - Oukasie	38	8.0
Ward 07 - Majakaneng	73	15.4
Ward 27 - Mamba	55	11.6
Ward 12 - Letlhabile	90	19.0
Ward 38 - Broedersdrom/Oskraal	32	6.8
Total	473	100.0
AGE		

15 -19	26	5.5
20 -24	85	18.0
25 -29	90	19.1
30 - 34	79	16.7
35 - 39	51	10.8
40 - 44	44	9.3
45 - 49	35	7.4
50 - 54	15	3.2
55 - 59	23	4.9
60-64	24	5.1
Total	472	100.0
HIGHEST EDUCATIONAL LEVEL		
None	31	6.6
Grade 1 - 5	22	4.7
Grade 6 - 8	75	15.9
Grade 9 - 12	274	58.1
Technical Education	31	6.6
Diploma	26	5.5
Degree	8	1.7
Post Degree	3	0.6
Other	2	0.4
Total	472	100.0
MARITAL STATUS		
Single, that is never married	254	53.8
Single, living with partner	104	22.0
Married and living with wife	73	15.5
A civil partner in a legally	7	1.5
parnership	17	3.6
Married & separated from your wife	10	2.1
Divorced	7	1.5
Widowed	472	100.0
Total		

4.2.4. EMPLOYMENT STATUS

South African unemployment rate has been reported to be 27, 1% (StatsSA, 2018). As indicated in table 4.2 below, majority of respondents were found to be unemployed accounting for 52.2% followed by 26.8% of those employed and then 10.1% of those who were self-employed at the time of the survey.

4.2.5. MONTLHY INCOME

Respondents reported their monthly income, as indicated in table 4.2 below majority of respondents were reported to be earning between R3 201 and R6 400 accounting for 10.4% followed by those earning between R801 and R 1 600 with 8.2% and then those earning R1 600 and R3 200 with 8.0%.

Table 4.2: Socio-economic characteristics of males aged 15 – 64 in Madibeng Local Municipality.

SOCIO-ECONOMIC CHARACTERISTICS OF RESPONDENTS		
VARIABLE	**FREQUENCY**	**PERCENTAGES**
EMPLOYMENT STATUS		
Unemployed	247	52.2
Employed	127	26.8
Self - employed/own business	48	10.1
Looking for employment	32	6.8
Tired of looking for employment	4	0.8
Other	15	3.2
Total		100.0
MONTLHY INCOME		
No Income	217	45.9
R1 - R400	21	4.4
R401 - R800	17	3.6
R801 - R1 600	39	8.2
R1 601 - R3 200	38	8.0
R3 201 - R6 400	49	10.4
R6 401 - R 12 800	32	6.8
R12 801 - R25 600	20	4.2
R25 601 - R51 200	6	1.3
R102 401 - R204 800	3	0.6
R204 801 Or More	8	1.7
Unspecified	23	4.9
Total	473	100.0

4.3. KNOWLEDGE AND INVOLVEMENT OF MEN IN FAMILY PLANNING

Knowledge and use of family planning methods is very important as it can contribute to a substantial reduction in fertility and unwanted pregnancies. It has been reported that knowledge of family planning services has been increasing worldwide. Low involvement of males in family planning services has been reported to be one of the factors hampering the use of family planning services in most countries. Lack of knowledge of where to obtain the family planning services has been reported to be one of the barriers of family planning services use in most of the sub – Saharan Countries.

Table 4.3: Percentage distribution of respondents by knowledge and involvement of men in family planning

KNOWLEDGE AND INVOLVEMENT OF MEN IN FAMILY PLANNING		
VARIABLE	**FREQUENCY**	**PERCENTAGES**
KNOWLEDGE OF FAMILY PLANNING		
Yes	302	63.8
No	131	27.7
Not Sure	40	8.5
Total	473	100.0
INVOLVEMENT OF MEN IN FAMILY PLANNING DECISION MAKING		
Yes	188	49.9
No	143	37.9
Sometimes	46	12.2
Total	377	100.0
DISCUSSION OF FAMILY PLANNING ISSUES WITH ONES PARTNERS OR SPOUSE.		
Yes	216	56.4
No	103	26.9
Sometimes	64	16.7
Total	383	100.0

4.3.1. KNOWLEDGE OF FAMILY PLANNING

To assess knowledge of family planning, men were asked if they had ever heard of family planning. About 473 men responded to this question, the table indicates that majority (63.8%) of the respondents in this study have intense knowledge about family planning while 27.7% confirmed that they have no knowledge of family planning. About 8.5% of respondents mentioned that they not sure if they have knowledge of family planning. This can be aligned to the study which was conducted in Zimbabwe in 1991 among men which reported the highest prevalence of knowledge of family planning methods (Mbizvo & Adamchak, 1991).

4.3.2. INVOLVEMENT OF MEN IN FAMILY PLANNING DECISION MAKING

Respondents were further asked whether they are involved in family planning decision making. As presented in table 4.3 above 49.9% of men were involved in family planning decision making in marriage or relationship. About 37.9% of participants mentioned that they were not involved in family planning decision making in their marriage or relationship while 12.2% mentioned that they were sometimes involved. This can be related to a study which was conducted long time around 1991 in Zimbabwe among men which found out that all men in the study were involved in family planning decisions in their relationships (Mbizvo & Adamchak, 1991).

4.3.3. DISCUSSION OF FAMILY PLANNING ISSUES WITH ONES PARTNERS OR SPOUSE

Respondents were also asked whether they discuss family planning issues with their partners or spouse. It came out clear from the results that most men accounting for 45.7% discuss family planning issues with their partner or spouse while 21.8% of men mentioned that they do not discuss and 13.5% mentioned that they sometimes discuss their family planning issues with their partners or spouse.

4.4. KNOWLEDGE, SOURCE OF INFORMATION, USAGE AND PREFERRED METHOD OF CONTRACEPTIVES

Couples have an option to use contraceptive methods to limit or space the number of children they desire to have. Percentage distribution of respondents by knowledge of contraceptives; source of information regarding contraceptives; frequency of usage of contraceptives and preferred method of contraceptives is presented in table 4.4 below.

4.4.1. KNOWLWDGE OF MALE CONTRACEPTIVE

Respondents were asked whether they know about male contraceptives. As presented in table 4.4 below out of 471 males residing in Madibeng, 62.4 indicated that they have heard of male contraceptives as compared to 31.2% of those who reported to have never heard about male contraceptives. The Madibeng local municipality is on the right direction as majority of males have knowledge of contraceptives. If all the awareness campaign programmes target the relevant audiences, the local municipality will eventually achieve the almost universal knowledge reported for the South African country for both men and women.

4.4.2. SOURCE OF KNOWLEDGE OF MALE CONTRACEPTIVES

Presented in table 4.4 below is the source of information about the male modern contraceptives, here only 350 respondents responded. Majority of respondents reported that they have heard about male contraceptives from either the radio or media accounting for 50.3% followed by those who heard from a friend and clinic/hospital with 19.4% and 18.3% respectively. The least source of information about male contraceptives was reported to be from pamphlets, flyers and brochures accounting for 3.4%. Most researchers found clinic and hospitals to be the most

preffered and trusted source of information about contraceptives and/or family planning services (Alege, et al, 2016).

4.4.3. CURRENT USAGE OF CONTRACEPTIVES BY PARTNERS

Madibeng male respondents were also asked to provide information regarding the current usage of contraceptives by partners, a total of 466 males responded. Table 4.4 below shows that 63.7% of partners were currently using any form of contraceptives followed by alarming total of about 30% who reported that they were not using any contraceptives at the time of the survey. Furthermore, only around 5.8% were not sure of using any form of contraceptives.

4.4.4. FREQUENCY OF USE OF CONTRACEPTIVES

Respondents were asked about the frequency of use of contraceptives and a total of 465 out of 473 responded. As presented in table 4.4 below, about 64.7% of responded were using contraceptive during at the time of the survey followed by 20.0% of those whom were not using any method of contraceptive and then 15% of those who confirmed that they use contraceptive sometimes

Table 4.4: Percentage distribution of respondents by knowledge, source of information, usage and frequency of use of any method of contraceptives.

Variable	Frequency	Percent
KNOWLEDGE OF CONTRACEPTIVES		
Yes	294	62.4
No	147	31.2
Not sure	30	6.4
Total	471	100.0
SOURCE OF KNOWLEDGE OF CONTRACEPTIVES		
Radio/Media	176	50.3
From a friend	68	19.4
Clinic/hospital	64	18.3
Pamphlet/flyers/ brochure	12	3.4
Other	30	8.6
Total	350	100.0
CURRENT USE OF ANY METHOD OF CONTRACEPTIVES BY COUPLES		
Yes	297	63.7
No	142	30.5
Not sure	27	5.8
Total	466	100.0
FREQUENCY OF USE OF CONTRACEPTIVES		
Yes	301	64.7
no	93	20.0
Sometimes	71	15.3
Total	465	100.0

4.5. CONTRACEPTIVE PREFERENCE AND THE CURRENT METHOD USED

4.5.1. PREFERRED METHOD OF CONTRACEPTIVES

Male respondents from Madibeng were also asked about the method of contraceptive they prefer, only 369 responded to this question. Unlike women, majority of the respondents preferred the male and female condoms accounting for 79.95, while others preferred oral contraceptive, sterilization, withdrawal and injectable with 6.0%, 3.3%, 2.7% and 2.2% respectively. The rest were less preferred by respondents. In most cases women would prefer injectable and oral contraceptives than men (Alege et al, 2016).

4.5.2. CURRENT USE OF CONTRACEPTIVE BY TYPE

As presented in table 4.5 below, only 315 males in the study area respondent to the question about the type of contraceptive they were currently using at the time of the survey. Majority of respondents were using condoms accounting for 78.7% followed by 7.0% and 5.1% of those who were using oral contraceptives and injectable respectively at the time of the survey. The prevalence of contraceptive use in this study is not far from what other studies have found, for instance, a study conducted by Alege et al. (2016) in Uganda reported about 62.2% of current use of contraceptive among women aged 15 – 49 years.

Table 4.5: percentage distribution of respondents by contraceptive preference and the current method used

Contraceptive Type	Preferred Type		Current use by Type	
	Frequency	Percentage	Frequency	Percentage
Sterilization (Male and female)	12	3.3	11	3.5
IUD and systems	3	0.8	3	1.0
Sub dermal implants	7	1.9	5	1.6
Oral contraceptives	22	6.0	22	7.0
Condoms (males and females)	295	79.9	248	78.7
Injectable	8	2.2	16	5.1
Emergency contraceptive pills	4	1.1	3	1.0
Spermicide agents	1	0.3	1	0.3
Fertility awareness approaches	2	0.5	4	1.3
Withdrawal	10	2.7	2	0.6
Abstinence	5	1.4	0	0
Total	369	100.0	315	100.0

4.6. BELIEVES, ATTITUDES, SPOUSAL SUPPORT AND REASON FOR USE OF CONTRACEPTIVES

Respondents were asked their views, beliefs and attitude towards contraceptives in general. Males from Madibeng local municipality were asked their belief about contraceptives and its impact on sexual performance. As indicated in table 4.6, majority of respondents' belief they still enjoy sex despite the fact that they are contraceptives accounting for 48.5% followed by those who believed that they could not feel anything. This indicated that majority of respondents perceived the use of contraceptives not to have effect on their sexual performance. Those who had a negative perception about contraceptive use and sexual performance were less with those who believed using contraceptives was against their belief and those who believed it pinches them accounting for 10.1% and 5.9% respectively. However, a total of 13.4% had other beliefs about contraceptive use and sexual performance accounted for 13.4%.

Respondents were also asked their views about contraceptive use safety, all males responded to this question. As indicated in table 4.6 below, most respondents perceived the use of contraceptives to be safe accounting for 74.7% whilst 13.4% were not sure about its safety. Only a total of 11.9% perceived the use of contraceptives not to be safe.

Table 4.6: Percentage distribution of respondents by believes, attitudes, spousal support and reason for use of contraceptives

Variable	Frequency	Percentage
Beliefs about contraceptives and its impact on performance during sexual intercourse.		
I enjoy it	221	48.5
It pinches me	27	5.9
It is against my belief	46	10.1
I can't feel it	101	22.1
Other	61	13.4
Total	456	100.0
Perceived safety of contraceptive usage		
Yes	352	74.7
No	56	11.9
Not sure	63	13.4
Total	471	100.0

Spousal support regarding the use of contraceptives		
Yes	258	54.8
No	135	28.7
Sometimes	78	16.6
Total	471	100.0
Reasons for the current use of contraceptives method		
Birth - spacing	99	31.4
Limiting birth	163	51.7
Other (specify)	53	16.8
Total	315	100.0
Places where contraceptives can be accessed		
Clinics/ hospitals	238	74.6
Doctors	13	4.1
Pharmacy	29	9.1
Shops	30	9.4
Other	9	2.8
Total	319	100.0
Satisfaction of provision of contraceptives		
Yes	247	76.9
No	44	13.7
Not sure	30	9.3
Total	321	100.0

4.6.1. SPOUSAL SUPPORT REGARDING THE USE OF CONTRACEPTIVE METHODS.

Respondents were asked whether they get encouragement to use any form of contraceptives from their partners. Mostly reported to have been encouraged to use contraceptives by their partenrs accounting for 54.8% follwed by those who never got support from their partners with 28.7%. Furthermore, only 16.6% of respondents reported to get support from their partners sometimes.

4.6.2. REASONS FOR USE OF CONTRACEPTIVES

As indicated in tabe 4.6 above, majority of respondents with 51.7% reported to use contraceptives to limit birth follwed by those who used contraceptives for birth – spacing with 31.4%. Alongside, 16.8% of respondents reported to use contraceptives for other reasons which were not specified.

4.6.3. PROVISION OF CONTRACEPTIVES

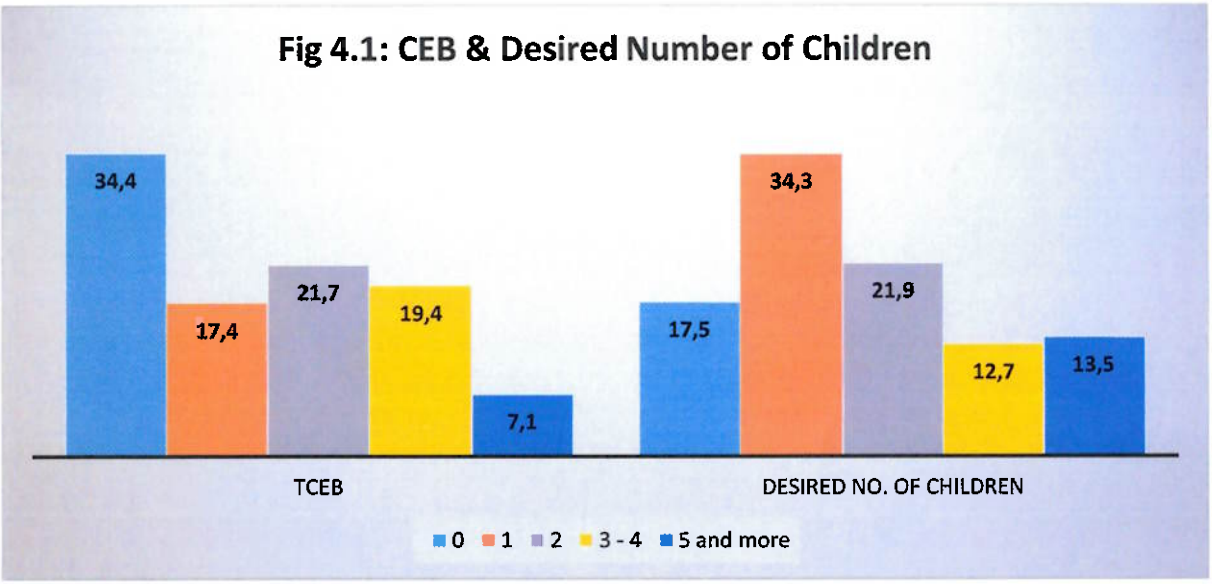
Males in the study were also asked to indicate places where they get their contraceptives from, and clinics and hospitals came out to be the most reported source with a total of 74.6% followed by pharmacies and shops accounting for

9.1% and 9.4% respectively. Doctors as a source of access to contraceptives reported only 4.1% while other sources reported a minimal percentage of 2.8. Respondents were also asked whether they are satisfied with the provision of contraceptives in heir area, a total of 76.9 reported that they were satisfied. On the other hand, about 13.7% reported that they were not satisfied whilst 9.3% were not sure whether they were satisfied with the provision of contraceptives in their area.

4.7. REPRODUCTIVE BAHAVIOUR

Figure 4.1 below present percentage distribution of respondents by total number of children ever born and the desired number of children. It is clear that, majority of males in Madibeng local municipality had never given birth to a live child accounting for 34.4%. For those who reported to have given birth to children, mostly had 2 kids at 21.7% followed by those who had 3 with 19.4% and those whi had one child at 17.4%. Only 7.1% reported a total of 5 and more children ever been born at the time of the survey. As for desired number of children, mostly desired to have a total of one child accounting for 34.3% followed by those desiring a total of two children with 21.9%. Interestingly, about 17.5% of respondents desired not to have children in the study.

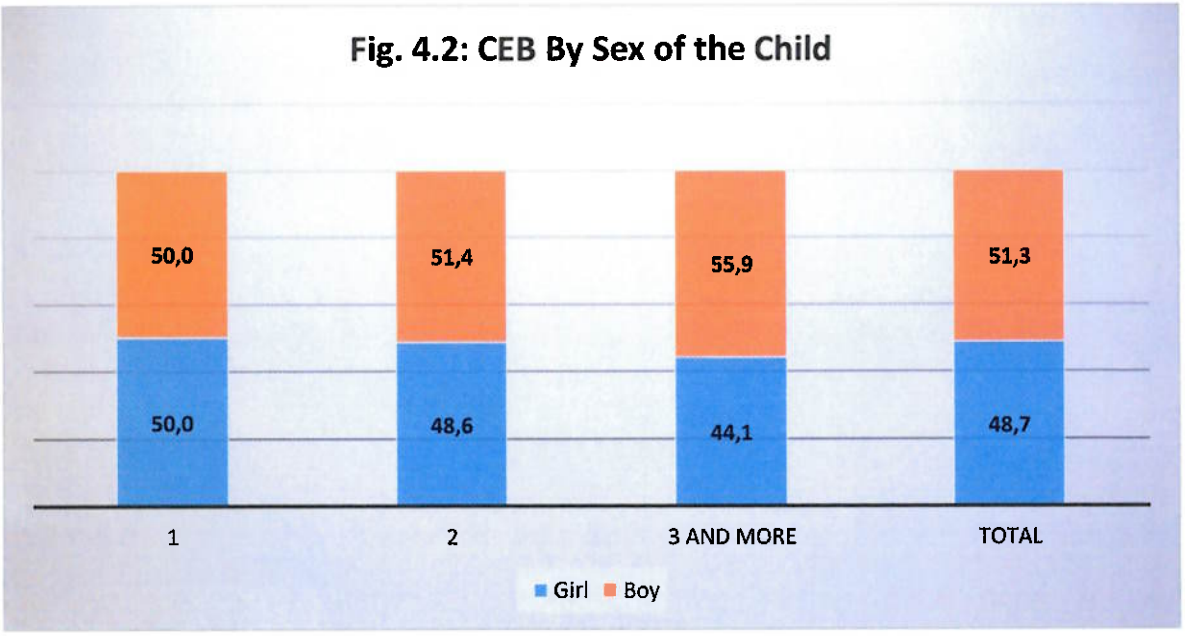
Fig 4.1: CEB & Desired Number of Children



4.7.1. TOTAL CHILDREN EVER BORN BY SEX OF THE CHILD

Figure 4.2 below present total number of children by sex of the child. Accordingly, for males who reported a total one child at the time of the survey both accounted

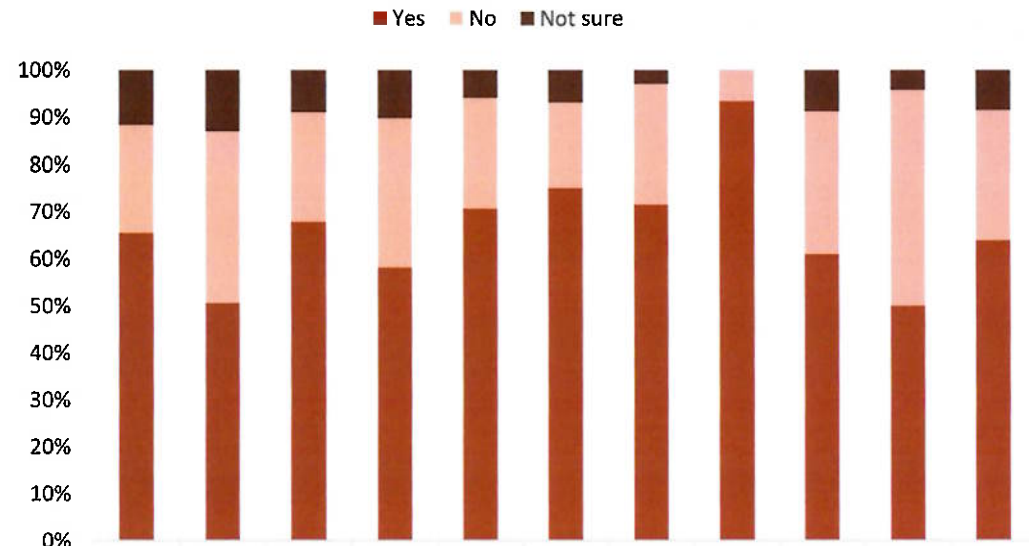
for 50% each. As for those who reported a total of two children, majority were boys with 51.4% whilst those who reported a total of 3 and more were still boys at 55.9%. Generally, majority of responded had boys accounting for 51.3% at the time of the survey.



4.8. KNOWLEDGE OF FAMILY PLANNING BY AGE

Figure 4.3 below present percentage distribution of respondents by knowledge of family planning and age. As reported in figure 4.3, majority of respondents had knowledge about family planning accounting for 63.8% followed by 27.8% of those who had no knowledge of family planning whilst 8.5% of respondents reported that they are not sure whether they have knowledge about family planning or not. Looking at knowledge of family planning by age, males aged 50 – 54 reported higher proportion of knowledge followed by those aged 40 – 44 accounting for 93.3% and 75.0% respectively. However, when looking to age group specifically, for all the age groups mostly had knowledge of family planning reporting more than 50% knowledge. Surprisingly, male aged 20 – 24 reported exactly 50.6% knowledge, at this age the expectation is to have more knowledge about contraceptives.

Fig 4.3: Knowledge of Family Planning by Age

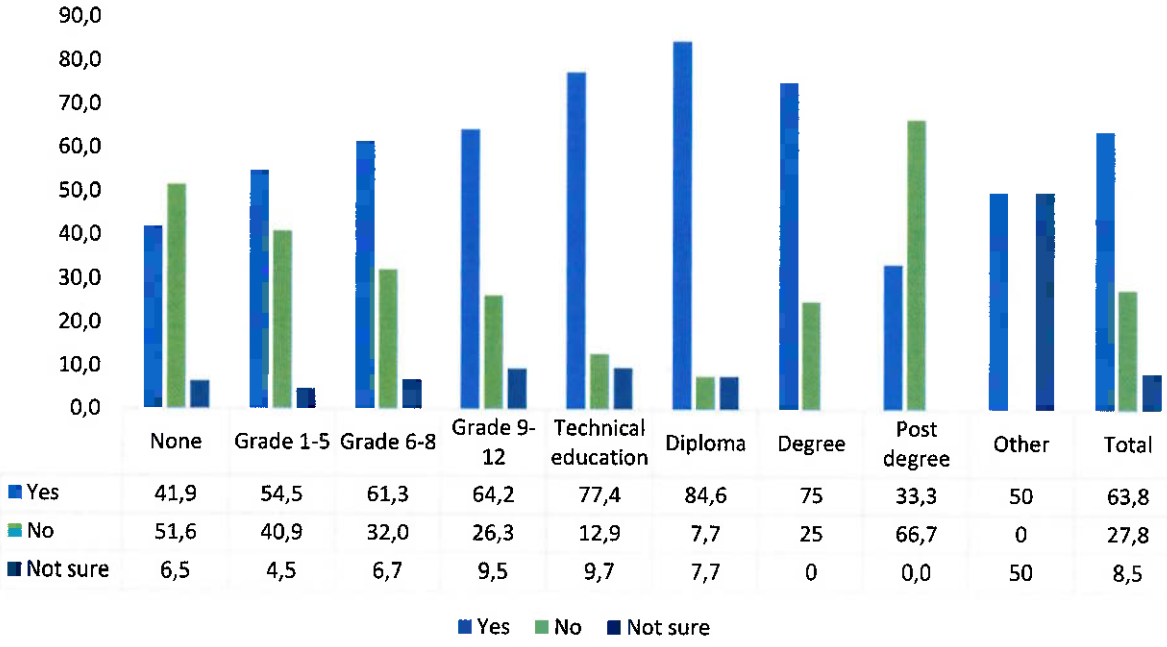


	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	Total
Not sure	11,5	12,9	8,9	10,1	5,9	6,8	2,9	0,0	8,7	4,2	8,5
No	23,1	36,5	23,3	31,6	23,5	18,2	25,7	6,7	30,4	45,8	27,8
Yes	65,4	50,6	67,8	58,2	70,6	75,0	71,4	93,3	60,9	50,0	63,8

4.9. KNOWLEDGE OF FAMILY PLANNING BY HIGHEST LEVEL OF EDUCATION

Figure 4.4 below present percentage distribution of respondents by knowledge of family planning and highest educational level. Education has been found by other studies to be the most contributing factor to contraceptive knowledge, use and attitude (Bietsch, 2015; Amu et al, 2017). Accordingly, findings in figure 4.4 below reveals that the higher the education the more the knowledge. Men with higher levels of education reported higher proportions of knowledge of family planning services with those with diploma, technical education, degree, and grade 9 – 12 reporting 84, 6%, 77, 4% and 64, 2% respectively. Shockingly, males with post degree level of education reported the highest level of no knowledge of family planning services accounting for 66.7%. As expected, ,most males with lower level of education reported no knowledge of family planning services with those with no education reporting 51,6% and those with grade 1 – 5 reporting 40,9%.

Fig 4.4: Knowledge of Family Planning by Educational Level

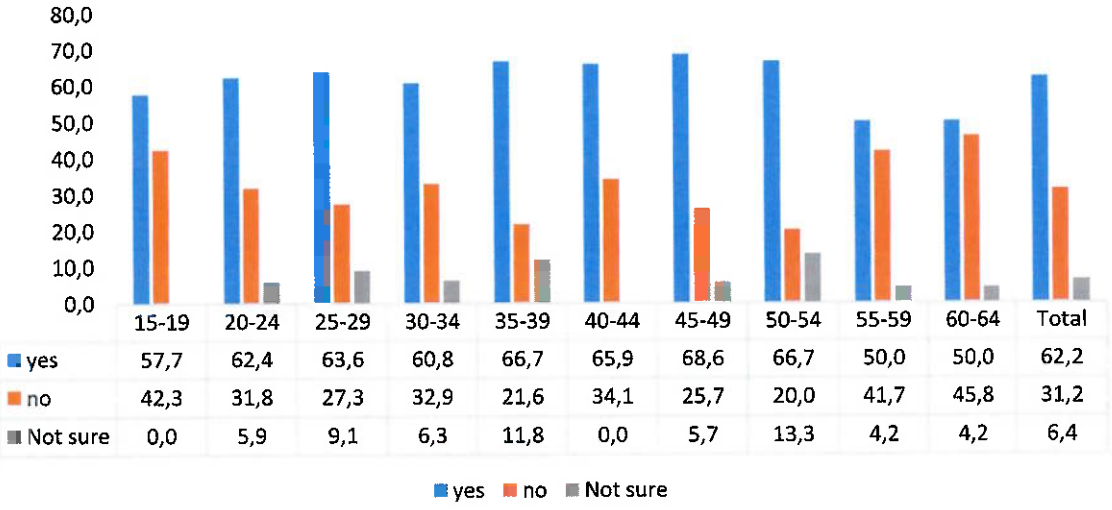


	None	Grade 1-5	Grade 6-8	Grade 9-12	Technical education	Diploma	Degree	Post degree	Other	Total
Yes	41,9	54,5	61,3	64,2	77,4	84,6	75	33,3	50	63,8
No	51,6	40,9	32,0	26,3	12,9	7,7	25	66,7	0	27,8
Not sure	6,5	4,5	6,7	9,5	9,7	7,7	0	0,0	50	8,5

4.10. KNOWLEDGE OF MALE CONTRACEPTIVES BY AGE

Age has been found to be the most determinant of knowledge of contraceptives. As indicated in figure 4.5 below at 60% average for age groups men reported knowledge of male contraceptive with age 55 – 59 and 60 – 63 years reporting a lower proportion of 50% each. A highlight is noticeable for age group 45 – 49 years where majority of respondents in that age group reported to have ever heard of male contraceptive accounting for 68, 6% as compared to 25, 7% of those who had no knowledge and 5,7% of those who reported not to be sure of whether they had knowledge or not. Generally, knowledge of male contraceptives was found to be higher in this study.

Fig 4.5: Knowledge of Male Contraceptives by Age

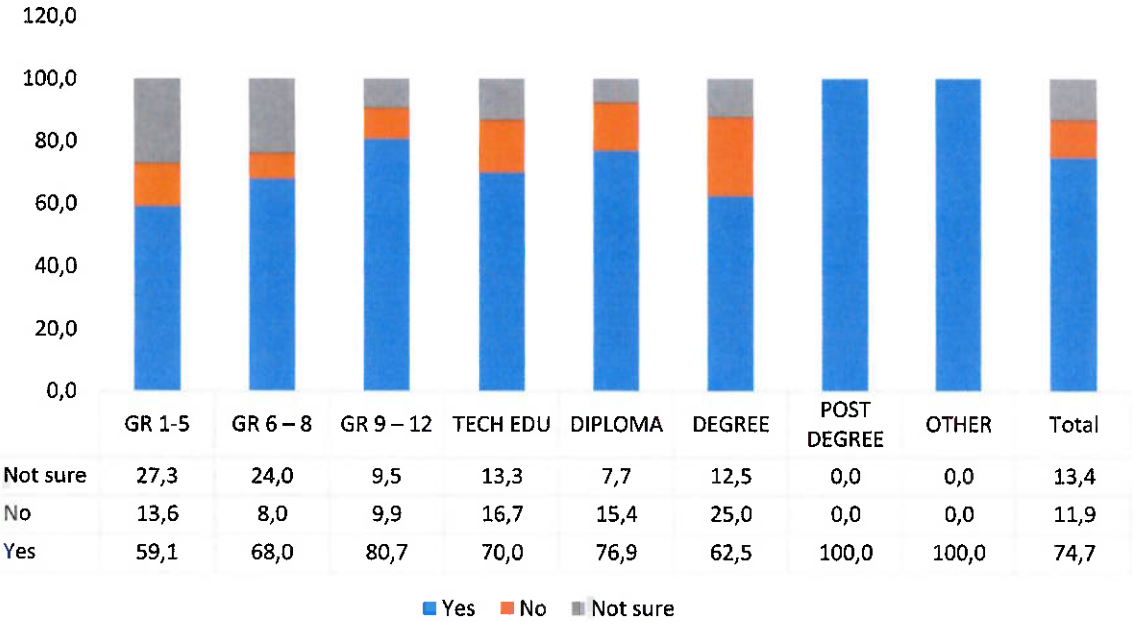


	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	Total
yes	57,7	62,4	63,6	60,8	66,7	65,9	68,6	66,7	50,0	50,0	62,2
no	42,3	31,8	27,3	32,9	21,6	34,1	25,7	20,0	41,7	45,8	31,2
Not sure	0,0	5,9	9,1	6,3	11,8	0,0	5,7	13,3	4,2	4,2	6,4

4.11. BELIEVE OF CONTRACEPTIVE' SAFETY BY HIGEST LEVEL OF EDUCATION

As indicated above, education has been seen to be the most predictor of contraceptive use, knowledge, beliefs and attitudes. It has come out clear in figure 4.6 below that males with post degree and other qualifications completely belief contraceptive use to be safe in their relationships. This is followed by those with higher secondary level of education (grade 9 – 12) with 80, 7%, and then diploma with 76, 9% and then those with technical education with 70%. As for those with grade 1 – 5, majority reported the use of contraceptives to be safe accounting for 59, 1% as compared to 27, 3% of those who reported to be not sure and 13, 6% of those who reported it not to be safe in the same level of education. Generally, the use of contraceptive is considered to be safe in this study.

Fig 4.6: Belief of Contraceptive Safety by Educational Level

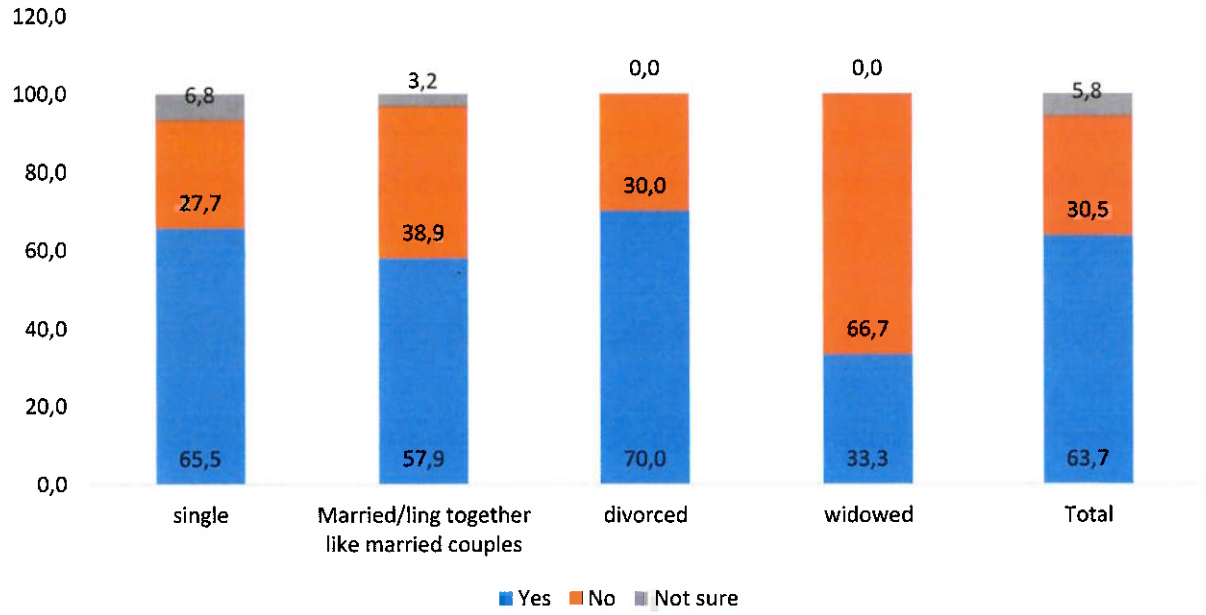


	GR 1-5	GR 6 – 8	GR 9 – 12	TECH EDU	DIPLOMA	DEGREE	POST DEGREE	OTHER	Total
Not sure	27,3	24,0	9,5	13,3	7,7	12,5	0,0	0,0	13,4
No	13,6	8,0	9,9	16,7	15,4	25,0	0,0	0,0	11,9
Yes	59,1	68,0	80,7	70,0	76,9	62,5	100,0	100,0	74,7

4.12. CURRENT USE OF CONTRACEPTIVES BY MARITAL STATUS

Marital status variable was further collapsed into single, married or living together like married couples, divorced and widowed as the number of initial categories which are eliminated did not give justifiable results. Majority of respondents reported higher proportion of use with divorced reporting the highest at 70% followed by single men at 65,5% except for widowed which reported lower proportion at 33,3%. As indicated in figure 4.7 below, majority of single men reported current use of contraceptives accounting for 65.5% as compared to 27, 7% of those who were not using contraceptives and 6, 8% of those who were not sure whether they were using contraceptives at the time of the survey. The same pattern was observed for married and divorced. However, those who were widowed reported higher numbers of non – use of contraceptives accounting for 66, 7%. The overall usage of contraceptives at the time of the survey was reported to be high.

Fig 4.7: Current Use of Contracetives by Marital Status



4.13. MONTLHY INCOME BY TOTAL NUMBER OF CHILDREN EVER BORN

According to the economic rational theory, the number of children one has depend on the economic benefit of those children. Income is inclusive, that is one has to have the number of children which they can afford to raise and also on the fact that they can afford better life for them. As presented in table 4.7 below, for men who reported to have no income in the study, majority of them had no children at 43, 4% followed by those who reported a total of two and one child (ren) with 20, 3% and 17, 5% respectively. The same pattern of fertility was reported for those earning between R1 – R400 and those earning R401 – R800. For those whom were earning an income of between R102 401 – R204 800 reported an expected number of children with those reporting a total of 1 child being high at 66, 7% followed by those who reported a total of 2 children. Contrary to the economic rational and wealth flow theories those who reported to have been earning an income of R204 801 and more had a total of between 3 and 4 at 25% and a total of 5 and more children at 12,5%. The reality is, based on the cost of raising a child even

earning the highest income will not sustain the benefit of having a large family size. Generally, majority reported a total of 2 and 3-4 children at the time of the survey.

Table 4.7: Monthly income by total number of children ever born

INCOME	NO CHILDREN	1	2	3-4	5 AND MORE	TOTAL
No income	43,4	17,5	20,3	14,6	4,2	100
R1 - R400	52,4	4,8	19,0	23,8	0,0	100
R401-R800	64,7	11,8	17,6	5,9	0,0	100
R801-R1600	21,1	18,4	15,8	21,1	23,7	100
R1601-R3200	26,3	18,4	21,1	21,1	13,2	100
R3201-R6400	10,2	22,4	26,5	34,7	6,1	100
R6401-R12800	16,7	16,7	30,0	33,3	3,3	100
R12801-R25600	25,0	25,0	25,0	15,0	10,0	100
R25601-R51200	0,0	0,0	50,0	33,3	16,7	100
R102401-R204800	0,0	66,7	33,3	0,0	0,0	100
R204801 OR MORE	50,0	0,0	12,5	25,0	12,5	100
UNSPECIFIED	39,1	17,4	21,7	13,0	8,7	100
TOTAL	20,14	19,42	26,62	26,62	7,19	100

4.14. TOTAL CHILDREN EVER BORN BY DESIRE FOR MORE CHILDREN

Table 4.8 below present total number of children ever born to male population aged between 15 and 64 years by desire to have more children. As expected, majority of respondents who reported to have never given birth to children have desire to have more children accounting for 68.0% as compared to those who have never given birth but have no desire to have children with 21.1%. Only 10.9% reported that they were not sure whether they want to have children or not. The same pattern have been observed for those who reported a total of one and two children with those reporting a total of two having a lower proportion. As for men who reported larger family size the pattern is otherwise. That is, women who reported a total of 3 – 4

children mostly reported to have no desire for more children accounting for 62.5% as compared to 27.3% of those with desire to have more children and 10.2% of those who were not sure of their desires. Furthermore, men who reported a total of 5 and more children, a total of 78.8% indicated no desire to have more children while 21.2% had a desire of having more children. A question might rise for those who have reported a total of 5 and more but still desire to have more kids, whether it is due to educational level, or as a result of either loss of the children or partners.

Table 4.8: TCEB by desire for more children

TCEB	DESIRE FOR MORE CHILDREN			TOTAL
	Yes	No	Not sure	
No children	100 (68.0%)	31 (21.1%)	16 (10.9%)	147(100.0%)
1	55(68.8%)	11(13.8%)	14(17.5%)	80(100.0%)
2	55(57.3%)	31(32.3%)	10(10.4%)	96(100.0%)
3 - 4	24(27.3%)	55(62.5%)	9(10.2%)	88(100.0%)
5 and more	7(21.2%)	26(78.8%)	0	33(100.0%)
Total	241(54.3%)	154(34.7%)	49(11.0%)	444(100.0%)

4.15. KNOWLEDGE OF MALE CONTRACEPTIVES AND METHOD OF CONTRACEPTIVES KNOWN

Respondents were asked to list the contraceptive methods they know, therefore table 4.9 below present percentage distribution of respondents by knowledge of contraceptives by type of contraceptives known. The idea was to diagnose which method is known by respondents who have indicated knowledge of male contraceptives, however those who reported no knowledge also listed types of contraceptives they know. As shown in table 4.9 below, majority of those who listed condoms as a type of contraceptive they know had reported knowledge about contraceptives accounting for 83.5%. About half (50%) of those who reported injection as a method they know had knowledge about contraceptives and more that

60% (66.7%) of those who reported sterilisation as a method known had knowledge of contraceptives. At least those who have reported a pill as a method of contraceptive they know had knowledge of contraceptives accounting for 100%. Percentages highlighted in red looks at the percentage distribution of respondents by method known only. Majority of respondents reported condoms as the type of male contraceptive they know with 92.1% followed by 1.4% of those who reported injection and sterilisation and a pill both at 1.0%. This simply indicates that other methods of male contraceptives were not known by respondents.

Table 4.9: knowledge of male contraceptives and method of contraceptives known

METHOD KNOWN	KNOWLEDGE OF MALE CONTRACEPTIVES			TOTAL
	YES	NO	NOT SURE	
Condom	223(83.5%)	29(10.9%)	15(5.6%)	267(100.0%) 92.1%
Injection	2(50.0%)	1(25.0%)	1(25.0%)	4(100.0%) 1.4%
Sterilisation	2(66.7%)	1(33.3%)	0(0.0%)	3(100.0%) 1.0%
Pill	3(100.0%)	0(0.0%)	0(0.0%)	3(100.0%) 1.0%
Don't Know	8(61.5%)	4(30.8%)	1(7.7%)	13(100.0%) 4.5%
Total	238(82.1%)	35(12.1%)	17(5.9%)	290(100.0%) 100%

4.16. DISCUSSION

The study assessed the knowledge, perceptions, attitudes, beliefs and usage of male modern contraceptive methods among 473 men aged 15 and 64 years in Madibeng Local municipality in the Bojanala District municipality in the North West Province. The study highlighted that majority of males aged between 15 and 64 years are found in wards 17 and 12 and were in between 20 and 39 years. The age distribution resembles the population distribution by age and sex of the North West

province and that of the country with less number of people in the upper ages and more in the middle ages (Statssa, 2018).

Education has been found to be linked with knowledge and use of contraceptives in other countries. That is, the higher the education the more the chances of knowledge and usage. Findings in the study found, majority of respondents reported secondary level with grade ranging between 9 and 12 as their highest level of education. This is keeping with the results reported by the SADHS 2016 where majority of both men and women had secondary level of education (National Department of Health, 2019). This might have been influenced by the age structure of the study population which is most concentrated in the middle ages. This is the same picture resembled by the Bojanala District municipality and that of the North West Province where mostly have some secondary and grade 12. According to Stats SA (2017b), quality of education in South Africa is still very poor, some of the deprived schools do not even meet the basic learning infrastructure requirements such as access to laboratories, libraries and Internet connections accompanied with less qualified educators. This result into learners experiencing learning deprivation, higher-grade repetition and dropout rates (Statistics South Africa, 2017b). The NDP has set universal access to ECD programmes as one of the vehicles to achieve long-term improvement in the quality of education in the country, but lower levels of education is still being reported in the province.

Marriage has lost its value and has been reported by other studies not to be universal anymore. Most respondents where single, this results can be substantiated by studies conducted in Africa and elsewhere in the world. For instance the study conducted in Mahikeng local municipality where most females where single (Rampagane, 2016) and the study conducted by Ayiga & Rampagane (2013) comparing South Africa with Uganda, and lastly the 2016 SADHS report where men were mostly never married (DoH, 2019). Unemployment was found to be high in the study. Most of respondents were unemployed, and this is in line with the province unemployment rate. The number of unemployed people is continuing to be high in

the province estimated at 47. 4% and 25.8% in the 2016 SADHS and the last quarter of 2018 Labour Force Survey (Stats SA, 2019). The findings for this study found more men to be earning between the lowest wealth quintile (R801 and R6 400) which is contrary to what the 2016 SADHS reported amongst men in the Province where most were in the middle class (DoH, 2019).

It has been reported that knowledge of family planning services has been increasing worldwide. Low involvement of males in family planning services has been reported to be one of the factors hampering the use of family planning services in most countries. Lack of knowledge of where to obtain the family planning services has been reported to be one of the barriers of family planning services use in most of the sub – Saharan Countries. Men in Madibeng reported a promising knowledge of family planning and male contraceptives with more than 60% though very low as compared to nearly 100% reported for men by 2016 SADHS report. The results for this study can however be aligned to the study which was conducted in Zimbabwe in 1991 among men which reported the highest prevalence of knowledge of family planning methods (Mbizvo & Adamchak, 1991).

Almost half of men were involved in decision making with regards to family planning issues and were involved in discussing family planning issues with their partners. This can be related to a study which was conducted long time around 1991 in Zimbabwe among men which found out that all men in the study were involved in family planning decisions in their relationships (Mbizvo & Adamchak, 1991). However in a study conducted in Kenya in 2017, involvement of men in decision making regarding Family Planning was not straight – forward as men were disagreeing with men being involve in family planning issues in the family. Interestingly, for men in Kenya general social norms were reported to play a major role in decision to use or not to use contraceptives with men playing greater role (Ochako et al, 2017).

Most researchers found clinic and hospitals to be the most preferred and trusted source of information about contraceptives and/or family planning services (Alege, et al, 2016). The study found out that men received information about male contraceptives from a variety of sources with media and radio playing a bigger role. This can be aligned to what Thummalachetty et al (2017) found among men in Uganda where peers, health providers and media were reported to be the source of information regarding contraceptives. Findings in this study conform to the general literature on contraceptive use among both men and women with the current use being more than 60% and 65% use them frequently. For instance, studies done in Nigeria, Western Cape in South Africa, Kenya, Venda, and Sub-Saharan Africa where most were currently using contraceptives (Raselokwane et al, 2016; Bietsch, 2015; Amu et al., 2017; Peer & Morojole, 2013; Thummalachetty et al, 2017; Ochako, 2017).

Condoms were reported to be the most preferred and currently used method by men in Madibeng, followed by oral contraceptive/ pill and injection. This can also be confirmed by the male modern contraceptive method known to men, as men reported condoms to be the male modern method they know and further Injections to a lesser extent. In other studies conducted in Nigeria and Kenya, where male condom came out to be the commonest known and used method of contraceptives among men. However in South Africa, the most commonly used method is injectable and male condoms, while the commonly known methods include male/ female condoms, injectable, implant, pills, emergency pills and sterilisation (Amu et al, 2017; Ochako et al., 2017; DoH, 2019).

Respondents believed that they can still enjoy sex despite the fact that they were using contraceptives and the use of contraceptives was perceived to be safe by men in Madibeng. This is in line with what the study conducted in Nigeria which reported that condom does not reduce sexual satisfaction (Amu et al, 2017). Spousal support regarding the use of contraceptives came out as a highlight and the reason for use

was also reported to limit birth and for birth spacing. The most source of information regarding contraceptives just like what other studies observed, came out to be health centres and pharmacies and respondents were satisfied with the manner in which they are provided in their area (Raselokwane et al, 2016; Bietsch, 2015; Amu et al., 2017; Peer & Morojole, 2013; Thummalachetty et al, 2017; Ochako, 2017).

Looking at the most determinants of knowledge of family planning, most of those who had knowledge were found in the middle to older ages between 40 and 54 years of age and were had secondary to higher degree as the highest level of education. As for knowledge of male contraceptive, the most predictors, age became to be not the most predictor as the pattern was similar, meaning knowledge was moderate at all ages. It was observed that being highly educated influenced men's perception about contraceptives with men with post degree and other qualifications completely reading contraceptive use to be safe in their relationships. Divorced and single men reported higher proportion of current use of contraceptives. This is in keeping with reports of other studies conducted in Africa and South Africa (Raselokwane et al, 2016; Bietsch, 2015; Amu et al., 2017; Peer & Morojole, 2013; Thummalachetty et al, 2017; Ochako, 2017).

With regards to reproductive behaviour, in responding to satisfying use and knowledge of contraceptives, majority of population under study reported to have never given birth to a child in their live. Fertility was observed to be low to moderate with mostly reporting a total of 2 and 3 children ever born. Reasonably, as fertility is still reported to be moderate, mostly reported desire to have more children at an average of 2 more children at least. The sex structure of children was observed to be balanced and fertility was found to be lower for those with no and low income. The results are familiar with what the 2016 SADHS, 2016 Community Survey and study conducted in Mahikeng observed (Rampagane, 2016; Stats SA, 2016; DoH, 2019).

5. CHAPTER 5: CONCLUSIONS AND RECCOMMENDATIONS.

The previous chapter focused on the findings of the study, which include the socio – demographic characteristics of the respondents; knowledge and involvement of men in family planning; knowledge, access, usage, belief of male modern contraceptives and the reproductive characteristics of males. The chapter further examined the relationship between knowledge, usage, attitudes, beliefs and access against the socio – demographic characteristics of male males aged 15 and 64 years residing in Madibeng Local Municipality.

5.1. CONCLUSION

The study examined knowledge, perceptions, attitudes, beliefs and usage among male modern contraceptive methods among men aged 15 and 64 years in Madibeng Local municipality in the Bojanala District municipality in the North West Province. Out of the 473 sampled men, the study concluded that mostly were from wards 17 and 12; in the middle ages; with secondary as the highest level of educations; with higher proportion single; higher unemployment rate; and mostly were earning lower income.

A promising knowledge of family planning as a broader component and specifically male contraceptive methods was acknowledged in the study. Family planning decision came out to be a joint decision as men agreed to they should be involved in decision taking in that regard, with media and clinics/ hospitals being the source of information around family planning issues. Most were currently using some form of contraceptives with condom being the most commonly used and preferred method. The use of contraceptives was believed not to have any harm towards sexual satisfaction while contraceptives were mainly used for birth spacing and limiting. Age and education became the predictor of family planning knowledge and male contraceptive method knowledge too. Marital status influenced the current use of contraceptive while being highly educated predicted the attitude towards the safety of contraceptive use. Reproductive behavior responded very well to the usage, attitude, knowledge, perceptions and beliefs gained from male population in Madibeng as fertility patterns and desires were moderate. The implication is, if the

male modern contraceptive knowledge and usage improves while attitude and change in behavior also improves, fertility for Madibeng Local Municipality might even go down which eventually could lead to a stabilized population growth rates. A stabilized population growth will then mean better live for all as government will be able to provide the services as per the needs of the population at least at a minimum expected level.

5.2. RECCOMMENDATIONS

In summary, the findings from this study suggest that:

- Improving the socio – economic and demographic factors is very key as they are the most determinant of knowledge, usage and beliefs of contraceptives in general.
- Family planning programs should at all times be inclusive and should target both men and women equally.
- Dissemination of information regarding family planning and specifically new methods of male modern contraceptives through mass media could potentially increase knowledge and uptake.
- The same approach should focus on family planning sensitization or awareness campaigns targeting key sectors of the population since knowledge and uptake of new male modern contraceptives by men is nonexistence in the province.
- There should also be focus on availability and free - to - easy access of new male modern contraceptives in the province and all district specifically.
- Men should be fully involved in decision making with regards to reproductive health and family planning issues.

In general, integrating men in reproductive health issues will lead to a greater uptake of contraceptives. In order to promote male contraceptive use generally, family planning could focus on increasing support of contraceptives, improve partner communication and joint family planning decision making. In that note, the government need to invest in access to reproductive health services generally as a tool for improving lives of South African men and the North West province in particular.

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OFFICIAL SIGN OFF

PREPARED BY

_____ 20.03.2019

DR RAMPAGANE K.V **DATE**

DD: POPULATION POLICY PROMOTION

RECCOMMENDED/ ~~NOT RECCOMMENDED~~ 25.03.2019

_____

MS NYOKONG SS **DATE**

D: POPULATION POLICY PROMOTION

APPROVED/~~NOT APPROVED:~~

_____

_____

_____ 21/9/03/25

MS MEKGWE MM

CHIEF DIRECTOR: COMMUNITY DEVELOPMENT **DATE**

APPENDIX A

QUESTIONAIRE

social development
Department:
Social Development
North West Provincial Government
REPUBLIC OF SOUTH AFRICA

CHIEF DIRECTORATE: COMMUNITY DEVELOPMENT

Private Bag X 6 ▪ Mmabatho, 2735 ▪ Provident House Building, University Drive ▪ MMABATHO
Tel: +27 (18) 388 –▪ Fax: +▪ E-mail: MMekwe@nwpg.gov.za

Enq: Mr.R Modau: 018 388 1671/082 324 2389

Questionnaire Administrator Name:	***For office use only:***
Date:	Questionnaire number:
	Questionnaire status:
	Ward:
	Sub Area:
	Local Municipality:

Male modern contraceptive methods: It's Knowledge, usage, perceptions, attitudes and beliefs- in the North West Province, a case study of the Madibeng Local Municipality in the Bojanala district

Consent Form

Attention Participants

The Population Policy Promotion Directorate would like to convey sincere gratitude to all respondent in taking time to participate in this study. The aim of the study is to assess knowledge, usage, perceptions, attitude and belief of males towards male modern contraceptives use. It is requested that participants sincerely respond to questions as objectively as far as possible. Please note that the information provided will be treated with strict confidentiality and professionalism as possible. As a matter of fact, anonymity is emphasized in this study, thus no identity particulars of the participants are required or needed.

INSTRUCTION:

- You are kindly requested to indicate your answer by putting a cross **(X)** where appropriate and explain/describe on the spaces provided
    - Where appropriate write as legible and neat as possible.

SECTION A: DEMOGRAPHIC INFORMATION OF THE RESPONDENTS

1. Age of the respondent

Number	Age	
1	15 – 19	
2	20 - 24	
3	25 - 29	
4	30 – 34	
5	35 – 39	
6	40 – 44	
7	45 – 49	
8	50 - 54	
9	55 – 59	
10	60 – 64	
11	65 and more	

2. Educational level

Number	Educational level	
1	None	
2	Grade 1 -5	
3	Grade 6 - 8	
4	Grade 9 - 12	
5	Technical education	
6	Diploma	
7	Degree	
8	Post degree	
9	Other (specify)	

3. Marital status

Are you currently...		
1	Single, that is never married?	
2	Single, living with partner?	
3	Married and living with [husband/wife]?	
4	A civil partner in a legally recognized civil partnership?	
5	Married and separated from your husband/wife?	
6	Divorced?	
7	Widowed?	

4. Employment status

Number	Employment status	
1	Unemployed	
2	Employed	
3	Self- employed/ own business	
4	Looking for employment	
5	Tired of looking for employment	
5	Can't work/ too young to work	
6	Other (specify)	

5. Monthly income for the respondents

Number	Monthly income	
1	No income	
2	R 1 - R 400	
3	R 401 - R 800	
4	R 801 - R 1 600	
5	R 1 601 - R 3 200	
6	R 3 201 - R 6 400	
7	R 6 401 - R 12 800	
8	R 12 801 - R 25 600	
9	R 25 601 - R 51 200	
10	R 51 201 - R 102 400	
11	R 102 401 - R 204 800	
	R 204 801 or more	
12	Unspecified	
13	No income	

SECTION B: THIS SECTION FOCUSES ON KNOWLEDGE AND INVOLVEMENT OF MEN INTO FAMILY PLANNING.

6. Do you know about family planning?

Number	Knowledge	
1	Yes	
2	No	
3	Not sure	

If no, proceed to question 10

7. If yes, explain what do you know about family planning?

_____

_____

_____

8. Are you involved in family planning decision making in your marriage/ relationship?

Number	Involvement	
1	Yes	
2	No	
3	Sometimes	

8.1. If yes, Explain, what role do you play in family planning issues?

_____

_____

_____

9. Do you normally discuss family planning issues with you partner/ spouse?

Number	Discuss	
1	Yes	
2	No	
3	Sometimes	

SECTION C: THIS SECTION FOCUSES ON KNOWLEDGE AND USAGE OF MALE CONTRACEPTIVES

10. Do you know what male contraceptives are?

Number	Knowledge	
1	Yes	
2	No	
3	Not sure	

If no, go to question 13

11. Where did you first know/ hear about modern male contraceptives?

Number	First knowledge	
1	Radio/ media	
2	From a friend	

3	Clinic/ hospital	
4	Pamphlet/ flyers/ brochure	
5	Other (Specify)	

12. Name the type of male contraceptives methods you know?

_____

_____

_____

13. Do you use contraceptive during sexual intercourse?

Number	Usage	
1	Yes	
2	No	
3	Sometimes	

If no go to question 15

14. What type of contraceptive do you prefer?

Number	Type of modern contraceptives	
1	Sterilization (male and female)	
2	Intrauterine devices and systems	
3	Subdermal implants	
4	Oral contraceptives	
5	Condoms (male and female)	
6	Injectable	
7	Emergency contraceptive pills	
8	Patches	
9	Diaphragms and cervical caps	
10	Spermicidal agents (gels, foams, creams, suppositories, etc.)	
11	Vaginal rings	
12	Sponge	
	NON –MODERN METHODS	
13	Fertility awareness approaches	
14	Withdrawal	
15	Lactational amenorrhea	
16	Abstinence	

15. Do you belief using contraceptives affect your performance during sexual intercourse?

Number		
1	I enjoy it	
2	It pinches me	
3	It is against my believe	
4	I can't feel it	
5	Other (specify)	

16. Do you believe using contraceptives is safe?

Number	Believe	
1	Yes	
2	No	
3	Not sure	

17. Does your spouse/ partner encourage you to use contraceptives?

Number	Usage	
1	Yes	
2	No	
3	Sometimes	

18. Are you and your partner/ spouse currently using any contraceptives?

Number	Currently using	
1	Yes	
2	No	
3	Not sure	

If no go to question 24

19. If yes, which method is you and your partner using?

Number	MODERN METHOD OF CONTRACEPTIVES	
1	Sterilization (male and female)	
2	Intrauterine devices and systems	
3	Subdermal implants	
4	Oral contraceptives	
5	Condoms (male and female)	
6	Injectable	
7	Emergency contraceptive pills	

8	Patches	
9	Diaphragms and cervical caps	
10	Spermicidal agents (gels, foams, creams, suppositories, etc.)	
11	Vaginal rings	
12	Sponge	
	NON –MODERN METHODS	
13	Fertility awareness approaches	
14	Withdrawal	
15	Lactation amenorrhea	
16	Abstinence	

20. What is the reason for using that method?

Number	Reason for usage	
1	Birth - spacing	
2	Limiting birth	
3	Other(please specify)	

21. Where do you find/ get your contraceptives from?

Number	Where	
1	Clinics/ hospitals	
2	Doctors	
3	Pharmacy	
4	Shops	
5	Other (specify)	

22. Are you satisfied with the provision of contraceptives in your area?

Number	Provision	
1	Yes	
2	No	
3	Not sure	

23. Any other information regarding knowledge and usage of contraceptives you would like to share

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Reproductive Health Characteristics

24. How many children have you ever given birth to?

Number	Total Children Ever Born	
1	0	
2	1	
3	2	
4	3 - 4	
5	>5	

If 0, go to question 25

24 (b). How many are Boys and Girls?

1	Girls	
2	Boys	
3	Not sure	

24 © How many are still alive? And how many are not alive?

1	Alive	
2	Not alive	
3	Not sure	

25. Do you have desire for more children?

Number	Fertility desire	
1	Yes	
2	No	
3	Not sure	

25(b). If yes how many? _____

25© And why?

_____

_____

_____

_____

25(d) If no why?

_____

_____

_____

Thanks for your time !!!