

**ALCOHOL USE/ABUSE AMONG TEENAGERS IN SELECTED HIGH
SCHOOLS IN MASERU CITY: THE DEVELOPMENT OF A HEALTH
EDUCATION PROGRAMME**

BY

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submitted

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DECLARATION

I declare that “ALCOHOL USE/ABUSE AMONG TEENAGERS IN SELECTED HIGH SCHOOLS IN MASERU CITY: THE DEVELOPMENT OF HEALTH EDUCATION PROGRAMME” is my own work and that all the resources that have been used or quoted have been indicated and acknowledged by means of complete references.


SIGNATURE

J.M. LETEKA


DATE

DEDICATION

This work is dedicated with love and appreciation to the following:

- My granddaughter Lieketseng/Nteboheleng.
- My daughters, Tselane and Polo.
- My late son, Mokole/Khosi.
- My late husband Mothabeng for his love and support during his lifetime.

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ABSTRACT

According to the World Health Organization (WHO), alcohol and drug related problems in Africa are becoming more and more a Public Health concern. Lesotho is no exception to this threat. There is a growing concern over the perceived rise in drinking in Lesotho. This is because use of alcohol has major public health consequences because of its relationship with many acute and chronic physiological, psychological and behavior problems. Studies have shown that alcohol is the most prevalent substance that is used worldwide and is also responsible for pervasive health, social and economic consequences, more so when young people are involved. There is need therefore to identify intervention strategies that can be used to prevent alcohol use and abuse in Lesotho.

A few studies that have been done revealed that alcohol problems are quite common in Lesotho and alcohol use is increasing among teenagers but there is severe lack of reliable data on the subject. The aim of the study was to gather information on alcohol use and abuse among teenagers in high schools. The findings of the study would be used as a basis for planning an appropriate health education programme as a prevention and intervention strategy. Secondly, the data from this study should serve as a basis for future much needed research on alcohol use among other groups of teenagers. For instance, those who are out of school, in rural areas and among adults in Lesotho.

An exploratory quantitative method was used based on the pilot project findings. An exploratory qualitative method was also used to examine perceptions, opinions and

interpretations of teenagers regarding alcohol use, abuse and its consequences. Qualitative data were also used to add richness to the quantitative study results.

The sample for the study was composed of three groups of people, students, teachers and parents. The analyses are based on a sample (N=412) representative of Form D's and E's in eight selected high schools in Maseru city. In an anonymous, self administered, structured questionnaire given out in classrooms, the students were asked about use of alcohol and other drugs. Teachers and parents also formed part of the sample, as they are role models for teenagers. Teachers also responded to a questionnaire while parents were involved in Focus Groups Discussions (FGD).

This study revealed that a lot of students in high schools have started using alcoholic drinks (67.2%), most of them for fun and because of peer pressure. Quite a number of students started using alcoholic drinks as early as 10 to 14 years of age and this includes both males and females, though the prevalence is higher among males than females. The preferred drinks are beer and wine.

Role modeling also seems to be taking part in influencing teenagers to drink. There is a relationship between parental, teachers and students' drinking. Students reported that their teachers drink. They have seen them drinking and when they are drunk. Some of the teachers sent students to go and buy alcohol for them. Students from families in which regular drinking occur, drink more often than students do from families in which members' only drink on special occasions.

All groups that were involved in the study, that is students, teachers and parents recommended that production and distribution of alcoholic drinks should be controlled and law restricting buying of alcohol by teenagers should be enforced. Another major recommendation by these groups is health education about effects of alcohol to the community as a whole.

A health education programme that would meet the needs of the teenagers, especially those that are still in schools has been outlined. This is Alcohol Use Prevention Programme in Schools (AUPPS) meant to teach students about alcohol use and its consequences. This would be done using different teaching methods and students, teachers and parents.

KEY TERMS

Alcohol abuse, Teenagers/adolescents-alcohol abuse, students and alcohol abuse, health education and alcohol usage, alcoholic drinks and students.

ACRONYMS

| | | |
|------------|---|---|
| A A | - | Alcohol Anonymous |
| A DEP | - | Alcohol and Drug Education Programme |
| AIDS | - | Acquired Immune Deficiency Syndrome |
| A.M.E | - | African Methodist Episcopal |
| A.U.P.P.S. | - | Alcohol Use Prevention Programme in Schools |
| C.A.R.P. | - | Community Alcohol Rehabilitation Programme |
| C.C.L. | - | Christian Council of Lesotho |
| CHAL | - | Christian Health Association of Lesotho |
| C.O.S.C. | - | Cambridge Overseas School Certificate |
| ES | - | Effect Size |
| F.G.D. | - | Focus Group Discussion |
| HIV | - | Human Immune-Deficiency Virus |
| H.S.A. | - | Health Service Areas |
| I.C.N | - | International Council of Nurses |
| L.A.C. | - | Lesotho Anglican Churches |
| L.E.C. | - | Lesotho Evangelical Churches |
| L.F.D.S | - | Lesotho Flying Doctors Service |
| L.L.D. | - | Lesotho Liquor Distribution |
| L.T.B. | - | Lesotho Traditional Beverages |
| N.C.A | - | National Council on Alcoholism |
| PATCH | - | Planned Action to Community Health |
| PHC | - | Primary Health Care |

| | | |
|----------|---|---|
| PRECEDE | - | Predisposing Reinforcing Enabling Causes in Educational Diagnosis Evaluation |
| PROCEED | - | Policy Regulatory Organizational Constructs Educational Environmental Development |
| R. C. C. | - | Roman Catholic Church |
| S. D. A | - | Seventh Day Adventist |
| SPSS | - | Statistical Packages for Social Sciences |
| STI | - | Sexually Transmitted Infections |
| TV | - | Television |
| UNISA | - | University of South Africa. |
| Z. C. C. | - | Zion Church of Christ |

THE BACKGROUND OF THE COUNTRY

The kingdom of Lesotho is a small land locked and mountainous country in Southern Africa, sharing all its boundaries with the Republic of South Africa. Administratively, the country is divided into ten districts, and the capital city is Maseru. Lesotho covers a land area of 30,355 square kilometers (See map of Lesotho, appendix A). It lies between longitude 27 degrees and 31 degrees at an altitude of between 1,500 and 4,000 meters above sea level (Lesotho Review 1998:12).

EDUCATION:

Lesotho is one of the African countries with a high literacy rate of 72 percent (Moji and Rojas 1998:18). The country has defined two general objectives for the development of the education system. These includes, provision of complete primary education for all children, that is, basic education as well as continuing education for youth and adults, particularly for those without formal training, provision of sufficient numbers of trainees with appropriate qualifications and technical and managerial skills, to ensure the development of the modern sector of the economy.

The churches were responsible for initiating Western type of education in Lesotho in the early 1830s. A network of primary schools has been developed overtime. There is one teacher's college, which is run by the government. This was established in 1975. Before the establishment of the college, the churches used to run seven small teacher training colleges that mainly produced teachers for the lower and primary levels. It is because of this effort that Lesotho managed to achieve one of the highest literacy rate of 72 percent as

indicated above. The only university in Lesotho, National University of Lesotho (NUL) was established in 1945 by the Roman Catholic Church. Originally, it was a Catholic University College founded to provide African Catholic students with post matriculation and religious guidance (NUL Calendar: 1997-2000).

Most of the schools are operated by religious missions but they receive government subsidies. The Ministry of Education (MOE) sets the standard seven examinations. This is a requirement for admission to secondary school. Junior secondary schools offer a three years course for the Cambridge Overseas School Certificate (C.O.S.C.). The categories and the numbers of educational institutions in Lesotho are summarized below.

Table 1.1 EDUCATIONAL INSTITUTIONS IN LESOTHO:

| CATEGORY | MISSION | GOV & COMMUNITY | PRIVATE | TOTAL |
|----------------------|---------|-----------------|---------|-------|
| Primary Schools | 1,238 | 93 | 2 | 1.333 |
| Secondary schools | 198 | 25 | 1 | 224 |
| Technical/Vocational | 14 | 5 | 0 | 19 |
| University | | 1 | | 1 |

Source: Ministry of Education: Planning & Statistics 2002.

From the above analysis, one could rightly say that education in Lesotho is like a “three-legged pot” that is a joint venture among mission, government and the community.

RELIGION:

The Basotho are predominately Christians. The main denominations are Roman Catholic (R.C.C.), Lesotho Evangelical (L.E.C.) and Anglican (A.C.L.) Churches. There are also congregations of Methodist, African Methodist Episcopalians (A.M.E.), Seventh Day Adventist (S.D.A.), Assemblies of God and many others that are coming up.

HEALTH CARE SYSTEM:

Lesotho being signatory to Alma-Ata Declaration is committed to Primary Health Care (PHC) as an approach to Health for all by the year 2000. For the past 18 years, the Ministry of Health and Social Welfare (MOHSW) has taken great strides towards the provision of PHC. The MOHSW aims at providing a comprehensive service in conjunction with various private agencies.

Lesotho operates under a system of Health Service Area (HSA), which has been structured to enable comprehensive preventive, primitive, curative and rehabilitative health care. These are geographical areas with populations ranging from 38,000 to 225,000 people who are served by HSA hospital. The hospital based in each area is responsible for the provision of all forms of health care to that community. It supervises all health centers in its area, training of all non-stipendiary staff, implementation of PHC and all government policies and provision of basic hospital services (Moji & Rojas 1993:42).

Government hospitals based in the district towns also have additional community health responsibilities within their district. There are 19 health service areas in Lesotho, 18 of them are based around hospitals and the nineteenth being Lesotho Flying Doctor Service

(LFDS) provides services to 12 remote clinics and uses Queen Elizabeth II hospital in Maseru as its referral center (Moji & Rojas 1993:44). The visiting health team includes a doctor, a pharmacy technician and a community health nurse. In particular, nine of the HSA hospitals are owned and run by churches linked to Christian Health Association of Lesotho (CHAL). Lesotho in its decentralized health care plan emphasizes community involvement and participation. The health care system basically consists of three levels such as:

*Village level, with a network of over 5,000 volunteer health workers
clinics/health centers, where teams serve from 6,000 to 10,000 people and
health service areas, with teams operating from referral hospital (Moji & Rojas
1993:40).*

Construction of filter clinics in the Maseru district has been on going to relieve pressure of the outpatient department of the national referral center, Queen Elizabeth II hospital. In addition to several general hospitals in Lesotho, there are two specialist hospitals and a privately run military hospital. Many additional services are available. These include local medical specialist as well as visiting specialist from South Africa who consult and operate on a regular basis (Lesotho Review 1999:11).

POPULATION:

The population of Lesotho has been projected to be 2,3 million by the year 2000 as it shows the growth rate of 2.6% per annum (Lesotho Government Bureau of Statistics 1998). The rapid rise in the population is serious, particularly when attempts have been done by the Lesotho government to control population growth. It demonstrates the need to lower child mortality rates and to raise the living standards in order to encourage smaller

healthy families. As a result of rapid population growth, the Lesotho population has a high proportion of children (41.4%). The 1996 Medium Projection estimate for children in the age range 5 to 19, a figure with important planning implications if sufficient educational facilities are to be provided to meet the needs of the school age population.

The population distribution is largely determined by topography and climate. Like many other developing countries, the majority (about 83%) of the population of Lesotho lives in the rural areas (Lesotho Review 1998:12). The large part of the population lives in the western side of the country and this has the highest urbanization. This is the so-called "Lowlands" of Lesotho and they contain seven of the ten district headquarters, towns, most of the population, and the best agricultural land. In 1995, the population density was estimated to be 68 persons per square kilometer. The Basotho (People of Lesotho) are a homogeneous group identified by one language (Sesotho) and have tradition related to marriage, child rearing and other practices.

Since most Basotho in the rural areas do not have much cash, their livelihood is based on subsistence agriculture. However, the 1995/1996 agricultural statistics revealed that arable land accounted for 10 percent of the total land area. The distribution of people among settlements within the country is neither random nor patterned. In the olden days Basotho clustered together in places that were favourable, making a living by farming in fertile river valleys and building their houses on the gentle slopes of hills and mountains (population census Analytical Report 1998:40).

These days, most of the people are gradually coming to settle in towns. This is because they no longer have cattle, the soil is no longer as fertile as it used to be and the actual arable land has itself decreased. This is a result of soil erosion caused by overgrazing and inappropriate agricultural practices. The people therefore move from the highlands to look for jobs to get money for food and to educate their children. The situation has been aggravated by entrenchment of mine workers from the Republic of South Africa. The Lesotho Highlands Water Project (LHWP) also contributed to movement of people from the highlands to the lowlands. Most of them had to relocate and resettle to make way for the LHWP development.

MASERU:

Maseru is the capital city of Lesotho and is situated on Mohokare (Caledon) river that forms the boundary with the Republic of South Africa. Maseru city monopolizes the urban structure that shows unbalanced population distribution. It presently has over 137,7000 inhabitants, which is 44 percent of the urban population and about 7 percent of the national population (See map of Maseru Appendix B). Since 1966 Maseru has grown from a town covering 23 square kilometers defined by Lesotho Government Gazette number 29 of 22 August 1980, with three quarters of its population residing outside the old boundaries where unplanned, un-serviced and uncontrolled settlement had mushroomed (Population Census Analytical Report 1998:41).

A lot of developments are taking place in Maseru. New buildings are coming up, replacing the dilapidated stone ones that existed during the colonial era. The pavements are always crowded with shoppers; workers and tourists while the roads are busy with commercial

and private vehicles. Shops, supermarkets, restaurants and apartment blocks as well as hotels of international standards are changing the shape of Maseru skyline. Supermarkets that are in the center of Maseru city have liquor stores attached to them. Most of the liquor stores are opened even on Sundays. The Moshoeshoe I International Airport lies on the outskirts of the town while the tarred road linking the country with main centers passes through the capital.

MALUTI MOUNTAIN BREWERY (MMB):

This is the only brewing company in Lesotho and is located in Maseru. Lesotho Liquor Distribution (LLD) is a subsidiary of Lesotho Brewing Company. They plan, implement and control the flow of Lesotho's commonly used beers, soft drinks, wines and connoisseur brands of liquor from brewery to the retailers throughout the country. MMB has been operating since 1982. Since then the domestic beer market has increased four folds as a result of its strategy of getting its products to as much of the population as possible. There are now nine (9) depots within Lesotho, the major ones are in larger towns and cities like Maseru, Maputsoe, Mafeteng, Mahale's Hoek, Butha-Buthe and strategically located remote depots at Qachas' Nek, Mokhotlong, Thaba-Tseka and Mount Moorosi.

The company employs 540 staff, 98 percent of which are Basotho. It produces and markets six different brands of beer in three different packets, 19 soft drinks flavours in 6 different packs through its Marotholi Beverages wing and sells a full range of wines and spirits from LLD's arm (Airborne 1998:18). Lesotho Traditional Beverages (LTB), as part

of MMB brews and markets Chibuku Leting, a traditional beer, which is regarded not merely as an alcoholic beverage, but also as food with substantial nutritional value. LTB also introduced the manufacture of “Mahleu” a vitamin, mineral and protein enriched non-alcoholic beverage which is produced in a range of fruit flavours e.g. pineapple, banana and strawberry (Lesotho Review 1998:26).

CHAPTER 1

ALCOHOL USE/ABUSE AMONGST TEENAGERS IN SELECTED HIGH SCHOOLS IN MASERU CITY: THE DEVELOPMENT OF A HEALTH EDUCATION PROGRAMME.

This chapter discusses the overview of the study. The statement of the problem is given and the background of the problem, purpose of the study, objectives as well as questions that need to be answered by the study are given. Limitations and scope of the study have been explained. At the end of the chapter, the researcher has stated the outline of the organization of the study report. Lastly, the chapter ends by stating the operational definitions of the major concepts used in the study.

1.1 INTRODUCTION:

Annually, on the 26th of June, an International Day Against Drug Abuse and Illicit Drug Trafficking is observed worldwide. Lesotho has always been participating in the celebration since 1985. The theme for 1995 was adopted as “youth and drugs”. In Lesotho the first Sunday of August is considered Churches Alcohol Prayer Day. The Queen mother usually leads the procession to the statue of Moshosho I (the founder of the Basotho nation) on this day, to pray for heavy drinkers and alcoholics. On this occasion, speeches condemning drunkenness are made. This is because he, himself was a complete non-drinker though as a

hospitable ruler he used to dispense large quantities of home made beer (joala) to his guests at Thaba-Bosiu. He even promulgated a law against the introduction and sale of spirits. He believed that one couldn't claim to be competent and execute his/her duties if he/she makes use of anything of an intoxicating nature.

Alcohol is considered a drug but unlike other drugs, it is legal and acceptable because consumption of alcohol is as old as man himself (Landy 1985:5). Indiscriminate use of alcohol is now a universal problem. To date cultures from many parts of the world have used alcoholic beverages to celebrate important events. Alcohol has been consumed as medicine, as a form of magic and part of worship services. The use of alcohol has major public health consequences because of its relationship with many acute and chronic physiological, psychological and behaviour problems. Many studies have shown that alcohol is the most prevalent substance that is used worldwide and is also responsible for pervasive health, social and economic consequences, more so when young people are involved. The accidental deaths and crimes committed while under the influence of alcohol have created social as well as health problems (Taylor and Miller 1995:32).

The results of the two studies (Acuda 1995:24 & Nkowane 1999:15) that were conducted in Zimbabwe among secondary school students in 1990 to 1994 confirmed that alcohol use and abuse do exist among young people. They revealed that nearly as many female students drink as regularly as male students though they still have a few schools where more males use alcohol (Acuda 1995:24).

A study conducted by Fuzile Magwa (1989) for the Christian Council's Alcohol and Drug Education Programme in Lesotho found that 11.5 percent of his sample drank alcohol everyday. He found that 45 percent of his sample of drinkers felt that they should stop drinking or cut down on their alcoholic consumption. In this study, men were more tolerant of drunkenness than women and saw drinking as primarily a means of socializing.

1.2 YOUTH AND ALCOHOL: LESOTHO SITUATION:

The health of young people is a concern that has gained importance during the last decade in both developed and developing countries. The Ministry of Health and Social Welfare in Lesotho made an effort to highlight the special needs of young people in relation to their sexuality, reproductive health and overall development. It proposed strategies to promote healthy behaviour among young people and action among the key players, at both local and national level.

The attainment of health for all Basotho people is major aim of the Lesotho Government. However, insufficient attention has been given to young people of Lesotho, because adolescents are less vulnerable to diseases than the very young and the old. Health problems specific to this group have been given little prominence until now. This was confirmed by the Honourable Minister of Health and Social Welfare when presenting the first document "Young People's Health and Development in Lesotho" in 1994.

In his address, the minister pointed out that we were faced with rapid changes in today's lifestyle such as declining traditional family structure, urbanization and migration and increasing occurrence of Sexually Transmitted Infections (STIs) and HIV/AIDS and many others. Therefore urgent steps must be taken to address these most serious issues. To respond to these needs, there must be coordination at all levels and call for changes in existing programmes and activities. In other words, to achieve and sustain the health of young people all must be involved, including the young people themselves as benefits to be gained are only great, for both and all of the society.

The report of the study that attempted to examine the numerous problems affecting the health development and welfare of Lesotho youth, revealed that alcohol and substance abuse is among many challenges that face the young people in Lesotho and confirmed the need for a collaborative effort of youth health promotion and achievement.

The problem of alcohol use and abuse in Lesotho is an eyesore: This is evidenced by a 1992 health survey conducted by Sechaba Consultants for the World Health Organization (WHO). In this study, 200 interviewees were asked to rank the most critical diseases for the Basotho nation. The findings revealed that alcoholism ranked the top most. As a result there is a growing concern over the perceived rise in drinking in Lesotho, more so because currently alcohol is readily available and abundant in the country. Furthermore, habits and practices that leads to excessive use of alcohol are accepted and implemented from the very early stages of life, hence illness affects even the most delicate group of society e.g. the youth, our

future nation. Therefore, unless the country makes an effort to spread the knowledge about alcohol use and alternative way of coping with problems leading to it, one sees very little changes of developing a healthy nation. Studies on alcohol use and abuse may hopefully help in the development of strategies for prevention and reduction of alcoholism in families, societies and nationwide.

1.3 THE STATEMENT OF THE PROBLEM:

A vast majority of students take drinking as a casual thing. They are not aware that alcohol is more of a depressant than a stimulant and that continuous intake of alcohol even in small quantities leads to undesirable consequences. Alcohol can be a false friend. It plays a major part in illness, premature death and traffic accidents (Howard 1995:14). Some students claim that alcohol is a good thing because it is a way of fund raising. They said that they are in high school because their parents managed to pay for their primary and secondary education through beer brewing (Beckman 1995:22). A young girl at the University of Dar-es-Salaam, Tanzanian declared, “yes, I know all this brewing leads to increased consumption, but had it not been for the brewing my mother did, I would never have been where I am now” (Beckman 1995:22). Students further indicated that they are making transition from drinking patterns characteristics of adulthood because it is now a common practice to serve alcoholic drinks as a gesture of hospitality and to facilitate interpersonal relationships.

Drug use between adolescents and young adults has become quite widespread. In many developing countries like Lesotho, alcohol consumption has been increasing dramatically over the last 18 to 20 years. There is an increasing incidence of alcohol related motor vehicle accidents among teenagers. Suicide, homicide, drowning and disease such as cancer of the mouth, esophagus and pharynx are some of the consequences of alcohol use and abuse by school children and students (Howard 1995:14). A lot of unplanned pregnancies occur in high schools because of liquor. The dropout rate is high between both male and female students, and most of the time this is a result of alcohol drinking.

In Lesotho, alcoholism is certainly not a new phenomenon. Nevertheless, researchers and policy makers only started focusing attention in it about 15 years ago. One of the first studies conducted in this area tried to ascertain the extent to which alcoholism adversely affected the population in the Scott Health Service Area by the then director of Community Health Care in that area. The survey found that approximately 20,000 people in the HSA caused a problem in their families because of drinking. Since then, two studies on drinking habit in Lesotho have been conducted. One was an ethnographic study on shebeens and the other was a study of the drinking habits of school students (Meursing & Morojele 1988:16). The former study showed that drinking in Lesotho has become divorced from social ritual and carried out in shebeens that serve people from a wide variety of social backgrounds at any time of the day. The latter revealed that although only 25 percent of students have taken alcohol before, 3 percent of the boys drank to get drunk, which indicates that the concept of drinking in moderation was not one that recommended itself to these young people.

Almost every restaurant in Maseru city also sells liquor of all types. There are some supermarkets that are selling alcoholic drinks as well, others have liquor stores or bars attached to them. There is one such liquor store, which seems to be conveniently placed for students from all over the city. It is situated behind supermarkets and next to the place where there are a lot of trees. It is interesting to watch male students with different uniforms removing off their school jerseys and putting them in their school bags, buying beer to go and drink at the particular spot under the trees. Fridays are the worst days for this experience. It is note worthy to state that in the country uniform for males at high school level is the same, so students can only be identified by the colour of the jersey they wear with regards to the school they attend.

The assumption of this has been that considerable value can be obtained from the study in that it can contribute to the best treatment of pre-alcoholics and prevention of drinking through coordinated efforts of various health professionals and the community. Moderate use of alcohol and marijuana is widespread and many people believe that judicious use of these substances may create no serious social or medical risks. Adolescents also regard drunkenness as humorous, enjoyable and harmless. It may be hypothesized that these young people may well be those who go out to drink heavily in late life, therefore there is need to prevent frequent use of these substances among high school students. This is why it is important to assess other factors that might contribute to the use and abuse of alcohol by young people. It is also assumed that those who drink have a wrong perception on effects of alcohol, gender, parental and peer pressure and this has an influence on the rate of drinking.

Narrow strategies of alcohol prevention have tended to yield rather unsatisfactory results, promoting researchers to study the problem further, in search of more effective preventive measures (Kennedy & Faigier 1989:11). However, comparable data are lacking, little is known about the specific course that leads teenagers into drinking. Perhaps getting the specific cause would lead to the development of a health education programme in an attempt to prevent, facilitate the stopping of alcohol intake by students.

Though not much has been done concerning high school students and their perception and related problems of teenagers as well as drinking patterns of the people in Lesotho, the present concern which stimulated the researcher to conduct this study is the rate at which high school students drink, because it is a new phenomenon. The researcher would like to know whether they are aware of the dangers they are exposing themselves to. Furthermore one would like to know the specific reasons why teenagers are now using and abusing alcohol so that additional measures can be taken to prevent this situation. This study therefore seeks to find out the proportion of high school teenagers who have already started drinking, as well as factors that contribute to the problem.

1.4 THE BACKGROUND OF THE PROBLEM:

European liquors were unknown to earlier generations of Basotho. Sotho home beer was used occasionally by adults during ritual ceremonies or as a way of fund raising. Adults did not go from house to house drinking beer and therefore children did not have any share in

beer drinking. The contact with whites and consequent western civilization resulted in heavier drinking patterns and also more marked use of and preference for European liquors.

After independence the spread of beer drinking increased because as part of development, hotels and bars sprang up all over Lesotho. Lesotho established its own factory for brewing namely, Maluti Mountain Brewery (MMB). To young people, independence meant freedom to do as one pleases. Young boys and girls started roaming about in villages drinking beer and wine. To adults, laws that restricted sale of liquor were a result of colonization and after independence every body felt that one was free to take as much liquor as he wanted, hence one can never find a social gathering without liquor.

Bottle stores and beer halls are to be found in even the remote areas. Drinking patterns have changed; the nutritious low alcohol content beer is changed for commercially prepared beers in high alcohol liquors such as brandy, gin and whisky. Community members who cannot afford expensive liquor resort to cheap home made concoction, mixture of home brew with wines and traditional things like horseshoe, batteries and yeast (Meursing and Morojele 1988:7). A study that was conducted in Mohlomi hospital in 1987 showed that, of all in-patients there, about half were suffering mainly from the consequences of alcohol abuse. It has also been recently discovered that in up to 90 percent of those in-patients admitted for depression, alcohol was a contributing factor. This is not necessarily in terms of one abusing alcohol only but that alcohol abuse in the family had led to family breakdown, financial

stress and physical assault. Data from district hospitals and Queen Elizabeth II, which is a referral hospital, show that the majority of trauma cases attended are alcohol related.

An indication of a growing concern over consumption of alcohol by high school students is Radio Lesotho programme on Tuesdays where teenagers are interviewed about several issues. One of the topics was how can youth assist in community development and prevention of crime. The majority of the students said that if teenagers could stop drinking and concentrate on their studies, Lesotho would develop faster and rate of crime would be lower.

As a result of growing concern over the perceived rise in drinking in Lesotho by both young and adults, various bodies (CCL, Blue Cross etc) were set up to fight against alcohol abuse. This was in addition to the AA that already existed. Community Alcohol Rehabilitation Programme (CARP) was set up in 1982. Its philosophy was based on the theory that alcoholism is a disease. Alcoholics may be rehabilitated but they still have the disease. The residential rehabilitation centre was therefore designed to provide a drying out period and equip people to resist the temptation to drink again once they had left the centre (Gill & Hall 1993:37).

In 1987 the Christian Council of Lesotho (CCL) set up an Alcohol and Drug Education Programme (ADEP) whose aim is prevention, through education about alcohol abuse and on counseling. ADEP concentrates primarily on educating leaders in various fields so that they

know how to prevent and deal with alcoholism (the researcher has been a member of ADEP). Literature reveals that there is a sharp increase in adolescents drinking at age sixteen and that the 3Ds (drinking, driving and drunkenness) are prevalent among teenagers (Spradley 1991:650). Among other things, poor attendance at classes, falling grades and difficulties with interpersonal relationships are visible social effects of drinking.

The use of alcohol by young people is often part of the normal process of anticipating adulthood. The problem however is that alcohol even in moderate doses may have exaggerated effects upon adolescents adopting the habit of drinking. Adolescence is a period of growth and maturation with increasing development of cognitive, social and physical skills. Because many of these skills are recently acquired in adolescence, the same dose of alcohol may be more disruptive to mental, physical and social functioning in adolescents as it would be in adults (Chefets 1983:50).

Lesotho is not able to cope with rapidly increasing numbers of young people and fails to provide every one with appropriate educational programmes suitable for their development. The resulting effects of inadequate employment include idleness, adoption of unhealthy behaviour and increasing illegal activities. The physical problems that the young people in Lesotho encounter are related to, among other things, substance abuse, accidents and intentional injuries. To be specific, these problems include physical addiction and consequent harmful effects of alcohol, tobacco and other drugs, which hamper their physical development. Young people find their life experiences molded by the society in which they live. The nature of their society

affects their health, development pattern of everyday life, aspirations and opportunities. During their development, young people in Lesotho are faced with a number of pressures including among others, excessive influence by parents and peer groups i.e. drinking and smoking habits, bad eating habits and indulgence in premarital sex (Young Peoples' Health and Development in Lesotho 1994:13).

Blue Cross at Thaba-Bosiu that was set up in 1990, is a residential rehabilitation center intended to be a national resource. Blue Cross believes that excessive drinking is learned behaviour, which is a response to certain stressors. People can therefore learn alternative forms of behaviour in response to those stressors. Despite widespread knowledge of the harmful effects of alcohol abuse, adolescents continue to adopt the drinking habit. Several studies have reported increase in drinking by high school students. Numerous anti-drinking programmes (by the Blue Cross) have been implemented in high schools to reduce and discourage starting to drink. Traditionally, programmes have employed a wide range of techniques including lectures, discussions, posters, films and dramas aimed at increasing students' awareness of the harmful effects of drinking, both short and long term, physical, psychological and social.

1.5 SIGNIFICANCE OF THE PROBLEM:

There is evidence that there is an alcohol abuse problem among the teenage population. Many people including the researcher have witnessed many instances of public drinking among the youngsters including high school students. There is more news coverage of the national

increase in teenage drinking and the attendant problems that go with it. Adolescents aim to drink because of peer pressure and emotional stress among other factors. It has been indicated earlier on that several attempts have been made but with no success. It is therefore necessary to develop a health education programme based on the identified influencing factors that lead to high school students' drinking or use of alcohol.

Most of high school students are adolescents. This can be considered a critical period for the formation of coping behaviour and responses such as using drugs to deal with stress, peer pressure and emotional distress (American Journal of Public Health 1997:5). It seems therefore that drug prevention programmes that focus on reducing exposure to risk factors and modifying the factors that are already present should be implemented.

Health education programmes emphasizing health effects of alcohol abuse and prevention may be successful, in particular, programmes emphasizing both immediate physiological effects of drinking and skill training in coping with social pressures to drink. Drink and drug refusal training may teach students how to refuse offers with confidence and without making limp excuses. This can also be an invaluable tool for helping to prevent relapses for clients with abstinence goals. Such programmes may show effectiveness as cessation strategies i.e. with youth, who have already adopted a drinking habit.

The problem of alcohol use particularly by youth, including high school students, needs a multi-sectoral approach, therefore a health education programme that involves parents, teachers as

role models, policy makers would be of help. It is hoped that the study of alcohol use and abuse among high school students will be of considerable value. This is the primary prevention of alcohol abuse and the health education would contribute to the best treatment of those who are already “down the road” to being alcoholics. According to Ellickson, Bell and McGuigan (1993:860), “delaying or reducing drug use during early adolescence clearly yields immediate benefits– reduced risk of accidents, unsafe sexual activity, early dependency and other health threatening behaviours”.

Knowledge and understanding of effects of alcohol can help students to retrain from drinking and therefore concentrate on their studies resulting in responsible future citizens of their country. After completion, students could also help adults to refrain from excessive use of alcohol and therefore secure their work, as they will be fit both physically and mentally. With increasing understanding of alcoholism and with gradual lessening of the stigma, it is hoped that alcoholism will be diagnosed early before the sufferer can lose health, home or happiness (Lynagh, Schfield & Samson-Fisher 199:55).

1.6 THE PURPOSE OF THE STUDY:

The purpose of the study is to identify factors that influence teenagers to use and abuse alcohol. Knowing attitudes of parents and teachers towards drinking by teenagers would help the researcher to understand some of the contributing factors. It is assumed that high school students, most of which are teenagers have already gained enough knowledge about effects of

alcohol, therefore, their perception of effects of alcohol would be of value in developing a health education programme which will strengthen the current prevention and control alcohol use by high school students. This would be through upgrading their knowledge of effects and implications of alcohol use (Physical, social and psychological). Furthermore, the study will provide data on which to base relationship between alcohol drinking and perception on effects of alcohol. The ultimate goal of the study is therefore to provide data on which to base development of appropriate health education programme. Hopefully appropriate time for intervention will be identified and students will be able to reduce, stop or recover from alcoholism.

1.6.1 AIM OF THE STUDY:

The aim of the study is to ultimately develop a health education program, based on the identified influencing factors for students to use alcoholic drinks. “ The factors important to an outcome must be diagnosed before the intervention is designed, if they are not, the intervention will be based on guess work and runs a greater risk of being misdirected and ineffective” (Robinson & Alles 1984:211).

Health education has been perceived as means to free people from factors that “enslave” them to unhealthy behaviours (Greenberg, 1991:68). The envisaged health education programme is therefore aimed at teaching teenagers how to achieve good health and make health an asset that they value. Specifically the aims of the study are:

- To identify the teenagers who are at risk of starting to use alcoholic drinks.
- To identify early, teenagers who have already started to use alcoholic drinks.
- To determine factors which contribute to alcohol use/abuse by teenagers.
- To develop a health education programme, based on the study findings.
- To determine the proportion of teenagers who have started using alcoholic drinks.

1.6.2 RESEARCH OBJECTIVES:

The objectives of this research study are:

- To assess the percentage of alcohol users among high school students.
- To identify factors influencing high school students to take alcoholic drinks.
- To assess attitudes, knowledge and perception of students, teachers and parents on abuse and effects of alcohol.
- To establish baseline data for development of a health education programme.
- To develop a health education programme that can be used as a means of preventing use of alcohol, especially by teenagers.

1.6.3 RESEARCH QUESTIONS:

The study will provide answer to the following questions.

- What proportion of high school students use alcoholic drinks?
- What are the influencing factors that make high school students take alcoholic drinks?
- How do students, teachers and parents perceive alcohol consumption and its effects?
- What/which health education programme can be developed as intervention strategy?

1.7 CONCEPTUAL FRAMEWORK:

The study seeks to identify causes of alcohol use and abuse by teenagers with the intention of developing a health education programme, as a way of intervention. Health education is a multi-disciplinary field of study. The multi-disciplinary nature of practice in education always mandates using multiple theories, in attempt to provide a comprehensive planning model that enable the researcher to assess and plan or achieve the said objectives and ultimately the said goals. Green and Kreuter in McMurray (1993:160) offer the precede-proceed model as a guide to health promotion, planning and evaluation. They further explain that the model is best used if the change agent begins with the final consequences (quality of life) then works back deductively to the original causes.

The PRECEDE-PROCEED model involves several phases as follows: social, epidemiological, behavioral and environmental, educational and organizational, administrative and policy diagnosis implementation and evaluation. PRECEDE-Predisposing, Reinforcing and Enabling Causes in Education Diagnosis and Evaluation is planning model that emphasizes a diagnostic process and a development of programme element that makes it likely that, target group members will adopt healthy behaviours. The PRECEDE part of the model will therefore be used to diagnose the multiple layers and dimensions of alcohol use by teenagers. The three factors, predisposing, reinforcing and enabling form the PRECEDE model which makes it possible to sort the behaviours that we observe into units for programme planning (Dignan and Carr 1987:62). When one studies a health behaviour or

outcome and classifies its dimensions in terms of the above-mentioned factors, the planning process is simplified. The PRECEDE model is a useful framework in which one can approach planning. Its importance is in the diagnosing function, which permeates all phases of planning process and increase the probability that the programme will focus on the right issues.

As indicated earlier on, the precede-proceed model involves:

1.7.1 SOCIAL DIAGNOSIS:

Here the needs and aspirations of the target group are assessed. They are best known by the group, therefore the group needs to be involved because it is in the position to know what health related outcomes are to be achieved. The outcomes may be social indicators, for instance, unemployment or use of alcohol. The diagnoses are based on the examination of what factors adversely affect the quality of life in a community. The examination sorts out the health problems and priorities that will, if solved, contribute to the quality of life.

1.7.2 EPIDEMIOLOGICAL DIAGNOSIS:

During this phase identification and ranking of goals or problems that may contribute to the social problems are done. This means that assessment of important indicators such as morbidity, mortality and disability is done, as well as identifying dimensions of each e.g. incidence, prevalence and intensity, the death of many young people as a result of Sexually Transmitted Infections (STI) including HIV/AIDS in particular.

1.7.3 BEHAVIORAL AND ENVIRONMENTAL DIAGNOSIS:

This phase reveals behavioral diagnosis of the problem selected in phase two. The identification of what causes behaviours that are related to health problems is done. These behaviours become the objectives of change, the outcome of the programme. Behavioral indicators in this study include consumption pattern, coping, preventive actions and self-care. Phase 3 diagnosis would therefore constitute specific dimensions of particular indicators, such as the frequency of alcohol consumption among adolescents or access to alcoholic drinks by teenagers which is an environmental indicator (McMurray 1993:161).

1.7.4 EDUCATION AND ORGANIZATIONAL DIAGNOSIS:

Phase four describes diagnoses in which the causes of the key behaviour were previously identified. At this stage, the predisposing, reinforcing and enabling factors, which would most likely bring about behavioral and environmental change are identified and prioritized (McMurray 1993:161).

1.7.5 PREDISPOSING FACTORS:

Dignan and Carr (1987:63) define predisposing factors as those that function to motivate an individual or group to take action. They include knowledge, beliefs, attitudes, perception and values that motivate an individual or group to behave in a certain way. Attitudes facilitate or hinder motivation for change. Attitudes such as “getting drunk is cool” and belief that “to be accepted I need to drink” may predispose teenagers to drinking (Faulkner, Ratner, Johnson, Bottorff and Unsworth 1996:326). Predisposing factors help in finding out whether one has a potential or not.

In this study as indicated earlier on, knowledge, beliefs, attitudes, values, cultural mores, genetic heritage and perceptions would be considered as factors that motivate teenagers to use and abuse alcohol. It would therefore help the researcher to find out whether teenagers have potential for drinking or not. Some teenagers believe that drinking is useful and enjoyable, and substance use is necessary to belong. This is their value, they desire to belong to peer groups (Smith and Maurer 1995:454). In many cultural ceremonies, almost everybody must at least have a taste of wine. Regarding genetic heritage, the supporters of the biological theory attribute substance abuse to genetically predetermined factors and inherited tendency towards dependence on specific substance such as tobacco and alcohol. (ICN 1997:11).

Socially one can argue that substance abuse is related to the social environment and the experiences that it provides. Young people grow up in an environment where drugs and other

substances are easily accessible and used by both young people and adults. Within the home environment, factors such as separation, divorce or death of the parents are also cited as predisposing factors. (ICN 1997:11).

1.7.6 ENABLING FACTORS:

They are environmental resources and personal skills that facilitate or hinder attainment of health behaviour (Smith and Maurer 1995:454). They provide the means to act on motivation. Understanding them and how they relate to health behaviour is the extent to which their absence will prevent an action from occurring. For instance, in this study enabling factors would be availability and affordability of alcoholic drinks. For example, the availability and affordability of alcohol on campus' social events are such factors. They give students easy access to alcohol and contribute to problem of drinking (Faulkner et al. 1996:330).

Teenagers are given money by their parents for various reasons such as lunch, transport to and from school. Some of them stay in rented rooms by themselves and they use some money for buying alcoholic drinks. Education is very expensive in Lesotho. There are many ways of making it affordable, for instance, MMB sponsors sports and when the national soccer team is going to play, particularly in the country, liquor promotions are done so that a lot of money to be donated can be collected. There are promotions like "buy two quarts and get one free" or "happy hour" whereby on Fridays between five and six o'clock in the afternoon prices of alcoholic drinks are lowered. These add to availability and easy access to teenagers.

1.7.7 REINFORCING FACTORS:

These are external forces, that is attitudes and behaviours of others (health professionals, peers and parents) that can affect the client's motivation to act in a healthy way (Clark 1996:132). They are actual and expected rewards and feedback an individual or group receives following a health behaviour or action (Smith and Maurer 1995:454). They actually reinforce the health behaviour or outcomes and motivate one to maintain the behaviour by giving support. The key consideration in understanding reinforcing factors is the extent to which their absence would mean loss of support for current actions of an individual or group (Dignan and Carr 1987:63). Reinforcing factors include perceived rewards resulting from the behaviour and feedback from significant others about the behaviour. When the consequences of the behaviour are perceived favourably and feedback from others is positive, the behaviour in question is reinforced (Clark 1996:132).

The rewards of drinking include feeling relaxed, momentarily forgetting of one's trouble and feeling like part of the group. Maluti Mountain Brewery (MMB) is the only brewing company in Lesotho. The role it plays significantly reinforces drinking in the country. As a brewing company, it provides abundant quantities of alcohol in the country, it supports and sponsors sports and sometimes donates medical equipment to hospitals. Each month every worker at MMB is given a case of beer free. Fund-raising events that sell alcohol to students reward them by making them feel like benefactors (Faulkner et al 1996:350). As a result of the above mentioned benefits from the brewing company, the policy makers are not willing to do

anything about the drinking in the country, more so because it even offers jobs to many citizens.

1.7.8 ADMINISTRATION AND POLICY DIAGNOSIS:

This phase is a diagnosis of effective strategies. At this stage, organizational and administrative capabilities and resources are assessed. This phase requires consideration of resources, time constraints as well as the selection of right combination of interventions to predispose, enable and reinforce desirable health habits (Breckon et al 1998:155). As reflected earlier on, the PRECEDE part of the model is supported by the PROCEED component. The policy, regulatory and organizational initiatives may be seen as enabling constructs for educational and environmental development. These will support actions and conditions conducive to health.

In Lesotho, there is a law that prohibits young people to buy alcoholic drinks but it is not enforced. People who drive under alcohol influence are arrested but let loose as soon as they recover or given a very light sentence if they have been involved in an accident. Random Breath Testing (RBT) is done but one never knows how often and what happens if one is over the limit. The administration and policies that are in place should be aimed at improving the quality of life. The programmes that are developed should help the adolescents to explore alternative ways of being together apart from drinking places. When they are together, for whatever purpose, they should enjoy being together without the use of alcoholic drinks. Recreational facilities would help teenagers to be busy and avoid whiling away time by drinking.

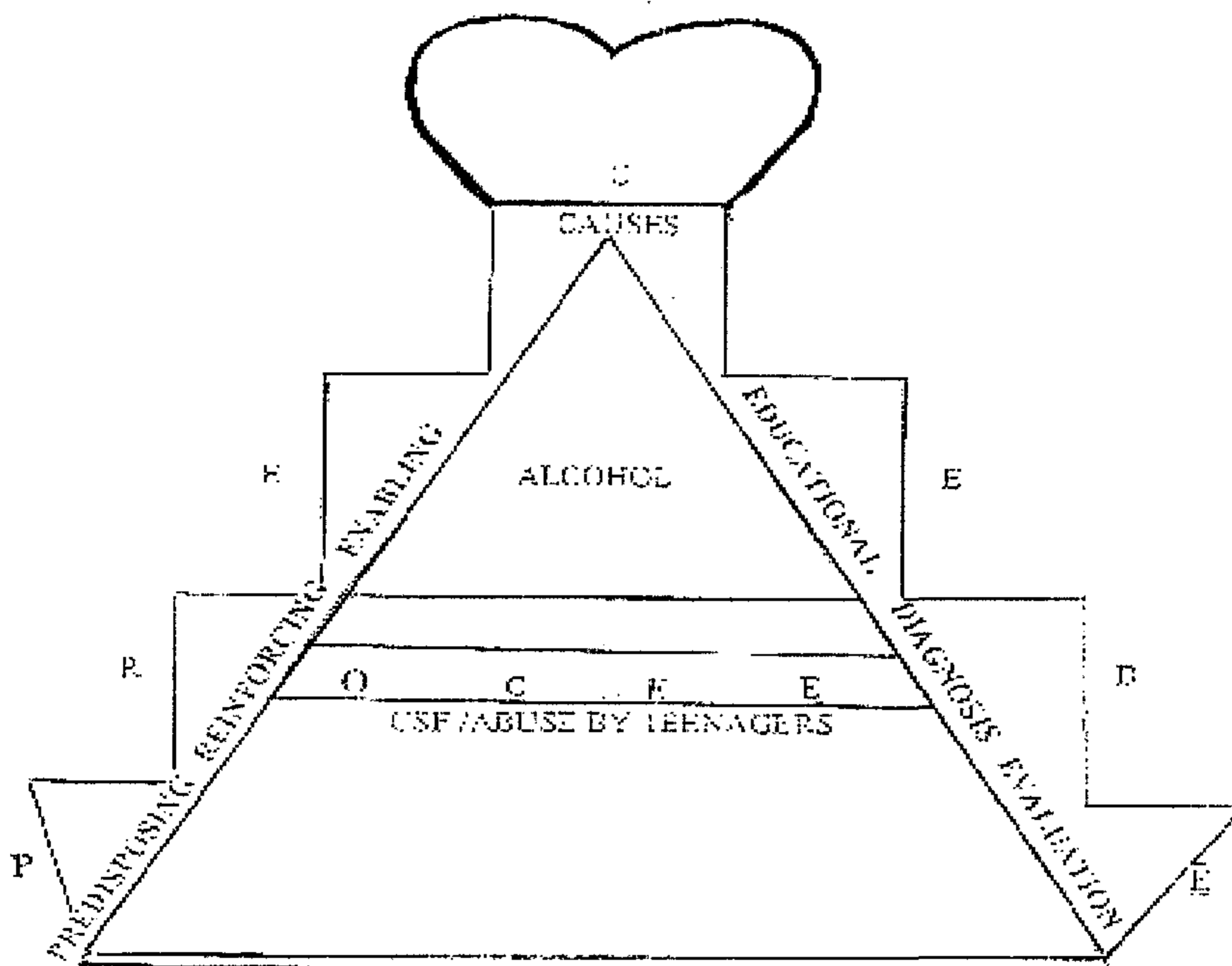
1.7.9 IMPLEMENTATION:

This phase represents the culmination of each of the previous phase that has been discussed and this should be as comprehensive as possible (McMurray 1998:162). The multi-factorial plan that is in line with risk factors identified in the previous phases should be implemented. The implementation should target as many risk factors as possible. The plan must be acceptable to the community. McMurray (1998:162) says that acceptability of the plan by the community is best accomplished by social marketing, that is, “developing the right product backed by the right promotion and put in the right place at the right price”. Kotler (1975)(in McMurray 1998:162) go on to say that, for health education and promotion, the product is the program and this is relevant for this study.

1.7.10 EVALUATION:

Though this phase is mentioned last, it is an integral and continuous part of the entire diagnosis process. According to this study, as has been mentioned in the implementation phase, the product is the programme. Here the quality of life is assessed. The educational objectives are sources of the criteria for evaluation. The extent to which the objectives are met represents process evaluation (Hawe, Deleging and Hall 1992 in McMurray 1998:162). The overall outcome evaluation represents a measure of the extent to which the global objectives were met (impact evaluation). Whether or not the programme goal was met is the outcome evaluation. In the Precede-proceed model, the success of the group can be evaluated according to both process and outcome (McMurray 1998:174).

Fig 1.1 PRECEDE-PROCEED model adopted from Green & Kreuter: 1991.



There is need to take the adolescents' lifestyle into account in protecting them against many risks facing them. Assisting them to achieve this type of protection should be the responsibility of everybody. Fig 1.1 is a schematic representation of this protection as well as steps that can be taken to achieve it.

LIMITATION AND SCOPE:

The study comprised of male and female teenagers in Forms D and E in the ten selected high schools, their teachers and parents. Only old schools (schools that are 5 years or more since their establishment) were purposefully selected. There are schools that are registered with the Lesotho Examination Council in the Ministry of education. Their final results are published in the examination results books that are distributed to registered schools all over the country and are open to members of the public for purchase.

Since many teachers in the schools teach Forms D and E, the sample teachers will not be limited to the class teachers only but to all teachers that are involved in teaching at those levels. However, non-Basotho teachers in the selected high schools will not be expected to complete the questionnaire but rather be interviewed because of cultural differences though they can share their observations and opinions. Parents of selected students will be invited for focus group discussions (FGD). Data guides development of programmes. It can also help community members design appropriate interventions.

1.9 DEFINITION OF KEY CONCEPTS:

1.9.1 Alcohol:

Any beverage that has alcohol in it and is used for the purpose of getting drunk. It is taken in the form of beer, wine, spirits etc.

1.9.2 Alcoholic:

A person who uses alcohol to excess every time he has a drink because he has lost control over his drinking habit.

1.9.3 Alcoholism:

A chronic behaviour disorder manifested by repeated drinking of alcoholic beverages in excess of the dietary and social uses of the community, and to the extent that interferes with the drinker's health or his social or economic functions (Zimberg 1982:4). Jellnek in Zimberg (1982:14) defines alcoholism as "any use of alcoholic beverages that causes any damage to the individual, society or both". He further classifies it into Alpha, Beta, Gamma and Epsilon. Some people view alcoholism as a disease characterized by the repetitive and compulsive ingestion of any sedative drug (in this study, alcohol) in such a way as to result in interferences with some aspects of the person's life. Viewing alcoholism as a disease implies that, there is a significant potential for improvement with treatment and small potential for spontaneous remission.

1.9.4 Drinking:

Use of alcoholic beverages to the point of getting intoxicated or drunk. This may become an uncontrolled habit, which leads to mental disturbance or an interference with bodily and mental health as well as interpersonal relationships.

1.9.5 Health Education:

A process with intellectual, psychological and social dimensions related to activities that increase the abilities of people to make informed decisions affecting their personal, family and community well being (Ross & Mico 1990:312 and Jarvis 1983:132) Health education is therefore aimed primarily at the voluntary actions people can take on their own, individually or collectively, as citizens looking after their own health or as decision makers looking after the health of others and the common good of the community.

Tones & Tilford (1995:11) define health education as “any intentional activity which is designed to achieve health or illness related learning, i.e. some relatively permanent change in an individual’s capability or disposition”. According to Jato (1986:1) health education is a process of teaching and motivating people to achieve that state of well being in which they are best to adapt themselves to their physical, social and psychological environment.

When health education is effective, it may facilitate the acquisition of skills and may even effect changes in behaviour and lifestyle. These are expected effects of health education to teenagers.

The emphasis in a variety of definitions that have been made is change of behaviour, ability to make decisions in order to improve or maintain one's health. In this study, the definition of health education by Robinson and Alles (1984:211) is appropriate. They define health education as "any combination of learning experiences designed to predispose, enable and reinforce voluntary adaptation of behaviour conducive to health".

1.9.6 Health Education Programme:

This is a conscious designing of combination of activities with the improvement of a specific population (in this study, teenagers) and based on needs assessment, sound principles of education and periodic evaluation using a clear set of goals and objectives.

1.9.7 High School Student/Form D and E student:

A student who is either in fourth or fifth year of study after standard seven. In Lesotho, primary education starts when a child is seven years old, so most of the students spent their teen period in high schools.

1.9.8 Social Drinker:

A person who drinks in order to be social but drinks within the limits set by the norms of his groups, which are that he should not drink so much that his motor coordination is visibly affected.

1.9.9 Teenagers/Adolescents:

Young population between the ages of 10 and 19 years. “Adolescence is an impressionable time when opinions, ideas and beliefs are being formed. Peer pressure and a desire to conform and experiment are powerful forces in shaping young people’s lives” (International Nurses Review 1990:80).

1.10 ORGANIZATION OF THE RESEARCH REPORT:

CHAPTER 1:

Presents an introduction and provides the statement and the background of the problem. It includes the significance of the problem of alcohol use by teenagers. The purpose of the study, the aims, objectives as well as questions to be answered by the study are reflected. The conceptual framework, which guides this study, has been described. This chapter also provides operational definitions of terms used in this chapter.

CHAPTER 2:

This chapter reviews literature related to alcohol use. This includes influencing factors for alcohol consumption by teenagers in particular, health implications of alcohol use as well as intervention strategies that have been implemented so far.

CHAPTER 3:

Describes the research methodology, the approach used to collect data from the subjects is explained. Format of the questionnaire for students and teachers is also provided.

CHAPTER 4:

Presents analysis of data from students. Interpretation, figures and tables are used to present the findings.

CHAPTER 5:

This chapter describes the findings and some interpretations from data collected from teachers. Tables and figure further illustrate the findings.

CHAPTER 6:

Discusses the findings of this study. The limitations of the study, conclusions and recommendations based on the study findings are presented.

CHAPTER 7:

This will include the outline of the health education programme plan that may be implemented based on the study findings.

SUMMARY:

This chapter gives the background of the programme and the nature of the problem of alcohol in Lesotho, by teenagers in particular. Research objectives, questions and the significance of the study are also outlined. Precede-proceed model suggested by Green & Kreuter (1991:160) has been described as well. This is because the study has been based on the two models. The major concepts that have been used in this study have been defined. The last part of the chapter reflects how the study has been organized.

CHAPTER 2

REVIEW OF RELATED LITERATURE

2.1 INTRODUCTION:

This chapter addressed adolescents and substance use and abuse, particularly alcohol. That is, patterns of drinking among teenagers, effects of alcohol on adolescents, interventions and solutions to problems of alcohol.

The ultimate goal of the study is to develop a health education programme as an intervention strategy of preventing use of alcohol by youth. Green and Kreuter in McMurray (1993:160) suggest the PRECEDE-PROCEED model to guide the research process in such a study in order to achieve its objectives. They explain that the model is best used if the change agent begins with the final consequences (quality of life). The model involves several phases as follows; social diagnosis, epidemiological diagnosis, behavioural and environmental diagnosis, education and organizational diagnosis and administrative and policy diagnosis, implementation and evaluation. The PRECEDE-PROCEED model will therefore guide the review of the related literature.

Although alcohol is as old as man himself, indiscriminate use is a new phenomenon. Alcohol had important social and cultural function. For instance during ritual ceremonies, communal planting and harvesting, alcohol is used. As development came by, it was accompanied by a

tremendous increase in the availability of alcohol. Aggressive marketing and advertising also support this. This is probably one of the predisposing factors to teenage drinking. The detrimental health effects of smoking and alcohol consumption have long been acknowledged. Efforts to prevent the habit have been the subjects of investigation since the 1960s (Lynagh, Schofield & Samson-Fisher 1997:43). This is partly because health habits that are established during adolescence are often risky, and many are resistant to change during the adult years (Levin 1997:22).

2.2 TEENAGE/ADOLESCENTS AND ALCOHOL USE/MISUSE:

Alcohol abuse among young people is of critical concern to community health nurses. When alcohol users and abusers are teenagers who are in school, the problem is compounded. There are many substances that can be used and abused by young people, the most common being alcohol, drugs and tobacco. It is certainly a cause for concern that the use of alcohol and drugs is widespread among adolescents and young adults, and that 6 to 10 percent of the users become chemically dependent (Maddi, Wadhwa and Haier 1996:247). Childhood and adolescence are times of experimentation, exploration, curiosity and search for identity. These involve risks to personal health, such as the abuse of alcohol, tobacco and other psychoactive substances (Nursing News June 1997:15).

The importance of adolescent health behaviour has been well documented globally. Tobacco, alcohol and drug abuse, unsafe sex, sun exposure, poor nutrition and even reckless driving all take root during adolescence (Levin 1997:21). The problem of substance abuse is becoming a serious problem in both the developing and developed countries. Abuse of alcohol is one of the leading causes of morbidity and mortality. The harmful effects of substance abuse go beyond the negative health consequences. A growing number of social problems are associated with the use of alcohol and other substances. Often, the effects are not limited to the individual but also to their families, friends, colleagues and society at large (ICN 1996:11). There is need to recognize that the health of youth represents a critical component for the health of future generations and of health development in general. Both the current and future health of young people depends very much on their own actions, choices and behaviours (W.H.A 1989:45). Everybody is aware of the extent of the health problems of youth, these include accidental injuries, maturity, abuse of alcohol and other drugs. There is a need therefore for healthy development among young people both in developed and developing countries.

Another concern is a high rate of unemployment among young people, as well as its consequences for their health and integration into society. Young people are beginning to drink alcoholic beverages at early age. Such factors as poor interpersonal relationships at home, at school and heavy drinking by parents are often associated with alcohol use as are peer pressure. Alcohol producers work hand in hand with media to influence young people to take up drinking. Furthermore, the use of sports idols and popular personalities in alcohol

advertisements gives the false appearance of being sophisticated and thus tempts young people to use alcohol (ICN 1997:11). For instance, in Africa, soccer is a favourite sport, and having adverts like “one beer”; one goal”, while famous soccer players like Marko Matiyane and Benny McKathy appear on TV screen might influence young boys to drink.

2.3 THEORETICAL FRAMEWORK FOR LITERATURE REVIEW:

The model identified for this study is PRECEDE-PROCEED as indicated in the introductory part of this chapter. The first phase of the PRECEDE-PROCEED model is social diagnosis. Here the major social problems of concern that influence the quality of life are identified.

2.3.1 SOCIAL DIAGNOSIS:

If the quality of life of teenagers is assessed, several health problems may be identified. The social indicators may present as unemployment, crime or level of personal achievement. Drug and alcohol abuse in lower income communities is a method of coping with unemployment, poverty and all accompanying social and economic situations. “Hanging out on the street corners” and drinking or abusing drugs give youth something to do. Wilson (1987:569) noted that youth who graduate from high school are eager to find jobs and work at improving their marketable skills as well as meet their needs. Constant disappointments created by lack of opportunities over a period of 2 or 3 years cause young people to develop unemployment life style. They become accustomed to not working and after some months or year, stop looking

for work. This is when they occupy themselves with unacceptable activities. This is because among the unemployed, drinking and use of other substances provide a pastime and an outlet for feeling of frustration (Nkowane & Jansen 1999:15).

Other obvious social effects in high school community may include poor attendance at classes, bad performance by students who drink and difficulties with interpersonal relationships (McMurray 1998:166).

2.3.2. EPIDEMIOLOGICAL DIAGNOSIS:

Use/abuse of alcohol amongst the youth seems to have been a long-standing universal problem in the so-called developed and developing countries. Over the past two decades, adolescents drug use in the United States has grown considerably (Selekman and Todd 1990:4). Alcohol is the most commonly abused chemical substance, with approximately 90 percent of adolescents drinking before they finish high school (Harrison and Hoffman 1987:247). One in seven high school seniors reports drinking to the point of collapse at least once a week. Nationally, 40 percent of high school seniors reported using drugs other than marijuana with cocaine and look alike substances being major drugs of abuse. Several large surveys conducted with adolescents have found that youngsters using drugs perceive their chemical use as primarily a social activity influenced mainly by peer and parental use (Blum: 1987:123).

As indicated earlier on, substance abuse by teenagers has risen dramatically in the last two decades. Illicit drug use by high school seniors, college students and young adults in the United States is the highest in the industrialized world, the most popular drug for youngsters is alcohol, which increases dramatically between the ages 13 and 18 (Maddi et al 1996:247). A 1990 national school based youth risk behaviour survey which measured the prevalence of particular health behaviour among youth aged 9 to 12 in U.S has noted that one third of all students reported having consumed five or more drinks on one occasion in the past month. Alcohol use on college campuses continues to be heavy, with 56 percent of college students reporting drinking five or more drinks at one occasion. Thus alcohol appears to be a common occurrence among high school and college students. This is not just the more deviant group as it was in previous generations. Hence, the impact on mental and physical health is substantial (Galanter 1990:192).

Substance abuse continues to be one of the most devastating problems faced by our society. In a survey of 7891 students, researchers found the use of the so-called legal drugs to be prevalent in all schools. Forty percent of the students said they had used alcohol and 27 percent tobacco in the 30 days prior to being questioned. This was carried out in 26 schools both private and public. The researcher found that alcohol and tobacco use ranked high in national statistics. Other findings include the information that: only small differences exist in the use of drugs among girls and boys. For instance, tobacco was mainly used by boys, many more cigarettes. More smokers reported using drugs and alcohol than did non-smokers. Students said that it was easy to obtain alcohol from their homes. When they did buy it at a

store, they most often choose beer and wine coolers (Cookfair 1996:309). Hence, the need to enforce laws on the cigarettes and alcohol to minors is very crucial.

The National Institute on Drug Abuse (United States) in its 1992 study revealed that 40.7 percent of high school seniors used an illicit drug at least once at some point in their lifetime, 27.9 percent reported binge drinking in two weeks before the survey and 17.2 percent daily smoking of cigarettes (Cookfair 1996:308). Binge drinking is a typical behaviour of teenagers who have just started drinking.

In a study that was conducted in Canada, the researcher found that the prevalence of alcohol use among college students is high. Estimates of college students who reported using alcohol at least once in the preceding year ranged from 81 to 87 percent (mean age 19.8). Of all students surveyed, 16.9 percent were binge drinkers on two or more occasions in that week. Age was found to be associated with binge drinking. Those who had recently achieved legal age (19-20 years old) were 1.8 times more likely to engage in binge drinking than those 21 years of age and older (Faulkner, Ratner, Johnson, Bottorff and Unisworth 1996:461). However, it is important to note that about half of students under the legal age did consume alcohol. These findings imply that the measures to combat alcohol/drug abuse continue. Special populations such as teenagers are in need of prevention and intervention efforts (Smith & Maurer 1995:558).

A wide variety of alcoholic beverages is now readily available in most communities. In a number of African countries, adult per capita consumption has risen nine times over a period of 12 years. In 20-30 percent of rural households, traditional beers are regularly brewed, with a least 90 percent to be produced for sale (Nkowane & Jansen 1999:15).

Two studies among secondary school students in 1990 and 1994 confirmed that alcohol use and abuse do exist among young people in Zimbabwe with life drinking rates of 20-60 percent (Acuda 1995:24). They showed that nearly as many female students drank regularly as males. Indeed in a few schools more girls than boys were using alcohol. Acuda also reports that in 1995, about 10 percent of admissions to the psychiatric units of a large Harare Hospital were due to mental complications of alcohol use. In 1991, it was estimated that 65 percent of all road traffic accidents in Zimbabwe were due to alcohol use. He further says that besides easy availability, other factors blamed for the escalation of alcohol problems include rapid urbanization, rapid socio-cultural changes, unemployment and economic hardship.

ALCOHOL USE AND ABUSE IN LESOTHO:

In Lesotho, these days, both local and modern alcohol beverages are easily accessible in both the rural and urban areas and the traditional brews are now income generating activity. As indicated earlier on in this report, traditional home brews are no longer as nutritious as they used to be, instead they are now a concoction of harmful ingredients which include things such as horse-shoe, tobacco, marijuana, snuff tobacco etc. The fact that illicit sale of

commercially prepared alcohol is run in homes, while licensed bottles stores, bars and hotels are outlet, made alcohol readily available in Lesotho. Selling alcoholic drinks to a person under 18 years of age in licensed premises is prohibited under the liquor proclamation No.58 of 1948 in Lesotho. The problem is, the law is silent about the usage of alcohol by these teens, and hence the implementation of the law is not enforced.

Availability and accessibility of alcohol in Lesotho has led to high prevalence rates of alcohol intake among the young people. These pose not only immediate hazards of accidents and injuries arising from increasing risk taking but also long term dangers. Heavy drinkers, particularly teenagers are at a high risk of having so many unacceptable consequences, mental disorders, malnutrition, ulcers just to mention a few (WHO 1993:32).

In 1988 Measuring and Morojele studied alcohol consumption patterns of high school students aged 11-22 years in Lesotho. The study showed that 25 percent of the students had drunk alcohol, 21 percent were exposed to alcohol (a sip or one drink) while 54 percent indicated that they had never had alcohol. Most boys and girls consumed alcohol and the intake increased with age.

2.3.3 BEHAVIOUR AND ENVIRONMENTAL DIAGNOSIS:

At this stage the specific health related behavioural and environmental factors which impact on the health problems targeted for action are identified and ranked (McMurray 1998:161). Previous phases in this chapter have already indicated a high incidence and prevalence of regular use of alcohol amongst teenagers. Several factors play a major role in the development of adolescent drinking behaviour, and ethnic origin is one of them.

Studies show that the lowest incidence of adolescent alcoholism was found among children exposed to alcohol early in life within a strong family or religious context, families where alcohol is mainly consumed with meals, where no moral importance is attached to drinking, where drinking is not viewed as proof of adulthood, social environment and experiences that it provides (ICN 1997:11). For instance, young people who grow up in an environment where drugs and other substances are easily accessible and are used by both young people and adults are more likely to abuse substances themselves. Similarly, other aspects of social environment such as sexual abuse are important contributory factors.

Drinking, smoking and drug taking are supported by authorities through advertising, public policies and ready availability. Historically, the above mentioned problems prevailed less in cultures where substances are less readily available and use patterns are rigidly prescribed. In Lesotho, the only traditional drink accepted during the days of Moshoeshoe I was called “Joala ba Sesotho” which was brewed out of germinated fermented sorghum only. Instead,

this traditional drink was nutritious. It was used by elderly men and women and responsibilities rather than age determined the selection criteria of who was to use it. This went hand in hand with the fact that a Mosotho child could not claim to be independent just because he is aged twenty-one or he is married. The drink was used as part of food and to celebrate ritual ceremonies. Children were not allowed to drink it. Even with the elders, drunkenness was shunned. They were not to be seen drunk and staggering in the village or around (Report of Alcohol Rehabilitation Seminar 1982:4). The majority of young people who drink, do so without causing problems for themselves and others, but there are number of them who show signs that they will experience drink related symptoms and problems. In some countries drinking is involved in about 60 percent of vehicular accidents, with the involvement of 17-20 years old drivers being markedly greater. Individuals under 21 years of age account for almost one in four fatalities associated with driving while intoxicated. Aggressive behaviour after drinking too much also leads to many young people being admitted to hospitals for injuries sustained during fights. This accounts for about 7 percent of adolescents' hospital admissions. Admission rates for treatment of adolescents' alcoholism and alcoholic psychosis are also increasing significantly.

The Traffic Department of Lesotho confirmed that there is an increase in drunken driving charges especially in the 18-21 years old group. Absenteeism from school as a result of drinking is reported with boys and girls at the age of 15 to-16 years. It is of importance to point out that long term frequent alcohol abuse results in psychosocial dysfunction, such as

parent child relationship deterioration and adolescents experiencing difficulties with friends and partners.

Alienation and loneliness are considered to be main causative factors of adolescent suicide (Salus 1994:13). The widespread use of alcohol and other illicit drugs among adolescents has been identified as an influential factor also contributing to observed increase rate of adolescents suicide (Garrison 1993:220). According to Globetti in Estes and Heinemann (1982:202), experimentation and use are quite common during the adolescent years. Estimates reveal that at least a sizeable minority of students (25% minimum) and often a substantial majority (80-90%) has used alcohol. Estes & Heinemann (1982:203) further say that 71 to 92 percent of high school students have indicated that they drink. The behaviour increases with age and is sex related. As age increases, the sexes become proportionately about equal in use.

Experimentation with alcohol begins about a year earlier in boys than in girls although by age 13 about one third of all adolescents have experimented with drinking. By age 14 about two thirds of all adolescents have tried alcohol (O'Malley, Johnston and Bachman, 1995:244). One percent of teenagers is engaged in binge drinking every month (American Public Health Association (APHA) 1996:118).

Alcohol consumption by teenagers varies from one place to another. Daily consumption and intoxication is reported more often among males than females. Most studies to date have found that boys have greater alcohol intake, drink more frequently, and have more episodes of

heavy drinking than girls (Kann et al 1996; Long & Boik, 1993 South Carolina Commission on Alcohol and Drug Abuse (SCC ADA); 1994 Teets, 1991). However, Thorlindsson and Villijahnsen's (1991:399) study of Icelandic 9th grade students showed that girls drink more frequently than boys. In their study on avoidance of alcohol use, Felton, Persons, Ward, Pate Saunders, Dowda & Trost (1999:33) found gender difference in alcohol avoidance, with more girls than boys avoiding alcohol. They further found out that girls delayed use longer than boys but abruptly increased alcohol use around puberty, while boys initiated use early with substantial progression in use over years. This is understandable because girls are particularly vulnerable at this time.

Interventions to promote alcohol avoidance should begin early specially for boys, however, given then prevalence of alcohol use, many students are in need of treatment programs. Strategies to minimize alcohol abuse must therefore, directly counteract influences such as numerous alcohol adverts, the presence of bars adjacent to schools, churches and availability of alcohol in grocery stores (Wilson 1993:31).

2.3.4 EDUCATIONAL AND ORGANIZATIONAL DIAGNOSIS:

Alcohol, tobacco and other drug use among children continue to be a major health concern. According to the 1994 National Household Survey on Drug Abuse conducted, eleven million children younger than 21 years of age 12-17 nearly doubled from 1992-1994. They found that every day 3,000 children begin smoking cigarettes (Halm, Sumpson and Kidd 1996:135).

There are good reasons to study the factors encouraging alcohol and drug use among adolescents and young adults so that the use can be brought under control.

Many theories have been put forth to explain why people use drugs. Several types of explanations exist, namely sociological, psychological and multi-factorial causation. However, certain themes have become consistent. These are pleasure, curiosity experimentation, and search for self-knowledge, relief of stress, immediate satisfaction, depression and powerlessness (Nursing News 1997:54). Maddi et al (1991:439) feel that factors that encourage alcohol and drug use by teenagers are probably biological and psychological, including addictive aspects of personality, peer pressure and poor parental models as well as major stressful events. Talashek, Garace and Starr (1994:131) also noted that, several combinations of biological, organizational and environmental elements need to be understood as they relate to the "substance abuse pandemic". They further indicate that this was confirmed by a four year longitudinal study which provide clear evidence for increase in alcohol and drug use due to peer pressure, poor parental model and major stressful events. Green & Kreter in McMurray (1998:161) categorize these causes into three groups, that is predisposing, enabling and reinforcing causes.

2.3.4.1 PREDISPOSING FACTORS:

There are a number of factors that may bring about behavioural and environmental change. Green in Dignan & Carr (1987:63) refers to them as predisposing factors and these include ones beliefs, knowledge, attitudes, values and perceptions. These may either facilitate or hinder motivation for change. With regards to youthful drinking, it is generally recognized in the literature that parents and peers exert the most salient influence on alcohol use (Estes and Heinemann 1982:206). There is a complex of familial, social and personality factors that predispose teenagers to use alcohol.

2.3.4.2 ENABLING FACTORS:

According to Dignan & Carr (1987:63) enabling factors include available resources needed to perform behaviour. They say that enabling factors are “those attributes of individuals, groups and health care delivery systems that make it possible for actions to occur”. As previously indicated in chapter one, both local and modern alcoholic beverages are easily accessible in both the rural and urban areas and the traditional brews are now an income generating activity.

The illicit sale of commercially prepared alcohol is run in homes (shebeens) and mainly operated by women, while licensed bottle stores, bars and hotels are the outlets (WHO/UNFPA 1994:31). This network makes alcohol readily available in Lesotho.

WHO/UNFPA further confirms that legally, providing intoxicating liquor to a person under 18 years of age upon licensed premises is prohibited under the liquor proclamation No.58 of 1948. The law is silent about usage hence implementation is not enforced. The above mentioned factors surely enable teenagers to get alcoholic beverages with ease.

In their study of adolescent's health problems in three districts of Lesotho, Motlomelo and Sebatane (1999:77 & 507) noted that alcohol seems to be available for everyone at any given time in Lesotho. Worse still, almost everybody who has money can buy them. Sechaba Consultants (1998:53) also found that 27 percent of the children aged 9 to 18 years not only had access to alcohol but also drank it. Cultural theories propose that collective attitudes towards the use of substances (alcohol included) such as ritual use related to religious ceremonies and use in social settings play an important role in shaping individual behaviour with respect to alcohol and other drugs (Nursing News 1997:54). Today, most cultures are loosening social controls, and substances are more easily obtained. For instance, over much of the world, the relatively low cost of alcoholic beverages, adolescents' easy access to money, and loosening of adults supervision have influenced greater alcohol experimentation and abuse in teenagers (Talashek et al 1994:132).

2.3.4.3 REINFORCING FACTORS:

Studies suggest that adolescents like adults view alcohol mostly in terms of sociability and in the sense of what it does for them rather than to them (Estes & Heinemann 1982:208). As indicated in chapter 1, when the consequences of the behaviour are perceived favourably and feedback from other is positive, the behaviour in question is reinforced (Clark 1996:). Teenagers want to belong and therefore they drink to please their friends and be accepted by the group. Adolescents emphasized, along with sociability, the idea that drinking symbolizes the rite of passage into adult status. They felt that it makes them smart and to appear as grown ups.

Adolescent drinkers generally agree that they or their peers drink to be one of the crowd, to celebrate significant occasions, or to enjoy themselves. Drinking then, among many adolescents appears to be an integral part of growing up, viewed by youth primarily as an introduction to adult status and a termination of adolescent dependency (Estes & Heinemann 1982:208).

The chief reason for drinking involves social and cultural factors. Children and adolescents perceive through watching others that, drinking is “fun”. People who are drinking are often laughing and perhaps celebrating. These people are typically family members, friends and celebrities on TV or movies- all of whom are powerful models. Through social learning

processes such as by watching TV shows, adverts, children and adolescents, acquire expectancies about the positive effects of alcohol. Teenagers also perceive that drinking is “sociable” and grown up, two things they generally want very much to be. As a result, when teens are offered a drink by their parents or friends, they are likely to see this as a very positive opportunity (Sarafino 1998:216).

In the late adolescence and early adulthood, drinkers drink frequently and always socially, with friends at parties or in bars. The social aspect is important in two ways. First in social drinking modeling processes affect the behaviour e.g. adolescents tend to adjust their drinking rates to match those of their companions. Secondly, drinking socially creates a subjective norm in individuals that the behaviour is appropriate and desirable. Adolescents may receive positive reinforcement for drinking if they like the taste of a drink or the feeling they get from it or if they think they succeeded in social relationships as a consequence of drinking. Having reinforcing experiences with drinking increases individual’s expectancies for desirable consequences when deciding to drink in future (Sarafino 1998:217).

2.3.5 ADMINISTRATIVE AND POLICY DIAGNOSIS:

It has been indicated in chapter 1 that in Lesotho liquor was not known. When it came, with the western people, Chief Moshoeshoe I, the founder of Basotho nation, enacted a law against selling of any alcoholic beverages. He believed that people could not perform their duties properly, if they are intoxicated. Even after so many years that Moshoeshoe had enacted the

law, it was still clearly stated that, providing intoxicating liquor to person under 18 years of age upon licensed premises is prohibited under liquor proclamation No. 58 of 1948. The law is silent about usage and implementation is not enforced (WHO & UNFPA 1994:31). According to Chenet & McKee (1997:1142) in countries where access to alcohol is controlled, the death rate from liver cirrhosis is less. This was the experience in Denmark, France and Finland.

2.3.6 EFFECTS OF ALCOHOL:

The effects of alcohol as a social relaxant result in diminished restraints and inhibitions and further increase risk taking behaviour. Excessive alcohol consumption impairs judgement and reduces psychomotor skills: often resulting in aggressive behaviour, suicidal attempts and injuries at home, at work and on the road (ICN 1997:11).

Alcohol is a Central Nervous System (CNS) depressant that leads to intoxication and psychomotor disturbances. Drinking alcohol gives an individual almost immediate feeling of calmness. Prolonged ingestion of alcohol can produce severe pathophysiologic conditions including cirrhosis of the liver, CNS damage and peripheral nerve damage (Jarvis 1983:538). Alcohol has significant effects on the immune system secondary to liver disease, bone marrow depression and malnutrition. These effects lower resistance to pneumonia and other infectious diseases. It is also known to interfere with the absorption of many nutrients including amino acids, glucose, thiamine and Vit A (Hutclock, Schubert and Thomas 1999:617).

According to Talashek et al (1994: 133) alcohol adversely affects nutrition as a result of deficiencies in folic acid, thiamin, iron, vitamin A,D and K. The skin, lungs, heart and bone marrow also are adversely affected by alcohol. Many gastroenterologic problems such as esophageal varises, peptic ulcer, pancreatitis alteration in intestinal motility and structural changes in the upper gastro intestinal tract are associated with ethanol use. Talashek et al (1994:133) confirm that chronic use of alcoholic drinks increases liver size and contributes to jaundice, hepatitis and cirrhosis. Studies indicate that adolescents drink because they expect enhanced sexuality, relation and others.

Marion (1996:176) states that overall 13 percent of the students reported that alcohol interfered with school, job or both. More alarming than the prevalence of alcohol consumption by adolescents, is the phenomenon of binge drinking that is, consuming an excessive number of drinks in one sitting. Binge drinking is associated with many problem behaviours including sustaining injuries, engaging in unplanned and unsafe sexual activities, driving under the influence, assaulting people and damaging property.

Another group of symptoms result from an intoxicated state. A high blood alcohol level depresses the central nervous system and impairs condition judgement. The central nervous system is affected; resulting in disordered thought processes and decreased coordination depression. Alcohol abuse is responsible for Wernicke-Korsakoff psychosis and dementia in addition to numerous other psychiatric problems. A teenager may describe symptoms, such as difficulties in school with missed classes or late assignments, memory blackouts, depression, thoughts of suicide and even attempts, destruction of property, violence or even

homicide. This non-social drinking is associated with sexual promiscuity, poor performance, social immaturity, lack of hobbies and interest, defensiveness, sensitivity and isolation, some of which may be psychologically based (Talashek et al 1994:132).

The high scholar who drinks a six pack of beer will show not only acute impairment but later continues to have diminished short-term memory and decreased ability to process cognitive information. Excessive alcohol use is a disruptive element in the family environment; partner and children are inevitably subjects to its consequences. If one of the partners is a heavy drinker or an alcoholic, that causes conflict, financial problems and sometimes violence. In fact it often leads to deterioration of the relationship and represents a factor in divorce in at least 25 percent of cases. All these affect children directly (Levin 1995:29). Studies of children of alcoholic parents have been done but are rather difficult to use because of methodological problems, for instance concerning the make up of samples. Often children of different ages and various stages of development are grouped together in the same samples. Factors such as the severity of the alcoholism of the parents, the seriousness of conflicts at home are not always taken into account. However, several studies show that children of alcoholic parents have a higher risk of suffering cognitive emotion or personality problems; for example, they have problems at school from bad results, to repeating the year (Knop 1986:274). From a study by Werner of population of adolescent aged 18 years, 41 percent had problems with relationship and different psychological problems as associated with the children of alcoholics (Zeithin 1994:140).

Indeed alcohol, tobacco and other drug abuse continue to threaten the health and socio-economic welfare of many people despite major legislature, law enforcement, and therapeutic and educational effort to prevent and treat these problems. In many countries, there are more deaths and disabilities from substance abuse than from other preventable cause. One out of four in the 2 million deaths in some countries each year is attributable to alcohol, tobacco and illicit drug use (Marcus et al 1996:361).

2.3.7 CHARACTERISTICS AND PATHS ALCOHOL USER:

Figure 2.1 symbolizes a beer mug turned upside down, may be to spill off beer or any alcoholic beverage. It shows characteristics of a typical alcohol user and paths that he/she may take. This depends on the success of the intervention that may take place.

Binge drinking, which is common amongst teenagers, is associated with many problem behaviours including sustaining injuries, engaging in unplanned and unsafe sexual activities, driving under the influence, assaulting persons or damaging property. Unsafe sexual activity can result in sexually transmitted infections (STIs) including AIDS or unwanted pregnancy.

Drinking and driving can lead to road traffic accidents, causing death or injury in addition to criminal record, which affects a young person's future.

Binge drinking is also associated with aggressive behaviour and can lead to rape and assault, the health consequences of which are well documented. A number of studies have suggested a link between alcohol use and sexual behaviour, showing that people who drink more heavily are more likely to have multiple partners and less likely to use condoms. (Graves 1995:27). Alcohol has severe adverse effects on people's lives on productivity and on health care systems in both developed and developing countries. World Health Assembly (WHA) declared that problems related to alcohol consumption were among the world's major public health concerns and contributed serious hazards for human health, welfare and life (W.H.A 1989:54).

Alcohol use causes significant harm to the physical, psychological and social health of individuals, families and communities all over the world. It is a risk factor and may cause or contribute to physical, psychological and social harm to both drinkers and non-drinkers, and can damage nearly every tissue and system in the body. Harm to the drinkers includes but not limited to alcoholic liver cirrhosis, heart disease, high blood pressure and stroke. Pancreatic inflammation may also be caused by alcohol use (Chenet et al 1998:52).

For non-drinkers, harm from alcohol use may begin prenatally in the form of fetal alcohol syndrome and fetal alcohol effects. Both drinkers and non-drinkers may suffer from the consequences of alcohol use. For instance, traffic crashes, drowning and suicides affect both drinkers and non-drinkers alike. While the causal connection of alcohol to criminal behaviour is complex, crime of violence consistently show strong relationship with alcohol use (Martin 1992:230).

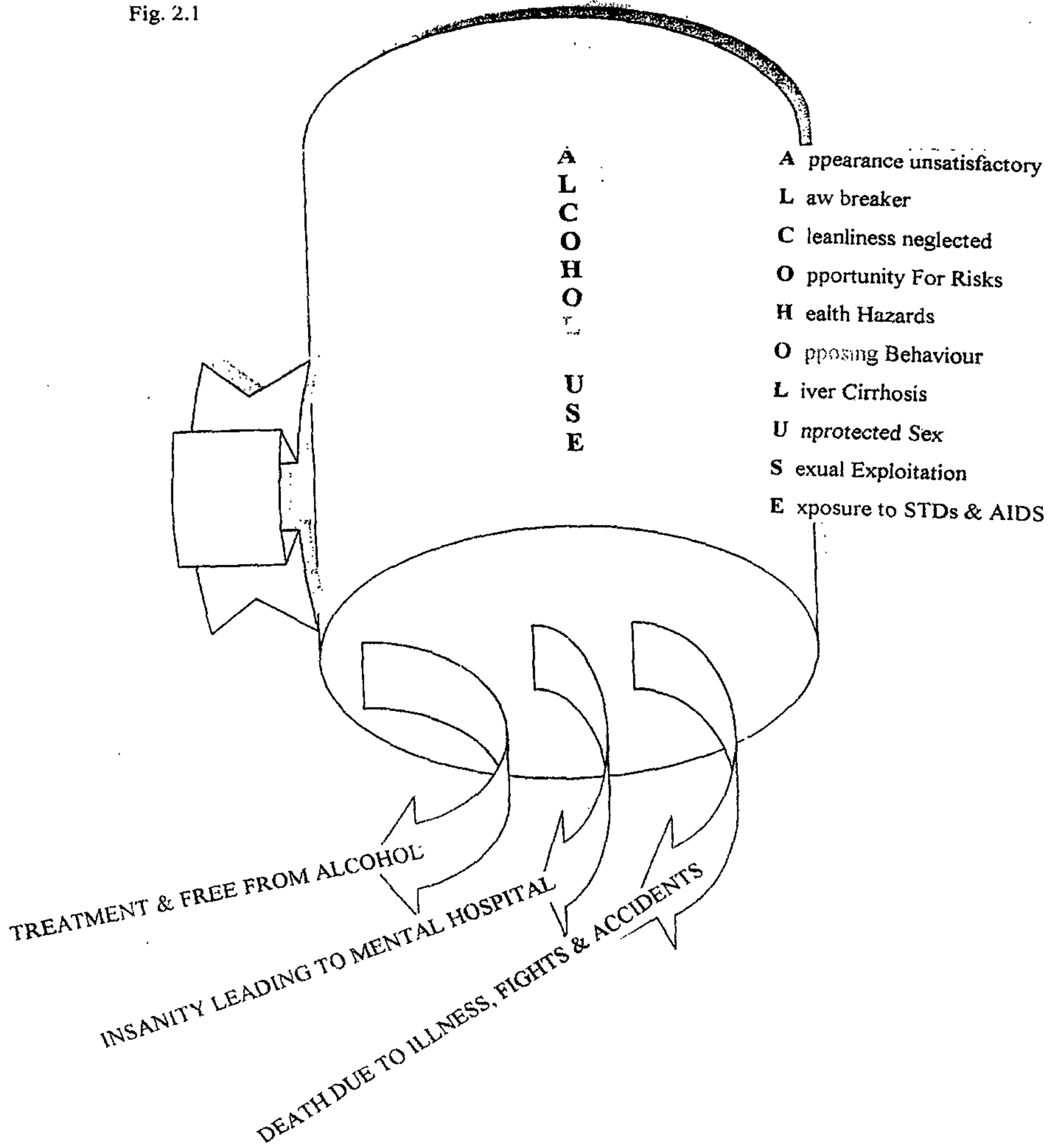
According to Fish and Nies (1996:105) unintentional injuries, homicide and suicide are the three leading causes of death in individuals 15-24 years of age. In addition, alcohol is involved in over half of those many motor vehicle fatalities that usually occur. They go further to say that alcohol consumption is more prevalent in young people aged 18-25 years than in any other age group. An additional risk behaviour in this population that has the potential of serious physical and psychological consequences is the practice of unprotected sexual intercourse. Approximately 1.1 million females become pregnant each year between the ages 15 and 19, with almost 84 percent of those pregnancies being unintended.

In addition to the effects of alcohol or characteristics of the alcohol user discussed above, there is deterioration in standards of hygiene and untidy appearance.

See the Characteristics and Paths for Alcohol User on Fig.2.1 next page.

CHARACTERISTICS AND PATHS FOR ALCOHOL USER.

Fig. 2.1



2.3.8 THE IMPLICATIONS OF ADOLESCENTS ALCOHOL USE/ABUSE AND DRINKING PROBLEMS:

The majority of young people who drink, do so without causing problems for themselves and others, but there are a number of them who show signs that they will experience drinking symptoms and problems. Other implications of alcohol use/abuse by adolescents as future citizens as cited by Bingham and Bargar (1995:17) are that children of alcoholics have a high risk of becoming alcoholic or marrying someone who becomes alcoholic. In up to 90 percent of child abuse cases, alcohol is significant factor. Children of alcoholics are also frequent victims of incest, child neglect and other forms of violence including exploitation.

2.3.9 INTERVENTION:

Alcohol and substance abuse remain a serious health problem among youth and is correlated with other adolescent problem behaviours including teenage pregnancy, school misbehaviour, delinquency and dropping out of school (D.Elio, Mundt, Bush & Iannatti 1993:354). It is further said that, because use of alcohol and other substances (abusable) begin prior to the senior year in high school, and early age of first use is associated with later problem use, it is important to identify correlates of initial substance use for the purpose of early intervention. Additionally, early intervention may reduce future adult health problems since alcohol abuse is involved in many health problems, and even moderate adolescent drug use is significantly related to decreased physical hardness in adulthood (Baumrind 1985:85). Perry and Jessor (1985:169) suggest that an important method of intervention might be to promote a "healthful

lifestyle". If behaviours that are known to strengthen health such as exercise and proper nutrition are initiated or enhanced, health-compromising behaviours such as alcohol or drug abuse may be reduced.

Several drug prevention or input chemical dependency programmes have been created to combat this growing epidemic. The majority of these programmes are based on the traditional disease model that is frequently utilized for adult alcoholics and drug addicts. Despite the popularity of disease model of addiction, there is presently little outcome data to support its effectiveness on adolescent substance abusers (Selekman & Todd 1990:45).

It is crucial to educate adolescents substance abusers and their families early in treatment about the fact that relapses are practically inevitable, but their occurrence can be an "opportunity for come back practice". Several studies have clearly demonstrated a strong association between family support and the prevention of relapses, either following treatment or once the substance abuser achieved abstinence without treatment. Selekman, Harrison & Hoffman (1989:85) found out that active parental involvement in Alcohol Anonymous or similar group was strongly associated with adolescent's abstinence. For instance, 63 percent of adolescents, whose fathers attended Alcohol Anonymous or similar group meetings for one year after discharge from residential, achieved a remarkable abstinence. Selekman (1989:87) developed a systematically oriented relapse prevention model for adolescent abusers participating in day treatment and residential settings (Just keeping you Honest Friends or Relapse Beasts and Monsters).

The most effective interventions in reducing the incidence and severity of the leading causes of disease and disability are those addressing personal health behaviours of individuals. Preventable health problems of adolescents and young adults are categorized into two major groups. One of these is injuries or violence that results in death and disability before the age of 25. The second includes lifestyles, e.g. drug and alcohol use that will affect this population throughout their life spans. The major risk factor for chronic disease in later years are rooted in behaviour during youth (Fisher & Nies 1996:105). Enabling the nation's youth to avoid risk behaviours and their associated health problems is a commitment that every individual, family and community must have if young people are to be helped.

IMPLEMENTATION:

This part of the program represents the culmination of each of the previous parts. Implementation should be as comprehensive as possible, given the information which surfaces from the diagnostic exercises. Available evidence supports the conclusion that providing young people with information on alcohol doesn't necessarily lead to behaviour change. The use of fear arousing approaches in particular, is unproductive, especially in view of the widespread adolescents belief in personal invulnerability (Edward & Peters 1994:84). Literature has revealed that comprehensive and social influence programmes were found to be successful. Social influence programmes include those whose primary purpose is to teach students about peer and other social pressures. The health education programme will therefore

include information about alcohol use as well as focusing on resistance skills training. Comprehensive programmes include information, decision making and resistance skill training (Edward & Peters 1994:86).

It has been mentioned in the previous chapters that Lesotho is committed to using Primary Health Care (PHC) as a strategy to achieve the goal of health for all. According to Edwards & Peters (1994:64) PHC is an important setting for identifying people at risk from heavy drinking and assisting them in reducing their alcohol consumption through brief interventions. PHC has been shown to be effective and efficient in acting as an advocate by public health for local communities. It has been further confirmed that intervention at primary level leads to reductions in alcohol consumption of around 15 percent and reductions in proportions of excessive drinkers of around twenty percent. PHC may therefore be used as a tool to prevent alcohol use among teenagers in high schools.

2.4 INFLUENCE OF FAMILY AND PARENTS:

Several factors have been identified that can influence teenagers to use alcohol. Amongst them are that the majority of teenagers who drink come from homes where parents have a drinking problem or where there is some kind of family disruption (Salus Vol 13). Adolescents and children drinking is often thought to be increasing rapidly and its origins are frequently attributed to unsatisfactory aspects of family life. Many opinions have been stated but relatively little good research has been carried out. According to Kozlowski et al 1990:122, the role of unhappy families was highlighted in a study of the early Bulgarian

where there was a report of a questionnaire study of over 1000 students aged 16-18 (Bozan 1980:40). The results showed that low parental control and disturbed emotional climate in the home were among the factors favourable to the spread of "negative phenomenon in youth", such as alcohol, tobacco and other drug use.

A Yugoslavian report described adolescents' alcoholism as a symptom of disturbed family relationships during a passing phase of adolescence. Many studies in Britain, United States and Australia showed positive correlation between parents' drinking and their children's drinking although the correlation size is usually over shadowed by the degree of relationship between a young person's drinking and that of his or her peer group (Kozlowski 1990:121).

As early as 1980, a study that was conducted in Northern Finland to determine the relationship between adolescents alcohol use and the type of family setting, revealed that on the average 59 percent of adolescents who had been drinking alcohol at the age of 14 years were from full standard families and 69 percent were from non-standard families. The risk of alcohol drinking or having been drunk still increased in non-standard families when data were adjusted for place of residence, social class and child's status in the family (Isohanni, Oja, Mailanen & Koironon 1994:134). The results suggest that a non-standard family structure is associated with early juvenile alcohol drinking.

In environments where adults regularly drink and support essentially prescriptive drinking norms, alcohol use serves to symbolize adults' status. It can therefore be expected that most of the teenage drinking that occurs is conditioned primarily by the positive sanctions and the

acceptance of drinking by adults (Estes & Heinemann 1982:207). Previous studies indicate that the odds of drinking are substantially higher among adolescents who perceive their parents to approve of drinking (Epstein et al 1995; Grube & Wallack, 1994; Webb, Baer, Getz & McKelvey, 1996). It is further claimed that among environmental factors, mothers and fathers avoidance of alcohol is associated with children's avoidance of alcohol. More mothers avoid alcohol than fathers. Among students who report alcohol use, 40 percent of mothers and 76 percent of fathers are drinkers. Best friend's avoidance of alcohol is also associated with student's avoidance of alcohol. Regarding adolescent's use of alcohol, influence has been shown to gain strength over parental influence (Webb, Baer & McKelvey 1995:775).

Sociological explanations also contend that certain factors in individual's relevant environment may contribute towards their use of drugs and alcohol. For instance, modeling has had an important effect upon individuals' use of alcohol. If parents or other key influences are alcohol users and abusers, young persons often tend to model the behaviour they see demonstrated in the home. Cultural theories propose that collective attitudes towards the use of substances such as ritual use related to religious ceremonies and use in social settings play an important role in exposing teenagers to alcohol and shaping their behaviour with respect to its use (Nursing News 1997:54).

2.5 RELATIONSHIP OF ALCOHOL AND DRUGS:

Substance abuse is indeed a worldwide problem. Statistics offer graphic and alarming details of relationship between alcohol, smoking, tranquilizers, illicit drug use and addictions (Nursing News June 1997:53).

A number of studies have documented that alcohol and tobacco consumption are related. The findings that there is moderately strong positive correlation between alcohol and tobacco consumption apply across various demographic variables, age, race and socio-economics status. Smokers are more likely to drink alcohol than non-smokers. This hold true even in younger age group, for instance, in a study of nearly 5000 American youths aged 12-17 years, 80 percent of the smokers in the same sample reported using alcohol, whereas only 45 percent of the non-smokers used alcohol by this age. The same relationship is evident with children and teenagers. This is evidenced by another study in which smoking and drinking habits of American children and teenagers aged 9-17 years were studied. Forty one percent of alcohol consumers smoked, whereas only 3 percent of alcohol abstainer smoked. (Galanter 1990:205).

It is therefore important to determine the mechanism that underlie alcohol-nicotine interactions in order to further understand those mechanisms that underlie alcohol abuse if adolescents are to be helped.

2.6 INFLUENCE OF PEER GROUP:

People generally respond to peer pressure in regard to substance use and abuse and tend to associate with those who share similar attitudes and practices (Jarvis 1983:543). Many study findings generally supports the assertion that adolescent drinking behaviour resembles that of their peers. The more one's peers use alcohol, the more likely one is to be a drinker, a heavy or a problem drinker (Galander 1990:113). This is for the same reason that adolescents want to belong, that is their value. During adolescence, peer begin to serve as credible sources of information, as role models for new behaviours and as bridges at alternative lifestyles, for instance, if a teen's chosen peers have health -enhancing patterns of behaviour such as using seat belt or not smoking then their influence can positively affect the teen's own health -related behaviour (Gills 1996:26). The adolescent's search for identity is markedly influenced by peer groups, which can have either a negative or positive influence on the individual. Most of the people refer to the adverse influence which peer could have on lifestyle practices, and mention specifically habits such as alcohol abuse, use of other drugs, cigarette smoking to mention a few. Peer group members by living up to the standards of the group in order to become more popular; may force a student to deviate from family standards. Decisions about the use of alcohol or developing sexual relations, for instance, are major decisions with far reaching consequences that a teenager may have to take. Psychological theories that attempt to explain why people use drugs cite that drugs, alcohol in particular, make certain individuals feel more capable of coping with a variety of life stresses. Another set of explanations proposes that many individuals become engaged in alcohol use through a desire for experimentation and sheer curiosity about the effect of alcohol. They may continue because of its pleasurable effects (Nursing News 1997:54).

The following are the most common stated reasons for using and abusing alcohol and these definitely reinforce their habit of drinking:

- Adolescents enjoy the euphoric effect
- To be accepted by peers
- To make them feel happier
- To celebrate on special occasion
- To be sociable
- To create a self-conception of being “smart and grown up”.
- To relieve anxiety and to seek relief from family, financial and personal problems (Salus 1990:22).

There are many more factors that have been cited by unknown author (see Appendix C). There is need therefore to consider cognitive, social and physical dimensions of development when planning a health education program. The adolescent’s perception of alcohol drinking is a myth and stereotyped about how to be with their peers, how to achieve adult status and how to prove one’s identity.

2.6 CONCLUSION:

As indicated earlier on in this study, the PRECEED-model places heavy emphasis on diagnostic activities. Used together with PROCEED model as they complement each other, PRECEDE has revealed that there are several reasons why teenagers use and abuse alcohol. Social, epidemiological, behavioural environmental as well as educational diagnoses have been made through literature review. This implies that intervention strategies must focus on

social, epidemiological, behavioural and educational needs of the teenagers. Massive educational programmes responsive to the needs of youth need to be launched. The school is a logical place to provide prevention efforts because it reaches more youth than any other single institution. Education must be started at the earliest grade level and be built throughout the basic educational curriculum to have the greatest positive effect on young people's values and patterns. If children develop good health behaviours and practice them throughout their lives, their morbidity and mortality will be changed significantly (Breckon, Harvey & Lancaster 1998:100). A school health programme is one of the strategies that can be used to prevent alcohol use/abuse by teenagers. Health behaviours are learned at an early stage of life.

Promoting school health education programmes is a significant opportunity to improve the health of a community and should not be overlooked. According to Breckon et al (1998:100) three fourths of all youth live in urban areas. Half of them use illegal drugs. More than half use alcohol and one-fourth use tobacco products before they are eighteen years old.

This shows that teenager's quality of life cannot be improved effectively by a single course or by the school alone. Education of school aged youth should be part of the responsibility of every community member. Every community member must participate in the process of programme planning. Community member must address health issues by strengthening their community health planning and health promotion skills. They should analyse data, set priorities, plan intervention and make decisions on health. This also implies that policies have to be in place or be developed and necessary resources have to be marshaled in accordingly as suggested by the PROCEED model.

2.7 SUMMARY:

In this chapter, the researcher discussed the literature, which was reviewed to identify factors that could contribute to alcohol use by teenagers, as indicated by the conceptual framework used in this study. The scope of the problem, which is alcohol use/abuse as well as its implications looking at different aspects of life was also, identified. The literature reviewed revealed a remarkable consistency in the influence of peer and family on teenage use of alcohol. The literature consulted also assisted with the conceptualization and operationalization of the present study.

The research of related literature was undertaken with the assistance of UNISA reference librarians. The researcher requested bibliography on the variables of interest. Access to Internet was also sorted out, in particular, in relation to the questionnaire.

CHAPTER 3

METHODOLOGY

3.1 INTRODUCTION:

The purpose of this study was to identify and indicate factors that influence teenagers to use and abuse alcohol. Knowing attitudes and perceptions of parents and teachers towards drinking by teenagers would help the researcher to understand some of the contributing factors to teenagers drinking. The ultimate goal of the study is to provide data on which to develop an appropriate health education programme. Hence in this section, the researcher provided a brief overview of the research methodology, which in this study describes how the researcher hopes to achieve this goal.

According to Polit and Hungler (1995:646), research methodology refers to the study of procedures and strategies for gathering and analyzing data in research investigation. The following sequence was adopted to explain how adolescents use or abuse of alcohol can be detected early and intervention programmes be put in place. Objectives of this study will be highlighted. The study design, the target population, sampling plan, procedure, size, instruments as well as reliability and validity will be discussed. The data collection plan and data analysis procedure will be discussed.

3.2 RESEARCH OBJECTIVES:

The research objectives were:

- To assess the rate of alcohol use amongst high school students;
- To identify factors influencing high school students to take alcoholic drinks;
- To assess attitudes, knowledge and perception of students, teachers and parents on use and effects of alcohol;
- To establish basement data for development of a health education programme; and
- To develop a health education programme for alcohol use prevention by teenagers.

3.3 RESEARCH DESIGN:

Burns and Grove (1993:772) refer to research design as the overall plan, which the investigators make in an attempt to obtain answers to the research questions. Its ultimate use is to guide data collection and data analysis. In this study, both qualitative and quantitative methods were used in the collection and analysis of data.

An exploratory quantitative method was developed based on the pilot test findings. The pilot test was carried out at one of the high schools in Maseru city. The pilot test school was not included in the main study. A self-report questionnaire was administered to both students and teachers. An exploratory qualitative method was also used to examine perceptions, opinions and interpretations of teenagers regarding alcohol use, abuse and its consequences. The purpose of this was to add richness to the quantitative data collected. Separate focus group

discussion for different groups, male and female students, teachers and parents were conducted. The sessions were conducted in English. However indigenous language – Sesotho was adopted when discussing with parents.

3.4 POPULATION:

Three specific groups were selected for the study. These were high school students who were in Form D and E, teachers and parents. Teenagers who were in the school setting were involved. Key international health organization have identified schools as institutions which potentially play an important role in influencing the present and future health behaviour and lifestyles of young people (US Depart 1991:298). The school is where students spent a large proportion of their waking life, this includes the development years in which health risk behaviours are often adopted as life-time habits (Lynagh, Schofield and Sanson-fisher 1997:43). It has also been recognized that the informal or “hidden” curriculum of a school can significantly influence students’ attitudes and behaviours. The message conveyed in the classroom can be reinforced or completely undermined by what occurs outside the classroom (Nutbean, Wine, Bauman, Harris and Leader 1993:44). The justification for the selection of the three groups of respondents is presented in the subsequent sections.

3.4.1 STUDENTS:

Students were selected because they have a potential for access to nearly the entire population of young people, so the school can be considered an ideal setting for health promotion intervention which target health risk behaviours of adolescents. Students' population consisted of final year students (Form Es) as well as those in penultimate year (Form Ds) in eight of ten schools that were selected. It was deemed essential to get information from finalists who should be knowledgeable about effects of alcohol, either from experience or education that they have gone through, information from Form Ds would help the researcher to find out whether these category of students have already started drinking or not. This would help the researcher to recognize the appropriate time for intervention or be aware of some of the influencing factors such as due to final years work.

3.4.2 TEACHERS:

Teachers can be perceived as role models for students as they spend most of their time with them at school. They are central to a school's functioning, but interventions targeting students may potentially change the health risk behaviour of teachers as well. Knowing their attitudes towards alcohol use would help one to understand the behaviour displayed by students regarding alcohol use. This would help identify resources needed for developing and implementing the health education programme. Teachers were therefore selected to triangulate data from students. Their ages ranged from between 30 and 67 years and their education experience was above 15 years. High school teachers who were present at the school at the time of interview were eligible to be included in the sample.

3.4.3 PARENTS:

Bandura in her social learning theory proposes that people initiate the behaviour of identified models. Parents act as role models for their children. Role player identifies, observes and initiates actions and the basic learning process underlying identification is observational learning. Parents' attitudes towards alcohol use would help one to predict students behaviours as Bandura's theory enhance understanding of developmental patterns of behaviour and proposes practical ways of modifying unsocial behaviour or adopting new situations. Including teachers and parents confirms the multi-sectoral approach as advocated by Primary Health Care (PHC), as well as community participation, which is its major principle. In summary, the reason for selecting parents as part of the sample is that, parents are role models for their children and therefore should be involved in developing them into future responsible citizens.

3.5 SAMPLING AND SAMPLE:

Sampling in this study refers to the process of selecting a group of subjects that are representative of the population being studied (Burns and Grove 1997:779). Multistage sampling method was used to get a representative sample of the target population irrespective of homogeneity. First, high schools in Maseru city were purposefully selected. Each high school has Form A,B,C,D and E. In this study, only Form Ds and Es were eligible. In Lesotho, there is no limit to the number of students to be enrolled for a particular class. The different schools have different sizes of population of students. For instance, in 1996 the

selected high schools had Form E class ranging between 42 and 117 students (Government documents 1996). Large groups are divided into smaller groups that are manageable. So it is not uncommon to find a class with three arms in many of the schools. Form D classes also ranged from 60 to 120 and some of them had up to three arms. There is no specific criterion for allocating individual student to any particular group except in cases where there is a choice between two subjects, for instance, one group doing sciences and the other commercial courses. All the schools were co-educational.

The third stage was random selection of stratum from students, amongst two or three groups of students of the same class. The final stage was to randomly select individual subjects amongst members of the group. Simple random sampling was used in this case. As indicated earlier on, information was collected from three specific groups; namely, students (main group), teachers and parents. All teachers in chosen schools were eligible for selection because there are very few teachers in high schools in Lesotho. Teachers who were available at the time when the researcher was at the school were asked to respond to the questionnaire developed for them. Parents of the selected students were also selected for the study.

3.5.1 SAMPLE SIZE:

The general rule of thumb is always to use the largest sample size possible. The larger the sample, the more representative of the population, the finding is likely to be (Wood and Haber 1990:120). Wood and Catanzaro (1988:240) further say that the sample must be representative of the designated population to allow the investigation to generalize findings to

the population of interest. This was confirmed by Wilson (1993:221), who stated that the larger the sample, the more valid and accurate the study because a larger sample is more likely to be representative of the population. He goes on to say that sampling error (the size of the deviation) is generally dependent on the size of the sample i.e. the larger the sample, the smaller the error. However, the research purpose, design and the size of the population should be considered.

On the other hand, whereas it may be true that the bigger the sample, the better the study becomes, it is better to make extra efforts to get a representative rather than to get a very large sample. In general, the desirable size is determined by the expected variation in the data. The more varied the data are, the larger the sample size, one needs to attain the same level of accuracy. Kirwood (1988:213) says that the eventual sample size is usually a compromise between what is desirable and what is feasible. The feasible sample size is determined by availability of resources i.e. time, manpower, transport and money.

In this study, the researcher came up with the following sample size per school after ensuring that the selected students are representative enough.

TABLE 3.1 NUMBER OF SUBJECTS SELECTED PER SCHOOL AND THEIR PERCENTAGES

| SELECTED SCHOOLS | SAMPLE SIZE | PERCENTAGE |
|-------------------------|--------------------|-------------------|
| 1 | 60 | 12.8 |
| 2 | 61 | 13.0 |
| 3 | 61 | 13.0 |
| 4 | 58 | 12.3 |
| 5 | 56 | 11.9 |
| 6 | 55 | 11.7 |
| 7 | 58 | 12.3 |
| 8 | 61 | 13.0 |
| TOTAL | 470 | 100.0 |

However, data from two schools, namely 2 and 7 (Form Ds) were wrongly processed, therefore were not indicated in the final analysis. Teachers who are Lesotho citizens and were available at the time when the researcher was at the particular school were given questionnaires to respond to. Thirty-three questionnaires were distributed to the teachers but only ten were returned and analyzed. These were from different schools included in the study.

3.6 INSTRUMENTS FOR DATA COLLECTION:

The instruments used for the data collection are: questionnaires, interviews and focus group discussion. These are described below.

3.6.1 QUESTIONNAIRE:

Questionnaire is a method of getting self-report information from respondents through self-administration of questions in paper and pencil format. A self-constructed questionnaire was used for the data collection for the study. This approach was used because it allows the investigator to question subjects about facts, ideas, behaviours, preferences, problems, feelings and attitudes (Wood & Catanzaro 1998:242). The sample size was estimated to be about 500 students. This is rather a large sample; therefore questionnaire was preferred as a method of collecting data. Furthermore, the questionnaire offers the possibility of complete anonymity and anonymous questionnaire often results in a high proportion of socially unacceptable responses i.e. responses in which the respondents admits to deviant behaviour or unpopular opinion (Pilot & Hungler 1985:280). Drinking by young people particularly adolescents is unacceptable behaviour all over the world and Lesotho is no exception.

The investigation therefore used questionnaire, which consists of multiple-choice questions to get facts, beliefs, attitudes, opinions, levels of knowledge and intentions of the students about use and abuse of alcohol. The questionnaire was adopted from MAST (Michigan Alcohol Screening Test) by Seizer, adopted for use with adolescents by Schuckit (1995:282).

Questions were also modified to suit Lesotho situation. It was modified because MAST questionnaire tends to miss early cases of alcohol abuse, let alone alcohol use. In the original work by Seizer, MAST was shown to have only a limited usefulness in early identification of alcoholism because it gave positive diagnosis in only 55 percent of subjects convicted of being drunk and disorderly, and only 2 percent of the car drivers who had temporarily lost their driving licenses for drunk driving offences.

Demographic data were collected in order to know the kind of population to be studied. Closed ended questions were used to get data that will indicate knowledge of students about effects of alcohol, their teachers' and parents' attitudes towards use of alcoholic drinks. A few open-ended questions were added to allow for a richer and fuller perspective on teenagers use/abuse of alcoholic drinks. As Polit & Hungler (1985:283) put it, though the richness may be lost when classification of answers is made, excerpt taken directly from open-ended responses can be extremely valuable in the research report in importing the "flavour" of the replies. They also say that open-ended questions give a lot of freedom to the respondent and therefore offer the possibility of spontaneity unattainable when a set of responses is provided.

3.6.2 FORMAT OF THE QUESTIONNAIRE FOR STUDENTS:

Questionnaire for students consisted of 3 sections; these sections are discussed below.

Section I: Personal Detail:

Item 1-2

This section highlighted details such as age, gender, religion, parents' occupation and their marital status and living place of students as well as people staying with them.

Section 2:

Item 1-10:

This part assessed people who could influence the subjects to drink such as friends, classmates and teachers smoking and drinking.

Item 11:

Asked whether the student drinks or not.

Item 12&13:

Students had to indicate age when they started drinking and whether they feel they would have thought of drinking later in life if they have not started drinking.

Item 14-20:

These items assessed availability of alcohol to subjects in terms of money to buy it, type of alcohol, drinking pattern, frequency of being drunk and amount of alcohol before one gets drunk.

Item 21-22:

These required subjects to indicate reasons for drinking and their feelings when they are drunk.

Item 23:

This item assessed use of other drugs by students apart from alcohol.

Item 24-28:

Here information about alcohol and school was determined e.g. distance between school and where alcohol is available, academic performance.

Item 29:

Classes missed because of alcohol and reaction towards students and teachers who drink.

Item 30-31:

These items assessed perceptions, opinions and knowledge about alcohol and its effects.

3.6.3 FORMAT OF THE QUESTIONNAIRE FOR TEACHERS:

First part of the questionnaire was personal particulars i.e. age, sex and marital status.

Item 1:

This requires teachers to state their teaching experience in the particular school.

Item 2-3:

Teachers were asked whether they suspected that some of their students drink and what made them suspect it.

Item 4-5:

Teachers were to state steps that they would take discovering that some students drink or what they would do in such circumstances.

Item 6:

This requires teachers to state the numbers of teachers in their particular school.

Item 7-8:

Teachers were to state the number of teachers that drink in their particular schools and how they know that their colleagues drink.

Item 9:

Required teachers to choose options or actions that should be taken against teachers who drink.

Item 10:

Required teachers to choose actions that should be taken against students who drink.

3.6.4 PILOT STUDY:

Polit and Hungler (1995:34) defined pilot study as a small-scale version, or trial run of the major study. Instruments such as questionnaires can be subjected to pilot testing in order to ascertain whether all respondents understand the questions in the same way, whether they understand the instructions and how relevant the questions are. In other words, pilot testing helps to increase the validity and reliability of the instrument such as questionnaire. In this study the pilot test of the questionnaire was done to determine clarity of questions, effectiveness of the instructions, completeness of the response sets, time required to complete the questionnaire and successfulness of data collection techniques.

3.6.4.1 THE RESULTS OF THE PILOT STUDY DONE AT ONE OF THE HIGH SCHOOLS:

The study included 48 Form E students but two of the questionnaires had to be discarded because they were half-filled. Data were then analyzed from 46 respondents. The respondents were between 16 and 26 years old with those who were 19 years old forming 39 percent of the group. They consisted of 13 female and 35 male students.

Out of the 46 respondents, 21 indicated that they have had alcohol drinks, in fact they have been drunk. This included 9 males and 12 females. One male indicated that he used dagga, while another indicated that he was also smoking. One male respondent further indicated that he once missed classes to go and drink. All males drink beer except 2 of which one drinks beer and spirits. Of the 21 respondents who drink, 11 belong to a Catholic Church, 7 belong to Lesotho Evangelical Church, and 2 belong to Anglican Church while one belongs to Methodist Church.

Out of 46 respondents, 33 indicated that their teacher drinks, they have seen them drunk/drinking. Three of the respondents added that the teachers smell liquor and one said that they come to school drunk. There are seven teachers in that school. Twenty-two respondents indicated that 3 of their teachers' drink, 10 said that 2 of the teachers drink while one said that 5 of them drink. This shows that even those students who do not drink have seen their teachers either drinking or drunk at some point. Almost all the students felt

that teachers who drink should be expelled from the school. Most of the students felt that teaching them about effects of alcohol would prevent them from drinking. Some said that liquor should not be sold to teenagers while others thought limiting the pocket money would prevent them from buying alcoholic drinks.

Responding to the question about reasons for drinking, 7 students said that they drink to please their friends, another 7 respondents said they drink to forget their problems, 4 respondents said they drink to have fun and 3 of them did not indicate reasons. Of the 21 respondents who drink, 16 indicated that their fathers drink, 2 indicated that their mothers drink as well while 6 indicated that their fathers drink and smoke. Out of 24 respondents who do not drink, 10 stated that their fathers drink.

Amongst those who drink, 4 indicated that all of their friends drink, 17 said that most of their friends drink and one said none of the friends drink. Five respondents indicated future drinking. This is amongst both those who drink and those who do not drink. It would be interesting to know why one feels that he will drink in future when he is not drinking now. The above result show that peer pressure is amongst major contributing factors to teenagers drinking.

This is confirmed by the fact that amongst those who do not drink fewer students indicated that their friends drink. However, those who do not drink, do not agree that teens get pressure from friends to drink alcohol.

Concerning smoking, 3 student respondents said that most of their friends smoke while 3 indicated that none of the friends smoke.

3.6.5 INTERVIEWS:

Interviews were also held with individual students and teachers. These are students that were in selected schools but were not included in the study. Though respondents answered the same questions that were on the questionnaire there was an opportunity to ask the respondents to elaborate, expand, clarify and illustrate their answers where and when necessary. Some questions can still be ambiguous even after making all efforts to construct them properly, so in interviews, the researcher was able to read the body language and take it as a cue to probe further. Furthermore, the respondents had opportunity to ask for clarification. There are no such opportunities in case of a self-report questionnaire.

Five students were interviewed, two females and three males from different schools. Teachers who were non-citizens were also interviewed using questions that were on the questionnaire for teachers. This is because only non-citizen teachers were not included in the sample that was to respond to the questionnaire. Only three teachers were interviewed, two males and one female. Information obtained from interviewees added ideas, confirmed opinions and clarified some interpretations to the data from respondents of the questionnaire.

3.6.6 FOCUS GROUP DISCUSSION:

The last method of collecting data was Focus Group Discussion (FGD). This is a discussion with a small group of people on a specific topic. It is highly efficient qualitative data collection in that, participants tend to provide checks and balances on each other that weed out false or extreme views (Patton 1990:335).

Knodel (1997:848), describes focus group discussion as follows:

“The technique” (focus group discussions) assembles a small group of individuals from the population to be studied in order to generate a discussion on preselected topics specified by the researcher.

A researcher follows prepared guidelines to introduce the issues to be discussed, asks open-ended questions to get the discussion underway, encourages participants to talk and interact with one another, and tries to keep the discussion on track.

According to Marshall and Rossman (1995:84) FGD allows the facilitator the flexibility to explore unanticipated issues as they arise in the discussion. They go on to say that the results of data collected through FGD have a high face validity because the method is readily understood and findings appear believable. However, there may be loss of time during FGD because of irrelevant issues. This is because the discussion is not strictly controlled. Only

one FGD was held. This is because the whole study is a learning experience and the researcher, as a student wanted to be involved in every step. The group consisted of eight parents, seven females and one male. This was a group of parents who were members of a social club, (Hloesanang Basali) whose main purpose is to generate money to be shared at the end of the year. The ultimate goal is education of their children. All parents had sons and daughters in high schools though they were in different schools. Elaborate notes were taken during the discussions particularly because no tape-recording was done.

Focus Group Discussion guidelines were also used to collect data particularly on the reasons for drinking and situations in which students drink. It was felt that students could freely discuss the mentioned issues. The information collected will give depth to the questionnaire results and act as comparative information.

3.7 COLLECTION OF DATA:

This is gathering of information needed to address a research problem (Pilot & Hungler 1991:643). In this study, data collection took place from March to July 1999. Preparations had been made in 1998 but because of the political unrest in the country, it took a while to start the actual task.

3.7.1 DATA COLLECTION FROM STUDENTS:

The researcher carried out the data collection exercise personally. The researcher took several steps to motivate students to participate and to tell the truth. Before classroom administration of the questionnaire, she described the procedure for answering the questions privately e.g. no access by teachers and parents. She also, after explaining the purpose of the questionnaire, strongly emphasized its anonymous nature, which minimized under reporting. It was also explained to the students, the right not to participate and that they could withdraw if they needed to do so.

Once subjects were selected, none withdrew but it became obvious that some students did not return the questionnaires that were distributed. This was done in class by the researcher to be filled in her presence. Students were asked to pile the questionnaires on the table as soon as they were through. The presence of the researcher was important because she was able to explain a few things that were not clear to some students, she made sure that students do not influence one another by discussing the questions. Questionnaires were immediately collected and this maximized response rate. This was further improved by the researcher promising to offer extra copies of the questionnaire to take home to those who wished to have them. However, the question of accuracy in giving information about alcohol by teenagers was difficult to deal with. It could be speculated that some youth, possibly those having the most difficulty with alcohol may provide inaccurate data, making reliable figures difficult to obtain (Estes, Smith-Difulo and Heinemann 1980:60).

In addition to collecting data on socio-demographic characteristics, the questionnaire contained several items covering consumption of alcohol and other illicit drugs. However, data from two schools, 2 and 7 respectively, (Form Ds) were wrongly processed, and therefore was not included in the analysis. In fact only data from Form E students have been reflected. Burns & Grove (1987:458) warn researchers against such instances.

“If the data entered into the computer are garbage (e.g. numbers from the data are typed in incorrectly or data typed into the wrong columns), the computer output will be garbage, and the researcher’s work may be completely in error”.

3.7.2 DATA COLLECTION FROM TEACHERS:

As indicated earlier on, questionnaires were distributed amongst teachers in their offices and in some cases on the school compound outside their offices. Explanations about confidentiality were done to individual teachers as they were to be collected later that day or any other day. Most of the questionnaires were given to teachers the day the researcher had to collect data from students. That was a convenient time as some teachers actually helped in assembling students for the exercise. Teachers who were Lesotho citizens and were available at the time when the researcher was at the school were given questionnaires. Thirty-three questionnaires were distributed amongst teachers, but only ten were collected and analyzed. These were from different schools that were included in the study. It is obvious that no questionnaires were collected from some schools.

3.7.3 COLLECTION OF DATA FROM PARENTS:

Focus group discussion (FGD) guideline was used to collect data from parents, in particular data on reasons for drinking and situation in which students drink. Much as this study is mainly based on quantitative data, it was necessary to get information through FGD since it involves talking to people without much restriction on what answers to give and what to say. FGD was meant to supplement and fill the gaps that cannot be explained fully by the quantitative analysis. It is also good in gathering information on attitudes, options and generalized descriptions of behaviour.

Parents are a valuable source of information regarding the behaviour of their children. Parents discussed alcohol use by teenagers freely on the day of their usual meeting. That had been explained to them and therefore had no problem having an extra item on their agenda that day. The researcher noted major points as the discussions were going on.

3.8 DATA ANALYSIS:

Data analysis was conducted to reduce, organize and give meaning to the data. This was determined by the research objectives and questions. Data were coded and entered into the computer software package, the Statistical Package for Social Sciences (SPSS). Descriptive and exploratory statistics such as frequencies and percentages were used to analyze research questions such as, what is the proportion of high school students who use alcohol, what is the

attitude of teachers, parents and students towards students who use alcoholic drinks and other substances. Same analysis techniques were used to describe and summarize the data. Qualitative aspect of data was also analyzed appropriately.

3.9 RELIABILITY AND VALIDITY:

There are many different methods of measuring research variables and collecting data. Each method has a number of strengths as well as weaknesses. Methods to formally assess the frequency of data collection instruments have been devised. Arguments about the quality of instruments used in order to draw conclusions about the study findings must be made; therefore reliability and validity of the methods used in a research process must be considered (Pilot & Hungler 1985:237).

3.9.1 RELIABILITY:

According to Parahoo (1997:397) reliability refers to the consistency of a particular method measuring or observing the same phenomenon. In other words it is concerned with how consistently the measuring technique measures the concept of interest. Reliability is concerned with such characteristics as dependability, consistency, accuracy and comparability (Burns & Grove 1997:219). It can be equated with stability, consistency or dependability of measuring tool (Pilot & Hungler 1985). The reliability of measuring tool can be assessed in different ways. The method chosen depends to a certain extent on the

nature of the instrument but also on the aspect of the reliability concept that is of greatest interest.

In this study, a pilot project was done in one of the high schools in Maseru City, which was not included in the study. This was to allow the researcher to determine the reliability of the measuring instrument. The questionnaire for students was based on MAST. It was modified, discussed with the promoters, then corrections made accordingly. Questionnaire developed for the teachers was also based on MAST, pre-tested and adjustments done accordingly.

3.9.2 VALIDITY:

According to Polit and Hungler (1991:367) validity refers to the degree to which an instrument measures what it is supposed to be measuring. They go on to say that validity of instrument is a determination of the extent to which the instrument actually reflects the abstract construct being examined. It has been indicated in the previous section that a pilot test was done among a group of students in one of the high schools in Maseru city. With any pilot test, the subject and techniques should be as similar to those planned for the large group regarding administration of the questionnaire such as the time it will take to complete, and the presence of confusing information. It may also help the researcher to use data collected at this time to evaluate entry and analysis methods that are planned for the large study (Burns & Grove 1997:52), this further strengthens validity claims. In fact, pilot study examines the reliability and validity of the research instruments. The consistency in the way the

questionnaire is administered, is important to validity (Burns & Grove 1997:362). Ethical considerations that were implemented hopefully made students, more comfortable so that they gave valid and reliable information.

3.10 ETHICAL CONSIDERATIONS:

In dealing with human beings in research situations, a number of ethical issues must be raised (Polit & Hungler 1987:16). There are three common ethical requirements that need to be considered in each study. These are voluntary participation, freedom from physical or psychological harm and distress, anonymity or confidentiality of information. In this study, those issues were catered for in the following manner:

- Permission was required from the National Research Committee to allow the researcher to conduct the study. The committee in turn advised the researcher to ask for permission from the Ministry of Education, as the study needed participation from both the students and teachers. Head teachers were also approached for permission to allow the students and teachers to spend some time responding to the questionnaire. This was done through written communication.
- Before the questionnaire was administered to both students and teachers, their permission was also sorted so that they could respond voluntarily. They were assured that their information would remain anonymous and would be treated with utmost

discretion. Teachers in particular were told that information was not going to be analyzed individually that is according to individual school. Both teachers and students were asked not to write their names on the questionnaire.

Teachers were also asked not to be present during the discussion with the students in order to reduce fear of punishment. Head teachers were not included in the discussions with teachers.

3.11 SUMMARY:

This chapter has reflected the research process that was followed when conducting this study. Selection of the subjects and methods of collecting data from various groups have been discussed at length. The chapter also outlines a brief explanation of how data have been analyzed as well as the validity and reliability of the methods and instruments used. Highlighting the ethical considerations that were followed during the research process concludes it.

CHAPTER 4

ANALYSIS AND INTERPRETATION

This chapter addresses the quantitative data gathered from students. Gathering of data was done as stated in chapter 3, through interviews, observations and questionnaires. An integration of both quantitative and qualitative analysis is important given their enriching nature when they are judiciously blended together (Polit & Hungler 1991:517). They are complementary, that is they mutually supply each other's lack. Each method has its own strengths and weaknesses, therefore integration of different methods and modes of analysis may diminish or overcome weaknesses of a single approach.

Although both methods constitute alternative ways of viewing and interpreting the world, they are not necessarily correct or incorrect but reflect what is actually happening. The blending of quantitative and qualitative data in a single analysis can lead to insight on the multiple aspects that might be unattainable without such integration (Polit & Hungler 1991:518). It is further indicated that a combination of the two methods reveals the potential for enhancements to the validity of the study findings.

As stated earlier, this section will deal specifically with the quantitative analysis. Subsequently qualitative analysis will be addressed. Data analysis will be based on and follow or answer the research objectives and questions that have been stated and asked in Chapter 1.

The following sequence will therefore be followed:

1. Proportion of high school students using alcoholic drinks.
2. Influencing factors for high school students to use alcoholic drinks, that is factors that predispose teenagers to use alcohol, factors that enable them to use alcohol as well as factors that reinforce the behaviour.
3. Students', teachers' and parents' perceptions on use of alcoholic drinks by teenagers.
4. Whether health education programme can be developed as an intervention strategy.

CHARACTERISTICS OF THE SAMPLE:

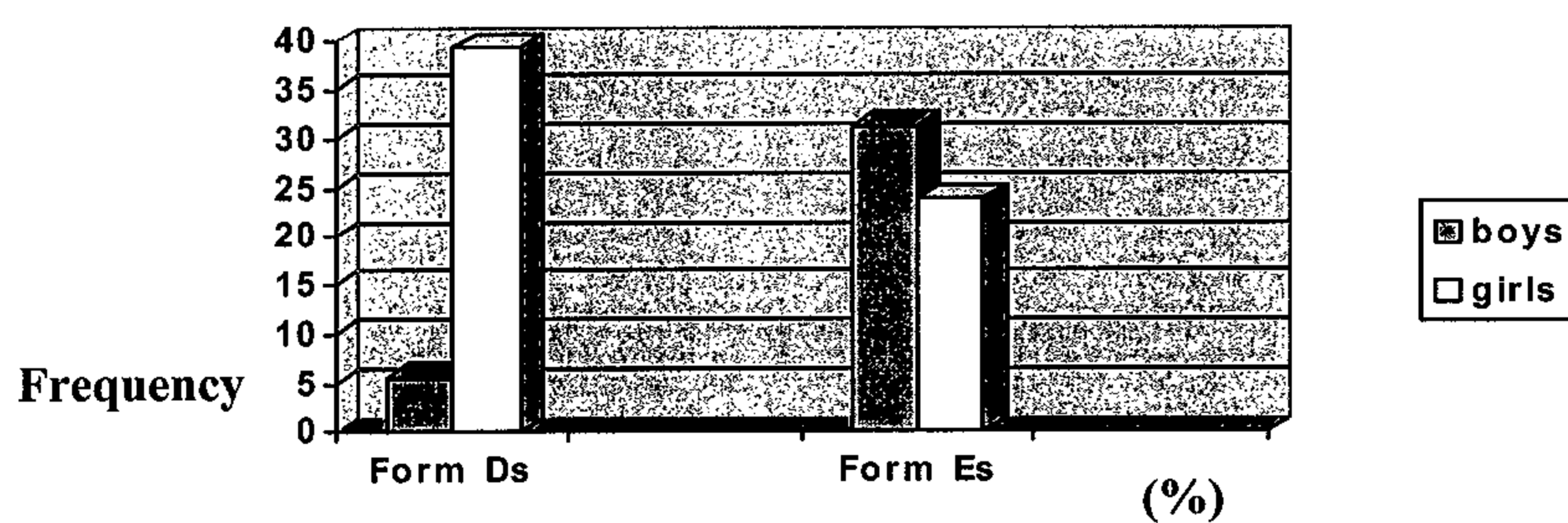
This section describes the characteristics of the student's sample for the study. The table below shows the respondents by grade and sex.

Table 4.1: Showing Sex of Sample Students:

| GRADE | BOYS | GIRLS | TOTAL |
|--------------|-------------|--------------|--------------|
| FORM Ds | 23 | 162 | 185 |
| FORM Es | 129 | 98 | 227 |
| TOTAL | 152 | 260 | 412 |

The analysis revealed that 23(5.6%) boys and 162(39.3%) girls respectively from Form D participated in the survey, while 129(31.3%) boys and 98(23.8%) girls respectively from Form E participated in the survey. On the whole 227(55.1%) Form E students and 185(44.9%) Form D students participated in the study. This analysis is further presented in pictorial form via histogram as shown in figure 4.1 below.

Fig 4.1 CLASS BY SEX OF RESPONDENTS N=412



RESPONDENTS BY AGE:

The target group for the study is teenagers; therefore age of the respondents was investigated. It could be observed that the majority 344(83.6%) of respondents fall between the ranges of 16-19 years of age as shown in table 4.2 below. This implies that schools, in particular high schools level, are correct settings for studies on teenagers.

TABLE 4.2 RESPONDENTS BY AGE N=412:

| AGE | FREQUENCY | PERCENTAGE |
|--------------|------------------|-------------------|
| 16-19 | 344 | 83.6 |
| 20-23 | 62 | 15.2 |
| 24-27 | 6 | 1.2 |
| TOTAL | 412 | 100 |

RELIGIOUS AFFILIATIONS:

Researcher exposed the religious affiliation of the respondents. This is to know whether there is any influence of religion on alcohol use. The results of the analysis of the responses of the students are as shown below.

Table 4.1: Showing Sex of Sample Students:

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Fig 4.1 CLASS BY SEX OF RESPONDENTS N=412

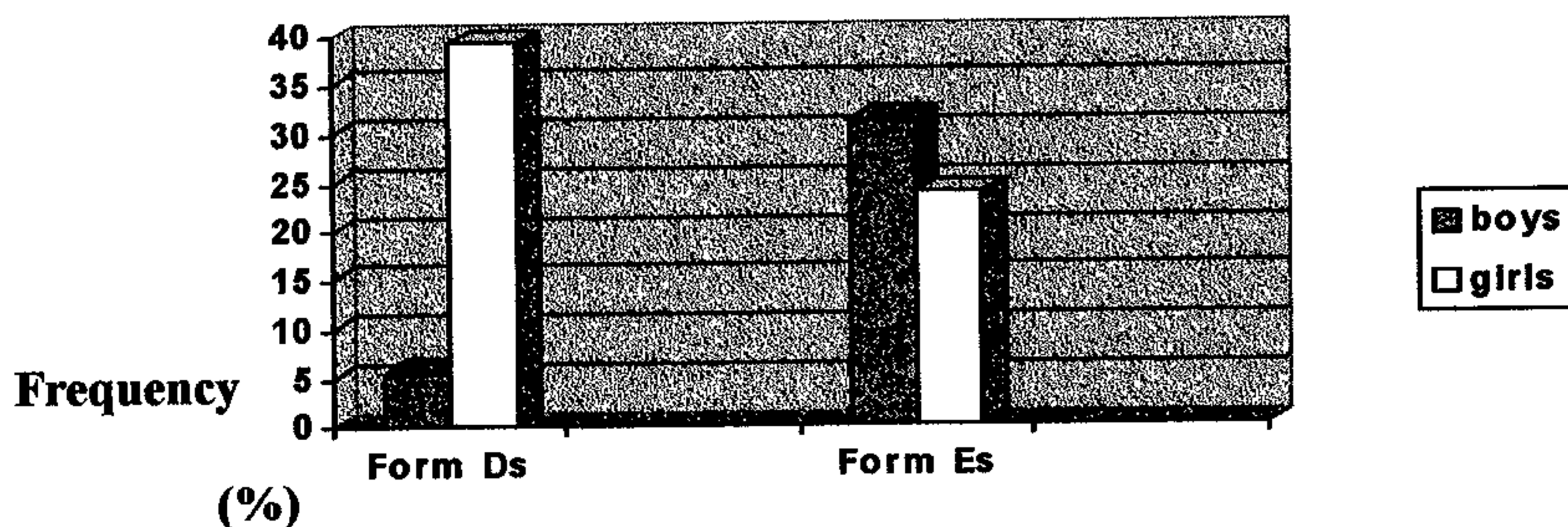


TABLE 4.3 RELIGIOUS AFFILIATIONS N=412:

| CHURCH | FREQUENCY | PERCENTAGE |
|----------------------------|------------------|-------------------|
| Roman Catholic | 152 | 37 |
| Lesotho Evangelical Church | 161 | 39 |
| Lesotho Anglican Church | 44 | 10.7 |
| Other | 55 | 13.3 |
| TOTAL | 412 | 100 |

This analysis revealed that respondents belong to different denominations regardless of the school they were attending. They mainly consisted of students belonging to Roman Catholic Church, Lesotho Evangelical Church, Lesotho Anglican Church and others. Denominations such as Zion Church of Christ, Seventh Day Adventist and Methodist were classified under others and they constituted 13 percent (55) of the sample.

FAMILY INCOME:

Financial ability to buy alcoholic drinks because one can afford to do so may be one of contributing factors to teenagers' use of alcohol. Students may be given too much pocket money and tend to misuse it. Family income (father's and mother's occupation) was therefore assessed so as to find out whether respondents get extra money, may be in the form of pocket money to buy alcoholic drinks.

TABLE 4.4 FATHER'S OCCUPATION N=412:

| FATHER'S OCCUPATION | FREQUENCY | PERCENTAGE |
|--------------------------------|------------------|-------------------|
| Self-employed | 119 | 28.9 |
| Civil servant | 131 | 31.8 |
| Private practice | 55 | 13.3 |
| Other | 40 | 9.7 |
| No response | 67 | 16.3 |
| TOTAL | 412 | 100 |

The analysis revealed that 67(16.3%) of the respondents did not indicate their fathers' occupation. This is probably because 103(25%) of them are from single parent families, separated, divorced and widowed parents.

Table 4.4 shows 119(28.9%) respondents who indicated their fathers' occupation as self-employed, 131(31.8%) who are civil servants, 55(13.3%) in private practice and 40(9.7%) respondents who indicated their father's occupation as falling under "other". This includes those who are not working at all or those who depend on getting jobs on and off.

MOTHERS' OCCUPATION:

Respondents' mothers' occupation was also investigated. The data in relation to this is as presented below.

TABLE 4.5 MOTHER'S OCCUPATION N=412:

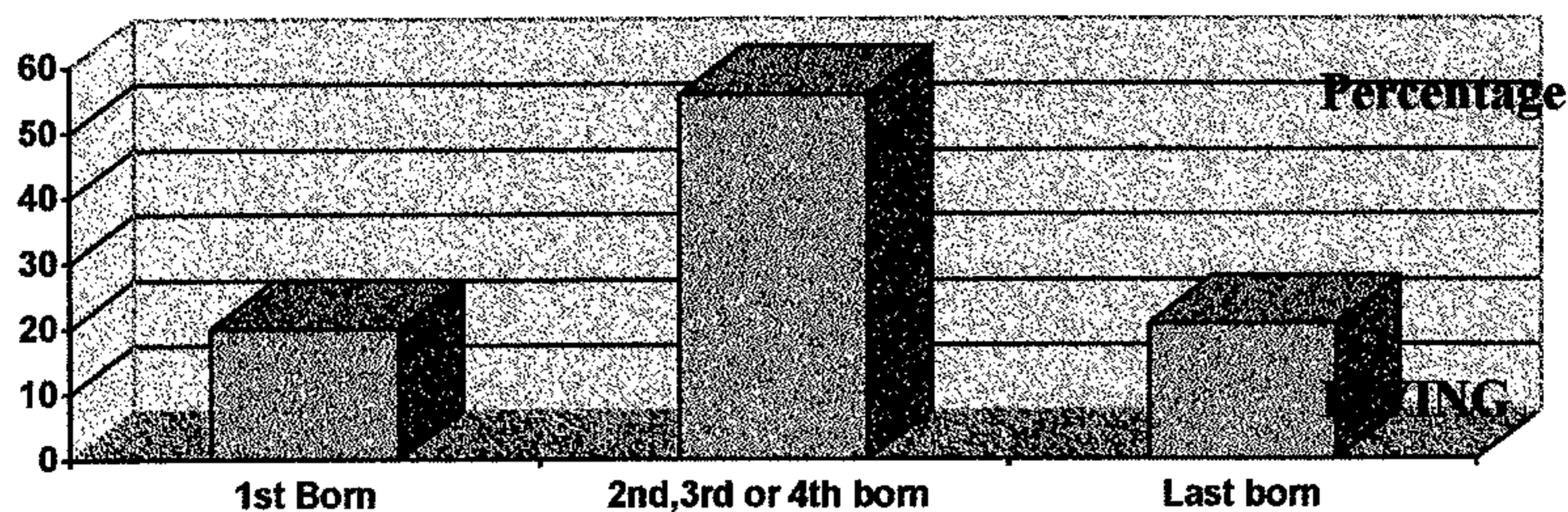
| MOTHER'S OCCUPATION | FREQUENCY | PERCENTAGE |
|--------------------------------|------------------|-------------------|
| Self-employed | 112 | 27.2 |
| Civil Servants | 129 | 31.3 |
| Private practice | 35 | 8.5 |
| Housewives | 107 | 26.0 |
| Other | 15 | 3.6 |
| No response | 14 | 3.4 |
| TOTAL | 412 | 100 |

Regarding mothers' occupation, only 14(3.4%) respondents did not respond to that item, probably for the same reason as for fathers' occupation. The analysis further revealed 112(27.1%) respondents who indicated their mothers' occupation as self-employment, 129(31.3%) Civil Servants, 35(8.5%) in private practice. Out of 398 respondents, 122(29.6%) indicated that their mothers' occupations fall under "other", this includes mothers who are housewives 107(26%).

Family size has an impact on the quality of life. For instance, it is harder to feed more mouths than a few. Respondents were therefore asked to indicate the size of their families. To this item, 8(20%) did not respond. Probably those are students who are from single parent families, 66(16%) respondents are between 1-3 in the family while 338(82%) are between 4-6 in their family.

Order of birth of a child can also influence his or her life. If first born is a boy, he is supposed to inherit the family's property upon death of the parents. Also culturally, the last born gets the "lion's share" of the parents property as he stays with them and takes care of them longer, or is the last one to leave the family to be on his own. The respondents were therefore asked to indicate their order of birth in the family. About 3 percent (15) of the respondents did not complete this item. Out of the remaining 397 respondents, 62(20%) are either second, third or forth born while 85(20.6%) are last born as illustrated in figure 4.2.

Fig 4.2 BIRTH ORDER OF RESPONDENTS N=412:



LIVING SITUATION:

Respondents were asked to indicate where they live and whom they live with during the school terms. This is because where students or teenagers live and who they live with may have an influence on their lifestyle. For instance, teenagers who live with their parents are likely to be guided and advised when necessary, whereas those who live away from home and with friends could be exposed to risky behaviours. In Lesotho, after constant strikes by students, especially boarding schools in 1980s, many schools closed down their boarding facilities. This led to students living with friends, siblings, relatives or one parent during school term. Table 4.6 shows respondents living situation.

TABLE 4.6 LIVING SITUATION (WHO DO YOU STAY WITH DURING SCHOOL TERM?):

| | FREQUENCY | PERCENTAGE |
|-------------------|------------------|-------------------|
| Parents | 300 | 72.8 |
| Other Students | 67 | 16.3 |
| Relatives | 26 | 6.3 |
| Grandparents | 10 | 2.4 |
| No response | 9 | 2.2 |
| Total | 412 | 100 |

Responses about living situation, in particular “who do you stay with during school term?” revealed that 300(72.8%) students stay with their parents during school time, 67(16.3%) students stay with other students, (this may be at the boarding facility or rented place), 26(6.3%) students stay with relatives while 10(2.4%) students stay with grandparents. On the whole it seems like this days, living with parents during school time is common particularly amongst younger students.

Further analysis reveals that 332(80.6%) students stay at home but that does not necessarily mean that they are staying with their parents. They may be staying with either siblings, relatives or staying with one parent or grand parents. Other students 65(15.8%) live in rented

places, 12(2.9%) students stay at the boarding school while only 3(0.7%) students indicated other (private accommodation). However, the issue of the place to stay for a student and who stays with him or her is very complicated in Lesotho, and yet has a great impact on the lifestyle of a teenager.

PREVALENCE OF ALCOHOL USE:

Alcohol abuse has touched every corner of the world. The traditional use of alcohol in rites and ceremonies is giving way to drunkenness. It is usually the high school, college and university students who take to drink because it is fashionable. Alcoholism is therefore a growing problem among the school age population (Watson 1989:182).

Respondents were asked whether they drank alcohol and also to indicate their drinking habit.

The analysis is as presented in figure 4.3, next page.

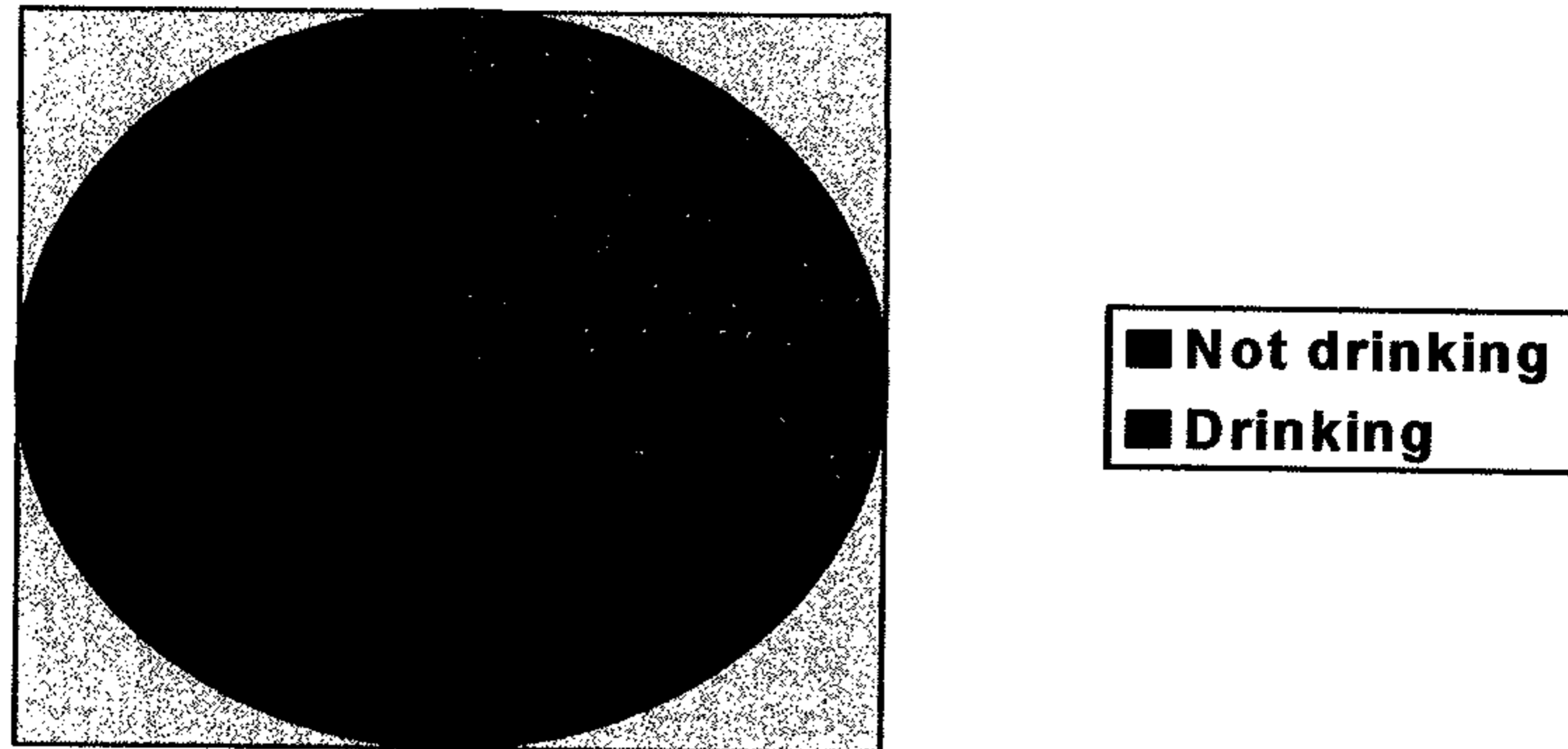


Fig 4.3 Proportion of students who drink N=412:

Out of 412 students, 276(67.2%) answered “yes” to the question “Have you ever had an alcoholic drink?” The rest of the students said no to the question.

HOW MANY TIMES HAVE YOU BEEN DRUNK IN YOUR LIFETIME?

In order to confirm that students actually drink, not just take a sip in traditional ceremonies or in church, they had to indicate the number of times when they were drunk. Only 243 students responded to this item, 33 students did not respond, probably because though they have had an alcoholic drink, they never actually got drunk. The responses are presented in table 4.7, next page.

TABLE 4.7 FREQUENCY OF BEING DRUNK IN A LIFETIME N=243:

| FREQUENCY | NUMBER | PERCENTAGE |
|------------------|---------------|-------------------|
| 1-5 times | 145 | 59.6 |
| 6-10 times | 34 | 14.0 |
| 11-15 | 15 | 6.2 |
| 16-20 | 49 | 20.2 |
| TOTAL | 243 | 100 |

Out of 243 students, 145(59.6%) students indicated that they have been drunk 1-5 times, 34(14%) students indicated being drunk 6-10 times in their lifetime, while 15(6.2%) students indicated that they have been drunk 11-15 times, and 49(20.2%) indicated that they have been drunk 16-20 times in their lifetime. The analysis shows that students actually drink and this causes a great concern, taking into account that they are still in school and need to further their studies.

AMOUNT OF ALCOHOL CONSUMED BEFORE GETTING DRUNK:

To further investigate the drinking habit of the students, they were asked to indicate the amount of alcohol they consume before they feel drunk. The analysis of the responses is presented in table 4.8 below.

TABLE 4.8 AMOUNT OF ALCOHOL CONSUMED BEFORE GETTING DRUNK:

| AMOUNT OF ALCOHOL | FREQUENCY | PERCENTAGE |
|--------------------------|------------------|-------------------|
| 1-2 Glasses | 115 | 47.3 |
| 3-5 Glasses | 56 | 23.0 |
| 6-8 Glasses | 72 | 29.7 |
| TOTAL | 243 | 100 |

Out of 243 students, 115(47.3%) indicated that 1 to 2 glasses are enough to make them drunk, 56(23.0%) students indicated 3 to 5 glasses of alcoholic drink while 72(29.7%) of them indicated that they feel drunk after drinking 6 to 8 glasses. However a few students did actually indicate that they need more than eight glasses of alcoholic drink in order to be drunk. This is unfortunate because as Landy (1995:35) says, with alcohol, little may be too much.

GENDER COMPARISON OF LEVEL OF ALCOHOL CONSUMPTION:

The literature that has been reviewed reveals that differences in drinking rates between sexes have all but disappeared. The most significant recent change in patterns of drinking has been the great increase in drinking by girls (Acuda 1995:24). This fact was investigated by finding out the proportion of females who are drinking as compared to the males who are drinking. Comparison of the level of drinking by both male and female respondents is demonstrated in table 4.9 below.

TABLE 4.9 DRINKING BY GENDER N=412:

| GENDER | DRINKING | % | NOT DRINKING | % | TOTAL | % |
|---------------|-----------------|------------|-------------------------|-----------|--------------|----------|
| Boys | 126 | 83 | 26 | 17 | 152 | 100 |
| Girls | 151 | 58 | 109 | 42 | 260 | 100 |
| TOTAL | 277 | 141 | 133 | 59 | 412 | |

Out of 260 female respondents, 151(58%) indicated that they already drink alcoholic beverages while 109 is not using any form alcohol. The figure (58%) is extremely high given the fact that in the past, females never drank in traditional Basotho culture. In fact in the past, it was unheard of for any woman or girl child to be seen drunk or drinking in any setting. The percentage of schoolgirls who drink is high and should not be condoned, especially given the consequences of alcohol consumption in relation to health problems. Also recent

scientific studies show a very high correlation between alcohol consumption and the incidence of sexually transmitted infections (STIs). It is equally disturbing to note the high incidence of alcohol consumption among male students as shown in table 4.9(83%).

PREFERENCE ON ALCOHOLIC DRINK:

It seems like preference on alcoholic drink depends on gender. When respondents were asked to indicate the type of alcoholic drink that they prefer, the majority of boys who consumed alcohol preferred to drink beer and whisky, whereas girls showed high preference for wine. The analysis is presented in table 4.10 below.

TABLE 4.10 PREFERENCE OF ALCOHOLIC DRINKS:

| ALCOHOLIC DRINK | BOYS | % | GIRLS | % |
|------------------------|-------------|-------------|--------------|-------------|
| Beer | 75 | 59.7 | 20 | 13.4 |
| Wine | 51 | 40.3 | 131 | 86.6 |
| TOTAL | 126 | 100% | 151 | 100% |

Out of 126 male students who drink, 75(59.7%) showed interest in beer while 51(40.3%) preferred wine and other types of alcoholic drinks including home made brew (taken by 9 respondents). Also out of 151 females students who drink, 131(86.6%) indicated that they drink wine while the rest take beer and other types of alcoholic drinks.

DRINKING VS ALCOHOL GROSS TABULATION N=412:

Comparison on alcohol consumption was made between the two levels of high school education, that is between Form D and E. Table 4.11 presents class alcohol cross tabulation.

TABLE 4.11 CLASS ALCOHOL GROSS TABULATION N=412:

| CLASS | DRINKING | % | NON- DRINKING | % |
|--------------|-----------------|----------|--------------------------|----------|
| Form Ds | 107 | 57.8 | 78 | 42.2 |
| Form Es | 165 | 72.7 | 62 | 27.3 |
| TOTAL | 272 | | 140 | |

The analysis shows that more students in Form E drink than students in Form D, 107(57.8 %) drink whereas out of 227 Form E students, 165(72.7%) drink. It would be interesting to find out whether Form E students drink because of stress due to final years work or other reasons.

RELIGION AFFILIATION VS DRINKING HABITS:

The influence of religion affiliation and drinking habits was investigated. The findings of the investigation are as presented in table 4.12 next page.

TABLE 4.12 RELIGIOUS AFFILIATION AND ALCOHOL DRINKING N=347:

| RELIGION | DRINKING | % | NOT DRINKING | % | TOTAL % |
|--------------------|-----------------|----------|-------------------------|----------|--------------------|
| RCC | 87 | 68 | 41 | 32 | 100 |
| LEC | 92 | 68.1 | 43 | 31.9 | 100 |
| ACL | 30 | 78.9 | 8 | 21.1 | 100 |
| OTHER RELIGIONS | 31 | 67.4 | 15 | 32.6 | 100 |
| TOTAL | 240 | | 107 | | 100 |

When relating religious affiliation to drinking habits, there was no significant difference found. From the analysis of 347 responses, it seems religion does not have a strong influence on non-use of alcohol. The narrative statement that will be cited later in the discussions confirms this.

Information about religious affiliation and drinking habits from 65 respondents was a bit confusing, as it was either contradictory or incomplete; therefore it was excluded from the analysis.

Lesotho is a Christian country, so even those who attended community, or government schools belong to one religious affiliation or other. Born and Fox (1993:27) say that religious

affiliation does not seem to be a strong deterrent against drinking among the adolescent population. The researcher's observation is that only the drinking pattern is influenced by religious affiliation. The result of this analysis shows that there is no relationship between religious affiliation and drinking. The influence or non-influence of religious affiliation on alcoholic drink intake was further confirmed by the response to the statement "when do you always drink?" Some students, who drink responded this way, "I usually drink after church or I drink on Sunday". Further analysis showed that among students who drink 66.9 percent reported that they drink with some regularity, that is daily, weekly and monthly. These responses are alarming because most schools belong to churches and traditionally, churches discourage alcohol use.

COMMENCEMENT OF DRINKING AMONG RESPONDENTS:

A comparison of alcohol use with age revealed that learning to use alcohol begins quite early in life. It was found that 83.6% of the respondents are between 16-19 years of age while only 1.2% is between 24 to 27 years of age. Table 4.13 below shows age when students started drinking.

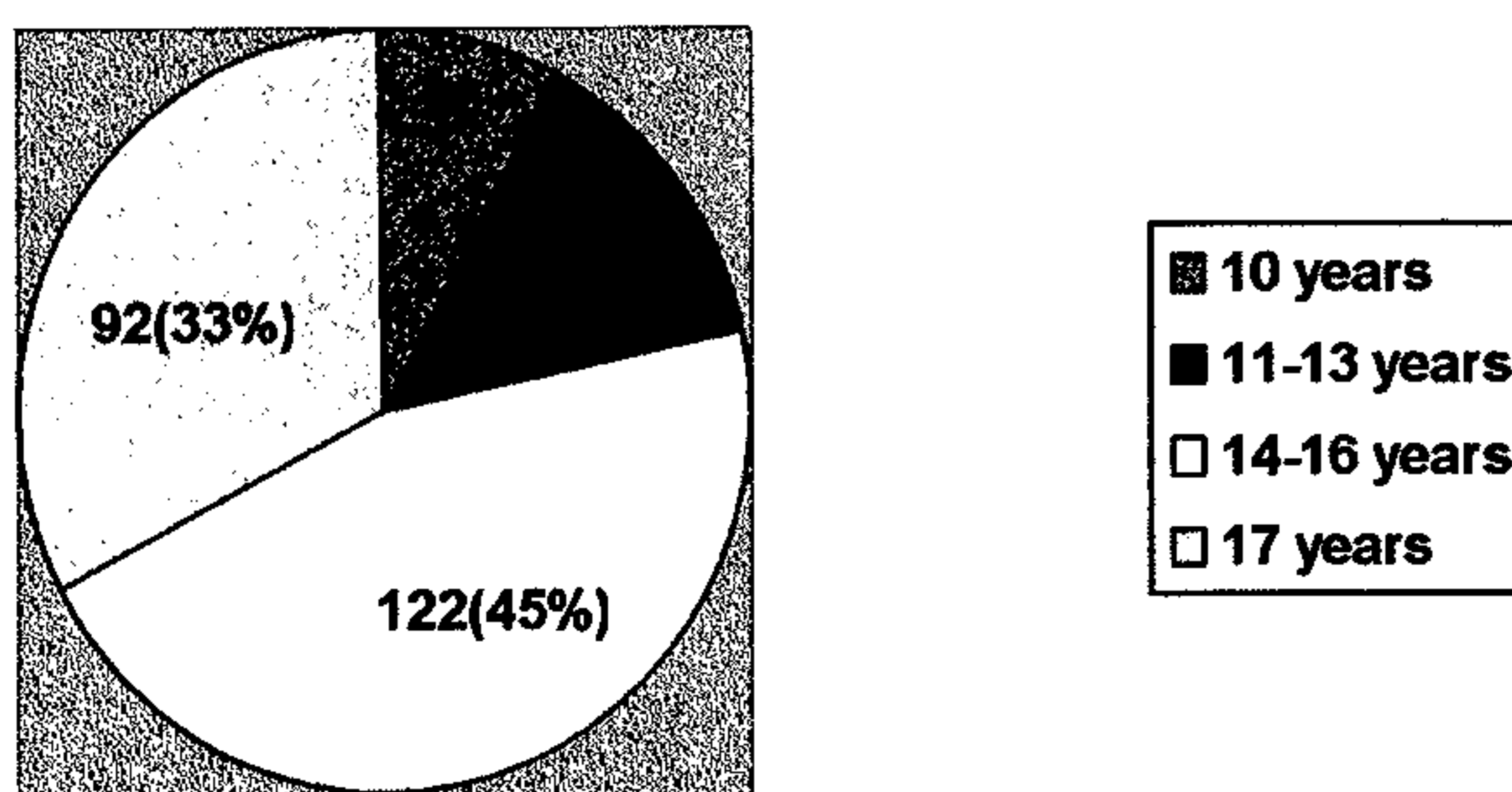
TABLE 4.13 COMMENCEMENT OF DRINKING BY RESPONDENTS:

| AGE | FREQUENCY | PERCENTAGE |
|--------------|------------------|-------------------|
| 10 years | 23 | 8 |
| 11-13 | 39 | 14 |
| 14-16 | 122 | 45 |
| 17 years + | 92 | 33 |
| TOTAL | 276 | 100 |

Table 4.13 shows that 23(8%) students started drinking when they were 10 years old, 39(14%) were 11 to 13 years old. The majority of students 122(45%) started drinking when they were between 14 to 16 years of age and 92(33%) when they were 17 years and older. The above finding was further translated into graphical form as shown in figure 4.3 below.

Fig 4.4 COMMENCEMENT OF DRINKING AMONG RESPONDENTS:

N=276:



This analysis causes a great concern because as Dr Nakajima (Director General of World Health Organization) (1995:3) once said habit-forming exposure to alcohol can start at a very early age, with grave consequences for health in later life.

TENDENCY TO DRINK FOR NON-DRINKERS:

Among those students who do not drink, 62(25%) indicated that they would drink in future. Perhaps the reason is that at present they may be under a strict parent who may not condone drinking. Hence they feel that when they are old and independent, they will drink.

FACTORS INFLUENCING ALCOHOL INTAKE:

This section presents the influencing factors to alcohol use by teenagers. These include factors that predispose them to alcohol use, factors that enable them to use alcohol as well as those that reinforce the behaviour.

MOTIVES FOR DRINKING:

Many different reasons are usually given by young people when they are asked for reasons why they drink. They say that they like the way alcohol helps them relax, forget worries, relate to people or have more fun (Watson 1989:28). This is probably to mask the real reasons for drinking and to state them in a way that will make them comfortable. Experience

from the pilot study has shown that only a small minority of adolescents may report that they drink because they are unhappy, depressed or angry.

Respondents were asked to indicate why they drink alcohol. The responses are given on Table 4.14.

TABLE 4.14 REASONS FOR DRINKING ALCOHOL: N=276:

| REASONS | FREQUENCY | PERCENTAGE |
|---------------------------|------------------|-------------------|
| To please friends | 29 | 10.5 |
| To forget problems | 22 | 8.0 |
| To have fun | 161 | 58.3 |
| Relaxation, avoid shyness | 30 | 10.9 |
| Combination of all | 7 | 2.5 |
| No response | 27 | 9.8 |
| TOTAL | 276 | 100 |

The analysis revealed that the majority of students 161(64.8%) drink for fun. This is supported by the majority 149 students who agreed that getting drunk is fun, this is data analysed somewhere in this section. The category of “others” which includes relaxation and avoiding shyness, ranks second in the list of reasons why teenagers use alcoholic drinks. It is

followed by pleasing friends 29(11.6%), forgetting problems 22(8.8%) and a combination of all, 7(2.8%), this means respondents indicated all reasons stated for drinking. The percentage of students who indicated all reasons may seem insignificant, but it shows that young people or teenagers have a number of challenges facing them.

FEELING WHEN DRUNK:

Respondents were asked how they feel when they are drunk. The responses are presented in table 4.15 below.

TABLE 4.15 FEELING WHEN DRUNK:

| FEELING | FREQUENCY | PERCENTAGE |
|----------------|------------------|-------------------|
| Happy | 149 | 54.0 |
| Relieved | 25 | 9.0 |
| Depressed | 5 | 1.8 |
| Sorry | 46 | 16.7 |
| Combination | 27 | 9.8 |
| No response | 24 | 8.7 |
| TOTAL | 276 | 100 |

The above analysis revealed that 149(54%) students feel happy when drunk. Feeling sorry and relieved of stress followed other feelings, when respondents are drunk. Some students

27(9.8%) indicated a number of feelings they have when they are drunk. This probably depends on why they are drinking at the particular time, that is whether it is because of stress, to please friends or to have fun. There was no response to this item from 24(8.7%) students.

USE OF OTHER DRUGS:

Literature reveals that there is moderately strong positive correlation between alcohol and tobacco consumption that applies across various demographic variables, age, race and socio-economic status. This is why respondents were asked whether they use other drugs and if yes, they should specify the type of drug they used. Quite a sizeable number of the respondents' (55) did not respond to this question. However, 61(17.7%) did indicate that they use other drugs though most of them did not specify the particular drug they were using. Very few said that they have tried dagga just to experiment the feeling while a few others used cigarette.

DISTANCE BETWEEN SCHOOL AND PLACE WHERE ALCOHOL IS AVAILABLE:

As mentioned earlier in chapter 1, in Lesotho there is one big brewing company, which distributes alcoholic drinks all over Maseru city, there are many liquor restaurants, bars, shebeens, liquor stores all over the town, and most of the schools are not very far from such

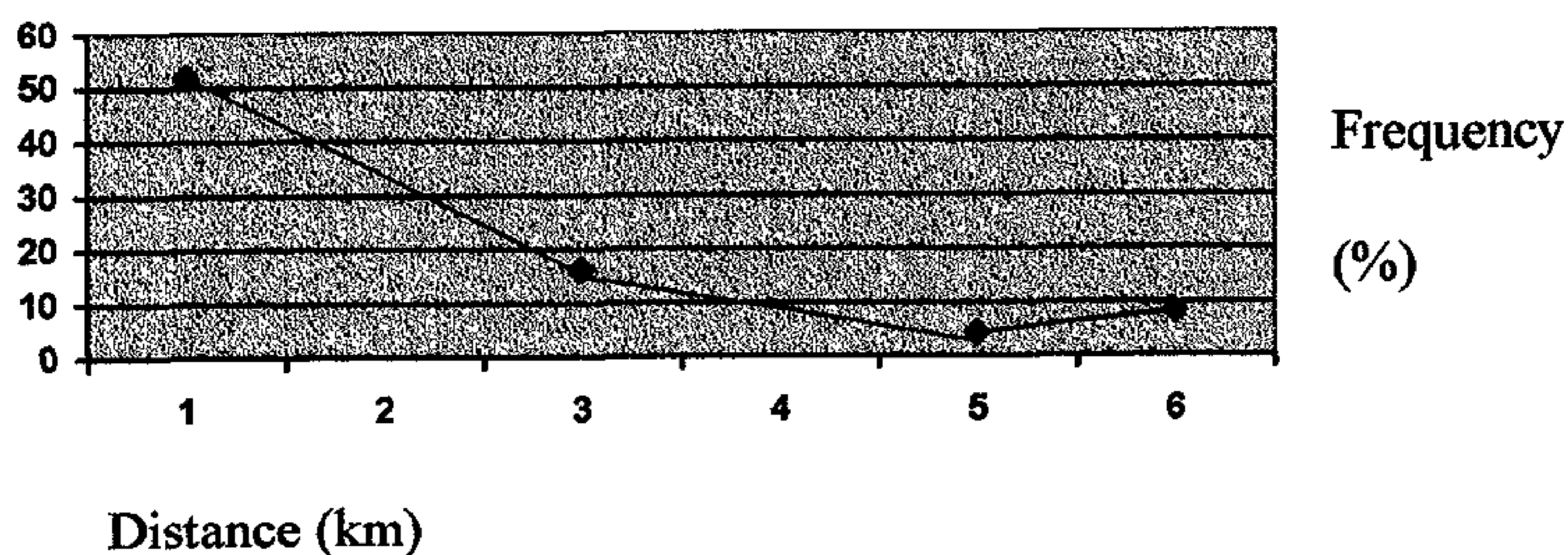
places. It was deemed necessary to find out the distance between the students' school and a place where liquor is sold. The data in relation to this is as presented in the table 4.16 below

TABLE 4.16 DISTANCE FROM STUDENTS' SCHOOLS AND ALCOHOL STORES:

| DISTANCE | FREQUENCY | PERCENTAGE |
|-----------------|------------------|-------------------|
| 1 km | 214 | 51.9 |
| 2-3 km | 67 | 16.3 |
| 4-5 km | 18 | 4.4 |
| 6 km + | 34 | 8.3 |
| Don't know | 79 | 19.1 |
| TOTAL | 412 | 100 |

The majority of the students 214(51.9%) indicated that their school is less than 1 kilometre away from a place where alcoholic drinks are available. These could be a bar, shebeen or liquor restaurant. This was followed by 67(16.3%) students who indicated 2 to 3 kilometres between school and a place where alcohol is sold. About 18(4.4%) students indicated 4 to 5 kilometres away from alcohol place. Out of 412 students, 79(19.1%) did not know the distance between their school and the place where alcoholic drinks are sold. Further analysis was presented in the form of graph in figure 4.4 next page.

Fig 4.5 DISTANCE FROM STUDENTS' SCHOOL AND ALCOHOL STORE:



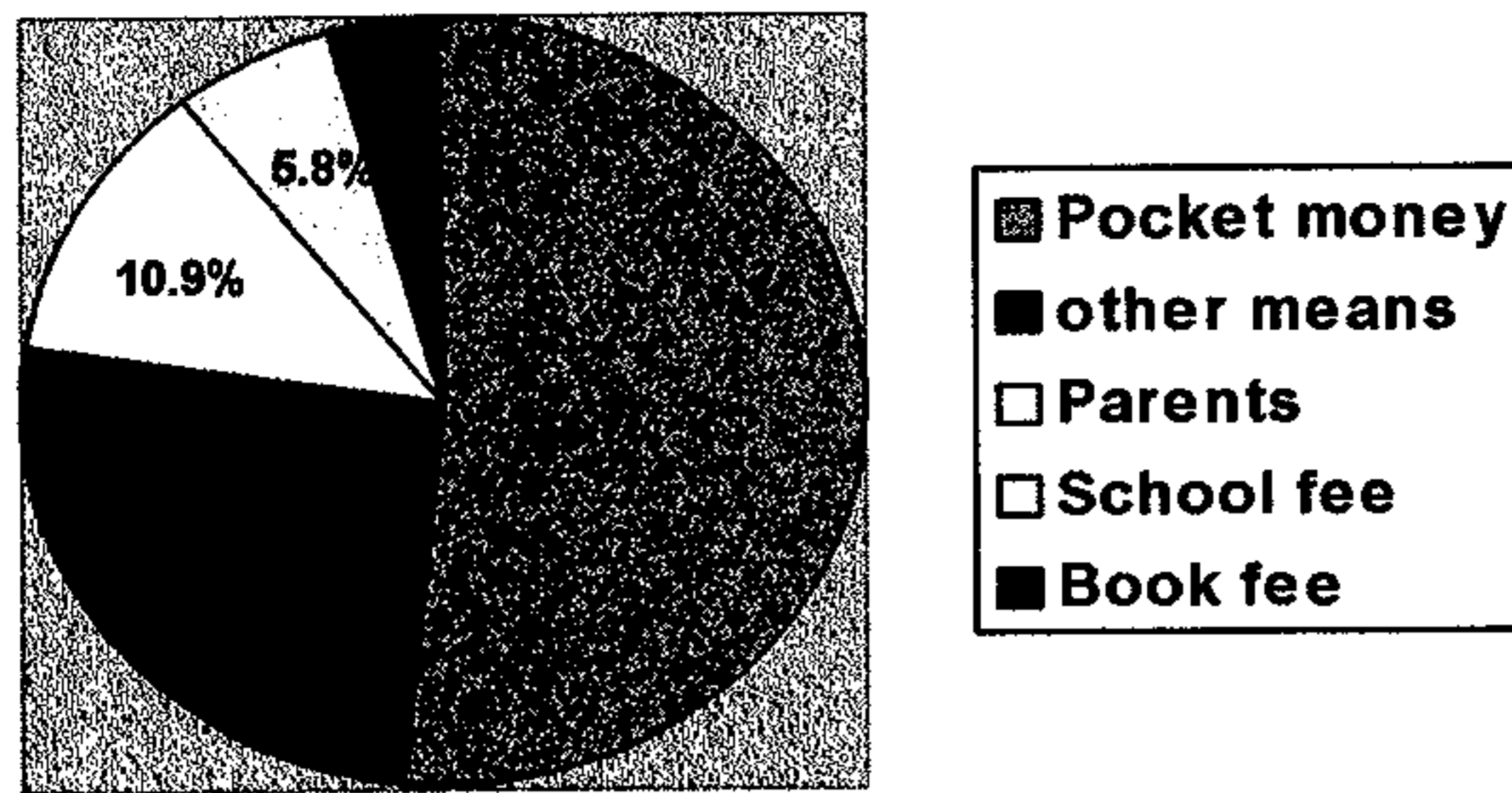
One of the influencing factors for teenagers to use alcoholic drinks is their availability in terms of distance as shown above and in terms of money. Students who drink were asked the means of purchasing alcohol. Their responses are presented in Table 4.17 and figure 4.5 below.

TABLE 4.17 RESPONDENTS SOURCES OF FINANCE FOR ALCOHOL:

| SOURCES OF MONEY | FREQUENCY | PERCENTAGE |
|-------------------------|------------------|-------------------|
| Pocket money | 126 | 45.7 |
| Other means | 63 | 22.8 |
| Parents | 30 | 10.9 |
| Schools fees | 16 | 5.8 |
| Book fees | 10 | 3.6 |
| No response | 31 | 11.2 |
| TOTAL | 276 | 100 |

Fig 4.6

RESPONDENTS SOURCES OF FINANCE FOR ALCOHOL:



The analysis revealed that 126(45.7%) students who drink use pocket money for buying alcohol, 63(22.8%) students have other ways of getting money for buying alcohol. These other sources include money from jobs after school hours or during the weekends and getting alcohol from friends. Furthermore, 39(10.9%) students ask for money from parents for different reasons, 16(5.8%) students use money for school fees while 10(3.6%) students actually use money provided for book fees. To this item, 31(11.2%) students did not respond.

As many as 190(53.5%) respondents did indicate that it is not easy to buy alcoholic drinks because they are students and they are recognised by their school uniforms. However, they do find other means of getting alcoholic drinks, for instance, sending older boys to buy for them.

PEER PRESSURE:

Findings of many previous studies support the assertion that adolescents drinking behaviour resembles that of their peers. It has also been found that, the more ones' peers use alcohol, the more likely one is to be a drinker, a heavy or a problem drinker (Galanter 1990:113). In this present study, the researcher investigated the number of respondents' friends who drink. The result is as presented in table 4.18 below.

TABLE 4.18 NUMBER OF STUDENTS' FRIENDS WHO DRINK N=276:

| FRIENDS WHO DRINK | FREQUENCY | PERCENTAGE |
|--------------------------|------------------|-------------------|
| None | 81 | 29.3 |
| Some | 108 | 39.1 |
| Most | 43 | 15.6 |
| All | 38 | 13.8 |
| No response | 6 | 2.2 |
| TOTAL | 276 | 100 |

The analysis revealed that amongst those who drink, 6(2.2%) students did not respond to this item. The analysis further revealed that 81(29.3%) students said that none of their friends drink, 108(39.1%) students said that some of their friends drink, 43(15.6%) students said that most of their friends drink, while 38(13.8%) students said that all of their friends drink. This means that about 69% of the respondents have some friends who drink.

SMOKING:

The respondents were asked whether they smoke or use other drugs. About 70(17%) students indicated that they do smoke or use other drugs. The respondents were further investigated as to whether their friends smoke. The responses are as presented on table 4.19.

TABLE 4.19 NUMBER OF STUDENTS' FRIENDS WHO SMOKE N=412:

| FRIENDS WHO SMOKE | FREQUENCY | PERCENTAGE |
|--------------------------|------------------|-------------------|
| None | 224 | 54.4 |
| Some | 135 | 32.8 |
| Most | 28 | 6.8 |
| All | 19 | 4.6 |
| No response | 6 | 1.4 |
| TOTAL | 412 | 100 |

To this item, 6(1.4%) students did not respond. The analysis also revealed that the majority of the students 224(54.4%) reported that none of their friends smoke, 135(32.8%) indicated that some of their friends smoke, 28(6.8%) students indicated that most of their friends smoke while only 19(4.6%) indicated that all of their friends smoke. On the whole, the above results about drinking and smoking friends show that peer pressure is amongst major

contributing factors to teenage drinking and other behaviours. However, those who do not drink, do not agree that teenagers get pressure from friends to drink alcohol.

PARENTAL INFLUENCE AND ALCOHOL INTAKE:

A moderate degree of relationship is found between students' alcohol use and parental use of alcohol. Therefore, in this study, parental drinking behaviour, parental attitudes towards alcohol were studied, as they are most studied family influences on adolescent drinking behaviour.

Of the 412 respondents, 162(39.6%) indicated that their fathers drink, 61(14.8%) respondents indicated that their mothers drink alcohol. Further analysis revealed that out of 163 respondents whose fathers drink, 119(73%) of them drink. Regarding smoking, out of 369 students who responded to the smoking item, about 130(35%) indicated that their fathers smoke and very few indicated that their mothers smoke. Then out of 130 students whose fathers smoke, 70(54%) smoke. As indicated earlier on in chapter 1, parents serve as role models for their children. Galanter (1990:116) had the same findings in which over half the teenagers whose parents did not drink, compared to only 12 percent of those with at least one regularly drinking parent who abstained. At the other end of the spectrum, the proportion of heavy drinkers was greater among those with at least one regularly drinking parent, compared to those whose parents did not drink at all.

Poor relationship between parents significantly increases the frequency of adolescents' alcohol consumption. One student in the Pilot study who actually reported that he started drinking after his father deserted his mother evidences this.

TEACHERS INFLUENCE ON DRINKING HABIT:

The researcher investigated the role of teachers in alcohol intake of students, that is, indicate the number of teachers who drink in their school and indicate evidence of their drinking. The data in relation to this are presented in table 4.20 and 4.21 respectively.

TABLE 4.20 NUMBER OF TEACHERS WHO DRINK GIVEN BY THE STUDENTS N=285:

| NUMBER OF TEACHERS DRINKING AS GIVEN BY STUDENTS | FREQUENCY OF RESPONDENTS | PERCENTAGE |
|---|---------------------------------|-------------------|
| 1-3 | 40 | 14 |
| 4-6 | 75 | 26.2 |
| 7-9 | 40 | 14 |
| 10 + | 130 | 45.8 |
| TOTAL | 285 | 100 |

Out of 412 respondents, 285(69%) indicated that their teachers drink. Of the 285 students who indicated that their teachers drink, 40(14%) indicated that in their school. 1-3 teachers

drink, 75(26.2%) students indicated that 4 to 6 teachers in their school drink, 40(14%) students indicated that in their school 7 to 9 teachers drink while the majority of the students 130(45.8%) indicated that 10 and more teachers in their school drink.

The analysis presented above reveals that even those students who do not drink have some evidence that their teachers drink, they may have seen them either drinking or drunk at some point. As indicated earlier on teachers are role models for students, they are with them most part of the day during school time.

The evidence students gave to prove that their teachers do drink are presented in table 4.21 below.

TABLE 4.21 EVIDENCE THAT TEACHERS DO DRINK N=285:

| EVIDENCE | FREQUENCY | PERCENTAGE |
|-----------------------------|------------------|-------------------|
| Seen drunk/drinking | 137 | 83.2 |
| Drunk at school | 6 | 2.1 |
| Smell liquor | 8 | 2.8 |
| Sent students to buy liquor | 4 | 1.4 |
| Drink with students | 12 | 4.2 |
| Other | 18 | 6.3 |
| TOTAL | 285 | 100 |

The majority of the students 237(83.2%) indicated that they have seen their teachers either drunk or drinking, 6(2.1%) students indicated that their teachers come to school drunk,

8(2.8%) revealed that their teachers smell liquor, 4(1.4%) students indicated that their teachers send some students to go and buy alcoholic drinks for them while 12(4.2%) students indicated that their teachers drink with students. "Other" in the above analysis indicates several options given by individual student. This means that 18(6.3%) students have seen some of the teachers while they were drinking, they were sent by some teachers to buy liquor and they also have teachers that smell liquor.

REACTIONS TOWARDS STUDENTS WHO DRINK:

Students were asked to suggest measures that should be taken against those who drink. The responses are as presented in table 4.22 below.

TABLE 4.22 Reactions Towards Students Who Drink N=412:

| REACTION | FREQUENCY | PERCENTAGE |
|-----------------|------------------|-------------------|
| Given treatment | 165 | 40 |
| Expelled | 124 | 30 |
| Suspended | 73 | 19 |
| Reprimanded | 45 | 11 |
| TOTAL | 412 | 100 |

Out of 412 students, 165(40%) suggested that students who drink should be given treatment, 124(30%) said that they should be expelled from school, 78(19%) students suggested that those who drink should be suspended and 45(11%) students suggested that those should be

reprimanded. This is surprising because the reaction of students towards teachers who drink is different. This will be revealed in the analysis of the next item.

REACTIONS TOWARDS TEACHERS WHO DRINK:

The reaction of the students to the teachers who drink was also investigated. The findings are presented in table 4.23.

TABLE 4.23 Reaction Towards Teachers Who Drink N=412:

| REACTION | FREQUENCY | PERCENTAGE |
|-----------------|------------------|-------------------|
| Expelled | 235 | 57 |
| To be given | - | - |
| Treatment | 86 | 21 |
| Suspended | 62 | 15 |
| Reprimanded | 29 | 7 |
| TOTAL | 412 | 100 |

The majority of the students 226(57%) feel that teachers who drink should be expelled from school, 86(21%) students feel that they should be given treatment in order to help them stop drinking, 62(15%) students feel that teachers who drink should be suspended as warning that if they do not stop or control their behaviour they will be expelled. About 29(7%) students feel that teachers who drink should be reprimanded.

SITUATIONS WHERE ALCOHOL WOULD BE ACCEPTED:

Places where students would accept alcohol as well as situations under which alcoholic drinks would be accepted were investigated. The responses are shown in table 4.24 below.

TABLE 4.24 SITUATIONS WHERE AND UNDER WHICH ALCOHOL DRINKS WOULD BE ACCEPTED:

| SITUATION | YES | % | NO | % | N |
|--|------------|----------|-----------|----------|----------|
| 1. At friend's house | 109 | 26.5 | 303 | 73.5 | 412 |
| 2. At a sporting event | 57 | 18.9 | 244 | 81.1 | 301 |
| 3. When you are with a boy/girl you are attracted to | 49 | 16.6 | 247 | 83.4 | 296 |
| 4. After school with friends | 43 | 14.9 | 45 | 85.1 | 288 |
| 5. At a disco dance with friends | 117 | 39.0 | 183 | 61.0 | 300 |
| 6. When you are upset | 58 | 19.4 | 241 | 80.6 | 299 |

Quite a number of students did not respond to some of these items particularly the third, fourth and sixth. Among situations that students see as fit for drinking, disco ranked high, 117(39%) students said they would accept alcoholic drink at a disco dance. This was followed by accepting an alcoholic drink at a friend's house, 109(26.5%). This further confirms that teenagers drink to have fun and please friends.

**ATTITUDES, OPINIONS AND KNOWLEDGE ABOUT THE EFFECTS OF
ALCOHOL:**

The researcher further investigated attitudes and opinions of students about use of alcohol.

The knowledge of the effects of alcohol in general was also investigated. The analysis of the responses is presented in table 4.25 below.

**TABLE 4.25 ATTITUDES, OPINIONS AND KNOWLEDGE ABOUT THE
EFFECTS OF ALCOHOL N=412:**

| ITEM | AGREE | DISAGREE | DON'T KNOW | NO RESPONSE | TOTAL |
|---|------------|------------|------------|-------------|-------|
| 1. Use of alcohol is a bad habit. | 36(8.7%) | 244(59.3%) | 132(32%) | — | 412 |
| 2. A drink in a while has no harm | 211(51.2%) | 161(39.1%) | 40(9.7%) | — | 412 |
| 3. Alcohol is food. | 58(14.1%) | 323(78.4%) | 31(7.5%) | — | 412 |
| 4. Drinking alcoholic beverages can lead to trouble with police. | 224(54.4%) | 52(12.6%) | 120(29.1%) | 16(3.9%) | 412 |
| 5. Drinking alcoholic drinks can lead to fights and arguments | 341(84.6%) | 37(7%) | 25(6.2%) | 9(2.2%) | 412 |
| 6. Alcohol drinks can make one forgets problems. | 60(14.9%) | 260(64.7%) | 82(20.4%) | 10(2.4%) | 412 |
| 7. You cannot trust people who refuse to drink with you. | 103(25%) | 176(42.7%) | 96(23.3%) | 37(9%) | 412 |
| 8.. People who drink a lot should be fired from work. | 221(53.6%) | 119(28.9%) | 52(12.6%) | 20(4.9%) | 412 |
| 9. Alcohol can make one sick. | 333(80.8%) | 37(9%) | 29(7%) | 13(3.2%) | 412 |
| 10. Students who do not drink get better grades than those who drink. | 182(44.2%) | 151(36.7%) | 64(15.5%) | 15(3.6%) | 412 |
| 11. Teenagers get pressurised by friends to drink alcohol. | 225(54.6%) | 88(21.4%) | 51(12.4%) | 48(11.8%) | 412 |
| 12. The fun of drinking is to get drunk. | 224(54.4%) | 63(15.2%) | 109(16.5%) | 16(3.9%) | 412 |

1. Use of alcoholic drinks is a bad habit:

Though a higher percentage of students drink as revealed by the results of this study, a high percentage of students 224(87.1%) indicated that drinking is a bad habit. This is probably why they think students who drink should be expelled from school 124(30%) or suspended 78(19%).

2. A drink in a while does no harm:

A lot of teenagers 211(51.2%) think a drink in a while does no harm. It seems like they are not aware of the addictive nature of alcohol. That is why it would be important to give them information about effects of alcohol.

3. Alcohol is food:

This item was included because traditional people have opinions that alcohol is food particularly home brew. The previous one was not the concoction of different harmful substances e.g. horseshoe, yeast and batteries that we have today, it was made out of sorghum only. However, very few students supported this idea. Only 1 percent said that alcohol is food.

4. Drinking alcoholic beverages can lead to trouble with police:

One would think students know the effects of alcohol because 224(54.4%) of them agreed to the above statement, only 52(12.6%) disagreed while 120(29.1%) said that they do not know.

This is further confirmed by 95 percent who agreed that alcohol use leads to fights and arguments as against 9 percent who disagreed while 6 percent did not know.

5. Drinking alcoholic drinks can lead to fights and arguments:

It seems that students know the implications of drinking evidenced by 341(84.6%) of them agreeing to the above statement. Only 37(9.2%) disagreed while 25(6.2%) did not know.

6. Alcoholic drinks can make one forget problems.

Only 60(14.9%) agreed to the statement that alcohol helps one to forget problems as opposed to 260(64%) students who disagreed and 82(20.4%) did not know. Amongst reasons for drinking, only 8 percent of the students indicated that they drink to forget their problems (see table 4.15). Both on the questionnaire and during the discussions, students indicated that drinking does not solve problems, they are only forgotten when one is drunk and seem worse when one becomes sober.

7. You cannot trust people who refuse to drink with you.

Although students 176(42.7%) feel that they can still trust people who refuse to drink with them, 25 percent is still a high figure to agree to the above statement. This is probably because teenagers value “to belong” so they feel one who refuses to drink with them is against belonging to a group.

8. People who drink a lot should be fired from work.

221(53.6) agreed to this statement, confirming the earlier opinion that teachers who drink should be expelled from schools indicated by 57 percent of the students. About 30 percent disagreed to the statement that drinkers should be fired from work while 13 percent did not know.

9. Alcohol can make one sick.

Quite a high number (333 or 80.8%) of the respondents agreed that alcohol can make one sick as against only 37 (9.3%) who disagreed. About 29 (7.2%) did not know. The discussions that were held with students that were not included in the study revealed that, in fact both drinkers and non-drinkers felt that after much excessive alcohol one becomes sick. This is because those who are drunk usually vomit, especially adolescents and the smell of alcohol or seeing somebody vomiting makes other people sick. Furthermore, drinkers usually have "hangover" the following day.

10. Students who do not drink get better grades than those who drink.

This statement was confirmed by 182 (4.2%) students who agreed that those who do not drink get better grades than those who do. However, 151 (36.7%) which is still a high percentage disagreed while 64 (15.5%) did not know. It would be interesting to find out the reason for such responses. Notably, 46 percent claimed to have good academic performance at school, 49.4 percent claimed to be on average while only 4.4 percent of the students indicated that their academic performance is bad. Though a high percentage of the students

(67%) indicated that they drink, a very low percentage (4.7%) missed school at one point because of alcohol. The rest missed school because of other reasons e.g. failure to pay school fees

11. Teenager gets pressurised by friends to drink alcohol.

It has been indicated earlier on under the results of the study that the majority of students who drink have some, most and all of their friends who drink as well. This shows that peer pressure is among major contributing factors to teenage drinking. This is confirmed by the fact that among those who do not drink, fewer students indicated that their friends drink. However those who do not drink do not agree that teenagers get pressure from friends to drink alcohol (88 or 21.4%).

12. The fun of drinking is to get drunk.

Table 4.25 shows that 224 (54.4%) students agreed that the fun of drinking is to get drunk. Only 63 (15.2%) students disagreed while 109 (26.5%) did not know. This confirms the reasons for drinking by 39 percent of those who drink. They indicate that they drink to have fun. Watson (1989:28) says that the initial desires of high school students to “fit in with the other kids” and to “feel older” are often replaced during high school by “having a good time”.

SUMMARY:

This chapter has revealed the findings from the information given by students as main subjects of the study. The proportion of high school students who are already using alcohol has been reflected. The analysis shows factors predisposing, enabling and reinforcing teenagers' use of alcoholic drinks. Having fun, forgetting problems and pleasing friends were the major reasons advanced for drinking. This was confirmed by responses to the question that required subjects to indicate how they feel when they are drunk. They indicated that they feel happy and relieved of stress as shown in Table 4.16.

CHAPTER 5

SECTION A

PRESENTATION OF THE QUESTIONNAIRE ANALYSIS AND INTERPRETATION OF DATA FROM TEACHERS

This section presents analysis of data collected from teachers on their perceptions about the use of alcohol by teenage students.

5. CHARACTERISTICS OF THE SAMPLE:

Thirty-three teachers were selected for the study. Of these teachers, 6 (60%) were females while the rest were males. There were 4 (40%) teachers who were between 30 – 40 year old, 4 (40%) between 41-50 years of age, 1 (10%) between 51 and 60 years old and another 1 (10%) who was between 61 and 70 years old. Three of the teachers were single, 5 of them were married and 2 widowed. Out of the 10 teachers, three had 1 to 2 years experience working in that school, and 7 had an experience of 5 years working in their particular schools.

5.1 INFORMATION ABOUT THE USE OF ALCOHOL:

Teachers were asked whether they ever suspected that some of their students drink. All 9 (90%) teachers suspected that some of their students drink. Only 1 (10%) teacher did not suspect any use of alcoholic drinks by his students. Teachers were also asked to indicate evidence of drinking by their students. Table 5.1 below shows factors that made teachers suspect that students drink.

TABLE 5.1 EVIDENCE OF DRINKING BY STUDENTS AS SUSPECTED BY TEACHERS:

| EVIDENCE | FREQUENCY | PERCENTAGE |
|-----------------|------------------|-------------------|
| Seen drinking | 5 | 50% |
| Appear drunk | 2 | 20% |
| Smell alcohol | 1 | 10% |
| Other | 1 | 10% |
| No response | 1 | 10% |
| TOTAL | 10 | 100% |

The analysis revealed that 50 percent of the teachers have seen the students either drunk or drinking, 20% of them noticed that students appeared drunk, 10 percent of the teachers indicated that some of their students smell alcohol while the other 10 percent indicated several options, these include noticing that students appeared drunk, they smell alcohol and has seen them drunk or drinking.

Teachers were asked to indicate measures they took when they suspected that students were using alcoholic drink. Eight percent of the teachers said that they talked to the students. In fact even the one who never suspected use of alcohol by his/her students, said that he would talk to the students. Twenty percent of the teachers said that they punished students who used alcoholic drinks, while ten percent said that the principal of the school was told. It is surprising that none of the teachers talked about involving parents.

5.2 EVIDENCE OF TEACHERS DRINKING ALCOHOL:

The researcher further investigated use of alcohol by teachers. The respondents were requested to state the number of teachers that drink in their school and the evidence they have that there teacher's drink.

The response to the question that required respondents to state the number of teachers that drink in their school and the evidence they can show to prove that their colleagues drink, was not very different from the student response. Five respondents said one teacher drinks in that school while two (20%) respondents did not know of any teacher who drinks in their school. It is worth noting that all teachers, who indicated that more than ten of their colleagues drink, are drinking themselves. Seven teachers (70%) have seen their colleagues drinking/drank, two (20%) indicated that their colleagues come to school drunk while one respondent indicated that some teachers have a smell of alcohol.

5.2 REACTION TO TEACHERS WHO DRINK:

Teachers were requested to suggest actions that can be taken towards teachers who drink. In response to this teachers (60%) feel that their colleagues who drink should be reprimanded. In fact, one teacher indicated that they should be warned first, if they continue then be expelled. Other teachers said other alternatives could be resorted to, for instance, health education and counselling.

The researcher delved into finding out whether teachers were aware that they are role models for students. They were asked to indicate whether they agree, disagree or do not know that students drink because their teachers, parents and friends drink. The analysis of the response to that item is presented in table 5.2 below.

TABLE 5.2 INFLUENCIAL PEOPLE N=10:

| INFLUENCE | AGREE | DISAGREE | DON'T KNOW | TOTAL |
|------------------|--------------|-----------------|-------------------|--------------|
| Teachers | 1(10%) | 8(80%) | 1(10%) | 10 |
| Parents | 1(10%) | 7(70%) | 2(20%) | 10 |
| Friends | 9(90%) | 0(0%) | 1(10%) | 10 |

The analysis revealed that most teachers (80% and 70%) disagree that teachers and parents influence students to drink. However, 90 percent of them agreed that friends do influence students to drink. Teachers mentioned other reasons for students to drink e.g. "they want to

experiment". In response to the question about the effects of alcohol use on students' performance, everybody agreed that drinking can affect students' performance though they were not asked to indicate whether for better or worse.

5.4 KNOWLEDGE OF STUDENTS MISSING CLASSES:

Teachers were asked of the days when students missed classes so as to find out the influence of alcohol use on them. The table below presents this data.

TABLE 5.3 DAYS WHEN STUDENTS MISSED CLASSES N=10:

| DAYS | FREQUENCY | PERCENTAGE |
|--------------|------------------|-------------------|
| MONDAY | 1 | 10% |
| FRIDAY | 5 | 50% |
| ANYDAY | 1 | 10% |
| DON'T KNOW | 3 | 30% |
| TOTAL | 10 | 100% |

Eight teachers (80%) noticed missing students while 2 (20%) never did. Further analysis shows that 50 percent of the teachers indicated that Friday afternoon is the time when most of their students usually miss classes the whole day. 10 percent of the teachers indicated that they usually miss their students on Monday mornings while another 10 percent indicated that students miss classes the whole and any day. This is further presented in Figures 5.1 and 5.2 next page.

Fig. 5.1 **TIMES WHEN STUDENTS MISS CLASSES N=10:**

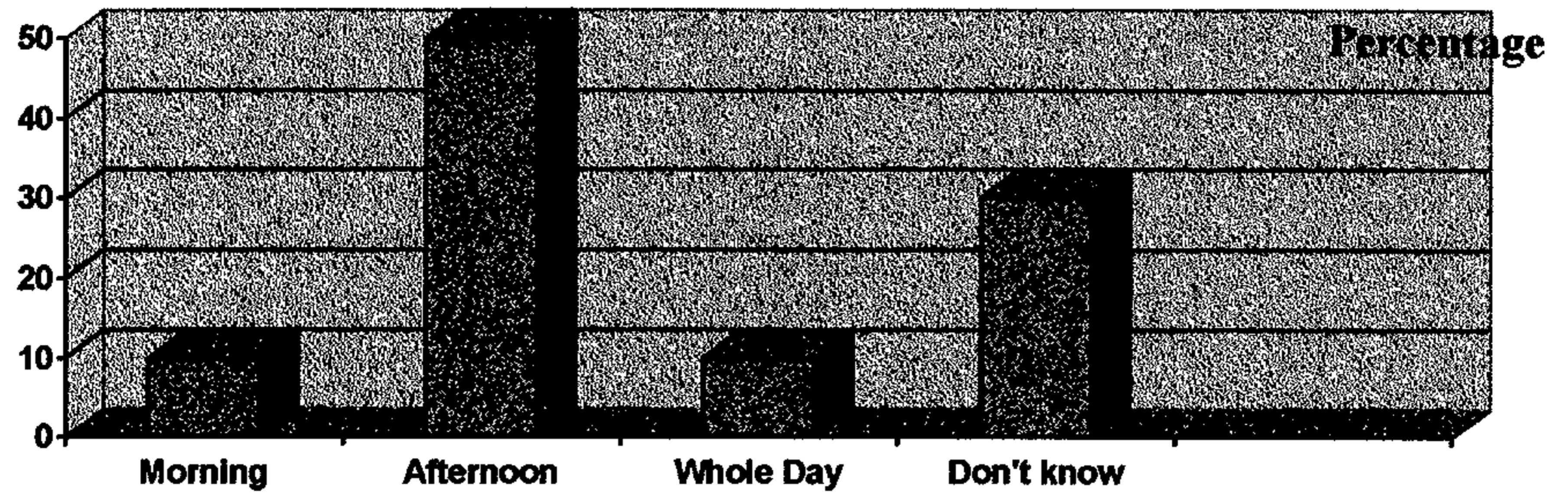
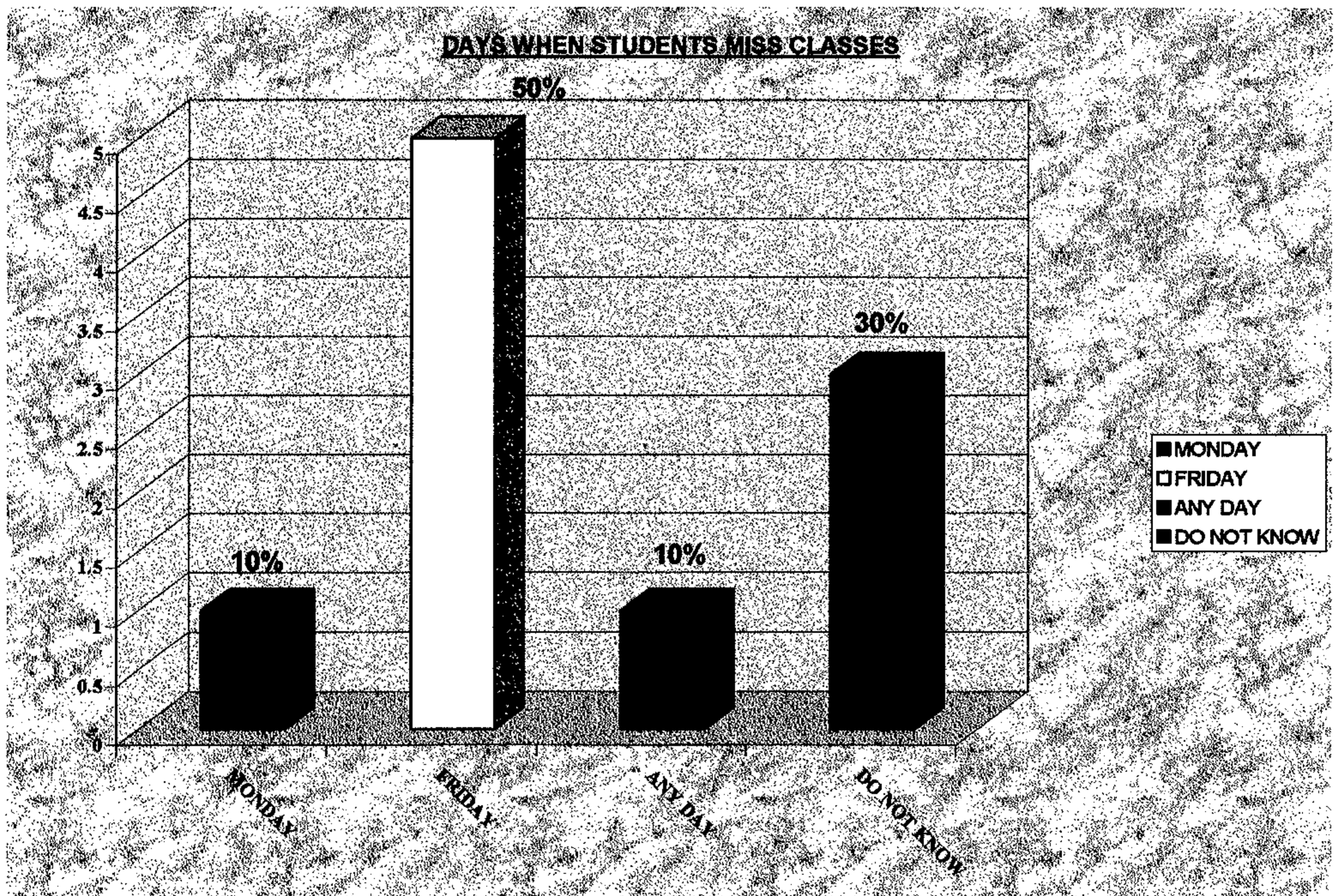


FIG. 5.2 **DAYS WHEN STUDENTS MISS CLASSES:**



USE OF ALCOHOL BY TEACHERS:

The researcher sought data from the teachers on the use of alcohol. The teachers were asked to indicate whether they drink or not. Responses to the questions are presented below.

TABLE 5.4 ALCOHOL USE AMONG TEACHERS N=10:

| GENDER | YES | NO | TOTAL |
|---------------|---------------|---------------|--------------|
| MALE | 4(40%) | 0(0%) | 4 |
| FEMALE | 1(10%) | 5(50%) | 6 |
| TOTAL | 5(50%) | 5(50%) | 10 |

The analyses of data above indicates that 50 percent of the teachers drink. Of these 40 percent are males and the rest females. All respondents who drink indicated that they drink once or twice a week. Teachers were also asked to indicate their reasons for drinking. Reasons for drinking by teachers were, to have fun indicated by 60% of the respondents who drink, and to relax, indicated by the rest of the respondents. One of the respondents also indicated that sometimes he/she drinks to please friends.

Respondents were also asked to state how they would feel if their students see them drinking or drunk. Out of 10 respondents one said that he would feel sad, 4 (40%) teachers indicated that they would feel embarrassed. Amongst these 4, 3 are not drinking. All four who drink

said they would not mind if students see them drinking or drunk. Nonetheless, it is worth noting that one of the teachers said that he suspected that his students drink because he sometimes sees them at the drinking place.

SECTION B

QUALITATIVE DATA FROM TEACHERS, STUDENTS OR PARENTS:

Qualitative data is based on the rationale that human behaviour can only be understood by getting to know the perspective and interpretation of events of the person or people being studied. ... By seeing things through their eyes, rather than by reliance on the measurement of concrete facts (Coachman & Davisan 1996:41).

The quantitative data from students, teachers and parents were coded. Themes were categorized concentrating specifically on personal accounts. The emphases, repetitions, patterns and similarities observed among different respondents were used as basis for categorizing the themes as shown at the end of this section. There was a general agreement among all respondents that drug abuse was common among adolescents in Lesotho. The most commonly used drugs were alcohol, tobacco and dagga. In response to the open ended question, which asked students to suggest best measures that can be taken to prevent teenagers from drinking alcohol, the following themes emerged from various respondents.

Theme 1. Parents' and teachers' drinking habit:

Students indicated that parents and teachers should stop drinking because students imitate them. Some students indicated that some of their friends do not see anything wrong with drinking as they take it as normal because they grew up seeing their parents drinking. One parent said that her son who was nineteen years old once said to her. "How come you are

surprised that I drink yet you know that I started dealing with alcohol since I was 10 years old?”. This was because the son used to help the father to sell alcoholic drinks at his restaurant during the holidays.

Theme 2: Purchasing Alcoholic Drinks for Elderly People:

It was suggested that teenagers should not be allowed to buy alcohol even if parents or older people have sent them. Quite a number of students did indicate that they know that their teachers drink because teachers sent them to buy alcohol for them. This came up even during group discussion, students said that they do not want to be victimized by teachers, so they do buy alcohol for their teachers even if it is against their will. In Lesotho, almost everybody can walk into a shop and buy alcohol or tobacco regardless of whether one is a teenager or an adult (Motlomelo & Sebatane 1999 - 37).

Theme 3: Limit on Amount of Pocket Money:

Students suggested that they should not be given too much money because they use it for buying alcohol. It is true that teenagers have many other sources or means of getting alcoholic drinks, but the fact that in this study, 31 percent of the respondents said that they use pocket money to buy alcohol, shows that limiting it would help reduce drinking by teenagers. One respondent indicated that he goes to the extent of stealing beer or wine.

Theme 4: Limiting Access to Alcoholic Drinks:

A great proportion of students felt that limiting availability of alcohol would reduce the use and abuse by teenagers. Different respondents stated this in different words. Some said all places selling alcoholic drinks e.g. shebeens, should be abolished. This is because these are places where teenagers feel free to get in and buy liquor. Group discussions revealed that shebeen owners really do not care to whom they are selling alcohol to. “Ke ne ke le sieo pitiking ea hae?” This is a response to a question, why do you sell alcohol to such a young person? And it simply means that one cannot prove that the person is young unless she was there when the particular person is born. Other students said that alcohol production and distribution should be controlled, while others said alcoholic drinks should be more expensive than they are now.

Theme 5: Awareness Campaign or Health Education:

Some respondents feel that teaching teenagers about the adverse effects of alcohol would help them. The quantitative data obtained supports this as 56.7 percent of respondents said that a drink once in a while does not harm.

Theme 6: Enforcing laws that Stipulate Age Restriction to Alcohol Purchase:

Law enforcement should be done. As indicated in previous chapters, in Lesotho a young person under 18 years of age should not be allowed to buy alcohol but practically no body cares who buys and how old. It was apparent from the discussion with the parents that teenagers do not even know that there is such a law. Teenagers think it is their parents' way

of threatening them so that they could stop drinking. However, the law is silent about the use of other drugs e.g. tobacco.

Theme 7: Strict Action on Teenagers who drink:

A lot of respondents also said that students who drink should be punished, reprimanded either by teachers or parents. "Parents should talk to them seriously".

Theme 8: Feeling of Hopelessness:

One other point that came up from parents was that a lot of teenagers feel hopeless because they can not fulfill the school requirements e.g. going on school trips, paying small amount of money that are required at school everyday because their parents cannot afford them. As a result their performance is bad at school. Then they resort to alcohol use, which makes matters worse. many parents also blamed peer pressures. Some said "these days our children cannot imagine a birthday party without alcohol drinks, impossible."

Theme 9: Social Factors:

In their individual interview discussions, teachers agreed that besides peer pressure, family disorganization is another factor, which leads to alcohol use by teenagers. They live in separated families, and therefore do not get support from anywhere, emotional or otherwise. Most of the time teenagers may be staying with both parents but the family does not perform the required role in relation to the children. It may be due to conflicts between parents or parents and children. The 5 percent and 3 percent of the respondents' families in separation

and divorce respectively may be insignificant but has a great impact on students school performance and lifestyle.

TABLE 5.5 THEMATIC CATEGORIES PREVENTIVE MEASURES AGAINST ALCOHOL USE/ABUSE BY TEENAGER N = 412:

| CATEGORY | THEME | RESPONSE PERCENTAGE |
|----------------------------|--------------------------------|----------------------------|
| Preventive Measures | Law enforcement | 53% |
| | Limit pocket money | 15% |
| | Regulate purchase | 36% |
| | Restrict availability | 30% |
| | Recreational facilities | 40% |
| | Good role modeling | 32% |

SUMMARY:

Chapter five reflects presentations, quantitative data and interpretation of data from teachers as well as their opinions on use of alcohol by students. On the whole, the analysis indicates that most teachers drink. Even teachers themselves have indicated this. The majority of them

are not aware that they are role models for their students. Teachers believe that students drink because of influence from their friends. The other part of this chapter reflects qualitative data from students, teachers and parents. Perceptions and opinions of students as teenagers, teachers and parents on alcohol use have been reflected. Most of the respondents feel that several measures can be taken to prevent use of alcohol by teenagers who are in school. These include law enforcement, limiting pocket money, regulating purchase of alcohol, restricting availability of alcohol, having recreational activities for teenagers and good role modeling.

CHAPTER 6

DISCUSSIONS, CONCLUSION AND RECOMMENDATIONS:

6.1 INTRODUCTION:

This section presents discussions of the major findings stated in the analysis section. It further outlines and justifies the conclusions drawn from these findings. Recommendations that are based on the findings for prevention and reduction of alcohol use and abuse by teenagers are proposed. Briefly, this section attempts to answer the research questions for this study, the major one being *“Can health education programme be developed as an intervention strategy against alcohol use by teenagers?”*

Finally, research questions that are beyond the limits of this study are highlighted so that further improvements of the study can be done and ultimately, the quality of life for teenagers in Lesotho can be improved. The research questions were as follows: -

- What proportion of high school students use alcoholic drinks?
- What are the influencing factors that make high school students take alcoholic drinks?
- How do students, teaches and parents perceive alcohol consumption and its effects?

6.2 DISCUSSION OF FINDINGS:

6.2.1 Research question 1: This question states that quite a number of measures of prevention activities among teenagers, especially high school students have been identified from the information obtained in this study. The fact that quite a lot of students do come into contact with alcohol and at quite an early age cannot be denied and there is necessity for prevention activities. It is evident from research results that alcohol use/abuse by teenagers is increasing in Lesotho despite the limitations that this study and the previous ones have. The first study that was done on alcohol use by high school students revealed that half of the sample (1137) had used alcohol at some point. The other half though not specifically on alcohol use/abuse but on health problems, showed that 27% drank alcohol and in this study it has been revealed that 67.2 percent of high school students use alcohol.

It is well known and documented that alcohol has serious health and social effects on everybody, especially on teenagers because of their vulnerability. What is important but not clear is why teenagers use alcohol and abuse alcohol.

6.2.2 Research question 2: What are the influencing factors that make high school students take alcoholic drinks?

The outstanding findings of this study were that there are a number of predisposing, reinforcing and enabling factors that lead to alcohol use by teenagers. Peer pressures, experiences with alcohol use at home, taking up from role models e.g. teachers and worst of

all availability of alcohol, seems to be encouraging increase of alcohol use by high school students. New brands of drinks have sprung up, designed especially to appeal to young people. The sparkling wines with their artificial colouring seem to aim specially at girls' and women's' taste. Advertisements try to impress that drinking belongs to the life of modern young and successful people. They are used to glamorizing alcohol, depicting it as an immense social asset. This is evidenced by TV adverts where students are graduating and a lot of beer is used to celebrate the event. From this, one would conclude that success, happiness and alcohol go together. Furthermore, media messages in magazine and billboards associate alcohol with glamour, sophistication and maturity. With the use of very attractive models, adverts create the illusion that liquor brings success, strength, wealth and sexual conquest (Wilson 1987:47). All these give the impressions that alcohol is an acceptable part of modern way of life. As revealed in the literature review, prime time television programmes often portrays drunkenness as humorous. If the quality of life of teenagers is to be improved, a few considerations about the findings in this study are worth noting.

6.2.3 Research question 3: How do students, teachers and parents perceive alcohol consumption and its effects?

The emphasis on getting drunk: Over 50 percent of the sample think a drink in a while does no harm. The same percentage of students say that getting drunk is fun and 39 percent indicated that they drink to have fun. The above mentioned factors seem to carry dangers for future drinking habits with a high risk of alcohol-related problems. Students are not aware that drinking could have serious health implications for them, and alcohol has two

unfortunate drawbacks namely, tolerance to its effects and addiction. Furthermore, every time a person takes a few drinks of alcohol at a social function, he permanently damages his brain, and probably his heart and liver too.

The discussion with parents, teachers and students revealed that it is general attitude throughout the world that drinking occasionally does no harm. This same attitude was found among Batswana, Swazis and Zimbabwean high school and university students as well as adult drinkers. There is a need therefore to find adequate means to limit the harm to which use of alcohol drinking is giving rise to. These may include development of health education programmes for school, which may prove effective in reducing demand for alcohol and subsequent problems.

6.2.4 ROLE MODELS:

There is a general agreement that youngsters need positive adult role models. Models come from many sources, the street, home, church, social service agencies, media and others. Because some are negative, especially those from TV and radio as indicated earlier on, youth must be exposed to positive role models for counter balance. In this study, out of 163 students whose fathers drink, 119 students also drink. It can also be concluded that the 15.7 percent who indicated that their mothers drink too, are amongst the 73 percent who drink. Their families in their own homes typically introduce teenagers to alcohol in different ways which they may not be aware of. Currently, their drinking experiences increases with age

and over 6 percent of high seniors report daily alcohol use (Estes, Smith and Heinemann 1980:59). This study revealed that about 22% of teenagers started drinking between the ages of 10 and 13 years old. Over 70% started drinking alcohol between the ages of 14 and 16 years old and above.

Adolescents exposed to parents, peer and religious systems that approve of drinking are more likely to develop drinking habits. Teenage abstainers are less exposed to drinking cultures and are more likely to have non-drinking parents and peers and to perceive their church or religion as disapproving of drinking. The family is extremely potent agent for influencing the decisions young people make about alcohol. Home atmospheres that are permissive about heavy drinking often promote the excessive use of alcohol by youth (Estes et al 1980:57). It was found out in this study that majority of students whose fathers drink also drink.

Adolescents seek adult roles. It is especially important for adults working with adolescents to be conscious of their actions, far more certain that they are setting a good example for their children in their own drinking patterns such as by moderating its use. Teachers and other adults also serve as role models for students. The schools are a logical place to provide prevention efforts because they reach more people than any other single institution. Teachers therefore need thorough education about alcohol so that they can deal effectively with youth on this subject. In this study, 68 percent of the students indicated that their teachers drink, they have seen them drinking/drunken, they smell liquor, sent the students to buy liquor for

them and other times they drink with students. It is evident that teachers are not aware that they are role models for students and this has an implication on their future lifestyle. Table 5.2 shows that 80 percent of the teachers disagree with statement that students drink because their teachers drink. Perhaps a study on teachers' use of alcohol would also help curb the behaviour. So far no study has been done in this country to find attitudes and perceptions of teachers on use of alcohol. Health education must be started at the grade level and be built throughout the basic educational curriculum to have the greatest positive effect on young people's values and behaviour pattern. According to Watson (1989:249), binge drinking, conflicts with parents about drinking and automobile accidents are more prevalent among teenagers who start drinking at 13 years. He further says that most of the boys who are problem drinkers in high school are likely to have the same problem six or seven years later. In this study, 45 percent of the students said that they had first taste of alcohol drink when they were 10 years old. This implies that there is a great need to identify young people who use or abuse alcohol in time to prevent later alcohol related problems.

Teenagers state so many reasons for their drinking even though they state them in different ways and words. They say that they like the way alcohol helps them relax, forget worries, relate to people and have more fun. Very few adolescents report that they drink because they are unhappy, depressed or angry. Encouragement by friends and pressure from peer groups at parties are the most commonly cited reasons for excessive drinking. This has been confirmed by Watson (1989:250) who found that the initial desires of seventh and eighth grade students to "*fit in with other kids*" and to "*feel older*" are often replaced during high

school by *“having a good time”*. Students say, *“as you are fighting your way to the top, it helps to have a taste of what’s up there”* (Damane 1982:16).

Drinking alcohol beverages at parties, particularly beer and wine by males and females respectively, has become a routine form of relaxation for many teenagers and teachers as shown in this study. Previous studies showed that by the end of their senior year, 93 percent of high school students have experienced or experimented with alcohol. Bitter consequences of alcohol use have well been documented; therefore preventive measures must be started early. Early detection of young people who have alcohol problems may help prevent later social problems. According to Watson (1989:230), parents, teachers and friends can help identify alcohol use/abuse by noting the behaviour displayed by teenagers e.g. unexplained absences especially Monday morning and Friday afternoon, erratic grades or erratic moods swings, alcohol on the breath at school and alcohol related problems with law enforcement officials. In this study, a large proportion of students were absent on Monday mornings and on Friday afternoons. Absence on Monday morning may not be unconnected with party-going on weekends or drug use on weekends. Absence on Friday afternoons may well be connected with ceremonies that students want to attend such as funerals, parties etc. In all these places, alcohol use is very rife.

6.3 CONCLUSION:

The study investigated the prevalence of alcohol use among teenagers at eight high schools and whether an appropriate health education programme could be developed as a preventive strategy. The greatest two variables influencing substance use among teenagers are peer pressure and having fun. Decreased emphasis on religion, low value on achievement, poor school performance, delinquency and high value on risk taking are other factors that are linked with adolescent substance use, particularly alcohol. The general conclusion is that teenagers, though still at school do come into contact with alcohol and this has a bearing on their future. The study observed that there are a number of predisposing, enabling and reinforcing factors that lead to consumption of alcohol by teenagers e.g. availability in terms of money and distance, models and lack of policies as well as law enforcement on alcohol use.

It is widely recognised that knowledge about effects of alcohol and belief about the social image of drinking might influence an adolescent to decide on whether to start drinking or not. This study shows that many teenagers consider drinking to be harmful to their health, evidenced by 84.8 percent of the sample saying that alcohol is not food, 85.6 percent saying drinking is bad and 64.7 percent saying that drinking does not solve problems, instead leads to fights and trouble with police. The results of this study suggest the need for comprehensive alcohol prevention programme, which is aimed at reducing alcohol consumption in general. A comprehensive programme including information, decision

making and resistance skills training should be developed. Intervention at the primary level leads to reductions in alcohol consumption of around 15 percent, reductions in proportions of excessive drinkers of around 20 percent (Edward & Peter 1994:182). Changes in the overall consumption of alcohol beverages have a bearing on the health of many people in any society. General alcohol control measures can be used to limit consumption.

6.4 LIMITATIONS OF THE STUDY:

The inquiry into students' alcohol use was limited in several ways. Though every effort was made to make the information valid and reliable, the nature of the study itself and conditions in Lesotho, Maseru in particular makes the degree of its validity and reliability unclear. First, a self-report questionnaire always carries the risks of under or over reporting. Secondly, the study was done in Maseru. This is the nearest town to the National University of Lesotho (NUL), the National Teachers Training College (NTTC) and National Health Training College (NHTC) and therefore all the mentioned institutions conduct their studies in the schools that are in Maseru city. As a result, one observes a lot of reluctance on the part of the teachers when permission is requested to conduct a study in their school.

Furthermore, from the students' response one observes that some of them fill the questionnaire just for fun or for the sake of doing it. This is evidenced by the fact that two of the respondents from different schools made the following remark after filling the questionnaire. "This was fun, when are you coming again with other questions on alcohol?"

In some schools the appointment was postponed until examination time. When the researcher got to the school at the appointed time, the school authority used examination as an excuse not to respond to the questionnaire. Examinations are usually written at the end of the quarter after which students have a short break. This is the time when one is likely to find a lot of students missing either because they have not yet come to school because the school fee for the quarter is not ready or they have been sent back home for not paying.

The picture of students using or abusing alcohol may not be clearly seen because the study was conducted on teenagers in school. Students who are having difficulty with alcohol are likely to be absent because of hangovers or drunkenness when the questionnaires are administered. In this study teachers indicated that they usually miss some students on Monday morning or Friday afternoons and yet those are the times that they allocate for study projects.

Another limitation is the fact that investigations were amongst students. A lot of useful information could be obtained from adolescents who are out of school. They may not be in school because of alcohol related reasons, or they may have started drinking because they are out of school. The study was conducted in Maseru city as indicated earlier on and that means students from rural areas were excluded. However, most of the students grew up and started their secondary education in the rural areas. They come to Maseru either because of transfer of their parents or especially because it is generally believed that education in urban areas is better than in the rural areas as facilities and resources are better too. Finally, use of

alcoholic drinks especially by students is frowned upon in Lesotho as in many other countries. This fact could have influenced some students to withhold some information or stated it in an acceptable way. Therefore the possibility that there could have been selective or inaccurate giving of information by respondents cannot be overlooked. The respondents however invested their time and made constructive suggestions in this study.

6.5 RECOMMENDATIONS:

- Alcohol drinking presents problem for most of the students in high school, which affects both males and females. To further define the dimension of the problem and to identify those factors important to the design of an appropriate education programme for its prevention and control, there was a need for a study of high school students' attitude. Despite limitations that this study has, the data obtained from it show that there is a need to develop a comprehensive health education programme, where information about effects of alcohol and organizations like Alcoholic Anonymous will be given. Specifically and based on the findings of this study, the following are recommended:
 - Availability of alcoholic drinks should be reduced e.g. controlling production and distribution.
 - A more comprehensive study covering several high schools in each district and involving all levels of education would definitely yield better results, which are more generalisable, therefore it is strongly recommended.

As there were several limitations in this study, there is a need for its replication under similar conditions in order to find more about it and improve it. A special survey of teenagers particularly those that are not in school should be done, to determine the age at which alcohol use begins and the associated factors which leads to its use. There should be a literature search for successfully applied educational programme, of other countries, which combat alcohol use and abuse by youth, particularly students.

Provision of alcohol education in schools and churches is highly needed. Encouraging responsible role models by teachers and parents who drink is recommended. Developing countries public awareness' campaigns to limit the number of alcohol consumption is also highly recommended. The major recommendation is that a health education programme where information on adverse effects of alcohol and implications for its use will be given should be developed. This will help in reducing the demand for alcoholic drinks. This programme should include but not limited to:

- Assertiveness and resistance skills training.
- Alternative methods of relaxing e.g. sports and other types of recreation.
provision for opportunity for social interactions that do not involve alcohol.
- Peer counselor sessions to assist young people with personal problems.

6.6 CONTRIBUTION OF THE STUDY ON NURSING:

The nursing profession has developed great effort to developing the unique great body of knowledge used in the delivery of health care to clients. Having a special body of knowledge that is based on scientific information is one of the hallmarks of a profession and is essential for fostering a sense of commitment and accountability to clients (Mussey 1996: 102).

Expansion of knowledge through research is useless and has little meaning for the profession if it remains only in research journals or in the minds of the researchers. It must be part of the active repertoire of knowledge of those directly engaged in practice. The society is gradually becoming knowledgeable particularly in developing countries like Lesotho, and beginning to question the care they receive. Today, more than ever before nurses are required to be accountable for the quality of client care they deliver. Because of the rising costs, clients are asking nurses and other health professionals to document the effectiveness of their services. All the above mentioned cannot be done if nurses do not engage in research. Investigations that are practice oriented can contribute significantly to validating the effectiveness of particular nursing measure and in improving the quality of life.

The ultimate goal of this study was a development of a health education programme based on information. Therefore there was a need to find out the magnitude of the problem of alcohol use by teenagers as well as why they do it. This in other words is a way of

improving the health of the young people who are future citizens, thus a healthy nation is built. Wilson and Clark (1993:4) say that a healthy nation is not one, which has an equitable distribution of resources, but one, which also has an active, empowerment community, which is vigorously involved, in creating the conditions necessary for healthy people. This can only be done through health education. The main task of health education is to enable not to coerce, nurses should be concerned with co-operation rather than with compliance (Wilson & Clark 1993:).

Much as several studies have been done on alcohol abuse, they are not enough to make valid conclusions. It is important to assess the levels of alcohol use and abuse among teenagers in order to facilitate appropriate intervention. Research in the area of substance abuse is difficult in terms of getting valid data due to social stigma attached to abuse and due to the legal ramifications involved in the area of drug abuse (Jarvis 1983: 554). Studies such as the present one are essential to valid planning and allocation of resources for prevention and treatment of substance abuse. Nursing research helps define the parameters of nursing, identifying the unique role that nursing has in the delivery of health care (McMurray 1998: 1800). The main reason for research in nursing is to improve practice, refine and extend the specific body of knowledge fundamental to nursing practice (Polit & Hungler 1991: 4). It has rightly been observed that "Knowledge is not only discovery of facts but also the discovery or examination of new relationships" (Hockey 1991 in McMurray 1998: 179).

Nursing research therefore informs practice by verifying and expanding nursing knowledge. This is what this study has tried to contribute. Besides that, the development of health education programme in order to teach students, teachers and parents about dangers of alcohol abuse and try and change their attitudes, beliefs and behaviours could make a contribution in improving the physical, social and psychological quality of life of all citizens.

CHAPTER 7

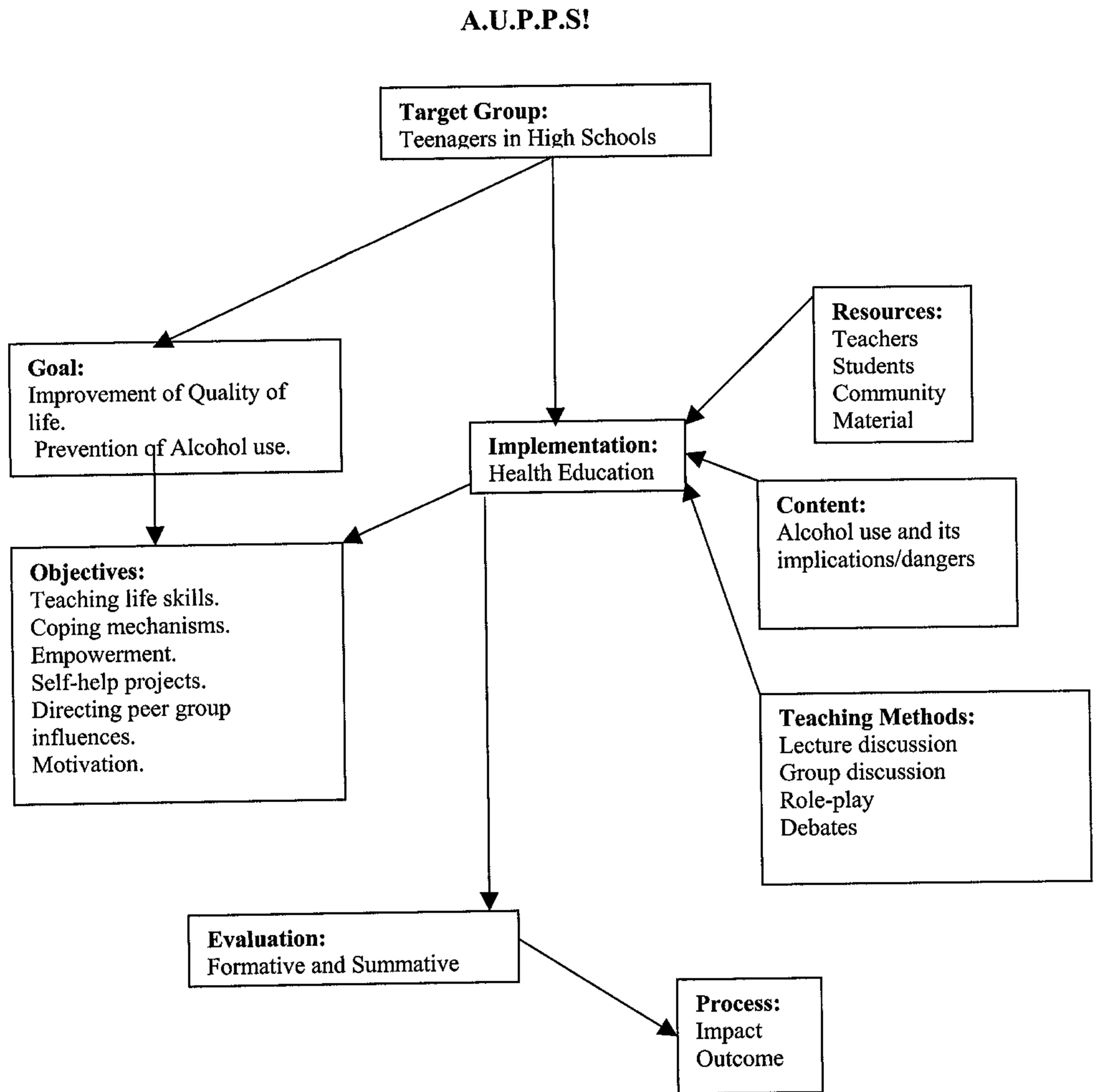
DEVELOPMENT OF A HEALTH EDUCATION PROGRAM

7.1 INTRODUCTION:

The ultimate goal of this study is to develop a health education programme as an intervention strategy of preventing use of alcohol by youth. Green and Kreuter in McMurray (1998:160) suggest the PRECEDE-PROCEED model as a guide to develop such a programme. They explain that the model is best used if the change agent begins with the final consequences (quality of life). The model involves several phases as indicated in chapter 1. This chapter will be devoted to the description of the health education programme against alcohol use by high school students, its implementation and evaluation.

See Fig 7.1 Alcohol use and prevention Programme in schools on the next page.

Fig 7.1: ACCOHOOL USE PREVENTION PROGRAMME IN SCHOOLS:



7.2 DESCRIPTION OF A HEALTH EDUCATION PROGRAMME-ALCOHOL USE PREVENTION PROGRAMME IN SCHOOLS (AUPPS):

Use of alcohol among teenagers is a growing concern all over the world. It seems that abstinence from alcohol is decreasing and consumption per head has a tendency to increase in adolescence in numerous countries. In general, the habits of alcohol consumption tend to be the same among the young generations who are exposed to more and more homogenous social influence. The study done by the researcher on prevalence of alcohol use/abuse among the teenagers in high schools, has presented evidence of a relatively high prevalence of drinking and “problem drinking” among high school student. This is a growing concern as revealed by literature.

7.3 DIAGNOSIS:

As indicated earlier on this chapter, the precede-proceed model was used to diagnose the problem of the teenagers. The findings were as follows:

7.3.1 Social diagnosis: This study revealed that there is a lot of absenteeism among high school students especially on Monday mornings and Friday afternoons. Other obvious social effects in the high school community include poor attendance at classes, bad performance by students who drink and difficulties with interpersonal relationships as revealed by the group discussions. It also revealed that there are several predisposing, enabling and reinforcing factors such as peer group pressure, poor role models like teachers and parents. Other social circumstances that influence drinking by teenagers include family violence, parents/children relations, poverty and unemployment.

7.3.2 Epidemiological diagnosis:

This is where assessment of important indicators such as mobility, mortality and disability is done, as well as identifying dimensions of each e.g. incidence, prevalence and intensity. In this study, 67 percent of the students indicated that they drink. They agreed that alcohol use could lead to problems with the police through fights or any forms of law breaking. The majority also said that alcohol use leads to accidents and sickness. So many young people die these days because of Sexually Transmitted Infections (STIs) including HIV/AIDS in particular, which in various cases is also related to drug and alcohol abuse. The study confirmed that alcohol use has part to play in the spread of the mentioned conditions as indicated in the previous chapters.

7.3.3 Behavioural and environmental diagnosis:

It has been mentioned in chapter 1 that these days, alcoholic drinks are available all over the country (Lesotho). It is available in terms of accessibility and affordability. Maluti Mountain Brewery (MMB) distributes alcohol all over through branches and depots. In towns alcohol is available even in supermarkets. Liquor restaurants are all over the towns, most of them next to the schools, evidenced by the fact that 64 percent of students indicated that their school is one kilometer from the place where alcohol is available. The study also revealed that teenagers start drinking at a very young age, 45 percent started when they were 14-16 years old. Some of them use other drugs as well e.g. smoking cigarettes and dagga. This leads to unacceptable behaviours such as missing classes, using school fees to buy alcohol and many others.

7.3.4 Educational and Organizational Diagnosis:

Predisposing factors: Students feel that most of them do not know the effects of alcohol and the implications of alcohol use, especially young people like them. This was evidenced by the fact that 57 percent of the students indicated that an alcoholic drink once in a while does no harm. About 35 percent of them actually drink, some of them regularly and 13.6 percent need 3-6 glasses of alcoholic drinks to get drunk. Beliefs such as alcohol helps one to relax, forget problems and helps one to establish relationships also predispose teenagers to drinking.

Reinforcing factors: Teenagers want to belong and therefore, students indicated that they drink to please their friends. Some of them have their parents and teachers drinking/drunken, as those are their role models. The ever presence of alcohol in the media is another reinforcing factor and encourages teenagers to drink.

7.3.5 Enabling factors:

As indicated earlier on, alcoholic drinks are available all over the country, and in all forms and states that suit everybody, young and old as well as both male and females. This enables young people to drink. Much as alcohol is expensive in Lesotho, it is available and accessible. This is due to the fact that brewing is done in homes as fund raising activity. Students are given pocket money and other money, which they easily convert into alcohol purchasing money. Also hotels, bars, liquor restaurants are all over the country. This enables students to easily get alcoholic drinks whenever they want. Students did indicate in this study that they have various means of getting alcoholic drinks e.g. from friends, using money meant to buy books, school fees as well as sending older students to go and buy for them.

7.3.6 Administrative and policy diagnosis:

There is law in Lesotho that prohibits young people to buy alcoholic drinks but it is not enforced. People who drive under the influence are arrested but let loose as soon as they recover or given light sentences if they have been involved in an accident. Random Breath Testing (RBT) is done these days but one never knows how often and what happens if one is found to be over limit.

The findings of this study clearly show that there is need for health education programme, which will help adolescents to explore alternative ways of being together apart from drinking places. When they are together they should enjoy being together or make use of other ways of celebrating without using alcoholic drinks. Recreational facilities would help teens to be busy and therefore avoid whiling away time by drinking.

7.4 PROBLEM TO BE ADDRESSED BY THE PROGRAMME:

In addition to the findings of the study indicated above, the literature reviewed revealed that the consequences of substance use, especially alcohol by teenagers are diverse, including acute and chronic health and emotional problems, disruption of interpersonal relationships school failure and criminal behaviour. Their behaviour as young people will most likely have an impact on their health as adults and health of their own children. There are substantial legal, psychological and social consequences of this extensive alcohol and drug use by adolescents and young adults. Kibel and Wagstaff (1993:12) confirm the fact that alcohol consumption can adversely affect health in a variety of ways. Regular intake of alcohol during

pregnancy has adverse affects on fetal growth and development. Consumption of alcohol has strong association with traffic and other accidents, child abuse, crime, family disruption and psychosocial problems, just to mention a few.

Substance abuse prevention is the way of the future. There is absolute need to develop an appropriate health education programme as an intervention strategy of preventing alcohol use by teenagers. Drinking is behaviour valued by teenagers, therefore the appeal for abstinence is likely to fall upon deaf ears. Teenagers accept efforts to alleviate misuse of alcohol and drinking problems better than attempts to stop their drinking. To day prevention programmes stress the right of teens to make their own choices about their own behaviour (Wilson 1987:53).

Another major concern is the extent to which culture is influenced into prevention projects. Because ethnic background, culture and customs influence drinking behaviour, they must be part of any prevention programme.

If an appropriate health education programme can be developed, it might address all problems that influence students' performance at school and role of different people in the intervention endeavour.

7.5 TARGET POPULATION:

The Programme is meant for teenagers at high schools. It has been indicated in chapter 4 that most of students of the sample were between 16 and 19 years of age. School is where most of teenagers are; students can spread knowledge to a larger group in community because from school they will communicate with their colleagues and families. Focus on adolescents is important for the following reasons: They are in the process of forming habits and can thus be influenced.

As indicated in Chapter 1, adolescence is a period of transition and they are going through a period of changing behaviour with so many challenges facing them and hence they are at risk. By learning at an early age, future problems will be prevented, and it is therefore a good investment to start early.

It is not enough for teenagers to know the facts about alcohol; they also have to be motivated to apply knowledge when it matters. Many factors influence young people and many messages come into their minds. One of the characteristics of adolescents is to rebel against the right, the sensible, and the recommendable thing to do. One of the findings in this study is that teenagers embark upon risk behaviour for the fun of it. However, a multi-sectoral approach will be used to deal with many challenges that they have.

7.6 THE GOAL OF THE PROGRAMME:

The programme is aimed at reducing the number of teenagers, (particularly in schools) using alcoholic drinks by 80 percent after ten months of implementing it. It is hoped that the information they will get and therefore the knowledge acquired will make them change their behaviour. The health education will hopefully help them have alternatives for solving their problems e.g. stress, academic as well as social problems. They will have skills in resisting peer pressure and be assertive enough to stand by their own decisions. In short the programme is aimed at improving the quality of life of every teenager in Lesotho.

7.6.1 OBJECTIVES OF THE PROGRAMME:

It is expected that at the end of the programme, candidates will be able to:

- Differentiate between various types of substances that are commonly abused in Lesotho.
- Analyze the physical effects, behavioural changes, social and family problems resulting from substance abuse so as to fight against the drinking habit.

The programme should:

- Increase the proportion of high school students who perceive social disapproval to be associated with the heavy use of alcohol.
- Increase the proportion of high school students who associate risk of physical or psychological harm with the heavy use of alcohol and other drugs.
- Increase the number of teenagers who are assertive enough to resist pressure from peer group in relation to alcohol use.

7.6.2 EDUCATIONAL OBJECTIVES:

About 80 percent of candidates should be able to define substance, abuse and dependency.

Explain signs and symptoms of substance abuse, especially alcohol so as to identify early those who are at risk of becoming alcoholics.

About 80 percent of the teenagers at high school level should be able to state the safe drinking limits.

About 80 percent of the high school students should be able to demonstrate knowledge and understanding of the effects and implications of alcohol use and abuse by teenagers.

7.7 IMPLEMENTATION:

This part of the programme represents the culmination of each of the previous parts. Implementation should be as comprehensive as possible, given the information which surfaces from the diagnostic exercise. Available evidence supports the conclusion that providing young people with information on alcohol doesn't necessarily lead to behaviour change. The use of fear arousing approaches in particular is unproductive, especially in view of the widespread adolescent belief in personal invulnerability (Edward & Peter 1994:6). Literature has revealed that comprehensive and social influence programmes have been found to be successful. Social influence programmes include those whose primary purpose is to teach students about peer and other social pressures. The health education programme will therefore include information about alcohol use as well as focusing on resilience skills training.

It has been mentioned in Chapter 1, that Lesotho is committed to using Primary Health Care (PHC) as a strategy to achieve a goal of health for all. According to Edward & Peters (1994:46) PHC is an important setting for identifying people at risk from heavy drinking and assisting them in reducing their alcohol consumption through brief interventions. PHC has been shown to be effective and efficient in acting as an advocate of public health for local communities. It has been further confirmed that interventions at the primary level leads to reduction in alcohol consumption of around 15 percent and reductions in proportions of excessive drinkers of around twenty percent. PHC will therefore be used as a tool to prevent alcohol use among teenagers in high schools. Along with one or two 45 minutes sessions a week that will be held for students in the program, there will be other activities such as meetings, debates, song competitions, drama, bashes, fun walk and campaigns during substance abuse week. As indicated earlier, peer education would be advisable therefore workshops will be conducted and some students may participate as facilitators on mass media- Radio slots once a month, TV Slots once in three months and Newspaper articles on alcohol abuse.

7.7 RESOURCES:

Three types of resources are needed for the programme of this nature. These are manpower, money and material. The findings of the study revealed that the intervention should include coordinated efforts of various health professionals and the community. It follows therefore that, teachers, parents and community at large including policy makers will have to join hands if the alcohol use prevention programme is to succeed. Teachers play an important role in

health education and role modeling. Personal health beliefs are communicated to children by teachers as well as by parents. Demonstrating positive health attitudes and behaviour is effective even when a health course is not established (Hopp 1990:388). Parents are expected to make important contributions to successful intervention efforts to prevent use and abuse of alcohol by teenagers.

Both parents and teachers should be made aware of the problems, which affects students in their area of jurisdiction. Hopp (1990:389) further says that if students' drinking problem can be identified, it may be a reflection of a problem at home or in the community. The students will therefore not be treated in isolation; after all they do not develop in isolation and are able to form associations with other individuals, which is a form of secondary socialization. In fact, the health education programme should be targeted at the students, their parents as well as the teaching personnel.

Peer pressures, often instrumental in influencing youth to drink, can also be used to curb drinking. Older students who can be identified as leaders and who have responsible attitudes and positive behaviour towards drinking can serve as role models for younger students. It may be easier for young people to identify with mature persons in their own age group than with adults (Estes et al 1988:450). In summary, involvement of the community, teachers, parents, and peer groups should be strongly emphasized.

7.8.1 FINANCIAL RESOURCES:

Fund raising needed, will assist in collecting money that may be needed to run the programme, particularly activities that are not within the school budget. Donor agents may be approached to assist financially. Health education unit of the M.O.H.S.W. may help with the supply material such as posters and leaflets.

7.8.2 MATERIAL:

The material needed will depend on the methods of teaching that will be used. However, chalkboard, chalk and posters will be used to facilitate the running of the lecture discussions. Leaflets and handouts can be taken home to further digest and internalize the information.

7.9 CONTENT:

The following content is suggested as forming the core of the proposed programme.

1. Definition of substance, abuse and dependency.
2. Physical signs and symptoms of substance abuse.
3. Emotional/psychological signs and symptoms of the substance abuse, alcohol in particular.
4. Commonly abused substances in Lesotho: Alcohol, tobacco and prescribed medicines.
5. Physical effects of alcohol abuse.
6. Behavioural changes.
7. Family and societal problems and co-dependency.
8. Myths and misconceptions on alcohol abuse.
9. Prevention and control of alcohol use.
10. Peer counseling for prevention and treatment of alcohol abuse.
11. Skills training

7.10 TEACHING METHODS:

The teaching-learning activities will include:

7.10.1 Lecture: Stimulates thought and develops critical thinking through reliance on verbal message. It conveys factual information and encourages dialogue between the teacher and the learner. Questions and answers enhance the effectiveness of the method.

7.10.2 Group discussion: Helps students learn from themselves and the resource person. Various students share their experiences and each one gains from them and is likely to apply knowledge obtained from group discussion.

7.10.3 Role-playing: Increases motivation and helps in acquiring skills in solving problems in human relations. It also helps the group to share an experience within the effective domain and thus allows for interaction that could have a deeper meaning than simple discussion.

Other methods include seminars, presentations, videos and film showing.

7.11 EVALUATION:

Evaluation is an ongoing process through which the extent to which objectives that have been achieved is determined. It is an integral and continuous part of the entire diagnostic process (McMurray 1998:162). Different types of evaluation will be done, that is process, impact and

outcomes to assess the programme. Learner evaluation will occur throughout the process of training, that is, formative and summative.

The study will show knowledge of the effects and implications of alcohol use by teenagers. Change of attitudes towards alcohol use will be demonstrated in their response to related questions. It is hoped that absenteeism due to alcohol use will be greatly reduced and a few, if not none, of the students will be seen in bars or specific spots for drinking.

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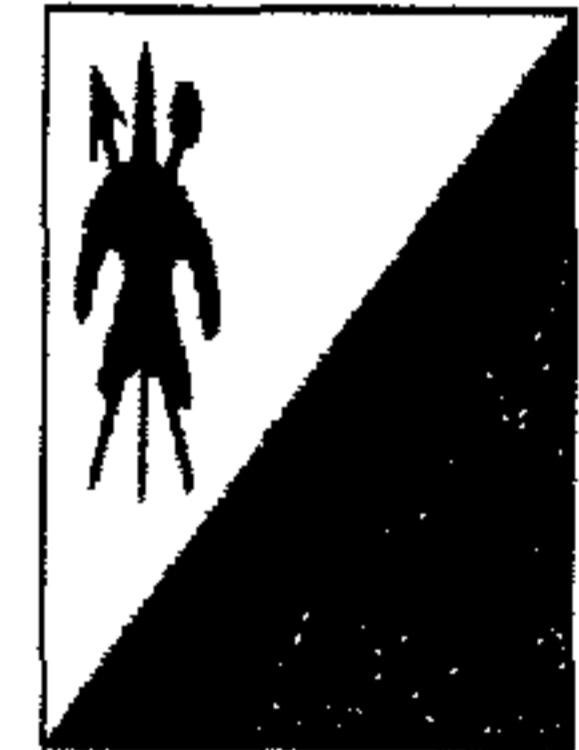
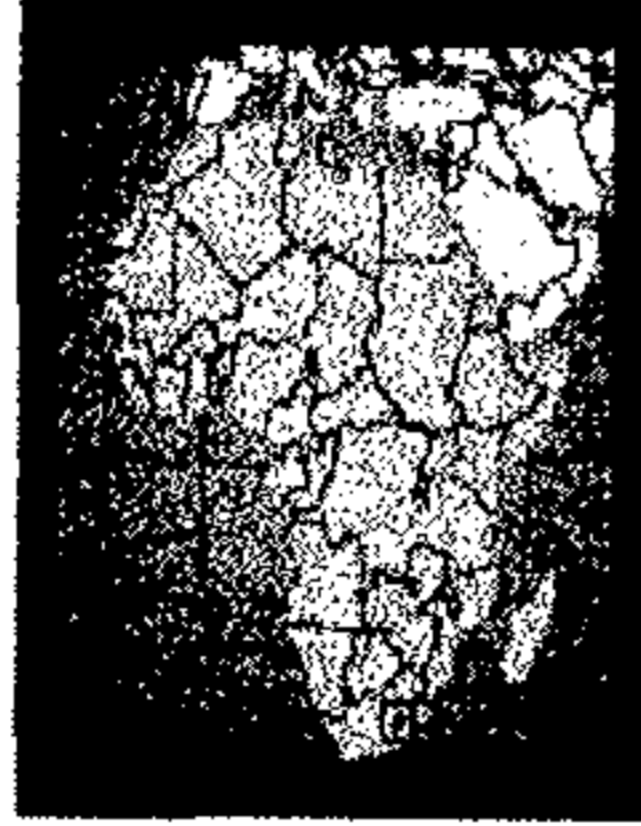
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APPENDIX A:

LESOTHO MAP



| | |
|-------------------------------------|--|
| Country (long form) | Kingdom of Lesotho |
| Capital | Maseru |
| Total Area | 11,720.13 a mi 30,355.00 sq Km (slightly smaller than Maryland) |
| Population | 2,177,062 (July 2001 est.) Note: estimates for this country explicitly take into account the effects of excess mortality due to AIDS; this can result in lower life expectancy, higher infant mortality and death rates, lower population and growth rates, and changes in the distribution of population by age and sex than would otherwise be expected |
| Estimated Population in 2050 | 2,849,325 |
| Languages | Sesotho (Southern Sotho), English (official), Zulu, Xhosa |
| Literacy | 83% total, 72% male, 93% female (1999 est.) |
| Religions | Christian 80%, indigenous beliefs 20% |
| Life Expectancy | 47.97 male, 49.74 female (2001 est.) |
| Government type | Parliamentary Constitutional Monarchy |
| Currency | 1 loti (L) = 100 lisente (cents) |

APPENDIX B:
MASERU MAP

APPENDIX C:
REASONS FOR DRINKING BY TEENAGERS

REASONS FOR DRINKING AND DRUG ABUSE

1. Curiosity: The thrill and excitement of trying something new. Very often leading to **SADNESS** and **SORROW**.
2. PEER PRESSURE: Persuaded by friends to try it and are told how "GOOD" it feels.
3. REVENGE: "I'm always told what to do, where to go, what to wear, what friends to go out with, I'LL SHOW THEM ONE DAY".
4. REJECTION: The fear of being "LEFT OUT". Not being accepted or losing someone special if I do not participate.
5. BAD EXAMPLE: My parents pop pills, drink and smoke. So WHY CAN'T I?
6. SHYNESS: I feel much better (AT EASE) talking to the opposite sex after a few drinks.
7. LOW SELF ESTEEM: Often masked by rebellious, "BIG DEAL" behaviour.
8. DIFFICULTY IN HANDLING PROBLEMS: Problems at school, the club, home etc.
9. LACK OF LOVE: You cannot buy your children – you must love them – SHOW NO FAVOURITISM.
10. LACK OF DISCIPLINE: Parents are afraid to correct their children.
11. INSECURITY: No confidence in their parents. "I FIND IT DIFFICULT TO TALK TO MY PARENTS".
12. PARENTAL BRUTALITY: Child abuse in any form will result in bitterness, resentment, hatred and confusion. A large number of young people take drink and drugs because of parental brutality.
13. TO IMPRESS: Most teenagers, if not all go through the "I want to be noticed" period.

APPENDIX D:
QUESTIONNAIRE FOR STUDENTS

QUESTIONNAIRE FOR STUDENTS

CONFIDENTIAL:

QUESTIONNAIRE FOR STUDY ON "ALCOHOL USE AMONGST TEENAGERS IN SELECTED HIGH SCHOOLS IN MASERU CITY: THE DEVELOPMENT OF A HEALTH EDUCATION PROGRAMME."

Dear Respondent,

I would be grateful if you could give a few minutes to complete this questionnaire. It is designed to assess alcohol use amongst teenagers. The information obtained will help in the identification of specific contributing factor/s to alcohol use so that an appropriate health education programme can be developed.

INSTRUCTIONS:

Please do not write your name.

Tick or write appropriately.

Please answer all questions.

Please tick or answer appropriately:

1. Class (a) D 1
(b)E 2
2. Age (a) 16-19 1
(b) 20-23 2
(c) 24-27 3
3. Sex (a) Male 1
(b) Female 2
4. Religion (a) R.C.C. 1
(b) L.E.C. 2
(c) L.A.C. 3
(d) Other 4 Please specify
-
5. Father's occupation
- (a) Self employed 1
(b) Civil servant 2
(c) Private practice 3
(d) Other 4 Please specify
-

6. Mother's occupation

- (a) Self employed 1
 - (b) Civil servant 2
 - (c) Private practice 3
 - (d) Other 4 Please specify
-

7. Parents' marital status

- (a) Single 1
- (b) Married 2
- (c) Separated 3
- (d) Divorced 4
- (e) Widowed 5

8. Living place

- (a) Boarding 1
 - (b) Rented place 2
 - (c) Home 3
 - (d) Other 4 Please specify
-

9. Who do you stay with during school time?

- (a) Other students 1
- (b) Parents 2
- (c) Grand parents 3
- (d) Relative 4

10. How many are you in your family?

(a) 1-3 1

(b) 4-6 2

11. What number are you in your family?

(a) First Born 1

(b) In Between 2

(c) Last born 3

SECTION B

1. How many of your friends smoke?

- (a) Most 1
- (b) Some 2
- (c) All 3
- (d) None 4

2. How many of your friends drink?

- (a) Most 1
- (b) Some 2
- (c) All 3
- (d) None 4

3. How many of the boys in your class drink alcohol at least once a week?

- (a) 0-10 1
- (b) 11-20 2
- (c) 21-30 3
- (d) 31 & Above 4

4. How many of the teachers in your school drink?

- (a) 1-3 1
- (b) 4-6 2
- (c) 7-9 3
- (d) 10+ 4

5. How do you know that they drink?

- (a) Seen them drinking/drunken 1
- (b) Come to school drunk 2
- (c) Smell liquor 3
- (d) Sent students to buy liquor 4
- (e) Drink with students 5

6. Does your father smoke?

- (a) YES 1
- (b) NO 2

7. Does your father drink?

- (a) YES 1
- (b) NO 2

8. Does your mother smoke?

- (a) YES 1
- (b) NO 2

9. Does your mother drink?

- (a) YES 1
- (b) NO 2

SECTION C

10. Have you ever had an alcoholic drink?

- (a) YES 1
- (b) NO 2

11. If yes, how old were you when you first took the alcoholic drink?

- (a) 10 yrs old 1
- (b) 11-13 2
- (c) 14-16 3
- (d) 17 + 4

12. If NO, do you think you will drink alcohol later in life?

- (a) YES 1
- (b) NO 2

13. If the answer to No. 11 is yes, how do you get your alcoholic drink?

- (a) Buy 1
- (b) Offer from friends 2
- (c) Other, please specify 3

.....

14. From your experience, is it easy to get alcoholic drinks over the counter

- (a) YES 1
- (b) NO 2

15. Where do you get money from to buy alcohol?

- (a) Pocket money 1
- (b) Book fees 2
- (c) School fees 3
- (d) Ask from parents for a different reason 4
- (e) Other, specify 5

16. What type of alcohol do you usually drink?

- (a) None 1
- (b) Beer 2
- (c) Home Brew 3
- (d) Wine 4
- (e) Other 5
- (f) Spirits 6

17. How often do you drink?

- (a) Daily 1
- (b) Weekly 2
- (c) Monthly 3
- (d) Other, specify 4

18. How many times have you ever drunk in your life?

- (a) Never 1
- (b) 1-5 times 2
- (c) 6-10 times 3
- (d) 11-15 times 4
- (e) 16-20 times 5

19. How much alcoholic drink do you consume before you get drunk?

- (a) 1-2 glass 1
- (b) 3-5 glass 2
- (c) 6-8 glass 3

20. Why do you drink?

- (a) To please friends 1
- (b) To forget problems 2
- (c) To have fun 3
- (d) Other (specify) 4

.....
21. How do you feel when you are drunk?

- (a) Happy 1
 - (b) Relieved of stress 2
 - (c) Depressed 3
 - (d) Sorry 4
 - (e) Other (specify) 5
-

22. Have you used other drugs besides liquor?

(a) YES 1

(b) NO 2

If yes specify _____

23. How far is your school from the place where alcohol is available?

(a) 0-1km 1

(b) 2-3km 2

(c) 4-5km 3

(d) 5 & above 4

24. How is your academic performance?

(a) Good 1

(b) Average 2

(c) Bad 3

25. How many times have you missed classes since the beginning of the year because

(a) Of alcohol 1

(b) Of other reasons 2

26. What do you think should be done to students who drink?

(a) Be suspended 1

(b) Be given treatment 2

(c) Be expelled from school 3

(d) Be reprimanded 4

27. What do you think should be done to students who drink?

- (a) Be suspended 1
- (b) Be given treatment 2
- (c) Be expelled from school 3
- (d) Be reprimanded 4

28. Is drinking a bad or good habit?

- (a) Bad habit YES 1
 NO 2
- (b) Good habit YES 1
 NO 2

29. Would you accept alcoholic drink when offered in the following situations?

- (a) At the friends home YES 1
 NO 2
- (b) At sport event YES 1
 NO 2
- (c) When you are with a boy/girlfriend
 you are attracted to YES 1
 NO 2
- (d) After school with friends YES 1
 NO 2

(e) At disco dance with friends

YES 1

NO 2

(f) When you are upset

YES 1

NO 2

SECTION D

30. A drink once in a while does no harm

YES 1

NO 2

Alcohol is food. YES 1

NO 2

Drinking alcoholic beverages can lead to trouble with police

Agree 1

Disagree 2

Don't know 3

Drinking alcoholic beverages can lead to fights and arguments

Agree 1

Disagree 2

Don't know 3

Alcoholic drinks can make one forget problems.

Agree 1

Disagree 2

Don't know 3

You cannot trust people who refuse to drink with you

Agree 1

Disagree 2

Don't know 3

People who drink a lot should be fired from their jobs.

Agree 1

Disagree 2

Don't know 3

Alcohol can make one sick.

Agree 1

Disagree 2

Don't know 3

Students who do not drink get better grades than those who drink.

Agree 1

Disagree 2

Don't know 3

Teenagers get pressurized by friends to drink alcohol.

Agree 1

Disagree 2

Don't know 3

The fun of drinking is to get drunk.

Agree 1

Disagree 2

Don't know 3

APPENDIX E:
QUESTIONNAIRE FOR TEACHERS

QUESTIONNAIRE FOR TEACHERS:

SEX:

FEMALE

MALE

AGE GROUP:

30 - 40

41 - 50

51 - 60

61 - 70

MARITAL STATUS:

Single

Married

Divorced

Separated

Widow

1. For how long have you been working in this school?

- a) 1 – 2 years
- b) 3 – 4 years
- c) 5 years

2. Have you ever suspected that your students are drinking?

- a) Yes
- b) No

3. If yes what made you suspect it?

- a) Appear drunk
- b) You have seen them drinking/drunken
- c) Have alcoholic smell
- d) Other (Specify)

.....

4. If the answer to No.2 is “yes” what did you do about it?

- a) Talk to the student/s about drinking
- b) Tell the Principal of the school
- c) Tell his parents
- d) Punish him/her

5. If the answer to No.2 is “NO” what would you do?

- a) Talk to the students about drinking
- b) Tell the Principal of the school
- c) Tell his parents
- d) Punish him/her
- e) Other (Specify)

.....

6. How many teachers are there in this school?
7. How many of them drink?
8. How do you know that they drink:
- a) I have seen them drinking/drank
 - b) They come to school drunk
 - c) They smell of alcohol
 - d) Other (Specify)
-
9. What do you think should be done to teachers who drink?
- a) Be expelled from school
 - b) Be reprimanded
 - c) Other (Specify)
-
10. What do you think should be done to students who drink?
- a) Be expelled from school
 - b) Be reprimanded
 - c) Other (Specify)
-
11. State whether you agree or disagree?
- Students drink because their teachers drink:
- a) Agree
 - b) Disagree
 - c) Don't know
- Their parents drink:
- a) Agree
 - b) Disagree
 - c) Don't know

Their friends drink:

- a) Agree
 - b) Disagree
 - c) Don't know
 - d) Other (Specify)
-

12. Drinking can affect students' performance:

- a) Agree
- b) Disagree
- c) Don't know

13. Do some of your students miss classes during the day?

- Yes
- No

14. If "yes" during which part of the day?

- a) Morning
- b) Afternoon
- c) Whole day

15. Which days are most of your students absent from school?

- Monday
- Tuesday
- Wednesday
- Thursday
- Friday

16. Do you sometimes drink alcoholic drinks?

Yes

No

17. If yes how often do you drink?

1 – 2 times a week

3 – 4 times a week

5 + times a week

18. Why do you drink?

To have fun

To forget my problems

To relax

To please friends

19. How would you feel if your students see you drinking?

Sad

Embarrassed

Do not mind

Good

Thank you for your cooperation.

APPENDIX F:

FOCUS GROUP DISCUSSION GUIDELINE

FOCUS GROUP DISCUSSION GUIDE FOR PARENTS OF TREENAGERS

Are young people involved in drug and substance abuse?

Are high school students also involved in substance abuse, particularly alcohol?

Why do teenagers use alcoholic drinks?

What could be done to address this problem?

APPENDIX G:

LIST OF LETTERS OF REQUEST

N.H.T.C

P/Bag A189

Maseru – 100

9th February, 1998.

The Chairman
National Research Committee
Ministry of Health & Social Welfare
Maseru – 100

Dear Sir/Madam,

I hereby request permission to conduct a study on “Alcohol use/abuse among teenagers in selected high schools in Maseru city: The development of a health education programme.”

This is for the fulfillment of a requirement for a doctoral degree that I am pursuing with UNISA.

The study is meant to identify specific factors, which lead to alcohol use by teenagers, so that an appropriate health education programme can be developed.

Hoping my request will be favourably considered.

Yours Sincerely,


J.M. Leteka.

N.H.T.C

P/Bag A189

Maseru, 100

12-02-98.

Lesotho Examinations Council
MASERU, 100
Lesotho.

Dear Sir/Madam,

I am a part-time student studying with UNISA. I am interested in adolescent health in Lesotho. As a fulfillment of a requirement for a doctoral degree that I am currently pursuing, I wish to conduct a study entitled "Alcohol use/abuse among teenagers in selected high schools in Maseru City: The development of a health education programme."

In preparation for collection of data, I need to know the number of candidates that have registered for C.O.S.C. final examination this year. I therefore humbly request for such information. This will help in calculating the sample size. The selected high schools are:

1. Adventville High School
2. Lesotho High School
3. LIFE High School
4. 'Mabatrhoana High School
5. Maseru Day High School
6. Maseru High School
7. Sefika High School
8. St. Catherine's High School
9. St. Jame's High School
10. St. Joseph's High School.

Hoping my request will be favourably considered.

Yours Sincerely,


J.M. Leteka

N.H.T.C.

Private Bag A 189

Maseru, 100

12-02-1998.

The Registrar,
Ministry of Education
P.O. Box 47
MASERU, 100

Dear Sir/Madam,

**Re: REQUEST FOR PERMISSION TO UNDERTAKE RESEARCH IN
HIGHSCHOOLS IN MASERU CITY.**

I hereby request for permission to undertake research within high schools in Maseru City.

The title of my study is "Alcohol use/abuse among teenagers in selected high schools in Maseru City: The development of a health education programme." This is the requirement for a doctoral degree that I am pursuing with UNISA.

The research activities will include distributing questionnaires to the students in selected high schools. Hopefully the information obtained will help in identifying the factors that contribute to the use of alcoholic drinks by teenagers so that an appropriate health education programme can be developed.

Hoping my request will be considered favourably.

Sincerely,


J.M. Leteka

N.H.T.C
Private Bag A189
Maseru, 100
8th June, 1998.

The Principal

.....
.....
.....

Dear Sir/Madam,

Re: REQUEST FOR PERMISSION TO UNDERTAKE RESEARCH

I am a part-time student studying with UNISA. As a fulfillment of a requirement for a doctoral degree which I am pursuing, I wish to conduct a research study on adolescent use and abuse of alcohol in high schools in Maseru City.

Your school is one of those high schools that form a sample. I therefore request for permission to conduct such a study. This will hopefully help in identifying specific factors that contribute to teenagers drinking.

The research activities will include responding to a questionnaire, which will take less than an hour to complete. This may take place whenever it is convenient to the school. I also wish to know the number of students in both Form D and E so that I can prepare adequately.

Thanking you in anticipation.

Yours Sincerely,


J.M. Leteka.