

SWAZI YOUTHS' ATTITUDES AND PERCEPTIONS CONCERNING ADOLESCENT PREGNANCIES AND CONTRACEPTION

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ABSTRACT

This study investigated Swazi adolescents' attitudes and perceptions concerning adolescent pregnancies and contraceptive practices in order to help address the continued challenge posed by large numbers of adolescent pregnancies in Swaziland. Thirty boys and thirty girls aged from 16 to 18, from an urban and a rural area participated in focus group interviews.

The adolescent girls revealed that they are expected to bear children at young ages and are competing for men's love by bearing their children. Adolescent boys expressed contradictory notions in expecting girls to refuse unprotected sex, but also maintaining that men are the sole decision-makers about sexual issues. The adolescent Swazi boys and girls identified health service barriers to accessing contraceptives, had reservations about using modern contraceptives, and preferred traditional contraceptives which they perceived to be without harmful side-effects.

OPSOMMING

Hierdie studie het Swazi adolessente se houdings en persepsies in verband met adolessente swangerskappe en voorbehoedpraktyke ondersoek om die volgehoue uitdaging van groot getalle adolessente swangerskappe in Swaziland aan te spreek. Dertig seuns en dertig dogters wie se ouderdomme van 16 tot 18 gewissel het, van beide stedelike en plattelandse areas, het aan fokusgroeponderhoude deelgeneem.

Die adolessente dogters het aangedui dat daar van hulle verwag word om op 'n vroeë ouderdom kinders te hê en die dogters het gewedywer vir die mans se liefde deur hulle kinders te baar. Adolessente seuns het weersprekende standpunte gehad deur enersyds te verwag dat dogters onbeskermde seks moet weier, maar andersyds dat mans die uitsluitlike besluitnemers oor seksuele aangeleenthede is. Die adolessente Swazi seuns en dogters het struikelblokke in die diensleweringprofessies geïdentifiseer wat hulle verhoed het om voorbehoedmiddels te bekom, hulle het bedenkinge oor moderne voorbehoedmiddels gehad en hulle het tradisionele voorbehoedmiddels verkies wat, volgens hulle menings, sonder nuwe-effekte was.

INTRODUCTION

Adolescents (boys and girls) aged 10-19 comprise nearly 25% of Swaziland's total population (MOHSW, 2001:12). According to the Ministry of Health and Social Welfare (MOHSW, 2001:9) the average age at first sexual intercourse was 17 years for girls and 19 years for boys. However, the Health Statistics Report (MOHSW, 2001:11) revealed that 5% of deliveries occurred among Swazi girls aged 15 years, indicating the initiation of sexual activities among this group of mothers to be 15, or even 14 years, of age. In Swaziland, 27% of the babies delivered during 2000 had adolescent mothers aged 15-19 (MOHSW, 2001:11). There are numerous negative consequences of adolescent parenthood for these young mothers and for their children. Adolescent pregnancies are generally associated with higher rates of maternal morbidity and mortality, and greater risks of clandestine abortions, delivery complications and low-birth-weight infants (Gupta & Da Costa Leite, 1999:125). These adolescent mothers might lose important educational opportunities, which could jeopardise their future earning capacities, and they could enter a vicious circle of poverty and destitution affecting themselves and their children.

Monthly sexual intercourse occurred among 60% of girls and 50% of boys at schools which participated in a Swaziland survey (MOHSW, 2001:11). The HIV-positive prevalence rate among adolescents was reported by the Swaziland National HIV/AIDS Programme (SNAP, 2002:13) to be as high as 32,5%, emphasising the need for condoms to prevent the spread of HIV, and for contraceptives to prevent adolescent pregnancies. This situation is not unique to Swaziland, because adolescent pregnancies contribute substantially to the overall total fertility rates in Sub-Saharan Africa (Barker & Rich, 1992:199). In Benin, Cameroon, Cote d'Ivoire, Kenya and Nigeria, premarital adolescents' conceptions ranged from 20% to 33% (Senanayake & Ladjali, 1994:140).

Contraceptive use among Swazi adolescent girls remained as low as 10%, accounting for the high adolescent pregnancy rate of 27% (SNAP, 1998:12). The major reasons cited for this poor use of contraceptives included partners' negative attitudes about contraceptives; trust that partners would not cause pregnancies; promises of marriage and experimentation to determine

whether or not the couple would indeed be fertile (MOHSW, 2001:11).

These findings indicated potential problems in accessing contraceptive services as well as contraceptive information and counseling by Swazi adolescents. Swaziland's National Reproductive Health Initiative (MOHSW, 2001:13) reported those adolescents' reproductive health needs and rights received inadequate attention from the Ministry of Health and Social Welfare. Male involvement in sexual and reproductive health initiatives remained marginalised in Swaziland. Consequently, men opposed initiatives about which they were ignorant and/or never consulted. Hlanze and Mkhabela (1998:2) suggested that men should be involved in reproductive health initiatives in order to improve the health of women.

Although 82% of Swazi's knew about modern contraceptives, only 29% had used them (SNAP, 2000:13). To aggravate these statistics, a 65% dropout rate has been recorded among Swazi users of modern contraceptives (Health Statistical Report, 1997:6) and up to 32% of the annual deliveries in Swaziland could be attributed to adolescent mothers, aged 19 or younger at their babies' births (MOHSW, 2001:11). This situation requires a scientific enquiry into Swazi adolescents' beliefs and attitudes about contraceptives which could deter adolescents from using effective contraceptives.

Traditional healers provide health care services to a large proportion of the Swazi population. In Swaziland there are an estimated 8 000 traditional healers, compared to 188 medical doctors and 3 200 registered nurses (MOHSW, 2001:2) providing formal, western health care services. Modern contraceptives (comprising mostly contraceptive pills, injections and male condoms) are provided by the western health care sector. It is not known what contraceptive advice traditional healers provide to their clients. No reports about collaboration between the traditional and western health care sectors pertaining to contraceptive services in Swaziland could be traced.

Definitions of terms used

Adolescent pregnancies: refer to girls aged 19 or younger who are pregnant.

Barriers to contraceptive use: indicate that obstacles, real or imaginary, could obstruct adolescents' access to contraceptives.

Condoms: are sheaths worn around an erect penis, often made from latex that prevents sperm from entering the vagina during sexual intercourse, thereby preventing conception. In this research report the term condoms imply male condoms only, as female condoms were not freely available to adolescents in Swaziland when this survey was done.

Contraception: means preventing conception in order to prevent an unplanned pregnancy.

Modern contraceptives: are contraceptives, or family planning methods offered by the formal or western sector of the health care services in Swaziland. Modern contraceptives comprise mainly contraceptive pills, injections, intra-uterine contraceptive devices (IUCDs) as well as condoms.

Traditional contraceptives: refer to measures obtained outside the formal health care sector to prevent conception and unplanned pregnancies. Traditional contraceptives might be obtained from traditional healers or from any community members. These include herbs, teas, vaginal plugs, specific rites, breast feeding and sexual abstinence (Silberschmidt & Rasch, 2001:233).

PURPOSE, PROBLEM STATEMENT, RESEARCH QUESTIONS AND OBJECTIVES

The main purpose of the study was to identify Swazi adolescents' attitudes and perceptions concerning adolescent pregnancies and contraceptives in order to help address the continued high adolescent pregnancy rate in Swaziland. Data obtained could be used to intensify family planning education among the Swazi adolescents, to design youth friendly services, and to improve adolescents' use of contraceptives.

Despite the availability of contraceptives, the number of adolescent pregnancies in Swaziland remains high - estimated to exceed 30% of all deliveries (MOHSW, 2001:11).

The problem guiding this research project could be stated in a question: "Do attitudes and beliefs deter Swazi adolescents from using contraceptives to prevent pregnancies?"

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

- What are the Swazi adolescents' attitudes and perceptions concerning adolescent pregnancies?
- Do Swazi adolescents believe in the utilisation of traditional contraceptives?
- Do Swazi adolescent males approve of their female partners' utilisation of modern contraceptives?
- Which factors influence Swazi adolescent females' utilisation of modern contraceptives?
- What challenges do Swazi adolescents encounter in accessing modern contraceptives?
- How can the utilisation of modern contraceptives by Swazi adolescents be enhanced?

The objectives of the study were to identify Swazi adolescents' beliefs and attitudes concerning:

- adolescent pregnancies;
- traditional and modern contraceptives;
- factors influencing their utilisation of modern contraceptives;
- access to modern contraceptives; and
- ways in which their utilisation of modern contraceptives could be enhanced.

ETHICAL CONSIDERATIONS

Permission to conduct this research was obtained from the Research and Ethics Committee of the Department of Health Studies, Unisa. Swaziland's National Health Team and the Ministry of Education granted permission for this study to be conducted. A representative from Swaziland's Ministry of Education selected the two schools where the focus group interviews had to be conducted. This was done because the Ministry of Education identified these two schools, one in an urban and one in a rural area, where adolescent pregnancy rates were high and continued to increase. The principals of the two schools also granted permission. The principals, with the help of educators, identified learners who were willing to participate in focus group discussions about adolescent pregnancies and the

utilisation of contraceptives. Only volunteers participated in the discussion groups. They were assured that they could withdraw their participation at any stage without incurring any negative consequences whatsoever. Learners were also assured that the information would not be linked to any person; the research report would not contain any names. The learners were requested to raise their hands if they agreed to participate in the focus group discussion.

RESEARCH METHODOLOGY

The central focus of this descriptive research was to examine Swazi adolescents' beliefs and attitudes about adolescent pregnancies and about contraceptives that could impact on their utilisation of contraceptives. A descriptive, exploratory, qualitative design was used in order to identify Swazi adolescents' beliefs and attitudes concerning adolescent pregnancies and contraceptives. 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. According to Merriam and Simpson (1995:61), the qualitative descriptive method allows the researcher(s) to study events as they happen in human life situations. Variables concerning the phenomenon can be studied and discovered during the course of the investigation (Brink & Wood 1998:29).

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 and Simpson (1995:61) indicate that the lack of statistical analysis is the main drawback in qualitative research, because such findings cannot be generalised to the entire population.

Data collection

Focus group interviews were used to identify Swazi adolescents' contraceptive attitudes and beliefs towards adolescent pregnancies and towards the utilisation of traditional and modern contraceptives. The advantages of using focus group interviews include that homogeneous groupings, according to gender, allowed participants freedom to share their contraceptive knowledge, attitudes and behaviours (Burns & Grove, 2001:424),

enabling multiple contraceptive attitudes and beliefs to be elicited within a short period of time within the focus groups enhancing the authenticity of the shared information (Morrison & Peoples, 1999:63). Separate focus group interviews were conducted with adolescent Swazi males and females in order to identify possible discrepancies between these groups' contraceptive attitudes and perceptions.

The major disadvantage of using focus group interviews (Holloway & Wheeler, 1998:150) is that the anonymity of participants cannot be maintained. In order to enhance anonymity, each group was assured that all contributions would be shared with the researchers only; that notes and transcriptions would be kept under lock and key and be destroyed as soon as the report had been compiled. The research report would present data obtained from all focus group interviews in anonymous ways, because no names would appear in the research report.

Another limitation for conducting focus group interviews (De Vos, 1998:325) is the process of recruiting relevant participants for each interview. This limitation was overcome by selecting adolescents from both urban and rural areas of Swaziland and by conducting separate focus group interviews with adolescent boys and girls.

Selection of the focus group sites and participants

A representative from the Swaziland Ministry of Education identified two schools (one in an urban and one in a rural area) where adolescent pregnancy rates were high. In each school, the class teachers identified 30 learners (15 boys and 15 girls), aged 16-18, who were willing to participate in focus group discussions about adolescent pregnancies and about contraceptive issues. Each group was homogeneous, boys or girls and within the same age ranges of 16-18 years, amounting to purposive sampling. Two groups of adolescents were interviewed at each school (one group of 15 adolescent boys and one group of 15 adolescent girls). The results from these groups were similar. The few differences that became apparent during the data analysis will be indicated in the research results section.

The items addressed during the focus group interviews reflected concerns raised by family planning providers

during meetings with the researchers. The main problems focused on determining whether Swazi adolescents

- believe in the utilisation of traditional contraceptives
- (males) approve of their female partners' utilisation of modern contraceptives
- (females') utilisation of modern contraceptives is influenced by specific factors, including adolescent childbearing practices among Swazi people
- encounter challenges in accessing modern contraceptives
- can enhance their utilisation of modern contraceptives.

The instrument was pretested by conducting two focus group interviews with ten (five male and five female) participants who were excluded from the actual focus groups. As they understood the questions and managed to engage in debates, no changes were required.

Conducting the focus group interviews

Focus group interviews were conducted in English as all participating adolescents attended English medium secondary schools in Swaziland. Technical issues were clarified in the local language (siSwati). The facilitator and the two note takers were fully bilingual in English and in siSwati. Two note takers recorded the proceedings of each focus group interview. The researcher audiotaped the focus group proceedings and compared these notes with the transcribed audiotape recordings.

An introductory question which related to contraceptive challenges in Swazi society was posed as an ice-breaker. Where necessary, probing was done by the facilitator who clarified/rephrased questions if necessary.

Trustworthiness of qualitative data obtained during focus group interviews

De Vos (1998:331) notes four aspects enhancing trustworthiness of qualitative data, namely truth value, applicability, consistency and neutrality. Truthvalue is concerned with the accuracy and truthfulness of scientific findings. Streubert and Carpenter (1999:29) advise that researchers should establish close association with

their subjects in order to enhance the credibility of the research results. One researcher taught health promotion at the schools before the study commenced. Member checking was also used for enhancing the credibility of the research results as five participants from each school were invited to review, validate and verify the interpretations and conclusions drawn from the focus group interviews. This exercise was done in order to enhance the authenticity of the research results (Streubert & Carpenter, 1999:29).

According to De Vos (1998:331) applicability refers to the degree to which the findings can be applied to other contexts and settings. Applicability was enhanced by conducting cross sectional focus group interviews with a variety of adolescents including girls and boys from rural and urban settings.

Krefting (1991:214) defines consistency in terms of the dependability of study results. Consistency was enhanced through member checking because five adolescents from each participating school checked the results and conclusions and agreed that these portrayed the information generated during their respective focus group interviews.

Neutrality refers to the degree to which the findings are a function solely of the information and conditions of the research, and not of individual biases, motivation or perspectives (Krefting, 1991:214). Neutrality was enhanced through member checking and field notes that were documented during each focus group interview by two facilitators present throughout the focus group interviews. These notes were compared with the audiotapes of each focus group. No major discrepancies were found.

ANALYSIS AND DISCUSSION OF RESEARCH RESULTS

Three main themes emerged from the focus group interviews. Although these themes did not appear to match the research questions or objectives, the data will be discussed according the themes and subthemes, supported by references to relevant literature. Conclusions, based on the research results will then be presented in terms of the research questions that guided this research project.

Themes and subthemes that emerged from the data analysis

The themes, with relevant subthemes, were:

Theme 1: Adolescents' beliefs and attitudes concerning Swazi childbearing practices

- Subthemes:
 - Decision-making
 - family planning practices
 - childbearing age
 - desired number of children.

Theme 2: Cultural Values

- Subthemes:
 - Cultural importance of children
 - Gender status
 - Importance of male fertility
 - Importance of female fertility.

Theme 3: Health Practices

- Barriers preventing the use of contraceptives.

Theme 1: Childbearing practices

Adolescents reported that early sexual intercourse was linked to childbearing practices among Swazi youth, where young women proved their fertility, and thus their marital value by bearing children during adolescence. This might account for the persistently high adolescent pregnancy rates of 27% in Swaziland (UNICEF, 1996:13). Four subthemes were identified: decision-making, family planning, childbearing age, and number of children.

Decision-making

Adolescent women affirmed that men were contraceptive decision-makers. Women sought men's approval to use contraceptives. Most studies on fertility and family planning focus on women, and ignore men, overlooking men as the primary contraceptive decision-makers in most African countries (Bankole & Singh, 1998:15). This is particularly relevant to societies like Swaziland where women are considered minors to the extent that women have no representation at most meetings and that their husbands' or partners' approval is required for contraceptive use (Women and Law in Southern Africa, 1998:200). Some girls indicated that women should be able to decide freely without being coerced by men on matters relating to their health. These girls' perceptions might indicate a potential de-

parture from the male-dominated decision-making processes of the traditional Swazi people.

Male adolescents confirmed that women should enhance their own empowerment by becoming more assertive about contraceptive issues and resisting unprotected sex. One young man said, "*girls should learn to be more self-directed in decision-making and should avoid pleasing men by having sexual intercourse with them at their (the girls') detriment*". In traditional societies, like Swaziland, the male is the dominant family member who determines all that takes place within a family (Mkhonta, 1999:4), including the utilisation of contraceptives. This finding reflected a departure from the traditional Swazi male perception as being the sole decision-maker about contraceptives, supporting a similar view expressed by the adolescent females.

Although both male and female adolescents perceived males to be the major decision-makers about the utilisation of contraceptives, both males and females expressed the view that females should become more assertive in this regard.

Family planning practices

Adolescent men indicated that young women could benefit from using contraceptives to prevent sexually transmitted infections as well as unplanned pregnancies. However, these males revealed contraceptive myths preventing the use of contraceptives, similar to those reported by Gule (1993:243). Some adolescent boys reported condoms to be the main cause of sexually transmitted infections and oral contraceptives as causing abortions. A 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. 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 breast feeding. These family planning methods were proved to be culturally acceptable, safe and reversible.

Thus some contradictions seemed to exist in the adolescent boys' minds who proclaimed that Swazi girls should be more assertive and insist on condom use in one instance, but disapproved of condom use in another instance.

Adolescent girls indicated that their sex partners disapproved of contraceptives. One girl stated that her partner maintained, *"if you really love me you won't mind to become pregnant"*. Girls reportedly competed with other girls for the love of specific men. If one girl becomes pregnant, she is likely to win the man's hand in marriage, because childlessness is considered to be a social and cultural handicap (Gule 1993:242) among the Swazi people. This situation results in girls becoming pregnant deliberately in order to bear children for their prospective husbands. Some girls complained that contraceptives cause high blood pressure, heart failure and obesity. Some adolescent women feared being ridiculed for using contraceptives.

Childbearing age

Adolescent women were of the opinion that commencing childbearing by the age of 18 was ideal, as this would enable a woman to bear the optimum number of children in her lifetime. Both girls and boys feared that the use of contraceptives could delay childbearing and cause sub-fertility, similar to Zwane's (2000:9) reported research results. One participant revealed, *"if girls delay to become pregnant they may not be able to fulfil their reproductive role of producing many children for their in-laws"*. In Swaziland, large families continue to be favoured, exerting pressure on their sons to marry young women in order to bear many children and expand the family and the clan. The practices of early marriage and polygamy promote poor contraceptive use.

Unexpectedly the adolescent boys were aware of some consequences of adolescent pregnancies, namely poverty, reduced job opportunities and the perpetuation of women's low status.

Number of children

Adolescent males realised that many children bring hardships to families with limited resources. Male adolescents stated that the ideal number of children per family range from two to four, while female adolescents considered two or three children to be the ideal number. However, both adolescent boys and girls explained that in the Swazi society the husband's family ("in-laws") expected women to bear a minimum of six children in a traditional type of marriage where the bridal price (called "lobola") had been paid by the husband. This cultural expectation limits the use of contraceptives and puts many women and children at risk of mortality and

morbidity due to complications of grand-multiparity.

This finding that both adolescent boys and girls viewed the ideal number of children not to exceed four was unexpected, because children are desirable and valued by the Swazi people.

Children are considered to be a family resource, ensuring adequate support during old age, and children bring joy to Swazi families (Gule, 1993:243). This finding might indicate a readiness on the part of adolescents to depart from Swazi traditions, expecting a woman to bear six or more children.

Theme 2: Cultural Values

Cultural values contribute to adolescents' non-utilisation of contraceptives. The subthemes which were identified, included the cultural importance of children, gender status and the importance of (male and female) fertility.

Cultural importance of children

Adolescent males revealed that children are important for the security and continuation of the family, family possessions and family name. One informant attested that *"a boy child is important for maintaining the family name"*. A woman who bears female children has no security for her family's future. This finding implies that women may not control their fertility until they bear boys who will take over their fathers' responsibilities of managing family affairs and pass the family name (father's surname) on to their children.

Adolescent women were of the opinion that children are important for determining and maintaining the political and social position of any specific family in the Swazi society, indicating that *"a family with fewer children is likely to loose land or be displaced by a more powerful family"*. This finding implies that women might not use contraceptives in order to maintain the social and political positions of their husbands' families. It further explains why women might be unable to use contraceptives without the permission of their husbands because the families' possessions and future powers could be jeopardised by limiting the number of children, especially boys, born to the man concerned. Historically, the perpetuation of the male line was important for the economic viability of individual families and for nation building (Women and Law in Southern Africa,

However, some informants recognised that many children aggravate poverty, and ill health among Swazi families. Hence women should use contraceptives in order to prevent unplanned pregnancies, or to space their children so as to protect their health to some extent. Presumably women could only do so with the approval of their husbands/male partners.

Gender status

The minority status of Swazi women was identified as contributing to the high adolescent pregnancy rates in Swaziland. Adolescent males confirmed that women are inferior partners to men and that women should seek permission from men to use contraceptives (although these same men indicated in response to another question that adolescent girls should insist on condom use). A young rural man said: *"It is unSwazi for women to control their pregnancy without the approval of a male partner - the decision-maker on sexuality issues"*. Another rural male participant said: *"Women are minors like children and should seek advice from men on sexuality issues, women should 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"*. Mkhonta (1999:4) also reported that decisions about fertility control rest solely with the husband, as the head of the Swazi family.

Conversely, urban-based adolescent boys stated that girls are trapped in a culture which perpetuates the minority status of women, and it is up to the women themselves to rise above that culture and fight for their reproductive rights. This is what one young urban man had to say: *"Women are controlled by men on decision-making even those that pertain to reproductive health. The power rests upon women to protect themselves from sexual abuse and use all possible means of preventing unplanned pregnancies. Women have the right to use safe, effective and convenient methods of family planning"*. This apparent discrepancy between urban and rural adolescent boys' opinions could not be explained from the data obtained during the focus group interviews, but might indicate that urban adolescent boys might have been more knowledgeable about and more accommodating toward women's utilisation of

contraceptives.

Young women were of the opinion that boys may physically, mentally or emotionally abuse them if they use contraceptives. One adolescent girl 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 believed, similarly to the urban boys, that women require more social status in the Swazi society, before women could exercise their reproductive rights and use contraceptives without men's knowledge or approval. Okore (1993:94) maintains that only free and emancipated women could fully participate in contraceptive decisions and actions. Bearing children at early ages, could compromise Swazi adolescent girls' attainment of educational qualifications which could help them to become financially and socially empowered to the extent that they could make independent contraceptive decisions.

Importance of male fertility

The focus group participants considered the importance of male fertility to be a contributory cause to adolescent pregnancies. Boys are perceived to be "real men" when they had impregnated girls. Even the boys' parents are excited if their sons prove capable of becoming fathers. Proven male fertility is a social position which every male aspires to achieve and maintain - even during old age, as stated: *"A man's health status is reflected when he continues to produce children during old age"*. In the polygamous Swazi culture men can continue to marry young women to prove the elderly men's health and virility, as long as their (young) wives continue to bear children. These aspects need to be understood against the knowledge that Swazi men boast about their virility and women about their fertility (Women and Law in Southern Africa, 1998:204).

Adolescent girls compete for the love of a man by bearing him a child, preferably a boy. An adolescent girl who has not given birth to a baby is unlikely to use contraceptives until she has "pleased" her boyfriend by bearing him a son, or a number of sons. This standpoint is supported by Rwomire's (1991:61) report which indicates that if a Swazi man has fathered children with different women, the woman who will win his hand in marriage, will probably be the woman who bore the most

children, especially sons.

Importance of female fertility

Female fertility is a fundamental value in the Swazi society, because barren women continue to be stigmatised by their families and by their society. As adolescents fear that contraceptives could cause infertility, they do not use contraceptives, lest they should face the consequences of infertility such as divorce, abandonment and bringing shame to their families. Adolescent women revealed that they engage in unprotected sexual intercourse because they want to prove to society that they are “real women” by proving their fertility, and social acceptability, with their pregnancies. These adolescent girls’ views are supported by other research reports (Gule, 1993:242; Russel, 1993:43; Women and Law in Southern Africa, 1998:205). These authors also indicate that a barren Swazi woman is a social disgrace and stigmatised.

Responses from the adolescent males favoured the reproductive ability of women. One young man said, “*a wife who is barren is useless and should be sent back to her family because she is unable to fulfil her reproductive role*”. The boys also acknowledged that a girl who produces male children is valued by her prospective in-laws. These adolescent boys’ views were similar to those reported by Women and Law in Southern Africa (1998:205), maintaining that being barren provides sufficient grounds for a Swazi husband to divorce his wife, or to procure the services of a younger substitute wife to bear children on the barren wife’s behalf.

Theme 3: Health Practices

Some factors were identified which pose challenges for the adolescents to access contraceptives and/or contraceptive knowledge from the health care services.

Barriers to family planning services

Adolescents indicated that the contraceptive information and services offered in Swaziland often exclude the youth. Consequently adolescents’ sexual and contraceptive needs are poorly addressed, possibly contributing to the high prevalence of adolescent pregnancies in the Swazi society.

Adolescent males stated that they are denied access to condoms because family planning providers perceive them to be too young to engage in sexual intercourse.

One boy said, “*a family planning provider who happened to know his mother threatened to report ... that he was obtaining condoms ...*”. Such negative attitudes from family planning providers prevent adolescents from accessing contraceptives, enforcing continued unprotected sexual intercourse in a society with high HIV-positive prevalence rates among the adolescents, and high adolescent pregnancy rates. Gule (1993:244) agrees with these adolescents’ views that some health care services in Swaziland are not user-friendly.

Adolescent girls reportedly had to change their school uniforms for ordinary clothes prior to accessing contraceptives, which could be denied to school girls. Adolescents from a rural area reported that family planning providers ridiculed them when they tried to access contraceptives. Financial constraints prevent adolescents from purchasing contraceptives at pharmacies. Failing to access contraceptives at the clinics, some adolescents end up getting pregnant despite their knowledge about contraceptives and their willingness to use contraceptives - even risking contravening cultural taboos in doing so.

Family planning providers reportedly fail to address adolescents’ sexual and reproductive needs, wanting adolescents to practise abstinence, and ignoring the fact that young people are indeed sexually active. Consequently, adolescents do not get sufficient information about contraception, and are denied access to contraceptives, even condoms, from clinics. This situation is aggravated by the lack of sex education in homes, communities, schools, and social clubs. Even family planning providers fail to provide sex and contraceptive education to adolescents. Silberschmidt and Rasch (2001:1819) also report that antagonism and resistance from contraceptive providers pose barriers to adolescents’ effective utilisation of contraceptives.

CONCLUSIONS IN TERMS OF THE OBJECTIVES GUIDING THIS STUDY

Adolescent boys and girls who participated in focus group interviews indicated that childbearing practices, cultural values and health practices influence the prevalence of adolescent pregnancies in Swaziland. These findings will be categorised according to the objectives guiding this study.

Swazi adolescents' beliefs and attitudes concerning adolescent pregnancies as well as traditional and modern contraceptives

Both male and female adolescents indicated that Swazi women should demonstrate their fertility prior to using any contraceptives. Adolescent girls compete for men by bearing children, especially boys. By becoming mothers adolescent girls demonstrate their womanhood and worth to prospective parents-in-law.

The data obtained during the four focus group interviews indicate that Swazi adolescent males favour traditional contraceptives, such as abstinence and breast feeding. They perceive these methods to be without side-effects and to be reversible. Both male and female adolescents fear that modern contraceptives could have negative consequences, including sterility.

Factors that influence Swazi adolescents' utilisation of modern contraceptives

Unfounded fears and myths about the perceived side-effects of modern contraceptives prevent some adolescents' utilisation thereof. Adolescent boys indicated that girls should refuse to have unprotected sex (without condoms); but these boys also indicated that Swazi men are the contraceptive decision-makers and that they do not like using condoms. Girls also indicated that Swazi men are the contraceptive decision-makers, but some girls (like some boys) also indicated that girls should become empowered to make their own independent decisions. Cultural values which impact negatively on Swazi adolescents' contraceptive experiences include that large families are valued, and that both adolescent males and females fear that contraceptives could cause infertility, a severely stigmatised condition in Swazi society.

The adolescent girls indicated that their male partners would not approve if they were to use contraceptives, while the boys indicated that the girls did not approve of them using condoms. Male-female expectations thus impact negatively on these adolescents' utilisation of contraceptives.

Swazi adolescents' access to modern contraceptives

Neither the adolescent girls nor boys could readily access contraceptives. The girls indicated that they could not obtain contraceptives from the clinics if they wore their school uniforms. Some boys indicated that nurses at clinics refused to supply them with condoms, and even threatened to inform their mothers that they requested condoms. The availability of modern contraceptives at clinics did make them accessible to Swazi adolescents.

Ways in which Swazi adolescents' utilisation of modern contraceptives could be enhanced

Improved sex education should be provided in families, at schools, youth clubs, churches and in the communities. Family planning providers should not obstruct adolescents from accessing contraceptives and/or contraceptive knowledge at clinics. Youth-friendly contraceptive sites should be established where adolescents could readily access contraceptives.

LIMITATIONS OF THE RESEARCH

Conducting focus group interviews on a sensitive topic such as attitudes and beliefs about contraceptives could give rise to ethical questions regarding confidentiality of sensitive information. De Vos (1998) states that the major limitation of using focus group interviews for data collection is that the data cannot be generalised to the entire population.

The sample size was relatively small, so the results might not be generalisable to all Swazi adolescents.

RECOMMENDATIONS

Adolescents could be assisted to use contraceptives more effectively and to reduce the number of adolescent pregnancies if:

- they could be taught about sex and contraception at home, school, church and youth clubs
- contraceptive myths could be addressed effectively and repetitively
- adolescent girls could be empowered to make better informed decisions
- adolescents could use family planning centers both in and out of school

- family planning providers could be sympathetic and helpful to all adolescents
- values clarification sessions could be conducted with boys and girls to debate mutual expectations
- adolescent girls could be encouraged to complete their schooling prior to becoming mothers - both boys and girls indicated the ideal age to be 18.

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 failed to meet the needs of adolescents, mainly because of continued cultural barriers which prohibit women from making independent decisions concerning reproduction. "Since the 1960s family planning programs have helped women around the world avoid 400 million unwanted pregnancies. As a result, many women's lives have been saved from high-risk pregnancies or unsafe abortions" (Hatcher, Rinehart, Blackburn & Geller, 1997:1). However, many Swazi women cannot use contraceptives to decide if and when they will have children, mostly due to persistent cultural expectations that every woman should have as many children as possible during her life. Unfounded myths about contraceptives' feared permanent side-effects further limit many women's utilisation of contraceptives. Many of these aspects could be addressed by continued sex education, especially to adolescents but also to adults throughout Swaziland. The reported negative attitudes of health service personnel, mostly nurses, who fail to provide contraceptives and fail to educate adolescents about responsible sexual and reproductive behaviours need to be addressed as a matter of utmost urgency before the number of adolescent pregnancies in Swaziland could begin to decline.

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