EFFECTS OF SCHOOL-BASED LIFE SKILLS TRAINING ON VIOLENCE AND HEALTH RISK BEHAVIOURS AMONG IN-SCHOOL ADOLESCENTS IN DELTA STATE

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CERTIFICATION

I certify that this research work was carried out by Lokoyi Ose-lovet Osita, under my supervision in the Department of Human Kinetics and Health Education, University of Ibadan, Ibadan, Nigeria.

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DEDICATION

This thesis is dedicated to God Almighty, my Mother Mrs.Catherine Ifechukwude Iyegbu and my children, Kemi and Tobi.

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ABSTRACT

Secondary school adolescents in Delta State are increasingly engaging in violence and health-risk behaviours which negatively affect their cognitive performance, emotions, choices and overall quality of life. This trend warranted the integration of life-Skills into the secondary school curriculum with a view to changing the in-school adolescents' negative behaviours. Previous studies have shown non implementation of life-Skills training included in the school curriculum in Delta State; hence the continued occurrence of violence and health-risk behaviours among the students. This study, therefore, determined the effects of school-based life-Skills (interpersonal Skills and problem-solving Skills) training on violence and health-risk behaviours of in-school adolescents in Delta State, Nigeria. The moderating effects of gender and religion were also examined.

The study adopted pretest-posttest control group, quasi experimental design with a 3x2x2 factorial matrix. The social learning and ecological theories were adopted for the study. Purposive sampling technique was used to select one co-education public secondary school with large student population from each of the three senatorial districts. Two hundred and sixteen (116 and 100 female) Senior Secondary I and II students with records of violence and health-risk behaviour in the three schools were purposively selected. Participants were randomly assigned to interpersonal Skills training, problem solving Skills training and the conventional groups. The training lasted eight weeks. Adolescents Violence Behaviour (r=0.81), Adolescents health-risk behaviour (r=0.76) questionnaires and Interpersonal and problem-solving Skills training manuals were used for data collection. Data were analyzed using Analysis of Covariance and Sheffe post-hoc test at 0.05 level of significance.

Treatment had a significant main effect on in-school adolescents' violence ($F_{(2,204)}$=34.67; n^2=0.25) and health risk behaviour ($F_{(2,204)}$=19.06; n^2=0.16). Adolescents exposed to problem-solving Skills training had the lowest reduction in violence ($\bar{x}$=64.04) and health-risk behaviour reduction ($\bar{x}$=98.07) than those exposed to interpersonal Skills (violence =$\bar{x}$=51.81; health risk = $\bar{x}$=88.33) and control group (violence =$\bar{x}$=43.43; health risk= $\bar{x}$=74.81). There were no significant main effects of gender and religion on violence and health-risk behaviours among adolescents. The two-way interaction effects of treatment and gender on violence behaviour was significant ($F_{(2,204)}$=5.05; n^2=0.047, P<0.05), and not significant on health-risk behaviour. The two-way interaction effect of treatment and religion was not significant on both violence and health-risk behaviour. The three-way interaction effects of treatment, gender and religion on violence and health risk-behaviour was not significant.

Problem-solving Skills and interpersonal Skills trainings were effective strategies for reducing violence and health risk behaviours among in-school adolescents in Delta State, Nigeria. Secondary school students therefore should be exposed to the two life-Skills training, regardless of gender and religion.

Keywords: In-school adolescents in Delta State, School-based life-Skills training, Problem-solving Skills, Interpersonal Skills, Violence and health-risk behaviour.

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CHAPTER ONE

INTRODUCTION

Background to the Study

Adolescence is a time of excitement and of anxiety, of happiness and of trouble, of discovery and breaks with the past and yet of links with the future. Vous and Baker, (2005) stated that adolescence is a vital stage of growth and development that marks the period of transition from childhood to adulthood and is characterized by rapid physiological changes as well as psycho-social maturation. During this period, young people extend their relationships beyond their immediate families and are extremely influenced by their peer groups and the world in general. The period of adolescence can also be described as truly the years of creativity, idealism, buoyancy and adventure, experimentation and risk-taking. Adolescence is therefore an evolutionary period in one's life, a time to harness one's potential but also a period of vulnerability.

In the Nigerian society, the problems of youth violence and health risk in adolescents have assumed wider dimensions. These behavioural problems especially in the Niger Delta region have assumed an alarming proportion. In recent times, behavioural problems among the youths include restiveness, militancy, kidnapping, hostage taking, armed robbery, oil pipe-line vandalism, hooliganism, cultism and gangsterism. In Niger Delta Region (NDR), about 90% of the crude oil in the country comes from the numerous, large, producing fields located in the swamps. Some have argued that the years of oil exploration activities and frequent oil spills have led to severe environmental degradation with resultant destruction of farmlands and aquatic flora and fauna. Consequently, Niger Deltans believed that the oil boom has impacted more negatively on their lifestyle. They argued that years of neglect by the government and other relevant agencies have resulted in the region, being the epitome of hunger, poverty and injustice. It is estimated that 10 million people in the area are destitute with 14 million people living in poverty in rural communities (Okonta, 2007). The degradation in natural resources of the area has greatly been linked with

the poor health patterns exhibited by the adolescents; yet they are rarely targeted in researches and interventions.

Rutter and Quine (2004) found in a study that health risk behaviours are promoted by boredom, rebellion, disorientation, peer pressure and curiosity. The study also identified psychological factors such as the changes in reproductive organs that occur during adolescence as a motivating force for experimenting with sex. They believe that the inability to tackle emotional pain, conflicts, frustrations and anxieties about the future were also the driving force for high risk behaviour. These risky sexual activities, according to Okonta and Oseji (2006), make this group more vulnerable to reproductive morbidities including sexually transmitted infections, unintended pregnancies and their complications. Jenkins (2011) observed that it is normal for young people to begin to separate from their parents and establish their own identity at this adolescent stage. In some cases, this may occur without a problem from parents and other family members. However, in other cases, the adolescent may find it difficult adhering to family rules and sanctions, often misinterpreted for wickedness, and the tendency for rebellion to occur, leading to conflict and violence as parents try to exercise authority.

The world health organization (WHO) (2002) defined violence as the intentional use of physical force or power, threatened or actual, against oneself, against another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation. Violence and abuse are used to establish and maintain power and control over another person and often reflect an imbalance of power between the victim and the perpetrator. The world report on violence and health identifies typology of violence that explains four modes of violence as physical, sexual, psychological attack, and deprivation. It further divides the general definition of violence into three sub-types according to the victim-perpetrator relationship: self-directed violence, Interpersonal violence, and collective violence.

The persistent spread of community violence shows that schools and their surroundings are no longer protected environments, but contribute to the everyday

violence reported within communities. Today, school violence has increased tremendously. In a school setting, an individual's social interactions usually consist of classmates holding similar values and ideas. As a result, adolescents are likely to engage in behaviours similar to those of their friends. Associations with violent peers may increase the likelihood of violent behaviour (Luthar, 1995 and Elliott, 1994). If violence is considered by a peer group to be a favourable response to conflict, individuals who are part of this group are more apt to resolve conflicts violently. Although students may handle situations in school through violent and unhealthy behaviours, the schools remain a place where they can learn not to display such behaviours. Centre for Disease Control (CDC) (2010) described school violence as a subset of youth violence which is a broader public health problem. The phenomenon of school violence encompasses all incidents in which any member of the school community is subjected to abuse, threats, intimidation or humiliation, or physical assault from a student, teacher or staff member.

Violence in schools has lasting effects on children, youths, the family, and the community. Morotti and Roberts (2000) opined that students who are repeatedly victimized generally show a broad range of emotional and behavioural problems, including sleep disturbances, separation anxiety, hyper-vigilance, irritability, regression, emotional withdrawal, blunt emotions and distractibility. Violence in school settings affects negatively the quality of teaching. Schools with high levels of violent behaviour may have a negative impact on the already low levels of neighbourhood cohesion and contribute to the intensification of overall crime in the larger society. Research has shown that violence such as frequent fighting, bullying, verbal and physical abuses are used in response to conflicts. Owoaje and Ndubisi (2010) asserted that among adolescents in school, fighting and bullying are the commonest forms of violence and have been associated with increased likelihood of physical injuries and psychosomatic health problems. Many researchers have advocated that increased attention be given to school climate, since school connections was found to be a major predictor of adolescent health, academic outcomes, violence

prevention and a protective factor in risky sexual and drug use behaviours (Ogba and Duze, 2013).

The way humans behave play a vital role in the maintenance of health and the prevention of disease. Steptoe and Wardle (2004) viewed Health-risk behaviour as any activity undertaken by people with a frequency or intensity that increases risk of disease or injury. CDC (2016) identified priority health risk behaviours as habits that contribute to unintentional injuries and violence such as motor vehicle crashes, homicide, and suicide, alcohol and other drug abuse, tobacco use, unhealthy dietary behaviours, physical inactivity and sexual behaviours that contribute to unintended teen pregnancy and sexually transmitted infections, including HIV/AIDS.These behaviours are usually established during childhood, through adolescence, and might culminate into a risky lifestyle in adulthood. Much of the mortality and morbidity is caused by individual behavioural patterns, polluted environment or poverty. Statistics shows that half of the premature death from the ten leading causes in developed countries is caused by preventable factors, such as tobacco use, alcohol abuse, physical inactivity, unhealthy dietary habits, risky sexual practices, and non-adherence to effective medication regimes and to screening programmes (Gray, 1993).

Health risk behaviours can have adverse effects on the overall development and well-being of 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, teen pregnancy can preclude youths from experiencing typical adolescent events such as graduating from school or from developing close friendship with peers. Action health incorporated (2003) opined that health risk behaviours contribute to unintentional injuries and violence as well as sexual behaviours that contribute to unintended pregnancy and sexually transmitted diseases, including HIV infection, liver cirrhosis and lung cancer.

Adolescents' behaviours that are distressing and socially disruptive, such as having multiple sex partners, can result in problems for the individual and others, while such behaviours as stealing or use of weapons, can result in problems for others as well as for the adolescents. Health-risk behaviours in adolescents can result in serious

consequences for the adolescents, their families, friends, schools and the society. In the 2003 national youth risk surveillance survey (YRSS) of the centers for disease control (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 had 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 in the YRSS; 22% reported the use of marijuana and 4% reported having used cocaine. Problem behaviours such as these put adolescents at risk in studying morbidities in adolescence and adulthood and even premature mortality.

Violence and health risk behaviours vary according to gender. Boys are more likely to experiment with fighting and skipping school and to drink more than girls. Saewye's (1998) study on gender differences in health and risk behaviour among adolescents shows that both younger and older girls were significantly more likely than their male counterparts to report a history of sexual abuse, dissatisfaction with weight, negative body image, and early participation in sexual intercourse. Younger and older boys are significantly more likely than girls to have positive body image, to rate themselves as healthier than their peers, to report no regular source of healthcare, to be sexually more experienced and to drink alcohol more often in greater quantity.

A study on religious activity and health risk among African American Youths revealed a negative association between religiosity and a variety of risk behaviours, including sexual behaviour, alcohol abuse, smoking marijuana or cigarettes (Brown, Lohr and McClenahan 1986. In a related study, Ofole and Agokei (2014) found religiosity among other variables to have negative impact in adolescents' risky sexual behaviours in Delta State. On closer examination, however, the religious–risk connection appears more complex in boys than in girls, African American teens are more likely to attend religious services and perhaps not surprisingly, are less likely to smoke cigarettes or drink alcohol. Yet, young African Americans have been known to engage in sexual intercourse and smoke marijuana as often as or even more often than

other youths of African origin (Johnston 2008). According to Ofole and Agokei (2014), there is still much controversy underlying the mechanism through which religion affects adolescents' sexual behaviour in Nigeria

There are indications that youths perceive religion as important, and are therefore active in religious worship and activities. These perceptions in the importance of religion as well as in its participation are associated with decrease in risk behaviours. (Sinha, Ramand and Richard, 2007). Religious variables were consistently associated with reduced risk behaviour with regard to smoking, alcohol use, truancy, sexual activity, marijuana use and depression. The study suggested however that while religion can be a voice of moderation and often promotes pro-social behaviour, teens are also inundated by multiple voices calling them to experimentation in risk-taking.

Health risk behaviours influence cognitive performance, emotions and the overall quality of life. The impact of risky behaviours on health is of such magnitude that it has become one of the priorities of the national and international health organizations. In Delta State, about one third of sexually active adolescents have had more than one partner (Oboro, and Tabowei, 2003). The fear is that health risk behaviours might culminate into a risky lifestyle. Literature suggests that teenage substance abuse is correlated to numerous risk behaviours including delinquency, conduct disorders at school, school dropout, violent and aggressive behaviours, unplanned and unprotected sexual intercourse,(Rutter and Quine, 2004).It is also indicated that 10-20% of youths engage in behaviours that put them at substantial risk for negative secondary problems such as sexually transmitted diseases, pregnancy and low self-esteem; (Youth Risk Behaviour Surveillance Survey, 2011 and Centers for Disease Control and Prevention, 2012)

United nations international children's emergency fund (UNICEF) (2005) has identified life Skills as a large 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 lives. Life Skills enables one develop adaptive and positive behaviour that help individuals deal

effectively with the demands of everyday life. Life skills are innumerable and the nature and definitions differ across cultures. However, an analysis of life skills field suggest that there are numerous sets of skills for the promotion of health and well-being of children and adolescents. These skills include decision making, problem solving,creative thinking, critical thinking, effective communication, interpersonal relationship skills, self awareness, empathy, coping with emotions and stress. Life skills training is an effective tool for empowering the youth to act responsibly, take initiative and control. It is based on the assumption that when young people are able to rise above emotional impasses resulting from daily conflicts, entangled relationships and peer pressure, they are less likely to resort to anti-social or high risk behaviours. Communication skills are an important process with which individuals can transfer ideas, information or feelings to others. It helps to express self both verbally and non-verbally through gestures.

It is appropriate to one's culture and for young people who are put in compromising situations, However, understanding these skills helps the adolescents to negotiate and apply refusal skills in reproductive health issues, alcohol consumption, tobacco smoking and drug use, become assertive, feel more acceptable and confident(USAID, 2006). Problem solving skills enhance abilities to identify problems correctly, understanding its sources and causes very constructively. These skills also assist one in choosing the best alternative from many to solve problems. Developing these skills enables adolescents to be accepted in the society, while learning to integrate into the social norms, which is essential to preventing delinquent behaviour. Baranowski (1997) opined that when children and adolescents are faced with social situations for which they are emotionally and cognitively unprepared, they respond with aggression or violence. Problem solving skills can improve students' ability to avoid violent situations and solve problems non-violently by enhancing their social relationships with peers, teaching them to interpret behavioural cues, and improving their conflict-resolution skills. Continuous and comprehensive evaluation (CCE) (2012) asserted that life skills can be effective in the more difficult task of achieving and sustaining behaviour change. Life skills focus on behaviour change or

developmental approach designed to address a balance in three areas - knowledge, attitude and Skills. Life Skills approaches are made more effective by with interactive teaching methods, which include role playing, open discussions, small group activities and other techniques that are an integral part of the approach. Children as young as 5 years of age can be taught using the life skills approaches. The assumption is that one-way communication which includes lectures, demonstrations without discussion, is not interactive. Rather, activities that engage participants in an active and positive way and in which they are attentive, reflective and actively involved could be said to be interactive. (Shure and Spivack, 1988).

The methods used in teaching life skills are built upon the social learning theory and on what we know of how young people learn from their environment, from observing how others behave and what consequences arise from behaviour. Life skills approach is an interactive educational methodology that focuses on acquiring knowledge, attitudes and interpersonal skills which are aimed at enhancing young people's ability to take greater responsibility for their own lives by making healthy choices, gaining greater resistance to negative pressures, and avoiding risk behaviours. Therefore, this study using two major skills, demonstrates the effectiveness of life skills training on adolescents' violence and health risk behaviour in Delta state.

Statement of the Problem

Adolescents' violence and health risk taking activities are on the rise and rapidly emerging as a global health concern. In a nationwide situational analysis survey of school violence in Nigeria conducted by the Federal Ministry of Education (2007), it was revealed that physical violence and psychological violence accounted for 85% and 50% respectively of the bulk of violence in schools.

Adolescents are vulnerable to many vices in the society because of the fact that they are ready to explore and experiment in their environment. It is worrisome that in Delta State, students and staff do not feel physically safe in secondary schools. There are reports of school principals, teachers and students who have been insulted, teased, harassed or verbally abused in the school. Adolescents are bedeviled with violence and

health risk behaviours, as there are increasing incidences of gang-rape, un-intended pregnancies, drug use, cooking and smoking of Indian hemp, hostage taking, gangs and cult activities, car snatching, kidnapping and robbery. Obviously, educators cannot carry out their mandate of educating in a violence ridden environment, yet little has been done to change conditions that give rise to violent and health risk behaviours.

The tide in violent upsurge can be stemmed with a school-based life skills approach in reproductive health education, alcohol and drug education and peace education because these can have more impact than teaching knowledge alone in dealing with these issues. When adolescents can make good decisions about their sexual and reproductive health, through adequate and reliable information, then they will have the opportunity of developing values and attitudes that agree with health goals, as well as the skills to behave in accordance with their knowledge and values.

However, implementing life skills education in schools has proved problematic because methods of teaching have remained conventional, thereby creating a gap. It is on this premise that the research examined the effects of school-based life skills training on violence and health risk behaviours of in-school adolescents in Delta State.

Main objective of the study

The main objective of this study was:

To determine the effect of school based life skills training on violence and health risk behaviours among in-school adolescents in Delta State.

Specific objectives of the study

The specific objectives of the study were:

1) To examine the effect of treatments on violence and health-risk behaviours among in-school adolescents in Delta State;
2) To determine the moderating effect of gender on violence and health-risk behaviours among in-school adolescents in Delta State;
3) To investigate the moderating effect of religion on violence and health-risk behaviours among in-school adolescents in Delta State;

4) To examine the interactive effect of treatment and gender on violence and health-risk behaviours among in-school adolescents in Delta State;
5) To determine the interaction effect of treatment and religion on violence and health-risk behaviours among in-school adolescents in Delta State;
6) To ascertain the interaction effect of gender and religion on violence and health-risk behaviours among in-school adolescents in Delta State;
7) To examine interaction effect of treatment, gender and religion on violence and health-risk behaviours among 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
   a) Violence related behaviours
   b) Health risk behaviours among in-school adolescents in Delta State.
2. There is no significant main effect of gender (male and female) on
   a) Violence related behaviours.
   b) Health risk behaviours among in-school adolescents in Delta State.
3. There is no significant main effect of religion (Christianity and Islam) on
   a) Violence related behaviours
   b) Health risk behaviour among in-school adolescents in Delta State.
4. There is no significant interaction effect of treatment and gender on
   a) Violence related behaviours
   b) Health risk behaviours among in-school adolescents in Delta State
5. There is no significant interaction effect of treatment and religion on
   a) Violence related behaviours
   b) Health risk behaviours among in-school adolescents in Delta State
6. There is no significant two-way interaction effect of gender and religion on
   a) Violence related behaviours
   b) Health risk behaviours among in-school adolescents in Delta State

7. There is no significant three-way interaction effect of treatment, gender and religion on
   a) Violence related behaviours
   b) Health risk behaviours of in-school adolescents in Delta State.

Delimitations of the Study

This study was delimited to the following:

1. Pre-test - post-test control group, quasi-experimental research design using 3x2x2 factorial matrix.
2. Male and female in school adolescents from selected public secondary schools in three local government areas in Delta state.
3. Two experimental groups and one control group
4. Multistage sampling technique
5. Independent variables of school-based life skills (Interpersonal and problem solving skills).
6. Dependent variables of violence related behaviours and health risk behaviours
7. Moderating variables of gender and religion
8. The adapted, modified and revalidated questionnaire of violence-related attitudes, behaviours and influence among youths as instrument for data collection
9. Cronbach alpha to determine the reliability of the instrument
10. Descriptive statistics of frequency counts and percentages to analyse the demographic attributes of respondents. analysis of co-variance (ANCOVA) to test the hypotheses set at 0.05 alpha levels.
11. Ten trained research assistants.

Limitations of the Study

The participants for this study were adolescents in the senior secondary schools; hence any generalization should be made only on adolescents in the senior secondary. The research aimed at using three hundred and nine (309) participants for

the study; however, owing to the inability of some of the students to continue with the experiment, only two hundred and sixteen participants concluded the study.

Significance of the Study

The promotion of children's health through schools is being recognized globally as an important means of influencing health behaviour. The findings of the study revealed that the eight weeks' life skills training which provided a platform through which in-school adolescents were exposed to knowledge of the school-based life skills and access to health information and services, had positive impact on the participants. Invariably, this study may increase the proportion of in-school adolescents who adopt protective measures (use condoms), abstained from early sexual debut, reduction in alcohol intake, tobacco use, a reduction in fighting and carrying of weapons. The report indicates that bullying, victimization, anti-social behaviour are reduced with the school based life skills training.

This study may have provided adequate information to various stakeholders and increased teachers' awareness on their roles in substance abuse prevention, by setting clearly defined roles, monitoring children's activities, praising children for appropriate behaviours and giving moderate, and consistent disciplinary actions when children break the rules as part of teaching boundaries. It also provides clear guidelines for appropriate social interactions and behaviour.

Operational Definition of Terms

Adolescents; Boys and girls in public secondary schools, age range from 13 to 19.

Aggression: Students' perception of how acceptable it is to behave aggressively, both under varying conditions of provocation and when no conditions are specified.

Bullying: The process of intimidating and maltreating a weaker person or a person in a more vulnerable situation.

Drug and alcohol use: To involve in self-medication, use of illicit drugs, and alcohol consumption.

Tobacco Use: Smoking of tobacco as well as chewing weeds.

Violence behaviour: Deliberate use of physical force or power, against fellow students, teachers or against a group or community, resulting in injury, death, psychological harm, mal - development or deprivation.

Health risk behaviour: Such activities which adolescents indulge in that make them prone to being infected with sexually transmitted infections, and other diseases.

Life Skills: Group of skills with the ability to induce positive behaviour in adolescents, so that they can deal effectively with the demands and challenges of everyday life.

Sexual behaviours: Activities such as masturbation, multiple sex partners, early sexual debut, unprotected sex, unintended pregnancy and homosexuality among students.

School-based life skills training: An intervention carried out within the school setting that provides regular access to children throughout their developmental years.

In-School Adolescents: Adolescents who are in secondary schools.

Interpersonal skills: A combination of communication, assertiveness, negotiation and skills for finding help.

Problem solving skills: A collection of goals setting skills, self esteem, value clarification and decision making skills.

Risk-taking: This refers to the tendency to engage in behaviours that have the potential to be harmful or dangerous and also have possible positive outcomes.

CHAPTER TWO

LITERATURE REVIEW

In this chapter, relevant theories, conceptual and empirical literatures have been reviewed and discussed under the following sub-headings:

1. Conceptual Framework for the Study

2. Theoretical Reviews

(a) Social learning theory

(b) Ecological learning theory

(c) Sub-cultural and Patriachal theories

(d) General strain theory

(e) Theories of adolescent development

3. Conceptual Reviews

(a) The concept of adolescence

(b) Concept of Violence

(c) Violence among adolescents

(i) Bullying

(ii) Aggression

(iii) Gangsterism

(iv) Cultism

(d) Concepts of adolescence health risk behaviour

(e) Patterns of Health Risk Behaviour among adolescents

(g) Drug and alcohol Use among adolescents

(h) Tobacco smoking behaviour among adolescents

(i) Risky Sexual Behaviours

(j) Adolescents Reproductive Health Needs

(k) Concepts of life skills

(l) Components of life skills

(m) Interpersonal skills

(n) Negotiation skills

(o) Skills for finding help

(p) Values

(q) Self Esteem

(r) Goal Setting

(s) Decision Making

(t) Impact of life skills Education

4. Empirical Review of Life Skills Based Interventions

(a) Effects of life skills Training on violence and health risk behaviour among adolescence

(b) Effects of life skills training on gender

5. Appraisal of Reviewed Literature

CONCEPTUAL FRAMEWORK FOR THE STUDY

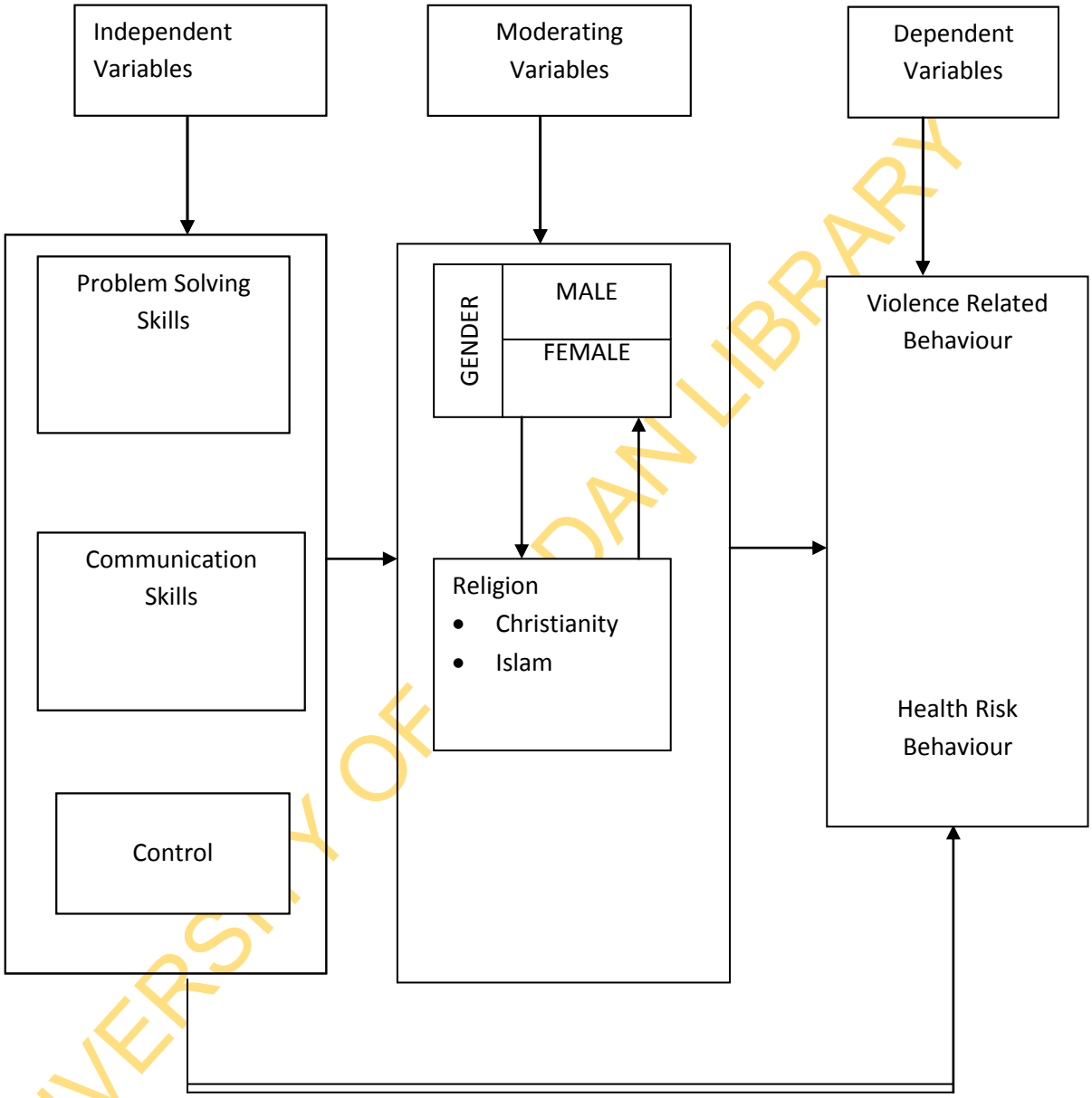


Figure 2.1: conceptual framework for the study

Source: Self-developed

THEORETICAL REVIEWS

The following theoretical approaches were adapted in this study.

Social Learning Theory (SLT) is a psychological theory of behaviour developed by Albert Bandura in 1977. The theory is based on the idea that we learn from our interactions with others in a social context, by first observing the behaviours of others, assimilating and imitating that behaviour, and thereafter developing similar behaviours especially if the observed experiences are positive ones or include rewards. Muro and Jeffrey (2008) believed that the social learning theory is a bridge between behaviourist learning and cognitive learning theories because it encompasses attention, memory, and motivation.

In the second and third stages of social learning, imitation and behaviour modeling, will occur by people observing positive and desired outcomes in the first stage. According to Bandura (1986) imitation involves the actual reproduction of observed motor activities. For an example, an instructor attends and observes a course. If he is entertained, informed, and approves of the way students respond to the course, he may be more likely to want to teach the course himself.

One of the other formats of learning is described as a form of internal reward, such as pride, satisfaction, and a sense of accomplishment. Muro and Jeffrey (2008) supporting Bandura's Social learning theory SLT concepts, suggest that this kind of learning also emphasises internal thoughts and cognitions and could help connect learning theories to cognitive developmental theories. In this regard, Bandura (1986) criticized the process and believed that external, environmental reinforcement is not the only factor that could influence learning and behaviour.

Application of SLT to the Study

Social learning theory posits that violence is learned through social experiences and that learning occurs through conditioning (Winfree, Backstrom, and Mays, 1994). It shows that an individual is conditioned by positive and negative social experiences and mechanisms. Behaviour, therefore, is acquired through the effects, outcomes, or consequences which it has on a person's environment and resulting appraisals

associated with it (Akers, 1985).In a school setting, an individual's social interactions usually consist of classmates holding similar values and ideas. As a result, adolescents are likely to engage in behaviours similar to those of their friends.

Applying the concepts of social learning theory to conflict resolution programmes results in the following propositions. As pro-social conflict resolution techniques are shown to produce positive outcomes and as individuals' perceptions of personal efficacy are enhanced, pro-social conflict resolution techniques are likely to be retained and reinforced in social interactions. As a result, pro-social problem-solving competence in interpersonal conflict situations can be increased.

Previous studies confirmed that at least part or many behaviours can be learned through modeling. Some examples that can be cited in this regard are that students, for instance, can watch parents read, watch the demonstrations of mathematics problems, or see someone acting bravely in a fearful situation (Bandura, 2006a). Based on this concept, aggression can also be learned through models. Researches indicate that children become more aggressive when they observe aggressive or violent models. From this view, moral thinking and moral behaviour are influenced by observation and modeling. Consequently, learning includes moral judgments regarding right and wrong which could partly be developed through modeling.

In this study, life skills training was carried out among in-school adolescents in Delta state, Nigeria with the aim of reducing violence and health risk behaviour. Based on the concept of SLT, individuals learn through modeling. The researcher and the research assistants served as models by empowering the participants to act positively towards achieving healthy lifestyles as adults. The intervention also addressed self efficacy of the adolescents in order to increase their ability to make their own decision on behaviour. Furthermore, when the risk of this behaviour is analyzed from a social cognitive learning perspective, it shows that the knowledge and Skills to exercise self protective behaviours are necessary but not sufficient (Bandura, 2008). During the intervention, the models emphasized interactive teaching methods, such as dramatization, songs, poetry, simulations, role playing, open discussions, small group activities and other techniques that are integral part of the life skills approach.

Programmes based upon the principles of social learning theory have successfully promoted social problem-solving competence, enhanced perceptions of self-efficacy, outcome expectations, and reduced high-risk behaviours (Caplan, Weissberg, Grober, Sivo, Grady, and Jacoby, 1992; Allen,Leadbeater and Aber, 1990). They have shown, for example, the relationships between these concepts and growth in coping skills and reductions in self-reported substance use. Since social Skills training have successfully reduced other high-risk behaviours, it is relevant to consider and discuss these same concepts in relation to conflict resolution. Through violence prevention training, adolescents are provided with the knowledge and opportunities for positive experiences and reinforcement in resolving interpersonal problem situations non-violently. Their perceptions of self-efficacy and expectations of the outcomes of competent behaviour may be enhanced through this modeling. This enhancement may foster adolescents' social problem-solving competence, which in turn could promote non-violent interpersonal conflict resolution strategies.

Basic assumptions of the social learning theory

Social learning theory has several assumptions and principles:

1. Humans are social beings who learn by observing the behaviour of others and the outcomes (reinforcements and punishment) associated with that behaviour.
2. Observed behaviours which are rewarded will be repeated (imitation).
3. The person whose behaviour is being imitated is called the role model and the process of imitation is called modeling**.**
4. Learning can sometimes occur without a change in behaviour. This behaviour may occur at a later time or may never occur.
5. Cognitive processes play an important role in learning. Some of these cognitive processes include attention, memory, rehearsal, motivation and expectations of reinforcement or punishment (Ormrod, 2004).

Ecological theory

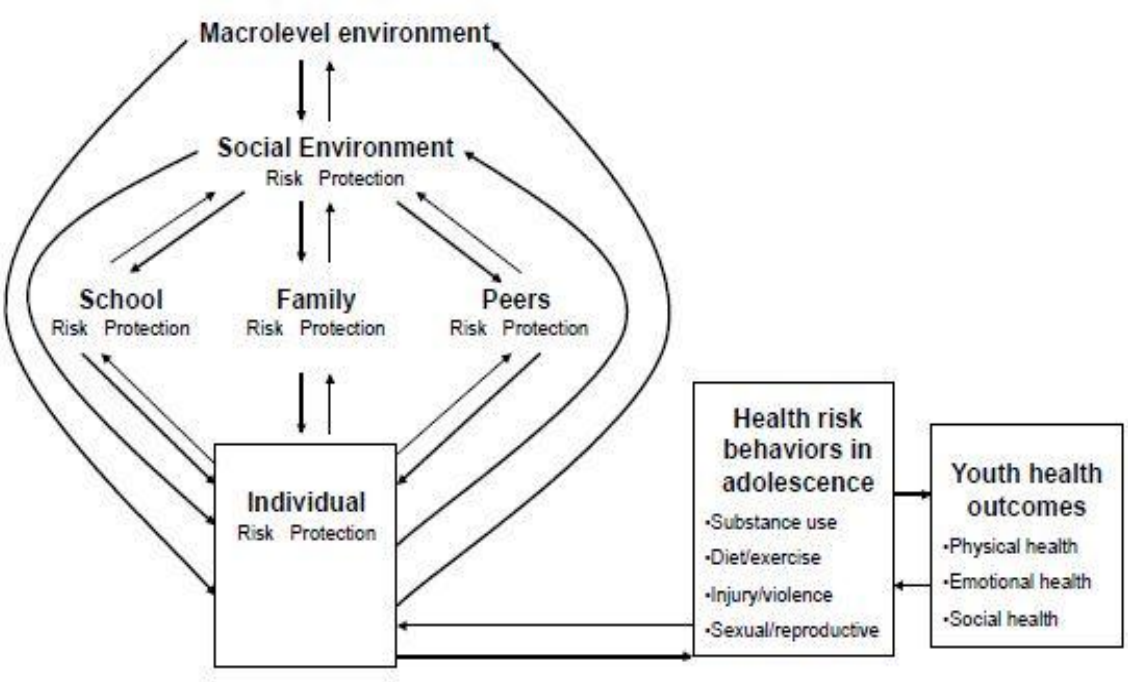
Brofenbrener's (1979) theory of the ecology of human development states that in order to understand human development, it is necessary to consider the environment surrounding an individual's immediate setting. It is the inter-relationship between the environment, the individual's behaviour, and the social processes that are important in the development of positive behaviour. Ecological models of violence have characterized violent actions as a result of individual, inter-personal, and social risk factors (Tolan and Guerra, 1994). Brofenbrener (1979) described violence as dependent on multiple influences within a person's immediate surroundings (for example, the individual, family, peers, school, and community) and influences outside the immediate environment (societal attitudes toward violence). Ecological models assume that the multiple levels influencing an individual have direct effects on an individual's risk for delinquent or violent activity (Tolan and Guerra, 1994). The ecological model has important implications for conflict resolution and violence prevention programmes. According to this model, interventions must be designed to address all possible influences of violent behaviour (Tolan and Guerra, 1994a; Zigler, Taussig, and Black, 1992). This presumption is supported by Gottfkedson and Gottfkedson (1993) who found that schools with high levels of disorder and high failure rates generally have poor climates while schools with a climate based on positive rewards, are more orderly and have less student misconduct.

School conflict resolution programmes often target the individual at the level of intervention while community-based intervention programmes may target multiple systems for intervention (Tolan and Guerra, 1994a; Tolan and Guerra, 1994b; Commission on Violence and Youth, 1993). Conflict resolution programmes that do not address the school environment appear to be destined for limited results. Gottfkedson (1987) pointed out that implementation of programmes in schools with a high number of problems is difficult unless the intervention is also aimed at improving the school as a whole.

Research on school environment programmes are limited, but it has indicated that school improvement programmes have been moderately successful in improving

the school environment, decreasing the number of suspensions, and decreasing the number of delinquent and drug-related activities in schools (Gottkedson, 1987, Lane and Murakami, 1987).

Ecological model of adolescent behaviour(Blum, McNeely, & Nonnemaker, 2002)



Assumptions of the ecological theory

The ecological theory has the following assumptions:

1. That human development is a process through which the growing person acquires a more extended differentiated and valid conception of the ecological environment and becomes motivated and able to engage in activities that reveal the person ability to restructure that environment at levels of similar or greater complexity in form and content.

2. That an individuals' behaviour is as a consequence of the interaction between the person and the environment. It is the question of an influence that is effective in both ways: person influences environment and environment influences person.

3. Environmental conditions produce different developmental results depending on the personal qualities of the individuals living under these conditions.

4. Development and socialization are influenced by the different width rounds or circles of the environment with which a person is in active inter-relation (Harkonen, 2007).

The subcultural and patriarchal theories;

These theories are a subset of the social learning theories of violence. The theory asserts that violence is not inherent but as a result individual nurture. These explanations of aggression and violence address issues of gender-centric attitudes and maintain that these behaviors are learned and precipitated by a combination of contextual and situational factors (O'Leary 1988). The social context of the "dysfunctional" family, for example, produces stress, aggressive personalities, and violent behavior. Or the situational factors like alcohol or drug abuse, financial problems, or marital infidelity accommodate exercises in aggression and violence. Probably, the most familiar of these social learning theories is the intergenerational transmission of family violence explanation which contends that people who have witnessed or suffered physical family violence when growing up have a greater likelihood of living in a violent domestic situation later on in life. There are also associations between those people who have been sexually abused, especially boys, becoming sexually abusing teenagers and adults (Kaufman and Zigler 1987).

General strain theory

General strain theory is a theory of criminology developed by Robert Agnew. Broidy, (2001) Robert Agnew's general strain theory is considered to be a solid theory, and has accumulated a significant amount of empirical evidence, and has also expanded its primary scope by offering explanations of phenomena outside of criminal behavior strain theory is a sociology and criminology theory originally developed in 1957 by Robert K. Merton. The theory states that society puts pressure on individuals to achieve a socially accepted goals (such as the American dream) though they lack the means, this leads to strain which may lead the individuals to commit crimes. However in response to studies that had failed to support traditional strain theory's core proposition that the inability to achieve desired goals such as middle-class status

or economic success would motivate adolescents to engage in delinquency, Instead of one general strain-producing source, Agnew identified three major sources

1) The failure to achieve positively valued goals, including the disjunction between expectations and actual outcomes and the perception of what would be a fair or just outcome and actual outcomes

2) The removal (or threat of removal) of positively valued stimuli that the actor already possesses (e.g., the death of a parent or the loss of a girlfriend)

3) Presentation with noxious or negatively valued stimuli, such as abuse. Agnew argued that much of this strain originates from negative relationships that the person has with others and the negative emotions (both emotional states and traits, with the latter being linked to cumulative exposure to strains) such as anger, frustration, and resentment that result from these relationships. The corrective response to these negative emotions may take the form of crime (especially when the costs of crime are relatively low, the individual is experiencing low levels of social control, and the individual is disposed to commit crime; Agnew 2006), with the behavioral solution being instrumental (get back what one lost), retaliatory (strike out against the perceived cause of the stress), or escapist (e.g., engage in substance use to alleviate the displeasure from the negative emotional state) in nature.

A number of factors converge to increase the risk of experiencing strains for adolescents. According to Agnew, adolescents

a) Experience lower levels of social control than children, which lowers the amount of protection against harms and strains afforded to teens by parents and other loved ones;

b) Are more likely to associate with delinquent peers, who in turn are more likely to get into conflicts with each other and those outside of the peer group;

c) Live in a larger, more demanding social world, with increased interactions governed by subtle social cues, resulting in an increased risk of failure and/or negative treatment by peers, teachers, and others;

d) Greater likelihood of viewing their world as aversive (due to a combination of increased egocentrism during the teen years and a tendency to blame others for problems);

e) Limited autonomy to pursue desires and immediate goals, including privileges reserved for adults

This likelihood of greater exposure to strains (for adolescents) is exacerbated due to an increased risk of employing crime as a coping strategy. Agnew suggests that teens have poorer problem-solving and social skills than adults (children have poor skills as well but are subjected to greater protection from parents) because they are inexperienced in using coping skills. Additionally, adolescents tend to lack important coping options available to adults, such as escape (e.g., leaving an abusive home or dropping out of school) or money (which often facilitates legal coping in response to strains). Adolescents, compared to younger children, are more likely to employ crime as a coping strategy because of the reduced cost of crime (because of the lower social control experienced by teens) and if they are exposed to delinquent peers, are more likely to use crime to cope because of peer pressure, socialization, and as a "face-saving strategy". Hence, crime and deviance should peak during adolescence because of the convergence between greater exposure/experience with strains and the increased likelihood of coping with the resultant negative affect experienced by engaging in crime/deviance.

Theories of Adolescents Developmental stages

Piaget's Period of Development

Piaget described development in terms of sequential changes in how children think. He proposed that children grow through three periods of development, each distinguished by a different way of thinking. Piaget's cognitive development through adolescence involves:

i. Movement from concrete to abstract thinking and

ii. decrease in egocentric thought.

Prior to adolescence, the thinking of a child is concrete. The acquisition of formal reasoning skills allows older adolescents (about age 15) to think about many possible outcomes of a situation that do not exist now. They can construct possibilities and assess probabilities. Imagine, for instance, that you pose the hypothetical situation of an adolescent pregnancy. An adolescent with formal reasoning skills (with appropriate guidance) could try to think through the full implications of parenting a new born. The transition from concrete to completed formal operational thinking could result in stages between the ages of 11-14. By sharing experiences with peers, adolescents learn that many of their thoughts and feelings are shared by almost everyone. This realization helps to feel less unique or less abnormal – and more like others. The egocentric thinking of early adolescence thus diminishes by about the age of 15 (Stroufe and Cooper, 1988).

Piaget's Theory of Cognitive Development

According to Wells (2004), the most well-known and influential theory of cognitive development is that of Swiss psychologist Jean Piaget. The theory grew out of decades of extensive observation of children, including his own, in their natural environments as opposed to the laboratory experiments of the behaviours. Although Piaget was interested in how children reacted to their environment, he proposed a more active role for them than that suggested by learning theory. He envisaged a child's knowledge as composed of schemas, basic units of knowledge used to organize past experiences and serve as a basis for understanding new ones.

Schemas are continually being modified by two complementary processes that Piaget termed assimilation and accommodation. Assimilation refers to the process of taking in new information by incorporating it into an existing schema. In other words, people assimilate new experiences by relating them to things they already know. On the other hand, accommodation is what happens when the schema itself changes to accommodate new knowledge. According to Piaget, cognitive development involves an ongoing attempt to achieve a balance between assimilation and accommodation that he termed equilibration (Wells, 2004).

At the centre of Piaget's theory is the principle that cognitive development occurs in a series of four distinct, universal stages, each characterized by increasing sophisticated and abstract levels of thought. These stages always occur in the same order, and each builds on what was learned in the previous stage. They are as follows:

i. **Sensory motor stage (infancy):**In this period, which has six sub-stages, intelligence is demonstrated through motor activity without the use of symbols. Knowledge of the world is limited, but developing, because it is based on physical interactions and experiences. Children acquire object permanence at about seven months of age (memory). Physical development (mobility) allows the child to begin developing new intellectual abilities. Some symbolic (language) abilities are developed at the end of this stage.

ii. **Pre-operational stage (toddlerhood and early childhood):**In this period, which has two sub stages, intelligence is demonstrated through the use of symbols, language use matures, and memory and imagination are developed, but thinking is done in a non-logical, non-reversible manner. Egocentric thinking predominates.

iii. **Concrete (elementary and early adolescence):** In this stage, characterized by seven types of conservation (number, length, liquid, mass, weight, area and volume), intelligence **operational stage** is demonstrated through logical and systematic manipulation of symbols related to concrete objects. Operational thinking develops (mental actions that are reversible). Egocentric thought diminishes.

iv. **Formal operational stage (adolescence and adulthood):**In this stage, intelligence is demonstrated through the logical use of symbols related to abstract concepts. Early in the period there is a return to egocentric thought.

Only 35 percent of high school graduates in industrialized countries obtain formal operations; many people do not think formally during adulthood.

Summarily, adolescents' ages between12 and 18 are at the "formal operation" stage of Piaget's cognitive development theory. It is characterized by an increased independence for thinking through problems and situations. During this period,

Adolescents have the ability to think about what is possible, instead of limiting their thought to what is real. Considering what they observed against a backdrop of what is possible; this means that they can think hypothetically.

At adolescence, it is also easier to think more abstractly and comprehend abstract logics inherent in proverbs and metaphors. During adolescence individuals begin thinking more often about the process of thinking itself, or meta-cognition. As a result, adolescents may display increased introspection and self-consciousness. A fourth change in cognition is that thinking tends to become multidimensional, rather than limited to a single issue. Adolescents describe themselves and others in more differentiated and complicated terms and find it easier to look at problems from multiple perspectives. Being able to understand that people's personalities are not one-dimensional or that social situations can have different interpretations depending on one's point of view permits the adolescent to have far more sophisticated and complicated relationships with other people.

Finally, adolescents are more likely than children to see things as relative, rather than absolute. This means that they are more likely to question others assertions and less likely to accept facts as absolute truths. This increase in relativism can be particularly exasperating to parents, who may feel that their adolescent children question everything just for the sake of argument. Difficulties often arise, for example, when adolescents begin seeing their parent's values as excessively relative (Wells, 2004).

CONCEPTUAL REVIEWS

Concepts of adolescence

Adolescence originated Sfrom Latin word "*adolescere*" which means to "grow into maturity" or "grow up'. Most definitions emphasize the difficulty and tension associated with this period. Others emphasize the biological changes that are geno-typically and phenol-typically evidenced during this period.

According to the Mosby's dictionary (2009), adolescence means to grow up. It is the period in development between the onset of puberty and adulthood. It usually begins between 11 and 13 years of age with the appearance of secondary sexual characteristics that span through the teenage years, terminating within the ages of 18 and 20, leading into adulthood. During this period, the individual undergoes extensive physical, psychological, emotional, and personality changes. Adolescents are often referred to as teenagers because of the age bracket (13-19 years) in which they fall into. This period marks the entry into adult life. A critical and challenging period for human development, a period in which an individual begins to develop a stance towards the world or forming an identity.

Amao-Kehinde (2008) defined adolescence as a period of storm and stress, a crisis looming period; a no man's land characterised by overlapping forces and expectations, a period when they are caught between two worlds (childhood and adulthood) and may lead to crises in the life of the adolescent.

Adolescence according to Adegoke (2003), is one of the most fascinating and complex transitions in the lifespan of a man, a time of accelerated growth and change second only to infancy; a time of expanding horizon, self discovery and emerging independence; a time of metamorphosis from childhood to adulthood.

World Health Organization (WHO)(2003) defined adolescence as a time of transition from childhood, during which young people experience changes following puberty but do not immediately assume the roles, privileges and responsibilities of adulthood. UNFPA (1997) annual report on adolescent reproductive health considered adolescence as a period of increased risk-taking and therefore susceptibility to

behavioural problems at the time of puberty and new concerns about reproductive health.

According to Makinwa-Adebusoye (1997), there is no universal definition of adolescence; biologically it is defined as the period of progressive transition between childhood and adult life which begins among the females with the onset of menstruation. Socially, however, adolescence is a period between the onset of menstruation and marriage. Thus, the adolescent period may be short if marriage follows soon after menarche, or long if, for some reasons, one is into education, a long period elapses before marriage.

Gleitman, Fridlund and Reisberg (2004) expressed the view that traditionally, adolescence is a stage of emotional stress. This notion goes back to the romantic movement of the early nineteenth century when writers such as the German poet, Johann Wolfgang von Goethe (1749-1833) wrote influential works that featured youths in desperate conflict with cyclical adult world that drove them to despair, suicide, negative sexual activities or violent rebellion.

Steinberg (1996), talking from the developmental change point of view, defined adolescence as a time of transition which includes important biological, social, emotional and cognitive changes that take place quite rapidly over a relatively short period of time accompanied by turmoil. The individual at this stage assumes adulthood and is emotionally accepted in most ways as an adult, by his peer group whom he refers his behaviour to, for approval. Chauhan (1998), on his part, remarked that adolescence is a process rather than a period, a process of achieving the attitude and beliefs needed for effective participation in the society. It is obvious that for an acceptable and active participation of an individual in the society, he or she needs to achieve attitudes and beliefs that adults adjudge to be in line with the norms of the society. From the foregoing, it can be said that adolescence is a critical stage and it actually dictates what adulthood will be in terms of life disposition.

Concept of Violence

Violence, as defined by the World Health Organisation (2002), and as cited in Federal Ministry of Education (2007), is the intentional use of physical force or power, threatened or actual, against oneself, against another person, or against a group of community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation. In this definition, there is a very strong correlation between intentionality and commission of an act itself, irrespective of the outcome it produces. It encompasses all types of violence and covers the wide range of acts of commission and omission that constitute violence and outcomes beyond deaths and injuries. Violence, broadly speaking, includes any condition or act that creates a climate in which the individual feels fear or intimidation in addition to being a victim of assault, theft or vandalism (Federal Ministry of Education, 2007; Aluede, 2011).

Violence is divided into three broad categories: self-inflicted, interpersonal, and collective. Each category is subdivided to reflect specific types of violence, settings of violence, and nature of violent acts (physical, sexual, psychological, and deprivation or neglect). Although analysis of specific types of violence is worthwhile, it is also important to understand their links. For example, victims of child abuse have an above average chance of becoming involved in aggressive and violent behaviour as adolescents and adults, and sexual abuse during childhood or adolescence has been associated with suicidal behaviour. Many risk factors, such as alcohol abuse, the availability of firearms, or socio-economic inequalities are also common in most types of violence.

Violence Among Adolescents

Violence in adolescents occur in a variety of settings, including homes, schools and communities and may take many forms such as child maltreatment, bullying, physical fighting, teen dating violence and homicide(World Health Organization, 2015).It is estimated that two out of every three youth are exposed to violence as victims or witnesses.(Attorney General's National Task Force on Children Exposed to

Violence,2012).Homicide, while less than 20 percent of all deaths in 2013, remains among the leading causes of death for adolescents each year. Many of the health issues that begin in adolescence as a result of violence can persist or worsen in adulthood. In addition to obvious outcomes such as injury and death, exposure to violence can cause mental health issues, relationship problems, future violence victimization or perpetration, and risky or unhealthy behaviours.

Violence occurs within the context of a larger set of factors, including social, physical and economic, environments among others. These circumstances—where youth live, learn and play— are referred to as the social determinants of health. For adolescents, family, friends, peers, schools, communities and societal messages are all part of the social environment that affects choices, behaviours, and current and future health. As a result, many adolescent health issues are challenging to address even in traditional health care settings, such as doctors' offices and emergency rooms. The family and home—where the youth live—can have a profound effect on whether they experience violence. Youth can be victims of child maltreatment, which includes abuse and neglect or witness violence from other family members. Reports suggest that by the time children are in adolescence, about 40 percent have been exposed to family violence(Attorney General's National Task Force on Children Exposed to Violence, *Defending Childhood*).Nationally, nearly 700,000 children were victims of abuse and neglect in 2013, and more than 1,000 died as a result of these abuse or neglect. According to the United States Department of Health and Human Services, Child Maltreatment (2013), experiencing child maltreatment can lead to similar consequences as .exposure to other forms of violence, such as increased future risks of perpetrating or experiencing violence, problems with alcohol or drugs, risky sexual behaviours and a compromised ability to develop healthy relationships in adulthood.

While violence crosses socioeconomic and other boundaries, poverty can increase the risk of exposure to violence (World Health Organization, Youth Violence).Some researchers have also found that most children may be at greater risk of child maltreatment, family violence and community violence when they grow up in

disadvantaged communities, or with careers with low education, substance abuse or mental health issues. (James and Saul, 2009)

The school environment—where adolescents learn—is another factor that can influence how they become or their involvement in risk taking and violence. Adolescents spend a considerable amount of time in school settings, interacting with adults and peers. Peers are important as young people pattern their identities within the context of relationships with others, peers can also play a role in youth violence through bullying, and physical fights. According to CDC's Youth Risk Behaviour Survey in 2013, 8 percent of high school teens were in a physical fight on school property and nearly 20 percent were bullied. In addition, 7 percent of high school students missed classes at least once in the previous month because of safety concerns. Neighbourhoods and communities are where the youths play makeup the third determinant that affects violence exposure among youth. Exposure to violence in the community, like the other factors, can put young people at risk causing physical and psychological harm that affect health and relationships in adolescence and adulthood among others. Community violence comprises disturbances in any form in public settings, either from shootings in neighbourhoods or bullying in after-school activities. The "built environment" of communities—the physical characteristics of the environment, such as buildings, parks, streets and other infrastructure—can also influence exposure to violence as violence is caused through human contact.

In all settings—including neighbourhoods and schools— nearly 18 percent of youths were reported carrying weapons in the past month and nearly 25 percent reported being in a physical fight in 2013. Gang involvement is also a significant issue as adolescents join these gangs as protective mechanisms. However because the formation of these gangs are not well articulated, there is the tendency for violence to erupt when the setup is disrupted. The violence that occurs through these gangs has the ability to permeate the communities.

Violence Among Nigerian Youths

Adeoye, Usman and Oyinloye (2012), posit that since the beginning of Nigeria's independence, there have been more than five scores of reported cases of violent crimes all over the university campuses, various communities all over the states; ranging from clashes among cults members, political clashes, land disputes, cultural violence, religious violence, tribal problems, Boko Haram syndrome among others. A militant group of "educated, well travelled Young men in Niger Delta. publicly announced its existence in March 2016. The Niger Delta Avengers as they are called, have attacked oil producing facilities in the Delta region, causing the shutdown of oil terminals and a fall in Nigeria's oil production to its lowest level in twenty years. The attacks causing the country to fall behind Angola as Africa's largest oil producer. The upsurge has hampered the Nigerian economy and destroyed its budget, threatens the peace stability and national unity of Nigeria (sahara reports 2016) \

At present, the country is in state of insecurity and people are living in fear. Majority of the youths are the ones involved and they perpetuate their acts using dangerous weapons terrorising people in rural and urban areas of the country. The increased use of weapons on campuses of learning and in the Nigerian society by adolescents resulting in the death of innocent citizens has generated fear and insecurity for all and sundry. Youth violence is one of the leading causes of death among young people in Nigeria and worldwide. An estimated 430 young people aged between 10 and 29 years die every day through interpersonal violence and an estimated 20 to 40 youths require hospital treatment for violence related injury. (Adeoye, Usman and Oyinloye, 2012).

Youth violence and homicide rates are lower in Western Europe and part of Asia and the pacific. It is however higher in Central and South America as in Eastern and Western America, as well as in Africa. As economic transformations accelerate rural-urban migration increases in Nigeria, yet, the rural poor are being converted into an urban poor due to cases of slums, erosion problems to mention but a few on the periphery of major urban centres. More and more of these urban centres are afflicted by high levels of armed violence perpetuated by some Nigerian youths. Most people agree that youth criminal violence is a serious social problem especially in Nigerian

society due to their notion to harm and kill others. Such actions break social norms (by violating the law) and causing insecurity. They threaten the country's social order, and they attack government security agents especially the police. As such, well meaning Nigerians should see youth violence in this nation as the biggest part of the general problems facing this country. Youth crime, according to Rogers (2001) does not only harm the victims but also harm the families, friends and disrupts the peace in the local community.

Nature of Violence Among Adolescents

Bullying

Bullying is defined as aggression that is intentionally carried out by one or more individuals and repeatedly targeted towards a person who cannot easily defend himself or herself (Olweus, 1993). It should be stressed that aggression is different from bullying. Aggression is a single act whereas bullying comprises repeated acts; and bully-victim relationships are characterised by an imbalance of power while aggression can be between two persons of equal power. Finally, including intentionality in the definition excludes acts bereft of malice. Till date, bullying has been difficult to define and compare because, as Kowalski, Limber, and Agatston (2008) noted the methods employed are varied. However, bullying has generally been defined as using an electronic medium, adopting the definition of Olweus, or something similar. Smith, Mahdavi, Carvalho, Fisher, Russell and Tippett (2008) defined bullying as an aggressive, intentional act carried out by a group or individual, using electronic forms of contact, repeatedly and over time against a victim who cannot easily defend himself or herself. Major components to this definition are that the act must be aggressive, intentional, repetitive, and with a power imbalance.

Bullying is deliberate, with the intention to cause harm. For example, friends teasing each other in a good-natured way are not bullying, but a person teasing another to upset them is bullying. Harmful outcome: one or more persons are hurt physically or emotionally. Direct or indirect acts**:** bullying can involve direct aggression, such as hitting someone, as well as indirect acts, such as spreading rumour. However, bullying

also has characteristics that set it apart from other aggressive behaviours: Repetition: bullying involves repeated acts of aggression: an isolated aggressive act, like a fight, is not bullying. Unequal Power: bullying involves the abuse of power by one or several persons who are (perceived as) more powerful, often due to their age, physical strength, or psychological resilience.

Bullying can involve many different types of behaviour. Physical, or 'direct' bullying hurts an individual in a tangible way, but 'indirect' actions such as stealing or damaging their belongings can hurt them emotionally. This also applies to verbal bullying, which involves name-calling or being otherwise insulted or humiliated. Relational or social bullying refers to behaviours that disrupt the victims' relationships with their peers (Crick and Grotpeter, 1995), such as social exclusion or spreading gossip. Bullying can be motivated by race, religion, culture, gender or sexuality. Sexual bullying may involve sexual acts or demands.

Cyberbullying, a relatively more recent phenomenon that has attracted increasing attention in the last decade, involves using electronic means such as the internet, email and mobile phones. It is particularly vicious, as nasty messages or images can be spread quickly and seen by many. Research evidence suggests that it tends to happen outside of school (Dehue, Bolman and Vollink, 2008).

Overall, it seems that bullying can be expected to occur in any school. Its prevalence in many countries suggests that most children will experience school bullying at some stage, be it as bullies, victims or as witnesses. There is a lot of variation in the reported rates, however, which is partly due to the different methodologies used to survey bullying. The most common method is self-reporting: asking pupils in questionnaires or interviews about their bullying experiences. Other ways include asking teachers or pupils to nominate which children are victims or bullies; observing children; and recording bullying incidents. Different methods produce different bullying estimates: peer and teacher nominations tend not to correspond well with self-report information and observations produce higher rates than surveys (Pepler, Craig, Connolly, Yuile, McMaster and Jiang, 2004). Large-scale surveys in individual countries have reported victimization rates of 9 to 32 per cent,

and bullying rates of 3 to 27 per cent (Stassen Berger, 2007). In the World Health Organisation's Health Behaviour in School-Aged Children 2001/02, a survey of 35 countries, the average incidence rates of victims and bullies were both 11 per cent (Craig and Harel, 2004, cited by Salmivalli, 2009).

Research shows that verbal abuse is the most common form of bullying, followed by relational and physical forms (Baldry and Farrington, 1999). Sexual bullying and dating aggression have similar levels to general bullying (Pepler, Craig, Connolly, Yuile, McMaster, and Jiang, 2006). Levels of cyber-bullying are more difficult to gauge: each time a malicious image or message is viewed. Bullies are generally more aggressive than other pupils. Some have poor social Skills, leading to difficulties in managing positive relationships, but others have advanced social competence, which enables them to manipulate others. It is unclear whether bullies have low self-esteem, but they may well be more likely to come from families with low parental monitoring and involvement, as well as inconsistent and harsh discipline (Schafer, Squire, Halverson and Gee 2005; Vaillancourt, Hymel and McDougall, 2003).

The majority of bully victims can be described as passive. Risk factors that have been identified for victimization include peer-rejection, finding social situations difficult, and experiencing loneliness. Victims may understandably have poor self-esteem, and a greater tendency towards depression and anxiety (Schafer, Squire, Halverson and Gee 2005; Nansel, Overpeck, Pilla, Ruan, Simons-Morton and Scheidt, 2001). According to Klomek, Sourander, Kumpulainen, Piha, Tamminen and Moilanen (2008), the impact of bullying in childhood can be long term. Some adult victims of childhood bullying report experiencing depression, poor self-esteem and inter-personal difficulties in adulthood.

A small proportion of bullies can be described as 'bully/victims'. These 'provocative bullies' are young people who bully others and are also bullied themselves. The proportion of this type tends to be higher in primary than in secondary schools (Roland and Idsoe, 2001; Schafer, Squire, Halverson and Gee 2005). Bully/victims are more likely to have poor social Skills and act in ways that go

against the norms of their peer group, such as behaving aggressively or interrupting other children. They may have low self-esteem, social maladjustment, attention difficulties and poor problem-solving abilities (Mynard and Joseph 1997). There is evidence that bully and bully victims come from families where parenting is inconsistent, sometimes abusive, and low in warmth (Schwartz, Proctor and Chien, 2001).

Overall, bullying decreases with age, although there is an initial increase during pupils transition from primary to secondary school (Olweus, 1993; Pellegrini and Long, 2002; Griffin and Gross, 2004; Pepler, Craig, Connolly, Yuile, McMaster, and Jiang, 2006. As children grow older, they develop better social Skills, which seem to protect them against bullying. However, there are also fewer pupils who might bully them, as bullies are typically older pupils Smith. Early research suggests that boys are more likely to be involved in bullying, but latter studies, which include indirect forms of bullying, show less of a gender difference (Craig, 1998; Stassen, 2007). Girls are more involved in verbal and relational bullying, and boys in physical (Reid, Gonzalez, Nordness, Trout, and Epstein, 2004). As yet, it is unclear whether there are consistent age or gender trends in cyber-bullying.

Aggression

Aggression is one of the most extensively studied areas in human behaviour. Despite a large number of aggression theories, numerous findings have indicated that aggression is a heterogeneous construct resulting in different phenotypes. Several studies have shown, through the use of the Buss–Durkee Hostility Inventory (BDHI), at least two factors representing different aspects of aggression. However, the nomenclature of these two components has differed from study to study. For example, the components of *experiential* and *expressive* hostility have been distinguished and the terms *covert* and *overt* aggression have been used as well (Meesters, and Muris, 2004). Although several articles used different nomenclatures and factors were not quite congruent with respect to subscale loadings, a considerable amount of semantic overlap between them cannot be questioned.

In addition to psychoanalytical explanations, learning theories, and the well-known frustration–aggression theory, recent psychobiological approaches have become more important. Whereas a central causal role of androgens (i.e., testosterone) has recently been questioned. It has been established that the central nervous serotonin system 5-hydroxytryptamine (5-HT) relates to specific components of aggressive behaviour associated with a lack of impulse control (Albert, Walsh, and Jonik, 1993).

On the basis of findings that personality traits are inheritable to a certain extent (30%–60%); molecular generic association studies have tried to relate candidate genes coding for transporters, receptors, and enzymes involved in neurotransmitter systems with personality (including aggressiveness and impulsivity) as well (Henning,Reuter and Burk 2005).

Nielson, Soresen, Hynne and Busse (1998) opined that one of the candidate genes that turned out to be associated with aggression, anger, and impulsivity is the tryptophan hydroxylase (*TPH*) gene. *TPH* is a rate-limiting biosynthetic enzyme in the serotonin pathway and regulates levels of 5-HT by converting tryptophan into 5-hydroxytryptophan, which is the direct precursor of 5-HT. It is conceivable that variations in the *TPH* gene could contribute to low activity of the 5-HT system. Two single nucleotide polymorphisms (SNPs) that show associations to aggression and anger-related traits have been detected on the short arm of chromosome 11 in neutron 7. Both polymorphisms have been shown to be in strong linkage disequilibrium. Of course, this does not mean that both polymorphisms must be identical with respect to their functions.

Gangsterism

Crawage (2005) defined gangsterism as the evolution of an urban identity determined along racial and economic lines. It includes the formation of groups with the aim of committing violence and crime, and defending themselves physically against violence of other groups. Musick (2004) classified gangs into three different categories. In the first category, named the scavenger gang's crimes, transgressions are usually not planned, and this group's members are often low achievers or school

dropouts. Secondly, territorial gangs are well-organised gangs that have initiation rites which separate members from non-members. Often, prospective members have to prove their loyalty to the group by fighting. The third category is the corporate gangs which are highly structured criminal conspiracies that are organized to sell drugs. It is believed that teenagers as young as fourteen could become members. All gangs have names and recognizable symbols.

The presence of gangs in schools in the United States of America has been reported as having doubled between 1989 and 1995. It was reported that youth gangs are linked to serious crime problems in elementary and secondary schools in the United States, and that scholars report much higher drug availability when gangs are active at their schools. Schools that have a presence of gangs have a higher violent victimization rate than those that do not have a gang presence (Hill, Howell and Hawkins, 1999) stated that teenagers who are gang members are far more likely to commit serious and violent crimes than other teenagers.

It is believed that learners and educators are fearful, not only at school, but also on their way to school and back home. They are afraid (not without reason) that they will be attacked by gang members. According to the Western Cape Education Department (WCED)(2003), gangs appear to choose the arrival and departure times of educators and learners deliberately, and they wait for learners at the school gate. This brings with it a terrorising "fear factor" which traumatises educators, learners and parents. Threats, intimidation and harassment engender fear, and result in the absenteeism of both educators and learners.

The WCED (2003) reported that not only does violence have a serious impact on learning, but educators are often absent because they need time off for trauma counselling and debriefing. According to a procedural manual for managing safety and security within WCED institutions, activities outside the school can often have a disruptive influence on what happens inside the school in a variety of ways. In was also pointed out that gang violence is both an internal and an external problem. Thornton, Craft, Dahlberg ,Lynch, and Baer,(2000) opined that other school gang-

related incidents in township schools are assaults, threats, fighting, vandalism, trespassing and disruptive behaviour.

Cultism

Secret cults are organizations of people who come together to pledge their allegiances, under an oath and have a social bond of obligation and dedication for the good of the organization. Their activities are kept secret and kept away from other members of the society or non-members of the group - thus the name "secret cult". Secret cults carry out their meetings when people are not aware of it, especially during the odd-hours and far away from residencies.

Secret cults are rampant in schools all over the world. It was known to be at its peak in tertiary institutions, but recently have extended their activities to primary and secondary schools. This social vice is eating up the educational and moral standards of students. Innocent ones are being lured into the vice and other social vices such as drug abuse, armed robbery, murder etc.

Over time, the activities of cult groups degenerated to membership for perpetrating all sorts of hellish acts that include robberies, political assassinations, drugs and arms dealings, and kidnapping. According to Okeke and Ukeme (2014) worse still is that today, thousands of teenagers as well as primary school pupils have been exposed to cultism. This ugly trend has not only contributed to decadence, but has also increased the spate of thuggery and violence witnessed in the country.The involvement of underage pupils and secondary school children who lack moral upbringing, has put the society at a risk. What started as power play 62 years ago has metamorphosed to an act of human beings being tortured, killed, and in most cases, their corpses hidden for days before being recovered. For females, their chances of survival during initiation are rare, because they are raped by different men, battered and forced to dispossess people of their belongings. A good number of cultists have been accused of gang-robbery, harassment and intimidation of male lecturers. Some have also been used by politicians to cause crisis in a bid to achieve their selfish gains.(Chika and Ukeme 2014)

Conflicts between cult groups are a major source of murder maiming and assault on campus. Nzimiro (1999) observed, military regimes and their tendencies towards extreme secrecy as the backbone of successful coups, and their virtually unchecked powers used in the execution of governance, constituted patterns admired and emulated by youth in their everyday life. In imitation of these two characteristics, student secret cult grew during military regimes. As posited by Nzimiro (1999) the era of moral ethos that respected honesty departed with the entrance of money making through control political power during early post-independence years. In Nzimiro's views therefore cultism in universities is an offshoot of growing power drunkenness among national leaders, and the prevalence of corruption. Cultists in universities are youth and involve themselves in contending with university authorities and with others who trespass into their sphere of influence and power. Hence, their violent confrontations with other secret cults whom they consider as opponents and threat to their supremacy. Sometimes, secret cults claim to protect their members from domination by school authorities and staff. Be this as it may. It is however, remarkable to note that control of their membership is absolute. No government school or family mechanism has nearly as strong a hold on youths, as do these cult groups.

Cult groups high level of control can be said to be typical of peer group influence over youth behaviour (Macionis, 1987). This is an ironic situation considering that youth culture usually promotes dissidence from authority. Due to the absolute nature of loyalty of cult members, a large part of control over youth behaviour resides in their hands. Consequently, they are able to secretly and assiduously execute their projects including their missions of violence. At this juncture, it is necessary to note that secret cults in tertiary educational institutions and even at the secondary educational level thrive, due to a culture of violence existing around them.

Youth violence has roots in other factors besides secret cultism. Lecturers and educational administrators have been known to be secret cult members too, thus lending their socializing influence to youth involvement in cultism. Parents are also members of various well known cult associations in their own rights, though these

same parents would wonder that their children join school secret cult groups. Divisions that engender violence also exist in tertiary educational institutions between cult members and the generality of the student population. Forcible recruitment into secret cults is not uncommon. A significant number of unwilling students have suffered assault, maiming and even death for refusal to join up. In recent years, increase of rape, blackmail, extortion and fear - induced acceptance of unwelcome male cultist attention by girls in tertiary educational institutions, have also been related to increase in cult-related activities.

Concept of Adolescents Health Risk Behaviours

Around half of all preventable premature adult deaths are attributable to acquired risk factors from adolescence, such as smoking, poor eating habits, and a lack of physical exercise (Pan American Health Organization Press release, 2007). Adolescent risk behaviours and choices tend to occur in a social context and may be synergistic. Evidence suggests that teenage substance abuse is correlated with numerous risk behaviours including delinquency, conduct disorders at school, school dropout, violent and aggressive behaviours, unplanned and unprotected sexual intercourse.

Centers for Disease Control and Prevention (CDC)(2012) reported that six types of health risk behaviours contribute to the leading causes of death, disability, and social problems: tobacco use; unhealthy eating; inadequate physical activity; alcohol and other drug use; sexual behaviours that may result in HIV infection, other sexually transmitted diseases (STDs), and unintended pregnancy; and behaviours that contribute to unintentional injury and violence. These behaviours, often established during childhood or adolescence, persist into adulthood, and are preventable. It is also indicated that 10-20% of youth engage in behaviours that put them at substantial risk for negative secondary problems such as sexually transmitted diseases, pregnancy and negative self-feelings (Wekerle, Wall and Knoke, 2004; Survey data from the U.S. Youth Risk Behaviour Surveillance Survey (2011).

Patterns of Health Risk Behaviours Among Adolescents

Drug and Alcohol Use Behaviour

According to the World Book Medical Encyclopedia, drug abuse is the harmful use of mind altering drugs. It adds that the term usually refers to problem with illegal drugs, which also include harmful use of legal prescription drugs, such as in self medication. Oshinkoya and Alli (2006) opined that drug abuse is a global health and social problem whose majority of the Nigerian youths ignorantly depend on one form of drug or the other for various daily activities such as social, educational, political, moral among others. Such drugs range from cocaine, morphine, heroine, alcohol, ephedrine, madras, caffeine, glue, barbiturates, amphetamines among others. In Oshikoya and Alli (2006), study on perception of drug abuse amongst Nigerian undergraduates identified dependence and addiction as one of the major consequence of drug abuse, characterized by compulsive drug craving seeking behaviours that persist even in the face of negative consequences. These changes culminate in maladaptive and inappropriate social behaviours, that place the individual at risk of harm. Experiment with drugs during adolescence (11–25 years) is common. At this age, they try so many new things. They use drugs for many reasons, including curiosity, because it feels good, to reduce stress, or to feel grown up. Using alcohol and tobacco at a young age increase the risk of using other drugs later.

Illicit drug use has become a global phenomenon and is no longer an issue that is limited to Western and industrialised nations, where since the 1960's, drug use has developed into an integral part of youth culture. The last 15 years has witnessed a sharp increase in drug use in transitional and developing countries in all regions. Globalisation and improved financial and economic infrastructures have enhanced the trade of various consumables, including illicit drugs. Many transitional countries such as China, the Russian Federation and Vietnam and developing countries like Indonesia, Iran and Bangladesh have experienced sharp increases in the availability of illicit drugs, along with subsequent increases in drug use and injecting drug use among specific sub-populations within particular nations (UNODC, 2006).

Many countries across Africa have become major way stations along drug trafficking routes for various narcotics being shipped to Europe and North America, increasing drug use among communities, particularly those which are vulnerable, has been reported. A wide range of West African countries (e.g., Senegal, Guinea-Bissau, Cameroon, Liberia, Côte D'Ivoire, Ghana, Togo, Benin, and Nigeria) are being used as transit hubs, especially for the transport of cocaine from South America. The increased availability of drugs, with a steady turnover and used as 'payments', has created domestic markets and pockets of drug use among vulnerable populations in all transit countries in Western Africa. Drug dependency and drug-related health consequences have thus far only been reported on a larger scale in Nigeria, where illicit drug use seems to have begun earlier and the relationship between sex work and drug use has also been noted (Adelekan and Rahman, 2006).

The general trend of an increase in drug use in the region is most visible and better documented for South Africa, which has developed a sophisticated and further evolving drug market in less than a decade. South Africa has become the primary regional domestic drug market for a variety of drugs. The South African Drug Monitoring Centre describes various drug-using populations, a wide variety of drugs being used and various drug use patterns, ranging from the recreational use of stimulants and ecstasy by clubbers to the problematic use of heroin, cocaine or amphetamine-type stimulant used by urban marginalised street youth. Significant regional and ethnic differences exist regarding the primary drug of choice. Methamphetamine use is currently regarded as the primary drug of choice in the West Cape coloured communities, whereas heroin is the drug of choice among black youth in Johannesburg and Pretoria.

Local researchers as well as drug treatment experts have expressed their concern regarding persistent heroin use in poor black communities. While significant increases in the availability of illicit drugs such as heroin and cocaine have been recorded in mainly coastal areas across the region, interior Africa also appears to have been affected. For example, current evidence suggests that countries such as Ethiopia, Zambia and Uganda may become new drug transit countries and the local availability

of such drugs will increase (UNODC, 2006). The available data on illicit drug use in this sub-region indicates that the availability and consumption of these drugs are higher than seen in the coastal regions of many other parts of Africa. Thus, the overall availability of illicit drugs in the entire region has grown considerably and very quickly; it is likely to develop along the lines of economic infrastructure, from coastal areas and densely populated areas to other areas within close geographic proximity to airports, railways and highways.

Alcohol Use

There are very few sources of information on drinking rates of young people in South Africa. Among the most informative studies concerning the prevalence of drinking behaviour of youth and adolescents have been one nationwide study among youth (Rocha-Silva, DeMiranda, Erasmus, 1995), and two localized studies among high school students in Cape Town (Flisher, Ziervogel, Chalton, Leger and Robertson, 1993a).

The most comprehensive study of alcohol use among youth in both urban and non-urban areas was conducted in 1994 (Rocha-Silva, DeMiranda, and Erasmus 1996). Although complete in assessing alcohol use among youth (young people aged from ten to twenty one years) in all parts of the country, the study focused on black people only. The results of that study revealed that 42.5% of the respondents reported having used alcohol at some stage during their lives. Overall, males were more likely to have consumed alcohol than females in both the urban areas (50.9% versus 40.9%), and the rural areas (47.2% versus 29.3%). For males, rates of lifetime alcohol consumption were slightly higher among those from the urban areas, while urban females were far more likely to have used alcohol than were their female counterparts. Two major studies (Flisher, Ziervogel, Chalton, Leger and Robertson 1993b; Flisher and Chalton,2001), conducted in 1990 and 1997, have assessed drinking rates among high school students of all population groups in the Cape Peninsula.

The 1990 study (Flisher, Ziervogel, Chalton, Leger and Robertson 1993b) involved a representative sample of 7340 students in Grades 8 to 12 from 16 high

schools. The sample comprised a Xhosa-speaking group consisting of black students, while the English-speaking and Afrikaans-speaking groups were more heterogeneous, and comprised persons from more than one of the other population groups (i.e. white, coloured, and a minority of Indian students). Of the total sample, 53.2% of respondents reported ever using alcohol, while 26.2% of the students had used alcohol within the week prior to the questionnaire being completed. Among the entire sample the rate of binge drinking was 15.4% with binge drinking defined as drinking 5 or more drinks on at least one occasion in the 14 days prior to the questionnaire being completed.

Flisher and Chalton (2001) study that was conducted in 1997 consisted of 2930 primarily black, coloured and white students in Grades 8 and 11 at 39 high schools in Cape Town. It revealed that the overall prevalence rate for alcohol use in the past month was 31%. Drug abuse may be defined as the "arbitrary" over dependence or miss-use of one particular drug with or without a prior medical diagnosis from qualified health practitioners.

In relation to alcohol, life skills programs attempt to teach individuals (young people, in particular) to make healthy, responsible, and appropriate choices about drinking in an effort to reduce alcohol misuse and problems related to excessive and abusive drinking patterns. This approach has been implemented in education and prevention through school-based programs and is also part of some initiatives that are not curriculum-based (Godfrey, Toumbourou, Rowland, Hemphill and Munro 2002; International Center for Alcohol Policies, 2000). The life skills education has been used to help parents support their children and also to help them assess their own drinking Kumpfer, Alvarado, and Whiteside, 2003). It has also been applied within settings where a need for reducing or preventing harm had been identified, for example among prison inmates (Wald, Flaherty, and Pringle, 1999).

The life skills approach is a useful component of alcohol education but its successful implementation requires additional supporting elements. These include, for example, the provision of balanced and appropriate information about alcohol consumption, drinking patterns, and outcomes. Given the wide range of cultural views

on alcohol, life skills programs need to be implemented in a culturally sensitive way and should address specific cultural issues.

Media and culture awareness have also been suggested as essential adjuncts to the life skills approach, beyond the critical thinking component that is already included. In addition, issues related to social environment, economics, and opportunity also need to be addressed, given their impact on the choices and decisions that people make about drinking and health in general.

Tobacco Smoking Behaviour

In one of the WHO's and the World Heart Foundation's data, posit that in Nigeria, 22.1% of school youth age between 12 to 17 years use tobacco, in South Africa, it is 19.4%, 15.1% in Ghana and 16.2% in Kenya. The Government of Nigeria seems to lose sight of its responsibilities, though it claims that tobacco should be regulated in a market oriented framework, which strikes an optimal balance and the need to ensure healthy work force. The fear is that youths are lured into early death from Cardio Vascular diseases (CVD), lung cancer and other tobacco related diseases. With this danger in mind, the Secretary-General of African heart Network, Dr. Kingsley Akinroye urged Nigerians not to be in partnership with industries that are injurious to them even if they cannot prevent their establishment. This was a reaction to the multi-billion naira investment deal between the last administration and British American Tobacco (BAT) to build a tobacco plantation in Ibadan for production of tobacco related products to the detriment of Nigerians. Already, Nigerian youths are being offered cigarettes through promotions and musical concerts.

Some teens will experiment and stop, or continue to use occasionally without significant problems. Others will develop addiction, moving on to more dangerous drugs and causing significant harm to themselves and the society at large. Despite the effort of many concerned bodies to curb this menace, many firms and individuals still present these drugs as though they are harmless. They give them slogans such as "for greatness" – "*for brighter life*", ___ "*for taste*" etc. which often lure irrational youths into drugs and alcoholism. Reports from all over the world about this menace for

instance are grim. The British officer for National Statistics reports that 12% of pupils aged (11–15) had used drugs. Amphetamines are used among students (Oshodin, 1998). Barbiturates are used by youths with suicidal tendencies rather than for addictive purpose (Anumonye, 1980). Madras abuse once reached epidemic proportions among students (Anumonye, 1980). However, cannabis (marijuana) appears to be the most commonly abused drug by our youths.

Marijuana is everywhere in our cities, motor parks, street corners, joints on campuses, uncompleted buildings, under flyovers etc. A survey of Ring Road outlets in Benin City, Ajegule in Lagos, Mabushi in Abuja, under flyover in Onitsha and others will amaze you of the number of youths involved in the intake of cannabis (Abudu, 2005). Cannabis is popularly known as "*'igbo'*, '*ganja'*, 'weed', morocco, Indian hemp' 'herb' 'pot; 'hash' marijuana". It comes from the Cannabis hemp plant, which is grown around the world. It grows profusely in this tropical climate with little or no care. Various farms of the plant are scattered over Delta State and other parts of Nigeria.

Risky Sexual behaviours

Risky sexual behaviours are defined as intentional behaviours that have potentials of causing harm to the individual. Risky sexual behaviours are those which increase the chance of contracting or transmitting disease, or increase the chance of the occurrence of unwanted pregnancy. Risky Sexual Behaviours like having more than one sexual partner, changing sexual partners frequently; having oral, vaginal or anal sexual contact without a condom; using unreliable methods of birth control, or using birth control inconsistently. Unsafe sexual practices are still occurring with sufficient frequency so that sexually transmitted diseases and unwanted pregnancies remain significant a public health concerns. The World Health Organization (WHO) reported in 2002 that unsafe sex was second among the top ten risk factors in the global burden of all diseases caused globally.

Research shows that comprehensive sex education and HIV prevention programmes are effective in reducing high-risk sexual behaviour among adolescents.

Based on over 15 years of research, the evidence shows that behavioural intervention programmes that promote appropriate condom use and teach sexual communication Skills reduce risky behaviour and also delay the onset of sexual intercourse(Esere 2008) High-risk sexual behaviour among adolescents can lead to serious long-term health consequences such as sexually transmitted infections (STIs), HIV/AIDS and unintended pregnancy. According to the Centres for Disease Control and Prevention (2012), approximately 870,000 pregnancies occur each year among women 15-19 years old, and about 3 million cases of STDs are reported annually among 10- 19-year- olds. Other statistical models suggest that half or more of all HIV infections occur before age 25, and is one of the leading causes of death in adolescents

In a study by the Henry J. Kaiser Family Foundation, alcohol and drugs were reported to play a significant role in decision-making about sex. In fact, in that study, nearly a third of a nationally representative sample reported that alcohol and drugs had contributed to their doing "more" sexually, than they would have done while sober. Also in the Kaiser Family Foundation, study, four out of five adolescents believe that people their age usually used drugs or alcohol prior to engaging in sexual activity, and 20% reported having had unprotected sex while under the influence of drugs or alcohol. Stuave and O'Donnell (2005) extended these findings by identifying that early drinking behaviour (during middle school) increased a youth's risk for a number of risky sexual behaviours including unprotected sex and having multiple partners, and an unintended pregnancy outcome. Contrary to these findings, Morrison (2003) found that alcohol use did not necessarily cause risky sexual behaviour. They contend that lack of access to and knowledge about condom use were more important issues to address with adolescents.

Unprotected sex and having multiple sex partners can lead to teenage pregnancy and sexually transmitted infections (STIs), including human immunodeficiency virus (HIV) infection. There are about 900,000 pregnancies annually among youths under 19 years (CDC, 2005a). Nearly 9.5 million new cases of sexually transmitted diseases occur in the United States each year among those ages 15-24 (CDC, 2005a), and although AIDS is relatively rare among adolescents, it is on

the rise. In 2003, 12% of those diagnosed with HIV/AIDS were between the ages of 13 and 24 years (CDC, 2005b). Since the progression from HIV infection to AIDS takes years, many current AIDS sufferers probably contracted the infections in adolescence.

Adolescents' Reproductive Health Needs

Within the framework of WHO's definition of health as a state of complete physical mental and social well-being and not merely the absence of diseases and or infirmity, reproductive health addresses all matters relating to the reproductive system at all stages of life. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Reproductive health care is the collection of information and services designed to help individuals attain and maintain the state of reproductive health by preventing and solving reproductive health problems. Reproductive health care includes a variety of prevention, wellness and family planning services as well as diagnosis and treatment of reproductive health concerns. Positive reproductive health means that individuals can manage their own sexuality and have unrestricted access to the full range of reproductive health care options. It is therefore the right of all male and female adolescents to be informed, to have access to safe, effective, affordable, and acceptable methods of contraception of their choice (Wisconsin Alliance for Women's Health, 2011).

Improving reproductive health of adolescents is fundamental to achieving the millennium development goal. World Health Organisation (2003) estimates that, one in every five people in the world is an adolescent, (between 10 and 19 years of age). With an estimated 1.2 billion adolescents alive today, the world has the largest adolescent population in history (Blum and Mmari, 2005). Adolescents lack reliable reproductive health information, and thus the basic knowledge to make responsible choice regarding their reproductive behaviour. In many countries around the world, leaders, community members, and parents are reluctant to provide education on sexuality to young men and women for fear of promiscuity. Many adolescents are

already sexually active often at a very young age. The reproductive health status of young people in terms of sexual activity, contraceptive use, child bearing, and STIs lays the foundation for the country's demographic feature.

During adolescence normal physical development may be adversely affected by inadequate diet, excessive physical stress, or pregnancy before physiological maturity is attainted. Adolescents are at high risk to acquire infertility associated with STIs and unsafe abortion. Current health services are generally not organized to fulfil the reproductive need and demands of adolescents. Many adolescents die prematurely every year, an estimated 1.7 million young men and women between ages of 10 and 19 lose their lives to accidents, violence, pregnancy related complications and other illnesses that are either preventable or treatable (Blum & Mmari, 2005). As a result, adolescent reproductive health (RH) is an increasingly important component of global health. Health care providers are therefore faced with the challenge of meeting the adolescents' reproductive health needs through basic sexual health information, creating an enabling environments for accessing affordable confidential reproductive health services

Concepts of Life Skills

According to WHO (1997a), life skills may be defined as abilities for adaptive and positive behaviour, that enable individuals to deal effectively with the demands of everyday life. Every school should enable children and adolescents at all levels to learn critical health and life skills. Such education includes comprehensive, integrated life skills education that can enable young people to make healthy choices and adopt healthy behaviour throughout their lives". The life Skills approach lends itself well to implementation across cultures and has been integrated into curriculum in various countries (Godfrey, Toumbourou, Rowland, Hemphill and Munro, 2002; International Center for Alcohol Policies, 2000).

Children exhibiting behavioural problems that are not addressed by appropriate interventions in the school will predictably continue to have social problems throughout their life. Children lacking social Skills develop problems in relationships

with other students and with the teachers, hence having low self-esteem. Therefore it is the responsibility of stakeholders to use interventions that can increase a child's sense of belonging, improve friendships, self-esteem and academic achievement (Edwards and Gfoerer, 2001).A child who lacks the social Skills to navigate the expectations of a classroom may feel isolated and unimportant. Adler's ideas about how to build a child's sense of belonging and social interest will help children excel both socially and academically in school (Edwards and Gfoerer, 2001). A positive group intervention that uses the natural school environment encourages the need to belong. Peer tutoring and class meetings are just a couple of ways to utilize interventions to promote social acceptance and provide interaction with others in the classroom. This can have benefits for all that are involved. Previously, the problem of generalizing Skills was discussed, but doing Skills work in small groups within the classroom benefits socially and academically, all who participate.

A Cochrane review of universal alcohol prevention programmes in schools concluded "Current evidence suggests that certain generic psychosocial and developmental prevention programs can be effective and could be considered as policy and practice options. These include the Life skills Training Program, the Unplugged program, and the Good Behaviour Game."(Foxcroft, and Tsertsvadze, 2011) A review by UNICEF found that approaches relying on life skills have been effective in educating the youth about health-related issues—such as alcohol, tobacco, and other drug use; nutrition; pregnancy prevention; and preventing HIV/AIDS and other sexually transmitted infections (STIs). Life skills education programmes can also be effective in preventing school drop-out rate and violence among young people. Nonetheless, these programmes can lay the foundation for skills demanded in today's job market.

Around the world, life skills-based education (LSBE)is being adopted as a means to empower young people in challenging situations. LSBE refers to an interactive process of teaching and learning which enables learners to acquire knowledge and to develop attitudes and skills which support the adoption of healthy behaviours. It is also a critical element in UNICEF's definition of quality education.

LSBE has a long history of supporting child development and health promotion in many parts. The 1989 convention on the rights of the child (CRC) linked life skills to education by stating that education should be directed towards the development of the child's fullest potential. The 1990 Jomtien Declaration on Education for All took this vision further and included life Skills among essential learning tools for survival, capacity development and quality of life. The 2000 Dakar World Education Conference took a position that all young people and adults have the human right to benefit from an education that includes learning to know, to do, to live together and to be.

The conceptual basis for most of the life skills work undertaken by the United Nations and its partners is the World Health Organization's skills for Health (UNICEF, 2005). In 1986, the Ottawa Charter for Health Promotion recognized life Skills in terms of making better health. choices. Life skills are a group of psychosocial competencies and interpersonal Skills that help people make informed decisions, solve problems, think critically and creatively, communicate effectively, build healthy relationships, empathize with others, and cope with and manage their lives in a healthy and productive manner (UNICEF,2005). Life skills-based education focuses on the development of knowledge, attitudes and skills that support people or children in taking a greater responsibility for their own lives. It helps children to acquire and practise good health behaviours along with the underlying knowledge and positive attitudes. It also helps children to develop and strengthen their general interpersonal and psycho-social capabilities. Life skills are abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and the challenges of everyday life (WHO,1999).Examples of interpersonal and psycho-social capabilities (or life skills) are assertion, negotiation, empathy building and stress-coping skills. Life skills-based education addresses real-life applications of knowledge, attitudes and skills, and makes use of participatory and interactive teaching and learning methods. A range of different terms are used to describe the concept of life skills based education at the country level, such as skills-based health education when the focus is on health issues; peace education when the focus is on

violence prevention, conflict management, or even civic education depending on the objectives of the learning area.

Traditional education tends to emphasize academic knowledge but do not sufficiently apply curriculum content to real-life situations. Traditional methods that are adopted, such as one-way teaching or invited expert lectures, sometimes overlook the need for interaction to develop and extend existing knowledge, attitudes and skills of the learners. They seldom deal with the kind of practical knowledge, attitudes and skills that children need in their own environment, while they are young and when they are growing up.

Hanbury (2008) asserted that introduction of life skills-based education in schools next to traditional education has many advantages over teaching according to traditional methods alone. Life skills-based education gives room for children to develop knowledge, attitudes and skills together that they can use in daily life. It also gives the opportunity to the children to clarify uncertainties, to try out new knowledge and skills, to be creative and to learn from each other.

The role of the teacher is different from that in traditional education. In life skills-based education, children do not learn only from the teacher, but also from their fellow students, for example through playing games and working in small groups. Use of participatory and interactive methods, which address skills, values and attitudes as well as information transfer, is not only useful for children in an academic sense, but also helps them to have better lives. More effective and relevant learning outcomes are likely to be the result. This does not mean that traditional education methods are not useful, but it rather shows that when the range of methods is expanded, benefits result for both teachers and students, in the skills based method.

Interpersonal Skills

These skills are occasionally also referred to as people skills or communication skills. Interpersonal skills are the skills a person uses to communicate and interact with others. They include negotiation, active listening, delegation, assertiveness and leadership. The term "interpersonal skills" is used often in business contexts to refer to the measure of a person's ability to operate within business organizations

through social communication and interactions. Interpersonal skills are how people relate to one another. Social skills are the tools that enable people to communicate, learn, ask for help, get their needs met in appropriate ways, get along with others, make friends and develop healthy relationships, protect themselves, and generally be able to interact with the society harmoniously. Social skills builds essential character traits like trustworthiness, respectful, responsibility, fairness, caring, citizenship which helps to build an internal moral compass in making good choices in an individual's thinking and behaviour and thus social competence. Communication encompasses the entire environment, the way we dress, the way we walk, how we, live and who our friends are. Our ability to communicate with one another, perhaps is the most difficult, yet essential aspect of human life. No one can really know us unless we are willing and able to communicate with them, in other words as well as actions. Communication is the process of giving, and receiving of information. It involves exchanging ideas, understanding, listening, expressing oneself, talking, and using body language facial expression and a host of other behaviours(comprehensive sexuality education 2003)

Assertiveness Skills

Flanklin (1998) defined assertiveness as a way of thinking and behaving that allows a person to stand up for his or her rights while respecting the rights of others. It is the ability to state positively and constructively your rights and needs without violating the right of others. Assertive attitude and behaviours are at the heart of effective advocacy. A person with an assertive attitude recognizes each individually, to have and express personal preference, feelings and opinions. The assertive individual not only believes in his or her rights but is committed to preserving those rights. An assertive attitude is important in recognizing that rights are being violated.

Assertiveness describes behaviour that indicates an individual ability to stand up for himself, can resist being "walked on', and that a person can exercise his or her rights without denying the rights of others. The basic assumption of assertive behaviours is that a person has the right (but not the obligation) to express his or her feelings, thought, beliefs and attitude. Assertive behaviours include:

1. The ability to express all manner of emotions, both pleasant, and unpleasant, in an open direct and honest manner;
2. The capacity to exercise one's right without denying the rights of others;
3. The confidence to stand up for oneself without undue anxiety;
4. The freedom to be able to make a choice as to whether or not assertive behaviours are appropriate in any particular situation.
5. Allows you to communicate needs, see limits and state positive and negative feelings.
6. An approach to life that allows you to retain or regain control over your own life, and can lead to increased self-esteem.

Negotiation Skills

Imobighe (1993) defined negotiation as voluntary problem-solving activity, in which two or more parties attempt to resolve their differences by reaching an agreement that defines their future behaviours. Negotiation, according to Bornstein and Bornstein (1988) is a specific type of problem solving behaviour that culminates in the settlement of a mutually acceptable behavioural exchange when people were previously unable to resolve their differences. Negotiation is a process used extensively in interpersonal relations. It is the act of bargaining to reach an agreement over a matter or matters in some dispute. It may be called when changes are being brought about in interpersonal relationship or where partners' attitudes to each other are changing for worse. According to the concise oxford dictionary (1998), to negotiate means to confer with others in order to reach a compromise or agreement. Negotiation is an interactive process which involves two or more people who have opposing views but want or need to reach some kind of resolution (McGuire, 2002).

Studies by Kaloff, Lear (1995) explored sexual negotiation issues among youths. Both represent attempts to relate gender roles and lack of partner communication to engaging in unwanted sex and confusion in the lack of preparation for sexual situation. Studies has shown that adolescents who can communicate openly about safer sex are more likely to reduce the risk of contracting HIV through safer sex

methods than those who do not discuss these issues (Catania, Coates, Kegeles, Fullilore, Perterson, Matin, Siegel and Hulley, 1992).

Skills for Finding Help

According to the comprehensive sexuality education trainers manual (2003) finding help means providing or seeking assistance or support in other to find remedy or relief from a problem, or make a situation more bearable.

Today, although young people increasingly feel independent, they are sometimes faced with many difficulties and problems such as unhappiness, annoyance, anger, inability to meet needs, lack of anxiety and hyperactivity. Consequently, these young people will require some help from older friends and family. Adults as role models and friends, need to help adolescents make transition into adulthood, by encouraging them to seek help.

- Good communication skills (verbal and non-verbal) which is primarily a willingness and ability to explain the problems or the need .
- Assertiveness–willingness to speak up, explain the issue to someone you may not know, continue explaining until you find someone who will listen or until you are understood.
- Counseling- willingness to learn more through discussion with someone else.
- Follow-up-ability to take action on what needs to be done to rectify the situation.

Values

These are important and lasting beliefs or ideals shared by the members of a culture about what is good or bad, desirable or understandable. Values have major influence on a person's behaviour and attitude and serve as broad guide line in all situation. Values are paramount in controlling our decisions. They are the reasons behind the decision we make every day. Values are related to specific task and responsibility e.g care consistence, creativity, diligent, discipline, enthusiasm, efficiency, excellence, fun, focus, hospitality, safety, trust, resourcefulness, vision, to mention but a few.

Values can be defined as broad performance concerning appropriate course of action or outcomes. Values can control one's decision for doing right or wrong. As such, values reflect a person's sense of right and wrong or what "ought" to be. "equal right for all" "excellence deserves admiration", and "people should be treated with respect and dignity" are representative of values. Values tend to influence attitude and behaviour. Types of values include ethnic values.

Value clarification is an approach to helping individuals recognize their own values and affirm publicly (ability to take a position on the values and defend it).Being clear about your own values or beliefs helps us to make decisions that feel right to us. Values help become the kind of person we want to be and live the kind of life we want to live . Values are not all equal. Many times, values reflect different people's ideas or preferences. These values make our lives and world around us a positive place to live. (CCE teachers manual 2012)

Self esteem

Self-esteem refers to global evaluations of self and it can also be regarded as self-worth or self-image (Santrock, 2002). For example, a person may perceive that he or she is not merely a person but a good person. This is a clear indication of worthiness of that person. Branden (1997) defined self-esteem as the disposition to experience oneself as being competent to cope with the basic challenges of life and of being worthy of happiness. To him, it is confidence in the efficacy of our mind, in our ability to think. By extension, it is confidence in our ability to learn, make appropriate choice and decisions, and respond effectively to change. It is also the experience that success, achievement, fulfilment and happiness are right and natural for us (Branden, 1997). Rosenberg Scholars and Schoenbach (1995) refer to self-esteem as the totality of personal attributes rather than a single dimension. In this sense, self-esteem can be considered as the reflector of the personality of man's social, psychological and cognitive disposition. Jambor and Elliott (2005), in line with the above, assert that self-esteem is a principal component of mental health. Self-esteem is an important concept since it is shown to have a pervasive and powerful impact on human cognition, motivation, emotion and behaviour (Campbell & Lavallee, 1993). Studies

have shown that it is highly correlated with overall psychological well-being achievement, ability to cope with stressful life events and sexual behaviour (Morris, Young & Jone, 2000). It is therefore worthy to say that individual's self-esteem determine the extent of his or her life accomplishment.

Researches have shown that self-esteem is not innate and can change (Branden, 1997 & Santrock, 2002). It can be high and low (Santrock, 2002; Jambor & Ellliott, 2005) and can be built over a period of time and not induced by drugs (Branden, 1997). Santrock (2002), posited that self-esteem can change especially in response to transition in life. For example, when children go from elementary school to middle school, their self-esteem usually drops (Santrock, 2002). The failure to live up to one's standard is especially implicated in connection with low self-esteem and depression. Branden (1997) notes that self-esteem is not euphoria or buoyancy that may be temporarily induced by drug, a compliment or a love affair. It is not an illusion or hallucination. If it is not grounded in reality, if it is not built over time through the appropriate operation of mind, it is not self-esteem. He therefore presented six pillars of building self-esteem namely:

The practice of living consciously: Respect for fact, being presented to what we are doing while doing it; seeking and being eagerly open to any information, knowledge, or feedback that bears on our interests, values, goal and projects; seeking to understand not only the external world, but also our inner world, so that we do not get out of self-blindness.

The practice of self-acceptance: The willingness to own, experience, and take responsibility of our thoughts, feelings, actions, without evasion, denial or disowning and also without self-repudiation, giving oneself permission to think one's thoughts, experience one's emotions and look at one's actions without necessarily linking, endorsing, or condemning them; the virtue of realism applied to the self.

The practice of self-assertiveness: Being authentic with others; treating our values and persons with decent respect in social context; refusing to fake the reality of who we are or what we esteem in order to avoid disapproval; the willingness to stand up for ourselves and ideas in appropriate ways and in appropriate contexts.

The practice of self-responsibility: Realizing that we are the author of our choices and actions, that each one of us is responsible for life and well-being and for the attainment of our goals; that if we need the cooperation of other people to achieve our goals, we must offer value in exchange; bearing it in mind that, the question is not "Who's to blame" but always "what needs to be done?"

The practice of living purposefully: To identify our short-term and long-term goals or purposes and the actions needed to attain them (formulating an action plan); organising behaviour in the service of those goals, monitoring action to be sure we stay on track; and paying attention to the outcome so as to recognize if, and when we need to go back to the drawing-board.

The practice of personal integrity: Living with congruency between what we know, what we profess and what we do; telling the truth, honouring our commitments exemplify in action the value we profess to admire. What all these practices have in concern is respect for reality. They all entail, at their core, a set of mental operations which naturally have consequences in the external world.

Since self-esteem virtually affects the total activities of man, studies have indicated that there is a correlation between self-esteem and sexual behaviour of people which in turn may influence the rate of vulnerability to diseases. Studies by Morris and Young (2000), found that low self-esteem could influence sexual permissiveness. However, all report that high self-esteem could influence risky sexual behaviour. It is reasonable here to conclude that self-esteem plays significant roles in making and marring the personality of individuals in the society.

Goal-setting

Goal-setting, according to Locke and Lathan (1990), is defined as a drive to reach a clearly defined end and this end is a reward in itself. Glein (2003), in his book, *Motivate to Educare* defined goal-setting as the act of taking the necessary steps to transferring dreams and or intentions to a formal whereby achieving a goal constitutes the primary motivating force behind work behaviour. The purpose of goal, to him, is to ultimately empower, authorize and enable one to move from dependency to independence or self-dependency. Most children know little about goal-setting and

most receive no instruction on how to do it. This might account for several unexpected outcome in terms of behaviour or academic achievement. It must be noted that without goals, one seldom accomplishes anything. Successful goal attainment furthers students' motivation in learning. Thus, teaching of goal-setting Skills in school to the adolescent will aid self-monitoring and evaluation Glein 2003).

The concept of goal pursuit is critical in students' achievement and motivation. Several studies have examined correlation among students' measure of cognitive ability, self-motivation, scholastic achievement and goal-setting and most studies have focused primarily on effects of goal-setting, self-efficacy and attribution on self-motivation Bandura (2013) in Pi-Yueh and Wen-Bin (2010) studied graduate students' self-efficiency in goal-setting and task achievement. The outcome of the study reflects that goal-setting influence ability and motivation to learn. Moreover, goal theories agreed that perceived competence is influenced by goals. In addition, Pi-Yueh and Wen-Bin (2010), noted that task performance is influenced by goal-setting.

Goal-setting helps an individual to achieve more since it provides one with a sense of direction and enables one to avoid distraction, while emphasising that like academic goals, the pursuit of social goals can help organize, direct and empower individuals to have greater achievements. This is possible because the process of achieving goals and seeing this achievement gives confidence that one will be able to achieve higher and more difficult goals. It also increases pride, satisfaction and confidence in one's achievement. In addition, goal-setting helps to eliminate attitude that could hold an individual back and cause stress and unhappiness. Therefore, goal-setting is desirable in all spheres of life be it academic, social, spiritual and sexual, as this helps individuals to be self-regulated and self-actualised.

Decision-making

Decision-making is a conscious and rational process in which a person carefully considers all options and corresponding outcomes (Curry, 2004). The process of decision-making is constantly guided by cognitive capacities and some related characteristics. This is why making a decision is not merely a cognitive process (Byrness, 2002; Cauffman & Steinberg, 2000) In these theories, decision-making was

idealised as a conscious, rational process in which a person considers options and its corresponding outcomes. The utility theory believes that people can and do associate appropriate probabilities with each outcome and then add personal utility or preference indices to each. It is suggestive of this theory that people make rational selection after considering all relevant information in order to maximise their personal utility or to minimise personal risk (Curry, 2004).

Impact of Life Skills Education

The impact of life Skills education has been debated. The basic questions to be addressed are how the impact of this (or any other) approach should be measured and what its desired outcomes are. For some, the acceptable outcome is measured in preventing people from drinking. For others, it is to enable the target audience to make informed choices and decisions about whether to drink and how to drink responsibly. How to measure an intangible result like this clearly presents a serious problem. It is difficult to quantify the development of Skills such as coping with stress or the development of interpersonal Skills. A qualitative assessment must often be sufficient (Ijagbulu, 1989). .

In particular, in developing countries where means and resources are often scarce, evaluation is difficult. For example, following up with a group of children in primary school to assess how they have developed can prove difficult due to high attrition rates. Some general patterns, nevertheless, have emerged from the evaluations that have been undertaken in this field. Certain "factors of success" have been identified (World Health Organization, 1999; 2003). These include the need for long-term programmes to train educators or providers; a focus on both generic and specific Skills; developmentally appropriate inputs; active students involvement; links to other subjects; user-friendly materials; and peer leadership components.

Where these factors have been implemented, life Skills programmes contributed to a decrease in alcohol mis-use, drug abuse, smoking, delinquency, violence, and suicide and to an improvement in pro-social behaviour. Other findings suggest a positive impact on mental health in relation to self-image, self-esteem, self-efficacy, and social and emotional adjustment and a decrease in social anxiety. School

performance has been shown to improve with regard to behaviour, academic achievement, and absenteeism (International Center for Alcohol Policies, 2000 & Botvin and Kantor, 2001; Life Skills Training, 2012).

The *Aban Aya Youth Project* (AAYP) is a programme designed to reduce rates of risky behaviours among African American children in 5th through 8th grade. AAYP is an Afro-centric social development curriculum instructed over a four-year period, beginning in the fifth grade. The number of lessons varies each year. The name of the intervention is drawn from two words in the Akan (Ghanaian) language: ABAN (fence) signifies double/social protection; AYA (the unfurling fern) signifies self-determination. The purpose of this intervention is to promote abstinence from sex, to teach students how to avoid drugs and alcohol and how to resolve conflicts non-violently.

Individual-Level Interventions seek to prevent or reduce violence by improving the social, emotional, or cognitive Skills of youths and their families. Such interventions include parent training and pre-natal and early childhood interventions. Solid evidence suggests that such interventions can be very effective in reducing violent behaviour among the youth (Howell and Hawkins 1998). In Baltimore, these programmes include home visitation programmes, parent training, and school-based programmes for building children's emotional and social capacities.

Youth violence can be traced to pre-natal and early childhood problems. Interventions focusing on these areas, such as the home visitation programme developed by Olds, Hills and Rumsey (1998), are therefore likely to be useful in reducing youth violence. Specifically, they address pre- and post-natal causes of neurological deficits that have been linked to persistent antisocial behaviour. As well, these interventions focus on early child-parent bonds, which have been found to be necessary for the development of cognitive functioning, trust, empathy, and resistance to deviant peers. Another justification for these interventions is that aggressive tendencies often crystallize by age eight, after which they become more resistant to treatment.

Though, evidence that school and community-based education programmes significantly decrease smoking rates are remote, School-based prevention programmes typically had short-term, but not long-term, effects on adolescents, Shermam, Lawrence, Heather and Barnes (1997) believed that, successful programmes are grade-, age-, and culture-appropriate and focus on the immediate consequences of smoking and on coping strategies. Education programmes are most effective when combined with strong anti-smoking policies at the schools and are part of a comprehensive local or state tobacco cessation effort.

The American Academy of Family Physicians' Tar Wars Programme, which is targeted to fourth- and fifth-grade students, has been shown to effectively educate children about the consequences of tobacco use. While mentoring programmes are appealing, little evidence exists to suggest that they reduce violent behaviour or delinquency. Research, including a national evaluation of the Big Brothers/Big Sisters programme, has shown that while they reduce drug abuse among youths, they do not reduce violent or delinquent behaviour (Sherman, Lawrence, Heather and Geoffrey, 1997). Dewar (2003) asserted that mentoring programmes had provided part-time and full-time summer jobs for about 500 youths, helped 258 families obtain drug treatment, and reduced the number of school days missed from more than 40 days per child to about 20. Because much of the most serious violence perpetrated by youths involves guns, interventions aimed at reducing the prevalence of gun-ownership among the youth are likely to be effective at reducing youth violence, especially fatal violence.

In general, life skills have been reported to have brought about tremendous improvement in problem solving, communication, and coping Skills among children and adolescents. It is these indicators and trends—often qualitative and anecdotal in nature—that indicate the potential of this approach and its particular contribution to the issue of alcohol use (Botvin and Kantor, 2001).

EMPIRICAL REVIEWS

Effects of Life Skills Training on violence and health risk behaviour of Adolescents

A wide range of anti-bullying interventions are used in schools, including circle time, drama or role play, group work, peer support and education, restorative justice and support group methods. Peer support initiatives, where some pupils are trained to offer support to others, are particularly popular in the United Kingdom, with an estimated 62 per cent of all schools using this method.

Studies have evaluated the effectiveness of the Olweus Bullying Prevention Programme in several diverse settings and elementary and middle school populations in the United States (Limber, 2004), and has shown that the programme had particular success in Norway, originally reducing bullying by 50 per cent (Olweus, 1993).with a noticeable impact on students as well as adults. Clear decreases have been observed in students' self-reported bullying behaviour (Limber., 2004), antisocial involvement (Olweus, 1999), victimization (Bauer, Lozano and Rivara, 2007) for white students, child victims' propensities to report bullying to adults at school, and students' perceptions that students intervene to put a stop to bullying (Bauer, Lozano and Rivara, 2007).

In the study by Otto-Salaj, Reed, Brondino, Gore-Felton, Kelly and Stevenson (2008), it was revealed that implicit in the negotiation Skills training is the assumption that the negotiation strategies taught to participants are perceived positively by sexual partners and are effective in persuading sex partners to use condom. According to the study of Shepherd, Weston and Peersman (1999), in their view of health education interventions offering information plus sexual negotiation skills development promote increased condom use in women as the result showed that health education information plus sexual negotiation skills development was associated with greater short term condom use than information alone. The study carried out by Popoola (2005) on sex negotiation strategies and safer sex practices among married women in Southwestern Nigeria revealed that only 32% of 167 women used for his study had the ability to comfortably discuss sexual matters with their

husbands. It was also found out that safer-sex practices by women were not significantly related to their sex negotiation skills.

A study on counseling in combination with pharmacotherapy in adolescent smokers show improved abstinence rates (Moolchan, Robinson and Ernst, 2004). In adults, the combination of nicotine patches with most other forms of nicotine replacement therapy (gum, lozenges, or spray, but not inhalers) is more effective than any replacement method alone. According to the Institute for Clinical Systems Improvement(2007),combining bupropion and nicotine replacement therapy results in improved abstinence rates compared with either therapy alone, but the difference is not statistically significant compared with the nicotine patch plus placebo.

Agbakuru and Ugwueze (2014), in their study which addressed the effect of assertiveness training on resilience among early adolescents, the results showed that assertiveness training is very effective in early-adolescents' improvement of resilience. It was revealed that social skills intervention could lead to positive change in behaviour. Assertiveness and resilience are traits that are linked together. They are inter related and inter connected. Being assertive makes one to be more confident and there by improves ones resilience. In other hand when one is very confident he or she can with stand adversities from life's tasks and therefore becoming more resilience.

Research on the Impact of Life skills Education on Adolescents in Rural School by Parvathy and Renjith (2015) found a significant increase in the knowledge level of students in problem solving Skills, critical thinking, decision making, self awareness and empathy as against an untrained group. The study was based on the hypothesis that Life skills knowledge level of the group that undergoes Life skills Education training will be better than that of the untrained group.

In a study examining victimization in Turkish schools by Aysun Dogan Ates and Bilge Yagmurlu (2010), it found clear gender differences when percentages were examined, it was found that boys were physically, verbally, and sexually victimized more than the girls. However, there was no significant difference in terms of percentages of boys and girls who reported being victimized in relational forms.

Similar findings were obtained when victimization scores were examined: boys reported higher levels of victimization in general and overall gender differences were significant for all age groups. The outcome of the study on comparative effectiveness of self-management, emotional intelligence and assertiveness training programmes in reducing the Potentials for Terrorism and Violence among Nigerian Adolescents (Ayodele , Olanrewaju and Sotonade .

Effects of Life Skills Training on Gender and Religion

In relation to gender, a study examining victimization in Turkish schools by Aysun and Bilge (2010) found clear gender differences when percentages were examined. It was found that boys were physically, verbally, and sexually victimized more than the girls. However, there was no significant difference in terms of percentages of boys and girls who reported being victimized in relational forms Similar findings were obtained when victimization scores were examined: boys reported higher levels of victimization in general and overall gender differences were significant for all age groups. The outcome of study on the comparative effectiveness of self-management, emotional intelligence and assertiveness training programmes in reducing the Potentials for Terrorism and Violence among Nigerian Adolescents Ayodele and Sotonade, 2014, indicated a significant gender difference training showed more improvement on resilience of the girls than that of the boys. The study showed that both the male and female was affected equally by the assertiveness training.

Nigerian adolescents are greatly affiliated with religious group yet sexually transmitted infections as well as HIV/AIDS are increasing. At every nook and cranny of Nigeria, urban and rural settlements are religious houses with the majority of worshippers being youths, premarital sexual intercourse among adolescents in Nigeria is also growing at an alarming rate despite its prohibition by these religious groups. Researchers are of the opinion that in spite of the apparent pervasive religiosity in the country, premarital sexual practices that culminate to unplanned pregnancy and sexually transmitted infections are on the increase (Morhason-Bello, Oladokun, Enakpene, Fabamiro, Obisesan and Ojengbede, 2008).

A study argued that religion influences adolescents' sexual behaviour directly and indirectly through mechanisms of social support and social control interacting at multiple levels of the adolescents' social context, however there is still controversy underlying the mechanism through which religion affects sexual behaviour of adolescents in Nigeria. Certainly, religious values are the source of moral proscriptions for many individuals. The teachings of the churches are likely to play a role in the formation of individual attitudes, values and decisions.

Findings regarding influence of religion on sexual behaviours have been mixed. For instance, Odimegwu's (2005) study, using 1,153 campus-based adolescents aged 10-24 years, showed a strong relationship between religiosity and adolescent sexual attitudes and behaviour. Similar finding was reported by Owusu (2011) using 1026 adolescents between 12 and 19 years of age in Lagos metropolis result show that religiosity is significantly related to multiple sexual partnerships. Findings in other contexts show that religious attendance delayed the sexual debut of males (Jessor, Costa, Jessor & Donavan, 1986). Crockett, Bingham, Chopak and Vicary (2004) also found that females who attended religious services more frequently were more likely to delay sexual debut.

Appraisal of reviewed literature

In this chapter, attempt has been made to examine relevant works of authors, both theoretically and empirically. Throughout the literature reviewed, it was clear that the issue of violence is globally worrisome. It is said to affect all aspects of life and cuts across social, political cultural and economic organisations. The supporting theories in literatures suggests that Adolescents Violence and risky behaviours are propelled by (1) what they observed and imitateed, (2) influence of the environment in which they are growing and (3) a result of strains and stressors. Literature revealed that cultism, gangsterism and weapon carrying behaviours of Adolescents in schools were offshoots of community violence. Growing power quest between groups, were major sources of murder, maiming, kidnapping, assaults and militancy, especially in the Niger Delta region.

From the review of research, suggestions are that minor physical abnormalities and brain damage may cause increase in the risk of early and persisted violence as may poor family management (poverty), poor parent-child relations and association with anti-social peers. But, race and parents drug use were not predisposing factors. Given the serious short and long term effects of bullying on children's physical and mental health, some countries are legally requiring schools to have an anti-bullying policy.

Health risk behaviours have been described as volitional involvement in patterns of behaviour that threaten the well-being of teens and limit their potentials for achieving responsible adulthood. Often exploratory, risk behaviours were considered a normal aspect of adolescent development. However, evidence suggests that the six types of health risk behaviours reported by CDC, includes tobacco use, unhealthy eating, inadequate physical activity, alcohol and other drug use, correlated positively with numerous risk behaviours including delinquency, conduct disorders at school, school dropout, violent and aggressive behaviour, unplanned and unprotected sexual intercourse and contribute to the leading cause of death disability and social problem. In Nigeria, notably, drug dependency and drug-related health consequences have been reported.

Life skills from literature, has received increased support for its teaching. Research reviewed revealed that violence can be reduced by various types of interventions that seek to teach children that violence is not an appropriate means of solving problems or controlling the behaviour of others.

In summary, not much has been done in literature to address violence and health risk behaviour simultaneously using school based approach but much emphasis were laid on Drug and alcohol, juvenile crime and teenage pregnancy based on community, and family intervention.

CHAPTER THREE

METHODOLOGY

This chapter presents the methodology that was adopted for the study. The chapter is discussed under the following sub-headings:

1. Research Design
2. Population of the Study
3. Sample and Sampling Techniques
4. Research Instrument
5. Validity of the Instrument
6. Reliability of the Instrument
7. Field Testing of the Instrument
8. Procedure for Data Collection.
9. Procedure for Data Analysis.

Research Design

This study adopted a pretest-post-test control group quasi-experimental research design. The design was used to determine the effectiveness of interpersonal and problem-solving skills training on violence related attitudes and health risk behaviours of secondary school students in Delta State.

Experimental groups were exposed to the treatments, which were the Life skills modules on; Interpersonal skills and Problem solving skills, while the control group received health instruction on environmental health and hygiene. A Pretest was administered to all the three groups. Treatment was given to only the experimental groups, while all the groups received the posttest

Outline of the design

The outline of the design is explained as follows

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 skills

X_2 - Problem Solving Skills

X_3 - Direct Method (control group)

Tabular Representation of the Research Design

Groups	Pre-test	Interpersonal Skills	Problem solving	Control Direct Instruction	Post-test
Experimental 1	√	√	-	-	√
Experimental 2	√	-	√	-	√
Control	√	-	-	√	√

Factorial Matrix

A 3×2×2 factorial matrix was adopted with treatment strategies varied at two levels. This is represented in the table below;

Treatment	Sex				Religion	
	Male	Female		Christian	Muslim	
Treatment 1 Interpersonal Training skills	33	39	72	67	5	72
Treatment 2 Problem solving Training skills	38	36	74	71	3	74
Control group	45	25	70	65	5	70
Total	116	100	216	203	13	216

Variables in the Study

Independent Variables: These are the treatment packages varied at 3 levels:

1. Interpersonal Skills
2. Problem solving Skills
3. Control-Environmental health education (Direct instruction)

Moderating Variables

These are:

1. Gender
2. Religion

Dependent Variables

These are:

1. Violence Behaviours **2.** Health Risk Behaviours

Population of the Study

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

Sample and Sampling Techniques

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

Using Yamane (1967) assumption of normal population, 400 participants are supposed to represent this population because they are above 100,000,\ however from the Informed Consent form 309 students volunteered for the training programme. The research adopted a multi stage sampling procedure.

The first stage involved the use of simple random sampling technique of fish bowl with replacement (giving equal chances) 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 school from Uwie, Oshimili South and Isoko South Local Government areas respectively. This is because the study was carried out before the recent merging of schools in Delta State, then about 50% of the schools were single sexed.

Students in Senior Secondary classes I and II students with records of violence and health risk behaviours were also selected using the purposive techniques. These selections were done because the schools were not sex segregated and adolescents in SS I and SS II were age appropriate.

In the third stage random assignment was used to assign St. Michaels Grammar School Oleh to experimental group I, Osadenis High School Asaba into Experimental group II while the Institute of Continuing Education Warri was assigned to control group. With the use of Informed Consent form, a total of 155 (male and female) students participants from Senior Secondary One and 154 from Senior Secondary two across the three schools volunteered for the study. This technique allows individuals chosen, to become part of the training on their own accord without being coerced into it.

Therefore, representative samples of 309 participants were originally chosen from each of the three schools. They were selected one week to the commencement of the training.

Tabular Presentation of Total Number of Participants in Selected School

S/N	Senatorial District	Name of School	Group Treatment	Number of students in selected classes		Total	Total number of students who completed the study		
				SS1	SS2		SS 1	SS 2	
1.	Delta South	St. Michael Grammar School, Oleh	I. C Skills	51	51	102	33	39	72
2.	Delta North	Osadenis High School, Asaba	P. S Skills	51	52	103	37	37	74
3.	Delta Central	Institute of Continuing Education Warri	Environmental Health D.I.	53	51	104	31	39	70
	Total			155	154	309	91	115	216

Research Instrument

The instrument and resources used for this study were four. They include:

1 The Adapted Standardized Violence-Related Behaviours, and Influences among Youths (VABIY)

a) Adolescents' Violence Behaviour questionnaire.(AVBQ)

b) Adolescents' Health Risk Behaviour Questionnaire.(AHRBQ)

2. Interpersonal Skills Training Manual

3. Problem Solving Skills Training Manual

4. Environmental Health Education Training Manual

The Adapted Violence-Related Attitudes Behaviours, and Influences among Youths (VABIY): A Compendium of Assessment Tools, (2^n ed) edited by Dahlberg, Tools, Swahn and Behrens (2005) and documented by centers for disease control and prevention, national centre for injury prevention and control. The original instrument has four sections viz attitude and belief assessment and environmental assessment Health Risk Behaviour assessment. However, the violence-related and Health Risk related assessments were adopted for the study.

The First part of the adapted and revalidated version of the VABIY was designed to elicit the demographic data of the respondents,

Section A; Adolescents Violence Behaviour Questionnaire.(AVBQ) is an adapted version of the VABIY. The instrument contains 31 items a five point likert type (12items), a six point rating multiple choice type (11items) and a five point likert type (8items).The instrument sought information on the dependent variables of violence behaviours.

Section B:Adolescents' Health Risk Behaviour Questionnaire. (AHRBQ)

The instrument contains 27 items which is a combination of 11items five point likert scale type questions and 16 item multiple choice questions. The instrument explored adolescents' health risk behaviour

The training manuals; (Interpersonal/communication Skills, Problem solving Skills and Environmental health education**)**

The manuals were designed to serve as guide for the training of in school adolescents. The training manual primarily provides advice and action, based on learning activities for life skills training and environmental health. The manual provides an outline and instructions for eight-week training. It includes a training schedule and instructions activities based on violence and health risk behaviours. Other information provided by the manual includes:

(a) Purpose of the training;
(b) Objectives of the training;
(c) Basic concepts underlining the training;
(d) Weekly programme outline;
(e) Resource/Instructional materials.

With adaptations from comprehensive sexuality education (Trainers Resource Manual by Action Health Incorporated, Healthy living and National Development Textbook by Lokoyi Ose-Lovet Osita and life skills handbook by Chair Handbury. Appendix II

Field Testing of the Instruments

In order to get familiarize with the research instruments, method and procedures and to allow for detection of any unforeseen constraints to the research

work, twenty four students from two missionary Secondary Schools (SS Peter and Mary Secondary, Asaba and St. Anthony's College, Asaba) who were not part of the study, but shared the same characteristics with the population, were used for field testing of the study.

Validity of the Instruments

The standardized instrument was revalidated to suite the local environment. Therefore in order to ensure that the instruments measured what they were supposed to measure (validity), a draft copy of the modified and structured instruments were presented to the researcher's supervisor, lecturers in the Department of Human Kinetics, and Health Education in the Faculty of Education, University of Ibadan. This was to ensure face, content and construct validity of the instrument. The instrument was amended based on the corrections and suggestions made.

Reliability of the Instruments

Reliability is an integral part of validity, which constitutes the basic attribute in research procedure and in order to ensure the reliability of the instruments, the violence behaviour assessment AVBQ and health risk behaviour assessment AHRBQ was administered on twenty four (24) secondary school students, who were not part of the study, but possess the same characteristics. The data collected was subjected to Cronbach alpha method to determine the internal consistency of the instrument. The Adolescent violence behaviour Questionnaire (AVBQ) showed a reliability coefficience (r=0.81) while Adolescent health risk behaviour Questionnaire (AHRBQ) rated as (r=0.76).

Inclusion and Exclusion Decisive Factors: The study excluded adolescents in the junior secondary and senior secondary schools three. The reason being that a lot of junior secondary school students were barely adolescents suited for the study, and the senior secondary school students at the time of this study were preparing for their senior secondary school certificate examination. Consequently the findings of this study can only be generalized on the adolescents in senior secondary school one and two.

Ethical issues

The ethical approval for this study was obtained from the of the Delta state Ministry of Basic Education, Ethical Review Committee. The researcher presented a letter of introduction from the Head of Department, Human kinetics and Health Education, University of Ibadan, and a copy of the research proposal.

Participants of the study were adequately informed about the essence of the study as informed consent forms duly signed by parents and caregivers were also obtained by each participant. In order to adhere to ethical standard of confidentiality of responses, the researcher did not include any identifier information such as name, address, phone number on the questionnaire. In order to ensure voluntary participation, the researcher explained the purpose of the research and made it discretionary for participants to either opt in or out.

Procedure for Data Collection

The authorities of selected secondary schools gave permission to carry out the study, having obtained a letter of introduction from the Head of Department of Human Kinetics and Health Education, University of Ibadan. After due procedure had been taken and participants selected, the purpose of the study was duly explained to the selected participants and consent forms were given to them. Only the students who signified their interest to participate in the study, and had duly signed the consent form participated in the study thereafter. Data for this study were collected by the researcher with the help of trained research assistants. Before the commencement of the study, the research assistants were instructed on the purpose of the study and their expected role in the study. Research assistants for treatment group 1 were trained on Interpersonal skills, while assistants for group two were trained on problem solving skills.

Pretest was administered to the participants in the treatment groups and control. The researcher supervised the pretest in the three treatment groups personally with the aid of research assistants. Violence Behaviour Assessments (AVBQ) and (AHRBQ) were administered for the pretest. The pretest was followed by the School based life-skills training programme which lasted for 8 weeks. The School based life-

skills training programme took place twice a week with the duration of 1hour for each contact. Each group was trained by the researcher and research assistants.

Treatment group one was exposed to Interpersonal skills using life skills approach for a period of 8 weeks. Treatment group 2 had problem solving skills training using the life-skills approaches for a period of 8 weeks. The control groups were given direct classroom instruction on personal health and environmental health one hour, two times a week for eight weeks.

Training procedure

Experimental group 1 (Interpersonal Skills Group)

The participants in this group were taught using the following steps:

Step 1: The teacher introduces the topic

Step 2: The teacher distributes the hands on activity work sheets to the participants

Step 3: The teacher briefly gives the participants an overview of what the lesson is all about and tells the participants that the content of the lesson is going to be learnt through interactive teaching.

Step 4: The teacher divides the participants into groups for brain storming, discussion, and simulation activities.

Step 5: The teacher asks the participants to select one person or two that will explain or demonstrate the Skills learnt.

Step 6: The teacher had previously taught the participants to visit counseling offices, health centers, police stations as places where they can find help.

Step 7: The teacher expatiates on the facts identified by the participants and also give further explanations as the case may be.

Step 8: The teacher gives the participants opportunity to ask questions

Step 9: The teacher concludes the lesson and asks the participants to read up or prepare to dramatize e.g.***esu the confuser*** against the next lesson.

Experimental group 2 (Problem solving Skills)

The participants in this group were taught using the following steps:

Step 1: The teacher introduces the topics.

Step 2: The teacher takes the participants through an in depth teaching of all the content of the lesson.

Step 3: The participants are given opportunity to ask questions.

Step 4: The teacher assigns participants to one activity or the other e.g. listen to the Crocodile River story and explain the values displayed.

Step 5: The teacher selects participants.

Step 6: The participants are appreciated after demonstration

Step 7: The teacher concludes the lesson and gives the participants homework to do before the next lesson.

Control Group (Direct Health Instruction Alone)

The participants in this group were taught using the following steps:

Step 1: The teacher introduces the topic

Step 2: The teacher takes the participants through the content of the lesson

Step 3: The teacher gives the participants opportunity to ask questions

Step 4: The teacher concludes the lesson and gives the participants homework to do against the next lesson.

Procedure for Data Analysis

Response of pretest and posttest questionnaire were collected on the spot, collated, coded and analyzed using descriptive statistics of frequency counts and percentage to describe participants' demographic attributes, while the inferential statistics of Analysis of Co-Variance (ANCOVA) was used to test the hypotheses set at 0.05 level of significance and Scheffe post-hoc to test pair-wise comparison of the treatment and control groups.

CHAPTER FOUR

RESULTS, ANALYSIS AND DISCUSSION

This study examined the effects of school-based problem solving and interpersonal Skills training on violence and health risk behaviours among in-school adolescents in Delta State, Nigeria. This chapter presents the analysis of data and discussion of results obtained.

Table4.1: Frequency Distribution of Participants Based on Gender

Variable	Frequency	Percentage (%)
Gender		
Male	116	53.8
Female	100	46.2
Total	**216**	**100.0**

Table 4.1 above shows that out of the total study participants, 116 (53.7%) were males, while, 100 (46.2%) were the females. This shows that majority of the participants were males.

Table4.2: Frequency Distribution of Participants Based on Religion

Variable	Frequency	Percentage (%)
Religion		
Christianity	203	93.99
Islam	13	6.01
Total	**216**	**100.0**

Table 4.2 above shows a high representation of participants who had Christian religious affiliation with a 203 (93.99%) while 13 (6.01%) were members of the Islamic faith.

Table4.3: Frequency Distribution of Participants Based on Age

Variable	Frequency	Percentage (%)
Age		
13-16	129	59.7
17-19	87	40.3
Total	**216**	**100.0**

Table 4.3 above shows that participants who were aged between 13 to 16 were 129 (59.7%) while 87 were aged between 17 and 19 (40.3%) . This shows that majority of the participants are between the ages of 13 and 16years

Hypotheses Testing:

H_{01} (a): There is no significant main effect of Treatment on Violence related Behaviours among in-school adolescents in Delta State.

Table4.4: Effect of Treatment on Adolescents Violence Related Behaviours.

Source	Sum of Squares	Df	Mean Square	F	Sig.	Partial Eta Square
Main Effect:						
Pretest of Violence related behaviours	16230.145 2.873	11 1	1475.468 2.873	62.582 .122	.000 .727	.771 .001
Treatment	1634.785	2	817.392	34.670	.000	.254
Gender	63.310	1	63.310	2.685	.103	.013
Religion	35.630	1	35.630	1.511	.220	.007
2-way Interactions:						
Treatment * Gender	237.922	2	118.961	5.046	.007	.047
Treatment * Religion	11.916	2	5.958	.253	.777	.002
Gender * Religion	.719	1	.719	.031	.862	.001
3-way Interaction:						
Treatment*Gender *Religion	1.409	1	1.409	.060	.807	.001
Explained	16230.145	11	1475.468			
Residual	4809.629	204	23.577			
Total	**21039.773**	**215**				

Significance at $p < 0.05$

The result in table 4.4 above shows that there was a significant main effect of treatment on violence behaviours among in-school adolescents in Delta state. ($F_{(2,204)}$ = 34.670; P < 0.05; η^2=0.254). Therefore the null hypothesis is rejected. The Partial eta square of 0.254 implies that treatment of interpersonal Skills, and solving Skills training and control accounted for 25.4% of the observed variance on violence related behaviours of adolescents.

Table 4.5 Estimated Marginal Mean Analysis of Treatment on Adolescent's Violence Behaviours.

Grand Mean= 53.28	N	Mean	Std Error	95% confidence Interval	
Treatment group				lower bound	Upper bound
Problem solving	74	64.040	.594	62.869	65.210
Interpersonal Skills	72	51.807	.603	50.618	52.997
Control	70	43.428	.611	42.224	44.631

Table 4.5 shows the result of the estimated marginal mean analysis on the magnitude of the mean scores, across the treatment groups. From the above result, it is shown that experimental group II (problem solving) had the highest mean score of (x=64.04), followed by experimental group I(Interpersonal Skills) with a mean score of (x= 51.81) and Control group with a mean score of (x=43.43). This reveals that problem solving was more effective compared to the group exposed to Interpersonal Skills.

Table 4.6; Scheffe Post-Hoc Pairwise Comparism of the Treatment Groups on Violence Behaviours

Treatment Group	Treatment Groups	Mean Difference	Std. Error	Sig	95% Confidence Interval	
					Lower Bound	Upper bound
Problem solving	Interpersonal Skills Control	13.1985 20.8880	6158 6202	000 000	11.6806 19.3592	14.7164 22.4168
Interpersonal Skills	Problem solving Skills Control	13.1985 7.6895	6158 6244	000 000	-14.7164 6.1504	-11.6806 9.2286
Control	Problem solving Skills Interpersonal Skills	20.8880 -76895	6202 6244	.000 000	-22.4168 -9.2286	-19.3592 -6..1504

Table 4.6 shows the result of the scheffe post –hoc test which revealed the actual source of the significant difference in violence behaviours obtained in the study. There were significant differences between Problem solving Skills and control, interpersonal Skills and control as well as problem solving Skills and Interpersonal Skills respectively.

$H_0$1(b)::There is no significant main effect of treatment on health risk behaviours of in-school adolescents in Delta state.

Table4.7: Effect of Treatment, on Adolescents Health Risk Behaviours

Source	Sum of Squares	Df	Mean Square	F	Sig.	Partial Eta Square
Main Effect:						
Pretest health risk Behaviours	21091.508	11	1917.410	30.353	.000	.621
	2.130E-04	1	2.130E-04	.000	.999	.001
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 group x Gender	203.777	2	101.889	1.613	.202	.016
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 result on table 4.7 above shows that there is significant main effect of treatment on health risk behaviours of in school adolescents in Delta state. ($F_{(2,204)}$ = 19.063 P < 0.05; η20.157) The Partial eta square of 0.157 implies that treatment of Interpersonal skills, problem solving skills and control accounted for 15.7% of the observed variance on health risk behaviours of adolescents.

Table 4.8 Estimated Marginal Means Analysis of Treatment on Adolescent's Health Risk Behaviours.

Grand Mean= 87.29	N	Mean	Std Error	95% confidence Interval	
Treatment group				lower bound	Upper bound
Problem solving Skills	74	98.070	.959	96.178	99.961
Interpersonal Skills	72	88.333	.972	86.417	90.248
Control	70	74.813	.986	72.869	76.756

Table 4.8 above shows that Experimental group II had the highest mean score of x = 98.07, followed by Experimental group I with a mean score of x= 88.33 and Control group with a mean score of x= 74.81. This reveals that problem solving was more effective compared to the group exposed to Interpersonal Skills.

Table 4.9: Scheffe Post-Hoc Pair wise Comparism of the Treatment on Health risk Behaviours

Treatment Groups	Treatment Groups	Mean Difference	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
Problem solving	Interpersonal skills	6.4500	.8852	.000	4.2679	8.6321
	Control	24.9743	.8916	.000	22.7764	27.1721
Interpersonal Skills	Problem solving	-6.4500	.8852	.000	-8.6321	-4.2679
	Control	18.5243	.8976	.000	16.3117	20.7369
Control	Problem solving	-18.5243	.8916	.000	-27.1721	-22.7764
	Interpersonal skills	-24.943	.8976	.000	-20.7369	-16.3117

Table 4.9 above shows the result of the Scheffe post –hoc test which revealed the actual source of the significant difference in health risk behaviours obtained in the study. There were significant differences between problem solving skills and control, interpersonal

skills and control as well as problem solving skills and Interpersonal Skills respectively. The result also revealed that both treatments are effective.

$H_0$2 (a): **There is no significant main effect of gender (male and female) on adolescents Violence related behaviours.**

The result in Table 4.4 shows that there is no significant main effect of gender on violence behaviours among in school adolescent behaviours in Delta State. ($F_{(1, 204)}$ = 2.685 P > 0.05 η^2 = .013) Therefore, null hypothesis is retained. The partial eta square of .013 implies that the main effect of gender accounted for 1.3% of the observed variance on adolescents' violence behaviours.

Table 4.10: Estimated Marginal Means Scores of Adolescent Violence Behaviours by Gender

Gender	Mean	Std . Error	95% Confidence Interval	
			Lower Bound	Upper Bound
Male	56.906	.848	55.235	58.578
Female	49.078	.913	47.279	50.878

The above result indicates that gender does not have any effect on adolescents violence behaviours of in-school adolescents in Delta state. Albeit, the result of the estimated marginal mean analysis showed a higher mean score for males (56.906) than females (49.078)

$H_0$2 (b): **There is no significant main effect of gender (male and female) Health risk behaviours of adolescents in Delta state**.

The result in Table 4.7 shows that there is no significant main effect of gender on health risk behaviours of in school adolescent in Delta state. ($F_{(2,204)}$ = 3.274 P >0.05; η^2 0.016) hence null hypothesis is retained. Partial eta squared of .016 implies that gender accounted for 1.6% of the observed variance on health risk behaviours among adolescents in Delta state.

Table 4.11: Estimated Marginal Means Scores of Adolescent Health Risk behaviours by Gender

Gender	Mean	Std. Error	95% Confidence Interval	
			Lower Bound	Upper Bound
Male	91.425	1.095	89.266	93.584
Female	82.487	1.180	80.161	84.812

The above result indicates that gender does not have any effect on health risk behaviours of in- school adolescents in Delta state. Albeit, the result of the estimated marginal mean analysis (Table 4.11 above) showed a higher mean score for males (91.425) than females (82.487).

$H_0$3 (a): **There is no significant main effect of religion (Christianity and Islam) on violence behaviours of in- school adolescents in Delta state**.

The result in Table 4.4 shows that the main effect of religion on adolescents' violence behaviours is not significant ($F_{(1, 204)} = 1.511$; $P > 0.05$ $\eta^2 = 0.007$) Therefore, the null hypothesis is retained. The partial eta square of 0.007implies that the main effect of religion accounted for 0.7% of the observed variance on adolescents' violence behaviours.

Table 4.12: Estimated marginal means scores of adolescent violence behaviours by religion

Religion	Mean	Std. Error	95% Confidence Interval	
			Lower Bound	Upper Bound
Christianity	53.681	.689	52.323	55.038
Islam	47.062	2.722	41.696	52.428

The above result indicates that religion does not have any effect on adolescents on the violence behaviours among in school adolescents in Delta state. Albeit, the result of

the estimated marginal mean analysis (Table 4.12) showed a higher mean score for Christianity (53.681) than Islam (47.062) .

$H_0$3 (b):**There is no significant main effect of religion (Christianity and Islam) on health risk behaviours of in- school adolescents in Delta state**.

The result in Table 4 shows that the main effect of religion on adolescents' violence behaviours is not significant ($F_{(1, 204)}$ = 1.644; P > 0.05 η^2 = 0.008) Therefore, the null hypothesis is retained. The partial eta square of 0.008implies that the main effect of religion accounted for 0.8% of the observed variance on adolescents' health risk behaviours.

Table 4.13: Estimated marginal means scores of adolescent health risk behaviours by religion

Religion	Mean	Std. Error	95% Confidence Interval	
			Lower Bound	Upper Bound
Christianity	87.932	.867	86.222	89.641
Islam	77.221	3.427	70.465	83.976

The above result indicates that religion does not have any effect on health risk behaviours among in school adolescents in Delta state. Albeit, the result of the estimated marginal mean analysis (Table 4.13 above) showed a higher mean score for Christianity (x= 87.932) than Islam (x= 77.221)

H_0 4(a):There is no significant two way interaction of treatment and gender on violence behaviours of in-school Adolescents in Delta State.

The two way interaction analysis on table 4.4 shows that there is significant interaction effect of treatment and gender on adolescents' violence-related behaviours.($F_{(1, 204)}$ = 5.046; P < 0.05 η^2 = 0.047). Therefore the null hypothesis is rejected**.** The partial eta square of 0.047 implies that treatment and gender accounts for 4.7% of the observed variance of violence related behaviours of adolescent in Delta state.

Table 4.14:Estimated Marginal Means Scores of Adolescents' Violence Behaviours from the Interaction of Treatment and Gender

Treatment	Gender	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
Problem solving Skills	Male	65.525	.652	64.240	66.809
	Female	59.724	1.110	57.536	61.912
Interpersonal Skills	Male	51.665	.805	50.077	53.253
	Female	51.970	.811	50.370	53.569
Control	Male	45.478	.967	43.572	47.383
	Female	42.280	.721	40.859	43.702

Table 4.14 revealed that adolescents exposed to problem solving as part of treatment had the following mean respectively (Male mean=65.525, Female mean=59.724), followed by those exposed to interpersonal skills (Male mean=51.665, Female mean=51.970) and the adolescents in the control group had the lowest mean score (Male mean= 45.478, Female mean= 42.280) respectively. This result is an indication that participants exposed to problem solving had the highest mean score than those exposed to interpersonal skills and the control group.

H_0 4(b):There is no significant interaction effect of treatment and gender on adolescents health risk behaviours.

The two-way interaction analysis on table 4.7 shows that there is significant effect of treatment and gender on Adolescents' health risk behaviours. ($F_{(1, 204)} = 1.613$; $P > 0.05$ $\eta^2 = 0.016$). Therefore the null hypothesis is retained. The partial eta square of 0.016 implies that treatment and gender accounts for 1.6% of the observed variance of health risk behaviours of adolescents in Delta state.

Table 4.15:Estimated Marginal Means Scores of Adolescent Health Risk Behaviours from the Interaction of Treatment and Gender

Treatment	Gender	Mean	Std . Error	95% Confidence Interval	
				Lower Bound	Upper Bound
Problem solving Skills	Male	99.075	1.082	96.942	101.207
	Female	95.167	1.843	91.534	98.800
Interpersonal Skills	Male	88.249	1.337	85.613	90.884
	Female	88.416	1.337	85.781	91.051
Control	Male	79.201	1.604	76.039	82.363
	Female	72.373	1.197	70.013	74.732

Table 4.15 above revealed that adolescents exposed to problem solving as part of treatment had the following mean respectively (Male mean =99.075, Female mean=95.167), followed by those exposed to interpersonal skills (Male mean=88.249, Female mean=88.416) and the adolescents in the control group had the lowest mean score (Male mean= 79.201, Female mean= 72.373) respectively. This result is an indication that participants exposed to problem solving had the highest mean score than those exposed to Interpersonal skills and the control group

H_0 5(a):There is no significant interaction effect of treatment and religion on violence related behaviours of in school adolescents in Delta State.

The two-way interaction analysis on table 4.4 shows that there is no significant effect of treatment and religion on adolescents' violence related behaviours. ($F_{(1, 204)} = .253$; $P > 0.05$ $\eta^2 = .777$). Therefore the null hypothesis is retained. The partial eta square of

.002 implies that treatment and gender accounts for 0.2% of the observed variance of health risk attitude of adolescent in Delta state

Table 4.16:Estimated Marginal Means Scores of Adolescents' violence behaviours from the Interaction of Treatment and Religion

Treatment	Religion	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
Problem solving Skills	Christianity	64.080	.602	62.894	65.266
	Islam	62.505	3.607	55.394	69.616
Interpersonal Skills	Christianity	51.845	.620	50.623	53.067
	Islam	51.271	2.554	46.236	56.306
Control	Christianity	43.776	.643	42.509	45.043
	Islam	40.260	1.935	36.446	44.075

Table 4.16 revealed that adolescent exposed to problem solving/religion as moderating the following mean respectively (Christianity/Problem Solving, mean=64.080, Islam/Problem Solving, mean=62.505), followed by those exposed to Interpersonal skills/Religion (Christianity-Interpersonal skills, mean=51.845,Islam interpersonal skills, mean=51.271) and the adolescents in the control group/Religion had the lowest mean score (Christianity-Control group mean=43.776, Islam-Control group, mean=64.080) respectively. This result is an indication that participants exposed to problem solving/religion had the highest mean score than those exposed to Interpersonal skills/religion and the control/religion.

H_0 5(b):There is no significant interaction effect of treatment and religion on health risk behaviours of in school adolescents in Delta State.

The two-way interaction analysis on table 4.7 shows that there is not significant effect of treatment and religion on adolescents' violence related behaviours ($F_{(1, 204)}$ = .409; P

> 0.05 η^2 = .004). Therefore the null hypothesis is retained. The partial eta square of .004 implies that treatment and Religion accounts for 0.4% of the observed variance of health risk behaviours of adolescent in Delta state.

Table 4.17:Estimated Marginal Means Scores of Adolescents' Health Risk Behaviours from the Interaction of Treatment and Religion

Treatment Groups	Gender	Mean	Treatment	95% Confidence Interval	
				Lower Bound	Upper Bound
Problem solving Skills	Christianity	98.096	.957	96.210	99.981
	Islam	96.997	5.734	85.692	108.301
Interpersonal Skills	Christianity	88.368	.983	86.429	90.306
	Islam	87.753	4.055	79.759	95.747
Control	Christianity	75.843	1.022	73.827	77.858
	Islam	65.570	3.065	59.528	71.612

Table revealed that adolescent exposed to problem Solving/Religion as a moderating variables of treatment had the following mean respectively (Christianity/Problem Solving, mean = 98.096, Islam/Problem Solving, mean=96.997), followed by those exposed to Interpersonal skills/Religion (Christianity-Interpersonal skills, mean=88.368, Islam Interpersonal Skills, mean=87.753,) and the adolescents in the control group/Religion had the lowest mean score (Christianity-Control group mean=75.843, Islam-Control group, mean=65.570) respectively. This result is an indication that participants exposed to problem solving/Religion had the highest mean score than those exposed to Interpersonal skills/religion and the control group/religion.

H_0 6(a):There is no significant two-way interaction effect of gender and religion on Adolescents violence related behaviours

The two-way interaction analysis on table 4.4 shows that there is no significant effect of gender and religion on adolescents' violence related behaviours. ($F_{(1, 204)} = .031$; $P > 0.05$ $\eta^2 = 0.001$). Therefore the null hypothesis is retained. The partial eta square of 0.001 implies that Gender and religion accounts for 0.1% of the observed variance of violence behaviours among adolescents in Delta state.

Table 4.18:Estimated Marginal Means Scores of Adolescent Violence Behaviours from the Interaction of Gender and Religion

Gender	Religion	Mean	Std . Error	95% Confidence Interval	
				Lower Bound	Upper Bound
Male	Christianity	57.026	.861	55.329	58.724
	Islam	54.202	4.056	46.207	62.197
Female	Christianity	49.642	.946	47.777	51.507
	Islam	42.620	3.210	36.293	48.947

Table 4.18 revealed that adolescents in the two religion group had the following mean respectively (Christian Males' mean=57.026, Christian Females' mean = 49.642), followed by (Islam Males' mean = 54.202, Islam Females' mean = 42.620) respectively. This result is an indication that participants who are Christian had the highest mean score than those who practise Islam.

H_0 6(b):There is no significant two-way interaction effect of gender and religion on adolescents' Health-Risk Behaviours

The two-way interaction analysis on table 4.7 shows that there is no significant effect of gender and religion on health risk behaviours among in-school adolescents in

Delta state. ($F_{(1, 204)}$ = .515; P >0.05 η^2 = .003). Hence the null hypothesis is retained. The partial eta square of .003 implies that gender and religion accounts for 0.3% of the observed variance of adolescents' health risk behaviours. This result implies that gender and religion when combined, does not have significant effect on adolescents health risk behaviours.

Table 4.19: Estimated marginal means scores of adolescent health risk behaviours from the interaction of gender and religion

Gender	Religion	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
Male	Christianity	91.517	1.097	89.355	93.679
	Islam	89.382	5.168	79.195	99.569
Female	Christianity	83.606	1.205	81.231	85.981
	Islam	69.622	4.085	61.568	77.675

Table 4.19 shows that the mean for Christians ($\overline{x}$=91.517) was higher among the males participants than their Muslim counterparts ($\overline{x}$= 89.382). Also, the mean for Christians ($\overline{x}$= 83.606) was higher among the female participants with a score of ($\overline{x}$=69.622). This implies that the Christian male and female participants performed better than their Muslims counterparts.

H_0 7(a):There is no significant three-way interaction effect of treatment, gender and religion on adolescents' violence related behaviours

The three-way interaction analysis on table 4.4 shows that there is no significant effect of treatment gender and religion on adolescents' violence behaviours. ($F_{(1, 204)}$ = .060; P > 0.05 η^2 = .001). Therefore, the null hypothesis is retained. The partial eta square of .001 reveals that treatment, gender and religion

accounts for 0.1% of the observed variance of health risk attitude of adolescent in Delta state. This result implies that interaction effect of treatment, gender and religion had no influence on adolescents violence behaviours.

Table 4.20:Estimated Marginal Means Scores of Adolescents' violence Behaviours from the Interaction of Treatment, Gender and Religion

Treatment	Gender	Religion	Mean	Std. Error	95% Confidence Interval	
					Lower Bound	Upper Bound
Problem solving Skills	Male	Christianity Islam	65.637 62.511	.667 3.434	64.322 55.741	66.952 69.280
	Female	Christianity Islam	59.719 ----------	1.115	57.521	61.918
Interpersonal Skills	Male	Christianity Islam	51.702 51.016	.833 3.434	50.060 44.246	53.344 57.786
	Female	Christian Islam	52.003 51.574	.838 3.440	50.351 44.792	53.655 58.357
Control	Male	Christianity Islam	45.539 43.995	.991 4.856	43.584 34.421	47.493 53.568
	Female	Christianity Islam	42.688 39.603	.778 1.991	41.155 35.679	41.222 43.528

Table 4.20 shows that "the mean scores of male Christian participants in problem solving group was overall highest ($\overline{x}$ = 65.4) followed by Christian female participants in interpersonal Skills group with mean scores of ($\overline{x}$ =52.003) and lastly by male Christian participants in control group (45.539). This indicates that the problem solving group was most effective among the groups with regards to gender and religion.

H_0 7(b):There is no significant three-way interaction effect of treatment, gender and religion on adolescents' health-risk behaviours

The three way interaction analysis on table 5 shows that there is no significant effect of treatment gender and religion on adolescents' health-risk behaviours. ($F_{(1, 204)}$ = .603; P > 0.05 η^2 = .003). Therefore, the null hypothesis is retained. The partial eta square of .003 implies that treatment and gender accounts for 0.3% of the observed variance of health-risk behaviours of adolescents in Delta state. This result implies that interaction effect of treatment, gender and religion had no influence on adolescents health risk behaviours.

Table 4.21:Estimated Marginal Means Scores of Adolescent Health Risk Behaviours from the Interaction of Treatment, Gender and Religion

Treatment	Gender	Religion	Mean	Std. Error	95% Confidence Interval	
					Lower Bound	Upper Bound
Problem solving Skills	Male	Christianity Islam	99.15 97.000	1.092 5.621	96.998 85.918	101.304 108.082
	Female	Christianity Islam	95.158	1.826	91.557	98.759
Interpersonal Skills	Male	Christianity Islam	88.294 87.500	1.363 5.621	85.607 76.918	90.982 99.582
	Female	Christian Islam	88.441 88.000	1.363 5.621	85.754 76.918	91.129 99.082
Control	Male	Christianity Islam	79.250 78.000	1.622 7.948	76.051 62.328	82.449 93.672
	Female	Christianity Islam	73.744 63.500	1.275 3.245	71.231 57.102	76.257 69.898

Table 4.21 above shows that the mean scores of male Christian participants in problem solving group was overall highest ($\overline{x}$ = 99.15) followed by Christian female participants in Interpersonal skills group with mean scores of ($\overline{x}$ =88.441) and lastly by male Christian participants in control group ($\overline{x}$=79.250). This indicates that the problem solving group was most effective among the groups in relation to gender and religion.

Summary of Findings

The findings from this study are summarized in the following sequence:

1. There is no significant main effect of treatment on violence and health risk behaviours among in-school adolescents in Delta State.

a. The main effect of treatment on violence behaviours of in school adolescents in Delta State was significant. Problem solving Skills training had the highest post test mean score over Interpersonal Skills, while participants in control group had the least mean score.

b. The main effect of treatment on health risk behaviours of in school adolescents in Delta State was significant. Problem solving Skills training had the highest post-test mean score over Interpersonal Skills, while participants in control group had the least mean score.

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

a. Gender did not have significant effect on violence and health risk behaviours of in-school adolescents in Delta state. However, the mean score for males was higher than females across the groups

b. Gender did not have significant effect on violence and health risk behaviours of in-school adolescents in Delta state. However, the mean score for males was higher than females across the groups.

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

a. Religion had no significant effect on the violence related behaviours of in school adolescents in Delta State. On the other hand, the main effect of religion on adolescents' health risk behaviours also did not show any significance.

b. Religion had no significant effect on the violence related behaviours of in school adolescents in Delta State. On the other hand, the main effect of religion on adolescents' health risk behaviours also did not show any significance.

4. There is no significant interaction effect of treatment and gender on violence and health risk behaviours among in-school adolescents in Delta State

a. The interaction effect of treatment and gender was significant on adolescents' violence behaviours. The mean score for the male respondents outweighed the females across in problem solving, Interpersonal Skills and control.

b. The interaction effect of treatment and gender was not significant on adolescents' health risk behaviours. The mean score for the male respondents outweighed the females across in problem solving, Interpersonal Skills and control.

5. There is no significant interaction effect of treatment and religion (Christianity and Islam) on violence and health-risk behaviours among in-school adolescents in Delta State.

a. The interaction effect of treatment and religion was not significant on both violence related and health-risk-behaviours of in school adolescents

b. The interaction effect of treatment and religion was not significant on both violence related and health-risk behaviours of in school adolescents.

6. There is no significant two-way interaction effect of gender and religion on violence and health-risk behaviours among in-school adolescents in Delta State

a. Interaction effect of gender and religion on adolescents' violence related behaviours was not significant**.** There was also an insignificant interaction effect of gender and religion on in-school adolescents

b. Interaction effect of gender and religion on adolescent health-risk behaviours was also not significant

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

a. The interaction effect of treatment, gender and religion was not significant on adolescents' pre-post violence related behaviours.

b. The interaction effect of treatment, gender and religion was not significant on adolescents' pre-post health risk behaviours.

Discussion of Findings

The purpose for this study was to determine the effects of school-based life Skills training (problem solving and Interpersonal skills) on violence-related and health risk behaviours of adolescents in schools in Delta State.

H0 1 The result based on table 4.4, shows that the main effect of treatment on violence related behaviours of these adolescents is significant. The result implies that the treatment packages are individually potent in stamping out violence among youths. This could be as a result of the participants being exposed to an eight-week treatment. While showing the effectiveness of the treatment strategies, it also shows the utilization of the treatment gains by the participants as well. Adolescents exposed to problem solving Skills training had the highest post-test mean score of violence and health-risk behaviours followed by those who received training on Interpersonal Skills. The participants in control group had the least mean score, implying that to reduce adolescents' violence-related behaviours, the treatment packages, (Interpersonal skills and problem solving Skills training) are veritable tools.

Problem solving was more effective because the students were engaged in such a way that all their energy and attention were dissipated on the task compared to the group exposed to Interpersonal skills. The findings of the study lend credence to the outcomes of researchers who exposed their subjects to various life Skills trainings such as Olweus (1993) who found that its' Bullying Prevention Programme, had success in Norway, as it reduced bullying by 50 per cent. Also, Ayodele and Sotonade (2014) found the effectiveness of self-management, emotional intelligence and assertiveness training programmes in reducing the potentials for terrorism and violence and maladaptive behaviours among adolescents in Nigeria. The findings are in line with Howell and Hawkins (1998), Olds, Hill and Rumsey (1998) and Sherman et al. (1997) who found that parents' training, pre-natal and early childhood interventions can be very effective in reducing violent behaviours among the youth. Subsequently, the report of Foshee, Bauman, Ennett, Suchindran, Benefield and Linder (2005) is also in agreement with the findings of this study; they submitted that

in preventing dating violence, school and community-based programmes have proved efficient. Parvathy and Renjith (2015) found a significant increase in the students' knowledge level, in problem solving skills, critical thinking, decision making, self-awareness and empathy as against the untrained group. The study was based on the hypothesis that life skills knowledge level of a group that undergoes Life skills Education training will be better than that of the untrained group

The result on 4.7 revealed the significance of the main effect of treatment on adolescents' health-risk behaviours. This implies that adolescents exposed to problem solving and Interpersonal skills will not exhibit adolescents' health risk behaviours compared to those left with no intervention. Moreover, having learnt such skills as communication assertiveness, negotiation skills, skills for finding help and problem solving training, they are more capable of avoiding health-risk behaviours. This result is consistent with Cochrane review of Foxcroft, and Tsertsvadze, (2011), a universal school-based prevention programme for alcohol misuse in young people which concluded that certain generic psycho-social and developmental prevention programmes such as Life skills Training Programme, can be effective in reducing health risk behaviours and could be considered as policy and practice options. Furthermore the report of Horowitz and Garber (2006), indicated that selective depression prevention programmes produce greater effect sizes than universal programmes.

The findings of the study also corroborate those of Breldenbush (2007) who reiterated that assertiveness training skills provided and equipped participants with appropriate skills to face life dilemma, to be firm and take control of their lives. These made them confident. In relation to these findings, this study shows that problem solving and interpersonal skills are efficacious in the reduction of health risk behaviours among adolescents. This is as a result of its activity based interactive approach, which enables adolescents to acquire knowledge, practise good health behaviours and positive attitudes. In-school adolescents exposed to problem solving skills had a high post-test mean scores for both violence and health risk behaviours, consequently, problem solving skills are a combination of life skills that enable the

individual to resolve conflicts, clarify personal values, aid self-monitoring and evaluation and enhance ability to make rational selection in order to minimize personal risk. Life skills howbeit focuses on behaviours change and developmental approach designed to address a balance of knowledge, attitude and skills. In a study by Agbakuru and Ugwueze (2014) addressing the effect of assertiveness training on resilience among early adolescent, the results show that assertiveness training is very effective in improvement of early-adolescents' resilience. It also reveals that social skills intervention could lead to positive change in behaviours.

H0 2: The study revealed that gender has no significant effect as a moderating variable on violence behaviours among in-school adolescents in Delta state. This implies that being a boy or girl did not influence violence behaviours in adolescents The main factors that influence adolescents' behaviours are mostly environment, exposure to violence, child abuse, peer influence, social class (family and school) etc. Invariably, the amount of influence of each factor is dependent on exposure. Adolescents are more likely to be dependent on their peers and therefore align themselves to their behaviours. On the other hand, environment can be a main factor for adolescents that come from violent family set-ups. It could also be as a result of early violence of child abuse. Adolescents with such backgrounds are more likely to exhibit such behaviours themselves. Social class has been known to influence one's behaviours especially inferiority complex exhibited by adolescents from low economic families. All of these are not dependent on gender and are more likely to be involved by any gender. Although the study did not show much gender significance, so many other works have integrated gender as a factor. How much significant gender plays is dependent on individual works. For instance the result is in contrast with the findings of Craig (1998) and Reid, Gonzalez, Nordness, Trout and Epstein (2004) who found boys to be more involved in physical bullying while girls were more involved in verbal bullying.

This study also revealed that there was no significant main effect of gender as a moderating variable, on health-risk behaviours of adolescents in Delta state, this implies that being a boy or girl did not influence health risk behaviours in adolescents.

This result also at variance with the findings of Wickrama, Conger, Wallace and Elder (1999) who found that gender significantly affect adolescents' health-risk behaviours. However, compared to health-risk factors, a few significant findings, Lundahl, Davis, Adesso, and Luka, (1997) have shown that gender can influence the level of risk. Boys are more likely to smoke in our environment compared to girls and girls are more prone to unintended pregnancies and abortion. Saewye's, (1998) study on gender differences in health and risk behaviours among adolescents has shown that alcoholics are more likely to give birth to drunks than people who do not drink. Girls are more likely than boys to binge-drink. Also that both younger and older girls were significantly more likely than their male counterparts to report a history of prostitution owing to economic factors, sexual abuse, dissatisfaction with weight, negative body image, dieting in earlier age, and earlier participation in sexual intercourse. Younger and older boys are significantly more likely than girls to have positive body image, to rate themselves as being healthier than their peers, to report no regular source of healthcare, to be sexually more experienced and to drink alcohol more often in greater quantity. The results as recorded in Table 4.4 and 4.7 revealed gender differences in the mean scores of the effect of life Skills training on participants' potential for violence and health risk behaviours it was shown that male participants benefited more from the training programme than their female counterparts. The results supported the previous findings that gender has been maintaining consistent direct impact on behavioural change (Ayodele, 2011).

H03: This study showed that there was no significant main effect of religion on adolescents' violence-related behaviours in Delta State. This finding is in contrast with the findings of Prather (2007) who concluded that religious beliefs serve to motivate and to inhibit social behaviours. Certainly, religious values are the source of moral proscriptions for many individuals the teachings of the churches are likely to play a role in the formation of individual attitudes, values and decisions. Research findings regarding influence of religion on sexual behaviours have been varied. For instance, Odimegwu (2005) study, using 1,153 campus-based adolescents aged 10-24 years showed a strong relationship between religiosity and adolescents' sexual

attitudes and behaviours. Similar finding was reported by Owusu (2011), using 1026 adolescents between 12 and 19 years of age in Lagos metropolis which showed that religiosity is significantly related to multiple sexual partnerships.

Findings in other contexts found that religious attendance delayed the sexual debut of males (Jessor, Costa, Jessor & Donavan, 1986). Crockett, Bingham, Chopak and Vicary (1996) also found that females who attended religious services more frequently were more likely to delay sexual debut. However, in line with the result of the present study is the findings of Eweniyi, Adeoye, Ayodele, Kolawole and Raheem (2013) who found that religious affiliation does not affect bullying behaviours.

The findings of the study also revealed that there was no significant main effect of religion on adolescents' health-risk behaviours. The outcome of this study is not in line with the submission of Harris (1996) that religious beliefs and practices have positive functions, enabling the individual to adapt to normative expectations of the group. In Ofole and Agokei (2014), religion directly and indirectly was reported to affect sexual decisions through religious norms and sanctions for noncompliance.Thefindings of Johnston, O'Malley Bachman and Schulenberg (2008) as well as that of Kuntshe and Gmel (2004) which found that religious groups of the people served as factor that can inhibit anti-social behaviours, does not agree with this finding.

H04: The result of this study revealed that there was a significant interaction effect of treatment and gender on adolescents' violence related behaviours. Furthermore, it was found that boys in the problem solving training group performed better than girls exposed in this first treatment group. On the other hand, females exposed to Interpersonal Skills were also better than the males in the same group. The verbal nature of girls and their ability to communicate effectively, might be responsible for the edge the females have over their male counterparts in the Interpersonal Skills. Girls also had better interpersonal relationship compared to male. The result obtained from problem solving training group was so owing to the fact that males had ability to solve problem than females. This finding is consistent with the report of Gillham, Hamilton, Freres, Patton and Gallop (2006), in a primary care setting. Girls in the

Penn Resiliency Programme had reduced depressive symptom scores compared with girls in the usual care control condition, whereas there was no such difference for boys. In addition, two school-based universal interventions (Ialongo, Werthamer, Kellam, Brown, Wang, & Lin, 1999) designed to prevent depression by improving achievement and mastery learning were found to be more effective for boys than girls. The report of Foshee, Bauman, Ennett, Suchindran, Benefield and Linder, (2005) is also in line with the findings of this study ; it submitted that some studies have evaluated programmes for adolescents designed to prevent dating violence, and the results showed the efficacy of school and community-based programmes.

The interaction effect of treatment and gender on adolescent health risk behaviours was not significant. This implies that none of the gender adjusted their health risk behaviours based on the treatment. The finding of this study is inconsistent with the findings of O'Donnell et al. (2005) that the intervention strategy for inner-city Black and Hispanic youths, a parent education program about normal sexual development and the challenges faced by developing teens resulted in improved communication between parents and their teens, improved family support of the teens, and fewer risk behaviours exhibited by the teens irrespective of gender. The findings of this study are not in agreement with that of DiClemente et al. (2001) whose study showed that gender and culturally specific interventions helped African-American girls develop HIV-avoidance behaviours. The interventions taught girls about HIV, about how to use condoms, about good communication skills and about healthy relationships. The findings also contradict that of Coyle, Kirby, Marin, Gomez, and Gregorich (2004) that particularly with boys, education about how to set and maintain personal limits with regard to engaging in sexual intercourse may be a useful preventive intervention for risky sexual behaviours. Their intervention helped boys identify their own sexual behaviours limits and develop strategies for maintaining these limits. The finding of this study is also not supported by Hall, Richardson, Spears, and Grinstead (1996) in which the post intervention scores indicated significant sex differences in the effectiveness of Positive adolescent life skills training (PALS) for eighth graders such that females made greater improvements shortly after

the intervention in social competence for assertiveness in refusing high-risk behaviours and handling criticism. At the 1-year follow-up, boys' improvement exceeded the females' only in handling criticism. The other sex differences in social competence persisted.

H0 5: The result of the finding indicated that there was no significant interaction effect of treatment and religion existing on adolescents violence-related behaviours, which means that the two treatments and religion if taken together did influence adolescents violence-related behaviours. In a similar manner, the two-way interaction between treatment and religion was not significant on adolescents' health behaviours. Some works have deduced that there is an interaction between treatment and religion on the behavioural patterns of youths, (Jessor, Costa, Jessor and Donavan, 1986) found that religious attendance delayed the sexual debut of males. however a few other works have indicated no actual interaction between these two factors. Examples of such works, this work however supports the latter assumption that there is no significant interactive effect. Religious beliefs and religious dispositions have always helped in modeling peoples ideals (Kutshe and Gimel, 2004). People however can be religiously endowed without being skilled. A lot of people also have had to have skills without being religious. Although the acquiring of skills can modify peoples' interaction with others. It does not completely change behaviours. There is no one factor that influences behaviours but a combination of these factors. Religion had always been at the forefront of modeling behaviours. It is also very arguable whether this assumption is accurate. A lot of so called religious people have been found invariable immoral. Morality is an aspect of behaviours that defines integrity. skills on the other hand influence our thinking but how they modify behaviours is relative and also depend on other factors. The acquiring of both religion and skills can be useful in defining how our behaviours can be patterned but whether they have a combined or interaction effect in determining behaviours is yet to be proven.

H0 6: This finding indicated no significant interaction effect between gender and religion in adolescents' violence-related behaviours. The two factors do not therefore depend on each other to influence adolescents' violent behaviours. It is certain that individually these factors influence how adolescents behave, but how they interact is not obvious. Studies have shown problems among girls to be as violent and in

occasions more violent than boys. Gender as a factor in violence is in some cases occasioned by the cause of the problem rather than whether they are girls or boys. Although because of physicality, boys are sometimes assumed to be more violent. Considering that violence could be physical as well as verbal, the effect could be determined by the actual harm done. Pitel, Geckora, Kolarcik, Reijneveld and Dijk (2012) found that there is a significant inverse relationship between religiosity and health risk behaviours in both genders and truancy in girls. This study did not quite support this view. Religion has a way of influencing behaviours but religion too can hinder behaviours as in cases of fanatism. Some fanatics have been found to be very violent in their conception of religious beliefs. Such concepts have sometimes led to killings and untold hardship on affected individuals. Religious violence has been known to be perpetrated by both genders in recent times. Cases of suicide bombing that are carried out in the Northern parts of Nigeria, in the middle East and all over the world are cases of concern.

H0 7: The result of the finding indicated that there was no significant three-way interaction effect of treatment, gender and religion existing on adolescents' violence-related behaviours, which means that the treatments, gender and religion if taken together did not influence adolescents violence related behaviours . In a similar manner, the three-way interaction among treatment, gender and religion was not significant on adolescents' health risk behaviours. 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 treatment, class types and religions on the bullying behaviours of secondary school students because the combination of class types and religions did not aid the effect of cognitive self-instruction and contingency management on bullying behaviours of secondary school students.This result is however in contrast with that of Jacob (2013) who observed that there was a three way interaction effect of treatment (mental health education), gender and religion on health attitude among in school adolescents in Kogi State.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

This chapter presents the summary, conclusion and recommendation for the study.

Summary

The study examined the effects of school based life-skills training (Problem solving and Interpersonal skills) on violence and health-risk behaviours among in-school adolescents in Delta State, Nigeria. The independent variable (treatment) was examined at three levels, problem solving skills, Interpersonal skills and control. Two moderating variables, religion and gender, were considered for the study. The dependent variables for the study were adolescents 'violence-related behaviours and adolescents' health risk behaviours.

The pretest-posttest control group quasi experimental research design was adopted for the study. The students in St Michaels College, Oleh (experiment group I) and Osadenis High school, Asaba (Experimental group II), and the students in Institute of Continuing Education (I.C.E) Warri (control group) formed the population of the study. The multistage sampling technique was used to select the participants. The first stage was the selection of two Local Government Areas, each from the three senatorial districts in Delta State using the simple random sampling technique of fish bowl with replacement. Purposive sampling technique was used in the second stage to select one co-educational public secondary school from Uwie, Oshimili South and Isoko South Local Government areas respectively. This is because the study was carried out before the recent merging of schools in Delta State, then about 50% of the schools were single sexed.

Students in Senior Secondary classes I and II students with records of violence and health risk behaviours were also selected using the purposive techniques. These selections were done because the schools were not sex segregated and adolescents in SS I and SS II were age appropriate.

In the third stage random assignment was used to assign St. Michaels Grammar School Oleh to experimental group I, Osadenis High School Asaba into Experimental group II while the Institute of Continuing Education Warri was assigned to control

group. With the use of Informed Consent form, a total of 155 (male and female) students participants from Senior Secondary One and 154 from Senior Secondary two across the three schools volunteered for the study. This technique allows individuals chosen, to become part of the training on their own accord without being coerced into it.

Therefore, representative samples of 309 participants were originally chosen from each of the three schools. They were selected one week to the commencement of the training. Out of 309 students, a total of 216 participants completed the training.

Data collected were analyzed using descriptive statistics of frequency counts and percentage for demographic data, while the inferential statistics of Analysis of Co-Variance (ANCOVA) was used to test the hypotheses.

The results revealed that Problem solving and Interpersonal Skills had significant main effect on adolescents' violence related and health risk behaviours. The findings further revealed among others that there was no significant main effect of gender and religion on adolescents' violence-related behaviours in Delta State.

Conclusion

Based on the findings from this research work, it was concluded that Problem solving and Interpersonal skills had significant main effect on adolescents' violence related and health risk behaviours. It was also concluded that there was no significant main effect of gender and religion on adolescents' violence-related behaviours among the participants. This Problem solving and Interpersonal skills were good and effective as intervention programmes in reducing adolescents' violence and health risk behaviours. From the findings, it was observed that with the help of the therapeutic packages, youths' maladaptive behaviours could be properly managed. The findings have shown that the treatment packages could be used as veritable tools in equipping adolescents with necessary skills that could be used to expedite some kinds of cognitive processes such as positive moods, decision-making, problem-solving, self-control, and self-reinforcement skills, therefore, bringing about better future and peaceful co-existence among the people of the world. This shows that if this method is well developed and used in training adolescents how to manage and control their violence-related behaviours and health risk behaviours, it will help alleviate the fear

that adolescents are prone to violence related behaviours and health risk behaviours, especially in Delta State. The method when explored among health educators and encouraged among students might result in greater improvement in mitigating violent behaviours and health risk behaviours among in-school adolescents.

Recommendations

Based on the findings of this study, these recommendations are hereby made:

1. The school based life-skills intervention should be used continuously in reducing violence and health risk behaviours among in-school adolescents because of the effect it had on the participants of the study. This will enable them to apply the skills learnt in coping with the various challenges in their transition into adulthood;
2. A re-organization of the national education systems and curriculum, to provide not only high standards of academic qualifications, but also Life skills, which are increasingly emphasized by employers of labour in the global society.
3. Life skills training should be organized in the form of capacity building for primary and secondary school teachers;
4. Establishment of functional youth friendly services in schools and youth centres. They should be equipped with appropriate facilities, and trained adult providers who respect adolescent's privacy and confidentiality.
5. Life skills approach should be adopted in the teaching of Health Education topics in secondary schools to ensure effective teaching and learning irrespective of gender.
6. Religious organizations irrespective of the type, should include in their programme violence and health risk reduction among youths.

Contributions to Knowledge

The study has contributed to knowledge in the following ways:

1. Working in groups using participatory and interactive method, produced good learning outcomes.

2. The training package would become a reference point, for all interested in reducing violence behaviours and health risk behaviours among out of school adolescents in and out of school.
3. Adolescents are now enabled to seek help and health information having been equipped with the right knowledge to make responsible choices.
4. The study has provided empirical evidence on the effectiveness of school-based life skills training, expanded the scope of literature and filled existing gaps.
5. The instrument used in this study, has been revalidated and its psychometric properties established, hence it can he adapted by other researchers.

Suggestion for Further Studies

It is suggested that other interested researchers can replicate this study and extend the sample to include secondary schools in other states. Life skills training can also be replicated among out of school adolescents in order to determine its effectiveness on their violence and health risk behaviours.

A Comparative analysis of this study in the South-South region of Nigeria. using other life-skills components to find out their effects on violence related behaviours and health risk behaviours and the most effective among the chosen methods can be used or compared with the one used in this study.

Further studies can be carried out considering other variables apart from the ones in this study, such as factors contributing to mitigating violence related behaviours and in order to reduce health risk behaviours among in-school adolescents.

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APPENDIX I

QUESTIONNAIRE ON EFFECTS OF SCHOOL-BASED LIFE SKILLS TRAINING ON VIOLENCE AND HEALTH RISK BEHAVIOURS AMONG IN-SCHOOL ADOLESCENTS IN DELTA STATE

Dear Respondent,

I am a postgraduate student in the Department of Human Kinetics and Health Education, University of Ibadan, Ibadan. This questionnaire is designed to investigate effects of school-based life Skills intervention on health risk behaviours and violence related attitudes of secondary school students in Asaba Metropolis. All information to be obtained from you is strictly for research purpose and will be treated as very confidential.

Kindly answer the questions as honest as you can.

Thanks for your anticipated co-operation.

Yours sincerely,

Lokoyi, O.L.O.

Section A: DEMOGRAPHIC INFORMATION

Name of School: ……

Religion Islam ( ) Christianity( )

Gender: Male( ) Female ( )

Age: 13-16 ( ) 17-19 ( )

Section A: ADOLESCENT HEALTH RISK BEHAVIOUR QUESTIONNAIRE

Sexual Behaviours Questionnaire (SBQ)

You are expected to tick either strongly disagree **(SD**), disagree **(D),** not sure **(NS),** agree (**A**) or strongly agree **(SA)**

		SD	D	NS	A	SA
1	I don't like using any form of protection during intercourse					
2	I insist on using a condom every time I have sexual intercourse, even if I know my partner well					
3	I have had sex with more than one person.					
4	I began to have sex before entering secondary school					
5	Sometimes I engage in sex in exchange for money, gift or favour.					
6	I have regular sexual intercourse with a sexual partner					
7	I take pills and anti- biotic to protect myself from infection					
8	I sometimes pull at the opposite sex's clothing in a sexual way					
9	If I get pregnant while in school I will abort it					
10	I don't mind having sex with same sex partner					
11	I have been forced by an opposite sex to do oral sex, other than kissing.					

You are expected to tick the one that applies to you **(1)** Walk, **(2)**Bicycle, **(3)**School Bus, **(4)**Tricycle (keke), **(5)**Private Car, **(6)**Commercial Bus

		1	2	3	4	5
12	How do you **usually** travel to and from school?					

You are expected to tick the one that applies to you**(1),**None **(2),**1 day**(3),**2or 3 days **(4),**4or 5 days **(5)**6 days and more

		1	2	3	4	5
13	During the past 30 days, how many days did you not go to school because you felt you would not be safe going to school?					

You are expected to tick the one that applies to you, in answering questions 14 and 15. **(1),**At no time **(2),**once **(3),**2 or 3 times **(4),**4 or 5 times **(5)**, 6 or 9 times

		1	2	3	4	5
14	During the past 12 months, while going to or coming from school, how many times did someone threaten to hurt you?					
15	During the past 12 months, how many times has someone stolen or deliberately damaged your property such as your locker, clothing, or books within the school premises?					

You are expected to respond to listed questions. You are asked to select the response that best corresponds to your beliefs.

16	How old were you when you first had a taste of alcoholic drink other than a few sips?	I Never had a taste of alcohol
		before 9
		Between 10 and 12
		13 or 14
		From 15 or older
17	Since you entered secondary school how many days have you had at least one drink of alcohol?	None
		1 or 2 days
		3 to 9 days
		10 to 19 days
		20 days and more
18	During the past 30 days, how many	None

	days did you have at least one drink of alcohol?	1 day
		2or 3 days
		4 or 6 days
		6 or more day
		Every other day
19	During the past 30 days, how many days did you have 5 or more drinks of alcohol in a row, that is, within a couple of hours?	None
		1 to 2 days
		3 to 4 days
		5 to 8 days
		9 to 10 days
		Every other day
20	During the past 30 days, how many days did you have at least one drink of alcohol within the school**?**	None
		1 or 2 days
		3 to 5 days
		6 or more days
		Every other day
21	How many times have you used substance like cocaine?	Never
		Once
		2 to 5 times
		up to 15 times
		Can't count

Have you ever tried cigarette smoking, even one or two puffs?

22	How old were you when you smoked a whole cigarette for the first time	I have never smoked
		Before 9 years old
		Between 10 and 12 years old
		12 and 14years old
		14 years and older
23.	During the past 30 days, how many days did you smoke cigarettes?	None (If you tick none in question 23, please go to question 26)
		None
		1 or 2 days
		5 to 10 days
		20 days
		Every day
24	During the past 30 days, on the days you smoked, how many cigarettes did you smoke per day?	1 cigarette per day
		2 to 5 cigarettes per day
		6 to 10 cigarettes per day
		11 to 20 cigarettes per day
		Can't count
25	During the past 30 days, how did you usually get your own cigarettes? (Select only one response.)	I bought them in a supermarket
		I gave someone else money to buy them for me
		I borrowed them from friends
		A person 18 years old or older gave them to me
		I got them some other way
26	During the past 30 days, how many days did you chew tobacco or snuff?	Never
		1 to 5 days
		6 to 9 days
		10 to 19 days

		Every day
27	During the past 30 days, how many days did you smoke cigars, cigarillos, or little cigars?	None
		1 to 5 days
		6 to 9 days
		10 to 19 days
		Every day

SECTION C: VIOLENCE RELATED BEHAVIOUR ASSESSMENT

You are asked to select the response that best corresponds to your beliefs.

		0 day	**1-day**	**2 or 3 days**	**4 or-5 days**	**6or more days**
1.	During the past 30 days, how many days did you carry a weapon such as a gun, knife, or club?					
2.	During the past 30 days, how many days did you carry gun?					
3.	During the past 30 days, how many days did you carry a weapon such as a gun, knife, or club on school property?					
4.	During the past 30 days, o how many days did you not go to school because you felt you would be unsafe at school or on your way to or					

	from school?					
5.	During the past 12 months, how many times has someone threatened or injured you with a weapon such as a gun, knife, or club on school property?					

		SD	D	NS	A	SA
6	Threatening to use a weapon is an effective way to avoid a physical fight.					
7	Avoiding or walking away from someone who wants to fight you is an effective way to avoid a physical fight.					
8	Carrying a weapon is an effective way to avoid a physical fight.					

You are expected to respond to listed questions. You are asked to select the response that best corresponds to your beliefs such as strongly disagree **(SD),** disagree **(D),** not sure **(NS),** agree **(A),** strongly agree **(SA)**

		SD	D	NS	A	SA
9	Teasing other students is not bad..					
10	I have said things about some students, that made other students laugh (made fun of them).					
11	I called other students names.					
12	I threatened to hit or hurt another student.					
13	Teachers know when students are being picked on or being bullied.					
14	As a Student I am not encouraged to report					

	bullying and aggression.					
16	Students know who to go to for help if they have been treated badly by another student.					
17	It is ok if class reps report it when one student hits another					
18	Teachers take action to solve the problem when students report bullying.					

Select the response that best corresponds to your behaviour.

		Number of times				
		0	1	2	3-4	5
19	How many times did you tease a student from your school?					
20	How many times did you push, shove, or hit a student from your school?					
21	How many times did you call a student from your school a bad name?					
22	How many times did you say that you would hit a student from your school?					
23	How many times did you leave out another student on purpose?					
24	How many times did you make up a story about some students to make other students dislike them there from?					

Kindly select the response that best corresponds to your belief such as strongly disagree **(SD),** disagree **(D),** not sure **(NS),** agree **(A),** strongly agree **(SA)**

		SD	D	NS	A	SA
1	There are gangsters and or cult groups in my neighbourhood.					
2	Everyone knows that there are gang members and cultists in this school, even the teachers.					
3	As a student I sometimes get involved in gang fight in other to rescue a student.					
4	Sometimes I could get others to join in beating up another student who deserves it.					
5	Gang members are trouble makers.					
6	It is okay to have a friend who is a gang member.					
7	There are good and bad gangs.					
8	I could join a gang in school if I like the members.					

APPENDIX II

TRAINING MANUAL

INTRODUCTION

This training manual primarily provides advice, and learning activities for life Skills training, which hopes to make impact on the behaviours and choices made by adolescents. It is flexible and can be adapted in varied learning environments.It is important that while focusing on teaching life Skills, emphasis will dwell on information, ability to act, motivation and the environment in order to achieve the set goals.

Purpose of Training

The purpose of school based Life Skills Training is to bring about a reduction in violence related and Health Risk Behavior among adolescents in Delta State.

Objectives

By the end of eight weeks of life Skills training which comprise interpersonal and problem solving Skills. It is expected that adolescents in Delta State will be able to:

1. master life Skills
2. apply life Skills in various life situations
3. exhibit more positive attitude and behaviour.

Modalities for the Programme

1. A period of eight weeks.
2. Adolescents in public secondary schools in Delta state
3. An hour, twice a week of participatory learning
4. Ground Rules for life Skills sessions e.g. we arrive on time

Basic Concepts Underlining the Training

The training manual was written to reflect the following basic concepts:

1. Violence prevention and conflict resolution.
2 Alcohol, tobacco and other substance use.

3 Sexual and reproductive health, HIV/AIDS, adolescent pregnancy and sexual behaviour.

4. Participatory activities based on experiential learning and small group work, are central to the training methods.
5. Non-threatening, non-judgmental, supportive learning environment where the needs of the individuals are catered for and learners view themselves as worthwhile.
6. Values, attitudes and Skills development activities, as well as practical, relevant information are used as a focus for positive health behaviour changes.

Outline of the Programme

1. Pretest of participants violence and health risk behaviour.
2. Direct Instruction (Personal health and hygiene) for a period of 8 weeks for the control group.
3. Interpersonal Skills for a period of eight weeks for Treatment group 1
4. Problem solving Skills for a period of eight weeks for treatment Group II
5. Posttest of participants violence and health risk behaviour

	Interpersonal Skills	Area of Training
1.	Effective Communication (2)	Listening, Expressing your feelings and showing positive attitude, relationship with family and friends, dressing.
2.	Assertiveness (2)	Reduce anger, fighting, bullying and aggression. Negative sexual advancement..
3.	Negotiation/Refusal (2)	Invitations to a drinking spree Invitations to a date Refusing early sexual start, abortion, use of condom
4.	Finding Help (2)	Relationships, emotional upheavals concerns about changes in the body, poverty, lack of shelter, harassment, bullying.

	Problem Solving Skills	
1.	Values (2)	Explore values on sexuality issues, virginity, fidelity, loyalty, violence, rejection.
2.	Self esteem (2)	Understand individual uniqueness, inner beauty, self appreciation, raise confidence.
3.	Goal setting (2)	Setting future goals
4.	Sexual Decision making	to smoke or take alcohol at a party.
5.	Decision making (2)	Examine choices, conducting options develop personal priorities set goals and have a direction in life.

Training Guide for Interpersonal Skills Experimental Group I

Week & Duration	**Training Objectives**	**Content**	**Training Method**	**Resource/ instructional Material**	**Evaluation**
Week 1 Day 1 1 Hour	At the end of the session, participants should be able to: **1.** .State the meaning of communication. **2.** Identify the types of communication **3.** Explain the importance of communication	Communication Definition Types Importance of communication	Demonstration Brainstorm & Role play.	Posters on communication Skills. Strips of paper.	State the meaning of communication. Mention types state two importance of good communication.

Week & Duration	Training Objectives	Content	Training Method	Resource/ instructional Material	Evaluation
Week 1 Day 2 1 Hour	At the end of the session participants should be able to **1**. Identify barriers to effective communication **2**. State why it is difficult to communicate about sexuality. **3.** Learn to apply the communication Skills in difficult life situations.	Barriers to communication reasons why sexual communication is difficult	Brainstorm Discussion Simulations or sexual situations	Pictures showing couple on a date. Role plays on dating.	What are the barriers to effective communication? Give two reasons why it is sometimes difficult to communicate. Give five instances where you have to apply communication Skills.
Week 2 Day 1 1 hour	At the end of the session, 1. Define negotiation. 2. Explain the process of negotiation. 3. Identify situations were negotiation is necessary.	Meaning of negotiation. Process of negotiation.	Brainstorm Discussion	Posters showing steps in successful negotiation. SWAT Chart.	What is negotiation? What are the processes of negotiation?
Week 2 Day 2 1 hour	At the end of the session, participants should be able to: 1. Identify factors that influence negotiation. 2. The advantages of negotiation 3. Apply negotiation Skills.	Factors that influence negotiation, Advantages of negotiation and Negotiation Skills.	Brainstorm group discussion	Posters showing steps in successful. negotiation SWAT chart	Mention the factors that influence Negotiation. State the advantages negotiation.

Week & Duration	Training Objectives	Content	Training Method	Resource/instructional Material	Evaluation
Week 3 Day 1 1 hour	At the end of the session, participants should be able to: 1) State the meaning of assertiveness 2) State the importance of assertiveness Skills	1) Meaning of assertiveness 2) Importance of assertiveness 3) What assertiveness Skills are	Group discussion, role play	Worksheets on Assertiveness; The Assert Formula	State the meaning of assertiveness. Mention the importance of Assertiveness Skills.
Week 3 Day 2 1 hour	By the end of the session, participants should be able to: **1.** State the difference between assertiveness passiveness and manipulation. State behaviour that requires assertiveness.	Difference between Assertiveness, passiveness and Manipulation Behaviours that improve Assertiveness Skills.	Telling Bimpe's story (Role play) Demonstration brainstorm.	Worksheet on assertiveness. Testing Your Assertiveness. Measure Your Assertiveness.	Write out the difference between Assertiveness, passiveness and manipulation.

Week & Duration	Training Objectives	Content	Training Method	Resource/instructional Material	Evaluation
Week 4 Day 1 1 hour	At the end of the session, participants should be able to: 1. State the meaning of finding help. 2. Identify situations that will require help.	Meaning of finding help. Situations that need finding help.	Brainstorm Discussion Role-play	Posters advertising NGO's. Handout on list of organizations that address youth needs. List of information contents.	State the meaning of finding help. Write five situations that may require finding help.
Week 4 Day 2 1 Hour	At the end of the session, participants should be able to: 1. Identify people who can help. 2. Discuss Skills necessary when seeking help.	Who can help Skills for seeking help	Group discussions. Investigation. Role play. Dramatization	Posters of NGO's Handout of list of places to find help	Mention the different people who can help What Skills are necessary when finding help? Mention two.
Week 5 Day 1 1 Hour	At the end of session, participants should be able to: 1) Explain the importance of finding help. 2) List factors that prevent young people from finding help.	Importance of finding help Factors that hinder young people from finding help	Class Discussion Brain storm	Posters of NGOs. Handouts of list of places to find help.	State the importance of finding help Mention four factors that hinder young people from finding help.

Week & Duration	Training Objectives	Content	Training Method	Resource/instructional Material	Evaluation
Week 5 Day 2 1 hour	At the end of the session, participants should be able to: 1. Describe steps to take when help is needed. 2. Identify agencies and characteristics of agencies that provide help.	Steps in finding help Agencies that can help. Characteristics of agencies that provide help to young people.	Brain storming Explanations	Posters of NGO's handouts of list of places to find help	State steps in finding help. List some agencies and their characteristics.
Week 6 Day 1 1 hour	At the end of the session, participants should be able to individually 1. Identify situations in their lives that need help.	Seeking and finding help.	Group discussion Report	Score cards representing various situations needing help.	Write out the situations in your life that need help.
Week 6 Day 2 1 hour	Actually seek out help for individual situations.	Finding help		Score cards representing help received	State how you found help.
Week 7 Day 1 1 hour	At the end of the session, participants should be able to: 1. Understand situations that put them at risk of HIV, pregnancy and STI's	Negotiating safer sexual behaviour	Demonstration	Role play scenes. Role play guidelines.	

Week & Duration	Training Objectives	Content	Training Method	Resource/instructional Material	Evaluation
Week 7 Day 2 1 hour	At the end of the session participants should: 1) Have an increased sense of pride 2) Demonstrate a sense of responsibility in negotiating and refusal Skills	Negotiating safer sexual behaviour	Demonstration Role play	Role play Scenenos& guidelines	State the lessons learnt from what is sexual behaviour.
Week & Duration	**Training Objectives**	**Content**	**Training Method**	**Resource/ instructional Material**	**Evaluation**
Week 8 Day 1 1 hour	At the end of the training participants should be able to: 1) Learn how to be assertive. 2) Apply it in everyday life.	Assertiveness	Role play	Role play scenarios & Guidelines	State how we can learn to be assertive.
Week 8 Day 1 1 hour	At the end of the training participants should be able to: 1) Have learnt not to be aggressive 2) Apply assertiveness Skills	Aggressiveness or passiveness	Role play	Scenarios & Guidelines	State how we can learn to be assertive.

Training Guide for Problem Solving Skills Experimental Group 2

Week & Duration	Training Objectives	Content	Training Method	Resource/instructional Material	Evaluation
Week 1 day 1 1 hour	At the end of the session, the participants should be able to: state the meaning of values. 2) Mention the importance of values in our lives.	Meaning of values Importance of values	Hands on Activity Brainstorming	Posters showing Basic human values	What are values? State the importance of values.
Week 1 Day 2 1 Hour	At the end of the session, participants should be able to: 1.State Some basic human values	Basic human values	Hands on Activities Brainstorming	Posters showing basic Human values	Mention some human basic values
Week 2 Day 1 1 hour	At the end of the session participants should be able to: 1) Describe sources of values 2) Discuss at least one parental and one communal value.	Source of values Parental & Communal values	Hands on activities Brainstorm	Posters showing basic human values	What are the sources of values? State two parental & two communal values
Week 2 Day 2 1 hour	At the end of the session participants should be able to: 1) Identify personal values 2) Affirm the personal values.	Personal values	Hands on activities Brainstorm	Posters showing basic human values	What are personal values?
Week & Duration	**Training Objectives**	**Content**	**Training Method**	**Resource/instructional Material**	**Evaluation**
Week 3 Day 1	At the end of the session, participants	Factors that influence	Hands on activities	Posters showing Basic human values	Mention factors that influence

1 Hour	should be able to: 1) State the factors that influence values. 2) Understand the effects of values on the individual.	values. Effects of values on the individual.	Brainstorming		values
Week 3 Day 2 1 hour	At the end of the session, participants should be able to: 1) Explore the values on Virginity Fidelity Violence Rejection	The Crocodile River story	Story telling Hands on activities	Posters showing basic human values	
Week 4 Day 1 1 hour	At the end of the session, participants should be able to: 1) Define self esteem 2) List the types of self esteem	Self Esteem Types of Self Esteem	Hands on activities	Posters of a movie star	Define self esteem Mention types of self esteem
Week 4 Day 2 1 hour	At the end of the session, participants should be able to: 1) Discuss the characteristics of high and low self esteem 2) Discuss the effects of high and low self esteem.	Characteristics of high and low self esteem. Effects of high and low self esteem.	Brainstorming Hands on activities Discussion	Posters of a movie star An IALAC Sign.	List the characteristics of high and low self esteem Mention two effects of high self esteem and four effects of low self esteem.

Week & Duration	Training Objectives	Content	Training Method	Resource/instructional Material	Evaluation
Week 5 Day 1 1 hour	At the end of the session participants should be able to: 1) State the meaning of goals. Mention the characteristics of good goals	Goals Types of goals Characteristics of good goal.	Brain storming Hands on activities	Work sheets Handouts on Getting there My future	What is a goal? State the characteristics of good goals.
Week 5 Day 2 1 hour	At the end of the session participants should be able to: 1) State the importance of goal setting. 2) Explain steps in achieving goals. 3) identify obstacles in achieving goals.	Importance of goal setting. Steps in achieving goals. Obstacles in achieving goals.	Brain storming Hands on activities	Worksheets Hand outs on what would my life be like setting a goal.	Mention the importance of goal setting.
Week 6 Day 1 1 hour	At the end of the session participants should be able to: 1) State the meaning of Decision making 2) Explain factors that influence decision making.	Decision making Factors that influence decision making.	Hands on activities Discussion	Posters of Decision making steps/models; Worksheets Handouts; * The DECIDE model * Who counts the most in my decisions. * A recent decision worksheet	Define decision making What factors influence decision making.
Week 6 Day 2 1 hour	At the end of the session participants should be able to: 1) Apply steps in decision making process	Decision making process	Brain storming Hands on activities	Posters Repeat Week 5 day2	State the steps in decision making.

Week & Duration	Training Objectives	Content	Training Method	Resource/instructional Material	Evaluation
Week 7 Day 1 1 hour	At the end of the session participants should be able to: 1) Discuss the importance of decision making. 2) State steps to improving decision making.	Importance of Decision making. Improving Decision making Skills	Brain storming Hands on activities	Repeat week 6 day 1	Mention the importance of decision making. List steps to improving decision making.
Week 7 Day 2 1 hour	At the end of the session participants should be able to: 1) Discuss barriers to decision making. 2) Understand how to overcome the barriers.	Barriers to Decision making	Brainstorm	Posters with the 8 decision making steps Worksheet on how do I decide about: sexual experience, sexual behaivour	State Barriers to decision making.
Week 8 Day 1 1 hour	At the end of the session participants should be able to: 1) State what sexual decision making means 2) Discuss the importance of sexual decision making.	Sexual decision making Importance of sexual decision making	Brainstorm Brain storm	Same as week 7 Day 2	What is sexual decision making and state their importance.
Week 8 Day 2 1 hour	At the end of the session participants should be able to: State the reasons why sexual decisions are difficult.	Sexual decision making	Brainstorm Hands on activities	Same as week 7 Day 2 and Wee 8 day 1.	State the reasons why sexual decisions are difficult to make.

ENVIRONMENTAL HEALTH EDUCATION TRAINING PACKAGE FOR CONTROL GROUP

Week & Duration	Training Objectives	Content	Training method	Resource/instructional material	Evaluation
Week 1 Day 1 1 Hour	At the end of the class, participants should be able to: 1. define health 2. state the qualities of good personal health	Health qualities	Direct instruction	Charts showing ways we maintain our health	Define healt
Week 1 day 1 1 hour	At the end of the class, participants should be able to: 1. state factors that affect health in the biological environment	Factors that affect health in our biological environment	Direct Instruction	Charts showing ways we maintain out health	State factors that affect health
Week 2 day 1 1 hour	At the end of the class participants should be able to: 1. state factors that affect health in the physical health the environment	Factors that affect health in the physical environment	Direct instruction	Charts showing ways we maintain our health	State factors that affect health in the physical environment
Week 2 day 2 1hour	At the end of the class participants should be able to: 1. state factors that affect health in the social environment	Factors that affect health in the social environment	Direct instruction	Charts showing ways we maintain our health	State factors that affect health in the social environment
Week 3 Day 1 1 Hour	At the end of the class, participants should be able to: Identify ways of maintaining health	Health maintenance	Direct instruction	Charts showing ways we maintain our health	How can health be maintained
Week 3 day 2 1 hour	At the end of the class, participants should be able to: Identify ways of maintaining health	Health maintenance II	Direct classroom Instruction	Charts showing ways we maintain out health	How can health be maintained
Week 4 day 1 1 hour	At the end of the class, participants should be able to: Understand and state the meaning of personal health hygiene	Personal and health hygiene	Direct classroom Instruction	Charts on hand washing after toilet use	State the meaning of personal health

Week 4 day 2 1hour	At the end of the class participants should be able to: Understand the meaning of body grooming and mention ways we care for the skin, hair and teeth	Body grooming care of the skin Care of the hair Care of the teeth	Direct classroom instruction	Charts showing creams for the skin, comb and toothpaste and brush	State the meaning of body grooming and mention way we care for the skin hair and teeth
Week 5 day 1 1 hour	At the end of the class, participants should be able to: Comprehend the meaning of body grooming and mention ways we care for the ear, nail and feet and care for clothings	Body grooming Care of the ear Care fo the nails and feet Care of clothings	Direct classroom Instruction	Charts showing soap and water, cotton bud and different clothings	Mention ways we care for the ear, nail and feet and care for clothings
Week 5 day 2 1 hour	At the end of the class participants should be able to: Define food hygiene and mention sources of ood contamination	Food hygiene sources of food contamination	Direct classroom instruction	Charts showing different foods with fly proof screes	State factors that affect health in the physical environment
Week 6 day 1 1hour	At the end of the class, participants should be able to: State the food hygiene practices	Food health hygiene	Direct classroom instruction	Charts showing different foods with fly proof screens	State various food hygiene practices in the home
Week 6 Day 1 1 Hour	At the end of the class, participants should be able to: State meaning of waste disposal	Waste disposal	Direct classroom instruction	Charts showing people sweeping court yard	State the meaning of environmental health
Week 6 day 2 1 hour	At the end of the class, participants should be able to: Comprehend the meaning of body grooming and mention ways we care for the ear, nail and feet and care for clothings	Body grooming Care of the ear Care fo the nails and feet Care of clothings	Direct classroom Instruction	Picture of refuse dump	State the meaning of waste disposal
Week 7 day 1 1 hour	At the end of the class participants should be able to: State the meaning of	Waste disposal	Direct classroom instruction	Pictures of refuse dumps	State the types of waste it examples

	waste disposal				
Week 7 day 2 1hour	At the end of the class, participants should be able to: State the types of waste with examples	Types of waste continued	Direct classroom instruction	Charts on types of waste	State the types of waste with examples
Week 8 Day 1 1 Hour	At the end of the class, participants should be able to: State the qualities of a good house	Qualities of a good house	Direct classroom instruction	Drawings of different types of houses and charts of the qualities of a good house	State the qualities of a good house
Week 8 day 2 1 hour	At the end of the class, participants should be able to: State the solutions to housing problems	Effect of poor housing conditions solutions to housing problems	Direct classroom instruction	Charts on types of housing	Identify the effects of poor housing condition State the solutions to housing problems

TRAINING PACKAGE FOR CONTROL GROUP

INTERPERSONAL SKILLS TRAINING PACKAGE

Lesson one: Meaning of Communication, Types of Communication and the importance of communication.

Day 1

What is Communication

Communication is the process of giving, receiving and understanding messages. Communication involves exchanging ideas, understanding, listening, expressing oneself talking and using body language, facial expressions and a host of other behaviours.

Types of Communication

Verbal Communication: This communication information sent through talking, singing, story telling etc.

Non verbal Communication: This type of communication sends and receives messages through pictures, facial expression and actions.

Importance of Communication

1. It enhances good interpersonal relationship between people.
2. Fosters understanding
3. Prevents or reduces conflicts.
4. Promotes respect for one another
5. Promotes self image

Lesson One: Barriers to Communication

Day 2

a. Sender Barrier: (Example includes manner of speech, speech in speech, complexity of message, use of technical terms body or facial expressions that do not match words.)

b. Listener Barrier: (Example includes, not listening, impatience, interruption, change of subject).

c. Other Barriers: (Examples include language, cultural background, lack of knowledge, physical challenge).

1. Read the following story '**eshu the confuser' (**This is a traditional story from Nigeria**)**

Eshu walked between two farmers. He was wearing green on his left side and red on his right side. So, one farmer saw he was wearing green and the other saw he was wearing red. After he passed, one of them asked the other, 'did you see that man walk past?' the other replied, 'He was wearing red'. They had a big argument about the issue until they nearly started fighting. Finally, they decided to continue working. Then Eshu walked between the farmers again. Because he was coming the other way, the farmer who saw green now saw red, and the one who saw red now saw green. After Eshu had passed, the first farmers said, 'I'm sorry, you were right. He was wearing red'. The other replied 'No you were right, he was wearing green'. This time they had an even bigger argument because each farmer was convinced he was right.

Why Sexual Communication is Difficult

Inability to express oneself

Low self esteem

Drug abuse, use of alcohol

Age difference

Topic may be regarded as taboo

Lack of sexual communication Skills.

Communication Skills

1. Active Listening Skills

* Establish eye contact with the other person.
* Listen to the person without interruption.
* Listen to the person without thinking of what to say next.
* Let the speaker know you are listening through body language.
* Emphatise with the speaker.

* Clarify what has been said.

2. Use the "I" so that you can express your feelings.
3. Paraphrase what the speaker is saying to ensure understanding.
4. **Boldness**: Avoid being shy
5. **Knowledge**: Have facts on issue to be spoken about.
6. Express feelings honestly and clearly without putting the other person down.
7. Offer possible non-verbal messages such as a smile or a touch.

Lesson 2 Day 1: Meaning and process of negotiation

Negotiation is a discussion aimed at arriving at a peaceful agreement.

Process of negotiation

State your position using 1 statements

Listen to the other person's position

Find out what the other person needs

Restate the person's position to be sure you understand it.

Brainstorm a win/win solution (propose creative alternatives that will work for both)

Agree on a solution, try it out and start again if it does not work.

Get an adult to intervene when physical force is involved.

Situations that May Need Negotiation

* What club to join?
* Use of alcohol/drugs
* Team game
* Leadership tussle
* Dating, where to go
* Types of parties to attend
* use of contraceptives
* To have or not have sexual intercourse

Day 2: Factors that influence negotiation

* Upholding one's values, discussion, communication
* Maintaining one's self esteem, tolerance, empathy

Advantages of negotiation

* Promotes co-operation
* Interpersonal relationship
* promotes self respect
* Assist in arriving at a peaceful agreement
* Sets mutual limit for sexual situations
* Provides opportunity for compromise
* promotes positive interaction
* Promotes understanding
* Promotes tolerance
* Enhances assertiveness
* promotes acceptance of responsibility.

Negotiation Techniques

S – Say no effectively

W – Why (give a clear reason for saying no)

A – Alternative (suggest alternative if you like)

T – Talk it out (discuss your feelings)

Lesson 3 Day 1: Assertiveness

What is Assertiveness?

Assertiveness means, standing up for what one beliefs in. It involves communicating one's feelings and needs without violating the rights of other people.

Importance of Assertiveness

Helps you avoid exploitation.

You can get what you want, while earning respect

It increases one's self esteem

It give a sense of fulfilment

Promotes friendship

Day 2: Distinction Between Assertiveness, Aggressiveness, Passiveness and Manipulation

Assertiveness does not involve violence, aggressive, rude, abusive and disrespectful behaviour or a bully. It means asking for what you need instead of assuming someone knows.

Aggressiveness means standing up for one's right at the expense of someone else's right. It involves blaming or criticizing the other person, putting other people down or using abusive language (name calling).

Passiveness means not expressing one's needs and feelings, or expressing them so weakly that they will neither be understand nor addressed.

Manipulation means pretending everything is alright and trying to get what you want in a dubious way. It is a tactic that usually makes others feel nervous, guilty or frustrated.

Lesson 3 Day 2: Assertiveness Skills

This requires: Taking a position

Stating and repeating one's position

Taking the offensive if need be

Offering compromise if need be

Refusing further discussion

Walking away from the scene

The ASSERT Formula

A – **Attention**: Get the other person to listen to you find the right time or place or method when you can be heard.

S – **Soon, simple and short**: Speak up, as soon as your right has been violated. Look the person in the eye and keep comment to the point.

S – **Specific Behaviour**: Focus on the behaviour that compromised your rights not the person. Tell the person exactly what behaviour disturbed you.

E – **Effect on me:** share the feelings you experienced as a result of the person's behaviour "I get angry when ….." "I get frustrated when".

R – **Response**: Describe your preferred outcome. What you would like to see happen. Instead and ask for some feedback on it.

T – Terms: Reach an agreement on how to handle the situation in future. Agree to disagree or come to a compromise, if not you have asserted yourself with dignity.

Behaviours that Improve Assertiveness

* Being honest, understanding your values and others
* Speaking up for oneself
* Having a positive self esteem
* Possessing good communication Skills.
* Having a positive body image and use of assertive body language.
* Communicating feelings and needs, as soon as the need arises do not wait.
* Repeating the message
* Setting limits and keeping them.

Lesson 4 Day 1

Meaning of Finding Help

Finding help means seeking assistance or support in order to find a remedy or relief from a problem or make a situation more bearable.

Situations where we need help There are many times when young people need help, though they may not always ask for help. The following situations may present a problem where help may be required:

Relationships, emotional upheavals, concerns about changes in the body, poverty, lack of shelter, harassment or bullying, education related problems, lack of personal items, unplanned pregnancy, drug and alcohol dependency, confusion resulting from conflicting messages, societal and family values, divorce or separation of parents, household disaster e.g. fire, flood, loss of home, violence, bereavement and financial problems.

Lesson 4 Day 2

People Who Can Help

When seeking help the following people can be of help

- Parents/guardians and other family members

- Counsellors, health practitioners, teachers, social workers.
- Religious leaders, law enforcement agents, trusted and experienced adults, specialized institutions, adolescent-focused NGOs, community members.

Skills Required When Seeking Help

* Good communication Skills (verbal and non verbal) which is primarily or willingness and ability to explain the problem or the need.
* Assertiveness – willingness to speak up, explain the issue to someone you may not know, continue explaining until you find someone who will listen or until you are understood.
* Counselling – Willingness to learn more through discussion with someone else.
* Follow up – Ability to take action on what needs to be done to rectify the situation.

Lesson 5 Day 1

Importance of Finding Help

- It makes it easier for one to cope with problems/concerns.
- It gives solutions to problems/concerns
- It gives an idea of where to go for additional help when it is needed.
- It relieves emotional trauma.
- It can improve the quality of life.

Factors that hinder young people from finding Help

- Ignorance (sometimes young people don't know that their situation can be helped/rectified.
- None-conducive environment (if an agency does not have its basic characteristics like if is not welcoming to young people)
- Lack of adequate knowledge about available services (they may be aware of the agencies but not the services they can offer).

- Inaccessibility of services (distance to be traveled, cost of service, restrictions on use)
- Fear of adults (some young people have found adults abusive or unapproachable; they find it difficult to approach an adult for help, especially a stranger.

Day 2

Characteristics of Agencies That Provide Help

Not all agencies provide help to adolescents, some are set up to provide services to adults only, which is why it is important to know what the characteristics of a youth-friendly services provider are when the person seeking help is a young person. The agencies must

Lesson 6 Day 1

1. Not require parental permission.
2. Be private and confidential
3. Free of charge or low cost
4. Have specialized services in the areas for which help is needed.

Places Where Help May Be Obtained Are

- School guidance department
- Non-governmental agencies such as ----------
- Community based organization such as ----------
- Local health facilities
- Health posts; police
- Health centres, private hospitals
- General hospital, Teaching hospitals
- Welfare department, youth centres

Lesson 6 Day 2

Field Trip

Situations in individual lives that will need help:

Participants are assigned to small groups to investigate (gather information about) different places or people that provide help. Using the list of places where help can be obtained. Students are to visit and gather information that will be brought back to and shared with the class. Each group leader makes the following presentation:

1. Location where help was found
2. Services provided
3. What were you restricted to
4. Who was available to help
5. How is help provided (emergency or on appointment)
6. Is the agency sex segregated?

PROBLEM SOLVING SKILLS TRAINING PACKAGE

Lesson 1 Values

Day 1

Meaning of Values

The word "Value" has several meanings. One is the actual worth of an object or item in monetary terms. Another meaning involves a more personal measure of worth, such as how important individual consider certain things, beliefs, principles or ideas people attach different worth to things based on their sense of values . When people attach great worth to something, they are usually ready to publicly proclaim or stand up for it.

Values are important to human lives because:

• Basic human values promote positive relationships among people;

• Values guide human behaviour, give purpose and direction to our lives;

• Values enhance good behaviour, attitudes and feeling;

• If we do not act according to our values, we may be unhappy;

• Understanding our values helps us to resist pressure to conform to other people's values and behaviour;

• Values help in decision-making.

Day 2

Some Basic human Values

Equity: understanding that all people have the same right

Honesty: Telling the truth, meaning what you say

Honour: Keeping your word

Respect: Treating everyone including yourself with dignity. Parents and elders always emphasize respect for elders, authority, communal laws and customs.

Self-control: Being able to control your own actions

Responsibility: Carrying out your obligations or duties, being answerable for your own actions

Social justice: Treating all people fairly

Week 2 Day 1

Sources of values:

Most values are derived from family, religious teachings, community, cultural traditions and their teachings, school environment, peer group, the media, and experiences.

Parental and Communal values

Parents and elders often emphasize respect for authority, community and duty to family. In terms of family, they often prescribe strict codes of how males and females should feel, dress and behave. They also influence the very concept that young people have regarding sexuality.

Young people today are in a state of confusion due to the conflicting messages received from parents and elders on one hand and the mass media on the other. The mass media include television, radio video, cinema, books, newspapers, magazines, billboards and large computer networks, including the Internet. The images projected by the media vary; they portray the individual as having personal freedom, personal choices and the right to live his or her own life. They also suggest how women and men should feel, dress and behave.

Week 2 Day 2

Personal Values

The development of personal values and standards of behaviour and effective decision-making Skills provides a framework for making the decision to abstain from risky behaviours such as sexual involvement and drug use. Abstinence, in turn, helps to provide a framework for enhancing quality of life for pre-teens and teens.

Week 3 Day 1

Factors that Influence Our Values

Children receive most of their values from parents, other family members, community cultural and religious teachings the media school and peers Most parents want their children to develop values similar to theirs though members of the same family may have different values. Open and honest communication between teenagers and parents concerning the family's attitudes and beliefs about specific values can help young people to broaden their outlook and understand the importance of family values. By examining the impact of a particular value on oneself and others, young people can clarify the value and assign merit to it. Once a young person has internalised a value, it is meaningful to him or her and becomes an effective aid in making wise, responsible decisions.

Week 3 Day 2

Values Clarification

Values clarification is an approach to helping individuals recognize their own values and affirm them publicly (ability to take a position on the value and defend it). Being clear about our own values and beliefs helps us to make decisions that feel right to us. Values help us become the kind of person we want to be and live the kind of life we want to live. Values aren't all equal. Many times, values simply reflect different people's ideas or preferences If values allow persons to hurt themselves, other,

CROCODILE RIVER — THE STORY (You can give names to the characters that fit your community)

Once there was a woman named Fatima who loved a man named Paul. They lived in a small village on a river bank. Malaria was common in the area, and Paul fell ill with the disease. There was a mission hospital across the river where quinine was available. Unfortunately, the bridge was washed out and the river was inhabited by crocodiles. Fatima went to Sinbad, a riverboat captain, and asked him to take her across. Sinbad said he would, if she would first have sexual intercourse with him. Fatima refused and asked her friend Margaret for help. Margaret refused to get involved but "knows she'll do the right thing." Paul's fever rose alarmingly and Fatima, feeling she had no other choice, agreed to Sinbad's terms. She brought Paul the quinine and he recovered. When she told him what she had done to get the quinine, he told her he never wanted to see her again, saying he could never respect a woman who obviously had so little respect for herself. As Fatima stood crying by the river, along came, Slug. Hearing Fatima's tale of woe, he felt sorry for her. He found Paul and beat him up. As the sun sets in the West, we see Fatima laughing while Paul gets what he "deserves".

Week 4 Day 1 and 2

Self-Esteem

Self-esteem is essentially a feeling we have about ourselves. We tend to base these feelings on self-knowledge, self-expectations, and standards for behaviour that we think others expect of us. When "I am what I could be" or pretty much "when I should be," then a person's self-esteem is positive or healthy. When "I am not I could be" and "not what I should be; then self-esteem tends to be low or unhealthy.

Self-esteem is closely identified with self-respect. It includes a proper regard for oneself as a human being and an accurate sense of one's personal place within larger society, among family, friends and people. Lack of self-esteem can lead to feeling of worthlessness.

It is important for young people to know themselves, value themselves and feel good about themselves. Teenagers need to identify and discover their positive qualities, personal strengths, physical attributes and special Skills as well as abilities.

Day 2

Factors That Influence Self Esteem

How a person feels about himself or herself is linked to the individual's family, norms and how we fit, gender, culture and tradition, mass media, religious teachings, environment, individual achievements and economic background. All these factors influence an individual's self esteem.

Types of Self-esteem

1. High self-esteem; An Individual with high self-esteem recognizes his or her own strengths and Skills and can accept and acknowledge successes and achievements. Such a person responds confidently to challenges and problems and practices positive thinking,

2 Low self-esteem: This is the opposite of high self-esteem. It is when a person experiences feelings of worthlessness, inadequacy, helplessness, inferiority, and a sense of being unable to improve his or her situation. Unlike the person who believes he or she can be successful, those with low self-esteem feel they cannot succeed or will fail.

Characteristics of High Self-esteem

• Believing in oneself and having self-confidence
• Accepting one's weaknesses and strengths
• Respecting and liking oneself and others
• Trusting oneself
• Making one's decisions based on what one feels is right, not what a friend may suggest
• Ability to make decisions, face challenges and cope with them

Characteristics of low self-esteem

• Lack of self-confidence

• Inability to express one's feeling and opinions

• Inability to accept oneself

• Not respecting or liking oneself and others

• Letting other people make decisions for one

• Not believing in one's ability and strengths

• Giving up easily

• Feeling disliked and unwanted

• Blaming others for one's failures

• Always wanting to please other people

• Always wishing to be someone else

• Easily influenced by others

Effects of High self-esteem

• Influences the way others feel about us

• Increases self-confidence

• Promotes self-satisfaction

• Enhances ability to cope with challenges.

Effects of Low self-esteem

• Lack of self-confidence

• Negative attitude towards life

• Inability to make decisions

• Feeling disliked and unwanted

• Inability to tackle new challenges and avoiding new experiences.

• Inability to follow one's own path

How to Improve Self-esteem

• Accept yourself the way you are

• Identify your strengths and weaknesses

• Identify your values and behave according to them

• Set realistic goals

• Develop your abilities and be proud of them

• Select realistic role models

• Cultivate positive relationships

• Be pleased with who you are

• Accept compliments

Week 5 Day 1 and 2

Goal Setting

A goal is something a person works to accomplish. It can also be described as a proposed achievement or accomplishment towards which efforts are directed. People who achieve their goals generally, are those who take time to clearly define what they want and pursue it realistically

Types of Goals

Goals are often separated into two types Long and short term goals

Long-term Goals: These are goals meant to be accomplished over a long period of time e g six months several years or over a lifetime

Short term Goals are goals someone sets to accomplish in a short period of time such as one week two weeks or a month

Characteristics of Good Goals

Good goals should be SMART i e

S Specific: Know exactly what you want to achieve

M Measurable: Progress made towards the set goals must be measurable.

A Achievable: Be sure the goal is something you have the ability to accomplish

R Realistic: Be sure the goal is something you can do and within the desired time frame

T Time bound: Set time limits.

Any goal may be easy or hard to achieve. Sometimes, things get in the way and may interrupt your plans Maybe a parent dies and there is now a need for you to work instead of finishing your education Your goal though is to complete school and get a good job.

Importance of Goal Setting

Goal setting is important because:

• It provides a guide for decision-making.

• It gives meaning and direction to one's activities; it enables one to have an idea of where one is going.

• Achievement of goals increases one's self esteem.

• It serves as motivation.

• It serves as an action plan

Lessons on goal setting may encourage teens to examine choices they may not have thought about and to consider these options responsibly. Learning to recognize and develop personal priorities order to manage time more effectively is a great step towards responsible decision making (next topic). This defining of priorities can help young people set goals and direct their lives in productive ways. Many adolescents need help in distinguishing between just drifting through life - letting external circumstances push and pull them with no real purpose or direction — and knowing where they are headed, why they chose this path, and how they are getting there.

Adolescents are more likely to reach the goals they set if they base them on their interests, abilities and values. As adolescents continue to grow and develop, they gain new abilities, which aid them in the setting of new goals. Choices are clearer when young people know what they want. By helping adolescents to set some goals that they can reach quickly, they gain small successes, which encourage them to work toward larger goals and gain control over their lives. The development of good goal-setting Skills during adolescence has a positive effect on a young person's entire life.

Steps in Achieving a Goal

Everyone should set goals for his or her life. It is easier to accomplish goals if one step is taken at a time. All goals involve making decisions and there may be an element of risk-taking. Sometimes mistakes are made. However, determination and the ability to identify the mistakes and make necessary adjustments improve one's chance of achieving the set goals.

1. Identify your goal. Know exactly what you want to achieve; ask yourself "What am I doing? Is it getting me where I want to be or what I want? If not, where is it taking me?";
2. Look at the possible alternatives. Figure out all your choices; possibly discuss the goal with family members, trusted adults and friends so as to get their support and help;
3. Make the decision. Figure out which is the best choice for you;
4. Develop a plan of action. Make plans and the necessary arrangements to achieve the goal;
5. Set time limits — know exactly when you want to accomplish your goal;
6. Take one step at a time;
7. Evaluate your progress;
8. Continue with your plans — do not give up.

Effects of Achieving Set Goals

• It increases self-esteem because you have accomplished something;
• It motivates you to set further goals and accomplish other tasks;
• You develop self-confidence;
• It makes you happy; possibly makes others (like family) proud;
• You feel fulfilled.

Obstacles in achieving goals

• Low self-esteem;
• Inability to identify the importance of the goal;
• Lack of resources;
• Peer pressure;
• Setting unrealistic and immeasurable goals;
• Procrastination;
• Lack of information;
• Changes in one's life circumstances;
• Changes in one's values;
• Lack of ambition;
• Fear of failure.

Week 6 Day 1 and 2

Decision Making

Decision making is the process of providing appropriate solutions to most situations in life. It is a process of selecting options from alternatives. Every day living requires decision-making. Some decisions require a great deal of thought while others do not. Young people make many decisions such as what clothes to wear, whom to play with, whom to have as a friend, whether to take a bus to school or trek, etc. These decisions do not require much thought. However, important decisions like choice of career, whether to stay in school, whether to be sexually active, whether to smoke or take drugs require serious thoughts and skills because such decisions have far reaching consequences.

Importance of decision making

• The identification of various options assists and others;

• It helps us identify our values;

• It helps in goal setting;

• It can minimize mistakes;

• It allows us to take control over and responsibility for our actions;

• Good decisions build self-esteem.

Factors that influence decision-making include:

1. Values

• What is right for me?

• Which is more important of the two or more options?

• What are my values /family values?

• Is my decision consistent with my values?

2. Goals

• What do I hope to accomplish by making the decision

• Will the consequences fit into my plans; are they suitable?

3. Parental/family expectations

• How will my decision affect members of my family?

• Will my decision meet the expectations of members of my family?

4. Information

• Do I have the knowledge necessary to make informed choices?

• Do I know who or where to ask for information?

5. Social pressures:

• Am I being influenced by my peers, media, religion etc?

• Is my choice based on other people's values or mine?

• Is my decision influenced by the need to feel a sense of belonging?

6. Circumstances/Situation:

• Do pressing circumstances or crises influence my decision?

• Have I made a decision simply because I want to prove a point?

• Have I made a decision because I want to escape from a particular situation?

Values are the principles we hold as important and worthwhile, which possess intrinsic quality or merit. Personal values provide the basis for critical decision making such as sexual decisions and life planning. Our family is the single most important influence on our value system. This will hold true throughout our lifetime At no other time will this value structure be more closely examined than in adolescence. As the need for independence from parental control grows, the need for inter-dependence becomes especially important. As young people begin to examine, identify, and internalize these family values (pertaining to treatment of other human beings; moral codes for honesty, justice, sexual behaviour; and personal responsibility), they will redefine them to be of personal, practical significance in their emerging autonomous world. An adolescent's interpretation of these family values can be critical for making quality life decisions.

Since not everyone holds the same values, family value systems will differ. Some values differ simply as a matter of personal preference or perspective. It is also important to recognize that values are not all equal. This is especially true when we identify critical issues. For values to mean anything or have an impact, they must be internalized and create a sense of ownership. Telling adolescents to "just say no" without first teaching them the value of abstinence is likely to have little meaning. Examination of the impact of a particular value on oneself and others can promote

understanding and assign merit to the value. Adults can explain how postponing early sexual intercourse can allow the young person freedom to choose and pursue a career, freedom to choose when and whom to marry (in some cultures), and freedom to choose whether and when to become a parent. The benefits of a value such as abstinence needs to be supported by others in the community in order to be seen as worthwhile. The positive impact of the choice must be of benefit to both the individual and significant others, such as family, for instance, young people can choose to develop and maintain a sexually abstinent lifestyle, both as a personal and a family value.

Ways in Which People Make Decisions:

• By impulse (jump into one quickly, without thinking)

• By procrastinating (putting off the decision)

• By not deciding (Letting whatever happens happen; losing control of the situation)

• By letting other people make decision for us

• By evaluating all choices and then deciding.

How to Improve Decision-Making Skills

• Gather lots of Information

• Check your feelings, values and goals against social pressures or circumstances.

Model for Decision Making -

In order to make a good decision, it is important to develop decision-making skills. The skills require individuals to follow certain steps. (It is important to have the following steps put onto a poster or written on the board.)

1. Define the Problem: This involves the identification of the problem and knowing what decision needs to be made.
2. Gather Information: Gather information about the problem. Know the possible alternatives and gather information on them.
3. Consider all the Possible Consequences: List the advantages and disadvantages of each alternative
4. Consider family and personal values: Review your personal beliefs and family values in relation to the possible alternatives.

5. Consider the Impact on other People: Consider how your decision affects people around you
6. Choose One Option: Based on the evaluation of the possible consequences, person and values, choose the option that will have the best outcome.

Week 7 Day 1 and 2

Barriers to Decision Making

Young people encounter some difficulties when they have to make decisions about important issues, e.g. decisions about sexual matters, decisions about drug and alcohol use. Their ability to make good decisions in these situations is affected by some factors. These include:

• Pressure from friends and peer group;
• Lack of access to adequate information and facts;
• Lack of decision-making skills;
• Inability to set goals and make plans;
• Inability to clarify values;
• Low self-esteem;
• Lack of guidance and support from trusted adults;
• Use of alcohol and other drugs.

How to Overcome the Barriers

• Learn to be assertive;
• Clarify your values;
• Learn to identify alternatives and evaluate their consequences;
• Set goals and plan towards achieving the goals;
• Choose the option that is consistent with your values and goals;
• Seek guidance and advice from trusted adults, such as counsellors, providers etc;
• Avoid use of alcohol and other drugs because they impede your ability to make good decisions.

Sexual Decision Making

• Decisions about sexuality are sometimes difficult because of sexual feelings, pressures and conflicting messages from partners, friends and society.

• The decisions about sexuality can affect one's future health and life plans, impact upon the lives of other people.

• The best sexual decision is usually one that is consistent with one's values and does not involve risking one's health or breaking the law.

Factors that Influence Decisions About Sexuality

• Sexual feelings (when sexual feelings are strong, they may push us moment to act when it would be wiser not to)

• Pressures and conflicting messages from partners, friends, society, the media, religion or cultural beliefs

• Ignorance - lack of knowledge;

• Concerns about sexually transmitted infections STI5 and unwanted pregnanc;

• Influence of drugs or alcohol;

•Parents' wishes;

• Guilt or fear;

• wanting to be accepted or popular;

• Force (we assume that having sexual intercourse is always a decision that we make but in many cases people are forced to have sexual intercourse by someone older, more powerful, or under grave threats).

Importance of Sexual Decision-Making

• Young people experience difficulties in making decision about whether or not to have sexual intercourse. However, because sexual decisions can affect one's future health and life plans, it is important to make responsible decisions about sexuality.

• It is important for young people to make sexual decisions before they find themselves in sexual situations. It is easier to assert oneself when a decision has been made, and it is then easier to stay out of or away from situations where a decision may be pressured.

Characteristics of Good Decisions

• Consistent with personal values;

• Based on accurate information and facts;

• Goal oriented and realistic.

Making Good and Responsible Decisions about Sexuality Prevents:

• Risk of unwanted pregnancy;

• Risk of contracting STIs and HIV/AIDS;

• Risk of abortion and its complications

• Emotional/psychological stress;

• Sexual abuse and exploitation;

It is important to establish sexual limits before one is in a sexual situation. Making sexual

decisions requires:

• Self control;

• Self respect;

• Assertiveness;

• Mutual respect;

• Effective communication;

• Adequate information;

• Negotiation;

• Taking into consideration the consequences of one's action.

TRAINING PACKAGE FOR CONTROL GROUP

Week 1 Day 1

Health is a state of complete physical, mental and social well-being of an individual and not merely the absence of disease or infirmity (WHO,1948). The constitution of the World Health Organization (WHO) in agreement with the United Nations (UN) charter stipulated that the following principles are basic to the harmonious relations, peace, happiness and security of all people.

Qualities of Good Personal health

1. Absence of disease and disability: Normal health connotes absence of disease and defects, which hinders one's ability to function effectively and enjoy life.
2. Vigour: This is a basic characteristic of a physically fit person; he is endowed with enough energy for everyday life activities and expectancies. He functions and copes effectively with his environment while avoiding fatigue and still having some reserved energy.
3. Good Appetite: The healthy person eats very well. He takes in food in the right quantities and qualities and at the right time.
4. Sleep; Ability to sleep well without undue disturbance. Sleep can be described as a total stoppage of activities naturally undertaken with a view to replacing the lost energy during consciousness.
5. Stable Weight: Fairly stable weight with minor fluctuations, which are not constant, is an indication of good-personal health.
6. Emotional stability: This is the ability of one to be at ease and relaxed and have one's emotion in check. Coping with and overcoming stress in everyday life.

Week 1 Day 2

Factors that Affect Health

Biological environment

The biological environment comprises all living things in an area, the plants, animals and microorganisms. All these living things are interdependent on each other. However man manipulates the environment. He cultivates useful plants to provide food clothing and shelter: he raises animals for meat, milk, leather, wool and other

useful products. In the case of manipulating the environment. man's health is adversely affected when he eats his food, and meat in an unhygienic condition, for example the typhoid bacillus (Salmonella typhoid) is known to be a causative agent of disease but the occurrence of outbreaks of the typhoid disease is a result of infected source of water supply, methods of sewage disposal, personal habits of people (poor hygiene) contaminated meat, milk and vegetables.

Week 2 Day 1

Physical Environment

The physical environment is made up of air, water, land and food.

Air: Air pollution affects man's physical emotional and economic well being. It invariably shortens the life as a result of its effects such as burning eyes, heart disease and asthma. Air pollution increases the deterioration of man made materials, and reduces agricultural production. All these in essence either directly or indirectly affect the health of an individual and the community adversely.

Water: Water is an essential part of the physical environment. A greater part of the human body is made up of water and has been set above 75 percent. No matter the quantity of food we eat, we never feely fully satisfied unless we take a glass of water. Water is an essential ingredient for domestic, industrial, agricultural and medical purpose mineral substance from mining, inorganic chemicals, petroleum plants and agricultural products cause damage to natural water and subsequently the health of man. Sometimes also man helps to pollute water by inadequate and careless refuse disposal, leading to intensified gastro intestinal diseases, such as cholera, dysentery and diarrhea etc. insufficient water supply contributes to less food and also to unhygienic living conditions.

Radiation: An essential element in the physical environment is the emission of rays or waves of energy which may be in the form of light or in the form of heat radiation to the whole body. Examples include the x-ray, infra red rays, radiations from the computer and the modern GSM handsets radiations are known to cause cancers over time.

Climate: Changes in the climatic conditions of an environment can affect the health of individuals. In Nigeria for example, the north suffers from severe drought leading to drying up of wells, rivers and other sources of water. Lives stocks and food production suffers greatly, food becomes scarce, and lives are lost by direct sunrays or through starvation.

Food: This is another of the numerous factors that affect the health of the individual in his physical environment nutritional deficiency results from insufficient types of food especially those rich in proteins. Too little of it or too much or even the absence of it affects health. Example include, emaciation and underweight, kwarshiorkor, and obesity.

Week 2 Day 2

Social Environment

This represents the environments which is entirely man-man it represents the situation of man as a member of society such as:

- Culture of the people;
- Superstitious beliefs and taboos;
- Religious beliefs;
- Attitudes and habits;
- Poverty and ignorance;
- Hate, love, anger and anxiety.

Week 3 Day 1 Health Maintenance

The personal health of an individual can be maintained in the following ways:

Regular Health Examination

Routine medical examination of the eye, ear, nose, mouth, lungs and heart are necessary checks that should be done to help the individual know the state of his health. People however dread to go for check up, because they are afraid of being diagnosed sick.

Care of Body Organ

The care of the body organ is a basic necessity in the practice of hygiene. Here the eye, ear, nose, tongue, teeth, the hair, fingernails and skin are to be observed physically for negative changes that might affect health.

Good Nutrition

Good food is likened to fresh air, which is essential to an individual's health. The food we eat every day should contain all the body builders, protective food energy suppliers. It is therefore necessary to understand that good nutrition is a point in measuring good health (you are what you eat).

Exercise and Recreation

These are essential to the maintenance of adequate personal health. Such exercises include walk, swimming or early morning jogging. Visits to parks to garden and zoos helps curb the effect of stress on daily life activities.

Rest, Sleep and Relaxation

Sleep can be described as the total stoppage of activities naturally undertaken with a view of replacing the lost energy during consciousness. Sleep represents the healthiest form of rest after engagement in the day's activities. Relaxation is a condition of becoming less tense, rigid, or energetic particularly after a daily routine or daily assignment. It is a condition of change in the tempo of activity to allow working muscles have a little rest. Relaxing on a couch outside the house perhaps under a tree in the cool evening is very therapeutic.

Week 3 Day 2 Health Maintenance II

Safety Consciousness

Safety consciousness is an important factor in the maintenance of good personal health, if individual in their perspective work places, on the road and at home, are safety conscious.

Prevention of Infection

Agents of infection abound in the environment where we dwell, refuse should be disposed regularly to avoid air and water pollution, living in standard houses that are not congested ill lighted or over crowded, is a step in maintaining good health.

Use of Available Health Care Services

The Federal Ministry of Health operates the nation's public health agencies, which embrace preventive and curative health care services. These services include the Federal Medical centers, state hospitals, teaching hospitals, local health care units, dispensaries, cottage hospitals and special health centres. Individuals should make use of these healthcare services during ill health, and counseling needs.

Week 4 Day 1 Personal Health and Hygiene

Personal Health

Personal health is an aspect of health education which informs and persuades an individual to action, geared towards helping and directing the individual to keep his body clean at its highest efficacy and so doing to bring himself to the best physically, socially and mentally.

Hygiene

This can be simply defined as the act and practices of making conscious efforts toward keeping oneself, living area and working areas clean in order to prevent illness and disease. Hygiene also means improving the health status of the individual, the environment and the community at large. Total hygiene practices include body grooming, hygiene of the alimentary canal, hygiene of the reproductive organ, correcting postural defects, water sanitation and environmental hygiene.

Week 4 Day 2 Body Grooming (Care of the skin, care of the hair, care of the teeth)

Body Grooming

To maintain healthy and hygienic body and mind, every part of the body must be taken care of e.g. teeth, hand, skin, hair, feet, nails, body etc.

Care of the Skin

The skin has pores through which germs of various kinds can penetrate into the body and through these same pores, waste matters comes out in form of sweat. To avoid germs in our body, there is a need to keep the skin constantly clean from dirt or dust and other waste matter from the body. To achieve this, a good bath once or twice per day is essential. Any time that one undertakes a strenuous exercise, there is also a

need for a bath. However, if there is a medical prescription for medical for body odour that required germicidal or antiseptic soap, otherwise a mild soap with clean water is all that is needed. During each bath, special care and attention must be paid to the genitals and anal area. After each bath, it is necessary to use a dry and clean towel to properly dry up the skin after bath. It is not advisable to share bathing equipment, including the towel with anybody. The use of fine organic moisturizers, cream (not bleaching creams), deodorants and antiperspirants are good for the skin and those who sweat a lot.

Care of the hair

The hair is described as our crowning glory; as such it is good to wash it regularly with mild shampoo instead of soap which can leave a film of stickiness in our hair. It is also advisable to keep it at a length and style that we can properly maintain in a clean manner at all times. Brush or comb your hair with a soft bristled brush or wide toothed comb. It is also good to oil your scalp with grooming oil preferably one hour before washing it. To avoid premature hair loss, do not apply dye to your hair because they contain chemicals that may cause hair and damage of scalp.

Care of the teeth The teeth are an important part of our body because they are located in the mouth which is the gate way to the stomach. The teeth and in fact the mouth as a whole needs proper care. It should be brushed two or three times daily most especially after meals or snacks and in the night before going to bed, to avoid tooth decay, halitosis (bad breath) etc. It is also very important to brush the tongue.

Week 5 Day 1 Body Grooming (Care of the hands and finger nails, care of the feet, care of the clothing)

Care of Hands and Finger Nails: The hands and finger nails need special care and always too. This is so because they are frequently used to touch objects or do things that make it contact bacterial. The same hands enter our mouth times without number, either directly or indirectly in a day. Therefore the hands should be washed regularly with clean water and medicated soap such as ‘dettol’ most especially after visiting the toilet and should be dried with a clean hand towel. The finger nails should be cut short

with a nail clip. This is necessary because long nails can hide more dirt and germs. They should not be trimmed too close to the skin.

Care of the feet: It is important to also care for our feet by scrubbing it with a pumice stone or mildly abrasive brush when bathing. Also, it is important to take time to wash very well in between our toes and to properly dry them before wearing our socks to avoid bad odour, germs and infection.

Care of clothing: It cannot be over emphasized that washing our clothing such as personal wear, underwears, scarf, uniform, bedsheet, pillow case, shoes, socks is as important as having regular bath. Mending, brushing, washing, ironing and proper storage are five important steps in helping to get the best out of our clothing, as dirty clothes can cause infection to our body and consequently affect our health.

Week 5 Day 2 Food Hygiene and Sources of food contamination

Food is a basic necessity for growth, development and sustenance of life. The need for food makes it worthwhile that great care is taken during its manufacture, transportation, purchase, and preparation, storage and preservation in order to make it wholesome for human consumption. Clean food is appealing and enhances life but – contaminated food results in diseases, and ill health, which are gateways to shortened lifespan.

Sources of Food Contamination

- Ignorance
- Poor habit
- Unhygienic environments for cooking
- Methods of food transport
- Unhygienic storage stems

Week 6 Day 1 Food Hygiene Practice in the Home

Some suggested food hygiene practices

- In the home, effective personal hygiene of the hair, nose and mouth should be observed through the use of scarf over the hair, and covering the nose during a flu episode and mouth when coughing.

- Food must be served in plates on clean tables and in decent environment.
- Cooked foods should be well covered and grains kept in air light buckets or bowls to avoid contact with flies cockroaches and rats.
- Refuse bins around the kitchen should be cleaned on regular basis.

Week 6 Day 1 Environmental Sanitation

Environmental sanitation can be defined as the process of keeping our surrounding clean always; the home, office, market or shop. Environmental sanitation is a regular exercise in Delta state, on every last saturday of the month. To achieve environmental sanitation, an intensive effort must be made by every individual to cut the grass or bush around their premises, sweep the premises and wash the gutters, have storage facility for domestic waste which should later be disposed into the mains on daily basis. All sources of after such as well, tap, streams or rivers, within the neighbourhood are kept clean and secured to prevent domestic animals or even human beings from going to pollute the place. All refuse that are inimical to human health must be burnt and or buried in pits far away from residential.

Week 6 Day 2 Waste Disposal

Waste is all useless and unwanted or discarded resulting from normal community activity.

Week 7 Day 1 Types of waste solid, liquid, gaseous

Solid

Liquid

Gaseous – dust, sooth, smoke, particles smoke

Week 7 Day 2 Types of waste continued

Refuse: domestic

Industrial and agricultural

Effluent – excreta, sewage water, run off water, industrial waste

Week 8 Day 1 Housing (Qualities of good housing)

Housing: inadequate housing is an environmental health problems

Qualities: clean air, ventilation, good light, adequate supply of portable clean water, freedom from noise. Efficient neighborhood facilities.

Week 8 Day 2 Effect of Poor Housing Conditions and Solutions to Housing Problems

(1) Spread of communicable disease such as scabies, cholera and diarrhoea

(2) Accident and injury

(3) Physical discomfort heat rashes

SOLUTIONS TO HOUSING PROBLEM

Town planning authorities should approve though land

Provision of low cost housing

Control of building material prices

Periodic inspection of living residential houses by public health officials

This manual was put together by the researcher with adaptations from: Life skills handbook by Clair Hanbury, Healthy Living and National Development (Textbook) and Comprehensive Sexuality Education(Trainers' Resource Manual.) by Action Health Incorporated

APPENDIX III

INFORMED CONSENT FORM

Greetings, I Ose-LovetOsita LOKOYI, a postgraduate student of the Department of Human Kinetics and Health Education, Faculty of Education, University of Ibadan, Nigeria.

I am presently carrying out a study on the Effects Of School-Based Life Skills Training On Violence And Health Risk Behaviours of In-School Adolescents In Delta State.

You will undergo an 8 weeks training. Before and after the training, you will be expected to answer some questions related to violence related behaviour and health risk behaviour. Your participation in this study is entirely voluntary. The information provided will be kept confidential and will not be disclosed to a third party. The questionnaire will require about 30mins of your time. Please try and give honest response as much as possible.

Thank you.

Student's content

Kindly sign below if you agree to take part in the study

Respondent's signature _______ Date _____

Parent's consent

Kindly sign below if you agree that your child/ward should take part in the study

Parent's signature _____ Date_____

APPENDIX IV

DELTA STATE SENATORIAL DISTRICTS, LOCAL GOVERNMENT AREAS AND NUMBER OF PUBLIC SECONDARY SCHOOLS

Delta Central		Delta North		Delta South	
LGA	No of Schools	LGA	No of Schools	LGA	No of schools
Ethiope East	24	Aniocha North	19	Bomadi	9
Ethiope West	26	Aniocha South	20	Burufu	19
Okpe	16	Ika North	17	Isoko North	16
Sapele	16	Ika South	18	Isoko South	19
Udu	14	Ndokwa East	26	Patani	9
Uwie	16	Ndokwa West	20	Warri North	10
Ugheli North	42	Oshimili North	12	Warri South	16
Ugheli South	24	Oshmili South Ukuani	10 10	Warri South West	6
	178		**152**		**104**

Source: Ministry of Education, Delta State.

APPENDIX V

Communication Skills training session

Participant's fillings consent forms while receiving their training packages

Participants submitting consent forms while receiving training packages

Outdoor rehearsals for poems and drama

Participants present poems on goal setting and decision making

Drama presentation on finding help

Drama presentation on finding help

Participants demonstrating assertiveness Skills

Participants in groups to be brainstorm on Esu the confuser and finding help

Brainstorm sessions on negotiation Skills