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AN EVALUATION OF SANCA'S LIFESTYLE PROGRAMME IN TWO SOWETO PUBLIC SCHOOLS

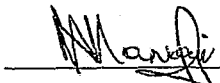
By Nyameka Mankayi

A research report submitted to the Faculty of Specialised Education,
The University of the Witwatersrand, Johannesburg, In Partial Fulfilment of the Requirements for the Degree of Master of Education (Educational Psychology)

May 2000

DECLARATION

I hereby declare that this dissertation is my own, unaided work. It has not previously been submitted to any other University for any degree or examination. It is being submitted for the degree of Master in Education (Educational Psychology) at the University of the Witwatersrand.



Nyameka Mankayi

October 2000

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ABSTRACT

This study evaluated the impact of the SANCA Lifestyle Programme on Grade 6 and 7 black learners in two Soweto schools. This was done with a view to investigate the appropriateness of the present SANCA Lifestyle Programme for black learners. A total of 260 learners participated in this study.

The main thrust of the study was to investigate the impact of SANCA's Lifestyle Programme on learners' psychosocial functioning and understanding of alcohol and drugs before and after the implementation of the SANCA Lifestyle Programme. Information was collated from the following instruments: biographical questionnaire, Psychosocial Functioning Inventory for Primary School Children (PFI-PRIM-C), alcohol and drug assessment questionnaire and programme evaluation questionnaire.

The Pre-test results revealed low self-image for the total sample on the PFI-PRIM-C which measures psychosocial functioning. The Post-test results revealed significant improvement in this area. The results showed significant differences between gender and age groups in the areas of psychosocial functioning status. In particular, there was also a significant difference between males and females with regard to states of anxiety ($p<0.001$). There was also a significant difference between the 10-13 year olds and 14-18 year old groups in levels of frustration ($p<0.001$) on the PFI-PRIM-C. After the Lifestyle Programme significant improvements were achieved.

A significant improvement was also found on the learners' knowledge of alcohol and drugs in the post-test period. There was no significant age or sex differences on alcohol and drug assessment questionnaire both in the pre-test or post-test periods.

The implications of the findings are that Lifestyle Programmes have the potential to be effective for black learners.

Keywords: Life Skills, Lifestyle Prevention Programme, drug and alcohol abuse, psychosocial functioning status, socio-economic status, ecological perspective, social support systems, relationships, self-image.

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CHAPTER 1-INTRODUCTION

1.1 Background to the study

History suggests that drug taking and alcohol dependence have been prevalent for centuries. Alcoholism and drug dependence are, however, a growing phenomenon internationally and the escalation of this problem has had negative effects on the economies of many countries. It was estimated that in the United States (US) tobacco usage costs the economy more than 100 billion dollars each year and, that alcohol usage costs in excess of $46 billion each year in lost productivity (Behrens, 1998). Similarly the South African economy was estimated currently to be losing approximately R5 billion from job accidents, lost productivity, damage to health, crime and family breakdown because of drug and alcohol abuse (Freemantle, 1985; SANCA[1] fact sheet, 1993).

It is likely that this problem was exacerbated in South Africa by a history of political violence, during the apartheid years. Political violence in South Africa is however, compounded now by criminal and domestic violence especially in poor areas and in townships. "According to the government's 1992 figures, South Africa (excluding the 'homelands') had 20 000 murders per year - an average of 55 per day" (Dawes and Donald, 1994:5). In the same period (1992), 24 812-rape cases were reported (Dawes and Donald 1994). These figures are likely to increase with the advent of increasing opportunities for South Africans to participate in international trade and travel which provide opportunities for illicit drug traffic networks to penetrate the local markets, particularly among the youth (Rocha-Silva et al., 1996).

Rocha-Silva et al. (1996) argue that alcohol and drug abuse in disadvantaged townships aggravate acts of violence. Conversely, it can be argued that violent environments also make people vulnerable to substance abuse (De Miranda, 1987).

In a study conducted by Everrat and Orkin (1993) on township youth, it was estimated that approximately one million four hundred thousand children live on the streets.

[1] South African National Council of Alcohol and Drug Dependence.

It was further estimated that four and a half million children are exposed to criminal and violent environments in South African townships. These children are potentially at risk of becoming offenders or victims of crime. In the same study Everrat and Orkin suggest that as many as three and half million children could be marginalised from society because their psychological development and education have been negatively interrupted by violence. Thus, conditions of extreme poverty, lack of emotional support, parental abuse, substance abuse, physical and sexual abuse, and family disruptions such as divorce or separation have compromised the potentially healthy development of the majority of children in South Africa, and constitute a source of great anxiety and stress on South African children which could result in them resorting to substance abuse (Hamburg, Elliot and Williams, 1998).

Dawes and Donald (1994) argue that it is extremely difficult to differentiate between the effects of the political violence and domestic violence to which South African children are exposed. They are exposed to violence at home, at school and in their communities, that is likely to result in the escalation of drug and alcohol dependence particularly at the adolescent stage (Parry, 1994; Rocha-Silva, De Miranda and Erasmus, 1996). This pattern of drug and alcohol abuse has emerged over the past thirty years in South Africa and is expected to continue in the light of the increasing drug trade. This has evoked much concern from Central Government, non-Government Organisations (NGOs), and professionals with an interest in these problems (Parry, 1994; Rocha-Silva, 1988; SANCA-situational Analysis, 1995).

According to researchers such as Donald et al. (1997) and De Jong et al. (1995) the majority of South Africa's youth, in particular black adolescents from disadvantaged communities, seem to need psychological and educational intervention programmes. They need these programmes because of the likely disruption to their physical and emotional development caused by violence resulting from apartheid practices, which put them at risk for drug, and alcohol abuse. However, most researchers argue that it is necessary to direct preventative programmes to all children at risk in this country, rather than limiting the intervention only to those children already identified as experiencing problems and needing help (Donald, et al., 1997).

There are various interaction programmes, viz. Life Skills Programmes that are used all over the world. De Miranda (1987) regards them as addressing particular attitudes, knowledge and skills, which, and are likely, to assist children to deal effectively with the demands and challenges of everyday life. He believes that the SANCA Lifestyle Programme in particular is an effective response to current problems of drug and alcohol abuse with the youth. In general, Life Skills Programmes promote the physical, mental and social well being of children and adolescents and equip them with effective psychosocial levels of competence, such as personal self management skills and social skills but more specifically they reduce intra-psychic motivations to use drugs and to reduce vulnerability to social influences to use drugs (Botvin and Botvin, 1992; De Jong, et al., 1995; Donald, Lazarus & Lolwana, 1997).

Against such a background, and prior to examining the effectiveness of the SANCA Lifestyle Programmes, it is important to review the relevant literature in relation to alcohol and drug prevention programmes.

1.2 Literature Review

The literature review is presented in three sections:

- Section one presents a brief overview of the ecological perspective of human development. This perspective postulates that to comprehend the determinants of individual development, it is necessary to understand the interaction that occurs between intra-personal factors (such as gender, age, etc.), inter-personal variables (such as social support systems) and the nature of the economic status of the individual. It is further argued in this study that this theoretical orientation and focus provides the best conceptual framework to justify and evaluate a programme of intervention such as the SANCA Lifestyle Programme utilised in this study (Thomas, 1992).
- Section two presents a number of studies on the efficacy and success of alcohol and drug prevention programmes in other countries with respect to their content and orientation.

- Section three presents an overview of SANCA's Lifestyle Programme and discusses its theoretical underpinnings. This theoretical input is vital to the interpretation of the construction, orientation and aim of the SANCA Lifestyle Programme. The main aim of this study is to evaluate this programme and its orientation.

1.2.1 The ecological perspective

The ecological perspective postulates that in society there is an interaction of factors such as intra-personal, inter-personal and socio-economic status between individuals and elements of society. For example, when assessing a child's learning capabilities, the emphasis must not only be on a child's cognitive processes but must also take into account the child's interactions with significant others. Significant others would include, influences by adults, other children, the wider environment such as parents, work, the family's community, the neighbourhood and the greater socio-political aspects, such as education and health on individual behaviour. An ecological view recognises that children live in a variety of contexts, each one impinging upon the other and with differing effects (Thomas, 1992). Thus, in evaluating the effectiveness of the SANCA Lifestyle Programme, SANCA Lifestyle Programme participants' socio-economic status and their family compositions are regarded as important and are specifically evaluated in this research. It is important at this stage to look at the two key factors that undergirds the ecological perspective viz. environment and family structure and environment and individual.

1.2.2 The environment and family structures

An ecological perspective is an appropriate approach to examine the interaction between environment and family structures. It is appropriate because it takes into that account people's lives are inextricably intertwined with the nature and quality of their environment (Thomas, 1992). Turton's research indicates that there are recurrent stressful events that occur in family structures, such as marital discord, parental substance abuse, separations, divorce and lack of emotional support, that are potentially stressful for children and adolescents.

It is reported that reaction to stress tends to vary from person to person depending on differing intrapersonal, interpersonal and environmental factors (Turton, 1986). For example, Barker (1988) and Dawes and Tredoux (1989), report that some children appear to cope adequately with potentially stressful events while others seem not to.

In the South African context, deprived families are commonly known to have large family members and to live in crowded dwellings characterised by inadequate food, poor physical health, and inadequate schooling (Richter, 1989).
Richter (1989) contends that both household density and family size have a negative impact on the physical and psychological development of children between ages 6 and 9 years. However, Duckitt (1983) argues that, although these living conditions are not pleasant, neither family size nor household overcrowding on their own, can fully explain the physical or psychological problems, including the alcohol and drug abuse of these children. For example, it has been reported that many people consider overcrowded living conditions to be more acceptable than the separations and divisions caused by the previous migrant labour system of South Africa (Hewatt, Lee, Nyakaza, Olver and Tyeko, 1984; Straker, 1992). It is also widely accepted that these conditions seem to provide a good social support system, which plays an important role in helping individuals cope with traumatic life events and increasing an individual's resilience to stress. The same researchers argue that people with little, or no social support systems, are more likely to be adversely affected by stressful factors than those with social and familial support.

Rutter (1983) and Gibson (1986) suggest that the closeness of a group of people can protect both the adults and children when they are faced with difficult situations. Thus, social groups, such as peers, schools, social and religious organisations, are support structures that can play a pivotal role in shaping one's approach to stressful situations. Another view, expressed by Ramphele and Wilson (1989) and Straker (1989), is that black South Africans tend to display feelings of inadequacy and low self-esteem due to the apartheid policies and racial prejudices of the past, and this prevents them from participating in society. Furthermore, their self-esteem depends on certain individual intra-psychic factors and the quality of social support. This view supports research that suggests that good social support networks can play a direct primary role in providing coping skills for dealing with stressful events (Turton, 1986). The absence of positive

support system, it is argued that, it renders people vulnerable to alcohol and drug abuse (Fraser and Hawkins, 1984)

1.2.3 The environment and the individual

Within the context of the ecological perspective a child is viewed as actively interacting with the environment. "This has led to the study of the interaction between the individual differences in each child and variables in the child's environment, rather than focusing solely on environmental or individual influences" (Carey, 1992 in Harcombe, 1993: 10). Thus it is necessary to examine a link between individual differences in anxiety and frustration levels and the use of defense mechanisms to cope with stressful events within the environment (Strelau, 1989). Lokare (1984) suggests that children from a lower socio-economic status tend to show higher levels of anxiety. Turton (1986) corroborates these findings by suggesting that socio-economic factors have a modifying effect in the relationship between life events and the experience of stress. To cope with stressful life events individuals use psychological defence mechanisms such as repression, denial, projection, displacement, rationalisation etc. (Strelau, 1989). These defense mechanisms might include use of drugs and or alcohol that might be seen as enabling one to cope. This is the position argued by SANCA in their work.

There also seems to be a link between stress and gender. Research on stress indicates that boys appear to be more vulnerable to most adverse psychosocial stress and react more aggressively than girls do. Furthermore, they have more negative interactions than girls do in the face of stressful events (Rutter, 1983; Stolberg, Complair, Currie and Wells, 1987). On the other hand, other researchers suggest that girls experience more psychosocial stress and become anxious. They score higher on all anxiety scales than boys do (Lokare, 1984; Turton, 1986; Thoits, 1988). Scholars such as Anthony (1987); Dawes and Tredoux (1989); and Shmukler (1989) examined the relationship between gender, age and stress. Their findings showed that boys are more vulnerable to stress in early childhood, while girls are more at risk in adolescence, yet both genders appear to cope with stress in the same manner in middle childhood.

1.3 Preventive programmes

Current literature points to the fact that the development of effective prevention programs requires an understanding of the complex etiology of drug and alcohol abuse. This is because initiation into drug and alcohol use results from a complex combination and interaction of many diverse factors sometimes including criminal and domestic violence (Hawkins, Catalano and Miller 1992; Bentler and Newcomb, 1989). Many programmes have been developed in this country and elsewhere to address alcohol and drug dependence. Dusenberg, Khuri and Millan (1992) state that developing effective treatment programmes has been costly, difficult and only moderately successful. The emphasis in most programmes has been placed on efforts to prevent the initiation and early stages of drug and alcohol use amongst children and adolescents. Such programmes include public education campaigns, school based approaches and legislation restricting availability of drugs. However, studies conducted by De Miranda (1987), Botvin and Botvin (1992), Bangert-Drowns (1988), Bruvold and Rundall (1988), Tobler (1986), assessing this kind of preventative approach, show that they have not had a major impact in the reduction of drug use.

The ineffectiveness of the many preventative programmes may be due to the fact that the focus of such programmes is based on the acquisition of knowledge about alcohol and drugs and does not take into account the individual emotional status. Further, they do not address other potential contributing factors to alcohol and drug abuse, such as socio-political factors. Therefore, it seems likely that programmes that address and develop certain life skills such as decision-making, relationships and self-awareness, have the potential for greater success in the prevention of drug and alcohol abuse, because they take into account the environment and its interrelationship with the individual (De Miranda, 1987; Botvin and Botvin, 1992; Bangert-Drowns, 1988; Bruvold and Rundall, 1988 and Tobler, 1986).

The United States of America (USA) and Australia have also experienced an escalation of alcohol and drug abuse with their youth population, and have developed preventive programmes to address the problem.

1.3.1 United State of America

The USA, in particular, has developed numerous preventative programmes. Thompson, Horn, Herting, Eggert (1997) however, note that, in USA, there has been a redefinition and elaboration of the concept of prevention. This redefinition clarifies the differences in orientation to prevention of the various approaches to intervention and goals. Preventive programmes are now classified as follows:

- Universal general prevention programmes. These programmes are directed at school populations including educational media campaigns. These would include radio, films, pamphlets, newspapers, broadcast and television education.

- Selective prevention programmes. These programmes target certain sections of population regarded as high risk for experiencing drug abuse, but who are not yet showing signs and symptoms of drug abuse. These are programmes that target high risk groups, such as children of drug addicts and alcoholics and would include awareness programmes and support services.

- Indicated Prevention Programmes. These programmes target youth who show, or indicate, early signs of drug involvement but are not yet categorised as abusing drugs. These would include life skills training and outpatient programmes by public and private institutions.

Thompson et al. (1997: 20) state, "Programme elements effective for meeting universal prevention goals may be ineffective or inappropriate for selective or indicated preventive interventions. Extant knowledge regarding the complexities of adolescent drug involvement, moreover, suggests that universal, selective and indicated prevention programmes should be multifaceted, addressing a range of adolescent problem behaviours and needs". There are, however, limited research findings on the success of the first two orientations. The Indicated Prevention Programmes are well described in the literature (Thompson et al., 1997).

1.3.1.1 Indicated Prevention Programme (The Personal Growth Class)

The Personal Growth Class (PGC) is a school based Indicated Prevention Programme which is designed by the research staff from the University of Washington for a specific high risk youth population. It was designed to reduce adolescent drug involvement and to increase school performance and emotional well being. Its theoretical framework is grounded in an ecological perspective. Therefore, the PGC's underlying principle is that adolescents' behaviours are shaped and reinforced within and by the environment (Thompson et al., 1997).

The PGC programme is based on the integration of social support and life-skills components:

- The social support component consists of group support, friendship development, teacher-student and peer relationships.
- The Life Skills training component focuses on self-esteem enhancement, decision making, personal control and interpersonal communication training units (Thompson et al, 1997).

The results of this programme show positive indicators of emotional well being from the participating youth. It may be argued that this is as a consequence of its ecological perspective, because it provides appropriate and contextualised support. Further, the findings of the Centre for Substance Abuse Prevention (CSAP), which is a federal programme, has shown from its national research that these programmes can do the following:

- Change youth behavior patterns related to substance abuse.
- Improve parenting skills and family relationships.
- Change individual characteristics, which predict potential for later substance abuse.
- Reduce delinquent behaviors frequently associated with substance abuse and drug related crime.
- Transmit generic Life-skills associated with short-term reductions in substance abuse among adolescents (CSAP national cross-site evaluations: www.samhsa.gov/csap/facts4.htm).

In the USA, the field of prevention seems to have made significant progress because of the Federal Department of Education's resource support to schools with its Safe and Drug Free Schools Programme. The Department aims to support alcohol, drug and violence prevention programmes and to assist in creating and maintaining safe learning environments (Ncadi, National Control Strategy, 1998; Thompson et al., 1997). Similar to the USA's Safe and Drug Free Schools Programme, the South African 2005 Curriculum has a learning area called Life Orientation, which aims to make schools safe and drug free (National Department of Education, 1997).

1.3.2 Australia

Australia, a first world country like the USA, is recognised internationally as a world leader in the drug control field. This is because of its co-ordinated and balanced approach to drug policy, and its achievement in the reduction of drug abuse (Australian report on Cannabis: Ministerial Council on Drug Strategy, 1993).

Australia has a National Drug Strategy (NDE), which was established in 1985 as a co-operative venture between government departments and the non-governmental sectors with the aim to minimise the harmful effects of drugs in its society. An independent Task Force on Evaluation was established in 1985 primarily to evaluate the progress and to make appropriate recommendations related to the NDE goals and strategies (Australian report on Cannabis: Ministerial Council on Drug Strategy, 1993).

The findings from the 1988 and 1991 evaluations of The Planning and Statistics Section: Department of Human Services and Health showed positive results in the areas of policy development and in achieving a broader inter-sectoral approach to drug issues. In addition, the number of relevant programmes and services were increased (Australian Drug Foundation: Statistics on Drug Abuse in Australia, 1994).

For example, community and state based programmes such as awareness and information programmes for young people, teachers and community groups were established (Australian Drug Foundation: Statistics on Drug Abuse in Australia, 1994).

The Australian Drug Foundation believes that there are three components of drug education that must be considered if one wishes to do effective awareness and information programmes:

- Knowledge of basic pharmacology – learners need to understand types of drugs, their compositions, such as chemical properties, actions and side effects, personal metabolism, and that no instance of drug use can be considered entirely safe.
- Development of abilities to act to minimise drug related risks – personal and social skills education should assist learners to develop abilities, such as stress management, and to distinguish between lower and higher risk drug use to minimise related harm in their personal lives and in the community.
- Analysis of public policy issues concerning drugs – learners must be enfranchised as citizens and be given an opportunity to participate in current public debates including the proposals of the programmes.

Drug education, then, will accord with the general role of schools, which is to inform, educate and prepare learners for living in society and for having the capacity to contribute to civil life as a citizen. In this way, drug education will not be about individual preferences but about how societies shape and respond to a serious social problem such as alcohol and drug abuse (Australian Drug Foundation: School based Drug Education; cf. References).

The National Drug Strategy household survey (1993) claims that there were positive changes in alcohol and drug use trends, and positive changes in people's attitudes to alcohol and drug use (Australian Drug Foundation: Statistics on Drug Abuse in Australia, 1994). The Australian findings seem to be consistent with the results of the USA Centre for Substance Abuse Prevention, in that there are positive indicators of emotional well being and a reduction of alcohol and drug abuse. These findings are also consistent with those theorists who believe in a multifaceted approach, if the problem of alcohol and drugs abuse is to be addressed successfully.

The Australian Drug and Alcohol Prevention Policy, which has been developed as part of an overall commitment to the health, safety and welfare of people, recognises "the need for effective and consistent action, while striking a proper balance between work, study, privacy, and concern for the individual" (Policy on alcohol and other drugs December 1997:1).

1.3.3 South Africa

Unlike Australia and America, South Africa is still a developing and transforming country, where progress in health, education and economy was hampered by apartheid. It is only now that a policy of primary prevention of alcohol and drug abuse has been extended to black schools. A National Life Skills Project Committee was formed in 1995. Its members are drawn from the Department of Education and the Department of Health, from the national and provincial levels to work together in the implementation of a Life Skills and HIV\AIDS Education Programme. Other relevant role players at national level, that are involved in Life Skills and HIV\AIDS Programmes, are drawn from non governmental organisations, teacher and student unions, and tertiary institutions. All these role players have been training teachers in the necessary skills and knowledge to do Life Skills education since 1997. By mid 1998, the implementation of a Life Skills Programme, based on experiential learning and alternative facilitation methods, had started in the schools (Nue Comment, 1999). Life Skills Programme is one aspect of the Life Orientation Learning Area of the Curriculum 2005, that will be discussed in the next section.

However, before the existence of this collaborative partnership (government departments, NGOs, etc.), SANCA had already, in 1979, developed a Lifestyle Programme to address alcohol and drug problems in schools.

1.3.3.1 SANCA's Lifestyle Programme

The SANCA Lifestyle Education Programme is an alcoholism and drug dependence preventative programme, available in South Africa. The motivation for Lifestyle education is based on two basic premises:

- The first premise is that our modern society condones and encourages alcohol and drug use. Therefore, every child today, at some point, will be faced with the question, "Am I going to use chemicals (alcohol or drugs), and if so, how, why, and what part will this behavior play in my lifestyle?" Excessive or inappropriate use of chemicals is often the result of insufficient information, lack of guidance, thought, and decision-making (SANCA Induction Manual, 1999). This approach is based on the assumption that drug abuse is the result of an irrational decision, and that individuals who choose to use drugs do so because they are unaware of the dangers of drug use. Therefore, once adolescents are given appropriate information, they will make a rational and well-informed decision not to use drugs (Botvin and Botvin 1992; SANCA publication leaflet, undated).

- The second is that much deviant and non-coping behaviour in adolescence, and in later life, is symptomatic of deeper underlying emotional problems. This is particularly so in the case of alcohol and drug abuse and dependence. Here, the problem is not the chemical alone but also the stress and anxiety within the person that makes him or her need the effect that alcohol or drugs can provide. This, therefore, suggests that a Lifestyle Programme that attempts to promote emotional development and feelings of self-esteem, is addressing the underlying problem.

The SANCA Lifestyle Programme emanates from an ecological perspective that emphasises the bond between the environment and the individual. SANCA states that in order to prevent drug and alcohol abuse, particularly in the adolescent population, it is important to create a programme that provides guidance in the acquisition of an internalised set of values, an ability to cope emotionally with the environment and in the enhancement of self-discipline (SANCA publication leaflet, undated).

1.3.3.2 Theoretical Underpinnings of the SANCA Lifestyle Programme

The SANCA Lifestyle Programme is based on Erikson's psychosocial theory of child development, which has a strong ecological perspective. Erikson's psychosocial theory of development is a stage theory that postulates that each stage of an individual's life is an adaptation of the maturing physiological and psychological individual to his particular society. These stages are the stages of the development of the ego. Erikson argues that there is a sense of self in relationship to a sense of social reality. This is similar to the ecological perspective that asserts that an individual should be viewed from an intra-personal, inter-personal and socio-economic perspective, all of which impinge and affect each other (Erikson, 1968).

According to Erikson, each stage has a central crisis, and the task of that phase is the resolution of that stage. However, Erikson did not believe that once a stage is passed that particular area of development is necessarily resolved. He believed that growth is sequential, and unresolved conflicts can be negotiated in later stages. Moreover, he saw development as an ongoing and continuous process throughout life. This is accepted as an important principle in the Lifestyle Programme that aims to help adolescents continuously to cope with physical, cognitive and social changes, and with the unresolved conflicts from previous stages (Erikson, 1968). The target population of the Lifestyle Programme is children in the pre-adolescence and adolescence stage who are still in the process of growing up.

According to Erikson's theory, Identity versus Identity Diffusion is the critical stage for adolescence. All adolescents are concerned about establishing their identity. They need to clarify who they are biologically and socially, and, as a result, they sometimes become preoccupied with themselves and how they appear to others. The potential crisis of this stage is identity diffusion. Adolescents can feel diffused when they have to contend with physical changes and social changes such as personal and social expectations and choices.

As pointed out in the preceding paragraph, the Lifestyle Programme acknowledges the dynamics of adjustment of this stage and considers it important to help adolescents to c[illegible] the physical, cognitive and social changes they are encountering.

Erikson's theory is based on the principle that "given a reasonable amount of guidance, a healthy child can be expected to follow specific inner rules of psychosocial development" (1963: 93). This principle is taken into account in the Lifestyle Programme. This programme focuses on pre-adolescents and adolescents' s psychosocial development. It concentrates on the positive development of aspects such as self-esteem, value clarification, decision making and it appears to offer the most constructive long term primary prevention strategy (De Miranda, 1987).

De Miranda's research has shown that drug and alcohol awareness and information alone will not necessarily make up primary prevention. "Awareness and information at its best will improve basic knowledge of the child, but will not automatically lead to the changes of attitudes and behavior so necessary to prevent the negative and destructive lifestyles of drug abuse" (De Miranda, 1987; 58). Primary prevention must, in addition, concentrate on the positive development of aspects such as self-esteem, value clarification, relationships etc., which can achieve attitudinal and constructive behavioural changes (De Miranda, 1987).

This is supported by reviews of other prevention research literature (Botvin and Botvin, 1992, Bangert-Drowns, 1988; Bruvold and Rundall, 1988; Tobler, 1986). These reviews indicate that drug abuse prevention programmes, which only involve the dissemination of information concerning the danger to health and its social and legal consequences of use, are ineffective. However, according to Botvin and Botvin, (1992); Bangert-Drowns, (1988); Bruvold and Rundall, (1988) and Tobler, (1986), the most promising approaches are those that target the psychosocial (such as, individual, family, community) determinants of drug and alcohol abuse. Furthermore, many researchers such as Du Paul and Eckert and those working in schools and mental health centres, argue that, to understand drug and alcohol related behaviour, it is necessary to understand the context of its origins as well as its relationship to biological, psychological and social factors (Du Paul and Eckert, 1994; Gresham 1994; Schinke, 1994).

1.3.3.3 Curriculum 2005: (Life Orientation vs Lifestyle Programme)

"Outcome Based Education (OBE) is a particular approach to education driving the curriculum in many countries at the moment including South Africa" (Malcolm, undated:1). Its motivation and practice differs from one country to the other as decided by various governments.

In South Africa, OBE is a new curriculum and, just like the new constitution, it can be regarded as embodying the most progressive and enlightened principles in the world. OBE fosters an approach to learning that encompasses a culture of human rights, multiculturalism and the sensitivity to the values of reconciliation and nation building. Its origins are from the labour movement (COSATU), and it encourages the recognition of skills from informal settings and the recognition of prior learning (National Department of Education, 1997 cited by unpublished notes Snell 1998).

OBE is also a management system that shifts its emphasis from "Traditional OBE" (syllabus which is content based and broken down into subjects, timetables, rote learning) to "Transformation OBE" (active learning). "It is 'learner centred' aimed at national development through individual and community development, where every student in a class learns something new everyday; where learning results in students changing the way they understand and act in the world around them" (Malcolm, undated:3).

OBE has eight Learning Areas e.g. Human and Social Sciences, Economic and Management Sciences, Technology etc. The Lifestyle Programme falls within the Life Orientation Learning Area, Life Orientation encourages:

- "an understanding of the uniqueness of the individual
- the intricacies of human relationships;
- and the interdependence of political and economic facets of communities and countries" (Life Orientation, January 1999:10).

Similar to the Lifestyle Programme, Life Orientation attempts to consider the complex integration of the individual within his or her social contexts. It therefore aims to achieve positive values, attitudes, behaviors and skills in the individual and the community. It also promotes the achievement of individual learners' potential by strengthening and integrating their self concept, capacity to develop healthy relationships and ability to make informed decisions (Life Orientation, January 1999).

It can be argued that OBE, Life Orientation Learning Area and the Lifestyle Programmes focus on very similar objectives and, therefore, could complement each other.

1.4. SANCA

1.4.1 Historical Background

SANCA was established in 1954. Immediately after its establishment a committee to investigate how other countries tackled drug and alcohol problems was formed. After the committee tabled its finding the first patient service was started in 1964, through a bi-weekly evening consultancy treatment service. By 1968, the outpatient clinical service was operating in the afternoons for 2 hours per day. There was, however, a growing concern with the escalating youth drug problem, and the then mayor of Johannesburg, Councillor A Widman, formed a Drug Action Committee in 1970 (SANCA Induction Manual, 1999).

In December 1972, Dr Boris Serebo, a medical practitioner, well known for his work in the field of Alcoholism, donated his established Alcohol Treatment Clinic to SANCA Johannesburg. As a result, on 27 December 1972, a Johannesburg daily outpatient clinic was established. In September 1977, the SANCA Johannesburg Outpatient Clinic became the first and only outpatient clinic registered under the drug rehabilitation legislation.

In August 1980, the SANCA Johannesburg Treatment Centre was opened, providing an outpatient programme similar to that offered by the Johannesburg Clinic (SANCA Induction Manual, 1999).

1.4.2 Service Provision

Since its inception, SANCA has developed five treatment centres to tackle the abuse of drugs and alcohol in South Africa. The programmes are offered by the Sylvian de Miranda Outpatient Clinic, Phoenix House Inpatient Treatment Centre, Soweto Outpatient Clinic, Soweto Day Care Centre and Centre for Alcohol and Drug studies (SANCA Induction Manual, 1999).

The Sylvian De Miranda Outpatient Clinic, which is sometimes referred to as the SANCA Johannesburg Clinic, provides a unique programme designed to treat alcohol and drug dependants of all race groups on an outpatient basis. The treatment programme also assesses clients who require admission into the Phoenix House programme (SANCA Induction Manual, 1999).

The Phoenix House Inpatient Treatment Centre only caters for young alcohol and drug dependants. It is run as a therapeutic community programme with intensive individual and group therapy. It also provides aftercare service for patients who have completed treatment. The aftercare service includes counselling and advice for families of alcohol or drug dependants or drug experimenters (SANCA Induction Manual, 1999).

The Soweto Outpatient Programme caters mainly for alcohol dependants from the Soweto area on an outpatient basis.

The Soweto Day Care Centre Programme provides treatment, supervision, schooling and food to young black children who have experimented with alcohol and or drugs and are school truants (SANCA Induction Manual, 1999).

The Centre for Alcohol and Drug Studies Programme is the information, education, training and prevention arm of SANCA Johannesburg. It is responsible for training and giving information to all professionals and para-professionals involved in drug and alcohol prevention programmes. One of its important programme is called "Lifestyle Education".

The Lifestyle Education Programme was designed to prevent abuse of alcohol and drugs among school children by teaching them values, communication, relationships, self-esteem, self-awareness, understanding of feelings, etc. (SANCA Induction Manual, 1999). The Lifestyle Programme is conducted mainly by trained volunteer workers, intern psychologists and fourth year social work students and SANCA social workers.

1.4.3 The Development of SANCA Lifestyle Programme

The SANCA's Lifestyle Programme is mainly conducted in schools. The rationale for this is, schools are the major social institution for children where children at risk can be addressed. Its focus is preventative rather than remedial. The first trial of the Lifestyle Programme was conducted in 1979 with five Grade 10 classes from White private schools. As a result of the trial project, a more comprehensive programme was developed in 1982 and implemented in 1983. Volunteer workers were drawn from social work students from Rand Afrikaans University, University of the Witwatersrand and the University of South Africa, as well as white housewives from the middle and upper middle class. The housewives were selected through a screening process that included interviews to assess their suitability for facilitating SANCA Lifestyle Programme with pre-adolescents and adolescents at schools. All the volunteers were trained in the Lifestyle Programme.

There is a lack of published material on the evaluation of the Lifestyle Programme. However, anecdotal data from SANCA's past and present staff members indicate that the Lifestyle Education Programme has positive effects on the learners and their attitude towards alcohol and drugs. However, any anecdotal data should be regarded with caution as it may be biased. The one research study done in 1985 had a number of sample limitations (these are explained in the next section).

It is therefore, the aim of this study to critically evaluate SANCA's Lifestyle Education Programme in two Soweto schools. However, due to the limited scope of this study and the time constraints, it was not possible to do an evaluation of the whole programme. Thus this project aims to evaluate the results of the Lifestyle Programme on the learners with regard to their psychosocial functioning and their knowledge of alcohol and drugs.

CHAPTER 2-THE STUDY

2.1. Rationale for study

Preventative programmes such as the SANCA's Lifestyle Programme need constant evaluation to determine their continued effectiveness in relation to set objectives. There has however, been a lack of follow-up research studies on this programme other than anecdotal data from field workers. Snipelepsky (1985), a Master's student from the University of the Witwatersrand investigated the "Implementation of a Mental Health Primary Prevention Programme in Selected Schools" as part of an evaluation process of the Lifestyle Programme. Her findings indicated that there were significant changes in the components of self-confidence, self-esteem and self-control in certain groups of learners in the sample. In the post-test phase a decline in the negative attitudes towards adults among the Grade 8 learners was noted. However, there were no significant changes in other components, such as family influences, personal freedom etc.

Snipelepsky's study was conducted 14 years ago, and it is likely that these findings are outdated. While Snipelepsky's study is valuable in terms of what has been discussed above, it is important to note that the sample was made-up of exclusively white high school learners from the middle and upper socio-economic classes. Therefore, these results cannot be generalised to the entire South African youth population.

The current study therefore investigates the relevance of this programme for a black population in two Soweto schools. The study will assess the effectiveness of the SANCA Lifestyle Programme for Grade 6 and 7 learners only.

2.2 The aim of the present study[2]

The study evaluates the effectiveness of the SANCA Lifestyle Programme in two Soweto public schools for Grade 6 and 7 black learners. The focus of the study is to determine the extent to which learners in the adolescence stages changed with respect to their psychosocial functioning as a result of the Lifestyle Programme. The study also investigates Grade 6 and 7 learners' knowledge of drugs and alcohol, as well as the appropriateness of Lifestyle Programme in its present form for black learners.

The aims of the study are:

1. To assess the working knowledge of drug and alcohol use, before and after the implementation of a school based Lifestyle Programme, in a sample of early adolescents (10-13 years), and of adolescents (14-18 years) learners.
2. To determine whether there was any difference between self-image of boys and girls before and after the implementation of the programme.
3. To determine the extent to which learners in early adolescence and adolescence changed with respect to psychosocial functioning in terms of the programme.
4. To determine if there was a link between the socio-economic status of the family and the learners' self-image.
5. To determine the appropriateness of the programme in its present form for black learners.

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[2] *Permission to do the study in both schools was granted by the Principals of each school, and the parents' approval was obtained.*

2.3. Research Methodology

2.3.1 Research context

This study was undertaken in Soweto. Soweto is one of South Africa's largest African townships. According to the Sunday Times' City Metro Newspaper (14\11\99), the National census report of 1996 stated that Soweto had, at that time, a population of about 1,029 million. The majority of its population is working class. However, Soweto has a wide range of socio-economic levels, from the extremely poor to the extremely rich resulting in income levels that are extremely diverse. However, the greater proportion of this population can be classified as unemployed and working class. It is reported that one in three Soweto households has a total household income of less than R1000 a month and just under six in ten households have an income of less than R1500. At the time of the survey, Soweto's middle class was estimated to be 15,4% of all households with a total monthly household income above R3000. It is also reported that about 80% of people living in informal settlements and hostels in and around Soweto have a total income of less than R1000 (Morris, 1999; Sunday Times' City Metro Newspaper, 1999).

Estimates by Statistics South Africa (1998) of educational status, shows that approximately 10% of adults in Soweto have no formal education while 25% have reached Grade 6 level. This suggests that 70% of the general population of Soweto have basic literacy skills, at least at functional literacy level. The same report states that most households are made up of nuclear families consisting of parents and children (45,5%). "Single mothers and children make up to 10,5 percent, single mothers with children and grandchildren make up 7,3% and households of three generations make up 5,3%" (Sunday Times, City Metro 1999:2). In addition, 43.07% of individuals are content with Soweto as a place to live, and would recommend it to others (67.07%) (Sunday Times' City Metro Newspaper, 1999).

2.4 Sample

Convenience sampling was used to select participants for the evaluation study. " In convenience sampling, the investigator merely chooses the nearest persons as respondents. What is lost in sampling accuracy is saved in time and money" (Bailey, 1982:97). It was convenient for the researcher to access this research setting and the participants. Thus the two schools closest to SANCA, Soweto branch, were selected for the study. Both schools are only one kilometre away from Soweto SANCA.

The sample consisted of learners in Grade 6 and 7 from two Soweto Township Primary schools. The sample consisted of 260 learners. The ages of the learners ranged from 10 years to 18 years. School A is situated in White City Township and is approximately 40 kilometres from the Johannesburg Central Business District (CBD). School B is situated at Mofolo Township approximately 38 kilometres from the Johannesburg CBD. The sample was made-up of 158 learners from School A and 102 learners from School B. These learners came from a mixture of socio-economic backgrounds, mainly the lower and middle-income brackets. The schools were in a mixed socio-economic environment. Table 2.4.1 gives the age and gender of the sample before and after the implementation of the SANCA Lifestyle Programme.

Table 2.4.1 Age and Gender of sample

	Before the Lifestyle Programme			After the Lifestyle Programme	
Variable	Category	Frequency	%	Frequency	%
Age	10-13 years	160	61.8	140	58.33
	14-18 years	100	38.2	104	42.60
Gender	Male	143	55	136	55.73
	Female	117	45	108	44.26

As indicated in the Table above, over half the sample consisted of pre-adolescents between the ages of 10-13 years. The total sample consisted of 55% males and 45% females. The sample size decreased from 260 to 244 at post programme testing because sixteen participants dropped out, They could not attend the Lifestyle Programme classes

which were conducted after school had finished. Three learners who attended all the sessions were absent from school when the post testing was done.

2.5 Instruments

The research instruments for the evaluation study consisted of five questionnaires:

- A biographical questionnaire,
- A drug and alcohol assessment questionnaire
- The Psychosocial Functioning Inventory for Primary School Children (PFI-PRIM-C)
- A programme evaluation questionnaire for the participants
- A programme evaluation questionnaire for the Lifestyle facilitators

The three questionnaires (biographical questionnaire, drug and alcohol assessment questionnaire and PFI-PRIM-C) were piloted before the pre-test phase in a sample of learners who were not participants in this study. The exercise was carried out to assess the accessibility of and participant responsiveness to the questionnaires. The results indicated a need for specific changes to simplify the language in the biographical and alcohol and drug questionnaires in order to make these instruments accessible to the target sample.

2.5.1 Biographical questionnaire

The biographical questionnaire was an adaptation of a tool used by Masukhu (1997) in a research project for the Department of Community Psychology at the University of Witwatersrand[3]. The aim of this questionnaire is to gather background information of the sample groups. This information includes household characteristics such as number of people living at home, family structure and types of employment done by family members.

[3] *Permission to use the questionnaire was granted by Masukhu whose research project's topic is Witkoppen Clinic: Kwena-Molapo Community Project.*

2.5.2 Alcohol and drug assessment questionnaire

An alcohol and drug assessment questionnaire was adapted from a J.C.E. project[4]. This questionnaire evaluated the extent of the information learners have on drugs and alcohol.

The questionnaire includes questions about the types of diseases caused by smoking and some of the signs that indicate if someone is on drugs, etc. Learners have to choose the right answer/s from those listed (cf. Appendix 1).

2.5.3 Psychosocial Functioning Inventory for Primary School Children (PFI-PRIM-C), 1997

The PFI-PRIM-C is a standardised questionnaire compiled by Perspective Training College (Pretoria) for primary school children. It is designed to measure problems in self-image, relationships with peers and family, and anxieties that children experience in personal and social functioning. It is known to be a useful assessment scale for those who wish to do intervention from an ecological perspective. As with the ecological model, the rationale behind the PFI-PRIM-C postulates that "social functioning is a dynamic concept that changes from day to day depending on the circumstances", (Faul, Hanekom, Niekerk, 1997: 5). Therefore, the PFI-PRIM-C is not a personality inventory designed to evaluate psychopathology but it is specifically constructed to measure psychosocial functioning. This questionnaire is selected as it is relevant for primary school children.

The PFI-PRIM-C is a three-point scale. Participants have to answer, always; never and sometimes. It has 98 items, which are designed to produce 16 different sub-scales namely *perseverance, satisfaction, future expectations, self-image, other's happiness, frustration, anxiety, attitudes towards adults, family problems* etc. This scale was validated with a convenience sample of 430 primary school learners.

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[4] *Permission to use the questionnaire was granted by the supervisor (Snell) of the Johannesburg College of Education (J.C.E.) project. The topic of the project is a Study on Drug Abuse and Misuse in South Africa.*

The reliability of the different sub-scales range between 0.60 and 0.89 with a standard error of measurement between 0.6 and 2.0. The scale categorises children cli ' ally into four categories, namely (a) no clinical problem, (b) uncertain (c) clinical problem, (d) severe clinical problem.

(a) No clinical problem indicates that, in the measured area, the child does n t have a problem that justifies clinical intervention.

(b) Uncertain area indicates that it is unclear if there is a clinical problem that justifies therapeutic intervention. Additional information is needed to decide whether the child falls in the no clinical problem area or the clinical problem area.

(c) Clinical problem indicates that there is reliable evidence that the child has a clinical problem that justifies therapeutic intervention in the area being measured.

(d) Severe clinical problem indicates that there is reliable evidence that the child has a clinical problem that justifies therapeutic intervention in the area being measured and, which is so severe that a distinct possibility exists that the child may attempt violence against himself or herself, or others.

2.5.4 Evaluation questionnaire for the learners

An evaluation questionnaire specifically devised by the researcher was administered to evaluate the learners' perceptions of the group process, the facilitators and certain aspects of the Lifestyle Programme. Aspects of the Lifestyle Programme evaluated were self-awareness, relationships, decision making etc.

The responses were scored on a three-point scale: yes, always; sometimes; no, never. The questionnaire includes questions such as: Did your group work well all the time? Did you like being in your group? Did each member get enough chance to participate? Did your facilitator help each member to participate (talk)? Did your facilitator listen to all members of the group? Were the topics relevant to you? Can you take independent decisions about using drugs and alcohol?

2.5.5 Evaluation questionnaire for the facilitators

The questionnaire was open-ended and designed by the researcher to evaluate the facilitators' perceptions of their groups and the Lifestyle Programme. This evaluation questionnaire for the facilitators was administered at the end of the Lifestyle Programme. Some of the questions asked were: How did your group work? What were the positive and negative aspects of your group? To what extent do you think individuals in your group

manifested drugs or alcohol problems? Do you think the topics were appropriate for Soweto children? Are there any topics you would like to discard? Give reasons why you would exclude some topics. In terms of your experience what recommendations would you make for a future programme?

2.6 Procedure

Access to the schools was negotiated with the school principals by the researcher. Since the participants in this study were minors, informed consent was obtained from their parents. Meetings for parents and teachers were held at each school, to discuss the aims and rationale of the Lifestyle Programme. All the prospective participants were also fully informed about the nature and purpose of this investigation a week before it took place.

Three phases were designed to ensure the effective implementation of research instruments.

2.6.1 Phase 1 (Pre-test)

The researcher and a social worker from SANCA administered the three instruments (biographical, alcohol and drugs questionnaires and the psychosocial functioning scale) to both Grade 6 and 7 participants prior to conducting the training programme. The sample of 260 was broken down into 8 groups of 31-32 learners seen over two days. The instructions were given in a vernacular language to ensure full comprehension and learner participation.

A register of the sample was maintained to check the attendance of all participants to the programme. The attendance was good (90.3%).

2.6.2 Phase 2 (Treatment)

This phase comprised the implementation of the Lifestyle Programme. In this phase the Researcher, 4 SANCA Social Workers, and an Intern Social Worker from University of South Africa conducted the SANCA Lifestyle Programme with the participants.

The programme providers had been trained by their training university institutions to facilitate the Lifestyle Programme Two social workers, who were employed at SANCA in 1998, had also received extra Lifestyle Programme training from the SANCA Educational Psychologist, who co-ordinates the Lifestyle training.

To ensure the consistency of presentation, meetings with the facilitators were held once a week before each session to discuss the content and the method of presentation. After each session there was feedback and discussions with facilitators.

A maximum of seventeen children was allocated to each facilitator. A register was marked in every session so as to monitor the learners who participated in each session. The programme was a structured chain of twelve-one-hour sessions covering the following topics: self-image, self-awareness, sexuality education, relationships, communication, alcohol and drugs, decision-making and value clarification.

In the twelfth session there was an evaluation response sheet that was administered to and completed by the learners. This questionnaire evaluated learners' perceptions of the group process, the facilitators and selected topics of the Lifestyle Programme. The facilitators were also asked to complete an evaluation of their groups and make recommendations for a future programme.

This study was executed during a cleaning period in one school, and after school hours at the other. Neither school has a guidance period. This made it difficult to maintain consistent attendance by participants. However, despite these disruptions, it was possible to fulfill the requirements of the study.

2.6.3 Phase 3 (Post-test)

Four months later a post test procedure was done, using the same instruments as in Phase 1 but excluding the biographical questionnaire. The aim of this was to assess the extent of the programme's impact on the children's self-image, attitudes towards adults and knowledge of drugs and alcohol.

2.7 Research Design

Most of the variables dealt with in this study were categorical and, as such, techniques based on the discrete data analysis were used. In particular, the Chi-squared analysis was performed on two-way cross-classified tables. The data was analysed at the University of the Witwatersrand using a statistical package called SAS 6.12.

Statistical design used a 0.05% confidence level to determine significant differences between the various factors analysed.

2.8 Statistical Analysis Data

The analysis of research findings was done in two parts,

(a) Descriptive analysis, which involved assessment of data in terms of proportions and percentages. Frequencies and their corresponding percentages were tabulated for each group.

(b) Statistical inference based on the Chi-squared analysis of contingency tables. Inter-group comparisons on quantitative data were carried out via Chi-square analysis.

In order to address the aims of the study, the responses are grouped in specific categories (cf. Appendices) for Table presentation. The comparisons of males vs. females, 10-13 year olds vs.14-18 year olds, pre-test vs. post-test on the PFI-PRIM-C and an alcohol and drug assessment questionnaire, before and after the implementation of the Lifestyle Programme, are presented in Chi-square Summary Tables (cf. Appendices). In the multiple-choice answers on the PRIM-C, a biographical questionnaire and a programme evaluation questionnaire, the results were presented as a percentage of the total number of participant responses (cf. Appendix 2a-3). Where more than one response was possible the percentage was derived from each category for age and gender separately (cf. Appendix1a-1e).

CHAPTER 3 - RESULTS

3.1 Introduction

The results of this study are presented in five sections. The first section presents the obtained biographical data on the sample. The second section examines the psychosocial functioning status of the participants of this study. The third section details the knowledge of the participants about toxic substances. The fourth section describes the evaluation of the Lifestyle Intervention Programme. This section is divided into three parts, namely: perceptions of the sample about the group process; perceptions of the facilitators and the evaluation of the different topics of the Lifestyle Programme. The fifth section examines the facilitators' perceptions about the implementation of the Lifestyle Programme in black schools. Throughout the presentation of the results, comparisons are made between the responses of two age groups, the 10-13 year olds and the 14-18 year-olds from the sample. The responses of these two groups in the period **before** the SANCA Lifestyle Intervention Programme and the period **after** the intervention programme are compared. Similarly, comparisons are made between the responses of the male and female participants. This was done for both the period **preceding** the implementation of the SANCA Lifestyle Programme, and the period **after** the programme was implemented.

3.2 Biographical Information

3.2.1. The Sample

Table 3.2.1.1 Household Size

Variable	1-6 people		7-12 people		More than 12 people	
	No.	%	N	%	N	%
Total No. of learners	148	57.36	101	39.15	9	3.49
Total participant responses - 258 out of a total sample of 260.						

The results showed that more than half (57.36%) of the sample lived with no more than 6 people at home. More than a third (39.15%) of the sample lived with 7-12 people per house and only 3.49% lived with more than 12 people. Therefore, most of the sample lived in homes with up to six persons. These results are similar to the general pattern of Soweto household size as described in Chapter 2.

Table 3.2.1.2 Family Structure

Variable	Single parent		Nuclear family		Extended family		Relatives	
	N	%	N	%	N	%	N	%
Total no. of learners	26	10.24	81	31.89	128	50.39	19	7.48
Total participant responses – 254 out of a total sample of 260								

The results showed that half (50.39%) of the sample came from extended families. A third (31.89%) came from nuclear families and a minority of the sample (10.24%) stayed with a single parent. It was noted that most children lived with their extended families. The percentage for the nuclear family is somewhat lower than that reported in the Soweto survey described in Chapter 2. This difference could relate to this specific sample only, but further investigation would be necessary to substantiate the reasons for this difference, which was beyond the scope of the present study. It is important however to

note the extent of the differences in family structure between this sample and the Soweto survey.

Table 3.2.1.3 Employment Status

Variable	White collar job		Blue collar job		White and blue collar jobs		Pension\ welfare		I don't know	
	N	%	N	%	N	%	N	%	N	%
Total no of learners	12	5.53	122	56.22	18	8.29	24	11.06	41	18.89
Total participant responses – 217 out of a total sample of 260										

In this study, it was found that more than half (56.22%) of the sample came from families where all the family members were in blue-collar employment, while 8.29% came from families with members in either blue-collar or white-collar employment. Thus about 65% of the sample was gainfully employed. The rest of the sample (11.06%) came from families that depend entirely for their income on disability grants or pensions, or (5.53%) ...milies in white-collar employment. However, 18.89% of participants had no knowledge of the category of employment of their family members. Thus, though they were employed, it was impossible to state whether they were in blue-collar or white-collar employment. However, if this percentage was added to the estimated 65% of the sample in some form of mainly blue-collar employment, the result is consistent with the overall findings of the Soweto survey (Morris, 1998; Sunday Times' City Metro, 1999) that asserts that the majority of Soweto inhabitants are working class.

In summary, more than half of the sample lived with six or less people, were from extended families and had family members in blue-collar employment.

3.3 Psychosocial Functioning Status

The participants were assessed on the Primary Functioning Inventory for Primary School Children (PFI –PRIM-C) that assesses the psychosocial functioning of children. A description of each sub-test is presented in Appendix 4.

The pre-test and post-test results were compared in respect of the two age groups and gender.

3.3.1. Primary Functioning Inventory for Primary School Children Results

The sub-tests, which form clusters of compatible information, were grouped together for the purpose of presentation. The first cluster is:

Cluster 1: 'Satisfaction', 'Problems with Friends' and 'Problems with the Father' sub-scales.

In terms of the total sample, on all three of these measured sub-scales, there was no significant difference between pre-test and post-test results. Therefore, the Lifestyle Programme produced no change in these three sub-scales. The 'Satisfaction' sub-scale measures problems that the child may have with regard to the way he or she perceives his or her life. The 'Problems with Friends' sub-scale measures the problems that the child may have with regard to his or her friends. Lastly, the 'Problems with the Father' sub-scale measures the problems that the child may have with regard to his or her father.

In the pre-test results, the majority of participants were rated as having no clinical problems on these three sub-scales, and the same results were obtained after the intervention programme. Thus the Lifestyle Programme made no difference to the sample with regard to the three measured sub-scales (cf. Appendix 2a).

Cluster 2: 'Self-image', 'Others Happiness' and 'Memory' sub-scales

The next cluster consisted of the sub-tests of 'Self-image' which measure the problems that the child may have with regard to his or her self-image. 'Others Happiness' measures the responsibility that the child may have in making other people happy and 'Memory' measures the problems that the child may have in remembering basic things.

Total sample

From this cluster, in terms of the total sample the results indicated a significant difference from the pre to post-test results on the 'Self-image' sub-scale.

Sub-test	*Group*	X^2	*P-value*
'Self-image'	*10-13 year old males*	*13.356*	*p<0.004*
	10-13 year old females	*40.982*	*p<0.001*
	14-18 year old males	*21.606*	*p<0.001*
	14-18 year old females	*21.714*	*p<0.001*

The most significant result for the total sample was on the 'Others Happiness' sub-scale.

Sub-test	*Group*	X^2	*P-value*
'Others Happiness'	*10-13 year old males*	*48.860*	*p<0.001*
	10-13 year old females	*62.661*	*p<0.001*
	14-18 year old males	*42.504*	*p<0.001*
	14-18 year old females	*15.662*	*p<0.001*

On the 'Memory' sub-scale a significant difference was found for all the learners.

Sub-test	*Group*	X^2	*P-value*
'Memory'	*10-13 year old males*	*9.083*	*p<0.028*
	10-13 year old females	*11.765*	*p<0.008*
	14-18 year old males	*9.595*	*p<0.048*
	14-18 year old females	*7.427*	*p<0.059*

This means that significant improvement was achieved on all three of these areas of psychosocial functioning.

Before the Lifestyle Programme more than 60% learners were rated by the PFI-PRIM-C as having clinical to severe clinical problems in these areas (cf. Appendix 2b). This suggests that learners had low self-image, felt responsible for making other people happy and were unable to remember basic things. The Lifestyle Programme, therefore, made improvement on Grade 6 and 7 learners as reflected by the results obtained from this cluster (cf. Appendix 2b).

Age and Gender Difference

When the results were analysed in terms of age groups and gender groups, the results showed no significant age or sex differences. In terms of aim 2 of this study, which sought to determine whether there was any difference between the self- images of boys and girls and between the two age groups, before and after the implementation of the programme, it was demonstrated that difficulties of self-image pertained equally to boys and girls, and to both age groups.

Cluster 3: 'Helplessness' and 'Family Problems' sub-scales

Total sample

Cluster 3 consisted of only the sub-scales of 'Helplessness' and 'Family Problems'. The 'Helplessness' sub-scale measures the feelings of the child with regard to the exhaustion of his coping abilities and the helplessness he may feel to do something about his life situation" (Faul and Hanekom, 1997: 13). The results on the 'Helplessness' sub-scale indicated that all males, irrespective of age, showed significant gains in the reduction of their feelings of helplessness after the programme. There was no significant difference amongst female groups on this sub-scale.

Sub-test	*Group*	X^2	*P-value*
'Helplessness'	*10-13 year old males*	*11.170*	*p<0.011*
	14-18 year old males	*10.068*	*p<0.018*

On the other hand, with regard to the 'Family Problems' sub-scale, which measures the problems the child may have in his family relationships, the results showed a significant impact for only the 14-18 year old males and no significant impact on the other learners. This suggests that with regard to the measured status of family problems the Lifestyle Programme was beneficial only for the adolescent males in the age range of 14-18 years old.

Sub-test	*Group*	X^2	*P-value*
Family Problems	*14-18 year old males*	*11.192*	*p<0.011*

These results suggest that with regard to the 'Helplessness' sub-scale, the Lifestyle Programme was appropriate for the needs of males but this did not hold true for the

females. The results indicated that the females remained with the same level of feelings of helplessness in coping with the environment. It is important to note that, in this cluster, more than half of the participants showed no clinical problem on the 'Helplessness' sub-scale before the implementation of the Lifestyle Programme (cf. Appendix 2c). This suggests that half learners felt that they had the ability to do something positive about their lives. However, for the other half of the sample, the programme was of no benefit to them in this area, but males benefited from the programme.

Though there was a significant improvement for the 14-18 year old males on the 'Family Problems' sub-scale, most learners showed no clinical problems either before or after the implementation of the programme. This suggests that the participants of the sample have good relationships with their family members. This confirmed the stability of the home environment before and over the period of the intervention programme.

Age and Gender Difference

On this cluster of sub-tests there were no significant differences between the age groups or gender groups.

In summary, the overall results from these two sub-scales showed significant improvement on the 'Helplessness' sub-scale for all males. A significant improvement for the 14-18 year old males on the 'Family Problems' sub-scale was also indicated (cf. Appendix 2c).

Cluster 4: 'Perseverance' and 'Future Perspective' sub-scales

Total sample

From this cluster, the results showed that the Lifestyle Programme was more effective for females in the age range of 10-13 years with regards to the 'Perseverance' sub-scale that measures the ability of the child to act with determination. The results indicated that pre-adolescent females persevered more than the older female group and all the males.

However, neither age group nor gender group showed clinical problems in this aspect in either the pre-test or the post-test.

Sub-test	*Group*	X^2	*P-value*
'Perseverance'	*10-13 year old females*	*4.853*	*p<0.028*

With regard to the 'Future Perspective' sub-scale, that measures the learners orientation towards future, the programme was effective for only the adolescent male group.

Sub-test	*Group*	X^2	*P-value*
'Future Perspective'	*14-18 years old males*	*13.535*	*p<0.019*

Age and Gender difference

No age or gender significant differences were demonstrated (cf. Appendix 2d).

In summary, the overall results on these two sub-scales showed significant improvements for adolescent males on the 'Future Perspective' sub-scale and for the 10-13 year old female participants on the 'Perseverance' sub-scale. While the overwhelming majority (93.33%) of the learners were categorised by the PFI-PRIM-C as having no clinical problems on these two sub-scales, there was a significant improvement in the two identified groups.

Cluster 5: 'Anxiety' and 'Frustration' sub-scales

The 'Anxiety' sub-scale measures "the feelings of insecurity and fear that the child may experience", while the 'Frustration' sub-scale measures "the reaction of the child to the problems in him or herself and in his or her environment that prevents him or her from achieving his or her goals and desires in life" (Faul and Hanekom, 1997: 13).

Total sample

In terms of the total sample, the Lifestyle Programme showed significant results for all the learners in this cluster except for the 14-18 year old females who did not benefit from the programme on the 'Anxiety' sub-scale. The 14-18 year old females remained anxious. It is important to note that before the implementation of the programme boys were identified as more anxious than girls.

Sub-test	*Group*	X^2	*P-value*
'Frustration'	*10-13 year old males*	*12.593*	*p<0.006*
	10-13 year old females	*11.974*	*p<0.007*
	14-18 year old males	*20.974*	*p<0.001*
	14-18 year old females	*15.079*	*p<0.001*
'Anxiety'	*10-13 year old males*	*47.225*	*p<0.001*
	10-13 year old females	*27.197*	*p<0.001*
	14-18 year old males	*47.225*	*p<0.001*
	14-18 year old females	*43.389*	*p<0.084*

Age and Gender Differences

In this cluster, before the implementation of the programme, there were significant differences across gender on the 'Anxiety' sub-scale but not for the 'Frustration' sub-scale; and significant differences across age on the 'Frustration' sub-scale but not for the 'Anxiety' sub-scale.

Sub-test	*Group*	X^2	*P-value*
'Anxiety'	*males and females*	*20.006*	*p<0.001*

The males in this sample were more anxious than females as assessed in this area by the PFI-PRIM-C in the pre-test period (cf. Appendix 2e). After the Lifestyle Programme there was no significant gender difference on the 'Anxiety' sub-scale. Both males and females appeared to experience the same anxiety levels. This suggests that both age groups appeared to experience the same anxiety level. However, it is important to note that many learners (67.58%) were identified by the PFI-PRIM-C as having clinical problems before the programme (cf. Appendix 2e). Therefore, the results suggest that the Lifestyle Programme attained improvement in this area.

With regard to the 'Frustration' sub-scale, in the pre-test there was a statistical significant difference between the age groups.

Sub-test	*Group*	X^2	*P-value*
'Frustration'	*10-13 &14-18 year olds*	*16.442*	*p<0.001*

The 14-18 year old group manifested significantly higher levels of frustrations than the 10-13 year old group (cf. Appendix 2b). After the implementation of the programme there was still a significant difference between the two age groups.

Sub-test	*Group*	X^2	*P-value*
'Frustration'	*10-13 &14-18 year olds*	*8.002*	*p<0.046*

The 14-18 year old group once more manifested significantly higher levels of frustration than the 10-13 year old group despite the implementation of the programme (cf. Appendix 2e). These results suggest that the older group (adolescents) coped less with problems in themselves and in their environment than the younger group (pre-adolescents) and that the programme made no difference for the older group.

In contrast to the findings regarding age, there was no statistical significant difference between males and females on the 'Frustration' sub-scale. This was the case in both the pre and post-test results (cf. Appendix 2e).

In summary, on the basis of the findings of this study, the results showed significant differences between pre-adolescents and adolescents, both in the pre and post-test periods with regard to the 'Frustration' sub-scale. In addition, no significant gender difference was demonstrated. On the 'Anxiety' sub-scale, the results showed no significant age difference both in the pre and post-tests. However, in gender difference a significant result in the pre-test period was demonstrated. No significant age difference was demonstrated. Therefore, the programme achieved no improvement on the 'Frustration sub-scale with regard to age. However, there was a significant improvement on the 'Anxiety' sub-scale with regard to gender.

Cluster 6: 'Stigma' and 'Attitude toward Adults' sub-scales

Cluster six consisted of 'Stigma' sub-scale which measures the feelings that the child has with regard being different from other children and the 'Attitude toward Adults' sub-scale which measures the attitude that the child has towards adults generally.

Total sample

In terms of the total sample the results showed that the Lifestyle Programme impacted positively on all males and 10-13 year old females on the 'Stigma' sub-scale.

Sub-test	*Group*	X^2	*P-value*
Stigma	*10-13 year old males*	*19.765*	$p<0.001$
	10-13 year old females	*13.718*	$p<0.003$
	14-18 year old males	*18.695*	$p<0.001$

However, the 14-18 year old females did not benefit from the Lifestyle Programme in this area. In contrast, regarding the overall results on the 'Attitude toward Adult' sub-scale the Lifestyle Programme results showed no improvement for all the learners.

Age and Gender Differences

Before the implementation of the programme, no significant age differences emerged on this cluster. However, after the implementation of the Lifestyle Programme, there were statistically significant changes on the 'Stigma' sub-scale between the 10-13 year and 14-18 year olds

Sub-test	*Group*	X^2	*P-value*
'Stigma'	*10-13 & 14-18 year olds*	*8.002*	$p<0.045$

Also, in the post-test, even though the overall results showed no significant results between the pre and the po ,t-tests, the statistical analyses indicated significant age and gender differences.

Sub-test	*Group*	X^2	*P-value*
'Attitude toward Adults'	*10-13 & 14-18 year olds*	*8.045*	$p<0.045$
	Male and Female groups	*16.560*	$p<0.001$

In summary, the results demonstrated significant differences in certain learners (all males and 10-13 year old females) on 'Stigma' sub-scale. No significant improvement was identified in the total sample on 'Attitude toward Adults' sub-scale. Therefore, some learners benefited from the Lifestyle Programme with regard to the 'Stigma' sub-scale, and did not benefit from the 'Attitude toward Adults' sub-scale as there was no significant difference yielded in terms of the total sample.

Cluster 7: 'Problems with School' and 'Problems with Mother' sub-scales

This cluster consisted of 'Problems with School' sub-scale, which measures the problems that a child has with regard to school and 'Problems with Mother' which measures the problems that a child has with regard to his mother.

Total sample

In terms of the total sample the results showed that the Lifestyle Programme was effective for adolescent males and adolescent females on the 'Problems with School' sub-scale.

Sub-test	*Group*	*X^2*	*P-value*
'Problems with School'	*14-18 year old males*	*6.200*	*$p<0.045$*
	14-18 year old females	*5.526*	*$p<0.019$*

On the 'Problem with Mother' sub-scale the overall results showed improvement only for adolescent males.

Sub-test	*Group*	*X^2*	*P-value*
'Problem with Mother'	*14-18 year old males*	*12.381*	*$p<0.002$*

This, therefore suggests that, with regard to the measured status of 'Problems with School', the Lifestyle Programme was only beneficial to the older group (14-18 year old males and females). With regard to the 'Problem with Mother' sub-scale, the Lifestyle Programme improved only the relationship of the older 14-18 year old males with their mothers.

Age and Gender Difference

From this cluster, significant age differences emerged only before the implementation of the programme.

Sub-test	*Group*	X^2	*P-value*
'Problems with School'	*10-13 &14-18 year olds*	*10.067*	*p<0.007*
'Problems with Mother'	*10-13 &14-18 year olds*	*8.267*	*p<0.016*

The pre-adolescents seemed to like school better than the adolescents (cf. Appendix 2g). However, it is important to note that the majority of participants (more than 80%) were rated as having no clinical problem by the PFI-PRIM-C in these areas before the implementation of the programme.

When the results were analysed in terms of gender, before the implementation of the programme in this cluster no significant sex differences emerged. After the implementation of the programme, with regard to the 'Problems with Mother' sub-scale, there was a significant gender difference. Male participants seemed to have good relationships with their mothers (cf. Appendix 2g).

Sub-test	*Group*	X^2	*P-value*
'Problems with Mother'	*male and female groups*	*9.672*	*p<0.022*

In summary, the learners on these two sub-scales showed significant improvement for adolescent males and females (14-18 year olds) on the 'Problems with School' and for the adolescent males only on the 'Problems with Mother' sub-scale. In the pre-test period, the results showed significant difference between the pre-adolescents and adolescents on both sub-scales.

No significant age difference was demonstrated in the post-test period and that suggests that the Lifestyle Programme has made improvements in these areas. With regard to gender, the results showed significant difference in the post-test period. Therefore, the Lifestyle Programme produced improvements in some aspects and not in others. This was particularly true for the differences between the age groups and gender groups.

These results are consistent with the third aim of the study, which sought to determine the psycho-social functioning status of Grade 6 and 7 learners, and aim 6 which sought to determine the appropriateness of the programme in its present form for black learners. The results showed that the Lifestyle Programme produced positive results in some areas of social functioning and not in others for some learners over an eight month period.

In addition, the fifth aim, which sought to determine if there was a link between the socio-economic status of family members and learners' self-image has also been achieved. Results of the biographical information and the 'Self-image' sub-scale were compared. A non-significant relationship between the 'Self-image' sub-scale and biographical factors (family structure, household size, employment status)(cf. Appendix 3a) was found. A high rate of low self-image of learners was found irrespective of the background they came from. Overall, the majority of the participants presented with low self-image, which was not linked to any particular socio-economic status as measured in this study.

3.4 Knowledge of Toxic Substances

The first aim of the programme, which was to assess how much knowledge about drug and alcohol there was among a sample of early adolescents (10-13 years old) and adolescents (14-18 years old) before and after the implementation of a school based Lifestyle Programme, was achieved. The results are described in tables (cf. Appendix 1a-1e). The pertinent results are presented below:

3.4.1 Knowledge of diseases caused by alcohol and drugs between the different age and gender groups in the pre and post-test.

In terms of the total sample there was a significant difference between the pre-test and post-test results in the knowledge of diseases linked to drug abuse irrespective of age and gender.

Topic	*Group*	X^2	*P-value*
Diseases caused by drugs	*10-13 year old males*	*39.977*	*p<0.001*
	10-13 year old females	*36.379*	*p<0.001*
	14-18 year old males	*32.479*	*p<0.001*
	14-18 year old females	*18.640*	*p<0.001*

When the results were analysed in terms of age groups and gender groups there was no significant difference between the ages and sexes and so overall the programme was appropriate for both age groups and sexes (cf. Appendix 1a).

3.4.2 Different types of drugs

Overall, the Lifestyle Programme improved all the participants' knowledge about different types of drugs, except for the females in the 14-18 year old group. Therefore the programme was not effective for the adolescent females on the knowledge about different types of drugs (cf. Appendix 1b).

Topic	*Group*	X^2	*P-value*
Different types of drugs	*10-13 year old males*	*13.361*	*p<0.010*
	10-13 year old females	*10.976*	*p<0.027*
	14-18 year old males	*14.160*	*p<0.015*

When the research data was analysed in terms of age and gender groups, no significant difference was found between the age and gender groups with regard to the knowledge of different types of drugs available in South Africa, both at the pre-test and in the post-test stage.

3.4.3 Signs and symptoms of a drugging person

In terms of the total sample, there was a highly significant difference between the pre and post-tests results. Therefore, there was a significant improvement irrespective of age and gender.

Topic	*Group*	X^2	*P-value*
Signs of a drugging person	*10-13 year old males*	*133.536*	$p<0.001$
	10-13 year old females	*145.379*	$p<0.001$
	14-18 year old males	*129.947*	$p<0.001$
	14-18 year old females	*53.771*	$p<0.001$

When the results were analysed in terms of age and gender groups, the results did not demonstrate any statistically significant differences in the knowledge of the signs and symptoms of a drugging person among the age or sex groups both in the pre- and post-tests results, again supporting the value of the programme for both age and gender groups (cf. Appendix 1c).

3.4.4 Alcoholic drinks

In terms of the total sample, the Lifestyle Programme improved the knowledge of the types of the alcoholic drinks among the 10-13 year old male group and the 14-18 year old females but not for the 10-13 year old females or the 14-18 year old males (cf. Appendix 1d). This was a strange result.

Topic	*Group*	X^2	*P-value*
Alcoholic drinks	*10-13 year old males*	*16.138*	$p<0.006$
	14-18 year old females	*11.411*	$p<0.044$

When the results were analysed in terms of the age groups and gender groups, the results demonstrated no significant difference in the knowledge of alcoholic drinks between the age and gender groups both in the pre-test and post-test periods. The Lifestyle Programme seemed to be appropriate for the total sample.

3.4.5 Organs that can be damaged by alcohol

In terms of the total sample, the results showed a significant difference between pre and post-tests for all the learners except for the 14-18 year old females.

Topic	*Group*	X^2	*P-value*
Organs that can be damaged by alcohol	*10-13 year old males*	*16.834*	$p<0.018$
	10-13 year old females	*18.855*	$p<0.009$
	14-18 year old males	*14.023*	$p<0.051$

When the results were analysed in terms of the age groups and gender groups, they did not demonstrate any significant differences in the knowledge of organs that can be damaged between the measured groups both in the pre and post- tests periods (cf. Appendix 1e).

In summary, it is noted that all the participants benefited in some aspects (such as recognising signs and symptoms of a drugging person and the relationship between the diseases, alcohol and drugs) of an alcohol and drug assessment questionnaire.

In some sub-sections (such as different types of drugs and organs that can be damaged by alcohol) it was only females in the 14-18 year old group who did not benefit from the Lifestyle Programme. With regard to the knowledge of the alcoholic drinks it was only the 10-13 year old males and 14-18 year old females who benefited from the programme. There is no clear explanation for these results, an assumption can be that those who benefited were more interested in some areas than the others, or perhaps it was too short a period for all the learners to benefit. However, it is of importance to note that the programme was of most benefit to the pre-adolescence stage and for both girls and boys.

3.5 Results from the evaluation questionnaire: Learners perspective

The Lifestyle Programme was evaluated after an interval of eight months. The evaluation questionnaire was divided into three parts namely (a) The participants' feelings about the group process of which they were a part, (b) perceptions of the facilitator and (c) the evaluation of the different topics of the Lifestyle Programme. The responses were analysed once again by age and gender. The results of the questionnaire are presented in

Appendix 5 and they suggest that group process was valid (P-value 0.591) and there was effective facilitation (P-value 0.907).

3.5.1 Perception of the group process

When the results were analysed in terms of age group and gender group, there was no significant difference between the ages and sexes in the way they viewed the group process. About half of the sample felt that their groups always worked well, group members always participated and responded well to the facilitators. More than a quarter said the group members sometimes participated well but not always. More than 90% of the participants attributed the group's working well to participation of the members, though to differing degrees (cf. Appendix 5).

There was an even balance in the views of the participants with regard to the reasons why the groups did not work well. About 25% reported that it was *sometimes* due to lack of participation, while another 25% stated that group members *never* wanted to participate. The overwhelming majority of the group members (91%) reported that they enjoyed being in their groups and would like to work with their groups again. Moreover, the majority of group members (70.19%) felt that each group member got enough chance to talk and participate.

In summary these results suggest that the group participants enjoyed working together.

3.5.2 Perceptions of the facilitator

With regard to how the participants perceived facilitation by their facilitators, no significant differences emerged when the ages and genders were compared. The results showed that the majority of the participants (more than 80%) felt that the facilitator always made it easy for individuals in the group to participate, listened to all group members, always helped each member to participate and understood everybody's needs. Therefore, the majority of learners (84%; P-value 0.796) evaluated the facilitation process positively (cf. Appendix5).

3.5.3 Evaluation of the Lifestyle Programme topics

When both age groups and sexes were asked about the Lifestyle Programme, there was no significant difference in the evaluation of the different topics of the Lifestyle Programme. The majority of participants (more than 80%) reported that the topics were always relevant in their lives. In response to the question, "after the programme do you consider yourself to be a better informed person?" the majority of participants (78%) considered themselves as better informed. When asked whether as a result they can communicate better with friends and families, e majority of participants (more than 78%) considered themselves as better able to communicate with their friends and family members. In addition they stated they could always take independent decisions about using alcohol and drugs and could always stand up for their rights.

Overall, the evaluation of the programme by the participants was extremely positive. The facilitators were rated very highly and seemed to have helped every group member to feel part of the group and to participate well. Therefore, aim six, which sought to determine the appropriateness of the Lifestyle Programme in its present form, for black learners, was further supported by positive results obtained from the analysis of evaluation questionnaire and the significant positive results demonstrated by an alcohol and drug assessment questionnaire and the PFI-PRIM-C.

3.6 Evaluation questionnaire: Facilitators' Perspective

An evaluation questionnaire for the facilitators was analysed qualitatively because it was an open-ended questionnaire.

In the present survey, it was found that the facilitators felt that the Lifestyle Programme was appropriate for Soweto children, whom they believed are at risk to alcohol and drug abuse. They suggested that no topics should be discarded from the Lifestyle Programme manual.

The facilitators felt that their groups worked well because the majority of children participated and co-operated well. Openness and participation were the key positive aspects that the facilitators reported. However, certain negative aspects were also reported by the facilitators: absenteeism, late arrival, disruptive behavior (for example, going to buy sweets when the sessions was supposed to start). The Lifestyle facilitators reported that there were signs of moderate drug taking among adolescents (14-18 year olds) in the groups and that there was resistance to talking about drug and alcohol problems. In addition, learners liked most to talk about poverty in general. For example, in one group, the topic was about self-awareness (three things that you like, three things that are positive about yourself etc.) but the group participants wanted to change the session and talk only about how to combat poverty.

In the present study, it was found that the facilitators felt that the Lifestyle Programme assisted learners to improve their psychosocial functioning and in turn improved the prevention of substance abuse within an at risk youth population (Lifestyle evaluation questionnaire). Therefore, Aim 6, which sought to determine the appropriateness of the programme in its present form for black learners, was verified by the facilitators, as well as by the positive results obtained from the evaluation questionnaires and the significant results from the PFI-PRIM-C and an alcohol and drug assessment questionnaire used in this study, as discussed in this chapter.

CHAPTER 4-DISCUSSION

The present study was an evaluation of the SANCA Lifestyle Programme in two Soweto schools. There has been a lack of research data to support this programme other than the study done by Snipelepsky in 1985, and anecdotal data from workers in the field. The focus of the study was to determine if the Lifestyle Programme was suitable for implementation in township schools. A recent article in the Star Newspaper quoted the Directorate of the SA National Council of Alcohol and Drug Dependency stating that "dagga appears to have taken over from alcohol as the most abused substance in Soweto schools," and that mandrax and cocaine usage is on the increase (Star, 25|2|2000). Given this statement, this study, and its findings, is of great importance in the war against drug abuse by the township youth of South Africa.

The sample in this study consisted of participants from a similar socio-economic background to that of a Soweto survey conducted in 1996 by Morris (1998), and the survey of the Sunday Times City Metro Newspaper (14\11\1999). Both these surveys evaluated the percentage of blue-collar workers, family size and family structure of the Soweto population. Therefore, the sample in this study can be taken as representative of the Soweto population. The majority of participants had good relationships with their family members. These results supported the quality of the home environment for these learners and reflected the nature of the extended family structure for a sizable proportion of the sample, which yielded a good and effective support system. In addition, the learners also had good relationships with their friends and showed no major problems with school. The establishment of good relationships with others would appear to decrease the state of feeling helpless about their living conditions. Perhaps one can attribute these positive results to the good social support that was clearly identified by the learners in the sample.

These results are congruent with those found in studies conducted by (Rutter 1986; Gibson 1986; Turton 1986) that reveal that increased social support (peers, schools and socials) can play a primary role in shaping one's approach to stressful situations.

Therefore, the positive results ('Satisfaction', 'Helplessness', 'Perseverance' and 'Future Perspective') demonstrated in this study are consistent with the studies of Gibson (1986) and Rutter (1986) that argue that the social groups such as family, peers and the school seem to provide good social support systems especially in situations of stress. This further suggests that participants who receive moral support from their family members and community, show better coping mechanisms in dealing with feelings of helplessness and therefore, can persevere with seeking solutions to problems and be satisfied with the manner in which they conduct their lives.

Research studies suggest that the socio-economic status of individuals including family structures, family size, type of employment, kind of support system available and self-image, are correlated to alcohol and drug usage and abuse (Turton, 1986). Although the economic and social status of the sample is similar to those identified by Turton as causal to alcohol and drug use and abuse, the current sample revealed good relationships with family members and friends. However, despite the positive support systems identified, these learners still presented with low self-image. More importantly, the prevalence of low self-image was found to be high in the sample, irrespective of the background the participants came from, and the degree of social support that they received. These results are supported by Ramphele (1989) and Straker (1989) who argue that black South Africans (both children and adults) tend to display feelings of inadequacy and low self-image due to the apartheid policies and racial prejudices of the past. However, this assertion is inconsistent with Turton's (1986) findings, that suggest that socio-economic factors have an impact on the relationship between life events and the experience of anxiety, low self-image and stress. This discussion articulates well with the aim of the study, that sought to determine if there was a link between the socio-economic status of family members and the learners' self-image.

Before the commencement of the programme, the majority of learners in the sample showed high levels of anxiety. These results are also consistent with Ramphele and Wilson (1989); Straker (1989) and Hamburg et al. (1998) for the same reasons as argued above. However, the researcher is aware that this could be related to performance anxiety and therefore is not directly related to self-image.

They further argue that the conditions of extreme poverty to which the youth have been exposed predispose them to high levels of anxiety and feelings of inadequacy. This was corroborated in the programme when the participants wanted to discuss how to combat poverty rather than discuss a Lifestyle topic on self-awareness, which was prepared for the session.

Even though the majority of learners showed high levels of anxiety, the present study found that boys were more anxious than girls. This is consistent with the work of Rutter (1983) and Stolberg (1989) who found the same results. However, the results are inconsistent with the studies of Lokare (1984), Turton (1986) and Thoits (1988), who conclude that, in stressful situations, girls score higher on all anxiety scales than boys. Although the boys in this study were identified as more anxious than girls, what is important is that the Lifestyle Programme decreased the anxiety levels of the majority of learners irrespective of gender. At the end of the study, the anxiety levels were within a normal range as confirmed by the post-test results. The findings are similar to the studies of Botvin and Botvin (1992), De Jong, et al. (1995; 93) and Donald, Lazarus and Lolwana (1997) that conclude that Life Skills Programmes promote the physical, cognitive and social well being of children and adolescents and in turn, auger well for the programme.

In addition, the Lifestyle Programme improved the self-image of the majority of learners. The same results pertain to studies conducted by Snipelepsky (1984) which revealed comparable positive feedback after the implementation of the Lifestyle Programme. This suggests that the Lifestyle Programme addresses the learners' self-image positively. Effective prevention programmes appear to be linked to enhanced self-image. This is consistent with the findings of Botvin and Botvin, (1992); De Jong, et al (1995) and Donald et al (1997), who suggest that the implementation of Life Skills Programme can promote the emotional development of pre-adolescents and adolescents. In essence, it is argued that such programmes develop levels of psychosocial competence. This study sought to, inter-alia, determine whether there was any difference between the self-image of boys and girls before and after the implementation of the programme.

The results showed no significant age or sex discrepancies with the self-image of the Grade 6 and 7 learners before or after the prevention programme. The main achievement of the programme was that it boosted the self-image of the majority of participants which is regarded by all studies as crucial to drug prevention, therefore, it is an appropriate programme for boys and girls and is suitable for pre-adolescents and adolescents.

Another finding of the study was that, before the benefit of the programme, younger children (pre-adolescents) appeared to be less frustrated than the older children (adolescents). These findings could be partially explained by the diffusion sometimes felt by adolescents when they have to contend with changes in personal and social expectations and choices (Erikson, 1963). Therefore, a Lifestyle Programme is crucial at this time because, it is argued, it addresses psychological, biological and social competence, particularly in the adolescent phase of development (Botvin and Botvin, 1992; De Jong, et al 1995, and Donald et al., 1997).

According to Erikson's psychosocial theory, the stage of adolescence is characterised by a conflict between Identity and Identity Diffusion. In this stage, adolescents are known to be concerned about establishing their identity as they undergo biological and social changes. As a result, they sometimes become preoccupied with themselves and how they appear to others. The pre-adolescents have not yet faced this critical stage which appears to yield high levels of frustration. Therefore, the present findings could be explained partially by this theory.

The results after the implementation of the programme, confirmed that the Lifestyle Programme was an effective programme to address the issue of frustration for both age and gender groups. The findings are similar to the studies of Botvin and Botvin, 1992; De Jong, et al., 1995 and Donald et al. 1997, where it is concluded that the Life Skills Programmes promote the individual psychosocial well being of children and adolescents.

These results answered one of the questions of this study which sought to determine the extent to which learners in early adolescence and adolescence change with respect to their psychosocial functioning as a result of the Lifestyle Programme, and to establish if the programme was more suitable to either age group. What is very encouraging is, this programme appears to be relevant for both age groups and for both boys and girls.

This study also aimed to assess the working knowledge of 10-13 year olds and 14-18 year old learners about alcohol and drug taking before and after the implementation of the programme. As discussed earlier, the increase in alcohol and drug abuse in township youth is alarming. This suggests a need for prevention programmes. The Lifestyle Programme is one of the prevention programmes used in South Africa. It aims to promote individual psychosocial functioning and competency with regard to emotional development and feelings of self-esteem. It also aims to increase alcohol and drug awareness so that learners can make rational and informed decision to use, or not to use, alcohol and drugs.

In the fight against alcohol and drugs, research studies show that there are some programmes which are successful and some are not. The programmes that seem to have the potential for greater success in the prevention of drug and alcohol abuse are those that address and develop certain life-skills (De Miranda, 1987; Botvin and Botvin (1992); Du Paul and Eckert, 1994). They address a range of adolescent problems and specifically aim to develop skills in decision-making and to increase knowledge about the dangers of alcohol and drug abuse (Thompson et al., 1997). The same researchers further argue that alcohol and drug and awareness and information alone do not necessarily make up an effective primary prevention programme. Thus, the Lifestyle Programme, provided to the learners in this study, contained alcohol and drug information as well as psychosocial information and the means to develop self-awareness, decision making, communication etc.

The present results showed that, for the total sample irrespective of age and gender, the learners' knowledge of alcohol and drugs increased. This ties in with overseas studies, such as the one of the Australian Drug Foundation, which believe that if one wants to do effective awareness and information programmes, then one has to provide knowledge of basic pharmacology (such as types of drugs, side effects, personal metabolism, distinguish between lower and higher risk use). An alcohol and drug assessment questionnaire and the Lifestyle Programme contain this information, and the data analysis has confirmed the positive results of the programme. The same results pertain to the USA Centre for Substance Abuse Prevention findings, which show positive indicators of emotional well being in youth after they have participated in its programme, which has a Life Skills component (CSAP national cross-site evaluations: http://www.samhsa.gov.csap/facts4htm).

It is clear that alcohol and drug information embedded in a Life Skills Programme is of significant value. The positive results of this project would appear to auger well for this sample in their response to alcohol and drug usage. The fact that changes were reflected in key areas known to be important in the campaign to improve the resistance of youth to drug and alcohol usage indicates the programme's potential value and effectiveness for black learners.

4.1 Evaluation of the Lifestyle Programme

There appears to be a consensus among Grade 6 and 7 learners and facilitators, that the Lifestyle Programme is a good programme for Black schools. The results from the evaluation questionnaire showed that most of the children liked the Lifestyle Programme and that they would like to attend it again. In addition, the majority of the learners stated that the Lifestyle Programme taught them better methods of assertiveness, communication, and decision making around whether to use alcohol and drugs or not.

The Lifestyle Programme, at least, has offered a service that has enabled its beneficiaries to communicate better with friends and family members, and has helped them to better make a decision on whether or not to use alcohol and drugs. This study also found that the facilitators felt that the programme assisted learners to improve their psychosocial functioning and, in turn, increased their knowledge on alcohol and drugs. Therefore, the perceptions of the participants, and the Lifestyle facilitators about the Lifestyle Programme and the positive significant results from an alcohol and drug assessment questionnaire and the PFI-PRIM-C, confirm research findings which argue that a preventative programme is likely to be beneficial if it targets the psychosocial (individual, family, communication, self-awareness) determinants of drug and alcohol abuse (Bangert-Drowns, 1988; Bruvold and Rundall, 1988; and Botvin and Botvin, 1992).

4.2 Limitations of the Study and Recommendations

In this study some of the areas of social and personal development targeted by the Lifestyle Programme showed no improvement, particularly in the areas of relationships with father and friends and with satisfaction in the manner in which the learners live. In addition, the Lifestyle Programme showed significant age or gender improvements for some learners and not for the others, for example in areas such as the levels of anxiety, and perseverance in seeking solutions to problems (cf. Appendix 2c to Appendix 2G). This would suggest that all these areas be investigated further by Lifestyle Programme developers for possible inclusion to identify necessary changes to these aspects of the Lifestyle Programme to improve their applicability for all learners.

Another limitation of the study is the small sample size; the study consisted of only learners in Grade 6 and 7 in two primary schools, which makes it impossible to generalise the findings to all black pre-adolescents and adolescents. The study was confined to a small township sample due to limited resources. In addition, the study was conducted at the end of the first term and it was impossible to do a follow-up assessment as it would necessitate conducting it in the next school year which was beyond the scope of the university academic year.

It is suggested that a similar study be undertaken with a much bigger sample size. Any further research should include a range of schools not only in the townships but also from the rural areas, as the rural areas are often excluded from studies such as this and a clear picture of rural trends cannot be deduced from urban results. Replicating this study with a different sample population, would assess universality in learners' psychosocial functioning, and their working knowledge of alcohol and drugs, and would serve to validate the findings of the current study.

It is recommended that the age range be broadened to investigate this approach with even younger children and not wait for the adolescence stage. This could enhance the aspect of prevention, which is an important dimension of drug intervention programmes.

The programme could go even further and target the community in general, as alcohol and drug abuse is most prevalent in the communities in which the majority of the children live.

The fact that the programme had to be accommodated outside the school time-table (after school and cleaning periods) made it difficult to maintain consistent attendance by participants. A future programme should attempt to ensure that the programme is allocated time within school hours so as to maximise the participants' attendance. This could easily be organised by including it in the Revised South African Education Curriculum Policy which has a Life Skills Programme as an element of the Life Orientation Learning Area (Life Orientation, Updated:1999).

The present study was limited only to aspects of the learners' psychosocial functioning, and to the extent of knowledge about alcohol and drugs. It is important for further research to go beyond the scope of these elements and to include the issue of actual drug use, which would present hard data and information on the actual drug and alcohol practices of the youth targeted by the present programme.

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APPENDICES

Appendix 1

Results from an alcohol and drug assessment questionnaire (A questionnaire was adapted from the Johannesburg College of Education project).

Appendix1a

Table 2.1.1: The knowledge of the 10-13 year and 14-18 year old group about diseases caused by drugs

Knowledge of relationship between drugs and diseases					
		Before the SANCA Lifestyle Programme		*After the SANCA Lifestyle Programme*	
Age Group	Response	Frequency	%	*frequency*	*%*
10-13 years old	Heart attacks	22	11.28	*58*	*18.83*
	Strokes	14	7.18	*54*	*17.53*
	Lung cancer	107	54.87	*125*	*40.58*
	Asthma	19	9.74	*70*	*22.73*
	Don't know	33	16.92	*1*	*0.32*
14-18 years old	Heart attacks	8	6.72	*36*	*16.14*
	Strokes	11	9.24	*38*	*17.04*
	Lung cancer	66	55.46	*92*	*41.26*
	Asthma	14	11.76	*55*	*24.66*
	Don't know	20	16.81	*2*	*0.90*
	Chi-square value	p>0.682		*p>0.824*	

Table 2.1.2: A table showing the knowledge of the male and female group about diseases caused by smoking

Knowledge of relationship between smoking and diseases					
		Before the SANCA Lifestyle Programme		*After the SANCA Lifestyle Programme*	
Gender	Response	Frequency	%	*Frequency*	*%*
Males	Heart attacks	14	8.43	*40*	*14.44*
	Strokes	11	6.63	*53*	*19.13*
	Lung cancer	93	56.02	*118*	*42.60*
	Asthma	17	10.24	*64*	*23.10*
	Don't know	31	18.67	*2*	*0.72*
Females	Heart attacks	16	10.74	*54*	*21.26*
	Strokes	11	9.40	*39*	*15.35*
	Lung cancer	93	55.03	*99*	*38.98*
	Asthma	17	10.74	*61*	*24.02*
	Don't know	21	14.09	*1*	*0.39*
	Chi-square value	p>0.694		*p>0.258*	

Appendix 1b

Table 2.2.1: The knowledge of the 10-13 year and 14-18 year old group about types of drugs

	Tick the drugs you have heard of	Before the SANCA Lifestyle Programme		*After the SANCA Lifestyle Programme*	
Age Group	Response	Frequenc y	%	*Frequency*	*%*
10-13 years	Dagga	65	43.62	*122*	*29.90*
	LSD	10	6.71	*40*	*9.80*
	Mandrax	29	19.46	*109*	*26.72*
	Heroin	2	1.34	*44*	*10.78*
	Cocaine	43	28.86	*93*	*22.79*
14-18 years	Dagga	42	41.58	*85*	*29.11*
	LSD	8	7.92	*35*	*11.99*
	Mandrax	23	22.74	*82*	*28.08*
	Heroin	2	1.98	*26*	*8.90*
	Cocaine	26	28.86	*63*	*21.58*
	Chi-square value	p>0.930		*p>0.697*	

Table 2.2.2: The knowledge of males and females about types of drugs

	Tick the drugs you have heard of	Before the SANCA Lifestyle Programme		*After the SANCA Lifestyle Programme*	
Gender	Response	frequency	%	*Frequency*	*%*
Males	Dagga	57	43.85	*116*	*29.74*
	LSD	9	6.92	*46*	*11.79*
	Mandrax	22	16.92	*105*	*26.92*
	Heroin	1	0.77	*38*	*9.74*
	Cocaine	41	31.54	*84*	*21.54*
Females	Dagga	50	41.32	*91*	*29.35*
	LSD	9	7.44	*29*	*9.35*
	Mandrax	31	25.62	*86*	*27.74*
	Heroin	3	2.48	*32*	*10.32*
	Cocaine	28	23.14	*72*	*23.23*
	Chi-square value	p>0.275		*p>0.837*	

Appendix 1c

Table 2.3.1: The knowledge of the signs of a drugging person between 10-13 years and 14-18 years

Tick signs that tell us someone is on drugs		Before Lifestyle Programme		*After SANCA Lifestyle Programme*	
10-13 years	Responses	Frequency	%	*Frequency*	*%*
	Shaking	26	14.36	*84*	*19.58*
	Vomiting	11	6.08	*61*	*14.22*
	Needle marks	12	6.63	*79*	*18.41*
	Nervousness	11	6.08	*70*	*16.32*
	Poor judgement	8	4.42	*86*	*20.05*
	Dilated pupils	10	5.52	*44*	*10.26*
	Don't know	103	56.91	*5*	*1.17*
14-18 years	Shaking	20	17.39	*79*	*22.38*
	Vomiting	7	6.09	*43*	*12.18*
	Needle marks	6	5.22	*59*	*16.71*
	Nervousness	11	9.57	*56*	*15.86*
	Poor judgement	12	10.43	*70*	*19.83*
	Dilated pupils	7	6.09	*44*	*12.46*
	Don't know	52	45.22	*1*	*0.28*
	Chi-square value	p>0.282		*p>0.575*	

Table 2.3.2: The knowledge of the signs of a drugging person between males and females

Tick signs that tell us someone is on drugs		Before Lifestyle Programme		*After SANCA Lifestyle Programme*	
	Responses	frequency	%	*frequency*	*%*
Males	Shaking	24	15.48	*92*	*21.05*
	Vomiting	7	4.52	*62*	*14.19*
	Needle marks	6	3.87	*75*	*17.16*
	Nervousness	12	7.74	*63*	*14.42*
	Poor judgement	13	8.39	*91*	*20.82*
	Dilated pupils	11	7.10	*52*	*11.90*
	Don't know	82	52.90	*0*	*0.46*
Females	Shaking	21	14.79	*71*	*20.58*
	Vomiting	12	8.45	*42*	*12.17*
	Needle marks	12	8.45	*63*	*18.26*
	Nervousness	10	7.04	*63*	*18.26*
	Poor judgement	7	4.93	*65*	*18.84*
	Dilated pupils	6	4.23	*36*	*10.43*
	Don't know	74	52.11	*1*	*1.16*
	Chi-square value	p>0.338		*p>0.568*	

Appendix 1d

Table 2.4.1: Knowledge of alcoholic drinks between the 10-13 year and 14-18 year olds

Tick the alcoholic drinks		Before Lifestyle Programme		*After SANCA Lifestyle Programme*	
Age	Responses	Frequency	%	*frequency*	*%*
10-13 year	Brandy	110	26.83	*134*	*26.75*
	Whisky	82	20.00	*118*	*23.55*
	Gin	38	9.27	*70*	*13.97*
	Beer	101	24.63	*123*	*24.55*
	Wine	69	16.83	*56*	*11.18*
14-18 years	Brandy	64	32.49	*99*	*26.68*
	Whisky	28	14.21	*82*	*22.10*
	Gin	19	9.64	*57*	*15.36*
	Beer	48	24.37	*90*	*24.26*
	Wine	34	17.26	*43*	*11.59*
	Chi-square value	p>0.538		*p>0.972*	

Table 2.4.2: Knowledge of alcoholic drinks between males and females

Tick the alcoholic drinks		Before Lifestyle Programme		*After SANCA Lifestyle Programme*	
	Responses	Frequency	%	*frequency*	*%*
Males	Brandy	93	30.59	*128*	*26.50*
	Whisky	54	17.76	*110*	*22.77*
	Gin	26	8.55	*73*	*15.11*
	Beer	73	24.01	*118*	*24.43*
	Wine	52	17.11	*54*	*11.18*
Females	Brandy	83	27.04	*105*	*26.99*
	Whisky	56	18.24	*90*	*23.14*
	Gin	30	9.77	*54*	*13.88*
	Beer	77	25.08	*95*	*24.42*
	Wine	53	17.26	*45*	*11.57*
	Chi-square value	p>0.937		*p>0.991*	

Appendix 1e

Table 2.5.1: Knowledge of organs that can be damaged by alcohol between the 10-13 year and 14-18 year olds

Tick organs that alcohol can damage		Before SANCA Lifestyle Programme		*After SANCA Lifestyle Programme*	
	Responses	frequency	%	*frequency*	*%*
10-13 years	Lungs	104	25.18	*118*	*20.92*
	Stomach	22	5.33	*60*	*10.64*
	Liver	34	8.23	*84*	*14.89*
	Brain	72	17.43	*110*	*19.50*
	Bladder	30	7.26	*54*	*9.57*
	Heart	51	12.35	*47*	*8.33*
	Kidney	56	13.56	*50*	*8.87*
	Blood vessel	44	10.65	*41*	*7.27*
14-18 years	Lungs	55	25.11	*88*	*20.56*
	Stomach	12	5.48	*43*	*10.05*
	Liver	22	10.05	*62*	*14.49*
	Brain	34	15.53	*79*	*18.46*
	Bladder	14	6.39	*49*	*11.45*
	Heart	24	10.96	*46*	*10.75*
	Kidney	31	14.16	*36*	*8.41*
	Blood vessel	27	12.33	*25*	*5.84*
	Chi-square value	p>0.997		*p>0.845*	

Table 2.5.2: Knowledge of organs that can be damaged by alcohol between males and females

Tick organs that alcohol can damage		Before SANCA Lifestyle Programme		*After SANCA Lifestyle Programme*	
Responses		Frequency	%	*frequency*	*%*
Males	Lungs	83	25.23	*108*	*20.11*
	Stomach	16	4.86	*56*	*10.43*
	Liver	29	8.81	*78*	*14.53*
	Brain	63	19.15	*104*	*19.37*
	Bladder	22	6.69	*60*	*11.17*
	Heart	39	11.85	*49*	*9.12*
	Kidney	43	13.07	*46*	*8.57*
	Blood vessel	34	10.33	*36*	*6.70*
Females	Lungs	78	25.24	*98*	*21.54*
	Stomach	19	6.15	*47*	*10.33*
	Liver	26	8.41	*68*	*14.95*
	Brain	43	13.92	*85*	*18.68*
	Bladder	22	7.12	*43*	*9.45*
	Heart	35	11.33	*44*	*9.67*
	Kidney	46	14.89	*40*	*8.79*
	Blood vessel	40	12.94	*30*	*6.59*
	Chi-square value	p>0.992		*p>0.717*	

Appendix 2

Results from the Psychosocial Functioning Inventory for Primary School Children (PFI-PRIM-C) (The questionnaire is designed by Perspective Training College in Pretoria).

Appendix 2a

Cluster 1. 'Satisfaction', 'Problems with Friends' and 'Problems with Father' sub-scales

Table 3.1.1: Psychosocial functioning scores of 10-13 year olds and 14-18 year olds of the total sample (N=260) as Measured by various sub-scales in Cluster 1 before and after programme.

		Before the SANCA Lifestyle Programme				*After the SANCA Lifestyle Programme*			
Age group	Sub-scale	No clinical problem	Uncertain	Clinical problem	Severe clinical problem	*No clinical problem*	*Uncertain*	*Clinical problem*	*Severe clinical problem*
10-13 years	Satisfaction	56.03	0.78	4.67	0.00	*55.74*	*0.41*	*1.23*	*0.00*
	Problems with Friends	53.13	0.78	6.25	1.17	*50.21*	*0.00*	*6.58*	*0.00*
	Problems with Father	52.92	0.00	6.61	1.17	*49.59*	*0.00*	*4.51*	*2.87*
14-18	Satisfaction	33.46	0.78	3.89	0.39	*40.57*	*0.82*	*1.23*	*0.00*
	Problems with Friends	32.81	0.00	5.47	0.39	*37.45*	*0.41*	*4.53*	*0.41*
	Problems with Father	31.52	0.00	5.45	1.56	*36.89*	*0.00*	*4.10*	*0.82*

Table 3.1.2: Psychosocial functioning scores of males and females of the total sample (N=260) as measured by various sub-scales in Cluster 1 before and after programme.

		Before the SANCA Lifestyle Programme				*After the SANCA Lifestyle Programme*			
Gender	Sub-scale	No clinical problem	Uncertain	Clinical problem	Severe clinical problem	*No clinical problem*	*Uncertain*	*Clinical problem*	*Severe clinical problem*
Male	Satisfaction	48.45	0.78	5.43	0.00	*52.46*	*1.23*	*2.05*	*0.00*
	Problems with Friends	45.91	0.39	7.78	0.78	*0.00*	*48.15*	*0.41*	*7.41*
	Problems with Father	0.00	47.67	5.43	1.55	*0.41*	*48.36*	*5.74*	*1.23*
Female	Satisfaction	41.09	0.78	3.10	0.00	*43.85*	*0.00*	*0.51*	*0.00*
	Problems with Friends	39.69	0.00	4.28	1.17	*39.51*	*0.00*	*3.70*	*0.41*
	Problems with Father	36.82	6.59	1.55	0.00	*38.11*	*2.87*	*2.46*	*0.00*

3.1.3: Psychosocial functioning Chi-square values for Cluster 1 before and after the implementation of the programme.

		Before the implementation of the programme		*After the implementation of the Programme*	
Sub-scale	Group	X	P-value	*X*	*P-value*
Satisfaction	10-13 year and 14-18 year olds	2.389	0.496	*0.866*	*0.648*
	Males and female	1.595	0.660	*4.388*	*0.111*
Problems with friends	10-13 year and 14-18 year olds	2.569	0.463	*4.676*	*0.32?*
	Males and females	2.407	0.492	*3.468*	*0.483*
Problems with Father	10-13 year and 14-18 year olds	2.986	0.392	*2.455*	*0.483*
	Male and female	2.290	0.514	*0.461*	*0.326*

Table 3.1.4: Final Lifestyle Programme results for the total sample on Cluster 1

Sub-scales	10-13 years old				*14-18 years old*			
	males		Females		*Males*		*Females*	
	X^2	P-value	X^2	P-value	*X^2*	*P-value*	*X^2*	*P-value*
Satisfaction	2.169	0.338	2.657	0.265	*3.376*	*0.337*	*4.308*	*0.116*
Problems with Friends	2.632	0.452	2.183	0.535	*1.079*	*0.583*	*1.080*	*0.583*
Problems with Father	0.878	0.831	5.168	0.160	*1.357*	*0.717*	*5.460*	*0.141*

Appendix 2b

CLUSTER 2. 'Self-image', 'Others Happiness' and 'Memory' sub-scales

Table 3.1.5: Psycho-social functioning scores of the 10-13 year olds and 14-18 year old (N=260)

		Before the SANCA Lifestyle Programme				*After the SANCA Lifestyle Programme*			
Age group	Sub-scale	No clinical problem	Uncertain	Clinical problem	Severe clinical problem	*No clinical problem*	*Uncertain*	*Clinical problem*	*Severe clinical problem*
10-13 years	Self- image	17.51	0.78	41.25	1.95	*35.25*	*4.92*	*16.39*	*0.82*
	Others Happiness	0.78	0.39	8.24	52.55	*13.11*	*5.33*	*24.59*	*14.34*
	Memory	19.21	1.31	39.74	3.49	*32.38*	*0.41*	*23.36*	*1.23*
14-18 years	Self-image	8.56	0.39	27.63	1.95	*25.82*	*2.87*	*13.52*	*0.41*
	Others Happiness	1.57	0.00	5.49	30.98	*9.02*	*4.51*	*16.39*	*12.70*
	Memory	8.73	1.75	21.83	3.93	*17.62*	*0.00*	*23.36*	*1.23*

Table 3.1.6: Psychosocial functioning scores of male and female learners in Grade 6 and 7 as measured by various sub-scales before and after the Lifestyle Programme.

		Before the SANCA Lifestyle Programme				*After the SANCA LifestyleProgramme*			
Gender	Sub-scales	No clinical problem	Uncertain	Clinical problem	Severe clinical problem	*No clinical problem*	*Uncertain*	*Clinical problem*	*Severe clinical problem*
Male	Self-image.	15.89	1.16	35.27	2.71	*31.56*	*4.51*	*19.26*	*0.41*
	Others Happiness	1.17	0.39	7.42	45.70	*13.93*	*5.74*	*20.49*	*15.57*
	Memory	12.61	2.17	34.35	5.22	*22.95*	*0.41*	*29.92*	*0.05*
Female	Self-image	10.08	0.00	33.72	1.16	*29.51*	*23.28*	*10.66*	*0.82*
	Others Happiness	1.17	0.00	6.25	37.89	*8.20*	*4.10*	*20.49*	*11.48*
	Memory	15.65	0.87	26.52	2.61	*54.10*	*0.00*	*16.80*	*0.41*

3.1.7: Psychosocial functioning chi-square values for Cluster 2 before and after the implementation.

		Before the implementation of the programme		*After the implementation of the programme*	
Sub-scale	Group	X	P-value	*X*	*P-value*
Self-image	10-13 year and 14-18 year olds	1.694	0.638	*0.572*	*0.903*
	Males and female	5.484	0.140	*3.854*	*0.278*
Others Happiness	10-13 year and 14-18 year olds	2.839	0.417	*0.971*	*0.808*
	Males and females	0.884	0.829	*2.633*	*0.452*
Memory	10-13 year and 14-18 year olds	4.102	0.251	*7.474*	*0.113*
	Male and female	4.650	0.199	*11.406*	*0.022*

Table 3.1.8: Final Lifestyle Programme results for the total sample Cluster 2

Sub-scales	10-13 years old				14-18 years old			
	males		Females		males		Females	
	X^2	P-value	X^2	P-value	X^2	P-value	X^2	P-value
Self-image	13.356	0.004	40.982	0.001	21.606	0.001	21.714	0.001
Others Happiness	48.860	0.001	62.661	0.001	42.504	0.001	15.662	0.001
Memory	9.083	0.028	11.765	0.008	9.595	0.048	7.427	0.059

Appendix 2c

CLUSTER 3. : 'Helplessness' and 'Problems with Family' sub-scales

Table 3.1.9: Psychosocial functioning scores of 10-13 year olds and 14-18 year old as measured by various sub-scales Cluster 3 before and after programme.

		Before the SANCA Lifestyle Programme				*After the SANCA Lifestyle Programme*			
Age group	Sub-scale	No clinical problem	Uncertain	Clinical problem	Severe clinical problem	*No clinical problem*	*Uncertain*	*Clinical problem*	*Severe clinical problem*
10-13 years	Helplessness	40.08	1.59	17.46	1.98	*47.95*	*1.23*	*7.38*	*0.82*
	Problems with Family	52.92	0.39	7.78	0.39	*54.51*	*0.00*	*2.87*	*0.00*
10-14 years	Helplessness	21.43	0.79	13.10	3.57	*31.97*	*1.64*	*7.38*	*1.23*
	Problems with Family	31.91	0.39	5.45	0.78	*40.98*	*0.00*	*1.64*	*0.00*

Table 3.1.10: Psychosocial functioning scores of males and females as measured by various sub-scales in Cluster 3 before and after programme.

		Before the SANCA Lifestyle Programme				*After the SANCA Lifestyle Programme*			
Gender	Sub-scale	No clinical problem	Uncertain	Clinical problem	Severe clinical problem	*No clinical problem*	*Uncertain*	*Clinical problem*	*Severe clinical problem*
Male	Helplessness	30.83	1.19	18.18	4.74	*43.44*	*2.46*	*7.79*	*2.05*
	Problems with Family	45.35	0.78	8.53	33.33	*53.69*	*0.00*	*2.05*	*0.00*
Females	Helplessness	30.43	1.19	12.65	0.79	*36.48*	*0.41*	*6.97*	*0.00*
	Problems with Family	39.92	0.00	4.26	0.78	*41.80*	*0.00*	*2.46*	*0.00*

3.1.11: Psychosocial functioning chi-square values for Cluster 3 before and after the implementation of the programme.

		Before the implementation of the programme		*After the implementation of the programme*	
Sub-scale	Group	X	P-value	*X*	*P-value*
Helplessness	10-13 year and 14-18 year olds	5.458	0.141	3.917	0.417
	Males and female	7.263	0.064	8.058	0.089
Problem with Family	10-13 year and 14-18 year olds	1.292	0.731	0.185	0.667
	Males and females	4.315	0.229	0.494	0.482

3.1.12: Final Lifestyle Programme results for the total sample on Cluster 3

Sub-scales	10-13 years old				14-18 years old			
	Males		Females		Males		Females	
	X^2	P-value	X^2	P-value	X^2	P-value	X^2	P-value
Helplessness	11.170	0.011	3.665	0.300	10.068	0.018	5.614	0.230
Problems with Family	3.950	0.139	2.781	0.249	11.192	0.011	1.020	0.601

Appendix 2d

Cluster 4. 'Perseverance' and 'Future Perspective' sub-scales

Table 3.1.13: Psychosocial functioning scores of 10-13 year old and 14-18 year old as measured by various sub-scales in Cluster 4 before and after programme.

		Before the SANCA Lifestyle Programme				*After the SANCA Lifestyle Programme*			
Age group	Sub-scale	No clinical problem	Uncertain	Clinical problem	Severe clinical problem	*No clinical problem*	*Uncertain*	*Clinical problem*	*Severe clinical problem*
10-13 years	Perseverance	57.25	0.00	3.53	0.39	*56.56*	*0.00*	*0.00*	*0.00*
	Future Perspective	47.64	0.00	12.99	0.79	*50.41*	*0.00*	*6.56*	*0.41*
14-18 years	Perseverance	36.08	0.00	1.57	0.70	*40.98*	*0.00*	*0.41*	*0.41*
	Future Perspective	28.35	0.00	7.87	0.79	*39.75*	*0.00*	*2.05*	*0.00*

Table 3.1.14: Psychosocial functioning scores of males and females as measured by various sub-scales in Cluster 4 before and after programme.

		Before the SANCA Lifestyle Programme				*After the SANCA Lifestyle Programme*			
Gender	Sub-scale	No clinical problem	Uncertain	Clinical problem	Severe clinical problem	*No clinical problem*	*Uncertain*	*Clinical problem*	*Severe clinical problem*
Male	Perseverance	51.17	0.39	2.73	0.39	*54.10*	*0.00*	*0.00*	*0.41*
	Future Perspective	42.75	0.00	10.59	0.78	*52.05*	*0.00*	*3.28*	*0.00*
Female	Perseverance	42.19	0.00	2.34	0.78	*43.44*	*0.00*	*0.41*	*0.00*
	Future Perspective	33.33	0.00	10.20	0.78	*38.11*	*0.00*	*5.33*	*0.41*

3.1.15: Psychosocial functioning chi-square values for Cluster 4 before and after the implementation of the programme.

		Before the implementation of the programme		*After the implementation of the programme*	
Sub-scale	Group	X	P-value	*X*	*P-value*
Perseverance	10-13 year and 14-18 year olds	1.963	0.580	*4.186*	*0.382*
	Males and female	1.386	0.709	*5.702*	*0.223*
Future Perspective	10-13 year and 14-18 year olds	2.601	0.457	*6.668*	*0.083*
	Males and females	1.142	0.767	*4.288*	*0.232*

Table 3.1.16: Final Lifestyle Programme results for the total sample on Cluster 4.

Sub-scales	10-13 years old				*14-18 years old*			
	Males		Females		*Males*		*Females*	
	X^2	P-value	X^2	P-value	*X^2*	*P-value*	*X^2*	*P-value*
Perseverance	7.571	0.109	4.853	0.028	*5.110*	*0.164*	*3.020*	*0.389*
Future Perspective	4.815	0.186	2.585	0.275	*13.535*	*0.009*	*6.074*	*0.194*

Appendix 2e

CLUSTER 5. 'Anxiety' and 'Frustration' sub-scales

Table 3.1.17: Psychosocial functioning scores of 10-13 years and 14-18 years old in Grade 6 and 7 as measured by various sub-scales in Cluster 5 before and after the Lifestyle Programme.

		Before the SANCA Lifestyle Programme				*After the SANCA Lifestyle Programme*			
Age	Sub-scales	No clinical problem	Uncertain	Clinical problem	Severe clinical problem	*No clinical problem*	*Uncertain*	*Clinical problem*	*Severe clinical problem*
10-13 years	Frustration	33.07	1.17	23.35	3.89	*44.03*	*2.47*	*10.29*	*0.41*
	Anxiety	4.69	1.56	40.63	14.45	*21.72*	*9.02*	*23.77*	*2.87*
14-18 years	Frustration	12.06	0.00	21.01	5.45	*30.04*	*0.00*	*12.35*	*0.41*
	Anxiety	3.13	0.00	26.95	8.59	*11.89*	*7.79*	*20.08*	*2.87*

Table 3.1.18: Psychosocial functioning scores of male and female learners in Grade 6 and 7 as measured by various sub-scales in Cluster 5 before and after the Lifestyle Programme.

		Before the SANCA Lifestyle Programme				*After the SANCA Lifestyle Programme*			
Gender	Sub-scales	No clinical problem	Uncertain	Clinical problem	Severe clinical problem	*No clinical problem*	*Uncertain*	*Clinical problem*	*Severe clinical problem*
Males	Frustration	21.71	0.78	26.74	5.81	*38.27*	*2.06*	*14.81*	*0.82*
	Anxiety*	0.78	0.39	39.69	14.40	*19.26*	*8.61*	*25.00*	*2.87*
Females	Frustration	22.87	0.39	18.22	3.49	*35.80*	*0.41*	*7.82*	*0.00*
	Anxiety	7.00	1.17	27.63	8.95	*14.34*	*8.20*	*18.85*	*2.87*

3.1.19: Psychosocial functioning chi-square values for Cluster 5 before and after the implementation of the programme.

		Before the implementation of the programme		*After the implementation of the programme*	
Sub-scale	Group	*X*	P-value	*X*	*P-value*
Frustration	10-13 year and 14-18 year olds	16.442	0.001	*8.002*	*0.046*
	Males and female	3.499	0.221	*6.757*	*0.080*
Anxiety	10-13 year and 14-18 year olds	2.692	0.442	*2.749*	*0.432*
	Males and females	20.006	0.001	*0.679*	*0.878*

Table 3.1.20: Final Lifestyle Programme for the total sample on Cluster 5 sub-scales.

Sub-scales	10-13 years old				14-18 years old			
	males		Females		Males		Females	
	X^2	P-value	X^2	P-value	X^2	P-value	X^2	P-value
Frustration	12.593	0.006	11.974	0.007	20.974	0.001	15.079	0.001
Anxiety	47.225	0.001	27.197	0.001	43.389	0.001	6.637	0.084

Appendix 2f

CLUSTER 6. 'Stigma' and 'Attitude toward Adults'

Table 3.1.21: Summary of Psychosocial functioning scores between 10-13 years old and 14-18 years old learners in Grade 6 and 7 as measured by various sub-scales in Cluster 6 before and after the Lifestyle Programme.

		Before the SANCA Lifestyle Programme				*After the SANCA Lifestyle Programme*			
Age group	Sub-scale	No clinical problem	Uncertain	Clinical problem	Severe clinical problem	*No clinical problem*	*Uncertain*	*Clinical problem*	*Severe clinical problem*
10-13 years	Attitude towards adults	26.07	12.06	17.51	5.84	*27.87*	*11.48*	*15.98*	*2.05*
	Stigma	28.63	1.57	25.10	6.27	*43.03*	*2.46*	*11.48*	*0.41*
14-18 years	Attitude towards adults	12.84	6.23	14.01	5.45	*20.90*	*4.92*	*11.89*	*4.92*
	Stigma	13.73	1.57	17.25	5.88	*29.92*	*0.41*	*9.84*	*2.46*

Table 3.1.22: Summary of Psychosocial functioning scores between males and females in Grade 6 and 7 as measured by various sub-scales in Cluster 6 before and after the Lifestyle Programme.

		Before the SANCA Lifestyle Programme				*After the SANCA Lifestyle Programme*			
Gender	Sub-scale	No clinical problem	Uncertain	Clinical problem	Severe clinical problem	*No clinical problem*	*Uncertain*	*Clinical problem*	*Severe clinical problem*
Males	Attitude towards adults	20.16	8.91	18.22	7.75	*27.05*	*6.97*	*14.75*	*6.97*
	Stigma	20.70	1.95	23.44	8.98	*39.34*	*2.05*	*12.70*	*1.64*
Females	Attitude towards adults	18.22	9.30	13.57	3.88	*21.72*	*9.43*	*13.11*	*0.00*
	Stigma	21.48	1.17	19.14	3.13	*33.61*	*0.82*	*8.61*	*1.23*

3.1.23: Psychosocial functioning chi-square values for Cluster 6 before and after the implementation of the programme.

		Before the implementation of the programme		*After the implementation of the programme*	
Sub-scale	Group	X	P-value	*X*	*P-value*
Attitude Towards Adults	10-13 year and 14-18 year olds	4.050	0.256	*8.045*	*0.045*
	Males and female	2.771	0.428	*16.560*	*0.001*
Stigma	10-13 year and 14-18 year olds	3.651	0.302	*8.067*	*0.045*
	Males and females	6.330	0.097	*1.256*	*0.740*

Table 3.1.24: Final Lifestyle Programme results for the total sample on Cluster 6 sub-tests

Sub-scales	10-13 years old				*14-18 years old*			
	males		females		*males*		*females*	
	X^2	P-value	X^2	P-value	*X^2*	*P-value*	*X^2*	*P-value*
Attitude toward adults	1.971	0.578	5.204	0.157	*4.998*	*0.172*	*6.107*	*0.107*
Stigma	19.765	0.001	13.718	0.003	*18.695*	*0.001*	*6.30*	*98*

Appendix 2g

CLUSTER 7. 'Problems with School' and 'Problems with Mother' sub-scales

Table 3.1.25: Summary of Psychosocial functioning scores between 10-13 years old and 14-18 years old learners in Grade 6 and 7 as measured by various sub-scales in Cluster 7 before and after the Lifestyle Programme.

		Before the SANCA Lifestyle Programme				*After the SANCA Lifestyle Programme*			
Age group	Sub-scale	No clinical problem	Uncertain	Clinical problem	Severe clinical problem	*No clinical problem*	*Uncertain*	*Clinical problem*	*Severe clinical problem*
10-13 years	Problems with School	52.44	2.44	7.32	0.00	*51.23*	*0.00*	*5.74*	*0.41*
	Problems with Mother	57.98	0.00	3.11	0.39	*53.69*	*0.82*	*2.46*	*0.41*
14-18 years	Problems with School	28.46	0.00	9.35	0.00	*38.11*	*0.82*	*3.69*	*0.00*
	Problems with Mother	32.30	0.00	4.67	1.56	*41.80*	*0.00*	*0.82*	*0.00*

Table 3.1.26: Summary of Psychosocial functioning scores between males and females in Grade 6 and 7 as measured by various sub-scales in Cluster 7 before and after the Lifestyle Programme.

		Before the SANCA Lifestyle Programme				*After the SANCA Lifestyle Programme*			
Gender	Sub-scale	No clinical problem	Uncertain	Clinical problem	Severe clinical problem	*No clinical problem*	*Uncertain*	*Clinical problem*	*Severe clinical problem*
Male	Problems with School	43.32	0.81	10.53		*48.36*	*0.82*	*6.15*	*0.41*
	Problems with Mother	48.06	0.00	5.43	1.55	*54.92*	*0.00*	*0.41*	*0.41*
Female	Problems with School	38.06	1.21	6.07	0.00	*40.98*	*0.00*	*3.28*	*0.00*
	Problems with Mother	41.86	0.00	2.33	0.78	*40.57*	*0.82*	*2.87*	*0.00*

3.1.27: Psychosocial functioning chi-square values for Cluster 7 before and after the implementation of the programme.

		Before the implementation of the programme		*After the implementation of the programme*	
Sub-scale	Group	X	P-value	*X*	*P-value*
Problems with School	10-13 year and 14-18 year olds	10.067	0.770	*3.550*	*0.314*
	Males and female	1.866	0.393	*3.449*	*0.327*
Problems with Mother	10-13 year and 14-18 year olds	8.267	0.016	*3.371*	*0.338*
	Males and females	2.374	0.305	*9.672*	*0.022*

Table 3.1. 28: Final Lifestyle Programme results for the total sample on Cluster 7

Sub-scales	10-13 years old				14-18 years old			
	males		Females		males		Females	
	X^2	P-value	X^2	P-value	X^2	P-value	X^2	P-value
Problems with school	3.146	0.370	3.070	0.215	6.200	0.045	5.526	0.019
Problems with mother	3.493	0.174	2.780	0.249	12.381	0.002	1.410	0.494

Appendix 3

Results of the 'Self-image' sub-scale, (a sub-scale from the PFI-PRIM-C) linked with a biographical questionnaire (adapted from the Department of Community Psychology Project at the University of the Witwatersrand).

Socio-economic factors by self-image

Family size	Self-image									
	No clinical problem		Uncertain		Clinical problem		Severe clinical problem		Total	
	Frequency (f)	%	f	%	f	%	f	%	f	%
1-6 people	40	15.44	2	0.77	101	39.00	5	1.93	148	57.14
7-12 people	25	9.65	1	0.39	72	27.80	4	1.54	102	39.38
>12	2	0.77	0	0.00	6	2.32	1	0.39	9	3.47
Total	67	25.87	3	1.16	179	69.11	10	3.86	259	100
Chi-square	p>0.941									

Type of family	Self-image									
	No clinical problem		Uncertain		Clinical problem		Severe clinical problem		Total	
	Frequency (f)	%	f	%	f	%	F	%	f	%
Single parent	6	2.35	0	0.00	20	7.84	0	0.00	26	10.20
Nuclear family	23	9.02	2	0.78	52	20.39	5	1.96	82	32.16
Extended family	30	11.76	1	0.39	93	36.47	4	1.57	128	50.20
Relatives	6	2.35	0	0.00	12	4.71	1	0.39	19	7.45
Total	65	25.49	3	1.18	177	69.41	10	3.92	255	100
Chi-square	p>0.759									

Type of employment	Self-image									
	No clinical problem		Uncertain		Clinical problem		Severe clinical problem		Total	
	Frequency (f)	%	f	%	f	%	F	%	F	%
White-collar job	3	1.38	0	0.00	9	4.15	0	0.00	12	5.53
Blue-collar job	29	13.36	1	0.46	84	38.71	6	2.76	120	55.30
White and blue collar job	5	2.30	0	0.00	12	5.53	1	0.46	18	8.29
Pension or welfare	9	4.15	0	0.00	15	6.91	0	0.00	24	11.06
I don't know	7	3.23	1	0.46	33	15.21	2	0.92	43	19
Total	53	24.42	2	0.92	153	70.51	9	4.15	217	100
Chi-square	p>0.876									

Appendix 4

The Psychosocial Functioning Inventory Scale for Primary School Children (PFI-PRIM-C)

The PFI-PRIM-C is a standardised questionnaire compiled by Perspective Training College (Pretoria) for primary school children. It is designed to measure problems that children experience in personal and social functioning. The PFI-PRIM-C has 16 different sub-scales.

A description of the different sub-scales of the PFI-PRIM-C is given below.

- 'Perseverance'

  "This sub-scale measures problems that the child may have to persevere, in other words, the inability the child may feel to act with determination. It is normally perceived that the troubled child has no perseverance and cannot act with determination towards a goal in life".

- 'Satisfaction'

  "This sub-scale measures problems that the child may have with regard to the unique feelings of well-being the child attaches to his or her life. The troubled child normally experiences dissatisfaction with his life in general".

- 'Future Perspective'

  "This sub-scale measures problems that the child may have with regard to the orientation he has towards his future. A troubled child normally has either no future perspective or an unrealistic future perspective in order to escape from his current unpleasant circumstances".

'Self-image'

"This sub-scale measures problems that the child may have with regard to the image the child has of him or herself. A troubled child normally has a low self-image".

- 'Responsible for others' happiness'

"This sub-scale measure the responsibility a child can feel to create other people' happiness. Normally a troubled child experiences that he has to be responsible for the happiness of others".

- 'Memory Loss'

"This sub-scale measures problems that the child may have to remember basic things".

- 'Frustration'

"This sub-scale measures the reactions of the child to the problems in him or herself and his or her environment that prevents him or her from the achievement of his or her goals and desires in life".

- 'Anxiety'

"This sub-scale measures the feelings of insecurity and fear that the child may experience. This scale is very sensitive to the specific developmental stage of the child. Anxiety is often perceived to be a problem with young primary school children, mainly due to the developmental stage they are in. Trouble in this developmental stage will have excessive anxiety levels".

'Helplessness'

"This sub-scale measure the feelings of the child with regard to the exhaustion of his coping abilities and the helplessness he may feels to do something about his life situation. The developmental stage of the child can play a role in this scale. It is sometimes found that children in a smaller developmental stage feel helpless, because they perceive adults to be in control of their lives and not themselves. If these feelings are correctly dealt with, it need to be serious problem".

- 'Attitude towards adults'

"This sub-scale measures the attitude the child has towards adults in general. It is normally perceived that the troubled child who was the victim of some kind of trauma where adults were involved (e.g. abuse, divorce, etc) has a negative attitude towards adults and they cannot trust adults anymore".

- 'Stigma'

"This sub-scale measures the feelings that the child has with regard to him or her being different from other children".

- 'Problems with School'

"This sub-scale measures the problems that a child may have in school".

- 'Problems with Friends'

"This sub-scale measures the problems that a child may have in his or her relationships with friends. Normally children who are troubled find it difficult to relate with friends".

- 'Problems with Mother'

"This sub-scale measures the problems that a child may have in his or her relationship with his or her mother. It is often encountered that young children still idealise their relationship with their mother. Primary school children therefore cannot always give a true picture of their relationship with their mother".

- 'Problems with Father'

"This sub-scale measures the problems that a child may have in his or her relationship with his or her father. In some instances, primary school children will also idealise their relationship with their father".

- 'Family Problems'

"This sub-scale measures the problems that a child may have in his or her family relationships. Primary school children are more honest with regard to their family as a whole, than with regard to their relationship with their parents". (Faul et al.,1997:12-15).

Appendix 5

The results of a guided evaluation questionnaire schedule for the learners. The researcher designed the questionnaire, and was given to the learners after the implementation of the Lifestyle Programme. The analysis is done by age and gender.

Perceptions of the group process

Questions	Yes Always	Some-times	No Never	P-value (age)	P-value (gender)
1. In your group did you find that your group worked well all the time?	51.98	3.47	44.55	0.591	0.171
2. If your group worked well was this because the members of the group always participated?	55.28	37.02	7.69	0.555	0.733
3. If your group did not work well together was this because the students did not want to participate?	24.88	37.32	37.80	0.974	0.032
4. Did each member get enough chance to talk and participate?	70.19	21.63	8.17	0.306	0.293
5. Did you like being in your group?	91.04	7.55	1.42	0.940	0.144
6. Would you like to work with this group again?	90.24	5.37	4.39	0.406	0.406
7. In your group did the members respond positively (well) to the facilitator?	59.81	32.06	8.13	0.082	0.456

Perceptions of the facilitator

Questions	Yes Always	Some-times	No Never	P-value (age)	P-value (gender)
8. Did the facilitator make the group easy to participate (talk) in?	84.39	13.66	1.95	0.907	0.796
9. Did your facilitator listen to all the members of the group?	81.04	12.80	6.16	0.634	0.722
10. Did your facilitator help each member to participate (talk)?	81.13	16.51	2.39	0.572	0.483
11. Did the facilitator understand everybody's needs?	80.66	16.98	2.36	0.091	0.912

Evaluation of the Lifestyle Programme topics

Question	Yes Always	Some-times	No Never	P-value (age)	P-value (gender
12. Do you think the topics were relevant for you?	80.83	16.58	2.59	0.680	0.201
13. After the program do you consider yourself to be a better-informed (learnt) person?	79.02	19.51	1.46	0.368	0.835
14. Are you able to communicate better with your friends?	78.10	18.10	3.81	0.407	0.542
15. Are you able to communicate better with your family?	84.13	10.10	5.77	0.202	0.250
16. Do you think you can take independent decisions about using drugs and alcohol?	87.56	7.18	5.26	0.198	0.250
17. Do you think you can stand up for your own rights now?	81.43	4.76	13.81	0.253	0.275

Appendix 6

Guided evaluation questionnaire: Facilitator's perspective

The researcher designed the questionnaire. It was an open-ended written questionnaire, which was filled in by the facilitators, after the implementation of the Lifestyle Programme.

How did your group work?

What were the positive aspects about your group?

What were the negative aspects about your group?

To what extent do you think that individuals in your group manifested drug\alcohol problems or other problems? Explain why?

Do you think the topics included in the programme were appropriate for the Soweto children? Explain why?

Are there any topics you would like to discard? What are they?

Give reasons for the topics you would exclude

Do you think the program worked well or not? Why?

In terms of your experience what recommendations would you make for a future program?

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