South African Journal of Education

Vol 23(1) 58 – 64

Risk behaviour of primary school learners in a disadvantaged community — a situation analysis

Maretha Visser
Department of Psychology, University of Pretoria, Pretoria, 0002 South Africa
mjvisser@postino.up.ac.za

The prevalence of substance use and high-risk sexual behaviour of 460 primary school learners, from four schools in a historically disadvantaged urban area, was investigated. It was found that 14% of the primary school learners in this study currently used alcohol, 4% smoked marihuana, 3% sniffed solvents, 9% used over-the-counter medicines and 2% used illegal drugs. Of the 24% of learners that reported being sexually experienced, only 40% protected themselves from HIV/AIDS and 35% used birth control measures. Furthermore, the learners indicated that they did not experience high levels of support from their families and friends and many of them were exposed to substance abuse in their homes. The majority of the learners were of the opinion that substance use and sexual activity were inappropriate behaviour for their age group. Recommendations are made for prevention strategies aimed at primary school learners.

Introduction

Risk behaviour of children and adolescents such as alcohol and drug abuse, unplanned pregnancies, unprotected sexual activities, interpersonal violence and delinquent behaviour are major concerns in South Africa today. Risk behaviour is usually studied in relation to adolescent development, because it is usually during this period of development that risk behaviour makes its debut (Irwin, 1993). Although risk-taking behaviour is considered part of adolescent development, contributing to independence and maturity (Plant & Plant, 1992), some adolescents engage in dangerous and health-compromising behaviour. Risk behaviour can be seen as behaviour that is either physically or emotionally dangerous or contribute to developmental problems for young people involved. In this study the focus is on substance use and risky sexual behaviour as risk behaviour that endanger the normal development of young people. The use of alcohol and drugs amongst young people can contribute to alcohol related injuries, academic, behavioural and relationships problems, as well as the development of a life style and long-term health problems (Ziervogel, Morojele, Van der Riet, Parry & Robertson, 1997/98). Unprotected sexual activity can contribute to a risk of teenage pregnancy and HIV contraction that can have a severe impact on the lives of young people involved (Ebersohn & Eloff, 2002).

Research results appear to support the hypothesis of interrelatedness between the different risk behaviours (Flisher, Ziervogel, Chalton, Leger & Robertson, 1996; Jessor, 1992; Jessor, Donovan & Costa, 1996). That allows researchers to identify common factors that may account for these risk behaviours. Risk behaviour is associated with personal attributes such as egocentrism and sensation seeking (Shiel, 1999), as well as social and contextual attributes. Jessor (1992) provides a framework consisting of a web of interrelated socio-psychological factors in order to understand the complexity underlying risk behaviour. The framework includes the social environment, the perceived environment, personality attributes, behaviour and biological and genetic factors. Each domain consists of various risk and protective factors. This framework emphasises the complexity of risk behaviour and shows that risk behaviour is functional, instrumental and goal-directed in terms of the individual's frame of reference (Jessor, 1992).

In this research the focus was on the extent of substance use and sexual behaviour as risk behaviour amongst young people, against the background of the current South African situation. Through identifying the extent of risk behaviour in the target group the need for cost-effective and innovative prevention and intervention programmes can be emphasized. The education sector has a special responsibility with regard to risk behaviour of learners. Data about the extent of risk behaviour can be used by educators, researchers, policy makers and analysts, planners and funders in strategic planning for education management (Cohen, 2002; Coombe, 2002; Kelly, 2002). Before discussing the research, the available data on substance use and sexual behaviour among young people is discussed.

Epidemiological research on substance use among young people

Substance abuse in particular is recognised as one of the most significant health and social problems in the community (Department of Health, 1995; Murray & Lopez, 1996; Parry & Tibbs, 1994; Weir-Smith, 2001). Against the background of community changes the availability and use of substances have become increasingly prominent during the past few years (Simon, 1998). Drinking and drug-taking trends are frequently used as general indicators of the quality of life in a community (Tucker & Scott, 1992). Worldwide trends indicate that, when a country experiences general and drastic socio-economic and political change as presently prevalent in South Africa, these changes frequently reverberate within the sphere of risk behaviour. It is estimated that 5.8% of the South African population over the age of 15 years is alcohol dependent (Department of Health, 1995), and for some communities this percentage can be as high as 30% (Parry, 1994). In a national longitudinal study, Rocha-Silva (1992) found that there is a progressive increase in the general level of drug and especially alcohol intake among adults. In the past decade this tendency continued and increased drastically. It is estimated that the proportion of drug and alcohol users among young people grows as the general level of intake among adults in the community increases (World Health Organisation, 1980).

In four major studies done amongst the South African young people (Flisher, Ziervogel, Chalton, Leger & Robertson, 1993a; Flisher, Parry, Evans, Lombard & Muller, 1998; Rocha-Silva, de Miranda & Erasmus, 1995; Weir-Smith, 2001), a fair degree of risk-proneness with regard to the development of alcohol related problems was found:

- Flisher *et al.* (1993a) found in their study with of a sample of 7 340 learners from 16 secondary schools in the Cape Peninsula, coming from both historically advantaged and disadvantaged communities, that 53% had previous experience of drinking alcohol.
- Rocha-Silva *et al.* (1995) found that 42% of the respondents, who were black youths from urban and rural areas, reported that they had had a drink of liquor at some time in their lives, while 34% of the sample reported current drinking patterns (in the 12 months preceding the survey). Current drinkers were more common in the urbanised areas, and more amongst males than females. They also found that regular use of alcohol (at least once a week) was common among the older age group (18–21 years).
- From the school survey of the South African Community Epidemiological Network on Drug Use, involving 6 000 learners in Grades 8 and 11, in 39 schools in the Cape Town area, it was found that the highest prevalence of substance use was in the Grade 11 male group where 50% reported current alcohol use and 36% reported binge drinking (more than five drinks per occasion) (Flisher *et al.*,1998; Parry, 1998).
- In a sample of 300 young people in Gauteng and Limpopo provinces, 50% of the young people in the rural area reported current

alcohol use. In the urban area females reported current use of wine (68%) and males used mainly malt beer (80%), hard liquor and home made liquor (67%). Alcohol was mainly used in the company of friends to socialise (Weir-Smith, 2001).

The data in these studies show a progressive increase in the use of alcohol during the past decade. The data also correspond with the baseline information in the United States where 25% of young people aged 12 to 17 years and 58% of youths aged 18 to 20 years reported to use alcohol (Center for Substance Abuse Prevention, 1993). This could be a worldwide tendency.

Concerning other drugs, Rocha-Silva *et al.* (1995) found that 3.8% of the black youth in their research group, admitted that they had used marijuana (dagga), 7.4% said that they had sniffed glue or petrol at some time in their lives, whilst 2% reported that they had smoked "white pipe". In the school study reported by Parry (1998) it was found that 3% of the Grade 8 and 16% of the Grade 11 males reported current dagga use, whilst 1.6% and 5.7% of these age groups, respectively, reported the usage of mandrax. Weir-Smith (2001) reported that over-the-counter drugs were especially popular among females (63% in the rural area and 53% in the urban area), whilst marijuana was mainly used by males (82% males in the rural area and 71% in the urban area). According to the Center for Substance Abuse Prevention (1993) corresponding data in the United States indicated that 6.4% of young people between 12 and 17 years of age and 15.5% between 18 and 20 years of age reported current use of marijuana, whilst 1.1% and 4.5%, respectively, used cocaine.

Epidemiological research on sexual behaviour and HIV/AIDS

Worldwide alcohol and drug use have been identified as potentially risky practices in terms of contracting and transmitting the HI virus (Drugs and Crime Brief, 2000). HIV/AIDS is at present a major health threat facing South African young people. The largest percentage of HIV infected people was found to be in the age group 15 to 29 years. Of the pregnant teenagers attending public antenatal clinics between 14% and 16% were HIV positive during the past two years (Department of Health, 2001; 2002). Although exact statistics about HIV/AIDS amongst the young people in the population are not available, research findings show that many of the young people engaged in risky sexual behaviour and were therefore at risk of being HIV infected. Although they had basic knowledge concerning HIV/AIDS, they did not see HIV/AIDS as a personal threat and did not understand how the virus is transmitted (Department of Education and Culture, 1990; Flisher, Roberts & Blignaut, 1992; Flisher *et al.*, 1993b; 1996; Mathews, Kuhn, Metcalf, Joubert & Cameron, 1990; Mathews, Everett, Binedell & Steinberg, 1995; Mayekiso & Twaise, 1993; Mogotsi, 1997; Visser, 1995). Flisher *et al.* (1993b) found that 17.4% of a group of 7 340 secondary school learners reported that they were sexually experienced and 60.5% of them used a method of contraception. The median age for the first sexual contact was 15.1 years. They concluded that adolescent sexual activity was characterised by early onset, multiple partners and a low incidence of contraception. In a sample of urban secondary school learners in Pretoria (n = 873) 36% learners reported being sexually experienced and 21% of this group reported having multiple sexual partners and 31% non-condom use (Visser, 2002). These results were confirmed by a more extensive study by Kushlick and Rapholo (1998). They reported that 49% of a stratified sample of 18 500 learners from 600 schools countrywide reported being sexually experienced. Half of the sexually experienced learners reported using a condom in a recent sexual experience. These results stress the need for cost-effective and innovative intervention and prevention programmes to prevent risk behaviour among young people.

Almost all the studies on youth and risk behaviour were done with adolescents in secondary schools. Although Rocha-Silva *et al.* (1995) and Weir-Smith (2001) included youth as young as 10 years of age in their studies, there are at present no specific data available about the younger group of learners. Learners in primary school can be described in terms of developmental tasks associated with the middle childhood and early adolescent years, which include broadening their horizons beyond the home setting and forming an identity in relation to social networks. In contrast to adolescence, the middle childhood and early adolescent years can be described as relatively calm years where the foundation for further development can be developed (Louw, Van Ede & Louw, 1998).

In this study a situation analysis will be made of the risk behaviour of learners in the senior primary school years with the aim of understanding their behaviour and enabling educators and researchers to develop appropriate intervention and prevention programmes for learners in primary school.

Theoretical approach

Bronfenbrenner's (1979) developmental theory, which focuses on ecological systems and the interaction between the individual and his/her context, formed the theoretical framework for this study. According to this framework risk behaviour can be related to individual psychological factors such as self-esteem, locus of control, need for acceptance, anxiety levels, sensation seeking and eagerness to act like adults (Center for Substance Abuse Prevention, 1993; Perkel, Strebel & Joubert, 1991; Shiel, 1999). Risk behaviour is, however, also closely linked to social and community factors such as access and exposure to substances, social norms that tolerate risk behaviour, peer pressure, socio-economic status, educational opportunities, social support and involvement with a social network (Levine, 1998; Jessor, 1992; Plant & Plant, 1992). The focus of this research was on the micro system level (the individual) being influenced by other levels of the system. The aim of the research was to have an impact on other levels of the ecological system such as the family, school and policy making systems in terms of intervention and prevention.

Research methodology

A descriptive epidemiological study (Katzenellebogen, Joubert & Abdool Karim, 1997) was done to determine the prevalence of substance use and risky sexual behaviour in a group of primary school learners. The method of sampling and information gathering used in this study was the following.

Participants

The participants in the study were 460 Grade 6 and 7 learners attending four primary schools in a historically disadvantaged urban area near the Pretoria metropolitan. Two of these schools had previously been approached to participate in development programmes of the University of Pretoria. The other two schools became interested in the programmes and approached the researchers to become involved. The schools can be seen as representative of schools in a lower socio-economic urban environment.

The data that are reported on formed part of the situational analysis used in the development of a life skills programme for Grade 6 and 7 learners with the aim of addressing risk behaviour. The aim of the project was explained to the whole group of Grade 6 and 7 learners attending the four schools and they all agreed to voluntarily participate in the project and to complete the questionnaire.

Questionnaire

A self-report questionnaire was developed for the study, based on the guidelines put forward by the Center for Substance Abuse and Mental Health Services (Kumpfer, Shur, Ross, Bunnell, Librett & Millward, 1993) and the US Department of Health and Human Services (Hawkins & Nederhood, 1995). The questionnaire was used to assess the extent of risk behaviour, the perceived reasons and the knowledge and attitude underlying risk behaviour. The questionnaire consisted of 59 questions. Besides biographical information, questions were asked referring to the use of different substances such as alcohol, marijuana, solvents and over-the-counter-medicines, hard drugs such as cocaine and LSD, as well as sexual behaviour, the use of contraceptives and

condoms. These questions provided information concerning:
- The number of learners involved in risk behaviour
- Perceived reasons for risk behaviour
- Perceived approval of risk behaviour by the individual and the family
- Perceived support and connectedness in the community
- Perceived personal well-being

A further section identified the general attitude of learners towards substance use and knowledge about the transmission of HIV/AIDS.

The majority of the questions could be answered in terms of "Yes", "No" and Don't know" and provided data on a categorical level. Attitudes were assessed on a three-point scale "Agree", "In between" and "Disagree". Opinions about 'reasons for risk behaviour' were encouraged by using an open-question format.

The questionnaire was completed in a classroom situation with the researcher and an interpreter present. Questions were set in English and Northern Sotho or Tsonga — the languages spoken by most of the learners. Although the questions were formulated in easy language, the interpreter was available for learners who had difficulty understanding any of the questions. The interpreter also provided the learners with some of the street names of the drugs when they were unclear about the substances described. The questionnaire was completed anonymously to ensure confidentiality and a true reflection of the attitudes and behaviour. A descriptive analysis was done on the responses of the learners.

Results and discussion

The results of the research will be given in terms of the different risk behaviours investigated and possible underlying reasons identified.

Biographical information

The group of 460 learners consisted of 52% Grade 6 and 48% Grade 7 learners. There were 209 (45%) boys and 232 (50%) girls, whilst 19 respondents did not indicate their gender. The ages of the learners varied from 9 to 17 years of age, with the majority of learners (70%) between the ages of 12 and 14 years (Table 1). The majority of the learners were therefore in the pre- or early-adolescent life stage. There were 14.5% learners in the age group 15 to 17 years. In advantaged areas, this age group is usually considered to be in secondary schools. It was found that the ages of the learners in this study were representative of learners attending primary schools in disadvantaged communities (Mwamwenda, 1995).

Table 1 Age groups (N = 460)

Age group	Number (%)
9 – 11 years	57 (12.5%)
12 – 14 years	321 (70%)
15 – 17 years	68 (14.5%)
Unknown	14 (3%)

Alcohol related behaviour

In order to understand the behaviour related to alcohol use, questions were asked concerning the learners' use of alcohol and their attitude towards the acceptance of alcohol related behaviour (Table 2).

From these results it could be inferred that alcohol is a known substance to many of the learners and that 27% had already consumed liquor of some kind, whilst 14% of them indicated that they had drunk alcohol during the 30 days prior to the study, to get intoxicated. Although some of them had used alcohol, the majority (87%) believed that it is not acceptable behaviour for people of their age. One aspect that could have influenced this behaviour pattern, was the perceived group value system obtained by asking the respondents how many of their friends used alcohol. Only 8% indicated that most of their friends used alcohol and 14% indicated that some of their friends used it. This suggested that the perceived norm for this group concerning alcohol related behaviour was negative and that peer pressure to use alcohol was not high. With reference to the long-term effects of alcohol the majority (51%) said that users may become ill, whilst 30% did not know. The most important perceived reasons for using alcohol were the following (this was an open question and learners could write down what they thought the reasons were):
- To forget their problems (23%)
- They like it or for fun (21%)
- Self-destruction, they do not care about themselves (7%)
- To feel good about themselves, brave and happy (6%)

Furthermore, of the 63 learners (14%) who indicated that they had drunk alcohol during the 30 days prior to the study, in order to get high, 59% were male and 37% female. The age variation of these learners was between 11 and 17 years, with the majority being 13 and 14 years of age. A small percentage of these learners (10%) perceived most of their friends as drinking alcohol, 27% said that some of their friends used alcohol, whilst 56% were of the opinion that none of their friends used alcohol. Their behaviour can therefore not be regarded as a reflection of high peer group pressure.

Table 2 Alcohol related behaviour (N = 460)

	Yes	No	Don't know	Not completed
Did you ever drink alcohol?	126 (27%)	301 (66%)	22 (5%)	11 (2%)
Did you drink alcohol the past 30 days to get drunk?	63 (14%)	355 (77%)	32 (7%)	10 (2%)
Is it acceptable for a person your age to drink alcohol?	10 (2%)	400 (87%)	37 (8%)	13 (13%)
Will a person who uses alcohol for a long time become ill?	233 (51%)	71 (15%)	136 (30%)	20 (4%)
	None	Some	Most	Not completed
How many of your friends drink alcohol?	338 (74%)	66 (14%)	38 (8%)	18 (4%)

Marijuana related behaviour

The same questions were asked with reference to the use of marijuana (dagga) (Table 3).

Table 3 Marijuana related behaviour (N = 460)

	Yes	No	Don't know	Not completed
Have you ever smoked dagga?	31 (7%)	404 (88%)	14 (3%)	11 (2%)
Have you smoked dagga the past 30 days?	17 (4%)	421 (91%)	17 (4%)	5 (1%)
Is it right for a person your age to smoke dagga?	14 (3%)	418 (91%)	19 (4%)	9 (2%)
Will a person who uses dagga for a long time become ill?	242 (53%)	72 (16%)	131 (28%)	15 (3%)
	None	Some	Most	Not completed
How many of your friends smoke dagga?	386 (84%)	26 (6%)	25 (5%)	23 (5%)

From Table 3 it can be inferred that marijuana is not such a prominently used substance by primary school learners, although 7% had had some previous experience using marijuana and 4% had smoked it during the 30 days prior to this study. Many of the learners did

not know what the long-term effects of marijuana use could be (28%), and the majority (91%) did not regard it as appropriate behaviour for a person of their age. The most important perceived reasons for using marijuana were the following:

- To feel good and strong (17%)
- To forget their problems (14%)
- Self-destruction, don't care about themselves (10%)
- Anti-social behaviour (6%)
- To give them health and energy (6%)
- Ignorance (6%)

Among the 17 learners who indicated that they currently used marijuana, 13 were male and 4 female and their ages ranged from 11 to 16 years. Friends may play a role in their marijuana smoking habit since 50% of them regarded their friends to be marijuana smokers as well.

The use of other substances

The learners were asked about their use of other substances such as sniffing of solvents, over-the-counter-medicines and "hard drugs" (Table 4).

It could be inferred that the use of solvents (such as sniffing glue or petrol) was not frequent amongst this group of learners: 3% indicated that they had used it during the 30 days prior to the study and 3% had also seen most of their peers sniffing substances. Respondents in the present study indicated that they perceived the reasons for using solvents mainly as destructive behaviour (such as not caring about themselves) and low socio-economic circumstances of street children (15%, respectively). It seemed that this group of learners identified less with using solvents than the respondents in the study by Rocha-Silva *et al.* (1995).

Over-the-counter-medicines may become a problem for the learners, because 13% indicated that they had already used it to get high and 9% indicated that they had used it during the 30 days prior to the study to become intoxicated. However, this question could have been interpreted wrongly. The learners could have used over-the-counter medicines for medical reasons and not as a drug even though it was specified in the question that they had used it "to get high". Although the percentage of the learners who indicated that they had used drugs such as cocaine, mandrax or LSD was low (2%), this may still be a cause for concern among this age group.

Table 4 The use of other drugs (N = 460)

	Yes	No	Don't know	Not completed
Have you sniffed substances (glue, petrol) to get high the past 30 days?	12 (3%)	425 (92%)	14 (3%)	9 (2%)
Have you used pain pills or cough medicine to get high the past 30 days?	41 (9%)	385 (84%)	26 (5%)	8 (2%)
Have you used drugs like cocaine, LSD, mandrax the past 30 days?	10 (2%)	413 (90%)	19 (4%)	18 (4%)

Sexual behaviour

Sexual behaviour is one of the most important risk behaviours amongst school children since it is related to teenage pregnancy and the transmission of HIV. Responses of the learners concerning their sexual behaviour and knowledge of HIV/AIDS are summarised in Table 5.

From these responses it can be seen that 24% of the learners were sexually experienced and that many of them regarded their friends as being sexually experienced too (46% saw some or most of their friends as being sexually experienced). This indicated a social climate that may influence risk behaviour. However, in spite of the social climate, 77% responded that they regarded it as inappropriate for learners of their age group to be sexually experienced.

In an open question "Why do you think some of your friends have sex?" the most common answers were the following:

- They want to be like adults (21%)
- It is bad behaviour, a lack of morals (19%)
- They have problems and a lack of care at home (16%)
- They are in love (14%)

From these responses it appeared that many of the learners did not regard sexual behaviour as appropriate for their age group.

An alarming factor was that many of the learners did not have accurate knowledge concerning the transmission of HIV and that many of them may be at risk of contracting the HI virus, even after years of HIV/AIDS awareness and information campaigns. Forty percent of the learners did not think that learners of their age group could get the virus. Furthermore, they were ignorant regarding the fact that a person does not know immediately when he/she has contracted the virus (46%) and that the virus can be passed on to someone even when the person looks and feels healthy (53%).

Table 5 Sexual behaviour of learners (N = 460)

	None	Some	Most	Not completed
How many of your friends have sex?	234 (51%)	112 (24%)	100 (22%)	9 (3%)
	Yes	**No**	**Don't know**	**Not completed**
Do you have sex?	108 (24%)	329 (72%)	16 (3%)	7 (1%)
Can someone your age get AIDS when having sex?	139 (30%)	184 (40%)	127 (28%)	10 (2%)
A person knows immediately when he/she contracts AIDS	110 (24%)	236 (51%)	102 (22%)	12 (3%)
A person who looks and feels healthy cannot pass the AIDS virus on	158 (34%)	205 (45%)	87 (19%)	10 (2%)
Is it right for a person your age to have sex?	37 (8%)	356 (77%)	52 (11%)	15 (3%)

Table 6 Data of sexually experienced learners (N = 108)

	None	Some	Most	Not completed
How many of your friends have sex?	22 (20%)	38 (35%)	45 (42%)	3 (3%)
	Yes	**No**	**Don't know**	**Not completed**
Can someone your age get HIV/AIDS when having sex?	43 (40%)	39 (36%)	25 (23%)	1 (1%)
If you have sex, do you use a condom to protect you from HIV/AIDS?	43 (40%)	53 (49%)	12 (11%)	0 (0%)
If you have sex, do you use birth control to prevent pregnancy?	38 (35%)	42 (39%)	23 (21%)	5 (5%)
Is it right for a person your age to have sex?	28 (26%)	62 (57%)	17 (16%)	1 (1%)

Among the 24% (n = 108) sexually experienced learners, whose responses are summarised in Table 6, only 40% indicated that they protected themselves from HIV by using condoms, 40% regarded learners in their age group to be at risk of contracting HIV and 35% used some kind of contraception to prevent pregnancy. These learners

may need some guidance regarding the importance of protection against HIV/AIDS. The group of sexually experienced learners consisted of 67% males and 26% females (7% did not indicate their gender). The youngest sexually experienced learners in this group were 10 years and percentages accumulated as the ages increased. It is not possible to say from these data whether peer influence played a role in motivating the learners' sexual behaviour or whether they associated themselves more with learners who are also sexually experienced. However, it appears that most of the learners (77%) who were sexually experienced see their friends as being sexually experienced as well (Table 6).

Attitudes towards substance use and AIDS

The attitudes of the learners towards the use of substances and people with HIV/AIDS were assessed. Learners were required to indicate their responses on a three-point scale (Agree/ In between/ Disagree). The majority of the learners indicated a negative attitude towards the use of substances. A significant number of respondents indicated that people who smoke marijuana should be put in jail (49%), that no one should use alcohol (59%), and they regarded drugs as being dangerous for a person's health (56%). On the other hand, 34% thought that people who used alcohol had fun, and only 31% responded that learners in their age group should not experiment with drugs. Furthermore, their attitudes towards people with HIV/AIDS were quite negative, since 46% said that learners with HIV/AIDS should not be allowed to attend their school.

Behavioural intentions

In order to assess the behavioural intentions of learners a number of everyday scenarios were described. The respondents were asked to explain how they would react in these situations (Table 7). This provided a self-report of behavioural intentions and cannot be regarded as their actual behaviour. Although behavioural intentions can play an important role in behaviour (Ajzen & Fishbein, 1980), a variety of other aspects could also influence actual behaviour (Perkel *et al.*, 1991; Plant & Plant, 1992).

Table 7 The use of other drugs (N = 460)

Scenario	Yes	No	Don't know	Not completed
If you were unhappy, would it make you feel better to have a drink/smoke/sniff?	27 (6%)	335 (73%)	91 (20%)	7 (1%)
If someone offers you a drink/smoke at a party to help you enjoy the party, would you accept it?	55 (12%)	230 (50%)	170 (37%)	5 (1%)
If your boy/girlfriend wants you to have sex to prove your love, would you do so?	88 (19%)	270 (59%)	93 (20%)	9 (2%)

Although most of the learners indicated that they would not agree to risk behaviour or be influenced by peer pressure, many of the learners were unsure of what they would do in all three situations. This of course, makes them more vulnerable to peer pressure, especially when their personal well-being and social circumstances as described below, are taken into account.

Personal well-being

According to Perkel *et al.* (1991) self-esteem is one of the most important personal factors influencing the development of risk behaviour. Of the respondents in this study 47% regarded themselves as generally happy and 42% experienced acceptance by others, indicating a positive self-experience. There were 22% of the learners who regarded themselves as being generally unhappy and 19% did not feel accepted by others. This could contribute to risk behaviour of learners.

Social support

Social support and the attitude of significant other people may also have an important influence on the behaviour patterns and habits of the learners. Questions were therefore asked to establish the extent of their social support systems (Table 8).

Table 8 Social support of learners

	Yes	No	Don't know	Not completed
If your parents/caregivers find out you use drugs, would you get into trouble?	243 (53%)	100 (22%)	102 (22%)	15 (3%)
Do the adults you stay with have a drinking or drug problem?	115 (25%)	271 (59%)	65 (14%)	9 (2%)
If you have a personal problem, is there an adult you can talk to?	169 (37%)	125 (27%)	140 (30%)	26 (6%)
If you have a personal problem, is there a friend you can talk to?	136 (30%)	104 (22%)	189 (41%)	31 (7%)
Do you take part in organised group activities (sport, church or youth group)?	250 (54%)	90 (20%)	97 (21%)	23 (5%)

From Table 8 it can be seen that 53% of the learners knew that their parents or caregivers disapproved of the use of drugs, whilst the others (22%) were not sure or knew that their parents would not mind (22%). For 25% of the learners alcohol or drug abuse was part of their lives since either a caregiver or a family member abused it. Among the respondents 37% indicated that they have an adult or a friend (30%) to talk to when experiencing personal problems. However, many of the learners also portrayed that they do not have an adult (27%) or a friend to talk to (22%). More than half of the learners (54%) indicated that they participated in some kind of organised activity after school, which also presented them with a support network. It can be estimated that at least 25% of the learners do not have or experience sufficient social and/or adult support, and may be vulnerable to and at risk of developing risk behaviour.

Conclusion

Comparing the results of this study with those of previous studies (Flisher *et al.*, 1993a; Flisher *et al.*, 1998; Parry, 1998; Rocha-Silva *et al.*, 1995; Weir-Smith, 2001), it appears that alcohol related behaviour is not as prominent among primary school learners as among secondary school learners. However, it is alarming to know that 14% of the learners (1 out of every 7), mostly under the age of 15 years, drank alcohol either to get drunk and forget about their problems or to feel good about themselves and have fun.

Concerning the use of other drugs, the findings for the primary school learners were similar to those made for the older age groups in the studies by Rocha-Silva *et al.* (1995), Parry (1998) and Weir-Smith (2001). In the present study 7% of the learners indicated previous and 4% current use of marijuana, whilst 3% reported using solvents to get high and 2% that they had already experimented with illegal drugs, such as LSD, mandrax and cocaine. Over-the-counter-medicine also has the potential of becoming a problem since 9% learners indicated that they had used some in the past 30 days to get high.

Substance abuse is not yet critical amongst the primary school learners involved in the present study. This is however the ideal opportunity for the implementation of primary and secondary prevention strategies. Since the perceived group norm and value judgement still largely excluded alcohol and drug use as acceptable beha-

viour, prevention can halt this risk behaviour before it gets out of hand. Primary school learners are still susceptible to being positively influenced by well-planned primary prevention programmes, forestalling their choice of negative behaviour patterns. However, since it is evident from this study that many of the learners are confronted with alcohol and drug abuse in their own homes (25%) and lack effective social and adult support systems, the programmes should include appropriate strategies overcoming these risk factors. Furthermore, some of the learners' experiences of not being happy (22%) and not being accepted by others (19%) need to be taken into account, since these feelings are often underlying the development of risk behaviour amongst young people (Jessor, 1992; Perkel *et al.*, 1991; Shiel, 1999).

Risk behaviour among primary school learners which needs urgent attention is, however, the practice of unprotected sex. It is alarming that 24% of the primary school learners indicate that they are sexually experienced and that only 40% of the sexually experienced learners protect themselves from HIV/AIDS and 35% use some form of contraception. That means that one of out every 8 learners are at risk of contracting HIV. Many of them indicated that they do not have sufficient knowledge of HIV transmission. Furthermore, it seems that sexual behaviour is becoming an accepted group norm since many (77%) of the sexually experienced learners view their friends as being sexually experienced as well. These issues need to be addressed urgently to prevent the risk behaviour patterns already apparent, and to avoid them becoming more serious problems as these learners progress to secondary school. These results can also reflect on the HIV/AIDS awareness programmes on school and community level (Parker, Dalrymple & Durden, 1998; Swart, 1998). It seems that the interventions have not been effective yet in preventing risk behaviour related to HIV/AIDS. Sherriff's (1997:10-11) comments on the community's reaction to the HIV/AIDS epidemic may still be applicable:

> "Much of the response to AIDS has been too much talk and too little action. We knew about AIDS so long but we didn't do enough and now it is too late. We have lost half a generation of time to do something significant."

The value of this research was described by Yach & Dick (1990:3):

> "The purpose of epidemiological research is to investigate the distribution and determinants of disease in the community with the objective of designing intervention strategies to promote the health and well-being of these communities. Epidemiological research thus has a clear implementation goal."

Before an intervention to address risk behaviour can be developed it is necessary to understand the underlying reasons for risk behaviour in the target group and to promote health-enhancing behaviour that satisfies the same needs as the risk behaviour and/or changes the context which instigates and maintains the behaviour (Jessor, 1992). Common prevention approaches utilised in schools involve information dissemination and teaching learners the factual information concerning risk behaviour and the dangers thereof (Botvin, 1995). The results of this study indicated that the learners already knew that alcohol and drug use and sexual behaviour were considered to be inappropriate at their age. They had negative attitudes towards drugs in general and knew that they have negative health implications.

In planning interventions the perceived reasons for risk behaviour (as identified by the learners) should rather be focused on. From the different reasons given for risk behaviour, a few common reasons have emerged:

- to forget their problems,
- a sense of self-destruction,
- for enjoyment, and
- to improve their self-esteem.

It should however be taken into account that the perceived reasons may differ from the experienced reasons of learners engaging in risk behaviour, as was the case in Ziervogel *et al.* (1997/98). However, it became apparent that prevention programmes should include strategies for empowering the learners on a personal level, to help them deal with personal problems, to develop their sense of well-being and to enhance their self-esteem. Concerning ecological factors interventions should focus on providing adequate social support systems, recreational facilities and organised group activities. Community and positive family relationships and support should also be encouraged. Intervention strategies should be designed and evaluated within the communities they are meant to reach (Ziervogel *et al.*, 1997/98). Therefore, a situational analysis will be needed in the development of interventions for every target group.

Acknowledgements

The financial support of the HF Verwoerd Trust Fund and the TUKS Rag Fund is acknowledged. I also thank my colleague Anne-Gloria Moleko for her contribution to this article.

References

Ajzen I & Fishbein M 1980. *Understanding attitudes and predicting social behavior*. Englewood Cliffs NJ: Prentice Hall.

Botvin GJ 1995. Drug abuse prevention in school settings. In: GJ Botvin, S Schinke & M A Orlandi. *Drug abuse prevention with multi-ethnic youth*. Thousand Oaks: Sage.

Bronfenbrenner U 1979. *The ecology of human development*. Cambridge: Harvard University Press.

Center for Substance Abuse Prevention 1993. *Prevention primer: An encyclopedia of alcohol, tobacco and other drug prevention terms*. Rockville MD: National Clearinghouse for Alcohol and Drug Information.

Cohen D 2002. HIV and education in sub-Saharan Africa: Responding to the impact. *Perspectives in Education*, 20:13-23.

Coombe C 2002. HIV/AIDS and education. *Perspectives in Education*, 20:vii-x.

Department of Education and Culture, Administration: House of Assembly 1990. *Care for our youth 2000*. Pretoria: Government Printer.

Department of Health 1995. *Report on Mental Health and substance abuse*. Pretoria: Mental Health Directorate, Department of Health.

Department of Health 2001. *National HIV and syphilis sero-prevalence survey of women attending public antenatal clinics in South Africa 2000*. Pretoria: Department of Health.

Department of Health 2002. *National HIV and syphilis sero-prevalence survey of women attending public antenatal clinics in South Africa 2001*. Pretoria: Department of Health.

Drugs & Crime Brief 2000. United Nations Office for Drug Control and Crime Prevention to study links between drug use and HIV in South Africa. *Drugs & Crime Brief*, 1:9.

Ebersohn L & Eloff I 2002. The black, white and grey of rainbow children coping with HIV/AIDS. *Perspectives in Education*, 20:77-86.

Flisher AJ, Roberts MM & Blignaut RJ 1992. Youth attending Cape Peninsula day hospitals: Sexual behaviour and missed opportunities for contraception counselling. *South African Medical Journal*, 82:104-106.

Flisher AJ, Ziervogel CF, Chalton DO, Leger PH & Robertson BA 1993a. Risk-taking behaviour of Cape Peninsula high-school students: Part IV Alcohol use. *South African Medical Journal*, 83:483-485.

Flisher AJ, Ziervogel CF, Chalton DO, Leger PH & Robertson BA 1993b. Risk-taking behaviour of Cape Peninsula high-school students: Part VIII Sexual behaviour. *South African Medical Journal*, 83:495-497.

Flisher AJ, Ziervogel CF, Chalton DO, Leger PH & Robertson BA 1996. Risk-taking behaviour of Cape Peninsula high-school students: Part IX: Evidence for a syndrome of adolescent risk behaviour. *South African Medical Journal*, 86:1090-1093.

Flisher AJ, Parry C, Evans J, Lombard C & Muller A 1998. The South African Community Epidemiology Network on Drug Use (SACENDU): Methodology and preliminary results. The tenth National Psychiatric Conference, Johannesburg.

Hawkins JD & Nederhood B 1995. *Handbook for evaluating drug and alcohol prevention programs, staff/team evaluation of prevention programs*. Rockville: Office for Substance Abuse Prevention, US Department of Health and Human Services.

Irwin C 1993. Adolescence and risk taking: How are they related? In: N Bell & R Bell (eds). *Adolescent risk taking*. London: Sage.

Jessor R 1992. Risk behaviour in adolescence: A psychosocial framework for understanding and action. *Developmental Review*, 12:374-390.

Jessor R, Donovan J E, Costa F 1996. Personality, perceived life chances, and adolescent behaviour. In: K. Hurrelman & S Hamilton (eds). *Social problems and social contexts in adolescence: Perspectives across boundaries*. New York: Aldine de Gruyter.

Katzenellenbogen JM, Joubert G & Abdool Karim SS (eds) 1997. *Epidemiology, a manual for South Africa*. Cape Town: Oxford

University Press.
Kelly M 2002. Preventing HIV transmission through education. *Perspectives in Education*, 20:1-12.
Kumpfer KL, Shur GH, Ross JG, Bunnell KK, Librett JJ & Millward AR 1993. *Measurements in prevention, a manual on selecting and using instruments to evaluate prevention programs. Center for Substance Abuse and Mental Health Services Administration Techinical Report 8*. Rockville: US Department of Health and Human Services.
Kushlick A & Rapholo G 1998. *Baseline survey into HIV/AIDS knowledge, attitudes and related life skills. Researched for the National Life Skills Task Team*. Braamfontein: Community Agency for Social Enquiry.
Levine M 1998. Prevention and community. *American Journal of Community Psychology*, 26:189-206.
Louw DA, Van Ede DM & Louw AE 1998. *Human Development.* 2nd edn. Pretoria: Kagiso.
Mathews C, Kuhn L, Metcalf CA, Joubert G & Cameron NA 1990. Knowledge, attitudes and beliefs about AIDS in township school students in Cape Town. *South African Medical Journal*, 78:511-516.
Mathews C, Everett K, Binedell J & Steinberg M 1995. Learning to listen: Formative research in the development of AIDS education for secondary school students. *Social Sciences Medicine*, 12:1715-1724.
Mayekiso TV & Twaise N 1993. Assessment of parental involvement in imparting sexual knowledge to adolescents. *South African Journal of Psychology*, 23:21-23.
Mogotsi M 1997. Knowledge and attitudes of school girls with regard to AIDS and sexual practices. *Health Systems Trust Update*, 27:20.
Murray CJL & Lopez AD 1996. Quantifying the burden of disease attributable to ten major risk factors. In: CJL Murray & AD Lopez (eds). *The global burden of disease: A comprehensive assessment of mortality and disability from diseases, injuries and risk factors in 1990 and projected to 2020*. Cambridge: Harvard University Press.
Mwamwenda T 1995. *Educational psychology, an African perspective.* 2nd edn. Durban: Butterworths.
Parker W, Dalrymple L & Durden E 1998. *Communicating beyond AIDS awareness, a manual for South Africa. Report commissioned by the HIV/AIDS and STD Directorate of the Department of Health as part of the 1997/98 Beyond Awareness campaign.* Pretoria: Department of Health.
Parry C 1994. Prevalence of alcohol misuse in South Africa: A review of empirical research. *Urbanisation and Health Newsletter, Medical Research Council of South Africa*, 21:33-38.
Parry CDH 1998. Report on the Cape Town UCT/MRC school study. Unpublished paper presented at the South African Community Epidemiology Network on Drug Use report back meeting, 15 October, Pretoria.
Parry CDH & Tibbs J 1994. Urbanisation and alcohol misuse. *Urbanisation and health newsletter, Medical Research Council of South Africa*, 21:1-2.
Perkel AK, Strebel A & Joubert G 1991. The psychology of AIDS transmission: issues for intervention. *South African Journal of Psychology*, 21:148-152.
Plant M & Plant M 1992. *Risk-takers: Alcohol, drugs, sex and youth*. London: Tavistock/Routledge.
Rocha-Silva L 1992. *Alcohol/drug-related research in the RSA: Meeting the challenges of the 1990s.* Pretoria: HSRC.
Rocha-Silva L, de Miranda S & Erasmus R 1995. *Alcohol/drug use and related matters: Young black South Africans (10-21years)*. Pretoria: HSRC.
Sherriffs P 1997. A time for review — HIV in a democratic South Africa. *Positive Outlook*, 4:10-12.
Shiel PJ 1999. Predictor variables of adolescent risk-taking behaviour. Unpublished Master's dissertation. Pretoria: University of Pretoria.
Simon D 1998. Drugs, development and the post-apartheid transition in South Africa. *Urban Health and Development Bulletin*, 1:35-39.
Swart K (ed.) 1998. *Life skills and HIV/AIDS Education Programme. Project report of the joint venture of the South African Departments of Health and Education.* Pretoria: Department of Education.
Tucker B & Scott BR (eds) 1992. *South Africa: Prospects for successful transition*. Cape Town: Juta.
Visser MJ 1995. The need for AIDS education in schools: An analysis of knowledge, attitude and behavioural intentions of students. *South African Journal of Education*, 15:130-138.
Visser MJ 2002. Life skills training as HIV/AIDS preventive strategy: Lessons from programme evaluation. Paper at the *African Conference on the Social Aspects of HIV/AIDS Research*. Pretoria, 1-4 September.
Weir-Smith G 2001. *WHO global initiative on primary prevention of substance abuse. Research Report*. Pretoria: Human Sciences Research Council.
World Health Organisation 1980. *Problems related to alcohol consumption.* Geneva: World Health Organisation.
Yach D & Dick J 1990. Implementation of research: The key to closing the gap between public health knowledge and action. Unpublished document, Centre for Epidemiological Research in Southern Africa, Medical Research Council.
Ziervogel CF, Morojele NK, Van der Riet J, Parry CDH, Robertson BA 1997/98. A qualitative investigation of alcohol drinking among male high school students from three communities in the Cape Peninsula, South Africa. *International Quarterly of Community Health Education*, 17:271-295.