COUNSELLING AND BEHAVIOURAL STUDIES JOURNAL

ISSN 2315-7518, Vol. 6, No 2, July 2016

COUNSELLING AND BEHAVIOURAL STUDIES JOURNAL

VOL. 6, No 2

JULY, 2016

ISSN: 2315-7518

Published by the

DEPARTMENT OF GUIDANCE & COUNSELLING,
Faculty of Education, University of Ibadan, Ibadan.

For
COUNSELLING ASSOCIATION OF NIGERIA
(Oyo State Chapter)

Printed by

HIS LINEAGE PUBLISHING HOUSE
09 Alli Street, Mokola Ibadan, Nigeria.
GSM: 0803 3596 818
E-mail: awemakin@gmail.com

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EFFECTS OF SCHOOL-BASED LIFE SKILLS TRAINING ON HEALTH RISK BEHAVIOUR AMONG IN-SCHOOL ADOLESCENTS IN DELTA STATE, NIGERIA

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Abstract

Adolescents in Delta State engage in such health risk behaviour as: smoking, alcohol use, drug abuse, multiple sexual partners and illegal abortion. Health risk taking threatens attainment of individual health and well-being, as well as sustainable national development. There is an urgent need to stem the tide of health risk taking among the youths who are leaders of tomorrow. This study investigated effects of school based life skills training on health risk behaviour among in-school adolescents in Delta State. A pretest-post-test control group quasi experimental research design was adopted in this study. Multi-stage sampling technique was adopted. Simple random sampling technique was used to select one local government area from each of the three senatorial districts. Purposive sampling technique was used to select one co-educational school each from the selected three local government areas. Three secondary schools were randomly assigned to two experimental groups and control group. A sample of two hundred and sixteen students was used in the study. Four research hypotheses were tested at 0.05 alpha level of significance. Data collected were analysed using ANCOVA. Findings showed that, there was a significant main effect of treatment (school based life skills training) on health risk behaviours among in-school adolescents ($F_{(2,204)} = 19.063$ $P<0.05$). Based on the finding, it was recommended that, school teachers should be re-trained

in the use of life-skills and should be encouraged to employ the approach in classroom teaching.

Keywords: In-school adolescents, school based life skill training, problem solving skills, interpersonal skills, health risk behaviour

Introduction

In Nigerian society, health risk behaviour among adolescents is assuming worrisome dimension. This is against the background of the fact that, adolescence is a period of experimentation, risk taking and vulnerability. Specifically in recent times, youths in Niger Delta engage in militancy, hostage taking and pipeline vandalization, obviously under the influence of alcohol use and various substances abuses.

Health risk behaviour is any activity undertaken that inhibits health and well-being. Behaviour within this definition include: non-use of medical services (consulting trained medical doctor, immunization and screening), non-compliance with medical regimens (dietary, diabetics and antihypertensive regimens) and poor lifestyle (diet, exercise, smoking, drug and alcohol consumption). Health risk taking predisposes an individual to disease thereby impairing health and well-being. Adolescence is characterized by creativity, experimentation and risk taking. In the 2003, National Youth Risk Surveillance Survey (YRSS) of the Center for Disease control and Prevention (CDC) (2004), 33% of youth aged 10-24 years said that, they had been in a physical fight, 17% reported carrying a weapon in the month prior to the study, 28% reported episodic heavy drinking in the previous month, 4% reported having sniffed or inhaled an intoxicating substance, 31% of sexually active males failed to use a condom and 79% of sexually active females had failed to use birth control pills during their last sexual intercourse; smoking cigarettes in the previous 30 days was reported by 28% of youths, 22% reported the use of marijuana and 4% reported having used cocaine. Health risk behaviour can result in serious and negative health consequences for the adolescents, their family, friends, schools and society at large.

Health risk behaviours can have adverse effects on the overall development and well-being of the youths. The behaviours can affect youths by disrupting their normal development or preventing them

from participating in typical experiences for their age group. For example, teenage pregnancy can prevent youths from experiencing typical adolescent events such as: graduating from school or from developing close friendship with peers.Action Health (2003) asserted that, health risk behaviours contribute to unintentional injuries and diseases. Increased incidences of unintended pregnancies and sexually transmitted diseases including HIV infection among adolescents are as a result of health risk behaviours such as: early sexual initiation, unprotected sexual intercourse multiple sexual partners, alcohol use and other substance abuses.

Life skill is a group of psychosocial and interpersonal skills that can help individuals make informed decisions, communicate effectively and develop coping and self-management skills towards leading healthy and productive life (United Nations International Children Emergency Fund, 2005). Life skillsare abilities for adaptive and positive behaviour that enables individuals to deal effectively with the demands of everyday life. Life skills are as innumerable as nature and the definition differs across cultures. However, problem solving and communication are prominent types of life skills.

Problem solving skills are abilities to identify problems correctly, understanding the sources and causes constructively. The skill can assist in choosing the best alternatives from many sources to solve a problem. Development of this skill enables an adolescent to be accepted in the society, while developing the acceptance of social norms, which is essential to prevent an adolescent delinquent behaviour. Baranowski (1997) opined that, when children and adolescents are faced with social situations for which they are unprepared emotionally and cognitively, they may respond with aggression or violence. Problem solving skills can improve adolescents' ability to avoid violent situations and solve problems non-violently by enhancing their social relationships with peers, teaching them how to interpret behavioural cues, and improving their conflict-resolution skills. World Health Organization(1999) described communication skill as an important process which is used by an individual to transfer ideas, information or feelings to others. It also helps to express oneself both verbally and non-verbally through gestures, in a way that, messages are not distorted and detached. Communication skill helps adolescents to negotiate, be assertive without getting aggressive, thus helping him or her to become more

acceptable and confident (United Nations Office on Drugs and Crime UNODC, 2006). Thus, Life skill training is an effective tool for empowering the youth to act responsibly, take initiativeto take control. It is based on the assumption that, when young people are able to rise above emotional impasses arising from daily conflicts, entangled relationships and peer pressure, they are less likely to resort to anti-social or health risk behaviour.

Gender and religion are the two moderating variables in this study. The use of gender as a moderating variable in an experimental study can yield useful practical information. Saewye (1998) found in a study on gender difference in health risk behaviour among adolescents that, both younger and older girls were significantly more likely than their male age mates to report a history of sexual abuse, dissatisfaction with weight, negative body image, more dieting and earlier age of sexual intercourse, while boys were significantly more likely than girls to drink alcohol more often in greater quantity. Youths hold religion in high esteem as most of them participate in religious activities in places of worship. Brown, Lohr and McClenahan (1986) in a study found a negative association between religiosity and a variety of risk behaviours, including: sexual behaviour, alcohol abuse, smoking marijuana or cigarettes smoking. Ofole and Agokei (2014) found religiosity among some variables to have negative relationship with adolescents' risky sexual behaviours in Delta State, Nigeria. Sinha, Ramand and Richard (2007) had earlier found that, religious variables were consistently associated with reduced risk behaviour as regards smoking, alcohol use, truancy, sexual activities, marijuana use and depression. The study however observed that, while religion can be a voice of moderation and often promotes pro-social behaviour, teenagers are also inundated by multiple voices calling them to experiment risk taking. Thus, the assumption that valuing religion and participating in religious activities moderate risk behaviours call for further examination.

The method used in teaching life skills is built upon the social learning theory. The theory is premised on the basic fact that, people learn not only through their own experiences, but also by observing the actions of others and results of those actions. The theory explains human behaviour in terms of continuous reciprocal interaction between cognitive, behavioural and environmental influences. Social learning theory is a valuable and effective tool for health educators to assist

students in gaining new health supportive skills (Recapp, 2015). Social learning theory is the foundation for the technique of behaviour modeling which is widely used in training programmes.

The achievement of a sustainable health behaviour change is a function of provision of training programme, using appropriate method of delivery. Life skills approach is an interactive educational method that focuses on acquiring knowledge, attitudes and interpersonal skills. Itaimed at enhancing young people's ability to take greater responsibility for their own lives by making healthy choices, thus gaining greater resistance to negative pressures and avoiding health risk behaviours.

Adolescents' social life in this contemporary society is bedeviled by health risk behaviours as there are increasing incidences of un-intended pregnancies, drug abuse, gang-rape and smoking of *cannabis sativa*. Obviously, such behaviours do not only affect health negatively, but also impede learning outcomes in school subjects;unfortunately little has been done to change conditions that give rise to risky healthbehaviours. This study demonstrates the effectiveness of life-skill training on health risk behaviour among in-school adolescents in Delta State, Nigeria.

Purpose of the Study

This study examined the effect of school based life skill training on health risk behaviour of in-school adolescents in Delta State.

Hypotheses

The following hypotheses were tested in the course of this study

1. There is no significant main effect of treatment on health risk behaviours of in-school adolescents in Delta State.
2. There is no significant main effect of gender (male and female) on health risk behaviour of in-school adolescents in Delta State.
3. There is no significant main effect of religion (Christianity and Islam) on health risk behaviour of in-school adolescents in Delta State.
4. There is no significant three-way interaction effect of treatment, gender and religion on health risk behaviour of in-school adolescents in Delta State.

Methodology

Research Design

The study adopted a pretest-posttest, control group, quasi-experimental research design. It made use of two experimental groups and one control group. Experimental groups were exposed to the treatments which are life skills modules on interpersonal/communication skills and problem solving skills, while the control group received health instruction on environmental health. Pretest questionnaire was administered on all the three groups, treatments given to experimental groups and all the groups received post-test questionnaire.

Experimental group 1	O_1	X_1	O_2
Experimental group 2	O_1	X_2	O_2
Control Group	O_1	X_3	O_2

Where

O_1	=	Pretest measure
O_2	=	Posttest measure
X_1	=	Interpersonal/communication skills
X_2	=	Problem solving skills
X_3	=	Environmental health education

Population

The population for the study comprised all adolescents from public secondary schools in Delta State, Nigeria.

Sample and Sampling Technique

The sample for this study comprised 309 students selected from three public secondary schools in Delta State but due to subject mortality, two hundred and sixteen (216) representing (70.5%) of the selected sample completed the study.

A multi-stage sampling technique involving three stages wasused to draw participants for this study. The first stage involved the use of simple random sampling of fish bowl with replacement to select one local government area from each of the three senatorial districts. The selected local government areas were: Uwie local government that represented Delta Central Senatorial district; Oshimili South,

represented Delta North senatorial district and Isoko South local government represented Delta South senatorial district. Purposive sampling technique was used in the second stage to select one co-educational public secondary schools from Uwie, Oshimili North and Isoko South local government areas respectively. In the third stage, random selection was used to assign Saint Micheal's Grammar School Oleh to experimental group 1, Osadenis High School Asaba to experimental group II, while the Institute of continuing Education Warri was assigned to control group. A total of 155 (male and female) participants from senior secondary Iand 154 from Senior secondary II across the three schools volunteered for the study.

Research Instrument

The instruments used for this study are as follow:

1. Violent-Related attitude behaviours and influences among youths which is a compendium of assessment tools (2nd ed) edited by Dahlberg, Toal, Swahn and Behrens (2005) and documented by Centers for Disease Control and Prevention. The original instrument has four sections viz attitude and belief assessment, environmental assessment, violent behaviour assessment and health risk behaviour assessment. In this study, healthbehaviour assessment was adopted.
2. The training manual (Interpersonal/Communication Skills, Problem Solving Skills and Environmental Health Education).The manuals provide outlines and instructions for eight weeks training. Training schedule, instructions and activities based on health risk behaviour are contained in the manual.
3. Adolescent Health Risk Behaviour Questionnaire (AHRBQ)

The health risk behaviour questionnaire (AHRPQ) was validated and tested for reliability by administering it on another sample different from the study area but with the same characteristics. The exercise yielded a Cronbach alpha value of 0.76 which was considered suitable for use in this study.

Procedure

Data Collection

The data collection exercise was undertaken with the assistance of five trained teachers. The AHRBQ was administered for the pre-test. The pretest was followed by the school based life-skills training programmes which lasted for 8 weeks. The school based life-skills training programme took place twice a week with the duration of 1 hour for each contact. Treatment group one was exposed to communication and interpersonal skills using life-skills approach for a period of 8 weeks. Treatment group two had problem solving skills training using the life-skills approach for a period of 8 weeks. The control group was given direct classroom instruction on personal health and environmental health one hour, two times a week for eight weeks.

Data Analysis

Data were analyzed with the use of inferential statistics of Analysis of Co-variance (ANCOVA).Hypotheses set at 0.05 level of significance.

Results

Hypothesis One

There is no significant main effect of treatment on health risk behaviour of in-school adolescents in Delta State.

Table 1: Effect of Treatment on Adolescents Health Risk Behaviour

Source	Sum of Squares	Df	Mean Square	F	Sig.	Partial Eta Square
Main Effect: Pretest health risk behavior	21091.508	11	1917.410	30.353	.000	.621
Treatment	2408.370	2	1204.185	19.063	.000	.157
Gender	206.840	1	206.840	3.274	.072	.016
Religion	103.825	1	103.825	1.644	.201	.008
2-way Interactions: Treatment	203.777	2	101.889	1.613	.202	.016

group x Gender						
Treatment group x Religion	51.714	2	25.857	.409	.665	.004
Gender x Religion	32.563	1	32.563	.515	.474	.003
3-way Interaction: Treatment x Gender x Religion	38.101	1	38.101	.603	.438	.003
Explained	21091.508	11	1917.410			
Residual	12886.696	204				
Total	**33978.204**	**215**				

The table one above shows that $F_{(2,204)}$, indicating the main effect of treatment on adolescent health risk behaviour is 19.063; P<0.05. The P value (0.000) is less than 0.05 alpha level of significance therefore there is significant main effect of treatment on adolescent health risk behaviour. The null hypothesis was not accepted. There was a significant main effect of treatment on health risk behaviour of in-school adolescents in Delta State. The partial Eta squared estimated was 0.157. This implies that, treatment accounted for 15.7% of the variance observed in the health risk behaviour after treatment.

Table 2: Estimated Marginal Means analysis of treatment on adolescents health risk behaviour

Grand Mean= 87.29	N	Mean	Std Error	95% confidence Interval	
Treatment group				lower bound	Upper bound
Problem solving Expgrp 2	74	98.070	.959	96.178	99.961
Communication Expgrp 1	72	88.333	.972	86.417	90.248

Control	70	74.813	.986	72.869	76.756

Table two above shows that, experimental group II had the highest mean score of 98.07 followed by experimental group I with a mean score of 88.33 and control group with a mean score of 74.81. This reveals that, problem solving was more effective compared with the group exposed to interpersonal and communication skills.

Hypothesis Two

There is no significant main effect of gender (male and female) on health risk behaviour of in-school adolescents in Delta State.

The result presented in table one shows that, $F_{(2,204)}$ indicating the main effect of gender on adolescent health risk behaviour is 3.274; P>0.05. The P value (0.72) is greater than 0.05 alpha level of significance hence, the null hypothesis is accepted. There is no significant main effect of gender (male and female) on health risk behaviour of adolescents in Delta State. Partial eta squared of 0.16 implies that, gender accounted for 1.6% of the observed variance on health risk behaviour among adolescents in Delta State.

Hypothesis Three

There is no significant main effect of religion (Christianity and Islam) on health risk behaviour of in-school adolescents in Delta State.

The result presented in table one shows that, $F_{(2,204)}$ indicating the main effect of religion on adolescent health risk behaviour is 1.644; P>0.05. The P value (0.201) is greater than 0.05 alpha level of significance hence, the null hypothesis is retained. There is no main effect of religion (Christianity and Islam) on health risk behaviour of in-school adolescents in Delta State. Partial eta squared of .008 implies that, gender accounted for 0.8% of the observed variance on adolescents' health risk behaviour.

Hypothesis Four

There is no significant three-way interaction effect of treatment, gender and religion on in-school adolescents health risk behaviour in Delta State.

The result presented in table one shows that, $F_{(2,204)}$ indicating the main effect of three-way interaction effect of treatment, gender and religion on health risk behaviour is .603; P>0.05. The P value (.438) is greater than 0.05 alpha level of significance hence, the null hypothesis is retained. There is no main effect of three-way interaction effect of treatment, gender and religion on in-school adolescents' health risk behaviour in Delta State. Partial eta squared of .033 implies that, three-way interaction effect of treatment, gender and religion accounted for 0.3% of the observed variance on adolescents' health risk behaviour.

Discussion of Findings

The purpose of the study wasto determine the effects of school based life skills training (problem solving and communication skills) on health risk behaviour of in-school adolescents in Delta State. The result revealed that, there was significant main effect of treatment on the adolescents' health risk behaviour.

This implies that, the adolescents exposed to problem solving and interpersonal/communication skills were more convinced not to exhibit health risk behaviours compared with the group not exposed to the training. This result is consistent with a research report of Breidenbust (2007) that, assertiveness training skills provided and equipped participants with appropriate skills to face dilemma to be firm and take control of their lives. In-school adolescents exposed to problem solving skills had higher posttest mean score. This result can be attributed to the fact that, problem solving skills are a combination of skills that enable the individual resolve conflicts.

The finding of the study revealed that, there was no significant main effect of gender on health risk behaviour of in-school adolescents in Delta State. This implies that, being a male or female did not aid the effect of the intervention. Male and female adolescents have the same perception of health risk behaviour. However, the result is at variance with Wickrama, Conger, Wallace and Elder (1999) who found that, gender significantly affected adolescent health risk behaviour.

The result of this study revealed that, there was no significant main effect of religion on adolescent. Being a Muslim or Christian does not have any impact on the effectiveness of the intervention. This finding may be as a result of the fact, that most preaching at worship centres of recent are no more directed at eliminating social vices ratheron wealth acquisition, and prosperity no matter the source.

In this study, it was found that, three way interactions among treatment, gender and religion was not significant. The result is consistent with Eweniyi, Adeoye, Ayodele, Kolawole and Raheem (2013) who reported that, there was no significant difference in the three way interactions of treatments, class type and religion on bullying behaviour of secondary school students because, the combination of class types and religion did not aid the effect of cognitive self-instruction and contingency management on bullying behaviour of secondary school students.

Conclusion and Recommendations

It was concluded that, Life skill (Problem solving and communication/interpersonal skills) training had significant main effect on in-school adolescent health risk behaviour. If the life skill approach is properly focused in the teaching of Health Education topics, there will be higher likelihood that, sustainable behavioural change will be achieved among adolescents who are vulnerable to health risk taking. The following are therefore recommended:

1. The use of life skill approach in the teaching of health education topics in secondary school should be encouraged to ensure effective teaching and learning.
2. Facilities and equipment needed for the use of lifeskill approach in classroom teaching of health education should be provided.
3. Religious leaders should endeavour to include in their sermon during worship sessions reduction of health risk behaviour among adolescents.
4. Life skill training should be organized in form of capacity building for secondary school teachers.
5. Secondary school teachers should attend educational seminars, conferences and workshops so as to keep them abreast of new and emerging methods, approaches and strategies for effective teaching.

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