UNIVERSITY OF THE WESTERN CAPE

Faculty of Community and Health Sciences

RESEARCH PROPOSAL

THE EFFECT OF A YOUTH DEVELOPMENT PROGRAMME COMBATTING ENGAGEMENT IN HEALTH RISK BEHAVIOURS AMONGST GRADE 8 LEARNERS IN A SELECTED HIGH SCHOOL IN THE PAARL AREA

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DECLARATION

I hereby declare that the proposal **"The Effect of a Youth Development Programme Combatting Engagement in Health Risk Behaviours Amongst Grade 8 Learners in a Selected High School in the Paarl Area"** is my own work, that has not been submitted for any degree of examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by means of complete references.

Name: Chanray Lozindi Cloete Date: October, 2018

Signature: 

Supervisor Date: October, 2018

Dr. Hamilton Grant Pharaoh

DEDICATION

I would like to thank and praise the Lord our God for allowing me the opportunity to have undertaken this challenge and successfully completing my thesis. I was discouraged at times but through His strength and guidance I was able to complete this study.

For my supervisor, Dr Hamilton Pharaoh who dedicated his time and effort in helping me to complete this study.

For my parents, uncles, aunt and cousins for your love and support.

For my friends and colleagues who encouraged me to complete this study.

For my fiancé who helped, supported and guided me through this journey.

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Abstract

Background: Health risk behaviours can directly affect health outcomes. Healthy behaviours such as exercising and eating sensibly can lower the risk of conditions like heart disease and diabetes, while unhealthy behaviours such as smoking and excessive drinking raise the risk of conditions like lung cancer and liver disease. In a study using two large national data sets, the Youth Risk Behaviour Survey (YRBS) and Add Health, the Center on Addiction and Substance Abuse (CASA) found that teenagers who consume alcohol or take illicit drugs are more likely to engage in sex, to do so at a younger age, and to have several partners. For adolescents who are 14 years old and younger, consuming alcohol or using drugs doubles and quadruples, respectively, the likelihood that sexual intercourse has ever been experienced compared to adolescents who have never used these substances. A study reported that early onset of alcohol, tobacco and other drugs, school problems, delinquency, and physical aggression are significantly associated with early onset of sexual behaviour. Alcohol use in adolescence has also been found to be related to more frequent sexual activity and less frequent use of condoms. **Aim**: To investigate and explore the effect of a youth development programme (YDP) of combatting health risk behaviours amongst 250 Grade 8 learners in a selected high school in the Paarl area. **Design**: A mixed method approach was used and the design of the study was a cross sectional, sequential explanatory study design. **Population and sampling**: The approach entailed a purposive sampling method where 250 registered learners from a selected school participated in the study. From this, focus group discussions of ten participants each were established among the participants of said study. This was based on the following representation: i) Gender; ii) Age; iii) Representation per class (Grade 8 divided into five different classes). The quantitative measures were collected by the means of survey questionnaires known as the Youth Risk Behaviour Survey (YRBS). Four focus group discussions (FGD), (two of females only), (males only) and (mixed group) were held to explore the effect of the YDP on the combatting of health risk behaviour engagement amongst the participants. These measures were performed pre-and post-intervention.

Data analysis and results: Qualitative: Two researchers were involved in the FGD's, one as the facilitator and the other one made notes and observations. The FGD's were recorded and transcribed verbatim and translated from Afrikaans to English soon after the interviews. Results was depicted in the form of tables, graphs and narration. Quantitative: Descriptive statistics from the YRBSS was used to depict the health risk behaviours by using frequencies and percentages to assess whether there were significant differences in the engagement of

health risk behaviours as stated by the pre-and post-test respectively. **Trustworthiness**: To ensure trustworthiness of the data captured, member checking was done with the group to verify recorded responses. A thematic analysis was used to expand on the findings of the surveys. **Ethics:** Ethical clearance was requested from the University of the Western Cape Research Committee and the Higher Degrees Committee of the University of the Western Cape. Permission was obtained from the Department of Education, Western Cape, Principles and governing bodies of the selected school involved. Informed written consent was obtained from the parents and informed assent from the learners. Learners were informed that participation is voluntary and anonymous and they can choose to partake or not or they can withdraw at any stage without any consequences. A detailed explanation of the purpose of the study was provided beforehand and throughout the study. Confidentiality was assured. Participants in the FGD's signed a disclosure statement for confidentiality purposes to make them aware of the ethical procedures in advance. This study also involved the making of audiotapes during the FGD's and for confidentiality purposes, all tapes were stored in a locked filling cabinet to which only the researcher had access. The results were available to all relevant stakeholders and participants.

Keywords: Health Risk Behaviours, interventions, life skills, youth development programme, decision-making

TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

ABBREVIATIONS AND ACRONYMS

AAHA – Accelerated Action for the Health of Adolescents

AIDS – Acquired Immune Deficiency Syndrome

CASA – Center on Addiction and Substance Abuse

CDC – Centers of Disease

CI - Confidence Intervals

DALY – Disability Adjusted Life Years

FGD – Focus Group Discussion

GBD – Global Burden of Disease

HIV – Human Immunodeficiency Virus

HRB – Health Risk Behaviour

LEQ – Life Effective Questionnaire

LST – Life Skills Training

MHRB – Multiple Health Risk Behaviour

SA – South Africa

SD – Standard Deviations

SEM – Standard Errors of the Mean

STD – Sexually Transmitted Diseases

SPSS – Statistical Package for Social Sciences

US – United States

UWC – University of the Western Cape

WHO – World Health Organisation

YDP – Youth Development Programme

YRBS – Youth Risk Behaviour Survey

YRBSS – Youth Risk Behaviour Surveillance Survey

DEFINITION OF TERMS

Health risk behaviour: Is behaviour or other factors that place a person at risk for disease. These diseases can include HIV/AIDS, diabetes, cancer, heart disease etc. It is an action that potentially threatens your health, or the health of others. Daily habits like the foods you eat, the time you go to sleep and how much activity you engage in throughout the day, have a significant influence on your health. Each of these behaviours positively or negatively affects you and dictates the overall state of your health (Waller, 2017).

Health risk: Is a disease precursor associated with a higher than average morbidity or mortality rate. Disease precursors include demographic variables, certain individual behaviours, familial and individual histories and certain physiological changes. A risk behaviour is an action on your part that may result in a bad or unwanted consequence (Mosby's Medical Dictionary, 9th edition, 2009, Elsevier).

Smoking: The act of inhaling and exhaling the fumes of burning plant material. A variety of plant materials are smoked, including marijuana and hashish, but the act is most commonly associated with tobacco as smoked in a cigarette, cigar, or pipe. Tobacco contains nicotine, an alkaloid that is addictive and can have both stimulating and tranquilizing psychoactive effects (Rose, Henningfield, Sweanor & Hilton, 1998).

Risky sexual behaviour is commonly defined as behaviour that increases one's risk of contracting sexually transmitted infections and experiencing unintended pregnancies. They include having sex at an early age, having multiple sexual partners, having sex while under the influence of alcohol or drugs, and unprotected sexual behaviours (Centers for Disease Control and Prevention, 2010).

Risky drinking (also called hazardous drinking) is defined by drinking above the recommended limits: greater than 14 standard drinks units per week or greater than 4 standard drinks on a single occasion in men, greater than 7 standard drinks units per week or greater than 3 standard drinks on a single occasion in women, any drinking in pregnant women or persons < 21 years old (Renaud, 2001).

Violence is defined by the World Health Organization as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death,

psychological harm, maldevelopment, or deprivation", although the group acknowledges that the inclusion of "the use of power" in its definition expands on the conventional understanding of the word (Krug et al., 2002).

Drug use: Use of drugs for psychotropic rather than medical purposes. Among the most common psychotropic drugs are opiates (opium, morphine, and heroin), hallucinogens (LSD, mescaline, and psilocybin), barbiturates, cocaine, amphetamines, tranquilizers, and cannabis. Alcohol and tobacco are also sometimes classified as drugs. The term drug abuse is normally applied to excessive and addictive use of drugs. Because such drugs can have severe physiological and psychological, as well as social, effects, many governments regulate their use (Steiner, 1998).

Life skills have been defined by WHO as “abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life”. They represent the psycho-social skills that determine valued behaviour and include reflective skills such as problem-solving and critical thinking, to personal skills such as self-awareness, and to interpersonal skills (WHO, 1996).

A **youth development organisation** exists to promote the positive, healthy development of young people. Youth development organisations are different from agencies and systems that exist to provide social control, treatment, or training for young people. The socialisation of youth is the youth organisation's primary task. Their mission is to provide the challenges, experiences, support, and help young people need to develop to their fullest potential. These community-based organisations work to meet needs in the environment and enhance the learning experiences of young people. No single organisation does it all (Pittman, 1993).

CHAPTER ONE

1. Introduction

1.1 Background

Around 1.2 billion people, or 1 in 6 of the world's population, are adolescents aged 10 to 19 years old. Most are healthy but there is still substantial premature death, illness and injury among adolescents. Illnesses can hinder their ability to grow and develop to their full potential. Alcohol or tobacco use, lack of physical activity, unprotected sex and or exposure to violence can jeopardise not only their current health, but also their health as adults and even the health of their future children. Promoting healthy behaviours during adolescence and taking steps to better protect young people from health risks are critical for the prevention of health problems in adulthood and for countries' future health and ability to develop and thrive (WHO, 2017). In May 2017, the WHO published a major report: *Global Accelerated Action for the Health of Adolescents (AA-HA!): Guidance to support country implementation*. The AA-HA! Guidance has drawn on inputs received during extensive consultations with Member States, United Nations agencies, adolescents and young people, civil society and other partners. It aims to assist governments in deciding what they plan to do and how they plan to do it as they respond to the health needs of adolescents in their countries. This reference document targets national-level policy-makers and programme managers to assist them in planning, implementing, monitoring and evaluation of adolescent health programmes.

Overall, the WHO carries out a range of functions to improve the health of young people, including:

- production of evidence-based guidelines to support health services and other sectors;
- making recommendations to governments on adolescent health and the provision of high quality, age-appropriate health services for adolescents;
- documenting progress in adolescent health and development; and
- raising awareness of health issues for young people among the general public and other interested stakeholders (WHO, May 2017).

Globally it was reported by McPherson et al., 2013, Rosario et al., 2013 & Jones et al., 2013, that a number of health risk behaviours begin in adolescence that affect health both at the time and in later years. Some of these behaviours contribute to the leading causes of mortality and morbidity among adolescents, such as suicide attempts, injuries and the various risks associated with unprotected sexual behaviour, conditions related to tobacco or alcohol use and overweight or obesity. The majority of adolescent death and illness are caused by risk behaviours that can be grouped into four categories: tobacco, alcohol and drug use; dietary behaviours; physical activity; and sexual behaviours (Centers for Disease and Control, 2016; Quinn et al., 2014). These key health-risk behaviours are often the focus of prevention strategies for non-communicable diseases and some sexual conditions (Patton et al., 2012 & Kann et al., 2013). A study conducted in Morocco, evaluating the content of school textbooks in relation to health lessons, concluded that the lessons in these textbooks are inadequate, inaccurate, or out of date, and hence need improvement (Khzami et al., 2012). In Morocco, the curriculum was also primarily based on the biomedical model and included a few instructions issued from the social health model. A high-quality health education programme is the cornerstone of promoting healthy behaviours in the school setting (Caussidier et al., 2011).

In a study done by Sirirassamee et al., 2013, the aim was to establish the prevalence of risky health behaviours among Thai youth and to characterise the prevalence of these behaviours by gender, age group, educational status and region. Data was analysed from a population-based, nationally representative, cross-sectional survey of 938 youth aged between 13 and 24 years old, sampled from Bangkok and four regions of Thailand. The 2011 Youth Risk Behaviour Surveillance System questionnaire was used to measure youth risk behaviours. This study found that 15.9% of respondents had engaged in physical fights, and 8.1% had been cyber bullied. The prevalence of current cigarette smoking, alcohol, and marijuana use were 22.3%, 27.9%, and 2.3%, respectively. The prevalence of risky behaviours among Thai youth were found to be high, including behaviours that contribute to unintentional injuries and violence, unsafe sexual behaviours, and cigarette and alcohol consumption.

South Africa's population is largely made up of young people; those who are below the age of 35 years old constitute about 66% per cent of the total population. Over 54 million South Africans, 18.5% are between the ages 10-19; and 24% are aged 15-24 (Stat SA, Mid-year population estimate). South Africa's National Youth Policy (2009-2014) defines youth as

persons from 15-34 years old. The policy is geared towards prioritising the needs of young people with respect to education, health and well-being, economic participation and social cohesion. As a big part of the population, young people are at the heart of the future of South Africa. While South Africa's history was driven by young people through the Soweto uprising in 1976, more recently young people are facing many challenges in modern day society. There is great benefit in investing in young people by creating pathways for accelerated development. When young people can claim their right to health, education and decent working conditions, they become a powerful force for economic development and positive change. Life skills and positive decision-making should be part of these intervention programmes and put into practice to develop sustainability so at-risk youths can carry it through their adulthood to maintain healthy lifestyles.

Attempted and completed suicide constitute a major public health problem among young people world-wide, including South Africa (SA). Suicide attempts and completed suicide increases during the adolescent period. One in five adolescents considers attempting suicide but statistics are frequently unreliable (Hilda et al., 2012). Data for this study were derived from the 2002 and 2008 South African Youth Risk Behaviour Surveys (YRBS). The study population comprised Grades 8, 9, 10 and 11 students in governmental schools in the nine provinces of SA (N = 10,699 in 2002 and 10,270 in 2008). Key outcome measures were suicide ideation and suicide attempts. Self-destructive behaviours, including suicide, have become a significant public health problem in many parts of the world, with South Africa being no exception. Every year almost one million people commit suicide, resulting in a global suicide rate of 16 per 100,000 people (WHO: Violence prevention, 2009). In the last 45 years suicide rates have increased by 60% worldwide. This increase might be partly caused by better registration procedures in many countries, with data available from 105 countries at the last update in 2011 as compared to 11 countries in 1950 (WHO 2012: suicide rates per 100 000 by country, year and sex). Whether, for example, the high rates of suicide in young people reported from India and China in recent years represents a rising trend or an under-reporting bias in older studies is unclear (Patel et al., 2007). Suicide is now believed to be among the three leading causes of death among those aged 15-44 years old in some countries and the second leading cause of death in the 10-24 years age group. These figures do not include suicide attempts which are up to 20 times more frequent than completed suicides.

According to the World Health Organisation, Mental Health: Suicide Prevention, 2012, South Africa has suicide prevalence data for 2007. This data shows that adolescents have the highest suicide rate compared to adults and the aged. In South Africa, suicide rates are believed to be higher than the worldwide average. According to a national household survey conducted in 2003, the annual suicide rate is 25 deaths per 100,000 people (Meel, 2003). In a more dated study, Flisher et al., 1977, reported suicide deaths to be high in spring or summer and more pronounced among less urbanized and low standard of living. Peltzer et al., 1998, reported suicide to be the leading causes of death for young people in Limpopo Province in the north-east of South Africa. It is suspected that suicide rates have increased nationwide in more recent years, especially among the youth (Mashego et al., 2009 & Reddy et al., 2003).

The study demonstrated that there is an increase in suicide attempts in the absence of suicide ideation, and that a high rate of learners felt hopeless. The result from our study suggests that evidence- and theory-based suicide prevention programmes should be developed to reduce the high suicide rate of (mainly black) school learners in South Africa. The school curriculum content should include information on mental health and suicide. The prevalence of depression and thus suicide ideation in young people should be reduced by early identification of at-risk students, for example, those experiencing forced sexual encounters, poor social support and previous suicide attempts (Shilubane et al., 2013). The government and non-governmental organisations should work collaboratively in providing in-service education to health promoters and school teachers to address risk behaviours in an integrated and comprehensive manner, for example within the WHO concept of health promoting schools (MacNab, 2013). The Department of Health and the Department of Education should work together in reviewing the content included in the Life Orientation (LO) subject. This will ensure that service providers and schools do not feel overwhelmed and overburdened by multiple single behaviour interventions but approach suicidal behaviour and related risk behaviours in a comprehensive manner, guided by systematic explorative and confirmative research to develop evidence- and theory-based suicide prevention and behaviour change programmes using intervention development frameworks such as Intervention Mapping (Bartholomew et al., 2011).

Furthermore, school-based interventions involving self-esteem enhancement and the development of life skills and healthy decision-making have been demonstrated to reduce the risk of suicide among the youth (Beautrais et al., 2008; & Bursztein et al., 2009).

In a study done in Paarl by Pharaoh et al., 2011, there is consensus that education on the prevention of health risk behaviour and an increased repertoire of life skills could facilitate a reduction in health risk behaviours. This article reports on the results of a survey among 1027 Grades 8-10 learners aged 13-18 years old, and profiles their engagement in smoking, drug use, drinking and sexual activity. It reports on the hypothesis testing for the relationship between life skills, as measured by the Life Effectiveness Questionnaire (LEQ), and engagement in the above-mentioned health risk behaviours, as measured by the Youth Risk Behaviour Surveillance Survey (YRBSS). The results concur with South African national surveys of youth risk behaviour regarding the nature and extent of engagement in health risk behaviours. Regression analyses indicated that the combination of the LEQ`s life skill domains (Time management, Achievement, Emotional control, Social competence, Active initiative, Self-confidence, Intellectual flexibility and Task leadership) significantly explained between 25% and 56% of the variance in the health risk behaviours (smoking, drinking, drug use, sexual activity). Similarly, this combination of LEQ`s life skill domains significantly explained 4.1% of the variance in physical activity. Time management significantly predicted sexual activity and drug use. Achievement and emotional control significantly predicted drinking, emotional control, time management, social competence, and initiative significantly predicted smoking. Thus, it is recommended that the abovementioned life skill domains be incorporated into intervention programmes or life orientation curricula in order to reduce the incidence of health risk behaviours among South African youth. In the Western Cape Province, the Paarl East area is considered to be an area where the youth engage in high risk behaviour in the same classification as the youth in areas such Manenberg, Khayelitsha and Bonteheuwel on the Cape Flats (Community Safety Departments of the Western Cape).

The youth development programme was therefore developed and implemented in 2017 amongst Grade 8 learners in a selected school in Paarl that focused on knowledge development, education of health risk behaviour, leadership development, relationship development and life skills development. All the information captured through these phases ultimately created an informed programme that attempted to reduce the current health risk behaviours of Grade 8 learners.

1.2 Problem Statement

Current health risk behaviour engagement among the youth is of great concern due to the fact that a larger proportion of the youth develop chronic diseases of lifestyle, such as hypertension and diabetes later in life. Interventions aimed at combatting HRB among the youth is therefore an important component to prevent this occurrence. In order for intervention programmes to be effective, research needs to focus on the impact of these interventions in order to build new knowledge that will ultimately create better and better programmes that cater for the challenges that the youth face on a daily basis.

1.3 Aim of the Study

To investigate the effects of a youth development programme combatting engagement in health risk behaviours amongst Grade 8 learners in a selected high school in the Paarl area.

1.4 Research Question

Does the implementation of a comprehensive youth development programme impact or combat the engagement in health risk behaviours amongst Grade 8 learners in Paarl area?

1.5 Significance of the Study

The majority of people engage in some sort of health risk behaviour but the youth represent a population at significant risk of engaging in health risk behaviours. Therefore, this study provides a window of opportunity for ongoing and comprehensive research to expand their knowledge on the prevention and reduction of risky behaviour. This study aims to add new knowledge to the already existing programmes that attempt to combat engagement in health risk behaviour among the youth. Thus, the gaps identified can be addressed. Evidence showed that young people need assistance in making health decisions relating to risky behaviour in order to protect themselves. This study is located within the pre-testing and immediate posting phase of the YDP implementation of the bigger study. This study will therefore contribute by i) determining the current health risk behaviour that the Grade 8 learners that will form part of the YDP implementation engage in; ii) determining health risk behaviour post-implementation in order to ascertain whether health risk behaviour engagement have changed following the implementation and iii) to explore the how the Grade 8 learners view the YDP and their HRB engagement pre-and post-implementation. This might assist the bigger project in understanding the impact of the YDP on health risk

behaviour engagement and whether adaptations need to be done for future implementation among the youth.

1.6 Objectives of the Study

The objectives of this study are:

1. To determine the HRB engagement of Grade 8 learners in a selected school in the Paarl area prior to the implementation of the designed YDP.
2. To determine the HRB engagement of the Grade 8 learners in a selected school in the Paarl area post-implementation of the designed YDP.
3. To explore the views of Grade 8 learners in a selected school in the Paarl area regarding the YDP and their HRB engagement pre-and post-implementation of the YDP.

CHAPTER TWO

2. Literature Review

2.1 Health Risk Behaviour

Health risk behaviour is behaviour or other factors that place a person at risk for disease. These diseases can include HIV/AIDS, diabetes, cancer, heart disease etc. It is an action that potentially threatens your health or the health of others. Daily habits like the foods you eat, the time you go to sleep and how much activity you engage in throughout the day have a significant influence on your health. Each of these behaviours positively or negatively affects you and dictates the overall state of your health (Waller, 2017).

Jackson et al., (2012) describes unhealthy risk-taking behaviour as driving too fast; texting or talking on the phone while driving, unprotected sex, smoking, excessive alcohol consumption, stealing, gang activity, or disordered eating.

According to the article "Family Solutions for Teen Help" (April 2012), high-risk behaviours are those that can have adverse effects on the overall development and well-being of youth, or that might prevent them from future successes and development. This includes behaviours that cause immediate physical injury (for example, fighting), as well as behaviours with cumulative negative effects (for example, substance use). Risk behaviours can also affect youth by disrupting their normal development or prevent them from participating in "typical" experiences for their age group. For example, teen pregnancy can prevent youth from experiencing typical adolescent events such as graduating from school or from developing close friendships with peers. High-risk behaviours can significantly impact the lives of youth and those around them. It is essential that parents, educators and other concerned adults become aware of the prevalence of these behaviours, the factors that increase their likelihood and what can be done to abate or prevent those risks.

The World Health Organisation (WHO) defines adolescence as the period from 10-19 years of age, which is a critical transitional period that includes the biological changes of puberty and the need to negotiate key developmental tasks, such as increasing independence and normative experimentation. It is the period characterised by physical, psychological and social changes and generally it is classified into two: early adolescence between 10-14 years

old, and late adolescence between 15-19 years old (WHO 2001, Adolescents: Health Risks and Solutions).

Early involvement in risk-taking has been found to result in the worst outcomes (Dryfoos, 1990). Most troublesome are risks taken in conjunction with other risks such as drinking and operating a motor vehicle or sexual activity without contraception; indeed, there is strong evidence that risk taking behaviours co-occur, taking place in a variety of domains (Irwin & Millstein, 1991).

The leading global risks for mortality in the world are high blood pressure (responsible for 13% of deaths globally), tobacco use (9%), high blood glucose (6%), physical inactivity (6%), and overweight and obesity (5%). These risks are responsible for raising the risk of chronic diseases such as heart disease, diabetes and cancers. They affect countries across all income groups: high, middle and low. Reducing exposure to these risk factors would increase global life expectancy by nearly 5 years (Mathers et al, 2001).

Risky sexual behaviour is commonly defined as behaviour that increases one's risk of contracting sexually transmitted infections and experiencing unintended pregnancies. They include having sex at an early age, having multiple sexual partners, having sex while under the influence of alcohol or drugs, and unprotected sexual behaviours (Centers for Disease Control and Prevention, 2010). Engagement in sexual behaviour is considered to be another group of high-risk behaviours for youth because of the potential physical (for example, STDs or sexually transmitted diseases) and socio-emotional risks they present. Youth may or may not be ready for the social and emotional implications of sexual activity, and many sexually active youths do not use safe sexual practices. Teens engage in sexual intercourse at a young age – 47% of youth nationwide. Among those who report engaging in sex, only 63% report having used a condom during their last intercourse and 17% report using alternative methods of birth control. Approximately half of the 19 million new STD cases diagnosed per year are of youth ages 15-19; and 13% of new HIV/AIDS diagnoses are of youth ages 13-24 years old. (Gutmacher Institute, 2006).

Smoking is a practice in which a substance is burned and the resulting smoke breathed in to be tasted and absorbed into the bloodstream. Most commonly the substance is the dried leaves of the tobacco plant which have been rolled into a small square of rice paper to create

a small, round cylinder called a "cigarette". Tobacco smoking is the most popular form, being practiced by over one billion people globally, of whom the majority are in the developing countries. Less common drugs for smoking include cannabis and opium, whereas other substances are classified as hard narcotics, like heroin, but the use of these is very limited, as they are usually not commercially available. Other smoking implements include pipes, cigars, bidis, hookahs and bongs. In the twentieth century, smoking came to be viewed in a decidedly negative light, especially in Western countries. Smoking substantially increases the risk of death from lung and other cancers, heart disease, stroke, chronic respiratory disease and other conditions. Globally, smoking causes about 71% of lung cancer, 42% of chronic respiratory disease and nearly 10% of cardiovascular disease. It is responsible for 12% of male deaths and 6% of female deaths in the world. Globally, at least one in ten adolescents aged 13 to 15 years old uses tobacco, although there are areas where this figure is much higher. Cigarette smoking seems to be decreasing among younger adolescents in some high-income countries (Lopez et al, 2004).

Worldwide, alcohol causes more harm to males (6.0% of deaths, 7.4% of DALYs) than females (1.1% of deaths, 1.4% of DALYs) reflecting differences in drinking habits, both in quantity and pattern of drinking. Besides the direct loss of health due to alcohol addiction, alcohol is responsible for approximately 20% of deaths due to motor vehicle accidents, 30% of deaths due to oesophageal cancer, liver cancer, epilepsy and homicide, and 50% of deaths due to liver cirrhosis. Alcohol is a drug and it is classed as a depressant, meaning that it slows down vital functions - resulting in slurred speech, unsteady movement, disturbed perceptions and an inability to react quickly. As for how it affects the mind, it is best understood as a drug that reduces a person’s ability to think rationally and distorts his or her judgment (Furby et al, 1992). Alcohol contributes to more than sixty types of disease and injury, although it can also decrease the risk of coronary heart disease, stroke and diabetes (Lopez et al, 2004).

Violence is defined by the World Health Organisation as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation", although the group acknowledges that the inclusion of "the use of power" in its definition expands on the conventional understanding of the word. This definition involves intentionality with the committing of the act itself, irrespective of the outcome it produces. However, generally, anything that is

excited in an injurious or damaging way may be described as violent even if not meant to be violence by a person and against a person (Krug et al., 2002).

Globally, violence resulted in the deaths of an estimated 1.28 million people in 2013 up from 1.13 million in 1990. Of the deaths in 2013, roughly 842,000 were attributed to self-harm (suicide), 405,000 to interpersonal violence, and 31,000 to collective violence (war) and legal intervention. In Africa, out of every 100,000 people, each year an estimated 60.9 die a violent death. Furthermore, violence often has lifelong consequences for physical and mental health and social functioning and can slow economic and social development (Global Burden of Disease, World Health Organisation, 2008).

Fighting and aggression include another group of self-injurious behaviours. It is second to vehicular accidents as the leading cause of death among those 15-34 years of age. Nationally, 36% of teens report having been involved in physical fighting over the last year with males (43%) outnumbering females (28%) dramatically. Similarly, both males and females reported carrying a weapon or a gun (19% nationally), however males (29%) outnumbered females (7%) significantly. Finally, suicide is one of the highest risk behaviours among youth today. Close to 17% (almost one out of every five) of youth report having considered suicide within the past year and 13% actually planned it (national and state numbers are similar). Among teens, 8.4% attempt suicide every year. Suicide now is the third leading cause of death among those ages 15-24, with 86% of those deaths from males and 14% from females (Gutmacher Institute, 2006).

A drug is any substance (other than food that provides nutritional support) that, when inhaled, injected, smoked, consumed, absorbed via a patch on the skin, or dissolved under the tongue causes a physiological change in the body (Stedman's Medical Dictionary. Retrieved 2014-05-01 – via Drugs.com). In pharmacology, a pharmaceutical drug, also called a medication or medicine, is a chemical substance used to treat, cure, prevent, or diagnose a disease or to promote well-being. Excessive use of stimulants can promote stimulant psychosis. Many recreational drugs are illicit and international treaties such as the Single Convention on Narcotic Drugs exist for the purpose of their prohibition (Bergström et al., 2014).
Illicit drug use is both a health and public concern because of the obvious negative physical effects it has on users. Effects of illicit drug use include, but are not limited to, brain damage and damage to major physical organs. It also has been linked to a host of other health

compromising behaviours such as risky driving, engagement in high-risk sexual behaviours, and violence. Recent estimates suggest that 22% of teens use marijuana and that 10% of teens used marijuana before the age of 13. Approximately 3% use cocaine. In recent years, methamphetamine use has become a serious concern in the United States. The low cost of the drug and the ease at which many youths are able to access this substance have contributed significantly to its rapid spread. The serious, immediate and long-term effects of methamphetamine have made it a top concern for many professionals and policy-makers. Today, about 3% of eighth graders, and over 4% of 10th and 12th graders report having tried or used methamphetamine nationally (Gutmacher Institute, 2006).

It is clear that the world faces some large, widespread and certain risks to health. The risk factors (for example, smoking, unsafe sex, drug usage) identified are responsible for one quarter of all deaths in the world. At the same time, dietary risk factors for high blood pressure, cholesterol and obesity, coupled with insufficient physical activity, are responsible for an increasing proportion of the total disease burden. Had the risks considered mentioned above not existed, life expectancy would have been on average almost a decade longer in 2004 for the entire global population. Evidence and research are already available for guiding policy decisions that could significantly improve global health (World Health Report: Reducing Risks, Promoting Healthy Life. Geneva, World Health Organisation, 2002).

Health risk behaviours such as alcohol and substance abuse, unplanned pregnancies and unprotected sexual activities, are practised by the South African youth at a seemingly alarming rate. The Medical Research Council Report on Mental Health and Substance Abuse, Pretoria (1998) recognised that substance abuse was one of the biggest health and social problems in South Africa. The report further states that 5,8% of the South African population 15 years and older were alcohol dependent, and the general adult level of intake of drugs, and especially alcohol, was progressively increasing. A national health risk survey that was carried out among adolescents Grade 8 to 11 by Reddy et al. (2010) showed with data pertaining to learners from Cape Town, that 31% engaged in alcohol abuse, 27% smoking cigarettes, and 7 % using cannabis. Among Grade 11 students, 58% of males and 43% of females were sexually active (Reddy et al., 2010).

In a study done by Pharaoh (2014), in Paarl amongst Grade 8 to10 learners the health risk behaviour engagement amongst the participants included the use of tobacco, alcohol and

other substances, unprotected sexual activity, poor dietary habits, physical inactivity, and other behaviours that contribute to unintentional injuries and violence. The results showed that learners were actively smoking (64.3%) and drinking (49.65%). A quarter of this sample used dagga (24.4%). The results pertaining to current use or engagement (last 30 days) showed that learners were actively smoking (36.2%), drinking (49.7%), and using "dagga" (14.8%). These findings show alarming increases compared to results from the 2008 South African Youth Risk Behaviour Survey (Reddy et al., 2010) among learners which indicated that 21% actively smoked and 10% used "dagga". Trends in alcohol use were similar despite efforts being made to educate the population on the prevention of health risk behaviours and the harmful effects of continued alcohol use. Understanding the role of these risk factors is important for developing clear and effective strategies for improving global health home countries (Mathers et al., 2001).

The results provide powerful input for policy actions when combined with information about interventions, their costs and their efficacy. Although risk exposure estimates are based on less-than-perfect data, they are often conservative because, as health improves, gains can multiply. For example, reducing the burden of disease in the poor may raise income levels, which, in turn, will further help to reduce health inequalities. Many cost-effective interventions are also known and prevention strategies can be transferred between similar countries (World Health Report: Reducing Risks, Promoting Healthy Life. Geneva, World Health Organisation, 2002).

2.2 Intervention Programmes in Health Risk Behaviours

According to WHO; Adolescents: Health Risks and Solutions (May 2017), there are many examples of effective policies and programmes that address adolescent health issues. They include: state graduated driver licensing programmes, teen pregnancy prevention programmes, violence prevention programmes, delinquency prevention programmes, mental health and substance abuse interventions, HIV prevention interventions, access to health services, disability and health, educational and community-based programs, injury and violence prevention, lesbian, gay, bisexual, and transgender health programmes. The second emerging issue is the increased focus on the use of positive youth development interventions for preventing adolescent health risk behaviours. Youth development interventions can be briefly defined as the intentional process of providing all youth with the support, relationships, experiences, resources, and opportunities needed to become successful and

competent adults. There is growing empirical evidence that well-designed youth development interventions can lead to positive outcomes. Ongoing, rigorous evaluation will determine what works, why it works, and how successful interventions can be applied.

In a study done by Jepson et al. (2010), the findings of a review of reviews of behavioural change interventions to reduce unhealthy behaviours or promote healthy behaviours were reported. Six different health-related behaviours were included in the review: healthy eating, physical exercise, smoking, alcohol misuse, sexual risk taking (in young people) and illicit drug use. The focus of interventions varied, but those targeting specific individuals were generally designed to change an existing behaviour (for example, cigarette smoking, alcohol misuse), whilst those aimed at the general population or groups such as school children were designed to promote positive behaviours (for example healthy eating). Almost 50% (n = 48) of the reviews focussed on smoking (either prevention or cessation). Interventions that were most effective across a range of health behaviours included physician advice or individual counselling, and workplace- and school-based activities.

Schools are critical settings for preparing students academically, they are also vital partners in helping young people take responsibility for their own health. School health programmes can help youth adopt lifelong attitudes and behaviours that support overall health and well-being-including behaviours that can reduce their risk for HIV and other sexually transmitted diseases (STDs). HIV/STD prevention programmes implemented by schools include prevention education programmes designed specifically to reduce sexual risk behaviours and youth asset-development programs, which provide adolescents with more general skills that help them engage in healthy behaviours and solve problems (CDC Healthy Youth School Connectedness: Strategies for Increasing Protective Factors Among Youth, CDC Youth Risk Behaviour Surveillance: Surveillance Summaries).

2.2.1 ***School health programmes***: according to the Centres of Disease, (2009) the youth's academic success is strongly linked with their health. Health related issues such as hunger, physical and emotional abuse and chronic illness can lead to poor school or academic performance. Health risk behaviours such as early sexual initiation, violence and physical inactivity are linked to poor grades and test scores and lower educational achievements. Academic success is an excellent indicator for the overall well-being of youth and a primary predictor and factor of adult health outcomes. Therefore, schools are the right place for a

health start and school health programs can have positive effects on educational outcomes, health risk behaviours as well as health outcomes (CDC, 2009). Schools play a critical role in promoting the health and safety of young people and helping them establish lifelong healthy behaviours. To establish and improve such programs it involves the school community as well as individuals, groups and organizations outside the school grounds.

2.2.2 ***Arts and Culture***: according to an evaluation of programme outcomes the Youth ARTS, 1995 showed that arts programmes can have an impact on the youth. Not only can the program enhance their attitudes about themselves and their future but it can also increase academic achievement and decrease criminal behaviour. The arts - whether they be during or after school - provide opportunities for youth from all backgrounds to do something positive with their talents and their time. (Janet Reno, Attorney General, Americans for the Arts, 1998).

According to Costello (1995) and Weitz (1996), a multi-component arts programme can provide at-risk youth and their families with numerous opportunities to build skills, enhance protective factors, and form community partnerships that help to prevent delinquency and violence while making a positive impact, not just in the youth and their families but also in their communities. Youths at risk are learners who have problems such as drug and/or alcohol abuse or are in trouble with the law. Their emotional and/or behavioural problems are barriers to their learning and development. In the Western Cape, there are five levels of support to prevent or resolve such problems. The type of support and the restrictions that may be placed on the learner depend on the nature of the problem. Interventions include educational, therapeutic and/or residential support services. The five levels of support are:

Level 1: Prevention in all schools

An early warning system, aimed at identifying children and families who may be particularly vulnerable, is implemented in all schools. Every effort is made in the classroom to prevent emotional and/or behavioural difficulties from occurring or worsening.

Level 2: Early intervention in all schools

Emotional support and guidance are provided for learners who are struggling with emotional and/or behavioural barriers to learning in the classroom.

Level 3: Schools-based support programmes

School-based support programmes, youth development programmes and deliberate intervention are provided for learners who are identified as being at risk of being expelled from school, being placed away from home, or entering the criminal justice system, and for whom temporary withdrawal from the classroom is necessary.

Level 4: Youth care and education centres

Where the learner does not benefit adequately from the support programme, referral to a residential or developmental programme at a youth care and education centre may be considered. The principle of using the least restrictive and most empowering (normative) environment applies throughout the system. Young people are referred to these centres in accordance with the relevant legislation. The centres provide accommodation and a structured programme. The framework for good practice in these institutions is based on the standards laid down by the United Nations Convention on the Rights of the Child.

These standards aim to:

- Build the capacity of educators and principals to meet the challenges of dealing with learners experiencing, or at risk of experiencing, emotional and/or behavioural barriers to their development.
- Improve services to learners at risk.
- Ensure the safety, education and development of these learners.

There are four youth care and education centres in the Western Cape:

- Faure Youth Care Centre
- Die Bult Youth Care Centre
- Ottery Youth Care Centre
- Wellington Youth Care Centre

Level 5: Special youth care and education centres

Special care is provided to young people who are in conflict with the law or in severe emotional turmoil and who may need to be physically, emotionally and/or behaviourally contained. Young people are referred to these centres by the courts under the relevant legislation for compulsory residence. Each young person is provided with an individual development plan to help him or her to be rehabilitated. A psychologist, occupational

therapist, professional nurse and social worker are available at the centre for consultation. The educators are specially trained in child care theory and practice. There are two such youth centres in the Western Cape:

- De Novo Special Youth Care Centre
- Eureka Special Youth Care Centre

(Specialised Education Support Services: Western Cape Education Department, Western Cape Government, 2013).

2.3 Youth and positive life skills development

Life skills have been defined by the WHO as "abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life". They represent the psycho-social skills that determine valued behaviour and include reflective skills such as problem-solving and critical thinking, to personal skills such as self-awareness and to interpersonal skills. Practicing life skills leads to qualities such as self-esteem, sociability and tolerance, to action competencies to act and generate change, and to capabilities to have the freedom to decide what to do and who to be. Life skills are thus distinctly different from physical or perceptual motor skills, such as practical or health skills, as well as from livelihood skills, such as crafts, money management and entrepreneurial skills. Health and livelihood education however, can be designed to be complementary to life skills education, and vice versa (WHO, 1996).

Advocates for Youth's popular family life education programme, "Life Planning Education: A Youth Development Programme", includes chapters on sexuality, relationships, health, violence prevention, and community responsibility as well as chapters on skills-building, values, self-esteem, parenting, employment preparation, and reducing sexual risk. Packed with interactive exercises, supplemental leaders' resources, participant handouts, and a complete guide to implementation, this resource is appropriate for use in schools and other settings for sexuality/life skills education, HIV prevention education, and pregnancy prevention and is for use with youth ages 13 to 18 years old (Hunter, 1995).

These programmes can benefit young people. Mentoring is often one component of a programme that involves other elements, such as tutoring or life skills training and coaching. The supportive, healthy relationships formed between mentors and mentees are both immediate and long-term and contribute to a host of benefits for mentors and mentees.

Benefits for youth:

- Increased high school graduation rates
- Lower high school dropout rates
- Healthier relationships and lifestyle choices
- Better attitude about school
- Higher college enrolment rates and higher educational aspirations
- Enhanced self-esteem and self-confidence
- Improved behaviour, both at home and at school
- Stronger relationships with parents, teachers, and peers
- Improved interpersonal skills
- Decreased likelihood of initiating drug and alcohol use (MENTOR, 2009; Cavell, DuBois, Karcher, Keller, & Rhodes, 2009).

Benefits for mentors:

- Increased self-esteem
- A sense of accomplishment
- Creation of networks of volunteers
- Insight into childhood, adolescence and young adulthood
- Increased patience and improved supervisory skills (U.S. Department of Labor, n.d.)

Mentoring can help youth as they go through challenging life transitions, including dealing with stressful changes at home or transitioning to adulthood. Close, healthy, supportive relationships between mentors and mentees that last for a significant portion of time (that is, more than one year) are central to success. Without this, mentoring programmes run the risk of harming young people who are paired with mentors ill-equipped to meet the mentees' needs. Specifically, relationships with mentors that last less than three months; where there is irregular and inconsistent contact; where there is a disconnect between the personalities, interests, and expectations of the mentors and mentees; where mentors are unprepared and lack skills to relate to youth; and where there is no emotional bond between the mentor and mentee have been found to be harmful to youth (Jekielek et al., 2002; Rhodes & DuBois, 2006).

Building life skills in children and adolescents and providing them with psycho-social support in schools and other community settings can help promote good mental health.

Programmes to help strengthen the ties between adolescents and their families are also important. If problems arise, they should be detected and managed by competent and caring health workers (Department of Psychiatry, University of Pittsburgh Medical Center, 2015).

Promoting nurturing relationships between parents and children early in life, providing training in life skills and reducing access to alcohol and firearms can help to prevent injuries and deaths due to violence. Effective and empathetic care for adolescent survivors of violence and ongoing support can help deal with the physical and psychological consequences (McNeely & Blanchard, 2009: The Teen Years Explained: A Guide to Healthy Adolescent Development). Academic success and achievement are strong predictors of overall adult health outcomes. Proficient academic skills are associated with lower rates of risky behaviours and higher rates of healthy behaviours. High school graduation leads to lower rates of health problems and risk for incarceration, as well as enhanced financial stability during adulthood. The school social environment affects students' attendance, academic achievement and behaviour. A safe and healthy school environment promotes student engagement and protects against risky behaviours and dropping out (Marin, & Brown, The School Environment and Adolescent Well-Being: Beyond Academics. Washington, DC: Child Trends; 2008).

The World Health Organisation (1999) suggested that life skills are important for healthy development and preparation of adolescents for their future. According to the WHO (1999), teaching life skills is essential for the promotion of a healthy child and adolescent development and for preparing young people for their changing social circumstances. Sport psychologists have argued that life skills can be taught in combination with athletic skills in sport contexts (Danish & Nellen, 1997). From this point of view, life skills are identified as skills that are required to deal with the challenges and demands that life throws at you (Hodge & Danish, 1999). These can be physical (for example, taking the right posture), behavioural (for example, communicating effectively) or cognitive (for example, making effective decisions) and can be transferable to other life domains (Danish & Donohue, 1995). These skills include the ability to perform under pressure, problem solving, critical and creative thinking, goal setting, handle both success and failure, communicate effectively, build healthy relationships, receive feedback and benefit from it. Life skills are similar to physical skills in the manner they are learned through demonstration and practice. Sport is a universal activity throughout our society. Life skills can thus be used to prevent or reduce high-risk

behaviours. Botvin Life Skills Training (LST) targets the primary psychosocial factors that facilitate substance use and other high-risk or antisocial behaviours. LST does not just focus on the dangers of alcohol and other drugs but also provides young people with the necessary skills to navigate challenging situations that expose teens to substances and other health risks. The learning objectives are:

- To teach students the necessary skills to resist peer pressures to smoke, drink and use drugs;
- To help students develop greater self-esteem and self-confidence;
- Build capacity for effective coping mechanisms with anxiety;
- Education about the immediate consequences of substance abuse;
- Improve cognitive and behavioural competency to reduce and prevent high-risk health behaviours (Botvin & Griffin, 2015).

Life Skills Training (LST) has been seen as an effective tool to reduce high-risk behaviour which includes: tobacco, alcohol, illegal drug use and other risk behaviours through a school-based prevention programme. The programme suggests the potential for fostering academic success and the reduction in health risk behaviours and it is claimed to have long term effectiveness (Botvin & Griffin, 2015). The LST programme provides knowledge, attitudes and the necessary skills which contributes to the ability to resist certain social influences. The program was designed to target social and interpersonal factors (Botvin & Griffin, 2015). There are three major components of the LST programme which includes: a personal component that teaches skills for self-management, a social competence component teaching social skills and a drug resistance component that teaches pro-health attitudes, health related content and resistance skills (Botvin & Griffin, 2015).

2.4 In Summary

Health risk behaviours is a problem among the youth globally; in Africa, South Africa, the Western cape and Paarl according to literature review. Interventions are needed and are implemented, but not enough research to show impact to build on the successes and to learn from non-successes, therefore research needed to ascertain the impact of youth development programmes.

To prevent disease and injury, it is necessary to identify and deal with their causes – the health risks that underlie them. Each risk has its own causes too, and many have their roots in

a complex chain of events over time, consisting of socio-economic factors, environmental and community conditions and individual behaviour. The two major approaches to reducing risk are: targeting high-risk people, who are most likely to benefit from the intervention and targeting risk in the entire population, regardless of each individual's risk and potential benefit (Mathers et al., 2001).

Rutter et al. (2002) reported that social psychological theories such as social cognition theory are commonly used in the development of interventions. Key elements of such theories include knowledge of health risks, perceived self-efficacy, goals and motivations and barriers and facilitators. Most health promotion interventions include one or more of the following components: education and knowledge building (around the health issue); motivation and goal setting (for example, alcohol brief interventions and counselling); and community-based techniques to encourage a change in behaviour or reduce structural or cultural barriers. These interventions can be delivered at three different levels, which were explored: individual, community and population level interventions. Individually targeted interventions are usually aimed at those with an existing 'risky' behaviour such as smoking or alcohol misuse. Community-level interventions focus on particular population groups such as people in a particular workplace or young people in schools. Finally, population level interventions tend to rely on the use of mass media activities, policies or legislation (Bandura A, 2004).

Mass media campaigns and legislative interventions have showed small to moderate effects in changing health behaviours. Generally, the evidence related to short-term effects rather than sustained or longer-term impact and there was a relative lack of evidence on how best to address inequalities. It is encouraging that there are interventions that are effective in achieving behavioural change. Further emphasis in both primary studies and secondary analysis (for example, systematic reviews) should be placed on assessing the differential effectiveness of interventions across different population subgroups to ensure that health inequalities are addressed. Halpern et al. (2004), reported that most public health and health promotion interventions - whether they focus on the individual, community, whole populations or the environment - seek in some way to change health behaviour by changing health-related knowledge, attitudes and/or structural barriers and facilitators.

Interventions aiming to achieve long-term, sustained behaviour change will require a different approach to evaluation. Currently, the majority of studies have a relatively short

period of follow-up, with the longest usually no more than two years. In order to determine long-term effectiveness, there is a need to develop longitudinal studies that can run alongside the intervention and revisit the participants at several time points, charting the challenges to sustaining the healthy behaviours and learning from those who have successfully maintained new, healthful habits. This would enable policy makers and those delivering the interventions to gain a deeper understanding of the strengths and weaknesses of the intervention, with a view to improving the effectiveness of future intervention (Jepson et al., 2010).

CHAPTER THREE

3. Methodology

3.1 Research Setting

The study was conducted in a selected high school in Paarl area amongst Grade 8 learners. The town, Paarl, is one of the most densely populated areas with ± 112 045 inhabitants. Ages between 0-14 years of age are made up 24,4% of the total population and ages between 15-64 years of age made up 69,2% and the elderly (65+) make up 6,4% (Census 2016 Municipal Report, Western Cape). Paarl is classified as peri-urban which is defined where rural and urban features co-exist, in environmental, socio-economic and institutional terms (Allen, Dávila & Hofmann, 2006b). This setting was thought appropriate due to the large youth population. Paarl East area is considered where high risk behaviour take place (Community Safety Departments of the Western Cape) and this area is chosen as the appropriate setting.

3.2 Research Design

To address the research question, the study made use of a sequential explanatory study design where both qualitative and quantitative data collections were used. According to Creswell, Clark, Gutmann and Hanson (2003), in this approach, the results from one method are used to help develop or inform another method. Data was collected through self-administrated questionnaires (YRBSS) which informed the structure of the interview guide for the qualitative data collection process. The qualitative data was collected and analysed second in the sequence, and help explain, or elaborate on the quantitative results obtained in the first phase. Focus group discussions (20 females), (10 males) and (mixed group – male and female) took place to explore the views of Grade 8 learners in a selected school in the Paarl area regarding the YDP and their HRB engagement pre-and post-implementation of the YDP.

3.3 Study Population and Sampling

All five high schools in Paarl were invited to partake in this study but only one responded, therefore the study only included the grade 8 learners of one high school. There were 250 learners registered for Grade 8 in the selected school. All the registered learners were invited to partake in the study and all those who gave written assent and received consent from their parents, 178 in total became participants in the research study. On the day of data collection,

152 learners were present but only 107 questionnaires were completed pre- implementation and used in the study. Post-implementation, 174 questionnaires were completed and used in the study. On completion of the quantitative section of the study, participants were selected to form part of the focus group discussions through purposive sampling. FGD's were held post implementation of the YDP during recess of school hours on the school premises in a safe, secure and private classroom that was made available on the day. The learners that participated in the YDP were invited to form part of the FGD's and all interviews were conducted on the same day. Four groups of ten participants were selected based on the following representation: i) Gender; ii) Age; iii) Representation per class (Grade 8 divided into five different classes). The four groups were divided into a male group (10), two female groups (20) and a mix group of males and females.

3.4 Data Collection and Procedure

3.4.1 Procedure

Following permission from the Higher Degrees Committee UWC, the Research Committee UWC, the Western Cape Education Department, the Principal and Governing Body of the school, appointments were made with the school principal and teachers and appropriate times were set up for the administration of the questionnaires. Information sheets, informed consent and assent forms were given to the teachers to give to learners to distribute to their parents to obtain parental consent and learner assent. In this manner, parents can feel comfortable with the knowledge that the school supported the research being conducted. The researcher can be contacted if clarity was needed regarding the research. The volunteered teachers attended a training session with the researcher in order to become familiar with the questionnaires to discuss or ask questions regarding the instruments or the procedures that followed. Prior to administering of the questionnaires, learners had to provide informed assent. The researcher explained the study and the need for participation to the principal, teachers and learners. The questionnaires were administered in class by either the researcher or educators who went for the training of the process.

3.4.2 Questionnaire (YRBSS)

The YRBSS were already within studies in South Africa and globally. Reddy et al., 2008, has reported that this measure has been used with good success in South Africa in the National

Youth Risk Behaviour Survey and deemed appropriate for use with this sample. Baseline information regarding health risk behaviours were obtained by using the Youth Risk Behaviour Surveillance Survey (YRBSS) (CDC 2002). The YRBSS is an instrument that monitors the priority of health risk behaviours that contribute to chronic lifestyle diseases or death (Centre for Disease Control and Prevention, 2002). This structured self-administrated questionnaire was used to collect the quantitative data. The questionnaire consists of 98 questions which cover areas pertaining to demographic details and health risk behaviour. The area pertaining to the health risk behaviours were divided under headings in the questionnaire with the total in brackets indicating the amount of questions covered under the respective heading. The YRBSS reported acceptable reliability with internal consistency ranging from .61 to 1 (Brener, Kann, McManus, Kinchen, Sundberg & Ross, 2002) indicating that the measures are reliable and appropriate for use in research (Foxcroft & Roodt, 2013).

The data collection tool is written in English but most of the learners first language is Afrikaans therefore questions were asked in Afrikaans and transcribed to English as most people in the Paarl area are Afrikaans speaking. The recordings were transcribed and translated by the researcher immediately post interviews.

The pre-testing through the use of the questionnaire took place during May and June 2017. The implementation of the Youth Development Programme (YDP) commenced during July and September 2017. Immediately following completion of the YDP during October-November 2017 post-testing of the health risk behaviour engagement of the learners was conducted using the same tool (questionnaire) as during the pre-testing.

3.4.3 Focus Group Discussions

This type of research (Webster, 1992) relies on words and observations to express reality and attempts to describe people in natural settings and environments. As a research tool, focus groups are designed to gather the experiences and perceptions of selected target populations on a particular topic. Semi-structured interviews were developed based on the assistance of the results of the surveys. Focus group discussions of four groups, namely twenty females

only, ten males only and a mixed group, Grade 8 learners at a selected school in the Paarl area regarding the YDP and their HRB engagement pre-and post-implementation of the YDP. Two researchers were involved in the FGD's, one facilitator and the other one made notes and observations. The focus group discussions were recorded and transcribed verbatim and translated from Afrikaans to English soon after the interviews. To ensure trustworthiness of the data captured, member checking was done with the group to verify recorded responses. Participation is voluntary and anonymous and learners could choose to partake or not or they could withdraw at any stage without any consequences. A detailed explanation of the purpose of the study was provided beforehand and throughout the study. Confidentiality was assured. The participants in the focus group discussions signed a disclosure statement for confidentiality purposes to make them aware of the ethical procedures in advance. This study also involved the making of audiotapes during the FGD. For confidentiality purposes, all tapes were stored in a locked filing cabinet, which only the researcher had access to.

Immediately following completion of the YDP during October and November 2017, focus group discussions were done to explore the views of Grade 8 learners in the selected school in the Paarl area regarding the YDP and their HRB engagement pre-and post-implementation of the YDP. For the purpose of this research study, it will only have these once-off measures. The bigger study will do post-implementation measurements twelve months and two years post-implementation, in order to measure longer term impact of the YDP.

3.5 Data Analysis

The quantitative data that was collected pre-and post-implementation was coded and captured on the Statistical Package for Social Sciences (SPSS) version 24. Data was analysed by means of descriptive and inferential statistical (T-test) tests and it was conducted to obtain a profile of the study population and present the results of the demographic information of the participants. This included percentages, standard deviations (SD), standard errors of the mean (SEM) and 95% confidence intervals (CI). Results were depicted in the form of tables, graphs and narration. Descriptive statistics from the YRBSS were used to depict the health risk behaviours by using frequencies and percentages to assess whether there were significant differences in the engagement in health risk behaviours as stated by the pre-and post-test respectively. Focus group discussions were conducted to explore the views of the current challenges experienced by learners regarding the impact of the YDP regarding their HRB

engagement and the facilitators or barriers they might or might not have encountered. Cross-tabulations were done with regard to the health risk behaviours mentioned in the survey. The cross-tabulations looked at the distributions across the intersection of age and gender per health risk behaviour. The results were tabularised and presented per HRB. The FGD's were recorded and transcribed verbatim and translated from Afrikaans to English soon after the interviews. The data was then expanded on the findings from the survey.

3.6 Validity and Reliability

The YRBSS has been used in studies globally and in South Africa (Brener et al. 2002; Neill, Marsh & Richards,1997), indicating that the measures are reliable and appropriate for use in research (Foxcroft & Roodt, 2013). Validity refers to the extent to which an instrument measures what it is supposed to be measuring (Sarantakos, 1997; 2000). Reliability is referred to as the ability of the research instrument to produce consistent results, when the results are repeated on more than one occasion (Sarantakos, 2005). A questionnaire is a self-administered tool, therefore, relying on the participants to complete it to the best of their ability and with honesty.

3.7 Trustworthiness

According to Lincoln & Guba, (1985) the purpose of trustworthiness in qualitative research is to support the argument that the inquiry's results are "worth paying attention to". The four aspects of trustworthiness involve credibility, transferability, dependability and confirmability and are relevant to both quantitative and qualitative studies which were adhered to. In order to address credibility, all stakeholders were invited to provide internal consistency, to participate and contribute to the study by obtaining data relevant to the research topic. Although Lincoln & Guba, (1985), suggested that it does not meet the definition of "triangulation", this technique provided richer and more credible data set than if information was only obtained from one source. Member checking was done during the FGD's and the participants had the opportunity to review the summary of the final results of the interviews. In order to address transferability, the data analysis documents were filed but was also available upon request by stakeholders. To address the issues of dependability and conformability, the researcher depended on an independent audit of the research methods by competent peers, the supervisors of the study. All information gathered was thoroughly

examined by the supervisors and this included the original transcripts, data analysis documents, comments from the member checking and the text of the study itself.

3.8 Ethical Considerations

Ethical clearance was requested from the University of the Western Cape Research Committee and the Higher Degrees Committee of the University of the Western Cape. Ethics approval number HS/17/1/35. Permission to conduct the study was obtained from the Department of Education, Western Cape, Principles and governing bodies of the selected school involved. Informed written consent was obtained from the parents and informed assent from the learners. Appointments with the school principal and teachers were made and appropriate times were set up for the administration of the questionnaire. Learners were informed that participation is voluntary and anonymous and they that they could choose to partake or not, or they could withdraw at any stage without any consequences. A detailed explanation of the purpose of the study was provided beforehand and throughout the study. The participants in the FGD's signed a disclosure statement for confidentiality purposes to make them aware of the ethical procedures in advance. This study also involved the making of audiotapes during the FGD. To protect the participant's confidentiality, all tapes were stored in a locked filing cabinet which only the researcher had access to. All relevant stakeholders received the results of the study.

According to literature, the National Youth Development Policy Framework (2002-2007), youth development is an integral part of addressing the challenges of post-Apartheid South Africa. In devising policies and programmes for the development of all South Africans the integration of issues and the specific challenges faced by young people is essential. Youth development is part of building a non-sexist, non-racist, democratic South Africa and it should be approached in a similar manner and with similar vigour as other crucial areas in need of transformation, that is, disability, gender and economic participation. This should be done in line with Government's broad approach to fundamentally address poverty and under-development through comprehensive, integrated, cross-sectoral and sustainable policies and programmes. Youth development in SA should be addressed in an environment where all stakeholders, including young people themselves, work towards common goals. It should demonstrate the distinctive and complementary roles of all ministries and departments, the

private sector, civil society, non-governmental organisations, youth groups and young people. The implementation of youth development programmes is the responsibility of all the institutions of government. To this end, much of the responsibility for planning, six coordinating and initiating effective and innovative strategies for youth development will rest equally with the National Youth Commission and individual government departments at the national, provincial and local spheres, forming the basis for the development of action plans and programmatic interventions at national, provincial and local spheres. An important departure point for youth development lies in the active involvement of young people in national development. Young women and men are not only a major resource to and inheritors of future society, but they are also active contributors to the nature of society today. Youth development provides a foundation and mechanism for youth participation in socio-economic development whilst recognising that young people should be protagonists of their own development and not merely recipients of government support. By placing young people and their development in the broader context of reconstruction and development, common developmental goals and a spirit of cooperation and co-ordination is encouraged. Youth development should be approached from a perspective that encourages an understanding amongst young men and women of the processes of governance and provides opportunities for their participation in national, provincial and local programmes.

The National Youth Development Policy Framework establishes national goals and central objectives. While the Youth Development Policy Framework is not prescriptive, it does establish principles for youth development and identify strategic intervention areas. Whilst individual departments will need to tailor their strategies and programmes within their areas of responsibility, there are nevertheless ground principles which should inform the processes of planning and implementation. Broadly speaking this includes the promotion of youth development through integrated planning and service provision and raising awareness of the centrality and integral nature of youth development with all clients and stakeholders in the private sector and civil society. The National Youth Development Policy Framework addresses youth development across all sectors. It endeavours to ensure that all young women and men are given meaningful opportunities to reach their full potential, both as individuals and as active participants in society. The Policy Framework highlights the major concerns and issues critical to the youth and gives direction to youth programmes and services provided by government and non-governmental organisations.

CHAPTER FOUR

4. INTRODUCTION

Chapter Four sets out to meet objectives one to three: 1) to determine the HRB engagement of Grade 8 learners in a selected school in the Paarl area prior to the implementation of the designed YDP; 2) to determine the HRB engagement of the Grade 8 learners in a selected school in the Paarl area post implementation of the designed YDP; 3) to explore the views of Grade 8 learners in a selected school in the Paarl area regarding the YDP and their HRB engagement pre-and post-implementation of the YDP.

4.1 Results for Baseline Data

4.1.1 Response Rate

A total of 250 Grade 8 learners were registered for 2018; 178 learners who consented to participate in the study filled out the questionnaires but only 107 (60%) were completed on the day and used in the study; 71 (40%) questionnaires were incomplete and not used. An overall response rate of 60% pre-implementation was achieved in this study.

4.2 Demographic Information

The mean age of the learners was 17,8 years old**.** The majority of the Grade 8 learners were aged 14 years (n=56, 52.3%) and 15 years (n=21, 19.6%) old, followed by 13 years (n=20, 18.7%) and 16 years (n=7, 6.5%) with 12 years and 17 years old (n= 1, 0.9%) respectively. The gender composition was unequal, with male learners comprising n=38, 35.5% and female learners n=67, 62.6%. The majority (79.4%, n=85) of the sample self-identified as ‘coloured’ using the racial categories from the South African population. 43.9% of the learner’s lives with both parents, while 34.6% only lives with a mother and 1.9% only lives with a father. 29% of the learners does not partake in any extra mural activities while 44% partake in sports.

Table 1. Demographic Information (n=107)

Variable	Frequencies	Percentage
Gender		
Female	67	62.6
Male	38	35.5
Missing	2	1.9
Total	107	100
Age		
12 years old	1	0.9
13 years old	20	18.7
14 years old	56	52.3
15 years old	21	19.6
16 years old	7	6.5
17 years old	1	0.9
Missing	1	0.9
Total	107	100
Race		
White	5	4.7
Black	9	8.4
Coloured	85	79.4
Indian	0	0
Missing	8	7.5
Total	107	100
Who do you live with?		
Mother and father	47	43.9
Mother	37	34.6
Father	2	1.9
Grandparents	18	16.8
Guardian	2	1.9
Missing	1	0.9
Total	107	100
Extra mural activity participation		
Youth group	14	13.1
Scouts	1	0.9
Sports	44	41.1
Arts	13	12.1
None	31	29.0
Missing	4	3.7
Total	107	100

4.3 Health Risk Behaviours

Objective one was to determine the HRB engagement of Grade 8 learners in a selected school in the Paarl area prior to the implementation of the designed YDP. Of the learners (107) that participated in the study, the majority gender was females (67), with the majority age group of 14 years old (56). Health risk behaviour engagement amongst the participants showed that 50.5% smoked, 56% drank alcohol, 21.5% have used dagga, 8.4% have used cocaine, 12.1% were sexually active, 68% were physically active and 54.2% were in a physical fight during the past twelve months.

Table 2: Frequency Distribution for engagement in Health Risk Behaviour (n=107)

Health Risk Behaviour	Responses	Frequency	Percentage %
Smoking	Yes	54	50.5
	No	53	49.5
	Missing	0	0
Drinking	Yes	60	56
	No	47	43.9
	Missing	0	0
Drug use: Dagga	Yes	23	21.5
	No	84	78.5
	Missing	0	0
Cocaine	Yes	9	9.4
	No	97	90.7
	Missing	1	0.9
Sexual activity	Yes	13	12.1
	No	91	85
	Missing	3	2.8
Physical activity	Yes	73	68
	No	34	31.8
	Missing	0	0
Violence related behaviour (physical fight)	Yes	48	54.2
	No	58	44.8
	Missing	1	0.9

Table 2 depicted the frequency distribution for engagement in health risk behaviour that the Grade 8 learners engaged in. The data was summarised according to the major HRB's:

smoking, alcohol use, drug use, sexual activity, physical activity and violence related behaviour. Below these HRB's were unpacked in order to demonstrate their engagement.

Table 3: Smoking (n=107)

The learners indicated at what age they smoked a whole cigarette for the first time and it was reported during the following ages: it was indicated that 5 learners already started smoking at age 8 years or younger, although the majority (59) of the learners did not smoke (55.1%), the majority learners, 20.6% smoked between the age of 13-14 years old. Thirty-eight (35.5%) of the learners indicated that they smoked during the past 30 days prior to the survey and ten (9.3%) of those learners reported that they smoked all 30 days. Twenty-four (22.4%) learners reported that they bought cigarettes in a store. Twenty-three learners smoked on the school property during the past 30 days ranging from one to two days (14 learners) to all 30 days (2 learners).

Question	Choices	Frequency n (%)
How old were you when you smoked a whole cigarette for the first time?	Missing	1 (0.9%)
	I have never smoked a whole cigarette	59 (55.1%)
	8 years old or younger	5 (4.7%)
	9 or 10 years old	5 (4.7%)
	11 or 12 years old	10 (9.3%)
	13 or 14 years old	22 (20.6%)
	15 or 16 years old	3 (2.8%)
	17 years old or older	2 (1.9%)
During the past 30 days, on how many days did you smoke cigarettes?	Missing	0 (0%)
	0 days	59 (55.1%)
	1 or 2 days	26 (24.3%)
	3 to 5 days	9 (8.4%)
	6 to 9 days	2 (1.9%)
	10 to 19 days	1 (0.9%)
	All 30 days	10 (9.3%)
During the past 30 days, how did you usually get your own cigarettes?	Missing	9 (8.4%)
	I did not smoke	60 (56.1%)
	I bought them in a store	24 (22.4%)
	Bought from a vending machine	2 (1.9%)
	I gave someone else money to buy them for me	5 (4.7%)

	I borrowed (or bummed) them from someone else	1 (0.9%)
	A person 18 years old or older gave them to me	3 (2.8%)
	I took them from a store or family member	1 (0.9%)
	I got them some other way	2 (1.9%)
During the past 30 days, on how many days did you smoke cigarettes on school property?	Missing	1 (0.9%)
	0 days	83 (77.6%)
	1 or 2 days	14 (13.1%)
	3 to 5 days	2 (1.9%)
	6 to 9 days	3 (2.8%)
	10 to 19 days	2 (1.9%)
	All 30 days	2 (1.9%)

Table 4: Alcohol Use (n=107)

Table 4 pertains to the engagement of learners with alcohol drinking. The age distribution was as followed: 13-14 years old was the majority age for engagement with alcohol, namely thirty-two learners (30%) in total. Fifty-one (47,6%) of the learners engaged in alcohol drinking the 30 days prior to the survey. Seventeen (15.9%) learners reported that they bought the alcohol in a store. Thirteen learners had a drink on school property during the past 30 days.

Questions	Choices	Frequency
How old were you when you had your first drink of alcohol other than a few sips?	Missing	1 (0.9%)
	I have never had alcohol	45 (42.1%)
	8 years old or younger	5 (4.7%)
	9 or 10 years old	6 (5.6%)
	11 or 12 years old	13 (12.1%)
	13 or 14 years old	32 (29.9%)
	15 or 16 years old	5 (4.7%)
During the past 30 days, on how many days did you have at least one drink of alcohol?	Missing	0 (0%)
	0 days	56 (52.3%)
	1 or 2 days	29 (27.1%)
	3 to 5 days	10 (9.3%)
	6 to 9 days	2 (1.9%)
	10 to 19 days	4 (3.7%)

	20 to 29 days	1 (0.9%)
	All 30 days	5 (4.7%)
During the past 30 days, how did you usually get the alcohol you drank?	Missing	3 (2.8%)
	I did not drink alcohol	61 (57%)
	I bought it in a store	17 (15.9%)
	I bought it at a restaurant, bar, or club	3 (2.8%)
	I bought it at a public event such as a concert or sporting event	3 (2.8%)
	I gave someone else money to buy it for me	2 (1.9%)
	Someone gave it to me	14 (13.1%)
	I took it from a store or family member	2 (1.9%)
	I got it some other way	2 (1.9%)
During the past 30 days, on how many days did you have at least one drink of alcohol on school property?	Missing	0 (0%)
	0 days	94 (87.9%)
	1 or 2 days	8 (7.5%)
	3 to 5 days	1 (0.9%)
	6 to 9 days	2 (1.9%)
	20 to 29 days	1 (0.9%)
	All 30 days	1 (0.9%)

Table 5: Dagga / Hashish Use (n=107)

Table 5 reports on the exposure of learners concerned with dagga/ hashish use. The majority of learners (n=14) were exposed to dagga use between the ages of 13-14 years, however, four learners indicated being aged 8 or younger and four learners being between the age of 9-12 years old. Thirteen learners used dagga 1 or 2 times during the past 30 days, four used dagga 3-9 times, one used dagga 10-19 times and three used dagga 40 or more times during the past 30 days. Twelve learners used dagga on school property.

Questions	Choices	Frequencies (%)
How old were you when you tried dagga / hashish (marijuana) for the first time?	Missing	3 (2.8%)
	I have never tried marijuana	82 (76.6%)
	8 years old or younger	4 (3.7%)
	9 or 10 years old	1 (0.9%)
	11 or 12 years old	3 (2.8%)
	13 or 14 years old	14 (13.1%)

During the past month (30 days), how often did you use dagga / Hashish (marijuana	Missing 0 times 1 or 2 times 3-9 times 10-19 times 40 or more times	1 (0.9%) 85 (79.4%) 13 (12.1%) 4 (3.7%) 1 (0.9%) 3 (2.8%)
During the past 30 days, how many times did you use dagga / Hashish (marijuana on school property?	Missing 0 times 1 or 2 times 3-9 times 10-19 times 40 or more times	2 (1.9%) 93 (86.9%) 8 (7.5%) 1 (0.9%) 2 (1.9%) 1 (0.9%)

Table 6: Drug Use (Cocaine): (n=107)

Table 6 shows the engagement or exposure of learners regarding any form of cocaine, including powder, crack, or freebase. During the past 30 days, seven learners used it for 1-2 times. Six learners have been exposed to methamphetamines, seven learners have taken steroid pills or injections without a prescription from a doctor, nine learners used a needle to inject illegal drugs into their bodies and eighteen learners have used illegal drugs on school property.

Questions	Choices	Frequency (%)
During the past 30 days, how many times did you use any form of cocaine, including powder, crack, or freebase?	Missing 0 times 1 or 2 times 3 to 9 times 40 or more times	2 (1.9%) 93 (86.9%) 7 (6.5%) 4 (3.7%) 1 (0.9%)
During your life, how many times have you used methamphetamines (also called speed, crystal, crank, or ice)?	Missing 0 times 1 or 2 times 3 to 9 times 10 to 19 times 20 to 39 times	0 (0%) 96 (89.7%) 6 (5.6%) 3 (2.8%) 1 (0.9%) 1 (0.9%)
During your life, how many times have you taken steroid pills or shots without a doctor's prescription?	Missing 0 times 1 or 2 times 20 to 39 times	3 (2.8%) 97 (90.7%) 6 (5.6%) 1 (0.9%)

During your life, how many times have you used a needle to inject any illegal drug into your body?	Missing 0 times 1 time 2 or more times	2 (1.9%) 96 (89.7%) 5 (4.7%) 4 (3.7%)
During the past 12 months, has anyone offered, sold, or given you an illegal drug on school property?	Missing Yes No	1 (0.9%) 18 (16.8%) 88 (82.2%)

Table 7: Sexual Behaviour (n=107)

In Table 7 it is shown the engagement for sexual behaviour. The first age of sexual intercourse has been reported by the learners as follows: seven learners reported being 11 years or younger; one learner 12 years old; three learners 13 years old; five learners 14 years old; four learners 15 years old and one learner 16 years old. Twelve learners reported that they had sex with at least one person, eight learners reported that they used alcohol or drugs before they engaged in sexual behaviour. Nineteen learners reported that they did not use a condom during their last sexual encounter. Further, four learners reported that no method was used during sex to prevent pregnancy.

Question	Choice	Frequency
How old were you when you had sexual intercourse for the first time?	Missing I have never had sexual intercourse 11 years old or younger 12 years old 13 years old 14 years old 15 years old 16 years old	1 (0.9%) 85 (79.4%) 7 (6.5%) 1 (0.9%) 3 (2.8%) 5 (4.7%) 4 (3.7%) 1 (0.9%)
During your life, with how many people have you had sexual intercourse?	Missing I have never had sexual intercourse 1 person 2 people 6 or more people	4 (3.7%) 84 (78.5%) 12 (11.2%) 2 (1.9%) 5 (4.7%)

Did you drink alcohol or use drugs before you had sexual intercourse the last time?	Missing I have never had sexual intercourse Yes No	1 (0.9%) 68 (63.6%) 8 (7.5%) 30 (28%)
The last time you had sexual intercourse, did you or your partner use a condom?	Missing I have never had sexual intercourse Yes No	4 (3.7%) 72 (67.3%) 12 (11.2%) 19 (17.8%)
The last time you had sexual intercourse, what one method did you or your partner use to prevent pregnancy? (Select only one response.)	Missing I have never had sexual intercourse No method was used Birth control pills Condoms Depo-Provera Withdrawal Some other method Not sure	1 (0.9%) 84 (78.5%) 4 (3.7%) 2 (1.9%) 7 (6.5%) 1 (0.9%) 1 (0.9%) 1 (0.9%) 6 (5.6%)

Table 8: Physical Activity (n=107)

Table 8 depicts the learner`s engagement in physical activity. Fifty-eight learners were physically active for sixty minutes during the past 7 days ranging from twenty learners for one day of the 7 days to six being active for all 7days. Only forty-five learners indicated that they attend physical education classes during certain days of the school week. The number of days in which they attend physical education ranged from 1 day (twenty-one learners) to 5 days (six learners). Fifty-seven learners expressed that during the past 12 months they played in 1 to 3 or more sports teams, nineteen in 1 team, twenty-one in two teams and seventeen in 3 or more teams.

Questions	Choices	Frequencies (%)
During the past 7 days, on how many days were you physically active for a total of at least 60 minutes per	Missing 0 days 1 day 2 days	0 (0.0%) 49 (45.8%) 20 (18.7%) 15 (14%)

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.)	3 days 4 days 5 days 6 days 7 days	9 (8.4%) 3 (2.8%) 3 (2.8%) 2 (1.9%) 6 (5.6%)
In an average week when you are in school, on how many days do you go to physical education (PE) classes?	Missing 0 days 1 day 2 days 3 days 4 days 5 days	3 (2.8%) 59 (55.1%) 21 (19.6%) 10 (9.3%) 6 (5.6%) 2 (1.9%) 6 (5.6%)
During the past 12 months, on how many sports teams did you play? (Include any teams run by your school or community groups.)	Missing 0 teams 1 team 2 teams 3 or more teams	2 (1.9%) 48 (44.9%) 19 (17.8%) 21 (19.6%) 17 (15.9%)

Table 9: Violence-Related Behaviour (n=107)

Assessment of violence-related behaviour and school-related violent behaviours. For example, did learners carry weapons on them personally during the past thirty days including whether any of the weapons was brought onto the school premises. Table 9 presents the findings related to the learners' self-reported behaviour in this section. The majority of learners (n=91) did not carry any weapons such as a gun, knife or club on school property, however, thirteen of the learners did feel the need to carry a weapon, thus putting them at risk, as well as showing the fear of being in some sort of danger thus needing to protect themselves. Thirty-one learners felt unsafe going to or from school. During the past 12 months, twenty-four learners were in a physical fight on school property. Learners were also asked to indicate whether during the past 12 months their girlfriend or boyfriend ever hit, slapped or physically hurt them on purpose as well as whether they have ever been forced to have sexual intercourse when they did not want to. Sixteen of the learners (15%) indicated that they have been hit, slapped or hurt physically on purpose whilst fourteen (13.1%) learners have been physically forced to have sexual intercourse when they did not want to.

Questions	Choices	Frequency (%)
During the past 30 days, on how many days did you carry a weapon such as a gun, knife, or club on school property?	Missing 0 days 1 day 2 or 3 days 4 or 5 days 6 or more days	3 (2.8%) 91 (85%) 8 (7.5%) 1 (0.9%) 2 (1.9%) 2 (1.9%)
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?	Missing 0 days 1 day 2 or 3 days 4 or 5 days 6 or more days	1 (0.9%) 75 (70.1%) 15 (14%) 12 (11.2%) 2 (1.9%) 2 (1.9%)
During the past 12 months, how many times were you in a physical fight on school property?	Missing 0 times 1 time 2 or 3 times 4 or 5 times 6 or 7 times 12 or more times	0 (%) 83 (77.6%) 16 (15%) 3 (2.8%) 2 (1.9%) 1 (0.9%) 2 (1.9%)
During the past 12 months did your boyfriend or girlfriend ever hit, slap, or physically hurt you on purpose?	Missing Yes No	0 (0%) 16 (15%) 91 (85%)
Have you ever been physically forced to have sexual intercourse when you did not want to?	Missing Yes No	2 (1.9%) 14 (13.1%) 91 (85%)

4.4 Cross-Tabulations

Cross-tabulations between health risk behaviour and identified demographic variables were done with regard to the health risk behaviours depicted in Table 2. The cross-tabulation looked at the distributions across the intersection of age and gender per health risk behaviour. The results have been tabularised and are presented per HRB.

4.4.1 Smoking and Age

In Table 10, smoking prevalence associated with age, illustrates that at least 50% of learners reported smoking across all age groups. The prevalence of smoking amongst 13, 14,15 and 16-year olds was 9.3%, 25.2% and 12.1% and 3% respectively. The prevalence for this group must be interpreted with caution since it represents a smaller group that has aged out for their grade and often present with a range of other challenges. The age group that smoked the most are 14 years old.

Table 10: Cross-tabulation: Age x Smoking (n=107)

Variable		Age							
		12	**13**	**14**	**15**	**16**	**17**	**Missing**	**Total**
Smoking	**Yes**	0	10	27	13	3	0		53
	No	1	10	29	8	4	1		53
Missing								1	1
N		1	20	56	21	7	1	1	107

4.4.2 Smoking and Gender

From Table 11 below the prevalence of smoking was 50%. The gender distributions for smoking reveals that more female learners reportedly smoke (n = 35), in comparison to male learners (n=18). Of the smoking sub-group, 16.8% were male and 32.7% were female.

Table 11: Cross-tabulation: Gender x Smoking (n=107)

Variable	Gender			
	Male	**Female**	**Missing**	**Total**

Smoking	**Yes**	18	35		53
	No	20	32		52
Missing				2	2
N		38	67	2	107

4.4.3 Drinking and Age

Table 12 captures the frequency distribution of the learners' drinking during the last 30 days across age groups. Drinking prevalence associated with age illustrates that the 14 years old age group presents with higher engagement of a total of twenty-eight learners. The age groups of 12 and 17 years old were the lowest with 1 in total.

Table 12: Cross-tabulation: Age x Drinking (n=107)

Variable		**Age**							
		12	**13**	**14**	**15**	**16**	**17**	**Missing**	**Total**
Drinking	**Yes**	1	7	28	10	4	1		51
	No	0	13	28	11	3	0		55
Missing								1	1
N		1	20	56	21	7	1	1	107

4.4.4 Drinking and Gender

Table 13 below clearly depicts a gendered pattern in alcohol consumption. Thirty (28%) of the sixty-seven female learners, engaged in drinking the last 30 days, in comparison to the twenty-one male learners (19.6%) who reportedly drank. Thus, females are reportedly engaged in drinking more than males.

Table 13: Cross-tabulation: Gender x Drinking (n=107)

Variable		Gender			
		Male	**Female**	**Missing**	**Total**
Drinking	**Yes**	21	30		51
	No	17	37		54
Missing				2	2
N		38	67	2	107

4.4.5 Drug Use (Cocaine) and Age

Table 14 below shows the frequency of drug use across the age groups of learners in the sample. From Table 13.5 it becomes evident that the highest frequency of cocaine use was indicated in the 15 and 14 year old age groups.

Table 14: Cross-tabulation: Age x Cocaine use (n=107)

Variable		Age							
		12	**13**	**14**	**15**	**16**	**17**	**Missing**	**Total**
Cocaine use	**Yes**	1	1	4	2	1	0		9
	No	0	19	51	19	6	1		96
Missing								2	2
N		1	20	55	21	7	1	2	107

4.4.6 Drugs Use (Cocaine) and Gender

Table 15 below illustrates the frequency of drug use (cocaine) over the last 30 days across the gender of learners. Only twelve (11.2%) learners out of the sample of 107 reportedly engaged in drug use during the past 30 days of who eight (8) were male (7.4%), four were female (3.7%). The majority of learners (91) did not use cocaine.

Table 15: Cross-tabulation: Gender x Cocaine (n=107)

Variable		Gender			
		Male	**Female**	**Missing**	**Total**
Cocaine use	**Yes**	8	4		12
	No	29	62		91
Missing				4	4
N		37	66	4	107

4.4.7 Dagga Use and Age

On further differentiation, the number of learners who reported using Dagga in the last month increased to 18.7% (n=20) as illustrated in Table 16, reflects the frequency distribution for dagga use across age groups. The majority of learners (85) did not use dagga.

Table 16: Cross-tabulation: Age x Dagga Use (n=107)

Variable		Age							
		12	**13**	**14**	**15**	**16**	**17**	**Missing**	**Total**
Dagga use	**Yes**	0	5	9	3	2	1		20
	No	1	15	46	18	5	0		85

Missing							2	2
N	1	20	55	21	7	1	2	107

From the above table, it becomes evident that 4.7% of 13 year olds; 8.4% of 14 year olds; 2.8% of 15 year olds; 1.9% of 16 year olds and 0.9% of 17 year olds reportedly smoked dagga in the last month. Within the group that reportedly smoked dagga, 13 and 14 year olds were most active. The most commonly reported frequency of smoking dagga was between one or two times per week, followed by 3 to 9 times per week.

4.4.8 Dagga use and Gender

On differentiation between dagga and other drugs, the reporting changed dramatically as illustrated in Table 17 below that reflects the frequency distribution for dagga use across genders.

Table 17: Cross-tabulation: Gender x Dagga Use (n=107)

Variable		**Gender**			
		Male	**Female**	**Missing**	**Total**
Dagga use	**Yes**	7	13		20
	No	30	54		84
Missing				3	3
N		37	67	3	107

The number of learners who reported using Dagga in the last month increased to 18.9% (n=20). Female learners constituted 12.1% (n=13) of the sub-group that acknowledged using dagga in the last month, in comparison to males who comprised 6.5% (n=7). The slight larger percentage use of dagga reported by females was tested empirically to determine if there was

a significant difference in dagga use based on gender. The results are reported later in the chapter.

4.4.9 Sexual Behaviour and Age

Table 18 captures the frequency distribution of the learners' sexual behaviour by age group. From the table, it becomes evident that 0.9% of 13 year olds; 6.5% of 14 year olds; 3.7% of 15 year olds and 0.9% of 16 year olds were sexually active. Within the sexually active group, 14 and 15 year olds were most active.

Table 18: Cross-tabulation: Age x Sexual Behaviour (n=107)

Variable		Age							
		12	**13**	**14**	**15**	**16**	**17**	**Missing**	**Total**
Sexual behaviour	**Yes**	0	1	7	4	1	0		13
	No	1	18	49	15	6	1		90
Missing								4	4
N		1	19	56	19	7	1	4	107

4.4.10 Sexual Behaviour and Gender

From Table 19 below it becomes evident that more male learners (12) were reportedly sexually active than female learners (1). Male learners constituted 11.2% of the sexually active group in comparison to females who comprised 0.9%. Five learners did not respond to the question of being sexually active. The gendered pattern that emerges here was tested empirically for significant differences in sexual activity between gender groups and the results are reported later.

Table 19: Cross-tabulation: Gender x Sexual Behaviour (n=107)

Variable		Gender			
		Male	**Female**	**Missing**	**Total**
Sexual behaviour	**Yes**	12	1		13
	No	25	64		89
Missing				5	5
N		37	65	5	107

4.4.11 Physical activity and Age

Table 20 reports on the frequency distribution of physical activity across the age groups. From the table, it becomes evident that 0.9% of 12 year olds; 14% of 13 year olds; 25.2% of 14 year olds; 11.2% of 15 year olds; 0.9% of 16 year olds and 0.9% of 17 year olds reportedly engaged in physical activity in the week prior to the survey. Within the physically active group 13 and 14 year olds were most active.

Table 20: Cross-tabulation: Age x Physical Activity (n=107)

Variable		Age							
		12	**13**	**14**	**15**	**16**	**17**	**Missing**	**Total**
Physical activity	**Yes**	1	15	27	12	1	1		57
	No	0	5	29	9	6	0		49
Missing								1	1
N		1	20	56	21	7	1	1	107

4.4.12 Physical Activity and Gender

From Table 21 it becomes evident that the majority of learners (53.3%, n= 57) were physically active during the seven days preceding the administration of the survey on the association of physical activity amongst learners, with age and gender. Within the gender groupings, 16.8% of male learners and 36.4% of female learners were reportedly physically active during the week preceding the survey. Male (18.7%, n=20) and female (26.2%, n=28) learners were physically inactive respectively.

Table 21: Cross-tabulation: Gender x Physical Activity (n=107)

Variable		Gender			
		Male	**Female**	**Missing**	**Total**
Physical activity	**Yes**	18	39		57
	No	20	28		48
Missing				2	2
N		38	67	2	107

4.4.13 Violence-Related Behaviour and Age

Table 22 demonstrates the relation between age and violence during the past 12 months such as being in a physical fight. The majority of learners were aged 14 (n=27). From the table, it becomes evident that 0.9% of 12-year olds; 5.6% of 13-year olds; 25.2% of 14-year olds, 7.5% of 15-year olds, 3.7% of 16-year olds and 0.9% of the 17-year olds reportedly engaged in violence related behaviour.

Table 22: Cross-tabulation: Age x Violence (n=107)

Variable		Age							
		12	**13**	**14**	**15**	**16**	**17**	**Missing**	**Total**
Violence related behaviour	**Yes**	1	6	27	8	4	1		47
	No	0	14	28	13	3	0		58
Missing								2	2
N		1	20	55	21	7	1	2	107

Table 23: Cross-tabulation: Gender x Violence (n=107)

Variable		Gender			
		Male	**Female**	**Missing**	**Total**
Violence related behaviour	**Yes**	21	25		46
	No	17	41		58
Missing				3	3
N		38	66	3	107

Table 23 demonstrates that more females (25) (23.3%) were involved in a physical fight than males (21) (19.6%).

4.5 Results for Post Intervention

Objective two is to determine the HRB engagement of the Grade 8 learners in a selected school in the Paarl area post implementation of the designed YDP.

4.5.1 Response Rate

A total of 250 Grade 8 learners were registered for 2018, 178 learners who consented to participate in the study filled out the questionnaires, but only 174 (98%) were completed on the day and used in the study, 4 questionnaires (2%) were incomplete and not used. An overall response rate of 98% was achieved post-intervention in this study which was significantly higher than the pre-implementation.

4.6 Demographic Information

There were 178 participants in the post-data collection, as to the 107 in the pre-data collection but only 174 questionnaires were completed and used in the study. The mean age of the learners was 34.8. The majority of the grade 8 learners were aged 14 (n=77, 44.3%) and 15 years (n=64, 36.8%) old followed by 16 years (n=17, 9.8%) and 13 years (n=13, 7.5%) with 17 years (n= 2, 1.1%) respectively, and no 12 years old age group. The gender composition was unequal with male learners comprising n=76, 43.7% and female learners n=95, 54.6%. The majority (72.4%, n=126) of the sample self-identified as 'coloured' using the racial categories from the South African population. 44.8% of the learner's lives with both parents, while 35.1% only lives with a mother and 3.4% only lives with a father. 20.7% of the learners do not partake in any extra mural activities while 47.1% partake in sports.

Table 24: Demographic Information (n=174)

Variable	Frequencies	Percentage
Gender		
Female	95	54.6
Male	76	43.7
Missing	3	1.7
Total	174	100

Age		
13 years old	13	7.5
14 years old	77	44.3
15 years old	64	36.8
16 years old	17	9.8
17 years old	2	1.1
Missing	1	0.6
Total	174	100
Race		
White	19	10.9
Black	24	13.8
Coloured	126	72.4
Indian	2	1.1
Missing	3	1.7
Total	174	100
Who do you live with?		
Mother and father	78	44.8
Mother	61	35.1
Father	6	3.4
Grandparents	21	12.1
Guardian	4	2.3
Missing	4	2.3
Total	174	100
Extra mural activities		
Youth group	29	16.7
Scouts	5	2.9
Sports	82	47.1
Arts	18	10.3
None	36	20.7
Missing	4	2.3
Total	174	100

4.7 Health Risk Behaviours

Table 25 depicted the frequency distribution for engagement in health risk behaviour post implementation of the designed YDP. The learners (174) that participated in the post-intervention phase of the study were in Grade 8. Females (95) were the majority gender. The majority age group were 14 years old (77 learners). Health risk behaviour engagement amongst the participants showed that 50.6% smoked, 58.6% drank alcohol, 20.1% have used

dagga, 10.3% have used cocaine, 15.5% were sexually active, 42.6% were physically active and 43.6% were in physical fight.

Table 25: Frequency Distribution for Engagement in Health Risk Behaviour (n=174)

Health Risk Behaviour	Responses	Frequency	Percentage %
Smoking	Yes	88	50.6
	No	85	48.9
	Missing	1	0.6
Drinking	Yes	102	58.6
	No	71	40.8
	Missing	1	0.6
Drug use: Dagga	Yes	35	20.1
	No	138	79.3
	Missing	1	0.6
Cocaine	Yes	18	10.3
	No	154	88.5
	Missing	2	1.1
Sexual activity	Yes	27	15.5
	No	145	83.3
	Missing	2	1.1
Physical activity	Yes	74	42.6
	No	97	55.7
	Missing	3	1.7
Violence related behaviour (physical fight)	Yes	76	43.6
	No	98	56.3
	Missing	0	0

The data was summarised according to the major HRB's: smoking, alcohol use, drug use, sexual activity, physical activity and violence related behaviour. Below these HRB's were unpacked in order to demonstrate their engagement.

Table 26: Smoking (n=174)

The learners indicated at what age they smoked a whole cigarette for the first time and it was reported during the following ages: it was indicated that eight learners already started smoking at age 8 years or younger, although the majority of the learners did not smoke (93) (53.4%), the majority learners, 27% smoked between the age of 13-14 years old. Sixty-two

(35.5%) of the learners indicated that they smoked during the past 30 days prior to the survey and 18 (10.3%) of those learners reported that they smoked all 30 days. Thirty-nine (22.4%) learners reported that they bought cigarettes in a store. The majority learners (135) stated that they did not smoke on school property, while thirty-nine learners did during the past 30 days ranging from 1-2 days (sixteen learners) to all 30 days (four learners).

Question	Choices	Frequency n (%)
How old were you when you smoked a whole cigarette for the first time?	Missing	2 (1.1%)
	Never smoked	93 (53.4%)
	8 years old or younger	8 (4.6%)
	9 or 10 years old	2 (1.1%)
	11 or 12 years old	10 (5.7%)
	13 or 14 years old	47 (27%)
	15 or 16 years old	11 (6.3%)
	17 years old or older	1 (0.6%)
During the past 30 days, on how many days did you smoke cigarettes?	Missing	0 (0%)
	0 days	94 (54%)
	1 or 2 days	42 (24.1%)
	3 to 5 days	10 (5.7%)
	6 to 9 days	6 (3.4%)
	10 to 19 days	1 (0.6%)
	20 to 29 days	3 (1.7%)
	All 30 days	18 (10.3%)
During the past 30 days, how did you usually get your own cigarettes?	Missing	21 (12.1%)
	I did not smoke cigarettes	97 (55.7%)
	I bought them in a store	39 (22.4%)
	Bought from a vending machine	4 (2.3%)
	I gave someone else money to buy them for me	5 (2.9%)
	A person 18 year or older gave them to me	1 (0.6%)
	I got them some other way	7 (4%)
During the past 30 days, on how many days did you	Missing	0 (0%)
	0 days	135 (77.6%)

smoke cigarettes on school property?	1 or 2 days 3 to 5 days 6 to 9 days 10 to 19 days 20 to 29 days All 30 days	16 (9.2%) 7 (4%) 7 (4%) 3 (1.7%) 2 (1.1%) 4 (2.3%)

Table 27: Alcohol Use (n=174)

Table 27 pertains to the engagement of learners with alcohol drinking. The majority of the age group was 52 (29.9%) between 13-14 years old. Eighty-eight (50.5%) of the learners engaged in alcohol drinking the 30 days prior to the survey. Twenty-five (14.4%) learners reported that they bought the alcohol in a store. Twenty learners had a drink on school property during the past 30 days.

Questions	Choices	Frequency
How old were you when you had your first drink of alcohol other than a few sips?	Missing I have never had alcohol 8 years old or younger 9 or 10 years old 11 or 12 years old 13 or 14 years old 15 or 16 years old 17 years or older	3 (1.7%) 69 (39.7%) 8 (4.6%) 8 (4.6%) 11 (6.3%) 52 (29.9%) 21 (12.1%) 2 (1.1%)
During the past 30 days, on how many days did you have at least one drink of alcohol?	Missing 0 days 1 or 2 days 3 to 5 days 6 to 9 days 10 to 19 days 20 to 29 days All 30 days	0 (0%) 86 (49.4%) 52 (29.9%) 20 (11.5%) 3 (1.7%) 5 (2.9%) 2 (1.1%) 6 (3.4%)

During the past 30 days, how did you usually get the alcohol you drank?	Missing	0 (0%)
	I did not drink alcohol	99 (56.9%)
	I bought it in a store	25 (14.4%)
	I bought it at a restaurant, bar, or club	7 (4%)
	I bought it at a public event such as a concert/sports event	4 (2.3%)
	I gave someone else money to buy it for me	17 (9.8%)
	Someone gave it to me	11 (6.3%)
	I took it from a store or family member	3 (1.7%)
	I got it some other way	8 (4.6%)
During the past 30 days, on how many days did you have at least one drink of alcohol on school property?	Missing	0 (0%)
	0 days	154 (88.5%)
	1 or 2 days	13 (7.5%)
	3 to 5 days	4 (2.3%)
	6 to 9 days	1 (0.6%)
	All 30 days	2 (1.1%)

Table 28: Dagga / Hashish Use (n=174)

Table 28 reports on the exposure of learners concerned with dagga/ hashish use. The majority of learners (n=15) were exposed to dagga use between the ages of 13-14 years, however, eight learners indicated being aged 8 or younger and nine learners being between the age of 9-12 years old. Eighteen learners used dagga one or two times during the past 30 days, ten used three to nine times, one used ten to nineteen times, three twenty to thirty-nine times and two used forty or more times. Twenty-five learners used dagga on school property.

Questions	Choices	Frequencies (%)
How old were you when you tried dagga / hashish (marijuana) for the first time?	Missing	3 (1.7%)
	I have never tried marijuana	132 (75.9%)
	8 years old or younger	8 (4.6%)
	9 or 10 years old	1 (0.6%)
	11 or 12 years old	8 (4.6%)
	13 or 14 years old	15 (8.6%)
	15 or 16 years old	5 (2.9%)
	17 years old or older	2 (1.1%)
During the past 30 days, how many times did you use marijuana?	Missing	4 (2.3%)
	0 times	135 (78.2%)
	1 or 2 times	18 (10.3%)
	3-9 times	10 (5.7%)
	10-19 times	1 (0.6%)
	20 to 39 times	3 (1.7%)
	40 or more times	2 (1.1%)
During the past 30 days, how many times did you use dagga / Hashish (marijuana on school property?	Missing	1 (0.6%)
	0 times	148 (85.1%)
	1 or 2 times	13 (7.5%)
	3-9 times	8 (4.6%)
	10-19 times	3 (1.7%)
	40 or more times	1 (0.6%)

Table 29: Drug Use (Cocaine): (n=174)

Table 29 shows the engagement or exposure of learners regarding any form of cocaine, including powder, crack, or freebase. During the past 30 days, eighteen learners have been exposed. Ten learners have been exposed to methamphetamines, twenty learners have taken steroid pills or injections without a prescription from a doctor, eleven learners used a needle to inject illegal drugs into their bodies and thirty-six learners have used illegal drugs on school property.

Questions	Choices	Frequency (%)
During the past 30 days, how many times did you use any form of cocaine, including powder, crack, or freebase?	Missing	0 (0%)
	0 times	156 (89.7%)
	1 or 2 times	7 (4%)
	3 to 9 times	6 (3.4%)
	10 to 19 times	2 (1.1%)
	20 to 39 times	1 (0.6%)
	40 or more times	2 (1.1%)
During your life, how many times have you used methamphetamines (also called speed, crystal, crank, or ice)?	Missing	0 (0%)
	0 times	164 (94.3%)
	1 or 2 times	3 (1.7%)
	3 to 9 times	5 (2.9%)
	10 to 19 times	1 (0.6%)
	40 or more times	1 (0.6%)
During your life, how many times have you taken steroid pills or shots without a doctor's prescription?	Missing	1 (0.6%)
	0 times	153 (87.9%)
	1 or 2 times	16 (9.2%)
	3 to 9 times	2 (1.1%)
	20 to 39 times	1 (0.6%)

	40 or more times	1 (0.6%)
During your life, how many times have you used a needle to inject any illegal drug into your body?	Missing 0 times 1 time 2 or more times	3 (1.7%) 160 (92%) 9 (5.2%) 2 (1.1%)
During the past 12 months, has anyone offered, sold or given you an illegal drug on school property?	Missing Yes No	6 (3.4%) 36 (20.7%) 132 (75.9%)

Table 30: Sexual Behaviour (n=174)

In Table 30 it is shown the engagement for sexual intercourse. The first age of sexual intercourse has been reported by the learners as follows: two learners reported being 11 years or younger; six learners 12 years old; four learners 13 years old; ten learners 14 years old; five learners 15 years old; two learners 16 years old and one learner 17 years old or older. Seventeen learners reported that they had sex with at least one person, six learners reported that they used alcohol or drugs before they engaged in sexual behaviour. Fifteen learners reported that they did not use a condom during their last sexual encounter. Further, six learners reported that no method was used during sex to prevent pregnancy.

Question	Choice	Frequency
How old were you when you had sexual intercourse for the first time?	Missing I have never had intercourse 11 years old or younger 12 years old 13 years old 14 years old	2 (1.1%) 142 (81.6%) 2 (1.1%) 6 (3.4%) 4 (2.3%) 10 (5.7%)

	15 years old	5 (2.9%)
	16 years old	2 (1.1%)
	17 years or older	1 (0.6%)
During your life, with how many people have you had sexual intercourse?	Missing	4 (2.3%)
	I have never had intercourse	141 (81%)
	1 person	17 (9.8%)
	2 people	8 (4.6%)
	5 people	1 (0.6%)
	6 or more people	3 (1.7%)
Did you drink alcohol or use drugs before you had sexual intercourse the last time?	Missing	3 (1.7%)
	I have never had intercourse	140 (80.5%)
	Yes	6 (3.4%)
	No	25 (14.4%)
The last time you had sexual intercourse, did you or your partner use a condom?	Missing	4 (2.3%)
	I have never had intercourse	141 (81%)
	Yes	14 (8%)
	No	15 (8.6%)
The last time you had sexual intercourse, what one method did you or your partner use to prevent pregnancy? (Select only one response.)	Missing	7 (4%)
	I have never had intercourse	141 (81%)
	No method was used	6 (3.4%)
	Birth control pills	3 (1.7%)
	Condoms	5 (2.9%)
	Depo-Provera (injectable)	2 (1.1%)
	Withdrawal	2 (1.1%)
	Some other method	1 (0.6%)
	Not sure	7 (4%)

Table 31: Physical Activity (n=174)

Table 31 depicts the learner`s engagement in physical activity. Seventy-four learners were physically active for sixty minutes during the past 7 days ranging from twenty-four learners for one day of the 7 days to nine being active for all 7 days. Only fifty-eight learners indicated that they attend physical education classes during certain days of the school week. The number of days in which they attend physical education ranged from one day twenty-nine learners) to five days (fourteen learners). Ninety-five learners expressed that they during the past 12 months played in one to three or more sports teams, fifty-one in one team, twenty-six in two teams and eighteen in three or more teams.

Questions	Choices	Frequencies (%)
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.)	Missing	3 (1.7%)
	0 days	97 (55.7%)
	1 day	24 (13.8%)
	2 days	12 (6.9%)
	3 days	12 (6.9%)
	4 days	12 (6.9%)
	5 days	4 (2.3%)
	6 days	1 (0.6%)
	7 days	9 (5.2%)
In an average week when you are in school, on how many days do you go to physical education (PE) classes?	Missing	3 (1.7%)
	0 days	113 (64.9%)
	1 day	29 (16.7%)
	2 days	12 (6.9%)
	3 days	3 (1.7%)
	5 days	14 (8%)
During the past 12 months, on how many sports teams	Missing	4 (2.3%)

did you play? (Include any teams run by your school or community groups.)	0 teams	75 (43.1%)
	1 team	51 (29.3%)
	2 teams	26 (14.9%)
	3 or more teams	18 (10.3%)

Table 32: Violence-Related Behaviour (n=174)

Assessment of violence-related behaviour and school-related violent behaviours. For example, did learners carry weapons on them personally during the past thirty days including whether any of the weapons was brought onto the school premises. Table 32 presents the findings related to the learners' self-reported behaviour in this section. The majority of learners (n=151) did not carry any weapons such as a gun, knife or club on school property however, twenty-two (12.6%) of the learners did feel the need to carry a weapon thus putting them at risk as well as showing the fear of being in some sort of danger thus needing to protect themselves. Fifty-nine learners felt unsafe going to or from school. Learners were also asked to indicate whether during the past 12 months their girlfriend or boyfriend ever hit, slapped or physically hurt them on purpose as well as whether they have ever been forced to have sexual intercourse when they did not want to. Twenty-five of the learners (14.4%) indicated that they have been hit, slapped or hurt physically on purpose whilst eighteen (10.3%) learners have been physically forced to have sexual intercourse when they did not want to.

Questions	Choices	Frequency (%)
During the past 30 days, on how many days did you carry a weapon such as a gun, knife, or club on school property?	Missing	1 (0.6%)
	0 days	151 (86.8%)
	1 day	12 (6.9%)
	2 or 3 days	4 (2.3%)
	4 or 5 days	2 (1.1%)
	6 or more days	4 (2.3%)

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?	Missing	0 (0%)
	0 days	115 (66.1%)
	1 day	30 (17.2%)
	2 or 3 days	17 (9.8%)
	4 or 5 days	5 (2.9%)
	6 or more days	7 (4%)
During the past 12 months, how many times were you in a physical fight on school property?	Missing	0 (%)
	0 times	136 (78.2%)
	1 time	23 (13.2%)
	2 or 3 times	12 (6.9%)
	4 or 5 times	2 (1.1%)
	12 or more times	1 (0.6%)
During the past 12 months did your boyfriend or girlfriend ever hit, slap, or physically hurt you on purpose?	Missing	1 (0.6%)
	Yes	25 (14.4%)
	No	148 (85.1%)
Have you ever been physically forced to have sexual intercourse when you did not want to?	Missing	2 (1.1%)
	Yes	18 (10.3%)
	No	154 (88.5%)

4.8 Cross-tabulations

Cross-tabulations between health risk behaviour and identified demographic variables were done with regard to the health risk behaviours depicted in Table 25. The cross-tabulation looked at the distributions across the intersection of age and gender per health risk behaviour. The results have been tabularised and are presented per HRB.

4.8.1 Smoking and Age

In Table 33, smoking prevalence associated with age illustrates that at least 50% of learners reported smoking across all age groups. The prevalence of smoking amongst 13, 14,15, 16 and 17 year olds was 4%, 23.6%, 19%, 3.4% and 0.6% respectively. The prevalence for this group must be interpreted with caution since it represents a smaller group that has aged out for their grade and often present with a range of other challenges.

Table 33: Cross-tabulation: Age x Smoking (n=174)

Variable		Age						
		13	**14**	**15**	**16**	**17**	**Missing**	**Total**
Smoking	**Yes**	7	41	33	6	1		88
	No	6	36	30	11	1		84
Missing							2	2
N		13	77	63	17	2	2	174

4.8.2 Smoking and Gender

In Table 34 below the prevalence of smoking was 87%. The gender distributions for smoking reveals that more female learners reportedly smoke (n = 49), in comparison to male learners (n=38). Of the smoking sub-group, 21.8% were male and 28.2% were female.

Table 34: Cross-tabulation: Gender x Smoking (n=174)

Variable		Gender			
		Male	**Female**	**Missing**	**Total**
Smoking	**Yes**	38	49		87

	No	37	46		83
Missing				4	4
N		75	95	4	174

4.8.3 Drinking and Age

Table 35 captures the frequency distribution of the learners' drinking during the last 30 days across age groups. Drinking prevalence associated with age illustrates that the 14 years' age group presents with higher engagement of a total of 41 learners. The age groups of 13 and 17 years old were the lowest with 5 and 1 in total.

Table 35: Cross-tabulation: Age x Drinking (n=174)

Variable		**Age**						
		13	**14**	**15**	**16**	**17**	**Missing**	**Total**
Drinking	**Yes**	5	41	32	9	1		88
	No	8	36	32	8	1		85
Missing							1	1
N		13	77	64	17	2	1	174

4.8.4 Drinking and Gender

Table 36 below depicts equal consumption of alcohol in the gendered pattern. Forty-four (25.3%) of the 95 female learners as well as 44 (25.3%) of the 76 male learners, engaged in drinking the last 30 days.

Table 36: Cross-tabulation: Gender x Drinking (n=174)

Variable		Gender			
		Male	**Female**	**Missing**	**Total**
Drinking	**Yes**	44	44		88
	No	32	51		83
Missing				3	3
N		76	95	3	174

4.8.5 Drug Use (Cocaine) and Age

Table 37 below shows the frequency of drug use across the age groups of learners in the sample. From Table 37 it becomes evident that the highest frequency of cocaine use was indicated in the 15-year-old age group (4.6%).

Table 37: Cross-tabulation: Age x Cocaine use (n=174)

Variable		Age						
		13	**14**	**15**	**16**	**17**	**Missing**	**Total**
Cocaine use	**Yes**	0	7	8	3	0		18
	No	13	70	56	14	2		155
Missing							1	1
N		13	77	64	17	2	1	174

4.8.6 Drug Use (Cocaine) and Gender

Table 38 below illustrates the frequency of drug use (cocaine) over the last 30 days across the gender of learners. Eighteen learners out of the sample of 174 (10.3%) reportedly engaged in drug use during the past 30 days of who nine (5.2%) were male and female each.

Table 38: Cross-tabulation: Gender x Cocaine (n=174)

Variable		Gender			
		Male	**Female**	**Missing**	**Total**
Cocaine use	**Yes**	9	9		18
	No	67	86		153
Missing				3	3
N		76	95	3	174

4.8.7 Dagga Use and Age

On further differentiation, the number of learners who reported using dagga in the **last month** increased to 19.5% (n=34), as illustrated in Table 39, reflects the frequency distribution for dagga use across age groups.

Table 39: Cross-tabulation: Age x Dagga use (n=174)

Variable		Age						
		13	**14**	**15**	**16**	**17**	**Missing**	**Total**
Dagga use	**Yes**	2	13	14	4	1		34
	No	11	61	49	13	1		135

Missing						5	5
N	13	74	63	17	2	5	174

From the above table, it becomes evident that 1.5% of 13 year olds; 7.5% of 14 year olds; 8% of 15 year olds; 2.3% of 16 year olds and 0.6% of 17 year olds reportedly smoked dagga in the last month. Within the group that reportedly smoked dagga, 14 and 15 year olds were most active. The most commonly reported frequency of smoking dagga was between one or two times per week, followed by three to nine times per week.

4.8.8 Dagga Use and Gender

On differentiation between dagga and other drugs, the reporting changed dramatically as illustrated in Table 40 below that reflects the frequency distribution for Dagga use across genders.

Table 40: Cross-tabulation: Gender x Dagga use (n=174)

Variable		**Gender**			
		Male	**Female**	**Missing**	**Total**
Dagga use	**Yes**	16	18		34
	No	57	76		133
Missing				7	7
N		73	94	7	174

The number of learners who reported using Dagga in the last month were 19.5% (n=34). Female learners constituted 10.3% (n=18) of the sub-group that acknowledged using dagga in the last month in comparison to males, who comprised 9.2% (n=16). The slightly larger percentage use of dagga reported by females was tested empirically to determine if there was

a significant difference in dagga use based on gender. The results are reported later in the chapter.

4.8.9 Sexual Behaviour and Age

Table 41 captures the frequency distribution of the learners' sexual behaviour by age group. From the table, it becomes evident that 0.6% of 13 year olds; 2.9% of 14 year olds; 9.2% of 15 year olds and 2.9% of 16 year olds were sexually active. Within the sexually active group, 15 year olds were most active.

Table 41: Cross-tabulation: Age x Sexual Behaviour (n=174)

Variable		Age						
		13	**14**	**15**	**16**	**17**	**Missing**	**Total**
Sexual behaviour	**Yes**	1	5	16	5	0		27
	No	12	71	48	11	2		144
Missing							3	3
N		13	76	64	16	2	3	174

4.8.10 Sexual Behaviour and Gender

From Table 42 below it becomes evident that more male learners (23) were reportedly sexually active than female learners (3). Male learners constituted 13.2% of the sexually active group in comparison to females who comprised 1.7%. Five learners did not respond to the question of being sexually active. The gendered pattern that emerges here was tested empirically for significant differences in sexual activity between gender groups and the results are reported later.

Table 42: Cross-tabulation: Gender x Sexual Behaviour (n=174)

Variable		Gender			
		Male	**Female**	**Missing**	**Total**
Sexual behaviour	**Yes**	23	3		26
	No	51	92		143
Missing				5	5
N		74	95	5	174

4.8.11 Physical activity and Age

Table 43 reports on the frequency distribution of physical activity across the age groups. From the table, it becomes evident that 3.4% of 13 year olds; 19% of 14 year olds; 15.5% of 15 year olds; 3.4% of 16 year olds and 1.1% of 17 year olds reportedly engaged in physical activity in the week prior to the survey. Within the physically active group 14 and 15 year olds were most active.

Table 43: Cross-tabulation: Age x Physical activity (n=174)

Variable		Age						
		13	**14**	**15**	**16**	**17**	**Missing**	**Total**
Physical activity	**Yes**	6	33	27	6	2		74
	No	6	43	36	11	0		96
Missing							4	4
N		12	76	63	17	2	4	174

4.8.12 Physical Activity and Gender

From Table 44 it becomes evident that the majority of learners (54%, n= 94) were physically inactive during the seven days preceding the administration of the survey on the association of physical activity amongst learners, with age and gender. Within the gender groupings, 22.4% of male learners and 20.1% of female learners were reportedly physically active during the week preceding the survey. Male (20.1%, n=35) and female (33.9%, n=59) learners were physically inactive respectively.

Table 44: Cross-tabulation: Gender x Physical Activity (n=174)

Variable		Gender			
		Male	**Female**	**Missing**	**Total**
Physical activity	**Yes**	39	35		74
	No	35	59		94
Missing				6	6
N		74	94	6	174

4.8.13 Violence-Related Behaviour and Age

Table 45 demonstrates the relation between age and violence during the past 12 months, such as being in a physical fight. The majority of learners were aged 15 (n=31). From the table, it becomes evident that 2.9% of 13 year olds; 16.7% of 14 year olds; 17.8% of 15 year olds, 5.2% of 16 year olds and 0.6% 17 year olds reportedly engaged in violence related behaviour.

Table 45: Cross-tabulation: Age x Violence (n=174)

Variable		Age						
		13	**14**	**15**	**16**	**17**	**Missing**	**Total**
Violence related behaviour	**Yes**	5	29	31	9	1		75
	No	8	48	33	8	1		98
Missing							1	1
N		13	77	64	17	2	1	174

Table 46: Cross-tabulation: Gender x Violence (n=174)

Variable		Gender			
		Male	**Female**	**Missing**	**Total**
Violence related behaviour	**Yes**	36	39		75
	No	40	56		96
Missing				3	3
N		76	95	3	174

Table 46 demonstrates that more females (39) (22.4%) were involved in violence related behaviour than males (36) (20.7%).

4.9 FOCUS GROUP DISCUSSIONS

Four focus group discussions (FGD's), two of females only, one of males only and one mixed group, were held to explore the effect of the YDP on the combatting of health risk behaviour engagement amongst the participants. Initially three FGD's were held, but an extra group

were added (females) as saturation was not reached as the first group did not give enough information with regard to their experiences. Two researchers were involved in the FGD's, one was the facilitator and the other one made notes and observations. The FGD's were recorded and transcribed verbatim and translated from Afrikaans to English soon after the interviews. To ensure trustworthiness of the data captured, member checking was done with the group to verify recorded responses. Learners were informed that participation is voluntary and anonymous and they can choose to partake or not or they can withdraw at any stage without any consequences. Participants in the FGD's signed a disclosure statement for confidentiality purposes to make them aware of the ethical procedures in advance. This study also involved the making of audiotapes during the FGD's and for confidentiality purposes, all tapes were stored in a locked filing cabinet which only the researcher had access to. The results were available to all relevant stakeholders and participants.

4.9.1 METHODOLOGY

4.9.1.1 Study Population and Sample

For this phase, the study population included representatives from Grade 8 and purposive selection was done between the participants that partook in the YDP. The groups consisted of high school learners aged between 12-17 years old, female and male. Participants were purposively selected in order to get a sample that would provide in-depth information regarding health risk behaviours that youth participate in and the reasons for participation. Four focus group discussions, two of females only, one of males only, and one mixed group were held with the learners from Grade 8. The learners were purposively selected following according to their age and gender. The four groups were divided into a group of ten male participants, two groups of ten female participants and a mixed group of thirteen participants.

4.9.1.2 Data Collection Methods

The study used both focus group discussions and semi-structured interviews as the methods of data collection. The focus group discussions were used to get more in-depth information on the perceptions, insights and beliefs of learners on the engagement of learners in health risk behaviours. Wilkinson (2004) stated that at the simplest level, a focus group is an informal discussion among a group of selected individuals about a particular topic. As a strategy for qualitative data collection, focus groups offer researchers a relatively "natural"

context for interviews (Neuman, 2006) in which participants are able to talk to each other, as well as to the interviewer. Unlike individual interviews, focus groups are designed to elicit a range of perspectives on a given topic and are less directive in their nature and less overtly researcher-led (Hennink, 2007). Focus groups differ from individual or group interviews, in that one of the jobs of the group facilitator is to stimulate *interaction* between participants, so that participants discuss, debate, agree, and disagree with each other, producing a lively, interactive encounter (Duggleby, 2005; Wilkinson, 2004).

Participants in the focus group interview are brought together because they possess certain characteristics related to the subject under study. Group members can influence each other by responding to ideas and questions that may not otherwise be brought out in measuring the quality and impact of a current or potential programme. While the purpose of focus groups is to promote self-disclosure among participants in a group(s) by ascertaining their perceptions, feelings, opinions and thoughts, focus group interviews are not intended to help groups or researchers reach decisions, gain consensus or establish how many people hold a particular view (Ludwig, 2000).

Kamberelis and Dimitriadis (2008: 375) indicated that focus groups are 'collective conversations', which can be small or large. According to Liamputtong (2009), the primary aim of a focus group is to describe and understand meanings and interpretations of a select group of people to gain an understanding of a specific issue from the perspective of the participants of the group. The purpose of the focus group discussion is to promote self-disclosure among participants and to obtain in-depth information on concepts, perceptions and ideas of a group. The characteristics of a focus group discussion according to Krueger and Casey (2000) include (i) having 5-10 participants; (ii) is composed of participants who are similar to each other; (iii) provide qualitative data; (iv) involves a topic of interest that has been carefully planned and (v) the session length is under two hours. Participants were chosen based on their knowledge or experience on the topic and questions and probes were planned in advance to focus attention on the topic. The discussion was planned to promote spontaneous dynamic interaction between participants so that ideas could be explored. The outcomes of the focus group discussions were therefore based on the responses of the group. It was thus deemed appropriate to make use of focus group discussions to explore the health

risk behaviour that learners engage in, the reasons why learners engage in these behaviours and possible ways to address the problem. Four focus group discussions were conducted with a total of forty-three (43) learners.

The semi-structured interviews focused on health risk behaviour engagement among learners in Grade 8 and were guided by the following questions:

1. What do you understand by health risk behaviours?
2. Why do you think learners participate in health risk behaviours?
3. How do you think it is harmful to participate in health risk behaviours?
4. During the programme what have you learnt from it?

4.9.1.3 Data Collection Procedure

Focus groups were conducted at the school, which was a convenient and familiar location. At each session a short description of the purpose of the project was given to familiarise participants with the process that was planned. Two researchers were involved in the focus group discussion, one of which was the facilitator and the other one made notes and recorded the observations. The facilitator then asked participants to respond to stimulus questions. The questions focussed on the following: "The reasons learners engage in health risk behaviour and interventions needed to assist in combating health risk behaviour among learners." Sessions were audio-recorded and lasted an average of one hour and were later transcribed verbatim.

4.9.1.4 Trustworthiness of the Data

The aim of trustworthiness in a qualitative inquiry is to support the argument that the inquiry's findings are "worth paying attention to" (Lincoln & Guba, 1985). Four issues of trustworthiness demand attention, namely credibility, transferability, dependability, and conformability. To address credibility, all stakeholders were included that play an active role within the study setting concerned with health risk behaviour amongst learners aged 12-17 years old in Grade 8 in order to ensure that information was obtained from various sources. This technique, while not meeting the technical definition of "triangulation" (Lincoln et al., 1985), provided a richer and more credible data set than if information was only obtained

from one source. During the focus group discussions to ensure that the data captured during this stage was trustworthy, the data was transcribed verbatim from the recordings, and member checking was done with the group to verify the recorded responses. The member checking, notes and observations were done to enhance the validity of the study. To address transferability, the data analysis documents used to generate the answer to the research questions were made available the thesis supervisors. The complete set of data analysis documents used within the concept maps is on file and available upon request. To address the issues of dependability and conformability, an independent audit of the research methods used was done by competent peers in this case, the thesis supervisors. All information generated was thoroughly examined by the supervisors and these include the original transcripts, data analysis documents, comments from the member checking, and the text of the dissertation itself.

4.10 RESULTS: FOCUS GROUP DISCUSSIONS

4.10.1 Demographic Data of the Participants

The qualitative data sets out to meet objective three of the study, to explore the views of Grade 8 learners in a selected school in the Paarl area regarding the YDP and their HRB engagement pre-and post-implementation of the YDP. Therefore, the FGD's aimed to explore the reasons for the continued engagement of youth in health risk behaviours and the possible solutions to address the delay, prevention and reduction that engagement. During this phase, four focus group discussions were conducted with a total of forty-three (43) learners including a male group of ten (10) learners, two female groups of ten (10) learners each and a mixed-gender group consisting of thirteen (13) learners (6 boys and 7 girls) from the age groups 12-17 years old in Grade 8.

4.10.1.1 Emerging Themes from the FGD's

The quantitative phase of this study identified smoking, drug and alcohol use, sexual activity, crime and violence as the health risk behaviours learners engage in. This informed or guided the qualitative (focus group discussion) phase in order to explore meaningfully this engagement further as well as the impact of the intervention to combat the HRB engagement. Three themes emerged from the learner perspective regarding the engagement and the impact

of the intervention. The health risk behaviour engagement with the three themes is then summarised at the end of this discussion into a concept map. The three themes are as follows and is individually explored:

1) Perceived reasons why youth engage in health risk behaviours

2) Places of exposure to health risk behaviour, and

3) Learner perspective on the impact of the intervention

Theme 1: Perceived reasons why youth engage in health risk behaviours

One of the themes that emerged was the perception about why youth engage in health risk behaviours. Seven distinct sub-themes were identified across all three groups. These themes included peer pressure, role modelling, experimenting, dysfunctional homes, stress, lack of communication and respect. Within the theme of peer pressure, it was evident that learners participated in health risk behaviours because there was a need for them to feel part of something or belong to a group and not to be left out. This sense of needing to belong meant that they would go with what others think in order to be included. Within the sub-theme of role modelling, there is a strong focus on the negative impact of role models on youth and some of this may have led to the experimenting phase where they want to know what all the hype is about. In addition, dysfunctional homes and stress also emerged as key reason for engaging in health risk behaviour. This is reflected in the responses relating to communication and respect as well where the learners escape from their personal situations at home and thus join groups where they feel a sense of belonging. Some learners mentioned that mutual respect was lacking at home, amongst family members and friends. The quotes are illustrated per group: female (F), male (M) and mixed group (MG). Table 47 reflects the themes and relevant quotes associated with the themes.

Table 47: Perceived reasons why youth engage in health risk behaviours

Subthemes	Experience	Reasons for engagement
Peer pressure	Feeling of acceptance/ belonging	"I have the fear of feeling left out or being avoided" (F) "My friend always gave me a cigarette to smoke because he said it was cool" (M) "Mixing with the wrong crowd just to fit in" (MG)
Role modelling	Poor role models	"I see the example from my parents who drink or smoke" (F) "Members in the community smoke dagga or drink freely everywhere" (M) "My parents send me to the shop to go buy their cigarettes" (MG)
Experimenting	Understanding by doing	"I want to know how it feels" (M) "I want to fit in with my friends" (F) "We see it by other people in the community" (MG)
Dysfunctional homes	Home environments do not provide support	"We engage in risky behaviours to escape from problems at home" (MG) "Due to stress related issues" (F)

		"I have poor or no family support" (M)
Stress	Circumstances at home and school	"My parent/s doesn't work" (F) "Poor coping mechanisms with school work" (M) "I smoke dagga to unwind" (MG)
Communication	Not knowing how to express thoughts, feelings and emotions	"I always use to say what I want before thinking first and hurting others with my words" (F) "My way of communicating with others and presenting myself were not always right" (M) "I always used to swear when I talk to people" (MG)
Respect	Not knowing how to conduct yourself in social or personal situations	"Before the programme I didn't have respect for other people, especially my friends, I treated them badly and I feel sad about it" (M) "I used to be very disobedient and back chatted my mother a lot" (F) "I used to swear a lot and that is wrong because I am a Christian" (MG)

Theme 2: Places of exposure to health risk behaviours

Participants across all three groups felt that the content of effective programmes should identify the contexts, sources or places where youth are perceived to be exposed to various HRBs. From their responses it becomes evident that learners assumed that "exposure" referred to HRBs such as drinking/alcohol and drug use and did not include other health risk behaviours such as sexual behaviour and physical inactivity. Table 48 summarises the places where youth were exposed to health risk behaviours according to the learners.

Table 48: Exposure to health risk behaviour

Places	Learners
At home, on school property, in the community, amongst friends and family members and on the streets	"Parents smoke and drink in front of us or send us to the shop to buy the cigarettes" (F) "Learners smoke on school property and does not even hide it when the teachers walk past them" (M) "Members in the community smoke dagga or drink freely everywhere" (MG) "My friend always came to fetch me so we can go buy cigarettes" (F) "I used to stand amongst my cousins who were smoking" (M)

Theme 3: Learner perspective on the impact of the intervention.

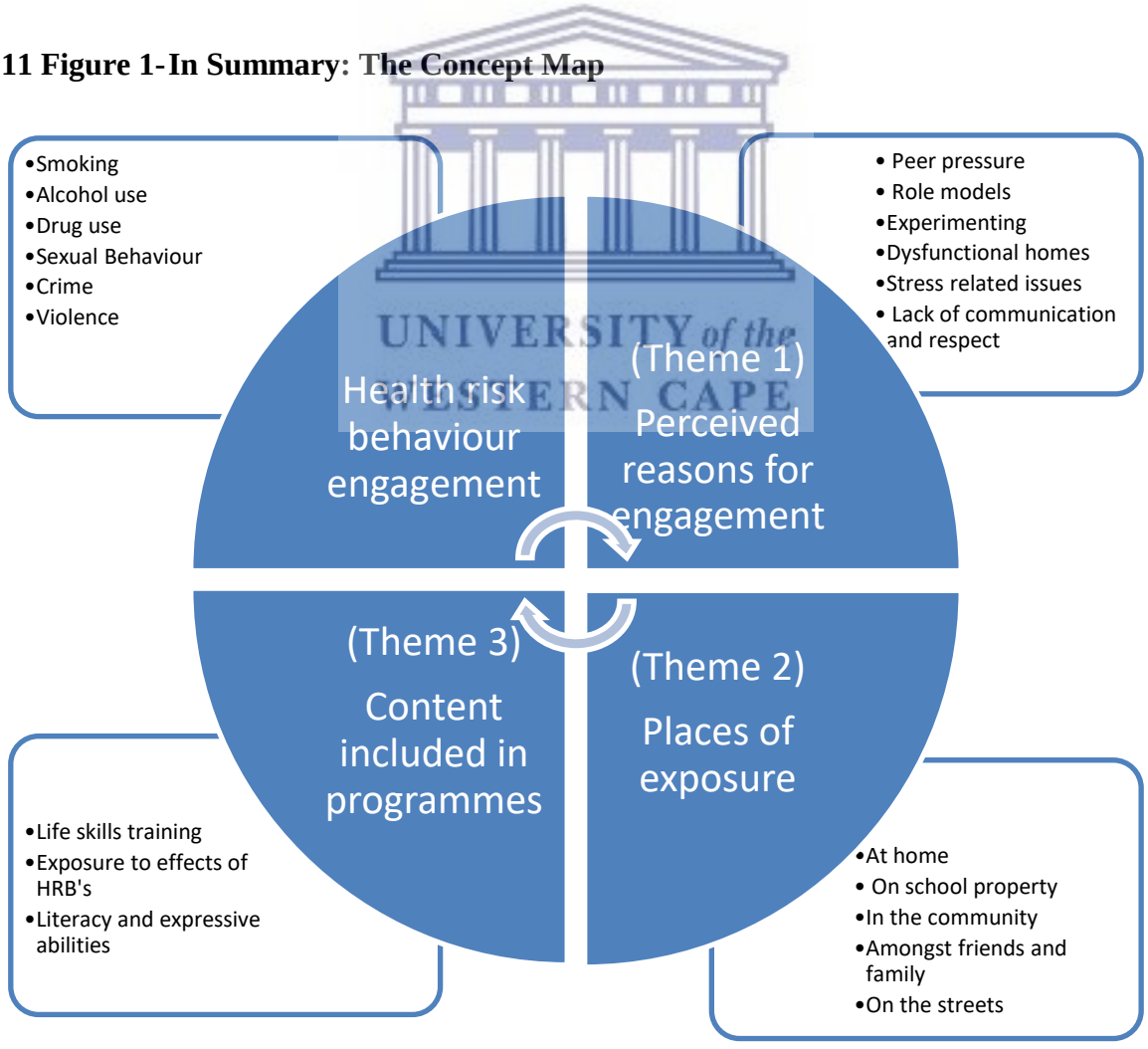
Participants expressed that effective programmes should also include specific content that were reflected in three sub-themes namely: 1) Life skills, 2) Exposure to the effects of health risk behaviour, and 3) Literacy and expressive abilities. Life skills, as specific content to be included, were identified by all participants as integral.

Table 49: Learner perspective on the impact of the intervention

Subthemes	Experience	Illustrative Quotes
Life skills training	The acquisition of skills for prosocial living, and effective management of self and relationships could mitigate engagement in HRBs	"The journal was a positive thing for me because I never used to like writing but now I do" (F) "I have gained a lot of knowledge which I now share with my family and friends and the programme boosted my self-confidence" (M) "I communicate better now with other people and have more respect for them" (MG)
Exposure to effects of HRB	Graphic or shocking visual or physical evidence of drug use is thought to be a deterrent to engaging in HRBs	"All the information of what cigarettes are made of opened my eyes to not smoke again" (F) "I am drinking less now because I saw what alcohol can do to your body" (M) "Violence can tear families apart" (MG)

Literacy and expressive abilities	Increasing their abilities to express their thoughts and feelings in a prosocial manner	"Education: being educated helps you think about what is good and what not" (F) "I smoke less now and exercise more" (M) "The programme was a positive influence on us because now we gained knowledge about the HRB's and can educate the next Grade 8's" (MG)

4.11 Figure 1-In Summary: The Concept Map



4.12 Impact of YDP

The implemented YDP was based on the following five pillars: knowledge development, education of health risk behaviour, leadership development, relationship development and life skills development. The information captured ultimately created an informed programme that attempted to reduce the current health risk behaviours of grade 8 learners.

Table 50: Depicts illustrative quotes as to the impact of the YDP had on the Grade 8 learners through FDG's

Pillars	Illustrative quotes
Knowledge development	"Violence can cause accidents and break up families" (F) "The programme taught me to make positive choices now with regards to smoking and drinking" (F) "Before I used to be a gangster but after the programme I learned how to deal and experience things without fighting and arguing" (M) "I used to bunk classes but when I heard what the programme was about I always wanted to be in class to learn more" (M) "Before the YDP I didn't fill in my questionnaire because I thought why should I do this, but after the programme I learned a lot" (MG)
Education of health risk behaviour	"I learned about all the chemicals in cigarettes" (F) "I used to eat unhealthy foods but not anymore since the programme, I exercise now more often" (F)

	"Alcohol use is also bad and the parents does it not knowing they are causing harm to their children especially women who breastfeeds" (F) "I learned that smoking can cause lung problems and cancer" (M) "We learned about all the different health risk behaviours and how it can damage your body and life" (MG)
Leadership development	"The journal had a positive impact because it planned my daily routine" (F) "The program is important because now I can teach the next Grade 8 learners about it" (F) "It was a good programme, I learned a lot, I gained knowledge on how to treat people better" (M) "I feel proud of myself because I was a different person before, but now I feel happy and good about myself" (M) "I was very disobedient before the programme, but I started to listen because it was good advice" (MG)
Relationship development	"Before the programme I was friends with people who smoke but not anymore" (F) "I don't back chat anymore to my teachers, I think before I speak now not to hurt other people's feelings" (F) "I learned how you present yourself to other people, to be considered to your friends" (M) "Before the programme, I treated my friends bad, I didn't have respect for them

	and now I feel sad about it because I didn't know I was so horrible to them but now I changed" (MG) "I wasn't obedient towards my mother and used to back chat a lot but ever since the programme I realised that it was wrong" (MG)
Life skills development	"The programme should focus more on teenage pregnancies because teenagers still get pregnant and then they must leave school" (F) "I learned how to respect people" (F) "I learned more self-confidence" (M) "I learned how to communicate better with other people, I didn't do that before" (M) "The programme changed my life, I never used to like writing but after the programme I do, also to get to know myself better and how to behave" (MG)

CHAPTER FIVE

5. Discussion

The first phase of the study was conducted to obtain baseline information about the health risk behaviours Grade 8 learners engaged in. The identified health risk behaviour engagement amongst the participants pre-implementation, from highest to lowest were physical activity, drinking alcohol, being in a physical fight, smoking cigarettes, dagga use, sexually active and using cocaine. In the post-data collection, the HRB's varied slightly from highest to lowest from drinking alcohol, smoking cigarettes, being in a physical fight, physical activity, dagga use, sexually active and cocaine use. The results showed that the learners definitely partake in HRB's due to different reasons and that the YDP made a slight change in behaviour.

An overall response rate of 60% pre-implementation was achieved in this study. According to methodological research, comparing different methods of administering questionnaires has focused on the issue of response rates, item response and on methods of increasing these, in particular in relation to postal surveys. The main reasons for non-response include respondent's unwillingness to participate in the study, the investigator's inability to contact respondents, for example, people who are out during home or telephone interview surveys; and communication barriers, for example, literacy barriers or sensory impairments. Non-response is thus likely to be influenced by mode of questionnaire administration, for example, people who have difficulty writing are unlikely to respond to a postal survey and hence differ in this respect to respondents (Roberts et al., 2004).

The lower the response rate to a study, the greater the danger that the responders may differ from non-respondents in their characteristics, which affects the precision (reliability) of the survey's population estimates, resulting in study bias, and weakening the external validity (generalisability) of the survey results. Even if the quality of the data obtained is good, a biased sample is of little value in making population estimates that represent the target population. While there is much literature reporting on differences between respondents and non-respondents in relation to individual studies, overall reviews and systematic reviews of

health-related literature on the differences between responders and non-responders are inconsistent or inconclusive (Cartwright 1983; McColl et al., 2001).
An overall response rate of 98% was achieved post-intervention in this study which was significantly higher than the pre-implementation. Face-to-face interview surveys have long been assumed to achieve higher response rates than postal and other types of surveys. A friendly interviewer on the doorstep can be motivating, and it may be easier to convince respondents of the legitimacy of the study in person, which should increase response rates. But narrative literature reviews, up until the 1990s, indicated that postal questionnaires, with at least two reminders and sponsorship by an official or respected body, could achieve response rates equal to interviews (85%) on appropriate topics (Cartwright, 1983; Scott, 1961; Austin et al., 1977). But response rates across all methods have declined over the past decade. This is evident when comparing the response rates over time to the British General Household Surveys (Walker et al., 2001).

According to Dillman (2000), a number of studies have since reported differences between response rates to telephone, face-to-face and postal questionnaires. Sykes and Collins (1988), compared three large British population surveys conducted during the 1980s: two studies of social attitudes, and a study of lifestyle, which all directly compared telephone and face-to-face interviewing. The telephone method achieved substantially lower response rates than face-to-face methods, and yielded more childless couples than couples with children. Research has also shown higher response rates for self-administered postal questionnaires compared with self-administration questionnaires handed out to people (for example, in hospitals) to complete and return (Gasquet et al., 2001).

Different modes of administration by different sequencing can also produce different response rates. In a survey of hospital in-patient experiences by Harris et al. (1997), patients were randomised to receive a postal questionnaire with telephone interview follow-up of non-respondents, or a telephone interview with postal follow-up of non-responders. The authors reported that the telephone first method had a higher response rate, and with higher item response. At an individual study level, the response rates to different modes of questionnaire administration are likely to vary by topic, and in particular for complex issues. There is less

information on electronic methods, which also suffer from an inability to cover target populations adequately.

Youness El Achhab et al., 2016 reported that a number of health risk behaviours begin in adolescence that affect health both at the time and in later years. Some of these behaviours contribute to the leading causes of mortality and morbidity among adolescents, such as suicide attempts, injuries and the various risks associated with unprotected sexual behaviour, conditions related to tobacco or alcohol use and overweight or obesity. The majority of adolescent death and illness are caused by risk behaviours that can be grouped into four categories: tobacco, alcohol and drug use; dietary behaviours; physical activity; and sexual behaviours. These key health-risk behaviours are often the focus of prevention strategies for non-communicable diseases and some sexual conditions.

In a study done by Aliakbar Haghdoost et al., 2014, the presented results provide a broad picture of the effect of family risk and protective factors on adolescents' health risk behaviours. We found that family attachment, further education and family religiosity were protective factors. On the other hand, boys versus girls, age, family history of risky behaviours, and parental attitudes favour toward antisocial behaviour, which could result in increased risky behaviours. In recent decades, dealing with the population of adolescents has become an international problem and this problem is important in Iran. According to the traditional system in Iran, the family plays an important role in training and guiding adolescents. The presence of various competitive institutions like schools, peers, the Internet, and satellite networks, which have deep potential differences in terms of values and ideals has changed the dynamics of the family and challenged family performance (Aliakbar et al., 2014).

There was also a significant difference in the HRB's between gender and age. The data showed pre- and post-implementation per HRB in smoking and drinking that females engaged more than males with the majority age group of 14 years old, males engaged more in cocaine use and sexual behaviour between ages 14 and 15 years old and with dagga use and violence related behaviour between the same ages with the majority female engagement.

Physical activity showed the same percentages between male and female between age group of 14 years old. One of the reasons could be that the females were the majority in the demographic information and in Grade 8. The majority age group for engagement was between 14-15 years old, but the onset age for HRB's were 8 years or younger, which is a big concern and means that intervention programmes should be implemented already at an early age. In the literature below is shows that alcohol is the HRB that were mostly used in another study.

Moodley et al., 2012, found that alcohol is the substance most commonly used by learners in Atteridgeville is consistent with studies conducted among learners in other parts of South Africa. When considering substance use by gender, males in this study generally had higher prevalence rates than females. A striking finding of this study is the high lifetime prevalence of alcohol use in female learners when compared with black female learners in previous South African studies. The higher rates of lifetime alcohol use in female learners in Atteridgeville may be part of a national trend of increased use of alcohol among black female learners in the period since those studies were conducted. The wide gender difference in cannabis use in this study has been demonstrated previously among black learners in other studies. Visser and Routledge (2007), suggest that differing male and female social roles could be one of the explanations for gender differences in the prevalence of substance use.

Fewer studies conducted in the United States have focused on gender differences in risk-taking behaviours, Oman, et al., 2013. Those that have done so have observed significant changes in behaviour by gender over time, with females' risk-taking behaviour on the rise, especially related to violence and heavy episodic drinking (Chun, et al., 2010). Furthermore, significant differences have been observed in behaviour by gender. For example, males are more likely than females to report impaired driving. Using a sample selected from the National Epidemiologic Survey on Alcohol and Related Conditions (N = 43 093), Chou et al. observed that 10.2% of male adolescents 18 to 29 years of age reported drinking while driving, compared to only 3.5% of females. Moreover, 16.0% of males reported riding with a drinking driver compared to 9.1% of females. These findings were corroborated by a study of 14 to 17 year olds that found that more than twice as many males as females reported driving after having consumed three or more servings of alcohol. Both males and females who report

risky driving behaviours also are more likely to engage in other risky behaviours, including smoking and drug use, Bina, et al., (2006). However, while female adolescents in general have lower risk-taking profiles, those exhibiting high-risk driving behaviours are more likely to engage in other high-risk behaviours than other females. This differs from males: those engaging in high-risk driving behaviours tend to have similar risk profiles to those who do not (Elliot, et al., 2006). Males' aggressive driving behaviours also have been associated with marijuana use (Begg, et al., 2004) and the thrill associated with driving unsafely.

According to Krantz, et al. (2002), regarding risky sexual behaviours, gender differences appear to be even more pronounced. For female adolescents, engaging in early onset, frequent, and unprotected sexual intercourse has been found to be associated with an increased risk for HIV infection. Those who use two or more illegal substances increase the odds of early sexual debut twelve-fold. Substance use, including cocaine as well as alcohol, cigarettes, and marijuana, also has been found to be linked to engaging in unprotected sexual intercourse among males (Nkansah-Amankra, et al., 2011 & Cavazos-Rehg, et al., 2010). Perception of risk among injection-drug users differs between males and females, with males less likely to perceive risk of HIV infection through casual sexual encounters. As a result of these observed differences, public health practitioners have concluded that the most successful interventions will be those that are both culture and gender specific (Jepson, et al., 2010).

The quantitative measures were collected by the means of the national data set questionnaire known as the Youth Risk Behaviour Survey (YRBS) (CDC, 2002), (Neill, Marsh & Richards, 1997), and engagement in the most prevalent health risk behaviours, as emerged from the survey data for this sample was also examined. The health risk behaviours assessed by the questionnaire included personal safety, violence related behaviours, tobacco and drug use, alcohol use, sexual behaviour and participation in physical activity. The quantitative data clearly showed that the youth do partake in HRB's, as discussed above. Over the past decade, evidence from a number of local studies reveals that youth in South Africa use alcohol, tobacco and other drugs, engage in unprotected sex, have unhealthy dietary habits, are physically inactive, and are both perpetrators and victims of violence (Frantz 2006, Reddy, James, McCauley, 2003; Swart, Reddy, Pitt, Panday, 2001; Swart, Reddy, Ruiter, de Vries,

2002; Swart, Seedat, Stevens, Ricardo, 2002). The YDP was immediately implemented after pre-data collection so there was not enough time say for instance over a period of a year's time before YDP implementation took place to see if there were significant changes with regards to their HRB's. The implication for intervention is that integrative programmes that address such multiple behaviours become imperative (Prochaska, 2008). The baseline data from the present study underscore the need for integrative programmes that address multiple risk behaviours effectively and can efficiently reduce the burden on schools and teachers consistent with the recommendation from Ten Dam (2002).

According to Durlak, et al., 2011, wider literature on universal prevention indicates that intervention effects are typically strongest immediately after the intervention, and they often decrease or disappear by long-term follow-ups. The general pattern for the interventions identified in our review differed from this norm. Often effect sizes were larger at later follow-ups, and in many cases, significant effects appeared for no or only one risk behaviour at the first post-intervention test, with further significant effects identified at long-term follow-up.

Several effective interventions made use of long-term booster sessions, delivered months or years after delivery of the main portion of the intervention. Neither the wider literature nor our review provided much evidence that the absolute length of intervention programmes is related to effectiveness. However, the use of booster sessions has been clearly linked to an increase in magnitude and longevity for intervention effects. This may explain why intervention effects for many studies persisted over time. (Kirby, et al., 2007; Cuijpers, 2002 & Bry, et al., 1992).

The qualitative data sets out to meet objective three of the study, to explore the views of Grade 8 learners in a selected school in the Paarl area regarding the YDP and their HRB engagement pre- and post-implementation of the YDP. Therefore, the FGD's aimed to explore the reasons for the continued engagement of youth in health risk behaviours and the possible solutions to address the delay, prevention and reduction of their engagement. The study population included representatives from Grade 8 and purposive selection was done

between the participants that partook in the YDP. Participants were purposively selected in order to get a sample that would provide in-depth information regarding health risk behaviours that youth participate in and the reasons for participation. The study used both focus group discussions and semi-structured interviews as the methods of data collection. Wilkinson (2004) stated that at the simplest level, a focus group is an informal discussion among a group of selected individuals about a particular topic. In order to confirm the information gained from the quantitative survey, the participants were asked to identify the common health risk behaviours that learners participate in according to how they perceive them. Once this was corroborated, the participants further expressed that the content of proposed programmes should address information on the health risk behaviours that learners were currently engaging in. According to Hale, et al. (2004), integrated risk prevention programmes can be effective across a range of health risk behaviours in adolescence, with effect sizes that are generally small but comparable to those of interventions that target single risk factors. The evidence is strongest for various forms of substance use and for school-based interventions.

Another clear theme that emerged was the perception about why youth engage in health risk behaviours. Seven distinct sub-themes were identified across all four groups. These themes included peer pressure, role modelling, experimenting, dysfunctional homes, stress, lack of communication and respect. Within the theme of peer pressure, it was evident that learners participated in health risk behaviours because there was a need for them to feel part of or belong to a group, and not to be left out. This sense of needing to belong meant that they would go with what others think in order to be included. Within the sub-theme of role modelling there is a strong focus on the negative impact of role models on youth and some of this may have led to the experimenting phase where they want to know what all the hype is about. In addition, dysfunctional homes and stress also emerged as key reason for engaging in health risk behaviour. This is reflected in the responses relating to communication and respect as well where the learners escape from their personal situations at home and thus join groups where they feel a sense of belonging. Some learners mentioned that mutual respect was lacking at home, amongst family members and friends. Researchers have found some evidence that these peer influences are reciprocal (Boxer, et al., 2006; Lavallee, et al., 2006; Multisite Violence Prevention Project, 2008). Children in groups in which the majority are

aggressive will become more so, and children in groups in which the majority are not aggressive will become less so.

Participants across all four groups felt that the content of effective programmes should identify the contexts, sources or places where youth are perceived to be exposed to various HRBs. From their responses it becomes evident that learners assumed that "exposure" referred to HRBs such as drinking/alcohol and drugs and did not include other health risk behaviours such as sexual behaviour and physical inactivity. Participants expressed that effective programmes should also include specific content that were reflected namely: life skills training, exposure to the effects of health risk behaviour and literacy and expressive abilities. Life skills, as specific content to be included, were identified by all participants as integral. All the information captured through these phases ultimately created an informed programme that will attempt to reduce the current health risk behaviour of learners in Grades 8. As mentioned in the illustrative quotes, not everybody filled in the questionnaires in the pre-data collection as they thought it was boring and didn't have the information yet of the YDP but post implementation skills were gained in better writing and planning of daily routines through the journal etc. Most of the learners that participated in the youth development programme reported that the programme had a positive impact on their lives and the decisions they make now regarding health risk behaviours.

In a study done by Hale, et al. (2004), this is likely related to the mechanisms for intervention effects. If, as theorised, these programmes are targeting more distal factors, such as common risk factors, or are preventing gateway effects, it may take longer for effects to emerge, and they may prove more pervasive. For example, nearly all interventions we reviewed targeted individual attributes and skills, such as self-efficacy, and social competencies, such as refusal skills and strengthening peer relationships and connectedness. It may take time for effects to trickle down to risk behaviours or for participants to internalise and apply learned skills or attitudes. It was relatively rare for the programmes to emphasise risk-specific knowledge. This fits the pattern of results we observed, because substance-specific knowledge would be less likely to influence multiple risk behaviours simultaneously and would also be more likely to disappear over time.

The majority of identified interventions took place in schools. Schools offer a useful context (and a captive audience) for the widespread dissemination of universal adolescent prevention programs. Systematic reviews in adolescent prevention in several domains suggest that school-based interventions are common. However, in the prevention of MHRBs, targeting schools may not only be practical, but also substantially contribute to effectiveness. This is because of the importance of school and peer effects for many risk behaviours. School climate, including student participation and engagement and teacher-student relationships, is associated with several health risk behaviours. Also, peer effects such as social mimicry, peer pressure, and social norms contribute to an increase in likelihood of risk behaviours, and these can be perpetuated in the school context. Targeting these common risk factors has been associated with reduced risk behaviour in several domains. School-based interventions provide a platform for effectively targeting common school and peer risk factors for MHRBs. However, it is important to note that similar reasoning can be applied to family-based interventions, and our review affirms their effectiveness, both individually and in combination with school-based interventions.

Through focus group discussions an in-depth understanding could be obtained that the intervention programme spoke to the learners need to belong, have worth and make better choices when equipped to do so. Knowledge alone does not impact behaviour change but the combination of knowledge, leadership, relationship and life skills development affords learners a greater chance to make healthier choices. Learners were able to reflect about themselves, their choices and their behaviour and make small strides in improving the way they live their lives.

6. Conclusion

The results from the survey demonstrated clearly that youth engage in health risk behaviours on a daily basis and it is still increasing regardless of the vast number and type of intervention programmes implemented. The results showed that females engaged in health risk behaviours more than males as they were the higher number in the demographic results that in turn requires programming to be sensitive to the impact of gender. The age group for these health risk behaviours between ages 13-14 years old were the highest, which means that intervention should start at an early age. Most of the learners reported that the reasons for engaging in

these health risk behaviours are because of peer pressure, poor role models, experimenting, dysfunctional homes, stress, lack of communication and respect. It is evident that they feel the need to belong to a group and not be left out, that the need for strong role models plays a big part to lead by example, in the responses relating to communication and respect as well where the learners escape from their personal situations at home and thus join groups where they feel a sense of belonging. The implication for planning a programme is that life skills education or development must be included as part of the integrative programme. It is also important to involve other stakeholders in the YDP like parents, teachers and community members, to determine the perceptions about the HRB's youth engage in and the factors influencing engagement. Interventions appear to be most effective when they include other aspects such as life skills, sport, and parental education or involvement. The above elements displayed positives and negatives on their own, but the studies with the best results were those that included more than one of these additional elements. The element of sport was particularly powerful at increasing positive, more realistic attitudes and perspectives regarding the self and others and these elements in turn were successful at reducing health risk behaviours. Parental involvement is also important for effective positive reinforcing effects of the intervention and maintaining long-term results. Particularly, life skills education was effective with females and helping learners in poorer areas to cope with community stressors.

According to the Health Guidance (Thomas, April 2018), role models are highly important for us psychologically, helping to guide us through life during our development, to make important decisions that affect the outcome of our lives, and to help us find happiness in later life. When we are growing up, we look to our role models for inspiration and use this as a blueprint for how we should behave when we're older. This is likely a survival function designed to help us to mimic the traits of those successful members of our society and thereby help us to be successful too. At the same time in later life its thought that our happiness is very much based on our perception of how our life should or could be and the gap between that and how it is in reality. In other words, it's striving for that same kind of success and achieving it that brings us happiness or otherwise when we're older. This is called 'actualization' by Goldstein. As such then, having the correct role model will ensure that we learn to be successful and adaptive in later life, and that we are happy when we are older having achieved that aim. It's very important to get the right one then for yourself, and

to provide one for your children. Of course, the most obvious role models for any child are the parents, followed by other immediate family and teachers. This is why it's so important in these roles to provide a good role model – as children will be imitating your behaviour.

In conclusion, this research provides insights into the risk behaviours that need to be considered if intervention programmes and preventive strategies are to be designed to promote adolescent's health in the selected high school in Paarl.

7. Recommendations

In relation to the study, there is a clear indication that the youth partake in health risk behaviours. It is of high importance that youth development programmes are implemented to reduce these behaviours but also to gain knowledge and life skills on how to deal with life challenges. Recommendations that emerged from the study:

- The expansion of the research study with more schools and learners forming part of the programme and study.

- The quantitative pre-data was collected upon which the YDP was implemented, following the completion of the programme the post data was immediately collected thus meaning that for this study the change of behaviour is not seen over an extended period following the completion.

- The study needs to be done over an extended period of at least five years to see the long-term effect of behaviour change amongst the learners and the impact on the school.

8. Limitations of the Study

- In the pre-data collection of the 178 learners who consented to participate in the study, only 107 questionnaires were completed which means a response rate of 60% was achieved. The lower the response rate to a study, the greater the danger that the responders may differ from non-respondents in their characteristics, which affects the precision (reliability) of the survey's population estimates, resulting in study bias, and weakening the external validity (generalisability) of the survey results.
- The learners over the period of the programme grew in understanding and maturity with respect to being fully committed to the research study therefore during the initial completion of the pre-implementation questionnaire not all questionnaires could be used due to it being incomplete.
- It is also important to involve other stakeholders in the YDP like parents, teachers, community members to determine the perceptions about the HRB's youth engage in and the factors influencing engagement. Interventions appear to be most effective when they include other aspects such as life skills, sport and parental education or involvement.
- Additionally, because of the sensitivity of some subjects like smoking and sexual activity, learners might underreport their behaviours, although by using different techniques learners were assured of anonymity.

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APPENDIX A

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18 October 2017

Ms C Cloete
Physiotherapy
Faculty of Community and Health Sciences

Ethics Reference Number: HS/17/1/35

Project Title: The effect of a youth development program combatting engagement in health risk behaviours amongst grade 8 learners in a selected high in the Paarl area.

Approval Period: 16 October 2017 – 16 October 2018

I hereby certify that the Humanities and Social Science Research Ethics Committee of the University of the Western Cape approved the methodology and ethics of the above mentioned research project.

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

Please remember to submit a progress report in good time for annual renewal.

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

PROVISIONAL REC NUMBER - 130416-049

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APPENDIX B

CONSENT FORM

Title of Research Project: The effect of a youth development program combatting engagement in health risk behaviours amongst grade 8 learners in a selected high school in the Paarl area.

The study has been described to me in a language that I understand and I freely and voluntarily agree that my child may participate. My questions about the study have been answered. I understand that my child's 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. The research includes making audio tapes of your child. To help protect your child's confidentiality all audio tapes will be stored in a locked filling cabinet, only the researcher will have access to it.

I **agree** that my child may be audio taped during his/her participation in this study. ☐

I **do not agree** that my child may be audio taped during his/her participation in this study. ☐

Participant's name……
Witness…….
Parent's signature…….
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: Dr. Hamilton Grant Pharaoh

Telephone: (021)959-2542/3662 **Email:hpharaoh21@gmail.com**
University of the Western Cape **Cell: 0735994733**
Private Bag X17, Bellville 7535 **Fax: (021)959-1217**

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APPENDIX C

ASSENT FORM

Title of Research Project: The effect of a youth development program combatting engagement in health risk behaviours amongst grade 8 learners in a selected high school in the Paarl area.

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

I **agree** to be audio taped during my participation in this study. ☐

I **do not agree** to be audio taped during my participation in this study. ☐

Participant's name……

Participant's signature…….

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: Dr. Hamilton Grant Pharaoh

Telephone: (021)959-2542/3662

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APPENDIX D

INFORMATION SHEET FOR PARTICIPANTS

Project Title: The effect of a youth development program combatting engagement in health risk behaviours amongst grade 8 learners in a selected high school in the Paarl area.

What is this study about?

This is a research project being conducted by Chanray Cloete at the University of the Western Cape. We are inviting you to take part in this research project because you are a grade 8 learner (ages 12-17) in this selected high school in the Paarl area. The purpose of this research project is to investigate the effect of a youth development program combatting engagement in health risk behaviours (smoking, drinking alcohol, drug abuse, unprotected sex, violence etc) amongst grade 8 learners in a selected high school in the Paarl area.

What will I be asked to do if I agree to participate?

The study will be done at your school. You will be asked to complete questionnaires about health risk behaviours [the Youth Risk Behaviour Surveillance Survey (YRBSS) and the Life Effectiveness Questionnaire (LEQ)]. When you are selected, you will also take part in focus group discussions. The questionnaires will take approximately 30-45 minutes to complete and the focus group discussions will include learners of the same age with the same number of males and females. The grade 8 learners of the school will be selected to take part in the comprehensive youth development programme that will run for a period of 6 months. The same learners who become part of the youth development programme will be required to complete questionnaires 6 months and 12 months' post completion of the questionnaire.

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Would my participation in this study be kept confidential?

The researchers will protect your identity and the nature of your contribution. To ensure this, your name will not be used on any of the surveys. The data collected will be coloured coded according to gender and age for identification purposes. This study will also involve the making of audiotapes during the focus group discussions to ensure trustworthiness. To ensure your confidentiality, all information gathered will be stored in a locket filling cabinet. Only the researcher will have access to the data. The school (principal and teachers) at the school or any unofficial party will not be able to access the information. If we write a report or article about this research project, your identity will be protected to the maximum extent possible. Learners in the focus group discussion will sign a disclosure form for confidentiality purposes to make them aware of ethical procedures in advance. In the event that information is obtained about any type of abuse or neglect we will have to break confidentiality and disclose to the appropriate individuals and/or authorities due to legal requirements. Data collected will be used in the form of publications and conference presentations.

What are the risks of this research?

There may be some risks from participating in this research study. All human interactions and talking about self or others carry some amount of risks. However, counselling will be provided by health professionals if and when necessary. We will nevertheless minimise such risks and act quickly to assist you if you experience any discomfort, emotional, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

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What are the benefits of this research?

Your school was chosen to take part in the study which gives you the opportunity to partake in the designed youth development programme whereby life skills training will form part of the programme. With specific recommendations to contribute to the success of intervention aimed at the youth this current proposal is written to determine the impact of the designed youth development programme not only in the immediate but over a long-term period. This research is not designed to help you personally, but the results may help the researcher learn more about the effects of the youth development programme as well as the health risk behaviour learners in grade 8 partake in as well as the barriers that prevent health risk behaviour change to take place. We hope that, in the future, other people might benefit from this study through improved understanding of the health risk behaviours the youth partake in. This study provides a window of opportunity for ongoing and wide-ranging research to expand their knowledge on the prevention and reduction of risky behaviour. This study aims to add new knowledge to the already existing programmes that attempt to combat engagement in health risk behaviour among the youth.

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

Participation in the research is not a course requirement. Your participation in this research is completely out of your own free will. 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 disciplined or lose any benefits to which you otherwise qualify. In the instance where you might fall ill or be admit to hospital, your participation in the study will be ended by the researcher without any consequences. If you decide to partake in the study and feel uncomfortable halfway throughout the study with regards to the process or questionnaires, you can decide to not participate further without any consequences.

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What if I have questions?

This research is being conducted by Chanray Cloete at the University of the Western Cape. If you have any questions about the research study itself, please contact my supervisor Dr Hamilton Pharaoh at: work number 021-9592542 or cell 0735994733, email: hpharaoh@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:

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APPENDIX E

FOCUS GROUP CONFIDENTIALITY BINDING FORM

Title of Research Project: The effect of a youth development program combatting engagement in health risk behaviours amongst grade 8 learners in a selected high school in the Paarl area.

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone by the researchers. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits. I understand that confidentiality is dependent on participants' in the Focus Group maintaining confidentiality.

I hereby agree to uphold the confidentiality of the discussions in the focus group by not disclosing the identity of other participants or any aspects of their contributions to members outside of the group.

Participant's name……..
Participant's signature……..
Date……

APPENDIX F

Youth Risk Behavior 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 types 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. Fill in the ovals completely. 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 #2 pencil or pen.**
*** Make dark marks.**
*** Fill in a response like this: A B C D**
*** 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. Who do you live with?
A. Mother and father
B. Mother
C. Father
D. Grandparents
E. Other guardian

4. How many people are in your house?
A. 2
B. 3
C. 4
D. 5
E. 6 and more

5. What is your religion?
A. Christian
B. Muslim
C. Hinduism
D. Judaism
E Other
F Do not belong to a religion

6. What is your race? (Select one or more responses.)
A. White
B. Black
C. Coloured
D. Indian

7. Do you partake in any extra mural activities?
A. Youth group

B. Scouts
C. Sports (eg. Hiking, soccer, netball etc)
D. Arts (eg. Dancing, singing, painting etc)
E None

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 behaviors.

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 Marijuana (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 speed, crystal, crank, 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 days
F. 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

LIENEKE BOESAK DEVELOPMENT PROJECTS

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08 November 2018

This serves to confirm that the Master's Degree thesis of **CHANRAY CLOETE** entitled:

"THE EFFECT OF A YOUTH DEVELOPMENT PROGRAMME COMBATTING ENGAGEMENT IN HEALTH RISK BEHAVIOURS AMONGST GRADE 8 LEARNERS IN A SELECTED HIGH SCHOOL IN THE PAARL AREA" has been proof-read and edited for submission to the University of the Western Cape.

LIENEKE BOESAK

Western Cape Government
Education

APPENDIX H

Directorate: Research

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REFERENCE: 20160224-8112
ENQUIRIES: Dr A T Wyngaard

Dr Hamilton Pharaoh
18 Murray Street
Charleston Hill
Paarl
7646

Dear Dr Hamilton Pharaoh

RESEARCH PROPOSAL: THE IMPLEMENTATION OF A DESIGNED YOUTH DEVELOPMENT PROGRAMME TO ADDRESS HEALTH RISK BEHAVIOUR AMONG GRADE 8 LEARNERS IN SELECTED HIGH SCHOOLS IN THE PAARL AREA

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. Educators' programmes are not to be interrupted.
5. The Study is to be conducted from **01 March 2016 till 30 March 2021**
6. No research can be conducted during the fourth term as schools are preparing and finalizing syllabi for examinations (October to December).
7. 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?
8. A photocopy of this letter is submitted to the principal where the intended research is to be conducted.
9. Your research will be limited to the list of schools as forwarded to the Western Cape Education Department.
10. A brief summary of the content, findings and recommendations is provided to the Director: Research Services.
11. 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: 24 February 2016

CHARLESTON HILL

SEKONDêR **SECONDARY**

Van der Stelstraat/Street
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Tel: 021 862 0212
Faks: 021862 7523
E-pos: charlestonhill.sec@wcgschools.gov.za

Prinsipaal/Principal
EP Claasen

27 February 2019

To whom it may concern

On behalf of Charleston Hill Senior Secondary School situated in Paarl I would like to confirm that Dr Hamilton Pharaoh has been conducting research at our school. The research included phases that was part of his PHD studies. Since 2016 up to the current date the programme designed during the PHD has been implemented in our school among grade 8 learners.
I can confirm that this has been in accordance with the permission given by the Western Cape Education Department which is granted from 2016-2021. The school in accordance to the WCED permission has therefore also given permission and will continue to do so as it is of great benefit to the school, learners, teachers and the broader community.
That permission has included masters and undergraduate student research as we believe that the benefit given to us as a school community should extend to the building of students at the University. We thus welcome and thank all students from the University of the Western Cape and University of KwaZulu-Natal who all play and will continue to play a meaningful role in the upliftment of our school and community.

Yours truly

.....
EP CLAASEN
SCHOOL PRINCIPAL

WES-KAAPSE ONDERWYS DEPARTEMENT
CHARLESTON HILL SEK/SEC
VAN DER STEL STR/ST.
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WESTERN CAPE DEPARTMENT OF EDUCATION

APPENDIX J

Interview Guide following intervention

Questions

1. What do you understand by health risk behaviour?
   Wat verstaan julle beteken gesondheidsrisiko gedrag – gee voorbeelde

2. Why do you think learners participate in health risk behaviours?
   Hoekom dink julle neem leerlinge deel aan die gesondheidsrisiko gedrag?

3. How do you think it is harmful to participate in health risk behaviour?
   Hoe is hierdie keuse skadelik vir jou? Watter skade kan verkeerde keuses soos dit aanrig?

4. During the programme what have you learnt form it?
   Jy het deelgeneem aan die program wat aangebied was. Wat het jy geleer en wat is jou ervaring of gevoel oor die program?

5. Has it change your thinking around participation in health risk behaviour?
   Het die program enigsins jou manier van dink en die keuse wat jy maak beinvloed?

6. Would you like the programme to be continued with you and your peers?
   Dink jy die program is belangrik vir jou en medeleerlinge. Moet daarmee aangehou word?

7. How do you feel about the programme?
   Wat is jou gevoel oor die program?

8. How has it made an impact on you?
   Hoe het die program jou beinvloed; voel jy anders oor jouself; kan jy aandui wat is anders?

9. Do you feel that you have learnt new skills and what are they?
   Dink jy dat jy nuwe vaardighede aangeleer het en wat is dit. Hoe help dit jou?

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