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List of abbreviations

AIDS	Acquired Immune-Deficiency Syndrome
ANC	Antenatal Clinic
ARH	Adolescent Reproductive Health
CDC	Centres for Disease Control and Prevention
CRHCS	Commonwealth Regional Health Community Secretarial
CSO	Central Statistical Office
DHS	Demographic Health Survey
ESRA	Economic and Social Reform Agenda
ECSACON	East Central and Southern Africa College of Nursing
ICPD	International Conference on Population and Development
IEC	Information Education and Counselling
IUCDs	Intra uterine contraceptive devices
FGD	Focus Group Discussion
FLAS	Family Life Association of Swaziland
FLE	Family Life Education
FP	Family Planning
HBM	Health Belief Model
HIV	Human Immuno-Deficiency Virus
KAP	Knowledge Attitude and Practice
LAM	Lactation Amenorrhoea Method
LP	Logical Positivist
MCH	Maternal and Child Health
MOH	Ministry of Health
NDS	National Development Strategy
NGOs	Non-Governmental Organisations

List of abbreviations

NUD*IST	Non-numerical Unstructured Data Indexing Searching and Theorizing
PASMI	Programme of Action for the Safe Motherhood Initiative
PHC	Primary Health Care
RH	Reproductive Health
RHMs	Rural Health Motivators
SHAPE	School HIV/AIDS and Population Education Programme
SNAP	Swaziland National AIDS/STD Programme
STDs	Sexually Transmitted Diseases
TAB	Traditional Birth Attendant
TFP	Traditional Family Planning
TFR	Total Fertility Rate
UNICEF	United Nations Children Fund
WFS	World Fertility Survey
UNICEF	United Nations Children Fund
UNFPA	United Nations for Population in Africa
WLSA	Women and the Law in Southern Africa
WHO	World Health Organization

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CHAPTER 1

Overview of the study

1.1 INTRODUCTION

In most developing countries, women spend a significant number of years either pregnant, lactating or doing both at the same time. Baker, Martin and Piwoz (1996:9) state that between the ages of 18 and 45 years, some women in Sub-Saharan Africa spend as much as 28,0% of their time pregnant and 65,0% lactating. Their fate could even be worse when they marry at young ages (12-15 years) and become pregnant before their bodies have matured physically (Bergstrom, Molin & Povey 1993:21). According to Smyke (1993:13), the maternal mortality rate in some African countries is as high as 1 000 per 100 000 live births. These high rates coupled, with high fertility (more than seven children per woman), means that for many African women the chances of dying from causes related to child bearing are at least 1:15. In contrast, the risk of maternal death in industrialised countries averages 27 per 100 000 live births (Hatcher & Kowal 1999:3).

The World Health Report (1998:97) maintains that, for every maternal death about 10-15 surviving women suffer illness or severe disability as a consequence of pregnancy. Indeed the majority of

women in Sub-Saharan Africa fall in the high-risk category of poor pregnancy outcomes. The risk tends to be increased with each successive pregnancy (Rees 1995:27).

According to Baker et al (1996:9), the most common obstetric risk factors include adolescent pregnancies (mothers aged 19 or younger at the time of the baby's birth), elderly women still giving birth (35 years of age or older), grand-multiparity (women having five or more live births), unsafe abortions and sepsis. Family planning therefore appears to be the main route for improving maternal health globally (Campbell 1997:186), although the pattern thereof varies between different countries, and even within countries with regards to health policies, the preferences of health service managers, the availability of contraceptive methods and the cultural environment into which these methods are introduced (Rees 1995:27). As much as Sengal (1993:51) noted that family planning services have produced effective results in the developed countries, in some underdeveloped countries a "contradiction" exists as women are willing to promote their health through family planning services, but fail to translate this willingness into concrete actions even when contraceptives are available to them (Kalanzi 1991:26).

This gap may be explained by looking at cultural institutions, because many women might fear losing their fertility as a result of various family planning methods (Silberschmidt & Rasch 2001:1819). Gule (1993:242) observed that the loss of fertility might jeopardise women's social status as potential husbands shun them and this could leave them with a lifelong stigma of being infertile, or subfertile and/or unmarried (WLSA 1998:204). According to Ndubani and Hojer (2001:110), the gap may also be explained by the fact that dominant "male attitudes" might interfere with the women's expressed desires to control their families' sizes. For example, in some cultures a husband may be a significant constraint to the use of contraceptives (Holland, Ramazanoglu, Sharpe & Thomson 1992:645-674). Similarly the use of abortion as a family planning method in some health care centres may be considered an illegal practice (Ankomah, Aloo-Obunga, Chu & Manlagnit 1997:45), and women may thus be obliged to seek unsafe abortions. Despite illness and high mortality rates being associated with high fertility and unsafe abortions, male-dominated legal and religious structures prevent women in many Sub-Saharan Africa countries, including Swaziland, from using contraceptives.

Religious customs and beliefs emphasise the spiritual importance of progeny, lineage and descent. It is believed that a person with many children will have souls on this earth to commune with in the after life, whereas the soul of a childless man or women will dwell in a wasteland of spiritual isolation

(Nazzar, Adonga, Binka, Phillips & Debpuur 1995:309). This custom may be a deterrent to the use of family planning services among Swazis, as they maintain similar beliefs. Kasenene (1993:77) noted that Swazis maintain that parents are a bridge between their ancestors and their children, and that deceased persons can be reborn. It is therefore believed that if Swazi women use family planning methods, they might prevent their ancestors from being reborn – incurring the wrath of these ancestors.

According to the Swaziland National AIDS/STD Programme (SNAP1998:12), the birth rate among Swazi women is particularly high, the norm being 6,4 births per woman. This scenario has many health and social consequences among childbearing women, especially those in the high-risk category, namely adolescents and elderly women. In 6,0% of recorded deliveries it was found that women were older than 35 years of age according to the Health Statistical Report (HSR 1997:6). The majority of these women were grandmultiparous, which means that they had each given birth to live infants on more than five occasions. They were, therefore, prone to poor pregnancy outcomes due to obstetric risk factors associated with grandmultiparity, such as prolonged labour, obstructed labour and post partum haemorrhage. These risks could be aggravated, if combined with mothers being older than 35 years of age at the time of giving birth.

Conversely, it was observed that adolescents between the ages of 15-19 years were responsible for 27,0% of recorded deliveries (Ministry of Health and Social Welfare Report 2001-2005:11). The consequences of adolescent parenthood are well documented and raise fundamental concerns about the health and social development of young mothers and their children. Adolescent pregnancies are generally associated with higher rates of maternal morbidity and mortality, and greater risks for clandestine abortions, delivery complications and low-birth-weight infants (Gupta & Da Costa Leite 1999:125). Such complications also occur among young Swazi women.

In addition, it was noted that the majority of girls who leave school due to pregnancy were losing important educational opportunities, jeopardising, their future prospects. As many as 82,0% of Swazi's who participated in a survey conducted during 1998 were knowledgeable about modern family planning methods, but the user rate was as low as 29,0% (SNAP 2000:13). Yet modern family planning methods are available in all health care facilities in Swaziland at a minimum charge of E10,00 per annum (equivalent to US \$1.95, according to the official exchange rate at the time of writing this report). In addition, Dlamini (1997:282) reported that in some pharmacies in Swaziland certain

contraceptives could be purchased over the counter without prescription.

Rees (1995:27) maintains that by using contraceptives effectively, Swazi women will be more able to improve the quality of their lives by:

- delaying pregnancies until they have completed their schooling/education
- spacing their children according to their families' needs and incomes
- planning their pregnancies in accordance with their career developments
- decreasing maternal morbidity and mortality, including deaths from unsafe abortions

On the other hand, women who do not use effective contraceptives might end up as unmarried mothers without adequate income and/or education. These mothers might then face the danger of entering a vicious circle of poverty and destitution affecting not only themselves, but also their children.

Of particular significance is the fact that according to the Health Statistical Report (1997:6) of Swaziland there was only a 29,0% use of modern family planning practices and a 65,0% dropout rate among users of family planning practices. This situation requires a scientific enquiry into factors which deter women from using effective family planning practices available in health care facilities throughout Swaziland.

1.2 BACKGROUND INFORMATION ABOUT SWAZILAND AND ITS HEALTH CARE SYSTEM

In order to contextualise the research problem the social background and the health care system of Swaziland will be discussed briefly.

1.2.1 Information about Swaziland

Swaziland is one of the smallest countries in Southern Africa, covering 17 600 sq kilometres. It has a population of approximately one million. Table 1.1 illustrates the population growth of Swaziland between 1986 and 2001. Swaziland is a landlocked country, which is almost completely surrounded by the Republic of South Africa except for the eastern part, which is bordered by Mozambique. The

country is divided topographically into four distinct areas: the Highveld, Middleveld, Lowveld and Lubombo Plateau.

According to Okpaluba, Hlatshwayo and Khumalo (1997:271), Swaziland has a largely homogenous society. Customs and traditions have been preserved, reflecting the Kingdom's unique national identity. In the Swazi society, the family occupies a central position in social life because of its traditional functions of procreation and socialisation (Kasenene 1993:74). Male headship is important in family formation, explaining preference for boy children in the Swazi society (WLSA 1998:24). This cultural practice, as observed by Gule (1993:243), is responsible for the high birth rate in Swaziland. The total fertility rate of Swaziland is among the world's highest, being 6,4 births per woman as recorded in the National Development Strategy (1998:50).

Women make-up 50,0% of the population, and about one third of these women are at the childbearing stage, ranging from 20 to 49 years (HSR 1997:6). This is particularly significant when noticing that approximately 49,0% of the population are younger than 15 years of age (Ministry of Health and Social Welfare Report 2001a:2), and a further 28,8% is under the age of 20 years according to SNAP (1996:3). This scenario has serious consequences for the future population, as the Swazi population could double by the year 2011, unless specific precautions are introduced (Development Plan 1996/7-1998/9:50).

Table 1.1: Population growth of Swaziland

	1986	1996	2001
Total population	668 124	937 747	1 095 094
Crude birth rates/1000	49,1	42,8	37,7
Crude death rates/1000	12,6	10,1	8,7
Rate of natural increase per annum	3,65	3,27	2,9
Total births (estimates)	33 402	40 766	44 633

(Source: Ministry of Health and Social Welfare Report 2001-2005:2)

Although women constitute half of the population and men comprise 34,0% of the population, the National Development Strategy (1998:57) notes that women are customarily a marginalised group. Their status is seen and valued in the reproductive arena, and infertile women would be seen as

having failed in marriage because they did not produce children (Okpaluba et al 1997:269). Indeed, children are generally seen as the only means of support in old age. The more children parents have, by implication, the greater their security will be in their old age. Consequently, Kasenene (1993:77) points out that large families are the norm in Swaziland. The minority status of women perpetuates even in decisions related to women's health, hence some women fail to practise family planning because of husband/partner disapproval (WLSA 2000:136). In fact, the family planning programmes in Swaziland, as observed by WLSA (1998:201), have centred on persuading men to allow their wives or partners to practise family planning rather than to create an enabling environment for women to make their own choices and thereby to exercise their reproductive rights.

Another cultural factor that contributes to the high fertility rate in Swaziland is polygamy, practised in a form of polygyny, which is an acceptable form of marriage in Swaziland (Dlamini 1997:294). Having more than one wife is seen as enhancing the status of men in the society. An important factor, however, is that the more wives a man has, the more children he is likely to have, as each wife has to bear children in order to justify her social position. In fact, Kasenene (1993:77) states that in Swazi religion, *'to have children is to rise from the dead'* as it has been indicated in the introduction (section 1.1) of this thesis. The practice of polygamy continues to exist in Swaziland, contributing to high population growth rates and ineffective family planning practices.

Russell (1993:48) reported that another contributing cause to the high fertility rate in Swaziland is extramarital conception. Although many Swazi's marry at a late stage, namely at approximately 30 years of age, most people engage in sex at the average age of 17 years in the case of girls, and 19 years in the case of boys (NPASMI 1997-2000:11). Evidence of such engagement in early sexual intercourse can be found in the high rate (27,0%) of adolescent pregnancies, as indicated by UNICEF (1994:11). According to the Health Statistical Report of 1997, a further 0,5% of deliveries conducted in health care facilities occur among girls younger than 15 years of age, suggesting that Swazi girls engage in sexual activities at an even younger age than 17 years (HSR 1997:6).

Adolescents generally have limited knowledge about family planning issues. The health consequences of adolescent pregnancies are greater than what is the case for women older than 20 years of age. Baker et al (1996:11) indicate that the risk of death among adolescent mothers is three times higher than what is the case for women aged 20-29 years. Such poor obstetric outcomes support the view expressed by Silberschmidt and Rasch (2001:1818) that adolescents have limited knowledge

about contraceptives, and therefore use family planning methods ineffectively.

Maternal mortality in Swaziland is a matter of public concern, being rated at 229 per 100 000 live births (National Development Strategy 1998:51). Grand-multiparity also heightens reproductive risks, a concern that becomes even more relevant when noting that 6,0% of recorded deliveries in Swaziland are by women who are older than 35 years of age (HSR 1997:6). In addition, frequent child bearing, which refers to the situation where a woman gives birth to a child every year, also occurs. On average a Swazi woman spends 34 years of her life either pregnant or breastfeeding if her fertility began at 15 years and ceased at 49 years (National Development Strategy 1998:51).

Direct causes of maternal death include pregnancy and /or labour complications. These causes are further compounded by the fact that traditional birth attendants conduct 44,0% of deliveries in Swaziland (Development Plan 1997/8-1998/9:162). According to Sweet and Tiran (1997:675), using untrained persons in pregnancy related conditions might cause poor management of maternal complications. The best possible health care is required to curb maternal mortality and morbidity rates, and to prevent unplanned pregnancies by using modern contraceptives (Population Report (2001:3).

Unsafe abortion is another contributory cause to maternal death, accounting for 19,0% of maternal mortality in Swaziland (National Development Strategy 1998:51). The high incidence of unsafe abortion may be attributed to the lack of reproductive health services in the community (Dlamini 1997:284) as well as to poor access to family planning services (Bergstrom et al 1993:65).

The Swazi government, through the Ministry of Health and Social Welfare Programme, provides information about family planning, but the dissemination of this information is mainly conducted through the distribution of pamphlets and broadcasts by the national radio station. Sex education is not included in the formal curriculum in Swaziland's public schools (Dlamini 1997:281). Many parents might lack knowledge and skills in teaching their children about sexuality issues, and especially about family planning choices.

Statistical knowledge of family planning is high (80,0%) in Swaziland (HSR 1997:6). However, according to SNAP (2000:13), the user rate is still limited, being only 29,0%. The dichotomy which exists between the knowledge and utilisation of family planning services, requires further

investigation. This study attempted to identify deterrents responsible for poor use of family planning services by Swazi women, despite the fact that 80,0% of Swaziland's people were apparently knowledgeable about family planning methods.

Table 1.2: Key health statistics of Swaziland

Population	912 876	1997
Annual growth rate	2,9%	1997
Total fertility rate	6,4%	1997
Contraceptive prevalence	29,0%	1997
Maternal mortality rate/100,000	229	1997
Adolescent pregnancy rate	27,0%	1997
Infant mortality rate/1000 live births	68	1997
HIV prevalence rate among pregnant women	34,2%	2000
Population below national total poverty line	65,5%	1997
Access to health facility less than 1 hour	63,4%	1997

(Source: Health Statistical Report 1997:6)

Table 1.2 summarises the most recent key health statistics of Swaziland which are of significance to this research. The HIV prevalence rate, as recorded by SNAP (2000), is reported annually in view of the rapid spread of the disease in Swaziland, and the statistics in this regard refer, therefore, to the year 2000.

1.2.2 The health care system of Swaziland

The Swaziland Government, through the Ministry of Health and Social Welfare, is the main provider of health services in the country. The principal objective of the Government in the health sector is "to improve the health status of Swazi people by providing preventive, promotive, rehabilitative and curative health services which are relevant and accessible to all" (Development Plan 1997/8-1998/9:162). In pursuing this policy, the Ministry of Health and Social Welfare, in 1983, adopted the primary health care strategy for the health service delivery system and care. The aim of the strategy is to reorient the health care delivery system by providing preventive and promotive services in all geographical areas as opposed to the provision of an urban based, curative biased, health care system that existed prior to 1983.

The primary health care system's contact points for family planning clients are the outreach sites and clinics. An outreach site in Swaziland is a part-time clinic visited by health personnel on specific days of each week. Swaziland's Development Plan (1996/7-1998-9:162) defines outreach sites as potential future sites for clinics, whilst a clinic is a formally constructed health care delivery point which offers full time services to communities on an outpatient basis (Ministry of Health and Social Welfare Report 2001a:2). The services offered at such clinics include environmental health, antenatal and postnatal services, immunisations, curative care and family planning services.

The second level of the health care system is a mini hospital which offers a range of health promotion services, including family planning, and which comprises about 24 to 42 beds for acutely ill patients. There is at least one health centre in each of the four regions of Swaziland (HSR 1997:12). Regional hospitals provide the highest level of health care in the regions, including care for emergencies and for patients referred from adjacent clinics and health centres.

As part of the primary health care strategy, the Ministry of Health and Social Welfare introduced a policy of decentralisation. One element of the decentralisation system is the involvement of nonprofessional health personnel – the rural health motivators. The main role of this health cadre is to encourage communities to participate actively in preventive health services, including family planning practices.

The traditional medicine sector provides alternative health care to a large proportion of the Swazi population. This sector, as outlined in the Ministry of Health and Social Welfare Report (2001a:2), is estimated to comprise 8 000 traditional healers as compared to the 188 medical doctors, 3 200 registered nurses, 900 nursing assistants and 2 700 rural health motivators in the western health care sector. It is not known by the western health sector what advice family planning clients obtain from the traditional healers. The extent to which the formal health care sector and the traditional healers collaborate on issues pertaining to contraception, is also not known in Swaziland.

1.3 PROBLEM STATEMENT

The problem statement guiding this research could be best phrased in a question, namely: "Which factors deter Swazi women from using family planning practices?"

1.4 RESEARCH QUESTIONS

In addressing the problem statement relevant to this study, the following research questions were posed:

- **Which** factors are responsible for poor use of modern family planning services in Swaziland?
- **Which** family planning practices do Swazi women generally use?
- **Which** factors influence the selection of a particular family planning method?

1.5 OBJECTIVES OF THE STUDY

The main purpose of this study was to identify factors that are responsible for the poor use of family planning services among Swazi women, focussing on

- factors responsible for poor use of modern family planning practices in Swaziland
- family planning practices that are prevalent among Swazi women
- factors that may influence the selection of a particular family planning method by Swazi women

1.6 SIGNIFICANCE OF THE RESEARCH

Conducting a study on factors which deter women from using family planning services is particularly relevant for health care providers, since more information about family planning attitudes and practices could contribute to the development of programmes that are particularly relevant to childbearing women in Swaziland.

In addition, policies on family planning can be formulated which could be culturally more acceptable to Swazi women and men. Similarly, a policy on adolescent reproductive health can be developed and adopted in schools. The findings from this study could be used to develop adolescent health programmes, which will address issues such as sexuality, adolescent pregnancies, and family planning.

Educational programmes presented via the media, and peer education at public gatherings can be developed in order to empower women on sexuality issues, and to assist them in making informed

decisions about their health, and about the welfare of their children. Nurse educators can also use the findings of this study to teach student midwives and community health nurses about family planning issues, particularly the socio-cultural aspects of family planning practices, that are apparently lacking in the curriculum (Swaziland Midwifery Curriculum 1995:14). In this way, appropriate family planning advice can be given to women. Finally, by incorporating the findings in the curriculum for nurses and midwives, the curriculum can be upgraded to address issues related to family planning practices in Swaziland.

In view of Swaziland's high birth rate of 6,4 (SNAP 1996:4), it could be assumed that Swazi women value large families. The actual number of pregnancies required to produce these births tend to be higher, since not all pregnancies come to term. In addition, the infant mortality rate is as high as 68/1 000 live births in Swaziland (SNAP 2000:13). Compared to women in developed countries, Swazi women start child bearing at the young age of 15 years, have large families, and make less use of family planning services than what their counterparts in other developing countries do (Hatcher & Kowal 1999:14).

Maternal mortality in Swaziland is high, being 229/100 000 live births (National Development Strategy 1998:51). The direct causes of maternal death are obstetric complications of pregnancy, labour and puerperium (NPASMI 1997-2000:34). Indirect causes are those that result from previous existing diseases which develop during pregnancy such as HIV/AIDS, malaria, diabetes and cardiac diseases (NPASMI 1997-2000:35). The National Development Plan (1996/7-1998/9:169) reported that every year about 92 mothers and 870 newborn babies die in Swaziland as a result of pregnancy related complications. The HIV pandemic among pregnant women in Swaziland, reported to be 34,2% during 2000 (SNAP 2000:27), will increase the maternal mortality rate even further. By contrast, the risk of maternal death in industrialised countries is as low as 27 per 100 000 live births (Hatcher & Kowal 1999:3).

By providing family planning services, maternal deaths amongst Swazi women could be reduced by as much as one third (NDS 1998:50). Family planning could allow Swazi women to avoid becoming pregnant at the extreme ages that pose the greatest risk to their health, namely below 19 and above 35 years of age. One fundamental goal of family planning, as outlined by the Centre for Disease Control (1999:8), is to make "every child a wanted child", hence the abortion rate can also be reduced if family planning was practised by the majority of women.

As much as the benefit of family planning to promote maternal and child health is well known, a poor use of family planning is still observed in Swaziland (SNAP 2000:13). It is, therefore, important to document factors that are responsible for the poor use of family planning services in Swaziland.

Based on the findings of this study, recommendations will be made to the Ministry of Health and Social Welfare of Swaziland to enhance the utilisation of contraceptives among Swazi women. Should these efforts succeed, a contribution will definitely be made towards:

- enhancing the effective utilisation of contraceptives among Swazi women
- enabling Swazi women to plan their pregnancies according to their education and/ or career needs
- reducing the number of adolescent pregnancies or other unwanted pregnancies among women in Swaziland
- reducing maternal mortality and morbidity as women can have the desired number of children at the appropriate time
- alleviating poverty as women can plan the size of their families in accordance with their financial resources
- enabling the population to balance the economy of the country because a high population growth aggravates poverty in underdeveloped countries

1.7 DEFINITION OF CONCEPTS

Clarification of specific concepts used in this study are outlined below:

1.7.1 Abortion

Abortion may be defined as the expulsion of the foetus either spontaneously or by induction, before the 24th week of pregnancy (Bennet & Brown 1993:272). Abortion can either be therapeutic or criminal.

Therapeutic abortion refers to the situation where a qualified medical doctor for a valid medical reason evacuates the uterus. This operative procedure must only be performed in the interest of the mother's life and her total well-being (Sellers 1993:1008).

Unsafe/criminal abortion is defined as a procedure for terminating an unwanted pregnancy either by persons lacking necessary skills or in an environment lacking the minimal medication standards or both (Ashford 1995:27). In Swaziland, procured abortion is a criminal offence and the abortionist is punishable by law (Dlamini 1997:284).

1.7.2 Adolescence

Adolescence is a transition from childhood to adulthood between 10-19 years (Otto & Gahwera 1998:3). This is a time for physical, psychological and social self-discovery. It is a period when children learn about themselves in relation to the people with whom, and the community in which they live (Compton's Interactive Encyclopaedia 1994). Adolescence can be classified into three different stages, namely:

- *Early adolescence* is a period between 10-15 years of age. At this stage, girls are biologically immature for effective child-bearing (Sellers 1993:1715).
- *Mid-adolescence* is a period between 16-17 years of age. At this stage girls are interested in heterosexual love but their bodies have not yet developed fully for childbearing purposes (Sellers 1993:1715).
- *Late adolescence* is a period between 18-19 years. In many instances these girls are able to maintain stable relationships and have the ability to develop more adult relationships (Sellers 1993:1715).

For the purpose of this study **adolescent** shall refer to a young person up to the age of 19 years. Barker and Rich (1992:209) maintain that women of that age are all susceptible to obstetric risks.

1.7.3 Family planning

Family planning is a process or activity engaged in by an individual, or family, in order to regulate the time of conception and frequency of childbearing (Pillitteri 1992:100). In this respect, family planning includes measures adopted by a family to control the rate of its growth in order to ensure healthy child spacing, so that the mother can regain her full strength and health before she has another baby. In addition, family planning is a means of ensuring that each child comes to the family and world at a time when it is wanted by the family that will have the responsibility of nurturing it

(Shongwe 1993:71).

Natural family planning refers to the monitoring of the physiological signs and symptoms to determine the fertile period (Gray, Kambic, Lanctot, Martin, Wesley & Cremins 1993:249). Natural family planning methods are means by which the couple use the daily observation of signs and symptoms of the fertile and infertile phases of the menstrual cycle to guide the timing of intercourse according to the desire to achieve or avoid a pregnancy (Ryder & Campbell 1995:233).

Traditional family planning implies the use of certain herbs, teas, vaginal plugs and abstinence from sexual intercourse in order to prevent conception (Silberschmidt & Rasch 2001:1823).

For the purpose of this study family planning shall include all birth control measures, irrespective of whether they are natural, traditional or scientific methods.

1.7.4 Grand multiparity

Grand multiparity refers to women who have had five or more live babies (Sellers 1993:1239). These women are susceptible to a series of obstetric complications, which might be difficult to be detected by inadequately trained health care professionals. It is extremely important, therefore, that these women practise family planning in order to safeguard their health, and even their lives.

1.7.5 High-risk pregnancy

A high-risk pregnancy is one that introduces a probable and/or definite increased threat or danger to the life and/or health of the mother and her baby (Sellers 1993:993).

1.7.6 Maternal death

Maternal death means the death of a woman, while pregnant or within 42 days after the termination of pregnancy, irrespective of the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes (NPASMI 1997-2000: 34).

Direct obstetric cause of death. This results from obstetric complications of pregnancy, labour and puerperium, from interventions, or from a chain of events resulting from any of the above (NPASMI 1997-2000:34).

Indirect obstetric cause of death. This results from any previously existing disease that developed during pregnancy, which was not due to direct obstetric causes, but which was aggravated by the physiological effects of pregnancy such as HIV/AIDS, malaria, diabetes mellitus, hypertension, and cardiac diseases (NPASMI 1997-2000:35).

Contributing causes of death. These are causes other than physiological causes which were found to contribute to delay, omission or incorrect obstetric management, leading finally to irreversible physiological changes causing the woman's death. These causes include the unavailability of blood, and a lack of transport to transfer the woman to a health care centre (NPASMI 1997-2000:35).

For the purposes of this study, maternal death includes direct, indirect and contributory causes of death.

1.8 THEORETICAL BASIS OF THE STUDY

1.8.1 Metatheoretical assumption

The metatheoretical assumption for this study maintains that cultural values are the prevailing and persisting guides influencing the behaviour of people. The success of any family planning programme will depend on the values people hold about that programme and whether they perceive it to be congruent with, or contradictory to, their cultural values.

1.8.2 Theoretical assumption

The theoretical assumption of this study is based on the fact that nursing care and health care practices must be congruent with the socio-cultural background of the client and that:

- The client and the health care provider are the products of a culture which influences their behaviour and practices.

- The client and the health care providers interact in order to attain the desired goal, which in turn influences the decision taken by a client to practise family planning.
- The client is also affected by social networks, influencing her behaviour regarding family planning.

1.8.3 Theoretical framework

The Health Belief Model (HBM) has been used as the theoretical framework for this study. The HBM was developed from the logical positivist paradigm of science (Thomas 1995:246). It stands out among social-psychological models of health related behaviour, and is basically a “value expectancy” model developed to explain an individual’s health actions under conditions of uncertainty. The perceived value of an outcome, and expectations that a given action will result in that outcome, are considered to influence behaviour (Harrison, Mullen & Green 1992:107). The premise of the HBM is that individuals will take action to prevent, control, or treat a health problem if they perceive the problem to be severe in its nature and/or in its consequences, if they perceive that the action will benefit them and produce desirable outcomes, and if they perceive few barriers to taking that action (Stout 1997:174). The health beliefs of a client are thus shaped by the social framework of the individual, hence the culture of a client must be considered when planning health related practices. The components of the HBM shall be discussed in greater depth in the next chapter, where a review of the relevant literature will be presented.

1.9 ORGANISATION OF THE REPORT

This research report is presented in six chapters.

Chapter 1 comprises the introduction to the field of study. The significance of undertaking the study is explained, and objectives as well as research questions are presented.

Chapter 2 reviews previous studies relevant to family planning practices. A number of factors which might influence the use of family planning practices are discussed, compared and contrasted.

The methodology of the research, the population, sample, instruments, reliability and validity of techniques applied in the study, are discussed in chapter 3.

In chapter 4 qualitative data obtained from focus group informants is presented, analysed, and the way in which items were selected for the structured interview schedules is illustrated.

Chapter 5 analyses and discusses quantitative data collected by means of interviews.

Conclusions, recommendations and limitations of the study are presented in chapter 6.

1.10 CONCLUSION

In this chapter, the background of family planning practices of Swazis, as well as the objectives of the study were discussed. The next chapter focuses on family planning studies that have been conducted internationally as well as regionally. This exercise will help in identifying similarities and differences in family planning practices worldwide, and in identifying a suitable research design for this study. Furthermore, items to be included in the research instrument will also be identified from the literature review.

CHAPTER 2

Literature review

2.1 INTRODUCTION

This chapter presents a review of family planning literature that was perused. Several sources of family planning practices were consulted, including libraries, World Health Organization (WHO) manuals, the WHO Reproductive Health Library CD-ROM, Ministry of Health and Social Welfare records, universities and the Planned Parenthood Association. It was noted that most literature acknowledged that Sub-Saharan Africa has the lowest rate of contraceptive use in the world, ranging for instance between 4,0% in Niger and 48,0% in Zimbabwe (CDC 1999:14). Several factors contributed to this low rate, including difficulties in obtaining contraceptive supplies, limited numbers of family planning clinics, the largely rural nature of populations in the region, the low socio-economic levels of women, high rates of infant and child mortality and the high value many cultures place on large numbers of children (Hatcher & Kowal 1999:14).

Based on this information, relevant literature was reviewed confirming some of the cited deterrents to family planning. The literature review is organised according to the research questions presented

in section 1.4.

2.2 FACTORS THAT ARE RESPONSIBLE FOR THE POOR USE OF MODERN FAMILY PLANNING SERVICES IN SWAZILAND

Limited studies that address factors responsible for poor use of modern family planning methods were identified in Swaziland. However, various studies conducted internationally were also reviewed, and were accordingly categorised as outlined in this chapter.

2.2.1 Societal attitudes toward family planning

In traditional societies like Swaziland, the male is the dominant family member who determines all that takes place within the family, including family planning (Mkhonta 1999:4). However, family planning research, policy and programmes side-stepped this important rule in Botswana (Chipfakacha 1993:82). The exclusion of men from family planning efforts has ramifications for the preferred family size and have consequently resulted in negative attitudes toward contraceptive use.

Bankole and Singh (1998:15) conducted a demographic and health survey in 18 developing countries, including 13 Sub-Saharan countries. The main objective of that study was to understand the role of husbands/men in reproductive decision-making by focussing on their preferred family sizes and intentions to have additional children. The phenomenon was examined by comparing the responses of husbands with those of their wives, in order to identify the similarities and differences in their perceptions. Logistic regression analyses compared the attitudes of respondents. The results showed that men and women in the countries involved desired large families (five or more children). However, husbands tended to want more children than their wives (two or more children than their wives). The use of modern family planning methods was low (20,0% for husbands and 13,0% for wives), but knowledge was high, ranging from 57,0% in Burkina Faso to 100,0% in Brazil. Knowledge of modern family planning methods was found to be lower among husbands in West Africa than elsewhere. Demographic characteristics, including age, type of marriage, literacy, type of work and area of residence predicted the use of modern family planning methods in nine out of 14 countries for which data was available. The findings by Bankole and Singh (1998) could be compared to the attitudes of Swazis regarding childbearing practices, where the fertility rate is as high as 6,4 births per woman and contraceptive prevalence is 29,0% (SNAP 2000:13). It is therefore important

to examine cultural practices which discourage the use of family planning in Swaziland.

A limitation of the study by Bankole and Singh (1998) was the exclusion of unmarried men and women, as these clients might have different reproductive goals from those of their married counterparts. With regard to the methodology of the study by Bankole and Singh (1998), in-depth interviews providing men's and women's attitudes, preferences and behaviours regarding contraception and childbearing practices would have yielded valuable additional information. A longitudinal study, succeeding this cross sectional survey might have provided a better understanding about reproductive attitudes and preferences concerning contraceptive use and fertility regulation issues in the communities included in the study by Bankole and Singh (1998).

Biddlecom, Casterline and Perez (1997:108) evaluated spouses' attitudes toward contraception in the Philippines. The sample comprised 780 matched couples from both rural and urban areas. The results revealed that 72,0% of the husbands and 77,0% of the wives approved of contraceptive use. At the couple level, however, men's perceptions about contraception often differed from those of their wives. Disagreements existed, particularly about the importance of certain contraceptive attributes, and about the extent to which these attributes applied to specific contraceptive methods. This disagreement was associated with lower levels of contraceptive use and with greater conflict over intentions to use contraceptives in the future. For example, when both spouses approved of family planning practices, 81,0% of couples shared the same intentions to use contraceptives. However, among couples who disagreed over contraceptive use, 43,0% of couples shared intentions about future contraceptive use. As much as the study by Biddlecom et al (1997:108) revealed negative attitudes toward family planning issues, it should be noted that it focussed only on couples, and ignored sexually active single adults and adolescents. In contrast, this research attempted to identify deterrents to the utilisation of contraceptives among Swazi women, men *and* adolescents.

2.2.2 Cultural barriers to family planning

In most African countries, including Swaziland, customs tend to emphasise the importance of childbearing (Ndubani & Hojer 2001:110). Consequently, family planning services may be poorly accepted in these societies. Another important consideration is the cultural acceptability of contraception to both users and providers. Tadiar and Robinson (1996:79) state that the prevalence of modern contraception in the Philippines among married women aged 15-49 is as low as 25,0%.

This finding may be due to the fact that the Philippines is a predominantly Catholic country which does not approve of the use of contraceptives. In Swaziland, on the other hand, contraceptive prevalence is 29,0% (SNAP 2000:6). This minimal use of modern contraceptives in Swaziland, could be due to fears of rumoured side effects. This possibility poses a challenge to family planning providers who should provide the relevant information to family planning clients and dispel unfounded negative attitudes towards family planning practices (Rees 1995:34).

◆ **Male attitudes toward family planning practices**

Mbizvo and Adamchak (1992:52) observed that there is a relative paucity of male contraceptive data in the scientific literature. Most studies on fertility and family planning focus on women, and ignore men. Bankole and Singh (1998:15) observed that these studies overlooked the primary fertility decision-makers in most African countries. This is particularly relevant to societies like Swaziland where women are considered to be minors to the extent that their husbands' approval has to be obtained for issues relating to family planning (WLSA 1998:200). Studies which focussed on both men and women were identified during the literature search, and these studies are briefly discussed in this report.

Mbizvo and Adamchak (1992:52) conducted a survey in Zimbabwe to ascertain male knowledge, attitudes and behaviours relating to fertility regulatory methods directed towards men. Stratified cluster sampling procedures were used, and a representative sample of 711 households completed questionnaires. The results showed that 1,8% of the respondents knew about male sterilisation (vasectomy) as a family planning method, compared to 74,0% who had knowledge about female contraceptive pills. Condom knowledge was as high as 37,8%, but the user rate was estimated to be only 6,0%. Acceptance of family planning methods was only 14,2% compared to 81,6% nonacceptance of family planning. The main reason for disapproval of family planning was the desire for additional children. The socio-economic characteristics of men who disapproved of modern family planning methods included their relatively young age (20-26 years), low educational level (primary education) and the fact that about 60,0% of the respondents resided in rural areas. In this study, socio-cultural characteristics will be examined to identify similar influences on the utilisation of family planning among Swazi men and women.

In another survey by Chipfakacha (1993), 260 Botswana men were randomly selected to form a research sample during face to face interviews. The District Health Team of Botswana investigated their knowledge, attitudes, practices and experiences with regard to family planning. The results demonstrated that knowledge about family planning was as high as 74,0% , and according to 81,2% of the respondents and health care facilities were identified as the main source of family planning services. Most men, (93,0%) associated modern family planning practices with condom use, and had minimal knowledge about other family planning methods. With regard to spousal communication about family planning issues, the majority (65,0%) of respondents were nonconversant about family planning issues, and regarded family planning issues as women's business. Contrary to the above statement, these men would be angry to the point of beating their wives, if they discovered that the women were using family planning methods. These men, according to Chipfakacha (1993:82), perceived family planning methods as promoting infidelity among women. The negative attitudes of men toward contraceptives were observed by Zwane (2000:9) as the main deterrent to family planning among Swazi women. This finding is consistent with MacPhail and Campbell's (2001:1613) report on 44 young men in Khutsong township, Republic of South Africa, in accordance with which it was revealed that deterrents to family planning included a lack of perceived risk of making women pregnant, peer norms in engaging in unprotected sexual intercourse, gender power relations, and the economic context of adolescent sexuality.

Odinegwu (1999) conducted a survey amongst a randomly selected sample of 927 married men and women residing in both urban and rural areas of Nigeria. A factor analysis process was used to measure respondents' attitudes towards, and utilisation of, contraceptive practices. The results revealed that 76,0% of respondents had a sound knowledge of contraceptives, but only 28,0% were using such methods at the time of the investigation. Fewer men than women (42,0% compared to 50,0%) had ever used modern or traditional contraceptives (Odinegwu 1999:87). However, attitudes toward family planning and marital relations were less positive among men than among women. For example, female respondents were more aware of the fact that a large family size contributed to social problems within marriage (55,0% females versus 40,0% males). The majority of women (75,0%) registered a high level of support for men playing a role in family planning, yet only 30,0% of men were of the same opinion. These findings demonstrated that even if women were inclined to use family planning methods, culturally they might not succeed as social support was important for the success of maintained contraceptive use. According to Erasmus and Bekker (1996:14) this is also the case with Swazi women who lack social support in practising family planning. It is therefore

important to identify partners who can act as change agents to promote and maintain family planning practices in the Swazi culture.

◆ **Gender issues**

According to Barker and Rich (1992:199) socio-cultural factors which are grounded in gender relations that enforce the subordinate status of women, impede the use of family planning services. In Swaziland, for example, high birth rates before marriage are an established social pattern (Shongwe 1992:73). This is confirmed by certain cultural practices regarding the handling of prenatal births, which include compensation payment for the girls' parents, the buying of offspring by their parents, and the absorption of children by the rural homestead (Russell 1993:43). When a woman who has born premarital children finally gets married, she is also expected to bear many children in the new family in order to justify her marital status (Russell 1993:43).

Similarly, in a situation whereby a man has fathered children from many women, the competition as to which woman will win his hand in marriage will probably be won by the woman who has delivered the largest number of children (Rwomire 1991:62). The WLSA (1998:205) points out that young women are justified in having premarital births in order to prove their ideal status as women, to their future in-laws. Contrary to this situation, a woman who is barren is stigmatised and her husband may decide to divorce her. In such a situation a substitute wife, usually a young relative, might be secured in order to produce children on behalf of the barren woman (WLSA 1998:205). This gender disparity against women signifies a need to educate women about reproductive rights and family planning. In a report by Gule (1993:242) a number of socio-cultural and gender issues were identified as the main deterrent to family planning in Swaziland.

Kinship structure. According to Gule (1993:243), the extended family system in Swaziland is a deterrent to family planning practices, since all decisions, even those that relate to health and family planning, must be endorsed by the extended family. Failure to comply with the demands of a large family can result in a variety of social problems. Motsa (1991:29) suggests that a Swazi woman may rather be advised to consult a traditional healer for family spacing purposes, than to limit the number of children by using contraceptives.

Contrary to the negative attitudes toward family planning observed among Swazis, Godley (2001:7) conducted a cross sectional survey among 1563 family planning clients in Thailand. The aim of the survey was to identify the role of kinship networks in contraceptive use. Results indicated that family planning clients with kinship ties were motivated to use contraceptives. Of these 39,0% used injectable contraceptives, 32,0% used oral contraceptives, whilst the proportion of those who did not use family planning was found to amount to 27,0%. By contrast, women who had no kinship ties were less motivated to use contraceptives. Of these, 23,0% used oral contraceptives, 26,0% used injectable contraceptives and 43,0% did not use any family planning method (Godley 2001:7). Therefore, it can be deduced that kinship ties had a positive effect on the use of contraceptives among Thai women.

Partners' disapproval of family planning. Culturally, Swazi women are not regarded as equal partners in marriage, but are considered to be inferior partners who cannot obtain contraceptives if their husbands should disapprove. Male dictatorship in Swaziland results in a lack of smooth communication between couples on family planning issues (Okore, Mahindi & Dlamini 1993:92). Consequently, many Swazi women fail to make effective use of family planning practices. Disapproval is associated with ignorance about methods of family planning, or with unfounded fears. Misconceptions about contraceptives are widespread, including the fear that contraceptives will change the quality of sexual relationships, produce deformed children, and have negative health consequences such as STDs and sterility in both the user and the partner (Gule 1993:243).

Misconceptions and negative attitudes toward family planning were found to be displayed by both men and women in Nigeria. Otiode, Oronsaye and Okonofua (2001:77) conducted twenty focus group discussions in Benin city in Nigeria, the purpose of the study was to explore attitudes and beliefs concerning the use of contraceptives and the results revealed negative attitudes toward the use of contraceptives. Oral contraceptives, for instance, were associated with infertility and frequent menstrual periods.

Intra-uterine contraceptive devices (IUCDs) were perceived to cause infertility, according to Carpenter and Rock (2000:384). Pelvic infections which are associated with the use of IUCDs, are believed to subject some clients to secondary infertility. Such findings might give rise to the widespread belief that IUCDs cause infertility. Injectable contraceptives were associated with paralysis and infertility, and condom use was perceived to promote promiscuity. According to

Hatcher, Rinehart, Blackburn, Gelter and Shettonn (1997:79) and WHO (1996:10), the use of oral contraceptives, IUCDs and injectable contraceptives, may delay fertility by a period of 4-9 months, but cannot result in infertility. Family planning providers should address these misconceptions in order to reduce the fears of clients to use contraceptives.

Bias and prejudice. Some Swazi men who know about family planning methods might feel that family planning is a white man's creation to reduce African numbers (Okore et al 1993:93). Others assert that family planning practices are against Swazi culture and that its use is against the will of God. Men are not totally to blame for their lack of knowledge and minimal participation in family planning activities. In general, family planning programmes are female oriented and are incorporated in maternal and child health services in most health care centres in Swaziland. In addition, these services are usually headed by female staff (Gule 1993:243). Male motivators have been trained to encourage their fellow men to use family planning methods, and to distribute nonprescriptive contraceptives such as condoms. However, very few men use family planning methods, and the majority still view family planning to be a foreign concept (Mkhonta 1999:8). The Swaziland Government Strategic Plan (2001-2005:13) addressed male involvement in family planning and reproductive issues by involving male motivators, educators and distributors of male oriented family planning methods. This effort is aimed at promoting open communication about sexuality issues among partners, and increasing contraceptive prevalence.

Women's status. In Swaziland, a woman's status is associated with motherhood. The more children a woman has, the more status she commands in society. On the contrary, childlessness is considered to be a social and cultural handicap (Gule 1993:242). It is for this reason that a woman cannot voluntarily use family planning as her status might be jeopardised if she should do so. Decisions about fertility control rest solely with the husband, who is the head of the Swazi family (Mkhonta 1999:4).

Sukati (1998:226) conducted a study that was aimed at understanding the views of Swazi women towards men's lack of commitment to family planning practices. In the study, a sample comprising 381 women selected from 21 enumerated areas, participating in face to face interviews. They represented rural, peri-urban and industrial settings, and their ages ranged from 15 to 49. The results showed that women identified a need for health providers to target men on health related issues including family planning (Sukati 1998:226). It became evident from the study that the health

providers sidelined the decision-makers in family planning issues such as family planning methods. In view of this shortcoming in the health care delivery system, women expressed a need to access female condoms. Such devices would empower women to use their reproductive rights should men refuse to use condoms (Sukati 1998:228). Indeed, Okore et al (1993:94) observed that only free and emancipated women could fully participate in practising family planning decisions and actions. This situation overlooks the fact that for family planning to work, both partners should be involved (Rees 1995:34). According to Tadiar and Robinson (1996:77), some methods of family planning require the cooperation of men. These include periodic abstinence, incomplete intercourse by withdrawal, male sterilisation, and the use of male as well as female condoms.

Value of children. In Swaziland children are desirable and valued. Men boast about their virility, and women about their fertility (WLSA 1998:204). The value of children is reflected in the National Health and Social Welfare Policy, which indicates that “providers of reproductive services shall respect the right of couples and individuals to decide freely and responsibly about the number and spacing of their children” (Ministry of Health and Social Welfare 2001a:18). Therefore, the Swaziland Government respects the rights of clients in determining the size of their families, as it could be improper and against human rights for family planning providers to impose their values on the community by encouraging women to limit the size of their families.

In Swaziland children are still considered to be a family resource and they bring joy to the family. Gule (1993:243) noted that having a large family in Swaziland is necessary to ensure adequate and continued support during old age. The social support provided by children is confirmed by the absence of social services for disadvantaged and senile members of the Swazi society. Lack of Government commitment to social services justify the need for partners to bear many children in order to secure their future. Furthermore, Swaziland is a patriarchal society, maintaining pressure on women to bear sons in order to carry on the family name. Historically, the perpetuation of the male line was important for the economic viability of individual families and for nation building (WLSA 1998:204). This practice is a significant deterrent to family planning practices among Swazi men and women.

High infant and child mortality rate. As stated in table 1.2, the infant mortality rate in Swaziland is high, being 68/1000 live births. The majority of families thus fail to use family planning services since they know that death can strike at any time and that this would reduce the number of their children

(Gule 1993:242). Consequently, women resort to having many children so that in an event of death there will be some children who would survive. In view of this potential danger, Swazi women may not routinely practise contraception, since it may leave families childless or small, should a number of children die. The implications of Gule's (1993) report is to reduce infant and child mortality concurrently with the implementation of effective family planning programmes.

Poor quality of family planning services. The negative attitudes of family planning providers, lack of qualified personnel, absence of client friendly policies and lack of resources including privacy in counselling family planning clients, could deter clients from utilising family planning services (Galvao, Diaz, Diaz Osis, Clark & Ellertson 1999:168). For example, a report from Ecuador by AbouZahr, Vlassorff and Kumar (1996:454) revealed that women failed to use family planning services because of rigid timetables and stipulations imposed on clients. Conversely, Abdool Karim, Abdool Karim and Preston-Whyte (1992:392) noted that poor attitudes of clinic staff were identified as the main barrier to the utilisation of effective family planning practices among adolescents in Durban. Hiltabiddle (1996:63) is of the opinion that, if family planning providers could be more conversant regarding adolescent sexuality issues, more adolescents might utilise effective family planning methods. It is important, therefore, to have user-friendly services in order to attract family planning clients. In Swaziland, some health facilities were found to be hostile to clients, explaining why some clients were not utilising these services (Gule 1993:244).

In view of the poor quality of family planning services, WHO (2001) is of the opinion that family planning services should be monitored for the quality of care rendered to clients. In Ecuador, Uganda and Zimbabwe an investigation of the quality of Family planning programmes was conducted in 1999 by Bessinger and Bertrand (2001:63). Observations and exit interviews were conducted with 1 858 family planning clients. The linked data was used to analyse the comparability of observations and exit interviews. The results revealed that 11 of the 25 quality of care indicators demonstrated good counselling skills among family planning providers. Clients were treated with respect. Information relating to problems emanating from contraceptive use revealed that 84,0%-87,0% clients were encouraged to verbalise their concerns.

The prevalence of contraceptive use varied per country showing a 71,0% prevalence of injectable contraceptives. The oral contraceptive prevalence rate in Zimbabwe was 62,0% and IUCD prevalence rate was 43,0% in Ecuador. Bessinger and Bertrand (2001:65) reports that the increase in

contraceptive prevalence in Zimbabwe is due to the quality of family planning services that is offered by the Zimbabwe family planning services. Therefore, it is important to provide quality services in order to promote contraceptive practices.

Access barriers. Access to family planning services is determined by physical and logistical factors, including the proximity of family planning services to the homesteads, as well as the availability of transport. Economic factors such as access to cash to purchase pills or condoms, and the cost of forfeiting wages also function as barriers to family planning services (AbouZahr, Vlassof & Kumar 1996:454). This aspect was investigated in the present study in order to determine whether cost was a deterrent to family planning services in Swaziland.

It was significant to note that the Ministry of Health and Social Welfare of Swaziland has embarked on a community-based family planning programme, which is aimed at making family planning services more accessible to clients (Ministry of Health & Social Welfare 2001b:3). Before the inception of the community-based family planning programme, contraceptives were available at the regular health care facilities. Some of the health care centres are geographically inaccessible, with a limited variety of family planning methods, minimal counselling services and lack of trained personnel to provide particular methods of contraception (Development Plan 1996/7-1998/9:169). These factors might further contribute to limited use of family planning services among Swazi women. The WHO (1995) recommends community-based family planning programmes, as such programmes have proved to be acceptable to communities, affordable when compared with clinic-based services, and convenient to clients.

Much as a community-based family planning programme might increase contraceptive prevalence in Swaziland, in some countries clinic-based family planning programmes offer better services than the community-based family planning programmes. In Bangladesh, Routh, Ashraf, Stoeckel and Barkat-e-Khuda (2001:82-89) conducted a survey among 365 women of reproductive age in order to evaluate the impact of changing from community-based family planning programmes to clinic-based family planning services. The study by Routh et al (2001) demonstrated an increase in the contraceptive prevalence rate from 54,0%-57,0% in urban cites and 40,0%-57,0% in rural cites. Clients revealed that clinic-based programmes offered private counselling and a wider variety of contraceptive methods which were not available in community-based family planning programmes. Family planning providers must, therefore, identify convenient sites for distributing contraceptives

in order to serve the needs of individual clients.

2.2.3 Attitudes of family planning providers

Family planning providers might contribute to the poor participation of clients in family planning services. In Tanzania for example, data from 327 mainland clusters was collected, using the Tanzanian Service Availability Survey. Data collection procedures from 1996 were used to analyse the prevalence of medical barriers by type of provider, facility where provider worked, and by location. The results revealed that there were certain medical barriers that were responsible for poor use of family planning services (Speizer, Hotchkiss, Magnani, Hubbard & Nelson 2000:16). The barriers are discussed briefly and include:

Provider overspecialisation. Doctors and nurses were the only professionals who could insert intra-uterine devices in Tanzania, but family planning providers who were in constant contact with clients did not have these skills, and thus could not provide these services. Therefore, the types of providers available at a particular facility were likely to be an important determinant for the choice of methods available at that family planning centre (Speizer et al 2000:16). Other factors included lack of equipment or supplies to provide different family planning methods to suite the unique needs or preferences of different clients.

Eligibility. Even if a facility had the appropriate equipment, supplies and qualified staff, a woman might be unable to obtain family planning if providers refused to serve clients who did not meet certain criteria, such as the minimum age of 18 and/or being married.

Age barriers. A measure of age barriers revealed that some family planning providers restricted access to family planning services to clients who were young (12-19 years of age). A high proportion (79,0%-81,0%) of the Tanzanian family planning providers imposed restriction particularly for oral contraceptives. More than one-third of providers imposed restrictions for condom distributions (Speizer et al 2000:17). The restriction imposed on condom and oral contraceptives exposed young sexually active women to unwanted premarital pregnancies. Stanback and Twum-Baah (2001:37) as well as WHO (2000:7), confirmed that age restriction was imposed by health providers because they were concerned about the safety and morals of young people should they be engaging in sexual relations.

Service restrictions. According to the parity of women, service providers might impose restrictions if they believed that clients had to have a minimum number of children before they were eligible for using contraceptive methods. The study by Speizer et al (2000:16) in Tanzania reported that parity restrictions were imposed on prescribing injectable contraceptives by midwives, auxiliary workers and medical aides. The mean number of children required before a woman could use injections as a method of contraception was 2,5 (Speizer et al 2000:17). Thus, parity restrictions represented an important barrier for young women who intended to avoid pregnancies by using injections.

Marital status. About 20,0% of Tanzanian family planning providers reported that they restricted the use of family planning methods to married women only. Indeed, such a practice might affect the ability of sexually active unmarried women to delay pregnancies or avoid unwanted pregnancies.

Training and eligibility barriers. Provider determined eligibility barriers were related to whether or not a provider received recent in-service training. When comparing providers, who had no reproductive health training in 1992-1996 to those with training during that period, the results revealed that there was no statistical difference among the two groups of family planning providers in terms of eligibility barriers. This finding suggested that the barriers were imposed by individual providers rather than at the national programme levels (Speizer et al 2000:18).

Provider bias. Another way of limiting access to methods is through bias. In Speizer et al's study, it became evident that 10,0%-13,0% of providers reported that there was at least one modern family planning method they never recommended (2000:18). In urban areas, providers never recommended implants and IUCDs for fear that they might interfere with fertility, even though WHO (1997b) confirmed that implants and IUCDs are safe and effective with minimal side effects. Thus, despite the physical availability of family planning methods, and despite higher levels of training in urban areas, provider bias might preclude women from using the method most appropriate for their specific needs.

Process hurdles. Requiring a woman to wait until her next menstrual period before receiving the pill, having an IUCD inserted or receiving her first contraceptive injection, is an example of a process hurdle (Speizer et al 2000:19). Generally, such a waiting time could be limited by confirming that a woman is not pregnant prior to prescribing these methods. Process hurdles therefore appear to be important deterrents to effective family planning practices.

2.2.4 Adolescent fertility

Adolescent fertility continues to contribute substantially to the overall fertility in Sub-Saharan Africa (Barker & Rich 1992:199). The consequences of early childbearing are often socially determined. In rural settings, for example, early childbearing could be encouraged to take place within marriage or consensual unions (Barker & Rich 1992:199). In other situations, however, adolescent pregnancies might result from limited knowledge and/or ineffective utilisation of contraceptives.

In Benin, Cameroon, Cote d'Ivoire, Kenya and Nigeria, a study by Senanayake and Ladjali (1994:140) reported that between one-third and one-fifth of adolescents reported premarital conceptions which resulted in adolescent pregnancies. Eggleston, Jackson and Hardee (1999:78) are of the opinion that limited knowledge about reproductive health could be the main factor contributing to adolescent pregnancies. It is from this perspective that family planning providers should identify socio-cultural barriers to family planning practices in order to design specific family planning programmes for adolescents. Such programmes should address the following areas:

- the advantages of female education
- sexuality education in the society
- the benefits of family planning to the society, to individual families, and to individual men and women

In Mali, a representative sample of 1 696 adolescents comprising 775 males and 921 females, aged between 15-19, were interviewed by Gueye, Castle and Konate (2001:56-59) about reasons for early sexual intercourse and family planning knowledge. The results revealed that peer pressure, curiosity and promise of marriage were the main reasons for women to engage in unprotected sexual intercourse. Boys reported that peer pressure came from two sources namely, their male counterparts, and from their girl friends who threatened to denounce them as impotent if they refused to have sexual intercourse with them. Consequently, contraceptive prevalence in Mali was found to be as low as 0,0%-18,0% (Gueye et al 2001:56-59).

The accuracy of young people's accounts of their sexual activities might produce inconsistent results. Young men might tend to over report their sexual activities to give the impression that they conformed to society's expectations (Singh, Wulf, Samara & Cuca 2000:22). This possibility was

supported by Eggleston, Leitch and Jackson (2000:79). These reports underscored the limitation of relying on self-reported data about sexuality issues. Singh et al (2000:27) pointed out that contraceptive use among adolescents apparently remains limited, being cited in 1992 as only 7,0% in Ghana. Adolescents might meet resistance and antagonism from family planning providers because they might regard adolescents as being too young to engage in sexual intercourse (Silberschmidt & Rasch 2001:1819). In Swaziland, adolescent pregnancy rates are high, accounting for 27,0% of all recorded deliveries (UNICEF 1996:13). It would seem that adolescents in Swaziland fail to practise family planning. The possible reasons for this situation will be addressed in this survey.

2.2.5 Religious barriers

Tadiar and Robinson (1996:79) suggest that there might be religious constraints to the potential use of contraceptives in predominantly Catholic countries such as the Philippines, where the Catholic Church opposes the use of “artificial ” family planning methods. The only “natural” method approved by this Church is the “ rhythm method” which has a high (60,0%-70,0%%) failure rate (CDC 1999:492). In addition, in the Christian tradition people are commanded by God to multiply and fill the earth (Genesis 9 verses 1:10). According to some views, this could imply that a woman can have as many children as she possibly can produce and that to limit family size could be viewed as being contradictory to the Bible’s teachings. Rwomire (1991:62) maintains that Swazi Christians are opposed to the use of modern family planning practices to the extent of relying on prayers as a preventive measure against pregnancy, rather than using contraceptives. In the present study, religion’s possible influences on the use of family planning methods was addressed.

2.2.6 Ethical barriers

Ethical issues related to family planning practices are particularly problematic because the right to procreate is a basic human right. This is particularly true with regard to abortion, one of the oldest and most widely used family planning practices (Smyke 1993:65). These ethical issues could be divided into three dimensions.

Firstly, *the rights of the foetus*: Human Rights movement argue that a foetus possesses humanity from conception, hence it should be accorded all human rights, including the right to life (Davis, Aroskar, Liaschenka & Drought 1997:135). Abortion is thus viewed as killing an unborn person,

irrespective of the stage of the pregnancy.

Jones (1995:96) is of the opinion that the legal status of the foetus poses a dilemma, because a foetus has limited rights. As the law stands, the foetus is not legally considered to be any doctor's patient. To be a (human) patient, the foetus would need to have the status of a person; this status is not accepted until complete expulsion from the mother has occurred.

Conversely, the second dimension addresses *the moral principle of autonomy*. This implies that a woman has the right to her own body and the right to determine her own fertility (Davis et al 1997:145), including the right to obtain an abortion should she desire to do so.

The third dimension relates to *the rights and obligations of the society* (Davis et al 1997:147). One of the factors for any society in balancing values is the question of where to draw the line and to specify under what conditions society will permit abortions to be legalised. The argument pertains to cases where women's health could be threatened by their pregnancies, or the additional child could place great economic and/or psychologic burdens on the families concerned (Davis et al 1997:147).

Despite these ethical arguments, abortions occur among most cultures throughout the world, as indicated by figures of 35 per 1000 women aged between 15 and 44 years (Henshaw et al 1999:30). In Scotland and Cuba, the extent of abortion between sub-groups of women differed because of the issue of legality of abortion (Bankole et al 1999:68). On the other hand, only a few African countries, including Zambia, Burundi and the Republic of South Africa, have legalised abortions (Silberschmidt & Rasch 2001:1816). In spite of this variation, a high number of abortions in any subgroup serve as a useful indicator of unmet family planning needs (Bergstrom et al 1993:70). In Swaziland, the procurement of abortion is illegal, except on medical grounds. Swazi women should thus use effective family planning methods in order to avoid unwanted pregnancies, as they do not have the option of procuring legal terminations of any unwanted pregnancies.

2.3 FAMILY PLANNING PRACTICES GENERALLY USED BY SWAZIS

According to Erasmus and Bekker (1996:14), traditional societies, including Swazis, use traditional family planning methods including abstinence, herbs and incomplete sexual intercourse. Modern family planning practices are generally not favoured by such societies (Campbell 1997:186). The

lack of men's involvement in modern family planning practices in Swaziland was investigated by Dlamini (1999:29). Data was analysed from 48 male respondents who were residing in the rural area of the Manzini district. The results revealed that knowledge about modern family planning was high in Swaziland (83,0%) but user rate was limited (20,0%). The respondents in Dlamini's survey cited four main reasons for failure to use condoms.

- They considered family planning methods to be a foreign concept and found it hard to adopt this practice since they were not made aware of the side effects of this new concept.
- There was no proper forum for men to discuss family planning issues; family planning activities were incorporated into the maternal and child health programmes and men were traditionally excluded from these activities.
- The majority of nurses were younger than their clients, and it was culturally unacceptable to discuss sexuality issues with young women.
- Men used traditional family planning methods, which included incomplete sexual intercourse, the use of herbs and abstinence, either total or periodic abstinence. Men indicated that they perceived traditional family planning methods to be convenient, reversible and without side effects (Dlamini 1999:18).

Dlamini's (1999) study could be criticised for focussing on men and for ignoring women and adolescents who might have had different reproductive attitudes. The use of closed-ended questions might have excluded some important cultural practices from being reported. Interviews might have probed more extensively into the subject matter. Nevertheless, this survey by Dlamini indicates that knowledge about modern contraceptives did not enable the Swazi male participants to use such contraceptives. On the other hand, men preferred using traditional contraceptives, because of perceived convenience, safety and reversibility.

In order to determine the prevalence of contraceptive use among Swazi women, Warren, Johnson, Gule, Hlophe and Kraushaar conducted a survey in 1992 involving 200 women of reproductive age, from both rural and urban areas. The results revealed that the value of total fertility among Swazi women was 5,0, children (5,4 in rural areas and 3,5 in urban areas). Women with primary education had, on average, three more children than women with high school education. With regard to family planning practices, only 17,0% of all women reportedly used contraceptives (pills accounted for 4,8% and injections for 4,4%). User rates in urban areas were more than double those in Swaziland, being

28,0% compared to 13,0% in rural areas (Warren et al 1992:11).

Warren et al's (1992:14) study revealed that abstinence within three months post delivery was practised by the majority of Swazi women (86,0%). Abstinence was reportedly practised by women who had attained high school education and who lived in rural areas.

2.4 FACTORS INFLUENCING THE SELECTION OF A PARTICULAR FAMILY PLANNING METHOD

Categories of factors which influence the selection of family planning methods were identified from the literature as social and demographic characteristics, safety, efficacy and social acceptability of contraceptives. Fikree, Khan, Kadir, Sajjan and Rahbar (2001:130) conducted interviews in Pakistan to establish factors which influenced the selection of family planning methods. Univariate analyses indicated that family planning practices were positively influenced by: high school education, residing in urban environments and giving birth to five live children.

A comparative study on the safety, efficacy and acceptability of medical and surgical abortions among 393 Vietnamese women indicated that the success rates for both medical (96,0%) and surgical abortions (99,0%) were high (Ngoc, Winikoff, Clark, Ellertson, Am, Hieu & Elul 1999:10). In addition, the study revealed that medical abortions were safe, effective and acceptable to urban women.

In India, Zavier and Padmadas (2000:29) investigated the factors which influenced the selection of nonpermanent contraceptives among childbearing women. Data on 2 029 married women were used from the Indian National Family Health Survey. Multivariate logistic regression analyses were used to identify factors influencing the selection of family planning methods. The results revealed that high school education, older age (30 years and older) and Christianity had positive correlations with the use of nonpermanent family planning methods.

Some women, however, felt that they could use emergency contraceptives once their pregnancies were confirmed. For example, a randomised study of 235 Asian women, attending family planning services for emergency contraceptives, revealed that clients used emergency contraceptives because they were perceived to be effective, safe and convenient for women who did not plan to be pregnant

(Cheng, Gulmezoglu, Ezcurra & Van Look 2000).

A study by Ehlers, Maja, Sellers and Gololo (2000:49) of 111 adolescent mothers in the Gauteng Province of the Republic of South Africa, indicated that the majority (62,16%) of adolescent mothers preferred injections, because they were deemed to be safe, necessitated one visit every three months to the family planning clinics and neither their boyfriends nor their parents needed to know about their contraceptive practices.

According to Kulier, Boulvain, Walker, De Candolle and Campana (2000) clients chose mini-laparotomy for permanent sterilisation because it was deemed to be effective and economic. Pererson (2000) is of the opinion that mini-laparotomy tubal ligation was safe in view of the low reported (1,0%) mortality and morbidity rate.

Contrary to the identified benefits of family planning methods, Mol, Ankum, Bossuyt and Van der Veen (1995:117-141) investigated the association between contraceptive methods (IUCDs, tubal ligation, oral contraceptives and condoms) and the risk of developing ectopic pregnancies. Twelve control case studies of women with confirmed ectopic pregnancies were conducted. The meta-analysis showed that patients who had used IUCDs were at nine times greater risk of developing ectopic pregnancies, compared to clients who used oral contraceptives and condoms (Mol et al 1995:140). Hence family planning clients were encouraged to use oral contraceptives and condoms as they were deemed to be safer than IUCDs. This study investigated which family planning methods Swazi women deemed to be safe, convenient and effective.

2.5 HEALTH BELIEF MODEL

The HBM was identified as the ideal framework for this study, as childbearing practice is a reflection of the health belief system of the individual women and society at large. The six concepts of the HBM used in the study, are perceived susceptibility, perceived barriers, perceived benefits, perceived cost, efficacy and cues to action.

2.5.1 Perceived susceptibility

The first component of the HBM, namely perceived susceptibility, is defined as the individual's (and



not the health professional's) perception of the degree of his/her susceptibility to a health condition (Frewen, Schomer & Dunne 1994:39). In reproductive health issues, Oheneba-Sakyi (1992:472) states that perceived susceptibility to pregnancy will positively influence the use of effective contraception. However, DeGraff and De Silver (1991:127) observed that some women fail to use family planning practices even though they perceived themselves to be susceptible to pregnancy. Peltzer (2001:55) investigated knowledge and practices regarding the correct use of condoms among 206 university students in the Republic of South Africa. The results indicated a low (29,0%) prevalence rate of condom use among male students. These students did not perceive themselves to be susceptible to STDs, including HIV, hence they were not using condoms. However, female students perceived themselves to be at risk of pregnancy and 49,0% were using female condoms. Therefore, perceived susceptibility to pregnancy might positively influence clients to use contraceptives. The present study attempted to establish whether those Swazi women who perceived themselves to be susceptible to pregnancy were using contraceptives and if so, which family planning methods they were using.

2.5.2 Perceived benefits of family planning services

The second component of the HBM is perceived benefits. The HBM proposes that the belief about effectiveness of family planning methods in preventing pregnancies should correlate positively with their consistent use (Hiltabiddle 1996:63). For example a cross-sectional survey of 557 adolescents enrolled in a hospital-based pregnancy prevention programme in the Harlem Hospital (USA) was performed by Lareque, Mclean, Brown-Peterside, Ashton and Diamond (1997:318). Multiple logistic regression analysis examined the combined relationship of the significant psycho social variables to consistent condom use. The results revealed that the strongest predictor of consistent condom use was the perceived benefit of avoiding pregnancies. Other factors included partners' preferences for condom use, male gender, and support for birth control by a parent (Lareque et al 1997:318). These factors might be important in planning interventions to increase condom use by sexually active adolescents in Swaziland and in other countries, an issue which has been addressed during this survey.

2.5.3 Perceived barriers to family planning practices

The third component of the HBM, namely perceived barriers of the health problem, is a degree to which the negative aspects of an action serve as barriers to action, causing avoidance. Rosenstock,

Stretcher and Becker (1988:179) observed that perceived barriers to health actions include such items such as phobic reactions, physical as well as psychological barriers, accessibility factors and even personality characteristics. However, Rees (1995:34) as well as Tadiar and Robinson (1996:77), observed that barriers to family planning may include those related to the country's laws, the influence of foreign agencies, medical barriers, a wide range of social and ethical issues and those that relate to the political situations of a country. These barriers were identified in this study

2.5.4 Perceived cost

The fourth component of the HBM is perceived cost. An estimated 120 million women in the developing countries do not practise family planning, even though they do not want to conceive. The major reasons for delaying the use of family planning methods might be costs in terms of transportation fees, payment for family planning consultations and treatments and the time missed from housework or paid work (Tadiar & Robinson 1996:79). However, this argument fails to explain why many women with access to free contraceptives in the Republic of South Africa, also fail to use contraceptives. Hubacher, Holtman, Fuentes, Perez-Palacios and Janowitz (1999:119) conducted a study in Mexico to estimate the costs of family planning services. Data was collected from 82 Mexican Ministry of Health facilities. The method for data collection included observation of providers and ancillary information for estimating the costs of services. The cost per minute of provider labour was used to estimate the cost of various types of family planning visits and cost per couple-year of protection for different contraceptive methods.

The results revealed that if providers lengthened their workdays, increased the counselling time and dispensed more contraceptives during each visit, the overall cost per couple-year of protection would decline from the 1995 level of E273.99 (\$23.2) to E207.86 (\$17.6) (according to the official equivalent rate US\$1 equals E11.81) by 2010 (Hubacher et al 1999:119). At couples' level, cost reduction might include transport costs and time spent for consultations. Therefore by improving the service delivery system, the Mexican Ministry of Health managed to offer more cost effective family planning services to its clients. Similar studies could not be traced in Swaziland. However, cost implications might deter the use of family planning practices and services. Should these considerations be important to Swazi men and women, such perceptions might be detected during focus groups and/or structured interviews and might assist in justifying the need to persuade the Swaziland

Ministry of Health and Social Welfare to offer free family planning services.

2.5.5 Efficacy

The fifth component of the HBM, efficacy, maintains that the effectiveness of a contraceptive method in preventing pregnancy is the standard measure against which other contraceptive methods are compared (Rees 1995:35). Two measures of efficacy are stated, the method effectiveness and the user effectiveness. According to Rees (1995:35) method effectiveness refers to the protection a woman receives when a method is used correctly, whilst user effectiveness is the success of a method in preventing pregnancy. In a WHO study in five countries on the effectiveness of natural family planning, it was revealed that 93,0% of women, representing a wide range of socio-economic and educational levels, were successful in using natural family planning methods (WHO 1998:6). According to this survey, the natural family planning methods included in the study were complete abstinence, periodic abstinence and coitus interruptus. This finding underscores the method efficacy and user effectiveness of natural family planning methods.

According to Hatcher et al (1994:154), the effective rate of condom use was 97,0% for beginners, whilst the effectiveness of oral contraceptives was 100,0% with the combined oestrogen-progesterone pills. An estimated 50,0%-75,0% of women for whom oral pills had been prescribed, would consistently use them for one year, while 25,0%-50,0% would stop using them within the first month of use (Hatcher et al 1994:227).

Natural family planning in the form of abstinence, was found to be 100,0% effective. Coitus interruptus (withdrawal), however, when used consistently and correctly, would produce an 80,0% efficiency rate (Hatcher et al 1994:342). Permanent sterilisation, which includes vasectomy and tubal ligation, was also found to be highly effective (Hatcher et al 1994:384). Vasectomy is not 100,0% effective until all sperm in the reproductive system is ejaculated, which could take up to six weeks. It is essential that sterilised men return to the health care facility for sperm counts until no sperm is detected in the semen. With regard to tubal ligation, method failure may result in ectopic pregnancies. In view of these findings, it is even more certain that family planning providers should recommend effective contraceptive methods to their clients. This study attempted to establish whether Swazi clients were using efficient family planning methods.

2.5.6 Cues to action

The sixth component of the HBM is cues to action. Specifically what constitute the cues to action and how they affect behaviour still needs intensive investigations. Mikhail (1981:70) stated that the use of mass media or other exposures to information from family planning providers might be influential in urging people to use a recommended effective family planning practice. Three studies will be discussed which demonstrate how communication might improve clients' compliance with family planning practices.

In family planning counselling, it is fundamental to inform clients about various methods in order that clients could make the right choice (Population Report 2001:1). Informed choice emphasises that clients select the method that best satisfies their personal, reproductive and health needs (Kim, Kols & Muccheke 1998:4). In order to develop a practical understanding of the concept of informed choice, in a study conducted by Kim et al (1998:4), data was gathered from observation and structured interviews at 25 delivery sites in Kenya. Transcripts of 176 counselling sessions were analysed to identify key counselling behaviours and assess the completeness of information provided to the clients. Both qualitative and quantitative methods were used to investigate the decision-making processes during the counselling sessions.

The results of Kim et al's (1998:4) study showed a collection of information on marital and reproductive history in 60,0% of counselling sessions with new Kenyan clients. Only 7,0% of the clients were asked about childbearing intentions. In 55,0% of the sessions, providers enquired about problems with currently used family planning methods. Only in 27,0% of these sessions did providers ask questions about changing family planning methods. It became evident in Kim et al's (1998:7) study that providers seldomly tailored their discussions about contraceptives to the specific client's reproductive needs or health risks; they maintained that a woman's right should be respected on reproductive issues. They rarely assisted women to understand personal implications of their choices of accepting a particular family planning method (Kim et al 1998:4).

Mahmood and Ringheim (1997:122) investigated the knowledge, approval and communication about family planning as correlates of desired fertility rates among spouses in Pakistan. The survey yielded information from a sample of 1 260 couples from both rural and urban areas. The results revealed that in urban areas, 40,0% of men and 50,0% of women did not want additional children, compared

to 26,0% of men and 37,0% of women in rural areas. Urban men and women were more likely to approve of family planning methods, whereas among rural residents, men were significantly more likely than women to know about family planning services. The influence of the spouses' fertility desires and communication about family planning suggested that concerted efforts to educate men about issues in reproductive health, and to facilitate communication between husbands and wives, would assist couples in agreeing upon and meeting their reproductive goals.

Agha, Karlyn and Meekers (2001:144) conducted a study in Mozambique among 5 142 sexually active adults, to test the hypothesis that exposure to communications and access to condoms increased the use thereof with partners. Multivariate analyses revealed that exposure to condom social marketing (CSM), advertising and communications were positively associated with condom use. For example 74% of the clients in Sofala and 76% in Manica, who were informed about family planning practices, knew a condom source and were motivated in using condoms compared with an average of 54% who were not informed about family planning in the entire province (Agha et al 2001:147).

The study by Mahmood and Ringheim (1997:122) provided this researcher with insight into the knowledge, approval and communication about family planning issues. However, it failed to identify the family planning methods that respondents were using, as well as those which men and women would prefer to use respectively.

2.6 CONCLUSION

The literature reviewed identified deterrents to family planning practices among childbearing women. These included cultural, economic, ethical as well as religious aspects. With regard to the family planning practices used by Swazi women, traditional contraceptive methods, including abstinence, incomplete sexual intercourse and the use of herbs, were identified as the ideal methods of family planning. Modern family planning methods were generally met with resistance and antagonism. Factors which influenced the selection of contraceptives were reportedly safety, reversibility, efficiency and cultural acceptability.

The HBM concepts were discussed as a suitable framework for the present study, since the motivation to use family planning is framed by the belief system of the individual. The research methodology is presented in chapter 3.

CHAPTER 3

Research methodology

3.1 INTRODUCTION

In the previous chapter a literature review was presented. Specific sociocultural factors, which might limit the use of family planning among Swazi women, were identified. In this chapter, the research methodology will be discussed in two phases. The first phase is concerned with focus group discussions (refer to section 3.8) and the second phase addresses the interview procedure (refer to section 3.10).

3.2 PERIOD OF RESEARCH

The research extended over a period of four years, from February 1998 to November 2001. The initial two years were concerned with the identification of related literature. Journals and publications on family planning issues were consulted. The service of the electronic mail from the International Family Planning Perspective (http://www.agi_usa.org/pubs/journals/2606300.html) came in handy with regard to the most recent information on family planning. The researcher also held informal

meetings with family planning providers in order to identify problems related to family planning among Swazi families.

The evaluation tool for focus group discussion was developed, pretested and utilised. A structured interview schedule was developed, based on the analysis of the focus groups and the interviews took place from January to June 2001. The remaining time was used for analyses, interpretation and discussion of research findings.

3.3 DESIGN OF THE STUDY

According to Cormack (1996:110), the research design represents the major methodological thrust of the study, being the distinctive and specific research approach which is best suited to answer the research questions. The research questions, the aim and the objectives of the study thus influence the selection of the research design (Brink 1999:100).

The purpose of the research design, as stated by Burns and Grove (2001:243), is to achieve greater control of the study and to improve the validity of the study in examining the research problem. The research design must therefore be appropriate to the purpose of the study, feasible given realistic constraints and effective in reducing threats to validity. The research design for this particular study was nonexperimental, exploratory and descriptive in nature. The purpose of selecting a nonexperimental design was to describe prevailing family planning practices among Swazis, and to further explore attitudes toward family planning practices.

3.4 NONEXPERIMENTAL RESEARCH DESIGNS

Nonexperimental research designs, as described by Brink (1999:110), can be categorised into two broad categories, namely: *ex-post factor design or correlational design* is concerned with describing existing relationships between independent and dependent variables. *The descriptive design* encompasses different designs utilising both quantitative and qualitative methods. In this study, descriptive research was used in order to identify family planning practices that exist among Swazi women, as well as beliefs and attitudes toward family planning practices. It also attempted to identify trends of family planning practices among different members of the society. Data obtained could be used to justify the need to intensify family planning education among different groups and to make

appropriate plans for improving the utilisation of family planning among Swazis.

3.4.1 Types of descriptive design

Descriptive design, according to Cormack (1996:184), may be simple descriptive, comparative descriptive or exploratory descriptive. In simple descriptive design, the variables of interest have been previously studied, either independently or in conjunction with other variables. The variable is partly controlled by the situation as in exploratory designs, but they are partly controlled by the researcher, who chooses the sample for the study. This design is used to examine the characteristics of a single sample. The comparative descriptive design is used to examine and describe the variables in two or more groups. In exploratory descriptive design, the researcher explores a particular area to discover what is there, the meanings attached to the discoveries and how these can be organised. Cormack (1996:184) observes that this type of study calls for intuition and insight on the part of the researcher. It calls for a degree of flexibility so that any discoveries can lead to a new body of knowledge. In this study, the researcher initially utilised the qualitative research approach (in which use was made of focus group discussions). The research findings from the qualitative approach were then used to develop a structured interview schedule for a quantitative research approach. The process of using both qualitative and quantitative research approaches is described by Burns and Grove (2001:239) as triangulation.

3.5 TRIANGULATION

Burns and Grove (2001:239) define triangulation as the collection of data from multiple sources for the same study and the data must all have the same foci. The purpose of using multiple methods in a study design according to Beitmayer, Ayres and Knafl (1993:237) is to overcome the limitations and biases that stem from using a single method, thus increasing the reliability of findings (Duffy 1993:143). In this study a multiple triangulation method was followed, in which both focus group discussions and structured interviews were used in order to enhance the validity of the findings and to overcome any biases that might stem from using a single method only.

The aim of triangulation is to achieve results in which the variance that is obtained reflects the measurement of the trait being studied. The rationale is that if a hypothesis survives testing by a series of complementary methods, it has a degree of validity unattainable when tested with any single

method because the research results are not method bound (Burns & Grove 1997:244).

The triangulation approach can be categorised into seven types:

- (1) *Data triangulation* involves the collection of data from multiple sources with intent to obtain diverse views of the phenomenon under the study for the purposes of validation (Cohen & Manion 1997: 236; De Vos 1998:359). Data triangulation was used for this study and data sources for the focus groups comprised adolescent males and females, elderly men and women, women of childbearing age, and rural health motivators. Data for the interview was obtained from adolescents, women of childbearing age and elderly women. Cross tabulation of data using the Statistical Package for Social Sciences (SPSS) computer program was done in order to compare the attitudes toward and opinions about family planning. For the focus group interviews, the Non-numerical Unstructured Data Indexing Searching and Theorizing (NUD*IST) computer program was used to analyse the results. The findings were compared by two different researchers and yielded similar findings. Burns and Grove (1997:244) assert that responses from such multiple data sources enhance the reliability of research results.
- (2) *Investigator triangulation* is a process whereby two or more investigators with diverse research training backgrounds examine the same phenomenon (Streubert & Carpenter 1999:306). Kimchi, Polivka and Stevenson (1991:365) noted that investigator triangulation requires that:
 - each investigator has a prominent role in the study
 - the expertise of each investigator is different
 - the expertise (disciplinary bias) of each investigator is evident in the study

The use of investigator triangulation according to Burns and Grove (2001:240) removes the potential for bias that may occur in a single investigator study. For this study, investigators comprised community nurse researchers who were familiar with the cultural aspects of family planning issues in Swaziland. The matron in charge of the health services identified community health nurses (one nurse in each of the four regions of Swaziland), who were involved in research activities in each of the four regions of Swaziland to assist the researcher in conducting the study. School teachers who were teaching biology were identified by the

head master of each school (one teacher per school in each region) to assist the researcher in conducting the study. Data presented by these different groups according to Streubert and Carpenter (1999:306) served to reduce bias that might have occurred if the investigator had executed the study without the input from other experts in the population of Swazi people.

- (3) *Time triangulation* is applied to both cross-sectional and longitudinal studies. Cohen and Manion (1997:236) maintain that cross sectional data is collected with time-related processes from different groups at one point in time, while longitudinal studies collect data from the same group at different points in time sequence. Cross-sectional studies compare the measurements for the individuals in different samples at one point in time, while longitudinal studies examine selected processes in the same individuals comparing the same sample repeatedly over time.

In the present cross-sectional study, the data collection extended over a period of six months. Cohen and Manion (1997:263) state that social changes and processes have limited effects on studies conducted within the same time frame, which was the case with this research where data was collected within a period of six months and there was no difference in data collected from the earlier and late respondents.

- (4) *Space triangulation* attempts to overcome the limitations of studies conducted within one culture or subculture, as “not all the behavioural sciences are culture bound, they are sub-culture-bound ” according to Cohen and Manion (1997:236). Space triangulation was not used in this study as research was conducted in the same country (Swaziland) and within the same subculture (Swazi). However, the study sample was drawn from all the four regions of Swaziland and urban, rural and peri-urban informants were included.
- (5) *Theoretical triangulation* draws upon alternative or competing theories in preference to utilising one viewpoint only (Cohen & Manion 1997:236). The present study utilised a single theoretical framework, namely the HBM (as discussed in section 2.7) and therefore did not utilise theoretical triangulation.
- (6) *Methodological triangulation* is defined by Kimchi et al (1991:365) as the use of two or more research methods in a single study. The difference can be at the level of design or data

collection. LoBiondo-Wood and Haber (1998:237) identified two different types of methodological triangulation:

- *the within method triangulation* which is used when the phenomenon being studied is multidimensional
- *the across method or between method triangulation* which involves combining research strategies from two or more research traditions in the same study. In this study, both quantitative and qualitative approaches were used in order to investigate family planning issues among Swazi people, thus meeting the requirement for methodological triangulation

A qualitative approach was used to gain insights into family planning practices and the findings of this approach were used to formulate an instrument for the quantitative approach. The main advantage for using methodological triangulation in the present study was to increase convergent validity of the findings (Burns & Grove 2001:240).

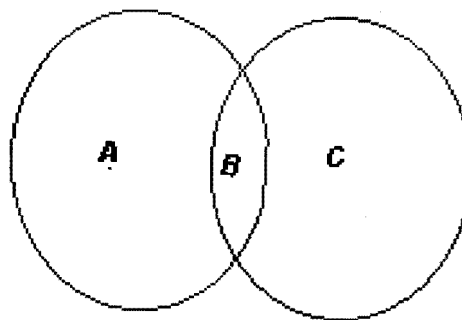


Figure 3.1

The triangulation of qualitative and quantitative research results

(Adapted from Mitchel 1986:22)

In figure 3.1, the circle labelled A represents qualitative research findings, whilst circle C represents quantitative research findings. By combining the qualitative research and quantitative research methods a more complex picture of a phenomenon could arise than if either type was used alone, (refer to A+B+C). This integration of methods can provide an expanded understanding of the scope of family planning issues in Swaziland and increase

confidence when results are generalised (Mitchel 1986:22).

- (7) *Analysis triangulation* is a situation whereby two or more analysis techniques are used for the same data set, and from the three principal levels identified by Cohen and Manion (1997:236) as, the individual level, the interactive level (groups), and the level of collectivities (organisational, cultural or societal). During the data gathering phase of this study, quantitative data was analysed using the SPSS computer program with the assistance of a statistician from the University of Swaziland (UNISWA). For the focus group discussions, the NUD*IST analysis program was used with the assistance of a senior lecturer from the Department of Advanced Nursing Sciences, University of South Africa (Unisa).

Burns and Grove (2001:241) identified the following concerns regarding triangulation procedures:

- How quantitative data and qualitative data can be compiled in the analysis.
- How divergent results between numerical data and linguistic data can be interpreted.
- How overlapping concepts that emerge from the data could be differentiated from each other.
- How to weigh data sources.
- Whether each different method used should be considered equally sensitive and weighted equally.

One argument in support of blending qualitative and quantitative data in a single project is that they are complementary and represent the two fundamental languages of human communication, which are words and numbers (Polit & Hungler 1991:518). Methodological triangulation increases support for validity (Burns & Grove 1997:245). Construct validity is enhanced when results are stable across multiple measures of a concept; statistical conclusion validity is enhanced when results are stable across many data sets and methods of analysis; internal validity is enhanced when results are stable across many potential threats to causal inference; external validity is supported when results are stable across multiple settings, populations and times.

In this particular study, the methodological triangulation method was used in order to offset limitations of using a single data gathering method. Views of different groups were obtained, these groups included elderly men and women, adolescent males and females, rural health motivators as well as women of childbearing age. These informants were interviewed at different geographical

areas, including urban and rural settings (space triangulation). Data collection was undertaken for a period of six months (time triangulation). Once the trend in family planning practice was established, a tool for quantitative data was developed (methodological triangulation). Quantitative data was analysed using the SPSS computer program, and the qualitative data was analysed using the NUD*IST program, thereby ensuring that analysis triangulation was done.

3.6 QUALITATIVE DESCRIPTIVE RESEARCH METHODOLOGY

A qualitative descriptive research method can include description of types, classes, or characteristics of a focus of interest (Cormack 1996:177). The central focus of descriptive research according to Kerlinger (in Merriam & Simpson 1995:61), is to examine facts about a situation, people or activities with which or whom certain events occur. Uys and Basson (1995:38) state that the most important methodological consideration in respect of descriptive studies is the collection of accurate data on the phenomenon to be studied. This data provides the bases for future research, generating questions and hypotheses for experimental studies (Burns & Grove 1997:30).

3.6.1 Strengths and limitations of a qualitative descriptive method

Merriam and Simpson (1995:71) point out that the qualitative descriptive method is easy to use, and that it produces accurate data. The rigour of such a qualitative research method is as demanding as in experimental studies. A second advantage is that it allows the researcher to study relationships or events as they happen in human life situations. A third advantage is the exploratory nature of the qualitative descriptive methods. Variables can be studied and new ones can be discovered concerning the phenomenon (Brink & Wood 1998:290). The limitations of qualitative descriptive research include the lack of predictive power. The researcher discovers and describes the situation, but is unable to generalise or predict with certainty, 'what will be' (Merriam & Simpson 1995:72). With respect to research methodology in qualitative research, Merriam and Simpson (1995:72) state that the main drawback is the lack of statistical analysis. The use of narrative discourse in the analysis and reporting of research often frustrates and discourages research consumers because such findings cannot be generalised to the entire population. These limitations were addressed by utilising both qualitative and quantitative approaches in the present study.

3.7 ORGANISATION OF THE STUDY

The study was conducted in two phases, the first phase was concerned with a qualitative design and the second phase was concerned with quantitative design. The various steps included in the two phases of data collection of this study design were as follows:

Phase 1: Focus group interviews

- Preparation for conducting focus groups
- The identification of categories of focus groups
- Selection of each focus group sample
- Identification of a suitable research setting
- Development and pretesting of the instrument used during focus group interviews
- Conducting the focus group interviews
- Analysis of trends and themes that emerged from the focus group interviews

Phase 2: Structured interviews

- Sampling
- Research instrument
- Pretest
- Conducting interviews
- Analysis of trends for interviews

3.8 PHASE 1 OF THE DATA COLLECTION PROCESS: FOCUS GROUP INTERVIEWS

De Vos (1998:314) defines a focus group as a “purposive interview of a specific topic taking place with eight to ten individuals with similar backgrounds and common interests”. Focus groups are used in performing qualitative studies (Twinn 1998:654). Merriam and Simpson (1995:71) state that focus group interviews can be used to gain understanding about a phenomenon before the main study can be undertaken. Fontana and Frey (1994:361) as well as MacDougall and Baum (1997:532) maintain that focus groups are an important tool for collecting qualitative data because they were found to be:

- inexpensive
- flexible
- stimulating
- elaborative
- assisting in information recall
- capable of producing rich data

De Vos (1998:324) indicated that focus groups are socially oriented and facilitate interaction between subjects thus enhancing the capturing of data generated by group interactions. An important consideration for using focus group interviews in the present study was to seek prevailing family planning practices from different social groups and further to identify similar or/and contrasting attitudes towards family planning practices, this is in line with the approach of Holloway and Wheeler (1998:150) to the use of focus group interviews. Polit and Hungler (1995:272) also confirm that focus group interviews are an efficient data collection tool. The advantages of using focus group interviews in the present study were the following:

- a homogeneous group (gender grouping or age grouping) enabled participants the necessary freedom to express their thoughts, feelings and behaviours candidly as recognised by Burns and Grove (2001:424)
- multiple views, attitudes and beliefs about family planning were elicited within a short period of time
- group dynamics generated authentic information (Morrison & Peoples 1999:62-65)

The major disadvantage of using focus group interview is that the anonymity of respondents cannot be maintained (Holloway & Wheeler 1998:150). It is from this perspective that White and Thomson (1995:256) recommend the use of telephone group interviews. Murray (1997:181) suggests the use of virtual focus groups, which uses computer-mediated communications such as electronic mail. The recommended electronic devices for maintaining anonymity in focus groups were not available to participants in Swaziland. In order to enhance anonymity, moderators clarified to each group that each participant's contributions will be shared with group members as well as the moderator. Participants were encouraged to keep confidential what was discussed during the meeting and the researcher was responsible to present data obtained from any focus group interview in anonymous ways. No names would appear in the research report.

Another limitation for conducting focus groups, as recognised by De Vos (1998:325), is the process of recruiting the relevant respondents for the interviews. This limitation was overcome by selecting a variety of respondents, including women of childbearing age, elderly men and women, rural health motivators and adolescents. According to Burns and Grove (2001:425), validity of data is enhanced when focus groups comprise a variety of sources.

3.8.1 Preparation for the focus group interviews

Torn and McNichol (1998:1203) state that the success of a focus group depends on adequate conceptualisation of the problem being investigated, as well as thorough groundwork. In order to gain insight into family planning issues a literature search was carried out (summarised in chapter 2), and informal meetings were held with people who were working with rural communities in order to identify respondents for the focus group interviews. The aim of the literature review and informal meetings, according to Carey (1994:226), was to develop relevant questions for the focus groups. The following questions which were relevant to the use of family planning methods among the Swazi people, were consequently formulated for use during the focus group interviews.

- Explain the importance of children in family formation.
- What is the ideal number of children each woman should bear?
- Do Swazis encourage the use of modern family planning methods?
- What are the traditional methods of preventing pregnancies?

The four questions provided a broad framework for the focus group discussions.

Four research assistants were identified, one from each region of Swaziland. The research assistants were community nurses with experience in family planning issues among Swazis, and using such experiences to encourage active participation of group members. However, to prevent bias of results, Torn and McNichol (1998:1203) warn that facilitators should not be immersed in the literature and data as was expected from the main researcher. The researcher met with the facilitators in order to develop and clarify guidelines for conducting focus group interviews, and to provide direction for the focus group process (Brooks, Fletcher & Wahlstedt 1998:28).

The guidelines developed stipulated the

- objectives of the focus groups
- number of participants in each group
- environment where each focus group interviews should take place
- roles within focus groups such as those of facilitator, note taker, and the researcher
- consent for conducting group interviews, tape recordings and for taking notes during the interviews
- commencement of group interviews, making use of an introductory question, moving from general to more specific questions, and from nonthreatening to questions that could be perceived as being more threatening
- importance of keeping to set dates and times of appointments
- distribution and discussion of questions to be used during focus group interviews
- maintaining records of daily interviews

Facilitators were requested to confirm appointment dates and times a week prior to each focus group interview, and again the day before the focus group interviews was due to take place. The facilitators were requested to adhere to the guidelines and questions in order to enhance the reliability of the findings.

3.8.2 Identification of categories of focus groups

In order to have a broader understanding of family planning issues, it was decided that the different samples for specific focus groups would comprise of the following:

- school going adolescent boys
- school going adolescent girls
- rural health motivators
- elderly men who were identified as community leaders
- women of childbearing age
- elderly women

Table 3.1: Participants in focus group interviews

Category of participants	Age range	Frequency	Cumulative frequencies
Adolescents males and females	16-18 years	60 (5 groups)	60
Rural health motivators	30-45 years	12 (2 groups)	72
Elderly men	40-55 years	14 (2 groups)	86
Women of childbearing age (pregnant women (30), postpartum women (25))	20-29 years	55 (5 groups)	141
Elderly women	46-60 years	30 (3 groups)	171

Table 3.1 reveals respondents who participated in focus group interviews. Each group comprised a maximum of twelve respondents, and a total of 17 groups were used. The rationale for selecting such diverse groups was to gain more insight, opinions, perceptions, attitudes and ideas about family planning from people representing different age and gender perspectives in the Swazi culture. Brooks et al (1998:27) assert that the key advantage of conducting focus groups with diverse groups, is to enhance the validity of the data.

3.8.3 Selection of the focus groups

The population relevant to this study had to be clearly identified. As the research topic addressed family planning practices, it became evident that members of the term 'family' should be consulted when exploring the cited topic. The definition of the word 'family' in a Swazi setting was broadened to include a union of a man, his wife or wives, offspring and kinship members (WLSA 1998:5). Based on this definition, the research sought to identify, through focus group discussions, the attitudes and practices of a specific group as it relates to family planning.

Streubert and Carpenter (1999:22) assert that participants in qualitative research are selected on the bases of their first hand experience with a culture or phenomenon of interest. The concern of the researcher was to develop a rich description of the Swazi culture, and to formulate relevant items for the structured interview schedule which would further investigate family planning issues. Consequently, the researcher decided to use a wider variety of respondents than only the 'family', as it was accepted that there were other respondents who are also knowledgeable about family planning practices. Identifying informants for focus group interviews was made possible by using experts such as teachers, community nurses and community leaders in each of the six categories identified for the

focus group interviews.

◆ **School going adolescents (boys and girls)**

The researcher contacted the Ministry of Education of Swaziland to identify high schools that reported high pregnancy rates. It was difficult to acquire that information since there was no definite system for reporting pregnancies among school going children. However, the representative in the Ministry of Education identified two schools, one in an urban and one in a rural area. The head masters from the identified schools also requested representatives from the Faculty of Health Sciences, UNISWA, to provide information about reproductive health issues, including contraception to the children attending these two schools. Consequently, the researcher went to the schools and gave the required reproductive health education to the school children.

In each of the two schools, the head master and the class teacher identified thirty senior students who were deemed to be knowledgeable about family planning issues. Each group was homogeneous, boys or girls and within the same age range of 17-19 years. This selection process is called purposive sampling. In order to limit bias of results which might occur when utilising a single group, two groups of adolescents were interviewed at each school (one group of adolescent boys and one group of adolescent girls at each school). The results from these groups were subsequently found to be similar, and will be discussed in chapter 4 which deals with the presentation and analysis of focus group interviews.

◆ **Rural health motivators**

A formal meeting was convened with nurse educators involved with the training of rural health motivators. The nurse educators were requested to conduct focus group interviews with the rural health motivators. Two groups of rural health motivators each comprising six persons, were identified; one in a peri-urban area and the other in a rural area. The group that was based in the peri-urban area of Mbabane, the capital city of Swaziland, consisted of rural health motivators who convened once a month to review current health problems in their community. The other group was a rural based one in the Northern Hhohho area who were undergoing their initial training in health care practices. The nurse trainer ensured that the identified respondents were conversant with family planning practices, but in order to avoid possible bias of results, the nursing background of the

researcher was not revealed to the participants.

◆ **Elderly men (community leaders)**

The chief representative in the rural area was consulted by the researcher with the assistance of the nurse who was practising at the Ndzingeni local rural health clinic. A meeting was arranged with the chief's representative who identified fourteen male traditional leaders to constitute the research sample. These elderly men were key informants about traditional practices, hence they were deemed to be sufficiently knowledgeable to discuss family planning practices, specifically with regard to men's views about family planning practices in the Swazi culture.

◆ **Women of childbearing age**

This group comprised 55 respondents (five groups) who were identified at health care institutions. They included thirty pregnant women who were recruited by midwives, and 25 postnatal clients who were either attending family planning clinics or who were mothers of young children, and who were recruited when they brought their children to the clinics for immunisations. All the identified clients used either traditional, natural or modern family planning methods and were willing to participate in this study.

◆ **Elderly women**

The chief representative in the rural southern region and urban Manzini region was consulted by the researcher with the assistance of the nurse who was practising as a regional community nurse. A meeting was arranged with the chief's representative who identified thirty elderly women to constitute this sample. These women meet regularly with chiefs at the community centre to discuss community development projects.

3.8.4 Identification of a suitable research setting

The identification of a suitable research setting is a critical decision in field research. Van Aswegen (1998:12) noted that the ideal research site is where:



- entry is possible
- there is a high probability that a rich mix of many of the processes, people, programmes, interactions and/or structures that may be part of the research question will be present
- the inquirer can devise an appropriate role to maintain continuity of presence as long as necessary
- both data quality and credibility of the research are acceptable

The selection sites for this study was indicated in the discussion of each category of sample selected. In general, the following criteria for selecting each site was identified:

- the relationship that the researcher had with both staff and the participants
- entry into the setting by observing all relevant cultural rules
- a high probability that a rich mix of respondents would be present in order for the researcher to monitor the progression of focus group interviews

These criteria were also relevant with regard to the interviews that were conducted as phase 2 of the study.

Streubert and Carpenter (1999:22) advise that qualitative research should be conducted in a setting that is natural for the participants. Based on this information, focus group interviews for adolescents took place at their schools, whilst interviews with rural health motivators, elderly women and traditional leaders were held at community centres. Focus group interviews with women of childbearing age were conducted at health care facilities.

3.8.5 Development and pretesting of the instrument used during focus group interviews

The semi structured instrument that was used for focus group interviews was a reflection of areas of concern which were raised by family planning providers after an informal meeting that was conducted by the researcher in order to establish problems encountered by family planning clients with regard to the utilisation of family planning services. Three main deterrents to family planning were identified which were:

- cultural practices surrounding family planning

- childbearing practices
- views on family planning practices

The semi-structured instrument used is attached as annexure 1 of this research report.

Pretesting of the instrument was done before the main study was conducted. Five respondents from each category were selected, and were asked to respond to the questions that had been developed. These five persons, who participated in pretesting the instrument, were excluded from the actual focus groups. A modification of the instrument was done since two of the questions were perceived to be ambiguous and respondents were providing conflicting responses to the same question. For example, question 1 was phrased as: What is your beliefs about family planning practices?, this question was changed to read as: Do you think Swazi women should use methods of family planning? Question 3 was phrased in this manner: Do you think it is healthy for women to use contraceptives? Was changed to read as: Are there any health problems related to the use of contraceptives that you have heard of? The structured interview is presented in annexure 1 of this research report.

3.8.6 Method of conducting focus group interviews

Focus group interviews were conducted in siSwati except for those involving the school going adolescents with whom interviews were conducted in English. The Sebenta National, an institution that is concerned with translating documents from siSwati to English, verified the translation of the transcripts as correctly reflecting the meaning of the questions and responses in both siSwati and English.

The facilitators ensured that participants were comfortably seated and in good view of the facilitators. An introductory question which related to family planning problems in the society was posed to participants as an ice-breaker. Where necessary probing was done by the facilitator who clarified questions that appeared ambiguous. Two note takers and the researcher recorded the proceedings and at the end of each discussion session notes were collected by the facilitator and given for safe keeping to the researcher. Audio-tapes were used in selected areas but could not be used in all areas because electricity is not available in all areas, whilst in certain areas electricity supplies are subject to frequent interruptions. Battery operated tape recorders were used in selected areas. However, batteries proved to be expensive and lasted for unpredictable periods only. The data collected from

the focus group interviews has been compiled in a comprehensive report that is attached as annexure 5 (focus group data).

3.8.7 Analysis of trends and themes that emerged from the focus group interviews

The goal of the analysis of findings of the focus group interviews was to identify trends as well as family planning patterns for different groups in order to formulate questions that could be applicable to the study. Qualitative content analysis was used to identify major themes and categories emerging from the data as advised by Tesch (in Brooks et al 1998:28).

Facilitators and a community nurse who was familiar with focus group interviews, worked together at identifying themes and to enhance the reliability and validity of data, as recommended by LoBiondo-Wood and Haber (1998:240). Major themes and subthemes were identified using the NUD*IST computer program, and were then verified with facilitators who were not involved in the analysis phase. The researcher's comments and questions during focus group interviews were not included in the analysis as Torn and McNichol (1998:1204) state that the elimination of such data reduces bias and contamination of data.

Five members of each focus group were invited after the data was compiled to validate the results before these were recorded. Themes which were developed from the report served as a spring board for developing the data collection instrument that was used for the structured interviews that were conducted as phase 2 of the study. A detailed account of the focus group interviews will be presented in chapter 4 of this report.

There were three main themes that emerged from the focus group interviews. The themes, with relevant subthemes, are listed as:

◆ **Theme 1: childbearing practices**

subthemes: *decision-making*
family planning
desired number of children

◆ **Theme 2: cultural values**

subthemes: *importance of children*
gender status
importance of male fertility
importance of female fertility

◆ **Theme 3: health practices**

subtheme: *barriers preventing the use of family planning*

Issues which emerged from these themes were then grouped and formulated as structured questions for phase 2 of the study, as presented in annexure 2 of this report (the structured interview schedule).

3.9 TRUSTWORTHINESS OF QUALITATIVE DATA

De Vos (1998:331) notes that there are four aspects which enhance trustworthiness of qualitative data, these are truth value, applicability, consistency and neutrality. To ensure that the research findings would be acceptable to the scientific community, it was important to examine these aspects.

3.9.1 Truth value

In qualitative research, truth value is concerned with the accuracy and truthfulness of scientific findings (Brink 1999:124). In order to enhance the truth value Streubert and Carpenter (1999:29) advise that prolonged engagement with subjects should be established by the researcher. To this end, the researcher was introduced to the subjects and assisted in community health promotion activities for a month before the research commenced. De Vos (1998:33) confirms that prolonged engagements enhance credibility of research results.

Another strategy that was employed to enhance the credibility of the findings was member checking. Five research participants from each group were invited to review, validate and verify the interpretations and conclusions of the research findings pertaining to the specific focus group interviews in which they participated. The objective of this exercise was to enhance the authenticity of the research results (Streubert & Carpenter 1999:29).

Peer debriefing was also employed as a strategy for enhancing credibility. The researcher invited the head of the Community Health Department, UNISWA and four regional matrons (nurse managers) of Swaziland to attend a debriefing session of the focus group results. These health experts confirmed some aspects of family planning issues among Swazi women that emerged during focus group interviews. This is in line with the view of Brink (1999:124) that peer evaluation enhances credibility of research findings. Data triangulation was another aspect of enhancing credibility of research results. Respondents for the focus group interviews represented various groups, including men, adolescents, elderly women and rural health motivators. Poggenpoel (in De Vos 1998:349) asserts that truth value is enhanced when data is drawn from multiple sources. Therefore, truth value in this study was enhanced through prolonged engagement, peer debriefing, member checking and triangulation.

3.9.2 Applicability

Applicability refers to the degree to which the findings can be applied to other contexts and settings, or with other groups (De Vos 1998: 349). It is the degree to which the results of a study can be generalised to settings or samples other than the ones studied. According to Brink (1999:124), generalisability of research results enhance external validity. In the present study, applicability was enhanced by conducting cross-sectional focus group interviews with a variety of respondents including women, men, adolescents, as well as elderly respondents. All group discussions revealed similar findings. Therefore, the findings from this study can be applied to various groups in the Swazi society. De Vos (1998:331) confirms that the criteria for evaluating applicability include using diverse samples, conducting focus group interviews within a fixed set of time, and producing detailed descriptions of the research findings.

3.9.3 Consistency

The third criterion of trustworthiness considers the consistency of the data. Krefting (1990:214) defines consistency in terms of the dependability of study results. In the present study, consistency was enhanced through peer examination, member checking and data triangulation, as indicated in section 3.5.

3.9.4 Neutrality

Neutrality refers to the degree to which the findings are a function solely of the informants and conditions of the research, and not of individual biases, motivations or perspectives (Krefting 1990:216-217). Confirmability was enhanced through member checking, data triangulation and field notes that were documented from each focus group interview by three different persons.

3.10 PHASE 2 OF THE DATA COLLECTION PROCESS: QUANTITATIVE RESEARCH METHODOLOGY

Having obtained data from the focus group interviews, it was important for the researcher to confirm the research findings using a quantitative, nonexperimental, descriptive method. The advantages of using a quantitative method were to:

- ◆ **Identify and explore events surrounding poor use of family planning among Swazi women**

The information about the demographic variables, such as gender, employment status, area of residence and marital status were used to describe the study sample, and to contextualise the research results against this biographic information.

- ◆ **Explore and test relationships**

The researcher explored attitudes and practices related to family planning and further identified factors associated with the poor use of contraceptives in Swaziland, this information was compared with the findings from the focus group interviews and yielded similar findings.

- ◆ **Validate information**

The information related to family planning practices was used to validate the results gathered from focus group interviews.

Based on the information from the focus group interviews, the following categories and questions were developed, and later on used during the structured interviews with selected participants:

◆ **Category 1: Child bearing practices**

- When should women get married?
- When should a woman start bearing children?

◆ **Category 2: Cultural values surrounding family planning practices**

- In a Swazi setting, who makes the decisions regarding family planning practices?
- What are the gender issues surrounding family planning?
- How important are children in the family?
- How many children should each woman have?

◆ **Category 3: Views on modern family planning practices offered at health centres**

- Which traditional family planning methods are used by Swazi couples?
- What are the health related barriers to the use of family planning practices?

3.10.1 Sampling for phase 2

Sampling can be grouped into two categories, namely probability and nonprobability sampling (Polit & Hungler 1995:232). Uys and Basson (1995:89) state that probability sampling is characterised by an equal chance of inclusion of each element in the sample. The concept 'randomness' is central to the process of obtaining a representative section of the population by applying probability sampling techniques. On the contrary, nonprobability sampling provides no assurance that every element could be included in a sample (Polit & Hungler 1995:232). Types of nonprobability sampling include:

- convenience sampling whereby the sample is drawn from a section of the population that is easily accessible

- purposive sampling is sometimes referred to as judgmental sampling (Brink 1999:141). Burns and Grove (1997:306) alluded to the fact that purposive sampling involves the conscious selection by the researcher of certain subjects or elements to include in the study. Efforts might be made to include typical subjects or typical situations. It was from this understanding that the researcher decided to use purposive sampling in identifying participants for phase 2 of the present study. According to LoBiondo-Wood and Haber (1998:240), purposive sampling is appropriate for conducting descriptive surveys that seek to describe lived experiences such as family planning issues.

Different experts were consulted in order to identify the participants for phase 2 of the data collection process. These experts included the following:

- teachers for the selection of school going adolescents, both boys and girls
- the chief officer in the rural community centre for the selection of elderly men and women in the community
- nurse educators who train the rural health motivators for the selection of rural health motivators, in peri-urban and in the rural areas
- nurses at the antenatal department for the selection of women of childbearing age who were deemed to be knowledgeable about family planning issues

In this way no sample was selected solely by the researcher in an attempt to reduce bias.

The Department of Statistics in the Ministry of Health and Social Welfare was consulted to identify health centres that recorded high birth rates. From the list provided, one health centre was identified in each district. A letter was sent to the regional matrons, explaining the objectives of the study and requesting permission to conduct interviews with clients. In each of the institutions/facilities where respondents were required, the health care providers using their judgement, identified typical subjects to be interviewed. This selection criterion, according to Babbie (1992:292), is appropriate for field researchers, as the researcher identifies a sample that will yield comprehensive understanding of the subject matter.

3.10.2 Research instrument developed for phase 2 of the data collection process

Face to face structured interviews were conducted with the selected participants, using a questionnaire that was developed for the study, based on information derived from the results of previously conducted focus group discussions and the literature that had been reviewed.

Polit and Hungler (1995:253) advise that when developing a research instrument four important dimensions should be observed, namely structure, quantifiability, researcher obtrusiveness and objectivity. The instrument developed for this study ensured that data was collected according to a *structured* plan that indicated the information to be gathered and the method of collecting data. The structured interview included questions that could be completed quickly, analysed easily and enabled direct comparisons between variables. However, open-ended questions were also included in order for respondents to reveal information in their own words. Hicks (1996:16) asserts that both fixed and unstructured questions should be used in order to produce rich data. Responses to open-ended questions were grouped into similar categories and subjected to analysis, with the assistance of a statistician.

The questions included in the structured interview was arranged in line with the research questions as presented in section 1.2 which are:

- Which factors are responsible for poor use of modern family planning services in Swaziland?
- Which family planning practices do Swazi women generally use?
- Which factors influence the selection of a particular family planning method?

The themes that emerged from focus group interviews were also included in the structured interviews. In addition, demographic data which describes the characteristics of respondents was included. The full structured interview schedule is attached in annexure 2 of this report.

3.10.3 Pretest

A pretest is a method used to test the instrument of a proposed study in order to refine the research tool before the main study is executed. The rationale for pretesting the research tool was to

- develop or refine the research instrument
- identify problems with the design of the instrument
- examine the reliability and validity of the research instrument

Ten respondents were recruited from health care centres as well as local schools. These ten persons who participated in the pretest were excluded from participating in the main survey. Items which were perceived to be ambiguous were modified and further tested for clarity by interviewing five additional respondents. Finally, all questions were well managed by respondents. Results of the interview were analysed by a statistician at UNISWA.

3.10.4 Conducting the interviews

Interviews were conducted by the researcher and two research assistants using the instrument described in section 3.10.2. The interviews were conducted over a period of six months. At the end of each day, interview forms were collected by the researcher and checked for completeness and clarity of information. Once all the required data had been collected, it was given to the statistician for compilation and analysis.

As the collected data was subjected to statistical analysis, it was important to gather it in a way that allowed data to be quantified after consultation with the statistician. The instrument developed ensured that data would be easily *quantified*. Polit and Hungler (1995:254) advise that the researcher should collect data after having spent time with respondents. To this end, the researcher was introduced to the interview respondents, had introductory discussions with each group and became familiar with the group members. Such efforts were made to eliminate *obtrusiveness*, which can occur when the respondents are not familiar with the interviewer. Finally, the researcher maintained *objectivity* when collecting data by utilising different research assistants. Polit and Hungler (1995:254) state that objectivity is maintained when independent researchers examine the same phenomenon and yield similar findings.

3.10.5 Advantages and disadvantages of interviews

According to Polit and Hungler (1995:290), the advantages of collecting data using face to face interviews are as follows:



- A high response rate: a well-designed interview study achieves 80%-90% response rate, thus reducing bias that might exist if the response rate was low.
- High audience coverage: many individuals, such as illiterate, elderly, blind or physically deformed people cannot complete questionnaires but can provide verbal responses to questions from a structured interview schedule.
- Clarity: interviews offer some protection against ambiguous questions. Rephrasing can offer a better clarification of the question.
- Conducting interviews permit greater control over the sample as opposed to asking respondents to personally complete questionnaires, where this could be done by inappropriate persons.
- Supplementary data may be obtained in an interview, where the interviewer can observe and judge the respondents' level of understanding and degree of cooperativeness.

The disadvantages of interviews include:

- interviewer bias
- anonymity of respondents cannot be maintained
- interviews tend to be costly and time consuming as only one person can be interviewed at any given time by one interviewer

The advantages of using structured interviews as a method of collecting data during phase 2 of this study, outweighed the disadvantages thereof, structured interviews provided information that confirmed results of focus group interviews.

3.11 ANALYSIS OF DATA COLLECTED DURING STRUCTURED INTERVIEWS

Data from the structured interviews were analysed by means of the SPSS computer program. This was made possible by assistance from the Department of Statistics at UNISWA. The data will be reported in chapter 5.

3.12 RELIABILITY, VALIDITY AND BIAS

In order for the research findings to be acceptable to the scientific community, it was important to

examine the aspects of reliability, validity and bias.

3.12.1 Reliability

Reliability is the degree of consistency or dependability with which a research instrument measures the attributes it is designed to measure (Burnad & Morrison 1994:74). Therefore, reliability is concerned with the consistency, stability and repeatability of the informants' accounts as well as the investigators' ability to collect and record information accurately (Brink & Wood 1998:299). In this study, reliability was enhanced by means of the following:

- Questions were pretested and yielded similar findings when compared with the main study.
- Different subgroups of the society were interviewed and revealed similar findings.
- Clinic records were reviewed and they served to confirm the family planning history given by participants.
- The interviews were conducted by three people (the researcher and two assistants) and in all instances yielded similar findings. Therefore, the instrument can be accepted as being reliable.

3.12.2 Validity

Validity, as observed by Polit and Hungler (1995:353), in research should be concerned with the accuracy and truthfulness of scientific findings. A valid study should demonstrate what actually exists and a valid instrument should measure what it is supposed to measure (Brink 1991:35). To enhance validity of this study, the following steps were taken:

- Respondents were drawn from the four regions of Swaziland and included different categories of women in the society (high school pupils, young adults and elderly women).
- The literature was examined to identify variables to be delineated (as discussed in chapter 2).
- The questions used for data collection were in line with the conceptual framework of the study.
- A senior lecturer from Unisa and a statistician from UNISWA examined each item for its appropriateness to the research questions.
- Pretesting of the data collection instrument was done with 10 respondents who did not participate in the main study.

Torn and McNichol (1998:1204) advise that validity should be evaluated against four measures: the inter-rater validity, content validity, correctional validity and semantic validity. In this study, the inter-rater validity was enhanced by inviting an independent researcher to analyse the research results. Content validity was enhanced by comparing the findings from interviews with the literature review. Correctional validity was enhanced by comparing the findings from focus group discussions with those from the structured interviews. These findings were found to be similar. Semantic validity was enhanced by the categories being mutually exclusive and exhaustive, as judged by the researcher and the statistician who was consulted after the structured interview schedule had been completed.

3.12.3 Bias

Bias is defined by Woods and Catanzaro (1988:319) as a systematic distortion of responses by the researcher, the respondents or by the instrument. In order to decrease bias:

- The researcher was dressed in accordance with the dress code of the society and never wore a nurse's uniform.
- The researcher made use of the services of two research assistants.
- Research was conducted in all the four regions of Swaziland.

Attempts were made to address issues of validity, reliability and bias through the following:

- A comprehensive literature study.
- An appropriate conceptual framework (HBM).
- A representative sample.
- Verified statistical findings.
- Congruence between research questions, objectives, findings and recommendations.

3.13 ETHICAL CONSIDERATIONS

According to Holloway and Wheeler (1998:43), research participants must grant permission voluntarily. In addition, permission also needs to be obtained from any relevant authorising body or institution. To this end, all relevant authorities were contacted in order to obtain the required permission. A letter was sent to the National Health Team of Swaziland, a body which is responsible

for all health activities in Swaziland. This body monitors health related activities and safeguards the health status of the population. Permission to conduct the study was subsequently obtained from the National Health Team (refer to annexure 3 of this report).

For the focus group interviews, permission was obtained from relevant parties, which were:

- The Ministry of Education and relevant head masters for the school going adolescents.
- The regional health team for the rural health motivators as well as for clients in health care institutions.
- Meetings were convened with community leaders in order to allow the researcher to conduct structured interviews with community members.

The various letters and meetings explained the objectives of the study, the required sample, as well as the period when the study would be conducted. Copies of these letters are attached as annexure 6.

With regard to the structured interviews that were conducted, a consent form was read to each participant, who was requested to raise a hand signifying acceptance to participate in the study, as advised by De Vos (1998:331). Literate respondents were requested to sign a consent form signifying their acceptance to participate in the study (see annexure 4). Participation was voluntary and respondents were allowed to discontinue at any stage of the process if they wanted to do so, without incurring any disadvantage by such withdrawal. Results were presented statistically and no names of persons nor institutions were linked to any responses in order to maintain anonymity of results. This was in line with the recommendations of Brink and Wood (1998:301). It was agreed that the research findings would be reported to the Ministry of Health and Social Welfare, Family Life Association of Swaziland and WHO Reproductive Health Section. No remuneration was paid to any participant.

3.14 CONCLUSION

In this chapter, the period of research, the research design, and methodology for collecting qualitative data are described. The quantitative and qualitative research designs were adopted in the present study because inadequate information could be traced regarding family planning practices in

Swaziland. Qualitative research was conducted in order to determine the attitudes and practices of Swazis toward family planning practices. The information gained from qualitative data was used to develop questions for a structured interview schedule (quantitative tool).

The procedures followed for pretesting the research instruments were explained. Trustworthiness of data was explained. The procedures for processing qualitative and quantitative data were discussed. In the next chapter, the data collected during phase one of the study (focus groups) will be presented.

CHAPTER 4

Presentation of results of focus group interviews

4.1 INTRODUCTION

The purpose of this chapter is to present and discuss the results of focus group interviews. Analysis was done by using the NUD*IST computer program. The information gained from the focus group interviews is relevant to the following objectives stated in section 1.5 of this study:

- to determine factors that are responsible for poor use of modern family planning practices in Swaziland
- to identify family planning practices that are prevalent among Swazi women
- to determine factors that may influence the selection of a particular family planning method

Three main questions were constructed in order to achieve the cited objectives. The questions which pertained to each of the focus group interviews dealt with the following aspects:

- section 1 dealt with views on cultural practices surrounding family planning and was aimed at answering objectives, 2 and 3
- section 2 dealt with views relating to childbearing practices as referred to in objective 1, this section was aimed at answering objective 1
- section 3 dealt with views on modern family planning practices, and sought answers relevant to objectives 1 and 3.

4.2 FOCUS GROUP INTERVIEWS

A total of 171 informants participated in the focus group interviews. The informants included:

- school going adolescents (30 males and 30 females)
- 12 female rural health motivators ranging from 30-45 years of age
- 14 elderly males (40-55 years of age), who were community leaders and well conversant with traditional childbearing practices
- 55 women of childbearing age, comprising 30 pregnant mothers and 25 postpartum clients
- 30 elderly women ranging from 46-60 years of age

Each of the 17 focus groups comprised 6-12 informants. Refer to table 3.1 for the classification of respondents for the focus group interviews.

The focus groups were generally open and lively and all participants spoke at least once during each interview session. However, interviews with adolescent girls were less spontaneous than those held with adolescent boys. The facilitator had to adhere closely to the interview guide, as there would otherwise have been minimal contributions from these girls. The reason for this apparent reservation could not be ascertained, but might be relevant to Swazi adolescent girls' fear of being known as sexually active, or of being known to be knowledgeable about reproductive issues. The themes and subthemes addressed are:

4.3 THEME 1: CHILDBEARING PRACTICES

Childbearing practices were perceived by the focus group informants as the cause for poor utilisation of family planning in Swaziland. Four subthemes were identified, namely: decision-making, family

planning, childbearing age and the number of children.

4.3.1 Decision-making

The elderly men revealed that men are regarded as the heads of the families and are assisted by elderly women on family health issues including family planning. These parties discussed issues relating to family planning indicating that the man is the only person who consults the family traditional healer for family planning advice. It was revealed by the group that it was contradictory to the Swazi practise for a woman to consult any healer for contraceptive practices without the approval of the man. As such, a Swazi woman was not expected to consult health care providers about family planning issues without the approval of her husband or the elderly female member of her family.

Elderly women were also of the opinion that men are the heads of families who make decisions related to family health, including family planning. However, elderly women regarded themselves as experts in reproductive health issues, and stated that they should be consulted by women for family planning advice. This view further limits women from fully practising their reproductive rights by requiring women to seek permission from other people to access and/or utilise family planning services.

Adolescent males also confirmed that men were regarded as heads of families, being responsible for family planning issues. However, adolescents further stated that young women were expected by society to be more assertive about family planning issues and to avoid being misled by men who wanted to engage in unprotected sexual intercourse. One young man said “girls should learn to be more self-directed on decision-making and should avoid pleasing men by having sexual intercourse with them at their detriment”.

Some adolescent women affirmed that men were decision-makers on family planning issues. This implied that these women could not utilise family planning services without the approval of men. They further revealed that their mothers-in-law were also responsible for advising them about family planning and child-rearing issues. Other adolescents vowed that they were not going to support cultural practices which accord a minority status to women to the extent of making decisions relating to family planning.

Women of childbearing age stated that they were trapped in a culture in which men dominate decision making in all aspects, including family planning issues. Pregnant informants revealed that their husbands were threatening to abandon them or secure an additional wife unless they became pregnant within a year since the birth of the youngest child. One respondent stated that “I carried an unwanted pregnancy to term when I was raped by a relative and my mother-in-law insisted that I should not reveal that I was raped as that revelation will bring shame to my family”. This finding confirms that Swazi women cannot practise family planning without the approval of either a husband or mother-in-law, even to terminate an unplanned pregnancy which resulted from being raped.

Discussions with the rural health motivators revealed contradictory findings. Some were of the opinion that men were decision makers in family planning issues, and recommended that such practices should be maintained. However, other rural health motivators felt that women were failing to use family planning services because of a lack of support from men in utilising male oriented family planning methods. They stated that women should be given the power to decide independently about family planning issues. They felt that some men were incapable of managing their own lives and it was impossible for such persons to manage the health of other family members, including the use or nonuse of contraceptives.

Informants from the five categories of the focus groups agreed that Swazi men are decision-makers in family planning issues. This finding is in line with the information discussed in section 1.2.1 of this study. However, elderly women, adolescent women and women of childbearing age recognised the advisory role of elderly women/mothers in law in decision making related to family planning issues. This response might be expected from Swazi women since culturally, a woman is expected to discuss any family planning issues with her mother in-law before the matter is reported to the head of the family (male).

The rural health motivators realised the need for women to be empowered to decide on issues relating to family planning, since they perceived men to be incapable of making such decisions. The issue of women’s empowerment on family planning issues revealed by rural health motivators might be a reflection of the basic health training received by rural health motivators, which makes them perceive health issues differently from other Swazi women in rural communities. Adolescent women stated that they were not going to conform to the cultural practices of having other people decide on issues relating to contraceptives. This finding reflected a shift from the Swazi traditional lifestyle to personal

values which promotes individuals to make informed decisions regarding their reproductive lives. Additionally, adolescent informants were attending school and their views might reflect the educational influence they were exposed to. According to Mbizvo and Adamchak (1992:52) male education on family planning issues must be encouraged in order for men (the decision makers) to appreciate the need for family planning.

4.3.2 Family planning practices

Information about family planning practices among elderly men revealed that men were against the use of modern family planning methods. They stated that “it was contradictory to Swazi tradition and against the will of the deceased for a couple to deliberately terminate fertility”. Based on this belief, men do not encourage women to practise family planning. When they were asked about the family planning methods that they were aware of, they did not want to discuss that subject. One man said “if I can discover that my wife is using contraceptives, I can divorce her”. Another man stated that “if a family planning provider would prescribe contraceptives for my wife, I would kill her/him just as she/he is destroying my family”.

Elderly men perceived the use of family planning methods to promote infidelity, and the user of family planning was perceived to have more than one sexual partner. It became evident from this group that modern family planning methods were associated with ill health and abnormalities in infants that are delivered by women who used contraceptives. Men also mentioned that medical conditions such as high blood pressure, headache and heart failure were prevalent among women who used contraceptives. Men were perceived to be generally weak and become mentally confused if their partners were using contraceptives. Traditional family planning methods such as the use of herbs and periodic abstinence were encouraged by the group as safe, effective and reliable family planning methods, since they have no side effects. It became evident from this discussion that elderly men who are the decision makers about family planning issues in Swazi families opposed the use of contraceptives. Also, health problems such as headaches, blood pressure and heart failure, which are associated with some systemic contraceptives were cited as barriers to the use of contraceptives.

Elderly women felt that family planning issues should be discussed with the mother-in-law. Young maidens have no right to decide on their own to control their fertility without the approval of their in laws. They further observed that women who use contraceptives were behaving irresponsibly.

They cited that the modern form of marriage, according to women's reproductive rights, is contradictory to Swazi practices. The traditional form of marriage was associated with Swazi traditional practices which promoted childbearing practices. The elderly women confirmed that traditional family planning methods were safe, reliable and without side-effects because they are male oriented. These family planning methods included abstinence, polygamy and the use of herbs. Therefore, deterrents to the use of family planning methods according to the discussion with elderly women included a lack of support from a female relative, cultural practices which accord men the right over the reproductive capacity of women and the reliance on traditional family planning methods.

Adolescent men were of the opinion that young women could benefit from using family planning in order to prevent unplanned pregnancies. However, they were not in favour of family planning methods because of feared misconceptions about some family planning methods. They perceived condoms to be the main cause of STDs as one young man said "the lubricant in the condom is the cause of a variety of STDs". Oral contraceptives were perceived to cause abortion. Another young man said "a friend who uses a condom is considered a fool by his mates since he does not conform to group norms". Girls were said to shun away from boys who use condoms. A young man alluded to the fact that "no girl can maintain a relationship with you if you do not engage in sexual intercourse with her". Adolescent boys also stated that men do not approve the use of modern family planning methods, but recommended traditional contraceptives such as abstinence, coitus interruptus and breastfeeding. These family planning methods were perceived to be reliable and safe.

Young men also revealed that family planning providers were to be blamed for poor distribution of family planning methods to youths. Some family planning providers were refusing to educate and/or prescribe contraceptives for adolescents. Other family planning providers were limiting discussions about contraceptives to male condoms and disregarded other contraceptive methods. As a result, adolescents have a limited knowledge on contraceptives. Also in the community there were no forums to address sexuality education and there were no programmes to address issues in family planning, according to the male adolescents. Consequently, adolescents relied on their friends for sexuality education and family planning issues.

Generally, deterrents to family planning according to adolescent men, included a lack of commitment by partners in utilising family planning methods, peer pressure, and negative attitudes associated with

contraceptive use. Negative attitudes displayed by family planning providers to adolescents, lack of sexuality education and contraceptive knowledge among community members were also cited as deterrents to the use of contraceptives by adolescents.

Adolescent women stated that their boyfriends did not approve of contraceptives, and that they complained that contraceptives cause ill-health. One girl stated that her boyfriend said "if you really love me, you won't mind to become pregnant". The girls also revealed that they compete with other girls for the love of men. If one girl becomes pregnant she is likely to win the man's hand in marriage. This results in poor family planning practices among young women in order to bear children for the prospective husband. Also young women feared to be ridiculed by their friends if they were using family planning methods. Young women were also meeting resistance from health care professionals at the family planning centres when they requested contraceptives. They further complained that there was no sexuality education in the community and in the school system which is designed for young people, hence they relied on their friends for family planning advice. On the other hand, young women were not ready to use contraceptives. They perceived that married couples who have regular sexual relationships should use contraceptives.

In summary, it became clear that adolescent women failed to use contraceptives because of disapproval from their boyfriends, fear of being ridiculed by their friends, lack of support from health care providers and lack of sexuality education from the school system and the community.

Rural informants affirmed that mothers-in law were promoting negative attitudes to men regarding the use of methods of family planning. They felt that women should use traditional family planning methods such as abstinence and lactational amenorrhoea. Negative attitudes toward contraceptives which were displayed by men and elderly women resulted in a lack of discussions about family planning practices with partners. Consequently, women were secretly seeking contraceptives from health care providers. Some women in the childbearing age preferred to use injectable contraceptives because neither their partners nor relatives would know that they were using contraceptives. Also, injectable contraceptives were found to be convenient and did not require frequent consultation with family planning providers, as one injection every three months met their contraceptive needs. Informants from both urban and rural areas feared that if their partners would discover that they were using contraceptives they would divorce them. However, respondents from urban areas felt that men were extending their role by interfering with contraceptive issues. They agreed that each woman

should be responsible for her own reproductive health and should make informed decisions about the size of her family. Therefore, disapproval by partners or an elderly female relative was cited by women of childbearing age as the main reason for their failing to use contraceptives.

The rural health motivators stated that men do not approve of the use of contraceptives, as they complain that contraceptives cause a variety of STDs. Men would, however, recommend the use of male condoms for preventing STDs when they have sexual intercourse with strangers. On the other hand, though, female oriented contraceptives were met with resistance and antagonism. Men were in favour of traditional family planning methods which included abstinence, coitus interruptus and breastfeeding. They perceived that the traditional contraceptives were safe and reversible and that they bear no side effects.

Regarding issues related to family planning practices, elderly men and women, adolescent women, women of childbearing age and rural health motivators revealed that men were against the use of modern methods of family planning. This finding is reflected in the low (29,0%) contraceptive prevalence rate which is revealed in table 1.2 of this study. Elderly men further revealed that it was contradictory to the Swazi tradition for a woman to deliberately terminate her fertility. This finding is in line with the Swazi society's attitudes toward family planning practices as revealed in section 2.2.1. However, adolescent men realised the need for engaging in family planning in order for women to prevent unplanned pregnancies. Since adolescents who engaged in this study were school-going, this finding might reveal that these adolescents recognised the advantages of engaging in family planning practices.

Elderly men, adolescent men, adolescent women and rural health motivators perceived that the use of contraceptives caused ill-health, such as high blood pressure, STDs and loss of libido. Elderly men further perceived that family planning practices promotes infidelity. Indeed, the rural health motivators revealed that men approved the use of condoms only when they were having sexual intercourse with their girlfriends as a prophylactic measure against STDs. This finding is in line with the misconceptions about the use of contraceptives, which are stated in section 2.2.2 of this study. Adolescent men and women feared to be ridiculed by their friends and/or partners if they used contraceptives. According to Gule (1993:243), partners' disapproval of contraceptive practices was associated with ignorance about the effects of contraceptives. Hence family planning providers should educate societies on family planning issues. Elderly women, adolescent men, women of

childbearing age and rural health motivators recommended the use of traditional contraceptives which included: abstinence, the use of herbs, coitus interruptus, polygamy and breastfeeding. They perceived that traditional contraceptives were effective, reversible and bear no side effect to the user (as revealed in section 2.3 of this study). Much as the traditional family planning practices were perceived to be effective, it must be understood that traditional family planning methods require the cooperation of a male partner. If Swazi males oppose the use of contraceptives and still value large families as indicated in section 2.2.2 of this study, any form of family planning method might remain ineffective. Family planning providers should intensify their teaching strategies and involve male motivators in order to promote contraceptive practices.

Adolescents complained that they were denied access to contraceptive methods by family planning providers. This information confirms the findings by Gule (1993:244) as indicated in section 2.2.2 of this study. It was further revealed that adolescents had no forum to address family planning issues in the society, consequently they relied on contraceptive information from their friends. This finding indicates a need to educate both in school and out of school adolescents on sexuality and family planning issues.

4.3.3 Childbearing age

Elderly males stated that women should marry at 20-25 years of age, when they were psychologically matured to bear the hardship of managing a family. However, they should start to bear children at 18 years of age in order to bear enough children for the clan. Late childbearing practices may limit a woman from producing an ideal number of children.

Elderly women were of the opinion that women should marry as soon as menarche occurred (13-15 years), as that was in their estimation, the ideal time for a woman to start childbearing. It was stated that women who marry at that early stage are likely to fulfil their marital role of bearing children. This finding seems to suggest that Swazi culture condones adolescent pregnancies. As such, these women may not practise family planning as they are expected by society to bear children at an early age. Tsabedze (2002:2) revealed a case whereby a young Swazi girl (12 years of age) was impregnated by a 55 year old man, who intended to marry that girl.

Adolescent women were of the opinion that women should start bearing children as early as 18 years

of age, as that was the ideal age for starting to produce the optimum number of children (in agreement with elderly men but in disagreement with elderly women). Early childbearing was perceived as a sign of maturity. If women were to be encouraged to start bearing children at an early age they would be more likely to bear many children because they were discouraged from practising family planning.

Adolescent males were of the opinion that women should start bearing children at 21 years of age, and one responded said “at 21 years of age, girls are matured to manage their families” (at least agreed with elderly men and adolescent women that women should bear children at 18 years or older). Some respondents, however, stated that a girl should begin her family at the age of eighteen years. One responded revealed that “if girls delay to become pregnant they may not be able to bear the optimum number of children required by the in-laws”.

With regard to adolescent pregnancy, boys acknowledged that adolescent pregnancy was a problem in the society. They were also aware of the consequences of adolescent pregnancy, namely poverty, embarrassment to the family and the community, low job opportunities and the perpetuation of low status of women. Boys further revealed that girls should be wiser and should avoid pregnancy while still attending school.

Although, the boys were aware of the consequences of early childbearing practices, it was evident that adolescent boys were generally promoting early (18 years) childbearing age in order for women to produce many children. This practice could be a deterrent to family planning practices, because women who start producing children at an early age are less likely to use contraceptives as informants stated that it was against the Swazi practices for women to prevent pregnancies.

Women of childbearing age expressed that eighteen years was the ideal childbearing age, but women should marry at 25 years. As one woman said “a man must marry a woman who has born him a child in order to be sure that the woman is fertile”. Infertility was the most feared complication for delaying to bear children. According to this group of childbearing women, fear of infertility was the main reason for the failure to use family planning among Swazi women of childbearing age.

The rural health motivators were of the opinion that women should start bearing children at twenty five year of age. They cited divorce, abandonment and poverty to be the consequences of early

childbearing practices.

With regard to childbearing age elderly males, adolescent women and women of childbearing age were of the opinion that childbearing should commence at 18 years. Whilst adolescent males and the rural health motivators cited 21 years as the ideal age for commencing childbearing. On the contrary, elderly women stated that the ideal childbearing age was at the onset of menarche (between 13-15 years). All the informants feared that any delay in childbearing might result in infertility. This perceived complication of delayed childbearing might be the cause of early sexual intercourse and a high (27,0%) adolescent pregnancy rate which is reflected in table 1.2, this situation results in high fertility rate in the Sub-Saharan Africa as indicated in section 2.2.4 of the present study.

4.3.4 Number of children

Elderly males stated that women were expected by society to bear many children. Failure to fulfil that role might bring shame to her family. They further stated that polygamy was practised in order for a man to produce many children for the clan. Therefore women should produce “as many children as the ancestors have given that family”. Based on this discussion, Swazi women might not practise family planning, since society expects them to bear many children. In addition, they fear to be cursed by their ancestors if they should limit the size of their families.

The discussion of elderly women centred around religious grounds for having many children. One woman said “children are a gift from God, and women should bear the ultimate number of children. According to the Bible, honest men were blessed with many children”. This discussion suggests that according to elderly Swazi women, religious beliefs are deterrents to family planning practices. Some rural women stated that five children was the ideal number for families. Others, however, pointed out that “the main responsibility of a married woman is procreation, hence they should bear many children in order to justify their social status”.

Adolescent males realised that a lot of children bring hardships to families due to limited resources. One young man said “I shall not allow my children to suffer because of insufficient resources. I want my children to have quality education, therefore I shall have one or two children”. Other respondents felt that two children were not sufficient to maintain the name of the family. They stated that four children was an ideal family size. Although one respondent realised the need for women to control

the size of their families, it appears that the young man was not in favour of limiting family size, and might therefore not recommend family planning practices.

Adolescent women who participated in the focus group discussions, explained that each woman should bear two to three children. However, the in-laws expected women to bear six children, more so in a traditional type of marriage where the bridal price (called 'lobola') was paid, women are expected to bear as many children as they could possibly produce. Since society expects women to bear many children, it seems unlikely for Swazi women to practise family planning.

Women of childbearing age felt that two to four children were an ideal size for families to feed, and to allow them to provide necessities for the entire family. They realised that men demand a lot of children, yet they might fail to support these children. One informant said "men demand many children yet they fail to provide for their needs". Similarly, women might be more inclined to adopt family planning practices in order to be able to distribute family resources amicably.

The rural health motivators acknowledged the fact that many children could cause hardships to families, but they thought that six was the ideal number of children for each family. Since rural health motivators are community based distributors of family planning, this finding suggests that negative attitudes of family planning providers toward family size might limit the use of contraceptives.

All the informants realised the need for women to produce children in the family. This was the cultural role of a woman as indicated in section 1.1 of the present study. However, elderly males and women expected women to produce as many children as they can possibly produce in order to justify their social status as revealed in section 2.2.1 of this study. Rural health motivators were of the opinion that six children were the ideal number, yet women who deliver more than five children are at risk of pregnancy complications which includes post partum haemorrhage, obstructed labour and disordered uterine contractions (Sweet & Tiran 1998:639-656). Adolescent males and females as well as women of childbearing age indicated that 1-4 children was the ideal number a woman should bear. Such a number of children do not put women at risk of pregnancy-related complications.

4.4 THEME 2: CULTURAL VALUES

Participants in focus group discussions identified cultural values as causes for poor use of family

planning methods.

4.4.1 Importance of children

Elderly males said children were important for the continuation of the family name, and that they served as social security for old age. As the Swaziland Government does not provide social security for the elderly, women might fail to practise family planning in order to have children who will supposedly support them during their old age.

Elderly women view children as a source of strength and hope during old age and they look up to them for social security. One woman said “children are fruits of a meaningful relationship, a family is said to be complete if it comprises children”. And another informant added that “one’s status rises with the number of children he/she produces”. Boys were said to be important to continue the family name whilst girls were a source of wealth as their fathers will acquire cattle or money in the form of the price paid for a bride (known as lobola) when each girl gets married. Children were important to both married and single women, as children will support their mothers when they are old.

From the foregoing discussion, it is evident that Swazi women might fail to practise family planning because of the role played by children in the society. Contrary to what has been revealed, one rural woman saw children as a liability, as her son could not support her because he had a large number of children. The following statement testifies to that: “My son has 14 children I know that he cannot provide basic needs for his children and he cannot support me although he works in the mines in the RSA”. This woman supports family planning because she believes that both she and her son could have benefited from limiting the size of his family.

Adolescent males were of the opinion that boys were important for the well-being of the family. One informant attested that “a boy child is important for maintaining the family name”. A woman who bears female children is not favoured because these girls will eventually leave home and join their in-laws, and no one will support the biological parents. It was also revealed that some mothers become excited when they become grandparents because that signifies that a new generation is born that will extend the family. This finding implies that women cannot stop having children until they produce boys who will take over their fathers’ responsibilities of administering their families’ affairs.

Adolescent women revealed that children were important for the political and social position of the family. In this regard, as one young woman said “a family with fewer children is likely to lose land or to be displaced by a more powerful family”. This finding implies that families might not be inclined to use contraceptives in order to maintain the social and political standing of the family.

However, some informants recognised that a lot of children were a direct cause of poverty and ill health among Swazi families. Hence women should use contraceptives in order to limit the size of their families in order to enhance their own and their families' well-being.

Women of childbearing age stated that having children was perceived to be a sign of wealth because families with many children could be assured of security in old age. Children were perceived to be the source of support in old age, especially in a polygamous relationship where competition for the love of a man is measured by the number of children a woman produces. Women were reluctant to use contraceptives because they perceived that contraceptives might result in infertility which is stigmatised in the Swazi culture.

The rural health motivators asserted that children signified the extension of a family tree, thus women should bear many children for future prosperity of the family. Children were also seen as the only source of support in old age, and the use of family planning might therefore limit future support for elderly members of the families.

Regarding the importance of children, all the groups revealed that children were perceived to be the social security for old age, and wealth was measured by the number of children the families had produced. This finding is in line with the information provided in section 2.2.2 of this study. Much as elderly women realised the social and political strength of having many children, some elderly women felt that children were a liability, and if many children were produced by families they might cause poverty, ill health and hardship. Despite the cited problems that might occur due to many children, the value of children was noted as a deterrent to family planning practices among Swazi women (as indicated in section 2.2.2 of this study).

4.4.2 Gender status

The minority status accorded to women, was identified as one of the causes for failure to practise

family planning among Swazi women.

Elderly males considered women to be inferior partners in marriage, who should conform to the demands of men, including the demands pertaining to family planning. These men asserted that a man should marry a woman who has born him a child to ensure that the woman is fertile. Barrenness was considered to be a social stigma. This is what one elderly man said “you have to be sure that a woman can produce children before you can marry her. You cannot marry a woman who shall fail to produce children and bring shame to the family”. This statement overlooks the fact that males could also be infertile.

Regarding family planning, elderly males were of the opinion that contraceptive use promotes infidelity. One man said “if I can discover that my wife is using contraceptives, I can divorce her because it means that she has more than one sexual partner. Besides, a woman is like a child who should seek family planning advice from a man who is the father of the family”.

This statement confirms that women are not expected to have more than one sexual partner, yet it is acceptable for men to have multiple partners. The following revelation was stated by one man in the group “it is healthy for a man to have many sexual partners, even adolescent girls. If a girl becomes pregnant, a man can marry her because she has proved to be an ideal woman”. This discussion seems to suggest that women were not expected to use contraceptives because they are inferior partners who should seek male advice in family planning issues. It could even imply that women who used contraceptives, were not regarded as “ideal women” by Swazi men who participated in this research.

It was also established from the group that contraceptive use had poor health consequences on men as one man said “if a woman is using contraceptives, a man becomes sexually weak and may also be mentally confused”. This discussion seems to suggest that men’s disapproval of family planning was based on the perceived health consequences that they might encounter. However, these men disregarded health problems that might be incurred by women as a result of frequent childbearing.

Elderly women were of the opinion that women should start childbearing practices as soon as they are married (at menarche) in order to justify their marital status. Any delay in bearing children might be associated with infertility, which carries a social stigma, and one woman attested to that by saying

“barren women are liable for a divorce, abandonment and a substitute wife is secured in order to bear children on behalf of the barren woman, thus cleansing her from the shame she has brought to her family and the entire society”. Men were not considered to be the cause of infertility as they were not stigmatised, divorced or abandoned if they were found to be infertile. Therefore, male disapproval to contraceptive use might be associated with the negative reaction by society to a woman who is infertile.

It was further affirmed by elderly women that family planning methods encouraged infidelity. One informant said “a woman who uses contraceptives has other sexual partners and is afraid that she might become pregnant and might not know the father of her baby should she become pregnant”. This finding seems to suggest that male infidelity is condoned by Swazi society but female infidelity is unacceptable and prevents men from allowing their wives to use contraceptives.

Adolescent males were of the opinion that women were inferior partners to men and that women should seek permission from men to use contraceptives. One rural based young man said “it is un-Swazi for women to consult health care providers for family planning purposes without the approval of men”. An urban based informant said “women are minors like children and should seek advice from men on family planning issues, women should also attain a lower level of education compared to their male counterparts in order to maintain their minority status and become economically dependent on men so that they fail to purchase contraceptives secretly”.

Conversely, urban based young men stated that girls were trapped in a culture which perpetuates the minority status of women, and it was upon women to rise above that culture and fight for their reproductive rights. This is what one adolescent had to say “women are controlled by men on decision-making even those that pertain to reproductive health and family planning. It is upon women to fight for their reproductive rights and to stand firm to fight against adolescent pregnancy and promote contraceptive use. Women have the power, they should use it to their advantage”.

Therefore it appears that adolescents from urban areas were aware that, in order to promote contraceptive use, the minority status of women should be overcome.

Adolescent women complained that their boyfriends prevented them from using contraceptives because they perceived contraceptives to cause ill health to both the user and partner. Young men

were also expected by society to marry a girl who proved to be a woman by giving birth to his child. This is what one female adolescent said “we fear that our boyfriends might reject us if we use contraceptives and that might limit our chances of getting married. In fact a girl stands a better chance of winning a man’s hand in marriage if she has born him a child”.

Girls felt that these young men were playing the role of husbands by controlling their lives. They believed that boys were despising them because they were women. They stated that as long as women were viewed by society to be minors they would be expected to conform to demands made by men, even those demands that pertain to family planning practices.

Women of childbearing age confirmed that men were expected by society to marry a woman who has born him a child and one informant said “a man should not marry a wife without the assurance that the woman is capable of bearing him a child”.

A woman of childbearing age who has no children, even if that woman is single, is perceived to be using contraceptives, which is viewed negatively by the Swazi society. Some respondents revealed that their partners were threatening to lay charges against family planning providers who prescribed contraceptives for their wives without their approval. Similarly, women were threatened by their husbands who would secure a second wife should these women fail to become pregnant within a specified time. This is what one pregnant informant from the peri-urban area had to say “my husband said if I was secretly using contraceptives and fail to fall pregnant within one year he was going to secure a second wife who will produce children on my behalf”. Women were thus failing to use contraceptives because of their minority status and their inability to make decisions without their husbands’ approval.

Although some of the rural health motivators upheld the superiority status of men by confirming that women were incapable of making reproductive decisions, some rural health motivators were of the opinion that men were incapable of managing their own lives and should not be trusted to make sound decisions about other peoples’ lives. One informant said “women should be given the right to plan their families according to their ability. Men are irresponsible and they cannot make fertility decisions for women”. This finding reflected that some women were aware of the fact that the inferiority status of Swazi women appeared to be a deterrent to contraceptive use.

All the informants revealed that Swazi women were considered to be inferior partners in marriage. Hence men decided for them when and how to control their fertility. Society expected women to conform with the minority status as indicated in section 2.2.2. of this study. Women thus failed to voluntarily use contraceptives because men should decide for them when to control fertility. Men also chose who to have sexual intercourse with, who to marry, and when to marry any woman. On the contrary, adolescent males realised the need for women to rise above their minority status and to decide freely on reproductive issues.

4.4.3 Importance of male fertility

Elderly males perceived male fertility to be important to such an extent that an old man was regarded as healthy if he impregnated a young woman. This is what one elderly man attested to “a man’s health status is reflected when he continues to produce children during old age”. This was the reason for men to continue marrying young women because it was perceived that they were maintaining their health. Contraceptive use would prove that men were unhealthy and might result to premature demise. This could explain why even elderly men would not allow their wives/partners to use contraceptives.

Elderly women were of the opinion that contraceptives were not healthy for either the users or their partners. Healthy families will continue to bear children, and the use of family planning was associated with health problem such as high blood pressure, uterine tumours and male impotence which might result in infertility. Women were discouraged from using contraceptives in order to maintain the healthy status of the family.

Adolescent males revealed that if a boy impregnated a girl he was perceived by his peers to be the ‘real’ man. Even his parents respected him because he would soon be a father. So male fertility was perceived to be a social position which every male was aspiring to achieve. This might be one of the reasons for male disapproval of contraceptive use.

Adolescent women stated that they competed for the love of a man by bearing him a child. It was, however, revealed that a man tended to favour a woman who has born him a boy more than the one who has born him a girl. Based on this finding, it became evident that male fertility was positively associated with the gender of the offspring. A woman who has born a girl was less likely to practise

family planning until she had 'pleased' a man by bearing him a boy. Similarly, a woman who has born a boy might continue 'pleasing' a man by producing more boys. Both these situations could serve as barriers preventing the use of contraceptives.

Women of childbearing age confirmed that the gender of a child was positively associated with the social status of the man. A boy child was perceived to be the strength and hope for the future of the family. It was also revealed that in a polygamous situation women competed for the love of a man by the number of male children they were capable of producing. A woman might not use contraceptives until she had delivered the desired number of boys.

The rural health motivators confirmed that a man became a 'real' man if he had a boy child. If the wife failed to produce a son "the man is justified to have a second wife or to engage in extramarital relationships in order to have an heir for the family". Swazi women failed to use contraceptives for fear of preventing the birth of a boy child.

Male fertility was associated with high social status according to all the informants. Elderly males realised the need for men to have many wives of different ages in order to prove their fertility during old age. The use of contraceptives might result in premature deaths according to elderly males and women. Adolescent males revealed that their status rose and they were respected by their peers and the entire society when they impregnated girls. Women, however, rated their love by men by the number of children borne. The value of children by Swazi men was identified as a deterrent to family planning practices (as indicated in section 2.2.2 of this study).

4.4.4 Importance of female fertility

Female fertility was generally seen to be a deterrent to family planning as every Swazi woman aspired to prove her fertility. Elderly males insisted that a man should marry a woman who has born him a child, as barrenness carried a stigma according to the family and the society. This finding seemed to imply that women failed to use contraceptives less they might become infertile and loose their social positions. The consequences of infertility, namely: divorce, abandonment and bringing shame to the family and society were feared by many Swazi women, and this consequently resulted in the poor use of family planning methods.

Elderly women expressed the opinion that they would be disappointed if they were to discover that their daughters-in-law and grandchildren were practising family planning. One of the rural respondents stated that “we look forward to having a large family and we do not expect young children to be disrespectful to us by controlling their fertility. Female fertility is important to extend the family clan and contraceptive use is unacceptable because it limits the size of the family”.

Responses from the adolescent males seemed to favour the reproductive ability of women as one young man from the urban school said “a wife who is barren is useless and should be sent back to her family because she is unable to produce children for the man”. These young men also acknowledged that a woman who produced male children was favoured by her husband because he was assured that the family name would extend to the next generation. Thus women fail to use contraceptives because their fertility appeared to be valued by their families.

Adolescent women revealed that they engaged in unprotected sexual intercourse because they wanted to prove to society that they were ‘real’ women as one young woman said “some girls engage in unprotected sexual intercourse because they want to prove their fertility when they become pregnant”. Young women were also aware that barrenness carried a social stigma and that women resisted to practise family planning for fear of becoming infertile. This finding might explain the increasing rate of adolescent pregnancies and poor utilisation of contraceptives among Swazis.

Women of childbearing age were also of the opinion that a man should marry a woman who has proven her fertility by bearing him a child. This is what one woman from the peri-urban area said “if a woman truly loves a man she should bear him a child and the man will be convinced that she is capable of producing children, then he will marry her”. Another woman from the royal area stated that “men become excited when their wives become pregnant”. This finding revealed that female fertility continued to be an important aspect among Swazis and contraceptive use might not be favoured by the society.

The rural health motivators were of the opinion that Swazis accorded high value to female fertility, and one responded said “a woman is considered a real woman when she has produced four or five children”. As long as Swazi women accorded high status to the reproductive ability of women, they would limit the use of contraceptives.

All the informants expressed that female fertility was important for the extension of the family clan, barrenness was considered to be a social stigma. Some women were inclined to start producing children before they were married in an effort to prove to be the ideal woman for the man, according to the adolescent women and women of childbearing age. Elderly women further revealed that they would be disappointed if their daughters-in-law were using contraceptives because they might become infertile, the most feared complication of contraceptives among all Swazis.

4.5 THEME 3: HEALTH PRACTICES

4.5.1 Barriers to health care services

Members of focus group discussions revealed that there were factors related to health services which limited the use of family planning methods among Swazi women.

Elderly males were of the opinion that family planning providers should educate clients about traditional methods of family planning. They asserted that traditional family planning methods were cheap, convenient, effective and culturally acceptable. These men were of the opinion that family planning providers might meet resistance from their clients should they promote modern family planning methods.

Elderly women felt that the use of modern contraceptives was responsible for ill health, and cited the use of condoms as the main cause of HIV infection and other STDs. Informants were of the opinion that oral contraceptives were responsible for high blood pressure and the use of IUCDs was associated with infanticide. One rural woman said “the loop and the pill destroy babies in the uterus, a woman who uses any of these family planning methods deserve to be divorced by her husband”.

Adolescent males stated that they were denied condoms at family planning centres because family planning providers perceived them to be too young to engage in sexual intercourse. One boy said “a family provider who happened to know my mother threatened to tell her that I was requesting for condoms at the clinic”. Such attitudes from family planning providers prevented clients from utilising the services.

Adolescent women revealed that health service staff were displaying negative attitudes toward

adolescents when they were seeking contraceptives at the family planning clinics. Adolescents from urban schools preferred to change out of school uniform into ordinary clothes in order to be attended to at family planning centres. Adolescents who were residing in rural areas feared to be ridiculed by family planning providers if they were seeking contraceptive advice at the clinic. There were financial constraints which limited adolescents from purchasing contraceptives at the pharmacy, and one informant had this to say “the clinic staff refuse to give us contraceptives because they say we are too young to use them. We do not have money to buy contraceptives at the pharmacy, so we end up getting pregnant because we are denied access to contraceptive use”. The negative attitudes of family planning staff, as well as financial constraints were seen as the main deterrents to the use of contraceptives among female adolescents.

Women of childbearing age complained that family planning centres lacked supplies of basic family planning methods. These centres also lacked privacy for counselling clients. Clients had to wait for long periods before they were attended to, and family planning providers displayed negative attitudes towards younger clients who needed their services. Consequently, clients were reluctant to use contraceptives.

The rural health motivators were of the opinion that family planning facilities offered limited methods of contraceptives and some clients were turned away because of limited contraceptive choices being available. In order to promote contraceptive use, the rural health motivators suggested that a variety of family planning methods should be made available to clients.

There was a general complaint about family planning services which were not user friendly according to focus group informants. Elderly women complained about the lack of family planning education by family planning providers. Adolescents and women of childbearing age were concerned about the negative attitudes that were displayed by family planning providers to their clients. The rural health motivators and women of childbearing age were concerned about limited resources and inaccessible contraceptive services. These cited hurdles were responsible for poor use of family planning services (as indicated in section 2.2.3 of this study).

4.6 ANALYSIS OF FOCUS GROUP INTERVIEWS' DATA ACCORDING TO THE HEALTH BELIEF MODEL

The findings from the focus group discussion are presented in line with the HBM, the theoretical framework for this study.

4.6.1 Perceived susceptibility

The findings from the focus group informants seem to suggest that Swazis do not perceive childbearing to be a risk to women's lives, expecting women to bear many children (refer to section 4.2.4 of this thesis). Additionally, women were expected to start childbearing practices at young ages (younger than 19 years of age), as revealed in section 4.2.3 of this study. Yet, the health consequences of adolescent pregnancies are greater than for women older than 20 years of age as indicated in section 2.2.4 of this study.

Swazi women might thus not be inclined to use contraceptives because the Swazi society supports childbearing practices. In Oheneba-Sakyi's view (1992:472), perceived susceptibility to pregnancy and its complications will positively influence the use of contraceptives. Family planning providers should aim at increasing perceived susceptibility to pregnancy in order for Swazi women to consider using contraceptives.

4.6.2 Perceived benefits

As indicated in section 2.5.2 of the study, the belief about the effectiveness of family planning methods in preventing pregnancies should correlate positively with their consistent use. The findings from the focus group informants revealed societal support for traditional family planning methods, and further revealed the negative attitudes displayed by Swazis toward modern family planning practices (refer to section 4.2.2 of this study). Education about the benefits of family planning is important in order to change attitudes in favour of modern family planning practices.

4.6.3 Perceived barriers

Perceived barriers to family planning practices, which were identified from the information gained

from focus group discussions, were socio-cultural (refer to section 4.3), health service factors (refer to section 4.4) and the negative attitudes Swazis hold about family planning practices (refer to section 4.2.2 of this study). Barriers to contraceptive practices might cause women to fail to use family planning practices as revealed in section 2.5.3 of this study. Effective family planning education is required in order to address barriers to family planning services.

4.6.4 Perceived cost

In section 2.5.4 of this study, it was revealed that some women failed to use contraceptives because of costs in terms of transportation fees, payment for family planning consultations and treatments. The adolescent women who participated in the focus group interviews indicated that there were financial constraints to the use of contraceptives (refer to section 4.4.1 of this study). This finding deserves the attention of the Ministry of Health and Social Welfare of Swaziland regarding the payment for family planning services.

4.6.5 Efficacy

The efficacy of a contraceptive method in preventing pregnancy is a standard measure against which other contraceptive methods are compared (refer to section 2.5.5 of this study). Focus group informants revealed that traditional family planning methods were safe, effective and reliable compared with modern contraceptives as outlined in section 4.2.2 of this study. Family planning providers should provide factual information about contraceptives and address misconceptions regarding family planning practices.

4.6.6 Cues to action

As indicated in section 2.5.6 of this study, exposure to information might positively influence members of society to use contraceptives. However, focus group informants demonstrated a lack of knowledge regarding contraceptives. Family planning providers should aim at using mass media to educate women about the benefits of using effective contraceptives.

4.7 CONCLUSION

Focus group interviews revealed that deterrents to family planning practices among Swazi women were related to socio-cultural expectations that women and men should bear children in order to justify their social status. This finding also implied that the number and the gender of children had a social bearing on women, hence women could not control their fertility voluntarily. Early childbearing practices were also encouraged in order for women to bear the optimal number of children. The minority status of women resulted in poor utilisation of methods of family planning. The negative attitude of family planning providers, and the scarce family planning resources influenced the use, choice as well as the physical accessibility of methods of family planning. These cited deterrents to the use of contraceptives were further investigated using the structured interviews. The results of these interviews will be presented and discussed in chapter 5.

CHAPTER 5

Analysis and discussion of quantitative data

5.1 INTRODUCTION

The purpose of this chapter is to present and discuss the information gained from the structured interviews which were developed following the results of the focus group interviews (see annexure 2 of this report). The statistical information in this chapter was derived from a sample of 205 purposely selected respondents from the four regions comprising Swaziland, as described in section 3.10.1. As a number of respondents failed to answer specific questions, the total number (n) of respondents therefore do not add up to 205 in all instances.

Personnel from the Department of Statistics, University of Swaziland used the SPSS program to analyse the data obtained from the interviews. The following statistical tests were used during the analysis of the data:

- Nonparametric tests were conducted because no assumption was made about the normal distribution of values in the population from which the sample was selected (Burns & Grove 2001:570).
- Cross tabulation was used for measuring nominal and ordinal data with the additional measure of statistical significance. This is in line with recommendations proposed by Hallett (1997:10).
- The Chi-Square test was used to determine the statistical significance of family planning practices and other variables, using significance levels of 0,05 and 0,01. For example, if the probability of uncertainty (P value) was more than 0,05 ($P > 0,05$) it indicated that the null hypothesis was rejected, while $P < 0,05$ indicated that the null hypothesis was accepted at 5,0% level. The “statistical significance” was based on the P value. Where P was less than 5,0%, the result was accepted as being statistically significant and where P value was found to be less than 1,0% ($P < 0,01$), the result was regarded as “highly significant” as advised by Freedman, Pisani, Purves and Adhikari (1991:437) and Spiegel (1992:249).
- The standard deviation test was used to measure the average amount that the sample distribution deviated from the mean score. This was in line with the approach prepared by Goodwin (1995:114).
- The Phi coefficient test was used with the Chi-Square test to describe the magnitude effect of relationships between two variables. According to Burns and Grove (2001:573), Phi values ranges from -1 to +1, with the magnitude of the relationship decreasing as the coefficient nears zero.
- Cramer’s V assisted in identifying the association between two variables. Cramer’s V is a modification of the phi-test used for contingency tables larger than 2x2. The value of the statistic ranged from zero to 1 (Babbie 1992:454; Burns & Grove 2001:573).

- Frequency distributions were compiled in order to arrange data belonging to the same category as advised by Spiegel (1996:36), and according to Valanis (1999:69). Frequencies, percentages and cumulative percentages are used to describe different variables, and allow for the clear presentation of data. Unfortunately the SPSS program produced percentages rounded off to the nearest full figure. While this is not the ideal percentage to report in academic writings, no changes occurred in the tendencies displayed in the research results.
- Observed frequencies and expected frequencies were used to describe data. According to Daniel (1999:573-575) and Freedman et al (1991:44-45), frequencies are numbers of subjects or objects in the sample that fall into the various categories of the variable of interest, for example, number of clients using different contraceptives (observed frequencies). Expected frequencies are the number of subjects or objects in the sample that one would expect to observe if some null hypothesis about the variable is true.

5.2 RESULTS OF THE INTERVIEWS

The results pertaining to the interviews will be discussed in this chapter. Where applicable, graphical presentations and/or tables will be used to show incidences of relevant values. Percentages will be used, followed by figures in brackets, indicating the number (n) of responses to a particular question.

5.3 SECTION 1: DEMOGRAPHIC DATA

The demographic information, including the respondents' ages, gender, marital status and religious affiliations, could provide a context against which to consider research results pertaining to contraceptive use or nonuse.

5.3.1 Age of respondents

The utilisation of contraceptives could depend on women's ages. Young women might need to use dependable contraceptives which would not compromise their fertility in any way, while older women might resort to more permanent contraceptive methods.

Table 5.1: Age distribution of respondents

Age	Frequency	Percentage	Cumulative percentage
Younger than 19 years	63	30,7	30,7
20-30 years	120	58,6	89,3
31-40 years	17	8,3	97,6
41 and above	5	2,4	100,0
TOTAL	205	100,0	

Table 5.1 reveals that 58,6% (n=120) of the respondents ranged between the ages of 20-30 years of age. These were suitable respondents for issues pertaining to family planning practices since they were at the appropriate childbearing period as stated by Baker et al (1996:8). Adolescents accounted for 30,7 % (n=63) of the respondents. Swazi adolescents were identified as a high risk group for pregnancy according to the MOH & SW Report (2001-2005:4), and their attitudes toward contraceptives need to be investigated in order to design more appropriate health care services, including contraceptive services. Additionally, 8,3% (n=17) of the respondents were in the 31-40 year category and 2,4% (n=5) were respondents aged 41 years and older. Data related to ages of the respondents will further be correlated with the methods of family planning practices in table 5.11.

5.3.2 The gender of respondents

All the participants in this section of the study were females. The gender bias in this study was based on the fact that respondents were recruited from health care centres, community centres and family planning clinics. These centres are mostly attended by women in Swaziland, and women were therefore found to be the most accessible respondents.

5.3.3 Marital status of respondents

The majority (73,2%, n=150) of respondents were single, whilst 26,8% (n=55) were married. Marital status and the use of family planning methods are compared in tables 5.9 and 5.12.

5.3.4 The type of marriage of respondents

Marriage in the Swazi society is a very serious undertaking, especially for the women. "At the same time it is an institution that every woman is expected to enter into. In Swazi culture marriage is not just a union between husband and wife but also a link between two families, who, through marriage, are starting a complex interrelationship that is bound to continue for a long time ... Her failure in marriage becomes their failure too, as it proves that they have failed to bring her up in the proper manner" (Dlamini 2000:73-74).

The analysis of this question was based on the responses of 55 married respondents. Only 10,9% (n=6) of these respondents were married according to a western type marriage, the remaining 89,1% (n=49) were married according to the Swazi customary form of marriage, which according to WLSA (2000:136), accords men the right over the reproductive capacity of women.

"If a (Swazi) man is found to have married according to Western civil law, he is despised and called by names. He is considered a fool as this type of marriage does not allow men to engage in polygyny" (Dlamini 2000:77). Women in polygynous marriages do not openly object to these types of marriages, probably due to the taboo in many African cultures preventing showing any signs of jealousy ((Dlamini 2000:80). "The most disturbing thing about it (polygyny) is that it often results in women entering a world of jealousy and uncertainty, since one wife may be pushed aside for another" ((Dlamini 2000:78).

5.3.5 Religious affiliation

All respondents were associated with the Christian religion. Of these, 77 (37,6%) were affiliated with the Zionist Christian Church (ZCC) which, according to Gule (1995:13), is a church that blends Christian beliefs with Swazi cultural practices.

5.3.6 Church approval for the use of family planning practices

The analysis to this question was based on 198 responses. The remaining 7 respondents were not sure whether their churches approved contraceptive use or not. Fifty percent (n=99) of the respondents revealed that their church approved of family planning practices, and the remaining 50,0% (n=99) reported that their church did not approve of family planning practices. The cross tabulation of family planning method used and the approval by church is shown in table 5.10.

5.3.7 Family planning methods recommended by the church

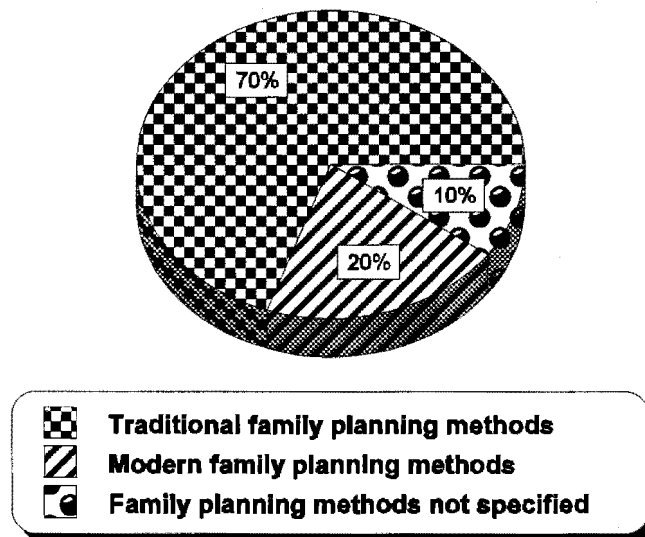


Figure 5.1

Family planning methods recommended by the church

The analysis of this question was based on 198 respondents. The majority of the respondents, (70,0%, n=139) stated that their churches recommended the use of traditional family planning methods, which included abstinence, breastfeeding and coitus interruptus. Only 20,0% (n=39) were encouraged by their churches to use modern family planning methods, which included condoms,

injectable, and/or oral contraceptives. Ten percent (n=20) of the respondents said their church recommended family planning, but it was not explicit which types of family planning methods were recommended by these churches.

5.3.8 Area of residence

The analysis for the area of residence was based on 201 of the respondents who were permanent residents of the cited areas. Four respondents had just recently relocated to the area under study, and their responses were therefore not included in this instance. A total of 57,0% (n=115) of the respondents were residing in rural areas, and respondents from the peri-urban areas, who were migrants from rural areas seeking employment accounted for 30,0% (n=60). Urban respondents accounted for 13,0% (n=26) of the total. The urban respondents had better access to family planning centres which are generally urban based, as stated in a report of the Ministry of Health and Social Welfare (2001-2005:6). Contraceptive use, and the area of residence of the respondents was cross tabulated in table 5.7.

5.3.9 Educational level of respondents

The majority of the respondents (68,0%, n=139) had attained secondary / high school education. This group was ideal to form a study population because of the positive relationship, which existed between education and the use of family planning practices as demonstrated by Nazar-Beutelspacher, Molina-Rosales, Salvatierra-Izaba, Zepata-Martelo and Halperin (1999:132). Indeed, 6,0% (n=12) of the respondents were university scholars pursuing undergraduate studies. Higher education might change reproductive behaviour and affect fertility among these respondents by:

- increasing knowledge of reproduction and contraception
- delaying entry into marriage or other unions
- changing attitudes about contraception and childbearing as recommended by CDC (1999:55).

In turn, early unplanned pregnancies might cause women to abandon their educational pursuits due to poor use of family planning as was the case with 21,0% (n=44) respondents who had achieved primary education, and 2,0% (n=4) who had no formal education. The relationship between education and the use of family planning shall be examined in table 5.6.

5.3.10 Engaged in paid employment

The majority of respondents were not gainfully employed, (69,8%, n=143). One respondent was self-employed (a traditional healer). Twenty nine (14,1%) were students attending higher institutions and the rest (15,6%, n=32) were gainfully employed.

5.4 SECTION 2: CHILDBEARING PRACTICES

Numerous interrelated and interdependent factors could influence a specific person's childbearing practices. Some of these factors, based on the literature reviewed and on the results of the focus group interviews conducted during phase 1 of this study, were addressed by specific questions in the structured interview schedules. Section 5.4 analyses and discusses these factors.

5.4.1 Decision-making

5.4.1.1 *Number of children born by each respondent*

The number of children borne by a woman might influence not only her intentions to bear more children, but also her use or nonuse of traditional and/or modern contraceptives.

Table 5.5 illustrates the number of children born by each respondent.

Table 5.2: Number of children born by respondents

Number of children	Frequency	Percentage	Cumulative percentage
No children	52 (5 pregnant)	26,0	26,0
1-2	84 (4 pregnant)	42,0	68,0
3-4	33 (8 pregnant)	16,4	84,4
5 or more	9 (6 pregnant)	4,5	89,0
Total number of pregnant women	23	11,0	100,0
Total	201	100,0	

The analysis of this question was based on 201 respondents, the remaining 4 of the respondents were excluded because their responses were irrelevant for this question. The majority of the respondents had two children (42,0%, n=84). Twenty six percent (n=52) had not given birth to children and 11,0% (n=23) were pregnant mothers whilst 4,5% (n=9) had given birth to more than five children. The number of children born was cross tabulated with the methods of family planning used by the respondents in table 5.8.

In order to assess the effect of the area of residence and the number of children born, a cross tabulation was done and table 5.6 gives the illustration.

Table 5.3: Cross tabulation area of residence and the number of children born

Area of residence	Children	None	1-2	3-4	5 or more	pregnant	Total
Rural	OF	41	38	14	6	16	115
	EF	29,8	48,1	18,9	5,1	13,2	115,0
Urban	OF	6	13	7	0	0	26
	EF	6,7	10,9	4,3	1,2	3,0	26,0
Peri-urban	OF	5	33	12	3	7	60
	EF	15,5	25,1	9,9	2,7	6,9	60,0
Total	OF	52	84	33	9	23	201
	EF	52,0	84,0	33,0	9,0	23,0	201,0

OF = observed frequencies
 EF = expected frequencies

Table 5.3 indicates that women who resided in the peri-urban areas had more children than those women who resided in either rural areas.

The Chi-Square value was 24.905, *df* 8, Phi .352, Cramer's V .249, Kendall's tau-b .138, Contingency coefficient .332, Spearman Correlation .154, and $P < 0.01$ indicating that the number of children born by women who participated in this survey, was highly significant in relation to this area of residence. The implication of this finding is to promote contraceptive practices which is locally acceptable in different areas of Swaziland in an effort to control the number of children born by women. These efforts should concentrate on peri-urban areas.

5.4.1.2 Number of additional children planned

The analysis for this question was based on 201 respondents. Only 19,0% ($n=38$) of the respondents had attained their fertility intentions, whilst the majority of the respondents, namely 83% ($n=167$) indicated that they desired more children. Of these, 50,0% ($n=84$) indicated that they wanted two more children, and 40,0% ($n=67$) stated that they wanted to bear four more children. Sixteen (10,0%) of the respondents said they wanted as many children as they could possibly produce. This finding was in line with the information given by elderly men and women who were informants in the

focus group interviews in section 4.2.4 of this study. Such findings might imply that Swazi women value large family sizes. Bergstrom et al (1993:21) warns that women who deliver many children were at risk of dying during childbirth.

5.4.1.3 The right of women to decide on the size of their families

The majority of the respondents, namely 83,4% (n=171), asserted that a Swazi woman cannot decide on the size of the family. This finding was revealed by focus group discussants (refer to section 4.2.1 of this study), and it confirms WLSA's (1998:205) report that Swazi women are minors and cannot make decisions relating to reproductive issues.

Respondents who thought women could decide about the size of their families accounted for 16,1% (n=33), of these respondents. These were liberated women who could practise family planning effectively. Only one respondent was unsure of how to respond to this question.

5.4.1.4 Decision-makers regarding reproductive issues

The majority of the respondents (64,0% , n=109) perceived that husbands/male partners should make decisions regarding family planning issues. This finding is in line with the findings from the focus group informants as indicated in section 4.2.1 of this research. Marwick (in WLSA 2000:30) asserted that Swazi women exerted little influence on decision affecting their reproductive lives. This finding indicates a need for family planning educators to change the attitudes of Swazi males in support for contraceptive practices.

Fourteen percent of the respondents (n=24) asserted that partners/couples should jointly make reproductive decisions. The remaining 22,0% (n=38) of the respondents were unable to respond to this question because at the time the study was conducted, they had no male partners, thus they felt that their responses might not reflect their true opinions on family planning issues.

5.4.1.5 The ideal childbearing age for a Swazi woman

Thirty-three percent (n=67) of the respondents acknowledged that women should start bearing children during the adolescent period. This finding was in support of the information given by the

focus group informants as indicated in section 4.2.3 of this research. Indeed, adolescent pregnancies in Swaziland are common, accounting for 27,0% of recorded deliveries, and society has learnt to condone it (Swaziland Government Strategic Plan 2001-2005:14). Recently, Tsabedze (2002:2) reported the case of a young woman (12 year of age), who was confirmed by a medical report, to be pregnant, indicating the magnitude of the adolescent pregnancy problem in Swaziland. Family planning providers should target women of all ages and educate them about the benefits of having contraceptives.

The majority of the respondents, being 64,0% (n=132) stated that between 20-25 years was an acceptable age for commencing with childbearing and 1,0% (n=2) of the respondents cited 26-30 years as the ideal age, the remaining 2,0% (n=4) of the respondents said a woman should bear children when she perceives herself to be ready for childbearing, irrespective of her age.

5.4.3 Family planning practices

5.4.3.1 Family planning methods of which respondents were aware

All the respondents answered this question. A number of the respondents indicated that they knew more than one method of family planning, therefore the responses do not total up to 205 in this section. All 205 respondents answered this question. A number of respondents indicated that they knew about more than one method of family planning. All these responses were recorded. Consequently the total number of responses (contraceptive methods known) could exceed 205.

Table 5.4: Methods of family planning known by respondents

FP methods	Frequency	Percentage
Tubal ligation	3	1,5
Pill	39	19,0
Condom	31	15,1
Injectable	55	26,8
IUCD	28	13,6
Traditional FP methods	110	53,6
Not aware of FP methods	8	3,9

The respondents were aware of the following methods of family planning: Tubal ligation according to 3 (1,5%) of the respondents. Oral contraceptives were cited by 19,0% (n=39) respondents, condom knowledge accounted for 15,1% (n=31), injectable contraceptives were revealed by 26,8% (n=55) and IUCD was known by 13,6% (n=28) respondents. Traditional family planning methods were mentioned by 53,6% (n=110) of the respondents and 8 (3,9%) of the respondents were not aware of any methods of family planning. Respondents who were not aware of family planning methods were at particular risk of becoming pregnant as noted by CDC (1999:118).

5.4.3.2 Sources of information on family planning

The majority of the respondents (55,0%, n=112) were informed by nurses/ family planning providers. This finding imply that family planning providers should have positive attitudes towards family planning clients as they were identified as knowledgeable about family planning issues. School teachers were identified by 18,0% (n=37) of the respondents as informants regarding family planning methods. Schools should therefore promote sexuality education, including contraceptive practices as an effort to curb adolescent pregnancy among school going women.

Friends were identified by 5,3% (n=11) as the informants for family planning practices. The media was cited by 5,3% (n=11) of the respondents as the mode of communication about family planning messages.

Parents were rated low (0,5%, n=1) in transmitting family planning messages. This finding might imply that parents were missing opportunities to address sexuality issues. The remaining 16,0% (n=33) could not remember who informed them about family planning methods.

5.4.3.3 Family planning methods used by respondents

In table 5.5 family planning methods used by respondents during the preceding six months are outlined. These methods were based on 199 respondents who were consistent in using the cited contraceptive methods.

Table 5.5: Family planning methods used by respondents

FP methods	Frequency	Percentage	Cumulative percentage
None	83	42,0	42,0
Injection	53	26,6	68,6
Condom	22	11,0	79,6
Abstinence	19	9,5	89,1
Pill	9	4,5	93,6
IUCD	3	1,5	94,1
Artificial	83	1,5	95,2
Traditional	5	2,5	97,7
Tubal ligation	2	1,0	100,0
Total	199		

Forty-two percent (n=83) of the respondents were not using any method of family planning, this finding is confirmed by a high birth rate that is prevalent among Swazi women as reported by the NDS (1998:57). Family planning providers should aim at providing sexuality education to sexually active people and further identify the presumed 'unmet need' for family planning. Injectable contraceptives were used by 26,6% (n=53) of the respondents. The main reason for choosing systemic contraceptives was partners' disapproval of contraceptive practices as indicated by women of childbearing age in section 4.2.2 of this thesis. Carpenters and Rock (2000:379) noted that the injectable contraceptives provided protection from pregnancy for three months and were recommended for clients who experience difficulties in accessing contraceptive services.

Only, 11,0% (n=22) of the respondents stated that their partners were using male condoms. These respondents could not access female condoms at their family planning centres. Low condom usage among respondents indicated the need to intensify family planning education among sexually active people, particularly in view of the HIV/AIDS pandemic among pregnant women in Swaziland as revealed in table 1.2 of this study.

Abstinence either total or periodic, was reported by breastfeeding mothers, accounting for 9,5% (n=19) of the respondents. According to Diaz and Croxatto (1993:815), the inhibitory effect of breastfeeding on fertility is still a major component of fertility regulation in traditional societies like

Swaziland, and women should be encouraged to use this method of family planning as it was found to be culturally acceptable.

Oral contraceptive use accounted for 4,5% (n=9) of the respondents. Carpenter and Rock (2000:370) asserted that oral contraceptives were 99,0% effective in preventing pregnancies, if used effectively by sexually active women. Respondents in this study revealed a high prevalence rate of oral contraceptives among women who had attained high school education (refer to table 5.5). This supports the findings of the WHO (2000:7) that the respondents' educational levels predict the effective use of oral contraceptives. Motivation to avoid pregnancy is also important for effective pill use.

Traditional family planning methods that are known to the respondents accounted to 2,5% (n=5), including:

- drinking a litre of water to flush out sperm after sexual intercourse
- engaging in physical activity or exercises following sexual intercourse in order to prevent sperm from reaching the internal reproductive system
- preserving a soiled pad in an airtight container following menstrual flow, and keeping it sealed until pregnancy is desired
- using herbs as vaginal douches after intercourse
- incomplete/ interrupted sex
- celibacy
- abstinence

Some of the traditional methods deserve to be further investigated for efficiency, as CDC (1999:24) noted that certain traditional family planning methods might be ineffective and/or harmful. For example, the use of herbs for douching postcoital is discouraged by Hatcher et al (1994:182), because douching increases the risk of pelvic infection and ectopic pregnancies (Hatcher et al 1994:182).

Artificial methods as well as the IUCDs were the contraceptive methods least used by respondents accounting for 1,5%, (n=3) respectively. The rationale for the low prevalence of IUCD use was not established. With respect to pregnancy prevention, IUCDs have an efficacy rate of approximately

98,0%. The low failure rate (1,0%-1,7%) makes it a safe and effective contraceptive method that should be more available to Swazi women. Counselling regarding the mechanism of action of IUCD is necessary in view of the rumoured abortion effect of the loop (in Swaziland).

In terms of perceived susceptibility, 42,0% (n=83) of the respondents did not perceive themselves to be susceptible to pregnancies, hence they did not use any contraceptives. In order to identify factors which limit the use of family planning practices in Swaziland, The methods of family planning were correlated with:

- educational attainment of the respondents
- area of residence
- number of children born
- marital status
- the approval of family planning by the church

Table 5.6: Cross tabulation: educational attainment and the use of the family planning methods

Educational attainment			Methods of family planning used								
Educational level	OF vs EF	None	Injection	Condoms	Pill	IUCD	Abstain	TL	Artificial	Tradition	Total
No formal education	OF	0	2	0	0	0	1	0	0	2	5
	EF	1,7	1,1	0,4	0,2	0,1	0,4	0,0	0,1	0,1	4,1
Primary education	OF	15	18	3	1	2	3	1	0	1	44
	EF	18,4	11,7	4,9	2,0	0,7	4,2	0,4	0,7	1,1	44,0
High school education	OF	59	31	18	8	1	16	1	3	2	139
	EF	58,0	37,0	15,4	6,3	2,1	13,3	1,4	2,1	3,5	139,0
University education	OF	9	2	1	0	0	0	0	0	0	12
	EF	5,0	3,2	1,3	0,5	0,2	1,1	0,1	0,2	0,3	12,0
Total	OF	83	53	22	9	3	19	2	3	5	199
	EF	83,0	53,0	22,0	9,0	3,0	19,0	2,0	3,0	5,0	199,0

OF = observed frequencies
 EF = expected frequencies
 TL = tubal ligation

Table 5.6 revealed that clients who had attained primary education were inclined to use injectable contraceptives as indicated by observed frequencies of 18 and expected frequencies of 11,7. Additionally, 15 of the respondents did not use any family planning method in that group and were at risk of becoming pregnant. Condom use was low, accounting for observed frequencies of 3 against the expectant frequencies of 4,9. Among the high school respondents, high abstinence was observed being 16 against an expected frequencies of 13,3, whilst condom use recorded a high observed frequency of 18 against the expectant frequencies of 15,4. Oral contraceptive use was high, being the observed frequencies of 8 against the expected frequencies of 6,3 and injectable contraceptive use was low, recording the observed frequencies of 31 against expected frequencies of 37,0. The majority of college respondents did not use contraceptives (90 observed frequencies against 5,0 expected frequencies). Only one respondent used condoms, while 2, respondents against the expected frequencies of 3,2, were using injectable contraceptives. It was not established in this study why college students did not use contraceptives although most colleges have family planning clinics available on their campuses.

According to Cramer's value of 0,316, contingency coefficient of .480, Kendall's tau-b test of -0,119, Phi of 0,547, Chi-Square value of 59.534, *df* of 24 and $P < 0,01$, there was a significant dependency between family planning method used and the educational attainment of respondents in this survey.

The implication of this finding is to include sexuality and family planning education in the school curriculum and also to encourage families and communities to provide sexuality and family planning education to women of child bearing age.

A cross tabulation of the area of residence and the use of family planning methods is presented in table 5.7.

Table 5.7: Area of residence and family planning method used

Area	Frequencies	No method	Some method	Total
Rural	OF	57	55	112
	EF	46,2	65,8	112,0
Urban	OF	9	17	26
	EF	10,7	15,3	26,0
Peri-urban	OF	16	45	61
	EF	25,1	35,9	61,0
Total	OF	82	117	199
	EF	82,0	117,0	199,0

OF = observed frequencies
 EF = expected frequencies

Table 5.7 shows that the majority of women who resided in rural areas did not practice family planning as indicated by the observed frequencies of 57 and the expected frequencies of 46,2. However respondents who resided in urban and peri-urban areas used some form of contraceptive (17 observed frequencies and 15,3 expected frequencies for urban residents and 45 observed frequencies and 35,9 expected frequencies for peri-urban respondents). Therefore, the use of family planning among women who participated on this survey depended on the area of residence, as supported by the Chi-Square value of 10,452, Phi value of 0,229, Cramer's V 0,229, Contingency Coefficient of 0,223, Kendall's tau-b value of 0,220 and $P < 0,01$.

Family planning providers should promote community based distribution of contraceptives in an effort to reach all groups of women.

The relationship between the number of children born and family planning methods used is indicated in table 5.8. The analysis for this question was based on 200 respondents who could relate family planning practices and the number of children born.

Table 5.8: Number of children born and methods of family planning

Children born	OF vs EF	Methods of family planning used									Total
		None	Injection	Condoms	Abstain	Pill	IUCD	Artificial	Tradition	TL	
None	OF	35	2	7	7	0	0	2	0	0	53
	EF	22,0	14,0	5,8	5,3	2,4	0,8	0,8	1,3	0,5	53,0
1-2	OF	24	28	10	10	7	1	1	2	0	83
	EF	34,4	22,0	9,1	8,3	3,7	1,2	1,2	2,1	0,8	83,0
3-4	OF	5	17	2	3	2	2	0	0	2	33
	EF	13,7	8,7	3,6	3,3	1,5	0,5	0,5	0,8	0,3	33,0
5 and above	OF	2	5	0	0	0	0	0	1	0	8
	EF	3,3	2,1	0,9	0,8	0,4	0,1	0,1	0,2	0,1	8,0
Pregnant	OF	17	1	3	0	0	0	0	2	0	23
	EF	9,5	6,1	2,5	2,3	1,0	0,3	0,3	0,6	0,2	23,0
Total	OF	83	53	22	20	9	3	3	5	2	200
	EF	83,0	53,0	22,0	20,0	9,0	3,0	3,0	5,0	2,0	200,0

OF = observed frequencies
 EF = expected frequencies
 TL = tubal ligation

Table 5.8 demonstrates that condoms and abstinence were used by those respondents who had no children, as indicated by the observed frequencies of 7 and expected frequencies of 5,8 in both instances. Injectable contraceptives were more prevalent among women who had given birth to 1-2, 3-4 and 5 or more children as indicated by the higher observed frequencies than the expected frequencies in each instance.

The number of children born was significantly dependant on the type of family planning used as indicated by $P < 0,01$, Chi-Square value of 91,233, *df* of 32, Phi value which was 0,675, Cramer's V 0,338, Contingency Coefficiency 0,560, Kendall's tau-b .069 and Spearman correlation 0,087. Women should thus be advised to use effective contraceptives in order to limit the number of their children.

Contraceptive use was further correlated with the marital status as outlined in table 5.9.

Table 5.9: Marital status and family planning used

Single	Frequencies	No method	Some method	Total
Yes	OF	60	87	147
	EF	61,4	85,6	147,0
No	OF	24	30	54
	EF	22,6	31,4	54,0
Total	OF	84	117	201
	EF	84,0	117,0	201,0

OF = observed frequencies

EF = expected frequencies

Table 5.9 demonstrates that single women were using some form of contraceptives as indicated by the observed frequencies of 87 and the expected frequencies of 85,6. However, married women were not using contraceptives as indicated by the observed frequencies of 24 and the expected frequencies of 22,6. This finding is in line with the Swazi cultural expectation that a woman is expected to bear children and should not control fertility as indicated by the focus group informants (elderly males) in section 4.2.2 of this study.

The Chi-Square test and the symmetrical measures demonstrated a negative association between marital status and the use of family planning methods (Chi-Square test 0,214, $P < 0,05$, Phi -0,033, Cramer's V 0,033, Contingency Coefficient 0,033, Kendall's tau-b -0,033, Spearman Correlation -0,033).

The use of family planning methods and the approval by the church was correlated and the results are demonstrated in table 5.10.

Table 5.10: Methods of family planning and the approval by the church

FP approval	OF vs EF	Methods of family planning used									Total
		None	Injection	Condoms	Abstain	Pill	IUCD	Artificial	Tradition	TL	
Yes	OF	45	14	10	16	4	3	3	4	0	99
	EF	40,5	26,5	11,0	10,0	4,5	1,5	1,5	2,5	1,0	99,0
No	OF	36	39	12	4	5	0	0	1	2	99
	EF	40,5	26,5	11,0	10,0	4,5	1,5	1,5	2,5	1,0	99,0
Total	OF	81	53	22	20	9	3	3	5	2	198
	EF	81,0	53,0	22,0	20,0	9,0	3,0	3,0	5,0	2,0	198,0

OF = observed frequencies

EF = expected frequencies

TL = tubal ligation

Table 5.10 demonstrates that injectable contraceptive was used by those respondents whose church disapproved of contraceptives as indicated by the observed frequencies of 39 and the expected frequencies of 26,5. Abstinence was mostly practised by the respondents whose church approved of contraceptives as revealed by the observed frequencies of 16 against the expected frequencies of 10,0. The type of family planning used depended on whether or not the church approved family planning practices as indicated by $P < 0,01$, Chi-Square value of 30,085, df 8, Phi 0,390, Cramer's V 390, Contingency Coefficient 0,363, Kendall's tau-b -0,043 and Spearman Correlation -0,048. This finding implies that churches should educate their congregates about the benefits of family planning.

5.4.3.4 *The use of family planning methods when engaging in sexual intercourse*

There were 132 responses to this question. Fifty-three percent ($n=70$) of the respondents were using contraceptives each time they engaged in sexual intercourse. Women apparently perceived themselves to be susceptible to pregnancies and used contraceptives. Forty seven percent ($n=62$) of the subjects did not use family planning methods with each sexual encounter. The implication of this finding is for family planning providers to study the antecedents of risk behaviour and to attempt to modify them.

The relationship between the age of respondents and the use of contraceptives before engaging in sexual intercourse is presented in table 5.11 and was based on 132 respondents who responded to this question.

Table 5.11: Cross tabulation: ages and the use of family planning methods before engaging in sexual relationship

Age	Frequencies	Yes	No	Total
Below 19 years	OF	12	12	24
	EF	12,7	11,3	24,0
20-30 years	OF	49	42	91
	EF	48,3	42,7	91,0
31-40 years	OF	8	8	16
	EF	8,5	7,5	16,0
41 and above	OF	1	0	1
	EF	0,5	0,5	1,0
Total	OF	70	62	132
	EF	70,0	62,0	132,0

OF = observed frequencies
EF = expected frequencies

When comparing the ages of the respondents and the use of family planning methods before engaging in sexual relationships, there was no statistical significance between these variables since the probability of uncertainty value was greater than 0,05 ($P > 0,05$).

Table 5.12 a cross tabulation of the marital status and the use of methods of family planning methods before engaging in sexual relationships.

Table 5.12: Cross tabulation: marital status and the use of family planning methods before engaging in sexual relationships

Marital status	Count	Yes	No	Total
Single	OF	53	36	89
	EF	47,2	41,8	89,0
Married	OF	17	26	43
	EF	22,8	20,2	43,0
Total	OF	70	62	132
	EF	70,0	62,0	132,0
Chi-Square test	31			

OF = observed frequencies
EF = expected frequencies

A comparison of marital status and the use of family planning methods each time the respondents were having sexual intercourse revealed that single respondents made use of family planning method each time they had sexual intercourse, the value being 53 whilst the expected count was 47,2. The findings suggest that single women, therefore, perceived themselves to be susceptible to pregnancies and were thus protecting themselves accordingly.

The majority of married respondents did not use contraceptives for each sexual encounter as indicated by a count of 26 against an expected count of 20,2. Married women in Swaziland are expected by society to bear children as indicated by elderly men in the focus group (refer to section 4.2.2 of this study). Gule (1993:244) noted that it would be unthinkable for women to limit the size of their families for economic or personal reasons.

There was statistical significance between the marital status and the use of family planning for every sexual encounter as the Chi Square test was 0,031 and $P < 0,05$ confirmed the correlation between the two variables.

5.4.3.5 Fear of becoming pregnant if women engaged in unprotected sexual intercourse

There were 205 respondents to this question. Sixty one percent of the respondents (n=125) perceived that they might become pregnant if they engaged in unprotected sexual intercourse. The remaining 39,0% (n=80) indicated that they did not mind becoming pregnant. Family planning providers should aim at educating women about the perceived risk of becoming pregnant, and should encourage women of childbearing age to use contraceptives.

5.4.3.6 The benefits of using contraceptives

The majority of respondents (50,7, % n=104) stated that the benefit of practising family planning was to promote the social status of the family and the remaining 49,3% (n=101) were not aware of the benefits of family planning. Family planning education should aim at increasing clients' knowledge regarding the benefits of using family planning practices.

5.4.3.7 The disadvantages of using contraceptives

Sixty percent (n=123) of the respondents stated that the use of contraceptives might result in infertility, and 39,0% (n=80), pointed out that the use of family planning methods could cause ill-health. The remaining 2 (1,0%) of the respondents were of the opinion that the use of contraceptives was a bad practice. These findings are in line with the results of the focus group informants (adolescent males, rural health motivators and the elderly males as stated in section 4.2.2 and 4.2.3 of this study). The implication of this finding is to educate community members about the advantages of practising family planning.

5.4.3.8 Methods of family planning that were perceived to be effective in preventing pregnancy

Some of the respondents gave more than one response to this question, so the total exceeds 100,0%. Injectable contraceptives were regarded by 55,0% (n=113) of the respondents to be the most effective method of family planning. However, the user rate of this method was low as indicated by 26,0% (n=53) of the respondents. The rationale for the low use of injectable contraceptives was the perceived side effect of becoming infertile after prolonged use of this contraceptive method as indicated by focus group informants (refer to section 4.2.2 of this study). Oral contraceptives were

perceived to be effective according to 40,0% (n=82) of the respondents. However, the user rate for oral contraceptives was only 4,5% (n=9). The reasons cited by focus group informants for poor use of oral contraceptives was that they were perceived to cause abortion as indicated by adolescent males in section 4.2.2 of this study.

5.4.3.9 The family planning methods which were considered safe for use

Abstinence was considered safe according to 17,3% (n=35) of the respondents. This finding supports the information revealed by focus group informants (elderly men, elderly women and rural health motivators, in section 4.2.2 of this study). Injectable contraceptives were perceived by 8,5% (n=17) respondents as a safe contraceptive method. Contrary to this finding, focus group informants perceived injectable contraceptives to be the main cause of infertility (refer to section 4.2.2 of this study). Oral contraceptives were cited by 40,5% (n=82) of the respondents as a safe family planning method. The low perceived safety rate of oral contraceptives might confirm that respondents were not in favour of oral contraceptives as revealed by the adolescent males in the focus group discussion (refer to section 4.2.2 of this study).

Only 21,7% (n=44) of the respondents considered condoms to be a safe contraceptive. This finding was in line with the information revealed by rural health motivators in section 4.2.2 of this research. However, adolescent males perceived that condoms were the main causes of STDs and were thus deemed to be unsafe for use (refer to section 4.2.2 of this study).

According to 4,5% (n=9) respondents, IUCDs were perceived to be a safe family planning method. CDC (1999:390) reveals that Copper T 380A has one of the lowest (0,6%) pregnancy rates of any contraceptive and should be used by women who wish to control their fertility.

Traditional practices, such as the use of herbs, accounted for 1,0% (n=2) perceived safety rate. These practices require extensive research to examine their effectiveness, particularly as CDC (1999:24) warns about their ineffectiveness and harm that might result from such use.

The calendar method was cited by 0,5% (n=1) respondent as being a safe contraceptive method, whilst coitus interruptus/withdrawal was suggested by two respondents to be a safe contraceptive method. Hatcher et al (1994:341) reveal that the safety of withdrawal depends on the male's ability

to withdraw prior to ejaculation.

5.4.3.10 Women who should practice family planning in the society

The majority of respondents (61,0%, n=125) perceived sexually active people to be the users of family planning methods. This finding was in line with the fact that sexually active people are generally at risk of becoming pregnant.

Women were identified by 25,3% (n=52) of the respondents as the people who should use family planning methods. Male partners were perceived by 8,3% (n=17) respondents as people who should utilise contraceptives. This finding is in accordance with the view of Hatcher et al (1994:342) that certain family planning methods, such as coitus interruptus, condom and abstinence, require the co-operation of partners in order to be effective.

Adolescents were viewed by 4,3% (n=9) of the respondents as the ideal group to use family planning methods whilst health personnel were identified by 1,0% (n=2) of the respondents as people who should use family planning methods, because they were knowledgeable about their effect and they were likely to identify and manage any side effects that might occur.

5.4.3.11 The availability of family planning information in the society

Figure 5.2 illustrates whether family planning was available in the society or not.

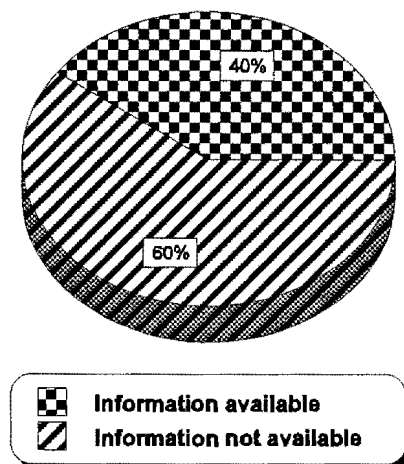


Figure 5.2

Is family planning information available in the society

The majority of the respondents (60,0%, n=123) stated that family planning information was not available in the society. This finding calls for health workers to ensure that family planning messages reach all people in the society. Forty percent (n=82) of the respondents admitted that family planning messages were available to members of the society.

There were multiple responses to this question, therefore the total does not add up to 100,0%. The majority of the respondents (77,5%, n=159) recognised that community education was the most effective mode of reaching different groups in the society regarding family planning issues.

The media (radio stations and newspapers) were identified by 12,0% (n=25) of the respondents as the “*port of call*” for family planning messages. Health workers were perceived by 6,3% (n=13) of the respondents as the ideal group to promote family planning in society. Indeed, it is vital that health workers should be knowledgeable regarding family planning issues in order to give factual information to the community.

Schools were identified by 3,4% (n=7) of the respondents as the right institution to deliver family planning messages to society. In fact, schools provide education to young children and can also ensure that values of family planning education are instilled in young women in order to ensure that they delay falling pregnant until they were ready to do so.

According to 1,5% (n=3) of the respondents, parents were perceived to be effective in reaching different groups for contraceptive advice. The low rating of parents indicated a lack of effective communication between parents and children regarding sexuality issues. Parents should be provided with factual information in order to educate their children effectively about reproductive health and family planning related issues.

Partners, friends and churches were each perceived by 0,5% (n=1) respondents as the source of information relating to family planning. Each of the groups mentioned has a potential of reaching its members, thus effective education in that regard is important.

5.4.3.12 Respondent’s opinions about peer education on family planning issues

Sixty seven percent (n=138) of the respondents revealed that peer education was not effective

because there was a lack of factual information among peer members and 5,0% (n=11) of the respondents felt that peer education could mislead young people. Twenty-six percent (n=54) of the respondents perceived peer education to be effective and suggested that it should be promoted in disseminating family planning messages. Two respondents provided no response to this question.

5.5 SECTION 3: CULTURAL VALUES

5.5.1 Importance of children in the Swazi society

5.5.1.1 The main responsibility of a married woman in reproductive issues

The majority (98,5%, n=202) of respondents revealed that the main responsibility of a married woman was to bear children, this finding was in line with the information revealed by all the members of the focus group informants in section 4.2.3. According to WLSA (1998:177) the Swazi custom of paying a bridal price (lobola) was meant to buy the reproductive capacity of a woman. Only 0,5% (n=1) stated that the role of a married woman was to check for STD infection, and to ensure that she was in a healthy state in order to reproduce the desired number of children.

Two respondents (n=1%) stated that the responsibility of a married woman was to avoid unwanted pregnancies. This response might be based on the fact that women are solely responsible for child rearing in Swaziland as noted by Kasenene (1993:89).

5.5.1.2 Respondents' opinions about induced abortions

Ethical issues relating to abortion proved to be a sensitive topic to discuss with respondents. Indeed, 5,8% (n=12) respondents declined from responding to this question. The analysis for this question was therefore based on the answers of 193 respondents.

The majority of respondents (86%, n=166) regarded abortion to be murder, a criminal offence and that it should be punishable by law. According to this argument, Davis and Aroskar (1991:129) maintain that the foetus possesses human characteristics from conception, and to kill it would thus be murder. Another position taken by respondents was a religious argument as 4,7% (n=9) of the respondents viewed abortion to be a sinful and an un-Godly practice. An additional 4,7% (n=9) of

the respondents perceived abortion to be a bad practice which should not be allowed in society . Davis and Aroskar (1991:128) state that if women are allowed to procure abortions, then moral choices can be made by individual women. However, if society denies this choice, the moral choice becomes determined for all by the values of some. Some Swazi health promoters viewed abortion as the main cause of maternal mortality and morbidity, according to 3,6% (n=7) of the respondents. In Swaziland, about 19,0% of maternal deaths are caused by abortions, according to the Swaziland Government Strategic Plan (2001-2005:10). Only 1,0% (n=2) of the respondents thought that abortion was a personal choice, based on the principle of autonomy which maintains that each woman has the right to her body and the right to determine her own fertility, as maintained by Davis and Aroskar (1991:130). However, in a country like Swaziland where abortion is illegal, it is not easy to exercise personal values pertaining to an ethical issues, like abortion. The law in Swaziland protects the foetus, which is defined as a person (Swaziland National Population Policy 2001).

5.5.1.3 Abortion practices in the Swazi society

There were 194 respondents who answered this question. The majority (89,2%, n=173) acknowledged that abortion was rife in the Swazi society, while the remaining 9,3% (n=18) stated that abortion was not practised in the society and only 1.5% (n=3) were unsure whether or not abortion was practised at all. This finding is generally observed in countries where abortion is highly restricted and official abortion statistics are unavailable (Bankole et al 1999:69).

5.5.1.4 Opinions about permanent sterilisations

Forty-nine percent (n=101) of the respondents viewed permanent sterilisation to be a bad practice and they believed that fertility should terminate at the appropriate time, without any artificial interfere. A further 2,0% (n=4) of the respondents asserted that permanent sterilisation was tantamount to murder and should be punishable by law, whilst 0,5% (n=1) perceived permanent sterilisation to be used as an ideal method of capital punishment for rapists. These negative attitudes demonstrated that the Swazi culture supports high fertility and strongly opposes permanent sterilisation.

Only 6,3% (n=13) of the respondents expressed the view that permanent sterilisation as opposing the will of God who wants people to multiply. They claimed that fertility was determined by the Creator and that it was sinful to interfere with nature. One respondent (0,5%, n=1) stated that permanent sterilisation could occur naturally and that no one should work against God's will.

From a health point of view, permanent sterilisation was seen to result in poor health, according to 24,0% (n=49) of the respondents. The common symptoms that were mentioned were headache, high blood pressure, oedema and recurrent bleeding.

Contrary to the negative attitudes mentioned, 11,0% (n=23) of the respondents perceived permanent sterilisation as a good practise, and 2,0% (n=4) proposed that permanent sterilisation was a personal choice and that people should be allowed to exercise their reproductive rights by seeking permanent sterilisation. However, 6,0% (n=13) of the respondents asserted that permanent sterilisation should be made available to women who have had a minimum of six children.

5.6 SECTION 4: GENDER STATUS

Swazi women find themselves in a context that is predominantly controlled by a strong patriarchal system as reflected by the following issues raised in local newspapers, indicating that Swazi women:

- are not allowed to take out loans without their husbands' permission
- can be left by their husbands at any time, and men can have as many wives as they like
- cannot have their cases tried in the courts of law without their husbands' presence, but men's cases go on trial without their wives (Dlamini 2000:77-82)

5.6.1 Importance of male fertility

Male fertility is highly acclaimed among the Swazi people, encouraging the continued existence of polygyny and even extra-marital sexual relations for men. If a married Swazi man "... has a child outside of the marriage, by a mistress, that child is brought home to be accepted and cared for by the married wife. She is expected to be joyful that she can be of service to her husband" (Dlamini

2000:76). This situation might explain why many Swazi women apparently remain reluctant to use contraceptives. Their husbands may procreate children outside their (polygynous) marriage, and expect their wives to raise these children with their own.

5.6.1.1 Does your partner approve of family planning?

The analysis for this question was based on 201 respondents who were using contraceptives at the time of the survey. Only 43,0% (n=86) of the respondents stated that their partners approve of family planning practices, and 0,5% (n=1) said her partner might consider family planning practices once she has produced a '*reasonable*' number of children. Bankole and Singh (1998:15) observed that couples' fertility intentions differ to the extent that men desired more children than their wives. Therefore the '*reasonable*' number of children that was suggested by the respondent might imply more children than the mothers' desired family size.

Fifty percent (n=101) of the respondents said that their partners did not approve of the use of contraceptives and one respondent (0,5%) admitted that her partner sometimes agreed and sometimes disagreed to use family planning methods. The remaining 12 (6,0%) were not sure whether their partners approved of contraceptive practices or not. McLean (cited by Gule 1993:243), observed that partners' disapproval of family planning might be associated with ignorance regarding family planning practices.

Table 5.13 reflects the cross tabulation of partners approval to using family planning methods, and the actual methods of contraception used by the respondents.

Table 5.13: Cross tabulation: does your partner approve of family planning and type of family planning method(s) which is used by respondents

Partners	OF vs EF	None	Methods of family planning used						Total
			Injection	Condoms	Pill	IUCD	Abstinence	TL	
No partner	OF	8	1	0	1	0	2	0	12
	EF	51	32	13	6	2	16	1	120
Yes	OF	32	25	14	4	1	8	2	86
	EF	364	227	94	43	13	111	9	860
No	OF	44	27	7	5	2	16	0	101
	EF	427	266	111	50	15	131	10	1010
Some-times	OF	0	0	1	0	0	0	0	1
	EF	4	30	1	0	0	1	0	10
Yes, if I have children	OF	1	0	0	0	0	0	0	1
	EF	4	30	1	0	0	1	0	10
Total	OF	85	53	22	10	3	26	2	201
	EF	850	530	220	100	30	260	20	2010

OF = observed frequencies
 EF = expected frequencies
 TL = tubal ligation

The findings summarised in table 5.13 show a contradiction as 32 women were reportedly not practising family planning yet they had indicated that their husbands/partners approved of the use of contraceptives.

Injectable contraceptives were the most common contraceptives used by respondents whose partners approved of family planning (observed frequency of 25 versus an expected frequency of 22,7). Male condom use was higher, accounting for 14 against an expected count of 9,4. This finding can be expected in view of the fact that condom use requires the cooperation of both partners (CDC1999: 433).

Another contradictory finding was that 7 respondents stated that they were using condoms yet their partners disapproved of the use of contraceptives. Further investigation is necessary to clarify this

finding. Forty-four respondents were not using any family planning method, and it was indicated that their partners did not approve of its use. Abstinence accounted for 16 against an expected count of 13,1 of respondents whose partners disapproved of the use of contraceptives.

There was no statistical significance between the approval of family planning methods and its utilisation, since the probability value was indicated to be $P > 0,05$.

5.6.1.2 The use of family planning method by partner

The analysis of this question was based on 182 respondents, who were willing to discuss contraceptives used by their partners. Twenty-six percent ($n=47$) of partners were using family planning whilst the majority (71,0%, $n=129$) were not practising contraception. Only 3,0% ($n=6$) of the respondents said their partners rarely used family planning methods.

5.6.1.3 Family planning method(s) used by partner

The analysis of the question regarding the different methods used was based on fifty-three respondents who gave acceptable responses. Condom use was the most prevalent (75,0%, $n=40$) among partners who used contraceptives. Abstinence was reported by 4,4% ($n=9$) of the respondents as their method of choice, and natural family planning in the form of periodic abstinence was practised by 1 respondent (0,5%). Artificial methods were cited by 1,5% ($n=3$) respondents, however, these artificial methods were not specified.

5.6.1.4 Partner's accompaniment to the family planning clinic

The analysis of this question was based on 187 responses. The majority (90,0%, $n=168$) were not accompanied by their partners to family planning centres. Yet, for the benefit of counselling, it is important that both parties should attend family planning sessions (Hatcher et al 1994:566). About 7,0% ($n=13$) of the respondents stated that they were accompanied by their partners to family planning clinics. Three percent ($n=6$) of the respondents did not have partners at the time of the interview, hence their responses were not included.

5.6.1.5 *The value of discussing family planning issues between partners*

The analysis of this question was based on 205 respondents. The majority of the respondents (95,0%, n=194) recognised the need for partners to communicate about sexuality issues. Partners' commitment is essential in contraceptive issues, as some contraceptives (such as natural family planning methods and condoms) require the cooperation of both partners. However, 5,0% (n=11) of the respondents objected to the idea of discussing family planning issues with their partners.

5.6.2 Importance of female fertility

Female fertility is of extreme cultural importance to Swazi women who are expected to bear as many children as possible and who only become accepted to be adults once they have become mothers (as discussed in chapters 1 and 2 of this thesis). "EmaSwati also emphasize the *buhle bemfati busemtini wakhe*. That may be translated to mean 'the beauty of a woman is in her home'. In other words she can only be judged by what she does in her home and for her family" (Dlamini 2000:77). If the Swazi women's greatest value is attributed to the care they render within their own homes, then their roles as wives and mothers must be of greater importance than that in cultures where women are encouraged to achieve accomplishments in education, business or specific professions. This situation reiterates the great cultural importance of bearing many children among the Swazi women.

5.6.2.1 *Single women and childbearing practices*

One-hundred and ten (53,7%) of the respondents stated that single women should bear children. According to WLSA (1998:29), this response reflects the cultural practice of condoning casual sex with unmarried women. Ten percent (n=11) of the 110 respondents pointed out that children provide reliable support for parents, and that single women should therefore bear children, in order to ensure the required social support. This finding was in line with the information given by elderly males in section 4.3.1 of this study. Only 46,3% (n=95) of the respondents acknowledged that single women should not have children.

5.6.2.2 *How does society react to a barren woman*

Approximately 95,0% of the respondents (n=194) stated that society would stigmatise a barren

woman, call her with derogatory names, insult her and blame her for infertility. Further more, a substitute wife is secured to produce children on behalf of a relative and “*cleanse*” the family of the shame that has been brought on them by the infertile woman. This finding confirms the information that was revealed by elderly women in the focus group discussion (refer to section 4.3.1 of this study). Three respondents (1,5%) stated that a barren woman is liable to be divorced. Eight respondents (4,0%) said society should advise a woman to seek treatment for infertility, and encourage her to ‘*keep trying for a child*’.

Family planning education is necessary among Swazis in order to change negative attitudes that society hold about the reproductive ability of women.

5.7 HEALTH ISSUES

Women’s health status can be permanently impaired by repeated pregnancies. Although pregnancy and childbirth are not illnesses, many mothers and babies suffer from complications as a result of problems which could arise during pregnancy and childbirth. “Throughout history, women’s experience of childbirth ranged from the most joyful and miraculous human experience to a dangerous journey into the unknown... but it was also common for mothers and babies to die at birth... For centuries, most cultures believed that it was a woman’s lot in life to suffer in this way” (Goosen & Klugman 1996:344). Health practices, including the effective utilisation of contraceptives, can considerably enhance women’s health status by enabling them to space their pregnancies so that their bodies could recuperate before the next pregnancy claims its physiological toll.

5.7.1 Health practices

Contraceptive health practices are influenced by the people’s culture and by the availability and accessibility of such services.

5.7.1.1 *Family planning methods that are available at family planning clinics*

The responses to this question shall not add up to 100,0% as some respondents gave more than one responses. Oral contraceptives were the most available contraceptives according to 81,0% (n=167) of the respondents. Injectable contraceptives were mentioned by 47,0% (n=97) of the respondents,

whilst condoms were readily available, according to 40,0% (n=82) of the respondents. Only one respondent (0,5%) stated that female condoms were available at her nearest family planning clinic, and 29,0% (n=60) of the respondents indicated that IUCDs were available at family planning clinics that they visited. Other contraceptive methods that were mentioned by the respondents included diaphragms (1,5%, n=3), foam (0,5%, n=1), permanent sterilisation, (1,5%, n=3) and artificial/mechanical methods (0,5%, n=1).

5.7.1.2 Availability of counselling at family planning clinics

Fifty,three percent (n=108) of the respondents acknowledged that counselling was offered at the family planning centres. One respondent (0,5%) indicated that counselling was sometimes offered and 16 respondents (8,0%) stated that she was not sure whether counselling was offered or not. Thirty nine percent (n=80) revealed that counselling was not offered at their family planning clinics. Such lack of counselling was perceived by the respondents as a shortcoming in the provision of family planning services.

5.7.1.3 Waiting time at family planning clinics

Forty one percent (n=84) of the respondents said that they usually waited for thirty minutes before they were attended to at the family planning clinic, while 35,0% (n=71) had to wait for up to one hour. Nine percent (n=18) indicated that they waited up to three hours and 1,5% (n=3) stated that the waiting time was determined by the number of family planning clients at the clinic on that day. The remaining 14,0% (n=29) were uncertain about the waiting time. The time spent in family planning clinics is important in terms of determining the quality of service and the survival of the programme, as clients who had to wait for more than an hour said that they would not use the service in future. These findings were in line with that of Gule (1993:244) who revealed that the “price” for contraception in terms of the time spent is too high, and that this in turn might result in poor use of family planning services.

5.7.1.4 Operating times of the clinic

According to 11,0% (n=23) of the respondents, the family planning services were operating on a daily bases, but the majority (69,0%, n=141) of the respondents stated that family planning services were

available on weekdays only. One (0,5%) of the respondents revealed that family planning services were available twice per week, and another respondent (0,5%) said family planning services were available three times a week. One respondent (0,5%) said family planning services were available once per month, and that this was an outreach service that operated on a monthly base. Thirty-eight (19,0%) of the respondents were not aware of the operating times of their family planning clinics. Service restriction limits the use of contraception, according to Speizer et al (2000:13), and such a situation was also pointed out by 10,6% (n=21) of the respondents in this study.

5.7.1.5 The request of partners' approval by family planning providers before prescribing contraceptives to clients

There were 170 respondents to this question, the other 35 did not answer this question. The majority of family planning providers (87,0%, n=149) did not require permission from husbands/partners to prescribe contraceptives for clients. This finding is an improvement from the findings by WLSA (1998:201) who noted that family planning providers were requesting partners' approval before prescribing contraceptives for their clients. Ten percent (n=17) of the respondents were requested by family planning providers to provide partners' consent before they were allowed to use contraceptives and 2,0% (n=4) said they were sometimes required to have the partners' approval before they were given contraceptives. Family planning providers were confirming the minority status of women in having a male partner decide the when and how a woman should control her fertility as indicated in section 2.2.2 of this study.

5.7.1.6 The quality of service offered at the nearest family planning clinic

Family planning services were perceived to be good according to 14,0% (n=28) of the respondents. This finding was revealed by clients who attended the urban family planning centres because of the accessibility of family planning services. However, 26,0% (n=53) perceived family planning services to be merely satisfactory, complaining that they had to wait long before they could access contraceptives.

Sixty percent of the respondents (n=124), confirmed that family planning services were of a poor standard, complaining about the negative attitudes displayed by family planning providers towards their clients. They also stated that there was a general lack of privacy when conducting family

planning counselling. The family planning services were said to be inaccessible and too expensive for an average Swazi client. The implication of this finding is to train and re-train family planning providers in order to have positive attitudes towards their clients. In addition, family planning services should be made accessible to clients. The cost of family services deserve special attention, as some clients might fail to pay for contraceptives and consequently not use them.

5.8 THE HEALTH BELIEF MODEL

The six aspects of the HBM are discussed in relation to the findings of the information gained from the structured interviews, which are:

5.8.1 Perceived susceptibility

Sixty-one percent of women who participated in this study did not perceive themselves susceptible to pregnancy should they engage in unprotected sexual intercourse as revealed in section 5.4.3.5 of this study. Yet, 47,0% of the respondents did not use contraceptives with each sexual encounter as indicated in section 5.4.3.4 of this study. Family planning providers should aim at increasing knowledge regarding contraceptive practices in order to encourage its effective use.

5.8.2 Perceived benefits

Respondents who participated in this survey were not conversant with the benefits of family planning practices as indicated in section 5.4.3.6 of this study. However, they perceived that family planning caused a variety of illnesses as demonstrated in section 5.4.3.7 of this study. It is important to educate women of childbearing age about the advantages of utilising family planning services.

5.8.3 Perceived barriers

Perceived barriers to family planning practices that were revealed by this study included:

- social expectation for a large family size as indicated by a high (83,0%) rate of women who wanted additional children (refer to section 5.4.1.2)

- lack of decision making abilities of women regarding family planning issues as revealed by 8,4% of the respondents (refer to section 5.4.1.3)
- partners' disapproval to contraceptive practices (as discussed in section 5.6.1.1, 5.6.1.2 and 5.6.1.4)
- ignorance about modern family planning practices as demonstrated in table 5.4
- residing in rural areas, as demonstrated in table 5.7, which might be associated with poor access to family planning services
- being married was associated with low use of contraceptives as indicated in table 5.9 and in table 5.12 of this study
- misconceptions and rumoured side effects of contraceptives as discussed in section 5.4.3.7 and 5.5.1.4
- gender status, women were perceived to be child-bearers and were thus not encouraged to control their fertility as revealed in section 5.5.1.1 of this study
- ethical issues, abortion was viewed as murder, as such, this family planning method was illegal in Swaziland at the time of conducting the study
- health service factors which included lack of support services, rigid time tables and the negative attitudes of family planning providers might turn away women from using the services

Family planning providers should aim at limiting the cited barriers and thus encourage women to use family planning services.

5.8.4 Perceived costs

Sixty percent of the respondents complained about the expense involved in family planning services (refer to section 5.7.1.6). The issue of payment for family planning services deserve urgent attention

by the Ministry of Health and Social Services of Swaziland as it might hinder the use of family planning services.

5.8.5 Efficacy

The injectable contraceptives were identified as the most effective method of family planning according to 55,0% of the respondents (refer to section 5.4.3.8). User effectiveness was not clearly demonstrated by the respondents in this study. Education regarding method effectiveness and user effectiveness is necessary in order to promote contraceptive practices among Swazi women.

5.8.6 Cues to action

It was revealed in this study that there was a general lack of family planning information in the Swazi society (refer to section 5.4.3.11). As such peer education lacked factual information and was perceived to be misleading (refer to section 5.4.3.12 of the study). It became apparent that family planning should use the media to distribute family planning messages as indicated in section 5.4.3.11 of this study.

5.9 CONCLUSION

In this chapter, the results obtained from the interviews were discussed. Deterrents to family planning practices were revealed in line with the aspects of the Health Belief Model, these were socio-cultural, ethical, attitudinal as well as factors relating to family planning providers. The conclusions and recommendations will be presented in chapter 6.

CHAPTER 6

Conclusion and limitations of this study: recommendations for future research

6.1 INTRODUCTION

The overall purpose of this study was to identify factors, which are responsible for poor use of family planning services in Swaziland using the HBM. The three objectives which guided this research, aimed to

- determine factors which are responsible for the poor use of modern family planning services in Swaziland
- identify family planning practices which are used by Swazi women
- document factors which influenced the selection of a particular family planning method

Research findings indicate some aspects that needed to be addressed. This chapter will focus on conclusions derived from the data obtained from the focus group interview and the questionnaires and make recommendations to relevant bodies.

6.2 CONCLUSIONS REGARDING THE OBJECTIVES OF THE STUDY

The major conclusions reached by analysing the data will be presented in accordance with the objectives which guided this research attempt, as outlined in chapter 1 of this thesis.

6.2.1 Objective 1: to determine factors which are responsible for poor use of modern family planning services in Swaziland

The study revealed that the following factors impacted negatively on the use of family planning services:

6.2.1.1 Value of children

The majority of the respondents (74,0%) had children and 83,0% indicated that they desired additional children (refer to table 5.2 and to section 4.3.1 and 5.4.1.2 of this study). Children were perceived as enhancing the social status, thus single women as well as adolescents desired children. The use of family planning practices might reflect negatively on Swazi women's social status.

6.2.1.2 Low level of education

Low utilisation of condoms was associated with respondents who had no formal education and those who had attained primary education. Conversely, condom use was observed among those respondents who had attained high school education (refer to table 5.6). There were misconceptions regarding the use of condoms according to focus group informants as indicated in section 4.2.2. Therefore, the study revealed that low educational attainment was associated with poor use of condoms.

6.2.1.2 Lack of support from partners

Fifty percent of the respondents revealed that their partners disapproved the use of contraceptives, 90,0% of their partners did not accompany their participants to family planning centres and 71,0% of the partners were practising family planning (refer to section 5.6.1.2 to section 5.6.1.5). The nonparticipation of partners in contraceptive issues was observed by Okore et al (1993:92)(refer to section 2.2.2 of this study) among Swazis and such attitudes still prevailed during the current study

as a deterrent to family planning practices.

6.2.1.3 Religion

Contraceptive use was perceived by some churches to be a sinful act, hence the respondents were not advised to use modern family planning methods. However, 70,0% of churches recommended the use of traditional family planning practices which according to CDC (1999:24) might not be effective in preventing pregnancies.

6.2.1.4 Legal status of abortion

As abortions were illegal in Swaziland at the time the study was conducted, clients were not allowed to access this method of contraception, and some respondents viewed abortion as murder.

6.2.1.5 Misconception about family planning

Low levels of knowledge about contraceptives and their functions resulted in misconceptions. For example, condoms were associated with male impotence, STDs and even with HIV. Oral contraceptives and injectable contraceptives were associated with promiscuity (refer to section 4.2.2 of this study). Ignorance and misconceptions limited the utilisation of family planning.

6.2.1.6 Social status of women

Swazi women acquire social positions by becoming mothers. As such, single women are also aspiring for that social status. Childless women are stigmatised and might be divorced or entitle a woman's husband to marry and additional wife. Women therefore feared using contraceptives, which might reportedly result in infertility, according to some respondents' perceptions.

6.2.1.7 Lack of knowledge about family planning

Limited knowledge regarding family planning methods and their actions acted as a barrier to the use of modern contraceptives. In this study 42,0% of the respondents were not using family planning methods. Nonuse of contraceptives was associated with ignorance about its use as indicated in section

4.2.2 of this study.

6.2.1.8 Inaccessible family planning services

Rural residents rarely used contraceptives because family planning services were inaccessible and too expensive for them (refer to table 5.7 of this study). The nonavailability of family planning services impacted negatively on its use.

6.2.1.9 Poor management of family planning services

It was apparent that family planning providers did not provide counselling services to clients. There were also supply constraints and clients had limited choices concerning the method of family planning. Family Planning centres were geographically inaccessible, making it difficult to access these services.

6.2.1.10 Lack of communication about family planning issues

Discussions about sexuality and family planning appeared to be taboo in the school curriculum, social groups, families and indeed in the entire society. The secrecy about sexuality issues prevented constructive discussions about fertility intentions and contraceptive use.

6.2.2 Objective 2: Identify family planning practices, which are used by Swazi women

In general, Swazi women who participated in this study did not practise family planning. Very few (27,0%) respondents used injectable contraceptives. Condom use accounted for 11,0% prevalence rate.

6.2.3 Objective 3: Determine factors which influence the selection of a particular method

Factors such as parity, age, residence, religious affiliation and mental status affected clients' choice of a particular method.

6.2.3.1 Accessibility

Respondents failed to use family planning services because they were geographically inaccessible to the rural community, there were operational constraints and some family planning providers required

the rural community, there were operational constraints and some family planning providers required partners' approval before prescribing contraceptives. Therefore these respondents did not practise contraceptives. Respondents who chose injectable contraceptives found them to be convenient because their partners did not need to know that they were using contraceptives. Also, injectable contraceptives were administered at three monthly intervals and were thus economic in terms of time and money.

6.2.3.2 *Affordability*

Financial costs probably prevented some clients from using contraceptives. Contraceptives are not issued free of charge in Swaziland. In addition to paying for contraceptives, clients also need to pay for transport to and from the health care facilities. This could place the utilisation of modern contraceptives beyond the financial means of many Swazi families, especially women who might be totally dependent on their husbands for money.

6.2.3.3 *Availability*

Oral contraceptives and injectable contraceptives were the most available contraceptives at the local family planning clinics. In spite of this availability, few women used contraceptives effectively in Swaziland, indicating that the mere availability of contraceptive services did not enable women to use these services.

6.2.3.4 *Effectiveness*

Injectable contraceptives were cited by 59,0% respondents as effective in preventing pregnancies. It could not be ascertained from the responses obtained during this investigation why only 59,0% of the respondents regarded injectable contraceptives to be effective, nor how they rated this efficacy against traditional family planning methods. The perception of the relatively low effectiveness of contraceptive injections might be attributable to a lack of knowledge among these Swazi women, or to incorrect use thereof.

6.2.3.5 Partners' approval

Injectable contraceptives were used by those respondents whose partners disapproved of the use of family planning. This research did not discover any circumstances under which Swazi men appeared to be willing to grant their wives permission to use contraceptives. Because Swazis still engage in polygyny, value large families and accord women status according to the number of children borne. Because male fertility is of extreme importance among the Swazi people, the psychological cost of using contraceptives, without the husband's approval, might be extreme. This was supported by a male respondent who stated during a focus group interview that he would be justified in murdering a health care worker who might have supplied contraceptives to his wife without his permission. Another man indicated that the discovery of his wife's use of contraceptives would be a sufficient reason for him to divorce her – a disdainful situation among Swazi women.

6.2.3.6 Marital status

Condom use was prevalent among unmarried participants and injectable contraceptives were used by married partners. Marital status apparently determined the method of contraceptives clients chose to use. Female condoms were not available, therefore the acceptability of this method could not be addressed. However, it became apparent that Swazi men used condoms because the decision then rested with them – not with the women. Conditions under which they would or would not use condoms were not clarified by these research results. Because of the continued existence of polygyny and the payment of the bridal prize (“lobola”) women are accorded the status of men's possessions (bought from their parents by paying the bridal prize) and the legal rights of minor persons. Therefore the decisions concerning the use of contraceptives among Swazi people, remain vested in the men. This cultural situation makes it virtually impossible for many Swazi women to make any independent decision concerning family planning issues.

6.2.3.7 Age

Respondents at the prime reproductive ages (20-30 years) used injectable contraceptives, oral contraceptives and condoms compared to respondents at the extreme ages (adolescents and elderly women). So the ages of the clients influences the method of contraceptives that were used by respondents who participated in this study.

6.2.3.8 Religion

Injectable contraceptives were commonly used by respondents whose Churches disapproved of family planning practices. This research did not involve religious leaders and thus could neither confirm nor deny the participants' reported perceptions concerning religious barriers to using contraceptives.

6.2.3.9 Social acceptance

Injectable contraceptives were prevalent among women whose partners disapproved of contraceptives. The social costs of using contraceptives might be inestimably high to the Swazi women, as discussed under the section concerning the "partners' approval".

6.3 CONCLUSIONS REGARDING THE HEALTH BELIEF MODEL

The HBM was used to identify factors responsible for poor use of family planning among Swazi women who participated in this study. Six components of the HBM were used as discussed in section 6.5.2 of this thesis.

6.3.1 Perceived susceptibility

About half of the respondents perceived themselves to be susceptible to pregnancies and were using effective contraceptives. Family planning workers should aim at increasing perceived susceptibility to pregnancy in order for clients to utilise family planning services.

6.3.2 Cost of family planning

As clients were paying for the family planning services, the reduction of fees might increase the use of contraceptives. Psychological and social costs require education in order to change negative attitudes towards contraceptive practices and to increase potential clients' levels of knowledge about contraceptives.

6.3.3 Perceived barriers

Barriers which included, social, religious, ethical as well as health related barriers require behavioural changes in order to promote the use of contraceptives.

6.3.4 Efficacy

Efficient contraceptives have to be promoted by family planning providers.

6.3.5 Cues to action

Open communication in the form of peer education, family education and community education on sexuality and family planning issues must be encouraged.

6.4 LIMITATIONS

Limitations that were inherent to the study will be discussed according to four topics which are:

6.4.1 Limitations regarding participants to the study

- Participation for the focus group discussions comprised adolescents, men, women and rural health motivators. Interview respondents comprised women only. The views of health care professionals and family planning providers might have enriched the findings of this study.
- Interviews for the study focussed on women. The study might have yielded valuable findings if men, couples and the extended families were included.
- Interviews with the other health care providers – traditional healers, spiritual healers and other relevant health care systems might have given alternative contraceptive practices prevailing in the Swazi society.

6.4.2 Limitations related to the method used for collecting data

- Conducting focus group interviews and structured interviews on a sensitive topic such as sexuality behaviour gives rise to ethical questions regarding confidentiality of information. Although respondents of this study were assured of the confidential nature of this research, Baren and Rich (1992:201) consider sexuality studies to be including in clients' private lives.
- The results of the focus group are generally not statistically significant, and De Vos (1998:21) states that the main limitation of using this data collection method is that data obtained cannot be generalised to the entire population.
- The sample size was relatively small, so the results could not necessarily be generalisable to the entire population of Swaziland.
- A longitudinal study of fertility intentions, practices and family planning might have given reliable results, as subjects would have been followed over a longer period of time than a cross sectional study that was conducted.

6.4.3 Limitations related to the health belief model

The HBM as a psychosocial framework emphasises the effects of beliefs on a decision making process carried out within the realms of interaction with other individual and events. Therefore, a model that attempted to understand sexuality behaviour of individuals across cultural groups such as transcultural family planning practices might have yielded valuable findings which could be applied in different cultural groups.

6.5 RECOMMENDATIONS BASED ON THE CONCLUSIONS OF THIS STUDY

Recommendations will be submitted to the Ministry of Health and Social Welfare, the Ministry of Education, Community Organisations/ families, for further research and recommendations to the Midwifery Department, UNISWA.

6.5.1 Recommendation to the Ministry of Health and Social Services

- Reproductive health policy has to be put in place in an effort to control unplanned pregnancies.
- Gender disparity in decision-making related to family planning practices must be addressed.
- Inadequately equipped family planning facilities deserve urgent attention in order to offer various family planning services.
- Negative attitudes of family planning providers deserve attention as it might limit access to various family planning services.
- Family planning centres should provide privacy to permit meaningful counselling. A key implication of the lack of privacy is the limited choice of contraceptive methods available to clients.
- The community-based distribution of family planning methods should be introduced in order to make the services accessible to communities, especially in the rural areas.
- Family planning services should target all sexually active people, male motivators should be encouraged to mobilise men. Professional counselling and continuous supplies of contraceptives should be maintained.
- Condom use must be promoted among sexually active people.
- Mass media campaigns must be promoted to curb unplanned pregnancies and promote the use of family planning services.

6.5.2 Recommendations to the Ministry of Education

- Sexuality education should be included in the school curriculum. Youths outside school deserve special attention.

- Family planning services should be made accessible to adolescents, the implications of this recommendation is to have flexible consultation hours for adolescents.

6.4.3 Recommendations to the community and families

- Sexuality education should be taught at community level as well as in families, the implication of this recommendation is to increase awareness of the consequences of adolescent pregnancies. The youth are a special target group because sex and pregnancy is not restricted to marriage.
- There is a need to recapture traditional values of chastity and self-control in sexual issues before and after marriage.

6.5.4 Recommendations to the Midwifery Department University of Swaziland

- The midwifery curriculum has to be reviewed in order to address the health beliefs of family planning clients before advising clients about family planning practice.

6.5.5 Recommendations for further research

Research should be conducted using the HBM in order to address the health beliefs and motivation for indulging into unprotected sex especially to adolescents.

A longitudinal study is needed to assess how societies respond to the changing values of large family sizes.

- A study that will address all health care givers is recommended in order to identify family planning methods suggested by individual groups.
- A replication of this study using a large sample and widening the population to include opinions and practices of men, traditional healers, policy-makers and family planning personnel.

6.5.6 Recommendation related to the Health Belief Model

The HBM provided an understanding of the perceived barriers to the use of contraceptives. It is therefore recommended that factors associated with compliance in health related issues should be taught to midwifery students in Swaziland using the HBM revealed by the findings of this research.

The quotation by Bergstron et al (1993:5) which state that “poor, powerless and pregnant” is the state of Swazi women who fail to practise family planning. This can be used to sum up this presentation.

6.6 CONCLUSIVE REMARKS

Family planning information and services are critical means for the attainment of reproductive health in any country. However, the mere availability of these services in Swaziland apparently fails to enable many Swazi men and women to access and utilise these services, mainly because of continued cultural barriers which prohibit women from making independent decisions concerning reproduction. This research highlighted a number of barriers which need to be addressed by Swaziland’s Ministry of Health and Social Welfare as well as the Ministry of Education in order to enable more Swazi women to access and utilise family planning services effectively. “Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last statement is the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice. Similarly, reproductive rights rest on the recognition of the basic right of all couples to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health” (Rao in Hatcher et al 1997:v).

“Population control must be regarded as part of the development of every society ... South Africa is experiencing its own population explosion. This is occurring primarily in the rural areas where the traditional belief of having many children still prevails ... Too rapid population increase has contributed to poverty and unemployment and a lowering of the quality of life of the majority of people in the country. The population development policy, improved education and greater gender equality in the developed areas have had the effect of slowing population increase” (Mitchell

1998:180). Although no similar quotation could be found for Swaziland, the implications are very similar. If this research succeeds in awakening the Swazi men and women to the dire necessity for making informed reproductive decisions and for enhancing gender equality in this country, then it has made a major contribution towards improving the quality of life of the Swazi people. One positive research finding relates to the perception of young males that women should assume responsibility for their fertility decisions and that women should complete their schooling prior to child rearing. This perception indicates a major departure from the dominant Swazi cultural perceptions about child rearing practices and holds some promise for realising future accomplishments in enabling more Swazi women to make use of effective family planning methods. As stated by Dlamini (2000:83), many attempts have been made to “... maintain a patriarchal ideology amongst emaSwati. It also becomes clear on the other hand that women are becoming ever more prepared to fight this battle to their utmost”.

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Annexure 1

Focus group interview

Guidelines for conducting focus group discussions

ANNEXURE 1

FOCUS GROUP INTERVIEW GUIDE

DEMOGRAPHIC INFORMATION OF THE GROUP

1. Group category

Adolescents

Elderly males/females

Rural health motivators

Traditional healers

2. Gender

Males

Females

3. Size of group

4. Study area

School

Health centre

Community centre

Any other (specify)

ASPECTS REGARDING THE SWAZI CULTURE

5. Inform us about the decision making process in childbearing issues

6. What is the role of a Swazi woman in reproductive issues

7. Who decides on the number of children in the Swazi family

ADOLESCENT SEXUALITY

8. Inform us about the cultural ways of preventing adolescent pregnancies

ATTITUDES TOWARDS FAMILY PLANNING PRACTICES

9. Inform us about the cultural practices of controlling childbirths
10. Is it recommended for Swazi women to use modern family planning practices
11. Are the family planning services acceptable in your community

GUIDELINES FOR CONDUCTING FOCUS GROUP DISCUSSIONS

3.1 Objectives of focus group discussion

The objective of the focus group discussion was to identify knowledge attitudes and practices on modern and traditional family planning practices.

3.2 Recruitment

Appointments were to be set with the focal person and identification of participants was to be arranged by the focal person. Follow up letters, reminder calls were to be done by the facilitator.

3.3 Number of group participants

The focus group participants were supposed to be between 10-15 per group, allowing each participant to contribute to the discussion.

3.4 Venue of group discussions

The facilitator, through the focal person, organised the venue, seating arrangement and refreshments.

3.5 A debriefing session before each group discussion and the roles of each member, being the facilitator, notes takers, and focal person were clarified.

3.6 A meeting after the discussion was held to clarify issues, check completeness of notes and completed documents were given to the researcher for safe keeping.

Annexure 2

Interview schedule

ANNEXURE 2

INTERVIEW SCHEDULE

SECTION 1 DEMOGRAPHIC DATA

- | | |
|---|--------------------|
| 1. AGE | Below 19 years |
| | 20-30 years |
| | 31-40 years |
| | 41 and above |
| 2. GENDER | Male |
| | Female |
| 3. MARITAL STATUS | single |
| | Married |
| | Divorced |
| | Separated |
| | Widowed |
| 4. TYPE OF MARRIAGE | Western |
| | Swazi law & custom |
| | Not applicable |
| 5. WHAT IS YOUR RELIGION? | |
| 6. DOES YOUR CHURCH APPROVE OF FAMILY PLANNING PRACTICES? | |
| 7. AREA OF RESIDENCE | Rural |
| | Urban |

Peri-urban

8. EDUCATIONAL LEVEL

no formal education

Primary education

Secondary / high school education

College / university

9. Are you engaged in paid employment? Yes

No

SECTION 2 CHILDBEARING PRACTICES

Decision -making

10. Number of children born

none

1-2

3-4

5 & more

11. Number of additional children planned?

12. Can a woman decide on the size of her family?

13. If the answer to question 12 is 'no' who should decide on her behalf regarding reproductive issues?

Childbearing age

14. What is the ideal childbearing age for a Swazi woman?

Family planning practices

15. List methods of family planning that you are aware of
16. Who informed you about the cited family planning methods?
17. Which family planning method are you using?
18. Do you use family planning each time you engage in sexual intercourse?
19. Do you fear that you might become pregnant if you engage in unprotected sexual intercourse?

20. What are the benefits of using family planning?
21. List methods of family planning that are effective in preventing pregnancy
22. Which family planning methods are safe for use by women?
23. Who should practice family planning in the society?
24. Is family planning information widely available in the society?
25. How should family planning messages reach different groups in the society?
26. What is your opinion about peer education on family planning issues?

SECTION 3 CULTURAL ISSUES

27. What is the main responsibility of a married woman in reproductive issues?
28. What is your opinion about induced abortion?
29. Is abortion practised in the Swazi society?
30. What is your opinion about permanent sterilisation?

SECTION 4 GENDER STATUS

Importance of male fertility

31. Does your partner approve of family planning?

32. Does your partner use family planning?
33. If the answer to question 32 is 'yes' which family planning method does your partner use?
34. Does your partner accompany you to a family planning centre?
35. Is it important for partners to discuss family planning issues?

Importance of female fertility

36. Should single women bear children?
37. How does the Swazi society react to a barren woman?

SECTION 5 FAMILY PLANNING SERVICES

38. Which family planning methods are available at your family planning clinic?
39. Is a family planning counselling service offered at your family planning centre?
40. How long do you wait before you are attended to at the family planning centre?
41. Does your family planning clinic operate on a daily basis?
42. Do health providers require partners' approval before prescribing contraceptives?
43. How can you rate the family planning service that is offered at your clinic?

Annexure 3

Permission to conduct a study

**THE CHAIR PERSON
NATIONAL RESEARCH HEALTH TEAM
PO BOX 5
MBABANE**

ANNEXURE 3

**P.O. BOX 669
MBABANE
24th JULY 2000**

**THE CHAIR PERSON
NATIONAL RESEARCH HEALTH TEAM
P.O.BOX 5
MBABANE**

Sir/ Madam,

RE: PERMISSION TO CONDUCT RESEARCH

I am a doctoral student with the University of South Africa (UNISA). As part of the requirements for my studies, I am supposed to conduct research to investigate the knowledge, attitudes and practices of different groups in the society. These groups comprise adolescents, women, and men. I shall begin with focus group discussions in community centres and educational institutions.

The information that will be gained from the focus group discussion will be used to formulate questionnaires for interview guide.

I am requesting to be attached to community health workers for each group that shall be visited in order for them to monitor the proceeding of the interviews.

Please find attached the guide for organising the focus group discussions. The interview questions will be forwarded in due course, when they are finalised.

Please note that ethical principles of conducting research shall be exercised through out the research process.

Thank-you for your assistance in this regard.

Yours sincerely,

**ISABELLA. S ZIYANE
(Researcher)**

Annexure 4

Consent form

**THE CHAIR PERSON
NATIONAL RESEARCH HEALTH TEAM
PO BOX 5
MBABANE**

CONSENT FORM

ANNEXURE 4

CONCENT FORM

I-----do grant permission to Isabella S Ziyane to interview me on sexuality and family planning issues, in order to complete her studies with the University of South Africa. I understand that the information that shall be given to the researcher will be solely used for study purposes and will be treated confidentially. I may discontinue at any stage of the interview when I feel otherwise and I shall not respond to the questions, which I do not want to respond to.

Signature of respondent

SWAZILAND



GOVERNMENT

Mbabane Public Health Unit
P.O. Box 1119
MBABANE

27th July, 00

Ms. Isabella S. Ziyane
P.O. Box 669
MBABANE

RE: PERMISSION TO CONDUCT RESEARCH IN HHOHHO REGION

This letter serves to acknowledge your letter dated 24th July, 2000 on the above subject.

The management views this exercise as means of essential Evaluation of Service Delivery, hence it is highly appreciated that, the Region will benefit from its findings.

Please confirm the exact dates of the study. The office is willing to afford you the necessary assistance at all times.

Yours faithfully

MARY L. MAGWAZA *mmagwaza*
REGIONAL PUBLIC HEALTH MATRON





Mpompotha High School

P.O. BOX 26, KUBUTA, SWAZILAND
Tel(+268) 207-9286

06-04-2001

RE: ISABEL ZIYANE

I hereby confirm and approve that the above officer was granted permission by the school administration to interview our school children on sexual problems and dangers.

We really appreciate your help.

Thank you

Yours Faithfully

I.M. LUKHELE

DEPUTY HEADTEACHER

Annexure 5

**Siswati and English version of
responses given by focus group
informants**

ANNEXURE 5

RESPONSES FROM THE FOCUS GROUP INTERVIEWS

Group categories

The responses which are presented were derived from a total of 171 informants who participated in the focus group interviews. The informants included school going adolescents (30 males and 30 females), female rural health motivators (12), elderly males (40-55 years of age, who were community leaders, fifty five women of childbearing age, comprising 30 pregnant mothers and 25 post partum clients and thirty elderly women ranging from 46-60 years of age.

The topics and sub-topics addressed were:

Aspects regarding the Swazi culture

The Swazi cultural practices regarding decision -making and the childbearing practices were perceived by the focus group informants as the cause for poor utilisation of family planning practices among Swazi women. Three questions were posed to group members, and the responses are presented for each group category.

Decision-making

The elderly men revealed that men are regarded as the heads of the Swazi families and are assisted by elderly women on family health issues including family planning. These parties discuss issues relating to family planning but the man is the only person who consults the family traditional healer for family planning advice. It was revealed by the group that it was contradictory to the Swazi practise for a woman to consult any healer for contraceptive practices without the approval of the man. As such, a Swazi woman was not expected to consult health care providers about family planning issues without the approval of her husband or the elderly female member of her family.

Elderly women were also of the opinion that men are the heads of families who make decisions related to family health, including family planning. However, elderly women regarded themselves as experts in reproductive health issues, and stated that they should be consulted by women for family planning advice. This view further limits women from fully practising their reproductive rights by requiring women to seek permission from other people to access and/or utilise family planning services.

Adolescent males also confirmed that men were regarded as heads of families, being responsible for family planning issues. However, adolescents further stated that young women were expected by society to be more assertive about family planning issues and to avoid being misled by men who wanted to engage in unprotected sexual intercourse. One young man said: *“Girls should learn to be more self-directed on decision making and should avoid pleasing men by having sexual intercourse with them at their detriment”*.

Some adolescent women affirmed that men were decision makers on family planning issues. They further revealed that their mothers-in-law were also responsible for advising them about family planning and child-rearing issues. Other adolescents vowed that they were not going to support cultural practices which accords a minority status to women to the extent of making decisions relating to family planning.

Women of childbearing age stated that they were trapped in a culture which men dominated decision- making in all aspects, including family issues. Pregnant informants revealed that their husbands were threatening to abandon them or secure an additional wife unless they became pregnant within a year since the birth of the youngest child. One responded stated that *“I carried an unwanted pregnancy to term when I was raped by a relative and my mother-in-law insisted that I should not reveal that I was raped as that revelation will bring shame to my family”*. This finding confirms that Swazi women cannot practise family planning without the approval of either a husband or mother-in-law, even to terminate an unplanned pregnancy which resulted from being raped.

Discussions with the rural health motivators revealed contradictory findings. Some were of the opinion that men were decision makers in family planning issues, and recommended that such practices should be maintained. However, other rural health motivators felt that women were failing to use family planning services because of a lack of support from men in utilising male oriented family planning methods. They stated that women should be given the power to decide independently about family planning issues. They felt that some men were incapable of managing their own lives and it was impossible for such persons to manage the health of other family members, including the use or non-use of contraceptives.

Therefore, informants from the five categories of the focus groups agreed that Swazi men are decision-makers in childbearing issues.

The role of Swazi women in reproductive issues

The role of Swazi women according to informants was to bear children, hence a woman should start producing children at an early age in order to achieve her optimum reproduction stage. Elderly males stated that women should marry at 20-25 years of age, when they were psychologically matured to bear the hardship of managing a family. However, they should start to bear children at 18 years of age in order to bear enough children for the clan. Late childbearing practices may limit a woman from producing an ideal number of children.

Elderly women were of the opinion that women should marry as soon as the menarche has occurred (13-15 years), as that was in their estimation, the ideal time for a woman to start childbearing. One respondent said *“women who marry at an early stage (less than 19 years of age) are likely to fulfil their marital role of bearing children”*.

Adolescent women were of the opinion that women should start bearing children as early as 18 years of age, as that was the ideal age for starting to producing the optimum number of children.

Adolescent males were of the opinion that women should start bearing children at twenty one years of age, and one responded said *“at 21 years of age, girls are matured to manage their*

families ” Some respondents, however stated that stated that a girl should begin her family at the age of eighteen years. One responded revealed that “ *if girls delay to become pregnant they may not be able to bear the optimum number of children required by the in-laws* ”.

With regard to adolescent pregnancy, boys acknowledged that adolescent pregnancy was a problem in the society. They were also aware of the consequences of adolescent pregnancy, namely poverty, embarrassment to the family and the community, low job opportunities and the perpetuation of low status of women. Boys further revealed that girls should be wiser and should avoid pregnancy while still attending school.

Although, the boys were aware of the consequences of early childbearing practices, it was evident that adolescent boys were generally promoting early (18 years) childbearing age in order for women to produce many children. This practice could be a deterrent to family planning practices, because women who start producing children at an early age are less likely to use contraceptives as informants stated that it was against the Swazi practices for women to prevent pregnancies.

Women of childbearing age expressed that eighteen years was the ideal childbearing age, but women should marry at twenty five years. As one woman said “ *a man must marry a woman who has born him a child in order to be sure that the woman is fertile* ”. Infertility was the most feared complication for delaying to bear children. According to this group of childbearing women, fear of infertility was the main reason for the failure to use family planning among Swazi women of childbearing age.

The rural health motivators were of the opinion that women should start bearing children at twenty five year of age. They cited divorce, abandonment and poverty to be the consequences of early childbearing practices.

With regard to the role of a Swazi woman in reproductive issues, focus group discussants were of the opinion that childbearing was the main role for Swazi women. All the informants feared that any delay in childbearing might result in infertility.

Who decides on the number of children in the Swazi family

All the group members felt that the male partners were the ones to decide on the number of the children since they are the heads of families who provide material support to their families. However, some elderly female respondents felt that it was God who decides on the number of children and it was against the will of God to deliberately terminate fertility. Elderly males were of the opinion that the ancestors decide on the number of children women should have. These men pointed out that it was against the will of the deceased to terminate fertility.

Elderly males stated that women were expected by society to bear many children. Failure to fulfil that role might bring shame to their families. They further stated that polygamy was practised in order for a man to produce many children for the clan. Therefore women should produce “*as many children as the ancestors have given that family* ”.

The discussion of elderly women centred around religious grounds for having many children. One woman said “ *children are a gift from God, and women should bear the ultimate number of*

children. According to the scriptures, honest men were blessed with many children”.

Some rural women stated that five children was the ideal number for families. Others, however, pointed out that *“the main responsibility of a married woman is procreation, hence they should bear many children in order to justify their social status”*.

Adolescent males realised that a lot of children bring hardships to families due to limited resources. One young man said *“I shall not allow my children to suffer because of insufficient resources. I want my children to have quality education, therefore I shall have one or two children”*.

Other respondents felt that two children were not sufficient to maintain the name of the family. They stated that four children was an ideal family size.

Adolescent women who participated in the focus group discussions, explained that each woman should bear two to three children. However, the in-laws expected women to bear six children, more so in a traditional type of marriage where the price called ‘lobola’ was paid, women are expected to bear as many children as they could possibly produce.

Women of childbearing age felt that two to four children were an ideal size for families to feed, and to allow them to provide necessities for the entire family. They realised that men demand a lot of children, yet they fail to support the male demand. One informant said *“men demand many children yet they fail to provide for their needs”*.

The rural health motivators acknowledged the fact that many children could cause hardships to families, but they thought that six was the ideal number of children for each family. Since rural health motivators are community based distributors of family planning, this finding suggests that negative attitudes of family planning providers toward family size might limit the use of contraceptives.

The reason stated by respondents for having children

Elderly males said children were important for the continuation of the family name, and that children serve as social security for old age.

Elderly women view children as a source of strength and hope during old age and they look up to them for social security. One woman said *“children are fruits of a meaningful relationship, a family is said to be complete if it comprises children”*. And another informant added that *“one’s status rises with the number of children he/she produces”*. Boys were said to be important to continue the family name whilst girls were a source of wealth as their fathers will acquire cattle or money in the form of the price paid for a bride (known as lobola) when each girl gets married. Children were important to both married and single women, as children will support their mothers when they are old.

Contrary to what has been revealed, one rural woman saw children as a liability, as her son could not support her because he had a large number of children. The following statement testifies to that: *“My son has fourteen children, I know that he cannot provide basic needs for his children*

and he cannot support me although he works in the mines in the Republic of South Africa". This woman supports family planning because she believes that her son could have benefited from limiting the size of his family.

Adolescent males were of the opinion that boys were important for the well-being of the family. One informant attested that "*a boy child is important for maintaining the family name*". A woman who bears female children is not favoured because these girls will eventually leave home and join their in-laws, and no one will support the biological parents. It was also revealed that some mothers become excited when they become grandparents because that signifies that a new generation is born that will extend the family.

Adolescent women revealed that children were important for the political and social position of the family. In this regard, as one young woman said "*a family with fewer children is likely to loose land or to be displaced by a more powerful family*". This finding implies that families might not be inclined to use contraceptives in order to maintain the social and political standing of the family.

However, some informants recognised that a lot of children were a direct cause of poverty and ill health among Swazi families.

Women of childbearing age stated that having children was perceived to be a sign of wealth because families with many children could be assured of security in old age. Children were perceived to be the source of support in old age, especially in a polygamous relationship where competition for the love of a man is measured by the number of children a woman produces. Women were reluctant to use contraceptives because they perceived that contraceptives might result in infertility which is stigmatised in the Swazi culture.

The rural health motivators asserted that children signified the extension of a family tree, thus women should bear many children for future prosperity of the family. Children were also seen as the only source of support in old age, and the use of family planning might therefore limit future support for elderly members of the families.

Adolescent sexuality

Cultural ways of preventing adolescent pregnancies

All the group members felt that it was important for adolescents to abstain from sexual intercourse in order to maintain their virginity. Abstinence was seen in the context of casual sex with a person who is not intending to marry that woman. However, in a stable relationship, abstinence was condoned because a man was expected to marry a woman who has proved to be fertile by bearing him a baby.

Attitudes towards family planning practices

Cultural practices of controlling childbirths

Traditional family planning methods such as the use of herbs and periodic abstinence, breastfeeding and coitus interruptus were perceived by all the members of the focus group participant to be safe, effective, reliable and culturally acceptable.

The use of modern family planning practices by Swazi women

Information about modern family planning practices among elderly men revealed that men were against the use of modern family planning methods. They stated that “ *it was contradictory to Swazi tradition and against the will of the deceased for a couple to deliberately terminate fertility* ”. Based on this belief, men do not encourage women to practise family planning. When they were asked about the family planning methods that they were aware of , they did not want to discuss that subject. One man said “ *if I can discover that my wife is using contraceptives, I can divorce her* ” . Another man stated that “ *if a family planning provider would prescribe contraceptives for my wife I would kill her/him just as she/he is destroying my family* ”.

Elderly men perceived the use of family planning methods to promote infidelity, and the user of family planning was perceived to have more than one sexual partner. It became evident from this group that modern family planning methods were associated with ill health and abnormalities in infants that are delivered by women who used contraceptives. Men also mentioned that medical conditions such as high blood pressure, headache and heart failure were prevalent among women who used contraceptives. Men were perceived to be generally weak and become mentally confused if their partners were using contraceptives. It became evident from this discussion that elderly men who are the decision makers about family planning issues in Swazi families opposed the use of contraceptives. Also, health problems such as headaches, blood pressure and heart failure, which are associated with some systemic contraceptives were cited as barriers to the use of family planning.

Elderly women felt that family planning issues should be discussed with the mother-in-law. Young maidens have no right to decide on their own to control their fertility without the approval of their in laws. They further observed that women who use contraceptives were behaving irresponsibly. They cited that the modern form of marriage according women reproductive rights, is contradictory to Swazi practices. The traditional form of marriage was associated with Swazi traditional practices which promote childbearing practices.

Adolescent men were of the opinion that young women could benefit from using family planning in order to prevent unplanned pregnancies. However, they were not in favour of family planning methods because of feared misconceptions about some family planning methods. They perceived condoms to be the main cause of STDs as one young man said “ *the lubricant in the condom is the cause of a variety of STDs*”. Oral contraceptives were perceived to cause abortion. Another young man said “ *a friend who uses a condom is considered a fool by his mates since he does not conform to group norms*”. Girls were said to shun away from boys who use condoms. A young man alluded to the fact that “ *no girl can maintain a relationship with you if you do not engage in sexual intercourse with her* ”. Adolescent boys also stated that men do not approve the use

of modern family planning methods, but recommended traditional contraceptives.

Adolescent women stated that their boyfriends did not approve of contraceptives, and that they complained that contraceptives cause ill-health. One girl stated that her boyfriend said *"if you really love me, you won't mind to become pregnant"*. The girls also revealed that they compete with other girls for the love of men. If one girl becomes pregnant she is likely to win the man's hand in marriage. This results in poor family planning practices among young women in order to bear children for the prospective husband. Also young women feared to be ridiculed by their friends if they were using family planning methods. Young women were also meeting resistance from health care professionals at the family planning centres when they requested contraceptives. They further complained that there was no sexuality education in the community and in the school system which is designed for young people, hence they relied on their friends for family planning advice. On the other hand, young women were not ready to use contraceptives. They perceived that married couples who have regular sexual relationships should use contraceptives.

Rural informants affirmed that mothers-in-law were promoting negative attitudes to men regarding the use of methods of family planning. They felt that women should use traditional family planning methods such as abstinence and lactational amenorrhoea. Negative attitudes toward contraceptives which were displayed by men and elderly women resulted in a lack of discussions about family planning practices with partners. Consequently, women were secretly seeking contraceptives from health care providers. Some women in the childbearing age preferred to use injectable contraceptives because neither their partners nor relatives would know that they were using contraceptives. Also, injectable contraceptives were found to be convenient and did not require frequent consultation with family planning providers, as one injection every three months met their contraceptive needs. Informants from both urban and rural areas feared that if their partners would discover that they were using contraceptives they would divorce them. However, respondents from urban areas felt that men were extending their role by interfering with contraceptive issues. They agreed that each woman should be responsible for her own reproductive health and should make informed decisions about the size of her family.

The rural health motivators stated that men do not approve of the use of contraceptives, as they complain that contraceptives cause a variety of STDs. Men would however recommend the use of male condoms for preventing STDs when they have sexual intercourse with strangers. On the other hand, though, female oriented contraceptives were met with resistance and antagonism. Men were in favour of traditional family planning methods which included abstinence, coitus interruptus and breastfeeding. They perceived that the traditional contraceptives were safe and reversible and that they bear no side effects.

Elderly men, adolescent men, adolescent women and rural health motivators perceived that the use of contraceptives caused ill-health, such as high blood pressure, STDs and loss of libido. Elderly men further perceived that family planning practices promotes infidelity, indeed, the rural health motivators revealed that men approved the use of condoms only when they were having sexual intercourse with their girlfriends as a prophylactic measure against STDs.

Women status in Swaziland

The minority status accorded to women, was identified as one of the causes for failure to practise family planning among Swazi women.

Elderly males considered women to be inferior partners in marriage, who should conform to the demands of men, including the demands pertaining to family planning. These men asserted that a man should marry a woman who has born him a child to ensure that the woman is fertile. Barrenness was considered to be a social stigma. This is what one elderly man said “ *you have to be sure that a woman can produce children before you can marry her. You cannot marry a woman who shall fail to produce children and bring shame to the family* ”. This statement overlooks the fact that males could also be infertile.

Regarding family planning elderly males were of the opinion that contraceptive use promotes infidelity. One man said “ *If I can discover that my wife is using contraceptives, I can divorce her because it means that she has more than one sexual partner. Besides, a woman is like a child who should seek family planning advice from a man who is the father of the family*”.

Women are not expected to have more than one sexual partner yet it is acceptable for men to have multiple partners. The following revelation was stated by one man in the group “ *it is healthy for a man to have many sexual partners, even adolescent girls. If a girl becomes pregnant, a man can marry her because she has proved to be an ideal woman*”. This discussion seems to suggest that women were not expected to use contraceptives because they are inferior partners who should seek males’ advice in family planning issues.

It was also established from the group that contraceptive use had poor health consequences on men as one man said “ *If a woman is using contraceptives, a man becomes sexually weak and may also be mentally confused*”.

Elderly women were of the opinion that women should start childbearing practices as soon as they are married (at menarche) in order to justify their marital status. Any delay in bearing children might be associated with infertility, which carries a social stigma, and one woman attested to that by saying “ *barren women are liable for a divorce, abandonment and a substitute wife is secured in order to bear children on behalf of the barren woman, thus cleansing her from the shame she has brought to her family and the entire society* ”. Men were not considered to be the cause of infertility as they were not stigmatised, divorced or abandoned if they were found to be infertile.

It was further affirmed by elderly women that family planning methods encouraged infidelity. One informant said “ *a woman who uses contraceptives has other sexual partners and is afraid that she might become pregnant and might not know the father of her baby should she become pregnant* ”.

Adolescent males were of the opinion that women were inferior partners to men and that women should seek permission from men to use contraceptives. One rural based young man said “ *It is un-Swazi for women to consult health care providers for family planning purposes without the approval of men*”. An urban based informant said “ *women are minors like children and should seek advice from men on family planning issues, women should also attain a lower level of*

education compared to their male counterparts in order to maintain their minority status and become economically dependent on men so that they fail to purchase contraceptives secretly”.

Conversely, urban based young men stated that girls were trapped in a culture which perpetuates the minority status of women, and it was upon women to rise above that culture and fight for their reproductive rights. This is what one adolescent had to say: *“ women are controlled by men on decision making even those that pertain to reproductive health and family planning. It is upon women to fight for their reproductive rights and to stand firm to fight against adolescent pregnancy and promote contraceptive use. Women have the power they should use it to their advantage “.*

Adolescent women complained that their boyfriends prevented them from using contraceptives because they perceived that contraceptives cause ill health to both the user and partner . Young men were also expected by society to marry a girl who has proved to be a woman by giving birth to his child. This is what one female adolescent said *“ we fear that our boyfriends might reject us if we use contraceptives and that might limit our chances of getting married, in fact a girl stands a better chance of winning a man’s hand in marriage if she has born him a child ”.* Girls felt that these young men were playing the role of husbands by controlling their lives. They believed that boys were despising them because they were women. They stated that as long as women were viewed by society as minors they shall be expected to conform to demands made by men, even those demands that pertain to family planning practices.

Women of childbearing age confirmed that men were expected by society to marry a woman who has born him a child and one informant said *“ a man should not marry a wife without the assurance that the woman is capable of bearing him a child ”.*

A woman of childbearing age who has no children, even if that woman is single, is perceived to be using contraceptives, which is viewed negatively by the Swazi society. Some respondents revealed that their partners were threatening to lay charges against family planning providers who prescribe contraceptives for their wives without their approval. Similarly, other women were threatened by their husbands that they will secure a second wife should they fail to become pregnant within a specified time. This is what one pregnant informant from the peri-urban area had to say *“ my husband said if I was secretly using contraceptives and fail to fall pregnant within one year he was going to secure a second wife who will produce children on my behalf ”.*

Although some of the rural health motivators upheld the superiority status of men by confirming that women were incapable of making reproductive decisions, some rural health motivators were of the opinion that men were incapable of managing their own lives and should not be trusted to make sound decisions about other peoples lives. One informant said *“ women should be given the right to plan their families according to their ability. Men are irresponsible and they cannot make fertility decisions for women”.*

All the informants revealed that Swazi women were considered to be inferior partners in marriage with men, hence men decide for them when and how to control their fertility.

Also it was revealed that male fertility was important in the society, and the use of contraceptives would be seen as lowering the status of a man in the society. Male fertility was discussed by different group members and their views are expressed as:

Elderly males perceived male fertility to be important to such an extent that an old man was regarded as healthy if he impregnated a young woman. This is what one elderly man attested to “ *a man's health status is reflected when he continues to produce children during old age*”. This was the reason for men to continue marrying young women because it was perceived that they were maintaining their health. Contraceptive use would prove that men were unhealthy and might result to premature demise.

Elderly women were of the opinion that contraceptives were not healthy for either the users or their partners. Healthy families will continue to bear children, and the use of family planning was associated with health problem such as high blood pressure, uterine tumours and male impotence which might result in infertility. Women were discouraged to use contraceptives in order to maintain the healthy status of the family.

Adolescent males revealed that if a boy impregnates a girl he is perceived by his peers as the ‘real’ man. Even his parents respect him because he will soon be a father. So male fertility is perceived to be a social position which every male is aspiring to.

Adolescent women stated that they compete for the love of a man by bearing the man a child. It was, however, revealed that a man tended to favour a woman who has born him a boy more than the one who has born a girl. Based on this finding, it became evident that male fertility was positively associated with the gender of the offspring. A woman who has born a girl is less likely to practise family planning until she has ‘pleased’ a man by bearing him a boy. Similarly, a woman who has born a boy might continue ‘pleasing’ a man by producing many boys.

Women of childbearing age confirmed that the gender of a child was positively associated with the social status of the man. A boy child was perceived to be the strength and hope for the future of the family. It was also revealed that in a polygamous situation women compete for the love of a man by the number of male children they were capable of producing. A woman might not use contraceptives until she has delivered the required number of boys.

The rural health motivators confirmed that a man becomes a ‘real’ man if he has a boy child. If the wife fails to produce a son “ *the man is justified to have a second wife or to engage in extramarital relationships in order to have an heir of the family*”. Swazi women fail to use contraceptives for fear of preventing an important pregnancy that might result in the birth of a boy child.

Male fertility was associated with high social status according to all the informants. Elderly males realised the need for men to have many wives of different age groups in order prove their fertility during old age. The use of contraceptive might result in premature death according to elderly males and women. Adolescent males revealed that their status rises and they are respected by their peers and the entire society when they impregnate girls. Women, however, rate their love by men by the number of children they have given birth.

The acceptability of family planning services in the community

Generally, family planning services were not acceptable by some members of the society because these services were perceived to encourage infidelity to women. Family planning services were culturally unacceptable because they limited the number of children women should have. Elderly men complained that modern family planning practices was responsible for sexually transmitted diseases, including the deadly HIV infection.

Young men also revealed that family planning providers were to be blamed for poor distribution of family planning methods to youths. Some family planning providers were refusing to educate and/or prescribe contraceptives to adolescents. Other family planning providers were limiting discussions about contraceptives to male condoms and disregarded other contraceptive methods. As a result, adolescents have a limited knowledge on contraceptives. Also in the community there were no forums to address sexuality education and there were no programmes to address issues in family planning, according to the male adolescents. Consequently, adolescents relied on their friends for sexuality education and family planning issues.

SISWATI VERSION OF THE FOCUS GROUP DISCUSSIONS

IMIBONO YETINHLELO LETEHLUKENE

Bebangu 171 bantfu labangenele tingcogco telucwaningo, bebahlukene kanjena:

- bogogo labangemashumi lamatsatfu
- emajaha langemashumi lamatsatfu
- tingabisa letingemashumi lamatsatfu
- bagcugcuteli labalishumi nambili
- bobabe labaphetse emphakatsini labalishumi nakunye
- emaqembu lamane abomakoti, labangemashumi lamatsatfu bebatetfele, bapopola emtfolamphilo. Labangemashumi lamabili nesihlanu bekubatedlane.

Imibono yabogogo

Emasiko labukene nekuhlela umndeni

Ngelisiko lesiSwati, ngubani lowengamele tindzaba temphilo kanye nekuhlelisa umndeni ekhaya?

Bonkhe bogogo bavumelana kutsi babe nguyena lowengamele tindzaba temphilo yemndeni lokufaka kuhlela kwemndeni. Basola litiko letemphilo lelikhutsata bomake kutsi bavikele intalo bangakancutfulisi kubobabe emakhaya.

Lomunye gogo wazer waphahluka watsi " kute muntfu lobita inyanga ekhaya kutsi itowelapha umfati ngaphandle kwendvodza. Lelisiko lekutsi make atelaphise lisha futsi licondze kubulala indlela emaSwati laphila ngayo".

Liqembu lelinyenti lagcizelela kutsi make ufanele ahloniphe umndeni angavikeli, kepha akhulise umndeni. Make ufanele atale bantfwana kuze kuphele intalo.

Bancoka kanganani bantfwana kumndeni nasemmangweni?

Bonkhe bogogo bachaza kutsi bantfwana ngumliba loya embhili, make umncoka ekhakhakhe nasemmangweni uma atale sive lesinyeti. Bafana bakhulisa sive kungako make angeke akhawule kutala aze atfole bafana. Emantfombatana wona aletsa amalobolo ekhaya, ngiwo nawo amncoka ngekusho kwalabanyenti. Make loyinyumba akatsandzeki emndenini, ubuyiselwa kubo noma atfolelwe inhlanti letawususa lihlozo lekungatfoli bantfwana emtini.

Bogogo labanye bachaza kutsi make longendzi ufanele atfole bantfwana khona batomgcina uma asakhulile futsi bamakhele likhaya. Munye kulabogogo watsi yena akavumelani nemcondvo wekutsi make longakendzi atfole bantfwana. Kusho kutsi lomake yingwadla, akadzingeki emphakatsini ngobe angaba nelufuto lolubi kuletinye tintfombi.

Tindlela tekukhulisa imindeni

Make ufanele endze uma amdzala kanganani? Acalenini kutala bantfwana?

Bogogo batsi intfombi yendza uma seyitfombile ngoba isuke seyivutsiwe. Kutala kufanele kucale ngaso lesosikhatsi khona make atotala bantfwana labaningi ngoba intalo isuke isekhona. Bantfwana bangelanyiswa uma sebaneminyaka lemitsatfu, khona make atokucina emva kwekutsi tidvumbu tehlukane.

Bogogo bakhanyisa kutsi ngisho esitsembini nguloyo naloyo mfati kufanele atale bakhe bantfwana ngoba kulihlazo kobitwa ngenyumba.

Lomunye gogo wachaza kutsi kuvikela ngemaphilisi kufana nekubulala bantfwana, futsi kuphambene nemtsetfo welibhayibheli ngoba inkholo ivumelana nemndeni lomkhulu.

Licembu lakhala ngemfundziso yesikolo kutsi idukisa bantfwana ibafundzise kugwadla ngoba batsi basebancane bafundzise tindlela tekuvikela. Labanye batsi bona bangajabha futsi badvumale uma batukulu noma bantfwana babo bangeva kutsi bayavikela intalo yabo. Lomunye watsi umfati lovikela intalo usuke edzelela bakubo, bekhakhakhe noma indvodza yakhe.

Make ufanele kutala bantfwana labangakhi?

Liqembu labogogo latsi make ufanele atale kugcwale indlu angiyinciphisi intalo yakhe ngoba bantfwana sipho lesivela kuNkulunkulu. Inkholelo yelibhayibheli yayinguletinyo tizatfu tekungavikeli ngekusho kwabogogo labanye. Batsi kwasemandlulo bantfu lebebakholwa, futsi batsembekile bebabusiswa ngebantfwana labanyenti njengesihlabatsi selwandle.

Kodwa labanye basho kutsi imphilo yalamuhla seyiguqukile futsi idulile, kuncono make atfole bantfwana labasihlanu nobe sitfupha khona make atokhona kubondla nekubanakekela.

Imibono ngetindlela tekuvikela letitfolakala emtfolamphilo

Bobabe bayatikhutsata yini tindlela tekuhlelisa tasemtfolamphilo?

Labanyenti bogogo abakukhutsati kuhlelisa ngetindlela temtfolamphilo. Batsi tibanga tifo tabogcunsula kanye namashayabhuqe we HIV. Bogogo baqinisa kutsi tindlela tekuhlelisa temtfolamphilo tibanga bugwadla esiveni. Lomunye waqinisa kutsi make losebentisa tindlela tekuvikela uchaza kutsi ulala nebantfu labehlukenengako ngeke ati neyise wemntfwana uma angaba nesisu yingako asebentisa tindlela tekuvikela. Labalidlazana bakhonona kutsi tindlela tekuvikela ngito letibange kutsi bomake batala kalukhuni baze bahlindzwe. Labanye bakhonona ngekutsi kuvikela ngekujova kubanga kutsi bomake bagcine batinyumaba. Futsi kuvikelwa kubanga sifo sengati, inhloko kanye nekukhuluphala. I loop yona ibulala bantfwana esinyeni, loyisebentisako ufanele aliwe yindvodza yakhe.

Khombisa tindlela tekuvikela tesintfu, uchaze kutsi tivikelanjani intalo?

Bogogo bavumelana kutsi ngesintfu kuvikela bobabe ngaletindlela letilandzelako:

- lijoyina ngembono walabanyenti
- kucencuka ngembono wabobonkhe
- sitsembu ngekusho kwalabanye
- timbita, lenikwe yinyanga leyelapha umndeni ngekusho kwalabalidlazana.

Bogogo bavumelana ngetindlela tesintfu , batsi tilungile, atigulisani, futsi atimhluphi make uma asafuna kwelamisa.

IMIBONO YEMAJAHA

Emasiko labukene nekuhlela umndeni

Ngelisiko lesiSwati, ngubani lowengamele tindzaba temphilo kanye nekuhlelisa umndeni ekhaya?

Onkhe emajaha avumelana kutsi bobabe ngitona tinhloko telikhaya leticondzene netindzaba temphilo yelikhaya kanye nekuhlelisa umndeni. Batsi akusiwo umhambo wema Swati kutsi inyanga yelaphe make ingakabitwa ngubabe. Bavumelana kutsi bomake abangatilinganisi nemadvodza bente labakutsandzako. Lelinye libhungu lagcizelela kutsi bomake babantfwana, tinkinga tabo temphilo tibonwa bobabe

Bancoka kanganani bantfwana kumndeni nasemmangweni?

Emabhungu lamanyenti achaza kutsi bantfwana ngumliba loya embili. Bafana bamcoka ngoba bakhulisa umndeni, kungako make afanele atale bafana kunemantfombatana lashiya likhaya ayokwendza. Make longatfoli bantfwana ufanele acosshwe ngobe angenamsebenti emendvweni.

Tindlela tekukhulisa imindeni

Make ufanele endze uma amdzala kanganani? Acalenini kutala bantfwana?

Linyenti labeka umbono wekutsi make angendza uma aneminyaka lengu 21. Bavumelana kutsi usuke asakhulile kuleso sigaba futsi angakhona kunakekela likhaya lakhe. Kodva kutfoli bantfwana ufanele acale uma ana 18 weminyaka. Uma intfombi yephuta kucala kutala ingeke ikhone kwandzisa sive ngobe intalo isuke seyiphelile. Emabhungu languhhafu atsi uma umfana amitsisa intfombi ukhombisa kutsi sowukhulile nabontsanga yakhe bayamhlonipha ngoga sowusesigabeni sekuba ngubabe.

Make ufanele kutala bantfwana labangakhi?

Emabhungu lamanyentane avumelana kutsi bantfwana labane balungile kodwa kufanele kube nebafana lababili kuze bavuse likhaya. Labalidlazana batsi make ufanele atale agcwalise likhaya ngoba walotjolelwa liko.

Imibono ngetindlela tekuvikela letitfolakala emtfolamphilo

Bobabe bayatikhutsata yini tindlela tekuhlelisa tasemtfolamphilo?

Onkhe emajaha avumelana kutsi bobabe abahambisani netindlela tekuvikela tasemtfolamphilo. Labanyenti batsi lijazi lemkhwenyane ngilokanye lelibanga bongcunsula. Lelinye lijaha latsi ubona ngemafutsa lasejazini lemkhwenyane kutsi abanga tifo kanye ne HIV. Emaphilisi ekuvikela akhipha tisu. Lijaha lelivikela intalo libukelwa phansi ngulamanye emajaha alihaye, nitintfombhi nato tiyalihaya lijaha lelivikelako. Ngekusho kwemajaha lamancane, tisebenti tasemtfolamphilo atitsandzi kunika tinhlobo tekuvikela bantfwana labasebancane labangakendzi, titsi abafundze kutiphatsa kahle hhayi kujaka umndzaka.

Khombisa tindlela tekuvikela tesintfu, uchaze kutsi tivikelanjani intalo?

Tindlela letavetwa ngulamajaha kwaba nguletilandzelako:

- kucencuka , ngekusho kwawo onkhe emajaha
- lijoyina uma kusikhatsi lesibi enyangeni, ngekusho kwelicenjana .

Kepha emjaha lamanyeeenti achaza kutsi tintfombi tingakwala uma ungalali nato, noma uma usebentisa lijazi lemkhwenyane.

IMIBONO YETINGABISA

Emasiko labukene nekuhlela umndeni

Ngelisiko lesiSwati, ngubani lowengamele tindzaba temphilo kanye nekuhlelisa umndeni ekhaya?

Tingabisa letinyenti tavumelana kutsi bobabe ngibona labacondzisa ngetemphilo yelikhaya kanye nekuhlelisa umndeni. Tonkhe tingabisa tavumelana kutsi bomake bafanelwe banikwe lilungelo lekutentela sincumo ngemphilo yabo hhayi kuphantfwa bobabe njengebantfwana.

Bancoka kanganani bantfwana kumndeni nasemmangweni?

Tonkhe tingabisa tavumelana kutsi bantfwana ngumliba loya embili. Likhaya lelite banntfwana

lilahlekelwa ngisho nemhlaba wekulima utsatfwe ngumndeni lomkhulu ngekusho kwalenye ingabisa. Bantfwana bamcoka kumisa futsi balelwe lilungelo lemndeni. Make loyinumba uletsa lhlazo kumndeni wakhe.

Tindlela tekukhulisa imindeni

Make ufanele endze uma amdzala kanganani? Acalenini kutala bantfwana?

Licembu lelinyentana laveta umbono wekutsi intfombi ifanele yendze uma ineminyaka lengu 18. Kodvwa labanye baveta kutsi ncono inntfombi yendze seyinebantfwana lengabatfola uma ineminyaka lengu 18 budzala.

Tingabisa tabona kutsi emantfombatana lacala kulalal aneminyaka lengu 14-15 akavami kwemitsa ngoba imitimbayayo isuke isemincane kutsi ingatfola bantfwana.

Tingabisa letinyenti taveta kutsi kuyengwa bangani ngiko lokubanga emantfombatana kutsi asheshe acale kulala. Bayawahleka, bawename emantfomabana baze bawabite ngetilima ngoba bangakaze balale nebfana.

Make ufanele kutala bantfwana labangakhi?

Linyenti, latsi bantfwana labangu 2-3 linani lelanelle kutsi make abondle, abafundzise aphindze abagcokise. Kodvwa licembu lelinye laveta kutsi basemtini bavame kufisa makoti kutsi atale bantfwana labevile esihlanwini.

Imibono ngetindlela tekuvikela letitfolakala emtfolamphilo

Bobabe bayatikhutsata yini tindlela tekuhlelisa tasemtfolamphilo?

Tonkhe tingabisa tatsi bobabe abavumelani netindlela tasemtfolamphilo. Ngisho nemajaha atsi kuvikela kubabangela butsakatsaka emtimbeni netifo letiningi, ngekusho kwetingabisa letinyenti. Tintfombi tisi kulukhuni kusebentisa tindlela tekuvikela uma labadvuna bangahambisani nalowoncondvo.

Khombisa tindlela tekuvikela tesintfu, uchaze kutsi tivikelanjani intalo?

Tindlela tekuvikela tesintfu letashiwo tingabisa nguleti:

- Iijoyina ngembono wetingabisa tonkhe
- kunatsa emanti lamanyenti emva kwekulala ngekusho kwalabancane
- kulondvolota sishubelo ebhodleleni ngembono walabanye

Ngembono wetingabisa letinyentana, letindlela letibhaliwe tingutonatona ekuvikeleni intalo.

IMIBONO YEBAHOLI BEMMANGO/ BOMKHULU

Emasiko labukene nekuhlela umndeni

Ngelisiko lesiSwati, ngubani lowengamele tindzaba temphilo kanye nekuhlelisa umndeni ekhaya?

Bonkhe bomkhulu bavuma kutsi ngesiSwati babe yinhloko yelikhaya lophetse imphilo yebantfwana nabomake. Gogo nguyena lomsitako ekushayeni umtsetfo wenchubo yasekhaya. Babe nagogo ngibona labasitanako ngemphilo yemndeni baze bafune ngisho inyanga yekwelapha. Lomunye babe wachza kutsi akusiwo umhambo wesiSwati kutsi inyanga ingngena ekhaya ilaphe bantfwana kungakancutfuliswa kubabe.

Bancoka kanganani bantfwana kumndeni nasemmangweni?

Bonkhe bomkhulu bavumelana kutsi bantfwana ngumliba loya embili, futsi bayakhona kunakekela batali uma sebugile. Lomunye mkhulu wachaza kutsi bomake bafanele batale bantfwana kugcwale libala, uma behluleka kutala baletsa lihlazo kubatalibabo. Linyeti lachaza kutsi inyumba ayitsandzeki emmangweni futsi ingaze yaliwe. Labancanyana batsi inhlanti ifanelwe ikhishwe batali kuze itale bantfwana badzadzewakhe bamgeze ehlazweni.

Tindlela tekukhulisa imindeni

Make ufanele endze uma amdzala kanganani? Acalenini kutala bantfwana?

Ngekusho kwabomkhulu, bomake bafanele bendze sebaneminyaka lengu 25. Kulesosigapa bangakhona kunakekela likhaya. Labanye babona kutsi make angendza aneminyaka lengu 20. Linyenti lavumelana kutsi make ufanele acale kutala uma ana 20 weminyaka. Kepha labancanyana batsi kufanele acale kutala uma aneminyaka lengu 18 budzala. Babona kutsi kubeleka ngekuhlindzwa kubangwa kutala make asamdzala.

Bomkhulu bachaza kutsi kuyimphilo kutsi indvodza lendzala itsandzane nentfombi lencane, ingabisa bese uyayitalisa. Kungako kuba neminyaka leminyenti emkhatsini wetincanakazana kanye nemachegu esitsembini.

Make ufanele kutala bantfwana labangakhi?

Bonkhe bavumelana kutsi make ufanele atale kuze kuphele intalo. Kuvikela intalo akuhambisani nemtsetfo wa Nkulunkulu ngekusho kwelinyenti.

Imibono ngetindlela tekuvikela letitfolakala emtfolamphilo

Bobabe bayatikhutsata yini tindlela tekuhlelisa tasemtfolamphilo?

Bonkhe bobobe batsi abatikhutsati tindlela tekuhlelisa temtfolamphilo. Lomunye mkhulu watsi "uma ngingeva kutsi umkami noma makoti uyahlelisa, ngingambuyisela kubo kuphele buhlobongalelolanga.

Bobabe labanyenti batsi kuhlelisa umndeni kubanga bugwadla ngobe umfati lohlelisako usho kutsi unemadvodza lamanyenti ngekusho kwabo babe labalidlanzana. Lomunye mkhulu watsi "linesi lelinganiketa umkami tindlela tekuhlelisa ngingambulalal ngobe naye abulala bantfwana bami". Lelicembu labakhombisa kutsi kuhlelisa kubanga bugwadla ngekusho kwalalidlazana nekutala tichwala ngekusho kwalabanye. Lijazi lemkhwenyane kutsiwa libanga gqunsula kantsi emaphilisi abanga kuphelelwa ngemandla endvodzeni ngekusho kwalabanye.

Khombisa tindlela tekuvikela tesintfu, uchaze kutsi tivikelanjani intalo?

Bavumelana kutsi ngesintfu kuvikela bobabe ngetindlela letilandzelako:

- Ijoyina ngekusho kwabobabe bonkhe
- kusebentisa timbita ngekusho kwabobabe labanyenti

Letindlela tekuhlelisa tiphatsana kahle futsi ngeke wemitse uma atisebentisa kantsi futsi atigulisani.

IMIBONO YABOMAKOTI (N=55)

Emasiko labukene nekuhlela umndeni

Ngelisiko lesiSwati, ngubani lowengamele tindzaba temphilo kanye nekuhlelisa umndeni ekhaya?

Bonhe bomakoti bakhala nelisiko lesiSwati lelenta indvodza kutsi ishaye umtsetfo ngisho nasetindzabeni tekuhlelisa umndeni. Labanyenti bakhala ngekutsi bomaketala babumelana netindvodzana tabo ngekugcilata bomakoti kutsi batale bantfwana labanyenti.

Bomakoti baveta kutsi emadvodza abo atsi uma bangemitsi kuze kuphele lomnyaka batawubabuyisela emakhaya akubo ngoba kute umsebenti wabo. Lomunye watsi uma angemitsi utamelamisa ngalomunye umfati lotawutala ngoba uyambona lomfati kutsi sewudziniwe.

Bancoka kanganani bantfwana kumndeni nasemmangweni?

Kutala bantfwana kufana nekubayinjinga, ngoba labantfwana batakondla noma sewugula noma sewuphela emandla, ngekusho kwabomakoti .

Tindlela tekukhulisa imindeni

Make ufanele endze uma amdzala kanganani? Acalenini kutala bantfwana?

Make ufanele kwendza uma ana 25 weminyaka ngekusho kwelinyenti. Kepha kutala angacala aneminyaka lengu 18 budzala. Kuphuta kucala ngoba make ahlela umndeni kugcina kumente make abe yinyumba.

Lomunye makoti watsi uma intfombi itsandza lijaha futsi itigcebela emendvweni ifanele ilitalele lelijaha kuze nalo libone kutsi lentfombi iyalitsandza, futsi ikhombise kutsi inhlanyelo ikhona.

Lidlanzana lavumelana kutsi babe ufanele kutsatsa intfombi lekhombisile kutsi inetitselo hhayi kutsenga kati esakeni.

Make ufanele kutala bantfwana labangakhi?

Bomakoti baba nomibono leyehlukene, linyenti latsi bantfwana labane bangakhona kutsi bondleke kahle. Labanye baphakamisa kutsi babili kuya kubatsatfu kungaba bantfwana labenele kwandzisa sive sekhakhakhe.

Linyenti labomakoti lakhombisa kuphatseka kabi ngabobabe labanganakekeli umndeni wabo. Baveta kutsi labanye bobabe bahamba batalisa kantsi kute nemali yekondla bantfwana lababatalako.

Imibono ngetindlela tekuvikela letifolakala emtfolamphilo

Bobabe bayatikhutsata yini tindlela tekuhlelisa tase mtfolamphilo?

Bonkhe bomakoti basho kutsi emadvodza akahambisani netindlela tekuvikela. Linyenti latsi "asiyitsi vu indzaba yekuvikela emakhaya ngoba ayifuneki. Sivele sihambe kungatsi siya edolobheni kantsi sesiyojova emtfolamphilo. Uma emadvodza angeva kutsi sihlelisa umndeni, singaphelelwa ngumendvo".

Lomunye makoti watsi indvodza yakhe yaze yaya emtfolamphilo yatsetsisa bonesi kutsi yini umfati wayo angelaisi? Kusho kutsi bayamvikelisa.

Khombisa tindlela tekuvikela tesintfu, uchaze kutsi tivikelanjani intalo?

Bomakoti labanyenti bati tindlela letinguleti:

- lijoyina
- kumunyisa

Batsi letindlela timcoka, atigulisani kantsi futsi make uyakhona kusheshe alamise uma asebentisa

letindlela tekuvikela

IMIBONA YEBAGCUGCUTELI

Emasiko labukene nekuhlela umndeni

Ngelisiko lesiSwati, ngubani lowengamele tindzaba temphilo kanye nekuhlelisa umndeni ekhaya?

Bonkhe bagcugcuteli batsi bobabe ngibona labengamele tindzaba temndeni kanye netekuhlela undeni. Bakhonona ngekutsi baba nebulukhuni emsebentini wabo uma bakhutsata bomake ngekuhlelisa umndeni ngoba bobabe bangabavumeli.

Bancoka kanganani bantfwana kumndeni nase mmangweni?

Bantfwana bancoka futsi bayatsandva. Likhaya lelingenabantfwana litsatswa ngekutsi lite titselo ngoba bantfwana ngumliba loya phanbili. Bafana bakhulisa sive sasemtini, emantfombatana wona aletsa emalobolo ekhaya. Make longotfoli bantfwana akatsandzeki, ubitwa ngemabito lamabi abe yinkhomo ledla yodywa lapha ekhakhakhe.

Tindlela tekukhulisa imindeni

Make ufanele endze uma amdzala kanganani? Acalenini kutala bantfwana?

Make angendza uma aneminyaka lengu 21 nebantfwana angacalaliso sokhatsi kubatala ngobe usuke askhulile kulesosigaba.

Make ufanele kutala bantfwana labangakhi?

Bomake bafanele batale bantfwana labangu 5 , kepha kufanele kube khona bafana labang 3 lokungenanai khona batakuvusa likhaya.

Imibono ngetindlela tekuvikela letitfolakala emtfolamphilo

Bobabe bayatikhutsata yini tindlela tekuhlelisa tasemtfolamphilo?

Bobabe akufanele kutsi bakhutsate tindlela tekuvikela tasemtfolamphilo ngobe bomake batsi letindlela tekuvikela tiyacwalisana. Lijazi lemkhwenyane lona lilungile ngoba livikela tifo tangentansi letifake iHIV nabogxcunsula.

Khombisa tindlela tekuvikela tesintfu, uchaze kutsi tivikelanjani intalo?

Linyenti lati letindlela letilandzelako:

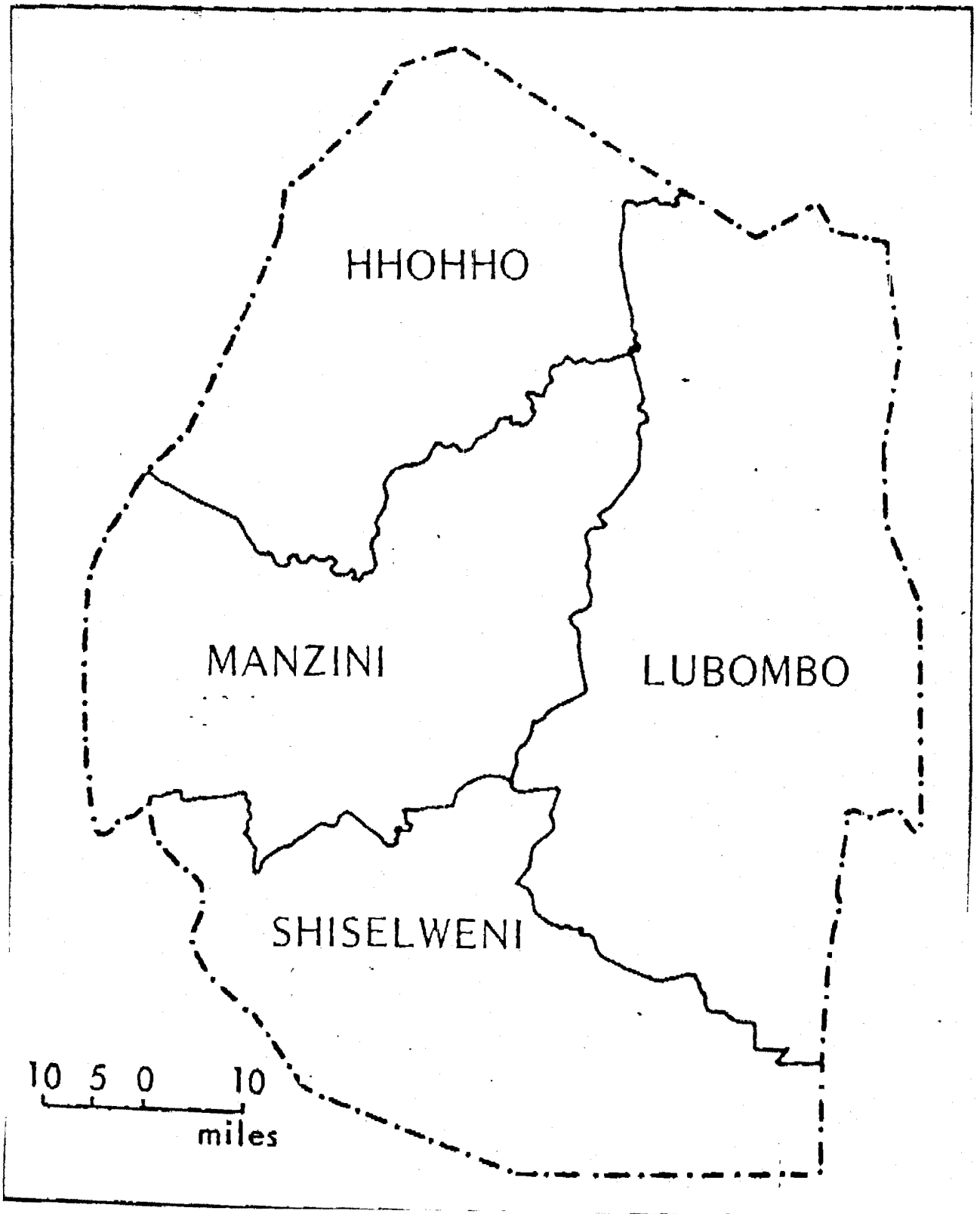
- kuncencuka
- kumunyisa, labangu
- lijoyina lelabalwa ngibo bonkhe

Bagcugcuteli babona kutsi letindlela tikahle futsi tiyasita atibangi kugula.

Annexure 6

Map of Swaziland

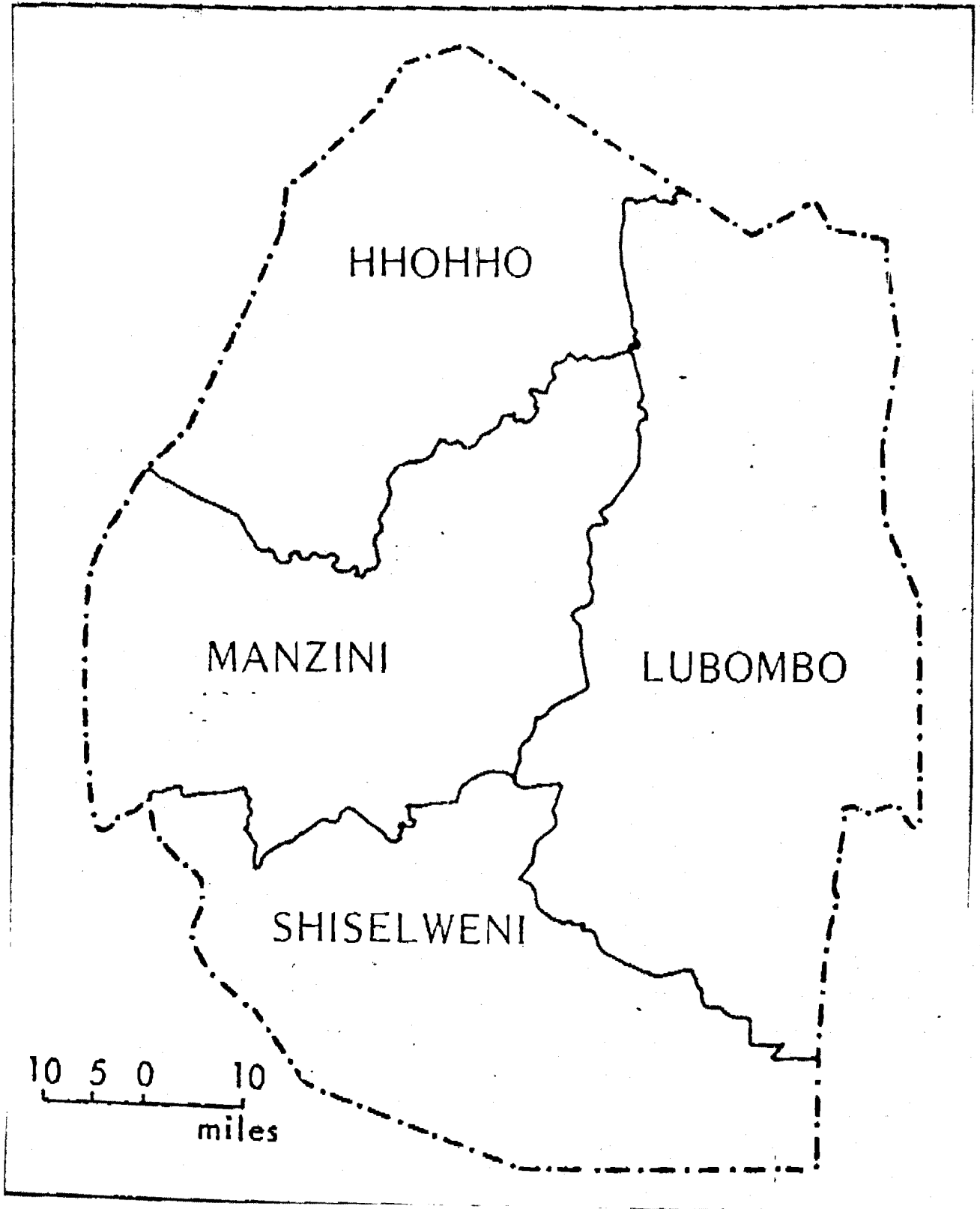
MAP OF SWAZILAND



Annexure 6

Map of Swaziland

MAP OF SWAZILAND



Annexure 7

Newspaper Reports

Twelve year old girl abused by her aunt's lover

BY LUCKY TSABEDZE

NGONINI - In yet another shocking sexual abuse case which has been perpetrated for sometime without being reported, it has been revealed that a 12-year-old girl (former grade 2 pupil) has been impregnated by an elderly Mocambican man.

The Mozambican Isaac Silindza (estimated to be above 50 years old) started abusing the 12 year-old (name deliberately held) early last year.

Silindza is a boyfriend to the girl's aunt with whom he has a child. According to the aunt, the discovery shock her.

She told the Swazi News that she saw the girl walk with a limp after having paid Silindza a visit on December 26, 2001.

"She started with refusing to take a bath in front of us. Actually she has been shy to take a bath with other children as far as I can remember. So, I did not think there was anything sinister in it. But what worried me was that she refused to change the underwear she had worn since Christmas," she said looking into the distance. She had spotted dirt on the girl's underwear. She was so annoyed by the girl's refusal to change the underwear such that she physically tried to undress the little girl but the girl resisted. After moments of struggling and seeing that her aunt was overpowering her the young girl confided in her.

"She started crying, murmuring something I would not hear. I stopped to hear what she had to say for not changing the dirty underwear.

I think she thought I had seen that she was bleeding from her vagina. That was the moment she told me that she had just slept with my boyfriend at his homestead," she said.

The girl went on to disclose that she had slept with the said rape suspect on several occasions all of which she did not report because Silindza threatened to beat her up. After the revelation the girl's family has since noticed that her under-wears have been disappearing of late and they suspect that Silindza was hiding them in an endeavour to destroy any possible sources of suspicion that they would come across. According to the girl's uncle, the girl stated that Silindza would wait for her along her way back home from school. "The homestead in which she stays is just by the road and he would call her in to come and clean his house, and she told us that is how he got hold of her all the time. Sometimes she came home at about 7 pm when school had knocked off after three" he said.

Silindza was arrested by police last week Friday.

RIGHT: The 12 year old victim whom the Swazi News cannot name because of her age.



Girl (12) is heavy with his child

NGONINI - The 12-year old girl who was sexually abused allegedly by Isaac Silindza was found pregnant by a medical test made at one of the country's hospitals but the family refused to believe the results and have not done a thing as far as her pregnancy is concerned.

According to them, they did not believe

what the doctor said after the tests. Actually they had dispatched the girl with a young woman and they thought she was joking when she said the doctor at the hospital found that she was pregnant.

"We have really taken this matter lightly so far. We have not gone back to the hospital or made arrangements for our girl to abort Silindza's developing

They could not believe doctor's results

child," said her aunt. Abortion is still illegal in Swaziland, whatever the circumstances.

The family told the Swazi News that they thought the police would come to tell them what to do next.

They further stated that they were awaiting a medical report.

"The doctor at the hospital told me that she had been injured on her insides and also disclosed that she

had conceived. I came back home and told the rest of the family but I guess they did not believe me. They actually dismissed me," the woman who accompanied the girl said. "Yes it is true she mentioned that the doctor at the hospital had mentioned that she was pregnant, but that was hard to believe. We just did not believe her," said the aunt.

One in 69 at risk of losing life during pregnancy in kingdom

BY EISA SEMMELINK

■ MBABANE - The probability of life being at risk every time a Swazi woman falls pregnant is estimated to be one in 69, compared with one in 5 100 in the United Kingdom and one in 3 500 in the United States of America.

This is just one of the startling facts revealed in a report entitled Safe Motherhood Initiative 1997 - 2000 to be released by the ministry of health and social welfare today.

The release of the report coincides with a national plan of action devised by the department and to be launched today to address the current status of sexual and reproductive health issues of adolescents and women.

The Safe Motherhood Initiative also responds to international calls for world governments and communities to renew efforts designed to reduce present high levels of morbidity and mortality among women.

According to the report the unacceptably high risk in Swaziland exists despite the fact that nearly 98% of pregnant women attend ante-natal care at least once; approximately two-thirds make five or more visits; and 80% of the population is within an hour's walking distance of a health facility.

The report attributes the present situation to the fact that nearly half of the mothers (44%) deliver at home and are only assisted by untrained traditional midwives, gogos, relatives or neighbours, whereas a full 16% of women attempt delivery on their own.

In addition, a large proportion of women at risk of pregnancy complications have unprotected sex - 27% of pregnant women are below the age of 20 years; 6% are above the age of 35 years; and 13% have had five children or more, the report states.

Haemorrhage is listed by the report as being the cause of 24% of deaths of expectant mothers, hypertensive diseases of pregnancy the cause of 19%, unsafe abortion of 19%, sepsis of 14%, and other causes 24%, which include lack of clinical skills to handle obstetric and abortion emergencies.

A physical shortage of adequately skilled nurse-midwives and doctors in maternity units also contribute to Swaziland's high maternal mortality rate, the report states, as do the facts that the referral system and the blood bank are virtually non-functional, and the fact that anaesthetists are in short supply.

According to the report traditional midwives pose special problems. Nearly a third administer traditional medicine to expedite labour, do nothing to a



woman who bleeds profusely postpartum; re-use the cord-cutting tools; and also attend to abnormal deliveries such as breech and multiple pregnancies that ideally should be referred.

Nearly half of all women who deliver at home indicate that they will deliver at home again with the next pregnancy, the report states.

In addition, a full 60% of expectant mothers book late in the second and third trimester, which may be too late to prevent or treat certain conditions.

"With syphilis being able to affect the foetus as early as the ninth week of pregnancy, abortions and stillbirths are thus to be anticipated among women who book too late."

The report concedes that the infant mortality rate has steadily declined from 98 in 1000 in 1986 to an estimated 74 in 1000 in 1993, and attributes the decline to a high immunisation coverage rate of more than 90%.

Yet it states that 54% of infant deaths occur within the first four weeks of birth and 19% within the first week of birth.

It comes to the conclusion that the causes of such deaths are largely associated with the health status

and quality of care given to the mother during pregnancy and delivery.

Dealing with adolescent sexual and reproductive health, the report points out that boys and girls aged 10 to 19 years account for nearly a quarter of the total population of Swaziland.

The report expresses its concern with early indulgence in sexual activity and the high frequency of unprotected sex, and states that some of the consequences are the following:

- High teenage pregnancies with nearly three out of ten antenatal clinic clients or delivery room women being adolescents aged 15 to 19 years.

- High HIV prevalence as evidenced by 17.8% of pregnant adolescents aged 15 to 19 being HIV seropositive. Of the adolescents with sexually transmitted diseases, 24.3% are HIV positive.

According to the report HIV prevalence among pregnant women aged 15 to 49 years is estimated to have increased from 3.9% in 1992 to 16.1% in 1994 and 19% in 1995.

In addition, the report states, other sexually transmitted diseases prevalent in pregnant women in Swaziland are gonorrhoea (4%), syphilis (14%), T.V. (23%) and moniliasis (37%).

Secondary infertility as a result of poorly treated sexually transmitted diseases, poor postpartum care and poor post-abortion services is also common in Swaziland, the report says.

According to the report, the World Health Organisation recommends the strengthening of ongoing

prenatal, natal, postnatal and post-abortion initiatives including the revitalisation of services essential for high risk pregnancies and obstetric emergencies.

The body further recommends that Safe Motherhood Initiative - promotive, preventive, curative and rehabilitative services be integrated into existing structures and delivered in a package form called the "Mother-Baby Package".

The thrust within this package is for:

- **Family planning** - to ensure that individuals and couples have the information and services to help them plan when and how many children to have.

- **Ante-natal care** - to prevent pregnancy complications where possible or detect them early and refer or treat them appropriately.

- **Clean and safe deliveries including postnatal care** - to ensure that all birth attendants that the knowledge, skills and equipment to perform clean and safe deliveries and prepare mothers for post-partum care, breastfeeding and child nutrition.

- **Essential obstetric care** - to ensure that essential care for high risk pregnancies, obstetric or post-abortion and newborn emergencies is made available to all women who need it on a 24-hour basis.

"The need to implement the proposed strategies and activities is an indication of commitment by the Ministry of Health and Social Welfare that safe motherhood, newborn health, family planning and adolescent sexual and reproductive health are priority areas of operation," the report states.

"The plan is further to be used by the Ministry of Health to mobilise resources (financially and externally) to effect the activities."

The Safe Motherhood Initiative is estimated to cost at least E13 per annum per woman of child-bearing age (15-49 years).

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NATIONAL NEWS

Educational system a source of poverty - chief economist

MBABANE - Chief Economist in the Ministry of Economic Planning and Development, Nqumthetho Dlamini on Thursday said the education system is one of the factors that have contributed to poverty in the country. Dlamini said the recent report on Poverty Assessment by the Poor has also shown that the standard of education especially at the University of Swaziland (UNISWA) is only for those living above the poverty line.

Crime

She said some people have justified crime as due to poverty. She said this yesterday during a two-day workshop on Poverty and Public Expenditures in Education and Health sectors at the Mountain Inn Hotel, Mbabane. It was attended by among others principal secretaries, lecturers from UNISWA (Faculty of Social Sciences) officials from the United Nations Development Programme (UNDP).

The workshop is aimed at discussing the role that

public expenditure management in health and education sectors can play as part of a poverty reduction strategy.

Dlamini said the subsidies do not appear to favour the poorest students to support tertiary levels of education, a level often not attained by the poor.

For instance, one can ask the question on how many students qualify for enrolment coming from schools like St Michael's High, Waterford KaMhlabatsheane compared to those at Lavundlamanani and Cusile.

"We should ask ourselves whether the resources are allocated fairly," she said. Dlamini also said government has also recognised the role and importance played by Non-Governmental Organisations (NGO's) in reaching the people at grassroots.

"It is for this reason that a working policy paper is being processed and this will definitely foster a strong relationship between government and NGO's.

"In this way the poverty concerns will be addressed directly and NGO's are more effective in the delivery of messages and activities to the grassroots in both the rural and peri-urban areas," she said.

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