

M. Pradal

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# **A Report on Attitudes towards Family Planning & Family Size in Botswana**

**By Pia du Pradal**

**March 1983**

## PREFACE

The following is a report on a survey which investigated the attitudes of Batswana men, women and youths to family planning and family size. The research was conducted between September 1981 and May 1982 by the students of the Department of Nursing Education, University of Botswana in conjunction with the Department of Maternal/Child Health and Family Planning, Ministry of Health.

The project was funded by the Research Triangle Institute in North Carolina (Sub-Contract No 9-214-1920) and further supported by US AID, Botswana which funded the services of the co-ordinator.

I would like to express my sincere thanks to the many people who assisted with this project. Particular mention should be made of Karen B Allen, Dr Ellen Fried and Dr Dennis Chao of RTI who supported the project during its implementation and provided invaluable assistance in the data analysis; Dr Mashalaba of the Department of MCH & FP whose sincere interest in the project stimulated it throughout; Mrs Kupe of the Department of Nursing Education who provided the full support of her faculty; and Mr C Gordon of US AID without whose encouragement the project would never have been implemented. I would also like to thank those students who participated in the project working long hours during weekends and holidays in order to keep the project on schedule and to rectify errors.

Finally, I would like to thank Chief Linchwe II for allowing us to conduct this research amongst the Bakgatla and the 826 respondents who answered the questions so explicitly. I hope this report will help the Ministry of Health clear some of their confusion concerning family planning.

Special mention should be made of the work conducted by Professor Isaac Schapera some fifty years ago amongst the Bakgatla in Mochudi. This has provided a rich source of information and has frequently been referred to in this document.

Pia du Pradal  
Project Co-ordinator  
March 1983

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## ABBREVIATIONS AND ANACRONYMS

Col	-	Column
CSO	-	Central Statistics Office, Ministry of Finance and Development Planning
Dis	-	Disagree
D/K or D K	-	Don't Know
FP	-	Family Planning
FWE	-	Family Welfare Educator
GOB	-	Government of Botswana
IUD	-	Inter Uterine Device
KAP	-	Knowledge, Attitude and Practice - Surveys of
Kgatla	-	Root of word referring to tribe; Bakgatle tribe, Mokgatla person, Kgatleng district
Kgotla	-	Tribal council and place where council meets
lolwapa	-	Yard or homestead
MCH & FP	-	Maternal/Child Health and Family Planning Department of
MOH	-	Ministry of Health
NIR	-	National Institute of Research
RTI	-	Research Triangle Institute, North Carolina
Sep	-	Separated, divorced or widowed
UB or UBS	-	University of Botswana, formerly University of Botswana and Swaziland
US AID	-	United States Agency for International Development
VD	-	Venereal Disease

1. INTRODUCTION

1.1 Background to the Project

Surveys of Knowledge, Attitude and Practice (KAP) of family planning are common throughout the world. This type of research is, however, relatively new to Botswana. Prior to this project, focus has been on the evaluation of the delivery system, rates of acceptance, drop-out levels together with a number of small attitudinal studies. Such research was conducted mainly in clinics with small samples of women. This pilot project was designed to compliment these earlier studies by interviewing Botswana men, women and teenage girls in their homes. In this way it was hoped to overcome the possible bias created by interviews being conducted within a health facility. It was also thought that in doing this, one would get a more representative sample of the population.

Since the family planning programme was introduced in Botswana in 1971 the Ministry of Health has had to deal with it cautiously, integrating it with the Department of Maternal and Child Health and emphasizing child spacing rather than population control. It has nevertheless been the subject of political controversy as the following quotation reveals:

"Family Planning in Botswana is taught and practiced as a measure for spacing pregnancies and not as a birth control programme and no mention is ever made of family size.

This was said in Parliament by the Minister of Health, Mr L M Makgenene, in reply to a question from the member of Parliament for Kanye South, Mr B S Gaseitsiwe who wanted to know 'what effect and influence the family planning propaganda, introduced many years ago, has had on the birth rate in Botswana.' (He) ... also wanted to know whether it is right for a government of a small population such as Botswana to persuade her people to have fewer children when 'shortage of manpower is the talk of the day.'"

(Botswana Daily News: March 10, 1981, No.45, p.2)

The few radio programmes dealing with family planning have aroused strong public criticism. Traditionally sexual matters were never discussed in public. Consequently, the more conservative members of society have taken offence and pointed out that such family planning health talks were offensive, despite the fact that the Ministry of Health had taken pains to discuss it as politely as possible.

In view of the sensitivity of the subject the Ministry of Health has been opposed to any large scale attitudinal survey which could evoke further criticism. Nevertheless, having decided that they require such information, it was proposed that a small pilot survey should be conducted by a local institute which - if successful - could lead to a second phase being carried out in other parts of the country. It was considered imperative that the researchers should have a thorough knowledge of Setswana culture in order to avoid possible blunders and to ensure correct sociological interpretation of the research findings. Ministry officials were furthermore frustrated at the number of studies conducted in Botswana which appeared to simply produce reports. They thought this survey would provide an excellent opportunity to involve local health workers; training and sensitizing them to the problems involved in the delivery of family planning.

The Department of Nursing Education, University of Botswana and Swaziland, was considered ideal to fill this role. The proposal that final year students should conduct this research for the Ministry met with enthusiasm from staff and students alike, who believed that the project would not only meet the requirements of the Ministry but would also strengthen their faculty and supplement their newly introduced course on 'Research in Nursing'.

## 1.2 Institutional Involvement

The research in this project was conducted by the students of the Department of Nursing Education who were supervised by the faculty head (Mrs Sarara Kupe) and members (Mrs Sheila Tlou and Mrs Naomi Seboni) together with the project co-ordinator who was a resident social anthropologist.

The Ministry of Health provided support throughout the project. Dr Mashalaba, Head of the Department of Maternal/Child Health and Family Planning (MCH&FP) was kept informed on progress and provided valuable advice at critical stages in the project. Members of the Health Education Unit and Senior Public Health Nurses helped direct attention to the areas which they considered important for research. The Department also assisted in disseminating the survey results by participating in a series of workshops, held in both rural and urban areas.

The project was officially affiliated to the National Institute of Research (NIR) which undertook to assist with secretarial services, the printing and dissemination of project reports.

During the final stage of the project the Ministry of Finance and Development Planning assisted in the data analysis by providing a statistician - Mr Seja Mokomane - from the Central Statistics Office (CSO). US AID funded the project through the Research Triangle Institute (RTI) in North Carolina and was supplemented by US AID Botswana. Besides funding RTI played an active role in the project with Ms Karen Allen assisting in the collection of literature and designing coding manuals for computer analysis; Dr Ellen Fried providing essential training in coding and continuous support during the latter part of the project; and Dr Dennis Chao training Mr Mokomane of the CSO in computer analysis.

### 1.3 Project Goals

The primary goals of the project are two-fold:

- (1) To understand the attitudes of men, women and youths from different socio-economic groups to family planning and family size; and
- (2) To provide the final year Nursing Education students with practical experience in health research and to sensitize them to some of the problems in the delivery of family planning in Botswana.

In July 1982 a report <sup>1</sup> was submitted to USAID (Contract No. 633-0206-C-00-1024-00) which evaluated the project in terms of the second goal. It found that despite a number of methodological problems the nursing education students had gained experience in research methodology - they had participated fully in the project design, data collection, data analysis and had written papers focusing on issues which they found interesting. The experience gained through this project had strengthened their awareness of the problems inhibiting the acceptance of family planning which, since they are the future teachers of Family Welfare Educators (FWE's) and other health workers, should have positive repercussions on the FP programme.

It was hoped at the start of the project that the students' papers would form the basis of the final report but fast approaching examinations resulted in these being of poor quality.

This report attempts to put together some of the mass of data that was collected in the course of the project. It presents an analysis of 'ideal family size', child spacing, customary and modern methods of spacing, KAP of contraception and factors affecting this, the phenomena of single mothers, and finally the need for public education on family planning.

A time perspective is given to the discussion in this report by drawing from the research done by Professor Schapera in Mochudi during the mid-1930s.

1. du Pradal, July 1982.

## 2. METHODOLOGY

### 2.1 A Pilot Project?

Although this project was originally intended to be a small pilot study in which 450 questionnaires would be administered that would test the research tools and make recommendations for a larger full-scale survey, enthusiasm on the part of the researchers together with an urgency on the part of the Department MCH&FP for information on the subject resulted in this project expanding into a more thorough survey in which 826 questionnaires were administered.

The original survey was designed to take place during six to eight months. This survey took two years to complete.

A factor which contributed to its expansion was that the RTI offered the opportunity to have the data computer analysed. After accepting this proposal it was discovered that the quality of the first 450 questionnaires left a great deal to be desired and that almost one half of them would have to be eliminated.<sup>1</sup> It was therefore decided not only to complete the outstanding interviews but also to enlarge the sample size in order to increase the reliability of the survey results.

Most of the fieldwork was conducted by the nursing education students although in the final phase a few sociology and demography students participated.

### 2.2 Target Groups

The survey focused on three target groups in both urban and rural areas, i.e. men, women and female youths<sup>2</sup> in Gaborone and Kgatleng District.

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1. For a further discussion of this see du Pradal, July 1982, p.33-34.

2. The exclusion of male youths was a result of time pressure and since this was to be a small, pilot study the researchers felt that the design of a questionnaire for this group could be left to the follow-up survey.

The researchers believed that for the family planning programme to be successful it is necessary to understand what men - as well as women - think about contraception. A major weakness in earlier studies and the delivery of family planning has been the lack of consultation with Batswana men. This would appear to have inhibited its acceptance since those men who are uninformed tend to view modern contraception with suspicion. A questionnaire was therefore designed examining their knowledge, attitude and practice of family planning which complimented the one designed for female respondents.

The Ministry of Health had expressed grave concern about the pregnancy rate amongst teenagers and the number of school girl drop-outs caused by this. A questionnaire was therefore designed to investigate this problem together with sections on KAP which were the same as those in the female questionnaires.

### 2.3 The Questionnaire

A basic questionnaire was formulated which sought to investigate the following areas:

- Personal Data
- Family Size - actual and ideal
- The role of adoption in modern Setswana society
- The incidence of unmarried mothers and related circumstances
- Child Spacing
- KAP on family planning: both modern and traditional methods were investigated
- Attitudes towards a number of misconceptions concerning contraception

Finally, two sequences of questions were developed measuring economic status: one for urban and the other for rural respondents.

This core questionnaire was then modified to suit the three target groups resulting in six variations

Rural Women	Rural Males	Rural Youths
Urban Women	Urban Males	Urban Youths

The questionnaires were translated into Setswana as politely as possible without losing their meaning. Accuracy was tested by having the third year students re-translate them into English.

Although the questionnaires were pre-tested and approved by faculty members of the Department of Nursing Education, Dr Mashalaba of the Department of MCH & FP and Mr C Gordon of US AID Botswana they were not evaluated as thoroughly as one might have wished because of heavy time pressure and the belief that this was to be a preliminary study which would result in an evaluation of the questionnaires before a second, more thorough survey was conducted.<sup>1</sup>

#### 2.4 Survey Areas

Since it is thought that the attitude and beliefs concerning family planning vary enormously in different parts of Botswana this pilot project was designed to survey both urban and rural areas taking care to identify the views of different socio-economic groups. The survey was therefore conducted in Old Naledi (Low Cost), Broadhurst (Medium Cost) and Tshaba Ntcha (High Cost) which represent three different socio-economic areas in Gaborone as well as a small, medium and large village Kgatleng District. It cannot be said that this district typifies rural Botswana, but no single district could be termed truly representative. Kgatleng was selected primarily on account of its proximity to Gaborone which would allow fieldwork to be done during weekends.

Chief Linchwe II, Paramount Chief of the Bakgatla, granted permission for the research to be conducted in his district and expressed his concern about schoolgirl pregnancies. He said that many parents had come to him distraught over the situation of their daughters. His wife who is a nurse by profession said that they had gradually tried to motivate the Bakgatla to practice child spacing by pointing out the economic and health advantages to them.

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1. For a further discussion of this and the flaws in the questionnaires see du Pradal July 1982, p.12-14.

Three different size villages were selected which have different types of local health facilities, something which it was thought may affect the KAP of the residents.

Mochudi, the tribal capital and administrative centre of the Bakgatla tribe, was selected as a sample of a large village. It has a population of 18 363 people,<sup>1</sup> a general hospital and a clinic, a primary and secondary school. As this 'village' is just 57 kilometres from Gaborone it was thought that the views would reflect those of modern Bakgatla.

Bokaa which was selected as a sample of a medium sized village has a population of 2 018 people<sup>1</sup> who are strongly involved in agriculture. These villagers have a good reputation for participating in self-help projects and were responsible for building the first "health-post" in their village. Today the community has a fully staffed clinic with a maternity ward and a team of FWE's.

Bokaa was also selected because of an interesting report by Kooijman (1978) in which she discussed the attitudes of some of her respondents to family planning.

Modipane is a small village with a population of 1 220 people.<sup>1</sup> It is characteristic of a number of villages along the South African border that rely heavily upon migrant labour. This village has a health post that is run by a FWE and is served by the Mobile Clinic which comes from Lentswe La Oodi, a village 15 kilometres away.

## 2.5 Sampling Techniques

A random sample was interviewed in each area by means of a method that is commonly used in social surveys in Botswana. In the smaller villages the students were assigned to different wards (sections) and instructed to work from the periphery inwards. In the process they were instructed to skip a certain number of households - the number being determined by the size of the village - and then to

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1. Figures taken from 1982 Botswana National Census.

interview one respondent in the next occupied household. The reason for starting on the outskirts was to take account of the traditional hierarchical village organization by which the poorest or lowest classes lived on the periphery of the village. It also ensured that the students covered their areas properly since they had to work towards the centre of the village where they would later be collected.

In Mochudi the same method was used but because of its expense, the survey was conducted in four wards which were randomly selected.

A similar method was used in the urban areas with each student being given a different section in which to work.

## 2.6 Data Analysis

The questionnaires went through two processes of analysis - the first was a manual analysis which provided preliminary results for the MOH which were used in the workshops; the second was a computer analysis conducted by Dr Dennis Chao (RTI) and Mr Mokomane (CSO). During the latter Mr Mokomane received training in data cleaning, statistics, stepwise and regression analysis, and the SAS computer package.

## 2.7 Workshops

Early in the project respondents expressed their confusion over the effects of family planning and requested that they be given feedback once the survey was completed. This was done by means of a series of workshops which took place in village kgotlas, sports clubs, church groups, youth clubs, schools, training colleges and even the Gaborone Prison. The emphasis during these meetings was on informal discussion with the students providing short lectures on contraception and correcting the prevailing misconceptions. These discussions provided valuable insights into some of the confusion that is associated with family planning.

3. THE SURVEY

3.1 Sample Size

826 questionnaires were administered and coded but some of these were eliminated either because the respondent was the wrong age or contradictory information was given bringing the validity of the data into question.

The analysis was therefore based on 782 questionnaires which consisted of 249 adult women, 250 men and 283 female youths. Table I provides a breakdown of this sample according to area.

TABLE I - SURVEY SAMPLE

<u>AREA</u>	<u>ADULT WOMEN</u>	<u>MEN</u>	<u>FEMALE YOUTHS</u>
<u>URBAN</u>			
Tshaba Ntcha	0	0	19
Broadhurst	53	52	50
Old Naledi	40	51	74
<b>URBAN TOTAL</b>	<b>93</b>	<b>103</b>	<b>148</b> <sup>1</sup>
<u>RURAL</u>			
Mochudi	52	47	46
Bokaa	50	52	42
Modipane	53	48	47
<b>RURAL TOTAL</b>	<b>156</b> <sup>1</sup>	<b>147</b>	<b>135</b>
<b>TOTAL</b>	<b>249</b>	<b>250</b>	<b>283</b>

1. The total is more than the sum of the three groups because it was unclear in some cases which area the respondent lived in

It will be noticed that in Tshaba Ntchu no adults were interviewed. This was because the students felt inhibited in interviewing adults in the high cost area whom they seemed to consider their social superiors. Although 50 youths were questioned in this area it was later discovered that 31 were 'live-in' domestic servants. These were classified together with the Old Naledi group since they resemble the youths in the low cost area rather than those of either the medium or high cost areas.

### 3.2 Age

Although the sample represents a random selection of households in each area the survey concentrated on women of child bearing age and their partners. The sample of adult women was between 19-55 years old with the mean age of rural women being 33.8 and urban women 29.4. It will be noted in Table II that the urban sample was heavily skewed towards younger men and women whereas the rural sample is more evenly distributed. This is not surprising since there has been a rapid urbanization of young people in search of employment.

The males interviewed were between 18 and 70 years old with the mean age of urban males being 31.2 and rural males 33.8.

The female youths were between 14 and 18 years old with the mean age being 16.6 in the rural area and 16.9 in the urban area. Interviews with girls who had not started menstruating were discontinued as it was thought that some of the questions were a little too explicit and may evoke parental disapproval.

### 3.3 Education

Table III provides a summary of the educational attainments of the respondents which are higher in the urban area than the rural.

TABLE II - RESPONDENTS' AGE

(A) ADULTS

	<u>19-24</u>	<u>25-29</u>	<u>30-34</u>	<u>35-39</u>	<u>40-44</u>	<u>45-49</u>	<u>50 +</u>	<u>Mean Age</u>
Urban Women	25%	34%	19%	11%	7%	2%	2%	29.43
Rural Women	23%	21%	11%	14%	10%	12%	8%	33.75
Urban Men	20%	21%	38%	7%	6%	5%	4%	31.14
Rural Men	25%	20%	17%	12%	9%	8%	10%	33.8

(B) YOUTHS

	<u>14</u>	<u>15</u>	<u>16</u>	<u>17</u>	<u>18</u>	<u>Mean Age</u>
Urban Youths	5%	11%	19%	21%	44%	16.9
Rural Youths	14%	13%	18%	15%	41%	16.6

TABLE III - EDUCATIONAL STATUS OF THE RESPONDENTS

<u>GROUP</u>	<u>NO FORMAL EDUCATION</u>	<u>LOWER PRIMARY STD 1-4</u>	<u>HIGHER PRIMARY STD 5-7</u>	<u>SECONDARY FORMS 1-3</u>	<u>SECONDARY FORMS 4-5</u>	<u>POST SECONDARY</u>
Urban Women	19%	11%	25%	15%	17%	13%
Rural Women	20%	23%	39%	14%	3%	1%
Urban Males	28%	8%	24%	14%	13%	12%
Rural Males	46%	11%	18%	14%	9%	2%
Urban Youths	10%	6%	26%	28%	31%	0
Rural Youths	8%	5%	62%	24%	2%	0

3.4 Marital Status

Table IV represents the marital status of the adult respondents - all the youths were single. The category 'married' refers to those who are married by either customary or western law; 'married before' refers to widows, divorces and separations; 'living with a partner' refers to those who are unmarried but who have set up a home together; and 'single' refers to those who do not fall into any of the previous categories and includes those who are engaged to be married if they have not yet set up a home together.

TABLE IV - MARITAL STATUS

<u>SAMPLE</u>	<u>MARRIED</u>	<u>LIVING WITH PARTNER</u>	<u>MARRIED BEFORE</u>	<u>SINGLE</u>
Rural Women	37%	5%	4%	52%
Urban Women	39%	4%	7%	53%
Rural Males	32%	21%	4%	44%
Urban Males	49%	28%	1%	24%

It is interesting to note that over one-half of the female respondents are single. There has been some concern in Botswana over what would appear to be a decline in marriage and an increase in female-headed households. This report looks at this phenomenon in section 12 where it points out that 84% of single women over 19 years old have children but only one third have established independent households of their own.

The low divorce rate that was recorded in the survey brought up the question of whether women in this situation refer to themselves as either married or single. This was followed up in Bokaa where it was found that during the past ten years the Court Clerk had not recorded a single divorce. She explained that many couples instead of getting married in the traditional manner with the passing of 'bogadi' (bridewealth) from the male's family to the parents of the bride, simply get engaged through a ceremony called 'pelo'. As a

result there is no need for divorce should the couple decide to separate. These couples, however, refer to themselves as married and not as engaged.

### 3.5 Economic Status

The survey attempted to establish the economic status of the respondent by identifying a profile on household employment together with access to - and control of - the different economic resources. Whilst this proved a tricky exercise, it was possible to establish five levels of relative wealth in the rural and urban areas. Difficulty, however, arose in equating these levels in the urban and rural areas. The analysis used was problematic and since time does not permit further work on this, it has been decided to omit this variable from the present report. It is recommended, however, that if there is a second phase to the project this should be further investigated.

### 3.6 Religion

Religion was thought to affect the KAP of respondents who were classified into four categories:

- Positive religions : i.e. Anglicans, Congregational, Methodist and other protestant.
- Negative religions : i.e. Roman Catholic, Zionist, Mazazuru, other African Apostolic, Seventh Day Adventist and Jehova's Witness.
- Dutch Reform : was separated because this church and its missionary hospitals frown on unmarried women practicing contraception. They maintain that "family planning" cannot occur outside of marriage.
- No religion :

Contrary to expectation this survey found no correlation between religion and KAP.

4. IDEAL FAMILY SIZE

4.1 No Children or Many Children?

Professor Schapera wrote:

"The Kgatla would readily agree with the Anglican Prayer Book that marriage is 'ordained for the procreation of children.' To them it is inconceivable that a married couple should for economic or personal reasons deliberately seek to restrict the number of its offspring, or even refrain from having any at all. They insist rather that a wife should bear her husband as many children as she can, provided only that she does not become pregnant until she has weaned the child already at her breast. A woman with a large family is honoured ... while a childless wife is an object of pity, often tempered with scorn."

(Schapera : 1940, p.213)

This study tried to ascertain exactly how many children today's rural and urban women want and the number that their partners expect them to bear. This was done by asking respondents to state the number of children they already have and the number which they would still like to have. They were also asked several attitudinal questions, e.g. :

'Do you think that a couple should have as many children as possible? Explain.'

'A woman who has no children is not really a woman. She should be pitied.

Agree                      Disagree                      Comments ... '

'A woman who has just one or two children should also be pitied.

Agree                      Disagree                      Comments ... '

The results show that about a quarter of the respondents would like to have the maximum number of children possible. (Males - 23%, Females - 25%). The strongest motivation for this are religious reasons and the desire for economic support in old age. Although many of these respondents gave "God's will" as their reason for wanting as many children as possible, religion is not as powerful

as was anticipated at the start of this research. Those who gave this type of response were equally distributed between religions that hold a positive view of FP and those that are negative towards it.

About two-thirds of the respondents said that they would feel pity for a woman who had no children - an opinion which was slightly stronger in the rural area than in Gaborone. Those who disagreed with this statement explained that 'it was not her fault' or that it was 'the will of God'. This condoling attitude changes when the woman has one or two children. She is neither pitied nor looked down upon as in Schapera's time. It is generally accepted that she may have chosen to limit her family size for economic or personal reasons. Those 26% who said that they would feel sorry for such a person explained that this was because she might lose her children. The remainder who disagreed with the question explained that she at least had someone to help her with domestic chores and who would care for her in old age. Furthermore, she had experienced motherhood.

These questions indicate that although women with no children are pitied there is no longer the same social pressure to have large families as there was in the past.

TABLE V - ATTITUDE TOWARDS WOMEN WITH NO CHILDREN, FEW CHILDREN AND THE MAXIMUM NUMBER POSSIBLE

<u>SAMPLE</u>	<u>WOMAN WITH NO CHILDREN PITIED</u>	<u>WOMAN WITH 1-2 CHILDREN PITIED</u>	<u>PEOPLE SHOULD HAVE MAXIMUM No OF CHILDREN</u>
Rural Women	74%	29%	33%
Urban Women	60%	28%	17%
Rural Males	69%	23%	26%
Urban Males	64%	22%	20%

#### 4.2 Analysing the Ideal

Although three-quarters of the respondents are in favour of limiting their family size since they do not want to have the maximum number of children possible, the ideal family size would appear to be between 4-6 children with an equal number of each sex.

Measuring an ideal such as family size is difficult since religious and social values may inhibit respondents with large families from indicating that they may perhaps have preferred to have had fewer children than they already have. The survey therefore tried to avoid causing possible offence by asking respondents the number of children they have by sex and how many more they would like to have. Consequently there is no record of those who would have liked to have had smaller families.

#### 4.3 Ideal Family Size according to the Sex of Respondent

This survey shows that women would ideally like to have 5.8 children and men would prefer 4.8. The average number which the female sample has at present is 3.3 and they would like an additional 2.5. 1% of women have more than six children and 27% said that they would like more than this number. One percent indicated that they do not want any children at all.

As mentioned, men would ideally like to have 4.8 children. It is interesting to note that one-half of this group said that they have no children with the result that the average existing family size is small with 1.9 children. Unlike the female respondents 21% of males said that they do not want any children at all. These are, however, young men whose mean age is 24.6 years.

#### 4.4 Ideal Family Size by the Age of Respondent

There would appear to be a strong correlation between age and ideal family size with the younger respondents preferring smaller families. The female youths that were interviewed would like to have 4 children with two of each sex whilst the younger males would only like to have 1.6 children, (almost) one of each sex.

TABLE VI - IDEAL FAMILY SIZE BY SEX & AGE OF RESPONDENTS

	<u>14-18</u>	<u>19-24</u>	<u>25-29</u>	<u>30-34</u>	<u>35-39</u>	<u>40-44</u>	<u>45 +</u>
Females	4	4.2	5.3	5.8	6.3	6.7	6.5
Males	-	1.6	3.1	4.4	7.8	8.4	7.2

The large difference in ideal family size between young men and women between 19-24 is worth noting. This is probably due to the fact that in this society, as in most, women are brought up to see themselves as mothers whereas fatherhood is a less important part in the socialization of young men. Brown found in her survey of secondary school students in Mochudi that 75% of the girls saw themselves as "mothers" whereas only 43% of boys saw themselves as "fathers". (1980 : p.26)

In this survey two-thirds of the young men between 19-24 years old said that they do not want any children. Although it is unlikely that they will continue to hold this view throughout their lives it is important for the MOH to note that at this age they do not want fatherhood. This has strong implications for the family planning delivery system.

#### 4.5 Ideal Family Size by Education

Prior to the survey it was hypothesized that with increase in formal education the ideal family size would decrease. Table VII confirms this and shows that those with no education would like 5.6 children whilst those who have eleven years of education (Form IV) or more would prefer 3.8 children.

TABLE VII - EDUCATION AND IDEAL FAMILY SIZE

	<u>NO FORMAL EDUCATION</u>	<u>LOWER PRIMARY STD 1-4</u>	<u>HIGHER PRIMARY STD 5-7</u>	<u>SECONDARY FORMS 1-3</u>	<u>FORM 4-5</u>	<u>POST SECONDARY</u>
Females	5.7	6.2	5.7	4.9	3.7	4.7
Males	5.5	5.4	4.7	3.5	3.1	4.1
MEAN	5.6	5.8	5.2	4.2	3.4	4.4

4.6 Ideal Family Size by Rural and Urban Area

It was expected that rural couples would want larger families than urban couples since it was believed that children still play an important role in farming whereas generally they do not contribute to the urban household economy until they are much older. It was therefore somewhat surprising to learn that there is not a great difference between the two areas in ideal number of children. Urban women would like 4.7 children whilst rural women would like one more child. There is virtually no difference between urban and rural men.

TABLE VIII - COMPARISON OF IDEAL FAMILY SIZE ACCORDING TO RESIDENTIAL AREA

<u>AREA</u>	<u>FEMALES</u>	<u>MALES</u>	<u>MEAN</u>
Broadhurst	4.2	4.7	4.5
Old Naledi	5.3	5.0	5.2
MEAN URBAN	4.7	4.9	4.8
Mochudi	5.9	4.6	5.3
Bokaa	5.4	5.0	5.2
Modipane	6.3	4.4	5.4
MEAN RURAL	5.9	4.7	5.3
MEAN TOTAL	5.3	4.8	5.1

Table VIII shows that the ideal in old Naledi is similar to that in the Kgatleng villages. This may be a result of similar education, economic status or because many of the residents in this area have recently migrated from the rural areas and therefore probably still hold rural values.

4.7 Ideal Family Size by Marital Status

Marital status would appear to affect the ideal family size with single women wanting 4.8 children and married women wanting 6.3.

The sample of unmarried women living with their partners is small (11 cases). This group, however, resembled single women without partners in that their ideal would be to have 4.2 children.

#### 4.8 Discussion of Some Factors Determining Ideal Family Size

The concept of 'large family' or 'many children' was not actually defined in the survey. Interviews in the rural area, however, indicate that a dozen or more children is considered a large family and this is desirable only if they can be supported. Five to six children is considered a 'healthy medium sized family' whilst in the urban area this would be four children.

Several socio-economic factors would appear to influence ideal family size. It was seen in the above discussion that the sex of the respondent influences ideal family size. Although men have the reputation for wanting large families to prove themselves to be 'a man amongst men', this seems to be unfounded and as can be seen in the preceding tables where other variables are held constant (e.g. education and residential area) men consistently want fewer children than women. This survey found that it is only amongst older men that the inverse is true.

As mentioned earlier, it was thought that rural Batswana would choose to have large families in order to ensure sufficient household labour for the various economic activities. It is dangerous to generalise on the basis of this survey in Kgatleng to the remoter parts of rural Botswana. Nevertheless this survey would indicate that this is true in a limited sense with the ideal being slightly larger in the rural area than Gaborone. Amongst wealthy rural households there is a tendency to educate the children and to employ labourers to carry out the various farming activities. It is amongst the rural middle class and poorer households that domestic labour is important since they cannot afford to pay wages. For the poorest families this factor becomes less important since they generally do not have the resources to carry out independent farming activities.

According to traditional ethics, it is believed that children should provide economic support to their parents during their old age.

Whilst the breakdown of gerantocracy has affected this custom, the belief is particularly strong amongst poorer people who hope that at least one of their children may find a financially rewarding occupation and assist them. If, however, this does not happen, there is still a tendency for wage earning children to give their parents some money at least on occasions.

Against these motivating forces there are negative factors inhibiting the number of children that a family may want. The most important of these is the financial cost of feeding, clothing and educating children today. Several respondents in the rural area said that it was unwise to have many children because with severe drought conditions such as they were experiencing at the time of the survey, it would be impossible to feed them.

It is not so clear from the present survey exactly how these forces operate although it would appear that amongst wealthy urban Batswana the desire is to have a smaller family that can be properly educated whilst the rural wealthy seem to be divided between this view and the desire to have a large family which they would have no problem in feeding. In a few cases, some of the children continue farming whilst others are educated and have careers.

5. CHILD MORTALITY

In the past people believed that there was a likelihood of all or several of their children dying and as a result they tried to guard against becoming childless by having larger families.

Schapera found that

"The average monogamous family will produce 4 children, of whom three will survive to maturity. Roughly three families out of five will lose one or more children, and roughly 14 families out of every hundred will lose three children or more. By the time a wife has grown too old to bear any more, she will on average have produced between five and six children, of whom perhaps 3 or 4 may still be surviving. Roughly two women out of three will have lost one or more children each, and roughly 19 out of every 100 will have lost three children or more."

(1940 : p.221)

TABLE IX - DISTRIBUTION OF DEATHS PER 100 FAMILIES  
1940 AND 1982 COMPARED

	NUMBER OF CHILDREN DEAD						
	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>
<u>1940</u>							
Whole group	42	29	16	9	3	1	1
Old Women	32	28	22	12	5	1	1
<u>1982</u>							
Rural Women	70	17	10	1	3	-	-
Urban Women	82	16	3	-	-	-	-

The data in this survey is difficult to compare with Schapera's since his sample includes women past menopause whom he refers to as 'Old Women' in the above table.

There is, however, a strong indication that the child mortality rate has declined considerably since his research.

In the rural area 30.1% of women experienced one or more of their children dying whereas in the urban area this decreased to 18.3%. If, however, one calculates the percentage of deaths in relation to live births the difference is not as large with a mean of 10.6 per one hundred births.

TABLE X - RURAL-URBAN CHILD MORTALITY RATE

<u>AREA</u>	<u>NUMBER LIVING CHILDREN</u>	<u>NUMBER DEAD</u>	<u>NUMBER OF LIVE BIRTHS</u>	<u>% DEATHS TO LIVE BIRTHS</u>
Rural	599	77	676	11.4%
Urban	218	20	238	8.4%
TOTAL	817	97	914	10.6%

The following Table XI provides the percentage of deaths by the age of the child.<sup>1</sup>

TABLE XI - AGE OF CHILDREN AT DEATH

<u>AGE</u>	<u>RURAL</u>	<u>URBAN</u>	<u>TOTAL</u>
less than one month	16%	20%	17%
1- 2 months	7%	5%	7%
3- 6 months	12%	25%	15%
7-11 months	12%	15%	17%
1- 2 years	30%	25%	29%
3- 5 years	19%	10%	17%
older	4%	-	3%

- 
1. There were 8 cases of respondents who could not remember the age of the child. These were excluded from the calculation.

TABLE XII - CAUSE OF CHILD MORTALITY

	<u>RURAL</u>	<u>URBAN</u>	<u>AVERAGE</u>
1. Gastro intestinal	20%	15%	17.5%
2. Bronchial	15%	15%	15.0%
3. Fever - unstated cause	3%	-	1.5%
4. Contagious disease	9%	-	4.5%
5. Accident	6%	5%	5.5%
6. Measles	6%	35%	20.5%
7. Other	14%	10%	12.0%
8. Unknown	28%	20%	24.0%

Apart from birth Batswana children would appear to go through a major crisis when they reach the age of 1-2 years which is about the time when the child is weaned - whether there is a relationship between this and mortality has not, however, been established in this study. It is interesting to note that in the urban area an earlier similar crisis occurs at 3-6 months which again coincides with the earlier weaning period amongst working women. If, however, one looks at the causes of deaths only 17.5% are accounted for by gastro-intestinal illnesses. Measles may be a more serious problem in the urban area although caution must be taken in generalizing on the basis of this very small sample size, i.e. 20 deaths.

Rural women seem to suffer more than twice as many miscarriages and still births as their their urban counterparts.

TABLE XIII - MISCARRIAGES AND STILL BIRTHS

<u>AREA</u>	<u>MISCARRIAGES</u>	<u>STILL BIRTHS</u>
Rural Women	22.4%	7%
Urban Women	10.8%	2.2%

It is not possible on the basis of this research to explain the cause of this difference. Perhaps it is a result of the heavy manual work carried out by rural women or perhaps they are slower

in seeking medical assistance when a miscarriage is threatening.

Child mortality no longer appears to be a strong motivating factor for having many children and the fact that very few focused on this would seem to support this.

6. CHILD SPACING

Although the GOB does not have an official population policy, the MOH has been able to promote FP by means of emphasising the importance of child spacing for the health of the mother and child. The idea of spacing pregnancies is not new to the Batswana who traditionally spaced their families by means of breastfeeding and abstinence for a period of two years after childbirth. Schapera tells us that a Mokgatla woman

... should not become pregnant until she has weaned the child she is suckling, which seldom happens until it is already able to walk about steadily."  
(1940 : p.221)

The reason for this was to protect the child from becoming sickly as a result of having been weaned too early. Such a child was called 'serathane', a state which was defined in the following manner.

' "It cannot suck the milk of the child in the womb so it will be given lots of porridge, and its stomach will swell, but it will remain very lean, and sometimes it becomes deaf or stupid, or does not grow properly." '  
(1940 : p.222)

In the past infanticide and abortion were sometimes practiced to avoid this situation.

Today with bottle feeding this sort of extreme action is no longer necessary and people in the surveyed areas no longer believe that children will be abnormal as a result of another pregnancy following too closely. However, it would appear that the belief that children should be spaced for maternal and child health has been successfully reinforced in these areas by the health personnel.

In the survey male respondents were asked

'Do you agree with child spacing? Explain why.'

Just over half answered the question, the remainder did not seem to know what was meant by this. The most important reason given for spacing children was to protect the health of the mother and child. 44% of those who answered the question gave this as a reason. The following are some of the responses given.

'The child grows well and the mother gains strength.'

'Child grows and mother rests.'

'Stops diseases such as malnutrition and others.'

22% focused on economic reasons and the work involved in caring for small children.

'It gives time to plan and for the mother to work.'

'Children are expensive to feed, clothe and education.'

'Life is tough.'

'So that the older child can look after the younger one.'

17% focused on the time required by the mother after a baby is born.

'Mother gets exhausted.'

'A woman becomes old faster if she gives frequent births.'

Some of those men who did not answer the question appealed for further information on the subject. As a 32 year-old married man put it

'If I knew I wouldn't be having as many children as now.'

Looking back in his questionnaire it was discovered that his wife is only 22 years old and they already have five children. In their case there does not appear to be any strong factor which would inhibit the practice of FP other than lack of education and knowledge of FP.

Health workers and the health talks given on Radio Botswana are the two most important sources of information. Of those who knew about child spacing 21% in the urban area got this information from a health worker and 24% from the radio. In the rural area the pattern

is similar with 24% learning from health workers and 17% from the radio.

95% of female respondents believe in child spacing by an average period of 3 years.<sup>1</sup> Given this high percentage it is disappointing to learn that only half the rural women have actually tried to space their children although this does increase to two-thirds in the urban area. 21% of rural women started to space their children after their first pregnancy. In the urban area 43% practiced child spacing from the start. 22% of those who had tried this experienced difficulties such as unsympathetic partners, bad side effects caused by contraception, misuse of method resulting in pregnancy, or the method proving unreliable.

It is possible that the relatively low practice of child spacing in the rural area relates to the attitude of their partners since it was found that only 52% of rural men actually approve of this, 3% disapproved and the remaining 45% did not know what was meant by child spacing. In the urban area - where two thirds of the women have tried to space their children - 72% of the men approve and the remainder did not know.

In a preliminary paper<sup>2</sup> it was speculated that those who did not approve of this were probably young, unmarried men. Further investigation shows that age is not as important a factor as education and marital status.

Table XIV gives a breakdown of data on these men according to residential area. Since the sample in each area is small we have included in the table information gained from the total 102 males who did not know of child spacing rather than an average for the 5 areas. This figure represents 40% of the total number of male respondents.

1. Women were not asked to give reasons since it was argued by the nurses that maternal/child health was common knowledge amongst Batswana mothers. During the pre-test of the questionnaires this was confirmed. Should this survey be followed up it may be useful to ask women who have not tried to space children why they had not done so.
2. du Pradal, December 1982, p.6.

TABLE XIV - SUMMARY OF DATA ON MALES WHO DO NOT KNOW ABOUT CHILD SPACING

<u>AREA</u>	<u>No</u>	<u>% OF SAMPLE</u>	<u>MEAN AGE</u>	<u>E D U C A T I O N</u>				<u>M A R I T A L S T A T U S</u>			
				<u>NO FORMAL EDUCATION</u>	<u>PRIMARY EDUCATION</u>	<u>SECONDARY FORM 1 - 3</u>	<u>SECONDARY FORM 4 &amp; 5</u>	<u>SINGLE</u>	<u>LIVING WITH WOMAN</u>	<u>MARRIED</u>	<u>SEP</u>
<u>URBAN</u>											
Broadhurst	11	21.6%	26.2	18%	27%	9%	45%	27%	46%	27%	-
Old Naledi	20	38.5%	29.2	70%	30%	-	-	35%	50%	15%	-
TOTAL URBAN	31	30%	27.2	52%	29%	3%	16%	32%	48%	19%	-
<u>RURAL</u>											
Mochuda	31	66%	28.9	59%	24%	14%	4%	68%	21%	11%	-
Bokaa	17	33%	34.9	77%	18%	6%	-	50%	25%	25%	-
Modipane	23	48%	35.6	74%	22%	-	4%	32%	36%	27%	5%
TOTAL RURAL	71	48%	33.1	68%	22%	7%	3%	52%	27%	20%	2%
TOTAL SAMPLE	102	41%	31.2	63%	24%	6%	7%	45%	34%	20%	1%

The mean age of this group was 31.2 years and ranged from 19-68 years. Lack of formal education would appear to influence awareness of child spacing in that 63% of these men had never been to school, 24% had up to seven years education, 6% had between 8-10 years and 7% had higher education. In contrast with this only 21% of those who approve of child spacing have no formal education.

In addition to education marital status would appear to be important. Of the total number of married men in this survey (89) 79% know and approve of child spacing whilst 21% do not know of it. It is possible that this information is passed on to married men by their wives or perhaps they simply pay more attention when the subject is discussed on the radio since it is more relevant to them than to single men. It is interesting to note that unmarried men who are living with their partner are the worst informed on the subject. On the other hand this group is the best informed when it comes to knowledge of contraception and it will later be seen that 60% approve of their partners using contraception.

Almost two-thirds of the youths believe in child spacing although only 43% could give a reason. As with men, the health of the mother and child are seen as important, followed by financial reasons and the time required by the mother after the birth of a child. The strongest disapproval of child spacing was, however, expressed by youths, but many did not give reasons for this.

TABLE XV - ATTITUDE TO CHILD SPACING

<u>ATTITUDE TO CHILD SPACING</u>	<u>WOMEN</u>		<u>MEN</u>		<u>YOUTHS</u>	
	<u>URBAN</u>	<u>RURAL</u>	<u>URBAN</u>	<u>RURAL</u>	<u>URBAN</u>	<u>RURAL</u>
APPROVE	94%	95%	72%	52%	65%	57%
DISAPPROVE	6%	5%	0	3%	30%	31%
DON'T KNOW	0	0	28%	45%	5%	12%

TABLE XVI - THE DESIRED PERIOD BETWEEN CHILDREN

<u>SAMPLE</u>	<u>NUMBER OF YEARS</u>					<u>6 &amp; MORE</u>
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	
Urban Women	2%	31%	35%	21%	10%	-
Rural Women	1%	21%	35%	23%	19%	1%
Urban Males	3%	47%	41%	6%	3%	-
Rural Males	7%	43%	33%	10%	6%	1%
Urban Youths	2%	38%	36%	11%	13%	1%
Rural Youths	-	23%	41%	13%	18%	5%
Schapera	6%	32%	29%	11%	2%	2%

The final row in this table includes the actual child spacing during Schapera's research.<sup>1</sup> It appears that ideally today Bakgatla women would like to have their children spaced by a larger gap than was practiced at Schapera's time.

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1. This survey collected the year of birth of each child born alive. Unfortunately this was not calculated during the computer analysis, so we are unable to compare the ideal with actual spacing.

7. CUSTOMARY METHODS OF AVOIDING PREGNANCY

Family planning was traditionally practiced by means of several methods - abstinence, coitus interruptus and in extreme cases abortion or infanticide. The latter methods will not be discussed in this report since they were not investigated in the survey.

As mentioned earlier, it was expected that children should be spaced by at least two years or until the last born child was weaned. This was achieved by means of the couple practicing abstinence for a certain period of time which could vary from a few weeks to two years depending on the tribe.<sup>1</sup> Where abstinence was practiced over a long time it was made easier - for wealthy men at least - by polygamy. Less fortunate men were expected to spend this period at the cattle-post where some women grumbled that they kept their concubines. After the prescribed period of abstinence the couple were ritually purified by a traditional doctor before being allowed "to share blankets", i.e. have sexual intercourse. It was believed, however, that the woman could not become pregnant whilst breastfeeding or at least until after she had started regular menstruation.

"The Kgatla hold that no woman can conceive unless she menstruates regularly. Her blood, they say, is needed to form the child. It accumulates steadily in the womb to form a large clot, which, unless she is pregnant must break every month and flow out, but which once she has conceived is absorbed into the body of the foetus."  
(Schapera 1940 : p.216)

Once the period of post-natal amenorrhoea had ceased pregnancy was avoided primarily through the practice of coitus interruptus or what was referred to locally as "spilling the blood outside". If, however, the male was unco-operative women would sometimes urinate or try to wash the semen out. Others would use herbs especially those of the 'phukutsa' shrub.

This survey tried to find out the extent to which these methods are still used today but instead of specifying the different methods

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1. Schapera states that the Bakgatla abstained for only 2-3 months (1940 : p.199)

they were referred to collectively as "Setswana methods of contraception". This is unfortunate as a very small percentage answered the question and it is thought that a far larger number of women have at some stage relied on breastfeeding, abstinence and coitus interruptus than was recorded. In fact their response to the question - "Do you think that coitus interruptus is a good form of FP?" - indicates that over 80% are aware of this method whereas in this section only 2% referred to it. Today less than a third of women consider coitus interruptus as reliable. Those who dislike it said that they believe that the restraining "damages the male psychologically" or "could kill the male". One respondent almost collapsed laughing when asked to explain why she disliked it. The answer she gave was practical - "it dirties the sheets!"

Nevertheless the attitude of those 30% of women and 20% of men who consider it to be a reliable form of contraception should not be discouraged since this method is acceptable to most religions which are anti-modern contraception. There are, however, a number of Zionist churches who disapprove of "spilling seed on the soil".

Fako, in his evaluation of the role of Independent African Churches in Botswana, found that such churches maintain that there should be no attempt to prevent pregnancy.

"The only generally acceptable method of birth control is abstinence (sic). This, however, has not proved to be a very successful method as the inclination for sex seems much greater than any wish against it." (Fako 1980 : p.73)

This survey shows that herbal medicines are still being used to avoid conception in both urban and rural areas. Some herbs are used externally, e.g. 'bo-humelela' herbs are tied around the woman's waist and only removed when wanting a child. Other herbs are taken internally. The 'mogonono' root, for example, is ground, boiled and drunk whilst hot. The daughter of a traditional doctor in Bokaa told us that she drank a herbal tea each morning in order to prevent pregnancy. She could not - or perhaps would not - remember the names of the herbs.

Most women (81%) no longer believe that breastfeeding protects the woman against pregnancy although only 57% of men and half the youths are aware of this.

Given that the Batswana traditionally practiced family planning it is puzzling that politically the subject has become sensitive and one wonders whether personal values have not become confused with customary beliefs.

8. MODERN CONTRACEPTION

The survey tried to measure the level of public awareness of modern contraception by asking

'Do you know of any modern methods of contraception?'

'Please name them.'

In this report only those who could actually name a method were recorded as having knowledge of contraception. The number of people who said that they knew of FP but could not name a method was very small (1.5% of women and no men) so excluding them did not affect the analysis.

Having established the different methods known to the respondents they were then asked which they liked or disliked and to provide reasons for their answers. Finally, women were asked what they were presently using and which methods they had previously tried. The data gathered in this section was used to discuss the attitude of Batswana men and women to the different methods as well as the current practice of FP in these areas.

The survey found the level of awareness of modern contraception to be relatively high although the quality of knowledge is weak with misconceptions concerning side effects being widespread. Despite this, the practice of family planning was found to be almost three times the national figure which is estimated at about 10%.<sup>1</sup> 28% of adult women in the surveyed areas are currently using contraception - 17% in Kgatleng and 37% in Gaborone. There would appear, however, to be a fairly high drop-out rate since it was found that 43% of the respondents had at some stage used FP. If the figures for those who are presently practicing FP are compared with those who have ever done so it seems that 44% of acceptors have discontinued.

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1. Source: Interview with Dr Mashalaba, October 1982.

8.1 Knowledge and Practice of Contraception

As was anticipated, awareness of modern contraception is more widespread amongst women than men with 80% of the former group being able to name at least one method whilst only 57% of males could do this. This relatively low level of awareness amongst both urban and rural males was expected because public education on the subject has concentrated primarily on women during their visits to the clinic. This lack of knowledge coupled with widespread misconceptions concerning the effects of contraception probably accounts for the negative view which many men have towards contraception.

Amongst the different methods of contraception used in Botswana the Pill is most popular and the method with which women are most familiar. This is followed by the IUD, Depo Provera and the Condom. Males, however, are more aware of the condom than any other method. (See Table XVII)

TABLE XVII - PERCENTAGE OF RESPONDENTS WHO COULD NAME THE METHODS OF FP

	<u>WOMEN</u>		<u>MEN</u>		<u>YOUTHS</u>	
	<u>URBAN</u>	<u>RURAL</u>	<u>URBAN</u>	<u>RURAL</u>	<u>URBAN</u>	<u>RURAL</u>
Pill	84%	72%	47%	46%	69%	80%
IUD	71%	58%	35%	23%	59%	62%
Diaphragm	28%	12%	-	-	16%	13%
Spermicide	24%	5%	11%	7%	10%	3%
Condom	43%	39%	55%	52%	56%	53%
Depo Provera	57%	46%	23%	18%	37%	47%
Other	3%	3%	9%	4%	3%	1%

The UNFPA evaluation of Botswana's Maternal/Child health and family planning programme recorded 13 300 new acceptors of contraception in 1979<sup>1</sup> of which 89% of the methods given were recorded. The

1. UNFPA, 1982, p.120 source of data from MOH Medical Statistics Unit.

The following table compares the percentage using the different methods for the country as a whole with the figures found in this survey.

TABLE XVIII - USE OF DIFFERENT METHODS OF CONTRACEPTION

	<u>PILL</u>	<u>IUD</u>	<u>CONDOM</u>	<u>INJECTABLE</u>	<u>OTHER</u>
1979 <sup>1</sup>	58%	15%	17%	7%	3%
1982 <sup>2</sup>	62%	25%	6%	5%	2%

1. National Figures

2. Survey

It cannot be said on the basis of this that there has been a general increase in the acceptance of the IUD and decrease in use of the condom since the surveyed areas include Gaborone. The percentages recorded are more likely to be representative of the urban and peri-urban parts of Botswana.

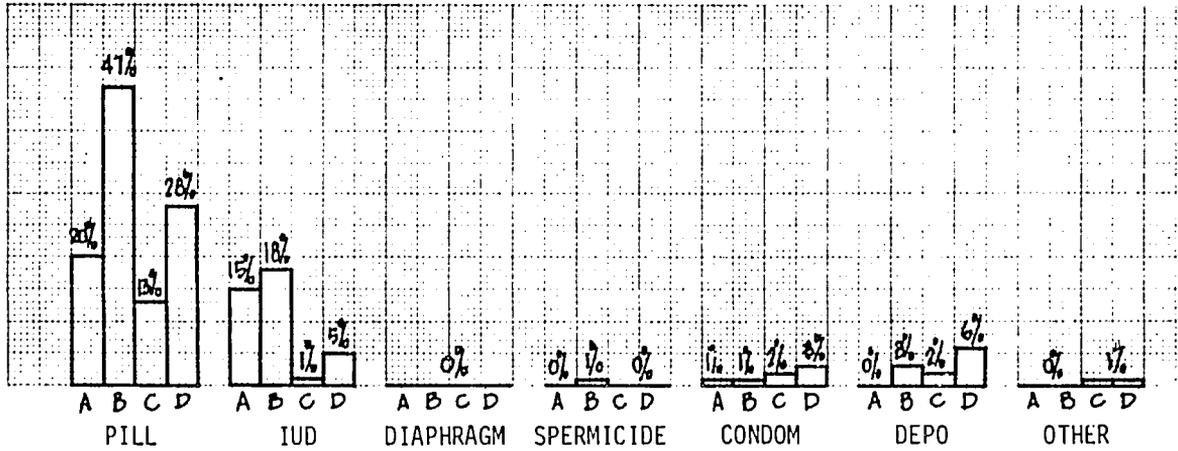
Barchart 1 gives a breakdown of use of different methods of contraception according to rural and urban areas. It presents a comparison of those who are presently using the different methods together with those who have ever used them which helps illustrate the discontinuation rate with the different methods.

## 8.2 Effect of Age on Knowledge and Use of FP

The age of the respondent was found to be significant <sup>1</sup> with the highest level of awareness being amongst men and women between 25-29 years old. Three-quarters of the men in this age group could identify at least one method of FP and 94% of women could do this.

Knowledge amongst males under 24 years and over 34 is, however, weak with less than half (43%) being able to name a method. It should be noted, however, that when asked specifically about the condom 69% of men aged 19-24 said that they had used it which indicates that knowledge of at least this method is fairly widespread.

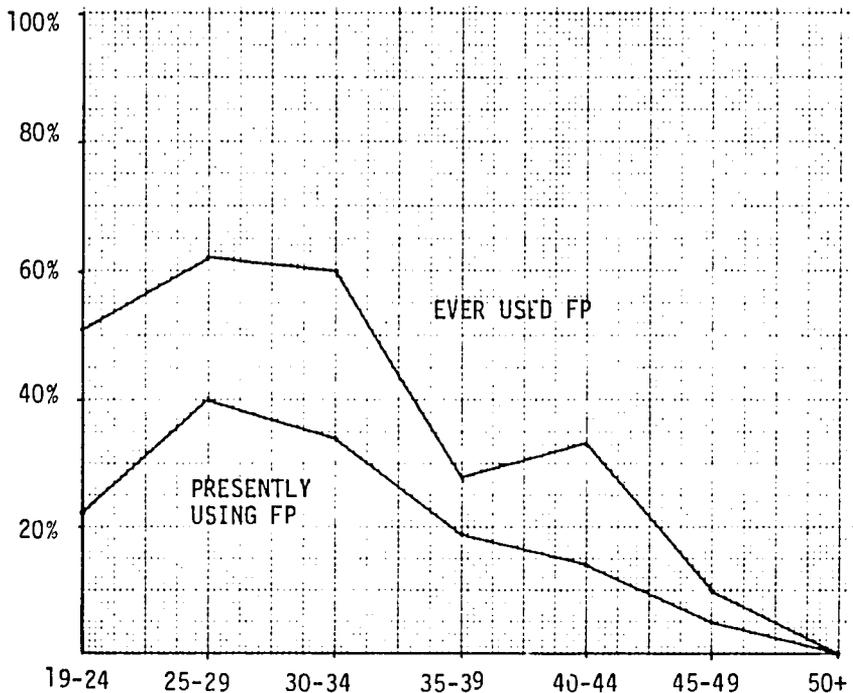
1. Correlation coefficient is -0.36491 for women. For men, however, it is less significant being -0.11697.



A - Urban Women Presently Using      B - Urban Women Ever Used FP  
 C - Rural Women Presently Using      D - Rural women Ever Used FP

BAR CHART 1: COMPARISON OF RURAL & URBAN USE OF FP.

In comparison to males, awareness of contraception is high amongst women between 19-39 years old, 87% of whom could name a method. This decreases to 57% of women aged 40-49 and then drops considerably for women over 50 years old with only 27% being able to name a method.



GRAPH A: FEMALE USE OF CONTRACEPTION BY AGE GROUPS.

Graph A shows that not only are women between 25-29 years the most informed, they are also the most receptive to FP. 40% in this age group are currently using contraception and a further 22% have tried it with the result that almost two-thirds have at some stage used a method of modern contraception.

60% of women aged 30-34 have used contraception but only 34% are presently practicing. Similarly, whilst just over half (51%) the women of 19-24 years old have used FP less than quarter (22%) are presently practicing.

The low contraceptive rate amongst women over 35 is worrying considering the increased danger caused by pregnancy at this age. Only 15% of women aged 35-49 are currently practicing modern contraception and only 23% have ever used it.



GRAPH B: MALE USE OF CONDOM BY AGE GROUPS.

There is also a strong correlation between age and the use of the condom as can be seen in Graph B. 69% of young men aged 19-24 have used the condom and 71% of men aged 25-29. This then decreases from 61% of men between 30-34 to 25% of men 50 years or older. It was somewhat surprising to learn that men over 30 are not more experienced with the condom as the MOH tried to promote its use in order to prevent the spread of VD by issuing free samples at all clinics about ten years ago.

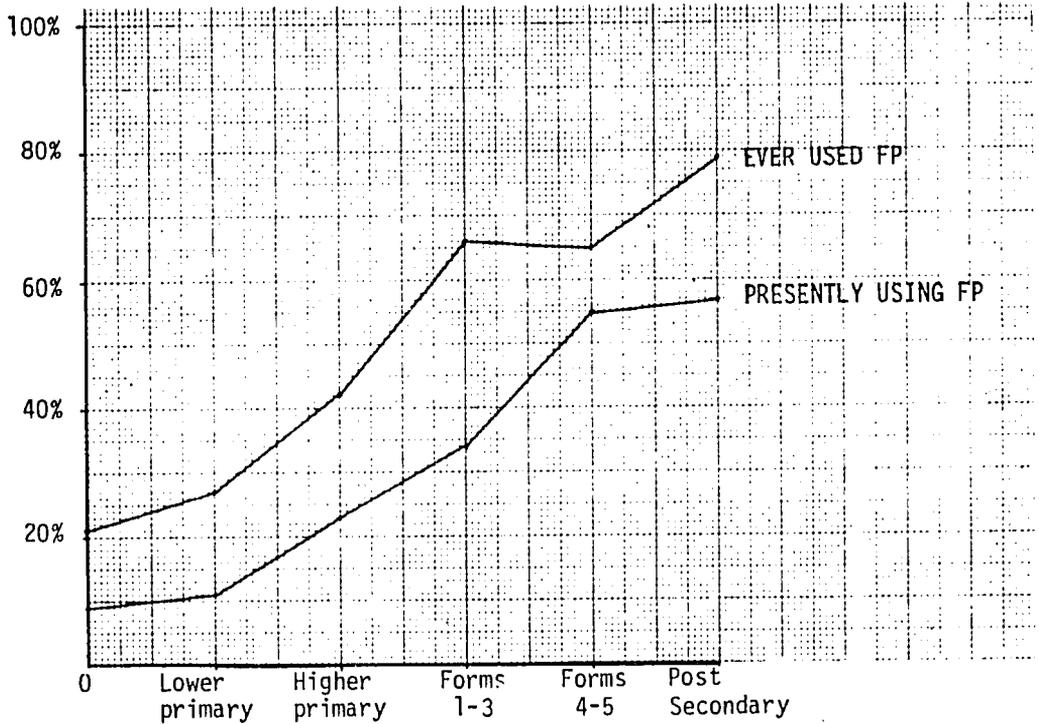
### 8.3 Effect of Education on Knowledge and Use of FP

Although education was found to be correlated with knowledge of contraception this was not quite as pronounced amongst women as was anticipated since over two-thirds of those without any formal education could identify a method of FP. This relatively high percentage increases to 96% of women with more than primary education, i.e. more than seven years of school.<sup>1</sup>

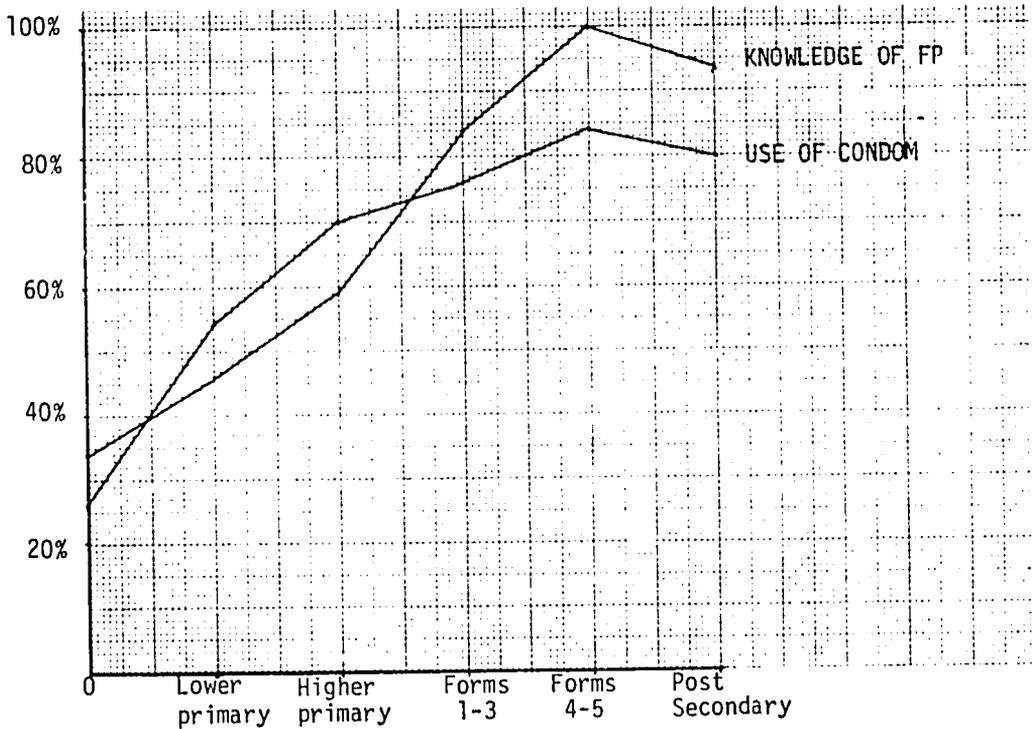
Level of education is of greater significance when it comes to the use of contraception as can be seen in Graph C. Whilst only 9% of women without education are presently using FP this increases to 54% of women who have more than 8 years of education. It is interesting to note that education does not appear to affect the drop-out rate in that the difference between those who have ever used contraception and those who are presently practicing remains relatively constant.<sup>2</sup>

Education would appear to be of greater significance amongst men than women for knowledge of contraception. The percentage of males who could name a method increased from 34% of those without any formal education to 92% of those with more than five years of education.<sup>3</sup>

- 
1. Correlation coefficient is 0.22596
  2. The correlation coefficient between those who are presently using any method of contraception is 0.34591 and 0.35303 for those who have ever used any method of contraception.
  3. Correlation coefficient is 0.48058



GRAPH C: FEMALE USE OF CONTRACEPTION BY EDUCATION.

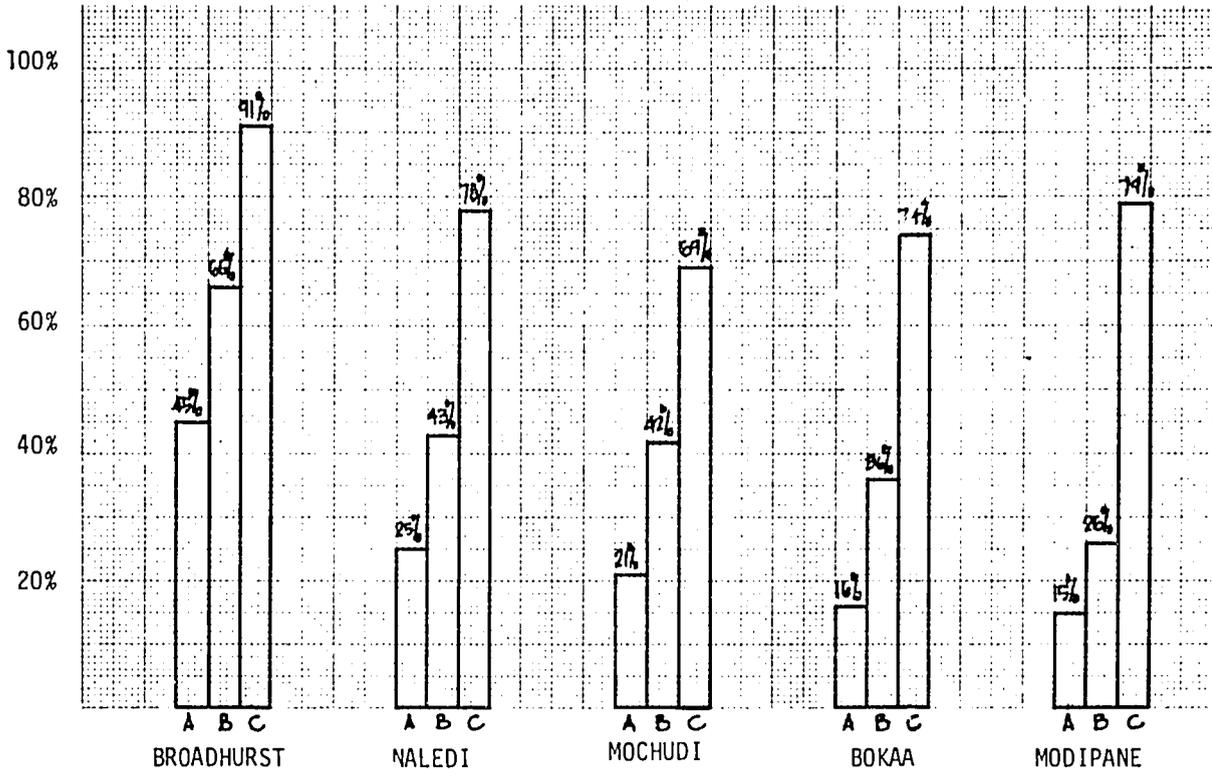


GRAPH D: MALE USE OF CONDOM & KNOWLEDGE OF FP BY EDUCATION.

As with age, education of males is also correlated<sup>1</sup> with the use of the condom. Graph D shows that with education the percentage of respondents who have used the condom increases steadily from 26% of those who have never been to school to 83% of those with more than 10 years education.

8.4 Effect of Residential Area on Knowledge and Use of FP

Barchart 2 compares awareness and use of FP in the five residential areas that were surveyed. It was hypothesized that both would be greater in the urban area than the rural area. It was also hypothesized that they would be influenced in Kgatleng by the type of health facility in the village.



A - Presently Using FP      B - Ever Used FP      C - Awareness of FP

BARCHART 2: COMPARISON OF KNOWLEDGE & USE OF FP AMONGST WOMEN

1. Correlation coefficient is 0.31319

As will be seen this survey cannot confirm these hypotheses conclusively although the data does suggest that they may be correct. As far as knowledge of contraception is concerned there is no difference between urban and rural males 57% of whom could name a method. Amongst women this knowledge is slightly higher in the urban area with 85% being aware of contraception compared with 74% in the rural area.

This difference is greater when one looks at the practice of FP. 56% of urban women have used contraception whereas only 35% of the rural women have done so. But this is less significant for the use of the condom since 60% of urban males have used it and only 5% less in the rural areas.

In fact, knowledge and use of contraception is very similar when Old Naledi and the Kgatleng villages (especially Mochudi) are compared. This may be a result of recent urbanisation of Naledi residents or similar standards of education. The difference is greater when Broadhurst is compared with the other areas and this would seem to confirm the importance of education since this group is more highly educated than any of the others.<sup>1</sup>

The second hypothesis was that the type of health facility and number of staff would affect both knowledge and practice of FP in the rural areas. This survey was unable to confirm this and although the data suggests that it may be correct it is recommended that this be further investigated.

The highest percentage of women in Kgatleng ever having used contraception occurred in Mochudi where 42% have used it and 21% are currently practicing FP. Mochudi is also the centre for the Regional Health Service and has both a hospital and clinic which provide FP services.

Not only has this village got a larger health team, the Paramount Chief who resides there and who is married to a nurse has personally

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1. FP services are easily available to residents in both urban and rural areas.

shown concern over the number of unwanted pregnancies in the district. According to his wife it was customary for poor families to come to his lolwapa and beg assistance to pay for their children's school fees. Traditionally the chief used part of the tribute paid to him by the tribe to assist such people. The Paramount Chief continued to help such people out of his own pocket long after the collection of tribute was abolished. However, about ten years ago Chief Linchwe II told villagers that it was within their power to control their family size through contraception and they should therefore no longer come to him for such help.

In Bokaa, 36% of the women have used FP and 16% are presently practicing. This village has a clinic with a maternity ward and a team of FWE's. It was therefore expected that both the level of knowledge and practice of FP would be greater here than in Modipane where there is only a health post with one FWE. It was consequently surprising to learn that the level of awareness was higher in Modipane and that there is little difference in the present use of contraception.

A factor which may help explain this and which was not investigated in this survey is the attitude of the clinic staff to FP. Keepile and Seloilwe<sup>1</sup> who interviewed the health personnel in Bokaa, found that contraception was treated with caution.

"(They) ... argue that since the introduction of the pill as a method of contraception, the incidence of hypertension has increased tremendously among Batswana. They feel that if they had the powers, they would not recommend the pill as a method of contraception. The staff preferred the loop ... "

Concern over the side effects of FP and a strong religious bias on the part of a high ranking member of staff resulted in "safe dates" being recommended where possible.

Such attitudes may help explain why this village with its highly efficient team of FWE's have not had a greater impact than the single FWE in Modipane.

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1. See du Pradal, July 1982, pp.22-25.

In addition to this, it was also noted that male opposition to their partners practicing FP was strongest in this village with 34% being against this. See Table XXI.

It would appear that the health service alone is insufficient to explain the practice of FP and other factors such as the attitude of health personnel and men must be brought into consideration.

8.5 Effect of Marital Status on Knowledge and Use of FP

There was no clear correlation between the marital status and their knowledge or use of contraception.

TABLE XIX - KNOWLEDGE AND USE OF FP ACCORDING TO MARITAL STATUS

	<u>SINGLE</u>	<u>MARRIED</u>	<u>LIVING WITH PARTNER</u>
Women who could name FP	80%	76%	75%
Women who used FP	59%	64%	25%
Women who are using FP	26%	36%	8%
Men who could name FP	49%	56%	66%

Whilst single women are slightly better informed on FP than married women they are a little less experienced in the use of FP. Amongst the male respondents those who are single are least informed and those who are most informed are living with a partner.

9. MISCONCEPTIONS AND CONFUSION CONCERNING CONTRACEPTION

The attitude of Batswana men and women to contraception is greatly affected by a number of misconceptions that would appear to be fairly widespread in the surveyed areas. The following discussion is based on three sources of information;

1. The survey asked a series of specific questions directed to some of these misconceptions in which respondents were asked whether they agreed or disagreed with different statements and to give reasons for their answers.
2. Respondents were asked whether they liked or disliked the different methods of contraception which they knew and to give reasons for their opinion. This section provided valuable insight into many misconceptions which were previously unknown to the team or researchers and were therefore not included in the survey.
3. Workshops, kgotla meetings and indepth interviews provided the opportunity to follow-up a number of "new" misconceptions which came out of the above.

Since most of the respondents gave only one reason for their opinion it is difficult on the basis of this survey to say how widespread some of these ideas are but discussions during the workshops would seem to indicate that they are in fact common in the surveyed areas at least. As a result of the informal way in which this information was collected it is not possible to correlate these misconceptions with age, education, religion or any other variable. This will have to be done in another survey.

The following presents some of the main misconceptions that inhibit Batswana from practicing family planning through the use of modern contraception.

9.1 The Pill

Discussions indicate that it is widely believed that the pill accumulates in the womb and that women who become pregnant after having been on the pill, produce abnormally large babies.

Men are seriously concerned about the pill causing bad side effects such as high blood pressure or cancer in themselves and strongly object to their partners using the pill. This peculiar idea stems from the belief that during sexual intercourse the blood of the male and female mix together. Consequently if women can suffer these side effects then so can their partner. One male expressed this concern by asking whether "it isn't better to use both the condom and the pill since the pill has side effects?"

There is also a belief that the pill inhibits the male's "sexual strength" and that it causes infertility in the female. Some men claimed that it causes venereal diseases and for this reason will not allow their partners to use it.

There is a great deal of confusion over the 28 and 21 day packets of pills. Why does the former have extra pills and why are they a different colour? How does the pill actually work? "If it kills the sperm, why doesn't the male take it?" "Is it legal to kill babies by taking the pill?" "What happens if there are 31 days in the month?" (Question confuses menstrual cycle with calendar month)

These misconceptions and the confusion discussed above are probably the main obstacle to acceptance of this method of contraception.

## 9.2 The IUD

Not only are women afraid of the pain and discomfort which may be caused by the IUD, they are also worried that it will perforate the womb. While there may be some foundation for such fears, many people believe that the IUD travels into the woman's body or may be pushed in during sexual intercourse and will eventually lodge itself in her throat. There is enormous fear of the pain and internal damage that will be caused while it is moving inside her body.

As in the case of the pill, some men believe that if their partner has an IUD, it will penetrate their own body, travel inside and cause the same damage as is believed with women.

Amongst uneducated Batswana there is very little knowledge of human physiology which makes it difficult for them to understand that although the IUD is placed in the uterus the male cannot penetrate beyond the cervix. It is therefore understandable that men and women believe that it could pierce the male and that it will interfere with sexual pleasure.

A few men said that it causes discharge and venereal disease. One woman asked whether "... the loop's strings harbour the VD germs?"

During the discussions there were many questions concerning how the IUD actually works, its reliability and the difference between the different types. One question that was asked was "If the 'copper-T' is unsafe for the foetus and a woman who is using it becomes pregnant, can't the doctor help her with an abortion?" This question, of course, brought into question the safety of the copper-T and 7 IUDs.

### 9.3 The Condom

Besides the widespread dislike of the condom because it lessens sexual sensitivity, there is also a fear that it may come off during intercourse and get stuck inside the woman's body. This they believe would result in the woman having to be hospitalized.

It is also believed that frequent use of condoms will weaken the male's "strength" which may result in sexual impotence. A few respondents asked whether the condom could be used more than once, and whether they have an expiry date.

It is interesting to note that although the condom has been promoted in order to prevent VD<sup>1</sup> just under half (49%) the males are aware of this function while an additional 7% know that it prevents a disease but do not know which one. Only a quarter of the female respondents are aware that the condom helps prevent the spread of VD. This is surprising since the questions were virtually rhetorical as it was thought that everyone already knew this.

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1. Incidentally, Batswana men do not like the pink condoms which they associate with menstrual blood. This colour should therefore not be used in trying to promote their use.

Despite their objections to the condom, this is actually the most popular method amongst males who seem to feel less threatened by their partner's possible unfaithfulness and the abovementioned side effects of the pill and IUD.

#### 9.4 The Diaphragm

The diaphragm is virtually unknown in Botswana. Discussions showed that people are interested in how it is fitted and whether it will be felt by the male during sexual intercourse. One policeman asked whether the diaphragm, if used frequently, causes VD in the male.

#### 9.5 Sterilization

Although sterilization is legal in Botswana it can only be done to men and women over the age of 35 and with the written consent of their married partner. This method is not widely known or practiced.<sup>1</sup> Discussions showed that there are some single women under this age with six children who genuinely want no more children and find other methods of contraception unsuitable. These women appealed for exceptions to be made to the above ruling.

There is great concern over what happens once a male or female is sterilized, exactly how irreversible is it? Can the male still perform sexually? Men - particularly those at the police training college - seemed to rule this out of the question.

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1. This survey came across only 3 cases amongst women and no men.

10. SOME OTHER MISCONCEPTIONS INFLUENCING ATTITUDE TO FAMILY PLANNING

10.1 Frequent Births are Necessary to Cleanse the Womb

It is an old Batswana belief that during sexual intercourse semen collects inside the woman's body and remains there until it is eventually cleansed through childbirth. It is also believed that menstrual blood is dirty and that heavy bleeding during birth purifies the woman's body. The survey tried to measure the effect of these beliefs by asking respondents to agree or disagree with the following statement:

"Childbirth cleanses the woman's womb, therefore a woman who does not have many children is unclean."

It would appear that this belief is more widespread in the rural than the urban area and is particularly predominant amongst rural women of whom 53% agreed with the statement, 35% disagreed and 12% were unsure. In general, however, the opinion would appear to be split between those who agree (38%) and those who disagree (40%) with the statement. (See Table XX)

This belief that childbirth cleanses the womb would appear to have fairly strong psychological effects as may be illustrated in the case of a respondent who - despite already having had eight children - was really upset that she had reached menopause. She said that she could feel the dirt inside her and at night she could not sleep because she was so full of it. As she described it, it felt like a large lump inside her stomach.

Some younger respondents said that a woman need not have many children in order to cleanse the womb, instead she could go to hospital and have it scraped clean!

10.2 Modern Contraception causes Infertility

The belief that modern contraception causes infertility in either the male or female was found to be not quite so widespread as was anticipated.

TABLE XX - ATTITUDE TO 4 MISCONCEPTIONS

	<u>CHILDBIRTH CLEANSES WOMB</u>			<u>FP CAUSES MALE INFERTILITY</u>			<u>FP CAUSES FEMALE INFERTILITY</u>			<u>WOMEN USING FP ARE PROMISCUOUS</u>		
	<u>Agree</u>	<u>Dis</u>	<u>D/K</u>	<u>Agree</u>	<u>Dis</u>	<u>D/K</u>	<u>Agree</u>	<u>Dis</u>	<u>D/K</u>	<u>Agree</u>	<u>Dis</u>	<u>D/K</u>
Rural Women	53%	35%	12%	23%	58%	18%	38%	53%	9%	22%	71%	6%
Urban Women	36%	58%	5%	17%	65%	17%	36%	54%	10%	19%	75%	6%
Rural Males	45%	27%	28%	34%	51%	15%	52%	33%	15%	45%	42%	13%
Urban Males	39%	40%	22%	36%	52%	11%	53%	34%	12%	42%	52%	6%
Rural Youths	30%	33%	37%	17%	47%	36%	24%	52%	24%	20%	63%	17%
Urban Youths	23%	45%	31%	16%	50%	34%	32%	43%	25%	21%	64%	15%
<b>AVERAGE</b>	<b>38%</b>	<b>40%</b>	<b>23%</b>	<b>24%</b>	<b>54%</b>	<b>22%</b>	<b>39%</b>	<b>45%</b>	<b>16%</b>	<b>28%</b>	<b>61%</b>	<b>11%</b>

Although just under a quarter of the respondents (24%) believe that it could affect the male in this manner, about a third (35%) of males believe this to be the case. Over half the respondents (54%) disagreed with this and 22% were unsure.

It is believed by some people that contraception in general causes female infertility. On the other hand there are those who realise that this could result from use of the Depo Provera. Unfortunately the way the question was phrased makes it unclear whether the respondent is thinking of this when they say that 'using modern contraception can damage a woman's ability to have children'.

### 10.3 Women who use FP are Promiscuous

There would appear to be an association in people's minds of contraception and promiscuity. During the pre-test of the questionnaire it was found that even practicing women said that women who use contraception are promiscuous. It was therefore necessary to change the statement to "All women who use FP are promiscuous".

The survey found the male respondents to be fairly divided in their opinion of this with 44% agreeing with the statement and 47% disagreeing. One out of five women apparently agree with this.

11. DISCUSSION OF MALE ATTITUDE TO FP

11.1 Attitude to their Partners Practicing Family Planning

Considering that the level of knowledge amongst males is relatively low, it was interesting to learn that 44% of the total sample would approve of their partners practicing family planning. Strongest support was found in Broadhurst where 63% approval was recorded. This was considerably more than old Naledi which had 42% approval and the three Kgatleng villages with 39% approval. A few men said that they would agree to this provided their partners did not use the pill or the IUD because they were afraid of the side effects. The response of women to a question on their partners' opinion of family planning suggests that there may even be stronger support amongst males in that 56% thought they would be in favour of practicing contraception, 28% did not know and 16% said that they would disapprove.

In contrast with what was anticipated, males were not aggressively opposed to their partners practicing contraception. Only 17% indicated that they would disapprove of this and 4% said that they had actually forbidden their partners from practicing. Amongst the female respondents, however, this figure is slightly higher with 10% saying that their partners had stopped them.

A more significant number of men said that they did not know about family planning and therefore could not express an opinion on the subject. This latter group represented 39% of the total sample with Mochudi males being the least informed on the subject. It is likely that in reality some of these men are not neutral but biased against FP because of their lack of knowledge and that they did not say so because they could not substantiate their answer.

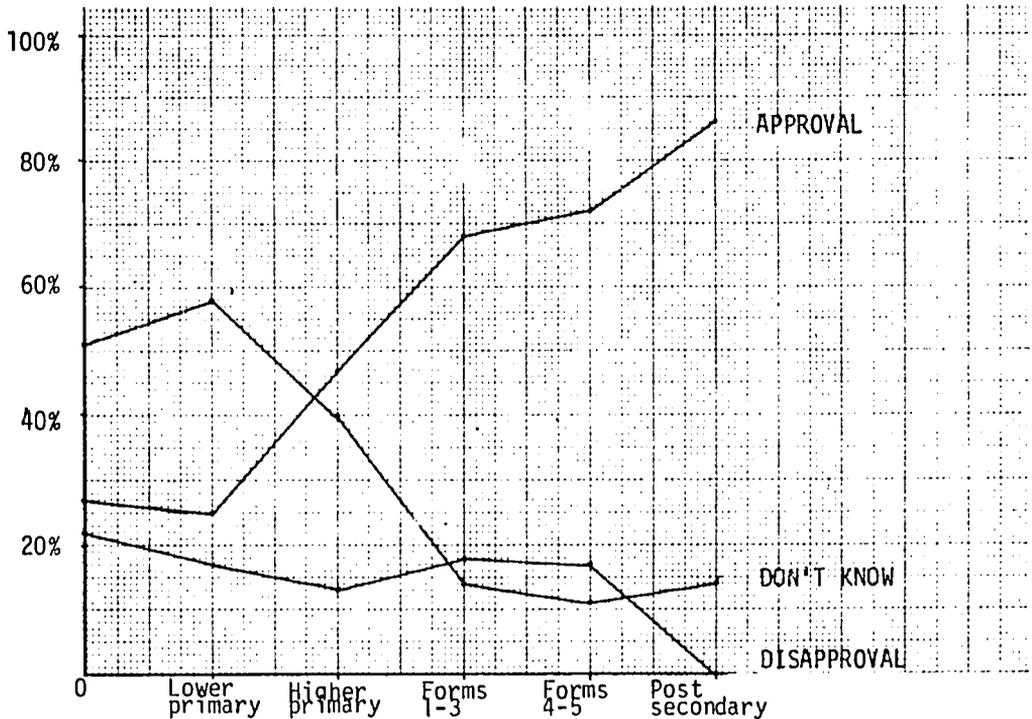
This was expressed early on in the survey when they told the researchers that they were against FP because they knew so little about it and appealed for further information. During the subsequent workshops this became even more apparent.

TABLE XXI - MALE ATTITUDE TO PARTNER USING FP

<u>AREA</u>	<u>APPROVE</u>	<u>DISAPPROVE</u>	<u>DON'T KNOW</u>
Mochudi	34%	12%	51%
Bokaa	40%	34%	26%
Modipane	39%	20%	41%
Broadhurst	63%	6%	31%
Old Naledi	42%	14%	44%
<hr/>			
MEAN	44%	17%	39%

It was surprising to learn that there would appear to be little correlation between age and attitude towards partner practicing FP. It was thought that younger men would be more open-minded on the subject whilst older men were likely to be more conservative and consequently disapproving. The difference in mean age between those who approve (31 yrs) and those who disapprove (37 yrs) is only 6 years while the mean age of those who do not know about FP is 33 years.

Education was, however, found to be strongly correlated with approval of FP. Whilst it would appear to be relatively insignificant for disapproval of the partner practicing FP. Graph E gives a breakdown of responses according to education. It shows that only 27% of all those with no education approve of FP which increases to 72% of those with secondary school education and 86% of those with higher education. Over half of those men with little or no education do not know about FP whilst only 13% of those with 8 years or more schooling gave this response.



GRAPH E: MALE ATTITUDE TO PARTNER USING FP BY LEVEL OF EDUCATION.

The marital status of the male does not appear to be of great significance although Table XXII shows that approval of contraception is somewhat stronger amongst men who have stable relationships, i.e. either married or living with a woman, than single men over half of whom do not know about FP or have not formulated an opinion on the subject.

## 11.2 Male Attitude to the Condom

As mentioned earlier, the survey found the condom to be the most popular method of contraception amongst males. There are probably two reasons for this: the first is that men feel that it is a

method which is in their control and that it does not allow their partners the sexual freedom which they believe will be encouraged by the other methods. Secondly (besides those who believe that the condom can get stuck in the womb) this method is thought to be relatively safe in that it can help protect against VD and does not have the side effects on the male caused by modern contraception.

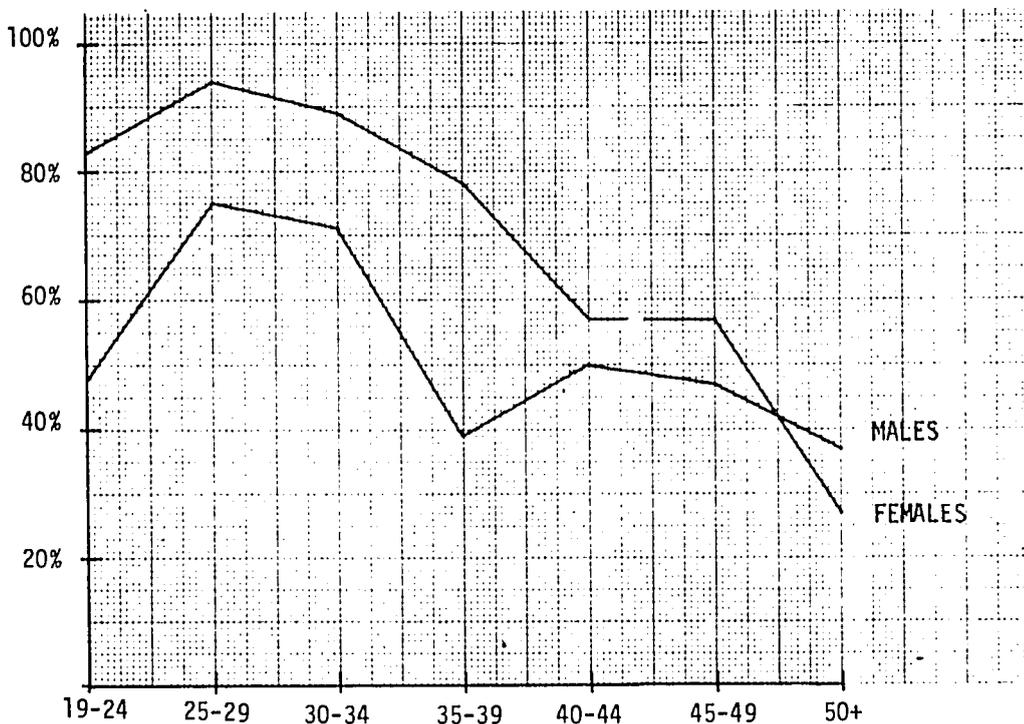
TABLE XXII - ATTITUDE OF MALES TO PARTNER USING FP ACCORDING TO MARITAL STATUS

<u>MARITAL STATUS</u>	<u>SAMPLE</u>	<u>APPROVE</u>	<u>DISAPPROVE</u>	<u>DON'T KNOW</u>
Married	91	44% <sup>1</sup>	22%	34%
		37% <sup>2</sup>	48%	34%
Single	74	34%	15%	51%
		23%	26%	42%
Living	66	58%	12%	30%
		36%	19%	22%
Separated	9	44%	33%	22%
		4%	7%	2%
Total	240	45%	18%	38%
		100%	100%	100%

- 
1. Row percentage
  2. Column percentage

The survey found that 58% of men have ever used a condom - 55% of rural men and 60% of urban men. The age group 19-29 is most experienced with 70% of this group having used it. Experience declines with increase of age.<sup>1</sup> (See Graph F)

- 
1. The correlation coefficient between age and ever used condom is -0.29596.



GRAPH F: COMPARISON OF MALE & FEMALE KNOWLEDGE OF FP BY AGE GROUPS.

Unmarried men - both those that are living with women and those who are single - are somewhat more experienced with the condom than married men in that just under two-thirds (64%) of these men have used it whilst this is the case for under half (49%) of married men.

There is a strong correlation between education and males who have ever used a condom.<sup>1</sup> Only 26% of men without any formal education have used it and experience increases to 83% of men with more than Junior Certificate (10 years education). (See Graph D) This is interesting because it was thought that men without education would be more willing to use the condom whilst those with education would be more inclined to rely on the female practicing contraception.

It is disappointing to learn that despite educational efforts on the part of the MOH just over half (56%) of males are aware that the condom prevents the spreading of sexually transmitted diseases and 49% knew that the disease was VD. Whether this is because men do not believe this, have not heard it, or have simply forgotten is unclear. Discussions suggest that beliefs concerning the transmission of VD are fairly complex and require further research.

### 11.3 Summary

Males are fairly divided in their attitude to their partners practicing family planning with 44% approving of this, 17% are clearly opposed to it and 39% saying that they are unsure. Discussions during the workshop indicated that this latter group are probably biased against contraception because of their lack of knowledge. This survey found that education is the single most important variable to be correlated with this and that age or marital status do not appear to be significant.

The negative attitude would appear to be primarily a result of the prevailing misconceptions and a concern that it might provoke promiscuous behaviour by their partners. With a stronger emphasis on addressing these problems through health education it is possible that a large proportion of those who are unsure will become more confident in FP.

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1. Correlation coefficient 0.4350

12. 'ILLEGITIMACY'

12.1 Unmarried Mothers

"In the olden days an unmarried girl who became pregnant was the object of universal scorn and suffered numerous public humiliations. Her child was often enough killed at birth, or if allowed to live always laboured under pronounced social stigma. Nowadays, with the increasing frequency of premarital pregnancies, the girl is no longer so harshly treated. But she is said to have been 'spoiled' (o senyegile), and she is seldom regarded with approval as a possible wife. An illegitimate child is also no longer killed, and is allowed to take full part in the normal tribal life. But it is often insulted and taunted, and is universally termed 'ngwana wa dikgoro' (a child whose father crept in through 'the fence', i.e. surreptitiously and with no legal right)."

(Shapera, 1970, p.171)

This survey has confirmed that the incidence of unmarried mothers is high in both Kgatleng and the urban areas with 84% of single women over 19 years old having children. Only 10% of single women in the rural areas are childless and less than a quarter (24%) of urban women.

Table XXIII provides a breakdown of the percentage of unmarried women in the different areas without children. The first column represents women who have never been married; i.e. single, single but living with their partner and engaged. The second column represents women without a partner.

These figures are higher than Syson's who calculated on the basis of the 1971 National Census that 75% of all single women over 19 years old are mothers.<sup>1</sup>

It was hypothesized that single parenthood occurred primarily amongst poorer, uneducation women.

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1. Syson, 1972, pp.4-5.

TABLE XXIII - SINGLE MOTHERS ACCORDING TO AREA

<u>AREA</u>	<u>WOMEN WHO HAVE NEVER BEEN MARRIED</u>	<u>SINGLE WOMEN</u>
Broadhurst	31%	33%
Old Naledi	10%	15%
MEAN URBAN	24%	26%
Mochudi	3%	3%
Bokaa	8%	8%
Modipane	20%	24%
MEAN RURAL	10%	10%
TOTAL	16%	18%

Only 18% of unmarried mothers in this survey have no education at all whilst 30% have completed at least 8 years of schooling. Table XXIV compares the educational attainments of single mothers with that of all the female respondents over 19 years old.

This Table shows that education is not correlated with single parenthood as could be expected because of the high rate of unmarried mothers.

Interviews show that it is generally believed that if a woman has not married by the age of 25, it is acceptable for her to start having children. Younger than this, it is believed, would spoil her chances of marriage. The mean age at which youths thought it would be acceptable to sleep with one's boyfriend was 20 although most (80%) disapproved of sex without the intention of marriage.

Sexual activity clearly starts before this age with 44% of 18 year old youths having children.<sup>1</sup>

1. See discussion pp.63-66.

TABLE XXIV - EDUCATION OF SINGLE MOTHER COMPARED WITH OTHER WOMEN

<u>LEVEL OF EDUCATION</u>	<u>SINGLE MOTHERS</u>			<u>SINGLE / NO CHILDREN</u>			<u>OTHER WOMEN</u>			<u>TOTAL WOMEN</u>	
	<u>NO</u>	<u>% OF SINGLE MOTHERS</u>	<u>TOTAL WOMEN</u>	<u>NO</u>	<u>% OF SINGLE</u>	<u>% OF TOTAL WOMEN</u>	<u>NO</u>	<u>% OF OTHER WOMEN</u>	<u>% OF TOTAL WOMEN</u>	<u>NO</u>	<u>COL %</u>
0	21	18%	45%	2	10%	4%	24	23%	51%	47	19%
Lower Primary Std 1 - 4	12	10%	27%	1	5%	2%	32	31%	71%	45	18%
Higher Primary Std 5 - 7	51	43%	61%	4	20%	5%	29	28%	35%	84	34%
Lower Secondary Form 1 - 3	22	18%	63%	5	25%	14%	8	8%	23%	35	14%
Higher Secondary Form 4 & 5	7	6%	35%	1	5%	5%	12	11%	60%	20	8%
Post Secondary	7	6%	50%	7	35%	50%	0	0	0	14	6%

TABLE XXV - AGE OF SINGLE WOMEN

<u>AGE</u>	<u>SINGLE MOTHERS</u>			<u>SINGLE WITHOUT CHILDREN</u>			<u>TOTAL SINGLE</u>	
	<u>NO</u>	<u>COL %</u>	<u>ROW %</u>	<u>NO</u>	<u>COL %</u>	<u>ROW %</u>	<u>NO</u>	<u>COL %</u>
19-24	40	33%	78%	11	55%	22%	51	36%
25-29	32	27%	87%	5	25%	14%	37	26%
30-34	19	16%	100%	0	0	0	19	14%
35-39	12	10%	86%	2	10%	14	14	10%
40-44	8	7%	80%	2	10%	20%	10	7%
45 +	9	8%	100%	0	0	0	9	6%

This increases to 78% of single women aged 19-24 having children, 87% of those who are 25-29 and 92% of single women over 30 years old.

## 12.2 Pregnancy Amongst Youths

One quarter of the 276 youths interviewed in this survey have been pregnant,<sup>1</sup> 18% in the urban area and 32% in Kgatleng. There is a large variation in the pregnancy rate in the different socio-economic parts of Gaborone with only 4% of girls in the high cost area and 7% in the medium cost area being mothers whereas almost half (49%) of those in the low cost area have children. In the rural area the incidence of single motherhood amongst youths increased from 25% in Mochudi, to 34% in Modipane and 37% in Bokaa.

Table XXV gives a comparison of the educational status of those youths who have been pregnant with those who have not. Only 21% of young mothers have had no education at all while 43% have had 5 to 7 years. It seems that most of these girls managed to get as far as Std 7 before their education was halted.

1. This includes those who were pregnant at the time of interview.

We cannot say on the basis of this survey what percentage stopped their education because of pregnancy. Nevertheless the drop-out rate due to pregnancy is clearly a problem as pointed out by the Headmistress at Old Naledi Secondary School who said that in 1981 90 girls and 70 boys enrolled at her school but by the end of the year 25 girls had dropped-out because of pregnancy. Leepile and Seloilwe's fieldwork in Mochudi support this. In their project paper they wrote that at the primary school level there are only one or two cases of pregnancy per annum but it becomes a serious problem during early secondary school. They quote a teacher who said that it is

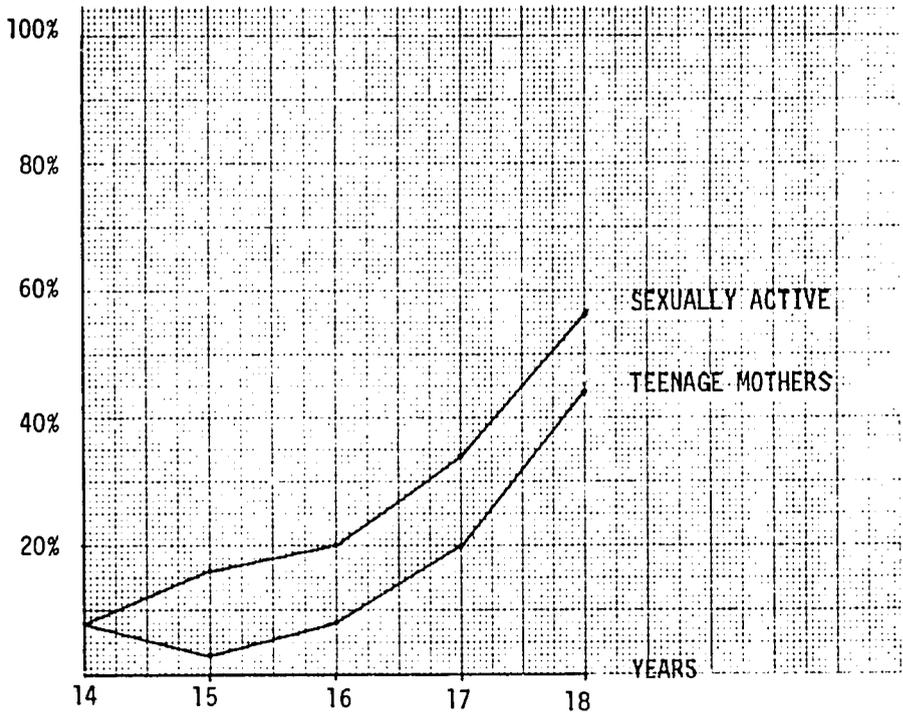
" ... most prevalent at Junior Certificate level and rare at Cambridge level. To illustrate (this) statement ... , in this school there were 240 in the beginning of 1981, by the end of the year there were 217 students. The rate of pregnancy was 23 during that year." 1

TABLE XXVI - EDUCATION OF TEENAGE MOTHERS

<u>LEVEL OF EDUCATION</u>	<u>SAMPLE SIZE</u>	<u>YOUTHS WITHOUT CHILDREN</u>	<u>YOUTHS WITH CHILDREN</u>
0	24	42%	58%
		5%	21%
Lower Primary Std 1 - 4	14	50%	50%
		3%	11%
Higher Primary Std 5 - 7	117	75%	25%
		43%	43%
Lower Secondary Forms 1 - 3	70	80%	20%
		27%	21%
Higher Secondary Forms 4 - 5	48	94%	6%
		22%	4%
Post Secondary	0	-	-
<b>TOTAL</b>	<b>273</b>	<b>75%</b>	<b>25%</b>

1. See du Pradal, July 1982, p.25.

Analysis of the row percentages in Table XXV shows that 58 out of every hundred uneducated girls are likely to become pregnant and as education increases this figure decreases so that 20% in lower secondary school and 6% in higher secondary are likely to become pregnant. However, one cannot conclude from this that education lowers the pregnancy rate. It may well be the inverse, i.e. that pregnancy lowers the education level with young mothers being forced out of school on account of this.<sup>1</sup>



GRAPH G: AGE OF TEENAGE MOTHERS & THOSE WHO ARE SEXUALLY ACTIVE.

1. See Brown's work (1980) on Mochudi secondary school pupils.

Graph G shows the correlation between increase in age and incidence of pregnancy. Whilst only 8% of 16 year old girls are mothers, this increases to 20% of 17 year olds and 44% of 18 year olds. This furthermore increases to 76% of single women aged 19-24 and 86% of those between 25 and 29.<sup>1</sup>

At least 37% of youths would appear to be sexually experienced in that they have either been pregnant or used contraception. Graph G also shows that sexual activity is also correlated with age. As in the case of pregnancy this increases with age with 20% of 16 year olds being active, 34% of 17 year olds and 56% of 18 year olds.<sup>2</sup>

One point which is worth noting is that only 21% of youths who have been pregnant are presently practicing contraception. It is difficult to say whether this is because they are no longer sexually active and therefore not at risk, or whether they are being influenced by the same misconceptions that were discussed above. As in the case of women there is also a fairly high drop-out rate in this group since 31% have at some stage practiced contraception.

### 12.3 Some Social Causes of Single Parenthood

Several factors contribute to the prevalence of single parenthood in Botswana. In the thirties Schapera attributed this to the many social changes resulting from European and missionary contact: the abolition of initiation schools with their moral teachings and strong sanctions against sexual intercourse being practiced by the uninitiated; the end of public humiliation caused by fellow tribesmen singing obscene songs during the night outside the huts of single, pregnant women; the breakdown of polygamy which absorbed 'surplus' young women who became junior wives to older men; and the effect of migrant labour with the large proportion of young men leaving their home villages for long periods of time to work on the South African mines.<sup>3</sup>

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1. See Table XXV, p.63.

2. Correlation coefficient 0.36909

3. See Schapera, 1933.

This last factor remains important with some 50 000 Batswana - mainly men - working in South Africa. During their brief visits home many of these men focus on relaxation, entertainment and drinking beer. They bring to the village money, glamour and, for young women, romance and the possibility of marriage.

Hoyt Alverson maintains that for the non-educated the main recreational centre is the shebeen with its drinking, dancing and sex.

"The primary noneconomic activity in town becomes sex. Sex play is important in the rural areas too but in town the movement from casual union to casual union, to marriage and to divorce, is rapid and often involves only transient commitments to others." (1978, p.87)

Younger women would appear to be fairly disillusioned with marriage and many apparently do not want to marry the fathers of their children. This attitude is fairly widespread amongst career women who are able to provide financial support to their children on their own. But even amongst rural women this disillusionment exists and there is a fear of marrying a drunkard who will beat them.

#### 12.4 'Illegitimacy' - The Problem as seen by Respondents

'Illegitimacy' in the European sense with all its moral connotations does not exist in Botswana. Such children are instead referred to as being 'fatherless' and their position in society will depend upon their mother's ability to support them. If she is young they are usually adopted by her parents who will care for them and often, as these children grow up they will refer to their biological mother as 'sister' although this does not mean that her real relationship to them is hidden.

In this survey respondents were asked:

"Do you think an 'illegitimate' child suffers in Botswana? Explain."

"A ha o lebile ngwana yo o senang rragwe o a sotlega mo Botswana? Tlhalosa."

The term 'illegitimate' was translated as 'fatherless'.

Most respondents feel that these children and their mother will suffer enormous economic insecurity unless she has employment and a good income, or alternatively unless her parents are wealthy - but they are well aware that such women are in a minority. Implicit in their response to this question is the assumption that the mother of such a child will not marry and that she will be the main provider for the child.

Youths argued that the mother would be forced to leave school and would be unable to seek work because they would have to remain in the village to care for their child. In reality this argument applies to poorer girls whose parents are unable or unwilling to assist them. It is not uncommon, however, for poor, elderly women to care for their grandchildren whilst their single daughters work as domestic servants or some other poorly paid occupation. It is expected that they should provide financial assistance to the elderly but often this is infrequent or not forthcoming. In such cases the children suffer the poverty of their environment.

Only 6% of women, 11% of males and 12% of youths felt that there was no difference between 'legitimate' and 'illegitimate' children. For the rest emphasis was placed on a single parent as opposed to two parents providing for the child. This may be explained in part by the fact that amongst the unskilled and uneducated in Botswana, men have far greater wage earning opportunities than women.

It is interesting to note that the respondents paid very little attention to the psychological effects of bringing up a child without a father figure with only 9% of women and 11% of males focusing on this. This is probably because it is expected that the mother's brothers and father who traditionally play a very important part in the upbringing of married women's children, should fill the role.

#### 12.5 Family Support to Single Mothers

Analysis of the relationship to the head of the household to the single mothers in this survey shows that one-third have set up independent households of their own: half the single mothers in

the urban area and one-fifth in the rural area. What is more only 15% in Gaborone have sent their children to be cared for in the rural area, the remainder are looking after their children by themselves. In Kgatleng 60% have remained in their father's or mother's homes with their boyfriends. In the urban area very few have remained with their parents but over a quarter are living with their boyfriends.

In effect this probably means that one-third of single mothers have to support their children on their own. The rest would appear to be absorbed into larger households in which it is likely that economic resources are shared.

12.6 Some Social Reasons why Single Women do not Protect Themselves Against Pregnancy

Given the difficulties in being a single parent it is surprising that women do not protect themselves against pregnancy.

12.6.1 The negative attitude of males towards contraception and the fear of this breaking their relationship

As suggested in the discussion on male attitude to their partners practicing FP it seems that single men have fairly poor knowledge of contraception and it is likely that they influence their girlfriends against contraception. A point that should be made in this connection is that although the survey did not find men to be strongly opposed to family planning, women believe this to be the case.

12.6.2 The desire to have a child to prove that they are fertile and perhaps to foster the relationship

Just under two-thirds of the male respondents maintain that women should prove their fertility prior to marriage. Women are fairly divided on the subject with 56% agreeing with this and 47% of youths. Approval of this stems from the fear that barren women are likely to be divorced and so they should try to avoid this humiliation by having a child prior to marriage. It is, therefore, not surprising that women become pregnant during their first serious relationship. Unfortunately many of these relationships turn sour with women being

TABLE XXVII - RELATIONSHIP OF SINGLE MOTHERS TO HOUSEHOLD HEAD

<u>RELATIONSHIP</u>	<u>NALEDI</u>	<u>BROADHURST</u>	<u>TOTAL URBAN</u>	<u>MOCHUDI</u>	<u>BOKAA</u>	<u>MODIPANE</u>	<u>TOTAL RURAL</u>	<u>TOTAL</u>
Respondent	59%	38%	50%	14%	24%	30%	22%	33%
Father	11%	0	6%	29%	32%	30%	30%	21%
Mother	4%	0	2%	46%	32%	5%	30%	19%
Boyfriend	19%	38%	27%	4%	0	25%	8%	16%
Brother	4%	9%	6%	7%	8%	0	6%	6%
Sister	0	5%	2%	0	4%	10%	4%	3%
Cousin	4%	9%	6%	0	0	0	0	3%

TABLE XXVIII - THREE BELIEFS AFFECTING ATTITUDE TO FP

	<u>WOMEN SHOULD PROVE FERTILITY</u>			<u>WOMEN TRAP MEN BY PREGNANCY</u>			<u>MEN DESERT PREGNANT GIRLFRIENDS</u>		
	<u>AGREE</u>	<u>DIS</u>	<u>D K</u>	<u>AGREE</u>	<u>DIS</u>	<u>D K</u>	<u>AGREE</u>	<u>DIS</u>	<u>D K</u>
Rural Women	51%	43%	6%	36%	50%	14%	75%	22%	2%
Urban Women	60%	34%	6%	40%	59%	1%	86%	10%	4%
Rural Males	63%	33%	4%	54%	34%	12%	69%	27%	4%
Urban Males	66%	27%	7%	51%	42%	7%	70%	27%	3%
Rural Youths	46%	47%	7%	29%	53%	18%	77%	14%	9%
Urban Youths	47%	47%	6%	35%	50%	15%	66%	22%	12%

left with the baby. Just over half the males believe that women become pregnant on purpose in order to trap their boyfriends into marrying them. It is interesting that only about one half of the female respondents - both adults and youths - disagree with this which seems to indicate that the belief is relatively common amongst women too. Despite this, almost three-quarters of all the respondents believe that men abandon their girlfriends once they are pregnant.

In this survey 65% of single mothers in the rural area believed that their boyfriends would marry them when they became pregnant and 49% in the urban area thought this. 60% of the rural women received some financial support from their children's father and 43% in the urban area although this support normally ends with the relationship. Should the woman have a child from another man this is usually used as an excuse to cut off all financial assistance. Men argue callously that single women could otherwise become wealthy from the support of the different fathers.

Even though it is often expected that women should prove their fertility, 53% of males said that they would not marry a woman

who had children from another man since they would cause trouble and jealousy within the marriage as well as being an additional financial burden. A few men said that they would consider such a marriage provided the children stayed with their maternal grandparents. 45% said that existing children would not influence them against a woman provided that they had a good relationship.<sup>1</sup>

### 12.6.3 Inhibitions at obtaining FP from Clinics

Many youths are inhibited at going to the clinic to obtain contraception. Most clinics have a separate time for family planning which means that if a young girl is seen there during that time it will quickly become common knowledge that she is sexually active or as one person put it - "All her aunties will know why she is there!"

In some clinics young girls are given a ticking-off and a lecture on morals. Apparently parents have asked the MOH not to give their daughters contraceptives as they fear it will encourage promiscuous behaviour. In such cases school girls and those of roughly that age group are discouraged from obtaining contraception.

Older women said that they would like to have two separate times for delivering FP - one reserved for young women and the other for older women. They do not like to have contraception discussed with them in front of "their daughters". These women are against having FP integrated with other services.

There are thus two arguments concerning the time of the delivery of FP. Youths and women whose partners are against contraception would like to increase the confidentiality by having this service integrated with others. Mature women and those who are not embarrassed by FP prefer to have it separate for convenience sake. Working women in the rural area would also like to have the service extended until after normal working hours.

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1. Urban and Rural males scored the same percentage response in both cases.

It is recommended that the MOH conducts an experiment in which they try to provide separate services for youths aged 13-19 in which FP is dealt with together with other health problems. In this way one could avoid the embarrassment caused by "daughters" being present when their mothers go for FP. It is also recommended that in the larger villages FP services be extended to at least one evening per month.

Thus, the sociological reasons for the high incidence of unmarried mothers may be attributed largely to the following factors.

1. lack of knowledge concerning contraception
2. fear of obtaining contraception because of the attitude of clinic staff and the lack of confidentiality caused by the clinic hours
3. the negative attitude of men towards contraception due to lack of knowledge and male possessiveness
4. the desire to have a child to endorse a relationship and to prove that the person is fertile
5. disillusionment with marriage.

13. THE NEED FOR EDUCATION ON CONTRACEPTION

The widespread misconceptions concerning contraception recorded in this survey brings to attention the serious need for public education on the subject.

13.1 Reaching Males

A major weakness in the family planning delivery system has been the exclusion of males with focus being placed almost entirely on women during the antinatal clinics. Men complained that their wives or partners had been encouraged to use contraception at the clinic but that they themselves had never been informed on the subject. They objected to their partners passing on this information to them and felt that the health workers should have discussed this with them personally. These men ignored the fact that the majority of males avoid the clinic unless they are ill.

Just over half (51%) the male respondents said that they thought mature men should be taught about family planning by health personnel, 16% did not think that this would be necessary and 34% did not answer the question. It is strongly recommended that FWE's try to discuss contraception with both partners during their home visits instead of concentrating on women. It is also suggested that talks be given in the village kgotlas, training colleges, trade unions and to the different voluntary organisations - football clubs, farmers' associations, etc.

During this project such talks which were given by the Nursing Education students and the Department of MCH & FP proved highly successful. Generally there was a rich exchange of questions and answers which reflected a real concern about the subject, but in one village where strong male opposition was encountered they were fortunate enough to obtain support from a middle-aged man who spoke of the way in which he and his wife had managed to limit their family to three well-spaced children by means of the condom. He condemned the frivolous attitude of young men and managed to bring the discussion to a more serious level. Such talks provide a

dynamic situation in which health workers learn about the fears and misconceptions of the public and are provided with an opportunity to discuss these in depth. An added advantage is that often people feel inhibited at expressing their real opinion on the subject but they may be encouraged to do so when they find out that their beliefs are not unusual.

It is strongly recommended that the Department of Nursing Education continue to hold such workshops in both urban and rural areas.

13.2 Reaching Youths

Over three quarters of the respondents supported the view that youths should be taught about human reproduction and family planning. The least support came from males with 59% agreeing to this, 10% disagreeing and 32% being unsure. Table XXVIII provides a breakdown of the attitude of each group to this. Respondents feel that such education should take place when girls are about 14 years old and boys a year older.

TABLE XXIX - OPINION ON YOUTHS BEING TAUGHT FP - THE APPROPRIATE AGE AND SOURCE OF INFORMATION

	YOUTHS SHOULD BE TAUGHT FP & HUMAN REPRODUCTION			MEAN AGE		TAUGHT BY <sup>1</sup>		
	YES	NO	D/K	GIRLS	BOYS	HEALTH	SCHOOL	PARENTS
	Urban Women	89%	4%	7%	13.5	15.2	29%	37%
Rural Women	78%	15%	7%	14.3	14.8	49%	26%	34%
Urban Males	63%	7%	30%	13.0	13.0 <sup>2</sup>	48%	35%	32%
Rural Males	54%	12%	34%	14.3	14.3	60%	11%	3%
Urban Youths	86%	10%	4%	14.5	15.2	47%	45%	32%
Rural Youths	81%	16%	3%	14.9	15.6	62%	29%	18%

1. This was an open-ended question to which respondents could give more than one answer. Percentage calculated on the basis of those who answered that youths should be taught.
2. Males were asked what age youths should be without specifying sex.

It is interesting to note that in each group rural respondents would rely more heavily on health workers educating their youths than the urban respondents. It is possible that in the rural areas health services are seen as more personal than in the urban areas or perhaps this is because urban parents feel more capable of dealing with this type of education than rural parents.

Over half the women said that they would discuss sex, pregnancy and FP with their sons and almost three-quarters would discuss this with their daughters. Nevertheless 50% indicated that they would send their children to someone else for this information which would seem to support the view that parents are embarrassed to discuss such matters with their children. But even if parents are willing to provide their children with this information this survey shows that the majority are not able to give accurate information on contraception since they themselves are poorly informed on the subject.

Only 15% of teenage mothers actually planned to have children, for the rest the pregnancy was accidental. With one out of four teenage girls getting pregnant there is clearly an urgent need for the Ministry of Health and the Ministry of Education to introduce a programme that addresses this problem.

It is recommended that family life education be introduced to adolescents during primary school. They should be taught about puberty and human reproduction.

During a talk given by Dr Mashalaba <sup>1</sup> and Mrs Kupe <sup>2</sup> to primary school leavers in Bokaa, it was learnt that these adolescents were genuinely confused about what happened to their body at puberty and 'the facts of life' in general. These 12-14 year olds asked such questions as: "Where do babies come from?" The reply which came from other children was "from the river", "from an aeroplane" or they are fetched at the hospital. This session emphasized the need for this type of education amongst adolescents. Care should be

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1. Head of the Department of MCH & FP - MOH

2. Head of the Department of Nursing Education - UB

taken in providing information without either shocking them or possibly causing offence amongst their parents.

Many teachers do not, however, feel confident to hold such discussions with their pupils. Perhaps the MOH could assist them by allowing a medical officer to visit the schools and give such talks to the students. Possibly the students of the Teachers Training Colleges who are presently being taught sex education as part of their curriculum, could conduct some practical work along this line in some of the schools. The Nursing Education Students should continue the work which they have started in this field and since they are pedagogists they could perhaps help train those teachers who are unable to deal with the subject.

It is strongly recommended that the Health Education Unit of the MOH develops a teaching manual containing information for a series of lectures and discussions together with posters and other teaching aids. The Family Life Association has developed such a manual entitled 'Discussion Guide of Family Life Education', (Mbabane - undated) in which family planning is integrated together with other subjects. This booklet contains information on six study units which deal with 'Maturation and Hygiene', 'Anatomy and Physiology', 'Becoming a Parent', 'Family Planning', 'Venereal Disease' and 'Decision Making'. It is thought that with such a guide teachers will find it much easier to discuss these subjects with their pupils.

Simple booklets or leaflets containing basic information aimed at reaching non-school going youngsters should be developed. These could be distributed by clinics to parents as well as directly to the youths and in this way may indirectly provide useful information to some of the uneducated older generation.

Radio programmes should continue to provide the sort of information on family planning that they have done in the past and to encourage responsible parenthood amongst youths. Attention should be brought to the high risk of teenage pregnancy and the social and psychological effects of such young motherhood.

There has been some pressure against this sort of publicity by parents who fear that this will corrupt the morals of the younger generation. It is unfortunate if youths are to be kept uninformed because of such misguided parental concern. The incidence of pregnancy is extremely high in the rural areas and the low cost areas of Gaborone. The parents of these children are very concerned about this problem and even though they will help support their daughters and grandchildren they would prefer to avoid this situation. In their view the 'illegitimate' child does not suffer, it is the teenage mother who suffers.

All attempts should be made to reach youths through voluntary organisations such as the Red Cross Societies, sports clubs, youth clubs, etc. Youngsters must be made aware that they can choose whether they want to become parents or not.

### 13.3 Correcting Women

The survey has shown that although women are generally aware that they could avoid pregnancy through contraception, their knowledge about the different methods is poor and their attitude towards FP is affected by the many misconceptions that are prevalent in both urban and rural areas.

The MOH should conduct an educational campaign correcting these misconceptions.

Women should be encouraged to use contraception to space their children. It was noted above that although 95% believe in child spacing, only 58% have actually tried to space their families.

14. CONCLUSION

Much has been achieved in promoting family planning in Botswana since the programme started in 1971 but as this survey has shown, there is a great deal of work left to be done.

Public awareness of contraception is high with 80% of women and 57% of men being able to name at least one method; the quality of knowledge is, however, weak with widespread misconceptions inhibiting its acceptance. This survey found that 28% of adult women and 21% of youths are presently practicing contraception although as many as 43% of the former group and 31% of the latter have at some stage used a modern method of family planning. The survey was unable to explain this high discontinuation rate. Despite this those who are practicing represent almost three times the national figure.

Acceptance of family planning would appear to be influenced by the quality of knowledge which a person has, their age, education and economic status although this last factor requires further research. The practice of contraception is also greatly influenced by the attitude of the male partner which is in turn affected by their lack of knowledge, their misconceptions and their fear of their partners becoming unfaithful to them.

It has been strongly recommended that the MOH conduct an educational campaign to help clear the confusion amongst males. The survey has shown that only 17% of males are strongly opposed to family planning, 39% are unsure about it and are probably biased against it because of their lack of knowledge. It is believed that with better information many of these men will approve of their partners practicing contraception or they themselves may become active by means of the condom - a method which has the greatest male support and which eliminates the problems of side effects and the apparent insecurity caused by the threat of possible increased promiscuity by their partners. The Population Center Foundation found that:

"The husband's support is a good predictor of future practice and continued use. Wives whose husbands do not support have low continuation rates." (Quoted in IPPF, 1981, p.3)

Women too require better information on the side effects of the different methods of contraception. It is therefore suggested that the Department of Nursing Education - perhaps with the assistance of the National Health Institute - continue to conduct workshops in both rural and urban areas, e.g. in village kgotlas, voluntary organisations, training centres, trade unions, the Botswana Defence Force and any other interested groups. The informal workshop situation provides participants with the opportunity to discuss freely their opinion on contraception without having to make a special visit to a health centre for professional advice - something which the majority would not do. It also provides a forum at which men and women can openly discuss these matters.

The survey shows that 25% of female youths have been pregnant and whilst this rate is much lower in the medium and high cost areas (7%), 49% of those in the low cost area and one-third in Kgatleng are single mothers. This in itself gives rise for concern but it is even more alarming that contraception may be refused to youths who are sexually active because of misplaced concern by their parents' generation. It is suggested that lessons concerning the morality of sex should be taught at home, in the schools, at churches and any other organisation except the clinic. Since at least 37% of youths are sexually active it is recommended that the attention of youths be focused on responsible parenthood rather than what they might consider outdated values.

It is strongly recommended that education on human reproduction commence in primary school and that family planning be introduced prior to the completion of Std 7 since many youngsters will not attend secondary school and it seems that this is about the age when the pregnancy rate becomes serious.

There has been strong social and political pressure against the Government of Botswana forming a population policy which it has been suggested has resulted in a weakening of the family planning programme.<sup>1</sup> Whilst we do not wish to comment on this issue

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1. See UNFPA 1982.

directly, it may be worthwhile pointing out that on the basis of this research it would appear that there is nothing inherent in Setswana culture which the practice of family planning violates. There are no taboos or customary moral values which it contradicts. The fact that family planning was traditionally practiced by means of coitus interruptus, abstinence and especially herbs supports this view. The concept of limiting the family size may be new - whereas in the past people focused on child spacing - but the severe economic changes which have occurred in recent times have resulted in three-quarters of the respondents thinking that it would be foolish to have the maximum number of children possible because of the prevailing high cost of living.

It is therefore recommended that the Ministry of Health together with the Ministry of Education try to develop an educational campaign - both formal and non-formal - which will help clear the prevailing confusion and thereby assist in eliminating the hardships caused by unwanted children.

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