Canadian Studies in Population, Vol. 21(1), 1994, pp. 35-49.

Socio-Cultural Constraints to Family Planning in Swaziland

Gugulethu Gule
University of Swaziland
Swaziland, Southern Africa

Abstract

Swaziland's population growth rate (3.2%) is among the highest in the world. It results from high and stable fertility, and rapidly declining mortality. Strategies aimed at reducing fertility have had little success, evidenced by only a slight decline of fertility from 6.9 children per woman in 1966 to 6.4 in 1986. Contraceptive prevalence has remained low (17% among all women), and compares unfavorably with that of other southern Africa countries. This paper discusses constraints to family planning in Swaziland and proposes the incorporation of these factors into all programs aimed at reducing Swaziland's population growth and fertility rates.

Résumé

Le taux d'accroissement démographique du Swaziland (3,2 pour cent) compte parmi les plus hauts du monde. Il résulte d'une fécondité stable et élevée et d'une mortalité en rapide déclin. Les stratégies de réduction de la fécondité ne se sont soldées que par un léger déclin -- de 6,9 enfants par femme en 1966 à 6,4 en 1986. Le recours à la contraception reste faible (17 pour cent parmi toutes les femmes) et se compare défavorablement aux pratiques des autres pays sud-africains. Le présent article examine les difficultés de la planification familiale au Swaziland et suggère qu'elles soient prises en ligne de compte dans tous les programmes visant à réduire les taux de croissance démographique et de fécondité.

Key Words: Swaziland, contraception, constraints, fertility

Introduction

Swaziland's annual population growth rate of 3.2% is among the world's highest, and is typical of growth rates in Sub-Saharan Africa. As a result of the high and relatively stable fertility and declining mortality, the country's growth rate has accelerated in the recent past from 2.8% over the 1966-1976 intercensal period to 3.2% between 1976 and 1986. Intervention programs aimed at reducing fertility have had little success. This is evidenced by the slight decline of the total fertility rate from 6.9 children per woman in 1966

to 6.4 in 1986, a decline of less than one child in two decades (Tumkaya, 1991). Mortality, on the other hand, has declined sharply. The infant mortality rate, for example, declined from 135 per thousand in 1976 (World Bank, 1985) to 99 per thousand in 1986 (Mamba, 1991). This decline in mortality is mainly a result of the programs mounted by the Ministry of Health, aimed at improving the general health of the Swazi people. These programs *inter alia* include the Combating Diarrheal Diseases Program, the Swaziland Expanded Program on Immunization, the Water and Sanitation Program, and the Rural Health Motivators Program (Gule, 1990a).

Though Swaziland has no explicit policy aimed at reducing the country's high population growth and fertility rates, the government has acknowledged that Swaziland has a population problem, and that the problem needs to be addressed urgently. For example, Swaziland's Development Plans have articulated the concern in their objectives (Matsebula, 1992). In addition, in his recent (October 1991) opening address of a Workshop on Population and National Development, the Prime Minister echoed the concern about Swaziland's rapid population growth rate when he stated (Dlamini, 1992: 26):

> Like many other nations, Swaziland is gradually sliding towards a serious socio-economic problem which is mainly caused by the worsening imbalance between the country's population numbers and development resources that the country has at its disposal. We simply have a population that is growing too fast for the available development resources.

The rapid increase of Swaziland's population has dire consequences on socio-economic development. The consequences *inter alia* include the following: an increase in unemployment and crime rates which have reached unprecedented levels; difficulty in providing adequate health care facilities; difficulty in providing adequate education facilities; difficulty in providing adequate clean water and sanitation facilities; and environmental degradation (soil erosion, mainly resulting from overgrazing and inappropriate farming methods, has become a very serious problem).

Despite the absence of a policy, Swaziland has had a family planning program since 1973 under the auspices of the Ministry of Health, among whose major objectives are to provide family planning services and information/education on family planning. The family planning program integrates family planning (FP) services with maternal and child health (MCH) services, the aim of the integration being to improve the health status of mother and child through child spacing.

The government is the principal provider of family planning services through its hospitals, health centers and clinics. However, the Family Life Association of Swaziland (FLAS), which is a non-governmental organization, has gained significance in the provision of family planning services. After just over ten years of operation, FLAS has gained popularity due to the wide range of services it offers which include family planning service provision, youth and family planning counselling, treatment of sexually transmitted diseases, and family life education. The counselling services of FLAS stand out as a major attraction particularly since such services are either grossly inadequate or non-existent in most government health centers.

While Swaziland's family planning program has had considerable success in raising awareness and knowledge of family planning methods, its impact on contraceptive use has been minimal. Consequently, the country's fertility level has declined only slightly. The high knowledge of contraceptives most likely results from the successful dissemination of information, through a wide variety of channels, by the Information, Education and Communication (IEC) Departments of the Ministry of Health and FLAS. The radio is the most commonly cited source of information about family planning (Swaziland Ministry of Health, 1990; Gule, 1992).

The 1988 Family Health Survey of Swaziland, which is the first comprehensive national survey to collect information on family planning found a very wide gap between knowledge and use (KAP-gap) of contraceptives (Swaziland Ministry of Health, 1990). The survey found that 82% of all women knew of at least one method of family planning, while only 17% of all women reported currently using contraceptives. The survey also found a substantial discontinuation rate of methods, about 14% of the women having discontinued the method of their choice. Subsequent studies in different parts of the country, as shown in Table 1, have also identified a large KAP-gap, the gap ranging from 52 to 65% (Gule, 1992; Mburugu and McCombie, 1992; Gule, 1993). It is evident from these data that knowledge of family planning methods in Swaziland is not necessarily a predictor of contraceptive use and change in reproductive behavior.

Though all the above mentioned studies have identified a wide gap between knowledge and use, they yield virtually no data to explain why people who know of contraceptives, some of whom even desiring to use birth control, still do not use family planning. The existence of the wide KAP-gap prompted FLAS to conduct a small scale national study in 1990 which utilized focus groups. The study, which is the first of its kind at national level, was aimed at identifying constraints to family planning in Swaziland.

Because of the small-scale and in-depth nature of the study, FLAS has received quick and useful feed-back which is essential for effective service provision. As a sequel to this study, the FLAS has undertaken another study to evaluate its IEC Department, and recommendations have been made for its improvement.

TABLE 1. PERCENTAGE OF ALL WOMEN KNOWING OF AT LEAST ONE METHOD OF FAMILY PLANNING AND PERCENTAGE CURRENTLY USING A METHOD IN SWAZILAND BY AREA.

Area (Year)	*Knowledge*	*Use*
Country (1988)	82.0	16.6
Malkerns (1991)	94.4	29.2
Industries (1991)	89.0	37.5
Siteki (1992)	88.6	35.9

Sources: Swaziland Ministry of Health, 1990, Tables V-1 and V-14, Gule, 1992, Tables 6 and 9, Mburugu and McCombie, 1992, Tables 5.1 and 5.4, Gule, 1993, Table 4.1 and 4.2.

The main objective of this paper is to discuss the socio-cultural constraints to family planning in Swaziland. These constraints, to a large extent, explain why the wide gap between knowledge and use of contraceptives exists. The primary source of information is the FLAS focus group discussion study (McLean, 1990). Supplementary information has been obtained from inter-personal communication with various people.

Contraception and Fertility

Family planning is a widely accepted concept in Swaziland because it is part of Swazi tradition and culture. It is mainly conceived as a method of spacing births, the ideal birth interval averaging 3 years (McLean, 1990). Hosein (1993: 4) contends that:

> Though the notion of a smaller family size is not yet internalized, there seems to be an increasing understanding of the relationship between means and the ability to support a large family.

The descriptors, *feed, clothe,* and *educate,* which are employed by the

Ministry of Health and the Family Life Association of Swaziland in their IEC campaigns, have been adopted by the majority of Swazis in defining family planning (McLean, 1990).

Despite the high knowledge of family planning, Swaziland's contraceptive prevalence among women in a sexual union or currently married, is low and compares unfavorably with that of other countries in the Southern Africa region (except Lesotho's), as shown in Table 2.

TABLE 2. PERCENTAGE OF CURRENTLY MARRIED WOMEN CURRENTLY USING CONTRACEPTION AND TOTAL FERTILITY RATES (TFR) IN SOUTHERN AFRICA, 1992.

Country	*Percent Using*	*TFR*
Botswana	33	4.8
Lesoth	5	5.8
Namibia	26	5.9
South Africa	48	4.5
Swaziland	19	6.2

Note: The figure for currently married women in Swaziland includes never married women with children.
Source: 1992 World Population Data Sheet.

Fertility transitions experienced by many developing countries have been associated with increased contraceptive use and improvements in women's education and status as well (Bongaarts *et al.*, 1990; United Nations, 1992). For example, the recent decline in Botswana's total fertility rate from 6.5 children per woman in 1984 to 5 in 1988 has been attributed to an increase in contraceptive prevalence (Lucas, 1992). In addition, Table 2 shows a high correlation between contraceptive use and fertility. The case of Lesotho is curious because the level of fertility is not at par with the level of use. Lesotho's fertility is most likely inhibited by high male absenteeism to South African mines.

In the light of the observations made elsewhere, and the tendency for higher contraceptive prevalence areas in Swaziland to have lower fertility (Ministry of Health, 1990; Mburugu and McCombie, 1992; Gule, 1993), one would expect that by increasing the country's contraceptive prevalence fertility would decline. In fact, in a study of fertility determinants in Swaziland,

Warren *et al.* (1992: 1) argue that "... future decreases in fertility in Swaziland are most likely to result from increases in use of contraception".

Barriers to Fertility Reduction

It has been argued by Caldwell and others (1992) that socio-cultural constraints to fertility reduction are weakening in Africa. Though this is true to some extent in Swaziland, they are still very strong forces to contend with. The identification and understanding of these factors is crucial and can facilitate the design and implementation of effective policies and programs.

High Infant and Child Mortality

The death of a child is greatly feared in Swaziland. It puts couples under pressure to have large families so that in case death occurs, there is still a significant and culturally acceptable number of children surviving to adulthood. This is typical in most Sub-Saharan countries. Consequently, reduced fertility has been associated with declines in mortality in these countries. For instance, the decline of the total fertility rate in Botswana and Zimbabwe has been associated with declines in mortality, the infant mortality rate being as low as 70 per thousand live births (Caldwell and Caldwell, 1990b), a level which is much lower than Africa's of 99 per thousand (Population Reference Bureau, 1992).

Though Swaziland's infant and childhood mortality rates have declined sharply, particularly during the past decade, mortality levels have not declined to levels which can be appreciated by couples. The infant mortality rate of 99 per thousand which is much higher than the rate of 70 mentioned above, still does not give parents the assurance that their children will survive to adulthood. This implies that in order for Swaziland to succeed in reducing fertility it has to invest in expanding health services, which should result in further declines in mortality.

Women's Status

Culturally, a woman's status in Swaziland is tied to motherhood. A woman gains full status when she becomes a mother. Childlessness is not only considered a social and cultural handicap, but carries a stigma as well. A childless woman is referred to as an *inyumba*, which literally translated means devoid of feminine qualities, not a woman, which accords her an

inferior status. Consequently, no women in Swaziland would deliberately opt to be childless, as is common in many developed societies.

So great is the fear of childlessness or sterility (even secondary sterility), that the idea of contraceptive use is repulsive to many women. The fear of sterility among Swazi women was found by McLean (1990) to be one of the primary determinants for nonuse and discontinuation of certain contraceptive methods. Some women feel that they should first prove their fertility before they can use contraceptives. This is tied to the belief that certain forms of contraceptives, such as the pill, can result in sterility. One woman expressing her fear stated that:

> I was afraid because I heard that some contraceptives travel in your body up to the ovaries and eat up all the eggs and you can become sterile (McLean, 1990:31).

It is not enough for Swazi women to bear one child. A woman is expected to produce as many children as God allows her to have. Swazi women view the practice of *lobola* (payment of bride price to the wife's family) as a cultural barrier to family planning (McLean, 1990). They feel duty bound to bear many children, or the number of children dictated by their in-laws. In fact, if a woman proves to be barren, the *lobola* may be recalled from her family. In lieu of returning the *lobola* the parents of the barren woman may send a younger sister (*umlamu*) or a niece (*inhlanti*) to bear children for the husband. These children, however, will belong to the barren woman until such time that she dies. Though the practice of sending *umlamu* or *inhlanti* to bear children is no longer very prevalent, it remains a nightmare to women. There is, however, an increasing feeling of threat among women of having co-wives. The fear emanates from the fact that the husband may either abandon the wife, or from the fact that meager resources would be shared, thus lowering her standard of living.

It should be noted that although Swazi culture encourages large families, it looks down upon a woman who has closely spaced children. Such a woman is said to produce children like chickens (*uyachunchusela*), which is derogatory. A woman is expected to abstain from sexual intercourse for close to seven months after birth (Swaziland Ministry of Health, 1990). Thereafter, she should practice traditional methods of family planning, such as withdrawal or using certain herbs, to ensure that her children are properly spaced. Suffice to say it is not only the woman's status that is elevated by parenthood, but also that of the male. Having children presents evidence of masculinity.

Value of Children

The Swaziland Government does not provide social security to the elderly. Consequently, parents must rely on their children for old-age support. Having a large family is thus desirable in order to ensure adequate and steady support from the children. Sons and daughters are valued for different reasons. The pressure to have at least one son stems from the fact that Swaziland is a patriarchal society, where male children are valued because they would continue the family name. A woman who only has girls is under pressure to continue giving birth until a boy is born.

The emphasis attached to male children does not mean that female children are less important. Girls are also valued because they are considered a source of wealth. The more daughters one has, the more cows, through *lobola*, one can expect. Today, daughters are considered of more value than in the past since they are viewed as more reliable and stable sources of support for their parents, particularly for their mothers, who in many cases are left alone after the death of their husbands. The high prevalence of alcohol and drug abuse among males has caused many of them to abandon their traditional responsibility of supporting their parents. There is even a saying, *intfombatane ayimlahli unina*, its connotation that it is better for a woman to bear daughters because she is certain they will always be by her side whenever their help is needed.

Under this scenario, where the Swazi couple is under pressure to have both boys and girls, it is difficult to adopt family planning.

Kinship Structure

In Swaziland, children do not only belong to the biological parents, but also to the extended family, just as the woman does not marry only the husband, but the husband's entire extended family as well. The couple can, therefore, not make independent decisions. All decisions, including the use of contraceptives, must be endorsed by the extended family. Women are under pressure to produce the number of children that is dictated by the in-laws. In the study by McLean (1990), some women considered interference from in-laws in the decision-making process a deterrent to contraceptive use.

Failure to comply with explicit or implicit demands of in-laws can result in a variety of problems, including being called all sorts of pejorative names. If in-laws are convinced that more children are still needed, they may convince, or even push the husband to take another wife, which is

undesirable on the part of the first wife.

If the cost of having an acceptable number of children in Swaziland is so high, how then are couples faced with such strong cultural values expected to willingly adopt modern family planning? These are some of the questions which have to be adequately addressed if family planning programs in Swaziland are to succeed.

Partner's Disapproval of Family Planning

Disapproval of the partner is a significant draw-back to contraceptive use in Swaziland. For example, the 1988 Family Health Survey found that 6% of female nonusers were not using contraceptives because their husband or father of their children disapproved of family planning (Swaziland Ministry of Health, 1990).

Though women report that their husbands or partners are key decision-makers in family planning and family size matters (McLean, 1990; Gule, 1993); McLean, 1990: 33) found that "when it came to practice behaviors, women seemed to take matters into their own hands". This implies that some women will adopt family planning despite the disapproval of their partner, which is an indication of high motivation to use. For women who are not married, motivation is even higher since many women's partners often default in supporting their children, or in some cases they don't support them at all, therefore bearing the burden of supporting the children on their own.

It is sad and disappointing to note that a significant number of maternal and infant deaths in Swaziland occur as a result of husband disapproval of family planning. These deaths, which result from complications during child birth, could have been avoided had husbands given consent for their wives to use contraceptives or be sterilized. What causes such insensitivity on the part of Swazi men? Is it mere ignorance? Or is it male ego coupled with other factors? Further research in this area could provide insight and better direction on how to address this problem.

It should be noted that though male disapproval of family planning is more dominant, women have also displayed similar behavior to their partners. There is a tendency for women to have a negative attitude towards the use of condoms. Male condom users report that coping with negative attitudes of women is the main problem with using condoms (McLean, 1990). Personal communication with a few industry based distributors (IBDs) revealed that this phenomenon is also common in industries where a Family

Planning/AIDS Project is promoting the use of condoms for preventing AIDS, sexually transmitted diseases and pregnancy. In fact one IBD was calling for intensified education campaigns aimed at dispelling misconceptions and negative attitudes towards condoms among women.

McLean (1990) contends that disapproval is usually associated with ignorance about methods or certain beliefs. For example, the use of the pill is associated with prostitution. Hence, allowing one's wife or partner to use the pill implies condoning prostitution. The use of contraceptives is believed to provide a sense of security, thus leading to promiscuous behavior. Some men fear that if women use contraceptives they will not age fast, consequently, they will be admired by other men, which is a threat to their male ego. The fear that some contraceptives cause impotence, produce deformed children, and affect women's health is also associated with male disapproval of family planning. Sometimes men know so little about the concept of family planning that they feel threatened to discuss or even approve of a concept they know little about.

Highly motivated women adopt family planning methods and hide the fact that they are using contraceptives from their partners. These women are not particularly happy to hide contraceptives from their partners because they consider it ideal for both partners to be aware (McLean, 1990). The injection and IUD are the most popular methods among these women because these methods do not have to be taken everyday and are easy to conceal. Women who are employed outside of their homes also opt for the pill because they can keep supplies at their places of work. In her study, McLean (1990) found that women who hid contraceptives did so because they feared physical abuse, being deserted once the contraceptive is discovered, and being linked to prostitution or promiscuity.

In the past, little attention has been paid to making men aware of their role in family planning. It is only recently that the Family life Association of Swaziland has made efforts to motivate men to actively participate in family planning. In 1992, a Male Motivation Campaign was organized by the FLAS with key male leaders being in the forefront of the campaign. The campaign has been so successful that the slogan "We Do It *Kanyekanye* (Together)" has been coined and is now used to promote the involvement of both partners in decision-making with family planning being just one aspect.

Misconceptions about Family Planning

False rumors regarding side effects of contraceptives, and ignorance about

how these methods work are key deterrents to their use in Swaziland (Swaziland Ministry if Health, 1990; Gule, 1993).

Some contraceptive methods are falsely associated with medical problems. For instance, the pill is believed to destroy the uterus and ovaries resulting in sterility among women (McLean, 1990). The pill is also believed to cause impotence in the man, and wetness in the woman, resulting in reduced sexual pleasure. People fear that the condom, if it comes off during sexual intercourse, may become lodged in the vagina and may "cause serious physical harm ... thus leading to female sterility" (McLean, 1990: 16). The condom is also associated with reduced sexual pleasure. Of the condom it is said:

> ... If you buy sweets you do not expect to eat them whilst in the plastic. Instead, you have to remove the plastic so as to eat the sweets and enjoy them (McLean, 1990: 21).

Access to Family Planning Services

Since most family planning methods (excluding surgical procedures) are virtually free in Swaziland, the cost of buying contraceptives is unlikely to be a deterrent to their use. Rather, people may be constrained by high transport costs. The "price" may be too high in terms of the time and effort required to get to the supply source, amount of time spent at the service point, and in maintaining the method. The combination of these factors, along with fear of side effects and partner's reaction, may lead to personal inertia among women, i.e., women not adopting family planning even though they see the need and have the desire to use contraceptives (Hosein, 1993).

Poor Quality of Family Planning Services

Most government and industry clinics and hospitals in Swaziland are overcrowded and under-staffed. As a result of being over-burdened with work nurses in these centers tend to give high priority to the sick. The healthy person seeking family planning is given low priority.

The centers do not offer proper counselling of clients, probably due to overcrowding and lack of training. In fact, "only about 40% of clinics have a trained family planning practitioner" (Hlophe, 1993: 153). One lady who had stopped using contraceptives claimed that:

> She (the nurse) told me that there are eight methods but was in too much of a hurry to relate them to me (McLean, 1990: 28).

Clients need to be properly advised on the most suitable method. They also need to be advised that if the contraceptive method chosen is not satisfactory, there is the option of switching to another form of birth control. In addition, proper instruction on usage of the chosen method should be given. Lack of proper counselling, particularly during the initial stages, may lead to high discontinuation rates. The danger of improper counselling is that people might discontinue the use of contraceptives and discourage a potential user from adopting methods in which problems had been experienced.

Some people are deterred from using contraceptives by the negative reception given by health providers. Nurses in Swaziland are said to be judgmental, uncaring, unfriendly and impatient. Typical comments from disgruntled people include:

> I don't go to a clinic, the nurses there are very proud - they ask you a lot of irrelevant questions tossing and turning you around, and sometimes they neglect you (McLean, 1990: 50).

> When I go to the clinic for a resupply they ask me what am I going to do with so many condoms - that makes me reluctant to go there for a supply (McLean, 1990: 22).

Negative attitudes by service providers toward contraception in general, and also specific methods, deter use of contraceptives in Swaziland. Some nurses discourage, or even forbid teenagers from using contraceptives, even if they are sexually active. They may bend their "rules" only if the teenager already has a child, which defeats the national goal of reducing the high rate of teenage pregnancies.

Some nurses ridicule men who have opted for male sterilization. One male university lecturer was amazed by the barrage of questions from nurses when he went for a vasectomy operation at a major private clinic. Had it not been for his high motivation he would not have gone through with the operation.

Sometimes there are shortages of certain contraceptive methods in clinics. This results in switching methods, or even discontinuation. It is common for women to change from the injection to the pill and vice versa (McLean, 1990).

Conclusion

The primary focus of Swaziland's Family Planning Program has been to increase awareness and knowledge of family planning methods. In this regard the program has been successful, evidenced by the virtual universality of knowledge about methods among both women and men. It is thus evident that little effort needs to be exerted in increasing knowledge. Rather, considerable effort, time and money should be spent on addressing socio-cultural barriers to family planning in order to increase contraceptive use and reduce fertility.

There is no doubt that the future success of family planning programs in Swaziland (success being measured in terms of increased contraceptive prevalence and fertility reduction) will be determined to a large extent, by the degree to which barriers to family planning are incorporated into IEC strategies. These strategies should be designed in such a way that they are feasible in the socio-cultural context of Swaziland.

Very little has been done to address the socio-cultural barriers to family planning in Swaziland. The Family Life Association of Swaziland has just begun scratching the surface. Strategies FLAS has utilized to address these barriers are: the Schools Family Life Education Program; Family Life Education in Communities Program; Radio Program; Videos for Teenagers and Men; Method-Specific Pamphlets; the Women's Empowerment Program; and the Male Motivation Program. Hosein (1993) argues that more intense and focussed efforts are required, and calls for massive, concentrated and repetitive treatment.

From the discussion above, it is recommended that Swaziland formulates an explicit national population policy providing a framework for systematically integrating socio-cultural constraints to family planning into all IEC strategies. The enunciation of a policy is necessary for two main reasons. First, the policy would indicate the government's commitment in reducing Swaziland's high fertility and population growth rates, thus giving a green-light for embarking upon or strengthening existing population related activities. Second, the policy would not only facilitate the design, strengthening, implementation, monitoring and evaluation of all strategies aimed at curbing the run-away population growth, but would also enable and facilitate collaboration among all sectors and departments involved in population issues.

As mentioned earlier, the analysis in this paper is derived largely from the study conducted by FLAS in 1990, and based on focus group discussions.

Focus-group discussions can yield insightful and rich data on socio-cultural barriers to the use of contraception. It is thus recommended that such small-scale studies be utilized in conjunction with conventional demographic surveys to enrich knowledge of socio-cultural factors. The advantage of small-scale studies is that they not only provide useful information as to why certain phenomena occur, but are also less expensive and provide quick feed-back to policy makers and service providers.

References

Bongaarts, J., W.P. Mauldin and J. Phillips. 1990. The Demographic impact of family planning programs. The Population Council Working Papers, No. 17. New York, NY: Population Council.

Caldwell, J.C. and P. Caldwell. 1990a. Cultural forces tending to sustain high fertility. In G. Acsadi, G. Johnson-Acsadi and R. Bulatao (eds.), Population Growth and Reproduction in Sub-Saharan Africa: Technical Analyses of Fertility and Its Consequences. Washington, DC: The World Bank, pp. 199-214.

Caldwell, J.C. and P. Caldwell. 1990b. High fertility in Sub-Saharan Africa. Scientific American, May, pp. 118-125.

Caldwell, J.C., I. Orubuloye and P. Caldwell. 1992. Fertility decline in Africa. Population and Development Review 18, Vol. 18, No. 2, pp. 211-242.

Central Statistics Office. 1980. Report on the 1976 Swaziland Population Census. Mbabane, Swaziland: Government Printer.

Dlamini, O. 1992. Opening Address by the Honourable Prime Minister, Mr. Obed Dlamini. In A. Okore (ed.), Proceedings of the National Workshop on Population and Development: Focus on Swaziland, October 9-11, 1991. Manzini: University of Swaziland, pp. 26-29.

Family Life Association of Swaziland. 1993. Twelfth Annual Report. Manzini: Family Life Association of Swaziland.

Gule, G. 1990a. Childhood Mortality in Swaziland: Levels, Trends and Determinants, Ph.D Dissertation. Philadelphia, PA: University of Pennsylvania.

Gule, G. 1990b. Socio-cultural factors affecting family planning programs in Sub-Saharan Africa: A research agenda. Paper presented at an Expert Group Meeting on Research on Socio-Cultural Factors Affecting Family Planning Programs in Developing Countries, UNFPA, New York, NY, 21-22 June.

Gule, G. 1992. Fertility, mortality and migration in Swaziland. In A. Okore (ed.), Proceedings of the National Workshop on Population and Development: Focus on Swaziland, October 9-11, 1991. Manzini: University of Swaziland, pp. 71-85.

Gule, G. 1992. Family Life Association of Swaziland: Malkerns Clinic Evaluation Study. Manzini: University of Swaziland.

Gule, G. 1993. Siteki Needs Assessment Study. Manzini: University of Swaziland.

Hlophe, M. 1993. The role of the Ministry of Health in population control. In A. Okore, C. Mahindi and S. Dlamini (eds.), Proceedings of the National Seminar on Population Policy for Development and Self-Reliance in Swaziland, October 7-9, 1992. Manzini: University of Swaziland, pp. 147-156.

Hosein, E. 1993. Family Life Association of Swaziland Information, Education and Communication Assessment. Arlington, VA: Datex Inc.

Lucas, D. 1992. Fertility and family planning in Southern and Central Africa. Studies in Family Planning, Vol. 23, No. 3, pp. 145-158.

Mamba, L. 1991. Mortality. Report on the 1986 Swaziland Population Census, Vol. 4. Mbabane: Government Printer, pp. 5.1 - 5.17.

Matsebula, M. 1992. Development goals in Swaziland: Strategies, achievements and policy implications. In A. Okore (ed.), Proceedings of the National Workshop on Population and Development: Focus on Swaziland, October 9-11, 1991. Manzini: University of Swaziland, pp. 86-105.

Mburugu, E. and S. McCombie. 1992. A Baseline Survey Report on The Industry Based Family Planning/AIDS Project. Manzini: Family Life Association of Swaziland.

McLean, P. 1990. Perceptions and Attitudes of Men and Women Towards Family Planning in Swaziland: A Qualitative Analysis. Boulder, CO: University of Colorado.

Swaziland Ministry of Health. 1990. Swaziland: 1988 Family Health Survey, Final Report. Atlanta, GA: Centers for Disease Control.

Tumkaya, N. 1991. Nuptiality and fertility. Report on the 1986 Swaziland Population Census, Vol.4. Mbabane: Government Printer, pp. 4.1 - 4.46.

United Nations. 1992. Strategies to Improve Contraceptive Use to Influence Demographic Trends in African Countries. New York, NY: United Nations Economic Commission for Africa.

Warren, C., J. Johnson, G. Gule, E. Hlophe and D. Kraushar. 1992. Fertility determinants in Swaziland. Population Studies, Vol. 46, pp. 5-17.

World Bank. 1985. Swaziland Population and Health Sector Review. Washington, DC: World Bank, Population, Health and Nutrition Department.

Received, July 1993; revised, March, 1994.