ABBREVIATIONS

AIDS:	Aquired Immuno-deficiency Syndrome
COSAD:	Council on Smoking, Alcohol and Drug Dependence
HIV	Human Immuno-deficiency Virus
LSD:	Lysergic Acid Diethylamide
MRC	Medical Research Council
RSA	Republic of South Africa
SACEC	Southern Africa Democratic Alliance Countries
TB	Tuberculosis
UNDP	United Nations Development Programme
UNISA	University of South Africa
UN-ODCCP	United Nations on Drug Control and Crime Prevention
USA	United Stated of America
WHO	World Health Organization

DEDICATION

I dedicate this work to

My late husband, Austin, my late daughter

Babazile, my children Nhlanhla, Bongile,

Bagcinile, Sandile, Thulie, Musa,

Mbongiseni, Celumusa and Menzi Mhongo.

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CHAPTER 1

Orientation to the study

1.1 INTRODUCTION

The problem of drug abuse in adolescents in Swaziland has increased drastically in recent years. This continual increase in drug abuse is affecting families and society at large in terms of crime, violence, corruption, and drainage of human, financial and other resources that could be used for social and economic development in Swaziland.

The Southern African Democratic Alliance Countries (SADAC) region is faced with a problem of becoming a user region of drugs such as heroin, cocaine, cannabis, alcohol and tobacco. Not only drug abuse, but also drug trafficking from one country to another is becoming a public health problem (Mamoliehi 2001:2).

Parents often learn of their adolescent children's drug abuse problem for the first time when the police arrest them. Parents do not have the knowledge to recognize the first symptoms of drug abuse in their children, and adolescents are not empowered enough to say no to others who lure them into the shady world of drug abuse.

1.2 BACKGROUND TO THE STUDY

Many adolescents in Msunduza township, Mbabane, Swaziland tend to loiter on the streets without any commitment to responsible activity and, as a result, engage in risky behaviours, such as sexual intercourse, drug abuse and criminal offences like house breaking and theft.

Parents in most families contribute to their children's risky behaviour in that they are ignorant of the danger of their own behaviour, for example drunkenness and quarrelling, and their inability to recognize the signs of drug abuse in their children.

Drug abuse in Msunduza Township increases the morbidity and mortality rates for a high prevalence of the Human Immuno-deficiency Virus/ Aquired Immuno-deficiency Syndrome (HIV/AIDS). There is evidence that hard drugs, alcohol and tobacco are increasingly being consumed and to a level that is affecting most countries worldwide with the resultant health problems and financial implications.

The problem usually starts with the "innocent" smoking of a cigarette at a young age. According to Muller (2002:32) in the United States of America (USA), about 1.1 billion people smoke tobacco. By 2025, the number is expected to rise to more than 1.6 billion. Most smokers start as young as 12 years old. Children start to smoke for various reasons but usually to be accepted into the peer group without thinking of the effect on their health later. Diseases associated with smoking tobacco include lung cancer, ischemic health as well as respiratory diseases such as emphysema, which not only lowers the individual's quality of life but also can lead to death. The smoking of tobacco in adolescence is often just the first step to the use of other more lethal substances.

Shaffer (2002:14) states that adolescents and young adults enjoy all-night dance parties known as "raves" and increasingly encounter more dangerous substances known collectively as "club drugs". The drugs used at raves include ecstasy and rohypnol, also known as "date-rape drugs", and are gaining popularity in the country. Although users may think that these substances are harmless, Leshner (2003:12) states that club drugs can produce a range of unwanted effects including hallucinations, amnesia and, in some cases, death. The so-called *rave parties* with the associated drugs used at these parties, have become more and more popular among adolescents in Southern Africa.

Thompson (2003:4) confirms that at least 7% of adolescents in the USA are addicted to alcohol and marijuana, even though they know about the dangers of these drugs, which means that they use the drugs in spite of the persistent, recurrent, psychological, mental and social consequences. The younger and productive age group's future is gravely endangered, as they are not fully developed physically, mentally or socially, and the drugs have more detrimental effects on their bodies. They are also easily tempted and usually not assertive enough to say "no" (Stanhope & Lancaster 1999:533).

According to Hynd (1998:4), anyone who does not recognize the escalation crisis inflicted upon all countries of the world resembles an ostrich that hides its head in the sand when faced with problems. Death resulting from the abuse of drugs, such as alcohol, cocaine/crack, ecstasy, heroin, Ritalin, marijuana, steroids, ketamine and nicotine in the USA is estimated to be about 191 222 per year (Wallace 2004:6). The World Health Organization (WHO) (2003:6) reports that as income and access to cash economy has increased in industrial countries, so has the use of industrially produced alcohol and other drugs. This has become a problem not only in developed countries, but worldwide. Urbanization; revolution in transportation; and communication with increasing articulation of local and global economies; involvement of gender roles; growing youth cultures; and the distance between the cultural experience of the young and their elders, all influence the pattern of drug use in developing societies.

Problems related to substance use among young people in developing countries are often linked to and precipitated by adverse socio-economic factors. Drug abuse by school children and/or most youngsters in Swaziland has adverse effects on their physical, mental, social, emotional and spiritual health (Council of Smoking, Alcohol and Drug Dependence (COSAD) 2001:3). Most developing countries in Africa and Swaziland, in particular, do not have the knowledge, human and financial resources to manage the drug problem; therefore drug

traffickers from other countries more and more use these countries as new markets. Prevention services in developing countries are also limited and, to date, most information on primary prevention projects and their cost effectiveness comes from developed countries. Developing countries such as the Republic of South Africa (RSA), the United Republic of Tanzania and the Republic of Zambia are novices in the management of the drug problem compared to the USA and others. These countries are now receiving support on the planning and implementation of evidence-based prevention strategies from countries such as the USA (WHO 2003:8).

The escalating drug and alcohol problem in the rest of the world has also affected Swaziland, which in comparison to South Africa is a poorer and less developed country. It is therefore time that families, schools, churches, government and non-governmental organizations see the truth about drugs and their effects and find a way to control the widespread problem.

Swaziland is a landlocked country, and shares borders with KwaZulu-Natal Province of South Africa in the west, south and north, Mozambique in the east, which makes drug trafficking into Swaziland easy as these borders are easily permeable. The drug abuse problem amongst adolescents in Swaziland is therefore expected to escalate unless immediate steps are taken to prevent this happening (Vilakati 2003:47).

1.3 RATIONALE FOR THE RESEARCH

This study was conducted for the following reasons:

- The extent of drug abuse and subsequent deaths among adolescents has increased in many countries.
- The SADAC region and Swaziland in particular is becoming the user region of a number of drugs imported illegally from other countries.

- The morbidity and mortality rates due to the use of drugs will also increase, as Swaziland has one of the highest HIV/AIDS rates in the world.
- Swaziland does not have the resources to deal with this escalating problem and is mostly ignorant about the extent of the problem and how to deal with it.
- Parents often accept that normal adolescents tend to be rebellious, feel insecure and are emotionally labile, and do not recognise these as possible symptoms of drug abuse before it is too late to manage the problem appropriately.
- Parents do not have the knowledge and therefore cannot recognise the signs of drug abuse in their children.
- Parents and adolescents should be made aware of the drug problem on their doorstep.
- To be able to assist parents and adolescents in this endeavour requires an understanding of the drug use problem amongst the adolescents of Msunduza Township, the level of their knowledge of various aspects of drugs and abuse thereof.
- The researcher found no research findings on adolescents' knowledge of drugs and drug abuse in Msunduza Township.
- It is therefore important to determine what adolescents in Msunduza Township know about drugs and drug abuse, as well as their opinions on the problem, to be able to make suggestions which could be applied to prevent and control the problem in Swaziland.

1.4 SIGNIFICANCE OF THE STUDY

The findings of this study could be used to educate adolescents and their parents on drug abuse in Msunduza Township, Mbabane, Swaziland and to develop strategies and policies to ensure effective control of the problem.

1.5 AIM OF THE STUDY

The terms “goal”, “aim” and “purpose” are often used interchangeably as synonyms (De Vos 1998:7). The aim of the study was to explore and describe the knowledge and opinions of adolescents, who abuse or abused drugs, on the drug abuse problem in Msunduza Township.

The objectives of the study were to

- Explore and describe the knowledge and opinions of adolescents who abuse addictive substances.
- Make recommendations to control the drug abuse problem amongst adolescents in Msunduza Township, Mbabane, and for further research in this field.

1.6 STATEMENT OF THE PROBLEM

According to Ndlangamandla (2003:5), drug abuse has increased in Swaziland since 2000. Due to the free flow of people between Swaziland, South Africa, Mozambique and other neighbouring countries, this problem is escalating daily. The high prevalence of HIV/AIDS presents devastating consequences for drug users in the country. As adolescents by their very nature are known to take risks and do not always have good relationships with their parents, they are the most at risk of drug abuse. This is especially true in a developing country such as Swaziland where the cultural ties are no longer as strong as formerly and people often tend to follow the example of others in developed countries without knowing the dangers which accompany the use of drugs or having the preventative and control measures in place to safeguard them or to treat drug abusers.

The study wished to explore and tackle the problem by answering the following research questions:

- What are the biographical features of the adolescent who abuses drugs in Msunduza Township?
- What is the extent of the drug abuse problem according to the adolescents who abuse drugs themselves in the township?
- What level of knowledge do the adolescents in the township who abuse addictive substances have of the causes of drug abuse?
- Did the adolescents who abuse drugs in the township start by smoking cigarettes, then drink alcohol and then move to illegal drugs?
- Who introduced the adolescents in the township to addictive substances?
- How has the abuse of addictive substances affected the lives of the adolescents in the township?
- What role have the parents/guardians, teachers and friends played in causing, preventing and dealing with the drug abuse problem amongst the adolescents in the township?
- What are the opinions of the adolescents who abuse addictive substance on the treatment and control measures available in Swaziland?

1.7 RESEARCH DESIGN AND METHODOLOGY

A quantitative, explorative, descriptive, cross-sectional research design was used to investigate drug abuse amongst adolescents who abuse drugs themselves in the Msunduza Township of Mbabane, Swaziland.

1.7.1 Quantitative research

Quantitative research “is normative and measures objective data” (Polit, Beck & Hungler 2001:195).

The study aimed to measure the extent of the drug abuse problem amongst adolescents in the Msunduza township of Mbabane, Swaziland. A quantitative approach was deemed the most appropriate to measure how widespread the problem is and what caused the drug abuse in this area.

1.7.2 Explorative design

Explorative descriptive research describes the variable in order to answer the research question. It also examines the relationships between (or causes of) phenomena (Brink 1996:109).

This study explored the adolescents' opinions on certain aspects as the researcher found no research on this topic in the Msunduza township.

1.7.3 Descriptive design

The main objective of descriptive research is "to accurately portray the characteristics of persons, situations, or groups and/or frequency with which certain phenomena occur" (Polit et al 2001:460). This study described the adolescents who abused drugs, their knowledge of the consequences and opinions on certain aspects of drug use.

1.7.4 Cross-sectional research design

A cross-sectional research design "focuses on the current context of the study at one point in time, and data are captured during one collection period" (Polit et al 2001:183).

The study was conducted in the context of the Msunduza township, Mbabane, Swaziland among adolescents who were currently abusing drugs. Another sample at another time or place might yield different results.

1.8 DATA COLLECTION

In this section, the population, sampling, the sample and the data collection instrument is described. In addition, the interview schedule used in this research is shortly explained. In chapter 3, these aspects will be described in more detail.

1.8.1 Population

In this study the population consisted of adolescents who abuse drugs in the Msunduza township.

The local police station and local schools in Mbabane estimated the number to be between 115 and 120. Some of the adolescents confessed to committing robbery and being involved in house breaking and school teachers reported others who had been aggressive, quarrelled with other children, and assaulted them for no apparent reason. This behaviour could be attributed to their drug abuse problem (Ndlangamandla 2003:10).

1.8.2 Sampling

The researcher decided to make use of a non-probability sampling method, as there was no official list of adolescents abusing drugs in the Msunduza township from which to work. Snowball or network sampling was considered the most convenient method to use as the adolescents abusing drugs were usually either part of a gang or knew each other. Early sample members were therefore asked to identify and refer to other people who met the eligibility criteria for the study (Polit et al 2001:237).

1.8.3 Sample

Sixty adolescents from an estimated 115 to 120 adolescents who abuse drugs in the Msunduza Township were ultimately used.

1.8.4 Data-collection instrument

The researcher selected the interview as data-collection instrument to ensure a better return rate and to be able to translate the questions for respondents who could not understand English (see annexure C for questionnaire). It also allowed the researcher to explain some of the questions better to ensure that the respondents understood them correctly.

1.8.5 Questionnaire

The researcher compiled an interview schedule (questionnaire) and coded it for analysis by computer. It was tested for content and face value validity by the supervisors and experts in the field. The questionnaire was then pre-tested on two adolescents who were not part of the study. After adjusting the questionnaire, it was photocopied and used for interviewing the respondents (see chapter 3).

1.9 DATA ANALYSIS

The completed interview schedules were sent to a statistician at UNISA who analysed the data using the SPSS Version 17 computer program. The data was presented in percentages and frequencies, from which the researcher presented it in tables, figures and graphs.

1.10 RELIABILITY AND VALIDITY

The research instrument was tested for reliability and validity.

1.10.1 Reliability

The reliability of an instrument is “the degree of consistency with which it measures the attribute it is supposed to measure” (Polit & Hungler 2001:412). According to Fain (2004:128), reliability refers to “the consistency with which an instrument tests or measures whatever it is supposed to measure”. After the literature review, the researcher designed the instrument specially to study the knowledge and opinions of adolescents who abuse drugs.

1.10.2 Validity

Validity refers to “the degree to which an instrument measures what it is supposed to be measuring” (Polit & Hungler 2001:418). According to Fain (2004:131), validity is “the accuracy with which an instrument or test measures what it is supposed to measure”.

In this study, the interview schedule was valid for the particular purpose of measuring the respondents’ knowledge and opinions.

1.11 ETHICAL CONSIDERATIONS

Permission was obtained from the Principal Secretary of the Ministry of Health and Social Welfare: Swaziland Government (see annexure A) and the participants themselves (see annexure B).

Chapters 1, 2, and 3 and the interview schedule were also presented to the Ethical Committee of the Department of Health Studies, University of South Africa (UNISA) for approval. The Committee gave permission for the study to be conducted.

The researcher gave particular consideration to ethical aspects because of the sensitive nature of the study. The respondents' right to self-determination was respected without penalty or preferential treatment. The researcher ensured that no physical, emotional, spiritual, economic, social or legal harm was caused to any respondent. The respondents' privacy was ensured by not sharing any of the collected information with others. The researcher assured the respondents that all the data would be treated as confidential.

Informed consent was obtained from each respondent (see annexure B).

1.12 LIMITATION

The study was conducted only in the Msunduza township, Mbabane, therefore the findings cannot be generalised to other parts of the country as conditions may differ.

1.13 DEFINITIONS

For the purposes of this study, the following key terms are used as defined below:

- **Drugs/Substances**

A drug is "any substance used in the diagnosis, cure, treatment, or prevention of a disease or condition" (Salerno 1999:5).

Drugs are chemical substances legal or illegal, natural or synthetic which when taken have biological effects (therapeutic or non-therapeutic in nature) on the body of the person who is taking them. These drugs could be taken in various forms such as in liquid form – alcohol, could be smoked – cannabis, or pill form and swallowed – amphetamines; in powder form, sniffed – cocaine or injectable –

Lysergic Acid Diethylamide (LSD), and in gas form and inhaled such as glue (Salerno 1999:90).

For the purpose of this study, “drugs” referred to any illegal (eg marijuana) and or harmful (eg glue) substance abused by adolescents in Msunduza township and which modified their perception, mood, cognition, behaviour or motor function.

- **Substance/Drug abuse**

Drug or substance abuse refers to “self-medication or self-administration of a drug in chronically, excessive quantities, resulting in physical and psychological dependence, functional impairment, and deviation from approved social norms” (Salerno 1999:88).

Substance abuse is “a maladaptive pattern of drug use despite knowledge of persistent recurrent social, occupational and psychological problems caused by drug use” (WHO 2004:10).

In this study, drug abuse refers to the self-medication and self-administration of chemical substances by adolescents in the Msunduza township obtained through illegal means and which modified their behaviour.

- **Adolescent**

Adolescent is “used to describe young people who are no longer children but who have not yet become adults. It also refers to their behaviour” (*Collins Cobuild English Dictionary*, 2001:22). Kaplan (1999:10) describes adolescents as being in a certain period in their life, which is “characterised by vibrant growth, vulnerability and risk-taking behaviour and is called *adolescence*”.

According to Kibel and Wagstaff (1997:115), adolescence is “a time of exploratory behaviour when fateful choices about eating, smoking, alcohol, drug use, and sex are being made – sometimes with lifelong consequences”.

In this study, adolescents were individuals between the ages 13 and18 years, who abused drugs.

1.14 OUTLINE OF THE STUDY

This chapter outlined the problem, the aim, objectives and significance of the study, and the population and sample and defined key terms.
Chapter 2 discusses the literature review undertaken for the study.
Chapter 3 describes the research design and methodology.
Chapter 4 covers the data analysis and interpretation.
Chapter 5 concludes the study, briefly discusses its limitations and makes recommendations for practice and further research.

1.15 CONCLUSION

This chapter provided an overview of the study, including the problem, background, methodology, and ethical considerations, and defined key terms. The researcher broadly outlined the extent of the drug abuse problem in the world and Swaziland in particular. The fact that adolescents are in one of the most vulnerable stages of their development and are involved in the abuse of drugs is of great concern to health professionals. Moreover, adolescents are more at risk in developing countries where the necessary knowledge of the dangers of drug abuse, ways to prevent and control the problem is lacking and because developing countries in Africa are seen as a new lucrative market for the drug trade.

Chapter 2 discusses the literature review undertaken on drugs and adolescent drug abuse.

CHAPTER 2

Literature review

2.1 INTRODUCTION

The researcher conducted a literature review on drugs and adolescent drug abuse. According to Polit et al (2004:800), a literature review serves to identify a relevant theoretical or conceptual framework for a research problem, lay the foundation for a study, inspire new research ideas and determine any gaps or inconsistencies in a body of research.

In this study, the literature review focused on various aspects of drug abuse, including the effects on adolescent drug abusers, their families, and communities at large. The literature review provided a general understanding of the variables that could contribute to drug abuse in adolescents. The literature confirmed that drug abuse affects the lives of adolescents holistically, namely their physical, mental, emotional, social, economic and spiritual health. Various key words relevant to the topic were used in the search, namely drug/substance abuse, drug addiction, crime, drug experiences, adolescence and mental disorders.

2.2 DRUG ABUSE AS AN INTERNATIONAL PROBLEM

Due to their socio-economic status, developing countries often tend to have more complex problems with the abuse of substances like alcohol, tobacco smoking, use of cannabis and the sniffing of glue and other volatile substances. With economic and social development, however, according to Scanlon (2001:40), this picture tends to change. Increased movement of people, better communication technology and improved socio-economic status to name but a few, also influences the drug trade and increase the drug abuse problem.

The type of drugs abused in the developing and developed countries also differs. Drug abusers in the developing countries start and often continue a lifetime of drug abuse with legal drugs, such as alcohol and tobacco smoking, and then do not move beyond the abuse of cannabis, whereas abusers in developed countries might start with the abuse of alcohol and cannabis but quickly move to more dangerous drugs or even start with the more addictive drugs like ecstasy and cocaine. How the drug abuse problem starts or continues is of minor importance compared to the millions of lives in both developed and developing countries which have been destroyed through illicit drug trade (United Nations On Drug Control and Crime Prevention [UN-ODCCP] 2001:10).

Drugs can be found all around us and no country can claim that drugs do not affect their societies (Rogers & McGee 2003:2; Mason & Henningfield 2001:40). If the amount of cannabis seized in the Southern African countries from 1999 to 2001 was used to judge the drug problem, it is clear that the abuse of cannabis in particular is a big problem in this region (see table 2.1). Nevertheless, these statistics should also be seen in context. For instance, the larger countries in this region, such as in the RSA, have had the biggest hauls of cannabis seized. This does not necessarily mean that the RSA has a bigger problem than the other countries in this region. It could merely be an indication that the RSA as the largest country and the more developed in this region also has the resources to control the problem more effectively and report on it more correctly.

Countries in transition or involved in wars have been found to be the most vulnerable for drug trafficking. Although table 2.1 indicates that Namibia and Mozambique had the lowest amount of cannabis seized in this period, it could be that, due to their socio-economic and political problems, they are unaware of the magnitude of the problem.

Table 2.1 Cannabis seized in kilograms in the Southern African countries, 1999-2001

COUNTRY	KILOGRAMS OF CANNABIS
RSA	289 943
Swaziland	33 283
Malawi	27 141
Lesotho	7 243
Zambia	7 000
Angola	2 829
Zimbabwe	1 816
Botswana	1 229
Mozambique	894
Namibia	282

Source: Mvubelo (2001:15)

The problem with drug and alcohol abuse is that it "drains the physical, intellectual, and economic resources of each individual as well as their families, communities and countries who can often least afford it" (Herrel & Roberts 2003:4-5).

According to Rehn, Jenkins and Cristal (2001:107-108) developing regions of the world fall in the middle range in terms of hazards associated with their drinking patterns. These regions include the RSA, South East Asia, Central and Eastern Europe. The hazards of intoxication prevalent in these regions include casualties (all types of accidents), violence and social problems, such as teenage pregnancies, that can often be attributed to adolescents' alcohol abuse.

2.2.1 Drug abuse in the United States of America

As in other countries, drug abuse in the USA often starts with the innocent use of addictive substances, which is seen by society as acceptable behaviour. Individuals start to become addictive to substances such as alcohol by using it on a regular basis and the smoking of cigarettes, which is available and acceptable

to buy and use. According to Drammond (2001:3), in the USA about 79,1% of teenage students drink.

The USA and Japan have the highest percentage of smokers in the world. A disturbing trend recently is the increasing number of teenage girls who smoke (De Haan 1997:39)

In the USA, marijuana is the most widely used illicit drug among America's youth and the number of teens using marijuana doubled between 1991 and 2001 from 1 in 10 to 1 in 5 (Mvubelo 2001:12). Among the youth who use drugs, approximately 60% use only marijuana. The marijuana users also tend to become younger and two-thirds of new marijuana users in the USA each year are between 12 and 17.

Fishburne (2003:8) states that an estimated 1,5 million Americans 12 years and older are chronic cocaine users. In addition, many youngsters have been attracted to the inexpensive, high purity heroin that can be sniffed.

Drug use among youth has increased and the age at which drug use begins has dropped. Although tobacco, alcohol and marijuana are the substances mostly tried, the use of heroin, cocaine, amphetamine and inhalants is also on the rise (Bachman & O'Malley 2004:16).

Herrel and Roberts (2003:8) examined a wide range of variables from biogenic to environmental factors to determine what makes one adolescent and not another more vulnerable to initial and continued drug use. They found (2003:10) that no single factor accounts for all known causes, consequences and patterns of drug use. Rather, interacting biological (e g, genetic influences), psychological (e g, depression and learning problems), social (e g, family instability), and environmental (e g, street violence) factors, sexual and physical abuse, gang

membership, neighbourhood drug trafficking and poverty appear to put adolescents at risk (Herrel & Roberts 2003:10).

2.2.2 Drugs in Africa

Njuki (2004:5) maintains that there are so many issues confronting Africa that substance abuse is not looked at as it should be. Both illicit drug trafficking and substance abuse are increasing in Africa. Cannabis, methaqualone, heroin and alcohol are included among the drugs used across the African continent. Moreover, the injection of heroin has caused heightened concern as intravenous drug use assists in the continued spread of HIV/AIDS across Africa (Njuki 2004:5).

The United Nations (UN) Program on HIV/AIDS estimates that Africa has some 25,4 million people, more than 60% of its population, living with HIV. People are watching loved ones die, young people are graduating without employment, and there are many who feel no joy, and see no future (Njuki 2004:5).

Njuki (2004:4) refers to *Kitwe*, a drama performed by young people from Mutende Cultural Assembly of Zambia, that set the tone as the United Methodists from Africa got down to work on ways to respond to the drug crisis. The drama portrays violence and risky social behaviours that are a consequence of alcohol and drug use in African communities.

According to Dandala (2004:4), the fight against alcohol and drug abuse has not been given the same prominence as the fight against HIV/AIDS, yet the two are interlinked. Dandala (ibid 2004:7) emphasises the breakdown of culture, urbanization and increasing use of the continent as a transit point in international drug trafficking and that the church must embrace its role and ministry to persons and communities burdened by the ill-effects of substance abuse.

2.2.2.1 Republic of Tanzania

The “hardest” drugs used in the Republic of Tanzania are a mixture of heroin, cannabis (marijuana) and mandrax. Of the youth, 89,6% use a mixture of heroin and mandrax, and 82,9%, especially females, use a cannabis/mandrax mixture (WHO/UN-ODCCP 2003:6). The onset of drug abuse tends to take place within family circles and, to a lesser extent, through agencies such as health care services, and social acceptance of drug use is viewed as fashionable and produces enjoyment.

2.2.2.2 Republic of Zambia

According to the WHO/UN-ODCCP (2003:6), the abuse of substances such as cannabis, heroin, cocaine and mandrax does not seem to be a major problem in the Republic of Zambia. However, it is often found to be the root cause of offences such as drunken driving, arrest for disorderly conduct, fights and arguments, drunk while operating a machine, and suspension or expulsion from school.

The most important health and social problems related to drug abuse in Zambia are:

- illnesses like tuberculosis (TB) and HIV/AIDS and difficulty to obtain health care.
- extreme poverty
- crime, such as robbery/burglary and other related offences
- few employment opportunities for young people
- substance use among close associates, namely drinking/smoking among fathers and cannabis use among close friends
- substance-related incidence, especially in youngsters

- use and approval of alcohol, cigarette and, to a lesser extent, cannabis smoking, especially among young men.

2.2.2.3 Republic of South Africa

The RSA with its infiltrative borders has become a lucrative market for drug traffickers and the drugs more often associated with developed countries.

Alcohol consumption and tobacco smoking followed by the smoking of cannabis is often also the route followed by drug abusers. Alcohol consumption has contributed to the prevalence of medical conditions, such as carcinoma of the mouth, oesophagus, stomach and pancreas, cirrhosis of the liver, peripheral neuritis, vitamin deficiency and malnutrition; psychological conditions, such as addiction to other drugs, delirium and dementia; personality deterioration, and psychotic reactions (De Haan 1997:40). Certain social problems that occur in the country are also often attributed to the use of alcohol, such as ordinary crimes, assault, family disorganization, homicide, and suicide.

A survey conducted between 1997 and 2003 in Bela-Bela (a rural area) and the Greater Pretoria Metropolitan area (urban), found a similar use of cannabis amongst the urban and rural youth (WHO 2003:9). As many as 80% of males between the ages of 10 and 14 years and 71% of females between 10 and14 years of age had used cannabis at least once, and this had occurred at home or at a friend's home. The reasons given for this drug use were to relieve stress, out of curiosity, for enjoyment and to be sociable (WHO 2003:10). Furthermore, drug abuse among adolescents resulted in the following:

- Urban youth performed poorly at work.
- The rate of injuries was four times higher among urban than rural youth.
- Family members in the urban areas facilitated substance use.

- The onset of tobacco, alcohol and cannabis use tended to occur between 10 and14 years.

2.2.2.4 Swaziland

Swaziland was known to be a cannabis-growing country and a transit point for hard drugs, but has become a consumer country of hard drugs. COSAD (1998:7), with the assistance of the Medical Research Council (MRC) in Johannesburg, RSA, reported that the majority of individuals who abused drugs in Swaziland started between the ages 10 and 19 years and the prevalence of substance abuse was higher among males than females. In 2004, the Swaziland Police Anti-drug Unit (Swaziland Police Department 2004:5) reported an increase in the number of already addicted individuals. The police further disclosed the following statistics of persons convicted and drug seizures in 2003:

- The Hhohho region of Swaziland had the most people convicted for the use of cannabis.
- The Manzini region had the most arrests for this drug in the country.
- In the Lubombo area the largest amount of cannabis was seized.
- Manzini and Lubombo were the only two regions in which heroin was found
- Shiselweni was the only region that had cocaine.

Table 2.2 Arrests, convictions and drug seizures in Swaziland, 2002

Region	Arrests	Convictions	Weight of Heroin	Weight of Cocaine	Weight of cannabis
Hhohho	**288**	**163**	**-**	**-**	**2 kilograms**
Manzini	**313**	**158**	**1 kilograms**	**-**	**8 kilograms**
Lubombo	**106**	**97**	**85 kilograms**	**-**	**89 kilograms**

Shiselwen	**98**	**67**	**-**	**6 kilograms**	**7 kilograms**
TOTAL	**805**	**485**	**86 kilograms**	**6 kilograms**	**7 kilograms**

Source: Swaziland Police Department (2003:25)

The above information on illicit drug trafficking and consumption clearly indicates the magnitude of the problem of substance abuse in Swaziland. Regarding substance abuse by region in Swaziland, the police reported no significant difference between the regions although certain drugs were found in abundance in some regions. For example, cannabis was found mainly in the Hhohho region. The United Nations Development Programme (UNDP) (2001:23) revealed that 70% of the homesteads in the highveld ecological zone of the Hhohho region even grew their own cannabis. As a result, serious damages in the form of physical, mental, emotional and spiritual health have been experienced by and observed in individuals, families and communities in Swaziland (COSAD 2001:10).

COSAD (1998:12) found that very little progress had been made towards attending to substance abuse, which had reached crisis proportions in Swaziland. COSAD (1998:12) emphasised that they had been like John the Baptist, “crying in the wilderness”, in their efforts to try and alert all sections of the community to recognize the seriousness of the situation. The situation has gone beyond the problem of substance abuse alone, for it relates to the current escalation of crime, road accidents, as well as family and social breakdown.

2.3 DRUGS ABUSED MOST BY SOCIETY AND THEIR EFFECTS ON THE ABUSERS

Cigarettes, tobacco and alcohol affect the user’s brain, causing the self-administration of that substance to be repeated. The repeated use of the substance can lead to sensitisation of motivational circuits in the brain and

ultimately to dependence. The outcome of the psychoactive substance is influenced by the user's biological, social, and cultural factors (Sweetney & Neff 2001:4).

The drugs mostly used by adolescents are cigarettes, tobacco, alcohol, marijuana, glue, paint, paint thinners, aerosols and polish remover.

2.3.1 Cigarettes

Cigarettes regularly serve as the starter drug-delivering agent. Cigarettes deliver the drug nicotine. Children become hooked on cigarettes at any age. Nicotine has demonstrated dose-related euphoric effects similar to those of cocaine and morphine (Henning, Miyasato & Jasinski 2004:16).

Cigarettes cause the worst of all drug habits found in the smoking of tobacco. The first step towards addiction may be as innocent as a boy's puff on a playground. Tobacco holds a special status as a gateway to the development of other drug dependencies not only because tobacco use reliably precedes use of illicit drugs, but because tobacco use is more likely to escalate to dependent patterns of use of more other dependence producing drugs (Ronald & Davis 2004:5).

Wood (2004:14) adds that cigarettes' toxic chemicals impair impulses and ethical controls, that is, cause addiction, brain damage, aboulia (impaired reasoning, ethical controls, and will power). Children may have conduct disorders and difficult temperaments resulting from the manner they were brought up. For instance, if the parents and other family members engage in substance abuse, children are likely to develop a range of affective, behavioural, cognitive and social problems. Many of these children present poor school readiness and performance, low bonding and attachment to school (Barber, Bolitho & BeHand 2003:14).

Mansell and Liu (2003:50) state that chronic drug use among adolescents is mostly prevalent among adolescents whose parents face many challenges that limit their ability to provide for the physical and/or emotional needs. These challenges include drug addiction, scarce financial resources, unstable housing, familial history of substance abuse and lack of social support from family and friends. Mansell and Liu (2003:50) go on to say that, on average, children affected by maternal addiction are susceptible to a high level of risk. From the time of their conception and continuing through childhood, their environment has been characterized by an accumulation of factors known to place children at increased vulnerability for physical, academic and socio-emotional problems. The majority of these children experienced pre-natal exposure to alcohol and other drugs. More factors that may lead to adolescent drug abuse include rigidity in parenting attitudes, single parenthood, stressful life events and large family size (Van Leeuven, Hopfer, White & Peterson 2004:27-29).

2.3.2 Tobacco

According to Yuji (2001:9), smoking is an established cause of a significant number of diseases, disabilities and deaths worldwide. It is not only harmful to the individuals who smoke but also to those who are passively exposed to tobacco smoke.Tobacco contains thousands of substances and nicotine is the one most frequently associated with dependence because it is the component that is psychoactive. Observable behavioural effects, such as mood changes, stress reduction and enhancement of performance, are common. Hodge, McLellan and Cerbone (2001:6) emphasise that when “the alarming problems of smoking are recognized these should be addressed as an individual, social, economic and environmental burden at the family, community, national, regional and global levels”.

According to Erikson and Mackay (2002.20-30), more than 5,500 billion cigarettes are manufactured annually, and there are 1,2 billion smokers in the world. This number is expected to increase to two billion by 2030. Green, Ball and Ottoson (1999:4) add that in spite of the real or apparent benefits of the psychoactive drug, the drug carries with it the potential harm, whether in the short or the long term. Such harm can result from the cumulative amount of psychoactive substance used; for example, the toxic effect of alcohol in producing liver cirrhosis.

Craig (2004:6) points out that in most cases people use psychoactive substances "because they expect to benefit from their use whether through the experience of pleasure or the avoidance of pain. The benefit is not necessarily gained directly from the psychoactive action of the substance. Someone drinking beer with colleagues may be more motivated by the feeling of fellowship this brings than the psychoactive drug effect on his health."

2.3.3 Alcohol

Alcohol is the most available drug on the market and is not illegal to use or possess. Alcohol abuse is "one of the most difficult to treat because the use is accepted at any social function and abusers deny that they are addicted. Alcohol is a depressant and sedative and becomes addictive when ingested in large amounts and at regular intervals. It slows down the activities of the nervous system that controls bodily functions, causes drowsiness, lack of concentration, slowness in thinking, impaired interpersonal relationships and leads to economic dysfunction and poverty" (Hodge et al 2001:6). These authors (ibid 2001:6) point out that the dangers of too much alcohol consumption include:

- mental deterioration
- lack of alertness, thus people under the influence of alcohol are prone to accidents

- damage of organs like liver, kidney and others; also permanent damage to the foetus if the abuser is pregnant
- blackouts
- convulsions
- severe psychological dependence
- death (from overdosage).

Alcohol affects the body as follows (Rehn et al 2001:107-108):

- It makes the individual carefree and sociable.
- It causes slurred speech. At this point it has begun to work. At this level in some countries, such as the USA and the RSA, once the individual has passed the legal intoxication level, he is not supposed to drive a motor vehicle.
- It impairs motor skills that mean that the individual cannot coordinate well enough to drive a car.
- It causes confusion. In this step, the individual cannot recognize things around him well.
- It causes the individual to go into a stupor that means that the individual is too drunk to know anything.
- It can cause the individual to go into a coma.
- Finally, it causes respiratory paralysis that is connected with the gag reflex. This means that when the individual vomits, he cannot get rid of the vomit because of the comatose state and death occurs.

Dakota and Forks (2003:120) define an alcohol-related problem as “drinking that causes problems with parents, teachers, friends or the law”. In their study on teen drug abuse, Dakota and Forks (2003:128) found that “25% of Americans die as a result of substance abuse. The average of 18 year old has seen 100,000 television commercials encouraging him or her to drink. That is why 90% of high

school seniors have tried alcohol, 53% get drunk at least once a month, 43% smoke marijuana and about 1/3 are smoking cigarettes; 95% of untreated addicts die of their addiction, 50% of traffic deaths are alcohol related, 40% assaults are alcohol related, 97% of addicts never see treatment."

Du Pond (2001:65) points out that an estimated that 10% of children (more than 7 million) have at least one parent who is dependent on alcohol or illicit drugs and 6% have at least one parent who is in need of treatment for illicit drug use. These estimates suggest that millions of children are currently being reared in environments characterized by maternal addiction.

Children of substance-abusing parents are widely considered at high risk for a range of biological, developmental and behavioural problems and "shockingly high numbers of children in the US" have mothers who are addicted to alcohol (Green et al 1999:4).

2.3.4 Marijuana

Marijuana is an addictive hallucinogenic drug, which is smoked by the abuser. It causes "an unnatural thirst or hunger, uncontrolled mood swings, talkativeness, impaired perception, disturbed judgment, mind disorders, a feeling of well being and euphoria (pleasant feeling of excitement and of escaping reality) and it alleviates anxiety" (Rehn et al 2001:112). These authors (ibid 2001:108) state that the dangers of the use of marijuana include:

- Excessive aggression when combined with alcohol
- Accidents due to distorted perception
- Physical damage in the form of bronchial irritation, risk of lung cancer, chromosome damage, ultimately brain damage
- It is usually the first step of addiction before abusers move to hard drugs.

2.3.5 Glue, paint, paint thinners, aerosols and polish remover

As marijuana is illegal to possess in Swaziland and in the RSA, it can be expensive to buy. Abusers therefore tend to abuse substances that are more readily available and not illegal to buy, such as glue and paint. The homeless and poor often abuse these substances. These substances have a depressant effect on the abuser when they are inhaled. They cause slurred speech, inability to focus, stupor and seizures. The individual tends to move slowly as if lethargic and has a "drugged appearance". The individual sometimes tends to become hostile and aggressive (Lopez 2001:12). Polish remover slows down the activities of the nervous system that control the body functions (WHO 2002:13).

According to Seigal (2003:4), inhalants are an assortment of chemicals and toxins that when inhaled are poisonous to the brain. They include common household items such as spray paints, air fresheners, glues, correction fluids and hair spray. Inhalants can cause disorientation, hallucination, memory loss and lack of coordination. Seigal (2003:8) states further that these inhalants "literally seal out the transfer of oxygen to the blood stream. The body can simply suffocate from lack of oxygen. The inhalants contain a wide variety of toxins, which target different body parts for example the brain, the skin, liver and kidneys." Addiction to Benzene and gasoline (petrol) causes serious injury to bone marrow and to the immune system. It is toxic to the reproductive organs, causes hearing and vision loss and said to be linked to an increased risk of leukaemia (Seigal 2003:14)

Seigal (2003:4) highlights the following signs of inhalant use:

- breath and clothing that smell like chemicals
- spots or sores around the mouth

- paint or stains on body or clothing
- dazed or glassy-eye look
- nausea or loss of appetite
- slurred speech
- red and running nose.

2.3.6 Cocaine

Cocaine is an extremely addictive drug and is illegal to possess or deal with. The effects of cocaine appear almost immediately after only a single dose and disappear within minutes. It makes the user feel euphoric, energetic, talkative and mentally alert, especially to the sensation of sight, sound, and touch. It can also temporarily decrease the need for food and sleep. The short-term physiological effects of cocaine include constricted blood vessels, dilated pupils, increased body temperature, increased heart rate, and an increase in the blood pressure. Large amounts of cocaine may lead to bizarre (strange in appearance), erratic (unreliable) and violent behaviour (UN-ODCCP 2002:45). The signs of cocaine dependence include (World Bank 1999:60):

- small constricted pupils
- injection marks
- bruises on the arms, thighs, groins, ankles and neck
- unnatural calmness
- drowsiness
- personality changes
- decreased appetite
- sexual drive
- tremors, vertigo, and muscle twitch

Some cocaine users feel restless, irritable and anxious, energetic, and competent (Mustonen 2002:4)

2.4 FACTORS CONTRIBUTING TO DRUG ABUSE AMONG ADOLESCENTS

Drug and alcohol use can change depending on factors such as the availability of drugs, introduction of new drugs in drug markets, new modes of administration, and rapid social changes. Some factors play a more direct role in the causation of the drug abuse problem amongst adolescents such as certain psychological factors, for example lack of behavioural control, depression and lack of support due to chaotic home environments where there is no family stability (William & Covington 1998:6). Family instability may be caused by many factors such as unrest, quarrels among family members; for example, father and mother, or parents and children (Taylor & Carry 1998:11).

Using alcohol and tobacco at a younger age increases the risk of using other drugs later. Some teens experiment and stop, or continue to use the drug occasionally without significant problems (WHO 2004:2). Lawson (2002:10) emphasises that adolescent smoking may seem an innocent activity yet it is a marker for potential drug abuse and depression.

Adolescents with emotional problems are “more likely to use drugs and to contemplate suicide. Another possibility is that the use of drugs aggravates pre-existing depression or other emotional problems. Drugs and alcohol may also impair the judgment of teens considering suicide and making suicidal attempts more likely” (Gordon 2004:6).

For adolescents there is a strong relationship between the use of drugs and violence. Those who engage in violent behaviour are extremely likely to report using alcohol and other drugs. Leningson (2002:10) found that 94% of violent adolescents reported using alcohol, 85% reported using marijuana, and 55% reported using several illegal drugs.

2.4.1 Adolescence as a developmental stage

The first transition for children is when they leave the security of the family and enter school (COSAD 1998:14). When they advance from elementary school to secondary and high school, they often face social challenges such as learning to get along with a wider group of peers. At this stage (early adolescence), children are likely to encounter drug use for the first time.

Du Pond (2001:20) identifies certain warning signs of teenage drug abuse, although there are other causes for these behaviours. Signs in the home include loss of interest in family activities and disrespect for family rules. Signs at school include loss of interest in learning, poor work performance and defiant of authority. Pollin (2004:4) observed physical and emotional signs in drug abusers among adolescents, such as being overly tired or hyperactive, argumentative, confusion and anxiety. Teenagers who use drugs do not see the link between their actions today and the consequences tomorrow. They also have a tendency to feel immune to the problems that other people experience (Kenny & Markou 2004:2; WHO 2004:2).

The costs and developmental consequences of adolescent drug problems on the youth, their family, and society include school failure, delinquency, vehicle accidents, arrests and increased risk for HIV/AIDS and other physical illnesses (Diamond, Barrette & Tejeda 2001:12). Condrin (2004:14) states that how teenagers feel about themselves plays a significant role in whether they choose to abuse alcohol or use other drugs. Condrin (2004:16) adds that an adolescent's "sense of self" can influence sexual behaviours and reaction to peer pressure, and, importantly, can be affected by the adolescent's relationship with his or her parents. A "sense of self" is an adolescent's self-evaluation of his or her progress in four key developmental areas (Condrin 2004:16):

- identity formation, independence, and peer relationships

- avoid alcohol and drug use.
- Low senses of self-esteem are more likely use alcohol and “hard” drugs such as ecstasy and cocaine.
- Parental involvement strongly correlates with teens’ sense of self and the decisions they make regarding alcohol and drug use.

Wallace (2004:6) emphasises the importance of understanding the role that the “self” definition plays in predisposing adolescents to destructive decision making and establishing a clear link between “who they are” and “what they do”.

According to Bray (2002:8), students who abused alcohol reported difficult family situations. Furthermore, alcohol abuse was their way of rebelling against their parents while “children with supportive parents are more likely to act independently of their friends and not succumb to drinking” (Bray 2002:9). Parents also have a major influence on whether or not kids decide to smoke or drink alcohol (Wallace 2002:9).

Green et al (1999:10) point out that young people who use substances dramatically increase their chances of becoming drug dependent, their vulnerability to life-threatening accidents and injuries, and their risk for other problems related to substance abuse. Further, the use of alcohol and other drugs in the adolescent years “has the potential to set patterns for future behaviors that have an impact on health beyond the adolescent years” (Green et al 1999:11).

According to Elliot, Huizinga and Menard (1999:14), 72% of adolescents who use drugs are five times likelier to have sex with four or five partners. Mixing drug use and sexual activity is particularly troublesome for 43% of adolescents as such behaviour places them at risk for sexually transmitted diseases and unintended pregnancies.

Adolescent substance use and risky sexual behaviour coexist. Sexually active adolescents are more likely to experiment with drugs, while young substance users are likely to initiate early sexual activity, and to have multiple partners (Laura 2000:65). Some adolescents develop a dependency, moving onto the use of other more dangerous drugs, posing significant harm to themselves and possibly to others.

Neff (2004:2) states that adolescence is "a time of trying new things. Adolescents use drugs for many reasons including curiosity because it feels good to reduce stress, to feel grown-up or to fit in. It is difficult to know which adolescents will experiment and stop using drugs and which will develop serious problems by continuing using drugs."

Parker, Diamond and Barrette (2001:4-5) stress that adolescent drug abuse is a public health problem of considerable national importance. Four out of ten girls in the USA will become pregnant before they reach the age of twenty and more than 900 000 adolescent pregnancies are reported every year (Chappell & McBright 1999:14).

2.4.2 Ineffective parenting

Children may have conduct disorders and difficult temperaments resulting from the manner they were brought up. For instance, if the parents and other family members engage in substance abuse, children are likely to develop a range of affective, behavioural, cognitive and social problems. Many of these children present poor school readiness and performance, low bonding and attachment to school (Barber et al 2003:14).

2.4.3 Lack of mutual attachment and nurturing

Family factors are influential in the genesis of adolescent drug abuse and behavioural problems. Poor relationships with parents and inadequate child rearing practices are closely linked to adolescent drug abuse (Johnson 2000:2).

Bronfenbrenner (2003:5) views the family as “a whole organism that is much more than merely the sum of individuals or groups that it comprises. During the many years that the family is together, family members develop habitual patterns of behavior and repeat these behaviors a thousand times. In this way each individual becomes accustomed to act and to respond in a specific manner within the family. Each member’s actions elicit a certain reaction from another family member over and over again, and over time. These repetitive sequences give the family its own form and style. Family influences may be experienced as an invisible force. This invisible force governs the behavior of the family members every time they are together. These forces include such things as spoken or unspoken expectations, rules for managing conflicts and implicitly or explicitly assigned roles.”

In the case of adolescent behavioural problems, Orbot (2003:5) maintains that the family’s lack of skills to manage a misbehaving youth can create a force that makes the adolescent inappropriately powerful in the family. For example, an adolescent may decide to establish his own life style like engaging in substance abuse or any form of delinquent behaviour.

Concerning the highest risk period for drug use among youth, Rogers and McGee (2003:3) found that the vulnerable periods are transitions, when they grow from one development stage to another, but exposure to risks can start even before a child is born and is one reason that mothers are advised to abstain from drugs during pregnancy.

Heavy use of marijuana may be dangerous for adolescents during puberty and is associated with diminished sperm motility, decreased sperm count, low

testosterone levels, irregular ovulation and decreased gonadotrophin levels (Streeton & Whelan 2001:4).

2.4.4 Factors in the wider environment

The environment is also important for children's development, including the mass media and entertainment industries, community institutions, religious bodies, political and legal systems, access to schooling, health services, recreational activities, vocational training and economic opportunities (WHO 2003:8).

"Risk factors" are the main factors that put young people at risk for drug use and "protective factors" are those associated with reduced potential for such use (Wood 2004:1). Furthermore, the risk factors that affect early development in the family are the most crucial, such as

- a chaotic home environment in which parents use substances
- ineffective parenting especially with children with difficult temperaments and conduct disorders
- lack of mutual attachment and nurturing.

Wood (2004:1) also identifies certain protective factors, namely

- strong bonds with family
- experience of parental monitoring with clear rules of conduct with the family unit and involvement of parents in the lives of their children
- success in school performance
- strong bonds with pro-social institutions, such as the school and religious organizations
- adoption of conventional norms about drug use.

The UNDP (2001:23) found that adolescents in Swaziland abuse drugs for the following reasons:

- peer pressure
- living with a family member who abuses substances
- socializing
- poverty
- accessibility, availability and affordability of drugs
- stress and sex.

2.4.5 Poverty

Poverty in the home may result in children committing crimes frequently associated with drug use. Theft, prostitution, teenage pregnancies and sexually transmitted diseases like HIV/AIDS are prevalent in adolescents whose parents are poverty stricken (Farrell & White 1998:12). Poverty deprives adolescents of such basic elements of development such as food, clothing and shelter. The extent to which a young person is exposed to physical and social unrest influences his or her health and development (WHO 2003:6). Adolescents who are depressed, have low self-esteem, feel as though they do not fit in or are out of the mainstream are at risk of developing serious alcohol and drug problems.

According to Gayle, Dakof and Parker (2001:13-14), the clinical picture of adolescent drug abuse is as complex as its aetiology. Drug abuse can be conceived both as a stimulus that creates problems in one or more developmentally important areas, and as a response to past or current life circumstances. Adolescent drug abuse frequently occurs with other clinical problems. Conduct disorder, depression, anxiety disorders, sexual acting out and academic problems co-occur with adolescent drug problems with significant regularity (Gayle et al 2001:14).

2.5 EFFECTS OF DRUG ABUSE ON SOCIETY

According to Shives (1999:44-50), substance abuse alters the normal living patterns of individuals and society as a whole.

2.5.1 Drug abuse and the family

The devastating effects of drug abuse on the family are those that pose the greatest threat to the family at large. When one member of the family abuses drugs, every family member suffers because it causes disruption and disharmony within the family.

Diamond et al (2001:12) and Preboth (2000:5) state that drug abusers often become so obsessed with the habit that everything going on around them is ignored, including the needs and situations of other family members, leading to a breakdown of the family as an entity. Besides possible criminal behaviour brought into the home by the drug user, the family suffers varying degrees of personal anguish both physically and psychologically (Preboth 2000:8). Family members are affected as they watch the destruction of an individual who is close to them. When younger children see an older person or parent using drugs, they may wrongly believe that it is normal and acceptable to take drugs (Sweetney & Neff 2001:4).

Page, Scanlan and Gilbert (1999:13) maintain that parents are responsible for their children's behaviour as it reflects the way they were socialized. The WHO (2003:9) states that when adolescents feel connected to their families and when both parents are involved in their children's lives, it influences how adolescents feel about themselves, and the choices they make about behaviours that affect their health. Furthermore, "adolescents need to have at least one adult who is committed to their well-being. They need adults they can turn to and adults who

will listen as they describe what they are experiencing and how they are coping" (WHO 2003:11).

2.5.2 Drug abuse and the school

Drug use is a problem for the school going adolescent because it undermines a student's academic ability, and performance. In the USA, for example, students who use marijuana regularly are twice as likely to get below-average marks or failing grades, and school dropouts are twice as likely to be frequent drug users.

Drugs can disrupt the entire school. When several students in a class abuse drugs, or absent themselves because of drug abuse, the progress of all the students is impeded. In addition, drug use brings into the school environment illegal practices connected to the drug use, namely prostitution, theft, and selling of drugs to others. None of these practices is conducive to the development of a healthy, productive life (COSAD 2001:8).

Liddle (2004:5) and Gordon (2004:14) list practical ways to fight adolescent substance abuse. Adolescent substance abuse should be addressed by a number of people who play vital roles in the lives of adolescents for example teachers, school counsellors, social workers, psychotherapists, parents, family members and different professional specialties whose contribution will result in the developmental outcome of each teen. Parental involvement in the life of adolescents should demonstrate respect, interest, caring and also knowledge about their world, the world that teens live in today, not the world that teens inhabited some years ago. Finding creative ways to meaningfully engage adolescents, knowing what their interests are, and what healthy activities they enjoy. Finally, Gordon (2004:12) refers to "faith-based addiction treatment", demonstrating faith and trust in God's power, promoting spirituality, respecting others' belief systems, obtaining information about their religious and spiritual belief, not imposing one's own religious or spiritual beliefs, and developing

empathy for their belief system. According to Gordon (ibid 2004:15), the benefits of spirituality include humility; inner strength development; a sense of meaning and purpose to life; a feeling of acceptance; love; tolerance; peace and harmony.

With regard to chemically dependent adolescents, Douglas (2004:6) states that chemicals destroy the body, mind and soul, and the victims come from family backgrounds that are not stable. Furthermore, there is often a history of mental illness in the family, and the parents have marital conflicts as well as many economic and social difficulties. These adolescents have unstable moods and are prone to depression. They have significantly more psychiatric disturbances and can only do well with the aid of intense psychotherapy. Douglas (2004:8) adds that as chemical dependency develops further, these adolescents can no longer trust themselves when using chemicals. The choice to use the drug or not is no longer available to them but they have to use to feel normal. The continued use of chemicals eliminates the ability to think logically and rationally.

According to Walter (2002:3), chemically dependent adolescents gradually change their peer group to include drinking and drug-using friends. They begin to use chemicals to block out pain and for the euphoric effect. Blackouts and drinking alone are strong indicators of chemical dependency in the adolescent population. With the progression of the diseases, family conflicts increase. The adolescent may withdraw from family and community activities. Problems with the police and school officials increase and become serious. The adolescent may become verbally abusive to parents and more rebellious to authority figures.

Physical deterioration begins, hiding and lying about drugs become more common. The adolescent feels more intensely isolated. Concerns begin to be openly expressed by parents, teachers and even peers. According to Walter (2002:4), the adolescent gradually loses all self-esteem and depression begins to set in. Persistent chemical use leads to institutionalisation or death.

2.6 DEALING WITH DRUG ABUSE

As the worldwide infiltration of drug abuse is a concern for many societies, the Global Initiative on Primary Prevention of Substance Abuse came into existence in 1997 (WHO/UN-ODCCP 2003:17). The Global Initiative was a project jointly executed by the United Nations International Drug Control Programme and the World Health Organization aimed at preventing the use of psychoactive substances by young people (WHO/UN-ODCCP 2003:17).

The project was implemented from 1997 to 2003 in three regions of the world where rapid/dramatic social change was in progress: RSA, Southern Asia, and Central and Eastern Europe. The project comprised five sets of interrelated prevention activities based on the mobilisation of local communities, namely

- baseline assessment
- training of local partners
- public health interventions
- monitoring of activities and
- post-intervention assessment.

The evaluation of activities led to the identification of best practices that could be adopted by other communities who wished to address the problem of substance abuse among the youth.

In the RSA it is believed that adhering to healthy child rearing can do much to prevent the development of those stresses that may, in later life, lead to abuse of dangerous substances (De Haan 1997:44).

Family-based programmes to reach families of children at each stage of development have been implemented as well as family programmes to train parents in behaviour skills (WHO 2003:12). These programmes include the

improvement of parent-child relationships including positive reinforcement; listening skills; communication and problem-solving skills; monitoring the activities of children, particularly during adolescence, and the development of consistent discipline and rule making skills

It was also suggested that the dangers associated with smoking should be stressed during health education, and specific protection should involve some control over the advertising of alcohol and exert pressure on all involved in the promotion of these products. Other factors that should be attended to are the promotion of anti-drug social norms and control of the advertising of alcohol (De Haan 1997:44).

Streeton and Whelan (2001:4) report that Zambia has designed programmes that facilitate socio-economic development, especially employment, and implemented measures such as:

- increasing youth educational employment
- increasing substance free recreational opportunities
- mobilizing co-ordination of community groups within existing structures
- educational campaigns for the prevention of substance abuse
- improving the infrastructure to control substance abuse in the adolescent
- increasing opposition to substance use in society
- reducing youth substance use especially among males between the ages 15 and 16 years.

Tanzania initiated strategies to reduce the availability of substances; mobilize communities against substance use; provide peer education to prevent substance use; provide education to enhance adolescent behaviour change;

strengthen existing networks of organizations that support youth-related activities, and engage in substance use prevention activities (WHO 2003:12).

Drug dependence is difficult to control due to compulsive drug use and craving leading to drug seeking and repetitive use even in the face of negative health and social consequences. Once dependent, individuals often fail in their attempts to quit. Dependence is a brain disorder and people with dependence have affected brain structure and function (Ronald & Davis 2004:14).

2.7 CONCLUSION

The literature review indicated that adolescent drug abuse is an ongoing and escalating global health problem. The long-term consequences of drug abuse include impaired psychological functioning, serious criminal involvement, marital problems and divorce, and job instability, which no country can afford to ignore.

This chapter discussed the literature review on adolescent drug abuse, including the extent of the problem internationally and in Swaziland; the drugs mostly abused by adolescents and their adverse effects, and factors that influence drug abuse in adolescents, as well as their effects on the lives of the individuals, families and schools. Finally, measures put in place to deal with the problem were outlined.

Chapter 3 describes the research design and methodology used.

CHAPTER 3

Research design and methodology

3.1 INTRODUCTION

This chapter outlines the research design and methodology. The focus of the study was on the drug abuse problem among adolescents in the Msunduza Township, Mbabane, Swaziland. The respondents were adolescents who abused drugs.

3.2 GEOGRAPHICAL AREA

To understand the research problem more clearly, it is necessary to give some background information of the region in which the study was conducted.

Swaziland is divided into four regions: Hhohho in the north-east with 29%, Manzini with 37%, Lubombo with 22%, and Shiselweni with 26% of the population (Vilakati 2003:45). Total population of Swaziland according to the 1997 census was 980 722 (Vilakati 2003:45). Figure 3.1 presents a map showing Swaziland's borders and figure 3.2 indicates the four regions and their population distribution.

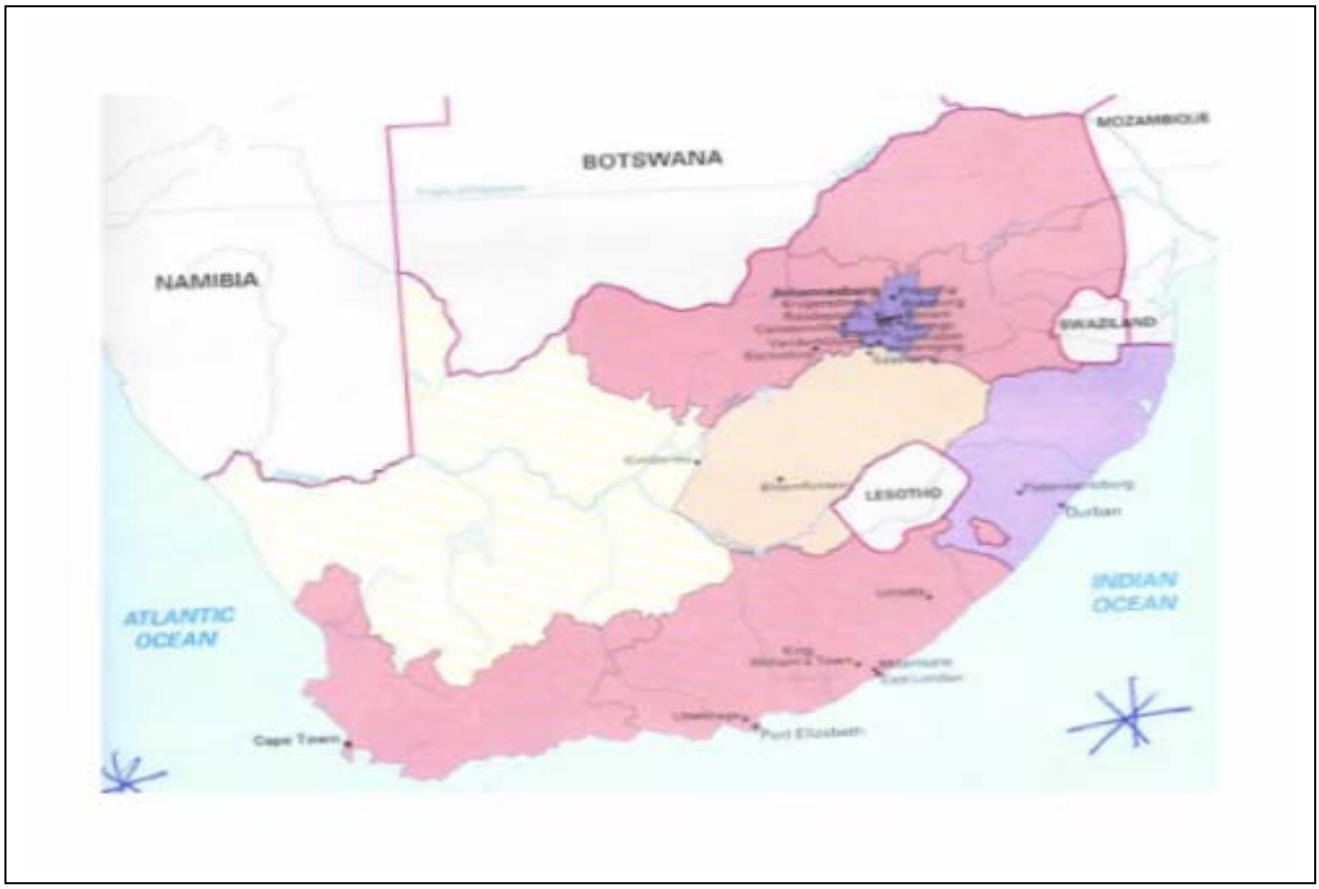


Figure 3.1 Map of South Africa showing borders of Swaziland

Source: Vilakati (2003:45)

The residents of Swaziland are homogenous in their language, culture and tradition. The majority of the inhabitants speak Siswati. Siswati and English are the country's official languages. About 80% of the population live in rural areas and depend on subsistence farming for their livelihood.

Swaziland's urban population is growing fast. People from rural areas migrate mainly to adjacent urban centres. They also migrate to the RSA and other countries to seek employment (Vilakati 2003:44). Not all the people who migrate to urban areas find employment. Many end up on the streets with no place to sleep and no money for food. Some girls become prostitutes to earn a living, men abuse some for money, and many boys and girls resort to drug abuse.

Figure 3.2 Regional population distribution of Swaziland

Source: Vilakati (2003:44)

The best high schools, such as St Michaels, Salesian, and Manzini Nazarene are located in Manzini. The Nazarene Nursing Institution, Nazarene Teacher Training College and University of Swaziland are also in urban areas (Vilakati 2003:44).

The Mhlatane High School, Waterford (KaMhlaba) High School, St Mark's, St Francis, Mater Dolorosa High School as well as the Faculty of Health Sciences of the University of Swaziland are located in the Hhohho region urban areas (Vilakati 2003:44). This is also the region where the biggest adolescent drug abuse problem exists and where this study was conducted.

This study was conducted in the Msunduza Township, the most densely populated township in Mbabane, which is notorious for adolescent delinquent behaviour. This behaviour can be attributed to drug abuse.

3.3 RESEARCH DESIGN

Polit and Hungler (2001:175) define the research design as a'the overall plan for obtaining answers to the questions being studied, and for handling some of the difficulties encountered during the research process".

A quantitative, exploratory descriptive and cross-sectional research design was used in this study to investigate the views and opinions of the families and adolescents about drug abuse. This design was selected because it was flexible and a lot of information could be gathered in the course of the research (Polit et al 2004:302).

3.3.1 Quantitative

According to Burns and Grove (2001:26), quantitative research is "a formal, objective, systematic process in which numerical data are utilised to obtain information about the world".

A quantitative research design was used because this study focused on "a relatively small number of specific concepts, used structured procedures and formal instruments to collect information, collected data under conditions of control and took special precautions to ensure objectivity" (Polit et al 2004:320).

The following characteristics of quantitative research made it suitable for this study:

- The research began with preconceived ideas obtained from the literature and the researcher's experience of the research problem and the interrelatedness of the various concepts.
- The researcher used structured approaches and formal instruments to collect information.

- The researcher collected the information under conditions of control using a copy of the same instruments or each participant during the interview.
- The interview schedule consisted of closed questions and was analysed by computer to ensure objectivity in the collection and analysis of the data.
- The numerical information obtained from the interview was analysed by statistical procedures.
- The researcher collected the data by asking the questions in the interview schedule and wrote down the responses.
- The researcher did not participate in the events under investigation but had to clarify the questions for the respondents and translate the questions into their home language, where necessary.

3.3.2 Cross-sectional

In cross-sectional research data is collected at one point in time (Polit & Hungler 2001:162). This type of research is especially appropriate for describing the status of the phenomenon at a certain fixed point (Polit & Hungler 2001:162). The most important advantage of cross-sectional research is that it is economical and easy to manage. Trends may change over time, which makes it difficult to generalise findings. In this study a phenomenon was studied in a certain context. The opinions and views of adolescents on drug abuse in the Msunduza township, Mbabane, Swaziland were obtained.

3.3.3 Exploratory

An exploratory design is aimed at “investigating the full nature of the phenomenon, the manner in which it is manifested and the other factors with which it is related” (Polit & Hungler 2001:18).

This study was exploratory because it aimed at exploring the knowledge and opinion of adolescents in the Msunduza Township, who abused drugs. Their knowledge and opinions had not yet been explored and documented.

3.3.4 Descriptive

According to Polit and Hungler (2001:196), descriptive research is used “to observe, describe, and document aspects of a situation. The researcher who conducts a descriptive investigation observes, counts, describes and classifies aspects of a situation.”

In this study a descriptive research design was employed to investigate the knowledge and opinions of adolescents about drug abuse.

3.4 RESEARCH POPULATION

A research population is “the entire aggregation of cases in which a researcher is interested” (Polit et al 2004:289). Burns and Grove (2001:226) define a research population as “the entire set or total group of persons or subjects that meet the sampling criteria”.

The population for this study comprised 115 to120 adolescents who abused drugs in the Msunduza Township, Mbabane, Swaziland.

3.5 SAMPLING

As it is impossible in any research to study the whole research population, a sample is always drawn which includes the attributes of the research population. Sampling involves selecting “a group of people, a subset of the research population, events, behaviours, or other elements with which to conduct a study” (Burns & Grove 2001:226).

3.5.1 The Sample

A sample is the “subset of cases drawn from the target or accessible research population” (Burns & Grove 2001:226). The researcher employed non-probability, snowball sampling in this study. In snowball sampling, early sample members were identified by the researcher as she judged that they would be suitable to include in the study because of their attributes and were interviewed. These early sample members were then asked to

refer the researcher to other respondents who they knew had the same attributes and were therefore eligible for the study. This sampling method was used as adolescents who abuse drugs are usually very secretive about their abuse and it would be difficult to find enough respondents for a valid and reliable study unless the respondents referred the researcher to other adolescents. The adolescents who abuse drugs usually know of others who also abuse drugs, and their parents could also refer the researcher to other families who have been affected by this problem (Polit & Hungler 2001:180; Polit et al 2004:291). The researcher therefore used her knowledge of the phenomenon to select the first few respondents for the study, in the belief that they would be able to provide answers to the research questions.

After interviewing the first few respondents who were fluent in answering the research questions, the researcher then moved on to contacting the individuals named by the group, and interviewed them until 60 respondents had been obtained in this way.

3.5.2 Sample size

According to Brink (1996:142-144), in quantitative research the number of respondents included in the sample is important as the bigger the sample, the better. Factors to be considered when determining the sample size, include the precision of the data-collection instrument (the less precise tool, the larger the sample needed) and the heterogeneity of the population. As the number of demographical variables increase, so must the sample size (Polit et al 2001:244).
In this study, the sample size was ultimately 60 respondents.

3.5.3 Eligibility criteria

Sampling criteria are “the characteristics essential for inclusion in the target population such as age limit. The researcher therefore decides what attributes members of the research population should have to be considered for inclusion in the sample” (Burns & Grove 2001:226).

To be included in this study, the respondents had to be

- adolescents between the ages of 13 and 21 years who abused drugs
- willing to take part in the research
- residents of Msunduza Township, Mbabane, Swaziland.

3.6 DATA COLLECTION

Data collection is “the precise systematic gathering of information relevant to the research purpose” (Burns & Grove 2001:44). In quantitative research a researcher moves from the beginning point of a study to the end point in a logical sequence of predetermined steps that are similar across studies, that means from the posing of a questions to the obtaining of an answer (Polit et al 2001:263).

According to Brink and Wood (1998:146), data collection depends on several factors. Firstly it depends on the level of the research question or, how much is known about the variable. Secondly, it depends on whether the researcher intends measuring relationships. Thirdly, it depends on whether the researcher intends to control the situation.

For this study, an interview schedule was developed to collect data regarding views and opinions of adolescents about drug abuse.

Brink and Wood (1998:157) describe a structured interview schedule as a “self-report form in which pre-specified questions are presented to all respondents in exactly the same order using the same wording. Such standardisations enable the researcher to compare the responses.”

For this study, interview schedule consisted of pre-developed items to which respondents indicated their responses and the researcher then marked the appropriate options.

3.6.1 The interview

An interview is a method of data collection in which one person (the interviewer) asks questions to another (the interviewee or respondent), interviews are conducted either face-to-face or by telephone (Polit & Hungler 2001:649).

The researcher went to the homes of the members of the initial sample in the Msunduza Township, and explained the nature and purpose of the study and their rights. The respondents were informed that participation was voluntary and those who were willing to take part in the study were asked to sign an informed consent form (see Annexure B). The researcher and the adolescent then arranged a suitable date for the interview.

On the specified day a suitable place in the home of the participant was identified and measures were taken with the cooperation of the members of the family to ensure privacy and that the respondents and the researcher were not disturbed in any way. The family provided jug with cold water and glasses for use during the interview, if necessary.

The interviewees were again reminded of their rights and assured that they could withdraw from the study at any time. The respondents then signed the informed consent. After completion of the interview the researcher thanked the respondents for their cooperation, and asked them for names of other possible respondents. This process was repeated until 60 interviews had been conducted.

The instrument used during the interview was a pre-planned, compiled structured interview schedule (see annexure C). Polit and Hungler (2001:205) list the following advantages of interviews:

- Closed questions in an interview schedule are easy to code and analyse by computer, but have the disadvantage of being too restricting.
- The interview method of data collection ensures that fewer items are left unanswered.

- The interview method is flexible and allows the researcher to explain and clarify items, if necessary. This, in turn, ensures a better return of the research instrument, and therefore more reliable data.

During the pre-testing of the instrument the researcher tried to expand on the choice provided in the closed questions to allow the respondents more freedom in answering during the interview (Polit & Hungler 2001:334).

The biggest disadvantage of the interview data-collecting method was that the researcher personally had to conduct all the interviews due to the sensitive nature of the problem. To avoid bias, the researcher did not make use of other interviewers and adhered as closely as possibly to the questions included in the interview schedule. The researcher decided not to make use of other researchers to help with the data collection as the researcher is a well-known member of the community of the Msunduza Township and was trusted by the community. However, this made the process very time consuming (Polit & Hungler 2001:205).

3.6.2 Format of the interview schedule

The interview schedule was the research instrument used in face-to-face contact with the respondents and consisted of the following five sections:

Section A: Biographical information (e g, age, gender, level of schooling)
Section B: Respondents' views on the extent of the drug abuse problem in the Msunduza Township, Mbabane, Swaziland
Section C: Respondents' knowledge of drugs and drug abuse
Section D: Information about the respondents' drug abuse problem
Section E: Respondents' views on the on prevention and control of the drug problem.
Section F: Respondents' views on the effectiveness of the available resources to treat adolescents with a drug problem.

3.6.3 Pre-testing

Pre-testing involves “determining the feasibility of using a given instrument in a formal study. It provides an opportunity to try out the technique or instructions that will be used with an instrument especially if it has never been used with a specific sample” (Brink & Wood 1998:259).

In this study the researcher pre-tested the study instrument by interviewing two adolescents who were not part of the study. Burns and Grove (2001:367) state that the interview schedule is tested to

- determine any weakness in the organisation and administration of the interview schedule
- enable the researcher to make any improvements and corrections before embarking on the actual data collection.
- ascertain the clarity and reduce any ambiguity in the working of the questions
- establish the instrument’s content validity.

After the pre-test, the researcher altered and corrected the instrument for clarification before commencing the main study.

3.7 VALIDITY AND RELIABILITY

Validity refers to “the degree to which an instrument measures what it is intended to measure” (Polit et al 2004:733).

Reliability refers to “the degree of consistency with which the instrument measures the attributes it is designed to measure” (Polit et al 2004:730). Validity and reliability of an instrument are not totally independent qualities. A measuring instrument, such as the interview schedule used in this study, cannot be valid unless it is reliable.

Making use of the test-retest method could not test the reliability of the research instrument, as the previous testing would have influenced the respondents. Objective measuring by asking the same questions to all the respondents ensured the reliability of the research instrument.

Moreover, the interview schedule together with chapters 1,2 and 3 were submitted to the Ethics Committee of the Department of Health Studies for approval.

3.8 ETHICAL CONSIDERATIONS

The researcher observed the following ethical considerations: obtaining permission to conduct the study and collect data; respecting the respondents' rights to self-determination, privacy, confidentiality and anonymity, fair treatment, and protection from discomfort and harm; and obtaining informed consent.

3.8.1 Permission to collect data

For this study, permission to collect data was sought from the Principal Secretary of the Ministry of Health and Social Welfare (see Annexure A). Written consent was obtained from the respondents (see Annexure B).

3.8.2 Right to self-determination

The right to self-determination "is based on the principle of respect for persons, and indicates that humans are capable of controlling their own destiny" (Burns & Grove 2001:160).

The researcher therefore treated the respondents as "autonomous agents" who had the freedom to conduct their lives as they chose without external controls. Accordingly, the respondents were

- informed about the purp9ose and significance of the study
- allowed to choose voluntarily to participate or not in this study
- allowed to withdraw from the study without fear of any penalty.

Furthermore, no coercion or deception was practised in the research as all respondents were fully informed Information was given to respondents in English or siSwati, depending on the preferred language, as some family members were illiterate.

3.8.3 Right to privacy

Privacy is “the freedom an individual has to determine the time extent, and general circumstances under which private information will be shared with or withheld from others” (Burns & Grove 2001:163).

In this study, the respondents privacy was protected in that they were informed that data gathered would only be shared with those involved in the research.

3.8.4 Right to confidentiality and anonymity

Confidentiality is “the management of private information shared by a subject” (Burns & Grove 2001:164). Anonymity is the right to “assume that the data collected will be kept confidential” (Burns & Grove 2001:166).

In this study, the researcher assured and maintained the respondents’ anonymity and confidentiality by the fact that no names appeared on the interview schedule.

3.8.5 Right to fair treatment

The right to fair treatment is “based on the principle of justice that states that people should be fairly treated and should receive what is due to them or owned by them” (Burns & Grove 2001:167).

The researcher ensured fair treatment by treating the respondents fairly and sensitively and her regard for any harm or discomfort that they might experience.

3.8.6 Right to protection from discomfort and harm

This right is based on “the ethical principle of beneficence, which states that one should do good and above all do no harm” (Burns & Grove 2001:167). The researcher assured the respondents that no harm would come to them and was alert to any discomfort, whether emotional, physical or psychological, they might experience.

3.8.7 Informed consent

Informed consent is “the prospective respondents’ agreement to participate in the study as subjects. Informing is the transmission of essential ideas and content from the researcher to the prospective respondents” (Burns & Grove 2001:168).

Te researcher allowed every prospective respondent an opportunity to choose whether to participate or not. The researcher explained the aim, purpose and duration of the study, the type of participation expected, how the results would be published, how confidentiality, and anonymity and privacy would be ensured. Then the researcher informed the respondents who she was and her qualifications, and who the supervisor was.

3.8.8 Research benefits

The respondents were informed that they would receive no monetary benefits from the study.

3.9 CONCLUSION

This chapter described the research design and methodology, including the geographical area of the study, population, data-collection instrument and ethical considerations. A quantitative approach was used to guide the study.

Chapter 4 presents the data analysis and findings of the study.

CHAPTER 4

Data analysis and findings

4.1 INTRODUCTION

The research design, methodology and data collection were dealt with in Chapter 3. This chapter discusses the data analysis and findings with reference to the literature reviewed.

The interview schedule used for data collection comprised five sections. Section A covered the respondents' biographic data; section B covered the extent of the drug abuse problems in Msunduza Township; section C examined the respondents' knowledge; section D collected data on the respondents' drug use; section E dealt with the respondents' views on the prevention and control of the drug problem, and section F covered their views on the effectiveness of the treatment.

4.2 RESEARCH OBJECTIVES

The objectives formed the framework of the study and were to

- explore and describe the knowledge and opinions of the respondents who abuse addictive substances.
- Make recommendations to control the drug abuse problem among respondents at Msunduza township of Mbabane, Swaziland.
- Make recommendations for further research.

4.3 DATA ANALYSIS AND FINDINGS

The researcher used frequency distributions to organize and analyse the data and presented the categorical variables by means of tables. The tables reflected

the numerical values obtained for a particular value as well as the percentage of the sample.

4.3.1 Section A: Respondents' biographical data

The biographical information provided background knowledge of the sample. The respondents comprised 60 adolescents, of whom 60,0% (n=36) were females and 40,0% (n=24) were males.

- **Item 1: Age (n=60)**

The respondents were asked to indicate their age. Table 4.1 represents the respondents' ages.

Table 4.1 Respondents' age (n=60)

Age in years	Number of respondents	Percentage %
16 years	3	5,0%
17 years	18	30,0%
18 years	14	23,3%
19 years	6	10,0%
20 years	7	11,7%
21 years	12	20,0%
TOTAL	60	100,0%

Of the respondents, 33,0% (n=18) were 17; 23,3% (n=14) were 18; 20,0% (n=12) were 21 and 5,0% (n=3) were 16.

The age of 17 is a prime and critical period for a high school student who is faced with a heavy academic workload, which needs strong commitment to cope with the situation.

In his study on drug use in secondary schools, Modzeleki (2000:10) reported that 20% of teens aged 12 to 17 years in Namibia fail to go to tertiary institutions due to drug abuse.

- **Item 2: Gender (n=60)**

The respondents' gender is depicted in Figure 4.1.

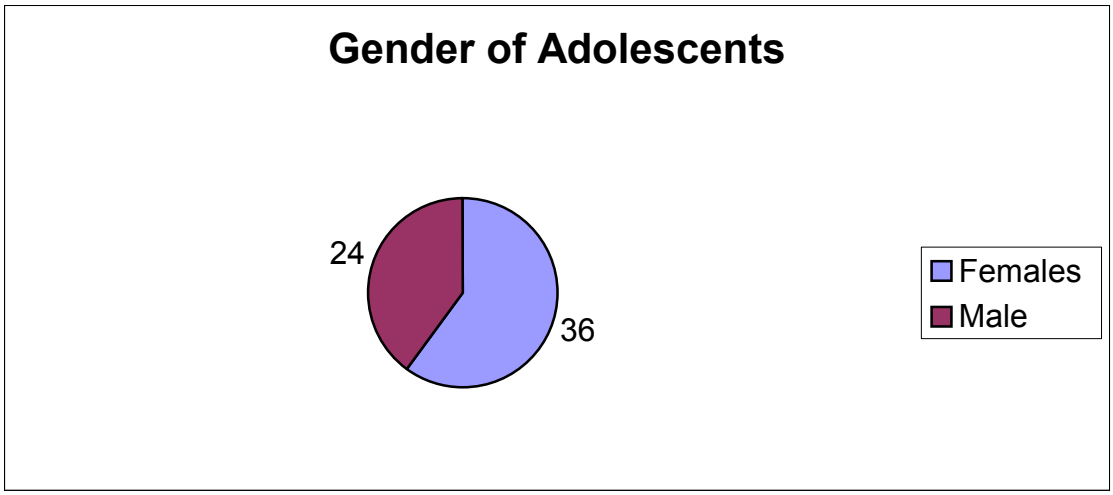


Figure 4.1 Respondents' gender (n=60)

Of the respondents, 60,0% (n=36) were females and 40,0%(n=24) were males. The findings indicate that the large percentage (60%) of females may be a marker for potential teenage pregnancies which contribute to the high morbidity and mortality rates related to high prevalence of HIV/AIDS in Swaziland.

Orford (2001:20) found that a high percentage of high school students in most countries are females who did not finish their high school education due to teenage pregnancies and HIV/AIDS problems.

- **Item 3: Level of education (n=60)**

The respondents were asked to indicate their level of education (see figure 4.2).

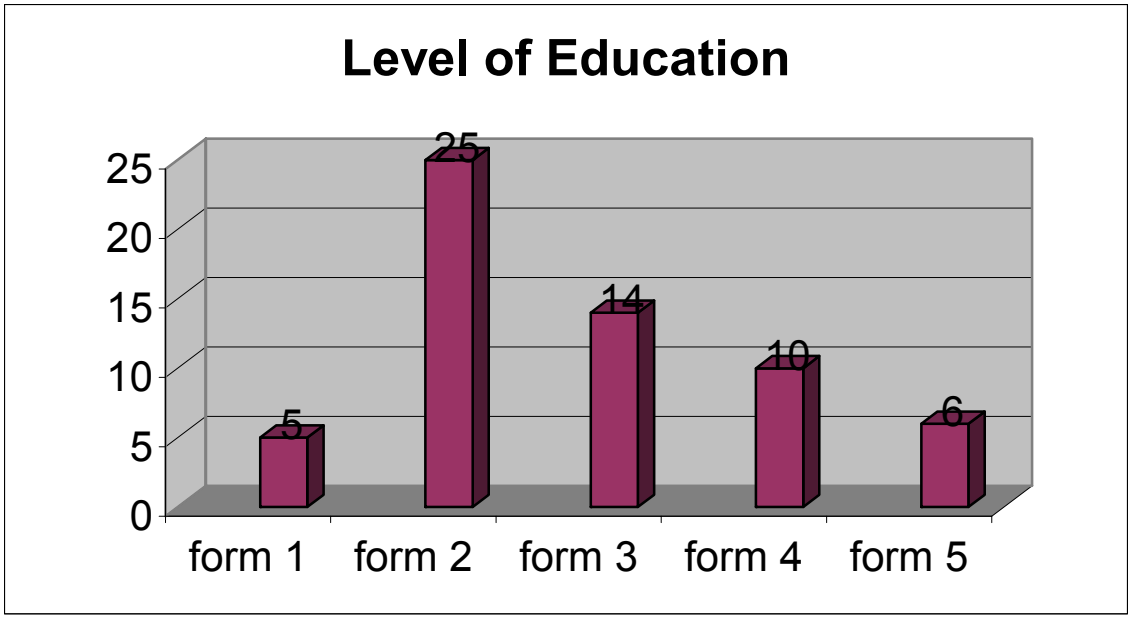


Figure 4.2 Respondents' level of education

Figure 4.2 indicates that of the respondents, 41,65% (n=25) were in form 2; 23,3% (n=14) were in form 3; 16,6% (n=10) were in form 4; 10,0% (n=6) were in form 5, and 8,3% (n=5) were in form 1.

The implication of the above study findings is that the higher the learner's level of education, the more responsible he/she should become in life. In a study on alcoholism in high schools, Baddy (2002:10) found that "children experiment drug use as early as primary school level in preparation for using hard drugs in high schools". Baddy (2002:10) adds that some students realize the consequences of drug use as they progress in high school, and ultimately withdraw and become responsible in life.

- **Item 4: Guardians directly responsible for the respondents (n=60)**

This item required the respondents to indicate whom their guardians were (see figure 4.3).

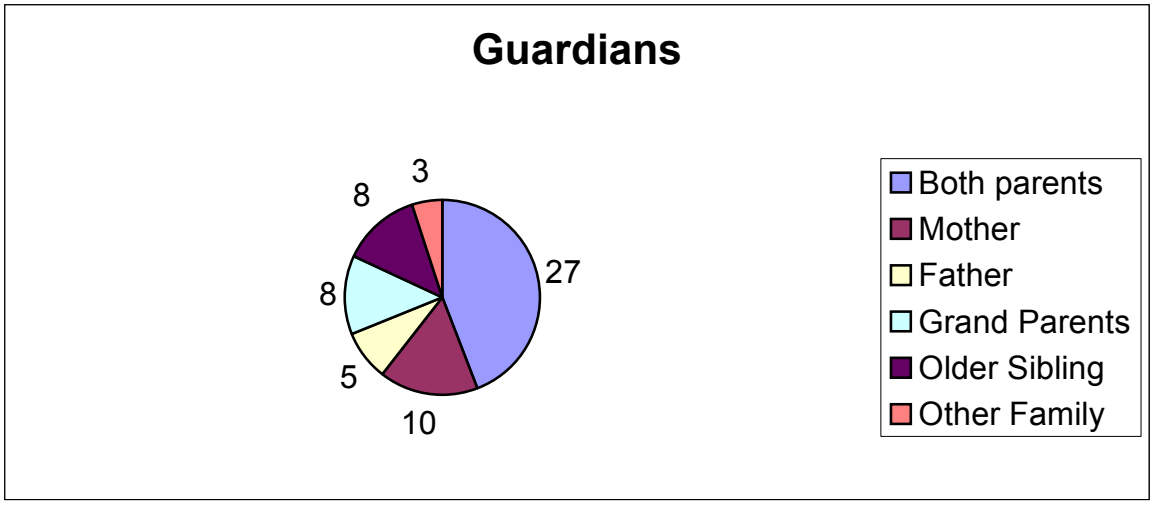


Figure 4.3 Guardians directly responsible for respondents

Figure 4.3 indicates that of the respondents, 45,0% (n=27) were under the guardianship of both parents; 16,7% (n=10) were under the guardianship of the mother; 13,33% (n=8) were under their grandparents; 13,33% (n=8) had older siblings who were directly responsible; 8,33% (n=5) were under their father's guardianship, and 3,33% (n=2) were under the guardianship of other family members.

The large number of respondents under the guardianship of both parents indicated irresponsible and ignorant parents in terms of child upbringing. Hancock (2004:4) found that "most parents do not realize the multiple drugs that kids have experimented with or that some teens may have a drug problem until it is too late".

Item 5: Other individuals staying in the same house with the respondents (n=60)

This item required the respondents to specify how many other individuals stay in the same house (see figure 4.4).

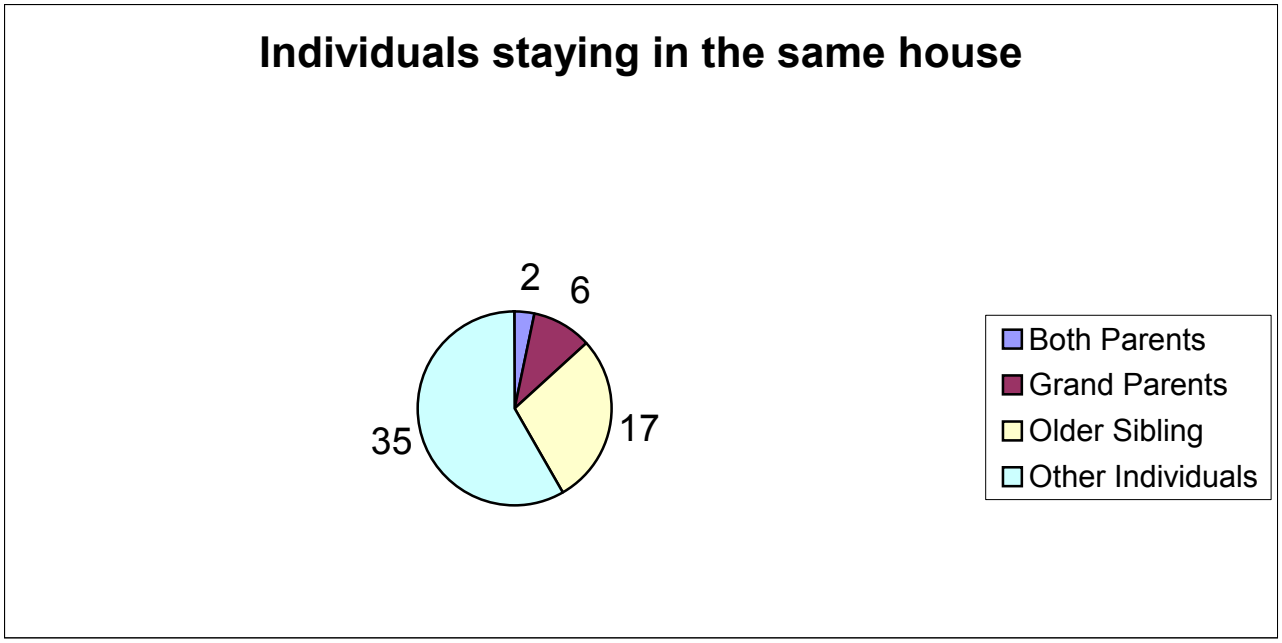


Figure 4.4 Individuals staying in same house (n = 60)

Of the respondents, only 3,3% (n=2) shared the household with both parents;
10,0% (n=6) shared the household with grandparents;
28,3% (n=17) shared the household with an older sibling, and
58,3% (n=35) shared the household with other individuals.

Figure 4.4 indicates that in most cases the household was also shared with other family members besides parents. Factors like lack of intimacy that both parents would have; overcrowding; lack of privacy; lack of recreation and communication with parents; problems with discipline, and clashes due to age difference could all lead them to go out to the streets where they interacted with others who abused drugs.

4.3.2 Section B: Extent of the drug abuse problem in Msunduza Township

In this section, the extent of the drug abuse in the Msunduza Township in Swaziland was investigated.

- **Item 6: Extent of the drug abuse problem in Msunduza = (n=60)**

This item tested the respondents' opinions on what they perceived as the extent of the drug problem in Msunduza Township.

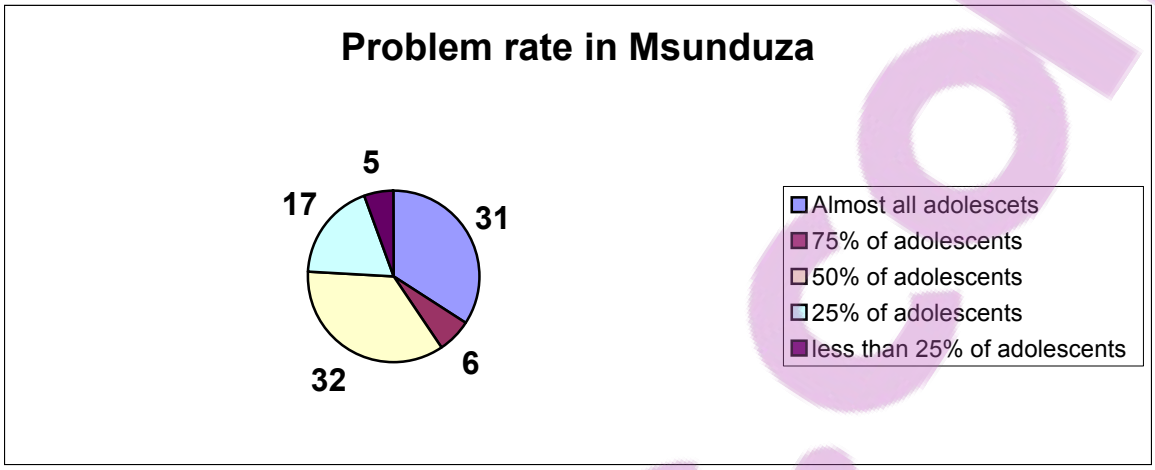


Figure 4.5 Respondents' opinion on the extent of the drug abuse problem in Msunduza (n=60)

Of the respondents, 51,7% (n=31) indicated that they were of the opinion that about 50% of the adolescents in the Msunduza township abused drugs; 28,33% (n=17) indicated that about 25% abused drugs; 10,0% (n=6) indicated that drug abuse was a very serious problem in the township as they felt that 75% of all the adolescents abused drugs; 8,3% (n=5) indicated that less than 25% abused drugs, and 1,7% (n=1) felt that almost all the adolescents abused drugs.

The study findings reveal that all the respondents indicated that there was, indeed, a drug abuse problem in Msunduza Township. In her study on adolescents' drug abuse and parental intervention, Mercy (2003:6) found that "almost 25%-50% of the 12 to17 year-old respondents have used drugs in the USA". Mercy (2003:6) states further that these findings related to the flexible parents' attitudes towards their children's life styles.

- **Item 7: Factors causing respondents' drug abuse (n=60)**

The respondents were asked to identify the factors that caused their own drug abuse. More than one item could have been chosen. Table 4.2 depicts the factors causing the respondents' drug problem.

Table 4.2 Factors causing respondents' drug abuse (n=60)

Factors causing respondents'drug abuse	Number of respondents	Percentage (%)
Boredom	8	13,3%
Curiosity	10	16,7%
Peer pressure	12	20,0%
Relationships at home	10	16,7%
Escape problems at home	8	13,3%
Escape problems at school	5	8,3%
Poverty	2	3,3%
Physical abuse	2	3,3
No cause	3	5,0%
TOTAL	60	100,0%

Of the respondents, 20,0% (n=12) indicated that drug abuse was caused by peer pressure; 16,7% (n=10) indicated curiosity; 16,7% (n=10) indicated poor relationships at home, 3,3% (n=2) indicated poverty or physical abuse, and 5,0% (n=3) indicated no cause.

The study result indicated that more than any other causes of respondents drug abuse curiosity, boredom, peer pressure, to escape problems at home and poor relationship at home seem to be the major causes.

Stephen (2003:24) states that some parents think that "children might have been pressured into taking drugs by peers or drug dealers, but children say they choose to use drugs because they want to relieve boredom, feel good, forget their troubles and relax, have fun, satisfy their curiosity, take risks, ease their pains, feel grown-up, show their independence, belong to a specific group or look cool".

4.3.3 Section C: Respondents' knowledge on drugs

In this section, the adolescents who participated in this study were asked about their knowledge on the drugs being abused.

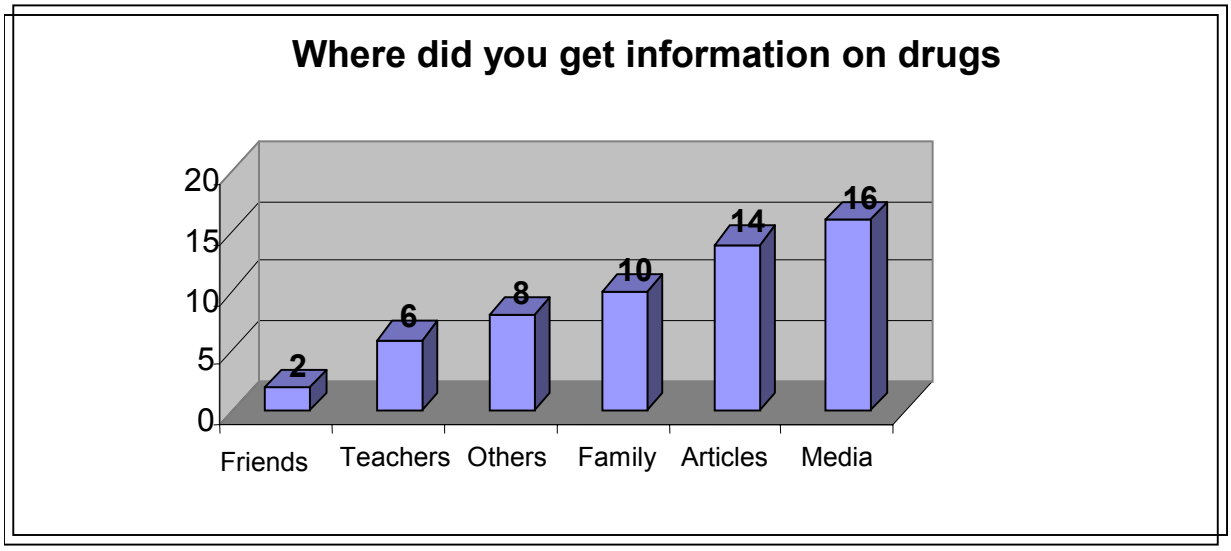
- **Item 8: What type of information about drug obtained (n=60)**

The respondents were asked what type of information related to drug use they had (see table 4.3).

Table 4.3 Knowledge of respondents on drug use

Aspects	Number of respondents	Percentage %
Smoking of cigarettes is addictive	10	16,7%
The regular use of alcohol may lead to addiction	8	13,3%
All drugs are addictive	2	3,3%
It is illegal to possess drugs	4	6,7%
It is illegal to sell drugs	4	6,7%
It is illegal to use drugs	10	16,7%
It is almost impossible to be rehabilitated from drug abuse	2	3,3%
The dangers of the various types of drugs	8	13,3%
How drugs are administered	10	16,7%
How to say "no" to drug use	2	3,3%
TOTAL	60	100,0%

Of the respondents, 16,7% (n=10) knew that smoking cigarettes is addictive; 13,3% (n=8) knew that the regular use of alcohol may lead to alcohol addiction; 3,3% (n=2) indicated that they were told that all drugs are addictive; 6,7% (n=4) knew that it is illegal to possess drugs; 6,7% (n=4) knew that it is illegal to sell drugs; 16,7% (n=10) indicated that it is illegal to use drugs, and only 3,3% (n=2) indicated that they were informed that it is almost impossible to be rehabilitated from drug abuse. It was noted that of the respondents, 16,7% (n=10) knew how



to administer drugs and only 3,3% (n=2) knew how to say "no" to drugs when offered to them.

The results indicated that only a quarter of the respondents knew enough about drugs and the legality governing their usage. It is imperative therefore to talk about drugs to adolescents at large. Everybody concerned about the adolescents' lives such as parents, teachers, health workers and social workers should do such communication.

With regard to the legality of being in possession of, using, and selling drugs, the responses indicated that with constant law re-enforcement against drug use and regular health education by health-care givers drug abuse in Msunduza Township can be controlled.

Item 9: Source of information on drugs (n=60)

The respondents had to indicate where they got their information about drugs (see figure 4.6).

With regard to their source of information on drugs, of the respondents, 26,7%(n=16) indicated the media; 23,3% (n=14) indicated articles; 10,0% (n=6) indicated teachers; 13,3% (n=8) indicated "Other" sources not listed; 16,7% (n=10) indicated family, and only 3,3% (n=2) indicated friends.

The fact that most of the respondents (26,7%) received information from the media poses a challenge to parents, teachers, and health professionals to communicate all the facts about drugs, including the dangers involved, to media offices before they publish or broadcast it.

Glusson and Harper (2005:5) state that most people start drug abuse while still very young and peer pressure, family problems, and most of all the media are to blame for this. The media makes some poisonous and harmful things seem good to use like cigarette smoking.

Stephen (2003:24) points out, however, that the media “can raise public awareness about a community drug problem and also reveal ways to prevent drug abuse among specific groups".

4.3.4 Section D: Respondents’ drug abuse

In this section, the respondents drug abuse were investigated.

- **Item 10: Statement relevant to respondent on the smoking of cigarettes (=60)**

In this item respondents were required to indicate statements relevant to them about cigarette usage. The respondents could choose more than one statement of the list provided (see table 4.11).

The first percentage in the last column in bold and brackets portrays the findings of the smokers only (n=33), while the second percentage is calculated out of the total number of respondents (n=60).

Table 4.4 Statements on cigarette smoking (n=33 and n=60)

Statements relevant to respondents	Number of respondents	Percentage %
I have never smoked cigarettes	27	45,0%
I stopped smoking cigarettes	0	0,0%
I only smoke cigarettes on occasion	4	**(12,1%)**
I smoke less than 20 a day	10	**(30,3%)**
I smoke between 21 and 30 a day	4	**(12,1%)**
I smoke between 31 and 40 a day	3	**(9,1%)**
I smoke more than 40 a day	12	**(36,4%)**
My family does not know about me smoking	11	**(33,3%)**
My family does not mind me smoking	3	**(9,1%)** 5,0%
Almost all my friends smoke	24	40,0%
Almost all my family smoke	4	6,7%
I am addicted to cigarettes	12	20,0%
Smoking is not healthy	55	91,7%
Smoking is accepted by society	7	11,7%%
I need to smoke to be accepted by my peers	18	30,0%

Of the respondents, 45,0% (n=27) indicated that they had never smoked cigarettes therefore 33 of the respondents were smokers, but none of the smokers had since stopped.

Of the smokers, only 12,1% (n=4) indicated that they were occasional smokers and only smoked when cigarettes were available; 30,3% (n=10) smoked less than 20 cigarettes per day; 12,1 (n=4) smoked between 21 and 30 cigarettes per day; 9,1 (n=3) smoked between 31 and 40, and 36,4%(n=12) could be considered very heavy smokers as they smoked more than 40 cigarettes per day.

All the respondents admitted that they were addicted to cigarettes.

Of the respondents, 40,0% (n=24) indicated that almost all their friends smoked; 30,0% (n=18) indicated that they needed to smoke to fit in with their peer group, and 6,7% (n=4) indicated that their families smoked. Of the smokers, 33,3% (n=11) indicated that their families were not aware that they smoked and 5,0% (n=3) of the whole group indicated that their parents would not mind if they

smoked. This correlated with the fact that 6,7% of the respondents' parents were smokers themselves.

Although smoking is generally accepted by modern society, only 11,7% (n=7) of the respondents confirmed this. This could be due to the fact that the community to which they belong to are still very traditional and do not like their children to smoke cigarettes.

Mercy (2003:6) states that many adolescents practise risk-taking behaviours as they are trying to find their own identity and independence. The characteristics of adolescence and peer pressure make them more vulnerable to experimenting with various activities that might be detrimental to their health and future prospects, including sex, cigarette smoking, alcohol use and abuse, or becoming addicted to drugs.

- **Item 11: Age when started smoking cigarettes (n=60)**

Here the respondents were required to reveal the age when they started smoking cigarettes (see figure 4.7).

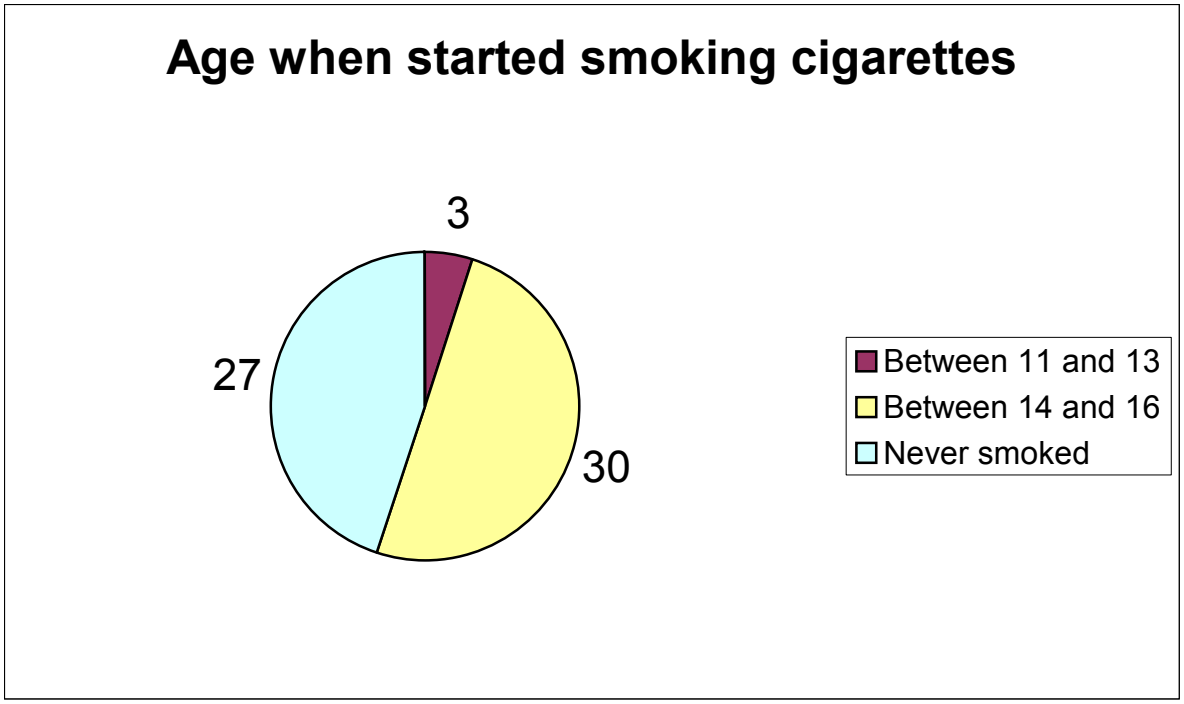


Figure 4.7 Age when respondents started smoking cigarettes (n=60)

Of the respondents, 50,0% (n=30) indicated that they had started smoking cigarettes between the ages of 14 and 16 years; 5,0% (n=3) had started to smoke between the ages 11 and 13 years, and 45,0% (27) had never smoked.

- **Item 12: Who offered the respondent the first cigarette? (n=33)**

Here the respondents were required to reveal who offered them cigarettes for the first time (see figure 4.8).

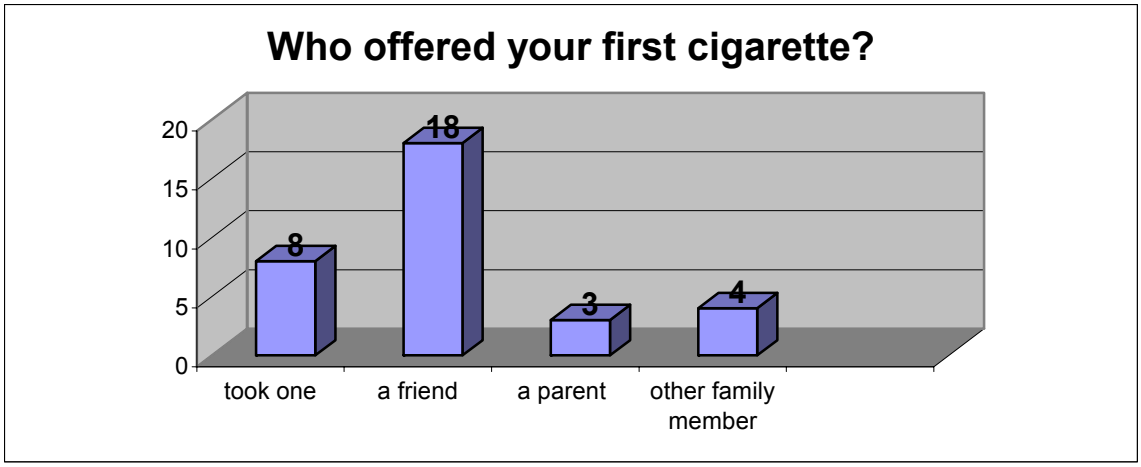


Figure 4.8 Who offered the first cigarette (n=33)

Of the smokers, 54,5%(n=18) indicated that **a friend** offered them the first cigarette; 24,2%(n=8) took the first one **themselves**; 12,1% (n=4) indicated that other **family members** offered them their first cigarette, and 9,1% (n=3) indicated that **a parent** offered it to them.

Glusson and Harper (2005:14) emphasise that it is very important to communicate with children to help them minimise their susceptibility to the influences of negative peer pressure and prevent them from picking up bad habits, including drug use. Parent and family members should set a good example by not smoking themselves or at least not offering children cigarettes.

- **Item 13: Age when started using alcohol n=60**

This item required the respondents to state the age when they started using alcohol (see figure 4.9).

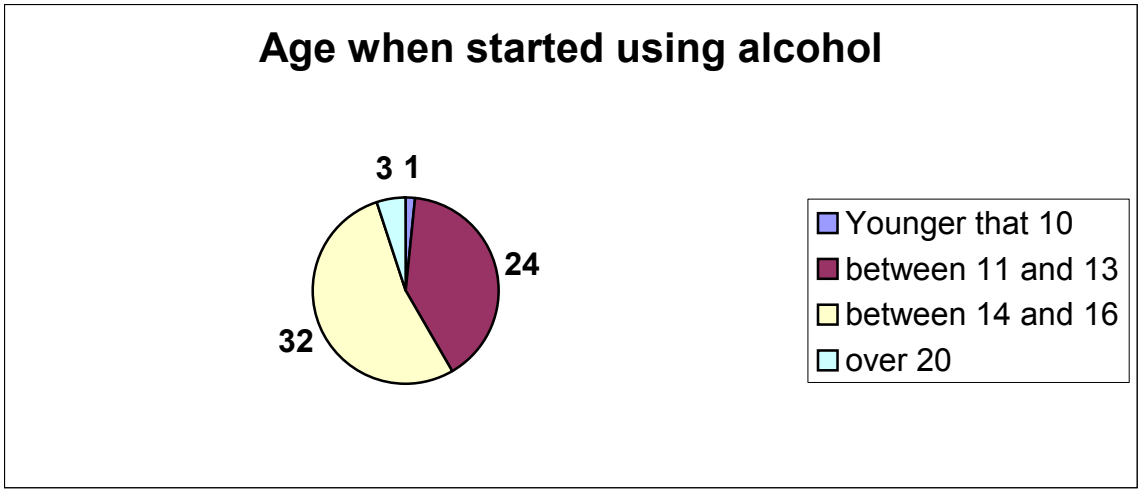


Figure 4.9 Age when started using alcohol (n=60)

Of the respondents, 53,3% (n=32) started using alcohol between the ages of 14 and 16; 40,0% (n=24) started between 11 and 13 years; 5,0% (n=3) started when they were older than 20 years, and 1,7% (n=1) started at younger than 10 years.

Since drug abuse which usually starts with the use of cigarettes and alcohol is prevalent throughout the adolescent stage, information should be provided to all stakeholders to prevent even cigarette smoking amongst adolescents.

- **Item 14 Statements on respondents' alcohol use (n=60)**

Here the respondents were asked to choose any number of statements applicable to their alcohol use/abuse (see table 4.12).

Table 4.5 Statements on the respondents' use/abuse of alcohol (n=60)

Statements	Number of respondents	Percentage %
I never drink alcohol	0	0,0%
I stopped using alcohol	0	0,0%
I drink alcohol only on special occasions	5	8,3%

I drink alcohol every day	10	16,7%
I drink alcohol 2 to 4 times a week	40	66,7%
I drink alcohol only a few times a month	5	8,3%
Alcohol is bad for your health	20	33,3%
My family does not know that I drink alcohol	14	23,3%
My family does not mind me drinking alcohol	5	8,3%
I am addicted to alcohol	5	8,3%
Almost all my friends drink alcohol	28	46,7%
Almost all my family members drink alcohol regularly	5	8,3%
One cannot become addicted to alcohol	14	23,3%
There is always alcohol at parties	55	91,7%
Drinking alcohol is accepted by society	8	13,3%
I will not be accepted by my friends if I do not drink alcohol	17	

- **Item 14: Who offered the respondents alcohol the first time? (n=60)**

This item required respondents to state who offered them alcohol for the first time (see figure 4.10).

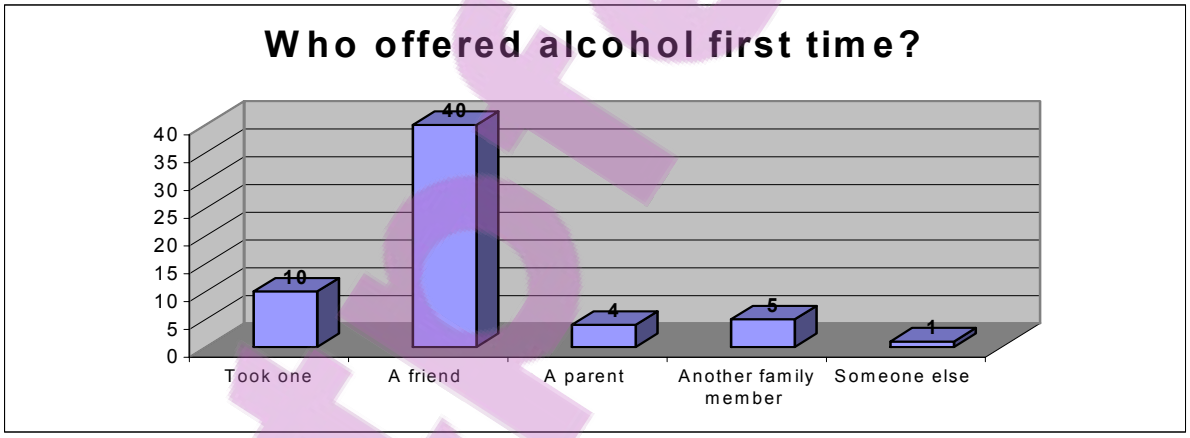


Figure 4.10 Who offered the respondent alcohol for the first time

Of the respondents, 66,7% (n=40) were offered alcohol for the first time by a friend; 16,7% (n=10) took alcohol themselves; 6,7% (n=4) were offered alcohol by a parent; 8,3% (n=5) were offered alcohol by a family member and only 1,7% (n=1) was offered alcohol by someone not mentioned in the interview schedule.

- **Item 15: Statements applicable to the respondents' use of cannabis (n=60)**

In this item respondents were required to indicate which of the statements on cannabis use listed in the interview schedule were applicable to their situation. The respondents could choose more than one statement (see table 4.12).

Table 4.6 Statements about respondents' cannabis use (n=60)

Statements	Number of respondents	Percentage %
I have never smoked cannabis	30	50,0%
I stopped smoking cannabis	2	3,3%
I only smoke cannabis on occasion	1	**(3,3%)**
I smoke cannabis less than 4 times a month	2	**(6,7%)**
I smoke cannabis every day	20	**(66,7%)**
I smoke cannabis 2 to 4 times a week	1	**(3,3%)**
I do not smoke cannabis more than once a week	3	**(10,0%)**
I smoke cannabis once a month	1	**(3,3%)**
My family does not know that I smoke cannabis	14	**(46,7%)**
My family does not mind me smoking cannabis	5	**(16,6%)**
I am addicted to cannabis	5	**(16,6%)**
Almost all my friends smoke cannabis	18	30,0%
Almost all my family members smoke cannabis	5	8,3%
One cannot become addicted to cannabis	4	6,6%
Smoking of cannabis is not good for your health	55	91,7%
Smoking of cannabis is accepted by society	2	3,3%
I will not be accepted in certain peer groups if I do not smoke cannabis	17	28,3%

The percentages indicated in bold and in brackets in the last column were calculated out of 30, which is the number of respondents who indicated that they smoked cannabis. The other percentages are the opinions of the whole sample (n=60).

From table 4.12 it is clear that half of the respondents smoked cannabis, and that 66,7% (n=20) smoked it every day. The two respondents, who had stopped

smoking cannabis, indicated that they used to smoke cannabis less than four times a month.

Of the respondents, 30,0% (n=18) indicated that their friends smoked cannabis; 28,7% (n=17) believed that they would not be accepted in the peer group if they did not smoke cannabis; 46,7% (n=14) indicated that their families did not know they smoked cannabis while 16,6% (n=5) indicated that their families did not know that they smoked cigarettes. Cigarette smoking would possibly be more acceptable to families than cannabis. Of the respondents, 91,0% (n=55**)** indicated that smoking of cannabis is not good for ones health, while their families would not mind if they knew they smoked cigarettes and 16,6% (n=5) indicated that their families would not mind if they smoked cannabis.

More families smoked cannabis (8,7%) than cigarettes (6,7%) according to the respondents. Of the respondents, only 6,7% (n=4) believed that cannabis was not addictive, and 3,3% (n=2) believed that the use of cannabis was accepted by society.

- **Item 16: Age at which the smoking of cannabis started (n=60)**

The respondents were asked to state the age at which they started smoking cannabis (see table 4.4).

Table 4.7 Age at which the smoking of cannabis commenced (n=60)

Age when started smoking cannabis	Number of respondents	Percentage
Younger than 10	1	1,7%
Between 11 and 13	10	16,7%
Between 14 and 16	30	50,0%
Between 17 and 19	15	25,0%
Over 20	4	6,7%
TOTAL	60	100,0%

Of the respondents, 50,0% (n=30) started smoking cannabis between the ages of 14 and 16; 25,0% (n=15) started between the ages of 17 and 19 years of age; only 1,7% (n=1) started at younger than 10 years, and 6,7%(n=4) started when they were older than 20 years of age.
The fact that the majority of respondents 93,3% (n=56) indicated that they started using cannabis between the ages of 10 and 19 implies that school and health authorities, community leaders and parents should focus their efforts on this age group to prevent the use of cannabis, which usually leads to the use of hard drugs later. This could also be why many adolescents do not complete their high school education.

The WHO (2002:6) found that 28,8% of adolescents aged 12 to 20 have used cannabis worldwide.

It should be noted that the majority of the respondents all started smoking cigarettes, using alcohol and smoking cannabis between the ages of 14 and 16 years.

The second largest group for smoking of cigarettes and using alcohol was the age group 11 to 13 years. This indicates that the age groups most at risk in the Msunduza Township are the children from 11 to 16 years of age. Health workers, parents, teachers and community members should focus their attention on children younger than 11 years to prevent drug abuse, and should start by preventing adolescents using cigarettes, alcohol and cannabis.

- **Item 17: Who offered the respondent cannabis the first time? (n=60)**

In this item respondents were required to indicate who offered them cannabis the first time (see figure 4.11).

Figure 4.11 Who offered the respondent cannabis the first time? (n=60)

Of the respondents, 80,0% (n=48) were offered cannabis by a friend; 6,6% (n=4) took cannabis themselves; 5,0% (n=3) were offered cannabis by a family member; 1,7%(n=1) by a parent and 6,7% (n=4) by someone else not mentioned in the interview schedule.

This study found that peer pressure plays an important role in the use of cigarettes, alcohol and cannabis, as friends were mostly responsible for introducing the adolescents to the drugs in Msunduza Township, Mbabane. Parents should get to know the friends of their children and at all time know what they are doing when they are with their friends. In addition, the findings indicated that parental behaviour also contributes a great deal to the problem.

- **Item 18: Information on the respondents' use of illegal substances (n=60)**

The respondents were asked to give information related to their use of illegal substances from a list provided in the interview schedule. The respondents could choose more than one item. Although it was clear that the respondents knew what the term "illegal drugs" meant, the research nevertheless defined it for them. See table 4.10 for information on the respondents' use of illegal drugs.

Table 4.8 Information on the respondents' use of illegal substances (n=60)

Information	Number of respondents	Percentage %
I use illegal drugs	13	22,6%
I use ordinary drugs bought over the counter	2	3,3%
I have experienced withdrawal symptoms	6	10,0%
Due to the use of drugs I have been in trouble at school	4	6,7%
Due to the use of drugs I have been in trouble with the law	5	8,5%
Due to the use of drugs I have been in trouble with my guardians/parents	3	5,1%
Due to use of drugs I have been in trouble with members of the community	4	6,7%
Almost all my family members use drugs	2	3,3%
I have been intoxicated to such an extent that I could not attend school	7	11,7%
I have been intoxicated to such an extent that I had to reduce my sports activities	2	3,4%
I have been intoxicated to such an extent that I had to reduce my social activities	4	6,7%
Due to drug use my performance at school deteriorated	5	8,5%
Due to drug abuse I have experienced interpersonal difficulties	8	13,3%
I can discontinue the use of drugs	11	18,3%
I have received treatment for my drug use	7	11,7%
I had to increase the amount of drugs I take to get the same effect	10	16,7%
I have used drugs for a longer period than I initially intended	11	18,3%
I have a persistent desire to use the substance	13	22,6%
I have tried unsuccessfully to stop using drugs on my own	11	18,3%
I need more time to recover from the effects of the drugs after using them	11	18,3%
I need to take drugs to cope with the expectations at school	7	11,7%
I need drugs to cope with the strain at home	10	16,7%
I have always been seen as a troublemaker	8	13,3%
Drugs help me to ignore what other people think of me	12	20,3%
I have always thought good about myself	10	16,7%
I like to provoke people	9	15,0%
I did not have many friends before I used drugs	12	20,0%
I am not addicted to drugs	1	1,7%
I need to take drugs before I can face the day	10	16,7%

Table 4.10 portrays the findings in relation to the total number of respondents (n=60). When the findings are analysed in relation to the number of respondents

who indicated that they use illegal drugs, the picture looks less favourable for these adolescents.

The respondents who indicated that they used illegal drugs (22,0%;n=**13**) already seem to be addicted as

- 84,7% indicated that they need more time to recover after using it.
- 84,7% had tried unsuccessfully to stop using the drugs on their own.
- 100,0% had a persistent desire to use the substance.
- 53,8% needed drugs to cope with the expectation at school.
- 76,9% needed drugs to face the day.
- 84,6% had been using drugs longer than they had intended.
- 46,1% had already experienced withdrawal symptoms.
- 76,9% had to increase the amount of drugs they took to get the same effect.

Of the respondents, 18,3% **(n=11)** believed that they could discontinue the use of these illegal drugs any time they liked.

The use of the illegal substances had interfered with their daily living, relationships in the following ways:

- 38,5% had experienced problems with the law
- 23,1% had experienced problems with their parents
- 30,7% had experienced problems with members of the community.
- 61,5% had experienced interpersonal difficulties.

The use of the illegal substances had interfered with their education and school activities as follows:

- 30,7% had experienced problems at school due to the use of illegal drugs
- 53,8% had been so intoxicated that they could not attend school
- 15,9% had been so intoxicated that they had to reduce their sports activities

- 30,7% had been so intoxicated that they had to reduce their social activities.
- 38,4% indicated that their performance at school had deteriorated

Drug abusers are often individuals with low self-esteem, and/or self-confidence. They use drugs to help them cope with the problems of living because they have not developed coping skills and feel inadequate for various reasons, such as poor parenting and lack of opportunities due to poverty and that they are not as intelligent as their peers. They therefore use drugs to give them confidence, to become accepted by their peers, to seek the attention they need, and to become popular. They may also use drugs to hide their true feelings, shyness or hurt. This was confirmed by the findings below.

The respondents indicated that they used illegal drugs for the following reasons:

- to cope with the expectations at school (53,8%)
- had always been troublemakers (61,5%)
- had always liked to provoke people (69,2%)
- did not have friends before they started using drugs (92,3%)
- to help them ignore what people thought of them (92,3%)

Of the respondents, 16,7% (n=10**)** indicated that they always thought (felt) good about themselves. This was contrary to the above findings and Stanhope and Lancaster's (1999:533) finding that young people used drugs to give them confidence.

Of the respondents, 16,7% (n=10) indicated that they used illegal drugs to cope with the strain at home. This confirmed the finding in item 7 where 5,13% (n=3) indicated that they had problems at home.

Of the respondents, only 3,3% (n=2) indicated that their parents also used illegal drugs, which corresponded with an earlier finding that a parent offered the respondents their first cigarettes, alcohol and cannabis.

- **Item 19: Age when respondents started using illegal drugs**

Unlike in the case of cigarettes, alcohol and cannabis where the majority started between the ages 14 and16, the respondents started using illegal drugs when they were older. Of the respondents, 76,9% (n=10) indicated that they were between the ages of 17 and 19 years and 23,1% (n=3) were older than 20.

Illegal drugs are expensive to buy and this could be one of the reasons why the respondents were older before they started using them. Moreover, drug addicts often start using drugs such as alcohol and cannabis before moving on to illegal drugs.

- **Item 20: Place where the drugs were used (n=60)**

In this item respondents were required to state where (place) they used drugs. Here drugs referred not only to hard-core drugs like heroin, LSD, but also to cannabis and alcohol (see figure 4.12).

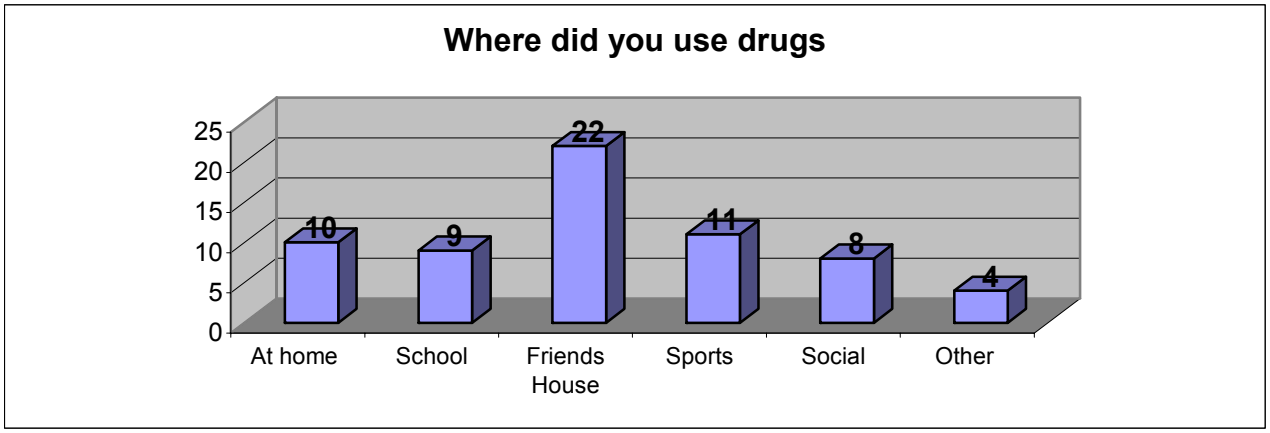


Figure 4.12 Location where respondents used drugs (n=60)

Of the respondents, 36,6% (n=22) used drugs at a friend's house; 18,3% (n=11)r at sports events; 15% (n=9) at school; 13,3% (n=8) at social events; 6,7% (n=4) always used drugs at other places, and 10,0% (n=6) always used drugs at home.

The findings indicate that the respondents had a better chance of using drugs at schools, sports, and social events, although some respondents indicated that they used drugs at home. Perhaps the parents were unaware of this. However, since some parents gave their adolescents cannabis, they could also be aware of their children using drugs at home. The fact that most of the respondents used drugs at friends home concurred with the findings that peer pressure played an important role in drug use in Msunduza Township, that friends had introduced them to it and that they used drugs to be part of the peer group.

The fact that some respondents indicated that they used drugs "somewhere else" implies that they used drugs at places other than the usual ones, which makes monitoring by parents, teachers or community leaders difficult if not impossible.

Stewart and Sundeen (1999:120) emphasise that parents should be involved in adolescents' life and should demonstrate respect, interests and caring in their children's lives. This is the only way to ensure that their children are safe at all times and not involved in risky behaviour.

- **Item 21: Where the respondents obtained the money for drugs (n=60)**

In this item the respondents were required to reveal where they got money to buy their drugs (see figure 4.13).

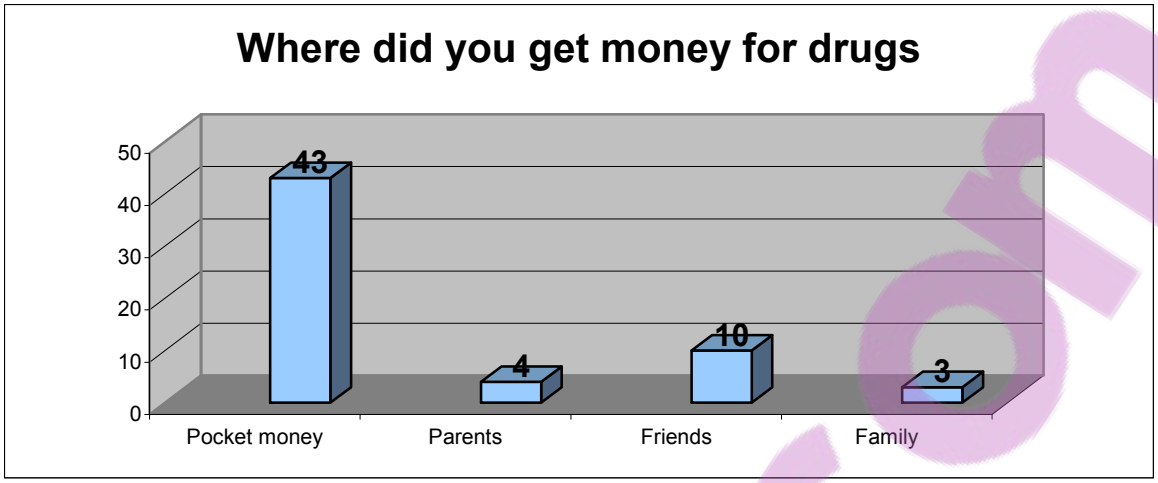


Figure 4.13 Where the money came from to pay for the drugs (n=60)

Of the respondents, 71,7% (n=43) indicated that they used pocket money for drugs; 16,7% (n=10) got money from friends; 6,7% (n=4) got money from parents, and 5,0% (n=3) got money from family.

Figure 4.13 indicates that most of the respondents used pocket money or money from friends to buy drugs. Therefore, it is imperative that parents ensure that pocket money for their children is just enough for their genuine needs and that the children list these needs in a budget for the guardians to see. The children will then not be tempted by big amounts of spending money.

- **Item 22: Criminal offences engaged in because of drug use (n=60)**

The respondents were asked to indicate criminal offences they had engaged in because of drug use (see table 4.3). It should be noted that criminal offences by adolescents in the Msunduza Township are not a serious problem at present.

Table 4.9 Criminal offences committed due to the use of drugs (n=19)

Criminal offences	Number of respondents	First % = out of 19 offenders Second % = out of 60 respondents
Stole money to buy drugs	6	31,7% (10,0%)
Violence/assault	8	42,1% (13,3%)
Petty theft	4	21,1% (6,7%)
Prostitution	1	5,3% (1,7%)
Number of offences	40	
TOTAL	19	

From the table 4.5 it is evident that 19 out of 60 (31,7%) of the respondents had been charged with criminal offences. Of the offenders, 42,1% (n=8) were charged with violent assault; 31,7% (n=6) with stealing to buy drugs; 21,1% (n=4) with petty theft; and 5,3% (n=1) (female) with prostitution. It is clear from table 4.3 that some of the respondents had been charged more than once as the 19 offenders who had been charged with offences had been charged 40 times.

Although the results indicate that a high percentage of the respondents had not been charged with any criminal offence, there is a possibility that through others' influence or being too secretive to be caught, the number of offences committed could be higher. The results indicate that it is imperative for law departments to re-enforce law measures against drug abusers. Parents and other members of the community should also report any criminal practices observed in the Msunduza Township.

- **Item 23: Who noticed drug usage the first time? (n=60)**

Here the respondents were asked to state who had first noticed their drug use (see figure 4.14).

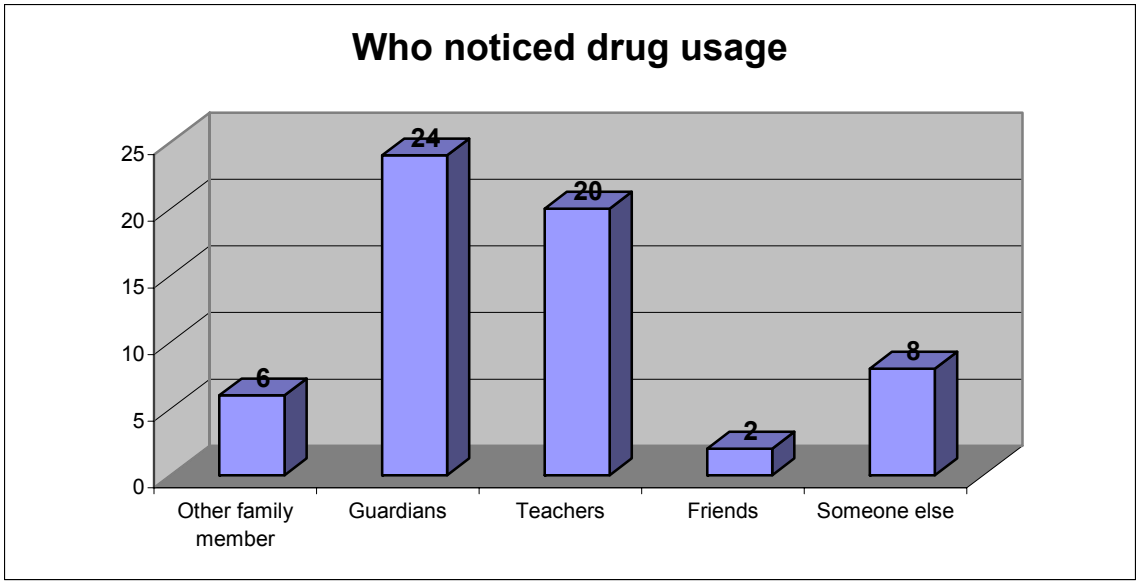


Figure 4.14 Who first noticed that the respondent used drugs (n=60)

Of the respondents, 40,0% (n=24) indicated that their guardians noticed it the first time; 33,3% (n=20) indicated teachers; 10,0% (n=6) indicated other family members; 3,3% (n=2) indicated friends and 13,3% (n=8) indicated someone else.

Children and adolescents spend most of their time with teachers at school and guardians at home. With good observation and commitment in children's life, both guardians/parents and teachers can be the first to notice drug use.
Baddy (1999:16) states that the time "spent with children at home and school should be used profitably to notice any misbehaviour in adolescents".

4.3.5 Section E: Respondents' views on prevention and control of drug problem

This section examined the respondents' opinions on how they felt drug use and abuse amongst adolescents had been addressed and should be prevented and controlled. The researcher was of the opinion that the drug users themselves

might have some suggestions that could help stakeholders to control the problem.

- **Item 24 Measures that should be taken by the law (n=60)**

The respondents were asked their opinions on the measures that should be taken by law departments related to drug users (see table 4.6). Of the respondents, 80,0% (n=48) indicated that the law departments should take the following measures against drug abusers.

Table 4.10 Measures suggested by respondents that should be taken by law (n=60)

Measures to be taken	Number of respondents	Percentage %
Stricter laws against selling drugs	48	80,0%
Punishment for possession of drugs	48	80,0%
Punishment when intoxicated	48	80,0%
Punishment for selling drugs	48	80,0%
No selling over-the-counter drugs to minors	48	80,0%
Police raids on homes	48	80,0%
Roadblocks by police	48	80,0%
Safe sport facilities	48	80,0%
Inform people about dangers	48	80,0%

All the respondents (80,0%; n=48) who answered this question agreed that the measures proposed to punish the drug abusers should be enforced, but also indicated that the provision of information to drug abusers and safe sports facilities were necessary to address this problem. Of the respondents, 20% (n=12) gave no opinion on this matter.

- **Item 25 Statements relevant to school (n=60)**

This item obtained the respondents' opinions on a list of statements that could be considered to be applicable to their school (see table 4.8). The respondents could choose more than one statement.

Table 4.11 Statements applicable to the respondents' schools (n=60)

Statement	Number of respondents	%
School rules are too strict	50	83,3%
Teachers know what students are doing	44	73,3%
Teachers know the students	44	73,3%
Teachers punish students without reason	0	0,0%
Teachers caution students about the dangers of drugs	27	45,0%
Teachers allow students to smoke cigarettes	1	1,7%
Teachers have strict control over students during sporting or social events	8	13,3%
Although teachers know students abuse drugs, they do nothing about it	2	3,3%
Teachers punish drug abusers	25	41,7%
Teachers support students who have problems	39	65,0%%

Although the majority of the respondents (83,3%; n=50) felt that the school rules were too strict, they also seemed to have confidence in the teachers as 73,3% (n=44) indicated that they felt that the teachers knew what they were doing; 73,3% (n=44) indicated that they knew all the students and did not punish the students without reason. The teachers had less control over students during sporting and social events, however, as only 13,3% (n=8) felt that teachers had control at these events. Teachers seemed to do their duty in the prevention of

drug abuse as 45,0% (N=27) of the respondents indicated that they cautioned students about the dangers of drugs; 41,7% (n=25) indicated that they punished drug abusers, and 65,0% (n=39) indicated that they supported students who had problems. Nevertheless, whether strict school rules and punishing drug abusers would effectively and positively deal with the problem is not known. Maree (2002:10) found that “school dropouts, teenage pregnancies and drug addiction in schools, are related to strict school rules, and heavy punishment". Of the respondents, 3,3% (n=2) felt that teachers knew that students abused drugs but did nothing about it, and 1,7% (n=1) indicated that they allowed students to smoke cigarettes. Teachers, therefore, appeared not to condone the use of drugs or smoking of cigarettes, but did what they could to help students.

- **Item 26 Statements that may be applicable to the respondents' guardians**

In this item the respondents were required to select any of the listed statements that, in their opinion, were applicable to their guardians (see table 4.9). The respondents could choose more than one statement form the list.

Of the respondents, 85,0% (n=51) felt that their guardians were too strict; 73,3% (n=44) felt that their guardians needed more control over them.

The respondents did not believe that their guardians should allow them to attend unsupervised parties, as only 1,7% (N=1) indicated that they should be allowed to attend such parties. The respondents indicated their trust in their guardians’ judgment and indicated that their guardians took steps when they realised that they were abusing drugs, as only 5,0% (n=3) felt that their guardians punished them without reason.

Table 4.12 Statements applicable to the respondents’ guardians (n=60)

Statement	Number of respondents	Percentage %

My guardians are too strict	51	85,0
My guardians need more control	44	73,3
My guardians should allow me access to unsupervised parties	1	1,7
My guardians punish me without reason	3	5,0
My guardians know the signs of drug use	10	16,6
My guardians should allow me to smoke cigarettes	0	0,0
My guardians should allow alcohol use	0	0,0
Although I abused drugs, they did nothing about it	1	1,7
My guardians are very understanding people	20	36,7
I have a good relationship with my guardians	27	45,0
My guardians care about me	40	66,7
My guardians are supportive	41	68,3
	40	66,7
	41	68,7

Of the respondents, 45,0% (n=27) indicated that they had a good relationship with their guardians; 66,7% (n=40) indicated that their guardians cared about them; 68,3% (n=41) indicated that they were supportive, and 33,9% (n=20) indicated that they were understanding people.

From table 4.9 it is clear that of the respondents, 55,0% (n=33) **did not** have a good relationship with their guardians; 33,3% (n=20) felt that their guardians did not care for them, and 31,6% (n=19) felt that their guardians were not supportive.

This finding corresponded with item 7 where 16,7% (n=10) of the respondents indicated "the poor relationships at home" and 13,3% (n=8) indicated that they escaped "the problems that existed at home" by using drugs.

None of the respondents were of the opinion that guardians should allow their children to smoke cigarettes or use alcohol. Only 16,7% (n=10) of the respondents indicated that their guardians knew the signs of drug use.

The above parental behaviour could make the home environment conducive to drug use if they are unsupportive, uncaring, and ignorant of the signs of drug use. Of the respondents, 10,% (n=6) indicated in item 15 that they used drugs at home, which is in line with the above finding.

McCaffrey (1999:2) maintains that “the most important tool we have against drug use is not a badge or a gun, it is a kitchen table. Parents can prevent drug use by sitting down with their children and talking with them – honestly and openly about the dangers of drugs to young lives.”

4.3.6 Section F: Effectiveness of available resources to help drug abusers

In this section the sources and the effectiveness of resources to address drug abuse were investigated.

- **Item 27 Respondents’ opinion of the effectiveness of treatment for drug users**

In this item respondents were required to indicate the outcome and effectiveness of the treatment (see table 4.7).

Table 4.13 Respondents’ opinion of the effectiveness of treatment for drug users (n=60)

Effectiveness	Number of respondents	Percentage %
Always	3	5,0%
Often	44	73,4%
Seldom	8	13,3%

No response	5	8,3%
Total	60	100,0%

Of the respondents, 73,4% (n=44) indicated that they believed that the treatment for drug users was often successful; 5,0% (n=3) indicated that treatment was always successful; 13,3% (n=8) indicated that treatment was seldom successful, and 8,3% (n=5) gave no responses.

According to the study results, most of the respondents believed that treatment would help drug users.

In a similar study, the WHO (2000:4) found that rehabilitation centres for chronic drug users worked well in restoring their disrupted health in both developed and developing countries. The findings of this study therefore challenge the government to establish more rehabilitation centres for people affected by a drug problem.

The problem usually starts with the “innocent” smoking of a cigarette or the use of alcohol at a young age. According to Muller (2002:32), the number of smokers is expected to rise to more than 1.6 billion by 2025. Most smokers start as young as 12 years old. Children start to smoke for various reasons but usually to be accepted in the peer group without thinking of the effect on their health in later years. Diseases associated with smoking tobacco include cancers of the lungs and ischemic health as well as respiratory diseases such as emphysema, which not only lowers the quality of life of the individual, but can lead to death. Smoking of tobacco in adolescence is often only the first stepping-stone to the use of other more lethal substances.

4.4 CONCLUSION

This chapter discussed the data analysis and findings at length. Throughout the discussion reference was made to relevant literature reviewed.

Chapter 5 concludes the study, briefly discusses its limitations and makes recommendations for practice and further research.

CHAPTER 5

Conclusion, limitations and recommendations

5.1 INTRODUCTION

This chapter concludes the study. The study set out to explore and describe the knowledge and opinions of adolescent drug abusers on the drug abuse problem in the Msunduza Township, Mbabane, Swaziland. In addition, the researcher wished to make recommendations to control the drug abuse problem amongst adolescents, in the Msunduza township of Mbabane, Swaziland, and for further research in this field.

5.2 SUMMARY

The problem of drug abuse in adolescents in Swaziland escalates every year, and in society at large in terms of crime, violence, corruption, and drainage of human, financial and other resources that could be used for social and economic development in Swaziland. Drug abuse also has a devastating effect on the adolescents themselves and their families.

Parents are often ignorant about the fact that their children are abusing drugs and frequently learn about the problem for the first time when the police arrest them. Parents do not know how to recognise the first symptoms of drug abuse in their children, and do not realise that the innocent smoking of a cigarette and drinking of alcohol could be the first step towards drug abuse. Peer group pressure has a strong influence on children and adolescents who abuse drugs are very secretive and will do anything in their power to prevent teachers and parents/guardians becoming aware of it. Hence the researcher decided to ask certain questions to the adolescents themselves who abuse drugs, and learn from this to empower all the stakeholders to deal with this problem.

The findings of this study could be used to educate adolescents and their guardians/parents on drug abuse in the Msunduza Township and develop strategies and policies to control the problem.

The objectives and research questions formed the conceptual framework of the study. The study wished to explore and tackle the problem by answering the following research questions:

- What are the biographical features of the adolescent who abuses drugs in Msunduza Township?
- What is the extent of the drug abuse problem according to the adolescents who abuse drugs themselves in the township?
- What level of knowledge do the adolescents in the township who abuse addictive substances have of the causes of drug abuse?
- Did the adolescents who abuse drugs in the township start by smoking cigarettes, then drink alcohol and then move to illegal drugs?
- Who introduced the adolescents in the township to addictive substances?
- How has the abuse of addictive substances affected the lives of the adolescents in the township?
- What role have the parents/guardians, teachers and friends played in causing, preventing and dealing with the drug abuse problem amongst the adolescents in the township?
- What are the opinions of the adolescents who abuse addictive substances on the treatment and control measures available in Swaziland?

The researcher used a quantitative, explorative, descriptive, cross-sectional research design. Snowball or network sampling was used as the adolescents abusing drugs were usually part of a gang or knew each other. Early sample members were therefore asked to identify a friend who also abused drugs and

refer the researcher to these people who meet the eligibility criteria for the study (Polit et al 2001:237). Out of an estimated 115 to 120 adolescents who abuse drugs in the Msunduza Township, sixty adolescents (or 50% of the population) formed the sample. The researcher used the personal interview method and an interview schedule to collect data. The SPSS computer program was used for data analysis and presentation in percentages and frequencies. The researcher presented the data in tables, figures and graphs and discussed the findings.

The findings are summarised according to the research questions.

(1) What are the biographical features of the adolescent who abuses drugs in the Msunduza township, Mbabane, Swaziland?

The average age of the sample was 18½ years. The oldest respondents were 21 and the youngest 16 years old. The advantage of interviewing an older group of adolescents was that they had more experience and could share their views on the drug abuse problem in their township with the researcher. There were more females than males in the sample. Of the respondents, the majority were in form 2 and lived with a single parent, siblings, grandparent or other family members. Only 45% (n=27) lived with both their parents.

The respondents commenced using cigarettes, alcohol and cannabis between 14 and 16 and hard drugs between 17 and 19 years.

(2) What is the extent of the drug abuse problem according to the adolescents who abuse drugs themselves in the Msunduza Township?

According to the respondents, there is a big problem of drug abuse amongst adolescents in the Msunduza Township. The majority of the respondents felt that fifty percent of the youth in the township abused drugs and attributed the problem to peer pressure and poor relationships and other problems at home.

(3) What level of knowledge do the adolescents in the township who abuse addictive substances have of the causes of drug abuse?

Most of the respondents knew that drugs were addictive; it was illegal to handle drugs, and it is often impossible to become rehabilitated once addicted. More respondents obtained information on how drugs should be administered than how to say "no" to drugs.

Of the respondents, 91,7% (n=55) indicated that smoking cigarettes, 33,3% (n=20) that drinking alcohol, and 91,7% (n=55) that smoking cannabis is not good for a person's health. The fact that fewer respondents indicated that drinking alcohol is not healthy than said the same about smoking cigarettes and cannabis could be due to the fact that all the respondents drank alcohol on a regular basis.

Of the respondents, 20,% (n=12) admitted that they were addicted to cigarette smoking, 8,3% (n=5) to alcohol, and 16,7% (n=5) to cannabis. Of the respondents who used illegal drugs, 84,6% (n=11) believed that they were not addicted to drugs, and only 15,4% (n=2) admitted being addicted. This indicated that the respondents were not well informed about the power addictive substances have over a person's life.

The majority of the respondents indicated that they obtained their knowledge from the media (26,7%; n=16) and articles (23,3%; n=14). The respondents who obtained their information from the media and by reading articles also indicated that smoking cigarettes, drinking alcohol and using drugs are addictive. The respondents who obtained their knowledge from friends and others (not listed in the interview schedule) indicated that the information was on how to administer

drugs. Some respondents obtained guidance from their families on how to say "no" to drugs.

(3) Did the adolescents who abuse drugs in the township start by smoking cigarettes, then drink alcohol and then move to illegal drugs?

Of the respondents, 45,0% (n=27) never smoked cigarettes, but all the respondents abused alcohol; 50,0% (n=30) never used cannabis. It is therefore clear that some of the respondents were addicted to alcohol and not necessarily cannabis or hard drugs or had started with cigarette smoking. Although relatively few respondents (21,7%; n=13) abused drugs such as cocaine and LSD, one child addicted to these drugs is one too many. Steps should be taken before more adolescents start to experiment with these drugs.

(4) Who introduced the adolescents in the township to addictive substances?

According to the majority of the respondents, friends introduced them to cigarettes, alcohol, cannabis and illegal drugs. In the case of cigarettes and alcohol, some respondents indicated that they took it themselves. This could be due to the fact that cigarettes and alcohol were readily available at their homes. Several respondents indicated that their guardians/parents and/or family members introduced them to all four types of substances.

The first people who noticed that the respondents were using harmful substances were family members and teachers, who became aware of the problem when the respondents were arrested for criminal offences, as 31,7% (n=19) of the respondents indicated that they had been arrested for 40 offences, such as violence, assault and stealing money. Intoxicated individuals usually cannot control their emotions and can become violent. The respondents stole money

and other goods to pay for their habit, as the pocket money they received from their guardians could not cover the cost.

(5) How has the abuse of addictive substances affected the lives of the adolescents in the township?

The abuse of harmful substances always affects the lives and health of the individual, and all the people connected to the abuser. Although the respondents indicated that they were not addicted to any of the named substances, the follow-up questions made it evident that they did have a serious problem of addiction. All the signs of addiction were already present, such as

- They needed a "fix" to face the day and help them cope.
- They take longer to recover after they have taken the substances.
- They need more and more of the drug to obtain the same effect.
- They had tried unsuccessfully to discontinue the use.
- They were plagued with a persistent desire to use the substance.
- Some had already experienced problems at home, in school, with members of the community and the police.
- They had been so intoxicated that they could not attend school, and had to reduce their sports and social activities
- Their performance at school had deteriorated

Furthermore, they were clearly already psychologically addicted to the substances, as they needed the drugs for confidence, peer acceptance, making friends, and hiding their true feelings, because the use of the drugs helped them to ignore what people thought of them. This further indicated their low self-esteem and lack of self-confidence.

The use of drugs did not bring them the happiness they sought, but rather augmented their problems, such as interpersonal relationships and relationships at home and school. They were seen as the troublemakers who provoked

people, and only welcome in the company of other drug users. As indicated by their level at school and on their own admission, their performance at school had deteriorated.

(6) What role have the parents/guardians, teachers and friends played in causing, preventing and dealing with the drug abuse problem amongst the adolescents in the township?

The study found that friends and peer group pressure were the major instigators of the drug abuse problem. This was augmented by the fact that they were adolescents and some had been experiencing problems at home. The fact that less than 50% of the respondents lived with both their parents and that some guardians also used drugs, also played a role in their drug abuse problem.

The first people who noticed that the respondents had a problem with drugs were the guardians and teachers. These are the people who are in the company of the adolescent most of the day and know them best. It is clear that although the respondents were of the opinion that they experienced problems at home and that their guardians/parents were too strict, they seemed to respect them and their judgment. Moreover, the respondents felt that their guardians could be stricter and should not allow children to smoke, use drugs, or go to unsupervised parties. They also revealed that their guardians were supportive and cared for them and immediately took steps when they realised there was a problem. This could be a sign that there should be better communication between the parties and that the respondents felt that the guardians could have prevented it from happening. The fact that the respondents mentioned poor relations at home could be due to the fact that they now had a problem with drugs.

Teachers seemed to play a positive role in the students' lives. Although, as in the case of the guardians, the respondents indicated that the teachers were too strict, they admitted that the teachers knew the students and knew what they

were doing. They also seemed to respect the teachers and their judgment. In addition, the respondents indicated that the teachers acted when they became aware of a student with a drug abuse problem, and supported them. However, the teachers did not have enough control over students during sporting and social events. The possibility that this could also be the occasion when students were motivated to use drugs, however, was not probed in the present study.

(7) What are the opinions of the adolescents who abuse addictive substances on the treatment and control measures available in Swaziland?

The majority of the respondents indicated that treatment was often successful, although 18,3% (n=11) indicated that they had tried unsuccessfully to stop using drugs. At least 11 of these respondents must have tried to stop without the help of professionals, as only 11,7% (n=7) of the respondents indicated that they had been treated by professionals but had not discontinued the use of drugs as they were part of the group who used illegal drugs.

All the respondents (80,0%; n=48) who responded to the questions indicated that there should be stricter law enforcement by the police and stricter laws against all aspects of drug use. Offenders should be punished for possessing drugs, being intoxicated, selling drugs, and also selling potentially addictive drugs to minors over the counter. The respondents believed that the police should raid the homes of suspected drug users, hold roadblocks to enforce the law, and ensure that sporting events are drug free. The police should also inform adolescents about the dangers of drug abuse.

5.3 LIMITATIONS OF THE STUDY

The researcher found the following limitations in the study.

The study was only conducted in one township in Mbabane and did not include adolescents' views from other townships, which could affect the generalisability of the findings. Conducting the study in the same township where the researcher lives caused some embarrassment and discomfort to the adolescents since some of their homes were known to be religious. Data collection could have been less embarrassing for the respondents if the researcher had made use of a questionnaire that they could complete privately and anonymously. Research on the same topic but with a different data-collection method could elicit different findings. The interview schedule should have included open questions to allow the adolescents to share their feelings and experiences in a more personal way.

5.4 RECOMMENDATIONS

Based on the findings, the researcher makes the following recommendations for practice and further research.

5.4.1 Addressing the drug abuse amongst adolescents in the Msunduza Township

The following recommendations are not new, but confirm that the measures people could take to prevent drug abuse are acceptable to adolescents drug abusers.

Adolescents and children:

- Assess adolescents' needs and take steps to address these needs.
- Educate school children from an early age, before the age of 10 years, on the dangers of drug use.
- Teach children life skills and to communicate their feelings to adults they trust.
- Encourage and motivate children to take part in sport events and hobbies that channel their energy into more productive activities.

- Children should always tell their parents if they have problems.
- Children should tell parents if they do not feel comfortable in a situation and learn to withdraw from such situations.
- Children should learn to say "no" to drugs.

Parents/guardians:

- Parents/guardians should enlighten themselves about the first signs of drug use and the dangers, as well as where they may seek help.
- Parents/guardians should educate their children on drug issues.
- Parents/guardians should never allow children to attend unsupervised parties.
- Parents/guardians should make sure that they know their children's friends.
- Parents/guardians should always know where their children are and what they are doing.
- Parents/guardians could be strict with their children, as the children prefer it that way as it makes them feel safe.
- Parents should go for marriage counselling to save their marriages as the presence of both parents in the lives of children could safeguard them from taking unnecessary risks.
- Parents/guardians should become more involved in the children’s lives and to take notice of any change in behaviour.
- Parents/children should to listen to their children and take notice of them when as they describe their problems.
- Parents/guardians should seek help for themselves if they are struggling with drug abuse.
- Parents/guardians should always be role models for their children.

Teachers:

- Teachers should ensure they have all the information related to drugs and drug abuse and should share this knowledge to the children at a young age.
- Teachers should continue to be on the lookout for any drug problems in the schools.
- Teachers should control and supervise social and sports events better to ensure that they are drug free.
- Teachers should make sure that all students take part in some sort of sports activity that helps them to get rid of energy in a healthy way. Sports activities would also prevent boredom, which can lead to experimenting with risky behaviour.
- As members of the community regard teachers as leaders and knowledgeable on various aspects, they should involve families, community leaders, social workers, health workers and religious counsellors in discussing adolescents' drug abuse issues and help them formulate plans to tackle and resolve the problem.
- Teachers should ensure that school rules and discipline regarding drug use are intensified and enforced.
- Teachers should continue to develop strong teacher-student relationship as students appreciate this and students who use drugs need them.

5.4.2 Further research

The researcher recommends that further research be conducted on the following topics:

- Determine what facilities are available in Swaziland for the treatment of drug abusers.
- Determine the types of "hard drugs" available in Swaziland.

- An in-depth study of a certain aspect of the problem, using a focus group.
- The long-term effects of the drug abuse on the lives of the same sample at a later stage.

5.5 CONCLUSION

This chapter summarised the study, discussed its limitations and made recommendations for practice (to tackle the problem) and further research.
The drug problem among adolescents in the Msunduza Township in Mbabane, Swaziland was undertaken to obtain their opinions on the problem and to determine what they know about drugs and the drug abuse problem. No new revelations were found or new knowledge gained which was not already generally well known about drug abuse amongst adolescents or what is available in the literature.

What was new and would help health planners and leaders in Swaziland is that the adolescents in this sample did not start with cigarettes and move through the ranks to illegal drugs. All the adolescents also abused alcohol to a great extent and very few were addicted to illegal drugs.

It was clear that these adolescents were very unhappy and crying out for help, that they trusted the adults and wished that they could have prevented this problem. Perhaps there is some hope for the youth of this township if the policy makers and caring adults act immediately and take the necessary steps to help these children, before they all become addicted to illegal drugs.

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