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Life Skills Approach to Child and Adolescent Healthy Human Development

Leena Mangrulkar, Research Associate, HHD/EDC
Cheryl Vince Whitman, Director, HHD and Senior Vice President, EDC
Marc Posner, Senior Research Associate, HHD/EDC

Health and Human Development Programs (HHD), a division of
Education Development Center, Inc. (EDC)

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Technical Revision: ***Dr. Matilde Maddaleno, Francisca Infante***
Editing: ***María Virginia Pinotti***
Design: ***Sylvia Singleton***
Cover photos: ***Armando Waak, OPS***

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Why Life Skills?

By the year 2010 there will be more adolescents (ages 10-19) alive in the world than ever before, and a significant proportion will live in the Latin America and Caribbean (LAC) Region. This cohort of young people can become either a gift or a burden to their countries depending on the capacity of governments, communities and families to develop the human potential of this generation. This paper describes one best-practice model for effectively contributing to the healthy development of adolescents: life skills programs.

Broadly defined, a life skills approach develops skills in adolescents, both to build the needed competencies for human development and to adopt positive behaviors that enable them to deal effectively with the challenges of everyday life. This paper identifies "Life Skills" as: 1) social and interpersonal skills (including communication, refusal skills, assertiveness, and empathy); 2) cognitive skills (including decision making, critical thinking and self-evaluation); and 3) emotional coping skills (including stress management and increasing an internal locus of control).

Theories of human development and adolescent behavior find these specific skills to be essential components of healthy development, and the skills that define a resilient child. Research also finds that these particular skills are mediators of behavior in adolescence. Results of program evaluations find that life skills development can: delay the onset of drug use, prevent high-risk sexual behaviors, teach anger management, improve academic performance, and promote positive social adjustment.

Effective programs help young people develop these skills through interactive teaching methods that include role plays, open discussion, skills rehearsal and small group activities. Informational content is incorporated into the program based on the personal, social and health tasks of adolescence within a specific culture. Based on the local context, a life skills program could include content about friendships, bullying, sexual relationships, anger management, perceptions about drug use, methods of birth control or prevention of malaria. Research finds that both skills development *and* informational content are necessary components of effective programs. Other key aspects are: targeting programs to early adolescents, modeling of skills through peer and social interaction, incorporation of interpersonal problem-solving skills, and the development of internal skills that can support positive outward behaviors.

Program providers need to be skilled in group process, interactive teaching methods, and to be respectful of adolescents. Importantly, they need to be perceived as role models by adolescents. Health care providers, counselors, teachers, parents, and peer leaders can fulfill these requirements, and programs can be applied in a variety of settings including health clinics, community centers, youth centers, churches, and schools.

Moving ahead an agenda of life skills programs in the Region requires advocating for this approach based on a sound research and theory base. The Pan American Health Organization, in collaboration with other agencies, is committed to supporting the pilot testing and evaluation of programs around the Region, the development of a LAC research base around skills development, and advocacy for this valuable approach to healthy development for adolescents.

Introduction

By the year 2010, the number of adolescents in the world will be larger than ever before in history – 1.2 billion young people ages 10 to 19. A significant proportion will live in Latin America and the Caribbean (LAC): almost 107 million young people (U.S. Census Bureau, 2000). Will this cohort of young people fulfill its potential as a gift to the Region? The answer, to a large extent, depends upon the capacity of families, governments, and communities to develop the human potential of this generation.

The Pan American Health Organization, along with other United Nations organizations, non-governmental organizations, country governments and others, has been building the infrastructure for making an agenda for youth development a reality. Policies and legislation that protect and promote young people are being created in many countries, with the participation of young people. There are expanding opportunities for health and social service professionals to build their skills to work with the adolescent population. And a growing research base about best practices in adolescent and youth development is providing them with the tools and the program models to do so more effectively than ever.

This paper describes one best-practice model for contributing to the healthy development of adolescents: a life skills approach. A key aspect of human development -- as important to basic survival as intellect -- is the acquisition of socio-cognitive and emotional coping skills. This approach, sometimes referred to as skills-based education, builds skills in these particular areas to strengthen an adolescents' protective factors, promote the competencies necessary to make a healthy transition to adulthood, and promote his or her adoption of positive behaviors. Effective programs apply skills to issues relevant to an adolescent's developmental tasks and social context, such as developing a sexual identity, understanding peer pressure, or managing emotions. This has been shown to impact on behaviors. For more than a decade, research on interventions that address these specific skill areas has shown their effectiveness in promoting desirable behaviors, such as sociability, improved communication, effective decision making and conflict resolution, and preventing negative or high-risk behaviors, such as use of tobacco, alcohol and other drugs, unsafe sex, and violence.

Based on this research and on theories of human development, we have identified three key categories of life skills: (1) social or interpersonal skills; (2) cognitive skills; and (3) emotional coping skills. For purposes of clarification, life skills programs as defined in this paper do NOT encompass technical/vocational skills (carpentry, sewing, computer programming), skills for helping a young person to get a job, such as interviewing skills, or skills for managing money, such as balancing a checkbook or opening a bank account. While many young people may benefit from programs that address these practical skills, the socio-cognitive and emotional coping skills addressed in this paper are shown to be core elements of human development.

Figure 1: What are the Key Life Skills?

Life skills fall into three basic categories, which complement and reinforce each other:

- Social or interpersonal skills, including communication, negotiation/refusal skills, assertiveness, cooperation, empathy.
- Cognitive skills, including problem solving, understanding consequences, decision making, critical thinking, self-evaluation.
- Emotional coping skills, including managing stress, managing feelings, self-management, and self-monitoring.

Development of these skills is closely linked to a pedagogy of active learning. Through participative teaching methods, such as role play, debates, situation analysis, and one-on-one problem solving, life skills programs can actively engage young people in their own development process.

Before we proceed, a note of caution is in order. A focus on individual skill development is a powerful methodology for promoting adolescent health, but it must be placed within a wider context. Adolescents in the Region often face multiple threats to their health including poverty, political violence and a lack of employment opportunities. Strategies that affect the larger political, media, family and community environment are also needed for long-term sustainable change. A comprehensive youth health agenda includes: (1) policies that advocate for services, employment opportunities and a quality educational system, (2) training of professionals to work with this population, (3) implementation of intervention, prevention and health promotion services, (4) organizational networks to support youth, (5) research that tests effective strategies and explores youth issues, and (6) channeled resources to fund these strategic efforts (PAHO, 1998a). Within this agenda, life skills represents a much needed and, as we argue in this paper, effective, model for health promotion programming. The last section of this paper, "Moving the

Agenda into the Future" outlines possible ways that these other strategies can support adoption of a life skills model for adolescents in Latin America and the Caribbean.

Purpose and Audience for this Paper

The approach outlined in this paper is not new. Skills development has formed a part of adolescents programming around the world, whether within youth development, asset building, pregnancy prevention, life planning, social and emotional learning, health education or substance abuse prevention initiatives. Decision making has long been a part of pregnancy prevention models, refusal skills are seen as critical to drug abuse prevention, and communication skills have been used to help aggressive or anti-social youngsters. But with the move towards a comprehensive programming that addresses multiple behaviors and competencies, the life skills approach is beginning to be recognized as an effective unifying framework. Innovative youth programs around the world incorporate skills development around issues of rights and citizenship, and creative conflict resolution.

Many international agencies, including UNICEF and the World Health Organization (WHO) have supported local programs in their work. The World Health Organization has been a strong advocate, developing conceptual papers and curricula, and convening working groups and training for governmental and non-governmental agencies throughout the world (WHO 1999, 1996, 1993). The Global School Health Initiative and the Health Promoting Schools Network have adopted life skills as a priority strategy for school health in many parts of the Region.

Given this background, this paper develops a framework of research, theory and arguments that deepen our understanding of a life skills approach. Specifically, the paper aims to:

- present the theoretical and research foundations of a life skills approach;
- define life skills and the effective teaching methodologies for developing them;
- analyze the challenges of implementing life skills programs in the Region; and
- develop a common language and vocabulary to advance the approach.

This paper is intended for government policy makers and program planners in the health, education and youth sectors, consultants from PAHO and other agencies in child and adolescent health, and program planners in non-governmental organizations, who are interested in adopting this approach.

The paper is divided as follows:

- **Chapter I** provides a summary of the situation of adolescents in the Region and the implications of health and education reforms on life skills programs.
- **Chapter II** summarizes eight key theories about child and adolescent development, learning and behavior.
- **Chapter III** defines the life skills approach, including content, teaching and programmatic concerns.
- **Chapter IV** presents the voices of the practitioners, drawing on interviews to offer real life lessons from implementing life skills programs in the field.
- **Chapter V** proposes strategies for moving forward this approach in the LAC Region.
- **Chapter VI** provides several program descriptions from the Region.
- **Chapter VII** offers some simple planning tools for initiating a customized life skills program.

Chapter I

Adolescents in Latin America and the Caribbean

Adolescents in Latin America and the Caribbean have the potential to make a powerful contribution to the Region's growth and development. Representing 20.5% of the total population of LAC, they can fulfill the potential of the economic and technological change occurring in the Region (U.S. Census Bureau, 2000). To seize this opportunity and wisely develop a program agenda for youth, we must first understand their situation in the Region. This section outlines key education, employment and health indicators.

[Education]

Education is a powerful means for reducing poverty and inequality. The LAC Region has made significant progress over the years in expanding access to schooling for young people at all levels. Children are getting a better start in life, as early childhood education is rapidly expanding in the Region. Enrollment rates in pre-schools in LAC rose from 3.4 % in 1960 to almost 23% in 1996. And close to 85% of the primary school age population is now enrolled in school (World Bank, 1999). However, LAC continues to lag behind other Regions in educational performance and competitiveness. One key reason has been the slow expansion of secondary school enrollment in LAC. In today's highly competitive economy, obtaining at least a secondary education is becoming a necessity for making a living. The average educational attainment of workers in OECD (Organization for Economic Cooperation and Development) countries is 11.1 years, and for East Asia (excluding China) it is 8.1 years, while LAC workers only obtain an average of 5.4 years (UNDP, 1994). Investing in universal secondary schooling must be a priority for the Region. Many Asian countries, faced with similar demographic patterns in the past, invested in universal secondary education. Many analyses found this was a significant contributing factor to the Asian "economic miracle" of the 1980s.

While higher education is becoming an attainable goal for young people in certain countries of the LAC Region (e.g., Argentina, Chile, Costa Rica, Panama, Peru, Uruguay and Venezuela, all with tertiary enrollment rates exceeding 25 %), the vast majority of young people in LAC will not have that opportunity (Guadilla in World Bank, 1999).

Gender disparities in the LAC Region, while less pronounced than in many other developing regions of the world, are substantial, especially in rural areas and in indigenous populations. According to one study, girls are *more* likely to attain a secondary education level than boys in all of the LAC countries studied except Bolivia, Guatemala and Peru (Alan Guttmacher Institute, 1998). However, better statistics are needed to understand the gender disparities not only in terms of enrollment rates, but also in terms of repetition, school completion and academic achievement (World Bank, 1999).

And, while the good news is that young people achieve more years of education than their parents, a study by ECLAC (Economic Commission for Latin America) found that an estimated 80% of urban youth come from households where parents had under 10 years of schooling. This is far less than the estimated 12 years of education needed to achieve a basic standard of living (ECLAC, 1997).

[Employment]

Youth make up from 40 – 50% of the workforce in the Region. This is not surprising given the low levels of secondary school enrollment in the Region. An analysis by ECLAC shows that 6 out of 10 new jobs created in the 1990s were in the "informal" sector, such as in bingo parlors or selling lottery tickets or soft drinks. Approximately 10 million children under the age of 14 are estimated to be working illegally, with no social security benefits, for low wages, and often under hazardous conditions (PAHO, 1998b; ECLAC, 1997 in Schutt-Aine, 2001).

And, youth *un*employment—estimates range from 35 to 66 percent—remains a problem (PAHO, 1998a). Data from household surveys in 15 countries show that youth (15 to 24 years old) who neither study nor work represent between 12% and 40% of poor households (ECLAC, 1997). The future for these young people, disconnected from society's educational system, without social security benefits, or other opportunities to gain capacity-building skills is very uncertain.

[Poverty and Inequality]

Poverty and extreme inequality continue to plague the LAC Region. In 1970, 40% of all households were poor. In 1994 that number was only reduced to 39%, while the absolute number of poor people has continued to grow (ECLAC, 1997). In 1993, an estimated 156 million people were living in poverty in the Region and 69 million in extreme poverty, mostly in the rural areas. ECLAC estimated that almost 1/3 of youth in the Region live in poverty, subjected to stunted growth, poor nutrition, tuberculosis and acute respiratory infections, and the lack of access to education. And many young people in LAC are raised in households headed by women, which tend to have a higher incidence of poverty. In Costa Rica, 21% of households are headed by women, in El Salvador that percentage is 35%, and in Trinidad and Tobago the percentage is 25%, reaching 32% in urban settings (Nuñez, et al, 2000).

Opportunities and wealth in LAC continue to be very unevenly distributed. The chance to earn a living wage, to get an education, to access health services, and to live free of disease and poverty varies widely from country to country and within countries. In Haiti, more than 70% of the population lives below the level of absolute poverty, and 13% of young people ages 15 –19 are illiterate. By contrast, 71% of young people in Argentina and 88% in Chile have a secondary education, some of the highest levels in the world (World Bank, 1999).

Young people growing up in rural areas have multiple disadvantages compared to their urban counterparts. In Latin America, illiteracy is 2 to 6 times higher in rural than urban areas, and the limited access to basic services (health and nutrition) is further exacerbated by the generally low educational attainment of women in rural areas. Many factors for rural children, such as poverty, geographic isolation, and the need to use children as domestic labor, severely limit their opportunities to pursue education beyond primary school. In Chile, rural youth have on average only 8.8 years of education, in Honduras, 5.3 years of education, and Brazilian rural youth attain only 4.2 years of education (IDB, 1998).

Another challenge to LAC governments is to provide services and opportunities for the nearly 40 million individuals from ethnic minorities (World Bank, 1999). Indigenous populations have the lowest educational attainment and highest poverty rates in the Region, making them among the most disadvantaged groups in the world.

And, there is concern that economic globalization and trade liberalization will exacerbate these disparities as skilled and educated young people reap the benefits from these trends, while the unskilled and under-educated face greater marginalization and exclusion.

[Health]

Young people face considerable challenges to their healthy development. In several of the poorer countries of the Region, infectious diseases, such as diarrhea, influenza, and pneumonia are still among the top five causes of death for 10 to 14 year olds (PAHO, 1998b). But, for many countries at the other end of the epidemiological transition, death and illness associated with risky behaviors, such as smoking, motor vehicle crashes, violence and high-risk sexual activity have begun to take on greater importance. During the last decade, the level of violence has increased throughout the world and is emerging as one of the most serious problems in the Region. Colombia, Puerto Rico, Venezuela, El Salvador and Brazil have the Region's highest levels of homicides in males of 15 to 24 years of age (ibid). In many countries such as Colombia, young people are living in situations of armed conflict, often resulting in forced resettlement. The impact on young people of witnessing and surviving violence, and in many instances participating as young military or guerilla recruits, is only just beginning to be understood.

Sexual and reproductive health is a fundamental aspect of all human beings and encompasses the right to sexual integrity, safety, privacy, equality, expression, education, and access to care. Adolescence is a critical time in the development of sexual identity, how one will care for him or herself sexually, and think about their sexuality through adulthood. The biological changes of puberty, greater independence from the family during the teenage years in some cultures, cultural and family expectations about gender and sexuality, cognitive development, and emotional growth time will shape an adolescent's sexual development. Thus, the period of adolescence represents an opportune time to address sexual and reproductive issues. By many indicators, mostly looking at behaviors and outcomes, these issues continue to be a cause for concern in the Region (Schutt-Aine, 2001).

In the seven countries with data from the Demographic Health Survey, between 53 and 71% of women have had sexual relations before their 20th birthday (UNFPA, 1997 in PAHO, 1998b, V.1). In the majority of countries in the Region, between 15 and 25% of all of the births in the Region occur in adolescents (UNICEF, 1997a), and the use of contraception is at its lowest in the

adolescent age range (UNFPA, 1997 in PAHO, 1998b, V.1). Surveys in the Caribbean suggest that 40% of girls and 50% of boys have no access to contraceptives at their first sexual intercourse (UNICEF, 1997a). Also, between 35 and 52% of adolescent pregnancies were not planned (UNFPA and Adolescents, 1997 in Schutt-Aine, 2001). Furthermore, poverty and education are important determinants of pregnancy in adolescence. Eighty percent of adolescent mothers in urban areas and 70% in rural areas belong to the poorest 50% of households (ECLAC, 1997). In Colombia, the Dominican Republic, Guatemala and Mexico, girls with more than 10 years of education were four times less likely to have initiated sexual activity by age 20 than those with less education (UNFPA and Adolescents, 1997 in Schutt-Aine, 2001).

Sexually transmitted diseases and HIV/AIDS are both serious problems in the Region. Each year 15% of adolescents between 15 and 19 years of age acquire an STD and knowledge about transmission, prevention and treatment is low (Macro International, 1996 in Schutt-Aine, 2001). The Caribbean countries overall suffer from the highest prevalence rates of HIV/AIDS. In 1999, the adult prevalence rate (the proportion of adults—15 to 49 years of age—living with HIV/AIDS) in the Caribbean Region was the second highest in the world (UNAIDS, 2000). Young people are disproportionately affected by HIV/AIDS, with almost half of all new HIV infections occurring in young people ages 15 to 24.

The use of tobacco, alcohol and other drugs pose serious health risks to young people in the Region. Inhalants are an important problem for the pre-adolescent population, used specifically by street children. Tobacco is responsible for some 135,000 deaths in LAC each year (WHO, 1997a; PAHO, 2000). According to WHO estimates, 40% of men and 21% of women smoke in developing countries in the Region of the Americas (WHO, 1998). Disaggregating this data by country reveals considerable variation. Low consumption countries (e.g. Peru, Guatemala) reported 350 cigarettes per person per year, while high consumption countries (e.g. Venezuela, Cuba) reported 2000 cigarettes per person per year (WHO, 1997a). Trends show that the age of smoking initiation is dropping, and that young women are beginning to pick up smoking at a faster rate than their predecessors do. Concern about the use of other drugs is growing, not only because of the increase in prevalence, but also because of new and more potent recreational drugs, such as cocaine in its base paste form (UNICEF, 1997b). Inhalants are also a concern for street children in many countries in the Region.

While this situational analysis (mostly comprised of outcome indicators) is not the whole story of adolescents in the Region, we can draw some important implications for adolescent programs.

- Adolescent needs vary widely in LAC depending on country, community, gender, socio-economic status, and ethnicity. One single program or curricula will not effectively serve a Bolivian adolescent from a rural community and an urban Jamaican adolescent. This paper will argue for life skills programs in which the content and specific skills are determined locally.
- Although this analysis presents the data on high-risk behaviors separately (smoking, early sexual intercourse, motor vehicle injuries), they are found to co-occur in behavioral patterns. This points towards building program models, such as a life skills approach, that address these multiple behaviors within a single program framework.
- Most of the data available (and presented in this analysis) focuses on problem behaviors and outcomes, with less emphasis on adolescent needs or assets. Research on issues such as relationship with parents, participation in the community, decision-making skills, or social competence can help to support approaches that address both behaviors and developmental assets.
- Finally, while the life skills approach is viewed as an alternative to single-problem programs, this analysis highlights the serious threats that young people in Latin America and the Caribbean face from violence, HIV/AIDS, early pregnancy, and substance abuse. This paper argues that the most effective life skills programs blend skills development with content on the issues relevant to the local context.

Health and Education Sector Reforms in LAC

What has been the response of LAC governments to the needs of the youth population? An overall analysis of the Region shows that significant progress has been made. A 1996 evaluation found that 26 countries of the Region have established National Adolescent Health Programs, although many only recently (Rodriguez-Garcia et al, 1999). In countries with experienced national programs, such as Colombia and Costa Rica, health professionals are trained to work with young people in health, education, and community settings. Health services specifically targeting adolescents deal with issues of reproductive health, mental health, and nutrition.

One key struggle has been to incorporate effective health promotion strategies into adolescent health services and programs. This is a challenge for the health sector in general, with a traditional focus on curative services in clinics and hospitals. Health promotion is especially critical in the field of adolescent health, given that many habits are formed during this stage of life (Burt, 1998). One recent ally in this struggle is health sector reform, occurring to some extent in all countries of the Region. The primary components of reform include decentralization of governance, community participation in local decision-making, a focus on primary health care and adoption of health promotion strategies. Health reform strategies could support adoption of life skills through:

- greater openness of the health sector to testing innovative models of health promotion, such as life skills
- community participation, which can facilitate training community leaders to work with young people
- young people's participation in health to promote peer leader training
- a focus on the family as a whole can facilitate teaching parents to work with their adolescents on life skills
- a move towards cost-effectiveness can encourage adoption of comprehensive programs, such as life skills
- greater collaboration between sectors can facilitate partnerships between health, education and youth development for reaching young people

Education reform could also have an impact on adolescent health programming and policies. Research has shown that a better education leads to better health outcomes, and that better health leads to greater school achievement (World Bank, 1999). Reforms are aimed at providing opportunities for community involvement in schools, improving the efficiency of school management, developing new curricula and teaching materials, and upgrading teachers' skills. The overlap in goals between education reform and health promotion/education programs includes:

- a focus on the whole child or student
- identifying clear objectives and student outcomes
- implementing student-centered learning
- encouraging active, hands-on, and cooperative learning
- focusing on critical thinking/high-order thinking for students
- training teachers to ensure effectiveness
- involving parents in learning activities
- considering school climate
- collaborating within a school, and between a community and a school (Haber and Blaber, 1995)

Together, the climate of reform provides an opening for countries in Latin America and the Caribbean to adopt a life skills approach to adolescent health promotion. This paper provides the theoretical and conceptual foundations of this approach, describes what is known about its effectiveness, begins to build a common language around skills development and provides guidance on how life skills can be implemented most effectively.

Chapter II

The Theoretical Foundations of the Life Skills Approach

Theories about the way human beings, and specifically, children and adolescents grow, learn and behave provide the foundation of a life skills approach. These theories are not mutually exclusive and all contribute to the development of a life skills approach. This section analyzes seven theories: child and adolescent development, social learning, problem behavior, social influence, cognitive problem solving, multiple intelligences, and risk and resilience. A chart on page 14 highlights each theory's key link to the development of life skills.

[Child and Adolescent Development Theory]

Understanding the complex biological, social and cognitive changes that occur from childhood through adolescence is at the core of most theories of human development.

Biological Changes

A fundamental change from childhood to early adolescence is the onset of puberty. When the hormones controlling physical development are activated, most children undergo a growth spurt, develop primary and secondary sex characteristics, become fertile and experience increased sexual libido. Puberty differs among boys and girls, with girls experiencing pubertal changes earlier than boys, so girls and boys of the same age are likely to be at quite different points in physical development between the ages of 10 and 14. Many young people may not be adequately prepared for these biological changes. Adolescent's concerns about appearance can sometimes lead to unhealthy dieting, and premature initiation of sexual intercourse before achieving a level of cognitive or emotional maturity (Eccles, 1999).

Development of Social Cognition

The process of understanding oneself, others, and relationships is an important part of growing into adolescence and adulthood. At two years of age, children are clearly recognizing their own image, and demonstrating the existence of a visual self-concept. By around eight years of age, children begin to reflect on their abilities, what they like and dislike, and how they generally feel and think about things. Social awareness moves from the egocentric perspective of the young child to the ability to understand, predict and respond to other's feelings and perspectives in early adolescence (Slaby et al, 1995). Thus, this stage of life is critical for developing empathy and perspective.

Learning to realistically evaluate oneself and one's abilities is another important process during childhood. Very young children tend to be overly optimistic about their abilities. As children move into middle childhood (approximately ages 7-10), they begin to reflect on their own successes and failures, and to match their achievements to internal goals and external standards. The pressures towards conformity, competition, and the need for approval complicate the process of self-evaluation as children begin to pay attention to the work of others as a way to assess their own abilities (Newman and Newman, 1998).

Self-efficacy is another dimension of the developing self-concept. Self-efficacy can be defined as the "degree to which individuals view themselves as being valuable, as causally important people, and as effective in shaping the events and outcomes in their lives." (Tyler, 1991, p.40).

Cognitive Development

Cognition can be defined as the process of organizing and making meaning of experience (Newman and Newman, 1998). According to Piaget, human beings make meaning of the world through interaction with the environment. From infancy through 18 months, babies learn about the environment through their direct sensory experience. By ages 5 or 6, they develop more complex tools for understanding the world through language, imitation, imagery, and symbolic play and drawing. Moving into early adolescence, the child begins to understand causal relationships and logic, and is becoming more sophisticated in problem

solving. Piaget believed that by adolescence, a person is able to conceptualize about many variables, allowing for the creation of a system of laws or rules for problem solving (Piaget, 1972).

While Piaget focuses clearly on an individual's interaction with the environment, social constructivists believe that knowledge is the result of social interaction and language, and thus is a shared experience. Vygotsky, a prominent cognitive theorist, proposed that new levels of understanding begin at an interpersonal level: originally between infant and adult, and then through continuous social interaction. He conceptualized that the distance between the actual and the potential stage of development of a child is determined by his or her problem solving capacity, when working alone vs. collaborating with adults and other, more capable peers (Newman and Newman, 1998; Vygotsky, 1978). Seen from this perspective, the social environment has a strong influence on the structure of one's thinking, and cognitive skills can be enhanced by more extensive, structured, high quality interactions with others.

Social Development and Family Context

Social interactions become increasingly complicated as children move into adolescence. More time is spent with peers, and interactions with opposite-sex peers increase. Middle childhood (from ages 7-11) represents this time of transition, when children move away from the home sphere and spend more time with peers, and school and community groups. Social status is earned through competence and performance with peers. During these critical years, children either learn to be competent or productive or to feel inferior, which can lead to long-lasting social, intellectual and emotional consequences (Hansen, et al. 1998; Csikszentmihalyi and Schneider, 2000).

While peers are important, family and parents continue to be an important influence into adolescence. Research done in the United States finds that an authoritative parenting style, defined as "warm and involved, but firm and consistent in establishing and enforcing guidelines, limits, and developmentally appropriate expectations" has consistently positive effects on adolescents (Steinberg, 2000). Another positive dimension is "psychological autonomy-granting", which is defined as the "extent to which parents encourage and permit the adolescent to develop his or her own opinions and beliefs." (ibid).

Interpersonal trust, defined as the general expectation that other people are reliable or dependable, is an important dimension of social competence. Research has found that people who trust are more capable of being trusted themselves, are liked by their peers, make friends easily, and are more autonomous in making and executing life plans (Tyler, 1991). Building trust is based on past history and the context of relationships.

The following chart traces some key developmental stages of childhood to middle adolescence, recognizing the role for skills acquisition.

Figure 2: Developmental Stages in Childhood and Adolescence

	Early Childhood Ages 4-6	**Middle Childhood Ages 7-10**	**Early Adolescence Ages 11-14**	**Middle Adolescence Ages 15-17**
Social Context	❑ Mostly within home ❑ Key interaction between child and adult care-takers/family	❑ Move from home into wider social contexts ❑ Develop a sense of industry ❑ Learn to cooperate with peers and adults	❑ Acquire greater independence ❑ Increase focus on peers ❑ Understand the perspective of others	❑ Autonomy from parents
Cognition	❑ Chooses from multiple ideas ❑ Explains why something is not fair	❑ Begin to plan consciously, coordinate actions, evaluate progress, and modify plans based on reflection and evaluation	❑ Thinks about short and long-term consequences ❑ Increasingly able to think abstractly, considering the hypothetical and the real ❑ Increasingly able to retrieve information and use it to solve new problems	❑ Uses problem-solving processes ❑ Speculates as to best alternatives ❑ Identifies uncontrollable factors ❑ Identifies external standards of fairness
Self-concept	❑ Children tend to be very optimistic about their abilities	❑ By age 10, able to self-reflect on abilities and own successes and failures ❑ Developing self-awareness	❑ Developing a sense of oneself as an autonomous individual	❑ Continuing to develop a sense of oneself as an autonomous individual

Source: Eccles, 1999; Crawford and Bodine, 1997.

Gender and Development

What are the differences between the process of development in girls and boys? Research done in the United States finds patterns of developmental asymmetry: boys are more psychologically at risk than girls throughout the years of childhood, and then girls—stronger and more psychologically resilient than boys in childhood—are suddenly at high risk in adolescence (Gilligan, 1993). Boys in childhood are more likely than girls to suffer from depression, develop learning disorders, and show many forms of out of control or out of touch behaviors. In early adolescence, girls' depression and related suicide attempts rise, often having shown no signs in childhood. Gilligan argues that boys' crisis revolves around finding ways to connect with others, and that for girls it is to find their own voice (ibid). This idea could have many implications for how skills, such as perspective taking, empathy and assertiveness, are developed differently in boys and girls.

Moral Development

Finally, moral development is an important dimension of human development. It can be defined as the "development of values and rules a person uses for balancing or adjudicating the conflicting interests of the self and others." (Westen, 1996). However, differing schools of thought offer very different perspectives on this definition and on how children develop moral reasoning and/or moral behaviors. Behaviorists believe that moral behavior, like other behaviors, is learned through processes of conditioning and modeling. Cognitive theorists, on the other hand, argue that moral development proceeds through a sequence just as a child's cognition develops. Kohlberg described stages of development that move from a child's preoccupation with the consequences of behavior on oneself to moral judgements that incorporate the rights of others, and eventually incorporate universal principles of ethics (Newman and Newman, 1998; Kohlberg, 1976).

A prominent challenge to that view by Carol Gilligan argues that women and men have differing perspectives on moral reasoning. According to Gilligan, women's moral conceptions are oriented towards issues of responsibility and care, while men's are oriented towards rights and justice (Gilligan, 1988). Exploring how both girls and boys develop moral reasoning within different cultures in LAC could provide a foundation for supporting the incorporation of values clarification and moral development within life skills programs.

In sum, there are critical changes that take place from middle childhood to adolescence. The biological transformations of puberty, the psychological changes that accompany an emerging sexuality, changing relationships with peers and family, and the growing ability for early adolescents to think abstractly, to consider multiple dimensions of problems, and to reflect on themselves and others represent a critical moment in human development. Whether young people move through these changes acquiring the requisite skills to make a healthy transition to adulthood, depends in large part upon the opportunities afforded them from their environment. "With rapid change comes a heightened potential for both positive and negative outcomes, creating important opportunities for families, schools, and out-of-school programs to interact with adolescents in a way that fosters growth and development." (Eccles, 1999, pg. 36).

The implications of human development theories for life skills programs are:

- Late childhood to early adolescence is singled out as a critical moment of opportunity for building skills and positive habits, since at that age there is a developing ability to think abstractly, to understand consequences, and to solve problems;
- The wider social context of early and middle adolescence provides varied situations in which to practice new skills with peers and other individuals outside of the family.
- Skills and competencies are recognized as important in a child's developmental pathway, and in developing a sense of oneself as an autonomous individual.

[Social Learning Theory]

This theory, which is also known as the Cognitive-Social Learning Model, is largely based upon the work of Albert Bandura (Bandura, 1977b). Bandura's research led him to conclude that children learn to behave through both instruction (i.e., how parents, teachers, and other authorities and role models tell them to behave) as well as observation (i.e., how they see adults and peers behaving). Their behavior is reinforced, or modified, by the consequences of their actions and the responses of others to their behaviors. Children learn to behave, then, through observation and social interaction, rather than just through verbal instruction. Similarly, children should be taught skills through a process of instruction, rehearsal, and feedback, rather than just instruction (Ladd and Mize, 1983). Bandura also stressed that self-efficacy, defined as confidence in one's abilities to perform

appropriate behaviors, is important to learning and maintaining behaviors, especially in the face of social pressure to behave differently. Thus, skills development not only becomes a question of outward behavior, but of internal qualities (such as self-efficacy) that support those behaviors (Bandura, 1977a).

Social Learning Theory had two profound influences on the development of life skills and social skills programs. One was the necessity of providing children with methods or skills for coping with internal aspects of their social lives, including stress reduction, self-control, and decision-making. Most life and social skills programs address these skills. The second was that, to be effective, life and social skills programs need to replicate the natural processes by which children learn behavior. Thus, most life and social skills programs include observation, role-play, and peer education components in addition to plain instruction.

[Problem-Behavior Theory]

As developed by Richard Jessor, this theory recognizes that adolescent behavior (including risk behaviors) cannot be reduced to a single source, but is the product of complex interactions between people and their environment. Problem-Behavior Theory is concerned with the relationships among three categories of psychosocial variables: (1) the personality system; (2) the perceived environmental system; and (3) the behavioral system. The personality system includes "values, expectations, beliefs, attitudes, and orientations toward self and society." The perceived environmental system concerns perceptions of friends' and parents' attitudes toward behaviors. And, similar to Bandura, the behavioral system is usually described as a certain set of socially unacceptable behaviors (the use of alcohol, tobacco, and other drugs, sexual behavior by persons below a certain age, delinquency, etc.).

Each psychosocial system contains variables that act as instigators or controls on problem behavior. The strength of these variables results in proneness: the likelihood that problem behavior will occur (Jessor, Donovan, and Costa, 1991). Weakening instigators or strengthening controls helps decrease a child's "overall proneness for problem behaviors" (that is, the likelihood that the child will engage in problem or unhealthy behaviors). Jessor's early work helped promote the development of life skills approaches that included strategies in all three systems. In more recent years, Jessor and the Problem-Behavior Theory have described two other systems of influence, the social environment (which includes factors such as poverty and family structure) and biology/genetics (including variables such as family history of alcoholism and high intelligence (Jessor, 1992). The biological genetic system of influence (like much genetic research) may be useful to identify children with a genetic propensity for particular risk behaviors (like alcoholism), but is still limited in its use in prevention. The social environment domain identifies other variables (behaviors such as poor school performance) that correlate with risk behaviors (such as the use of alcohol and other drugs). These variables, if changed, will affect others—regardless of the workings of the causal links among the variables. Thus, developing skills such as values clarification (to better understand one's own values and beliefs) and critical thinking (to clearly recognize and analyze the values of the social environment) can have an impact on behavior, and can be even more effective in coordination with programs that affect other variables, such as poverty reduction programs, clinical health services or school dropout prevention.

[Social Influence Theory]

Social influence approaches are based upon the work of Bandura (see above) as well as the psychological inoculation theory developed by researchers, including McGuire (1964, 1968). Social influence approaches recognize that children and adolescents will come under pressure to engage in risk behaviors, such as tobacco use. Social pressures include "peer pressure, models of smoking parents, and smoking-related messages in the mass media that feature attractive smokers" (Evans, 1998). Social influence programs anticipate these pressures and teach children about both the pressures and ways to resist them before they are exposed (much like vaccination builds resistance to diseases before children are exposed to those diseases in the environment).

This theory was spurred by research demonstrating that programs that merely provided information on the consequences of risk behaviors (such as smoking), and/or used fear to try to prevent children from engaging in these behaviors were unsuccessful. Research into these programs found that, "Fear induced by knowledge of the long-term dangers of smoking appeared to be insufficient to prevent its onset among many young adolescents, when exposed to social pressure to engage in the behavior." (ibid).

This approach was first used by Evans (1976; et al, 1978) in smoking prevention programs. The approach is now usually referred to as "peer resistance education," and is used in a broad range of curricula to prevent the use of tobacco, alcohol, and other drugs, as well as high-risk sexual activity. Meta-analysis of prevention programs revealed that social influence programs were more effective than programs based solely on information or affective education (Hansen, 1992). Usually, these programs are

targeted at very specific risks, tying peer resistance skills (as well as the classroom exercises used to teach that skill) to very particular risk behaviors (such as marijuana use), attitudes (such as the opinion that using marijuana is wrong), and knowledge (e.g. the consequences of using marijuana on a child's memory, lungs, and reproductive health). Social resistance training is usually a central component of social skills and life skills programs.

[Cognitive Problem Solving]

This competence-building model of primary prevention theorizes that teaching interpersonal cognitive problem solving (ICPS) skills to children at a young age can reduce and prevent negative inhibited and impulsive behaviors. Research shows differing levels of interpersonal thinking skills in children displaying positive social behaviors versus children displaying early high-risk behaviors (including antisocial behaviors, inability to cope with frustration, and poor peer relations). The defining skills focus on the ability to generate alternative solutions to an interpersonal problem and secondly, the ability to conceptualize the consequences of different behaviors. Relationships between these problem solving skills and social adjustment were found not only in preschool and kindergarten children, but also in adolescents and adults.

An intervention based on this research, the ICPS intervention (also called "I Can Problem Solve"), develops interpersonal cognitive problem-solving skills starting in preschool, with the ultimate goal of preventing later and more serious problems by addressing the behavioral predictors early in life. Solving hypothetical dilemmas, thinking aloud, role playing, and providing performance feedback are some methodologies for teaching these skills. Research done with preschool and kindergarten children found that those receiving the ICPS training became better able to cope with typical everyday problems than those who did not. By learning to consider more solutions and consequences, they became better able to cope with frustration, better able to wait, and less overemotional and aggressive when goals could not be satisfied immediately (Shure and Spivack, 1980). Thus, problem-solving, especially as applied to social or interpersonal situations, and starting early in life, is a critical part of life skills programs.

[Multiple Intelligences: Including Emotional Intelligence]

Howard Gardner published "Frames of Mind" in 1993, challenging the prevailing view of human intelligence as an uncomplicated set of cognitive and symbol-using capacities, acknowledging primarily only verbal/linguistic and mathematical/ logical abilities. Gardner proposed the existence of eight human intelligences that take into account the wide variety of human thinking capacities. These include linguistic, logical/mathematical, musical, spatial, bodily/kinesthetic, naturalist, interpersonal and intrapersonal intelligences. This theory postulates that all human beings are born with the eight intelligences, but they are developed to a different degree in each person, and that in developing skills or solving problems, individuals use their intelligences in different ways.

The theory of multiple intelligences has important implications for educational systems, and for incorporating a life skills approach to promotion and prevention. Recognizing other intelligences, beyond the traditional verbal and mathematical skills, implies that teachers should teach to this broader range of skills. Secondly, a variety of classroom instruction methods are needed to engage the different learning styles of the students. This implies the use of participatory, active learning methods that stimulate the use of musical, spatial, naturalist and other intelligences, and allows children and young people to engage different intelligences simultaneously.

Other researchers have expanded the thinking on the two "personal" intelligences: interpersonal intelligence, the ability to understand and discern the feelings and intentions of others, and intrapersonal intelligence, the ability to understand one's own feelings and motivations. Daniel Goleman popularized this idea in his book, *Emotional Intelligence,* which argues that knowing how to manage one's emotions is at least as important for success in life as intellect (Goleman, 1997). This idea has served as the basis of some of the work in social and emotional learning (Weissberg et al, 1998; Hawkins et al, 1992).

[Resilience and Risk Theory]

Resilience and risk theory attempts to explain why some people respond better to stress and adversity than others. Resilience theory argues that there are internal and external factors that protect against the social stressors or risks of poverty, anxiety, or abuse. If a child has strong protective factors, he or she can resist the unhealthy behaviors that often result from these stressors or risks. Internal protective factors include self-esteem and internal locus of control, while external factors are primarily social supports from family and community, such as positive role models or health services (Luthar and Zigler, 1991; Rutter, 1987). According to Bernard (1991), the characteristics that set resilient young people apart are social competence, problem solving

skills, autonomy, and a sense of purpose. Although the social environments of these young people are marked by risk, they also have "protective qualities, including caring and supportive relationships, high expectations, and opportunities for youth participation, and involvement." (Meyer and Farrell, 1998, p. 472). Prevention programs can target a broad array of those etiologic determinants. An understanding of the relationship of the child to the environment is the foundation of what is often called a comprehensive prevention approach. Such an approach employs strategies that maximize resilience and minimize risk, involving not only the young person, but also the family and the community, as well as health care providers and other service providers (often through case management or a "full-service" approach). Resilience and risk theory provides an important part of a foundation for a life skills approach:

- Social-cognitive skills, social competence, and problem-solving skills serve as mediators for behaviors, both positive and negative. In other words, life skills programs designed to prevent specific problem behaviors (e.g., high-risk sexual activity, social rejection) or promote specific positive behaviors (e.g., healthy peer relationships, positive school adjustment) do not simply address the behaviors directly. Rather, they build the competencies or skills that are shown to mediate the behaviors.

- It is apparent that there is not a one-to-one relationship between risk factors and behavioral outcomes. "Recent findings in behavioral epidemiology indicate that mental health problems, social problems, and health-risk behaviors often co-occur as an organized pattern of adolescent risk behaviors" (Greenberg et al, 1999, p. 4). Programs that teach social and emotional skills had positive effects in multiple realms, such as decreasing aggression in boys, decreasing suspensions and expulsions, decreasing drug use and delinquency, increasing academic test scores, and increasing positive attachments to school and families (Hawkins et al, 1992). Thus, effective life skills programs address and have an impact on multiple behaviors.

- Many of the risk factors that threaten the health and well-being of adolescents (e.g., poverty, mental illness in family members, racial injustice) are out of the range of what most health promotion and prevention programs can do. Life skills programs address the mediating factors that research shows can be influenced to promote health and well-being.

The following chart illustrates critical risk factors and resilience or protective factors that influence healthy child and adolescent development.

Figure 3: Risk and Resilience Factors of Child and Adolescent Development

RISK FACTORS	PROTECTIVE (RESILIENCE) FACTORS
Individual Characteristics	
❑ Constitutional handicaps: perinatal complications, neurochemical imbalance, sensory disabilities ❑ Skill developmental delays: low intelligence, social incompetence, attention deficits, reading disabilities, poor work skills and habits ❑ Emotional difficulties: apathy, emotional immaturity, low self-esteem, poor management of emotions ❑ School problems: scholastic demoralization and school failure	❑ Cognitive skills ❑ Social-cognitive skills ❑ Social competence ❑ Problem solving skills ❑ Internal locus of control ❑ Sense of purpose ❑ Positive sense of humor ❑ At least average intelligence

RISK FACTORS	PROTECTIVE (RESILIENCE) FACTORS
Family and Social Characteristics	
❑ Family circumstances: low social class, mental illness or substance abuse in the family, large family size, child abuse, stressful life events, family disorganization, communication deviance, family conflict, and poor bonding to parents ❑ Interpersonal problems: peer rejection, alienation, and isolation	❑ Secure attachment to parents ❑ High expectations from family members ❑ Secure attachment to peers or other adults modeling positive health and social behaviors
Environmental Characteristics	
❑ Little emotional and social supports ❑ Harsh or arbitrary student management practices in schools ❑ Availability of alcohol, tobacco and illicit drugs and of firearms and weapons in school/community ❑ Community laws and norms favorable to substance use, firearms, and crime. ❑ Community circumstances: neighborhood disorganization, extreme poverty, racial injustice, high unemployment	❑ Connection between home and school ❑ Caring and support, sense of "community" in classroom and school ❑ High expectations from school personnel ❑ Youth participation , involvement and responsibility in school tasks and decisions ❑ Opportunities for youth participation in community activities ❑ Community norms and laws unfavorable to substance use and firearms

Source: Bernard, 1991; Kotliarenco et al, 1997; Luther and Zigler, 1992; Rutter, 1987.

[Constructivist Psychology Theory]

The core of constructivist psychology is that individual development, including higher mental function, is rooted in social sources. A child's cognitive development is thought to be a collaborative process, developed through interactions with other people and with the environment. Thus, the individual is not the center of knowledge-making but rather gets his or her learning and understanding through social interaction.

Educators and psychologists Piaget and Vygotsky suggest that a key mechanism for child development is the cognitive conflict that is created through social interaction; a contradiction between a child's existing understanding and a child's experiences with others, especially peers slightly older or more knowledgeable, causes him or her to question current beliefs and seek new levels of understanding. Vygotsky in particular argues that "Learning awakens a variety of internal developmental processes that are able to operate only when the child is interacting with people in his environment and with his peers" (Vygotsky, 1978, p.90). Separating the individual from his or her social influences is thought to be impossible, and learning itself is viewed as culturally and contextually specific.

A key element in Vygotsky's theories is the idea of the zone of proximal development (ZPD). He argues that to understand the relationship between development and learning, we need to distinguish between two different developmental levels: the actual level of development and the potential level. The actual refers to the problem solving that a child can do alone, versus the potential development that occurs when the child problem solves under adult guidance or with more capable peers.

Finally, from the constructivist psychology perspective, the learning environment takes on a prominent role in guiding a child's development and will be, in turn, influenced by the collaborative learning and peer interactions taking place.

The constructivist perspective has three important influences on a life skills approach. One is the significance of peer collaboration as the basis for learning skills, especially problem-solving skills. Secondly, the constructivist approach highlights the importance of the cultural context in infusing any life skills curriculum with meaning; the adolescents themselves co-create the content through the interaction of the factual information with their particular cultural environment. Finally, this perspective acknowledges that the development of skills through the interaction of the individual with the social environment can influence both the learners and the environment (peer group, classroom, youth group, etc.).

[Summary]

In sum, each of these theories provides a piece of the foundation for justifying skills development and differing perspectives on why these skills are important. Some focus more on behavioral outcomes, justifying skills development as a way to move adolescents towards the behaviors that developmental expectations, cultural context and social norms find appropriate. Others focus more on the acquisition of skills as the goal itself, since competency in problem-solving, interpersonal communication, and resolving conflicts can be seen as crucial elements of healthy human development. Finally, some theoretical perspectives view life skills as a way for adolescents to actively participate in their own process of development and the process of constructing social norms. By teaching young people *how* to think rather than *what* to think, by providing them with the tools for solving problems, making decisions and managing emotions, and by engaging them through participative methodologies, skills development can become a means of empowerment. The following chart pulls out the implications of each theory for life skills programs:

Figure 4: Implications of Theories for Developing Life Skills

Child and Adolescent Development Theory	❑ Early adolescence (10–14) is singled out as a critical moment of opportunity for building skills and positive habits, since at that age there is a developing self-image and ability to think abstractly and to solve problems ❑ The wider social context of early and middle adolescence provides varied situations in which to practice new skills with peers and other individuals outside of the family ❑ Developing skills and competencies are recognized as critical to a child's developmental pathway and sense of oneself as an autonomous individual
Social Learning Theory	❑ Teaching life skills needs to replicate the natural processes by which children learn behavior (modeling, observation, social interaction) ❑ Children need to develop the internal skills (self-control, stress reduction, self-management, decision-making) that can support positive outward behaviors
Problem-Behavior Theory	❑ Behaviors are influenced by an individuals' values, beliefs and attitudes, and the perception of friends and family about those behaviors. Therefore, skills in values clarification and critical thinking (to evaluate oneself and the values of the social environment) are an important aspect of life skills programs
Social Influence Theory	❑ Peer and social pressures to engage in unhealthy behaviors can be defused by addressing them before the child or adolescent is exposed to those pressures, thus pointing towards early prevention, rather than later intervention ❑ Teaching children resistance skills is more effective at reducing problem behaviors than just providing information or provoking fear of the results of the behavior
Cognitive Problem Solving	❑ Poor problem-solving skills are related to poor social behaviors, indicating the need to include problem-solving as an aspect of life skills programs ❑ Teaching interpersonal problem-solving skills at earlier stages in the developmental process (childhood, early adolescence) is most effective

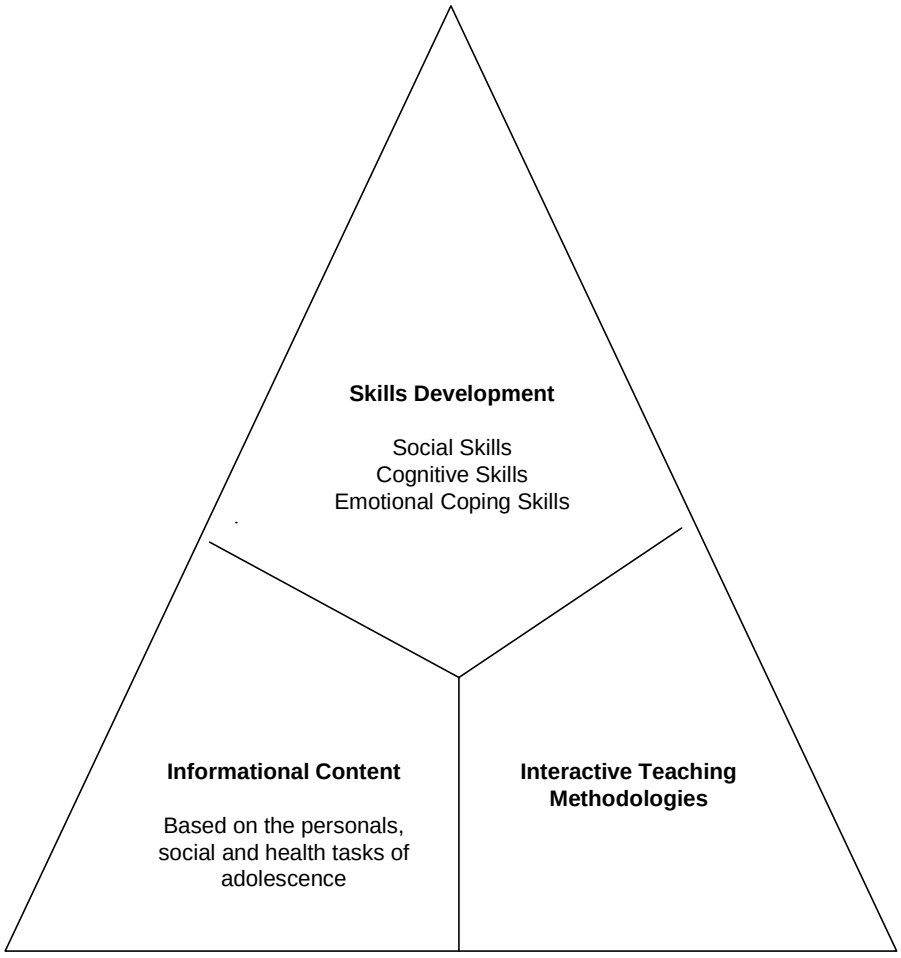
Multiple Intelligences (Including Emotional Intelligence)	❑ A broader vision of human intelligence points towards using a variety of instructional methods to engage different learning styles. ❑ Managing emotions and understanding one's feelings and the feelings of others are critical to human development and can be learned by children in the same way as reading and arithmetic.
Resilience and Risk Theory	❑ Social-cognitive skills, social competence, and problem-solving skills can serve as mediators for behavior. ❑ The specific skills addressed by life skills programs are part of the internal factors that help young people respond to adversity and are the traits that characterize resilient young people.
Constructivist Psychology Theory	❑ The learning process occurs through social interaction in peer learning, cooperative groups, or open discussion situations ❑ Developing life skills in adolescents, like other processes of teaching and learning, is infused with layers of cultural beliefs and values ❑ Developing skills through the interaction of the individual and the social/cultural environment can lead to changes both in the individual and in the environment (peer group, classroom, family, youth group)

Chapter III

The Life Skills Approach: Putting it All Together

From this broad base of theory, program developers often ask, "Exactly what does a life skills program look like? What are the critical life skills that promote healthy development and minimize harm and risk?" While the local context determines the specific skills and content focus, the three key elements of life skills programs are: skills development; information/content addressing relevant social and developmental tasks; and interactive methods of teaching and learning. In addition, program planners need to think through who will provide the program and in what setting. Given the types of pedagogy and learning strategies essential to developing life skills, how will selection and professional development of the providers be handled? This next section moves from the theory base into the specifics of life skills programming by addressing the three key elements, and providing suggestions for evaluation, training and program setting.

Figure 5: Key Elements of Life Skills Programs



[Defining Specific Life Skills]

Various youth and health organizations and adolescent researchers have defined and categorized the key skills in different ways. Categorizations depend on the desired outcome, the disciplinary perspective of the program developer or research and the dominant theories underlying program design. The following are examples of life skills categories that focus on social competencies, violence prevention, and general health promotion:

- skills related to social knowledge, perception, and emotional encoding and decoding, perspective taking, interpersonal reasoning, and interpersonal problem-solving (Bierman and Montimy, 1993).
- cooperation, assertion, responsibility, empathy, and self-control (Gresham and Elliott, 1989).
- social entry skills, conversational skills, conflict-resolution and problem-solving skills, and anger-control skills (Guevremont et al, 1990).
- decision making/problem solving, creative thinking/critical thinking, communication /interpersonal relationships, self-awareness/empathy, and coping with emotions/stress (WHO, 1993).

As mentioned in the Introduction, the skills categories used in this paper are divided into: social skills, cognitive skills, and emotional coping skills.

Figure 6: Life Skills

LIFE SKILLS	Social Skills	Cognitive Skills	Emotional Coping Skills
	- Communication skills - Negotiation/refusal skills - Assertiveness skills - Interpersonal skills (for developing healthy relationships) - Cooperation skills - Empathy and perspective taking	Decision making/problem solving skills - Understanding the consequences of actions - Determining alternative solutions to problems Critical thinking skills - Analyzing peer and media influences - Analyzing one's perceptions of social norms and beliefs - Self evaluation and values clarification	- Managing stress - Managing feelings, including anger - Skills for increasing internal locus of control (self-management, self-monitoring)

These three skill categories are not employed separately, but rather complement and reinforce each other. For example, a program aimed at promoting social competence in children would teach ways to communicate feelings (a social skill), to analyze different ways of handling social situations (a cognitive skill), and to manage their reactions to conflict (an emotional coping skill). The following section gives an overview of these categories of skills and explores the research that supports their use in various programmatic contexts.

Developing Social Skills

The adolescent years represent a very challenging time as relationships with parents, peers and others become more complex. Effective social interactions are a critical factor for successful functioning in the home, school and work.

One perspective on social skills, linking them directly to behavioral outcomes, is the social skills deficit model. This model hypothesizes that children who fail to develop the skills for interacting with others in a socially acceptable manner early in life are rejected by their peers and engage in unhealthy behaviors (violence, the abuse of alcohol and other drugs, etc.). One of the best predictors of chronic delinquent offending and violence in adolescence is antisocial behavior in childhood (Pepler and Slaby, 1994). Research has also indicated that about half of young children rejected by their peers do not have social deficits, but rather a high rate of aggressive behavior learned at home (Patterson, 1986). These children tend to respond to their rejection by peers with aggression, initiating a cycle of aggressive behavior and peer aggression that escalates as the children get older (Bierman and Montimy, 1993). Young people with deficits in social skills may band together, thus reinforcing their isolation from their mainstream peers, as well as their unhealthy behaviors. Thus, the children who do not learn to share toys, smile at peers, and take turns during play in preschool may find themselves involved in a peer group, defined by fighting and the abuse of alcohol and other drugs in adolescence (ibid).

From a prevention and health promotion perspective, research supports the development of skills including communication, assertiveness, refusal, and negotiation.

- In the area of substance abuse, prevention programs have focused on assertiveness training and communication strategies for refusal and negotiation, combined with problem solving and decision-making skills and relaxation techniques (Botvin et al, 1998; Hansen, 1992).
- In the area of preventing high-risk sexual behaviors, interventions have combined knowledge-based education with social-skills training, including teaching negotiation skills and refusal skills, to produce changes in contraceptive behavior of adolescents (Nangle and Hansen, 1993, pg. 115). Research found that problems associated with adolescent sexual activity (low contraception use, STDs, and teenage pregnancy) were related to deficits in communication skills, assertion skills and problem-solving skills (ibid, p. 127).
- Many conflict resolution and violence prevention programs are geared towards developing social skills and understanding about alternatives to violence. One project, Resolving Conflict Creatively Program (RCCP) targets "problem-solving and communication skills used in deescalating conflict," including: active listening, expression of feelings, perspective taking, negotiation, and encountering bias." (Sadowski, 1998). "Social skills training… focus(es) on increasing positive social skills with which to handle inevitable social disagreement and conflict… As (they) employ these skills, anger is reduced through improved communication, and the consequences of uncontrolled anger are therefore reduced." (Deffenbacher et al, 1996, p.150).

Perspective taking and empathy are two critical social skills. While research has supported the idea that children's social awareness begins from an egocentric perspective, it has also found that even young children have an awareness of others' feelings, and often respond to the distress of others' based on their level of empathic understanding. Programs in violence prevention have successfully taught specific skills that link perspective taking and empathy to appropriate behaviors. Young people are found to show increased skill in identifying and relating to another person's feelings if a real-life role model demonstrates empathy for a character in a distressful situation (Feshbach, 1982; Shure and Spivack, 1988). Guiding children to practice these empathic responses within conflict situations can build habits of thinking and caring about other people's perspectives and feelings and help them to come up with nonviolent solutions instead of resorting to aggression (Slaby and Guerra, 1998).

Developing Cognitive Skills

Most adolescent programs using a life skills approach combine both social skills and key cognitive skills: problem solving and decision-making. "Problem solving" is identified as a course of action that closes the gap between a present situation and a desired future one. This process requires that the decision maker be able to identify possible courses of action or solutions to a problem and to determine which is the best alternative solution (Beyth-Marom et al, 1989). According to Bandura's social learning theory, people who experience developmental difficulties are those who are less able to set appropriate goals and to generate ways of achieving those goals (Bandura, 1977). The work of Shure and Spivack reiterated the importance of problem solving and goal setting in healthy development. Young people need to "learn how, not just what to think earlier on" (Shure and Healey, 1993). In some prevention research that idea is applied to skills that help children to resist peer and media influences by learning how to think critically about messages from peers and the media (Botvin, et al, 1998).

Another crucial aspect of cognition is related to self-evaluation or being able to reflect on the value of one's actions and qualities to self and others, and is related to expectancy or the degree to which one expects that one's efforts to shape life's outcomes actually determine the results. People who believe they are causally important in their own lives tend to "engage in more proactive, more constructive and healthier behaviors related with positive outcomes." Research found correlations between this kind of thinking and behaviors such as smoking cessation, contraceptive use among females and males, and academic achievement (Tyler, 1991).

Social-cognitive models explore how cognition interacts with the family/peer context and existing beliefs/values to affect behavioral outcomes. The "habits of thought" model is one such social-cognitive model, mostly applied to modifying aggressive behaviors. Interventions address an individual's content of thought (by modifying beliefs that support violence), process of thought (by developing skills in social problem solving), and style of thought (by managing impulsive processing of thought) (Pepler and Slaby, 1994).

Finally, research has shown decision-making to be much more complicated than a simple rational process (Beyth-Marom, et al, 1989). Management of difficult choices, especially under stress, involved both cognitive thinking skills (identifying issues or problems, determining goals, generating alternative solutions, envisioning possible consequences) and emotional coping skills (calming oneself under stress, listening carefully and accurately, determining the best choice) (Elias and Kress, 1994).

Developing Emotional Coping Skills

Skills for coping with emotions through learning self-management and controlling stress (often incorporating social problem-solving skills) are a critical dimension of most life skills programs. The bulk of the research in this area focuses specifically on anger reduction or conflict management, but social competency programs and substance abuse prevention programs also acknowledge their importance. Cognitive-relaxation coping skills target emotional and physiological arousal, and focus on increasing skills for emotional control. Relaxation techniques are taught to help young people calm down, so that they are better able to think about and deal effectively with frustration and provocation (Deffenbacher et al, 1996, p. 150). Managing anxiety is another important emotional coping skill. "Anxious children tend to have distorted perceptions of the degree of threat present in certain situations, and lack the self-efficacy or effective coping skills to manage their internal distress." (Greenberg et al, 1999, p. 30).

Emotional coping skills also include strengthening an internal locus of control, or a belief in personal control and responsibility for one's life, and in a generalized expectation that one's actions will be reinforced. Aspects of this include: learning to delay gratification of short-term rewards, to put forth personal efforts in the service of actualizing goals, and to seek help in times of distress. While patterns of thinking are an important determinant of locus of control, Bandura describes the importance of motivation for setting goals and initiating tasks, and perseverance to the task. Programs that effectively develop these three skill sets (social, cognitive, emotional coping skills) in adolescence can have a powerful impact on development, providing young people with the competencies needed for growth. However, as we will discuss in this next section, skills acquisition alone is not enough. It needs to be combined with informational content addressing the social and developmental tasks relevant to this stage in life.

[Defining Information/Content Areas]

While some programs attempt to teach life and social skills generically, research indicates effective programs include normative content and teaching children to apply skills to specific behaviors (Tobler and Stratton, 1997; Dusenbury and Falco, 1995; Donaldson, Graham, and Hansen, 1994; Hansen, 1992; Caplan, Bennetto, and Weissberg, 1991; Dodge, Pettit, McClaskey, and Brown, 1986; Hawkins and Weiss, 1985) Accurate and developmentally appropriate content of relevance to young people (for example, sexuality, substance use, nutrition and fitness, or interpersonal conflict) provides a context for learning skills. Recent research shows that skills are not automatically and consistently applied to every problem or social task encountered. Rather, to produce a meaningful effect on development or behavior, adolescents need to practice and apply learned skills to "specific, relevant social tasks".

Perhaps a crucial question to ask is: who determines what those relevant social tasks are? While life skills programs focus on teaching adolescents more how to think, rather than what to think, values and beliefs will always be implicit in any program. In some, the transmission of values may be an explicit goal, for example in a life skills program that incorporates youth citizenship. Two of the skills mentioned in this paper are critical thinking and values clarification. Life skills programs should facilitate a critical evaluation of social norms and peer influences, and can help young people explore their own values and personal

meaning through self evaluation. Importantly, whether the values are implicit or explicit, the specific content of a life skills program should be determined locally, through dialogue and participation of adults and adolescents, and based on the local health risks and competencies of young people.

Research and theory supports the incorporation of specific kinds of content into a skills program: perceptions (e.g., actual vs. perceived levels of drug use by peers), stereotypes (e.g., gender bias in the media), community statistics (e.g., level of volunteerism of teenagers), health information (e.g., how to use a condom), and help-seeking information or community resources (e.g., where can I get free counseling for depression). Programs based on social influence theory effectively addressed the attitudes of young people about specific behaviors, such as marijuana use, and life skills training programs by Botvin effectively modified the perceptions of young people about peer drug use (Evans, 1998; Botvin et al, 1990).

The following figure gives an overview of informational content on which life skills can be applied:

Figure 7: Information Content to Accompany the Development of Life Skills

		Examples of Informational Content
Specific Content Areas	Violence Prevention/ Conflict Resolution	- Stereotypes, beliefs, attributions, and cognitive scripts that support violence - Identifying potential situations of conflict - Levels of community violence - Myths about violence perpetuated by the media - Roles of aggressor, victim, and bystander
	Alcohol, Tobacco and other Substance Use	- Social influences to use alcohol, tobacco and other drugs - Potential situations for being offered a substance - Misperceptions about levels of alcohol, tobacco, and other drug use in community/ by peers - Effects of alcohol, tobacco, and other drug use - Community resources to address drug use in the community
	Interpersonal Relationships	- Friendships - Dating - Parent/child relationship
	Sexual and Reproductive Health	- Information about STDs/HIV/AIDS - Myths and misconceptions about HIV/AIDS - Myths about gender roles, body image perpetuated by the media - Gender equity (or lack of it) in society - Social influences regarding sexual behaviors - Dating and relationships - Information about sexual anatomy, puberty, conception and pregnancy - Local rates of HIV/AIDS, STDs, teenage pregnancy - Alternative methods of birth control - Locating and seeking services
	Physical Fitness/ Nutrition	- Healthy foods - Exercise/sports - Preventing anemia and iron deficiency - Eating disorders - Body image

[Defining Effective Teaching Methods]

The methodology for developing skills is a critical aspect of effective programming. Research and theory show that not only is a life skills approach made *more effective* by using interactive teaching methods, but that skills are learned *through* interaction, role playing, open discussions, small group activities and other techniques that are an integral part of the approach.[1] Research has shown that children as young as 5 years of age can be engaged in skills development using these methods. Familiarizing

[1]The definition of interaction, or interactive teaching methods, is not yet developed or generally agreed upon. It could be assumed that one-way communication including lectures, preaching, demonstration, films without discussion, are not interactive. Activities that engage participants in an active and positive way and in which participants are attentive, reflective and actively involved could be thought to be interactive (Nat. Conf. on Drug Abuse Prev. Research, Hansen, p. 11).

children with communication, negotiation and problem solving skills early in childhood is an important prevention strategy (Shure and Spivack, 1979, 1980). Some programmatic research singles out interactive methods as an important component of success in programs. Research in the realm of substance abuse prevention found that interactive programs were significantly more effective than non-interactive programs (Tobler, 1992).

Social Learning Theory provides some of the theoretical foundation that explains why interactive teaching techniques work. Bandura's research, discussed earlier, found that people learn what to do and how to act by observing others, and behaviors are reinforced by the positive or negative consequences viewed by the learner (Bandura, 1977b). In addition, retention of behaviors can be enhanced by rehearsal: "when people mentally rehearse or actually perform modeled response patterns, they are less likely to forget them than if they neither think about them nor practice what they have seen" (ibid).

A model of skills development is shown in the following figure:

Figure 8: Cycle of Skills Development

Promoting Skill Concepts
- Defining skills concepts
- Generating exemplars, both positive and negative
- Encouraging verbal rehearsal
- Correcting misperceptions

⇩

Promoting Skill Acquisition and Performance
- Providing opportunities for guided rehearsal
- Evaluating performance
- Providing feedback and recommendations for corrective actions

⇩

Fostering Skill Maintenance/Generalization
- Providing opportunities for self-directed rehearsals
- Fostering self-evaluation and skill adjustment

Constructivist theory provides an alternative justification to the behavioral perspective. Vygotsky argues that social interaction and the active engagement of the child in problem solving with peers and adults is the foundation of the developing mind. He also takes it one step further to say that the interaction can facilitate adolescent's participation in the construction of cultural practices and social norms. In an example, a role play about resolving a situation of conflict can both enhance the skills of the role-playing adolescent, and can reinforce positive social norms about peaceful conflict resolution through the engagement of an audience of peers (Meyer and Farrell, 1998 p. 478).

Many programs capitalize on the power of peers to influence social norms and individual behaviors. By working cooperatively with peers to promote prosocial behaviors, the normative peer structure is changed to support health behaviors, and may also increase the attachment of high-risk peers to these prosocial norms (Wodarski and Feit, 1997 p.198). Peer groups are formed naturally and in these group situations, adolescents can experiment safely with newly acquired skills in an atmosphere of positive peer support, as set by the adult program provider (Hansen et al, 1998).

In sum, the methods for skills acquisition involve cooperative learning, peer support, continual opportunities for rehearsal, accurate feedback and constructive criticism, and modeling of skills by other peers and adults. Some of the possible methods of skills acquisition, many of which are not loud and boisterous activities, include:

- ❑ role playing
- ❑ situation analysis
- ❑ small group work
- ❑ debates
- ❑ one-on-one rehearsal
- ❑ decision mapping or problem trees
- ❑ literature content analysis
- ❑ relaxation and trust-building exercises

- games

This next section discusses the kinds of potential program providers and the challenges they face using these methods of teaching.

[Program Providers and Training]

Program providers for life skills programs require a blend of professional and personal qualities. Some individuals bring these to the job and others must be trained to acquire them. Who can teach life skills effectively? Usually life skills programs are offered by social workers, counselors, teachers, and psychologists or other health care providers. It is essential that the leader is a role model who is successful or competent, possesses high status, and has control over rewarding resources (Bandura, 1977a). Health care providers often fulfill these expectations, as do many teachers, community leaders and parents. However, many adults will need to unlearn authoritarian and didactic approaches to learn to become effective program providers.

Same age or older peer leaders have been included in many studies testing social influence and competence enhancement approaches to substance abuse prevention (Botvin et al, 1998) and in social skills training approaches to promote children's social interaction (Elliot and Gresham, 1993). Peer leaders have been found to play a role in social influence approaches to behavior change given that they are generally credible and accessible role models (Botvin et al, 1998; Tobler, 1992). Peer leaders usually assist an adult program provider and have specific and well-defined roles (Botvin et al, 1998; Perry and Jessor, 1985). An added benefit of using peer leaders is that the young leader him or herself often benefits from the position as a role model and program provider (Tobler, 1992).

Several studies have found that "generic personal and social skills substance abuse prevention programs can be effective, whether the primary providers are project staff, social workers, graduate interns, peer leaders or classroom teachers." (Botvin, 1986; Botvin et al, 1995).

Parents are in a unique position to affect the behavior of their children. Indeed, children develop skills such as communication, problem solving, and critical thinking through modeling at home. Interest continues to grow in training parents on how to enhance their own skills, thereby improving the social and emotional learning, problem-solving and communication skills of their children (Shure, 1999). More research is needed to understand the different teaching methodologies, theoretical background, skill set and training of a life skills program that would involve parents.

What is clear is that all of these types of possible providers have the *potential* to possess the characteristics of an effective life skills program provider. The interactive teaching methods required by life skills programs point towards choosing providers with the following characteristics:

- Competence in group process; someone who can enhance interaction and simultaneously focus and direct the group (Tobler, 1992)
- Ability to act as a guide as opposed to being dominating (ibid)
- Respect for the adolescent and his or her freedom of choice and individual self-determination (ibid)
- Personality traits that include: warm, supportive, and enthusiastic (Ladd and Mize, 1983)

Given the challenging methods posed by a skills-based approach, ensuring adequate training for program providers can be a key factor in program effectiveness. Health and education sector reforms in Latin America and the Caribbean provide an opening for training health professionals and teachers in a new way: using active teaching methods, focusing on the whole child and adolescent, and building skills in conjunction with providing information. The community participation aspect of health and education sector reform could provide the opportunity to train and involve community leaders, counselors, health workers, peer educators, as well as parents.

A pervasive concern is that health care providers, youth workers and teachers are often expected to work with adolescents to develop skills that they themselves may not possess (e.g., assertiveness, stress-management and problem-solving) Furthermore, program providers may need help with their own sexual health issues, substance abuse problems, or violence in the home. Studies on health promotion programs for teachers have shown that they can result in specific health benefits to providers, as well as improved attendance, morale, and quality of learning (Allegrante, 1998). Some parent-focused interventions have addressed this concern by helping parents (as program providers) to develop skills in their children (Shure and Spivack, 1979), while also helping parents improve their own problem-solving, parenting and stress-management skills.

Training adults in active teaching methodologies can be difficult but essential. Research on training health educators found that some teachers were uncomfortable with participative methodologies, but with practice, they began to overcome their reluctance (Basen-Engquist et al, 1994).

In many ways, training of life skills programs mirrors the teaching principles of the programs they are trained to implement. Provider training should incorporate active teaching methodologies that include what is known about adult learning styles. The trainer models the activities (e.g., open discussion, role plays, and cooperative group work), and the participants require extensive opportunities for practicing those methods. Combined with feedback, this model mimics the skills development process discussed earlier for adolescents. Informational content should include an analysis of the adults' perceptions of adolescence, their own stereotypes and myths, and clarification of their own values around issues relevant to young people.

Another issue concerns program providers' level of comfort addressing the sensitive issues and questions that adolescents raise. Hygiene, sexual health, dating, friendships, and difficult decisions about the future are topics that a life skills program provider needs to be prepared to discuss –either by answering questions or knowing where to go for more information. This requires training in content about adolescent sexuality, stages of development, body image and resources available in the community.

Developers of *Teenage Health Teaching Modules,* a skills-based health education curricula, trained program providers on how to:

- establish the program environment where open communication is valued, constructive problem-solving occurs, and positive peer interaction is valued;
- use interactive teaching strategies;
- model skills and apply skills to particular behaviors, including how to give encouragement and praise to reinforce positive social norms (O'Donnell et al, 1995, p. 90);
- teach complex social skills;
- provide resources for health information and referral; and
- deal with sensitive issues (Blaber, 1999).

The specifics of training vary widely in terms of design, length, content and methodology. Results from research on staff training, mostly for life skills programs that address specific behaviors, found:

- A multiphase approach to staff development is important, and includes continued training and booster sessions (Hansen, 1992; Botvin, 1986)
- Approaches to training should fit the skills level of the providers (Gingiss, 1992)
- Active participation of providers in making decisions about program adoption is important
- In terms of length of program training, research in alcohol and drug abuse prevention programs found that training should be at least 10 sessions long (a session equal to about 45 minutes) in the first year, at least 5 sessions long in the subsequent years, and at least 3 years in duration for effectiveness (Dusenbury et al, 1997b)
- Pairing experienced life skills program providers with new trainees is an effective strategy for training (Dusenbury and Falco, 1995)

[Program Settings]

Life skills development can be and has been incorporated into programs in a wide variety of settings, including health clinics, schools, hospitals, community centers, early childhood centers, schools, and youth centers. The following are some examples of life skills programs in different settings.

- Doctors, nurses, psychologists, counselors, and community health workers throughout Latin America and the Caribbean have begun to form teams to provide not only curative health services, but also health promotion. Life skills programs can be implemented in youth participation programs, counseling groups, and peer education programs.
- Many NGOs around the Region provide reproductive health services, after-school programs, counseling programs and youth leadership programs, making them a potential setting for life skills programs.
- School reform provides opportunities for school activities to include parent training in life skills, and for peer education and counseling programs to incorporate a life skills approach.
- Parenting programs are beginning to take hold in many community and health centers, providing an opportunity for life skills training for parents.

[Evaluation of Life Skills Programs]

Evaluating the effectiveness of a life skills program requires a clear program design. What is the overall purpose of the program and what are the measurable goals? What are the expected outcomes in terms of improvement in skills, changes in behavior, or changes in attitude or beliefs in the adolescent? What changes could be expected in the program environment or program provider? Although developing measurable indicators often lags behind advances in program design, existing life skills initiatives provide guidance on how to capture impact.

Process components measure the extent to which the program actually reaches the intended audience, and how the program is implemented. Two important dimensions are coverage and quality. Extent of provider training, fidelity to the program design, and program duration are just some of the components of implementation that may affect intervention outcomes. Measuring the extent to which program implementation is the same in all program sites is a key to comparing effectiveness.

The outcome indicators selected for the program depend on the desired goals of the program. Life skills programs generally analyze changes in skills levels, attitudes and beliefs, as well as changes in behavioral outcomes. These can be both self-assessed and assessed by program providers and parents. In the substance abuse prevention arena, the following are often the critical skills measured: assertiveness, refusal skills, locus of control, decision-making, and problem-solving (Botvin, 1986). The Social Skills Rating System (SSRS) (Gresham and Elliot, 1990) is one of many different rating systems that have been used to assess students' social skills, including cooperation, assertion, empathy, and self-control. Social and emotional adjustment can be measured through many different scales including the Survey of Adaptational Tasks of Middle School (Elias et al, 1992). This survey asks teachers, parents and students about adjustment in middle school (generally ages 10-14 in the United States). Other scales include the Self-Perception Profile for Children, which measures children's perceptions of personal competency (Harter, 1985). More research that measures skills, competency, adjustment and other key components of life skills programs is needed for the Latin American and Caribbean Region.

Depending on the desired behavioral outcomes, programs can measure substance use, changes in sexual behavior, decisions made about smoking, condom use, etc. Substance abuse prevention programs often apply objective measures of alcohol or tobacco use, such as breathalyzers, and violence prevention often looks at numbers of conflicts, or whether conflicts result in violence.

Changes in attitudes and knowledge is another component of an evaluation plan. In the area of violence prevention, a number of self-report measures assess the attitudes and knowledge of adolescents about violence. For example, the Beliefs Supporting Aggression Scale (Slaby and Guerra, 1988) measures normative beliefs about aggression, and the Attitude Towards Conflict Scale (Lam, 1989) measures how young people feel about different methods for resolving conflicts.

Since life skills programs tend to be comprehensive in scope, it is important to acknowledge proposed effects beyond changes in individual behaviors, attitudes or skills. Changes in social norms or norms among peers, changes in program providers, and changes in connection to community, family, parent or school are all potential effects and should be measured.

While a detailed guide to evaluating life skills programs is beyond the scope of this paper, existing life skills programs give examples of measures, indicators and evaluation plans that can be adapted and tested in the local context.

Chapter IV

Key Implementation Issues and Challenges

Exemplary life skills programs in Latin America and the Caribbean offer many lessons learned, as do programs in other parts of the world. The *PAHO Experts Meeting on Life Skills and Human Development*, which took place September 8-10, 1999, gave an overview of progress in the field in LAC. This section presents ingredients of successful implementation, and reviews the experiences of programs from LAC, as well as North America. To gain an understanding of implementation issues, we conducted telephone interviews with seven individuals who are directly involved in life skills programs from Costa Rica, El Salvador, Colombia, Venezuela and a regional initiative for the Caribbean countries.

The interviews focused on such issues as:

- Advocacy strategies to gain support for life skills in the health and education sectors
- Policy: what it states, is it enforced, and how life skills have influenced policy
- The conditions, concerns and interests of program providers
- Building cooperation across programs and sectors
- Marketing and disseminating the life skills approach
- The important role of materials as a tool
- Program sustainability and expansion
- The need for indicators and evaluation

At the heart of implementation is a planning process that begins with assessment. What outcomes does a country or community want to achieve? What assets and resources should be used? Ensuring a fit between the program to be used, the interests and needs of providers and young people, and local conditions and resources is essential. Chapter VI provides a tool to guide program planners through a relatively efficient process of considering all these issues to produce a customized conceptual framework relevant to specific national or local issues.

Overall, many health and education specialists note that too many efforts begin and end with a needs assessment. Often, the results are never translated into action. Planning, they note, is an important foundation, but not an end in itself.

A discussion of implementation issues follows:

[Advocacy Strategies]

Many of the interviewees report that senior level policy makers, in both the health and education sectors at the national and local levels, need to be convinced of the importance of health promotion and disease prevention strategies. Often with the focus on traditional academics in schools and treatment and curative care in the health sector, there is little room for prevention. Said one program director from the Caribbean, "Every day when you open the newspaper, there is an important human development issued presented –AIDS, malnutrition, violence. But there is no connection between this reporting and the public policy agenda. You know that when there is no debate or fight about the issues and their role in the budgeting process, they are not important. We must provoke these debates about the importance of prevention and skill building for young people, or we are sitting on a time bomb. We must provoke arguments about how to address them with the chief technocrats and have these issues feature prominently on the public agenda. We must clarify our language about health promotion and life skills. We must also learn to be more savvy in using the media, and health promotion has to do a better job of selling itself."

In advocating for life skills or skills-based health education, it is not always obvious which arguments or approaches work best with which audiences. What may be obvious or appeal to health and education planners first, may not be the most persuasive issue. For example, the chief of police for a U.S. college campus reports that the college president and trustees were not persuaded to take action when presented with statistics on high rates of student drinking, vandalism, sexual assaults, and related car crashes. What did make a difference was his report stating that a very large number of students were dropping out, due to alcohol-related problems, creating an **economic** loss for the university. Appendix B presents ideas for a variety of arguments concerning life skills and research evidence on its effectiveness. These arguments can be tested and adapted to suit your needs.

[Supporting Policy]

Most LAC program representatives stated that policy and legislation exist in their countries to support adolescent health promotion programs. Typically, they take the form of requirements for school teachers to address prevention of substance abuse or health education in general. Laws also exist in many countries of the Region to make adolescent health a priority.

However, ministries in many LAC countries have not operationalized these policies, citing a lack of materials and guides for teaching prevention, or training health personnel to use promotion strategies. Typically, no budget line items exist to fill these needs.

At the local level, LAC representatives report uneven support from school authorities and health directors. However, in some countries such as Colombia, program implementers noted that support for the life skills approach grew as school authorities began to see the impact of the program on teachers, students, and the environment in the school.

[Conditions, Concerns and Interests of Program Providers]

The enthusiasm, buy-in, and involvement of program providers, whether health workers, counselors, teachers or volunteers, are key to program success. In fact, many local programs have taken hold and expanded very successfully, without any national policies, due to the talent and commitment of the local participants.

One respondent commented on the challenge of gaining the support of program providers, as well as the necessity of involving them from the beginning stages of needs assessment. Often, these program providers are paid very low wages and live below the poverty level, taking on second jobs to survive. Responding to the concerns of providers and considering ways to develop their own life skills to achieve immediate and long lasting benefits in their personal and professional lives should be one priority for program implementation. As mentioned earlier, health promotion programs can provide positive benefits to the program providers themselves.

[Building Cooperation across Sectors and Programs]

Coordination between competing curricula and programs is one of the challenges, especially for schools, in incorporating adolescent health promotion programs. Many of the program directors frequently field complaints by overworked teachers about having to implement "yet one more program." In one common example, the health ministry relies on teachers to take a lead role in prevention during epidemics of malaria or dengue, as well as to implement separate health education programs on alcohol use, sexual education, and prevention of HIV. The Caribbean government agency, CARICOM, which acts as a coordinating body between countries and ministries, is working to reduce the duplication of health promotion efforts. Competition among different UN agencies, each offering different materials and curricula for health education, social learning and life skills, is confusing and often duplicative.

Life skills as an approach may now enjoy several advantages in the face of this challenge. First, the focus on skills development can defuse local tensions around approaching certain public health issues with adolescents, such as HIV/AIDS. Secondly, life skills can be seen as a unifying framework for health promotion that can cut across many different health and development issues. Substance abuse, citizenship, sexual health, building friendships, life planning and anger management can all be addressed within a comprehensive life skills program. And, exploring the connections between these issues and the related behaviors can enrich understanding.

Another positive development is that the UN agencies are signed on to a skill-based approach as part of a basic health package. The materials they offer may still be different, but at least there is a new consensus on the preferred approach and methods to be used.

Coordination between the health and education sectors has also proved challenging, although many interviewees note that the two sectors find common ground in the overlapping goals of life skills development, health education and health promotion was helping to surmount this barrier.

[Marketing and Dissemination]

In order for a life skills program to take hold and expand, the program's successes, lessons learned and materials need to be disseminated in some way. While most of the programs used in this analysis are still in the stages of pilot testing, a few found that the successful implementation of the program was selling itself. In Colombia, teachers who have used the life skills curriculum and directors of schools who have seen its impact are doing their own marketing; the teachers are training others in participative methodologies and in implementing a life skills curriculum. Others noted that an influential leader can best promote an effective life skills program.

[Program Materials]

Without adequate and appropriate materials, the ability to spread the use of a life skills approach is very limited. Of the very few evaluated programs, materials tend to be in English, which may or may not be relevant to the needs of countries in the LAC Region, and are costly to purchase or reproduce. Materials often need to be adapted to local needs, but practitioners often don't know how to do that without undermining the core aspects of the approach. Revision is made more difficult when health patterns, issues, and the research base change continuously.

Many interviewees report that developing curriculum modules for training program providers and working directly with young people are the most costly aspect of program development. Most of the programs did extensive bibliographic searches and consulted existing life skills programs, including *¿Cómo planear mi vida?, Sin drogas, Más libres*, the Life Skills Training Program of Cornell University, the life skills guides of the WHO, and the curriculum of Mexfam, an NGO in Mexico. Even when program providers decided to use a specific curriculum, they often found it difficult to adapt to their population and setting.

Materials reproduction is an ongoing challenge. Little agreement or understanding exists on questions such as: Who owns the product? Who has rights to reproduce the products in volume, and who provides the resources to do so? The following methods of reproduction, cited by the interviewees, have both advantages and disadvantages:

- Free distribution of materials by the government or other agency. This method enables anyone to receive materials. However, some individuals noted that when materials are free, people may perceive them to be of less value. Ideally, even if materials are free, they should be combined with training to maximize their effectiveness, as well as tracking of who orders and uses them to monitor efforts.

- Free licensing and permission that allows individual states, cities, or school districts to print their own from a master copy. This option reduces the centralized cost to the original publisher and encourages reproduction and use. However, control is lost over quality and monitoring of use. Giving away such rights also eliminates any incentives for the original publisher or NGO to reproduce and provide the materials.

- Selling materials for a modest fee to cover basic costs. Sometimes the program developer or NGO that has created the material is willing to reproduce and distribute the program. The user needs to pay a fee, but also benefits from the NGO's investment in advertising and promotion, quality control, monitoring of use, and ongoing revision and distribution. Training may also be provided with the program materials.

[Program Sustainability and Expansion of a Life Skills Initiative]

The scarcity of resources is a constant pressure for most of the programs, and program provider training is rarely ongoing. Research has shown that programs endure when providers receive a continuum of training, such as pre-training assessment, face-to-face skill building, and follow-up mentoring and coaching. Most of the LAC programs in this analysis are relatively new, so they are just beginning to develop mechanisms for follow-up. Structures for ongoing monitoring and follow-up include:

- El Salvador is developing intersectoral committees, consisting of representatives from the Ministry of Health, Ministry of Education, and NGOs that will monitor the progress of the use of the manual on Adolescent Health.
- Venezuela plans on developing a network, made up of persons from the Ministry of Education in the different districts, which will address issues of prevention and control of tobacco use, and monitor training and the curriculum.
- In Nicaragua and Costa Rica, individuals in the Ministries of Health and PAHO will monitor training and program implementation.

- In Colombia, personnel from the NGO that developed and implemented the program will continue to monitor the progress in schools.

Funding is often secured for only the first few phases of curriculum development, facilitator training or pilot-testing. As in many new educational and health initiatives around the world, sustaining resources for long-term implementation is a challenge. Institutionalization of the initiatives at the local level, with leadership from a local organization, was cited as a priority. The quality of planning for the many phases of program implementation often determines whether a program will be sustainable over the long term.

[Summary]

Many valuable lessons have been learned from existing programs in LAC, which can be helpful for guiding new life skills initiatives. Those key lessons are:

- Strong advocacy requires a clear understanding of the life skills approach and clear arguments, adapted to the particular audience and setting, for its effectiveness
- Data on local needs is critical for determining program objectives
- Buy-in and involvement of local program providers from the beginning, at the needs assessment stage, is key to program effectiveness and sustainability
- Program providers themselves have health needs that should be taken into account in program implementation, and can potentially be addressed through life skills programs
- The life skills approach can serve as a unifying framework for the many competing and duplicative adolescent health programs in a particular setting
- Support and technical assistance for curriculum development (which can involve either adapting pieces of existing curricula or developing original curricula) is needed at the Regional or country level
- Planning for all stages of the program, from needs assessment through institutionalization of the program, is key to sustainability

Chapter V

Moving the Agenda into the Future

The life skills approach can potentially change the way adolescent health promotion is addressed in the Region. By providing a unifying framework, this approach can help to move the Region away from the ineffective and costly single-problem focused strategies. Building on a conceptual foundation of skills, program developers have the flexibility to create highly innovative and creative programs.

Fulfilling this potential takes both vision and resources. In collaboration with the many local, country, and international organizations that provide leadership in this field, the Adolescent Health Program at the Pan American Health Organization proposes the following strategies:

(1) **Support countries to carry out programmatic and evaluation research** on effective life skills programs. Important research questions include:

- What age is appropriate for developing specific life skills?
- How does skills development differ by gender?
- How should a life skills program differ when implemented in different settings (e.g., a health clinic, a school or youth groups)?
- How should a life skills program differ when implemented by different program providers (e.g. social workers, counselors, volunteers, health personnel, teachers, parents or peer leaders)?
- What is the cost of a basic life skills program package?
- What modules should an effective provider training include?
- What short and long-term impact does skills acquisition have on adolescent developmental needs, protective and risk factors, and behaviors? What impact does it have on program providers, parents and the environment?
- How can a life skills approach best be adapted for parenting programs?

(2) **Support intersectoral and interdisciplinary collaboration** around the issue of life skills by coordinating adolescent health promotion efforts at the Regional and country level.

(3) **Support countries in the pilot testing of a variety of life skills programs that are**

- targeted towards the developmental and skills needs of girls
- applied in different settings (health centers, youth centers, schools, church groups)
- targeted towards different populations (urban/rural adolescents, younger/older adolescents, indigenous populations)
- implemented by different program providers
- targeted towards different skills needs and issues

(4) **Support the advocacy of a life skills approach.** This paper, along with others from the WHO, UNICEF, and other agencies, provides a conceptual foundation for this approach based on human development. A dialogue can be continued through regional conferences and meetings to develop a shared language and framework for the Region.

(5) **Support development of networks of life skills** program models, research, human resources, and institutions in the Region.

(6) **Mobilize resources for a life skills agenda.** The Pan American Health Organization will work with other partners to channel resources to move ahead this agenda that could make life skills programs a reality for the healthy development of adolescents around the Region.

Chapter VI

Customizing a Life Skills Conceptual Framework

The following are questions that can help you design a framework for a life skills program:

Vision
1a. What change do you want to affect in the healthy development of children and adolescents in the future—How? Why?
1b. How does your vision relate to larger national or local efforts in the education, health and youth sectors?
2. What are the **major issues** for the healthy development of children and adolescents that are important to address in your community or country?
3. What specifically are your **core beliefs** about the capacities of:

Children (ages 4-10)	Adolescents (ages 11-19)

4. What **theory(ies)** best fits with your vision of change, the issues to be addressed, and your core beliefs about the capacities of children and young people? Are you trying to change individual behaviors? Promote resilience? Prevent specific behaviors? Change social norms in the classroom or community?

5) What particular skills, for what age group, and what content will your program address?

Target age group _____

SKILLS	CONTENT
Social skills	
Cognitive skills	
Emotional coping skills	

6) **Explain your Program:** What is the simplest explanation of your life skills initiative?
Why do you think developing these skills in adolescence is important? Does the goal of the life skills program target issues of importance to the public?

Description of Life Skills Initiatives in the Americas

The following program descriptions give an idea of the initiatives in life skills that have been developed and are being developed around the LAC Region.

[Venezuela]

The organization *Prevención Alternativas*, an NGO in Venezuela, has been working on the issue of prevention and control of tobacco use, and subsequently has expanded this to include alcohol and other drugs. The initiation for the program came from PAHO's Program on Prevention and Control of Tobacco Use and the interest of the Ministries of Health and Education in Venezuela to address substance abuse in young people in the school setting.

The program consists of two interrelated components: the design of prevention curricula to use with adolescents in the classroom, and the development and testing of a teachers' manual and teacher training on drug abuse prevention.

The coordination for the program is carried out between the Pan American Health Organization, the government's Anti-Tobacco Commission (working with the Ministry of Health and the Ministry of Education) and two NGOs, *Acardio* and *Prevención Alternativas*. At the present time, *Prevención Alternativas* is developing the pilot test of the teacher training manual in 4 states of the country, plus the capital city, working with 2 schools in each state.

The teacher training manual is based on the experience of the Life Skills Training curriculum developed by Gil Botvin, existing curricula used in Latin America, including *Sin drogas, Más libres*, and the work around adolescent life project development.

The curriculum for training teachers includes the following components:

- Drawing out teachers' own perceptions about alcohol, tobacco and other drug use
- Theoretical framework of prevention of alcohol, tobacco and other drug use
- The role that teachers can play in preventing substance use
- Developmental framework of adolescence
- Development of life skills
  - *Self-esteem*
  - *Communication*
  - *Conflict resolution*
  - *Decision-making*
  - *Stress and anxiety management*
  - *Critical thinking – especially around understanding mass media messages*
  - *Handling peer pressure*

The teacher training will be approximately one week long and the focus is on training school counselors. Follow up to teacher training is expected to be addressed by a support network of educational coordinators that work in each district.

[Colombia]

The Ministry of Health in Colombia found in a 1993 study that violence, specifically homicide, was a leading cause of death in the country, and that young people were especially affected. Based on these findings, *Fe y Alegría*, a national-level NGO, was commissioned to develop and pilot test a curriculum of life skills development in their schools, targeting marginalized young people.

Three curriculum modules were developed:

1. Expressing and Managing Feelings
2. Assertiveness
3. Managing Conflicts

The specific health topics interwoven into the curriculum were violence, alcohol and tobacco use. The overall goals of the program were two-fold:

1. To open up the schools to focusing not only on the cognitive aspects of youth development, but also on the integral formation that includes emotional needs and social needs
2. To approach the problem of violence through the learning of interpersonal skills

Training of teachers was done on-going approximately twice a month. In the first meeting, teachers learned the tools of the participative methodology and the theory of adolescent psychology. In the second meeting, they learned to evaluate and reinforce the work in the classroom. The classroom curriculum was implemented in two-hour sessions per week.

Trained teachers are now beginning to train other teachers, and the follow up is conducted by the members of the *Fe y Alegría* staff. The life skills curriculum has been expanded to include critical thinking and decision-making, and in the future will possibly include modules on effective communication and empathy for the construction of community solidarity.

[El Salvador]

Two studies were key to the move to work on life skills development in El Salvador. The first was an epidemiological study of the situation of adolescent and youth health in the country, which identified a high incidence of teen pregnancy, a high incidence of violence among young people, and the pervasiveness of youth gangs. In 1997, a qualitative study about adolescence and reproductive and sexual health was commissioned by the Ministry of Health, UNICEF, and the German Technical Cooperation Agency (GTZ), and resulted in the formation of a technical team at the national level to address adolescent health issues. The national strategy for reproductive and sexual health included developing life skills in adolescence through the health service setting.

The curriculum for training health personnel was designed by an interdisciplinary team of educators, curriculum developers and psychologists. The first Unit of the curriculum is about life skills, and is adapted from a curriculum developed in Costa Rica for the Pan American Health Organization.

The training at this time is just beginning to be developed and will probably consist of one or two days of training, and three or four weekends working directly with young people on developing life skills. Techniques that will be used in training are role play, drawings, drama and group discussion.

The health personnel training will start with 25 municipalities which comprise the intervention zones. These are the areas of the country in which the GTZ and others already have experience. The Ministry of Health is identifying the health personnel who are assigned to work in the area of adolescent health as part of interdisciplinary health teams.

The follow-up to training and the monitoring of progress is expected to be done by intersectoral committees in each district, consisting of local education and health personnel, and staff from NGO's.

[Costa Rica and Nicaragua]

Costa Rica and Nicaragua are both involved in the process of training health personnel in how to work with adolescents in the community. The work in Costa Rica has a number of antecedents including the Ministry of Health program to form youth health promoters around the issues of AIDS, and the National Youth Movement working with young people in groups. The First Lady of Costa Rica has been very interested in the area of adolescent health and has been moving the agenda forward. In Nicaragua, the Ministry of Health has been exploring methodologies for how to work with adolescents in groups in the community. The *Brigadistas*, a national level community-based organization, has been moving this agenda ahead in Nicaragua.

The curriculum, which has been piloted in both Costa Rica and Nicaragua, was developed with a focus on the cognitive, affective and cultural context in which adolescents live, and included the role of learning life skills within that context as a part of the curriculum.

The curriculum modules include:

- Identity
- Reproductive and sexual health
- Violence prevention
- Self-esteem
- Peer pressure
- Solidarity
- Citizens' rights
- Adolescent rights
- Citizenship

The five-day long training of health personnel incorporated the use of participative methods, including role play, dramatizations, group games and open discussions. Three days were spent training health personnel in content and theory about adolescence and the group process. In the last two days, young people from the community participated in the training to give the health personnel an opportunity to work hands-on with adolescents. The goal of the training is to allow health personnel to develop and work with groups of adolescents in their community.

The training in Nicaragua was just completed and leaders within the Ministry of Health are in charge of following-up and monitoring the progress of the work done by health personnel with young people. In Costa Rica, the Ministry of Health will monitor the development of adolescent groups through their national adolescent health program.

[Caribbean Community Member Countries (CARICOM)[2]]

The CARICOM member countries have a longstanding history in the area of life skills, dating back to at least 1981. Health and Family Life Education (HFLE), the term of reference that CARICOM uses for life skills, aims to empower young people with skills such as decision-making, creative thinking, critical thinking, and the ability to empathize in areas relevant to a young person's physical, emotional and social health.

In 1981, PAHO and the University of the West Indies (UWI), Cave Hill Campus, Barbados, formed a partnership with the goal of strengthening the health curriculum in the Teachers' Colleges in the Eastern Caribbean. In 1982, 1983 and 1984, they conducted workshops to develop a prototype HFLE curriculum for teacher training programs and a plan to introduce the curriculum into Teachers' Colleges. At these workshops, participants also developed a plan to produce modules in HFLE, develop strategies to implement and evaluate them and provide training for teacher trainers. From 1985 to 1991, this initiative lost most of its momentum.

In 1991, partly in response to a set of CARICOM guidelines on HFLE, an interagency group was formed and convened by PAHO, and included UNESCO, UNFPA, the Carnegie Project and Faculty of Education, UWI, Cave Hill Campus. Their main purpose was to develop a core curriculum guide, which they accomplished by producing, "Core Curriculum Guide for Strengthening Health and Family Life Education in Teacher Training Colleges in the Eastern Caribbean in 1995." Many Teachers' Colleges in the region used the Core Curriculum Guide as the framework for their HFLE program, devoting from 40-60 hours of teaching time to HFLE as an optional course.

Parallel to this effort, the Fertility Management Unit (FMU) of the Department of Obstetrics and Gynecology at the University of the West Indies, Mona campus, in Jamaica, provided important input to HFLE. Through the leadership of Dr. Phyllis McPherson-Russell, FMU had been delivering trainer-of-trainer programs for health education professionals in the Eastern Caribbean. In October 1993, FMU had organized a regional meeting in St. Kitts with representatives of Ministries of Education, the Teachers' Colleges, PAHO, and the Faculty of Education to address: 1) creating and managing change in HFLE and 2) meeting the need for training teachers in HFLE in the region. By 1995, FMU had trained approximately 300 people.

Through the CARICOM resolutions of the Standing Committee of the Ministers of Education in 1986,1988, 1992 and 1994, there was also support for the implementation and promotion of HFLE. The Regional Education Policy, developed through CARICOM and adopted by Ministers of Education in 1993, also called for the development of life skills. However, the extent to which these resolutions actually had an impact on the development and implementation of HFLE in member countries is difficult to track.

[2] Antigua and Barbuda, the Commonwealth of the Bahamas, Barbados, Belize, the Commonwealth of Dominica, Grenada, the Cooperative Republic of Guyana, Jamaica, Montserrat, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, the Republic of Suriname, and the Republic of Trinidad and Tobago.

In 1994, there was added commitment to HFLE when the CARICOM Standing Committee of Ministers of Education passed a resolution supporting the development of a comprehensive approach to HFLE by CARICOM and the University of the West Indies. In order to reduce overlap in the programs being implemented and curriculum overload, support was also solicited from United Nations agencies working in the region. The commitment gave rise to the CARICOM Multi-Agency Health and Family Life Education Project. Partner agencies include: the CARICOM Secretariat, Caribbean Child Development Center, UWI Schools of Education and the Advanced Training and Research in Fertility Management Unit (FMU), PAHO/WHO, UNESCO, UNDCP, UNFPA, UNDP, UNIFEM, and UNICEF. At that point it was agreed that UNICEF would conduct overall coordination.

In 1995, a very comprehensive report, "A Strategy for Strengthening HFLE in CARICOM Member States", presented in great detail the progress of the region, factors that presented obstacles and specific objectives for future activities. The report described the historical 20-year development of HFLE programs with most (93%) at the primary level, and an emphasis on content or information over skills and participatory methods. The report acknowledges that with no evaluation, the extent of implementation was unknown and there was significant variation from country to country. By 1995, the report stated that only Jamaica had developed a specific national HFLE policy, setting the framework for effective action by all national and international agencies. In other countries, statements had been made within overall educational policies to express government commitment to HFLE. The same report identified many factors that would determine the effectiveness and sustainability of HFLE programs. For example, there was a stated need to place HFLE high on the agenda of policy makers and to hold them accountable, in order to ensure that action is taken to implement national and international agreements. Another factor was ensuring coordination within and among donor agencies as well as between regional and national programs. It was found that uncoordinated timeframes and plans result in isolated and vertical programs. Another factor that made it difficult to carry HFLE forward was weak leadership. At the regional level, direction was inconsistent. At the national level, often just one individual in the Ministry of Education was designated to the mammoth task of strengthening HFLE programs in all schools in their country. Another factor was the school environment. This report recognized that HFLE is dependent on the larger vision of health promotion and the extent to which the school itself must promote health, links to health services and provide a healthy psycho-social and physical school environment. As has been described about Latin America, the Caribbean also faces a great need for quality materials, the use of participatory methods, and a strengthened infrastructure for teacher training.

In the period from 1995 to the present, individual countries made many efforts to develop curriculum and train teachers. For example, Grenada developed its own Health and Family Life Education Curriculum in 1996, as did St. Vincent and the Grenadines in 1997. St. Lucia, as well, made advances in creating and using HFLE curricula.

Momentum at the regional level slowed until recently. From March 26 to April 5, 2001, UNICEF, PAHO and the University of West Indies, Cave Hill, convened 30 teacher educators or tutors from Teachers' Colleges in the CARICOM countries (many of whom had long been involved in HFLE). The purpose was to: 1) strengthen tutors' skills in HFLE, particularly the use of interactive teaching methods across content areas and 2) develop action plans for sustaining HFLE back in their institutions. Perhaps at this time, there is more momentum to carry forward many elements of the strategy plan set forth in October 1995.

Definitions

Autonomy: The ability to behave independently, to do things on one's own.

Cognition: The process of organizing and making meaning of experience. Interpreting a statement, solving a problem, synthesizing information, critically analyzing a complex task; all are cognitive activities

Empathy: The capacity to share an emotional response with another person, as well as the ability to discriminate the other's perspective and role.

Locus of control: Generalized expectancies people hold about whether or not their own behavior will bring about the outcomes they seek.

Modeling: The process of learning through observing the patterns of behavior displayed by role models.

Perspective taking: The ability to see another person's point of view and predict the other person's thoughts and feelings accurately.

Role models: Individuals whose patterns of behavior are often observed, held in high regard, and used to guide the thoughts, feelings and actions of others.

Self-efficacy: A sense of confidence that one can perform the behaviors that are demanded in a specific situation.

Self-esteem: The evaluative dimension of the self that includes feelings of worthiness, pride and discouragement.

Self-regulation: Setting goals, evaluating one's own performance, and adjusting one's behavior flexibly to achieve these goals in the context of ongoing feedback.

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Appendix A

Life Skills Programs/Resources

Fe y Alegría
Colombia
Contact: Amanda Bravo, Coordinación Pedagógica Nacional
Calle 34 No. 4-94
Phone: (571) 323-7775
E-mail: fyacolcpnal@col.net.co

AIDS Action Programme for Schools
UNICEF—Zimbabwe
P.O. Box 1250
Harare, Zimbabwe
Contact: Fabio Sabatini
Phone: (263-4) 703-941; Fax: (263-4) 731-849

Curriculum 2005
South Africa
Department of Education
URL: http://www.polity.org.za/govdocs/misc/curr2005.html
Contact: Dr. Chabani Manganyi

Social Decision-Making and Problem Solving (ISA-SPS)
Department of Psychology
Rutgers University, Livingston Campus
New Brunswick, NJ 08903
Contact: Maurice Elias
Phone: (732) 445-2444; Fax: (732) 445-0036

Seattle Social Development Project (SSDP)
Social Development Research Group (SDRG)
University of Washington – School of Social Work
130 Nickerson, Suite 107
Seattle, WA 98109
Contact: David Hawkins
Phone: (206) 286-1805
Email: sdrg@u.washington.edu
URL: http://weber.u.washington.edu/~sdrg

Life Skills Training Program
Cornell University Medical College
Institute for Prevention Research
411 E. 69th Street, KB-201
New York, NY 10021
Contact: Gilbert Botvin
For information about research conducted with LST: (212) 746-1270
For information about the program or ordering curriculum materials, contact publisher:
1-800-636-3415 or (609) 921-0540
E-mail: sabrod@aol.com
URL: www.lifeskillstraining.com

Second Step Violence Prevention Curriculum
Research Network on Successful Adolescent Development Among Youth in High-Risk Settings
Grossman et al
The Committee for Children
2203 Airport Way South, Suite 500
Seattle, WA 98134-2027
Contact: Barbara Guzzo
Phone: (800) 634-4449; Fax: (206) 343-1445

Interpersonal Cognitive Problem-Solving (I Can Problem Solve)
Shure and Spivak
Allegheny University
Broad and Vine
Mail Stop 626
Philadelphia, PA
19102-1192
Contact: Myrna B. Shure
Phone: (215) 762-7205

Skills for Action
Quest International, Lions Quest Programs
P.O. Box 4850
Neward, OH 43058-4850
USA
Phone: (800) 446-2700
URL: http://www.quest.edu

Promoting Alternative Thinking Strategies (PATHS) Program
Prevention Research Center
Pennsylvania State University
Henderson Building
South University Park, PA 16802
Contact: Mark Greenberg
Phone: (814) 863-0241; Fax: (814) 863-7963
URL: http://weber.u.washington.edu/~paths/

Teenage Health Teaching Modules
Center for School Health Programs
Education Development Center, Inc.
55 Chapel St.
Newton, MA 02458
Contact: Christine Blaber

Resolving Conflict Creatively Program
Aber, Jones, Brown, Chaudry, Samples
RCCP National Center
163 Third Ave., #103
New York, NY 10003
Contact: Linda Lantieri
T: (212) 387-0225
F: (212) 387-0510
E-mail: ESRRCCP@aol.com

Social Competence Program for Young Adolescents
(Formerly called: Positive Youth Development Program – Yale/New Haven Social Problem Solving Program)
E-mail: rpw@uic.edu
Roger Weissberg

Appendix B

Life Skills Advocacy Tools

[Why Use a Life Skills Approach?]

- Social, cognitive and emotional coping skills are **essential components for healthy development in childhood and adolescence,** and are needed for making a successful **transition from childhood to adulthood**.
- Life skills programs can specifically address the needs of **children growing up in disadvantaged environments** that lack opportunities to develop these skills.
- Social competence and problem-solving skills are among the characteristics that **define a resilient child**.
- Knowing how to manage emotions and interpersonal relationships is as important **to success in life** as intellect.
- Health promotion and prevention **programs focusing only on transferal of information are less effective** than programs incorporating skills development.
- The social, cognitive and emotional coping skills targeted by life skills programs are shown to be **mediators of problem behaviors.**
- Life skills have an impact on **multiple adolescent health and development needs**.
- A life skills approach helps schools address multiple demands for prevention education curricula by presenting a **comprehensive, unified approach** to meeting many needs.
- Communication skills, decision-making skills, critical thinking skills, and negotiation skills needed for healthy development are also **skills that are valued by employees in the workplace**.
- Life skills programs **promote positive social norms** that can impact the greater environment of adolescent health services, schools, staff and families

[What Research Shows]

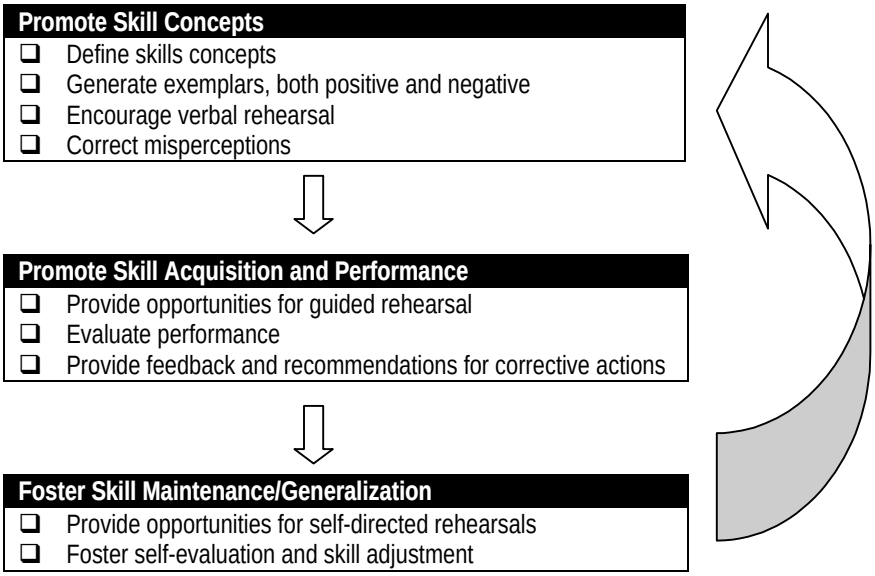
Life skills programs can:

- Delay the onset age of the **abuse of tobacco, alcohol, and marijuana** (Hansen, Johnson, Flay, Graham and Sobel, 1988)
- Prevent **high-risk sexual behavior** (Kirby, 1994; Schinke, Blythe and Gilchrest, 1981)
- Teach **anger control** (Deffenbacher, Oetting, Huff and Thwaites, 1995; Deffenbacher, Lynch, Oetting and Kemper, 1996; Feindler, et al, 1986)
- Prevent **delinquency and criminal behavior** (Englander-Golden et al, 1989)
- Improve health-related behaviors and **self-esteem** (Young, Kelley and Denny, 1997)
- Promote positive **social adjustment** (Elias, Gara, Schulyer, Branden-Muller and Sayette, 1991)
- Improve **academic performance** (ibid)
- Prevent **peer rejection** (Mize and Ladd, 1990)

[Effective Life Skills Program Providers]

Can be.....	Should be perceived by adolescents as....	Should have these qualities....
❑ Teachers ❑ Counselors ❑ Peer leaders ❑ Social workers ❑ Health workers ❑ Parents ❑ Psychologists ❑ Physicians ❑ Other trusted adults	❑ Credible ❑ Trustworthy ❑ High status ❑ Positive role model ❑ Successful ❑ Competent	❑ Competent in group process ❑ Able to guide and facilitate ❑ Respectful of children and adolescents ❑ Warm, supportive, enthusiastic ❑ Knowledgeable about specific content areas relevant to adolescence ❑ Knowledgeable about community resources

[Cycle of Skills Development]



[Life Skills Programs: Informational Content]

*"The combination of **general skills training** with **domain-specific instruction** may be the most effective way to prevent particular social problems".*

Domain specific instruction can include how to:

- ❑ Negotiate sexual relationships
- ❑ Resolve conflicts without violence
- ❑ Prevent parasites or ringworm
- ❑ Refuse drugs and alcohol
- ❑ Develop positive peer relationships
- ❑ Critically analyze media messages
- ❑ Prevent anemia or iron deficiency
- ❑ Assert rights as a citizen
- ❑ Access community health services

[Life Skills Programs: Teaching Methodology]

*Effective life skills programs "replicate the **natural processes** by which children learn behavior."*

Natural processes include:

- ❑ modeling
- ❑ observation
- ❑ social interactions

*"When people **mentally rehearse or actually perform** modeled response patterns, they are less likely to forget them than if they neither think about them nor practice what they have seen".*

Skills can be practiced through:

- ❑ role playing
- ❑ situation analysis
- ❑ small group work
- ❑ debates
- ❑ one-on-one rehearsal
- ❑ decision mapping or problem trees
- ❑ literature content analysis
- ❑ relaxation and trust-building exercises
- ❑ games

[Life Skills Programs: Provider Training]

Effective training shows providers how to:

- ❑ establish an effective, safe and supportive program environment
- ❑ model the skills addressed in the program
- ❑ access resources for health information and referral
- ❑ apply interactive teaching methodologies: role plays, dramatizations, debates, small group work, open discussions
- ❑ manage group process
- ❑ address sensitive issues in adolescence
- ❑ provide constructive criticism and positive reinforcement and feedback

[Life Skills Sets]

Social Skills	Cognitive Skills	Emotional Coping Skills
Communication skills Negotiation/refusal skills Assertiveness skills Interpersonal skills (for developing healthy relationships) Cooperation skills	Decision making/problem solving skills ❑ Understanding the consequences of actions ❑ Determining alternative solutions to problems Critical thinking skills (to analyze peer and media influences)	Managing stress Managing feelings, including anger Skills for increasing internal locus of control (self-management, self-monitoring)

Skills-based health education including life skills: An important component of a Child-Friendly/Health-Promoting School. WHO gratefully acknowledges the generous financial contributions to support the layout and printing of this document from: the Division of Adolescent and School Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, Atlanta, Georgia, USA.Â The principles and policies of each of the above agencies are governed by the relevant decisions of its governing body and each agency implements the interventions described in this document in accordance with these principles and policies and within the scope of its mandate. iii. Life skills and leadership education programmes that address VAWG must be firmly rooted in theories of youth development, violence prevention and health behaviour change. Conduct a situational analysis or needs assessment before programme development to understand the needs and wants of a community and determine whether infrastructure exists or must be developed. Provide safe spaces for girls to meet, learn, build community and develop skills.Â To realize this dedicated approach to adolescent girls, international NGOs mobilized their resources and the Haiti Adolescent Girls Network established a small grant fund to support grassroots and local organizations, stipulating that they pay mentors a stipend and create spaces dedicated to adolescent girls.