

**Mental health promotion in Western Cape schools:
An exploration of factors relating to risk,
resilience and health promotion**

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Thesis submitted in fulfillment of the requirements for the
PhD degree in the Faculty of Education,
University of the Western Cape



SUBMITTED: MAY 2005

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Mental health promotion in Western Cape schools:
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resilience and health promotion

KEYWORDS

Mental Health Promotion

Youth at risk

Resilience

Health Promoting Schools

Adolescents

Well-being

Support

Barriers to learning

School-based intervention

Youth development



ABSTRACT

Mental health promotion in Western Cape schools: An exploration of factors related to risk, resilience and health promotion.

Recent South African research has confirmed that there is reason to be concerned about the mental health status and well-being of our youth. School-going youth are engaging in a wide array of risk behaviours that seriously threaten their well-being and hamper their chances of experiencing success in the future.

The aim of this research was to explore factors relating to risk, resilience and health promoting schools in order to enhance the well-being of youth in South Africa. Resiliency research served as a primary framework for this study. Resiliency research is grounded in psychological theories, which endorse the fact that human beings possess an innate imperative for growth, development and success, which unfolds naturally in the presence of certain environmental attributes. Resiliency research situates risk in the broader social context of racism, war and poverty, not in individuals, families and communities, and thus moves away from a deficit and pathology focus to an examination of strengths within a systemic framework (Benard, 2004b).

This research utilized both qualitative and quantitative research methodologies. The quantitative aspect involved a survey that was conducted with grade nine learners at seven high schools in the Western Cape. The survey assessed risk and resilience profiles of participating youth. The risk component assessed the following risk areas: substance abuse, bullying and harassment, violence and safety, diet and exercise, depression and suicide, and sexuality. The resilience component assessed the extent to which young people experience caring relationships, high expectations and meaningful participation in the school, at home, in their community and amongst their peers. This component also assessed the extent to which this support translated into the development of internal strengths that would assist young people to make the right choices and succeed, despite being exposed to risk factors. Moreover, school connectedness was also examined by this component. In addition, the qualitative aspects of the investigation involved focus groups with the same learners who participated in the survey. The aim was to supplement the information gathered from the survey regarding issues of risk, resilience and support. Questionnaires were distributed to and interviews conducted with guidance counselors or school psychologists. This was to ascertain their views regarding the mental health status of youth, support for learners and staff members, and the health promoting schools concept.

Results from the risk component of the survey indicate that the youth in the study are engaging extensively in various risk behaviours. Substance abuse, bullying and harassment, and depression and suicide, are challenges for all schools to focus upon. Schools that are well resourced have to deal more with issues pertaining to substance abuse and depression. Schools that are poorly resourced have to contend more with issues pertaining to violence and safety. Learners who come from impoverished communities are engaging with greater intensity in a wide array of risk behaviours. Results from the resilience component indicate that while learners appear to be receiving adequate support in terms of external assets (caring relationships, high expectations and meaningful participation), these assets can be greatly improved within the different domains of school, home, community and peers. Internal assets such as co-operation and communication, self-efficacy, empathy, problem solving, self-awareness and, goals and aspirations, could be enhanced for most learners. The results for school connectedness highlight the role of schools in securing positive outcomes.

Focus group interviews with learners revealed that they are knowledgeable about risk behaviours and the importance of not engaging in risk behaviours. However, the powerful nature of peer pressure was highlighted. Learners also felt that it was very hard to communicate with parents, as parents did not listen to them or attempt to understand them. Learners said that they also found it very difficult to communicate with teachers. Learners felt overwhelmed by pressure from peers to engage in risk behaviours as well as pressure from parents and teachers to perform well academically. Interviews with teachers revealed that teachers are experiencing tremendous pressure in trying to adhere to the demands of the new curriculum. There is very little support available to teachers to cope with the demands of their jobs and the demands of the learners. Another key finding from the questionnaire was that most schools have not been exposed to the health promoting schools concept. Even though health related policies or activities are in place, these are operating as part of independent initiatives and not as part of a common goal directed at developing the school into a healthy school.

Recommendations of this study include adopting a strengths perspective when developing policies and planning interventions for youth; expanding existing interventions to include resiliency frameworks; integrating resilience principles into the health promoting schools framework, the whole school development framework and inclusive education; focusing on the development of health promoting schools to provide supportive environments; focusing research efforts on resilience; integrating resiliency programmes into the life orientation curriculum; developing Education Support Services staff to promote resilience and develop schools into health promoting schools; and developing school and community partnerships to promote resilience in communities.

B.A Johnson

May 2005

DECLARATION

*I hereby declare that **Mental health promotion in Western Cape schools: An exploration of factors related to risk, resilience and health promotion** is my own work; that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.*

Bridget Johnson

15 May 2005

Signed: _____



DEDICATION

To my husband, Quinton, a truly exceptional human being, who offered so much love, patience, guidance and support during this process;

To my children, Chelsea and Michaela, who willingly sacrificed precious moments and never complained;

To my mother, who has always assisted me so that I could succeed;

To my late father who would have been so proud of this achievement; and most importantly,

To almighty God who throughout my life, provided me with the external supports to develop the internal strengths I needed to make my dreams come true!



ACKNOWLEDGEMENTS

I hereby wish to acknowledge the support and assistance of the following individuals and organizations that contributed significantly to this study:

Prof Sandy Lazarus, my supervisor and mentor, who throughout this study, served as a great inspiration with her leadership, knowledge, skills and talent. It is an honour and a privilege to work with her.

The staff and learners of the participating schools who availed themselves for the study. Their support for this work greatly encouraged me.

My colleagues at the University of the Western Cape, for their constant encouragement, motivation and assistance. Prof. Dirk Meerkotter, Prof. Ratie Mpofu and Prof. Aslam Fataar, were especially supportive of my development. A special thanks to Prof. Lena Green for sharing her wisdom, insight and experiences.

Bonnie Benard and Kiku Annon of WestEd for their support with the research instruments and data analysis. Thanks also to Helen Cahill of Melbourne University for support with regard to the MindMatters programme.

The funders who provided the financial aid for the study, namely, the SYLFF Foundation, the VLIR Youth Wellness Project, the Mellon Foundation and the Spencer Foundation.

My friends, neighbours and extended family, who assisted in various ways to enable me to complete the dissertation. To be truly blessed is to have one's life filled with so much love, care and kindness.

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CHAPTER ONE

INTRODUCTION

1.1 MOTIVATION FOR THE STUDY

The increasing prevalence of risk behaviours and suicide amongst young people in South Africa (MRC, 2003) is cause for concern and warrants an in-depth investigation into prevalence, causes and prevention strategies. As there is a lack of evidence regarding the effectiveness of programmes aimed at specific risk behaviours, it is important to extend the boundaries of enquiry to encompass holistic, comprehensive approaches that attempt to promote general well-being and build resilience amongst all young people. Youth programmes that focus on what is wrong with youth have failed to improve the social, health or economic status of youth in our society (Blum, 1998). Not everyone with risk factors goes on to develop a mental disorder and the importance of protective factors is becoming more recognized (Mrazek & Haggerty, 1994). The area of mental health promotion provides a framework for investigation and intervention that could assist in the prevention of issues that place youth-at-risk and contribute to the development of healthier, happier and more productive young people. Mental health promotion activities are aimed at individuals, groups, or large populations to enhance competence, self-esteem, and a sense of well-being rather than to intervene to prevent psychological or social problems or mental disorders.

This research aims to explore factors related to risk, resilience and health promoting schools in order to promote resilience amongst youth in South Africa. The key objectives of this study are firstly, to determine the mental health needs of youth in the Western Cape. Secondly, to determine the form and extent of support being provided through schools to those most at risk for negative outcomes. Thirdly, to facilitate the development of appropriate support systems to promote well-being and build resilience. Fourthly, to extend the application of the health promoting schools framework to include mental health promotion and resilience. It is envisaged that this research will generate new knowledge in terms of how South African schools can help prevent learners from

experiencing mental health problems and at the same time, build resilience amongst our youth.

1.2 BACKGROUND TO THE STUDY

The following section aims to provide a framework of understanding for the research. It explores the concepts of mental health, mental health promotion, health promoting schools, youth-at-risk, depression, suicide, resilience and support.

1.2.1 Gaining an understanding of mental health

An understanding of mental health and of what constitutes good mental health is an important precursor to any investigation into mental health promotion. Most definitions of mental health encompass the components that contribute to “improved physical health, increased emotional resilience, greater social inclusion and participation and higher productivity” (Department of Health (DoH), 2001:72). The World Health Organization (WHO) describes mental health as “a state of well-being in which individuals are able to realize their own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and are able to make a contribution to their community” (WHO, 2004a: 5). The Social Science Research Unit (SSRU, 2001) defines mental health as the capacity for each of us to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face. According to the Health Advisory Service (1995), the components of Mental Health include the following capacities,

- The ability to develop psychologically, emotionally, intellectually and spiritually;
- The ability to initiate, develop and sustain mutually satisfying personal relationships;
- The ability to become aware of others and empathise with them;
- The ability to use psychological distress as a developmental process so that it does not hinder or impair further development. (HAS, 1995:15).

There is therefore growing support for an understanding of good mental health as not only involving the absence of mental illness but also as a resource for reaching one's full potential (Evidence for Policy and Practice Information (EPPI), 2001). The EPPI report (2001) identifies three key factors, which may mediate between positive mental health and causes of mental ill health, namely, coping skills, self esteem and social support. Any intervention aimed at improving the mental health status of individuals should therefore focus on coping skills and self esteem at the individual level and social support at the level of families, communities and environment.

1.2.2 Establishing a link between mental health and health promotion

This notion of focusing not only on individuals but also families, communities and the environment is firmly located within the concept of health promotion, which stems from the notion of primary prevention. In 1986, the Ottawa Charter was produced in response to a growing need for a new public health movement around the world (Reddy & Tobias, 1994). Central to the strategies described in the charter is a recognition of the fact that alongside the attention given to individual lifestyles, action also has to be taken to influence the underlying social and economic conditions and physical environment which influence health directly and have an important impact on health behaviour choices. The health promotion concept therefore involves developing healthy people and environments and in this way contributes to the prevention of ill health. According to Reddy and Williams (1996), health promotion means educational, political, economic, environmental and medical strategies designed to reduce disease and promote health.

1.2.3 The development of mental health promotion

The WHO positions mental health promotion within the broader context of health promotion and public health,

The promotion of mental health is situated within the larger field of health promotion and sits alongside the prevention of mental disorders and the treatment and rehabilitation of people with mental illness and disabilities. Like health promotion, mental health promotion involves actions that support people to adopt and maintain healthy lifestyles and which create supportive living conditions or environments for health (WHO, 2004b: 6).

This understanding of mental health promotion is endorsed by Hodgson, Abbasi and Clarkson (1996:56) who define mental health promotion as “the enhancement of the capacity of individuals, families, groups or communities to strengthen or support positive emotional, cognitive and related experiences”.

By working to increase self-esteem, coping skills, social support and well-being in all individuals and communities, mental health promotion therefore is,

- an approach that empowers people and communities to interact with their environments in ways that enhance emotional and spiritual strength;
- an approach that fosters individual resilience and promotes socially supportive environments (SSRU, 2001).



According to SSRU (2001), mental health promotion involves the population as a whole, and is oriented toward building strengths, resources, knowledge and assets for health, with the people and communities involved in controlling issues and processes. Mental health promotion sees all people as holistic beings regardless of diagnosis. Mental health promotion applies equally to all people – it emphasizes how important a mental health promotion approach can be to improve their well-being and quality of life so as to improve their vulnerabilities. It is based on the belief that everyone has resources to draw on, skills to offer and talents to be nurtured. Mental health promotion therefore focuses on individual strengths as opposed to weaknesses. It seeks to build on personal and community resources for the development of health and the well-being of all individuals.

In the end, all efforts are to be geared towards empowerment of young people to take control of their lives. According to SSRU (2001), empowerment is the very basic framework upon which the foundation of mental health promotion is constructed. They hold the view that empowerment is mental health promotion – people and communities

recognizing and fostering their own sense of personal strength through determining their own destinies and having the personal and material resources to do so in a supportive environment. They believe that empowerment in mental health promotion also involves a sense of personal control; the feeling that one can rely on oneself or others when facing difficult situations.

In summary, a mental health promotion approach is built on the foundation of fostering personal resilience through empowering all individuals to strengthen their coping skills, self esteem and personal efficacy and to effectively utilize the resources offered by a supportive environment. It is the most appropriate framework for this study which hopes to contribute towards young people being resilient in the wake of extreme adversity, as opposed to being at risk for negative mental health outcomes.

1.2.4 Health promoting schools as a strategy for mental health promotion

The aforementioned holistic principles are a key part of the health promoting schools framework. In terms of this framework, health is defined as overall well-being and includes physical, social, psychological, spiritual and environmental health. The World Health Organisation (WHO) defines a health promoting school as follows,

The health promoting school is a place where all members of the school community work together to provide students with integrated and positive experiences and structures that promote and protect their health. This includes both the formal and informal curricula in health, the creation of a safe and healthy school environment the provision of appropriate health services and the involvement of the family and wider community in efforts to promote health (WHO, 1996:2).

According to the National Guidelines for the development of Health Promoting Schools/Sites in South Africa (DoH, 2000:10), a number of principles and priorities find resonance in the health promoting schools approach. These include,

- A commitment to intersectoral collaboration through co-operative governance;
- Empowerment of communities through optimal participation in and ownership of initiatives that affect their lives;
- Social inclusion, particularly of people who have been historically excluded and marginalized;
- An emphasis on human rights and responsibilities;
- A holistic approach to development and comprehensive approaches to action that target all aspects of the system;
- The development and provision of quality, affective and efficient services and programmes, where existing material and human resources are optimally utilized;
- Improved access to services, with a commitment to equity and redress in the development and provision of services, with a particular emphasis on those who are most vulnerable;
- A common understanding of and commitment to national priorities in terms of factors that place young people at risk, such as poverty, HIV/AIDS, drug and other forms of abuse and various forms of violence;
- A recognition of schools as important settings to address the challenges outlined above with a particular emphasis on life skills education as a preventative strategy.



The health promoting schools framework therefore provides a supportive framework for mental health promotion. It provides comprehensive strategies for addressing issues that place learners at risk (DoH, 2000). It addresses needs for support, the need for parent-school collaboration, community partnerships and in the process, facilitates whole school development. It has the potential to facilitate resilience by providing a supportive environment for young people.

According to Swart and Reddy (1999), South Africa has adopted and commenced with implementing the health promoting schools concept in an attempt to address the historical imbalances and its consequences. The transition from an Apartheid government to a democratic government in 1994 resulted in major transformations in terms of policy and practice in the Education, Health and Welfare sectors in South Africa. Equity and redress, non-discrimination and cost-effectiveness were some of the principles that governed new policies in these sectors. In terms of interventions in working with individuals and communities, there was a shift from the medical model to the systemic model. For example, in the health sector, this meant moving away from the traditional model of

school health which emphasized screening for impairments, growth monitoring, assessment for nutritional conditions and health education (Swart & Reddy, 1999). In education this meant that psychological and other education support services would focus less on change within the individual and look at facilitating change at the level of the school, the family and the community. The development of health promoting and inclusive schools has formed a key part of this change process (Johnson & Lazarus, 2003).

1.2.5 Utilising the curriculum as a key strategy to address challenges

The following definition of what constitutes a curriculum provides the basis for all discussions related to curriculum in this study. This definition is favoured because of its comprehensive nature and because it emphasises the fact that curriculum is so much more than just the lessons taught in a classroom,



The curriculum in its full sense comprises all the opportunities for learning provided by a school. It includes the formal programme of lessons in the timetable; the so-called ‘extra-curricular’ and ‘out of school’ activities deliberately promoted or supported by the school; and the climate of relationships, attitudes and styles of behaviour and the general quality of life established in the school community as a whole. Whatever formal programme is adopted, account has to be taken of the other less formal and seemingly less structured programme, and of the interactions between the two (Department of Education and Science (DES), 1980).

The curriculum therefore has to take broader socio-cultural issues into account and factor in their influence on the learning process. Over the past ten years, thinking related to the curriculum in South Africa has been informed by the fact that, “Issues such as poverty, inequality, race, gender, age, disability and challenges such as HIV/AIDS all influence the degree and way in which learners can participate in schooling” (DoE, 2003:2). The curriculum in South Africa aims to develop the full potential of each learner as a citizen of a democratic South Africa. Integral to this process is outcomes-based education,

“Outcomes-based education forms the foundation of the curriculum in SA and strives to enable all learners to achieve to their maximum ability “(Department of Education (DoE), 2003:1). The curriculum is governed by learning area statements. All the learning area statements try to create an awareness of the relationship between social justice, human rights, a healthy environment and inclusivity. Learners are also encouraged to develop knowledge and understanding of the rich diversity of this country, including the cultural, religious and ethnic components of this diversity (DoE, 2003).

The most significant development of the new curriculum for the purposes of this study is the Life Orientation (LO) learning area. According to the DoE (2003:3), the Life Orientation learning area guides and prepares learners for life and its possibilities. Specifically, the LO learning area equips learners for meaningful and successful living in a rapidly changing and transforming society. The LO learning area is central to the holistic development of learners. It is concerned with the social, personal, intellectual, emotional and physical growth of learners and with the way in which these facets are interrelated. The focus is the development of self in society. The learning area’s vision of individual growth is part of an effort to create a democratic society, a productive economy and an improved quality of life.

Life Orientation encompasses Life Skills Education (LSE). It is here where many of the skills related to developing resilience are dealt with. The skills that relate to enhancing personal strengths to ward off adversity are imparted. These include self growth, listening skills, interpersonal skills, goal setting, tolerance, communication, conflict management, negotiation skills, counseling skills, social skills, coping skills, assertiveness, problem-solving skills and so forth.

In 2003, UNICEF commissioned a three-month investigation into Life Skills Education (LSE) activities nationally in South Africa in order to prioritise the direction for future development. The UNICEF workshops revealed that,

Life skills should be all encompassing and taught across the curriculum as well as through the special focus in the Life Orientation learning area. Within schools, all subjects should teach those aspects of life skills relevant to them. Communities and families should all be involved in monitoring and evaluating life skills education. LSE activities in schools need to be integrated more closely with communities (UNICEF, 2004:58).

The UNICEF workshops revealed the belief that participants have that general well-being can be achieved through LSE and is summed up best as follows, “I believe all individuals will enjoy greater resilience and serenity if enabled with life skills” (UNICEF, 2004:69).

1.2.6 A focus on youth placed at risk

Numerous studies have been conducted in South Africa to ascertain the extent to which young people are at risk for self-destructive behaviours (Gould, King, Greenwald, Fisher, Schwab-Stone, Kramer, Flisher, Goodman, Casino & Shaffer, 1998; Flisher, Parry, Bradshaw & Juritz, 1997; Flisher, Joubert & Yach, 1992). More recently the focus has been on the relationships between various risk behaviours and more specifically, on the relationship between risk behaviours and suicide (Flisher, Kramer, Hoven, King, Bird, Davies, Gould, Greenwald, Lahey, Regier, Schwab-stone & Schaffer, 2000). A key reason for the focus on risk behaviour amongst adolescents has been the link between poor mental health and other behaviours that are damaging to health and also the link to mental health problems in adulthood. Poor mental health for example, has been associated with alcohol and drug abuse, physical illnesses, violence and suicidal ideation/attempts (Flisher et al, 2000).

During 2002, the South African Medical Research Council (MRC) conducted a comprehensive nationwide survey to demonstrate the prevalence of risk behaviours of youth in the South Africa. The MRC Report (2003:12) revealed the following: 17% of learners carried weapons and 41% had been bullied in the past month; 14% belonged to gangs during the past six months, and 10% had been forced to have sex. On school property during the past month 9% of learners carried weapons, 15% were threatened or

injured and 19% were injured in physical fights, while a third (32%) felt unsafe at school. Over one third of learners (35%) had ever been driven by someone who had been drinking, while 8% had ever driven after drinking. Alcohol consumption ranged from 49% for ever having used it, 32% for drinking in the past month and 23% had engaged in binge drinking in the past month. With regard to smoking, 31% had ever smoked. Among current smokers, 84% had been exposed to passive smoking in the past week, and 48% of them had a parent or guardian who smoked. Drug consumption varied from 13% for ever using dagga, 12% for heroin, 11% for inhalants and 6% for Mandrax. With regard to sexual behaviour, 41% of learners had had sex, and the age of initiation of sexual activity was under 14 years for 14% of them. Among the learners that had ever had sex, 54% had more than one past sexual partner, 70% had had sex in the past three months, 14% had had sex after consuming alcohol or drugs, only 2% practiced consistent condom usage, 16% had been pregnant, and overall, 72% had received education regarding HIV and AIDS. Eleven percent of learners were stunted (low height for age), 9% were underweight (low weight for age), and 4% had wasting (low weight for height). The prevalence for being overweight was 17% and the prevalence of obesity was 4%. With regard to physical activity, 29% had no physical education classes and 25% watched TV for over 3 hours per day. With regard to hygienic practices among learners, 89% brushed their teeth daily, 89% had their own toothbrushes and 76% washed their hands after going to the toilet.

In other studies, young people themselves have also been involved in identifying key areas of concern in terms of their mental health and well being in international studies. They have identified the following as requiring urgent attention (EPPI, 2001),

- violence;
- bullying;
- physical appearance;
- coping with stress and anxiety;
- social support;
- opportunities for recreation.

Coping with stress and anxiety and the need for social support are two areas of concern that have been identified as important for this study. These two areas of concern are closely linked to depression and suicide. The World Health Organisation has identified depression as the mental health illness that will dominate the field by the year 2020 (WHO, 1999a). The reason for exploring the area of depression is that it has been strongly associated with high rates of suicidal ideation. This could vary in intensity from transient thoughts of wishing to be dead, to the making of plans and finally, to actual attempts to commit suicide (Farmer, Redman, Harris, Webb, Mahmood, Sadler & McGuffin, 2001).

Of concern is the fact that there seems to be a steady increase in the number of incidences of attempted suicide and actual suicide-related deaths amongst young people. Kerfoot (2000) points out that suicide rates in young men in general have shown an overall upward trend since the early 1970s and deliberate self harm is increasing amongst young women. Also, while severe mental illness such as schizophrenia and other psychotic disorders are low amongst young people, suicide has been identified as a major cause of mortality in this age group. In a study conducted in the Cape Peninsula (Flisher, Ziervogel, Chalton, Leger & Robertson, 1993) the prevalence of a wide range of risk-taking behaviour among high school students in the Cape Peninsula was investigated. It was found that 19% of students had seriously thought about harming themselves in a way that might result in their death, 12.4% had told someone that they intended to put an end to their life and 7.8% had actually tried to put an end to their life. This situation has intensified according to the latest MRC Report (MRC, 2003) which states that in the past six months, a quarter of learners (25%) had experienced feelings of sadness or hopelessness, 19% had considered suicide and 17% had attempted suicide; 28% of those who attempted suicide required treatment.

If we agree that reducing morbidity and mortality among adolescents depends on early recognition and identification of health risks (Harrison, Beebe & Eunkyung, 2001), then we need to seriously consider the reasons for the continuing increase in incidences of self-harm amongst adolescents. While the reasons for self harm vary considerably, it was

found that significantly large numbers of suicidal subjects experienced family conflict, problems at school and problems with boy/girlfriends during the preceding six months when compared to a control group (Pillay & Wassenaar, 1997). These results serve to emphasise the importance of supportive relationships at school, at home and within their social circles.

1.2.7 A shift in focus from risk to resilience

Despite the risk results presented earlier, the area of resilience research provides us with possible solutions to the dilemma of increased engagement in risk behaviours by South African youth. According to the SSRU (2000), resilience is an integral concept in the explanation of mental health promotion. Our capacity for resilience determines whether we bounce back from our lows and learn from them in a positive way or whether we are left in a state of frustration, depression or self-destruction. Individual resilience is the vital sense of flexibility and the capacity to re-establish one's own balance; the essential feeling of being in control with regard to oneself and to the outside world. The sense of being in control can be related to,



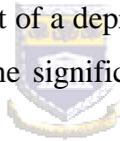
- a sense of being - the way we are and how we feel about ourselves;
- a sense of belonging - the way we relate to others and to our social, physical and cultural environments; and
- a sense of becoming – what we do in our lives, our aspirations and how we develop.

According to Benard (1997), at least 50% and usually closer to 70% of children born into extremely high-risk environments grow up to be not only successful but confident, competent and caring persons. She expresses the concern that even though focusing on children and families at risk have succeeded in getting needed services to children and families, it has led to stereotyping, tracking, lowering expectations for many students and even prejudice and discrimination. Benard (1997) sees resilience as the human capacity of all individuals to transform and change, no matter what the risks; as an innate self-righting mechanism. Resilience skills, according to Benard (1997), include the ability to form relationships (social competence), to problem-solve (metacognition), to develop a

sense of identity (autonomy), and to plan and hope (a sense of purpose and future). Benard (1997) also stresses the power of teachers to tip the scale from risk to resilience. This relates to our understanding of the role of health promoting schools in facilitating mental health promotion,

A key finding from resilience research is that successful development and transformative power exist not in programmatic approaches per se but at the deeper level of relationships, beliefs and expectations and willingness to share power. Schools need to develop caring relationships not only between educator-student but also between student-student, educator-educator, and educator-parent. Overall, schooling that has been a turnaround experience for stressed young people is described by them as being like ‘a family’, ‘a home’, ‘a community’ and even a sanctuary’ (Benard, 1997:2).

It seems therefore that the key to facilitating resilience is the support that is provided to the young person in distress. This support needs to occur at different levels such as the individual, the family, peer, community and the school environment. McClean (1984), points out that to avoid the development of a depressive outlook and to foster self esteem, a supportive environment or at least one significant other is needed to provide support, encouragement and positive regard.



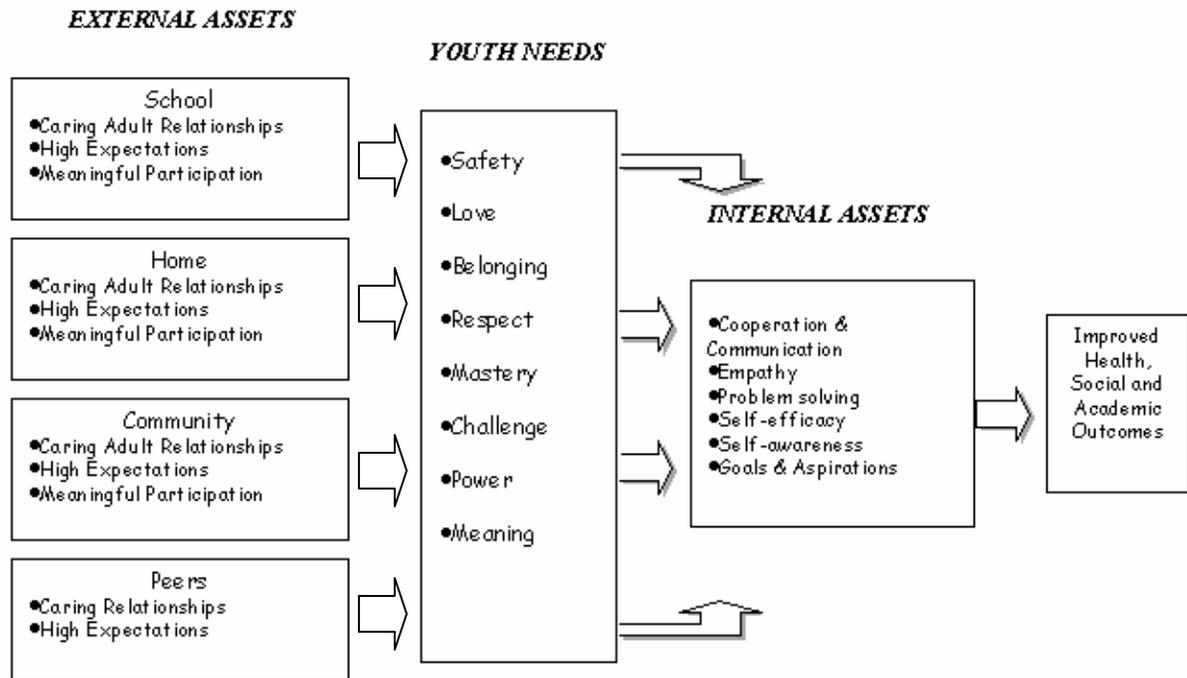
1.2.8 The provision of support as the key to facilitating resilience

This emphasis on support is the cornerstone of the youth development or resilience model developed by Bonnie Benard and colleagues, that serves to inform the resilience module of the California Healthy Kids Survey (WestEd, 2003a),

When young people experience home, peer, school and community environments rich in the developmental supports and opportunities of caring relationships, high expectations and opportunities for meaningful participation, these needs are met. In turn, youth develop the individual characteristics that define healthy development and successful learning—and protect against involvement in health-risk behaviors such as alcohol, tobacco, and other drug abuse and violence (WestEd, 2003a: 2&3).

The aforementioned beliefs and principles are captured in the following model,

Figure 1.1 The Youth Development Conceptual Model (YDCM) (WestEd, 2003a: 3)



In terms of the aforementioned model, support in the form of caring relationships, high expectations and meaningful expectations from significant others in the lives of youth which meet the needs for safety, love belonging, respect, mastery, challenge, power and meaning will result in the development of internal strengths such as co-operation and communication, empathy, problem-solving, self-efficacy, self-awareness and goals and aspirations which in turn will result in improved health, social and academic outcomes.

The Youth Development Conceptual Model serves as an important model to explore within the health promoting schools framework in order to maximize the potential of young people to achieve favourable life outcomes and to contribute positively to the relatively young South African democracy.

1.3 RESEARCH AIMS AND METHODOLOGY

This research aimed to explore factors relating to risk, resilience and health promoting schools in order to promote resilience amongst youth in South Africa. The specific research objectives were as follows,

- To determine the mental health needs of Western Cape youth;
- To determine the strengths of Western Cape youth;
- To determine the form and extent of support being provided to Western Cape youth;
- To explore the health promoting schools framework as a strategy for support provision and thus securing the well-being of Western Cape youth.

This research will have a significant impact on the development of mental health promotion in schools in terms of,

- Developing the capacity of schools, educators and parents to secure healthier outcomes for youth;
- Facilitating the development of various forms of support for learners;
- Facilitating the development of a curriculum aimed at promoting the well-being of learners;
- Further developing the health promoting schools framework to include mental health promotion and resilience;
- Informing policy and practice on strategies for facilitating mental health promotion within the schools.

This research followed a descriptive design. Quantitative and qualitative research methodologies were employed. Data collection techniques included surveys, questionnaires, interviews and focus groups. A survey was conducted with grade nine learners at seven high schools in the Western Cape. The survey assessed risk and resilience profiles. The risk component assessed bullying and harassment, violence and safety, diet and exercise, depression and suicide, and sexuality. The resilience component assessed the extent to which young people experience caring relationships, high expectations and meaningful participation in the school, at home, in their community and amongst their peers and the extent to which this support translated into the development

of internal strengths. School connectedness was also examined. Focus group interviews were held with a sample of the same learners who participated in the survey. The aim was to supplement the information gathered from the survey regarding issues of risk, resilience and support. Questionnaires were distributed and interviews conducted with guidance counselors or school psychologists. This was to ascertain their views regarding the mental health status of youth, support for learners and staff members, and the health promoting schools concept.

The various techniques were chosen because they were most likely to provide accurate information, elicit the data needed to gain an understanding of the phenomenon in question, contribute different perspectives on the issue and make effective use of the time available for data collection (Glesne & Peshkin, 1992). Also the use of both quantitative and qualitative methods minimised many of the limitations associated with focusing on one or the other approach.

1.4 CHAPTER OUTLINE



The first chapter outlines the motivation and rationale for the study. It highlights the need for research that will lead towards the prevention of youth at risk and the development of positive outcomes for youth. It examines the school system and the health promoting schools framework as a means for the provision of support to young people in order to strengthen their resilience. Chapter two presents a literature review of scholarly works related to notions of risk, resilience, support and health promoting schools. The key words served as a guide for the literature review. Journal articles, books, policy documents, reviews, theses, conference presentations and various published and unpublished works were utilised. Chapter three outlines in detail the methodology utilized in this investigation. The processes and techniques involved in gathering and analyzing the data are discussed. Chapter four presents the research findings related to the risk profiles of the youth involved in the study. Chapter five presents the resilience profiles of the youth involved in the study. Chapter six presents the findings related to support and the health promoting schools framework. Chapter seven presents the research

findings according to seven case studies. Chapter eight involves a detailed discussion of the research findings and links the findings to relevant theory. Chapter nine presents conclusions and recommendations. Reflections on the extent to which research aims were met are made. The limitations of the study are presented and proposals for future research are outlined.

1.5 CONCLUSIONS

This study is concerned with developing resilient youth who are able to experience success in the wake of extreme adversity. It draws upon mental health promotion, health promoting schools and resilience research as organizing frameworks to inform its research process and findings. A mental health promotion approach is built on the foundation of fostering personal resilience through empowering all individuals to strengthen their coping skills, self esteem and personal efficacy and to effectively utilize the resources offered by a supportive environment. The health promoting schools framework provides an organizing framework for enhancing external supports such as the school, the home, community and peers. The resilience framework focuses on the development of internal strengths and characteristics that assist young people in making the right choices to secure successful outcomes. It is hypothesized that providing young people with the necessary external strengths in the form of school, home, community and peer support within a health promoting schools framework, will lead to overall positive mental health and well-being.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

Because of its particular history of Apartheid that involved many human rights violations, the South African situation requires a unique approach to healing the transgressions of the past and its resultant negative mental health outcomes. What is required is a focus on healing and positive outcomes in the wake of numerous challenges. The following chapter aims to explore in detail the notions of positive mental health and well-being and the mechanisms for achieving these optimal states. This is achieved by exploring,

- the progression from an emphasis on illness and risk to an emphasis on well-being and resilience, and
- enabling mechanisms and support systems that facilitate the transition from risk to resilience.



An attempt is made throughout this chapter to relate developments in these areas to the South African context in an attempt to generate solutions for the mental health problems experienced by the youth in South Africa.

2.2 MENTAL HEALTH

2.2.1. Exploring mental health

For those involved in the field of mental health, there is general consensus that mental health is not simply the absence of mental illness, but also means having the skills necessary to cope with life's challenges (National Association of School Psychologists (NASP, 2003). It therefore by implication involves competence and strength and is a positive and desirable human state. Mental health is described by the World Health Organisation as the foundation for well-being and effective functioning for an individual

and for a community (WHO, 2004b: 11). According to the WHO (2004b), mental health has been variously conceptualized as a positive emotion or affect such as feelings of happiness, a personal trait inclusive of the psychological resources of self-esteem and mastery and as resilience which is the capacity to cope with adversity.

Good mental health is not just important for certain individuals but is important for everyone, especially school-going children, and mental health problems cannot be ignored. “If ignored mental health problems can interfere with children’s learning, development, relationships and physical health” (NASP, 2003:1). The identification, treatment and prevention of mental health problems amongst the youth is therefore of critical importance. We are however cautioned by Landsman (1994) that metaphors from the medical model still pervade the prevention model of mental health. The focus is largely on tertiary prevention and on the provision of curative services. Inherent in Landsman’s caution is the awareness that the focus in mental health promotion ought to be largely on promotion of positive mental health and on securing the well-being of all individuals, not just those experiencing mental health problems.



Mental health is therefore the product of biological, psychological and social environments (both past and present), health, care and lifestyle (Brown, 2001). This view is endorsed by the WHO (2004b) who states that mental health and illnesses are determined by multiple and interrelated social, psychological and biological factors,

The clearest evidence for this relates to the risk of mental illness which in the developed and developing world is associated with indicators of poverty, including low levels of education and poor housing and low income. The greater vulnerability of disadvantaged people in each community to mental illness may be explained by such factors as the experience of insecurity and hopelessness, rapid social change and the risks of violence and physical ill health (WHO, 2004b: 11).

This systemic view draws our attention to the fact that good mental health is not solely the responsibility of the individual but also the responsibility of the society in which the

individual finds him/herself. This understanding of health and mental health can hold the key to more effective healing practices and service delivery.

2.2.2 A holistic and systemic approach to mental health

In order to develop a holistic and systemic approach to mental health, it is important to first understand the core principles of systems thinking as it relates to matters of mental health and well-being.

According to Moloï (2002), systems thinking teaches that we will arrive at a better understanding of any social phenomenon if we look at the whole picture. We then learn not to view events as isolated phenomena but to see them in relation to other issues, events and forces around us. Systems thinking encourages us to analyse events in terms of multiple, rather than single causation. It is a way of thinking about and a language or discourse for describing and understanding the forces and interrelationships that shape our behaviour. Moloï (2002) further explains that individual and collective behaviour is embedded in the natural world in which people live and interact. Behaviour can therefore be said to be dynamic rather than static as it is based on dynamic interaction with the natural world that surrounds us. As far as transformation is concerned, Moloï (2002) argues that inputs and outputs exist in a system where a transformation occurs. The inputs are the products of the environment that influence the system and the outputs are the influence of the system on the environment. Both inputs and outputs are separated by factors such as time.

There are several advantages of systems thinking as it applies to mental health (Ruegger & Johns, 1996:77),

- Systems thinking allows for environmental factors to be considered alongside personal factors in understanding and responding to problems presented by families;
- Systems thinking moves away from simplistic cause and effect explanations as such explanations often lead to scapegoating within families as well as schools and other systems;

- Systems thinking is an approach which includes work with individuals, families and communities and therefore includes individual work and social reform;
- Systems thinking avoids making judgements from the outside, but attempts, rather, to start from people's own understanding of their situation from within their systems.

Relating directly to systems thinking is the eco-systemic framework developed by Urie Bronfenbrenner. Eco-systemic thinking essentially emphasizes the multiple contexts in which an individual develops. These contexts or systems are known as the microsystem, mesosystem, exosystem and macrosystem. The microsystem is the innermost level and speaks to the individual's immediate environment (individual, family influences). The mesosystem is the second level and speaks to connections among things in the microsystem (community, cultural influences). The exosystem is the third level and speaks to social settings not containing the individual (societal influences). The outermost level and speaks to values, customs, laws, beliefs and resources (global influences) (Bronfenbrenner, 2005; Kohn, 2000). According to eco-systemic thinking, development consists of environmental systems ranging from fine-grained inputs of direct interactions with social agents, to the broad-based inputs of culture (Kohn, 2000). Eco-systemic theory argues that development must therefore be studied within a social context.

Systems thinking in general and eco-systemic thinking in particular, enables us to think more broadly about the factors that impact upon mental health. It enables us to understand more clearly why some individuals present with mental health problems and others don't; why manifestations of ill health present more readily amongst individuals in impoverished communities; and that focusing solely on the individual in trying to understand behaviour is limiting. A systemic approach holds much promise in terms of intervening effectively in the lives of individuals and communities and restoring health and well-being.

Systems theory teaches us that mental health and well-being cannot be extricated from social and cultural variables. This confirms the WHO view that "mental disorders are inextricably linked to human rights issues" (WHO, 2004c: 5). It seems that if we are

serious about ensuring the health and well-being of all people, advocacy and strong political intervention is required. According to the WHO (2004b), a climate that respects and protects basic civil, political, economic, social and cultural rights is fundamental to the promotion of mental health. We can therefore no longer see only the manifestations of ill mental health and ascribe them to individual factors. Once we recognize that society has a large role to play in the manifestations of individual and collective ill health, then we need to advocate for large-scale societal changes beginning with how we understand ill health to how we deliver services.

2.2.3 Mental health in South Africa

The Department of Health in South Africa has identified mental illness as a major cause of morbidity as well as some mortality particularly amongst citizens at risk in South Africa (DoH, 1997). Common manifestations are identified as interpersonal violence, gender and age-specific forms of violence, trauma, neurosis of living under continual stress, post-traumatic stress reactions and disorders, substance abuse, suicide, and adjustment-related reactions and disturbances in children and the elderly (DoH, 1997). Whilst the manifestations of mental illness are no different from those found in other countries, what is significant about South Africa is the fact that the Department of Health regards the citizens most at risk as those belonging to communities that have endured state neglect and abuse for decades. Due to the segregated nature of service provision in the past, mental health promotion and the provision of services have been seriously neglected in the poorest communities. These communities, due to their socio-economic status, poverty and resultant pressures, also required health services the most.

What is becoming evident are the parallels between the South African situation and the indigenous people of other countries. Mental illness seems to manifest most strongly in South African communities that have been displaced and oppressed. Furthermore, services have not been geared towards securing the well-being of the communities that require them most. Services have not been made available, let alone adapted to the cultural perspectives and needs of the people they serve. What is being manifested as

signs of ill mental health is largely as a result of the devastation of 400 years of colonization, including Apartheid (Lazarus, 2004). Lazarus (2004) argues that we need to recognize the role of historical trauma in the high substance abuse and violence figures in South Africa and invest in healing of the trauma that has resulted.

In redressing the inequalities of the past, the Department of Health has expressed its commitment towards successfully improving and promoting the psychosocial well-being of all communities (DoH, 1997). The emphasis in service provision at present is in terms of ensuring adequate services to all South Africans. Efforts are geared towards primary health care with prevention and health promotion regarded as urgent priorities. Once these basic services are in place, one would need to advocate for a framework of intervention that takes into account communities' cultural beliefs, values and practices and place a high premium on the contribution that these beliefs, values and practices can make towards healing. These current developments and future initiatives in the mental health area are becoming increasingly important in lieu of the increase in mental health problems amongst the youth.



The South African government's commitment to the health and well-being of young people is demonstrated in the Report of the Medical Research Council (MRC) of South Africa (2003). The report states that since 1994, the SA Government has undertaken several international legislative and country-level policy initiatives to promote the health and well-being of young people, for example, by signing the World Summit Declaration and the ratification of the Convention on the Rights of the Child, and the Framework Convention for Tobacco Control. The National Plan of Action for Children is cited as a further illustration of existing commitments to improving the health of the youth in SA. The Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and Sexually Transmitted Infection (STI) Strategic Plan for South Africa 2000-2005 is mentioned which highlights youth and their sexual behaviour as a priority both for research and service delivery.

The Ministry of Education's five year plan entitled "The Tirisano Programme" to transform the education and training system in SA from one of segregation and disparity to one of equal opportunity for all South Africans is lauded by the MRC report (2003). This programme spans both the educational and health needs of learners to include sexuality, gender, substance misuse and HIV and AIDS. Additionally, a Drug Policy that bans the use, distribution and possession of both legal and illegal drugs has been implemented within the school system is also noted. According to the MRC Report (2003), the above policies have established a constitutional and legislative foundation, which in turn creates the milieu needed to promote health and development interventions for young people.

According to Flisher, Cloete, Johnson, Wigton, Adams and Joshua (2000), approximately half of all provincial departments of Health and Education have developed policy documents regarding school health; in most provinces there is collaboration between departments in developing programmes for school-aged young persons; and in almost all provinces school health programmes are currently being implemented in primary and secondary schools and even pre-primary schools, "Such programmes include counselling and other mental health interventions, feeding programmes and education regarding the environment, sexuality and life skills" (Flisher et al, 2000:114).

A significant development for the purposes of this study is the development of National guidelines for the development of health promoting schools/sites in South Africa (DoH, 2000). This document outlines the vision and principles to guide the development of health promoting schools/sites in South Africa, "The purpose of the guidelines is to put in place comprehensive strategies that will improve the ability of schools/sites to enhance the well-being and development of their community" (DoH, 2000:16).

2.2.4 Mental health status of youth in South Africa

In discussing the mental health status of youth in South Africa, it is important to first sketch the social and political circumstances that they are faced with in order to fully

understand the manifestations of mental health problems amongst the youth. Findings presented in the Foresight Youth Report of the Department of Arts, Culture, Science and Technology (DACST, 1998) will be the primary frame of reference.

The South African population is an overwhelmingly young one. This is confirmed by the DACST Report (1998) and the MRC Report (2003). Young women and men aged between 14 and 35 comprise 39% of the total South African population (DACST, 1998) with children and adolescents below the age of 19 years making up half of South Africa's population (MRC, 2003). The overall trend is that young women and men comprise the bulk of the total population, with the lower age group comprising a greater proportion of the youth than the higher age group. Those aged between 14 and 21 comprise 43% of all youth in the country, and those aged 30 and 35 comprise just over a fifth (23%) of youth (DACST, 1998).

The extent of underdevelopment that the African population of South Africa endured under Apartheid is clear when we look at the age distribution of the South African population by race and gender. A large proportion of African people is made up of infants and young children, while among those aged 15 years or older, the proportion of people in each age category steadily decreases. Among Coloureds and Indians, a transitional profile of age distribution is emerging. The situation is somewhere between that of developing and developed countries. Among whites, the profile is typical of industrialized countries. There are proportionately fewer infants, pre-school children and children of school-going age, than in the other population groups, while the proportion of older people is increasing.

Almost half (49%) of African youth live in households that at some point in time are unable to feed their children. The same is true of 35% of Coloured, 11% of Indian and 6% of White youth. The phenomenon of being unable to feed the children in a household was most common among youth living in households in traditional rural dwellings (57%), informal dwellings in backyards (54%), and informal settlements (53%).

Youth living in informal settlements and in informal backyard dwellings commonly express feelings of being very unsafe. The very high incidence of domestic violence, rape and physical abuse has a severely negative effect on the youth. Exposure to negative media and programming contributes to this culture of violence. Moral degradation has led to a justification of criminal activities for personal gain, with gang members seen as role models in poverty-stricken urban areas. Alarming numbers of youth are being diagnosed as HIV positive. Many communities lack basic domestic infrastructure such as running water and sanitation, which leads to contamination and disease. Welfare services are inaccessible and ineffective in curbing widespread substance abuse and the high incidence of teenage pregnancy. The degradation of the family unit has a negative effect on the formation of core value systems for young people (DACST, 1998).

Considering the aforementioned data, it is therefore not surprising that the mental health status of the youth in South Africa warrants serious concern. Increasing incidences of crime, violence, self - harm and homicide suggest that urgent intervention is required. It is estimated that 20% of children in South Africa suffer from a mental illness due to the high levels of violence and family problems (Depression and anxiety support group, 2002). It is further estimated that three and a half million youth in South Africa have experimented with drugs and similar substances during the past year. One in six are expected to become drug dependent. Suicide has become a leading cause of death in the 15 to 24 year age group. AIDS is surging ahead and the spread of HIV infection is particularly alarming (The Youth Enrichment Programme, 2002). According to Brian Robertson (2001), Southern African children, some of whom are still living in virtual war zones (due to gang activity), have been found to have excessively high levels of anxiety and other mental health problems and this contributes to the increasing prevalence of youth suicide and of serious assaults and homicide by younger and younger perpetrators.

The results of the National Risk Behaviour Survey (MRC, 2003) as presented in chapter one confirm the aforementioned findings regarding the status of youth in South Africa. It also seems that the aforementioned state of affairs will not easily dissipate in the near future. According to Flisher et al (2000), there is evidence that the prevalence rates of

risk behaviour will continue to rise with the increased urbanization of young people in South Africa. This is confirmed by the DACST Report (1998) which argues that South African youth will face significant challenges in the foreseeable future as forces, both within and outside of their control affect the health of young people around the world. Accidental death and violence are high among youth. Experimentation with tobacco, alcohol and drugs cause addictions and negative behaviour. Unprotected sexual activity results in unwanted pregnancies and the spread of sexually transmitted diseases, including HIV/AIDS. A lack of information and affordable health care has adverse repercussions on the health of the youth. Failure to curb sexual and physical abuse and domestic violence can lead to the incapacitation of the victims and a degradation of the family unit. Ineffectiveness of government policy and the justice system is leading to the formation of vigilante groups and a general breakdown of law and order. The resultant stress may cause young people to demonstrate dangerous levels of anger and aggression. Gang members seen benefiting from criminal activities with little fear of prosecution may justify this lifestyle in the eyes of young people. An increase in drug trafficking in South Africa will lead to further degradation of communities. A catastrophic death rate among youths is a real threat as HIV-positive people increasingly develop AIDS, which will remove a large portion of the country's current and future economically active population.

Of greater concern is the fact that these problems have spilled over into the schools and are having a negative impact on the learning process. Many schools have been affected by HIV/AIDS, alcohol and drug abuse, violence, theft, disruptive behaviour and other problems. "No school is untouched or can afford to be complacent" (The Youth Enrichment Programme, 2002:1). However, the majority of South African schools have insufficient facilities and resources, particularly in rural areas. Many teachers, particularly in mathematics and physical science are poorly qualified with limited in-service training taking place. Large classes and high learner-teacher ratios inhibit high-quality education. Moreover, youth demonstrate poor analytical and creative problem-solving abilities relative to international standards (DACST, 1998).

According to Simpson (2002), no effective strategy for preventing violence in schools can be developed unless we understand the legacy of Apartheid and its impact upon education. Schools were vehicles of opposition against the state. Disruption, chaos and violence were acceptable means of demonstrating unhappiness with the ruling apartheid regime. Education was not available to all and many young people did not receive adequate education. Many hopes were dashed as opposed to dreams being realised through education. Any attempt to address the needs of the youth have to take into account the past and reconstruct new meaning in terms of the purpose and value of education. Part of the process would involve building bridges with communities and recreating a sense of belonging in society (Simpson, 2002). The school should therefore become the vehicle for developing strengths and enhancing competencies, for ensuring positive outcomes for our youth, for producing young people that make a positive contribution towards society.

According to the MRC Report (2003), almost 12 million children are enrolled in schools and they account for 28% of the total population. The South African Schools Act of 1996 makes schooling compulsory for all 7 to 15 year olds. The school therefore facilitates access to a large number of young people. Furthermore, schools in South Africa provide a relatively stable environment that can influence the lives of a wide array of people such as learners, educators, parents and community. Many schools have the infrastructure to support health promotion interventions making them ideal centers for community development,

The transition to democracy has made schooling compulsory, which means large numbers of young people are now engaged in the process of education. The school setting therefore provides an appropriate social context to obtain information about young people and their behaviours, and this setting is also ideal for future health interventions (MRC, 2003:14).

Irrespective of the challenges presented earlier, there are therefore, many positive factors which augur well for South African youth. According to the DACST Report (1998), South Africans have a strong, diverse culture. South African youth demonstrate a strong affinity for and natural interest in sport which provides them with a positive, constructive

pastime. Youth also demonstrate creative potential, which is manifested in a strong diverse culture of music. The overall welfare of youth is improving as a result of the government's strong national policies with regard to primary health care, HIV/AIDS and tobacco smoking (DACST, 1998).

In summary, while steady progress is being made in most areas related to youth development, greater attention has to be paid to meeting the mental health needs of youth. This is to prevent the tidal wave of crime and risk behaviour mentioned earlier from developing into a groundswell that will engulf our communities and undermine the good attempts aimed at developing a truly democratic society in which the youth could play an active and positive role. One way of meeting the needs of our youth is to look towards health promotion for intervention strategies.

2.3 MENTAL HEALTH PROMOTION

2.3.1 Mental health in the context of health promotion

According to the WHO, the twin aims of improving mental health and lowering the personal and social costs of mental ill health can only be achieved through a public health approach, "Within a public health framework, the actions that can improve health include the promotion of health, the prevention of illness and disabilities and the treatments and rehabilitation of those affected" (WHO, 2004b: 15).

The advantage of the public health model within which health promotion is located, is that society as opposed to the individual is the client. Emphasis has therefore moved from addressing the health of the individual to considering the social aspects of health, including life style, socio-economic status, and preventive education (Strein, Hoagwood & Cohn, 2003). A central characteristic of the public health model is its emphasis on prevention. At the centre of prevention is the belief in the efficacy of early intervention (Adelman & Taylor, 2003, Strein et al, 2003). The goal of research within this public health framework is to develop specific interventions targeted towards the causal processes that lead to illnesses (Adelman & Taylor, 2003). The hopeful result in public health is the ultimate reduction in rates of particular disorders in populations (Strein et al,

2003). However, recently the focus is on the promotion of health, instead of the exclusive focus on the reduction of disease (Adelman & Taylor, 2003).

According to Simeonsson and Simeonsson (1999), to address children's health problems, needs and priorities within schools, the public health framework of universal, selected and indicated primary prevention, may be a useful model to design comprehensive programmes and services. Essential elements of a comprehensive community-based school health programme include health education, health activities and health services.

Simeonsson and Simeonsson (1999) argue that in order to develop a comprehensive programme to prevent health problems and promote the health of children in schools, a systemic approach must be taken. This systemic approach can be placed within the well-known conceptual model of primary, secondary and tertiary prevention, with an emphasis on primary prevention. They stress that this is in contrast to the medical model which has served as a major framework for health and health-related services in the schools. Within the medical model, the focus is typically on secondary prevention, in which the goal is to reduce the prevalence and severity of specific health conditions. In primary prevention the focus is on the prevention of illness and injury that is, on reducing the number of new cases of health problems. They list three levels of prevention activities (Simeonsson & Simeonsson, 1999:3),

- Universal prevention – programs and services based on the assumption that everyone is at average risk and has average needs;
- Selected primary prevention – addresses subgroups at increased risk and having increased needs. At this level identification for prevention efforts is based on membership in a group at increased risk, not on characteristics of the individual child;
- Indicated prevention – identification of increased risk is based on individual characteristics.

According to Simeonsson and Simeonsson (1999), these three levels of universal, selected and indicated prevention thus reflect increased levels of risk and increased degrees of specificity in providing prevention and health promotion services. The advantage of the afore-mentioned prevention approaches is that it secures the well-being

of all individuals by providing tailor-made solutions based upon needs assessments that take into account a particular community's available resources, values and belief systems.

The public health perspective has large-scale implications for education support services in general and for school psychological services in particular. Conceptualizing school psychological services from a public health perspective provide an even broader framework that can increase both the efficacy and efficiency of school psychologists' work (Strein et al, 2003). Specific aspects of the public health model that have particular relevance to school psychology include (Strein et al, 2003:27),

- Applying scientifically derived evidence to the delivery of psychological services;
- Strengthening positive behaviour versus focusing only on decreasing problem-behaviour;
- Including a strong focus on prevention, as well as treatment;
- Accenting community collaboration and linked services; and
- Using research strategies that may improve the knowledge base of school psychology and provide an effective framework for evaluating school psychological services.



The implications for the training of school personnel and future professionals include in-service and continuing education to ensure a common understanding and commitment to a comprehensive approach among administrators, teachers, social workers, physicians, allied health professionals, counsellors and school psychologists. Various members of the school-based team should be provided interdisciplinary training (Simeonsson & Simeonsson, 1999). Simeonsson and Simeonsson (1999) argue that we need to take into account the interacting roles of health, psychological and academic variables in defining the adaptive development and functioning of students.

In summary, an emphasis on psychodynamic approaches to mental health problems involving long-term treatment with much focus on the past are declining. Approaches that treat youth and families as collaborators in their care and that emphasise focusing on strengths, environmental factors, and interventions that have been proven to work, are increasing (Prodente, Sander & Weist, 2002). These new approaches based on the health

promotion framework are geared towards promoting the well-being of whole populations and focusing on the prevention of mental health problems as opposed to focusing on treatment. Interventions are informed by research aimed at determining and meeting the needs of communities. Communities take responsibility for their own well-being and are provided with the necessary skills to maintain good mental health. Health education, health activities and health services are core elements of each intervention. The focus of school psychological services changes to be more prevention oriented, geared towards community collaboration, aimed at strengthening positive behaviour and applying research strategies to provide effective services. The aim is ultimately to prevent mental health problems and to promote sound mental health of children in schools.

2.3.2 Mental health promotion as a focus in health promoting schools

Prodente et al (2002) contend that the neglect of child and adolescent mental health in the United States reflects a public health crisis and the public is generally unaware of the crisis or its component parts. There is thus a strong need to raise public awareness of problems in systems of child and adolescent mental health. Prodente et al (2002) argue that a second major component of raising public awareness should focus on the advantages of providing services in natural settings, with schools being the most universal natural setting (apart from homes). They believe that when more comprehensive services are provided in schools, the likelihood that students referred for services will actually receive them increases dramatically.

These arguments are supported by the National Association of School Psychologists (NASP) (2003) who argues strongly that mental health services for children and youth must be accessible. They regard schools as ideal settings to provide mental health services to children and youth. They argue that virtually every community has a school and most youngsters spend six hours a day there with trained, caring professionals. The school environment is (NASP, 2003:1),

- Tailored to learning and development;
- A natural context for prevention and intervention;

- Connected to community resources;
- Familiar and accessible to students and parents; and
- Designed to promote communication between home and school.

Adelman and Taylor (2000) support the utilization of schools for health intervention, “those concerned with enhancing the health status of children and adolescents know that schools provide an important venue for their efforts” (Adelman & Taylor, 2000:2). The recognition of schools as important venues for health related interventions led to the development of school-based health centers in the United States,

Minority children are at greater risk of poor health and are less likely to have a regular source of health care. Increasing access to health care is one of the primary reasons that school-based health centres (SBHCs) were established (Brown & Bolen, 2003: 48).

Historically, school-based mental health services have focused on students in special education and typically have been developed in responses to changes in special education legislation. More recently, education reform and an increasing emphasis on educational achievement have laid the groundwork for expanding school mental health and social services (Brener, Martindale & Weist, 2001). Brener et al (2001) argue that schools must have systems in place to address barriers to learning for all students, not just those in special education. The authors report that findings from the School Health Policies and Programs Study (SHPPS) 2000 indicate that states, school districts and schools are moving toward more comprehensive and effective school-based mental health care.

Prodente et al (2002) note that over the past decade, there has been a significant growth in expanded school mental health programmes that provide a full range of mental health care (assessment, treatment, case management, prevention) to youth in both general and regular education, through partnerships between schools and mental health agencies and programmes in the community. These programmes grew out of the realization that children’s mental health needs were not being met effectively by traditional programmes as well as the realization that children who are under stress, or who present with emotional or behavioural problems, have difficulty learning. The development of the

expanded school mental health framework has therefore been related to reform efforts both in children's mental health and education.

The Centre for Mental Health in Schools (2002) in California supports the argument that advancing mental health in schools is about much more than expanding services and creating full service schools. It is about establishing comprehensive, multifaceted approaches that help ensure schools are caring and supportive places that maximize learning and well-being and strengthen students, families, schools, and neighbourhoods. The document argues that there is a tendency to discuss mental health mainly in terms of mental illness, disorders or problems and that this de facto definition has led school policy makers to focus primarily on concerns about emotional disturbance, violence, and substance abuse and to de-emphasise the schools role in the positive development of social and emotional functioning. The document stresses that the definition of mental health in schools should encompass the promotion of social and emotional development (i.e. positive mental health) and efforts to address psychosocial and mental health problems as major barriers to learning.



Weist (2003) laments the fact that in the US they are really very far from a public health approach and even further from the WHO's model of health promoting schools, "The WHO's model of health promoting schools, emphasising population-based health promotion at the base, and the treatment for youth with serious problems at the apex, is essentially inverted in the US" (Weist, 2003: 80). As a consequence, Weist (2003) feels that staff who work in schools are contending with a flood of serious problems and crises, making the implementation of preventive and health promoting services very difficult. Weist (2003) argues that they need to look to examples from other countries that are prioritizing broad mental health promotion strategies for all youth in schools.

As part of South Africa's efforts towards social and economic transformation, much emphasis is being placed on education as being a primary site for achieving healthy development. Current policy proposals on education support and special needs in South Africa advance the idea of health-promoting centers of learning through a holistic

approach to institutional development (De Jong, 2000:1). Since 1994, much work has been done in terms of developing health promoting schools in South Africa. Following on from the national workshop in 1994 where various stakeholders in Health, Education and Welfare endorsed the health promoting schools concept, an international health promoting schools conference was held at the University of the Western Cape (UWC) in 1996. This resulted in the establishment of the Reference Group for Health Promoting Schools, a volunteer organisation comprising of various stakeholders who supports the development of health promoting schools in the Western Cape (Flisher et al, 2000). Various accredited courses have also been developed by the School of Public Health and Faculty of Education at University of the Western Cape, for education and health practitioners who wish to assist schools to become health promoting institutions. As a result of these courses, participants have established health promoting schools in most of the provinces across the country.

Many South African schools are involved on a daily basis in the activities mentioned by the WHO as activities of a health promoting school. What is required, however, is for these activities to be co-ordinated and recognized as part of the health promoting schools concept and for schools to be recognized as health promoting schools (Johnson, 1998). This is confirmed by research conducted into three case studies of health promoting schools in Cape Town (Omar, 2003). Omar (2003) found that educators understood health promotion and health promoting schools in the context of the practical tasks or activities that the schools engaged with. Omar (2003) reports on studies of health promoting strategies in schools in South Africa that involve tackling challenges such as,

- Violence gangsterism, HIV/AIDS, malnutrition and cigarette smoking in Athlone; Violence and gangsterism in Atlantis; Violence, gangsterism and malnutrition in Ocean View;
- Extending physical education programmes outside school time in Bellville;
- The restructuring of district and school health services, malnutrition and violence in Mitchells Plain;
- Deworming, HIV/AIDS and malnutrition programmes in Khayelitsha;
- HIV/AIDS, life skills, deworming and screening of hearing and impairment disorders in Kwazulu-Natal;
- Environmental cleaning programmes, tobacco smoking, air pollution, HIV/AIDS and life skills in Johannesburg.

According to the national guidelines for the development of health promoting schools (DoH, 2000), the key components of health promotion need to be located within the context of whole school education institution development. Lazarus, Davidoff and Daniels (2000, in DoH, 2000), argue that the health promoting schools/sites perspective should be located within a whole development framework, thereby ensuring that all elements of school life are taken into account and developed accordingly. According to the whole school development framework, the health promoting schools/sites perspective should be located within a broader strategy and vision of building an effective school; life skills education should be located within the health promoting schools/sites framework and the inclusive school perspective could also be located within this framework, with the principle of inclusion being one key value, principle and strategy for promoting well-being,

This perspective focuses particularly on issues of diversity and discrimination, with an emphasis on developing a welcoming, non-discriminatory and flexible environment and curriculum, where access to learning is facilitated through addressing barriers to learning and development in all elements of school life (DoH, 2000:20).

Johnson and Lazarus (2003) present a model developed locally at a primary school in a disadvantaged area on the outskirts of Cape Town. The model demonstrates how the health promoting school concept provides a strategy to address a range of difficulties experienced not only by learners but by teachers as well. Psychological services, social work, remedial education, occupational therapy, school health and guidance and counselling services are provided by the school via a form of teacher support team (TST). The entire staff is involved. The teachers are committed to health prevention and promotion and also offering 'curative' assistance. The problems of the child are viewed and addressed contextually, reflecting a systemic approach. The school has adopted a whole school development approach to dealing with the many challenges that their children present.

The integration of a whole school development and health promoting schools perspective also finds resonance in a National Mental Health Promotion Programme in Australia. This programme is known as the MindMatters programme. The aim of the MindMatters programme is to support Australian secondary schools in promoting and protecting the mental health of members of school communities. The programme uses a whole school approach to mental health promotion and suicide prevention and aims to enhance the development of school environments where young people feel safe, valued, engaged and purposeful (MindMatters, 2002). According to MindMatters (2002), a health promoting school is one that takes action and places priority on creating an environment that will have the best possible impact on the health of students, teachers, and school community members and which recognizes the interaction and connection between its curriculum, policies, practices and partnerships. The focus in the MindMatters programme are the three areas which make up the health promoting schools framework, namely, curriculum teaching and learning; school ethos and environment; and partnerships and services. The MindMatters programme emphasizes the promotion of mental health of all young people within the school community. It is a comprehensive school mental health programme influenced by the World Health Organisation definition of what constitutes a health promoting school. It is governed by intervention at four levels namely,

Table 2.1. : A Comprehensive School Mental Health Programme (adapted from MindMatters, 2002:20).

Type of intervention	Who is involved	Level of intervention
Create environment conducive to promoting psycho - social competence and well-being	Entire school community	Whole school environment
Mental health education – knowledge, attitudes and behaviour	All students and teachers	Part of general curriculum
Psycho-social interventions and problems	Students needing additional help	20-30% of students
Professional treatment	Students needing additional mental health intervention	3-12% of students

Health promotion through schools therefore proposes a holistic and comprehensive approach to dealing with difficulties and promoting well-being. In this approach an ecosystemic view is adopted whereby the problems that are manifested are understood

not only in terms of the individual but the environment as well. The health promoting school concept entails the transformation of the school environment and all who form part of that environment. The principles of school-based assistance teams such as indirect service delivery, consultation, the development of classroom teachers, should be combined with the principles of health promotion through schools that emphasise holistic, integrated and comprehensive approaches to health-related matters. An endeavour of this kind could provide us with an approach to address many current and future social and educational difficulties in South Africa and elsewhere (Johnson & Lazarus, 2003). These initiatives are crucial if we hope to address the mental health problems of youth that result in the many interventions for young people categorized as being 'Youth at Risk'.

2.4 YOUTH PLACED AT RISK

In this section 'Youth at Risk' is discussed as 'Youth placed at risk' as the traditional term serves the medical model that places the responsibility for being at risk and for reducing that risk on the shoulders of young people. Being placed at risk implies that society should carry a major responsibility for the position in which these young people find themselves. This systemic view implies that society should put the structures in place that meet the needs of young people and in doing so, reduce the probability that young people would engage in risk behaviours. The very notion of risk will be explored below and this will be followed by an examination of how these notions translate in terms of meeting the mental health needs of youth and addressing barriers to learning.

2.4.1 Deconstructing the notion of risk

According to Pianta and Walsh (1996), risk refers to an actuarial or probabilistic relation between one index, for example, poor academic skills and the likelihood of attaining a given outcome of interest, such as dropping out of school, given specified conditions or factors. Risk does not refer to a causal process or etiological relation, that is, where one thing causes another, although a risk factor may indeed be integral to the etiological

process. Risk status is a way of describing the likelihood that a given individual will attain a specific outcome, given certain conditions. Assigning risk status to an individual means that he or she shares characteristics similar to a group in which there is a known probability of attaining a certain outcome that is greater than the probability in the general population.

Risk factors are also defined as those characteristics, variables or hazards that, if present for a given individual, make it more likely that this individual will develop a disorder (Mrazek & Haggerty, 1994). It therefore impacts on an individual's ability to cope and increases the chances of a negative a mental health outcome. Research on risk and on the factors attenuating risk has received considerable attention in recent years.

For Garmezy (in Rolf, 1999), the concept of risk had been a useful tool for inquiry into the etiology of the problem of interest, the prediction of disorder, the identification of "protective factors" and the translation of this information into early intervention and prevention programmes. According to Garmezy (in Rolf, 1999), another key element of the concept of risk was the link between risk status and preventive intervention. Garmezy (in Rolf, 1999) felt that risk status should be viewed as an index of eligibility for preventive intervention. Garmezy (in Rolf, 1999) believed that risk research held considerable promise for developing prevention and early intervention strategies; that knowing the risk coefficients associated with differing risk factors, and the outcomes they predict, could only add to the information base used to make decisions about how best to utilise scarce resources. Furthermore, Garmezy (in Rolf, 1999) argued that identifying children who do well despite their risk status and understanding the factors distinguishing them from their peers who do not do well, facilitate the development of prevention and early intervention strategies.

What is critical then to risk reducing efforts is understanding variations in individual's responses to risk factors. These variations suggest ways that the risk situation can be modified to produce positive and negative outcomes, that is, why some people cope well with particular hazards, whereas others do not. Rutter (1987) has termed these positive and negative responses to risk and hazards 'protective' and 'vulnerability' mechanisms

respectively. For Rutter (1987), protective mechanisms operate to ameliorate or reduce the reaction to risk factors that in ordinary circumstances lead to a negative outcome. In contrast, vulnerability mechanisms intensify the reaction to risk factors and hazards and lead to poor outcomes.

It is believed that some risk factors play a causal role while others merely mark or identify the potential for a disorder. Incorporated in these definitions of risk factors is the concept of vulnerability which is a predisposition to a specific disease process. Having vulnerability traits may increase an individual's risk for developing a disorder but other risk factors may also be necessary for the illness to be expressed (Mrazek & Haggerty, 1994).

According to Pianta and Walsh (1996), educators have been notoriously inaccurate in their use of the term "at risk", and appear fundamentally to misunderstand its applications,



Often the term "at risk" is used as a labelling device to describe individual children without specifying the outcome that they are likely to attain, that is, exactly for what is the child at risk? Educators are also ignorant of the wider conceptual context in which risk is used – the context of prevention. The very notion of risk is meaningless by itself, that is to say that it makes no sense to label children or anyone at risk unless one specifies for what and the level of risk. It is absurd to argue that one group is at risk and another is not. We are all more or less at risk for certain outcomes – how high the risk depends a lot on the immediate conditions. The coefficient of risk changes as conditions change (Pianta & Walsh, 1996:20).

Pianta and Walsh (1996) argue that risk cannot therefore be understood as a static concept; that because education is primarily an effort to induce change, there is a dynamic quality to the relations between what a child brings to school and what a school brings to a child, which continually alters the risk coefficient of individuals and groups.

Mrazek and Haggerty (1994), argue that risk factors can reside within the individual, or within the family, community, or institutions that surround the individual. They can be

biological or psychosocial in nature. If we wish to effectively address risk factors, we need to take these factors into account and intervene at these different levels. Models of intervention need to include both individualistic model and systemic models. The impact of psychosocial conditions is particularly important when assessing risk factors in the South African system. The majority of learners in South Africa are particularly vulnerable due to the effects of poverty, crime, violence, substance abuse and HIV/AIDS. There are however, many reservations about viewing our learners as being at risk for negative outcomes.

2.4.2 Barriers to learning

According to the Center for Mental Health in Schools (2002), the notion of barriers to learning encompasses external and internal factors. Even the best schools find that too many youngsters are growing up in situations where significant external barriers regularly interfere with their reaching full potential. Some youngsters also bring with them intrinsic conditions that make learning and performing difficult. As a result, at every grade level there are students who come to school every day not quite ready to perform and learn in the most effective manner. In developing an enabling component to address barriers to learning and development, a major emphasis is on improving neighbourhood, home, school and classroom environments to prevent problems and enhance youngsters' strengths. At the same time, essential supports and assistance are provided for those who need something more to address barriers and engage or re-engage them in schooling and enable learning.

Taylor and Adelman (2002) are of the strong opinion that mental health in schools is not some extraneous and separate agenda but rather an integral facet of achieving the educational mission. They argue that a comprehensive, multifaceted and integrated component for addressing barriers to learning and enhancing healthy development is needed that embeds mental health in a continuum of interventions, ranging from systems for positive development and prevention of problems, systems of early intervention to

address problems as soon after onset as feasible and systems of care for those with chronic and severe problems.

Prodente et al (2002) agree that school personnel are generally more receptive to mental health programmes in schools when they are framed as reducing and removing barriers to student learning, “This language allays fears and suggests that mental health is a central component related to educational achievement” (Prodente et al, 2002:178). The primary aim of school mental health programmes may be viewed as enabling learning by addressing those emotional and behavioural problems that can hinder the educational process (Prodente, Sander & Weist, 2002).

In the past (pre-1994), South African schools would often refer ‘learners with special needs’ (educational, physical or emotional needs) to special schools. This usually only benefited previously advantaged groups and previously disadvantaged groups did not have access to these services. Often learners from disadvantaged communities would have to drop out of school as the mainstream schools were not equipped to assist them. However, since 1994, policy development and legislative changes to education and training have been based on the principles of human rights and social justice, non-discrimination, non-racism and non-sexism, democracy and equality (Lomofsky & Green, 2004).

In 1996, the National Commission on Special Needs in Education and Training (NCSNET) and the National Committee for Education Support Services (NCESS) was established to investigate the development of an inclusive education system. The NCESS/NCSNET Report (Department of Education (DoE), 1997), first introduces the concept of ‘barriers to learning’ as a framing for the development of an inclusive education system. The NCESS/NCSNET Report recognizes the fact that the previous education system was not responsive to the majority of learners in South Africa. The Report recommends a shift away from a predominantly individualistic approach to a systemic approach in understanding and responding to learner difficulties and disabilities. The Report argues that the system must be transformed to accommodate individual

differences among learners and proposes that the separate systems of education ('special' and 'ordinary') be integrated to provide one system that is able to recognize and respond to the diverse needs of the learner population. These new proposals allow all children, irrespective of their needs, to have access to education. The Report further recommends that all centers of learning should be welcoming to all learners and other members of the teaching and learning community.

The Education White Paper 6 (DoE, 2001) translates these principles into a policy and advocates for the development of a four-tier system aimed at assisting schools to become inclusive and supportive which is designed to assist schools to accommodate learners with diverse learning needs which include physical, emotional, social or learning needs (Johnson & Lazarus, 2003). The role of education support services becomes critical in the provision of support to address barriers to learning. The National Guidelines for the development of Health Promoting Schools (DoH, 2000) highlights the value of and need for education support services in the process of addressing barriers to learning and development, particularly in terms of providing support to schools as they attempt to address the many challenges facing them. It states that support services have a very important role to play in helping to build a positive teaching and learning environment and responsive curriculum to minimize and possibly remove barriers to learning and development, and to address issues that place learners at risk.

2.5 FROM RISK TO RESILIENCE

2.5.1 Shortcomings of the 'risk' approach

Constantine, Benard and Diaz (1999) argue that understanding the factors that place learners at risk can help to inform prevention and early intervention programmes. At the same time, however, the application of risk factor focused prevention often leads to the identification, labeling and stigmatizing of youth, their families and their communities. As South African youth, families and communities emerge from an era of racial classification and try to transcend barriers related to labeling, stigmatization and

stereotyping, it is important to reflect upon and critically analyse frameworks that involve similar practices.

Children who are labeled as “at risk” are not well served by society and its schools (Pianta & Walsh, 1996). It is not beneficial to those it is intended to serve. Labelling youth as being ‘at risk’ belongs to the pathology model. The pathology model through its focus on studying problems, illnesses, disorders, deviance and risks have not provided information as to what interventions do work. Ultimately, the potential for prevention surely lies in increasing our knowledge and understanding of reasons why some children are not damaged by deprivation (Benard, 1999). More importantly, focusing on individuals who do not succeed does not allow us to embrace those individuals who do manage to succeed, despite being exposed to a system designed to allow individuals to fail based on racial classification and related stereotyped notions of ability and intelligence (Werner & Smith, 1992 in Constantine et al, 1999).



There is also the concern that a focus on young people’s risks or deficits often obscures teachers’, parents’, and other helpers’ vision in seeing the assets or strengths that young people have; that a focus on deficits leaves teachers, parents and other helpers feeling helpless and hopeless. Furthermore, there is the concern that these attitudes can lead to burn-out and translate into self-fulfilling prophecy. It seems that with an emphasis on “children at risk”, the task of removing all the factors that can create significant stresses for children seem overwhelming. Rather than promoting action, it tends to promote labeling and inaction (Louis, 1997).

This sense of being overwhelmed that result in non-action is prevalent in many South African schools at present. Teachers feel overwhelmed by and ill-equipped to deal with the many psychosocial problems that learners present. As a result, there is little or no intervention to meet learners’ needs. The identification of risk factors do not inform helpers as to what does work and what they can do to prevent problems (Werner & Smith, 1992 in Constantine et al, 1999). Teachers need to know how to prevent learners

from falling within the youth at risk categories, how to strengthen them and assist them to succeed despite adversity.

Werner and Smith (1992 in Constantine et al, 1999) believe that it is to resilience research and, to the study of how young people with multiple risk factors have successfully developed despite risk, that the prevention and education fields must turn to find answers. They argue that resilience factors have far more predictive power than risk factors and should provide the research base for planning preventive interventions.

2.5.2 Resilience as a new paradigm for research and practice

Interventions that focus on resilience point to what should be added to children's lives to give them better tools for coping with diverse, stressful settings (Louis, 1997). Resilience research tends to question why some who are reared under adverse circumstances appear to live healthy and productive lives while others do not appear to overcome the adversities experienced in early life (Blum, 1998). The emphasis is therefore on understanding and developing potential rather than problem intervention. Strumpfer (2002) concurs that human functioning cannot be understood solely within a problem-oriented framework. In contrast to the pathological interest in what can go wrong, he confirms that there are attempts to discover 'what can go right'. Recently much research has been directed toward understanding why some children appear to be resilient and why they come to maturity relatively unscathed by the organic and psychosocial insults that prevent so many of their peers from achieving optimal intellectual, social and emotional functioning (Mrazek & Haggerty, 1994).

Barbarin and Richter (1999) also voice their concern about the deleterious effects of focusing on the negative aspects of individuals belonging to communities in poverty. They argue that focus on the adverse effects of community danger on children's development may unintentionally minimise the significance and beneficial effects of socio-cultural resources found to varying degrees in all communities. They believe that these resources can constitute important protective and supportive mechanisms that wield a powerful influence in the lives of children and their families,

For example by sharing material resources and providing personal affirming ideologies that serve to normalize children's perception of their socio-economic disadvantage, communities can buffer the potentially deleterious effects of material hardship and dangerous environments on social development. When children perceive that others live in similar circumstances of economic hardship and danger and experience neighbours as protective and nurturing, then poverty and danger become less salient features of their self-image (Barbarin and Richter, 1999: 326).

Efforts to understand and promote social competence in children must then analyse the synergies created in the relationship of a family to its community.

A consistent finding over the last two decades of resilience research is that most children and youth, even those from highly stressed families or resource-deprived communities, do somehow manage to make decent lives for themselves. These include children who experience divorce, live with step-parents, lose a sibling, have Attention Deficit Disorder, suffer developmental delays, become delinquent, run away, get involved with religious cults, and so forth. More make it than do not. Also, more than 70 to 75% include children in foster care, were members of gangs, were born to teen mothers, were sexually abused, had substance-abusing or mentally ill families and grew up in poverty. Even in worst-case scenarios, when children experience multiple and persistent risks, still half of them overcome adversity and achieve good developmental outcomes (Benard, 2004a).

The findings of Werner and Smith also confound a core belief of many risk-focused social scientists – that risk factors predict negative outcomes. Protective factors make a more profound impact (predict positive outcomes for 50-80%) on the life course of children who grow up under adverse conditions, than do specific risk factors or stressful life events (predictive for 20% to 49% of high risk population). More importantly, the supports and opportunities serving as protective factors for youth facing adversity apply equally to all young people,

Resilience is a normative process of human adaptation encoded in the human species and applicable to development in both favorable and unfavorable

environments. The innate self-righting tendencies and environmental protective factors that account for the resilience of young people facing adversity and challenge are precisely the same supports and opportunities that nurture us all (Benard, 2004a:10).

Moving from a risk focus to a resilience focus grounds practice in optimism, an essential component in building internal motivation in both adults and youth. Even at the community level, a resilience paradigm provides optimism, hope and motivation. (Benard, 1999). “The prevention research community is heartened by the accumulating research evidence that resilience and youth development approaches work” (Benard, 2004a:2). Furthermore, Werner and Smith (1992, in Constantine et al, 1999) argue that resilience research findings may also transcend ethnic, social, geographical and historical boundaries as it addresses our common, shared and basic human needs. The development of resilience may parallel the process of healthy human development, a dynamic process in which personality and environmental influences interact in a reciprocal, transactional relationship.



The solution to preventing South African youth from suffering from the adverse effects of risk factors lie in exploring this notion of resilience and more importantly, how to develop strengths that mitigate against negative mental health outcomes.

2.5.2.1 Evolution of the concept of resilience

(a) International developments

Abraham Maslow made the following observation that could be regarded as one of the earliest observations related to resilience,

Healthy people are so different from average ones, not only in degree but in kind as well, that they generate two very different kinds of psychology. It becomes more and more clear that the study of crippled, stunted, immature and unhealthy specimens can yield only a cripple psychology and a cripple philosophy. The study of self-actualizing people must be the basis for a more universal science of psychology (Maslow, 1970:180).

Norman Garmezy (in Rolf, 1999) is generally credited as being the founder of the contemporary research study of resilience. Garmezy's interest in resilience started with work on schizophrenia that he began together with Eliot Rodnick. They found that patients with schizophrenia tended to present as two different groups, one more competent and functional than the other. They then proceeded to try to understand what contributed to these different outcomes. They then initiated a search with schoolchildren who came out of highly stressed environments and yet who seemed to be very adaptive. The search focused upon asking principals about children who generated concern in the beginning because of their troubled backgrounds but who became adaptive and good citizens, and in the end generated lots of pride amongst teachers (Rolf, 1999).

An interview with Garmezy (in Rolf, 1999) reveals that the term 'resilient' came in not as a simile for competence but as an extension of competencies despite an early background of very high stress experiences. Competence was therefore the term for a variety of adaptive behaviours and resilience was seen as manifest competence despite exposure to significant stressors. According to Aldwin, Sutton and Lachman (1996), stressful episodes early in life, form a context for the development of coping resources in later life. Garmezy (in Rolf, 1999) argued that one cannot talk about resilience in the absence of stress,

I have to think two ways about this. I have to think of a single great stressor and its consequences and I think also of the cumulation of stressors in which the environment, the family and the background all add up to generate negative events and circumstances that ordinarily would bring a child down but in many instances do not (Rolf, 1999:8).

Garmezy (in Rolf, 1999) believed that children in poverty provide a good opportunity to observe resilience and its development, "If you think of the cumulation notion of stressors, poverty bares it" (Rolf, 1999:8).

Masten (1997) argues that classic resilience research focused on the development of competence, confidence and caring in the face of risk and adversity – a traditional

psychopathology perspective. Moving beyond the trait theories of resilience, an emergent research direction is the examination of the construct of resilience as a dynamic developmental process. They all have in common the developmental theme of meeting youth needs for love and belonging, respect, identity, power and meaning. These approaches all share the belief that it is adult society's responsibility to provide the developmental supports and opportunities to that meet these needs and promote positive developmental outcomes in youth ultimately resulting in improved health, social and academic outcomes.

According to Benard and Marshall (1997), this new operational philosophy emanates from a fundamental belief in every person's capacity for successful transformation and change no matter what their life's circumstances. It is a philosophy that is urgently required in the reconstruction of South African society. Embedded within this philosophy is the fundamental belief that every South African has the ability to succeed irrespective of the policies and beliefs of the past. Many of the current policies and research in South Africa reflect a move away from a psychopathological and medical model of viewing human behaviour to a more systemic approach. There is the recognition of the role of society and government in particular to provide support and opportunities to meet the needs of our youth and promote positive developmental outcomes.

(b) National developments

There has been a marked interest in recent years in the field of positive psychology in South Africa. De Beer and Korf (2004), confirm that a number of dissertations and publications have been published in this regard. South African researchers tend to focus on specific constructs and dimensions of well-being in ongoing research in their field.

According to Strumpfer (1990), Antonovsky (1979), introduced the concept of salutogenesis and proposed that the origins of health and not only disease be investigated. This was as a result of observing individuals who coped quite well and stayed healthy despite being exposed to multiple stressors and severe traumatic experiences. According to Breed (1997, in De Beer, 2004:3), the salutogenic individual,

- Has an optimistic life view;
- Experiences the environment as understandable and meaningful;
- Actively engages with the environment;
- Willingly tackles challenges;
- Sees demands to be handled against available resources;
- Sees resources as under own control or that of meaningful others;
- Is convinced of his/her own ability to control or influence events.

Initially, researchers believed that the pathogenic view and salutogenesis could be seen as two ends of the same continuum with terminal illness on the one end and total wellness on the other end. Strumpfer (1990) challenged this notion and proposed that the criteria for psychological well-being and the criteria for psychopathology are to a great extent independent and that well-being and pathology are not just endpoints of the same continuum; that the absence of psychopathology does not necessarily indicate well-being or the presence of psychological strengths. Subsequently, low scores on measure of well-being or psychological strengths do not necessarily indicate pathology.



South African researchers proposed that that salutogenesis (an emphasis on health) should be broadened to include fortigenesis (an emphasis on strength). Wissing and van Eeden (1997) developed this further to suggest a sub-discipline called Psychofortology which would include the origins of psychological well-being and ways to enhance well-being. Pretorius (1997) developed the construct and theory of fortitude to explain the ability to manage stress and stay well as a consequence of an appraisal of self, the family and support of others. Fortological constructs that have been identified as core dimensions of the salutogenic individual include: sense of coherence, locus of control, self-efficacy, hardiness, potency and learned resourcefulness (DeBeer & Korf, 2004). Dispositional optimism, positive illusions, constructive thinking, hope, subjective vitality and resilience have also been highlighted as constructs relating to the maintenance and enhancement of psychological wellness (Strumpfer, 2002; Coetzee & Cilliers, 2001).

Strumpfer (2002) points out though, that the weakness of the new labels of positive psychology and psychofortology is their one-sidedness. Strumpfer (2002) proposes interdisciplinary team approaches that allow more holistic integration and understanding. Strumpfer (2002) argues that in view of all things human, systems thinking is imperative,

In disentangling fortigenic and pathogenic factors, it is exceedingly important not to think in terms of simple, linear models, since they are most likely to offer an insufficient basis for understanding (Strumpfer, 2002:17).

The integration of systems thinking and fortology is imperative for the purposes of this study. Killian (2004) also supports the value of a systems and ecological approach to resilience and employs these frameworks to support vulnerable children experiencing poverty, violence and HIV/AIDS in communities in South Africa. The purpose of this study is to take these thoughts one step further and develop schools into supportive environments that foster resilience and enhance well-being.

2.5.2.2 Various definitions of the concept of resilience

It is important at this stage to consider the various understandings and definitions of the term. This is to assist in the clarification and application of this term within this particular research.

Cowen (2001) alerts us to the danger of using terms merely because they are popular and reflect the sentiments and politics of a particular time. Cowen (2001) fears that individuals may utilize certain terms in order to align with ‘in-terminology’ without necessarily being clear about what the concepts entail. Terms such as primary prevention, resilience, charter schools and empowerment are mentioned as concepts that are particularly in danger of such abuse,

To adopt a concept simply because it is “pretty”-sounding and zeitgeisty, without regard for its core defining meaning, encourages wheel-spinning, muddled communication and in the end, slows down the development of important and promising domains (Cowen, 2001:11).

Considering the potential of resilience research in terms of providing new insights into human behaviour and motivation and the development of alternative forms of intervention, it is therefore important to unpack the true meaning of resilience.

Werner and Smith (1992 in Constantine et al, 1999) defined resilience as an unusual or marked capacity to recover from or successfully cope with significant stresses. These stresses would be of both internal and external origin. Resilience has also been defined as “the process of, capacity for or outcome of successful adaptation despite challenging or threatening circumstances” (Masten, Best & Garmezy, 1990:426). According to Masten et al (1990) it requires competent functioning despite exposure to one or more risk factors. These aforementioned definitions therefore focus on the individual’s ability to successfully overcome adversity and cope with numerous stressors.

Benard and Marshall (1997) provide an extended definition. According to the authors, the process of resilience is the process of healthy human development, of meeting the basic human needs of caring and connectedness, for respect and challenge, and structure and for meaningful involvement, belonging and power. Also, a nurturing environment that meets these basic needs enables us to directly access our innate resilience. It is an inside-out process that begins with one person’s belief and emanates outward to transform whole families, classrooms, schools and communities. This extended definition speaks to the process of resilience in terms of relationships with others and the development of positive families, communities and societies. This comprehensive understanding of resilience as involving core relationships relate to many traditional and indigenous beliefs.

It is interesting to note that Heavyrunner and Morris (1997) argue that the concept of resilience is embedded within Native American traditional cultural practices,

Resilience is not new to our people; it is a concept that has been taught for centuries. The word is new, the meaning is old. We have long realized how important it is for children to have people in their lives who nurture their spirit, stand by them, encourage and support them. This traditional process is what contemporary researchers, educators and social service providers are now calling fostering resilience (Heavyrunner & Morris, 1997:1).

Weaver (2002) also explains the connections between resilience and indigenous notions of wellness. Weaver (2002) argues that in most societies, wellness is often associated with prevention of illness and is based on a medical model of health. This model is a more narrow conceptualisation of wellness than that embraced by First Nations Communities. Weaver (2002) sees wellness as a holistic concept that encompasses all aspects of individuals and communities including physical, mental and spiritual dimensions. “Balance among these different dimensions promotes both prevention and healing” (Weaver, 2002:5).

Weaver (2002) also stresses the importance of spirituality, “Wellness and spirituality are inseparable. Wellness is harmony of the body, mind and spirit; illness is disharmony in one or more areas” (Weaver, 2002:7). Weaver (2002) emphasizes the connection between wellness and cultural identity and argues that wellness reinforces and is reinforced by a sense of cultural identity,

Wellness is a holistic concept that includes connections among various aspects of a whole. Connections exist across generations including ancestors and people yet to be born. The sacred and secular are two parts of a unified whole (Weaver, 2002:12).

This link with traditional cultural beliefs and practices serves as a vital link for resilience research in South Africa. The African concept of Ubuntu is one that endorses the notion of connectedness, of support, of the importance of family and community bonding in terms of strengthening individuals and overcoming adversity. The essence of Ubuntu is that “ ‘A person can only be a person through others’. It is through you that I am who I am, and do what I do – for which I thank you” (Kagan, 2002:1). The basic philosophy of resilience research therefore relates to African traditional and cultural beliefs and as such is a framework that will be readily accepted and endorsed by the people of South Africa. It represents familiar and respected practices, it honours tradition and serves to heal and build society.

A further extension of the definition of resilience is found in the area of health realization in the United States. Mills (1997) describes health realization as a new wellness paradigm in psychology. Mills (1997) believes that health realization offers the most compelling

explanation of the process of tapping innate resilience. According to Mills (1997) the goal of health realization is to reconnect people to the health in themselves and then direct them in ways to bring forth the health in others. The result is a change in people and communities which builds up from within rather than being imposed from without.

“The underlying principle of the health realization model is that resilience is innate and in all humans and is directly accessible” (Benard, 1999:272). These thoughts are further supported by Mills (1993, in Benard, 1999), who argues that the capacity for mental health, wisdom, intelligence, common sense and positive motivation is in everyone despite his or her risk factors. The health realization model therefore aims to reconnect people to themselves and each other through educational and not therapeutic means. It consists of teaching, accessing and overcoming the barriers leading to innate resilience. Health realization makes several contributions to resilience theory,

It demonstrates the process of inside-out change. Through realizing one’s own innate health, one experiences a sense of self-efficacy, a sense of personal empowerment and motivation to work with others to build a critical mass that in turn creates community change. It has found that a caring, nurturing environment is necessary for accessing innate resilience and mental health. Health realization involves a process of deep changes in belief systems, requiring practitioners to actively listen and connect with a person’s inner core of mental health (Benard, 1999:272).

The area of health realization holds much promise for the people of South Africa. It is based on a belief in the inherent promise that each individual holds and the power of that promise to influence society in a positive manner. It is an essential framework for viewing young people in South Africa and the promise that they hold for a better society. It is a departure from the negative views of certain population groups imposed from without and that formed the foundation of Apartheid policies and laws. These negative views resulted in much psychological damage in terms of people’s self concept and self esteem and has a significant role to play in the negative behavioural outcomes experienced in terms of crime and violence.

2.5.2.3 The factors and processes involved in fostering resilience

In gaining a comprehensive understanding of resilience, it is important to examine the factors and processes involved in fostering resilience.

“Resilience-based practice ideally has two foci: to reduce risk and to strengthen protective factors” (Early & Maye, 2000:123). Garmezy (in Rolf, 1999) examined protective factors in attempting to understand the processes involved in fostering resilience,

What protective factors really speak to is the unanticipated avoidance of failure and deficits by a child subjected to multiple stressors. It’s when you say, “Well how can that be? ...that child should have gone under a long time ago but he/she hasn’t” (Rolf, 1999:10).

Garmezy (in Rolf, 1999), therefore advocated looking into the world of the child and looking into the child himself or herself in order to make a tabulation of the protective elements which seem to compete against the stressors children are exposed to with victory in overcoming the stressful elements. Garmezy (in Rolf, 1999) saw resilience as a combination of psychosocial elements and biological predispositions, an aggregate of protective factors; a function of the interaction of multiple, complex factors.

Masten (1997) points out certain attributes of resilient children as determined by longitudinal studies namely,

- Good parenting;
- More time before the next child came along;
- More appealing temperaments as babies;
- Better intellectual skills;
- More connections with pro-social adults;
- Fewer separations from caregivers;
- Better physical health;
- More responsible;
- Self-confident;
- Motivated to achieve;
- Took advantage of opportunities such as military service or community education to shape their lives in positive ways.

While these studies give us some indication of the characteristics involved in resilience, they are not complete indications of what is required for success. Many of the characteristics required for success are not available to South African children and yet many have succeeded despite these limitations.

The following list of protective factors highlighted by Mrazek and Haggerty (1994), presents an indication of personal characteristics and environments that serve to enhance resilience. It presents a framework for the development of interventions to foster resilience,

- Connections to positive role models;
- Feelings of self worth and self-efficacy;
- Feelings of hope and meaningfulness;
- Attractiveness to others;
- Talents valued by self and others;
- Faith and religious affiliations;
- Socio-economic advantages;
- Good schools;
- Other opportunities to learn or qualify for advancement in society;
- A knack for seeking out people and environments that are good for their development.

Masten (1997) and Mrazek and Haggerty (1994) emphasise the importance of parenting and cognitive development. They believe that if good parenting and good cognitive development are sustained, human development is robust even in the face of adversity.

Heller, Larrieu, D'Imperio and Boris (1999) categorise protective factors in terms of three main categories namely,

- Dispositional/temperamental attributes of the child (responsiveness, independence, intellectual ability);
- A warm and secure family relationship;
- The availability of extra-familial support (peers and teachers).

According to Mrazek and Haggerty (1994), theoretical explanations for the phenomenon of resilience involve the interaction of risk factors, including individual vulnerability and protective factors to explain why some are spared and some are not. Vulnerable

individuals are those who, by virtue of genetic predisposition, chronic illness, hardship, deprivation or abuse, are more susceptible to life stressors than others. Thus they are at risk for failure to master, mature and adapt. Rutter (in Mrazek & Haggerty, 1994) defined protective factors as those factors that modify, ameliorate or alter a person's response to some environmental hazard that predisposes to a maladaptive outcome. Protective factors do not necessarily foster normal development in the absence of risk factors but they may make an appreciable difference on the influence exerted by risk factors. Protective factors can also reside within the individual or the family, community, or institutions and can be biological or psychosocial in nature (Mrazek & Haggerty, 1994).

According to Masten (1997), children who floundered had few individual or family resources that appear to protect human development. They also appeared to be more vulnerable to stress in childhood, already showing signs of being easily upset and having worse attention skills than their competent peers. As they grew older they began to contribute to the stress in their own lives through their own behaviour or choices. This observation explains why some children succeed and others don't and stresses the need to provide extra support to those who are particularly vulnerable.

Another interesting observation by Masten (1997) is the fact that outcomes worsen as risk factors pile up in children's lives and concomitantly, resilience becomes less common. It becomes important therefore to provide support and protective environments to prevent exposure to unbearable risk and to strengthen resilience as far as possible. Interventions should therefore also target multiple risk factors to minimize their impact upon our children.

Although young people who have overcome adversity deserve to be recognized and praised for their achievements, one must not lose sight of the cost involved for these young people. According to Masten (1997) youth pay a toll in the struggle to overcome adversity, exacted from either the level of adversity or the strain of rising above it. We must therefore not argue that if some young people could rise above severe circumstances

then all should be able to do so but we should rather actively assist others to achieve as well and offer them the necessary support to do so.

2.5.2.4 Implications for action

“Resilience research promises to move the prevention and treatment fields beyond their focus on ‘what’ to an emphasis on ‘how’” (Benard, 1999:270). This section therefore looks at the mechanisms involved in transforming resilience theory into practice.

According to Masten (1997), the understanding of resilience and protective factors that has now emerged compels us to develop intervention programmes that are aimed at addressing multiple risks. These intervention programmes need to be based on an understanding of protective factors and how to nurture these factors and should be compelled to provide the necessary resources to counterbalance high risk (Masten, 1997). A significant factor in fostering resilience in children is the role of the school. Supportive, nurturing school environments are crucial. Positive relationships between teachers and learners, learners themselves, teachers and parents, and the school and its community must be encouraged and developed. According to Masten (1997), child/mentor relationships or more personal school environments that encourage closer child/teacher bonds are examples of fostering protective relationships. Giving children opportunities to learn about their talents and to experience mastery in learning taps the self-efficacy / learned hopefulness systems that motivate human adaptation,

Research on resilience challenges the field to build a connectedness or sense of belonging, by transforming our families, schools and communities to become “psychological homes” where youth can find mutually caring and respectful relationships and opportunities for meaningful involvement (Benard, 1999:271).

According to Oddone (2002), school administrators, teachers, and school mental health professionals can apply a broad systemic approach to enhancing resilience in schools by emphasizing protective factors such as,

- Providing for meaningful participation at school that engages students and staff beyond traditional measures of success (e.g. beyond grades or test scores);
- Increasing students capacity for prosocial bonding by teaching and modeling prosocial behaviour, and by providing settings for interpersonal connections of sufficient quality and intensity to allow for development and appreciation;
- Identifying expectations and setting clear, consistent boundaries in ways that emphasise desired social norms, defined in concrete terms rather than vague ideals, rather than simply listing behaviours that are discouraged or forbidden;
- Teaching life skills that enable students to participate successfully in relationships at school and elsewhere;
- Providing care and support so that students have a sense of belonging at school that protects them from feeling alienated;
- Setting and communicating high expectations, which convey optimism, hope, and confidence in students, and recognize their capacity to succeed. (Oddone, 2002:2).



Oddone (2002:5) cites the following examples of protective factors at school,

- Caring, respectful relationships contributing to a sense of belonging;
- High expectations focusing on strengths and assets;
- Stabilising routines and practices on which students can depend;
- Opportunities to experience mastery in day-to-day life.

Oddone (2002) speaks to the relationship between resilience factors and health and safety and academic performance. When neglected, mental health and safety concerns can function as obstacles to academic performance. At the same time, when educators and parents set and uphold high academic expectations, they convey faith and confidence in what works and what is right among students and in schools. Because of their relationship to protective factors and assets that exist among students, high academic expectations contribute to safe and orderly schools and enhance student mental health. Within a resiliency approach, concerns about academic performance and mental

health/safety in schools are addressed in concert with one another, rather than being treated as competing priorities.

Related to issues of academic performance is assessment. A key issue in psychological services within education at present is the practice of assessment. Assessment in the past focused on identifying the areas of weaknesses that required remediation. Masten (1997) argues that we cannot overlook the positive assets of children in our assessments. An assessment must include the building blocks of resilience and recovery as well as the risks, symptoms and problems in a child's life. We need to remember that children live multifaceted lives within multiple contexts – in families, schools, peer groups, sports teams, religious organisations and other groups. Each context is a potential source of protective factors as well as risks. While we are moving in the right direction in terms of noting the limitations of assessment in the past, we need to incorporate much of the present thinking around resilience in order to truly appreciate and nurture the strengths of our learners.



Resiliency-based programmes represent the type of programmes urgently required within the South African school system in order to fully realize the potential of our young people,

Resiliency-based programs are built upon community-wide, intersectoral collaborations and are not bound by traditional agency roles or administrative constraints; are focused on enhancing competence in young people at least as much as reducing a given risk behaviour or undesirable outcome; see youth as part of the solution, not just the focus of the problem; start early in the life of young people; are intensive, continuous and developmentally appropriate; have staff who are collaborative, interdisciplinary and not overly professionalised; are willing to do what it takes to be successful and values young people (Blum, 1998:1).

Schools in South Africa have to be transformed to vehicles of hope. Schools have moved from vehicles of active resistance against the state to vehicles of change towards a democratic, unified society. Schools can be further developed to becoming vehicles for

the development of resilient, healthy and productive citizens. As principal Woodall of La Cima Middle School in Tucson, Arizona says,

We are all ‘at risk’ in this day and age and that lowers expectations. It leads us, as educators, to feeling stressed, discouraged, possibly even burned out. By focusing on resiliency, we can turn that lens around. We can work with strengths and assets in our students and in ourselves – protective factors – rather than focusing only on deficits or risk factors. We can focus on what does work rather than getting stuck on, and frustrated by, what doesn’t (Oddone, 2002:1).

Educators in South Africa are experiencing the pressure of a new education system and youth who present with increasing social and psychological problems. Input on the extent to which young people in South Africa are at risk for adverse outcomes serve only to demotivate them. A focus on resiliency factors within learners and even educators can provide optimism and hope for the future,

Fostering resilience means changing our belief systems to see youth, their families and their cultures as resources instead of problems. Rather than situating risks in the characteristics of youth, their families and their communities, this initiative situates risk in the social contexts of racism and poverty. This initiative asks, what are the personal, social, and institutional resources that promote successful adolescent development despite these risks? (Benard, 1999: 275).

2.6 ENABLING MECHANISMS AND SUPPORT SYSTEMS

The issue of supporting and strengthening young people in order to develop positive outcomes as opposed to high risk outcomes will be further explored in this section. The focus will be on the school as an enabling environment and the important role of the school in conjunction with the community in supporting young people and developing their potential.

2.6.1 A framework for tapping resilience

Children are remarkably resilient when they get the help they need. Children and youth thrive when they feel safe and supported. Parents and teachers sometimes need help in their effort to provide a system of support that meets each child's individual needs. This system of support involves,

- Love and encouragement of parents and family;
 - Guidance of teachers and other important adults;
 - Consistent expectations and support;
 - Access to mental health and other helping professionals;
 - Services that respect and respond to personal and cultural differences.
- (NASP, 2003:1).

Benard and Marshall (1997) provide us with a framework for tapping resilience. This framework utilizes the school system as a vehicle for fostering resilience in children. It is a systemic approach that takes into account all the factors within the school environment that could have either a positive or a negative impact upon the learner. It aims to intervene at both the individualistic and systemic level in order to maximize efficiency and success. The focus for Benard and Marshall (1997) is on creating healthy systems. They believe that the foundation for change to tap resilience begins and rests with planners' belief in resilience and they set about to test and reinforce positive beliefs in the potential of all young people.

Resilience and health realization hold tremendous promise for all schools and communities. This change is relatively inexpensive because it involves a shift in thinking system-wide and does not require entirely new systems or programmes to be created. It is about mindset changes and developing new philosophies that inform new ways of responding and being. It involved minimal resources, financial or human resources. In short, it is an ideal strategy for developed and developing countries alike.

2.6.2 The role of teachers in creating optimal environments

Mills (1997) develops this train of thought further by clearly illustrating how teachers can create optimal climates and environments within the classroom. Mills (1997) believes that all youth potentially have within their psychological make-up, the capacity for an

intrinsic motivation to learn, along with a genuine, unforced interest in understanding and mastering the subject at hand. He argues that irrespective of how alienated a youth has become, a healthy, motivated frame of mind can be re-engaged in most youth.

Mills (1997) believes that creating optimal learning environments holds many advantages for teachers as well as learners. He argues that creating an optimal learning environment makes the job of teaching less stressful and overwhelming; that creating a positive affective climate produces a classroom of more motivated students who, overall, exhibit less resistance to learning and absorb lessons faster and with better retention. For Mills (1997) the key lies in teachers accessing positive mental states within themselves. Mills believes that they are then more likely to engage their students' healthier states of mind. Healthy teachers are more likely to create a classroom atmosphere, which consistently promotes cooperation, motivation, creativity and learning. This will counter negative behaviour on behalf of the children. Mills argues that children's negative, insecure thoughts and behaviours are more likely to be triggered when insecurity, judgement, anger and other negative feelings arise in their environment.



The creation of healthy classrooms and schools is also seen as a key strategy in reconstructing a positive teaching and learning environment in schools in South Africa.

2.6.3 The creation of healthy classrooms and schools

The Carnegie Council Task Force on Education of Young Adolescents and the Centre for Mental Health in Schools in the United States are in agreement that schools are not in the mental health business and that school systems are not responsible for meeting every need of their students, "But when the need directly affects learning, the school must meet the challenge" (Center for Mental Health in Schools, 2002:9).

Kupermine, Leadbeater, Ulazek, and Hicks (1995, in Center for Mental Health in Schools, 2002) argue that it is possible that middle school students from more dangerous and less cohesive neighbourhoods are more likely to perceive the school, by comparison,

as a safe haven. Prevention programs could therefore capitalize on this by augmenting funding for school-based after-school activities and promoting positive relationships between teachers and children from more distressed neighbourhoods. This argument is supported by Oddone (2002:3) who says that “Schools are among the safest places for children and students are less likely to be victims of violence while at school than when they are away from school.”

Given that in many schools the majority of problems stem initially from external factors, the first concern in preventing large numbers of learning, behaviour and emotional problems is to improve environments and systems that affect how well youngsters flourish. This involves broad-band interventions that not only facilitate positive development but are also designed to directly minimise factors that interfere with development and learning. Such interventions are key to meeting the best interests of all youngsters without targeting and labeling specific individuals, and continuous efforts to improve environments and systems are basic to reducing the number who require specialized assistance. Sound broad-band interventions are an essential foundation on which to build support programmes and services and also, are the best screening procedure for identifying specific persons who need additional interventions (Adelman & Taylor, 2000).

Just as the school has to be understood in relation to its social context, so with the classroom which is a subsystem of the whole school system. Interactions occur not only with the school, but also with the families and peer groups of the students in class. Beyond this, especially through the school as a whole, the classroom interacts with the community and the social system as a whole. The classroom therefore becomes a microcosm or small-scale reflection of society as a whole. A positive environment needs to be created that, as far as possible, matches the needs and values of the people concerned and that contributes to the well-being of all learners. Physical, social and instructional aspects of the classroom environment need to be taken into account and developed in a manner supportive of the learning process and the well-being of learners in the classroom (Donald, Lazarus & Lolwana, 2002).

Factors that could impact upon the well-being of learners in the classroom are the following,

- Physical aspects: Building facilities, noise, lighting, ventilation, temperature, displays, seating, class size;
 - Social aspects: interpersonal relations between teacher and students and between students themselves;
 - Instructional aspects: how the teaching/learning process is structured and how materials are used in the process.
- (Donald et al, 2002).

Other aspects that need to be taken into account are the multidimensional role of the teacher (as educator, researcher, leader, manager, supporter), and the processes involved with developing a democratic classroom (Donald et al, 2002). Teachers therefore have to engage in a constant process of self reflection and awareness of the dynamics within themselves and their classrooms that impact upon well-being and constantly strive to develop a healthy classroom environment.



2.6.4 Health Promoting Schools

According to the World Health Organisation, every child has the right and should have the opportunity to be educated in a health promoting school (HPS) (WHO, 1997). “A Health Promoting School can be characterized as a school constantly strengthening its capacity as a healthy setting for living, learning, and working” (WHO, 1998:2). The health promoting school aims at achieving healthy lifestyles for the total school population by developing supportive environments conducive to the promotion of health. It offers opportunities for and requires commitment to the provision of a safe and health-enhancing social and physical environment (ENHPS, 1993 in Donald et al, 2002). The actual development of HPS depends upon the implementation of five health promoting strategies as defined by the Ottawa Charter (1986), namely, the curriculum, support services, environment, community involvement and policy. The Ottawa Charter was a response to the need for a new public health movement around the world which would

take into account the influence of social and economic conditions and physical environment which apart from individual lifestyle choices also have an important impact upon health behaviour choices (Reddy & Tobias, 1994).

2.6.4.1 Curriculum

For the concept of health promotion through schools to become an integrated part of the school system, curriculum issues have to be addressed (Johnson, 1998). For the purposes of this research, curriculum is broadly defined and includes all the opportunities for learning provided by the school,

It includes the formal programme of lessons in the timetable: the so-called “extracurricular” and “out of school” activities deliberately promoted or supported by the school; and the climate of relationships, attitudes and styles of behaviour and the general quality of life established in the school community as a whole (Tones, Dixey & Green, 1995:2).

Curriculum development in HPS should focus on the development of skills and prepare individuals for the future. Learning should be fun and the emphasis should be on the practical application of skills (Johnson, 1998). This is in line with modern approaches to curriculum development generally and in health education,

Modern approaches to curriculum development in health education have emphasized the principle of the ‘spiral curriculum’, issues being dealt with in appropriate ways at appropriate ages. They have also taken a life skills approach, stressing concepts such as self-esteem, empowerment, and decision-making skills, rather than a purely information-based approach (Downie, Tannahill & Tannahill, 1996:111).

Life skills education forms a critical part of the curriculum of a HPS. This involves the development of personal skills and includes a programme of staff development (Donald et al, 2002),

Life Skills are indispensable in the process of empowering individuals to engage and cope successfully with life and its challenges. The development of life skills

promotes psychosocial competence. This has a pivotal role to play in the promotion of health in its broadest sense – in terms of physical, mental, and social well-being. Life skills education enhances a person’s coping resources through promoting personal and social competence and confidence (Donald et al, 2002:96).

The Valley Trust (in UNICEF, 2004) noted the impact of life skills education in their schools in South Africa,

...seeing shifts in teachers paradigms of themselves, of their learners and of the learners’ parents. We are seeing teachers become motivated and start loving their teaching. We are seeing teachers starting to work together and start working together with parents for the first time. We are seeing authoritarian classroom climates where teachers used ‘killer words’, corporal punishment etc change into happy, caring places where teachers are giving children the opportunity to learn and practice life skills in every subject (UNICEF, 2004:63).

Life skills educators in South Africa have also noted the impact of life skills education on community resilience. The UNICEF report (2004) emphasises the importance of looking at the resilience and strengths of people, and those who survive and even thrive despite the incredible difficulties they experience in life and captures these quotes from one of the respondents in their workshops,

I have been astonished with the level of life competency in communities – on personal, family and communal level. In the communities where I participated in research, community members have demonstrated initiative, compassion, and pragmatism. It is important to nurture these strengths so they may be used to help those who have lost hope or who are beginning to give up (UNICEF, 2004:49).

2.6.4.2. Support services

The HPS approach calls for a reorientation of health services. This implies that education support services should be co-ordinated and accessible to all who need them. These services would also need to provide comprehensive programmes, including curative, preventive and health-promotive aspects (Donald et al, 2002).

The reorientation of services involves redefining the role of school psychologists and other education support personnel. This is recognized broadly by Adelman and Taylor (2003) who argue that school psychology has a bigger role to play in assuring schools achieve their mission. That role involves broader issues related to intervention development, or improvement of schools as systems. They endorse Strein et al's (2003) view that a public health perspective can provide a broad framework that will increase both the efficacy and efficiency of school psychologists' work. They believe that escaping old ideas about the functions of school psychologists requires a deep appreciation of the reality that schools are in the education business, not in the physical or mental health business. Schools also have responsibility for all their students, not just for those having problems (Adelman & Taylor, 2003).

According to Adelman and Taylor (2003), all who are employed by schools systems are expected to support the basic mission. And, given prevailing accountability measures, the value of their work is judged in terms of whether it can improve achievement test scores. They do realise that there are some factors that need to be addressed in order for instruction to proceed. Thus they are willing to devote personnel to such matters. But, they address these matters in an ad hoc, piecemeal manner that limits impact and keeps the enterprise marginalized and fragmented in policy and practice. Stated simply, much of what school psychologists do is viewed as supplementary,

The key to ending marginalisation is making the case for a shift in educational reform policy that moves education support from the margins into a position of being an essential and primary component for schools to achieve their mission. School psychologists must strengthen the rationale for their work. This includes clarifying a set of functions that encompass all students and making the case that such functions are essential in enabling schools to fulfill their mission (Adelman & Taylor, 2003:86).

School health services play a critical role in developing HPS. Closer collaboration between the school health service, teachers and parents is noted by Moon (1993) as a potential benefit of the health promoting school project,

The knowledge and skills a school nurse can contribute to the development of a health promoting school are invaluable and the health promotion projects will seeks to foster closer co-operation between school nurses and teachers (Moon, 1993:417).

The school nurse is largely exempted from the pressures that teachers have to face and has greater access to various education support services and can serve as a critical link between the school and these services (Johnson, 1998). Nutbeam (1995) alerts us to the fact that it is the health sector that has provided substantial resources for the development and implementation of HPS even though most of the activity regarding HPS had its origins in the education sector. Nutbeam (1995) advocates that both sectors work together to develop schools into health promoting institutions. Kolbe (1992) supports this stance,

If efforts to prevent the health risks among youth are to be effective and efficient, we must combine the health expertise and health resources of health agencies with the necessary organizational capacity and policies of education agencies. Neither health not education agencies can do the job alone. Both need each other (Kolbe, 1992:137).



2.6.4.3 Environment

The development of a supportive environment in HPS includes both the physical and psychosocial environment of the school. According to Donald et al (2002) the buildings should be safe, including facilities for students with special needs, basic health regulations should be met and the prevailing style of management should be one which encourages empowerment of all sectors in the school and which encourages teamwork and constructive conflict management at all levels.

Promoting the mental health and well-being of all young people is a vital part of the core business of teachers by creating a supportive school environment that is conducive to learning. Teachers need to be comfortable and confident in promoting and teaching for mental health. Specific, targeted interventions, provided within a whole-school

framework, addresses the needs of the minority of students who require additional support (Wyn, Cahill, Holdsworth, Rowling & Carson, 2000:594).

An exceptional example of an environment that is aimed at promoting the well-being of learners is found within the Gatehouse project in Australia (Patton, Glover, Bond, Butler, Godfrey, Pietro & Bowes, 2000). The Gatehouse project provides unique information on the relationship between the social environment and the emotional well-being of young people. The conceptual framework of the Gatehouse project emphasizes healthy attachments with peers and teachers through the promotion of a sense of security and trust, effective communication and a sense of positive self-regard based on participation in varied aspects of school and community life. A school social climate profile is derived from a questionnaire survey of students. An adolescent health team uses this information to set priorities for change within the school. Interventions may focus on the promotion of a positive social climate of the whole school or in the classroom. Curriculum-based health education is also used and based on materials that are relevant to the normal developmental experiences of teenagers. These are integrated into the mainstream curriculum and incorporate a strong component of teacher professional development. Lastly, the intervention promotes linkages between the school and broader community with a particular emphasis on the needs of young people at risk of school drop-out (Patton et al, 2000).

2.6.4.4 Community involvement

The development of a HPS involves strengthening community action and participation. The school is therefore encouraged to develop stronger links with the local community. This would include greater community participation in the life of the school as well as the school contributing to the life of the community (Donald et al, 2002).

School-community partnerships can weave together a critical mass of resources and strategies to enhance caring communities that support all youth and their families and enable success at school and beyond. Strong school-community connections are critical

in impoverished communities where schools often are the largest piece of public real estate and also may be the single largest employer. Comprehensive partnerships represent a promising direction for efforts to generate essential interventions to address barriers to learning, enhance healthy development and strengthen families and neighbourhoods (Centre for Mental Health in Schools, 1999:2).

The health promoting schools strategy cannot be effective if it is not supported by the school community. Parents and community members need to be informed of the concepts and of projects aimed at promoting good health. They need to be actively involved as far as possible in developing the school into a HPS (Johnson, 1998). The broader community needs to know about the HPS projects and work with project staff to ensure consistency of health messages that are given to children. Projects may prompt changes in their own thinking about health. They may also be able to offer support, financial or in kind (Moon, 1993).



The success of parent-school collaboration rests upon the recognition and application of the following characteristics of collaboration: trust, openness, honesty; positive, caring attitudes; personal connections; being equals; understanding of power, conflict and roles; and schoolwide commitment (Gareau & Sawatsky, 1995). For collaborative efforts to be successful, there needs to be a collaborative culture in the school as a whole. There should be collaboration between staff members, staff and parents, staff and students, and students themselves (Johnson, 1998).

2.6.4.5 Policy

The development of healthy public policy involves a policy that incorporates a health-promoting vision and principles. This includes broad policies that promote inclusion and equity in terms of race, gender and ability as well as more specific policies like no smoking in public spaces (Donald et al, 2002). According to the WHO, a HPS implements health promoting policies and practices such as,

- An overall policy supported by school administration and management as well as teaching practices that help create a healthy psycho-social environment for students and staff;
- Policies on equal treatment for all students;
- Policies on drug and alcohol use, tobacco use, first aid, and violence that help prevent or reduce physical, social and emotional problems. (WHO, 1999b:2).

According to the National Guidelines for the Development of Health Promoting Schools (DoH, 2000), policy development entails analyzing and engaging in the development of education policies at all levels of the education system: national, provincial, district/regional and institution/site levels. This is to ensure that they support the development of health and well-being of all members of the learning community (DoH, 2000). The guidelines state that governing bodies of education institutions have collaborative responsibility for implementing and developing education policy at site level. The guidelines propose that the following areas need to be addressed through school/site policy,

- 
- Development of a supportive and welcoming environment for all members of the school/site community, including the development of an anti-bias, anti-discriminatory, human rights culture;
 - Development of a safe environment which is free of harmful substances and violence and crime, and which fosters and maintains positive discipline and behaviour;
 - Facilitation of co-ordinated, integrated support services within the school/site in collaboration with district and other support services;
 - Development of guidelines and comprehensive strategies to address priority issues such as HIV/AIDS;
 - Fostering of health through the provision of nutritious food in the school/site (for example, in the kitchens, at tuckshops, from vendors, and in lunches or lunch boxes);
 - Encouragement of physical activities, sport and cultural recreation. (DoH, 2000:21).

2.7 THEORETICAL FRAMEWORK FOR THE STUDY

The aim of this chapter has been to explore in detail various understandings of what constitutes mental health or well-being and the processes involved with achieving and maintaining a positive emotional state. These understandings were applied to youth in

general and to the youth in South Africa in particular. Herewith, follows a summary of the main findings and framework for the ensuing research.

Within the context of health as a concept that includes physical, mental, social and spiritual well-being, not only the absence of disease, mental health is further defined as being equipped to handle the stresses and various challenges of life. Good mental health is seen as very relevant to children as mental health problems can interfere with the learning, developmental and social processes. Much emphasis is placed on the fact that good mental health is dependent upon biological, psychological and social factors. Indigenous notions of what constitutes good mental health is explored. The importance of cultural and spiritual influences in determining the well-being of individuals is stressed. The contribution of indigenous knowledge towards understanding and securing the well-being of individuals is recognized. The role of society in contributing towards the mental health problems of indigenous communities is highlighted as is the role that society can play in restoring good mental health to indigenous communities.



A focus on mental health in South Africa reveals that individuals most at risk for mental health problems are those belonging to communities that have been oppressed. There is however, a strong commitment from the present government to redress the inequalities of the past and provide services to previously disadvantaged communities where the most basic services were lacking. Needless to say, the mental health of the majority of youth in South Africa have been seriously compromised as a result of the social and political injustices that left most African communities impoverished, not only in terms of resources but also in terms of cultural heritage. The high rate of crime and violence and various forms of abuse are a reflection of this. These problems are also having a negative impact on education and schools are under threat. Notwithstanding the enormous challenges, schools are still regarded as the place where much healing and reconstruction can take place, where young people that will make a positive contribution to society can be produced. Schools and education still represent much hope for the people of South Africa. Furthermore, the strengths of the youth of SA are presented which signify the importance of focusing on positive aspects of youth if we hope to change things.

A public health framework is critical for prevention of ill mental health amongst large populations. The area of health promotion provides us with a strategy for preventing problems amongst the youth. Health promotion advocates an integrated framework of health education, activities and services. The involvement of the community is a crucial part of any intervention. The interacting roles of health, psychological and academic variables have to be taken into account in the development of a comprehensive health program. Within a public health framework, the risk and protective factors of populations and subsequently of youth are nested within community levels of risk for or protection from disease with the explicit aim of promoting health. The reorientation of services and school psychology in particular, is important to the success of mental health interventions at school level. There is much support for research and data-based decision-making to develop specific interventions to promote health. Mental health promotion in schools involves establishing comprehensive, multifaceted approaches that help ensure schools are caring and supportive places that maximize learning and well-being, and strengthen students, families and neighbourhoods. Mental health in schools should encompass efforts to address psychosocial and mental health problems as major barriers to learning. The school as an ideal setting to provide mental health services to youth is emphasized.

The fact that youth are at risk for adverse outcomes more now than ever before is highlighted. Yet, the services that are available are by no means adequate for meeting their needs. The psychosocial problems of youth are impacting upon their abilities to be successful. In addressing barriers to learning and development, a major emphasis is on improving neighbourhood, home, school and classroom environments to prevent problems and enhance strengths. The aim is to produce a safe, healthy, nurturing environment/culture characterized by respect for differences, trust, caring, support and high expectations. These principles are entrenched in the new education policies in South Africa.

The strengths and weaknesses of identifying youth as being at risk are discussed. The concept of risk has been a useful tool for enquiry into the etiology of the problem of

interest, the prediction of the disorder, the identification of ‘protective factors’ and the translation of this information into early intervention and prevention programs. Risk impacts upon an individual’s ability to cope and increases the chances of a negative mental health outcome. Some risk factors play a causal role while others merely mark or identify the potential for a disorder. Because education is primarily an effort to induce change, there is a dynamic quality to the relations between what a child brings to school and what a school brings to a child, which continually alters the risk coefficient of individuals and groups.

The application of risk-focused prevention have, however, often led to identification, labeling and stigmatizing of youth, their families and their communities. Focusing on individuals who do not succeed does not allow us to embrace those who do succeed despite being exposed to a system designed to allow individuals to fail based on racial classification and related stereotyped notions of ability and intelligence. A focus on risks or deficits obscures teachers’, parents’ and other helpers’ vision in seeing the assets or strengths that young people have; a focus on deficits leaves all concerned feeling helpless and hopeless.



Resilience factors have far more predictive power than risk factors. Most children and youth, even those from highly stressed families or resource-deprived communities, do somehow manage to make decent lives for themselves. A resilience paradigm provides optimism, hope and motivation. Focus on the adverse effects of community danger may unintentionally minimize the significance and beneficial effects of socio-cultural resources found in all communities. The supports and opportunities serving as protective factors for youth facing adversity should apply equally to all young people.

An attempt was made to define resilience for the purposes of this research. Classic resilience focused on the development of competence, confidence and caring in the face of risk and adversity – a traditional psychopathology perspective. Currently, resilience is seen as a dynamic developmental process. The developmental theme of meeting youth needs for love and belonging, respect, identity, power and meaning. These approaches all

share the belief that it is adult society's responsibility to provide the developmental supports and opportunities to meet these needs and promote positive developmental outcomes in youth, ultimately resulting in improved health, social and academic outcomes. Once again the importance of indigenous beliefs in contributing to resilience and wellness is highlighted. This is related to health realization which speaks to reconnecting people to the health in themselves and then directing them in ways that bring forth the health in others. The aim is a change in people and communities, which builds up from within rather than being imposed from without. The underlying principle is that resilience is innate and in all humans and is directly accessible.

The understanding of resilience and protective factors compel us to develop intervention programmes aimed at addressing multiple risks. A significant factor in fostering resilience in children is the role of the school. Supportive, nurturing school environments are crucial. Positive relationships between teachers and learners, learners themselves, teachers and parents and the school and its community must be encouraged and developed. A positive, affective learning environment produces a classroom of more motivated students who exhibit less resistance to learning and absorb lessons faster and with better retention that makes the job of teaching less stressful.

One way of improving the support at school level is the adoption of the health promoting schools concept. It provides strategies for mobilizing staff, students, parents, support services and other agencies to constantly strive to develop a healthy setting for living, learning and working. It ensures an operational life skills curriculum, reorientation of support services, a supportive environment, community involvement and the adoption of appropriate policies.

In summary, if we are to be effective in our efforts to promote the well-being of our youth, we need to realise the importance of exploring the field of public health and health promotion frameworks. We need to expand out thinking about what constitutes good mental health and consider the importance of cultural and spiritual influences on mental health or well-being. We need to examine the role of politics and society in contributing

towards mental health problems and seriously consider interventions and advocacy in these areas if it will help to improve the well-being of certain communities. We need to focus on prevention efforts while not neglecting much need treatment services. We need to utilize the school as a setting for mental health promotion efforts. In fact, schools need to become health promoting schools in order to provide comprehensive mental health services. This involves complete transformations in the perceptions of educators about the potential of their learners. A positive reframing of the value and worth of young people needs to occur. Classrooms need to be transformed to healthy environments that benefit both learners and educators. Within the health promoting schools framework, the potential for promoting resilience amongst youth is increased as this framework emphasizes healthy policies, supportive environments, life skills education, reorientation of services and strengthening school and community partnerships. Furthermore, the health promoting schools initiative is closely linked to inclusive education and addressing barriers to learning is a core component of this initiative which in turn, is a core component of achieving the educational mission of schools. Most importantly, these new developments do not require major restructuring in terms of school systems as much as it requires mindset changes which make it relatively inexpensive in terms of financial and human resources. It is therefore an attractive framework for securing the well-being of youth in South Africa at present.

2.8 CONCLUSIONS

This chapter has attempted to provide an in-depth overview of the various concepts, theories and policies that will inform this study. Reference will be made to the theoretical findings of this section later in the thesis. Chapter eight will serve as the discussion chapter and the findings of chapters four, five and six will be related to the literature review. The following chapter is the research methodology chapter and provides in detail, the research aims and objectives, significance of the research, the research methodology employed, research instruments and procedure, analysis, ethical considerations and limitations of the study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

The aim of this chapter is to outline and discuss in detail the methodology utilized in this study. The chapter begins with a concise motivation for the study. The research aims and objectives are restated, as is the significance of the research and ethical considerations. The appropriateness of utilising both quantitative and qualitative methodological approaches for this study is explained. The strengths and weaknesses of each approach are provided as well as justifications for the choice of various data collection instruments. The processes and techniques involved in gathering and analyzing the data are therefore presented in detail.

Professionals involved with youth are concerned about the increasing prevalence of violent behaviours, alcohol and drug abuse, depression and suicide, bullying and harassment, risky sexual practices and HIV/AIDS amongst our youth. Schools and communities are looking for solutions to the difficulties that the youth are experiencing and they wish to mobilize all efforts to achieving positive outcomes. In an attempt to address these challenges, this research examines the risk and resilience profiles of youth at selected schools in the Western Cape and then, explores the health promoting schools framework as a strategy to provide support to all young people.

3.2 OBJECTIVES AND SIGNIFICANCE OF THE RESEARCH

The research aims and purpose are restated here, in an attempt to remain focused in terms of the purpose of the research,

Alignment with purpose helps researchers to stay focused on the research process as it unfolds and to avoid bringing in their own agenda. In this sense it helps researchers to avoid crossing lines. It can also help them to get back on track if they have temporarily lost their focus (Meulenberg-Buskens, 2002:21).

Furthermore, clarification of the research aims and objectives allows one to assess the benefits of the selected research methodology (Mouton & Marais, 1990). It also allows one to assess the ‘usefulness quality’ of the research, an aspect that Meulenberg-Buskens (2002) emphasizes as important particularly for countries such as South Africa with its particular research history. In the past, research endeavours were not always in the best interests of the participants of the research. As this research is firmly grounded in a health promotion framework, issues of social responsibility and usefulness become particularly important.

3.2.1 Research aims and purpose

This research aimed to explore factors relating to risk, resilience and health promoting schools in order to promote resilience amongst youth in South Africa. The specific research objectives of this study were as follows,

- To determine the mental health needs of Western Cape youth;
- To determine the strengths of Western Cape youth;
- To determine the form and extent of support being provided to Western Cape youth;
- To explore the health promoting schools framework as a strategy for support provision and thus securing the well-being of Western Cape youth.

It can be seen that this research was aimed not only at determining the current risk status of Western Cape youth but also at determining their strengths and support systems in order to promote their health and well-being. The benefits and advantages to the participants in the form of promoting well-being was therefore an integral part of the research process. The following section on the significance of the research provides comprehensive insight into this approach.

3.2.2 Significance of the research

Meulenberg-Buskens (2002) emphasizes the abilities of a research study (particularly qualitative research) in terms of its ability to bring about change towards a better quality of life and how research results can lead to recommendations for action. Meulenberg-Buskens (2002) notes that qualitative research can take the researcher's interpretations out of the researcher-respondent relationship into other relationships such as those with policy makers, academia, funders, and so forth. These comments, while focusing on qualitative research, are applicable to this study with its health promotion focus as it compels the researcher to social action and change.

It is hoped that this research will have a significant impact on the development of mental health promotion in schools in terms of,

- Developing the capacity of schools, educators and parents to secure healthier outcomes for youth;
- Facilitating the development of various forms of support for learners;
- Facilitating the development of a curriculum aimed at promoting the well-being of learners;
- Further developing the health promoting schools framework to include mental health promotion and resilience;
- Informing policy and practice on strategies for facilitating mental health promotion within the schools.

3.3 RESEARCH METHODOLOGY

This research followed a mixed-method design. Quantitative and qualitative research methodologies were employed to meet the research aims as “this approach promotes more complex research designs and these oblige researchers to be more clear about what it is they are setting out to study” (Fielding & Schreier, 2001:14). In terms of meeting the primary aims of the research, namely, determining the needs, strengths and support experienced by the youth and exploring the health promoting schools framework as a strategy for support provision, quantitative research methodology was considered the most appropriate means of gathering this information via the utilization of surveys and

questionnaires, "...In a quantitative approach the researcher tries to measure the degree in which certain aspects she assumes the phenomena consists of, are present in reality" (Meulenberg-Buskens, 1997:1).

However, in terms of furthering our understanding of these issues and adding depth to the information received, qualitative research methodology was also considered to be an appropriate means of gathering this information via focus groups and interviews,

Qualitative work can assist quantitative work in providing a theoretical framework, validating survey data, interpreting statistical relationships and deciphering puzzling responses, selecting survey items to construct indices and offering case study illustrations (Fielding & Schreier, 2001:15).

In this study, the qualitative research process occurred after the quantitative research process where the researcher could clarify certain findings, understand certain anomalies and develop deep insights into certain phenomena. The process allowed for collection of a wealth of information that would otherwise not have been possible utilizing only one research methodology,



Accepting the case for interrelating data from different sources is to accept a relativistic epistemology, one that justifies the value of knowledge from many sources, rather than to elevate one source of knowledge (or more accurately, to regard one knowledge source as less imperfect than the rest) (Meulenberg-Buskens, 1997:1).

According to Kleining and Witt (2001:18) "Qualitative data lack abstraction and quantitative data lack meaning". A mixed method design as employed by this research, therefore reduces the limitations and enhances the strengths of both methodologies. Apart from the validation of findings, the research findings also illuminate any discrepancies in the information that came to the fore as a result of the triangulation process. This will serve to enhance our understandings of the phenomena under investigation. This serves to endorse Meulenberg-Buskens' (1997) view that the difference between findings from different knowledge sources can be as analytically illuminating as their points of coherence.

3.3.1 Quantitative research methodology

Quantitative research is defined as the numerical representation and manipulation of observations for the purpose of describing and explaining the phenomena that those observations reflect (Encyclopedia Free Dictionary, 2004). According to the Encyclopedia (2004), it is used in a wide variety of natural and social sciences, including physics, biology, psychology, sociology and geology, and begins with the collection of statistics based on real data, observations or questionnaires.

Quantitative research methodology is traditionally defined within a positivist tradition and as a result, encompasses empirical conceptions such as universal laws, evidence, objectivity, truth, actuality, deduction, reason, fact and mathematical data (Winter, 2000). According to Kleining and Witt (2001), quantitative data operate at a higher level of abstraction than qualitative or everyday information. In empirical research, quantification has many advantages; most prominent is the reduction of complex data to aspects that are regarded as important for a particular purpose - an easier processing of larger volumes of data as a result of it.



The following belief expounded by Thorndike (1904, in Fierro, 2004) served to form the foundation of quantitative research methodology namely, that anything that exists exists in a certain quantity and can be measured. This belief led to the view expounded by Ogburn (1927, in Fierro, 2004) that when you cannot measure, your knowledge is meager and unsatisfactory. According to Gage (1994:372 in Fierro, 2004:1),

The ideals of quantitative research call for procedures that are public, that use precise definitions, that use objectivity; seeking methods for data collection and analysis that are replicable so that findings can be confirmed and disconfirmed and that are systematic and cumulative – all resulting in knowledge useful for explaining, predicting, and controlling...

A quantitative research method is therefore appropriate where quantitative measures of variables of interest are possible, where hypotheses can be formed and tested and inferences drawn from samples to populations (Fierro, 2004). Quantitative research

incorporates the statistical (how many) element, designed to quantify the extent to which a target group are aware of, think this, believe that or are inclined to behave in a certain way (Mori, 2003).

At the most simplistic level, numbers and statistical processes form the core of a quantitative research approach while words form the basis of qualitative research (Robson, 1993). While previously, quantitative methodology was deemed to be a much more superior methodology to employ due to its objective nature, this has changed substantially with more researchers recognizing the value of qualitative methodology and utilizing the two methodologies to enhance their findings,

Quantitative research, long held to be the only form of research that was statistically valid and reliable, is now being used in conjunction with qualitative research methodology in studies that cannot adequately describe or fully interpret a situation. The two are so intertwined that a study of quantitative research is nearly impossible without referring to both methods (Fierro, 2004:3).

3.3.2 Qualitative research methodology



There is much evidence that qualitative research methodology has gained prominence and is fast becoming a preferred methodology for conducting research, particularly amongst social scientists (Berg, 2001, Meulenber-Buskens, 2002, & Morgan, 1997). Many definitions of qualitative research methodology exist, from more general understandings to the more specific. It is also becoming more varied, individualistic and heterodox in its application and therefore researchers find it hard to give one specific definition of qualitative research (Meulenber-Buskens, 2002). This section will therefore attempt to provide a comprehensive understanding of qualitative research methodology.

Qualitative research is about finding out what people do, know, think and feel by observing, interviewing and analyzing documents (Patton, 1990). The emphasis is on process, on understanding why certain things occur, not only what is going on (Mostyn, 1985 in Brenner, Brown & Canter, 1985). It concerns itself mainly with the meanings

which people give to their experiences, thoughts and emotions. It is a creative, interactive and dynamic process that produces descriptive and theoretical knowledge (Meulenberg-Buskens, 2002).

Qualitative research deals with the familiar everyday life of the setting that one has chosen to study, does not remove people from their natural settings and values the opinions of the participants (Marshall & Rossman, 1989, Mouton & Marais, 1990; Radnor, 1994). According to Meulenberg-Buskens (1997:1), qualitative approaches are characterized as follows,

- Qualitative research is oriented towards an insider's perspective;
- The contextualisation of the process of knowledge construction is emphasized;
- The research design is open and flexible;
- Validity and reliability of the research results depend to a high degree on the researcher's skills and sensitivity;
- The scope of the research tends to be of small scale.

Smaling (1992) confirms and extends these notions of qualitative research by linking it to aspects of empirical research. According to Smaling (1992:174), qualitative research can be characterized on the basis of four aspects of empirical research: the nature or preconception of the object of study, the method of data collection, the method of data-analysis and the research design,

- First, the object of study is the world as defined, experienced or constituted by the investigated people. This also means that the qualitative researcher does not always study the conscious cognitions and conscious experiences of the subjects, for these subjects constitute their world, partly, without awareness of their constituting activities;
- Second, the method of data collection is open, flexible and not strictly regimented. Unstructured or depth interviews or participant observation, for instance, are preferred to precoded questionnaires and systematic observation techniques;
- Thirdly, the method of data-analysis does not include a representation of an empirical system (the gathered data) in a numerical-mathematical system for the purpose of reasoning analytically within this mathematical system;

- Fourthly, the qualitative research design implies an interactive, cyclical relation between data-collection and data-analysis alternating continuously and influencing each other. In this manner, it is possible to select data that have relevance for analysis and to stop gathering data when new data do not add new information with regard to the research problem. On the other hand, new data may be an inducement to change the analysis or the research problem (cf. Maso, 1989).

Smaling (1992) therefore enriches our understanding of qualitative research methodology by placing it within an empirical framework.

For the purposes of this research, it is important to be aware of the strengths and weaknesses of the qualitative approach and how to overcome these. One of the strengths of the qualitative approach is the fact that it allows researchers to explore issues in detail (Ferreira, Mouton, Puth, Schurink & Schurink, 1988; Mouton & Marais, 1990). The views of the participants are regarded as more important than the views of the researcher and the goal of qualitative research is to describe and understand these views (Marshall & Rossman, 1989). The freedom and flexibility that this form of research allows also results in valuable information that would not otherwise be gained by quantitative methods (Babbie & Mouton, 2001).

One of the major criticisms of qualitative research methodology is that it is very subjective and therefore not thought to be scientifically credible (Brenner, 1985; Denzin & Lincoln, 2000). The validity and reliability of qualitative research methodology is seriously questioned by many researchers. Its flexible nature is cited as one of the reasons for it being regarded as unscientific (Fiese & Bickham, 1998). Furthermore, Wimmer and Dominick (1997) point out that it is often difficult to draw definite conclusions from the findings or to at least generalise them to larger groups because of the small scale of the method and the often unrepresentative samples that are used.

3.3.3 Issues of reliability and validity

Mouton and Marais (1990) encourage researchers to employ triangulation of different methods in order to compensate for the lack of each individual method. This view is endorsed by Johnson and Chopra (2002) who argue that the collection of data from different sources and using different methods allows for triangulation and strengthens the basis from which to draw conclusions and make recommendations.

Marshall and Rossman (1989) encourage researchers to ensure that data collection methods are explicit; negative instances of the findings are displayed and accounted for, biases are discussed, strategies for data collection and analysis are made public, field decisions altering strategies or substantive focus are documented, data is preserved, participants' truthfulness is assessed and theoretical significance and generalizability is made explicit.

According to Meulenber-Buskens (2002), there are many ways in which qualitative researchers can strive towards quality in their research. Many of these guidelines concern research acts and research decisions. The guidelines include learning techniques and gaining methodological insight, triangulating methods and data-sources and leaving an audit trail. Meulenber-Buskens (2002) supports the view of Mason (1996) that qualitative researchers must constantly take stock of their actions and their role in the research process and subject these to the same critical scrutiny as the rest of their data. Furthermore, Meulenber-Buskens (2002) proposes that researchers share their observations and reflections with other research participants as this sharing will automatically stimulate personal reflexivity, "Dialogical openness is absolutely crucial in the striving towards all four dimensions of quality: technical quality, usefulness quality, social responsibility quality and recognisability quality" (Meulenber-Buskens, 2002:21).

Lincoln and Guba (1985 in Marshall & Rossman, 1989) argue that internal validity, external validity, reliability and objectivity are inappropriate constructs for qualitative inquiry and propose four alternative constructs namely,

- Credibility: within the parameters of that setting, population, and theoretical framework, the research is valid;
- Transferability: triangulating multiple sources of data can enhance generalizability;
- Dependability: the concept of replication is itself problematic as we live in a changing world; and
- Confirmability: provide controls for bias in interpretation by involving a person who critically questions the analyses.

Finally, Fielding and Schreier (2001) caution us about utilizing the terms triangulation and validity interchangeably. They remind us that the value of triangulation lies more in its effects on ‘quality control’ than in its guarantee of validity,

Theoretical triangulation does not necessarily reduce bias, nor does methodological triangulation necessarily increase validity. When we combine theories and methods, we do so to add breadth or depth to our analysis, not to pursue an ‘objective truth’ (Fielding & Schreier, 2001:16).

This research utilizes various methods of data collection with the aim of fully understanding the phenomena of risk, resilience and support both in terms of statistics to determine prevalence and words to determine the underlying dynamics of the phenomena under investigation. The triangulation process that occurs could enhance the case for quality and generalizability, and is therefore regarded as a bonus in addition to the wealth of information is generated through the mixed method design.

3.4 RESEARCH DESIGN

3.4.1 Participants

The sample for this particular study comprised a cross section of nine high schools in the Western Cape representing a diverse population of learners and communities (rural and urban, wealthy and impoverished, previously advantaged and disadvantaged). Grade nine learners (two classes per school) were participants in the study. The sample provided an adequate range of schools within the South African secondary or high school education landscape and serves as a representative subset of the population under study in terms of

sample size and composition for the purposes of conducting an in-depth study (Bowling, 1997).

This study focused on collecting school-level data as opposed to district level data. “School level data are especially valuable if schools in a district vary markedly in their student demographics, programs, or services” (WestEd, 1999:22). Considering the complexities of our student demographics, this was clearly the best option. Also, “School-level planning is strongly encouraged so that the program is owned by and relevant to each unique school site” (WestEd, 1999:22). The theoretical framework of this study promotes empowerment, ownership and needs-based intervention and the sampling is therefore in accordance with the values and principles of health promotion. Having complied with CHKS requirements regarding sampling and procedures, there is great confidence that this study collected representative data.

3.4.2 Data collection techniques



According to Robson (1993), the selection of data collection techniques depends on the conceptual framework, research questions and sampling criteria. For the purpose of this research and in terms of the mixed method design, a survey was conducted, focus groups were held, interviews were conducted and questionnaires were administered. This section explores the strengths, weaknesses and application of these data collection techniques.

Glesne and Peshkin (1992) advise researchers to ensure that the techniques chosen are likely to elicit the data needed to gain an understanding of the phenomenon in question, contribute different perspectives on the issue and make effective use of the time available for data collection. In this study, the aforementioned data collection techniques enabled the researcher to not only meet the aims and objectives of the research but also to extend the boundaries of enquiry and gain valuable insights, all within the limited time frame available for the research.

3.4.2.1 Surveys

The American Statistical Association (ASA, 2004:1) states that surveys,

- Are used most often to describe a method of gathering information from a sample of individuals. This sample is usually just a fraction of the population being studied;
- Can be conducted in many ways including over the telephone, by mail or in person;
- Gathers information from only a part of a population of interest – the size of the sample depends on the purpose of the study;
- Collected by means of standardized procedures so that every individual is asked the same question in more or less the same way;
- Individual respondents should never be identified in reporting survey findings. Results should be presented in anonymous summaries (tables and charts);
- Provide a speedy and economical means of determining facts about our economy, about peoples knowledge, attitudes, beliefs, expectations and behaviours;
- Provide an important source of basic scientific knowledge.

The California Healthy Kids Survey (CHKS) was utilized for this study as it provides a standardized questionnaire that is administered in a particular way as set out in the guidebook for administering the survey (WestEd, 1999). It is conducted in person and is speedy to administer. It is economical in terms of human and economic resources and provides a vast array of information regarding risk and resilience profiles of youth.

3.4.2.2 Interviews

Meulenberg-Buskens (2002) regards the interview as the main technique in qualitative research. The aim of the interview is to find out what is in and on someone else's mind (Patton, 1990), is a verbal technique to obtain information (Meulenberg-Buskens, 1997) and is a strong, open-method where the interviewer tries to learn the respondent's perspective (Wester, 1996). It is described as a form of conversation but it is not the same as a conversation between participants that meet in an everyday context. The interview is organized to meet the interests of the researcher, and these are related to a search for answers to specific questions. Dependent on the course of the conversation, the

interviewer decides when and how the topics that are central in the study should be brought up (Babbie & Mouton, 2001, Brenner, Brown & Canter, 1987, Foster & Potgieter, 1995, Wester, 1996).

According to Fontana and Frey (1994:361), interviewing has a wide variety of forms and a multiplicity of uses. The most common type of interviewing is individual, face-to-face verbal interchange, but it can also take the form of face-to-face group interviewing, mailed or self-administered questionnaires, and telephone surveys. Interviewing can be structured, semi-structured or unstructured. It can be used for marketing purposes, to gather political opinions for therapeutic reasons, or to produce data for academic analysis. It can be used for the purpose of measurement or its scope can be the understanding of an individual or group perspective. An interview can be a one-time, brief exchange, say five minutes over the telephone, or it can take place over multiple, lengthy sessions, sometimes spanning days, as in life-history interviewing.

Interview questions can include (Patton, 1990),



- Behavioural questions to obtain description of behaviour and activities;
- Opinion or value questions that inform goals and intentions;
- Knowledge questions to elicit understanding of concepts; and
- Demographic questions to inform community action.

The capacities of the interviewer in regard to role-taking, conversation techniques and language use are seen as essential for the success of this study (Wester, 1996). Sieber (1993) and Bowling (1997) stress the importance of establishing a trusting, relaxed environment as this will encourage open responses. The effectiveness of the interview is dependent upon the questions used as well as the effectiveness of listening and responding (Babbie & Mouton, 2001). Meulenberg-Buskens (2002) stresses the importance of a receptive attitude and the exclusion of subjective perceptions, observations and conceptualization from the dialogue with respondents. Foster and Potgieter (1995) warn that bias may be caused by the interviewers' personal characteristics such as sex, age, race or it may be as a result of the interviewers'

expectations which are transmitted by non-verbal cues such as tone of voice, nodding, and so forth. An assumption fundamental to qualitative research is that the participant's perspective on the social phenomenon of interest should unfold as the participant views it, not as the researcher views it (Brenner, Brown & Canter, 1987). Irrespective of these technical interview skills, according to Wester (1996), the interviewer's activities should be evaluated from the perspective of analysis, as every interview should contribute to meeting the goals of the study.

It was important for the purpose of this study to win the trust of the interviewees (teachers) in order for them to feel free to share their hopes and fears with regard to the well-being of our youth, themselves and their colleagues. As the interviews occurred after the survey and feedback process, teachers were familiar with the researcher and confident about the value of the research as well as the research process. The researcher's training as a psychologist was useful in terms of remaining objective while at the same time empathic and eliciting the necessary information. The researcher's experience as a guidance counsellor at a high school also served to assist in understanding the dynamics involved with being a guidance counselor under difficult conditions and resulted in teachers sharing issues related to staff development and challenges with senior staff, management and the department of education.

3.4.2.3 Focus group interviews

According to Berg (2001), focus group interviews are either guided or unguided discussions addressing a particular topic of interest or relevance to the group and the researcher. Merton, Fiske and Kendall (1956, in Fontana & Frey, 1994) developed the term 'focus group' to apply to a situation in which the interviewer asks group members very specific questions about a topic after considerable research has already been completed. In combination with other methods, focus groups can provide preliminary research on specific issues in a larger project or follow up research to clarify findings from another method (Morgan, 1997). According to Fontana and Frey (1994), group interviews can also be used for triangulation purposes or employed in conjunction with

other data gathering techniques, “Group interviewing has long been used to complement survey research and is now being used to complement participant observation” (Fontana & Frey, 1994:373). Morgan (1997) concurs and contends that there is no ‘one right way’ to do focus groups, that focus groups can serve a number of different purposes. Used in a self-contained fashion, they can be the basis for a complete study. Used with other methods they can either supplement another primary method or combine with other qualitative methods in a true partnership.

There is widespread consensus that focus groups are a valuable technique for collecting information from young children and teens, as well as from elderly adults (Morgan, 1997 & Berg, 2001). The informal group discussion atmosphere of the focus group interview structure is intended to encourage subjects to speak freely and completely about behaviours, attitudes and opinions they possess (Berg, 2001). The focus group allows for creativity, for a variety of ideas from a variety of respondents. The focus group lends itself to spontaneity, the researcher’s role is more muted as the facilitator of the discussion (Strebel, 1996). The group interview has the advantages of being inexpensive, data rich, flexible, stimulating to respondents, recall aiding, and cumulative and elaborative, over and above individual responses (Fontana & Frey, 1994). Furthermore,

The synergistic group effect allows one participant to draw from another or to brainstorm collectively with other members of the group. A far larger number of ideas, topics and even solutions to a problem can be generated through group discussion than through individual conversations (Berg, 2001:112).

According to Fontana and Frey (1994), the skills required of a group interviewer are not significantly different from those needed by an interviewer of individuals. The interviewer must be flexible, objective, empathic, persuasive, a good listener, and so on. However, Fontana and Frey (1994) do point out the necessity of following additional skills: The interviewer must keep one person from dominating the group, must encourage recalcitrant respondents to participate to ensure the fullest possible coverage of the topic. The interviewer must also balance the directive interviewer role with the role of moderator which calls for the management of the dynamics of the group. Also, the

researcher must be aware of the following weaknesses of the focus group interview: The emerging group culture may interfere with individual expression, the group may be dominated by one person, the group format makes it difficult to research sensitive topics, 'groupthink' is a possible outcome, and the requirements for interviewer skills are greater because of group dynamics. Morgan (1997) therefore recommends that for complex problems, focus group size should be kept to no more than about seven participants.

The focus groups in this study comprised of an average of eight participants. It was certainly a challenge to ensure that certain members of the groups did not dominate the discussion. It was, however, a very positive experience to hear the voices of the youth as they shared the challenges of being a young person in a fairly new democracy and their concerns for the well-being of all young people. Once gain, the researcher's skills as an interviewer in terms of her profession as a psychologist was very useful. At the same time, it served as a challenge as the young people had so much to share that the research process could easily have become a group therapy session. The researcher had to constantly be aware of this danger and focus on the research purpose. The focus group as a method for gathering data with adolescents is a positive experience for the young people concerned as it encourages them to verbalise their feeling and experiences and to generate solutions amongst themselves for the challenges they face.

3.4.2.4 Questionnaires

According to Best and Kahn (1998), there are many advantages to utilising questionnaires. Questionnaires tend to reduce issues of bias as the respondents do not have to be concerned about the presence of the researcher. There is significant ease of tabulation as respondents can use machines to analyse and capture data. It enables collection of data from large samples. There is a significant ease of completion as respondents have time to refer. It is also more cost effective in comparison to interviewing. Furthermore, questionnaires allow for large amounts of data to be collected from different sources. Its greatest advantage is that one is able to collect and analyse data quickly and cost effectively (Ogunniyi, 1992).

At the same time however, the disadvantage is that questionnaires answer ‘what is happening’ and not ‘why is it happening’, so we are not able to fully understand the phenomenon under investigation. Other disadvantages (Best & Kahn, 1998) include, sample limitation as it does not include people who cannot read. There is no verbal contact and gained through observation and clarification are lost. There could be doubts related to the persons responsible for completing and returning the questionnaire. Finally, response rates tend to be low.

For the purpose of this study, the questionnaires included closed and open questions so as to ensure that information regarding what is happening is collected as well as the reasons why certain things may or may not be happening. The interviews also further substantiated and motivated the responses gathered from the questionnaires. In this study, it was important to utilise questionnaires to determine the extent to which schools were health promoting and able to provide support to learners in order to enhance their resilience and contribute to their well-being. The questionnaires assessed five areas namely policy, environment, service delivery, life skills education and school and community partnerships. The information gleaned from the questionnaires were sufficient for the purposes of this study as it was not one of the aims to ascertain the reasons for schools being more or less health promoting.

3.4.3 Research instruments

The following research instruments were utilized to meet the research aims,

1. The California Healthy Kids Survey (CHKS)

CHKS Modules A, C & F were utilized to determine the extent to which the young people are engaging in risk behaviour. These modules explore alcohol or drug abuse, bullying and harassment, violence and safety, depression and suicide, diet and exercise, and sexual health.

CHKS Module B was utilised to determine the extent to which young people receive support and are resilient. This module explores external assets (support at

- home, school, community & amongst peers) as well as internal assets (individual strengths).
2. Interviewing schedules for focus groups (learners) and interviews (teachers).
 3. MindMatters tool 2: A questionnaire of the MindMatters programme of Australia designed to determine the extent to which schools are health promoting.

3.4.3.1 Background to research instruments

(a) The California Healthy Kids Survey (CHKS)

The CHKS is a comprehensive youth health risk and resilience data collection service sponsored by the California Department of Education (CDE). The project grew out of CDE's commitment to promoting the well-being and positive development of all youth. It is rooted in the recognition that improvements in academic achievement cannot occur without addressing the health and behavioural risks that confront their state's youth and establishing environments that support learning (WestEd, 1999:i).



Secondary school survey items were primarily drawn from two existing instruments: (a) the state-mandated, biennial California Student Survey (CSS); and (b) the Centers for Disease control and Prevention's Youth Risk Behaviour Survey (YRBS). Many results are comparable to national and other prominent surveys. Three main criteria guided final item selection,

- Value for addressing drug use and violence;
 - Value for providing a well-balanced set of comprehensive youth health-risk and resilience data; and
 - Value to schools for needs assessment and program development.
- (WestEd, 1999:4).

According to WestEd (1999), the resilience assessment module was newly developed with the assistance of an advisory panel of national experts. It fills the need for a comprehensive measure of protective factors and resilience traits or assets for prevention

and youth development programs. Details of the survey content are to be found in Appendix I. The actual survey is available at www.wested.org/hks.

(b) Interviewing schedule – Focus group interviews

The questions for the focus groups were based on the research aims and objectives, were informed by the literature review and theoretical framework of the study and were also informed by the findings of the survey (see Appendix II).

(c) Interviewing schedule – Individual interviews

The interviewing schedule was designed to meet the research aims and objectives, was informed by literature in general and the health promoting schools framework in particular. The questions were also informed by the findings of the survey but focused more on support provision (see Appendix III).



(d) MindMatters Tool 2

MindMatters is a programme for Australian secondary schools aimed at promoting and protecting the mental health of members of school communities (MindMatters, 2002:1). The MindMatters programme provides resources to schools in order to promote positive mental health and all materials are based on the health promoting schools framework. The resource materials provided include questionnaires for schools to assess where they are at in terms of support and optimal mental health. The aim is to strengthen the capacity of schools to promote the well-being of their learners. MindMatters tool 2 is specifically aimed at enabling educators to consider what is happening at their school as a basis for planning and prioritizing some areas for action to promote mental health. The questionnaire or audit asks educators to consider policies and practices across the three areas of,

- Curriculum teaching and learning;
- School organization and ethos;
- Partnerships with parents, health services and agencies.

Educators are requested to be as reflective, comprehensive and as realistic as possible in their assessment of what is currently happening in their schools (MindMatters, 2002: 43).

In summary, herewith follows an overview of the research design that demonstrates how the instruments were selected in order to meet the research aims and objectives.

Table 3.1. Overview of the research design

OBJECTIVES	INSTRUMENTS	PARTICIPANTS
To determine the mental health needs and strengths of our youth;	1.CHKS A, C, F & B (risk & resilience)	PILOT: 1 grade 9 class x 2 schools
To determine the form and extent of support being provided to learners;	2.Interviewing schedule for Focus groups	MAIN STUDY: 2 Grade 9 classes per school X 7 schools
To explore the health promoting schools framework as a key strategy in addressing mental health needs.	1. MM TOOL2 2.Interviewing schedule	Guidance Teachers

3.4.4 Procedure

The process of data collection could be described as a six-phase process that occurred over one and a half years from 2003 to 2004. The first phase was the pilot study and involved the piloting of the various research instruments. The second phase involved the survey process. The third phase involved feedback to the various schools on the results of the survey. The fourth phase involved the focus groups. This was followed by interviews with the guidance counsellors, which constituted the fifth phase. The final phase involved the distribution of questionnaires. The various phases of the research process occurred interchangeably and were not mutually exclusive. Herewith follows a detailed account of the research process.

The first form of contact with the randomly selected schools within the sampling plan was a telephonic conversation with the principals of the schools concerned. This time was used to outline the aims and objectives of the research and requesting an appointment to explain in detail what the research was about and what participation would entail. What was particularly significant was the fact that all principals were open to discussing the possibility of their school participating in the research. This was possibly facilitated by the fact that a summarized copy of the research proposal was available to be sent to the schools before the meeting as per request. Once the details of the research process were explained to the principals, they did not hesitate to agree to their school participating in the study. It seems that the principals could instantly see the value of the research in terms of the benefits to the school, namely,

- The study would provide them with information about the needs and strengths of their learners that they would not otherwise have;
- It would enable them as managers to plan effectively to meet the needs of their learners. It would enable the guidance counselors to prioritise in terms of the life orientation curriculum, as they have to cover a wide range of life skills topics within a particular year. It would also enable them to involve their parents and communities in meeting the needs of their youth and the combined efforts would be a lot more successful than school-based efforts alone;
- The data would also strengthen the case for efforts to meet the needs of their learners and provide them with the necessary support to be successful;
- School staff are also generally aware of international and national trends with regard to the extent to which the youth are at risk for certain destructive behaviours but they could see the value of this research in providing them with information on the status of their learners.

What was important for principals was also the fact that the focus of this research was not on the risk profiles of learners as much as it is on the resilience profiles of their youth. Also, the emphasis on providing support to learners to strengthen their abilities to make the right choices and live successful lives was appealing to them. In terms of the South African context, it is something that the South African society is striving for with regard to their youth.

3.4.4.1 Phase One – The pilot study

The pilot study occurred during the first terms of 2003. The aim of the pilot study was to pilot the research instruments for suitability in the South African context. For this purpose, two completely disparate public schools were selected. School A is situated in a wealthy community and is a school that was advantaged by the previous Apartheid system. The learners are predominantly of European descent and English is the home language. School B is situated in an impoverished community and is a school that was disadvantaged by the previous Apartheid system. The learners are predominantly of African descent and English is not their home language. Many of the parents of the learners of School B serve as domestic workers, building or gardening staff for the parents of School A, once again highlighting the effects of the previous Apartheid system.

In the pilot study the learners of both schools felt that the survey was user-friendly. They understood the questions asked and were able to ask if there was anything that was not clear (for example, 'soda pop' was puzzling to learners at both schools). The learners at School B took about fifteen minutes longer to complete the questionnaire. This was expected as English is not their home language even though it is the instructional language at school. After completing the survey, a discussion was held with the learners to determine the strengths and weaknesses of the instrument and to make recommendations to improve it. They did feel that some of the questions were repetitive but when it was explained that we needed to look at the prevalence of certain behaviours over the past year, past month and past week, it made sense to them. When learners at School B were asked whether they would have preferred the questionnaire in their own language, it was surprising to me that most felt that it would not really make a huge difference as they did all their subjects in English at school. When asked about the fact that the survey instrument is an American instrument and whether they felt that that was a challenge in terms of the different cultures and lifestyles, the learners at both schools felt that there was not really much difference between the two cultures when it came to teen activities. They felt that the media has a large role to play in teenagers in South Africa

being exposed to the American culture and being strongly influenced by it. It was thought that the learners would be surprised by the substance abuse questions, that they would not be exposed to such a wide array of behaviours and would therefore not understand many of the questions asked. There was therefore much surprise when the learners informed me that heroin, cocaine, methamphetamines and ecstasy was available in their communities and that the questions related to these substances were not foreign to them.

After administration of the survey at both schools, it was felt, with confidence, that the CHKS was an appropriate tool to meet the aims of the study and was user-friendly and appropriate to the learners in our schools. The researcher decided to administer the survey being the best person to answer any questions or concerns that the learners might have. The researcher also decided to include the class teacher in the survey process to assist with any challenges in terms of language for second or third language speakers.

Approximately, four weeks after the survey administration, the pilot schools received feedback in the form of copies of the two reports (risk and resilience findings) and a detailed session where the results were explained to the principal and the guidance counsellor. The principals were very impressed with the fact that they got feedback in the first instance as they said that very often they would not get feedback from researchers. They also appreciate the usefulness of the information they received as they were able to gain a better understanding of their learners and how best to assist them to achieve their full potential. They especially appreciated the resilience report as it contained strategies for enhancing external and internal support for their learners. The two schools were very appreciative of the feedback and were most willing to provide any further assistance in terms of the research process.

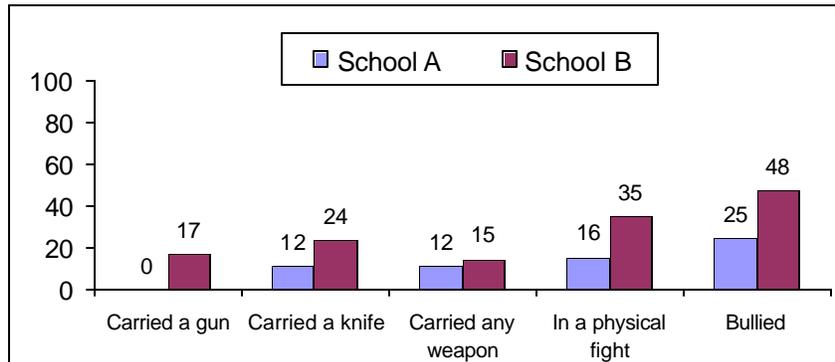
The results of the survey also served to inform focus group questions in verifying certain responses and eliciting more detailed information about certain aspects of the survey. These questions were also piloted at School A and B. The learners were most willing to participate in the focus groups and the researcher found that this was because they are not presented with many opportunities to express their feelings even though it was largely

according to the aims of the research. The only concern was that the learners felt that they often did not understand the researcher, as the language used was too sophisticated for them. One learner had an interesting way of conveying this. After an awkward period of silence after asking for comment upon a question, he said, “ Miss, you speak too high for us”. The researcher then realised that working at a tertiary institution and being involved with mostly senior students, had caused her to lose touch with young people and how they communicate. Many of the questions were then rephrased and the conversation flowed freely.

(a) Results of the pilot study

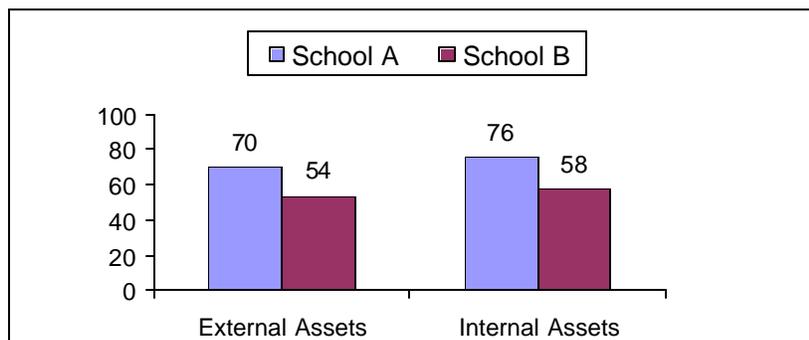
The basic premise that underlies the risk and resilience survey is the belief that where learners score high on external assets, they will score low on risk behaviours and where learners score low on external assets, they will score high on engagement in risk behaviours. Furthermore, where learners score high on external assets, they tend to score high on internal assets too. This relationship was found to exist in the results of the pilot study where learners at school A scored high on external assets and low on risk behaviours and learners at school B scored low on external assets and scored high on risk behaviours. Furthermore, learners at school A scored high on internal assets and learners at school B scored low on internal assets which means that learners at school A have greater internal strengths that would enable them to resist engaging in risk behaviours. These results further served to validate the use of the questionnaire amongst South African learners. The following charts depict the aforementioned relationships more clearly,

Chart 3.1 Percentage of learners engaging in selected risk behaviours at School A and School B.



For most of the behaviours relating to violence and safety, learners at school A scored significantly lower than learners at school B. Zero percent of learners at school A reported carrying a gun whereas 17% of learners at school B reported carrying a gun. Twelve percent of learners at school A reported carrying a knife whereas 24% of learners at school B reported carrying a knife. Twelve percent of learners at school A reported carrying any weapon whereas 15% of learners at school B reported carrying any weapon. Sixteen percent of learners at school A reported being in a physical fight whereas 35% of learners at school B reported being in a physical fight. Twenty-five percent of learners at school A reported being bullied whereas 48% of learners at school B reported being bullied. These results indicate that while learners at both schools are at risk, a significantly higher number of learners are at risk at school B than at school A.

Chart 3.2 Percentage of learners scoring high on total external assets and total internal assets at School A and School B.



From the results in the chart it is evident that learners at school A scored significantly higher in terms of total external assets (70%) than learners at school B (54%). Learners at school A therefore receive much more support at school, at home, in their community and amongst their peers than learners at school B. Learners at school A also scored higher for total internal assets (76%) than learners at school B (58%). This support translates into inner strengths that will enable learners at school A to have more favourable outcomes despite being exposed to risk behaviours. It therefore stands to reason, according to the Youth Development Conceptual Model, that learners at school B will be more at risk for undesirable outcomes than learners at school A.

3.4.4.2 Phase Two – The survey

The survey took place during the second term of 2003. An agreement was signed with WestEd about adhering to their ethical codes and procedural guidelines. The CHKS Survey Checklist (WestEd, 1999:14) served as a guideline in terms of planning and administering the survey (available at www.wested.org/hks). Answer sheets were purchased from WestEd. An electronic scale and height instrument was borrowed from the Medical Research Council (MRC). All procedures were carried out by the researcher with the assistance of the class teacher or guidance counsellor where necessary. This was to ensure that the procedures were standardized and accurate. The schools decided when it was appropriate for the research to take place. As stated earlier, learners could refuse to participate and where this happened it caused a bit of restlessness at the beginning but this did not impact upon the process too much. At some schools one period of fifty minutes was sufficient, at other schools the learners requested more time. This had been anticipated and schools had made the necessary arrangements. Learners' weights and heights were taken once they started to fill in the questionnaires. They would be called one by one to have the measures taken and filled in on the answer sheet by the researcher. There were rare instances where learners were not comfortable with being weighed and they were allowed to abstain. Generally, the process was successful thanks to the kind assistance of the guidance teachers.

3.4.4.3 Phase Three – Feedback to participants

Feedback occurred during the third term of 2003. The response by schools was overwhelming. Schools were not only appreciative of the information they received but it also motivated them to act upon the information that they received. It was wonderful to witness the care and concern of principals and staff towards their learners. The data allowed them to really understand the challenges that their learners face. One principal summarized the information himself and presented it first to the staff and then to the governing body and parents. He utilized the data not only to alert his staff and parents to the challenges faced by the learners of his school but also to mobilize them to provide the necessary support to prevent the young people from succumbing to the challenges that they are faced with. At other schools, guidance counsellors took the initiative to present the findings to the rest of the staff and to prepare summaries for the governing body. It seems that principals and educators do wish to assist their learners but are often not sure where to start or how to proceed. The reports from CHKS provides them with information on where to start in terms of what the most immediate concerns are and how to proceed in terms of the strategies for proving external support as well as strengthening the learners inner resolve so that they do not succumb to the pressures of their environment. Furthermore, it appears that schools are starting to realise that they need to attend to the emotional, social and other needs of their learners as these have a serious impact upon their abilities to learn.

3.4.4.4 Phase Four – Focus group interviews

The focus group interviews with learners commenced during term three 2003 and could not occur during term four as the Department of Education does not allow research during the fourth term. The rest of the focus groups occurred during 2004. The schools decided upon times that would suit them for the focus groups to occur calling for researcher flexibility (Le Compte, 2000).

An average of eight learners of mixed race, gender and age participated in each focus group. These were volunteers from the group who had participated in the survey. A key feature of the focus groups was that learners seemed to have a need to talk about the challenges of being a teenager. The fact that they were participating in a research project was secondary. They wanted primarily to share their thoughts and feelings.

One of the focus groups was particularly challenging to the researcher. The learners started to tell intimate details of their life. One learner said that her friend was HIV positive and all she could think about was death. The way that this was relayed was indicative of her own experience and distress. Another learner in the group spoke of her previous two suicide attempts and her desire to attempt suicide again. Yet another spoke of the violence in his home. The researcher tried at first to be strict about the research agenda heeding Sieber's (1993) call for the researcher to also be objective, but found it hard not to address these concerns that were presented. Needless to say, the researcher was torn between her research agenda and professional ethics as a psychologist. In the end, a flexible research approach that involved allocating more time to this interview, allowed for both goals to be achieved. At the other schools, the need for students to share their experiences was also present but not as starkly as in the previous example. The other focus groups also reinforced the dire need of young people in general to be heard and for someone to listen to what their needs and strengths are.

3.4.4.5 Phase Five – Individual interviews

The interviews with guidance counsellors occurred in term two of 2004. These teachers also needed to share their experiences as guidance counsellors in schools at the present time. These interviews presented insights that would otherwise not have been gleaned from the other data collection techniques and have a large role to play in terms of support provision to learners. The willingness of the teachers to participate in the interviews despite their very hectic teaching schedules was very encouraging. The willingness of teachers to accommodate the research agenda is also indicative of their approval of the research process, their commitment to improving things for their learners and the positive

research relationship that had been established over the past year. The importance of a relationship with the interviewee is stressed by Powney and Watts (1987) and Denzin and Lincoln (2000), who believe that the relationship should be signified by empathy, sensitivity, humour and sincerity. At the same time they caution that the researcher must also be aware that own personality, mood, interest, experiences and bias can affect the responses of the interview.

Teachers were very relaxed and shared freely of their experiences. There were hesitations where the questions revolved around staff dynamics and management issues but, largely, the teachers were open, honest and frank in their responses. These hesitations were noted for analysis purposes (Bowling, 1997, Rubin & Rubin, 1995). The responses were tape-recorded and while there may have been an initial hesitation to speak with the tape on, this was quickly overcome and the conversation flowed freely. An interview schedule was utilized to guide the discussion but the aim was to be largely flexible and open to new insights (Babbie and Mouton, 2001). While the schedule was available upon request, most teachers did not request a copy of the questions beforehand. These interviews flowed more freely than when the questions were given beforehand. An interesting observation was that when teachers perceived that the interview was over, they started to chat quite freely about their observations about school matters and their personal hopes and concerns regarding their school and the education system. The researcher felt that this was really valuable information but could not put the tape on again. These moments of complete trust and openness highlighted the need for teachers to have someone objective to share their thoughts and feelings with no fear of judgement or reprisal and the utmost confidence in the confidentiality of the session.

At this stage of the research process, the researcher could also present teachers with a summary of the research results so that they could compare their research results with the national and provincial results of the MRC (2003) survey and with the rest of the research participants. Teachers found the summary to be very useful in order once again to prioritise their life skills lessons and interventions and to determine how to focus their efforts in providing support.

3.4.4.6 Phase Six – Questionnaires

Each of the guidance teachers received the MindMatters questionnaire to complete. Although there is a South African equivalent developed by Dehran Swart of the MRC (Swart, 1999), the Australian instrument is more comprehensive. In addition it was more appropriate for the high school system, whereas the South African instrument seems to be more suited to the primary school system. Also, one of the teachers said that the questionnaire made him aware of all the possibilities in terms of providing support to learners and also how much work needed to be done in this area at his school. The researcher therefore selected the ideal scenario which makes it easier to see where the gaps are and to set goals to work towards the ideal. Return of the questionnaires was a challenging exercise. Numerous telephone calls were made to secure the questionnaires and in some instances, the forms had to be personally collected. All forms were returned in the end. The questionnaire served as a great reflective instrument for teachers, especially with the constant focus on outcomes-based education and matters academic. The questionnaire allowed teachers to focus on the emotional, physical, social and spiritual needs of learners and how these could be met through the health promoting schools concept. The collection of all data was finalized by mid-June 2004.

3.5 ANALYSIS OF DATA

3.5.1 Survey

The survey analysis was conducted by WestEd, California, who analysed the data utilizing SPSS. Two reports (risk and resilience) for each school were compiled. Data for all the schools was also provided on CD-rom in SPSS format. As only individual results for each school was provided by WestEd, composite tables and graphs still had to be compiled to reflect results across schools. Results are presented according to the order of data collection with School A being the first and School I being the last school where data collection occurred.

Analysis of the resilience and youth development module occurred as follows:

Students had a choice in indicating for each item in the module how much it applied to them,

- 4: Very much true
- 3: Pretty much true
- 2: A little true
- 1: Not true at all

The values (4,3,2,1) attached to each response option were averaged, and then the following score categories were derived,

High	The percent of students with average item response above 3;
Moderate	The percent of students with average item response of at least two and no more than 3; and
Low	The percent of students with average item response below 2.

Each of the 17 assets has a chart summarizing the percentage of students who responded in the High category, as well as several summary charts showing all three categories (WestEd, 2003a).



3.5.2 Focus group and individual interviews

Thematic analysis was employed for the focus groups and interviews. According to Miles and Huberman (1994) themes are a form of data reduction analysis that sharpens, sorts, focuses, discards and organizes data so that final conclusions can be drawn and verified. Themes were developed in accordance with the research aims and purpose and research questions. This is in accordance with Merriam 's (1998) view that devising categories is largely an intuitive process, but it is also systematic and informed by the study's purpose, the investigator's orientation and knowledge and the meanings made explicit by the participants themselves. The broad area of risk, resilience and support were used as guidelines. Transcripts were read repeatedly, recurring themes were noted and highlighted, and grouped according to the aims of the research (Le Compte, 2000,

Miles & Huberman, 1994). Being personally involved with the interviews and analysis assisted in the process (Bowling, 1997).

3.5.3 Questionnaires

This information was analysed according to the health promoting schools concept. The five categories of policy, environment, life skills education, parent involvement and service delivery were utilized for analysis. Schools were understood as dynamic organizations in the process of becoming health-promoting sites. This is in accordance with the WHO definition of a health promoting school as a place that is constantly striving towards being a healthy setting for living, learning and working. Gaps were identified and recommendations were made in terms of the schools' ability to provide support to enhance the well-being of their learners.

3.6 ETHICAL CONSIDERATIONS



Most researchers are in agreement that all research endeavours should be firmly grounded in ethical practice; that people's right to privacy should be respected, that confidentiality should be respected, that participation should remain anonymous, that safety should be guaranteed, that trusting environments should be secured and that the research process should not be pursued at the expense of the participants concerned (Babbie & Mouton, 2001, Miles & Huberman, 1994; Sieber, 1993). As the key role-players in this research were minors, the research was guided by the Children's Research Rights (Berk, 1991:62) in terms of ethical practise,

Protection from Harm

Children have the right to be protected from physical or psychological harm. If in doubt about the harmful effects of research, investigators should seek the opinions of others. When harm seems possible, investigators should find other means for obtaining the desired information or abandon the research;

Informed Consent

Informed consent of parents as well as others who act on the child's behalf should be obtained for any research involving children, preferably in writing;

All research participants, including children, have the right to have explained to them all aspects of the research that may affect their willingness to participate in language appropriate to their level of understanding. Adults and children should be free to discontinue participation in research at any time;

Privacy

Children have the right to concealment of their identity on all information collected in the course of research. They also have this right with respect to written reports and in any formal discussions about the research;

Knowledge of Results

Children have the right to be informed of the results of research in terms that are appropriate to their understanding;

Beneficial Treatments

If experimental treatments believed to be beneficial are under investigation, children in control groups have the right to alternative beneficial treatments if they are available.

Permission was granted by the Western Cape Education Department to conduct the research. Strict adherence to the ethical conduct of the research was maintained. Schools were informed of the entire research process firstly by telephone or letter (see Appendix IV) and then by means of an interview. The research proposal was available for scrutiny and schools then decided whether they wished to participate. The names of participating schools, learners and educators are not reflected anywhere. Schools are referred to as schools A, B, C, D, E, F, G, H & I. Learners were also asked not to write their names or identify themselves in any way on the survey forms. The principal of the school and the educators concerned could decide when the research could take place so as to minimise the impact upon the school programme. Consent forms for the study were made available (see Appendix V). Principals, their staff and their governing bodies took responsibility for the administration of consent forms. Students were informed of the aims and purpose of the research before commencement of the research. Issues of confidentiality and privacy were clearly spelt out to them. Even where parents gave consent, students could refuse to participate in the study. Time was allowed for students to leave if they wished and some students chose to exercise this right.

Schools also received feedback of the research findings. The researcher made appointments to discuss the findings with the school principal and with the guidance

counsellors / life orientation teachers. Schools were presented with two research reports. The one report presented the findings of the risk profiles of the learners. The second report presented the resilience findings and also contained information on strategies to enhance the resilience of their youth. A copy of the thesis and summary of the research findings will be made available to the Western Cape Education Department as requested by them.

3.7 CONSTRAINTS AND LIMITATIONS OF THE RESEARCH

3.7.1 Sample

It was very challenging to find a representative sample of schools. Our past history placed learners into schools according to their race. At present this situation has not changed much. Whilst learners can now choose to go to any school, socio-economic status largely determines school demographics. The final selection of schools encompasses a full spectrum of learners across all races and socio-economic groups though. It should also be borne in mind that this sample focused on school-going youth and does not represent youth who do not attend school. Furthermore, some learners who were absent on the day could be the learners who are more likely to engage in risk behaviours.

3.7.2 Instruments

The quantitative instruments utilized for the study are American and Australian instruments. While many challenges were minimised by the pilot study and the triangulation process, it would have been ideal to utilize instruments that were specifically designed for the South African context. This is possible now that the MRC have completed their national risk survey with their instrument available in eleven official languages. However, they have not yet developed resilience instruments for South African use. This was the main reason for utilizing the CHKS in this study, which was more focused upon the resilience results than the risk results.

The South African and Australian instruments for the evaluation of health promoting schools could be combined to develop a more comprehensive South African instrument. This is therefore a recommendation for further research.

3.7.3 Analysis of the survey

The answer sheets of the survey had to be sent to the United States for analysis whereas it would be more cost-effective for a South African centre to offer such a service to schools. More schools could then have been included in the study and benefitted from the results. Also, a service such as this should be offered to all schools as the potential and benefits for this kind of research is vast.

3.8 CONCLUSIONS

This chapter has sought to outline the research methodology utilised for this study. It has demonstrated how a mixed method design was the most appropriate design in order to meet the aims and objectives of this study. Quantitative and qualitative research methodology was employed in order to maximize the strengths and minimize the weaknesses or challenges of each method. The process was a complementary one where the results of the quantitative methods were utilized to inform the qualitative methods and vice versa. The aim was to obtain data that was reliable, valid and at the same time provided depth and insight to the phenomena being investigated. An interesting process of triangulation occurred where data was used within and across particular methodologies to improve reliability, validity, richness and quality of the data.

The following chapters will serve to demonstrate how this process has contributed to a very rich understanding of what our young people are experiencing. More importantly, it elucidates how we can provide them with the necessary support in order to maximise their potential, and to help them succeed despite the many challenges that they face on a daily basis. These important findings are thus contained in chapters four, five six and seven.

CHAPTER FOUR

RESEARCH FINDINGS

RISK PROFILES

4.1 INTRODUCTION

This chapter presents the findings of the California Healthy Kids Survey (CHKS) core module and modules C and F. These modules focus on the risk behaviours of young people. In this instance the risk behaviours of the grade nine learners who formed part of this study are reflected. It should be borne in mind that the aim of this research was not to generalise to the South African population but rather to reflect upon risk behaviours of this particular sample, and in the following chapter to reflect upon the resilience status of these same learners. However, the National Youth Risk Behaviour Survey of 2002 (MRC, 2003) will serve as South African and Western Cape baseline data in the instances where the same questions from the U.S Centers for Disease Control and Prevention's (CDC) Youth Risk Behaviour Survey (YRBS) were utilised. It should also be noted that the National Youth Risk Behaviour Survey (MRC, 2003) requested learners to reflect upon their behaviour during the past six months as opposed to during the year. The aim of presenting the South African data is to place the results of this study in a larger context and to see if the trends reflected by the sample are also occurring on a large scale. This is in order to distinguish between local circumstances and broader socio-cultural trends. While a representative sample of youth was selected for this study, generalisations will be limited to the specific population from which it was drawn. It is not the purpose of this research to make direct comparisons and draw conclusions based upon comparisons but rather to reflect upon trends and gain an in-depth and enriched understanding of this particular sample.

4.2 SURVEY RESULTS

The following points are necessary in order to understand the data presented in the tables,

- The data was reviewed and the answer sheets of students who grossly exaggerated their substance use or had inconsistent response patterns were discarded;
- In anonymous, confidential surveys like the CHKS there is a high degree of validity in student answers – even with sensitive questions because a few students may under-report any given behaviour, but there are also those who will over-report instead, resulting in a natural balancing out (WestEd, 2004a: 4);
- Students whose responses might not be valid because they did not take the survey seriously, were careless in their responses, or did not answer truthfully were removed. While no student was removed based on only one of these criteria, some students were removed based on meeting two or more of the following criteria,
 - the degree of inconsistency in their responses;
 - exaggerated drug use;
 - marking that they used a fake drug that was inserted in the list of multiple real drugs; and,
 - marking that they did not respond honestly to all questions in the reliability question at the end of the survey.

These criteria rely heavily on substance use measures because there are a variety of ways to cross check for inconsistencies across items. In practice, these rejection criteria generally reduce the number of students in a sample by about two percent (WestEd, 2004:5);

- The results reflected in the tables have been rounded off which explains why some responses add up to 99% or 101%;
- Where the question allowed respondents to select more than one response, the total adds up to much more than 100%.

Where reference is made to the South African National Youth Risk Behaviour Survey of 2002 (MRC, 2003) the national results for grade nines will be referred to as well as the Western Cape results for grades 8, 9, 10 and 11 combined. These results are also rounded off for consistency with the results of this study.

4.2.1 MODULE A: CORE RISK BEHAVIOURS

This module assesses a broad range of key youth health-risk behaviours: alcohol, tobacco, and other drug use; violence and school safety, including harassment; and physical education and eating habits (WestEd, 2003b). The tables are to be found in Appendix VI.

4.2.1.1 Sample characteristics

(a) Response rates

Table 4.1 (see Appendix VI) represents the student sample characteristics and response rates. This study focused on grade nine learners and the sampling plan included diverse learners from a broad range of schools in and around the Cape, including schools from the urban metropole and rural metropole. Schools were selected from former Department of Education groupings such as the House of Assembly (predominantly ‘White’ schools), House of Representatives (predominantly ‘Coloured’ schools) and Department of Education and Training (predominantly ‘Black’ schools). Schools C and I were previously Department of Education and Training schools. Schools D, F and G were former House of Assembly schools. Schools E and H were former House of Representatives schools. Schools from the former House of Delegates were not included in this study. Teachers and learners were very positive about the research, resulting in an average response (participation) rate of 92%.

(b) Age



Table 4.2 (see Appendix VI) summarizes the size of the final, valid sample by grade and age. Because drug use and other risk behaviours increase and change with age, understanding these differences is important developmentally for implementing effective and appropriate programmes (WestEd, 2003b). The majority of youth who participated in this study (52%) was 14 years of age. While this is the second year of high school for South African youth, it is well known that grade 9 is a time of great risk and that much experimentation occurs during this period. The youth are particularly vulnerable to peer pressure at this time. It is also interesting to note that at schools C and I there are older learners within grade nine, some exceeding 16 years and even learners who are 18 years and older. This could increase the likelihood of younger learners experiencing peer pressure from older learners and being encouraged to engage in risk activities associated with older adolescents. In another South African study (Swart, Reddy, Ruiter and de Vries, 2003) where learners were expected to fall within the 13 to 15 year age group, 48% of the learners were also found to be 16 years and older. The authors also attribute this phenomenon to the legacy of Apartheid education that was characterized by a lack of

schools for Black learners, limited access to schools, as well as late entry and re-entry into the education system.

(c) Gender

Table 4.3 (see Appendix VI) summarizes the gender of the respondents. Twelve percent more females than males participated in this study. The prevalence of risk behaviour amongst females versus males will be reflected upon later. It is well known that females tend to experience puberty and related changes earlier than males and this is especially noticeable amongst grade nine learners. One would therefore expect girls to be engaging more readily in certain risk behaviours than boys at this stage.

(d) Race and ethnicity

Table 4.4 (see Appendix VI) provides the response rates for the major racial/ethnic groups in the Western Cape. Students who selected more than one group were counted in each, so that percentages add up to more than one hundred (WestEd, 2003b). This was an interesting question for this sample considering South Africa's particular history, where race was a prominent issue and resources were allocated accordingly. Twenty-seven percent of learners selected more than one category reflecting a shift amongst the youth from seeing themselves strictly according to one particular racial category or stereotype. Thirty-seven percent of learners selected 'African'. This category was selected by various learners at all participating schools. The majority of learners (43%) selected the classification 'Coloured'. This is especially prevalent in schools D, E and H. Schools C had learners that predominantly selected 'Black' (62%) and the learners at school I predominantly selected 'Black' (48%) and 'African' (51%). The learners at schools F and G predominantly selected 'White' (74% respectively). These are indications of the dominant groups in ethnic/race terms at each school. Please note that while school D falls within the category of a former House of Assembly school (predominantly White learners), the student population has changed to reflect predominantly 'Coloured' learners (96%). Furthermore, the percentage of learners selecting more than one category

is significantly higher for schools D, E, F, G and H than schools C and I, possibly reflecting greater racial integration of learners at schools D, E, F, G and H.

Swart et al (2003) also noted in their study of cigarette use among male and female grade 8-10 students of different ethnicity in South African schools, that a significant percentage of learners (16,5%) did not know where to place themselves within the historical “race” categorization used in South Africa. The authors attributed this to a possible lack of understanding of the question, reluctance to place themselves into racial categories or a lack of awareness of the racial categorization system that was used in South Africa or a combination of these reasons.

(e) Transience

Table 4.5 (see Appendix VI) reports on how many times in the past year respondents have changed residences. While the majority of learners (70%) did not have to move over the past year, it is interesting to note that learners at schools C and I have experienced the most transitions, with 59% and 64% respectively having moved over the past year. This places these learners most at risk for adjustment related difficulties and for engaging in risk behaviours. These learners would experience great social and emotional upheaval each time they move and try to adapt to their new environments.

(f) Class grades received

Table 4.6 (see Appendix VI) allows examination of the students’ self-reported scholastic performance. The aim of the question was to be able to demonstrate to school and community leaders how local risk behaviours are related to achievement in order to discuss how reducing these barriers to achievement need to be part of school improvement efforts (WestEd, 2003b). An interesting observation in the table is the fact that schools C and I are the ones where more students have reported receiving mostly A level grades. Learners at schools D, G and H have reported the lowest number of A level grades. In reality the academic results at these schools are very different to what is

reflected in this table with schools D, G and H achieving better results than schools C and I as reflected in pass or promotion rates each year. This points towards a huge discrepancy between students' perceptions of how well they are doing and how well they are really performing. It is, however, important to note that the South African education system has changed and that learners' progress are no longer presented according to grades but rather according to grade levels such as levels 1 to 4. What is reported by the students could therefore also be the result of uncertainty in terms of these new developments in education in South Africa.

(g) Truancy

Table 4.7 (see Appendix VI) provides information on truancy; specifically, the number of times that students self-reported skipping school or cutting classes in the past 12 months (WestEd, 2003b). A large number of learners in the sample (41%) reported skipping school or cutting classes one or more times over the past year. This is cause for concern. Truancy is particularly rife in schools E (49%) and F (58%), with repeated offenders to be found mostly in School I (6% playing truant once a month or more). It is interesting to note that the schools with highest truancy levels (E, F and I) are found outside of Cape Town in traditionally semi-rural areas.

4.2.1.2 Alcohol and other drug use (AOD use)

(a) Overall use (lifetime prevalence)

Table 4.8 (see Appendix VI) shows the overall prevalence rates for alcohol and other drug use (any use, regardless of how many times) reported over the respondents' lifetime (WestEd, 2003b). An alarmingly high percentage of learners (64%) reported some form of AOD use in their lifetime. It is alarming due to the fact that we are focusing on very young learners - grade nine learners. However, the type of substance used and prevalence and frequency of use should be examined more closely to place the aforementioned results into perspective.

Alcohol

Fifty-eight percent of the learners in this sample reported use of alcohol in their lifetime, with a smaller percentage (12%) reporting one time (once-off) use than those reporting more regular use (46% reporting 2 or more times). Frequency of use (more than 4 times) is most prevalent at schools D (64%), G (54%) and H (41%). These results are consistent with the MRC (2003) results. The results of the sample are higher than the results for grade nines nationally (58% versus 47%) but within a similar range for the Western Cape region (58% versus 64%).

Marijuana

An average of 21% of learners in this sample reported using marijuana in their lifetime with 8% reporting use of marijuana once and 13% reporting use of marijuana more than twice. Frequency of use is highest at schools H (30%), G (16%) and D (16%). The learners in this sample are reporting higher levels of use for grade nines nationally (12%) but within the norms for use amongst Western Cape learners (19%).



Inhalants

An average of 11% of learners in this sample report use of inhalants in their lifetime. These results are consistent with grade nine use nationally (12%) and greater than use reported for the Western Cape (8%). The highest percentages of one time use is reported for schools I (13%), D (10%), H (10%) indicating rife experimentation at these schools. Most frequent use is to be found at schools C (8%), F (6%) and I (5%), indicating highest risk for dependency due to intensity of use.

Cocaine

Five percent of learners in this sample reported use of cocaine. This is consistent with use amongst grade nines nationally (6%) and amongst youth in the Western Cape (4%). One time use is reported at schools I (16%), C (4%) and G (2%) indicating that experimentation is highest at school I. More frequent use (2 or more times) is reported at

schools C (2%), E (2%), H (3%) and I (6%) which raises concerns about dependency due to intensity.

Methamphetamines

There has been much media attention recently surrounding the use of methamphetamines (commonly known as 'straw' or 'tuk tuk') amongst the youth in the Western Cape. The aforementioned results reflect one time use at schools I (22%), C (10%), H (5%), D (4%), E (4%) and F (2%). More frequent use is found at schools I (12%), C (6%), H (6%), D (2%), F (2%).

LSD

One time use is reported for schools I (25%), E (12%), G (8%), C (6%) and D (2%) with frequent use reported for schools I (17%) and C (6%)

Ecstasy

One time use is reported for schools H (11%), I (10%), D (8%), F (4%), and C (2%), with frequent use reported for schools C (6%), H (5%) and I, G and D (2% respectively). The use of 'club drugs' such as ecstasy is significantly higher (average of 8%-12%) for the sample when compared with the MRC (2003) baseline data (average of 6%).

Heroin

Six percent of the sample report use of heroin during their lifetime. This is lower than the national averages (12%) and consistent with the average use for the Western Cape (6%). One time use is reported for schools I (10%), C (6%) and D (2%). Frequent use is reported for schools I (18%) and C (8%).

Other Drugs

Five percent of learners in the sample report using 'other drugs' in their lifetime with 8% of learners at schools I and D; 5% of learners at school H and 2% of learners at schools C and G reporting one time use. Frequent use was reported by learners at school C (6%). The aforementioned results reflect that learners at most of the schools in the sample are

susceptible to trying a substance once, particularly learners at schools I, C, D, H and G. Learners at schools I and C are most likely to be frequent users of drugs and learners at schools D, F, G and H are most likely to be frequent users of alcohol.

(b) Thirty-day prevalence (current use)

The 30-day rate in Table 4.9 (see Appendix VI) is a standard indicator of current use. Comparing lifetime and current use helps differentiate AOD experimentation from regular use (WestEd, 2003b). The results reflected in table 4.9 confirm that learners at schools D, F and G are most at risk for alcohol abuse and learners at schools I and C are most at risk for drug abuse if one considers the current use of these substances. The current use of alcohol (36%) and marijuana (8%) amongst the learners in this sample is consistent with use reported amongst grade nines nationally (31% and 9%) and is lower than reported use regionally (44% and 11%).



(c) Use frequency and level

The CHKS provides measures of both the frequency and level of use of alcohol and marijuana. In Table 4.10 (see Appendix VI) consumption of alcohol on more than three days for the last month is reported for all schools in the sample: G (18%), F (16%), D (12%), H (11%), I (10%), C (10%) and E (8%). Use of marijuana on more than three days over the last month is reported for schools I (7%), D (6%) and C (2%).

(d) Lifetime drunkenness

Tables 4.11 and 4.12 (see Appendix VI) report the times or frequencies that students had ever been very drunk or sick after drinking alcohol or high from using an illicit drug. Students define for themselves what constitutes drunkenness or being very high (WestEd, 2003b). In Table 4.11 (see Appendix VI) an average of 31% of learners in the sample reported being very drunk or sick after drinking alcohol. Learners at schools H (44%), D (43%) and F and G (32% respectively) report the highest number of learners who

experienced sickness or drunkenness one or more times. More learners (19%) experienced sickness or drunkenness often (2 or more times) than those who experienced it once (12%).

(e) Lifetime “high”

According to Table 4.12 (see Appendix VI), fifteen percent of learners in this sample have experienced a high from using drugs. Greatest frequency (2 or more times) has been experienced by learners at schools D (18%), G (13%) and H (12%).

(f) Heavy episodic (binge) drinking

According to Table 4.13 (see Appendix VI) binge drinking was experienced by 15% of learners in this sample. This is lower than the national (24%) and regional averages (34%). The highest levels of binge drinking was reported for schools D (19%), I (19%), H (18%) and G (16%).



(g) Drinking styles

Table 4.14 (see Appendix VI) reports the preferred drinking style of those respondents who drank alcohol (how they liked to drink) (WestEd, 2003b). Most learners (33%) wished to feel the effects of alcohol consumed (from ‘a little’ to ‘until drunk’). Twenty-three percent of learners at school D like to feel the effects of alcohol a lot. Greater numbers of learners at schools H (11%), F (9%) and I (8%) are very serious about their drinking and are insistent upon getting drunk.

(h) Drinking and driving

Table 4.15 (see Appendix VI) asks students about the number of times they ever drank and drove or were driven by a friend who had been drinking. This assesses the overall risk to youth by adolescent drinking and driving in general (WestEd, 2003b). Learners at schools D (42%), E (32%) and H (32%) are most at risk for alcohol-related vehicle crashes. This relates to alcohol consumption amongst these learners and their peers and families. Learners at schools C and I are the least at risk. This could be due to lower alcohol consumption or socio-economic circumstances as these learners come from impoverished areas where few people own cars.

(i) Alcohol of other drug use and intoxication at school

Tables 4.16 and 4.17 (see Appendix VI) provide the percentages of students who currently used alcohol or marijuana, or were ever intoxicated on any substance at school. These questions provide insight into the drug-use environment at the schools as well as the proportion of youth at risk of both substance use and educational problems (WestEd, 2003b). Table 4.16 provides the percent of students who currently consumed alcohol or marijuana at school in the past 30 days. Alcohol consumption on school property amongst the sample in the study is consistent with national and regional trends (an average of 9%). Learners at school I (29%), school C (20%) and E (11%) are more likely to consume alcohol on school premises than learners at the other schools. The smoking of marijuana is less prevalent amongst the learners of this study with only 2% reporting use on school property. This is lower than national and regional trends (4% to 6%). Learners at school I (7%), C (4%) and D (2%) reported use more than once on school property.

Table 4.17 shows frequency rates for 'ever' being drunk or high at school, regardless of the substance or where it was consumed. Seven percent of learners reported ever being drunk or high on school property. Six percent of learners at school I, 5% of learners at school H and 2% of learners at schools D, F and G reported being drunk or high two or more times on school property.

(j) Alcohol or other drug use correlates and influences

Perceived harm

Table 4.18 (see Appendix VI) shows students' perceptions of the harmfulness of frequent use of both alcohol and marijuana (WestEd, 2003b). Only 41% of learners believe that alcohol is extremely harmful whereas 73% of learners believe that marijuana is extremely harmful. Ten percent of learners believe that alcohol is largely harmless while 8% believe that marijuana is largely harmless. Greater numbers of learners at schools C (77%) and I (51%) consider both alcohol to be extremely harmful and marijuana to be harmless (16% and 13% respectively). Learners at school G have different views and only 21% consider alcohol to be extremely harmful and only 55% consider marijuana to be extremely harmful. It seems that learners' views are influenced by use of these substances and societal norms.

Peer sanctions against use

Table 4.19 (see Appendix VI) shows the percentage of students who indicated that their peers would stop them from using alcohol or marijuana (WestEd, 2003b). It seems that the young people in the sample are more likely to stop their friends from using marijuana than using alcohol. Fifty-two percent (19%+33%) of the learners reported that their friends would not stop them from using alcohol and 31% (8%+23%) reported the same for marijuana. Learners at schools C, D and G are least likely to be stopped from using alcohol and learners at schools C, E and I are least likely to be stopped from using marijuana.

Estimated peer use

Table 4.20 (see Appendix VI) reports respondents' estimates of the proportion of their peers that are engaged in AOD use (WestEd, 2003b). Most learners (70%), believe that some of their peers (10% to 90%) have tried marijuana. Eleven percent of the learners believe that half of their peers have tried marijuana. This is much higher than students reporting use, thereby confirming the overestimation of peer engagement in risk behaviours by young people.

Availability

To shed light on AOD availability, students were asked generally about their perceptions of how difficult it is for their age-peers to obtain alcohol and marijuana and then more specifically about how often they have been offered a drug at school. More detailed information about drug availability is available from Module C (WestEd, 2003b). Table 4.21 (see Appendix VI) summarizes the proportion of those who thought it was easy or very easy for their age-peers to obtain alcohol and marijuana (WestEd, 2003b). Fifty-one percent of learners find it easy to obtain alcohol and 30% find it easy to obtain marijuana. Learners at schools D, E, F, G and H find it easiest to obtain both alcohol and marijuana and learners at schools C and I find it most difficult to obtain these substances. It seems that socio-economic circumstances plays a role here as both schools C and I are situated in impoverished areas. Reported use of these substances indicates that they are available.

Availability at school

Table 4.22 (see Appendix VI) reports the frequency that someone offered, sold, or gave youth an illegal drug on school property in the past 12 months (WestEd, 2003b). Eleven percent of the learners in the sample were offered an illegal drug on school property once during the past 12 months and 8% of learners were made an offer two or more times. More learners at schools H (34%), D (27%), C (23%) and G (21%) were offered drugs one or more times than at the other schools. As these results are higher than national grade nine (18%) and regional (20%) results, it is evident that learners at these schools are at high risk of substance abuse.

(k) Alcohol and drug use measures

From the results presented in Table 4.23 (see Appendix VI), it is evident that the females are more likely to engage in risk behaviours than the males. They are more likely to experiment with substances as well as engage in extreme use of these substances such as binge drinking or becoming high and taking risks such as utilising substances at school. While some males do engage in the high-risk use of these substances, they are still less than the females in terms of this particular sample. It also seems that while the females are more likely to abuse alcohol and drugs, they are also more aware of the dangers and

risks involved in utilising these substances. This supports the contention that knowledge about the dangers of alcohol and drugs are not enough to dissuade use. There are other factors involved in assisting youth to make the right choices. It confirms that it is important to impart the necessary skills to resist peer pressure as well as provide the necessary support systems to sustain the information, skills and attitudes acquired that will prevent them from abusing substances.

4.2.1.3. Tobacco Use

(a) Lifetime prevalence (ever used)

Table 4:24 (see Appendix VI) displays the percentage of students who ever tried smoking a cigarette or using smokeless tobacco (WestEd, 2003b). Fifty-six percent of learners in this sample reported trying a cigarette, even one or two puffs in their lifetime. This is consistently higher than national trends (31% of grade nines) and consistent with Western Cape trends (51% of youth). Learners at schools C and I reported lowest rates of smoking cigarettes (12% and 16%) of all the schools. However, these learners reported highest rates of smoking tobacco (11% and 12%) of all schools. Smoking is most prevalent at schools D and H (predominantly 'Coloured' schools). The MRC Report (2003) also found cigarette smoking to be most prevalent amongst 'Coloured' learners.

(b) Thirty-day prevalence (current use)

Table 4.25 (see Appendix VI) shows the percentage of youth who reported smoking at least once during the 30 days prior to the survey, as well as daily (WestEd, 2003b). 'Any smoking' for this sample is reported at 25% for this sample and daily smoking is 6% for this sample. This is consistent with national trends for 'any cigarettes' (23% and 6% for grade 9) and lower than the Western Cape (38% and 16%). Daily smoking is most prevalent at schools D (10%) and H (20%). At school H the smoking prevalence exceeds national and Western Cape norms for daily smoking. Use of smokeless tobacco is much lower for this sample than for the national and regional norms.

(c) Smoking on school property

Table 4.26 (see Appendix VI) presents the frequency of students who smoked on school property in the past 30 days and can be compared to alcohol and marijuana use on school property (WestEd, 2003b). For this sample, smoking on school property is rife at schools H (29%), I (19%), E (18%) and C (14%), possibly reflecting upon poor discipline in this regard at these schools. Daily use is also most prevalent at schools H and E.

(d) Use influences

Peer sanctions

Table 4.27 (see Appendix VI) shows the percentage of students who indicated that their peers would stop them from using cigarettes, as a gauge of social disapproval and can be compared with those for alcohol and marijuana use (WestEd, 2003b). It is interesting to note that 49% of learners feel that their friends will try to dissuade them from using cigarettes whereas 50% of learners feel that their friends will not stop them from using cigarettes. One could therefore argue that there is almost a 50-50 chance that they will or will not try to stop them. Learners at schools H (66%) and D (60%) and C (56%) feel that their peers are least likely to stop them from smoking cigarettes.

Perceived harm

In Table 4.28 (see Appendix VI), students report on their perceptions of harm from frequent cigarette smoking and can be compared with the results for alcohol and marijuana (WestEd, 2003b). Ninety-three percent of learners feel that daily or almost daily use of cigarettes is harmful. Compared with the number of learners who do smoke cigarettes this is unexpected but once again confirms that knowledge about the harmful nature of a substance does not necessarily dissuade learners from utilising those substances. Another factor that could be playing a large role here is the intense anti-tobacco campaign that has been launched nationally to inform people of the dangers of smoking. South Africa has developed very strict anti-tobacco legislation.

Availability

Table 4.29 (see Appendix VI), shows students' perception of the difficulty of obtaining cigarettes (see for alcohol and drugs) (WestEd, 2003b). For learners at schools C (44%) and I (57%) it is difficult to obtain cigarettes. On the other hand, for learners at schools H (95%), G (95%), D (87%), F (85%) and E (64%), it is easy to obtain cigarettes.

Estimated peer use

Eighteen percent of learners believe that half of their peers smoke cigarettes at least once a month. Thirty-one percent of learners believe that more than half of their peers (60% - 100%) smoke at least once a month. This is especially prevalent in schools H (54%), D (54%), F (42%) and E (32%).

(e) Tobacco use by gender and grade

According to Table 4.31 (see Appendix VI), the females are more likely than the males to engage in cigarette use at the experimental as well as regular use level. However, the males are very close in terms of regular use. The females also seem to be more aware of the dangers of smoking than the males. This does not seem to deter use though. With awareness of the dangers of smoking, one would expect fewer females than males to engage in smoking.

4.2.1.4. Violence and Safety

(a) School harassment, victimisation, and violence

The CHKS assesses the annual (past 12 months) frequency of a wide range of specific forms of victimisation or harassment at school, from the verbal to the physical (WestEd, 2003b).

Verbal harassment

Three CHKS questions in table 4.32 (see Appendix VI), deal with verbal harassment: the spreading of ‘mean rumours and lies’ about a person, having sexual jokes or gestures made, and having been made fun of for the way one looks or talks (WestEd, 2003b). Almost half of the learners surveyed experienced some form harassment over the past year. Forty-two percent of learners in this sample experienced rumours and lies spread about them at least once. Forty-percent had sexual jokes and gestures made towards them and being made fun of was experienced by 43%. Learners at schools D, E, G, and H experienced the most harassment.

Physical violence

Table 4.33 (see Appendix VI), provides the results for three questions relating to physical violence at school (WestEd, 2003b). Thirty-four percent of the learners in this sample were pushed, shoved or hit at least once on school property over the past twelve months. Twenty-five percent were afraid of being beaten up. Twenty-four percent were in a physical fight. Learners at schools E and I seem particularly vulnerable even though physical abuse is being experienced by learners in varying degrees at all the schools. The prevalence of physical fighting on school property among this sample is lower than the national and provincial norms. The prevalence amongst grade nines nationally is 34% and for the Western Cape province it is 30%. However, twenty-five percent is still significantly high for this sample.

Property theft and damage

Table 4.34 (see Appendix VI), offers results for two items relating to property damage at school (WestEd, 2003b). Stolen and damaged property is a problem at all schools in the sample with up to 39% of learners having something stolen or damaged over the past year. Purposeful destruction of property seems to be a problem at school D in particular and school F, G and H to a lesser extent. Forty-seven percent of learners at school D admit to having destroyed school property at least once, 30% of learners at school F, 28% of learners at school H and 26% of learners at school G. Only a total of 27% of learners at all the schools in this sample admit to having damaged school property on purpose while

a total of 73% of learners at all the schools in this sample say that they did not engage in such behaviour.

(b) Weapons at school

According to Table 4.35 (see Appendix VI), 9% of learners in this sample admitted to carrying a gun one or more times over the past year on school property. Sixteen percent admitted to carrying any other weapon one or more times over the past year. Seven percent of learners admit to carrying any weapon one or more times to school over the past month. These results are consistent with the Western Cape results (7%) for carrying any weapon over the past 30 days and is lower than the national results for grade nines (12%). Schools most at risk for the carrying of guns to school are schools I, C and E; for carrying any other weapon are schools D, E, H and I; and for carrying any weapon over the past 30 days are schools C and I. These results once again highlight that safety is often related to socio-economic circumstances as learners at schools C and I feel most under threat and have the need to protect themselves or even threaten others. This applies to schools D, E and H to a lesser extent and is virtually a non-issue for schools F and G.

Carrying weapons (general)

Tables 4.35 and 4.36 (see Appendix VI), shows the self-reported frequency with which guns, knives, clubs/bats, or any other weapons were carried to school in the past 30 days and past 12 months (WestEd, 2003b). Six percent of learners in this sample admit to carrying a gun over the past thirty days. This is lower than the prevalence in the Western Cape (9%), and the prevalence amongst grade nines nationally (9%) but is still significantly high. These results confirm that prevalence is rife in more impoverished areas as learners at schools C (19%), I (9%) and E (6%) admit to carrying a gun at least once in the past month. Prevalence at school C is significantly higher than the provincial and national averages, indicating serious intervention is necessary at this school. Thirteen percent of learners in this sample admit to carrying any other weapon at least once over the past 30 days. This is lower than the national (19%) and provincial (20%) averages. Once again, prevalence is highest at schools I (19%), C (19%) and E (18%).

Awareness of weapons

To provide a sense of the awareness of weapons at school, the CHKS asks about how often respondents had seen someone carrying a gun, knife, or other weapon at school in the past 12 months, as reported in table 4.37 (see Appendix VI) (WestEd, 2003b). An average of 43% of learners in this sample report having seen someone at least once with a weapon on school property during the past twelve months. This is especially at schools E (65%), I (53%) and D (57%). Ten percent of learners report having been threatened or injured at least once on school property over the past twelve months. This is lower than the number of learners having had this experience over the past six months in terms of the national results (16%) and the results for the Western Cape (13%). More learners at schools I (21%), D (13%) and E (11%) have experienced threats or injuries at least once than at the other schools. Prevalence at school I is higher than national and regional prevalence indicating a need for intervention in this regard.

Peer sanctions of weapons at school

Table 4.38 (see Appendix VI), presents student perceptions of how much their friends would disapprove if a student known to them carried a weapon to school, and can be compared to the results for peer disapproval of ATOD use (WestEd, 2003b). An average of 33% of learners in this sample report that their friends would not disapprove if some student they knew carried a weapon to school. This is a disturbing result as it points to acceptance of an undesirable situation. Schools where weapon carrying seems to be acceptable amongst peers are schools C, I and D. Most of the learners indicated that their peers would not disapprove of them carrying a weapon to school. Forty-nine percent of learners at schools C and I, and forty percent of learners at school D said that there would be no peer disapproval for the carrying of weapons at school.

Harassment causes: hate-related behaviour

Table 4.39 (see Appendix VI), provides the annual frequency with which respondents reported that they were harassed or bullied on school property for any of the following six reasons: race/ethnicity/national origin, gender, religion, sexual orientation, a physical or mental disability, or any other reason (WestEd, 2003b). Forty percent of learners in

this sample reported having been exposed to *any* form of harassment over the past year. (last category in the table). This is consistent with the results obtained for the question related to bullying over the past six months in the national survey. Forty-five percent of grade nines nationally reported experiencing some form of bullying and forty-two percent of learners in the Western Cape reported having been bullied. The most frequent reasons for bullying and harassment amongst this sample are religion (experienced by 20% of this sample). This is followed by race and ethnicity (17%), gender issues (13%), disability (11%) and sexual orientation (8%).

School safety concerns

Table 4.40 (see Appendix VI), reports how safe students felt when they were at school (WestEd, 2003). In general most learners in this study felt safe at school. Only an average of 8% of learners reported feeling unsafe at school with highest levels reported for schools C (19%) and I (17%). This seems to be inconsistent with the results of the national study which reports that 34% of grade nines nationally do not feel safe at school and 23% of learners in the Western Cape do not feel safe at school. Results for schools C and I seem to be representative of learners in the province. However, 52% (school C) and 57% (school I) of learners respectively report feeling very safe at these two schools. This could be because they see their school as a safe haven in relation to their communities. The results of the focus groups will shed more light on this unusual occurrence.

(c) Other violence-related indicators

Gang membership

Table 4.41 (see Appendix VI), presents the frequency that students reported they had ever been members of a gang. Although it may seem that youths would be reluctant to disclose their gang affiliations, this is not usually the case. Gang members typically are proud of their gang membership and do not attach any social stigma asserting this in a survey (WestEd, 2003b). Only 10% of learners in this sample report having ever belonged to a gang with the highest numbers reported at schools F (15%), I (15%), C (11%) and G

(10%). These results are consistent with the national results for grade nines (13%) and the Western Cape results for grades 8,9,10 and11 (13%). However, the results for schools F and G are unusual, as the profile of these schools would suggest that learners from these very affluent backgrounds would not belong to gangs.

Relationship violence

Table 4.42 (see Appendix VI), reports the results on a victimisation item that is not specific to the school: whether students had been hit, slapped or physically hit on purpose by a boyfriend or girlfriend in the past year (WestEd, 2003b). An average of six percent of learners in this sample reported that they had experienced physical violence from their partner over the past 12 months. This is lower than the results reported for grade nines nationally (14%) and for the Western Cape over a six-month period (15%). Learners at school I are most at risk for physical violence (11%). This is followed by school C (7%), E and H (6% respectively) and school D (5%). Interesting to note is that this profile once again reflects the socio-economic status of the learners at the respective schools, with the learners from the more impoverished backgrounds more likely to experience abuse and violence than the learners from the more affluent backgrounds.

(d) Violence-related behaviour by gender and grade

The summary Table 4.43 (see Appendix VI) reveals that while both girls and boys are experiencing bullying and harassment, boys are at greater risk than girls. At every school we find that some boys and girls have been involved in a physical fight. Boys are, however, more involved in physical fighting and are more likely to carry weapons to school. Girls are therefore more likely to report that they feel safe at school than boys and this is reflected in the table. Only at schools D and I do boys feel more safe than girls. At school H girls and boys feel equally safe. Only at school F was no weapon carrying necessary at all. In summary, schools do not appear to be safe havens and this would undoubtedly have a negative impact on learning and overall well-being.

4.2.1.5. Physical and mental health

According to WestEd (2002b), promoting healthy personal habits, providing for enjoyable physical activities, offering good food choices, and addressing depression are just as important to positive youth development and school success as keeping youth safe and drug-free. Students who are hungry, sick, troubled or depressed cannot function in the classroom. Students who eat well and exercise regularly, are better able to maintain the energy levels needed for learning and to maintain positive emotional development.

(a) Food consumption and nutrition choices

Nutritious food choices

Table 4.44 (see Appendix VI), displays the percentages of students reporting that they ate foods from each of six categories of fruits and vegetables at least once per day as well as those learners that had at least five servings of any of them. This is based on the US department of Agriculture's five-a-day campaign that encourages everyone to eat at least five servings of fruits and vegetables a day (WestEd, 2003b). An average of 76% and 81% of learners respectively reported that they had had fruit and vegetables within the last 24 hours. An average of 60% of learners reported that they had had 100% fruit juices within the last 24 hours. Forty-four percent of the learners in this sample reported having at least five or more portions of fruit and vegetables each day. This could be improved for all learners but particularly for learners at schools C, D and H.

Milk consumption

Table 4.45 (see Appendix VI), provides data on milk consumption (WestEd, 2003b). Thirty-one percent of learners reported having had milk or joghurt at least once over the past 24 hours with fifty-one percent of learners reporting that they had milk or joghurt more than twice in the past 24 hours. While these are generally good results, of concern is the fact that nineteen percent did not have any form of milk or joghurt over the past 24 hrs. Learners at schools C, E, H and I are least likely to consume milk and joghurt while learners at schools D, F and G are most likely to consume milk or joghurt. National

results (MRC, 2003) reveal that less than half of grade nines (44%) drank milk frequently over the past week and only 52% of youth in the Western Cape drank milk frequently over the past week.

Soda ('gas cooldrink')

According to Table 4.46 (see Appendix VI), most learners in this sample (59%) reported drinking sodas over the past 24 hrs. Soda consumption is highest amongst learners at schools D, E, H and I and lowest amongst learners at schools C, F and G.

Fried potatoes

Tables 4.46 and 4.47 (see Appendix VI), report on the consumption of two 'undesirable foods': soda drinking as a gauge of calorie and sugar intake, and eating French fries and other fried potatoes, as a gauge of calorie and total fat intake. These extra calories contribute to overweight and obesity (WestEd, 2003b). An average of sixty-nine percent of learners in this sample reported eating fried potatoes during the past 24 hrs. Learners at schools I (93%), E (81%) and C (72%) reported the most prolific consumption of fried potatoes (more than once in the past 24 hours). Learners at schools D (58%) and G (52%) reported the lowest consumption.

Breakfast consumption

Table 4.48 (see Appendix VI), presents data on breakfast consumption on the day of the survey. Students who eat breakfast have been found to learn better, perform higher on standardised test scores, have better attendance rates at school, and be less apathetic and lethargic (WestEd, 2003b). An average of 31% of learners in the sample reported that they did not have breakfast that morning. This is significantly high and is of concern as it has implications for the learners' abilities to learn effectively. Only 59% of learners at School E reported having breakfast on the morning of the survey. Schools F (81%) and G (74%) reported the highest levels of breakfast consumption.

(b) Physical activity

Tables 4.49 and 4.50 (see Appendix VI), present the proportion of youth who engaged in aerobic exercise as well as physical activity three or more days per week (WestEd, 2003b). Forty-seven percent of learners in this sample reported having engaged in vigorous physical activity over the past seven days. This is consistent with national grade nine results (48%) and Western Cape (regional) results for grades 8,9,10 and 11(40%). Forty-one percent of learners in this sample reported having engaged in moderate exercise over the past seven days. This is an improvement upon national grade nine results (33%) and Western Cape results (32%). The most inactive learners seem to be found at schools C, D and H.

Most learners in the sample (69%) report having engaged in strengthening and toning exercises over the past seven days. This is a positive result since Physical Education is no longer a separate subject in our schools. Even though it has been integrated into the Life Orientation curriculum, it more likely not to happen than to be a part of regular school activities. Learners at schools C (43%), D (40%), I (39%) and H (33%) are most inactive.

(c) Depression-related feelings

Table 4.51 (see Appendix VI), provides an indicator of depression risk: the percentage of students who had felt so sad or hopeless almost every day for two weeks or more that it stopped them from doing some usual activities (WestEd, 2003b). An average of thirty-one percent of learners in the sample report feeling so sad and hopeless almost every day for two weeks or more during the past 12 months that they stopped doing some usual activities. For the same YRBS question, 23% of grade nine learners nationally and 23% of learners in the Western Cape reported that they felt the same. While all schools sampled have significant numbers of learners feeling the same way, schools D, E and I have the greatest numbers of learners who felt this way with reports of 40%, 36% and 33% respectively. These results are significantly higher than the national and regional averages and warrant serious attention by these schools.

(d) Asthma

Table 4.52 (see Appendix VI), provides an estimate of the proportion of students ever diagnosed with the disease (WestEd, 2003b). Twenty-percent of learners in this sample report being diagnosed with asthma. Asthma is particularly prevalent amongst learners at schools H (30%) and D (28%). A large number of students at school I (34%) report not knowing if they have asthma. These learners do not have free access to medical care so the results for this group could be much higher than reported.

(e) Body mass index

Table 4.53 (see Appendix VI), represents the Body Mass Index of respondents as calculated from the height and weight values (WestEd, 2003b). The majority of learners in the sample (78%) are of an acceptable weight. Three percent of this sample is underweight. While only 6% of these learners are overweight, a further 13% are at risk for overweight. When compared with the national results, a smaller number of students in this sample are underweight than calculated for grade nines nationally (11%) and grades 8,9,10 and 11 in the Western Cape (6%). A similar picture emerges for learners who are overweight and those at risk for overweight. The results for the sample are less than for national grade nine (6% vs 14%) and Western Cape results (13% vs 22%).

Summary of Module A: Core risk behaviours

The results of the core survey are consistent with various studies internationally and locally related to risk behaviour amongst grade nine learners. The learners in this sample are clearly engaging in various risk behaviours. Experimentation is rife across all schools. Bullying and harassment and depression seem to be challenges for all schools to address. Alcohol and drug abuse seem to be the predominant challenges at previously advantaged schools. Violence and safety issues seem to be the predominant challenges at previously disadvantaged schools. At this stage it appears that all learners urgently require generic life skills to deal with the many challenges they are faced with as teenagers.

4.2.2. MODULE C: ALCOHOL AND DRUG USE

This module provides more detailed information on the areas related to AOD use and violence presented in Module A. While some items may appear repetitive the significance of this module is the fact that it gives a clearer indication of risk as it reflect intensity, consistency and dependency. This sets it apart from the results in Module A that mainly reflects experimentation of substances and occasional rather than regular violence.

4.2.2.1. Alcohol and drug use

This first section is designed to promote a better understanding of the patterns and dynamics of alcohol and other drug use and the factors that need to be taken into consideration in programme planning (WestEd, 2003b).

Alcohol use

According to Table 4.54 (see Appendix VI), 45% of learners reported having used alcohol during the past six months with highest levels of weekly use reported at schools G (12%), H (10%), F (8%)) and D (7%) and daily use at school I (3%).

Marijuana use

According to Table 4.55 (see Appendix VI), 16% of learners report having used marijuana over the past six months with highest levels reported at schools C (25%), G (21%) and H (21%) and with monthly use reported at school D (6%).

Inhalant use

According to Table 4.56 (see Appendix VI), only 7% of learners reported inhalant use with highest levels at schools C (21%) and I (16%) and most frequent use (daily) reported at school C (5%).

Cocaine, methamphetamine or other stimulant use

According to Table 4.57 (see Appendix VI), only 7% of learners reported stimulant use with highest levels at school C (17%). Monthly use is reported at schools C (4%) and I (3%). Weekly use is reported at schools C (2%) and H (2%).

Psychedelics, ecstasy or other club drug use

According to Table 4.58 (see Appendix VI), only 8% of learners reported stimulant use with highest levels at school C (19%) and school I (14%). Weekly use is reported at schools C (2%) and H (2%) and almost daily use is reported at school I (2%).

Any other drug use

According to Table 4.59 (see Appendix VI), 7% of the learners report having used other drugs during the past six months. Of these learners, 22% of learners at school C, 4% at school D, 2% at schools E and F and 8% at school I report having used any other drugs more than once. Weekly use was reported at schools C (5%) and H (2%) and almost daily use (2%) as well as daily use (2%) is reported at school C.



Poly drug use

Table 4.60 (see Appendix VI), reports on the frequency in the past six months that high school students engaged in polydrug use, or using two or more drugs together at the same time (for example using alcohol with marijuana, or cocaine with pills) (WestEd, 2003). An alarming 10% of learners report polydrug use during the past six months with the majority of these learners at school C (32%). The other learners at risk are to be found at schools I (11%), D (10%), G (8%), H (6%) and E (4%). Monthly use is reported at school C (11%), weekly use at schools C (3%) and H (2%) and daily use at school D (2%).

Ever used needle to inject illegal drugs

Table 4.61 (see Appendix VI), provides the proportion of high school students that had ever used a needle to inject an illegal drug, the fastest and most efficient way to take heroin and other drugs. (WestEd, 2003b). Four percent of the sample report ever using a needle to inject an illegal drug. Twelve percent of learners at school I and 11% of

learners at school C report using a needle to inject an illegal drug. Two percent of learners at schools D, G and H also report using a needle to inject an illegal drug.

Ever illegally used steroids

Table 4.62 (see Appendix VI), presents the self-report from high school students of whether they had ever illegally used steroids (pills or injections) (WestEd, 2003b). Five percent of learners in this sample report using steroids during their lifetime. Of these learners, 11% are from School I, 9% from school C and 7% from school E.

4.2.2.2. Alcohol and drug use-related problems (ever)

Occurrence of problems while using alcohol / drugs

Table 4.62 (see Appendix VI), enables students to see a connection between their alcohol and drug use and any problems (WestEd, 2003b). The most significant problems experienced by learners in the sample that relates to their substance abuse is (in descending order): forgetting what happened or passing out (7%), money problems (6%), hurting or injuring themselves (5%),  trouble at school, problems with schoolwork, damaging friendships (4%), fighting with other kids (3%), unwanted or unprotected sex, traffic violations (2%). Sixty percent of learners at school D reported using drugs and forty percent reported never having had problems. This group is therefore at highest risk for problems related to substance abuse, as they are least aware of the dire consequences of substance abuse.

Driving under the influence of alcohol

Table 4.63 (see Appendix VI), asks students more narrowly about their own drinking and driving in the past 30 days (WestEd, 2003b). Eight percent of learners in this sample reported driving under the influence of alcohol over the past thirty days. This is consistent with national grade nine results (9%) and Western Cape results (8%) for grades 8,9,10 and 11. Frequent driving under the influence (two or more times) is found amongst learners at schools I (10%), C (9%), E (5%) and D (2%).

Frequency of alcohol cessation and marijuana cessation attempts

Tables 4.64 and 4.65 (see Appendix VI), provide the proportion of high school respondents that ever tried to quite using alcohol or marijuana (WestEd, 2003b). From tables 4.64.and 4.65 it is evident that 17% of learners have tried at least once to quit using alcohol and 10% of learners have tried at least once to quit using marijuana. Attempts to quit using alcohol are lowest (no attempts) amongst learners at schools G (40%) and D (36%). Attempts to stop using marijuana are lowest amongst learners at schools C and I (14% respectively). Serious attempts to stop using alcohol (more than four times) are found at schools E (7%), D (2%) and I (2%). Serious attempts to stop using marijuana (more than four times) are found at schools C (2%) and G (2%).

4.2.2.3. Cessation efforts and need for help

Perceived need for counselling / treatment for alcohol/drug use

Table 4.66 (see Appendix VI), provides additional information on the dynamics of cessation and potential treatment need (WestEd, 2003b). Schools where more than ten percent of learners need help for their alcohol or other use are schools E (16%), I (15%), C and H (12% respectively). 'Don't know' is calculated are requiring some frm of intervention as it is better for these learners to receive some help than none at all.

Likelihood of suspension / expelled / transferred for ATOD use on school property

Table 4.67 (see Appendix VI), gives us an indication of tolerance or lack of tolerance for AOD use on school property and subsequently gives us an indication of school rules and the enforcement thereof (WestEd, 2003b). Schools G, H and F have very little tolerance for AOD use at school. Eighty percent, seventy-five percent and sixty-two percent of learners felt that they would very likely be suspended or expelled for ATOD use. It seems that discipline is either lacking or not taken seriously at schools I and C as only thirty-eight percent and forty-nine percent of learners respectively felt that it was very likely that they would be expelled for ATOD use.

Likelihood of finding help for alcohol and drug use at school

Table 4.67 (see Appendix VI), gives us an indication of the likelihood that a learner would find help for alcohol and drug use at school. A greater percentage of learners (55%) felt that it was likely that they would get help for using alcohol or other drugs at school than those who felt that they would not (45%). Learners at schools D (64%), E (60%), C (62%) and G (58%) were most certain of getting help, and learners at schools I (52%), H (50%) and F (55%) were most uncertain of getting help. Whether learners felt confident of getting help did not necessarily depend upon whether the school had the resources to provide help, as learners did not necessarily utilize the resources available to them.

Estimated occurrence of marijuana use, cocaine/crack and methamphetamine use among known adults

To shed light on broader social influences that might support use, the CHKS asks students about how many adults they know are users of marijuana, cocaine, or methamphetamine (Tables 4.69 to 4.71) (WestEd, 2003b). According to Tables 4.69, 4.70, 4.71 (see Appendix VI), it seems that adult substance use is highest amongst communities related to schools C and I and lowest amongst communities related to schools D, F and G. Marijuana use is highest amongst adults at school D and H (26% respectively). Cocaine or crack use is highest amongst adults at schools I (14%), C (11%) and E (11%). Methamphetamine use is highest amongst adults at school C (18%).

4.2.2.4. Drug availability and selling

While Module A reports on the proportion of students who thought it was easy to obtain alcohol and other drugs, Module C assesses the sources of drugs and the respondents own involvement in the drug distribution network.

(a) Sources for drugs

Table 4.72 (see Appendix VI), reports on where respondents think their peers get drugs (WestEd, 2003b). The most common sources for obtaining drugs (in descending order) are ‘at parties or events outside of school’ (28%), ‘dealers’ (28%), ‘friends’ (27%), ‘in the neighbourhood’ (24%), ‘at school’ (19%), ‘at home’ (10%), ‘other’ (10%). Schools that are most vulnerable are schools C and I as these learners mostly obtain drugs at school. The rest of the learners are mostly obtaining drugs from outside of the school.

(b) Occurrence of selling drugs

Table 4.73 (see Appendix VI), reports the proportion of students who engaged in selling drugs in the twelve months prior to the survey (WestEd, 2003b). Six percent of learners in the sample report selling drugs one or more times to someone during the past 12 months. The highest frequency of learners selling drugs (two or more times) occur at schools I (10%), C (9%) and E (5%).



(c) Likelihood of marijuana use in next year

Table 4.74 (see Appendix VI), reports on the likelihood that students might use marijuana in the next year. Future intent to use drugs is a powerful predictor of use (WestEd, 2003). Eight percent of learners in the sample indicate some likelihood of marijuana use in the next year with highest levels of probability reported at schools D (25%), C (12%) and F (10%). Learners at school G and H are confident that they will not smoke marijuana in the next year.

4.2.2.5. Violence, safety and delinquency

While the core Module A asks key questions about violence and safety in the school environment. Module C asks more about violence-related behaviour in general. Tables 4.75 and 4.76 provide the annual frequency of physical fights and of fighting among

groups. They provide an indication of the overall climate of physical violence (WestEd, 2003b).

(a) Occurrence of a physical fight

As seen in Table 4.75 (see Appendix VI), an average of 27% of learners in the sample report having been involved in a physical fight during the past twelve months with 13% having been involved more than once. Fighting seems most prevalent at schools I (38%), C (34%) and H (34%).

(b) Occurrence of a physical fight between groups

Table 4.76 (see Appendix VI), presents the frequency of participation ‘in a physical fight between groups of kids’ (WestEd, 2003b). Group fighting seems most prevalent at schools I (37%) and C (33%).



(c) Weapons use and availability

Table 4.77 (see Appendix VI), reports on the extent to which respondents utilised a weapon to threaten or bully someone (WestEd, 2003b). Ten percent of learners in this sample reported using a weapon to intimidate someone. This is consistent with the national grade nine prevalence (11%) and is higher than the regional average for grades 8,9,10 and 11 (7%). Weapon use for intimidation is most prevalent in schools C (31%) and I (16%). Only learners at school G are completely exempt from this type of activity, with 0% reporting use of weapons to intimidate.

(d) Availability of firearms

Table 4.78 (see Appendix VI), provides data on how easily youths believe they can obtain a gun if they wanted to get one (WestEd, 2003b). Fifteen percent of learners in this sample are easily able to get access to a gun if they wanted to. From the above results it

seems that access to firearms are not restricted to any particular school and are therefore not restricted to learners from any socio-economic or racial group. It does seem, however, that learners at schools H (25%) and E (21%) have easiest access to a gun.

(e) Safety

School days missed due to feeling unsafe

Table 4.79 (see Appendix VI), reports the number of days out of the past 30 that respondents actually did not go to school because they felt unsafe at school or on the way to or from it (WestEd, 2003b). Fourteen percent of learners in this sample report missing school in the past 30 days due to feeling unsafe. This is less than the national grade nine prevalence (24%) and the regional prevalence for grades 8,9,10 and 11 (18%). From the above results it seems that school safety is an issue that would have to be seriously addressed at schools C (36%) and I (31%) in particular.

Safety of neighbourhood



Table 4.80 (see Appendix VI), reports how safe students felt when they were in their neighbourhood (WestEd, 2003b). An average of eighty-two percent of learners in this study felt safe in their neighbourhood. Of the eighteen percent who feel unsafe, learners at schools I (27%), D (25%) and E (22%) feel most unsafe in their neighbourhood.

(f) Forced sex

Table 4.81 (see Appendix VI), reports upon being forced to have sexual intercourse, a more serious form of relationship violence (WestEd, 2003b). Eight percent of learners in this sample report being forced to have sexual intercourse when they did not want to. This is consistent with national grade nine results (10%) as well as Western Cape results (9%) for grades 8,9,10 and 11. High levels of violence in terms of sexual intercourse are recorded for schools C (21%) and I (16%).

(g) Occurrence of being arrested

Many of the behaviours assessed by this survey are illegal for youth. Table 4.82 (see Appendix VI), gives the percentage of youth who reported having actually been arrested for any reason in the 12 months prior to the survey (WestEd, 2003b). Only eight percent of learners in this sample report having been arrested by the police at least once over the past 12 months. Arrests have been experienced mostly by learners at schools C (29%) and I (22%). This seems consistent with the high levels of violence and intense engagement in risk behaviour by learners at these schools reported thus far. This could also be influenced by the fact that many of the learners at these schools are much older than the learners at the other schools. Learners at schools D, G, F and H report 0% occurrence of arrest.

4.2.2.6. Suicide ideation

Suicide is now the third leading cause of death among adolescents aged 15 to 19 in the US. An estimated 3 million youth aged 12 to 17 said they thought about or tried to commit suicide in 2000 and 37% of these youth actually tried to kill themselves (WestEd, 2003b). As reported in Tables 4.83 to 4.89, the CHKS asks four questions relating to suicide that were derived from the YRBS: whether students ever considered, planned or attempted suicide in the 12 months prior to the survey.

Seriously considered attempting suicide

According to Table 4.83 (see Appendix VI), 20% of learners in this study report seriously considering attempting suicide in the past 12 months. This is consistent with national grade nine results (19%) and Western Cape results (20%) for grades 8,9,10, and 11. There is little variation in the results across schools indicating that this is a general challenge facing all schools.

Planned method of attempting suicide

According to Table 4.84 (see Appendix VI), 18% of learners in this study report having made a plan about how they would commit suicide. This is within range of the national grade nine results (16%) and the Western Cape results (17%) for grades 8,9,10 and 11. While there is cause for concern at all schools, learners at schools D, C and I are more at risk than others.

Attempted suicide

According to Table 4.85 (see Appendix VI), an average of 13% of learners in this sample report actually attempting suicide in the past twelve months. This is lower than the national grade nine results (18%) and the Western Cape results (17%) for grades 8,9,10 and 11. Each school has learners that actually attempted suicide over the past 12 months. The highest number of attempts as well as greatest frequency of attempts are recorded at schools C and I.

Suicide attempt that required medical treatment

According to Table 4.86 (see Appendix VI), only 4% of learners in this sample report that their suicide attempt resulted in an injury or poisoning that had to be treated by a doctor or nurse. This is significantly less than the national grade nine results (25%) and the Western Cape results (25%) for grades 8,9,10 and 11. The seriousness of the suicide attempts at all schools in this sample are reflected in the above table with as many as 11% of learners in school C requiring medical treatment.

Summary of module C: Alcohol and drug use

Module C presents the frequency and intensity with which the learners in this study are engaging in risk behaviours in general and alcohol and drug abuse, violence and safety and depression and suicide in particular. This section presents us with the reality that there is a distinct difference in the extent to which learners are engaging in risk behaviours. Learners from schools C and I are engaging in various risk behaviours with greater intensity and frequency than learners from the other schools. Schools D and H

also have high levels of engagement in risk behaviours. It seems at this stage that these learners are placed at greater risk because of their socio-economic circumstances and the poverty in their communities.

4.2.3 MODULE F: SEXUAL BEHAVIOUR

Module F focuses on sexual behaviour and provides more insight into this area than is provided by the questions in this regard in Module A.

4.2.3.1. Sexual behaviour and pregnancy

(a) Prevalence of sexual intercourse

Table 4.87 (see Appendix VI), presents the proportion of respondents who reported ever having sexual intercourse (WestEd, 2003b). An average of fourteen percent of learners in this sample report having ever had sex. This reporting is significantly lower than the number of grade nines nationally (41%) and Western Cape learners (38%) in grades 8,9,10 and 11. The highest number of learners to report engaging in sexual intercourse are to be found at school I (33%) and the lowest number of learners are to be found at school G (2%).

(b) Age at first intercourse

Table 4.88 (see Appendix VI), provides the age of first sexual intercourse (WestEd, 2003b). In this sample, 18 % of learners report having sex younger than 14 years. This is higher than the national grade nine results (15%) and lower than the Western Cape results (13%) for grades 8, 9,10 and 11. Of concern is the fact that 34% of learners at school C and 16% of learners at school I indicate that they have had sexual intercourse for the first time when they were younger than 11 years. This could possibly indicate very high levels of child sexual abuse. Zero percent of learners at schools F and H report having had

sexual intercourse younger than 11 years, which stand in stark contrast to the results for schools C and I.

(c) Number of sexual partners

Table 4.89 and 4.90 provide respondents' estimates of the number of sexual partners in their lifetime and in the past three months (WestEd, 2003b). An average of sixteen percent of learners in this sample report that they have had sex with two or more partners in their lifetime (Table 4.89 – see Appendix VI). This is significantly lower than the national grade nine results (54%) and the Western Cape results (48%) for grades 8,9,10 and 11. However, 30% of learners at school C, 28% of learners at school I, 24% of learners at school F and 22% of learners at school E, report having had sex with two or more partners. Seven percent of learners in this sample reported having had two or more partners in the past 3 months (Table 4.90 – see Appendix VI). Only learners at schools G and H reported not having had two or more partners.



(d) Alcohol and drug use

Table 4.91 (see Appendix VI), relates the use of drugs or alcohol to sexual activity (WestEd, 2003b). Ten percent of learners in this sample report having drunk alcohol or used drugs before they had sexual intercourse the last time. This is consistent with national grade nine results (14%) and Western Cape results (16%) for grades 8,9,10 and 11. Learners at schools I (17%), D (13%), F (12%) and C (12%) are most at risk for this type of activity.

(e) Contraceptive use

Condom use during last sexual intercourse

Table 4.92 (see Appendix VI), reports the use of condoms (WestEd 2003b). A greater number of learners in this sample (14%) admit to not using a condom during last sexual intercourse than the number who admit to actually using a condom (13%). This is very

worrying if one considers the high risk of pregnancy, sexually transmitted diseases and most importantly, the risk of HIV/AIDS. Also, if one considers the vast resources, human and otherwise, that have been spent on HIV/AIDS campaigns over the past few years, this outcome reflects poorly on the effectiveness of these campaigns. At schools D, E, F and G more learners used condoms than those who did not use condoms. At schools C, H and I more learners did not use condoms than those who did.

Methods of pregnancy prevention during last sexual intercourse

Table 4.93 (see Appendix VI), reports the use of contraceptives to prevent pregnancy (WestEd, 2003b). Ten percent of learners in this sample admitted to not using any form of contraception. This is significantly lower than the national grade nine results (29%), the Western Cape results (24%) for grades 8,9,10 and 11.

Five percent of learners in this sample admitted to using birth control as a form of contraceptive. This is consistent with the national grade nine results (8%) and the Western Cape results (8%) for grades 8,9,10 and 11.



Twelve percent of learners in this sample admitted to using condoms as a form of contraceptive. This is significantly lower than the national grade nine results (44%) and the Western Cape results (41%) for grades 8,9,10 and 11.

Zero percent of learners in this sample reported using injectables. This is in stark contrast to national grade nine results (12%) and Western Cape results for grades 8,9,10 and 11 (17%).

One percent of learners in this sample reported using withdrawal methods as a form of contraceptive. This is consistent with national grade nine results (4%) and lower than Western Cape results for grades 8,9,10 and 11 (7%)

Zero percent of learners in this sample reported using any other method as a form of contraceptive. This is consistent (in terms of the range 0-5 %) with national grade nine results (2%) and Western Cape results for grades 8,9,10 and 11 (1%).

(f) Pregnancy

Table 4.94 (see Appendix VI), reports the number of pregnancies (WestEd, 2003b). Nine percent of learners in this sample report that they have either been pregnant or have gotten someone else pregnant. Five percent of learners are unsure. This is consistent with the national grade nine results (13%) and the Western Cape results for grades 8,9,10 and 11 (13%). Prevalence (one or more times) is highest at schools C (27%) and I (24%) and zero prevalence is reported at school D.

(g) Likelihood of having sexual intercourse one or more times during next year

To gain insight into projected behaviour choices, the CHKS measures student intentions to have intercourse one or more times during the next year and these results are reflected in Table 4.95 (see Appendix VI). Seventeen percent of learners in this sample report that they may have sexual intercourse one or more times during the next year with the highest number at school F (26%).

(h) Forced intercourse

Table 4.96 (see Appendix VI), reflects the responses to the question of forced sexual intercourse (WestEd, 2003b). Thirteen percent of learners in this sample report that they were forced to have sexual intercourse when they did not want to. At school C 31% of learners reported that they had been forced and at school I, 25% of learners report that they had been forced. A large number of learners at schools E and F (12% respectively) have also experienced forced sexual intercourse. These results are of grave concern and need to be seriously addressed by the schools affected. Only learners at school G (0%) did not experience forced sexual intercourse.

(i) Beliefs about the prevalence of sexual intercourse

Table 4.97 (see Appendix VI), provides respondents' estimates of the percentage of their peers who ever had sexual intercourse. Documenting these estimates gives insight to perceived norms that shape their own behaviour choices (WestEd, 2003b). There is great uncertainty amongst learners at all schools in this study with regard to whether their peers have ever had sexual intercourse. An average of 30% of learners in this study have had sexual intercourse. Only seven percent of learners would therefore have made the correct projection. Twenty-eight percent of learners would therefore have overestimated the number of learners engaging in sexual intercourse. This has major implications in terms of peer pressure as learners are more likely to engage in behaviours that they believe are common amongst their peers.

(j) Intentions and attitudes about sexual intercourse

Agreement that teen abstinence is better choice than sexual intercourse

Agreement that for some teens having a baby is a good decision

Tables 4.98 and 4.99 (see Appendix VI), assess attitudes about abstaining from sexual intercourse and about teen parenting (WestEd, 2003b). It is positive to note that most learners in this sample (78%) believe that abstinence is a better choice than having sexual intercourse. This could partly be ascribed to the national sexuality and HIV/AIDS curriculum that advocates abstinence as a first choice. An interesting observation is that an equal amount of learners in schools C and I (37%) and 27% of learners in school E do not agree that abstinence is a better choice. While 76% of learners in this sample do not agree that having a baby is a good idea, an alarming 24% of learners do think it is a good decision. Of these learners who think it is a good idea, 59% attend school C and 51% attend school I – more than half the learners at each school. This peculiar result is worth closer examination.

(k) Communication with parents and other adults in the family about sexuality

The CHKS measures the extent to which youth have opportunities to discuss sexuality issues with their parents or other adults in their family and these results are reflected in Table 4.100 (see Appendix VI) (WestEd, 2003b). The topic uppermost in parents minds in South Africa at this time is undoubtedly HIV/AIDS (47%), followed by parenting (43%), delaying sexual onset (35%), answering questions about sex (33%), their opinions about teenagers having sex (32%) and then birth control (28%). At schools C and I parenting issues are more prominent than HIV/AIDS, with HIV/AIDS having the least prominence at school I.

Summary of module F: Sexual behaviour

There is much inconsistency amongst the learners in reporting whether they have ever had sexual intercourse with an average of 73% reporting that they have never had sex. Most prominent concerns in this section is the issue of multiple partners, alcohol/drug use before last sexual intercourse, lack of condom use, being forced into unwanted sexual intercourse and communication with adults about sexuality. The learners at schools C and I are most at risk in these areas with learners at schools E and F also at risk. It is evident that much work still needs to be done in the area of HIV/AIDS and sexuality and that interventions to date have not been very successful. This is evident in the results that reflect that the youth in this sample are not using condoms, that some teenagers think that having a baby is a good idea, that a significant number of learners have had multiple partners and that HIV/AIDS are not being discussed in communities where the young people are most sexually active.

4.3 LEARNERS' VIEWS OF THE ISSUES THAT PLACE THEM AT RISK

The results of the survey have provided us with quantitative data regarding the extent to which young people are engaging in risk behaviours. While the quantitative data is very valuable on its own, the results of the focus groups gives us insight into the thoughts and

feelings of the young people who participated in the survey. It provides us with particular insights that could not be gained from the survey and at the same time, validates the results of the survey. The focus group discussions confirmed that young people are faced with various challenges that threaten to impact negatively upon their health and well-being. These range from substance abuse to various forms of conflict. It is clear from the focus groups that learners have an idea of what is considered right and wrong but that peer pressure is a huge factor that determines whether they engage in risk behaviours or not.

The responses were first analysed according to the broad themes of risk and resilience and then further analysed according to emerging themes which for the risk category were substance abuse, sexuality and relationships, bullying and harassment, academic pressure, challenges at home, peer pressure and community-specific issues. Akrikaans responses were translated into English.

4.3.1 Substance abuse



It is clear from the focus group interviews that learners are aware of the dangers and consequences of drinking and smoking. They are not happy about some of the behaviours that they witness amongst their peers and are not afraid to voice their opinions in this regard. They do not support the fact that young people are engaging in these behaviours. Learners at school C expressed their outrage at the fact that young children are drinking and smoking,

I can't take that a small girl – 10 years – she is drinking alcohol, smoking and smoking is not right for us teenagers. It's gonna affect your lungs. You are too small to smoke, and alcohol is... most of the teenagers are doing alcohol, but it's not a good idea, it's not right (School C).

Learners at school F also stated that young people were drinking for all the wrong reasons,

Also, children over weekends, at parties, want to try to impress their friends or they want to drink their problems away (School F).

At school H, learners revealed that most of them smoked. What was surprising was the fact that the learners who smoked were taken aback by that fact that younger learners wished to smoke,

And it is like most of the students at the school smoke and that. We can't say, it's like whole, like half of the school smokes. And when the Grade 8's come, we were like surprised because they all came, looking for, it's like a whole half of the Grade 8's came to us and that, like came to the people that's smoking (School H).

At school I, the learners revealed that the youth not only had access to but were also utilizing serious drugs, not only cigarettes and alcohol,

Young people are experiencing drugs....Cocaine...Dagga...Alcohol (School I)

4.3.2 Sexuality and relationships

What was unexpected in lieu of the results of module F, was the firm stance by most learners on early sexual activity. This seemed contrary to the results of module F. Most young people felt that it was wrong to be sexually active at their age. Furthermore, they supported abstinence and waiting until they were older,

It's not good for teenagers just to have sex. Must ..., he must abstain till your time comes. You mustn't hurry for some things. These are things for adults, not for teenagers (School C)

Ma'am, these people... I know there's many youth here, I like using the word "youth" also, because we are youth, Ma'am. Many of these boys and girls are sexually active, ma'am, which is actually quite wrong, Ma'am (School D)

For many, relationships are a challenge. Girls confess that their difficulties evolve around the opposite sex, "Mostly with guys" (School E) and boys revealed the same, "Women" (School E). They did not seem to fully understand the nature of romantic relationships with the opposite sex and how to further develop these. It also appeared as though sex did not necessarily occur within stable, long standing relationships, that the two were separate.

4.3.3 Bullying and harassment

As revealed by the survey, bullying and harassment is a large problem for many learners. The experience of bullying is also more prevalent amongst girls. Many learners revealed that they are terrified of the other girls at school. The issues that result in conflict are often very minor and sometimes unavoidable, such as looking at another person,

I am scared of the women at this school because when you walk past them in the morning then they look at you like that, as if they wish you dead (School E).

Girl 1: You get that, the group of girls. There's a group of girls that smokes and do this and this. And then they walk around and then they want to tell everyone what you must do and they're forever giving you dirty looks and like that

Girl 2: Exactly. And they'd wear make-up to school and if you just look at them like "why you wearing make-up"? Then they want to jump down your throat or say something like that (School H).

Another learner confirmed that physical violence could even be the results of falling out with the wrong crowd,

Sunelle was talking on her phone and a girl walked past and grabbed her phone. Then Sunelle said, "Give my phone back" and then she wanted to hit Sunelle over her own phone, over her own phone! (School E)

At school I, learners take bullying to the other extreme by carrying guns and knives and which they use to scare the other learners, "They want other children to be scared at them" (School I).

4.3.4 Academic pressure

The pressure to perform academically also weighed heavily on many learners. The sheer volume of the work seemed to overwhelm learners more than the difficulty level of the work. Learners are finding it hard to balance the work and extra-mural activities,

Boy: The work, ya the work at the moment is a bit much.

Boy: It's not hard, hard, it's not like we're struggling to do it, it's just so much of it, like every subject you get homework, I mean. And then there's sports and extra-curriculars. So it's tough.

Girl: Ya, I think some teachers are fine, some teachers really are expecting, thinking that their subject is the only subject, which is quite natural. But it makes it quite difficult sometimes (School G).

One learner's account of how this issue affects him, illustrates clearly the pressure that young people experience and creates concern for their well-being,

For example like one, one day we'll get homework for each of our subjects. So even it's a half an hour homework each from six subjects, that's quite a while. School ends at three, and then you have cricket practice till six and then you have supper, Then, and then I just feel like going to bed, but you have to do your homework. And then ten o'clock comes and you still got more homework to do and I just think, OK I'm just not going to do it. So I go to sleep and the next day they say "do that homework, catch up the homework" and you get more homework, and it builds up, builds up, builds up (School G).

One learner at school H related how his experiences are compounded by the fact that his parents don't understand and this places him under more pressure,

Uhm... pressure like as in like work and that uhm... like you get a big work load and then assignments and like everybody like, all the teachers just pile it on to you and then you don't have time to complete everything. And then like when you get your report and you did bad and your parents like carry on with you like "why didn't you do so well" and all that. And they don't understand why, that like you explain to them "the teachers gave me a lot of work" and all that. They don't understand that. They say "no, you must just do better" and that's it, that's my experience (School H).

For many learners the pressure to do well was excessive and was aggravated by the school's emphasis on performance and awards,

The school also to a certain degree. There's many awards and things that they give. So there's lot of pressure on your shoulders (School F).

4.3.5 Challenges at home

Conflict at home seemed to be an issue that disturbs learners at school C. For one learner it was an issue of marital conflict.

So the parents, maybe they are fighting and you want some help. So you don't know where to go...And they said there's nothing wrong, but they're still fighting. And that is my problem (School C).

For other learners, the rules at home were too strict and were unmanageable. Of concern was the fact that they related this to suicide attempts,

Our parents, they have strong rules, so we can't manage to follow those rules. So it's ...not right. So sometimes, its...teenagers, they'll commit suicide, so the rules are so difficult. We can't follow them, all of them. We can't (School C).

They always say that it helps in some way but they are difficult rules, they have difficult rules. That's why me, I did commit suicide once (School C).

The pressure to be grown up also places learners in a difficult position. They clearly feel the need for support and assistance that they do not seem to be getting,

You must know what's right and what's wrong, and you must be able to do stuff on your own, because you're like an adult now. We're not, we're not adults yet, we don't understand everything, we haven't been through life like properly. (School H).

4.3.6 Peer Pressure

When asked what the most prominent issue is that impacts upon the well-being of young people today, the learners all responded in the same way namely, "Peer pressure!". It seems that most young people are finding it hard to resist the pressure to engage in various risk behaviours. While some are able to fight for what they believe is right, many fear being ostracized, isolated, rejected and made fun of. One learner was able to stand up to his peers but his example illustrates how difficult it is,

Once I had some friends and they were doing alcohol, smoking or something like that. I stay in Khayelitsha and they said that if you don't want to do this, you'll not walk with us. And me, I tried smoking and drinking alcohol. So one day, I drink too much. So I went home and I was feeling dizzy and my mom saw

that I did some alcohol and some smoking. So she hits me. And that day, I go back to them. I told them that the things which they are doing, they are not right. And then they said you mustn't walk with us and then I just left them (School C).

Learners are aware that what their friends are doing is wrong but find it hard to resist and say no. The need for acceptance overrides their values and principles,

Like the reason why peer pressure like so a big issue is because we have a lot of pressure nowadays and like we're constantly faced like with like "come and take a smoke" and then like you know yourself that you don't smoke, but now just to be like part of the gang to like fall in and "no it's OK, yes I'll take a smoke". But it's not for you. You just do it to impress your friends like, that's the example, Miss (School D).

They are scared other children, other children will think that they are not cool. Even if they don't agree, they will do it just to be accepted (School F).

They go out in groups and there is one child who has a lot of cigarettes and then everyone uses it because it's there (School F).

Sometimes if you don't use drugs, they say you don't belong in the group and you must leave them (School I).



Different groups also have different rules that apply in terms of what must be done to be accepted. While for some it may be to engage in risk behaviours, for other groups it may be to dress a particular way or to perform well. Whatever, the issue, the pressure is intense to fit in and be accepted,

Girl: No, but it depends on which group you are in. Every group has their own thing that you must do to be in their group

Boy: Wear certain clothes and...

Girl: Yes, wear same clothes or smoke

Girl: ...do certain things (School F).

Learners who are isolated often have to find ways to cope,

Girl: They just play whole day on the computer

Girl: Or they play piano

Girl: No, they are on their own. Learn to play piano, act in a pantomime, they do something that they find interesting (School F).

For most learners, relationship pressures are also intense,

To have sex ...we...are not like that, and don't know about that, because you must make a decision. Because on the one hand you don't want to lose him and on the other hand, you can lose your virginity (School E).

4.3.7 Community-specific issues

The challenges of the community also impact heavily upon the learners. For learners at school F the drinking problems of the community affected them, "Many drinking problems in the town" (School F). Learners at school I were also affected by the shebeens in their community, "In our culture you get the shebeens. You get alcohol, you buy alcohol at the shebeens"(School I). Learners are clearly concerned about these environmental influences. Matters that arose that were exclusive to some schools were as follows,

For learners at school C, violence and safety and HIV/AIDS are prominent issues,

Like my friend, I make some example of, my friend has HIV. What is good advice I can give to her or him. I can't just say that eat apples, exercise, go to the clinic, because she will think that "I'm gonna die". And she needs good advice that will make her strong. So I need good advice. What advice that I can give some positive people that get infected with HIV?

I have a problem here. Is it safe to stay with your father, you are too ... and that seeing that you are a daughter, you are a girl? Is it safe?

Learners at school F felt that young people engaged in risk behaviours because they were bored,

I think for example why children drink and use substances is because they are so bored. Because I mean, there's little...really very little things to do in town because we are reasonably small....(School F).

Motivation was also a big problem, " It's hard to motivate the children " (School F).

For learners at school G, broader social and political issues were of concern,

I also think maybe like just in South Africa in general in some areas, I think it's quite bad crime and I feel scared that someone might come and burgle your house or something, like come and harm or something like that, it sometimes so I feel quite... that make people more, sort of feel more insecure.

Learners at school I were clearly disturbed by the high prevalence of rape in their community,

- Johnson: OK. Now those are some of the difficulties of being a young person. What are other difficulties of being a young person that you find? What are the other difficulties or problems young people have?
- Boy: Get raped
- Johnson: OK, so there are a lot of people getting raped. OK, why does that happen? Why do you think that happens? So who's most at risk of getting raped? Is it the young girls or the... what type of... who's getting raped?
- Learners: Young girls
- Johnson: So it's more or less your age? But then who's abusing them? Who's doing it?
- Girl: Their fathers, brothers, cousins

It seems that girls are under threat from strangers as well as family members. Learners also reported that the community does not do anything about it because the perpetrator also threatens to kill them if they report it.

In summary, the results of the focus group interviews confirm the results of the risk survey, namely that youth are engaging in a wide variety of risk behaviours; that substance abuse, bullying and harassment, depression and suicide, violence and safety and sexual promiscuity are major issues in their lives. What the focus groups reveal that is not evident in the risk survey, is the enormous pressure that young people experience on a daily basis. This includes peer pressure and the pressure to perform academically. These factors seem to have a large role to play in youth engaging in risk behaviours. What is also evident from the focus groups is the fact that young people do have the knowledge regarding the dangers of engaging in risk behaviours but they do not seem to

have the skills to resist the peer pressure that encourages them to engage. They state clearly that substance abuse and early sexual activity amongst young people are wrong but this does not seem to deter them from engaging in these behaviours. What is also evident is that fact that there are certain challenges that are more prominent in certain communities than others and that a generalist approach to dealing with risk behaviours may not be enough.

4.4 CONCLUSIONS

From the results of the core module, it is evident that the young people who participated in the survey are engaging in risky behaviour. This is not unusual considering the developmental stage that they are in namely the stage of identity formation. It is well recognised that grade nine learners are at the brink of adolescence and are thus highly susceptible to peer pressure and experimentation. Most young people will therefore experiment with alcohol and various substances, they will engage in various undesirable behaviours that include violent and unsafe activities, they will experiment with sex and sexuality, and may even be the perpetrator or recipient of bullying and harassment.

The learners in this sample are readily engaging in 'normal' teenage activities. Learners at school D seem in particular to be most active when it comes to engaging in various risk behaviours. There is, however, very little distinction at this stage between the learners in terms of their behaviour and the various schools they are at or the communities from which they hail. Challenges that are common to all schools are alcohol and drug abuse, bullying and harassment and depression. Challenges that seem to be more particular to more disadvantaged schools are issues of violence and safety. Challenges that seem to be more particular to more advantaged schools seem to be alcohol and drug abuse.

From the results of the core survey, however, it is evident that all young people need to be skilled in resisting peer pressure and making the right choices. The learners in this sample appear to be very vulnerable to peer pressure and experimenting with various substances and engaging in a wide range of risk behaviours. While the core module

reveals that all learners are vulnerable and seem to be experimenting, module C allows a closer look at alcohol and drug abuse, violence and depression and suicide. While core Module A focuses more on the prevalence of certain behaviours, module C focuses on the frequency and intensity of certain behaviours. It also examines the issues related to behaviours in and around the school. From module C we learn that learners at schools C and I seem to be engaging in various risk behaviours with greater intensity than the learners at the other schools. Learners at these schools are also experiencing greater risk in terms of violence and safety issues. It also seems easier to engage in risk behaviour and violent behaviour at these schools. To a lesser extent learners at schools E and H also seem to engage in violence-related behaviours with greater frequency than learners at the other schools.

Alcoholism and issues related to sexuality seem to be a great problem at schools E and F. Alcoholism and drugs, particularly marijuana and club drugs, seem to dominate at schools D and G. Schools D, and G seem to be unaffected by drug-related or violent activity. These students seem to have access to substances and weapons in their communities. Hard core drugs (cocaine, heroin, etc) seem to be as prevalent in the communities as it is at schools C and I. Drugs, guns and violence seem to occur on school premises at schools C and I. Learners at schools E, F and H are less at risk as these schools also seem to be less tolerant of these behaviours.

While depression and suicide is common to learners at all schools, frequency and intensity is higher at schools D, C and I and highest at school C. It seems therefore that learners at schools D, E, F, G and H are offered some form of protection from various risk behaviours in terms of their schools being places of safety while learners at schools C and I experience pressure from their communities as well as at their schools. The high pressure of coping within their communities combined with the pressure of coping at school could explain the high prevalence of depression and suicide and frequency and intensity of suicide attempts at these two schools.

Module F, which reflects on sexual health, reveals that an average of 14% of young people involved in the study are sexually active. These learners are not using condoms. This is of grave concern when one considers the threat of HIV/AIDS in South Africa. They are being coerced into sexual activity, they are engaging while under the influence of alcohol or drugs, they are having sex with more than one partner within a short period of time and they do not think that having a baby is a bad idea. Learners at schools C and I are most under threat in terms of the above risk factors. Many of these learners have had intercourse before age 11. Many have been forced into sexual intercourse and have multiple partners. Learners at schools E and F are also demonstrating high levels of sexual activity. In general, parents at most schools seem to find it easier to talk to their children about HIV/AIDS and parenting than sex. Parents of learners at school C and I seem least interested in talking about HIV/AIDS and birth control.

The responses of the learners in the focus groups have provided a glimpse into their world and the challenges they have to face. It is clear that learners find themselves in a very difficult position. They do have the knowledge in terms of what they should or shouldn't do. The key difficulty is resisting the pressure that comes with being part of a particular group. Fear of being isolated or excluded seems to override their knowledge of the negative effects of engaging in risk behaviours. The expressiveness with which learners revealed that the biggest threat to their well-being is peer pressure, indicates the magnitude of the challenge and that they are at a loss for how to deal with the problem. If we hope to address the problem of youth at risk, we need to urgently address the problem of peer pressure, as it is clear that learners have the necessary knowledge to make the right decisions but this is not enough. Skills, attitudes and values need to be strengthened and constantly reinforced. Clearly, young people are not able to manage this on their own, they need the support of their families, friends, schools and communities to be successful.

The results of the California Healthy Kids Survey and the focus groups therefore reveal that urgent intervention is required to prevent our youth from making the wrong choices and destroying their lives. As a new democracy, we need to develop young people with the necessary skills to be resilient and succeed, despite the challenges facing them. It is

clear that our young people are under tremendous pressure. This is confirmed by the results of the National Youth Risk Survey of 2002 (MRC, 2003) and by the results of this study. They need to be provided with much support to navigate their way through the various challenges facing them and to charter a successful course for themselves and their communities.

The following chapter will examine the resilience profiles of the various learners at the respective schools and we will then be able to determine the extent of the work that needs to be done at school level to support these young people. What is beginning to emerge from the risk results is that certain high risk activities are able to occur at certain schools such as smoking, substance abuse and violence. This provides some protection for those learners and eases the pressure to engage in these activities.



CHAPTER FIVE

RESEARCH FINDINGS

RESILIENCE PROFILES

5.1 INTRODUCTION

It is the purpose of this chapter to present the resilience findings of the survey conducted with the sample of grade nine learners as well as the findings of the focus groups. In the previous chapter the risk profiles of the learners in the study produced alarming results. It is evident from the results presented in the previous chapter that young people are engaging in a wide range of risk behaviours.

The resilience profiles will provide an indication of the external and internal supports or strengths of the young people in this study. It will provide an indication of the extent to which the young people in this study are supported in the school, home, community and amongst peers. It will also provide an indication of the extent to which certain positive and supportive characteristics are present in order to strengthen them and ward off adversity. The profiles enable us to see how support to young people can be improved and how internal strengths can be developed in order to secure more successful outcomes.

It should be borne in mind that these aspects are the focus of this study, namely, how resilience can be fostered and nurtured in young people so that they can succeed despite the many challenges facing them. Before the presentation of results a brief background to the development of the module and rationale for the module according to the Aggregated State Report of Fall 1999 to 2000 (WestEd, 2000) will be presented.

5.2 BACKGROUND

The rationale behind the development of the RYDM and its inclusion in the CHKS is that assessing the strengths, competencies, and positive social and health attitudes and behaviours exhibited by youth is as important as it is to identify their risk and problem behaviours (WestEd, 2000). It became evident during the course of this research that teachers were often aware that young people were engaging in risk behaviours. Reports such as the National Youth Risk Behaviour Survey 2002 (MRC, 2003), while it provided clarity on the extent to which young people were engaging in various behaviours, often resulted in despondency, as teachers were not provided with solutions for improving the situation. The RYDM provides strategies to improve supports and internal strengths and in so doing, provides hope in what is presented as an otherwise hopeless scenario.

In the RYDM, youth development is defined as the process of promoting the social, emotional, physical, moral, cognitive and spiritual development of young people through meeting their needs for safety, love, belonging, respect, identity, power, challenge, mastery, and meaning (WestEd, 2000).  It is the belief of the developers of the RYDM that schools can promote healthy behaviours as well as successful learning in young people by creating climates and teaching practices that honour and meet these developmental needs. This belief is based on long term studies of positive youth development in the face of environmental threat, stress, and risk (resilience research), which identify the principles to guide practice as caring relationships, high expectation messages, and opportunities for participation and contribution in all environments in a young person's world: home, school, community, and peer groups (WestEd, 2000).

The focus on what enables young people to succeed despite adversity is critical in a world where the challenges facing young people are enormous. While it may not be possible to prevent young people from being exposed to various risk behaviours, it may be possible to provide them with the supports and skills to make the right choices in any situation. Furthermore, in a developing country such as South Africa, fiscal resources may be scarce but human capital and goodwill is more readily available and the will to

help young people is strong enough to mobilize various stakeholders to provide the necessary support to assist young people to make the right choices. This research is therefore quite timeous as various community and people's organizations are getting together to fight the scourge of drugs (methamphetamines in particular) and gangsterism. All these initiatives augur well for a combined effort to strengthen our youth and communities and to develop a long-term collaborative strategy to ensure success for the young people of the Western Cape and South Africa.

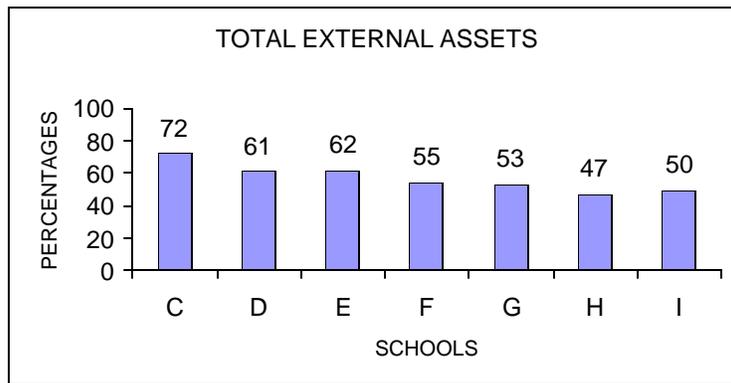
A summary of the resilience results for the sample of learners involved in this study is found in Appendix VII. The average percentage for each category is presented in the final column. It should be noted that only the percentage of learners who scored High for each category is presented, as this is the ideal scenario - that all learners should ideally score High for all categories. As there is no baseline South African study to compare these results to, comment will be limited to trends for this sample. The results obtained for the American sample will also be provided and even though a direct comparison is inappropriate, important lessons can be gleaned from similar or dissimilar trends and patterns. The results from the summary table are presented in the graphs that follow. The details of this analysis is outlined in chapter three.

5.3 EXTERNAL ASSETS

5.3.1 Total external assets

The following chart (5.1) depicts the percentage of learners scoring high on all external assets. These external assets include all four areas assessed by the survey namely, school, home, community and peer environments and three variables namely, caring relationships, high expectation and meaningful participation.

Chart 5.1 Percentage of learners scoring high on all External assets



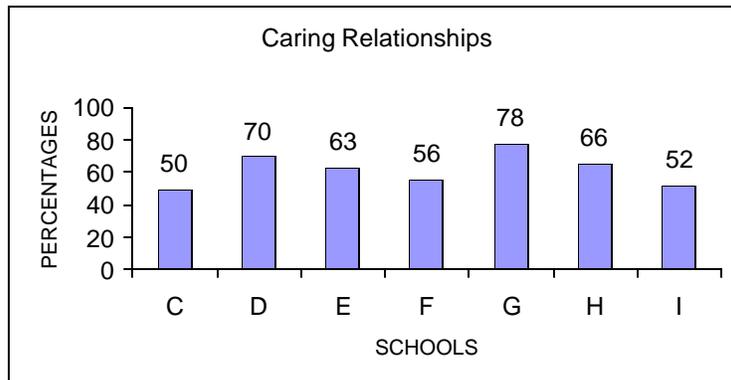
From the above chart, it appears that learners at school C (72%) are most confident about support received in the four areas (school, home, community and peer environments) and three variables (caring relationships, high expectations and meaningful participation). Of concern are the results for school H. Less than half of the learners at school H (47%) report high levels of support. Also, only half of the learners at school I (50%) report high levels of support. The results in chapter four are seen in a new light in the context of these findings. One is less concerned about the risk results for school C in lieu of these results but also more concerned for school H and I as these learners do not seem to have much external support to meet the challenges facing them. Of great interest is the fact that the average percentage of learners in this study scoring high for external assets (57%) is the same as the average percentage of grade nine learners in the Aggregated State Report of Fall 1999 to Fall 2000 (WestEd, 2000) indicating that this is an area that needs to be improved for learners in general.

(a) Caring relationships

The following chart (5.2) depicts the percentage of learners scoring High for caring relationships. Caring relationships are defined by WestEd (2000) as supportive connections to others in the student's life who model and support healthy development and well-being. According to WestEd (2000), caring relationships are arguably the most critical factor protecting healthy and successful child and youth development even in the face of much environmental stress, challenge and risk. The RYDM asks students how they perceive caring relationships (assessed by the following activities: taking interest in,

talking with, listening to, helping, noticing and trusting) in the four environments of home, school, community and peer groups.

Chart 5.2. Percentage of learners scoring high on Caring relationships



A closer look at caring relationships reveals that learners at schools G (78%) and D (70%) experience caring relationships to a greater extent than learners at the other schools. Learners at schools C (50%) and school I (52%) experience the least amount of caring relationships in their lives. If one considers that caring relationships is the most critical factor in determining successful outcomes then learners at schools C and I are most at risk. The results in chapter four revealed that these learners are most likely to be exposed to issues related to violence and safety and AOD use. The results for school F (56%) are also fairly low. This may relate to the fact that school F is also a boarding school and they may not receive as much care, as they perhaps would receive if they were living at home. The results in chapter four reveal that learners at schools F are most prone to alcohol abuse and issues related to sexuality. The average percentage of learners in this study scoring high for caring relationships (62%) compares favourably to the average percentage of grade nine learners in the Aggregated State Report of Fall 1999 to Fall 2000 (58%) (WestEd, 2000).

(b) High expectations

The following chart (5.3) depicts the percentage of learners scoring High on High Expectations. According to WestEd (2000), high expectation messages are the consistent communication of direct and indirect messages that the student can and will succeed

responsibly. It reflects a belief in the youth's innate resilience and ability to learn and is a pivotal factor in the home, school and community environments of youth who have overcome the odds. The RYDM asks youths their perceptions of the messages they receive from adults in their home, school and community as well as their peers in terms of their ability to follow rules, be a success, do their best, try to do what is right and do well in school (WestEd, 2000).

Chart 5.3 Percentage of learners scoring high on High expectations

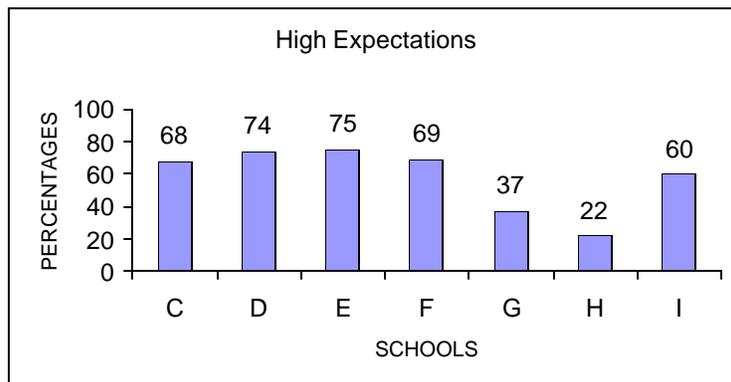


Chart 5.3 reveals that only 22 % of learners at school H and 37% of learners at school G are receiving messages that they can and will succeed. This is an unexpected result as these learners come from fairly secure backgrounds and well-established schools. This phenomenon would have to be explored further within each particular school, as it is more likely to be school and community specific. As 'high expectations' is a 'challenge plus support' (WestEd, 2002) message one wonders whether the challenge to do well exists but the support is missing or whether the support exists but the challenge is missing at either of the two schools. Learners at schools E (75%) and D (74%) seem to be well supported in terms of the belief that they can and will succeed which augers well for their future. The average percentage of learners in this study scoring high for high expectations (58%) is significantly less than the average percentage of grade nine learners in the Aggregated State Report of Fall 1999 to Fall 2000 (68%) (WestEd, 2000). One could argue that the schools and communities in this sample could improve significantly in terms of encouraging their learners to succeed and transmitting positive messages with regard to their belief in the youth's ability to succeed.

(c) Meaningful participation

The following chart (5.4) depicts the percentage of learners scoring high on meaningful participation. According to WestEd (2000), meaningful participation is the involvement of the student in relevant, engaging and interesting activities with opportunities for responsibility and contribution. Providing young people with opportunities for meaningful participation is seen as a natural outcome of environments that convey high expectations. Positive developmental outcomes seem to be associated with youth being given valued responsibilities, planning and decision-making opportunities and chances to contribute and help others. The RYDM asks youth about their opportunities to make decisions in their families and schools, to do fun and interesting things and to participate in a way that makes a difference in their families, schools and communities (WestEd, 2000).

Chart 5.4 Percentage of learners scoring high on Meaningful participation

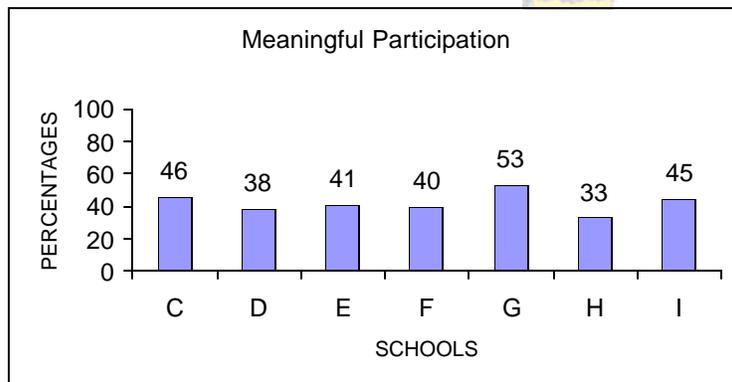


Chart 5.4 reveals that more learners at school G (53%) scored high for meaningful participation than at any other school. This seems contrary to the belief that meaningful participation is directly related to high expectations for school G but holds true for school H (refer Chart 5.3). It seems that learners at school H do not perceive that significant individuals in their lives think that they can and will succeed and opportunities for meaningful participation are not provided. The interplay between these two events could result in a vicious cycle where students do not achieve or participate because it is not believed that they can achieve or that they have anything valuable to contribute. Learners at school D also reported high on high expectations but low on meaningful participation.

The difficulty is that if learners at school D are expected to perform but opportunities for meaningful participation are not created and their voices are suppressed, it could lead to frustration and feelings of despair. In chapter three it is evident that suicidal ideation is very high for school D that could possibly be related to this situation.

In general, meaningful participation could be significantly improved for all schools in the sample. The average percentage of learners in this study scoring high for meaningful participation (42%) is slightly higher than the average percentage of grade nine learners in the Aggregated State Report of Fall 1999 to Fall 2000 (34%) (WestEd, 2000). This could be due to the new curriculum that places great emphasis on the development of a human rights culture in our schools and on the development of democratic classrooms.

5.3.2 School environment

(a) Total external assets: School environment



Chart 5.5 reflects the extent to which learners scored high on external assets in the school environment. These external assets are caring relationships, high expectation and meaningful participation. According to WestEd (2000), the rationale for this item is the substantial evidence that indicates that teachers and schools have the ability to transform children at risk into resilient beings. The school could serve as a buffer to the overwhelming demands of a pressurised or violent community. Resilient children tend to use school activities as a support for healthy adjustment and achievement and a good teacher often serves as a positive role model. Also, effective schools in high poverty communities tended to create an ethos that provided caring relationships, high expectation messages and opportunities for meaningful participation and contribution. What is sought is a positive school climate, an inviting asset-rich environment that meets students' developmental needs for love and belonging, respect, accomplishment, challenge, identity, power and meaning (WestEd, 2000).

Chart 5.5 Percentage of learners scoring high in external assets in the School environment

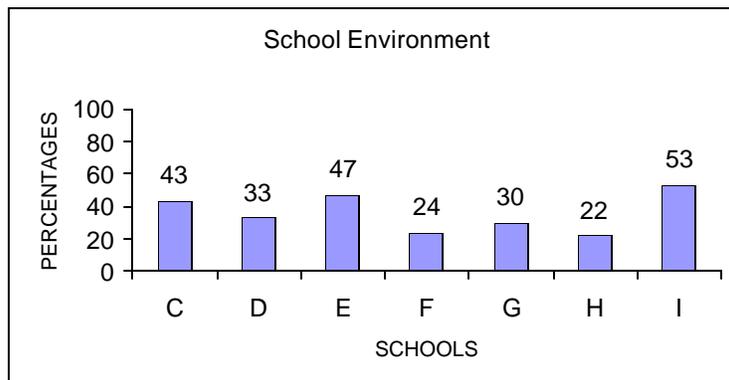
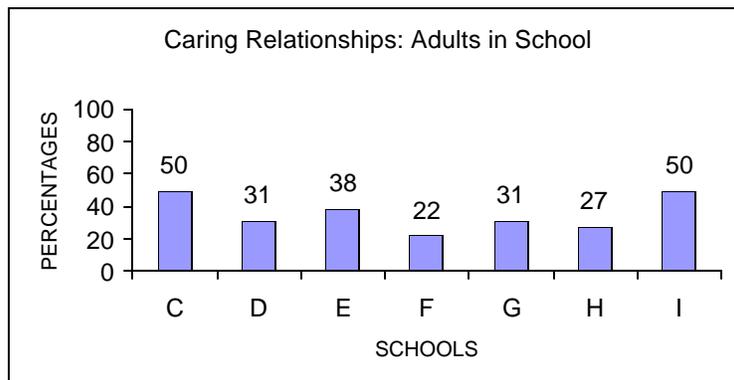


Chart 5.5 reveals that only 22% of learners at school H and 24% of learners at school F scored high in external assets in the school environment. These learners do not feel confident about the caring relationships at their school in combination with high expectations and meaningful participation. Learners at school I (53%) seem to be experiencing a more positive school ethos than the learners at the other schools. The average percentage of learners in this study scoring high for school environment (36%) is the same as the average percentage of grade nine learners in the Aggregated State Report of Fall 1999 to Fall 2000 (36%) (WestEd, 2000). In general, it seems that this is an area that could be improved for all schools.

(b) Caring relationships: Adults in school

The following chart (5.6) depicts the percentage of learners who scored high on caring relationships: adults in school. According to WestEd (2000), a caring relationship with a teacher is perhaps the most powerful motivator for academic success. Numerous studies prove that youth of all ages state that they want a teacher who cares. The positive health and academic outcomes resulting from caring relationships have also been demonstrated by mentoring projects such as Big Brother / Big Sister. Students who felt cared for by their teachers and connected to their school are less likely to be involved in health risk behaviours (WestEd, 2000).

Chart 5.6 Percentage of learners scoring high on Caring relationships: Adults in school



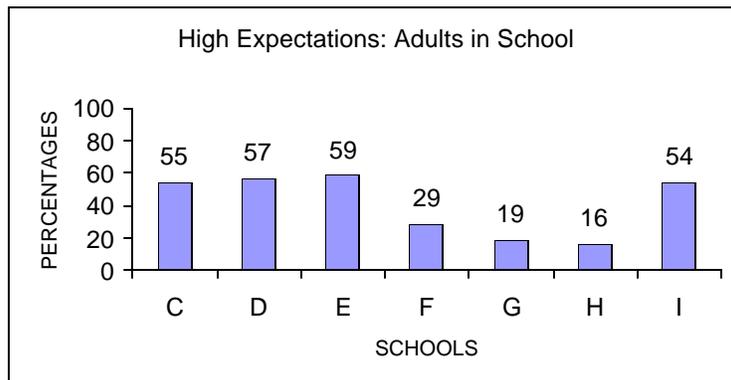
A greater number of learners at schools C and I (50% respectively) have scored high for caring relationships: Adults in school than at the other schools. The data provided in chapter three identified these two schools as most at risk for AOD abuse and violence and safety issues. With results as provided in this table, interventions that are school-based will most likely be successful in terms of securing positive outcomes for these learners at risk. Concern for school H grows as only 27% of learners scored high for caring relationships at this school and the risk profile presented in chapter three for this school was moderately high. School F is also of concern as only 22% of learners scored high for caring relationships which makes these learners vulnerable to peer pressure and risk behaviours even if their risk profile as presented in chapter three may not have been as severe as for the other schools. The average percentage of learners in this study scoring high for caring relationships in the school environment (36%) is almost the same as the average percentage of grade nine learners in the Aggregated State Report of Fall 1999 to Fall 2000 (35%) (WestEd, 2000). Once again this is clearly an area that needs to be explored and developed by all schools.

(c) High expectations: Adults in school

The following chart (5.7) depicts the percentage of learners who scored high for High expectations: Adults in school. According to WestEd (2000), high expectations, with the necessary support to meet them, directly relate to positive academic outcomes. Schools which establish high expectations for all youth have high rates of academic success and

also have lower rates of problem behaviours such as dropping out, alcohol and other drug abuse, teen pregnancy and delinquency than other schools. Success depends upon conveying positive and high expectations at several levels, starting with the belief level (the students has everything that he or she needs to be successful), the curriculum (respects the way humans learn), grouping practices (promoting a sense of belonging) and assessment (authentic assessments). According to WestEd (2000), through these organisational structures and practices, students can learn the other critical resilience traits of cooperation and communication, empathy and problem solving.

Chart 5.7 Percentage of learners scoring high for High expectations: Adults in school



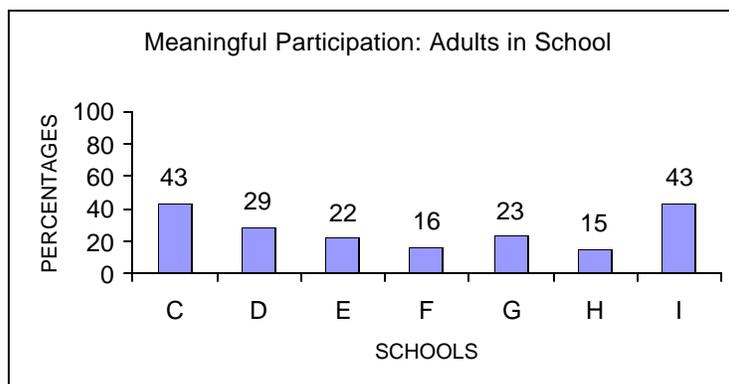
The learners at schools H, G and F do not seem to experience high expectations from the Adults in their school. Only 16% of learners at school H, 19% at school G and 29% at school F scored high for this variable. This is in direct contrast to the other schools where at least half of the learners scored high. Once again, learners at school H appear most vulnerable in terms of this kind of support. It is interesting to note that these three schools (F, G and H) are older than the other schools, are steeped in tradition and have a reputation for being particularly stern with their learners. These schools also place lots of pressure upon their learners to perform academically. Learners at school E (59%) seem to be receiving a lot more motivation from their teachers and there seems to be a greater belief in their abilities to succeed than learners at other schools in the sample. The average percentage of learners in this study scoring high for high expectations in the school environment (41%) is in the same range as the average percentage of grade nine learners in the Aggregated State Report of Fall 1999 to Fall 2000 (46%) (WestEd, 2000).

This once again emphasises the need for all teachers to see the potential of their learners and to nurture this potential.

(d) Meaningful participation: Adults in school

The following chart (5.8) depicts the percentage of learners who scored high for Meaningful participation: Adults in school. According to WestEd (2000), a challenging area for schools is increasing the opportunities for students to be contributing members of the school community. This is certainly a challenge for South African schools as well. The new South African curriculum does, however, encourage a much more facilitative role for the teacher and a more active role in the learning process for the learner. This is clearly a positive development as Rutter (in WestEd, 2000) also points out that in schools with low levels of delinquency and school failure, the students were treated responsibly and reacted accordingly. Long-term studies in the United States also reveal that student-driven learning contributed to the avoidance of poverty, teen pregnancy, drug abuse, resulted in graduation from high school and so forth. Opportunities to participate in meaningful activities and roles helps students engage their intrinsic motivation and innate ability to learn (WestEd, 2000). The fact that the classroom and school must become a democratic community (WestEd, 2000) is a notion that is strongly endorsed by the new South African curriculum.

Chart 5.8. Percentage of learners who scored high for Meaningful participation: Adults in school



From the results presented in Chart 5.8, it seems that staff at schools C and I are taking the new curriculum very seriously and are making a concerted effort to build democratic classrooms and schools. These two schools are also relatively young schools and are not as steeped in tradition as the other schools and F, G, H in particular. It could be argued that it is easier then for these schools to adopt the new curriculum than the schools that have implemented the old curriculum and responded to learners in a more traditional, stern manner. Once again, only 15% of learners at school H and 16% of learners at school F have scored high for this variable. A bleak picture is starting to emerge in terms of these learners experiencing school support and subsequently being able to access resources at school to assist them to rise above the various challenges facing them as teenagers. The average percentage of learners in this study scoring high for meaningful participation in the school environment (27%) is somewhat higher than the average percentage of grade nine learners in the Aggregated State Report of Fall 1999 to Fall 2000 (20%) (WestEd, 2000). It seems that having these principles as an integrated part of the new curriculum may be advantaging our schools but still much work needs to be done in terms of teachers allowing learners to have more of a say and to participate actively in matters pertaining to the school.

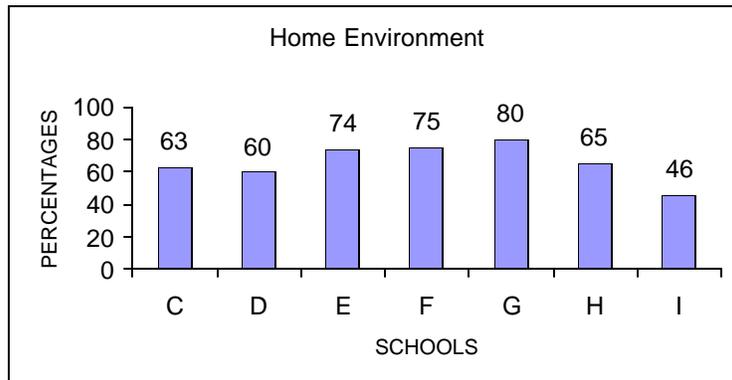


5.3.3 Home environment

(a) Total external assets: Home environment

The following chart (5.9) depicts the percentage of learners who scored high on total external assets: home environment. According to WestEd (2000), feeling connected to one's family and having positive family experiences is the most powerful protective factor in the lives of young people and schools working in partnership with families create a powerful fabric of protection and achievement motivation. Strengths-based approaches that go beyond employing families merely as workers for the school but actively involve families in management and decision-making of the school tend to result in vast improvements in academic and social behaviour among the students.

Chart 5.9 Percentage of learners who scored high on Total external assets: Home environment



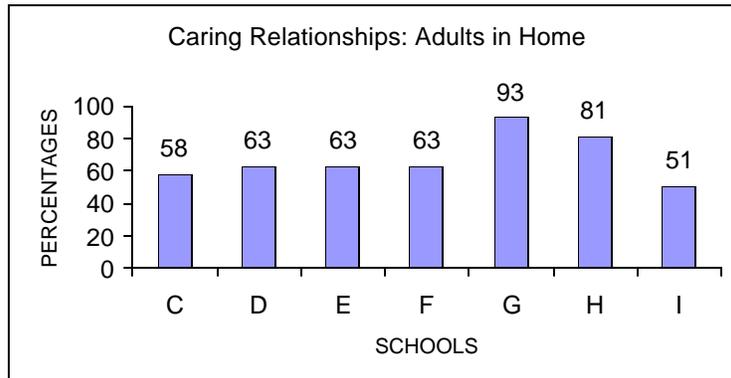
Only 46% of learners from school I scored high for total external assets: home environment. This is in stark contrast to school G where 80% of learners scored high for this variable. It is also interesting to note that where school support was low in the previous tables, home support is high in this table and vice versa. This provides much hope, as the combination of the two settings will certainly improve outcomes for these learners. Also, the school becomes a refuge for those learners who do not have support at home or in their communities. The average percentage of learners in this study scoring high for total external assets: home environment (66%) is similar to the average percentage of grade nine learners in the Aggregated State Report of Fall 1999 to Fall 2000 (64%) (WestEd, 2000). Support for learners within the home from schools E, F and G is therefore significantly higher than the average, more or less the same for schools C, D and H and significantly lower for school I. This is a good indicator of where intervention in home support needs to occur.

(b) Caring relationships: Adults in home

The following chart (5.10) depicts the percentage of learners who scored high for Caring relationships: Adults in home. According to WestEd (2000), research has shown that the most powerful protective factor in the lives of children was the presence of a primary caregiver. The need for a primary caregiver relates to meeting children's needs for love and trust. It is therefore strongly advised that where a small percentage of students score

in the high range the school needs to provide supports and opportunities for families to increase their positive care giving (WestEd, 2000).

Chart 5.10 Percentage of learners who scored high on Caring relationships: Adults in home



Ninety-three percent of learners at school G and 81% of learners at school H scored high for caring relationships. Compared with only 51% of learners at school H and 58% of learners scoring high for this variable, this is a very positive result. Parents of learners at schools G and H are more likely to have higher educational qualifications, fall within a higher income bracket. They could have more time to be available to their children than parents of learners at schools I and C. This could have a role to play in terms of how much care and support they are able to give. It is interesting to note that 63% of learners at each of the other three schools scored high for this variable. These schools are also more average in terms of parents' educational status, income and availability than the parents at the other schools. The average percentage of learners in this study scoring high for caring relationships: home environment (67%) is significantly higher than the average percentage of grade nine learners in the Aggregated State Report of Fall 1999 to Fall 2000 (54%) (WestEd, 2000).

(c) High expectations: Adults in home

The following chart (5.11) depicts the percentage of learners who scored high on high expectations: adults in home. According to WestEd (2000), high parental expectations, backed up with family support and love, is repeatedly associated with academic and life

success. “The most commonly cited message promoting resilience is the caregiver’s belief in a child’s capacities – believing in the child when it doesn’t even believe in itself” (WestEd, 2000:19). Other family characteristics cited by WestEd (2000) as critical include, structure, fair and clear rules and expectations, empowering discipline, guidance, rituals, encouraging strengths and interests and providing the freedom to develop and grow. Furthermore, deep belief and structure meets a child’s needs for safety, love, belonging, respect and meaning (WestEd, 2000).

Chart 5.11 Percentage of learners who scored high on High expectations: Adults in home

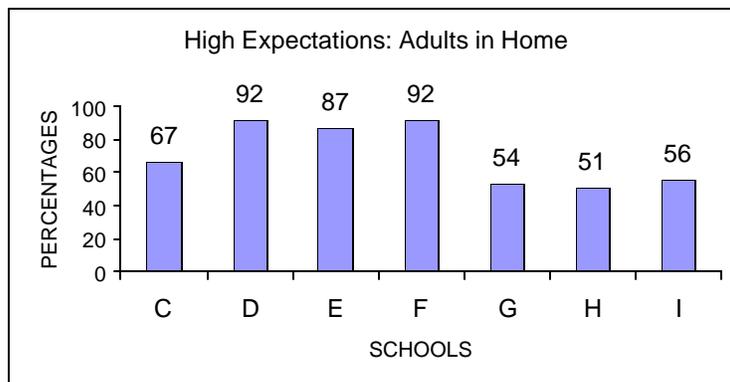
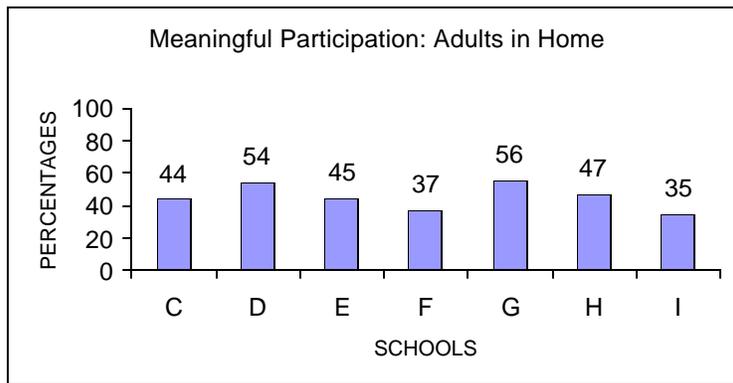


Chart 5.11 presents some unexpected results. Where care-giving could be described as average considering the number of learners who scored high (schools D, E and F), expectations for success are exceptionally high. Where care-giving could be described as high (schools G and H), expectations seem low, considering the percentage of learners scoring high for this variable. Learners in school I seem to be in the most challenging position as only 51% scored high for caring relationships and only 56% scored high for high expectations. This chart therefore reveals the specific gaps for intervention in terms of family support. The average percentage of learners in this study scoring high for high expectations: home environment (71%) is less than the average percentage of grade nine learners in the Aggregated State Report of Fall 1999 to Fall 2000 (80%) (WestEd, 2000). What this highlights is the fact that in general, young people are getting the message that there is the belief that they can and will succeed.

(d) Meaningful participation: Adults in home

The following chart (5.12) depicts the percentage of learners who scored high on meaningful participation: adults in home. According to WestEd (2000), research has shown that the family background of resilient children and youth is usually characterised by many opportunities for the youth to participate in and contribute to the life of the family. Also, when youth grow up in families where they have some decision-making power and responsibility, they learn self-management and control (autonomy) which is a critical predictor of healthy outcomes. Schools also have a role to play in family involvement programmes and modeling ways for families to make decisions and have fun together.

Chart 5.12 Percentage of learners who scored high on Meaningful participation: Adults in home



Only thirty-five percent of learners at school I and 37% of learners at school F scored high for meaningful participation: adults in home. This does not auger well for the ability of the rest of the learners to make autonomous decisions and would have an impact on the ability of those learners to resist peer pressure. Fifty-six percent of learners at school G and 54% at school D scored high which indicates that these learners are more likely to have their opinions respected and are more likely able to assert themselves and make the right decisions. If one considers the fact that less than half of the learners at schools C, E and H, scored high for this variable, then much work needs to be done within homes regarding advocacy for meaningful participation. The average percentage of learners in this study scoring high for meaningful participation: home environment (45%) is higher

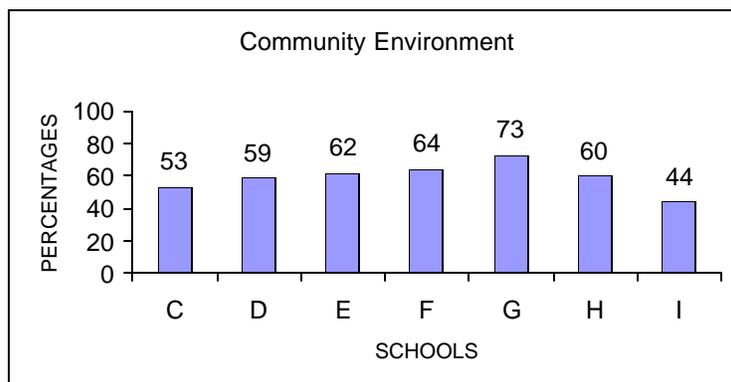
than the average percentage of grade nine learners in the Aggregated State Report of Fall 1999 to Fall 2000 (38%) (WestEd, 2000). This could be as a result of the transformation within South African society as a whole where concerted efforts are being made to respect the opinions of others, where we have a new constitution that advocates freedom of speech and responsibility.

5.3.4 Community environment

(a) Total external assets: Community environment

The following chart (5.13) depicts the percentage of learners who scored high on total external assets: community environment. According to WestEd (2000), evidence is accumulating that transforming schools and creating a resilience safety net for all children depends not only on family involvement but community involvement as well. Schools and community-based organisations have unique and complimentary strengths that can be drawn on to encourage healthy and successful development. Schools must therefore form partnerships with community-based organisations, social service agencies, business and so forth and serve as resource centres for communities (WestEd, 2000).

Chart 5.13 Percentage of learners who scored high on Total external assets: Community environment



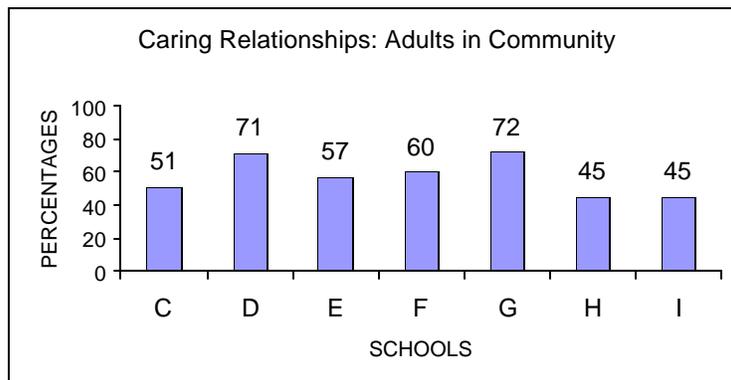
Seventy-three percent of learners from school G scored high on total external assets: community environment. This is a strong indication of community support for these learners. Only 44% of learners from school I scored high on total external assets:

community environment. This is cause for concern as a lack of support from community members could create the environment for young people to be vulnerable to various kinds of abuse and susceptible to the engagement in various risk behaviours. For school I therefore, school-community links, community involvement and support should be a priority. Schools C and D should also re-examine this aspect of student life and the impact it has on behaviour and academic performance and improve relations in this regard. The average percentage of learners in this study scoring high for total external assets: community environment (59%) is within the same range as the average percentage of grade nine learners in the Aggregated State Report of Fall 1999 to Fall 2000 (61%) (WestEd, 2000). This is a fairly positive result therefore.

(b) Caring relationships: Adults in community

The following chart (5.13) depicts the percentage of learners who scored high on Caring relationships: Adults in the community. According to WestEd (2000), one caring person has the power to change outcomes of a child at risk to a child at promise. This person could be a youth worker, a social worker, neighbour, grandparent, older friend, minister, and so forth. According to WestEd (2000), there are many concerns about the fact that the many demands of a technological society has created a fragmentation of community and family. As a result, young people are being isolated in their schools and in their communities. Two US-based projects are working towards restoring these social networks and providing much needed support for young people namely, the Big Brothers/Big Sisters mentoring programme as well as neighbourhood-based youth organisations. These projects offer schools powerful partnerships in improving the health and well-being of students (WestEd, 2000).

Chart 5.14 Percentage of learners who scored high on Caring relationships: Adults in community



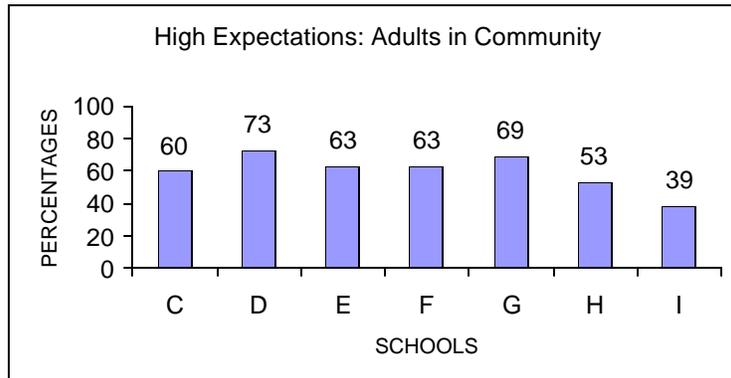
A closer look at the relationships between learners in this study and their communities reveals that large numbers of learners at schools G (72%), D (71%) and to a lesser extent, school F (60%), scored high for caring relationships with adults in their community. At the other schools which could be said to constitute half of the sample, the support from a caring adult is not too encouraging. Only 57% of learners at school E scored high and only 51% of learners at schools C scored high. Fewer learners at schools H and I receive support with only 45% scoring high respectively. The average percentage of learners in this study scoring high for caring relationships: adults in community (57%) is within the same range as the average percentage of grade nine learners in the Aggregated State Report of Fall 1999 to Fall 2000 (60%) (WestEd, 2000).

(c) High expectations: Adults in community

The following chart (5.14) depicts the percentage of learners who scored high on high expectations: adults in community. According to WestEd (2000), it is of concern that most adults have low expectations of youth and express little belief in their capacity. Public opinion has increasingly regarded youth as problems instead of seeing their potential. Most adults have only negative opinions of teenagers and even have negative opinions of younger children. “Schools alone cannot create the safety net of supports and opportunities vital to the healthy development of children and youth. Schools must work in partnership with students, families and their communities (WestEd, 2000:23). Through

partnerships young people are able to prove themselves as worthy citizens and communities are able to develop positive attitudes towards them.

Chart 5.15 Percentage of learners who scored high on High expectations: Adults in community



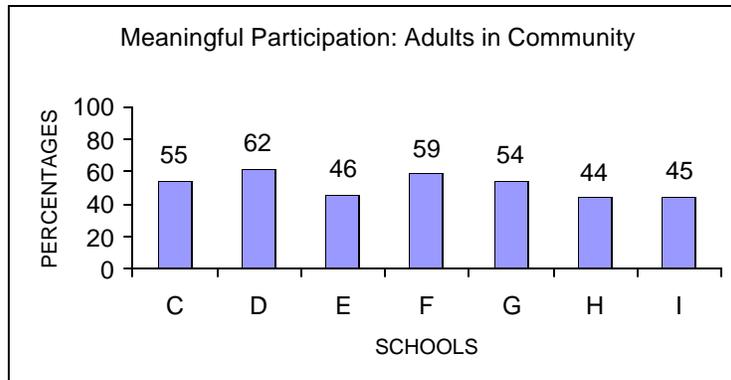
While most learners participating in this study experienced high expectations from adults in their community, the fact that only 39% of learners at school I experience high expectations suggest an apathy particular to this community. Learners at school H also experienced some form of apathy as only 53% of these learners scored high for this variable. The average percentage of learners in this study scoring high for high expectations: adults in community (60%) is within the same range as the average percentage of grade nine learners in the Aggregated State Report of Fall 1999 to Fall 2000 (64%) (WestEd, 2000).

(d) Meaningful participation: Adults in community

The following chart (5.15) depicts the percentage of learners who scored high on Meaningful participation: Adults in community. According to WestEd (2000), the natural result of having high expectations for youth, for viewing them as resources and not problems, is the creation of opportunities for them to be contributing members and leaders in their community. The aim is to develop a sense of belonging and connection to the community. What is recommended is that schools and community-based youth-serving organisations build partnerships to provide after-school programmes that provide a wide range of opportunities for youth to develop competencies based on their own

interests, life goals and dreams. It is proposed that by engaging in leadership roles, youth make personal investments and commitments to adults and other peers involved in the organisation and to the larger community (WestEd, 2000).

Chart 5.16 Percentage of learners who scored high on Meaningful participation: Adults in community



Less than half of the learners at schools H (44%), I (45%) and E (46%) scored high for meaningful participation in the community indicating that their communities may not be as open to youth participation as one would like. There also seems to be some positive developments in this regard for learners at school D as 62% scored high for this variable. Overall, this is an area that can be greatly enhanced though. The average percentage of learners in this study scoring high for meaningful participation: adults in community (52%) is significantly higher than the average percentage of grade nine learners in the Aggregated State Report of Fall 1999 to Fall 2000 (43%) (WestEd, 2000). This could be due to the fact that members of South African communities are still relatively close despite technological advancements, although this could change with time.

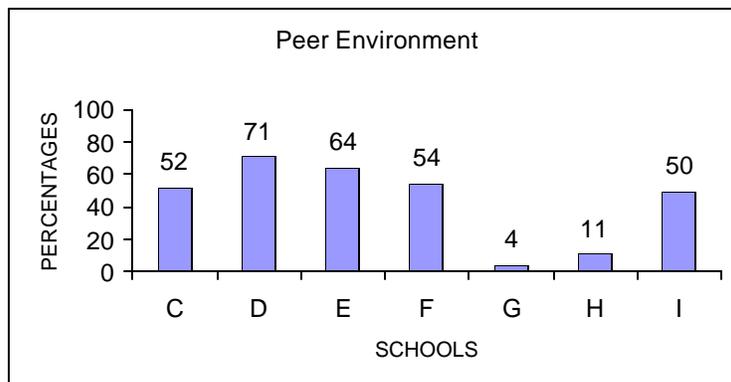
5.3.5 Peer environment

(a) Total external assets: Peer environment

The following chart (5.16) depicts the percentage of learners who scored high on total assets: peer environment. According to WestEd (2000), peer influence is a powerful developmental force. Whilst peer pressure is often associated with engagement in risk

behaviours, it can also be a powerful positive force and a protective factor. Schools should therefore engage this influence as a support and opportunity essential to healthy adolescent development. Schools must create a sense of community rich in opportunities for caring relationships and high expectation messages as these two external assets enhance peer relations between children and youth in and outside of school and meet their developmental needs for love, belonging, respect, accomplishment, identity, power and meaning in positive ways (WestEd, 2000).

Chart 5.17 Percentage of learners who scored high on Total external assets: Peer environment

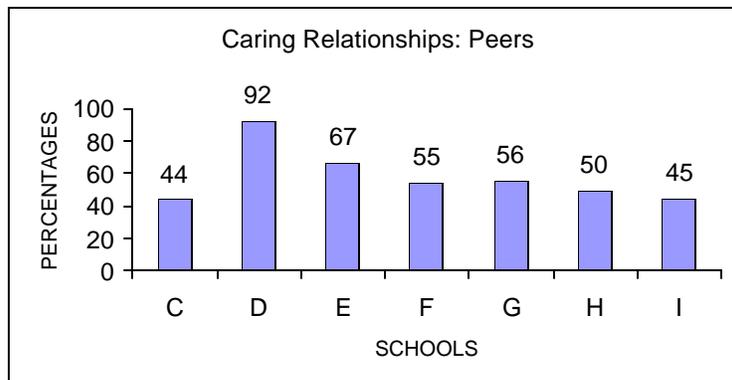


There are huge discrepancies in the scoring of learners with regard to this variable. The most supportive peer environment seems to be at schools D (71% scored high) and E (64% scored high). This is in stark contrast to the number of learners scoring high for this variable at schools G (4%) and H (11%). Because of these low scores, one could assume that peer pressure would be a serious problem at these schools and positive peer support would have to be introduced. At least half of the learners at schools C (52%), F(54%) and I (50%) scored high for a supportive peer environment. This still leaves room for improvement. This area of peer support could be the area that has the greatest influence in terms of turning things around for learners at all schools. The average percentage of learners in this study scoring high for total external assets: peer environment (44%) is significantly lower than the average percentage of grade nine learners in the Aggregated State Report of Fall 1999 to Fall 2000 (57%) (WestEd, 2000). This could serve as an indication of the need to further develop youth programmes and to support youth organisations in the Western Cape.

(b) Caring relationships: Peers

The following chart (5.18) depicts the number of learners who scored high on caring relationships: peers. This scale was designed by WestEd to measure how students behave towards each other. According to WestEd (2000), a positive school climate depends to a great extent on creating caring empathic student-to-student relationships and schools, homes and community organisations must provide youth with every opportunity to be a support and resource to each other. The aim is for youth to develop empathy, become compassionate adults and create caring communities. This will help to eradicate many problems associated with the decline in societal and adult support.

Chart 5.18 Percentage of learners who scored high on Caring relationships: Peer environment



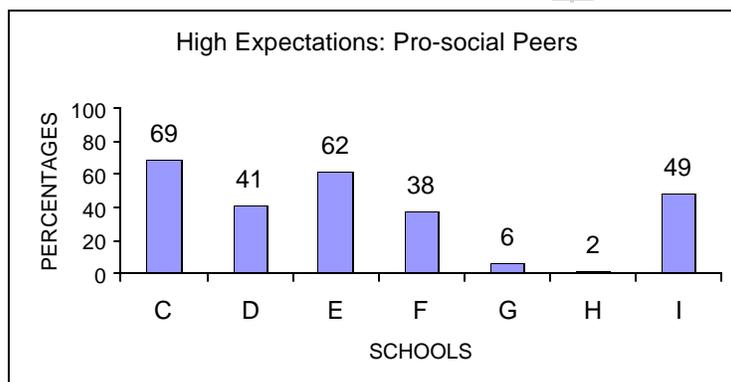
School D has the highest results in the area of peer support with 92% of learners scoring high for this area. School E also seems to have positive results for this area with 67% of learners scoring high for this variable. At least half of the learners at schools F (55%), G (56%) and H (50%) experience caring relationships with their peers. Only 44% of learners at school C scored high and only 45% of learners at school I scored high for this variable. This is interesting as these two schools fared most poorly on issues related to violence and safety (refer chapter four). This supports the argument that caring relationships lead to the development of empathy which would relate to understanding and not harming others. The average percentage of learners in this study scoring high for caring relationships: peers (58%) is within the same range as the average percentage of

grade nine learners in the Aggregated State Report of Fall 1999 to Fall 2000 (59%) (WestEd, 2000).

(c) High expectations: Pro-social peers

The following chart (5.19) depicts the percentage of learners scoring high on high expectations: pro-social peers. WestEd (2000) developed this category to examine what students do together and to separate pro-social peers from their antisocial counterparts. It is based on the premise that creating small groupings of students who share common interests, goals, activities, and/or concerns helps foster an environment that promotes caring peer relationships focused on pro-social activities. According to WestEd (2000), if a small percentage of students score high in the asset of perceived expectations from their peers, this signifies that youth need many opportunities to form positive, healthy peer relationships both during school hours as well as in after school programmes.

Chart 5.19. Percentage of learners scoring high on High expectations: Pro-social peers.



It seems that learners from school C are presented with opportunities to form healthy peer relationships as 69% of learners scored high for this variable. The same seems to apply to school E as 62% of learners scored high for this variable. In relation to these scores, exceptionally low numbers of learners scored high for this variable at schools H (2%) and G (6%). It seems that these two schools need programs and organisations that “engage young people with diverse positive role models, build confidence and self esteem, teach communication skills in the context of relationships and activities, support and show

genuine concern for young people, help youth to realise their educational objectives and allow youth to be of service to the larger community” (WestEd, 2000:27). The average percentage of learners in this study scoring high for high expectations: pro-social peers (38%) is within the same range as the average percentage of grade nine learners in the Aggregated State Report of Fall 1999 to Fall 2000 (40%) (WestEd, 2000).

5.3.6 Discussion: External assets

It appears from the results that at least half of the learners in this study are receiving adequate support in terms of caring relationships, high expectations and meaningful participation. However, considering the results of the risk survey which indicate that learners are engaging extensively in risk behaviours, greater efforts could be made to improve support for all learners. A closer look at the results reveals that caring relationships is the area that needs to be focused upon for learners at schools C, I and F. High expectations is the area that needs to be focused upon for learners at schools G and H. Meaningful participation is an area that needs to be focused upon by all schools.



Considering the low percentage of learners scoring high in external assets in the school environment, very few learners seem to experience caring relationships, high expectations and meaningful participation in their schools. Meaningful participation is the area that needs most to be improved, followed by caring relationships and high expectations. Learners at schools C and I seem to experience school support more strongly than the learners at other schools. Learners at schools H, G and F seem to be least positive about the support in their schools.

In six of the seven schools in this study, 60% - 80% of learners scored high for home environment indicating very high levels of support at home. The results for learners at school I stood in stark contrast to the other learners as only 46% of these learners scored high for total assets in the home environment. Most learners at schools G (93%) and H (81%) scored high for caring relationships. Most learners at schools D (92%) and F

(92%) scored high for high expectations. Most learners at schools G (56%) and D (54%) scored high for meaningful participation.

More than half of the learners at six schools in this study scored high for community support. Only 44% of learners at schools I scored high for this asset. Only 45% of learners at schools H and I scored high for caring relationships in their community. Only 39% of learners at school I scored high for high expectations in their community whereas more than half of the learners at the other schools scored high for this asset. Less than half of the learners at schools H, I and E scored high for meaningful participation in their communities.

The results for schools G and H with regard to peer support, are in stark contrast to the results of the other schools as only 4% of learners at school G and only 11% of learners at school H scored high for this asset. Seventy-one percents of learners at school D and 64% of learners at school E scored high for this asset. In terms of caring relationships though, only 44% of learners at school C and 45% of learners at school I scored high for this asset whereas more than half of the learners at the other schools scored high for this asset. In terms of 'high expectations: pro-social peers', while scores were generally low, the poorest scores were obtained for schools H and G as only 2% and 6% of learners respectively scored high for this asset.

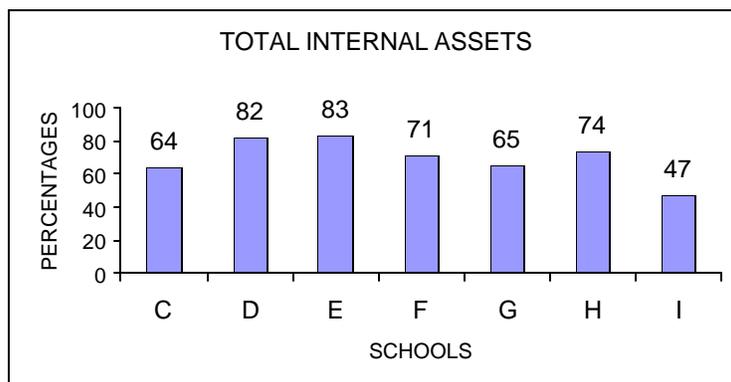
In summary, it seems that while it may appear initially that learners are receiving adequate support in the areas of caring relationships, high expectations and meaningful participation, a closer examination of the results for these assets at school, at home, in their communities and amongst their peers reveals that for each school there is a specific area that requires urgent intervention. Furthermore, it appears that at school level all three assets need to be improved upon. The results therefore provide clear indications of the areas that need to be focused upon in order to optimize the support to learners so that they can develop the necessary internal assets to help them make the right choices and resist peer pressure to engage in risk behaviours.

5.4 INTERNAL ASSETS

5.4.1 Total internal assets

The following chart (5.20) depicts the percentage of learners scoring high on total internal assets. According to WestEd (2000), the resilience or youth development approach focuses on environmental change, on providing the ‘protective’ developmental supports and opportunities (external assets) that, in turn, will engage students’ innate resilience and develop their capacities for positive developmental outcomes. The internal assets that are utilised in this module are the ones consistently described as important in building resilience namely, co-operation and communication, self-efficacy, empathy, problem solving, self-awareness, and goals and aspirations. However, WestEd (2000) cautions that the internal assets are not intended to measure whether a student is resilient or not but should be seen as outcomes of the youth development process and as indicators of whether the necessary environmental supports and opportunities are in place. “The internal assets are a second source of data (the first being the perceived external assets) for determining whether a student’s Home, School, and Community, and Peer Environments are providing the support for these important internal assets” (WestEd, 2000:30).

Chart 5.20. Percentage of learners scoring high on Total internal assets.



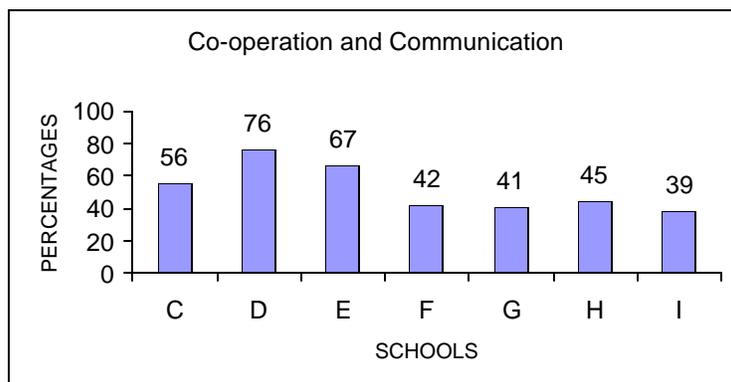
More learners scored high for total internal assets at schools E (83%) and D (82%) than at the other schools. Only 47% of learners scored high for total internal assets at school H. This is a poor reflection on the external support that they receive and is consistent with

the results reflected in the previous section on external assets. Considering the results of the risk survey, intervention is urgently required for the learners at this school in all areas related to youth development and support. The other schools could focus on the external assets identified as requiring strengthening and perhaps improve their results for internal assets. The average percentage of learners in this study scoring high for total internal assets (69%) is within the same range as the average percentage of grade nine learners in the Aggregated State Report of Fall 1999 to Fall 2000 (68%) (WestEd, 2000). These results therefore seem typical for grade nines.

5.4.2 Co-operation and communication

The following chart (5.21) depicts the percentage of learners scoring high for cooperation and communication. According to WestEd (2000), the social competence asset refers to having flexibility in relationships, the ability to work effectively with others, to effectively exchange information and ideas, and to express feelings and needs to others. This attribute facilitates the development of caring relationships and the lack of this social skill is associated with adult criminality, mental illness and drug abuse (WestED, 2000).

Chart 5.21. Percentage of learners scoring high on Co-operation and communication



At four of the seven schools involved in this study, less than half of the learners scored high for this asset. This is cause for concern as it indicates that large numbers of learners in this study could be at risk for some form of criminality, mental illness or drug abuse.

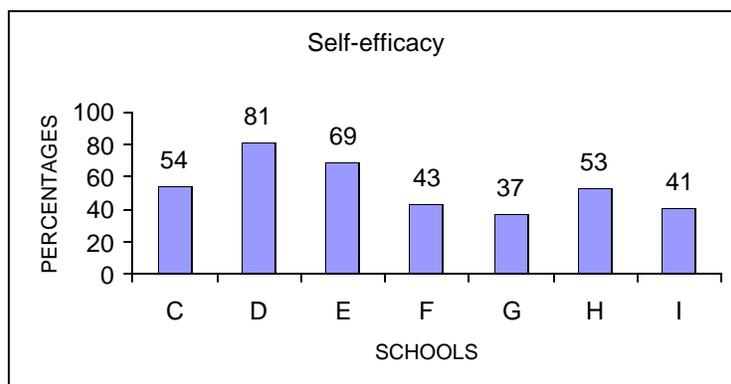
This is confirmed by the findings presented in chapter four, especially when one relates the results for learners at school I (module C results) with the poor results for this question (only 39% of learners scored high). The average percentage of learners in this study scoring high for co-operation and communication (52%). This is within the same range as the average percentage of grade nine learners in the Aggregated State Report of Fall 1999 to Fall 2000 (50%) (WestEd, 2000).

5.4.3 Self-efficacy

The following chart (5.22) depicts the percentage of learners scoring high for self-efficacy. According to WestEd (2000), self-efficacy refers to the belief in one's own competence and feeling one has the power to make a difference. It is related to task mastery, the sense of doing something well, and to self-agency, having the ability to act and exert one's will. "Self-efficacy is a critical component of developing one's identity and sense of self – the major developmental task of the adolescent years" (WestEd, 2000:31).



Chart 5.22. Percentage of learners scoring high on Self-efficacy



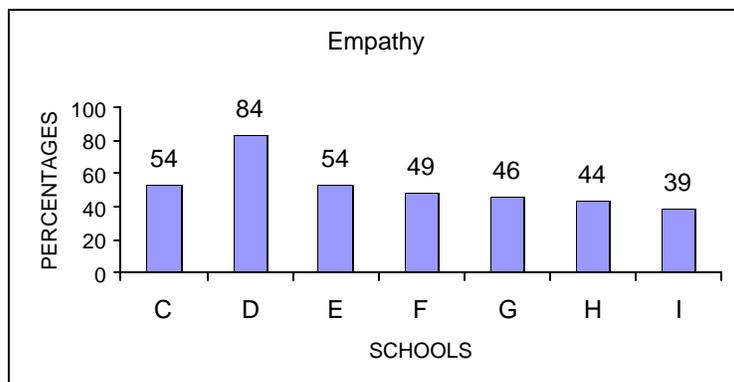
There is a huge variance in the results for the various schools. Eighty-one percent of learners scored high on this asset at school D. These learners seem to be presented with opportunities to master certain tasks and seem to be receiving positive feedback with regard to their efforts. Learners at school G, however, do not seem to be getting the opportunities and subsequently the feedback for mastery and identity as only 37% of learners scored high on this asset. The same concerns surfaced for learners at schools I

(41%) and F (43%). The average percentage of learners in this study scoring high for self-efficacy (54%) is within the same range as the average percentage of grade nine learners in the Aggregated State Report of Fall 1999 to Fall 2000 (58%) (WestEd, 2000).

5.4.4 Empathy

The following chart (5.23) depicts the percentage of learners scoring high for empathy. According to WestEd (2000), empathy could be described as the understanding and caring about another’s experiences and feelings and is considered essential to healthy development and the root of morality and respect. Lack of empathy is associated with bullying, harassment, teasing and other forms of violence (WestEd, 2000).

Chart 5.23. Percentage of learners scoring high on Empathy

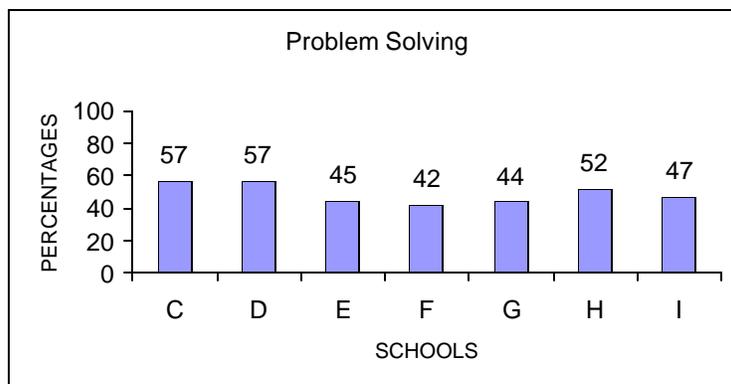


The learners at school D scored very high for this internal asset. However, less than half of the learners at four schools in the study, scored high for this very important asset, indicating the need for much work in this regard. The results for school I is once again consistent for the results obtained on safety and violence, that learners at his school do not have much empathy (only 39% scored high) and are therefore more likely to engage in undesirable behaviours towards others. The average percentage of learners in this study scoring high for empathy (53%) is within the same range as the average percentage of grade nine learners in the Aggregated State Report of Fall 1999 to Fall 2000 (54%) (WestEd, 2000).

5.4.5 Problem solving

The following chart (5.24) depicts the percentage of learners scoring high for problem solving. According to WestEd (2000), problem solving includes the ability to plan, to be resourceful, to think critically and reflectively, and to creatively examine multiple perspectives before making a decision or taking action. Research on successful adults has consistently identified the presence of these skills (WestEd, 2000).

Chart 5.24. Percentage of learners scoring high on Problem solving



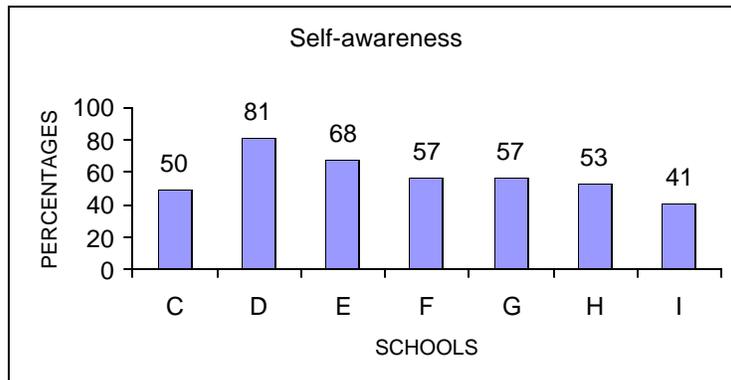
There is fair consistency in the results obtained from the various schools for this asset. At all schools, learners could be given more “opportunity to directly problem-solve in an ongoing and authentic capacity” (WestEd, 2000:32). The average percentage of learners in this study scoring high for problem solving (49%) is within the same range as the average percentage of grade nine learners in the Aggregated State Report of Fall 1999 to Fall 2000 (46%) (WestEd, 2000). This clearly an area that could be developed by all working with young people.

5.4.6 Self-awareness

The following chart (5.25) depicts the percentage of learners scoring high for self-awareness. According to WestEd (2000), self-awareness is about knowing and understanding one’s self; is a hallmark of successful and healthy human development and includes developing an understanding of how one’s thinking influences one’s behaviour,

feelings, and moods as well as an understanding of one's strengths and challenges. It is regarded as critical for the development of insight and self-control (WestEd, 2000).

Chart 5.25. Percentage of learners scoring high on Self-awareness



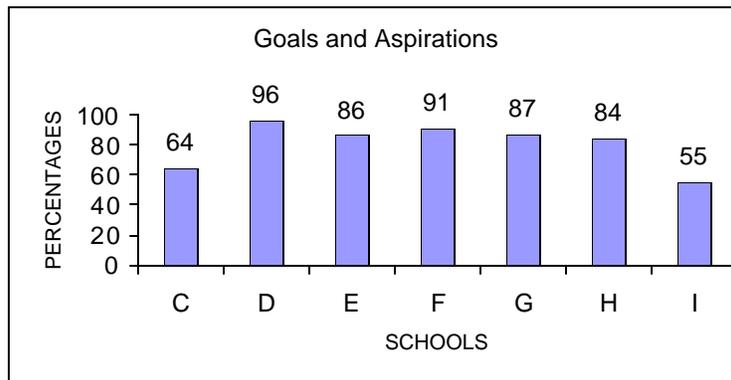
Eighty-one percent of learners scored high on self-awareness at school D. This is a positive result for this school as the learners at School D were experimenting with many risk behaviours as indicated by the results in chapter four. With this result, the possibility exists that they would be able to exercise a certain amount of self-control when faced with risk situations in future. Only 41% of learners at school I scored high for this asset. This result seems to place these learners more at risk even though they may be experimenting as much as any other adolescent. At schools C, H, F and G, there is room for improvement as just over half of the learners scored high for this asset. School E has a positive result with 68% scoring high for this asset. The average percentage of learners in this study scoring high for self-awareness (58%) is within the same range as the average percentage of grade nine learners in the Aggregated State Report of Fall 1999 to Fall 2000 (57%) (WestEd, 2000).

5.4.7 Goals and aspirations

The following chart (5.26) depicts the percentage of learners scoring high for goals and aspirations. According to WestEd (2000), having goals and aspirations refers to using one's dreams, visions, and plans to focus the future and involves having high expectations and hope for one's self. Goals and aspirations are seen as an expression of the intrinsic motivation that guides human development. Young people who have goals

and aspirations develop a sense of deep connectedness that is regarded as the most powerful individual asset protecting against negative developmental outcomes (WestEd, 2000).

Chart 5.26. Percentage of learners scoring high on Goals and aspirations



The percentage of learners scoring high for this asset is the highest of all assets in this study. This could reflect the emphasis on academic performance at all schools. Two schools where the learners do not seem to have high expectations and hopes are schools I and C. Only 55% of learners at school I and 64% of learners at school C scored high for this asset. It seems that being faced with poverty issues is having a negative effect on these young people in terms of what they could expect from the future. The average percentage of learners in this study scoring high for goals and aspirations (80%) is the same as the average percentage of grade nine learners in the Aggregated State Report of Fall 1999 to Fall 2000 (80%) (WestEd, 2000). This is clearly a strength amongst school-going learners.

5.4.8 Discussion: Internal assets

From the results for total internal assets, it appears initially as though the learners have the necessary internal strengths to cope with the challenges of being a teenager today. Most learners at schools C to H seem to score highly for total internal assets. Only school I has poor results with only 47% of learners scoring high for total internal assets. Upon closer examination of the respective characteristics though, a new picture emerges. The area of co-operation and communication needs to be further developed amongst learners

at schools I, G, F and H. Self-efficacy needs to be further developed amongst learners at schools G, I and F. Empathy needs to be further developed at schools I, H, G and F. Problem-solving needs to be further developed amongst learners at schools F, G, E and I. Self-awareness needs to be further developed amongst learners at school I. Goals and aspirations is the one area that is well developed at most schools and that could still be further developed at school I.

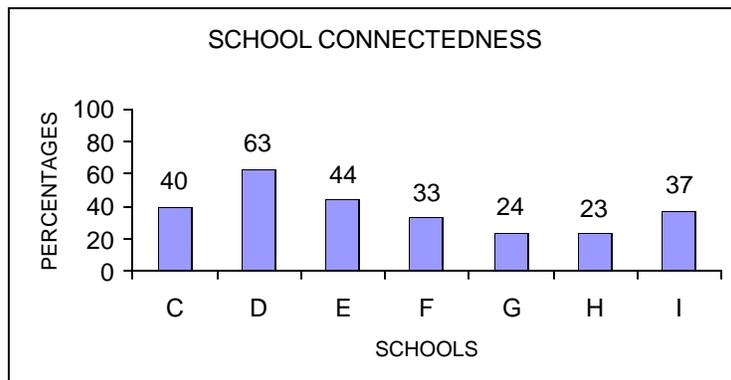
The results therefore provide us with clear indications of the areas that could be further developed in order to strengthen our youth and thereby strengthen their resistance to risk behaviour. These results also provide us with useful information for focusing life skills programmes and interventions. Improvements in external assets will also lead to improvements in internal assets and the gaps that have been identified could be minimized if improvement in external assets occur.

5.5 SCHOOL CONNECTEDNESS



The following chart (5.27) depicts the percentage of learners scoring high for school connectedness. According to WestEd (2004b: 18&19), the first large scale study to examine protective factors as well as risk factors in the individual, family, and school, found that the most critical finding is that students who felt "connected" to either their family or school were less involved in health-risk behaviours across the board. The researchers stated, "While much emphasis is placed on school policies governing adolescent behaviors, such policies appear...to have limited associations with the student behaviors under study. Rather, school connectedness, "influenced in good measure by perceived caring from teachers and high expectations for student performance," was found to make the critical difference. The Resilience & Youth Development Module includes the 5 items listed above from the Ad Health study that operationalize Ad Health's School Connectedness Scale.

Chart 5.27 Percentage of learners scoring high for School connectedness



The results in the above chart confirm that School D is able to provide good external supports and subsequently foster internal strengths amongst their learners. The fact that 63% of learners scored high for this asset suggests that they are receiving the necessary support from their school. Unfortunately, this does not seem to be the case at all schools in the sample. Most learners do not seem to be receiving the support they require for optimal success. Learners at schools H and G are particularly vulnerable as only 23% and 24% of learners scored high on this asset respectively. Historically however, these two schools are renowned for their positive academic results with learners performing very well, even better than the learners at the other schools.

5.6 LEARNERS' VIEWS OF THE FACTORS THAT PROMOTE RESILIENCE

The focus group interviews with learners covered various aspects related to receiving and requiring support as young people. They also spoke of their needs and possible solutions to the challenges they experience as young people. This section will highlight general issues related to support, support at home, at school, in the community, amongst peers, related matters and finally, proposals for support provision.

5.6.1 General issues related to support

Most learners raised the issue of trust as being an important characteristic for selecting the person that they would confide in,

I'm going to the person whom I trust (School C).

Maybe an older friend of yours or someone that you know you can trust and someone you know who's responsible (School D).

I have a friend out of all that I can trust and share everything with and she also tells me things (School E)

While it is hard enough for young people to admit to having a problem that requires assistance, it is even harder for them to express their feelings. Most young people seem to have great difficulty expressing themselves appropriately and to the right people,

Maybe you don't know how to say it. Maybe you just don't know how to bring it across to somebody (School D).

Yes, I cannot talk so easily about problems. So, if ...keep it to myself (School E).

The thing is I find that sometimes emotions are something that you don't always share, I mean even it's there is something there. It's very difficult to share what you're actually feeling (School G).

This inability to share emotions is particularly hard in certain situations,

Yes, like if you get raped. You can't like, you won't just go to the person "I got raped, help me". You will like, you don't know how to say it. You... and maybe you're also scared to uhm... like, like cry in front of the people. Maybe you're like scared to show emotions at any, in any way, ...(School D).

The focus group interviews also revealed that there are still many stereotypes that prevent young people from seeking help. These stereotypes range from the belief that men do not express their feelings, to the fact that seeking help indicates that you are a person who can't cope to even the misperception that psychologists are associated with crazy people,

- Girl: They (peers) judge many people which is wrong
Boy: Looks like they can't cope with that problem
Girl: Or they think you're abnormal
Boy: We all have problems, but now they think because they can cope, they are better (School F).

Some learners who have access would rather see a psychologist than their teachers though,

Either your friends or if you can't speak to your parents, you actually ask your parents if you can go see like a psychologist that's just doesn't know anything about you. It's just like a normal, not a school psychologist (School G).

Young people are aware of the counselling services via the toll-free numbers and other services they offer but still find it hard to call in,

Ma'am, we feel "who are you speaking to"? I mean, if you phone, you have no idea who you're speaking to, I mean, the person could be thinking, I mean, ya, you feel being judged (School D).

Even though the support structures may be in place at school, learners do not make use of them,

- Boy: That's why we've got Mr So we can talk to him.
Girl: I don't think many people do, because it sort of, it also takes a lot of time, I mean, you've got to go in a break and go find him and, you know, and actually, I mean, I find I have no breaks free. If I get half an hour break once a week or twice a week, I'm lucky, because I'm always doing this or that or the other thing or project (School G).

What was interesting was the various perceptions that learners have, for example that you only go see a counselor if the problem is really serious,

- Boy: It depends, I don't know, me personally I don't have enough, like my problems aren't big enough, I wouldn't go speak to him about not having enough time to do homework or anything like that (School G).

In summary, learners were most concerned about issues of trust. They felt that they would turn to someone they could trust when needing support. This person would be a parent for some, a friend or teacher for others and even a professional person. Each learner had different views on which person would suit them best. Learners also seemed to have great difficulty expressing themselves and showing emotion. There are also many misperceptions and stereotypes that prevent young people from seeking help. Learners also felt that it was not necessary to seek help unless the problem was of a very serious nature.

5.6.2 Support at home

Many learners do not feel that they get the support they need at home. For many learners, a big issue is the fact that their parents do not want to listen to them,

Yes, they don't want to listen to me. They said I'm too young; I must follow their rules, because I'm under their roof. So I can't manage to do that (School C).



I'll personally say that they must respect us and listen when we have something to tell them, and not just bite in or tell us to keep quiet, because they're right and we're not right (School H).

I have three sisters. Now every Wednesday evening it's girls' night. Now my mom does not talk to my two eldest sisters because that can now do all these things already, because then she says to me, "You know you're too young, you can't do it" and so on (School E).

Learners feel that their parents do not understand them,

Miss, uhm... the adults don't understand that the children, the teenagers want to experience stuff and they want to experience life, and the adults don't think that they were also young and they also experienced the stuff that we want to experience. They want to keep you inside and not experience life (School H).

They just scold more. Can't understand us every day (School E).

Learners revealed that many parents do not know what is happening, what their children are up to,

Certain parents just accept it or they believe that their child will not do it. They do not know what is going on (School F).

They don't know that their children are doing drugs (School I).

An interesting revelation was the fact that some learners felt that the parents were aware of what was happening but chose to ignore it either because of their guilt at working long hours or because they see it as a phase that the child is going through,

When the children come home and the child...and the parents feel guilty to punish the child because he is not home all day (School F).

Yes, some children's parents know that they use alcohol, think it's perhaps just a phase that the child is going through (School F).

Alternatively, some parents know all too well what is happening even though they may not know where the learners are obtaining the substances from,

Miss, and my parents they did smoke when they were thirteen, but they don't want me now to experience.... Because they say now the stuff that's now in, is more worse than what that time were. There were no like drugs and that stuff that's now, Mandrax and all that (School H).

Some of the parents they know that their children they use drugs, but they don't know where they get it from (School I).

Some parents are very strict and learners interpret this as their parents not trusting them. Parents are so concerned that their children are going to engage in risk behaviours, that

they only cause conflict when they falsely accuse them of doing things that they did not do,

Trust, like when you go to parties and like that. Then my mother will tell me “I don’t want you to drink” and all that like maybe I don’t drink and then she still says “Oh, you’re drinking tonight” and all that. And then I’m like “No”, and they assume things. Like the one time I came in like smelling like smoke and whatever like. There’s a party and people do smoke so, it’s like “Why are you smelling like smoke”? “You’re smoking” and all that (School H).

The way that the learners presented their arguments in general are indicative of a group of young people desperate to be heard and understood. They felt the need to express all their frustrations with the situations that they find themselves in,

Girl: When one young person does something wrong, they label everybody, all of us. When they talk about uhm... like if someone, a girl goes to a dance now and she gets raped, then she’d label all the 16-year olds.

Boy: Miss, and there was a few boys that overdosed in drugs at the disco, now your parents don’t want you to go, because of that in the uhm...

Girl: Miss, and they also say when it comes to clubs and that, it’s not that they don’t trust you going there; they don’t trust the people that is there. Miss, but we’re also...

Boy: And yet we are responsible to say “No”.

Girl: It doesn’t mean that one person can do, they just think we can be so easily influenced. I mean everyone isn’t like that. (School H)

Many learners felt that the reason many children engaged in risk behaviours was because their parents were too strict and the children then enjoyed disobeying them,

It's for a child...some children's parents are so strict that it is a "rush" for the children to smoke because they may not do it (School F).

Miss, and like the drugs. I'm making an example like uhm... the parents say we can't do this, we can't do that, we can't smoke. Then we go behind their backs and we do, like people do worse stuff even what ...they say we do (School H).

Of concern are the instances where parents don't want to listen to young people who want to tell that they are being abused or have been raped, "Sometimes your parents can ignore you when you say you're being raped by your uncle" (School I).

The inability of parents to listen them could have a serious impact upon the behaviour of some learners and in one instance was cited as the reason for someone attempting to commit suicide,



I was feeling, I was miserable, because they didn't want to listen to me. Every time when I told them things, they didn't want to listen to me. That's why I took, I took the tablets, I don't know... and I took all of them. So I was feeling dizzy. I told them that... and they asked me "why were you doing this"? I told them that's because of the difficult rules (School C).

Learners generally find it hard to communicate with their parents. They find it easier to talk about school-related issues but find that they fear that relationship issues and behaviour issues will evoke a negative reaction,

Like school. If you have a problem at school, but you can't talk about your relationships or things like that...They keep you tight, they're very protective over you, and you just mention something and they will...(School D).

But it also depends what, but if it is something they can know, then you can probably talk to them about that problem. So it depends actually on what it is (School E).

In some extreme cases, attempts at communication can evoke strong verbal responses from the parents and lead to the learner internalising,

And also, like my Mommy, Ma'am. When I try to tell my Mommy something, it's like she don't want to listen to me, Ma'am. Then I must be rude and force my way into get something to say. And then she wanna be cross with me and then she starts swearing at me whatever. And I just feel sometimes like I'm gonna swear back at her, but then I just turn around and walk away (School H).

Some learners would like their parents to talk to them about relevant issues,

I am not excluded, it's just that it is not spoken to me like she speaks to them. And she must actually talk to me, because I am actually getting big now (School E).



Some learners see their parents' inability to listen to them as a sign of disrespect,

Miss, but I don't understand, Miss. They expect respect from you, but then they don't give respect in return, so how do they expect us to respect them if they don't respect us. So it doesn't actually work. It's stupid, because I'm not gonna listen to my Mom if she's not gonna listen to me. So, Miss...(School H).

At some schools, however, there were good relationships between parents and their children and learners realize that good relationships between children and their parents can exist,

Girl: I go to my parents, yes.
Boy: Ya, same here.
Boy: Same here (School G).

Miss, not all parents. Like some of my friends. They can go to their mother and tell their mother this and that, some of my friends their mothers... they can go dance and whatever, whatever. I won't dare tell my Mommy "Mommy, I want to go dance", because I know for a fact she's going to say "No". So, it's not all parents also (School H).

An exceptional instance occurred where one learner stood up to remind others that they are fortunate to have parents and emphasised the point that some learners do not have parental guidance and support,

...not all of us have two parents in the house every day of their lives, and to like be there for them and to tell them the different things about the different sex, stuff like them (School D).

In summary, the most prominent issue for the learners was the fact that they felt that their parents do not want to listen to them. They do not feel that they can share their views or that their opinions are respected. They feel that their parents do not understand them or even attempt to understand them. They feel that their parents do not realize what it is like for them to be teenagers in present society. They are concerned that the parents do not know what their children are up to. They also felt that many parents are turning a blind eye to their children's bad behaviour due to their guilt for having to work long hours. They felt that many parents were too strict and as a result, their children chose to disobey them. Of concern was their frustration at not being heard or understood and how that could lead to contemplating suicide. Learners also expressed the desire for their parents to talk to them about relevant issues such as HIV/AIDS. Some learners also saw the failure of parents to listen to them as a sign of disrespect towards them. It seems that effective communication is one of the greatest barriers to positive parent-child relationships; that learners want to have a positive relationship with their parents but their parents' inability to listen or understand them causes great conflict and frustration.

5.6.3 Support at school

Learners' views on the support they receive from their teachers and their schools mirrored the results of the survey. Learners do not feel that their teachers care about them

or that they can go to them with their problems. Their interactions with teachers evolve mostly around their schoolwork and issues related to peak academic performance. Even where teachers have availed themselves for support, learners do not feel comfortable discussing their personal problems with them as they fear that their teachers may not hold them in the same regard when they become aware of their personal circumstances. Learners were also adamant that they would tell teachers they were experiencing problems only when the nature of the problem is such that they have no-one else to turn to or when the problem is very serious.

One learner was clear about whether he feels that teachers care,

I don't think the teacher cares about you. All the teacher cares about, is about your... for they give you the information that they have. It's all the teacher has to do. Not to care for you. The only one, the only person who can care for you, is your mother. That is why I choose to like, some problems, I choose to get through with my mother, to tell my mother. Of which the teacher, I don't think the teacher is a good idea, to tell your teacher the problems, some of the problems. But ya, the problems we can tell the teacher is about when your uncle, your uncle rapes you or abuse you. You can tell your teacher, because you can't tell your mother. That is, that it's her brother. You cannot just expose that. It would cause a lot of problems. You must first go to the teacher and the teacher arrange some things to go to talk to your mother and tell your mother about this (School C).

Learners feel that they have to relate to teachers in a particular way that makes it hard for them to confide in them,

Like if you have to go to a teacher, then you'll have to talk in a... how can I say manner... like a high manner. You can't speak like normal like you would be able to speak to somebody your age....Like, you speak like, respectable, and like, you know, use nice English (School D).

Even though teachers are available, learners find it very hard to trust teachers,

Girl: There are many, but we just don't want to, we just don't feel that we want to go to them with our problems ...There are always two teachers who share everything with each other

Another girl: And in the staff room then....(School E).

The teacher can tell the whole school about your problem (School I).

I don't think people confide in teachers very often (School G).

The learners felt very strongly about not going to one of the teachers for help due to the nature of the teacher/learner relationship,

Girl: Yes, and also it is still, whatever it's about confidentiality and stuff, he's still sort of one of the teachers, and so, you know, he teaches us, he's like, you know, gives us homework and everything. So it's like, he's our teacher, we're his pupils, which makes it slightly sort of almost awkward/creepy (School G).

One learner clearly expressed the concern that the teacher would think poorly of you if they knew your problems,

It is just ... let's say you go to...for example, she is very straightforward...let's say it is a very big problem and you say you have that problem, like, what must she think of you? (School F).

Learners were quick to draw distinctions about whether teachers could be trusted or not. They mentioned that not all were uncaring and untrustworthy. They felt that there were one or two teachers that they could go to in times of need,

Most of them I like. They are relatively friendly and when you need help, then you can go ask, but also not everyone (School E).

I trust my teacher! (School C).

You do find teachers that's caring, then you'll again find some that totally doesn't care (School H).

Some of them are nice, some are strict (School I).

Learners felt that in some instances that the school rules or teachers were too strict. A very worrying revelation was that the learners were being beaten at one school even though this is outlawed in schools,

Boy: This is too strict, Miss

Boy: Like, like is they catch you smoking, then they take you to the police station plus they'll fine you ...plus they call the parents in plus you get detention (School H).

Shout a lot and punish us (School I).

Learners also felt offended by favouritism of certain learners at the expense of others,

It's always as uhm....sir needs someone to go out for him, go to the office or so, then he just asks that specific person. How must the other children feel? (School E).

A concern of learners is the fact that many teachers do not seem to have the patience to explain the work properly to them or were not very creative in class,

You can talk till you're blue. She will say the same thing every time. And then later she leaves me, even if you still don't understand, because she knows you won't come again (School E).

We need better teachers... I don't like the teachers here, Miss. The teachers here they don't, they don't like, some like is half deaf or something ...(School H).

In terms of ethos and environment, the learners had some good ideas for improving this area with schools C and I requiring improvement in the most basic areas,

I would like to plant some vegetables here at school. We don't have plants, we don't have vegetables, you know. So I would like to have plants here (School C).

I'd like my school to be secure. And if we had a library and computers... There are no computers for the learners (School I).

There also seems to be a need to attend to the toilets at school D and an end to smoking in the toilets at school I.

Friendly teachers seemed to be regarded as an asset. Learners advocated for teachers who were able to chat with them and laugh with each other, not only in the classroom but at all times,

I like it when you can talk well with someone. Here are quite a few with whom I get along well, they laugh with each other ... and it's things like that, yes. He mustn't only be nice in class, he must always be nice (School E).

One school had however, introduced a novel way of supporting learners at school,

Girl: Also our class teachers, we're doing a sort of interview thing where we talk to them for five minutes once a term or something like that.

Boy: Ya, ya

Girl: So that's meant to be sort of getting us some extra support as well (School G).



Some schools are well resourced and are able to offer their learners many avenues of support. This is not common though,

Boy: It's quite... pretty much everything has been done, I mean they've got all the bases, if you do have a problem, it's just sometimes difficult to go and speak (School G).

The Life Orientation curriculum has a large role to play in teaching learners the knowledge, attitudes values and skills required to make the right choices. Teachers have clearly been busy implementing the new curriculum in class and learners felt free to comment upon their experiences in this regard.

Learners spoke about the work that they covered,

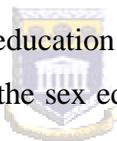
OK, I learn that in Life Orientation, that it's not a good idea to, to have a baby when you are young – teenage pregnancies – because sometimes you have baby new, you are young and your boyfriend dumps you if you have a baby, and he goes, he goes to find another girl. And you, and you, and you.... while you have a baby, you have no future and you can't, you can't, you can't go back to school. You must just look after a baby and you must find a job to, to, to support your baby and yourself (School C).

Some learners identified gaps in the curriculum that was important to them and these gaps also provide ideas about important areas for teachers to focus on in the curriculum.

One learner raised the issue of anger management and related it to bullying at school,

I think they must bring anger management, Ma'am, because some of these guys are just way too angry. They've got too many pent up feelings and they just want to take it out on the other people, like I sometimes, I do sometimes. I speak of experience, but still. Ma'am but some of these guys when they bully you and all, Ma'am, it's all the pent up feelings from home, Ma'am (School D).

Another learner raised the fact that sex education should be reinforced as it seems that the learners have not really benefited from the sex education which they have received when one considers their behaviour,



So I think if we can have more sex education, and I know sometimes the people, the youth as we are called, we hate hearing about sex, sex the whole time and sex education. People get tired of it. Ma'am, but I guess you must drill it into them until they listen, Ma'am (School D).

Another learner's comments demonstrated the fact that lessons regarding abstinence, contraception and the use of condoms have been effective in causing her to think critically about the pros and cons of sexual activity and prevention although other learners may need some more information regarding these issues,

I think it's a good idea to wait, because other, other children they prevent and they say that I'm not gonna use a condom, because I prevent. What if he's gonna have some disease, like STD? So I think it's a good idea to wait till you're old (School C).

One learner was adamant that the curriculum does not stress the issue of abstinence strongly enough, that too much emphasis is placed on condoms,

I think abstinence, Ma'am. That's what's missing. I think it's the seriousness of it. I mean, people just think slip on a condom, Ma'am, I mean that all that you do. I think that to abstain, take it very serious and think hard about it (School D).

Learners at school F felt strongly that the curriculum must take into account their specific needs. For them substance abuse (drinking and smoking) was more of a serious problem than HIV/AIDS which was being emphasized in the curriculum,

We have many projects like about AIDS and sexually transmitted diseases and so forth, but it is, in our schools it is not such a big problem, but smoking and drinking is an actual problem here and there really isn't much attention being paid to it. It's as I said, the department focuses on racism and alcohol, and AIDS, while at our school it is just between smoking and drinking where the problem lies (School F).

In summary, the strongest issue that came to the fore was the fact that learners felt that their teachers did not care about them; that the teachers' main concerns evolved around their schoolwork. Learners also expressed feeling uncomfortable in sharing their problems with teachers. They felt that they were expected to relate to teachers in a particular way only and that sharing their problems with them would change that professional relationship that they have. They also felt that they could not trust the teachers as they would share their problems with other staff members. They were mostly concerned that sharing their problems would cause the teacher to think poorly of them. Some learners felt that the teachers were too strict which also made it hard for them to regard them as caring beings with whom to share problems. Learners expressed their concern regarding favouritism of certain learners. They were also concerned about the fact that some teachers were impatient with them and were not very creative in their teaching. On a positive note, some learners felt that their teachers were caring, friendly and trustworthy. They felt that their school provided adequate facilities and support structures. Learners had ideas for improving the ethos and environment at their school. They were also positive about Life Orientation at their school. They appreciated what they had learned and had ideas for improving the curriculum to meet their respective needs.

5.6.4 Support in the community

In some communities, learners get very little support and are also exposed to negative influences. This does have an impact upon learners. At one school the learners felt that it was better for them to be at school as drug abuse was rife in their community,

Yes, it's better here at school, because there in the community they do drugs, you see, and you stop (School C).

Another learner raised the fact that alcohol was readily available at cost and there was no control in this regard which would make it easier for learners to gain access to alcohol,

They cater for the farming community. They have the R2 per litre wine bags at ... There is no control (School F).

In other communities, the support is available, but learners would not utilize it for various reasons. For one learner the issue was that if they could not share with their own mother, they surely could not share with another person. For another learners the issue was that the community would think badly of you or even reject you if they knew what your problems were,

There are certain people but we won't choose to talk to them... If I can't even share things with my own mother, how can I share it with others (School E).

I think it's more about what other people are going to think of you if they know what your problems are. Are they going to think less of you, because you're a ... or avoid you and you may feel rejected or perhaps you will be driven out of the community (School F).

One learner shared that her extended family offered to help but that she could not go to them because of their troubled past,

Miss, my family is, they're messed up. Most of my cousins... it is. Uhm... most of my eldest cousins, they were like in jail already and some of them smoke buttons and they smoke this and my uncles smoke that and... you can't go to them, because most of the time they're on a high and then they like say "Don't do it", ... you can't (School H).

Furthermore, learners do not seem to have good experiences of clinics and other outside organizations,

When we go to them, they will say that they are busy (School I).

These obstacles do not affect all learners though. Some learners are fortunate enough to have access to various forms of support,

No, the thing is because the system's there, you know if you're actually desperate, you could go there even if it wouldn't be like the first choice. If you were desperate, there would be something (School G).

In summary, some learners revealed that their communities were places where they were exposed to negative influences such as drugs and alcohol and that the school served as a refuge for them. Even those learners who felt that their community was supportive, were hesitant to share their problems with them for fear of gossip, being stereotyped or even rejected. For some, extended family was also not always an option for support because of their troubling behaviour. Furthermore, learners felt that community organizations such as clinics were not always friendly and helpful. Learners were therefore aware of what was available but would not utilise the services or offers of help as they did not feel confident that it would be in their best interests to do so.

5.6.5 Support amongst peers

According to this study, there does not seem to be much reliable support amongst peers for learners who experience difficulties. While most learners say that they will go their friends for help if they have a problem, many learners feel that it will not be so in every instance. Some reasons cited for not sharing problems with friends that friends themselves being involved in risk behaviour and the fact that they will gossip,

My friends are chaotic (School E).

Your friends will gossip (School I).

It seems that when learners take their problems to their peers, they have to present it in a particular way, in an acceptable way and then they do not necessarily get the support they would like,

Like sometimes your peers, Ma'am. They have a different perspective of how sex should be taken. They would brag about things like, you know, they generalize, they'll generalize, I'm talking about boys, they speak dirty about sex and stuff. You'll maybe take it the wrong way and you'll like express it differently. So it depends who you talk to (School D).

There is the concern that peers may not take the problem seriously enough and may even laugh about it,

I think they will laugh at my problems. If everyone is together and so. It is better to confide in only one, someone whom you can trust (School E).

Ya, if Chris tells me something, he might think it's really serious, but I'll, I might not take it seriously. I might like laugh, and I would say "OK, that's nice Chris" and laugh and tell someone else, when he actually finds it quite serious, but he didn't (School G).

Young people would therefore be very cautious about what they take to their friends,

Girl: Stuff like something that's exclusively your problem, you probably wouldn't go and tell anything to your friends.

Boy: Ya, you wouldn't go talking about your problems at home with your friends unless one, unless it's like a small thing and they also like...

Girl: Or unless it was like really serious and you trusted a friend very much (School G).

Another issue that came to light was the fragile nature of peer groups. There tends to be as much conflict within peer groups as there are between groups. One learner pointed out how easily conflict can arise because of jealousy within a particular group,

Okay, I was very good friends with a girl. When I met her, we became very good friends. And I am one of those people, I try hard to give equal attention to each one but it does not always work out like that. Then the

one always gets more attention than the other one and then the other one gets jealous because they say I'm neglecting them and so on (School E).

There seems to be much competition amongst friends that cause much heartache,

Friends must be less jealous because that is not ...it's the biggest thing around which everything evolves (School E).

The focus group discussions also revealed that some schools have developed a peer support system that young people can go to for help,

It's like three learners that represent the grade and they are, they're trained to be counselors, peer counselors. So they're like your age, you won't feel out of place and stuff like that. You can like talk to them like you want to talk (School D).

Other sources of support that were mentioned by learners include Lifeline, Childline, Soul buddies, Churches, Mosques, Youth organizations and other family members.



In summary, while most learners said that they would speak to a friend if they needed someone to talk to, there were also instances where they did not feel confident to share their difficulties with friends. Some learners felt that their friend were not the best form of support due to engagement in risk behaviours, gossiping, boasting about negative behaviours and not realising the serious nature of the problem. They would therefore carefully consider what they thought would be acceptable or not to share. Learners also revealed the challenges involved in belonging to and remaining within a particular peer group. This was also important to consider before sharing difficulties with members of the peer group. On a positive note, some learners mentioned that they found the peer counselling groups at their schools to be very useful for support.

5.6.6 Proposals for support provision

In an attempt to find support systems and persons that learners could approach for support, they were asked to describe the most suitable candidate to meet their needs. Learners provided some ideas on the type of person they felt they could easily relate to.

Learners at school D regarded patience and experience as important criteria,

I would say someone who has either been in the situation and has gone through it and is successfully over the problem so he can speak of experience, so he maybe can console you in a way (School D).

Learners at school E felt that it would have to be someone they know but not of that particular community,

To go to someone older ...someone that I know, but not in the community, an acquaintance (School E).

Learners at school F felt that to have someone from outside that is not connected to the school and where parents would not be able to interfere would be important,

Rather from outside, then you now, then you know he won't ...the school is not connected to it and your parents (School F).



Learners at school H would like a time and space to speak with someone from outside the school and express their feelings,

Maybe like not even a teacher. Not even a teacher, maybe somebody from outside. Maybe once a week, or even like your whole class should have a period in the week like where you can go and speak to that person, express your feelings and stuff like that (School H).

Learners at school G felt that they would like a situation where there could be casual chatting with someone who is trained, friendly but not too familiar and who would be able to leave contact details for the learners to contact them at a more appropriate time,

Like come to the class and give like a lecture whatever and then give like them number of something or like a number to contact of their colleagues or stuff that you can... Because if a teacher comes in, it's quite a problem "come speak to me after class", then no one is going to speak to them, because if you see someone... If everyone leaves and you see someone

like staying behind, then everyone is gonna know they have a problem.
(School G).

The request of learners at school I was a person who listens to them,

Try to listen to the children when they talk to them (School I).

In summary, the fact that school counsellors are not available at every school, could be a large determining factor in terms of learners not approaching teachers for help. This brings us to school-specific differences in responses. Schools D, F and G are able to employ guidance counsellors full-time from mostly private funds. Schools C, E, H and I have Life Orientation teachers who are paid for by the Department of Education and who may or may not provide some limited form of counselling service. The issues presented by various learners differ markedly from school to school. Schools C and I have to deal with serious issues such as HIV/AIDS, rape, violence and substance abuse. Learners at schools E and F have to deal with academic demands, peer relationships and alcohol abuse. Learners at schools D, G and H have to deal with academic demands and peer and other relationships. For learners at schools C and I the school is a safe haven and place of refuge from the demands of their homes and communities. For learners at the other schools, support is more available from the home, community and peers and the school. It is clear also that schools D, F and G have the resources and infrastructure to provide their learners with extra support.

5.7 CONCLUSIONS

The resilience module has demonstrated the extent to which the young people in this study are being supported and how this in turn builds internal supports that could help them to overcome adversity and be successful. On average, the learners in this sample seem to be comparing favourably with learners from other studies although this would be a tentative observation rather than a direct comparison.

Of all the areas covered in the external assets section, school environment was the environment in which learners experienced the least support. On average, only 36% of learners scored high for this asset. This result relates to school connectedness where an average of only 38% of learners scored high for this asset. Peer support was also cause for concern considering how much time learners spend in the company of their peers and the fact that the average number of learners scoring high for this asset was 44%. It was, however, positive to note that an average of 66% of learners scored high for support within the home environment. This could explain the fact that an average of 69% of learners scored high for total internal assets.

A closer look at the results for the respective schools paints an interesting picture that speaks to school-specific interventions. For learners at school C, D, E and I, the school seems to offer hope in terms of school-based support when the community does not seem to offer much support. For learners at schools F, G and H, home and community offer much hope where the schools does not provide much support. While peer environment could be improved for most schools, poor results were obtained for schools G and H, especially for the category high expectations: pro-social peers. This is an indication of the fact that their peers are not likely to dissuade them from engaging in risk behaviour and an indication of the fact that they do not have many positive influences that could be utilised for the good of other young people. Overall, learners at school I seem to be the most vulnerable. They seem to have the least support in all areas and as a result fare the poorest in terms of internal assets.

These results offer guidance in terms of how to intervene at the respective schools in order to improve the support and developmental outcomes for the learners. While school I and H may need a whole school development approach within a health promoting schools framework with task teams that will focus on the various areas; the other schools could adopt a priority approach where they focus on an area identified as an immediate priority and later attend to the other areas that have also been prioritised for subsequent intervention. The value of these results lies in their hopefulness. It provides schools with results that could be utilised for planning interventions. It could form part of whole school development, staff development, school-community partnerships and so forth.

The results of the focus group discussions once again emphasized that there are general and school-specific needs when it comes to emotional support. All learners desire some form of support that is independent from school, home, community or peers. They say that they require someone who is trained, fairly young, able to listen and understand, advise without being judgemental; someone whom they can trust and who will honour the confidentiality contract and whom they will not have to encounter every day. In the absence of this ideal situation, learners are aware of other support systems that are available such as national support services and their toll-free numbers, guidance counsellors, peer counsellors, social workers, psychologists, youth counsellors, church / mosque leaders, clinic staff and their parents, friends and teachers. Learners are very cautious about approaching these persons for support, however. Issues of trust, confidentiality, familiarity, stereotyping are factors that prevent them for going for help unless they feel that the situation is really serious.

Of concern is the fact that learners admit to choosing to suppress rather than communicate their problems. Work needs to be done not only to make support services freely available but also to assist learners to feel more secure about utilizing support services that are available. The role of the school is critical as it is here that learners feel the least secure about accessing support. It is clear that schools are much more concerned about the academic performance of their learners. Although this is not necessarily incorrect, urgent intervention is required where the emphasis on academic performance is compromising the well-being of learners.



It is interesting to note that learners have the most conflict about receiving care and support from schools than from any other sector and it is here where they mostly experience academic stress, bullying and harassment and peer pressure. In summary, support to learners at all schools could be improved. Barriers to the school providing help and learners seeking help need to be explored further and these barriers need to be addressed. This is to prevent the suppression of emotions and unresolved conflict that would be one of the contributing factors to the high levels of depression amongst young people. Schools also need to connect with each other and share ideas for providing support to learners so as to ensure the development of optimal forms of support. The issue of support cannot be addressed independently of whole school development however, as the ethos and environment of the school contribute greatly to whether learners feel supported and cared for by the teachers. The following chapter therefore expounds upon the notions of support provision by exploring these notions in terms of the health promoting schools framework. The health promoting schools framework provides us with a framework for planning and delivering interventions that will improve support for the learners and strengthen any efforts in this regard.

CHAPTER SIX

RESEARCH FINDINGS

THE HEALTH PROMOTING SCHOOLS FRAMEWORK

6.1 INTRODUCTION

The aim of this chapter is to present the findings of the questionnaires that were completed by guidance teachers or school counsellors and subsequent interviews with these teachers or counsellors. The questionnaires and interviews explored the support provided by the respective schools to their learners using the health promoting schools approach as a framework. In chapter five we saw that the area where support was most lacking and where considerable improvement could be made, was the school environment. It is hoped that the following results of the questionnaires and interviews could help the schools to reflect on their policies and practices and to identify the areas where improvement could be made.



The questionnaire that was utilised was the MindMatters questionnaire (ref chapter three) that is based on the health promoting schools (HPS) concept. The aim of the questionnaire is to determine the extent to which schools adhere to the health promoting schools framework. In South Africa, the health promoting schools framework is still interpreted in terms of the original five principles of HPS namely, school policy, environment, life skills education, school-community partnerships and service provision. The extent to which schools are considered to be health-promoting is usually determined by the extent to which these five principles are adhered to in terms of the overall school functioning or in terms of specific interventions that are occurring at the school. It is recognised that many high schools may not have been introduced to the health promoting schools concept but are operating according to these five principles. What is required is a reorientation of their vision for their schools as a health promoting institution. The various health-promoting activities need then to be seen in terms of the school endorsing

this overarching framework and implementing the various activities according to the principles outlined by the Department of Health (2000).

The Australian model, according to the MindMatters programme (MindMatters, 2002) is to organise the five principles into three main categories, namely: curriculum teaching and learning; school organisation, ethos and environment; and partnerships with parents, health services and agencies. Policies and practices are considered across these three areas. The questionnaire also asks teachers to mention up to five priorities for action (MindMatters, 2002: 43). Some teachers chose not to respond to this section.

The results of the questionnaire will therefore be presented according to the three main categories outlined above. This is to determine the extent to which schools are health-promoting and are able to provide students with the support they require to maximise their potential and achieve favourable life outcomes. The results of the interviews will be integrated according to the three categories and will shed further light on the situation within the various schools.



6.2 SCHOOL HEALTH POLICIES AND PRACTICES

According to MindMatters (2002:43), health-relevant policies are regulations, principles, expectations and/or rules that are designed to encourage healthy environments and health enhancing behaviour. Practices are the various ways in which policies are implemented and are frequently used as a measure of the effectiveness of policy.

6.2.1 Policies

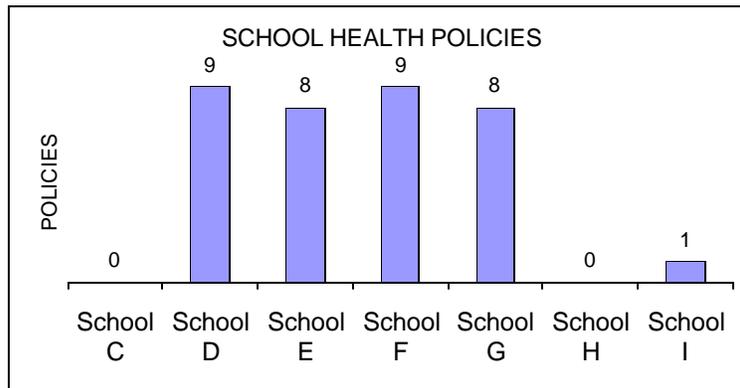
The MindMatters questionnaire (2002:43), asks whether the school has a policy in the following nine areas,

- Bullying;
- Welfare and discipline;
- Gender equity / discrimination / harassment;
- Racism and cultural sensitivity;

- Critical incident policy;
- Reported or suspected child abuse;
- Staff health and welfare;
- Referral of suspected student health problems;
- Administration and safe storage of medication.

The following results are organised according to the extent to which teachers indicated that policies existed at their schools with regard to the aforementioned areas.

Chart 6.1. Extent to which schools have health policies



The school counsellors / guidance teachers at schools C and H reported that their schools do not have policies in place that address any of the areas listed by the questionnaire. In contrast, schools D and F seem to have policies in place that address all of the areas mentioned in the questionnaire. At school E, policy is only lacking in terms of issues related to critical incidents. At school G, policy is only lacking in terms of staff health and welfare. School I on the other hand, only seems to have a policy in place related to welfare and discipline and not in any other area. Policy development is clearly an area that has to be prioritised at schools C, H and I.

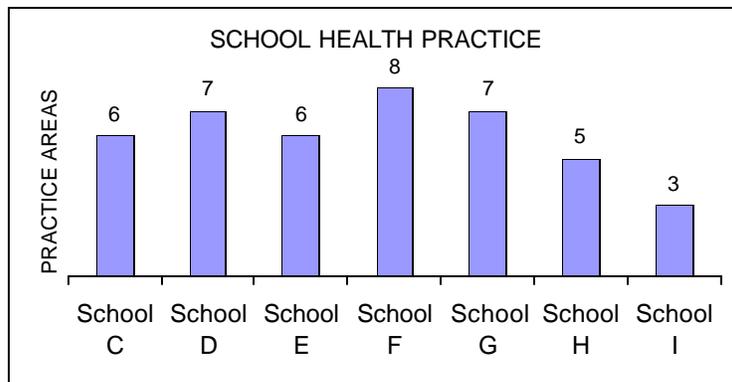
6.2.2 Practice

The MindMatters questionnaire (2002:44), asks whether the following practices occur in the school,

- Staff members act as role models;
- Girls and boys have equitable access to resources;
- Staff members seek help when feeling stressed;
- Staff members support colleagues;
- Teachers have a clear understanding of emergency procedures;
- Students and staff rehearse evacuation plans;
- The school addresses issues of stress in transition from schools;
- Promoting students' health and welfare is a priority.

The following results are organised according to the extent to which teachers indicated that the aforementioned eight practices do occur in their school.

Chart 6.2 Extent to which health practices occur



School F is the only school that indicated that all school health practices listed occurred at their school. Both schools D and G indicated that the only practice that was missing at their school was the practice of staff members seeking help when feeling stressed. Schools H and I indicated the same challenge at their schools. Schools C and E indicated that only two practices did not occur at their schools. For School C it was staff members acting as role models; and girls and boys having equitable access to resources. For school E it was teachers having a clear understanding of emergency procedures; and students and staff rehearsing evacuation plans. School H had the same challenges as school E in this regard. School I only listed three practices that occurred at their school. The three practices that were listed by school I relate only to staff indicating a possible alienation between staff and students.

6.2.3 Priorities for action

The teacher at school C felt that it was important for her school to develop policies in all areas mentioned above and then to implement the policies. She felt it was also important then to review the policies in terms of necessity and to examine implementation practices and also to examine the impact of the policies on the various stakeholders. There is therefore a clear commitment to improving the situation at her school with regard to policy implementation and practice as well as evaluation and monitoring of the policies developed.

The teacher at school D identified “help for staff regarding stress” and greater interaction with parents as the two key priorities at her school. Whilst they have the necessary policies and practices in place, they clearly require support and assistance in order to sustain and strengthen what they do.

The teacher at school E identified a code of emergency procedures and a fire drill as priorities for action as they are non-existent at the school. At the same time, she indicated a review of most existing policies at the school related to health. This reflects a positive commitment to improving policy and practice at the school.

Although the teacher at school F indicated that all policies and practices mentioned were in place at her school, she also provided a list of priorities for action. She listed a code of conduct with suitable punishments for misbehaviour like bullying and racism; sport and other extra-mural activities; special welcome programmes for new pupils; a first-aid educator and well-equipped first aid kit; a counsellor and life orientation programmes for grades 10 to 12 as well.

Staff welfare and staff stress are two areas that were identified by the teacher at school G as priorities for action. While the needs of learners are clearly being met, the needs of teachers are not being adequately attended to. This is very important as the stress of teachers will undoubtedly have an impact upon their ability to provide support to learners.

The following areas were listed as priorities for action by the teacher at school H: bullying and most other policies listed; referral of suspected health problems; critical incident policy; help for staff members feeling stressed; teachers having a clear understanding of emergency procedures related to medical and hospital treatment.

The teacher at school I identified the development of a school health promotion policy as a priority. If this is done within the framework of the health promoting school, then health related policies would be developed, a healthy school ethos and environment would be created, it would facilitate school-community partnerships, support services to the school and facilitate the process of life skills training and programmes in the school.

6.2.4 Teacher's views on youth at risk and school health policies and practices

Most teachers seem to be aware of the difficulties that their learners are experiencing although they may not be aware of the precise extent to which they are at risk. They listed difficulties ranging from physical and sexual abuse, rape, divorce, HIV, poverty, neglect (school C), to depression, drugs, pregnancy (school D), to 'TUK', alcohol, bullying and harassment, verbal abuse (school E), to Satanism, racism, career decision-making, substance abuse (school F) to peer pressure, bullying and bribery, relationship issues (school G), alcohol, drugs, 'TUK', teenage pregnancy, gender issues (school H), to hunger, malnourishment, emotional immaturity (school I).

The teacher at school D pointed out that children have essentially changed, "since 1997, the needs have changed, children are more depressed. As the years have gone by, there's a tremendous sense of loss, no meaning, drifting, no sense of purpose". She felt that it could be the reason that children turn to drugs and promiscuity. "it's something different, maybe it will be the answer". She also expressed the concern that most adults have no idea what of the problems that teenagers face and the pressure that they are under, "I can see the generation gap, we have no idea what it's like to be a teenager today". She explains further, "You've got to grow up so quickly. Children never get a chance to really be kids today". The issues of peer pressure was also highlighted, "you've got to be out

there, you've got to be happening, you've got to be clubbing, you've got to have had sex first, or kissed first or had a drink first or been drunk and if you haven't, 'pische'(sound)".

These views are supported by the teacher at school F. She felt that that parents can't conceive that their children are at a particular stage already, "Their children are growing up so quickly...It's as though it catches them unawares". She also raised issues related to early exposure to adult issues, "Internet pornography, internet sex, those things. Uhm, then it shocks you when you see that they know something about it". Furthermore, she raised the issue that the well-being of learners seem to be threatened by their fear of the future. She finds this particularly to be the case amongst grade eleven and twelve learners. This could largely be because the learners at school F largely belong to the previously advantaged sector of the population and issues related to affirmative action could weigh heavily upon them, "In terms of well-being, grades eight to ten are doing relatively well but grades eleven and twelve are concerned about the future".

At school C, a unique issue seems to be that many of the learners do not live with their parents, and as a result they "don't get that parental support" and even worse, "some of them have been raped, physically abused, sexually abused at home by their relatives, by their neighbours". The teacher felt that the abuse, drug abuse and lack of parental care results in crime, "they become so loose that they end up being criminals outside".

The teacher at school I also pointed out the difference between the learners at his school and the learners at other schools,

I think we're still living in two worlds. There's many factors that play a role in development. Unfortunately, our learners come from a very poor background, which means they come to school without breakfast, they are undernourished and this has an impact on their mental development. You cannot just look at a thirteen year old or a fourteen year old learner and think that they are like the rest of South Africa. I think they don't get enough brain food. They're not exposed to reading, there's not a culture of asking questions, and the environment where they come from, the house isn't always conducive to healthy development.

While there are generally common problems experienced by all teenagers, it is interesting to note that issues related to poverty and overcrowding manifest largely in schools C and I.

With regard to policy and practice to address the issues faced by their learners, teachers admitted to the policies being more commonly understood than written down and yet many of them followed procedures for executing policies when the situation demanded it,

If we have certain problems with kids here at school, we first call the parents in and then we discuss it and we see if we can solve the problem amongst us. If a child is abusing alcohol or whatever, we know exactly what route to follow. The policy on AIDS that we are supposed to have, we don't have that at all, that is the thing that maybe I have to work on. BRIDGES are going to help us with a policy on drugs (School E).

We have a totally zero tolerance approach to things like bullying and sexes and racism. They're not explicit but it would be in the minds of the people and the governing body (School G).

In summary, while schools F, D, G and E seem to have the necessary policies in place to deal with risk behaviours, schools C, H and I require much assistance in this regard. The establishment of policies seem to translate effectively into practice as the extent to which health practices are evident in the school seem to directly related to the extent to which schools have health policies in place. What is also evident is that schools that were previously advantaged seem more likely to have the necessary health structures and procedures in place than schools that were previously disadvantaged. The questionnaire was most helpful to teachers as it enabled them to realize what was in place at their schools and what was lacking. It also assisted them to prioritise interventions in this regard (health policy and practice). Each school prioritised their interventions according to their specific needs. The interviews revealed that teachers are aware of the difficulties that the young people are experiencing and that the nature of these difficulties are dependent upon socio-economic circumstances.

6.3 CURRICULUM TEACHING AND LEARNING

According to MindMatters (2002:14), the area of ‘curriculum teaching and learning’ is concerned with,

- What is taught in the formal curriculum;
- The teaching and learning strategies employed;
- The classroom climate established by teachers;
- The consideration given to the diverse learning needs of students;
- Teachers’ access to professional development.

MindMatters (2002:15) further states that a focus on curriculum may involve,

- Requiring all teachers to organise classroom structures and activities to promote interaction and positive classroom climate;
- Developing a classroom curriculum program which addresses mental and social health issues;
- Designing activities in a range of subject areas which aim to equip students to talk about what it is to be human and to face change, challenge, success, failure, frustration and accomplishment;
- Reviewing the practices associated with formative assessment and feedback to students;
- Providing opportunities for students to experience success engaging in real tasks;
- The promotion of a culture of high but achievable expectations.

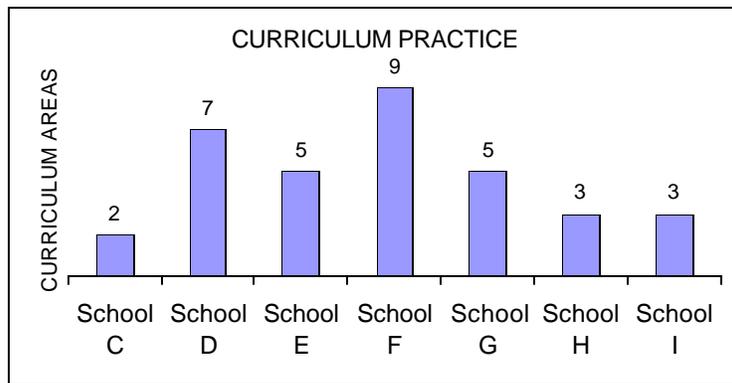
6.3.1 Practice

The MindMatters questionnaire (2002:45), asks how satisfied teachers are with the following current practice in their school,

- The school has a comprehensive health education curriculum;
- It acknowledges cultural diversity in attitudes to mental health problems;
- Provides opportunities for students to learn about diversity;
- A vision and rationale for the inclusion of sensitive issues is stated;
- Sufficient time per week is allocated to mental health;
- Teachers receive information about mental health resources;
- Teachers attend development programs on mental health and suicide;
- Consultation occurs with parents when addressing sensitive areas in health;
- Parents participate in and learn about the school health curriculum.

The following results are organised according to the extent to which teachers indicated that they are satisfied with current practice in aforementioned nine areas at their school.

Chart 6.3 The extent to which teachers are satisfied with current practice



The guidance teacher at school F indicated that she was satisfied with the current practice in her school with regard to the curriculum in all areas listed by the questionnaire. The teachers who were least satisfied with curriculum practice at their schools were the teachers at schools C (satisfied only with two areas), H and I (satisfied only with three areas respectively). The areas which most schools felt dissatisfied with were cultural diversity in attitudes to mental health problems, teachers receiving information about mental health resources, and parents participating in and learning about the school health curriculum. The areas most schools felt satisfied with are: the school has a comprehensive health education curriculum, provides opportunities for students to learn about diversity, a vision and rationale for the inclusion of sensitive issues is stated, and, consultation occurs with parents when addressing sensitive areas in health.

6.3.2 Areas covered: basic understanding relevant to age

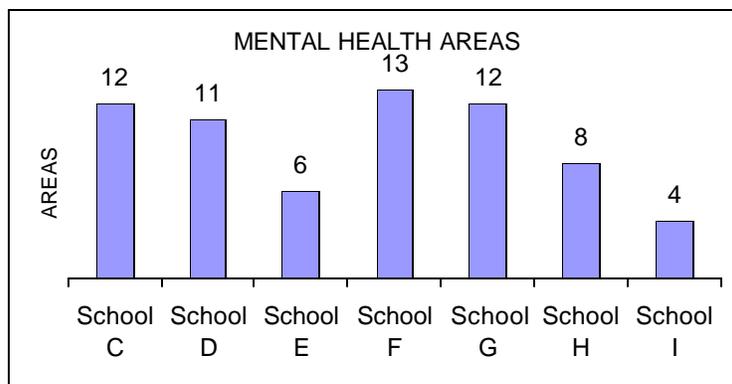
The MindMatters questionnaire (2002:46), asks how satisfied teachers are that the following areas relevant to mental health are covered in their school,

- Victimization;
- Racism;
- Protective behaviours;
- Mental health;

- Sexuality;
- Community health resources and services;
- Personal and cultural identity;
- Friendships and relationships;
- Grief and loss;
- Body-image;
- Mental illness;
- Spiritual well-being;
- Physical activity.

The following results are organised according to the extent to which teachers indicated that they are satisfied with current practice in aforementioned thirteen areas at their school.

Chart 6.4 Extent to which teachers are satisfied that mental health areas are covered.



Most schools were fairly satisfied that the areas related to mental health listed in the questionnaire are covered at their school. However, schools I and E reported that less than half of the areas were covered satisfactorily at their school (only 4 and 6 areas respectively). At school H eight areas are covered satisfactorily. Schools C and G however, reported that only one area was not covered. For school C it was the area of mental health and for school G it was the area of victimisation. For school D the areas of community health resources and services; and grief and loss need to be covered satisfactorily. An interesting observation is the fact that at most schools mental illness is covered but mental health is not. Areas covered most satisfactorily are friendships and relationships, sexuality, physical activity, spiritual well-being, body image, personal and

cultural identity, and racism. This could be due to the new life orientation curriculum that emphasises these areas.

6.3.3 Personal and social skills

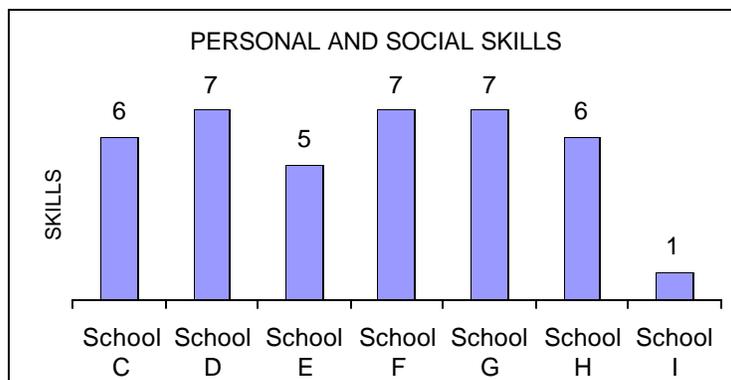
The MindMatters questionnaire (2002:47), asks teachers to indicate their level of satisfaction with the opportunities provided for students to acquire the following personal and social skills that contribute to positive mental health,

- Communication / assertiveness;
- Decision-making / problem-solving;
- Help-seeking;
- Non-violent conflict resolution;
- Stress management;
- Developing and maintaining social relationships;
- Esteem building.

The following results are organised according to the extent to which teachers indicated that they are satisfied with opportunities provided for students to acquire the aforementioned seven skills.



Chart 6.5 Extent to which teachers are satisfied with opportunities for students to acquire skills



Teachers at schools D, F and G are satisfied that their learners are provided with opportunities to acquire all the personal and social skills listed in the questionnaire. Schools C and H feel that opportunities could still be provided in one of the areas listed. For school C the area is developing and maintaining social relationships and for school H

the area is communication and assertiveness. School E lists stress management and, developing and maintaining social relationships as areas for improvement. School I could only list satisfaction with one area namely, help-seeking which is an area that is satisfactory for all schools.

In summary, it is interesting to note the developments with regard to the curriculum. The national life orientation curriculum is geared towards providing all learners with the necessary knowledge, skills, attitudes and values to enhance their lives. Most schools have reported positively in terms of personal and social skills acquired by learners. The curriculum could be further developed in terms of mental health matters though. It seems that mental illness is still the focus as per the medical model and as opposed to mental health. The areas of resilience and fortitude still need to be included in the curriculum even though health promotion is a key component of the life orientation curriculum.

6.3.4 Priorities for action



The teacher at school C felt that she would firstly emphasise the importance of the aforementioned personal and social skills. She would follow up on whether learners implemented the skills where situations called for their utilisation and discuss the various scenarios in order to strengthen learners in the utilisation of the skills. She would create weekly sessions where various issues could be discussed in class and she would encourage the learners to use the skills as much as they can and to learn to deal with stressful situations. The teacher is therefore committed to the practical implementation of life skills acquired by learners and to providing support in the implementation of the life skills.

The teacher at school D identified non-violent conflict resolution, stress management and communication and assertiveness skills as priorities for action. While students do acquire these skills at school, greater emphasis needs to be placed on these areas and in the stated order of priority.

Although indicating that she is very satisfied with all areas of curriculum teaching and learning listed in the questionnaire, the teacher at school F also identified the following priorities for action: life orientation for grades eight to twelve; leadership programmes; encouraging learners to take part in at least one summer and one winter activity (cultural or sport); religious instruction; and speakers on different topics. There is therefore an ongoing commitment to improve the curriculum.

The teacher at school G commented that the personality of the educator whose responsibility it was to impart personal and social skills and their personal level of skill that would be the determinant of how well the skills are imparted. While not dissatisfied with the opportunities provided to learners to acquire the listed skills, there was room for improvement.

The following areas were prioritised by the teacher at school H: mental health; availability of and use of mental health resources; professional development programmes relevant to mental health and youth suicide; parents granted an opportunity to learn about the content of the school health curriculum; stress management, communication, and non-violent conflict resolution. There are thus many gaps in terms of curriculum teaching and learning that could be filled.

The teacher at school I prioritised teacher training and identified the following areas for training: stress management, conflict resolution and communication. Once again the need to support teachers are emphasised and more importantly, to assist teachers to deal with stress.

6.3.5 Teacher's views on curriculum teaching and learning

All the teachers interviewed were very passionate about the issue of curriculum teaching and learning. However, feeling of frustration about the new curriculum, the training involved and the pressure placed on teachers were expressed,

So much is expected now, you're expected to more than just teach. It's the sport, it's the extra lessons, it's the pushing and pulling to get the child through the subject because children don't have the work ethic they used to have. You feel like you are pushing this cart up the hill with no assistance and then to top it all, the department will ask could you fill in file XYZ and then these forms as well and could it be done in triplicate. We are expected to do too much (School D).

Outcomes-based education is putting a lot of pressure on us, moderation, meetings, workshops. Most of our Saturdays are filled. They promise us feedback as in terms of where's this going, what's the purpose of it, nothing like that. So, we don't know if we're on the right track. It's all well to let us, say, sit through workshops from the morning till the afternoon but there's nothing practical that we can come back with to implement at the school. That's still the problem and that's still something they don't see (School H).

To date most of the training that they received from the Department of Education had been related to the new curriculum and were inadequate,

Has been more curriculum subjects than any other thing! I get support from the subject advisor but it's based on the curriculum, I mean Life Orientation as a subject. I need to be trained on how to cope and how to enable them (learners) to cope (School C).

It would be good to start with school counsellors, people who are getting stuff done to them all the time, to actually have some sort of debriefing, perhaps among themselves in groups, you know if a group of psychologists got together and say "well, we will give two hours a week" or something like that. I think that would be tremendous (School G).

Teachers are clearly not coping with the demands of the new curriculum and the challenges in the classroom.

In summary, schools D, E, F and G seem to be progressing well in terms of curriculum practice. Schools C, H and I need assistance in this area. In terms of mental health areas that are covered, most schools are progressing well with the exception of schools E and I. Only school I seemed to experience difficulty with providing opportunities for the development of personal and social skills. Once again, the priorities for action section reveals that teachers are keen to improve their teaching and the opportunities that they provide for their students. While there are many positive developments in terms of the

Life Orientation curriculum in schools, teachers are also under tremendous pressure to cope with the many new curriculum developments in education.

6.4 SCHOOL ORGANISATION, ETHOS AND ENVIRONMENT

According to MindMatters (2002:16), the school ethos is affected by the policies, procedures, practices and organisational structures as well as the attitudes and values within the school and its community. Important components include,

- The provision of a safe and supportive learning and social environment;
- Welfare and behaviour management strategies;
- The provision of ongoing opportunities for students to participate in meaningful activities that promote positive relationships, a sense of belonging, pride and self-worth.

MindMatters (2002:16) further states that a focus on school ethos may involve the school in,



- Developing an organisational culture that promotes a safe and stimulating environment where members of the school community can work, learn and play, free from harassment, racism, stigma or bullying;
- Revising or developing welfare and critical incident policies;
- Providing supportive management of the key transitions into and out of high school;
- Instituting activities to promote student involvement in the governance of the school;
- Developing pastoral care, peer support programs, civic or community service activities;
- Using multicultural or arts festivals as an opportunity for engagement, participation and health promotion;
- Implementing a staff mental health program dealing with issues of shared decision-making, communication, positive recognition and collegial support;
- Collaborating with parents and students.

Furthermore,

The culture of the classroom is a key component of school ethos. Success in school is more likely when students perceive that their teachers believe in them, show a caring approach, provide them with ongoing opportunities to engage in purposeful learning, and reward and acknowledge participation, effort and achievement (MindMatters, 2002:16)

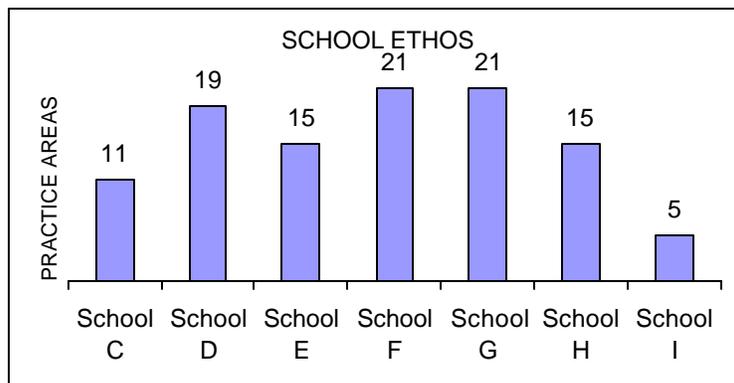
6.4.1 Practice

The MindMatters questionnaire (2002:48), asks teachers to indicate their level of satisfaction with the following situation in their school,

- The physical environment contributes to positive mental health;
- Students are protected from unwanted visitors at school;
- Toilets provide sufficient privacy for males and females;
- There are adequate areas for active and passive games and pursuits;
- Students participate in beautifying the school;
- School buildings are well designed and maintained;
- Opportunities are provided to develop positive and meaningful relationships;
- Teachers are supportive of students and other staff members;
- Students are supportive of staff members and other students;
- Students are encouraged to participate in decision-making processes;
- Students are encouraged to be active participants in the learning process;
- School actively discourages physical and verbal violence amongst students;
- School actively discourages physical and verbal violence between students and staff;
- Positive social experience for all students is promoted;
- Opportunities are provided for students to experience success in many ways;
- Positive physical activity for all students is promoted;
- Positive academic experience for all students is promoted;
- Students feel a sense of belonging to the school;
- The school reflects the cultural values of the school community;
- Competition is structured to support the growth of students;
- Students with special learning needs are identified and supported.

The following results are organised according to the extent to which teachers indicated that they are satisfied with the current situation in their school related to the aforementioned twenty-one practices.

Chart 6.6 Extent to which teachers are satisfied with current practices



Teachers at schools F and G have indicated that they are satisfied with current practices related to school organisation, ethos and environment as indicated by the various areas in the questionnaire. School D indicated dissatisfaction with only two areas namely, students participating in beautifying the school and students encouraged to be active participants in the learning process. On the other hand, school I could only indicate satisfaction with five areas namely, toilet privacy, opportunities to develop positive relationships, teachers are supportive, students are supportive and positive academic experience for all students is promoted. Also, four of these areas (excluding positive relationships) are satisfactory for the other schools as well, reflecting a general trend for all schools as part of the academic experience. The areas most teachers are dissatisfied with include students participating in beautifying the school and, school buildings being well designed and maintained. Only schools D, F and G seem to be satisfied with these areas. These schools were previously advantaged schools and would therefore possibly have had the best possible resources for design and maintenance.

6.4.2 Priorities for action

The teacher at school C felt that it was important to encourage team building between all the stakeholders. She felt that learners and parents should be motivated and encouraged to look after their environment. She felt that the establishment of a healthy relationship between staff, students and families and the community was important. She felt that physical and verbal violence amongst students should be discouraged and respect between students and teachers should be encouraged. Intervention at all levels is

therefore required and the health promoting schools framework would be most useful in this regard.

The teacher at school D identified a “sense of belonging (to curb vandalism)” and “students with special learning needs” as priorities for action. Once again, while the school does have these practices in place, these areas could be improved. The “sense of belonging” priority could relate to the fact that most learners at school D do not live in the surrounding area of the school but are transported by their parents to school from different areas where they live.

The teacher at school F identified the following priorities for action with regard to school organisation, ethos and environment: assembly meetings; academic class environment and encouragement of all learners to try their best; motivation with certificates; extra classes; and interschool sporting events. These were listed even though she indicated that practice with regard to school organisation, ethos an environment at her school was quite satisfactory.



The teacher at school H identified the following priorities for action: student participation in beautifying the school; support for the personal and social growth of students; students with special needs identified and supported. There is therefore a need for students to be supported in terms of the organisation, ethos and environment of the school.

The teacher at school I stressed that the code of conduct at the school should be revised and strictly implemented. This related strongly school development issues and the necessity for a whole school development approach to meeting the needs of the school.

6.4.3 Teachers views on learner support, school organization, ethos and environment

Schools varied in terms of whether they felt that their learners required support. Some schools were positive about the support that their learners were receiving at school,

We have a positive learning culture here at the school. We still have that respect. We can cope and handle the learners (School E).

We have programmes for all their needs (School F).

Other schools felt that support for learners is required,

We need support definitely and support in such a way that it will make a difference in the child's life in terms of emotions. I am trying as a guidance teacher to give them the support, to advise here and there but I still feel that a lot needs to be done. We don't have any support structures. I have been trying to do it myself because I cannot just leave them like that (School C).

A few years ago, the school was a bit chaotic at times and we had to put systems in place. Now we're getting there. We are not there yet. We are making an effort of improving the learning environment of the learners (School I).

The teachers themselves are clearly not doing well though,

I think they are strained and I think they are horrible overloaded and only somebody who works with teenagers or knows schools will be able to understand (School D).

I think a lot of teachers are actually in crisis. There's an enormous turnover of staff. I think a lot of staff are doing a very good job but I think a lot of staff are in despair. They are just literally coping with one crisis after the other (School G).

School have to find their own ways to cope and have embarked on some innovative ventures,

Also, once a month someone will say, okay, all staff come down on Friday after school, we get together, it's a little pub down there and we can have a glass of wine or a cold drink or we just sit and chat and that's been very good for moral as a time out (School D).

We had a lovely weekend the girls organised, a weekend away. We had a lovely weekend in Saldahna Bay, we just chilled. Just to bring us together again and just to relax and chat and talk (School E).

There is still a lot of hope amongst some staff members,

Just meeting people around here, it makes you feel that you are accepted. I think there is care, I would say so! (School C).

When I started teaching, I found them very close knit, very supportive of the school, very supportive of each other (School H).

We're like any normal staff. Some of us get along well with others but others don't get along. But on a professional level, we respect each other (School I).

Each school has a challenge that is particular to its own setting. For school C it is a question of crime,

It's not so safe when you leave the school. There's been incidents where teachers were robbed, teachers bags were taken, so that makes you feel that you are not safe and you don't know what is going to happen to you.

For school G it's the question of service conditions,

Study leave, I mean, that is just another point. You know, teachers who have given out and given out, they go off, they come back and they are refreshed and renewed perhaps for another decade, but when teachers cannot do this anymore, they don't get that renewal and that refreshment. So obviously they're going to deteriorate.

For school H, it's about teambuilding,



Uhm... in this year though, like I'm saying this whole vision building and people unpacking issues in the staff room uhm... a lot of petty issues were raised that caused, you can see, clear tension between certain members of the staff. I'm hardly in the staff room and I have reason, I just keep away not to become involved in those things. I think you just generally find that anywhere, but general relationships are quite good between teachers.

For school I, it's about cultural differences,

Uhm... you see for the years that I've been at this school, I've also grown and I'm learning a lot every year about how many of my colleagues how they think, how they operate and how they do things, and I've come to a point that my way is not the norm. Uhm... the decision making process might be slightly different that I go through, but that doesn't mean that my way is the right way. Uhm... so ya, I also think that many of my colleagues, they've got... say Matric plus two or three years college uhm... at College Eastern Cape, rural Bantu education uhm... And then there's a group that's more urban, varsity.

From the responses it seems that each of those challenges are being approached with an open mind and with the aim of growing through the experiences.

In summary, teachers seem generally satisfied with current practices with regard to school organization, ethos and environment. Teachers at schools C and I felt that these were areas that could still be developed. Teachers listed their priorities for action in these areas. Most teachers felt that their learners were receiving sufficient support at school. These were the teachers from the older, more established schools. Other teachers recognized that their learners required much support that was not currently possible for the school to provide. Teacher stress and burnout was also raised in this section. Teachers pointed out how efforts by the principal and other staff members served to energise and strengthen them. What was also evident was the fact that each school had its own unique set of circumstances that contributed towards stress amongst teachers.

6.5 PARTNERSHIPS AND SERVICES

According to MindMatters (2002:17), 'partnerships and services' refers to links between the school, families, community members and service providers. It entails ongoing communication and consultation with teachers, students, parents, community members and health agencies. MindMatters (2002:17) argues that building effective partnerships with parents and health services is critical when accessing support for students who have mental health problems. However, good partnerships with parents, neighbouring schools, leisure groups or health practitioners require an investment of time and requires thorough and ongoing communication. A proactive and structured approach to building or maintaining partnerships is recommended.

6.5.1 Practice

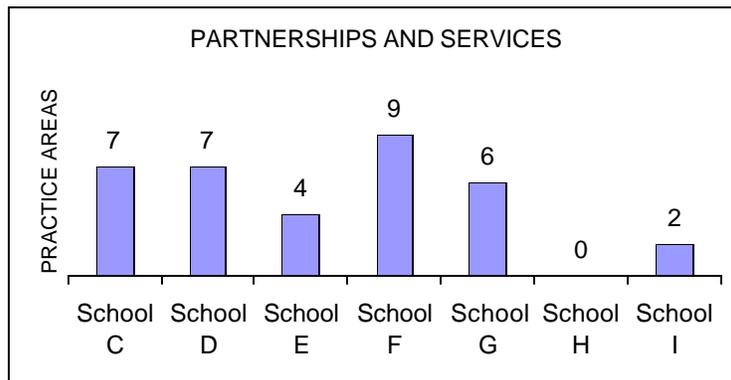
The MindMatters questionnaire (2002:50), asks teachers to indicate whether or not their school is active in the following areas,

- There is regular exchange between community and the school;
- A broad range of parents is actively involved in the life of the school;
- The curriculum contains health-related activities with children interacting with carers;
- Local groups participate collaboratively in school activities;
- Parents are involved in decision-making and policy development at school;

- Local mental health services are accessed for counselling and referral;
- Counselling and support services are available for distressed students;
- There are adequate community support services to meet students' needs;
- There are specific mental health services for students who are mentally ill or at risk;
- There is consultation between health personnel and teachers about the curriculum;
- Health personnel participate in the delivery of the curriculum;
- School maintains a database of support and referral agencies with details.

The following results are organised according to the extent to which teachers indicated that they are satisfied that their schools is active in the aforementioned twelve areas. Data for school H was incomplete for this section of the questionnaire.

Chart 6.7 Extent to which teachers are satisfied with their school’s activities



It seems that the area of partnerships and services is the area that can be improved for all schools. School I could only indicate two areas that were satisfactory namely, parental involvement in decision-making and policy development and, counselling and support services for distressed students. The areas most in need of improvement for schools are having a broad range of parents actively involved in the school; consultation between health personnel and teachers about the curriculum; and health personnel participating in the delivery of the curriculum. The area teachers were most satisfied with was the availability of counselling and support services for distressed students.

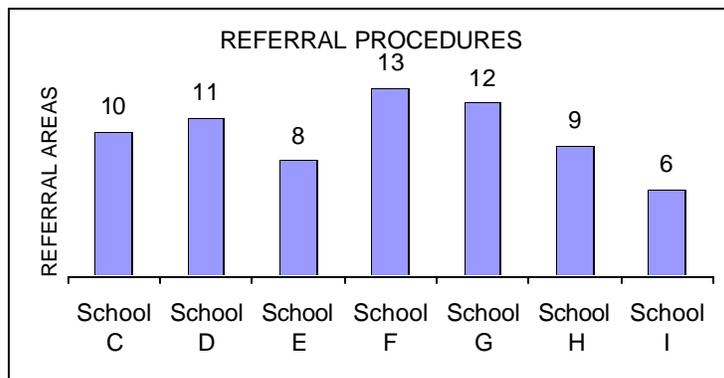
6.5.2 Referral Procedures

The MindMatters questionnaire (2002:51), asks teachers to indicate whether or not referral procedures are in place for the following,

- Truancy;
- Youth unemployment;
- Behaviour problems;
- Grief and loss counseling;
- Neglect, sexual, emotional or physical abuse;
- Students' concerns about their friends;
- Suicidal behaviours;
- Teenage sexuality and relationships;
- Drug and alcohol use by students and their families;
- Mental illness of students or their family;
- Anger management;
- Divorce and family problems;
- Victims of racism.

The following results are organised according to the extent to which teachers indicated that the aforementioned thirteen procedures are in place.

Chart 6.8 Extent to which teachers indicated that referral procedures are in place



School F indicated that referral procedures are in place for all areas listed by the questionnaire. School D indicated that the areas where procedures for identification and referral of students with specific health needs are required are, youth unemployment and victims of racism. Adequate referral procedures are in place at most schools, with less than 50% of procedures in place at school I only. Procedures are in place at all schools for behaviour problems; all forms of abuse; students' concerns about their friends; and suicidal behaviours. The areas most lacking at schools are victims of racism and youth unemployment, followed by grief and loss counselling; anger management; and divorce and family problems.

6.5.3 Priorities for action

The teacher at school C felt that more communication between stakeholders, the school and the community, is required. Regular visits to school by health agencies are also a priority. Workshops need to be conducted to empower parents, teachers as well as learners with regard to health matters. Parents need to be informed about school policies. Youth development programmes must be established in schools as well as in the community to promote health in the community. These priorities emphasise the large need in terms of health matters and raises the importance of empowering learners, teachers, parents and other community members.

The teacher at school D identified youth unemployment and victims of racism as priorities for action. These priorities relate to pertinent social issues at previously advantaged schools. Many issues related to integration of learners from disadvantaged communities still have to be resolved. Youth unemployment is an issue that affects all learners and particularly learners who were advantaged in the past and who felt more secure then than they do now.



The teacher at school F listed services and structures that are in place and are available should they require them. She stated that social workers are available; the school invites health workers for information on health issues; psychologists are available for scholastic and psychological problems and vocational guidance; there is a guidance teacher at school; one teacher acts as head of a specific grade and is there for the needs of that specific group. These are lessons for other schools in terms of successful partnerships and services.

The teacher at school H listed the following priorities for action: parental involvement in school-related activities; local groups' participation in school activities; community support services to meet students' mental and social health needs; an up-to-date database of referral agencies; review of the following procedures- truancy, anger management, etc. Support at all levels is therefore required.

6.5.4 Teachers' views on community support and partnerships and services

While most teachers are doing the best they can, support from parents and service providers can be greatly improved to assist them in their task as educators and to ease the pressure that they are experiencing. Support from parents and the community is still the area most in need of development,

If the parents can be involved in matters at school, informed about what is happening, with regard to their kids at school so that they are able to do something at home. The parents must know that the teachers are aware about the problems that the child is facing and the parent on the other hand must also do something about that...I would love to see more of the people in this area coming. I strongly believe that if we can involve the people around here, we will perhaps see a change.... we only see them when there are parent meetings and then from there we don't see them anymore, you know, it delays the whole thing (School C).

I don't often experience parents really backing us. I think they feel so tired of disciplining them they dump the child at school and by some osmosis or magic process we are going to transform the child....Parents really need to get involved. I think they need to back the school. I think they need to see us as an ally, as a partnership not against their kid but working with us for the good of the kid (School D).

Not all schools have negative experiences though,

This community is quite sound.... The parents are concerned for the well-being of their children....The child is obviously from an advantaged background, quite apart from his socio-economic status, just in terms of the effort that the parents have made....There's a tremendous back up from the home and community environment (School G).

The experiences that teachers have of education support services are dependent upon their situations and can be improved. Teachers receive help when they go and find it but they have to take the initiative,

With my school psychologist, if we need, we'll call them and he normally comes in...We see less of them because I have to contact them (School E).

The psychologist has not come since I've been here. They probably think that we don't need it – not since there's been clinics or not (School F).

Realising that they cannot depend upon education support services, schools have taken the initiative to get assistance wherever they can from other sources,

If there are referrals I need to make, I do make them...I have managed to arrange with the Red Cross people to get them some food parcels. I just do these things you know out of my own....I do call social workers (School C).

We have a group that been training peer educators... We have people coming in...the social worker...the police. We have children going to visit universities, technikons, career exhibitions, open days at Stellenbosch or Cape Tech or UCT... (School E).

We are in close links with the university of Stellenbosch but that's on an academic and on the management side....We've got a donor from Holland who is going to sponsor some computers now (School I).

It seems that the various activities at the school seem to operate very loosely though. There needs to be a co-ordinated effort to maximise the benefits of service offered at the schools.

With regard to education support services,  NGOs or other organisation introducing the HPS concept to teachers, this has been very limited in these schools. Teachers have either not heard of the concept at all or been introduced to it in an unsustainable manner. Overall, however, the feeling towards the concept has been very positive. Teachers were open to the initiative and felt that their colleagues would be too. Most teachers associated the concept with the curriculum or else with health activities and practices.

Introduction to the concept,

I think it's brilliant but what you were saying is in the Healthy Schools plan. (School D).

As guidance counsellors we've been introduced to it...Dr Cloete (School E).

Health promoting schools....No... (School F).

That is definitely coming in from the Department of Education and it's coming through in my own subject. So its not really coming from the school as such, it's coming from there (School G).

Acceptance and endorsement of the concept by teachers,

I think some know and some don't actually know, ja, some might know, some don't actually know what the schools have (School C).

It is very definitely there because we believe in a holistic approach to the child, you know, we look at the child's spiritual, mental and physical and indeed psychological needs. So it's very much there (School G).

I don't think teachers will be opposed to something like that (School H).

Activities associated with the concept,

We took part in National TB awareness week. We made posters and stuff and then continued in AIDS. We have a little project knitting beautiful blankets..some are skew...the children in the AIDS home can play, they can use the blankets for their dolls. (School E)

A lot of our activities are health promoting when I think about extra-murals and everything include things that is sport, drama, various things which are very much health promoting ...but it's not actually specifically done for that reason (School G).

I think that at our school we have quite a healthy environment that the students are working in...very patient teachers that teach here. They go out of their way with what we have to cope with...students are very willing to learn...I think the culture of learning, that is healthy and positive (School H).

In summary, most schools seem to find parental involvement a challenge. Teachers would like parents to be more involved in their children's education as well as school events. Reasons for poor involvement include apathy, lack of transport, work pressures, and uncertainty of roles. Schools also receive very little assistance from education support services such as the district support structure. Teachers often have to seek help on their own and initiate contacts and support. With regard to health promoting schools, most teachers have only been fleetingly introduced to the concept and only have a vague idea of what it entails. In general, however, teachers are positive about the concept and the benefits for their school to subscribe to the concept.

6.6 CONCLUSIONS

The results of the questionnaires and interviews bring us to a debate that has been raging in South Africa, and the Western Cape in particular, over the past ten years. That debate evolves around measuring or evaluating schools as health promoting institutions. Furthermore, as is evident from the results in this section, the disparity in resource allocation in the past to schools of different races, have led to certain schools having more access to financial and education support services. As a result they have been able to offer more to their learners in terms of psychological services and have stronger school-community/service provider partnerships. Schools F, G and D are schools that have had access to greater financial resources and education support services. Schools I, C, H and E have been significantly less well resourced. Even though things have changed politically, these schools are still struggling to meet the needs of their learners and to establish school-community partnerships, as is evident in the various charts. The section on 'priorities for action' also point out that teachers are eager to improve matters for their learners and are committed to establishing the various policies, practices and partnerships that could be beneficial to their school. The WHO definition of a health promoting school as a school that is constantly striving to enhance its capacity as a healthy setting for living, learning and working is therefore the most appropriate definition to be applied.

Irrespective of what they do or do not have in place at their school, all teachers have demonstrated an awareness that the situation at their school can be improved and have prioritised areas for improvement. It is therefore important to see the schools as being in different stages in terms of their journey towards becoming fully-fledged health promoting institutions. It is important to note also that the high schools are engaging in health policies, practices and partnerships as part of the daily academic enterprise and not as part of the goal to becoming a health promoting institution. A cursory awareness of the health promoting schools framework exists amongst teachers that could be improved. Teachers need to know that the health-related activities they normally engage in could be much more effectively executed when integrated and placed within the HPS framework

for action and when goals are set based upon realising the mission of the school as a health promoting institution.

Another challenge that has emerged over the past ten years has been the question of whether a whole school development approach or a specific needs-based approach should be adopted in transforming schools into health promoting institutions. In terms of the whole school development approach, the entire school would be introduced to the concept and commit to its implementation in their school and HPS principles would govern all activities offered by the school. According to the specific needs-based approach, a specific project that the school would identify as requiring urgent attention would be addressed according to the HPS framework. It is suggested that the whole school development approach would perhaps be best suited to schools that have many gaps in terms of policies, practices and partnerships such as schools I, H and C. The entire school community would then embark upon setting up the necessary policies, practices and procedures that would ensure the well-being of the learners as well as teachers, parents and community. The needs-based approach would probably be best suited to schools who have most policies, practices and partnerships in place and who need to pay serious attention to specific projects as the need arises.

Whilst it is ideal for all schools to adopt a whole school development approach, teachers have reported that their schools may not be ready for this in lieu of the many new developments introduced into schools since 1994. These teachers have found it easier to introduce the concept by demonstrating its effectiveness in terms of a specific project and then to slowly introduce the concept to other projects and eventually to the school as a whole. This may seem contrary to the MindMatters programme that is based on the whole school development approach and is introduced via the curriculum, but it is possibly the most effective solution to the complex situation of South African schools and reflects two pathways to the development of health promoting institutions. It involves communities deciding what works best for them and detracts from a past governed by top-down development and implementation of policies to bottom-up development and implementation governed by universal frameworks. This is in harmony with the WHO

view that good health is a choice and cannot be forced. It regards each school as unique and encourages them to generate unique and indigenous solutions to their problems.

Research clearly has a large and important role to play in the development of healthy schools. It can assist in creating awareness about gaps and act as a catalyst for change. At the same time, research needs to offer support in some form or another, possibly by way of lessons learned from successful case studies. These ideas will therefore be explored further in the ensuing chapters.



CHAPTER SEVEN

RESEARCH FINDINGS

CASE STUDIES

7.1 INTRODUCTION

This chapter will discuss the findings in the context of each school. In the previous three chapters (four, five and six), the findings were analysed according to general trends across all seven schools. This chapter provides a case study analysis. It is important to note that it was not the intention of this study to do case study research. It is hoped that discussing the findings as case studies will provide greater insights into the phenomena under investigation namely, exploring the factors related to risk, resilience and health promoting schools in order to foster resilience amongst our youth and can be used as a basis for reflection and action by each school.



The reason for the discussion of findings in terms of context is because “resiliency research has clearly shown that fostering resilience, i.e., promoting human development, is a process and not a programme” (Benard, 2004a:5). According to Benard (2004a), resiliency research promises to move the prevention, education, and youth development fields beyond their focus on programme and what we do; to an emphasis on process and how we do what we do; to move beyond our fixation with content to a focus on context. The focus on context is especially important for South African studies as each school context has its own particular dynamics depending upon previous resource distribution based on race, class and culture. While much has changed in the political landscape in South Africa (with the focus on building a democratic society and equitable distribution of resources), there is still much work to be done with regard to redress of past imbalances. The effects of the past such as large-scale poverty do have an impact upon the well-being of learners and informs mental health interventions in various schools.

In this chapter, the seven schools involved in the study will be grouped according to particular contexts based on past educational systems, resource allocation to schools and socio-economic status of learners and their families. This is a difficult process as there is currently much migration of learners to schools outside of the areas in which they live. It is interesting to note, however, that particular racial categories still dominate in certain groups despite an attempt to move away from classification according to racial categories. This research endorses the national Medical Research Council (MRC) of South Africa's view that information collected and analysed according to racially segregated lines such as Black/African, Coloured, White or Indian, is in order to address the inequities in provision of services along these racially segregated lines. This does not necessarily mean that the researchers subscribe to these classifications (MRC, 2003; Swart, Reddy, Ruiter & De Vries, 2003).

The discussions of findings for the seven schools are presented as Group One (schools D, F & G), Group Two (schools E & H) and Group Three (schools C & I). Schools in Group One was advantaged in the past and was governed by the Education department known as the House of Assembly (HOA). These communities are predominantly wealthy and the parent body comprises mainly of professionals who occupy prominent positions in society. Learners are predominantly White. Schools in Group Two were disadvantaged in the past and were governed by the Education department known as the House of Representatives. These communities are predominantly of average socio-economic status and the parent body comprises mainly of skilled and unskilled workers. Most workers are currently employed. Learners are predominantly Coloured. Schools in Group Three were strongly discriminated against in the past and were governed by the Education department known as the Department of Education and Training (DET). These communities are predominantly impoverished and the parent body comprises mainly of unskilled workers who are largely unemployed. Learners are predominantly Black/African.

7.2 REVIEWING THE FINDINGS AS CASE STUDIES

This section serves to examine each school as a case study within a particular group. At the end of this section, the various overall patterns that begin to emerge will be discussed in detail.

7.2.1 Group One (ex-House of Assembly schools)

7.2.1.1 School D

(a) Understanding the context

School D is situated in a highly urbanized and fairly affluent area. The area is a traditionally 'Afrikaner' area, the racial group who endorsed and fervently supported Apartheid. On the outskirts, the school is surrounded by large commercial enterprises. The school has always been very well resourced. It was originally built for "White" learners. It has large sports fields, a swimming pool and various indoor recreational facilities. The classrooms are adequate and class sizes average at 35 learners per class. Most learners do not live in the surrounding area. They are transported by their parents from middle class communities. The learners are mostly 'Coloured'. These communities are not impoverished and social problems are related to issues of race, social status, divorce, alcoholism, drug abuse and relationships. These communities are largely English-speaking. Parents have very high expectations for their children. The staff are dedicated and committed to providing the best possible education for the learners. The principal is held in high esteem by the community, the parents of the learners and the staff. The school has a reputation for producing maintaining high standards of discipline, good academic results and exemplary students.

(b) Risk results

The learners at school D are engaging in a wide range of risk behaviours. Alcohol use and drugs such as marijuana and club drugs seem to be most prevalent. At this stage, it appears more experimental than habitual. The engagement in these risk behaviours appear to occur more in the community in which they live than at the school. This indicates that the school is successful in curbing these behaviours but that the school needs to work with the home and community to help curtail these behaviours in the community. The high incidences of depression need to be explored further.

(c) Resilience results

The resilience results for this school seem very positive. There is a clear and positive relationship between total external assets (support at home, school, community and peers) and total internal assets (internal strengths). Therefore the outcomes for these learners are more likely to be positive than negative despite their engagement in risk behaviours. The scores for caring relationships and high expectations across all four support domains are higher than the average for all schools in the study. Meaningful participation is an area that could be improved. For school environment, learners are scoring below average for total external assets and caring relationships and above average for high expectations and meaningful participation. In terms of home environment, learners are scoring below average for total external assets and caring relationships and above average for high expectations and meaningful participation. These learners are also receiving above average support from their community. The scores for caring relationships, high expectations and meaningful participation are above average. While the high expectations from parents, school and community are positive, it can also place pressure on learners to perform and could partly explain the depression results. The score for meaningful participation in all three external assets was higher than the average for all schools indicating that these learners are more likely to have their voices heard and their opinions values that are positive. The results for peer support seem most promising. The total external assets score for this variable was highest for all schools.

The score for caring relationships amongst peers is exceptionally high. Herein may lie the answer to dealing with the depression concern. Peer counseling and support could be one answer for this school in terms of an intervention strategy. However, the score for high expectations amongst peers could be improved as this will help curb the engagement in risk behaviours. If peers were encouraged and supported to deter engagement in risk behaviours, the current results for risk behaviours could be reduced. For total internal assets, the score is exceptionally high, the second highest score in the group. This reflects a positive relationship between external assets and internal assets for this school. The area that has the highest score is goals and aspirations. The area that requires development is problem-solving. This school also has the highest score for school connectedness that reflects very positively on the school and their efforts in providing the best possible learning environment for their learners.

(d) Health promoting schools results

School D is one of the few schools  engaging in many positive health-promoting activities. School D indicated that they have the necessary policies and practices in place. Learners are provided with sufficient opportunities to acquire personal and social skills. The school is progressing well with regard to curriculum practice. The teacher indicated positive feelings about school organisation, ethos and environment. The learners are receiving adequate support at school. There is a need for parents to get more involved. The teacher also felt that the school could benefit from the health promoting schools concept.

(e) Recommendations

Despite the largely positive outcomes for this school, life skills education could be greatly improved as the learners do not seem to be deterred from experimenting with various risk behaviours. Greater emphasis could be placed on abuse of alcohol and various substances. Most importantly, however, is the need for interventions in terms of depression and suicide. While learners in this group seem more likely to feel depressed

and contemplate suicide than devise a plan and commit suicide, the very high rate of depression is of concern.

Although the learners at this school appear to receive adequate support from their home, school, community and peers, there are areas that could be improved upon. In terms of school and home environment, caring relationships between staff and learners and parents and their children could be enhanced. While the learners appear to have very good relationships with their peers, this needs to be extended to include learners deterring their peers from engaging in risk behaviours. Problem-solving is an area that also needs to be developed. This would assist learners to find creative ways to resist engaging in risk behaviours and to focus upon securing a bright future.

Health promoting activities already offered at school could be co-ordinated within a health promoting schools framework. With teachers tackling the various challenges presented above in a holistic way, the school will only experience greater success with their youth. The challenges mentioned earlier in terms of risk and resilience, would be best addressed within the HPS framework. Future interventions could be needs-based, once the challenges of risky behaviour, AOD abuse and depression and suicide are dealt with.

7.2.1.2 School F

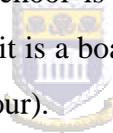
(a) Understanding the context

School F is situated in a rural area outside of Cape Town. This area is also part of the Cape Winelands. The production of top quality wines is a priority in this area. The community comprises of wealthy 'White' farmers, largely unskilled and impoverished 'Coloured' workers and to a lesser extent, poverty-stricken 'Black' seasonal workers. After ten years of democracy, racism is still rife in this community. All race groups are finding it hard to adjust to the new democratic South Africa. The school is situated in the heart of the town. It is occupied predominantly by 'White' learners. The school only

opened its doors to other races after democracy. There are many adjustment issues related to these new developments but the school is open-minded and flexible in its approach and tries very hard to accommodate the diverse needs of all its learners. The school also serves as a boarding school that results in specific challenges related to this type of schooling. The school has hostel accommodation, a swimming pool and vast, well-developed sports fields.

(b) Risk results

The main challenges for this school are alcohol use and sexual promiscuity. The school environment itself seems impenetrable when it comes to guns, violence and AOD use. This is largely as a result of the school being intolerant of these behaviours. The school is therefore a place of safety for the learners. There is however, reason to be concerned about the high levels of alcohol use amongst the youth. Two factors could be considered as reasons for this: the fact that the school is situated in the Cape Winelands which facilitates easy access and, the fact that it is a boarding school which brings challenges of boredom and loneliness (refer chapter four).



(c) Resilience results

Learners scored below average for total external assets. In terms of the RYDM, this is unusual as their overall engagement in risk factors is also low. Normally, youth who do not engage in risk behaviours, have very high levels of support at home, school, community and amongst peers. Learners scored below average for caring relationships and meaningful participation in general. The fact that the school is a boarding school and the community is very conservative could explain the poor results in terms of caring relationships. Learners experience high expectations but these are not supported in terms of caring relationships and meaningful participation. For school support, learners are scoring below average for total external assets, caring relationships, high expectations and meaningful participation. This could be ascribed to the strict nature of the school and its Afrikaner traditions that are patriarchal and authoritarian in nature. For home

environment, learners have scored above average for total external assets, reflecting positive support in this area. There is, however, a large discrepancy between high expectations and meaningful participation. Parents could therefore be demanding academic excellence without allowing children to engage in meaningful discussion with them. This would place a lot of pressure on the learners. In terms of community support, learners have scored above average for all areas. This means that they experience their community as being supportive of them. In terms of peer environment, learners scored above average for total external assets indicating positive support.

In terms of total internal assets, these learners scored above average. The score for goals and aspirations are higher than for most schools except school D. This again, reflects upon the pressure that learners would experience. Learners scored below average for school connectedness. In terms of the RYDM, if school support were increased, these learners could score higher for external assets and subsequently the results for internal assets could also be further improved and positive outcomes secured.



(d) Health promoting schools results

The guidance teacher indicated that the school has all the necessary health promoting policies and practices in place. The teacher indicated that she was satisfied with current curriculum practices at her school; that relevant mental health issues are being addressed. She felt satisfied that the learners are provided with opportunities to acquire personal and social skills. With regard to organization, ethos and environment, the teacher felt that she was satisfied with current practices. The teacher indicated that the area of partnerships and services could be improved, especially parental involvement.

(e) Recommendations

Priorities for intervention in terms of risk behaviours at this school would be alcohol abuse and sexuality education. Learners need not only knowledge, but also assistance with skills, values and attitudes in order to address these risk areas. Learners have stated

that often the life skills education that they receive do not address the issues that they need assistance with (refer chapters four and five).

Priorities for intervention in terms of building resilience include caring relationships and meaningful participation across the domains of family, school, community and peers. Caring relationships, high expectations and meaningful participation could be improved at school level. Parents could be more open to meaningful participation in the home. Caring relationships also need to be improved amongst the youth. In conjunction with the above recommendations, life skills education could assist with the further development of internal strengths. School connectedness is an area that requires much attention in order to build resilience amongst the youth at this school.

In order for the school to be developed into a health promoting school, there needs to be a co-ordination of existing health-promoting activities. Teachers could start with the areas that have been identified above as requiring urgent intervention and later address various needs as they are identified and prioritized.



7.2.1.3 School G

(a) Understanding the context

School G is situated in an urban context. The school is in the midst of a residential and commercial area. It is surrounded by institutions of note such as an internationally renown and prestigious university, state residences and numerous historical buildings. The school facilities and resources are extensive with a swimming pool, clubhouse, tennis courts and sports fields. This is a result of having been an advantaged education institution under the past regime. While the learner population is predominantly 'White', it has changed to reflect the regional population landscape and includes learners from all races. The school community comprises wealthy and powerful individuals. Parents have vast resources and are very involved with their children's education. The school is able to employ two thirds of extra staff with funds from the parents. School G has a proud

history of being an academically sound institution. The school is also well known for their achievements in sport and cultural activities. The principal is well known in the community and generates much respect from parents, community members and other stakeholders. Discipline is a priority at the school and the staff and principal are very strict with learners.

(b) Risk results

The risk results are consistent with adolescents from privileged backgrounds where the issues are not poverty-related but encompass broader social issues. Problems relate largely to alcohol and drug use and depression. The drug use is confined to marijuana and club drugs that are related more to social activities. This school seems impenetrable when it comes to drug-related or violent activity. The school offers a secure and safe space for learners. Engagement in risk behaviours is low for learners from this school when compared with other schools.



(c) Resilience results

These results appear to be incongruent with the Youth Development conceptual Model (refer chapter one) and with the profile of the school. Learners are scoring below average for total external assets despite scoring low for risk behaviours. The fact that they are not engaging extensively in risk behaviours is not necessarily related to the support that they are receiving across the four domains of family, home, school and peers. Furthermore, the score is low for total internal assets that is surprising considering the school's academic and sporting and cultural achievements. The three areas that could provide answers to this dilemma appear to be school connectedness, school support and peer support.

For total external assets, learners scored the highest of all schools for caring relationships but second lowest for high expectations. It seems that while caring relationships in general could be a deterrent in risk behaviour, the perception that they are not expected to

achieve much is impacting negatively upon their internal strengths. Learners scored above average for meaningful participation. This means that they do experience many opportunities to express their opinions. For school environment, learners scored below average for total external assets, caring relationships, high expectations and meaningful participation. There is clearly a need for improvement in all areas related to school support. For home environment, learners scored the highest of all schools for total external assets, caring relationships and meaningful participation. They therefore receive most of their support at home. For high expectations, however, learners scored below average. They do not appear to believe that the adults in their home trust that they can and will do well. In terms of community support, learners scored above average for all areas. Their community is therefore very supportive of them. In terms of high expectations, it seems that the community is more supportive in this regard than the school and the home. The results for peer environment are of grave concern. Learners scored lowest of all schools for total external assets indicating that this is not a positive source of support for them. Even though more than half of the learners scored high for caring relationships, only six percent scored high for high expectations: pro-social peers. Their peers will therefore not deter them from doing wrong or try to encourage them to do right.

For total internal assets, the learners scored below average for all areas except goals and aspirations. It seems that while personal goals and aspirations are high amongst these learners, there is not much support for them in terms of high expectations in the home or at school. This appears to be impacting heavily on scores for internal assets. For school connectedness, the score is second lowest for all schools indicating that this is the area where intervention will only yield very positive results in terms of internal assets.

(d) Health promoting schools results

The school is open to exploring the HPS concept as a means to improving the teaching and learning environment. While most components of the HPS concept are in place, the school could benefit from the HPS organizing framework. The teacher indicated that all

the necessary policies were in place. Most health practices were in place. Current curriculum practice could be improved. Most mental health areas were covered. The learners are provided with opportunities to acquire a variety of personal and social skills. The teacher indicated that he was satisfied with current practices related to school organization, ethos and environment. Partnerships and services could be improved but more in relation to support services than parental involvement.

(e) Recommendations

Two areas that could be prioritized for intervention in terms of risk behaviours are alcohol and drug use and depression. Priorities for intervention in terms of resilience are high expectations in general. At the level of the school environment, caring relationships, high expectations and meaningful participation need to be improved. Parents could be encouraged to raise their expectations of their children in terms of their abilities to succeed. Most importantly, learners need to be encouraged to expect exemplary behaviour from their peers.



For the development of this school into a HPS, current health promoting activities could be co-ordinated. The priorities identified above could serve as an entry point to encourage the staff of the school to adopt a common vision of addressing these challenges in a holistic way. Future interventions could be based upon identified need. Even though historically, the school has very positive academic and sporting and cultural results, they could possibly enhance the well-being of the learners by adopting a health promoting schools approach. The HPS approach advocates for a supportive learning environment where learners would feel that the adults in their environment believe in them and trust that they can do well. Learners would experience more caring, greater participation and peer relationships would be greatly enhanced resulting in even better outcomes for learners and for the school.

7.2.1.4 Discussion (ex-House of Assembly schools)

As a group there are certain key similarities and differences between the three schools. Similarities include being well-resourced, offering extensive facilities and activities, being well organized, well disciplined, offering safe learning environments, being impenetrable to violent and criminal activities, empowered and affluent parent bodies, well respected principals, supportive communities and sound academic results. Engagement in risk behaviours are low with the exception of school D where experimentation is high but intensity is still low. The risk behaviours to be addressed include alcohol and club drugs, depression and suicide and to a lesser extent, sexual promiscuity.

With regard to resilience results, the outcomes for these schools are positive as learners experience caring relationships at home and in their communities. Areas that could be improved varies from schools to school. For schools D and F meaningful participation could be improved, for school G high expectations could be improved. While all schools could improve in terms of caring relationships, meaningful participation and high expectations at school level, learners at school D scored highest for school connectedness. It is interesting to note learners at school D also scored high for internal assets indicating a possible link between school connectedness and internal assets. Learners at school G scored very low for school connectedness and also low for internal assets. Furthermore, the high engagement in risk behaviours as witnessed at school D could relate to the fact that many of the learners come from different communities where engagement in risk behaviours is high. Yet, it seems that the school serves as a safe haven for these learners by providing the necessary resources, structures, policies and discipline to counter the effects of exposure to risk behaviours in their respective communities.

All schools could benefit from the health promoting schools framework as it would help to create the supportive, caring and democratic ethos and environment at schools that learners require, focus the life skills programme to address the needs that have been prioritized, strengthen the relationship between the school and its community, ensure that

policies are in place to address the needs that have been identified and enlist the support of education support services to strengthen the initiatives that are already in place at the schools.

Although the aforementioned schools are well resourced and seem to be functioning fairly well in terms of meeting the academic needs of these learners, it is interesting to note that these learners still require help with risk behaviours, do not have optimal results when it comes to internal strengths necessary for resilience and do not seem to experience optimal caring relationships, high expectations and meaningful participation at school level. The health promoting schools approach could very well turn this around and provide the optimal environment at school level to secure their well-being.

7.2.2 Group Two (ex-House of Representatives schools)

7.2.2.1 School E



(a) Understanding the context

School E is situated in a rural area outside of Cape Town. This area forms part of the Cape wine lands, well known for its production of award winning wines. It is a largely Afrikaans-speaking community. The area has a history of alcohol abuse as a result of its situation in the wine lands and the resultant easy access to alcohol. Families are mostly of working class status. The learners are mostly 'Coloured'. Class sizes average at 35 learners per class. The building is a modern, enclosed school building. The school has modern facilities, ample classrooms, an indoor arena and adequate sports fields. There is a positive relationship between the school and the community. The staff are dedicated to their task as educators. The principal is warm, nurturing and supportive.

(b) Risk results

Alcoholism, drug use and sexual promiscuity feature most strongly amongst these learners. This could be attributed to the area in which the school is situated and the history of the community. There seems to be some engagement in violence-related behaviours in the community as a result of this. This is not extended to the school however. Substance use and violence are not experienced at this school. This school is therefore also a place of safety for the learners. Learners appear to be engaging in sexual activities at a young age and are not protecting themselves against pregnancy, STDs and HIV/AIDS.

(c) Resilience results

The resilience results for this school seem very promising. Total external asset score is very positive. Learners experience strong support in terms of caring relationships and high expectations. Meaningful participation could be improved. For school environment, this school received the highest score for total external assets. Learners experience caring relationships and high expectations from their teachers. This is very positive for the school as it reflects well on their relationships with their learners. The area at school that needs improvement is meaningful participation. Improving this area could serve to strengthen relationships even further. For home environment, learners have also scored high in terms of total external assets. A closer look at these results reveal that caring relationships in terms of adults in the home could be improved. The adults have high expectations of the learners but do not engage in meaningful participation. For community environment, total external assets score is higher than the average for the groups of schools. The community is supportive but does not engage in meaningful participation. The results for peer support are also very positive. The scores for caring relationships and high expectations are high. This augurs well for positive outcomes for the learners at this school.

The total internal assets score for this school is high in relation to the other schools. There is clearly a positive relationship between the external and internal assets for learners at this school. Goals and aspirations is an area that is well developed. Problem-solving is an area that requires attention. This school also has the second highest score for school connectedness.

(d) Health promoting schools results

School E has some familiarity with the HPS concept and is open to exploring the concept further. Most policies and practices related to health are in place. Approximately half of the current practices related to curriculum teaching and learning are in place. Less than half of the areas related to mental health are adequately covered by the curriculum. Two areas, stress management and developing and maintaining social relationships, could be improved in personal and social skills. While there is room for improvement, the school is progressing adequately in terms of school organization, ethos and environment. The area of partnerships and service could be greatly improved. This includes parental involvement and support services. Procedures for referrals could also be improved.

(e) Recommendations

Priorities for intervention in terms of risk for these learners are alcohol and drug use and sexuality and HIV/AIDS education. Priorities for intervention in terms of resilience would be meaningful participation at home and at school. Caring relationships could be further improved in terms of the home environment. This could help to reduce engagement in risk behaviours even further. In terms of internal assets, problem-solving needs to be developed. This asset will also help reduce engagement in risk behaviours as learners acquire the skills to be assertive and make better judgements.

With regard to the health promoting schools framework, priorities for intervention could involve the co-ordination of health promoting activities already offered. The areas prioritized for intervention could serve as a catalyst for the development of the school as

a health promoting school. The staff seems willing and able to embark on this process. The results for this school indicate that the staff already have a holistic approach towards the academic development of their learners and their personal well-being.

7.2.2.2 School H

(a) Understanding the context

School H has a very interesting history as it is a previously disadvantaged school situated in a previously advantaged area. The learner population comprises mostly of 'Coloured' learners and some 'Black African' learners. The learners do not live in the area surrounding the school but are transported from surrounding areas. There are various levels of poverty and resultant AOD abuse, crime and violence in the areas in which the learners live. The parents of these learners are mostly working class and some could be classified as middle-class. The school has a proud history of sound academic achievements and sound discipline. The staff are dedicated and committed to ensuring the best possible outcomes for their learners despite their lack of resources. The school does not have a swimming pool and the sports fields could be upgraded. Some of the classrooms comprise prefabricated materials, which means that the classrooms are very hot in summer and very cold in winter. The staff experience great difficulty in terms of parental support as the parents do not live in the area surrounding the school. The community surrounding the school are also apathetic as they do not have children or grandchildren who attend the school. The principal and staff overextend themselves to ensure that they acquire the resources to create the best possible environment for the learners but it is a constant battle for them.

(b) Risk results

These learners are engaging with intensity in a wide range of risk behaviours. This seems to be as a result of the communities in which they live which are fairly impoverished. The school offers some refuge in terms of these activities as crime and violence and AOD use

is curtailed at school. The learners engage in violence-related behaviours. This seems to be related more to their community than their school. It seems that the school is not tolerant of drugs on school premises or crime and violence at school. The discipline at school seems to offer some form of protection from risk behaviours.

(c) Resilience results

The learners have the lowest score for total external assets. While the score for caring relationships is above average, the scores for high expectations and meaningful participation are weak. In fact the number of learners scoring high for these assets are the lowest for the group of schools in the study. School connectedness, school support, family support, community support and peer support are all in need of intervention. For school environment, the scores are below average for total external assets as well as caring relationships, high expectations and meaningful participation. The scores are the weakest for the group of seven schools. For home environment, total external assets are fair in relation to the group. The score for caring relationships is very high, the second highest for the group. High expectations is poorest for the group but meaningful participation is slightly above average. Learners therefore receive some care in their home environment but need to experience high expectations as well. For community environment, total external assets seem to be fair but a closer look at the various areas reveals that the scores for caring relationships, high expectations and meaningful participation are below average for the group. Meaningful participation is lowest for the group indicating that learners do not have much control or power over their environment. The results for peer environment are also very weak. For total external assets, they score second lowest for the group. For high expectations, they score the lowest for the group. These learners are therefore most vulnerable to risk behaviours in the peer environment as they are least likely to be discouraged from engaging in high risk behaviours. Half of the learners scored high for caring relationships amongst peers. This asset should therefore be utilized in a positive way to improve high expectations and overall peer environment.

For total internal assets, the score for is above average. The high score for caring relationships seem to have a positive influence on internal assets. Areas that could be improved are co-operation and communication, self-efficacy, empathy and self-awareness. Improvements relating to high expectations and meaningful participation could enhance these results. For school connectedness, this school has the lowest score. Enhancement in this regard could greatly influence the results for internal assets and secure better outcomes for these learners.

(d) Health promoting schools results

There are many levels at which intervention needs to occur such as school ethos and environment, policy, life skills education, community support and intersectoral collaboration. The teacher indicated that there were no health policies in place. About half of the health practice areas listed were adequately covered by the school though. The teacher felt satisfied with only three areas in terms of curriculum practice but reported that eight areas related to mental health are covered satisfactorily. The teacher felt that there are sufficient opportunities for students to acquire personal and social skills. Assistance is required for this area of curriculum teaching and learning though. While satisfactory, there is room for improvement with regard to learner support, school organisation, ethos and environment. Parental involvement and community support is lacking.

(e) Recommendations

Priorities for intervention with regard to risk for these learners include life skills education in general, with a focus on alcohol and drug use and violence and safety issues. Priorities for intervention in terms of resilience would be high expectations and meaningful participation across home, school and community domains. With regard to the school and community environment, caring relationships, high expectations and meaningful participation needs to be improved. With regard to the peer environment,

high expectations could be greatly improved, where peers discourage one another from making the wrong choices and encourage pro-social behaviour.

Because of the difficulties that have been revealed by the research, this school would benefit from a whole school development approach to developing the school as a health promoting school. The staff as a whole would need to commit to the vision and principles of becoming a health promoting school. All areas relating to policy, ethos and environment, life skills education, school and community partnerships and intersectoral collaboration would need to be examined and interventions developed to strengthen these respective areas.

7.2.2.3 Discussion (ex-House of Representatives schools)

Both schools E and H belonged to the same education department (pre-1994), have minimal resources, have predominantly 'Coloured' learners, have parents who are mostly working class, have learners who have problems with AOD abuse and violence and safety, belong to communities where there is much engagement in risk behaviours, have schools that do not tolerate risk behaviours of any kind on the school premises. There are however, critical differences between these two schools. Learners at school H are engaging in risk behaviours with greater intensity, belong to communities where a wider range of risk behaviours are encountered, have less support at home, in their community and at school. The result is that learners at school E fare better in terms of internal assets. What is demonstrated here is that despite a legacy of disadvantage, positive support at school level can turn things around for learners and develop internal strengths that secure positive outcomes. Furthermore, a combination of lack of support at school, home and in the community for learners at school H has very negative effects on internal assets and could result in uncertain outcomes for learners. While school E could become a health promoting schools by extending existing programmes, policies, relationships, ethos and so forth, school H would require more extensive work in terms of an overhaul of existing policies, relationships ethos and so forth.

7.2.3 Group Three (ex-Department of Education and Training schools)

7.2.3.1 School C

(a) Understanding the context

School C is situated in Phillippi East in the Western Cape. The community is largely Xhosa-speaking and learners are mostly of the 'Black' population. The area is filled with low cost housing. Some families in the area qualify for a state subsidy and are able to build very basic shelters made of cement blocks for their families. Most of the dwellings are insufficient for the needs of the families and often have adjoining wooden and iron structures that serve as extra bedrooms or living space. Those who do not qualify for the subsidy tend to erect informal dwellings made of wood, iron or plastic on vacant land. There is much tension between community members who qualify for housing and those who don't and many issues related to illegal occupancy of homes built for others. Unemployment and poverty is high with resultant crime and violence. Abuse and violence against women and children is rife. There are also high rates of HIV and AIDS.

The school stands out in stark contrast to its environment. It is part of a very modern building. There are large classrooms, huge hallways, indoor sports facilities and a hall. The building is most inappropriate for a school as it was designed for another purpose. It is comprised mostly of steel and glass and is fairly new. Every sound echoes through the building. The wind howls and swirls around the building on a windy day. There is constant dust and sand in the building. The ventilation and lighting is poor. There is constant noise in the school. At first teachers had to accommodate up to 100 learners in their classrooms due to the shortage of schools. Most learners live outside of the area in which the school is situated. Most do not live with their parents. Many were sent to Cape Town to secure an education and live with relatives or even on their own. Most learners are bussed in to school daily from surrounding areas such as Khayelitsha. The learners are however, very happy to be at their school. They say it offers them respite from the communities in which they live. The crime and violence in the areas in which they live

(Khayelitsha) are exceptionally high. Learners come from areas where there is no formal housing, electricity or water. The school seems to serve as a refuge to them.

(b) Risk results

The risk results from school C are consistent with the activities in the communities in which they live. Drug use, alcohol use, crime, violence and safety are most prominent. Intensity in engagement is also high at school C. Furthermore, it seems that learners are able to engage in risk and violent behaviour at school. Drugs are freely available in the community. Drugs are also available at school. The carrying of guns and violence also occurs in the community and at school. The frequency and intensity of depression and suicide is highest at school C. This could be as a result of pressure at home, in the community and at school. Learners at this school are also being coerced into sexual activity, engaging in sex while under the influence of alcohol or drugs, having sex with more than one partner within a short period of time and do not think that having a baby is a bad idea. Parents appear not to be interested in talking about HIV/AIDS and birth control.



(c) Resilience results

The resilience results are positive. Total external assets are exceptionally high for these learners. Their experiences of caring relationships, high expectations and meaningful participation are quite positive. It is generally higher than the average for all schools. Most promising are the results for school support. The results confirm that the school is perceived in a positive way when compared with other schools. This confirms the role that the school can play in terms of being a home and a refuge for these learners. In terms of home environment, there could be more improvement in terms of caring relationships, high expectations and especially meaningful participation as the scores are generally lower than the average. This could somehow be related to the fact that they do not live with their parents but with caregivers or on their own. For community environment scores are also lower than average for caring relationships and high

expectations but slightly improved for meaningful participation. This could be due to cultural influences where learners are able to engage with members of the community in which they live. At the same time, the break down of traditions as a result of urbanization could be influencing the low scores for caring relationships and high expectations. Results for peer environment are very promising when one looks at total external assets. While caring relationships could be improved, high expectations are very positive. This implies that learners may not be as close as they could in terms of caring for each other but they are able to discourage each other from wrongdoing. To curb the high levels of violence and abuse or bullying and harassment, caring relationships should be restored.

For internal assets, these learners score low in relation to other schools. It seems that much work needs to be done in this area. There is much hope in the results for school connectedness. Most of the hope to improve the results for internal assets lay with the school and with the school connecting with the families and communities to provide support for these learners. The teachers and the school are evidently held in high esteem by the learners and communities.



(d) Health promoting schools results

The health promoting schools results provide an understanding of the high score for external assets. The guidance teacher could hold the key to the results. Her positive attitude and approach to the learners and to developing the school as a health promoting environment could explain the high results for school support and total external assets. This is despite the fact that the teacher indicated that there are no health policies in place at her school. School health practices seem to occur satisfactorily though. The teacher indicated that much work needed to be done with regard to curriculum practice. Most areas related to mental health were covered though. Learners are provided with sufficient opportunities to acquire personal and social skills. The teacher indicated that much work needed to be done in the area of school organisation, ethos and environment. The teacher felt that only half of their needs were being met in terms of partnerships and services. While referral procedures are adequate, there is room for improvement.

(e) Recommendations

Priorities for intervention in terms of risk for school C include violence and safety issues, depression and suicide, sexuality and HIV/AIDS and alcohol or drug use. Priorities for intervention in terms of resilience include caring relationships, high expectations, meaningful participation in the home environment; caring relationships and high expectations in the community environment; caring relationships in the peer environment; and, all internal assets. Priorities for intervention for the development of the school into a health promoting school involve strengthening the positive effects of the school. A whole school development approach with the entire staff involved in developing relevant policies, a healthy and supportive ethos and environment, providing life skills education, encouraging school and community partnerships and facilitating intersectoral collaboration will serve to strengthen the positive experience of the school for the learners.



7.2.3.2 School I

(a) Understanding the context

Of all the schools involved in the study, the context for school I is the harshest. The school is situated in an industrial area. It is surrounded by informal homes that are built on the boundary of the school and some residents have even incorporated the school fence in building their shelter. There are a few brick homes scattered nearby. Not all some dwellings have water and electricity. Unemployment is rife. The community is characterized by poverty, abuse, crime and violence. The community is characterized by stress and tension as a result of unemployment, overcrowding and displacement.

The school buildings are inappropriate for the needs of high school learners. Classrooms are overcrowded. There are no sports fields at all. The school has to request permission from other schools to utilize their fields if they wish to play sport. Recreational space for learners is virtually non-existent. There are no computer facilities for learners. The library

is under-resourced. There are no labs for science. Teaching at this school is a challenge as a result of the lack of resources and the immense need amongst learners. The parents and community are not involved in the school and there is very little communication between the two parties bar the formal meetings that occur.

(b) Risk results

The learners are exposed to various risk-related activities in the community. These activities are impacting upon the school. The school does not offer much protection against risk behaviours from outside. The crime and violence that is experienced in the community is spilling over into the school. The learners are exposed to risk behaviours in both settings. The learners are engaging in risk behaviours with greater intensity than at the other schools in the study. Hard core drugs (cocaine and heroin) are more prevalent in this community than in others. Drugs, guns and violence are experienced in the community and at school. Frequency and intensity of depression and suicide is higher than at all other schools, bar school C. Learners are being coerced into sexual activity, engaging while under the influence of alcohol or drugs, having sex with more than one partners within a short space of time, are not using condoms and do not think that having a baby is a bad idea.

(c) Resilience results

For total external assets, these learners have the second lowest score. With regard to caring relationships, the score is the lowest for the group of schools. The result for high expectations is positive as it is slightly above average as is the results for meaningful participation. The greatest gap in terms of support for these learners is therefore the area of caring relationships. For school environment, the results are quite positive. This school has the highest score for total external assets. The scores for caring relationships, high expectations and meaningful participation are all above average in relation to the average score for all schools. The school is therefore clearly a beacon of hope for these learners. In terms of community environment, the total external assets score is the lowest

for the group. The scores for caring relationships, high expectation and meaningful participation are all below the average for the group. This reflects the poor support for the learners from their community. For peer support, half of the learners scored high. A closer examination of this asset reveals that caring relationships could be improved as this score is below average. While the score for high expectations is below fifty percent, it is above average for the group. This means that while learners do experience that their peers will try to dissuade them from engaging in risk behaviours, this still needs to be enhanced in order to assist young people to make the right choices.

For internal assets, this school seems to have fared very poorly. The score for total internal assets is the lowest for the group. The learners have scored below average for all areas. This is not surprising considering the lack of support in the home and community in terms of caring relationships, high expectations and meaningful participation. In terms of school connectedness, the score is more positive than negative. It seems that the education experience may be positive but the problems of the community impact upon the school. These results indicate that the school does offer some hope for learners. The Youth Development Conceptual Model holds true for this school with regard to the relationship between high risk behaviours, low external assets and low internal assets. The poor external supports results in poor internal strengths that translate into high engagement in risk behaviours.

(d) Health promoting schools results

The teacher indicated that school I only has one health policy in place. Only three out of eight health practices occurred at their school. The teacher indicated that he was satisfied with only three out of nine curriculum practice areas at his school. Only four out of thirteen mental health areas were covered. The teacher indicated that he was only satisfied with the opportunities for their students to acquire one personal and social skill, namely, help-seeking. He was also largely dissatisfied with current practices related to school organization, ethos and environment. The teacher also indicated that partnerships

and services were lacking at their school. Less than half of the referral procedures were in place at his school.

(e) Recommendations

Priorities for intervention in terms of risk include life skills education, violence and safety, depression and suicide, sexuality and HIV/AIDS and alcohol and drug use. Priorities for intervention in terms of resilience include caring relationships across all four domains of school, home, community and peers; caring relationships, high expectations and meaningful participation in the community environment; and caring relationships and high expectations amongst peers. Developing the school into a health promoting school could involve adopting a whole school development approach. The school needs to develop a health promoting vision for the school that addresses the concerns raised above. Policies, ethos and environment, life skills education, school and community partnerships and intersectoral collaboration all need to be developed and supported. This will entail commitment from the staff and education support services. While financial resources are not required, much human resources will be required to improve the outcomes for the youth of this school.

7.2.3.3. Discussion (ex-Department of Education and Training schools)

The legacy of apartheid is clearly evident in the results for these two schools. There are the results of poverty, which is reflected, in the high rates of crime and violence in these communities. There is the complete lack of resources evident in the inappropriate school buildings and learning environment of these learners. These learners have to deal with risk behaviours in their communities as well as at their schools. Learners at school C are attempting to escape the crime and violence of the communities by traveling to a school outside of their area. Learners at school I do not have this option. What is interesting is that the learners at both these schools scored higher for total external assets in their school environment than the learners at the other schools. These learners therefore have positive views of their schools, their teachers and their education. Herein may lay the

answer to the concerns for these youth. Despite the high exposure to risk in their communities and school environments, the schools can turn things around for these youth. By providing a safe and protective learning environment, internal strengths can be enhanced and positive outcomes secured. The health promoting schools framework is very helpful in this regard but it is an intervention that will require much effort and commitment from all stakeholders.

7.3 CONCLUSIONS

Examining the schools as case studies and placing them in categories or groups according to past resource allocation has yielded some interesting results. Schools that were privileged in the past appear to have learners that engage minimally in risk behaviours. These learners generally receive positive support at home and in their communities. School support is not rated as highly by the learners though. Schools that have received fewer resources in the past appear to have learners that engage extensively in a wide range of risk behaviours. These learners receive average support from their homes and communities. School support is positive for one school and negative for the other. Schools that were harshly discriminated against by past laws appear to have learners that engage extensively and with greater intensity and severity in risk behaviours. These learners receive very little support from their homes and communities, but school support is rated more highly for these schools than for the other schools though.

The impact of support received at home, school, community and amongst peers upon internal strengths varies from school to school. School connectedness also varies from school to school. While some schools could merely co-ordinate activities and structures to this end, other schools would need to set up new structures where little or none exists.

In each of the three groups, there is a school where the learners seem to have greater chances of reaching successful outcomes despite the many challenges facing them. In group One it is school D, in group Two it is school E and in group Three, it is school C. The critical difference for these schools seem to be that they receive greater support at school level than the other schools in the group. Their scores for school support and

school connectedness are higher and subsequently, the scores for total internal assets are higher. According to the Youth Development Conceptual Model, this tends to auger well for success for these learners. These conclusions are based on results for the resilience profiles (see Appendix VII) as well as the questionnaires and interviews. These results further support the contention of many studies into resilience that schools can make a difference. It also further supports the contention of this research that the development of health promoting schools is a key to fostering resilience and securing success amongst South African learners.

What is becoming evident from the research findings is that our schools need a broad vision and strategy plan for fostering resilience amongst our youth combined with a school-specific plan developed by schools themselves. This should be based on research results demonstrating risk and resilience profiles of their specific learners. This broad vision should be geared towards securing the well-being of all our youth as the research has shown that all young people need support even though the life skills area to be addressed could differ from school to school. At the same time, the operational strategy derived from the vision should be cognizant of the inequities of the past and how it still influences the present and aim to address these inequities. Interventions should be school-based as the school setting is still regarded as most effective for promotion, prevention and intervention activities geared towards securing the well-being of young people. The health promoting schools strategy offers an effective strategy to dealing with challenges that young people and schools face today. The Youth Development Conceptual Model provides the principles for fostering resilience and the hope that adverse circumstances and obstacles to success can be overcome.

This chapter has sought to group schools to examine similarities and difference amongst schools in order to inform intervention strategies that are not necessarily program-based but process-oriented. The following chapter will serve to revisit the literature to further discuss the findings of this research.

CHAPTER EIGHT

SYNOPSIS AND DISCUSSION

8.1 INTRODUCTION

The aim of this chapter is to discuss the research findings in relation to the theoretical framework and literature review presented in chapter two. This chapter revisits systems thinking, risk, resilience and the health promoting schools concept. It reflects upon the aims of the research, which was to determine the mental health needs of youth, their strengths, support systems and the health promoting schools concept as a strategy for well-being. The discussion begins with an understanding of the findings in terms of the theoretical framework. An attempt is then made to examine the implications for intervention and change.

8.2 REVISITING THE THEORETICAL FRAMEWORK



The findings of this study are contextualised according to systems thinking. The aim is to arrive at a better understanding of the findings by looking at the whole picture and not to view the findings as isolated phenomena but rather to see them in relation to other issues, events and forces (Moloi, 2002). Systems thinking enables one to understand the history and context that influence the manifestations of risk behaviour and that influence the resilience results. At the same time, systems thinking reminds us of the dynamic nature of behaviour. It points out that individuals are not just passive recipients of environmental influences but that they have the ability to influence events as well; that just as negative political and social events can impact negatively upon individuals, positive interventions can also impact positively to change deleterious effects. As such, viewing the findings according to systems thinking presents us with possibilities for transformation and change.

The theoretical foundation for this research has been systems thinking in general and Urie Bronfenbrenner's eco-systemic framework in particular. As stated in chapter two, systems thinking essentially endorses the principles that mental health and well-being cannot be extricated from social and cultural variables; that good mental health is not solely the responsibility of the individual but also the responsibility of the society in which the individual finds him/herself. Eco-systemic theory endorses the World Health Organisation's (2004b) view that a climate that respects and protects basic civil, political, economic, social and cultural rights is fundamental to the promotion of mental health; that we can no longer see only the manifestations of poor mental health and ascribe them to individual factors. Furthermore, once we recognize that society has a large role to play in the manifestations of individual and collective ill health, then we need to advocate for large-scale societal changes beginning with how we understand ill health to how we deliver services.

The research findings of this study show that active engagement in risk behaviours and resultant mental health problems are particularly concentrated amongst learners at schools in areas where poverty, overcrowding and unemployment are rife. Recent South African studies have confirmed that poverty plays an important role in failure to attend school which in turn places young people at risk for engaging in crime and violence (Liang, Flisher & Chalton, 2002). There also seems to be an interesting correlation between the degree of engagement in risk behaviours and the extent to which those learners belong to communities who were oppressed in the past. For example, learners at schools C and I, who belong to communities where political oppression was most rife in the past and where poverty is still rife at present, appear to be engaging in risk behaviours with greater intensity than learners at other schools. Learners at schools H, E and D belong to communities where oppression occurred, though to a lesser extent, and their engagement in risk behaviours is also evident though perhaps less intense. Learners at schools F and G belong to communities that did not experience oppression. These learners seem to have many of their needs met and generally engage with less intensity in risk behaviours.

The findings therefore confirm the view of the Department of Health (1997) that whilst the manifestations of mental illness in South Africa are no different from those found in other countries, what is significant about South Africa is the fact that the citizens most at risk are those belonging to communities that have endured state neglect and abuse for decades. These communities experience great difficulty in accessing appropriate health care and services. This is confirmed by a South African study that reported contraceptive non-use amongst adolescents to be associated with being from DET schools. Possible explanations include socio-economic and cultural factors, a higher probability that students had recently migrated into an urban area, lesser access to health services and lesser exposure to health promotion efforts (Flisher & Chalton, 2001a).

Kirmayer, Brass and Tait (2000) point out that cultural discontinuity, which is related to urbanization, has been linked to high rates of depression, alcoholism, suicide and violence in many communities, with the most profound impact on youth. Recent studies in Cape Town have pointed out that rapid urbanization is frequently accompanied by housing difficulties, crime, poverty, unemployment, and separation from extended families, which in turn may lead to substance use (Flisher, Parry, Evans, Muller & Lombard, 2003). Flisher and Chalton (2001a) also found a relationship between urbanization and certain risk behaviours such as use of alcohol, cannabis, cannabis mixed with Mandrax, being a victim of violence, perpetration of an act of violence and suicidality. The authors concluded that urbanization is associated with an increase in the prevalence rates of some risk behaviours.

The learners at schools C and I belong to communities that have experienced oppression and displacement, who are forced to live informally, whose cultural values and principles appear to have been damaged by urbanization and Apartheid. These communities do as a result, reflect high levels of alcohol and drug abuse, crime and violence and show high rates of depression and suicide. Flisher et al (2000) raise the likelihood of multiple risk behaviours in children and adolescents with inadequate resources, stressors, functional impairment or psychopathology. There is therefore a significant relationship and interplay between various risk behaviours, lack of resources, stressors, impairment or

psychopathology. This explains why the learners from impoverished communities in this study are engaging in a wide range of risk behaviours at any given time.

Current research has demonstrated a statistically significant association between suicidal ideation or attempt and stressful life events, poor family environment, parental psychiatric history, low parental monitoring, low instrumental and social competence, sexual activity, marijuana use, recent drunkenness, current smoking and physical fighting (King, Schwab-stone, Flisher, Greenwald, Kramer, Goodman, Lahey, Shaffer & Gould, 2001).

The findings of this study are also consistent with research that has confirmed that South Africa has high levels of violence, and that exposure to violence has serious implications for mental health. Recent research (Ward, Flisher, Zissis, Muller & Lombard, 2001) has found that the levels of violence in children's homes and communities are far too high and many children are already suffering the effects of exposure to violence. Exposure to one type of violence also puts children at risk for exposure to another type. An additional finding is that much of children's exposure to violence appears to be community violence as opposed to family or school violence. The learners at schools C and I and to a lesser extent, D, E and H are clearly exposed to community violence, which impacts upon their well-being.

The high risk results for schools C and I should therefore be seen in the light of these community contexts. What is being manifested as signs of ill mental health could be largely as a result of 400 years of colonization, including Apartheid (Lazarus, 2004). We need to recognize the role of historical trauma in the high substance abuse, sexual abuse and violence figures reflected for schools C and I and, as advocated by Lazarus (2004), invest in the healing of the trauma that has occurred. There is also a need to develop cross-cultural and multi-national programmes that address the underlying conditions such as poverty, gender inequality and male social dominance (King, Flisher, Noubary, Reece, Marais & Lombard, 2004).

These findings suggest that mental health is the product of biological, psychological and social environments (both past and present), healthcare and lifestyle as espoused by Brown (2001). The World Health Organisation (2004b) is in agreement with this view and states that the risk of mental illness is associated with indicators of poverty, including low levels of education and poor housing and low income. The individuals engaging in risk behaviour should therefore be seen in context, as a result of the environment in which they live and the pressures brought to bear by that environment. This would explain the high prevalence of risk behaviour in schools C, I, D, H and E, with greater intensity in schools C and I and low prevalence of risk behaviour in schools F and G. Schools F and G are situated in communities that have always had resources and where exposure to risk is therefore minimal. It stands to reason therefore that health does not just mean the physical well-being of the individual but refers to the social, emotional and cultural well-being of the whole community (Brown, 2001).

The findings of this research provide impetus for the concern raised in chapter two that while great progress has been made in most areas related to youth development, greater attention has to be paid to meeting the mental health needs of youth in order to prevent the undermining of good attempts aimed at developing a truly democratic society in which the youth could play an active and positive role. The seriousness of this situation of youth placed at risk is highlighted in the next subsection.

8.3 REVISITING ISSUES OF RISK

From the findings of this study, it is evident that the young people who participated in the survey are engaging in a wide array of risk behaviours. Challenges that are common to all schools are alcohol and drug abuse, bullying and harassment, and depression and suicide that speaks to the need for mental health intervention at all schools and with all learners. These findings are consistent with areas of concern identified by young people in other studies, namely, violence, bullying and coping with stress and anxiety (EPPI, 2001).

Recent surveys (MRC, 2003; DACST, 1998) in South Africa have confirmed high levels of alcohol misuse among high school students, with alcohol being the most common substance of abuse and cannabis (marijuana) the most frequently reported illicit drug of abuse among adolescents. The MRC study (2003) revealed that amongst South African youth in general, alcohol consumption and drug consumption have reached alarming proportions. In this study, challenges that seem to be particular to more affluent schools are alcohol and drug abuse. Alcoholism and drugs, particularly marijuana and club drugs seem to dominate at schools D, E, F and G. This is consistent with recent South African studies that have shown that the risk of being drunk is associated with being White and with being exposed to public drunkenness on a daily or at least weekly basis (Parry, Morojele, Saban & Flisher, 2004).

A recent local study revealed that cannabis smoked together with methaqualone is the second most common primary drug of abuse in Cape Town. Cocaine and heroin are emerging as problem drugs of abuse among adolescents in large metropolitan centers while ecstasy use occurs mainly among adolescents who attend rave parties and clubs (Parry, Myers, Morojele, Flisher, Bhana, Donson & Pludderman, 2003). According to this study, hard core drugs (cocaine, heroin, etc) seem to be more prevalent in the communities and at schools C and I. Furthermore, recent studies have shown that the profile of drug use among South African adolescents, especially in large metropolitan centers in many ways mirrors that found globally among adolescents. This in turn reflects an expansion of global drug markets to developing countries such as South Africa (Parry et al, 2004). According to Parry et al (2004), multiple indicators have pointed to both the expansion of adolescent drug markets and various negative consequences associated with adolescent AOD use. It is noted therefore that the transition to a new democracy also impacts upon risk behaviours as access to world markets and free travel leads to drugs becoming readily available.

The abuse of substances has negative implications for the health and well-being of individuals, which include injury and death from interpersonal violence, motor vehicle accidents, drownings, increased probability of engaging in high risk sexual behaviours,

suicidal ideation and behaviour, conduct and mood disorders, academic difficulties, absenteeism, truancy and school drop-out (Parry et al, 2003). This confirms the potential that substance abuse by young South Africans has to burden the health, social welfare and criminal justice systems of the country.

Issues of violence and safety come to the fore very strongly for learners from schools C and I in this study. These issues of violence and safety are confirmed by the MRC Report (2003). Drugs, guns and violence seem to occur not only in communities but also on school premises at schools C and I. It also seems easier to engage in risk behaviour and violent behaviour at these schools as there seems to be a lack of discipline at these schools and/or policies that speak to risk behaviours. Learners at schools E, F and H are less at risk as these schools also seem to be less tolerant of these behaviours. These activities are virtually non-existent at schools D and G. Learners at schools D and G seem to be unaffected when it comes to violent activity. It seems therefore that learners at schools D, E, F, G and H are offered some form of protection from various risk behaviours as their schools are places of safety where risk behaviours are not tolerated.



Tobacco use is especially prevalent amongst learners at schools H, D and E. These learners are largely from communities that were previously disadvantaged and that were known as 'Coloured' communities. Recent research has pointed out that youth smoking behaviour may be affected by anti-social adult behaviour, subjective adult norms and community affirmation (King, Flisher, Mallett, Graham, Lombard, Rawson, Morojele & Muller (2003). Smoking is particularly rife within 'Coloured' communities. This has been confirmed by the MRC Report (2003). Furthermore, recent studies in Cape Town have shown that not being raised by both parents was associated with cigarette and alcohol use by 'Coloured' students and with cannabis use by females (Flisher, Parry, Evans, Muller & Lombard, 2003). Among the explanations offered for the relationship between substance use and not being raised by both parents are that families with one biological parent are more likely to be characterized by circumstances which in turn are associated with substance use, such as economic hardship, increased residential mobility and psychological stress (Flisher et al, 2003).

The results of this research also confirm the steady increase in depression and the number of incidences of attempted suicide and actual suicide-related deaths amongst young people as reported by Kerfoot (2000); Flisher et al (1993) and the MRC Report (2003). While depression and suicide is common to learners at all schools, frequency and intensity is higher at schools D, C and I and highest at school C. Learners at schools C and I experience pressure from their communities as well as at their schools. The high pressure of coping with poverty and violence in their communities combined with the pressure of coping at school could explain the high prevalence of depression and suicide and frequency and intensity of suicide attempts at these two schools. The anomaly that occurs with school D (very high prevalence of depression) could be as a result of the fact that while the school is considered affluent, many learners who attend that school are from impoverished communities where poverty and violence is experienced. These results also confirm the WHO (1999a) prediction that depression is likely to be the mental health illness that will dominate the field by the year 2020. Furthermore, recent studies in South Africa have indicated that depression and low self esteem in the family context are independently associated with suicide ideation and attempts (Wild, Flisher and Lombard, 2004).



The results of this study are also fairly consistent with the MRC results (2003) for sexuality. Module F of this study reveals that an average of thirty percent of young people involved in the study are sexually active. Schools most affected are schools E, F, C and I. Many learners are not using condoms. Many are being coerced into sexual activity, engaging while under the influence of alcohol or drugs, having sex with more than one partner within a short period of time and do not think that having a baby is a bad idea. Learners at schools C and I are most at risk for sexual violence. Many of these learners have had intercourse before age 11, have been forced into sexual intercourse and have had multiple partners as evidenced by the findings. Recent South African research (King, Flisher, Noubary, Reece, Marais & Lombard, 2004), has pointed out that rape is the most frequently reported crime against South African children; that a study in 1995 revealed that more than 50% of teenagers in impoverished in Cape Town had been coerced into having sex. King et al (2004) warn that the high prevalence of coercive sex

amongst adolescents also has significant implications for the HIV/AIDS epidemic in South Africa. Sexual assault increases the risk for HIV-transmission, since trauma and concomitant sexually transmitted disease infection are more likely. Furthermore, according to King et al (2004), an association between childhood sexual abuse and subsequent high-risk sexual behaviour has been established. Other adverse conditions include suicidal behaviour, substance use, academic risk, behavioural problems, emotional deregulation, anti-social behaviour and increased levels of aggression. Sexual violence is also found to take place in non-nurturing environmental and familial contexts such as poor parent-child relationships, family stress and parental psychopathology. There exists in this study also an interesting correlation between the high levels of sexual violence reported at schools C and I and reporting of suicide attempts. Learners at school C report the highest levels of sexual violence and also the highest level of suicide attempts and medical treatment as a result of the attempt.

This study reveals that most parents also seem to find it easier to talk to their children about HIV/AIDS and parenting than sex. Parents seem to find it easier to talk about consequences of sexual activity than about sexuality possibly pointing towards denial of sexual activity amongst the youth. Parents of learners at school C and I seem least interested in talking about HIV/AIDS and birth control despite the high prevalence of HIV/AIDS and teenage pregnancy in these communities. This places the young people at risk for sexually related risk events. According to Flisher and Chalton (2001a), contraceptive non-use can be regarded as a risk behaviour in that it can expose one to risk of pregnancy and in the case of barrier methods, sexually transmitted diseases. These findings are consistent with a recent study conducted in state high schools in Cape Town. This study revealed that the proportion of sexually active students has increased since 1990 and that large numbers of students are at risk for pregnancy and sexually transmitted infections (Flisher, Reddy, Muller & Lombard, 2003). An unexpected response was that a large number of learners at schools C and I indicated that they thought that having a baby is a good idea. This could be due to the fact that many young women are having babies to qualify for the monthly state grant and in this way, provide an income for their families.

These studies present an understanding of the plethora of risk behaviours that learners from schools C and I and to a lesser extent, schools D, E and H, engage in; that the reasons for engagement are rooted in interrelated systems of negative circumstances, behaviours and consequences over which learners can exercise little control. In trying to find explanations for unsafe sexual behaviour among South African youth, a recent review pointed out the powerful impact of the proximal and distal contexts (proximal = interpersonal relationships and organizational environment; distal = culture and structural factors), and in particular, the pervasive effect of poverty and social norms (Eaton, Flisher & Aorob, 2003).

The findings of this study are also consistent with the findings of the Youth Enrichment Programme (2002) with regard to experimentation with drugs and similar substances, drug dependency, suicide and HIV/AIDS. These findings are further confirmed by the DACST report (1998), which argues that South African youth will face significant challenges as forces within and outside of their control will affect their health. They report that accidental death and violence are high and experimentation with tobacco, alcohol and drugs, as have been reflected in the findings, cause addictions and negative behaviour. Unprotected sexual activity results in unwanted pregnancies and the spread of sexually transmitted diseases and HIV/AIDS. The DACST Report (1998) states that the stress of living in impoverished communities may cause young people to demonstrate dangerous levels of anger and aggression. This is clearly reflected by the results of the violence and safety module in this study for certain schools and also the bullying and harassment results for each school.

It is evident therefore that our youth have been placed at risk due to their specific circumstances. These include historical issues as well as current issues related to globalisation, democracy and other social issues. The learners who participated in this study could therefore be regarded as being vulnerable. According to Mrazek and Haggerty (1994), having vulnerability may increase an individual's risk for developing a disorder but other risk factors may also be necessary for the illness to be expressed.

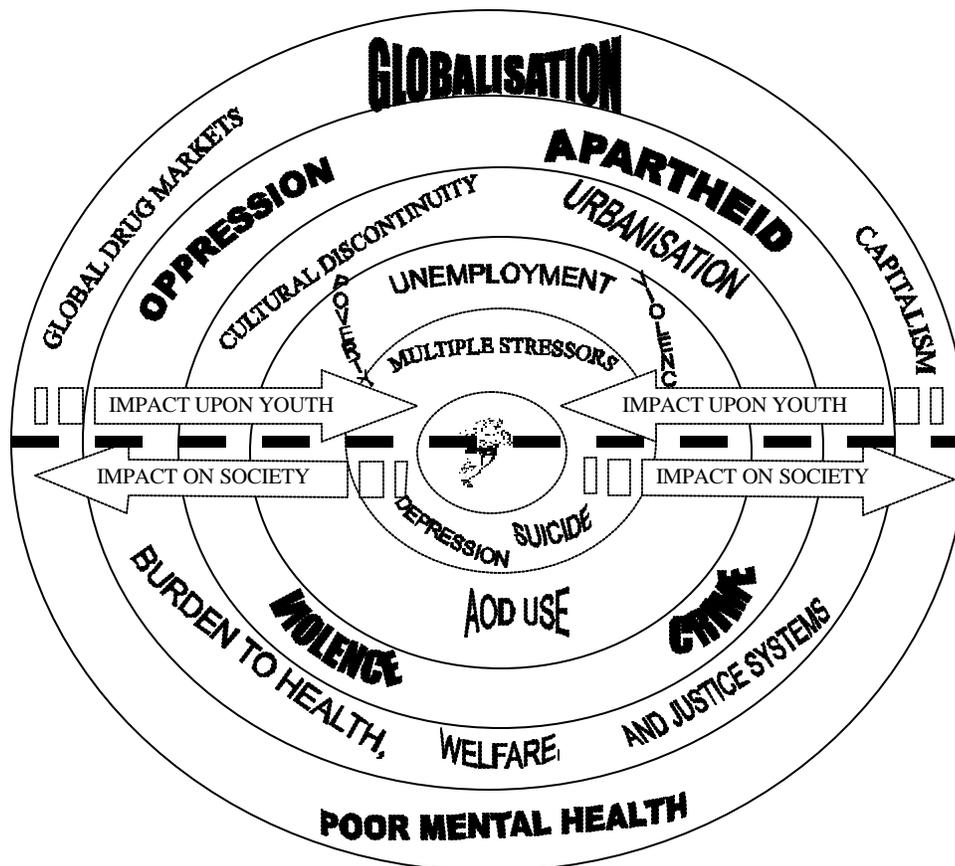
According to Pianta and Walsh (1996), risk status is a way of describing the likelihood that a given individual will attain a specific outcome, given certain conditions, and risk status should be viewed as an index of eligibility for preventive education. There is therefore room to intervene in the lives of the learners engaged in this study. According to Pianta and Walsh (1996), because education is primarily an effort to induce change, there is a dynamic quality to the relations between what a child brings to school and what a school brings to the child, which continually alters the risk coefficient of individuals and groups.

The understanding of the youth who engaged in this study as being placed at risk is governed by the belief that there is still opportunity to intervene and alter the current status of youth and that education plays a critical role here. According to Mrazek and Haggerty (1994), risk factors can reside within the individual or institutions that surround the individual and can be biological or psychosocial in nature. Models of intervention therefore need to include systemic models that focus on all levels including the individual.



The findings therefore reveal that there is a dynamic interplay between global, national, local (community) and individual events that manifest as risk behaviours. In terms of the eco-systemic framework, the engagement in risk behaviours amongst the youth in this study can be understood as follows,

Diagram 8.1.: Inputs and Outputs – Youth placed at risk



The diagram attempts to demonstrate that the youth are placed at risk by globalisation, which emphasizes capitalism and leads to increased free trade between developed and developing countries. This allows for expanded drug markets and for illegal drugs to penetrate South African markets. Globalisation also provides impetus for social injustices and oppression as materialism increases. South Africa also has the added burden of a past characterized by Apartheid and racial oppression. The effects of these past and present influences are uncertainty, urbanization, poverty, unemployment and resultant violence at community and family levels. This in turn places stress upon young people. The stressors experienced are related to crime, violence, cultural discontinuity, academic pressure and an uncertain future. This places young people at risk for mental illness.

This diagram also attempts to demonstrate that young people tend to respond to the stressors in their environment by engaging in risk behaviours. Some young people tend to internalize their feelings and present with depression and suicide. Others tend to act out and engage in substance abuse, crime and violence. This places a burden upon communities, schools and society. This affects the health sector, welfare and justice systems. At a global level it manifests as poor mental health of populations and nations.

In summary, according to systems thinking and the eco-systemic framework, we can therefore understand the manifestations of risk behaviour amongst the learners in this study as being partly the result of the impact of globalisation and social injustice at a global level, Apartheid and resultant oppression as well as the transition to a new democracy at a national level, poverty and violence at a local or community level, and various forms of abuse at family level, all impacting upon the individual or child. The possible result of all these factors is that the child responds to this pressure by presenting with depression and suicide, by engaging in substance abuse, irresponsible sexuality, crime and violence which in turn has a negative effect upon society or the world as a whole in the form of mental health issues and compromised well-being of whole populations.

8.4 REVISITING ISSUES OF RESILIENCE

It is not the aim of this research to focus primarily on the phenomenon of risk although the findings of the risk survey serve to inform the level of curative and preventive services required for the young people involved in this study. The reason for focusing on resilience research in this study as mentioned in chapter one, is the fact that the area of resilience research provides us with possible solutions to the dilemma of increased engagement in risk behaviours by our youth. Furthermore, resilience research is based upon the belief that every person has the capacity for successful transformation and change no matter what their life's circumstances (Benard & Marshall, 1997) and as such, is a positive framework for South African youth. Resilience research focuses on traits and coping skills and supports that help young people survive or even thrive in a challenging

environment and offers hope rather than the sense of futility which emerges when considering the enormity of the obstacles facing disadvantaged children and youth (Frey, 1998). South Africans have the advantage of a strong, diverse culture with great emphasis on morality, human rights and values. South African youth demonstrate a strong affinity for and natural interest in sport and demonstrate creative potential. The overall well-being of youth is improving as a result of the government's strong national policies on primary health care, HIV/AIDS and tobacco smoking (DACST, 1998). Education policies that address barriers to learning are also positive developments. There is therefore much promise in accessing these strengths for the benefit of the youth, especially family, school, community and peer support.

As stated earlier, in terms of the theoretical framework, most important for the purposes of this study is the belief that while individuals are influenced by their environments, they also have the ability to influence their environments, depending upon their responses to their situations. While the effects of Apartheid, urbanization and poverty cannot be denied, individuals do have the ability to rise above their circumstances and secure successful outcomes. The resilience framework focuses on the development of internal strengths and characteristics that assist young people in making the right choices to secure successful outcomes. It is hypothesized in this study that providing young people with the necessary external strengths in the form of school, home, community and peer support within a health promoting schools framework, will lead to overall positive mental health and well-being.

As mentioned previously, a cornerstone of this research has been the Youth Development Conceptual Model (refer chapter one) (WestEd, 2003). In terms of this model, support in the form of caring relationships, high expectations and meaningful participation from significant others which meet the needs for safety, love belonging, respect, mastery, challenge, power and meaning will result in the development of internal strengths such as co-operation and communication, empathy, problem-solving, self-efficacy, self-awareness and goals and aspirations. This, in turn, will result in improved health, social and academic outcomes. According to the YDCM, learners who score high for risk

behaviours will score low for external and internal assets. Learners who score low for risk behaviours, will score high for external and internal assets.

While this model was confirmed by the results of the pilot study, the findings of the main study have yielded some very interesting results. For schools C and G, this model is not confirmed. Learners at school C have scored high for most risk behaviours and high for total external assets. Learners at school G have scored low for most risk behaviours and low for total external assets. While learners at school C score high on external assets, they do not score high on internal assets and while learners at school G score low on external assets, they score slightly higher than school C on internal assets. Furthermore, the YDCM contends that there is a strong correlation between scoring high in total external assets and academic performance. Historically, learners at school C do not fare well academically and learners at school G score very well academically.

What the discrepancy in the results highlights is the complex nature of the South African education system and the fact that there are many factors influencing academic performance and successful life outcomes. Learners at school C seem to experience very poor family and community support and very good school support whereas learners at school G seem to experience very good family and community support and very poor school support. What is very interesting is the fact that historically, school G was very well resourced and therefore does not lack facilities and structures to provide support. However, school connectedness seems lacking. School C on the other hand, was very poorly resourced and lacks facilities and structures but school connectedness seem more positive. It seems that support at school level and school connectedness are not dependent only upon financial resource allocation but rather upon caring relationships, high expectations and meaningful relationships, a significant finding for this study.

At this point, it should be borne in mind also that the sample size was too small for significant patterns to emerge to prove or disprove the principles of the YDCM. Furthermore, resiliency is not determined by the presence of all protective factors. Protective factors merely serve to enhance the resilience of a child. These factors can and

should be developed to strengthen a child's resilience (Frey, 1998). The results of this research therefore serve as a guide to identify the areas that need to be developed in enhancing resilience and well-being. The findings of this research indicate that there is a need to develop external and internal strengths amongst all learners.

With regard to external strengths, Masten (1997) and Mrazek and Haggerty (1994) emphasise the importance of parenting and cognitive development. They believe that if good parenting and good cognitive development are sustained, human development is robust even in the face of adversity. The findings reflect that a large number of learners in this study scored high for support within the home environment. These learners seem to be receiving adequate family support. The importance of a warm and secure family relationship as a protective factor is supported by Heller et al (1999). Learners scored higher for high expectations than caring relationships. It is evident that families are placing great emphasis on school performance. The low score for meaningful participation in the home could be indicative of the fact that we are a new democracy and young people do not yet seem to have much leeway to express their opinions or to participate in decision-making.



Learners at school I have scored significantly lower than learners at the other schools and therefore it seems that they cannot depend upon family support as a protective factor. Protective factors in the family or home include: positive attention from caregivers during the first year, early nurturing, unconditional acceptance from at least one person, positive relationships with parents, close relationship with a sibling, parental support of achievement, structure and rules in the home, intact family structure for first two years, four or fewer children in the home, lack of genetic predisposition to risk, first born males, two parents in the home during teen years, strong maternal role models for teen mothers (Frey, 1998).

The focus groups revealed many challenges with regard to “unconditional acceptance”, “positive relationships with parents”, “parental support of achievement” and either too little or too much “structure and rules in the home”. Learners found it hard to

communicate with their parents. They felt that it was easier to communicate about academic matters than about other matters of importance to them such as relationships. While they mostly experienced their parents as caring, they also felt that they were too strict at times. They felt that their parents did not understand the pressures that they were experiencing, especially with regard to schoolwork. Parents demanded academic excellence. Some also felt under pressure to be grown up and responsible and they did not feel ready to do that. Many expressed the desire to be understood and for their parents to communicate with them and to trust them. Some expressed the concern that parents were not aware of what their children were up to and that their children often disobeyed them when they felt that the rules their parents imposed were unreasonable. In one instance it was also mentioned that parents sometimes were aware of the risk behaviours that their children engaged in but chose to ignore it as part of growing up or alternatively, because they felt guilty about working too hard.

The availability of extra-familial support (peers and teachers) is seen as a protective factor by Heller et al (1999). Protective factors in this domain include personally supportive role models, unconditional acceptance by at least one other person, encouragement of pro-social values and appreciation of individual's unique talents (Frey, 1998). In the results, less than half of the learners scored high for peer support. While the results for caring relationships amongst peers were positive at some schools, this area was particularly poor for schools C and I. Poor results overall were obtained for schools G and H, especially for the category high expectations: pro-social peers. This is an indication that their peers are not likely to dissuade them from engaging in risk behaviour and an indication that they do not have many positive influences that could be utilised for the good of other young people.

It is evident from the findings of this study that all young people need to be skilled in resisting peer pressure and making the right choices. These learners appear to be very vulnerable in terms of succumbing to peer pressure and experimenting with various substances and engaging in various behaviours. Coping with stress and anxiety and the need for social support has also been identified by young people in the EPPI Report

(2001) as requiring urgent attention (refer chapter one). As sound mental health involves having the skills necessary to cope with life's challenges (NASP, 2003), it is clear that young people urgently need life skills education and that they need the support of their families, friends, schools and communities.

The focus group interviews revealed that few young people are able to fight for what they believe is right. Being rejected and isolated is a reality for them. They also revealed that every peer group has its own rules about what one needs to do to be accepted. This ranged from smoking and drinking to wearing certain clothes or performing well academically. In almost all instances, the emotional overrides the intellectual where the fear of rejection is stronger than the fear of consequences for engaging in risk behaviours. Young people are also under tremendous pressure to have sex within relationships. Friends were not regarded as reliable forms of support due to their own engagement in risk behaviours, different moral values, jealousy and competitiveness.

Recent studies suggest that interventions which aim to protect adolescents from engaging in risk behaviours by increasing their self esteem are likely to be most effective and cost efficient if they are aimed at the family and school domains (Wild, Flisher & Lombard, 2004). Low self esteem in the family and school contexts and high self esteem in the peer domain were significantly and independently associated with multiple risk behaviours in adolescents of both sexes (Wild, Flisher, Bhana & Lombard, 2004).

Eaton, Flisher and Aarob (2003) caution that peer pressure does not, however, have the same negative influence on all youth and that young men appear to be influenced to a greater extent than young women. The authors also remind us that peer pressure is not necessarily a negative influence and that positive examples set by friends and role models can promote safer behaviour. Schools D and E have very positive results in terms of total assets for peer environment. This could be due to the fact that these schools have peer education and peer counseling programmes. Learners are therefore active in various committees and structures in the school.

Heavyrunner and Morris (1997) emphasize the importance of community in fostering resilience. They argue for the importance of people who nurture the spirit of children, who stand by them, encourage them and support them. The learners from impoverished communities in this study did not score high for community support. The cultural principle of 'Ubuntu', where young people receive support and are guided by their elders is not reflected in the findings. This could be partly ascribed to the urbanization process and loss of cultural values and identity. Furthermore, urbanization has led to poverty and crime and violence and youth are more likely to experience anxiety than support (Flisher and Chalton (2001b).

Weaver (2002) argues that wellness reinforces and is reinforced by a sense of cultural and community identity. Schools H, C and I have the least amount of support from their communities in terms of caring relationships and high expectations. They are also least likely to engage in meaningful participation in their communities. Moral degradation has led to a justification of criminal activities for personal gain, with gang members seen as role models in poverty-stricken urban areas (DACST, 1998). This once again reflects the eco-systemic approach where society has to take responsibility for not supporting the youth and for breaking down moral values and principles.

In the focus group interviews the learners spoke of poor community support. Some even felt that it was better for them to be at schools than in their communities because of the substance abuse, crime and violence in their communities. Many felt that they could not share their problems with community members for fear of rejection or even of being driven out of their communities. They also found the health services in their communities to be hostile and unhelpful. A significant finding was that each community had its own predominant issues that learners had to contend with. Community-specific issues for learners from school C were violence, safety and HIV/AIDS; for school D it was racism, for school E it was alcohol abuse; for school F it was boredom, low motivation and alcohol abuse; for school G it was fear of crime and broader social issues; for school H it was substance abuse; for school I it was violence towards women.

Learners at school G have scored very high for community support which causes one to question whether the fact that this community is economically well resourced enables them to offer support to their youth. It appears that they do not have to engage in basic living concerns and are therefore able to engage in activities such as support and guidance and mentoring. These learners clearly have the protective factors outside the home as espoused by Frey (1998) namely, exposure to mainstream society, access to resources for meeting basic needs, access to leadership positions, opportunities for decision-making, meaningful participation in the community, lack of frequency and duration of stressful events, external support systems, effective feedback and praise, quality attention from a caring adult, multigenerational support network, clear and enforced boundaries.

According to Masten (1997), a significant factor in fostering resilience in children is the role of the school. Supportive, nurturing school environments are crucial. Positive relationships between teachers and learners, learners themselves, teachers and parents and the school and its community must be encouraged and developed (Masten, 1997). Of all the areas covered in the external assets section in this study, school environment was the environment in which learners reported the least support. On average, only thirty-six percent of learners scored high for this asset. This result relates to school connectedness where an average of only thirty-eight percent of learners scored high for this asset. It is interesting to note that learners have the least confidence about receiving care and support from schools than from any other sector and it is here where they mostly experience academic stress, bullying and harassment and peer pressure.

Schools F and H have scored lowest for total external assets – school environment. School H fares poorly on all three areas of support (caring relationships, high expectations, meaningful participation), raising concern about the environment at the school in terms of learner support. According to Henderson and Milstein (1996:2 in Frey, 1998:5) “More than any institution except the family, schools can provide the environment and conditions that foster resiliency in today’s youth and tomorrow’s

adults”. The findings reveal that our schools need support to provide the necessary environment to foster resilience.

The focus group discussions revealed that learners do not feel that their teachers care about them or that they can go to them with their problems. They do not feel comfortable about teachers knowing their problems. They felt that they would go to their teachers for support only in exceptional circumstances. These would be if their parents did not believe them or assist them. Learners revealed that even where the necessary support structures are in place, they find it very hard to speak to teachers. Their interactions with teachers are centred around academic performance. Strictness was often associated with a lack of caring. Friendliness was regarded as sign of caring and accessibility and where teachers were perceived as friendly, learners scored high for school support.

The results of the focus group discussions with learners in this study emphasized that there are general and school-specific needs when it comes to emotional support. All learners desire some form of support that is independent from school, home, community or peers. They require someone who is trained, fairly young, able to listen and understand, advise without being judgemental; someone whom they can trust and who will honour the confidentiality contract and whom they will not have to encounter every day. In the absence of this ideal situation, learners are aware of other support systems that are available such as national support services and their toll-free numbers, guidance counsellors, peer counsellors, social workers, psychologists, youth counsellors, church / mosque leaders, clinic staff and their parents, friends and teachers. Learners are very cautious about approaching these persons for support however. Issues of trust, confidentiality, familiarity and stereotyping are factors that prevent them for going for help unless they feel that the situation is really serious. The need for schools to provide access to these services and related emotional support is therefore highlighted by the findings.

The findings confirm that there is a need for schools to build bridges with communities and recreate a sense of belonging in society (Simpson, 2002). For learners at schools C,

D, E and I, the school seems to offer much support when the community does not seem to offer much support. Schools and communities should work together to support young people. The fact that schools should become the vehicle for developing strengths and enhancing competencies; for ensuring positive outcomes for our youth and for producing young people that make a positive contribution towards society is confirmed by the findings. Benard and Marshall (1997) believe in utilizing the school system as a vehicle for fostering resilience in children. Protective factors in this domain include high, realistic achievement standards, peer support of education, community support of education, provision of educational opportunity, positive school climate, exposure to caring teachers and participation in early childhood programs (Frey, 1998).

Benard (2005) describes turnaround teachers/mentors as caring individuals who develop relationships with their students. They convey the message that they are there for the youth. They help to meet the basic survival need of overwhelmed students and their families. On a more comprehensive level, they may even connect students and their families to outside community resources in order to find food, shelter, clothing, counseling, treatment and mentoring. This is clearly evident at school C. This result is very positive as it speaks to the power of teachers to provide supportive environments and turn schooling into positive experiences for learners. These positive experiences could result in strengthening internal strengths and assisting youths to make the right choices and be successful.

According to Benard (2005), human beings are genetically predisposed to form relationships (social competence), to problem-solve (metacognition), to develop a sense of identity (autonomy) and to plan and hope (a sense of purpose and future). Benard (2005) argues that even though some individuals can express these capacities in the absence of a facilitative environment, it is clearly the presence of a nurturing climate that draws them forth and encourages their expression. This places the power in the hands of teachers and schools “to tip the scales from risk to resilience” (Benard, 2005:2).

Most learners in this study with the exception of learners from school I, seem to have the necessary internal strengths to cope with the challenges that they currently face. However, specific strengths need to be developed amongst various learners. If we regard the results for internal strengths as outcomes of the youth development process and indicators of whether the necessary supports are in place, then it is clear that external supports to date are not adequate and could be greatly enhanced.

It is the contention of this research that these and other recommendations by resiliency theorists and practitioners could be even more effective if placed within a health promoting schools framework which provides us with a strategy for providing support to enhance resilience. The following section will explore the findings related to health promoting schools in more detail and then proceed to make the links between resilience and health promoting schools.

8.5 REVISITING THE HEALTH PROMOTING SCHOOLS STRATEGY

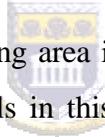


The health promoting schools framework as outlined in chapter two provides an organizing framework for enhancing external supports such as the school, the home, community and peers. The findings have shown the schools in this study are largely unaware of the HPS framework. Schools are engaging in health-promoting activities but these activities are largely uncoordinated and fragmented. Access to education support services is limited. The extent of parent and community involvement differs from school to school. Life skills education does occur but not necessarily according to the needs of learners. The extent to which schools have policies in place and the ethos of the school also differs from school to school. There is therefore little consistency and consensus. Schools concur that this is an area with much potential and which could be further developed.

According to the European Network for Health Promoting Schools, the health promoting school aims at achieving healthy lifestyles for the total school population by developing supportive environments conducive to the promotion of health. It offers opportunities for

and requires commitment to the provision of a safe and health-enhancing social and physical environment (ENHPS, 1993 in Donald et al, 2002). It becomes important to revisit issues of health promoting schools in order to find ways to change the negative effects of social and political events upon the youth in South Africa.

A very recent review of evaluation studies pertaining to health promoting schools in South Africa has revealed evidence that the health promoting school has some influence on various domains of health for the school community. The review has also revealed that it is possible to integrate health promotion into the school curriculum and policies successfully (Mukoma & Flisher, 2004). The health promoting schools framework as a strategy could therefore facilitate the integration of resiliency research into mainstream educational practices, which has been mentioned by other researchers as a challenge (Frey, 1998). The extent to which the five strategies for developing a health promoting school are in evidence at the schools in this study varies from school to school.



The fact that the Life Orientation learning area is compulsory has ensured that life skills education occurs regularly at all schools in this study. The curriculum is implemented from pre-school through to high school. 'Issues are being dealt with in appropriate ways at appropriate ages' thereby realizing the principle of the spiral curriculum espoused by Downie et al (1996). The life orientation curriculum stresses attitudes, values and skills 'rather than a purely information-based approach' (Downie et al, 1996). The implementation of the life orientation curriculum holds much promise for the promotion of resilience amongst the youth. Donald et al (2002) argue that life skills are indispensable in the process of empowering individuals to cope successfully with life and its challenges. The fact that all the schools are committed to implementing the curriculum augurs well for the development of resilient youth in South African schools. However, teachers need to see the life orientation curriculum as one vital part of the health promoting schools framework so that the efforts and benefits in the classroom could extend beyond the classroom. This would also ensure that the full sense of curriculum is realised, where curriculum includes 'extracurricular and out of school activities and the climate of relationships, attitudes and styles of behaviour and the general quality of life

established in the school community as a whole' (Tones et al, 1995). Placing the life orientation learning area within the health promoting schools framework would also ensure that 'shifts in teachers' paradigms of themselves, of their learners and of the learners' parents occur; where teachers become motivated and start loving their teaching; working together and working with parents; and most importantly, where authoritarian classroom climates where teachers use 'killer words' and corporal punishment, change into happy, caring places where teachers are giving children the opportunity to learn and practice life skills in every subject' (UNICEF, 2004).

However, it is evident from the interviews that teachers are experiencing much stress. This is as a result of the pressures associated with implementing a new national curriculum. Teachers are experiencing frustration with the new curriculum, the many changes, the training involved, and lack of support and feedback. Teachers feel that there are so many demands placed upon them and that there is no room for creativity. They feel that there are constant demands placed upon them to do more. They feel that any support that they receive from the department of education relates to curriculum matters and not emotional matters. They feel that there is a need to attend to the emotional needs of learners and teachers. They receive workshops on curriculum matters when they require workshops on how to cope. Teachers are generally keen to improve their teaching and the opportunities that they provide to their students despite the pressures they experience. It is important to note that while there are many positive developments with regard to the curriculum, teachers are under tremendous pressure to cope. While the developments in terms of life skills education in South Africa are positive, much more could be done to support teachers and thus enable them to support learners.

While there has clearly been a reorientation of health and education services in order to create access to services for all learners (Donald et al, 2002), there is also much confusion with regard to what is offered and what is not, how to access services and in some instances schools experience the services to be less accessible than ever before. The reorientation of services in the Western Cape has involved 'redefining the role of psychologists and other education support personnel', a necessity espoused by Adelman

and Taylor (2003). Multidisciplinary teams are in operation at district level. These teams assist schools with all issues that interfere with learning ensuring that schools can be successful in their core mission, which is education (Adelman & Taylor, 2003).

Teachers revealed that they often have to take the initiative when it comes to receiving support from their district support centers. Most teachers feel that the support that they receive from the Department of Education is worse than before. Previously advantaged as well as previously disadvantaged schools experience challenges in trying to access support. As a result, schools tend to reach out to other service providers. This results in uncoordinated and fragmented service delivery. The development of district support centers was supposed to be aimed at alleviating this type of challenge and to enhance the delivery of co-ordinated, linked services. For most teachers the concept of health promoting schools was largely unknown but they understood it in terms of the holistic development of the child. Despite their concerns about workload and skepticism of other staff members, teachers were very open to exploring the concept and the implications for their school.



The health promoting schools concept can enhance the effective delivery of services as the multidisciplinary team at the district centre could easily link with the teacher support team at the school to meet the needs of learners and teachers. While developments in these areas have also been positive for schools in the study, there is room for further developments and greater efficiency if support services are offered within a health promoting schools framework. There is also room for greater collaboration between health and education.

Support services could furthermore plan interventions that target all youth, not just high risk youth, provide developmentally appropriate structures, develop peer support groups, bring integrated social services into the school and so forth (Frey, 1998). At present support services work with teacher support teams at school, which are primarily aimed at supporting 'at risk' youth.

There is much emphasis in the health promoting schools concept on promoting warm, nurturing, safe and supportive environments. Wyn et al (2000) argue that promoting the mental health and well-being of all young people is a vital part of the core business of teachers by creating a supportive school environment that is conducive to learning. Unfortunately, the responses from the teachers in this study seem to indicate that they do not feel that this is part of their core business. Rather, mastering the curriculum is their core business. There is the belief the task of securing the mental health and well-being of learners rests with support service personnel.

The schools that are classified as previously disadvantaged schools, are unable to provide supportive environments as described by Donald et al (2002). These schools cannot guarantee that the buildings are safe with facilities for students with special needs; that basic health regulations are met and that the prevailing style of management is one that encourages empowerment of all sectors in the school and which encourages teamwork and obstructive conflict management at all levels.



Teachers provided different views on whether they felt that their schools provided a supportive environment to the learners. Teachers at schools D, E, F and G were positive about the environment that their school provided. Teachers at schools C, H and I felt that they were not able to adequately attend to the needs of the learner and provide them with the support they required. They were trying very hard to provide them with adequate support though, despite the many issues that learners presented with. As far as support for teachers is concerned, the environment was generally very stressful. Most teachers were stressed, were absent from school very often due to illness and most schools experienced a high turnover of staff. Teachers therefore attempted to find their own ways to cope and support each other. The factors contributing towards a stressful environment varied from school to school and varied from crime at school, to service conditions, staff conflict and cultural differences. Teachers therefore experienced school-specific stress in addition to pressure from the Department of Education.

What is clearly required at these schools are environments that build resiliency for learners as well as teachers. These include secure, positive environments, flexible learning environments, contact with supportive adults; environments that build on student strengths, celebrate successes and celebrate student successes with parents, promote cooperation, not just competition, develop and support mentoring programs, convey a sense of caring, trust and responsibility (Frey, 1998).

The health promoting schools concept facilitates school and community partnerships as it includes greater community participation in the life of the school as well as the school contributing to the life of the community and weaves together a critical mass of resources and strategies to enhance caring communities that support all youth and their families and enable success at school and beyond (Donald et al, 2002, Centre for Mental Health in schools, 1999). School G is the only school that has demonstrated strong community action and participation. Most schools have challenges with parental and community involvement. The reasons differ for each school. School-community partnerships are weakest in areas where risk behaviours are prevalent and where youth face the most challenges.



According to Johnson (1998), for collaborative efforts to be successful, there needs to be a collaborative culture in the school as a whole which entails collaboration between staff members, staff and parents, staff and students, and students themselves. Teachers revealed that for the most part, they only see parents at parent meetings. Teachers feel that often parents just place the child at school and abscond any further responsibility towards the child's education. Teachers feel that parents need to work in partnership with the school for the well-being of the child. Parent involvement is very limited in all spheres of school life. Most parents were reluctant to serve on the school governing body. Some schools did not however, seem to present opportunities for parents to participate and only met with them at parent meetings and formal activities such as prize giving ceremonies.

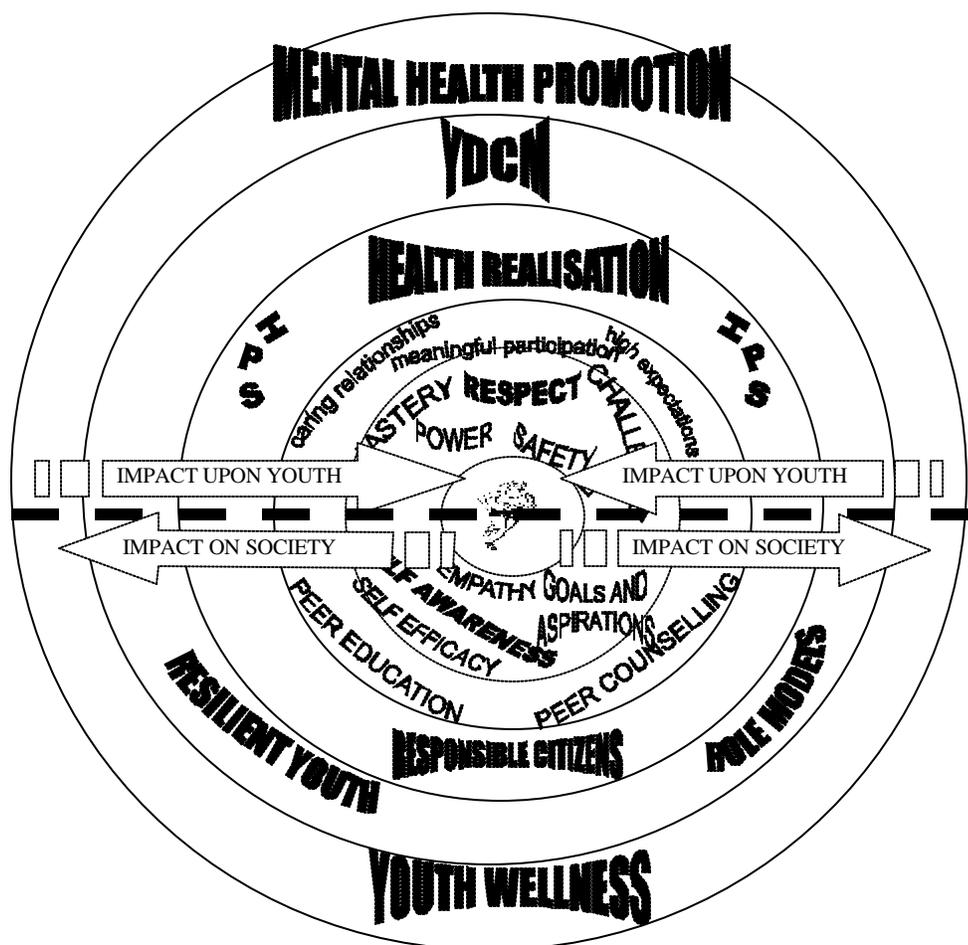
Most of the schools in this study would need to place great efforts into achieving this collaborative culture. Furthermore, these schools need to be made aware that the success of parent-school collaboration rests upon the recognition and application of the following characteristics of collaboration: trust, openness, honesty, positive and caring attitudes, personal connections; being equals; understanding of power, conflict and roles; and school wide commitment (Gareau & Sawatsky, 1995).

Healthy policy formulation differed significantly from school to school with some schools only having very broad policies based on national directives like an HIV/AIDS policy, to schools having broad policies that promote inclusion and equity as well as specific policies like no smoking (Donald et al, 2002). It is clear from the findings that the establishment of policies is tied to healthy practice at schools. The extent to which health practices are evident at the various schools are clearly related to the extent to which schools have health policies. Schools that were previously advantaged have most structures and procedures in place whereas schools that were previously disadvantaged do not seem to have the necessary structures and procedures in place. Teachers are also very much aware of the difficulties and challenges that their learners face. These challenges are dependent upon the socio-economic circumstances of the learners. Disadvantaged schools such as C, H and I have many gaps with regard to the establishment of various policies and procedures to deal with risk behaviours.

What is lacking at the schools in the study is an integration of a health promoting vision and principles in their policy development. What is required is that school policy development address issues related to the development of a supportive and welcoming and safe environment; the facilitation of co-ordinated and integrated support services; the development of guidelines and comprehensive strategies to address priority issues; the fostering of health through the provision of nutritious food; and the encouragement of physical activities, sport and cultural recreation.

In summary, the health promoting schools strategy can therefore strengthen resiliency initiatives and improve inputs and outputs as follows,

Diagram 8.2: Inputs and Outputs – Resilient Youth



Discussion of diagram 8.2

The diagram illustrates that global efforts aimed at mental health promotion and youth wellness could influence national policies, programmes and initiatives that promote sound mental health. This, in turn, could impact positively upon community initiatives and the development of healthy policies and programmes. The development of health promoting schools as part of this initiative strengthens the care and support available to young people. The diagram aims to demonstrate that adoption of the Youth Development Conceptual Model at national level and Health Realisation principles at community and school level could impact upon communities, families, schools, the peer environment and subsequently the youth in very positive ways. The provision of care and support at these different levels could result in the youth experiencing love, mastery, respect, challenge,

meaning, safety, power, belonging and so forth, essential ingredients in developing internal strengths.

The provision of support at various levels, would enable young people to develop internal strengths such as self awareness, empathy, cooperation and communication, goals and aspirations, self efficacy and so forth. The ultimate result would be a society filled with resilient youth who experience positive outcomes and are able to build a better society. This could result in young people who are seen as achievers and role models occupying positions such as youth leaders who are engaged in helping at community level in the form of peer education and counselling. This could all lead to responsible citizens at national level and resilient youth who experience well-being at global level.

8.6 CONCLUSIONS

In terms of systems thinking and the eco-systemic framework, the findings have shown that the environment impacts as much upon the individual as the individual impacts upon the environment. This is in terms of mental health issues in general and engagement in risk behaviours in particular. South Africa with its history of Apartheid and current transition to democracy has impacted in a particular way upon communities, families, schools, peers and individuals. Affected individuals in turn, respond in a particular way to peers, schools, families, communities and South African society. This process is largely negative at present and there is an opportunity to transform this process into a positive one where support is experienced by young people and they then radiate positive effects from the individual to the societal level. In trying to develop a democratic society and young people who will make a positive contribution to this new society, we need to provide the necessary support at various levels that will enhance internal strengths and build resilience. The research findings have confirmed that the young people in South Africa are in distress but at the same time, there is much opportunity to reverse the damage of the past and to develop resilient young people who will make the right choices. There is room for the development of health promoting schools that will facilitate this process. What is needed is the coordination of positive efforts in schools.

There is an opportunity in the present time for the reframing of the disempowering view of ‘youth at risk’ to the empowering view of ‘youth placed at risk’ who can experience success when barriers to success are removed.

There is thus a need for general interventions that will pertain to all schools but also school-specific interventions that will meet the needs of each individual school. There is a need for national policies that will govern intervention in terms of mental health promotion in schools. At the same time, there needs to be flexibility with regard to how schools interpret and implement the policy proposals. Schools need to embark on a process where they determine their own needs and strategise around the best possible way to meet those needs. This will enable schools to assist in healing the transgressions of the past, which affects impoverished communities, and the impact of change from an oppressive society to a democratic society, which affects all young people. Once these issues are addressed, a change not only in the risk profiles of young people will be witnessed but also a change in the academic performances of young people across the country. The aim ultimately is to address all the challenges that interfere with the learning process in order to meet the educational mission of schools as advocated by Adelman and Taylor (2003).

Frey (1998) correctly points out that it will take a concerted effort to incorporate the simple strategies suggested by researchers to create the type of institutional change that is necessary to foster resilience. Frey (1998) emphasizes that the simple goal is to create quality environments in which success is possible for all and is in agreement with the position of this research that the place to begin is with a consideration of organizational practices and programs that are working and then to build from our strengths and successes.

While this chapter has therefore reviewed the findings in terms of the literature review of chapter two, the following chapter presents the conclusions and recommendations and in so doing, hopes to enhance the well-being of our youth.

CHAPTER NINE

CONCLUSIONS AND RECOMMENDATIONS

9.1 INTRODUCTION

The aim of this chapter is firstly, to revisit the purpose of the study in order to determine whether the research aims and objectives have been met; secondly, to make recommendations based on the research findings; thirdly, to discuss the limitations of the research; and finally, to discuss implications for future research.

9.2 REVISITING THE PURPOSE OF THE STUDY

The aim of this research was to explore factors relating to risk, resilience and health promoting schools in order to promote resilience amongst youth in South Africa. The research objectives of this study were as follows,



- To determine the mental health needs of our youth;
- To determine the strengths of our youth;
- To determine the form and extent of support being provided to our youth;
- To explore the health promoting schools framework as a strategy for support provision and thus securing the well-being of our youth.

It can be seen that this research was aimed not only at determining the current risk status of our youth but also at determining their strengths and support systems in order to promote their health and well-being. The benefits and advantages to the participants in the form of promoting well-being was therefore an integral part of the research process. While this research examined risk factors, the main focus was on resilience and the development of health promoting schools. The research process involved raising awareness of a problem, investigating it in depth and at the same time investigating the literature for ways of solving it.

Resiliency research served as a primary framework for this research. This research framework as espoused by Benard (2004b), is based on research findings that a large number of youth growing up in high risk conditions develop social competence despite exposure to severe stress and lead successful lives. It has the underlying principle and belief that all human beings are born with innate resiliency which is the capacity to develop the traits necessary for success namely, social competence, problem-solving, autonomy, and a sense of purpose and belief in a bright future; that everyone has an inborn capacity for self-righting and for transformation and change. The emphasis is on family, school and community environments that elicit and foster the natural resiliency in children. The protective factors that alter or even reverse potential negative outcomes have been categorized into caring relationships, high expectations and opportunities for meaningful participation. Resiliency research situates risk in the broader social context of racism, war and poverty, not in individuals, families and communities. It is a move away from a risk, deficit and pathology focus to an examination of the strengths that youths, their families, their schools and their communities can contribute to promote healing and health. Resiliency research provides evidence that nature has provided protective mechanisms for human development that appear to transcend ethnic, social class, geographical and historical boundaries. According to Benard (2004b), it is grounded in the psychological theories of Erikson, Bronfenbrenner, Piaget, Kohlberg, Gilligan, Steiner, Maslow and Pierce which endorse the fact that human beings possess a biological imperative for growth and development, which unfolds naturally in the presence of certain environmental attributes. It proposes that when human needs for caring, connectedness, respect, challenge, power and meaning are met, then socially competent people who have a sense of their own identity and efficacy, who are able to make decisions, set goals and believe in their future, will be the result.

An important distinction between interventions based on resiliency research versus interventions based on risk research, is the emphasis on process and not on programme development. Traditionally, the development of specific programmes to addresses issues related to youth at risk would be a primary focus. This research proposes that the development of supportive environments that result in the unfolding of processes that

foster resilience. The fostering of resilience involves relationships, beliefs and opportunities for participation and power. According to Benard (2004b), resiliency research involves changing paradigms from risk to resilience, from control to participation from problem-solving to positive development, from Eurocentrism to multiculturalism, from seeing youth as problems to seeing them as resources, from institution-building to community-building, and so forth. Benard (2004b) argues that fostering resilience requires changing personal belief systems to see resources and not problems in youth, their families and their cultures; transforming not only families, schools and communities but creating a society premised on meeting the needs of its citizens, young and old. It therefore entails working on the policy level as well.

The reason for endorsing the frameworks, beliefs and principles of resiliency research for this study is because various South African studies (UNICEF, 2004; MRC, 2003; DACST, 1998; Flisher et al, 1992, 1993, 1997, 2000) have shown that the youth are engaging in risk behaviours at an alarming rate. While youth from all races and backgrounds are at risk, those individuals from poverty-stricken and previously disadvantaged environments are most at risk. What is lacking, however, is a comprehensive, school-based intervention aimed at transforming the situation of 'youth at risk'. This intervention would need to go beyond focusing on specific program development to the development of theories, policies, beliefs and practices that promote resilience. The intervention would have to transcend traditional scope of practice boundaries in terms of practice within health, education, welfare and other related sectors. Most importantly, this intervention would have to offer hope to youth who are evidently in despair when one considers the results for depression and suicide. It is evident that interventions and programs to date have not been very successful when one considers the increase in risk behaviours amongst youth.

In this study, both qualitative and quantitative research methodologies were utilized in order to meet the aims and objectives of the study. The quantitative aspect involved a research survey that was conducted with grade nine learners at seven high schools in the Western Cape. The survey assessed risk and resilience profiles of participating youth.

The risk component assessed the following risk areas: substance abuse, bullying and harassment, violence and safety, diet and exercise, depression and suicide and sexuality. The resilience component assessed the extent to which young people were experiencing caring relationships, high expectations and meaningful participation in the school, at home, in their community and amongst their peers. This component also assessed the extent to which this support translated into the development of internal strengths that would assist young people to make the right choices and succeed despite being exposed to risk factors. School connectedness was also examined by this component.

The qualitative aspect involved focus group interviews with the same learners who participated in the survey. The aim was to supplement the information gathered from the survey regarding issues of risk, resilience and support. Interviews were also conducted with guidance counsellors or school psychologists in order to ascertain their views regarding the mental health status of youth, support for learners and staff members and the health promoting schools concept. Finally, questionnaires were handed to these same teachers to determine the extent to which their schools were engaging in health promoting activities.



Results from the risk component of the survey indicate that the youth in the study are engaging extensively in various risk behaviours. Substance abuse, bullying and harassment and depression and suicide are challenges for all schools to focus upon. Schools that are well resourced have to deal with issues pertaining to substance abuse and depression. Schools that are poorly resourced have to contend more with issues pertaining to violence and safety and sexuality. Learners who come from impoverished communities are engaging with greater intensity in risk behaviours than other learners. This increases the chances of dependency, crime, violence and school drop-out.

Results from the resilience component of the survey indicate that while learners appear to be receiving adequate support with regard to external assets – caring relationships, high expectations and meaningful participation, these assets can be improved for learners within the different domains of school, home, community and peers. At school level, all

external assets (caring relationships, high expectations and meaningful relationships) can be greatly improved upon for all schools. At home level, caring relationships is most commonly experienced. High expectations and meaningful participation are areas that require intervention. Not all learners are secure in the knowledge that their parents believe that they can and will succeed and they do not seem to be able to communicate openly and freely with their parents. At community level, support varies from schools to school and is specific to communities. At peer level it appears that some schools are experiencing positive results with peer support amongst learners. This is typically at schools where peer support programmes or structures are in place. At other schools, much work needs to be done in this area as learners report that they are not receiving positive support from their peers. Internal assets such as co-operation and communication, self-efficacy, empathy, problem-solving and self-awareness need to be developed for most learners. The result for school connectedness was overwhelmingly positive for one school (School D) in relation to other schools.



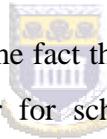
The interviews with learners revealed that they are very knowledgeable about risk behaviours and the importance of not engaging in risk behaviours. They revealed though that they find peer pressure very hard to resist and often they engage in behaviours that they do not agree with in order to be accepted in a group. The powerful nature of peer pressure was highlighted in the interviews. Learners revealed that certain behaviours were expected when belonging to certain groups and the nature of this behaviours varied from engaging in risk behaviours, to wearing particular clothing and even to performing well academically. Learners also felt that it was very hard to communicate with parents, as they did not listen to them or attempt to understand them. They felt that parents were too strict and for some this was very frustrating. Learners said that they also found it very difficult to communicate with teachers. They raised issues of trust, professionalism and lack of care as some of the issues that would prevent them from turning to their teachers for assistance when they experienced problems. Learners stated that they found it easier to turn to peers or friends when they needed someone to talk to but that they would turn to professionals when they felt that the problem was serious enough. Utilizing guidance teachers, psychologists, parents, community members, lifeline or childline depended

upon individual choice as each learner had different views about whom they felt they could trust. What was most evident from the focus group discussion was the fact that learners felt overwhelmed by pressure from peers as well as parents and teachers. They proposed that an ideal situation for them would be to have an independent counsellor, not linked to the school, available to listen and understand them.

The interviews with guidance teachers revealed that they were experiencing tremendous pressure in trying to adhere to the demands of the new curriculum. There is very little support available to teachers to cope with the demands of their jobs or even to cope with the demands of the learners. Teachers felt that the learners were experiencing many challenges as society had changed and young people were exposed to so much more in terms of risk behaviours. Most teachers felt that their schools were trying their best to meet the needs of the learners but that there was still room for improvement. Most schools had not been exposed to the health promoting schools concept. Even though health related policies or activities were in place, these were operating as part of independent initiatives and not as part of a common goal towards developing the school into a healthy school. The questionnaire served to encourage action to develop their schools into health promoting institutions.

An in-depth look at the results as individual case studies revealed that the legacy of Apartheid is still evident. Schools that are situated in impoverished areas have greater challenges with regard to the youth engaging with great intensity in multiple risk behaviours. They are also less likely to have the necessary policies and structures in place to provide support to their learners. Schools that were better resourced seemed to have less challenges with regard to risk behaviours. They also have better support and structures in place that could assist learners in becoming resilient. While health efforts should be geared towards securing the well-being of all individuals, there is room for focusing efforts on identified needs of specific populations, especially formerly oppressed people. The case studies also revealed that there were not clear relationships between risk and resilience for all the schools. According to the Youth Development Conceptual Model (refer chapter one), one would expect poor external supports to

correlated with poor internal strengths. This was only clearly evident in the results for school I (refer Appendix VII). The model also proposes that one could reasonably expect high external supports to correlated with high internal strengths. This is only evident in the results for schools D and E (refer Appendix VII). This reveals that the situation at schools in South Africa are very complex, that there are no clear cause and effect relationships only patterns that reveal areas that could be further developed to reach the ideal situation of high external assets and high internal assets. When working with South African schools it is important to realise that each school has its own unique needs and a any intervention needs to adapt according to these needs. In essence, different schools need different things at different times and each school need to decide for themselves what works best for them. This research has pointed out areas for each school that could be developed in order to improve the relationship between external and internal assets and subsequently, to enhance the resilience of the youth involved in this study. It therefore provides critical information that could inform school-based interventions.



An unexpected and positive result was the fact that learners from schools in impoverished areas rated their schools much higher for school support (caring relationships, high expectations and meaningful participation) than schools that were better resourced. This result points towards the power of individual schools and teachers to provide positive support to learners irrespective of socio-economic circumstances and resources. The results pertaining to total external assets: school environment and school connectedness for schools I, E and C (refer Appendix VII) are the clearest examples of this. While these schools do not have the resources and infrastructure of other previously advantaged schools, they have committed teachers who are trying very hard to make a difference as is evidenced by the findings in chapter six.

The results for school connectedness are also positive. School D is has the unique situation of being a previously advantaged school with infrastructure and resources. This school currently has a majority of learners from previously disadvantaged backgrounds. While the risk results revealed that these learners were engaging extensively in a wide array of risk behaviours, the total external assets and total internal assets scores (refer

Appendix VII) reveal that these learners have the necessary supports to increase the chances of successful outcomes despite exposure to risk. Furthermore, school connectedness was found in other studies to make a critical difference with regard to engagement in risk behaviours. This could explain why the results for engagement in risk behaviours within the school environment are very low for the learners of school D, even though the exposure to risk in the community is very high. Feeling connected to their school because they experience caring from their teachers and high expectations, decreases the chances that they will engage in risk behaviours in this setting and increases the chances that these learners will be successful.

In summary, the youth in this study are faced with numerous challenges that impact upon their well-being. The extent to which they have the necessary strengths and supports to meet these challenges and be successful despite exposure to risk, varies from school to school. What this study highlights in the complexity of the South African context, which is constantly evolving as a result of attempts to address the inequalities of the past and develop as a new democracy. What this study also reveals is the power of South African schools and teachers to change the future for our young people. In the past, the struggle for liberation from political oppression was fought largely from schools and other education institutions. At present, there is much hope in schools playing a key role in the struggle against risk behaviours that threaten the future of our youth. What is required is not necessarily financial resources but human resources in the form of schools and teachers who are committed and dedicated to providing the necessary support to ensure the success of learners. The challenge is that schools and teachers are under tremendous pressure. The health promoting schools framework is a strategy for providing the necessary support to learners without necessarily adding to the pressure experienced by teachers. It involves developing a common vision and co-ordinating existing health promoting initiatives offered by the school. Ensuring the development of critical life skills via the curriculum is a key part of this process. The results suggest that all learners can experience resilience in the wake of numerous challenges if our schools adopt the health promoting schools concept and address the challenge of risk by providing supportive environments that promote well-being.

It is the purpose of this chapter to offer recommendations that would lead to a comprehensive intervention based on the belief that it is possible to achieve successful outcomes despite the challenges faced by our youth.

9.3 RECOMMENDATIONS BASED ON THE RESEARCH FINDINGS

This section will present general recommendations for all schools. It incorporates systemic thinking, health promotion principles and resilience theory. This study has identified needs and strengths in a way that has led to a search of the literature to find answers. The aim is to promote resilience amongst our youth by advocating for necessary philosophical and practical changes as indicated by the literature and the research findings.

(a) Intervention at a global and national level

Revisiting our views and perceptions of youth



In terms of systemic thinking, it is evident that change needs to be effected at the societal level. There needs to be a philosophical change in terms of how learners and young people in general are viewed. A shift in mindset needs to occur in terms of viewing and responding to young people. This mindset needs to involve viewing young people in a positive light. They need to be seen in terms of their strengths as opposed to their weaknesses. Greater emphasis needs to be placed on their potential for success rather than their potential for failure. Subsequently, intervention programmes should be framed positively. It should be based on the belief that all young people have the ability to be successful. It should be strengths-based and solution-focused.

Looking at language and communication

The language used to describe youth and to plan for their futures needs to change. The language should be positively-oriented. Adults should model the beliefs that they have in the youth by planning interventions that will benefit them. Most importantly, young people should have a say in interventions that are designed for them. Consultation should

occur and interventions should be partly developed by young people where it is possible to do so.

Seeing solutions and not only challenges

It is important as a nation to focus on solutions and not just the challenges that we are faced with in terms of our youth. The National Youth Risk Behaviour Survey (MRC, 2003) presented the country with the risk profiles of our youth but it did not present any solutions. It was not the brief of that survey to suggest solutions but careful consideration needs to be placed upon the value of presenting challenges without solutions. It serves largely to demotivate those working with youth. Any intervention that highlights weaknesses should also highlight strengths and provide possible solutions.

Extending the national campaign 'Your child is my child'

The South African campaign designed to reduce incidences of child abuse, child trafficking, kidnapping, street children and so forth which is commonly known as the 'Your child is my child' campaign needs to be extended to encompass enhancement of strengths and resiliency. Communities need to be encouraged to provide support to young people that will ensure that they are able to ward off adversity and succeed despite the challenges in their environment. African and other indigenous cultures and traditions need to be restored where children are able to approach elders for guidance and wisdom. The impact of urbanisation such as unemployment and resultant crime and violence could possibly be lessened if communities made concerted efforts to practice traditional ways. This could minimise the effects of poverty on the youth and subsequently interrupt the negative cycle of a lack of education, unemployment, crime and abuse.

Working towards one nation, one positive view of youth

There is a lot of emphasis on nation-building in South Africa at present. This emphasis could be extended to include the health promotion view of health and well-being for all. This implies that the nation is united in its pursuit of health and well-being for youth of all races. The positive view of youth and the focus on strengths should therefore not only apply to young people belonging to communities that were oppressed in the past but also

to communities that were advantaged in the past. All young people are having to adapt to the new South Africa and all young people are battling with the challenges of this new democracy. If we hope to curb the high rates of depression and suicide amongst all our youth, we need to ardently pursue the philosophy of one nation, one positive view of our youth.

All sectors working together

For resiliency research and development to be successful, it is important for all sectors that are committed to improving the lives of young people to work together. These sectors are primarily education, health and welfare. All three sectors should be introduced to resiliency research and should commit to adopting its principles. Intervention planning should occur with all sectors present in order to ensure that the principles of resiliency research are entrenched within each intervention strategy and that it translates into practice.



Changing reporting, television and newspapers

For resilience to be successfully promoted, it is important for the media to adopt the philosophy and principles of resiliency. Reporting on youth and youth activities need to focus on positive initiatives and successful projects that show young people in a positive light. Television, newspapers and magazines can make greater efforts to improve the extent to which this occurs. Young people need to see possibilities in terms of their future not only the alarming HIV/AIDS statistics, crime and violence and unemployment statistics that govern the news. Greater exposure should be given to young people who serve as role models and mentors.

Tapping into existing initiatives

It is also useful to tap into existing initiatives that are aimed at supporting young people. The Soul City campaigns and Love Life campaigns are taken seriously by the youth in South Africa. These campaigns could be extended to focus on resiliency. Resiliency research should be seen as a core part of the many life skills initiatives across the country.

This would be an easy way to garner understanding and support for the concept of resilience and for applications of the concept.

Focusing on health promotion

Government spending needs to focus more on health promotion. While there are many positive developments in this area, there is still room for improvement. Focusing on health promotion is more cost effective as it reaches larger numbers of the population. With resiliency research a large part of health promotion interventions, even greater savings would occur in the long term as the need for mental health services for adults in future would then be greatly reduced.

Tapping into health promotion for resilience to find its place

It is important for resiliency research to gain greater prominence within health promotion. This would facilitate its application in the Department of Health in the Directorate of Health Promotion. Within education, there is a firm place for health promotion within the Life Orientation learning area. Grounding resiliency in health promotion would lead to a greater understanding of the philosophy and principles of resiliency.

Featuring in the national Life Orientation curriculum

The promotion of resilience amongst youth should feature more prominently in the national Life Orientation curriculum. Issues related to developing resilience should be more seriously addressed. The Life Orientation programme should include knowledge, skills, attitudes and values related to resilience.

Including a resilience component in the National Youth Risk Behaviour Survey

The National Youth Risk Behaviour Survey will be repeated every three to five years, which means that there is an opportunity to include a resiliency component to the survey. This will serve as a more useful assessment of the status of youth in this country. The inclusion of a resilience module needs to be actively pursued.

Ensuring a clear understanding and promotion of resilience concept

It is important to ensure that there is a clear understanding of the concept of resilience and the application of the concept. Many practitioners tend to associate resilience research with poverty and with assisting high-risk children to rise above their circumstances. Clarification of the concept in terms of its location in health promotion is very important for the South African context. The promotion of the concept is also dependent upon common understandings in terms of its meaning and application.

Focusing on resiliency

In line with other national initiatives in health and education, it would be useful to dedicate a day to resiliency research. This would enable schools and related institutions to focus on resilience and mobilize all efforts to achieving resilience amongst our youth apart from efforts that are integrated into health and education programs and that are ongoing throughout the year.

(b) Intervention at policy level



HPS policy to reach schools

National policy related to health promoting schools must be finalized. Health promoting schools policy must be integrated into all school-based initiatives whether in the Department of Health or Education. Each school must have a copy of the policy. They must receive it as part of their documentation from the Department of Education. This is necessary to ensure that it is accepted as a core part of education business.

HPS policy to offer practical guidelines for the establishment of HPS

Health promoting schools policy needs to be developed that not only speaks to the philosophies and theoretical frameworks that govern the HPS initiative but that also offer practical guidelines for the implementation or developments of health promoting schools. Policy documents needs to be practical and user-friendly. Schools need clarification of the HPS concept and how to implement it in their schools. Health promoting schools policy has to be clear on all aspects related to the development of health promoting

schools. Schools need to know how to develop their schools into health promoting schools. They need to know how to access support services to assist them in the process of developing the school into a health promoting school. They need each step of implementation to be clarified. They also need to adapt the policy and implementation guidelines to suit their particular circumstances.

Policy to clarify processes involved with resiliency

It is imperative that aspects of resiliency research are incorporated into health promoting schools policy. It needs to be seen as a critical component of the development of health promoting schools. Schools need to understand how the health promoting schools concept facilitates the development of resilience in children. They need to see that the entire philosophy, strategy and day to day running of the school needs to be geared towards the provision of support for all learners in order to foster resilience. The entire school community needs to be involved in the development of the schools into a health promoting school and subsequently into providing the necessary support for young people to become resilient.



Principles of whole school development and inclusive education to be integrated

The principles of whole school development and inclusive education need to be integrated with health promoting schools policy. This is currently evident in Draft 4 (DoH, 2000) of the policy guidelines. Greater refinement should occur where this integration translates into practice in the development of health promoting schools.

Teachers and other Education Support Services to provide input

There needs to be greater consultation with teachers, community members and other education support services personnel in the development and implementation of health promoting schools policy. It is the commitment of these individuals that enable the realization of policy. Furthermore, there are many initiatives that teachers, community members and education support services personnel are responsible for and that policy makers are unaware of. The experiences that are gained in the process are invaluable in terms of how it can facilitate the implementation of the health promoting schools concept.

(c) Education support services (ESS)

ESS personnel need to have guiding framework

Education support services personnel need to have a more specific guiding framework for the implementation and support of health promoting schools. Often these professionals are committed to the concept and the implementation thereof but are uncertain of their role in the process. This guiding framework needs to come from their superiors so that it is seen as a critical component of their work.

ESS needs to take responsibility for HPS

Education support service personnel need to take responsibility for the development of health promoting schools. Most initiatives need to have a change agent that is outside of the school to motivate and support teachers as they try to provide the best possible learning environment for their learners. Education support service personnel are in the best position to offer this service. Furthermore, support for health promoting schools is then seen as an integral part of the education system and further legitimizes the process.



ESS personnel need training in resiliency

Education support services personnel require training in resiliency. They need to be exposed to the development of resiliency research. They need to understand the concept and implementation thereof. They need to be trained in fostering resiliency so as to train teachers and other community members how to promote resiliency in youth.

ESS personnel need support

These service providers will also require support for their work. It is important that their support network extends outside of education and they are able to access help from individuals working for Health and Welfare. It is important to ensure that all role-players are motivated and encouraged to do resiliency work even though the positive nature of the field tends to keep individuals motivated.

ESS personnel to facilitate processes of support (school/community)

Education support services personnel have a critical role to play in accessing support from communities, businesses and NGOs for the school. They are both inside and outside of the school and it is therefore easier for them to facilitate positive relationships between the school and outside organizations. The combined subjective and objective view of the school that they have could assist in mediation where there may be unresolved conflict or resistance to supporting the school.

(d) Utilising the HPS, Whole School Development and Inclusive Education frameworks to foster resilience

Access for sharing

Most schools now have computers and access to the Internet. There is therefore an opportunity for schools to share their experiences with others with regard to the development of health promoting schools and the fostering of resilience. This sharing is crucial to sustaining the interest in and motivation for health promoting schools and resiliency. The national or even regional department of education could be encouraged to create a web address and newsletter for sharing initiatives related to resiliency and health promoting schools.

Positive stories to be shared

It is important for positive stories to be shared with others. It is not easy for schools to remain motivated with the constant demands from the department of education. Hearing about successes at other schools and learning from them serves as a motivating tool for schools. Also, lessons in resilience that comes from own or others experience makes the concept more tangible and reinforces support for it.

School support network

A school support network for resiliency will also facilitate support for the concept and support for the implementation of initiatives that foster resilience. Schools could connect with schools that are closest to them as well as schools from other areas. Connecting with

schools close by ensures ready access to support in the environment. Also, lessons from schools that are close by are more relevant as schools then share the same or similar communities and support service personnel.

Quarterly sharing meetings

Schools in a specific area should try to meet once per terms in order to share their experiences. Schools can learn from each other in terms of meeting challenges in their environment. These meetings can serve to motivate teachers to stay positive and to encourage their colleagues to maintain a positive view of the youth in the wake of numerous challenges.

Annual conferences and awards evenings

The implementation of annual conferences or seminars and awards evenings to acknowledge work done in the area of resilience will also serve to motivate schools to implement the health promoting schools concept and to foster resilience. These events could be organized by education support services personnel. It also presents a forum for sharing ideas. This could be a regional event.

Workshops to share challenges and successes

Regular monthly or quarterly workshops could be held to work through challenges experienced by schools in trying to foster resiliency. It is also an opportunity to share successes and to learn about what does and what does not work. This could be a gathering of schools in a particular cluster.

(e) School and community partnerships

Equal partners with parents

For school and community partnerships to be successful, schools need to see parents as partners and parents needs to see schools as partners in promoting resilience in their children and in enhancing their well-being. Often parents do not wish to connect with schools as they do not feel welcome in the environment. Alternatively, they feel relegated

to the periphery and that they have to do menial labour for the school. Parents need to have a say in important decisions that affect their children. Furthermore, resiliency research recognizes the prominent role of parents in fostering resilience and enhancing well-being in their children.

Democratic processes

Involvement of parents should be guided by democratic processes. Parents must be treated fairly and with respect. Their voices should be heard with respect to the best ways to support their children. They also have valuable contributions to make in terms of facilitating community involvement.

Acknowledgements

Parents must be acknowledged for their contributions. It is important to demonstrate appreciation for their inputs. Parents who are appreciated will encourage others to participate and to support the school as well.



Meeting basic needs

Parents in impoverished areas need to have their basic needs met before they can embark on service provision to the school. Many health promoting schools initiatives enable parents to work in vegetable gardens and generate food or an income for themselves. This facilitates the meeting of basic needs, which is then rewarded with service.

Partnerships with businesses

Businesses are often approached to support schools and the response is often poor. It is important for businesses to see that supporting a school that has as its primary mission the fostering of resilience amongst its youth, will inevitably benefit business as well. Young people who are supported are less likely to engage in risk behaviour, are more likely to discourage others from doing so, and are more likely to make a positive contribution to the community in which the business is situated. This approach is far more likely to garner support for the school than an isolated request.

Proactive principals

A proactive principal is a critical factor in school and community partnerships. A principal who is known to the parents, community, businesses and other stakeholders is more likely to receive support from the community. This involves getting to know people by name, advertising the activities of the school, highlighting the successes of the school and so forth. The principal has to let the community know about resiliency initiatives at the school and how working together to foster resilience amongst the youth is beneficial to all partners.

(e) Teacher development

In-service training for resiliency

Teachers will require in-service training with regard to resiliency. This will be ongoing training to ensure that the positive approach to learners and to the programme is sustained. This will also include aspects related to resiliency such as developing a positive self-esteem, problem-solving, empathy, and so forth. Life skills training for managing depression and suicide, bullying and harassment, AOD use and other areas are also important but need to be addressed within a resiliency framework.

Teacher rewards

It is imperative that teachers are acknowledged and rewarded for their efforts in fostering resilience. This will encourage them to continue to do so. This reward need not be financial but could take the form of announcement of special efforts made by teachers to support young people.

(f) Classroom development

Warm and welcoming environments

An important aspect of resiliency training is the development of a warm and welcoming classroom environment. Learners need to feel nurtured in their learning environment. This will facilitate an eagerness to learn and to co-operate in class.

Democratic environments

Classrooms must be managed democratically. Learners should participate in decision-making as far as possible. They should be involved in the setting of class rules and incentives for good performance. Their voices should be heard and their opinions valued. This will improve the area of meaningful participation, which is a critical component of resilience.

Active learning

Learners need to be actively engaged in the learning process. They need to generate new knowledge and be granted opportunities to be creative. They need to engage in group work and learning from others. This will facilitate the development of internal strengths and peer support which are critical components of resilience.

Inclusive education

The classroom environment needs to be inclusive. Learners with diverse needs should be accommodated. Learners need to respect and support each other. Teachers should treat all children equally while providing extra support to those who require it.

Structural building elements

Structural elements of the building need to be considered. For a classroom to be considered healthy, aspects of ventilation, lighting, seating, cleanliness and so forth need to be attended to. This will facilitate the development of a supportive environment in which resilience could be fostered.

Positive communication

It is important that learners know that only positive responses and approaches are tolerated in the classroom. Feedback and all forms of communication should be strengths-based as opposed to deficits-based. This will instill habitual forms of responding, which the young people will carry with them throughout their lives.

Discipline

Discipline is an important aspect of resilience. In the classroom, discipline must be framed within resiliency and democratic practices. Negative connotations of discipline must be removed. Young people need to acquire discipline in order to meet their goals in life.

(g) Peer development

Supportive peers

There needs to be a concerted effort at school level to instill the notion of support amongst peers. There is much competitiveness amongst peers that is not conducive to relationship building and support. Peer support is a critical component of resiliency and much more attention needs to be paid to this area.

Pro-social behaviours

It seems that young people are more likely to encourage deviant behaviour than deter their peers from engaging in risk behaviours.  It is important to encourage pro-social behaviour amongst peers in the classroom, within the school and the broader community. Parents and community members ought to be approached to assist with this.

Be community-service oriented

The youth must be encouraged to serve their communities. They should act as volunteers as far as possible. They must help to meet the social needs of their community. This will help develop responsibility and deter engagement in risk behaviours. This will also enable community to see youth in a positive light and to respond positively to them.

Connect with NGOs

Youth could connect with NGO's in their communities to provide various services. This will also assist them in reaching their goals and aspirations. The work experience could help define the future careers. It would also enable them to be of service to their communities in addition to occupying a particular job one day.

(h) Individual development

Life skills

Young people need life skills training in addition to the life orientation curriculum to which they are exposed at school. This training should encompass knowledge, attitudes, skills and values. The fact that engagement in risk behaviours seem to have increased demonstrates that more needs to be done to facilitate change in behaviours.

Volunteering

Young people need to acquire the habit of volunteering. The benefits of volunteering in terms of experience, exposure and personal and social development needs to be conveyed to them.

Caring for others

Young people need to learn to care for others. There are NGOs who could assist in terms of placements with the elderly or with orphans. There is a particularly great need for volunteers to work with HIV/AIDS orphans. This will help to develop empathy, which in turn will dissuade young people from engaging in violence and abuse towards others.

Sports and culture

Young people need to participate in sports and cultural events. This has been proven to be a deterrent to engaging in risk behaviours. It also encourages leadership skills, participation, team-building, peer support and so forth. Schools need to be assisted in offering these events at schools in impoverished areas. Engagement in these activities tends to build internal strengths and facilitates resilience and positive outcomes.

9.4 LIMITATIONS OF THE STUDY

This study was restricted to seven schools that were representative of the learner population of the Western Cape. While the study could refer to previously advantaged or disadvantaged schools or learners, the delineations are not as evident in the present time

as it was in the past. One therefore has to exercise caution when generalizing the findings.

A larger sample would have been ideal in order to study the application of the principles of the YDCM (refer chapter one) but was not possible for the purposes of this particular research study. One way of overcoming this limitation would be to link with the National Youth Risk Behaviour Survey that will be conducted in future.

The study was conducted in English even though learners spoke different languages. While schooling is offered in English at the high schools involved in the study, translation of the survey and interviewing schedules could have led to more open and honest results with learners feeling more comfortable with the language.

This study focused on youth who were at school at the time of the study. This means that out of school youth and absentees were excluded. This could have influenced the results as youth who play truant or drop out are more likely to engage in risky behaviour. The term 'youth' in this study therefore applies largely to 'in-school' youth.

The research instruments were not developed in South Africa. While the instruments were clearly user-friendly, greater successes could possibly be obtained with instruments that are developed locally. The National Youth Risk Behaviour Survey (MRC, 2003) can now be utilised instead of the risk modules of CHKS. This study did not link with the national survey in terms of the instrument utilized because this study occurred before the national study. A resilience module could be developed in collaboration with other South African researchers who are also currently exploring positive psychology.

The schools involved in this study are state schools. Private schools were therefore excluded. It is therefore not possible to comment upon possible risk or resilience profiles of this group, which tends to consist of affluent youth and communities.

This research was innovative for South African purposes as there exists no national precedent for this kind of research where risk and resilience profiles of learners were studied. This is both advantageous and disadvantageous. It was advantageous as it presents us with new ideas for approaching the issues of risk and resilience. It also enables us to develop unique South African solutions to the challenge of youth wellness. It was disadvantageous as this study had to rely quite heavily on international initiatives and studies in this regard. These international studies do not have the specific South African history and vast dynamics in terms of diversity and equity that we have.

This research is also the first phase in a process that involves identifying a possible framework of intervention to address the problems of risk and to foster resilience amongst our youth. With few precedents in South Africa in this regard, it is tentative in its conclusions and recommendations but very optimistic about the possibilities.

9.5 IMPLICATIONS AND SUGGESTIONS FOR FUTURE RESEARCH



It is important for future research to link with the National Youth Risk Behaviour Survey in order to add this important aspect to the research process but also to work with larger numbers in terms of collection of data, data analysis and interpretation. It is also important to link with research groups in South Africa who have an interest in fostering resilience in children. South African studies to date have focused on fortitude.

It is also important in terms of the philosophy of this particular research to implement and evaluate the processes advocated to foster resilience in schools. This includes training, implementation and evaluation. Schools need assistance to implement the processes being advocated. The seven schools involved in this study could serve as pilot schools for this process.

The importance of finding South African solutions to South African challenges cannot be emphasised enough. The aim is to generate solutions that will suit the particular history, current status and future of a particular school. All this should take place within the

health promoting schools framework and resiliency research framework as these frameworks have been proven to transcend challenges of race, ethnicity and socio-economic status.

Collection of informal data on the factors that place youth at risk or alternatively, that foster resilience should also be encouraged. Many innovations occur in communities that do not necessarily have strengths in data gathering and report writing. Research students should be deployed to these communities to assist with data gathering and processing. At the same time, skills should be imparted to these communities to accurately record their own data. Acknowledgement of the work done by these communities and their contributions to the research process should also be given.

Consultation with the developers of the national mental health promotion programme in Australia, MindMatters, could occur to assist with the development of a comprehensive learning programme that addresses risk and resilience issues within a health promoting schools framework. This programme could be integrated into our Life Orientation Curriculum.



9.6 CONCLUDING REMARKS

The reason for embarking on this research was concern for the well-being of South African youth. There is clearly a need to provide support in the wake of the numerous challenges facing them. This research has explored aspects of risk, resilience and health promoting schools in order to generate possible solutions to the problem. In the end it was found that the solution is not necessarily a specific programme of intervention but rather a facilitation of certain processes to access an inherent ability to succeed despite harsh circumstances. The facilitation of processes involves accessing support at home, school, in the community and amongst peers. The value of this approach is that it is available to all young people. It just needs to be nurtured. The health promoting schools framework serves to provide a strategy for strengthening and accessing support and contributing to well-being. It is a framework that has proven to be acceptable to schools

but need to be clarified for understanding and needs to be part of education policy and strategic planning documents. South African schools have demonstrated that this is a framework that is positive and that can be adapted to suit their needs. Framing resiliency research within the health promoting schools concept will facilitate adoption of both frameworks by schools and enhance the well-being of all learners.

It is important to find indigenous solutions to South African challenges. This research is a first step in discovering and advancing frameworks that are flexible, adaptable and grounded in an eco-systemic paradigm – an approach which recognizes that mental health is greatly influenced by social circumstances, and that resilience research can enable us to develop young people who rise beyond the challenges of adversity, to contribute positively to society.



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APPENDICES

APPENDIX I

THE CALIFORNIA HEALTHY KIDS SURVEY

The Survey Content is as follows (WestEd, 1999:6):

Module A: Core

The core survey module covers five priority areas: alcohol and drug use, tobacco use, violence and school safety, physical activity and diet. It provides a comprehensive overview to health-related behaviour and attitudes. Respondents are asked about their substance-using behaviours over their lifetime and in the 30 days prior to the survey; school violence, the past year. In addition, it includes basic demographic background questions (age,sex,race/ethnicity) and three items that assess the reliability of answers.

Module B: Resilience Assessment

The growing popularity of resilience or asset-based prevention and youth development programs created a need for a comprehensive measure of protective factors and resilience traits that is theoretically sound, developmentally and culturally appropriate, reliable and valid. Developed with the assistance of a national panel of experts, it consists of 65 items assessing the 19 developmental assets most consistently identified by researchers as associated with health-risk behaviour protection and positive youth development. These include caring relationships, high expectations, opportunities to participate in meaningful activities, social competence, autonomy, sense of meaning, and purpose. Items assess attitudes toward school, family background, communication, neighbourhood conditions, and in positive activities.

“The RYDM has met the demanding criteria specified by a national resilience research panel. It is the only student assets survey currently available that: (a) is derived from an explicit research-based theoretical foundation; (b) provides a comprehensive and balanced coverage of both external and internal assets; (c) has assured developmental and cultural appropriateness for California students through extensive pre-test focus groups and field testing; and (d) has demonstrated the psychometric reliability and construct validity for each of its individual asset measures and asset clusters” (WestEd, 2003:2)

Module C: Alcohol Use, Drug Use, and Violence

This module consists largely of additional items from the California Student Survey relating to AOD use and violence, including recent frequency of AOD use in the past six months, problems experienced, perceived use by peers and adults, and friends’ attitudes. Less school-specific than the core, it includes general questions about fighting, delinquency (including drug sales), bullying and weapons possession. It can help you understand the dynamics of these problems and provides greater comparability to state norms. It also includes YRBS-derived suicide-related items.

Module F: Sexual behaviour and pregnancy prevention

The items in this module, the majority derived from the YRBS, assess sexual experience, patterns, and attitudes, pregnancy history, and HIV-related risk behaviours. They cover number of partners (a main HIV risk factor), perception of peer behavioural norms, use of contraception, AOD use before sexual intercourse, family, and exposure to HIV/AIDS education. Early sexual activity is associated with involuntary first intercourse, sexually transmitted diseases (including HIV infection, and unwanted pregnancy).

APPENDIX II

¹INTERVIEWING SCHEDULES

FOCUS GROUP 1: LEARNERS

Thesis Aims:

To determine the mental health needs and strengths of our youth

To determine the form and extent of support being provided to learners

Questions:

(a) Needs and Strengths

What would you describe as the most pressing needs that teenagers experience today?

What resources or strengths do you think young people possess that could assist them in meeting their needs?

(b) Factors that contribute to well-being

What in your view contributes to the development of positive mental health or well-being of young people?

What in your view contributes to the psychological distress of young people?

(c) Support (What support is provided)?

In your opinion, what forms of support is provided to young people to contribute to positive mental health or well-being?

What role does the school play in contributing to the well-being of young people?

What policies are in place to meet the needs of young people?

How has the environment at school been transformed to provide support?

How has the curriculum been adapted to secure well-being?

How do the school and community work together to provide you with support?

What other service providers are involved in the school to help in providing support?

(d) Support (What support could be provided)?

In your opinion, what forms of support could be provided to young people to contribute to positive mental health or well-being?

What role could the school play in contributing to the well-being of young people?

What policies could be put in place to meet the needs of young people?

How could the environment at school be transformed to provide support?

What ideas do you have for a curriculum that is aimed at securing well-being?

How could the school and community work together to provide you with support?

What other service providers could be involved in the school to help in providing support? How could they be involved so as to be helpful to you?

(e) General / Other

Do you have any other comments related to the mental health or well-being of learners?

THANK YOU

APPENDIX III

²INTERVIEWING SCHEDULES

Guidance Counsellors

Aim:

To evaluate the health promoting schools framework as a key strategy in addressing mental health needs of learners

Questions:

(a) Assessment of well-being

If you were to provide an assessment of the mental health or well-being status of the learners at your school, what would your response be?

What about the status of teachers?

(b) How schools could promote well-being

In your opinion, how could the school contribute to the mental health or well-being of the learners? Teachers?

(c) What is in place?

What mechanisms are in place at school to provide support to learners?

Teachers?

(d) What should be in place

What kinds of training or support do you think teachers require in order to meet the mental health needs of learners?

(e) The health promoting schools framework

To what extent have you been exposed to the HPS concept?

In what ways do you think that the HPS concept could be helpful in providing much needed support to learners and teachers in order to promote their well-being?

Describe the ethos or environment of the school. Do you have any ideas or suggestions for improving the ethos of the school? (The relationships amongst learners at school? Amongst staff members?)

What kinds of policies are in place to meet the needs of learners and how could this be improved?

Describe the relationship between the school and its community and suggest ways for improving this relationship?

How does the curriculum of the school contribute to the well-being of the learners? What are your suggestions for improvements in this regard?

Which service providers are available to the school? Describe the relationship between the school and its service providers. Suggest ways for improving these relationships in order to contribute to the well-being of learners and teachers

(f) General / Other

Any other comments related to the mental health or well-being of learners or teachers?

THANK YOU

APPENDIX IV



University of the Western Cape

Private Bag X17 Bellville 7535 South Africa
Tel. 021-9592246
Fax: 021-9592647 / 3358

Faculty of Education

The Principal
*****High School
Khayelitsha

Dear *****

Re: A request for your school to participate in a pilot study

I hereby wish to request that your school serve as a pilot site for my PhD study. The study wishes to obtain risk and resilience profiles of our youth. The aim of the study is essentially to find ways to strengthen the resilience of our youth so that they may overcome adversity and look forward to a bright future.

Being involved in the pilot process of the study means assisting me to determine whether the questionnaires are suitable for South African schools. The instrument that we will use is an American instrument and we need to adapt it before we can conduct a main study. The results of the pilot will be made available to the school as it will serve to inform the school of the mental health status of some of their youth. The results could therefore be utilised to inform educational programmes and interventions that the school may wish to offer. It will also inform the life orientation curriculum in particular. I wish to assure your school of issues of confidentiality. The CHKS is very strict about ethics and confidentiality and a memorandum of understanding has been signed with them in this regard.

I am hoping that one grade nine class could be available on Thursday, 27 February 2003 for about one hour to fill in the questionnaires. I will then also require a small group (10 girls and boys) for one hour to answer some focus group questions (it does not have to be the same class). The school could determine what time would suit them and I will make arrangements accordingly.

The WCED (Dr Ronald Cornelissen) has been appraised of the study and I will bring the letter of consent with me on the day of the survey.

I hope and trust that you will be able to assist me in this regard and I look forward to your response.

Best wishes and kind regards
Bridget Johnson
Tel: 959 3633 / 2246

APPENDIX V

THE CALIFORNIA HEALTHY KIDS SURVEY 2003 SECONDARY SCHOOL

Dear Parent

Your child is being asked to be a participant in the California Healthy Kids Survey (CHKS). The survey forms part of a study that is being conducted by the University of the Western Cape, to assess the usefulness of the CHKS for South African purposes. Your written permission on this form is required for your child to be in the survey. The following are facts to help you make your decision:

BACKGROUND TO THE SURVEY

The CHKS is a comprehensive youth health risk and resilience data-collection tool to assess needs and improve prevention and health programs. The CHKS is designed to send a positive message of the importance of a healthy lifestyle and to promote the development of a comprehensive school health program. It aims to foster school and community collaboration in tackling these critically important issues. The CHKS requests information to understand the impact of strategies and programs, not to identify specific schools with problems. The survey results will provide guidance for improving health programs and services to help staff strengthen programs.

SURVEY CONTENT

The survey will gather information on health-risk behaviours as well as protective factors. The survey will gather information on health risk behaviours such as physical activity and nutritional habits; substance abuse, violence and safety. It will also gather information on protective factors such as positive home environments, good family and peer relationships, mentoring opportunities, etc. The results of the survey often highlight successes. The survey is called "Healthy Kids" precisely to highlight a positive message, rather than focus on problem or bad behaviour.

STUDENT SELECTION

Your child is being asked to participate in the survey because s/he is in a classroom that was chosen at random (by chance).

IT IS VOLUNTARY

Your child does not have to take the survey. There will be no penalties against you or your child for not participating. Students only have to answer the questions they want to answer and they may stop taking it at any time. Before the survey begins, the survey's purpose, content and procedures will be explained again. Your child will be able to ask questions.

IT IS ANONYMOUS & CONFIDENTIAL

Your child's privacy is protected. No names will be recorded or attached to the survey. No information will permit your child to be identified or connected with his/her answers.

THE PROCESS IS TRANSPARENT

The Western Cape Education Department has granted permission for the research to be conducted. The school will receive a copy of the results of the survey.

THANKING YOU

Bridget Johnson
Registered Psychologist / Lecturer
Faculty of Education
UWC

THE CALIFORNIA HEALTHY KIDS SURVEY

IHEREBY DO / DO NOT (please circle choice)
GRANT PERMISSION FOR MY CHILD TO PARTICIPATE IN THE SURVEY

Parent Guardian's Signature
Child's name and grade
Date



APPENDIX VI

RESEARCH DATA RISK PROFILES

4.2 SURVEY RESULTS

4.2.1 MODULE A: CORE

4.2.1.1 Sample characteristics

(a) Response rates

Table 4.1: Student sample characteristics

SCHOOL	C	D	E	F	G	H	I	TOTAL
SAMPLE								
Target (n)	78	63	92	60	59	67	93	512
Final (n)	70	57	89	54	55	54	93	472
AVE RESPONSE RATE (%)	90%	90%	97%	90%	93%	81%	100%	92%

(b) Age

Table 4.2: Age of sample

	C	D	E	F	G	H	I	AVE
12+less	0	0	0	0	0	0	1	0%
13	5	0	3	4	2	4	4	3%
14	5	74	78	55	66	78	11	52%
15	40	26	16	42	32	16	30	29%
16	21	0	2	0	0	2	18	6%
17	19	0	0	0	0	0	14	5%
18+more	9	0	0	0	0	0	22	4%

Q: How old are you?

(c) Gender

Table 4.3: Gender of sample

	C	D	E	F	G	H	I	AVE
MALES	42	35	47	43	48	44	49	44%
FEMALES	58	65	53	57	52	56	51	56%

Q: What is your sex?

(d) Race and ethnicity

Table 4.4: Ethnic/racial characteristics of sample

	C	D	E	F	G	H	I	AVE
African	37	20	48	25	21	57	51	37%
Khoisan	2	2	1	0	2	0	2	1%
Indian	0	4	5	2	8	0	0	3%
Black	62	0	2	9	2	0	48	18%
Coloured	3	96	84	17	19	83	0	43%
White	0	15	3	74	74	0	0	24%
Other	0	7	2	8	6	4	0	4%

Selected more than one	3	37	44	32	26	43	2	27%
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Q: How do you describe yourself? (Mark all that apply)

(e) Transience

Table 4.5: Frequency of residence changes, past 12 months

	C	D	E	F	G	H	I	AVE
O times	42	85	72	81	80	91	36	70%
1 time	24	11	14	13	15	7	39	18%
2 or more times	35	4	14	6	6	2	25	13%

Q: During the past year, how many times have you moved (changed where you live)?

(f) Grades

Table 4.6: Grades, past 12 months

	C	D	E	F	G	H	I	AVE
Mostly A's	49	4	20	23	4	2	56	23%
A's and B's	23	29	39	31	11	4	19	22%
Mostly B's	11	4	10	13	11	4	9	9%
B's and C's	9	38	10	10	28	31	5	19%
Mostly C's	4	5	6	12	11	12	2	7%
C's and D's	2	16	11	12	25	35	5	15%
Mostly D's	0	4	2	0	9	8	0	3%
Mostly F's	2	0	1	0	0	4	4	2%

Q: During the past 12 months, how would you describe the school grades you mostly received

(g) Truancy

Table 4.7: Truancy, past year

	C	D	E	F	G	H	I	AVE
O	69	53	51	42	67	71	61	59%
1-2	20	28	22	36	22	21	14	23%
A few times	9	18	23	19	7	8	18	15%
Once a month	0	2	1	2	2	0	1	1%
Once a week	2	0	1	2	0	0	3	1%
More	0	0	2	0	2	0	2	1%

Q: During the past 12 months, about how many times did you skip school or cut classes?

4.2.1.2 Alcohol and other drug use

(a) Overall use

Table 4.8: Lifetime Prevalence (ever used)

	C	D	E	F	G	H	I	AVE
None	60	17	36	34	33	39	32	36%
Any AOD use	40	83	64	66	67	61	68	64%

Alcohol

	C	D	E	F	G	H	I	AVE
0	71	17	37	35	31	37	69	42%
1 time	9	9	24	8	8	12	12	12%
2-3 times	11	9	16	22	8	10	6	12%
4+ times	9	64	23	35	54	41	13	34%

Marijuana

	C	D	E	F	G	H	I	AVE
0	87	80	89	90	75	58	77	79%
1 time	6	4	5	6	10	12	14	8%
2-3 times	4	4	3	4	10	16	6	7%
4+ times	4	12	3	0	6	14	3	6%

Inhalants

	C	D	E	F	G	H	I	AVE
0	91	88	97	90	90	88	82	89%
1 time	2	10	1	4	8	10	13	7%
2-3 times	6	0	1	4	2	0	4	2%
4+ times	2	2	0	2	0	2	1	1%

Cocaine

	C	D	E	F	G	H	I	AVE
0	94	100	97	100	98	97	79	95%
1 time	4	0	0	0	2	0	16	3%
2-3 times	0	0	1	0	0	3	3	1%
4+ times	2	0	1	0	0	0	3	1%

Methamphetamines

	C	D	E	F	G	H	I	AVE
0	85	94	94	96	100	89	66	89%
1 time	10	4	4	2	0	5	22	7%
2-3 times	6	0	1	2	0	3	6	3%
4+ times	0	2	0	0	0	3	6	2%

LSD

	C	D	E	F	G	H	I	AVE
0	88	98	88	100	92	100	59	89%
1 time	6	2	12	0	8	0	25	8%
2-3 times	2	0	0	0	0	0	10	2%
4+ times	4	0	0	0	0	0	7	2%

Ecstasy

	C	D	E	F	G	H	I	AVE
0	92	90	99	96	98	84	89	93%
1 time	2	8	0	4	0	11	10	5%
2-3 times	4	0	0	0	2	5	2	2%
4+ times	2	2	1	0	0	0	0	1%

Heroin

	C	D	E	F	G	H	I	AVE
0	86	98	100	100	100	100	72	94%
1 time	6	2	0	0	0	0	10	3%
2-3 times	6	0	0	0	0	0	7	2%
4+ times	2	0	0	0	0	0	11	2%

Other Drugs

	C	D	E	F	G	H	I	AVE
0	92	92	99	100	98	95	90	95%
1 time	2	8	1	0	2	5	8	4%
2-3 times	2	0	0	0	0	0	1	0%
4+ times	4	0	0	0	0	0	0	1%

Q: During your life, how many times have you used or tried...?

(b) Thirty-day prevalence (current use)

Table 4.9: Any current AOD use, past 30 days

	C	D	E	F	G	H	I	AVE
None	69	55	63	60	54	67	42	59%
Any	31	45	37	40	46	33	58	41%
Alcohol	24	41	34	42	45	32	37	36%
Marijuana	4	8	5	4	6	11	15	8%
Inhalants	8	2	2	6	0	3	20	6%
Cocaine	8	0	3	0	0	3	16	4%
Meth	14	2	2	2	0	3	20	6%
Ecstasy	13	4	0	0	0	0	8	4%
LSD	2	0	2	0	2	0	16	3%

Q: During the past 30 days, on how many days did you use...?

(c) Use frequency and level

Frequent current use

Table 4.10: Frequency of current alcohol and marijuana use, past 30 days.

	C	D	E	F	G	H	I	AVE
ALCOHOL								
None	76	59	66	58	55	68	63	64%
1 or 2 days	14	29	26	26	27	21	25	24%
3 – 9 days	8	10	4	12	14	8	7	9%
10-19days	0	2	1	4	2	0	3	2%
20+days	2	0	3	0	2	3	3	2%
MARIJUANA								
None	96	92	95	96	94	89	85	92%
1 or 2 days	2	2	4	4	6	11	8	5%
3-9 days	0	6	1	0	0	0	3	1%
10-19days	2	0	0	0	0	0	3	1%
20+days	0	0	0	0	0	0	1	0%

Q: During the past 30 days, on how many days did you use...?

(d) Lifetime drunkenness

Table 4.11: Ever very drunk or sick from drinking alcohol

	C	D	E	F	G	H	I	AVE
0	82	56	77	68	69	56	78	69%
1 time	8	15	13	10	14	12	11	12%
2-3 times	3	15	4	10	12	17	8	10%
4+times	7	13	6	12	6	15	4	9%

Q: During your life, how many times have you been very drunk or sick after drinking alcohol?

(e) Lifetime ‘high’

Table 4.12: Ever ‘high’ from using drugs

	C	D	E	F	G	H	I	AVE
0	92	78	94	90	79	71	91	85%
1 time	4	4	3	4	8	17	3	6%
2-3 times	0	8	1	6	9	5	4	5%
4+times	4	10	1	0	4	7	1	4%

Q: During your life, how many times have you been ‘high’ (loaded, stoned or wasted from using drugs)?

(f) Heavy episodic (binge) drinking

Table 4.13: Current binge (episodic heavy) drinking, past 30 days

	C	D	E	F	G	H	I	AVE
0 days	90	81	89	88	85	83	81	85%
1-2 days	4	15	4	8	10	3	11	8%
3+days	6	4	7	4	6	15	8	7%

Q: During the past 30 days, on how many days did you use 5 or more drinks of alcohol in a row, that is, within a couple of hours?

(g) Drinking styles

Table 4.14: Desired level of alcohol consumption, drinking style or preference

	C	D	E	F	G	H	I	AVE
Don't drink	82	23	49	30	31	50	57	46%
Sip or two	9	15	25	36	25	11	19	20%
Feel it a little	2	33	16	19	31	24	9	19%
Feel it a lot	2	23	5	6	10	5	7	8%
Until drunk	5	6	4	9	2	11	8	6%

Q: How do you like to drink alcohol?

(h) Drinking and driving

Table 4.15: Ever driven after drinking (respondent or by friend)

	C	D	E	F	G	H	I	AVE
Never	90	58	68	75	80	68	82	74%
Any	10	42	32	25	20	32	18	26%
1 time	3	5	15	6	13	12	4	8%
2 times	3	7	9	8	6	8	3	6%
3-6 times	2	18	6	6	2	8	3	6%
7+times	2	11	2	6	0	4	3	4%

Q: During your life, how many times have you ever driven a car when you had been drinking alcohol, or been in a car driven by a friend when he or she had been drinking?

(i) AOD use and intoxication at school

Current use on school property

Table 4.16: Any current alcohol and marijuana use on school property, past 30 days

	C	D	E	F	G	H	I	AVE
ALCOHOL								
0 days	80	98	89	100	100	100	70	91%
1-2 days	10	2	7	0	0	0	20	6%
3+ days	10	0	4	0	0	0	9	3%
MARIJUANA								
0 days	95	98	99	100	100	100	94	98%
1-2 days	2	0	1	0	0	0	5	1%
3+days	2	2	0	0	0	0	2	1%

Q: During the past 30 days, on how many days on school property, did you ...have at least one drink of alcohol...smoke marijuana?

Lifetime intoxication at school

Table 4.17: Ever drunk or high on school property

	C	D	E	F	G	H	I	AVE
0 times	90	96	96	96	92	88	92	93%
1 time	10	2	3	2	6	7	3	5%
2-3 times	0	2	0	0	0	5	3	1%
4+ times	0	0	1	2	2	0	3	1%

Q: During your life how many times have you been drunk or 'high' on drugs on school property?

(j) Use correlates and influences

Perceived harm

Table 4.18: Perceived harm of frequent alcohol and marijuana use

	C	D	E	F	G	H	I	AVE
ALCOHOL								
Extremely harmful	77	33	43	33	21	31	51	41%
Harmful	7	37	29	35	38	49	22	31%
Somewhat	7	24	16	26	23	18	14	18%
Mainly harmless	5	7	7	7	19	3	4	7%
Harmless	5	0	4	0	0	0	9	3%
MARIJUANA								
Extremely harmful	80	65	81	87	55	71	74	73%
Harmful	0	27	7	9	27	11	5	12%
Somewhat	5	4	1	2	12	14	6	6%
Mainly harmless	0	4	3	0	4	0	2	2%
Harmless	16	0	7	2	2	3	13	6%

Q: How harmful do you think it is to use the following substances frequently (daily or almost daily)?

Peer sanctions against use

Table 4.19: Peer pressure not to use alcohol and marijuana

	C	D	E	F	G	H	I	AVE
ALCOHOL								
A lot	32	20	29	32	22	22	39	28%
Some	16	11	29	26	22	28	14	21%
Not much	5	35	14	17	26	22	12	19%
Not at all	48	35	28	26	30	28	34	33%
MARIJUANA								
A lot	38	41	59	72	54	39	46	50%
Some	9	29	7	19	27	27	7	18%
Not much	7	12	1	4	13	15	7	8%
Not at all	47	18	32	4	6	18	39	23%

Q: How much would your friends stop you from using the following substances?

Estimated peer use

Table 4.20: Student perception of percent of marijuana use among peers

	C	D	E	F	G	H	I	AVE
None	62	8	52	15	10	0	73	31%
10%	13	16	20	35	29	24	9	21%
20%	2	12	7	15	21	16	1	11%
30%	4	8	9	23	15	18	6	12%
40%	2	16	1	4	10	5	4	6%
50%	13	18	7	0	12	18	6	11%
60%	2	6	1	6	2	3	1	3%
70%	2	8	3	0	2	5	0	3%
80%	0	6	0	2	0	8	0	2%
90%	0	2	0	0	0	3	0	1%
All of them	0	0	0	0	0	0	0	0

Q: About what percent of students in your grade have done the following? Ever tried marijuana?

Availability

Table 4.21: Perceived difficulty of obtaining alcohol and marijuana

	C	D	E	F	G	H	I	AVE
ALCOHOL								
Very difficult	45	8	25	4	6	3	42	19%
Fairly difficult	2	8	14	10	13	18	14	11%
Fairly easy	2	29	21	26	44	29	4	22%
Very easy	9	43	26	48	33	32	14	29%
Don't know	43	12	15	12	4	18	25	18%
MARIJUANA								
Very difficult	40	12	41	10	11	11	49	25%
Fairly difficult	8	13	9	16	22	11	6	12%
Fairly easy	0	19	3	16	19	28	6	13%
Very easy	6	31	13	16	26	22	4	17%
Don't know	46	25	33	41	22	28	35	33%

Q: How difficult is it for students in your grade to get any of the following substances if they really want them?

Availability at school

Table 4.22: Offered illegal drugs on school property, past 12 months

	C	D	E	F	G	H	I	AVE
0 times	77	73	95	96	79	66	87	82%
1 time	15	13	4	4	11	19	10	11%
2 or 3 times	4	7	0	0	4	6	4	4%
4+ times	4	7	1	0	6	9	0	4%

Q: During the past 12 months, how many times on school property have you...been offered, sold, or given an illegal drug?

(k) Alcohol and drug use measures

Table 4.23: Selected alcohol and drug use measures, by gender and grade

	C		D		E		F		G		H		I	
	F	M	F	M	F	M	F	M	F	M	F	M	F	M
LIFETIME AND CURRENT ATOD USE														
During your life, did you ever														
Drink alcohol	29	30	92	65	64	62	66	64	78	60	62	71	33	29
Use inhalants	6	14	12	12	3	3	4	14	4	16	19	6	17	21
Smoke marijuana	13	15	27	6	8	16	7	14	26	24	36	50	14	30

During the past 30 days, did you														
Drink alcohol	20	29	51	14	33	37	48	35	46	44	30	35	42	27
Use inhalants	8	10	3	0	0	4	4	10	0	0	5	0	21	24
Smoke marijuana	3	5	12	0	5	6	0	10	4	8	9	17	6	22

LEVEL OF INVOLVEMENT (HIGH RISK PATTERNS)														
During your life, have you ever														
Been very drunk or sick after drinking alcohol														
	15	16	47	13	15	9	34	10	35	19	38	39	18	12
Been high from using drugs														
	3	0	26	0	3	9	10	5	22	8	20	19	6	9
During the past 30 days, did you														
Drink 5 or more drinks of alcohol in a couple of hours														
	7	14	28	0	2	22	11	14	23	8	18	19	23	12
ATOD USE AT SCHOOL														
During your life, have you ever been drunk /high on school property?														
	17	0	6	0	0	9	3	5	7	8	9	19	3	9
During the past 30 days, did you use marijuana on school property?														
	0	11	3	0	3	0	0	0	0	0	0	0	3	4
PERCEIVED HARM														
Frequent (daily or almost daily) use of ... is extremely harmful														
Alcohol	96	81	94	93	91	84	96	90	82	80	100	93	91	79
Marijuana	92	69	97	94	92	87	100	95	96	91	100	93	86	86

4.2.1. 3. Tobacco Use

(a) Use prevalence and patterns

Lifetime prevalence (ever used)

Table 4.24: Ever used cigarettes or smokeless tobacco, lifetime

	C	D	E	F	G	H	I	AVE
A Cig, even 1 or 2 puffs								
0 times	73	30	36	30	36	24	78	44%
1 time	8	9	15	15	13	10	7	11%
2 or 3 times	14	8	17	30	11	10	9	14%
4+ times	5	53	32	25	40	55	6	31%

A whole cig								
0 times	89	49	58	58	55	49	84	63%
1 time	4	10	14	10	4	9	8	8%
2 or 3 times	4	4	10	12	6	2	1	6%
4+ times	4	37	18	21	36	40	7	23%
Smokeless tobacco								
0 times	89	92	96	94	98	90	88	92%
1 time	2	4	1	2	0	2	8	3%
2 or 3 times	7	2	0	2	0	2	3	2%
4+ times	2	2	3	2	2	5	1	2%

Q: During your life, how many times have you used or tried...?

(b) Thirty-day prevalence (current use)

Table 4.25: Any and daily current use of cigarettes and smokeless tobacco, past 30 days

	C	D	E	F	G	H	I	AVE
Cigs								
Any	14	29	25	18	23	50	16	25%
Daily	0	10	8	0	2	20	3	6%
Smokeless Tobacco								
Any	11	2	4	0	0	5	6	4%
Daily	0	0	0	0	0	0	0	0

Q: During the past 30 days, on how many days did you use...?

(c) Smoking on school property

Table 4.26: Current smoking on school property, past 30 days

	C	D	E	F	G	H	I	AVEAL
None	86	92	82	93	96	71	81	86%
Any	14	8	18	7	4	29	19	14%
1 or 2 days	10	6	5	2	2	11	11	7%
3 – 9 days	4	2	6	4	0	9	4	4%
10-19days	0	0	0	0	0	3	1	1%
20-30days	0	0	8	0	2	6	3	3%

Q: During the past 30 days, on how many days on school property did you smoke cigarettes?

(d) Use influences

Peer sanctions

Table 4.27: Peer pressure not to use cigarettes

	C	D	E	F	G	H	I	AVE
A lot	33	14	35	36	22	16	48	29%
Some	11	26	23	27	31	18	5	20%
Not much	2	28	15	20	37	29	5	19%
Not at all	54	32	27	18	10	37	42	31%

Q: How much would your friends stop you from using the following substances...cigarettes?

Perceived harm

Table 4.28: Perceived harm of frequent cigarette smoking

	C	D	E	F	G	H	I	AVE
Extremely harmful	80	18	47	31	26	19	70	42%
Harmful	14	53	33	54	42	53	9	37%
Somewhat harmful	5	22	7	10	26	19	6	14%
Mainly harmless	0	2	9	4	6	6	3	4%
Harmless	2	4	4	0	0	3	13	4%

Q: How harmful do you think it is to use the following substances frequently (daily or almost daily)? Cigarettes.

Availability

Table 4.29: Perceived difficulty of obtaining cigarettes

	C	D	E	F	G	H	I	AVE
Very difficult	42	0	18	2	2	3	46	16%
Fairly difficult	2	4	12	2	2	0	11	5%
Fairly easy	2	10	13	20	25	10	9	13%
Very easy	6	77	51	65	70	85	10	52%
Don't know	48	10	6	10	2	3	24	15%

Q: How difficult is it for students in your grade to get any of the following substances if they really wanted them? Cigarettes.

Estimated peer use

Table 4.30: Estimated prevalence of peer cigarette smoking at least once a month.

	C	D	E	F	G	H	I	AVE
None	57	0	12	2	4	0	56	19%
10%	11	4	13	4	13	10	9	9%
20%	7	2	8	4	10	0	4	5%
30%	2	8	8	12	17	13	3	9%
40%	2	12	4	18	15	5	4	9%
50%	20	21	21	16	13	18	16	18%
60%	0	19	9	14	12	8	1	9%
70%	0	10	9	10	10	23	3	9%
80%	0	15	8	8	2	13	0	7%
90%	0	10	5	8	2	10	2	5%
All of them	2	0	1	2	2	0	2	1%

Q: About what percent of students in your grade have done the following? Smoke cigarettes at least once a month?

(e) Tobacco use by gender and grade

Table 4.31: Selected tobacco use measures, by gender and grade

	C		D		E		F		G		H		I	
	F	M	F	M	F	M	F	M	F	M	F	M	F	M
During your life, did you ever smoke a cig	9	13	53	47	44	36	40	45	61	28	62	44	13	16
During the past 30 days, did you smoke a cigarette	20	5	39	6	21	31	11	27	37	8	57	40	16	16
During the past 30 days, did you smoke cigarettes daily?	0	0	12	6	5	11	0	0	0	4	13	27	3	3
During the past 30 days, did you smoke cigarettes on school property?	14	14	9	6	9	29	8	5	0	8	33	23	22	16
Frequent use of cigarettes is extremely harmful	100	93	91	100	90	82	96	95	96	92	91	91	92	74

4.2.1.4 Violence and Safety

(a) School harassment, victimisation, and violence

Verbal harassment

Table 4.32: Verbal harassment on school property, past 12 months

	C	D	E	F	G	H	I	AVE
Rumours/ lies spread about you								
0 times	74	46	51	67	50	52	65	58%
1 time	11	30	28	25	22	33	23	25%
2 or more times	15	23	21	8	28	15	11	17%
Sex. jokes, comments, gestures made to you								
0 times	74	45	60	63	58	55	61	59%
1 time	13	15	16	10	15	18	20	15%
2 or more times	13	40	23	27	26	27	18	25%
Made fun of because of looks/way you talk								
0 times	72	46	41	66	54	58	62	57%
1 time	15	16	21	14	19	15	20	17%
2 or more times	13	38	38	20	28	27	18	26%

Q: During the past 12 months, how many times on school property have you...?

Physical violence

Table 4.33: Physical violence on school property, past 12 months

	C	D	E	F	G	H	I	AVE
Been pushed, shoved, hit								
0 times	60	64	56	79	77	67	60	66%
1 time	20	18	20	8	12	24	29	19%
2 or more times	20	18	24	13	12	8	10	15%

Been afraid of being beaten up								
0 times	72	78	67	85	85	80	58	75%
1 time	14	18	24	13	11	16	28	18%
2 or more times	14	4	9	2	4	4	14	7%
Been in physical fight								
0 times	74	78	79	87	74	70	70	76%
1 time	19	13	11	13	13	10	18	14%
2 or more times	7	9	11	0	13	20	12	10%

Q: During the past 12 months, how many times on school property have you...

Property theft and damage

Table 4.34: Property theft on school property, past 12 months

	C	D	E	F	G	H	I	AVE
Had property stolen/ damaged								
0 times	65	57	63	69	59	56	56	61%
1 time	21	21	19	19	30	29	24	23%
2 or more times	14	21	18	12	11	15	20	16%
Damaged property on purpose								
0 times	82	54	83	71	74	72	76	73%
1 time	11	17	10	16	19	16	15	15%
2 or more times	7	30	7	14	7	12	9	12%

Q: During the past 12 months, how many times on school property have you...

(b) Weapons at School

Carrying weapons (school)

Table 4.35: Weapons on school property, past 12 months and 30 days

	C	D	E	F	G	H	I	AVE
Carried a gun (past year)								
0 times	86	96	87	96	98	94	83	91%
1 time	6	2	10	2	0	4	11	5%
2+times	8	2	4	2	2	2	6	4%
Any other weapon (past year)								
0 times	87	78	78	92	89	82	79	72%
1 time	6	11	11	0	2	10	11	7%
2+times	6	11	11	8	9	8	10	9%
Any weapon (past 30 days)								
0 days	81	95	96	100	98	96	79	92%
1 day	15	2	2	0	2	4	15	6%
2+days	4	4	1	0	0	0	6	2%

Q: During the past 12 months, how many times on school property have you...

During the past 30 days, on how many days did you carry any weapon (gun, knife, or club) on school property?

Carrying weapons (general)

Table 4.36: Weapons possession, past 30 days

	C	D	E	F	G	H	I	AVE
Carried a gun (past 30 days)								
0 days	81	98	94	98	98	100	90	94%
1 day	7	2	6	0	2	0	6	3%
2+days	12	0	0	2	0	0	4	3%
Any other weapon								
0 days	81	94	82	94	94	87	79	87%
1 day	6	0	12	2	0	7	16	6%
2+times	13	6	6	4	6	7	5	7%

Q: During the past 30 days, on how many days did you carry...

Awareness of weapons

Table 4.37: Awareness and use of weapons on school property, past 12 months

	C	D	E	F	G	H	I	AVE
Seen someone with a weapon								
0 times	64	44	35	80	60	69	47	57%
1 time	8	25	21	12	17	10	18	16%
2 or more times	28	32	44	8	23	20	35	27%
Been threatened or injured								
0 times	90	87	88	96	93	91	79	89%
1 time	8	13	9	4	4	4	10	7%
2 or more times	2	0	2	0	4	4	11	3%

Q: During the past 12 months, how many times on school property have you...

Peer sanctions of weapons at school

Table 4.38: Peer disapproval of weapon possession

	C	D	E	F	G	H	I	AVE
A Lot	36	40	41	53	47	38	30	41%
Some	15	20	28	34	40	26	21	26%
Not very much	11	33	20	6	11	28	6	16%
Not at all	38	7	11	8	2	8	43	17%

Q: How much would your friends disapprove if some student they knew carried a weapon to school?

Harassment causes: hate-related behaviour

Table 4.39: Reason for harassment on school property, past 12 months

	C	D	E	F	G	H	I	AVE
Race, Ethnicity								
0 times	81	85	85	74	94	94	64	82%
1 time	12	7	9	14	2	6	23	10%
2 or more times	7	7	6	12	4	0	13	7%

Religion								
0 times	66	94	89	92	91	92	41	81%
1 time	17	2	9	4	4	8	25	10%
2 or more times	17	4	2	4	6	0	34	10%
Gender								
0 times	82	88	93	100	96	94	55	87%
1 time	11	9	6	0	4	2	26	8%
2 or more times	7	4	1	0	0	4	18	5%
Sexual orientation								
0 times	89	92	95	100	92	100	76	92%
1 time	9	6	4	0	2	0	15	5%
2 or more times	2	2	1	0	6	0	8	3%
Disability								
0 times	86	93	99	94	94	95	61	89%
1 time	8	4	0	6	4	0	23	6%
2 or more times	6	4	1	0	2	5	15	5%
<i>Any of the 5</i>	50	30	27	33	24	13	36	30%
Any other reason								
0 times	82	76	82	74	83	78	72	78%
1 time	9	11	9	16	8	12	13	11%
2 or more times	9	13	8	10	9	10	14	10%
<i>Any harassment</i>	51	44	39	44	30	28	46	40%

Q: During the past 12 months, how many times on school property were you harassed or bullied for any of the following reasons?

School safety concerns

Table 4.40: Perceived safety of school

	C	D	E	F	G	H	I	AVE
Very safe	52	16	25	32	24	22	57	33%
Safe	29	80	69	64	72	78	26	60%
Unsafe	9	4	6	4	4	0	9	5%
Very unsafe	10	0	0	0	0	0	8	3%

Q: How safe do you feel when you are at school?

(c) Other violence-related indicators

Gang membership

Table 4.41: Gang involvement, lifetime

	C	D	E	F	G	H	I	AVE
No	89	93	94	85	90	94	85	90%
Yes	11	7	6	15	10	6	15	10%

Q: Have you ever belonged to a gang?

Relationship violence

Table 4.42: Physical violence by boy/girlfriend, past 12 months

	C	D	E	F	G	H	I	AVE
Does not apply	59	52	52	57	50	38	46	51%
No	33	43	42	42	48	56	43	44%
Yes	7	5	6	2	2	6	11	6%

Q: During the past 12 months, did your boyfriend or girlfriend ever hit, slap, or physically hurt you on purpose?

(d) Violence-related behaviour by gender and grade

Table 4.43: Violence-related behaviour and experiences, by gender and grade

	C		D		E		F		G		H		I	
	F	M	F	M	F	M	F	M	F	M	F	M	F	M
During the past 12 months at school, have you been harassed or bullied for any of the following reasons?														
Race, ethnicity or national origin														
	12	29	14	17	11	21	28	24	0	12	4	12	35	44
Religion														
	25	47	5	6	10	13	7	9	7	12	4	10	67	56
Gender														
	6	40	14	11	2	13	7	5	7	0	5	5	53	46
Gay/Lesbian or thought you were														
	3	21	8	6	2	8	0	0	7	8	0	0	21	32
Physical / mental disability														
	17	6	8	5	0	3	10	0	4	8	5	6	35	49
Any other reason														
	12	30	19	32	16	18	28	24	18	16	20	26	37	29
During the past 12 months at school, have you been in a physical fight?														
	18	39	14	39	2	43	3	26	11	42	16	47	30	39
During the past 30 days at school, did you carry a weapon?														
	13	29	5	6	0	9	0	0	0	4	0	11	19	24
Feels safe:														
In school	82	78	95	100	98	89	97	96	100	92	100	100	88	76
Ever belonged to a street gang														
	9	16	8	5	0	13	17	13	4	17	4	5	12	17

4.2.1. 5. Physical and mental health

(a) Food consumption and nutrition choices

Nutritious food choices

Table 4.44: Eating of fruits and vegetables at least once per day, past 24 hrs

	C	D	E	F	G	H	I	AVE
100% fruit juices	63	50	61	51	72	41	80	60%
Fruit	76	56	80	81	77	78	81	76%
Vegetables	80	76	87	81	92	67	83	81%
5 or more portions	37	30	52	56	50	29	55	44%

Q: During the past 24 hrs (yesterday), how many times did you...

Milk consumption

Table 4.45: Drinking of milk and eating of yoghurt, past 24 hours

	C	D	E	F	G	H	I	AVE
0 times	28	15	26	6	8	27	23	19%
1 time	40	25	24	38	32	33	22	31%
2 times	17	37	25	19	28	19	24	24%
3 times	7	6	13	19	11	4	15	11%
4 times	3	10	5	13	6	8	9	8%
5 or more times	5	8	7	4	15	8	7	8%

Q: During the past 24 hrs (yesterday), how many times did you drink milk or eat yoghurt? (In any form, including in cereal).

Soda

Table 4.46: Drinking of soda, past 24hrs

	C	D	E	F	G	H	I	AVE
0 times	41	35	32	51	55	38	34	41%
1 time	29	12	24	25	21	20	17	21%
2 times	18	16	19	14	13	16	18	16%
3 times	4	22	12	6	8	9	6	10%
4 times	9	6	2	2	4	13	8	6%
5 or more times	0	8	11	2	0	4	17	6%

Q: During the past 24 hours (yesterday), how many times did you drink soda pop?

Fried potatoes

Table 4.47: Eating of fried potatoes, past 24 hours

	C	D	E	F	G	H	I	AVE
0 times	28	42	19	37	48	38	7	31%
1 time	34	29	29	37	35	38	31	33%
2 times	23	13	24	16	9	10	20	16%
3 times	4	10	9	8	0	10	19	9%
4 times	4	0	9	0	4	2	9	4%
5 or more times	8	6	9	2	4	2	14	6%

Q: During the past 24 hrs (yesterday), how many times did you eat French fries, potato chips, or other fried potatoes?

Breakfast consumption

Table 4.48: Eating of breakfast

	C	D	E	F	G	H	I	AVE
No	36	33	41	19	26	34	30	31%
Yes	64	67	59	81	74	66	70	69%

Q: Did you eat breakfast today?

(b) Physical activity

Table 4.49: Exercise on at least three of the past seven days

	C	D	E	F	G	H	I	AVE
For at least 20mins that made you sweat and breathe hard	39	36	42	49	69	36	60	47%
For at least 30mins that did not make you sweat and breathe hard	28	36	48	46	42	16	69	41%
Either	52	58	70	64	76	40	84	63%

Q: On how many of the past 7 days did you...?

Table 4.50 Frequency of exercise to strengthen or tone muscles, past seven days

	C	D	E	F	G	H	I	AVE
0 days	43	40	19	25	19	33	39	31%
1-2 days	28	32	45	52	44	29	18	35%
3 or more days	30	28	36	23	37	38	43	34%

Q: On how many of the past 7 days did you do exercises to strengthen or tone your muscles? (For example, push-ups, sit-ups, or weight lifting)

(c) Depression-related feelings

Table 4.51: Frequency of sad and hopeless feelings, past 12 months

	C	D	E	F	G	H	I	AVE
No	83	60	64	70	74	68	67	69%
Yes	17	40	36	30	26	32	33	31%

Q: During the past 12 months, did you ever feel so sad and hopeless almost every day for two weeks or more that you stopped doing some usual activities?

(d) Asthma

Table 4.52: Students with asthma

	C	D	E	F	G	H	I	AVE
No	62	58	69	78	77	64	53	66%
Yes	19	28	19	14	17	30	13	20%
I don't know	19	14	12	8	6	6	34	14%

Q: Has a doctor ever told you or your parent/guardian that you have asthma?

(e) Body mass index

Table 4.53: Student body mass index

	C	D	E	F	G	H	I	AVE
Underweight	-	1	4	0	2	5	5	3%
Acceptable	-	80	77	78	90	73	70	78%
At risk of overweight	-	11	8	19	4	18	18	13%
Overweight	-	8	10	2	4	4	8	6%

Q: How tall are you without your shoes on? How much do you weigh without your shoes on?

4.2.2. MODULE C: ALCOHOL AND DRUG USE

4.2.2.1. Alcohol and drug use

Table 4.54 Alcohol use during past 6 months

	C	D	E	F	G	H	I	AVE
None	66	45	63	42	37	58	74	55%
1 or 2 times	11	13	21	19	21	8	13	15%
A few times	7	24	7	17	27	12	6	14%
Once a month	11	5	1	6	2	8	3	5%
Once a week	2	7	4	8	12	10	1	6%
A few times a week	0	4	2	6	2	2	0	2%
Once or more a day	2	2	1	2	0	2	3	2%

Q: During the past six months, about how many times have you used these substances without a doctor's orders? Any alcohol.

Table 4.55 Marijuana use during past 6 months

	C	D	E	F	G	H	I	AVE
None	75	83	96	94	79	79	85	84%
1 or 2 times	11	6	1	6	13	8	8	8%
A few times	9	6	1	0	8	10	1	5%
Once a month	2	6	0	0	0	2	1	2%
Once a week	2	0	1	0	0	0	1	2%
A few times a week	0	0	0	0	0	0	1	0%
Once or more a day	0	0	0	0	0	0	2	0%

Q: During the past six months, about how many times have you used these substances without a doctor's orders? Marijuana.

Table 4.56 Inhalant use during past 6 months

	C	D	E	F	G	H	I	AVE
None	79	98	99	94	98	100	84	93%
1 or 2 times	5	0	1	2	2	0	7	2%
A few times	0	2	0	0	0	0	2	1%
Once a month	9	0	0	0	0	0	4	2%
Once a week	2	0	0	0	0	0	4	1%
A few times a week	0	0	0	4	0	0	0	1%
Once or more a day	5	0	0	0	0	0	0	1%

Q: During the past six months, about how many times have you used these substances without a doctor's orders? Inhalants

Table 4.57 Cocaine, methamphetamine or other stimulant use during past 6 months

	C	D	E	F	G	H	I	AVE
None	72	98	100	98	100	94	87	93%
1 or 2 times	17	0	0	0	0	2	4	3%
A few times	4	2	0	2	0	2	3	2%
Once a month	4	0	0	0	0	0	3	1%
Once a week	2	0	0	0	0	2	1	1%
A few times a week	0	0	0	0	0	0	0	0%
Once or more a day	0	0	0	0	0	0	1	0%

Q: During the past six months, about how many times have you used these substances without a doctor's orders? Cocaine, methamphetamine or other stimulants...

Table 4.58 Psychedelics, ecstasy or other club drug use during past 6 months

	C	D	E	F	G	H	I	AVE
None	81	96	95	96	98	94	86	92%
1 or 2 times	14	0	5	4	2	2	7	5%
A few times	2	4	0	0	0	2	4	2%
Once a month	0	0	0	0	0	0	1	0%
Once a week	2	0	0	0	0	2	0	1%
A few times a week	0	0	0	0	0	0	2	0%
Once or more a day	0	0	0	0	0	0	0	0%

Q: During the past six months, about how many times have you used these substances without a doctor's orders? Psychedelics...ecstasy...or other club drugs...

Table 4.59 Any other drug use during past 6 months

	C	D	E	F	G	H	I	AVE
None	69	96	98	98	100	98	90	93%
1 or 2 times	17	4	1	2	0	0	7	4%
A few times	5	0	1	0	0	0	1	1%
Once a month	0	0	0	0	0	0	1	0%
Once a week	5	0	0	0	0	2	0	1%
A few times a week	2	0	0	0	0	0	0	0%
Once or more a day	2	0	0	0	0	0	1	0%

Q: During the past six months, about how many times have you used these substances without a doctor's orders? Any other drugs...

Table 4.60 Poly drug use during past 6 months

	C	D	E	F	G	H	I	AVE
None	68	91	95	100	92	94	88	90%
1 or 2 times	13	2	2	0	6	2	8	5%
A few times	5	6	2	0	2	2	1	3%
Once a month	11	0	0	0	0	0	0	2%
Once a week	3	0	0	0	0	2	0	1%
A few times a week	0	0	0	0	0	0	1	0%
Once or more a day	0	2	0	0	0	0	1	0%

Q: During the past six months, about how many times have you used these substances without a doctor's orders? Two or more drugs at the same time.

Table 4.61 Ever used needle to inject illegal drugs

	C	D	E	F	G	H	I	AVE
No	89	98	99	100	98	98	88	96%
Yes	11	2	1	0	2	2	12	4%

Q: During your life, have you ever used a needle to inject an illegal drug into your body?

Table 4.62 Ever illegally used steroids

	C	D	E	F	G	H	I	AVE
No	91	98	93	98	100	98	89	95%
Yes	9	2	7	2	0	2	11	5%

Q: During your life, have you ever used steroid pills or shots without a doctor's orders?

4.2.2.2. AOD-related problems (ever)

Table 4.63: Occurrence of problems while using alcohol / drugs

	C	D	E	F	G	H	I	AVE
Does not apply / I never used	57	40	74	51	57	58	67	58%
Traffic ticket /traffic accident	5	2	2	0	0	0	6	2%
Money problems	9	5	5	6	0	4	10	6%
Trouble at school	9	2	4	4	0	4	7	4%
Problems with schoolwork	7	5	4	2	4	6	1	4%
Fight with other kids	0	7	4	2	0	4	1	3%
Damage a friendship	0	7	7	9	4	0	2	4%
Hurt or injure yourself	5	11	1	9	4	4	1	5%
Unwanted or unprotected sex	7	5	0	2	0	0	0	2%
Forget what happened or pass out	2	9	5	11	9	13	2	7%
Other problems	7	12	4	6	2	6	0	5%
More than one problem	7	14	5	15	4	8	0	8%
Never had problems	0	40	8	26	30	15	1	17%

Q: Has using alcohol or other drugs ever caused you to have any of the following problems? Mark all that apply

Table 4.63: Driving under the influence of alcohol, past 30 days

	C	D	E	F	G	H	I	AVE
Never	77	98	91	100	100	98	81	92%
1 time	14	0	5	0	0	2	8	4%
2 or 3 times	5	0	5	0	0	0	2	2%
4 or 5 times	2	2	0	0	0	0	3	1%
6 or more times	2	0	0	0	0	0	5	1%

Q: During the past 30 days, how many times did you drive a car or other vehicle when you had been drunk with alcohol?

Table 4.64 Frequency of alcohol cessation attempts

	C	D	E	F	G	H	I	AVE
Never used, does not apply	69	45	60	51	53	56	63	57%
No attempts	26	36	16	34	40	20	15	27%
1 time	2	13	15	11	6	18	13	11%
2 or 3 times	2	4	1	4	2	6	6	4%
4 or more times	0	2	7	0	0	0	2	2%

Q: How many times have you tried to quit or stop using alcohol?

Table 4.65 Frequency of marijuana cessation attempts

	C	D	E	F	G	H	I	AVE
Never used, does not apply	79	78	90	88	79	71	72	80%
No attempts	14	13	9	8	12	12	14	12%
1 time	0	7	1	4	8	10	10	5%
2 or 3 times	5	2	0	0	0	8	3	3%
4 or more times	2	0	0	0	2	0	0	1%

Q: How many times have you tried to quit or stop using marijuana?

4.2.2.3. Cessation efforts and need for help

Table 4.66: Perceived need for counselling / treatment for alcohol/drug use

	C	D	E	F	G	H	I	AVE
Never used	68	39	71	54	60	57	73	60%
None, but do use	20	54	13	38	33	31	12	29%
Yes, felt that I needed help	2	2	3	2	0	0	9	3%
Don't know	10	5	13	6	8	12	6	9%

Q: Have you ever felt that you needed help (such as counselling or treatment) for your alcohol or other use?

Table 4.67: Likelihood of suspension / expelled / transferred for ATOD use on school property

	C	D	E	F	G	H	I	AVE
Very likely	49	58	55	62	80	75	38	60%
Likely	9	26	8	29	16	13	10	16%
Not likely	9	12	6	2	2	2	18	7%
Don't know	33	4	31	8	2	10	34	17%

Q: In your opinion, how likely is it that a student will be suspended, expelled, or transferred if he or she was caught on school property using or possessing alcohol or other drugs?

Table 4.68: Likelihood of finding help for ATOD use at School

	C	D	E	F	G	H	I	AVE
Very likely	44	41	35	23	27	26	38	33%
Likely	18	23	25	21	31	24	10	22%
Not likely	9	25	18	38	31	22	11	22%
Don't know	29	11	22	17	10	28	41	23%

Q: In your opinion, how likely is it that a student would find help at your school from a counsellor, teacher or other adult to stop or reduce using alcohol or other drugs?

Table 4.69 Estimated occurrence of marijuana use among known adults

	C	D	E	F	G	H	I	AVE
None	71	72	76	87	72	74	72	75%
Some	19	26	15	11	26	16	14	18%
Many	5	2	6	0	2	10	8	5%
Most or all	5	0	2	2	0	0	6	2%

Q: About how many of the adults you know use marijuana?

Table 4.70 Estimated occurrence of cocaine/crack use among known adults

	C	D	E	F	G	H	I	AVE
None	71	91	82	90	98	92	74	85%
Some	11	7	11	10	2	4	14	8%
Many	9	0	6	0	0	2	8	4%
Most or all	9	2	1	0	0	2	4	3%

Q: About how many of the adults you know use cocaine or crack?

Table 4.71 Estimated occurrence of methamphetamine use among known adults

	C	D	E	F	G	H	I	AVE
None	64	100	93	96	100	90	81	89%
Some	18	0	0	2	0	8	7	5%
Many	8	0	6	0	0	2	9	4%
Most or all	10	0	1	2	0	0	2	2%

Q: About how many of the adults you know use methamphetamines?

4.2.2. 4. Drug availability and selling

(a) Sources for drugs

Table 4.72: Sources for obtaining drugs

	C	D	E	F	G	H	I	AVE
At school	33	14	18	4	17	10	38	19%
At parties or events outside of school	19	46	23	25	40	31	12	28%
At home	12	14	19	4	4	6	10	10%
In the neighbourhood	7	52	20	13	17	43	15	24%
Friends	2	45	30	19	35	49	7	27%
Dealers	2	39	42	25	37	49	2	28%
Other	5	21	3	6	17	18	1	10%
Don't know	19	27	24	55	31	10	19	26%

Q: Where do most kids at your school who use drugs get them? (Mark all that apply)

Table 4.73: Occurrence of selling drugs

	C	D	E	F	G	H	I	AVE
None	81	100	93	98	100	100	82	93%
1 time	9	0	1	2	0	0	8	3%
2 or 3 times	7	0	2	0	0	0	6	2%
4 or more times	2	0	3	0	0	0	4	1%

Q: During the past 12 months, how many times have you sold drugs to someone?

Table 4.74: Likelihood of marijuana use in next year

	C	D	E	F	G	H	I	AVE
Sure it will not happen	79	61	86	83	100	100	75	83%
Probably will not happen	9	14	8	8	0	0	16	8%
Even chance (50-50)it will happen	5	7	3	8	0	0	6	4%
Probably will happen	5	14	0	2	0	0	1	3%
Will happen for sure	2	4	2	0	0	0	1	1%

Q: How likely do you think it is that you will smoke marijuana in the next year?

4.2.2.5 Violence, safety and delinquency

Table 4.75 Occurrence of physical fight, past 12 months

	C	D	E	F	G	H	I	AVE
None	66	75	78	87	76	67	62	73%
1 time	16	16	11	10	10	15	21	14%
2 or 3 times	7	7	6	4	8	15	10	8%
4 or more times	11	2	6	0	6	4	7	5%

Q: During the past 12 months, how many times have you been in a physical fight?

Table 4.76 Occurrence of physical fight between groups, past 12 months

	C	D	E	F	G	H	I	AVE
None	67	82	76	89	92	83	63	79%
1 time	20	15	18	8	4	11	21	14%
2 or 3 times	4	2	2	4	4	6	13	5%
4 or more times	9	2	4	0	0	0	3	3%

Q: During the past 12 months, how many times have you been in a physical fight between groups?

(a) Weapons use and availability

Weapons use

Table 4.77: Occurrence of weapon use to intimidate, past 12 months

	C	D	E	F	G	H	I	AVE
None	69	93	94	94	100	96	85	90%
1 time	17	7	2	6	0	2	10	6%
2 or 3 times	7	0	1	0	0	0	3	2%
4 or more times	7	0	2	0	0	2	3	2%

Q: During the past 12 months, how many times have you used any weapon to threaten or bully someone?

(b) Availability of firearms

Table 4.78: Perceived difficulty of obtaining a gun

	C	D	E	F	G	H	I	AVE
Very difficult	55	36	49	36	37	44	60	45%
Difficult	14	20	7	26	25	15	6	16%
Easy	9	11	8	9	2	17	5	9%
Very easy	5	7	13	4	2	8	6	6%
Don't know	18	25	23	25	33	17	23	23%

Q: If you wanted to get a gun, how difficult would it be for you to get one?

(c) Safety

School days missed due to feeling unsafe



Table 4.79: Occurrence of school days missed due to feeling unsafe, past 30 days

	C	D	E	F	G	H	I	AVE
None	65	93	88	98	98	96	69	87%
1 day	25	5	5	0	2	2	14	8%
2 or 3 days	3	0	6	2	0	0	10	3%
4 or more days	8	2	1	0	0	2	7	3%

Q: During the past 30 days, on how many days did you not go to school because you felt unsafe at or on your way to or from school.

Safety of neighbourhood

Table 4.80: Perceived safety of neighbourhood

	C	D	E	F	G	H	I	AVE
Very safe	53	17	39	45	29	27	39	36%
Safe	28	58	38	43	61	63	34	46%
Unsafe	9	23	15	10	10	10	19	14%
Very unsafe	9	2	7	2	0	0	8	4%

Q: How safe do you feel in the neighbourhood where you live?

(d) Forced sex

Table 4.81: Ever forced into unwanted sexual intercourse

	C	D	E	F	G	H	I	AVE
No	79	95	91	96	98	98	84	92%
Yes	21	5	9	4	2	2	16	8%

Q: Have you ever been forced to have sexual intercourse when you did not want to?

(e) Occurrence of being arrested

Table 4.82: Occurrence of being arrested

	C	D	E	F	G	H	I	AVE
None	71	100	98	100	100	100	79	93%
1 time	20	0	2	0	0	0	11	5%
2 or 3 times	7	0	0	0	0	0	4	2%
4 or more times	2	0	0	0	0	0	7	1%

Q: During the past 12 months, how many times have you been arrested by the police?

4.2.2.6 Suicide ideation

Table 4.83: Seriously considered attempting suicide, past 12 months

	C	D	E	F	G	H	I	AVE
No	73	73	88	83	86	79	81	80%
Yes	27	27	12	17	14	21	19	20%

Q: During the past 12 months, did you ever seriously consider attempting suicide?

Table 4.84: Planned method of attempting suicide, past 12 months

	C	D	E	F	G	H	I	AVE
No	79	71	87	85	84	90	75	82%
Yes	21	29	13	15	16	10	25	18%

Q: During the past 12 months, did you make a plan about how you would attempt suicide?

Table 4.85: Attempted suicide, past 12 months

	C	D	E	F	G	H	I	AVE
0 times	74	91	93	96	96	95	70	88%
1 time	16	4	2	2	2	0	21	7%
2 or 3 times	5	4	4	2	2	5	6	4%
4 or more times	5	2	1	0	0	0	4	2%

Q: During the past 12 months, how many times did you actually attempt suicide?

Table 4.86: Suicide attempt that required medical treatment, past year

	C	D	E	F	G	H	I	AVE
Did not attempt	68	88	80	94	94	91	71	84%
No	22	11	17	6	2	7	24	13%
Yes	11	2	2	0	4	2	5	4%

Q: If you attempted suicide during the past 12 months, did any attempt result in an injury, poisoning, etc that had to be treated by a doctor or nurse?

4.2.3 MODULE F: SEXUAL BEHAVIOUR

4.2.3.1. Sexual behaviour and pregnancy

(a) Prevalence of sexual intercourse

Table 4.87: Ever had sexual intercourse

	C	D	E	F	G	H	I	AVE
No	79	89	89	86	98	95	67	86%
Yes	21	11	11	14	2	5	33	14%

Q: Have you ever had sexual intercourse?

(b) Age at first intercourse

Table 4.88: Age of first sexual intercourse

	C	D	E	F	G	H	I	AVE
Never had sexual intercourse	37	80	76	59	94	90	47	69%
11 yrs or younger	34	3	6	0	6	0	16	9%
12 yrs old	14	0	2	0	0	5	9	4%
13 yrs old	3	3	4	18	0	0	4	5%
14 yrs old	0	7	8	18	0	5	5	6%
15 yrs old	0	7	4	6	0	0	4	3%
16 yrs old	3	0	0	0	0	0	1	1%
17 yrs old or older	9	0	0	0	0	0	14	3%

Q: How old were you when you had sexual intercourse for the first time?

(c) Number of sexual partners

Table 4.89: Number of sexual intercourse partners

	C	D	E	F	G	H	I	AVE
Never had	50	79	77	59	95	94	45	71%
1 person	21	17	2	18	0	6	26	13%
2 people	9	0	8	12	0	0	14	6%
3 people	9	0	4	0	0	0	5	3%
4 people	6	0	0	6	0	0	5	2%
5 people	0	0	8	0	5	0	1	2%
6 or more people	6	3	2	6	0	0	3	3%

Q: During your life, with how many people have you had sexual intercourse?

Table 4.90: Number of sexual intercourse partners, past 3 months

	C	D	E	F	G	H	I	AVE
Never had	47	84	76	56	100	88	41	70%
Had sex intercourse but not during past 3mths	31	3	11	11	0	6	30	13%
1 person	8	9	2	17	0	6	20	9%
2 people	8	3	0	11	0	0	4	4%
3 people	0	0	7	0	0	0	1	1%
4 people	3	0	2	0	0	0	1	1%
5 people	0	0	2	0	0	0	1	0%
6 or more people	3	0	0	6	0	0	1	1%

Q: During the past three months, with how many people did you have sexual intercourse?

(d) Alcohol and drug use

Table 4.91: Alcohol / drug use before last sexual intercourse

	C	D	E	F	G	H	I	AVE
Never had sex	61	81	76	59	95	87	45	72%
No	27	6	20	29	0	7	38	18%
Yes	12	13	4	12	5	7	17	10%

Q: Did you drink alcohol or use drugs before you had sexual intercourse the last time?

(e) Contraceptive use

Table 4.92: Condom use during last sexual intercourse

	C	D	E	F	G	H	I	AVE
Never had sex	53	84	75	65	95	89	51	73%
No	40	6	4	6	0	11	29	14%
Yes	7	9	21	29	5	0	20	13%

Q: The last time you had sexual intercourse did you or your partner use a condom?

Table 4.93: Methods of pregnancy prevention during last sexual intercourse

	C	D	E	F	G	H	I	AVE
Never had sex	44	79	76	59	95	93	53	71%
No method	22	0	6	12	0	7	20	10%
BC pills	17	0	0	6	0	0	9	5%
Condoms	11	10	16	24	5	0	17	12%
Depo –or other injectables	0	0	0	0	0	0	0	0%
Withdrawal	0	7	0	0	0	0	0	1%
Some other method	0	0	0	0	0	0	0	0%
Not sure	6	3	2	0	0	0	1	2%

Q: The last time you had sexual intercourse, what one method did you or your partner use to prevent pregnancy?

(f) Pregnancy

Table 4.94: Frequency of being or getting someone else pregnant

	C	D	E	F	G	H	I	AVE
Never	62	100	94	94	95	93	66	86%
1 time	12	0	2	0	0	0	15	4%
2 or more times	15	0	0	6	5	0	9	5%
Not sure	12	0	4	0	0	7	9	5%

Q: How many times have you been pregnant or gotten someone pregnant?

Table 4.95: Likelihood of having sexual intercourse one or more times during next year

	C	D	E	F	G	H	I	AVE
Sure it will not happen	54	58	70	63	62	67	56	61%
Probably will not happen	27	24	15	12	30	20	25	22%
Even chance (50-50) it will happen	12	9	7	8	4	9	6	8%
Probably will happen	5	5	3	12	2	4	5	5%
Will happen for sure	2	4	5	6	2	0	8	4%

Q: How likely do you think it is that you will choose to have sexual intercourse one or more times in the next year?

(g) Forced intercourse

Table 4.96: Ever forced into unwanted sexual intercourse

	C	D	E	F	G	H	I	AVE
No	69	97	88	88	100	93	75	87%
Yes	31	3	12	12	0	7	25	13%

Q: Have you ever been forced to have sexual intercourse when you did not want to?

(h) Beliefs about the prevalence of sexual intercourse

Table 4.97: Student perception of percent of peers who have had sexual intercourse

	C	D	E	F	G	H	I	AVE
None	49	9	16	10	30	24	56	28%
10%	21	27	20	37	46	28	9	27%
20%	9	13	7	12	14	13	7	11%
30%	2	11	7	4	6	13	3	7%
40%	0	21	13	20	2	7	4	10%
50%	6	14	15	6	0	9	9	8%
60%	2	0	8	6	0	2	1	3%
70%	4	2	4	0	0	2	1	2%
80%	2	4	4	4	0	2	1	2%
90%	0	0	3	2	2	0	1	1%
All of them	4	0	2	0	0	0	8	2%

Q: About what percent of students at your school grade do you think ever had sexual intercourse?

(i) Intentions and attitudes about sexual intercourse

Table 4.98: Agreement that teen abstinence is better choice than sexual intercourse

	C	D	E	F	G	H	I	AVE
Very much agree	37	60	50	65	56	66	42	54%
Agree	27	29	22	17	33	19	22	24%
Disagree	15	7	10	13	8	9	15	11%
Very much disagree	22	4	17	4	2	6	22	11%

Q: Please indicate whether you agree or not with the following statements. For teens your age, abstinence (not having sexual intercourse) is a better choice than having sexual intercourse.

Table 4.99: Agreement that for some teens having a baby is a good decision

	C	D	E	F	G	H	I	AVE
Very much agree	38	4	13	6	8	11	32	16%
Agree	21	2	6	4	0	4	19	8%
Disagree	28	7	23	11	8	11	23	16%
Very much disagree	13	88	57	79	84	73	26	60%

Q: Please indicate whether you agree or not with the following statements. For some teens under 18 yrs old, it is a good decision to have a baby.

(j) Communication with parents and other adults in the family about sexuality

Table 4.100: Percentage of topics discussed with parents/adult family, past 6 months

	C	D	E	F	G	H	I	AVE
What your parents think about teenagers having sex	34	38	31	31	36	27	30	32%
Your questions about sex	35	25	43	35	32	33	31	33%
Reasons why you shouldn't have sex at your age	39	36	38	33	38	32	32	35%
How your life would change if you became a father / mother	48	33	47	40	44	42	46	43%
Birth control	29	29	31	13	38	20	38	28%
AIDS/HIV and other sexually transmitted diseases	39	51	51	60	56	47	25	47%

Q: In the past 6 months, have you talked with your parents or other adults in your family about...?

APPENDIX VII

Table 5.1 Summary of Resilience Results

Percent of students scoring High in Assets (%)	SCHOOLS							
	C	D	E	F	G	H	I	AVE
TOTAL EXTERNAL ASSETS	72	61	62	55	53	47	50	57
Caring relationships	50	70	63	56	78	66	52	62
High expectations	68	74	75	69	37	22	60	58
Meaningful participation	46	38	41	40	53	33	45	42
School Environment	43	33	47	24	30	22	53	36
Caring relationships: Adults in school	50	31	38	22	31	27	50	36
High expectations: Adults in school	55	57	59	29	19	16	54	41
Meaningful participation: Adults in school	43	29	22	16	23	15	43	27
Home Environment	63	60	74	75	80	65	46	66
Caring relationships: Adults in Home	58	63	63	63	93	81	51	67
High expectations: Adults in Home	67	92	87	92	54	51	56	71
Meaningful participation: Adults in Home	44	54	45	37	56	47	35	45
Community Environment	53	59	62	64	73	60	44	59
Caring relationships: Adults in Community	51	71	57	60	72	45	45	57
High expectations: Adults in Community	60	73	63	63	69	53	39	60
Meaningful participation: Adults in community	55	62	46	59	54	44	45	52
Peer Environment	52	71	64	54	4	11	50	44
Caring relationships: Peers	44	92	67	55	56	50	45	58
High expectations: Pro-social peers	69	41	62	38	6	2	49	38
	C	D	E	F	G	H	I	AVE
TOTAL INTERNAL ASSETS	64	82	83	71	65	74	47	69
Co-operation and Communication	56	76	67	42	41	45	39	52
Self-efficacy	54	81	69	43	37	53	41	54
Empathy	54	84	54	49	46	44	39	53
Problem Solving	57	57	45	42	44	52	47	49
Self-awareness	50	81	68	57	57	53	41	58
Goals and Aspirations	64	96	86	91	87	84	55	80
	C	D	E	F	G	H	I	AVE
SCHOOL CONNECTEDNESS	40	63	44	33	24	23	37	38