

**THE PREVALENCE OF HEALTH RISK BEHAVIOURS
AMONG HIGH SCHOOL LEARNERS IN THE CITY OF
MASERU, LESOTHO**

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Table of contents

Abstract	iii
Declaration	v
Acknowledgements.....	vi
Definition of terms.....	viii
List of Acronyms	x
List of figures	xi
List of Tables	xi
List of Appendices	xii

Abstract

This study was the first of its nature in Lesotho. Engagement in health risk behaviours is a public health concern, due to the consequences thereof. Concurrent engagement in risk behaviours has severe consequences on health and occupational abilities of the youth. The aim of the study was to establish and document the prevalence of risk behaviours among high school learners in the city of Maseru, Lesotho.

Methodology: The study was a cross-sectional survey in which a two stage sampling method was used to recruit a representative sample (N=1121) from Forms A, B, C, D and E in seven high schools. The US Youth Risk Behaviour Survey (US YRBS) was used to develop a Lesotho Youth Risk Behaviour Survey (LYRBS) self-administered questionnaire that was completed by the participants. Data analysis was conducted using the analytic components of STATA 10.0. Descriptive statistics and associations between and across categories of risk behaviours were drawn. Pivot tables in Microsoft Excel were also used to develop clusters of multiple behaviour engagement. Eleven clusters were drawn.

Results:

The overall response rate was 63.4%. Comparison could only be made with other countries due to absence of empirical nationwide data on youth risk behaviours in Lesotho. As a result the study will provide prevalence on behaviour and not discuss trends in depth. Gender was found to be a determinant of participation in behaviours, as well as age of initiation. Some of the male learners reported age of onset in some of the behaviours to be as low as 8 years old or younger. Substance use related behaviours were the most prevalent. Lifetime prevalence of alcohol consumption was 51.8%; tobacco use 19.6%, dagga use 16.9%, use of inhalants 12%, prescription drugs 8.4% with 10.7%. Substance use in one month preceding data collection was reported as follows: dagga use 6.2% and binge drinking 17.5%. A high proportion (71.6%) of the learners had parents smoked and more than half (57.7%) were exposed to passive smoke. As for safety on the road, 30.4% of the learners had been driven by a drunk driver, 6% had driven drunk, 13.1% had walked alongside the road intoxicated with alcohol, 21.9% had not used a seat belt as passengers and 21.9% had not used it when driving. With reference to aggressive and violent behaviours 15.9% had carried a weapon, 10.9% had used mathematical compass or divider as a weapon, 22.2% had been involved in a fight, 20.1% were

threatened at school, 38.4% had been bullied and 26.3% were bullied at school. As for partner violence 10.2% had slapped a partner and 4.6% had forced someone into sex. Suicide related behaviours were dominated by female participants. Overall, 12.8% of the learners had attempted suicide and 28.8% had felt sad to an extent that daily activity had been affected. 44.6% of the learners reported having had sex in a lifetime. In three months, 9.9% reported having had multiple sexual partners, 5.7% were intoxicated before having sex in their last sexual encounter, 3.6% had contracted sexually transmitted illnesses and 8.4% had never used condoms. 4.9% had used unhealthy weight control measures, 28.5% had watched TV or played computer games for more than 2 hours on a school day, 31.9% had not done high intensity exercise in a week and 33.1% had gambled. 41.4% of the learners had engaged in 6 or more behaviours concurrently 41.4%.

Conclusion:

The young age of initiation of risk behaviours reported shows that engagement in Lesotho begins in childhood. This has been associated with severe consequences on health and well-being in adulthood. Substance use may be the root cause of risk behaviour associated problems that Lesotho may face. Risk behaviours often co-occur; therefore may lead to complex consequences on quality of life. This motivates for the study of multiple engagement in risk behaviours, particularly those associated with substance use.

Recommendations:

It is recommended that research in risk behaviour engagement among children be conducted to draw information that would enable planning of appropriate intervention. Integrated planning and design of intervention strategies to delay the age of initiation of risk behaviours, could lead to an improved quality of life in adulthood.

Keywords

Concurrent engagement in risk behaviours; Health risk behaviours; Occupational performance; Occupational injustice; Youth

Declaration

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Definition of terms

Concurrent engagement in risk behaviours refers to engagement in multiple risk behaviours simultaneously.

Form refers to the high school levels or grades. In Lesotho these levels are referred to as Forms.

Health risk behaviours are defined as “behaviors that contribute to the leading causes of morbidity and mortality among youth and adults,” Center for Disease Control and Prevention (2008:1). The term risk behaviours and health risk behaviours will be used interchangeably across the dissertation.

Healthy Occupational choices could refer to a deliberate decision to enter and commit to an occupational role through participation, acquire or maintain a healthy habit or undertake a healthy personal project.

Occupation is defined as “a synthesis of doing, being and becoming” (Wilcock, 1999:1) in which doing encompasses tasks and activities in everyday life that consume personal resources such as time and energy (CAOT, 1995 in Dickie, 2009:18).

Occupational choices refer to “deliberate commitments to enter an occupational role, acquire a new habit, or undertake a personal project,” (Kielhofner, 2008:15). These choices influence the kinds of occupational performance that are engaged in on a daily basis.

Occupational justice is described as enabling individuals and communities to reach their full potential as occupational beings, through universal access and equal opportunity to resources and opportunities to engage in health enhancing occupations (Townsend & Wilcock, 2004:78).

Occupational injustice refers to denial, restriction or limitation of fair access to opportunities for engagement in occupations. Individuals may experience

occupational injustice in the form of occupational risk factors, namely; occupational imbalance, occupational alienation, occupational deprivation (Townsend & Wilcock, 2004:78).

Occupational alienation refers to “prolonged experiences of disconnectedness, isolation, emptiness, lack of a sense of identity, a limited or confined expression of spirit, or a sense of meaninglessness” (Townsend & Wilcock, 2004:80).

Occupational deprivation is defined as prolonged denial or restriction to engagement in meaningful occupations by forces outside of the person’s control (Whiteford, 2003:222).

Occupational imbalance was said to be a condition that is made up of three classes: under-occupied, over-occupied and un-occupied (Townsend & Wilcock, 2004:82).

Youth: In Lesotho, youth are classified into three categories namely: developing youth aged 12 to 15 years, well developed youth aged 15 to 25 years and young adults aged 25 to 35 years (www.lesotho.gov.ls/gender/, n.d: Accessed 03/03/2009). The age range for the youth in this study will be between 12 and 24 years of age.

List of Acronyms

CEO	Chief Education Officer
ECOL	Examination Council of Lesotho
EMIS	Education Management Information System
FPE	Free Primary Education
IDM	Institute of Development Management
IECCD	Integrated Early Childhood Care and Development
IT	Information Technology
LCE	Lesotho College of Education
LDTC	Lesotho Distance Teaching Centre
LP	Lerotholi Polytechnic
NCDC	National Curriculum Development Centre
NFE	Non-formal Education
NUL	National University of Lesotho
PIEP	Primary In-service Education Programme
SSU	Schools Supply Unit
TSC	Teaching Service Commission
TSD	Teaching Service Department
TTI	Thaba-Tseka Training Institute
TVD	Technical and Vocational Department
TVET	Technical and Vocational Education and Training
TVT	Technical and Vocational Training

Ministry of Education and Training (2005:8-9).

List of figures

Figure	Page
Figure 3.1: Structure of the Ministry of Education and Training, Lesotho	41
Figure 4.1: Age (in years) distribution of the participants	53
Figure 4.2: Age distribution of the participants by gender	54
Figure 4.3: Frequencies of multiple risk behaviours that participants engaged in	67

List of Tables

Table	Page
Table 4.1: Demographic data of participants	55
Table 4.2: Percentages of participants engaged in behaviours relating to personal safety	56
Table 4.3: Percentages of participants who used tobacco	57
Table 4.4: Percentages of participants who used alcohol	58
Table 4.5: Percentages of participants who used other substances	59
Table 4.6: Percentages of participants who engaged in aggressive behaviours	61
Table 4.7: Percentages of participants who engaged in suicide related behaviours	63
Table 4.8: Percentages of participants who engaged in sexual behaviours	64
Table 4.9: Percentages of participants who were physically inactive	65
Table 4.10: Behaviour clusters	69-71

List of Appendices

Appendix	Title
Appendix One	Letter to Principal Secretary
Appendix Two	Original Lesotho Youth Risk Behaviour Survey- 2010
Appendix Three	Ethics Approval
Appendix Four	Lesotho Youth Risk Behaviour Survey- 2010- Final version
Appendix Five	Letters of approval from schools
Appendix Six	Parent Consent Form
Appendix Seven	Parent Information Sheet
Appendix Eight	Learner Assent Form
Appendix Nine	Learner Information Sheet
Appendix Ten	Selected behaviours for concurrent risk behaviour analysis

List of figures

Figure	Page
Figure 3.1: Structure of the Ministry of Education and Training, Lesotho	39
Figure 4.1: Age (in years) distribution of the participants	52
Figure 4.2: Age distribution of the participants by gender	53
Figure 4.3: Frequencies of multiple risk behaviours that participants engaged in	67

List of Tables

Table	Page
Table 4.1: Demographic data of participants	54
Table 4.2: Percentages of participants engaged in behaviours relating to personal safety	55
Table 4.3: Percentages of participants who used tobacco	56
Table 4.4: Percentages of participants who used alcohol	57
Table 4.5: Percentages of participants who used other substances	58
Table 4.6: Percentages of participants who engaged in aggressive behaviours	60
Table 4.7: Percentages of participants who engaged in suicide related behaviours	62
Table 4.8: Percentages of participants who engaged in sexual behaviours	63
Table 4.9: Percentages of participants who were physically inactive	64
Table 4.10: Behaviour clusters	68-70

List of Appendices

Appendix	Title
Appendix One	Letter to Principal Secretary
Appendix Two	Original Lesotho Youth Risk Behaviour Survey- 2010
Appendix Three	Ethics Approval
Appendix Four	Lesotho Youth Risk Behaviour Survey- 2010- Final version
Appendix Five	Letters of approval from schools
Appendix Six	Parent Consent Form
Appendix Seven	Parent Information Sheet
Appendix Eight	Learner Assent Form
Appendix Nine	Learner Information Sheet
Appendix Ten	Selected behaviours for concurrent risk behaviour analysis

Chapter One.....	5
1.1. Background to Lesotho and Maseru district	6
1.2. Background to the study	7
1.3. Reported risk behaviour engagement	10
1.4. Aim of the study	11
1.5. Objectives	11
Outline of chapters.....	11
Chapter Two.....	13
2.1. Introduction	14
2.2. An occupational perspective of risk behaviours	14
2.3. Reported Youth Risk behaviours in Lesotho.....	16
2.4. Youth Risk behaviours in other countries:	17
2.4.1. Behaviour related to intentional or unintentional injury	18
2.4.2. Substance use	20
2.4.3. Sexual Behaviour	21
2.4.4. Physical inactivity	23
2.5. Consequences of engagement in risk behaviours	23
2.5.1. Consequences of behaviours relating to personal safety on the road.....	24
2.5.2. Consequences of tobacco use	24
2.5.3. Consequences of alcohol and other drug use	28
2.5.4. Consequences of aggressive behaviours	31
2.5.5. Consequences of engagement in sexual behaviours	32
2.5.6. Consequences of physical inactivity.....	33
2.6. Consequences of co-existing behaviours	34
Chapter Three	36
3.1. Study setting	37
3.2. Study design	39

3.3. The questionnaire	39
3.4. Ethical	40
3.4.1. Ethical approval.....	40
3.4.2. Ethical considerations	40
3.5 Pilot study	41
3.6. Sampling.....	43
3.6.1. Population	43
3.6.2 Profile of the schools included in the sample	44
3.6.3 Sample population size	45
3.6.4. Selection criteria.....	45
3.6.4.1 Inclusion criteria.....	46
3.6.4.2 Exclusion criteria	46
3.7. Data collection	46
3.7.1 Gaining access to schools.....	46
3.7.2 Recruitment of learners	47
3.8. Data management	48
3.9. Data analyses	49
Chapter Four	51
4.1. Description of participants	52
4.1.1. Demographic profile	52
4.2. Prevalence of risk behaviours.....	55
4.2.1. Behaviours relating to personal safety on the road	55
4.2.2. Prevalence of tobacco use among participants.....	56
4.2.3. Prevalence of alcohol use	57
4.2.4. Prevalence of use of other substance	58
4.2.5. Prevalence of aggressive behaviours	60

4.2.6. Prevalence of suicide related behaviours.....	62
4.2.7. Prevalence of sexual behaviour	63
4.2.8. Prevalence of participants who were physically inactive	64
4.3. Onset of selected risk behaviours.....	65
4.3.1. Smoking	65
4.3.2. Dagga	65
4.3.3. Alcohol	65
4.3.4. Sexual intercourse	66
4.4. Concurrent engagement in risk behaviours	66
4.5. Conclusion.....	70
Chapter Five.....	71
5.1. Introduction.....	72
5.2. Concurrent engagement in risk behaviours	72
5.2.1. Age.....	73
5.2.2. Gender	74
5.2.3. Form.....	74
5.3. Patterns of engagement	74
5.3.1. Addictive behaviours	75
5.3.1.1 Tobacco use	75
5.3.1.2 Alcohol use	77
5.3.1.3 Dagga and other substance use.....	78
5.3.1.4 Gambling	79
An occupational science perspective of addiction	81
5.3.2. Aggressive behaviours	83
5.3.3. Sexual behaviours.....	84
5.4. Conclusion.....	86

5.5. Limitations of the study	86
Chapter Six	88
6.1. Conclusion	89
6.2. Recommendations	90
6.2.1. Intervention	90
6.2.2. Future research	91

Chapter One

Introduction to the study

Introduction

In 2000, a policy decision was made to formulate a vision for the growth and improvement of Lesotho by the year 2020. This led to the development of a Vision 2020 document. The country made a commitment to attain a healthy and reputable human resource base by the year 2020, with a strong economy, a well managed environment, and well established technology and Basotho will be united as a nation and at peace with self and neighbours (National Vision Document 2004:4). Indicators that were identified for the vision of a healthy and recognized human resource base included being conscious of healthy lifestyles, hygiene practices, good nutrition and partaking in sporting and recreational activities. In addition to these, “there shall be no new HIV and AIDS infections” (National Vision Document 2004:6). This vision relates to behaviours that were studied.

1.1. Background to Lesotho and Maseru district

Lesotho is a mountainous country landlocked by South Africa. The country covers about 30, 355 square kilometres (Bureau of Statistics, 2009:1). Three-quarters of the country popularly known as the “Kingdom in the Sky” constitute highlands rising to nearly 3,500 metres above sea level in the Drakensberg also known as the Maluti Mountain range (UNDP, 2007:8). The country has a population of about 1, 8 million (Bureau of Statistics, 2007:2). People from Lesotho are called Basotho (singular being Mosotho) who communicate in two official languages, namely Sesotho and English. Lesotho is a monarchy that is governed through a democratic government. Administratively the country is divided into ten districts with community councils, constituencies (Bureau of Statistics, 2009:1) and chief led villages within them.

Despite a small population, Lesotho is one of the poorest countries in the world ranking at 103 among 135 developing countries with an overall poverty line of approximately R150.00 and a food poverty line of approximately R84.00 (UNDP 2008: html). It is evident that Basotho are facing a crisis of food shortage and this is likely to impact negatively upon the health of children and youth as among other concerns their nutrition requirements might not be met. This crisis has led to people migrating from the rural areas to the urban settings in search for means to overcome the poverty burden, therefore cities like Maseru have become overcrowded with

people from different regions of the country. This contributed to the decision to conduct the current study in the city of Maseru.

In achieving the goals of Vision 2020, various programs were developed targeting different age groups in the society. Although the majority of the population (55.8%) is between 5 and 29 years of age, the country has a substantial youth population of about 36% who are between the ages of 10 and 24 (Bureau of Statistics, 2005:10). Most of the youth in this age group are found in schools and it is this population group that the vision relates to, as they will be in the productive age by 2020. To achieve the goals of Vision 2020, it becomes necessary to pay attention to current possible factors among young people that may work against the achievement of the goals.

1.2. Background to the study

One of the programs that targeted adolescents in Lesotho was the School Health Programme. This programme was part of a Community Mental Health programme of the only psychiatric referral hospital in Lesotho namely; Mohlomi Hospital. The School Health programme was aimed at curbing the escalating numbers of admission of youth to psychiatric institutions across the country. Majority of the youth were admitted on grounds of engagement in some health risk behaviours such as dagga smoking and excessive alcohol consumption. Prevention of mental illness and promotion of mental health among youth were the main areas of focus.

The researcher was assigned to the Community Mental Health programme on a full time basis in 2006. Some of the activities that were performed included conducting clinic, home and prison visits to provide health education on mental health and rehabilitation. To raise awareness on mental illness and stigma, radio talk shows were hosted. In addition to that, public gatherings and workshops for different sectors of the public were conducted. Strengthening collaboration with different sectors and members of the public such as teachers, police, community leaders and traditional healers was done to create a safe and supportive environment for the mentally ill persons. This was also done to enable early identification of signs of mental illness and appropriate referral.

During visits to high schools, teachers reported an increase in substance abuse, engagement in sexual activities at an early age, attempted suicide, and acts of violence amongst the learners. This was based on their personal judgment, because there had been no research conducted or statistical records to provide evidence. However, concurrently an increase in suicide rate, teenage pregnancy and substance abuse among adolescents was observed throughout the country (The Kingdom of Lesotho 2005:5). Mental Observation Units and the referral hospital provided the statistics. Teachers were also alarmed by a number of their learners being diagnosed as HIV positive, some of them as young as fourteen years old. Teenage girls were identified as one group in Lesotho that was at the most risk of contracting HIV (USAID, 2008:html). Young people in general were also at the highest risk of HIV infection. In 2005 youth between 15-29 years of age accounted for 75% of reported HIV/AIDS cases with 55% of all cases being women (The Lesotho Ministry of Health and Social Welfare, 2005:html). This highlights an urgent need for measures to curb engagement in health risk behaviours that could lead to HIV infection among youth.

Adolescence as a life stage presents a challenge in achieving developmental tasks. These include a sense of identity, striving for independence, entering relationships characterized by love and gaining a sense of control over impulses and emotions (Dulcan & Wiener 2006:19-20). This time is dominated by experimentation, taking miscalculated risks and pushing boundaries with authorities in a struggle to define self and make own rules. Engagement in activities like sexual intercourse, smoking, alcohol consumption, and taking illicit drugs put youth at risk of ill health. These activities are classified as risk behaviours (Reddy et al., 2003:1). These behaviours constitute things that youth do that are not health giving. This actual doing of occupation is defined as occupational performance. From an occupational point of view adolescence is an occupational development stage during which health could be affected in both positive and negative ways and engagement in risk behaviours is a negative way.

As a developing country, Lesotho is undergoing transformation towards a better economy as envisioned for 2020. These changes are accompanied by lifestyle changes, which are often associated with certain behaviours, which may lead to lifestyle diseases (Reddy, et al., 2003:16). For the youth these associated behaviours are predominantly risk behaviours, which may influence their state of health in adulthood (Africa et al, 2008). Most health risk behaviours are likely to be engaged in for extended periods of time, because they can easily be adopted as habits and some are addictive. For example, smoking, alcohol consumption and drug use are addictive, and poor dietary practices, sedentary and sexual behaviours could become habits and ways of living. Kleinert (2007:1057) suggested that drug and alcohol use could be a means to escape poverty and hopelessness for adolescents in developing countries. Engagement in health risk behaviours would hinder attainment of the country's vision by 2020.

It has been widely acknowledged within the profession that, if doing is meaningful and purposeful, health and well-being are attained (Wilcock, 2006:139). This implies that doing has a positive impact on health. As an occupational therapist, the researcher developed interest in identifying the behaviours that youth in Lesotho are engaged in. For example, youth who engage in risk behaviours could also derive meaning from activities such as drinking alcohol with friends and the purpose could be entertainment. However, for these learners doing could have a negative impact on health and well-being, as the behaviours have the potential to result in premature death, incarceration or disability. As a result the behaviours could affect the occupational lives of the youth as well as limit their occupational potential and quality of life, therefore placing them at risk of experiencing occupational risk factors. Within occupational therapy literature, not much attention has been dedicated towards the study of risk behaviours from an occupational perspective. It is advocated that risk behaviours could be understood from an occupational performance and an occupational justice view. As a result, the study will contribute to a body of knowledge in these areas.

Furthermore, the findings of the study could shed light on clusters of behaviours that youth engage in that require urgent attention. Particularly those health risk

behaviours that could result in the development of the country not progressing as envisioned. To establish the role of occupational therapy in public health in Lesotho, the findings could be used to design occupation based intervention to promote health and well-being among youth. However, the current study focus is on youth in schools in the city of Maseru only.

1.3. Reported risk behaviour engagement

Risk behaviours have been identified as leading causes of morbidity and mortality among youth in the US (CDC, 2008:2). Consequently the Youth Risk Behaviour Surveillance System (YRBSS) was developed by the Centers for Disease Control (CDC) as a means to monitor the prevalence of these behaviours (ibid). The information yielded is used for planning and evaluation of prevention programmes.

Other countries other than the USA, have also ventured on initiatives to study youth risk behaviours and prevent engagement in them. These studies have been conducted in countries such as South Africa (Reddy et al., 2003; Flisher et al., 2003:537-541, Flisher et al. 2006:825-830, Africa et al., 2008:473), China (Lee & Tsang, 2004:88-95; Wang et al., 2009:116), Turkey (Alikasifoglu et al., 2007:1253-1260), Brazil (Lopes Neto, 2005:S166), Namibia (Rudatsikira et al., 2007: html; Chinsembu et al., 2008:129), Zambia (Siziya et al., 2008), Swaziland (Buseh, 2004:359) and Nigeria (Morhason-Bello et al., 2008:89) among other. This highlights the important need to be at par with other countries by identifying and establishing the prevalence of risk behaviours for Lesotho.

The intention of the study is to gain insight on the prevalence of risk behaviours among high school learners in the city of Maseru, Lesotho. A study of this nature and magnitude had previously not been conducted in Lesotho. Therefore, the study will provide relevant baseline data on occupations of concern and this could inform development of intervention programmes aimed at promoting healthier occupational choices among the youth. It is envisaged that different sectors of the public could make use of the findings of this study to alert them to the needs of the youth in Lesotho. This would enable them to respond accordingly with regards to their expertise. These include curriculum developers, educators, police, correctional

services, the health sector; youth programme developers, religious organisations, politicians and parents.

1.4. Aim of the study

To establish the prevalence of risk behaviours among the youth who are high school learners in the city of Maseru, Lesotho.

1.5. Objectives

The objectives focused on different health risk behaviours. These were:

- To establish the socio-demographic profile of high school learners who engage in health risk behaviours in schools in the city of Maseru.
- To determine the proportion of learners who engage in risk behaviours related to personal safety.
- To determine the proportion of learners who engage in violence-related behaviours.
- To determine the proportion of learners who express feelings of sadness or have attempted suicide.
- To determine the proportion of learners who engage in tobacco use.
- To determine the proportion of learners who use alcohol.
- To determine the proportion of learners who use illicit drugs.
- To determine the proportion of learners who engage in sexual behaviours.
- To determine the proportion of learners who engage in physical activity.
- To establish relationships between different groups of learners within and across categories.

Outline of chapters

This dissertation will be made up of six chapters. These will entail a review of literature that will be presented in chapter 2. The review will outline the prevalence of the different types of health risk behaviours in different settings. Behaviours that were studied include those related to personal safety, violence, tobacco, alcohol, illicit drug use, sexual behaviours, depression and suicide, sedentary behaviour and nutritional habits.

In chapter 3, the methodology is discussed in-depth. Introduction of the chapter will be followed by an outline of the study. This will be complemented by presentation of the structure of the Ministry of Education and Training in Lesotho as the administrative entity of education in the country. The study design will be stated and the data collection tool introduced thereafter. Thereafter a description of the pilot study and sampling will follow respectively. Data collection as the crux of the study along with management and analysis shall then be engaged at length. This account will also include discussion of methodological limitations and how they were overcome.

The findings of the study will be presented in chapter 4, which will be followed by a discussion of those findings in chapter 5. This chapter will end off with an outline of the study limitations. To bring the research journey to a close a conclusion will be drawn along with recommendations to form the last chapter (chapter 6).

Chapter Two

Literature Review

2.1. Introduction

This chapter will provide an outline of the view points of health risk behaviours according to previous studies. An occupational perspective of risk behaviours will serve as a theoretical reference point for this study, therefore it will be presented first. This will be followed by an outline of prevalence of risk behaviours reported in Lesotho and in other countries. Consequences of participation in risk behaviours will then be discussed. Lastly, concurrent engagement in these behaviours and the consequences thereof will be engaged.

2.2. An occupational perspective of risk behaviours

An occupational perspective could be described as a way of considering the influence of participation in occupations on health and illness. This view embraces the occupational nature of humans. From an occupational perspective, there are a number of ways through which health risk behaviours may be understood. However, for the purposes of this study two approaches will be adopted. These two approaches are viewing risk behaviours in light of occupational performance or as doing and the impact on health, and from an occupational injustice point of view.

The first approach could entail using Hagerdorn's (2000:26) analytical taxonomy that proposes a hierarchy for analysing levels of occupation in which types occupational performance could be seen to occur at three levels. These levels are the organisational, developmental and effective levels. All the risk behaviours can fit at least one of these occupational performance types.

The second occupational perspective is that consequences of risk behaviours may lead to the experience of occupational risk factors. Risk behaviours could be both a cause and a consequence of occupational risk factors. These risk factors are occupational alienation, deprivation and imbalance (Townsend & Wilcock, 2004:75-87). Participation in risk behaviours could result in occupational dysfunction in different spheres of an individual's occupational life, therefore impacting on the overall well-being and quality of life. Helbig & McKay (2003:141) indicated that with reference to addictive behaviours, occupational risk factors may be experienced because the behaviour could affect the health of the individual and impact on the

larger society. Risk behaviours may potentially impact on health and wellbeing at the micro, meso and macro levels, as behaviours occur within a social environment. The consequences of these behaviours could affect the person and the environment. Wilcock & Townsend (2009:193) indicated that participation in occupations is “interdependent and contextual and is a determinant of health and quality of life.”

Engagement in risk behaviours could indicate that participation in occupations can have a negative impact on health. This presents a challenge to Occupational Therapists as it is widely accepted in the profession that meaningful and purposeful occupations promote health and well-being. Wilcock (2006:139) indicated that “if well-being is to be attained, doing needs to provide meaning and purpose.” Youth who engage in risk behaviours could also derive meaning from activities such as drinking alcohol with friends and the purpose could be entertainment. In this case, this activity does not promote the health of the youth in question. A realization that occupations could be detrimental to health has led to a proposed review of the profession’s shared assumptions that view engagement in occupations from a positive stance only (Hammell, 2010:41). This study could contribute to this body of knowledge that is aimed at showing that occupations of choice, which are both meaningful and purposeful can be detrimental to health.

The influence of environment on occupational engagement could show that behaviours are likely to differ with context. Forsyth & Kielhofner (2006:75) related that “environment potentially offers opportunities, resources, demands and constraints” for occupational engagement. At times, different environments can elicit the same behaviour and a single environment can lead to multiple behaviours. Barry & Jenkins (2007:15) added that there is an inextricable link between individuals and their environments. This shows that risk behaviours are environment dependant. When unhealthy occupational choices are made, they will often be followed by participation in occupations which will lead to ill health.

Gaining an understanding of these behaviours as forms of doing that have an impact on health, well-being and future quality of life would allow occupational therapists to establish their role in public health. This is very important for Lesotho as currently

occupational therapists are not involved in public health. Occupational therapists and scientists have a unique understanding of what people do which enables them to adopt a different approach towards intervention.

2.3. Reported Youth Risk behaviours in Lesotho

There is hardly up to date empirical information available on youth risk behaviours in Lesotho. However, in the Mental Health Policy draft (The Kingdom of Lesotho 2005:5), an increase in the suicide rate among adolescents was reported. This was said to be coupled with teenage pregnancy and substance abuse. Depression was one of the leading psychiatric illnesses among both among males and females, ranking second in females and fourth in males (The Lesotho Ministry of Health and Social Welfare, 2005: html). Despite the absence of an empirical study to verify these statistics, they are similar to findings across the world. The lifetime risk of depression among women was 20-25% compared to that of men which was 7-12% (Khandelwai et al., 2001:7). This indicates that the likelihood of depression in a life time is higher among females than males.

Alcohol was identified as one of the common causes of mental illness among Basotho males. WHO (2004:2) highlighted that “70% of the 67 patients treated for substance abuse had alcohol as their primary substance of abuse during the period January to June 2003, and 78% of the patients treated were males.” Alcohol use seems more prevalent among the youth and young adults.

Binge drinking is common, particularly among young males. WHO (2004:1) reported that 36% of the hazardous drinkers (n=348) were males. Alcohol consumption can start as early as five years old. Baingana et al. (2006:335) highlighted that “8.8% of children between the ages of 10 and 14 years, and 4% of those between 5 and 9 years in Lesotho currently use alcohol.” This often continues and becomes worse as they progress into adulthood.

Other adverse effects of alcohol use that have been reported in Lesotho include, violence, abuse and traffic accidents. WHO (2004:2) added that alcohol consumption accounted for 37% of assault injuries at Quthing Hospital (a secondary hospital in

the Quthing district) in 1988. The statistics could be worse in the present day. In Maseru an estimate of over 60% casualty cases attended to at Queen II Hospital (only public tertiary hospital in Lesotho) were alcohol-related (The Kingdom of Lesotho, 2005:5). Alcohol consumption may increase the incidence of injury.

Dagga induced psychosis has also been listed among the five most prevalent psychiatric illnesses in Lesotho, despite being an illegal substance. The present economic status of the country has led to an increase in the poverty rate. According to UNDP (2008: html) the Human Poverty Index value for Lesotho was 34.6% and the country ranks as 103 among 135 developing countries. This makes Lesotho one of the poorest countries in the world. Basotho have resorted to growing and selling dagga to earn a living. Laniel (1998: html) and Bloomer (2009:49) supported this view by pointing out that one of the three main sources of hard currency in Lesotho was production of dagga. Growing of the substance has resulted in it being easily accessible, to the youth. In Sesotho dagga is referred to as “matekoane”.

The danger associated with the production of dagga in Lesotho is that other recreational drugs can be derived from this substance. For example, “white pipe” which is common in South Africa is made from a mixture of Mandrax and low grade dagga (Laniel, 1998:html). Youth sometimes couple dagga use with alcohol consumption; this could lead to substance-induced psychosis. Co-existence of risk behaviours is a major concern for the health of the youth as the future human resource base of the country. The findings of this study could be utilized development of appropriate intervention to prevent and reduce engagement in health risk behaviours among youth in Lesotho.

2.4. Youth Risk behaviours in other countries:

Other countries across the world are more advanced than Lesotho in the study of risk behaviours among youth. The US engages in the exercise of youth risk behaviour surveillance bi-annually. This shows the importance of understanding and establishing the prevalence of risk behaviours as they have been associated with adverse consequences on health and well-being.

2.4.1. Behaviour related to intentional or unintentional injury

Intentional and unintentional injuries have been suffered by youth around the world as a result of multiple factors that put them at risk. Some of the behaviours include violence, traffic related activities, suicide and bullying. Traditionally schools have been regarded as safe havens that are able to provide learning, engaging and socializing environments that are capable of producing disciplined and well behaved future citizens of a country. However, in the past years there has been an increase in risk behaviour engagement on school property or on the way to or from school (Reddy et al, 2003:12). Bullying has been identified as the most common form of violence that occurs among learners in schools.

The act of bullying can be described as a display of power relations, in which the more powerful display aggression towards the less powerful. Lopes Neto (2005:S165) defined bullying as “a form of interpersonal power affirmation by means of aggression.” Bullies were more likely to be males than females. In a study that aimed at documenting and comparing the prevalence of injury-related behaviours among adolescents in six sites in South Africa, 33% of the male learners in grade 8 in one site had bullied others. Victims made up 44.5% of the same group (Flisher et al., 2006:828). However, in Turkey the percentage of bullies was far less than that of victims. A study was conducted in Istanbul where bullying behaviour was investigated among 3519 learners. 22% of the learners were victims, whereas 9.2% were bullies (Alikasifoglu et al., 2007:1253-1260). Bullying is a behaviour that may be indicative of poor interpersonal relationship skills. Other risk behaviours have been associated with bullying. Alikasifoglu et al. (2007:1253) highlighted that physical fighting, substance use, not adhering to road safety regulations and sexual activity were more prevalent among bullies.

Another injury related behaviour that was studied was fighting. In Namibia a study on prevalence of physical fighting and associated factors was conducted. 50.6% of the 6283 learners that participated had been involved in a physical fight and substance use was positively associated with the fighting, (Rudatsikira et al., 2007: html). Namibia had the highest prevalence rate in physical fighting. The co-occurrence of physical fighting and substance use was also found among US high

school students. A study that focused on physical fighting on school property and associated variables was conducted and 13857 US students participated. 13.5% of the learners had engaged in fighting on school property and they also reported use of alcohol, illegal substances, stealing or damaging property intentionally and using weapons (Rudatsikira et al., 2008: html). Youngblade & Theokas (2006:58) added that risk behaviours could occur individually, although they often occur concurrently. Male learners were more likely to engage in physical fighting than female learners.

In South Africa learners from six sites reported engagement in a number of injury-related behaviours. Learners in Cape Town participated in road-related risk behaviours more than learners from other sites. 52.8% of 1449 Grade 11 learners reported having travelled without using a seat belt, 27% of the learners had travelled with an intoxicated driver and 18.9% had cycled without wearing a motorcycle helmet (Flisher et al., 2006:828). In comparison with learners in Hong Kong, 32.4% had rarely or never worn a seatbelt and 62.5% had not used a bicycle helmet (Lee & Tsang, 2004:90). However, in the US only 11.1% learners had travelled without wearing a seatbelt and 29% had been passengers in a vehicle driven by an intoxicated driver (Centers for Disease Control and Prevention, 2008:1). Learners put themselves at risk of injury by not adhering to road safety precautions. Flisher et al. (2006:827) noted a tendency of injury-related behaviour occurring in the urban settings more than in the rural areas.

The prevalence of suicide attempts among learners in Hong Kong was 3.5% (Lee & Tsang, 2004:90). In another area in China, Guangzhou, 5988 students participated in a study and the suicide attempt prevalence rate was 3.2 % (Wang et al., 2009:116). It could be deduced that the incidence of suicide attempts was low among Chinese learners. Similar findings were derived from a study in the United States, where 6.9% of the learners had attempted suicide (Centers for Disease Control and Prevention, 2008:1). South Africa had the highest prevalence (17.3%) of attempted suicide among learners (Reddy et al., 2003:96). The Community Mental Health Team in Lesotho had expressed concern about the apparent increase in the rate of suicide attempt by learners. This was despite the absence of data to verify or discredit the increase. The proximity of Lesotho to South Africa could see youth from

the two countries engaging in similar risk behaviours, therefore enabling sharing of ideas on interventions. However, without data on these behaviours from Lesotho collaboration is less likely. As a result, this study aims to provide baseline data on the prevalence of youth risk behaviours.

2.4.2. Substance use

Engagement in behaviours related to intentional or unintentional injury has been found to co-occur with other risk behaviours such as use of substances and/or having sex. The prevalence of alcohol use appears to be higher than that of other substance use in many countries. For example, in Hong Kong, China 58.1% of high school learners had consumed alcohol in a lifetime as compared to 1.5% who had sniffed glue (Lee & Tsang, 2004:90). Other recreational drugs were not reported on. The pattern in the US was similar, with 75% of learners having drunk alcohol and 4.4% using recreational drugs (Centers for Disease Control and Prevention, 2008:1). South Africa did not fall behind with alcohol consumption among learners dominating the substance use statistics. The first South African YRBS found that 49% of the learners had used alcohol in a lifetime compared to heroin (12%) and use of inhalants (11%) (Reddy et al., 2003:12). Alcohol appeared to be a major problem among youth in South Africa, as was the case in Lesotho despite the absence of recent data.

Smoking cigarettes and cannabis was reported by learners who participated in the South African YRBS. 31% of the learners had smoked and 13% had used cannabis (Reddy et al., 2003:12). The learners also reported exposure to second hand smoke and the highest rate of exposure (56%) was from parents or guardians. Second hand smoking can expose non-smokers to dangers associated with inhalation and probably increase the likelihood of the non-smoker eventually smoking. In another study conducted in South Africa, female learners reported use of alcohol (24%) and 15% had smoked cigarettes (Africa et al., 2008:473). This shows that youth are prone to risk behaviours regardless of their gender.

Prevalence of tobacco use and exposure was compared between learners in Uganda and those in Malawi. Learners in Malawi (6.2%) were more likely to have smoked than their peers in Uganda (5.6%) (Adamson & Mpabulungi, 2007:45). The exposure to tobacco-related advertisements was regarded as high and this was thought to have an impact on the rate of tobacco use. The rates in both countries are particularly low in comparison to the prevalence rate in South Africa. Through this study the frequency of smoking among high school learners will be measured as well as exposure to second-hand smoke.

Cigarette smoking, alcohol consumption and drug use have been positively associated with sexual risk behaviour in learners in Namibia (Chinsembu et al., 2008:129). In Zambia use of dagga and alcohol increased the likelihood of learners having sex (Siziya et al., 2008). This further supports the view of co-occurrence of risk behaviours, hence the need for an instrument like the YRBS that takes into account the possibility of co-existence of risk behaviours.

2.4.3. Sexual Behaviour

The present HIV/AIDS pandemic in Southern African, has led to a growing research body on sexual risk behaviours among adolescents. In Zambia and Namibia the Global School-Based Health Survey (GSHS) developed by the World Health Organization (WHO) was used in surveys. The results indicated that in Zambia 13.4% of 2136 learners reported partaking in sexual intercourse (Siziya et al., 2008:1). In Namibia an overall prevalence rate of 33.2% in sexual activity among learners 6367 was reported with the males being more active than females (Chinsembu, 2008:129). The YRBS and the Knowledge Attitudes, Beliefs and Practice (KABP) survey which were developed by CDC and WHO respectively, were used in Swaziland (Buseh, 2004:358). A prevalence rate of 54% among 941 learners was found. All instruments were modified for the specific country. Swaziland seems to have the highest prevalence rate of sexual behaviours among learners. Lesotho does not fall far behind, with an adult prevalence rate of about 23% (USAID, 2008:html). In all the countries male learners were more likely than female learners to engage in the activity, except for Lesotho where females were more likely (14.3%) to

have intergenerational sex than males (5.6%) the same age of 14-24 years (ibid). The risk of contracting illnesses for sexually active learners is a concern.

In South Africa 41% of the learners reported having had sex in a lifetime and 70% were sexually active within 3 months prior to the survey (Reddy et al., 2003:111). In another study among female adolescents, 27% of 801 girls reported current sexually active (Phillips & Malcom, 2006:426-437). For the above sub-Saharan African countries, the age of initiation of sexual activity ranges between 13 and 15 years of age, with Swaziland learners starting at the youngest age.

Other African countries also seem to be faced with the same sexual activity concern among the youth, as a result of the HIV/AIDS pandemic. In Ethiopia 20 434 youth were recruited for a study to explore risky sexual behaviour and its association with substance use (Kebede et al., 2005:html). The study compared the behaviours of in and out-of-school youth and generally in school youth had a lower prevalence. For example, 12 months prior to the study, 1.4% of learners reported engagement in unprotected sex, compared to 20.7% of out-of school youth who reported the same behaviour. The overall rate of sexual activity was 82% (ibid). This prevalence rate is close to that of South Africa, even though the rate was only based on school going youth.

In Nigeria an overall sex prevalence of 28.3% was reported (Morhason-Bello et al., 2008:89). The overall prevalence rate for this sample (N=695) was similar to that among adolescent girls (27%, $n=801$) in a study conducted in South Africa (Africa et al., 2008:473). The male learners in Nigeria had a higher prevalence rate (65%) of sexual exposure than the females (34.5%), as in other African countries. It could be deduced that high school learners in the African continent are predominantly sexually active and this is in line with their developmental stage.

In Hong Kong, China, a study 3.4% of 26 111 learners reported engagement in sexual intercourse (Lee & Tsang, 2004:88). Similar to the African countries, the males were more likely to engage than the females. It was noted that the age of initiation was before 13 years of age for children whose parents were less educated

(Lee & Tsang, 2004:91). This group also had a higher prevalence rate for other health risk behaviours. The difference between the overall prevalence of sexual activity of learners in China as compared to learners in Africa is notable. Maybe partnerships could be formed to inform practices in Africa that could aid in decreasing the risk of youth contracting sexually transmitted illness and HIV.

The Youth Risk Behaviour Surveillance that was conducted in the United States in 2007 indicated that 47.8% of high school learners had engaged in sex in a lifetime and 35% of them were currently active (Centers for Disease Control and Prevention, 2008:1). The findings were compatible to those of the Caribbean where 47% of the adolescents had had sex in a lifetime (McBride et al., 2005:S47). Learners who rated their relationship with parent(s) as 'great' were less likely to engage in HIV risk behaviours (McBride et al., 2005:S51). This could indicate that there are numerous determining factors associated with engagement in risk behaviours and these factors may be contextual, as in family or community.

2.4.4. Physical inactivity

Physical inactivity has been identified as an area of concern with regards to youth risk behaviours. In the US about 65% of the youth were not meeting the recommended levels of physical activity (Centers for Disease Control and Prevention, 2008:1). In South Africa 25% of the learners reported not having Physical Education classes in their schools and 25% of them watched television more than 3 hours per day (Reddy et al., 2003). Physical inactivity seems likely to co-occur with sedentary behaviour. Co-occurring risk behaviours tend to have severe outcomes.

2.5. Consequences of engagement in risk behaviours

The consequences of partaking in risk behaviours differ in degree of severity. Some can be reversed whereas others may be fatal or result in a disability. Occupational performance may be negatively affected by these behaviours on the one hand. On the other hand, dysfunctional occupational performance that is characterized by

engagement in occupations, tasks and activities that are detrimental to health, may result in occupational injustices.

2.5.1. Consequences of behaviours relating to personal safety on the road

Road safety is crucial for ensuring safe travelling, whether by foot, car or any other form of transport. To ensure this safety, there are precautions that have to be adhered to by road users. These include using a seatbelt when driven and when driving, using protective gear when riding a bicycle and avoiding walking alongside the road when intoxicated. The consequences of these behaviours could be fatal, traumatic and potentially result in disability.

Alcohol consumption and drug use contribute to the consequences of behaviours relating to personal safety on the road. More than one third (36.2%) of the persons injured were involved in road accidents in Maseru with 61.1% of them as pedestrians (Bureau of Statistics, 2009:33). These statistics are relatively high and they show that pedestrians are more likely to get injured in road accidents. This is concerning as some youth walk alongside the road intoxicated, therefore becoming prone to accidents and consequently death.

2.5.2. Consequences of tobacco use

Behaviours related to use of tobacco or its products included smoking cigarettes, using snuff and passive smoking. Lack of research in occupational therapy on the effects of tobacco use on occupational performance or engagement indicates an urgent need for research in this area, particularly among youth. However, other fields have embarked on research to study the consequences of youth tobacco use in depth.

Tobacco use is a worldwide concern that contributes largely to the burden of disease in both developing and developed countries. Tobacco has been found to be a leading cause of preventable diseases and premature death compared to any other drug (Mathers et al, 2006:948). By 1999 tobacco consumption accounted for an estimated 4 million deaths annually. If the current trends in tobacco use remain the

same, a 10 million increase in deaths annually is projected by 2030 (Guindon & Boisclair, 2003:vii). This makes tobacco consumption a public health emergency. In addition to the resultant fatal potential outcome of tobacco use, it may be a predictor [and precipitator] of engagement in other health risk behaviours (Strine et al., 2005:186). Tobacco could be regarded as the initiation drug as adolescents often resume substance use by smoking or using other tobacco products.

Studies have been conducted at length across the world to establish the effects of tobacco use on health among different groups of societies. In one study, a review of literature on the long-term relationship between starting to use tobacco before 18 years of age and behavioural consequences in adulthood was conducted (Mathers et al., 2006:948-958). The study drew from studies done between the years 1980 and 2005. 100 papers were reviewed and it was established that youth tobacco use definitely predicted emotional, health and social problems that became evident in adulthood. Among Japanese youth, early onset of smoking among was found to predispose them to contracting cancer as a result of smoking for longer and inhaling large amounts of smoke (Hara et al., 2010). The study also established that there was a higher risk of cancer among individuals who had started smoking before the age of 17 years as compared to those who started after 20 years of age.

Other physical ailments were also attributed to smoking. In a study involving 4472 participants a strong association between “smoking- related cancer, cardiovascular disease and peptic ulcer” was found (Hozawa, et al., 2006:196-198). Smoking was also identified as a risk factor for atherosclerosis (Garbin et al., 2009). Added to that, the oral health of tobacco users has been found to be threatened. Tobacco has been identified as the leading cause of oral ailments as well as loss of teeth (Beaglehole & Petersen, 2005). Among oral diseases, tobacco use caused oral cancer, periodontal disease, halitosis, discoloration of teeth and a reduced ability to taste and smell (Reibel, 2003:23-27). These consequences are likely to impede daily function and social interaction, therefore affecting the well-being and quality of life of the individual.

Other than physical ill health, smoking was coupled with the possibility of psychiatric disorders. This finding was derived from a review of five cohort studies (Mathers et al., 2006:953). More specifically, smoking was linked to an increased risk of developing panic attacks and panic disorder in young adulthood years (Goodwin, Lewinsohn & Seeley, 2005:690). Mood disorders have also been associated with smoking, in particular depression. In their study Strine et al. (2005:185-186) found that there was a strong association between smoking and health-related quality of life (HRQOL). From the sample (N=82 918), current smokers (N=18 960) reported depressive symptoms, anxiety and mental distress more frequently than those who never smoked. This further illustrates the likelihood of a strong association between smoking and psychiatric disorders, therefore suggesting that smoking may be a contributing factor or manifestation of psychiatric illnesses such as depression.

Substance abuse or dependence has been coupled with smoking. Early initiation of smoking has been associated with the increased likelihood of alcohol and other substance use, therefore predisposing the individual to alcohol and drug dependence or abuse in adulthood (Mathers et al., 2006:948). Alcohol dependence and abuse are known psychiatric disorders (De Miranda & Wilson, 2002:182-183) that have adverse impacts on function, role performance and social interaction. Presence of a psychiatric disorder limits occupational performance and engagement, therefore may lead to the experience of occupational risk factors.

There are a number of predictors of adolescent initiation of tobacco use. One predictor of smoking and panic attacks in youth was having parents who smoke (Goodwin, Lewinsohn & Seeley, 2005:690). Adolescents whose parents smoke may be exposed to the dangers of second-hand smoke within the home environment. They are also likely to mimic the behaviour of their parents as their role models. Exposure to second-hand smoke has been associated with adverse effects on the health of children. For example, a study conducted in Taiwan established that there was a relationship between household environmental tobacco smoke and the heightened prevalence of respiratory problems such as asthma, wheeze and bronchitis symptoms in children (Tsai, Huang & Lee, 2010:16). Implications of exposure to passive smoking could be costly as well as potentially fatal.

The negative impact of smoking to the economic status of families and nations is evident. This may be affected in two ways; one being the cost of healthcare for treatment of tobacco-related illnesses and the other being loss of productivity due to absence. For example, from 1999 to 2004 it was found that passive smoking in the U.S accounted for about 15 000 to 75 000 coronary heart disease related deaths and treatment ran a cost of up to \$6 billion per year (Lightwood et al., 2009:17). As for loss of productivity, smoking resulted in absence from work, accounting for an extra 10.7 days absence annually (Lundborg, 2007:117). Another source of loss of production could be impaired function among the productive age group as a result of the consequences of smoking. The economic burden of tobacco use could be underestimated, because of the predisposing nature of the behaviour to other risk behaviours, particularly when risk behaviours tend to co-exist. Simultaneous engagement in risk behaviours could have worse economic and functional implications. As a result, identifying and gaining an understanding of the multiple risk behaviours that high school learners in Lesotho engaged in would enable development of comprehensive intervention to minimize the associated economic and functional implications.

In conclusion, tobacco use has been shown to be a preventable leading cause of morbidity, mortality and impaired function worldwide, despite society's tolerance and in some instances encouragement or modeling of the behaviour to children and youth. Engagement in tobacco use could precipitate engagement in other health risk behaviours, therefore increasing the severity of the consequences on health and well-being. It is evident that it takes time and prolonged use for tobacco effects to surface, therefore indicating that tobacco is a "slow killer". The findings of this study show that high school learners in Lesotho are already using tobacco products, so they are at risk of suffering the most adverse effects of tobacco use during their adulthood years. In the year 2020 the learners' age range will be 22 and 37 years, therefore being at the developmental stage of adulthood. This shows that the country is faced with a challenge of reversing these potential consequences as they threaten the country's development vision of establishing a healthy human resource base by the year 2020. The urgency of decreasing tobacco consumption globally is being

strategically addressed by the World Health Organisation (WHO) through development of a treaty named the WHO Framework Convention on Tobacco Control (FCTC) (Petersen, 2003:137). Lesotho has signed this public health treaty; however measures such as legislation or policy on tobacco control are not yet in place (Moremoholo, 2008:14). The study will provide information on health risk behaviours pertinent to Lesotho, thereby convincing the Basotho to take action towards curbing among others tobacco consumption as it has been associated with the onset of other risk behaviours, particularly alcohol consumption.

2.5.3. Consequences of alcohol and other drug use

Prescription or over-the-counter medication, tobacco, alcohol, dagga and other illicit substances are classified as drugs. In literature they are often referred to as psychoactive or psychotropic drugs (Ghodse, 2005:2). The terms 'drug' and 'substance' are often used interchangeably. In the DSM-IV-TR these drugs are referred to as substances (First, Frances & Pincus, 2004:123). Use of these substances can be for various reasons, such as medical, recreational or casual depending on the nature of the drug. The different ways of drug use could be associated with differing degrees of severity of the effects of the particular substance. In this section, the consequences of alcohol, illicit drugs, dagga, inhalants and over-the counter medication use will be discussed.

Alcohol consumption could result in alteration of mood known as intoxication. Episodes of intoxication could result in problems in behaviour and psychological functioning such as aggression and physical fights (De Miranda & Wilson, 2002:181). Data from a Youth Violence Survey in the U.S 2004 was used to determine associations between early initiation of alcohol use and engagement in three different types of violence; namely, dating violence, peer violence and suicide attempts among 856 seventh grade learners (Swahn, Bossarte & Sullivent, 2008:301). An association was found between alcohol use and the three violent behaviours. Youth who began alcohol consumption before 13 years of age (13%), were more likely to engage in dating and peer violence victimization and perpetration as well as attempt suicide or report suicide ideation. Violence-related injuries and

suicide attempts could result in fatalities, therefore increasing the mortality rate among youth.

In another longitudinal study, alcohol-related injuries among Canadian adolescents and young adults (N=2389) who reported to emergency departments were found to increase (Lea, Black & Asbridge, 2009:330-336). The types of injuries that they presented with were violence-related, self inflicted and unintentional. Use of substances alters the function of the central nervous system, hence the change in behaviour coupled with poor cognitive functioning. In Korea, early onset of alcohol consumption (before 13 years of age, 35.1%), coupled with cigarette smoking (21.1%) and sexual intercourse (1.5%) among 13-19 years old learners (N=63 884) was found to predict later suicidal behaviour (Kim & Kim, 2010:20-25). Like tobacco, age of initiation of alcohol was a predictor of engagement in other risk behaviours, therefore further complicating the consequences of consuming alcohol.

Adverse effects on health could negatively affect the quality of life of youth who consume alcohol. A study on the relationship between Health-Related Quality of Life and use of three drugs among youth (N=2235) was conducted in Taiwan (Chen & Storr, 2006:9-16). These commonly used drugs were alcohol (7%), tobacco (5%) and betel nut (1%). An association was found between alcohol use and lower level health-related quality of life, with alcohol consuming youth reporting suffering bodily pains and experiencing role-related emotional problems. The health-related quality of life did not worsen despite the presence of concurrent use of tobacco or betel nut. Although, no significant change (decrease) in quality of life was indicated for concurrent engagement in risk behaviours, the consequences could be more detrimental to health and well-being. Ghodse (2005:2) indicated that serious unfavourable effects are associated with drug use, whether the use was casual or recreational.

Concurrent use of different substances could result in drug dependence, although different substances on their own could induce drug dependence. For example, individuals who started using cannabis during adolescent years were more likely (2-4times) to develop drug dependence within a year and similar findings applied to

those who used inhalants (Chen, Storr & Anthony, 2009:320). This was in comparison to individuals who resumed cannabis and inhalant use in adulthood. Drug dependence is a diagnosable psychiatric disorder that is characterised by a number of clinical features. Wilson & De Miranda (2002:197) highlight that dependence presents as a cluster of symptoms of a cognitive, behavioural and physiological nature and despite evident substance use-related problems the individual continues using the substance(s).

Drug dependence could precipitate occurrence of other psychiatric disorders. A prospective test was used to evaluate the relationship between cannabis use, dependence and abuse and development of panic attacks and panic disorder overtime (Zvolensky et al., 2008:1021). The findings indicated that a prospective association exists between cannabis use and dependence and the increased likelihood of panic attacks and panic disorder. Other than the possibility of psychiatric disorders, substance use has been associated with the incidence of physical consequences such as violence and injury. In South Africa it was found that cannabis and other drugs accounted for the burden of injuries at trauma units where between 33% and 62% of the patients tested positive for at least one drug (Parry et al., 2005:431). Further to that, substance use, particularly alcohol and cannabis were found to contribute to risky sexual behaviour among eighth grade students (2204) in South Africa (Palen et al., 2006:762). Cannabis and alcohol using students (39%) were found to put themselves at risk of contracting sexually transmitted illnesses as well as HIV, by intermittently using condoms (25-75% of the time) and having multiple partners.

The findings suggest that prevention or delaying the age of initiation of all substance use could limit engagement in other risk behaviours. In addition to that, use of one substance could predict use of other substances. It is imperative that measures are put in place to curb or discourage participation in risk behaviours, particularly among youth. This is because addiction to substances could limit their ability to become who and what they have the potential to become, as satisfying the addiction could be an occupation that fills their time.

2.5.4. Consequences of aggressive behaviours

Aggressive behaviours that were investigated in this study were related to being victimized, perpetration and partner violence. This shows that aggressive behaviours may result in violence. Behaviours such as bullying and violence have been identified as problems of aggression that are prominent among adolescents in schools (Turagabeci, Nakamura & Takano, 2008:1). The violence emanating from aggressive behaviours could result in injuries, trauma or premature death.

Violence may negatively impact on the health and well-being of both the perpetrator and the victim. The perpetrator could live in fear of revenge from the victim and the victim may be left traumatized or injured. The effects of violence could affect school performance and may lead to psychiatric disorders, particularly psychological problems that may have longer lasting effects than physical injuries (Swahn et al., 2008:37). Furthermore, the burden of injury among youth around the world has been accounted for by violence related behaviours (Smith et al., 2008:145) as well other behaviours such as substance use.

Like other risk behaviours, aggressive behaviours often co-occur. A study aimed at understanding how different forms of violence; namely dating, peer violence and suicide related was conducted and strong associations were found between different types of violence among high school learners (N=4131) in the US (Swahn et al., 2008:37). Increased odds of partaking in one form of violence or the other were found between victimization and perpetration for both peer and dating violence (range OR= 2.63 to 11.43). It was also established that different forms of violence co-existed. These types of violence were classified as self-harm, dating violence and peer violence.

Engagement in aggressive behaviours is likely to also be associated with participation in other risk behaviours, such as sexual behaviours, substance use and smoking. In a study among Mexican learners (N=7960) risk factors associated with dating violence among the learners were violence within the family and having multiple lifetime sexual partners (Rivera-Rivera et al., 2007:477). Youth who were exposed to intra-familial violence were more likely (1.5 to 2 times) to be perpetrator

and victims of partner violence. Gang membership, alcohol and illicit use were also associated with partner violence. Partner violence is likely to lead to actions such as forced sexual interaction. This further solidifies the view that risk behaviours, tend to co-occur. The findings indicate a need for intervention not only directed at the learners as peers and partners, but at parents as well.

Acknowledging and understanding that risk behaviours often co-occur would enable more informed and appropriate intervention planning directed towards reduction of the burden of injury. Swahn et al. (2008:37) suggested that lack of understanding of how different types of violence were related may have led to ineffective violence prevention strategies. The potential fatal consequences of violence highlight the urgency of studying risk behaviours and planning intervention according to the need at hand.

2.5.5. Consequences of engagement in sexual behaviours

In Lesotho the prevalence of HIV/AIDS in 2005 was 23.2% among the productive age group of 15-49 years (UNDP, 2007:45). The majority of the participants in this study may fall within this age group. When youth expose themselves to the risk of contracting HIV and sexually transmitted illnesses through participation in risky sexual behaviours, they will add to the burden of disease caused by the pandemic in Lesotho. This study will establish the extent of engagement in risky sexual behaviours among high school learners.

Some of the risky behaviours that youth engage include having multiple partners, not using a condom and being intoxicated before having sex. A study aimed at determining the relationship between substance use and engagement in risky sexual behaviour among learners (N=2204) in Mitchell's Plain, Cape Town. It was found that there was an association between being intoxicated with either alcohol or marijuana and having sex with a stranger (Palen et al., 2006:763). In a similar study in Tanzania, it was established that substance use had a role to play in increasing the exposure of youth to the risk of contracting sexually transmitted illnesses and HIV (Urassa et al., 2008: 159). These youth were found to engage in unprotected sex.

However, the participants in the study that was conducted in Cape Mitchell's Plain, Cape Town were found to use condoms at the same rate as those who had not used substances. Although this is a positive behaviour despite a general belief that those who are intoxicated lack the ability to make health enhancing decisions related to sexual practices, a concern remains for youth who engage with strangers. A study in Europe showed that low self-control was associated with risky sexual practices (Vazsonyi, Trejos-Castilli & Huang, 2006:753.e8). It is therefore imperative to study and understand patterns of sexual behaviour among youth in Lesotho and this study will explore these patterns.

2.5.6. Consequences of physical inactivity

Physical inactivity could be associated with sedentary behaviour. This is an example of unhealthy ways of living that could predispose the individual to chronic diseases of lifestyle when engaged in for a prolonged period of time (Reddy et al., 2003:15). Furthermore, physical inactivity could deny youth the vitality and well-being associated with being healthy and physically fit. Youth have been found to be overweight or obese; this predisposes them to conditions such as cardiovascular disease, orthopaedic complications, breathing difficulties and diabetes (Vivier & Tompkins, 2008:11). Inactivity then becomes a major public health concern that contributes to chronic disease epidemic (Amosun et al., 2007:257), besides obesity among adolescents has been identified as a public health crisis (Vivier & Tompkins, 2008:11). Youth in Lesotho may be no exception.

Inactivity could be a sign of poor weight management and other unhealthy weight control measures could be used to compensate for the physical inactivity. Use of methods such as inducing vomiting, prolonged fasting or using laxatives may be harmful to the individual. These have been associated with eating disorders (American Psychiatric Association, 2004:583), therefore youth who engage in such behaviours could predispose themselves to these psychiatric disorders. The consequences of eating disorders include severe physiological difficulties due to undernutrition, as well as psychological problems. This disorder like other psychiatric disorders is often comorbid with other disorders such as depression; obsessive

compulsive behaviour and in some instances personality disorders (ibid). Unhealthy weight management behaviours could be regarded as forms of occupational dysfunction in which engagement is detrimental to health and well-being.

Like other behaviours, inactivity could co-exist with engaging in sedentary behaviour like gambling, alcohol consumption, substance use or smoking. Pathological gambling is classified as an impulse control disorder (Kaliski, 2002:267). Behaviours such as stealing, fire-setting and aggressive outbursts are also classified as impulse control behaviours and although not impossible, they are less likely to co-occur. More commonly substance abuse co-exists with these behaviours.

Consequences of impulse control behaviour include criminal activity, severe interpersonal problems and debt (Kaliski, 2002:267). Other consequences of gambling include the increased likelihood of developing stress-related physical illnesses like hypertension, angina, cirrhosis of the liver, as pathological gambling is often associated with substance use (Morasco et al, 2006:976). Co-occurrence of gambling and other behaviours may create complex health problems that could be challenging to manage as the addicted individual might lack insight into their problem behaviour.

2.6. Consequences of co-existing behaviours

The consequences of engagement in multiple risk behaviours are more severe than those attributed to partaking in single behaviours. This is because co-existing risk behaviours are likely to result in co-existing health problems, therefore posing a bigger threat to health, well-being, as well as present and future quality of life. In addition, co-morbidity could present an enormous challenge to intervention, hence why risk behaviours are a public health concern worldwide.

Finding effective treatment modalities for co-existing physical problems may not be as complex as in co-occurring mental health problems. Nonetheless, evidence suggesting the most effective forms of intervention for co-existing mental health difficulties is limited (Hides et al., 2007:132). The difficulty stems from the different effects of different psychiatric problems. For example, use of more than one

substance could present a complex clinical picture, because each substance has its own effects. Furthermore, a pre-existing mental illness could be worsened by substance use (Ghodse, 2005:329). The consequences of participation in these behaviours could increase the burden of disease within and across countries. Developing countries like Lesotho which are already confronted with extreme poverty, food shortage and HIV/AIDS are likely to suffer the effects worse than developed countries. It is therefore imperative for these countries to consider taking multiple risk orientated measures to curb and prevent engagement in co-occurring risk behaviours, so as to decrease morbidity and mortality among youth.

Intervention directed at prevention of risk behaviours is often directed at single behaviours or those that fall within the same cluster, such as substance abuse or injury-related behaviours. This undermines the nature of risk behaviours to co-occur. Programme outcomes that are discipline specific and limited in their scope have been identified as obstacles to the development of intervention that cut across problem areas (Lubell & Vetter, 2006:167). As a public health issue, different sectors have to collaborate and form partnerships to address this concern, instead of developing sectoral interventions that are less effective.

Chapter Three

Methodology

3.1. Study setting

The study context was schools in Maseru. Maseru is the capital of Lesotho, the largest district of the country and the only city of the Maseru district. It is the most populated district in Lesotho with about 429 000 people who make up 22.9% of the entire population (Bureau of Statistics, 2009:7). Approximately 225 000 people reside in the city of Maseru (Bureau of Statistics, 2009:12). As an urban setting, it poses challenges for the youth in that the social environment is not supportive and nurturing (Frey et al., 2009:2). The occupational choices and participation in such an environment are influenced by the culture and expectations of the community.

Many youth spend a significant amount of their time being educated within the school setting. In 2006, there were about 519 000 learners enrolled in primary and secondary education in Lesotho, which accounted for about 29% of the entire country's population. 94 500 of these learners were in high school (Bureau of Statistics, 2009:73). In 2007, 97 936 learners were enrolled, in 2008 the number of learners increased to 103 317 and in 2009 there were about 111 400 high school learners enrolled (Ministry of Education and Training, 2009). This shows a steady increase in learner enrolment.

Introduction of the Free Primary Education Policy in 2000 could have accounted for the increase in learner enrolment. In line with the United Nation's Millennium Development Goals (MDGs) (United Nations, 2010:html) and other international agreements, the Government of Lesotho committed itself to the provision of compulsory, universal free primary education (Ministry of Education and Training, 2005:2). This improved access to education for children who previously did not have access.

The Free Primary Education policy began at standard one and annually increased by level (Ministry of Education and Training, 2005:2) up to ten years of schooling. The first seven years of schooling, referred to as primary school level and the later three years known as secondary school level (Bureau of Statistics, 2009:73). This policy was implemented at all primary schools that follow the school calendar prescribed by the Ministry of Education and Training, despite ownership of the school. However,

only government secondary schools extended the implementation of the policy to the level of junior secondary.

Early childhood care and development education, basic (primary), lower secondary which is also known as junior secondary (Form A-C), higher secondary (Form D-E) and tertiary educations constitute the school system in the country (Bureau of Statistics, 2009:72). Schools with higher secondary level are known as high schools, whereas secondary schools are those that have Form A-C only. The majority of schools in Lesotho were owned by churches such as the Anglican, Methodist, Roman Catholic and the Lesotho Evangelical. The proprietor of the rest of the schools are mostly government and community, some are unknown (Ministry of Education and Training, 2005:16). Regardless of the proprietor all the schools are accountable to the Ministry of Education and Training. Gaining access to schools and recommending or implementing interventions within requires knowledge and understanding of the structure of the Ministry of Education and Training in Lesotho. This enables approaching relevant persons and ensuring that protocol is observed. Without this knowledge gaining access may be time consuming. Observing protocol was important for this study and this was aided by knowledge of this structure below.

The structure of the Ministry of Education and Training

The Ministry of Education and Training in Lesotho is organized such that the Minister of Education and Training heads the ministry and is supported by the Assistant Minister. The Principal Secretary (PS) succeeds the Assistant Minister in the line of command (Ministry of Education and Training, 2005:16). All other heads of departments report to the Principal Secretary including the Central Inspectorate who houses the Chief Inspectorate-Secondary who granted permission to access the schools in this study. Protocol dictated that the letter (Appendix 1) seeking permission to conduct the study be addressed to the Principal Secretary, but be submitted to the Central Inspectorate, upon whose absence the Chief Inspectorate-Secondary was left in charge. The officer advised that schools in the city of Maseru would best be divided according to proprietor not regional demarcations as those crossed between districts, despite being within a 10km radius to the city. The researcher then decided to cluster schools according to proprietor.

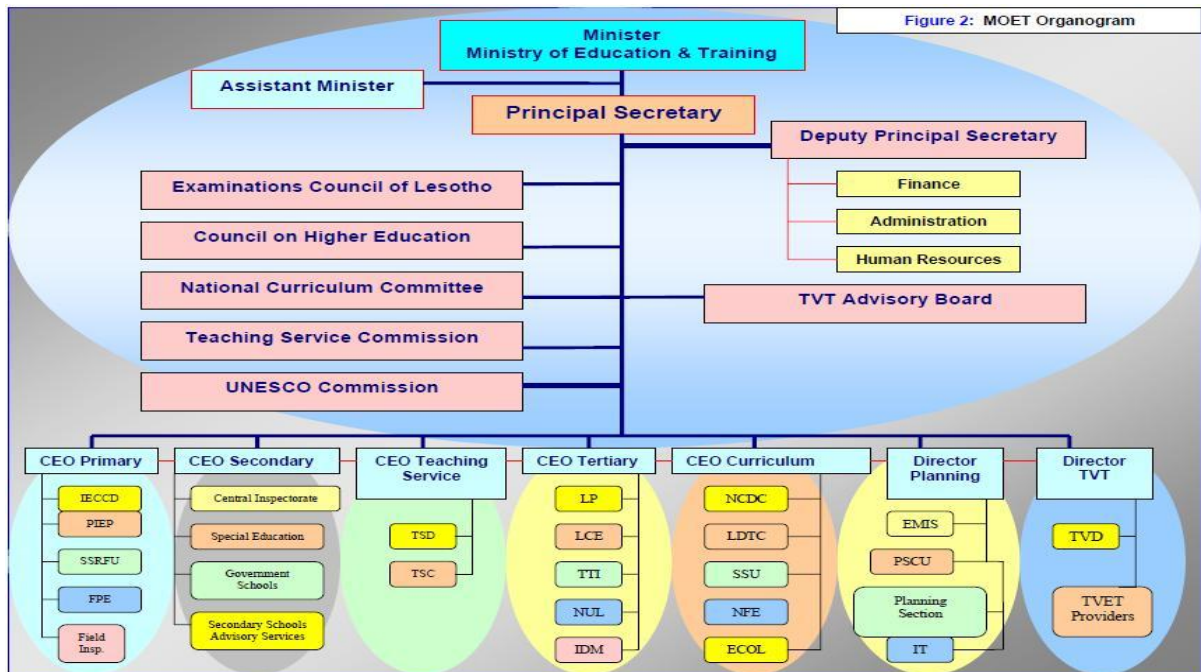


Figure 3.1: Structure of the Ministry of Education and Training Lesotho¹ (Ministry of Education and Training, 2005:16).

3.2. Study design

The research design was a school based cross-sectional survey of the health risk behaviours amongst high school learners in the city of Maseru, Lesotho.

3.3. The questionnaire

- **Development of the questionnaire**

The study instrument was an hour long paper-based, self-administered questionnaire. The US Youth Risk Behaviour Survey (US YRBS) (CDC, 2008) was used as the basis from which the Lesotho YRBS was developed. The validity and reliability of which had been established (CDC, 2004:5). However, the Lesotho YRBS was not tested for both reliability and validity as both exercises were beyond the scope of this study; therefore it was designed to ensure clarity. This was tested in the pilot study. Questions were added and others were modified to suit the context of Lesotho. Some of the changes made included addition of questions related to socio-economic status,

¹ Refer to abbreviation list (page vii) for outline of abbreviations

changes in responses to questions and rephrasing of questions was done to enable relevance to the context of Lesotho. The Lesotho YRBS developed into a 112 item long questionnaire (Appendix 2) that was divided as follows:

- Section A: demographic information
- Section B: questions about personal safety on the road
- Section C: violence-related behaviours
- Section D: questions on suicide
- Section E: tobacco use
- Section F: questions about drinking alcohol
- Section G: questions about matekoane use
- Section H: drug use
- Section I: sexual behaviour
- Section J: questions on body weight
- Section K: questions on physical activity
- Section L: nutrition.

The questionnaire was administered in English since this is the medium of communication in high schools in Lesotho. However, time constraints and lack of funding also contributed to the decision not to present the questionnaire in Sesotho, which is the home-language.

3.4. Ethics

3.4.1. Ethical approval

The study obtained ethical approval from the University of Cape Town, Faculty of Health Sciences Human Research Ethics Committee (FHS HREC REF: 075/2010, Appendix 3).

3.4.2. Ethical considerations

Confidentiality and anonymity were maintained throughout the study process. The participants were not requested to write their names on the questionnaire. Participant numbers were allocated for each questionnaire to enable differentiation between

schools, but there were no features that could identify the actual participant. It was emphasised that partaking in the study was voluntary and the participants had the right to withdraw at any point in time. Furthermore, that declining the invitation to be part of the study would have no bearing on the relationship between the learner or the parent and the school authorities. This was done after the learners were given the opportunity to read through the information sheet and again while they were completing the questionnaire. The participants were also reminded that they were not obliged to give responses if they felt uncomfortable, hence one participant only responded to 45 questions.

The potential risk of causing mental distress was addressed by warning the participants beforehand that some of the questions in the study instrument could be provocative, particularly for those who already had mental or stress-related issues. However, at no point did the researcher expose the participants to unnecessary psychological or physical stress intentionally, therefore ensuring non-maleficence. It was also announced that if any of the respondents suffered distress after completing the questionnaire or felt they needed psychological support; the Community Mental Health team was ready to assist, with the permission of the participant.

Some learners who had either not returned the parent consent form or whose parent(s) had declined the invitation expressed an interest to partake in the study. However, after establishing their age, it was decided that they be denied the opportunity to participate. Those who were eighteen years and older were allowed to override the decision made by their parent(s). The rationale for this was that at the age of eighteen, the youth legally become recognised as adults who can make informed decisions.

3.5 Pilot study

A pilot of the instrument was conducted as it was crucial to establish whether both the modifications made and the language used were appropriate and understandable. For this reason, the pilot study was part of the process of developing the instrument. Learners from one school that was not initially sampled were identified for the pilot study and arrangements were made with the school

principal. Selection of the participants for the pilot study was such that they represented the different levels of high school, namely, Form A-E. A total of 30 learners were presented with the questionnaire during the pilot study. Six learners were recruited from each form and the age range was between 13 and 18 years or beyond. 63.3% were female and 36.7% were males. Ethical considerations were also applied for the pilot study. The pilot was conducted in a classroom setting and the time required to fill the questionnaire was noted, as this would be used to determine the time required for administering the questionnaire during data collection.

The following modifications were made with input from the pilot study and a final version of the Lesotho Youth Risk Behaviour Survey (LYRBS) questionnaire was developed (Appendix 4):

Section A: Question one was changed from being categorical to nominal to allow for more accurate analysis in relation to age. It was noted that only three of the thirty learners understood question 6, which related to the number of sleeping rooms in their houses. Therefore, the question was left out. Apart from that, any room in a crowded dwelling could be used as a sleeping room, so the question did not correctly capture information on overcrowding. It was decided that the question may be irrelevant; therefore it was excluded from the questionnaire.

The question on cellphone use (question 12) was also deemed inappropriate, because it did not relate to any other question. The question also did not provide much information on risk behaviours, because it only asked what the cellphone was used for. For purposes of shortening the questionnaire; it was also removed from the instrument. Further to that, it was established that schools had a rule that disallowed cellphones on school property. Learners did not understand what disabled meant (question 15), so a Sesotho word for disability was added.

Section B: In question 24 the learners did not know what gambling was and a Sesotho word for gambling was added.

Section D: There was lack of flow from question 47 to 48; therefore presentation of these questions was switched around.

Section K: Question 105 relating to the presence of sports or physical education on the school timetable, was confusing for the learners. This was denoted in the variety of responses from learners of the same level and school. It was later discovered from the principal that there was no physical education provided to the learners who met the inclusion criteria for this study and who were at schools in Maseru. Time for sports was limited to periods of preparation for sports tournaments.

The learners completed the questionnaire within the anticipated 1 hour duration, with the first learner finishing within half an hour and the last one in exactly an hour. It was worth noting that the learner who finished last was not a Form A learner. This meant that most Form A learners would require more than an hour to fill in the questionnaire.

3.6. Sampling

3.6.1. Population

The study population comprised of all learners in Form A,B,C,D,E in mixed gender high schools within a 10km radius of the central business district of the city of Maseru. Only schools that followed the calendar set by the Ministry of Education and Training were included. Of the twenty schools in the city, two did not meet these criteria. One school did not follow the ministerial calendar and curriculum. The other was a single gendered school. Therefore, the study population comprised of learners in 18 high schools. The total population of learners was $n= 9726$ and learners from the two schools that did not meet the criteria were $n= 962$.

Five of the schools that met the criteria were owned by the Government, another five by the Lesotho Evangelical church, four by the Roman Catholic church, two by the Anglican church and the last by the Seventh Day Adventist and Methodist churches respectively. For criterion selection of schools, the schools were clustered according

to the owner. Based on proprietorship, a representative school was randomly selected from each cluster (using the “pick out of hat” method). Six schools were initially selected from the following clusters: Anglican church, Government, Lesotho Evangelical church, Methodist church, Roman Catholic church and the Seventh Day Adventist church. However, the response rate for the selected Anglican church school was lower than 50%. Therefore, a second Anglican church school was recruited.

3.6.2 Profile of the schools included in the sample

School A is a school owned by the Seventh Day Adventist Church. It has 837 learners enrolled. The church founded the school as a secondary school (with Form A-C only) in 1990 and became a high school (with Form A-E) in 1994. Beginning the day with prayer and having a week of prayer in the first and second half of the school are the activities prescribed by the church for the school to adhere to. Further to that, the school is expected to submit both a financial and a progress report to the church and the Ministry of Education and Training on an annual basis. This expectation applies to all the schools. Another similarity between the schools is the structure of the schools’ governing body. It comprises of the proprietor as the chair of the school board, succeeded by a parent representative, a teacher representative and the Chief of the area where the school is situated. Other than that, all the teaching personnel salaries are paid by the Government of Lesotho regardless of the proprietor.

School B was founded by the Lesotho Evangelical Church in 1981 as a night school for secondary school level learners (Form A-C). Currently the school is a day time high school that has 1010 learners. The school also offers night classes to high school learners who are unable to become full-time learners. It is expected that the school principal attend an annual meeting called the Presbytery (a church organised annual meeting) where the school’s finances and progress are reported on.

The Anglican Church established **school C** as a secondary school in 1981 and then converted it to a high school in 1985. In the same year (1985) the church founded **school D** and it became a high school in 1991. School C currently has 709 learners

whereas school D has 584 learners. Both schools are expected by the Anglican church to attend Ashes Wednesday, mass and celebrations organised by the church. The schools has a feeding scheme, so that learners have one meal (lunch) at the school. It is expected that the schools pay a development fund to the church, as well as provide an annual report.

In 1988, the Methodist Church of South Africa founded a secondary school (**school E**) which became a high school in 1992. There are about 920 learners in the school. Unlike other church based proprietors, the Methodist church does not have any set activities for the school to participate in except for submitting an annual report.

School F is a government owned school that has 760 learners. The school started to operate in 1998 as a high school. Although, there are no specific activities other than school activities stipulated by the proprietor, a report is expected on an annual basis. The school receives a government subsidy for maintenance and utilities. The subsidy is motivated for on an annual basis.

School G is owned by the Roman Catholic church. The principal gave written consent for participation in the data collection phase of the study, however declined any further meetings with the researcher. Consequently, subsequent meetings to gain further information on the school could not be held.

The seven schools were identified using cluster and random sampling. These methods were repeated for selection of the sample of the study.

3.6.3 Sample size

1769 learners were recruited to participate.

3.6.4. Selection criteria

The following criteria were employed for recruitment of participants:

3.6.4.1 Inclusion criteria

- Learners in mixed gender schools (schools with both boys and girls) that are in the city of Maseru
- Learners in schools that had Forms A through to E.
- Learners from schools that follow the schools calendar provided by the Ministry of Education and Training.
- All learners in the streams from Form A-E.

3.6.4.2 Exclusion criteria

Based on the following criteria, learners were excluded from the study:

- Learners who expressed difficulty in completing the questionnaire independently as a result of difficulty comprehending the English language or who were unable to write.
- Learners whose parents have not given consent.
- Learners whom, despite their parents having given consent refuse to give assent.
- Learners who are absent from school on the day of the data collection.
- Learners whom for one reason or the other were not in the designated venue at the time allocated for questionnaire administration.

3.7. Data collection

3.7.1 Gaining access to schools

To gain access to the learners, permission was requested from the Principal Secretary (PS) of the Ministry of Education and Training in writing. However, as day-to-day matters such as these are not directly handled by the office of the PS, the researcher was directed to the office of the Central Inspectorate. This is the officer in charge of all secondary education in the Maseru district. In the absence of the officer in charge, the assistance of Chief Inspectorate- Secondary was sought. A letter introducing the researcher and requesting support for the study from the Principals of the selected schools (Appendix 5) was obtained. These were then submitted to the schools and permission for involvement of the

learners in the respective schools was granted by signing and stamping this letter.

3.7.2 Recruitment of learners

After permission for conducting the study was received from the school principals, information on the number of streams for each Form was requested. All the selected schools had more than one stream for each level. The number of learners in each representative stream was also obtained. A stream was then randomly selected to represent each Form, namely one stream each from: Form A, Form B, Form C, Form D and Form E. The streams for each Form were written separately on pieces of paper, which were then folded by the researcher to conceal the writing. The folded papers were then put inside a container and raffled by one of the school personnel, and then the researcher picked one piece of paper which would reveal the stream that was to represent the particular Form. This was repeated with all the other Forms until the five Forms were represented.

After establishing the exact number of learners who were expected to take part in the study, the Sesotho version of the parent consent forms (Appendix 6) and information sheets (Appendix 7) were issued to the school principals. It was agreed that a week prior to data collection, learners would be issued with parent consent forms to take to their parents and guardians for signing. These would be returned to respective class teachers for the researcher to collect. Appointments for data collection were also negotiated and established.

The majority of the learners did not return the parent consent forms while some parents had declined the invitation for their children to partake. This considerably reduced the number of learners who took part in the study. All the principals commented that they were regarded as legal guardians of the learners when they were in school. Therefore, they thought it was not necessary to involve the parents. Apart from that, no previous researchers had requested the permission of parents, despite a number of studies being conducted in the schools.

Learners who did not submit parent consent forms or whose parents had refused participation were excluded from the study. Those who were granted permission were given assent forms (Appendix 8) and information sheets (Appendix 9) that were both translated into Sesotho. After reading the information sheet they were given an opportunity to ask for clarification and then they were requested to fill in learner assent forms.

Collecting data

The learners who gave permission were asked to fill in the questionnaire. This process was overseen by the researcher in person. Wednesdays at 3.30pm and Fridays at 2pm were the days and times that the principals selected. Some schools had assigned a teacher to assist the researcher with logistical arrangements, such as preparation of the venue. The teacher also ensured that learners settled down and were ready for the researcher. Learners were advised not to write their names on the questionnaire to ensure anonymity and emphasis was put on how confidentiality would be upheld.

After completing the assent forms, these were collected and learners who had declined were asked to leave the venue with the teacher. Pencils and questionnaires were then handed out to the learners. The instructions for filling in the questionnaire that are provided on the cover page were read with the learners. Following this, the process of filling in the questionnaire began under the supervision of the researcher. It took the learners between 40 minutes and an hour to complete the questionnaire.

3.8. Data management

The responses were assigned dummy codes and captured on spreadsheet before being imported to STATA 10.0 (StataCorp, 2007) for cleaning. Variables were labelled and options recoded and then analysis began.

3.9. Data analyses

The process of analysis began with descriptive statistics such as frequencies, percentages, calculating the mean age of subjects, range and standard deviation. After determining frequencies, it was decided that some items were either irrelevant or had frequencies that were too low. Items 22, 70, 71, 72, 73, and 74 were excluded from analysis, because their frequencies were 2% or lower. Lack of consistency in responses to Item 103 resulted in the item being left out of further analysis. Participants from the same school and the same class had a variety of responses to the question of whether physical education or sports was scheduled on their school timetable. It was deduced that the question could have been misunderstood. Section L focused on nutritional habits and comprised of six items. The section was eliminated from analysis for two reasons; one being that compared to other YRBS instruments the section did not elicit enough information to allow for comparison. Secondly, given the country's current food shortage crisis, it was likely that some participants would not have access to a variety of food to enable selection, therefore the section was irrelevant.

To establish relationships between and across categories the Chi-square test was used. For example, within categories; in Section C, it was explored whether carrying a weapon at school was associated with threatening others with a weapon at school. An example of across categories could be establishing relationships between demographic data (Section A) and engagement in risk behaviours. For instance, finding out whether having parents that are employed was related to access to pocket money.

A selection of behaviours that the participants reported was used to determine concurrent engagement in risk behaviours using spreadsheet. The criteria for selection entailed behaviours that participants report to have done in 30 days prior to data collection, not those that they were subjected to, such as being threatened or being driven drunk. However, other lifetime behaviours were included due to their clinical relevance and likelihood to recur, such as addictive behaviours. A total of 35 behaviours were chosen (Appendix 10). From these, clusters of risk behaviours that the participants engaged in were developed using pivot tables in spreadsheet. In

order to contain the data, the clusters had to be pre-determined. Eleven clusters were drawn based on the associations derived from the Chi-square test and literature. Analysis of the clusters was done for gender and age.

Chapter Four

Results

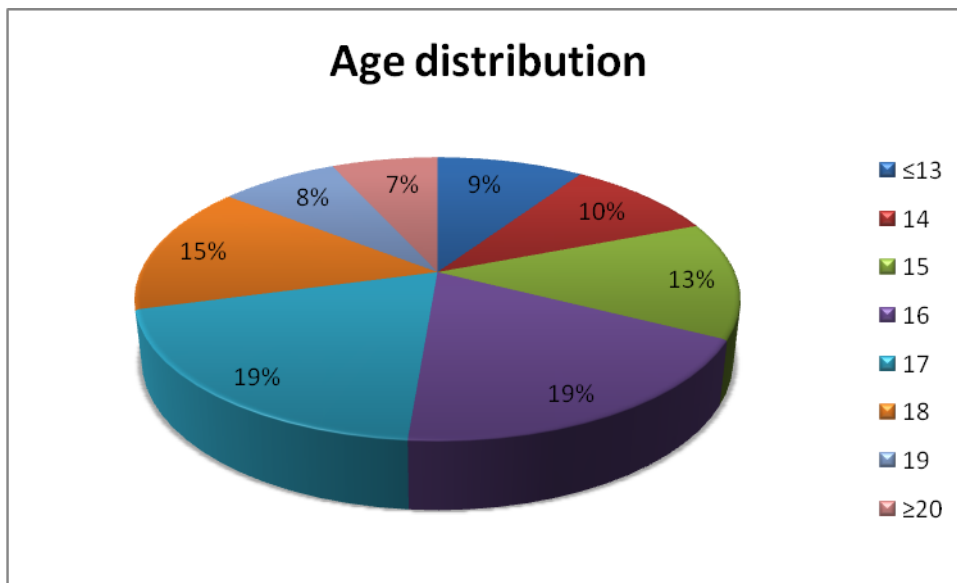
4.1. Description of participants

This section provides demographic details of the participants followed by a description of the findings. 1769 participants were sampled for the study. However, only 1122 participants completed the questionnaire, therefore attaining a response rate of 63.4%. Of the 1122 that completed the questionnaire, one questionnaire was excluded on the basis that it was incomplete; therefore the sample size was 1121.

4.1.1. Demographic profile

Of the 1121 participants 50.1% (N=562) were female and 49.9% (N=559) were male. The majority of the sample were Lesotho citizens by birth (93.6%, N=1049). Figure 4.1 depicts the participant's age distribution in years.

Figure 4.1: Age (in years) distribution of the participants



The age range was between 12 and 27 years. The mean age was 16 years with a standard deviation (sd) of 2.09 and a confidence interval (CI) of between 16.3 and 16.5. Participants who were 20 years and older represented the smallest proportion of 6.8% (76) of the sample. The highest proportion in age distribution was of 17 years old participants (19.5, N=218). Male participants made up the highest proportion (20.9%) at age 17 and a similar proportion was found for the females at age 16. Age distribution in years is presented in Figure 4.1 while figure 4.2 presents

the age distribution by gender. Age group 17 had the highest proportion of male participants of 20.9% (N=117) and the least male represented age group was that of 13 years old or younger. With regards to females, the highest proportion of them was 16 years old (20.2%) and age group 20 years and beyond had the least female participants (5%).

Figure 4.2: Age distribution of the participants by gender

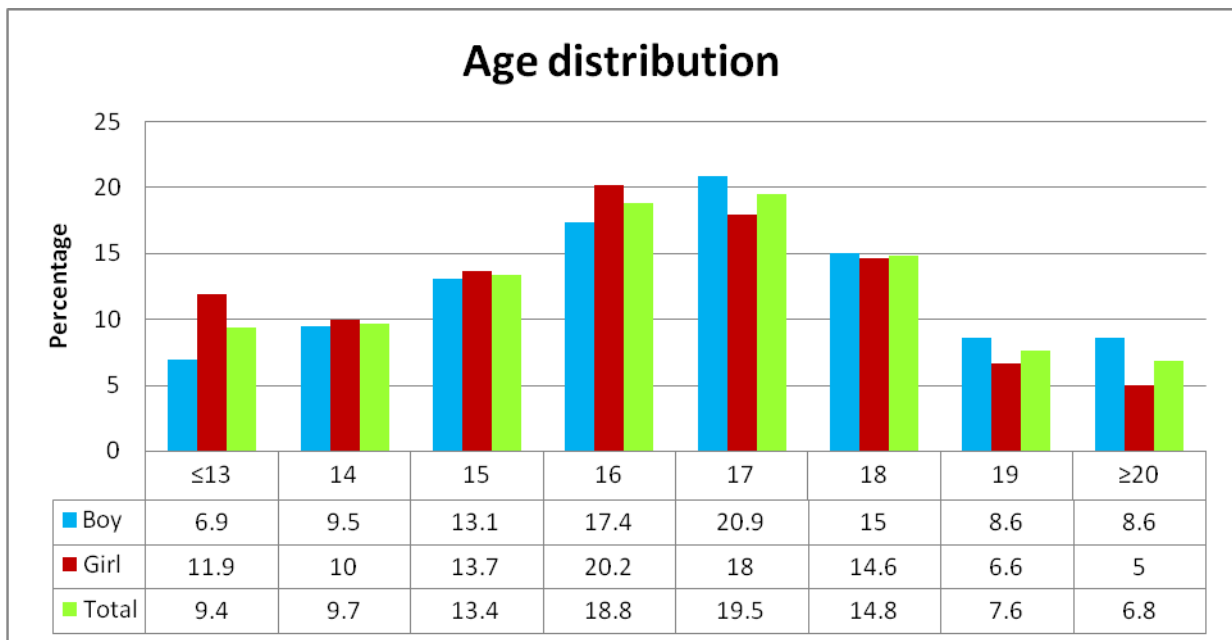


Table 4.1 presents the demographic data of the participants. Distribution according to Form did not differ much (ranging between 18% and 23%), however the highest proportion of participants was in Form D (22.7%, N=254).

Table 4.1: Demographic data of participants (N=1121)

Variable	Category	No. of participants	Total percentage %
Form	Form A	217	19.4
	Form B	203	18.1
	Form C	202	18
	Form D	254	22.7
	Form E	245	21.8
	TOTAL		1121
Transport to school	Walk	504	44.9
	Public transport	535	47.7
	Car	79	7.1
	Bicycle	3	0.3
	TOTAL		1121

The most commonly used means of transport to get to school was public transport (47.7%, N=535) and the least used was bicycle (0.3%, N=3). Participants with disabilities accounted for 7.6% of the sample. The majority of the participants lived with both parents (43.7%, N=484) or in households headed by mothers (21.3%, N=237) as compared to 4.4% (N=49) who lived with the father as a single parent. 8.4% (N=89) participants live in multigenerational households. Other participants (N=148, 13.4%) lived with other relatives or other learners (in hostels) or with siblings only and five participants did not answer the question.

Most working parents were in full-time employment: 40.9% (N=452) of the mothers and 36.3% (N=402) of the fathers. 80.5% (N=893) of the participants were given pocket money with 21.6% (N=240) receiving an amount more than M50.00 per month (Equivalent to R50.00). A Chi-square test indicated that there was a significant association between the parent's employment ($p=0.000$ for mothers and $p=0.014$ for fathers) and access to pocket money.

4.2. Prevalence of risk behaviours

Engagement in risk behaviours could have adverse effects on health, well-being and the quality of life of the individual and others. Depending on the risk behaviour in question and the intensity of engagement, the effect could be rectified while others may not be reversible. Presentation of the findings in this section will be in relation to the outcome of risk behaviours. Frequencies of engagement in risk behaviours will be presented as per section within the questionnaire. This will be followed by a detailed account of the number of behaviours that participants engaged in.

4.2.1. Behaviours relating to personal safety on the road

Table 4.2: Percentages of participants engaged in behaviours relating to personal safety on the road

Risk behaviour	% of male participants (N=559)	% of female participants (N=562)	% of participants (N=1121) engaged in behaviour
Drive while drunk	10.2	1.8	6
Driven by drunk driver	31.9	29.1	30.4
Walk along road after alcohol use	18.9	7.4	13.1
Walk along road after dagga use	7	0.9	3.9
Walk along road after drug use	5.7	1.1	4.7
No seat belt when driven	13.6	12.5	13
No seat belt when driving	26.6	17.1	21.9
Driven by smoking driver	57.2	52.4	54.8

Adherence to road safety regulations by some participants was poor and this could have fatal effects. 6% of the participants put their lives at risk of death or injury by driving after drinking alcohol as well as when driven by a drunk driver (30.4%). Participants also walked alongside the road intoxicated. 13.1% walked alongside the road after consuming alcohol and 8.6% had used other substances, including dagga.

Apart from that, participants did not use seatbelts both when they were driving (21.9%) and when driven (13%). Therefore, they were prone to road vehicle accidents as passengers, drivers and as pedestrians. In all behaviours more males than females engaged in the behaviour. Participants who did not use a seat belt when driven were less likely to use it when they were driving. A strong association ($p=0.000$) was established between using a seat belt when driving and when driven. Another strong association ($p=0.000$) within this category was found between drunken driving by the participants and being driven by a drunk driver. This could be an example of behaviour imitation on the part of the participants. An example of relationships across categories was depicted by a strong association between binge drinking and walking alongside the road drunk ($p=0.000$). It may be evident that binge drinkers may take high risks, therefore may be prone to road traffic accidents.

4.2.2. Prevalence of tobacco use among participants

Smoking is a behaviour that could potentially lead to chronic illness such as cancer and eventually death (Mathers et al, 2006:948). However, this is preventable by not using tobacco or avoiding the vicinity of those who smoke. Table 4.3 below describes the use of tobacco and its products.

Table 4.3: Percentages of participants who used tobacco

Risk behaviour	% of male participants (N=559)	% of female participants (N=562)	% of participants (N=1121) engaged in behaviour
Days smoked per month	19.9	4.5	12.2
Cigarettes per day	18.1	3.8	10.2
Smoke cigarettes at school	6.6	0.9	3.8
Passive smoking	61.6	53.8	57.7
Have smoking guardian	71	72.2	71.6
Did not try to stop smoking	3.4	0.7	2.1
Snuff use	2.2	3.4	2.8
Used snuff at school	0.5	1.8	1.2

12.2% of the participants admitted to smoking on a number of days per month and 3.8% reported smoking at school, thereby probably exposing others to passive smoking. Exposure of participants to second-hand smoke (57.7%) was alarming, particularly when 71.6% of the guardians smoked. Therefore, participants were likely to be exposed to passive smoking at home or when with their guardians ($p=0.00$), at school and on the way to and from school, thereby increasing the risk of contracting illnesses associated with second-hand smoking. It could also be deduced that participants could copy the behaviour of smoking from their roles models (guardians). According to a Chi-square test, the number of days smoked was significantly associated with having a smoking guardian ($p=0.03$). This shows that if guardians are to play a role in discouraging smoking, they should set a good example by stopping smoking.

Using one substance could also expose the learner to other substances or other risk behaviours. A significant association was found between smoking cigarettes and alcohol and dagga use ($p=0.00$). An association was also established between smoking cigarettes and gambling ($p=0.00$).

4.2.3. Prevalence of alcohol use

Alcohol can be addictive (Helbig & Mckay, 2003:141). When addiction sets in an individual's ability to function optimally within various roles may be compromised.

Table 4.4: Percentages of participants who used alcohol

Risk behaviour	% of male participants (N=559)	% of female participants (N=562)	% of participants (N=1121) engaged in behaviour
Have drunk alcohol	59.4	44.3	51.8
Had one drink in past month	32.3	15.9	24
Had five drinks in a row	24.7	10.3	17.5
Days drank at school per month	10.2	4.7	7.4
Sit in class drunk	5.9	2.9	4.4

Overall, 51.8% of the participants had consumed alcohol in their lifetime. 7.4% of them had drunk at school and 4.4% sat in class after consuming alcohol. Learners could drop out of school and opt to partake in the behaviour without restrictions that could be posed by school regulations. This could commonly be found in binge drinkers. 17.5% of the participants had binge drunk in the month preceding data collection. The concern is that these learners could choose to focus their energy on tasks aimed at sustaining the addiction, such as seeking money for alcohol. Impaired cognition due to intoxication could result in behaviours and actions that could lead to injury, incarceration or death. Like other risk behaviours, alcohol use has been found to co-occur. A Chi-Square test showed that there was an association ($p=0.000$) between binge drinking and sitting in class drunk. Another relationship was established ($p=0.002$) between having consumed alcohol in a lifetime and having been involved in a fight.

4.2.4. Prevalence of use of other substance

Table 4.5: Percentages of participants who used other substances

Risk behaviour	% of male participants (N=559)	% of female participants (N=562)	% of participants (N=1121) engaged in behaviour
Used dagga in life	25.9	7.8	16.9
Used dagga last month	10.6	1.8	6.2
Used dagga in school	4.1	0.9	2.1
Attended class after dagga use	4.3	0.7	2.3
Used inhalers	14.7	9.3	12
Other illegal drugs	1.8	1.1	2.3
Offered illegal drugs at school	5	1.3	3.1
Use prescription drugs	6.1	10.7	8.4

There is a significant difference between male and female substance use as depicted in Table 4.5. According to Lesotho's regulations (Bloomer, 2009:49), dagga is an illegal drug. However, 16.9% of the participants had committed the crime of using dagga during their lifetime. 2.3% of the participants were also using other

illegal drugs which could lead to incarceration, let alone addiction. This highlights learners' vulnerability to mental illness, violence and injury. Some participants went further to commit this crime on school property during school hours by smoking dagga at school (2.1%) and some (2.3%) even sat in class after having used dagga. Prescription drugs were mostly used by female participants (10.7%). With other drug use the males dominated engagement. 25.9% male participants had used dagga compared to only 7.8% female users. Either participants themselves or community members were encouraging the behaviour of substance use by offering 3.1% participants illegal drugs at school. Within this category a strong association ($p=0.000$) was found between having used dagga in the month prior to the study and using inhalants. This is an example of multiple drug use. Another example of multiple drug use was depicted in the strong association found between recent dagga use (past month) and binge drinking ($p=0.000$).

4.2.5. Prevalence of aggressive behaviours

Details of engagement in aggressive behaviours are outlines in Table 4.6 below.

Table 4.6: Percentages of participants who engaged in aggressive behaviours

Risk behaviours	% of male participants (N=559)	% of female participants (N=562)	% of participants (N=1121) engaged in behaviour
Carried weapon	29.4	2.5	15.9
Carried gun	7.5	0.9	4.2
Carried weapon at school	12.3	1.6	7
Used dividers in maths set as weapon	15.4	6.5	10.9
Felt unsafe at school	9.5	7.3	8.4
Felt unsafe on way to school	6.3	9.1	7.7
Been threatened at school	27.7	12.5	20.1
Threatened someone at school	12.2	4.1	8.1
Been bullied	34	42.7	38.4
Bullied at school	22.3	30.3	26.3
Been involved in fight	29.7	14.8	22.2
Been injured in fight	5.5	5.7	5.6
Fought at school	19.7	12.3	16
Watched fight at school	71.1	64.4	67.7
Been slapped	12.2	10.7	11.4
Slapped partner	10.4	10	10.2
Been forced into sex	3.6	11.6	7.6
Forced sex	7	2.1	4.6

Aggressive behaviours may be associated with violence. The outcomes of such behaviours include injury, death, trauma, decreased role performance as a result of living in fear. This could lead to paranoia and potentially mental illness and/or

dropping out of school. For instance, carrying a weapon could be indicative of an intention to make use of the weapon and associated with a feeling or need to protect oneself. Some weapons could have deadly effects, such as guns and knives. 4.2% of the participants reported having carried a gun and 7% had carried weapons at school. A strong association was found ($p=0.000$) between carrying a weapon at school and threatening others with weapons at school. This indicates a likelihood of weapon carriers being perpetrators of violence on peers.

Further to that, 20.1% of the participants had been threatened at school and 26.3% had been bullied at school. The school environment should provide an atmosphere conducive for learning. However, carrying weapons, bullying and threatening others could result in participants feeling unsafe at school. 8.4% of the participants took the decision to miss school as they felt unsafe at school. The academic performance of these participants would be affected and others could go further to decide to drop out of school, therefore limiting their future potential to contribute to the development of their country.

Fighting was prevalent among 22.2% of the participants. 29.7% of the male participants as compared to 14.8% of the female participants. Of these, 12.3% females fought at school compared to 19.7% males. Only 2.5% of the female participants did not fight at school, whereas 10% of the male participants who engaged in fighting fought at school. Both participants who fought and those who watched fights were likely to feel unsafe both at school and within their communities, therefore affecting their well-being and quality of life. 67.7% of the participants had watched a fight at school.

Aggressive behaviours may manifest into criminal activities such as partner violence ranging from assault to rape, therefore presenting the likelihood of incarceration. A strong association ($p=0.000$) was found between threatening others and slapping a partner. The proportion of female participants who were physically forced into sex was three times higher (11.6%) than that of male participants (3.6%). Furthermore, female participants were more likely to become victims of aggressive behaviours, such as being bullied (42.7%) and feeling unsafe at school (7.3%) or on the way to

school (9.1%). However, more male participants (12.2%) reported being slapped by a partner than female participants (10.7%), although the proportion of those who slap their partners was equal for both genders (approximately 10%). An association was found ($p=0.000$) between lifetime alcohol drinking and having slapped as partner. Substance use appears to be to heavy impact upon the lives of the youth. Partner violence could be associated with feelings of sadness.

4.2.6. Prevalence of suicide related behaviours

Table 4.7 provides a detailed presentation of learners engaged in suicide related behaviours.

Table 4.7: Percentages of participants who engaged in suicide related behaviours

Risk behaviour	% of male participants (N=559)	% of female participants (N=562)	% of participants (N=1121) engaged in behaviour
Felt sad	26.4	31.2	28.8
Felt sad and needed treatment	23.5	35.7	29.6
Had suicide thoughts	11.9	18.9	15.4
Attempted suicide	9.9	15.7	12.8
Planned suicide attempt	9.5	16.2	12.9
Attempt led to injury	2.5	3.7	3.1

Female participants dominate all depression and suicide related behaviours. A number of reasons could account for this dominance. However, in relation to reported risk behaviour, there was a significant association between feeling sad and being forced into sex ($p=0.00$). 28.8% of the participants had experienced feelings of sadness. 31.2% of the female participants felt sad, as compared to 26.4% of the males. Attempted suicide was also more prevalent among females (15.7%) than males (9.9%). 3.1% of the participants had been injured as a result of attempted suicide. A marginal association ($p=0.006$) was found between the number of days of smoking cigarettes and depression. Another significant relation ($p=0.000$) was found

between having had at least one drink recently (one month prior to data collection) and feeling depressed. This could suggest that participants who are depressed may use substances.

4.2.7. Prevalence of sexual behaviour

A detailed account of the sexual behaviours that participants engaged in is in Table 4.8 below.

Table 4.8: Percentages of participants who engaged in sexual behaviours

Risk behaviour	% of male participants (N=559)	% of female participants (N=562)	% of participants (N=1121) engaged in behaviour
Engaged in sex	48.1	41.1	44.6
Never used condom	8.9	7.8	8.4
Multiple partners in life time ≥ 2	31	29.2	30.1
Multiple partners in last 3 months ≥ 2	9.5	10.3	9.9
Intoxicated before sex	7.4	4.1	5.7
No birth control method used	8.3	6.8	7.5
Self or partner pregnant	4.3	3.6	3.9
Have children	1.6	1.6	1.6
Had abortion	1.8	1.3	1.5
Had STI	4.1	3	3.6
Had STI but not treated	7.9	7.5	7.7
Not yet tested for HIV/AIDS	62.4	64.2	63.3

The risk of contracting HIV/AIDS and other sexually transmitted illnesses is relatively high in Lesotho, particularly among female youth. These illnesses have adverse long term effects on the well-being and quality of life of individuals, over and above adding to the burden of poverty, mental illness and unemployment. 44.6% of the participants had engaged in sexual intercourse and 8.4% had never used condoms,

therefore exposing themselves to the risk of contracting illnesses. In the last three months prior to the study, 9.9% had had multiple partners and 3.6% had been infected with sexually transmitted illnesses. Female participants had a higher (10.3%) proportion of multiple partners in the last 3 months than the males (9.5%). Only 1.6% of the participants had children, this low proportion could be accounted for by school regulations in which girls are expelled from school when they fall pregnant and unfortunately not many are able to re-enter the school system after having children. Associations ($p=0.000$) within this category were established and they were found between being intoxicated before the last sexual encounter and not using condoms, as well as having multiple partners in three months preceding data collection and contracting sexually transmitted illnesses.

4.2.8. Prevalence of participants who were physically inactive

Table 4.9 provides details on physical inactivity among the participants.

Table 4.9: Percentages of participants who were physically inactive

Risk behaviour	% of male participants (N=559)	% of female participants (N=562)	% of participants (N=1121) engaged in behaviour
Doing nothing about weight	18.6	18	18.3
Use unhealthy weight reduction methods	2.2	5.2	4.9
Did not do high intensity exercise	31	32.7	31.9
Did not do low intensity exercise	18.6	19.2	18.9
Sedentary behaviour for > 2	28.4	28.6	28.5

Data was collected during the sports season at high schools. However, 31.9% of the participants were not participating in high intensity exercise activities over a period of a week. Apart from that, 28.5% spend more than 2 hours watching television or

playing computer games on a school day. This points out that participants who spent 2 hours or more engaging in sedentary behaviour did not use their time to engage in physical activities. This could affect their performance at school as well as their future.

Using unhealthy weight control methods such as vomiting and inducing diarrhoea and others could predispose an individual to eating disorders. This placed 4.9% of the participants at risk of developing eating disorders, due to adopting unhealthy habits of weight management.

Gambling is a sedentary behaviour (Morasco et al., 2006:977) that was another example of an addictive behaviour which participants reported engaging in. 33.1% of them had gambled. This behaviour was more prevalent among male (47.4%) than female participants (18.9%).

4.3. Onset of selected risk behaviours

4.3.1. Smoking

24.1% (N=53) of those who smoked (19.6%, N=219) had started smoking before the age of 13. 6.8% started when they were 8 years old or younger (N=15).

4.3.2. Dagga

19.2% (N=32) of the participants who reported using dagga (14.9%) had initiated before the 13th birthday with the youngest (7.2%) initiating use at 8 years of younger. Under reporting was observed when the participants reported lifetime use (16.9%), although age of onset of dagga use shows a 19.2% prevalence.

4.3.3. Alcohol

More than half (53.3%, N=312) of the participants who consumed alcohol (N=585) initiated drinking by 14 years of age or younger. 27.9% (N= 163) of those who drank alcohol started drinking when they were 12 years old or younger, with the youngest 4.3% (N= 49) starting at 8 years or younger. A discrepancy was noted in reporting

lifetime alcohol use. According to the age of initiation, 53.3% of the participants had consumed alcohol, but with reference to the question about lifetime alcohol consumption the prevalence is 51.8%.

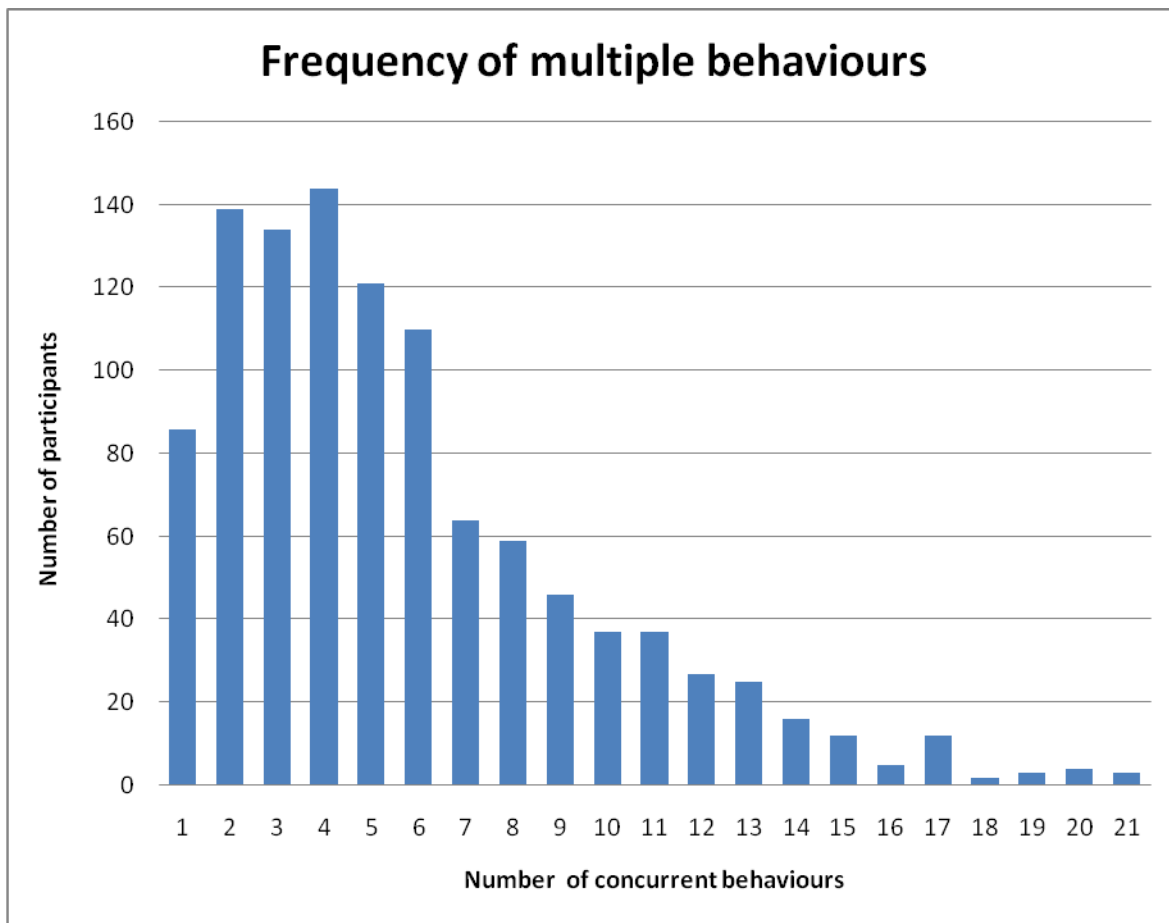
4.3.4. Sexual intercourse

40.9% of those who had sexual intercourse (44.6%), started as early as 14 years old or younger. 25% (N=125) engaged in the behaviour when they were only 11 years old or even younger.

4.4. Concurrent engagement in risk behaviours

Less than half (41.4%) of the participants participated in six or more behaviours concurrently and 55.9% engaged in between one and five behaviours. 2.7% reported not taking part in any form of risk behaviour. This is depicted in Figure 4.3 below.

Figure 4.3: Frequencies of multiple behaviours that participants engaged in



Risk behaviours often co-occur and the consequences of concurrent engagement can be severe. A selection of 35 behaviours (Appendix 10) was drawn from the instrument. These behaviours were chosen on the basis that they entail actual doing by the sample and they were reported as current (occurring within 30 days prior to data collection). The highest number of behaviours participated in was 21 and 3 male participants, engaged in these behaviours. 30 participants reported to have not engaged in any risk behaviours. The clusters represent only 15.2% of the sample. The grouping of behaviours into clusters as shown in Table 4.10 was informed by literature and results of associations between behaviours. However, the exercise was not intended to be exhaustive, rather it focused on behaviours that have the most concerning consequences to health and well-being. The following are clusters of behaviours that were found to exist simultaneously:

Table 4.10: Behaviour clusters

Cluster	Co-occurring behaviours	Number of participants engaged in behaviours concurrently
Cluster One	Did not use seat belt when driving Did not use seat belt when driven Gambled Drank alcohol in lifetime	Total=37
Cluster Two	Drove drunk Drank alcohol in lifetime Had sexual intercourse Drank one in past month Days smoked Had multiple sexual partners in last 3 months	Total=9
Cluster Three	Days smoked Drank alcohol in lifetime Had sexual intercourse Forced someone into sex Binge drunk in past month Attempted suicide	Total=2
Cluster Four	Drank alcohol in lifetime Drank one in past month Binge drunk Cigarettes smoked per day Fought	Total=31
Cluster Five	Drank alcohol in lifetime Binge drunk Smoked dagga in lifetime Smoked dagga last month Days smoked Drank one in the last month	Total= 29

Cluster Six	Used inhalants Used prescription drugs to get high Drank alcohol in lifetime Binge drunk Smoked dagga in lifetime Smoked dagga last month	Total=2
Cluster Seven	Had sexual intercourse Did not use condoms Used no birth control method Binge drunk Drank alcohol in lifetime Had multiple sexual partners in last 3 months	Total=1
Cluster Eight	Walked alongside road drunk Drank alcohol in lifetime Walked alongside road after dagga use Smoked dagga in lifetime	Total=35
Cluster Nine	Carried a weapon Fought Use mathematical compass as weapon Threatened another person Slapped partner	Total=13
Cluster Ten	Carried a weapon Carried a gun Threatened another person	Total= 13
Cluster Eleven	Weight plan Did not engage in high intensity exercise Did not engage in low intensity	Total=2

	exercise Engaged in sedentary behaviour for 2 or more hours a day Drank alcohol in lifetime	
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This presentation should stimulate an interest in using clusters to describe engagement in risk behaviours. Substance use related clusters appear to be more prevalent than other clusters of behaviour.

4.5. Conclusion

Strong associations between use of different substances and other risk behaviours supports the view that risk behaviours are more likely to co-exist. Other than that, the associations could suggest that substance use may increase the likelihood of engagement in other risk behaviours. This could result in severe consequences for health and well-being.

The distribution of partaking in risk behaviours between male and female participants highlights the risk of ill health which the male participants may be at, as compared to the females. This is despite there being more female than male participants in this study. The male participants dominate engagement in all behaviours with the exception of suicide related behaviours, use of prescription drugs to become intoxicated and having multiple sex partners in the 3 months prior to data collection. The risk of contracting sexually transmitted illnesses and HIV may be higher for females than male participants. This is similar to the current HIV prevalence among males and females in Lesotho. The young age of initiation reported in sexual and substance related behaviours is concerning. This calls for appropriate measures to be put in place.

Chapter Five

Discussion

5.1. Introduction

Engagement in health risk behaviours constitutes doing that is dysfunctional and could have adverse effects on the health and well-being of the participants in the present day and in the future. This is because engagement in these behaviours during preteen years and adolescence may continue into adulthood.

The aim of the study (Chapter One) was to establish the prevalence of health risk behaviours among high school learners in the city of Maseru, Lesotho. Concurrent engagement in risk behaviours will be presented first, as guided by the associations established in Chapter four, risk behaviours tend to co-exist. Thereafter, prevalence of risk behaviours will be discussed with regards to consequences as a result of addictive, aggressive and sexual behaviours. Within this discussion, age of initiation and gender will be emphasised. This is because early onset of risk behaviour may have implications on the physical, psychological and occupational abilities of the individual. Discussing gender will emphasise its significance to intervention planning and implementation. Lesotho's population consists of more females than males and this is also found within the education system. The sample was representative of gender proportions in the country. The distribution of the sample closely resembled the gender distribution of both the country (51.3% females, 48.7% males) and the Maseru district (52.3% females, 47.7% males) (Bureau of Statistics, 2009:10). Of the 1121 participants 50.1% (N=562) were female and 49.9% (N=559) were male. The prevalence of behaviours will also be compared to those of countries such as South Africa and the US. Lastly, the limitations of the study will be outlined.

5.2. Concurrent engagement in risk behaviours

Co-existence of risk behaviours is evidently concerning, more so when the consequences of each behaviour are likely to be experienced, but simultaneously. 41.4% of the participants engaged in 6 or more behaviours. This highlights a need for appreciation and understanding of multiple risk behaviour engagement to enable appropriate intervention planning. Inability to plan accordingly may be a result of focus on single risk behaviours. Added to that, the increasing burden of disease and

injury associated with concurrent engagement in health risk behaviours could be indicative of failure on the part of single behaviour directed interventions.

This single problem approach to youth risk behaviours appears to undermine the dynamic occupational and social nature of human beings. An individual has multiple roles that are socially constructed. Social roles press for certain role specific behaviours and actions. Forsyth & Kielhofner (2006:74) related that most of the time when individuals act or engage in occupations, it is in partial or full fulfilment of their social roles. Multiple roles co-exist within a single person, which means that different behaviours associated with those roles also co-exist. As a result, risk behaviours are also more likely than not to co-occur. This solidifies the need to develop an interest in concurrent engagement of these behaviours.

The results of this analysis highlight a higher frequency of engagement in substance use related clusters, which concurs with the results on prevalence. In single risk behaviour prevalence, the incidence of substance use was higher than those of other behaviours, particularly alcohol consumption. This shows that planning of intervention to curb engagement in risk behaviours should include an aspect of limiting substance use.

Using an occupational lens, it is noted that simultaneous engagement in risk behaviours could mark patterns of occupation or an occupational repertoire. The repertoire depicted by the clusters indicates a likelihood of complex health consequences and a resultant experience of occupational injustice associated with each of the behaviours that make up the cluster. The age, gender and form, could also shed light on who would be likely to experience occupational risk factors as a result of multiple risk behaviour engagement. Consequences of concomitant engagement will be discussed in depth when presenting single behaviours.

5.2.1. Age

The number of behaviours that the participants engaged in concurrently gradually increased with age and reached a peak at age 16 and 17, then began to decrease.

At twenty years or older the number of co-occurring behaviours decreased. The reason could be that at this age the participants are beginning to mature as they become young adults and probably have gone past the stage of experimenting. The youngest and the oldest participants engaged in the least number of behaviours concurrently. This is despite literature showing that early engagement in one risk behaviour could set off engagement in other behaviours.

5.2.2. Gender

The female participants simultaneously took part in up to 15 behaviours. The males generally engaged in the highest number of behaviours (between 16 and 21). This shows that intervention for large numbers of concurrent behaviours may need to be focused on the male respondents. More female than male participants engaged in between one and five behaviours.

5.2.3. Form

Form A: participation was concentrated between 0 and 7 behaviours and from there on until 17 behaviours, less than 10 participants engaged in more behaviours than 7. Form D and E participants engaged in more behaviours with up to 11 behaviours with more than 10 participants partaking. Following this peak, the number of participants declined, although there was no consistent pattern depicted. The senior class members appear to be in much more need of intervention than the junior classes.

5.3. Patterns of engagement

The Lesotho Youth Risk Behaviour Survey set out to establish the age of onset and prevalence of addictive behaviours such as smoking cigarettes, cannabis use, alcohol consumption and gambling, as well as sexual and suicide related behaviours. The age of initiation of engagement in certain health risk behaviours has been associated with impaired role performance, increased morbidity and mortality among youth and in adulthood. Added to that, early onset of participation in one risk behaviour was found to predict engagement in other risk behaviours. These

behaviours will be discussed in this section. The focus of discussion will be on the age of initiation given the likely consequences, the gender, prevalence and the emerging pattern of engagement. An occupational perspective will then follow. Comparison will be mainly with South Africa as the neighbouring country, so that if patterns of engagement are similar or different, the two countries could share strategies on dealing with health risk behaviours among youth. The US will also be compared to, because the Lesotho YRBS is a modified version of the US YRBS. Apart from that, the US could be regarded as the “father” of youth risk behaviour research.

5.3.1. Addictive behaviours

A discussion of youths’ use of addictive substances and their display of addictive behaviours will be elaborated upon in this section. The significance of the age of initiation in the behaviour and the potential effect of their participation is presented. Although the substances that they were likely to be addicted to varied, the consequences of each on the youths’ occupational performance are similar and thus the consequences are discussed together. Nonetheless, the consequences of tobacco use were distinctive from other substances. Consequently tobacco use is presented individually. Gambling is an addictive behaviour and not a substance, so it will be discussed on its own.

5.3.1.1 Tobacco use

The survey results showed that of the 19.6% who had ever smoked, 24.1% had started smoking before the age of 13. 2.3% of this group were female and 21.8% were male. Those who started at 8 years or younger accounted for 6.8% of those who had ever smoked. Similar findings were reported in South Africa where 6.2% of the smoking learners initiated before the age of 10 (Reddy et al., 2003:98) and the male participants dominated (40%) the overall engagement (30.5%) in smoking. In the US, the overall prevalence in having smoked was 46.3% and 10.7% initiated smoking before they were 13 years old (CDC, 2010:10-17). The prevalence of smoking in Lesotho appears to be relatively lower than in other countries. Smoking also seems to be more prevalent among males than females.

The evidence on the consequences of engagement in risk behaviours (Chapter Three) shows that age of initiation, particularly of smoking is an important factor in predicting engagement in other risk behaviours (Strine et al., 2005:186). Early smoking has been associated with other substance use and potential development of drug dependence in adulthood (Mathers et al., 2006:948). Smoking had also been found to be a predictor of engagement in other risk behaviours that are not substance related, such as sexual or suicide related behaviours. Goodwin, Lewinsohn & Seeley (2005:690) reported that early smoking could consequently lead to the development of psychiatric disorders like panic attacks and panic disorder. Further to that, early smoking has been associated with the likelihood of developing cancer (Hara et al., 2010). Early onset of smoking appears to negatively impact on both physical and psychological wellbeing, as well the quality of life of the individual.

As a leading cause of preventable disease and premature death, tobacco use is of relevance to the occupational therapy profession, despite lack of research specific to tobacco use within occupational therapy literature. Tobacco use in the form of smoking cigarettes or using snuff can be described as an action or task within a broader spectrum of occupational performance or doing. The burden of disease related to chronic illnesses such as cancer and mental illness has severe effects on the occupational lives, well-being and quality of life of individuals.

Even though Lesotho envisions a healthy human resource base by 2020, but has no measures in place to control tobacco use. Lesotho has signed the World Health Organisation Framework Convention on Tobacco Control (WHO FCTC, 2003), but there are currently no laws or policies that control the selling, use and advertising of tobacco products (Moremoholo, 2008:5). This shows that tobacco use might not be viewed as a major health hazard, which is a different view from what literature suggests. For example, tobacco accounts for an estimated 4 million deaths a year in comparison to 3 million annual AIDS related deaths (Guindon & Boisclair, 2003). More than half (54.8%) of the participants were exposed to second-hand smoke in the past 30 days. This makes up a significant percentage of the country's future

human resource base that is at risk of a chronic illness, therefore, the urgency of legislature, policy and enforcement of control on tobacco use is emphasised here.

5.3.1.2 Alcohol use

In 2006 it was established that in Lesotho, 8.8% of children between the ages of 10 and 14 years consumed alcohol (Baingana et al., 2006:335). The findings of this study could suggest that the prevalence of early alcohol consumption has increased, because the proportion appears to have doubled. This shows that alcohol consumption among children and youth is a major concern in the Lesotho, because the effects of this behaviour could be detrimental to health and well-being.

The results of this study showed that of the 51.8% of youth who reported to have drunk alcohol, 27.9% started when they were 12 years old or younger. The youngest (8.4%) participants indicated that they had started at 8 years or below. Male participants dominated engagement within the initiation age range of 11-12 years; however there was little difference between males (6.5%) and females (5.8%). Based on this, it is proposed that intervention for both genders within this age group is necessary. The likelihood of female youth to begin consumption was higher between 11 and 12 years of age. This could also mark a time in adolescent life where females are more likely to begin alcohol use as compared to other years.

Comparatively, the prevalence of having drunk alcohol was exceptionally high in the US (72.5%) and 21.1% started before 13 years of age (CDC, 2010:13). In South Africa, those who had ever drunk accounted for close to half of the participants (49.1%) and 12% of them initiated use at 13 years of age or younger (Reddy et al., 2003:102). Although, the statistics in this study are not as high as the findings in the US, the prevalence of alcohol consumption in Lesotho is higher than that of South Africa. However, the occurrence of binge drinking in this study (17.5%) was lower than that reported in South Africa (23%). This occurrence is still relatively high and remains a concern. The consequence of addiction or drug dependence could be dysfunctional occupational performance which could lead to health and social problems (Helbig & McKay, 2003:141) and academic difficulties. As a result of

intoxication, the participants may have encountered difficulties in performing school related tasks and activities. Their scholastic performance may progressively deteriorate depending on the frequency of engagement in this behaviour which may even develop into drug dependence.

Easy access to alcohol could account for the prevalence and early onset of use in Lesotho. 75% of available alcohol in the country is home brewed (Lesotho Council of NGOs, 2006). Apart from cultural purposes, Basotho brew alcohol and sell it as a means of livelihood, therefore many children are likely to be exposed to alcohol consumption at a young age, because the guardian brews. Children as young as 5 years old have been reported to consume alcohol (Baingana et al., 2006:335). Alcohol use among children and adolescents is a problem that the country has to acknowledge and address, because of the consequences thereof.

Alcohol use, particularly among youth who initiated in the preteen years had adverse effects on interpersonal relations. Consumption that began before 13 years of age was associated with violence and suicide related behaviours (Swahn, Bossarte & Sullivent, 2008:301). Furthermore, early onset coupled with smoking and engagement in sexual intercourse has been associated with suicide related behaviour (Kim & Kim, 2010:20-25). Concurrent risk taking could have regrettable consequences on the wellbeing of the person. In this study an association was found ($p=0.002$) between having consumed alcohol in a lifetime and having been involved in a fight.

5.3.1.3 Dagga and other substance use

14.9% of the participants who reported using dagga (19.2%) had initiated dagga use before their 13th birthday. 7.2% of the latter subgroup started using dagga at or before the age of 8. The proportion of participants who initiated dagga use before 13 years in South Africa was almost 5 times lower (4.2%) than that found in this study (Reddy et al., 2003:104). 7.5% of the participants in the US had begun dagga use before the age of initiation of dagga use was not reported in the US YRBS US (CDC, 2010:14), the lifetime use prevalence was above one third of the sample (36.8%).

The US seems to face a bigger challenge of the consequences associated with dagga use as compared to Lesotho and South Africa. Since Lesotho is known to be a nation growing dagga for livelihood purposes (Bloomer, 2009:49), easy access to the substance could have accounted for the extensive use among the respondents. This highlights the need for more vigorous law enforcement against production and distribution of substances, particularly dagga.

As with tobacco and alcohol, early initiation of dagga use has been associated with severe consequences. Drug use may result in intoxication which could result in impaired cognitive function, destructive or poor social interaction and behavioural problems. The likelihood of developing drug dependence within a year of using dagga was 2-4 times higher among individuals who started early (Chen, Storr & Anthony, 2009:320). Drug dependence is a psychiatric disorder that can predict and precipitate occurrence of other disorders (Zvolensky et al., 2008:1021), therefore creating complex occupational dysfunction. These consequences could contribute to the experience of occupational injustice.

5.3.1.4 Gambling

The prevalence of gambling among the respondents was 33.1%. Over half 23.6% of them were male, and 9.5% were female. South Africa and the US had not reported on the prevalence of gambling, therefore not allowing for comparison with these two countries. Gambling is a behaviour that could become addictive and in its severity, pathological. In a study in Connecticut, 11.8% of 110 participants were found to be probable pathological gamblers (Pietrzak & Petry, 2006:764). This form of gambling has been said to warrant classification as an impulse control disorder (Kaliski, 2002:267). Engagement in criminal activities, severe interpersonal problems with aggression and financial problems are outcomes of gambling (ibid). This shows that gambling is likely to co-occur with other risk behaviours other than substance use or aggression. For example, gambling is a sedentary behaviour (Morasco et al., 2006:977) therefore could be associated with effects of sedentary lifestyle, such as prolonged physical inactivity. Pathological gambling could also be associated with other psychiatric disorders, such as mood, personality, attention-deficit and other

impulse control disorders (American Psychiatric Association, 2004:672). The likely comorbid presence of pathological gambling and other disorders is consistent with other risk behaviours as they often co-occur and as result have a complex more severe outcome on health and well-being.

Even though this study did not measure the severity of participation in gambling, the participants may not have been pathological gamblers yet, but some of them could have been problem gamblers. This type of gambling is characterised by among others neglect of responsibilities and commitments, excessive preoccupation with the activity, lying and cheating to feed the habit (Delfabbro, Lahn & Grabosky, 2006:587). This would destroy relationships between the youth and their peers or family, therefore affecting the well-being of others.

Low self esteem, isolation, depression and poor general health were identified as threats to psychosocial wellbeing that were experienced by problem gamblers in a study in the Australian Capital Territory (Delfabbro, Lahn & Grabosky, 2006:591). These outcomes of gambling are likely to have adverse consequences on role performance, as a result of preoccupation with the activity; therefore school performance could consequently decline. Gambling, regardless of the degree of severity appears to have a corollary of occupational, psychological, social and economic difficulties for the gambler and participants in their social environment. Although adolescent gamblers could be said to not have much to lose in terms of finances, they could gamble with other commodities, such as food or clothes or participate in criminal activities to enable them to continue participation. Continuation of gambling into adulthood could result in pathological gambling, which has more severe consequences on occupational performance and health.

As engagement increases in frequency, the consequences on health could become more severe and despite that the individual would continue with the activity, because it is addictive. Further to that, crime could limit the occupational performance of the youth in that when incarcerated there would be limited opportunities to participate in occupations. In this study there was a strong association ($p=0.000$) between gambling and cigarette smoking, alcohol drinking and dagga use. Youth could

engage in non-organised gambling, such as betting on teams, playing cards for money or other activities that could otherwise be regarded as no-risk leisure activities. Regulation of this behaviour by law enforcement authorities would therefore be a challenge.

The proportion of youth who reported to have gambled was relatively high. This could be attributed to the type of question that was asked, the focus was on lifetime participation rather than current involvement. However, as an addictive behaviour it may possibly recur, therefore there is concern when more than one third of the participants have gambled.

An occupational science perspective to addiction

Addictive behaviours constitute a form of doing that the participants are currently engaged in. When this doing occurs over a prolonged period of time, the consequences may predict who and what the youth become in adulthood. Wilcock (1999:5) indicated that becoming encompasses aspects of “potential and growth, transformation and self-actualization.” Through engagement in addictive behaviours, youth could limit their potential to become what they aspire to be, despite being at school. Occupational injustice is a concept that will be used to discuss addictive behaviours from an occupational science perspective.

Occupational injustice can be a cause and/or outcome of engagement in risk behaviours. With reference to addictive behaviours, occupational injustice could be experienced as either a result of engagement in dysfunctional occupational performance or a cause of disruption in occupational performance. By partaking in addictive behaviours, the participants consequently have limited their occupational opportunities, as well as restricted themselves from fully experiencing health enhancing occupations that promote well-being. This is because an individual’s daily occupational repertoire and performance becomes limited to only comprise of addiction related behaviours, possibly resulting in occupational imbalance (Helbig & McKay, 2003:141). Other aspects of occupational performance and engagement that are particularly important for survival could be neglected, therefore limiting

occupational potential and negatively impacting on health. This example entails aspects of being under-occupied in some areas of occupation and being over-occupied with addiction related activities, therefore, showing that occupational performance may lead to occupational risk factors.

For example, Polatajko, et al. (2007:78) indicated that occupational alienation was experienced when forces outside the individual's control dictate occupational choices in a way that hinders or disrupts synchrony between the person's aspirations and their choices. Therefore, the person is left feeling inadequate, stressed, hopeless and without a sense of belonging. This could eventually lead to suicide-related behaviours in youth. Although, suicidal behaviours have been associated with early substance use, feelings of inadequacy, stress, loneliness and lack of a sense of belonging could be associated with gambling. The consequences of gambling, such as serious interpersonal relations problems, neglect of responsibilities and commitments and stress (Morasco et al, 2006:976) could result in occupational alienation related to engagement in other occupations. Gambling may therefore contribute to the experience of occupational injustice.

Similarly, substance use could be a cause and a consequence of occupational deprivation. For example, the participants in this study reported alcohol use from as early as 8 years old or younger and it is probable that dependence may have developed due to prolonged use. This could be an example of addiction to alcohol restricting engagement in occupations related to the role of a learner despite the occupations being meaningful to the individual, therefore performance would deteriorate. When obtaining alcohol becomes a priority, other meaningful occupations may be neglected and the occupation itself becomes a restricting factor to engagement in other meaningful occupations. The individual may in turn resort to binge drinking in an attempt to mask these feelings of failure, therefore creating a vicious cycle of increasing severity of dysfunctional occupational performance and experiences of occupational deprivation. Lack of meaning in life has been identified as a trigger of addiction relapse (Helbig & McKay, 2003:143). In the same manner as alcohol dependence could lead to the experience of occupational deprivation, this applies to other substances. However, there is a need for further exploration of

occupations that are detrimental to health that may be meaningful to the individual or community in relation to occupational risk factors.

5.3.2. Aggressive behaviours

Acts of aggression may manifest as violence, the consequence of which could include injury, incarceration, trauma and death. These aggressive actions pertain to social interaction and are a sign of poor interpersonal skills. Smith et al. (2008:145) indicated that a physical injury is both a threat to physical and psychological well-being. When such acts occur, particularly within the school setting, occupational performance could be negatively impacted and specifically school performance could deteriorate. The following section focuses on aggressive behaviours that took place at school as well as those that relate to partner relations.

Aggressive behaviours reported by the participants included having threatened someone with a weapon at school (8.1%), carried a weapon at school (7%), having fought at school (16%), slapping a partner (10.2%) and having forced someone into sex (4.6%). These statistics show the proportion of perpetrators of both peer and dating violence. Suicidal behaviours have been associated with engagement in these forms of violence (Swahn et al., 2008:37). Suicide could be regarded as a form of aggressive or violent behaviour towards the self.

In this study those who were victims of these behaviours had been bullied (38.4%), been threatened at school (20.1%), been slapped by a partner (11.4%) and been forced into sex (7.6%). Being a victim of aggressive behaviour could limit an individual's occupational abilities. Violence-related risk behaviours could restrict the victim from exercising occupational choice and engagement out for fear. This would result in occupational deprivation and would limit the victim's ability to build a social identity. The aforementioned findings do not render school as the safest environment to be in, especially when 67.7% had watched a fight at school. Fear of the perpetrator could also be associated with experiences of occupational marginalization. This occupational risk factor was referred to as restriction in exercising decision-making power about when, how and what occupations to

participate in (Townsend & Wilcock, 2004:81). Participants reported carrying weapons, fighting, threatening others and being threatened, slapping a partner and being slapped and being bullying. Some of these behaviours took place at school and this could have made others feel unsafe, to an extent that they would decide not to attend school, therefore eventually dropping out of school.

Comparatively, in the US, 5.6% of the participants had carried weapons at school, 7.7% had threatened others with a weapon at school and 11% had fought at school. With reference to being a victim of partner violence, 9.8% had been slapped by the partner, 7.4% had been forced into sexual intercourse and 19.9% were bullied at school (CDC, 2010:13). Based on these findings high school learners in Lesotho appear to resort to more aggressive measures than those in the US. Partner violence was also rife in South Africa. 9.8% had been forced into sex, 13.6% had been slapped by a partner and in comparison to Lesotho, the prevalence of partner violence was higher in South Africa. As for peer violence, 19.3% had been involved in a fight at school, 9.2% had carried weapons at school and 9.2% had threatened someone with a weapon at school (Reddy et al., 2003:90). South African youth appear to resolve interpersonal relation issues through violence more than both the US and Lesotho.

It is disturbing to establish that some participants had sexually violated others' rights, which is a crime. Since risk behaviours can co-occur aggressive behaviours could be associated with other behaviours. For example, partner violence was found to be associated with suicidal behaviour (Swahn et al., 2008:31), implying that partner violence could lead to death.

5.3.3. Sexual behaviours

Of the 44.6% participants who had sex, 40.9% started at the early age of 14 or younger. A quarter of them (25%) engaged in the behaviour when they were 11 years or under. The findings are consistent with those of South Africa with 41.1% reported to have engaged in sexual intercourse and 14.4% having started before age 14 (Reddy et al., 2003:111). The proportion of those who initiated sex before 14

years of age was remarkably high among the participants in this study compared to those in South Africa. In the US, there was an overall 46% prevalence of engagement in sexual intercourse and 5.9% initiated before the age of 13 years (CDC, 2010, 20). This shows that youth are exposed to the risk of contracting sexually transmitted illnesses from as early as 14 years old or younger.

In Lesotho the prevalence of HIV/AIDS in 2005 was 23.2% among the productive age group of 15-49 years of age (UNDP, 2007:45). The majority of the participants in this study fall within this age group and they reported engagement in behaviours that could put them at risk of contracting sexually transmitted illnesses including HIV. These behaviours included that 9.9% of youth reported having two or more sexual partners in the three months preceding data collection. Further to this 10.3% of the female participants reported having multiple partners, compared to 9.5 % of male participants. Of further concern was that 8.4% reported never using a condom while and 5.7% indicated that they had been intoxicated before having sex. There was a strong association ($p=0.000$) between these two behaviours. This could be expected, because an intoxicated individual is in an altered state of mind in which judgement could be clouded, therefore leading to failure to make decisions such as using condoms. This places youth at risk of contracting HIV or other sexually transmitted diseases.

HIV/AIDS may have adverse effects on health, well-being, quality of life and occupational performance. The illness may lead to “absence, illness, premature death and early retirements that result in loss of skills and experiences and declining productivity, therefore damaging an already strained economy,” (USAID, 2008: html). The presence of illness could restrict participation in meaningful and purposeful occupations, therefore resulting in occupational risk factors such as occupational imbalance. Townsend & Wilcock (2004:82) pointed out that occupational imbalances related to “the need for a range of occupations that promote health-giving routines and social inclusion.” The stigma attached to contracting sexually transmitted illnesses could prevent youth from seeking medical attention. The stigma could limit participation, thereby intensifying the experience of occupational injustice. This threatens the country’s vision of having a healthy human resource base by the year

2020 where there will be no new HIV infections (National Vision Document, 2004:6). The absence of measures that are readily available to learners in high schools in Lesotho could lead to continued engagement in these behaviours. One crucial entity that is currently missing is content related to safer sexual practices in the high school curriculum. As a result the learners may not be well informed about the risks and consequences of their behaviours; therefore presumably are unable to make informed decisions.

5.4. Conclusion

In conclusion, concurrent risk behaviour engagement seems to create an enormous challenge for occupational therapists, as the consequences are likely to affect the occupational lives of the participants. In addition to that, the age of initiation and gender have been identified as factors that predict prevalence in health risk behaviours. Age of initiation has been found to be a predictor of co-occurring behaviours and to have the most severe consequences on health. Although, the focus of the study was on high school learners, risk behaviours appear to begin during primary school.

5.5. Limitations of the study

As indicated in Chapter Three, gaining consent from the parents of the learners was difficult. This resulted in the process of data collection being drawn out longer while waiting for consent to be granted. In instances where classes had learners who were 18 years and older, the learners were asked to give consent, because legally they were regarded as adults who can make informed decisions.

Honesty and accuracy might have been compromised for data from two schools, because the classes were overcrowded and learners had to share desks. This means that learners were able to see what each other was reporting. This could not be avoided as there was no other venue available. However, the integrity of all the data collected was not compromised as this only happened in two schools.

Another limitation of this study is that there could have been self-reporting bias. To reduce this, emphasis was put on anonymity, voluntary participation and honesty in reporting. Added to that, there were no familiar authorities that the participants would have thought would be able to trace them from the responses given. The results may pertain to only those who were present at the venue when the survey was administered. However, the results may not be significantly affected as those who were absent accounted for a smaller proportion.

Chapter Six

Conclusion and Recommendations

6.1. Conclusion

The aim of the study was to establish the prevalence of health risk behaviours among high school learners in the city of Maseru, Lesotho. Study results show a significant participation in these behaviours and that they were likely to co-exist. In addition to that, it was evident that involvement in the behaviours started earlier than adolescent years. Concurrent engagement in risk behaviours, gender and age of initiation were found to be important influences of prevalence of health risk behaviours.

It is disturbing to realise that the prevalence of engagement in majority of the risk behaviours is higher for learners in Lesotho than those in South Africa, yet there are hardly any school-based interventions directed at management of these behaviours. The participants dominated engagement in alcohol, dagga and sexual behaviours. In particular, the participants for this study initiated engagement in these behaviours at an exceptionally young age as compared to their peers in South Africa. This indicates that the burden of disease is suffered worse in Lesotho, despite the limited availability of resources to manage such diseases. This burden is likely to overflow into South Africa as referrals for health services, thereby adding to the burden of disease on South Africa. As a result, health risk behaviours among high school learners in Lesotho need to be treated as a matter of emergency, if the country envisions achieving its national vision by the year 2020.

The study highlights important issues pertinent to the future development of youth in Lesotho. As occupational beings, the future quality of life of these youth may be affected by their current doing, therefore it is imperative as occupational therapists to focus attention on this form of participation and develop appropriate intervention. This study will create evidence that could be disseminated to the public. In addition to that, the role of occupational therapy and science in public health may be embraced, therefore enabling implementation of occupation-based intervention directed towards curbing participation in these behaviours.

The occupational therapy profession in Lesotho is still in the explorative stages within public service. This study will inform the growth of the profession by

emphasising the possible long term consequences of partaking in risk behaviours. The level of awareness that will be raised by this study could facilitate support for the profession to approach intervention to combat risk behaviour engagement among the youth from an occupational perspective.

6.2. Recommendations

6.2.1. Intervention

Review of programmes aimed at addressing single behaviours is strongly advised, as the results of this study indicate that youth in high schools in Lesotho engage in these behaviours concurrently. A place to start would be to review the current School Health Programme which focused mainly on health education on single topics pertaining to mental health and illness. Such a programme and many others that are directed towards youth could be strengthened by incorporating an occupation-based focus.

The programmes could be occupational performance directed as well as provide opportunities for occupational engagement. Starting by focusing on occupational performance would enable the current performance/doing that is detrimental to health to be addressed through population-based treatment and rehabilitation. Concurrent to that, opportunities for engagement in healthier occupations could be provided, therefore facilitating occupational engagement, thereby using occupations to transform the youth. This would make it possible for the youth to reclaim their occupational lives by engaging in health enhancing occupations, therefore reducing the morbidity and mortality associated with engagement in risk behaviours.

Occupational therapy has a role in designing programmes in contribution to the country's efforts in poverty reduction, so as to create healthier means to sustain livelihoods, rather than resorting to growing and selling dagga. Nonetheless, there is an urgent need for legislation and policies on use of substances such as tobacco and alcohol. Law enforcement institution may require strengthening to enable them to enforce regulations around substance production in the communities, therefore limit access to them by the youth. Added to that, the schools also have a

responsibility to make the school environment a drug free environment. Integrative approach to risk behaviours could enable formation of partnerships between disciplines to allow for development of comprehensive intervention (Lubell & Vetter, 2006:167).

6.2.2. Future research

There is an urgent need to establish factors that precipitate initiation of risk behaviours among children. Research of this nature could be conducted among learners aged between 8 and 13 years, because this is the age range within which learners in this study reported to resume engagement in risk behaviours, particularly those pertaining to substance use. This would enable planning of intervention targeted at those factors, so as to delay the age of initiation and in turn prevent the likelihood of consequences associated with early initiation.

Further to that, a national youth risk behaviour survey among learners in Lesotho is highly recommended as it would elicit information on the extent of engagement nationwide. The information elicited from a study of this magnitude would make a strong motivation for changes and developments a macro level. For example, review of the current primary and high school curriculum to include health and physical education, as well as lifeskills. In addition to that, this could encourage development of policies aimed at collaboratively addressing concurrent engagement in risk behaviours rather than focusing on developing programmes that address single or discipline-specific behaviours. Another proposition would be to systematically monitor engagement in these behaviours on a consistent period of time so as to enable generation of evidence on whether interventions that may be put in place are effective or not, therefore permitting revision.

Continued research in occupational therapy and science is recommended to further understand concurrent engagement in risk behaviours and the impact on health, well-being and quality of life. This would grow the body of knowledge in this area, therefore allowing for dialogue on how occupational therapists could intervene in this public health issue. In addition to that, the concept of occupational performance

potentially resulting in occupational risk factors has not been explored in occupational therapy literature and through this study; dialogue may be encouraged, therefore facilitating further exploration. Lastly, establishment of a strong research body in Lesotho would ensure dedication of time and resources to facilitate continuous research that could inform different stakeholders on patterns of engagement and other factors pertaining risk behaviour engagement. This would enable the country to share information and seek support from other institutions of this kind such as the Medical Research Council of South Africa and the Centers for Disease Control in the US.

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APPENDICES

APPENDIX ONE

Letter to Principal Secretary

P.O. Box 14764
Maseru 100
Lesotho

26th February 2010

The Principal Secretary (PS)
Ministry of Education and Training
Maseru 100
Lesotho

Re: Permission to conduct research in high schools in the city of Maseru

Dear Sir

I am currently enrolled at the University of Cape Town in the Masters' of Science in Occupational Therapy programme and I am a sponsee of the National Manpower Development Secretariat. As a requirement for qualification, I have to complete a research thesis. The title of my research is "The prevalence of health risk behaviours among high school learners in the city of Maseru, Lesotho. I have obtained ethical approval from the Research Ethics Committee of the University of Cape Town to conduct the study, as stipulated in the attached letter (REC REF 075/2010).

The learners that will take part in the study will be selected from four schools that represent four different areas of the city of Maseru, namely the central, south, north and west. The selected schools are Lithabaneng High School, Thetsane High School Khubetsoana High School and Lesotho High School. One stream per Form will be randomly selected and the learners in those streams will partake in the research. However, a pilot study of the research instrument will be conducted prior to the data collection period and it will be piloted in a school that will be willing to participate.

My interest in the field of study was ignited by my work as an Occupational Therapist serving in the Mental Health Programme in the Ministry of Health and Social Welfare, Lesotho.

I intend to cause minimal disruption to the school programme during the process of data collection and suitable times will be negotiated with the schools. I therefore, kindly request permission to gain access to the abovementioned schools to conduct the study.

For more information on the study please do not hesitate to contact me on:

Cellphone number: 58736598

Fax number; 22315587

Email: Matumo.Ramafikeng@uct.ac.za OR matumocr@yahoo.co.uk

I hope my request reaches your favourable consideration.

Yours faithfully

'Matumo Ramafikeng (Ms).

APPENDIX TWO

Original Lesotho Youth Risk Behaviour Survey- 2010

Lesotho Youth Risk Behaviour Survey- 2010

This survey is about health behaviour. 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 promotion programmes 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 marks in this class. If you are not comfortable answering a question, just leave it.

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 and then circle the response that best describes what you do. When you are finished, follow the instructions of the person giving you the survey.

Thank you very much for your help.

DIRECTIONS

Use a #2 pencil that is provided only.

Circle the response that you choose.

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

Section A: Information about yourself
--

- 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. Are you a girl (woman) or a boy (man)?**
 - A. Girl (woman)
 - B. Boy (man)

- 3. In what Form are you?**
 - A. Form A
 - B. Form B
 - C. Form C
 - D. Form D
 - E. Form E

- 4. Are you a Mosotho?**
 - A. No
 - B. Yes, by birth
 - C. Yes, by acquired citizenship

- 5. What type of dwelling do you live in?**
- A. A brick house
 - B. Rented apartment/ flat (Malaene)
 - C. A hut
 - D. A shack
 - E. Other
- 6. How many sleeping rooms are there in your house?**
- A. One room
 - B. Two rooms
 - C. Three rooms
 - D. Four rooms or more
- 7. Where do you sleep?**
- A. I sleep in the same house with my parents/guardians
 - B. I sleep in another house on our property
 - C. I sleep next door
 - D. I sleep in the dormitory or hostel
- 8. List all the people who live in your household (You can choose more than one option)**
- A. Mother
 - B. Father
 - C. Sister
 - D. Brother
 - E. Uncle
 - F. Aunt
 - G. Grandfather
 - H. Grandmother
 - I. Other relative
 - J. Domestic worker

- 9. How do you mainly get to school?**
- A. I walk
 - B. I take public transport (a bus, minibus taxi or 4+1)
 - C. I go by car
 - D. I use a bicycle
- 10. During the past 6 months how do you describe your marks?**
- A. Mostly A's (80% or more)
 - B. Mostly B's (70% - 79%)
 - C. Mostly C's (60% - 69%)
 - D. Mostly D's (50% - 59%)
 - E. Mostly E's (40% - 49%)
 - F. Mostly F's (39% or less)
 - G. I don't know
- 11. In a month how much pocket money do you get?**
- A. I don't get any pocket money
 - B. Less than RM5.00
 - C. From M5.00 to M10.00
 - D. From M11.00 to M20.00
 - E. From M21.00 to M30.00
 - F. From M31.00 to M40.00
 - G. From M41.00 to M50.00
 - H. More than M50.00
- 12. What do you use your cellphone for?**
- A. I do not have a cellphone
 - B. I use my cellphone for calls only
 - C. I use my cellphone for SMSs only
 - D. I use my cellphone for calls and SMSs only
 - E. I use my cellphone for facebook only
 - F. I use my cellphone for calls, SMSs and facebook

- 13. Does your father have a paid job? (Paid job includes self-employed having a shop, a taxi, rented apartments, street vending)**
- A. Yes, he works 5 or more days a week
 - B. Yes, he works less than 5 days a week
 - C. No, he gets money from Social Welfare
 - D. No, he is unemployed
 - E. No, he is ill or disabled
 - F. No, he is on pension
 - G. I don't have a father (or male guardian)/ my father passed away
 - H. I don't know
- 14. Does your mother have a paid job? (paid job includes self-employed e.g. having a shop, a taxi, rented apartments, street vending, sewing, catering)**
- A. Yes, she works 5 or more days a week
 - B. Yes, she works less than 5 days a week
 - C. No, she gets money from Social Welfare
 - D. No, she is unemployed
 - E. No, she is ill or disabled
 - F. No, she is on pension
 - G. I don't have a mother (or female guardian)/ my mother passed away
 - H. I don't know
- 15. Do you consider yourself disabled in any way (mentally or physically)?**
- A. Yes
 - B. No

**Section B: The following questions ask about your
safety**

16. How often do you use a seat belt when you are in a vehicle (e.g. car, van, taxi, or truck) driven by someone else?
- A. Never (0 times)
 - B. Rarely (1 time)
 - C. Sometimes (2 or 3 times)
 - D. Often (4 or 5 times)
 - E. Very often (6 or more times)
 - F. I have never been in a vehicle (car, van, taxi or truck) that has seat belts
17. During the past month (30 days), how often were you in a vehicle (car, bus, van, taxi or truck) driven by someone who had been drinking alcohol?
- A. Never (0 times)
 - B. Rarely (1 time)
 - C. Sometimes (2 or 3 times)
 - D. Often (4 or 5 times)
 - E. Very often (6 or more times)
 - F. I have never been in a vehicle (car, van, taxi or truck)
 - G. I don't know if the person had been drinking
18. During the past month (30 days), how often were you in a vehicle (car, bus, van, taxi or truck) driven by someone who was smoking cigarettes?
- A. Never (0 times)
 - B. Rarely (1 time)
 - C. Sometimes (2 or 3 times)
 - D. Often (4 or 5 times)
 - E. Very often (6 or more times)

F. I have never been in a vehicle (car, van, taxi or truck)

19. How often do you use a seat belt when you yourself drive a vehicle (e.g. car, van, taxi, or truck)?

- A. Never (0 times)
- B. Rarely (1 time)
- C. Sometimes (2 or 3 times)
- D. Often (4 or 5 times)
- E. Very often (6 or more times)
- F. I do not drive a vehicle (car, van, taxi or truck)

20. During the past month (30 days), how often did you drive a vehicle (car, taxi, bus or truck) when you yourself had been drinking alcohol?

- A. Never (0 times)
- B. Rarely (1 time)
- C. Sometimes (2 or 3 times)
- D. Often (4 or 5 times)
- E. Very often (6 or more times)
- F. I have never driven a vehicle (car, van, taxi or truck) when I had been drinking alcohol
- G. I do not drive a vehicle (car, van, taxi or truck)

21. During the past month (30 days), how often did you walk alongside a road when you had been drinking alcohol?

- A. I have never walked alongside a road after I had been drinking alcohol
- B. Rarely (1 time)
- C. Sometimes (2 or 3 times)
- D. Often (4 or 5 times)
- E. Very often (6 or more times)
- F. I don't drink alcohol

22. During the past month (30 days), how often did you walk alongside a road after you had been smoking dagga (matekoane)?

- A. I have never walked alongside a road after I had been smoking dagga (matekoane)
- B. Rarely (1 time)
- C. Sometimes (2 or 3 times)
- D. Often (4 or 5 times)
- E. Very often (6 or more times)
- F. I don't smoke dagga (matekoane)

23. During the past month (30 days), how often did you walk alongside a road after you had taken other drugs?

- A. I have never walked alongside a road after I had taken other drugs
- B. Rarely (1 time)
- C. Sometimes (2 or 3 times)
- D. Often (4 or 5 times)
- E. Very often (6 or more times)
- F. I don't take other drugs

24. During your life, how often have you gambled?

- A. Never (0 times)
- B. Rarely (1 time)
- C. Sometimes (2 or 3 times)
- D. Often (4 or 5 times)
- E. Very often (6 or more times)

25. When you rode a bicycle during the past 6 months, how often did you wear a helmet?

- A. I did not ride a bicycle during the past 6 months
- B. I never wore a helmet
- C. I rarely wore a helmet
- D. I sometimes wore a helmet
- E. Most of the time I wore a helmet

F. I always wore a helmet

Section C: The following section asks about violence-related behaviours.

26. **During the past month (30 days), on how many days did you carry a weapon such as a gun, knife, screwdriver or club (molamu)?**
- A. Never (0 days)
 - B. Rarely (1 day)
 - C. Sometimes (2 or 3 days)
 - D. Often (4 or 5 days)
 - E. Very often (6 or more days)
27. **During the past month (30 days), on how many days did you carry a gun?**
- A. Never (0 days)
 - B. Rarely (1 day)
 - C. Sometimes (2 or 3 days)
 - D. Often (4 or 5 days)
 - E. Very often (6 or more days)
28. **During the past month (30 days), on how many days did you carry a weapon such as a gun, knife, screwdriver or club (molamu) while at school?**
- A. Never (0 days)
 - B. Rarely (1 day)
 - C. Sometimes (2 or 3 days)
 - D. Often (4 or 5 days)
 - E. Very often (6 or more days)
29. **During the past month (30 days), how many times have you used a mathematical compass or divider as a weapon at school?**
- A. Never (0 times)

- B. Rarely (1 time)
- C. Sometimes (2 or 3 times)
- D. Often (4 or 5 times)
- E. Very often (6 or more times)

30. During the past month (30 days), on how many days did you not go to school (miss school) because you felt you would be unsafe at school?

- A. 0 days
- B. 1 day
- C. 2 or 3 days
- D. 4 or 5 days
- E. 6 or more days

31. During the past month (30 days), on how many days did you not go to (miss) school because you felt you would be unsafe 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

32. During the past 6 months, how many times has someone threatened or injured you with a weapon such as a gun, knife, screwdriver, mathematical compass, divider or club (molamu) at school?

- A. Never (0 times)
- B. Rarely (1 time)
- C. Sometimes (2 or 3 times)
- D. Often (4 or 5 times)
- G. Very often (6 or more times)

- 33. During the past 6 months, how many times have you threatened or injured someone with a weapon such as a gun, knife, screwdriver, mathematical compass, divider or club (molamu) at school?**
- A. Never (0 times)
 - B. Rarely (1 time)
 - C. Sometimes (2 or 3 times)
 - D. Often (4 or 5 times)
 - E. Very often (6 or more times)
- 34. During the past month (30 days), what was the one way in which you were bullied most? (Choose one answer)**
- A. I was never bullied
 - B. I was called names, was made fun of, or teased in a hurtful way
 - C. I was hit, kicked, pushed, shoved around or locked indoors
 - D. Others told lies or spread false rumours about me and tried to make people dislike me
 - E. I was made fun of because I am a foreigner
 - F. I was made fun of because I am disabled or an albino
 - G. I was made fun of because my family is poor
 - H. Others made sexual jokes, comments or signs to me
 - I. I was bullied because of my weight (underweight or overweight)
 - J. I was bullied in some other way
- 35. During the past 6 months, have you been bullied at school?**
- A. Yes
 - B. No
- 36. During the past 6 months, how often were you in a physical fight (e.g. hitting, punching, biting)?**
- A. Never (0 times)
 - B. Rarely (1 time)
 - C. Sometimes (2 or 3 times)
 - D. Often (4 or 5 times)

E. Very often (6 or more times)

37. During the past 6 months, how often were you in a physical fight (e.g. hitting, punching, biting) in which you were injured and had to be treated by a doctor or nurse?

- A. Never (0 times)
- B. Rarely (1 time)
- C. Sometimes (2 or 3 times)
- D. Often (4 or 5 times)
- E. Very often (6 or more times)

38. During the past 6 months, how often were you in a physical fight (e.g. hitting, punching, biting) at school?

- A. Never (0 times)
- B. Rarely (1 time)
- C. Sometimes (2 or 3 times)
- D. Often (4 or 5 times)
- E. Very often (6 or more times)

39. During the past 6 months, how often have you watched a physical fight (e.g. hitting, punching, biting) at school?

- A. Never (0 times)
- B. Rarely (1 time)
- C. Sometimes (2 or 3 times)
- D. Often (4 or 5 times)
- E. Very often (6 or more times)

40. During the past 6 months, did your boyfriend or girlfriend ever hit, slap, or physically hurt you on purpose?

- A. Yes
- B. No
- C. I do not have a boyfriend or girlfriend

41. **During the past 6 months, did you ever hit, slap, or physically hurt your boyfriend or girlfriend on purpose?**
- A. Yes
 - B. No
 - C. I do not have a boyfriend or girlfriend
42. **Have you ever been physically forced to have sexual intercourse (when the penis enters the vagina or anus) when you did not want to?**
- A. Yes
 - B. No
43. **Have you ever physically forced someone to have sexual intercourse (when the penis enters the vagina or anus) when he/she did not want to?**
- A. Yes
 - B. No

Section D: The following questions are about sad feelings and attempts at 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.

44. **During the past 6 months, have you ever felt so sad or hopeless that you stopped doing some usual activities for two weeks or more in a row?**
- A. Yes
 - B. No
 - C. I don't know
45. **During the past 6 months, have you ever felt so sad or hopeless that you needed to seek treatment from a doctor, counsellor or clinic?**
- A. Yes
 - B. No

- 46. During the past 6 months, did you ever seriously consider attempting suicide (that is take some action to end your life)?**
- A. Yes
 - B. No
- 47. During the past 6 months, did you make a plan about how you would attempt suicide (that is take action to end your life)?**
- A. Yes
 - B. No
 - C. I have never thought about killing myself
- 48. During the past 6 months, how many times did you actually attempt suicide (that is take action to end your life)?**
- A. 0 times
 - B. 1 time
 - C. 2 or 3 times
 - D. 4 or 5 times
 - E. 6 or more times
- 49. If you attempted suicide during the past 6 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 6 months
 - B. Yes
 - C. No

Section E: The following questions are about tobacco use

- 50. How old were you when you first smoked rolled tobacco (BB) or a cigarette?**
- A. I have never smoked rolled tobacco or 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
- 51. During the past month (30 days), on how many days did you smoke cigarettes or rolled tobacco (BB)?**
- 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
- 52. During the past month (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

- 53. During the past month (30 days), how did you usually get your own cigarettes? (Choose only one answer.)**
- A. I did not smoke cigarettes during the past 30 days
 - B. I bought them in a store, supermarket, spaza, petrol station or from a street vendor
 - C. I asked someone who smokes
 - D. I gave someone else money to buy them for me
 - E. I borrowed 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
- 54. During the past 30 days, on how many days did you smoke cigarettes at school?**
- 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
- 55. During the past year, have you ever tried to stop smoking?**
- A. I have never smoked
 - B. I did not smoke during the past 12 months
 - C. Yes, I tried to stop smoking
 - D. No, I did not tried to stop smoking
- 56. During the past month (30 days), on how many days did you use snuff?**
- 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

57. During the past 30 days, on how many days did you use snuff at school?

- 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

58. During the past week (7days), how many days have people smoked in your presence?

- A. 0 days
- B. 1 to 2 days
- C. 3 to 4 days
- D. 5 to 6 days
- E. 7 days

59. Do your parents/ guardians smoke?

- A. Both my parents/ guardians do not smoke
- B. Both my parents/ guardians smoke
- C. Only my father/ male guardian smokes
- D. Only my mother/ female guardian smokes
- E. I don't know

Section F: The following questions are about drinking alcohol. This includes drinking beer, wine, home brew, cider and spirits such as brandy, gin, vodka, or whiskey. For these questions, drinking alcohol does not include drinking a few sips of home brew for cultural purposes or wine for religious purposes.

60. **During your life, how often have you had at least one drink of alcohol (a beer, a cider, a tot of brandy or home brewed alcohol like hopose)?**
- A. Never (0 days)
 - B. Rarely (1 or 2 days)
 - C. Sometimes (3 to 9 days)
 - D. Often (10 to 19 days)
 - E. Very often (20 or more days)
61. **How old were you when you had your first drink of alcohol (a beer, a cider, a tot of brandy or home brewed alcohol like hopose) other than a few sips?**
- A. I have never had a drink of alcohol
 - B. 8 years old or younger
 - C. 9 - 10 years old
 - D. 11- 12 years old
 - E. 13 - 14 years old
 - F. 15 - 16 years old
 - F. 15 - 17 years old
 - G. 18 years old or older
62. **During the past month (30 days), how often did you have at least one drink of alcohol (a beer, a cider, a tot of brandy or home brewed alcohol like hopose)?**
- A. Never (0 days)
 - B. Rarely (1 or 5 days)
 - C. Sometimes (6 to 9 days)

- D. Often (10 to 19 days)
- E. Very often (20 to 30 days)

63. During the past month (30 days), how often did you have 5 or more drinks of alcohol (a beer, a cider, a tot of brandy or home brewed alcohol like hopose) in a row, that is, within a couple of hours?

- A. Never (0 days)
- B. Rarely (1 or 5 days)
- C. Sometimes (6 to 9 days)
- D. Often (10 to 19 days)
- E. Very often (20 to 30 days)

64. During the past month (30 days), how many days did you have at least one drink of alcohol (a beer, a cider, a tot of brandy or home brewed alcohol like hopose) at school during school time?

- A. Never (0 days)
- B. Rarely (1 or 5 days)
- C. Sometimes (6 to 9 days)
- D. Often (10 to 19 days)
- E. Very often (20 to 30 days)

65. During the past 6 months, how often did you attend school (sit in the classroom) after drinking alcohol?

- A. I have never attended school after drinking alcohol
- B. Rarely (1 time)
- C. Sometimes (2 or 3 times)
- D. Often (4 or 5 times)
- E. Very often (6 or more times)
- F. I don't drink alcohol

Section G: The following questions are about matekoane use. Matekoane is also called marijuana, zolo, dagga, ganja or hashish

- 66. During your life, how many times have you used matekoane/ marijuana?**
- A. Never (0 times)
 - B. Rarely (1 or 2 times)
 - C. Sometimes (3 or 9times)
 - D. Often (10 or 19 times)
 - E. Very often (20 or more times)
- 67. How old were you when you tried matekoane/ marijuana for the first time?**
- A. I have never tried matekoane
 - 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
- 68. During the past month (30 days), how often did you use matekoane/marijuana?**
- A. Never (0 days)
 - B. Rarely (1 or 5 days)
 - C. Sometimes (6 to 9 days)
 - D. Often (10 to 19 days)
 - E. Very often (20 to 30 days)

69. **During the past month (30 days), how often did you use matekoane/marijuana at school during school time?**
- A. Never (0 days)
 - B. Rarely (1 or 5 days)
 - C. Sometimes (6 to 9 days)
 - D. Often (10 to 19 days)
 - E. Very often (20 to 30 days)
70. **During the past 6 months, how often did school (sit in the classroom) after smoking matekoane/marijuana?**
- A. I have never attended school after smoking matekoane
 - B. Rarely (1 time)
 - C. Sometimes (2 or 3 times)
 - D. Often (4 or 5 times)
 - E. Very often (6 or more times)
 - F. I don't smoke matekoane

Section H: The following questions are about other drug

71. **During your life, how often have you sniffed glue, benzene or inhaled petrol, paint or paint thinners to get high?**
- A. Never (0 times)
 - B. Rarely (1 or 2 times)
 - C. Sometimes (3 or 9times)
 - D. Often (10 or 19 times)
 - E. Very often (20 or more times)
 - G. I don't know this drug
72. **During your life, how often have you used cocaine including powder, crack or rocks?**
- A. Never (0 times)

- B. Rarely (1 or 2 times)
- C. Sometimes (3 or 9times)
- D. Often (10 or 19 times)
- E. Very often (20 or more times)
- F. I don't know this drug

73. During your life, how often have you used mandrax?

- A. Never (0 times)
- B. Rarely (1 or 2 times)
- C. Sometimes (3 or 9times)
- D. Often (10 or 19 times)
- E. Very often (20 or more times)
- F. I don't know this drug

74. During your life, how often have you used heroin?

- A. Never (0 times)
- B. Rarely (1 or 2 times)
- C. Sometimes (3 or 9times)
- D. Often (10 or 19 times)
- E. Very often (20 or more times)
- G. I don't know this drug

75. During your life, how often have you used tik?

- A. Never (0 times)
- B. Rarely (1 or 2 times)
- C. Sometimes (3 or 9times)
- D. Often (10 or 19 times)
- E. Very often (20 or more times)
- F. I don't know this drug

76. During your life, how often have you used a needle to inject any illegal drug into your body?

- A. Never (0 times)

- B. Rarely (1 or 2 times)
- C. Sometimes (3 or 9times)
- D. Often (10 or 19 times)
- E. Very often (20 or more times)

77. During your life, how have you used any other illegal drug not mentioned above, like ecstasy, LSD, magic mushrooms or speed?

- A. Never (0 times)
- B. Rarely (1 or 2 times)
- C. Sometimes (3 or 9times)
- D. Often (10 or 19 times)
- E. Very often (20 or more times)
- F. I don't know these drugs

78. During the past 6 months, has anyone offered, sold, or given you an illegal drug at school?

- A. Never (0 times)
- B. Rarely (1 or 2 times)
- C. Sometimes (3 or 9times)
- D. Often (10 or 19 times)
- E. Very often (20 or more times)

79. During your life how often have you used over-the-counter or prescription drugs (such as cough mixture, pain killers and diet pills) to get high?

- A. Never (0 times)
- B. Rarely (1 or 2 times)
- C. Sometimes (3 or 9times)
- D. Often (10 or 19 times)
- E. Very often (20 or more times)
- F. I don't know these drug

- 80. During your life, where did you get the money to buy drugs?**
- A. I used my pocket money
 - B. I asked my parents/guardians for money and pretended it was for something else
 - C. I used my own money that I worked for
 - D. I stole money from my family members
 - E. I stole items from my house and sold them
 - F. I did not buy drugs

Section I: The following questions are about your sexual behaviour.

- 81. Have you ever had sexual intercourse (when the penis enters the vagina or the anus)?**
- A. Yes
 - B. No
- 82. How old were you when you had sexual intercourse (when the penis enters the vagina or the anus) 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
- 83. During your life, how many people have you had sex (when the penis enters the vagina or the anus) with?**
- A. I have never had sexual intercourse
 - B. 1 person

- C. 2 people
- D. 3 people
- E. 4 people
- F. 5 or more people

84. During the past 3 months, how many people have you had sex (when the penis enters the vagina or the anus) with?

- A. I have never had sex
- B. B.I have had sex, but not in the last 3 months
- C. 1 person
- D. 2 people
- E. 3 people
- F. 4 people
- G. 5 or more people

85. The last time you had sex (when the penis enters the vagina or the anus), did you drink alcohol or use drugs before you had sex?

- A. I have never had sex
- B. Yes
- C. No
- D. I don't remember

86. When you have sex (when the penis enters the vagina or the anus), how often do you or your partner use a condom?

- A. I have never had sexual intercourse
- B. We never use a condom
- C. We rarely use a condom
- D. We sometimes use a condom
- E. We use a condom most of the time
- F. We always use a condom

- 87. When you have sex (when the penis enters the vagina or the anus), what one method did you or your partner mostly use to prevent pregnancy? (Select only one answer.)**
- A. I have never had sex
 - B. No method was used to prevent pregnancy
 - C. Birth control pills
 - D. Condoms
 - E. Injection (e.g. Depo-Provera)
 - F. Withdrawal (penis removed from vagina before ejaculation)
 - G. Morning after pill
 - H. Some other method
- 88. If you are a girl, have you ever been pregnant, if you are a boy have you ever made someone pregnant?**
- A. Yes
 - B. No
 - C. I don't know if my partner was pregnant
- 89. Do you have child/ children of your own?**
- A. Yes
 - B. No
- 90. Have you or your partner had an abortion?**
- A. Yes
 - B. No
 - C. I don't know if my partner had an abortion
 - D. I/my partner has never been pregnant
 - E. I have never had sex
- 91. If you or your partner had an abortion, where did the abortion take place?**
- A. In a hospital, clinic or private doctors' rooms
 - B. At a traditional healer/ doctor's place

- C. In another place
- D. I don't know where the abortion took place
- E. I don't know if my partner had an abortion
- F. I/my partner has never been pregnant
- G. I have never had sex

92. Have you ever had a sexually transmitted infection (STI) such as drop, discharge or seso?

- A. I have never had sex
- B. I do not know what an STI is
- C. No, I have never had a sexually transmitted infection (STI)
- D. Yes, I have had a sexually transmitted infection (STI)
- E. I don't know

93. If you had a sexually transmitted infection (STI) did you get treatment?

- A. I have never had sex
- B. No, I have never had a sexually transmitted infection (STI)
- C. Yes, I had treatment for a sexually transmitted infection (STI)
- D. No, I did not have treatment for a sexually transmitted infection (STI)

94. Do you think that you could get the HIV infection in your lifetime?

- A. Yes
- B. No
- C. I don't know

95. Do you think you are able to protect yourself from getting the HIV infection?

- A. Yes
- B. No
- C. I don't know

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

A. Yes

B. No

97. **Have you ever had an HIV / AIDS test?**

D. Yes

E. No

Section J: The following questions are about your body weight.

98. **How do you describe your weight?**

A. Very underweight (very thin)

B. Slightly underweight (thin)

C. About the right weight

D. Slightly overweight (fat)

E. Very overweight (very fat)

99. **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

100. **During the past month (30 days), which one of the following did you do the most to lose weight or to keep from gaining weight? (Choose one answer)**

C. Exercise

D. Eat less food, fewer calories or low fat foods

E. Go without eating for 24 hours or more

F. Take diet pills, powders or liquids without a doctor's advice

G. Vomit

- H. Take laxatives
- I. None of the above
- J. All of the above

Section K: The following questions ask about physical activity

101. In the past 7 days, on how often did you exercise or participate in physical activity for at least 20 minutes, such as soccer, netball, volleyball, basketball, tennis or running?

- A. I did not take part in physical activity last week (7 days)
- B. 1 day
- C. 2 days
- D. 3 days
- E. 4 days
- F. 5 days
- G. 6 days
- H. Everyday

102. In the past week (7 days) what was the main reason for you not taking part in physical activity (Choose one response)?

- A. I took part in physical activity last week (7 days)
- B. I did not want to take part in physical activity last week (7 days)
- C. I was ill
- D. I felt unsafe, frightened or scared to go to the ground/ gym to take part in physical activity
- E. I do not have the equipment, gear, ground or gym for physical activity
- F. I don't know

103. In the past 7 days, on how often did you participate in physical activity for at least 30 minutes, such as fast walking, slow bicycle riding, sweeping, mopping or polishing the floor?

- A. I did not take part in physical activity last week (7 days)
- B. 1 day
- C. 2 days
- D. 3 days
- E. 4 days
- F. 5 days
- G. 6 days
- H. Everyday

104. On an average school day, how much time do you spend watching TV, playing video games or computer games?

- A. I do not watch TV, play video games or computer games
- 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
- H. I do not have access to a TV, video games or computer games

105. In an average week when you are in school, on how many days do you have sports or physical education (PE) classes on your school timetable?

- A. We do not have sports on our school timetable
- B. 1 day
- C. 2 days
- D. 3 days
- E. 4 days
- G. Everyday

Section L: The following questions ask about the food you ate or drank in the past 7 days. Think about all the meals and snacks you had from the time you woke up until you went to bed. Be sure to include food you ate at home, at school, at restaurants or anywhere else.

- 106. During the past 7 days, how many times did you eat fresh fruit?**
- A. Very often (6 or 7 days)
 - B. Often (4 or 5 days)
 - C. Sometimes (2 or 3 days)
 - D. Rarely (1 day)
 - E. Never (0 days)
- 107. During the past 7 days, how often did you eat uncooked vegetables? (carrots, lettuce, cucumber, peppers)**
- A. Very often (6 or 7 days)
 - B. Often (4 or 5 days)
 - C. Sometimes (2 or 3 days)
 - D. Rarely (1 day)
 - E. Never (0 days)
- 108. During the past 7 days, how often did you eat vegetables that were tinned or cooked?**
- A. Very often (6 or 7 days)
 - B. Often (4 or 5 days)
 - C. Sometimes (2 or 3 days)
 - D. Rarely (1 day)
 - E. Never (0 days)
- 109. During the past 7 days, how often did you eat fast foods like makoonya, chips, fried chicken, pie, russian, fried fish, pizza or hamburger?**
- A. Very often (6 or 7 days)

- B. Often (4 or 5 days)
- C. Sometimes (2 or 3 days)
- D. Rarely (1 day)
- E. Never (0 days)

110. During the past 7 days, how often did you drink milk or eat mafi? (Include milk that you drank from a glass, cup or carton or with cereal/ porridge).

- A. Very often (6 or 7 days)
- B. Often (4 or 5 days)
- C. Sometimes (2 or 3 days)
- D. Rarely (1 day)
- E. Never (0 days)

111. During the past 7 days, how often did you drink a can, bottle or glass of soda, such as Coke, Fanta, Sprite, Coee? (Do not include diet soda).

- A. Very often (6 or 7 days)
- B. Often (4 or 5 days)
- C. Sometimes (2 or 3 days)
- D. Rarely (1 day)
- E. Never (0 days)

112. During the past 7 days, how often did you eat foods like potato chips, chocolate, sweets, popcorn, cake, muffins?

- A. Very often (6 or 7 days)
- B. Often (4 or 5 days)
- C. Sometimes (2 or 3 days)
- D. Rarely (1 day)
- E. Never (0 days)

This is the end of the questionnaire.

Thank you very much for your help.

APPENDIX THREE

Ethics Approval



Health Sciences Faculty
Research Ethics Committee
Room E52-24 Grootte Schuur Hospital Old Main Building
Observatory 7925
Telephone [021] 406 6338 • Facsimile [021] 406 6411
e-mail: sumayah.ariiefdien@uct.ac.za

17 February 2010

REC REF: 075/2010

Ms M Ramafikeng
c/o Prof L Amosun
Occupational Therapy

Dear Ms Ramafikeng

PROJECT TITLE: THE PREVALENCE OF HEALTH RISK BEHAVIOURS AMONG HIGH SCHOOL LEARNERS IN THE CITY OF MASERU, LESOTHO.

Thank you for submitting your study to the Research Ethics Committee for review

It is a pleasure to inform you that the Ethics Committee has **formally approved** the above-mentioned study

Approval is granted for one year till the 28th February 2011.

Please submit an annual progress report (FHS016) if the research continues beyond the expiry date. Alternatively please submit a study closure report (FHS 010) if the study is completed within one year so that we can close our file.

Please would you obtain research ethics approval from a local, Lesotho-based research ethics committee if one exists in the country.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the REC. REF in all your correspondence.

Yours sincerely


PROFESSOR M BLOCKMAN

CHAIRPERSON, HSF HUMAN ETHICS

Federal Wide Assurance Number: FWA00001637.

Institutional Review Board (IRB) number: IRB00001938

This serves to confirm that the University of Cape Town Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP) and Declaration of Helsinki guidelines.

The Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.

APPENDIX FOUR

Lesotho Youth Risk Behaviour Survey- 2010- Final version

Lesotho Youth Risk Behaviour Survey- 2010

This survey is about health behaviour. 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 promotion programmes 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 marks in this class. If you are not comfortable answering a question, just leave it.

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 and then circle the response that best describes what you do. When you are finished, follow the instructions of the person giving you the survey.

Thank you very much for your help.

DIRECTIONS

Use a #2 pencil that is provided only.

Circle the response that you choose.

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

Section A: Information about yourself
--

1. **How old are you?**

2. **Are you a girl (woman) or a boy (man)?**
 - A. Girl (woman)
 - B. Boy (man)

3. **In what Form are you?**
 - A. Form A
 - B. Form B
 - C. Form C
 - D. Form D
 - E. Form E

4. **Are you a Mosotho?**
 - A. No
 - B. Yes, by birth
 - C. Yes, by acquired citizenship

5. **What type of dwelling do you live in?**
 - A. A brick house
 - B. Rented apartment/ flat (Malaene)
 - C. A hut
 - D. A shack
 - E. Other

6. Where do you sleep?

- A. I sleep in the same house with my parents/guardians
- B. I sleep in another house on our property
- C. I sleep next door
- D. I sleep in the dormitory or hostel

7. List all the people who live in your household (You can choose more than one option)

- A. Mother
- B. Father
- C. Sister
- D. Brother
- E. Uncle
- F. Aunt
- G. Grandfather
- H. Grandmother
- I. Other relative
- J. Domestic worker
- K. Other learners

8. How do you mainly get to school?

- A. I walk
- B. I take public transport (a bus, minibus taxi or 4+1)
- C. I go by car
- D. I use a bicycle

9. During the past 6 months how do you describe your marks?

- A. Mostly A's (80% or more)
- B. Mostly B's (70% - 79%)
- C. Mostly C's (60% - 69%)
- D. Mostly D's (50% - 59%)
- E. Mostly E's (40% - 49%)
- F. Mostly F's (39% or less)

G. I don't know

10. In a month how much pocket money do you get?

- A. I don't get any pocket money
- B. Less than RM5.00
- C. From M5.00 to M10.00
- D. From M11.00 to M20.00
- E. From M21.00 to M30.00
- F. From M31.00 to M40.00
- G. From M41.00 to M50.00
- H. More than M50.00

11. Does your father have a paid job? (Paid job includes self-employed having a shop, a taxi, rented apartments, street vending)

- A. Yes, he works 5 or more days a week
- B. Yes, he works less than 5 days a week
- C. No, he gets money from Social Welfare
- D. No, he is unemployed
- E. No, he is ill or disabled
- F. No, he is on pension
- G. I don't have a father (or male guardian)/ my father passed away
- H. I don't know

12. Does your mother have a paid job? (paid job includes self-employed e.g. having a shop, a taxi, rented apartments, street vending, sewing, catering)

- A. Yes, she works 5 or more days a week
- B. Yes, she works less than 5 days a week
- C. No, she gets money from Social Welfare
- D. No, she is unemployed
- E. No, she is ill or disabled
- F. No, she is on pension
- G. I don't have a mother (or female guardian)/ my mother passed away

H. I don't know

13. Do you consider yourself disabled (bokooa) in any way (mentally or physically)?
- A. Yes
 - B. No

Section B: The following questions ask about your safety

14. How often do you use a seat belt when you are in a vehicle (e.g. car, van, taxi, or truck) driven by someone else?
- A. Never (0 times)
 - B. Rarely (1 time)
 - C. Sometimes (2 or 3 times)
 - D. Often (4 or 5 times)
 - E. Very often (6 or more times)
 - F. I have never been in a vehicle (car, van, taxi or truck) that has seat belts
15. During the past month (30 days), how often were you in a vehicle (car, bus, van, taxi or truck) driven by someone who had been drinking alcohol?
- A. Never (0 times)
 - B. Rarely (1 time)
 - C. Sometimes (2 or 3 times)
 - D. Often (4 or 5 times)
 - E. Very often (6 or more times)
 - F. I have never been in a vehicle (car, van, taxi or truck)
 - G. I don't know if the person had been drinking

16. **During the past month (30 days), how often were you in a vehicle (car, bus, van, taxi or truck) driven by someone who was smoking cigarettes?**
- A. Never (0 times)
 - B. Rarely (1 time)
 - C. Sometimes (2 or 3 times)
 - D. Often (4 or 5 times)
 - E. Very often (6 or more times)
 - F. I have never been in a vehicle (car, van, taxi or truck)
17. **How often do you use a seat belt when you yourself drive a vehicle (e.g. car, van, taxi, or truck)?**
- A. Never (0 times)
 - B. Rarely (1 time)
 - C. Sometimes (2 or 3 times)
 - D. Often (4 or 5 times)
 - E. Very often (6 or more times)
 - F. I do not drive a vehicle (car, van, taxi or truck)
18. **During the past month (30 days), how often did you drive a vehicle (car, taxi, bus or truck) when you yourself had been drinking alcohol?**
- A. Never (0 times)
 - B. Rarely (1 time)
 - C. Sometimes (2 or 3 times)
 - D. Often (4 or 5 times)
 - E. Very often (6 or more times)
 - F. I have never driven a vehicle (car, van, taxi or truck) when I had been drinking alcohol
 - G. I do not drive a vehicle (car, van, taxi or truck)
19. **During the past month (30 days), how often did you walk alongside a road when you had been drinking alcohol?**
- A. I have never walked alongside a road after I had been drinking alcohol

- B. Rarely (1 time)
- C. Sometimes (2 or 3 times)
- D. Often (4 or 5 times)
- E. Very often (6 or more times)
- F. I don't drink alcohol

20. During the past month (30 days), how often did you walk alongside a road after you had been smoking dagga (matekoane)?

- A. I have never walked alongside a road after I had been smoking dagga (matekoane)
- B. Rarely (1 time)
- C. Sometimes (2 or 3 times)
- D. Often (4 or 5 times)
- E. Very often (6 or more times)
- F. I don't smoke dagga (matekoane)

21. During the past month (30 days), how often did you walk alongside a road after you had taken other drugs?

- A. I have never walked alongside a road after I had taken other drugs
- B. Rarely (1 time)
- C. Sometimes (2 or 3 times)
- D. Often (4 or 5 times)
- E. Very often (6 or more times)
- F. I don't take other drugs

22. During your life, how often have you gambled (ho becha ka chelete)?

- A. Never (0 times)
- B. Rarely (1 time)
- C. Sometimes (2 or 3 times)
- D. Often (4 or 5 times)
- E. Very often (6 or more times)

23. When you rode a bicycle during the past 6 months, how often did you wear a helmet?

- A. I did not ride a bicycle during the past 6 months
- B. I never wore a helmet
- C. I rarely wore a helmet
- D. I sometimes wore a helmet
- E. Most of the time I wore a helmet
- F. I always wore a helmet

<p>Section C: The following section asks about violence-related behaviours.</p>
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24. During the past month (30 days), on how many days did you carry a weapon such as a gun, knife, screwdriver or club (molamu)?

- A. Never (0 days)
- B. Rarely (1 day)
- C. Sometimes (2 or 3 days)
- D. Often (4 or 5 days)
- E. Very often (6 or more days)

25. During the past month (30 days), on how many days did you carry a gun?

- A. Never (0 days)
- B. Rarely (1 day)
- C. Sometimes (2 or 3 days)
- D. Often (4 or 5 days)
- E. Very often (6 or more days)

26. During the past month (30 days), on how many days did you carry a weapon such as a gun, knife, screwdriver or club (molamu) while at school?

- A. Never (0 days)
- B. Rarely (1 day)

- C. Sometimes (2 or 3 days)
- D. Often (4 or 5 days)
- F. Very often (6 or more days)

- 27. During the past month (30 days), how many times have you used a mathematical compass or divider as a weapon at school?**
- A. Never (0 times)
 - B. Rarely (1 time)
 - C. Sometimes (2 or 3 times)
 - D. Often (4 or 5 times)
 - E. Very often (6 or more times)
- 28. During the past month (30 days), on how many days did you not go to school (miss school) because you felt you would be unsafe at school?**
- A. 0 days
 - B. 1 day
 - C. 2 or 3 days
 - D. 4 or 5 days
 - E. 6 or more days
- 29. During the past month (30 days), on how many days did you not go to (miss) school because you felt you would be unsafe 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
- 30. During the past 6 months, how many times has someone threatened or injured you with a weapon such as a gun, knife, screwdriver, mathematical compass, divider or club (molamu) at school?**
- A. Never (0 times)

- B. Rarely (1 time)
- C. Sometimes (2 or 3 times)
- D. Often (4 or 5 times)
- E. Very often (6 or more times)

31. During the past 6 months, how many times have you threatened or injured someone with a weapon such as a gun, knife, screwdriver, mathematical compass, divider or club (molamu) at school?

- A. Never (0 times)
- B. Rarely (1 time)
- C. Sometimes (2 or 3 times)
- D. Often (4 or 5 times)
- E. Very often (6 or more times)

32. During the past month (30 days), what was the one way in which you were bullied most? (Choose one answer)

- A. I was never bullied
- B. I was called names, was made fun of, or teased in a hurtful way
- C. I was hit, kicked, pushed, shoved around or locked indoors
- D. Others told lies or spread false rumours about me and tried to make people dislike me
- E. I was made fun of because I am a foreigner
- F. I was made fun of because I am disabled or an albino
- G. I was made fun of because my family is poor
- H. Others made sexual jokes, comments or signs to me
- I. I was bullied because of my weight (underweight or overweight)
- J. I was bullied in some other way

33. During the past 6 months, have you been bullied at school?

- A. Yes
- B. No

34. During the past 6 months, how often were you in a physical fight (e.g. hitting, punching, biting)?

- A. Never (0 times)
- B. Rarely (1 time)
- C. Sometimes (2 or 3 times)
- D. Often (4 or 5 times)
- E. Very often (6 or more times)

35. During the past 6 months, how often were you in a physical fight (e.g. hitting, punching, biting) in which you were injured and had to be treated by a doctor or nurse?

- A. Never (0 times)
- B. Rarely (1 time)
- C. Sometimes (2 or 3 times)
- D. Often (4 or 5 times)
- E. Very often (6 or more times)

36. During the past 6 months, how often were you in a physical fight (e.g. hitting, punching, biting) at school?

- A. Never (0 times)
- B. Rarely (1 time)
- F. Sometimes (2 or 3 times)
- G. Often (4 or 5 times)
- H. Very often (6 or more times)

37. During the past 6 months, how often have you watched a physical fight (e.g. hitting, punching, biting) at school?

- A. Never (0 times)
- B. Rarely (1 time)
- C. Sometimes (2 or 3 times)

- D. Often (4 or 5 times)
- E. Very often (6 or more times)

38. During the past 6 months, did your boyfriend or girlfriend ever hit, slap, or physically hurt you on purpose?

- A. Yes
- B. No
- C. I do not have a boyfriend or girlfriend

39. During the past 6 months, did you ever hit, slap, or physically hurt your boyfriend or girlfriend on purpose?

- A. Yes
- B. No
- C. I do not have a boyfriend or girlfriend

40. Have you ever been physically forced to have sexual intercourse (when the penis enters the vagina or anus) when you did not want to?

- A. Yes
- B. No

41. Have you ever physically forced someone to have sexual intercourse (when the penis enters the vagina or anus) when he/she did not want to?

- A. Yes
- B. No

Section D: The following questions are about sad feelings and attempts at 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.

- 42. During the past 6 months, have you ever felt so sad or hopeless that you stopped doing some usual activities for two weeks or more in a row?**
- A. Yes
 - B. No
 - C. I don't know
- 43. During the past 6 months, have you ever felt so sad or hopeless that you needed to seek treatment from a doctor, counsellor or clinic?**
- A. Yes
 - B. No
- 44. During the past 6 months, did you ever seriously consider attempting suicide (that is take some action to end your life)?**
- A. Yes
 - B. No
- 45. During the past 6 months, how many times did you actually attempt suicide (that is take action to end your life)?**
- A. 0 times
 - B. 1 time
 - C. 2 or 3 times
 - D. 4 or 5 times
 - E. 6 or more times
- 46. During the past 6 months, did you make a plan about how you would attempt suicide (that is take action to end your life)?**
- A. Yes
 - B. No
 - C. I have never thought about killing myself

47. If you attempted suicide during the past 6 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 6 months
- B. Yes
- D. No

Section E: The following questions are about tobacco use

48. How old were you when you first smoked rolled tobacco (BB) or a cigarette?

- A. I have never smoked rolled tobacco or 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

49. During the past month (30 days), on how many days did you smoke cigarettes or rolled tobacco (BB)?

- 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

50. During the past month (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

51. During the past month (30 days), how did you usually get your own cigarettes? (Choose only one answer.)

- A. I did not smoke cigarettes during the past 30 days
- B. I bought them in a store, supermarket, spaza, petrol station or from a street vendor
- C. I asked someone who smokes
- D. I gave someone else money to buy them for me
- E. I borrowed 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

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

- 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

- 53. During the past year, have you ever tried to stop smoking?**
- A. I have never smoked
 - B. I did not smoke during the past 12 months
 - C. Yes, I tried to stop smoking
 - D. No, I did not try to stop smoking
- 54. During the past month (30 days), on how many days did you use snuff?**
- 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
- 55. During the past 30 days, on how many days did you use snuff at school?**
- 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
- 56. During the past week (7days), how many days have people smoked in your presence?**
- A. 0 days
 - B. 1 to 2 days
 - C. 3 to 4 days
 - D. 5 to 6 days
 - E. 7 days

57. Do your parents/ guardians smoke?

- A. Both my parents/ guardians do not smoke
- B. Both my parents/ guardians smoke
- C. Only my father/ male guardian smokes
- D. Only my mother/ female guardian smokes
- E. I don't know

Section F: The following questions are about drinking alcohol. This includes drinking beer, wine, home brew, cider and spirits such as brandy, gin, vodka, or whiskey. For these questions, drinking alcohol does not include drinking a few sips of home brew for cultural purposes or wine for religious purposes.

58. During your life, how often have you had at least one drink of alcohol (a beer, a cider, a tot of brandy or home brewed alcohol like hopose)?

- A. Never (0 days)
- B. Rarely (1 or 2 days)
- C. Sometimes (3 to 9 days)
- D. Often (10 to 19 days)
- E. Very often (20 or more days)

59. How old were you when you had your first drink of alcohol (a beer, a cider, a tot of brandy or home brewed alcohol like hopose) other than a few sips?

- A. I have never had a drink of alcohol
- B. 8 years old or younger
- C. 9 - 10 years old
- D. 11- 12 years old
- E. 13 - 14 years old
- F. 15 - 16 years old
- G. 15 - 17 years old
- H. 18 years old or older

- 60. During the past month (30 days), how often did you have at least one drink of alcohol (a beer, a cider, a tot of brandy or home brewed alcohol like hopose)?**
- A. Never (0 days)
 - B. Rarely (1 or 5 days)
 - C. Sometimes (6 to 9 days)
 - D. Often (10 to 19 days)
 - E. Very often (20 to 30 days)
- 61. During the past month (30 days), how often did you have 5 or more drinks of alcohol (a beer, a cider, a tot of brandy or home brewed alcohol like hopose) in a row, that is, within a couple of hours?**
- A. Never (0 days)
 - B. Rarely (1 or 5 days)
 - C. Sometimes (6 to 9 days)
 - D. Often (10 to 19 days)
 - E. Very often (20 to 30 days)
- 62. During the past month (30 days), how many days did you have at least one drink of alcohol (a beer, a cider, a tot of brandy or home brewed alcohol like hopose) at school during school time?**
- A. Never (0 days)
 - B. Rarely (1 or 5 days)
 - C. Sometimes (6 to 9 days)
 - D. Often (10 to 19 days)
 - E. Very often (20 to 30 days)
- 63. During the past 6 months, how often did you attend school (sit in the classroom) after drinking alcohol?**
- A. I have never attended school after drinking alcohol
 - B. Rarely (1 time)
 - C. Sometimes (2 or 3 times)
 - D. Often (4 or 5 times)

- E. Very often (6 or more times)
- F. I don't drink alcohol

Section G: The following questions are about matekoane use. Matekoane is also called marijuana, zolo, dagga, ganja or hashish

- 64. During your life, how many times have you used matekoane/ marijuana?**
- A. Never (0 times)
 - B. Rarely (1 or 2 times)
 - C. Sometimes (3 or 9times)
 - D. Often (10 or 19 times)
 - E. Very often (20 or more times)
- 65. How old were you when you tried matekoane/ marijuana for the first time?**
- A. I have never tried matekoane
 - 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
- 66. During the past month (30 days), how often did you use matekoane/marijuana?**
- A. Never (0 days)
 - B. Rarely (1 or 5 days)
 - C. Sometimes (6 to 9 days)
 - D. Often (10 to 19 days)
 - E. Very often (20 to 30 days)

67. **During the past month (30 days), how often did you use matekoane/marijuana at school during school time?**
- A. Never (0 days)
 - B. Rarely (1 or 5 days)
 - C. Sometimes (6 to 9 days)
 - D. Often (10 to 19 days)
 - E. Very often (20 to 30 days)
68. **During the past 6 months, how often did school (sit in the classroom) after smoking matekoane/marijuana?**
- A. I have never attended school after smoking matekoane
 - B. Rarely (1 time)
 - C. Sometimes (2 or 3 times)
 - D. Often (4 or 5 times)
 - E. Very often (6 or more times)
 - F. I don't smoke matekoane

Section H: The following questions are about other drug use.

69. **During your life, how often have you sniffed glue, benzene or inhaled petrol, paint or paint thinners to get high?**
- A. Never (0 times)
 - B. Rarely (1 or 2 times)
 - C. Sometimes (3 or 9times)
 - E. Often (10 or 19 times)
 - F. Very often (20 or more times)
 - G. I don't know this drug
70. **During your life, how often have you used cocaine including powder, crack or rocks?**
- A. Never (0 times)
 - B. Rarely (1 or 2 times)

- C. Sometimes (3 or 9times)
- D. Often (10 or 19 times)
- E. Very often (20 or more times)
- F. I don't know this drug

71. During your life, how often have you used mandrax?

- A. Never (0 times)
- B. Rarely (1 or 2 times)
- C. Sometimes (3 or 9times)
- D. Often (10 or 19 times)
- E. Very often (20 or more times)
- F. I don't know this drug

72. During your life, how often have you used heroin?

- A. Never (0 times)
- B. Rarely (1 or 2 times)
- C. Sometimes (3 or 9times)
- D. Often (10 or 19 times)
- E. Very often (20 or more times)
- F. I don't know this drug

73. During your life, how often have you used tik?

- A. Never (0 times)
- B. Rarely (1 or 2 times)
- C. Sometimes (3 or 9times)
- D. Often (10 or 19 times)
- E. Very often (20 or more times)
- F. I don't know this drug

74. During your life, how often have you used a needle to inject any illegal drug into your body?

- A. Never (0 times)
- B. Rarely (1 or 2 times)

- C. Sometimes (3 or 9times)
- D. Often (10 or 19 times)
- E. Very often (20 or more times)

75. During your life, how have you used any other illegal drug not mentioned above, like ecstasy, LSD, magic mushrooms or speed?

- A. Never (0 times)
- B. Rarely (1 or 2 times)
- C. Sometimes (3 or 9times)
- D. Often (10 or 19 times)
- E. Very often (20 or more times)
- F. I don't know these drugs

76. During the past 6 months, has anyone offered, sold, or given you an illegal drug at school?

- A. Never (0 times)
- B. Rarely (1 or 2 times)
- C. Sometimes (3 or 9times)
- D. Often (10 or 19 times)
- E. Very often (20 or more times)

77. During your life how often have you used over-the-counter or prescription drugs (such as cough mixture, pain killers and diet pills) to get high?

- A. Never (0 times)
- B. Rarely (1 or 2 times)
- C. Sometimes (3 or 9times)
- D. Often (10 or 19 times)
- E. Very often (20 or more times)
- F. I don't know these drugs

- 78. During your life, where did you get the money to buy drugs?**
- A. I used my pocket money
 - B. I asked my parents/guardians for money and pretended it was for something else
 - C. I used my own money that I worked for
 - D. I stole money from my family members
 - E. I stole items from my house and sold them
 - F. I did not buy drugs

Section I: The following questions are about your sexual behaviour.

- 79. Have you ever had sexual intercourse (when the penis enters the vagina or the anus)?**
- A. Yes
 - B. No
- 80. How old were you when you had sexual intercourse (when the penis enters the vagina or the anus) 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
- 81. During your life, how many people have you had sex (when the penis enters the vagina or the anus) with?**
- A. I have never had sexual intercourse
 - B. 1 person
 - C. 2 people

- D. 3 people
- E. 4 people
- F. 5 or more people

82. During the past 3 months, how many people have you had sex (when the penis enters the vagina or the anus) with?

- A. I have never had sex
- B. I have had sex, but not in the last 3 months
- C. 1 person
- D. 2 people
- E. 3 people
- F. 4 people
- G. 5 or more people

83. The last time you had sex (when the penis enters the vagina or the anus), did you drink alcohol or use drugs before you had sex?

- A. I have never had sex
- B. Yes
- C. No
- D. I don't remember

84. When you have sex (when the penis enters the vagina or the anus), how often do you or your partner use a condom?

- A. I have never had sexual intercourse
- B. We never use a condom
- C. We rarely use a condom
- D. We sometimes use a condom
- E. We use a condom most of the time
- F. We always use a condom

- 85. When you have sex (when the penis enters the vagina or the anus), what one method did you or your partner mostly use to prevent pregnancy? (Select only one answer.)**
- A. I have never had sex
 - B. No method was used to prevent pregnancy
 - C. Birth control pills
 - D. Condoms
 - E. Injection (e.g. Depo-Provera)
 - F. Withdrawal (penis removed from vagina before ejaculation)
 - G. Morning after pill
 - H. Some other method
- 86. If you are a girl, have you ever been pregnant, if you are a boy have you ever made someone pregnant?**
- A. Yes
 - B. No
 - C. I don't know if my partner was pregnant
- 87. Do you have child/ children of your own?**
- A. Yes
 - B. No
- 88. Have you or your partner had an abortion?**
- A. Yes
 - B. No
 - C. I don't know if my partner had an abortion
 - D. I/my partner has never been pregnant
 - E. I have never had sex
- 89. If you or your partner had an abortion, where did the abortion take place?**
- A. In a hospital, clinic or private doctors' rooms
 - B. At a traditional healer/ doctor's place

- C. In another place
- D. I don't know where the abortion took place
- E. I don't know if my partner had an abortion
- F. I/my partner has never been pregnant
- G. I have never had sex

90. Have you ever had a sexually transmitted infection (STI) such as drop, discharge or seso?

- A. I have never had sex
- B. I do not know what an STI is
- C. No, I have never had a sexually transmitted infection (STI)
- D. Yes, I have had a sexually transmitted infection (STI)
- E. I don't know

91. If you had a sexually transmitted infection (STI) did you get treatment?

- A. I have never had sex
- B. No, I have never had a sexually transmitted infection (STI)
- C. Yes, I had treatment for a sexually transmitted infection (STI)
- D. No, I did not have treatment for a sexually transmitted infection (STI)

92. Do you think that you could get the HIV infection in your lifetime?

- A. Yes
- B. No
- C. I don't know

93. Do you think you are able to protect yourself from getting the HIV infection?

- A. Yes
- B. No
- C. I don't know

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

A. Yes

B. No

95. **Have you ever had an HIV / AIDS test?**

A. Yes

B. No

Section J: The following questions are about your body weight.

96. **How do you describe your weight?**

A. Very underweight (very thin)

B. Slightly underweight (thin)

C. About the right weight

D. Slightly overweight (fat)

E. Very overweight (very fat)

97. **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

98. **During the past month (30 days), which one of the following did you do the most to lose weight or to keep from gaining weight? (Choose one answer)**

A. Exercise

B. Eat less food, fewer calories or low fat foods

C. Go without eating for 24 hours or more

D. Take diet pills, powders or liquids without a doctor's advice

E. Vomit

- F. Take laxatives
- G. None of the above
- H. All of the above

Section K: The following questions ask about physical activity

- 99. In the past 7 days, on how often did you exercise or participate in physical activity for at least 20 minutes, such as soccer, netball, volleyball, basketball, tennis or running?**
- A. I did not take part in physical activity last week (7 days)
 - B. 1 day
 - C. 2 days
 - D. 3 days
 - E. 4 days
 - F. 5 days
 - G. 6 days
 - H. Everyday
- 100. In the past week (7 days) what was the main reason for you not taking part in physical activity (Choose one response)?**
- A. I took part in physical activity last week (7 days)
 - B. I did not want to take part in physical activity last week (7 days)
 - C. I was ill
 - D. I felt unsafe, frightened or scared to go to the ground/ gym to take part in physical activity
 - E. I do not have the equipment, gear, ground or gym for physical activity
 - F. I don't know

101. In the past 7 days, on how often did you participate in physical activity for at least 30 minutes, such as fast walking, slow bicycle riding, sweeping, mopping or polishing the floor?

- A. I did not take part in physical activity last week (7 days)
- B. 1 day
- C. 2 days
- D. 3 days
- E. 4 days
- F. 5 days
- G. 6 days
- H. Everyday

102. On an average school day, how much time do you spend watching TV, playing video games or computer games?

- A. I do not watch TV, play video games or computer games
- 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
- H. I do not have access to a TV, video games or computer games

103. In an average week when you are in school, on how many days do you have sports or physical education (PE) on your school timetable?

- A. We do not have sports on our school timetable
- B. 1 day
- C. 2 days
- D. 3 days
- E. 4 days
- F. Everyday

Section L: The following questions ask about the food you ate or drank in the past 7 days. Think about all the meals and snacks you had from the time you woke up until you went to bed. Be sure to include food you ate at home, at school, at restaurants or anywhere else.

- 104. During the past 7 days, how many times did you eat fresh fruit?**
- A. Very often (6 or 7 days)
 - B. Often (4 or 5 days)
 - C. Sometimes (2 or 3 days)
 - D. Rarely (1 day)
 - E. Never (0 days)
- 105. During the past 7 days, how often did you eat uncooked vegetables? (carrots, lettuce, cucumber, peppers)**
- A. Very often (6 or 7 days)
 - B. Often (4 or 5 days)
 - C. Sometimes (2 or 3 days)
 - D. Rarely (1 day)
 - E. Never (0 days)
- 106. During the past 7 days, how often did you eat vegetables that were tinned or cooked?**
- A. Very often (6 or 7 days)
 - B. Often (4 or 5 days)
 - C. Sometimes (2 or 3 days)
 - D. Rarely (1 day)
 - E. Never (0 days)
- 107. During the past 7 days, how often did you eat fast foods like makoonya, chips, fried chicken, pie, russian, fried fish, pizza or hamburger?**
- A. Very often (6 or 7 days)

- B. Often (4 or 5 days)
- C. Sometimes (2 or 3 days)
- D. Rarely (1 day)
- E. Never (0 days)

108. During the past 7 days, how often did you drink milk or eat mafi? (Include milk that you drank from a glass, cup or carton or with cereal/ porridge).

- A. Very often (6 or 7 days)
- B. Often (4 or 5 days)
- C. Sometimes (2 or 3 days)
- D. Rarely (1 day)
- E. Never (0 days)

109. During the past 7 days, how often did you drink a can, bottle or glass of soda, such as Coke, Fanta, Sprite, Coee? (Do not include diet soda).

- A. Very often (6 or 7 days)
- B. Often (4 or 5 days)
- C. Sometimes (2 or 3 days)
- D. Rarely (1 day)
- E. Never (0 days)

110. During the past 7 days, how often did you eat foods like potato chips, chocolate, sweets, popcorn, cake, muffins?

- A. Very often (6 or 7 days)
- B. Often (4 or 5 days)
- C. Sometimes (2 or 3 days)
- D. Rarely (1 day)
- E. Never (0 days)

This is the end of the questionnaire.

Thank you very much for your help.

APPENDIX FIVE

Letters of approval from schools

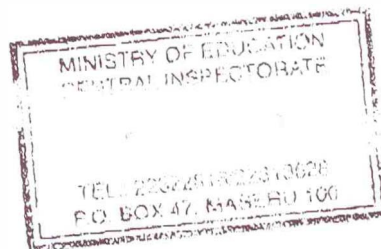
DATE: 02/March/ 2010
TO: The Principal
Thetsane High School
St.James High School
Khubetsoana High School
Methodist High School
Sefika High School
Itekeng High School
FROM: Chief Inspector – Central Inspectorate

Signed: 

RE: **INTRODUCTION OF A RESEARCHER**

This letter serves as an introduction of Ms Matomo Ramafikeng (RMEMAT001) who is studying for her Master's program in Occupational Therapy at University of Cape Town. Her intention is to undertake her research at your school focusing on learners mostly. Her introduction letter from her university is attached for your reference.

We hope that you will give her due assistance and support.



DATE: 02/March/ 2010

TO: The Principal
Thetsane High School
St.James High School

✓ Khubetsoana High School

Methodist High School

Sefika High School

Itekeng High School

FROM: Chief Inspector – Central Inspectorate

Signed: *M. M. M.*

RE: **INTRODUCTION OF A RESEARCHER**

This letter serves as an introduction of Ms 'Matumo Ramafikeng (RMFMAT001) who is studying for her Master's program in Occupational Therapy at University of Cape Town. Her intention is to undertake her research at your school focusing on learners mostly. Her introduction letter from her university is attached for your reference.

We hope that you will give her due assistance and support.



17/03/10



DATE: 02/March/ 2010

TO: The Principal

✓ Thetsane High School

St.James High School

Khubetsoana High School

Methodist High School

Sefika High School

Itekeng High School

FROM: Chief Inspector – Central Inspectorate

Signed: Matumo Ramafikeng

RE: **INTRODUCTION OF A RESEARCHER**

This letter serves as an introduction of Ms 'Matumo Ramafikeng (RMFMAT001) who is studying for her Master's program in Occupational Therapy at University of Cape Town. Her intention is to undertake her research at your school focusing on learners mostly. Her introduction letter from her university is attached for your reference.

We hope that you will give her due assistance and support.



Received: 02-03-2010.

Godi ampone C.

Principal). Contact Teacher:





**School of Health and Rehabilitation Sciences
Faculty of Health Sciences**

Division of Occupational Science and Therapy
School of Health and Rehabilitation Sciences, Faculty of Health Sciences

F45 Old Main Building, Groote Schuur Hospital,
Observatory 7925

Tel: +27 (0) 21 406 6401 Fax: +27 (0) 21 406 6323

Internet: www.uct.ac.za

25 Feb. 10

PS (Education)
Ministry of Education & Training
Maseru
Lesotho

RE: Ms Matumo Ramafikeng (RMFMAT001)

Ms Matumo Ramafikeng is registered for the Masters' program in Occupational Therapy. The completion of a research thesis is a requirement for the qualification.

The title of the research is "The prevalence of health risk behaviours among high school learners in the City of Maseru". She has obtained approval from the Ethics Committee of the University of Cape Town to carry out the study. The outcome of the study will inform the design of interventions and curriculum development that promote the health of the youth at schools.

As the supervisors of the thesis, we are writing to request that Ms Ramafikeng be given the necessary permission to access the schools for the purpose of the study.

Thank you for your assistance.

Regards

Prof SL Amosun (PhD)
Supervisor

Ms Roshan Galvaan
Supervisor

DATE: 02/March/ 2010

TO: The Principal
Thetsane High School
St.James High School
Khubetsoana High School
Methodist High School
✓ Sefika High School
Itekeng High School

FROM: Chief Inspector – Central Inspectorate

Signed: 

RE: **INTRODUCTION OF A RESEARCHER**

This letter serves as an introduction of Ms 'Matumo Ramafikeng (RMFMAT001) who is studying for her Master's program in Occupational Therapy at University of Cape Town. Her intention is to undertake her research at your school focusing on learners mostly. Her introduction letter from her university is attached for your reference.

We hope that you will give her due assistance and support.



Received & On 03-03-2010

Principal Mrs Mahula

Contact Person: 'MANTOA Dlamini'

DATE: 02/March/ 2010

TO: The Principal
Thetsane High School
St.James High School
Khubetsoana High School
Methodist High School
Sefika High School
✓ Itekeng High School

FROM: Chief Inspector – Central Inspectorate

Signed: _____

RE: **INTRODUCTION OF A RESEARCHER**

This letter serves as an introduction of Ms 'Matumo Ramafikeng (RMFMAT001) who is studying for her Master's program in Occupational Therapy at University of Cape Town. Her intention is to undertake her research at your school focusing on learners mostly. Her introduction letter from her university is attached for your reference.

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DATE: 02/March/ 2010

TO: The Principal
Thetsane High School
St.James High School
Khubetsoana High School
✓ Methodist High School
Sefika High School
Itekeng High School

FROM: Chief Inspector – Central Inspectorate

Signed: _____

RE: **INTRODUCTION OF A RESEARCHER**

This letter serves as an introduction of Ms 'Matumo Ramafikeng (RMFMAT001) who is studying for her Master's program in Occupational Therapy at University of Cape Town. Her intention is to undertake her research at your school focusing on learners mostly. Her introduction letter from her university is attached for your reference.

We hope that you will give her due assistance and support.



DATE: 02/March/ 2010

TO: The Principal

- Thetsane High School
- ✓ St.James High School
- Khubetsoana High School
- Methodist High School
- Sefika High School
- Itekeng High School

FROM: Chief Inspector – Central Inspectorate

Signed: *Mogae*

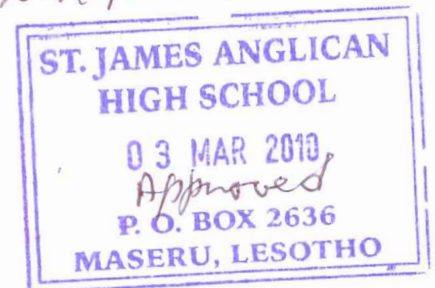
RE: **INTRODUCTION OF A RESEARCHER**

This letter serves as an introduction of Ms 'Matumo Ramafikeng (RMFMAT001) who is studying for her Master's program in Occupational Therapy at University of Cape Town. Her intention is to undertake her research at your school focusing on learners mostly. Her introduction letter from her university is attached for your reference.

We hope that you will give her due assistance and support.



*Received 03-03-2010
Mogae (Principal)*





**School of Health and Rehabilitation Sciences
Faculty of Health Sciences**

Overseas of Communication Sciences and Disorders,
Nursing and Midwifery, Occupational Therapy, Physiotherapy

F45 Old Main Building, Groote Schuur Hospital,
Observatory 7925
Tel: +27 (0) 21 406 6401 Fax: +27 (0) 21 406 6323

Internet: www.ucape.ac.za

25 Feb. 10

PS (Education)
Ministry of Education & Training
Maseru
Lesotho

RE: Ms Matumo Ramafikeng (RMFMAT001)

Ms Matumo Ramafikeng is registered for the Masters' program in Occupational Therapy. The completion of a research thesis is a requirement for the qualification.

The title of the research is "The prevalence of health risk behaviours among high school learners in the City of Maseru". She has obtained approval from the Ethics Committee of the University of Cape Town to carry out the study. The outcome of the study will inform the design of interventions and curriculum development that promote the health of the youth at schools.

As the supervisors of the thesis, we are writing to request that Ms Ramafikeng be given the necessary permission to access the schools for the purpose of the study.

Thank you for your assistance.

Regards

Prof SL Amosun (PhD)
Supervisor

Ms Roshan Galvaan
Supervisor

APPENDIX SIX
Parent Consent form

TUMELLO EA MOTSOALI

'Na _____ motsoali/moholisi oa _____ (lebitso la ngoana) ke fana ka tumello ea hore ngoana oaka a nke karolo boithutong boo morutuo oa University of Cape Town 'Matumo Ramafikeng a bo etsang.

Ke balile ka hloko tlhalosetso ea boithuto bona, 'me ke lumella ngoana oaka ho araba lipotso tseo atlang ho li botsoa malebana lintho tseo a li etsang. Ke fuoe monyetla oa ho botsa lipotso malebana le boithuto bona, 'me ke arabetsoe ka mokhoa o khotsofatsang. Ke tsebisitsoe hore sephetho sa boithuto bona se tla sireletsa boitsebiso ba ngoana oaka boo etla sala ele lekunutu ebe phatlalatso etla hlaha ka mokhoa oa lipalopalo feela.

Kea hlokomela hore boithuto bona ha bona kamano efe kapa efe le kholiso eaka ea ngoana oaka le hore kena le tokelo ea ho se fane ka tumello ea hore ngoana oaka a nke karolo boithutong bona, 'me hoo ke khetho eaka. Hape 'na le ngoana oaka rena le tokelo ea ho ikhula boithutong bona ka nako efe kapa efe.

T'soaea **E** (ka selikalikoe) ha o lumella ngoana ho nka karolo boithutong bona.

T'soaea **Che** (ka selikalikoe) ha o sa lumelle ngoana ho nka karolo boithutong bona. **(T'soaea ele 'ngoe feela).**

E

Che

Tekena lebitso la hao mona _____

Letsatsi la tekeno _____

APPENDIX SEVEN
Parent Information Sheet

TLHALOSETSO EA MOTSOALI KA BOITHUTO

Motsoali ea khabane

'Matumo Ramafikeng ke morutua oa sekolong sa thuto e phahameng University of Cape Town, ea etsang lengolo la Masters' ea Science in Occupational Therapy. O lakatsa ho etsa boithuto ka le bana ba likolo tse phahameng ka har'a motsemoholo oa Maseru. Boithuto bona bo chaelletsoe monoana ke Komiti e kholo ea lipatlisiso le boit'soaro ea lefapha la koetliso ea tsa bophelo ea University eo ea Cape Town (REC REF: 075/2010).

Sepheo sa boithuto bona ke ho batlisisa le ho tseba ka litloaelo le mait'soaro a bana ba likolo tse phahameng a ka behang maphelo a bona tsietsing. Sena se tla etsoa ka hore baithuti ba arabe lipotso ka mokhoa oa ho ngola. Likolo le lihlopha tsa bana li khethiloe ka mokhoa oa lotho. Litaba tse tla fumaneha boithutong bona litla sebelisoa molemong oa boithuto, ho ngola tlaleho ea boithuto bona, molemong oa thuto le liphatlalatso tse tsebahalang le molemong oa sechaba ka kakaretso. Baithuti ha baa lebelloa ho fana ka mabitso a bona ele ho sireletsa boitsebiso le seriti sa bona ha ho fanoa ka tlaleho kapa phatlalatso ea se fumanoeng boithutong bona.

Molemo oa ho nka karolo boithutong bona ke hore ngoana oa hao o tla fana ka taba tsa bohlokoa bo boholo tse ka sebelisoang ho ntlafatsa maemo a bophelo bo bottle ba batho ba banyenyane lilemong joaloka eena. Hape baithuti ba tla le monyetla oa ho fumant'soa tlhabollo ea maikutlo haeba ba bont'sa tlhoko e joalo. Empa ho etsa joalo ho tla ba bolokolohing le boikhethelong ba moithuti ka mong ha a bolela litlhoko tsa hae. Haeba litlhoko tsa moithuti li hloka tlhabollo e tebileng, ho ka etsoa litlhophiso tsa ho fetisetsa moithuti Lefapheng la Mafu a Kelello ka tumellano le ngoana ea joalo.

Bohlokoa bo bong ba ho nka karolo boithutong bona ke hore ngoana oa hao o tla Kenya letsoho hore moloko o tlang o ruoe tsebo ka mathata aka bakoang ke litloaelo le mait'soaro a bana ba likolo tse phahameng. Sephetho sa boithuto bona seka sebelisoa ke mafapha kapa batho ba etsang manane-thuto a bana ba likolo tse

phahameng ka har'a naha esita le lefat'seng ka kakaretso. Hona ho tla thusa le hore litlhoko tsa bana ba likolo tse pahahameng li fihleloe. Ha joale ha hona pale e lokolisang mait'soaro kapa litloaelo tse kabang kotsi maphelong a bana ba likolo tse phahameng ka har'a naha ea Lesotho leha linaha tse ngata tsa lefat'se lise li hatetse pele haholo ntlheng. Ka hona ngoana oa hao o tla fana ka pale e tla thusa ho etsa likhakanyetso tsa ho pharalla ha mathata a bophelo a bakoang ke litloaelo kapa mait'soaro a bana ba likolo tse phahameng.

Ho tla etsoa litlhophiso le likolo tse tla nka karolo boithutong bona ho tla fana ka sephetho sa boithuto bona ka mokhoa oa lipalopalo eseng mabitso kapa boitsebiso ba baithuti. Nakong ea phano ea tlaleho, ho tla fanoa ka monyetla oa ho buisana ha holoanyane ka kotsi ea mathata a bakoang ke boit'soaro maphelong a baithuti. Baithuti ba bont'sang thahasello ea ho khaohana le litloaelo tse ka bang kotsi maphelong a bona kapa ba lakatsang ho tlaleha liketso tsa tlhekefetso, batla fumant'soa monyetla oa ho tlalehela ea etsang boithuto, 'me litlhophiso tse lokelang li tla etsoa le mafapha a amehang a 'Musu.

Mathata a ka bakoang ke ho nka karolo boithutong bona ke hore ngoana aka qala ho elelloa hore litloaelo kapa boit'soaro ba hae bo kaba kotsi bophelong ba hae.

Hose ho entsoe litlhophiso le likolo hore boithuto bona bo se kena kenana le nako ea ho rutoa ha ngoana oa hao. Ho nka karolo boithutong bona ke ka boithaopo, 'me uena le ngoana oa hao le ka nka qeto ea ho se nke karolo boithutong bona kapa ho ikhula ka nako efe kapa efe har'a boithuto bona. Hona ha hona ho ama likamano tsa ngoana oa hao le matichere a hae kaha boithuto bona ha bona ho kenyeletsa matichere.

Bakeng sa litlhakisetso oka ikopanya le batho ba latelang:

'Matumo Ramafikeng- nomorong ea fax ea 22315587

Mrs. Roshan Galvaan

Occupational Therapy Department

School of Health and Rehabilitation Sciences
University of Cape Town
Nomorong ea 0027(21) 406 6042

Professor S.L Amosun
Physiotherapy Department
School of Health and Rehabilitation Sciences
University of Cape Town
Nomorong ea 0027(21) 406 6444

Professor Marc Blockman
Chair: Research Ethics Committee
UCT Faculty of Health Sciences
Nomorong ea 0027(21) 406 6492

Ka boikokobetso

'Matumo Ramafikeng

APPENDIX EIGHT

Learner Assent Form

TUMELLO EA MOITHUTI

'Na _____ (lebitso la hao) ke amohela ho nka karolo boithutong boo morutuo oa University of Cape Town 'Matumo Ramafikeng a bo etsang.

Ke balile ka hloko tshalosetso ea boithuto bona, 'me ke amohela hore ke tla araba lipotso tse malebana le lintho tseo ke li etsang. Ke utloisisa hore ke tla fua monyetla oa ho botsa lipotso malebana le boithuto bona, 'me li tla arabeloa ka mokhoa o khotsofatsang. Ke tsebisitsoe hore sephetho sa boithuto bona se tla sireletsa boitsebiso baka boo etla sala ele lekunutu ebe phatlalatso etla hlaha ka mokhoa oa lipalopalo feela.

Ke hlokometse hore nka hana ho araba tse ling tsa lipotso, hape kena le bolokolohi ba ho tlohela ho kenela boithuto bona ka nako efe kapa efe.

T'soaea **E** (ka selikalikoe) ha o lumela ho nka karolo boithutong bona.

T'soaea **Che** (ka selikalikoe) ha o hana ho nka karolo boithutong bona. (**T'soaea ele 'ngoe feela**).

E

Che

Tekena lebitso la hao mona _____

Letsatsi la tekano _____

APPENDIX NINE
Learner Information Sheet

TLHALOSETSO EA MOITHUTI KA BOITHUTO

Moithuti ea ratehang

'Matumo Ramafikeng ke morutua oa sekolong sa thuto e phahameng University of Cape Town, ea etsang lengolo la Masters' ea Science in Occupational Therapy. U lakatsa ho etsa boithuto le bana ba likolo tse phahameng ka har'a motsemoholo oa Maseru. Boithuto bona bo chaelletsoe monoana ke Komiti e kholo ea lipatlisiso le boit'soaro ea lefapha la koetliso ea tsa bophelo ea University eo ea Cape Town (REC REF: 075/2010).

Sepheo sa boithuto bona ke ho batlisisa le ho tseba ka lintho tseo u li etsang letsatsi le letsatsi tse ka amang bophelo ba hao ole moithuti. Sena se tla etsoa ka hore u arabe lipotso ka mokhoa oa ho ngola. Sekolo le sehlopha sa hao li khethiloe ka mokhoa oa lotho. Litaba tseo o tla fana ka tsona boithutong bona litla sebelisoa molemong oa boithuto, ho ngola tlaleho ea boithuto bona, molemong oa thuto le liphatlalatso tse tsebahalang le molemong oa sechaba ka kakaretso. Lebitso la hao ha lena ho hlahisoa ele ho sireletsa boitsebiso le seriti sa hao ha ho fanoa ka tlaleho kapa phatlalatso ea sephetho boithutong bona.

Haeba u sa utloisise ho hong ka lipotso tse botsoang, oka botsa motsamaisi oa liphuputso ho ofa tlhakisetsa. Ha hoka etsahala hore hobe le lipotso tse ka o phahamisang maikutlo, oka atamela motsamaisi oa liphuputso 'me oa buisana le eena. Haeba bothata ba hao bo tebile, oka fetisetsoa t'sebeletsong ea Lefapha la Mafu a Kelello ka tumello ea hao.

Molemo oa ho nka karolo boithutong bona ke hore u tla fana ka taba tsa bohlokoa bo boholo tse ka sebelisoang ho ntlafatsa maemo a bophelo bo botle ba batho ba

bacha joaloka uena. Hape u tlabana le monyetla oa ho fumant'soa tlhabollo ea maikutlo haeba bont'sa thahasello e joalo. Empa ho etsa joalo ho tla ba bolokolohing le boikhethelong ba hao ha u bolela litlhoko tsa hao.

Bohlokoa bo bong ba ho nka karolo boithutong bona ke hore u tla kenya letsoho hore moloko o tlang o ruoe tsebo ka mathata aka bakoang ke litloaelo le mait'soaro a bana ba likolo tse phahameng. Sephetho sa boithuto bona seka sebelisoa ke mafapha kapa batho ba etsang manane-thuto a bana ba likolo tse phahameng ka har'a naha esita le lefat'seng ka kakaretso. Hona ho tla thusa le hore litlhoko tsa bana ba likolo tse phahameng li fihleloe. Ha joale ha hona pale e lokolisang mait'soaro kapa litloaelo tse kabang kotsi maphelong a bana ba likolo tse phahameng ka har'a naha ea Lesotho leha linaha tse ngata tsa lefat'se lise li hatetse pele haholo ntlheng eno. Ka hona u tla fana ka pale e tla thusa ho etsa likhakanyetso tsa ho pharalla ha mathata a bophelo a bakoang ke lintho tseo bana ba likolo tse phahameng ba li etsang letsatsi le letsatsi.

Ho tla etsoa litlhophiso le sekolo sa hao hore ho tle ho fanoa ka sephetho sa boithuto bona ka mokhoa oa lipalopalo eseng mabitso kapa boitsebiso ba baithuti. Nakong ea phano ea tlaleho, ho tla fanoa ka monyetla oa ho buisana haholoanyane ka kotsi ea mathata a bakoang ke boit'soaro maphelong a baithuti. Haeba o bont'sa thahasello ea ho khaohana le litloaelo tse ka bang kotsi bophelong ba hao kapa oa lakatsa ho tlaleha liketso tsa tlhekefetso, u tla fumant'soa monyetla oa ho buisana le motsamaisi oa boithuto, 'me litlhophiso tse lokelang li tla etsoa le mafapha a amehang a 'Musu. Ka thoko ho moo, u tla fumana monyetla oa ho itlhatlhoba ka kotloloho malebana le mait'soaro le litloaelo tsa hao ha u nka karolo boithutong bona.

Mathata a ka bakoang ke ho nka karolo boithutong bona ke hore u ka qala ho elelloa hore lintho tseo o tloaetseng ho li etsa li kaba kotsi bophelong ba hao. Ho ka

etsahala hore u iphumane o nahanisa ka thata lintho tseo o li etsang, hoo u ka amehang maikutlong.

Hose ho entsoe lithophiso le sekolo sa hao hore boithuto bona bo se kena kenana le nako ea ho rutoa ha hao. Ho nka karolo boithutong bona ke ka boithaopo, 'me u na le tokelo ea ho se nke karolo boithutong bona kapa ho ikhula ka nako efe kapa efe har'a boithuto bona. Hona ha hona ho ama likamano tsa hao le matichere a hao.

Bakeng sa litlhakisetso oka ikopanya le batho ba latelang:

'Matumo Ramafikeng- nomorong ea fax ea 22315587

Mrs. Roshan Galvaan

Occupational Therapy Department

School of Health and Rehabilitation Sciences

University of Cape Town

Nomorong ea 0027(21) 406 6042

Professor S.L Amosun

Physiotherapy Department

School of Health and Rehabilitation Sciences

University of Cape Town

Nomorong ea 0027(21) 406 6444

Professor Marc Blockman

Chair: Research Ethics Committee

UCT Faculty of Health Sciences

Nomorong ea 0027(21) 406 6492

Ka boikokobetso

'Matumo Ramafikeng

APPENDIX TEN

Selected behaviours for concurrent risk behaviour analysis

List of risk behaviours

1. Did not use seat belt when driven
2. Did not use seat belt when driving
3. Drove drunk
4. Walked alongside road drunk
5. Walked alongside road after dagga use
6. Gambled
7. Carried weapon
8. Carried a gun
9. Used compass as weapon
10. Threatened others
11. Was involved in fight
12. Slapped partner
13. Forced partner into sex
14. Attempted suicide
15. Days smoked
16. Cigarettes smoked per day
17. Used snuff
18. Drunk alcohol
19. Drank one in last month
20. Drank five drinks in a row in last month
21. Used dagga
22. Smoked dagga in last month
23. Used inhalants
24. Used prescription drugs to get high
25. Had sexual intercourse
26. Had more than one partner last 3 months
27. Was high last time had sex
28. Never used a condom
29. Did not use birth control measures
30. Had an abortion
31. Did nothing about weight

32. Used unhealthy weight control strategies
33. Did not do high intensity exercise last week
34. Did not do low intensity exercise last week
35. Spent 2 hours in sedentary behaviour