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Development of UNICEF Latin America/ Caribbean (LAC) Well-Being Indicators

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DEVELOPMENT OF UNICEF LATIN AMERICA/CARIBBEAN (LAC) WELL-BEING INDICATORS

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PART 1: BACKGROUND

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Mark Edberg, Ph.D.

"We are not the sources of problems; we are the resources that are needed to solve them.
We are not expenses; we are investments.
We are not just young people; we are people and citizens of this world."
(From the Children's Statement, UN Special Session on Children, May 2002)

I. Introduction

In brief, the task of this overall effort is to develop a set of indicators (quantitative and qualitative) to monitor progress in addressing the health, well-being and rights of adolescent males and females in the LAC region. The underlying approach is one of positive youth development, in which youth are viewed as assets, not as problems. In order to determine appropriate adolescent indicators for this purpose, Part I of this document is a background paper that reviews research, program models, and international frameworks with respect to adolescents, then presents a definition of adolescent development and well-being that allows for the delineation of indicators of progress. The review in Part I thus includes: 1) current data on the state of adolescent well-being in the LAC region; 2) a summary of a wide range of youth prevention/intervention theories and approaches (including those known as "positive youth development"); 3) a summary of the rights-based approaches undergirding UNICEF programs and current perspectives and frameworks from the LAC region; and 4) a preliminary definition of adolescent well-being with implications for development of indicators. Within this review I will also include a brief discussion of current work I am engaged in regarding the development of a framework for understanding and measuring progress with respect to racial/ethnic health disparities in the U.S., which includes several ecological domains and respective indicators that may provide some insight as to structuring indicator domains.

In Part II, a set of domains for measurement and concomitant indicators is presented based on the background information in Part I, and based on an extensive review by UNICEF experts as well as input from adolescent experts and monitoring/evaluation representatives at a UNICEF-TACRO meeting held on October 3, 2008. Part II also includes a review of indicator sources, and a spreadsheet (in Excel format) displaying the indicator domains, indicators, and, where possible, data sources.

II. Situation Analysis – Adolescents in the LAC Region

Adolescence Defined

The Convention on Rights of the Child defines a child as "every human being below the age of 18 years unless, under the law applicable, majority is attained earlier" (Article 1). However, there is variation in the age range that is included under the category *adolescent,* which often includes ages that fall within the defined child range as well as those outside that range. The World Health Organization (WHO 1986; Bennet & Tonkin 2003) and the Pan American Health Organization define adolescent in the context of several related age groups: adolescent includes ages 10-19; young people includes those age 15-24 years old; and the "young population" refers to youth between ages 10 and 24. El Codigo de los Ninos y Adolescentes, in Peru, defines adolescents as between age 12 and 18 (see Rodriguez 2004). For purposes of this report, it should be noted that in the U.S., definitions differ by agency. The Centers for Disease Control and Prevention (CDC) points to the 10-19 year old range as defining adolescence, recognizing that there is a wide range of developmental variation within that age. CDC also refers to 20-24 year olds as young adults, but acknowledges that these young adults have many developmental and health needs similar to adolescents. The Health Resources and Services Administration (HRSA), however, in its *Bright Futures* guidelines, defines adolescence as between 11-21 years old (see National Adolescent Health Information Center 2004). A recent study of a health-related quality of life measure for (Reinfjell et al. 2006) defined "young adolescents" as between ages 13-15. Given that most definitions of adolescence include physical, sexual, cognitive, emotional and social components, age 10 is very likely the lowest reasonable age for the construct of "adolescent," even though variance in maturity occurs across social and cultural contexts.

Adolescent development (according to PAHO 1998) is defined as a continuous process in which adolescents develop competencies, life skills, and social networks. Competency is viewed as the ability to adapt to diverse ecologies and environments within a specific context. Health and well-being, education, employment, and social participation are essential to support adolescent development. Adolescent development is seen in a life-course perspective, such that it is critical to provide support for families, communities, and relevant institutions so that they can contribute to and shape adolescent development.

Health/Social Status of Adolescents in the LAC Region

The health and well-being of adolescents, as defined, is deeply tied to broad socioeconomic factors. In this respect, the Latin American and Caribbean region is arguably the most unequal region in the world (Shepard 2003), despite its relatively high GNI by developing region standards. The high GNI masks both country inequalities (Haiti and Nicaragua are both very poor) and serious within-country inequalities that very by income, geographic location, region, gender, and

ethnicity. By some estimates (ECLA), 50 percent of LAC adolescents are poor. The situation of adolescents overall is inextricably related to these inequalities and the poverty and social exclusion they represent. Inadequate educational and social spending, discrimination against ethnic minority peoples, rural-urban differentials, and many other factors contribute to a complex system of inequality. And even though adolescents represent approximately 30 percent of the region's population, and by some estimates, 70 percent of premature death among adults is due to conduct initiated during adolescence, many LAC governments have not made them a priority (Maddaleno et al. 2003).

Shepard's extensive review (Ibid) highlights the following areas of greatest concern:

- *Gender disparities*: In education (though improving), in labor and available jobs, among indigenous and rural populations, in sexuality, adolescent pregnancy and abuse, and (for boys) disproportionate school dropout, crime, violence and substance abuse.
- *Education*: High dropout rates, poor education quality, inadequate infrastructure, cost barriers, and other issues.
- *Child labor*: A significant percentage of children under age 14 are working due to family poverty. Advocacy and support programs have made some headway in this area.
- *Recreation and use of leisure time:* Youth unemployment rates are very high, especially in the Caribbean, but there are generally very little data on what adolescents do in their leisure time.
- *Adolescents involved in violence in communities*: The LAC region is the most violent in the world, particularly in connection with gangs and the drug trade. Violence is the leading cause of death for young Caribbean men. Some punitive policies towards gangs may be excessive and not account for non-violent gang related aspects.
- *Adolescents in detention and juvenile justice systems*: Abuse, torture and other deprivations are common, as is treatment of adolescents as adults. There are many barriers and inadequacies in these systems.
- *Child and adolescent abuse and exploitation*: There are substantial legal and cultural impediments to protection against abuse (physical and sexual), as well as forms of enforced abuse, related, for example, to sex trafficking, armed conflict, the drug trade, and street children.
- *Substance abuse*: A significant problem, especially for boys/young men. Alcohol is the most abused substance. Tobacco, marijuana, and a rising use of inhalants are problems.
- *Sexual and reproductive health including HIV/AIDS*: Though fertility rates have declined, sexual activity and risk at young ages is prevalent. HIV/AIDS is a serious issue with prevalence rates among adolescents highest in the Caribbean. Many factors contribute: Intergenerational sex, population and gender vulnerabilities, and particularly vulnerable populations such as commercial sex workers, MSM, and IDUs.

These issues should be understood in light of broad socioeconomic change in the LAC region over the past few decades. Among the key changes is the overall move to market economic structures in lieu of the older, autarkic or import-substitution models, creating on the one hand reduced inflation and selectively-increased wealth, and on the other instability, increased poverty and inequality (United Nations, World Youth Report 2007), which has serious impacts on the health, welfare, education and employment possibilities for youth. Substantial gains have been made in education over the region as a whole (e.g., enrollment, attainment). However, as noted, the overall figures mask significant disparities and exclusions. Educational opportunities "remain inadequate for a large proportion of urban youth; young people in rural areas tend to have even less access to formal schooling and are often effectively excluded from secondary and tertiary education" (Ibid, p. 51). According to ECLA data (2004, 2005), youth unemployment was higher in 2002 than in 1990. In 2002, about 18 percent of 15-19 year olds, and about 27 percent of 20-24 year olds were neither in school or work. In 15 of the region's countries at least one in four residents live below the poverty line; in seven of them more than half the population is poor (UNDP 2004). Associated with these kinds of conditions, echoing Shepard's overview, are violence[1], extensive migration (both internal and external), and mistrust of government and social institutions – including the idea of democracy itself.

At the same time, Many LAC countries have a rich tradition of political activism and participation, and youth have been a part of this, as evidenced in the Penguin Revolution of 2006 (see below). Yet there is evidence (World Youth Report 2007; Latinobarometro 2004) that motivation to participate in the political process is waning among youth, and that there is an increased tendency to participate – if at all – through demonstrations and non-conventional means. This may be a result of a relative lack of change in and through mainstream political institutions, and it also may be directly related to increases in poverty and social exclusion among youth.

Regional differences in adolescent health and well being can be illustrated by the different trajectories of HIV/AIDS. The Caribbean region, for example, has the highest HIV/AIDS prevalence rate in the world after sub-Saharan Africa. Data suggest that in one-third of all new cases, infection occurred between age 15 to 24. Of the 12 countries with the highest HIV prevalence in the Latin America and the Caribbean (LAC) Region, nine are from the Caribbean (see PAHO 2003); these include Haiti, the Bahamas, Guyana, Jamaica, and Trinidad and Tobago. About 83 percent of AIDS cases are diagnosed in people between the ages of 15 and 54; one-third of all new cases are in the 25 to 34 year-old age group. With an 8-10 year incubation period, about one third of these new AIDS cases resulted from infection between 15 and 24 years old (Ibid). The high incidence of HIV among youth has been linked to early sexual initiation and low condom use among young people. According to a nine country CARICOM study of adolescents in school, almost half (47 percent) of sexually active youth reported

[1] According to ECLA (2204), 62.5 percent of males age 15-24 who die in Columbia, and 46.1 percent who die in El Salvador are homicide victims.

not using a condom. The majority of St. Lucia at-risk youth interviewed for the study said they were worried about HIV/AIDS, yet the use and knowledge of contraception was low. In Jamaica, the level of knowledge about sexuality and contraception is reportedly high among adolescents, but it does not translate into preventive behavior (World Bank 2003). At the same time, the particular trajectories for HIV/AIDS risk in Mexico, Central America and South America are different, with country-specific variation in some cases.

The challenge addressed in this document and efforts to follow is to select indicators that both represent a holistic, diverse understanding of adolescent well-being and are practical to collect, so that an effective and useful monitoring protocol can be implemented.

III. Theoretical, Research and Other Models Related to Adolescent Well-Being

As one key basis for determining *what* to measure with respect to adolescent well-being indicators, the following section includes a broad review of models and approaches for understanding adolescent health, health risk, and well-being. These models/approaches include social/behavioral science approaches from the United States and other LAC countries, models/approaches that originate in planning and policy documents, and understandings concerning social justice that focus on issues of racism, exclusion, and health inequity.

1. Behavioral/Social Science Models – U.S. Based

There are a host of theoretical frameworks from behavioral/social science disciplines in the U.S. that are used to guide adolescent health prevention/intervention programs. Some of the most widely used frameworks focus on risk behavior and exposures to negative factors and situations that are correlated with health problems (Schwartz et al 2007 categorize these as “prevention science” approaches) – in other words, the focus is on prevention of the negative rather than support for the positive, though most of these approaches do include some support for positive or “protective” factors as well. The set of theoretical frameworks generally linked to the idea of *positive youth development* (PYD), by contrast, emphasize support for the factors/situations that promote healthy or positive behaviors (defined in different ways). Even so, the theory and practice of PYD takes many forms in the research and intervention literature, each of which has different implications in terms of the kinds of indicators that could be relevant. Unlike the general perspective common to UNICEF and related programs, PYD as it is employed in the United States is not typically a rights-based model or particularly related to democratic participation, but originates in social and behavioral theory, particularly theory related to adolescent development and its impact on health and risk behavior.

The following is a brief, summary review of a sample of current, major theoretical/program frameworks from this body of social and behavioral science,

ranging from those that are risk/negative exposure oriented to those that focus on positive development.

The Risk and Protective Factors Model

This is arguably the seminal theoretical framework underlying the several "prevention science" models, at least in the U.S. The *risk and protective factors* model is epidemiological in nature, addressing correlations between the presence or absence of one or more risk or protective factors in the lives of youth and negative behavioral outcomes, including substance abuse, sexual risk, school dropout, violence, and others. Hawkins, Catalano, and colleagues (Hawkins, Catalano & Miller, 1992; Catalano & Hawkins, 1995; Hawkins et al., 2000) synthesized the risk factor research[2] into the widely used, comprehensive approach that has been a template for prevention program funding across multiple agencies in the U.S. In brief, the model lays out an algorithm of factors (or forces) that, over the youth development process, are said to increase or decrease the likelihood that a given youth will engage in problem behaviors (violence, delinquency, substance abuse, school dropout, HIV/AIDS risk behavior, or others): Exposure to *risk factors* increases the likelihood of problem behavior; exposure to *protective factors* buffers the risk factors and reduces the likelihood of problem behavior. Under the Hawkins & Catalano model, risk factors are organized into the following domains: *individual* (e.g., biological and psychological dispositions, attitudes, values, knowledge, skills, problem behaviors); *peer* (e.g., norms, activities, attachment); *family* (e.g., function, management, bonding, abuse/violence); *school* (e.g., bonding, climate, policy, performance); *community* (e.g., bonding, norms, resources, poverty level, crime, awareness/mobilization); and sometimes, the domain of *society/environmental* (e.g., norms, policy/sanctions) as well. Protective factors under this model are not as well specified, and have been organized into a smaller set of similar domains: *individual* (e.g., gender, intelligence, temperament); *social bonding* (attachment/commitment to positive, prosocial individuals and groups); *healthy beliefs* and *clear standards for behavior* (in families, schools, communities).

Others following the same general approach have focused more extensively on *protective factors*. Thus several variants of this model focus more on protective rather than risk factors, with resulting programs concentrating more on enhancing protective factors and less on mitigating risk factors (Pransky 1991; Benson, Galbraith, & Espeland, 1994; Search Institute 1998; Benard, 1996, 1991) -- using the terminology *resilience* for these protective qualities (Garmezy, 1991). Behavioral outcomes are said to be determined by the degree of resiliency that exists in the face of risk factors that may be present (Benard, 1991). The protective factor approaches are clearly related to those that fall in

[2] The synthesis draws on a significant amount of research regarding the impact of risk factors across multiple domains (see, for example, Beier et al., 2000; Lipsey & Derzon, 1998; Loeber & Hay, 1997; Yoshikawa 1994; Grizenko and Fisher 1992; Hawkins et. al. 1992; Dryfoos 1990; Tolan and Guerra 1994; Kumpfer and Turner 1990–91; Brook et al 1990; Petraitis et al 1995; Dembo et al 1989; Spatz-Widom, 1989; Bell & Jenkins, 1993; Osofsky & Fenichel, 1994).

the applied developmental science or PYD category – these will be discussed in more detail below.

Problem Behavior Syndrome and Behavioral Cluster Models

A second group of theoretical models recognizes that exposure to risk factors creates a meaningful context for action beyond reactive behavioral responses to that exposure. These models have viewed risk for substance abuse, delinquency, early sexual activity and other practices together as a "problem behavior syndrome," where the risk factors and behavioral trajectories are similar and/or overlapping (Jessor & Jessor 1977; Donovan and Jessor 1985; Jessor et al., 1991; Donovan et al., 1988; Elliott et al., 1989), and occurring in peer clusters (Oetting and Beauvais 1987). Catalano and Hawkins (1995), for example, noted that of the 19 risk factors they identified for adolescent problem behavior, 16 are common for both delinquency and substance abuse; 11 are common for violence and substance abuse; and 9 are common for all three. Problem behavior approaches differ from risk/protective factors models in part because they frame risk behavior not just in terms of discrete or specific behaviors, but as elements within a pattern that reflects a general relationship of some kind between the individuals involved in these behaviors and the "conventional world"; that is, the segment of society for which the risk behaviors are viewed as negative or antisocial. (Keeping in mind that it is not just risk behavior, viewed objectively, that is at issue, for there are many risk behaviors that are conventionally viewed as acceptable, even admirable.)

Viewing risk behavior as reflective of a more generalized social position and worldview draws both from social control theories (e.g., Hirschi,1969) and strain theory (e.g., Merton 1938; Messner & Rosenfeld 1994) in the reference to a relationship between "deviant" individuals as a group and the rest of society that develops due to a lack of social bonding or to discordance between goals/needs and available pathways for attaining those goals/needs. Thus adolescents who, for a wide variety of reasons --including the frustration of aspirations due to poverty, racism, school failure, social disorganization in the community or family, or other such factors -- are said to have a low commitment to conventional society and do not endorse its values are more likely to engage in delinquent behavior and substance abuse, and are more likely to have stronger bonds to peers who are involved in the same behavior patterns (see Elliott et al., 1985, 1989; Hawkins and Weis, 1985).

This certainly makes intuitive sense; however, the nature of that worldview is not entirely clear, and is not sufficiently explained via the conventional/non-conventional or pro-social/anti-social dichotomies. For one, those dichotomies themselves are unclear: What is being assumed or operationalized in the construct "conventional society" for example, given the complex relationships between the multiple socioeconomic, racial/ethnic, religious and other subgroups that compose American, Latin American/Caribbean, and other sociocultural landscapes?

A key strength of the risk and protective factors approaches – clarity and cohesiveness -- also leads to an important weakness. As described above, risk

and protective factor approaches seek to identify specific correlates or predictive factors that can be analytically isolated and addressed as if the health risk behaviors at issue were the output of an algorithm, where the various risk factors or precursors are essentially equivalent operational units within that algorithm. Lost in this paradigm is the synthetic perspective, the idea that behavior and its antecedents have a coherence beyond any such algorithmic model. People process the conditions of their existence into ways of life that take on their own meanings and justifications, which then contribute to motivation for action – a quality that may be referred to as *generative* (Edberg 2007). Exposure to risk and protective factors may *set up* such conditions, but it does not explain how people configure and act in their worlds in light of such exposure.

Developmental Pathways Approaches

Another related perspective addressing the integration and operation of risk factors includes several theoretical approaches that have traditionally focused on crime and violence as an outcome of a developmental pathway (or trajectory) beginning at an early age. These pathway approaches, however, differ in key assumptions about the factors influencing a particular trajectory. Moffit (1997) offers a dual taxonomy of offenders, arguing that two key types of offenders are significantly different. For *adolescent limited* (AL) offenders, behavior is situational, temporary, and thus generally limited to adolescence (a product of lack of maturity, social influence, and other factors). The second and more serious type are *life course persistent* (LCP) offenders, who are said to have neuropsychological traits related to biological or early-exposure risk factors that set them on a permanent pattern of antisocial behavior beginning as a young child and persisting in stages throughout adulthood. Gottfredson and Hirschi's *general theory of crime* (1990) holds that violence and criminality result from low self-control that is a function of insufficient parental or social controls (e.g., monitoring, punishment). Lack of self-control becomes a permanent feature very early, before age 10, and is, according to the theory, a precursor to increasing involvement in delinquency and violence. Sampson & Laub (1993; in what is known as "age-graded theory") also focus on the role of social controls in determining the continuum of involvement in delinquency and violence over the course of an individual's development. However, there are important differences. Sampson & Laub do not view developmental trajectories as set or determined by early influences alone, but allow for individual agency and change across the lifespan. Social controls – and particularly informal social controls, including those related to social capital and conventional social involvement – may positively influence behavioral outcomes at any point during a life course. The nature of influential social controls, though, varies by general developmental or age bracket.

These three examples of pathway approaches reflect the way in which risk factor exposure is operationalized vis a vis behavioral outcome. While presenting the outcome of risk factor exposure in terms of some common attitude/behavior patterns with respect to delinquency and violence (e.g., lack of self-control, antisocial), these patterns are still largely framed as reactive to specific factors or

influences – though, as noted, Sampson & Laub allow for the interaction of individual agency within that overall process. The programmatic solution, just like the other theoretical approaches discussed thus far, is typically to mitigate or change those factors.

Self-Concept Models

Going beyond the syndrome or cluster theories is an approach that seeks to understand an internal dynamic behind clusterings of risk behavior and risk factors. A key construct in this research is *self-concept*[3]. Markus and Wurf (1987, pp. 299-300) describe self-concept as an internal mechanism that *mediates and regulates* behavior: "It interprets and organizes self-relevant actions and experiences; it has motivational consequences, providing the incentives, standards, plans, rules and scripts for behavior; and it adjusts in response to challenges from the social environment." Markus and Nurius (1986) further posit that an individual's array of self-representations includes *possible selves*—that is, representations of selves that could be, should be, are not desirable, and so on, or that represent past, current or future selves. These, according to Markus (1987) serve as incentives or motivation for behavior. Less clear, however, is the origin of these possible selves for a given individual. The literature on self-concept theory focuses on possible selves derived from internal physiological and cognitive processes or indirect learning (e.g., Bandura 1977, 1986; Anderson 1984a and b; Trope 1983; McGuire 1984; Suls & Miller 1977; Schoeneman 1981), but does not fully address the question of mechanisms through which broader sociocultural and context-based sources of possible selves are processed and incorporated.

Oyserman & Markus (1990) link adolescent self-concept and delinquent or violent behavior by proposing self-concept as a construct that could organize the diverse explanations for delinquency (as described in this review). If the "task of adolescence" is to "try on," experiment, and move towards resolving the question of identity/social role (Erikson 1968), then the "possible selves" element of the self-concept is said to be highly salient. If an adolescent is able to construct satisfying possible selves in the "conventional domains" of family, friends or school, these will serve as motivational resources in a successful transition to adulthood. If not, the adolescent may seek alternative ways to define the self. A pattern of delinquency and violence is one such alternative route towards positive, and prestigious, self-definition (Erikson 1968; Hirschi, 1969; Sutherland & Cressey, 1978).

That (negative) alternative route is only available if there is a social context that supports it. Thus self-concept theorists have linked the process of youth identity formation to specific social contexts. In particular, Oyserman and Packer (1996) explain the way in which the sociocultural group or context serves as a semiotic mediator, assigning meanings, possibilities and values to different patterns of action and thus providing a frame for interpreting and generating

[3] Interestingly, the bulk of this research occurred in the 1980s and early 1990s and has not been pursued extensively since.

action. Drawing from the theories of Ogbu (1991) and Bourdieu (1990; 1977) among others, they note that the identity-formation process is connected to the limits inherent in specific social fields as well; thus, for example, in high poverty situations where academic success, generally speaking, may not be perceived as related significantly to available life-paths, then the behavior patterns and meanings associated with academic success may not be valorized. By contrast, behaviors and meanings associated with life-paths that are viewed as salient will be more highly valorized. In a circumscribed social world where violence is connected to such life-paths, it will have a correspondingly higher social value and thus individual decisions to engage in violence are likely to be influenced accordingly.

A concern is that the possible selves construct has been operationalized via defined typologies of self – feared selves, expected selves, the popular self, etc., for purposes of assessing relationships between specific typologies and behavior. Although this provides a useful tool for comparative research, it may also limit the kinds of data obtained about the role and types of possible identities[4].

Socioecological Models

The self-concept theorists, particularly in their more recent work (e.g., Oyserman & Packer 1996) move towards a connection with an important body of theory that centers on the relationship between specific (health) risk behaviors (e.g., violence, drug dealing) and socioeconomic position; that is, where the nature of the involvement in violence and its causal constellation differ by the socioeconomic position of particular groups, and the political-economic context that shapes marginality and alterity. In this sense, the "possible selves" aspect of self-concept (to use Oyserman & Markus' terminology) is directly influenced by socioeconomic constraints present in particular communities. For example, it has been argued that drug use/involvement is motivated more powerfully by economic factors for minority youth than for nonminority youth. Research has shown that experimental drug use among adolescents is *positively* related to socioeconomic status (Baumrind 1985; Kaplan et. al. 1986; Simcha–Fagan et. al. 1986); that is, the kind of drug use characteristic of lower SES youth is less experimental and more connected to drug trafficking. And, clearly, drug trafficking places youth at much higher risk for violence (Herrekhol et al., 2000; Blumstein 1995; Spunt et al., 1990; Goldstein, 1985). The aggregation of social, economic and political conditions that promote a co-occurrence of risk behaviors has been described in other contexts by Singer as a *syndemic* (Singer 1994).

These arguments also draw from strain theory (e.g., Merton 1938; Messner & Rosenfeld 1994) and from theories concerning the isolated and uniformly poverty-ridden nature of inner city "underclass" communities (Wilson 1987; Sampson & Wilson 1995), where economic opportunities are so limited and there

[4] That limitation may be mitigated by a new version of the Possible Selves Questionnaire (PSQ) called the PSQ-QE, for "Qualitative Extension," in which the respondent is asked to provide an open-ended description of their most important future possible self and its meaning to them (see Kurtines et al. in press).

is a historical pattern of disconnection from mainstream economic activity, that drug selling and other aspects of the "street economy" become the dominant playing field for achievement, material gain and status (see also Bourgois 1996, 1989; Anderson 1999; 1992, 1990; Fagan 1992; Fagan & Wilkinson 1998; Edberg 1992), and thus have a strong role in the development and perpetuation of norms and attitudes about risk behavior, including violence. Some of the work in this area describes "codes of the street" that govern violent or other risky interpersonal interactions, with reference to the immediate social context of such codes.

Several theorists working from a socio-ecological approach also connect the structural context to identity. Focusing on young men, Messerschmidt (1993; 1997) described violence and other risk behaviors *as a means to achieve an appropriate performance of male gender where other routes are circumscribed*. Wilkinson's rich interview data from interviews with violent offenders is an exploration of the ways in which violence – and gun violence in particular -- becomes such an important tool for negotiating personal status (Wilkinson 2004).

Applied Developmental Science Approach

This is the approach most clearly connected to PYD. As described in Schwartz et al (2007), the *applied developmental science* approach centers on the concept that youth have the potential to *thrive,* defined as "fulfilling one's potential and contributing positively to one's community" (Ibid, p. 120). Akin to the "resilience" approaches introduced earlier in conjunction with the risk and protective factors model, the applied developmental science approach does not focus on risk exposure as the primary mechanism for unhealthy or "negative" behavior, but on protective factors or *assets* (Schwartz et al. 2007; Scales et al. 2000, 2005; Theokas et al. 2005; Lerner et al. 2005). In particular, the applied developmental science approach has been operationalized as "Five Cs" of positive youth development: *competence, confidence, connection, character, and caring*. The approach draws from earlier research (e.g., Lerner 1984) concerning the "plasticity of human development" (Schwartz et al 2007).

Because this approach is relatively new, development and testing of measurements/indicators of the "Five Cs" is still ongoing. A research base comparable to the prevention science approaches does not yet exist. Moreover, one of a number of key questions concerns the applicability of this approach across socioeconomic situations – are the "Five Cs" relevant to youth in a high poverty urban (or rural) setting? Across cultures and national contexts? Finally, how different is the applied developmental science approach from the protective factors/resilience school, or "positive" developmental pathways theorists such as Sampson & Laub (1993). The applied developmental science approach, as Schwartz et al (2007) note, still more or less operates in the same domains as the basic risk and protective factors approach – individual, family, peer, school, neighborhood. These domains may not be sufficient to account for broader societal, transational/global and even virtual domains that are increasingly present for adolescents.

It may also be the case – though there are no data to support this – that the idea of thriving and how it is defined needs work in order to become cross-culturally and cross-situationally appropriate. What does it mean to "thrive," for example, in a favela in Sao Paolo? Or in a tiny rural village in Honduras? In either location, the institutions of civil society are either marginally present or in a vastly different form than that envisioned by developmental science practitioners in the U.S. In short, the social field within which adolescent development occurs conditions to a great extent the nature of personal goals, expectations and the nature of succeeding or "thriving."

The Positive Youth Development (PYD) Approach

As a theoretical perspective, PYD evolved in reaction to the long history of adolescent development (from Lerner 2005: see, for example, Hall 1904; Freud 1969; Erikson 1959, 1968; Benson et al. 2006; Roth et al 1998) in which the developmental period known as adolescence has been viewed as a precarious and dangerous time such that, "if positive development was discussed in the adolescent development literature – at least prior to the 1990s – it was implicitly or explicitly regarded as the absence of undesirable behavior" (Lerner 2005, p. 3). Positive development "was depicted as someone who was *not* taking drugs or using alcohol, *not* engaging in unsafe sex, and *not* participating in crime or violence" (Ibid). Advances in the study of particular aspects of adolescence and development beginning in the 1960s and 70s laid the groundwork for more institutionalized research as evidenced (in the U.S.) by the Society for Adolescent Medicine, the Carnegie Council on Adolescent Development, and journals such as the *Journal of Adolescent Health* and the *Journal of Research on Adolescence*.

The emerging PYD perspective was built on an understanding that adolescence is a diverse developmental period in which youth interact with biological change within a multi-layered, ecological web of self and self-definition, and family, peer, social, societal and institutional relationships – a *person-context relationship*. As described by Lerner (2005 p.8; 2002), "A major source of diversity in developmental trajectories are the systematic relations that adolescents have with key people and institutions in their social context; that is, their family, peer group, school, workplace, neighborhood, community, society, culture, and niche in history." This perspective, in concert with work in developmental science, comparative psychology, and "positive psychology" (Seligman 1998a and b, 2002) produced a revised view of adolescence that integrates nature and nurture divisions, and encompasses a range of domains, including (Lerner 2005; Damon & Lerner 2006):

- Biological development (Gottlieb et al 2006)
- Perceptual and motor development (Thelen & Smith 2006)
- Personality, affective and social development (e.g., Bronfrenbrenner & Morris 2006; Rathunde and Csikszentmihalyi 2006)
- Culture and development (Schweder et al 2006)
- Cognitive development (Baltes et al 2006; Fischer & Bidell 2006)
- Spiritual and religious development (Oser, Scarlett & Bucher 2006)

- Diverse development (Spencer 2006)
- Positive youth development (Benson et al 2006)

Basic tenets of the PYD perspective incorporate these domains as well as domains that have been discussed within the context of other approaches (from Lerner 2005):

- PYD is promoted via a youth-context alignment. This involves the marshaling of developmental assets, and an understanding that community-based programs are a vital source of these assets.
- PYD includes the "Five Cs" outlined above with respect to applied developmental science, and the hypothesis that an individual manifesting the Five Cs across time ("thriving") will also manifest a 6th C, *contribution* – contributions to self, to family, to community, and to the institutions of civil society.
- PYD and risk or problem behaviors are inversely related.

In terms of potential indicators for the LAC region, there is one increasingly well-known set of indicators used in the U.S. (and in some LAC countries) that is associated with the PYD approach, and that contrasts clearly – albeit overlapping with respect to a few items -- with risk and protective factors approaches. This is the Search Institute's list of 40 developmental assets (www.search-institute.org/assets) that is said to represent a comprehensive inventory of positive youth development goals and measures. The entire asset list is organized under the following domains:

<u>External Assets</u>

- Support
- Empowerment
- Boundaries and expectations
- Constructive use of time

<u>Internal Assets</u>

- Commitment to learning
- Positive values
- Social competencies
- Positive identity

Within each of these domains, there are a number of specific assets that vary by age group. For adolescents, the specific assets are set out in Table 1.

TABLE 1: SEARCH INSTITUTE DEVELOPMENTAL ASSETS

Asset Type	Asset Name & Definition	Brief Description
EXTERNAL		

ASSETS		
SUPPORT	**Family Support**	Family life provides high levels of love and support.
	Positive Family Communication	Young person and her or his parent(s) communicate positively, and young person is willing to seek advice and counsel from parent(s).
	Other Adult Relationships	Young person receives support from three or more non-parent adults.
	Caring Neighborhood	Young person experiences caring neighbors.
	Caring School Climate	School provides a caring encouraging environment.
	Parent Involvement in Schooling	Parent(s) are actively involved in helping young person succeed in school.
EMPOWERMENT	**Community Values Youth**	Young person perceives that adults in the community value youth.
	Youth as Resources	Young people are given useful roles in the community.
	Service to Others	Young person serves in the community one hour or more per week.
	Safety	Young person feels safe at home, at school, and in the neighborhood.
BOUNDARIES AND EXPECTATIONS	**Family Boundaries**	Family has clear rules and consequences, and monitors the young person's whereabouts.
	School Boundaries	School provides clear rules and consequences.
	Neighborhood Boundaries	Neighbors take responsibility for monitoring young people's behavior.
	Adult Role Models	Parent(s) and other adults model positive, responsible behavior.
	Positive Peer Influence	Young person's best friends model responsible behavior.
	High Expectations	Both parent(s) and teachers encourage the young person to do well.
CONSTRUCTIVE USE OF TIME	**Creative Activities**	Young person spends three or more hours per week in lessons or practice in music, theater, or other arts.

	Youth Programs	Young person spends three or more hours per week in sports, clubs, or organizations at school and/or in community organizations.
	Religious Community	Young person spends one hour or more per week in activities in a religious institution.
	Time at Home	Young person is out with friends "with nothing special to do" two or fewer nights per week.
INTERNAL ASSETS		
COMMITMENT TO LEARNING	**Achievement Motivation**	Young person is motivated to do well in school.
	School Engagement	Young person is actively engaged in learning.
	Homework	Young person reports doing at least one hour of homework every school day.
	Bonding to School	Young person cares about her or his school.
	Reading for Pleasure	Young person reads for pleasure three or more hours per week.
POSITIVE VALUES	**Caring**	Young person places high value on helping other people.
	Equality and Social Justice	Young person places high value on promoting equality and reducing hunger and poverty.
	Integrity	Young person acts on convictions and stands up for her or his beliefs.
	Honesty	Young person "tells the truth even when it is not easy."
	Responsibility	Young person accepts and takes personal responsibility.
	Restraint	Young person believes it is important not to be sexually active or to use alcohol or other drugs.
SOCIAL COMPETENCIES	**Planning and Decision Making**	Young person knows how to plan ahead and make choices.
	Interpersonal Competence	Young person has empathy, sensitivity, and friendship skills

	Resistance Skills	Young person can resist negative peer pressure and dangerous situations.
	Peaceful Conflict Resolution	Young person seeks to resolve conflict nonviolently.
POSITIVE IDENTITY	**Personal Power**	Young person feels he or she has control over "things that happen to me."
	Self-Esteem	Young person reports having a high self-esteem.
	Sense of Purpose	Young person reports that "my life has a purpose."
	Positive View of Personal Future	Young person is optimistic about her or his personal future.

Note, however, that *none of the assets in the Search Institute list address broader political, societal or economic factors* that are often the cornerstone upon which other assets can be built.

Other Positive Youth Development (PYD) Formulations

The Search Institute together with the Social Development Research Group (Benson et al 2004) identified eight concepts of development needed for successful young adult development. They include 1) physical health; 2) psychological and emotional wellbeing; 3) life skills; 4) ethical behavior; 5) healthy family and social relationships; 6) educational attainment; 7) constructive engagement; and 8) civic engagement. The physical health, psychological and emotional well-being, and healthy relationship categories are domain-level categories, whereas the other categories refer to specific skills, attainments, or behaviors.

Lickona and Davidson (2005) identify eight strengths of character that are predictive of human flourishing over a lifetime. These strengths include being 1) a lifelong learner and critical thinker; 2) a diligent and capable performer; 3) a socially and emotionally skilled person; 4) an ethical thinker; 5) a respectful and responsible moral agent; 6) a self-disciplined person who pursues a healthy lifestyle; 7) a contributing community member and democratic citizen; and 8) a spiritual person engaged in crafting a life of noble purpose. Many of these eight "strengths" group together multiple strengths that are often perceived as deriving from distinct cognitive, behavioral, psychological, and emotional areas of development. One example would be combining cognitive skills with attitudes toward learning and ethics. Another would be combining observable behaviors, such as acting responsibly, with intrinsic values implied by being moral.

Health Promotion/Behavioral Theory

In addition to, and often integrated with the theoretical approaches described thus far, there is a significant body of social/behavioral theory that is used for health promotion efforts in general, not just those focusing on adolescent health behavior. These theoretical approaches can be categorized in terms of their explanatory level – where they locate the "cause" or agent of behavior: at the individual, social and group, or societal and cultural level (Edberg 2007). A very brief sample of these theories and their explanations of behavior, organized in these categories, is as follows:

Individual Level

- Health Belief Model (Becker 1974; Janz & Becker 1984): Behavior based on individual assessment of susceptibility, severity, costs and benefits of action, along with the presence of cues to action, and self-efficacy.
- Theory of Planned Behavior (Fishbein and Ajzen 1975; Ajzen & Fishbein 1980; Ajzen 1991): Behavior based on individual attitude towards the behavior, perception of norms related to the behavior, and perceived control over behavior.
- Transtheoretical Model/"Stages of Change" (DiClemente & Prochaska 1982; Prochaska & DiClemente 1983): Behavior change occurs in specified stages, with different principles of change relevant to each stage.

Social and Group Level

- Social-Cognitive Theory (Bandura 1986; 1977): Behavior results from reciprocal interaction between individual and social environment. Key principles include vicarious learning (via social models) and self-efficacy (confidence in ability to make behavior change).
- Social Network Theory (see Wasserman & Faust 1994; Pescosolido & Levy 2002): Behavior is a function of the relational characteristics of social networks (e.g., influencers, bonds, boundaries)
- Diffusion of Innovations (Rogers 1995): New technologies, information or behaviors are adopted by a group or populations in a complex process that involves influencers, knowledge acquisition, trial of behavior, and adoption decisions.

Societal and Cultural Level

- Community Mobilization (Freire 1970; Minkler & Wallerstein 2002): Communities engage in action to change conditions through processes of participation, capacity building, and empowerment.
- Political Economy (Singer 1994; Farmer 1998; Wolf 1982): Individual behavior is understood as a function (at least in part) of the surrounding political-economic situation – e.g., the distribution of wealth and resources, the availability and nature of employment, marginalization, and discrimination.
- Cultural Theory (Mead 1928; Geertz 1983; Kleinman 1981): Behavior is related to the learned and shared frameworks – among groups and

societies -- for interpreting, communicating and acting in relation to events, life-cycles, tasks, social roles, that are referred to as culture.

2. Approaches/Models from or Specific to the LAC Region

A considerable number of ongoing adolescent-related program efforts have been implemented in LAC countries, many in collaboration with UN organizations (e.g., World Bank, UNESCO, UNICEF), EU countries/funders, or global NGOs. While some adolescent programs and interventions draw from the social/behavioral science approaches described above, there is more of an emphasis within the LAC on participation/civic engagement strategies, as well as on issues of employability and employment protection, cultural identity, spirituality, and specific vulnerable populations (e.g., indigenous youth, street youth).

Youth Development as Participation

Much more prevalent in LAC discourse surrounding youth than in the U.S. is a focus on existing and emerging forms of civic participation among youth (e.g., Leon 1996) as an important marker of youth development. Most regional policy statements contain language regarding participation. Organizations such as Innovations in Civic Participation (ICP, at www.icp.org) have partnered with the Inter-American Development Bank Youth Unit to discuss ways to support capacity-building for youth service and volunteerism. Social participation of this nature is linked with democratization, and is viewed as a means of increasing social inclusion and participation in the development process. Programs that develop skills, knowledge and values to support strong communities and participatory culture contribute to this goal. The Inter-American Bank Youth Development and Outreach Program (IDB Youth) also focuses on the role that youth play in the building of democracies, sustainable economies and equitable society. Following this basic approach, IDB Youth engages in the following program activities targeting Latin American and Caribbean youth (www.iadb.org):

- Capacity building – training, leadership development
- Youth Network – A regional network of IDB youth delegates, involved as social entrepreneurs and agents of change
- Outreach and Communication – Public awareness, advocacy and a public-private collaboration for information and resource exchange
- Alliances – within IDB, to facilitate the work in support of youth
- Policy Advocacy and Formulation – Promoting policies in support off youth development
- Partnership Development – Promotes strategic alliances, represents the IDB on the Inter-American Working Group on Youth Development

The goal of participation is buttressed by efforts to improve information accessibility regarding youth activities, programs, support networks, and organizations. The UNESCO Youth Portal (Portal de Juventud para America

Latina y El Caribe), at www.youthlac.org is one such attempt. The Portal provides: theme and country information; records access and virtual library; youth event billboard; access to Internet tools for information management; chat room; e-groups and lists; technical/advisory support for groups working with youth; distance courses and seminars (e-learning); news bulletins; and a Latin American e-magazine for Youth Research and Studies.

While the focus in this paper is on the LAC region, addressing community participation is also a feature of global youth strategies in general, as evidenced, for example, in youth components of *Community-Driven Development* programs (World Bank 2006c), and in the policy and planning approach detailed by the Inter-Agency Working Group on Children's Participation (2008).

The issue of civic engagement and participation was highlighted by the recent (2006) "Penguin Revolution" in Chile, involving a mass walkout and strike by Chilean students as young as age 11 to protest inequalities in the school system, and demand free public transportation, free college entrance examinations, rehabilitated public schools, and equality of education. The student movement and its mass rallies, aided by cellphone technology, has been viewed by many as a new evolution in youth democratization (COHA 2006).

Life Skills Approach

The idea of life-skills development is a relatively common feature LAC adolescent development strategies, often discussed in connection to employment preparation (see below). A particular type of life skills approach is also recognized as a best practice in the U.S. (e.g. Botvin et al. 2006). The Pan American Health Organization life skills approach (PAHO 2001) draws heavily from several of the social/behavioral theories described above as U.S.- based, as well as others (U.S. and elsewhere) that are not mentioned.

- First, the document refers to child/adolescent development theory that encompasses: biological changes and adjustment to those changes (Eccles 1999); development of social cognition – including capabilities with respect to social relationships, self-assessment and self efficacy (Slaby et al. 1995; Newman & Newman 1998, Tyler 1991); cognitive development (Piaget 1972); social and family development (e.g., Csikszentmihalyi, M. and Schneider, 2000; Hansen et al. 1998); gender and development (e.g. Gilligan 1993); and moral development (e.g., Newman & Newman 1998; Kohlberg 1976).
- Second, the approach draws on social learning/social cognitive theory (Bandura 1986; 1977); problem behavior theory (outlined above in III.1); social influence theory (e.g., Evans et al. 1998; McGuire 1968, 1964); cognitive problem solving (Shure & Spivack 1980); the idea of "multiple intelligences" (e.g. Goleman 1997); and resilience and risk theory (outlined above in III.1).
- Finally, it draws on constructivist psychological theory, in which cognitive development and learning is understood to be a social (not individual) process (Vygotsky 1978).

In the PAHO approach, life skills to be developed through a range of program components are organized in three categories:

- *Social skills*: Communication, cooperation, interpersonal, empathy and others.
- *Cognitive skills*: Decision making, understanding consequences, critical thinking, and others.
- *Emotional coping skills*: Managing stress, anger, general self-management.

Programs based on or piloting this approach have been implemented in El Salvador, Venezuela, Nicaragua, Costa Rica and Columbia. Within CARICOM, the life skills approach is called Health and Family Life Education (HFLE) and has been in use sine the early 1980s, particularly in the Eastern Caribbean (PAHO 2001).

Youth Development and Employment

An additional and common focus of youth development programs in the LAC region is the preparation and capacity for productive employment. This may involve specific work skills, and it may also involve *life skills* (as described above), such as responsibility, teamwork, time management, values, communication, and others. An example is the International Youth Foundation's "entra 21" program, implemented in 18 LAC countries (World Bank 2006). These interventions typically include short-term training connected to labor market needs; a curriculum that includes technical training, job-seeking skills, and general life-skills; and internships with local employers.

In the Dominican Republic, the Youth Development Project includes several employment-related efforts. One is the *Youth Employment Program* (IDB 2001) or Juventud Y Empleo – JyE; the other is the Ministry of Education's *Second Chance Education* programs. Very much like "entra 21," the JyE program includes both life skills and technical/job-related skills, which are determined by market needs. The program is being evaluated with respect to its impact on employment, but also on self-esteem, return to education, risk behavior, gang involvement and violence (World Bank 2006b). The *Second Chance* program is an attempt to address the very low 53 percent secondary school completion rate. Youth leave school because of the need to earn money as well as other factors, and thus the program offers flexible evening and weekend classes at low expense to complete basic 8th grade education or a high school diploma. The curriculum also includes life skills training.

Resiliency

The concept of *resiliency* in the LAC region and generally outside the U.S. context may have a broader meaning than it does within the U.S. Escalante (2007) argues that in the U.S. the term refers to a kind of *homeostasis,* an ability to return to a "normal" state following a traumatic or difficult experience. By

contrast, the broader meaning refers to a lifelong self-development process that incorporates the following dimensions:

- A self-confidence in the face of adversity that comes from moral depth, and from personal convictions.
- A capability to show empathy, altruism, and compassion, and to share in the suffering of others.
- Values and a deep appreciation for life that are neither just intellectual nor experiential, but allow a resilient individual to "accept the paradoxes and uncertainties of existence."

In addition, resiliency is a quality that relies on personal characteristics, a supportive community/social group, and cognitive aspects – perceptions of control, adaptability, etc.

To foster resiliency in youth and adolescents, the following are viewed as general strategies:

- Instill the capacity for caring and supportive social relations.
- Help youth learn to care for others, through volunteerism and other activities.
- Help youth establish routines and structure.
- Help youth learn to rest, relax and conserve strength.
- Help youth learn to take care of themselves, in their diet, exercise, and habits.
- Help youth learn how to advance towards their goals, including the achievement of small or incremental gains.
- Help youth build and maintain self-esteem.
- Help youth learn to put things in perspective and maintain a positive attitude.
- Help youth look for opportunities for self-discovery.
- Help youth to understand and accept change as part of life.

Finally, resiliency can be said to be constructed via five "building blocks": confidence, autonomy, initiative, work, and identity.

This broader construction of resiliency, however, is not always the way in which it is used or interpreted in the LAC. A major recent study of adolescent health in Jamaica, for example (Wilks et al. 2007; Fox & Gordon-Strachan 2007), defines resiliency as "any characteristic/factor which protects persons from engaging in risky behaviour which include early unsafe sexual activity, violence, and ganja (marijuana) smoking "(Wilks et al. 2007, p. 3). This is very much the same understanding of resiliency as described in Section III.1 above in conjunction with "protective factors."

Youth Development and Sexual/Reproductive Health (The Guttmacher Institute)

Adolescent health and well-being in the LAC region has also been understood with respect to connections between sexual/reproductive health and broader youth and family issues. According to the Guttmacher Institute (accessed at www.guttmacher.org) increased and sustained investment in sexual and reproductive health services results in tremendous benefits to women, families and societies. In addition to improving overall health, sexual and reproductive health services contribute to economic growth, societal and gender equity, and democratic governance – and thus to adolescent well-being.

The *Protecting the Next Generation Program* in the LAC region seeks to persuade key decision makers to acknowledge and address young people's sexual and reproductive health needs with regard to sex education, contraceptive access and counseling, and prevention of sexually transmitted infections (STIs), including HIV. The Guttmacher Institute documents and analyzes young people's knowledge, concerns, preferences and behavior; examine and suggest evidence-based improvements to policies and programs; and communicate this knowledge to policymakers, health care providers, media, researchers and activists.

In the LAC, the Guttmacher Institute works with research and communications partners in Guatemala, Honduras and Nicaragua—in collaboration with the Pan American Health Organization and a regional research center in Costa Rica (also with support from the Swedish International Development Cooperation Agency) -- to identify and address the sexual and reproductive health needs of adolescents in Central America. The project aims to increase awareness and understanding of the factors that place young people at risk for early, unwanted pregnancy and STIs in each of the three focus countries. The Institute is also working to assess existing youth-oriented policies and programs in each country, identifying opportunities to implement policy recommendations.

3. Models from Planning and Policy Documents

These models are not primarily *scientific* models, in the sense that they are not typically the basis for theoretical research, empirical research, or specific research-based program models. Instead they are framed as the basis for understanding the issue and general policy/program development. At the same time, they are often broader than strict science-based models, and incorporate social circumstances, inequities, and other elements that are difficult to include in a scientific paradigm.

Pan American Health Organization (PAHO) Regional Strategy

The goal of the most recent (draft) *Regional Integrated Strategy for Adolescent and Youth Health 2008-2018* (PAHO June 2008) is to strengthen the integration of the health sector's response and coordination with other sectors, and to: (a) protect the achievements made in existing National Adolescent Health Programs, (b) address the unfinished agenda in guaranteeing young people access to integrated health services that incorporate prevention and promotion with a focus on reaching vulnerable groups, and (c) respond to new challenges

brought by the changing context (e.g., economic changes, demographic "window" in which there is a larger proportion of working age persons relative to the dependent population).

Importantly, the Strategy defines a healthy adolescent or youth as someone who fulfils the biological, psychological and social tasks of development with a sense of identity, self-worth and belonging, sees a positive path for the future, is tolerant of change and diversity, and has the competencies to engage as an active member of the community and labor force. According to PAHO, this is manifested in young people as *healthy eating habits, engaging in physical activity, mental health and wellness, and a responsible and positive approach to sexuality and sexual health* – though for purposes of this paper it should be noted that these indicators do *not* clearly reflect the definition of adolescence that precedes them.

Policy prescriptions from the Strategy are outlined below in Section IV.

World Health Organization (WHO) Adolescent Health and Development Initiative

Although somewhat dated, the very comprehensive WHO report entitled *Programming for Adolescent Health and Development* (WHO 1999) acknowledges a shift from policies and services that focus solely on prevention (of negative risk behavior) to those that focus on building the potential of adolescents, and the attainment of an array of skills. Among other key documents, the WHO Strategy references the prescient Ottawa Charter for Health Promotion, which – even at the time of its adoption in November 1986 -- outlined the following prerequisites for health: peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. With respect to programs and strategies that share a holistic approach, the WHO report cites a number of examples. One program is the Adolescent Development Programme of the Service Volunteered for All (SERVOL) program in Trinidad and Tobago, which uses the Spiritual, Physical, Intellectual, Creative, Emotional and Social (SPICES) curriculum aimed at overall personal development (Cohen 1991).

A second exemplary approach described in the WHO report comes from the Carnegie Council on Adolescent Development (1995), which defined a generic set of abilities that goes beyond academic or cognitive competencies to include vocational, physical, emotional, civic, social, and cultural competence. The outcomes of adolescent development are summarized as follows:

- *Self-worth* – the ability to contribute and to perceive one's contribution as meaningful; the perception that one is a "good person" and that one is valued by oneself and others;
- *Safety and structure* – the perception that one is safe both physically and psychologically, in other words, access to adequate food, clothing, shelter, and security, including protection from hurt, injury, or loss. The existence of organized group structures in life can allow young people the freedom to experiment with behavior and to test their social abilities, while providing limits;

- *Belonging and membership* – being a participating member of a community; involved in at least one lasting relationship with another person; the perception that one is strongly attached to an institution, organization or community outside of family;
- *Intimate relationship* – the perception that one is loved by kin, and fully appreciated by friends;
- *Mastery and future* – the perception that one is accomplished and has abilities valued by oneself and others; awareness of one's progress in life;
- *Responsibility and autonomy* – the perception that one has some control over daily events; one is a unique person with a past, present and future roles to play;
- *Spirituality* – connectedness to principles concerning families, cultural groups, communities and ideas of the divine; an awareness of one's own personality and individuality.

Achievement of these outcomes entails the building of "key life skills" that will allow youth to function within, and contribute to, the communities and societies in which they live. Key life skills are 'abilities for adaptive and positive behavior that enable individuals to deal effectively with the demands and challenges of everyday life." The goals of this process can be categorized as follows:

- *Physical health and development* – using the knowledge, desire, and ability to develop and maintain a healthy and fulfilling lifestyle; acting in ways that best ensure current and future physical health, for oneself and others;
- *Intellectual development* – learning in school and other settings to gain basic knowledge, numeracy, literacy; using critical thinking, creative problem-solving and expressive skills and conducting independent study;
- *Vocational heath and employability* – the mastery of skills and attitudes to identify opportunities for economic security, including management of time and money, and dealing with other people in commercial relationships: understanding career options and the steps necessary to reach goals;
- *Civic and social health* – collaborating with others for the greater good; the knowledge, motivation and ability to form and sustain friendships and relationships through communication, cooperation, empathizing, negotiation, patience; and taking initiative and responsibility for one's own conduct;
- *Cultural health* – understanding and respecting one's culture;
- *Emotional health* – acquiring the knowledge and ability to develop and maintain a personal sense of well-being; and understanding one's own emotions and adapting to changing situations;
- *Moral development* – understanding and acting upon the distinctions between right and wrong.

In an analysis of over 100 programs in the United States that address delinquency, prevention pregnancy, drug use, and dropping out of school, *six common themes (guiding concepts) emerged as vital to successful outcomes*:

skills building; participation; membership; norms and expectations; adult-youth relationships; and accurate information/services. The Carnegie report urged youth program developers to think beyond information and service provision and provide meaningful personal support and opportunity. Moreover, to link programs and an assessment of their intended youth populations, it may be necessary to categorize the circumstances in which some adolescents live: temporary or permanent loss of family and/or primary caregiver; sexual abuse or exploitation; disability; warfare or other emergencies; addiction; extreme poverty, especially when this leads to work in hazardous situations.

The WHO report adds that a necessary step in the planning and programming process is to clarify guiding concepts, and to determine whether the guiding concepts that underlie the goal of investing in young people's long-term development differ from those which underlie programmatic responses to problems that result in illness and injury among youth. Assessment and analysis of the situation for youth (in any country) should include:

- information on adolescent health status and behavior – both with positive (resilience and coping) and negative implications on health and development
- the social and political factors influencing such behavior, since the context in which young people live is not only rapidly changing, but is also specific to their societies.
- The current sectoral responses provided for adolescents in a variety of settings
- Availability and usage of activities in the areas of health care, education, social support, recreation and vocational training offers a picture of both the potential opportunities for young people and a profile of those reached

According to WHO, the assessment process is typically hampered by the lack of systems in place to routinely collect basic health status information. Moreover, data categories often pertain to children and adults, and therefore the data needed to support the case for addressing adolescent problems frequently do not exist, resulting in the so-called "measurement trap" (WHO p. 159).

A common feature of successful country efforts to assess the situation of adolescents is the establishing of an interagency, cross-sectional task force or collective body to jointly assess the country situation, improve data collection systems, and initiate a planning process. It is important that data about adolescents be obtained from all relevant sectors because no single sector deals with all the aspects of adolescent life: governmental agencies (ministries of education, justice, youth, finance, labor, health, and the census bureau); intergovernmental agencies; bilateral donors; NGOs; academic institutions; mass media; families. Finally, understanding the capacity of the various settings to provide interventions and related training is key to identifying needs for technical assistance and locating technical resources.

International Youth Foundation

Founded in 1990, this international organization identifies and secures support for programs around the world (in some 70 countries) that demonstrate effectiveness in making positive change in the lives of young people. These programs, documented in IYF's *What Works* publications, focus around four themes that IYF has identified as key for positive youth development:

- *education* and learning opportunities, both in and out of school;
- *employability*, to improve young people's ability to find employment, engage in entrepreneurship, and engage in productive work;
- *leadership and engagement*, to inspire support and promote youth engagement and citizenship; and
- *health education and awareness,* to prepare youth/young people to live healthy lives and to have the skills and knowledge necessary to make informed choices.

These program areas are based on a conception of prevention as building the confidence, character, competence and "connectedness" of young people.

The following table (Table 2) summarizes a selection of the models/approaches reviewed above and their implications for programming and measurement.

TABLE 2: THEORETICAL AND PROGRAM APPROACHES TOGETHER WITH THEIR OPERATIVE DYNAMIC, THE TYPE OF PROGRAM COMPONENTS, AND MEASUREMENT

Theory/Approach	Operative Dynamic	Program Response/Outcome Measurement
Risk/Protective Factors	Exposure to risk vs. protective factors	Reduce risk factors, support protective factors. *Measured by*: Baseline and followup assessments of change in the specified indicators (many instruments already developed).
Problem Behavior	Exposure to multiple risk vs. protective factors, creating high risk peer groups	Reduce clusters of risk factor exposure, support protective factors. *Measured by*: Baseline and followup assessments of change in the specified indicators (many instruments already developed).

Pathways	Early exposure to internal/external risk factors creating trajectory of delinquent behavior	Early identification, treatment of temperament and control problems; or later change in control environment. *Measured by:* Baseline and followup behavioral assessments, risk factor measures.
Self-Concept	Perceived possible selves motivates behavior to achieve self-concept that is socially valued	Among adolescents, work to expand perceived possible selves (as motivators and mental models) to include positive selves that are integrated with and contribute to community and society. *Measured by*: Baseline and followup Self-Concept instruments such as the Possible Selves Questionnaire (Kurtines, in press).
Socioecological	Socioeconomic context shapes utility and value of risk behavior patterns, including substance use and selling, violence	Change socioeconomic environment to increase availability and value of non-criminal opportunities. *Measured by*: Change in community socieoeconomic measures (number of jobs available, etc.); baseline/followup measures of opportunity perception.
Applied Developmental Science and Positive Youth Development (PYD)	Youth have the potential to thrive if developmental assets are supported	Marshaling of community, school, family and other supports to maximize development of the “5 Cs” (or “6 Cs” with the addition of contribution). *Measured by:* Developmental Assets instrument, measures of

		resources/programs available.
Health Promotion Theory: Individual	Health behavior results from individual decisionmaking processes	Education, skill-building, seek to impact behavior decision process. *Measured by:* Baseline and followup assessments of knowledge, skills, attitudes.
Health Promotion Theory: Social and Group	Health behavior results from individual-group interaction, group processes	Change group processes, build support networks, support individual ability to interact positively with group influence. *Measured by:* Assessment of change in group processes, tracking of change in group behavior or norms.
Health Promotion Theory: Societal and Cultural	Behavior tied to social, structural, cultural context and constraints	Necessary to make change in structural, contextual conditions (e.g., through policy), and broad public (cultural) attitudes (e.g., through media). *Measured by:* Change in broader social indicators, changes in (shared) cultural beliefs and practices.
Youth Development as Participation	Development and social competence related to participation in public decision making processes strengthens connectedness to society and reduces risk behavior	Increase opportunities for youth participation in local, national governance and information dissemination. *Measured by:* Data on number of youth involved in governance, number of youth-based dissemination outlets (Internet, other)

Life Skills/Employment Development	Development of general skills and employment skills increases the likelihood of academic and employment success, reduces alienation and delinquency	Curricula and skills based programs that focus on development of life skills. *Measured by:* Competency assessments (program level), youth employment data
Resiliency	A combination of confidence, positive attitude, adaptability, supportive social relations, work, values, goal-setting and other qualities helps adolescents remain resilient in the face of adversity	Programs, curricula or activities that specifically foster these qualities and help adolescents develop autonomous capabilities. *Measured by:* Survey or interview data with items reflecting the idea of resiliency; data on evidence of achievement or success
Social Inclusion/Exclusion	Behavior of youth is related to degree of "connectedness" with society – thus exclusion promotes anti-social behavior and goals	Policies and legal remedies to ensure equity, prohibit discrimination or exclusion, support participation, and support economic opportunities. *Measured by:* Documenting policies and legislation, compliance, educational attainment, income distribution, employment, data on representation.

4. Health Disparities, Racism and Social Exclusion and Connections to Adolescent Well-Being

The Connection between Racism/Discrimination and Adolescent Behavior

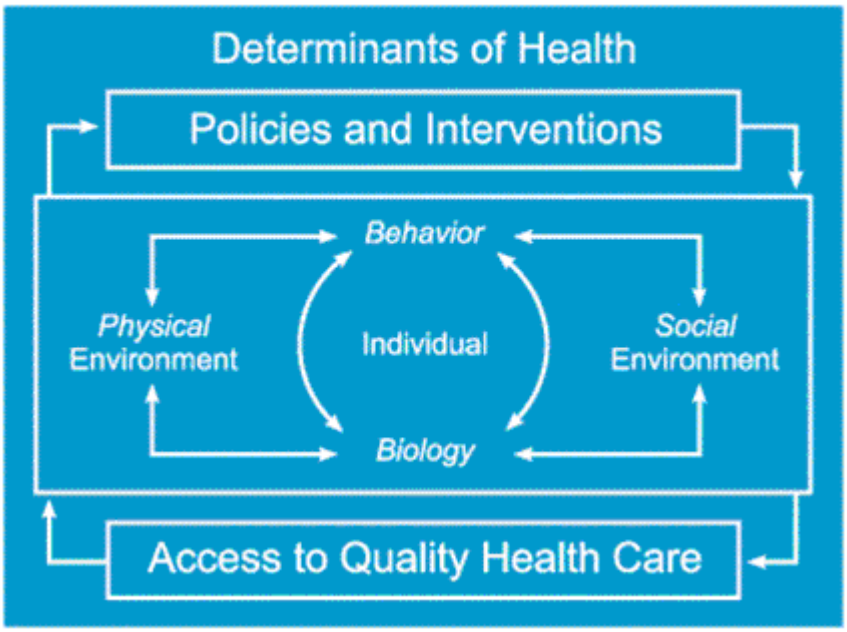
In addition to the theories and approaches discussed thus far, in the LAC region the issue of racial/ethnic heritage and its connection to socioeconomic status, social status, and available social roles and pathways for youth is salient, particularly because of the diverse mix of African, indigenous, European, South Asian and other peoples in the region. Studies – for example, by the World Bank – have documented strong links between poverty, social exclusion,

unemployment, growing up in neighborhoods with drug trafficking and violence, and other factors, with Afro-Latino or Afro-Caribbean background (see, for example, Moser and van Bronkhorst 1999; Gacitua-Mario, Sojo and Davis 2001). Even in Brazil, where there is an extensive history of mixed race populations and a Constitutional prohibition against racism and racial discrimination, the UN Commission on Human Rights (1995) has noted the relative absence of Afro-Brazilians in the media, in Parliament, and in other key social institutions. The Commission report specifically acknowledged a "color hierarchy" in Brazil, and stated that "the correlation between social stratification and different shades of skin colour is so close that it cannot be without significance" (Ibid, P. 8). The existence of structural social exclusions of this nature, as already discussed in this document, cannot help but impact on the expectations adolescents have about their future, their stake in and connection to larger society, and, therefore, patterns of behavior.

Models for Understanding the Impact of Racial/Ethnic Health Disparities

In identifying the scope of measurement for adolescent well-being, it may also be useful to consider a set of domains and measures that have recently been developed by the U.S. Office of Minority Health (OMH), within the Department of Health and Human Services. These domains form the basis for a Strategic Framework for Assessing Progress Towards the Elimination of Racial/Ethnic Health Disparities ("Strategic Framework"). The Office of Minority Health developed this Framework for purposes similar to the UNICEF project: It was necessary to find an overall rationale that could guide program development and measurement of progress towards the twin goals of improving racial/ethnic minority health and racial/ethnic health disparities. The additional relevance of this Framework lies in the fact that racial/ethnic disparities in health are understood to occur within an ecology of contributing factors – by now a well-accepted principle of public health (see Green and Kreuter, 1999; Green, Potvin, and Richard, 1996; Evans and Stoddart, 1990; and others). As an example, Figure 1 below (DHHS, 2000: p.18) describes the ecological understanding of factors (or determinants of health) contributing to health established in the Department of Health and Human Services major planning document *Healthy People 2010,* encompassing an interrelationship among behavior, biology, the physical and social environments, which also interact with policies, interventions, and access to quality health care. The HP2010 schematic is general, applying to any population. The key for understanding racial/ethnic health disparities is adapting such a framework for specific "health disparity" populations.

Figure 1. Healthy People 2010 Determinants of Health



The U.S. Office of Minority Health (OMH) Strategic Framework. The OMH Framework is therefore an ecological framework intended to clarify understanding of the kinds of factors contributing to racial/ethnic minority health disparities, and as a means of systematically guiding policy, program development, research and evaluation to increase effectiveness and increase the likelihood of measurable progress. It utilizes a logic model structure and builds on current expertise, dividing the factors contributing to racial/ethnic health disparities into three levels or domains: 1) individual-level factors; 2) environmental- and community-level factors; and 3) systems-level factors. These contributing factors interact and form the context for health impacts and outcomes. They also represent the basis for the targets to be addressed by a range of strategies and practices that can be deployed in health promotion programs and policies.

- ***Individual-level factors*** include the knowledge and attitudes people have about health risks, prevention and treatment; the skills people have/do not have to put health knowledge into practice; behavior—what people do or do not do that has impacts on their health or the health of others; and an individual's genetic background, which may enhance or reduce susceptibility to particular health conditions.

- ***Environmental- and community-level factors*** encompass a broad array of phenomena, including the physical environment (both natural and built), social and cultural characteristics of a community, economic and political conditions which undergird many of these social and cultural

characteristics, as well as institutional, organizational, and other issues. These factors are generally not within the control of specific individuals.

- ***Systems-level factors*** refer to the kinds of systems a community, State, or region might have (or not have) and approaches used (or not used) for identifying the problems or needs—health-related or otherwise—in respective jurisdictions and directing resources to address these problems or needs. Whether such systems, including public health and health care systems, and approaches *effectively* address such problems or needs depends upon the presence or absence of many systems characteristics, including resources, leadership, institutional commitment, strategic planning, organization, availability of data, a user-centered orientation, evaluation, performance measurement, and others.

For each of these domains, the Strategic Framework development process included and extensive effort to set out *expected impacts* by domain, and then to identify or create indicators by which progress towards attianment of those impacts could be measured.

In broader terms, the *reasons* minority populations have often fared worse (in terms of health status) are complex, and are difficult to separate from the historical experience of racial/ethnic minorities in the U.S. or other countries where this is an issue. The general experience of discrimination, social exclusion, lack of access to resources, higher exposure to environmental risk, and higher prevalence of poverty – to name a few factors – has contributed to patterns of living in which health-related beliefs, attitudes, expectations, mistrust and behavior have evolved that cannot help but reflect this experience. In addition, migrant and indigenous populations may hold different understandings about health and health care.

What these historical circumstances produce is a *trajectory of health* for particular populations, which includes their vulnerability and exposure to disease, and the systems of knowledge, attitude and practice related to health that developed in response to their vulnerability and historical experience within a larger society – or, you could say, a larger environment. This combination of *vulnerability*, *circumstance* and *response* forms the larger set of forces that, together, create the differences in health status referred to as health disparities.

Socioeconomic status (SES) itself is a key factor, because of its significant implications for health. While racial/ethnic minority populations include members across socioeconomic categories, it is fair to say that these populations are over-represented in lower socioeconomic groups, which means that the consequences of low SES fall harder on minority populations. Low SES is (see, for example, Kawachi et al. 1999) widely associated with health risks and problems, such as nutrition, smoking, injuries, environmental pollution, unemployment, low income, family dysfunction, psychosocial stress, presence of community violence, limited recreational space, and the like. Socioeconomic factors do not refer just to income: Housing segregation by race/ethnicity (regardless of income) is associated with a range of health risks (Williams &

Collins 2001; Richards & Lowe 2003, p.1171). Neighborhood characteristics (e.g., crime, lack of recreation space) intertwined with socioeconomic status also have an impact on such health conditions as obesity, violence and substance use (see Morland et al 2002; Shihadeh & Flynn 1996; LaVeist & Wallace 2000).

Another way to synthesize the impact of these broad social and economic factors in producing health disparities is to think of poverty and social marginalization as creating groups of people (defined by their socioeconomic status, race/ethnicity, etc.) with poor access to the inter-related systems of health, economic and social resources. This general access-poor relationship generates patterns of living that focus more on survival and achieving social goals (e.g., family needs, access to resources) within a very limited sphere, as opposed to maximizing health or overall well-being in its broadest social meaning. This view is expressed in the literature on *vulnerable populations* (Sebastian 1999; Sebastian 1996; Aday 1993; Flaskerud & Winslow 1998), and, for example, the research of medical anthropologists such as Dressler and colleagues (see what is called the structural-constructivist model of health disparities in Dressler et al. 2005).

For many adolescents in the LAC, the idea of a *trajectory* is also relevant – where adolescents have poor access to the same kinds of social resources noted above, they are more likely to develop along pathways or trajectories that respond to imperatives and needs of the social worlds in which they live and confront on a daily basis.

Social Exclusion and Adolescent Well-Being

Finally, a *social determinants of health* approach addresses the linkage between health of a population or group (including youth/adolescents) and a wide range of factors together under the rubric of social exclusion (World Health Organization 2005). Exclusion, and lack of participation in decision-making, have adverse implications for health; thus the general remedy involves increasing social *inclusion.* A Canadian initiative, Inclusive Cities Canada (ICC), has set out five dimensions of social inclusion to be addressed and monitored (O'Hara 2006). The dimensions are as follows, together with a sample of the indicators proposed for monitoring:

- *Institutional recognition of diversity* – measured by number, types and effectiveness of policies, initiatives and programs, as well as actual data on diversity
- *Opportunities for human development* – measured by resources available for schools, school graduation and attendance, access to schools
- *Quality of civic engagement* – number, types and effectiveness of public participation processes based on shared decision-making, amount of civic funding available to support the community sector, public perceptions of access
- *Cohesiveness of living conditions* – measured by income distribution, income inequality, poverty, housing affordability, workforce diversity
- *Adequacy of community services* – Number, types and perceived effectiveness of culturally sensitive policies/programs of community

organizations, indicators of health care and social service access, morbidity/mortality data, public transit access and ridership.

Other efforts to develop indicators of social inclusion (Nolan 2003) focus on similar categories, with the addition of other useful measures, such as persons living in jobless households, self-report health status, and number of persons with low educational attainment. Both Nolan and the ICC initiative make a distinction between the use of *primary and secondary indicators,* where the former are key indicators capturing the essence of the problem and the latter are indicators capturing additional and specific dimensions of the problem.

5. *Implications of Prevalent Theories, Models and Approaches for UNICEF-Supported Efforts and the Identification of Positive Adolescent Well-Being Indicators*

Social/behavioral theory approaches range from those focusing on prevention of negative behavior to those accentuating positive supports, the substantial research behind these efforts *supports an ecological, domain based structure for defining adolescent well-being*. However, the domains should not be restricted to individual, family, peer, school, and community levels so common in the social/behavioral canon. Sociecological and other perspectives have demonstrated the key role of social, economic and cultural domains in delineating a context or social field within which individuals, families, peers, communities, and even schools operate, as well as the importance of assessing and addressing social exclusion/inclusion as an important determinant of health, general and adolescent. Work in the LAC has highlighted the role of participation and the link between adolescent development and democracy, and linked the life-skills concept to adolescent development and to employability. Finally, some of the health promotion theories discussed here are primarily oriented to the development of specific programs, and are thus not as useful for region or country-wide frameworks – except insofar as they support general (measurable) objectives of increasing skills, knowledge (for individuals); however, the broader social/cultural theories do, for example, address the engagement of communities in a participatory process of change, and account for the influence of economies, structural factors and culture in health and well-being. Once again, however, the *division of these theories into levels* supports the necessity of such an organizational pattern for the adolescent well-being indicators.

The development of a Strategic Framework (described above) for understanding and planning efforts to eliminate health disparities in the U.S. offers useful guidance for the identification of LAC adolescent well-being indicators. The Strategic Framework addresses the broad complex of factors that contribute, at many levels, to health disparities, and, conversely, addresses the kinds of individual, community and systemic factors that need to be strengthened in order to promote (and enable) increased health status. Importantly, the Framework includes the multiple community assets that need to be in place – from transportation, to accessible health care, to resources, employment, and community/social capital – in order to achieve this goal. Like the PYD orientation,

it is not just a list of risk factors, but of necessary assets. These assets are organized, again, in domains, and parallel in a number of ways the kinds of multilevel assets and resources necessary for adolescent health and well-being.

Moreover, the process of framing domains, then translating these domains into expected impacts and indicators by domain serves as a model for the process to be undertaken in this effort.

IV. Legal Frameworks, Commitments, Indicators and Policies in the LAC Region Pertaining to Adolescent Well-Being

There are a host of conventions and legal frameworks related to the protection of children and adolescents, and near universal ratification of the Convention on Rights of the Child. However, as Landgren has demonstrated (2005), despite the broad formal commitment of governments, "these international commitments have had insufficient practical impact" (Ibid, p. 217), in part because of the persistence of traditional practices and in part because the pattern of child protection has focused on legal remedies, services for victims, and smaller scale, palliative projects (in contrast to broader systemic reform). The following is a brief outline of a number of key legal and policy frameworks, at the global, regional and country levels related to child and youth protection and well-being.

1. Global Frameworks

The UNICEF Child Protective Framework

With respect to protecting children and youth from violence, exploitation and abuse, the UNICEF Child Protective Framework provides a set of essential guidelines (www.unicef.org/protection). These are:

- **Attitudes, traditions, customs, behaviour and practices:** Refers to attitudes and traditions that facilitate abuse. Generally addressed through careful education and awareness focusing on the harmful effects of such abuse, and offering alternative practices.
- **Governmental commitment to fulfilling protection rights:** Refers to the government commitment to child protection – if a government does not take the lead, backed by a strong legal environment, it is difficult to expect compliance.
- **Open discussion and engagement with child protection issues:** Refers to both the ability for children to speak up about their concerns as well as the attention of the media and civil society.
- **Protective legislation and enforcement:** Appropriate legislation, together with its implementation and enforcement, are necessary to prevent abuse.
- **The capacity to protect among those around children:** All those who interact with children (health workers, teachers, police, social workers,

others) need to have the motivation, skills and authority to identify and respond to child protection abuses.

- **Children's life skills, knowledge and participation:** When children are aware of their right not to be abused/exploited, and are aware of the services available to protect them, they are more resilient and less vulnerable to abuse.
- **Monitoring and reporting:** An effective monitoring system – especially if participatory and locally-based -- is key to an informed and strategic response
- **Services for recovery and reintegration:** Child victims are entitled to care and non-discriminatory access to basic social services – services that foster the health, self-respect and dignity of the child.

Convention on Rights of the Child

While the theoretical paradigms outlined above concerning adolescent well-being are based in behavioral and social science, an additional set of frameworks to consider are those based on human rights constructs as they pertain to youth. The key legal framework with respect to adolescent well-being in the LAC region is the Convention on Rights of the Child (CRC). The CRC includes the following tenets (abstracted from all CRC articles):

- Prohibition of any discrimination based on personal characteristics (e.g., race, gender, etc.), or based on speech or action, and no denial of rights of minority or indigenous populations to practice their own culture, religion or language.
- Best interests of the child, with consideration for the rights and duties of parents
- Conformance with safety, health, and appropriate capacity of institutions/programs serving youth
- Action by signatories to ensure rights (including economic, social and cultural rights).
- Respect for rights/responsibilities/duties of parents (both parents) or guardians, but charged with providing direction and guidance according to the evolving capacities of the child. Signatory pledge of support for parents/guardians in their duties.
- Right to life, survival and development for children/youth
- Right to a name, a nationality, and care by parents. Respect for these rights, and when deprived of any of them, the provision of assistance and protection.
- No separation of child from parents against their will, unless deemed necessary for best interests of child. Where enforced separation occurs, the right of the child to maintain relations and direct contact with the parent(s).
- Family reunification and family contact across State lines.
- Commitment to take measures against trafficking and abduction of children.

- Freedom of expression for children/youth (except when harming others or threat to national security). Similarly, the right of children/youth to express views – including in court and in all matters affecting that child/youth.
- Freedom of thought, conscience and religion.
- Freedom of association and peaceful assembly.
- No arbitrary/unlawful interference with privacy.
- Diversity of media and information sources available to children/youth.
- Signatory pledge to take all appropriate measures to protect children from physical/mental violence, injury and abuse, negligent treatment, exploitation, and sexual abuse, and the provision of social programs to support this aim.
- Special protection and assistance for children/youth deprived of family environment, and a competent, consent-based adoption process.
- Protection and assistance for refugee children
- Commitment to ensure a full and decent life, and special care for children who are disabled
- Right to the highest attainable standard of health and access to care, with particular focus on infant/child mortality, pre/postnatal care, preventive health care, and family planning.
- Right of benefit from social security
- Right to a standard of living sufficient for physical, mental, spiritual, moral and social development.
- Right to education, on the basis of equal opportunity, and the provision of support/programs towards that goal.
- The right to recreation and play.
- Protection from economic exploitation, sexual exploitation, and sexual abuse, or any other form of exploitation, and appropriate support and measures provided for the recovery of exploited children.
- Protection from and prevention of illicit drug use
- Prohibition against torture of children, or of life imprisonment for anyone below 18 years old. Arrest/detention only in conformance with the law, in a humane and dignified manner, and with right to counsel, language interpretation. Presumption of innocence until proven guilty. Preference for remedies that avoid judicial proceedings.
- Commitment to prevent children under age 15 from taking part in armed conflict or hostilities.

Note the very broad set of rights and obligations incorporated in this document, to which all LAC countries are signatories. The rights and obligations span the gamut from issues of discrimination, parent obligations/child rights, identity, religion, exploitation, access to information, free speech and assembly, fair and humane juvenile justice practices, protection from risk behaviors, and many more. In a unified definition of adolescent well-being, the language of rights and the language of social/behavioral science will have to be blended.

Millenium Development Goals

In 2000, at the United Nations Millenium Summit, a visionary set of goals was placed at the center of the global agenda for development. The goals were framed in measurable terms, and included targets for combating poverty, hunger, disease, illiteracy, environmental degradation and discrimination against women, as well as human rights, democracy and governance commitments. The overall goals (MDGs) are as follows:

MDG1: Eradicate extreme poverty and hunger
MDG2: Achieve universal primary education
MDG3: Promote gender equality and empower women
MDG4: Reduce child mortality
MDG5: Improve maternal health
MDG6: Combat HIV/AIDS, malaria, and other diseases
MDG7: Ensure environmental sustainability
MDG8: Develop a global partnership for development

While the MDGs are not targeted to adolescents per se, the goals and outcomes are certainly relevant to adolescent well-being domains. Since, as documented by UNFPA (2005), young people are highly impacted by poverty[5], MDG poverty-reduction strategies should focus on, and include as partners, young people. The education goal should include the elimination of barriers to school attendance; the right to literacy, numeracy, life and livelihood skills; a closing of gender and wealth gaps vis a vis access to education; and relevant educational programs, including vocational education. The gender equality MDG should promote access to education, sexual/reproductive health information (and other services); promote full participation; implement zero tolerance for violence against women; and prohibit discrimination. The child mortality MDG, with respect to adolescents, refers to delay of adolescent marriage; access to reproductive health services and information; and nutrition and breastfeeding support for young mothers. Similarly, the maternal health MDG (for adolescents) should involve alternatives to child marriage, access to information/services, and access to pre and post-natal care and nutrition services. The MDG concerning HIV/AIDS, malaria and other diseases should entail programs encouraging delay in sexual initiation, reduced sexual partners and condom use; access to prevention and testing services, especially for those at high risk; implement interventions; and link HIV/AIDS and sexual/reproductive health education and services. The environmental sustainability MDG, for adolescents, refers to participation in decisionmaking processes, and increasing young people's awareness regarding environmental issues and solutions. Finally, the MDG regarding global partnership involves support for Youth Employment Network commitments; support for education and vocational training; and partnering with young people to develop skills for leadership, advocacy, and civil society involvement.

[5] Estimate that 325 million young people live on less than $1 a day, and 515 million young people live on less than $2 a day (UNFPA 2005).

UNICEF's Medium Term Strategic Plan (MTSP) for 2006-2009 outlines a range of UNICEF plans and activities oriented around the MDGs (as well as World Fit for Children) to be addressed. Child protection issues, for example, are discussed in terms of the emphasis in the Millenium Declaration on vulnerable populations, and the World Fit for Children's plan of action to create a protective environment around vulnerable children.

A World Fit for Children

In May, 2002, at a UN Special Session on Children, commitments made eleven years before at the World Summit for Children were re-affirmed, and the "World Fit for Children" declaration (and documents) was accepted. Basic principles were: put children first; eradicate poverty: invest in children; leave no child behind; care for every child; educate every child; protect children from harm and exploitation; protect children from war; combat HIV/AIDS; listen to children and ensure their participation; and protect the Earth for children. The document acknowledges progress made since the World Summit for Children, together with a call to address continuing challenges. The resulting Plan of Action includes the following recommendations (summarized):

- Access to quality, free education and opportunity for adolescents to develop individual capacities in a safe, supportive environment.
- Support and strengthening for families, and children's rights.
- Recognizing that many children live without parental support (e.g., refugees, street children, orphans, trafficked, children, incarcerated children, etc.), facilities and services are needed to protect and support them.
- Access to information and services to promote child survival, development, protection and participation.
- Combating chronic poverty on all fronts.
- Recognizing that globalization and interdependence create opportunities but also create insecurities, inequality, poverty, and exclusion, a commitment to extend the benefits of social and economic development to all, including children.
- Eliminate discrimination, for any reason.
- Take measures to ensure full and equal enjoyment of human rights and fundamental freedoms.
- End discrimination against indigenous children.
- Full rights for women, and protection from discrimination, violence and abuse.
- Recognition of changing roles for men, and the sharing of parenthood.
- Reduction of disparities.
- Address environmental problems that affect the health of children.
- Overcome housing shortages and inadequate housing.
- Take measures to manage resources and conserve the environment in a sustainable manner.

- Implementing the legal standards and goals of the CRC and its protocols, through legislation, national entities, monitoring and evaluation, and enhancing awareness.

The *World Fit for Children* (WFC) document goes on to set out multiple steps for implementing this plan, including the necessary partnerships and entities that should be involved, and an extensive listing of actions and strategies, some of which include measurable impacts (e.g., health impacts, educational benchmarks, literacy, etc.), some which specify processes that must occur, and some that are not currently framed such that they could be measured.

United Nations Declaration on the Rights of Indigenous Peoples

The Declaration (Report of the Human Rights Council, United Nations General Assembly 61st Session, September 7, 2007) asserts the right of indigenous families and communities to retain shared responsibility for the upbringing, training, education and well-being of their children, consistent with the rights of the child: to live in freedom and peace without the threat of violence, forcible removal, or genocide; to be educated in their own language and culture; to be protected from economic exploitation and hazardous work conditions; for improvement in economic and social conditions; special attention to indigenous individuals with disabilities; and to ensure that indigenous women and children enjoy full protection against violence and discrimination.

Convention on the Rights of Persons With Disabilities (CRPD)

The Convention (General Assembly 61st Session, United Nations. December 6, 2006) pertains to issues of disability in general as well as specific concerns related to children/youth. In general, the Convention holds that:

- disability is an evolving concept; a disability results from the interaction between persons with impairments and attitudinal and environmental barriers.
- mainstreaming disability issues is an integral part of relevant strategies of sustainable development.
- children with disabilities should have full enjoyment of all human rights and fundamental freedoms on an equal basis with other children, as per the Convention on the Rights of the Child,

Thus, for children, a principle of the Convention is Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities. Many of the rights for children with disabilities follow the same pattern as the CRC: Equal rights and freedoms; best interest of the child; freedom to express views freely; fostering of an education system that promotes respect for the rights of children with disabilities; freedom from exploitation, violence and abuse; birth registration and identity; respect for home and family, family life, fertility, care within the family or wider family if possible; right to education; right to health/health care without discrimination; and freedom to participate in cultural, learning and recreational activities.

Convention on the Elimination of All Forms of Discrimination Against Women

The following are selected aspects of this 1981 Convention[6] that pertain in particular to women and children:

Family education includes an understanding of maternity as a social function, a common responsibility of men and women, where the interest of children is primary (Article 5).

- Suppression of all forms of traffic in women or exploitation or prostitution of women (Article 6).
- Equal rights with respect to nationality of children (Article 9).
- Elimination of discrimination and equal rights to education, including in career and vocational education (Article 10).
- Access to education for family well-being, including family planning (Article 10).
- Equal employment opportunity (Article 11).
- Equal access to health care services including family planning (Article 12).
- Equal responsibilities and rights with respect to children (including guardianship, wardship, etc.), and the right to decide freely on number and spacing of children (Article 16).
- No recognition of child marriage; minimum marriage age and marriage registration.

2. Regional Frameworks

Pan American Health Organization (PAHO) Regional Strategy

The (draft) *Regional Integrated Strategy for Adolescent and Youth Health 2008-2018* (PAHO 2008) mentioned above encompasses seven strategic categories of action to improve the effectiveness of actions promoting the health and well-being of young people in the region:

Strategic information and innovation

- Promote the use of data on young peoples' health disaggregated by age, sex, ethnicity, and household income to be disseminated through a Regional database.
- Encourage the use of a gender-based and cost-benefit analysis, new technologies (e.g. geographical information systems), and projection models to strengthen current and future planning, delivery, and monitoring of policies and interventions.
- Monitor and evaluate current health services, health promotion, and disease prevention programs to assess their quality, coverage, and cost.

[6] G.A. res. 34/180, 34 U.N. GAOR Supp. (No. 46) at 193, U.N. Doc. A/34/46)

- Support regional and national research on the impact of new and innovative approaches to improve the health and development of young people.

Enabling environments and evidence-based public policies

- Promote and establish environments that foster health and development for young people by addressing determinants of health and promoting safe communities.
- Member States should develop, implement, and enforce policies and programs that are evidence-based and consistent with the UN Convention of the Rights on the Child and other international/regional human rights conventions and standards. The importance of environments that promote behavioral change and health is well recognized in public health and PAHO will continue to promote evidence-based interventions in this area.
- A balance should be achieved between the implementation of short-term programs targeting those young people already engaged in risky behavior and/or with health problems and health promotion and prevention programs.

Integrated and comprehensive health services

- Promote the effective extension of social protection by scaling up the provision of quality health services - including promotion, prevention, treatment, and care - to increase the demand and utilization by young people.
- Based on the principles of primary health care, these services should be comprehensive, address young people from a holistic perspective and be developmentally appropriate.
- All young people should have access to affordable, non-judgmental, culturally appropriate and confidential services.
- Alternative and innovative models of service delivery can expand access, such as mobile clinics, school-linked health services, pharmacies, among others.

Human resource capacity building

- Support capacity building for policy makers, program managers, and health care providers to develop policies and programs that aim to promote youth and community development and quality health services that address the health needs of young people in an integrated manner.
- Build capacity in the use of evidence-based interventions and in monitoring and evaluation, using new technologies, such as e-learning platforms to help meet the demand for professionals trained in the provision of adolescent and youth health services.

Family, community, and school-based interventions

- Engage young people, their families, communities, and schools in the provision of culturally sensitive promotion and prevention programs as part of the comprehensive approach to improving their health and wellbeing.

- Research shows that parental involvement is associated with positive outcomes in health and education. It is critical to establish opportunities for the meaningful participation and empowerment of young people, their families and communities in the decision-making process, design and implementation of programs that affect them.

Strategic alliances and collaboration with other sectors

- Improve collaborative relationships within the health sector and with partners to ensure that actions and initiatives in adolescent and youth health and development are coordinated, minimizing duplication of efforts and maximizing the impact of limited resources.

- Particular emphasis should be placed on strengthening collaboration between United Nations agencies, Organization of American States organs and agencies, government entities, private organizations, universities, media, civil society, youth organizations, and communities (including the religious community, teachers, parents, and young people).

Social communication and media involvement

- Capitalize on the reach and influence of media on young people, working with the media to create positive images of young people and promote positive behaviors, social norms and commitment to health issues.

- Use social communication techniques and new communication technologies to encourage young people's ability to adapt and maintain health-enhancing lifestyles and to access health-related services, and actively respond to promotion of negative behaviors where this influence could be detrimental to health.

PAHO/SIDA Family and Community Health Initiative

This initiative, entitled "Family and Community Health Initiative: Supporting Maternal Health, Child Survival and Healthy Lifestyles in Young People" 2005-2007, (PAHO March 2007) is a regional initiative focusing on Honduras, Nicaragua, Guatemala, and El Salvador. The initiative is guided by five main principals –the Millennium Development Goals (MDG) 3, 4, 5, and 6, human rights and equality, gender, participation, and harmonization with Country Cooperation Strategies (CCS) with priorities of other agencies, and with a sector-wide approach and poverty reduction strategies.

The strategic focus of the PAHO/SIDA initiative is as follows:

a) Support priority and high-impact countries to attain the Millennium Development Goals (MDG) regarding Infant and Maternal Mortality and the transmission of HIV/AIDS, and support the implementation of the World Health Organization (WHO) initiative for universal access to prevention, treatment, and care.

b) Prioritize and target actions in Sexual and Reproductive Health (SRH) to vulnerable and high-risk populations (mother-child, youth, poor and indigenous populations)

c) Provide the FCH Area's technical cooperation in a comprehensive and integrated manner, with the participation of relevant FCH units and other PAHO units, in relevant settings and levels (health services, family and community) with a life-cycle, gender and participatory approach.

3. LAC Country-Level Legal and Policy Frameworks

Many LAC countries have created national frameworks for the implementation and assurance of standards and goals outlined in the CRC and other documents. The earliest of these (post-CRC) occurred in Brazil, which underwent a popular participatory process to enact the Estatuto del Nino y el Adolescente (ECA) (UNICEF 2004). The ECA defines adolescents as anyone between 12 and 18 years old, and is divided in two parts – the first outlining the rights of minors; the second outlining provisions for supporting and protecting minors[7]. To implement and monitor the law, a national Council for the Rights of Children was created, along with multiple state and municipal-level councils. Following Brazil's example, other LAC countries created codes and concomitant frameworks: A Code for of Minors in Peru (1992); a Family Code and Law for Minor Lawbreakers in El Salvador (1993, 1994); the Juvenile Justice Responsibility Law in Costa Rica (1996); Children and Adolescent Code in Honduras (1997); Law of Adoptions in Paraguay (1997); Children and Adolescent Code in Nicaragua (1998),; and similar legal codes in the following years in Venezuela, Bolivia, Panama, Mexico, Guatemala, Ecuador, Dominican Republic and Uruguay, as well as additional laws in Paraguay. In Latin America, as of 2004, only Argentina, Columbia, Chile and Cuba had not enacted legislation incorporating the CRC, according to UNICEF (2004).

According to the UNICEF Innocenti Research Center (UNICEF 2004c), the LAC region has seen a widespread adoption of legislation and legal codes related to families and children, with family issues often addressed in detail. Where codes have been adopted, all contain provisions related to the right to education. Child labor is addressed in some of the codes – Paraguay was cited as an example (Ibid p. 6).

A number of LAC (primarily in Latin America) countries have established agencies or commissions youth, children and families (UNICEF/OACNUDH 2006). The UNICEF report (2004c), in fact, concluded that there was a "flourishing of coordinating bodies in Latin America" (p. 19). For example:

- Argentina: creation of the National Council of Youth and Families
- Ecuador: National Council for Children and Adolescence (2004)
- Nicaragua: National Council for Integral Assistance and Protection of Children and Adolescence
- Guatemala: National Commission against Child Abuse

[7] "Minor" is the term used in these documents.

- Honduras: creation of a National Commission of Human Rights for the promotion and protection of child rights

Perhaps more important with respect to the eventual development and collection of indicators, LAC countries have established national plans of action for youth and child well-being, which, by nature, should include specific steps and (measurable) objectives. Examples include:

- Chile: National Policy in favor of Children and Adolescence and Integrated Plan of Action for 2001-2010
- Costa Rica: National Agenda for Children and Adolescence 2000-2010
- Nicaragua: National Action Plan for Youth and Adolescence 2002-2011;
- Peru: National Action Plan for Children and Adolescence 2002-2010

In addition, Latin American countries have put in place legal entities and positions such as defense counsels and advocates, and have instituted the separation of juvenile and adult systems, as well as provided social and support services.

The process in Caribbean countries has been slower (UNICEF 2004b). As of 2004, only two, Haiti and Suriname, give the CRC priority over national legislation, and the provisions focusing on the rights of women have been implemented more quickly than those focusing on the general rights of children and youth. The slow and fragmented pace of CRC adoption may be due in part to the legacies of colonialism and slavery, which still persist in both legal doctrines and cultural practices (Ibid). There are exceptions. In the Dominican Republic, post-CRC legislation has included the Code for the Protection of Children and Adolescents (1994), the Law Against Family Violence (1997), and the General Youth Law (2000). Youth risk behavior data have been collected from a subset of CARICOM countries (PAHO dataset).

However, in 2001, CARICOM adopted a Regional Strategy for Youth Development. Key thematic priorities for the Plan were: social and economic empowerment opportunities for youth development; adolescent and youth protection; adolescent and youth leadership, governance and participation; and adolescent and youth health and reproductive rights. Crosscutting areas included gender rights and equalities, capacity building, and youth participation. These priorities were then expanded into a range of actions.

The differences between the adoption of laws and the creation of institutions and actual practice, however, have varied widely. The adoption of harsh anti-gang legislation in Central America and degraded prison conditions in Brazil are but a few examples.

4. LAC Protocols for Measurement (Indicators) of Adolescent Health/Well-Being

There is a complex set of sources and indicators that pertain (or may pertain) to adolescent well-being in the LAC region. Some are global data sets

such as the Demographic and Health Survey (DHS). Several LAC countries have also instituted standard indices for measuring adherence to child rights standards in the CRC. The Mexican Child Rights Index is divided by developmental stage -- infant (0-5), school-age (6-11) and adolescent (12-17). The adolescent index focuses on three "rights domains":

- Right to life – prevention and avoidance of premature death.
- Right to education – right of all to attend school and to finish secondary school.
- Right to be free from labor exploitation – no illegal or harmful work, or unfair pay.

In Ecuador, a similar child rights index has been created, also divided into three developmental stages and calculated using a 10-point scale. Data on adherence is collected by the Observatory for the Rights of Children and Adolescents, and disseminated through two channels: a periodic bulletin and an annual report entitled "The State of Rights."

The following table, Table 3, outlines a sample of indicators and their associated sources/datasets related to adolescent health and well-being that are collected in the LAC region. As the table indicates, there are many relevant data sources and indicators that could potentially be utilized to monitor a broad, holistic definition of adolescent well-being. However, not all of the data are collected region-wide. Some are derived from select countries and studies. Thus a next step will entail a detailed review of all these data sets, following agreement on a definition of adolescent well-being and indicators, to identify the extent to which data are available region-wide.

SUMMARY OF EXISTING LAC ADOLESCENT WELL-BEING INDICATORS		
AREA	**INDICATOR**	**SOURCE**
DEMOGRAPHIC/SOCIAL		
Population	Total population of adolescents and young people	United Nations
	Population by age, sex (15-24)	US Census International Database
	Percentage of adolescents as part of the total population	United Nations
	Percent distribution of adolescents ages 10-15 by parental figure in the home (by age, sex)	JYRRBS
	Mean household size and mean number of persons per bedroom (ages 10-15)	JYRRBS
Poverty	Percentage of young people who live in a state of poverty	United Nations
	Percentage of young people who live in a state of absolute poverty	United Nations
	Percent poverty and indigence, ages 15-19; 20-24	ECLAC
	Percent of adolescents ages 12-17 who live in poverty	Mexican Child Rights Index
	Incidence of poverty in unemployed adolescents	Mexican Child Rights Index

HEALTH		
Services	Percentage of centers of primary health care that have specific plans for adolescent and young adult health	
	Number of adolescent health good and services incorporated into guaranteed portfolios of entitlements (social security, MOH)	GSHS
	Demand: Percent of adolescent population that has access to specific health goods and services	GSHS
	Coverage: Percent of adolescent population covered by specific services (SS/MOH)	GSHS
	Youth population with right to health services	IMJ
Mortality	Juvenile mortality rate	IMJ
Injury	Adolescent and young adult mortality from motor vehicle accidents	PAHO, Mexican Child Rights Index
Tobacco	Prevalence of tobacco use between adolescents and young adults	PAHO
	Percentage of adolescents and young adults who smoked cigarettes, one or more days, on the last 30 days	GSHS
	Proportion of smokers who ever tried to stop smoking cigarettes in the past 12 months	GSHS
	Percent youth ages 13-15 who currently use any tobacco product	WHO/CDC
	Percent youth ages 13-15 who currently smoke cigarettes	WHO/CDC
	Percent youth ages 13-15 who are current smokers and smoke more than 6 cigarettes per day	WHO/CDC
Drugs	Percentage of adolescents and young adults who one or more times in his life used drugs	GSHS
Alcohol	Percentage of adolescents and young adults who during the last 30 days consumed, at least one or more days, some beverage that contained alcohol	GSHS
	Per capita alcohol consumption (GTET15 years of age) by gender	
	Abstention rate 10-18 years of age by gender	
Nutrition	Number of days of hunger in past 30 days	GSHS
	Prevalence of obesity and overweight in adolescents and young adults	
Suicide	Mortality from adolescent and young adults suicide	PAHO
	Percentage of adolescents and young adults who have attempted to commit suicide in the last 12 months	GSHS
	Mortality per 100,000 population caused by suicide	UN Office on Drugs and Crime
	Number of adolescent deaths, ages 12-17 caused by suicide	Mexican Child Rights Index
Maternal Health	Prevalence of anemia (hemoglobin GTLT 12 g/dl)	

	among women adolescents and young adults	
	Maternal mortality ratio of adolescents and young adults	
	Youth maternal mortality rate	IMJ
	Specific rate of fertility in women adolescents and young adults	PAHO
	Age-Specific fertility rate per 1000 Women, ages 15-20	UNFPA
	Births per 1,000 ages 15-19; 20-24	US Census International Database
	Percentage of women adolescents and young adults that had an unplanned pregnancy	
	Percent adolescent women 15-19 begun childbearing (urban, rural, no education/primary)	UNFPA
	Age when first gave birth	ORC Macro
	Percentage of women ages 15-19 who had children or who are currently pregnant	ORC Macro
	Percentage of deliveries in women adolescents and young adults	PAHO
Sex/Contraception	Percentage of adolescents and young adults with unsatisfied demand for contraceptives	PAHO
	Percentage of the adolescent and young adult population that had sex in the last 12 months	FHI
	Average age at first sexual intercourse	FHI
	Number of sexual partners among young people	FHI
	Percentage of young people who had more than one sexual partner in the last 12 months	UNGASS
	Percentage of young people who used condoms consistently with the nonmarket couples	FHI
	Percentage of young people who reported condom use during last time they had sex	UNGASS
	Percentage of young people who used a condom in their first sexual relation	FHI
	Percentage of sexually active youth who currently sue any contraceptive method, ages 15-19; 20-24 (male/female)	MEASUREDHS
	Age of first marriage (male/female)	ORC Macro
	Percent youth who reported higher risk sex in last year, ages 15-24 (male/female) [defined as sex with non-marital, non-cohabiting partner]	UNAIDS
	Percent youth, ages 15-24 who used a condom the last time they had higher-risk sex, of those reporting having high risk sex	UNAIDS
STIs	Percentage of reported cases of Sexually Transmitted Infections (STIs) in adolescents and young adults	
HIV/AIDS	Percentage of young people who voluntarily seek HIV testing	FHI

	Prevalence of HIV between pregnant and young women (15-24 years)	PAHO
	Proportion of young people (15-24 years) who are sexually active, were tested for HIV in the last 12 months and know the results	UNGASS
	Percent female youth ages 15-24 who know a place to get tested for HIV	UNICEF
	Percent female youth ages 15-24 who have been tested	UNICEF
	Percent female youth ages 15-24 who have been informed of HIV test results	UNICEF
	Correct Beliefs on HIV transmission	FHI
	Knowledge of HIV prevention methods	FHI
	HIV knowledge, percent females 15-24 who know that a person can protect herself from HIV by consistent condom use	UNFPA
	HIV knowledge, percent males 15-24 who know that a person can protect himself from HIV by consistent condom use	UNFPA
	Percentage of adolescent and young adults population with extensive correct knowledge on the forms of HIV/AIDS transmission	UNICEF
	Percent female youth, ages 15-24 who know that a person can be protected from HIV infection by one faithful, uninfected partner	UNICEF
	Percent female youth, ages 15-24 who know that a person can be protected from HIV infection by consistent condom use	UNICEF
	Percent female youth, ages 15-24 who know that a person can be protected from HIV infection by abstaining from sex	UNICEF
	Percent female youth, ages 15-24 who know that HIV cannot be transmitted by supernatural means	UNICEF
	Percent female youth, ages 15-24 who know that HIV cannot be transmitted by mosquito bites	UNICEF
	Percent youth ages 15-24 who know a healthy-looking person can be infected with HIV	UNAIDS
	Percent youth, ages 15-24 who can identify two protection measures and reject three misconceptions about HIV	UNAIDS
	Mortality from AIDS in adolescents and young adults	
	Annual incidence of recorded cases of AIDS in the adolescent and young adult population	PAHO
	HIV/AIDS prevalence, ages 15-24 (male/female)	UNFPA
	HIV prevalence among pregnant youth ages 15-19; 20-24 (urban/non-urban)	UNICEF
EDUCATION		

Enrollment/Attendance	Net enrollment rate at the Second teaching level	ECLAC
	Gross enrollment ratio at the Third teaching level	ECLAC
	Urban school attendance by quintile of per capita household income, classified by sex and age	ECLAC
	Primary school enrollment, gross percent of school age population (male/female)	UNFPA
	Secondary school enrollment, gross percent of school age population (male/female)	UNFPA
	Percent net secondary enrollment (male/female)	UNESCO
	Gross tertiary enrollment rate (male/female)	UNESCO
	Average number of years of education completed, ages15-24	ECLAC
	Out of school youth	IMJ
Academic performance	Percent having trouble getting homework done (by sex)	JYRRBS
	Percent with trouble reading (by sex)	JYRRBS
	Percent with learning problems	JYRRBS
	Percent with behavior problems	JYRRBS
	Mean numeracy and literacy scores	JYRRBS
Gender	Enrollment rate of girls and boys in primary school	
	Ratio of girls to boys, Primary education	UNFPA
	Ratio of girls to boys, Secondary education	UNFPA
Literacy	Youth literacy rate (male/female)	UNHDR/UN Statistics Database of Millennium Indicators
	Percentage of urban adolescents and youth you are illiterate, grouped by age and sex	ECLAC
	Illiteracy rate, Percent of population 15-24 (male/female)	UNFPA
	Rate of illiteracy for rural youth	IMJ
Extracurricular	Percent involved in an organized extracurricular activity at school, by sex, age, school type and location of school	JYRRBS
EMPLOYMENT		
	Rate of juvenile unemployment of, ages15 and 24, by sex	United Nations
	Proportions of workers engaged in low-productivity occupations, ages 15-19; 20-24 (by sex)	ECLAC
	Juvenile unemployment rate	IMJ
	Economically active population rate (male/female), ages 15-19; 20-24	ILO
	Participation rate or urban youth population in economic activity, ages 15-24	ECLAC
	Percent adolescents ages 12-17 who work, who are looking for word, or who don't work but are looking for work	Mexican Child Rights Index

SOCIAL PROTECTION		
	Number of days in the past 30 days parents of guardians understood their problems and worries	GSHS
PARTICIPATION		
	Percent claiming to be 'very' or 'somewhat' interested in politics, ages 18-24	Latinobarómetro
	Percentage of youth ages 18-24 who show support for or satisfaction with democracy	Latinobarómetro
	Level of trust in key political institutions, ages 18-24	Latinobarómetro
	Percentage claiming to have participated politically, ages 18-24 (categories: contact with official, work for party, work for other group, signed petition, public demonstration, illegal protest)	Latinobarómetro
	Percent youth ages 18-29 who voted in last federal election	IMJ
	Percent youth that belonged to a club or non-governmental organization	IMJ
CRIME/VIOLENCE		
	Number of juvenile suspects per 100,000 inhabitants brought into formal contact (suspected, arrested, cautioned) with the criminal justice system	UN Office on Drugs and Crime
	Number per 100,000 inhabitants convicted juveniles admitted to prison on a selected day	UN Office on Drugs and Crime
	Mortality rate per 100,000 population homicide	UN Office on Drugs and Crime
	Mortality from adolescent and young adult homicides	PAHO, Mexican Child Rights Index
	Rate of physical attacks during the past 12 months	GSHS
	Number of times in a physical fight during past 12 months	GSHS
	Percent in past year, caused a fight/attack, ages 10-15	JYRRBS
	Percent carrying a weapon to school in past month, ages 10-15, by sex	JYRRBS
	Percent ever belonging to a gang, ages 10-15, by sex	JYRRBS
Victimization	Percent in past year ever been physically abused, ages 10-15	JYRRBS
	Percent in past year been victim of physical attack, ages 10-15	JYRRBS
RELIGION/RELIGIOSITY		
	Frequency of church attendance in past month, by sex	JYRRBS
HOUSEHOLD PROTECTIVE FACTORS		

Caring relationships	Percent ages 10-15 responding always to 'Care/interest in your school work,' by sex	JYRRBS
	Percent ages 10-15 responding always to 'Care/interest – talks with you about problems,' by sex	JYRRBS
	Percent ages 10-15 responding always to 'Attention – never too busy to pay attention to you,' by sex	JYRRBS
	Percent ages 10-15 responding always to 'Listening – listens when you have something to say,' by sex	JYRRBS
High expectations	Percent ages 10-15 responding always to 'Rules – expects you to follow the rules,' by sex	JYRRBS
	Percent ages 10-15 responding always to 'Personal best message – always wants you to do your best,' by sex	JYRRBS
	Percent ages 10-15 responding always to 'Believes in child – believes you will be a success,' by sex	JYRRBS
OUTSIDE-HOUSEHOLD PROTECTIVE FACTORS		
Caring relationships	Percent ages 10-15 responding always to 'Care/interest – really cares about you,' by sex	JYRRBS
	Percent ages 10-15 responding always to 'Attention – notices when you are not there,' by sex	JYRRBS
	Percent ages 10-15 responding always to 'Attention – notices when you are upset about something,' by sex	JYRRBS
	Percent ages 10-15 responding always to 'Listening – listens when you have something to say,' by sex	JYRRBS
High Expectations	Percent ages 10-15 responding always to 'Validation – tells you when you do a good job,' by sex	JYRRBS
	Percent ages 10-15 responding always to 'Personal best message – always wants you to do your best,' by sex	JYRRBS
	Percent ages 10-15 responding always to 'Believes in child – believes you will be a success,' by sex	JYRRBS
LIFETIME RISKY BEHAVIOR		
	Percent having ever cheated on a test, ages 10-15	JYRRBS
	Percent having ever deliberately damages something that didn't belong to them, ages 10-15	JYRRBS
	Percent having ever been in a fight with a weapon, ages 10-15	JYRRBS
	Percent having ever taken something from a store, ages 10-15	JYRRBS
	Percent having ever stolen something from someone, ages 10-15	JYRRBS
	Percent having ever gone somewhere to steal something, ages 10-15	JYRRBS

ECLAC=Economic Commission for Latin America and the Caribbean
UNFPA=United Nations Population Fund

GSHS=Global Student-based Health Survey
PAHO=Pan-American Health Organization
FHI=Family Health International
IMJ=Instituto Mexicano para la Juventud
ILO=Internacional Labour Organization
WHO=World Health Organization
CDC=Centers for Disease Control and Prevention
ORC Macro= Macro International
UNHDR=United Nations Human Development Report
JYRRBS=Jamaican Youth Risk and Resiliency Behavior Survey

In addition to the indicators described above, the UN Development Group (UNDG) commissioned the development of performance measures for gender equality to be used by UN Country Teams (UNCTs). The draft set of these indicators (Beck & Patnaik 2007) is organized in the form of a *scorecard,* in which each domain of assessment is rated based on a graduated score: exceeds minimum standards; meets minimum standards; needs improvement; inadequate; or missing/not applicable. Domains and subdomains are as follows:

1. *Planning (CCA/UNDAFs)*
    - Adequate analysis related to gender equality and women's empowerment
    - Gender equality in outcomes
    - Gender equality in outputs
    - Gender-sensitive indicators included
    - Gender equality in baselines
2. *Programming*
    - Gender perspectives are adequately reflected in programming
    - UNCT support for national priorities related to gender equality and/or women's empowerment
    - UNCT support to gender mainstreaming in programme based approaches
    - UNCT support to gender mainstreaming in aid effectiveness processes
3. *Partnerships*
    - Involvement of National Machineries for Women/Gender Equality and women's departments at the sub-national level
    - Involvement of women's NGOs and networks
    - Women from marginalized groups (e.g., HIV-positive women, poor rural women, indigenous women, etc.) included as programme partners and beneficiaries in key UNCT initiatives
4. *UNCT Policies and Capacities*
    - Resident Coordinator supports multi-stakeholder Gender Theme Group

5. Implications of Legal Frameworks, Commitments and Policies for UNICEF-Supported Efforts and the Identification of Positive Adolescent Well-Being Indicators

Almost all the international legal frameworks encompass a substantial inventory of rights that include social development, health, participatory, informational, protection, and many other focal areas. To translate these extensive rights-components into a workable understanding of adolescent well-being that can be effectively implemented with respect to monitoring and evaluation requires – as reiterated in this report – a condensed, domain-based definition that can be operationalized with a clear set of basic (and perhaps optional as well) indicators per domain. This is even more the case when considering the manner in which CRC and MDG obligations inevitably are implemented in national policy, through a myriad of organizational bodies at the state and local level, standards, requirements for funds, resources and services, and more amorphous goals such as "increased participation" or the dissemination of "positive images of youth," which must be operationalized in a way that is measurable across national contexts.

As documented in this report, there are numerous indicators and measures collected within the LAC region (or by the UN globally) that touch on many of the domains relevant to adolescent well-being. However, these measures are not collected uniformly, or by all countries. A substantial effort will be necessary to identify the data available, not available, and potentially available, to monitor the implementation of obligations and policies under these frameworks and institutions within an overall, regional evaluation of adolescent well-being.

V. A Preliminary Working Definition of Adolescent Well-Being for LAC Monitoring

The theoretical, program, policy and legal frameworks, taken together, encompass a far-reaching set of dimensions and rights associated with a healthy life for youth and adolescents. In narrative terms, an overall and preliminary definition of adolescent well-being could be stated as follows:

> *Adolescence is a unique period of growth in which protections and supports from family and other social institutions are still necessary, but at the same time restrictions and opportunities must be opened up to allow for and respect the diverse development and participation of young people in the full range of public, social, economic and cultural life, free from exploitation, abuse and discrimination.*

Given the multiplicity of specific constructs by which adolescent well-being can be defined, the conclusion discussed throughout this report is that adolescent well-being must be considered in terms of *domains,* which represent

a typology of these constructs. Moreover, the domains to consider should reasonably represent the full ecological spectrum of factors that matter with respect to well-being, considering rights-based, policy/program-based and social/behavioral science-based perspectives. Based on the reviewed materials, the key domains for assessing adolescent well-being from a positive perspective – without a focus on statistics emphasizing the incidence prevalence of risk behaviors -- should include:

- *Health:* Basic health status; access to health and social services for families and adolescents.
- *Identity:* Legal identity, opportunities for establishment of identity and self without discrimination; respect for expression of opinions.
- *Social Relationships and Attitudes:* Positive relationships with, and support from family, peers, school and the community.
- *Gender:* Gender equity.
- *Education:* Belief in the utility of school completion, guarantee of and support for school attendance/completion, reduction of barriers to education.
- *Skills and Capacity:* Adequate skills and knowledge to secure employment, participate in civic and community affairs, and make informed decisions about health.
- *Participation:* Opportunities for social and political participation, and recognized contribution, at multiple levels.
- *Information:* Access to information, positive media treatment of adolescents (not solely negative).
- *Spiritual Life:* Opportunities for a spiritual life of the individual's choice without discrimination.
- *Juvenile Justice:* Fair and humane treatment by the legal system, alternatives to confinement where possible.
- *Exploitation and Abuse:* Protection from exploitation and abuse of all types – physical, labor, sexual, trafficking/abduction.
- *Economic Opportunity:* Access to productive employment at many levels, but at a level that can sustain families and individuals.
- *Economic and Social Stake:* Belief in a social place – an adolescent's expectation that there is a viable future for him/her, socially, culturally and economically.

At the same time, adolescent well-being cannot be assessed fully through static, uniform standards that are easy to measure. Well-being is integrally tied to the context within which adolescents find themselves, and, for example, to beliefs they have and realities they confront with respect to the potential for assuming fulfilling social roles: The fewer or less likely are such available roles, the more likely a given youth will gravitate towards behavior patterns and roles that may stand outside, and in conflict with, core social/economic institutions and patterns. Adolescence is a period in which young people develop a personal and social identity, a sense of efficacy, skills and capabilities, connections to social

institutions, a worldview, and much more. Basic indicators of health and economic status, or of risk behavior alone, do not necessarily capture the process by which adolescents interact with their larger context and choose a path (or paths) that makes sense. Their ability to do so in a way that has positive consequences for themselves and their respective societies must also be captured in a definition and indicators of well-being.

VI. Next Steps

Based on the background material reviewed in Part I, the next steps will include:

- Finalization of a definition of adolescence, adolescent well-being, and its relevant measurement domains.
- Identification of “expected impacts” by domain.
- Identifying indicators that exist, or need to be developed and implemented, across the LAC region to measure the expected impacts.
- Identifying data collection and reporting mechanisms for the selected indicators.

These steps are developed further in Part II, following this section.

PART II: DOMAINS AND INDICATORS

PROPOSED UNICEF LATIN AMERICA/CARIBBEAN (LAC) WELL-BEING INDICATORS FOR ADOLESCENTS AND YOUTH (AGES 10-24)

Mark Edberg, Ph.D.

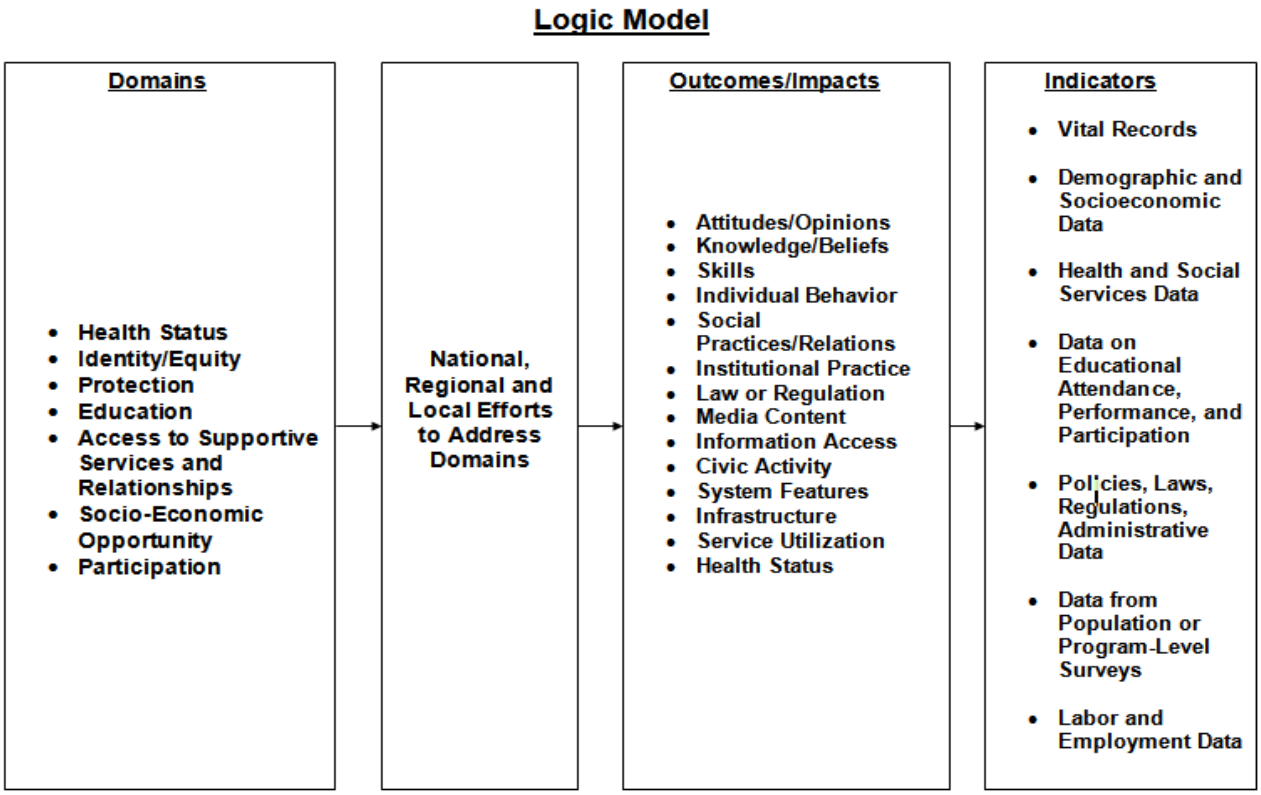
I. Introduction

Part II of this document follows from the background material presented in Part I, a draft set of indicators and rationale (September 2008), and from the results of a TACRO workshop on October 3, 2008, at which input on the indicators was solicited from a diverse group of adolescent health specialists and monitoring/evaluation representatives. Approaches and frameworks for understanding adolescent/youth well-being, as well as key legal and policy frameworks are reviewed in the Part I background section, with a preliminary rationale for identifying well-being indicators. This rationale was further developed in a September 2008 draft set of indicators (UNICEF Latin America/Caribbean Well-Being Indicators for Adolescents and Youth Age 10-24), which proposed a broad, draft set of indicators that could be implemented, at multiple levels, in the LAC region to assess progress with respect to domains representing a positive orientation to adolescent/youth well-being, as well as relevant aspects of the Millenium Development goals (MDGs), Convention on the Rights of the Child (CRC), and other statements and obligations to which LAC nations are signatories. That document was then reviewed at the October TACRO meeting, resulting in this revised section.

II. Rationale for Proposed Indicators

Notes on Structure

As described in Part I, the best strategy for developing a set of indicators to measure progress is to use a logic model structure and proceed through a series of steps that move from broad conceptualization to specific data: 1) defining the issue and its parameters, including the problem to be addressed and the range of factors contributing to the problem; 2) organizing the contributing factors into “actionable domains”; 3) identifying the impacts to be expected by domain in order for progress to occur; 4) defining indicators for each of these impacts; 5) identifying any existing data sources for the indicators; and 6) setting out the practical methods and means for collecting the data. The latter step also involves an arrangement or matrix of indicators that is organized by potential user, because all indicators are not applicable to all users, even with respect to the same domain. A small local program cannot be expected to measure impact using the same indicators that a regional system could use. The following is an illustrative diagram of such a logic model:



This document builds on the previous work to outline an overarching *logic model* (linking causal domains, to impacts, to indicators) that will be the basis for a matrix of indicators and data sources. The matrix will allow a user to assess a possible range of indicators and data sources (for the indicators) in each domain. *Monitoring progress* will be accomplished based on the collection and reporting of a selection of indicators within each domain – *where the entire set of domains represents adolescent/youth well-being from a positive viewpoint*.

This process follows the logic of large planning frameworks and documents that set out objectives and then include standards for measurement of those objectives. An excellent example of this from the U.S. is *Healthy People 2010* (*HP2010*). The *HP2010* compendium [http://www.healthypeople.gov/Document/tableofcontents.htm#under and http://www.healthypeople.gov/data/midcourse/default.htm] provides a framework for prevention and intervention efforts by identifying a multi-level set of national goals and objectives for the decade. It builds on previous national planning documents and was developed through a broad consultation process, drawing on the best available scientific knowledge. In addition to objectives, it provides an extensive set of indicators for measuring progress of disease prevention and health promotion programs and related efforts over time. *HP2010* covers 28 health issue *focus areas* (e.g., access to quality health services, cancer, diabetes, HIV, injury and violence prevention, mental health and mental disorders, nutrition and overweight, physical activity and fitness, public health

infrastructure, substance abuse, tobacco use), with 955 measurable or developmental objectives and subobjectives. Developmental objectives/sub-objectives are defined as those for which baseline data and targets were lacking at the beginning of the decade, but for which there was a potential data source and a reasonable expectation of data points by mid-decade to facilitate target-setting (During a mid-decade review of the progress, many developmental measures became measurable after national baseline data became available; others did not).

In this document, the outcome/impact domains, indicators, and data sources discussed are all compiled in one large accompanying matrix. *Matrix 1: Inventory of Indicators and Data Sources for Measuring LAC Region Adolescent Well-Being* is an overall, "master listing" of adolescent/youth well-being domains, linked to outputs, outcomes/impacts, indicators and data sources. Some of these indicators and data sources are only available in the U.S. or European Union (EU), but they have been included as illustrative of the type of data source that could provide the information referred to by the indicators. Data sources not currently available in the LAC region are marked with an asterisk.

Adolescent/Youth Well-Being: Domains

Proposed domains from the September 2008 report were, as noted, reviewed at the October TACRO meeting and then revised. These domains were intended to represent the dimensions of adolescent/youth well-being that are to be measured. The domains reflect a positive youth orientation, as opposed to an emphasis on risk behavior or negative consequences (e.g., violence, substance abuse, HIV/AIDS, early pregnancy, school dropout, drug selling). Moreover, taken together, the domains *represent an overall definition of adolescent well-being.* Progress towards improved adolescent well-being will be measurable as progress within and across the domains. The definition appears in two parts – the first is a background statement on the parameters of adolescent development as context for the definition, the second is the definition itself:

> ***Part 1, Background:*** *The developmental stage of adolescence is understood herein as the period from 10 to 19 years of age, acknowledging that characteristics of this stage may extend up to age 24, and that adolescent well-being is also determined by early child development before age 10.*
>
> ***Part 2, Definition:*** *Adolescent well-being is a comprehensive construct that includes the ability to acquire knowledge, skills, experience, values, and social relationships, as well as access to basic services, that will enable an individual to negotiate multiple life domains, participate in community and civic affairs, earn income, avoid harmful and risky behavior, and be able to thrive in a variety of circumstances, free from preventable illness, exploitation, abuse and discrimination. It also refers to*

the ability of the surrounding society (e.g., family, peers, community, social institutions) to support those aspects of well-being. Adolescent well-being depends on the full realization of rights outlined in the Convention on Rights of the Child (CRC) to protection and support related to family and other social institutions, health, employment, juvenile justice, religion, culture and identity.

The key domains for assessing adolescent well-being presented at the October 2008 TACRO meeting were:

- *Health:* Basic health status; access to health and social services for families and adolescents, health risk behavior, health knowledge/awareness, environmental quality.
- *Identity:* Legal identity, opportunities for establishment of identity and self without discrimination; respect for expression of opinions and spirituality.
- *Social Relationships and Attitudes:* Positive relationships with, and support from family, peers, school and the community.
- *Gender:* Gender equity.
- *Education:* Belief in the utility of school completion, guarantee of and support for school attendance/completion, reduction of barriers to education.
- *Participation:* Opportunities for social and political participation, and recognized contribution, at multiple levels.
- *Information:* Access to information, positive media treatment of adolescents (not solely negative).
- *Juvenile Justice:* Fair and humane treatment by the legal system, alternatives to confinement where possible.
- *Protection:* Protection from exploitation and abuse of all types – physical, labor, sexual, trafficking/abduction.
- *Socio-Economic Opportunity:* Access to productive employment at many levels, but at a level that can sustain families and individuals. Belief in viable economic/social future.
- *Adolescent/Youth Serving Systems:* Access to social services and other support services for youth.

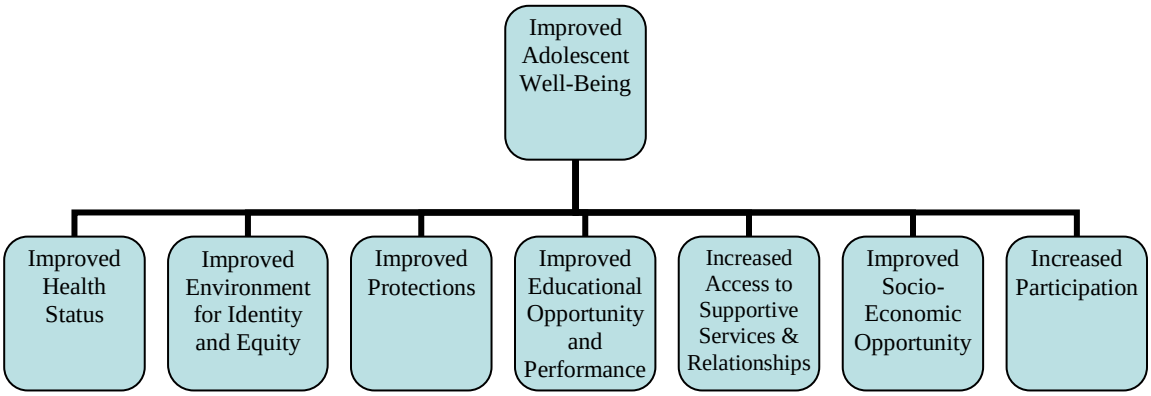
Based on discussions at the October TACRO meeting, these domains have been modified and consolidated, as described below. While these domains represent a positive well-being perspective, some data on risk behaviors should be included in the overall calculation of progress.

Potential Outcomes/Impacts by Domain

The next step is to map potential outcomes and impacts (as well as output measures) to each of the domains as a precursor to identification of indicators, where outputs are defined as actions/activities implemented, outcomes are short-term results, and impacts are defined as long term gains (e.g., 5 years). Potential

outcomes/impacts within each domain could include a range of *types*: Impacts related to access (to health care, education, social services); impacts related to knowledge/awareness; impacts related to skills; economic impacts (e.g., employment, training); impacts related to equity, exclusion and discrimination; impacts related to perceptions and expectations; impacts related to rights and conditions within the justice system; impacts related to recognition and identity; impacts related to participation, and more. Note that, at the level of outcomes/impacts, it is still a conceptual exercise. The next level, development of indicators, requires that each of the outcomes/impacts be specified in measurable terms.

The outcomes/impacts below are intended to represent both the spectrum of approaches to adolescent/youth well-being (in June, 2008 report) and the views of LAC representatives expressed at the October 2008 TACRO meeting. In addition to being organized by domain, they are organized in the attached Matrices as short-term outcomes vs. longer term impacts. They are also phrased as *results* of some activity. When utilized, at baseline the outcomes/impacts would be phrased in terms of the content itself. For example: At baseline, health status might be measured in terms of morbidity from infectious disease; from then, it would be assessed in terms of a change from baseline – e.g., decrease in morbidity from chronic disease. For purposes of monitoring and evaluation, progress towards adolescent well-being should be understood as the aggregate result of progress in each of the domains, as illustrated in the following figure:



Domain 1: Health Status

Health status (selected):

- Reduced morbidity and mortality from infectious disease
- Reduced morbidity and mortality from lack of nutrition
- Reduced morbidity and mortality from intentional violence
- Reduced morbidity and mortality from accidents and unintentional injuries

Health risk behavior:

- Reduction of tobacco use

- Reduction in drug/alcohol use
- Reduction in HIV/AIDS and STI risk behaviors
- Reduction of involvement in intentional violence, interpersonal violence and gangs
- Reduction in unintentional injuries, such as from car accidents
- Reduction of early pregnancy

Health knowledge/skills:
- Increased knowledge of HIV risk and prevention
- Increased knowledge about tobacco risk and prevention
- Increased knowledge about substance abuse risk and prevention
- Increased knowledge about family planning
- Increased knowledge about hygiene and prevention of infectious disease
- Adequate skills and knowledge to make informed decisions about health

Environmental Quality:
- Availability of clean water
- Availability of sanitation systems
- Living conditions free from toxic pollutants

Domain 2: Identity and Equity
- Existence of legal rights, protections and processes related to national identity, indigenous culture, spiritual belief, others.
- Increased evidence showing social recognition of ethnic/indigenous identity including language, cultural practices, and religion
- Increased recognition of, and social practices promoting equality of individual identity regardless of gender.
- Increase in the freedom of adolescents to affiliate with social, educational, political, family and civic groups of their choosing (connectedness).
- Positive treatment of adolescents in the media, opportunities for adolescent voices in the media.

Domain 3: Protection
- The enactment of legal frameworks and policies for protection from exploitation, violence and abuse, social exclusion, harmful traditional practices, juvenile justice abuses, discrimination (e.g., based on race, gender, culture, disabled status).
- Institutional enforcement of those protections.
- Protections in place for adolescents in emergencies such as war, civil conflict, and natural disasters.
- Education and information provided to the public with respect to legal protections and sanctions regarding abuse
- Increased awareness among adolescents and all others about the protective frameworks and policies, and their enforcement.

Domain 4: Education

- Elimination of barriers to primary and secondary education, regardless of gender
- Increased access to adult and "second chance" educational opportunities, including vocational school
- Increased attendance at school
- Increases in literacy and academic performance
- Increase in adolescent belief in the utility of school completion (bonding to school)
- Increased resources, staff allocated for schools
- Increased access to higher education

Domain 5: Access to Supportive Services (Health, Social) and Relationships

- Designated national government agency or unit focusing on adolescents/youth
- Designated local agency/unit focusing on adolescents/youth
- Regularized data collected on the well-being of adolescents/youth
- Increased access to basic health services, including treatment, preventive services, and family planning.
- Increased access to social services
- Increase in the practice of equitable and humane treatment in the justice system, and increased access to services (e.g., legal representation) that help insure this.
- Increased access to information (libraries, the Internet, etc.)
- Increased use of media and communications to disseminate health information for adolescents/youth
- Increase in the prevalence of caring and supportive family, peer, school and community environments
- Increase in access to positive peer activities (including recreation, social, civic, work)
- Resources and finances budgeted for adolescent supportive services and policies.

Domain 6: Socio-Economic Opportunity

- Reduction in family poverty level
- Reduction in adolescent/youth poverty level
- Increase in employment rate for adolescents/youth (all gender categories)
- Access to productive employment at least at a level that can sustain families and individuals
- Access to training and skills development for employment
- Adequate skills and knowledge to secure employment
- Opportunities to develop and engage in (legal) economic activity
- Belief in a social place – an adolescent's expectation that there is a viable future for him/her, socially, culturally and economically.

Domain 7: Participation

- Increase in knowledge among adolescents about civic affairs.
- Increase in adolescent knowledge and capabilities to access information.
- Increase in youth-led organizations and activities in schools and communities and networking
- Increase in the number of social action activities involving adolescents, and/or for adolescents.
- The institutionalization of adolescent participation in civic affairs, in the form of youth committees, councils, representation, and other forms.

Note that output measures are not listed above – some output measures are listed in Matrix 1, but many will be specific to the program, intervention or policy that is implemented. In general, the left side of Matrix 1 (attached, as an Excel spreadsheet) include separate columns for output, outcome and impact, and list all the above outcomes/impacts by domain. It also notes for a number of domains if the outcomes/impacts refer in a general sense to legal protections, social practices, institutional practices, or awareness. These categories will be more clearly delineated with respect to indicators.

Potential Core Outcomes/Impacts and Indicators

From the set of outcomes/impacts listed above and the corresponding indicators presented below and in Matrix 1, the following is a core set of outcomes/impacts representing all domains. Indicators for these core impacts/outcomes are marked with a "*" in Matrix 1.

Domain 1: Health Status

- *Health status (selected)*: Reduced adolescent morbidity and mortality (all causes)
- *Health risk behavior:* Reduction in risk behaviors for which data are collected/available (e.g., tobacco use, drug/alcohol use, HIV/AIDS & STI risk, violence, injuries, early pregnancy)
- *Health knowledge/skills*: Increased knowledge of health risks and prevention skills for which data are collected (e.g., tobacco risk and prevention, substance abuse risk and prevention, family planning, hygiene and prevention of infectious disease)
- *Environmental quality*: Availability of clean water and sanitation systems

Domain 2: Identity

- Legal rights, protections and processes related to national identity, indigenous culture, spiritual belief, others.

Domain 3: Protection

- The enactment of legal frameworks and policies for protection from exploitation, violence and abuse, social exclusion, harmful traditional

practices, juvenile justice abuses, discrimination (e.g., based on race, gender, culture, disabled status).
- Institutional enforcement of those protections.

Domain 4: Education
- Increased access to primary, secondary, adult and "second chance" educational opportunities, regardless of gender
- Increases in attendance, literacy and academic performance

Domain 5: Access to Supportive Services (Health, Social) and Relationships
- Designated government agency or unit focusing on adolescents/youth
- Increased access to social services, and basic health services, including treatment, preventive services, and family planning.
- Resources and finances budgeted for adolescent supportive services and policies.

Domain 6: Socio-Economic Opportunity
- Reduction in adolescent/youth poverty level
- Increase in employment rate for adolescents/youth (all gender categories)
- Access to training and skills development for employment

Domain 7: Participation
- Increase in knowledge among adolescents about civic affairs.
- The institutionalization of adolescent participation in civic affairs, in the form of youth committees, councils, representation, media involvement, and other forms.

III. Indicators and Data Sources

Potential Indicators for Outcomes/Impacts, by Domain

Each general outcome/impact identified by domain in the previous section must now be operationalized into specific indicators. To the right of the Domain and Output/Outcome/Impact columns on Matrix 1, indicators are listed for each of the potential outcomes/impacts (and some outputs) described above, and classified according to the following categories:

Indicator Content:
- Attitudes/Opinions (A/O)
- Knowledge/Beliefs (K/B)
- Skills (S)
- Individual Behavior (IB)
- Social Practices/Relations (SP/R)

- Institutional Practice (IP)
- Law or Regulation (L)
- Media Content (MC)
- Information Access (IA)
- Civic Activity (CA)
- System Features[8] (SF)
- Infrastructure (I)
- Service Utilization (SU)
- Health Status (HS)

Potential Data Sources for Indicators

The process of identifying indicators goes hand-in-hand with identifying data sources for the indicators, because in many cases the choice of indicator will be governed by indicators that are collected in specific data sources. In Matrix 1, where there are any existing data sources for the indicator, these will be listed, with an asterisk next to those sources which are not available in the LAC region. Where there are *data collection mechanisms* that would enable the collection of the indicator – for example, an existing survey – but that don't currently collect that data, a data item will be recommended for addition (e.g., a new question or set of questions added to a survey). Where the data are not collected and there is no current mechanism for collecting the data, a recommendation will be made as to possible mechanisms. Data sources will generally fall into the following categories:

- Vital records (morbidity, mortality)
- Demographic and socioeconomic data
- Health and social services data (e.g., resources allocated, services provided, clinic or program utilization)
- Data on educational attendance, performance and participation
- Policies, laws, regulations, administrative data
- Data from population or program-level surveys (self-report) – behavior, knowledge, attitudes
- Labor and employment data

For reference, the following are examples of major sources of relevant indicators and data from the LAC region, the U.S., and European/Global sources (not including the LAC). Not all of these data sources pertain to the LAC, but those that do not may provide guidance on types of potential indicators and accompanying data. A major caveat: for purposes of this LAC effort, caution must be exercised in selecting indicators and data sources, since different data sources may use different processes, age-ranges, or methods of calculation and therefore the data are not actually comparable. Also important, and noted where

[8] Such as a committee, an agency, a task force, etc.

possible in the descriptions below, even data from large data sets (e.g. DHS) are typically collected only from selected countries in the LAC region, not from all.

A. LAC Region Data Sources (Including Global Data Sources that Contain LAC Country Data)

1. Pan-American Health Organization (PAHO)

In 1995, the Regional Core Health Data and Country Profile Initiative was launched by the Pan American Health Organization / Regional Office of the World Health Organization (WHO) to monitor the attainment of health goals and compliance with the mandates of the member states, in addition to ensuring the availability of a basic set of data to be collected annually that would make it possible to characterize the health situation and trends in the countries of the Region of the Americas. In 1997, PAHO adopted a resolution on the collection and use of core health data to:

- evaluate the health status of the population and health trends,
- provide empirical basis for identifying the population groups with greater health needs,
- stratify epidemiological risk,
- determine critical areas, and
- examine the response of the health services to provide input for policy-making and setting priorities in this field.

PAHO provides an online table generator, a multidimensional query tool that offers a collection of 117 indicators for 48 states and territories of the Americas from 1995 to 2007. The system presents data and indicators on:

- demographics
- socioeconomic information
- mortality by cause indicators
- morbidity and risk factors
- access, resources and health services coverage.

It is worth presenting here a lengthy (although condensed) listing of these indicators, many of which will be useful with respect to monitoring adolescent/youth well-being (PAHO 2007).

Demographics:
Population
Proportion urban population
Population by age brackets
Proportion economically dependent
Population growth
Fertility and birth rates
Death rates
Life expectancy

Socioeconomic:
Available calories
Literacy rate
Primary school enrollment
GNI and GDP per capita
GDP growth
Highest/lowest income ratio
Proportion of population below national poverty line
Unemployment
CPI growth

Mortality:
General mortality, by age
Infant mortality
Under-5 mortality
Maternal mortality
Child deaths from measles, tetanus, intestinal infections, respiratory infections, diphtheria, pertussis
Mortality from communicable disease
Mortality from TB, AIDS, circulatory system disease, heart disease, cerebrovascular disease, various malignant neoplasms, diabetes, cirrhosis, liver disease
Mortality from external causes
Mortality from accidents (including vehicle)
Mortality from suicide, homicide

Morbidity:
LBW
Nutritional deficiency – under 5
Breastfeeding
Dental problems (DMFT)
Child cases of polio, measles, diphtheria, pertussis
Cases of tetanus, cholera, rabies, yellow fever, plague, dengue, malaria, parasites, TB, AIDS (by gender), leprosy, malignant neoplasms
Prevalence of overweight
Adolescent tobacco use
Malaria risk

Resources, Services, Coverage:
Access to improved water source
Access to improved sanitation
Proportion immunized
Prevalence of contraceptive use
Adolescent fertility rate
Pregnancies/deliveries attended by trained personnel

Ratio of physicians, nurses, dentists
Number of outpatient care facilities
Hospital beds ratio
Outpatient care visits ratio
Hospital discharges ratio
National health expenditures as proportion of GDP
Under-registered deaths
Proportion of deaths with unknown conditions

Fifty-seven indicators from the basic indicators database are published annually in the format of a brochure in English and Spanish. The first edition of Basic Indicators was published in 1995. From the 2003 update on, data is presented by country and subregions.

2. UNICEF Data

Without question, UNICEF itself already provides a major source of indicators and data for the LAC region, as part of its several global data systems concerning children and women. UNICEF is the lead United Nations (UN) agency responsible for the global monitoring of the child-related Millennium Development Goals (MDGs), and assists countries in collecting data via the Multiple Indicator Cluster Surveys (MICS), the international household survey protocol developed following the 1990 World Summit for Children. Since 1995, nearly 200 MICS have been implemented in approximately 100 countries, through three rounds of surveys (1995, 2000 and 2005-6). The next round of surveys (MICS4) will take place in 2009-2010.According to UNICEF, the latest round of MICS data is generating data representative of almost one in four children living in developing countries. MICS provides statistically sound, internationally comparable estimates of indicators on:

- Child Survival and Development
- Education and Gender Equality
- Child Protection
- AIDS

MICS (MICS3, the latest round) data are collected through modular survey questionnaires that can be customized to the needs of particular countries. There are three questionnaires: a household questionnaire, a questionnaire for women aged 15-49, and a questionnaire for children under the age of 5 (addressed to the mother or primary caretaker of the child). MICS3 surveys cover much of what was covered in earlier rounds, and provide updated estimates and trends for many indicators. In addition, new indicators are included to provide baseline data or estimates of coverage for other priority issues. The current round of MICS is focused on providing a monitoring tool for the World Fit for Children, the Millennium Development Goals (MDGs), as well as for other major international commitments, such as the UNGASS on HIV/AIDS and the Abuja targets for

malaria. Data on 21 of the 48 MDG indicators are collected in the third round of MICS, offering the largest single source of data for MDG monitoring. With respect to the LAC, the following countries are represented in the MICS: Antigua and Barbuda, Argentina, Barbados, Belize, Bolivia, Brazil, Chile, Columbia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, St. Kitts-Nevis, St. Lucia, St. Vincent and the Grenadines, Suriname, Trinidad and Tobago, Uruguay, and Venezuela.

The following modules are included:

Household:
Household characteristics, household listing, education, child labour, water and sanitation, salt iodization, insecticide-treated mosquito nets, and support to children orphaned and made vulnerable by HIV/AIDS, with optional modules for disability, child discipline, security of tenure and durability of housing, source and cost of supplies for ITNs, and maternal mortality.

Women:
Women's characteristics, child mortality, tetanus toxoid, maternal and newborn health, marriage/union, contraceptive use, HIV/AIDS knowledge, malaria, polygyny, female genital mutilation, and sexual behaviour, with optional modules for unmet need, security of tenure, and attitudes toward domestic violence.

Children:
Children's characteristics, birth registration and early learning, vitamin A, breastfeeding, care of illness, malaria, immunization, and anthropometry, with optional modules for child development, and source and cost of supplies of ORS, antibiotics and antimalarials.

Note that a substantial amount of the data collected under the MICS does not apply to the age-range (10-24) that is the focus of the adolescent/youth effort, or the data collected cover a portion of the range. However, as emphasized below under the Next Steps section, these data collection mechanisms are prime candidates for the addition of new data items or the expansion of age ranges to cover the adolescent/youth population.

UNICEF is working closely with other household survey programs, in particular the Demographic and Health Surveys (DHS) program to coordinate survey questions and modules and to ensure a coordinated approach to survey implementation. DHS surveys are conducted in around 10 countries a year and besides the MICS are the primary sources of data on many health and household indicators. Coordinating both the countries surveyed and the questions included in the questionnaire modules ensures that there is maximum coverage of countries in the household surveys and provides comparability across surveys.

UNICEF's global databases on key indicators go through a rigorous and ongoing process to ensure data quality. The databases, updated annually with the assistance of UNICEF's 140 field offices, are found at http://www.childinfo.org/ UNICEF data appear in key UNICEF publications such as *The State of the World's Children* and *Progress for Children*, as well as in sector-specific reports such as *Countdown to 2015*; *Malaria and Children*; and *Pneumonia: The Forgotten Killer of Children*. They are also used for evidence-based policy analysis such as in the ongoing *Global Study on Child Poverty and Disparities* being carried out in 40 countries and seven regions through UNICEF support (http://www.unicefglobalstudy.blogspot.com/)

UNICEF also promotes data dissemination through DevInfo, a downloadable database system that tracks progress towards the MDGs and monitors commitments to sustained human development. DevInfo generates tables, graphs and maps, even for trend data. It is can be an advocacy and planning tool for national statistics offices, UN agencies, donors and civil society, contributing to greater MDG awareness and knowledge at the country level and to evidence-based policy-making. The software can be downloaded at http://www.devinfo.org/

UNICEF MENA Region. Of note, the MENA Region has just recently developed a draft set of adolescent and youth indicators (June 2008). In some ways, this effort parallels the LAC Region effort; however, the MENA domains and indicators are not based on an overall positive youth development approach. For this reason there is some overlap, but only to an extent. MENA adolescent/youth domains include:

- Demographics – adolescent/youth population, adolescent/youth percentage of total population, marriage, and others.
- Poverty – Youth living in poverty, underweight youth, water deprivation, etc.
- Education – Compulsory education, literacy, enrollment, gender, education among disabled.
- Livelihoods and economic participation – Economically active youth population, labor force participation, unemployment, activity/inactivity.
- Health and reproductive health – Fertility, marriage, maternal mortality, risk behavior prevalence (tobacco, drug abuse, condom use), age of first sex, anemia, obesity, HIV/AIDS, HIV/AIDS knowledge.
- Mortality – Lifespan, major causes of death.
- Migration – Ratio of youth to adult migrants, desire to migrate, percentage of youth migrants.
- Civic participation – Voting age, age requirements for public office, age of marriage without parental consent, number of youth organizations, existence of youth council, number/percentage of youth participating in civil society, school organizations.

- Armed conflict – Number of adolescent/youth refugees, internally displaced youth.
- Child protection – Child homicides, victims of violence, corporal punishment, trafficking victims, repatriation, female genital cutting, child marriage, child labor rates, children in detention, children not living with parents, number of social workers, birth registration, suicide.
- Youth in emergencies – Probability of survival, egregious violations, involuntary participation in armed forces, reunited children, demobilized children, landmine morbidity/mortality.
- Information and communication technologies – Computer and Internet access, computer/Internet use, mobile phones, telephone use.

3. Demographic and Health Surveys (MEASURE DHS), by ORC Macro/Macro International

The DHS surveys are nationally-representative household surveys that provide data for a wide range of monitoring and impact evaluation indicators in the areas of population, health, and nutrition. The surveys are funded/sponsored by USAID and conducted in approximately 80 countries. LAC region countries from which DHS data are collected include: Brazil, Columbia, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Paraguay, Peru, and Trinidad and Tobago.

In general, DHS indicators provide data on the following topics:

- Anemia - prevalence of anemia, iron supplementation
- Child Health - vaccinations, childhood illness
- Education - highest level achieved, school enrollment
- Family Planning knowledge and use of family planning, attitudes
- Female Genital Cutting - prevalence of and attitudes about female genital cutting
- Fertility and Fertility Preferences - total fertility rate, desired family size, marriage and sexual activity
- Gender/Domestic Violence - history of domestic violence, frequency and consequences of violence
- HIV/AIDS Knowledge, Attitudes, and Behavior - knowledge of HIV prevention, misconceptions, stigma, higher-risk sexual behavior
- HIV Prevalence - Prevalence of HIV by demographic and behavioral characteristics
- Household and Respondent Characteristics- electricity, access to water, possessions, education and school attendance, employment

- Infant and Child Mortality - infant and child mortality rates
- Malaria - knowledge about malaria transmission, use of bednets among children and women, frequency and treatment of fever
- Maternal Health - access to antenatal, delivery and postnatal care
- Maternal Mortality - maternal mortality ratio
- Nutrition - breastfeeding, vitamin supplementation, anthropometry, anemia
- Wealth/Socioeconomics - division of households into 5 wealth quintiles to show relationship between wealth, population and health indicators
- Women's Empowerment - gender attitudes, women's decision making power, education and employment of men vs. women

Relevant to this effort, the DHS *Youth Corner* website highlights DHS findings about youth and features in-depth profiles of young adults ages 15-24 from more than 30 countries worldwide. The data comes from surveys conducted in Africa, Asia, Latin America and Eastern Europe since 2000. MEASURE DHS has interviewed thousands of young people and gathered valuable information about their education, employment, media exposure, nutrition, sexual activity, fertility, unions, gender issues, and general reproductive health, including HIV prevalence.

The data can be found under "Country Profiles" in two formats: QuickStats and Key Indicators. "QuickStats" features 12 important indicators, such as the percentage of young women and men who have sexual intercourse before age 18. For a more in-depth look at youth in a particular country, "Key Indicators" offers data for more than 25 indicators, reproductive health and women's empowerment, where available. This data is disaggregated by age (15-19 and 20-24) and by sex. All of the data were reanalyzed after standardization to make them comparable. In addition, Youth Corner includes a full list of all DHS publications related to youth, with links to the reports.

4. US Census International Database

The U.S. Census International Data Base (IDB) offers a variety of demographic indicators for 226 countries and areas of the world, including Latin America and the Caribbean. The IDB provides the following indicators: age-specific population, age-specific fertility rate, age-specific mortality rate, and prevalence of contraceptive use by method and age.

The following Latin American countries are included in the IDB: Antigua and Barbuda, Argentina, Aruba, Bahamas, Barbados, Belize, Bermuda, Bolivia, Brazil, Cayman Islands, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Puerto Rico, Saint Kitts and Nevis, Saint Lucia, Saint Martin, Saint Vincent and the Grenadines, Uruguay, Venezuela, and the Virgin Islands.

5. UNDP Human Development Reports

Every year since 1990, UNDP has been publishing a human development index (HDI) based on a philosophical approach to development that seeks to create an enabling environment so that people can live long and healthy lives. The HDI goes beyond GDP measures to provide a composite measure of three aspects of human development: living a long and healthy life (measured by life expectancy); being educated (measured by adult literacy and enrollment in primary, secondary and tertiary school levels); and having a decent standard of living (measured by purchasing power parity, PPP, income). Among the many relationships revealed by the HDI are contradictions between a country's income and its HDI. HDI LAC region countries for which HDI data are available include all those listed for the UNICEF MICS, as well as the Bahamas and Haiti.

6. ECLAC (Economic Commission for Latin America and the Caribbean)

ECLAC, one of five UN regional commissions, produces the CEPALSTAT Databases and Statistical Publications. While most of the information disseminated is produced by official agencies of countries and international agencies, its presentation, systematized and documented for the region as a whole, is a useful contribution to the spectrum of statistical data. Available databases include: Social Statistics (population, education, housing, health, poverty and income distribution); Economic Statistics (national accounts, external sector, internal prices, government finance, agricultural statistics, labor and remunerations, monetary indicators); Environment Statistics (air, water, seas and coastal Areas, land and soils, biota, energy, disasters, natural disasters, human settlements, transportation and infrastructure, solid waste, environmental management); Demographic Statistics; Millenium Development Goals; Gender Statistics; Statistics for Sustainable Development; Science and Technology Statistics; and Technologies of Information and Communication Statistics.

7. UNFPA (United Nations Population Fund)

UNFPA supports countries in using population data for policies and programs to reduce poverty. UNFPA helps governments, at their request, to formulate policies and strategies to reduce poverty and support sustainable development. The Fund also assists countries to collect and analyze population data that can help them understand population trends. In the LAC region, UNFPA is involved with data collection in the following countries: Argentina, Bolivia Brazil, Belize, Guyana, Saint Lucia, Jamaica, Suriname, Trinidad and Tobago, Anguilla, Antigua and Barbuda, Aruba, Bahamas, Barbados, Bermuda, British Virgin Islands, Cayman Islands, Dominica, Grenada, Montserrat, Netherlands Antilles, Saint Kitts and Nevis, Saint Vincent and the Grenadines, Turks and Caicos Islands, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Uruguay, and Venezuela. In each country, UNFPA collects data on the following indicator categories: population, socioeconomics, health,

adolescent reproductive health, gender equality, and reproductive health disparities.

8. GSHS (Global Student-Based Health Survey -- WHO)

The Global School-Based Student Health Survey (GSHS) is collaborative surveillance project designed to help countries measure and assess the behavioral risk factors and protective factors in 10 key areas among young people aged 13 to 15. The GSHS is a relatively low-cost school-based survey which uses a self-administered questionnaire to obtain data on young people's health behavior and protective factors related to the leading causes of morbidity and mortality among children and adults worldwide. The key topics addressed by the survey are: Alcohol and other drug use; dietary behaviors; hygiene; mental health; physical activity; protective factors; respondent demographics; sexual behaviors; tobacco use; and violence and unintentional injury. In Latin America and the Caribbean, GSHS data are collected from the following countries: Anguilla, Argentina, Bahamas, Bolivia, Brazil, Cayman Islands, Chile, Colombia, Costa Rica, Dominica, Ecuador, Grenada, Guatemala, Guyana, Jamaica, Mexico, Montserrat, Nicaragua, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Trinidad and Tobago, Uruguay, and Venezuela.

9. Family Health International (FHI)

Family Health International (FHI) is among the largest and most established nonprofit organizations active in international public health with a mission to improve lives worldwide through research, education, and services in family health. In Latin America, FHI works in: Brazil, Dominican Republic, El Salvador, Guatemala, Guyana, Haiti, Honduras, Jamaica, and Mexico. FHI primarily collects data on adolescent sexual and reproductive health, including unintended pregnancies, sexually transmitted infections (STIs), HIV/AIDS, contraception, sexual risk behavior, and access to reproductive health care, to name a few.

10. Instituto Mexicano para la Juventud (IMJ)

The mission of the Mexican Institute for Youth is to promote, generate and articulate integrated youth public policy that emerges from the recognition that youth are diverse and subjects as well as actors in their own destiny. Public policy should respond to their needs, supporting improvement of their quality of life and their full participation and national development. The Mexican Institute for Youth has three programs: National Youth Program 2002-2006 (ProYouth), Moderate Term Plan, and Youth Power. For these programs, indicators are measured in the areas of: juvenile emancipation (school enrollment, unemployment), fostering youth well-being (access to services, youth and maternal youth mortality rates), development of youth organization and citizenship (voting, belonging to clubs), youth creativity supports, and equitable opportunities for excluded youth (poverty, illiteracy). Importantly for purposes of the UNICEF indicators effort, IMJ conducts a National Youth Survey collecting data in nine areas: education, employment, health, sexuality, procreation, public

life, private life, values, and access to justice and human rights. The survey is conducted among youth ages 12-29.

11. International Labour Organization (ILO), Bureau of Statistics, Global Youth Employment Trends

The International Labour Organization (ILO) focuses on increasing opportunities for productive work in conditions of freedom, equity, security and human dignity. Specifically, ILO promotes rights at work, decent employment opportunities, enhanced social protection and better dialogue with respect to work-related issues. There are several seta of data: a) The *Statistical Information and Monitoring Programme on Child Labour* (IPEC-SIMPOC), with data from Honduras, El Salvador, Guatemala, Nicaragua, Dominican Republic, Costa Rica, Colombia, Brazil, Belize; b) the *Labor Force Survey,* a standard household-based survey of work-related statistics, collected in Argentina, the Bahamas, Barbados, Belize, Bermuda, Bolivia, Brazil, Cayman Islands, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Puerto Rico, Saint Lucia, Uruguay, and Venezuela; and c) the *Laborsta* database, including labor statistics such as economically active population, employment, unemployment, etc., collected from Antigua and Barbuda, Argentina, Aruba, Bahamas, Barbados, Belize, Bermuda, Bolivia, Brazil, Cayman Islands, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Puerto Rico, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Trinidad and Tobago, Uruguay, Venezuela, and the Virgin Islands.

12. Jamaican Youth Risk and Resiliency Behavior Survey (JYRRBS)

The Jamaica Youth Risk and Resiliency Behaviour Survey, a collaborative effort of the University of the West Indies (UWI), Mona, the Jamaican Ministry of Health (MoH), and United States Agency for International Development/Jamaica Caribbean (USAID/J-CAR), with technical assistance from the MEASURE Evaluation Project, gathered information from 1318 participants (599 males and 721 females) island-wide who were 15 - 19 years of age. The main objectives of the survey were to: describe lifestyle and behavior patterns (exercise, cigarette smoking and alcohol consumption) by demographic and socio-economic characteristics; determine and document the context of adolescent reproductive and sexual health, including the magnitude, determinants and consequences for adolescents' lives; determine the association between resiliency and markers of abnormal mental health on risk-taking behaviours, including involvement in violence; obtain anthropometric measurements, fasting glucose levels and cholesterol levels in youth and relate these to chronic disease risks; and identify the sources of information influencing adolescents' health and health seeking behavior. The study provides important data on the health status, health seeking behavior, risk and resiliency factors affecting Jamaican youth. Data support the conclusion that protective factors, such as improved educational levels, parental

involvement and expectations, and positive mental health trends should be augmented in order to improve reproductive and sexual health outcomes, reduce risky behaviors, and inform subsequent adolescent health policy and programs.

While this survey was done in Jamaica only, it may provide a model that can be adapted in other LAC countries.

13. United Nations Department of Economic and Social Affairs (UNDESA)

UNDESA collects data in the areas of: social Indicators (child-bearing, child and elderly populations, contraceptive use, education, health, housing, human settlements, income and economic activity, literacy, population, unemployment, water supply and sanitation), and population statistics, as well as environmental and energy data. Sources of social indicators are: civil registrations, population registers, other administrative records, population and housing censuses, and social and demographic surveys. Under the category of demographic and social statistics, UNDESA collects[9]:

- Size and structure of the population, births, deaths, and migration
- Social Security and Welfare
- Distribution of income and consumption; wealth and poverty
- Public order and safety
- Family formation, families and households
- Health, human functioning and disability
- Housing and its environment
- Learning and education
- Economic Activity
- Allocation of Time and Time Use

14. Save the Children

Save the Children is working in those countries identified by the United Nations as having the highest levels of rural poverty in the region: Bolivia, El Salvador, Guatemala, Haiti, and Nicaragua. In addition, the agency works directly with three Save the Children Alliance members in Honduras, Mexico, and the Dominican Republic.

In line with the global initiatives of Save the Children, the priorities of the Latin American and Caribbean region include: 1) neonatal health and reproductive health; 2) early childhood development and primary education; 3) food security and nutrition; and 4) emergency response and preparedness.

Save the Children collects data in the areas of: educational attainment and literacy for youth and children; childhood development; reproductive health in adolescence; hunger and malnutrition, among others.

15. Child Rights Indices

Several LAC countries have also instituted standard indices for measuring adherence to child rights standards in the CRC. The Mexican Child Rights Index

[9] This information is not fully clarified.

is divided by developmental stage -- infant (0-5), school-age (6-11) and adolescent (12-17). The adolescent index focuses on three “rights domains”:

- Right to life – prevention and avoidance of premature death.
- Right to education – right of all to attend school and to finish secondary school.
- Right to be free from labor exploitation – no illegal or harmful work, or unfair pay.

In Ecuador, a similar child rights index has been created, also divided into three developmental stages and calculated using a 10-point scale. Data on adherence is collected by the Observatory for the Rights of Children and Adolescents, and disseminated through two channels: a periodic bulletin and an annual report entitled “The State of Rights.”

16. UN Office on Drugs and Crime

UNODC assists member states regarding illicit drugs, crime and terrorism. The three pillars of the UNODC work program are:

- Field-based technical cooperation projects to enhance the capacity of Member States to counteract illicit drugs, crime and terrorism;
- Research and analytical work to increase knowledge and understanding of drugs and crime issues and expand the evidence-base for policy and operational decisions; and
- Normative work to assist States in the ratification and implementation of the international treaties, the development of domestic legislation on drugs, crime and terrorism, and the provision of secretariat and substantive services to the treaty-based and governing bodies.

In pursuing its objectives, UNODC makes efforts to integrate and mainstream the gender perspective, particularly in its projects for prevention and the provision of alternative livelihoods, as well as those against human trafficking.

Data collected and reported on:

- Alternative development
- Corruption
- Crop monitoring
- HIV/AIDS
- Human trafficking
- Illicit drugs – production, patterns of use and trafficking, drug seizures
- Justice and prison reform and global criminal justice systems
- Money-laundering
- Organized crime, crime trends
- Terrorism prevention

Data are compiled for a number of countries and regions, including Africa, the Balkans, Afghanistan, the Caribbean, countries in Western Europe, and others.

17. UNESCO

UNESCO serves as a clearinghouse – for the dissemination and sharing of information and knowledge – while helping member states to build their human and institutional capacities in diverse fields. UNESCO promotes international co-operation among its 193* (as of October 2007) member states and six associate members in the fields of education, science, culture and communication. Through its strategies and activities, UNESCO is actively pursuing the Millennium Development Goals, especially those aiming to:

• halve the proportion of people living in extreme poverty in developing countries by 2015
• achieve universal primary education in all countries by 2015
• eliminate gender disparity in primary and secondary education by 2005
• help countries implement a national strategy for sustainable development by 2005 to reverse current trends in the loss of environmental resources by 2015.
• UNESCO and the United Nations Millennium Goals

Thus data are collected in the following areas:

- Education
- Literacy
- Science and Technology
- Culture and Communication

B. U.S. Indicators/Data Sources (Examples)

1. The CDC Behavioral Risk Factor Surveillance System

Established in 1984 by the Centers for Disease Control and Prevention (CDC), the Behavioral Risk Factor Surveillance System (BRFSS) is a state-based system of health surveys that collects information on health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. For many states, the BRFSS is the only available source of timely, accurate data on health-related behaviors.

Currently, data are collected monthly in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam. More than 350,000 adults are interviewed each year, making the BRFSS the largest telephone health survey in the world. States use BRFSS data to identify emerging health problems, establish and track health objectives, and develop and evaluate public health policies and programs. Many states also use BRFSS data to support health-related legislative efforts.

The BRFSS questionnaire is developed jointly by CDC and state health departments.

The questionnaire has five sections:

- Fixed Core
- Two Rotating Cores
- Optional Modules
- Emerging Core
- State-Added Questions

All states ask these questions every year. They cover topics such as:

- Health Status
- Health Insurance
- Routine Checkup
- Diabetes
- Smoking
- Pregnancy
- Women's Health
- HIV / AIDS
- Demographics

Asked every other year, Rotating Core Questions cover topics such as:

Odd-Numbered Years

- Hypertension
- Injuries
- Alcohol Use
- Vaccinations
- Colorectal Screening
- Cholesterol

Even-Numbered Years

- Physical Activities
- Fruit and Vegetable Consumption
- Weight Control

Based on their needs, states can select from a list of standardized questions, known as optional modules. Past topics have included:

- Diabetes
- Sexual Behavior
- Family Planning
- Health Care Coverage
- Health Care Utilization
- Preventive Counseling Services
- Cardiovascular Disease
- Arthritis
- Quality of Life
- Hypertension Awareness
- Fruit and Vegetable Consumption
- Exercise
- Weight Control
- Folic Acid
- Skin Cancer
- Social Context
- Tobacco Use Prevention
- Smokeless Tobacco Use
- Firearms

- Cholesterol Awareness
- Colorectal Cancer Screening
- Oral Health
- Immunization
- Injury Control
- Alcohol Consumption

Emerging core questions typically focus on "late breaking" health issues. They are evaluated each year to determine their potential value in future surveys.

States can add their own questions to explore health issues not already covered in the survey.

Recent examples of State-added questions include:

Arkansas
Do you have one or more smoke detectors installed in your house?

Colorado
Have you ever smoked a cigar, even just a few puffs?

Florida
Have you ever been vaccinated against hepatitis B?

Idaho
Has your well water been tested in the past 12 months?

Kentucky
Prior to the change in the regulation for operating and riding as a passenger on a motorcycle, how often did you and/or other individual(s) wear protective headgear (helmet)?

Maryland
Do you now always use condoms for protection?

South Dakota
Have you heard about the Breast and Cervical Cancer Control Program, otherwise known as “All Women Count!”, that pays for Pap smears and mammograms for women who meet certain age and income guidelines?

Who uses BRFSS survey results?

- State and Local Health Departments
- CDC
- Academic Researchers
- Health Professionals
- Nonprofit Organizations
- Insurance Companies
- Managed Care Organizations
- Students
- The Media
- The Military

2. The CDC Youth Risk Behavior Surveillance System

Similar to the BRFSS, the Youth Risk Behavior Surveillance System (YRBSS) monitors priority health-risk behaviors and the prevalence of obesity and asthma among youth and young adults. The YRBSS includes a national school-based survey conducted by the Centers for Disease Control and Prevention (CDC) and state, territorial, tribal, and local surveys conducted by state, territorial, and local education and health agencies and tribal governments.

The Youth Risk Behavior Surveillance System (YRBSS) monitors six categories of priority health-risk behaviors among youth and young adults including

- behaviors that contribute to unintentional injuries and violence;
- tobacco use;
- alcohol and other drug use;
- sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV) infection;
- unhealthy dietary behaviors; and
- physical inactivity.

In addition, the YRBSS monitors the prevalence of obesity and asthma.

In 2007, the YRBSS included a national school-based survey conducted by CDC, 44 state surveys, five territory surveys, and 22 local surveys conducted among students in grades 9–12 during January 2007—February 2008.

3. The National Longitudinal Survey of Youth (NLSY) – NLSInfo.org

The **National Longitudinal Surveys (NLS)** are a set of surveys designed to gather information at multiple points in time on the labor market activities and other significant life events of several groups of men and women. For more than 4 decades, NLS data have served as an important tool for economists, sociologists, and other researchers.

The NLSY97 consists of a nationally representative sample of approximately 9,000 youths who were 12 to 16 years old as of December 31, 1996. Round 1 of the survey took place in 1997. In that round, both the eligible youth and one of that youth's parents received hour-long personal interviews. Youths continue to be interviewed on an annual basis. The NLSY97 is designed to document the transition from school to work and into adulthood. It collects extensive information about youths' labor market behavior and educational experiences over time. Employment information focuses on two types of jobs, "employee" jobs where youths work for a particular employer, and "freelance" jobs such as lawn mowing and babysitting. These distinctions will enable researchers to study effects of very early employment among youths. Employment data include start and stop dates of jobs, occupation, industry, hours, earnings, job search, and benefits. Measures of work experience, tenure with an employer, and employer transitions can also be obtained. Educational data include youths' schooling history, performance on standardized tests, course of study, the timing and types of degrees, and a detailed account of progression through post-secondary schooling.

Aside from educational and labor market experiences, the NLSY97 contains detailed information on many other topics. Subject areas in the questionnaire include: Youths' relationships with parents, contact with absent parents, marital and fertility histories, dating, sexual activity, onset of puberty, training, participation in government assistance programs, expectations, time use, criminal behavior, and alcohol and drug use. Areas of the survey that are potentially sensitive, such as sexual activity and criminal behavior, comprise the self-administered portion of the interview.

One unique aspect of the NLSY97 is that Round 1 contains a parent questionnaire that generates information about the youths' family background and history. Information in the parent questionnaire includes: parents' marital and employment histories, relationship with spouse or partner, ethnic and religious background, health (parents and child), household income and assets, participation in government assistance programs, youths' early child-care arrangements, custody arrangement for youth, and parent expectations about the youth.

***3. The Guide to Clinical Preventive Services* (2006 edition,** http://www.ahrq.gov/clinic/pocketgd/pocketgd.htm)

This is not a data source, per se, but a set of indicators. It includes the U.S. Preventive Services Task Force (USPSTF) recommendations on screening,

counseling, and preventive medication topics, as well as clinical considerations for each topic. The USPSTF, sponsored by the Agency for Healthcare Research and Quality (AHRQ), is composed of an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services.

4. The Partnership for Prevention's *Priorities for America's Health* (2006, http://www.prevent.org/content/view/46/96/)

This is also not a data source, but it lists cost-effective clinical preventive services recommended by the USPSTF and the Advisory Committee on Immunization Practices (ACIP). The recommendations include primary and secondary preventive services offered by healthcare providers in clinical settings, including immunizations, screening tests, counseling, and preventive medications. The Partnership for Prevention and the National Commission on Prevention Priorities rank these preventive services based on the clinically preventable burden (CPB), which measures the health impact on the relevant population and the cost-effectiveness (CE) of each service. The *Priorities for America's Health* is important in the performance measure process because it identifies and emphasizes the most valuable preventive services that can be offered in medical practice.

5. The Guide to Community Preventive Services* (also referred to as *The Community Guide, http://www.thecommunityguide.org)

This is a Federally sponsored initiative, and, again, is not a data source but a compendium of standards which can be indicators. *The Community Guide* was developed and is maintained by the nonfederal Task Force on Community Preventive Services (TFCPS), whose members are appointed by the Director of the Centers for Disease Control and Prevention (CDC). Although convened by the Department of Health and Human Services, the TFCPS is an independent decision-making body. *The Community Guide* summarizes current knowledge about the effectiveness, efficiency, and feasibility of interventions to promote community health and prevent disease. It offers recommendations regarding population-based interventions to promote health and to prevent disease, injury, disability, and premature death–appropriate for use by communities and health care systems. The TFCPS makes its recommendations based on systematic reviews of topics in three general areas: changing risk behaviors; reducing diseases, injuries, and impairments; and addressing environmental and ecosystem challenges.

6. AHRQ's *National Healthcare Quality Report* (*NHQR*) (2006, http://www.ahrq.gov/qual/nhqr06/nhqr06report.pdf) and **AHRQ's *National Healthcare Disparities Report* (*NHDR*)** (2006, http://www.ahrq.gov/qual/nhdr06/nhdr06report.pdf)

These two reports provide a comprehensive assessment of the quality of health care in the U.S. Each report has a different focus. The *NHQR* addresses the current, overall state of health care quality and the opportunities for

improvement. Measures in the *NHQR* are organized around four dimensions of quality (effectiveness, patient safety, timeliness, and patient centeredness) and cover four stages of care (staying healthy, getting better, living with illness or disability, and coping with the end of life). Effectiveness is subdivided by medical condition. The *NHDR* focuses on health equity across the spectrum of populations in the U.S. The *NHDR* tracks disparities across AHRQ's priority populations relative to the same quality of health care dimensions used in the *NHQR* as well as an access to care dimension. Access to care measures assess the ability to connect to care, the quality of care received within the health care system, patient perceptions of care, and health care utilization. Although data for some priority populations may not be available, the *NHDR* attempts to examine and track disparities for racial and ethnic minorities, low-income groups, women, children, elderly, residents of rural areas, and individuals with special health care needs relative to comparison populations.

7. Performance Snapshots (http://www.cmwf.org/snapshots)

The Snapshots is an established online resource about health system performance developed under a grant from the Commonwealth Fund. It builds on a series of chart books published by the Commonwealth Fund and draws on an ongoing review of the research literature, including studies published in academic journals and reports by government agencies and private foundations. Approximately 84 "snapshots" are organized in various ways, including by performance domains similar to the dimensions of health care quality in AHRQ's *NHQR* and *NHDR* (e.g., effectiveness, patient safety) and by selected areas of interest (such as specific age group, gender, type of care, type of insurance, or major disease category). Each snapshot presents data in chart or graph formats that respond to questions posed about health care quality. For example, using National Health Interview Survey data, a graph of the percentage of adults ages 65 and older who received recommended vaccinations might be presented as a response to the question "how many elderly adults are immunized to help prevent influenza and pneumonia?" The question itself reflects an intervention or practice that is being measured.

8. Child Trends

Child Trends (CT), founded in 1979, is a non-profit, non-partisan research center that studies children at all developmental stages. The organization's mission is to improve child outcomes by providing research, data, and analysis to those who are policymakers, decisionmakers, program providers, the media and others. CT identifies emerging issues, evaluates programs, and provides data-driven guidance on policy and practice. Important for this effort, CT produces a range of research briefs as well as the *Child Indicator* newsletter. Through the website there is also access to the CT Data Bank, which tracks more than 100 indicators covering the following general domains: health; social/emotional development; income, assets and work; education and skills; demographics; and family and community. These data are, however, for the U.S., but are instructive in terms of potential indicators. As one example, a report and study published in

Child Indicators (Vandivere et al 2004) utilized four domains to assess school success and child well-being: Cognitive knowledge and skills; social skills; school engagement; and physical well-being. The data were based on teacher assessments in these areas.

9. Kids Count

Kids Count is a program of the Annie E. Casey Foundation, focused on helping vulnerable children and families. The *Kids Count* Data Center (new version launched in January 2008) contains more than 100 measures of child well-being, including the 10 measures used in the annual KIDS COUNT Data Book. The Data Center includes the most recent data available on education, employment and income, poverty, health, basic demographics, and youth risk factors for the U.S., all 50 states, D.C., Puerto Rico and the U.S. Virgin Islands and features data for the 50 largest U.S. cities. Depending on availability, three to five years of trend data is currently available for most indicators. *Kids Count* Data Book indicators are primarily risk-focused – not reflecting a positive well-being model – and include:

- A KIDS COUNT overall rank
- Low-birthweight babies
- Infant mortality
- Child deaths
- Teen deaths from all causes
- Teen births, by Age Group
- Teens who are high school dropouts
- Teens not attending school and not working
- Children living in families where no parent has full-time, year-round employment
- Children in poverty (100%)
- Children in single-parent families

There are also a set of “Right Start” indicators, but these focus on infants and maternal characteristics.

10. SEARCH Institute

The Search Institute is an independent nonprofit organization whose mission is to provide data, analysis, technical and program assistance, as well as materials. As noted in the June 2008 report, the SEARCH Institute developed the “40 Assets” inventory, which is the basis for a set of surveys to use in assessing the presence/absence of these assets. About 3 million young people in thousands of communities have been surveyed since 1990.

Since its creation in 1990, Search Institute’s framework of Developmental Assets has become the most widely used approach to positive youth development in the United States. Grounded in extensive research in youth development, resiliency, and prevention, the 40 Developmental Assets represent the relationships, opportunities, and personal qualities that young people need to avoid risks and to thrive. Studies of more than 2.2 million young people in the

United States consistently show that the more assets young people have, the less likely they are to engage in a wide range of high-risk behaviors (see table below) and the more likely they are to thrive. Assets have power for all young people, regardless of their gender, economic status, family, or race/ethnicity. Furthermore, levels of assets are better predictors of high-risk involvement and thriving than poverty or being from a single-parent family.

The average young person experiences fewer than half of the 40 assets. Boys experience three fewer assets than girls (17.2 assets for boys vs. 19.9 for girls). As described in the June 2008 report, the entire asset list is organized under the following domains:

External Assets
- Support
- Empowerment
- Boundaries and expectations
- Constructive use of time

Internal Assets
- Commitment to learning
- Positive values
- Social competencies
- Positive identity

Within each of these domains, there are a number of specific assets that vary by age group (see Table 1, June 2008 report).

11. Social Development Research Group (SDRG)

SDRG, affiliated with the School of Social Work at the University of Washington in Seattle, is the home base for the *risk and protective factors* model for understanding adolescent/youth risk behavior, and for addressing these issues programmatically (Catalano & Hawkins 1995; see the June 2008 report for full description). The focus of SDRG's research and interventions are on drug abuse, delinquency, risky sexual behavior, violence, and school dropout. SDRG has conducted an extensive amount of research, producing more than 400 articles, books, and monographs. Access to the University's vast libraries is augmented by the group's own collection of more than 10,000 reprints, books, and journals, and the organization has extensive data collection and data management staff. SDRG is responsible for the development and management of the widely used *Communities that Care* intervention and the *Communities That Care Youth Survey,* an instrument that assesses risk and protective factors in the domains of individual, family, peer, school, and community. These instruments, or sections from them, have been used by some LAC countries.

12. Major National Surveys: National Household Survey, National Health and Nutrition Examination Survey

Several major, periodic national health surveys are conducted in the U.S., including the National Survey on Drug Use and Health (formerly the National Household Survey on Drug Abuse) and the National Health and Nutrition Examination Survey (NHANES). The NSDUH is conducted for the Substance Abuse and Mental Health Services Administration (SAMHSA) of the Department of Health and Human Services, and provides a major data source for drug/alcohol use and mental health morbidity, risk behavior and knowledge. The National Health and Nutrition Examination Survey (NHANES) is a set of studies designed to assess the overall health and nutritional status of adults and children in the United States. The survey is unique in that it combines interviews and physical examinations. NHANES is a major program of the National Center for Health Statistics (NCHS), part of the Centers for Disease Control and Prevention (CDC) and has the responsibility for producing vital and health statistics for the U.S.

C. Global and European Union (EU) Data Sources (non-LAC)

1. The European Health for All Database (HFA-DB)

Established in the mid-1980s, HFA-DB is a central database of independent, comparable and up-to-date basic health statistics. It has been a key source of health information in the European Region since that time. The database is updated biannually and contains about 600 indicators for the 53 European WHO member states, including: demographics; health status; health determinants (e.g., lifestyle, environment); and health care.

2. OECD Data

The OECD Secretariat has been publishing health statistics since the mid-1980s. The coverage of its Health Data files is very wide and for many indicators the series goes back as far as 1960. Some 1200 series were selected for the 2008 version of the information system according to whether they were relevant to the description of key aspects of health care systems, sufficiently consistent to enable cross-national comparisons and available in a significant number of countries. Although many of the variables still do not satisfy all three criteria, these statistics were included to help to encourage greater conceptual convergence among OECD Member countries. The data comprise some 1200 different series, with selected long-time series from 1960 onwards. Most data cover the 1980s and 1990s, with many series up to 2005 or 2006, and selected data up until 2007. The following data are available:

Health expenditure

- Total expenditure on health, % of gross domestic product
- Total health expenditure per capita, US$ PPP
- Public expenditure on health, % total expenditure on health

- Pharmaceutical expenditure, % total expenditure on health
- Pharmaceutical expenditure per capita, US$ PPP (NEW)

Health care resources

- Practising physicians, density per 1 000 population
- Practising nurses, density per 1 000 population
- Medical graduates, density per 1 000 practising physicians
- Nursing graduates, density per 1 000 practising nurses
- Hospital beds, density per 1 000 population (NEW)
- Acute care beds, density per 1 000 population
- Psychiatric care beds, per 1 000 population (NEW)
- MRI units per million population
- CT Scanners per million population
- Mammographs per million population (NEW)
- Radiation therapy equipment per million population (NEW)

Health care activities

- Doctor consultations per capita
- Hospital discharge rates, all causes, per 100 000 population
- Average length of stay for acute care, all conditions, days
- Coronary artery bypass grafts (CABG), per 100 000 population
- Coronary angioplasties, per 100 000 population
- Caesarean sections, per 100 live births

Health status (Mortality)

- Life expectancy at birth, females, males and total population
- Life expectancy at 65 years old, females and males
- Infant mortality rate, deaths per 1 000 live births
- Potential years of life lost (PYLL), all causes females and males (NEW)
- Suicides, deaths per 100 000 population (NEW)

Chronic conditions (non-communicable diseases)

- Acute myocardial infarction (NEW)
- Causes of mortality, deaths per 100,000 females, males and total population
- Hospital discharges, per 100,000 total population

Cerebro-vascular diseases

- Causes of mortality, deaths per 100,000 females, males and total population
- Hospital discharges, per 100,000 total population

Cancer (NEW)

- Causes of mortality, deaths per 100,000 females, males and total population
- Hospital discharges, per 100,000 total population

Diseases of the respiratory system

- Causes of mortality, deaths per 100,000 females, males and total population
- Hospital discharges, per 100,000 total population

Diabetes
- Causes of mortality, deaths per 100,000 females, males and total population
- Hospital discharges, per 100,000 total population

Risk factors

- Tobacco consumption, % of females, males and adult population who are daily smokers
- Alcohol consumption, litres per population aged 15+
- Overweight, percentage of females, males and adult population with a 25<BMI<30 kg/m2
- Obesity, percentage of females, males and adult population with a BMI>30 kg/m2
- Overweight or obesity, percentage of females, males and adult population with a BMI>25 kg/m2

OECD also publishes other databases of social indicators. One of these is the Family Database. In view of the strong demand for cross-national indicators on the situation of families and children, the OECD developed this on-line database on family outcomes and family policies with indicators for all OECD countries. The database brings together information from different OECD databases (for example, the OECD Social Expenditure database, the OECD Benefits and Wages database, or the OECD Education database, and databases maintained by other (international) organizations. Development of the Family database is an ongoing process and release or updating of indicators is not linked to any particular point in time. Not all indicators can already be presented on cross-national basis. The first batch of indicators was released by the end of 2006, but work is ongoing on the preparation of new indicators for release throughout 2007. OECD plans to update existing indicators on a regular basis.

3. UN Development Group Gender Equality Measures

The UN Development Group (UNDG) commissioned the development of performance measures for gender equality to be used by UN Country Teams (UNCTs). The draft set of these indicators (Beck & Patnaik 2007) is organized in the form of a *scorecard,* in which each domain of assessment is rated based on a graduated score: exceeds minimum standards; meets minimum standards; needs improvement; inadequate; or missing/not applicable. Domains and subdomains are as follows:

Planning (CCA/UNDAFs)
- Adequate analysis related to gender equality and women's empowerment
- Gender equality in outcomes
- Gender equality in outputs
- Gender-sensitive indicators included
- Gender equality in baselines

Programming
- Gender perspectives are adequately reflected in programming

- UNCT support for national priorities related to gender equality and/or women's empowerment
- UNCT support to gender mainstreaming in programme based approaches
- UNCT support to gender mainstreaming in aid effectiveness processes

Partnerships

- Involvement of National Machineries for Women/Gender Equality and women's departments at the sub-national level
- Involvement of women's NGOs and networks
- Women from marginalized groups (e.g., HIV-positive women, poor rural women, indigenous women, etc.) included as programme partners and beneficiaries in key UNCT initiatives

UNCT Policies and Capacities

- Resident Coordinator supports multi-stakeholder Gender Theme Group

Table 2 (attached) is a modified version of Table 1, with indicators and data sources listed *only* for those available in the LAC region.

IV. Next Steps

Based on this document, several key issues need to be resolved:

- Identifying the balance between existing data responsive to the domains/indicators, and where additional data could be collected through existing mechanisms
- Identifying new data collection needs
- Dissemination, technical assistance in implementation.
- Disscussion of developing a website to facilitate access to and use of measures.

A similar process was undertaken by UNAIDS in developing indicators for monitoring implementation of the *Declaration of Commitment on HIV/AIDS* (see UNAIDS 2007). The indicators were selected, including a core set of indicators categorized by National or Global level, and by Knowledge/Behavior and Impact. For users, each indicator is described together with methods of measurement, data sources, and the purpose and applicability of the indicator.

ATTACHED TO THIS DOCUMENT IS A MATRIX SHOWING OUTPUTS, OUTCOMES, IMPACTS AND INDICATORS BY DOMAIN, AS WELL AS EXAMPLES OF EXISTING DATA SOURCES.

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