

YOUTH RISK BEHAVIOUR



Rakshika Bhana

Health Systems Trust

Introduction

South Africa is undergoing various transitions which impact directly on the lives of young people. The emergence of compulsory schooling for youth acknowledges that the schooling environment is important for youth to acquire knowledge and life skills that equip them to make informed life decisions, ultimately reducing morbidity and mortality arising from risky behaviour patterns.

Several policies, legislation and health promotion initiatives have emerged from the process of health sector reform to address critical imbalances in youth health and developmental issues. The five-year Implementation Plan for Tirisano¹ (working together), launched by the Ministry of Education in 2000, is a call to transform the education system in SA from one of segregation and disparity to one of equal opportunity for all South Africans. The plan targets both the educational and health needs of learners with regard to HIV/AIDS, substance abuse, gender and sexuality. However, the key challenge is to systematically monitor behaviours that place youth at risk and to develop a broad evidence base for intervention planning.

The National Youth Risk Behaviour Survey (NYRBS) 2002,² is the first comprehensive national baseline survey to be conducted in SA since the implementation of the compulsory education system, and contributes significantly to informing the evidence base for future health promotion intervention planning. The overall objectives of the survey were to:

- ◆ provide provincially and nationally representative data on youth risk behaviour
- ◆ inform intervention development
- ◆ inform health policy development and adaptation

- ◆ establish baseline data to assess and project how risk behaviours change over time and to provide an early warning system for future epidemics.

This chapter summarises and comments on selected key findings of the survey and concludes by highlighting some of the general recommendations for action. Findings from the 2004 study of HIV and sexual behaviour among young South Africans³ are included in another chapter in this Review.

Framework for Monitoring and Evaluation

Policy initiatives at a national level that entrench the South African government's commitment to improving and promoting the health and well being of youth in SA are:

1. The National Youth Policy, 2000
http://www.nyc.gov.za/documents/policies/ny_policy_2000.doc
2. National Youth Development Policy Framework [2002 - 2007]
http://www.nyc.gov.za/documents/policies/dev_%20policy_frame_01_07.doc
3. Policy Guidelines for Adolescent and Youth Health, 2001
4. Implementation Plan for Tirisano, 2000-2004
<http://education.pw.gov.za/content/tirisano/6.pdf>
5. HIV/AIDS and STD Strategic Plan for South Africa 2000-2005
<http://www.doh.gov.za/aids/docs/aids-plan/index.html>
6. Health Goals, Objectives and Indicators 2001-2005
<http://www.doh.gov.za/docs/indicators.html>

Data

Background

South Africa's youth, i.e. children and adolescents under the age of 20, comprise approximately 43% of the country's total population of 44.8 million and almost 12.5 million children are enrolled in schools.⁴ Adolescence is characterised as a period of experimentation with the emergence of new behavioural patterns, which if continued, may lead to the development of lifelong negative habits, placing young people at risk of a broad range of health problems. Among these problems are HIV/AIDS, sexually transmitted infections (STIs), unwanted pregnancies, pregnancy-related complications, substance abuse, gender-based violence, sexual abuse, and accidents. The majority of these health problems place young people at added risk of developing physical and long-term psychological trauma.

The report suggests that the school environment offers an ideal social context to obtain information about young people and their behaviours and is also an appropriate locale for future health interventions.²

The survey population comprised 10 699 public school learners from grades 8, 9, 10, and 11 in the nine provinces with the majority of the sample (78.7%) aged between 14 and 18 years inclusive, while 8.4% were below 14 years and 12.9% above 18 years. Fifty-four percent of the learners were female and 46% were male. Data on the risk behaviours relating to intentional and unintentional injuries, substance abuse, sexual behaviour, nutrition, physical activity and hygiene were collected over a period of three months from August to October 2002. Selected findings are shown in Table 1.

Intentional and unintentional injury

This component of the study focused on behaviours related to violence, road traffic safety and suicide. According to the South African National Burden of Disease study (NBD) injuries (intentional and unintentional) accounted for approximately 22% of deaths in the 15-24 years age group. Of these, homicide and violence accounted for the greatest percentage (61%) followed by road traffic accidents (21%) and suicide (10%).⁵

During the six months preceding the survey, 14.9% of learners were threatened or injured by someone with a weapon. Partner violence^a was reported by 13.6% of learners and 9.8% were forced to have sex.

Among those who had driven a vehicle, 21.4 % of drivers always

wore a seat belt and significantly more male drivers (25%) than female drivers (17.9%) wore a seat belt. Of concern however, is that learners under the legal driving age of 18 years also responded to questions regarding their own driving behaviour, implying that learners below the legal age for driving may be driving illegally.

This is the first school-based study that explores the prevalence of non-fatal suicides. Often data on non-fatal suicidal attempts are difficult to collect, unreliable and under-reported and this is largely due to the social stigma associated with suicide. The report suggests that in the six months preceding the survey, one in four learners (24.6%) had sad or hopeless feelings that extended for a period of two weeks or more, and of those who attempted suicide, 27.8% required medical treatment as a consequence. Nationally, there were no significant gender differences in the expression of sad and hopeless feelings and suicide attempts; however, at provincial level learners in Gauteng reported a significantly higher prevalence (34.1%) of feelings of sadness and hopelessness than the national rate (24.6%). Of significance, is that the Eastern Cape reported the lowest percentage (17.7%) of learners with feelings of sadness and hopelessness in the country, even though the Eastern Cape has one of the highest levels of socio-economic deprivation.

Injuries, both intentional and unintentional, are a leading cause of mortality and morbidity among South African youth and result in significant costs not only to the individual but also to their families, community, the health services and inevitably society as a whole. Learners are faced with numerous stressful life challenges, which if not detected and dealt with in the early stages, can lead to long term mental health problems. Prevention efforts, aimed at improving the mental health status of learners, require emphasis on conflict management and negotiation skills to empower learners to effectively cope with stressful and demanding life situations.

Substance abuse

Globally, tobacco and alcohol consumption are ranked among the ten leading causes of death. In SA, deaths arising from alcohol dependence in the 15-24 year age group account for 2.4% of total deaths in this category.⁵

Nationally, approximately 1 in 3 learners (30.5%) reported ever having smoked cigarettes in their lifetime and 1 in 2 learners (49.1%) had consumed at least one drink of alcohol in their lifetime. With regard to the age of initiation, 6.2% of learners had tried smoking a cigarette before reaching the age of 10 years and 12% of learners reported having had their first drink before the age of 13 years.

^a Learners who were assaulted by a boyfriend/girlfriend.

Table 1: Selected youth risk behaviour indicators of high school learners attending public schools in SA by province, 2002

	EC	FS	GP	KZN	LP	MP	NC	NW	WC	SA
Intentional and Unintentional Injury										
Percentage of learners who had sad or hopeless feelings ^b	17.7	28.5	34.1	21.8	26.7	25.9	23.2	21.9	23.2	24.6
Percentage of learners attempting suicide who required medical treatment ^c	31.9	21.7	30.2	24.6	34.1	29.7	25.9	23.6	25.4	27.8
Substance Abuse										
Percentage of learners having ever smoked	27.5	40.4	41.4	18.2	21.6	35.2	38.4	31.5	51.1	30.5
Percentage of learners having ever smoked before the age of 10 years	6.0	7.0	6.3	4.9	4.9	9.2	9.2	7.1	7.5	6.2
Percentage of learners having ever used alcohol	45.4	58.7	62.1	38.8	36.5	52.4	71.5	53.4	63.5	49.1
Percentage of learners having ever used alcohol before the age of 13 years	8.4	14.8	14.9	9.6	8.2	13.7	13.3	14.9	18.6	12.0
Sexual Behaviour										
Percentage of learners sexually active	43.6	47.0	47.0	37.1	42.4	40.7	45.4	35.2	37.8	41.1
Percentage of learners sexually active before the age of 14 years	12.5	18.8	19.1	15.6	11.5	15.7	10.8	9.9	12.5	14.4
Percentage of sexually active learners who ever used condoms as a method of contraception ^d	30.6	54.0	58.6	32.3	49.6	49.2	47.1	55.0	40.7	44.8
Percentage of sexually active female learners having been pregnant ^d	12.5	15.9	13.3	21.8	29.8	27.1	9.3	17.1	12.0	19.1
Percentage of sexually active learners who ever had a sexually transmitted infection ^d	4.1	6.8	3.4	14.6	6.8	5.9	3.9	5.1	8.0	7.4
Nutrition										
Percentage of learners underweight-for-age ^e	7.7	9.5	7.4	7.2	12.1	8.2	14.3	14.2	6.0	9.0
Percentage of learners overweight-for-age ^f	17.1	14.3	18.5	22.9	10.5	17.0	12.3	11.9	21.5	17.2

b Feelings that stopped learners from doing some usual activities for two or more weeks in a row, during the six months preceding the survey.

c Includes those learners who made one or more suicide attempts during the six months preceding the survey.

d Of those who were sexually active.

e Learners with weight-for-age under 2 standard deviations from the norm.

f Learners overweight according to the age-dependant body mass index (BMI) cut-offs (25-29.9 kg/m²).

Compared to the national prevalence (49.1%), the percentage of high school learners who had consumed alcohol is alarmingly high in the Northern Cape (71.5%). The prevalence of ever having used alcohol (84.1%) and cigarettes (66.7%) was much higher among White learners than other race groups.

Smoking prevalence in learners is less than that reported in the Global Youth Tobacco survey conducted in SA in 1999 and 2002, where the prevalence of learners who have ever smoked cigarettes was 46.7% in 1999 and 37.6% in 2002.⁶ Although the current survey suggests a drop in the reported cases of learners having ever smoked cigarettes, learners still remain unaware about the harmful effects of cigarette smoke from others. In the week preceding the survey, exposure to environmental tobacco smoke was 84% among current smokers and 56% among learners who had never smoked.

Children begin smoking and drinking for various reasons, most of which relate to environmental influences associated with 'growing up', and the use of these substances during

adolescence usually leads to life long addiction. School-based smoking cessation programmes and public health interventions need to improve awareness about the harmfulness of exposure to environmental tobacco smoke. The link between substance abuse and road traffic accidents also needs to be emphasised.

Sexual Behaviour

A broad range of behaviours relating to sexuality, namely sexual practices, partner patterns, contraceptive use, pregnancy experience, abortion and STIs were investigated in the survey.

Nationally, a staggering 41.1% of learners reported having had sex and 14.4% of learners experienced their first sexual encounter at the age of 14 years or younger. Among learners who reported ever having had sex, 70.2% had one or more sexual partners in the 3 months preceding the survey. The provincial prevalence of learners (both males and females) who reported ever having sex, and sexual initiation before 14 years, was lowest for North West (35.2% and 9.9%) and highest in Gauteng (47% and 19.1%).

Figure 1: Percentage of female learners (who have had sex) reporting ever having been pregnant, by age, 2002

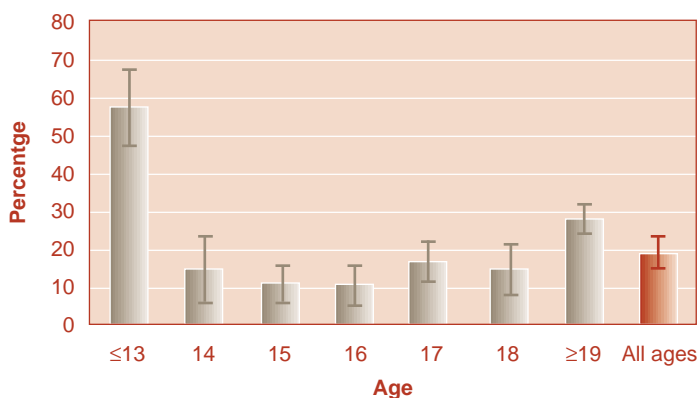
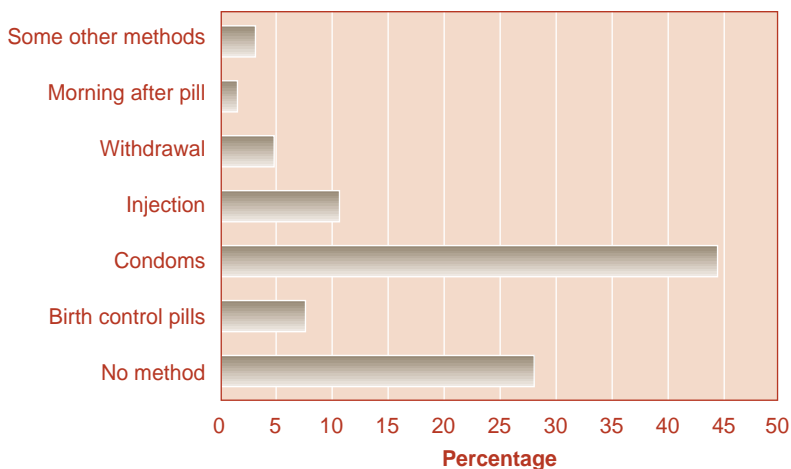


Figure 2: Percentage of high school learners (or their partners) who used various methods of contraception, 2002



The national prevalence of learners *who have had sex* who reported ever having been pregnant was 19.1% [95% CI 15.4 - 22.9]. This cannot be directly compared with the South African Demographic and Health Survey (SADHS) results of 1998,⁷ which showed 16.4% of *all* women aged 15-19 years having ever been pregnant. Of serious concern however in the NYRBS is the significantly higher percentage of learners aged 13 years or under (57.6%) reporting having ever been pregnant compared to the older ages, indicating that younger learners are inadequately prepared for the responsibility that goes with sexual activity.

Learners were asked to report a method that they *or their partner* used most often to prevent pregnancy (Figure 2). Of those who had sex, significantly more learners mostly used condoms (44.8%) compared to any of the other methods of contraception. Gender differences in condom use were 48.4% for males and 40.5% for females. The prevalence of other methods of contraception reported by female learners were: injection 17.2%, birth control pills 7.4%, withdrawal method 5.2%, some other methods 2.7% and morning after pill 1.7%. The 1998 SADHS showed that only 4% of sexually active women (aged 15-19) reported using condoms as their current method of contraception, with the most common method of contraception being the injectable (51%).

The national prevalence of learners ever having had a STI was 7.4% and of those who had had an STI, 63.6% reported receiving treatment. The report shows no significant difference between male and female learners. The reported prevalence of having had an STI among KwaZulu-Natal learners (14.6%) who ever had sex was significantly higher than the national prevalence, while Gauteng learners (3.4%) reported the lowest prevalence.

The survey showed that the national prevalence of learners who thought they could 'get HIV infection in their lifetime' was 12.2% with little difference between males and females. Race differences however indicate more African (12.9%) than White (6.9%) learners felt susceptible to contracting HIV in their lifetime. When asked whether they were able to protect themselves from getting HIV, once again, there was no significant difference between males and females however, a significantly higher percentage of White (78.3%) than African (64.8%) learners felt confident that they were able to protect themselves from getting HIV. This perception of vulnerability in youth is fundamental to understanding precautionary behaviour and is the foundation upon which behaviour change intervention strategies should be based.

An increase in the usage of condoms as a contraceptive method is suggestive evidence of behaviour change in youth. However,

there is no simultaneous improvement in other key related sexual behaviour indicators. The high prevalence of teenage pregnancy in younger age groups highlights both the health and socio-economic risks that adolescents place themselves under by becoming pregnant at an early age. Health complications associated with early parenthood are high for both the teen mother and unborn child.

Nutrition, dietary behaviours and physical activity

Nutritional status indicators provide useful insight to socio-economic status. The survey showed that the national prevalence of underweight (weight-for-age <2SD from norm) was 9.0%; stunting (height-for-age <2SD from norm) was 11.4% and wasting (weight-for-height <2SD from norm) was 4.0%, whilst 17.2% of learners were found to be overweight and 4.0% were classified as obese.⁹

The high prevalence of stunting in the Coloured and African communities (Figure 3) is indicative of existing levels of poverty and underdevelopment, whilst the increasing prevalence of overweight, associated with urbanisation and industrialisation, suggests increased consumption of fatty foods and reduced levels of physical activity in learners. The survey further highlights that Northern Cape, North West, Limpopo and Free State learners displayed higher levels of undernutrition whilst higher levels of obesity and overweight were found in the Western Cape, KwaZulu-Natal and Gauteng learners.

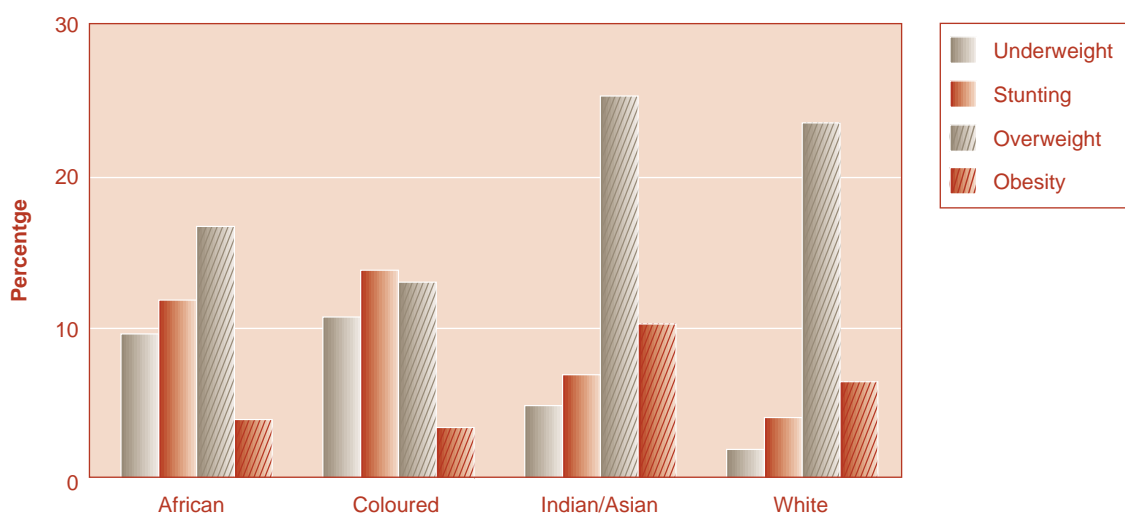
Survey recommendations

The results of the baseline survey provide an evidence base for determining priority risk behaviours and for setting of objectives for future youth behaviour change interventions to reduce the prevalence of health related and social behaviours that place learners at risk. The recommendations presented in the report provide a national framework for action. The report recommended that:

- ◆ The NYRBS be repeated on a triennial basis.
- ◆ Existing structures be revised so as to create a Youth Development Programme (YDP).
- ◆ Adequate resource allocation across a cluster of YDPs should be made available.
- ◆ Full involvement and empowerment of youth in taking charge of their own destiny as part of the process of participatory democracy should be facilitated.

g Learners obese according to the age-dependant body mass index (BMI) cut-offs ($\geq 30 \text{kg/m}^2$).

Figure 3: Percentage of high school learners who were underweight, stunted, overweight or obese by ethnic group, 2002



- ◆ A well resourced and planned strategy for the dissemination of the results of the NYRBS findings needs to be facilitated across social clusters in all nine provinces, to all stakeholders including local communities.
- ◆ The NYRBS could provide a platform for the development of a single integrated database in government for policy, planning and resource allocation with regard to motor vehicle crashes, sexual abuse, nutritional status, school surveys, child grants, etc.
- ◆ The findings from this survey be used to identify which determinant studies should be undertaken, and these will in turn inform the development of comprehensive intersectoral interventions.
- ◆ The stakeholders involved in youth health and development should participate in future NYRBS and in the ensuing programmes and interventions.
- ◆ The research agenda for young people should be expanded.

Acknowledgements

Permission to use the NYRBS data was kindly granted by the principal investigator Prof. Pricilla Reddy of MRC.

References

- 1 Department of Education. Implementation Plan for Tirisano 2000-2004. Pretoria
<http://education.pwv.gov.za/content/tirisano/6.pdf>
- 2 Reddy SP, Panday S, Swart D, Jinabhai CC, Amosun SL, James S, Monyeki KD, et al. Umthenthe Uhlaba Usamila – The South African Youth Risk Behaviour Survey 2002. Cape Town: South African Medical Research Council; 2003.
URL: <http://www.mrc.ac.za/healthpromotion/healthpromotion.htm>
- 3 Pettifor AE, Rees HV, Steffenson A, Hlongwa-Madikizela L, MacPhail C, Vermaak K, Kleinschmidt I. HIV and sexual behaviour among young South Africans: a national survey of 15-24 year olds. Johannesburg: Reproductive Health Research Unit, University of the Witwatersrand; 2004.
URL: <http://www.rhu.co.za/images/Docs/national%20survey%20RHRU.pdf>
- 4 Statistics South Africa. Census 2001. Census in Brief. Pretoria: Statistics South Africa; 2003.
URL: <http://www.statssa.gov.za/>
- 5 Bradshaw D, Groenewald P, Laubscher R, Nannan N, Nojilana B, Norman R, Pieterse D, Schneider M. Initial Burden of Disease Estimates for South Africa, 2000. Technical Report. Cape Town: Medical Research Council; 2003.
- 6 Swart D, Reddy P. The 2nd GYTS in South Africa - National and Western Cape Highlights. Cape Town: South African Medical Research Council; 2003.
URL: http://www.cdc.gov/tobacco/global/gyts/factsheets/SA_factsheet.htm
- 7 Department of Health, Medical Research Council & Measure DHS+. South Africa Demographic and Health Survey 1998, Full Report. Pretoria: Department of Health; 2002.
URL: <http://www.doh.gov.za/facts/1998/sadhs98/>