Section Eleven:

Overview of Skills-Based Health Education and Life Skills

OVERVIEW OF SKILLS-BASED HEALTH EDUCATION AND LIFE SKILLS

Adapted from: *Life Skills Approach to Child and Adolescent Healthy Human Development* by Mangrulkar, L; Vince-Whitman, C; and Posner, M. Health and Human Development Programs, Education Development Center, Newton, MA (unpublished document).

Introduction

By the year 2010, there will be 1.2 billion youth between the ages of 10 and 19. A growing proportion of these young people will be living Asia, Africa and Latin America. Whether or not this generation will be able to reach its full potential depends on the capacity of families, schools and communities to help youth acquire the skills they need not only for their basic survival, but also for the full development of their social, emotional and cognitive abilities. The challenge of meeting their needs is both clear and compelling; skills-based health or "life skills" education is one way to meet this challenge.

What is Skills-Based Health ("Life Skills") Education?

Skills-based health education focuses on the development of "abilities for adaptive and positive behaviour that enables individuals to deal effectively with the demands and challenges of everyday life" (WHO 1993). The acquisition of life skills can greatly affect a person's overall physical, emotional, social, and spiritual health which, in turn, is linked to his or her ability to maximise upon life opportunities. The success of skills-based health education is tied to three factors: 1) the recognition of the developmental stages that youth pass through and the skills they need as they progress to adulthood, 2) a participatory and interactive method of pedagogy, and 3) the use of culturally relevant and gender-sensitive learning activities.

The primary goal of skills-based education is to change not only a student's level of knowledge, but to enhance his or her ability to translate that knowledge into specific, positive behaviours. Participatory, interactive teaching and learning methods are critical components of this type of education. These methods include role plays, debates, situation analysis, and small group work. It is through their participation in learning activities that use these methods that young people learn how to better manage themselves, their relationships, and their health decisions.

The foundation of this pedagogy is based on a wide body of theory-based research which has found that people learn what to do and how to act by observing others and that their behaviours are reinforced by the positive or negative consequences which result during these observations. In addition, many examples from educational and behavioural research show that retention of behaviours can be enhanced by rehearsal. As Albert Bandura, one of the leading social psychologists in the area has explained, "When people mentally rehearse or actually perform modelled response patterns, they are less likely to forget them than if they neither think about them nor practice what they have seen" (Bandura, 1977).

Cooperative learning or group learning is another important aspect of skills-based programs. Many skills-based programs capitalise on the power of peers to influence the acquisition and subsequent maintenance of positive behaviour. By working cooperatively with peers to develop prosocial behaviours, students change the normative peer environment to support positive health behaviours (Wodarski and Feit). "As an educational strategy, therefore, skills-based health education relies on the presence of a group of people to be effective. The interactions that take place between students and among students and teachers are essential to the learning process."*

In addition to the use of participatory, interactive teaching methods, skills-based health education also considers the developmental stages (physical, emotional, and cognitive) of a person at the time of learning. Each learning activity is designed to be appropriate to the students' age group, level of maturity, life experiences, and ways of thinking. At the same time, participatory activities provide the opportunity for students to learn from one another and appreciate the differences, as well as similarities, among individuals in the classroom setting.

In general, skills-based education targets three broad categories of life skills, cognitive skills, and emotional coping skills. Most programs incorporate each of these skills into their lessons.

Figure 3: Examples Of Life Skills

Social Skills	Cognitive Skills	Emotional Coping Skills
•Communication skills •Negotiation/refusal skills •Assertiveness skills •Interpersonal skills (for developing healthy relationships) •Cooperation skills	• Decision making/problem solving skills -Understanding the consequences Of actions -Determining alternative solutions to problems • Critical thinking skills (to analyse peer and media influences)	• Managing stress • Managing feelings, incl. anger • Skills for increasing internal locus of control (self-management, self-monitoring)

These three skill categories are not mutually exclusive, but rather complement and reinforce each other. For example, a program aimed at promoting social competence in children would teach ways to think about and determine alternatives for handling a potentially violent situation (cognitive skills); to communicate feelings about the situation and get help from others, if needed (social skills); and to manage personal reactions to conflict (emotional coping skills).

To be effective in supporting quality learning outcomes, skills-based health education must be used in conjunction with a specific subject or content area.** Learning about decision-making, for example, is more meaningful if it is addressed in the context of a particular issue (e.g., the decisions we make about tobacco use). In addition, while skills-based education focuses somewhat on behaviour change, it is unlikely that a

* "Handouts 1-5 on Life Skills Education," Gillespie, A. UNICEF (unpublished document)
** This paragraph adapted from "Handouts 1-5 on Life Skills Education," Gillespie, A. UNICEF (unpublished document)

learning activity will affect behaviour change if knowledge and attitudinal aspects are not addressed (e.g., a student will not try to negotiate for effective condom use if he/she doesn't know that they can prevent disease transmission or doesn't believe that condoms are necessary). Therefore, it is important for skills-based approaches to be accompanied by activities which focus on students' knowledge and attitude.

The following figure gives an overview of informational content on which skills-based health education can be applied:

Figure 4: Information Content That Can Accompany Skills-based Health Education

		Examples of Informational Content
Specific Content Areas	Violence prevention/ Conflict resolution	• Potential situations of conflict • Myths about violence perpetuated by the media • Roles of aggressor, victim, and bystander
	Alcohol, Tobacco and other Substance Use	• Social influences to use alcohol, tobacco and other drugs • Potential situations for being offered a substance • Misperceptions about levels of alcohol, tobacco, and other drug use in community/ by peers
	Social Relationships	• Friendships • Dating • Parent/child relationship
	Sexual and Reproductive Health	• Information about STIs/HIV/AIDS • Myths and misconceptions about HIV/AIDS • Myths about gender roles/body image perpetuated by media • Gender equity (or lack of it) in society • Social influences regarding sexual behaviours • Dating and relationships
	Physical Fitness/ Nutrition	• Healthy foods • Exercise/sports • Preventing anaemia and iron deficiency • Eating disorders

In addition, skills-based education emphasises the use of learning activities which are culturally relevant and gender-sensitive. To achieve this, the learning activities offer numerous opportunities for participants to provide their own input into the nature and content of the situations addressed during the learning activities (e.g., creating their own case studies, brainstorming possible scenarios, etc.). This approach ensures that the situations are realistic and relevant to the everyday lives of participants. It is critical that the skills youth build and practice in the classroom are easily transferable to their lives outside the classroom.

Why Is Skills-Based Health Education Important?

Over the last decade, a growing body of research has documented that skills-based interventions can promote numerous positive attitudes and behaviours, including greater sociability, improved communication, healthy decision-making and effective conflict resolution. Studies demonstrate that these interventions are also effective in preventing negative or high-risk behaviours, such as use of tobacco, alcohol and other drugs, unsafe sex, and violence. The table below summarises some of the results from research studies conducted on skills-based education programs. It is important to note that research has also found that programs which incorporate skills development into their curricula are more effective than programs which focus only on the transfer of information (e.g. through lecture format).

Research shows that skills-based health education programs can:

- Delay the onset age of the **abuse of tobacco, alcohol, and marijuana** (Botvin et al, 1995. Hansen, Johnson, Flay, Graham, and Sobel, 1988)
- Prevent **high-risk sexual behaviour** (O'Donnell et al., 1999; Kirby, 1994; Schinke, Blythe, and Gilchrest, 1981)
- Teach **anger control** (Deffenbacher, Oetting, Huff, and Thwaites, 1995; Deffenbacher, Lynch, Oetting, and Kemper, 1996; Feindler, et al 1986)
- Prevent **delinquency and** (Young, Kelley, and Denny, 1997)
- Promote positive **social adjustment criminal behaviour** (Englander-Golden et al. 1989)
- Improve health-related behaviours and **self-esteem** (Elias, Gara, Schulyer, Branden-Muller, and Sayette, 1991)
- Improve **academic performance** (Elias, Gara, Schulyer, Branden-Muller, and Sayette, 1991)
- Prevent peer rejection (Mize and Ladd, 1990)

Who Can Teach Skills-Based Health Education?

Teachers, counsellors, psychologists, school nurses, and other health care providers have all been involved in the delivery of skills-based health education. Key to the success of teaching these skills is comprehensive training for program providers around the basic characteristics of skills-based education. Such training should aim to: 1) increase providers' knowledge around the content of what is being taught/learned; 2) increase providers' familiarity and level of comfort with using participatory and interactive teaching methodology in the classroom; 3) increase providers' understanding of developmental issues in learning; and 4) strengthen providers' skills in the management of classroom behaviour, given that skills-based education is used primarily in a large group setting and often deals with sensitive topics.

EFFECTIVE TRAINING ON SKILLS-BASED EDUCATION TEACHES PROVIDERS HOW TO:
➢ Establish an effective, safe and supportive program environment
➢ Access resources for health information and referral
➢ Address sensitive issues
➢ Model the skills addressed in the program
➢ Apply interactive teaching methodologies in the classroom
➢ Provide constructive criticism, positive reinforcement and feedback
➢ Manage group process

Whichever agency plays the primary role in the implementation of skills-based health education, it is equally important for program providers to collaborate with other local stakeholders and community members in all stages of planning and delivery. For example, providers may want to invite parents to attend training programs to enhance their own skills for communicating with their children or for coping with difficult personal circumstances. Likewise, other community members (e.g., health care workers or police officers) might be invited to participate in specific learning activities both in and outside the classroom. The table below summarises who might be ideally suited to teach skills-based education.

Effective Life Skills Program Providers

Can be…	Should be perceived as…	Should have these qualities…
• Counsellors • Peer leaders • Social workers • Health workers • Teachers • Parents • Psychologists • Physicians • Other trusted adults	• Credible • Trustworthy • High status • Positive role model • Successful • Competent	• Competent in group process • Able to guide and facilitate • Respectful of children and adolescents • Warm, supportive, enthusiastic • Knowledgeable about specific content areas relevant to adolescence • Knowledgeable about community resources

What Are Some Of The Challenges To Implementing Skills-Based Health Education?

Some of the major challenges associated with implementing skills-based education are:

1. Health care providers, youth workers and teachers are often expected to help adolescents develop skills that they *themselves* may not possess. Program providers may need help building assertiveness, stress-management, and/or problem-solving skills for themselves before being able to teach these skills in the classroom. Therefore, an important component of any training program is the inclusion of activities in which potential providers can also address their own personal needs.

2. There is a need to train adults in using active teaching methodologies. Skills-based health education encourages participation by all students, and as a result, can create classroom dynamics with which some teachers are not familiar. Research, however, has found that teachers who were initially uncomfortable with the idea of using participatory methodologies in their classrooms overcame their reluctance after practising these methods during training sessions. Provider confidence is essential to the success of skills-based education.

3. Program providers may feel uncomfortable addressing the sensitive issues and questions that may arise. Some providers may feel unprepared to communicate with their students about sensitive topics such as sexual and reproductive health, violence, and relationships. They also may not know where to go to access additional information on these topics. Again, training teachers prior to implementation on how to best address and respond to questions or comments about sensitive topics is key to overcoming this challenge. Providers should also be encouraged to interact and meet with one another throughout the school year to share ideas and suggestions.

4. Program providers are underpaid and overworked. Program providers may not have the morale or energy to learn new teaching methodologies. Therefore, providers need to understand how skills-based education can have immediate and long-lasting benefits not only on their students' lives but also on their own personal and professional lives. Training programs should include activities which help teachers build skills that they can use in their daily lives, e.g., to improve relationships, avoid sexual violence or harassment, or overcome alcohol or drug use. Studies have shown that skills-based education programs can indeed improve attendance and morale among providers. (Allegrante, 1998)

5. Teachers are often asked to implement many different curricula and instructional efforts, without a clear understanding of the relationships among them and the relative benefits of each. A lack of coordination between school administrators, curriculum coordinators and health and education sectors can result in a number of competing curricula. This can prove to be frustrating to overworked teachers who may start to view new programs as just another addition to their existing workload. Key to overcoming this challenge is a close collaboration between all involved, including teachers, so that there is a clear understanding of how new curricula can realistically be used to complement what is already being implemented.

What Are Some of the Keys to Success When Implementing Skills-Based Health Education?

At the heart of implementation is a planning process that begins with the end in mind. Ensuring a fit between the program, the interests and needs of providers and young people, local conditions and resources is essential. As the challenges suggest, nothing can be implemented without the enthusiasm, buy-in and involvement of the providers. Providers, i.e., teachers, health workers, counsellors, and volunteers, are perhaps the most critical component to the implementation process. In fact, many programs have been successful, even in the absence of any national policies, due to the talent and

commitment of local level people. Examining, taking into account, and responding to the concerns, interests and needs of providers' personal and professional working conditions is a major factor in program success.

Despite the challenges that may accompany the implementation of skills-based education, the rewards and positive outcomes which may result from such programs are immeasurable. By creating a coordinated effort between stakeholders, both local and national, program planners and advocates can help to ensure an educational program that is both effective and sustainable.

References

Allegrante, J. (1998). School-Site Health Promotion for Staff. In *Health is Academic: A Guide to Coordinated School Health Programs*. Editors Marx, E and Frelick Wolley, S. New York: Teachers College Press.

Bandura, A (1977). *Social learning theory*. Englewood Cliffs, NJ: Prentice-Hall.

Botvin, G.J. Schinke, S.P. Epstein, J. A., & Diaz, T. (1995). The effectiveness of culturally focused and generic skills training approaches to alcohol and drug abuse prevention among minority youth: Two-year follow up results. *Psychology of Addictive Behaviours*. 9: 183-194.

Deffenbacher, J., Oetting, E., Huff, M., Thwaites, G. (1995). Fifteen-month follow-up of social skills and cognitive-relaxation approaches to general anger reduction. *Journal of Counseling Psychology*. 42(3): 400-405

Deffenbacher, J., Lynch, R., Oetting, E., and Kemper, C. (1996). Anger reduction in early adolescents. *Journal of Counseling Psychology*. 41(2): 149-157.

Elias, M., Gara, M., Schulyer, T., Brandon-Muller, L., and Sayette, M. (1991). The promotion of social competence. *American Journal of Orthopsychiatry*. 6(13): 409-417.

Englander-Goldern, P., Jackson, J., Crane, K., Schwarkopf, A., and Lyle, P. (1989). Communication skills and self-esteem in prevention of destructive behaviours. *Adolescence*, 14: 481-501.

Feindler, E., Ecton, R., Kingsley, D., and Dubey, D. (1986). Group anger-control training for institutional psychiatric male adolescents. *Behaviour Therapy*. 17: 109-123.

Hansen, W., Johnson, C., Flay, B., Graham, J., and Sobel, J. (1988.) Affective and social influence approaches to the prevention of multiple substance abuse among seventh grade students: Results from Project SMART. *Preventive Medicine*. 17: 135-188

Kirby, D. (1994). School-based programs to reduce sexual risk-taking behaviours: Sexuality and HIV/AIDS education, health clinics, and condom availability programs." Paper presented at the American Public Health Association Annual Meeting, San Diego, October 31, 1994.

Mize, J. and Ladd, G. (1990). A cognitive-social learning approach to social skill training with low-status preschool children. *Developmental Psychology.* 26(3): 388-397

O'Donnell L et al. (1999). The effectiveness of the *Reach for Health* Community Youth Service Learning Program in reducing early and unprotected sex among urban middle school students. *American Journal of Public Health.* 89:176-181.

Schinke, S, Blythe, B, and Gilchrest LD. (1981) Cognitive-behavioural prevention of adolescent pregnancy. Journal of Counseling Psychology 28 451-454.

Young, M., Kelley, R. and Denny, G. (1997). Evaluation of selected life-skills modules from the contemporary health series with students in Grade 6. *Perceptual and Motor Skills*. 84: 811-818.

Wodarski, JS and Feit, MD. (1997) Adolescent Preventive Health: A Social and Life Group Skills Paradigm. Family Therapy. v. 24. no.3. 191-208.

World Health Organisation. Programme on Mental Health. (1993) Life Skills Education in Schools.