THE UNDERSTANDING OF HEALTH PROMOTION AMONG YOUTH ATTENDING SECONDARY SCHOOLS IN RURAL SETTINGS

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ABSTRACT

Background: Several chronic health conditions that previously manifested in adulthood are now increasingly being identified in young people. Various health risk behaviours established during youth results in chronic diseases of lifestyle as well as behaviours leading to injury, trauma and substance abuse. Current evidence proposes that a school health programme could become one of the most efficient means available to improve the health promotion and education of people as it reaches large numbers of young people in a replicable and sustainable way.

Aim: The purpose of the study was to determine health risk behaviours and investigate the understanding and perception of health promotion among adolescent learners attending secondary schools in the Theewaterskloof region.

Objectives: 1) To determine the health risk behaviours that secondary school learners in the Theewaterskloof region engage in; 2) to explore and describe the understanding and perceptions of health promotion among secondary school learners in the Theewaterskloof region and 3) To explore and describe the understanding and perceptions of health promotion among life orientation educators in the Theewaterskloof region

Methodology: The study used a sequential explanatory mixed methods approach. Quantitative data was collected by means of the Youth Risk Behaviour Surveillance Survey and qualitative data through focus group discussions. Ethics was obtained from the Research Ethics Committee of the University of the Western Cape (13/2/3) and permission was obtained from the Western Cape Education Department, school

governing bodies, learners, parents and guardians of identified schools regarding the research.

Results: Data from 276 participants in Grades 8-11 from secondary schools in a rural district within the Western Cape, South Africa was analysed. The most significant health risk behaviours engaged in by the participants was substance abuse, sexual activity and physical inactivity. In focus group discussions held with both the learners and educators, the most prevalent health risk behaviours were; substance use and sexual activity. Although the health risk behaviours were such a pertinent issue for both the learners and educators, current health promotion strategies were inadequate. In terms of health promotion strategies the learners highlighted the need for adequate support and guidance from both their parents and educators. They also made reference to themselves, their parents and educators playing a role in the improvement of their health status. The educators felt that parents needed to play their role in health promotion by disciplining their children and by being better role models. They were also of the opinion that the current socio-economic climate of the Theewaterskloof region predisposes learners to specific health risk behaviours. According to them, an effective health promotion strategy would include parents, educators and learners working together to promote better health behaviours.

Conclusion: Health risk behaviours are rife in rural communities. Even though the adolescents feel that the management of the trajectory of their health is their responsibility, they see a need for collaboration between educators, parents and themselves in developing health promotion.

Implications for the future: Further research needs to be done in the production of health promotion and then the implementation of strategies involving the youth and the community at large.

KEYWORDS

Adolescence

Health-promotion

Rural

Secondary schools

Health risk behaviours

DECLARATION

I declare that "*Health promotion among youth: The role of secondary schools in rural settings"* 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.

Brent Hess January 2016

Signature: _____

Witnesses:

_____

Prof. Julie Phillips

_____

Dr. Firdouza Waggie

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TABLE OF CONTENTS

TITLE PAGE 1

ABSTRACT 2

KEYWORDS 5

DECLARATION 6

ACKNOWLEDGEMENTS 7

TABLE OF CONTENTS 8

LIST OF FIGURES 13

LIST OF TABLES 14

CHAPTER 1 15

INTRODUCTION 15

1.1 Introduction to chapter 15

1.2 Background to study 16

1.3. Problem statement 21

1.4. Aim of the study 22

1.5. Objectives of the study 22

1.6. Significance of the study 23

1.7. Definition of terms 25

1.8. Abbreviations used in the study 27

1.9. Outline of the thesis 28

CHAPTER 2 30

LITERATURE REVIEW 30

2.1 Introduction 30

2.2 Adolescent Health Risk Behaviours 30

2.2.1 Sexual Behaviours 32

2.2.2 Tobacco Use 34

2.2.3 Alcohol Use 36

2.2.4 Physical Inactivity and Obesity 37

2.2.5 Violence 39

2.3 Development of health promotion 40

2.4 Theoretical Frameworks 42

2.4.1 Social Ecological Model (SEM) 43

2.4.2 Health Belief Model 44

2.5 Prevention strategies for Health Risk 47

2.5.1 School-based Prevention Strategies 47

2.5.2 Parenting Programmes 51

2.5.3 Public Health Programmes 53

CHAPTER 3 57

METHODOLOGY 57

3.1. Introduction 57

3.2. Research setting 57
3.3. Research design 59
3.4. Data collection methods 59
3.4.1. Quantitative Phase 60
3.4.2 Qualitative Phase 65
3.5 Ethics 68
3.6 Summary of the Chapter 69
CHAPTER 4 70
QUANTITATIVE RESULTS 70
4.1 Introduction 70
4.2 Description of the Study Sample (n=276) 70
4.3 Prevalence of Health Risk Behaviours 73
4.3.1 Alcohol Use 73
4.3.2 Tobacco Use 74
4.3.3 Marijuana and Drug Use 74
4.3.4 Behaviours that contribute to violence 78
4.3.5 Physical inactivity 81
4.3.6 Sexual activity 84
4.4 Summary 86
CHAPTER 5 88

QUALITATIVE RESULTS 88

5.1 Introduction 88

5.2 Perception of learners regarding health promotion 88

5.2.1 Description of participants (Learners) 89

5.2.2 Themes 89

5.2.3 Theme 1: Awareness of prevalent health risk behaviours 89

5.2.4 Theme 2: Factors contributing to engagement in health risk behaviours 93

5.2.5 Theme 3: Possible prevention strategies of health risk behaviours 96

5.2.6 Theme 4: Stakeholders responsible for prevention strategies 98

5.3 Perceptions of the Educators 100

5.3.1 Description of participants (Educators) 100

5.3.2 Themes 100

5.4 Summary 104

CHAPTER 6 105

DISCUSSION 105

6.1 Introduction 105

6.2 Prevalent health risk behaviours among school learners 105

6.3 Learners understanding of Health Promotion 112

6.4 Life Orientation Educators understanding of Health Promotion 114

CHAPTER 7 116

CONCLUSION, RECOMMENDATIONS AND LIMITATIONS 116

7.1 Introduction 116

7.2 Conclusion 116

7.3 Recommendations 117

7.3.1 Rural health risk behaviours compared to urban 117

7.3.2 Community and departmental strategies for Health promotion 118

7.3.3 What does the study recommend from a research point of view? 118

7.4 Limitations 119

REFERENCES 121

APPENDICES 145

APPENDIX A: QUESTIONNAIRE 146

APPENDIX B: INFORMATION SHEET 190

APPENDIX C: CONSENT FORM 195

APPENDIX D: ETHICAL CLEARANCE 196

APPENDIX E: WESTERN CAPE EDUCATION DEPARTMENT RESEARCH CLEARANCE LETTER 197

APPENDIX F : FOCUS GROUP CONFIDENTIALITY BINDING FORMS 198

LIST OF FIGURES

Figure 1: Map of Theewaterskloof region within the Overberg District Municipality, Western Cape, South Africa 58

Figure 2: Percentage of high school learners, who used alcohol, smoked and used drugs in their lifetime 76

Figure 3: Percentage of high school learners currently engaging in alcohol use, smoking and marijuana use 77

Figure 4: Percentage of high school learners involved in behaviours contributing to violence in the last month 78

Figure 5: Percentage of high school learners involved in behaviours contributing to violence in the last year 80

Figure 6: Percentage of high school learners involved in physical activity in a week 82

Figure 7: Percentage of high school learners involved in physical education 83

Figure 8: Percentage of learners who are sexually active 84

Figure 9: Percentage of high school learners engaging in risky sexual behaviours . 85

LIST OF TABLES

Table 1: Socio-demographic characteristics of the study sample..... 71

CHAPTER 1

INTRODUCTION

1.1 Introduction to chapter

Health risk behaviours in the youth are on the increase both internationally and nationally (Jackson, Henderson, Frank and Haw, 2012; Phillips, 2008; WHO, 2007). Smoking, violence, unsafe sexual activity, alcohol consumption and physical inactivity are all classified as some of the major health risk behaviours amongst youth both nationally (Reddy, et al., 2010) and internationally (Brooks, Magnusson and Klemera, 2011; Leatherdale and Ahmed, 2010). Schools have been identified as an ideal setting for health intervention strategies to combat health risk behaviours in adolescents (UWC, 2006; Mukoma and Flisher, 2004; WHO, 1996). Literature investigating health risk behaviours and the school as a setting for certain strategies are limited in the rural areas of South Africa when compared to their urban counterparts. This chapter therefore outlines the rationale for conducting the research regarding health risk behaviours among adolescents in rural schools. Furthermore the aims, objectives and significance of the study are outlined. The chapter ends with the definition of terms and abbreviations used in the study.

1.2 Background to study

Adolescence is perceived to be the healthiest phase in life with regards to morbidity and mortality (Phillips, 2008; Call et al., 2002). However, the effects of engagement in health risk behaviours within this phase could lead to a burden of health problems later on in life. Health risks taken during this adolescent phase can influence long term implications for health and well-being of the individual and for the society as a whole (Phillips, 2008). Ultimately, the effects of health risk behaviours within adolescence could lead to a burden of health problems later on in life. Jackson et al., (2012) alerted that if health risk behaviours are established during adolescence, they are often continued into adulthood, affecting health and wellbeing in later life. Therefore, this adolescent phase is extremely important from a public health point of view (Irwin, 2003). In South Africa the Youth Risk Behaviour Surveillance Survey (YRBSS) that was conducted in 2008 alerted to the understanding that risk behaviours established in youth resulted in chronic diseases in the middle age (Reddy et al., 2010). Due to the fact that experimentation and exploration accompanies this adolescent period more than those of other age groups, and it is often described as developmental and a time for first experiences of various kinds (Phillips, 2008; Call et al., 2002), it becomes essential to address the needs of this group.

Various health risk behaviours have been identified during this risk taking period and these include physical inactivity, violent behaviour, alcohol and substance abuse, as well as sexually activity. Physical inactivity has been identified as a major public health problem contributing to the non-communicable disease epidemic (Frantz, 2006). Results from the Second South African National Youth Risk Behaviour Survey indicated that nationally 41.5% of learners had participated in insufficient or no

physical activity (Reddy et al., 2010). Physical inactivity could lead to obesity or other diseases such as type 2 diabetes mellitus. In rural South Africa significant levels of child obesity have been reported, with the prevalence particularly amongst girls (Kimani-Murage et al., 2011). The increasing level of childhood obesity could be directly associated to a greater risk of co-morbidities like hypertension (Li, Chen, Srinivasan and Berenson, 2004), type 2 diabetes (Hsia, Neubert, Rani, Viner, Hindmarsh and Wong, 2009), neuromuscular disorders and psychosocial problems (Shan, Xi, Cheng, Hou and Wang, 2010) later on in life. The rise in diabetes is echoed in a study completed by Wechsler, McKenna, Lee and Dietz (2004) that stated that type 2 diabetes was unfamiliar among young people ten years ago, but now accounts for nearly 50% of new cases among children or adolescents. According to Hsia et al., (2009) the overall use of insulin in children and adolescents also markedly increased, thus indicating the rapid growth in type 1 and 2 diabetes.

Violence is another risk behaviour that could lead to injury, trauma and substance abuse. Phillips and Malcolm (2010) have noted that it is a problem of epidemic proportions among youth. They further stated that youth either engage in or is affected by violence or violence related behaviours. Violence amongst youth cannot be viewed in isolation as this phenomenon is often associated with an increase in participation in alcohol use and substance abuse. Together this could be a recipe for disaster as youth violence not only affects its victims, but also their families, friends and communities. According to a survey conducted by Butchart, Kruger and Nell (1997) in Johannesburg, South Africa, 3.5% of violence victims were 13 years old or younger, of which 21.9% were aged 14–21 years old and 52.3% were among the ages 22–35 years old.

Alcohol use is notable health risk behaviour and is a cause of death in 5% of young people between the ages of 15 and 29 years old worldwide. In South Africa alcohol and tobacco use appears to be on the increase and this is indicated in the study by Reddy et al., (2010) who reported on 2008 data and highlighted that 21% of learners in Grades 8-11 were tobacco smokers, while 35% have used alcohol during the past month. However, in a study by Pharaoh, Frantz and Smith (2011) on 2010 data, it was reported that 64% smoked and 50% of the learners drank alcohol. This increase in preventable health risk behaviours is cause for concern. In addition, with regard to smoking (whether cigarettes or alternative substances) one in five learners smoke tobacco, with a substantial percentage of learners reported having used illegal drugs, like dagga and methamphetamine which is widespread in the Western Cape (Reddy et al., 2010). Highlighting this growing concern from literature has led to the Department of Education designing a national strategy for the prevention and management of alcohol and drug use amongst learners in schools (DOBE, 2013). The motivation was based on the fact that alcohol and drug use leads to academic difficulties and resultant drop out from school. Thus it is evident that even government departments recognise the public health concern.

One other concerning health risk behaviour is the increase in risky sexual behaviour and its consequences. In some countries, up to 60% of all new HIV infections occur among 15-24 year olds. In South Africa around 25% of young men and just fewer than 5% of young women reported engaging in concurrent relationships (Steffenson, Pettifor, Seage, Rees and Cleary, 2011). More than two decades ago, Eaton, Flisher and Aaro (2003) indicated in their review that at least 50% of young people were sexually active by the age of 16 years old and a range of between 5%-25% having

more than four partners per year; and between 50% and 60% of sexually active youth report never using condoms. And in a more recent study by Maluleke (2010), it was highlighted that young people were likely to have sexual intercourse without a condom in return for money, and to abuse substances before sexual intercourse. Although these concerns are serious a study by Pettifor et al., (2005), indicated that the South African youth engaged in less risky sexual behaviour than their American counterparts.

These statistics highlight the need for appropriate interventions at an early stage. Internationally these health risk behaviours are also highlighted. In the United States the leading causes of morbidity and mortality are related to health risk behaviours that are established during childhood and adolescence and may extend into adulthood (Kann et al., 2014). Tobacco use globally is widespread among youth, especially in developing countries and attributes to more than four million deaths a year (Asma et al., 2002; Murray and Lopez, 1997). Magnusson et al., (2007) has reported that in England by age 15, 40% of young people at this stage would have tried smoking tobacco and reported more than two episodes of drunkenness. These international studies further depict the health risk behaviour epidemic.

Literature also suggests that when attempting to address these concerns, it is important to note that there are discrepancies between urban and rural health and that the health risk behaviours between the urban and the rural counterparts differ with regards to prevalence and type (Peer, Bradshaw, Laubscher, Steyn and Steyn, 2012; Papandrea, Winefield and Livingstone, 2010; Groft, Hagen, Miller, Cooper and Brown, 2005). The number of obese and overweight children in the United States has doubled

in the last twenty years with rural residents experiencing increased prevalence compared to its urban counterparts (Tai-Seale and Chandler, 2010). The study further concedes that the impact of obesity increases the risk of death from all causes about 1.5 times.

Groft et al., (2005) argues that the rate of health compromising behaviours such as smoking, obesity and heavy drinking in rural Canada exceeds the national average. The socio-economic status of rural Canadians is generally poorer than that of the urban Canadians (Groft et al., 2005). In Australia, Papandrea et al., 2010 also highlights the fact that adolescents living in rural Australia appeared to have a heightened risk for developing mental health problems. In rural South Africa, Kimani-Murage et al., (2010) observed under-nutrition and the prevalence of obesity among adolescent girls. Peer et al., (2012), pointed out high levels of inactivity and inadequate micro-nutrient intake in rural populations compared to their urban counterparts within South Africa. These findings raise the concern of the increased risk of the rural adolescents. Rural communities are faced with more barriers to the supply resources of support as opposed to their urban counterparts. It is thus imperative to establish effective health promotional interventions in order to combat the disparities to these rural communities and ensure improved healthcare.

The Ottawa Charter for Health Promotion (WHO, 1986) described health promotion as the process of enabling people to increase control over their health and its determinants, and thereby improve their health, which includes supportive environments. The supportive environments included particular settings which offer practical opportunities for the implementation of these strategies from the Ottawa

Charter such as schools. The World Health Organisation (WHO) recognises school health programmes and promotion as an effective tool to prevent health risks among youth and simultaneously improve education (WHO, 2007). Kolbe (2005) suggest that the school health programme could become one of the most efficient means available to improve the health and education of people. Schools can thus significantly, help learners adopt and maintain healthy eating and physical activity behaviours amongst other behaviours. Interventions modifying health risk behaviours are more likely to be effective and sustainable if they are implemented in adolescence. Current evidence proposes that school-based physical activity interventions may be effective in the development of healthy lifestyle behaviours and that the best primary strategy for improving the long-term health of children and adolescents through exercise may be creating lifestyle patterns of regular physical activity (Dobbins, DeCorby, Robeson, Husson and Tirilis, 2009).

Therefore, a school can be a sufficient and cost effective setting where health promotion programmes can take place to improve the education and health of young people. However, these settings can only be used effectively if there is an understanding of strategies that can be used to intervene.

1.3. Problem statement

There is evidence that health risk behaviours are on the increase amongst the youth and there is clearly a need for adequate prevention strategies. Rural areas are not excluded from the increase in health risk behaviours and various health risk behaviours has been highlighted in adolescents in rural areas (Tai-Seale and

Chandler, 2010; Lurie et al., 2008). Current literature focuses primarily on developed countries and urban areas; and limited information exists on rural areas (Kimani-Murage et al., 2010; Tai-Seale and Chandler, 2010; Lurie et al., 2008). WHO (2007) reported that schools were adequate sites for implementing health intervention strategies and thus it would be relevant to establish the role rural schools can play in assisting with prevention strategies that will decrease health risk behaviours among the youth.

1.4. Aim of the study

To determine health risk behaviours and investigate the understanding and perception of health promotion among adolescent in secondary schools in the Theewaterskloof region.

1.5. Objectives of the study

1. To determine the health risk behaviours that secondary school learners in the Theewaterskloof region engage in.

2. To explore and describe the understanding and perceptions of health promotion among secondary school learners in the Theewaterskloof region.

3. To explore and describe the understanding and perceptions of health promotion among life orientation educators in the Theewaterskloof region.

1.6. Significance of the study

Literature highlights an increase in the prevalence of adolescent health risk behaviour over the last few decades, which often continued into adulthood. Studies have shown adolescence to be a vulnerable transitional period of physical and psychological development in which one transitions from one living circumstance to another. In this period adolescents are susceptible to an array of risks that may compromise their current and future health. Jackson et al., (2012) alerted to the fact of established health risk behaviours during adolescence that are often maintained into adulthood, affecting health and wellbeing in later life. Health risk behaviour during adolescence can therefore influence long term implications for health and well-being of the individual and for the society as a whole (Phillips, 2008).

Impetus to engage in health risk behaviours may stem from different reasons for adolescents living in urban versus rural areas. Urbanisation, globalisation, technological and social changes amongst others all add to the discrepancies between rural and urban areas.

More research and data is readily available for urban areas and much less so for rural. It is therefore important for researchers to examine the risk behaviours among adolescents in these different settings, specifically rural. Through better understanding of occurrence of risk behaviour, motivations for engagement and the consequences for development, more effective prevention approaches may be adopted.

An important step is recognising the different approaches to health promotion – those focusing on individuals and those focusing on communities and society. Societal focus

derives from the recognition that an individual's capacity to change the way in which he or she lives is constrained by the social and physical fabric of society.

The significance of this study was to provide understanding and prevalence of health risk behaviour in rural areas. After establishing health risk behaviours, the study attempted to ascertain the adolescents' perception and knowledge about health promotion. In doing so, it provides widespread data of their health status and restrictions to improving their health. The results will aid in developing and building better strategies and policies to improve rural adolescent health while reducing engagement in health risk behaviours. By understanding the risks, challenges and demands faced by rural adolescents, a way forward could be implemented by empowering young adolescents to make informed and responsible decisions conducive to their well-being. Providing adolescents with the necessary life skills in conjunction with targeting key contextual factors influencing youth behaviour could be used to reduce or prevent high risk behaviour. In this way adolescents would develop confidence to engage in creative problem-solving in order to overcome barriers to self-development.

1.7. Definition of terms

Adolescents: A young person who is developing from a child into an adult (Oxford Advanced Learners Dictionary, 2015)

Adolescence: Is described as the human growth and development that occurs after childhood and before adulthood. People aged between 10 to 19 years old (WHO, 2015).

Health Promoting School: "A health promoting school is a school that is constantly strengthening its own capacity as a healthy setting for living, learning and working" (WHO, 1996, para 1)

"A Health Promoting School is a place where all members of the school community work together to promote the health and well-being of learners, educators, general staff, parents and the wider community." (Department of Health Western Cape, 1995)

Health Risk Behaviour: Activities that can damage one's health or well-being (Zweig, Lindberg and McGinley, 2001)

High School Learner: These are learners normally aged 12-18 years old who attend high school

Chronic Diseases of Lifestyle: Group of diseases that share similar risk factors because of exposure, over many decades, to unhealthy diets, smoking, lack of exercise and possibly stress. These results in various long-term disease processes culminating in high mortality rates (MRC, 2006)

Life Orientation: it is a learning area or subject intended to equip learners with the skill, knowledge, attitudes and values to face life's challenges in an informed, confident and responsible way (DoE, 1997)

Life Orientation Educator: Educators responsible for teaching life orientation as a learning area (van Deventer, 2009)

Rural: "Rural areas are defined as sparsely populated areas in which people farm or depend on natural resources, including villages and small towns that are dispersed through these areas. In addition, they include the large settlements in the former homelands, created by the apartheid removals, which depend for their survival on migratory labour and remittances." (Rural Development Framework, 1997)

1.8. Abbreviations used in the study

The following abbreviations have been used in the thesis:

CDC: Centres for Disease Control and Prevention

FGD: Focus Group Discussion

HBM: Health Belief Model

HPS: Health Promotion School

HIV/AIDS: Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome

LO: Life Orientation

OBE: Outcomes Based Education

SCM: Social Consensus Model

SEM: Social-Ecological Model

STI: Sexually Transmitted Infections

YRBS: Youth Risk Behaviour Survey

YRBSS: Youth Risk Behaviour Surveillance Survey

WHO: World Health Organisation

1.9. Outline of the thesis

Chapter One includes the background, problem statement, aims, objectives and significance of the study. Furthermore it contains the definitions, abbreviations used and a brief outline of the thesis. The overall aim of the study was to determine health risk behaviours and investigate the understanding and perception of health risk behaviours and health promotion among high school learners in the Theewaterskloof region. Engagement in health risk behaviours during this life period could lead to a burden of health problems later on in life as well as a continuation of these risk behaviours into adulthood.

Chapter Two offers a review of pertinent literature regarding adolescents and health risk behaviours among adolescents. Adolescence is a period of life that involves rapid growth and development in an ever changing environment. During this period engagement in health risk behaviour vary considerably between populations based on various psychosocial processes. Grounded on the aforementioned, this chapter focuses on the period of adolescents, overview of adolescent health, the prevalence and consequences of health risk behaviours among adolescents and prevention strategies for health risk behaviours. In order for effective strategies to be implemented, there should be understanding of the health risks and reason for engagement in health risk behaviours.

Chapter Three is a description of the methodology of the study. The aspects discussed in this chapter are research setting, research design, data collection methods, data analysis and ethics. The study was conducted in rural Western Cape Province and used an explanatory mixed methods approach. The sequential strategy employed

involved collecting qualitative data after a quantitative phase in order to explain and follow up on the initial quantitative results.

Chapter Four covers the quantitative results of the study. The Yamane formula was used to obtain a representative sample. A self-administered questionnaire was used to obtain the quantitative data and descriptive statistics was used to summarize the health risk behaviours engaged in by learners. The categorical data was expressed as frequencies and percentages and cross tabulations were used to determine associations.

Chapter Five presents the results of the content analysis of the focus groups held with educators and learners. Themes were established through thematic analysis of transcripts. The results highlighted factors that steer adolescents into the engagement of health risk behaviours.

Chapter Six presents the integrated discussion of the results presented in chapter four and five. The chapter is organised to systematically outline and discuss the quantitative results and themes established in the qualitative data. The health risk behaviours that learners predominantly engaged in were substance abused, sexual activity and physical inactivity.

Chapter Seven, the final chapter, concludes the study by summarising findings, making recommendations for future research and discusses any limitations that were encountered during the study. The study illustrated that many school going adolescents engage in multiple health risk behaviours and that a multifaceted approach is needed to address the problem.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This chapter reviewed the available literature related to health risk behaviours of adolescents. Firstly, an overview of the various types of health risk behaviours adolescents engage in is provided, and secondly the theoretical orientations that provide a theoretical framework guiding studies related to health risk behaviour are highlighted. The chapter concludes with an overview of the prevention strategies available for health risk behaviours.

2.2 Adolescent Health Risk Behaviours

The World Health Organisation (WHO) describes human growth and development that occurs after childhood and before adulthood as adolescence (WHO, 2015). During this period a young person develops from a child into an adult (Oxford Advanced Learner's Dictionary, 2015; WHO, 2015). Phillips (2005) designates adolescence as a unique biological and psychosocial stage of the life cycle, distinct from both childhood and adulthood. Rapid growth and development during adolescent years is accompanied with a great deal of change taking place physically, socially and emotionally (Reininger, et al., 2003). Reininger et al., (2003) further stated that the adolescent period is one of curiosity, experience and seeking for personal identity

while exhibiting an excessive drive for new and novel sensation and stimulation. According to Burt (2002) this is also the period in which the task of establishing self-identity, partnering, learning how to handle growing sexual maturity and developing the capacity for economic viability occurs.

Adolescents are particularly influenced by social factors as they attempt to develop a sense of identity. To cope with the pressures adolescents depend on the families, communities, schools, workplaces and health services to learn a range of skills to help them manage. Developing health risk behaviours often serve as social and/or psychological progressions in trying to achieve adult status and acceptance from peers. According to Jessor, Jessor and Finney (1973), youth engaging in health risk behaviours is a way of marking a transition from less mature to more mature or from youth to adult. The health risk behaviours are considered to be purposive and important enough for the individual to engage in despite possible legal repercussions. Health risk behaviours can be desirable and sought out by peers, but socially disapproved by institutions of authority or the larger society (Jessor, 1991).

Engagement in health risk behaviours is multifactorial and patterns established during the adolescent period could have a long lasting negative effect on the health of the youth in the future. The current youth are facing far more complex health challenges than their parents and yet most of the major health problems for young people are largely preventable (Tylee, Haller, Graham, Churchill and Sanci, 2007).

Over the past decade, South African literature has consistently documented health risk behaviours as a concern among adolescents. Studies done in the Western Cape denotes that health risk behaviours are at epidemic proportions among adolescents (Moodley and Phillips, 2011; Phillips and Malcolm, 2010; Reddy et al., 2010). These

health risk behaviours are predicted to rise considerably over the next decades if effective measures are not introduced to curb the health risk burden.

According to the WHO (2015) individuals engage in health risk behaviours such as sexual risk behaviours, physical inactivity, unhealthy diets, tobacco smoking and alcohol consumption. The health risk behaviours discussed in this chapter are: sexual behaviours, tobacco use, alcohol use, physical inactivity and obesity and violence.

2.2.1 Sexual Behaviours

Adolescent sexual behaviours and sexual characteristics vary greatly between countries and regions (Ashton, Dickson and Pleaner, 2009; WHO, 2002). The risks associated with engagement in sexual activity and inadequate reproductive health education of adolescents is unintended pregnancy, sexually transmitted infections and HIV (Ashton et al., 2009). HIV in particular is a problem of epidemic proportions in this part of the world. The Sub-Saharan Africa region accounts for 10% of the world's population yet more than 63% of HIV-infected people worldwide reside in this area. In 2014, statistics showed that 66% of the world's new HIV-infected population lived in Sub-Saharan Africa (UNAIDS, 2014). Phillips and Malcolm (2006) noted that the youth in Sub-Saharan Africa was challenged with the growing HIV/AIDS pandemic. According to a report by WHO (2002), 99% of the HIV infections prevalent in Africa are attributed to unsafe sex. Malcolm & Phillips (2011) concluded that risky sexual patterns which include unprotected sex and multiple sexual partners were practiced by college students in the Western Cape Province despite their knowledge of the risk of HIV/AIDS transmission. Despite the severity of the HIV/AIDS pandemic in South

Africa, studies revealed that more than 50% of adolescents did not practice safe sex and use condoms when having sexual intercourse (Malcolm and Phillips, 2011; Reddy et al., 2010).

Besides not practicing safe sex by using a condom the practice of having multiple sexual partners was also noted. This practice of multiple sexual partners was shown both internationally and nationally. In the United States 46.8% of learners had sexual intercourse and 15% of those learners reported having multiple partners (Kann et al., 2014). In South Africa a study by Reddy et al., (2010) reported a 37.5% national prevalence of learners who ever had sex. Among those who ever had sex, the national South African prevalence for having two or more sexual partners was 41.1% (Reddy et al., 2010). Thomas (2014) in South Africa also concluded 55% of sexually active adolescents practising unsafe sex by having multiple sexual partners.

Having multiple sexual partners also increases the likelihood of an individual being exposed to sexually transmitted diseases such as HIV. According to Lurie et al., (2008) the predominant mode of HIV infection throughout southern Africa is unprotected heterosexual intercourse.

The studies as described above are alarming, especially in the South African context where HIV is one of the fastest growing epidemics in the world (Taylor, Dlamini, Kagoro, Jinavhai and de Vries, 2003). It would therefore be important for preventative strategies to be used. However, according to NCS (2009) even though knowledge of risk if HIV is higher with having multiple sexual partners, people still did not spontaneously mention reducing sexual partners as a method of reducing the spread of HIV. Lurie et al., (2008) also noted that prevention programmes in South Africa that

target secondary transmission between those known to be HIV-positive and their sexual partners are still underdeveloped in generalised epidemic settings. Subsequently, Lurie et al. (2008) also found that there were higher rates of consistent condom use in urban South African HIV-positive participants with current and regular sexual partners as opposed to rural participants. Moodley and Phillips (2011) argue that sexual decision-making is an important factor that influences sexual practices, but being knowledgeable about the consequences of risky sexual behaviour is not enough to bring about expected behavioural change in youth. Despite their awareness of health risks, adolescents still engage in risky sexual behaviours.

2.2.2 Tobacco Use

Nicotine is highly addictive and smoking is frequently associated with social activities and psychological factors. There are approximately 1.3 billion tobacco users worldwide with nearly 1 billion of these users living in low and middle income countries (Van Zyl-Smit, et al., 2013). Within South Africa, it is estimated that 7 million people smoke cigarettes (Van Zyl-Smit et al., 2013). Peer, Bradshaw, Laubscher, Steyn and Steyn (2012) observed that South African urban youth were more likely to smoke as opposed to their rural counterparts.

Smoking onset, regular use and dependence for the majority of adults started during adolescence, before the age of 18 years old (Peer et al., 2013; Call et al., 2002). Furthermore, it is known that those who initiate smoking earlier are less likely to stop smoking and one third to half of the young people who experiment with cigarettes become regular smokers (Swart and Reddy, 2003). South Africa displayed a high rate

of initiation of smoking before the age of 10 years old (Swart and Reddy, 2003). In 2010 a national health risk survey among adolescents in South Africa found that 21% of learners smoked cigarettes and 6.8% smoked their first cigarette before the age of 10 years old (Reddy et al., 2010). It was further noted that significantly more males than females smoked and that the Western Cape Province had the highest prevalence of current smokers as well as learners ever having smoked (Reddy et al., 2010).

It is estimated that tobacco use accounts for around 6 million preventable deaths every year (van Zyl-Smit et al., 2013). Smoking tobacco is associated with significant health risk and reduced life expectancy (van Zyl-Smit et al., 2013; Reddy et al., 2013; Peer et al., 2012). Tobacco smoking directly increases the risk non-communicable diseases such as tuberculosis (TB), chronic obstructive pulmonary disease (COPD), cancer, strokes and heart disease, which are the leading causes of death and disability globally (van Zyl-Smit et al., 2013; Peer et al., 2013; WHO, 2004). The mortality rate among current smokers in South Africa is nearly double that of non- or ex-smokers (van Zyl-Smit et al., 2013).

A further concern is that cigarette smoking in adolescence represents a crucial entry-point to illicit drugs (Ennet, Tobler, Ringwalt and Flewelling, 1994). Other researchers mentioned similar findings in that tobacco is often the first drug used by young people who then go on to use alcohol and illicit drugs (Ozcan and Ozcan, 2002). Furthermore, because of the clustering of smoking with other risk behaviours, it is considered to be a risk factor for several health-compromising behaviours (Fleming, Kim, Harachi and Catalano, 2002). Curbing youth and early tobacco use can therefore have a major impact on reducing morbidity and mortality in older age groups.

2.2.3 Alcohol Use

Alcohol has been consumed in human populations for centuries. In recent years global alcohol consumption has increased with most of the increases occurring in developing countries (Phillips, 2008; Phillips and Steyl, 2008; WHO, 2002).

A study in 2008 mentioned that there seemed to be a general acceptance of drinking alcohol among adolescents within a local community in the Western Cape, provided that they did not become drunk or irresponsible (Phillips, 2008). The study further showed that being under the legal age to purchase alcohol did not deter youth from obtaining alcohol as informal pubs within the community, called “shebeens”, create environments that allow adolescents to gain easy access to alcohol (Phillips, 2008). One in every two South African learners had drunk alcohol at least once in their lifetime and furthermore one in ten learners initiated their first drink before age of 13 years old (Reddy et al., 2010; Phillips, 2008). Phillips et al., (2008) also found a strong relationship with between binge drinking and other substance use, such as smoking and drug use. It was also reported that learners in the Western Cape have significantly higher alcohol use before sex when compared to the national average (Pharaoh et al., 2011; Reddy et al., 2010).

Development of diseases, dependence on alcohol and intoxication are risks associated with harmful alcohol consumption (WHO, 2015; Reddy et al., 2010). Internationally, as well as in the South African context, alcohol continues to be one of the most significant health risk behaviour engaged in by adolescents and is growing in popularity amongst this group (Kann, 2014; Health and Social Care Information Centre, 2012; Reddy et al., 2010; Phillips, 2008).

Ellickson, Tucker, Klein and McGuigan (2001) stated that global increases in alcohol consumption in recent decades and the increased social acceptance with widespread experimentation during adolescence are areas of great public health concern. Associated with early age onset of alcohol consumption is the growing concern of frequent heavy drinking later on in life. According to WHO (2015), approximately 3.3 million deaths are attributed to harmful use of alcohol. These findings show that alcohol is a drug that is commonly used, despite the fact that it is linked to long-term health and social consequences such as intoxication, dependence and direct biochemical effects (Reddy et al., 2010).

2.2.4 Physical Inactivity and Obesity

There are dire consequences of physical inactivity in adolescents that include; obesity, diabetes and hypertension, amongst other diseases of lifestyle (Figaji and Phillips, 2010; van Sluijs, McMinn and Griffin, 2007). Obesity, one of the risks associated with low physical activity, is characterised by excessive bodily fat, while being overweight is exceeding the expected or normal bodily weight for one's age, height and build (Mirriam Webster's Collegiate Dictionary, 2002). Although health benefits of physical activity have been proven, many adolescents still fail to meet the current guidelines for sufficient physical activity (Kahn et al., 2010).

Prevalence of adolescent obesity and physical inactivity and the related health problems are increasing in many developed and developing countries (Dobbins et al., 2009; van Sluijs et al., 2007).

International as well as local studies suggest that the majority of overweight and obese adolescents are predominantly in rural areas (Tai-Seale et al., 2010; Kimani-Murage et al., 2010). Obesity displayed in rural areas may reflect the consequence of other health risk behaviours such as increased sedentary behaviour, decreased physical activity and over nutrition (Kimani-Murage et al., 2010). Dobbins et al., (2009) raises similar results in their review of school-based interventions globally, indicating that diet and physical activity are important factors in maintaining a healthy body mass index range.

Various studies have shown that South African adolescents do not meet the required amount of physical activity to gain the health benefits (Figaji and Phillips, 2010; Reddy et al., 2010; Kahn et al., 2008). Research indicates that physical activity appears to decline the greatest between the ages of 13-18 years old (Figaji and Phillips, 2010; Kahn et al., 2008). The physical activity levels in developed countries have shown to be no different than in developing countries (Phillips, 2006).

The World Health Organisation report (2015) showed that 3.2 million deaths annually can be attributed to insufficient physical activity. Lifestyle factors which include physical activity can play a major role in prevention and treatment of diseases of lifestyle such as diabetes and obesity (Wing et al., 2001). A positive correlation exists between support from family for physical activity and the levels of both moderate and vigorous levels of physical activity (Figaji and Phillips, 2010). Adolescent level of physical activity is influenced through their parents modelling, attitudes and encouragement to being physically active (Figaji and Phillips, 2010; Kahn et al., 2008).

2.2.5 Violence

International and South African research suggest that violence among the youth is reaching epidemic proportions (Phillips, 2008; Soriano, Rivera, Williams, Daley and Reznick, 2004). Violence may be described as aggressive behaviour that may be physically, sexually or psychologically abusive. Consequences of violence are far broader than just the death and injuries. Victims of violence are at risk of psychological and behavioural problems, including depression, alcohol abuse, anxiety and suicidal behaviour amongst others (Krug, Dahlberg, Mercy, Zwi and Lozano, 2002).

The impact of youth violence impacts all sectors of society and places a strain on public services and communities. Youth violence deeply harms not only its victims, but also their families, friends and communities (WHO, 2002). Violent young people frequently commit a range of crimes and display other social and psychological problems. Globally it is estimated that an average of 565 young people between 10-29 years old die daily through interpersonal violence (WHO, 2015; Reddy et al., 2010). Furthermore for every young person that dies 20-40 youth require hospital treatment for violence-related injuries (WHO, 2015). Family factors such as poor parental supervision, harsh physical punishment to discipline children, low level of attachment between parent and child, low socioeconomic status of the family are closely related to adolescent violence (WHO, 2002). Furthermore social political and cultural factors such as gangs, low levels of community cohesion, quality of the country's governance and income inequality have all been linked with youth violence globally (WHO, 2002).

Violence has become a widespread problem in schools in South Africa: sexual violence, harassment, intimidation, rape and the murder of educators and learners on school premises are daily events (Mokhobo and Viljoen, 2007). The South African

youth has provided evidence that they are engaging in or affected by violence and violence-related behaviours in their community and at school (Phillips and Malcolm, 2010). Studies specifically among adolescents and students in the Western Cape found that youth violence impacted negatively on the health sector, family and society and places a huge strain on public services (Phillips et al., 2008; Reddy et al., 2008). Consistent with international findings (Kann et al., 2014), almost one third of South African learners are involved in physical fights, with male learners being more likely to be involved in a fight than female learners (Reddy et al., 2008).

2.3 Development of health promotion

The concept of promoting good health has been around as long as there have been attempts to improve the publics' health. However the term health promotion is relatively new phrase that was first used during the 1980's (Mold and Berridge, 2013). Health promotion is defined by WHO as the process of enabling people to increase control over and to improve their health (WHO, 1986). Over the years health promotion continuously developed globally to address the needs of the populations

During the nineteenth century the populations of Britain and other Western nations grew rapidly and were accompanied by industrialisation and urbanisation (Mold and Berridge, 2013). These rapidly expanding cities did not keep pace with the growth in key facilities such as housing and sanitation, which led to poor living and working conditions. Throughout the nineteenth century there were a series of epidemics of diseases such as cholera and typhoid which thrived in these conditions (Mold and Berridge, 2013). Sanitation reform, the removal of sewerage and waste in combination

with the provision of clean water dominated nineteenth-century public health focuses and health promotion (Melosi, 2000; Hamlin, 1998).

During the early twentieth century social hygiene marked the development of health promotion globally. The concept of health was concerned with the social influences on individual and public health and aimed to encourage preventive medicine (Mold and Berridge, 2013). The mid twentieth-century most Western countries adopted policies that promoted preventing disease and promoting good health. Ryle (1948) proposed a notion of health as a positive condition and not just absence of disease. Health professionals thus began working in local communities to improve health.

In 1986 the Ottawa Charter for Health promotion was introduced on the backs of various initiatives that were introduced in the late 1970's and early 1980's (WHO, 1986). Public health emphasised the wider social influences upon collective and individual health. The notion of risk was broadened to include the risks that individuals or groups of individuals pose to the rest of the community, not just their own health. Strong emphasis on prevention of disease was identified as well as supportive environments for health. Furthermore, intersectional cooperation as well as public and community involvement together with government is necessary to make healthy environments possible (Mold and Berridge, 2013).

The South African national policy for health promotion practice is based on the principles and approach of the 1986 Ottawa Charter for Health Promotion (Coulson, 2000). It establishes five (5) key action areas for health promotion, namely:

- To promote safe environments
- To develop healthy public policy

- To promote community action
- Develop personal skills
- Re-orient the health service

This five-pronged approach is effective not only within the health sector, but within other sectors as well such as schools and places emphasis on the environment rather than personal behavioural change. Health promotion thus demands a multi-disciplinary approach that requires input of social scientists, health workers, communication specialists and policy analysts, amongst others, to be successful (Coulson, 2000).

2.4 Theoretical Frameworks

There are various theories for prevention of health risk behaviours. This study employs the use of two frameworks which attempts to explain the research problem to guide the study. The first framework used is the Social Ecological Model which provides a background that supports a multi-level strategy to attaining optimal health. It includes various levels in which it can influence the health risk behaviour.

The second theory employed is the Health Belief Model. This framework helps to clarify the forces that influence individual health behaviour. The purpose of this framework is to demonstrate the reasons individuals partake in the health risk behaviours. This model is based on the individual and the actions that they take to improve their health.

2.4.1 Social Ecological Model (SEM)

The Social Ecological Model of Health Promotion represents a multi-level approach to health. It consists of multiple dimensions of influence, with the individual at the core of the model, surrounded by a further four dimensions representing the interpersonal, organisational, community and policy levels (McLeroy, Bibeau, Steckler and Glanz, 1988; Bronfenbrenner, 1979). It provides a framework for understanding how individuals and their social environments mutually affect each other across the lifespan (Wendel and McLeroy, 2015).

The individual level aims to increase the individual's knowledge and influence on his or her attitude and beliefs regarding health. The SEM highlights the importance of providing the individual with high-quality and appropriate information.

The second dimension of the SEM represents the interpersonal level. This level aims to facilitate individual behaviour change by affecting social and cultural norms and overcoming individual-level barriers. Examples of these are friends, family, health care providers and community health workers.

The third dimension of the SEM represents activities implemented at an organisational level. These activities are intended to facilitate individual behaviour change by influencing organisational systems and policies. Examples of these are healthcare systems, employers or worksites, healthcare plans, local health departments and professional organisations, amongst others.

The fourth dimension represents the activities implemented at a community level. These activities are also intended to enable individual behaviour change by leveraging

resources and participation of community-level institutions such as media and community advocacy groups, amongst others, which represent the potential sources of community communication and support.

The last dimension of the SEM represents prevention activities at a policy level. These activities involve interpreting and implementing existing policy. State, local and governmental agencies may support policies that promote healthy behaviour.

The SEM provides a framework for the understanding of the dynamic inter-relations of the various personal and environmental factors that are experienced by the learners. In order to effectively explore and describe the health risk behaviours that the learners engage in, the entire social ecological system in which growth occurs needs to be taken into account. The extent of interaction within the various dimensions of the SEM will assist in the understanding and perception of the adolescent's response to the health risk behaviours (Bronfenbrenner, 1979).

2.4.2 Health Belief Model

The Health Belief Model (HBM) was originally developed in the 1950's by a social psychologist working in the U.S. Public Health Service. It was developed in an effort to explain why so many people failed to participate in programmes to prevent disease, and then was later extended to explain differing reactions to symptoms and to explain variations in adherence to treatment (Rosenstock, 1974).

The HBM provides a means to analyse forces that influence health behaviour. It breaks down health decisions into a series of stages and offers a catalogue of variables that influence health action (Hochbaum, 1958). The likelihood that persons

will follow a preventative behaviour is influenced by their subjective weighing of the costs and benefits of the action. A central construct in the HBM is perceived risk, which is posited as a necessary prerequisite to behavioural change. Perception involves the following elements: Perceived susceptibility and perceived seriousness of the condition (Hochbaum, 1958). The combination of the perceived susceptibility and seriousness is termed the perceived threat. The perceived threat is a cognitive component and is influenced by information. This threat creates a pressure to act, but does not determine how the person will act. Generally the HBM contend that individuals who recognise that their behaviour places them at risk are more likely to adopt a less risky behaviour than those who do not.

The HBM thus provides a framework for motivating people to take positive health actions that uses the desire to avoid negative health consequences as the prime motivation. The HBM compels the individual to take personal responsibility for their health which could in turn lead individuals to believe that it is their fault if they cannot solve their own problems.

In South Africa previously, there was a hierarchical structure of society, which included wealth, prestige and power (Taylor and Yu, 2009). This structure was constructed on the basis of race and lasted for decades, it institutionalised inequality and placed restrictions on where people could live, work and the type of education they had access to (Taylor and Yu, 2009). It is along this background that South African history ensured that Socio-Economic Status (SES) is distributed along racial lines. During this time government spending on education was vastly unequal across the race group. White South Africans benefitted most during this regime while black, coloured and

other non-white South Africans did not. The Theewaterskloof municipal area, where this study is located, falls in the South African rural landscape which was previously disadvantaged along the racial lines. According to the socio-economic profile, Theewaterskloof has a poverty rate of 35% and a literacy rate 78.4%. This is inferior to the provincial average which is 22.1% and 87.2% respectively (Western Cape Government Provincial Treasury, 2014).

Literature also showed significant disparities in the abilities of children associated with SES (Lee and Burkham, 2002). Better educated parents are able to directly offer support such as helping with homework and have easier access to information that will help with their children's health, social and emotional well-being, all of which will feed into educational achievement. Additional shortages of resources in this community generally add to the burden experienced by schools with low SES learners.

Based on the HBM theory, one can see how the SES of the Theewaterskloof area impacts on the decision making of the individual with regards to HRB's. The lower SES family background characteristics predispose the learners in the Theewaterskloof community to engaging in health risk behaviours.

Due to the lower socio-economic status, people cannot afford the correct health services and has less access to information. Learners in poorly performing and low socio-economic status schools find it especially hard to overcome the disadvantage of low reading scores, hence they have less chance to effectively change their health beliefs.

2.5 Prevention strategies for Health Risk

Underlying determinants of health risk behaviour has led to a numerous approaches to the prevention of these behaviours. Identifying promising intervention strategies has led to multiple studies reviewing the evidence on “what works” in preventing single as well as multiple health risk behaviours. Identifying promising intervention programmes could help inform future intervention strategies and policies. The literature review highlights the following prevention strategies.

2.5.1 School-based Prevention Strategies

In 2008 the South African youth population was estimated at 9 747 000 with at least 70% enrolled in schools (Reddy et al., 2008). Advantages associated with schools having large numbers of young people, is that schools always presented the ideal venue to propagate health related information which may assist in reducing health risk behaviours. Plummer et al., (2007) suggests that school-based programmes reach large numbers of young people in a replicable and sustainable way. Within a health promoting school system, health education can be used to provide learners with opportunities to acquire the knowledge, attitudes, and skills necessary for making health-promoting decisions, achieving health literacy, adopting health-enhancing behaviours and promoting the health of others (UWC, 2006; UWC, 1996; WHO, 1996,).

Prior to 1994, the Republic of South Africa passed a series of acts to marginalise and deprive certain groups of people, namely Blacks, Coloureds (Mokhobo and Viljoen, 2007; Panday, 2007; Beinart and Dubow, 1995,). Inequalities imposed on the

marginalised black groups in South Africa produced negative impacts in the form of poverty, malnutrition, violence, crimes and the fuelling of HIV/AIDS. One of the policies enshrined in the then Apartheid constitution, was the Bantu Education Act (1953) which ensured that black children would receive “inferior” education. The well-being of this group was continuously deprived leading to economic setbacks which disabled them to lead healthy lifestyles (Mokhobo and Viljoen, 2007). Overcrowding in schools, under qualified educators, lack of infrastructural facilities and insecurity of these marginalised groups threatened their health and impacted negatively on well-being and wellness of the school population (Mokhobo and Vijoen, 2007; Mohlala, 2006).

To eradicate the inequalities of the apartheid educational system, South Africa adopted the Health Promoting Concept in 1994 (WHO AFRO, 2013; UWC, 1996). The following year the World Health Organisation launched a global school health initiative with a vision manifested in the creation of health promoting schools (WHO, 1996).

A health promoting school is a place where all stakeholders of the school work together to provide the scholars with integrated and positive experiences and structures which promote and protect their health (WHO, 1996). It is reported that a combination of intervention with educators, parents and children can have an enduring effect in reducing violent behaviours, heavy drinking, and sex by age 18 among multi-ethnic children (Hawkins, Catalano, Kosterman, Abbott and Hill, 1999). Thus a health promoting school (HPS) engages health and education officials, educators, learners, parents and community leaders in efforts to promote health using all the measures at its disposal. Within this philosophy every educator-child interaction becomes an opportunity to promote good health. Educators therefore need to be aware of the

potential their interactions and behaviour have to influence the behaviour of their learners. The most effective schools at promoting health and wellbeing are those which embed the core principles in their everyday practices and their curriculum. In 1996 the national conference on Health Promoting Schools was held in Bellville in an attempt by main stakeholders in education in South Africa to compile an inclusive agenda on health and health promoting schools for the country (UWC, 1996). Health promoting schools encourages health and well-being of the learners, educators, general staff, parents and wider community. Health promoting schools address problems within its own context holistically and systematically, thus taking responsibility for prioritising its needs and accessing resources.

HPS use five key components to discourse various situations namely: Skills, Policies, Environment, Community and Services (SPECS).

Skills: Building the necessary skills of the school community

Policies: Developing policies to guide and direct activities at the school

Environment: Creating a safe and healthy environment for living, learning and working

Community: Strengthening interaction between the school and the surrounding community

Services: Accessing services appropriately and effectively.

The focus of the South African education system was to have a holistic approach which not only focused on the academic aspect but also on the life skills learners required to be successful (van Deventer, 2009). For this reason the addition of life orientation as a subject was added to the curriculum. Life Orientation was included as

a new learning area in the Grade R-9 and as a new subject in Grades 10-12. The purpose of the learning area/subject was to prepare learners with skills, knowledge, attitudes and values to face life's challenges in an informed, confident and responsible way (van Deventer, 2009). The Grades R-9 focused on Health Promotion, Social Development, Personal Development, Physical Development and Movement and Orientation to the World of Work whereas in the Grades 10-12 the learning outcomes of Life Orientation were Personal Well-being, Citizenship Education, Recreation and Physical Well-being and Career and Career Choices (Department of Education, 2003). According to van Deventer, 2009, Life Orientation equipped learners to address the needs and challenges they encounter.

According to Jacobs and Frantz (2014) if implemented suitably, the Life Orientation curriculum could provide a platform to address various public health issues. These public health issues are the health risk behaviours that potentially lead to chronic diseases of lifestyle (Jacobs and Frantz, 2014). Furthermore, the various health risk behaviours that the young people in the Western Cape engage in form a significant part of the Western Cape burden of disease (Myers and Naledi, 2007).These concerns could be reduced by using schools as a platform to encourage learners to adopt a healthy lifestyle.

However, recent evidence has identified challenges with life orientation as a subject in the curriculum and these include the fact that the subject was undervalued by both learners and staff members from other academic disciplines (Jacobs and Frantz, 2014). Educators teaching Life Orientation felt that they required more resources and support to teach the subject (Jacobs and Frantz, 2014). Therefore, it is somewhat

evident that although there is a clear problem and successful intervention strategies have been identified within available settings, there is a need to get stakeholder buy-in and to understand the views of the stakeholders.

Although there are developments indicating a new vision for education, there is still a dire need for health promotion in schools in South Africa. The HPS framework was recognised as a strategic, holistic and comprehensive response to the challenge of barriers to learning and a successful strategy for creating safe and supportive environments in schools as centres of care and support (WHO AFRO, 2013; UWC, 2006).

2.5.2 Parenting Programmes

Parent-child relationships and family-based interventions are favourable strategies for producing positive effects on psychological, physical, social and economic well-being of youth (Wessel, 2012; Sanders, 1999). Positive parent-child relationships have shown to buffer and mediate the effects of wider family and community factors (Gardner, Sonuga-Barke and Sayal, 1999). Despite the importance of family relationships, most parents are not prepared for the parenting role and thus draw from their own experiences of being parented. This could prove to be problematic if parents themselves were raised with negative parenting styles (Wessels, 2012). Furthermore, lack of financial resources affects the parent's ability to provide nutrition, health care and education, making parenting more difficult and often leading to parent depression. Depressive parents are more likely to use harsh punishment and are more inconsistent with responses to their children's behaviour (Gould and Ward, 2015). Harsh and

inconsistent parenting that lacks warmth increases the likelihood of children engaging in health risk behaviours (Gould and Ward, 2015, Jackson, Henriksen and Foshee, 1998).

Programmes that provide parents with information regarding child development and teach them how to effectively discipline, monitor and manage family conflict and improve communication are good prevention strategies addressing the youth violence and health risk behaviours (Gould and Ward, 2015, Krug et al., 2002). According to Jackson et al., (2012), parenting and family-based programmes have been shown to positively impact on smoking, drinking and illicit drug use behaviour. Cochrane reviews highlighted that the Strengthening Families Programme for Parents and Youth 10-14 has been shown to reduce smoking, alcohol and illicit drug use after four years (Gates, McCambridge and Smith 2006; Foxcroft, Ireland and Lowe, 2003). Parenting programmes are a range of interventions which include efforts to improve parents' knowledge of young children's development, their stimulation for learning, management of their behaviour and relationships with their children (Ward and Wessels, 2013). The majority of the highlighted studies were completed in the United States of America and further research is still needed in other contexts, such as developing countries (Wessels, 2012, Gates et al., 2006). Within the South African context, the majority of the programmes developed are more likely to be situated in urban areas, with a clear lack of programmes in rural areas (Wessels, 2012). Currently in South Africa, two parenting programmes have been developed and have been found to be effective (Gould and Ward, 2015). These programmes are the Thula Sana and a Book-Sharing programme. South Africa and other African countries are testing

numerous other parenting programmes for youth for their efficacy in the African context (Gould and Ward, 2015).

Interventions to support and develop positive parenting in South Africa are mandated by Chapter 8 of the Children's Amendment Act (Act No. 41 of 2007). Section 144 develops the capacity for parents to act in the best interest of their children by focusing on key areas namely; strengthening positive relationships with families, improving the care-giving capacity of parents and using non-violent forms of discipline (Gould and Ward, 2015).

In addition, The National Development Plan 2030 (NDP) aims to eliminate poverty and reduce inequality by 2030 (National Planning Commission, 2011). Nineteen (19) indicators has been listed that will enable South Africa to attain that goal. These include: increase in employment, increase in per capita income, increase in quality of education and ensuring that all people live safely (National Planning Commission, 2011). Success within the NDP would lead to better educated youth which are more likely to be employed in better-paying jobs, thus laying the groundwork for positive parenting (Gould and Ward, 2015; National Planning Commission, 2011).

2.5.3 Public Health Programmes

Public Health focusses on the health of communities and populations as a whole and does not focus on individual patients. The aim of Public Health is to preserve, promote and improve health with emphasis on prevention of disease and injury from occurring and reoccurring, rather than on treating the health consequences (WHO, 2002).

In South Africa, healthcare that meets the needs of adolescents is crucial in fighting the battle against HIV/Aids, STI's and teenage pregnancy (Ashton, Dickson and Pleaner, 2009). These are some of the consequences of the prevalent health risk behaviours engaged in rural communities. Currently, adolescents face a HIV infection rate crisis where more than 60% of South Africans under the age of 15 years old today could die of AIDS related causes in the next five to ten years (UNAIDS, 2014). The preventative initiatives for adolescents are either school based or have been implemented in government hospitals and clinics (Thomas, 2009). The adolescent-friendly clinic initiative is an accreditation programme designed to address quality of adolescent health services at primary-care level and strengthen public sectors ability to respond to adolescent health needs (Dickson, et al., 2007). National Adolescent Friendly Clinic Initiative (NAFCI) recognised that the public health sector is a sustainable way of providing health services that can reach out to most adolescents (Ashton et al., 2009). The NAFCI implements an innovative approach by:

- making health care services more accessible and acceptable to adolescents,
- establishing national standards and criteria for adolescents health care in clinics throughout the country,
- building the capacity of health care providers to improve service performance for the delivery of adolescent-friendly services.

The programme was started in South Africa based on the research done prior to the programme starting. The research showed that 45% of the total population are young, making adolescents in South Africa a priority. More than 60% of the new HIV infections occur among the aged 15-25 years old and more than a third of the babies born in South Africa are born to mothers less than 18 years old. These results demonstrate

the endemic health risk behaviour among the adolescents of South Africa. The NAFCI programme uses public health clinics as a vehicle for providing services to deal with the HIV epidemic. “Young people need information and skills, health and counselling services and a safe and supportive environment to grow and develop in good health’ (Ashton et al., 2009, 38). The NAFCI was formed to accommodate these needs of young people (Ashton et al., 2009).

2.6 Summary

South African adolescents, like adolescents from elsewhere are undergoing a developmental transition in a rapidly changing climate. In trying to achieve adulthood, adolescents engage in health risk behaviours which vary greatly, depending on their circumstances and/or environmental stresses. These circumstances or stresses are very different when urban is compared to rural settings and inequalities are excessive. Health Risk Behaviour is thus a multi-faceted phenomenon that involves numerous psycho-social processes. Therefore, in order for effective preventative strategies to be implemented, one needs to have a good understanding of the health risks behaviours engaged in, and the reasons adolescents become involved in these behaviours. Providing health care services that meet the needs of adolescents should be a multifactorial in approach and should be encouraged in all environments that adolescents come into contact with such as family, peers, schools and primary healthcare facilities. This study draws attention to school based programmes, parenting programmes and public health programmes.

Furthermore, the present study looked at a combination of two health models to provide a holistic framework to fortify this study. The Health Belief Model focuses on

the individual while the Social Ecological Model focuses on the environment influences on the individual. Characteristics of both will provide an all-inclusive framework in addressing the concern of adolescent engagement in health risk behaviour.

CHAPTER 3

METHODOLOGY

3.1. Introduction

This chapter outlines the research methods that were used to collect and analyse the data for the study. This study consisted of two phases; a quantitative and qualitative phase. A description of each phase, including the procedure followed the methods of data collection and the analysis of the data is also provided. The chapter concludes with an outline of the ethics considered in the study.

3.2. Research setting

The study was conducted in the Theewaterskloof region. Theewaterskloof is situated in the jurisdiction of the Overberg District Municipality in the Western Cape and covers an area of 3232km$^{2.}$ There are seven towns within the Theewaterskloof region, namely Botriver, Caledon, Genadendal, Grabouw, Greyton, Riviersonderend and Villiersdorp. The largest town in the region is Grabouw. According to Census 2011, the local municipality has a total population of 108 790. The population age distribution consist of the following: Children (aged 0-14 years) 23.9%, Working age (aged 15-64 years) 67.3% and Aged (aged 65 years and above) 8.8%. Theewaterskloof is demographically typical of the Western Cape in its proportion of “coloured” (62.9%) and “Black African” (23.4%) youth.

Figure 1 below displays a map of the Theewaterskloof region within the Western Cape Province, South Africa.

Figure 1: Map of Theewaterskloof region within the Overberg District Municipality, Western Cape, South Africa

The study was conducted in two of the seven towns, namely Grabouw and Genadendal. Grabouw was included as it has the most secondary schools in the region. In addition, both Grabouw and Genadendal are the towns where the University of the Western Cape is running a research programme called: “Building Capacity for Sustainable Development at Rural Service-Learning Sites”.

Grabouw has thirteen schools of which four are secondary schools and nine are primary. In Genadendal there are three schools of which one is a secondary school and the other two are primary (http://www.schools4sa.co.za/province/western-cape/). Schools participating in this study are co-educational and the learners are predominantly Afrikaans-speaking except for one school in Grabouw where the learners are Xhosa-speaking.

3.3. Research design

The study used an explanatory mixed methods approach, specifically the sequential strategy. The explanatory mixed methods design involved collecting qualitative data after a quantitative phase in order to follow up on the quantitative phase in more depth. Therefore, the explanatory follow-up built on the initial quantitative results. The mixing of the data then occurs in the discussion.

In the quantitative phase of the study a questionnaire was used to collect data on the health risk behaviours of learners at the selected schools. The qualitative phase used focus group discussions to obtain a better understanding of the perceptions of the participants (both the learners and the educators) regarding strategies for health promotion.

3.4. Data collection methods

As indicated above, the data collection methods were divided into two phases and will be described separately for each phase.

3.4.1. Quantitative Phase

3.4.1.1 Study Population and Sampling

Grabouw and Genadendal were selected as the study sites. Grabouw has four secondary schools and Genadendal has one. Consent for this study was received from three (3) out of the four (4) secondary schools in Grabouw and from the secondary school in Genadendal. The study population comprised of learners from the four secondary schools in the Grabouw and Genadendal region that were enrolled for the 2014 academic year. This consisted of 2756 learners registered for the 2014 academic year. To obtain a representative sample from these schools the Yamane Formula (Israel, 2009) was utilised. The formula has a 95% confidence level and P=.5 was assumed for the equation.

$$n = \frac{N}{1 + N(e)^2}$$

Where n is the sample size, N is the population size and e is the level of precision.

$$n = \frac{2756}{1 + 2759(0.05)^2}$$

$$= 348$$

Therefore approximately 348 learners were needed to participate in the study. Stratified random selection of learners from Grade 8-11 of the respective schools were done using grade as the stratum.

3.4.1.2 Data Collection Methods

A self-administered questionnaire (Appendix A) was used obtain the quantitative data. The questionnaire consisted of two sections. The first section measured demographic characteristics such as gender, age group, school grade and race/ethnicity. The second section measured health risk behaviours and was adapted from the Youth Risk Behaviour Surveillance System (YRBSS) developed by the Centres for Disease Control and Prevention (CDC) (Kann et al., 1999).

The original questionnaire measures eight (8) domains of health risk behaviours. These domains include tobacco use, alcohol use, drug use, sexual activity, behaviours leading to violence, perceptions of body weight, suicidal thoughts and behaviours related to physical activity. The original questionnaire demonstrated acceptable reliability statistics of .51 to .88 (CDC, 2000). The instrument has also been found to have both face and content validity. Furthermore the YRBSS has been used in South Africa and deemed appropriate for use in the South African context (Reddy et al., 2010).

Phillips (2006) however found that some of the items of the original YRBSS yielded poor face and content validity in a sample of high school learners in the Helderberg Basin, Western Cape, South Africa. The setting reported by Phillips (2006) is similar to the current study's setting. In her study Phillips (2006) found that the items related to perceptions of body weight and suicide yielded poor face and content validity. In addition, only ten percent of that study reported using motor vehicles as they primarily made use of public transportation.

Therefore, for the current study the YRBSS was abbreviated by excluding the items described above as the target group of the current study experienced similar economic constraints.

The abbreviated YRBSS was piloted to high school learners, not participating in the main study, before the final version of the questionnaire were adopted for use in the study. The questionnaire was administered to twelve learners of similar demographic profile as the intended sample schools. This was done in an attempt to assess its level of understandability, its ability to be completed and the time it takes to be completed. The questionnaire was administered in English as the learners indicated that they felt comfortable completing the questionnaire in English.

A 15 minute discussion followed the completion of the questionnaire to discuss the face validity of the instrument. All learners within the pilot study managed to complete the questionnaire in less than 50 minutes. Although English was the second language to some of the learners, the responses from these learners were that they were able to understand and complete the test questions. No themes emerged from the discussion that warranted a need to change or rephrase the questionnaire. The results indicated that the instrument was relevant to the population and was easily used by the learners in the designated grades. The abbreviated YRBSS that assessed six domains of health risk behaviours was thus adopted for use in the study. The domains included:

Behaviours contributing to violence. The questions on violent related behaviours measured days missed from school due to safety reasons, the frequency and severity of physical fights, physical fights that lead to injury, abusive behaviour of partners, forced sexual intercourse and carrying weapons.

Tobacco use. Questions on tobacco use measured lifetime and current patterns of cigarette use, age of initiation of smoking and smoking on school property. Lifetime tobacco use refers to having ever tried cigarette smoking, even one or two puffs. Current tobacco use refers to smoking in the past 30 days.

Alcohol use. Questions on alcohol use measured lifetime and current patterns of alcohol use, age of initiation of alcohol use, drinking on school property and binge drinking. Lifetime alcohol use refers to having at least one drink of alcohol during your lifetime, excluding drinking a few sips of wine for religious purposes. Current use refers to drinking at least one drink of alcohol during the past 30 days.

Drug use. Questions on drug use measured lifetime and current patterns of drug use, age of initiation of drug use and attempts made to use drugs on school property. Lifetime drug use refers to having used any form of drug during your life. Current drug use refers to the use of any form of drugs during the past 30 days.

Sexual activity. Questions on sexual activity measured the prevalence of sexual activity, age of first sexual intercourse, number of sexual partners, condom and contraception use, and alcohol or drug use before sexual intercourse. Sexual activity refers to consensual sexual intercourse and did not include practices of oral sex.

Physical Activity. Questions on physical activity measured patterns of and participation in physical activity, participation in physical exercise in past 7 days, sedentary behaviours such as television watching and playing computer games and participation physical education.

3.4.1.3 Data Collection Procedure

Information sheets (Appendix B) and consent forms (Appendix C) were distributed to the participants at the participating schools during the life-orientation period. The self-administered questionnaires were then distributed to those learners who had completed the consent forms. The questionnaire was self-administered and most of the learners completed the questionnaire in their classrooms or homes. The Life Orientation educators placed all the completed questionnaires in a sealed box for the researcher to collect afterwards. A period of 14 days was utilised to obtain all the completed forms.

3.4.1.4 Data Analysis

The Statistical Package for Social Sciences (SPSS) version 23 was used to analyse the data. Descriptive statistics was used to summarize the health risk behaviours learners participated in. Categorical data was expressed as frequencies and percentages. Furthermore, cross-tabulations were used to determine associations between socio-demographic variables and respective health risk behaviours. For categorical variables, chi-square tests were used to test for significant differences. The level of statistical significance was set at alpha level of 0.05, thus a p-value less than 0.05 was considered statistically significant.

3.4.2 Qualitative Phase

3.4.2.1 Study Population and Sampling

The study population for the qualitative phase comprised of Life Orientation (LO) educators and learners (that participated in the quantitative phase) from the respective schools in the Theewaterskloof municipal region.

LO educators were purposively selected for the sample due to their involvement with health promotion education at a school setting. LO educators from secondary schools participating in this study were identified to form part of the focus group discussion (FGD). An in depth focus group discussion was conducted so as to gain the necessary information that was needed based on the research objective of this study. Five (5) educators formed part of the FGD.

Learners enrolled in the secondary schools participating in this study were selected to form part of the focus group discussion. Learners needed to be 12 years and older and in Grades 8-11 to be eligible to participate in the FGD's. Only 29 learners indicated their willingness to participate in the focus group discussion. Three (3) FGD was held with the learners, which consisted of two (2) groups of ten (10) and one (1) of nine (9).

3.4.2.2 Data Collection Methods & Procedure

Methods of data collection for this phase of the study included focus group discussions (FGDs) with both learners and educators.

a) Three focus group discussions were held with purposively selected learners. The FGDs were held with the learners to facilitate an understanding of their health risk

behaviours and engagement therein. Furthermore, health promotion strategies as preventative measures were also discussed in keeping with the aim of the study. The discussions were facilitated by the researcher. The discussions were recorded using a digital voice recorder and was uploaded to the researchers computer and then saved to USB memory stick. The memory stick was kept and stored in a lockable cabinet. The voice recordings were transcribed verbatim using a professional transcription service. The recorded data was collected in English and Afrikaans. Afrikaans transcripts were translated to English. Notes were also made during the focus group discussion by the researcher. No scribe or moderator was present during the FGDs.

b) One focus group discussion was held with the educators (n=5) to establish their views, current insights and experiences regarding health promotion.

The FGDs for both learners and educators were held in a classroom at the school at the end of the school day. The discussions were facilitated by the researcher. The discussions were opened with a broad question and were guided by prompts that enabled the researcher to reach the objectives of the study. The discussions were recorded and additional notes were taken by the researcher throughout the discussion. Each discussion lasted for between 20 - 40 minutes. The discussions were ended when the participants indicated that they had nothing further to add to the discussion.

3.4.2.3 Trustworthiness

To ensure rigor and trustworthiness of the study, strategies proposed by Lincoln and Guba (1985) were integrated and used in this study. Lincoln and Guba (1985) state

that validity in qualitative research is inherent in the researcher's use of procedures of authenticity and trustworthiness. The four qualitative criteria for trustworthiness according to Lincoln and Guba (1985) are:

Confirmability: To ensure confirmability, field notes, recorded interviews and analysis should be submitted to the study supervisor (Lincoln and Guba, 1985). To demonstrate the impartiality of the research interpretations, transparency of methods was ensured by the researcher. An audit trail is possible as raw data, analysis notes, process notes, personal notes and preliminary developmental information is available from the researcher.

Credibility: According to Shenton (2004), credibility ensures how congruent the research findings are with the reality. To ensure that the data captured during this stage was trustworthy, member checking was done with the respective groups in order to verify recorded responses. The member checking, notes and observations were done to enhance the validity of the study.

Transferability: Transferability refers to the "extent to which the findings can be applied in other contexts or with other respondents" (Babbie and Mouton, 2001, p277). Participants in the FGD were purposively selected with set criteria. In addition, the information obtained from the FGDs was specific to this small number of individuals in this particular setting. Thus the findings and conclusion of this study cannot be generalised or transferred to other populations or settings.

Dependability: Similar to reliability, dependability provides evidence that similar findings would be achieved, if the same procedures are repeated by another

researcher (Shenton, 2004). To improve dependability, a thorough description of research methods was transcribed in detail.

3.4.2.4 Data Analysis

The recorded focus group discussions were transcribed verbatim for analysis. Truth value was achieved by member checking and debriefing sessions after the FGD. A thematic analysis was employed. All the analysed data was listed and then coded into categories and subcategories using content analysis. The sorting of categories was continued until no more categories were established. The data was then re-checked to ensure that it was correctly categorised. This was followed by the identification and clustering of categories in order to create themes from the data. Verbatim quotes were used to represent themes where possible. After themes were identified, an independent researcher generated themes as well. This strategy was employed to all the focus group manuscripts.

3.5 Ethics

Ethics clearance and permission to conduct the study was obtained from the Research Ethics Committee of the University of the Western Cape (Appendix D). Permission was also obtained from the principals of the schools, the circuit leader of the Theewaterskloof community and the Western Cape Education Department (Appendix E). Further consent was obtained from parents, guardians, learners and the educators of the four schools involved in the study. Parents and guardians where issued with information sheets regarding the study as well as consent forms. These documents

were given to the learners to take home to the parents informing them of the research and requesting their consent. Learners were also issued with consent forms and information documents regarding the study. These documents were printed in English and Afrikaans. They were informed that participation in this study was completely voluntary and that they had the right to withdraw from the study at any time. Participants were ensured that all information obtained will be for the purpose of research and remain confidential. All participants in the study were assured that the quantitative data were anonymous and the qualitative data were confidential. Participants were also assured that they could withdraw from the study at any time. Participants of the focus group discussions signed a focus group confidentiality binding form (Appendix F). All recorded data, transcripts and questionnaires collected are kept in a locked filing cabinet to which only the researcher has access. Appropriate feedback will be given to all the stakeholders. Participants were given the assurance that they would be referred to appropriate professionals if the need arose.

3.6 Summary of the Chapter

This chapter described the methods and procedures used to collect data for the two respective phases of the study. The data analysis for both phases was also outlined. The results of the quantitative data analysis will be outlined in Chapter Four.

CHAPTER 4

QUANTITATIVE RESULTS

4.1 Introduction

This chapter describes the results of the statistical analysis that attempted to meet the first objective of the study. The research question attempted to establish the health risk behaviours of adolescent learners in the Theewaterskloof region. The results are summarised, and illustrated with tables and figures.

4.2 Description of the Study Sample (n=276)

Of the 348 learners approached for participation, 276 had signed parental consent forms and completed the YRBSS questionnaire. The overall response rate was 79.3%. Due to the fact that the questionnaire was self-administered, not all the questionnaires were completed in full and occasionally respondents omitted questions. Questions not answered were categorised and documented as missing data.

Table 1 portrays the demographics of the study sample.

Table 1: Socio-demographic characteristics of the study sample

VARIABLE	FREQUENCY (n)	PERCENTAGE (%)
GENDER (n=271)		
Male	104	38.4%
Female	167	61.6%
AGE (n=274)		
13-15 Years	96	35%
16-17 Years	116	42.3%
18 Years & Older	62	22.6%
SCHOOL GRADE	**(n=255)**	
Gr. 8	47	17%
Gr. 9	56	20.3%
Gr. 10	47	17%
Gr. 11	105	38%

RACE (n=271)

White	2	0.7%
Black	81	29.9%
Coloured	186	68.6%
Indian	1	0.4%
Other	1	0.4%

Table 1 highlights the majority of the study sample in terms of gender and race respectively were; female n = 167 (61.6%) and Coloured n = 186 (68.6%). The age group that was predominant was the group of learners that categorised themselves as 16-17 years n = 116 (42%). In terms of the school grade, the Grade 11 learners were in the majority and they made up 38% of the sample (n = 105).

4.3 Prevalence of Health Risk Behaviours

The first objective of the study attempted to ascertain the prevalence of health risk behaviours among high school learners of the Theewaterskloof region. Below follows a brief exposition of the reported health risk behaviour prevalence in each domain of the YRBSS.

4.3.1 Alcohol Use

A lifetime prevalence of alcohol use was reported by 67.4% (n=186) of the study sample. Half of the sample (50.7%, n=140) reported current alcohol use and (12.8%, n=34) had their first drink of alcohol before the age of 12 years old.

A higher percentage of females (65.9%, n=91) reported current alcohol use. The difference between males and females was non-significant. A higher percentage of Coloured learners (61.5%, n=83) reported current alcohol use than African Black Learners (38.5%, n=52). The difference between these two groups is significant [χ^2 = 6.40, p=.011]. Furthermore the age group 16-17 years old reported the highest

percentage of alcohol use (49.6%, n=69) when compared to the other age groups. The difference between these groups is significant [χ^2=28.97, p=.000].

4.3.2 Tobacco Use

A lifetime prevalence of tobacco use was reported by 56.7% (n=152) of the study sample. A third of the study sample (35.6%, n=96) reported current tobacco use and (8.6%, n= 23) had their first cigarette before the age of 12 years old.

A higher percentage of males (37.6%, n=38) reported current smoking. The difference between male and female was not significant. Significantly more Coloured learners (41.7%, n=75) than African Black learners (22.2%, n=18) reported currently smoking cigarettes [χ^2 = 8.38, p=.004]. Furthermore, the age group 16-17 years old reported the highest percentage of current smokers (50%, n=48), when compared to the other age groups. Interestingly, Grade 10 learners are currently using tobacco the most (62.2%) and also show a high lifetime use (74.4%).

4.3.3 Marijuana and Drug Use

Participants were requested to report on drug use, and separate marijuana and other drugs.

A lifetime prevalence of marijuana use was reported by 20.2% (n=54) of the study sample. A tenth of the study sample, (11.6%, n=31) reported current marijuana use and (3.8%, n=11) had their first use of marijuana before the age of 12 years old.

A higher percentage of males (18%, n=18) reported marijuana use. The difference between males and females was significant [$\chi^2 = 5.07$, p=.024]. A higher percentage of Coloured learners (13.5%, n=24) reported current marijuana use than African Black learners (7.5%, n=6). The difference between the two was not significant. Furthermore, the highest percentage of reported marijuana users are between the ages of 16-17 years (14.2%, n=16), which was non-significant.

A lifetime prevalence of current other drug use was reported by 14.9% (n=41) of the study sample. No significant difference in learners reporting current drug use with regards to gender, race and age.

The substance use reported on this group of participants was alcohol, tobacco, marijuana and other drugs. Figure 2 and 3 depicts the prevalence of the various substances used by the participants. In Figure 2 the graph shows the use of these substances in the participant's lifetime and Figure 3 shows the current use.

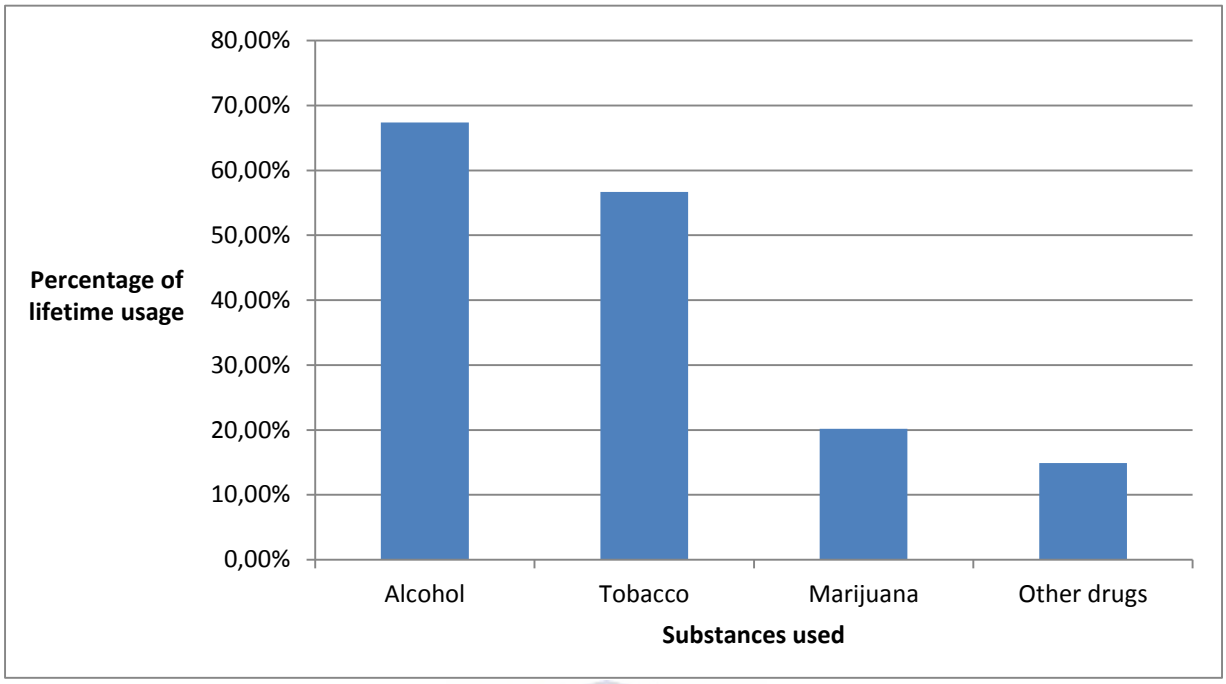

Figure 2: Percentage of high school learners, who used alcohol, smoked and used drugs in their lifetime

Figure 2 clearly shows that the substance of choice for the learners was alcohol. The largest number of participants (67.4%) consumes alcohol and uses this substance more than any other. The participants ages range from 13 years to 18 years and older.

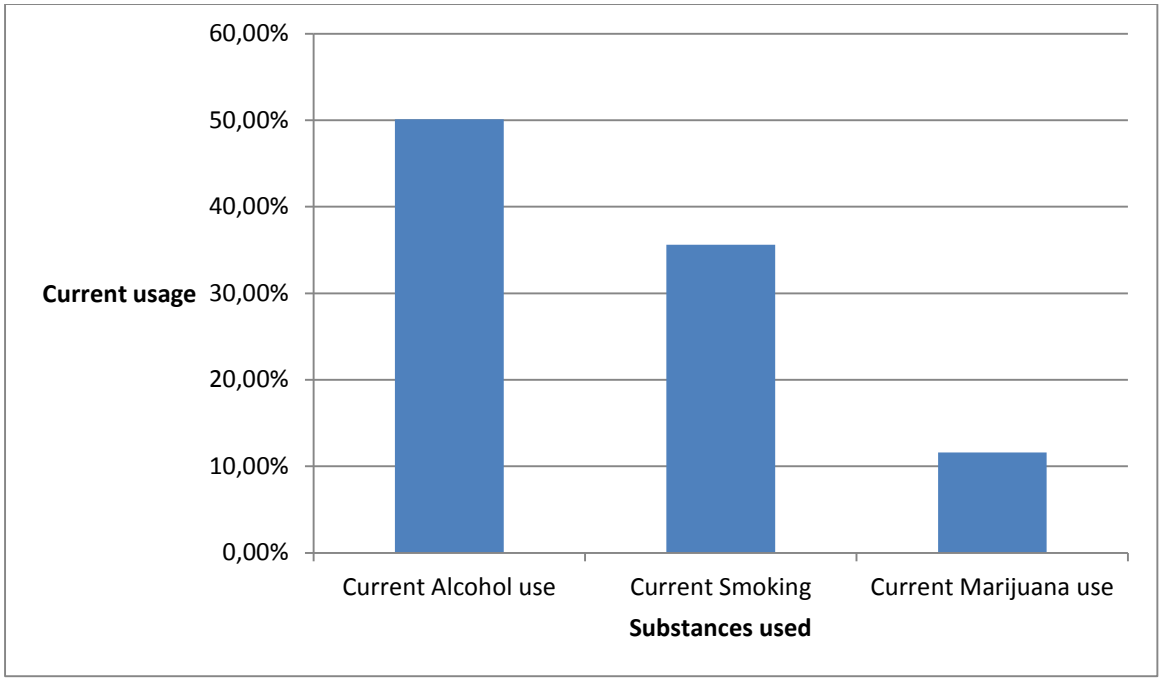

Figure 3: Percentage of high school learners currently engaging in alcohol use, smoking and marijuana use

Figure 3 highlights that currently the learners are still engaging in more alcohol use than any other substance use.

4.3.4 Behaviours that contribute to violence

Participants were requested to report on behaviours that contribute to violence which included current (last 30 days) and past 12 months.

Overall 18% (n=49) of the learners missed school because they felt unsafe during the 30 days preceding the study. During the past month 17.4% (n=47) of the sample was in a physical fight on the school property one or more times. Of the learners, 12.4% (n=33) has been physically hurt on purpose by their partner. Learners partaking in this study reported that 10.9% (n=29) has been physically forced to have sexual intercourse against their will. This is portrayed in Figure 4.

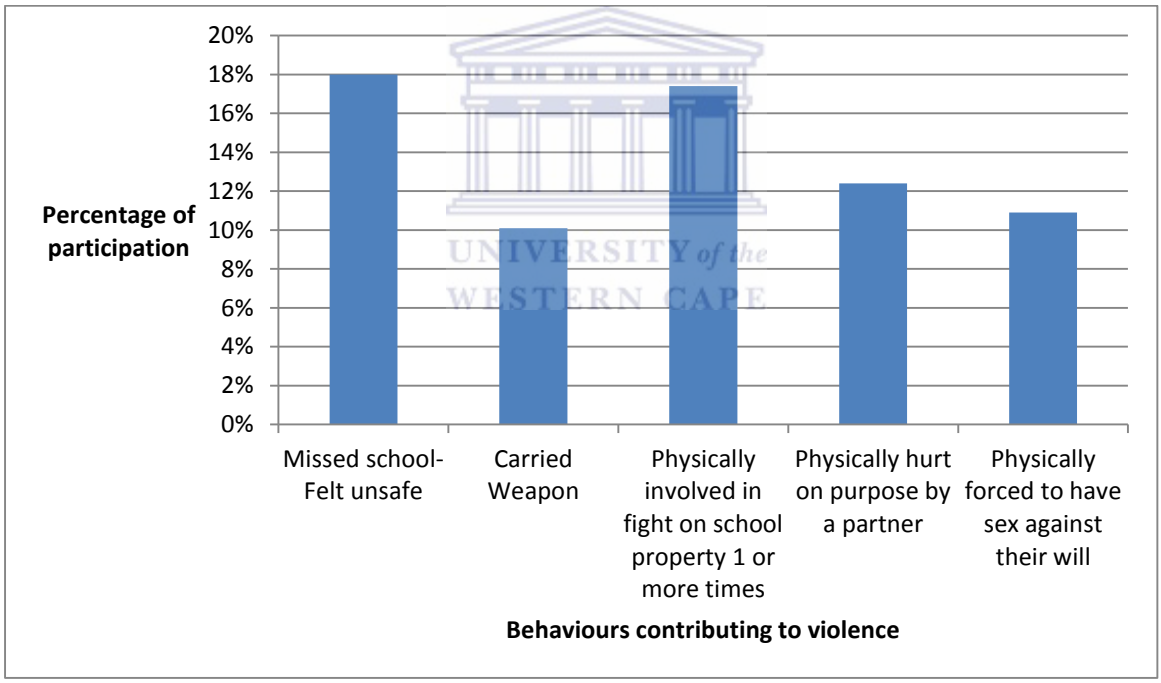

Figure 4: Percentage of high school learners involved in behaviours contributing to violence in the last month

When it came to carrying a weapon a tenth of the sample, 10.1% (n=28) carried a weapon. Within this 10.1%; 6.6% (n=18) specifically carried a gun and 5.2% (n=14) carried a weapon on school property.

During the past 12 months, 14.7% (n=40) of the sample size was threatened with a weapon at school. Furthermore, 32.8% (n=89) was involved in a physical fight one or more times during the past 12 months. The learners who have been in a physical fight and had to be treated by a doctor or nurse in the last twelve months preceding the study comprised of 11.4% (n=31) of the total sample. These results are presented in Figure 5.

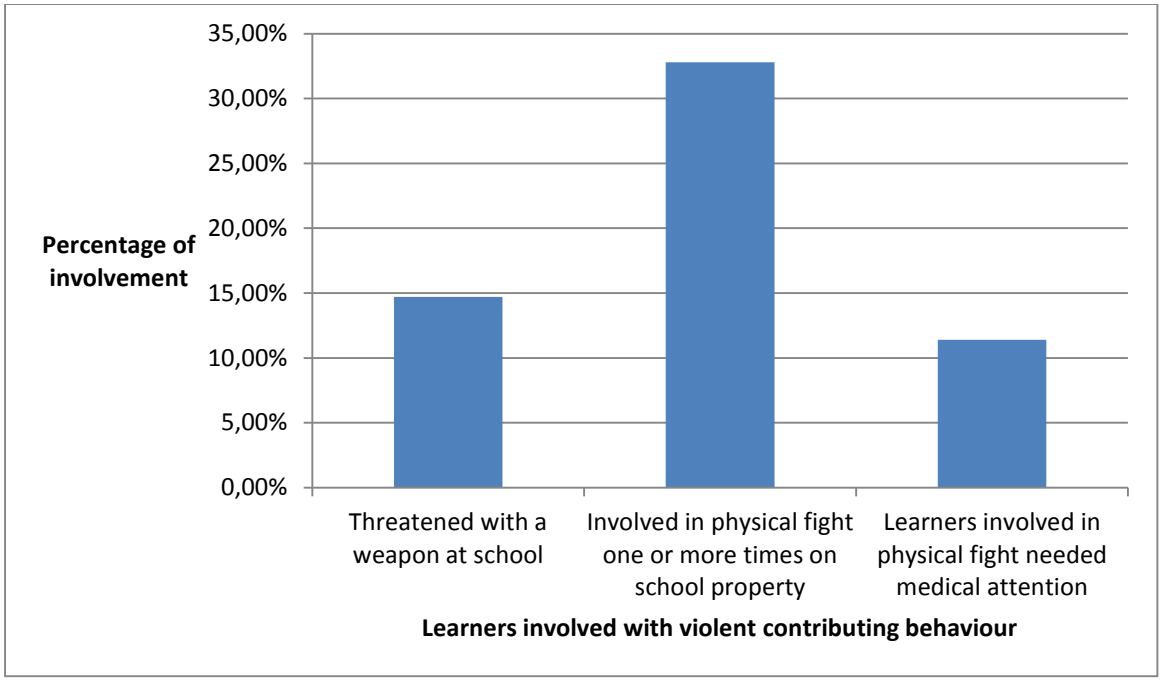

Figure 5: Percentage of high school learners involved in behaviours contributing to violence in the last year

Figure 5 clearly shows the violent behaviour of leaners at school over the past year as a high percentage of learners were involved in physical fights at school.

There was no significant difference in the frequency of male and females feeling unsafe [χ^2 =1.67, p>.05]. However, significantly more males (22.8%) compared to females (3%) carried a weapon [χ^2=23.87, p=.00]. There was no significant difference in the frequency of African Black learners (9.9%) and Coloured learners (11.1%) carrying weapons [χ^2 =0.01, p>.05]. The age group with the highest percentage of learners carrying weapons is between 16-17 years (13.2%), this is however not significant [χ^2 =1.56, p>.05].

No significant difference between incidences of male versus female bullying [χ^2=0.60, p>.05]. Considerably more Coloured learners (72.2%) were bullied at school compared to (27.8%) of African Black learners [χ^2=0.21, p>.05].

4.3.5 Physical inactivity

Only 4.4% (n=11) of the learners met the required minimum of daily physical exercise which is 60 minutes or more.

In the week preceding the study 33.3% (n=84) did not take part in any physical activity, 37.3% (n=94) participated in 1-2 days of physical activity, 19.4% (n=49) did 3-4 days physical activity, 5.6% (n=14) did 5-6 days physical activity and 4.4% (n=11) did daily physical activity. This is shown in Figure 6.

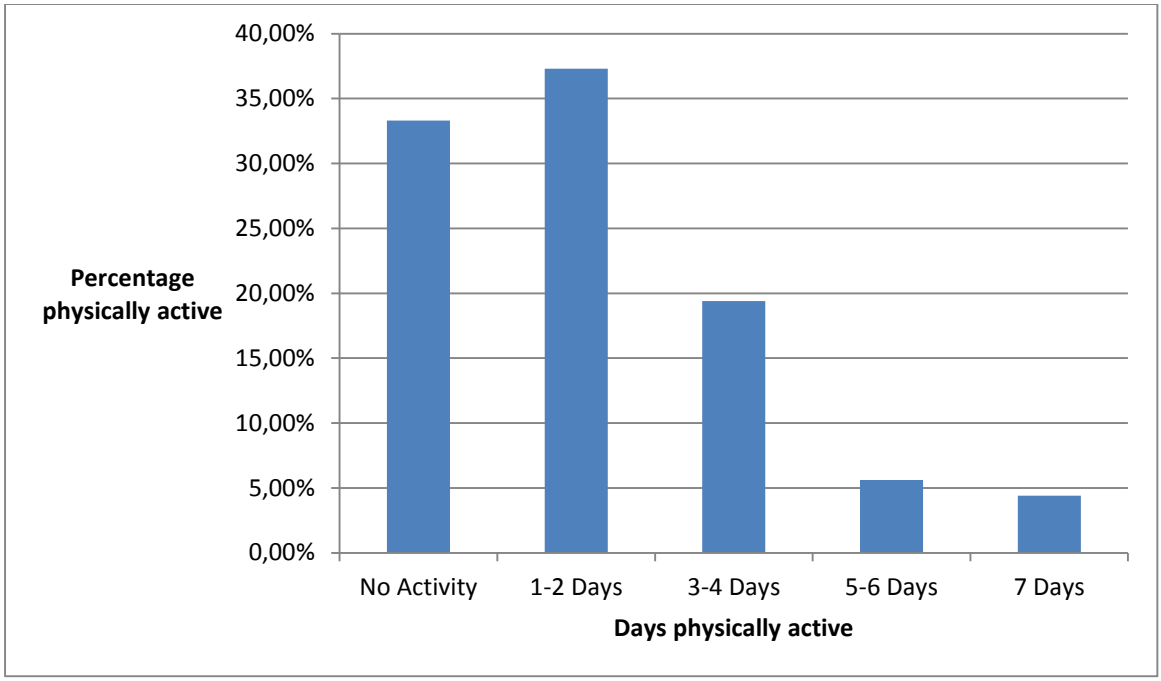

Figure 6: Percentage of high school learners involved in physical activity in a week

With regards to current physical education; 50.4% (n=127) of the respondents did not attend physical education. On an average school day only 10.8% (n=27) do not watch TV, 17.1% (d n=43) watches for an hour or less and 72.1% (n=181) watch TV for one hour or more per day. Overall 48.8% (n=124) of the learners reported that they played video or computer games on a normal school day. Figure 7 depicts the number of participants who participated in physical education and who did not.

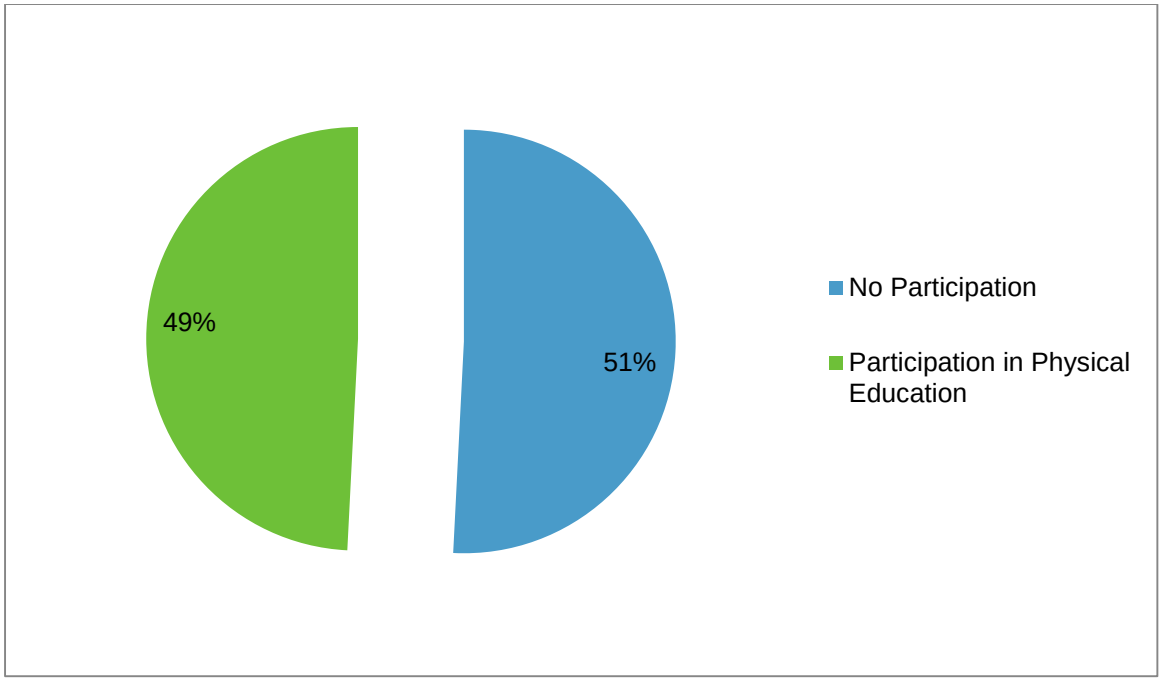

Figure 7: Percentage of high school learners involved in physical education

Significantly more females (69%, n=58) than males (31%, n=26) participated in no physical activity [χ^2=9.19, p=.03]. A higher percentage female learners (57.6%, n=87) reported no physical education participation compared to male learners (39.4%, n=39). The difference between these two groups was significant [χ^2 = 8.65, p=.03]. Coloured learners (36.7%, n=62) reported a higher prevalence of physical inactivity as opposed to African Black learners (26%, n=20). The difference between the two groups was non-significant [χ^2=3.04, p=.39]. Furthermore 50% (n=63) of the 16-17 years old reported no participation in physical education, which is the highest compared to other age groups. The difference between the age groups is however not significant [χ^2=10.52, p=.11].

4.3.6 Sexual activity

Of the study sample size 31.9% (n=83) reported being sexually active. This is seen in Figure 8.

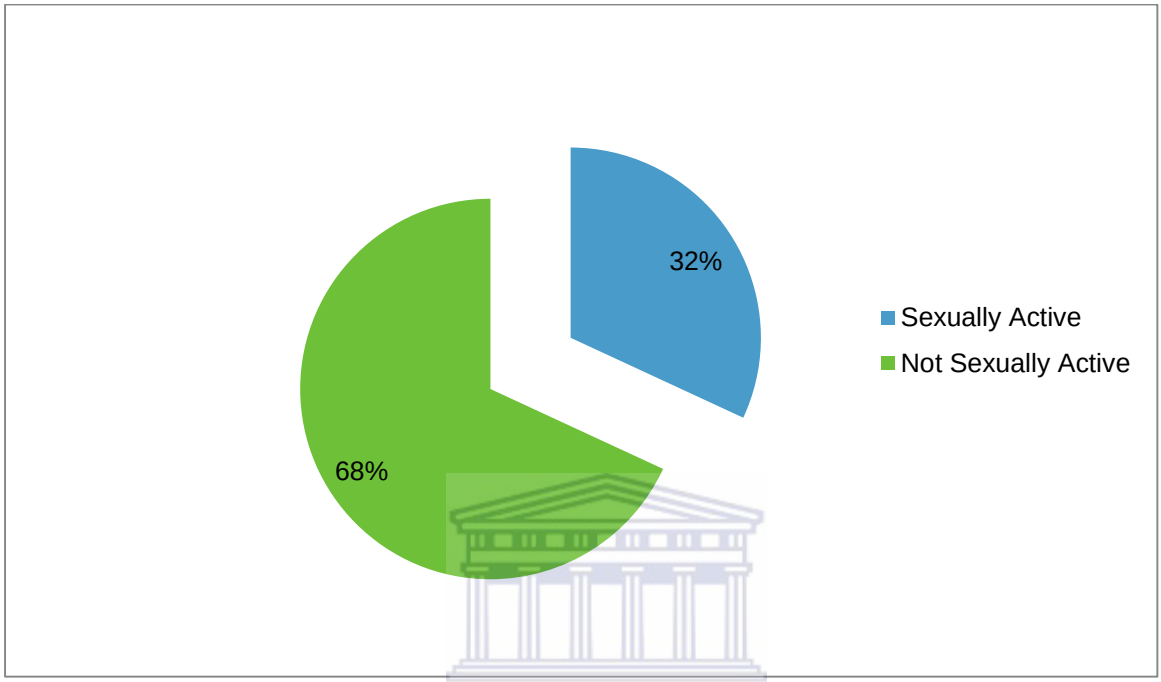

Figure 8: Percentage of learners who are sexually active

The prevalence of learners who reported having had first sexual intercourse before the age of 12 years old was 4.5% (n=12). At the time of the study, the age group 16-17 year olds were the most sexually active at 51.8% (n=43).

The following items were grouped together as risky sexual behaviour; having more than one sexual partner at a given time, not using a condom during sex and alcohol and drug use before engaging in sexual activity. Of the learners who reported ever having sex in their lifetime, 21.6% (n=54) reported having had more than one sexual partner. Only 21.7% (n=57) of those who ever had sex reported that they used a

condom. Of the sexually active study sample, 24.7% (n=22) used drugs or alcohol before their last sexual encounter. These results are summarised in Figure 9.

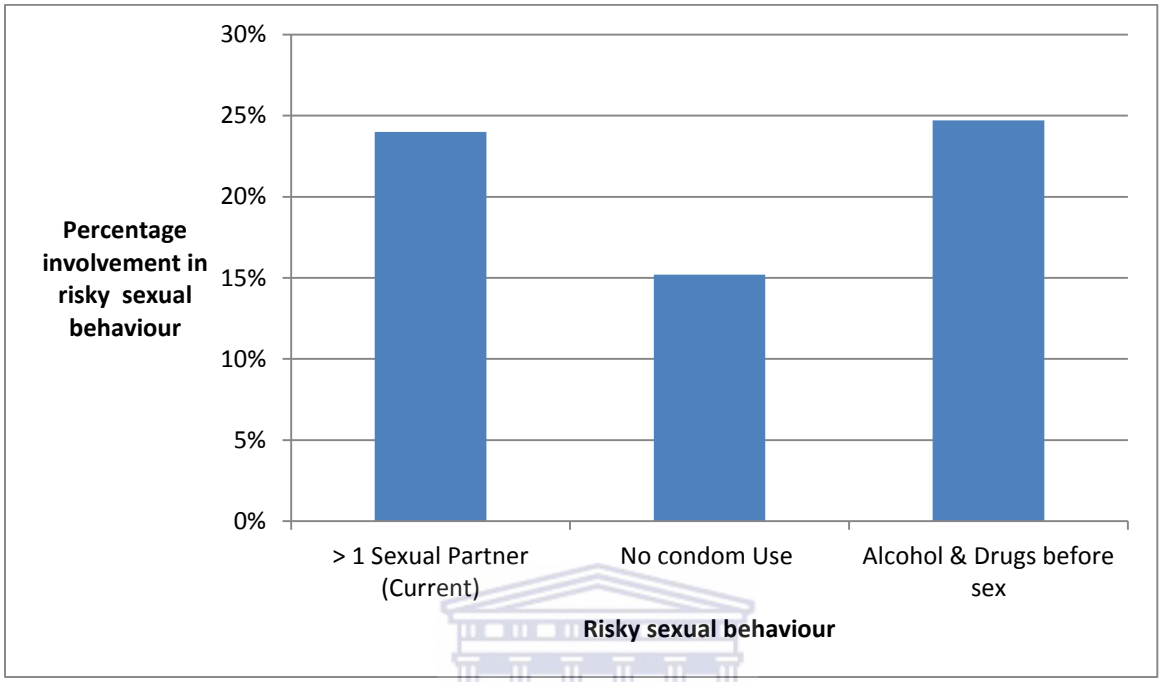

Figure 9: Percentage of high school learners engaging in risky sexual behaviours

A higher percentage of male learners (38.4%, n=38) reported being more sexually active than female learners (27.4%, n=43). There was no significance in frequency with the difference between male and female with regards to sexual activity [χ^2=2.90, p=.09]. A higher percentage of African Black learners (53.8%, n=43) than Coloured learners (21.6%, n=37) reported that they were sexually active. The difference between the two groups was significant [χ^2 = 24.45, p=.00]. Furthermore the age group 16-17 years old (51.8%, n=43) reported the highest percentage of sexual activity when compared to the other age groups. The difference between the groups was significant

[χ^2=36.75, p=.00].

Males (11%, n=11) had a higher incidence of alcohol and drug use before sex than females (6.9%, n=11), which was significant [χ^2=12.20, p=.00]. Significantly more African Black learners (12.3%, n=10) than Coloured learners (6.4%, n=11) indicated that they had alcohol and drugs before sex [χ^2=18.92, p=.00]. Additionally, within the sexually active age category 18 years and older 17% (n=10) used alcohol and drugs before sex. The difference between the age groups was significant [χ^2=33.17, p=.00].

Significantly more males (28.7%, n=29) than females (17%, n=27) use condoms [χ^2=11.23, p=.00]. A higher percentage African Black learners (43.2%, n=35) than Coloured learners (12.6%, n=22) used condoms. The difference between the two groups were significant [χ^2 = 32.62, p=.00]. The age group of learners 16-17 years old (47.4%, n=27) reported significantly more condom use than the other age grouped learners [χ^2=36.53, p=.00]. More learners within the age group 18 years and older (39.7%, n=23) reported condom use. The difference between the age groups were significant [χ^2=36.53, p=.00]. .

4.4 Summary

The first objective of the study intended to identify health risk behaviours among high school learners in the Theewaterskloof region. The outcome revealed that a large amount of learners were engaging in health risk behaviours. Significant differences exist between groups, such as male and female, “African black” and “Coloured” and ages 13 and 18. The outcome revealed that most significant health risk behaviour with

regards to gender, race and age was sexual activity. Due to the seriousness of these behavioural patterns, it is necessary to identify intervention methods to curb this behaviour.

The following section therefore focuses on the acuity and insights of the learners attitudes that influence their choice of behaviour. It unpacks their reasons and reflects their experiences and explanatory accounts. It also gives some insight into their thoughts on possible health prevention strategies. The section also highlights the educators' responses to health risk behaviour as well as their ideas regarding possible health promotion strategies.

CHAPTER 5

QUALITATIVE RESULTS

5.1 Introduction

This chapter contains the content analysis of the focus group discussions which attempted to answer the questions stated in the second and third objectives of the study. These objectives aimed to identify the understanding and perceptions of learners and educators with regards to health promotion strategies in the Theewaterskloof community. This section of the chapter intends to discuss themes and categories. Findings are presented according to themes and are illustrated with verbatim quotes.

Focus group discussions were held with both the learners and the educators. They were relaxed during the discussion and often used an array of body language to express themselves. The discussion was opened with a broad question to which the participants were asked to express their opinions, experiences and suggestions regarding health promotion.

5.2 Perception of learners regarding health promotion

Three focus group discussions were held with learners of the selected schools in the Theewaterskloof region. A total of twenty nine learners (n=29) were included.

5.2.1 Description of participants (Learners)

The participants included ten Grade 8 learners (FGD 1), in the second focus group there were ten Grade 10 learners (FGD 2) and finally, there were participants from a mixed group of learners from Grades 8 to 11 (FGD 3). The participants were male and female and included coloured and black learners.

5.2.2 Themes

Thematic analysis of the transcripts of the focus groups with the learners yielded four main themes:

- Awareness of prevalent health risk behaviours
- Factors contributing to engagement in health risk behaviours
- Possible prevention strategies of health risk behaviours
- Stakeholders responsible for prevention strategies

Verbatim quotes were used to further illustrate the above mentioned themes to emphasise the respective factors.

5.2.3 Theme 1: Awareness of prevalent health risk behaviours

The learners in the focus group discussion displayed a high awareness of the health risk behaviours prevalent within their community. They also displayed an awareness of the danger of engaging in these HRB's. This theme was thus divided into two

categories namely: Prevalent health risk behaviours and risk of involvement in health risk behaviours.

5.2.3.1 Prevalent health risk behaviours

Most of the learners stated that sex, cigarette smoking, drug and alcohol use was the most prevalent health risk behaviours.

> *"Everyone thinks it is the drugs, it is wine and sex-stuff, man…"*
>
> *(FGD 1)*

> *"Smoking and then teenage pregnancies"*
>
> *(FGD 2)*

> *"It is tik, man. It is tik that is the cause."*
>
> *(FGD 1)*

With regards to drug use, learners were aware of the various drugs used by learners. Drugs noted by the learners included dagga, "tik" and mandrax. The following excerpts illustrate this:

> *"Yes, I think it is also more…I think mandrax and tik[1]"*

[1] Tik is the name commonly used in South Africa for the stimulant drug, Crystal Methamphetamine (Morris & Parry, 2006).

(*FGD 1)*

"*A lot smoke dagga (marijuana)"*

(FGD 2)

There was no real consensus regarding the ages that learners start engaging in health risk behaviours. During the discussion some learners would mention specific ages for certain health risk behaviours, while others would just mention a range of ages. Other learners got excited about the answers and shouted out various ages. It is illustrated in the excerpts below:

"No, for wine it is mostly 15 years onwards."

(FGD 2)

"No, so from 11, 12, 13…"

(FGD 1)

"16…16…From 13…From 13…From 10 upwards…Under 10…No, what are you talking about?"

(FGD 1)

5.2.3.2 Risk of involvement in health risk behaviours

The learners noted that the engagement of certain health risk behaviours could lead to the engagement of other risky behaviours. Participants alerted that some substance use could lead to risky sexual activity. This is expressed in the following statements:

"Wine yes it leads to teenage pregnancies"

(FGD 3)

"Tik drives them to other stuff…this is why it leads to sex"

(FGD 1)

Learners in the focus groups also noted that substance use could lead to the use of stronger or harder substances. Most learners start with cigarette smoking and move on to harder substances such as "dagga". The most frequently used drug seems to be "dagga", also known as marijuana. The above-mentioned is illustrated in the statement below:

"A lot smoke dagga (marijuana) because cigarettes becomes to light for them"

(FGD 2)

From the FGD it is noted that the risk behaviours are not perceived as a threat to the participants' health, but rather looked at as the norm. The perception exists that the risk behaviours are widespread through the communities and are rife. This is despite the fact that they know that engagement in one HRB could lead to engagement in others. This is illustrated in the following statement:

"…everyone smokes when they go to a party at night, and it is just smoking,"

(FDG 1)

"We not worried because we all smoke."

(FDG 2)

"And if adults do it, then it seems to them, as if it is correct what adults are doing, then they also do it, because they think from a young age already that it is correct to smoke."

(FGD 2)

5.2.4 Theme 2: Factors contributing to engagement in health risk behaviours

The participants' emphasised two main areas of concern under the above-mentioned theme. These two areas were peer pressure and role models or significant others. Subsequently this theme was further divided into two categories; peer pressure and role models or significant others.

5.2.4.1 Peer pressure

Participants highlighted that peer pressure is a contributing factor to engaging in HRB's. They noted that the pressure is extensive and that it occurs both in groups as well as the individual exerting pressure on themselves. The quotations below elucidate this.

"Group pressure…plenty. There is a lot."

(FGD 2)

"They "act"…to impress friends…"

(FGD 3)

"Mostly, probably because children want to be in (accepted) and…"

(FGD 3)

Peer pressure presented in many forms. Pressure varied from the individual wanting to be "in" by placing pressure on him/herself to being forced by others. Some learners expressed the fact the individuals placed pressure on themselves because of what was experienced in the community. An example of this is illustrated below:

"Group pressure in the sense, that if you do not take a puff, one puff, because it is not going to do anything ("to you")"

(FGD 3)

"Group pressure in the form of…everyone smokes when they go to a party at night, and it is just smoking, and you just take one puff"

(FGD 3)

Learners also expressed it is not easy to avoid pressure. It is generally accepted that the pressure exists. The quotation below elucidates this.

"You are only locked in and is not going to assist you, come out…"

(FGD 1)

"Group pressure…There is a lot…"

(*FGD 2)*

Participants thought that trying to avoid pressure and avoid engaging in health risks behaviours is a futile practice. It was reflected in the following statement:

"Now what is the purpose you go to jail and gets 20 years…then you get out than things are even worse. Then you sell drugs to youngsters."

(FGD 1)

5.2.4.2 Role models and significant others

The second category is the influence of role models or significant others on youth in the engagement of HRB's. The participants highlighted that the increased prevalence of HRB's of adolescents could be as a result of their relationships with their parents and/or significant others, not being disciplined from a young age and parents putting certain pressures on the children or limiting their children.

"Some parents "drill" the children"

(FGD 3)

"Discipline, actually starts from a young age and then they will see the children are…the children will out of themselves, learn discipline"

(FGD 3)

"Parents. They keep the children "tight" and then…how can I say…They do not give the children a chance to get out of their…nests"

(FGD 3)

Participants were of the opinion that adults act as role models for adolescents. Children mimic what adults do, as indicated by the following statement:

> *"And if adults do it, then it seems to them, as if it is correct what adults are doing, then they also do it, because they think from a young age already that it is correct to smoke."*

(FGD 2)

5.2.5 Theme 3: Possible prevention strategies of health risk behaviours

In an attempt to outline the possible prevention strategies participants made reference to themselves, parents and educators to assist in the prevention of health risk behaviours. Most participants believed that it was up to them to stop the risk behaviours.

> *"For me everything starts with you, man. Your entire life depends on yourself and the choices you make for yourself. It is not about other people, because at the end of the day, it is only about you."*

(FGD 3)

> *"Yourself. It starts with you"*

(FGD 3)

> *"It will not help, because they must decide for themselves to leave it.'*

(FGD 3)

Participants also expressed that they have confidence in the educators to play a role in preventing health risk behaviours. If support and guidance is obtained from trustworthy educators, it could assist in the prevention of health risk behaviours as displayed in the excerpt below:

> *"Educators also play a role...as I can…some educators you can trust, which you can approach whom you think is trustworthy."*

(FGD 3)

Participants could not reach consensus regarding the fact if HRB's can be stopped. Two views were discussed regarding this. This discussion caused a lot of excitement and resulted in raised voices and shouting. Some of the participants were of the view that HRB's can be stopped if they stand together:

"*We can, if we all agree to do it, then…"*

(FGD 2)

> *"There can be, but we are not entirely sure."*

(FGD 2)

Other members of the FGD were of the opinion that it is impossible to stop.

> *"…because a lot of people are using it, and they would not want to go with you, it will be a flop (failure)."*

(FGD 2)

"It will never stop. No. It will not stop."

(FGD 1)

It became evident from the discussions that smoking in particular was not regarded as health risk behaviour and was almost regarded as normal. There seems to be a passive acceptance for smoking:

"We are not worried because we all smoke."

(FGD 2)

This acceptance is even despite the awareness of the dangers and consequences of smoking as illustrated in the excerpt below:

"…especially with the smoking and that you allow your life to be actually shortened and weakens your lungs…It stands in your way."

(FGD 3)

Participants displayed apathy to health risk behaviours. There is a feeling that no one else is concerned about the risk, and even less so in them.

"We are not worried. We only think that is your life and not ours."

(FGD 2)

5.2.6 Theme 4: Stakeholders responsible for prevention strategies

The majority of the learners felt that the choice of stopping or ending the engagement of health risk behaviours begins with the individual. Participants felt that learners

should concentrate on themselves to abate the health risk behaviour. Participants discussed their views with regards to those perceived stakeholders responsible for prevention strategies.

Learners within the community should connect with each other in order to change their thoughts. Excerpts below illustrate this.

"It can be stopped, but you need to be strictly held… We say people do not want to stand together. This is the biggest thing; everyone wants to do their own thing..."

(FGD 3)

"*Not speak but as connect. So, that their thoughts can change… get their own characteristics right…"*

(FGD 3)

"The children must just take note and must learn…They must prove that they are better. They must not do the wrong things that other people want to do…"

(FGD 1)

5.3 Perceptions of the Educators

A focus group discussion was held with five (n=5) life orientation educators from the selected school in the Theewaterskloof region. This study purposively used life orientation educators.

5.3.1 Description of participants (Educators)

The educators were Coloured and consisted of two (2) male educators and three (3) female educators.

5.3.2 Themes

There are four themes from the data gathered from the focus group discussion with the educators.

- Prevalent health risk behaviours
- Factors that contribute to engagement in health risk behaviours
- Possible prevention strategies of health risk behaviours
- Stakeholders responsible for prevention strategies

Verbatim quotes were again used to further illustrate the above mentioned themes to emphasise the respective factors.

5.3.2.1 Prevalent health risk behaviours

Participants discussed their opinions with regards to their perception of the most prevalent health risk behaviours that the learners engage in. The discussion

highlighted that sexual activity, teenage pregnancy and drug usage was the most prevalent HRB's. The notion was discussed that learners are irresponsible with regards to sexual activity/behaviours.

"They are irresponsible when it comes to sex."

Female Educator 1

"Smoking, drinking, immature sexual relationships, using drugs."…"

Male Educator 1

"Unprotected sex is dangerous and tik (methamphetamine)"

Female Educator 2

5.3.2.2 Factors that contribute to engagement in health risk behaviours

There were various factors within the community contributing to the engagement in health risk behaviours. Participants alerted that the socio-economic environment of the learners, forces the learners in particular health risk behaviours. One of the factors is poverty of the learners. Learners will engage in sex for monetary or luxuries which they cannot afford. These sentiments are illustrated by the following excerpts:

"They buy and pay for the girls that they are using. Buy them Kentucky (KFC)."

Female Educator 1

So, if she can get a sugar daddy as she claims, then it means poverty, as that little money that that man dangles in front of her, seems attractive."

Female Educator 2

Further causes of their behaviour are obtained from their parents or caregivers. Parents do not give their learners good examples to live by.

"I want to add to what was said about parents who are not fulfilling their roles…the child looks for those values from the parents but it is missing…"

Female Educator 2

"…the mother sleeps together with her boyfriend in front of the child. It is not even the child's father. So, for that child, sexual relationships and lose relationships are part of life."

Female Educator 3

5.3.2.3 Possible prevention strategies of health risk behaviours

Participants were in agreement that the most important member involved in the prevention strategies of health risk behaviours are the parents. They felt that the parents did not play a strong enough role within the learners lives to assist in lessening the problem. The excerpts below demonstrate these:

'Parents, have actually ignored their roles completely."

Female Educator 1

"Yes, they do not fulfil their roles. And in some households the children are the bosses and I think this is where everything goes wrong."

Female Educator 2

"Supervision under a parent. Because children can tell their parents. Girls go and come in the house just as they want."

5.3.2.4 Stakeholders responsible for prevention strategies

Participants noted that the responsibility for prevention strategies involved different stakeholders. Those stakeholders mentioned where the learners, parents and educators that plays a role in prevention. Note was also made about the curriculum which provides the educator with a good starting point to implement awareness and prevention strategy. The following quotations illustrate these sentiments.

"Three parties are involved: Parent, child and educator"

Female Educator 2

"Life orientation is for me a very nice syllabus. We really touch on very concrete things…and I feel it has an impact on some children. So it helps certain children…"

Female Educator 3

"Everything is in place with LO. We are actually talking about sexual activity, drugs, in fact everything that is not allowed, which actually breaks down the community.

Female Educator 2

5.4 Summary

The results of the qualitative data help us understand some of the factors that predispose learners of the Theewaterskloof community to engage in health risk behaviours. It also helps us to understand the factors that help maintain their engagement in health risk behaviours.

The educators as well as the learners believed that the most common health risk behaviours were sex, alcohol consumption and drugs. Educators are of the opinion that parents do not take responsibility and do not play an active role in preventing learners from partaking in health risk behaviours. Furthermore educators mentioned that parents and care-givers are not positive role models for the learners. Learners mimic the health risk behaviours engaged in by their parents and significant persons in their lives. Learners however believed that they should better manage themselves and take more ownership in helping prevent health risk behaviours. Learners were also of the opinion that behaviour change will take place if individuals stand together to stop the cycle of health risk behaviours. They also mentioned that not being correctly disciplined by parents has a negative effect on their engagement in health risk behaviours.

The next chapter will present an integrated discussion of the qualitative and quantitative data.

CHAPTER 6

DISCUSSION

6.1 Introduction

This study aimed to determine health risk behaviours engaged in by adolescents and to investigate the understanding and perception of health promotion in secondary schools in the Theewaterskloof region. In order to achieve the aim, the following objectives were met; firstly a health risk behaviour questionnaire was used to establish which health risk behaviours are most prevalent among high school learners within the Theewaterskloof region. Secondly, focus group discussions were held with educators and learners to establish the perceptions and understanding of educators and learners regarding health risk behaviours and health promotion within the Theewaterskloof region. This chapter presents an integrated discussion of the results presented in the preceding chapter. The discussion will outline the health risk behaviours engaged in by learners and their understanding of health promotion. It will further look at the understanding of educators with regards to health promotion.

6.2 Prevalent health risk behaviours among school learners

The findings of the first phase of the study broadly showed that the health risk behaviours that learners predominantly engaged in were substance use, sexual activity and physical inactivity. A study conducted in 2011 by Pharaoh, Frantz and

Smith (2011) showed similarities in that the HRB's that their study sample engaged in were also substance use, sexual activity and physical inactivity.

The current study's findings indicated that 67.4% of learners consumed alcohol and 56.7% of the sample smoked tobacco. The findings of these substance use prevalence rates are similar to other studies completed in the South African context (Sauls and Frantz, 2013; Pharaoh et al., 2011; Reddy et al., 2010; Phillips, 2005). Sauls and Frantz (2012) reported that 70% of the participants in their study indicated to have consumed alcohol and nearly half (46%) indicated having smoked. This was similar to the current study however their study was only conducted among Grade 10 learners whereas the current study was conducted among Grade 8-11 learners. Pharaoh et al., (2011) used a similar sample of Grade 8-11 learners in their study and reported 50% alcohol consumption and 64% smoking. As can be seen in these results, the trend of substances use in these studies remains high, despite efforts being made to educate the population on the prevention of health risk behaviours and the harmful effects of continued alcohol and cigarette use.

The current study reported the substance most used within 30 days preceding the completion of the questionnaire was alcohol (50.7%). Both the national health risk surveillance studies completed in South Africa reported that alcohol was the most commonly used substance by all South Africans of all ages (Reddy et al., 2010; Reddy et al., 2003). According to the above-mentioned study South African learners that had drunk alcohol in the past month, specifically in the Western Cape were 44.3% in 2002 and 53.0% in 2008. Of concern is that in over the past 13 years the consumption of

alcohol among learners has increased to more than 50% and is still above 50% in this study.

This study found that alcohol consumption among coloured learners was significantly higher than black learners. In the 2002 and 2008 South African Youth Risk Behaviour Survey results displayed similar results in that there were higher percentages of White and Coloured learners who had ever drunk alcohol compared to Black learners. Phillips (2008) reported parallel results in her study within a similar setting of female high school learners with significant more alcohol use among Coloured learners as opposed to Black leaners.

In this study, lifetime and current tobacco use was, 55.1% and 34.7% respectively. This is alarming as both these findings are higher than the national average in 2008 which was 29.5% and 21.0% respectively (Reddy et al., 2010). Studies by Phillips, (2005), Pharaoh et al., (2011) and Sauls and Frantz, (2013) displayed similar results. Phillips (2005) reported a lifetime prevalence of 45.1% and current use of 32.5% and Sauls and Frantz (2013) reported 46% of their study sample was tobacco smokers. Pharaoh et al., (2011) reported much higher percentage of current smokers in their study of 64%. These similarities could be attributed to the fact that the population (adolescent learners) and settings (Western Cape Province) of studies conducted by Phillips (2005) and Sauls and Frantz, (2013) are similar to the current study. Reddy et al., (2010) also reported that the Western Cape had the highest prevalence of lifetime and current smokers, which was significantly higher than their reports of the national average. Internationally, a study in Canada reported a 55.9% lifetime use of cigarettes but a rather low 14.1% current rate of smoking among a sample of rural adolescents (Groft et al., 2005). This study's current rate of smoking was much lower than the

current one. These figures are disturbing and should raise specific concerns for the Western Cape Province with regards to the prevalence of tobacco smoking. Nationally and internationally current smoking levels are lower than the current study. The Western Cape has not reduced the number of current smokers over the last few years and need to look at more effective measures to lessen the numbers of current smokers.

Coloured learners were twice more likely to smoke tobacco than the Black learners. Similar race variations were observed within the 2002 and 2008 South African National Survey in that significantly more Coloured learners were current smokers when compared to Black learners. A possible reason for the increased representation smoking prevalence in the Western Cape is that the Western Cape is demographically predominantly Coloured citizens. As mentioned in Chapter Three, Theewaterskloof is demographically typical of the Western Cape in its proportion of Coloured and Black African" youth. The reasons as to why Coloured learners smoke more than Black learners are currently not clear.

Marijuana is the most widely used illegal drug globally and is considered as the main drug problem in Africa (Winstock, 2015; United Nations Office for Drug Control and Crime Prevention, 2000). This study reported a 20.2% lifetime prevalence of marijuana which is fairly consistent with Pharaoh et al., (2011) who reported 24% marijuana smokers. The South African Youth Risk Behaviour Survey reported that the Western Cape Province had the highest national prevalence of lifetime marijuana use with 18.6% in 2002 and 24.5% in 2008 (Reddy et al., 2010; Reddy et al., 2002). The results in 2008 are quite similar to what was found in the current study and that in the last 7

years there has only been a decrease of 4.3%. Internationally marijuana use is also quite high with reports of learners showing a lifetime use of 49.5% (Groft et al., 2005). In terms of gender the present study also showed more than double the amount of male learners reported marijuana use compared to female learners. Both of the national studies also reported more male than female use of marijuana (Reddy et al., 2008; Reddy et al., 2002). In the Canadian study males also used double the amount of marijuana when compared to females (Groft et al., 2005). Similarly in a study completed in America, Schepis, et al., (2011) noted more male marijuana use. However, their study documented racial and psychosocial characteristics as the main traits of gender differences in marijuana use. Within the current study no reasons where identified for the increase in male use as opposed to female use.

A large percentage of the learners who participated in this study were sexually active (31.9%). The current findings were similar to the national study conducted in 2008 (37.5%) (Reddy et al., 2010). However, Pharaoh et al., (2011) and Phillips (2005) reported a lower percentage of sexual activity 19.4% and 27.6% respectively. Furthermore, of the learners who reported ever having sex in their lifetime, 60.7% reported having two or more sexual partners. This result is slightly higher than the results expressed in studies by Phillips and Malcolm (2006) (45.3%), Pharaoh et al., (2011) (54%) and Moodley and Phillips (2011) (43%). These studies also took place in the Western Cape. Nationally, 52.3% of the sexually active learners had more than one partner (Reddy et al., 2010).

Of the sexually active learners, a quarter (24.7%) used drugs or alcohol before their last sexual encounter. This result was elevated in comparison to the results reported

by Reddy et al. (2010) where 14% of their participants consumed alcohol or drugs before sexual intercourse and similar to the study by Pharaoh et al. (2011) (21.6%).

According to Lurie et al., (2008), the predominant mode of HIV infection in South Africa is unprotected heterosexual sex. His study further reports poor consistent condom use in rural South Africa, which is the setting for the present study. This study reported that only 21.7% of the sample used a condom during sex. In studies by Malcolm and Phillips, (2011) and Reddy et al., (2010) more than 50% of adolescents did not use condoms during sexual intercourse. These figures are alarming especially due to the fact that South Africa has been documented as having a fast-growing HIV rate, with the highest prevalence among young people aged 15 to 24 years old (Hartell, 2005; Stephenson, 2000).

Black learners engagement in sexual activity was more than double that of Coloured learners. Phillips and Malcolm (2006) found similar results in their study among adolescent girls in the Western Cape that showed that significantly more Black learners (48.9%) reported ever having sex when compared to Coloured learners (12.9%).

With regard to the age groups 51.8% of the learners within the 16-17 year old age group were sexually active. This was significant when compared to other age groups. Phillips and Malcolm (2006) reported more learners in the age groups 16 and 17 reported ever having sex than learners in the age groups 13, 14 and 15.

According to The World Health Organisation the recommendation of daily physical activity for adolescents is 60 minutes. This study highlights that a considerable amount learners are inactive. More than 95% of the learners failed to meet the World Health

Organisations' minimum requirement of 60 minutes per day of physical activity. Only 4.4% of the learners participated in sufficient daily physical activity in the week preceding the survey. One third (30.4%) does no physical activity at all. This result is more or less on par with the 28.8% of physical inactivity reported by Reddy (2010) in the second South African Youth Risk Behaviour Survey and the 32% of physical inactivity reported by Frantz (2006) in a local community in the Cape Town Metropole.

Learners that do not participate in any physical activity miss out on the health benefits associated with participation in regular physical activity. An important health benefit is generally good health in your later years of life. According to Van Sluijs et al., (2007) when low levels of physical activity are evident during adolescence it persists into adulthood. This then places individuals at risk of obesity and other health problems such as cancer later on in life (Figaji and Phillips, 2010; Van Sluijs, 2007). The school setting is an ideal situation for physical education to take place (Dobbins et al., 2009). However, almost half (49.0%) of the learners did not partake in physical education as a subject. Significantly, more females did not participate in physical education than males. Kahn et al., (2008) and Figaji and Phillips, (2010) also found that more males than females participated in physical education.

One of the lowest health risk behaviours was violence. Violence was categorised as being involved in a physical fight on the school's property, feeling unsafe at school, carrying a weapon, being forced to participate in sexual activity and partner violence. This study showed that nearly one in five learners (18%) missed school because they felt unsafe. There was no significant difference reported between males and females with regard to feeling safe. Phillips and Malcolm, (2010) results also show that 21.5%

of the participants missed school because they felt unsafe. The prevalence of participants that was involved in a physical fight on the school property was 17.4%. According to the study by Phillips and Malcolm (2010) 27.2% were involved in a physical fight. The result now is much lower than the study done in 2010.

Of the learners participating in this study 12.4% were physically hurt on purpose by their partner and 10.9% reported that they were coerced into having sexual intercourse against their will. Compared to another study 13.6% learners were physically hurt on purpose by their partner and 12% reported having been forced to have sex (Phillips and Malcolm, 2010). There again seems to be a decline in this type of violent behaviour between 2010 and this year.

In this study 10% of the learners carried a weapon. This result was lower than the national prevalence of learners carrying a weapon. In 2002 the percentage of those carrying a weapon was 16.7% and in 2008 it was 15.1%. A decrease in prevalence of learners carrying a weapon in the last few years was noted.

6.3 Learners understanding of Health Promotion

This section aims to discuss the objective focussing on the knowledge of high school learners regarding the promotion of their health. Learners participating in the FDG displayed an acute knowledge of prevalent HRBs in the community. Three FGD's with the learners generated the data for this phase of the study. As presented in the previous chapter, these learners also mentioned the most prevalent health risks being: "wine and sex stuff", "smoking and then "teenage pregnancies" and "tik". This does

not really correlate with what was found in the quantitative results as that revealed physical inactivity as additional health risk behaviour.

The results show that the reasons for engaging in the health risk behaviours included peer pressure and a sense of wanting to be “cool”. Sauls and Frantz (2013) also found that adolescents imitate those that they are surrounded by or just simply engage in common practices within their communities.

The learners communicated that if adults smoke then it must be acceptable. The perceived risk of tobacco use is greatly diminished due to the fact that learners see their parents smoking and deem it acceptable. Learners do not recognise that smoking is threat to their health as it is a normalised practice in the community. The learners mentioned poor adult guidance at young age and poor role-modelling by parents predisposes learners to health risk behaviours. The results from Figaji and Phillips (2010) and Kahn (2008) depict poor parental role-modelling with regard to attitudes and beliefs around physical activity. They felt that parents directly influenced learners (Figaji and Phillips, 2010; Kahn et al., 2008). Furthermore, Phillips (2008) also reported that parent’s role-modelling played a part in socialising of adolescents on the issue of alcohol.

The Health Belief Model described by Hochbaum (1958), is underpinned by two concepts; susceptibility and seriousness of the condition. The combination of the two concepts is the perceived threat, which is a cognitive component that is influenced by information. The information received by learners from their parents is that smoking and alcohol use is acceptable and therefore, parents smoking and drinking could be seen as contributing factor to the increased use by adolescents.

Health promotion is described as the process of enabling people to increase control over and improve their health (WHO, 1986). Learners were of the opinion that effective change could occur through engagement with the learner as an individual, the parents and the educators. Parents that are knowledgeable regarding the risk associated with smoking and alcohol use would be more likely to cease engagement in that behaviour if they better understood the effects of their actions. By improving the capacity of the parents to control their health risk, they could possibly make better choices by not engaging in health risk behaviours thus being better role models for the learners.

6.4 Life Orientation Educators understanding of Health Promotion

According to the educators the most prevalent HRB's engaged in by their learners were sexual activity and substance use. These opinions expressed are in unison with the results obtained from the qualitative data.

The educators expressed that poor socio-economic statuses of the learners environments could predispose them to these health risk behaviours. Research has demonstrated that living in impoverished families and environments are associated with behaviours such as smoking tobacco and drinking alcohol (Phillips, 2008; Jessor et al., 2005).

The educators who participated in the focus group discussions suggested that parents do not play an active and/or positive role in the lives of learners. They also mentioned that the correct supportive environments were not created within the community to provide effective health promoting action. This statement is supported by literature in

that young people's participation in health risk behaviours extend beyond the adults with direct responsibility for them (their parents) but can be linked with the actions of the adults in the local community (Brooks, Magnusson, Spencer and Morgan, 2012). The educators felt that they only have the ability to stop learners engagement of these HRB's while learners are in the classroom and/or on the school grounds.

The Social Ecological Model describes different levels of influence on health promotion. The multi-level approach of health promotion focusses on organisational, community and policy levels in addition to the interpersonal level. For the promotion of health to be effective, a multi-level approach should be employed in this community (Bronfenbrenner, 1979).

Programmes within the community aimed at improving the socio-economic status could aid in limiting risky health behaviour associated with living in impoverished environments. The creation of supportive centres within the community such as wellness centres could support members of the community to strive healthy lifestyles. Schools provides the perfect setting to promote health to learners as well as members of the community.

CHAPTER 7

CONCLUSION, RECOMMENDATIONS AND LIMITATIONS

7.1 Introduction

This chapter abridges the main findings of the study. It concludes the thesis and highlights the recommendations and limitations of the study.

7.2 Conclusion

The aim of the study was to determine the health risk behaviours and investigate the understanding and perception of health promotion in secondary schools in the Theewaterskloof region. In order to realise the aim the following objectives were achieved; the health risk behaviours of adolescent learners were established using a health risk behaviour questionnaire, focus group discussions were held with the learners to explore the perceptions and understanding of health risk behaviours and health promotion within the Theewaterskloof region and finally a focus group discussion with the educators to explore their understanding of the health risk behaviours and health promotion.

The cross-sectional data of health risk behaviours derived from the study illustrate that many high school learners are engaging in several health risk behaviours, the top three being substance use, sexual activity and physical inactivity. The results also highlight their exposure to other health impacting risks such as violence.

The qualitative data obtained through the focus group discussions highlighted prevalent risk behaviours that were mostly identical to what was found in the quantitative phase. The results also showed the factors that predispose the learners to engage in these health risk behaviours and maintain this engagement. The learners' beliefs around health promotion were to take personal responsibility for their participation in health risk behaviours and that parents and teachers need to work with them to come up with health promoting strategies.

The focus group discussion held with the educators highlighted that they thought substance use and sexual activity were the predominant health risk behaviours. They also felt that the socio-economic status of the learners contributed to the engagement in these health risk behaviours. Furthermore, they believed that the learners' parents were not positive role-models for the learners. In order to eradicate the problem with health risk behaviours and promote health the educators thought that the parents needed to be better role-models for their adolescent children. In addition they felt that the parents, teachers and learners needed to work together to promote health.

7.3 Recommendations

7.3.1 Rural health risk behaviours compared to urban

There are notable differences between learners of urban and rural schools with regard to health promotion. An important recommendation would be for rural schools to promote healthy eating and physical activity to their learners as a higher percentage of rural learners are overweight as opposed to urban counterparts. Additionally, schools in the urban areas have access to better and more primary health care centres

as opposed to their rural counterparts. The National Youth Policy 2009-2014 recommends that access to youth friendly health related programmes and services should be improved by government partnering with relevant stakeholders, particularly in the rural areas.

7.3.2 Community and departmental strategies for Health promotion

Since 1994 the South African Government has embarked on numerous international and local policies and initiatives in order to address the health and well-being of its young people. An effectively implemented health promoting school programme is the ideal method for addressing health and wellbeing among adolescents and the surrounding community. HPS programme engages the Health and Educational departments as well as communities on various intersectional levels. Similar to any new development, HPS can only benefit from critical analysis and reflection in each setting where it is in place. The HPS should then be adapted according to the results established from regular analysis. Hence each HPS would effectively address needs specific to that setting.

7.3.3 What does the study recommend from a research point of view?

Health risk behaviours among adolescents in South Africa are at epidemic proportions. The learner's level of engagement in health risk behaviours following this study is similar to the level of engagement in the first Youth Risk Behaviour Surveillance Survey which was conducted in 2002. When comparing various studies within the South African context, no marked reduction of the engagement in HRBs was noted.

Recommendations from the comparative research used in this study appear not to have been implemented. Furthermore, role-modelling or the lack thereof, was a prevalent theme in this study and educating parents on the importance of role-modelling could assist with decreasing the HRBs.

Therefore this study recommends that planning and implementation of health programmes should include the learners, parents and educators specific to the setting or in this instance the school. Secondly, to educate parents on health risk behaviours in order for them to become better role models. Awareness about health risk behaviours needs to be raised within the community by having easy access to centres and organisations offering information, support and guidance on decreasing health risk behaviours.

7.4 Limitations

The results of the present study should be interpreted in the light of the following limitations.

1. Data collected from the quantitative phase of the study was collected by means of self-administered questionnaires. This type of self- reporting opens itself up to bias and misreporting especially when the particular behaviour is seen to be undesirable. Furthermore, research was dependent of the educator's issuing and collection of the questionnaires to the learners
2. The sample was fairly homogenous in terms of schooling and age. Sampling included adolescents at four schools in the Theewaterskloof municipality and learners between the ages of 12-19 years old. The findings are thus generalised

to adolescents in school only and do not include those who dropped out of school. Thus the findings of this population are limited.

3. The current study explored risk behaviours within one demarcated community setting namely Theewaterskloof municipality. Caution must be exercised in extrapolating from these findings due to environmental and sampling variations between the different studies.
4. Being a lower socio-economic community, most of the learners walk to school. Results could have been altered if they included walking to school as a physical activity and not just look at sporting codes as physical activity.

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APPENDICES

APPENDIX A: QUESTIONNAIRE

Youth Risk Behaviour Survey

This survey is about health behavior. It has been developed so you can tell us what you do that may affect your health. The information you give will be used to develop better health education for young people like yourself.

DO NOT write your name on this survey. The answers you give will be kept private. No one will know what you write. Answer the questions based on what you really do. Completing the survey is voluntary. Whether or not you answer the questions will not affect your grade in this class. If you are not comfortable answering a question, just leave it blank.

The questions that ask about your background will be used only to describe the type of students completing this survey. The information will not be used to find out your name. No names will ever be reported. Make sure to read every question. Circle the correct or most suitable answer. When you are finished, follow the instructions of the person giving you the survey.

Public reporting burden for this collection of information is estimated to average 45 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

Thank you very much for your help.

DIRECTIONS

* Use a pencil only.

* Make dark marks.

* If you change your answer, erase your old answer completely.

1. How old are you?

A. 12 years old or younger

B. 13 years old

C. 14 years old

D. 15 years old

E. 16 years old

F. 17 years old

G. 18 years old or older

2. What is your sex?

A. Female

B. Male

3. In what grade are you?

A. 8th grade

B. 9th grade

C. 10th grade

D. 11th grade

E. Ungraded or other grade

4. Are you South African?

A. Yes

B. No

5. What is your race? (Select one or more responses.)

A. White

B. Black

C. Coloured

D. Indian

E. Other

6. How tall are you without your shoes on?

Directions: Write your height in the space below.

Height

Meters_____

7. How much do you weigh without your shoes on?

Directions: Write your weight in the space below.

Weight

Kilograms_____

The next 5 questions ask about safety.

8. When you rode a motorcycle during the past 12 months, how often did you wear a helmet?

A. I did not ride a motorcycle during the past 12 months

B. Never wore a helmet

C. Rarely wore a helmet

D. Sometimes wore a helmet

E. Most of the time wore a helmet

F. Always wore a helmet

9. When you rode a bicycle during the past 12 months, how often did you wear a helmet?

A. I did not ride a bicycle during the past 12 months

B. Never wore a helmet

C. Rarely wore a helmet

D. Sometimes wore a helmet

E. Most of the time wore a helmet

F. Always wore a helmet

10. How often do you wear a seat belt when riding in a car driven by someone? else?

A. Never

B. Rarely

C. Sometimes

D. Most of the time

E. Always

11. During the past 30 days, how many times did you ride in a car or other vehicle driven by someone who had been drinking alcohol?

A. 0 times

B. 1 time

C. 2 or 3 times

D. 4 or 5 times

E. 6 or more times

12. During the past 30 days, how many times did you drive a car or other vehicle when you had been drinking alcohol?

A. 0 times

B. 1 time

C. 2 or 3 times

D. 4 or 5 times

E. 6 or more times

The next 10 questions ask about violence related behaviours.

13. During the past 30 days, on how many days did you carry a weapon such as a gun, knife, or club?

A. 0 days

B. 1 day

C. 2 or 3 days

D. 4 or 5 days

E. 6 or more days

14. During the past 30 days, on how many days did you carry a gun?

A. 0 days

B. 1 day

C. 2 or 3 days

D. 4 or 5 days

E. 6 or more days

15. During the past 30 days, on how many days did you carry a weapon such as a gun, knife, or club on school property?

A. 0 days

B. 1 day

C. 2 or 3 days

D. 4 or 5 days

E. 6 or more days

16. During the past 30 days, on how many days did you not go to school because you felt you would be unsafe at school or on your way to or from school?

A. 0 days

B. 1 day

C. 2 or 3 days

D. 4 or 5 days

E. 6 or more days

17. During the past 12 months, how many times has someone threatened or injured you with a weapon such as a gun, knife, or club on school property?

A. 0 times

B. 1 time

C. 2 or 3 times

D. 4 or 5 times

E. 6 or 7 times

F. 8 or 9 times

G. 10 or 11 times

H. 12 or more times

18. During the past 12 months, how many times were you in a physical fight?

A. 0 times

B. 1 time

C. 2 or 3 times

D. 4 or 5 times

E. 6 or 7 times

F. 8 or 9 times

G. 10 or 11 times

H. 12 or more times

19. During the past 12 months, how many times were you in a physical fight in which you were injured and had to be treated by a doctor or nurse?

A. 0 times

B. 1 time

C. 2 or 3 times

D. 4 or 5 times

E. 6 or more times

20. During the past 12 months, how many times were you in a physical fight on school property?

A. 0 times

B. 1 time

C. 2 or 3 times

D. 4 or 5 times

E. 6 or 7 times

F. 8 or 9 times

G. 10 or 11 times

H. 12 or more times

21. During the past 12 months, did your boyfriend or girlfriend ever hit, slap, or physically hurt you on purpose?

A. Yes

B. No

22. Have you ever been physically forced to have sexual intercourse when you did not want to?

A. Yes

B. No

The next question asks about bullying. Bullying is when 1 or more students tease, threaten, spread rumors about, hit, shove, or hurt another student over and over again. It is not bullying when 2 students of about the same strength or power argue or fight or tease each other in a friendly way.

23. During the past 12 months, have you ever been bullied on school property?

A. Yes

B. No

The next 5 questions ask about sad feelings and attempted suicide. Sometimes people feel so depressed about the future that they may consider attempting suicide, that is, taking some action to end their own life.

24. During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?

A. Yes

B. No

25. During the past 12 months, did you ever seriously consider attempting suicide?

A. Yes

B. No

26. During the past 12 months, did you make a plan about how you would attempt suicide?

A. Yes

B. No

27. During the past 12 months, how many times did you actually attempt suicide?

A. 0 times

B. 1 time

C. 2 or 3 times

D. 4 or 5 times

E. 6 or more times

28. If you attempted suicide during the past 12 months, did any attempt result in an injury, poisoning, or overdose that had to be treated by a doctor or nurse?

A. I did not attempt suicide during the past 12 months

B. Yes

C. No

The next 11 questions ask about tobacco use.

29. Have you ever tried cigarette smoking, even one or two puffs?

A. Yes

B. No

30. How old were you when you smoked a whole cigarette for the first time?

A. I have never smoked a whole cigarette

B. 8 years old or younger

C. 9 or 10 years old

D. 11 or 12 years old

E. 13 or 14 years old

F. 15 or 16 years old

G. 17 years old or older

31. During the past 30 days, on how many days did you smoke cigarettes?

A. 0 days

B. 1 or 2 days

C. 3 to 5 days

D. 6 to 9 days

E. 10 to 19 days

F. 20 to 29 days

G. All 30 days

32. During the past 30 days, on the days you smoked, how many cigarettes did you smoke per day?

A. I did not smoke cigarettes during the past 30 days

B. Less than 1 cigarette per day

C. 1 cigarette per day

D. 2 to 5 cigarettes per day

E. 6 to 10 cigarettes per day

F. 11 to 20 cigarettes per day

G. More than 20 cigarettes per day

33. During the past 30 days, how did you usually get your own cigarettes?

(Select only one response.)

A. I did not smoke cigarettes during the past 30 days

B. I bought them in a store such as a convenience store, supermarket, discount store, or gas station

C. I bought them from a vending machine

D. I gave someone else money to buy them for me

E. I borrowed (or bummed) them from someone else

F. A person 18 years old or older gave them to me

G. I took them from a store or family member

H. I got them some other way

34. During the past 30 days, on how many days did you smoke cigarettes on school property?

A. 0 days

B. 1 or 2 days

C. 3 to 5 days

D. 6 to 9 days

E. 10 to 19 days

F. 20 to 29 days

G. All 30 days

35. Have you ever smoked cigarettes daily, that is, at least one cigarette every day for 30 days?

A. Yes

B. No

36. During the past 12 months, did you ever try to quit smoking cigarettes?

A. I did not smoke during the past 12 months

B. Yes

C. No

37. During the past 30 days, on how many days did you use chewing tobacco?

A. 0 days

B. 1 or 2 days

C. 3 to 5 days

D. 6 to 9 days

E. 10 to 19 days

F. 20 to 29 days

G. All 30 days

38. During the past 30 days, on how many days did you use chewing on school property?

A. 0 days

B. 1 or 2 days

C. 3 to 5 days

D. 6 to 9 days

E. 10 to 19 days

F. 20 to 29 days

G. All 30 days

39. During the past 30 days, on how many days did you smoke cigars, cigarillos, or little cigars?

A. 0 days

B. 1 or 2 days

C. 3 to 5 days

D. 6 to 9 days

E. 10 to 19 days

F. 20 to 29 days

G. All 30 days

The next 6 questions ask about drinking alcohol. This includes drinking beer, wine, wine coolers, and liquor such as rum, gin, vodka, or whiskey. For these questions, drinking alcohol does not include drinking a few sips of wine for religious purposes.

40. During your life, on how many days have you had at least one drink of alcohol?

A. 0 days

B. 1 or 2 days

C. 3 to 9 days

D. 10 to 19 days

E. 20 to 39 days

F. 40 to 99 days

G. 100 or more days

41. How old were you when you had your first drink of alcohol other than a few sips?

A. I have never had a drink of alcohol other than a few sips

B. 8 years old or younger

C. 9 or 10 years old

D. 11 or 12 years old

E. 13 or 14 years old

F. 15 or 16 years old

G. 17 years old or older

42. During the past 30 days, on how many days did you have at least one drink of alcohol?

A. 0 days

B. 1 or 2 days

C. 3 to 5 days

D. 6 to 9 days

E. 10 to 19 days

F. 20 to 29 days

G. All 30 days

43. During the past 30 days, on how many days did you have 5 or more drinks of alcohol in a row, that is, within a couple of hours?

A. 0 days

B. 1 day

C. 2 days

D. 3 to 5 days

E. 6 to 9 days

F. 10 to 19 days

G. 20 or more days

44. During the past 30 days, how did you usually get the alcohol you drank?

A. I did not drink alcohol during the past 30 days

B. I bought it in a store such as a liquor store, convenience store,

supermarket, discount store, or gas station

C. I bought it at a restaurant, bar, or club

D. I bought it at a public event such as a concert or sporting event

E. I gave someone else money to buy it for me

F. Someone gave it to me

G. I took it from a store or family member

H. I got it some other way

45. During the past 30 days, on how many days did you have at least one

drink of alcohol on school property?

A. 0 days

B. 1 or 2 days

C. 3 to 5 days

D. 6 to 9 days

E. 10 to 19 days

F. 20 to 29 days

G. All 30 days

The next 4 questions ask about Maijuana (Commonly known as Dagga) use.

46. During your life, how many times have you used marijuana?

A. 0 times

B. 1 or 2 times

C. 3 to 9 times

D. 10 to 19 times

E. 20 to 39 times

F. 40 to 99 times

G. 100 or more times

47. How old were you when you tried marijuana for the first time?

A. I have never tried marijuana

B. 8 years old or younger

C. 9 or 10 years old

D. 11 or 12 years old

E. 13 or 14 years old

F. 15 or 16 years old

G. 17 years old or older

48. During the past 30 days, how many times did you use marijuana?

A. 0 times

B. 1 or 2 times

C. 3 to 9 times

D. 10 to 19 times

E. 20 to 39 times

F. 40 or more times

49. During the past 30 days, how many times did you use marijuana on school property?

A. 0 times

B. 1 or 2 times

C. 3 to 9 times

D. 10 to 19 times

E. 20 to 39 times

F. 40 or more times

The next 11 questions ask about other drugs.

50. During your life, how many times have you used any form of cocaine, including powder, crack, or freebase?

A. 0 times

B. 1 or 2 times

C. 3 to 9 times

D. 10 to 19 times

E. 20 to 39 times

F. 40 or more times

51. During the past 30 days, how many times did you use any form of cocaine, including powder, crack, or freebase?

A. 0 times

B. 1 or 2 times

C. 3 to 9 times

D. 10 to 19 times

E. 20 to 39 times

F. 40 or more times

52. During your life, how many times have you sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high?

A. 0 times

B. 1 or 2 times

C. 3 to 9 times

D. 10 to 19 times

E. 20 to 39 times

F. 40 or more times

53. During your life, how many times have you used heroin (also called smack, junk, or China White)?

A. 0 times

B. 1 or 2 times

C. 3 to 9 times

D. 10 to 19 times

E. 20 to 39 times

F. 40 or more times

54. During your life, how many times have you used methamphetamines (also called Tik, speed, crystal or ice)?

A. 0 times

B. 1 or 2 times

C. 3 to 9 times

D. 10 to 19 times

E. 20 to 39 times

F. 40 or more times

55. During your life, how many times have you used ecstasy (also called MDMA)?

A. 0 times

B. 1 or 2 times

C. 3 to 9 times

D. 10 to 19 times

E. 20 to 39 times

F. 40 or more times

56. During your life, how many times have you used hallucinogenic drugs, such as LSD, acid, PCP, angel dust, mescaline, or mushrooms?

A. 0 times

B. 1 or 2 times

C. 3 to 9 times

D. 10 to 19 times

E. 20 to 39 times

F. 40 or more times

57. During your life, how many times have you taken steroid pills or shots without a doctor's prescription?

A. 0 times

B. 1 or 2 times

C. 3 to 9 times

D. 10 to 19 times

E. 20 to 39 times

F. 40 or more times

58. During your life, how many times have you taken a prescription drug (such as OxyContin, Percocet, Vicodin, Adderall, Ritalin, or Xanax) without a doctor's prescription?

A. 0 times

B. 1 or 2 times

C. 3 to 9 times

D. 10 to 19 times

E. 20 to 39 times

F. 40 or more times

59. During your life, how many times have you used a needle to inject any illegal drug into your body?

A. 0 times

B. 1 time

C. 2 or more times

60. During the past 12 months, has anyone offered, sold, or given you an illegal drug on school property?

A. Yes

B. No

The next 7 questions ask about sexual behavior.

61. Have you ever had sexual intercourse?

A. Yes

B. No

62. How old were you when you had sexual intercourse for the first time?

A. I have never had sexual intercourse

B. 11 years old or younger

C. 12 years old

D. 13 years old

E. 14 years old

F. 15 years old

G. 16 years old

H. 17 years old or older

63. During your life, with how many people have you had sexual intercourse?

A. I have never had sexual intercourse

B. 1 person

C. 2 people

D. 3 people

E. 4 people

F. 5 people

G. 6 or more people

64. During the past 3 months, with how many people did you have sexual intercourse?

A. I have never had sexual intercourse

B. I have had sexual intercourse, but not during the past 3 months

C. 1 person

D. 2 people

E. 3 people

F. 4 people

G. 5 people

H. 6 or more people

65. Did you drink alcohol or use drugs before you had sexual intercourse the last time?

A. I have never had sexual intercourse

B. Yes

C. No

66. The last time you had sexual intercourse, did you or your partner use a condom?

A. I have never had sexual intercourse

B. Yes

C. No

67. The last time you had sexual intercourse, what one method did you or your partner use to prevent pregnancy? (Select only one response.)

A. I have never had sexual intercourse

B. No method was used to prevent pregnancy

C. Birth control pills

D. Condoms

E. Depo-Provera (injectable birth control)

F. Withdrawal

G. Some other method

H. Not sure

The next 7 questions ask about body weight.

68. How do you describe your weight?

A. Very underweight

B. Slightly underweight

C. About the right weight

D. Slightly overweight

E. Very overweight

69. Which of the following are you trying to do about your weight?

A. Lose weight

B. Gain weight

C. Stay the same weight

D. I am not trying to do anything about my weight

70. During the past 30 days, did you exercise to lose weight or to keep from gaining weight?

A. Yes

B. No

71. During the past 30 days, did you eat less food, fewer calories, or foods low in fat to lose weight or to keep from gaining weight?

A. Yes

B. No

72. During the past 30 days, did you go without eating for 24 hours or more (also called fasting) to lose weight or to keep from gaining weight?

A. Yes

B. No

73. During the past 30 days, did you take any diet pills, powders, or liquids without a doctor's advice to lose weight or to keep from gaining weight? (Do not include meal replacement products such as Slim Fast.)

A. Yes

B. No

74. During the past 30 days, did you vomit or take laxatives to lose weight or to keep from gaining weight?

A. Yes

B. No

The next 8 questions ask about food you ate or drank during the past 7

days. Think about all the meals and snacks you had from the time you got up until you went to bed. Be sure to include food you ate at home, at school, at restaurants, or anywhere else.

75. During the past 7 days, how many times did you drink 100% fruit juices such as orange juice, apple juice, or grape juice? (Do not count punch, Kool-Aid, sports drinks, or other fruit-flavored drinks.)

A. I did not drink 100% fruit juice during the past 7 days

B. 1 to 3 times during the past 7 days

C. 4 to 6 times during the past 7 days

D. 1 time per day

E. 2 times per day

F. 3 times per day

G. 4 or more times per day

76. During the past 7 days, how many times did you eat fruit? (Do not count fruit juice.)

A. I did not eat fruit during the past 7 days

B. 1 to 3 times during the past 7 days

C. 4 to 6 times during the past 7 days

D. 1 time per day

E. 2 times per day

F. 3 times per day

G. 4 or more times per day

77. During the past 7 days, how many times did you eat green salad?

A. I did not eat green salad during the past 7 days

B. 1 to 3 times during the past 7 days

C. 4 to 6 times during the past 7 days

D. 1 time per day

E. 2 times per day

F. 3 times per day

G. 4 or more times per day

78. During the past 7 days, how many times did you eat potatoes? (Do not count french fries, fried potatoes, or potato chips.)

A. I did not eat potatoes during the past 7 days

B. 1 to 3 times during the past 7 days

C. 4 to 6 times during the past 7 days

D. 1 time per day

E. 2 times per day

F. 3 times per day

G. 4 or more times per day

79. During the past 7 days, how many times did you eat carrots?

A. I did not eat carrots during the past 7 days

B. 1 to 3 times during the past 7 days

C. 4 to 6 times during the past 7 days

D. 1 time per day

E. 2 times per day

F. 3 times per day

G. 4 or more times per day

80. During the past 7 days, how many times did you eat other vegetables?

(Do not count green salad, potatoes, or carrots.)

A. I did not eat other vegetables during the past 7 days

B. 1 to 3 times during the past 7 days

C. 4 to 6 times during the past 7 days

D. 1 time per day

E. 2 times per day

F. 3 times per day

G. 4 or more times per day

81. During the past 7 days, how many times did you drink a can, bottle, or glass of soda or pop, such as Coke, Pepsi, or Sprite? (Do not include diet soda or diet pop.)

A. I did not drink soda or pop during the past 7 days

B. 1 to 3 times during the past 7 days

C. 4 to 6 times during the past 7 days

D. 1 time per day

E. 2 times per day

F. 3 times per day

G. 4 or more times per day

82. During the past 7 days, how many glasses of milk did you drink? (Include the milk you drank in a glass or cup, from a carton, or with cereal. Count the half pint of milk served at school as equal to one glass.)

A. I did not drink milk during the past 7 days

B. 1 to 3 glasses during the past 7 days

C. 4 to 6 glasses during the past 7 days

D. 1 glass per day

E. 2 glasses per day

F. 3 glasses per day

G. 4 or more glasses per day

The next 8 questions ask about physical activity.

83. On how many of the past 7 days did you exercise or participate in physical activity for at least 20 minutes that made you sweat and breathe hard, such as basketball, soccer, running, swimming laps, fast bicycling, fast dancing, or similar aerobic activities?

A. 0 days

B. 1 day

C. 2 days

D. 3 days

E. 4 days

F. 5 days

G. 6 days

H. 7 days

84. On how many of the past 7 days did you participate in physical activity for at least 30 minutes that did not make you sweat or breathe hard, such as fast walking, slow bicycling, skating, pushing a lawn mower, or mopping floors?

A. 0 days

B. 1 day

C. 2 days

D. 3 days

E. 4 daysF. 5 days

G. 6 days

H. 7 days

85. During the past 7 days, on how many days were you physically active for a total of at least 60 minutes per day? (Add up all the time you spent in any kind of physical activity that increased your heart rate and made you breathe hard some of the time.)

A. 0 days

B. 1 day

C. 2 days

D. 3 days

E. 4 days

F. 5 days

G. 6 days

H. 7 days

86. On an average school day, how many hours do you watch TV?

A. I do not watch TV on an average school day

B. Less than 1 hour per day

C. 1 hour per day

D. 2 hours per day

E. 3 hours per day

F. 4 hours per day

G. 5 or more hours per day

87. On an average school day, how many hours do you play video or computer games or use a computer for something that is not school work? (Include activities such as Nintendo, Game Boy, PlayStation, Xbox, computer games, and the Internet.)

A. I do not play video or computer games or use a computer for something that is not school work

B. Less than 1 hour per day

C. 1 hour per day

D. 2 hours per day

E. 3 hours per day

F. 4 hours per day

G. 5 or more hours per day

88. In an average week when you are in school, on how many days do you go to physical education (PE) classes?

A. 0 days

B. 1 day

C. 2 days

D. 3 days

E. 4 days

F. 5 days

89. During an average physical education (PE) class, how many minutes do you spend actually exercising or playing sports?

A. I do not take PE

B. Less than 10 minutes

C. 10 to 20 minutes

D. 21 to 30 minutes

E. 31 to 40 minutes

F. 41 to 50 minutes

G. 51 to 60 minutes

H. More than 60 minutes

90. During the past 12 months, on how many sports teams did you play?

(Include any teams run by your school or community groups.)

A. 0 teams

B. 1 team

C. 2 teams

D. 3 or more teams

The next 8 questions ask about other health-related topics.

91. Have you ever been taught about AIDS or HIV infection in school?

A. Yes

B. No

C. Not sure

92. Have you ever been tested for HIV, the virus that causes AIDS? (Do not count tests done if you donated blood.)

A. Yes

B. No

C. Not sure

93. When you are outside for more than one hour on a sunny day, how often do you wear sunscreen with an SPF of 15 or higher?

A. Never

B. Rarely

C. Sometimes

D. Most of the time

E. Always

94. During the past 12 months, how many times did you use an indoor tanning device such as a sunlamp, sunbed, or tanning booth? (Do not include getting a spray-on tan.)

A. 0 times

B. 1 or 2 times

C. 3 to 9 times

D. 10 to 19 times

E. 20 to 39 times

F. 40 or more times

95. Has a doctor or nurse ever told you that you have asthma?

A. Yes

B. No

C. Not sure

96. Do you still have asthma?

A. I have never had asthma

B. Yes

C. No

D. Not sure

97. On an average school night, how many hours of sleep do you get?

A. 4 or less hours

B. 5 hours

C. 6 hours

D. 7 hours

E. 8 hours

F. 9 hours

G. 10 or more hours

98. During the past 12 months, how would you describe your grades in school?

A. Mostly A's

B. Mostly B's

C. Mostly C's

D. Mostly D's

E. Mostly F's

F. None of these grades

G. Not sure

This is the end of the survey.

Thank you very much for your help.

APPENDIX B: INFORMATION SHEET

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2542, Fax: 27 21-959 1217

E-mail: hess.brent@gmail.com

Project Title: Health promotion among youth: The role of secondary schools in rural settings.

What is this study about?

This is a research project being conducted by Brent Hess at secondary schools in the Theewaterskloof Municipal Region. The purpose of this research project is to determine the role secondary schools in the rural Theewaterskloof municipality play in the promotion of health amongst its learners. The information will be used to recommend strategies for improved health promotion in schools in Genadendal and Grabouw.

What will be asked to participants?

As a learner, you will be asked to complete a health risk behaviour questionnaire and possibly participate in a focus group discussion to further explore and expand on your perceptions of learners with regards to health risk behaviours. You would give your consent for the researcher to use the information provided in his study. The study will take place at the respective schools' premises.

As an educator you will be asked to participate in a focus group discussion to establish your insights and views of health promotion offered at your institution. The study will take place at the respective schools' premises. You would give your consent for the researcher to use the information provided in his study.

Will participation in this study will be kept confidential?

We will do our best to keep your personal information confidential. To help protect your confidentiality, all data collected from learners and educators at the respective schools will be kept confidential in a locked file to which only the researcher has access. Confidentiality and the right to withdraw from the study at any time will be assured to the participants. The surveys are anonymous and will not contain information that may personally identify participants.

In accordance with legal requirements and/or professional standards, we will disclose to the appropriate individuals and/or authorities information that comes to our attention concerning child abuse or neglect or potential harm to you or others.

What are the risks of this research?

There are no known risks associated with participating in this research project.

What are the benefits of this research?

The results of this study may help the researcher learn more about the current strategies of secondary schools in Theewaterskloof municipality about health promotion and health risk behaviours among the youth. We hope that we can recommend strategies for health promotion in rural schools and possibly in the future that other people might benefit from this study through improved understanding.

Do you have to be in this research and may you stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating

at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

What if I have questions?

This research is being conducted by Brent Hess, Department of Physiotherapy at the University of the Western Cape. If you have any questions about the research study itself, please contact the supervisor, Prof J Phillips at: Department of Physiotherapy, UWC, Bellville, Cape Town.

Tel: 021 959 2452

Email: jphillips@uwc.ac.za

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Head of Department: Prof A Rhoda

Dean of the Faculty of Community and Health Sciences: Prof J Frantz

University of the Western Cape

Private Bag X17

Bellville 7535

This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.

APPENDIX C: CONSENT FORM

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-959 2542, Fax: 27 21-959 1217
E-mail: hess.brent@gmail.com

CONSENT FORM

Title of Research Project: Health promotion among youth: The role of secondary schools in rural settings

The study has been described to me in a language that I understand and I freely and voluntarily give consent for my child to participate. My questions about the study have been answered. I understand that his/her identity will not be disclosed and that he/she may withdraw from the study without giving a reason at any time and this will not negatively affect him/her in any way.

Participant's name.....
Parent/Guardian's name.....
Parent/Guardian signature.....
Witness.....
Date.....

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Study Coordinator's Name: Brent Hess

University of the Western Cape

Private Bag X17, Belville 7535

Telephone: (021)959-2807

Cell: 073 267 3767

Fax: (021)959-1217

Email: hess.brent@gmail.com

APPENDIX D: ETHICAL CLEARANCE

UNIVERSITY of the
WESTERN CAPE

OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH DEVELOPMENT

05 March 2013

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape has approved the methodology and ethics of the following research project by:
Prof C Schenck (Social Work)

Research Project: Building capacity for sustainable development at rural service learning sites.

Registration no: 13/2/3

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

APPENDIX E: WESTERN CAPE EDUCATION DEPARTMENT RESEARCH CLEARANCE LETTER

Western Cape Government
Education

Directorate: Research

Audrey.wyngaard2@pgwc.gov.za
tel: +27 021 467 9272
Fax: 0865902282
Private Bag x9114, Cape Town, 8000
wced.wcape.gov.za

REFERENCE: 20130605-12249
ENQUIRIES: Dr A T Wyngaard

Mr Gerard Filies
Faculty of Community & Health Sciences Interdisciplinary
Teaching and Learning Unit
UWC
Private Bag X 17
Bellville
7535

Dear Mr Gerard Filies

RESEARCH PROPOSAL: BUILDING CAPACITY FOR SUSTAINABLE DEVELOPMENT AT RURAL SERVICE-LEARNING SITES

Your application to conduct the above-mentioned research in schools in the Western Cape has been approved subject to the following conditions:

1. Principals, educators and learners are under no obligation to assist you in your investigation.
2. Principals, educators, learners and schools should not be identifiable in any way from the results of the investigation.
3. You make all the arrangements concerning your investigation.
4. Approval for projects should be conveyed to the District Director of the schools where the project will be conducted.
5. Educators' programmes are not to be interrupted.
6. The Study is to be conducted from **15 July 2013 till 20 September 2014**
7. No research can be conducted during the fourth term as schools are preparing and finalizing syllabi for examinations (October to December).
8. Should you wish to extend the period of your survey, please contact Dr A.T Wyngaard at the contact numbers above quoting the reference number?
9. A photocopy of this letter is submitted to the principal where the intended research is to be conducted.
10. Your research will be limited to the list of schools as forwarded to the Western Cape Education Department.
11. A brief summary of the content, findings and recommendations is provided to the Director: Research Services.
12. The Department receives a copy of the completed report/dissertation/thesis addressed to:

    The Director: Research Services
    Western Cape Education Department
    Private Bag X9114
    CAPE TOWN
    8000

We wish you success in your research.

Kind regards.
Signed: Dr Audrey T Wyngaard
Directorate: Research
DATE: 05 June 2013

APPENDIX F : FOCUS GROUP CONFIDENTIALITY BINDING FORMS

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2542

e-mail: hess.brent@gmail.com

Title of Research Project: Health promotion among youth: The role of secondary schools in rural settings.

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way. I agree to be audio-taped during my participation in the study. I also agree not to disclose any information that was discussed during the group discussion.

Participant's name……..

Participant's signature……..

Witness's name……..

Witness's signature……..

Date……