Adopting the Life Skills Approach

If the Life Skills approach is to be incorporated into prevention efforts that are part of a national education or health curriculum, there must be sufficient political will to support the initiative at the country level. Public health professionals, educators, and social service providers are in a unique position to make the case for adopting this important intervention.

MOBILIZING SUPPORT

In order to win a place for the Life Skills intervention in school curricula, decision makers must appreciate the methodology's capability to promote students' psychosocial development and improved overall well-being. Policy makers must understand that by using the Life Skills approach one can simultaneously address a variety of issues threatening the health and well-being of youth (e.g., conflict, violence, smoking, depression). This approach also can prevent substance use by passing on to students skills for conflict resolution, stress management, decision making, and drug refusal skills. In generating the political commitment needed to spur the adoption of the Life Skills methodology, the connection between these skills and improved health, maturity, and emotional intelligence must be made clear. The cost-effectiveness and economic benefits of the approach also must be argued.

Political support also can be generated by connecting the school-based Life Skills program with a broader campaign or national priority, such as a national tobacco control campaign or a citywide, youth development initiative. Integration into existing initiatives, along with the support of intersectoral partnerships, can help ensure a broader community of participants, increased public attention, and sustainability of the program. When looking for appropriate campaigns with which to partner, moving beyond the health and education sectors—that is, the traditional advocates of substance use prevention—and linking up with other social welfare and children's rights initiatives can help ensure a broader base of support for the Life Skills initiative.

The health sector can certainly play an important role in advocating the adoption of the life skills methodology.

LIFE SKILLS PROGRAM PLANNING

The long-term success of prevention programs can benefit from a participatory approach that ensures the active involvement of as many stakeholders as possible. Stakeholders are persons or organizations that could benefit from program involvement or successful program outcomes. Stakeholders of a Life Skills school-based substance use pre-
vention program may include youth, parents, teachers, administrators, and health and social service practitioners.

Participating stakeholders in the planning process should provide input into the definition of the problem (particularly regarding “perceived needs”) and feedback on planned activities. In addition, the active participation of teachers and other practitioners can inform the efforts of planners regarding the design of appropriate training activities. Early and active participation by stakeholders not only increases their connection to the project, ensuring a higher level of support and involvement, but it also makes program elements more realistic and relevant to participants’ life experiences.

The needs assessment is a useful tool for identifying the gaps that exist in services and resources, as well as the possible barriers to meeting needs. In addition, this assessment can provide policy makers with country-specific evidence needed to facilitate policy changes and commitment of resources.

Upon describing the magnitude of the problem (e.g., increased tobacco use by teens) the program hypothesis can be created (i.e., “If teens have the skills to resist social influence to smoke, then smoking prevalence among this group will decrease”). Next, the needs assessment process should determine the target audience and catchment area that the program will serve.

The target audience and catchment area should be rendered as precisely as possible. In order to target the intervention toward reducing risk among the most susceptible individuals, planners must examine the patterns of individual characteristics or social conditions inferring the greatest risk on youth. Possible characteristics of the target audience and catchment area include:

- age group—for instance, preteens or older adolescents;
- gender;
- socioeconomic status—education level, social class, economic factors;
- ethnicity—language and cultural context;
- Data sources for assessing and evaluating activities;
  - surveys or questionnaires,
  - interviews,
  - observation,
  - focus groups or community forums,
  - medical and program literature,
  - vital statistics,
  - clinical and school records, and
  - physical examinations.
• special population groups—e.g., pregnant teens or homeless youth;
• geographic area—urban, rural, disadvantaged areas; and
• locale—public schools, private schools, schools serving high-risk populations.

This analysis not only should define who in the catchment area is most at risk, but it also should reveal which risk elements experienced by these youth are modifiable. During recent years, knowledge of the etiology of substance abuse—including tobacco use—has demonstrated that there is no single factor that determines consumption; clearly, tobacco use depends on multiple factors. This makes the design of such prevention programs more complex, since they must address several modifiable risk factors at the same time. The interplay of protective factors must also be carefully assessed.

Setting Goals and Objectives

The next step in the planning process is the formulation of program goals and objectives. Program goals describe in general terms what outcomes are expected from program activities. The goals provide program direction. Program objectives, on the other hand, describe in specific, measurable terms what the program hopes to achieve. The objectives guide the project and provide indicators and time frames that are useful for determining progress towards achieving program goals.

Careful attention to the development of program objectives will help ensure the success of the Life Skills intervention. Objectives are critical tools that program monitors (at national and regional levels) as well as project facilitators (teachers and counselors at the classroom level) will use to measure progress.

According to some health planners (Kettner, et al, 1990), there are several elements that characterize well-written objectives. The first is clarity: any jargon or confusing terminology should be eliminated; the easier the objective is to understand, the more likely it is to be used by program staff. Objectives also should also be measurable, specifying what results are expected and how they will be measured (e.g., post-test, observation, or questionnaire). In addition, objectives should be time-limited, with specific target dates set for achieving and measuring results. They should also clearly assign responsibility both for achieving and measuring the targeted action. Finally, it is important that objectives be realistic.

To be truly successful, a “Life Skills” program must clearly establish its target audience, including determining characteristics such as age, gender, socioeconomic status, and ethnicity.
Defining program scope, sequence, and duration involves deciding when to initiate the program (i.e., at what grade level), what general topics will be addressed, how to sequence program sessions (e.g., when to schedule booster sessions), and how long the intervention will run. (See Appendix B for evaluating results of various formats used in Botvin's Life Skills Training.)

It is important to take into consideration how the prevention program fits into the larger existing school curricula. The better the integration of the program into current curriculum initiatives, the more likely the intervention will be supported and sustained over the long-term.

At this stage in the process, a decision should be made regarding whether to design a Life Skills program or to adapt an existing one. For programmers who choose to adapt an existing program, WHO has published several resource materials that include samples of Life Skills programs and case studies of countries that have developed or adapted such programs (WHO, 1997b). WHO recommends carefully weighing the costs and time associated with adapting programs versus developing programs, keeping in mind how much each offers toward obtaining a culturally and linguistically appropriate intervention.

Creating Program Strategies

Whether designing or adapting program strategies, the most fundamental characteristic of Life Skills activities is interaction. Examples of instructional activities that are interactive include role playing, debate, dramatization, paired and small group instruction, and cooperative learning activities (e.g., team projects).

Life Skills are taught using an interactive, problem-solving approach that arranges activities as a series of steps. First, the students identify the problem, then they brainstorm all possible solutions. They then examine the advantages and disadvantages of each solution, and the best solution is agreed upon. Students next devise plans for carrying out selected solutions. Based on these fundamental problem-solving and negotiating skills, more specific adaptations are made.

“Life Skills” program objectives should set specific target dates for achieving measurable results.
abilities can be developed, such as the ability to manage peer pressure or media influence.

**Designing Training Modules**

Effective training is critical to the full implementation of the intervention. The Life Skills program should address technical assistance needs and resources in terms of program orientation, initial training in Life Skills, ongoing support and motivation, and program evaluation. Whether the instructor chosen for this intervention is a classroom teacher, school counselor, or peer facilitator, opportunities should be created for program facilitators to interact with student leaders during the training and orientation phases (IUAC, 1990).

In the training assessment, plans should carefully note the traditional teaching styles and methods used in regional and local settings. In some countries in the Region where didactic methods or learning "by rote" or memorization is the preferred approach to instruction, the interactive, seemingly non-formal methods that characterize Life Skills instruction may be completely new to teachers and counselors. In this case, such innovative methods may appear to threaten the status quo, and programmers must plan accordingly.

The training of Life Skills facilitators should follow the experiential methods that have been found to be so critical to the success of these prevention programs. The training program should offer sufficient assistance to program facilitators to acquire the necessary expertise in methods they may perceive as unconventional or opposed to their traditional methods. Experiential or participatory training validates the trainees’ expertise and insight, and creates ample opportunities to share information and practice new skills. Opportunities to practice program activities can serve as both a skill-building and confidence-building tool.

Training modules should include activities that provide trainees with an understanding of the theoretical and conceptual framework underlying Life Skills; such an understanding is needed to increase facilitators’ commitment to the program. Eventual mastery of program methods and belief in program principles by facilitators will prove crucial to full implementation of the intervention.

In addition to building facilitators’ expertise in the instructional methods and theory behind Life Skills, most facilitators will likely need additional training on the facts and issues related to substance use among young people. To serve as a resource for their students, they must exhibit a good grasp of the

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**Elements of the facilitator training program may include:**

- rationale for implementing Life Skills in schools;
- allocation of decision making authority and resources to a training coordinator responsible for planning, managing, and coordinating training activities;
- development of a trainers-of-trainers group to conduct initial training;
- regularly scheduled follow-up or in-service training to address facilitators’ concerns and provide updates on tobacco use and progress toward reaching program goals; and
- evaluation of training activities to assess both skill and confidence levels of participants.

Adapted from WHO, 1998 June.
facts. Training in this area will also increase their confidence with students and their commitment to reducing substance use.

Particular attention also should be given to developing the program capacity needed to carry out intervention evaluation activities. Planners should explore a wide range of options for addressing this type of capacity building. For instance, it may be that a core staff of trained evaluators already exists at the national level, whether working through the ministries of health and of education or attached to universities or non-governmental organizations. If the decision is made to train local facilitators to conduct evaluation activities, special care should be taken to streamline and simplify the activities so that facilitators do not feel overburdened by these additional demands.

**Developing Materials**

The development of program materials can often become a resource-intensive aspect of program design, due to the amount of time, money, and technical expertise required to produce high quality, effective products. Programmers should explore alternatives that can facilitate material design in a more cost-effective manner, such as:

- Enlist the support of universities or research institutions that are looking for training and publication opportunities for their graduate students or research associates.
- Adapt materials that have already been tested with groups as similar as possible to the target audience.

Although the amount and variety of training materials will differ according to local needs and resources, many Life Skills substance use prevention programs have found the following types of materials necessary:

- training guides, including materials for simulation exercises;
- instructor’s manual, including background information, suggested strategies, and discussion guides for each session;
- student workbooks;
- visual aids (e.g., videos, posters, and cassette tapes); and
- evaluation materials (e.g., surveys, interview guides, checklists).

Some of Colombia’s experience working with parents has shown that there might be a need to develop workbooks for parents (Bravo, Gálvez and Martínez 1998). There also has been some experience working with peer facilitators, and training guides for young people may also be needed.

Program developers may also choose to develop or adapt promotional materials that schools and regional officials can use to advise the media and larger community of their Life Skills substance use prevention efforts. This effort would educate the public, enlist its support for program activities, and publicize progress toward reducing tobacco use.

Before moving from the planning to the implementation stage, program developers should outline the responsibilities of stakeholders, staff, and part-
nering institutions so that accountability is clearly communicated. Reaching consensus on the assignment of responsibilities is particularly critical to the success of large, national programs that involve players from a range of sectors and organizations.

**EVALUATION OF LIFE SKILLS PROGRAMS**

Life Skills interventions for substance use prevention should be evaluated to ensure their effectiveness, optimal operation, and overall impact of the program. Evaluation objectives should be quantifiable, clear, and explicit, and they should incorporate baseline data describing both the target population and the parameters of the problem identified during the program planning. The purpose of the evaluation is to measure program operation and outcomes in relation to stated objectives.

Evaluation should begin at the start of program implementation by piloting the newly adopted materials. This makes it possible to determine how the program is functioning and which elements are working the best. This type of evaluation, often called process or formative evaluation, should be repeated periodically to determine the extent to which planned activities are being carried out. It provides an opportunity to “fine tune” program operations and activities. It also assesses the acceptance of the program by both instructors and students, and it can gauge their level of participation in planned activities.

Outcome evaluation, another type of program evaluation, measures program outcomes. Outcome evaluation can also include an assessment of the overall impact of the intervention.

Indicators related to substance use that could be assessed pre- and post-intervention include:
- use of tobacco,
- age of onset,
- cotinine (a metabolite of nicotine) or carbon monoxide levels,
- intention to smoke, and
- quit rates.

Other “soft” indicators describe students’ level of knowledge regarding the negative effects of smoking, the perception of social acceptance of tobacco use—or norms—and the awareness of tobacco advertising and promotion (i.e., media literacy). In addition, the evaluation should include the outcomes of spin-off programs in the larger community.

It also is important to include demographic information in the assessment tools used. This type of data is needed to identify whether the intervention is equally effective among all types of participants (DHHS, 1993).

The ideal evaluation instrument incorporates an experimental design comparing case and control groups. Data describing both groups is collected via a pre-tested survey to assess and compare the prevalence of smoking, age of onset, and knowledge, attitudes and practices associated with tobacco use. However, using controls may not be feasible and could raise ethical questions about unequal access to services. There also are limitations to the survey design (e.g., impossible to ensure the accuracy of the information self-reported; difficult to control completeness of answers), and the high level of expertise needed to design such an instrument might be prohibitive. However, existing...
pre-tested tools are certainly available for adaptation and their use should be encouraged.

Primary data also can be collected through interviews, observations, or physical examinations, such as measuring the cotinine levels of student participants. Program planners must assess the accuracy, cost, and time associated with each option in order to choose the best evaluation method. Planners should consider using existing and available validated instruments or partnering with research institutions or organizations skilled in evaluation methods.

Program evaluations typically involve the following steps:

1. posing questions about the project and determining outcomes to measure;
2. developing conceptual framework or “logic model;”
3. setting standards (or indicators) of effectiveness;
4. determining level of measurement and type of evaluation needed;
5. selecting or designing evaluation instruments;
6. selecting participants and piloting test instrument and batteries;
7. revising instruments;
8. collecting and analyzing data.

Fink, 1993; DHHS, 1993.