Spousal Communication and Family Planning Behavior in Northern Cape, South Africa

by

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DECLARATION

I declare that *Spousal Communication and Family Planning Behavior in Northern Cape, South Africa* is my own work, that it has not been submitted for any degree or examination at any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

GLORIA NOKUTHULA DE GITA

SEPTEMBER 2007

SIGNED: . . . . . .

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ABSTRACT

Spousal communication on issues related to family planning (FP) and reproductive health is important in influencing fertility limiting behaviour. In South Africa, studies analyzing the relationship between spousal communication and FP behaviour are virtually nonexistent. Understanding this relationship is critical for less developed countries where fertility remains at substantially high levels. In most countries, the isolation of men's participation in FP issues is acknowledged as one of the major causes of poor performance of most FP programs. In addition, lack of spousal communication about FP is identified as one of the reasons for low levels of contraceptive use among women. Two main hypotheses in this study were examined: First, the level of husband-wife communication about FP and second, spousal communication association with contraceptive use in three distinct areas in the Richtersveld (Northern Cape) area. The sample consisted of 130 couples (n =260). The dependent variable was discussion of FP. The independent variables were contraceptive use, age, education, number of living children, race and duration of marriage. Correlation analysis shows that there is a positive significant correlation between age and discussion; number of sons and discussion; and number of daughters given birth to with discussion of FP. However, couples highest level of education is positively correlated with FP discussion and couples' intention to use FP is positively correlated with their age and FP discussion.

Logistic regression models revealed that education attainment and duration of marriage were significant predictors of contraceptive use, with duration of marriage being the stronger predictor of the two. The use of contraceptives increased with the increase in the frequency of discussion of FP. The proportion of couples who

reported their spouses' disapproval of contraception was smaller among those who had discussed FP with their husband than among those who had never done so.

The emphasis and strategies of FP programs have changed over time. However, meeting contraceptives needs of couples and improving quality of FP services continues to be a challenge in Richtersveld. Access to FP touches on many issues. Barriers can be geographical, economic, lack of FP knowledge, incorrect use of FP methods as well as spousal negative attitudes. In Richtersveld for example, obstacles to contraceptive use included inconvenient clinic hours, long distances, high transportation cost and contraceptive shortages. Because of some of these obstacles, many couples stopped using contraception within a few months or a year after adopting a method even though they did not want another child. Moreover, it becomes difficult for the couples to get the method they want to use. As contraceptive prevalence rises, it becomes vital for FP programs to shift their emphasis away from adopting a method to shape couples attitudes towards FP and change their behaviours by supporting correct use of contraceptives.

Key Words: Agreement; Contraceptive Use; Education; Family Planning; Fertility Preferences; Religion; Reproduction; South Africa; Spousal Communication; sub Saharan Africa.

Chapter One: Introduction

1.1 Background of the Study

The importance of spousal communication in influencing fertility limiting behaviour is frequently emphasized in family planning (FP) programs and research. Other scholars have argued that spousal communication is one of the steps of logical fertility decision making (Mott and Mott 1985). A plethora of studies has shown that spousal communication is positively associated with contraceptive use. However, studies investigating the link between spousal communication and contraception especially in less developed countries remain rare (Becker et al. 1996). As a result, communication interventions have been implemented to motivate couples to talk about contraceptive use, number of children and birth spacing, seeing that little is known about reproductive decision making (Blanc et al 1996).

The association between spousal communication and FP use is widely acknowledged. However, efforts to determine whether spousal communication translates into contraceptive behaviour are uncertain. A common assumption is that communication leads to FP use. For example, majority of studies (e.g., Oyediran 2005 and Schoemaker 2005) suggest that the use of FP methods leads to greater communication because couples need to talk about their reproductive cycle (see also Sharan and Valente 2002). If communication follows adoption of contraceptive use then it would be unnecessary for programs to facilitate communication.

It seems to be very difficult to draw inferences about the direction of the relationship between FP use and communication because most research on spousal communication is based on cross sectional data. Some researchers who have studied spousal communication and attitudes towards

contraception in various settings have noticed this limitation in their work (Bawah 2002; Feyisetan 2000).

Becker et al. (1996) supports the view that couples joint decision making forms the basis of FP use. According to Becker, programs which are aimed exclusively either at men or women may fail in their purpose. He believes that most sexual, FP and child bearing decisions are potentially made by both couples. This implies that it is very useful to distinguish contraception use resulting from joint planning.

A study in the Philippines failed to show that joint decision making was strongly associated with contraceptive use than individual decision making (Ogawaa, 1982). As researchers pointed out that the index of decision making used could have been faulty and the husband tendency to consider FP a woman's concern may have subdued differences (Lozare 1976). It is not stated whether couple's joint decision making is more strongly associated with FP use than decision making by either spouse alone, of which, the most particular interest are the dynamics of decision making process and how and whether spousal communication affects this dynamics.

The effect of spousal communication upon FP use may be mediated by the relative power of each spouse in the decision making process (Sharan and Valente 2002). A Ugandan study suggest that women's poor social status and vulnerability prevent their ability to express and argue for their own interest with their partners and recommend a clear consideration of gender inequality as an important factor of the study of the reproductive outcome (Blanc et al. 1996).

1.2 Statement of the Problem

Although FP programs are emplaced in most countries including South Africa, emphasis is always on teaching men and women about the importance of FP and the use of contraceptives and correction of fertility problems. Little is done on educating couples about the importance of communication and negotiated agreements on contraceptives and fertility. Although armed with the knowledge about contraceptives and fertility, decision making becomes a major issue. The lack of communication especially on issues pertaining to contraceptives and fertility is influenced by a number of factors such as age difference between couples, religious beliefs and the influence of the extended family. All these initiatives seem to have little effect as is evident by the number of children born to majority of families especially in poor communities. Some of these programs are not effective because of imperfect use and dissatisfaction of available methods. However, different opinions about contraceptive use among couples might be a major problem.

1.3 Objectives of the Study

The main objective of this study was to assess spousal communication on contraceptives use and FP behaviour. The specific objectives were to increase our understanding of:

- The level of spousal communication in terms of fertility and FP behaviour.
- External factors that affect spousal communication on issues related to FP behaviour.
- Education and its relationship to spousal communication.
- Whether or not couples have similar attitudes and preferences towards small family size and use of FP.

1.4 Rationale/Justification of the Study

The prevalence of unmet need for family planning is primary justification for family planning programs, but the causes of unmet need have not been much investigated in some areas in South Africa, especially in Richterveld (Namaqualand). The failure of individuals to use contraceptives when they would like to stop child bearing result in what is defined as unmet need for family planning .However, unmet need can result from supply side factors that render family planning services unavailable or from other constraints that serve to prevent individuals from acting on their fertility preferences (Short 2002). The purpose of this study is to re-examine the utility of unmet need for family planning and to address several questions about the concept: 1) Is the concept valid, that is, are contradictions between fertility preferences and contraceptive behaviour real? 2) Does unmet need have any bearing on large process of fertility transition? What is the connection between the unmet need, the demand for spousal communication and contraception use?

1.5 Organization of the Study

The study is organized as follows. The second chapter presents the literature review of studies on spousal communication and contraceptive use in Africa and other countries. The third chapter on research methodology presents the analytical approach of the study and data used in this study. The fourth presents findings of the study and discussion. The last chapter summarizes important aspects of the study and provides the conclusion pertaining to findings and recommendations.

1.6 Conceptual Framework

Family planning (FP) programs are capable of changing couples reproductive goals and behaviour (Ndikabandi and Nsenqimana 1991). Family planning acts as a positive function over

fertility and acts as a negative function of the ideal number of children. Reproductive goals can be measured in terms of couples desire to continue or to stop child bearing whereas reproductive behaviour can be measured in terms of efforts to prevent further pregnancies. A change in reproductive intention or goal implies a change in couples intention or goal from wanting more children to no more children and stop child bearing. However, a change in reproductive behaviour implies a change in couple's behaviour from no use of contraceptives to the use of contraceptives (Entwisle, et al. 1986).

Communication between spouses is positively associated with contraceptive use, duration and effectiveness of use, and negatively associated with demand for children and fertility preferences towards large family sizes (Djamba 1994). Furthermore, communication is assumed to lead to greater empathy and to increase a couple's ability to act together to achieve goals. However, because of the sensitivity of the topic, feelings of shyness or modesty, and fear of challenging the husband's, women are less likely to initiate discussions about FP and sexual activity. Nonetheless, most women are willing to talk about reproductive matters if the topics are initiated by their husbands.

Chapter Two: Literature Review

2.1 Introduction

Researchers have attempted to explain why people in less developed countries do not limit the birth of their children instead they are spacing them (Ewbank 1989; Nortman 1989). One explanation is that this is according to traditional value and practices (Omari 1984). In Africa, for example, people spaced their children but did not limit them meaning whatever traditional methods used for fertility control were aimed at postponing the coming of the next child to a future time rather than preventing it. There were various methods of FP accompanied by religious rituals but people were not interested in limiting the number of their children in spite of the fact that modern FP methods are aimed at that.

2.2 Fertility in Africa

Majority of people in the less developed world and contemporary Africa in particular prefer small families to large families due to social, economical and financial constraints (see Bulatao and Lee 1983; Easterlin and Crimmins 1985; Singh and Casterline 1985; Mason 1987 for a thorough discussion). One way to achieve smaller families is to use FP. While some women are able to practice FP with the support of their partners, others practice it without the knowledge of their partners (Blanc et al. 1996; Biddlecom and Fapohunda 1998; Castle et al. 1999). This is because in some societies, issues dealing with FP or contraception and fertility cannot be discussed openly. Spousal communication on issues related to FP and reproductive health ensures that couples discuss issues that are relevant to the upbringing of their families (Biddlecom and Fapohunda 1998). Where communication exists, couples are free to engage in practices or behaviours that enhance their lives. For example, couples may seek medical advice for any problems or complications arising from the use of FP.

There are a number of factors that influence spousal communication. For example, religious beliefs have been found to have a huge impact on spousal communication in many parts of Africa and elsewhere (Adongo et al. 1998; Bawah 2002; Lehrer 2004). Some topics such as contraception and fertility cannot be discussed between spouses particularly in societies where males dominate decision-making. Discussing such topics with the opposite sex is considered unreligious (Freedman 1987). In male-dominated and traditionally oriented settings, women can only get advice on such topics from their social networks (Behrman et al. 2002).

Kinship systems also play an important role in influencing fertility of married couples (Adongo et al. 1998). Therefore, decision making between the couple becomes difficult because one has to justify to the extended family the reasons for reaching such a decision. Most of the time extended family elders tend to have control over the couple's ultimate family size.

With the advance of medical science, some infertility or fertility problems can be solved. Couples need, however, to be open to each other so that if need be, they seek professional help. Again, religious believes tend to bar some couples from such discussions which results in unfulfilled life, full of sadness and sorrow.

To a large extent, fertility preferences depend on individual choice but for couples this may not be the case. It is important for couples to discuss their opinions about their preferred family size. Such discussions should be based on mutual understanding and trust. Since women are at risk of giving birth and biologically nurturing the baby, the child needs the mother more than the father. In most cases, a woman's movement is restricted because she has to take care of the child

leaving men with, generally, limited care for the children particularly in societies where child rearing is the sole responsibility of a woman.

The number of children ever born has a direct effect on a woman's health. Most males particularly in traditional and male-dominated societies don't put the health of the woman into consideration. As a result many women die while giving birth because of their poor health conditions (Menken et al. 2003). Effective communication in such a case would save the lives of many because health problems would be identified early and appropriate action taken in order to save the lives of women. Most males—particularly traditional African males—have a negative attitude towards contraception. This is related to their beliefs and values that are pronatalist. They believe that contraception is based on western ideologies and thwarts their efforts of producing more offspring. The past and the present are absolutely different: Having many children in the past was less demanding than at present. In the contemporary world, having too many children is socio-economically demanding and generally associated with poverty, poor health and poor quality of education for the children, and ultimately a less fortunate future.

Considering the high rate of divorce in South Africa—estimated at 526 per 100,000 married couples (Statistics South Africa 2006)—and the total fertility rate which is estimated at 2.7 in 2006, it is imperative to conduct research that assesses the effect of communication on couples FP and reproductive behaviour. This is because men and women make important contributions to childbearing and upbringing of their children yet most fertility studies continue to focus on women alone. The assumption of woman's primacy in fertility and contraception use has generally been downplayed and often neglected men's role in studies of fertility and FP.

In the last few decades women's movements have encouraged an examination of issues of power and spousal communication/agreement in terms of fertility. This approach has expanded the demographic focus from individual to families with the family as the context in which negotiation takes place. The importance of spousal communication and agreement in the use of FP cannot be overemphasized since majority of male partners are still exercising authority over their spouses. This means that any approaches to the understanding of contraception and FP methods in South Africa must take this issue into consideration. Studies on FP process in other countries have demonstrated the dominance of males over females in issues related to FP and reproductive health. For example, in Bangladesh where Islamic faith is more predominant, women are not supposed to go out in public. Hence men and children do a lot of outdoor activities including going to clinics to get medicine for the women. Davis (1987) pointed out that a husband in Bangladesh community is the provider who brings home contraceptives to his wife. Davis (1987) is not sure whether the husband has an influence on whether the couples reach a certain agreement on the use or non use of contraceptives in this case. Thus, he suggested that in order to achieve any success in the use of modern FP methods, husbands must be included in what he calls "social marketing of oral contraceptives."

It is a sociological principle that social networks have an influence on the socialization of individuals and also in the way they solve their problems (Freedman 1987; Behrman et al. 2002). For instance, on issues related to sex, fertility and childbearing processes, women talk a great deal among themselves and the influence among them is great. This influence can far exceed any level of communication that they have with their husbands.

In less developed countries, many people are still having the desire to have too many children. Sanders and Carver (1985, p. 232) stated that in India poor families still have a large number of children in spite of their poverty. One argument, which has been presented often especially in relation to the provision and accessibility of modern methods in fertility control and management, is that poor families lack financial support to afford contraceptives. Unless the national governments subsidize the provision of contraceptives and make them part of health delivery system, access to contraception will be available to women from impoverished settings.

Another argument is based on the level of education and the need for small sized families. This argument follows the modernization theory which argues that as women become more educated, their fertility will decline compared with their non-educated counterparts (Molnos 1972; Bongaarts et al. 1984). These scholars pointed out that education and information on modern FP methods in particular, would help influence fertility decline (Coytaux et al 1987).

Studies from other parts of Africa, for example Oni (1985), have found that the demand for children among African women is still high irrespective of high education levels. Dow and Werner (1983) argue that the use of more information and mass education on FP has an influence on fertility decline. In their study of rural Kenyan women, Dow and Werner (1983) found that women were not adjusting their fertility level as a result of information about FP activities. Their findings show that there are other factors that prevent women from using modern methods of FP. What could those factors be? Lack of spousal communication and agreement on fertility and the use of contraceptives could be some of them.

Early formulations of intention to use contraceptives depended largely on two assumptions: That couples have at some level a concept of ideal family size and that it is appropriate to their social context or as optimal for their own family situation. This means that pregnancies occurring before that ideal are wanted and all those happening afterwards are unwanted. This basic formulation requires the assumption that births take place in stable marriages. Others have described this method of assessing excess fertility as assuming idealized conditions, namely no divorce or separation and fixed family goals (Omari 1987).

According to Shireen and Jejeebhoy (2002), few studies compared the perspective of women and their husbands on women's rate and the extent to which they have and should have a voice for their own lives. The extent of spousal agreement reported in some studies that explored spousal convergence has focused on reproductive attitude and preferences (Mason and Taj 1987; Bankole 1995; Becker 1996; Bankole and Singh 1998; Mason and Smith 2000). Current review of studies reporting attitudes of women and their husbands concerning reproductive health found that with respect to fertility and FP, the proportion of agreement between partners across the number of studies ranges between 60-70 percent (Becker et al. 1996). In Asia, Mason and Smith (2000) found that spousal agreement on desire for additional children ranges from 70-90 percent. While the study conducted in Pakistan explored attitudes and perceptions of women and their husbands with regard to aspects of reproductive health and female independence and suggested considerable divergence in spousal perceptions of women's autonomy (Sothar and Kazi 1996).

India has been known for unequal gender relations (Altekar 1962; Karve 1965, as cited in Shireen and Jejeebhoy 2002). Husbands are assumed to "own women and have the right to

dominate them." In general, women are defined as inferior. Cultural and regional differences are found in women's situation and vulnerability (Dyson and Moore 1983). Since unequal gender relations reject women decision making role in FP, it prevents women from moving around freely, inhibit their access to material resources and expose them to violence in the household.

Studies on the various aspects of African fertility have been conducted by a number of scholars and the results vary across different regions (Bankole 1995; Adongo et al. 1998; Freedman 1987; Behrman et al. 2002). However, one key finding stands out: Fertility remains high with associated low levels of contraceptive use. A number of factors have been identified as key to high fertility and these will be reviewed in chapter two on literature review.

Governments of less developed countries are working very hard to reduce fertility to low levels. Although modern FP methods have been introduced in virtually all over the world, acceptance levels are still too low largely due to various religious and socio-cultural beliefs (Omari 1988a). Some countries have adopted FP methods as a solution to control fertility. This is a recent innovation in many countries and its acceptability has been very low. However, the majority of countries have not experienced fertility decline.

Although traditional methods of FP have been used by many societies in the past, their use is slowly disappearing due to social changes (Omari 1984). This change affects majority of young people who would like to have children and would like to have them when they are ready. Since these young people are ignorant of traditional methods of fertility control, the only alternative for them is the modern FP methods. Yet, this alternative method of fertility control is faced with problems. Some people are not readily accepting them because of a number of factors such as

lack of social networks, lack of spousal communication about FP, religious and socio-cultural factors and spousal disapproval of FP methods.

2.3 Wealth Flows Theory

Caldwell (1976; 1977; 1978; 1980 and 1982) has tried to explain fertility problems in less developed countries. He has given no other theoretical explanation other than the "Wealth flow theory" to explain why people in developing countries like to have more children in spite of the problems they experience related to poverty, low levels of education and economic development. Caldwell's theory of "Wealth flows" is a redefinition of the demographic transition theory based on his research experience in less developed countries.

Briefly, the wealth flows theory argues that there are two types of societies in the world. One in which it is economically viable and rational to have as many children as one can, and the second, in which it is not economically viable to have many children. He argues that since no surviving society has reproduced itself biologically at a maximum level, social and personal constraints have been put on the ceilings of human fertility. According to his understanding, the ceiling has been higher in the first type of society rather than in the second. Demographers holding to classical transition theory have been able to show that due to urbanization and industrialization, which was taking place, a shift of labour which was needed for the labour force occurred. The residential patterns and economic changes demanded that the old sufficiency and self contained institutions like the family to be replaced by new situations like factory and labour groups. Thus, the labour force for family survival was no longer dependent on children (Freedman 1983, as cited in Omari 1988a).

Freedman (1979) found that the expense of bringing up children prevented the smooth flow of investment in non–familial opportunities which were available outside the family circle due to the industrial development. This kind of bias on urban development as a factor that influence fertility decline has been emphasized for a long time. Johnson (1984) points out that this urban-bias theoretical model among demographers has made it difficult for planners to put an emphasis on rural development as a determinant factor in fertility decline. He and many researchers today agree that the urban bias theory is not historically true and may not be viable for the understanding of fertility behaviour in less developed countries.

Caldwell (1978) modified this classical theory and came up with a wealth flow theory, that is male and female children have value at the family level. For Caldwell, the cultural superstructure of the traditional society is family morality. The family is the centre of both production and reproduction system whereby males dominate the decision making. In this way, heads of the household do not only control the labour force, but the source of labour forces as well. Studies from various less developed countries seem to support this theoretical basis. The fact that children contribute much to the adult population in the household economy is supported by studies in Bangladesh (Cain 1977). In Nepal, girls aged six to eight spend nearly two hours daily watching younger siblings thereby releasing mothers for other work (Johnson 1984). This happens in most African societies. These children may have been paid little or no salary, but their contribution to the household economy should not be underestimated (Caldwell 1976).

The wealth flows theory, which stipulates that wealth flow is from adults to patriarchs, has been criticized by several researchers, and among them is Turshen (1984, p.42) who attributes the failure of the theory to the result of historical development and relation to capitalism. Turshen

and others who follow a Marxist analysis of demography, criticizes the theory because it dumps all classes in the same category. She argues that the demographic theory which Caldwell has tried to reformulate suffers mainly in two areas. First epistemologically it is not true; second ontologically, it confuses the cause and the effect. Turshen sees this confusion arising from the development of the theory itself based on the neoclassical interpretation of development. Turshen thinks that this theory collapses because it does not take into consideration the economic variable of migration instead it focuses only on fertility. It also looks at pre-capitalist societies as static. She then offers her own views on demographic dynamics as related to the mode of production. She emphasized that cultural control of reproduction was available to pre-capitalist and it takes the position that over population and under capitalism is a symptom of under development rather than cause of poverty. Turshen stretches her argument too much and put her emphasis on the labour migration as an influencing factor for fertility.

2.4 Modernization Theory and Education

Caldwell (1980) suggests that education, in particular western education, will help to reduce fertility in Africa. The value systems and norms in the literature emphasise the need and benefit of a nuclear family. Thus, the western cultural value system will enforce the desire to attain smaller families and will then lead to fertility decline. However, he warned that this will not succeed unless mass education at primary school level is introduced. Once this has happened, the western concept of the child-centred family will emerge. The emphasis has been put more on women than on men, because according to this theory, women are ultimate decision makers for the adaptation of new technology. After all, women are individually responsible for their fertility control, according to the western value system.

Molnos (1972) concluding on the future that cultural material has on fertility, stated that the new associations should be created and reinforced between the small family and modern status symbol such as education, money and good housing so that the absolute and detrimental association of large families with economic well being and social status is gradually replaced. This is a class oriented proposition in fertility decline.

In Richtersveld (Namaqualand) and other parts of African countries, the majority of people will not get the level of education which will influence the process envisaged by Omari (1988a). The small size of families found in urban areas among the elites is a tiny proportion of the population whose life styles and attitudes have been influenced by the western education and knowledge. Majority of people in Africa live in rural areas where traditional values and norms are in operation. These values and norms may influence fertility control among women and many families (Omari 1988a).

Many studies focus on education as an influential factor in fertility decline. But few questioned the rationality behind decisions made to have children in the family. Child bearing is bio-and socio-cultural (Omari 1988a). It is bio–cultural because in the sense that in many cases during the child bearing process, the baby has to pass through the woman's womb even with the modern technology in reproduction. Somehow, the human essence in matters of sperm and ovary must be there. The way this human essence developed and eventually brings the child to the world includes decision making and couples communication about fertility control, which is a cultural process.

2.5 Social Development Process and Fertility

Couples decide on matters concerning fertility on the basis of reality that they are experiencing. People in less developed countries base their rational choices on the basis of experiences and what they see fit for them and their future. For example, couples in Richtersveld (Namaqualand) have access to modern FP services, but not all couples are utilizing the modern methods in fertility control. What are the reasons behind this attitude? Kocher (1984) analyzing the effects of economic development and income on fertility decline in rural areas of less developed countries states that there are four distinct categories of determinants of parental need for children in which their fertility decline is affected:

1. The direct cost and benefit of children.
2. The opportunity cost of children.
3. The family income and wealth.
4. The family task and norms.

Then he expanded his argument by stating that couples will not take deliberate action to limit fertility unless they expect that the benefit will exceed the cost of doing so. Couples will only be motivated to limit fertility if they perceive that it is advantageous for them to do so, this is more likely to happen if the number of children survive.

2.6 Changes towards Gender Balance

According to Becker et al. (1996), a change towards gender balance in contraceptive research has accompanied a complete view of the determinants of contraceptive use. The Demographic and Health Survey (DHS) program has gathered information from men about fertility and

contraception in a number of countries in the less developed world. This extension also fits common policy trend towards encouraging men to share more justifiably with women the responsibilities of fertility control and parenting (Bongaarts and Bruce 1995).

Among numerous studies on whether men agree with their partners (e.g., Bankole et al 1998), nearly none investigate men's view on contraception broadly and thoroughly. A number of studies focus on men's overall approval of family size whereas few examine men's attitude towards specific males' methods such as condoms or vasectomy. Men's views about the full range of available methods have been largely ignored (Mbizvo and Adamchak 1992).

The effect of spousal communication on FP use may also be mediated by the relative power of each spouse in the decision making process. A study in Uganda suggested that a woman's social and economic vulnerability inhibits their ability to express and argue for their own interest with their partner and specific consideration of gender inequality as an important factor of the study of reproductive outcome (Dodoo 1998). A study in India found that husbands were main decision makers and initiators of the discussion about use of FP (Raju 1987). Imbalances in marriages favour men and husband's opposition to contraception use may be sufficient to block the use in many cases. While wife's opposition in preventing use if husband is favourably inclined will occur less often. This asymmetry generally means that when spouse disagree women's intentions to use FP may be thwarted than men (Becker et al. 1996).

2.7 Spousal Communication and Decision Making

The effect of spousal communication on FP may also be disturbed by the power of each spouse in the decision making process. A study in Uganda portrayed that women's social and economic

defencelessness hinder their ability to express and argue for their own interest with their partners and recommend explicit consideration of gender inequality as an important component of the study reproduction out come (Blanc at al. 1996).

It is useful to distinguish between contraceptive use resulting from a joint practice and use by any spouse alone without consultation. A study in the Philippines failed to demonstrate that joint decision making was more strongly related to contraceptive use than individual decision making. In this study, researchers pointed out that because the guide of decision making used could have been faulty and husband's tendency to consider FP women's anxiety may soften differences (Lozare 1976). It conclusively shows that, couples joint decision making is strongly associated with FP use.The differences between individual's sexual contraceptive behaviour and intention to space birth or end child bearing are among the highest in the world. Understanding the way spousal discussion affects the accuracy of reported partner's attitude towards FP may help policy makers to organize programs designed to lower unmet need (Becker et al. 1996).

Caldwell and Caldwell (1987) pointed out that men and their lineage rule over reproduction and decision matters on FP in Nigeria and elsewhere in Africa. Although no study has evaluated that hypothesis with empirical data, he emphatically argued that men are dominant decision makers on fertility matters in Africa (Isiugo-Abanihe 1994). However, the findings by Oni and McCathy (1991) are not consistent with those reported by Caldwell and Caldwell (1978). In the study of demographic innovators, Oni and McCathy (1991) reported that husbands usually made the decision to limit family size over half of marriages. They also found a high proportion of marriages in which wives makes the decision. Oni and McCathy (1991) report no incidence of wives taking the decision meaning what Caldwell (1978) suggested is that decision making does

not follow the logic modernization theories which hold that women become more involved in decision making process as modernization continues. Caldwell (1978) also highlighted that marriage in which wives are more likely to make family size decisions tend to be traditional ones, while husbands or both spouses are more likely to take joint decision in modern marriages. Other studies have looked at the decision making process from the stand point of couples based on couple data (Makinwa-Adebusoye 1997). A similar study by Mott and Mott (1985) found that there is a high degree of couple agreement on the use of FP but significant disagreement on fertility desire. In their conclusion those differences are not important for fertility outcome because they tend to be cancelled out at aggregate level.

Spousal communication is the key element in the adoption and continuous use of FP since it allows couples to discuss and exchange ideas that may modify held beliefs (Effar 1997; Roudi and Ashford 1996). Open communication about FP gives couples a chance to discuss family preferences and ways to accomplish them (Bertrand, et al. 1989). There is a general belief in Africa that couples do not discus FP and reproductive issues together (Musalia 2000, as cited in Musalia 2003).

Data from many African countries portray that communication between couples about FP is related to couples contraceptive use (Effah 1997). DHS data from seven African countries (Botswana; Burundi; Ghana; Kenya; Senegal; Sudan and Togo) show that the percentage of women who use modern contraceptives is higher among those who have discussed FP with their spouses than those who have not (Roudi and Ashford 1996).

The beginning of couple's discussion about FP initiates the start of the power negotiation process. Couples realize that agreeing on the number of children they will have is their best interest and this plays a role in declining large family ideology for which Africa has been known for (Cadwell 1982, p.333). Rosen and Simons (1971) found that in Brazil, a small family size is associated with great equity in family decision making process. In Sudan and Egypt, contraceptive use was high for couples that jointly made decision to use contraceptives (Nawar 1984, cited in Musalia 2003).

Spousal communication is vital in promoting contraceptive use but what is it that makes couples start talking to each other about FP in communities where high fertility was once a custom? This question can be answered by examining the extra influences that may cause couples to reconsider their fertility preferences (Cadwell and Cadwell 1987).

In many studies spousal communication has been associated with contraceptive use (Blanc 2001). Blanc made it clear that this association does not mean that communication increases contraceptive use, the reverse may be true. Couples who have already decided to use contraceptives may then tend to talk about sexual health (Salway 1994). He also stated that in Ghana women who had discussed contraceptives with their husbands were likely to be current users than those who had not. Hence in China, female factory workers and their husbands who received FP education emphasizing spousal communication and shared responsibility were not falling pregnant frequently and do abortion than couples whose members were educated about spousal communication alone and those who participated (Wang et al. 1998).

Some studies have shown that men are more likely to use condoms in casual relationships as a protection of STI's and pregnancy. The analysis of questionnaires completed by nearly 900 Rwandan women who reported having one partner, found that couples communication was associated with increased condom use, only if the discussion was specific such as discussing condom use or STI risk (Pile et al. 1999).

Since discussion between couples about sexuality, contraception and safe sexual practices causes anxiety and conflict, some researchers argue that attention to inter personal relations and communication should become part of overall design of FP programs. Recommended strategies for enhancing couple communication should include attempts to enlist the co-operation of men by providing them with educational services and FP communication skills (Bawah et al. 1999).

Kritz et al (1995) studied a number of dimensions of spousal agreement and found relatively high levels on the desire for more children, spousal communication on FP in the past year and wife's say on family size. He concluded by stating that these levels vary according to ethnic groups and appears to be related to women's status in their respective societies. On the other hand, Kanuri and Hausa (1991) also found high levels of communication and joint decision making among the Yoruba, Ibo and Ijaw. In contrast with Kanuri and Hausa (1991) tribal groups in which most husbands and wives agreed that they never talk about FP and the wife has no say on family size. Kritz et al (1995) found that Yoruba, Ibo and Ijaw spouses were more likely to agree that they did talk about FP in the past year and that their wives have a say on matters related to family size.

Kritz et al (1995) investigated whether agreement on fertility desires, spousal communication about FP and wife's opinion on family size could predict spousal agreement on the use of FP. Their study showed that spousal communication on FP was the best predictor of contraceptive use, even after controlling for spousal agreement on fertility desires, communication on FP, wife's say on family size, and spouses socio–economic characteristics e.g., education, work, religion, *etc*. These authors concluded that efforts to increase contraceptive use will remain ineffective unless combined information, education and communication strategies are first directed towards men.

Bankole (1995) examined the importance of spousal agreement for reproductive outcomes. He examined the effect of joint fertility desires on fertility using panel data from 1984 and 1986 surveys in Nigeria. He found that spousal agreement/disagreement is a significant determinant of successive fertility in situations where the couples disagree on the desire for more children. His analysis shows that the subsequent fertility falls between fertility of spouses who want more children and those who want to stop having more children. He also found that desires for couples carry the same weight as successive fertility. When he disaggregated the analysis by the number of living children, he found that husbands' desires became more important when the family size is small and wives' desires become more important when the number of living children is large. Bankole (1995) interpreted these findings using life cycle argument bearing in mind that in the Yoruba cultural context, women obtain increased autonomy and status within the household as they secure their position within their natal families.

It has been observed that in matters related to reproductive issues, women in several less developed communities have no say. Opinions and decision on when to have another child and

the number of children to have are often made by men and their kinsmen (Caldwell and Caldwell 1987, 1990; Macdonald 1985). Moreover, issues related to contraceptives are not discussed simply because the views of a woman who bear the burden of pregnancy and child birth are not considered to be essential. In a nutshell, this implies that the number of children a woman bears is perceived to reflect the desired fertility of her husband and his kinsmen.

In many studies in the less developed world, men's desired fertility has been observed to be higher than those of women (Ascadi and Ascadi 1990). Caldwell and Caldwell (1990) highlighted that men place high premium on children with the consequence that they desire larger family than their wives do. He also noted that the minimal involvement of women in decision making process regarding child bearing is one of the main reasons for high fertility in Sub-Saharan Africa.

Women in less developed countries are more often perceived to exercise little or no control over their economic or reproductive lives (Feyisetani 2000). They suggested that caution must be taken to avoid overgeneralization since the amount of control of men over their wives from place to place could change over time and be influenced by several factors.

The role of communication in bridging spousal communication on desired fertility and contraceptive adoption can not be over emphasized (Feyisetani 2000). Observed gender differences in fertility desires attributed to differences in the relative position of men and women in the society (Fapohunda and Todaro 1988; Frank and McNicol 1987) could be lessened through effective spousal communication on fertility expectations. However, lack of communication may also be a product of relative position of men and women.

Bankole and Singh (1998) highlighted that fertility and FP research in less developed countries, as well as policy and program formulation, has mainly relied on data collected from women. However, current focus on spousal communication research is to include men. The information that has become available from surveys conducted in the past suggested that men and women do not have similar fertility attitudes and goals (Bankole 1993). Although the range of fertility and FP has expanded to include broader reproductive health issues as sexual transmitted diseases from which data from men and women are needed.

2.8 Husband Desire and Fertility

Bankole (1995) stated that husband desire is dominant in predicting couples behaviour when the number of living children is small whereas the wife's desire becomes dominant as the number of children increases. Changes in reproduction, fertility and contraceptive behaviour have been reported in South Africa (Du Plessis 1996). However, lack of appropriate data prevented thorough analysis (Chimere–Dan 1993). The existing evidence indicates that fertility has been declining for three decades. This trend is noticeable in industrialized urban areas and in poor rural areas (Chimere-Dan 1996).

In other parts of South Africa where data are accessible, marriage appears to be losing its significance as a prerequisite for social accepted sexual relations in Transkei (Preston-Whyte 1993). An important part of this incident is the high rate of sexual activity among never married teenagers (Ncayiyane 1991). The study in Transkei also portrays that the desire for pregnancy and being pregnant are the main reasons for women to discontinue using contraceptives.

Husband objections were also highlighted as well as sexual inactivity and fear of side effects (Chimere-Dan 1996).

Economic theory of fertility with assumptions based on urban and industrialized countries does not verify African reality. Caldwell (1997) argues that the later generation transfer of wealth, which he assumes is generally from children to parents, is a major determinant of high fertility. The theory addresses the rural life of most African households and argues that in subsistence rural economy existing in most Sub-Saharan African countries large families constitute family assets. However, some studies have shown that assets flow has modest effect on childbearing.

Taking into consideration other aspects of African households, Fapohunda and Todaro (1988) suggested the "Transition framework" which puts the reproductive decision making on the individual rather than at the household level. The framework incorporates the notion of spousal separateness. In African countries with polygamous households it is not an uncommon experience for a husband and a wife to belong to the same household but operate separate incomes and have different economic responsibilities, and interest with regard to child bearing and issues of resource allocation in general (Kritz and Makinwa - Adebusoye 2001).

According to Isiugo–Abanihe (1985) there is a desire to perpetuate the lineage which results in large kinship networks. The presence of kinship ensures that biological parents often get economic support from close kin through child fostering. The resulting differentials in the cost of children to a conjugate pair may lead to differences in the demand for children and high fertility level. Women enjoyment of any decision making is powerfully shaped by social institutions (Mason 1987). The patriarchal, hierarchical and polygamous group of many African

households tends to spread the low status of women in African societies. Early marriage and polygamous unions are institutions that perpetuate women subordinated position and make them powerless in matters affecting their reproduction (Kritz and Makinwa–Adebusaye 2001). Ebigbola (1992) views that in marriage a woman assumes a low status relative to all members of her husband's family, which is elevated by high educational attainment ownership and control of substantial residence.

On the basis of change in African family in Nigeria, Caldwell (1987) advanced the argument that men and their lineage rule over reproduction and decision on matters related to family size in Nigeria and else where in Africa. A view persists that men are major decision makers on fertility matters in Africa (Kritz and Gurak 1991). Several studies emanating from a survey of women status and fertility which consist of data on married couple in five Nigerian ethinic groups: the Hausa, Ibo, Yuruba, Ijaw and Kanum, looked at several dimensions of women decision making, spousal communication and spousal agreement on the desire for more children, and wife on FP (Kritz and Makinwa-Adebusoye 1994; 1995; Makinwa-Adebusoye and Kritz 1997). These studies confirm that spousal communication levels vary across ethnic groups and appear to be related to women's status in their respective societies. For example, a spouse from the group in which women's status is the lowest have a higher level of disagreement on fertility desire than those from ethnic groups in which women status is higher. Higher level of decision making and joint decision making were highlighted among Yoruba, Ibo, and Ijaw in contrast with Kanum. Overall, women shortcoming is augmented by lack of education, legal rights and inheritance rights and reinforced by customs that place very great value on high fertility in African societies.

In many African societies childless couples are frowned upon. The main problem is that any childless couples fail high fertility (Musalia 2003). Fertility decision making is not found within a marriage family unit, instead it is encapsulated within a social system. In extended family and social system, the nuclear family is relatively powerless in fertility decision making process (Caldwell and Caldwell 1987; Frank and McNicoll 1987). Neglecting male component in predicting fertility levels meant that the power dynamics in understanding were not considered important. Yet failure to incorporate power dynamics in African families has potential to lead to serious misinterpretation (Biddlecom et al 1997). Further, the role of men in understanding demographic dynamics is starting to come out in the literature. Rosen and Benson (1982) stated that there is recognition that the number of children the couple would like to have and the decision about whether to use FP methods requires engagement in negotiation between men and women.

2.9 Social Networks and Spousal Communication Barriers

In line with Hollabach's observation of the way couples interact with kin, neighbours, peers, community leaders, health professionals and state authorities on what transpires within couple's, Musalia (2003) explored the role of social networks in influencing whether the spouses talk to each other about FP. Watkins (1990) pointed out that "even if the couple is in the bedroom, the echoes of conversations with kin and neighbours influence their action." The question is: Do these echoes stimulate spouses to talk about FP on the basis of discussion they have had with their friends. As a result, it is expected that those who engage in discussion with others about FP are more likely to discus FP with their spouses. Perhaps this comes by the way of talking about day events which may include a discussion on what other men and women think about FP.

Changes observed at the FP level represent a change of what is going on in the society. What happens at the family level is the end result of a social process that is initiated and agreed upon social networks (Musalia 2003). The reduction of the gender gap between men and women in terms of their understanding of FP is an outcome of what is going on within social networks.

Other scholars (e.g., Musalia 2000, as cited in Musalia 2003; NCPD 1993; Westoff and Rodriguez 1995) have highlighted that the media has been credited with facilitating an increase in contraceptive use in less developed countries. An analysis of the 1989 Kenya DHS which revealed that 50 percent of those who heard a FP message over the media were using contraception. This percentage compared with 14 percent who were using contraception and did not remember having heard FP message over the media (Westoff and Rodniguez 1995). Jato et al. (1999) recorded similar results for Ghana, Tanzania, and Thailand. The media is important in disseminating and evaluation of new reproductive behaviour. However, it is through social networks that behaviour change. At best the mass media creates awareness about new ideas such as use of contraceptives; the rest is left on social networks (Musalia 2000, as cited in Musalia 2003). Katz and Lazafield (1955, p.32) pointed out that communication researchers should take full account of inter personal context to check more complex aspects of media influence.

These authors, therefore, confirmed that social relations are important and should be considered in interpreting media products. According to Liesbes and Katz (1990) it is within social networks that people create meaning out of media messages. This meaning has common property since it arrives through discussions that involve negotiations among various people within the social network. Social networks, therefore, mediate potential effect of media, the consequences of media exposure is to give social networks something to talk about and evaluate (Musalia 2000, as

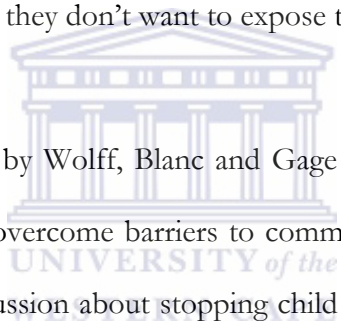
cited in Musalia 2003). The major shortcoming of media studies is their failure to examine the process through which media message is translated into action. Incorporation of social networks in the study of how spouses start talking about FP is the first step in disentangling the ongoing and complex process of understanding behaviour change (Jato et al. 1999).

Some researchers are intrigued by couples who are unable to communicate effectively about what affects their quality of life (Lasee and Becker 1997). One of the arguments regarding this issue is that spousal communication about the ways to limit childbearing may imply that such matters could raise suspicion or imply that men want to have children outside of marriage. If a woman says that she want to bear few children, the man may think she is no longer interested in him. He may go outside marriage in order to bear more children. If he is open minded and tells his wife that they need to limit the number of children, the woman might also think that the man is no longer interested in her.

In some societies, where women are expected to bear many children for their husbands, the introduction of FP can result in imbalance of power relationship between couples. Taking into consideration 36 focus group discussion with married men and women, young and old men and women randomly chosen male and female opinion leaders, living in rural Northern Ghana between 1994 and 1996, Bawah et al. (1999) pointed out that child spacing is greatly valued, as it is in other parts of Sub-Saharan Africa. However, contraception use is activating tension in gender relation. Such tensions sometimes led to marital separation, physical abuse of wives and opposition of family members. Ghanaian woman said "if you discus FP with other men, they will get you and beat you" (Biddlecom et al. 1997). In a study conducted in Costa Rica, Indonesia, Mexico and Senegal, the most common reason cited for not negotiating female

condom use with their husband was fear of violence, withdrawal of economic support or suspicion of unfaithfulness (Rivers, et al. 1998).

Differences in race and ethnicity have also been found to produce barriers to couple's communication about sexual issues. Ford, Sohn and Lepkowski (2001) concluded that different racial and ethnic group of different networks may have different expectations about gender roles and communication in relationships which may affect the likelihood that contraceptive use will be discussed. Discussing sex-related issues is too embarrassing for some couples. Generally, women are supposed to know little about sex and men with little knowledge of sexual matters may avoid discussing them since they don't want to expose their ignorance.



In Uganda, research conducted by Wolff, Blanc and Gage (2000) stated that formal education was taken as a primary way to overcome barriers to communicate about sexual matters. These researchers also stated that discussion about stopping child bearing, particularly conversation in which the wife voiced out her opinion, occurred among educated couples more than among uneducated couples (Wolff et al. 2000). Based on research in Uganda, Blanc (2001) suggested that because direct communication can generate conflict, it is best to promote direct discussion of such sensitive topics by having someone other than the couples to raise them in public forums.

2.10 Males' Involvement in Family Planning Practice

Bankole and Singh (1998) also emphasised that failure to involve men in FP can have serious implications even when women are educated and motivated to practise FP. They may not use contraceptives because of their husbands' opposition. Individual interviews in Sudan showed that the male partner decides if couples can use contraceptives. If they do, males supply the

methods (Khajifa 1988). Others have questioned the validity of estimates of unmet need derived from information collected from women only (Dodoo 1998).

Male partners may play a vital role in decision making regarding contraceptive use, timing and the ideal family size and they have greater influence than their spouse (Frank and McNicoll 1987). However, the perception that men have more influence on reproductive decisions because they typically control the family assets as they are generally known as the head of the household may not be effective at all times as their influence is more likely to depend on other factors and to vary over time by location (Bankole and Singh 1998).

According to Casterline (1991) Synthesis Framework, contraceptives behaviour is jointly determined by motivation to practise contraception versus the cost of contraception. The costs encompass much more than the accessibility of FP services. They include psychological and cultural factors that act as a barrier to contraceptive practise among men and women motivated to practise contraception. Thus, the expanded definition of the cost of contraception is consistent with the growing recognition that unmet need for FP services can not be attributed solely to inadequate access in many settings.

According to Kulezyeki, et al. (1996), there is less evidence about men's views about abortion as a measure of fertility control given that about one in four pregnancies worldwide is terminated deliberately. As a result, one might assume that unmarried men do not know about their partner's unwanted pregnancies or abortions yet some evidence indicates otherwise (Greene and Biddlecom 2000).

Most studies that examine men's views on contraception do so in limited ways, mainly by asking overall approval of contraception or few methods such as condoms or vasectomy (Sarkar 1993). Generally, approval of contraception in most less developed countries is very high and differences between men's and women's approval of contraceptive use tend to be very small (Ezeh et al 1996). The high level of men's approval of contraception may be influenced by the desire to project a modern image to an interviewer or to provide socially desirable answer (Greene and Biddlecom 2000).

The study in the Philippines that focussed in more detail on the perceived cost of FP found that men expressed strong views about methods and their various attributes and their views were similar to women's overall views although the level of disagreement among matched spouses was substantial (Biddlecom et al. 1997). A study of lower income Egyptian men's opinion of contraception found that they heard specific concerns about health and sexual side effects of contraceptives from their wives such as fatigue brought on by use of pills or bleeding from using IUD (Ali 1996). He also highlighted that men's view on contraception may vary with the reason for using contraceptives. He used Dakar, Senegal as an example where researchers found that acceptance of contraception among men was significant even among males from the most conservative background (Posner and Mbodji 1989).

A number of studies on whether or not men know contraceptives methods stand in contrast with very few studies on how men acquire this knowledge and whether the knowledge mean anything in practice (Greene and Biddlecom 2000). Efforts have been made to learn about men's sources of information on FP including media exposure and their social networks (Mbizvo and Adamchak 1991). These authors argue that in many settings little efforts have been made to

educate men about reproduction and FP. Better understandings of what men are learning and from whom or where they learnt would be of interest (Greene and Biddlecom 2000). According to their understanding, the degree to which males are informed about reproductive health especially the experience of their partners is relatively unknown.

One of the main reasons for including men in studies of reproduction is due to the fact that they prevent women who want to use contraception (Green and Biddlecom 2000). According to (Green and Biddlecom 2000) this has inspired numerous studies of reproductive behaviour of couples with a special emphasis on the extent of spousal disagreement. However, the justification is the other way round that women might prevent men from using contraceptives and even more men might deny women who want to have more children. The literature is replete with the assumption that men stand in the way of women's desire for small families.

Regardless of the emphasis on men's pronatalistic actions, existing evidence does not support this characterization. For example, only a small fraction of women who state in survey interviews that they want to delay or limit childbearing claiming that their partners opposition is the main reason they do not intend to use contraception (Westoff and Bankole 1995). Casterline et al. (1997) examined assumptions that men prevent women from using contraceptives in three areas: Spousal relations, differing fertility preferences, and pronatalism of one partner. They found men's influence is likely to be more indirect that can be indicated by single survey question.

An outstanding assumption about men's fertility preferences is that men want more children than women do. One of the arguments is that men do not bear the physical or often even the

economic cost or repeated childbearing borne by the women (Green and Biddlecom 2000). The fertility preferences of men as a group are the same as those of women in less developed countries (Mason and Taj 1987).

A review of data from 17 DHS for both men and women (Ezeh et al. 1996) found that men's ideal family size ranged from 3 to around 9 children in West Africa, and about 3 to 5 children in North Africa. In their documentation, gender differences in fertility preferences were very small except for West Africa where men's ideal family size exceeded by 2 to 4 children (Greene and Biddlecom 2000).

Mott and Mott (1985) contributed by clarifying that the small differences found between men's and women's fertility preferences at the aggregate level can obscure substantial disagreement between men and women at couple's level. A study in Malaysia and Taiwan showed that, overall, congruence between men and women on family size preferences and sex preferences was high but agreement was low among couples. Becker et al. (1996), Coombs and Ming-Cheng (1981), Fernandez (1978), did an extensive review of couple's studies in which they evaluated the correspondence between the husband and wife on a variety of reproductive measures across surveys in less developed countries. They discovered that the direction of spousal communication is important as in the case with the level of agreement. However, spousal differences in desired family size do not imply that they are more pronatalist. A couple study in India showed most preferences for additional son and when there was a disagreement the husbands tended to be less pronatalist than wives mainly because males have less dependence on sons for old age support (Jejeebhoy and Kulikorni 1989). This study also illustrates the fact that husbands and wives can have differences in childbearing decisions. Preferences of boys may also

make men more pronatalist than women. Spousal disagreement on reproductive maters relates to ways in which men and women communicate their preferences.

In West Africa, nearly 75 percent of men reported that they had never discussed FP with their wives. In East Africa fewer than 40 percent said they had never discussed and in North Africa the percentage was even lower (Becker et al. 1996; Ezeh et al. 1996). In situations where men discuss FP with their wives, it is important to note that communication can also be nonverbal especially where there is no tradition of discussion between the spouses about sexual intercourse or contraception (Balmer et al. 1995). According to Van de Walle and Maiga (1991), failure to communicate about sex and other reproductive matters can lead to failure to act on commonly held preferences depending on how decisions are made this can also mean behaviour remains unchanged. A study in Uganda by Blanc et al. (1996) examined the ways in which negotiations occurs within the sexual unions. Detailed questions were asked about couples' communication and how they resolve their disagreement and comparison were made between partners. The researchers found that both communication and disagreement were uncommon: one third of the respondents had discussed FP or child spacing with their spouses. Most respondents believe that they had a clear understanding of their partner's desire. Each partner tended to claim responsibility for decisions and women were more likely than men to perceive disagreement with their partner over reproductive issues (Greene and Biddlecom 2000).

Theoretical models of reproductive decisions are numerous but most application use data from the United States (e.g., Beckman 1983; Hollenbach 1980; 1983; Thomson 1990; 1997; McDonald et al. 1990). These authors focus less on whether men dominate decision making and more on how spousal disagreement gets resolved and the specific spousal characteristics and desire that

affect the couple reproductive behaviour. Other studies on decision making drawn on specific questions such as who is the main decision maker and who has the final say on a given matter (Green and Biddlecom 2000). These have become standard questions for a number of national surveys. For example, 55 percent of husbands and wives interviewed in a survey in Egypt said that they are on the use of FP method and 37 percent husbands said they had the last word (Trottier et al. 1994).

A study in Sudan showed that 45 percent of ever married men stated that FP decision should be made jointly by couples while 30 percent said it was a husband's right alone (Khalifa 1988). Even in the United States where fertility is low and where more than 75 percent of men aged 20-29 years believed that men and women share equal responsibility for decision about contraception, generally men are twice likely to claim that they have greater responsibility on contraceptive decisions as they are to say women do (Grady et al. 1996).

According to Djamba (1994) results from surveys do not support the assumption that men are opposed to FP or that they have little interest in spacing and limiting births. On the contrary, there is evidence that men are aware of FP and are open to learning more about it. In a Zimbabwean national survey of men with reproductive age wives, Mbizvo and Adamchak (1991) found that virtually all men had received FP information mainly from radio and personal communications. Interestingly, nearly 85 percent of these Zimbabwean men said that they would like to learn more about FP.

Research conducted in two suburbs of Accra in Ghana revealed that men showed interest in using FP services for themselves and their wives (Armstrong and Onsei 1989, as cited in Djamba

1994). Similarly, data from a 1982 survey of male Khartoum residents in Sudan showed that three in five men with reproductive age wives wanted to use FP and more than half of the men wanted to learn more about male and female sterilization (Mustafa and Mumford, 1984).

A study conducted in Dakar, Senegal, for example, shows that only about six percent of teachers oppose the use of FP. This value represents the highest rate across all employment categories. Moreover, it does not appear surprisingly high given the fact that teachers want relatively more children than do other workers (Posner and Mbodji 1989).

Other studies show that there are currently married women who are not using a contraceptive method because of opposition from their husbands. This shows that the husband's opposition is not the most important reason for non-use of contraceptive methods. In fact, majority of women who reported their husbands as disapproving have never discussed FP with them. Thus, the perception of husband's opposition is associated with the lack of communication. For example, when women are ignorant of their spouse's views they assume them to be negative (Bongaarts and Bruce 1995). In Kenya, for example, the lack of communication between spouses proved to be a more common obstacle to contraceptive use than male opposition (MacCauley et al. 1994).

According to (Becker et al. 1996; Ezeh 1993; Ross and Winfrey 2001) men's and women's reproductive goals differ. Difference in reproductive preferences between couples affects contraceptive use. This has led to studies that focus on comparing couples. Comparing individuals who make up a couple and treating couples as a unit for analysis adds a different point of view and enhances our understanding of the importance of spousal communication

about FP and contraceptive use. On the other hand, couple level approach involves two individuals who matters most in contraceptives use decision making. Furthermore, their differences are more real in terms of their reproductive outcome. An important limitation of the couple level approach is that it does not cover the preferences of men and women who are not in legal or cohabiting union (Bankole and Singh 1998).

Chapter Three: Methodology

3.1 Introduction

Richtersveld is situated in the North West part of South Africa. It is part of the Northern Cape Province. Its northern boundary, the Orange River, is the border to neighbouring Namibia (Figure 1). Richtersveld is classified as semi-desert since it receives very low rainfall of less than 300 millimetres per annum. On the coast it rains even less because of cold Benguela currents that frequently bring dense sea fogs to this coastal desert region as well up to the Namibian border.

In the whole region of Richtersveld, health services are generally poor leading to poor contraception use. However, people do have limited knowledge of contraceptives and information about how to use them. This is mainly due to poor resources and limited number of health workers. Educational attainment levels in the whole area are generally very low. Majority of them have matric (high school certificate) or completed primary school. People who live in the area for work don't stay long because of the harsh environment.

Serious diseases are very rare in Richtersveld. For example, the HIV/AIDS prevalence is very low (Alexkor HIV prevalence survey April 2003) although there is no clear reason for low prevalence of HIV/AIDS, this might be possibly due to the low level of migration, late initiation of sexual activity in life and may be couples have fewer sex partners than other parts of South Africa. According to the census of 2001, the population size of Richtersveld was 10,124 and it was dominated by Coloureds.

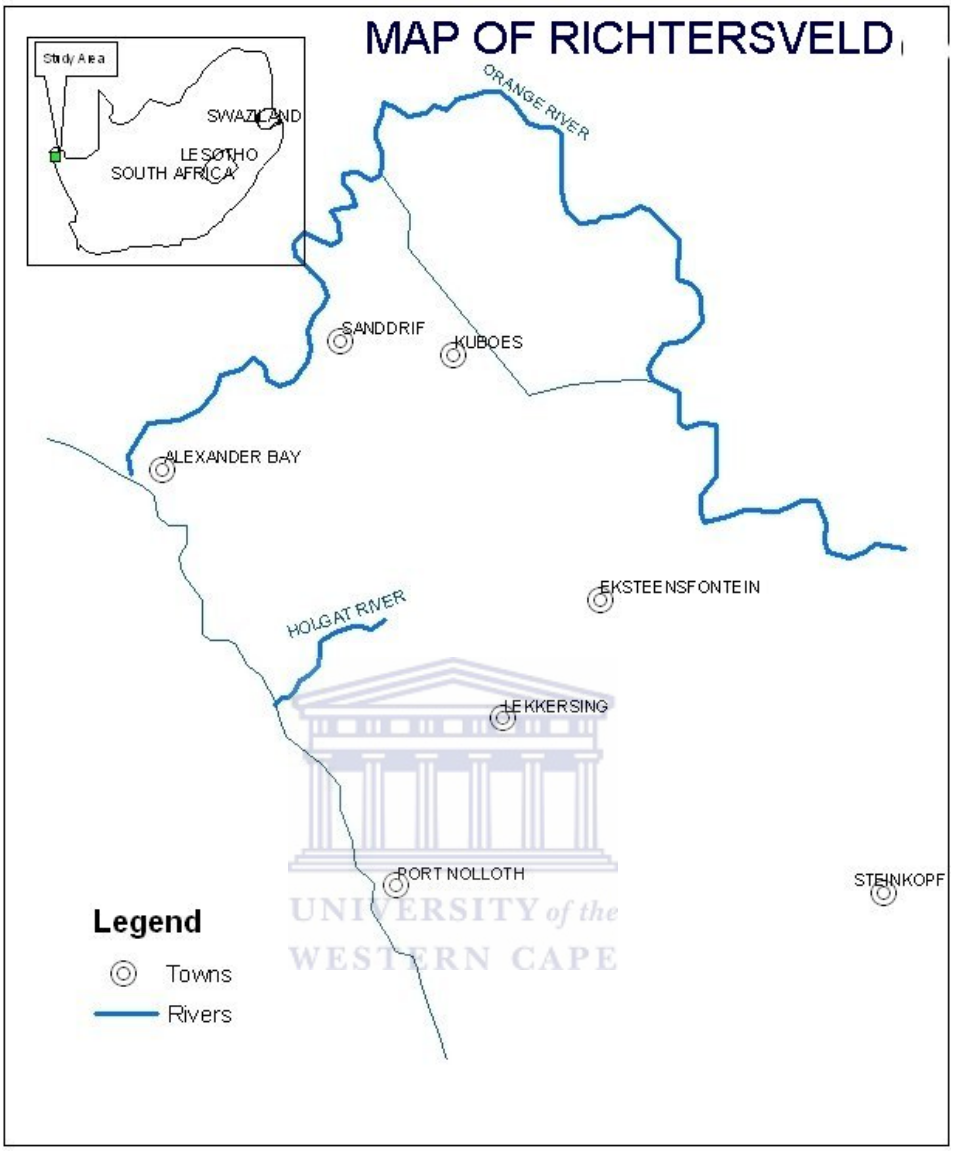


Figure 1: Map of the Study Area

3.2 Description of the Study Sites

3.2.1 Alexander Bay

Alexander Bay is a self contained coastal mining town situated in the North West corner of South Africa at the mouth of the Orange River. It was formerly put on the map in 1927 after the discovery of diamonds by Dr. Marenskey. Alexander Bay is synonymous with diamonds which were discovered along the coast in 1926. Dr Marenskey discovered 487 diamonds under one stone. It was at his request that the government intervened to prevent the diamond market from collapsing due to over production. The population size of Alexander Bay in 2004 was 1,452 of which 3 percent of this population was Black/African, 64 percent Coloureds and 33 percent Whites. In the whole town there is only one hospital, one doctor and few nurses.

3.2.2 Port Nolloth

Port Nolloth is situated on the west coast of South Africa, approximately 80 km from the Namibian border. It has a strange desert atmosphere as it is arid and barren coastal plain, yet it holds attraction to visitors. Rainfall is about 45mm a year mostly from the mist which encroach from February to July covering the coast in fine chummy blanket. Initially, Port Nolloth served as copper mining area but received a lease of the discovery of alluvial diamond along the coast of Namaqualand in 1926. The population size of Port Nolloth in 2004 was 4,658 of which 17 percent of that population was Black/African, 76 percent Coloureds 7.2 percent Whites. In Port Nolloth there is at least one public hospital.

3.2.3 Kuboes/Sandrift

Kuboes is a very small village town situated in the heart of Richtersveld Mountain on the node between dry semi-desert mountain and green oasis along the Orange River. Kuboes is very hot

and dry. However, it still contributes to one of the most attractive diverse in southern Africa. Succulents such as the ancient Kokerboom share the rocky soil with birds, reptiles and insects. Temperature is up to 40 degrees celsius in summer. Although it is a winter rain area it mostly receives less than 50mm rain a year.

Residents of Kuboes are those who were staying in Alexander bay. They were removed from Alexander bay after the discovery of diamond. The population size of Kuboes in 2004 was 1,137. This comprised of 10 percent Whites, 19 percent Black/African and 71 percent Coloureds. There is one small clinic and one health worker with no doctor in Kuboes. The clinic normally closes at 1 o'clock every day. After 1 o'clock they only serve people who are already inside the clinic.

3.3 Research Design

Information on issues related to spousal communication and FP was collected by a structured questionnaire that was administered to respondents in the Northern Cape Province. The study included quantitative and qualitative questions with the latter being useful in better understanding quantitative results and improving the validity of the study as a whole. Inclusion of qualitative questions allows study participants to express why they think and act the way they do and also describes the economic and social factors that affect participant's decisions. The purpose of the study was clearly explained to the respondents and they were assured of confidentiality. Respondents were asked to complete a consent form which is consistent with ethics rules. They were informed that the data collected will be stored in a secured place in the Department of Statistics at the University of the Western Cape. The privacy of the participants was highly respected and they were informed of their right to refuse to respond to any of the questions they felt uncomfortable with or decline from participating in the entire study.

3.4 Data Collection

The study area involved three towns in the Northern Cape Province in the Richtersveld (Namaqualand) which is Alexander Bay, Port Nolloth and Kuboes. Population files from each region were obtained from Municipality offices and used to list out the total number of couples. This list was used as the sampling frame from which a random sample was finally selected. The file providing age of the couples and the house number was used as the guide.

Two pre-tested questionnaires for husbands and wives were used for data collection from the 3rd to the 28th of September 2005. The background section of the questionnaire gathered socio-demographic information and data were collected from 130 households. Separate interviews were conducted with two household members, the husband and the wife.

Information was also collected from respondents on knowledge and use of contraception, FP discussion, fertility and a wide range of variables including pregnancy questions. However, males were asked about background characteristics, fertility experiences, contraceptive knowledge and use, marriage and reproductive preferences.

Some questions on contraception were adopted from the Demographic and Health and Survey (DHS) questionnaire and included information on whether the respondents had ever attempted to prevent pregnancy, their age at first attempt to prevent pregnancy and whether they had ever heard of contraceptives. In the FP module, the questionnaire contained a number of modern and traditional methods and respondents were asked whether they have ever used any of those methods. Other information was sought on the source of information about contraceptive use. Detailed questions were asked about current methods, of contraceptive use and intention to use

in the future. The male questionnaire was similar in structure to the female questionnaire, but shorter.

The sampled population comprised of couples, defined as married men and their wives. A marriage included either legal union or cohabitation. Women of reproductive age (i.e., 15–49 years) were selected and their spouses were interviewed irrespective of their age. Couples with one or more children, couples who have no children and pregnant women were also included in the study. Couple data sets were created comprising of husbands' and wives' FP discussions, contraceptive use and other fertility related matters.

Seven males and seven females aged 21 and above, who speak and write English and Afrikaans and portrayed extensive knowledge of FP were hired as field workers. They all had matric certificate and they were working in pairs (male and female).They were given adequate training which took two days. They interviewed husbands and wives separately. If both partners happened to be at home during the interviewers visit, the two of them were interviewed simultaneously. In total, three visits were made to every household. Respondents who were not available after three visits were no longer contacted. The privacy of the participants was highly respected and their rights to refuse to participate were acknowledged whether they had reasons or not. The participants were also allowed not to answer any questions which would make them feel uncomfortable, or to stop answering questions in the middle of the interview. Effort was made to seek respondent's cooperation. The general impression was that most of the respondents had never been involved in any kind of research before, except for the census. A total of 130 couples were interviewed from different areas. The overall response percentage was 50 percent for males and 50 percent for females respectively

Sample Size

A random sampling design was used to generate the sample size. Each region was divided into two sections, A and B. Within each section, the sample was drawn. The following formula based on the Bernoulli distribution was used to calculate the sample size:

$$N = \frac{2.6 * P(1-P)}{a^2};$$

where;

N is the sample size;

P is the maximum expected proportion of couples (=0.5);

a is the margin of sampling error tolerable (=0.05);

n is the sample size divided by hundred (=2.6);

$$N = \frac{2.6 * 0.5(1-0.5)}{(0.05)^2} = 260$$

(that is, 130 couples)

3.5 Methods of Analysis

Data entry was done in Microsoft Access and transferred into STATA™ using Stat Transfer software version 7. Data analysis was performed using STATA™ statistical software version 8. Assessment of the association between contraceptive use (the outcome variable) and the relevant explanatory variables was done by both bivariate and multivariate methods. In bivariate analysis, contingency tables were used to identify the patterns among the study variables and to select candidate variables for inclusion in the multivariate analysis.

Chi-square test was used to test the relationship between independent variables and their outcomes. Correlation analysis was used to identify the dependent variable and to assess the extent to which the responses given to each of the variables correlates. The correlation analysis is specified as follows:

$$R = \frac{1}{n-1}\sum_{i-1}^{n}\frac{x_i - \mu_x}{\sigma_x}\frac{y_i - \mu_y}{\sigma_y}$$

where;

μx and σ_x denote the sample mean and the sample standard deviation respectively for the variable *x;* and

μy and σy denote the sample mean and the sample standard deviation respectively for the variable *y*.

Alternative statistical methods of handling several variables simultaneously were examined, if spousal communication and agreement had an effect on FP behaviour. Logistic regression analysis was used since this type of regression is appropriate for categorical dependent variables. The logistic regression included five variables: education attainment, age group, marital status, duration of marriage and residence. These variables were included in the model to examine their effect on FP discussion. The reduced form model of logistic regression can be written as follows:

$$y = b_0 + b_1 x_1 + b_{12}(x_1)^2 + b_2 x_2 + \ldots + b_n x_n + \mu;$$

where;

y is independent variable, discuss

b_0 is an intercept;

x_1 *to* x_n are a series of variables such as couple's age, education attainment, marital status, duration of marriage, region of residence, *etc.*

A binary probit model (Long 1997) is also used as the method of analysis. It is estimated as:

$$Pr(y=1/xi) = F(xi\ \beta),$$

where;

F is a standard normal cumulative distribution function;

X represents a vector of control variables;

y=1 if a woman used any method of contraception in the interval, and zero otherwise.

Heckman selection model was employed to test for selectivity biasness. According to Berk (1983) if selectivity bias exists, the expected value of the disturbance term is no longer zero and tends to correlate with the exogenous variables. Heckman models assume an underlying regression relationship in which the dependent variable is a function of a vector of predictor variables that respondents could be selected for (Bawah 2002).

3.6 Measures of Contraceptive Use

Generally it is assumed that couples may have children because they want to or they do nothing to prevent pregnancies. Some couples are unable to bear children whereas others are partially sterile and cannot have as many children as they desire or cannot conceive as often as they might wish to do so (Bankole and Singh 1998). Yet some couples conceive very frequently, against their desire, if no contraception is used.

The effectiveness of any FP program depends on the communication and agreement between couples (Omari 1988b). The problem of relative effectiveness does not depend on the choice of birth control but on mutual agreement and not assumption of the desire of the other partner. Respondents were grouped into two groups during data analysis: Those who were currently using contraceptives and those who were not.

Respondents were asked a number of demographic and fertility-related questions such as whether they had wanted a child at the time of their last pregnancy or whether they had discussed FP. For those who responded about the discussion of FP in the affirmative, they were further asked about who usually initiate such discussion. Contraceptive use included couples' combined level of agreement, frequency of discussion about FP, religious affiliation, wife's age, and household assets were added to control for demographic factors that may have an effect on spouse's fertility desires.

Communication was measured by a set of questions which assessed the extent to which spouses communicated about FP methods and their discussion on the number of children they would like to have in the future. If either FP or ideal family size had been discussed, the communication variables were given the value of one and zero otherwise.

A number of control variables were used in regression models. Current age and the number of living sons and daughters of either partner were expected to be positively related to the ideal number of children. Daughter or son preference was addressed by comparing the number of living sons and living daughters on the ideal number children. Wife's or husband's education level was measured categorical, primary, secondary and tertiary.

Three types of factors that might influence fertility or contraception decisions were studied, i.e., age difference between couples, religion and education. Modelling decision making on the above factors requires data from women and men who answered questions about couple communication, negotiated agreements and the degree of gender influence on fertility or contraception outcome.

3.7 Study Variables

The following are background variables for the study: Age, religion, education, population group, marital status, duration of marital union, ideal family size, children ever born, number of sons, number of daughters, number of daughters and sons who were born alive, died later and number of current living children. A measure of wealth, represented by a living standards index (LSI), is constructed using data on household assets and employing principle component analysis (PCA). The asset data included information on household ownership of a number of consumer items such as a television, video deck, radio, car and electricity. Each asset is assigned a weight that is generated through PCA and resulting assets scores are standardized in relation to a standard normal distribution with a mean of zero and a standard deviation of one (Rutstein and Johnson 2004). The sample is then divided into population quintiles with the lowest and highest quintiles representing the poor and the rich households respectively.

3.7.1 Independent Variables

The main dependent variable in this study is FP discussion. The following independent variables are used for different models depending on the study question or research objectives:

- Attitude towards FP;

- Knowledge of FP;
- Fertility preference – ideal family size;
- Discussion about FP;
- Frequency of discussion in previous year;
- Issues (or items) discussed;
- Result of discussion;
- Spousal perception of the other partner's attitudes towards FP and fertility preferences;
- Initiator of discussion about FP;
- Decision maker to use or not to use contraception

3.7.2 Description of the Variables

Couples were asked whether they were using contraceptives at the time of the study. The ideal number of children was defined as the number of living children they had plus the additional number of children they were expecting to bear before they reach the end of their childbearing period. Couples were asked the following question: "If you could go back to the time you were not having any children and could choose the number of children to have in your entire life, how many of those children would you like to be boys and how many would you like to be girls. The variables consisted of three categories of responses indicating "number of boys" and "number of girls," and "It's up to God." The ideal family size for those with surviving children was predicted to be dependent on the couple's communication.

The agreement on FP by both partners and communication about FP were covariates of ideal family size among them. The relationship between communication and ideal family size was tested using correlation analysis. Since both partners were given an opportunity in the questionnaire to indicate high and low fertility motives, it was possible to compare the responses of husbands and wives to see the extent to which they agree. Responses to a direct question such as "Did you discuss FP with your partner?" gave an indication of the level of communication about FP.

The attitude towards the use of FP was evaluated by asking questions such as "Do you approve or disapprove of FP?" and "Do you think your husband approves/disapproves the use of FP?" These questions were asked separately to both husbands and wives and their answers were compared. The relationship between this approval and socio economic status was measured by the LSI. To capture the influence or awareness of couples to each other and compatibility of their views, couple's variables were created in order to compare the responses of husbands and wives to these three questions: "Who usually initiates discussion about FP?", "How did you end up the discussion on FP?", "Do you intend to use contraceptives in the future?" In each case logistic regression was used to predict the largest negative association of ideal family size. For example, both partners disapproved of FP, neither had discussed it nor knew of the source of information about FP. The association of each couple variable of ideal family size was expected to be positive. Wives' and husbands' responses were grouped to make most of couple's variables. Couple's age was divided into five groups: less than 20 years, 20–29, 30–35, 36–41, and 42 and over.

Religion: Responses about religious affiliation were divided into four categories: Catholic, Protestant, Islam and Traditional. Several categories of couple's religion were created based on the reported religious affiliation. For example, couples practicing Christianity were also grouped together.

Couple's education: Was grouped into three: primary, secondary, and tertiary, for both husband and wife.

Couple's occupation: Was divided into five categories: employed, self employed, unemployed, house wife and retired.

Couple's fertility preference: Had one variable: ideal family size which was defined as the number of children a wife or husband would choose to have for their entire life.

Couple's ideal family size: Had two categories: total number given and non-numeric responses indicating 'up to God.'

Couple's gender preferences for their children: Were grouped into four categories: total number of boys, total number of girls, either number, and up to God.

Family planning discussion between partners: Is dichotomous with both wife and husband reporting no discussion, and one or both partner's reporting discussion. The outcome variable was current contraceptive use and it was dichotomous variable with one or both partners reporting use and both partners reporting non-use.

Chapter Four: Data Analysis

4.1 Introduction

This chapter presents the results of the study as follows: The first section presents findings on the socio-demographic characteristics of the sample. The second section presents a discussion on knowledge and use of contraception.

4.2 Socio-demographic Characteristics of the Sample

Table 1 presents the percentage distribution of husbands and wives by selected background variables. The results show that the mean age is 35 years for husbands and 32 years for wives. While the data indicates fairly levels of education for husbands and wives, the husbands are generally more educated than their wives. A comparison of reported levels of educational attainment reveals that 19 percent of husbands attained primary schooling compared with 20 percent for wives. Husbands and their wives do not differ much in their religious composition and their ideal family size due to the general tendency for women who belong to different religious group before marriage to adopt their husband's religion after marriage (Bankole 1995). The association between certain variables of interest and demographic characteristics may reflect the influence of other associated demographic characteristics. For example, the association between education and contraceptive use may be due to an association between age and contraceptive use, since age and education may be correlated.

Table 1 also presents descriptive statistics for couples by race. Half (52 percent) of the respondents were Coloureds, about 42 percent were Black/African and 7 percent were Whites. The results show that 61 percent of the respondents were married couples compared with 39 percent who were living together and 41 percent had been together for more than four years.

Almost all couples had access to electricity, radio and television. However, a small percentage of couples had access to cars and tractors. There was 5 percent difference between couples ideal family size - ranges between one to two children. However, about 7 percent of males' ideal family size ranged between five to 10 children. Majority (54 percent) of couples had one to two children ever born and 80 percent of the couples had surviving children alive. The total percentage of couples who had living sons was 51 percent compared with 37 percent of living daughters. The number of sons who were born alive and died later was about 5 percent compared with couples who lost two sons (1 percent), and couples who lost one daughter constituted 3 percent compared with less than 1 percent of couples who lost two daughters. Generally, most couples had all their children alive at 80 percent compared with 20 percent of couples who had no children. Mortality rate seems to be very low in the study area, about 92 percent of couples had their children alive and only 7 percent of the couples were unfortunate to lose one or two of their children's, daughter or sons.

Table 1 **Percentage distribution of selected socio-demographic characteristics of couples in Richtersveld (Namaqualand)**

Characteristic	Females	Males	Total
Age group			
20-29	39.06	30.77	34.92
30-35	25.78	20.77	23.28
36-41	21.09	24.62	22.85
42-57	14.06	23.85	18.96
Mean age	32.41	35.38	33.88
Educational attainment			
Primary	20.16	19.20	19.68
Secondary	66.67	70.40	68.54
Tertiary	13.18	10.40	11.79
Race			
Black/African	40.00	42.31	41.16
Coloureds	53.08	50.00	51.54
Whites	7.69	7.69	7.69
Religious affiliation			
Catholic	26.92	28.46	27.69
Protestant	11.54	10.77	11.16
Tradition	3.08	4.62	3.85
Other	58.46	56.15	57.30
Marital status			
Married	-	-	60.76
Living together	-	-	39.23
Duration of marriage/Living together			
1	-	-	16.15
2	-	-	25.38
3	-	-	16.92
4+		-	41.53
Household possessions			
Electricity	_	_	98.46
Radio	_	_	82.69
Television	_	_	88.85
Video deck	_	_	28.85
DVD player	_	_	40.77
Land phone	_	_	30.77
Car	_	_	30.38
Tractor	_	_	2.69

Table 1 ***(Cont'd)***

	Females	Males	Total
Ideal family size			
0	13.48	8.11	21.59
1–2	57.30	62.16	119.46
3–4	29.21	29.73	58.94
Mean ideal family size	1.16	1.22	2.38
Children ever born			
0	-	-	17.60
1–2	-	-	53.84
3–4	-	-	20.76
5–10	-	-	7.92
Mean of children ever born	-	-	1.18
Has any living children			
Yes	-	-	80.00
No	-	-	20.00
Number of living sons			
0	-	-	40.00
1–2	-	-	51.54
3–4			6.92
5–10	-	-	1.54
Mean number of living sons	-	-	0.97
Number of living daughters			
0	-	-	50.77
1–2	-	-	37.31
3–4	-	-	11.15
5–10	-	-	0.77
Mean number of living daughters	-	-	0.89
Are there any of your children dead?			
Yes	-	-	7.79
No	-	-	92.31
Number of sons dead			
0	-	-	93.33
1			5.49
2	-	-	1.18
Mean number of sons dead	-	-	0.78
Number of daughters dead			
0	-	-	95.77
1	-	-	3.85
2	-	-	0.38
Mean of daughters dead	-	-	0.46
N			260

Source: Spousal communication study.
Note: "-" Not applicable.

Table 2 presents results from the analyses of variance and chi-square tests indicating differences in FP discussion between husbands and wives. Couples who discussed FP tended to be significantly better educated than those who did not discuss FP. Significance is also observed between race of the couple and their religion. However, couple's ideal family size and FP discussion showed no sign of significance.

Table 2 **Results of analyses of variance and chi-square tests indicating differences between husbands and wives**

	Discussed family planning		
Characteristic	**Yes**	**No**	**Chi-square test**
Race	**N**	**N**	
Black	87	14	0.01**
Coloureds	87	33	
Whites	16	4	
Educational attainment			
Primary	29	15	0.03**
Secondary	133	31	
Tertiary	26	3	
Religion			
Catholic	60	7	
Protestants	25	4	0.02**
Tradition	8	2	
Other	97	37	
Ideal family size			
0	15	2	0.65
1-2	79	13	
3-4	42	4	
5-10	-		

Notes: *p<.05.**p<.01.***p<.001.

4.3 Knowledge and Use of Contraceptives

Table 3 presents the results on the knowledge of contraceptives for women and men by study location. Knowledge here refers to the fact that the respondents have heard of a contraceptive method and not necessarily that they have enough knowledge of the method.

In Port Nolloth and Kuboes about 97 percent of women had heard of FP whereas all women in Alexander bay had heard of FP. Virtually all women had heard of the pill and injection while condoms seemed to be known in Port Nolloth and Alexander Bay (92 and 79 percent respectively) and little known in Kuboes (43 percent). About 94 percent of women in Port Nolloth and 86 percent of women in Alexander bay highlighted that they had used contraceptives before whereas only 43 percent in Kuboes had used contraceptive. There is high percentage of women who reported that they were using contraceptives in Kuboes and Port Nolloth (87 percent and 73 percent respectively) and only 45 percent women were using contraceptives in Alexander bay.

About 47 percent of women approved of FP in Kuboes whereas almost all women approved of FP in Port Nolloth and Alexander bay (92 percent and 93 percent respectively), and 72 percent of women in Port Nolloth had the intention to use FP methods in the future whereas 55 percent of women in Alexander bay and 47 percent of women in Kuboes had the intention to use FP methods in the future. Almost all women know the source of FP. Discussion of FP does not correspond with approval of FP among all women: 88 percent of women discussed FP in Port Nolloth whereas in Alexander Bay and Kuboes only 53 percent respectively women discussed FP.

As in the case of women, in Port Nolloth and Kuboes, about 97 percent of males had heard of FP whereas all males in Alexander bay had heard of FP. Almost all males had heard of the pill, injection and condoms. About 94 percent of males in Port Nolloth and 75 percent in Alexander bay reported that they had used contraceptives with their wives before whereas only 30 percent

of males reported that they had used contraceptives with their wives in Kuboes. About 79 percent of males were using contraceptives with their wives in Port Nolloth and 73 percent in Kuboes. Only 43 percent of males reported that they were using contraceptives with their wives in Alexander bay. In Alexander bay and Port Nolloth about 83 percent of males approved of FP and only 47 males approved of FP in Kuboes. Almost all males know the source of FP. However, about 83 percent reported discussion of FP in Port Nolloth and about 50 percent of males in Kuboes and Alexander Bay reported discussion of FP.

Figure 1 displays the prevalence of couple's contraceptive use by type of method and for the three research sites. In Alexander bay, 21 percent of the couples were using injections, 7 percent condoms, 7 percent pill and 29 percent were sterilized while 14 percent did not respond and 22 percent of the couples were not using any method. In Kuboes/Sandrift, 20 percent of the couples were using injection and 15 percent were using the pill, 57 percent did not respond, and 8 percent of the couples were not using any method. In Kuboes/Sandrift couples had poor knowledge of condoms and sterilization methods because there were no couples who were using condoms or highlighted that one of them was sterilized. Couples might not be using condoms because of the poor supply of condoms compared to other methods. However, in Port Nolloth 30 percent of the couples were using condoms, 31 percent injection, and 7 percent pill - which is the same as in Alexander bay. However, 6 percent of the couples were sterilized, 8 percent did not respond and 17 percent of the couples were not using contraceptives at all.

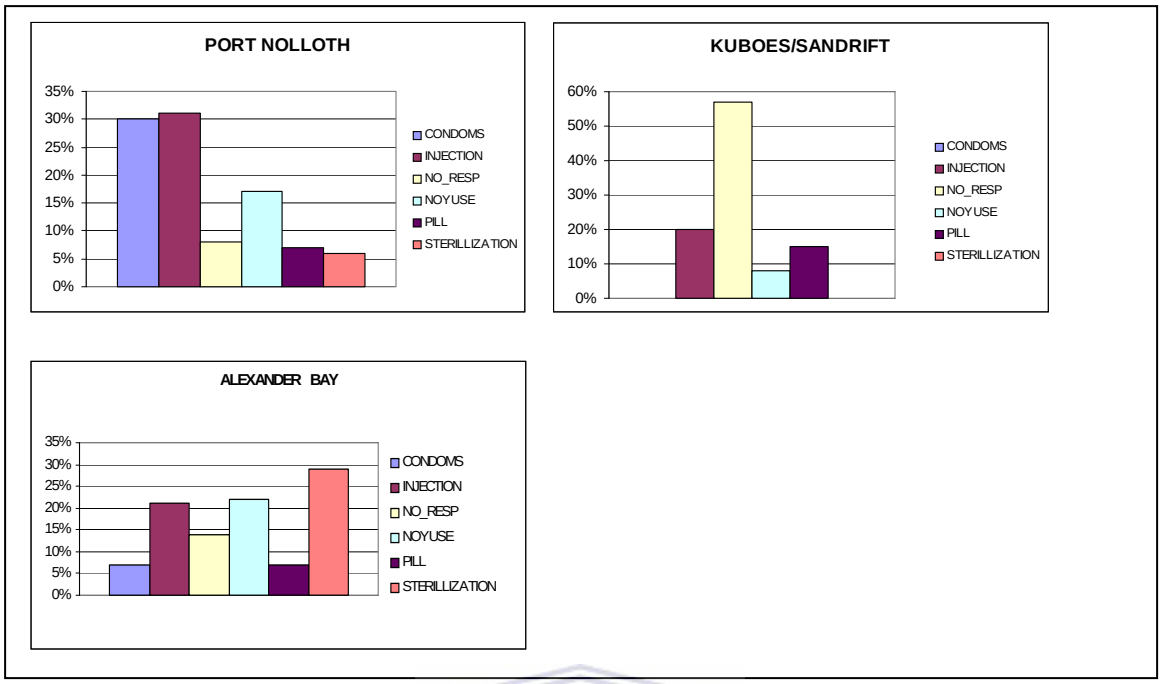


Figure 2 **Percentage distribution of couples using contraception at the time of the survey by type of method.**

Table 3 **Percentage distribution of selected variable related to knowledge, use and attitudes towards contraceptives by gender and area of residence**

	Women				Men			
Characteristic	**Port-Nolloth**	**Alexander Bay**	**Kuboes**	**Total**	**Port-Nolloth**	**Alexander Bay**	**Kuboes**	**Total**
Ever heard of FP								
Yes	97.18(69)	100.00 (29)	96.67 (29)	98.00	95.77 (68)	100.00 (29)	96.67 (29)	97.00
No	2.82 (2)	-	3.33 (1)	2.00	4.23 (3)	-	3.33 (1)	3.00
Method heard of								
Pill	97.18 (69)	100.00 (29)	93.33 (28)	97.84	77.22 (55)	89.66 (26)	86.67 (26)	84.52
Injection	94.37 (67)	96.55 (28)	93.33 (28)	94.75	87.32 (61)	89.66 (26)	90.00 (27)	88.99
Condom	91.55(66)	79.31 (23)	43.33 (13)	71.39	90.14 (64)	82.76 (24)	96.67 (29)	89.86
Female sterilization	47.89(34)	62.06 (18)	36.67 (11)	71.49	36.62 (26)	68.96 (20)	30.00 (9)	45.19
Male sterilization	2.82 (2)	55.17 (16)	3.33 (1)	20.44	5.63 (4)	62.06 (18)	16.67 (5)	28.12
IUD	1.41 (1)	31.03 (9)	3.33 (1)	11.92	1.41 (1)	34.48 (10)	6.67 (2)	14.19
Period abstinence	14.08 (10)	24.12 (7)	3.33 (1)	13.84	5.63 (4)	20.68 (6)	3.33 (1)	9.88
Herbs	7.04 (5)	10.34 (3)	0.00	5.79	8.45 (6)	6.89 (2)	0.00	5.11
Lactation amenorrhea	0.00	10.34 (3)	0.00	3.45	0.00	10.34 (3)	0.00	3.45
Withdrawal	0.00	17.24 (5)	3.33 (1)	6.86	2.81 (2)	24.14 (7)	3.33 (1)	10.09
Ever use FP								
Yes	94.36 (67)	86.21(25)	43.33 (13)	75.08	94.36 (67)	75.86 (22)	30.00 (9)	67.00
No	5.80 (5)	13.79 (4)	56.66 (17)	24.92	5.88 (4)	24.14 (7)	70.00 (21)	32.99
Current use of FP								
Yes	73.23 (52)	45.28 (24)	86.67 (26)	70.00	79.46 (55)	41.37 (12)	73.3 (22)	64.38
No	26.76 (19)	54.72 (29)	13.33 (4)	29.93	20.31 (14)	59.26 (17)	26.66 (8)	35.61

Table 3 ***(Cont'd)***

Characteristics	Women				Men			
	Port-Nolloth	Alexander Bay	Kuboes	Total	Port-Nolloth	Alexander Bay	Kuboes	Total
Attitude towards FP								
Approves	91.54 (65)	93.10 (27)	46.67 (14)	77.56	81.69 (58)	82.76 (24)	46.66 (14)	70.37
Disapproves	4.23 (3)	3.45 (1)	13.33 (4)	7.53	10.00 (7)	6.90 (2)	13.33 (4)	10.76
No opinion	4.23 (3)	3.45 (1)	36.66 (11)	15.58	8.45 (6)	10.34 (3)	40.00 (12)	19.12
Husbands approves	74.24 (52)	83.00 (24)	3.33 (1)	61.29	-	-		
Wife's approves	-	-	-	-	77.46 (55)	86.21 (25)	40.00 (12)	67.89
No	7.42 (5)	6.89 (2)	30.00 (9)	15.28	2.86 (2)	-	10.00 (3)	4.28
Don't know	18.30 (13)	10.34 (3)	43.33 (13)	23.43	20.00 (14)	14.00 (4)	50.00 (15)	28.00
Intention to use contraceptives								
Yes	71.83 (51)	55.17 (17)	46.67 (14)	57.83	81.69 (58)	37.93 (11)	27.00 (8)	48.87
No	21.12 (15)	31.03 (9)	46.67 (14)	33.20	9.85 (7)	44.83 (13)	43.33 (13)	32.67
Not sure	1.41 (1)	10.34 (3)	-	4.00	1.40 (1)	-	6.67 (2)	4.02
Don't know	5.63 (5)	3.45 (1)	6.67 (2)	5.04	7.04 (5)	17.24 (5)	23.33 (7)	15.87
Knows source of FP								
Yes	97.18(69)	100.00 (29)	96.66 29)	97.95	95.77 (68)	100.00 (29)	96.66 (29)	97.48
No	2.82 (2)	-	3.33 (1)	2.05	4.23 (3)	-	3.33 (1)	2.52
Discussed FP								
Yes	88.06(63)	52.00(15))	53.33 (16)	64.02	83.09 (59)	50.00 (14)	50.00 (15)	61.11
No	11.94 (8)	48.00 (14)	46.66 (14)	35.98	16.90 (12)	50.00 (14)	50.00 (15)	38.89
Number of Respondents								

Source: Spousal communication study; **Notes:** "FP**" -** Family Planning; The numbers in parentheses refer to the number of respondents in the specific category.

4.4 Reasons for Non-use of Contraceptive

Individuals who were not using contraceptives at the time of the survey were also asked to state their reasons for not using contraceptives. This information is presented in Table 4 which shows that more females (11.43 percent) than males (4.88 percent) indicated non use as a result of being married. About 6 percent of females stated health reasons whereas 7 percent of males did not use due to the opposition of their wives. Twenty percent of females and 4.88 percent males expressed that they wanted more children. A higher (62.86 percent) of females than males (48.78 percent) do not use contraceptives due to religious reasons.

Table 4 **Percentage distribution of couples by reasons for not using contraception**

Reason	Females	Males
Currently married	11.43 (4)	4.88 (2)
Health	5.71 (2)	-
Husband/Wife opposed	0.00	7.32 (3)
Want more children	20.00 (7)	4.88 (2)
Religious prohibition	62.86 (22)	48.78 (20)
Other reasons	-	34.39 (14)
Total percentage	**100 (35)**	**100 (41)**

Notes: "-" Not applicable; The numbers in parentheses refer to the number of respondents in the specific category. **Source:** Spousal communication study.

4.5 Reasons for Discontinuing Contraceptive Use

It is the goal of many governments concerned with rapid population growth to ensure that a high proportion of women or couples adopt contraceptive use. However, due to some reasons such as those that are medically related, a number of individuals who adopt certain contraceptive methods tend to discontinue them. In the survey, women and men were asked some of the reasons for discontinuing use. These results are provided in Table 5 which show that about 4 percent of women and men stopped using contraceptives because they were sexually inactive. About 11 percent of women stopped

due to experiencing side effects whereas another 42 percent stopped due to health reasons. It is very interesting to note that about 13 percent of women stopped because they wanted more children whereas this percentage is very high for men at 93.88 percent. Other women and men stopped due to "other reasons" at 30.91 percent and 2.04 percent respectively.

Table 5 **Percentage distribution of couples' reasons for discontinuing use of contraceptives**

Reason	Females	Males
Sexually inactive	3.64 (2)	4.08 (2)
Side effects	10.91 (6)	-
Health reasons	41.82 (23)	-
Wanted more children	12.73 (7)	93.88 (46)
Other reasons	30.91 (17)	2.04 (1)
Total percentage	**100 (55)**	**100 (49)**

Notes: "-" Not applicable; The numbers in parentheses refer to the number of respondents in the specific category. **Source:** Spousal communication study

4.6 Discussion of Family Planning According to Selected Background Variables

Table 6 compares the characteristics of couples by whether they discussed FP or not. Respondents are compared in terms of a number of socio-demographic variables such as age, marital status, race, education level, religion affiliation, children ever born, ideal family size, ever use contraceptives, intention to use, current use and living standards. Differences are observed between two groups of respondents with respect to education, religion, FP intentions, ever use, and current use of knowledge of FP.

The results in Table 6 show that respondents who indicated that they had discussed FP with their husbands or wives are more educated than those who had not. For instance, 71 percent of those who had discussed FP with their husbands or wives had secondary education compared with 63 percent of those who said they had not discussed. About 14 percent of those who had discussed FP with their husbands or wives had tertiary

education compared with two percent of those who said they had not discussed. However, only 15 percent of husbands and wives who had primary education discussed FP compared with 31 percent who had not discussed. In terms of religious affiliation, the results show that 31 percent of those who had discussed FP were Catholics compared with 14 percent among those who had not discussed.

Table 6 also compares the characteristics of couples in Alexander bay, Kuboes and Port Nolloth who had discussed FP and those who had not according to whether they reported that they had discussed FP with their husband or wife. All couples indicated that they had discussed FP issues with their husbands or wives. In Alexander bay, 65.30 percent of those who had discussed FP with their husbands or wives had secondary education compared with 40 percent of those who said they had not discussed. About 24 percent of those who had discussed FP with their husbands or wives had tertiary education compared with 40 percent among those who said they had not discussed and only 10 percent of couples who had primary education discussed FP compared with 20 percent who had not discussed. While in Kuboes 48 percent of those who had discussed FP with their husbands or wives had primary education, this percentage was low at 44 percent among those who said they had not discussed. And 41 percent of those who had discussed FP with their husbands or wives had secondary education compared with 56 percent among those who said they had not discussed and only 11.11 percent who had not discussed FP had tertiary education.

In Port Nolloth, 80.36 percent of those who discussed FP had secondary education compared with 78.95 percent among those who said they had not discussed. While 9.82 percent of those who had discussed FP had secondary education, 5.25 percent among those who said they had not discussed and only 9.82 percent who had discussed FP had

primary education compared with 15.79 percent of those who had not discussed. Twenty six percent of those who had discussed FP were Catholics. Although 51 percent of those who had discussed FP said they intend to use contraceptive in the future, only 20 percent of those who had not discussed FP indicated that they intended to use a method. In Kuboes, 22 percent of those who had discussed FP were Protestants compared with 15.38 percent of those who had not discussed. Fifty percent of those who discussed FP said they intend to use contraceptive in the future whereas only 31 percent of those who had not discussed FP indicated that they had no intention to use contraceptives. However, in Port Nolloth only 38 percent of those who had discussed were Catholics, compared with 32 percent of those who had not discussed it. Eighty two percent of those who had discussed FP said they intend to use contraceptive in future. Only 56 percent of those who had not discussed indicated that they had no intention to use a method.

4.7 Discussion of Family Planning According to the Number of Children Alive and Ideal Family Size

Almost all couples had knowledge of FP in all the three research areas. In Alexander Bay about 71.43 percent of those who had discussed FP had one to two children alive compared with 80 percent of those who had not discussed it and 86 percent of those who had discussed FP had an ideal family size ranging between one to two children compared with 100 percent of those who had not discussed FP. While in Kuboes 50 percent of those who discussed FP had one to two children alive compared with 65 percent of those who had not discussed and 70 percent of those who had discussed have an ideal family size ranging between two to three children compared with 14 percent of those who had not discussed FP. In Port Nolloth about 46 percent of those who had discussed FP had one to two children alive compared with 33 percent of those who had

not discussed FP, and 49 percent of those who had discussed FP, had an ideal family size ranging between one to two children compared with 14 percent of those who had not discussed FP.

About 14 percent of couples who had discussed FP had no children compared with 20 percent of those who had not discussed in Alexander bay. In Kuboes, 11 percent of couples who had discussed FP had no children compared with 4 percent of those who had not discussed, and in Port Nolloth only 25 percent of couples who had discussed FP had no children compared with 28 percent of those had not discussed. About 17 percent of couples who had three to four children had not discussed FP in Kuboes. While only 14 percent of couples who had three to four children in Alexander Bay had discussed FP. In Port Nolloth, 20 percent of couples who had three to four children had discussed FP compared with 17 percent of those who had not discussed. Moreover, 8 percent of couples who had five to 10 children had discussed FP in Port Nolloth compared with 22 percent of those who had not discussed.

The ideal family size of couples who had discussed FP ranges between one to two children. About 87 percent of couples in Alexander bay had discussed FP compared with 86 percent of couples who had not discussed FP in Kuboes. Forty percent of couples in Port Nolloth had discussed FP compared with 50 percent of those who had not discussed it. Very few couples, who had discussed FP, had their ideal size ranging between three to four children in all the three areas. While 70 percent of couples who had discussed FP in Kuboes had an ideal family size of three to four children compared with 14 percent of those who had not discussed it, only 35 percent of couples who had discussed FP in Port Nolloth had ideal an family size of three to four children compared with 30 percent of those who had not discussed it.

4.8 Discussion of Family Planning By Race

In Alexander bay 16 percent of those had discussed FP with their wives or husbands were Black Africans compared with 20 percent of those who had not discussed. Fifty-seven percent of Coloureds had discussed FP compared with 40 percent of those who had not discussed and about 28 percent of Whites discussed FP with their wives or husbands compared with 40 percent of those who had not discussed. In Kuboes, 96 percent Coloureds had discussed FP compared with 4 percent of those who had not discussed. Only 4 percent Black/African couples had discussed FP compared with 4 percent of those who had not discussed, whereas 68 percent of Black couples had discussed FP compared with 66 percent of those who had not discussed in Port Nollloth. About 29 percent Coloured couples had discussed FP compared with 33 percent of those who had not discussed and only 2 percent of Whites had discussed FP with their husbands or wives.

4.9 Discussion of Family Planning by Age

Between the ages of 20 and 29 about 16 percent of couples had discussed FP with their husbands and wives in Alexander bay compared with 60 percent of those who had not discussed. In Kuboes 30 percent had discussed FP compared with 50 percent of those who had not discussed whereas 42 percent of couples discussed FP in Port Nolloth compared with 32 percent of those who did not discussed. About 24 percent couples in Alexander bay, 11 percent in Kuboes and 28 percent in Port Nolloth had discussed FP compared with those who had not discussed (8 and 21 percent respectively) in Kuboes and Port Nolloth in the age group 30-35 years. About 37 percent of couples in Alexander bay and Kuboes in the age group 36-41 years had discussed FP with their husbands and wives compared with 23 percent in Kuboes who had not discussed.

Whereas in Port Nolloth 17 percent had discussed FP, compared with 26 percent of those who had not discussed. Generally, very few couples between the ages of 42 and 57 years had discussed FP with their husband and wives.

Almost all couples who had discussed FP in Port Nolloth and Alexander bay had used contraceptives before (86 and 96 percent respectively) compared with 60 percent in Alexander bay and 84 percent in Port Nolloth of those who had not discussed. Whereas 51 percent of couples in Kuboes who had used FP had discussed FP compared with 69 percent of those who had not discussed it.

About 54 percent of those who had discussed FP had one to two children alive compared with 55 percent of those who had not discussed, and 59 percent of those who have discussed FP had an ideal family size ranging between one to two children compared with 68 percent of those who had not discussed FP. Although 68 percent of those who had discussed FP said they intend to use contraceptive in the future, only 39 percent of those who had not discussed FP indicated that they intended to use a method. However, 80 percent of couples who had knowledge of FP discussed FP compared with 20.8 percent of those had not discussed. About 83 percent of those who discussed FP reported that they had used contraceptives before compared with 54 percent of those who had not discussed. Seventy two percent of those who had discussed FP reported that they were currently using contraceptives. However, 63 percent reported that they were not currently using contraceptives and had not discussed FP.

Table 6 **Percentage distribution of couple's by whether they discussed FP according to selected background characteristics**

Characteristic	Total		Alexander Bay		Koeboes		Port Nolloth	
	Discussed FP	Did not discuss FP	Discussed FP	Did not discuss FP	Discussed FP	Did not discuss FP	Discussed FP	Did not discuss FP
Marital status								
Married	62.11(118)	50.00 (25)	93.88 (46)	40.00 (2)	66.67 (18)	42.31 (11)	47.37 (54)	63.00 (12)
Living together	37.89 (72)	50.00 (25)	6.12 (3)	60.00 (3)	33.33 (9)	57.69 (15)	52.63 (60)	36.80 (7)
Education attainment								
Primary	15.43 (29)	30.61 (15)	10.20 (5)	20.00 (1)	48.10 (13)	44.00 (11)	9.82 (11)	15.79 (3)
Secondary	70.74 (133)	63.26 (31)	65.30 (32)	40.00 (2)	40.74 (11)	56.00 (14)	80.36 (90)	78.95 (15)
Tertiary	13.83 (26)	2.00 (3)	24.49 (12)	40.00 (2)	11.11 (3)	_	9.82 (11)	5.26 (1)
Religion								
Catholic	31.57 (60)	14.00 (7)	26.53 (13)	-	14.81 (4)	3.80 (1)	37.71 (43)	31.58 (6)
Protestant	13.15 (25)	8.00 (4)	14.29 (7)	-	22.22 (6)	15.38 (4)	10.53 (12)	-
Tradition	4.2 (8)	4.00 (2)	2.00 (1)	-	-	-	6.14 (7)	10.53 (2)
Other	51.05 (97)	74.00 (37)	57.14 (28)	100.00 (5)	62.00 (17)	80.79 (21)	45.61 (52)	57.89 (11)
Race								
Black/African	45.79 (87)	28.00 (14)	16.32 (8)	20.00 (1)	3.70 (1)	3.84 (1)	68.42 (78)	66.67 (12)
Colored	45.79 (87)	66.00 (33)	57.47 (27)	40.00 (2)	96.29 (26)	96.15 (25)	29.82 (34)	33.33 (6)
White	8.42 (16)	6.00 (3)	28.57 (14)	40.00 (2)	-	-	1.75 (2)	-
Age group								
20–29	33.51(63)	44.00 (22)	16.32 (8)	60.00 (3)	29.63 (8)	50.00 (13)	41.95 (47)	31.57 (6)
30–35	25.00 (47)	12.00 (6)	24.49 (12)	-	11.11 (3)	7.69 (2)	28.57 (32)	21.05 (4)
36–41	25.53 (48)	20.00 (10)	36.73 (18)	-	37.03 (10)	23.08 (6)	17.85 (20)	21.05 (4)
42–57	15.95 (30)	24.00 (12)	22.49 (11)	40.00 (2)	22.22 (6)	19.23 (5)	11.61 (13)	26.31 (5)
Children ever born								
0	20.63 (39)	14.29(7)	14.29(7)	20.00 (1)	11.54(3)	3.85 (1)	25.44(29)	27.77 (5)
1-2	53.44(101)	55.10(27)	71.43(35)	80.00(4)	50.00(13)	65.38(17)	46.49(53)	33.33 (6)
3–4	20.63 (39)	16.33(8)	14.29 (7)	-	34.64(9)	19.23 (5)	20.18 (23)	16.67 (3)
5–10	5.29 (10)	14.28 (7)	-	-	3.85 (1)	11.54 (3)	7.89(9)	22.22 (4)

Table 6 ***(Cont'd)***

Characteristic	Total		Alexander Bay		Koeboes		Port Nolloth	
	Discussed FP	Did not discuss FP	Discussed FP	Did not discuss FP	Discussed FP	Did not discuss FP	Discussed FP	Did not discuss FP
Ideal family size								
No kids	11.03 (15)	10.52 (2)	2.63 (1)	-	-	-	15.90 (14)	20.00 (2)
1-2	58.88 (79)	68.42 (13)	86.84 (33)	100.00 (2)	30.00 (3)	85.71 (6)	48.86 (43)	50.00 (5)
3-4	30.88 (42)	21.05 (4)	10.53 (4)	0.00	70.00 (7)	14.29 (1)	35.22 (41)	30.00 (3)
5-10	-	-	-				-	-
Ever use contraceptives								
Yes	86.31 (164)	54.00 (27)	85.71 (42)	60.00 (3)	48.15 (13)	30.77 (8)	95.61 (109)	84.20 (16)
No	13.68 (26)	46.00 (23)	14.28 (7)	40.00 (2)	51.85 (14)	69.23 (18)	4.39 (5)	15.79 (3)
Intend to use								
Yes	68.57 (120)	38.77 (19)	51.02 (25)	20.00 (1)	50.00 (13)	30.77 (8)	82.00 (82)	55.55 (10)
No	24.00 (42)	30.61 (15)	36.69 (17)	40.00 (2)	38.46 (10)	42.31 (11)	15 (5)	11.11 (2)
Not sure	2.29 (4)	4.08 (2)	4.08 (2)	20.00 (1)	3.86 (1)	-	1.00 (1)	5.56 (1)
Don't know	5.14 (9)	26.53 (13)	10.20 (5)	20.00 (1)	7.69 (2)	26.92 (7)	2.00 (2)	27.78 (5)
Heard of FP								
Yes	79.16 (190)	20.83 (50)	90.70 (49)	9.25 (5)	50.94 (27)	49.05 (26)	85.71 (114)	14.28 (19)
No	-	-	-	-	-	-	-	-
Currently using								
Yes	71.68 (123)	63.30 (19)	48.90 (23)	-	81.25 (13)	88.88 (8)	80.00 (88)	61.11 (11)
No	28.32 (49)	36.67 (11)	51.06 (24)	100.00 (3)	18.75 (3)	11.11 (1)	20.00 (22)	38.88 (7)
Living standards								
First quintile	14.74 (28)	34.00 (17)	-	2.04 (1)	11.11 (3)	42.31 (11)	31.58 (6)	21.05 (24)
Second quintile	23.15 (44)	10.00 (5)	-	6.12 (3)	11.11 (3)	11.54 (3)	10.52 (2)	33.33 (38)
Third quintile	21.05 (40)	14.00 (7)	-	4.08 (2)	7.40 (2)	7.69 (2)	26.31 (5)	31.57 (36)
Fourth quintile	22.10 (42)	14.00 (7)	20.00 (1)	42.86 (21)	33.33 (9)	7.69 (2)	21.05 (4)	10.52 (12)
Last quintile	18.95 (36)	28.00 (14)	80.00 (4)	44.89 (22)	37.04 (10)	30.76 (8)	10.52 (2)	3.51 (4)

Notes: "-" Not applicable; **Source:** Spousal communication study.

4.10 Spousal Approval or Disapproval of FP

Table 7 shows the relationship between couples discussion frequency. In all the three study areas the results showed an inverse relationship with discussion frequency even though these areas had different contraceptive prevalence and FP approval rates. However, this analysis could not reveal whether variables other than spousal discussion contributed to the reported information.

Table 7 **Percentage of couple's discussion frequency**

	Discussion frequency			
Residence	**1–2**	**3–4**	**5+**	**Total**
Alexander Bay	35.62 (26)	54.79 (40)	9.59 (7)	100 (73)
Kuboes	59.38 (19)	37.50 (12)	3.13 (1)	100 (32)
Port Nolloth	21.08 (35)	31.32 (12)	47.59 (79)	100 (126)

Source: Spousal communication study.
Notes: Percentages are weighted. Numbers in parentheses are sample sizes. Analysis is limited to couples who disapprove/approve FP and excludes couples who said they did not know their partners attitudes. Discussion frequency is that reported by both husband and wife.

Table 8 presents the reasons for approving FP and the results indicate that the predominant reason for approving FP for both husbands and wives is to limit births. However, 30.77 percent of wives and 23.96 percent of husbands approve FP for both limiting and spacing births.

Table 8 **Percentage distribution of couple's reasons for approving FP**

Reason for approving FP	**Females**	**Males**
Birth limiting	43.27 (45)	45.83 (44)
Birth Spacing	25.96 (27)	29.17 (28)
Both	30.77 (32)	23.96 (23)
Other	-	1.04 (1)
Total percentage	**100 (104)**	**100 (96)**

Source: Spousal communication study.

4.11 Spousal Perception and Attitudes towards FP

The perceptions of husband's attitude towards FP were compared with their wives' actual attitudes by frequency of discussion and these results are presented in Table 9. The overall proportion of women who correctly reported their husbands' attitude was larger if discussion had occurred than if it had not, regardless of whether husbands

reported approval or disapproval. Although the study showed accurate reporting of partner approval rose with discussion, the accuracy of women's reports of partner disapproval was lower. The more discussion occurred the larger the number of respondents in the whole study approved of FP.

In the whole study 8.30 percent of couple both husbands and wives disapprove FP, 78.26 percent approved and 13.44 percent had no opinion. The results also indicate substantial agreement in reported discussion about FP with only 20.83 percent maximum of couples in disagreement about whether FP had been discussed in the past year.

Table 9 **Percentage distribution of wives by perception of their husbands' family planning attitude, according to husbands' reported attitude and frequency of discussion**

Husband attitude and discussion frequency	Total number of males	Wife's perception	
		Approval	Disapproval
Husband approved			
1-2	20	76.92	3.57
3-4	29	82.86	-
5+	26	90.32	-
Husband disapproved			
1-2	4	15.38	3.57
3-4	6	17.14	2.77
5+	5	16.12	-
Husband had no opinion			
1-2	2	7.69	-
3-4	-	-	-
5+	-	-	-

Source: Spousal communication study; **Notes:** Discussion is that reported by women.

4.12 Correlation Analysis of Selected Variables

Table 10 presents the results of correlation analysis of selected variables. Similar to the other tables, the analysis is conducted in several stages. The results show that there is a positive significant correlation between age, number of sons and number of daughters given birth to. Negative correlation is observed between the highest education level, age of the respondents, number of sons, and number of daughters given birth to. This implies that couples who reported that they had sons, had 0.22 fewer sons than their

counterparts who did not have sons. Similarly, couples who reported that they had daughters had 0.36 fewer daughters than those who did not have daughters. However, couples highest level of education is positively correlated with FP discussion. As expected, couples' intention to use FP is positively correlated with their age and FP discussion.

Table 10 **Pearson correlation coefficients for selected variables**

	Age	Number of sons given birth to	Number of daughters given birth to	Highest education	Religion	FP discussion	Race
Age	-	0.266**	0.395**	-0.347**	0.062	0.029	0.144*
Number of sons given birth to	0.266**	-	0.256**	0.225**	0.080	0.082	0.041
Number of daughters given birth to	0.395**	0.256**	-	-0.369**	0.079	0.097	0.075
Highest education	-0.347**	-0.225**	-0.369**	-	-0.124*	0.210**	0.092
Religion	0.062	0.080	0.079	-0.124*	-	0.195**	-0.101
Marital status	-0.433**	-0.051	-0.229**	0.118	-0.022	0.099	-0.139*
FP discussion	-0.029	0.082	0.097	0.210**	0.097	-	0.323**
Intention to use FP	0.181**	-0.002	0.106	0.036	0.093	0.323**	-

Source: Spousal communication study.
Notes: **p<0.01; *p<0.05.

4.13 Multivariate Analysis of Discussion of FP

Table 11 presents odds ratios from logistic regression models predicting the likelihood that couples had ever discussed FP with their spouses. First, a model that predicts spousal communication as a function of couple's education is estimated. Second, a model is fit that controls for the effect of age, marital status, duration of marriage and residence. From these models we can asses whether differences in couples age, marital status and residence account for any education association and spousal communication about FP. Third, a model is fit that further controls for marital status and duration of marriage. Interactions between education and two variables (religion and race) are tested in order to examine whether their effect vary significantly across education groups. Because none of the interaction was statistically significant, they had been excluded from the analysis. Based on the literature reviewed earlier, five covariates (education, age, marital status and duration of marriage and residence) are targeted for the analysis.

Table 11 **Logistic regression of discussion of FP by selected socio-demographic variables**

Variable	Model 1	Model 2	Model 3	Model 4
Education attainment				
Primary (r)	1.00	1.00	1.00	1.00
Secondary	2.22*	2.71*	3.85*	1.96
Tertiary	4.48*	5.55*	7.22**	3.27
Age group				
20–29 (r)		1.00	1.00	1.00
30–35		3.03*	2.22	1.75
36–41		2.70*	1.55	1.74
42–57		1.14	0.56	0.59
Marital status				
Married (r)			1.00	1.00
Living together			0.52	0.57
Duration of marriage				
1 year (r)			1.00	1.00
2 years			2.37	3.33*
3 years			2.59	4.62**
4 years+			5.37**	5.49**
Residence				

Alexander Bay				1.00
Koeboes				0.15**
Port Nolloth				0.89
Log like hood	**-117.39**	**-112.74**	**-105.33**	**-96.62**
N	**237**	**235**	**235**	**234**
Prob> chi2	**0.03**	**0.00**	**0.00**	**0.00**

Source: Spousal communication study.
Notes: **p<0.01; *p<0.05 level; "r" – Reference category; "-" No estimates calculated due to few cases;

Model 1 shows that couples who had secondary and tertiary education were significantly more likely than couples that had primary education to discuss FP with their spouses. In Model 2 when we control for age group, we find that education still maintains significance with an increase in odds ratios (ORs) over Model 1. Further, Model 2 shows that couples in the middle age groups (30-41 years) are more likely to discuss FP than young couples. There is no effect for older couples (42-57 years). While the effect of education on discussion of FP maintains significance in Model 3, age group and marital status shows no significance whereas duration of marriage is significant particularly for those who have been married four years and above. When Models 1 through 3 are compared the ORs for education groups do not change greatly after adjusting for age and marital status. Model 4 which also controls for residence shows no significant effect for education, age group, and marital status but for duration of marriage and residence. We observe that the ORs for those married two, three, and four years and above are 3.33, 4.62, and 5.49 respectively. The results for residence show that those living in Kuboes are significantly less likely than couples who are staying in Alexander Bay to discus FP with their spouses.

Table 12 presents ORs from logistic regression models predicting comparison of likelihood that couples have ever discussed FP with their spouses. Model 1 treats discussion as a function of couple's race and by comparing the odds, we can assess whether differences between wives and husbands in work status account for any of the

association between race and spousal communication about FP. Model 3 adds further controls for couple's current age and education, and model 4 adds residence and several background characteristics. Model 1 shows that Coloured women are less likely than black African, Whites and males to discuss FP. When models 1-3 are compared, the odds ratios for race groups slightly change after adjusting for occupation and age. Couple's age has no effect on couple's discussion. Kuboes females are less likely than Alexander bay and Port Nolloth females and males to discuss FP. Generally, education has no effect on discussion as well as work status.

4.14 Predicting Ever Use of Contraceptives

Spousal communication about FP is critical for contraceptive use (Ezeh 1993; Nyblade and Menken 1993; Kritz and Gurak 1991, p. 89-112).Other scholars such as Khan et al (1998) "Women who discuss FP with their spouses are almost four and half times more likely than those who do not to have ever used modern contraceptives. While discussion may be generated by desire to use contraceptives, as a measure of husband-wife interaction, discussion of FP is in a reflection of women's autonomy."

Table 12 **Odds ratios of ever use of contraception by selected demographic characteristics**

Variables	Model 1	Model 2	Model 3	Model 4
Race				
Black/African	1.00	1.00	1.00	1.00
Coloureds	0.14 **	0.12**	0.13	0.21
Whites	0.36	0.41	0.04	0.03
Age group				
20–29 (r)		1.00	1.00	1.00
30–35		1.81	4.27	1.17
36–41		0.75	1.21	1.37
42–57		0.39*	2.47	3.73
Living standards index				
First quintile			1.00	1.00
Second quintile			0.55	0.41
Third quintile			1.00	1.00
Fourth quintile			0.39	0.25
Last quintile			0.64	0.99
Education				
Primary			1.00	1.00
Secondary			1.00	1.00

Tertiary			1.00	1.00
Ideal family Size				
0			2.74	5.79
1–2			1.01	7.05
3–4			1.00	1.00
5–10			1.00	1.00
Discussed family planning				
Yes				0.17
No				1.00
Locality				
Alexander Bay				1.00
Kuboes				0.01*
Port Nolloth				1.00
Log like hood	**-117.30**	**-109.77**	**-23.96**	**-18.68**
N	**252**	**250**	**84**	**80**
Prob> chi2	**0.00**	**0.00**	**0.00**	**0.00**

Notes: "r" – Reference category; "-" No estimates calculated due to few cases; **p<0.01; *p<0.05.

4.15 Spousal Communication and Current Contraceptive Use

Lack of spousal communication about FP is identified as one of the reasons for the low level of contraceptive use among women (Bawah 2002; Lwanga and Lameshow 1991). To assess the relationship between spousal communication and current use of contraception, couples who indicated that they were practicing contraception and the proportion of contraceptive users among non users is computed according to their discussion status. To determine whether this relationship persist if other variables are controlled, a multivariate probit regression model is estimated with current use of contraceptives as dependent variable taking the value of (0 and 1) and as a function of FP discussion, controlling for background characteristics of respondents. The results of this model are presented in Table 13. Age, education, number of children alive, ideal family size, FP discussion, respondents contraceptive use intention and previous contraceptive experience are included as independent variables in the model. The results show that spousal communication significantly predicts ever use of contraceptive. For example couples who discussed FP issues with their spouse are about 79.17 percent higher than those who did not. Also as expected, couples who indicated an intention to use contraceptive methods in the future are about 68.57 percent higher than those who

have no intention to use contraception. From these findings it is expected that couples who indicated intention to use contraceptives may translate such intention to action. According to Coale's (1973) pre conditions for fertility control, he pointed out that for people to reduce fertility, they must have (1) thought about it, (2) found reduced fertility to be advantageous, and (3) have access to the techniques of fertility reduction.

Therefore, couples who indicated an intention to use contraceptives can be considered as having thought about FP and decided that it is advantageous. For couples with previous contraceptive use experience, the model shows no effect of spousal discussion on contraceptive use. Although the results from the model demonstrate that discussion of FP promotes contraceptive use. The issue that still remains unresolved is the question of the reverse (Bawah 2002). Based on the results one can not conclude that the direction is one way, that spousal discussion promotes contraceptive use than visa versa. Bawah (2002) reported equal possibility that use of contraceptives could generate discussion of FP.

Table 13 **Probit estimates of current contraceptive use among all couples**

	Model 1	
Variables	**Coefficient**	**Standard Error**
Age		
20–29	0.67	0.15**
30–35	1.11	0.22 **
36–41	0.10	0.18
42–57	0.07	0.22
Education		
Primary	0.37	0.22*
Secondary	0.58	0.11**
Tertiary	0.31	0.24
Number of children alive		
0	0.18	0.19
1	0.67	0.17**
2	0.75	0.19**
3	0.57	0.29*
4+	0.59	0.10 **
Ideal family size		
0	0.15	0.31
1-2	0.45	0.17**
3-4	0.85	0.22**
5+	1.00	1.00

Discussed FP		
Yes	0.57	0.10**
No	0.34	0.23
Ever use contraceptives		
Yes(r)	1.00	1.00
No (r)	1.00	1.00
Intends to use contraceptives		
Yes	0.91	0.12**
No	0.54	0.19**
Not sure	0.67	0.68
Don't know	0.11	0.37
Log like hood	**-61.398**	
N	**119**	
Prob> chi2	**0.00**	
Pseudo R^2	**0.12**	

Notes: "r" – Reference category; "-" No estimates calculated due to few cases; **p<0.01; *p<0.05 level.

To estimate the relationship of specification errors or bias, Heckman selection model is employed for sample selectivity. Heckman selectivity is considered to utilize regression methods to estimate behavioural functions. Results of the test shown in Table 14 reveal no problem of selectivity.

Table 14 **Coefficient of Heckman probit selection model for test of sample selectivity**

	Main model		Selection model	
Variables	**Coefficient**	**Standard Error**	**Coefficient**	**Standard Error**
Age	1.00	1.00	1.00	1.00
Education level				
Primary (r)	1.00	1.00	-	-
Secondary	0.44	0.14***	-	-
Tertiary	1.00	1.00	-	-
Discuss FP				
Yes	0.44	-0.20*	-5.55	1.19***
No (r)	1.00	1.00	1.00	1.00
Intends to use FP				
Yes	0.11	0.04**	5.41	-
No	1.00	1.00	1.00	1.00
Unsure	1.00	1.00	1.00	1.00
Ever use Contraceptives				
Yes	-0.29	0.21	1.63	1.59
No (r)	1.00	1.00	1.00	1.00
RHO	**1**	**-**	**-1**	**1**
Log likelihood test	**Rho=0**	**Chi (1)=4.67**	**Prob Chi2=0.03**	

Notes: *p<0.05; **p<0.01; *** p<0.001; "r" reference category; All figures are overall statistics for both models (Coefficients and Standard error).

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Chapter five: Discussion, Conclusion and Recommendation

5.1 Discussion

This study set out to examine the effect of spousal communication in influencing fertility and FP behaviour and also examined other factors that affect spousal communication such as age, race, religion, number of living children and educational attainment. Specifically, the study attempted to answer the following questions: What is the level of husband-wife communication about FP in the study areas? Is husband-wife communication associated with contraceptive use?

The results suggest that spousal communication about FP strongly predicts contraceptive use even when other factors are controlled for in the model. Estimates of this model showed a marginal significance at $p<0.05$. According to Bawah (2000), these findings are theoretically sound because people might be expected to discuss FP before they use contraceptives and not the reverse. The results also show that other significant factors that influence contraceptive use include respondent's level of education and their intention to use contraceptives.

The study also found that couples who view FP favourable tend to communicate about FP and tend to adopt FP methods compared with those who do not favour FP. Not surprisingly, young couples are more likely than older ones to talk about FP probably because child bearing is more applicable to them. Further, the results also show extensive differences among racial groups in spousal communication about FP and ever use of contraceptives methods. By contrast ethnic background is an important determinant of spousal communication (Sharon and Valente 2002). These findings are supported by previous research in Nepal which shows that ethnicity accounts for more

differentials in reproductive behaviour than do socio economic variables (Niraula and Shresta 1989). Ethnic differentials in early childhood mortality have also been observed in Nepal (Chloe, et al. 1989). But no consistent patterns of differentials among ethnic communities have emerged in studies conducted so far. Further, the reason why ethnic background should account for differentials in reproductive outcome or behaviour including spousal communication is not clear (Sharon and Valente 2002).

The tendency to approve use of FP was widespread among respondents in this study and there was a considerable range of variation in couple's attitudes towards FP. In many studies husband-wife communication has been found to be the most significant indicator of contraceptive use (Lwanga and Lameshow 1991). However, these studies used all three dimensions of effective communication between husband and wives agreement on approval of FP. Other studies have used discussion as a measure of communication between husband and wife (Nicholas, et al. 1986). The general objective in this study was to explore all the three dimensions.

The limitation of this study, however, was that the amount of information available to measure husband-wife communication was insufficient. Only questions related to FP were asked although the analysis included all three dimensions of effective communication on FP as suggested by (Hill and Stycoss 1959 as cite in De Rose et al. 2004). Information on the depth of couple's communication was lacking and there were no data concerning duration and extent of discussion. However, there were data concerning the end or the result of discussion between spouses on FP. Since husband-wife communication emerged as an important predictor of FP, this study recommends that future research should include broader definition of communication, not only on the subject of FP but also for other matters in the family that require communication

between spouses such as decisions about child schooling, food purchase, and property acquisition (see Lasee and Becker 1997).

Another difference between this study and other studies is that other studies have defined discussion more broadly. For example, Lozare (1976) measured communication between Filipino husbands and wives in 10 different areas. In his research, he included financial and family matters, future plans, education of children, work current events, recreation and entertainment, religion, FP and matters pertaining to sex. It is reasonable to suspect that correct reporting of disapproval does not increase after discussion because spouses might misinterpret each other's attitudes in terms of FP approval. For example, if a wife is willing to discuss FP, her husband may interpret this as approval of FP rather than giving a clear indication of partner attitude. The discussion itself may lead couples to assume that their spouses approve of contraceptive use. Discussion imparts knowledge exchange especially if the husband initiated or participated in a discussion on contraception in order to use a method (De Rose, et al. 2004).

Some respondents find it difficult after reporting that there has been discussion on contraception, to acknowledge ignorance of a partner's contraceptive attitudes. These respondents may report their partner's attitude even if they are unsure (Bankole and Singh 1998). Such an explanation is consistent with the reduced likelihood of answering "don't know" among couples who have discussed FP.

This study assumed that women who have discussed FP with their spouses are more likely than those who have not to think that their partners approve, whether or not he actually does. The relationship between discussion and reporting accuracy is not an issue if discussion makes couples think that their partners approve of contraceptive use. Yet

the literature provides evidence that women's adoption of FP put them at risk of adverse outcomes such as victims of partner's violence when their husbands opposed contraception (Bawah, et al 1999). Contraception discontinuation is likely to be higher for women who start using a method on the assumption that their partners approve of use and later discover he does not (De Rose, et al. 2004). One should not quickly discount couples who state that their partners hinder contraceptive use, while also reporting that no relevant discussion had occurred.

Reports on spousal disapproval may in fact be more accurate among couples who have not discussed FP with their spouses than among those who have discussed because of reliance on nonverbal and other forms of communication in some cultures. In cultures like these, discussion may confuse perception of partner's true attitudes. According to (De Rose et al 2004), researchers need to be cautious about construing relationships between perception of partner preference and discussion as a simple as a causal one.

In order to fully understand the relationship between discussion and communication to lower fertility is by encouraging spousal discussion. Better measures of communication than the limited discussion variable in the DHS can be constructed using insights gleaned from qualitative data (Castle et al. 1999). Similarly, longitudinal surveys would enhance our understanding of the dynamics and implications of partner's communication. In England, public discussion of contraceptive methods has been argued to have promoted fertility decline (Caldwell 1999).

In sub Saharan Africa, discussion of contraception between women and their sister-in-law supports covert contraceptive use (Castle et al. 1999) and promotes both spousal discussion and overt use (Holloss and Larsen 1997). Discussion within social networks

also promotes contraceptive use (Boulay and Valente 1999). Phillips et al (1997) argue that discussion plays an important role in legitimizing uptake in settings with low contraceptives prevalence. Communication research has shown that mass media interventions work by stimulating discussion within social networks which then leads to subsequent contraceptive uptake (Sharan and Valente 2002). Therefore, understanding of discussion in social networks and between spouses should be useful.

Most respondents demonstrated lack of information about FP in this study. Respondents cited religion as one of the greatest barrier in practicing and discussing FP. As a result, some of the field workers were not welcomed. People believed that Christianity is against the use of FP methods. Although most of the participants could mention at least five of the FP methods, few of them understood how those methods worked because most couples used two methods at the same time, e.g., pill and condom or condom and injection. Those couples highlighted that FP methods are unreliable.

Although most respondents demonstrated basic knowledge of FP methods, as we went further asking general questions, we noticed that their knowledge about FP was too limited. There was a widespread misconception about the danger of using contraceptives, especially the pill. Some respondents said they were using the pill in the past and yet they became pregnant. Others said they were scared to use FP because they might become infecund. Besides that people had little knowledge about FP while unavailability and inaccessibility of FP services were the most important barriers inhibiting couples from using FP. The supply of contraceptives seemed to be unreliable. These findings raise several issues. While the choice of contraceptive method must be left to the couples, lack of knowledge of some methods reduces the choice of available methods. However, the knowledge of more effective methods particularly female and

male sterilization increases the choice of long term methods. Another advantage is that this provides opportunity to FP education services and all other FP sources to give little coverage to the lesser used methods. The tendency of downwards trend in knowledge need to be corrected.

The assumption in this study was that FP is not new in African societies. There have been traditional methods which were adopted to regulate, manage and control both fertility and sexual behaviour of people. Family planning aims at controlling and managing fertility without affecting sexual behaviour. That is where cultural factors emerge. When one is applying FP method as a fertility control and management, one tends to operate in a different way from cultural context (Omari 1988c). But more important, FP methods tend to deal with one aspect of the reproductive system and leaves out teaching which were included in the traditional African FP process of child spacing (ibid). Teaching like motherhood, family life education and fatherhood were part of the fertility control and management.

These teachings were included in initiation ceremonies, rituals related to child birth and taboos concerning sexual behaviour and management. They were not taught in abstract but in social–cultural context (ibid). They were designed to help solve specific socio-cultural problems related to fertility and reproductive process in general. It was a good approach to population issues rather than departmental approach which tends to be followed in the FP methods and techniques.

The present study has discovered that issues of socio-cultural factors in FP are complex. There are no determinant factors that show whether fertility level is high or low in Richtersveld. One has to dig into complex factors to determine which factors influence

contraceptive use and fertility and which do not. For example, it is a well established finding that education is a determinant factor of contraceptive use and fertility decline. That is, the more the woman is educated, the smaller the family size would be. This means that education for women and overall general mass education is a necessary step towards low fertility level and contraceptive use. This assumption is questioned in the light of this research in spite of the emphasis put on it by other researchers. Borgaarts et al. (1984) concluded that there is evidence that education affects fertility in Nigeria. The more educated women were, the fewer children they had (see also Caldwell 1980; Dow and Werner 1981).

The arguments on the questioning of this line of thought are based on one ground. We have to distinguish between family size and fertility level when dealing with population issues in Africa. Couple's may decide to have few children, thus use contraceptives to control their fertility level. Ogawaa (1982) who studied fertility levels in Indonesia using multivariate analysis, found that although education was positively related to fertility levels, small farmers and villagers had low levels of education and low fertility level as well. This implies that there are other factors influencing such a decline. Cleland (1985) using data from the World Fertility Survey suggests that the participation of women in non-familial work is neither necessary nor sufficient pre-condition for fertility decline. Education as a determinant of contraceptive use and fertility can help us understand the relationship between formal education and fertility. One of the reasons for a family's non accessibility to FP methods and techniques is poverty (Omari 1987). Couple's tend to have many children because they do not have access to FP methods and techniques whereas those with education, better jobs and better income have access to FP and techniques.

This argument fits very well in the free market economy and in the capitalist economy countries where FP is part of the economic system (Omari 1988c). When you are poor, everything passes above your head. But how about Richtersveld where FP services are part of the health care system provided by the government? In an attempt to find out what influences contraceptive use, Richtersveld has different ethnic groups which are spread throughout the regions although dominated by Namas (Coloureds). They all have different cultural inheritances including languages. These cultural inheritances may influence the fertility level of a particular geographic area. Geographical differences may also tell us the relationship between economic activities that exist in particular society and fertility level (Omari 1988c).

What is the future of FP in an African society like Richtersveld? Do we expect it to succeed as a fertility control and management of FP? What are the tools that are needed to make FP educational process more effective? This could take form of a mass education through, open discussions. Since discussions between partners about sexuality and contraception are likely to cause anxiety and even outright conflict. Some experts argue that attention to interpersonal relations and communication should become part of the overall design of FP. Recommended strategies for enhancing couple communication include attempts to enlist the cooperation of men by providing them with FP, and educational services (Bawah et al. 1999).

Efforts to help sexual partners talk to each other about reproductive health matters are limited. Few have been evaluated. However, Family Health International (FHI) has developed and is evaluating a tool to help men and women communicate openly with each other about sex and other issues affecting their sexual health. This communication tool to facilitate group discussions was first presented in 1996 by FHI's AIDS Control

and Prevention Project. Women's Initiative at a satellite meeting of the Eleventh International Conference on AIDS. Since that time, various initiatives using the dialog process have been conducted in Asia, Africa, and Latin America and the Caribbean. However we need to be careful for whom and for what purpose this FP education will be used.

In 1997, for example, the Indian Institute of Health Management Research, with financial assistance from FHI, tested Dialogue among 400 married men and women (about 200 each) from one rural and one urban area of Jaipur district, India. Two-thirds of the men were truck drivers, who are considered at high risk for HIV infection due to a tendency to have multiple sexual partners. Similarly, two-thirds of the husbands of women respondents were truck drivers. Researchers trained to guide and record the Dialogue process conducted 60 focus group discussions, 12 of which involved men and women talking to each other. Main discussion points included, the roles and responsibilities of men in the family, gender equity, virtues of a good man and a good woman, knowledge of symptoms, causes and prevention of sexually transmitted infections (STIs) and HIV/AIDS, use of condoms, immoral sexual behavior of men, and safer sexual practices.

Interviews with the approximately 400 men and women prior to the Dialogue sessions showed that spousal communication about sexual matters hardly existed. Discussions were largely limited to husbands expressing their desire for or satisfaction with sex. About 60 percent of respondents reported discussing STIs with their spouses but most women had simply suggested that their husbands should be careful to avoid infection. Nearly half of the 128 truck drivers and a quarter of the 81 men from other professions admitted having sex with multiple partners. This practice put their wives at risk of STI/HIV infection. But only 18 percent of the men reported regularly using condoms

while having extramarital sex and only 12 percent reported doing so while having sex with their wives.

In contrast, interviews conducted after the Dialogue sessions with a selected group of couples representing about one-fourth of the total participants showed marked changes in both men's and women's attitudes towards sex, sexuality, and sexual health. Some 70 percent of the 92 respondents reported being more comfortable sharing such issues with spouses during Dialogue discussions. More importantly, condom use doubled for men having extramarital sex from 18 percent to 36 percent and for men having sex with their wives from 12 percent to 23 percent (AIDSCAP Project 1997)

In all areas covered in this study most husbands and wives ideal family size preference is small, ranging from three to four children. However husband's ideal family is greater than their wives. This is true in Sub-Saharan Africa and evidence from Ghana, Kenya and Zimbabwe suggest that the norms that support large family are not uniform even within those regions. At the aggregate level, husbands in Sub-Saharan Africa are more likely than their wives to want a large family. No apparent difference between the number of children desired by husband and wives in other regions (Bankole and Singh 1998).

In all the three study areas, there is substantial inconsistency between the preferences of spouses. In about two thirds of couples, excluding those who said "up to God," husbands and wives differ by two children or more in the family size they consider ideal. The findings also show that in all areas husband's wants larger family than their wives. Thus, husbands and wives differ in their fertility goals although the degree of the difference and its importance for the behaviour vary across the areas. These two indicators of reproductive preferences have implications for fertility and FP behaviour.

They show that decline in family size preferences, which is necessary predecessor of decline in actually fertility, tends to occur first among wives. Furthermore, the results indicate that wives have better understanding of the benefit of spacing their children and the danger associated with having birth in short intervals than their husbands. Therefore, contraceptive use either to space or limit family size is likely to be initiated by wives rather than their husbands in this study. But success in achieving a smaller family size will depend on how responsive husbands fertility preferences are to the changes in their spouse's preferences and on the influence of husband's preferences and on couple's reproductive behavior (Bankole and Singh 1998).

Contraceptive knowledge is high among husbands and wives in all three areas. Only small differences are observed between the reporting of marital/living together partners. On the other hand husbands are more likely than wives to report use of traditional methods. While differential reporting of condom use between couples is an important source of inconsistency, it does not appear to be the sole cause. This finding highlights possible problems associated with the conventional measure of contraceptive prevalence based on couple's reports. According to Bankole and Singh (1998) studies of fertility and FP will benefit from adopting measures of contraceptive use that are based on the reporting of both partners.

The level of contraceptive use when one spouse wants more children but the other does not is not easy to predict. Generally, in most studies the overall results of the multivariate analysis show that the wife preference exerts a stronger influence on the couple's contraceptives behaviour in all areas where the variable significantly predicts contraceptive behaviour. Although this study included only few areas in Richtersveld (Namaqualand), the results show that Richtersveld and the rest of developing countries

may differ in important ways. Among the areas covered in Richtersveld there is more agreement between spouses on contraceptive use as a result about 90 percent of the couple's highlighted that they were using contraceptives that implies agreement on ideal number of children. On the other hand, in Alexander Bay, Port Nollloth and Kuboes, although levels of agreement as to fertility intentions are similar across all areas, couples in Alexander bay and Port Nolloth are more likely to agree on the use of contraceptives, whereas the reverse is the case for couples in Kuboes.

In terms of contraceptive use, inconsistency in spousal reporting is evident in all three areas studied. The proportion of couples in which only husbands or only wives report use are very similar across all the areas. However, because use of FP methods is lower in most countries, these differences imply a greater relative bias in measurement of contraceptive prevalence in those areas than in other countries.

5.2 Conclusion

In conclusion, restricting my argument to spousal communication, discussion may cause couples to perceive their partners as more accepting of FP than they actually are. This may mean that any reduction in unmet need for contraception through improvements in spousal discussion may be overstated, this need to be taken into consideration when searching for efficient ways to reduce unmet need without increasing spousal violent behaviour.

5. 3 Recommendations

Moreover, findings suggest that more work is needed on couple's differences on contraceptive use and FP behaviour. The investigation of spousal communication on contraceptive use and ideal family size should be extended to other areas of Richtersveld.

In addition, survey questions should be more specific, include broader definition of communication not only on the subject of FP but also for other matters in the family that require communication between spouses such as decisions about child schooling, food purchase, and property acquisition. Attempts to examine issues as to why couples report contraceptive use differently will benefit from information gathered in-depth surveys of couple's attitudes, preferences and behaviour regarding contraceptive use, discussion and FP. Longitudinal data are required to gain better understanding of effects of couple's attitudes on contraceptive use and FP in Richtersveld.

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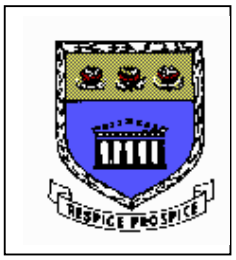
Appendix: 1



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Confidential: Data used for Research Purposes only

Spousal Communication and Family Planning Behaviour in South Africa

FEMALE QUESTIONNAIRE

INTRODUCTION TO RESPONDENT

My name is _____. I am doing Masters Degree at the University of the Western Cape. I am doing a survey in order to learn about couple's communication on family planning and their feelings about family planning in general. I'll begin with some questions about you yourself and then ask about conversations you've had about family planning with your husband. Please be as accurate as possible, since your answers will help me understand the experiences of married couples in this area today. Your participation in this survey is completely voluntary. You may refuse to answer any question and you can change your mind at any time and withdraw from this survey without any penalty. I would appreciate your taking a few minutes to answer some questions. Feel free to ask for explanation if you don't understand any of the questions that I ask. Everything you tell us will be kept fully confidential. If you would like to find out more about this survey you can contact my supervisor, Dr HV Doctor on 021 959 3023 or 076 104 4001. May I begin now? *Thank you very much for agreeing to talk with me.*

SECTION 1: INDENTIFICATION

Locality: _____ |_|
Respondent's ID: _____|_|_|_|
Spouse ID: _____|_|_|_|
Language of interview: Afrikaans…1 English…2 Zulu…3 Xhosa…4 Sotho…5 Other (specify)_____ 6
Name of enumerator: _____
Gender of enumerator: _____ M F
Date of interview: _____|_||_||_||_||_||_||_|
Time begun: _____|_||_|·|_||_| AM/PM

Outcome of interview:

First Visit:	Complete...1 Refused...2 Other (SPECIFY)_____3
Second Visit:	Complete...1 Refused...2 Other (SPECIFY)_____3
Third Visit:	Complete...1 Refused...2 Other (SPECIFY)_____3

SECTION 2: RESPONDENT'S BACKGROUND *Firstly I would like to know about your background and your education level*			
NO.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**SKIP**
1	In what month and year were you born?	MONTH …… DON'T KNOW MONTH ……98 YEAR… DON'T KNOW YEAR ……9998	
2	What is your religion?	CATHOLIC ……...……1 PROTESTANT …..……2 ISLAM…….....…….…..3 TRADITIONAL …...…..……4 OTHER SPECIFY …… ……5	
3	In which province were you born?	WESTERN CAPE ….……1 EASTERN CAPE…...…….2 NORTHERN CAPE…...……3 FREE STATE ……...……4 NORTH WEST ……...…..…..5 KWAZULU NATAL ……6 GAUTENG...……..……7 MPUMALANGA…...……..8 NORTHERN ……..……..…..9 OTHER COUNTRY ...…… …….. 10	
4	Which race group do you consider yourself?	BLACK/AFRICAN ……...1 COLOURED …..……...2 WHITE ……..3 ASIAN/INDIAN …….4 OTHER (SPECIFY) ...…… ……5	
5	Have you ever attended school?	YES ……...……1 NO ……...……..2	
6	What is the highest (standard/year) you completed?	LESS THAN ONE YEAR ...…….00 SUB A/CLASS 1……...…….71 SUB B/CLASS 2……...…….72 STANDARD 1……...……01 STANDARD 2……...…02 STANDARD 3……...03 STANDARD 4……...04 STANDARD 5……...…05 STANDARD 6……...…06 STANDARD 7……...07 STANDARD 8……...……08	For all respon ses →Q8

		STANDARD 9……...……09 STANDARD 1……...10 FURTHER STUDIES INCOMPLETE…….11 DIPLOMA/OTHER POSTSCHOOL COMPLETE…….…….12 FURTHER DEGREE COMPLETE……..13	
7	Why have you never attended school?	SCHOOL TOO FAR ……1 TOO EXPENSIVE……....2 WAS OBLIGED TO WORK.....3 PARENTS DID NOT SEE THE IMPORTANCE…….4 OTHER (SPECIFY) …..…….....5 DON'T KNOW...…….....8	
8	What is your occupation?	EMPLOYED…….…… …1 SELF EMPLOYED …..……... 2 UNEMPLOYED ……...……3 HOUSE WIFE ……..4 RETIRED ……5 OTHER SPECIFY …… …..……..6	
9	What is your current marital status?	SINGLE …...……..1 MARRIED/LIVING TOGETHER ……2 DIVORCED …….……3 WIDOWED …...…….4 OTHER SPECIFY..…… ……5	
10	If married, For how long have you been married?	LESS THAN ONE YEAR…..... 1 ONE TO TWO YEARS…… 2 THREE TO FIVE YEARS ...….3 MORE THAN FIVE YEARS…4 OTHER SPECIFY……..…… ……5	

SECTION 3: REPRODUCTION

Now I would like to ask about all the pregnancies that you have had in your lifetime. By this I mean all children born to you, whether they were born alive or dead. I understand it is not easy to talk about children who have died or pregnancies that you have terminated before the full term but it is important that you tell us about all of them.

11	Have you ever given birth?	YES……1 NO…….……2	→Q19
12	How many children have you ever given birth to?	NUMBER: __ __	

13	How many sons have you ever given birth to?	NUMBER: __ __	
14	How many daughters have you ever given birth to?	NUMBER: __ __	
15	Has living children?	YES……1 NO……..……2	
16	Have you ever given birth to a boy or girl who was born alive but later died? *If No,* PROBE: Any baby who cried or showed signs of life but survived only a few hours or days?	YES……..……1 NO……..……2	
17	How many boys have died? And how many girls have died? *If None, Record '00'.*	BOYS DEAD: __ __ GIRLS DEAD: __ __	
18	How old were you when you gave birth to your first child?	Age: __ __ CAN'T REMEMBER ……..…88 DON'T KNOW……...…99	
19	Are you pregnant?	YES . . . . . 1 NO . . . . . 2 UNSURE 8	 →Q22 →Q22
20	How many months pregnant are you? *Record Number Of Completed Months.*	MONTHS: __ __	
21	At the time you became pregnant did you want to become pregnant <u>then</u>, did you want to wait until <u>later</u>, or did you <u>not want</u> to become pregnant at all?	THEN … . . . . . 1 LATER . . . . . 2 NOT AT ALL 3	
SECTION 4. CONTRACEPTION *Now I would like to talk about family planning, the various method or ways that a couple can use to delay or avoid a pregnancy.*			
22	Have you ever heard of any methods which could help in preventing pregnancy?	YES . . . . . 1 NO 2	 →Q46
23	What methods have you ever heard of? "CIRCLE ALL METHODS MENTIONED"	PILL .. . . . . 01 IUD . . . . . 02 INJECTIONS . . . . . 03 DIAPHRAGM/FOAM/JELLY. . . . .04 CONDOM . . . . . 05 FEMALE STERILIZATION. 06 MALE STERILIZATION. .. . 07 PERIODIC ABSTINENCE.. 08 WITHDRAWAL . . . . 09 LACTATIONAL	

		AMENORRHEA METHOD .11 HERBS……..12 OTHER (SPECIFY)……..... ……13	
24	From whom did you first get information about methods to avoid pregnancy? "ONLY ONE ANSWER IS ACCEPTABLE"	MOTHER…… 1 SISTER…… 2 FATHER……. 3 TEACHER…….. 4 HEALTH INSTITUTION /NURSE……5 DOCTOR……. 6 FRIENDS ……..…….7 SPOUSE ……..……..….....8 OTHER RELATIVES …….....9 RADIO/TELEVISION…….. 10 NEWSPAPER/MAGAZINE/ POSTER.....11 OTHER (SPECIFY)…… 12	
25	Would you say that you approve or disapprove of using family planning for yourself?	APPROVE . . . . 1 DISAPPROVE . . .. 2 NO OPINION 3	
26	What do you approve family planning for?	BIRTH LIMIT ……..1 BIRTH SPACING …….2 BOTH…….……3 OTHER SPECIFY …….....4	
27	Do you think your husband approves of family planning?	YES……..……...1 NO……..…….. 2 DON'T KNOW….....3	
28	Did you ever discuss family planning with your husband in the previous years?	YES ……..…..1 NO…….……2	
29	How often within last year?	ONCE ……...……1 TWICE……....2 THREE TIMES…….....3 MORE THAN THREE TIMES……4 OTHER SPECIFY…… ……5	
30	What were the items that you discussed?	NUMBER OF CHILDREN …..1 SPACING OF CHILDREN..….2 FAMILY PLANNING ……..… METHODS.....3 OTHER (SPECIFY) ……4	
31	Who usually initiates discussion about family planning?	MYSELF ……1 MY HUSBAND…….…….2 OTHER	

		(SPECIFY)……..... 3	
32	How do you end up the discussion? On family planning?	QUARRELLING ……...1 AGREEING ON THE USE OF CONTRACEPTIVES…….2 DISAGREEING ……..…..3 OTHER SPECIFY …… …….....4	
33	Have you ever used contraceptives?	YES …….....……1 NO…….....…….2	→Q43
34	What methods have you ever used? "CIRCLE ALL THE RESPONSES"	PILL .. . . . . 01 IUD . . . . . 02 INJECTIONS . . . . . 03 DIAPHRAGM/FOAM/JELLY. . . ..04 CONDOM . . . . . 05 FEMALE STERILIZATION. 06 MALE STERILIZATION. .. . 07 PERIODIC ABSTINENCE....08 WITHDRAWAL . . . . 09 LACTATIONAL AMENORRHEA METHOD .11 HERBS…….12 OTHER (SPECIFY)……..... …….13	
35	Are you currently using contraceptives?	YES …….....…… 1 NO …….....…….. 2	→Q43
36	What methods are you currently using?	PILL .. . . . . 01 IUD . . . . . 02 INJECTIONS . . . . . 03 DIAPHRAGM/FOAM/JELLY. . . ..04 CONDOM . . . . . 05 FEMALE STERILIZATION. 06 MALE STERILIZATION. .. . 07 PERIODIC ABSTINENCE.. 08 WITHDRAWAL . . . . 09 LACTATIONAL AMENORRHEA METHOD .11 HERBS…….12 OTHER (SPECIFY)……..... ……..13	
37	Between you and your husband who decided to use contraceptives?	MY SELF…….....1 MY HUSBAND …….....…. 2 BOTH OF US…….....…. 3	
38	How old were you the time you started using contraceptives?	LESS THAN 15…….....……. 1 15-19…….....……2 20-24…….....……. . 3	

		25 AND ABOVE…….....……4 OTHER (SPECIFY) ……..... 5 CAN'T REMEMBER…….8	
39	How many children did you have at the time you started using contraceptives?	ONE…….....……...1 TWO …….....2 THREE…….....…….3 FOUR AND ABOVE…….....4 OTHER (SPECIFY)…….....….5 CAN'T REMEMBER…….8	
40	Have you ever stopped using contraceptives at some point?	YES…….....……1 NO…….....…….2	→Q42
41	What was the reason for stopping using contraceptives? " CIRCLE ALL THAT APPLY"	SEXUALLY INACTIVE…….....…….1 SIDE EFFECTS…….....…….. 2 BECAME PREGNANT……..... ….3 HEALTH REASONS…….....…… 4 WANTED MORE CHILDREN ….....….....5 OTHER (SPECIFY)…….....……..6	
42	If you are not using contraceptives, why are you not using? Check Q35.If "NO" ask this question If "YES" → Q44	CURRENTLY MARRIED NEED CHILDREN .....1 HEALTH REASONS….....….….....2 HUSBAND OPPOSED…..……. 3 WANT MORE CHILDREN .....….....4 MENOPAUSE …….....5 RELIGIOUS PROHIBITION …..... 6 KNOWS KNOW METHOD….....7 OTHER (SPECIFY)…..…….8	
43	Do you intend to use contraceptives in the future?	YES…….....……...1 NO…….....…… ...2 NOT SURE…….....…….3 DON'T KNOW…..…….8	
44	Do you think your husband has a positive attitude towards family planning?	YES…….....……...1 NO…….....……2	→Q44
45	If yes, what makes you think he has a	HE STRICTLY WANT A	

	positive attitude towards family planning?	CERTAIN NUMBER OF CHILDREN .....….1 ENCOURAGING YOU TO USE CONTRACEPTIVES ….....……2 OTHER (SPECIFY)….....…….....3	
SECTION 5. FERTILITY PREFERENCES *Now I have some questions about the future/past. Would you like to have (a/another)child or would you prefer not to have any (more) children?*			
46	CHECK Q15 HAS LIVING CHILDREN If you could go back to the time you did not have any children and could choose exactly the number of children to have in your whole life, how many would that be? NO LIVING CHILDREN- If you could choose exactly the number of children to have in your whole life, how many would	NUMBER:_ _ UP TO GOD/NON-NUMERIC….....……. 98 OTHER…….....…….99	
47	How many of these children would you like to be boys, how many would you like to be girls and for how many would it not matter?	BOYS NUMBER:_ _ UP TO GOD/NON-NUMERIC….....…… 98 OTHER SPECIFY…….....……99 GIRLS NUMBER:_ _ UP TO GOD/NON-NUMERIC…….....…….. 98 OTHER…….....…….99 EITHER NUMBER UP TO GOD/NON-NUMERIC…… ..... 98 OTHER SPECIFY…….....……99	

"These are the questions that I wanted to ask you. Thank you very much for talking with me today. I very much appreciate your help in my research project about spousal communication."

Time finished: _____|_||_|·|_||_| AM/PM

Appendix: 2

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Confidential: Data used for Research Purposes only

Spousal Communication and Family Planning Behavior in South Africa

MALE QUESTIONNAIRE

INTRODUCTION TO RESPONDENT

My name is _____. I am doing Masters Degree at the University of the Western Cape. I am doing a survey in order to learn about couple's communication on family planning and their feelings about family planning in general. I'll begin with some questions about you yourself and then ask about conversations you've had about family planning with your husband. Please be as accurate as possible, since your answers will help me understand the experiences of married couples in this area today. Your participation in this survey is completely voluntary. You may refuse to answer any question and you can change your mind at any time and withdraw from this survey without any penalty. I would appreciate your taking a few minutes to answer some questions. Feel free to ask for explanation if you don't understand any of the questions that I ask. Everything you tell us will be kept fully confidential. If you would like to find out more about this survey you can contact my supervisor, Dr HV Doctor on 021 959 3023 or 076 104 4001. May I begin now? *Thank you very much for agreeing to talk with me.*

SECTION 1: INDENTIFICATION

Locality: _____ |_|
Respondent's ID: _____|_|_|_|
Spouse ID: _____|_|_|_|
Language of interview : Afrikaans…1 English…2 Zulu…3 Xhosa…4 Sotho…5 Other (specify)_____ 6
Name of enumerator: _____
Gender of enumerator: _____ M F
Date of interview: _____|_||_||_||_||_||_||_|
Time begun: _____|_||_|.|_||_| AM/PM

Outcome of interview:

First Visit: Complete...1 Refused...2 Other (SPECIFY)_____3

Second Visit: Complete...1 Refused...2 Other (SPECIFY)_____3

Third Visit: Complete...1 Refused...2 Other (SPECIFY)_____3

SECTION 1: RESPONDENT'S BACKGROUND Firstly I would like to know about your background and your education level.			
NO.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**SKIP**
1	In what month and year were you born?	MONTH …… DON'T KNOW MONTH …….98 YEAR… DON'T KNOW YEAR …….9998	
2	What is your religion?	CATHOLIC ……..……1 PROTESTANT …..……2 ISLAM…….....…….…..3 TRADITIONAL …...…..……4 OTHER SPECIFY …… ……5	
3	In which province were you born?	WESTERN CAPE ….……1 EASTERN CAPE…...…….2 NORTHERN CAPE…...……3 FREE STATE ……...……4 NORTH WEST ……...…..…..5 KWAZULU NATAL ……6 GAUTENG...……..……7 MPUMALANGA…...……..8 NORTHERN ……..…….…..9 OTHER COUNTRY ...…… ……. 10	
4	Which race group do you consider yourself?	BLACK/AFRICAN ……...1 COLOURED …..……...2 WHITE ……..3 ASIAN/INDIAN …….4 OTHER (SPECIFY) ...…… …… 5	
5	Have you ever attended school?	YES ……...……1 NO ……...……..2	
6	What is the highest (standard/year) you completed?	LESS THAN ONE YEAR ...…….00 SUB A/CLASS 1……...…….71 SUB B/CLASS 2……...…….72 STANDARD 1……...……01 STANDARD 2……...…02 STANDARD 3……...03 STANDARD 4……...04 STANDARD 5……...…05 STANDARD 6……...…06 STANDARD 7……...07 STANDARD 8……...……08	For all responses →Q8

		STANDARD 9……...……09 STANDARD 1……...10 FURTHER STUDIES INCOMPLETE…….11 DIPLOMA/OTHER POSTSCHOOL COMPLETE…….…….12 FURTHER DEGREE COMPLETE……..13	
7	Why have you never attended school?	SCHOOL TOO FAR ……1 TOO EXPENSIVE……....2 WAS OBLIGED TO WORK.....3 PARENTS DID NOT SEE THE IMPORTANCE……..4 OTHER (SPECIFY) …..……..... ……5 DON'T KNOW...…….....8	
8	What is your occupation?	EMPLOYED…….…… …1 SELF EMPLOYED …..……..... 2 UNEMPLOYED ……...……3 HOUSE WIFE ……..4 RETIRED …….5 OTHER SPECIFY …….…… …..……..6	
9	What is your current marital status?	MARRIED……. 1 LIVING TOGETHER …… 2	
10	If married or living together, for how long have you been married?	LESS THAN ONE YEAR…..... 1 ONE TO TWO YEARS…… 2 THREE TO FIVE YEARS ...….3 MORE THAN FIVE YEARS…4 OTHER SPECIFY……..…… ……5	

SECTION 2: REPRODUCTION

Now I would like to ask about all the children that you have fathered in your lifetime. By this I mean all children, whether they were born alive or dead. I understand it is not easy to talk about children who have died but it is important that you tell me about all of them.

11	Do you have any sons or daughters whom you have fathered and are alive?	YES……1 NO……..……2	
12	How many children have you ever fathered and are alive?	NUMBER: __ __	
13	How many sons have you ever fathered and are alive?	NUMBER: __ __	
14	How many daughters have you ever fathered and are alive?	NUMBER: __ __	
15	Has living children?	YES…….1 NO……..……2	

16	Have you ever fathered a boy or girl who was born alive but later died? *If No,* PROBE: Any baby who cried or showed signs of life but survived only a few hours or days?	YES……..……1 NO……..……2	
17	How many boys have died? And how many girls have died? *If None, Record '00'.*	BOYS DEAD: __ __ GIRLS DEAD: __ __	
18	How old were you when you fathered your first child?	Age: __ __ CAN'T REMEMBER ……..…88 DON'T KNOW……...…99	

SECTION 3. CONTRACEPTION

Now I would like to talk about family planning, the various methods or ways that a couple can use to delay or avoid a pregnancy.

Note: Any questions talking about the wife refer to the current wife of the husband.

19	Have you ever heard of any methods which could help in preventing pregnancy?	YES . . . . . 1 NO 2	→Q42
20	What methods have you ever heard of? "CIRCLE ALL METHODS MENTIONED"	PILL .. . . . . 01 IUD . . . . . 02 INJECTIONS . . . . . 03 DIAPHRAGM/FOAM/JELLY. . . ..04 CONDOM . . . . 05 FEMALE STERILIZATION. 06 MALE STERILIZATION. .. . 07 PERIODIC ABSTINENCE.. 08 WITHDRAWAL . . . . 09 LACTATIONAL AMENORRHEA METHOD .11 HERBS……..12 OTHER (SPECIFY)……..... ……13	
21	From whom did you first get information about methods to avoid pregnancy? "ONLY ONE ANSWER IS ACCEPTABLE"	MOTHER…… 1 SISTER…… 2 FATHER……. 3 TEACHER…….. 4 HEALTH INSTITUTION /NURSE……5 DOCTOR……. 6 FRIENDS …….…….7 SPOUSE ……..……..….....8 OTHER RELATIVES ……....9 RADIO/TELEVISION…….. 10	

		NEWSPAPER/MAGAZINE/ POSTER.....11 OTHER (SPECIFY)…… 12	
22	Would you say that you approve or disapprove of using family planning for your wife (or family)?	APPROVE . . . . ……1 DISAPPROVE . . .. 2 NO OPINION 3	
23	What do you approve family planning for?	BIRTH LIMIT ……..1 BIRTH SPACING …….2 BOTH…….……3 OTHER SPECIFY …….....4	
24	Do you think your wife approves of family planning?	YES……..……...1 NO……..…….. 2 DON'T KNOW…….....3	
24	Did you ever discuss family planning with your wife in the previous years?	YES ……..…..1 NO……..……2	
25	How often within last year?	ONCE ……...……1 TWICE……...2 THREE TIMES…….....3 MORE THAN THREE TIMES…….4 OTHER SPECIFY…… ……5	
26	What were the items that you discussed?	NUMBER OF CHILDREN …..1 SPACING OF CHILDREN..…2 FAMILY PLANNING ……..…. METHODS.....3 OTHER SPECIFY …… ……4	
27	Who usually initiates discussion about family planning?	MYSELF ……1 MY HUSBAND…….…….2 OTHER (SPECIFY)……..... 3	
28	How do you end up the discussion? On family planning?	QUARRELLING ……...1 AGREEING ON THE USE OF CONTRACEPTIVES…….2 DISAGREEING ……..…..3 OTHER SPECIFY …… …….....4	
29	Have you or your wife ever used contraceptives?	YES …….....……1 NO…….....…….2	
30	What methods have you ever used? "CIRCLE ALL THE RESPONSES"	PILL .. . . . . 01 IUD . . . . . 02 INJECTIONS 03	

		DIAPHRAGM/FOAM/JELLY. . . ..04 CONDOM . . . . . 05 FEMALE STERILIZATION. 06 MALE STERILIZATION. .. . 07 PERIODIC ABSTINENCE.. 08 WITHDRAWAL . . . . 09 LACTATIONAL AMENORRHEA METHOD . 11 HERBS……12 OTHER (SPECIFY)……..... …… 13	
31	Are you or your wife currently using any method?	YES ……..…… 1 NO ……..…….. 2	
32	What methods are you currently using? "CIRCLE ALL THAT APPLY"	PILL .. . . . . 01 IUD . . . . . 02 INJECTIONS . . . . . 03 DIAPHRAGM/FOAM/JELLY. . . .. 04 CONDOM . . . . . 05 FEMALE STERILIZATION. 06 MALE STERILIZATION. .. . 07 PERIODIC ABSTINENCE.. 08 WITHDRAWAL . . . . 09 LACTATIONAL AMENORRHEA METHOD . 11 HERBS……12 OTHER (SPECIFY)……..... …… 13	
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		OTHER (SPECIFY)…….....……..3	
38	If you and your wife are not using any method to prevent pregnancy why are you not using?	CURRENTLY MARRIED NEED CHILDREN .....1 WIFE OPPOSED.....…….2 WANT MORE CHILDREN .....….....3 RELIGIOUS PROHIBITION ….....4 KNOWS KNOW METHOD….....7 OTHER (SPECIFY)…….....…….8	
39	Do you and your wife intend to use any method in future?	YES…….....……...1 NO…….....…… ...2 NOT SURE.....…….3 DON'T KNOW....…….8	
40	Do you think your wife has positive attitude towards family planning?	YES…….....……...1 NO…….....……2	
41	If yes, what makes you think she has a positive attitude towards family planning?	HE STRICTLY WANT A CERTAIN NUMBER OF CHILDREN .....….1 ENCOURAGING YOU TO USE CONTRACEPTIVES ….....……2 OTHER (SPECIFY)…….....…….....3	
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		SPECIFY…….....……99 GIRLS NUMBER:_ _ UP TO GOD/NON- NUMERIC…….....…….. 98 OTHER…….....…….99 EITHER NUMBER UP TO GOD/NON- NUMERIC…… ..... 98 OTHER SPECIFY…….....……99	

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