

STRENGTHENING HEALTH AND FAMILY LIFE EDUCATION IN THE REGION



**The Implementation, Monitoring, and Evaluation of HFLE
in Four CARICOM Countries**

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EXECUTIVE SUMMARY

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EXECUTIVE SUMMARY

NEED AND STUDY RATIONALE

Globally, several studies have pointed to the positive impact that life skills-based health education programmes have on the attitudes and behaviours of young people, but no such evaluation has been conducted in the Caribbean. While a Regional Curriculum Framework to support Health and Family Life Education (HFLE) guides country efforts, CARICOM, UNICEF, and the Ministries of Education and HFLE Coordinators in four countries (Antigua and Barbuda, Barbados, Grenada, and St. Lucia) identified the need for a Common Curriculum to support the delivery of classroom lessons. This evaluation was designed to document the development, implementation and impact of the initial roll-out of this Common Curriculum for youth in Forms 1, 2, and 3, when life skills become critical in helping students avoid risks and make healthy choices that protect their futures.

CURRICULUM DEVELOPMENT

Building on learning and resources from past efforts in the region, a Common Curriculum, with specific interactive, life skills-based classroom lessons, was developed for two HFLE content themes: *Self and Interpersonal Relationships*, and *Sexuality and Sexual Health*. Selected in collaboration with the Ministries of Education, these two themes address priority health issues of violence and HIV /AIDS. Taken together, they aim to provide youth with knowledge and skills that promote healthy behaviours and contribute to school and future success. Using the Regional Curriculum Framework as a guide, HFLE Country and Regional Coordinators and educators came together to develop and then refine coordinated lesson plans for Forms 1-3. Lessons in Form 1 provide a foundation that is supplemented and reinforced as students get older and meet new challenges. This “spiralling” assures that content and core skills are covered each year at developmentally appropriate levels, as students’ sophistication to apply these skills increases.

Research on health promotion and education shows that benefits are more likely to be achieved when programmes have a strong theoretical grounding. The foundation for a life skills approach is based on multiple theories of child and adolescent development, cognitive learning, and social influences. These have depicted how knowledge, attitudes, and skills can help youth avoid problem behaviours and foster personal resiliency to counter risks and negative peer pressures. Previous studies have demonstrated that competence in the use of life skills may reduce the chances of young people engaging in aggressive and anti-social behaviours, substance use, and related risks, including early and unprotected sexual intercourse. These, in turn, have serious and often life-long health and social consequences (UNICEF, 2000; World Health Organization, 2003).

By providing life skills education in Forms 1-3, students have opportunities and hours to practice skills they need, both now and in the future. In addition to being theoretically grounded, the extensive, collaborative development process helped assure that the Common Curriculum is culturally appropriate to the life experiences of adolescents in the Caribbean. Critical health issues are tackled through participatory activities that are both timely and relevant—for schools, families, and students. Care was also taken to assure that lessons address gender differences in both development and challenges faced. Finally, the fully-scripted lessons are designed so they

can be used by teachers, even if they have relatively little experience delivering health education or leading interactive activities, as is often the case.

To support teachers, a companion training manual was developed, and trainings were offered annually in the participating countries. Back in their classrooms, these trained teachers facilitated interactive exercises designed to build life skills, including critical thinking, problem solving and decision making; communication, negotiation and refusal skills; healthy self-management, coping, and help-seeking. This focus is supported by research that shows that youth who fail to acquire these skills are more likely to engage in unhealthy behaviours, such as violence, early sexual risk taking, and abuse of alcohol and drugs, and to be at higher risk of poor academic performance.

EVALUATION STUDY OBJECTIVES

By implementing the Common Curriculum in diverse school settings and countries, the overarching goal is to have a positive impact on student health. Consistent with a logic model that guided the development of the curriculum and its evaluation, improved student health will, in turn, ultimately improve students' school attendance and enhance their learning outcomes. Toward this end, this evaluation study sought to:

- Finalize, implement, and monitor a standardized, Common Curriculum that conforms to the HFLE Regional Framework and has two content themes: *Self and Interpersonal Relationships* and *Sexuality and Sexual Health*. Together, these themes address the critical need for violence and HIV prevention within the region;
- Study the impact of this curriculum on student outcomes, along with the process of implementation in the four countries.

WHAT WE DID

Two types of evaluation were conducted. Process evaluation documented Common Curriculum lesson development, teacher training, and implementation. It also provided data to guide refinement of the curriculum and training materials for dissemination. Impact evaluation assessed student outcomes resulting from curriculum implementation. Data also provide useful information about student knowledge, attitudes, skills and behaviours at the regional level. These data can be used to monitor student health and inform programme and policy initiatives.

Process evaluation included interviews with school administrators and HFLE Coordinators, periodic observations of teachers delivering Common Curriculum lessons, and teacher and student unit assessments completed in the intervention schools after units addressing the two content themes were taught. Teachers were asked to provide feedback about what works and what needs to be improved.

The impact evaluation employed a quasi-experimental pre-post matched pairs design to examine the impact of the Common Curriculum implementation on students. The primary question addressed is: *Do students in intervention schools report more positive attitudes and norms, greater knowledge, more life skills, and fewer risky behaviours than students in their paired comparison schools?* Two critical factors shaped the context in which this question was

addressed. First, the Common Curriculum was designed to supplement--not supplant--other ongoing efforts in the region to train teachers on the HFLE Framework and support the delivery of life skills education. Thus, the evaluation compares “standard practices” that, in most schools, includes delivery of health education with the provision of “enhanced” Common Curriculum lessons. While this comparison may mute differences in student outcomes between delivery of standard practices and the new intervention, it acknowledges that health education efforts, guided by the Regional Framework, have been underway in the Caribbean. Second, this curriculum was developed in tandem with carrying out evaluation activities. That is, lessons were developed, revised, and refined, informed by the process evaluation. Teachers were trained and delivered lessons for the first time during the impact evaluation period, while they still were becoming familiar with the new content and pedagogy.

Country Coordinators and Ministries in Antigua, Barbados, Grenada and St. Lucia each identified three pairs of schools that were similar in terms of size, urban/rural location, academic performance, gender composition, and perceived student behavioural risk. All schools selected were willing and had the capacity to implement the intervention and evaluation procedures. Administrators agreed to:

- Assign teachers to lead two forty-minute HFLE periods per week (timetabled)
- Expose students to three years of the reinforcing, spiralling Common Curriculum
- Ensure that teachers who teach the Common Curriculum would receive basic training in HFLE provided annually by the HFLE Country Coordinator.

Intervention schools began implementing the new HFLE Common Curriculum with all Form 1 students during the 2005–2006 school year. Form 2 was implemented during the 2006–2007 school year, and Form 3 was implemented during the 2007–2008 school year. Thus, the Common Curriculum was introduced in stages. Each year, teachers in the intervention schools were offered training on the new *Self and Interpersonal Relationships* and *Sexuality and Sexual Health* lessons. In the comparison schools, students received standard HFLE or other health classes that were already part of the curriculum. As with the Common Curriculum, what was taught in the comparison schools was often guided by the HFLE Regional Curriculum Framework.

ACCOMPLISHMENTS AND FINDINGS

“[HFLE class] teaches you about life and mostly about yourself, and it teaches you how to handle situations which may occur in life.” Form 2 Student

“I enjoyed seeing the students come alive with authentic pedagogy as opposed to textbook information that is dry and boring.” HFLE Common Curriculum Teacher

Process Evaluation

With input from teachers, HFLE Coordinators, and the Regional HFLE Coordinator, an EDC development team transformed the HFLE Regional Curriculum Framework into skills-based

lessons that are: multi-year (Forms 1-3); fully scripted; interactive; skills-based; spiralling, and focus on the chosen content themes: *Self and Interpersonal Relationships* and *Sexuality and Sexual Health*. A total of 40 Form 1 lessons were initially developed for the two units, based on initial in-country assessments of what was possible and important to cover. However, based on teacher feedback and observations, it became apparent that less classroom teaching time was available than at first assumed. Therefore, 10 lessons per unit were developed for Forms 2 and 3. Throughout the study, feedback from teachers and Country Coordinators was incorporated into a final, revised package of lessons for dissemination, with 10 lessons per unit for each Form.

During Year 1, a training of trainers was attended by Country Coordinators, representatives of teacher colleges, and others. Following this event, multi-day trainings in each country were led by Country Coordinators; training days were observed by UNICEF and EDC staff. Based on feedback from the first-year implementation, a Training Manual was created to help assure teachers were prepared similarly across countries.

In the intervention schools, student and teacher unit assessments were collected at five time points. Numbers of participating students per assessment ranged from 714 to 1279; numbers of participating teachers ranged from 9 to 17. Periodic classroom observations in intervention and comparison classrooms were conducted, although due to resource constraints, fewer observations were held than planned. Baseline and follow up teacher surveys were conducted; 42 teachers completed baseline surveys. At follow up, 21 teachers completed surveys. Administrator and Country Coordinator end-of-year surveys/interviews were conducted as time and resources allowed. Taken together, these evaluation activities documented the process of implementation and its challenges.

Overall, teachers were very enthusiastic about the Common Curriculum; most were comfortable with lesson content. Teachers reported students were engaged in activities and learned new things. They felt lessons were developmentally and culturally appropriate and covered important topics. Results for student unit assessments are consistent with these findings. Further, most teachers felt that the lessons would have a “moderate” or “large” impact on students, and a majority said they would be “very likely” to recommend lessons to their peers. Examples drawn from classroom observations conducted by Coordinators document this enthusiastic reception. For example, as one observer noted:

“The students demonstrated their knowledge of the skill using the scenario, but more important were their attitudes and opinions on cell phone availability, use and misuse, and the rules they believe should be put in place. They then utilized critical thinking and highlighted a number of other issues...peer pressure to have the latest and more expensive [things], envy and conflict, stealing, bullying, breakup of friendships because of gossip, inappropriate ways of acquiring the phones or the money to do so. The discussion was spirited, but focused. The continuing activity was for them to write letters to authorities on the topic of whether cell phones should be allowed in schools.”

Despite enthusiasm, teachers expressed concerns throughout the study about whether there was enough time to complete lessons. Indeed, only 20-35% of teachers said lessons fit teaching time. Teachers had ongoing problems with scheduling HFLE class time, disruptions and time

management. This raises issues about whether sufficient time is allocated for HFLE (or can be, given other priorities and school schedules). Many teachers had little classroom experience, or any experience using the pedagogic, interactive strategies that are integral to Common Curriculum. Further, there was substantial teacher turnover from year to year, as well as some turnover within a year that impeded lesson completion. Late teacher assignments made advanced planning for training difficult.

Despite these challenges, the Common Curriculum had a positive impact on practice at the intervention schools. Overall, these teachers reported receiving more HFLE training than comparison school teachers (even though teachers in the intervention schools had reported less training at baseline). They also reported higher levels of preparedness to teach HFLE, and greater comfort teaching HFLE topics.

By follow up, nearly 60% of the intervention school teachers, but less than 20% of comparison school teachers, said HFLE is more important than other subjects. Also, fewer reported administrative barriers to teaching HFLE. Moreover, at the end of the study, virtually all teachers—in both intervention and comparison schools—wanted additional training on HFLE.

Impact Evaluation

Over 4000 student surveys were collected to inform the impact evaluation. As shown below, during Fall 2005, 2364 Form 1 students completed baseline surveys. During Spring 2008, 1909 Form 3 students completed follow up surveys.

Country	Form 1 (2005) Students	Form 3 (2008) Students
Antigua	299	135
Barbados	698	488
Grenada	525	583
St. Lucia	842	703
TOTAL SAMPLE	2364	1909

Students were an average age of 12.0 years at the baseline Form 1 Survey; students surveyed at the Form 3 follow up were an average age of 14.7 years. All students present on the day of survey administration completed surveys. In addition to informing impact evaluation, results from surveys provide the region with information about the attitudes, knowledge, and behaviours of youth as they advance from Form I to Form III.

The curriculum was intended to be a three-year programme. However, more students than expected may not have attended the same school for Forms 1, 2 and 3, making it difficult to assess level of exposure to the Common Curriculum, which was intended to be a three-year intervention. Nonetheless, there is a significant and positive difference in HFLE exposure: Virtually all students in the intervention schools (96%) reported they had HFLE in prior years, compared to 81% of those in the comparison schools.

Planned analyses, comparing matched pairs of schools, reveal no pattern of significant positive effects of the Common Curriculum on Form 3 students' self-reported attitudes, behaviours, and skills in health domains related to the themes of *Self and Interpersonal Relationships* and

Sexuality and Sexual Health. Multiple outcomes were examined, including peer norms, attitudes, and refusal skills related to substance use, violence, and sex; lifetime and recent reports of risk behaviours; HIV/AIDS related knowledge and stigma; and self-reported life skills related to interpersonal relationships, sexual relationships, and help-seeking from adults. Findings from additional descriptive and multivariate analyses provide similar results.

While this evaluation of HFLE has not identified a consistent pattern of positive effects on student health outcomes, there are no significant negative effects either. That is, student reports are very similar across conditions. However, it is important to note that there may be benefits that were not assessed. Moreover, findings may reflect initial implementation difficulties that were experienced during the roll-out of the Common Curriculum, as well as the difficulty of showing differences between the “standard” health education provided to students in the comparison condition and the “HFLE enhanced” lessons in the new curriculum. Once a programme is institutionalized and teachers have experience in its delivery, more benefits may be identified. This calls for ongoing monitoring of implementation, fidelity, and outcomes.

Consideration of Limitations, Challenges and Study Contributions

Multiple factors can influence the outcome of a study, particularly in the real-life settings of schools and classrooms, where there are competing priorities and complex demands. Here, attribution of outcomes to the intervention was complicated by a number of significant implementation challenges. These include the fact that lessons were not fully implemented in any year, finding time to teach remained problematic, and ongoing problems with teacher selection, turnover, and training persisted. Further, all teachers in intervention schools and comparison schools received basic training in HFLE. Topics taught in intervention and comparison schools were at times similar, placing the emphasis on discerning differences in pedagogy. Although information was obtained on the process of lesson implementation during each Form (i.e., through unit assessments completed by teachers and students and a small number of classroom observations), process information was relatively limited. For example, there was not systematic collection of data on such variables as what lessons—or pedagogy—worked best or were preferred by teachers and students, what social and environmental factors may have influenced effectiveness (e.g., frequency/length of classes, classroom composition). In future studies, examination of these factors may yield important information for supporting implementation and improving student outcomes.

At this time, there is insufficient evidence to conclude that implementation of the Common Curriculum in the four countries has resulted in a measurable impact on student health indicators. However, this does not mean that HFLE is not working or that it is unimportant for students' health and well-being. Rather, during the initial years of developing and implementing the Common Curriculum, the evaluation did not detect significant improvements over standard HFLE practices (as delivered in comparison schools). However, many lessons were learned about the process of classroom implementation and challenges faced by schools and teachers in the initial stages of programme adoption. Future evaluation will help document progress in meeting these challenges and monitor the benefits to students when lessons are fully implemented and effectively delivered.

In addition to focusing on differences between schools adopting the Common Curriculum and those in the comparison condition, there are multiple ways that information obtained can be used to further efforts in the region. Each of the participating countries has obtained valuable data on student health indicators to inform policy and practice directions; these data can also be used to establish a baseline for monitoring trends over time. Finally, documentation of both the successes and obstacles faced by schools and teachers as they implemented the programme can inform dissemination efforts.

RECOMMENDATIONS

The evaluation of the implementation and impact of efforts to introduce a Common Curriculum that supports the HFLE Regional Curriculum Framework has provided many lessons for informing future directions. It also raises critical questions that need to be addressed at the Ministry level to maximize the success of dissemination and provide the infrastructure needed for full delivery. The findings in the preceding sections identify challenges both with regard to the scope of the HFLE Common Curriculum and with regard to the process of school adoption and implementation. To be effective in teaching students the life skills that will promote their health and well-being as well as school success, addressing these challenges is critical.

One set of challenges pertains to the curriculum. Documentation of implementation challenges raises questions regarding: How many units (and lessons within a unit) can be realistically taught per year? Can and should this time allotment be the same for all three Forms? What “dosage” of HFLE is likely to maximize benefits for students? Should the health targets of units and lessons be narrowed to assure that priority health problems, such as violence and HIV/AIDS, are sufficiently addressed?

Another set of challenges pertains to implementation. Difficulties of achieving full implementation raise questions that must be considered at the Ministry and school level. For example: How can a cadre of teachers be identified, trained, and retained to deliver effective lessons? How can lesson delivery be monitored to support fidelity and increase effectiveness? What Ministry and school administrative support is needed to assure implementation? Since students change schools, how can school programmes, such as this curriculum be implemented country-wide?

As these broader questions are being addressed, there are several concrete steps that can be taken to move forward HFLE efforts:

First, this study has shown that implementation issues are a major factor in all pilot countries. Therefore, the success of HFLE relies on the ability of Ministries to sustain support for HFLE and ensure that HFLE is timetabled into classroom schedules and that this schedule is adhered to. In addition, both Ministry and local school administrator support is needed to ensure early selection of teachers and allow time for training. Training is critical to success, given the sensitivity of much of the content covered and the fact that many teachers had not previously led interactive, participatory exercises.

Second, observations and documentation of classroom delivery support the importance of providing a standardized curriculum, as done here. The availability of a fully scripted

curriculum facilitates lesson delivery in a way that a Regional Curriculum Framework alone does not. This is especially important when, as is often the case, there is teacher turnover and many teachers assigned to HFLE have limited experience either with the content or pedagogy. It is notable that teachers and students welcomed the interactive, participatory approaches of HFLE as well as the activities that were incorporated in the Common Curriculum.

Third, even with specified lessons, classroom delivery varied across countries, schools, and classrooms. To maximize benefits to students, monitoring and documenting classroom implementation is important for assuring that the goals of the Regional Curriculum Framework and Common Curriculum are addressed and the lessons are taught with sufficient fidelity to maximize effectiveness.

Fourth, competing priorities for classroom time must be balanced with the goals of HFLE. In this evaluation, only two HFLE units were developed, delivered and evaluated; it was difficult for many teachers to implement 10 lessons per theme. However, two other themes—one addressing eating and fitness and the other, managing the environment—are also regional priorities. For these four themes to be addressed, it will be important to make hard decisions about what and how much can be covered in each Form.

Finally, findings point out the need to better understand the many factors that influence implementation, fidelity to the Common Curriculum, and outcomes achieved. In addition to documenting effectiveness as dissemination proceeds, it is important to learn from and attend to the realities of what happens in classrooms, and how teachers can be best prepared and supported in the delivery of life skills-based health education.

In sum, this evaluation marked a positive step forward in developing and documenting classroom implementation of a HFLE Common Curriculum. Findings are the result of successful, multi-year, collaborative efforts across the region and within each participating Ministry and school, and underscore both the challenges and potential of coordinated curriculum and training approaches to meet student health needs.

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