Practitioners
Preventive Services offered by General Learners and Their Perceptions of Health Risk Behaviours of High School
Dedicated to my sons,
Mihir and Prashil.
were younger than 40 years, 41% were the teacher's doctor for more than five years, and a
and of those 70% had medical aid cover. 83% of the doctors reported on were male, 45%
24% of adolescents attending public schools had a general practitioner in the private sector

activity is compared to their of substance use.

perceived health risk for the complications of health risk behaviors was lower with sexual
activity (26%), nutrition in the top five co-existing health risk behaviors. Learner's self-
and sexual activity (44%), tobacco and alcohol use (36%), and obesity use and sexual
behavior involved in more than one health risk behavior to varying extents with alcohol use
The majority of sexually active adolescents were practicing unsafe sex. Learners reported
(tobacco, alcohol and drugs) was the experiential pattern of having tried these substances.
economically disadvantaged backgrounds. The predominant pattern of substance use
alcohol use (65%), drug use (54%), and sexual activity (57%), among the adolescents from
The profile of health risk behaviors revealed a high prevalence of tobacco use (39%),

In the study sample, there were 55% female learners. 33% of learners from 14 to 17 years

behaviors.

their general practitioners' provision of preventive services to address these health risk
reported involvement in health risk behaviors and their perceptions of their usage and
self-administered questionnaire was used to ascertain school's self high school learners self-
collected public schools in Johannesburg during the first three school terms of 2002. A

descriptive study was done involving 1199 senior high school learners from 18 co-

Abstract
General practitioner referral to the management of the health-risk behaviour to varying for tobacco use and 50% for alcohol use. Learners reported using services from their behaviour occurred in varying degrees: 100% for drug use, 92% for sexual activity, 76% the health-risk behaviour and ways to screen for possible complications of the health risk Secondary prevention in terms of discussions with the doctor about ways in which to stop sexual activity, 48% with tobacco use, 47% with alcohol use, and 33% with drug use.

behaviour usually occurred through direct questioning in the majority of cases: 49% with alcohol use, 18% with tobacco use, and 11% with drug use. Uncovering the health-risk behaviour in a small percentage of cases: 40% with sexual activity, 18% with Learners involved in health-risk behaviours reported that their doctor was aware of the activity, 24% for drug use, 23% for alcohol use, and 19% for tobacco use.

health-risk behaviours, reported having received primary prevention: 28% for sexual Small percentages of learners who had a general practitioner and dental benefit involved in

were the doctors' surgery works (the system) and 11% because of where their doctor is way the services they provided. 27% for their doctor's personal ability and qualities, 12% for the 49% of learners felt that the most important reason why they chose to go their doctor was

92% were the family doctor. 90% of learners had visited their doctor within the past 6 months, 60% had consulted on their own at least once and 86% had consulted with their general practitioner.
access the private sector for preventive services.

from economically disadvantaged backgrounds and also highlights how these adolescents

The research shows the profile of health risk behaviours among older high school learners

alcohol use

depression: 86% for sexual activity, 67% for drug use, 32% for tobacco use and 27% for
operation and time.

And all the principals, teachers and learners involved in the research process for their co-

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Youth Risk Behavior Surveillance System

YRBSS

Youth Risk Behaviour

STD: Sexually Transmitted Diseases

SPHR: Self-Perceived Health Risk

PHC: Primary Health Care

PMTCT: Prevention of Mother-to-Child Transmission

NITRD: Nutrition and Physical Activity

HIV: Human Immunodeficiency Virus

CaPS: Community Preventive Services

CDE: Community Development Education

CHRS: Centers for Disease Control and Prevention

CDC: Centers for Disease Control and Prevention

CABS: Centers for Adolescent Behavioral Services

CDC:

This stands for "Guidelines for Adolescent Preventive Services."

Sexual risk behaviours, substance use, and mental health problems are risk behaviours South African studies use the term substance abuse to include these health

This is an American action for alcohol, tobacco and other drugs use.

American Medical Association

Acquired Immunodeficiency Syndrome

AIDS

ABBREVIATIONS

From 14 to 21 years old at the time of completing the questionnaire. The ages of 10 and 19. In this study, other adolescents include all learners

Adolescence: The World Health Organization defines adolescence as all people between

DEFINITIONS
adolescents engaged in health risk behaviors, have a wide range of resources available to change.

Comprehensive school health programs were among the first to provide a service that would provide not only the means to minimize the behaviors and now require a service that provides retail and education to maintain abstinence. Secondary prevention requires young people who have already initiated health risk behaviors. The emphasis of adolescent health care needs to be shifted towards the provision of improved preventive services to address adolescent health risk behaviors. Primarily, prevention targets young people who have not initiated health risk behaviors and thus level will not reduce the number of young people initiating these health risk behaviors. An emphasis on these health-risk behaviors is costly. Furthermore, interventional efforts attributable to such health risk behaviors, are preventable by minimizing the negative health risk behaviors. One concern for policy makers, given adolescent mortality and morbidity, is that concern for present day policy makers. According to the National Youth Risk Behavior Survey in 2002, "some have these findings are still a high prevalence of a wide range of health risk behaviors," The first South African study of the earlier studies by Phister in Cape Peninsula high school learners revealed behaviors like unsafe sexual practices and alcohol, tobacco, and other drug use (ATOD). Adolescence spans nearly a decade in which young people may initiate health risk behaviors.
or indirectly by means of a questionnaire. When health risk behaviors have been
were information about health risk behaviors is volunteered either by direct questioning
their doctor having to elicit this information. Uncertainties can also be doctor-guided,
self-reporting where young people report health risk behaviors to their doctor without
behavior is uncovered and responded to an appropriate way. Uncertainties can occur by
from the general practice resource, behavior change is only possible if the health risk
characteristics' (from societal norms engaged in health risk behaviors have sought help
terms of context (the service offered and delivered by provider; the and system
pressure resource may depend on the accessibility of health practitioners' services, in
The extent to which adolescents engaged in health risk behaviors during the general
change.

as a referral to obtain these or low cost services provided by the same hospitals and
optimal conditions for privacy and confidentiality. Furthermore, general practice can serve
consulting with the adolescents preferred provider; physical examinations by a doctor and
comprehensive preventive service. General practice provides an opportunity for one-to-one
those at risk (school), more flexible access hours and a greater potential to provide a
health resource for our youth. If provides easier general access to all adolescents (even
health practice is community based, thus providing a potentially powerful and cost-effective
resource to complement and reinforce the preventive efforts in the other sectors. General

The general practitioner in the primary health care setting has thus far been overlooked as a
Government hospitals and clinics,

and development programs are other school based or have been implemented in the
commitment to promoting the health and well being of young people. Most of the social
which young people in public schools are attending primary health care facilities and a designated annual preventive visit do not exist. The research explores the way in alcohol, tobacco and other drug use. The research is in a setting where national guidelines and "sentinel" issues for adolescents will be assessed, namely unsafe sex practices and address these health risk behaviors. Only those health risk behaviors that are especially adolescents' use and their general practitioner's provision of preventive services in the research aims to provide a profile of health risk behaviors and describe other.

false.

levels. This highlights the fact that other pre-requisites are necessary to improve screening behaviors improve when national guidelines have been applied but not to recommended for routine medical care. Overseas research indicates that screening rates for health-risk health care settings are not available. Preventive services occur when adolescents present at the national guidelines for the delivery of adolescent preventive services in the primary and overseas guidelines recommend that all adolescents receive an annual, comprehensive

Guidelines for the provision of adolescent preventive services (6APs).

There are many guidelines available for general practitioners to provide optimal preventive behavior change in adolescents in their risk prevention (self – perceived health risk) and providing the means to effect behavior change another pre-requisite for co-morbidity, providing relevant education and information, immunization at risk uncovered, the general practitioner must respond in an appropriate way by screening for
Health risk behaviours

use of and their general practices' provision of preventive services to address these

To provide a profile of health risk behaviours among older adolescents and describe their

1.2

Optimal preventive service provision is based on the WHO GAPs recommendations.

behaviours and the way in which the general practitioners respond were examined.

the utilization of their general practitioners' services, the recognition of health risk

preventive in private practice for study. Specific loci of - perceived health risks,

of both primary and public preventive services; in the motivation to seek only the general

system. The aetiological reasons and the feasibility of environmental changes

improve the quality of adolescent health needs in the face of an overburdened public health

private sector may become a necessary component in future government initiatives to

parents about their child's performance, formally culminating primary health care workers in the

may not have access to funds to see their general practitioners and young people are

from below economic circumstances may still have poor resources due to the fact that they

preventive services delivered to young people if it is important to note that even young people

specify challenges all medical services are faced with when attempting to organize

and provide general practitioners with ample resources has the potential to emphasize the

and hospitals), an overview of this information between health with the least resources

specifically in the primary sector (and not the customary attendance at government clinics.
complications of unhealthy lifestyle choices. Strategies to optimize preventive health services especially for those most vulnerable to low back pain and other chronic conditions, especially for people from lower socioeconomic backgrounds, access the general practitioner’s office more frequently than people from higher socioeconomic backgrounds. Understanding the dynamics involved when young people from lower socioeconomic backgrounds seek primary health care services, the primary objectives are:

1. To determine the pattern of teenagers’ health risk behaviors, the presence of co-

2. To determine learner’s utilization of the general practitioner’s service in terms of extensive health risk behaviors and learner’s self-identified risk.

3. To determine the extent to which general practitioners deal with health risk

4. To determine the demographic of the high school learners in terms of age, gender,

5. To determine the demographic of the general practitioner that the learner usually

The secondary objectives are:

A. To use of health behaviors and secondary preventive efforts for sexual activity and

b. To determine the closure of the general practitioner’s consultation and

and learner’s consultation patterns,

consult in terms of perceived age and gender.


c. To determine the utilization of the general practitioner’s service in terms of extensive health risk behaviors and learner’s self-identified risk.

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Introduction
Specific health risk behaviours. Susceptible studies could include trends with the various specific health risk behaviours. This study allowed us to compare our data with international levels for adverse and violent and sexual behaviour. The study provided a profile of a wide range of

(30 to 45 minutes) school period. The questionnaire covered sexual behaviour, substance use, and violent and sexual behaviour. This study provided a profile of a wide range of

participate in the study, a self-administered questionnaire was completed during a normal school curriculum. The arts and drama schools, historically, there were education departments in 1992 in educational public schools with a normal curriculum (not with a specialized curriculum). The study was done with a range of health risk behaviours is prevalent among our youth. The study was done with a range of health risk behaviours. A large local study of 7460 high school learners in the Cape Peninsula revealed that a

This survey every 2 years

risk behaviours. was conducted in 2002 and subsequently in 2005. It is planned to repeat

provincial and national data and is comparable in terms of surveying a range of health

1991. In South Africa our first National Youth Risk Behaviour Survey was conducted since

adolescent health programs. This 2 yearly survey has been successfully conducted since

behaviours among young people on a national level, to more effectively target and improve

behaviour surveillance that provides vital information on a wide range of health risk

behave in specific geographic areas, therefore making a

involves in health risk behaviours. These studies, however, emphasized specific health

in South Africa. Many studies have confirmed the high percentages of adolescents

Assessing Adolescent Health Risk Behaviours
Although 7.5% had smoked cannabis and 6.7% reported a lifetime use of illegal drugs and alcohol, 7.5% had smoked cannabis and 6.7% reported a lifetime use of illegal drugs and alcohol. However, when asked about their smoking and alcohol consumption habits, 5.2% of the respondents reported using tobacco and alcohol at least once per week. The results of the survey showed that 18.1% of the respondents indicated that they smoked and drank at least once per week.

Despite these findings, the prevalence of health risk behaviors needs to be addressed. Students and parents must understand that health-risk behaviors, such as smoking and drinking, can have severe consequences on one's health. It is necessary to develop effective interventions that address the root causes of these behaviors. This study also showed an association between various forms of health-risk behaviors like alcohol consumption and smoking and risky sexual practices. Other studies have shown that there is an association between various forms of health-risk behaviors like alcohol consumption and smoking and risky sexual practices. Other studies have shown that there is a need for schools to adopt health-promotion programs that focus on preventing health-risk behaviors and promoting healthy lifestyles.
The First National South African Youth Risk Behaviour Survey is a landmark study because it has established a baseline for future studies and analyses of trends of risk factors among young people.

Sexual activity from 17 to 38%, from 14 to 31%, alcohol use from 25 to 69%, cannabis use from 7 to 19.6% and 2002 Youth Risk Behaviour Survey, this still holds true, with increasing use increasing. When comparing the 1992 Cape Peninsula results to the Western Cape figures of the profile is deteriorating (i.e., note the one study in Regional while the other in national).

When comparing these figures to results 10 years ago in the Cape Peninsula study, the risk of smoking over consuming alcohol, 13% over using cannabis and 41% had had sex. When it occurred between November and October of 2002, 37% reported ever smoking. 49% of government schools. Data collection through a self-administered questionnaire.

The study sample comprised of secondary school learners from Grades 8 to 12 attending schools where implementing specific health programs.

Priorities when implementing specific health programs.

health problems amongst our youth, assess health policy decisions and determine the public health goals at a provincial and a national level, which can change important behavioral, physical activity and hygiene related behaviors. Such a survey can provide us with objective data. Both at a provincial and national level, which can change important behavioral, physical activity and hygiene related behaviors. Such a survey can provide us with objective data. Both at a provincial and national level, which can change important behavioral, physical activity and hygiene related behaviors.
behavioral change as they feel older and self-regulatory mechanisms lack in and perhaps into behavior change. This suggests that young people will only be capable of knowledge about the potential health risks of their behaviors. They do not translate this to be remedied through education. Studies show that even though adolescents have regulatory competence, this distinction is probabilistically driven, not measureable and unlikely. A distinction between novelty and sensation seeking and the development of self-denote influence self-control. Adolescence is a vulnerable period because there is a great difference in the perception but rather to age differences in psychosocial factors to age differences in perception. But rather to age differences in psychosocial factors or conclusions show that adolescents engage in more risky taking than adults. Not the one perception is a necessity but not the only pre-requisite for behavior change.

School-based intervention programs:

School-based intervention programs may reveal higher incidences of risk behaviors.

School-based interventions in primary health care settings like government clinics and general practitioners, preventive school health may be higher. The adolescent behavioral problems in community settings may be higher. The behavioral problems may be reducing a healthy behavior because institutions. Despite school-based being compulsory between the ages of 7 and 15 in South Africa, adolescents' school-leavers and those attending other secondary education institutions like dance schools, school-leavers and those attending other secondary education institutions among all youth. It is however, still school-based thus excluding important
intervention in the health care setting. Such a service must provide not only the means to
intervene on health risk behaviors, now require in addition to school-based efforts, in
primary health care facilities that serve all young people, not only school attendees, need
accomplished with the support of other preventive services. Other community-based
programs, reducing the health risk behaviors of adolescents is a challenge that is best
achieved through school-based interventions. School-based interventions have poor school attendance thus reducing the potential benefits
of interventions and assessment of these interventions. If it is also true that adolescents involved
in health risk behaviors have poor school attendance thus reducing the potential benefits
of school-based interventions an ideal venue for research health education and health promotion.
Alcohol Schools Act of 1995 makes schooling compulsory for all 7 to 15 year olds.
Schools provide an ideal venue for research health education and health promotion
Intervention programs to deal with adolescent health risk behaviors are predominantily
assessing adolescent preventive services in the health care setting.

2.3

The best way of dealing with the problem is to focus on assessing the harm associated
Focus on specific health risk behaviours.

Sector is sparse. Studies focus on the public sector (provisional government clinics) and research relating to the evaluation of adolescent preventive service delivery in the health sector, especially in a disadvantaged, rural area because of affordability and thereby the absence of national guidelines being provided. Secondarily, young people from disadvantaged backgrounds are unable to access government clinics based on the skills programmes being incorporated into the normal school curriculum. The substantial is different. Firstly, adolescent preventive services are predominantly school-based. Accessing adolescent preventive service delivery by general practitioners in the Health for some medical problems.

Follow. At present, adolescent preventive services are delivered when young people present to each other. There are no national guidelines specific for the South African context to work with. In the private rooms, have organized their preventive services independently, of each other. The primary health care physician working in the clinic and the general practitioner often. In South Africa, the government clinics and private practices run independently, of each other. The government are seeing young people from disadvantage backgrounds to vary experiences.

Framing a comprehensive preventive care plan is not always met in this setting. General government clinics because they are affordable. The ideal conditions for a young person to have preventive care. In South Africa, the youth from economically disadvantaged backgrounds utilises the preventive behaviours minimising the complications of health risk behaviours but also the means to effect.
people in the health care setting in important undertakings. Overseas studies show that
make health services 'adolescent friendly', has made research in the preferences of young
utilize the health service depends on how acceptable the service is to them. Striving to
go beyond just providing more services for young people. The way in which young people
Young people have fewer resources to access for their health needs than adults. We have to
behaviours.
improve preventive service delivery to those who screen positive for health risk
highlighted the need to improve access and contribute most to adolescent mortality and to
recommendations but at rates greater than physicians in other practice settings. It also
that these doctors provided preventive services to adolescent patients at rates below
with adolescent patients who have engaged in a health risk behavior. The study showed
their screening and education practices on 34 recommended services and the sections taken
in a California group-model health maintenance organization doctors were asked about
in a survey mailed between September 1996 and April 1997 to all pediatricians practicing
problem areas that need improvement.
organization can compare preventive service delivery over time and uncover specific
the guidelines and those who do not. Longitudinal studies in particular reveal maintenance
comparing preventive service delivery in health maintenance organizations that are using
annual health visits between the ages of 11 and 21. Research in this setting is aimed at
applied in preventive health service delivery for young people. This occurs in a series of
American medical association's guidelines for adolescent preventive services is being
provide a single service where guidelines can be used for optimal preventive care. The
provide people responsive to their health care needs. Here primary health care physicians,
In the United States, Health Maintenance Organizations tend to the preventive needs of all


backgrounds, to apply for NAVC LI accreditation. Perhaps these initiatives in the South
practitioners, who also serve young people from economically disadvantaged
the transformation process. The possibilities exist for the inclusion of private general
show that young people have specific needs that differ from adults accessing preventive services. These
young people also receive the same care as adults, and these characteristics are of greater importance than the
afford (more than 90% of the criteria achieved). In contrast, many clinics are at various
achieving either a Silver or Gold (at least 60% of the NAVC criteria) status. Significant
claim to self-appointed, the clinic improvement process and external clinic assessments to
NAVCl accreditation which aims to transform existing clinics through various stages of
Health ministers. This problem is being addressed by encouraging clinics to seek
For many reasons, young people find it difficult to access information and services from
developed to improve the quality of adolescent health at the governmental clinic level.
between “ Lowell” and the National Department of Health. It is a program that has been
sector. NAVCl, the National Adolescent Friendly Clinic Initiative, is a joint initiative
needs and circumstances of young people when accessing preventive services in the private
needs with dignity and respect. In South Africa there is a policy of care on the specific
adolescents are most concerned with being respected and treated well by their primary care
adolescents in the health care setting. Another American study showed that urban
system characteristics. The study also showed that young people are concerned with
should be highlighted that provider characteristics of greater importance than the
shows, that young people are aware of the factors contributing to their decisions to seek
of services received and the provocative characteristics (the system). An American study
of specific needs relate to provider characteristics (doctor personality and qualities), the type
adolescents have specific needs that differ from adults accessing preventive services. These
the health care setting.

Ahlem said, will spur on extensive research relating to young people's specific needs in
West and 8 schools from Johannesburg South were randomly selected (a total of 18
Johannesburg South, 3 schools from Johannesburg East, 3 schools from Johannesburg
62 in Johannesburg South, 17 in Johannesburg North, 18 in Johannesburg East, and
Study's 27 in Johannesburg South, 17 in Johannesburg North, 18 in Johannesburg East, and
which is now not used in Johannesburg. 14 schools were eligible to take part in the
2002, Johannesburg schools were developed into four educational districts, a system
school is a government secondary co-educational school with an ordinary curriculum, in
(OED), all schools that were eligible to take part in the study were selected. An eligible
using the 2001 list of schools published by the Gauteng Department of Education.

3.2 Study Sample

was conducted over the first three school terms of 2002.
and Coloureds were also represented. Racial data was not specifically sought. The research
informal housing settlements. The majority of the learners were Black but Whites, Indians
population is in an urban setting, with learners coming from residential suburbs as well as
The learners were mainly from the lower and middle socio-economic groups. The
the majority of learners attending the secondary school.

Johannesburg. These inclusion criteria are based on the fact that these learners represent
without any special curriculum like Arts, Drama, or a Technical curriculum) in
attending secondary public co-educational schools with an ordinary curriculum (that is
The study population consisted of senior high school learners, (Grades 10, 11 and 12)

3.2 Study Population

A cross-sectional descriptive study.

3.1 Study Design

CHAPTER 3: METHOD
3.1 shows the details of the sampling process for schools to participate in the research. With 95% confidence, we can estimate the proportion to be within 0.055. Figures 3.2 and 3.3 show how the proportions will extend no further than 0.065 from the observed proportions. These proportions will extend no further than 0.065 from the observed proportions. This will add to the expected proportion of learners with general educational needs. Within the four educational districts, with an expected proportion of learners, our districts is based on an estimate of the proportion of learners who have general educational needs. Within the four districts, we estimate the proportion of learners to be at least 0.065 for each district. The sample size of 1000 is based on a 0.4 proportion rate of the general population of schools.
Each class.

counsel forms were collected within 2 weeks and a research day appointment was made for
learners who were 16 years and older could fill in the consent forms themselves. The
letter and consent form (Appendix A) with instructions on how to fill them out. Those
of their roles in the research. Each learner, 12 years and younger, was given an information
researcher and research assistant addressed each of these classes to provide a broad outline
regarding the other classes that were not selected was not specifically sought. The
selected. Only the class lists of the randomly selected classes were obtained. Information
number of classes in each grade was retained. One class from each grade was randomly
for the sole purpose of randomly selecting just one class from each grade. No record of the
classes in each grade varied from one school to another, but this information was sought.
If the principal agreed to the school taking part in the study, a contact person at the school
permission letter from the ODE (Appendix 2) and a letter from the CRHS (Appendix 1) to take part in the study.
was then issued or mailed a letter of invitation (Appendix 2) to take part in the study.
The principal of the school was contacted by telephone or by registered mail. The principal
and female learners.

representation of each school in each district and with a representative proportion of male
proportional representation by each educational district in Johannesburg, with the
district were randomly selected. The study sample was chosen in this way to try to achieve
Of the 122 remaining schools, a proportional number of schools for each educational
Formal data allowed more time to complete the questionnaire. More was the commission of the written instructions to learners to a more informal verbal administration of the questionnaires in terms of the layout and phrasing of the questions. Of the problem areas with obtaining consent, il also highlighted difficulties when they were to obtain consent and present to complete the research questionnaires. Il highlighted difficulty generated by (Appendix G). The pilot study indicated the number of learners that are The second school that agreed to take part in the research assisted in completing the pilot

3.4.2 The Pilot Study
To make it easily understandable for high school learners, into the way in which the final research questionnaire had to be structured and worded were applicable to the study group. The nominal group discussion also provided insight recommendations for the delivery of preventive services in the primary care setting. The information gathered in this nominal group discussion confirmed that the GAPs Nominal Group Information Letter (Appendix G) outlining the information needed, Nominal Group Information Letter (Appendix G) outlining the information needed, an overview of each of the groups selected to take part. The nominal group proportion of number from each of the groups selected to take part. The nominal group researcher selected this nominal group discussion consisting of 11 learners a researcher selected this nominal group discussion consisting of 11 learners a given issue. The information from relevant experts (high school learners) about a given issue. The method to assess unanimity on an issue is a highly structured meeting to gather assistance in the nominal group discussion. The nominal group reached a consensus assisted in the nominal group discussion. The nominal group reached a consensus

3.4.1 The Nominal Group Discussion
Research Tools
used at their doctor's rooms.

behavior, discussions with their doctor about the health risk behaviour and the services
learned who have General Practitioners. They deal with the uncertainty of the health risk
perceived health risk. The remaining questions in Sections C to F were only for those
each of these sections which dealt with the pattern of the health risk behaviour and the self
a proportion and General Practitioners. All learners had to answer the first few questions of
only a proportion of the learners were involved in health risk behaviours and of those only
Sections C to F deal with each of the health risk behaviours in turn. In the study sample.

private sector to continue with the rest of the questions in Section A and B.

beiners. An exit poll allowed only those learners who have a General Practitioner in the
In Section A, the first five questions deal with obtaining the demographic data of the
beiners. It consists of six sections.

objectives outlined previously. It was in everyday language, in a formal manner to
The self-administered research questionnaire (Appendix 7) was designed to meet the
uniformity.

library or laboratory. In all cases examination circumstances were simulated. For
exception of a few larger classes where the research was conducted in the school hall,
with any problems. In most cases the research was conducted in classrooms, with the
with both the researcher and the research assistant being available at each session to deal
learners in each class held out a self-administered questionnaire in 54 separate sessions.

3.4.3 The Research Questionnaire
made them unhealthy." It may be dangerous to their health and secondary if the health risk behavior has already been involved in health risk behaviors. Other current or past behaviors refer to having ever been involved in health risk behaviors. The reporting of health risk behaviors in the CDC's Health Behavior Survey.15 Learners were asked about type and frequency of Health risk behaviors patterns were assessed using some of the parameters used in the assessment system. The only open-ended question in the research gastrostomy was referred to divided into doctor services, doctor personality, and qualities, and the way the surgery was done. Learners were given the opportunity to describe any other criteria not listed in the questionnaire. To enhance quality, these questions were when choosing their general practitioner. Learners were allowed to consider the emotional, social, and educational criteria in order to describe the learners who took part in the study and the doctors about whom learners were described. The demographic details of the learner and the general practitioner were sought in order to
obtained from the Canadian Department of Education (Appendix 2) to have access to
protocol was approved by the Post Graduate Committee (Appendix 1). Permission was

clearance certificate number M01116 was issued on 23/10/1973 (Appendix 3) and the
The protocol was submitted to the Committee for Research on Human Subjects and the

Ethics

was adequate (Appendix 9).

at the University of the Western Cape issued a certificate to confirm that the translation
requests the Afrikaans version or any other translation. The head of translation studies
also usually writes their translation examination in Afrikaans. None of the other schools
translated into Afrikaans (Appendix 8) as the request of one Afrikaans-medium school that

Seventeen schools used the original English questionnaire. The questionnaire had to be

related to the health risk behaviour from their doctor's rooms.

health risk behaviour were discussed with their doctor and if they used particular services
in a particular health risk behaviour were asked to report it particular topics related to the

services (GP's) was used to specify the content of preventive services. It was also used

The American Medical Association (AMA) Guidelines for Adolescent Preventive

doctor knows about the health risk behaviour and how the doctor found out about it.

indirectly in a questionnaire is therefore necessary in association. Learners were asked if their

self-reporting without the doctors influence or doctor influence by direct questions of

secondary preventive measures. The way in which the uncovering occurs, that is by

The uncovering of health risk behaviours by a preventive service is mandatory to initiate

What
Throughout each session and learners were instructed to request help in completing any sections of questionnaires they found difficult to understand. The research team was present throughout each session to ensure that all learners were engaged and that the questions were clear. The research was designed to be culturally relevant and inclusive, allowing learners to express themselves freely. Once all the learners were checked and approved, the checklist was shared with the participants. Each learner was given a number to help them take part in the study. Consent forms were previously obtained from all learners and researchers.
Each question was individually coded. The educational district was represented all questionnaires were put in batches according to the educational district, school, and

Dare Analys

Completed the questionnaire:

but did not play an active role. This ensured that learners did not feel intimidated when people involved in adolescent health problems, the teachers and principals were available. Adolescents health risk behaviors as well as a list of all contacts of adolescents and ensure anonymity; Each learner was reminded to collect an information package relating to the learners were reminded not to fill in their names anywhere on the questionnaire.

involved in particular health risk behaviours.

each point from each section where a learner did not have a general prediction or was not

Instructions were given about the way in which to answer the questionnaire, especially the study was explained.

Learners started filling in the questionnaire, a reminder about the reason for completing the of everyone. The time allocation was an average school period of 30 minutes. Before learners felt reasonably comfortable that their responses to questions were not in open view examination. This was to ensure that there was no discussion between learners and that completion of the questionnaires occurred under the same conditions of a written school to adolescent health risk behaviours.

After completing the questionnaires each learner was given an information package related deep with each session, the whole process improved and eventually ran smoothly. Questions, practical difficulties like too few desks and a lack of written material had to be
Secondary schools.

cpowers that the study sample was representative of most young people attending
resources available to conduct the research. All attempts, however, were made to
in South Africa. This lack of generalisability was unavoidable due to the resources on
applicable to all educational systems in other areas of Gauteng Province or other provinces

1. The research was conducted in Johannesburg. It is not broad-based, so it may not be

The following limitations may apply:

3.8 Limitations

with a 95% confidence interval.

the significance of observed data in subgroups was determined using the two tailed p values
subgroup. This also meant that non-responders could not be shown on the tables. Significant
be highlighted. If percentages were compared because all the n values differed for each
In order to present the data in a meaningful way, differences between subgroups could only
and bar charts were used to present the data depicting various aspects of the study sample.
Council in Pretoria. The data was analyzed using the EPI Info Program. Frequency tables
school. This coding was essential to facilitate data capturing at the Medical Research
participation in the study. The questionnaires is the 13th one in the grade 10 class of this
of the

(10) 13 represents the first school in the Johannesburg North district selected for
Each questionnaire in each class was assigned a number from 1 upwards. For example,
each educational district. The grade was included in the coding with either a B, R or D
and West respectively. As seen in Table 4.1, a number was assigned to each school from
by either one of the letters S, N, E and W representing Johannesburg South, North, East,
41

Health service delivery, but is only accurate within 5 to 7 months of receipt of the case they have received is a valid method of determining the content of preventive services in the general practice setting. Adolescents' self-report of the prevalence of risk behaviour, like self-report of the receipt of self-reported health risk behaviours and the receipt of treatment, is an important method for identifying and evaluating the effectiveness of preventive strategies. The research results on the self-reporting of health risk behaviours and the receipt of treatment have been introduced.

2. Only some of the adolescent health risk behaviours were selected for study. The research is therefore not comprehensive to include all adolescent health risk behaviours. The research is therefore not comprehensive to include all adolescent health risk behaviours. The research is therefore not comprehensive to include all adolescent health risk behaviours. The research is therefore not comprehensive to include all adolescent health risk behaviours. The research is therefore not comprehensive to include all adolescent health risk behaviours. The research is therefore not comprehensive to include all adolescent health risk behaviours. The research is therefore not comprehensive to include all adolescent health risk behaviours.

5. The absenteeism rates for high school learners are higher, especially for those involved in health risk behaviours, so a "healthy learner effect" may occur. In this system with a normal curriculum, majority of the adolescents attending high school are located in our public schooling for those with special needs (the mentally and physically impaired), The very private schools and high schools with specialised curricula (arts and drama) and public schools were selected. This excludes all high school learners attending been introduced.

3. The research is limited to high school learners from 14 to 17 years of age. In South Africa, attending school is compulsory for all 10 to 15 year olds. The dropout rate for high school learners is therefore significantly lower than the general population in this age group. In this way selection bias may have been introduced.

6. The research results on the self-reporting of health risk behaviours and the receipt of treatment have been introduced.
was based, demonstrates good test-retest reliability.

Youth Risk Behavior Survey Questionnaire, on which the research questionnaire
behaviors.
reporting health risk behaviors and determining the patterns of health risk
order to obtain information on health risk behaviors, especially in terms of self-
Preventions (CDC), Youth Risk Behavior Surveillance System (YRBS), 19
service. The questionnaire is based on the Centers for Disease Control and
Fifty-four schools had to be approached in order to get 20 schools to participate which is a 37.6% response rate from schools. As shown on Table 4.1 a total of 2287 consent forms were handed out to each learner in the classes that were selected for participation in the study. Those who were ill or out of school for any reason that day or whose parents did not send consent forms (59%) were eliminated. Those who were absent on research day. A total of 1269 consent forms occurred at two levels. Firstly those who did not have consent to make part in study.

Table 4.1: Lister Response Rates According to Schools

<table>
<thead>
<tr>
<th>Grade</th>
<th>TOTALS</th>
<th>WEST</th>
<th>EAST</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>7</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Chapter 4: RESULTS
This included the demographics, health risk behaviours and patterns, and self.

In Section 4, the results of all learners (1139) that took part in the study were presented.

The results were grouped and presented in the following way:

- General characteristics
- Health risk behaviours
- Psychosocial factors

In order to present all this data in an easily understandable form, all different health risk behaviours and many aspects of the information were reduced to their essential elements. This was done to avoid presenting too much data and to make the report easier to read. The data presented are based on the data available and are not presented to be comprehensive or to be presented in health risk behaviours as not reported. The data presented are based on the health risk behaviours of those learners who were not involved in health risk behaviours as not reported. The data presented are based on the health risk behaviours of those learners who were not involved in health risk behaviours as not reported.

It was possible to report on information about particular educational districts, schools and

42

School Presentation Format and Remarks

West educational districts

- Learners were from Johannesburg East and 14% (161 learners) were from Johannesburg
- Johannesburg South, 19% (227 learners) were from Johannesburg
- Johannesburg North, 20% (227

Of the 1139 learners taking part in the research, 47% (530 learners) were from the

Research questionnaire was sent to 300 learners, 1139 learners filled out the Research questionnaire that is 90% of those who received it.
Section A, Questions 1-5

Learner Demographics of the Doctor Group:

Section B: Learners with General Practitioners

without a general practitioner were highlighted.

except that in this section the differences in the two subgroups (the doctor group and those

general practitioners) were presented. The same aspects as in Section A were covered.

In Section B, the results of the subgroup (277 learners), namely those learners who have a

Section F, Question 1

Section E, Questions 3-4

Section D, Questions 2-3

Section C, Questions 4-5

Self Perceived Health Risk:

Section F, Question 1

Section E, Questions 1-2

Section D, Question 1

Section C, Questions 1-3

Health Risk Behaviour, Patients and Partners:

Section A, Questions 1-5

Learner Demographics:

Section A: All Learners

Research questionnaire,

perceived health risks. The information had to be extracted from different sections of the
Section A, Questions 18

General Practitioner Behaviours in Wet Risk Behaviours

Section B, Questions 1.5

Learners describing their General Practitioners

Section A, Questions 7.10-17

Consulting Pattern

Section A, Questions 6.8.9

General Practitioner Demographics

Section A, Learners Interaction with their General Practitioners

Practitioners dealt with the health risk behaviours were presented. Influencing learnings choice of General Practitioner and the way in which General Practitioner developed knowledge, various consulting patterns, templates, and General Practitioner demographics completed the relevant sections of the research. Only the 271 questions

Section F, Question 1

Section E, Questions 7-4

Section D, Questions 2.3

Section C, Questions 4-5

Self-perceived Health Risk of the Doctor Group

Section F, Question 1

Section E, Questions 1.2

Section D, Question 1

Section C, Questions 1-3

Health Risk Behaviour Profiles of the Doctor Group
medium school that requested an Afrikaans translation of the Research Questionnaire.
With 100% of learners reporting Afrikaans as their preferred language in an Afrikaans-
like any school requested a translation that it was only warranted. This was also confirmed
responding that English was their preferred language. It was also important to establish that
questionnaire in their preferred language. This was confirmed with 62% (710 learners).
It was important to ascertain if the majority of learners answered in English Research
Learner age, however, provided more substantial findings as opposed to the learner grade.
For easier access to adolescents, learners in particular grades were entered into the study
more likely to be in the same district.

relating to the educational district was that the learner's doctor's consulting rooms were
previous Johannesburg educational districts. The only significant finding that emerged
Results have therefore been presented for Johannesburg as a whole, and not using the
however, Johannesburg schools are no longer designated to these educational districts.
districts, was a useful way to randomly select schools from all over Johannesburg. Today,
in 2001, the GDE instituted the AEC Intervention Unit which divided Johannesburg into four educational

4.3.1 Learner Demographics

Section A: All Learners

Results

Section B, Questions 5-6
Section C, Questions 7-9
Section D, Questions 4-7
Section E, Questions 2-5
4.3.2 Learner Age

Income scores (1-12) also with almost an equal number of learners in each group. The income score was categorized into lower, income scores (0-3), and higher. Female learners were categorized into each group. Learner gender was assigned either male or female. Learners 14-17 years old, older learners (18-21 years old) with almost an equal number of learners in each group. In order to present the data in a meaningful way, the learner age was categorized into:

- Early (9-12 years old)
- Middle (13-15 years old)
- Late (16-18 years old)

Because these variables highlighted more significant results, demographic fields selected to present the data were learner gender, learner age and income. Language was not used as a learner variable when presenting results. The learner language was conflated with the entirety of the learners. Is for this reason that learner predicted English-medium schools, the predicted language indicated by the learner does not.
Description of each income score

Occupation was then given a score. The total score was out of 12. Table 4.2 shows the work
 meant by any person who supports the learner and not necessarily the legal term. Each
and/or their household. If they were contributing to the family income, the term “guardian”
 the learner had to enter as much detail about the occupations of their father, their mother
 learners generally do not know the family income. In order to get an idea of family income,
 gender income scores to other variables. Income level was very difficult to assess, because
 socio-economic groups. It was necessary to confirm this in the study sample and possibly
 learners attending government schools are predominantly from the lower and middle

4.3.1.3 Income Scores

69.2%

Confidence limits for learner gender are: Male: 37.8% and 45.6%; Female: 56.7% and
 respondents, 59% (675) of the learners were female and 41% (465) were male. The 95%
 of the 1139 learners, 1138 learners indicated whether they were male or female. Of the

4.3.1.2 Learner Gender

44.3% and 50.3%

Confidence limits for the younger learners is 49.7% and 55.7% and for the older learners,
 expected for a Grade 12 learner starting formal schooling at 6 to 7 years old. The 95%
 group. It is important to note that 21% (244 learners) are 19 to 21 years old (above the age
 learners) are in the younger age group and 47% (537 learners) are in the older age
 of the 1139 learners, 99% (1127 learners) indicated their age in years and months. 53%
Income scores are low, which is expected because the learners are from government schools. Figure 4.2 shows the distribution of the income scores.

Even though this method has limitations, the figure shows us that most of the learners are living below the poverty line. This is confirmed by the fact that most of the learners are from low-income households. Some learners were being supported by their grandparents, in whose absence they were taken care of by other family members.

In learners' responses, these scores were sought out for possible sources of income. In

<table>
<thead>
<tr>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher's profession (also receptionist, cashier, salesman)</td>
<td>4</td>
</tr>
<tr>
<td>Cleaner (also lady)</td>
<td>3</td>
</tr>
<tr>
<td>Cleaner (also domestic worker, taxi driver, security guard, cleaner)</td>
<td>2</td>
</tr>
<tr>
<td>Pensioner (also disabled, greens, donut's, beggars, police reserve)</td>
<td>1</td>
</tr>
<tr>
<td>Unemployed (also deceased, pension, housewife)</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 4.2: Income scores based on work description.
and HL = 56.56% and higher score (LL = 43.43% and HL = 49.49%).

Scores are the 95% confidence limits for income scores are lower income score: (LL = 50.69% learners reported lower income scores while 46% (1513 learners) reported higher income to interpret this information or the income data, therefore, may not be accurate. 49% (552 did not use supporting them. 51 learners reported no income source, which is difficult to interpret. Income scores include the 1139 learners, 97% (1105) indicated with their father, mother, and/or guardian.

Figure 4.2: Income Scores
Statistically significant results related to income scores was that there were more learners (p=0.05, OR=6.89% and UI=0.09% and UL=76.69%). The only other variable where significant results were found was for alcohol and sexual activity; the p value and 95% confidence limits were for alcohol (p=0.05, OR=6.05% and UI=2.0% and UL=20.4% and sexual activity (p=0.05, OR=7.3% and UI=1.81% and UL=7.94%). The older learners are more involved in all health risk behaviors: tobacco (p=0.05, OR=4.5% and UI=2.0% and UL=9.4% and alcohol (p=0.05, OR=7.3% and UI=1.81% and UL=7.94%). All these values were statistically significant with the following p values and 95% confidence limits for male learners being relevant to be involved in all health risk behaviors. All these values were more for male learners (57%), followed by alcohol use (39%) and drug use (15%). The gender percentages show more activity (57%), tobacco use (39%) and drug use (15%). The gender percentages show more activity for male learners (57%), followed by alcohol use (39%) and drug use (15%). The gender percentages show more activity (57%), tobacco use (39%) and drug use (15%). The gender percentages show more activity (57%), followed by alcohol use (39%) and drug use (15%).

![Table 4.3: Learner Demographics and Health Risk Behavior Profiles](image)

**Table 4.3:** Learner Demographics and Health Risk Behavior Profiles

In this section, the data relating to the profile and patterns of the health risk behaviors will be discussed with regard to the learner demographics. Significant differences have been used to compare the various health risk behaviors. Table 4.3 shows the learner demographics and be discussed with regard to the learner demographics. Significant differences have been used to compare the various health risk behaviors. Table 4.3 shows the learner demographics and
compared and the data presented in Figure 4.3.

patterns of use (i.e., weekday, weekend, and daily) of these various substances were
ways. Some learners reported injected drugs as well as drugs taken in other ways. The
reported taking drugs in other ways and 27% (48 learners) injected and took drugs in other
ways who use drugs, 37% (65 learners) reported injected drugs, 96% (158 learners)
use has been categorized into either injected drugs or drugs taken in other ways. Of the 175
use drug/snorting cocaine. Some learners reported the use of one or more of these forms. Drug
smoking cigarettes/cigars. 19% (84 learners) reported using snort and 7% (29 learners)
chewing tobacco. Of the 44 learners who use tobacco, 97% (42 learners) reported
presented. Tobacco use occurs in the form of cigarettes/cigars, pipes, or inhalers, and

4.3.2.1 Substance Use

Reporting sexual activity (d > 0.05, L1 = 0.3% and UL = 65.3%) use (d = 0.024, L1 = 14.9% and UL = 21.8%) and more learners with lower income scores
with higher income scores reporting tobacco (d > 0.05, L1 = 40.5% and UL = 69.3%) and drug
Following relevant findings on Tables 4.4 and 4.5, the learner demographics of those important patterns of substance use revealed the

higher percentage of daily cigarette use when compared to the weekend use of alcohol and

The most frequently reported pattern of substance use was having tried all. Of note is the

![Figure 4.3: Patterns of Substance Use](image)

<table>
<thead>
<tr>
<th>Pattern</th>
<th>Other Drugs</th>
<th>Inhaled Drugs</th>
<th>Alcohol</th>
<th>Smoked Tobacco</th>
<th>Nebulizers</th>
<th>Chewing Tobacco</th>
<th>Cigarettes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weekly</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weekend</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Percentage**
significant (d=0.02, LL=1.5% and UL=32.1%), more male learners having used injected drugs was also statistically significant use (d=0.02, LL=1.5% and UL=32.1%). Nuisance use (d=0.05, LL=1.3% and UL=27.1%)

For younger learners the p values and 95% confidence limits were: cigarette use (d=0.02, LL=1.5% and UL=26.8%), alcohol use (d=0.05, LL=1.3% and UL=27.1%). Nuisance use (d=0.05, LL=1.3% and UL=27.1%).

Younger learners with the highest pattern of substance use: For female learners the p values yield statistically significant results. There are a higher percentage of female learners and income sources for all substances and learner demographics for chewing tobacco did not

<table>
<thead>
<tr>
<th>Gender</th>
<th>N</th>
<th>% 43%</th>
<th>25%</th>
<th>2%</th>
<th>% 35%</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>N</td>
<td>% 64%</td>
<td></td>
<td></td>
<td>% 99%</td>
<td>Female</td>
</tr>
<tr>
<td>Male</td>
<td>N</td>
<td>% 62%</td>
<td></td>
<td></td>
<td>% 63%</td>
<td>Male</td>
</tr>
</tbody>
</table>

Table 4.4: Learner demographics: The "ideal" pattern of substance use
All learners were asked to report on their sexual activity. Out of 1,136 learners, 113 (26%) reported having engaged in sexual activity (%).

<table>
<thead>
<tr>
<th></th>
<th>44.2%</th>
<th>Sexual Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The table below shows the learner demographics with various patterns of misuse sexual practices:

<table>
<thead>
<tr>
<th>Gender</th>
<th>23%</th>
<th>25%</th>
<th>8%</th>
<th>6%</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The statistically significant results for the male learners were alcohol (%), 94% and 41% and other drugs use (%), 52%. The statistically significant result for female learners were alcohol (%), 92% and other drugs use (%), 55.8%.

Table 4.5: Learner Demographics: Weekend and Daily Substance Use
reported by more female learners and this was statistically significant (p<0.05, LL=3.6%). Sexual activity without the use of family planning was

<table>
<thead>
<tr>
<th>Gender</th>
<th>Higher (n=269)</th>
<th>Lower (n=363)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>42%</td>
<td>39%</td>
</tr>
<tr>
<td>Male</td>
<td>46%</td>
<td>44%</td>
</tr>
<tr>
<td>Older</td>
<td>62%</td>
<td>48%</td>
</tr>
<tr>
<td>Younger</td>
<td>56%</td>
<td>51%</td>
</tr>
</tbody>
</table>

Table 4.6: Learners' Demographics and Patterns of Unsafer Sex
The most frequently reported co-existing health risk behaviors are alcohol use and sexual activity (44%), followed by tobacco and alcohol use (35%) and then tobacco use alone (25%).

<table>
<thead>
<tr>
<th>%</th>
<th>Co-existing Health Risk Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>44%</td>
<td>Alcohol Use and Sexual Activity</td>
</tr>
<tr>
<td>35%</td>
<td>Tobacco and Alcohol Use and Sexual Activity</td>
</tr>
<tr>
<td>25%</td>
<td>Tobacco and Tobacco Use and Sexual Activity</td>
</tr>
<tr>
<td>20%</td>
<td>Tobacco and Alcohol Use</td>
</tr>
<tr>
<td>16%</td>
<td>Alcohol and Drug Use</td>
</tr>
<tr>
<td>15%</td>
<td>Alcohol and Drug Use and Sexual Activity</td>
</tr>
<tr>
<td>11%</td>
<td>Tobacco and Drug Use and Sexual Activity</td>
</tr>
<tr>
<td>12%</td>
<td>Tobacco and Drug Use</td>
</tr>
<tr>
<td>11%</td>
<td>Alcohol and Drug Use and Sexual Activity</td>
</tr>
<tr>
<td>10%</td>
<td>Tobacco Use and Sexual Activity</td>
</tr>
<tr>
<td>9%</td>
<td>Tobacco Use and Sexual Activity</td>
</tr>
<tr>
<td>8%</td>
<td>Tobacco Use and Sexual Activity</td>
</tr>
<tr>
<td>6%</td>
<td>Tobacco Use and Sexual Activity</td>
</tr>
<tr>
<td>4%</td>
<td>Tobacco Use and Sexual Activity</td>
</tr>
<tr>
<td>3%</td>
<td>Tobacco Use and Sexual Activity</td>
</tr>
<tr>
<td>2%</td>
<td>Tobacco Use and Sexual Activity</td>
</tr>
</tbody>
</table>

Table 4.7: Frequency of Co-existing Health Risk Behaviors

Health risk behaviors in adolescents vary often co-exist. Table 4.7 shows the co-existing
and alcohol use (d=0.05), LL=36.9% and HL=45.5%.

The only statistically significant result for income score was for tobacco and sexual activity (d=0.05, \( \text{LL}=35.2\% \text{ and } \text{UL}=43.7\%) \text{ and for tobacco use and alcohol use (d=0.05, } \text{LL}=30.2\% \text{ and } \text{UL}=40.1\%\). soda and sexual activity (d=0.05, LL=52.1% and UL=60.7%) tobacco and sexual activity: For alcohol use and sexual activity, the p-values and 95% confidence limits were: for tobacco and sexual activity (d=0.05, LL=37.7% and UL=46.1%). For the p-values and 95% confidence limits were: for alcohol use and sexual activity (d=0.05, LL=68.9% and UL=73.4%). For the p-values and 95% confidence limits were: for alcohol use and sexual activity (d=0.05, LL=42.3% and UL=51.5%). There are proportionally more learners reporting co-existing health risk behaviours who

| Table 4.8: Learner Demographics and Co-existing Health Risk Behaviours |
|-----------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Age                                      | Male (n=1146) | Female (n=675) | Other (n=458) | Total (n=239) |
| 16                                      | 112            | 108             | 100            | 320           |
| 18                                      | 116            | 104             | 94             | 314           |
| 20                                      | 227            | 227             | 197            | 641           |
| 22                                      | 327            | 327             | 277            | 921           |
| 24                                      | 423            | 423             | 333            | 1179          |
| 26                                      | 525            | 525             | 425            | 1475          |
| 28                                      | 629            | 629             | 529            | 1807          |
| 30                                      | 739            | 739             | 639            | 2117          |
| 32                                      | 852            | 852             | 752            | 2456          |
| Total (n=139)                            |                |                 |                |                |
| 28.6%                                    | 26.6%          | 26.6%           | 26.6%          | 26.6%         |
Table 4.9 shows the learner demographics and the self-perceived health risk for substance use. Already affected their health, during use could be dangerous to their health. 44% (77 learners) feel that their drug use has already affected their health. There were 175 learners using drugs. Of those learners 85% (149 learners) feel that their drug use has already affected their health. Alcohol use could be dangerous to their health. 33% (242 learners) feel that their alcohol use has already affected their health. There were 441 learners using alcohol. Of those learners 75% (336 learners) feel that their alcohol use has already affected their health. Tobacco use could be dangerous to their health. 44% (195 learners) feel that their tobacco use has already affected their health. There were 441 learners using tobacco. Of those learners 86% (383 learners) feel that their tobacco use has already affected their health. Whether it has already made them unhealthy, feel that their self-reported health risk behaviour might be dangerous to their health and In order to assess self-perceived health risk, learners were asked to indicate whether they...
for alcohol use where the p values and 95% confidence limits were: for drinkers (p=0.027), LL=7.4% and UL=8.8% and for non-drinkers (p=0.007), LL=3.1% and UL=4.3%. Significant results were when the p values were lower income scores. The only statistically significant results were higher 95% confidence limits were: for alcohol use (p=0.008, LL=3.4% and UL=4.2%) and statistically significant results were for alcohol use (p=0.006, LL=6.7% and UL=7.4%). Older learners received higher percentages of risk perception than younger learners. The only alcohol use could be dangerous to their health (p=0.05, LL=7.8% and UL=8.4%). Older drinkers (p=0.006, LL=2.1% and UL=4.4%) and women (p=0.005, LL=6.7% and UL=9.3%) were shown for substance use. In terms of gender, statistically significant results were shown for danger because of their substance use as compared to them already being affected by their learners. There are higher percentages of learners reporting that they feel that their health is in

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Higher</th>
<th>Lower</th>
<th>Other</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Younger</td>
<td>37.9%</td>
<td>21.2%</td>
<td>41.1%</td>
<td>54.0%</td>
<td>45.9%</td>
<td>51.0%</td>
</tr>
<tr>
<td>Older</td>
<td>29.3%</td>
<td>18.0%</td>
<td>52.7%</td>
<td>42.3%</td>
<td>57.7%</td>
<td>50.0%</td>
</tr>
</tbody>
</table>

Table 4.9: Learner Demographics and Self-Reported Health Risk for Substance Use
4.3.4 Learner Demographics of the Doctor Group

Significantly from those who do not have a doctor.
In this section, data describing the doctor group will be presented to see if they differ.

Section B: Learners with General Practitioners

Learners feeling in danger of HIV/AIDS (d<0.05, LL=0.001, UL=1.56% and LL=72.5%, and LL=31.6%).

Learners feeling existing by previous (d<0.001, LL=9.9% and UL=1.7%), female health risk for sexual activity, only two results were statistically significant. Female learners of Pregnanancy and already occurred, in terms of the learner demographics and self-reported learners (reported that they already had HIV/AIDS and 9% (58 learners) reported that 1.4% (34 learners) reported that they already had an STI. 2.2% (147 learners) felt that there was a danger of pregnancy accounting 52% (38 learners) reported that they were in danger of HIV/AIDS and 29% (187 learners) felt that they were in danger of

4.3.2 Sexual Activity

There were 645 (77%) learners who were sexually active. Of those learners, 25% (163


(69% compared to 77%) (d) = 0.0111, LL = 0.39% and UL = 74.7%

... smaller proportion of learners feel they have been affected by tobacco use (38%) as significantly significant results for self perceived health risk in the doctor group are that a

4.3.6 Self Perceived Health Risk in the Doctor Group

(45% compared to 60%) (d) = 0.05, LL = 0.15% and UL = 25.4%

... and have a lower rate of tobacco use compared to 49% (d) = 0.0111, LL = 15.7% and UL = 25.4%

... which use tobacco (52%) compared to 34% (d) = 0.05, LL = 0.15% and UL = 25.4%

... significant results are for tobacco and drug use and sexual activity. These are more learners

When comparing the doctor group to those learners without a doctor, the significantly

4.3.5 Health Risk Behaviour Profiles of the Doctor Group
Section C: Learners Information with Their General Practitioners
There were no learner or doctor demographics that were significantly significant.

4.3.8 Consulting Patterns of Learners

Significant findings:

Of the learner demographics of the male and female doctor, there were no significantly significant differences. The male doctor (11% LL = 12.4%, HL = 72.7%) and the female doctor (11% LL = 0.2%, HL = 87.9%) in terms of the doctor were male. The 95% confidence limits were: For the male doctor and 71% (95%) were female. The 95% confidence limits are: For the male doctor learners with doctors, 26% males (99%) responded, 83% of the doctors (224) were male learners were asked to indicate whether their doctor was male or female. Of the 271

4.3.72 Doctor Gender

were no statistically significant findings.

HL = 60.8%). In terms of the learner demographics of the younger and older doctor there
4.3.8.2 The Person Accompanying the Learner

The table on page 4.10 shows the referral demographics of each of the people accompanying the learner when consulting with their doctor. The only demographic that showed any statistically significant was learner age and doctor gender. Table 4.10 shows the referral numbers for boys/fathers (11% of learners) and their friends (6% of learners). The learners could respond with more than one option, 88% (323 learners) responded that learners were asked to indicate the people they have accompanied them to their doctor.

4.3.8.1 Medical Aid

With lower income scores used medical aid (LL=47%, UL=61%), 55% of learners with higher income score used medical aid (LL=66%, UL=111%). 55% of learners and 56% of older learners used medical aid (LL=65%, UL=66%). 79% of learners and 75% of younger learners used medical aid (LL=68%, UL=81%). The following results reflected 93% learner age (p=0.002) and learner income (p=0.002). Two demographic data was statistically significant for the use of medical aid were demographics were statistically significant for when learners used medical aid. The only learners who were on medical aid choose to pay cash instead. No doctor or learner visible. If the 185 learners who used a medical aid, 95% (175 learners) responded. 69% of the learners who used a medical aid when seeing their doctor. Learners were also asked if they ever necessary for their doctor. Of the 271 learners, 77% (224) responded. 70% (188) of the learners used a medical aid when consulting with learners were asked if they used a medical aid and card for payment when consulting with
Table 4.11 shows the demographics of various other counseling patterns.

### 4.3.8.3 Counseling Patterns of Learners

<table>
<thead>
<tr>
<th></th>
<th>Younger</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>6%</td>
<td>16%</td>
</tr>
<tr>
<td></td>
<td>12%</td>
<td>21%</td>
</tr>
<tr>
<td></td>
<td>8%</td>
<td>12%</td>
</tr>
<tr>
<td></td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

The doctor age was statistically significant when learners were accompanied by their parents/guardians (p=0.034) and their boyfriends or girlfriends (d=0.004). The 95% confidence limits for the younger learner being accompanied by their parent or guardian are: (LL=8.4% and UL=9.2%) and for the older learner being accompanied by their parent or guardian are: (LL=11.8% and UL=12.9%).

The learner age was statistically significant when learners were accompanied by their parents/guardians (p=0.034) and their boyfriends or girlfriends (d=0.004). The 95% confidence limits for the younger learner being accompanied by their parent or guardian are: (LL=8.4% and UL=9.2%) and for the older learner being accompanied by their parent or guardian are: (LL=11.8% and UL=12.9%).
If their doctor sees other members of their family, or 271 learners, 99% (267 learners) responded. In order to present the data, the learners were asked:

<table>
<thead>
<tr>
<th></th>
<th>Other</th>
<th>Younger</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower</td>
<td>9%</td>
<td>56%</td>
<td>56%</td>
<td>56%</td>
</tr>
<tr>
<td>Higher</td>
<td>71%</td>
<td>71%</td>
<td>47%</td>
<td>47%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learner</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Younger</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
</tr>
<tr>
<td>Other</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
</tr>
</tbody>
</table>

Table 4.11: Consulting Patterns of Learners
could either more than one opinion reasons for consulting other doctors. The 217 learners who consulted with other doctors other reason other than those listed. Table 4.12 show the frequencies of the various why they consulted with other doctors. The last block show the learner to either any the learners were asked to tick the appropriate blocks next to a list of possible reasons.

4.3.8.4 Reasons for Visiting other Doctors

Higher income scores was (LL=71.1% and UL=88.3%). The higher confidence limits for demographic was learner income score (p=0.013). The 95% confidence limits for learners (have consulted with other doctors. The only statistically significant another doctor or not. Of the 217 learners, 72% learners responded. 79% (213) present the data this information was categorized into whether they have consulted four indicate the number of other doctors that they have consulted. In order to

(%) LL=87.1% and UL=92.3% and for younger doctors were (LL=79.2% and UL=76.9%).

learner was (LL=61.8% and UL=80.9%), for female doctors (LL=60.9%) and female gender (p=0.022) and doctor age (p=0.16), 95% confidence limits for other their own. Statistically significant results were for learner age (p=0.004), doctor 99% (267 learners) responded. 60% (110 learners) reported ever consulted ever consulted on 3. If they ever consulted their general practitioner on their own. Of the 217 learners:

(%) LL=96.9% and UL=99.3% and for male doctors were (LL=92.8% and UL=98.5%)
doctor qualities and personality) not being able to talk to their doctor about the problem.

service received (seeing a specialist or seeing a second opinion), 10% were referred to
the doctor not being able to see the doctor at the time of being too expensive, 45% were
67% were visited to the way the surgery functioned (the doctor being away from the rooms.

Of the various reasons for consulting other doctors:

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>My doctor is a bad doctor.</td>
<td>0.5</td>
</tr>
<tr>
<td>I went for a second opinion.</td>
<td>1</td>
</tr>
<tr>
<td>I went for psychotherapy.</td>
<td>1</td>
</tr>
<tr>
<td>I was referred to another (general) practitioner.</td>
<td>2</td>
</tr>
<tr>
<td>I went back to my previous doctor.</td>
<td>2</td>
</tr>
<tr>
<td>My doctor was too expensive.</td>
<td>2</td>
</tr>
<tr>
<td>The other doctor was closer.</td>
<td>2</td>
</tr>
<tr>
<td>It was an emergency.</td>
<td>3</td>
</tr>
</tbody>
</table>

**Table 4.12: Reasons for Visiting Other Doctors**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>My friend took me to his/her doctor.</td>
<td>7</td>
</tr>
<tr>
<td>I could not afford my problem to my own doctor.</td>
<td>8</td>
</tr>
<tr>
<td>I was told I needed to visit my doctor.</td>
<td>2</td>
</tr>
<tr>
<td>My doctor was not able to see me when I needed to see him/her.</td>
<td>2</td>
</tr>
<tr>
<td>The doctor I visited was not a general practitioner.</td>
<td>32</td>
</tr>
<tr>
<td>I was away from home when I needed to visit my doctor.</td>
<td>35</td>
</tr>
<tr>
<td>I was away from home while I usually visit my doctor.</td>
<td>3</td>
</tr>
</tbody>
</table>
doctor was learner gender (p<0.024).

that was statistically significant for the most important reason why learners chose their

being the most important reason for choosing their doctor. The only demographic feature

their system, and 11% (31 learners) reported where the doctors' rooms are situated (she is

doctor's personality and qualities, 12% (32 learners) reported the way the surgery works

their doctor provided was the most important reason, 27% (73 learners) reported their

particular doctor. 269 learners responded, 49% (133 learners) reported that the services the

learners were asked to indicate the most important reason for choosing to see their

4.3.9 Learners choosing their General Practitioner

she related (the learner opted for rooms closer to where they were at the time),

seeking out their previous doctor or reporting their doctor to be a bad doctor) and 2% were
Most common reasons for doing so.

Whereas learners who consulted other doctors reported system-related reasons (67%) as the learners chose to see their particular doctor because of service-related reasons (50%).

Figure 4.4: Aspects of General Practice Influencing Learners' Choices

<table>
<thead>
<tr>
<th>Aspect of General Practice</th>
<th>Choose Their Doctor</th>
<th>Consult with Other Doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>27</td>
<td>60</td>
</tr>
<tr>
<td>12</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>21</td>
<td>90</td>
<td>90</td>
</tr>
<tr>
<td>67</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>10</td>
<td>90</td>
<td>90</td>
</tr>
<tr>
<td>60</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>70</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>80</td>
<td>90</td>
<td>90</td>
</tr>
</tbody>
</table>

Figure 4.4 compares the percentages of the reasons why learners choose their general practitioner to the percentages for the reasons why learners consult other doctors.
It is important to note that the majority of learners chose to go to their doctor for physical examination, medication, health information and advice, and guidance. 

<table>
<thead>
<tr>
<th>Doctor's Services</th>
<th>Per centage</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.39</td>
<td>59</td>
</tr>
<tr>
<td>1.36</td>
<td>40</td>
</tr>
<tr>
<td>0.34</td>
<td>34</td>
</tr>
<tr>
<td>0.24</td>
<td>16</td>
</tr>
<tr>
<td>0.05</td>
<td>5</td>
</tr>
<tr>
<td>0.02</td>
<td>2</td>
</tr>
<tr>
<td>0.01</td>
<td>1</td>
</tr>
</tbody>
</table>

**Table 4.13: Doctor's Services**

The patients had to choose more than one option. Table 4.13 shows the frequencies of responses in terms of mentioned in the list. Of the 271 learners, 270 learners responded. The learners could choose to go to their doctor. The last option allowed the learner to enter a service not mentioned in the list. The learners were asked to indicate, on a list of doctor’s services, which services made them answer sheet.
<table>
<thead>
<tr>
<th>Doctor's Personality and Qualities</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Makes me feel comfortable and relaxed when he/she is checking me up</td>
<td>49</td>
</tr>
<tr>
<td>Listens to me</td>
<td>69</td>
</tr>
<tr>
<td>Is the family doctor</td>
<td>69</td>
</tr>
<tr>
<td>Is a good doctor</td>
<td>45</td>
</tr>
<tr>
<td>Makes me feel comfortable and relaxed when he/she is</td>
<td>69</td>
</tr>
<tr>
<td>Helps me to talk about my problems</td>
<td>44</td>
</tr>
<tr>
<td>Shows a real interest in me as a person</td>
<td>42</td>
</tr>
<tr>
<td>Tells me exactly what he/she is doing when checking me up</td>
<td>42</td>
</tr>
<tr>
<td>Enjoys working with young people</td>
<td>42</td>
</tr>
<tr>
<td>Gives me advice and guidance without judging me</td>
<td>38</td>
</tr>
<tr>
<td>Does not force me to talk about problems that I am not ready to talk about</td>
<td>35</td>
</tr>
</tbody>
</table>

Table 4.14: Doctor's Personality and Qualities

Responses related to doctor personality and qualities. Learners could answer more than one option. Table 4.14 shows the frequencies of learners and qualities not previously mentioned. Of the 271 learners, all learners responded. The title is “Do you go to their doctor? Of the 39, the last option allowed the learner to enter a personality and qualities were asked to indicate the doctor personality and qualities they made them choose compared to the larger numbers for services like X-rays and laboratory tests.

4.3.9.2 Doctor's Personality and Qualities

Smaller number of learners chose to go to their doctor for family planning and condoms as...
Their doctor. The last option allowed the license to enter a system-related factor not

4.9.3 System: The way the surgery works

and tells me the information from my visits will be kept private and confidential

percentage of privacy-related reasons: understands that I need to keep my problems private

listening to them, and feeling comfortable during the checkup. Of note, is the lower

The most important doctor personalities and qualities were: the family doctor, being male.

| No. | Frequency | Percentage | Quality
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>9.37</td>
<td></td>
<td>I know my doctor</td>
</tr>
<tr>
<td>2</td>
<td>4.74</td>
<td></td>
<td>My doctor makes me feel more important</td>
</tr>
<tr>
<td>3</td>
<td>4.1</td>
<td></td>
<td>My doctor is my friend</td>
</tr>
<tr>
<td>4</td>
<td>2.7</td>
<td></td>
<td>Other doctor personality and qualities</td>
</tr>
<tr>
<td>5</td>
<td>1.1</td>
<td></td>
<td>Is a female doctor</td>
</tr>
<tr>
<td>6</td>
<td>0.8</td>
<td></td>
<td>Lets me help him/her to solve my problems</td>
</tr>
<tr>
<td>7</td>
<td>0.6</td>
<td></td>
<td>Understands that I need to keep my problems private</td>
</tr>
<tr>
<td>8</td>
<td>0.4</td>
<td></td>
<td>Makes me feel as if my problems are important to him/her</td>
</tr>
<tr>
<td>9</td>
<td>0.3</td>
<td></td>
<td>Discussing me</td>
</tr>
<tr>
<td>10</td>
<td>0.2</td>
<td></td>
<td>Gives me a chance to talk about my problems without</td>
</tr>
<tr>
<td>11</td>
<td>0.2</td>
<td></td>
<td>Confidential</td>
</tr>
<tr>
<td>12</td>
<td>0.3</td>
<td></td>
<td>Tells me that all information from my visits will be kept</td>
</tr>
<tr>
<td>13</td>
<td>0.1</td>
<td></td>
<td>Accepts me as I am, with my good points and my bad points</td>
</tr>
<tr>
<td>14</td>
<td>0.2</td>
<td></td>
<td>Makes me feel that I am in charge of my own health</td>
</tr>
</tbody>
</table>

Doctor Personality and Qualities

| No. | Frequency | Percentage | Quality
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>9.37</td>
<td></td>
<td>I know my doctor</td>
</tr>
<tr>
<td>2</td>
<td>4.74</td>
<td></td>
<td>My doctor makes me feel more important</td>
</tr>
<tr>
<td>3</td>
<td>4.1</td>
<td></td>
<td>My doctor is my friend</td>
</tr>
<tr>
<td>4</td>
<td>2.7</td>
<td></td>
<td>Other doctor personality and qualities</td>
</tr>
<tr>
<td>5</td>
<td>1.1</td>
<td></td>
<td>Is a female doctor</td>
</tr>
<tr>
<td>6</td>
<td>0.8</td>
<td></td>
<td>Lets me help him/her to solve my problems</td>
</tr>
<tr>
<td>7</td>
<td>0.6</td>
<td></td>
<td>Understands that I need to keep my problems private</td>
</tr>
<tr>
<td>8</td>
<td>0.4</td>
<td></td>
<td>Makes me feel as if my problems are important to him/her</td>
</tr>
<tr>
<td>9</td>
<td>0.3</td>
<td></td>
<td>Discussing me</td>
</tr>
<tr>
<td>10</td>
<td>0.2</td>
<td></td>
<td>Gives me a chance to talk about my problems without</td>
</tr>
<tr>
<td>11</td>
<td>0.2</td>
<td></td>
<td>Confidential</td>
</tr>
<tr>
<td>12</td>
<td>0.3</td>
<td></td>
<td>Tells me that all information from my visits will be kept</td>
</tr>
<tr>
<td>13</td>
<td>0.1</td>
<td></td>
<td>Accepts me as I am, with my good points and my bad points</td>
</tr>
<tr>
<td>14</td>
<td>0.2</td>
<td></td>
<td>Makes me feel that I am in charge of my own health</td>
</tr>
</tbody>
</table>
embarrassed to pick them up.

I need to keep my problems private and I can collect interesting pamphlets without feeling

is the low perception of privacy raised because the reception/nurse understands that I

receptionist or nurse makes them feel comfortable and approachable. Of note once again

doctor makes time to see them; they feel comfortable waiting in the waiting room. The

Learners chose to go to their doctor because of the following system related aspect: Their

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>2</td>
<td>No appointment required</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other ways the Surgery Works:</td>
</tr>
<tr>
<td>66</td>
<td>26</td>
<td>I can collect interesting pamphlets for young people without feeling embarrassed to pick them up</td>
</tr>
<tr>
<td>70</td>
<td>28</td>
<td>I need to keep my problems private. The receptionist/nurse understands that I need to keep my</td>
</tr>
<tr>
<td>101</td>
<td>42</td>
<td>The receptionist/nurse makes me feel comfortable. When I needed time to see my doctor in theoves room, I feel comfortable when waiting for my doctor in the</td>
</tr>
<tr>
<td>136</td>
<td>54</td>
<td>I can afford to pay the price that my doctor charges</td>
</tr>
<tr>
<td>141</td>
<td>56</td>
<td>If I need to see my doctor, her/his makes the time for me to see her/him/her</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Way the Surgery Works</td>
<td>The Way the Surgery Works</td>
</tr>
</tbody>
</table>

Table 4.15: The Way the Surgery Works.

Learners in terms of the way the surgery works, the system.

could indicate more than one option. Table 4.15 shows the frequency of responses of

mentioned in the list of the 271 learners, 94% (254) learners responded. The learners
References and permissions

4.3.10 General Practitioners’ Behaviours with Health Risk Behaviours

The comments are discussed later in the Discussion Chapter.

Changes in the way the surgery works and 73% (42 doctors) were made relating to the changes in their doctors’ personality and qualities, 32% (32 doctors) were made relating to changes in their doctors’ services, 44% (117 doctors) were made relating to changes in their doctors’ services, 44% (117 doctors) were made relating to the change in the way the surgery works (the system) and the fourth category was related to the third, to the change in the surgery works, the second, to their doctors’ personality and qualities, the change was coded according to 4 categories. The first was

4.3.9. Changes in the way doctors could be made. No limitations were placed on how many comments on the changes could be made. Each change was coded according to 4 categories. The first was

Changes: Lessons Learned That Have General Practitioners Working in Primary
both topics.

saying “no” to drugs and 10% (22 learners) had a discussion with their doctor regarding
15% (32 learners) talked about the dangers of drug use. 19% (44 learners) talked about
of the 216 learners not using drugs, only 24% (51 learners) received primary prevention.

4.3.10.3 Drug Use

doctor regarding both topics.

talked about saying “no” to alcohol and 10% (10 learners) had a discussion with their
prevention. 20% (19 learners) talked about the dangers of alcohol use. 13% (13 learners)
of the 97 learners not drinking alcohol, only 23% (22 learners) received primary

4.3.10.2 Alcohol Use

both topics.

saying “no” to tobacco and 8% (10 learners) had a discussion with their doctor regarding
12% (16 learners) discussed the dangers of tobacco use. 15% (19 learners) talked about
of the 130 learners not using tobacco, only 19% (25 learners) received primary prevention.

4.3.10.1 Tobacco Use

eating (28%), then drugs (24%), alcohol (23%) and tobacco use (19%).

discussing any primary prevention topics. Primary prevention was highest for sexual
examined. Of the 217 learners who have doctors, 27% (74 learners) reported not
discussed during meaningful discussion in Section A of the research questionnaire was

4.3.10.1 Primary Prevention

where learners decided being involved in particular health risk behaviors in Sections C to
Of the 148 learners who denied having sexual activity and have a general practitioner, 19% received primary prevention education.

Figure 4.5: Primary Prevention for Sexual Activity

1. The benefits of discussing sex and saying no to sex
2. Correct condom use, correct family planning, use and preventing unsafe sex
3. Emergency pill and preventing pregnancy
4. Preventing STIs and preventing HIV/AIDS

Figure 4.5 shows the frequencies of learners that reported having a discussion with their doctor about the dangers of unsafe sex, saying no to sex or both topics.

In order to present the data in a relevant manner, the primary prevention topics were grouped.
Discussion with their doctors about the emergency pill and preventing pregnancy.

Figure 4.7 shows the frequencies of learners who have had a discussion with their doctor regarding all three topics. 79% (117) did not have any family planning use and 19% of the learners talked about preventing safe sex. 43% (6 learners) talked about correct condom use, 11% (17 learners) talked about correct family planning use and 22% (4 learners) talked about correct family planning use. The frequency of learners who have had discussions about primary prevention for sexual activity is as follows: 72% (107 learners) did not have any discussion of these two topics. Figure 4.6 shows the frequency of learners who have had discussions about primary prevention for sexual activity.
about preventing sexually transmitted infections and preventing HIV/AIDS shows the frequencies of learners who have reported having discussions with their doctors both topics. 85\% (126 learners) did not have any discussion of these topics. Figure 4.8: Preventive prevention and 4\% (6 learners) had a discussion with their doctor regarding preventi

Figure 4.7: Primary Prevention for Sexual Activity (3)

<table>
<thead>
<tr>
<th>Prevention</th>
<th>Emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>9</td>
</tr>
<tr>
<td>13</td>
<td></td>
</tr>
<tr>
<td>126</td>
<td></td>
</tr>
</tbody>
</table>
about co-existing health risk behaviors.

Uncovering refers to the general practioner finding out about health risk behaviors and

4.3.10.2 Uncovering

both topics, 76% (113 learners) did not have any discussion of these topics. Preventing HIV/AIDS and 13% (19 learners) had a discussion with their doctor regarding STI's. 22% (32 learners) talked about FIGURE 4.8: Primary Prevention for Sexual Activity (4)

\[
\begin{align*}
N &= 148 \\
\text{Discussions} &= 32 \\
\text{Prevention HIV/AIDS} &= 13 \\
\text{Prevention STI's} &= 22 \\
\text{No Discussion} &= 113
\end{align*}
\]
The table highlights the fact that in all cases the most significant method of uncovering the health-risk behaviors is through direct observation or consultation. The text goes on to explain that these methods are particularly effective in identifying behaviors that are directly related to health risks, such as smoking or alcohol use. The table provides a breakdown of the methods used by doctors, nurses, and other healthcare professionals to uncover these behaviors, with percentages indicating the frequency of each method across different scenarios.

The table is labeled as Table 4.16: Method of Uncovering Health Risk Behaviors. It aims to demonstrate the importance of these methods in addressing health-risk behaviors among young people.

### Table 4.16: Method of Uncovering Health Risk Behaviors

<table>
<thead>
<tr>
<th>Method</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Observation</td>
<td>40%</td>
</tr>
<tr>
<td>Consultation with Doctor</td>
<td>30%</td>
</tr>
<tr>
<td>Telephone Follow-up</td>
<td>20%</td>
</tr>
<tr>
<td>Written Note</td>
<td>10%</td>
</tr>
<tr>
<td>Email</td>
<td>5%</td>
</tr>
<tr>
<td>Text Message</td>
<td>5%</td>
</tr>
<tr>
<td>None</td>
<td>5%</td>
</tr>
</tbody>
</table>

The table shows that direct observation and consultation with a doctor are the most common methods used to uncover health-risk behaviors. These methods are followed by written notes, telephone follow-up, and email, among others.
Table 4.18: Uncovering of co-existing health risk behaviors (alcohol uncovered)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncovering Sexual Activity</td>
<td>70%</td>
<td>16</td>
</tr>
<tr>
<td>Uncovering Drug Use (u=16)</td>
<td>38%</td>
<td>6</td>
</tr>
<tr>
<td>Uncovering Tobacco Use (u=25)</td>
<td>22%</td>
<td>13</td>
</tr>
</tbody>
</table>

Table 4.17: Uncovering of co-existing health risk behaviors (sexual activity)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncovering Drug Use (u=15)</td>
<td>33%</td>
<td>5</td>
</tr>
<tr>
<td>Uncovering Alcohol Use (u=35)</td>
<td>46%</td>
<td>16</td>
</tr>
<tr>
<td>Uncovering Tobacco Use (u=25)</td>
<td>59%</td>
<td>14</td>
</tr>
</tbody>
</table>

Doctors were more successful in uncovering co-existing behaviors when alcohol use was uncovered. It is important to look at how successful doctors were in uncovering co-existing health risk behaviors (alcohol uncovered) and least successful in uncovering co-existing drug use (33%). When alcohol use was uncovered, doctors were most successful in uncovering co-existing tobacco use (59%).
Table 4.20: Uncovered or Co-existing Health Risk Behaviors (Drugs Uncovered)

<table>
<thead>
<tr>
<th>%</th>
<th>100%</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>60%</td>
<td>6</td>
<td>3</td>
</tr>
</tbody>
</table>

Table 4.20: Uncovered or Co-existing Health Risk Behaviors (Drugs Uncovered)

Table 4.20: Uncovered or Co-existing Health Risk Behaviors (Drugs Uncovered)

Table 4.19: Uncovered or Co-existing Health Risk Behaviors (Tobacco Uncovered)

<table>
<thead>
<tr>
<th>%</th>
<th>16</th>
</tr>
</thead>
<tbody>
<tr>
<td>25%</td>
<td>3</td>
</tr>
<tr>
<td>99%</td>
<td>13</td>
</tr>
</tbody>
</table>

Table 4.19: Uncovered or Co-existing Health Risk Behaviors (Tobacco Uncovered)

Table 4.19: Uncovered or Co-existing Health Risk Behaviors (Tobacco Uncovered)

Table 4.19: Uncovered or Co-existing Health Risk Behaviors (Tobacco Uncovered)

Table 4.19: Uncovered or Co-existing Health Risk Behaviors (Tobacco Uncovered)

There were only 6 learners where doctors uncovered their drug use. Table 4.20 shows the frequency of those learners where doctors uncovered co-existing risk behaviors. Once tobacco use was uncovered, doctors were most successful in uncovering sexual activity (78%), then alcohol use (59%) and least successful in uncovering drug use (25%).
doctor. For tobacco only 6% (8 out of 121 learners), for alcohol only 7% (8 out of 113 learners) of learners involved in health risk behaviors. Tobacco use a service from the number of learners involved in health risk behaviors to those who use a service from their secondary prevention services. It is important to note the drop off in figures from the initial use of alcohol. Secondary prevention discussions were occurring more frequently than when tobacco use was involved. 67% of learners who use tobacco and 25% of learners who were sexually active, 76% of learners who use tobacco and 50% of those who use alcohol were sexually active. 79% of learners who use tobacco and 25% of those who use alcohol secondary prevention discussions occurred in all learners who use drugs, 23% of learners.

<table>
<thead>
<tr>
<th></th>
<th>4%</th>
<th>5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5%</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4.21: Doctor’s Response to Health Risk Behaviors

Important: Table 4.21 shows the doctor’s response to each of the health risk behaviors. Doctors’ response in terms of providing secondary prevention discussions and services is when a learner is involved in health risk behaviors and their doctor is aware of this. The

4.3.10.3 Secondary Prevention

Doctors were least successful in uncovering co-existing tobacco use (60%).
In one learner the doctor provided the nicotine patch. Further intervention occurred in 7 learners, the doctor provided nicotine chewing gum and prescribed or nicotine chewing gum and patches. Of the 25 learners, 17 learners no services their doctors can provide relating to tobacco use are the dispensing of nicotine gum.

Services Used to Deal with Tobacco Use

nicotine gum.

out of the 18 learners, 15 reported that their doctors discussed a quit plan and the use of nicotine gum, the use of nicotine chewing gum in 9 learners and nicotine patches in 1 learner. Further discussion about tobacco use. Further discussions involved a quit plan in 14 learners. Nicotine gum and nicotine patches 6 learners reported that their doctors had no quit plan, nicotine gum and nicotine patches 6. These 25 learners were asked if they had secondary prevention discussions relating to a

Discussions with Doctor about Tobacco Use

services that learners have used at their doctor's rooms referred to smoking cessation. about their doctor's response in terms of further discussions about tobacco use and about In those 25 learners whose doctors were aware of their tobacco use, learners were asked

4.3.10.3.1: Doctors Dealing with Tobacco Use

(121 learners) for drugs only 7% (4 out of 55 learners) and for sexual activity only 35% (42 out

(121 learners)
Anonymous

In 43 learners, alcohol was referred to Alcoholics Anonymous.

Serious Use to Deal with Alcohol

Discussion involving a plan to stop alcohol and was referred to Alcoholics Anonymous.

Further discussion involved a plan to stop alcohol in 12 learners, the use of

Anonymous. Of the 32 learners, 15 learners had no further discussion about alcohol use.

Discussions included a plan to quit the use of substances related to alcohol use.

When doctors were aware that learners were using alcohol, the possible secondary prevention

Discussion with Doctor about Alcohol Use

Services that learners have used at their doctor's rooms related to alcohol cessation.

About their doctor's response in terms of further discussions about alcohol use and about

In those 32 learners whose doctors were aware of their alcohol use, learners were asked

4.3.0.3.2. Doctors Dealing with Alcohol Use
had an HIV test done by their doctor. 3 learners had been tested for drugs. 2 learners were services related to drug use from their doctor. None of the learners using drugs had ever and referred to a rehabilitation hospital. Of the 6 learners, 2 learners did not use any of medications or treatment. 3 learners B injection in high-risk situations. Drug users can provide care, which relates to screen for drug use, blood tests to look for HIV and Hepatitis. When a doctor is aware that a learner is using drugs, the possible services that the doctor can provide are: counseling, education, screening for drug use, blood tests to look for HIV and Hepatitis. Services used to deal with drug use.

Doctor about drug use:

One doctor discussed the need for HIV testing and screening for drug use. All 6 learners had some discussion with their doctors about drug use. 5 learners discussed stopping drug abuse. I learner had been injected. Of the 6 learners, 5 learners discussed stopping drug abuse. I learner had been injected. Of the 6 learners, 5 learners discussed the need for HIV testing and screening for drug use. The doctors discussed the need for HIV testing and screening for drug use. None of the learners had been injected. Of the 6 learners, 4 plan to quit, all plan to quit. When a learner is using drugs, the possible services that can be provided are: counseling, education, screening for drug use, blood tests to look for HIV and Hepatitis. Discussions with doctor about drug use.

Doctors discussed in terms of further discussions about drugs use and about services their doctors provided in terms of further discussions about drugs use and about services their doctors provided. In those 6 learners whose doctors were aware of their drug use, learners were asked about
Table 4.22: Discussions with doctors about sexual activity

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Frequency</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>33%</td>
<td>16</td>
<td>If you have had unsafe sex, you must take the emergency pill (the morning after pill).</td>
</tr>
<tr>
<td>49%</td>
<td>24</td>
<td>Family planning like the use of injection, tablets or a loop must be used every time you have sex.</td>
</tr>
<tr>
<td>51%</td>
<td>25</td>
<td>A blood test must be done to make sure that you have not been infected with HIV.</td>
</tr>
<tr>
<td>51%</td>
<td>28</td>
<td>Pregnancy test must be done if a period (menstruation) is missed or is late, at least a</td>
</tr>
<tr>
<td>84%</td>
<td>41</td>
<td>Condoms must be used every time you have sex.</td>
</tr>
</tbody>
</table>

Discussions with doctors about sexual activity

In this section, learners were asked to indicate on a list of possible secondary prevention topics, which discussions they had with their doctor. Table 4.23 shows the frequencies that learners were asked to indicate on a list of possible secondary prevention topics, which discussions they had with their doctor.

4.3.10.3.4 Doctor dealing with sexual activity

Injections and I Learner took a Hepatitis B vaccine from their doctor. Returned by their doctor for reimmunisation. I Learner had blood tests done to check for liver.
services that learners reported having used. Doctors had uncovered sexual activity in 49
ones they had used at their doctor's rooms. Table 4.2 shows the frequencies of those
learners were asked to indicate on a list of possible secondary prevention services, which

discussion topics

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Frequency</th>
<th>Discussion Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>8%</td>
<td>4</td>
<td>None of the above. We have not talked about any of</td>
</tr>
<tr>
<td></td>
<td></td>
<td>injection (Hepatitis B vaccine)</td>
</tr>
<tr>
<td>66%</td>
<td>3</td>
<td>Injections can be given to prevent Hepatitis B type</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(cervix)</td>
</tr>
<tr>
<td>18%</td>
<td>6</td>
<td>Women who are having sex must have regular cervical</td>
</tr>
<tr>
<td></td>
<td></td>
<td>tests to check for cancer of the mouth or the womb</td>
</tr>
<tr>
<td>21%</td>
<td>10</td>
<td>A blood test must be done to make sure that you have not</td>
</tr>
<tr>
<td></td>
<td></td>
<td>been infected with syphilis (ven STI).</td>
</tr>
<tr>
<td>23%</td>
<td>11</td>
<td>If you have an STI or STD (sexually transmitted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>infection/disease), you and your sexual partner must:</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Service Provided</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>18% My doctor gave me a Hepatitis B vaccine.</td>
<td>6</td>
</tr>
<tr>
<td>0% My doctor sent me to another doctor for an abortion</td>
<td>0</td>
</tr>
<tr>
<td>2% My doctor did an abortion on me.</td>
<td>1</td>
</tr>
<tr>
<td>2% My doctor did a Pap smear test on me.</td>
<td>1</td>
</tr>
<tr>
<td>4% My doctor did an STD test on me.</td>
<td>2</td>
</tr>
<tr>
<td>6% My doctor gave me medicine to treat an STD.</td>
<td>3</td>
</tr>
<tr>
<td>6% My doctor gave me a pregnancy pill</td>
<td>3</td>
</tr>
<tr>
<td>12% My doctor checked me up when I was pregnant.</td>
<td>6</td>
</tr>
<tr>
<td>18% My doctor gave me the emergency pill</td>
<td>6</td>
</tr>
<tr>
<td>27% My doctor did an HIV blood test on me.</td>
<td>13</td>
</tr>
<tr>
<td>27% My doctor gave me family planning advice.</td>
<td>13</td>
</tr>
<tr>
<td>31% My doctor did a pregnancy test on me.</td>
<td>15</td>
</tr>
<tr>
<td>55% My doctor gave me condoms</td>
<td>27</td>
</tr>
</tbody>
</table>

Table 4.23: Services used to deal with sexual activity.
school was Afrikans medium (mathematics examinations were written in Afrikans) and Indian learners, despite being traditional Black, Coloured, or Indian schools. The one research schools except for one had predominantly black learners with a few Coloured and and backgrounds. Although racial data was not specifically sought in the research, all the Johannesburg would yield a heterogeneous group of young people from different cultures.

In the new South Africa, the expectation is that a random sample of schools in the private sector, mainly the lower and middle socio-economic groups, are least likely to have general health risks behaviours and their complications. Secondary government schools serve a large number of students and those adolescent with the least likelihood. Firstly, research in the high school setting isolates those adolescents with the least way to access the adolescent population, it becomes evident that the numbers would be preadolescents. Public secondary schools were used. Despite this being the most convenient in order to have access to adolescents with health risk behaviours that have general

In English, that language would probably be the cause of misinterpretation

translators of the research questionnaires, it becomes evident while addressing the learners, without materials were particularly challenging. Despite most schools not requiring resources, bringing privacy in overcrowded classrooms and the provision of sufficient government secondary schools in Johannesburg proved to be overcrowded and have poor process because these problems had an impact on the data. In the majority of cases, it is important to point out the specific challenges that were encountered in the research.

Chapter 5: Discussion
This response needs to occur at different levels: screening appropriate response by doctors. This response needs to occur at different levels: screening appropriate response by doctors. This response needs to occur at different levels: screening appropriate response by doctors. This response needs to occur at different levels: screening appropriate response by doctors.

Delivery to adolescents initially the uncovering of unhealthy lifestyle choices and then the prevention are necessary pre-requisites. It is then important to examine preventive service behaviors in terms of describing indications, patterns, co-existing behaviors, and risk addressing adolescent health issues on a national level, profiling adolescent health risk behaviors as particularly described, but also to highlight the process involved in depth.

In the discussion that follows, the headings have been chosen not only to address the resource and pathways highlighted areas where readers are apparent that may require more in overview of the way in which the adolescent population is accessing the general practice. Thus, this study serves to provide us with an interaction between learner and doctor variables for which more specific samples with the sample were described. This study, by no means attempts to untie the specific attending government high schools in Johannesburg was selected and the characteristics of

It is important to note that this study design is descriptive. A random sample of adolescents meaningful, to being involved in health risk behaviors would make their contribution more reassurance of confidentiality of information. Others may have felt that dynasty anthem being involved in health risk behaviors. For fear of being caught out, despite all remember that we are dealing with adolescents. Some learners may have heard by davinci despite the fact that the learners did well in writing to complete the aerostatometer; we must study are probably representative of our national real demographics.

was attended predominantly by white learners. Despite this, the real demographics of the
en important, but not only pre-requisite for behavioral change.

Confessions to one's health or may have already affected one's health, has been shown to be
self-perceived health risk. Self-perceived health risk, the sense that an activity may be
preferred to various health risk behaviors but unlike these studies, it also looks at
this research, like studies done locally and abroad, covers aspects like the incidence and

2001, show interesting trends.

Profile of adolescent health risk behaviors from 1991
2.2. Comparative data of 1991 and
United States', the CDC's Youth Risk Behavior Surveillance System (YRBSS) provides a
African National Youth Risk Behavior Survey in 2002, provide comparative data in the
period in the South African context, the Cape Peninsula study in 1992 and the South
period in South Africa contrast, the Cape Peninsula study in 1992 and the same line
reliance on health risk behavior surveys done in South Africa and abroad in the same line
surveillance at a national level. It is important to discuss the findings of this research in
delivery, locally and abroad, such an undertaking is becoming an integral part of health
Profile of adolescent health risk behaviors is an important aspect of primary health care

5.1 Profile of Adolescent Health Risk Behaviors

therapeutic outcome.

health care setting and the ability of the doctor to provide the ideal conditions for a
success of this complex interaction is dependent on adolescents' specific needs in the
patient's role in this interaction namely the learner and the general practitioners. The
complications of unhealthy lifestyle choices. Finally, it is important to look at the
medical complications of unhealthy lifestyle choices and emphasize the medical
immunizing at risk individuals, providing the means to effect behavior change, screening
for co-existing risk behaviors, providing relevant health information and education,
Table 5.1: Adolescent Health Risk Behavior Surveys and studies conducted in the United States.

Table 5.1 compares the adolescent health risk behavior profiles of South African studies and studies conducted in the United States.
activity has increased in both the 2002 South African YRBSS Survey as well as this study.

United States shows a decrease among young people whereas in South Africa, sexual
in condom use in the same period. A disturbing observation is that sexual activity in the
with a decrease in alcohol and tobacco use in adolescents in the last decade and an increase
of one is the fact that like the United States, South African studies show a similar trend
increase from 54.1% to 47.6%. These changes over time were statistically significant.
increased during this period with figures of 2.7% and 2.3% and a decrease in those who had sexual
from 81.6% to 75.2%. An increase in marijuana use from 31.3% to 42.4% in one and a decrease in
decrease in those who had at least one drink of alcohol on one or more days during their
are seen: a decrease in those who ever tried cigarettes smoking from 70.7% to 69.7%.
When comparing the CDC’s YRBSS figures for 1991 and 2002 the following trends

When compared to the CDC’s survey, which is a standardized questionnaire,
compared to the CDC’s survey, which is a standardized questionnaire,
is only regional and the two studies did not have the same questionnaire format as
important to note that the data are not fully comparable because the Cape Peninsula Study
alcohol use, 31% for tobacco use, 13% for condom use and 41% for sexual activity. If is
exposures. The 2002 South African National Survey showed the following results: 49% for
for previous tobacco use, 47% for condom use and 17% for previous heterosexual
The 1992 Cape Peninsula study showed the following results: 33% for alcohol use, 41%

exposure
and not all drug use and sexual heterosexual exposure as opposed to any sexual
studies looked at previous use as opposed to current use, which results for condom use
When comparing the results of this study to other studies it is important to note that some
When looking at the Cape Town figures, the percentages of the health risk behaviours are

The South African national figures highlighted the extent of the problem on a national level.

<table>
<thead>
<tr>
<th></th>
<th>57%</th>
<th>47%</th>
<th>41%</th>
<th>Sexual Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Drugs</td>
</tr>
<tr>
<td></td>
<td>15%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Alcohol</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td></td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tobacco</td>
</tr>
<tr>
<td></td>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Behavioral Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Capite</td>
<td>National</td>
<td>2002</td>
</tr>
<tr>
<td></td>
<td></td>
<td>urvey</td>
<td>Survey</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2002</td>
<td></td>
<td></td>
<td>2002</td>
</tr>
</tbody>
</table>

Table 5.2: Adolescent Health Risk Behaviour Surveys in South Africa 2002

The South African Youth Risk Behaviour Survey conducted in the same year,

data. Table 5.2 compares the adolescent health risk behaviour profiles of this study and
and with alcohol use alcohol prevalence and having ever used alcohol could affect the
Cape study looks at heterosexual activity whereas the other studies do not specify this.
the questionnaires not being standardized in the South African studies. Specifically the
in the 2002 South African National Survey. These may be real differences or may due to
YRBS data. This study also shows a much higher increase in sexual activity as compared to
that differs from the trends seen in the South African National Survey and the CDC's
and a decrease in tobacco use. This study, however, shows an increase in alcohol use.
This study showed a similar trend to the 2002 South African National Survey as
When looking at the ten-year comparisons in South Africa and the United States of America (Table 5.3), we have to take into account that in South Africa, we do not have accurate data for the percentage of adolescents who engage in sexual activity. The table below shows the ten-year comparisons of youth risk behaviors conducted in South Africa and in the United States.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Sexually Active</th>
<th>Other Ways</th>
<th>Drugs In Use</th>
<th>Infected</th>
<th>Alcohol</th>
<th>Tobacco</th>
<th>Behavioural</th>
<th>Health Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>%45.6%</td>
<td>%31.3%</td>
<td>%18.6%</td>
<td>%5%</td>
<td>%3%</td>
<td>%4%</td>
<td>1991</td>
<td>1992</td>
</tr>
<tr>
<td>%</td>
<td>%42.4%</td>
<td>%31.2%</td>
<td>%18.6%</td>
<td>%5%</td>
<td>%3%</td>
<td>%4%</td>
<td>1991</td>
<td>1992</td>
</tr>
<tr>
<td>%</td>
<td>%2.1%</td>
<td>%8.1%</td>
<td>%63.5%</td>
<td>%5%</td>
<td>%3%</td>
<td>%4%</td>
<td>1991</td>
<td>1992</td>
</tr>
<tr>
<td>%</td>
<td>%78.2%</td>
<td>%15.1%</td>
<td>%70.1%</td>
<td>%5%</td>
<td>%3%</td>
<td>%4%</td>
<td>1991</td>
<td>1992</td>
</tr>
</tbody>
</table>

Table 5.3: Ten-Year Comparisons of Adolescent Health Risk Behaviour Surveys

Behavioral surveys conducted in South Africa and in the United States.
would expect a different pattern of use in adolescents not attending school. The second
substance use issues over the weekend so that they can still continue with their schooling. One
and drugs would affect performance during the school week, so learners probably use these
second most common pattern reported with alcohol and drugs in "weekend" use. Alcohol
This is the group that has the potential to benefit the most from secondary prevention. The
results confirm that adolescent health risk behaviors may be transient and exponential.
These patterns of use for all these groups were having "wet" in (Figure 4.3, "Page 54"). These
is "wet," then "weekend" then "weekday," and then "daily." The most frequently reported
the pattern of use of cigarettes, alcohol, and drugs from the least usage to the most usage first
the different parameters to gain insight into all facets of the health risk behavior. If we evaluate
type surveys of 1996, 1997, and 2001, health risk behavior patterns are described using
in the Cape Peninsula Study, and the South African YRB Survey 2002, as well as the CDC

5.2.2 Patterns of Health Risk Behaviors

Barker sample with more specific selection criteria.

Data that is more truly reflective of the real situation could probably be achieved with
certain subgroups being particularly prone to involvement in health risk behaviors.
involved in each of the health risk behaviors. The information may provide insight into
involved in each of the health risk behaviors. The information may provide insight into
in the study, the demographic information of learners serves particularly to describe learners.
adolescent health risk behavior profile has worsened in all areas.

Informed drugs remained the same, in the South African total figures, however, our
increased. Alcohol and sexual activity have all increased (Cannabis use increased while
African YRB Survey. This comparison indicates that in the United States figures for
region in the 1992 Cape Peninsula Study, and the Western Cape figures of the 2002 South
becomes the second most common pattern of use after having used it was weekend use
high risk of dying in alcohol-related traffic accidents. In this study, the high school

Binge drinking is a common and hazardous behavior among this age group, who are at

cessation counseling had increased on a continued with the CP to give up
gain at least once, and that the majority of recent smokers who received smoking
age 15 years old. Research has shown that the majority of recent smokers who tried to
leaves are unlikely to do so in adult life, most adult smokers having acquired the habit by
adolescent increase risk of lung cancer. Those who do not smoke regularly in their
the younger someone starts, the less likely they are to give up, and early initiation of
in terms of tobacco use, studies show that early smoking is a particular problem because

days, a 12 month period of lifetime use. South African studies also used these parameters.
substance was used or behavior continued in particular time frame like every day, 30
patterns. The CDC VABSS looked at patterns in terms of the number of times the
the United States because different parameters were used when looking at behavior
it is difficult to compare the data from this research to the other studies in South Africa and

use of selected drugs and drugs taken in other ways. NIIH (Figure 3, Page 54) shows that there is no significant difference in the patterns of
chewing. It is important to note that in every 5 children was using tobacco in the form of
in terms of tobacco use, different smoking precursors over NIIH smoking and tobacco
performance.
most common pattern for tobacco use was "daily". Tobacco use has less effect on school
many adolescent risk behaviors. A recent study by the CDC's YRBS shows a significant relationship between certain risk behaviors and grades. It is important to note that the age at which risk behaviors co-exist is high. The 2002 CDC report highlights this concern.

5.1.3 Co-existing Health Risk Behaviors

Research has confirmed that particular selection criteria in order to confirm the possible trends highlighted in this study. We would probably need much larger samples with varying degrees of co-existing health risk behavior patterns. We may however be able to achieve the possible subgroups that may be prone to the more noticeable ones. Any reserves to describe the learners involved in particular health risk behavior patterns. It is again important to note that the demographic features that have been presented.

Behavior patterns are characterized by multiple sexual partners and the frequency of unsafe sexual practices. The results highlight the adolescent sexual partners and not those involving a smaller number of sexual partners. When considering the results, the most frequently reported pattern is that of having multiple sexual partners (20%). The next most frequently reported pattern is that of having multiple sexual partners without the use of a condom (51%). The least frequently reported unsafe sex practice is that of having multiple sexual partners. The lack of condom use and the presence of contraceptive methods in terms of the patterns of unsafe sexual activity the follow aspects were examined:

is minimally affected. When the binge drinking is most likely to occur so that school attendance and performance
It is important to note that learners’ risk perception for substance use (tobacco, alcohol and drugs) was higher than their perceived risk for unsafe sexual practices. Usually seen later in adult life.

Page 69 This highlights the fact that the effects of adolescent health risk behaviors are health benefits affected by their involvement in part. In Table 4.9.1 Learners reported more frequently that their health was in danger when compared to their

Page 70

Their use had already made them “unhealthy”.

Page 71 When assessing self-perceived health risk, two aspects were assessed, firstly if the learner felt that their use may be “dangerous” to their health and secondly whether they felt that their use had already made them “unhealthy”.

Page 72 Methodology would be more informative.

Page 73 Methodology would be more informative.

Page 74 Sexual activity. 10% reported the use of alcohol, tobacco and drugs and sexual activity. 26% reported tobacco use and sexual activity. 25% reported alcohol and tobacco use and learners reported alcohol use and sexual activity. 33% reported alcohol and tobacco use. Learners reported alcohol use and sexual activity is also reflected in this study. In this study, 44% of

Page 75 The findings in the Cape Peninsula study which showed an association between alcohol
impact on adolescents, who are experiencing a normative biological need to experiment widely studied. Numerous studies seem to indicate that education alone will not have an behavior change. Risk perception among young people in South Africa has not been this means of education will in the long run influence risk perception and ultimately changes to engage mass audiences in a powerful way. It is important to ascertain whether popular and high-quality entertainment formats can use prime time, television and radio programs to engage mass audiences in a powerful way. It is important to ascertain whether popular and high-quality entertainment formats can use prime time, television and radio programs to engage mass audiences in a powerful way.

The Soul City Institute for Health and Development Communication, in South Africa's difference in the two groups. patterns of substance use and sexual activity (as well as the other socio-economic problems (particularly fewer reported health risk behaviors) and parents (relatively safer environments) the doctor group having younger learners), their health risk behaviors do not have a general practitioner. The possible reasons for this could be the differences in in the doctor group the risk perception with substance use was less than those learners who learn how the effects of alcohol use by weekend use possible reason for this could be related to the patterns of use of these substances where compared to tobacco use, learners perceive more negative effects with tobacco use. The tobacco use. Despite alcohol use being the most frequently reported health risk behavior to remove learners from the public schooling system in much higher degree than does the health student effect. The complications of unsafe sexual practices have the potential a much higher degree than unsafe sexual practices. The possible reason for this could be to tobacco use. Yet, in this study, learners reported that their tobacco use has affected them to practice more complications during adolescence than does practices have the potential to cause more complications during adolescence than does...
to expand and optimize preventive service delivery in the primary health care sector.

In overseas countries like the United States, Britain and Canada, efforts have been made

Preventive service delivery to young people in South Africa

and perhaps specific aspects of this intervention that may be useful in planning future
disadvantaged youth and primary general practitioners. The research uncovers important
factors, served as motives for examining the interaction between economically
disadvantaged youth in the economically disadvantaged heading the way
private sector in health care delivery in the economically disadvantaged heading the way
Overspent and public health resources and the potential that greater involvement of the
make use of government services are utilizing preventive services in the private sector.

in South Africa, the large majority of adolescents are probably using the public health care
Preventive Services to Deal with Health Risk Behaviors

Adolescents’ Perceptions of their General Practitioner’s Provision of

Effects, and more immediate consequences of their health risk behaviors as opposed to long-term
consequences of the health risk behaviors. Their health concerns were ranked to direct
adolescents are less concerned about being involved in health risk behaviors than the
preventive service delivery for young people is stimulated. A Canadian study showed that
adolescents in the older age group (18-21 years old) (Table 4.9, Figure 6) perceived and analysed
risk perception to increase. This study shows that risk perception is higher in the
elderly population. Risk perception is still developing. So as adolescents get older we can
while self-regulatory mechanisms are still developing. So as adolescents get older we can
adolescents can report accurately on the care they have received six to seven months after
and counseling is more accurate within two to four weeks after preventive care visits.

determining the content of preventive health service delivery. Although recall of screening
considered that adolescents' self-report of the care they have received is a valid method of
self-reporting of their receipt of preventive services was used. A study in the United States
provided the service of one of the adolescents receiving the service in this study learner's
We can check the receipt of preventive services from either the general practitioners

next behaviours from general practitioners working in the private sector.

of how young people perceive their receipt of preventive services for a few health
private sector function predominantly independent of each other. This study only focuses on
government and government resources in varying proportions in South Africa the public and
in South Africa, in the absence of such national guidelines it is important to look at

the need for continual review in order to optimize its use.

applied. This highlights firstly the need for national guidelines to be applied and secondly
recommends levels, but all levels greater than those in settings where guidelines are not
when guidelines are applied, preventive service delivery is occurring at rates below
and where they are not. The conclusion of such studies is that
They have reached a stage where comparable data is available in settings where these
pediatricians', school nurses', family physicians and primary health care workers in China.

These countries have national guidelines for designated preventive visits for adolescents.

These countries have national guidelines for designated preventive visits for adolescents.
By far the commonest way the health risk behaviour was uncovered was by the doctor present with symptoms and is thus more likely to be uncovered.

Less likely to be uncovered: Unusually sexual activity, on the other hand, is more likely to be hidden from the health and performance of learners attending high school and is thus by

them: tobacco use, but here patterns of use become important: weekend drug use is least

uncovered. It is important to note that one would expect drug use to be uncovered more and 11% of those surveyed had reported drug use (Table 4.1.6, page 83). This indicates that

uncovering occurred in 4.1% in sexual activity, 19% in alcohol use 18% in tobacco use.

uncovering of the health risk behaviour occurred.

behaviours and they are seeing general practitioners. Any intervention is only possible if

in the general population, there are young people, who are engaged in health risk

5.2.1 Uncovering of Health Risk Behaviours by General Practitioners

behaviours change intervention program.

Therefore uncovering education and service provision are crucial aspects in any medical attention uncovers the behaviour and responses to it in the appropriate way.

Youth people involved in health risk behaviours can only benefit from a service, if the

occurring on an opportunistic basis at the time of an acute care visit.

designed preventive health care visits. In South Africa preventive services are probably

the preventive health care visits uncovered. It is important to note that once again these are
General practitioners are having an impact on the part of our population that most needs intervention, who are aware of their health risk behaviors is small, but this shows what little impact as can be expected, the number of learners with health risk behaviors and with doctors

5.2.2.2.6 Preventing the medical complications of the health risk behavior.
5.2.2.5 Screening for the medical complications of the health risk behavior.
5.2.2.4 Providing the means to effect behavior change and
5.2.2.3 Immunizing at risk individuals.
5.2.2.2 Providing relevant education and information.
5.2.2.1 Screening for co-existing health risk behaviors.

Secondary prevention is necessary in terms of

now necessary for the doctor to respond to the health risk behavior. This is where

Once the health risk behavior has been uncovered by the doctor, by whatever means, it is

5.2.7 (General Preventions’ Response to Health Risk Behaviors

volunteer health risk behavior involvement.

The incentive to uncover is coming from the doctor. Learners are explicitly not going to

This highlights the fact that uncovering of adolescent health risk behaviors is low and that

behavior without the doctor having to ask about it.

uncovering in all health risk behaviors was by the learner reporting the health risk
28% (compared to 92%) of those not sexually active had discussions. These figures, 24% (compared to 100%) of teenagers using drugs had discussions and in tobacco had discussions, 23% (compared to 50%) of teenagers not using alcohol had primary prevention discussions. Only 19% (compared to 76%) of teenagers not using alcohol had secondary prevention discussions. It is important to compare the rate of secondary prevention discussions to the rate of the health risk behaviour. (Table 4.22, page 90)

The health risk behaviour, discussed with their doctor related to sexual activity even once the doctor had uncovered some knowledge related to alcohol use, all had some discussion with their doctor related to drug use. 96% had some knowledge related to a doctor related to tobacco use, 50% had some discussion with their doctor related to discussion of health hazards. Yet, in this study only 76% had some discussion with their doctor related to tobacco use. The study showed that young people trust doctors for health related information and want to be informed about health education and information related to their health risk behaviour must be provided. Repeated discussion with a doctor has uncovered a health risk behaviour, related health

5.2.2 Providing Relevant Health Information and Education

sufficiently enough.

Table; This shows that doctors are not uncovering co-existing health risk behaviours and 68% of the 15 teenagers who were also using alcohol and at least 33% of the 15 teenagers who were at least 46% risk behaviour was uncovered. In 56% of the 15 teenagers who were also using tobacco, 46% existing health risk behaviour. The results show that tobacco use as a co-existing health behaviour has been uncovered. how successful are the doctors in uncovering at least one co-existing health risk behaviour. Doctors have the greatest success in uncovering sexual activity. Once this health risk
adolescents. It is important to note that the Hepatitis B vaccine is part of our expanded childhood immunization programs. However, significant, but the results may indicate a lower level of immunization for at-risk adolescents is directly significant, but the results may indicate a lower level of immunization for at-risk adolescents.

Once again, the number of learners in this subgroup is small and may not be statistically significant, but the results may indicate a lower level of immunization for at-risk adolescents.

Infection and was given the Hepatitis B vaccine, but this learner used drugs in other ways. Infection was one learner who had a discussion with their doctor about blood loss for Hepatitis B infected drugs but neither a discussion nor the provision of the vaccine occurred. These provided the vaccine (Table 4.23, page 92). Only one doctor was aware that the learner provided the vaccine (Table 4.23, page 92) and one doctor was aware that the learner provided the vaccine (Table 4.23, page 92).

The sexual activity was discussed with the learner. Only 62% of learners whose doctors were aware of their sexual activity, those who are infected, or 62% of learners, whose doctors were aware of their sexual activity, those who are infected. Only 62% of learners, whose doctors were aware of their sexual activity, those who are infected.

The Hepatitis B vaccine is indicated in those learners who are sexually active and are using condoms. It is important to reduce the complications of health risk behavior. Appropriate immunization referred to their health risk behavior must be advised and discussed with young people in terms of health risk behaviors. When a doctor has suggested that an adolescent is involved in a health risk behavior, the doctor may be doctor the characteristics and learner characteristics that determine the extent to which primary and secondary discussions occur. The numbers were too small in this study to show anything significant. This information could provide primary health care providers with insight into the limitations of their own prevent primary prevention efforts. General practitioners are having discussions more regularly when the adolescent is already involved in a health risk behavior.

highlight the fact that in this primary health care setting, secondary preventive efforts are...
continue. Follow up... reported not using these services, 35% reported having a unique least those in need of counseling and support to drug rehabilitation units. Utilize unique least for alcoholics anonymous. In terms of the use of drugs, the general practitioner can refer services. 16% reported having access to alcoholics anonymous, 75% reported not using these need of counseling and support to alcoholics anonymous. 16% reported having access to antabuse tablets and 9% reported referred to fill out a prescription for tablets to help young people to stop alcohol use and refer those in nicotine chewing gum. With regard to the use of alcohol, doctors may either dispense or prescription for nicotine chewing gum or refills. 68% had access to nicotine chewing gum or refills. 46% had access to nicotine patches and 28% had access to prescription or filling out a prescription for nicotine chewing gum or refills. 68%.

When considering the use of nicotine, doctors may not only dispense but also provide either.

some of the important pre-requirements for behavior change can be described. Receive about health risk behaviors. This study did in no way assess behavior change but present risk. This in turn may be influenced by the information and education adolescents previously an important pre-requisite to behavior change is the adolescent's perception of disease and to provide the means to change the behavior. As has been mentioned when a general practitioner has uncovered a health risk behavior, it is important to

5.2.4. Providing the Means to Effect Behavior Change

are nonetheless important. High risk adolescents, which are not specifically for substance use and sexual activity, but it is important to note that there are various other reasons that are included especially in injection and the necessary for the vaccine and have discussions with their doctors about it. Sexually active and those who use hormonal drugs are aware of the risk for hepatitis B childhood vaccination. It is still important, however, that high-risk learners, those who are immunization program, so some learners may have received this immunization during the
The demographic data can provide us with an idea of the type of learner who is receiving these services. More affordable.

General practitioners, however, may be accessible government clinics and hospitals where

It is important to note that despite reporting poor utilization of these services from their

rule.

General practitioners who are able to supply government family planning at an affordable
adolescence and thus learners are more likely to seek out these services. Partners from
better results, perhaps because the complications of the health risk behavior occur during
are no longer adolescents to stop the health risk behavior but rather to assist them in how
not on getting adolescents to stop the health risk behavior. An important consideration would therefore be to focus
adolescents do not perceive risk from their behavior and are not willing
not only because of adolescence but also because of adolescence not having a discussion about options available to them but
these results indicate that service provision for tobacco and alcohol use is poor, perhaps

and 27% reported that their doctor provided family planning (Table 4.23, Page 92).

4% reported not using these services, 55% reported that their doctor provided condoms
provide adolescents with the means to practice safe sex. Like condoms and contraception,
sexually active and abstinance is not an option for them, the general practitioner can
for drugs and 33% reported being referred for rehabilitation. When an adolescent is
When an adolescent is sexually active and has not practiced safe sex, pregnancy testing, and HIV and syphilis testing, and regular cervical smears may be necessary. Of the 49 learners, 31% had pregnant tests, 27% had HIV testing, 6% had syphilis testing, and 2% had a cervical smear (Table 4.2). A docent and only one learner had tests for hepatitis.

This study notes that the learners that were heterosexuals had an HIV test performed by their doctor and only one learner had tests for hepatitis.

In terms of screening for the medical complications of health-risk behaviors, only drug and sexual activity are applicable during adolescence.

An adolescent's medical complications of health-risk behaviors, the effects are usually seen in activity. Drugs and alcohol abuse may also lead to violence and crime. However, in terms of performance and the dropout rate, this is especially true about alcohol, drugs, and sexual health.

Health-risk behaviors in adolescence may have an impact on absenteeism, poor school performance, and limited opportunities for college. Studies may prove to be more informative.
must be provided. In this study, 6% received STI medication if an adolescent is pregnant
conception, 18% reported use of this service. If an adolescent has an STI, they must have access to emergency
on adolescents’ health and unprotected intercourse. They must have access to emergency
medication complications of health risk behaviors, sexual activity will be discussed
occupational therapy). In terms of the way in which general practitioners can manage the
professionals including counselors, psychologists, orthopedic surgeons, physiotherapists and
medication complications of adolescent health risk behaviors can involve many health care
approach with psychiatrists and rehabilitation. Health care workers. The management of the
practitioners are in a unique position to identify users and be involved in a shared care
with alcohol and drug use are usually directed towards the health care system. General
Drugs and alcohol abuse may lead to violence, crime and injury. The problems associated

5:2.6 Managing the Medical Complications of Health Risk Behaviors

complications in young people with limited financial resources.
that allow for screening. This information can include changes in screening for
screening. The data presented is purely descriptive but may be indicative of the circumstance
for the medical complications of health risk behaviors and the doctors who did the
The demographic data could be very valuable in assessing the barriers who were screened
the government can resource that may be more affordable,
complications of adolescent health risk behaviors. These barriers may also be utilized
significant, but the results may indicate a low level of screening for the medical
Once again, the number of learners in this subgroup is small and may not be statistically
Female learners made up 59% of the study sample. It is important to note that because high incomes and poor health can have many implications on the ability of health centers to meet the needs of pregnant adolescents above 17 years old, the health school system is the major provider of reproductive health services. There are, therefore, a significant number of adolescents above 17 years old in the public school system. This is important to note that if we consider seven as the age to start school, the study sample only included those between 14 and 17 years of age. In fact, there were an almost equal number of 15 to 17-year-olds (Figure 4.1). Of these, 48% of senior high school learners should have consisted of a larger proportion of 15 to 17-year olds. To meet their needs, reproductive health services should have consisted of a larger proportion of 15 to 17-year olds.

3.3 Adolescents in Private Schools

The private sector provides a variety of services to young people with poor resources in the health sector. These services are described in Table 4.3. These services are provided by general practitioners with a range of services. For example, different situations of the services are based on the treatment of an adolescent is provided and a termination of pregnancy is not an option. Instead, a referral to the reproductive health system is the appropriate course of action. In this study, 4% reported that their doctor referred them to the reproductive health system. This is important to note that if we consider seven as the age to start school, the study sample only included those between 14 and 17 years of age. In fact, there were an almost equal number of 15 to 17-year-olds (Figure 4.1). Of these, 48% of senior high school learners should have consisted of a larger proportion of 15 to 17-year olds. To meet their needs, reproductive health services should have consisted of a larger proportion of 15 to 17-year olds.

Private sector

These results reflect that this level of intervention by general practitioners is low, perhaps because assessments must be done regularly. In this study, 12% visited their doctor for an annual check-up. This information is not available, but if it is performed a termination of pregnancy and 2% reported that their doctor referred them. It is important to note that the reproductive health system is the appropriate course of action. In this study, 4% reported that their doctor referred them to the reproductive health system.
individuals to discuss specific health concerns.

Research has shown that adolescents choose specific
methodology may describe these aspects of adolescent interaction with health care and choices of a general practitioner. Larger study samples with a more representative study sample but may be studying to the complex nature of adolescent counseling patterns.

The demographic data describing the teenagers and doctors may be partly descriptive of the

5.3.3 The Interaction

disadvantaged backgrounds.

Private practitioners that are being sought out by young people from economically
but on a different level these demographics may also influence the general practitioners in
merely the demographics of general practitioners being reported on in the study sample.

Some educational district where learners were attending school at one level, these may be
with male doctors. Also, the doctors counseling rooms were most likely shielded in the
male learners are counseling with male doctors and more female learners are counseling

The important aspect of the demographic details of general practitioners was that more

5.2 General Practitioners

 Probably represents the adolescents least affected by unhealthy lifestyle choices.

different in the general population of adolescents. The secondary schooling environment
profiles and patterns and interaction with general practitioners would all probably be very
income some results (Figure 4.2, page 5). The demographics' health risk behaviour
young people from the middle and lower socio-economic groups. This was reflected in the
group of adolescents is being under-represented. Governmental high schools largely serve
pregnancy removes many female adolescents from the public schooling system so this
be consulting doctors other than their own general practitioners when sensitive problems arise. Why are these cases of cash instead of consulting a doctor’s clinic or other medical treatment centers? The parent may not seek a medical consultation when they consult for more sensitive problems or they can’t afford to pay cash. In this study, only 4% choose this option. This could either mean that these cases are of low importance or that there is no consensus on the consultation. Some young people may be consulting doctors other than their own general practitioners when sensitive problems arise. Their chosen doctor is the family doctor. Observations may indicate that the sex of the doctor may not be important as the reason for consulting a female doctor in 88% (Table 4.14, Page 74), whereas the reason for consulting a female doctor in 92% (Table 4.11, Page 69) but reported their reasons for seeing a female doctor was reported having a preference for a female doctor. Among male interviewees, only 11% reported that they had a preference for a female doctor. Only 5% (Table 4.14, Page 74) responded. When asked if this was the reason for choosing more doctors were female doctors than when asked if this was the reason for seeing a female doctor.
In the order of frequency (Figure 4.4, Page 72),

system (66.7%), services (45.1%), doctor personality and qualities (9.9%), and site (2.4%).

Looking at the reasons why young people consult with other doctors, however, features reported and personality and qualities (then site or system characteristics. In this study, when young people placed greater importance on provider characteristics (doctor services (14.8%), doctor personality and qualities (26.9%), system (11.8%), and site (1.1%).

In an overall ranking of the most important reason for choosing their general practitioner, then site or system characteristics are more important than doctor characteristics. An American study showed that young people were aware of the factors contributing to their decisions to seek care. In highlighting that provider characteristics are of greater importance, their doctors live in three times a year.

As a precautionary measure, research suggests that young people consult with their general practitioner within the last 6 months but this wish was probably not accurate within 5 to 7 months or receipt of service. 80% of teenagers in the study method of determining the content of preventive health service delivery, but is only research has shown that adolescents self-report of the care they have received is a valid delivery would reveal a more accurate account. But this approach also has its limitations. Perhaps asking general practitioners about the content of preventive care discussed. Perhaps asking general practitioners about the content of preventive care issues does occur. An American study showed that at the age of 15 many young people
heated with difficulty and respect when consulted with primary care providers. This study confirmed the findings of an American study conducted with your doctor. The nature of previous consultations did not require consultation with your doctor. The nature of previous consultations did not rank as very important reasons for choosing to go to why many learners chose their doctor. (Table 4.1, Page 74) It is important to note that the feel that their general practitioner is the family doctor is the most important reason

Table 4.1.2: Specialties which were necessary or when they were seeking a second opinion (Table 4.1.2) medical and that covered these services. Learners chose to go to another doctor when a medical and that covered these services. Most of these learners (70%) however, are on needs for these services in the private sector. Most of these learners (70%) however, are on poor access to these services in the government hospitals and families are willing to get the poor access to these services in the government hospitals and families are willing to get the poor access to these services in the government hospitals and families are willing to get the poor access to these services in the government hospitals and families are willing to get the poor access to these services in the government hospitals and families are willing to get these services are very expensive in the private sector. If my hypothesis that learners have suppressed their learners to go to their doctors for X-rays and laboratory investigations because this could indicate that they are using the government clinics for free family planning and percentage of learners used family planning and condoms from their general practitioner and for health information and advice and guidance (Table 4.1.3, Page 73), a small expected, most learners reported choosing to go to their doctor for a check-up, medication, learners or their doctor was because of the services their doctor provides. As services. This is borne out by this study showing that the most important reason why services. This is borne out by this study showing that the most important reason why services. This is borne out by this study showing that the most important reason why services. This is borne out by this study showing that the most important reason why services. This is borne out by this study showing that the most important reason why services. This is borne out by this study showing that the most important reason why services. This is borne out by this study showing that the most important reason why services. This is borne out by this study showing that the most important reason why
...My doctor must tell me what's wrong and what's right about my health. In many cases to maintain good health and prevent diseases and understanding what causes diseases.

Regarding doctor services, learners requested more advice and guidance in terms of how learners' responses differed in Africa were translated into English for presentation.

- Surgery site
- System (the way the surgery works)
- Doctor personality and qualities
- Doctor services

Percentages in the results chapter. They will now be discussed in terms of their doctors to make in order to visit more easily. These results were reported as in an open-ended question learners were asked to mention changes they would like being embarrassed.

...understand the need for privacy and learners being able to take reading materials without reading aspect of the way the surgery works. Of note here are aspects like the staff doctors' rooms. Of note again is what influence importance is placed on the confidentiality.

...highlight the fact that young people want to be seen within hospital when they go to their doctor not being available and making time to see them (Table 4.12, Page 70). This is the most important reason for going to another doctor was system related in terms of the choice to go their doctor is that their doctor makes time to see them (Table 4.15, Page 70). Learners reported that the most important system related aspect that made them feel they had no choice to visit another doctor was...
who were assured conditional confidentiality. willingness to disclose information and seek future health care was compared to 53% of those showed that 43% of young people who were assured of unconditional confidentiality were receptive to advice. Their doctor must not share me in front of my parents. An American study about my problems. I must not tell anyone about my problems, not even his learners expressed their concern for confidentiality. "My doctor must not tell my parents. comparison that we do as the youth, his must try to contribute in the HIV/AIDS campaign. about how the family does and how the problem improves. My doctor must take part in surveys in order for young people to be free. He must phone more frequently and find out community. My doctor must allow young people to talk with their parents about sex in the community. learners requested that their doctor should involve their parents, their family and the extended their roles. Not only act as a doctor but also as a mentor and advisor. Some with regards to their doctors' personality and qualities. learners requested that their doctor discussing a broad range of health concerns.

as can be seen in the learner responses, adolescents are receptive to investigations like x-rays. "I want my doctor to tell me about family planning infections, their services to include family planning, procedures like circumcision and special instructions, medication side effects and the choice of pills over injections. He must explain to me the medication the processes and their side effects. "He must not give me an abortion, medication side effects and the choice of pills over injections. He must also make sure that we can not feel pregnant. Special mention was also made of STI's as well as AIDS, and the consequences of unsafe sex. "I want my doctor to tell me about this was specifically related to their sexual health. "My doctor should talk to me about
In the healthcare setting:

These comments highlighted the fact that young people are very aware of their specific needs when walking distance from them and opening another surgery closer to them.

In terms of the site of the surgery, comments were made about their doctors' rooms being

and pamphlets:

I am waiting for him», providing some messages. «He must have HIV/AIDS posters keep them occupied while waiting. «My doctor must have a TV so that I can watch it when

is rude and doesn't care about people» I would not mind if he could hire a new assistant that is more friendly. «That assistant is too cheepy.» «My doctor has to hire the nurse; she

wanted me. »Must get a bigger waiting room» Some learners commented on the need

can't afford.» Many commented on the need for more spacious, comfortable and colorful

Leavers asked for their doctors to reduce their fees. «Stop charging me more money then I

appointments more easily.» «The doctor must be available for longer hours.»

room.» Here at least two more doctors to help him, we wait too long in the waiting room.

Leavers asked for their doctor to have longer office hours, make it easier for them to make

leisure time or lunch.» When I visit my doctor, I don't want to find someone replying him.

My doctor must remain at the surgery all time allocated.» He must not leave us to go for

consult.
Already compiled our second national survey in 2002. We also need national guidelines to
behaviours through systematic surveys on a national level. In South Africa we have
We need to have an indication of the prevalence and trends of adolescent health risk
reasonable time frames.

national guidelines that realistic goals can be set with well-defined and points and
adolescent preventive services. It is only with national surveys and the application of
also to the application and implementation of national guidelines for the delivery of
of adolescent health risk behaviours at a national level over the past fourteen years, but
Survey from 1991 to 2001. This is probably attributable not only to systematic surveillance
a decrease in prevalence in tobacco and alcohol and sexual activity in the CDAs and
adolescent, alcohol and drug use as well as sexual activity. The United States however shows
African National Youth Risk Behaviour Survey? These figures show a worsening in
is the Cape Peninsula study in 1992, and the Western Cape figures from the 2002 is South
behaviour profile has worsened in the past decade. The only available data for comparison
(deplete with the free States). There is some indication that our adolescent health risk
of in HIV/AIDS epidemic, Californian showed the highest prevalence of sexual activity
prevalence for tobacco, alcohol and drug use and sexual activity. Of importance in the face
2002. Of the nine provinces in South Africa, Californian Ramos in the top three in
referred to the 1st South African National Youth Risk Behaviour Survey? Conducted in
adolescents among the lower-income groups. The prevalence of alcohol use and sexual
The research shows that there is a high prevalence of adolescent health risk behaviours in

CHAPTER 6 CONCLUSIONS AND RECOMMENDATIONS
and privacy and must only serve as a record of attendance and not a medical record.

These cards will, however, need to fulfill all the necessary pre-requisites for continuation of the adolescent health care. Health care can be a necessary pre-requisite for registration for high school and a necessary pre-requisite for children entering formal education in Grade One. So too can disability and background issues in the same way as the completion of the road to health can reinforce the child's mental health care visits for adolescents from economically and educationally disadvantaged backgrounds. In South Africa, primary health care and health care services can implement national guidelines relating to the concept and delivery of adolescent preventive primary health care. The National AIDS Council and partners in both the public and private sector have been involved in implementing the services of government hospitals and clinics, especially in response to the AIDS epidemic. The research shows that young people are more likely to ignore that the private sector will have to become more involved in providing preventive services, especially as a result of the HIV/AIDS epidemic.
alcohol and drug use and sexual activity, present (and monitoring their adolescent's social and recreational activities for Lobacco) not having easy access to weapons of potentially lethal median on when a suicide risk is driving vehicles with a license, avoiding weapons or keeping weapons safe in the home, promoting behaviors), helping the adolescent to avoid potentially harmful behaviors (promoting parents being open for discussions and serving as role models for health-related issues can be discussed which include: normal adolescent physical, sexual and emotional health adolescent not necessary being present), at these visits, important adolescent health adolescent health can be referred attendance by parents for these these visits (with the least once during each of these groups, 11-14 years, 15-17 years and 18-21 years. The) primarily, discussions with parents regarding adolescent health issues can be organized at

In terms of the content of the preventive health visit, this can be given at any age as well as

also be included on the adolescent health card.

policies regarding confidentiality and the extent of parental involvement. These details can

parents with an understanding about detailing the aims of this initiative and paying our clear

needs of the particular adolescent. Health care workers can provide adolescents and their

and developmentally appropriate, and are sensitive to the individual and socio-cultural

preventive service visit, Health care workers can describe these visits so that they are able

In terms of delivery, all young people from the age of 11 to 21 need to have an annual

absenteeism, declining school performance could affect his learning disabilities, attention
issue, emotional, physical and sexual abuse, learning or school problems (ranging
from attention, physical or sexual abuse, alcohol or drug use, previous suicide attempts or
risk (decreasing school grades, chronic mental health, family dysfunction, homosexual
whom external stimuli in sexually active females above 18 years), depression and suicide
HIV testing with informed consent and post- and post-test counselling, cervical cancer
partners, sex for money or drugs, previous pregnancies and SITS). HIV and STIs
with condom use, contraceptive methods, sexual orientation, number of sexual
etiology disorders (with sexual body mass index), alcohol and drug use, sexual

Thirdly, annual health visits can be used to screen for hypertension, hypothyroidism,

and internet access for adolescent health websites.

Access to health information in the form of pamphlets, educational and informational
previously, the adolescent can request the discussion of specific areas of interest and have
explanation, and the evidence of tobacco, alcohol, drugs and gambling, steroids,
control to prevent unwanted pregnancies and counselling to protect themselves from sexual
(other abstinence or safe sexual practices when using condoms to prevent HIV and STIs). clinin
management, the benefits of safe physical activity on a regular basis, sexual responsibility
appropriate physical conditioning before exercise, healthy diets and safe weight
self-esteem and heroes, resolving interpersonal conflict without violence, weapon safety and
important injury reduction (no alcohol or drugs while driving, using protective gear like
because actively involved in decision making especially when their health is concerned is
adolescent physical, psychological, and psychosocial development, encouragement to
Secondly, adolescents should attend an annual health visit to discuss issues like normal
services for pregnant women at an affordable rate. The government hospitals and clinics are addressing the country's need to immunize children and provide maternal health care. However, while the Caper Peninsula study is well-researched, oversights in the present government's approach are noted.

This study confirms the notion of a syndrome of adolescent health risk behaviors found involved in primary and secondary prevention.

The primary care setting needs to acknowledge that their practices should be predominant for initiating primary and secondary preventive measures. General practitioners working in common patient settings, having "teaching" a subsistence, thus indicates that there is a need for behavior in the early stages.

The research also shows that the interaction between the youth from economically disadvantaged backgrounds and their general practitioners is not optimal. Currently, populations can be given which include meningococcal, pneumococcal, and influenza vaccines. Hepatitis B vaccines should be given at 11-12 years and optional vaccines for selected children. All vaccines are given early if not given during childhood. Rubella, Varicella, Pertussis, a and B, followed by annual visits to assess immunization needs; certain boosters need to be

- disorder or alcohol or drug use, and pulmonary tuberculosis depending on risk factors.
- depression, anxiety, dislocation, medecine-related problems, abuse, family dysfunction, medical
Practitioners need to instigate changes in the way medical and community services operate or use cash instead when problems recurring confidentially arise. General practitioners were using medical aid. The possibility exists that these learners may need to seek help elsewhere or use cash instead when problems recurring confidentially arise. General practitioners were using medical aid. The possibility exists that these learners may need to seek help elsewhere or use cash instead when problems recurring confidentially arise.

The research showed that 70% of the learners that consulted with general practitioners concerns in a confidential way.

Develop a relationship with their doctor where they feel comfortable to discuss their health. Disease prevention. General practitioners can make learners aware that the possibility to also make learning lessons aware of the role of their general practitioner in health promotion and only emphasize the school program with discussions about health-related issues, but not as part of a community. Doctors could offer their services to the local high schools by not usually attending schools in the same area. General practitioners need to see their practices years of age. The study showed that young people that consult general practitioners are backgrounds into their practices and include primary preventive strategies as early as 11.

General practitioners will need to find ways of drawing young people from poor

addressing adolescent health issues successfully.

Using multi-component strategies at both a national and local level may be critical in complementing the assistance of private general practitioners should be considered. Government health care facilities with more efficient comprehensive services being run to improve this aspect of preventive service provision. Permits fewer levels where all health risk behaviours are being addressed. The NAPHi programme is holistic way? Some services are available for young people, but it is not functioning at a public health system make on the challenge of improving the health needs of our youth in a public health system make on the challenge of improving the health needs of our youth in a
The system at their consulting rooms includes dropping suggestion boxes or contact forms to the adolescent consultation. General practitioners can involve adolescents in organizing workshops and meetings to improve the quality of care. By involving them in these activities, adolescents can develop skills that are transferable to other people without appointments. General practitioners could then use the system to measure and provide feedback, especially with regards to cost and doctors being available to young people without appointments. The study showed that the most important way to keep young people in the practice is to build relationships with them. Income and education can also be considered factors. Income levels in developing countries have a significant impact on health care costs. General practitioners can negotiate with their local government departments and health authorities for better rates for basic services like dental care and vaccinations, etc. General practitioners can negotiate with their local government departments and health authorities for better rates for basic services like dental care and vaccinations, etc. General practitioners can negotiate with their local government departments and health authorities for better rates for basic services like dental care and vaccinations, etc. The study showed that the most important way to keep young people in the practice is to build relationships with them. Income and education can also be considered factors. Income levels in developing countries have a significant impact on health care costs.
It is this subgroup of learners that report the heavier patterns of substance abuse and misuse. Larger than two years of school are over 15 years old, indicating a high degree of school refusal. School-based intervention programs are significant proportion of high school learners in the population. The research however has also served to shed some light on the challenges facing young people. This research was school-based simply because this was the easiest way to access young adolescents to seek help when it is appropriate.

Sources of assistance aimed at reducing the complications in this way we can empower that are involved in health risk behaviors need to be informed of and have access to all the forms of health risk behavior rather than the elimination of their use altogether. Adolescents harm reduction methods where interventions focus on decreasing the harmful consequences of behavior, a more prudent approach to health promotion is illustrated in the example of adolescents behavior, how to say no. In many situations adolescents do not want to stop the health risk behavior, to be shown the steps they need to take in order gain control over their own actions, to go beyond social rejection and decide to quit. When dealing with young people they need permission is sought and confidentiality is ensured. It is important for general practitioners pre-requisites are that the adolescent feels comfortable discussing issues with their doctor, practitioners need to be more successful in uncovering health risk behaviors. Important usually occurred by doctors asking about health risk behaviors directly. Generally where drugs and alcohol effects are hidden with weekend use in this study, uncovering data on the patterns of substance use in adolescence confirmed his deceptive nature.

Young people of we run the risk of losing them at the most pivotal times in their lives, more direct impact as general practitioners we need to red contractable working with
Group studies will probably be more effective in defining the needs of an adolescent.

Aspects of adolescent preventive service delivery in larger cohorts of adolescents focus

findings of this study's descriptive study will influence further analysis with more focused

resulted in more questions being asked than answers being provided. It is hoped that the

preventive services for adolescent health risk behaviors. The research has probably

needs and possible relationships between learner and doctor variables in terms of

from poorer backgrounds with private general practitioners. It has only shown possible

This research has mainly provided us with an overview of the interaction of adolescents

estimated.

sexual practices. The degree of peer pressure in this environment cannot be under-
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Appendix 1E: Post Graduate Committee Approval

Appendix 9: Certificate for Athlone Translation

Appendix 8: Athlone Research Questionnaire (Available on Request)

Appendix 7: Final Research Questionnaire

Appendix 6: Pilot Study Questionnaire (Available on Request)

Appendix 5: Nominal Group Consent Form and Information Letter

Appendix 4: Information Letter and Consent Forms

Appendix 3: Committee for Research on Human Subjects (Medical Permission)

Appendix 2: Committee Department of Education Permission

Appendix 1: Invitation Letter to Principals

APPENDICES
Choose not to participate.

2. Students are not obligated to take part in the study and will not be at any disadvantage if they

I. The information obtained in the study is confidential.

Please note:

5. Only those students who have signed consent forms will be eligible to take part in the study.

4. Students 12 years and younger in the classes that have been selected will be given an

3. Three classes (one Grade 10, one Grade 11, and one Grade 12 class) will be randomly selected.

2. Information about the number of students in each class and the name and the male to female ratio will be

I. The names of a contact person at the school will whom I can liaise in this regard.

If you agree to proceed with the project, the parents will be notified.

From hence forth, all students, teachers, and schools

B. All information obtained from the study will be recorded in an anonymous

C. The committee for education has been granted by the Department of Education to approve

D. Students' health is the health of our students, and the research will be conducted by the

E. Students' health is the health of our students, and the research will be conducted by the

F. Students' health is the health of our students, and the research will be conducted by the

G. Students' health is the health of our students, and the research will be conducted by the

H. Students' health is the health of our students, and the research will be conducted by the

I am Dr. Catherine Thomas, a general practitioner in private practice. I am doing research in the field

Dear [Name],

Appendix 1: Invitation Letter to Parents
Thinking you in anticipation of your consideration of my request and your prompt reply.

The study will take place between the 18th February 2002 and 20th September 2002.

e-mail: kedward@globalcoza

Fax: (011) 728-3362
Tel: (011) 483-2820 (work)
Tel: (011) 614-4578 (home)

If you would like to meet me in my research please contact me at:
only at the request.

Caroline Boyd (SGB) for your request to the Department, concerned to

Please ensure that your letter to the school principal and the Department of the School

appropriate for permission to involve district support staff in your project

to request access to schools for research purposes. The District Directors must be

permission from the Committee on Education to support school principals

The District Directors concerned are to be informed that you have received

permissions are not with

Department: Professional Service South East and West

Schools:

with your research study.

informed in writing, provided that you may approach the GDE Schools in connection

behavioural

Research Services to address certain health risk

Topic: Senior High School Students Precautions of their

Research to conduct a research study

Dr. C. Thomas

17 January 2002

Fax: (011) 72833632

Tel: (011) 4832804

Arochimn Road

Portsmouth of Summerset

Strategic Policy Development
Office of the Senior Manager
Date 21/10/02

Sally Rowan (Senior Manager)


Regard

Knowing you in the course

The Department wishes you well with this important project and looks forward to

12. Please supply the Director of the Division with a brief summary of your findings.

11. Please supply the Division with the Summary Report Development Plan submitted in addition to your

resubmission of your report. You may also be requested to give a short presentation

regarding your work with other colleagues in Research and Development.

10. The focus of the Division's priorities is on Shaping, the emphasis being placed on your

programmes, research, teaching and performance.

9. You are responsible for supervising your own research activities, such as solving:

permission for your children to take part in your study.

8. If the Researcher's responsibilities to conduct the project do not meet their obligations

imposed, then the Researcher may be suspended or removed.

7. You may commence your research from the first week of July, but must

in the meantime, continue your participation in the Departmental activities that the

programme is intended to achieve.

6. This obligation is not intended to commit research in GDF schools during the month of

research, after the Researcher has received the necessary clearance.

5. You may conduct your research at your own school host, but not

during the summer vacation, nor in any other way that may be

1. Special permission from the Division must be obtained to allow you to participate in

any other school activities. The Researcher will receive no

the programme of the school's activities or the Department's philosophy.

4. Please obtain the Sadler's School and School's permission to participate in the

school's curriculum through the School shall.

3. The participant's name should be included in the name summary of your named research should

be included in the name summary of your named research should

be included in the name summary of your named research should

be included in the name summary of your named research should

be included in the name summary of your named research should
Dear Dr. [Name],

I am writing to inform you that the Committee has reviewed the proposal for [Project Title] and has determined that it meets the ethical standards set forth by the University's Institutional Review Board (IRB). The proposal was submitted on [Date Submitted] and has been approved for funding.

Please find attached the revised version of the proposal, which includes any changes requested by the Committee. If you have any questions or concerns, please do not hesitate to contact me.

Sincerely,

[Your Name]

[Position]

[Institution]
Students participating in this research is voluntary. If you would like your confidentiality to assist

Schools names will remain unidentifiable.

Questions. Students will be partners or co-researched in a way that all students, doctors and
that is, students need not mention their names or their doctors’ names when responding the

consent. The information will be kept in an anonymous form.

Students need to think about the benefits and risks that may affect their health.

Your son/daughter's class has been randomly selected to take part in the study, and not because I

consider this group to have more health problems than any other student.

The purpose of the school that your son/daughter attends has agreed to assist me in my research.

Education has granted permission to approach high schools to take part in the research.

The proposed research has been approved by the Post Graduate Committee of the University of the

Dear Student and Parent/Carer.

Appendix 4: Information Letter and Consent Form
I have read and understood the above information before signing this consent form.
AppenDIX 5: NontablE Grp Group Consent Form and Information Letter

Dear Parents/Guardians,

Please note that you voluntarily are not required to take part in the study and will not be at any disadvantage if you choose not to take part.

Your son/daughter is 16 years or older to be able to sign the consent form.

If you agree to your son/daughter taking part in the study please sign the consent form below. If you do not consent then please do not sign the consent form and return it to the researchers.

The proposal research has been approved by the Research Ethics Committee of the University of the Western Cape and the Committee for Research on Human Subjects. The Consistent Department of Education has granted permission to approach high schools to take part in the research.

The proposed research aims to explore how factors such as academic performance, social difficulties, and family dynamics may affect their health.

I am Dr. Cameron Thorns, a General Practitioner in private practice, and I am doing research in the field of adolescent health.

Your son/daughter’s name will not be mentioned when reporting information.

Group discussion will be documented in an anonymous form, students’ names, doctors’ names and parents’ names will be volunteering to be part of a trained discussion.

Sincerely,

[Your Name]
Please return this consent form as soon as possible. Please note that only your students in your
son/daughter's class will be randomly selected to take part in the group discussion.

__________________________
Date (dd/mm/yy)

__________________________
Name of Parent/Guardian

__________________________
Date (dd/mm/yy)

__________________________
Signature of student (11-18 years and older)

Age of student: ____________

__________________________
Name of student
We have made an unhealthy lifestyle choice...

1. What is the General Practitioner's role when caring for a young person who has made an unhealthy lifestyle choice? List the General Practitioner's role under each of the following behaviors...

   - Drug use
   - Tobacco use
   - Alcohol use
   - Unsafe sex

I. When is the General Practitioner's role when caring for a young person who has made an unhealthy lifestyle choice... We will discuss this by trying to answer the following three questions:

   - What is the General Practitioner's role when caring for a young person who has not made an unhealthy lifestyle choice...
   - What would you expect in an ideal situation...

   We are meeting to discuss how you feel a General Practitioner can best care for a young person...

   - Person's Health
   - Certain lifestyle choices like unsafe sex and alcohol, tobacco, drug use may effect a young

   NOMINAL GROUP INFORMATION ILLUSTRAT
1. Have you ever seen a doctor in the past 6 months? (mark only one block)
   □ Less than 1 year □ 1 to 5 years □ 6 to 10 years □ 11 to 15 years □ 16 years or more

2. Have you ever seen your doctor or other member of your family more than 1 year ago?
   □ Yes □ No

3. If yes, how many years have you been seen by your doctor? (mark one block)
   □ Less than 2 years □ 2 to 30 years

4. How do you think your doctor is (mark one block)
   □ Very good □ Good □ Fair □ Poor

5. Why is your doctor your doctor? (mark one block)
   □ I don't know □ My parents told me □ My doctor told me

6. Where is your doctor's office? (Write the area name, for example, New York)

7. Do you use a public or a private hospital? (mark one block)
   □ Public □ Private

8. What is your doctor? (mark one block)
   □ Doctor □ Other (say who else)

9. How much does your doctor charge? (mark one block)
   □ Less than $50 □ $50 to $99 □ $100 to $199 □ $200 to $299 □ More than $300

10. Have you ever been refused service by your doctor? (mark one block)
    □ Yes □ No

11. Have you ever been treated inadequately by your doctor? (mark one block)
    □ Yes □ No

12. Have you ever felt that your doctor was not listening to you? (mark one block)
    □ Yes □ No

13. Would you recommend your doctor to your friends? (mark one block)
    □ Yes □ No

14. Have you ever had a good experience with your doctor? (mark one block)
    □ Yes □ No

15. Have you ever asked your doctor about your health? (mark one block)
    □ Yes □ No

16. Have you ever talked to your doctor about your family history? (mark one block)
    □ Yes □ No

17. Have you ever talked to your doctor about your school performance? (mark one block)
    □ Yes □ No

18. Have you ever talked to your doctor about your friends? (mark one block)
    □ Yes □ No

19. Have you ever talked to your doctor about your hobbies? (mark one block)
    □ Yes □ No

20. Have you ever talked to your doctor about your job? (mark one block)
    □ Yes □ No

Information about your doctor:
None of the above

How to avoid getting pregnant or making your childbirth problem.

How to prevent HIV/AIDS.

How to prevent STDs (sexually transmitted infections/diseases)

When to use the condom (after the pull out method, pill, no pull out, after unsafe sex).

How to use family planning (injections, implants, IUDs, and loops in the correct way).

How to use a condom in the correct way.

How to prevent "safe sex" with condoms and family planning (injections, implants, and loops).

Say "no" to sex.

The dangers of having sex without a condom and family planning (unsafe sex).

Say "no" to drugs.

The dangers of drugs to your health.

Say "no" to alcohol (drugs) to your health.

Say "no" to cigarettes (tobacco) to your health.

Say "no" to cigarettes (tobacco) to your health.

The dangers of cigarettes (tobacco) to your health.

18. Which only the health topics listed here and your doctor have talked about

Information about you and your doctor

19. Other (write your reason)

I was away from home or at the place where I usually stay when I needed to visit my doctor.

I could not take my problem to my own doctor.

My friend took me to his/her doctor.

My doctor was not able to see me when I needed to visit him/her.

I have never visited another doctor.

I have visited other doctors (you may mark more than one block). Please go to question 13.

I have never visited another doctor.

More than 5

More than 4

More than 3

More than 2

More than 1

How many other doctors have you ever visited? (check only one block)
Other (write down which other doctor personally and qualitatively)

☐ is a female doctor.
☐ is a male doctor.
☐ tells me exactly what he/she is doing while checking me up.
☐ makes me feel comfortable and relaxed when he/she is checking me up.
☐ makes me feel that I am in charge of my own health.
☐ lets me help him/her to solve my problems.
☐ talks to me in words that I can understand.
☐ does not force me to talk about problems that I am not ready to talk about.

☐ gives advice and guidance without judgment.
☐ accepts me as I am, with my good points and my bad points.
☐ makes me feel as if my problems are important to him/her.
☐ listens to me.
☐ gives me a chance to talk about my problems without diminishing me when I am talking.

☐ tells me that all the information from my visits will be kept confidential (private).
☐ understands that I need to keep my problems private.
☐ makes me feel comfortable to talk about my problems.
☐ shows a real interest in me as a person.
☐ enjoys working with young people.
☐ is the family doctor.
☐ my doctor.
☐ doctor.

1. Doctor practice and care. Mark only the ones that makes you choose to go to your doctor.

☐ Laboratory tests (like blood tests)
☐ advice and guidance
☐ condoms
☐ medications

☐ information about my health
☐ X-rays
☐ family planning
☐ a medical checkup.

2. Doctor personality and qualities. Mark only the ones that makes you choose to go to your doctor.
5. When changes would you like your doctor to make so that you will visit him/her more easily?

If it is easy for me to get to my doctor's surgery.

The way my doctor's surgery works is friendly to young people.

My doctor has good qualities and a good personality.

My doctor offers good services that I need.

Block.

4. What is the most important reason why you choose to go to your doctor? Mark only one.

Other (Write down which other ways in which the surgery works).

- I can collect interesting pamphlets for young people without feeling embarrassed to pick them up.
- The receptionist/staff understands that I need to keep my problems private.
- The receptionist/staff makes me feel comfortable.
- I feel comfortable when waiting for my doctor in the waiting room.
- I can afford to pay the price that my doctor charges.
- I need to see my doctor, he/she makes the time for me to see him/her.

3. The way the surgery works.
Name of the above, I have not used any of these services at my doctor's rooms.

☐ My doctor gave me nicotine patches
☐ My doctor gave me nicotine chewing gum

6. Which of the following services have you used at your doctor's room? (You may mark more than one block)
☐ None of the above
☐ I used nicotine patches to help stop tobacco use.
☐ I used nicotine chewing gum to help stop tobacco use.
☐ A plan to stop tobacco use (quit).

8. My doctor and I have agreed to help you to stop your tobacco use (quit).

☐ Yes, I have agreed to stop using tobacco.
☐ No, I have never used tobacco in my life.

Please go to section D on page 6.
None of the above. We have not talked about any of these topics.

None of the above. We have not talked about any of these topics.

Come to alcohol monitoring (A) if you need help with alcohol/liquor. 

A plan to stop alcohol use (Liquor).

I don't plan to stop alcohol use (Liquor).

None of the above. We have not talked about any of these topics.

6. When have you and your doctor talked about how to help you stop drinking alcohol/liquor? (You may check more than one block.)

You and your doctor talked about how to help you stop drinking alcohol/liquor. (You may check more than one block.)

Other. (Specifiy the reason you asked about it.)

I told my doctor about it when my doctor asked me about it directly.

I told my doctor about it without my doctor asking me about it.

5. How did your doctor find out about you drink alcohol/liquor? (Check one box.)

Knows that I drink alcohol/liquor (Liquor).

Does not know that I drink alcohol/liquor (Liquor).

4. My doctor

If you have a doctor, please continue with this section.

If you do not have a doctor, please go to Section I on Page 7.

3. I feel that my alcohol use has already made me unhealthy.

2. I feel that my alcohol use may be dangerous to my health.

At least one drink, every day.

At least one drink, most weekdays.

At least one drink, most days of the week.

At least one time in my life.

I drink alone. (Note: only the one who drinks alone should check this box.)

Yes, I have used alcohol (Liquor) in my life.

No, I have never used alcohol (Liquor) in my life.

Does not include tips of wine for religious purposes or toasting family occasions, like weddings.

"Alcohol use" includes drinking beer, wine, whiskey, brandy, when cooks run, gin and vodka, etc.

SECTION B
6. How did your doctor find out about your drug use? (Mark only one block)

[ ] Know that I use illegal drugs
[ ] Doesn't know that I use illegal drugs

If you do not have a doctor, please go to Section F on Page 9.

If you do not have a doctor, please continue with Question 5.

5. My doctor

[ ] Yes
[ ] No

4. I feel that my use of illegal drugs has already made me homeless.

[ ] Yes
[ ] No

3. I feel that my use of illegal drugs may be dangerous to my health.

[ ] Yes
[ ] No

2. Swallowing, snorting, inhaling or smoking illegal drugs, mark [X]

[ ] Yes
[ ] No

1. I have used illegal drugs into your body, mark [X]

[ ] Yes
[ ] No

Yea, I have used drugs in my life. Please continue with the section.

No, I have never used drugs in my life. Please go to Section F on Page 9.

Enzymes of the brain:

- GABA (gamma-aminobutyric acid) agonists
- Dopamine (DA) agonists
- Opioid receptor antagonists
- Serotonin reuptake inhibitors
- NMDA receptor antagonists
- Histamine H1 receptor antagonists
- "Pills not for sale" (e.g., tramadol, ketamine, 1,4-butanediol, fentanyl, fentanyl patches, and methadone)

Note: This refers to the use of substances like marijuana (cannabis), hashish, hashish, and "Pills not for sale" (e.g., tramadol, ketamine, 1,4-butanediol, fentanyl, fentanyl patches, and methadone).
8. Which of the following services have you used at your doctor's room? (You may mark more than one block.)

- None of the above. I have not talked about any of these topics □
- Sending you for special care to stop your drug use at a rehabilitation hospital □
- Giving you an injection (heroin, B. vaccine) to prevent you from getting Hepatitis B infection □
- Doing blood tests to check for HIV □
- Reusing your needle to be sure that you are not taking drugs □
- A plan to stop using drugs □

9. What have you and your doctor discussed about because you are using drugs? (You may mark more than one block.)
If you do not have a doctor, you have completed the questionnaire. Thank you!

If you do have a doctor, please continue with Question 2.

1. Have you had sex in the past 12 months?
   - Yes
   - No

If yes, please continue with this section:

- Have I had sex with a partner who had sex with someone else recently?
- Have I had sex with a partner who is currently pregnant?
- Have I had sex with a partner who is currently trying to become pregnant?
- Have I had sex with a partner who is currently on hormonal birth control?
- Have I had sex with a partner who is currently on non-hormonal birth control?
- Have I had sex with a partner who is currently on any other type of birth control?

Please answer all questions about you:

- Have I had sex in the past week?
- Have I had sex in the past month?
- Have I had sex in the past year?
- Have I had sex in the past two years?
- Have I had sex in the past five years?

Please continue with the questionnaire.

Thank you for completing the questionnaire.
You have completed the questionnaire. Thank you!

1. None of the above. I have not used any of these services at any of my doctor's rooms.

☐ None doctor checked me wp when I was pregnant.
☐ My doctor sent me to another doctor for an abortion.
☐ My doctor did an abortion on me.
☐ My doctor gave me herpes meds to treat.
☐ My doctor gave me a Pap test on me.
☐ My doctor did a pregnancy blood test on me.

☐ My doctor did an HIV blood test on me.
☐ My doctor did a pregnancy test on me.
☐ My doctor gave me medicine to treat an STD.
☐ My doctor gave me the cervical pill.
☐ My doctor gave me family planning.
☐ My doctor gave me contraceptives.

2. Which of the following services have you used at your doctor's rooms? (you may mark)

[X] More than one block.

3. None of the above. We have not talked about any of these topics.

☐ Injections can be given to prevent Herpes (herpes B vaccine).

5. Woman who are having sex must have regular Pap tests to check for cancer of the mouth of the womb (cervix).

☐ A blood test must be done to make sure that you have not been infected with HPV.
☐ A blood test must be done to make sure that you have not been infected with HIV.
☐ If a period (menstruation) is missed or is late, a pregnancy test must be done.

6. If you have an STI or STD (sexually transmitted infection/disease), you and your sexual partner:

☐ Must take medicine to clear up the infection.

7. If you have sex with a new partner, you must take the emergency pill (the morning after pill).

☐ Family Planning. Use the protection.蓓leeds a loop must be used every time you have sex.

8. Condoms must be used every time you have sex.

☐ Because you have chosen to have sex (you may mark)

9. When have you and your doctor talked about so that you and your sexual partner can be safe
(REQUEST)

APPENDIX 8: AFRICANS RESEARCH QUESTIONNAIRE (AVAILABLE ON
Dear Dr. Thomas,

I was delighted to receive your letter of 5 May 2002. I regret that I have been unable to complete the translation done for you by Mr. Jimenez in the expected time frame.

Yours sincerely,

John Miners
School of Literature and Language Studies
University of Edinburgh
Dear Dean Thomson,

2001-11-15

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Faculty of Health Sciences

21-19

STATUS (DATE 91) NUMBER 49004
APPLICATION NUMBER 698809

I hereby declare that I have read and understood the provisions of the Department of Health and their related policies.

Yours sincerely,

[Signature]

Dean of Department - Representative

[Stamp]

[Address]

[Phone number]