



## Evaluation of a teacher-led, life-skills intervention for secondary school students in Uganda

John D. McMullen<sup>a,\*</sup>, Nadia McMullen<sup>b</sup>

<sup>a</sup> Stranmillis University College, Belfast, United Kingdom

<sup>b</sup> Queens University, Belfast, United Kingdom



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### ABSTRACT

**Rationale:** Despite a recognised need for mental health and life skills promotion for young people in low- and middle-income countries (LMICs), the evidence base for accessible and effective interventions is limited.

**Objectives:** The objectives of this study were to determine if a school-based, teacher-led, life skills-focused, and manualised intervention was effective in increasing self-efficacy, reducing internalising problems, promoting prosocial behaviour, and developing a sense of connectedness among secondary school students in Uganda.

**Method:** A cluster controlled, before-and-after study was employed in four schools, with one school acting as a wait-list control. In total, 620 students aged 13–18 completed baseline questionnaires, with 170 of those completing the same measures post-intervention. Interviews were also completed with four teachers and four students who had finished the intervention. Teachers from the intervention schools completed three days of training on the life skills manual and subsequently delivered the programme over a school year. The manual, written by the lead researcher with support from local facilitators, incorporated 24 lessons plans designed to promote mental health and resilience, develop communication skills, and teach life skills for the present and future. Training sessions also provided guidance on pedagogical approaches required to deliver this type of content effectively.

**Results:** Analysis of Covariance (ANCOVA) demonstrated that the intervention group had a significant increase in general self-efficacy,  $F(1,167) = 20.10, p < .001, \eta^2 = 0.107$ , significant reductions in internalising problems (depression/anxiety-like symptoms),  $F(1,167) = 11.14, p = .001, \eta^2 = 0.063$ , and an increase in overall 'Connectedness'  $F(1,167) = 15.00, p < .001, \eta^2 = 0.082$ , when compared to the control group. Effect sizes for these variables were medium. There was an increase in prosocial attitudes/behaviour that did not reach significance after Bonferroni correction.

**Conclusions:** Despite limitations, including sample size at post-intervention and lack of randomisation, the study demonstrated that it is possible to deliver an effective, school-based, culturally-appropriate life skills intervention, involving local facilitators in design, delivery, and evaluation.

### 1. Introduction

It is estimated that mental health difficulties affect 10–20% of children and adolescents worldwide (Kieling et al., 2011). The strong promotion of mental health and wellbeing in the United Nations' 2015–2030 Sustainable Development Goals (UN, 2015) is important due to the vast gap between need and resource availability, especially in low- and middle-income countries (LMICs). The evidence base for affordable and effective interventions is limited, especially for those targeting children and adolescents (Barry et al., 2013; Jordans et al., 2016; Patel et al., 2008). Poor mental health in childhood is often associated with educational, health and social problems in adulthood,

which can exacerbate the effects of poverty and impede the achievement of basic development goals in LMICs (Kieling et al., 2011). Interventions carried out in collaboration with families, schools and communities have demonstrated some social, emotional, and economic benefits (Chisholm et al., 2016; Weare and Nind, 2011).

Recent meta-analyses from the Collaborative for Academic, Social, and Emotional Learning have provided strong evidence for the effectiveness of school-based social and emotional learning (SEL) interventions. Durlak et al. (2011) found that universal SEL programmes involving 270,034 kindergarten and high school students resulted in significantly improved social and emotional skills, attitudes, behaviour, and academic achievement. A more recent meta-analysis had similar

\* Corresponding author. Stranmillis University College, Belfast, BT9 5DY, Northern Ireland, United Kingdom.

E-mail address: [j.mcmullen@stran.ac.uk](mailto:j.mcmullen@stran.ac.uk) (J.D. McMullen).

findings and highlighted that benefits were similar regardless of students' race, socioeconomic background, or school location (Taylor et al., 2017). Most of these programmes took place within the USA. There is much smaller evidence-base in LMICs due to the scarcity of rigorous research. However, systematic reviews have provided some evidence of the effectiveness of school-based interventions in reducing internalising symptoms (Tol et al., 2011) and in improving behaviour, self-efficacy, and self-esteem (Barry et al., 2013) in LMICs. Perceived self-efficacy—the belief in one's ability to succeed in specific situations—is described as a prospective and operative construct that can facilitate goal-setting, persistence in face of barriers, and recovery from setbacks (Schwarzer and Jerusalem, 1995).

UNICEF defines life skills as psychosocial abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life. Life skills education programmes should involve participatory learning, be evidenced-based, be delivered by competent facilitators and then appropriately evaluated. They are generally designed to facilitate the practice and reinforcement of psychosocial skills in a culturally and developmentally appropriate way (UNICEF, 2003). Schools are the primary location in communities in which to reach young people and to deliver interventions. Due to lack of resources, individual treatments are often not feasible as a first-line strategy in LMICs, and hence there is support for group interventions in community or educational settings (Barenbaum et al., 2004). School attendance can be beneficial in and of itself. For children living with difficult circumstances, stability can be reintroduced by attending school regularly and thereby having some structure to their daily life. Teachers have already developed relationships with children and parents and are well-placed to recognise the signs of emotional distress and provide support (Yule, 2002).

As in other sub-Saharan African countries, both initial teacher education and in-service training are often superficial and inadequate with little impact on classroom practices (UNESCO, 2015). While the Ugandan Government has introduced universal primary and secondary education, this recognition of the importance of education does not appear to be reflected in commitment of finance and other resources. Only 3.3% of GDP has been allocated to the education sector, which is below the average level of funding that is provided in other LMICs. The average teacher-to-pupil ratio in Uganda is 1:57 (TISSA, 2014). The average in the classes that this intervention took place was approximately 1:80. In addition, there is often wide age range of age and ability in each class. Education system performance indicators in Uganda are generally low. Many children start school late, are over age throughout their school career, and dropout early. While almost every child enrolls at the start of primary school, only 49% percent enter secondary school, and only 10% complete all 6 years of secondary school. Teacher dissatisfaction, absenteeism, retention, and professional development are all major concerns in the Ugandan education system (TISSA, 2014). As a result of these challenges and others, didactic pedagogy and rote learning is typical. Therefore, there are significant training needs associated with the implementation of a teacher-led life skills intervention in Uganda since Life Skills education requires a participatory, active learning approach with open discussion between students and teacher/facilitator.

Previous school-based interventions in Uganda and neighbouring Democratic Republic of Congo have demonstrated effectiveness in reducing psychological distress and promoting well-being (Ager et al., 2011; Claessens et al., 2012; McMullen et al., 2013; O'Callaghan et al., 2013). A life skills-based health empowerment intervention with adolescents in India demonstrated significant improvement in resilience, internal health locus of control and self-determination, and reduced pathological behaviour among adolescents (Sarkar et al., 2017).

The primary objective of the study was to determine if 'Living Well', a school-based, teacher-led, life skills-focused, and manualised intervention was effective in increasing self-efficacy and reducing internalising problems among secondary school students in Uganda. The

secondary objective was to determine if the intervention was effective in promoting prosocial behaviour and developing a sense of connectedness to others. We anticipated the Living Well intervention combined with usual support to be superior to usual support alone for both primary and secondary outcomes.

## 2. Method

### 2.1. Design

This cluster-controlled before-and-after study used a wait-list control group. Random allocation of schools to intervention and control arms was not possible due to practical and logistical reasons.

### 2.2. Participants and setting

The study took place in four secondary schools in Uganda. All four schools are supported by Fields of Life (FOL), an international development charity that has been working in East Africa for 20 years in partnership with government and local communities. FOL have constructed 117 schools in East Africa, 90 of which are in Uganda. The four schools in this study were all located in particularly deprived areas and were selected by the researchers and FOL senior staff as being suitable to host the intervention based on three criteria: 1) specific and identified needs in the areas the intervention seeks to address; 2) capacity and motivation to deliver the intervention; and 3), to be able to identify two male and two female teachers who were involved in pastoral care, counselling or child protection to complete the training. Students from three schools received the intervention (Schools 1, 2 and 3) and one acted as a waitlist control (School 4). Table 1 displays sample characteristics at trial baseline.

In consultation with the school staff, it was decided to include all students aged 13 + with the exception of those in 'candidate years', where they are completing national exams and often on study leave. Therefore Senior 3 and Senior 5 students in each school were assessed at baseline. The manualised intervention had been written to be delivered in six months. However, after training the teachers advised that this would be difficult due to exam pressures and vacations. They decided to complete over one year. Following this there was additional delay before commencement. As a result, none of the Senior 5 students that were assessed at baseline began the intervention. In addition, a number of students were on study leave, when the facilitators returned to complete the post-intervention questionnaires. Therefore, only 170 completed both pre and post-intervention questionnaires. As evidenced in Table 1, these same issues affected the control school as much as the intervention schools. The teachers who delivered the intervention stated that very few students dropped out of the programme and that they left school due to financial reasons.

Due to delay of intervention commencement, and it taking longer than expected, many of the older pupils had left the school or were on study leave, when the facilitators returned to complete the post-intervention questionnaires. Therefore, only 27% of the students ( $n = 170$ )

**Table 1**  
Study sample characteristics.

	Region	Participants (n)		Age		Gender -
		Pre-intervention	Post-Intervention	Mean	Range	Male
School 1	North	319	34	15.4	14–17	19 (56%)
School 2	Central	90	35	15.3	14–18	16 (46%)
School 3	East	47	23	15.7	13–17	10 (44%)
School 4	Central	164	78	15.3	13–18	41 (53%)
(C)						
Total		620	170			

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