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Preface

The Region of the Americas has a long-standing commitment to protect and improve the health and wellness of our young persons, as expressed in the Regional Strategy for Improving Adolescent and Youth Health and the Plan of Action on Adolescent and Youth Health, 2010-2018. Since the adoption of the Regional Strategy in 2008 and the Plan of Action in 2009, there have been various major developments on the global and regional level, including the inauguration of the Sustainable Development Goals (SDGs) era and the launch of the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030), with new commitments and mandates that directly affect the positioning of young people in the global and regional health and development agenda.

These new developments create the demand and opportunity for PAHO and the Region to take stock of the current status of the health of young people and the regional response, in order to make the changes needed to ensure that all young people in the Region not only survive, but thrive, and have the opportunity to realize their rights to physical and mental health and well-being. As the Plan of Action on Adolescent and Youth Health is nearing its end, it is also timely to look forward to the formulation of a new adolescent and youth health agenda at this time. One that is more integrated to the life course and to factors to promote and improve their health and development.

As described in Part I of this report, we currently have the largest cohort of adolescents and youth in the history of the Americas. This creates a window of opportunity for fast economic growth, if the appropriate social and economic investments are made in health, education, and the economy. Investment in young people is essential to harness the benefits of the demographic dividend that several countries in the Region are experiencing. However, we also note the challenges young people in the Region face, including low secondary school enrollment and completion rates, poverty, and unemployment.

Part II describes the current status of the health of young people, illustrating that the past years brought limited health gains for adolescents and youth. Each year, more than 80,000 adolescents aged 10-19 years die in the Region of the Americas,
many due to preventable causes, such as homicide, suicide, and traffic fatalities. Many more suffer from ill health due to mental health challenges, nonfatal injuries, and other causes. Adolescent pregnancy, unsafe abortions, HIV, and STIs continue to threaten the health and wellness of young people in the Region.

In Part III, the report highlights the significant progress made in the development and implementation of regional and country-level actions, including the establishment of adolescent health programs in most countries, strengthening of the availability and use of strategic information, expansion of health services for adolescents, capacity-building of stakeholders in a range of adolescent health topics, and introduction of school- and family-based interventions.

Unfortunately, we have to conclude that these advances have not yet translated into major health gains for young people in the Region. Urgent and targeted action is required to update and adapt the regional and country-level responses to accelerate progress towards improvement of the health and well-being of young people in the Americas.

Based on the lessons learned in the regional response, Part IV of the report proposes key priorities for action to accelerate progress towards the improvement of the health and development of young people in the Region. The recommendations coincide with the spirit of the SDGs and the lines of action proposed by the Global Strategy for Women's, Children's and Adolescents' Health: programs and interventions must be based on evidence and prioritize the groups living in situations of vulnerability. Actions must be intersectoral and address the social determinants of adolescent and youth health, and young persons must be engaged as partners in the design, implementation, and monitoring of interventions targeting them.

Young people are at the center of the SDG agenda, and strategic investment in the health and development of young people is key to achievement of the SDGs. PAHO remains committed to supporting the Region in achieving these goals.
Acknowledgments

PAHO/WHO acknowledges all the following who contributed to this document:

Authors: Sonja Caffe (PAHO/WHO), Bruce Dick (consultant), Maria del Carmen Calle (consultant), Katia Diaz (consultant).


Other contributors: Sheila Samiel (consultant), Sheoran Bhupendra (YTH), Hernan Rosenberg (consultant), William Heisel (IHME), Katherine Leach-Kemon (IHME), Michelle Subart (IHME), Kevin O’Rourke (IHME), Danique Gigger (intern), Terrilia Ravaliere (intern).
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA-HA!</td>
<td>Global Accelerated Action for the Health of Adolescents Framework</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired immunodeficiency syndrome</td>
</tr>
<tr>
<td>APR</td>
<td>A Promise Renewed</td>
</tr>
<tr>
<td>ASRH</td>
<td>Adolescent sexual and reproductive health</td>
</tr>
<tr>
<td>BMI</td>
<td>Body mass index</td>
</tr>
<tr>
<td>CARICOM</td>
<td>Caribbean Community</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>CICAD</td>
<td>Inter-American Drug Abuse Control Commission</td>
</tr>
<tr>
<td>CLADEM</td>
<td>Latin American and Caribbean Committee for the Defense of Women’s Rights</td>
</tr>
<tr>
<td>CLAP</td>
<td>Latin American Center for Perinatology, Women and Reproductive Health</td>
</tr>
<tr>
<td>COMISCA</td>
<td>Consejo de Ministros de Salud de Centroamérica [Council of Ministers of Health of Central America]</td>
</tr>
<tr>
<td>CRC</td>
<td>Committee on the Rights of the Child</td>
</tr>
<tr>
<td>CSE</td>
<td>Comprehensive sexuality education</td>
</tr>
<tr>
<td>DALY</td>
<td>Disability-adjusted life year</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic and Health Surveys</td>
</tr>
<tr>
<td>DMFT</td>
<td>Decayed, missing, and filled teeth (index)</td>
</tr>
<tr>
<td>DPT</td>
<td>Diphtheria, pertussis, and tetanus vaccine</td>
</tr>
<tr>
<td>ECLAC</td>
<td>Economic Commission for Latin America and the Caribbean</td>
</tr>
<tr>
<td>EWEC</td>
<td>Every Woman Every Child</td>
</tr>
<tr>
<td>FGL</td>
<td>Family, Gender and Life Course Department (PAHO)</td>
</tr>
<tr>
<td>FCTC</td>
<td>Framework Convention on Tobacco Control</td>
</tr>
<tr>
<td>GBD</td>
<td>Global Burden of Disease</td>
</tr>
<tr>
<td>GSHS</td>
<td>Global School-based Student Health Survey</td>
</tr>
<tr>
<td>GYTS</td>
<td>Global Youth Tobacco Survey</td>
</tr>
<tr>
<td>HED</td>
<td>Heavy episodic drinking</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
</tr>
<tr>
<td>HPV</td>
<td>Human papillomavirus</td>
</tr>
<tr>
<td>IDB</td>
<td>Inter-American Development Bank</td>
</tr>
<tr>
<td>IHME</td>
<td>Institute for Health Metrics and Evaluation</td>
</tr>
<tr>
<td>ILO</td>
<td>International Labour Organization</td>
</tr>
<tr>
<td>IMAN</td>
<td>Integrated Management of Adolescent Needs</td>
</tr>
<tr>
<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
</tr>
<tr>
<td>Acronym</td>
<td>Definition</td>
</tr>
<tr>
<td>---------</td>
<td>------------</td>
</tr>
<tr>
<td>LAC</td>
<td>Latin America and the Caribbean</td>
</tr>
<tr>
<td>LGB</td>
<td>Lesbian, gay, and bisexual</td>
</tr>
<tr>
<td>LGBT</td>
<td>Lesbian, gay, bisexual, and transgender</td>
</tr>
<tr>
<td>MICS</td>
<td>Multiple Indicator Cluster Surveys</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
</tr>
<tr>
<td>NCD</td>
<td>Noncommunicable disease</td>
</tr>
<tr>
<td>NEET</td>
<td>Not in education, employment, or training</td>
</tr>
<tr>
<td>NGO</td>
<td>Nongovernmental organization</td>
</tr>
<tr>
<td>OAS</td>
<td>Organization of American States</td>
</tr>
<tr>
<td>OCTs</td>
<td>Overseas Caribbean territories</td>
</tr>
<tr>
<td>OID</td>
<td>Inter-American Observatory on Drugs</td>
</tr>
<tr>
<td>ORAS - CONHU</td>
<td>Organismo Andino de Salud - Convenio Hipólito Unanue (Andean Health System - Hipólito Unanue Convention)</td>
</tr>
<tr>
<td>PAHO</td>
<td>Pan American Health Organization</td>
</tr>
<tr>
<td>SDGs</td>
<td>Sustainable Development Goals</td>
</tr>
<tr>
<td>SDH</td>
<td>Social determinant of health</td>
</tr>
<tr>
<td>SES</td>
<td>Socioeconomic status</td>
</tr>
<tr>
<td>SGBV</td>
<td>Sexual and gender-based violence</td>
</tr>
<tr>
<td>SIA</td>
<td>Sistema Informático del Adolescente (Adolescent Information System)</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and reproductive health</td>
</tr>
<tr>
<td>SRHR</td>
<td>Sexual and reproductive health and rights</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
</tr>
<tr>
<td>Td</td>
<td>Tetanus and diphtheria vaccine</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNESCO</td>
<td>United Nations Education, Scientific and Cultural Organization</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children's Fund</td>
</tr>
<tr>
<td>UNODC</td>
<td>United Nations Office on Drugs and Crime</td>
</tr>
<tr>
<td>YLD</td>
<td>Years of life lost due to disability</td>
</tr>
<tr>
<td>YLL</td>
<td>Years of life lost due to premature mortality</td>
</tr>
<tr>
<td>YRBS</td>
<td>Youth Risk Behavior Survey</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
Executive Summary

This report presents the latest available data from countries of the Region with the aim to: 1) analyze the health situation of adolescents and youth in the Region; 2) summarize the current status of the implementation of PAHO’s Regional Strategy and the Plan of Action; and 3) provide perspective on how stakeholders can act to improve the health and well-being of young persons in the Americas, taking into account recent regional and global commitments, strategies, and targets. In doing so, the report offers a comprehensive view of health relating to young people in the Americas.

The report is divided into five parts:

- Part I provides a profile of adolescents and youth in the Americas, with a focus on demographic and socioeconomic characteristics.

- Part II analyzes the health status of adolescents and youth in the Americas, guided by the health-related targets and indicators from the regional Plan of Action.

- Part III reviews key actions taken on the regional and country level in the seven strategic areas proposed by the Plan of Action, highlighting progress and challenges.

- Part IV describes the evolving global and regional context of the health and development of young people and the implications that has for the regional response.

- Part V presents adolescent and youth health profiles with the latest available data from countries in the Region on a range of adolescent and youth health indicators.

Current state of adolescent and youth health:

This report discusses the opportunities and challenges for adolescent and youth health in the Americas. We currently have the largest cohort of young people in the history of the Americas, an estimated 237 million. In 2015, those aged 10-24 constituted 24% of the total population in the Americas and 26% of that in Latin
America and the Caribbean (LAC). The current demographics create a window of opportunity for fast economic growth, if the appropriate social and economic investments are made in health, education, and the economy.

Adolescence is generally a healthy stage of life, with low mortality and morbidity, compared with other age groups. However, each year, more than 80,000 adolescents aged 10-19 years die in the Region, many due to preventable causes such as homicide, suicide, and traffic fatalities. Moreover, the inequities in many parts of the Region pose challenges for young people. These include the disproportionate burden of poverty and unemployment among young people, and significant numbers who are neither in school nor employed.

In recent decades, the Region has made marked socioeconomic progress. Over the 2004-2014 period, the income pyramid in LAC underwent a historic transformation, in which 72 million people escaped poverty and 94 million joined the middle class. Significant progress has been made in the development and implementation of regional and country-level adolescent and youth health actions, including the establishment of adolescent health programs in most countries, strengthening of the availability and use of strategic information, expansion of health services for adolescents, capacity-building of stakeholders in a range of adolescent health topics, and introduction of school- and family-based interventions.

While these efforts have brought some health gains for adolescents and youth, these gains are limited, and not all groups benefitted equally from this progress. Some 25 to 30 million people in the Region risk falling into poverty, many of whom are youth. Around 150,000 young people aged 15-24 die each year in the Region, of which around 80% are males, indicating the significantly higher risk of young males to die prematurely. Many more youth suffer from ill health due to mental health challenges, nonfatal injuries, and other causes. Adolescent pregnancy, unsafe abortions, HIV, and STIs continue to threaten the health of our young people. LAC has the second-highest adolescent fertility rate in the world, estimated at 66.5 births per 1,000 girls 15-19 years old for 2010-2015, compared to 46 births per 1,000 girls in the same age group worldwide. This report also profiles youth who are living in specific situations of vulnerability, such as those with disabilities, LGBT, indigenous, and Afro-descendant youth.

The Sustainable Development Goals and the Global Strategy for Women’s, Children’s and Adolescents’ Health highlight young persons as a critical group,
reiterating the triple benefit generated by investment in young people: healthy young people now, healthy adults in the future, and healthy future generations. The potential to reap the benefits from the demographic dividend, and to achieve the SDGs without leaving any young person behind, will require comprehensive, intersectoral and pro-equity actions aimed at empowering young people, addressing the social determinants of their health, and maximizing the positive benefits of the family, schools, communities, social media, and other social platforms, to create an environment in which every young person can thrive.

Lessons learned and recommendations:

The lessons learned from the implementation of the Plan of Action suggest some changes needed to accelerate progress towards improving the health and well-being of young people in the Region. These include:

1. Ensuring that adolescent and youth health programs are adequately funded, are multisectoral, and address the social determinants of health;

2. Fostering an adolescent-responsive health system, and implementing school-, family- and community-based interventions to protect and promote the health of children and adolescents from a life course perspective;

3. Ensuring that approaches are evidence-based, target the groups in situations of vulnerability from an equity perspective, and are scaled up;

4. Implementing rigorous monitoring and evaluation to inform strategic planning and timely adaptations to improve efficiency and effectiveness of programs and services;

5. Developing new modalities for capacity-building that will yield sustainable results; and

6. Empowering and engaging young people as agents of change.

By implementing these recommendations and learning from past experiences, the Region can improve the health situation for today’s young persons and for generations to come.
Introduction

Investing in the health of young people generates a triple benefit: 1) healthy young people now; 2) healthy adults in the future; and 3) healthy future generations. The Sustainable Development Goals (SDGs) (1) and the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030) (2) highlight the strategic importance of young persons for the success of the 2030 Agenda for Sustainable Development. In addition, a recent report from the Lancet Commission on Adolescent Health and Wellbeing stated that this generation of adolescents and young adults can transform all of our futures if we ensure they have the resources to do so (3).

In 2008, PAHO Member States adopted the Regional Strategy for Improving Adolescent and Youth Health and, in 2009, the Plan of Action on Adolescent and Youth Health, which provided a comprehensive focus for collective regional efforts aimed at protecting and improving the health of adolescents and youth in the Region of the Americas for the 2010-2018 period (4). The Regional Strategy and the Plan of Action proposed regional goals and objectives for the health of adolescents and youth, as well as strategic action to be taken on the regional and country level to achieve these goals.

Since adoption of the Regional Strategy and Plan of Action on Adolescent and Youth Health, there have been important developments related to adolescent and youth health, most importantly, the SDGs and the Global Strategy for Women’s, Children’s and Adolescents’ Health, outlining a more ambitious, integrated, multisector, and pro-equity health and development agenda. As the implementation period for the regional plan of action is drawing to an end, it is appropriate to take stock of the current status of the health of young people in the Region, and of the regional response, to inform the development of a new regional adolescent and youth health agenda that is aligned with the SDGs and Global Strategy and builds on achievements and lessons learned.

This regional adolescent and youth health report aims to: 1) analyze the current status of the health of adolescents and youth in the Region; 2) summarize the current status of the implementation of the Regional Strategy and the Plan of Action; and 3) provide a forward-looking perspective on how regional and country-level stakeholders can update and galvanize actions to improve the health and well-being of young persons in the Americas, taking into account recent regional
and global commitments, strategies, and targets. These include the Strategy for Universal Access to Health and Universal Health Coverage (Resolution CD53.R14) adopted by PAHO Member States in 2014 (5), the SDGs (1), the Global Strategy for Women’s, Children’s and Adolescents’ Health (2), and the Global Accelerated Action for the Health of Adolescents (AA-HA!) (6).

This report has drawn from a number of sources, including an assessment of the implementation of the Regional Strategy and the Plan of Action for adolescent and youth health, mortality statistics and other data reported to PAHO by Member States, global databases, and a review of the scientific literature. Also included in this report is an analysis for this age group and the Region based on the 2015 Global Burden of Disease data prepared for PAHO by the Institute for Health Metrics and Evaluation (IHME).

The report is divided into five parts:

- Part I provides a profile of adolescents and youth in the Americas, with a focus on demographic and socioeconomic characteristics.
- Part II analyzes the health status of adolescents and youth in the Americas. The analysis is guided by the health-related targets and indicators from the regional Plan of Action.
- Part III reviews key actions taken on the regional and country level in the seven strategic areas proposed by the Plan of Action, highlighting progress and challenges.
- Part IV describes the evolving global and regional context of the health and development of young people and the implications that has for the regional response. Part IV also considers how the Region can transform the legal, policy, and societal environments to ensure that all young people can survive and thrive and can have the opportunity to realize their right to health, especially those who are living in situations of vulnerability.
- Country profiles: Part V presents adolescent and youth health profiles. Each profile presents the latest available data on a range of adolescent and youth health indicators drawn from the Plan of Action on Adolescent and Youth Health (4). The country profiles are based on international estimates, data reported to PAHO, and published survey data, in some instances adapted to incorporate new national data reported by countries.
Age group terminology

In line with the Regional Strategy and the Plan of Action, this report covers the health of young persons in the age group 10-24 years. This age range includes overlapping groups, who are referred to as “adolescents,” “youth,” and “young persons” (WHO) (Table 1) (7).

Table 1: Age group terminology used in this report

<table>
<thead>
<tr>
<th>Term</th>
<th>Age group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescents</td>
<td>10-19 years</td>
</tr>
<tr>
<td>Youth</td>
<td>15-24 years</td>
</tr>
<tr>
<td>Young persons</td>
<td>10-24 years</td>
</tr>
</tbody>
</table>

Source: (7).

A more detailed classification proposed by PAHO in 2005 (8,9), identifies the stages of pre-adolescence, early adolescence, middle adolescence, late adolescence, youth, and young adulthood, specifying that in general adolescence starts earlier in girls (Annex A).

The age group terminology used in this report is aligned with that of the World Health Organization as presented in Table 1. In addition, the report will apply the following simplified subgroups and age ranges:

- Early adolescence: 10-14 years
- Late adolescence: 15-19 years
- Young adulthood: 20-24 years

In some exceptional cases, data will be presented for other age groups outside of those mentioned, depending on the age groups used to calculate certain international indicators.
Part I

A PROFILE OF ADOLESCENTS AND YOUTH IN THE AMERICAS
I.1: Socio-demographic profile of adolescents and youth in the Americas

I.1.1 The adolescent and youth population in the Americas

Currently, the population of young people (10-24 years) in the Americas is the largest in the history of the Region, at an estimated 237 million and is projected to decrease to 230 million by 2030 (Figure I.1).

Figure I.1: Estimated number of adolescent and youth (10-24 years) in the Americas, and percentage of the total population, 2000-2030

Source: (10).
In 2015, the age group 10-24 constituted 24% of the total population in the Americas and 26% of that in Latin America and the Caribbean (LAC) (Table I.1) (10).

Table I.1: The adolescent and youth population in the Americas, 2015

<table>
<thead>
<tr>
<th></th>
<th>Total population</th>
<th>Adolescents 10-19 years</th>
<th></th>
<th>Youths 15-24 years</th>
<th></th>
<th>Young persons 10-24 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>The Americas</td>
<td>992,225,000</td>
<td>157,079,000</td>
<td>16</td>
<td>158,503,000</td>
<td>16</td>
<td>236,941,000</td>
</tr>
<tr>
<td>North America</td>
<td>357,838,000</td>
<td>45,345,000</td>
<td>13</td>
<td>48,635,000</td>
<td>14</td>
<td>71,136,000</td>
</tr>
<tr>
<td>Latin America and the Caribbean</td>
<td>634,387,000</td>
<td>111,734,000</td>
<td>18</td>
<td>109,868,000</td>
<td>17</td>
<td>165,805,000</td>
</tr>
<tr>
<td>South America</td>
<td>418,447,000</td>
<td>71,265,000</td>
<td>17</td>
<td>70,304,000</td>
<td>17</td>
<td>106,027,000</td>
</tr>
<tr>
<td>Central America</td>
<td>172,740,000</td>
<td>33,229,000</td>
<td>19</td>
<td>32,390,000</td>
<td>19</td>
<td>48,984,000</td>
</tr>
<tr>
<td>Caribbean</td>
<td>43,199,000</td>
<td>7,240,000</td>
<td>17</td>
<td>7,175,000</td>
<td>17</td>
<td>10,795,000</td>
</tr>
</tbody>
</table>

Source: (11).

Several countries in the Americas are going through the demographic transition, the shift from high birth and death rates to low fertility, low mortality, and longer life expectancy. The demographic transition is linked to a decline in the ratio of dependents (children and the elderly) to the productive work force, which generates a potential for the “demographic dividend” (10, 11). With fewer people to support, a country has a window of opportunity for rapid economic growth if strategic social and economic policies are developed and investments made (10, 11). The window of opportunity for the demographic dividend varies by country. Most countries are well into the demographic transition, while others are just initiating or have not yet entered into the demographic transition (Figure I.2).
Figure I.2: The projected window of opportunity* for the demographic dividend in the Region and in selected countries in the Americas, 2000-2050

*Ratio of dependents < 1.0 is the window of opportunity.

Source: (10).

Data Visualization
Projected window of opportunity for the demographic dividend in the Americas, 2000-2050
I.1.2 Puberty

The second decade of life is a period of rapid and profound biological, cognitive, emotional, and social development and change. Early adolescence (10-14 years) is characterized by rapid biological transformations for boys and girls, including hormonal changes and the introduction of the capacity to reproduce. Late adolescence (15-19 years) is typified by pubertal maturation and progressive adoption of more adult roles and functions. During adolescence and young adulthood, individuals normally acquire or consolidate the social, cultural, emotional, educational, and economic resources to maintain their health and well-being across the life course (3, 9).

Throughout the life course, the human brain is constantly developing through a process called neuroplasticity. While it was previously thought that the bulk of brain development occurred in the early life years, emerging evidence and understanding in neuroscience suggest that brain functions continue to develop well into adulthood. Research indicates that adolescent brain development is markedly different from brain development in childhood. During childhood the focus is on dendritic outgrowth and synaptogenesis or synaptic growth, allowing the brain to increase significantly in weight and size. In contrast, brain development during the second decade (which continues into early adulthood) appears to focus on synaptic pruning, the process of shedding weak and irrelevant synapses in order to increase the efficiency of the brain. It is believed that synaptic pruning is dependent on the neuron’s responses to environmental factors and external stimuli. This brain development stage characterized by a high rate of synaptic pruning is considered a critical period, where the individual is disproportionately receptive to environmental stimuli. This emerging knowledge explains the adaptive learning and rapid acquisition of interpersonal and emotional skills during adolescence. It also underscores the critical importance of ensuring a secure and stable social environment for adolescents, in order to support optimal development of the brain functions needed for longevity and for social and emotional wellness in adulthood (3, 12, 13).

I.1.3 The social determinants of adolescent and youth health in the Americas

Social determinants of health are the conditions in which people are born, grow, develop, live, work, and age (3, 14, 15). These include structural determinants (such as the socioeconomic and political context, socioeconomic position,
gender, ethnicity, education, occupation, and income), as well as intermediary determinants (such as behaviors and biological factors, psychosocial factors, and the health system) (Figure I.3) (15, 16).

Figure I.3: The social determinants of health

An analysis of the social determinants of health and adolescence identified national wealth, income inequality, and access to education as the strongest determinants of adolescent health (16). In addition, safe and supportive families and schools, and positive and supportive peers were highlighted as crucial to helping young people develop to their full potential and attain the best health in the transition to adulthood (16).

The following paragraphs elaborate on selected determinants, including education, employment, poverty, ethnicity, gender family, peers and media in relation to the health of adolescents and youth.
Education

The level of education is one of the most important determinants of opportunities for employment, income, and health. Education beyond the primary level has been associated with health benefits across the life course, including lower male injury mortality, lower female fertility, improved adult health, and increased survival of future children (16).

In the Americas, the literacy rate of youth (15-24 years old) is estimated at higher than 98%, with a gender parity index close to 1 (17). However, the percentage of adolescents enrolled in secondary school is significantly lower, for most countries ranging between 60% and 80%, with consistently more girls enrolled in all countries, with the exception of Guatemala and Paraguay. A few countries in the Region, including Guatemala, Honduras, Nicaragua, and Suriname, have secondary school enrollment rates below or close to 50% (Figure I.4).

![Figure I.4: Net secondary school enrollment in selected countries in the Americas, by sex, latest available year](source: (17).)
There are marked differences in educational attainment between and within countries, and between subgroups. In most countries, females slightly outperform males in the completion rate for upper secondary education (Figure I.5), and young persons from the higher wealth index quintiles have clear advantages when compared with their counterparts from lower wealth index quintiles (Figure I.6) (17).

Indigenous and rural youth are also less likely to complete secondary school than are nonindigenous persons and those living in urban settings (18).
Employment

Many persons enter the work force as adolescents, as part-time or full-time workers. Based on available information from 18 countries, the Economic Commission for Latin America and the Caribbean (ECLAC) estimates that around 76 million persons between the ages of 15 and 29 years, equaling 50% of persons in that age group, are employed in Latin America, of which 10% are both studying and working (18).

According to the International Labour Organization (ILO), not all forms of work done by young persons should be classified as child labor to be avoided. Participation by adolescents in work that does not affect their health and personal development or interfere with their schooling can potentially have a positive influence on their development and future employment opportunities (18, 19). Nevertheless, there are risks and potential negative consequences associated with early entry into the labor force, including interruption of education, difficulty in finding decent work, and decreased wages, job security, and social security coverage. Young persons who enter the work force early may end up in the informal sector in low-paying jobs, with limited opportunity for upward mobility, or even in jobs that are classified as dangerous (18-20).

The ILO defines youth unemployment as the share of the labor force ages 15-24 without work but available for and seeking employment (19). According to modeled ILO data for the period of 2015 through 2017, among world regions and subregions, Latin America and the Caribbean was expected to show the largest increase in youth unemployment over that time period, and North America was projected to have a slight decrease (Table I.2) (21). In addition to the general difficulty that young persons have in finding decent work, there are also specific groups of young people who face additional challenges in finding decent employment. This is true for those with disabilities and for young persons who face other types of exclusion, such as ethnic minorities and young persons living with HIV.

Table I.2: Estimated youth unemployment rate and number in the world and in the Americas, by subregion, 2015-2017

<table>
<thead>
<tr>
<th>Region/Subregion</th>
<th>Unemployment rate (percentage)</th>
<th>Unemployed youth (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>World</td>
<td>12.9</td>
<td>13.1</td>
</tr>
<tr>
<td>Americas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latin America and the Caribbean</td>
<td>15.7</td>
<td>16.8</td>
</tr>
<tr>
<td>North America</td>
<td>11.8</td>
<td>11.5</td>
</tr>
</tbody>
</table>

Source: (21).
NEET: The term “NEET” refers to young persons who are not in education, employment, or training. An estimated 21% of young people in the age group 15-29 in Latin America and the Caribbean are in this category, with 76% of them female (22). Notably, despite higher secondary school enrollment and completion by females, they are disproportionately represented in the NEET category. The NEET status is concerning, because it exponentially increases the risk of social exclusion and poverty across the life course. The NEET status does not necessarily mean that these young people are not contributing to society, since many, in particular females, may be engaging in informal household-related tasks such as child care and housekeeping. This greater engagement of females in informal household tasks may partially explain why there are more females in the NEET category, while girls outperform boys in secondary school enrollment and completion rates.

Not all NEET youth remain in that position. Instead, they may be moving in and out of this status, depending on the availability of employment opportunities. An important component of national efforts to make young people thrive is the implementation of programs to keep young persons in school as long as possible and to facilitate optimal school-to-work transitions, with decent employment opportunities.
In recent years, the Region has made remarkable macroeconomic progress. Over the 2004-2014 period, the income pyramid in LAC underwent a historic transformation, in which 72 million people escaped poverty and 94 million joined the middle class (23). However, the gains are not necessarily stable, and not all groups benefitted equally from this progress. An estimated 25 to 30 million people in the Region risk falling back into poverty, many of whom are youth, women, or persons of indigenous or African descent (23). From 2004 to 2014, the percentage of extremely poor and moderately poor youth aged 15-29 years has decreased, but the percentage of vulnerable youth has increased during this period (Figure I.7) (22).

Ethnicity

This determinant is highly relevant for the Americas, considering its ethnic diversity. In its policy on ethnicity and health (24), PAHO recognizes indigenous peoples, Afro-descendants, and Roma as ethnic groups that experience structural discrimination, exclusion, poverty, lack of access to basic services (such as water and sanitation), low levels of education, low rates of participation and representation in decision-making processes, and more employment in low-paying jobs (25-30).
More than 400 different indigenous groups are represented in the Americas, totaling some 45 to 48 million people (31). Around 90% of indigenous people in the Region live in just five countries: Bolivia, Guatemala, Peru, Ecuador, and Mexico (32). In Bolivia and Guatemala, the majority of the population is indigenous, 62% and 60%, respectively. In contrast, in Brazil, Paraguay, and Venezuela, the indigenous population comprises less than 3% of the total population (31, 33). In the Caribbean, Suriname and Guyana also have small indigenous populations, 2% and 10%, respectively (34).

Indigenous groups currently account for around 17% of those living in extreme poverty in Latin America, even though they represent less than 8% of the population (28). Indigenous young people tend to have lower levels of educational enrollment and attainment, as compared with their nonindigenous counterparts (35). Analysis of data from 11 Latin American countries revealed a more than 20-point illiteracy gap between indigenous and nonindigenous populations (28). As elaborated in Part II of this report, indigenous adolescents are also disproportionately affected by early pregnancy (36).

All the subregions of the Americas have large Afro-descendant populations, each with their specific historically developed population dynamics. A common theme is the subordinate place that Afro-descendant groups tend to occupy in societies (originating from the history of slavery), along with greater levels of poverty and social and political exclusion in most subregions, perhaps with the exception of the Caribbean (37). Afro-descendants may well be the most invisible and marginalized population group in Latin America, even with a population size of more than 100 million. Brazil has the largest number of Afro-descendant inhabitants, in both absolute and relative terms. Other Latin American countries with significant Afro-descendant populations include Colombia, Costa Rica, Cuba, Ecuador, Mexico, Panama, and Venezuela (37). Available data for Afro-descendants indicate lower educational achievements and greater representation in the lower wealth quintiles, as compared with other ethnic groups (37, 38).

The limited available data on the Roma population indicate that Roma households often live in extreme poverty, lacking electricity, clean water, sanitation facilities, and access to public health services (29).
Gender

Some of the key health-related patterns among young people aged 10-24 years in the Americas illustrate the critical importance of gender dynamics in this age group. The following paragraphs highlight mortality and sexual and reproductive health (SRH) of young persons as examples to illustrate the importance of gender dynamics in the health of adolescents and youth.

As detailed in Part II of this report, around 150,000 young people aged 15-24 years die each year in the Region, of which around 80% are males (39), indicating the significantly higher risk of young males to die prematurely. Nine out of 10 homicide deaths and 3 out of 4 suicide deaths in this age group are among males. In order to reduce preventable deaths among young men, in particular those due to violence, it is essential to understand the underlying factors contributing to these differences between males and females. A study conducted in Mexico, the United States, and the United Kingdom presents some key findings and considerations regarding masculinity and being a young man (Box I.1) (40).

Box I.1: The “Man Box”

A recent study (40) defined the “Man Box”—a set of socially reinforced rules about what “real men” should do—in terms of in seven pillars: 1) self-sufficiency; 2) acting tough; 3) physical attractiveness; 4) rigid masculine gender roles; 5) heterosexuality and homophobia; 6) hypersexuality; and 7) aggression and control.

Among the study’s key findings and conclusions were:

• Young men’s ideas about masculinity are strongly connected, in complex ways, with how they feel about themselves. Some men are able to reject restrictive, negative social pressures related to masculinity, but many embrace these pressures and rules, as well as the version of manhood they represent.

• Young men in the Man Box, it appears, experience some reward for meeting these societal expectations. However, the Man Box also exacts a high cost in terms of mental health. It tells men they should always be tough, no matter the circumstances. It tells them to act strong even when they feel uncertain. Their bravado and outward posture that “all is fine” mask deep insecurities, depression, and frequent thoughts of suicide. Those in the Man Box are even less likely to turn to peers and friends for help when they need it.

• Study results show that young men are learning to embrace emotional vulnerability, but that they most often grapple with emotions on their own or with the support of women in their lives. By and large, young men do not seek
emotional support from their fathers. Fear of appearing vulnerable or gay still has a powerful influence over young men’s behaviors, particularly for men in the Man Box.

• Quantitative and qualitative data underscore that the Man Box is a place of risky health behaviors, particularly alcohol abuse and dangerous driving. In all three countries, men in the Man Box are more likely than those outside of it to report regular binge drinking and recent traffic accidents.

• Young men’s sense of physical attractiveness, while relatively high, still links primarily with muscle bulk and body shape, as opposed to a more inward, individual sense of confidence and attractiveness.

• The Man Box is an enormously violent place, with negative repercussions for young men themselves, for young women, and for others around them:
  ° Men inside the Man Box are dramatically more likely to both experience and perpetrate all three forms of bullying included in the study: verbal, online, and physical.
  ° Men inside the box are also far more likely to report having perpetrated sexual harassment against a woman or girl in the last month.

• The overall conclusion is that the Man Box is alive and well in Mexico, the United Kingdom, and the United States. At the same time, a majority of men interviewed support ideas of gender equality.

• The harmful effects of the Man Box are severe, real, and troubling. The majority of men who adhere to the rules of the Man Box are more likely to put their health and well-being at risk, to cut themselves off from intimate friendships, to resist seeking help when they need it, to experience depression, to think frequently about ending their own life, to use violence against other young men, to experience violence, and to sexually harass women.

• Breaking out of the Man Box is not something that young men can do on their own. Navigating the rewards and punishments of manhood is a real dilemma in many settings. Young men and young women, parents, educators, the media, teachers, romantic partners, and all members of society have a role to play in reinforcing positive, equitable, unrestrictive ideas of manhood.

Source: (4).

Part II also elaborates on the persistently high levels of adolescent fertility and the growing trend in pregnancies in girls under 15 years old in LAC countries. Among the underlying gendered causes of inequalities that contribute to vulnerability and risk for early pregnancy (“gender drivers”) is tolerance and acceptance of sexual and gender-based violence. These gender drivers play out at the individual, relationship, and community level, and they can be sustained in institutional or systemic responses, such as service delivery protocols, legislation, and policy frameworks (41).
There is growing recognition of the importance of engaging boys and young men in sexual and reproductive health and rights (SRHR) and gender equality, both for their own health and for the health of women and girls (42, 43). Some of the evidence for this comes from the currently ongoing Global Early Adolescent Study (GEAS), a 15-country study among adolescents aged 10-14 years on the evolving nature of gender norms and social relations. That study has found that young adolescents begin to endorse and internalize norms and values that perpetuate gender inequalities, and that parents and peers are especially central in shaping these attitudes. These results suggest that the investment in and engagement of young adolescents, in particular boys, should start early (44, 45).
Family, peers, school, community and media

It is well-established that the health and development of adolescents are profoundly affected by the relationships with parents, peers, the school and their communities (15, 16, 46). Significant associations have been found between low levels of connectedness or emotional attachment with the family, peers, school and community, and increased risk of negative health outcomes and behaviors such as anxiety, depression, suicide ideation and attempts, unsafe sex, unplanned pregnancy, and substance use (46). On the other hand, positive relationships and high levels of connectedness can promote emotional and physical well-being, and protect adolescents from engaging in behaviors that may compromise their health in the short, medium and long term.

A life course perspective on the social determinants of health recognizes the importance of time and timing in understanding how the social determinants operate at the various stages of life to influence health across the life course (3) (Figure I.8).

Figure I.8: The changing influence of selected social determinants of health across the life course

![Figure I.8: The changing influence of selected social determinants of health across the life course](image)

Source: (3).

Family connectedness is among the most important factors that protect against poor health outcomes in adolescents. As illustrated in Figure I.5, the family remains a constant factor across the life course, even though over time the emphasis shifts from family of origin to one’s own family. In contrast, the influence of education
and school, peers and media changes over time, and may be the strongest during adolescence (3).

The social environment may have positive, protective, or harmful effects. For instance, young people whose parents smoke or drink alcohol are more likely to engage in these behaviors (16). Similarly, strong connections with prosocial peers can support positive health, while peer engagement in harmful behaviors can contribute to adoption of these behaviors. An example of extreme negative peer influence is the involvement in youth gangs. Studies suggest that young people can be drawn to gang life in search of belonging, self-esteem and protection. Lack of supervision and limited access to after-school activities or opportunities to develop hobbies or play sports are potential risk factors for gang involvement (47).

As elaborated in the following section, the emergence of new digital technology and social media can amplify peer connections and influence in a positive as well as negative way.

I.2: Young people in the digital era

There is a marked difference between the current cohort of young people and previous generations in the place and meaning of digital technology in their daily lives. Young people are often referred to as “digital natives” because they were born after such digital technology as the Internet, cell phones, computers, Facebook, Twitter, and other social media had been introduced or were going to scale. As a result, these young people have never known a world without these media, and digital technology plays a central and ever-increasing role in their lives.

By contrast, their parents and older generations are referred to as “digital immigrants.” They generally do not have such an intuitive relationship with digital technology, and they need to make an effort to adapt to the new digital world.

The mobile phone was adopted throughout the world at a historic pace (Annex I.A). Currently, all age groups, including adolescents, rely on mobile-cellular technology for making phone calls and accessing other digital services and platforms, including the Internet and social media. Access to the Internet and utilization of digital technology are also well integrated in the Region (Table I.3).
The percentages of Internet users in North America, South America, and Central America are above the global average, while the figure for the Caribbean is slightly below that average (Figure I.9).

**Table I.3: Selected information and communication facts and figures for the Americas, 2017**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of individuals of all ages using the Internet in the Americas</td>
<td>65.9%</td>
</tr>
<tr>
<td>Proportion of individuals aged 15-24 years using the Internet in the Americas</td>
<td>88.4%</td>
</tr>
<tr>
<td>Proportion of households with Internet access in the Americas</td>
<td>65.3%</td>
</tr>
<tr>
<td>Internet penetration rate for men in the Americas</td>
<td>65.1%</td>
</tr>
<tr>
<td>Internet penetration rate for women in the Americas</td>
<td>66.7%</td>
</tr>
</tbody>
</table>

Source: (48).

The percentages of Internet users in North America, South America, and Central America are above the global average, while the figure for the Caribbean is slightly below that average (Figure I.9).

**Figure I.9: Internet users in the world and in the Americas, by subregion, 2017**

Source: (48).
At the global level, the proportion of women using the Internet is 12% lower than the proportion of men (48). The Americas is the only region where the Internet user gender gap is inverted, with more women than men using the Internet (48).

Facebook is widely used in the Region (Figure I.10 and Annex I.B). The data on Facebook use by age group clearly illustrate that young persons have a substantial lead in the use of social media.

Figure I.10: Facebook use among all ages and among those aged 16-24 years, by sex, in selected countries in Latin America and the Caribbean, March 2017

Source: (48).

Young people use information and communication technology in a multifunctional and integrated way. This includes doing homework, finding information, staying connected with their interests, and communicating with others. Digital technology is also increasingly used as a public health tool, to provide information and services for young persons. However, evidence regarding best practices in the use of digital technology to improve the health of young people remains limited at this time.

In addition to the benefits, there are also a range of potentially negative consequences of the high level of use and dependency of young persons on digital technology. These include excessive and compulsive use of social networking sites, dependency on and influence of virtual relationships, internet gaming, exposure to online predators, and cyberbullying. Ongoing research is needed to increase
understanding of the risks and threats associated with young people’s use of digital technology, and to inform measures to protect them from these risks and threats.

PAHO conducted an in-depth literature review of 37 articles on the use of technology in adolescent health. The digital technology used in the articles included electronic TV monitoring devices, web-based interventions, mobile phone and social media interventions, and the target behaviors included weight management, smoking, alcohol consumption, mental health, sexual and reproductive health, and management of chronic conditions. Twenty-six of these articles reported positive results from the implementation of digital health technologies and techniques in adolescent health, three presented neutral results, seven presented mixed results, and one presented negative results.\(^1\) The study, which documented this negative impact, was a mobile health intervention targeting adolescents aimed at management of their diabetes.

### I.3: Adolescents and youth in situations of vulnerability

While all young people have opportunities and challenges, some groups of young people face specific circumstances—often outside of their control—that create additional layers of vulnerability and thus require specific attention. The following paragraphs highlight difficulties faced by young people with disabilities; migrant youth; young persons deprived of their liberty; lesbian, gay, bisexual, and transgender (LGBT) youth; and young people living with chronic conditions.

**Young persons with disabilities:** These persons encounter the same challenges as their peers do when going through puberty and growing up, but they also face the stigma and marginalization associated with living with a disability. Around the world, people with disabilities have poorer health outcomes, lower education achievements, less economic participation, and higher rates of poverty compared to people without disabilities (50).

Data on the prevalence of disability in adolescents are limited, both globally and in the Region. The available data differ substantially, depending on the definitions, age groups, and data collection methodologies used in studies. Based on the

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\(^1\) Unpublished 2017 PAHO review on the impact of eHealth on adolescent health.
2010 census round in the Region and national disability surveys, the prevalence of disabilities in adolescents for selected countries ranged from around 2.5% to more than 8% (Table I.4 and Table I.5).

Table I.4: The prevalence of disabilities in adolescents in selected countries in Latin America and the Caribbean, based on the 2010 census round

<table>
<thead>
<tr>
<th>Country</th>
<th>Year of census</th>
<th>10-14 years</th>
<th>15-19 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argentina</td>
<td>2010</td>
<td>6.0</td>
<td>5.8</td>
</tr>
<tr>
<td>Aruba</td>
<td>2010</td>
<td>2.8</td>
<td>3.7</td>
</tr>
<tr>
<td>The Bahamas</td>
<td>2010</td>
<td>4.0</td>
<td>4.8</td>
</tr>
<tr>
<td>Barbados</td>
<td>2010</td>
<td>2.6</td>
<td>2.4</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>2011</td>
<td>4.1</td>
<td>4.1</td>
</tr>
<tr>
<td>Cuba</td>
<td>2012</td>
<td>3.0</td>
<td>3.1</td>
</tr>
<tr>
<td>Panama</td>
<td>2010</td>
<td>6.6</td>
<td>4.9</td>
</tr>
<tr>
<td>Suriname</td>
<td>2012</td>
<td>3.1</td>
<td>3.3</td>
</tr>
</tbody>
</table>

Source: PAHO analysis of 2010 census data from selected countries.

Marginalization of young persons with disabilities occurs because of a lack of access to several essentials: education adapted to their type or level of disability; decent employment when they are ready to transition to the world of work; and appropriate and quality health services, including sexual and reproductive health services. Most countries lack specific legislation, strategies and resources to facilitate full and equal access to education, training, social services, rehabilitation and health services for young persons with disabilities.

In 2014, the PAHO Member States adopted the Plan of Action on Disabilities and Rehabilitation (Resolution CD53.R12) (51). With this step, the Member States recognized that disability is a public health issue, a human rights issue, and a development priority. The Member States committed to a range of actions to improve the lives and health outcomes of persons with disabilities. These included
making disability a priority in their national health policies; strengthening the legal framework and regulations in the countries and their enforcement in order to protect the human rights of persons with disabilities; and improving the production, analysis, and use of disability data in national information systems.

Table I.5: The prevalence of disabilities in children and youth in selected countries of the Americas, based on national surveys, 2010-2015

<table>
<thead>
<tr>
<th>Country</th>
<th>Year of survey</th>
<th>Age group</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chile</td>
<td>2015</td>
<td>2-17 years</td>
<td>5.8%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>18-29 years</td>
<td>7.1%</td>
</tr>
<tr>
<td>Dominican Republic</td>
<td>2013</td>
<td>0-9 years</td>
<td>7.3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10-19 years</td>
<td>6.1%</td>
</tr>
<tr>
<td>El Salvador</td>
<td>2015</td>
<td>0-12 years</td>
<td>8.4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>13-18 years</td>
<td>8.0%</td>
</tr>
<tr>
<td>United States of America</td>
<td>2015</td>
<td>5-15 years</td>
<td>5.3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>16-20 years</td>
<td>5.9%</td>
</tr>
</tbody>
</table>

Sources: (52-55).

**Migrant youth:** The term “migrant” refers to a range of categories of persons who move away from their habitual place of residence, including across international borders or within a State (56, 57). People can choose to migrate to seek better opportunities elsewhere, or they may be forced to move away by circumstances or forces beyond their control. Regardless of the reason for migration, migrants can face health challenges due to limited access to resources, insecurity, family separation, discrimination, and other difficulties. Circumstances of forced or irregular migration amplify the challenges and risks for the migrants (57).

The Region of the Americas has seen an increase in the number of people who have migrated across borders. That figure reached 63.7 million in 2015, of whom 808,000 were defined as refugees (58). Forced migrants within country borders accounted for an estimated 7.1 million people, of whom the majority are in Colombia (58, 59).
Young people may migrate to seek better opportunities for education and income. On the other hand, they may face unique challenges when they are forced to move with their families, move without their families, or if migrating parents leave them behind to take care of younger siblings. As refugees, young people, in particular girls, are at disproportionate risk for harm and violence, including kidnapping, physical violence, sexual harassment, and rape (60).

Because of the critical role of the social environment—including the family, peers, and the school—during adolescence, separating youth from these social settings due to migration can have irreparable consequences for their development if there are no programs and services available to fill these gaps (46, 61).

In general, policies and measures related to migration do not include provisions to address the specific challenges faced by migrant youth. For instance, without measures to legalize their status, undocumented adolescents who may have been brought into the country by their parents, remain unregistered. Without proper documentation, migrant young persons may have limited or no access to health and social services, education, and decent employment.

**Young persons deprived of their liberty:** Article 37 of the Convention on the Rights of the Child (CRC) states that “no child shall be deprived of his or her liberty unlawfully or arbitrarily; the arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time; [and] every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age” (62).

Young people can be detained for a number of reasons, including administrative detention and judicial detention. Administrative detention occurs when, as the result of a decision of an executive or administrative body, a child is placed in any public or private setting from which he or she cannot leave at will (63). Minors—as defined by the law of the country—can be administratively detained or institutionalized for many reasons, including for care, protection, treatment, or illegal immigration. Judicial detention takes place when young persons are suspected or convicted of a crime, also referred to as “children in conflict with the law.”
Without entering into the many human rights and legal dimensions associated with the detention of minors, within the context of this report it is important to note that deprivation of liberty negatively affects the development of a young person. The poor juvenile court structures, poor conditions of detention centers, and lack of internal and external controls place young persons deprived of their liberty at disproportionate risk of harm. Depending on the conditions and services of the detention location, detained young persons are at increased risk for communicable disease such as tuberculosis and HIV, as well as violence, rape, and mental health problems. Youth-focused efforts must include seeking alternative measures for young persons in conflict with the law, reaching young persons with appropriate health services while detained, and, following detention, ensuring support for successful re-integration into society.

**LGBT adolescents and youth:** In September 2013, the PAHO Member States adopted a landmark resolution addressing the causes of disparities in health service access and utilization for LGBT persons (64). The resolution acknowledges the political, sociocultural, and historic barriers and violence that LGBT persons face in the community and when accessing health services. It also urged Member States to work to promote the delivery of health services to all people, with full respect for human dignity and health rights, taking into account the diversity of gender expression and gender identity.

The limited available data on LGBT adolescents and youth confirms their disproportionate risks and vulnerabilities (65-68). According to data from the 2015 national Youth Risk Behavior Survey (YRBS), lesbian, gay, and bisexual (LGB) students in the United States were 140% more likely (12% vs. 5%) to not go to school at least one day during the 30 days prior to the survey because of safety concerns, as compared with heterosexual students. LGBT youth were also at greater risk for depression, suicide, substance use, and risky sexual behaviors. Nearly one-third (29%) of LGB youth had attempted suicide at least once in the prior year, as compared to 6% of heterosexual youth.

A survey with more than 10,000 adolescents aged 13-17 years from a wide range of social, cultural, and ethnic backgrounds in the United States found that many LGBT adolescents are profoundly disconnected from their communities. Those LGBT adolescents also believe to a greater extent than their non-LGBT peers do that
they must leave their communities in order to make their hopes and dreams come true. When given an opportunity to describe their most important problem or the one thing in their lives they would like to change, LGBT adolescents and their non-LGBT peers had different experiences and priorities. The non-LGBT adolescents listed exams/grades, college/career, and financial pressures related to college and jobs as their most important problems. In contrast, LGBT adolescents described their most important challenges as being directly related to their identity as LGBT, such as nonaccepting families, bullying, and fear of being open or out (69).

**Young persons living with chronic conditions:** These young persons have the same developmental issues, challenges, and needs as their peers, in addition to dealing with their chronic condition. While information is limited on the burden of chronic conditions among young persons in the Region, the available data suggest a significant burden, ranging from respiratory conditions such as asthma to diabetes, cancers, epilepsy, skin and musculoskeletal conditions, and HIV. Each year in the Americas, more than 600 adolescents aged 10-19 die from epilepsy and more than 1,000 from diabetes and heart disease (39). In an analysis of data from the 2015 Global Burden of Disease (GBD) study conducted for PAHO by the Institute for Health Metrics and Evaluation (IHME), skin diseases and asthma were among the top 3 risk factors for disability-adjusted life years (DALYs) in LAC for the age group 10-14 years, and in the top 10 for the age group 15-19 years.

Chronic conditions can be challenging in any stage of life, but the physiological and psychosocial dimensions of adolescence bring added difficulties. Chronic illness during puberty may cause temporary or permanent delays in growth and development, as well as impair the psychosocial development of the young person (70, 71). Some studies have found that young persons with chronic conditions are at higher risk for depression and self-harm, including suicidal ideation and attempts (72).

Another important aspect of chronic disease management in adolescents is the effective transfer of the adolescent from pediatric to adult care. This can take place in early adolescence, depending on the legislation and the health system policies and practices in the country. Careful consideration and attention must be given to facilitate an effective transition, ensuring appropriate support for the adolescent (73).
Conclusion

This profile of young people in the Americas sketches a portrait of opportunity and challenges. The presence of a historically large cohort of young people in the Region provides the opportunity for rapid socio-economic growth, if strategic investments are made in the health and development of young people. On the other hand, secondary education completion rates among young people in the Region are low, below 50% in many countries, which reduces the chances for young people to gain decent employment as they transition into adulthood. Other challenges include the disproportionate burden of poverty among young persons, youth unemployment, and significant numbers of young people who are neither in school, nor employed. The profile also highlights groups of young people who are living in specific situations of vulnerability, such as young people with disabilities, LGBT, indigenous and Afro-descendant youth. The potential to reap the benefits from the demographic dividend, and to achieve de SDGs without leaving any young person behind, will require comprehensive, intersectoral and pro-equity actions aimed at empowerment of young people, addressing the social determinants of their health, and maximizing the positive benefits of the family, the school, the community, social media, and other social platforms, to create an environment in which every young person can thrive.
Part II

THE CURRENT STATUS OF THE HEALTH OF ADOLESCENTS AND YOUTH IN THE AMERICAS
II.1: Introduction

The Regional Strategy for Improving Adolescent and Youth Health and the Plan of Action on Adolescent and Youth Health have the overarching goal of contributing to the health of young people in the Region of the Americas (4). This is to be accomplished by developing and strengthening an integrated health sector response and by implementing effective adolescent and youth health promotion, prevention, and care programs. The Plan of Action proposes a set of 8 health goals, with 19 targets, that are related to mortality, unintentional injuries, violence, substance use and mental health, sexual and reproductive health, nutrition and physical activity, chronic diseases, and protective factors (4) (Annex IIA). The following sections of Part II of this report present a status update on the health of adolescents and youth in the Americas, based on these health goals.

II.2: Mortality and morbidity

Adolescence is generally a healthy stage of life, with low mortality and morbidity, compared with other age groups. The 2016 report from the Lancet Commission on Adolescent Health and Wellbeing (3) proposed classifying countries into three categories, depending on the pattern of disease burden in the adolescent and youth population (10-24 years).

Box II.1: Regional adolescent and youth health goals 1-3

Goal 1: Reduce adolescent and youth mortality
  - Reduce the mortality rate of adolescents and youth ages 10-24 years

Goal 2: Reduce unintentional injuries
  - Reduce the mortality rate caused by road traffic injuries among men 15-24 years of age

Goal 3: Reduce violence
  - Reduce the suicide rate among those 10-24 years old
  - Reduce the homicide rate among men aged 15-24 years

Source: (4).
The first category is “multiburden countries,” with disability-adjusted life year (DALY\(^2\)) rates due to infectious diseases, nutritional deficiency, and sexual and reproductive health (SRH) (including HIV) of 2,500 per 100,000 or more per year. These are countries with little evidence of having passed through an epidemiological transition. These nations tend to have high burdens of infectious and vaccine-preventable diseases, undernutrition, and adverse sexual and reproductive health events.

The second category is “injury-excess countries,” where the burden of disease shows evidence of having passed through the first phase of the epidemiological transition, but where rates of preventable injury are high. These are countries with DALY rates due to unintentional injuries and violence of 2,500 per 100,000 per year or more, combined with nutritional deficiency and SRH (including HIV) of less than 2,500 per 100,000.

\(^2\) The sum of the years of life lost due to premature mortality and the years lost due to disability.
The third category is “noncommunicable-disease-predominant countries.” These NCD-predominant nations have DALY rates of less than 2,500 per 100,000 for infectious diseases, nutritional deficiencies, and SRH/HIV, as well as for unintentional injuries and violence.

The Lancet report places the countries of North America in the NCD-predominant category, as well as Argentina, Chile, Peru, and Uruguay. Most of the remaining South American, Central American, and Caribbean countries are placed in the injury-excess category. A few countries, including Guatemala and Haiti, are in the multiburden category (3).

Each year in the Americas, around 80,000 adolescents (10-19 years) and 150,000 youth (15-24 years) die (Figure II.1). On average, 70% to 80% of these deaths are among males.

Figure II.1: Number of adolescent and youth deaths in the Americas, by age group and sex, 2008-2013

<table>
<thead>
<tr>
<th>Year</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of countries reporting</td>
<td>44</td>
<td>45</td>
<td>43</td>
<td>39</td>
<td>39</td>
<td>37</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescents (10 - 19 years)</td>
<td>58,659</td>
<td>59,406</td>
<td>56,410</td>
<td>58,445</td>
<td>59,406</td>
<td>56,125</td>
</tr>
<tr>
<td>Youth (15 - 24 years)</td>
<td>117,233</td>
<td>119,595</td>
<td>118,817</td>
<td>117,603</td>
<td>118,817</td>
<td>113,779</td>
</tr>
</tbody>
</table>

Source: (39).
Homicide, suicide, and road traffic injuries are the leading causes of death among adolescents and youth in the Americas (Figure II.2, Annex II.B, Annex II.C).

The data show little variation in adolescent and youth mortality over the 2008-2013 period (Figure II.3). Consistently, males die at higher rates, with the highest mortality rates in males aged 15-24 years.
Analysis of percentage changes in mortality for the 2008-2012 period shows differences among countries, between age groups, and between the two sexes that can contrast with regional averages. While some countries show progress in some or all groups, others are dealing with increased mortality (Figure II.4 through Figure II.6). (It is important to note that due to the small population sizes in some Caribbean countries, relatively small changes in the number of deaths can create major shifts in the trends.)
The countries with the largest percentage decreases in overall mortality rate included Bermuda, El Salvador, Grenada, Guatemala, and Suriname. The countries with the largest percentage increases in overall mortality rate included Aruba, the Bahamas, and the Dominican Republic. Notably, Brazil, the Dominican Republic, Honduras, and Mexico had increases in total mortality rate for both males and females in all age groups.
Chile, Ecuador, El Salvador, Guatemala, and Nicaragua had decreased mortality rates in both males and females of all age groups. The remaining countries showed differences between the sexes and age groups.
The countries with the largest percentage decreases in all homicides included Costa Rica, Ecuador, El Salvador, Guatemala, Nicaragua, and Saint Kitts and Nevis. For suicide, they were Chile, Colombia, Guatemala, Nicaragua, Panama, and Suriname. And for mortality due to road traffic injuries, they were Belize, Bermuda, Chile, Costa Rica, El Salvador, Peru, Puerto Rico, Suriname, and the U.S. Virgin Islands.

The countries with the largest increases in homicide rates among males were Belize, the Dominican Republic, Honduras, Mexico, and Peru. Of particular concern was the significant increase in homicide rates among females in a number of countries, including the Bahamas, Belize, Cuba, Mexico, Paraguay, and Peru. Also worrisome was suicide, in both sexes, with the largest increases being in Argentina, Cuba, the Dominican Republic, Honduras, Peru, and Puerto Rico. Similarly concerning are the mortality rates due to road traffic injuries, with the largest increases in Argentina, Aruba, Dominica, the Dominican Republic, Guatemala, Honduras, Nicaragua, and Uruguay.

Intentional homicide is by far the most important cause of death among young people, in particular males, in the Region. The grand majority of homicides are
also perpetrated by males (74). In order to improve efforts aimed at reduction of homicide, it is critical to understand the details and patterns of these events (who, how, and why). Intentional homicides can be related to other criminal activities (robberies, gangs, organized crime), to interpersonal conflict, or to socio-political causes (74). These relationships can vary significantly between countries. For example, for the period 2008-2011, 44% of homicides in Jamaica were related to gangs and organized crime, and 40% were related to robbery or other criminal acts. By contrast, 47% of homicides in Costa Rica during the period 2006-2012 were related to robbery or other related criminal acts, and 36% were related to interpersonal conflicts (74).

In terms of mechanisms, homicides can be perpetrated with firearms, sharp objects (such as knives), or other means (i.e., strangulation, blunt force). In the Americas, between 60% and 70% of intentional homicides are perpetrated with firearms. At the country level, this can vary: for example in 2011, 24% of homicides (all ages) in Costa Rica were perpetrated with firearms, 38% with sharp objects, 12% with blunt force, and the remaining 26% through other means. On the other hand, 67% of homicides in Belize in the same year were perpetrated with firearms, and 20% with blunt force (74).

Beyond homicide deaths, several forms of nonfatal violence also contribute to the burden of disease among young persons in the Region. These include physical, emotional, and mental harm caused by bullying, physical, sexual, and psychological abuse.

It is important to note that adolescent and youth deaths do not happen randomly, but are often related to contextual factors, including the social determinants of health, such as education and socioeconomic status. The following paragraphs and figures describing selected countries illustrate the importance of advanced analysis of mortality data, for increased understanding of the relationship between adolescent and youth mortality and social determinants, and the most vulnerable groups within countries and communities.

For example, an analysis of deaths in youth aged 15-24 years due to road traffic injuries in Belize showed that between 2010 and 2015, the rate remained stable in the districts with the highest wealth index, while it increased significantly in the poorer districts (Figure II.7) (75).
National averages may disguise inequalities in subgroups. In 2014, Chile reported an adolescent suicide rate of 5.1 per 100,000 (39). However, analysis of suicides by region indicated marked differences in patterns among the regions in the country. Between 2008 and 2014, the regions with the highest income had a downward trend in suicide rates, while the rates in the poorer regions increased (Figure II.8) (75).

Figure II.7: Mortality rate in 2010 and 2015 due to road traffic injuries in Belize, among youth aged 15-24 years, by wealth quintile level

Figure II.8: Changes in suicide rates among adolescents aged 10-19 in Chile, between 2008 and 2014, on national level and by wealth quintile index of their region of residence

Source: (75).
When analyzed by the concentration of indigenous populations in the regions in Chile, the data showed consistently higher adolescent suicide rates in the regions with the highest concentrations of indigenous populations, as compared with the regions with the lowest concentrations, and also the national rates (Figure II.9).

Figure II.9: Changes in suicide rates among adolescents aged 10-19 in regions in Chile, from 2008 to 2014, by concentration of indigenous populations

Sources: (39, 75).
Disability-adjusted life years (DALYs) for a disease or health condition are calculated as the sum of the years of life lost (YLL) due to premature mortality in the population and the years lost due to disability (YLD) for people living with the health condition or its consequences. One DALY can be thought of as one lost year of “healthy” life. The sum of these DALYs can be thought of as a measurement of the gap between current health status and an ideal health situation, free of disease and disability (76).

According to findings from an analysis of data from the 2015 Global Burden of Disease (GBD) study conducted for PAHO by the Institute for Health Metrics and Evaluation (IHME), the leading causes of DALYs in adolescents aged 10-14 years are iron deficiency anemia and skin diseases, such as acne, interpersonal violence and road traffic injuries in the age groups 15-19 years and 20-24 years (Table II.1).

Table II.1: Leading causes of disability-adjusted life years (DALYs) lost in Latin America and the Caribbean, by age group and sex (rates per 100,000 population), 2015

<table>
<thead>
<tr>
<th>Rank</th>
<th>10-14 years</th>
<th>15-19 years</th>
<th>20-24 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Both sexes</td>
</tr>
<tr>
<td>1</td>
<td>Iron deficiency anemia (1,354)</td>
<td>Iron deficiency anemia (1,046)</td>
<td>Iron deficiency anemia (1,203)</td>
</tr>
<tr>
<td>2</td>
<td>Skin diseases (772)</td>
<td>Skin diseases (922)</td>
<td>Skin diseases (846)</td>
</tr>
<tr>
<td>3</td>
<td>Asthma (661)</td>
<td>Asthma (603)</td>
<td>Asthma (633)</td>
</tr>
<tr>
<td>4</td>
<td>Road traffic injuries (571)</td>
<td>Anxiety disorders (568)</td>
<td>Conduct disorders (471)</td>
</tr>
<tr>
<td>5</td>
<td>Conduct disorders (562)</td>
<td>Migraine (567)</td>
<td>Road traffic injuries (443)</td>
</tr>
</tbody>
</table>

Source: Analysis of data from the 2015 Global Burden of Disease (GBD) study, conducted for PAHO by the Institute for Health Metrics and Evaluation (IHME).

According to the GBD analysis, the leading causes of DALYs of young persons in Latin America and the Caribbean have shifted since 1990, with communicable, maternal, neonatal, and nutritional diseases generally declining in rank, and conditions such as self-harm (suicide and attempted suicide) and conduct and mental health disorders becoming more prominent (Figure II.10, Figure II.11, and Figure II.12).
In the age group 10-14 years, intestinal nematode infections, lower respiratory infections, drownings, and diarrheal diseases dropped substantially on the list of DALYs between 1990 and 2015, and road traffic injuries, conduct disorders, and asthma went up in rank. Iron deficiency anemia remained the top cause of DALYs in the age group 10-14 years, in both 1990 and 2015 (Figure II.10).

Figure II.10: Changes in causes of adolescent disability-adjusted life years (DALYs) lost in those 10-14 years old (both sexes), Latin America and the Caribbean, 1990-2015

Source: Analysis of data from the 2015 Global Burden of Disease (GBD) study conducted for PAHO by the Institute for Health Metrics and Evaluation (IHME).
In the older adolescents (15-19 years), the five leading causes for DALYs lost remained constant, with violence, injuries, and mental health disorders as prominent causes. Self-harm rose in rank from 11th to 8th, and drownings went down, from 8th to 14th (Figure II.11).

Figure II.11: Changes in causes of adolescent disability-adjusted life years (DALYs) lost in those 15-19 years old (both sexes), Latin America and the Caribbean, 1990-2015

Source: Analysis of data from the 2015 Global Burden of Disease (GBD) study conducted for PAHO by the Institute for Health Metrics and Evaluation (IHME).
Similarly, the top eight leading causes in youth 20-24 years old remained stable. Drug use disorders, HIV/AIDS, and congenital defects rose noticeably in rank, and drownings, epilepsy, and tuberculosis declined substantially (Figure II.12).

Figure II.12: Changes in causes of youth disability-adjusted life years (DALYs) lost in those 20-24 years old (both sexes), Latin America and the Caribbean, 1990-2015

Source: Analysis of data from the 2015 Global Burden of Disease (GBD) study conducted for PAHO by the Institute for Health Metrics and Evaluation (IHME).
In Latin America and the Caribbean in 2015, the leading risk factors for DALYs for young adolescents (10-14 years) were malnutrition, alcohol and drug use, poor kidney function, and unsafe water, sanitation, and handwashing. Prominent risk factors for youth 15-24 years included alcohol and drug use, occupational risks, unsafe sex, sexual abuse and violence, and malnutrition (Table II.2). Tobacco featured as risk factor number 11 for youth (15-24 years).

Table II.2: Leading risk factors for disability-adjusted life years (DALYs) lost in Latin America and the Caribbean, by age group and sex, 2015

<table>
<thead>
<tr>
<th>Rank</th>
<th>10-14 years</th>
<th>15-19 years</th>
<th>20-24 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>1</td>
<td>Malnutrition</td>
<td>Malnutrition</td>
<td>Alcohol and drug use</td>
</tr>
<tr>
<td>2</td>
<td>Alcohol and drug use</td>
<td>Low glomerular filtration</td>
<td>Occupational risk</td>
</tr>
<tr>
<td>3</td>
<td>Unsafe water, sanitation and handwashing</td>
<td>Unsafe water, sanitation and handwashing</td>
<td>Malnutrition</td>
</tr>
<tr>
<td>4</td>
<td>Low glomerular filtration</td>
<td>Unsafe sex</td>
<td>Low glomerular filtration</td>
</tr>
<tr>
<td>5</td>
<td>Unsafe sex</td>
<td>High fasting plasma glucose</td>
<td>High fasting plasma glucose</td>
</tr>
<tr>
<td>6</td>
<td>High fasting plasma glucose</td>
<td>Alcohol and drug use</td>
<td>Unsafe sex</td>
</tr>
<tr>
<td>7</td>
<td>Air pollution</td>
<td>Sexual abuse and violence</td>
<td>Unsafe water, sanitation and handwashing</td>
</tr>
<tr>
<td>8</td>
<td>High blood pressure</td>
<td>Air pollution</td>
<td>High blood pressure</td>
</tr>
<tr>
<td>9</td>
<td>Tobacco</td>
<td>High blood pressure</td>
<td>Sexual abuse and violence</td>
</tr>
<tr>
<td>10</td>
<td>Other environmental</td>
<td>Tobacco</td>
<td>Air pollution</td>
</tr>
</tbody>
</table>

Source: Analysis of data from the 2015 Global Burden of Disease (GBD) study conducted for PAHO by the Institute for Health Metrics and Evaluation (IHME).
The presented data on adolescent and youth mortality and DALYs lost underline the lack of progress and the unfinished regional agenda for adolescent and youth mortality and risk factors. For the Region, among the critical requirements for progress in reducing preventable adolescent and youth mortality are increasing the understanding of the specific circumstances of these deaths, identification of the most affected groups, and application of evidence-based interventions to address the circumstances and risk factors.

Beyond homicide, other types of violence are highly relevant when it comes to adolescents and youth. These include nonfatal violence, bullying, and sexual violence, which all contribute to disabilities, depression, and such high-risk behaviors as smoking, substance use, and sexual risk-taking.

The World Health Organization (WHO) and PAHO recommend evidence-based interventions for the prevention of adolescent suicide, road traffic injuries, and youth violence (including bullying), applying an ecological perspective (Annex II.D1) (6, 76).

II.3: Adolescent and youth mental health and substance use

Mental health

The WHO defines mental health as a “state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (78). WHO’s Mental Health Action Plan 2013-2020 (78) uses the term “mental disorders” to denote a range of mental and behavioral disorders that fall within the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10). These include depression, bipolar affective disorder, schizophrenia, anxiety disorders, dementia, substance-use disorders, intellectual disabilities, and developmental and behavioral disorders. The Action Plan also covers suicide prevention and such conditions as epilepsy (78). Mental disorders have been associated with increased alcohol use; violence; such diseases as cancer, cardiovascular diseases, and HIV; increased risk of poverty; and premature death (78).
The WHO Action Plan has four objectives: 1) to strengthen effective leadership and governance for mental health; 2) to provide comprehensive, integrated, responsive mental health and social care services in community-based settings; 3) to implement strategies for promotion and prevention in mental health; and 4) to strengthen information systems, evidence, and research for mental health. The Action Plan identifies the early stages of life as an important opportunity to promote mental health and prevent mental disorders, as up to 50% of mental disorders in adults begin before the age of 14 years (78).

After the WHO Action Plan was approved, the PAHO Member States adopted the Plan of Action on Mental Health 2015-2020 in 2014 (77). The goal of the regional Plan of Action is to promote mental well-being; prevent mental and substance-related disorders; offer care; enhance rehabilitation; emphasize recovery; and promote the human rights of persons with mental and substance-related disorders, in order to reduce morbidity, disability, and mortality (77).

In addition to suicide deaths, suicidal behaviors (including ideation, planning, and attempts) are important indicators of the mental health of young people. An analysis of data generated by the most current Global School-based Health Surveys (GSHS) conducted in 28 LAC countries between 2007 and 2013 provides some insight into suicidal behaviors for subregions of the Americas (Annex II.E) (79). The percentage of students aged 13-15 years who seriously considered suicide (ideation) ranged from 14.8% in Central America to 20.7% in the English-speaking Caribbean, and the percentage of students who actually attempted suicide ranged from 13.2% in Central America to 18.0% in the Caribbean. The use of alcohol and the perception of having poor social support substantially increased the prevalence of suicidal

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**Box II.2: Regional adolescent and youth health goal 4**

Reduce substance use and promote mental health

- Reduce the percentage of adolescents between the ages of 13 and 15 who have consumed one or more alcoholic beverages during the last 30 days
- Reduce past-month use of illicit substances among those 13-15 years old
- Reduce tobacco use among adolescents and youth 15-24 years of age

*Source: (4).*
behaviors in both males and females in this age group. By contrast, having strong parental relationships appeared to serve as a protective factor against suicidal behaviors in both sexes.

These GSHS results are consistent with the findings of a multicountry analysis of a school health survey conducted in six Overseas Caribbean Territories (OCTs) (Aruba, British Virgin Islands, Cayman Islands, Montserrat, Saint Eustatius, and Saint Maarten) during 2011-2013 (80). In this study, 23.6% of the respondents ages 15-19 years had seriously considered suicide in the 12 months preceding the study. Statistically significant associations were found between suicidal behaviors and family connectedness. Respondents with very low to low family connectedness were more likely to consider or attempt suicide (80).

In the countries with two GSHS data points for suicidal ideation, the percentage of adolescents who seriously considered suicide was similar to or higher than the previous survey results (Figure II.13), suggesting that the situation is worsening instead of improving (79).

Figure II.13: Percentage of students aged 13-15 who seriously considered attempting suicide in the past 12 months, in selected countries in Latin America and the Caribbean, 2007-2016

Source: Last two Global School-based Health Surveys in the respective countries (81).
Substance use

The use of substances by adolescents is not just a public health concern because of the contribution to DALYs lost due to mortality and disability, and the negative behavioral consequences associated with intoxication. There is a growing body of evidence from neuroscience indicating that the use of psychoactive substances during adolescence, particularly heavy use, may have implications across the life course due to the effect on brain development (12, 13).

Psychoactive substances may generate neural adaptations that increase the risk for substance-use disorders in adulthood. In addition, adolescent alcohol and marijuana users have shown changes in brain structure and functions, including lower brain volume in several regions of the brain, and reduced white matter integrity. Studies have associated reduced white matter integrity with cognitive instability, and higher white matter integrity with optimal cognitive, behavioral, and emotional development (12, 13).

Alcohol and other substance use in youth has been associated with increased risk of motor vehicle crashes, as well as violence, reduced school performance, sexual risk behaviors, and relationship challenges with parents and peers (12, 13, 82-85). The following subsections will review the use of alcohol, tobacco, and psychoactive substances in young persons in the Region of the Americas.

One of the main sources for standardized information on substance use among young people is the GSHS, which is coordinated by the CDC and WHO and collects data among students aged 13-15 years (recently extended to 17 years) (81).

A second major source of information on substance use among young people is the Organization of American States (OAS). The Inter-American Observatory on Drugs (OID) is the statistical, information, and scientific research branch of the Inter-American Drug Abuse Control Commission (CICAD), which the OAS established in 1986. The OID helps countries to improve the collection and analysis of drug-related data by promoting the establishment of national observatories and the use of standardized methods. The OID publishes studies and comparative analyzes regarding drug issues in the Americas, based on the work of national drug observatories. The Report on Drug Use in the Americas, 2011 (86), was the first analysis of drug trends in OAS Member States, covering the period of 2002-2009 and dealing with trends in five groups of substances. The Report on Drug
Use in the Americas, 2015 (87), contains an exhaustive analysis of drug use in OAS Member States and offers a hemispheric and subregional outlook with respect to the consumption of psychoactive substances in recent years. The 2015 publication is based on information provided directly by Member States. The information was updated to the end of 2014, and came mainly from three sources: national studies among secondary school students, general population studies, and surveys of university students. The secondary school student surveys covered the 8th, 10th, and 12th grades (or the equivalent in each country), corresponding with the ages 13, 15, and 17.

The GSHS and OAS data are used in this report. However, their age groups and data collection methods are not identical and so should not be compared.

Alcohol

Dimensions of alcohol consumption that correlate with harms caused by alcohol include the patterns of drinking as well as the overall volume of drinking over the past month, the past year, or the lifetime. Any use of alcohol among adolescents is considered a risk, given the impact of alcohol on brain development. The earlier the initiation of alcohol use, the higher the risk of having episodes of heavy drinking and developing an alcohol use disorder later in life. Any episodic drinking occasion is a risk for intoxication, injuries, or even death. It is important to note that in non-tolerant youth, lower alcohol concentrations can lead to serious intoxication and poisoning. In the GSHS, the prevalence of heavy alcohol use is defined as at least five drinks (or the equivalent of 60 grams of pure alcohol) on a drinking occasion in the past 30 days (81), which is the same definition used in adult surveys, to allow for comparison between the age groups (86). The Inter-American Uniform Drug Use Data System (SIDUC) defines binge drinking as the consumption of five drinks or more on a single occasion during the two weeks prior to the survey, expressed as a percentage of the respondents who consumed alcohol in the past month (86, 87).

GSHS survey data shows variances between countries in current alcohol use (Figure II.14). The countries with the highest percentages of current alcohol use are Dominica (54%), Saint Lucia (54%), Jamaica (52%), Saint Vincent and the Grenadines (51%), and Argentina (50%). While in most countries more males than females are current drinkers, the gender gap is narrow, and there are several countries with
The data also illustrate the early introduction of alcohol. Among the students who reported having had at least one drink during their lifetime – other than a few sips – the majority had the first drink prior to age 14 (Figure II.15). The males tend to have a few percentage points higher proportions of early starters.
Among students who ever had at least one drink, apart from a few sips.

The percentage of lifetime alcohol users who report that they have been “really drunk” at least once ranged from 10% to over 30%. While in most countries more males than females are in this category, several countries, including Uruguay, Chile, Cayman Islands, Anguilla, and British Virgin Islands, had more females in this category (Figure II.16).
Among students who ever had at least one drink, apart from a few sips.

Figure II.16: Percentage of students aged 13-15 years who ever drank so much alcohol that they were really drunk, by sex, in selected countries in Latin America and the Caribbean, 2007-2016

<table>
<thead>
<tr>
<th>Andean Subregion</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bolivia (2012)</td>
<td></td>
</tr>
<tr>
<td>Peru (2010)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Caribbean</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anguilla (2016)</td>
<td></td>
</tr>
<tr>
<td>Antigua and Barbuda (2009)</td>
<td></td>
</tr>
<tr>
<td>Bahamas (2013)</td>
<td></td>
</tr>
<tr>
<td>Barbados (2011)</td>
<td></td>
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Source: (81).

*Among students who ever had at least one drink, apart from a few sips.

Figure II.17 provides an overview of the ways the students obtained alcohol in the 30 days preceding the GSHS survey, showing striking differences among the subregions. In the Caribbean, home and family were most frequently named as sources, while in Central America, friends were the most frequent source. According to this information, efforts to curtail alcohol use among adolescents should target family and friends as important sources for adolescents to obtain alcohol.
From the 18 countries with data on past-month alcohol use among secondary school students in OAS reports published in 2011 and in 2015 (86, 87), 14 showed reductions in past-month alcohol use among females and males. The other four countries—Antigua and Barbuda, Argentina, Costa Rica, and Saint Vincent and the Grenadines—reported increased past-month alcohol use.
Tobacco

The use of tobacco is not limited to smoking of cigarettes, but includes chewing, sniffing, application to the skin, and placing tobacco between the teeth and gums (smokeless tobacco use). Based on the data from the most recent Global Youth Tobacco Surveys (GYTS), the percentage of current tobacco users among adolescents aged 13-15 years in the Americas ranged from 1.9% in Canada to 28.7% in Jamaica (Figure II.18). With the exception of Argentina, Colombia, and Ecuador, more male students than female students reported recent tobacco use (88).

Figure II.18: Current tobacco use among adolescents aged 13-15 years, by sex, in selected countries in the Americas, 2008-2015

Source: (88).
The WHO Framework Convention on Tobacco Control was developed by countries in response to the globalization of the tobacco epidemic. The treaty provides guidance for tobacco control, including measures to address the supply side as well as the demand side of tobacco (89). The treaty recommends specific measures to limit young persons’ access to tobacco products, including by prohibiting the sale of tobacco products to or by persons under the age set by domestic or national law, or younger than 18 years. The WHO and PAHO recommend evidence-based interventions to reduce adolescent tobacco use and exposure (Annex II.D2).

Other psychoactive substances

The use of other psychoactive substances such as marijuana, inhalants, and cocaine, remains relatively low among young people in the Americas. However, careful consideration must be given to trends in the use of these substances.

GSHS data for Latin America and the Caribbean suggest early initiation of the use of these psychoactive substances, with marijuana as the one most commonly used, after tobacco and alcohol (81), and with marked differences between countries. Reported lifetime marijuana use in adolescents aged 13-15 years in the GSHS ranged from 3% in Bolivia to 16% in Anguilla (81). The OAS data showed similar trends for the use of marijuana by secondary school students, ranging from 1.7% in the Dominican Republic and Venezuela to 34.9% in Chile (Figure II.19). In most countries, reported lifetime and recent (past-month) marijuana use was higher among males, with close to or more than twice as many males as females having used marijuana within the past year (87).

Inhalants used to cause psychoactive or mind-altering effects include solvents, aerosols, gases, and nitrates. Most of these substances are common household items, and are therefore not controlled. The past-year use of inhalants among countries of the Region ranged from 0.5% to 11.0%, and past-month use from 0.2% in Venezuela to 7.1% in Barbados (87). The countries with the highest past-month use at the last OAS survey were Barbados, Grenada, and Saint Lucia (87). Of the countries with two data points, 18 of them showed an increase in the past-month use, and 8 showed a decrease. Some of the decreases were quite substantial, for instance, in Jamaica from 9.5% in 2006 to 4.2% in 2013, in Brazil from 10.0% in 2004 to 2.2% in 2010, and in Guyana from 7.0% in 2007 to 2.8% in 2013 (87).
Lifetime use of cocaine in the secondary school population ranged from 0.6% in Venezuela to 6.0% in Chile, with most countries in the range of 1% to 3% (87). Past-year use ranged from 0.3% in Venezuela to 3.6% in Chile, with most countries in the 1%-2% range. Past-month use ranged from 0.1% in Suriname to 1.7% in Chile.
II.4: Sexual and reproductive health

Adolescence is a critical life stage for sexual and reproductive health (SRH), due to the rapid physical, hormonal, and emotional changes during puberty, including menarche for girls and their new biological capacity to reproduce. Good adolescent SRH requires the development of a positive, respectful, responsible approach to sexuality and sexual relations; the possibility of having pleasurable and safe sexual experiences free of coercion, discrimination, and violence; and the freedom to responsibly decide if, when, and how often to reproduce.

Promoting and protecting adolescent SRH includes ensuring optimal access to information and education and appropriate health services (including safe, effective, affordable, acceptable contraception), as well as protection from coerced and forced sex. Undesired outcomes include sexually transmitted diseases, HIV, unplanned pregnancies, and unsafe abortions. Any of these can have repercussions that extend beyond adolescence and across the life course, even spilling over into the next generation.

Sexual initiation

Early sexual initiation has been identified as a risk factor for adverse SRH outcomes, especially in the absence of comprehensive and supportive SRH services. The rate of early sexual initiation among adolescents differs noticeably among countries and between the sexes, as shown in Figure II.20. The percentage of early initiators is consistently higher among males.
The GSHS data showed similar results. Among 14 LAC countries with data for the 2010-2016 period, the percentage of students aged 13-15 years old who had ever had sexual intercourse ranged from 18.9% in El Salvador to 33.5% in Barbados (81), also with consistently higher percentages of male early initiators, in several countries up to twice as many (81).

The available Demographic and Health Surveys (DHS) data also indicates a relationship between age of sexual initiation and both education (Figure II.21) and income level (Figure II.22) (91).

Figure II.20: Percentage of respondents aged 15-19 who had their first sexual intercourse by age 15, by sex, in selected countries in Latin America and the Caribbean, 2011-2015

Source: (91).

Figure II.21: Median age of sexual initiation of females aged 20-24 years in selected countries of Latin America and the Caribbean, by level of education, 2011-2015

Source: (91).
Girls bear disproportionate risks for adverse SRH outcomes, including early pregnancy. Maternity-related causes are now the leading cause of adolescent girl mortality on global level (6). Other physical consequences and risks of early pregnancy include damage to the pelvic floor, preeclampsia, eclampsia, ruptured membranes, and premature delivery (92-94). In addition to physical consequences, early pregnancy has various potential mental health implications, including anxiety, depression, posttraumatic stress (especially when the pregnancy is the result of sexual violence), suicidal thoughts and attempts, and suicide deaths (92-94).

Adolescent pregnancy is linked to poverty, social exclusion, sexual and gender-based violence (SGBV), and early marriage/union. Consequently, adolescent pregnancy disproportionately affects girls who are already marginalized, and it also has major long-term consequences for their educational and employment opportunities (92-95). As a result, adolescent pregnancy contributes to the
maintenance of intergenerational cycles of poverty, exclusion, and marginalization, as children born to adolescent mothers are themselves at elevated risk of poverty and poor health outcomes.

Latin America and the Caribbean (LAC) has the second-highest adolescent fertility rate in the world, estimated at 66.5 births per 1,000 girls 15-19 years old for 2010-2015, compared to 46 births per 1,000 girls in the same age group worldwide (96). Trends over time indicate the adolescent fertility rate remained stable in LAC from 1990 to 2000, followed by a slow downward trend over the next 15 years. In contrast, there has been a much steeper decline in the total fertility rate in women in older age groups in LAC (Figure II.23) (96). Currently, an estimated 15% of all pregnancies in LAC occur among girls younger than 20 years old (97).

In the Americas, there are substantial differences in the adolescent fertility rate among subregions, countries, and subgroups in countries. As presented in Figure II.24, Central America has the highest adolescent fertility rate, followed by South America. The figure also indicates that South America has seen the slowest decline in adolescent fertility rates of any of the subregions (96).
Meanwhile, adolescent fertility rates in Canada and the United States are below the global average and have been declining steadily over the past decade. The United States recently reported a record decline in adolescent fertility in all racial and ethnic groups, falling 8% from 2014 to 2015, to a historic low of 22.3 births per 1,000 females 15–19 years old. In this same age group, similar or greater declines were reported for Hispanic (8%) and non-Hispanic black females (9%) (98).

The estimated country-level adolescent fertility rates range from 11.3 births per 1,000 girls in Canada to 100.6 per 1,000 girls in the Dominican Republic. The majority of countries with the highest estimated adolescent fertility rates are in Central America, with the highest rates in Guatemala, Nicaragua, and Panama. In the Caribbean, the Dominican Republic and Guyana have the highest estimated adolescent fertility rates. In South America, Bolivia and Venezuela have the highest rates (Table II.3).
Table II.3: Trends in adolescent fertility rates (births per 1,000 women 15-19 years old) in the Americas, by subregion and country, 1980-2015

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Source: (96).
Adolescent girls with no education or only primary education may be up to four times more likely to initiate childbearing than are girls with secondary or higher education (Figure II.25).

Figure II.25: Percentage of adolescents aged 15-19 years who had begun childbearing, by education level, in selected countries of Latin America and the Caribbean, 2008-2016

Similarly, girls from households in the lowest wealth index quintile are three to four times more likely to initiate childbearing, as compared to girls from the highest wealth index quintile (Figure II.26).
Figure II.26: Percentage of adolescents aged 15-19 years who had begun childbearing, by wealth index quintile, in selected countries of Latin America and the Caribbean, 2008-2016

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<td>13.6</td>
<td>12.8</td>
<td>17.2</td>
<td>13.6</td>
<td>12.8</td>
<td>17.2</td>
<td>13.6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nonindigenous</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Urban</td>
<td>6.4</td>
<td>8.6</td>
<td>6.8</td>
<td>6.4</td>
<td>8.6</td>
<td>6.8</td>
<td>6.4</td>
<td>8.6</td>
<td>6.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rural</td>
<td>6.4</td>
<td>8.6</td>
<td>6.8</td>
<td>6.4</td>
<td>8.6</td>
<td>6.8</td>
<td>6.4</td>
<td>8.6</td>
<td>6.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>12.8</td>
<td>17.2</td>
<td>13.6</td>
<td>12.8</td>
<td>17.2</td>
<td>13.6</td>
<td>12.8</td>
<td>17.2</td>
<td>13.6</td>
</tr>
</tbody>
</table>

Census data in selected countries show that indigenous girls are also disproportionately affected by early pregnancy, with the highest percentages of adolescent mothers being among rural indigenous girls (Table II.4).

Table II.4: Percentage of adolescent mothers in selected countries of Latin America and the Caribbean, by age group, type of residence (urban/ rural), and indigenous versus nonindigenous origin, 2010-2011

<table>
<thead>
<tr>
<th>Country (census year)</th>
<th>Age group (years)</th>
<th>Indigenous</th>
<th>Nonindigenous</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
<td>Rural</td>
<td>Total</td>
</tr>
<tr>
<td>Brazil (2010)</td>
<td>15-17</td>
<td>10.6</td>
<td>22.9</td>
</tr>
<tr>
<td></td>
<td>18-19</td>
<td>26.8</td>
<td>46.9</td>
</tr>
<tr>
<td></td>
<td>15-19</td>
<td>17.0</td>
<td>31.6</td>
</tr>
<tr>
<td>Costa Rica (2011)</td>
<td>15-17</td>
<td>8.5</td>
<td>20.3</td>
</tr>
<tr>
<td></td>
<td>18-19</td>
<td>23.6</td>
<td>42.1</td>
</tr>
<tr>
<td></td>
<td>15-19</td>
<td>15.2</td>
<td>28.7</td>
</tr>
<tr>
<td>Ecuador (2010)</td>
<td>15-17</td>
<td>9.0</td>
<td>9.6</td>
</tr>
<tr>
<td></td>
<td>18-19</td>
<td>28.9</td>
<td>34.2</td>
</tr>
<tr>
<td></td>
<td>15-19</td>
<td>17.4</td>
<td>18.5</td>
</tr>
<tr>
<td>Mexico (2010)</td>
<td>15-17</td>
<td>6.3</td>
<td>7.4</td>
</tr>
<tr>
<td></td>
<td>18-19</td>
<td>23.4</td>
<td>27.4</td>
</tr>
<tr>
<td></td>
<td>15-19</td>
<td>13.2</td>
<td>14.8</td>
</tr>
<tr>
<td>Panama (2010)</td>
<td>15-17</td>
<td>16.9</td>
<td>20.5</td>
</tr>
<tr>
<td></td>
<td>18-19</td>
<td>38.8</td>
<td>54.2</td>
</tr>
<tr>
<td></td>
<td>15-19</td>
<td>26.0</td>
<td>32.4</td>
</tr>
<tr>
<td>Uruguay (2010)</td>
<td>15-17</td>
<td>6.0</td>
<td>4.1</td>
</tr>
<tr>
<td></td>
<td>18-19</td>
<td>20.2</td>
<td>25.8</td>
</tr>
<tr>
<td></td>
<td>15-19</td>
<td>11.6</td>
<td>12.5</td>
</tr>
</tbody>
</table>

Source: (36).
Pregnancy in girls younger than 15 years

In general, data collection and reporting efforts related to adolescent pregnancy have focused on the age group 15-19 years, the age group for the international adolescent fertility indicator. Recently, the indicators proposed for the SDGs expanded international monitoring of adolescent pregnancy to the age group 10-19 years, disaggregated by 10-14 years and 15-19 years (100). This will hopefully result in increased efforts to generate data on pregnancies in girls younger than 15 years.

According to estimates of the United Nations Population Fund (UNFPA), 2% of women of reproductive age in LAC had their first delivery before the age of 15, and LAC is noted as the only region in the world with a trend in more pregnancies among girls younger than 15 years (93). The bullet points below summarize the available quantitative and qualitative information on pregnancies in girls under 15 years of age in the Region of the Americas:

- In 2015, Planned Parenthood Global published a report based on a multicountry study of the health effects of forced motherhood on girls 9-14 years old (101). The study was conducted in Ecuador, Guatemala, Nicaragua, and Peru. Pregnancy in girls under 15 years old had increased in all four of those countries. In Ecuador, according to census data, it had increased by 74% over the preceding decade. In Nicaragua, the number of pregnant women 10-14 years old increased 47% over 9 years, from 1,066 in 2000 to 1,577 in 2009. In Guatemala, the reported number of deliveries in girls 10-14 years old increased from 4,220 in 2013 to 5,100 in 2014. The girls tended to have low levels of education; some had never attended school. A large proportion of girls who had been in school had not returned to school postdelivery at the time of the follow-up interview (in Peru 77% dropped out; in Guatemala, 88%). The majority of the study participants suffered some type of complication with their pregnancy (63% in Peru, 71% in Ecuador). These complications included anemia, nausea/vomiting, urinary or vaginal infections, and more severe complications such as preeclampsia, eclampsia, membrane rupture, premature delivery, and postpartum hemorrhage, as well as mental health issues (55% in Peru, 91% in Ecuador, 100% in Nicaragua). Among the mental health issues were stress, fear, depression, anxiety, and posttraumatic stress. In Peru and Nicaragua, 7% to 14% of the study participants reported having
contemplated suicide during their pregnancy. In all the participating countries, having sex with a minor constituted a crime. Often the aggressors were persons close to the girls, such as a cousin, stepbrother, stepfather, biological father, or neighbor.

• In 2016, the Latin American and Caribbean Committee for the Defense of Women’s Rights (CLADEM) published a report from a study in 14 countries titled *Girl Mothers: Child Pregnancy and Forced Child Maternity in Latin America and the Caribbean* (102). The study defined forced child pregnancy or maternity as a situation in which a minor under the age of 14 gets pregnant without having sought and/or without wanting the pregnancy, and interruption of the pregnancy is denied to her, made difficult, delayed, or hindered (102). In addition, The Rome Statute of the International Criminal Court (ICC) considers a forced pregnancy a crime against humanity or a war crime, depending on the context and characteristics of the case (102). The CLADEM study concluded that there were no specific data on pregnancies or abortions in girls under age 14 for any of the countries studied except El Salvador, where pregnancies in that age group were recorded. These records indicated that one-fifth to one-third of those pregnancies resulted in childbirth. In the other countries, statistics on pregnancies were drawn from delivery data and thus only reflected a subset of pregnancies in girls under 14, since child pregnancies often do not go to term. In all 14 countries, engaging in sexual relations with girls younger than 16 years is considered rape. With the exception of Brazil, Honduras, and Uruguay, kinship is considered an aggravating circumstance for statutory rape of minors or violation. However, only 6 of the 14 countries presented statistics on the denouncement of sexual violations of girls under age 14, and information regarding judicial investigation of the reported cases was scarce. In cases where denouncements were made, the level of impunity was very high, estimated to be up to 90%. In the countries that were studied, the abused girl’s mother is often investigated, detained, and prosecuted. Almost all the countries had some type of protocol on violence against women, but none had protocols, guidelines, or policies designed to address the problem of sexual violence against girls in a specific and comprehensive manner. Seven countries had State centers that provide care for and/or house pregnant adolescents and adolescent mothers, and all 14 countries

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3 Argentina, Bolivia, Brazil, Colombia, Dominican Republic, El Salvador, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Puerto Rico, and Uruguay.
had private entities that specialize in the care of pregnant young women. In some cases the pregnant girls were involuntarily housed in public or private institutions and forced to give their infants up for adoption. In the majority of the 14 countries, continuity of education was guaranteed by law, but about half of the pregnant girls interrupted their studies due to health problems, discriminatory prejudices against pregnant girls or child mothers, and other circumstances. An estimated 40% of this group gave up their studies forever.

• States Party to the Belem do Para Convention reports that were made to the Follow-up Mechanism to the Belem do Para Convention (MESECVI) during 2013-2016 regarding pregnancy in girls under 15 years (104) included the following information:

  ° Paraguay reported that two of the births each day were to girls aged 10 to 14 years; that between 2009 and 2011, the number of live births to mothers between 10 and 14 years increased by 4%; and that 21.3% of the maternal deaths registered up through September 2012 were in the 10-14 age group.

  ° Guatemala reported that in 2012, 13.3% of births corresponded to girls aged 14 years; that 9,450 abortions were registered among girls and adolescents; and that 80 girls died from causes linked to maternity.

  ° In Peru, the reported percentage of mothers between 12 and 14 years was 12.5% in 2011 and 13.2% in 2012.

  ° Chile reported that in 2011, with hospital discharges for pregnancy, birth, and puerperium that ended in abortion, 3,387 of them were among girls aged 10-19 years, and that 10% of maternal deaths were among girls and adolescents.

  ° In 2014, Argentina registered 2,600 live births to mothers aged 10-14 years, with a survival rate of 87.4%.

  ° For 2014, Mexico reported 11,012 births among girls younger than 14 years.

  ° For 2015, Venezuela reported 5,399 live births among girls aged 10-14 years.

  ° Costa Rica reported that from 1983 to 2000, the annual average number of births to mothers younger than 15 years was 460, and that since 2000, it has increased to an average of 500 per year.

  ° Honduras reported that in 2015, 33,035 deliveries were among girls aged 10-19 years, of which 845 were to girls 10-14 years old.
As mentioned, sexual violence is of critical importance when it comes to adolescent girls’ SRH, as adolescent girls may be particularly vulnerable to experience sexual violence perpetrated by intimate partners or others in their environment, including family members. Figure II.27 provides a snapshot of females in the age group 15-19 years, reporting having experienced sexual violence.

Figure II.27: Percentage of females aged 15-19 years who ever experienced sexual violence in selected countries in Latin America and the Caribbean, 2010-2015

Maternal mortality is an important cause of death in girls and young women in the Region, and each year around 2,000 females aged 10-24 die from maternal causes (Table II.5). Although several countries have been able to provide good-quality maternal health care, adolescents (especially those under 15) continue to face an elevated risk of maternal mortality. This is a result of exposure to biological factors, such as insufficiently matured reproductive systems, and to socioeconomic and geographic factors, such as poor health care access in remote rural areas, racial/ethnic minority bias, stigma, and poverty.

Table II.5: Reported deaths due to pregnancy, childbirth, and the puerperium among adolescents and youth (10-24 years) in the Americas, 2009-2014

<table>
<thead>
<tr>
<th>Year</th>
<th>(no. of countries reporting)</th>
<th>Ranka (#)</th>
<th>Number of deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>10-19 years</td>
<td>15-24 years</td>
</tr>
<tr>
<td>2009</td>
<td>(45 reporting)</td>
<td>#5</td>
<td>#4</td>
</tr>
<tr>
<td>2010</td>
<td>(43 reporting)</td>
<td>#5</td>
<td>#4</td>
</tr>
<tr>
<td>2011</td>
<td>(39 reporting)</td>
<td>#5</td>
<td>#4</td>
</tr>
<tr>
<td>2012</td>
<td>(39 reporting)</td>
<td>#6</td>
<td>#4</td>
</tr>
<tr>
<td>2013</td>
<td>(37 reporting)</td>
<td>#6</td>
<td>#4</td>
</tr>
<tr>
<td>2014</td>
<td>(26 reporting)</td>
<td>#6</td>
<td>#4</td>
</tr>
</tbody>
</table>

Source: (39).

a Rank in the leading causes of death in the age group in the specified year.
Due to the lack of progress in the reduction of adolescent pregnancy, PAHO, UNFPA, and the United Nations Children’s Fund (UNICEF) held a technical consultation in August 2016 with global, regional, and country-level stakeholders to take stock of the situation and agree on strategic approaches and priority actions to accelerate progress (41, 105). The meeting pinpointed key factors that contribute to adolescent pregnancy in LAC. These included young women’s lack of knowledge about their sexual and reproductive health and rights (SRHR), poor access to and inadequate use of contraceptives, restrictive laws and policies, limited education and income, sexual violence and abuse, early unions, and unequal gender relations (41, 105).

The meeting participants also identified the following seven priority actions to accelerate the reduction of adolescent pregnancy in LAC (41, 105):

1. Make adolescent pregnancy, its drivers and impact, and the most affected groups more visible with disaggregated data, qualitative reports, and stories.
2. Design interventions targeting the most vulnerable groups, ensuring the approaches are adapted to their realities and address their specific challenges.
3. Engage and empower youth to contribute to the design, implementation, and monitoring of strategic interventions.
4. Abandon ineffective interventions and invest resources in proven interventions.
5. Strengthen intersectoral collaboration to effectively address the drivers of adolescent pregnancy in LAC.
6. Move from boutique projects to large-scale and sustainable programs.
7. Create an enabling environment for gender equality and adolescent SRHR.

Contraceptives

Contraceptive prevalence is defined as the percentage of women aged 15-49 who are married or in a union who are using a contraceptive method. Unmet need for contraception is defined as the percentage of women aged 15-49 currently married or in a union who are fecund and want to space births or limit the number of children they have and who are not currently using contraception (106). As a result of these definitions, much of the data available on contraceptive prevalence and unmet need is for the age group 15-49 years. That provides an overall
picture of contraceptive use and unmet need, but it does not reflect the situation among young people, as contraceptive prevalence is generally lower and unmet need higher among younger women. However, this is changing, and increasingly surveys such as the DHS, which are supported by the U.S. Agency for International Development (USAID) and the MICS, which are assisted by UNICEF, are calculating this data disaggregated by subgroups, including the 15-19 years and 20-24 years age groups. Nevertheless, these indicators and data fail to capture young women who are not married or in union but who are sexually active and wishing to prevent pregnancy. Table II.6 provides an overview of the contraceptive prevalence in selected LAC countries, as measured with DHS or MICS surveys.

Table II.6: Contraceptive prevalence and unmet need (percentage) among women aged 15-24 years who are currently married or in union, in selected countries of Latin America and the Caribbean, 2009-2015

<table>
<thead>
<tr>
<th>Country (year and study)</th>
<th>15-19 years</th>
<th>20-24 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Current use of any modern method of contraceptive</td>
<td>Unmet need</td>
</tr>
<tr>
<td>Argentina (2012 MICS)</td>
<td>32.8</td>
<td>NA</td>
</tr>
<tr>
<td>Barbados (2012 MICS)</td>
<td>51.4</td>
<td>37.3</td>
</tr>
<tr>
<td>Belize (2011 MICS)</td>
<td>33.8</td>
<td>30.8</td>
</tr>
<tr>
<td>Bolivia (2008 DHS)</td>
<td>6.1</td>
<td>37.9</td>
</tr>
<tr>
<td>Colombia (2015 DHS)</td>
<td>28.5</td>
<td>19.3</td>
</tr>
<tr>
<td>Costa Rica (2011 MICS)</td>
<td>64.1</td>
<td>19.7</td>
</tr>
<tr>
<td>Cuba (2011 MICS)</td>
<td>67.0</td>
<td>11.2</td>
</tr>
<tr>
<td>Dominican Republic (2013 DHS)</td>
<td>51.7</td>
<td>21.4</td>
</tr>
<tr>
<td>Guatemala (2014/15 DHS)</td>
<td>7.7</td>
<td>21.9</td>
</tr>
<tr>
<td>Guyana (2009 DHS)</td>
<td>13.9</td>
<td>NA</td>
</tr>
<tr>
<td>Honduras (2011/12 DHS)</td>
<td>14.1</td>
<td>17.7</td>
</tr>
<tr>
<td>Haiti (2012 DHS)</td>
<td>8.2</td>
<td>35.3</td>
</tr>
<tr>
<td>Peru (2012 DHS)</td>
<td>10.2</td>
<td>19.3</td>
</tr>
<tr>
<td>Saint Lucia (2012 MICS)</td>
<td>57</td>
<td>NA</td>
</tr>
<tr>
<td>Suriname (2010 MICS)</td>
<td>NA</td>
<td>37.0</td>
</tr>
</tbody>
</table>

Sources: (91, 99, 107).

a NA = not available.
Condom use

Adolescence is a life stage of rapid physical, emotional, and social development, characterized by increasing experimentation with adult roles, and development of behavioral patterns, including sexual behaviors, that may last throughout the life course. If used consistently and correctly, condoms can prevent unwanted pregnancy and the transmission of HIV and other sexually transmitted infections (STIs) during adolescence and beyond. Given that benefit, encouraging correct and consistent condom use during adolescence is an important component of SRH promotion.

Several sources compile information on the use of condoms by young people. However, surveys of this kind are not conducted regularly by all countries, thus making it difficult to accurately assess patterns and trends in condom use among adolescents and youth. This subsection draws on data available from a variety of sources, including the MICS, DHS, and other studies conducted by individual countries. The specificity and comparability of the data depend on various aspects, including how the question is defined. The MICS asks about the use of condom at last sex with a nonmarital, noncohabiting partner in the past 12 months, by persons aged 15-24 years. In some countries the data are collected for females only, and in others this data is collected for males and females. The DHS uses the indicator of condom use at last premarital sex, defined as the percentage of young, never-married people (aged 15-24) who used a condom at last sex, out of all young single sexually active people surveyed.

Rates of condom use with nonregular partners differ noticeably in the Americas, and are consistently higher among males (Figure II.28). Peru had the lowest percentage of condom use among females, followed by Guatemala. Cuba had the highest reported percentage of condom use among females (Figure II.28).
HIV and other sexually transmitted infections

HIV

According to the United Nations Program on HIV and AIDS (UNAIDS), an estimated 76,000 adolescents aged 10-19 years and 223,000 young people aged 15-24 were living with HIV in LAC in 2016 (108), more females than males in the Caribbean, and more males than females in Latin America. Annex II.F provides an overview of the estimated number of adolescents living with HIV in LAC countries in 2015.

An estimated 19,300 new HIV infections occurred in the age group 15-19 years in 2016, and 39,600 in the age group 15-24 years (108). Between 2000 and 2015, the estimated number of new HIV infections in the age group 0-14 years declined by more than 60% in LAC due to the progress in the Region with the prevention of mother-to-child transmission of HIV. In contrast, the decline in the estimated number of new infections in the age group 15-24 years has been much slower (Figure II.29) (108).
An estimated 2,600 young persons aged 15-24 years died in LAC in 2016 due to AIDS-related causes. Between 2000 and 2015, the number of AIDS-related deaths in LAC decreased sharply among children, and modestly in young people aged 20-24, while it shows a slightly increasing trend in adolescents aged 10-14 years and 15-19 (Figure II.30) (108).
Sexually transmitted infections (STIs)

The WHO estimates that more than 1 million STIs are acquired every day worldwide (109). This transmission takes place predominantly during sexual intercourse or other intimate genital contact. Some STIs can also be spread through nonsexual means, such as via blood or blood products, or from mother to child during pregnancy, childbirth, and breast-feeding. There are more than 30 different bacteria, viruses, and parasites known to be transmitted through sexual contact. Eight of these are linked to the greatest incidence of sexually transmitted diseases: hepatitis B, herpes simplex virus (HSV or herpes), HIV, human papilloma virus (HPV), syphilis, gonorrhea, chlamydia, and trichomoniasis. The first four are incurable, and the latter four are curable. Most STIs can be prevented through safe behaviors, such as consistent condom use, and two of them (HPV and hepatitis B) can be averted with vaccination. When STIs are symptomatic, the typical symptoms include vaginal discharge, urethral discharge or burning in men, genital ulcers, and abdominal pain. However, it is important to recognize that the majority of STIs are asymptomatic, without obvious symptoms of disease. Asymptomatic or subclinical infections cannot be identified without special testing, and therefore many infections are undiagnosed.

STIs are important causes of morbidity and mortality, given their contribution to complications such as pelvic inflammatory disease, infertility, ectopic pregnancy, miscarriage, fetal and infant deaths, low birthweight and prematurity, and congenital infections. Studies have demonstrated a strong association between HIV infection and both ulcerative and nonulcerative STIs (110-112). There is also biological evidence that the presence of an STI increases shedding of HIV, and that STI treatment reduces HIV shedding (112). Mother-to-child transmission of an STI can result in stillbirth, neonatal death, low birthweight, prematurity, sepsis, pneumonia, neonatal conjunctivitis, and congenital deformities (110). HPV infection causes more than half a million cases of cervical cancer and a quarter million cervical cancer deaths each year (113).

Information regarding STIs in adolescents is very limited for several reasons. These include the complexities associated with conducting research with biological specimens among adolescents; the general lack of access for adolescents to SRH services, including STI services; the underestimation of the incidence and prevalence of STIs among adolescents due to the lack of data; reduced perception
of risk or recognition of infection among adolescents; and the limited availability of noninvasive methods for STI diagnosis (e.g., urinalysis, self-collected vaginal swabs).

However, the limited number of studies that do exist indicate a significant STI burden among adolescents. This is true for young men who have sex with men (MSM), and also among young women. For instance, a recent small study conducted in northern Brazil found a chlamydia prevalence of 11% in a sample of 154 young women between 16 and 20 years of age (114). Similarly, some studies conducted in Latin America found chlamydia prevalence rates ranging from 7% to 31% among young women (115-116). A recent cost-effectiveness study conducted in the United States concluded that opt-out chlamydia testing for high-risk young women is cost-saving, because it improves health outcomes at a lower net cost, considering the costs of testing and the lifetime costs and quality-adjusted life expectancy associated with chlamydia infection (117).

A review paper looking at STI services for adolescents and youth in low- and middle-income countries concluded that adolescents in these settings tend to have limited knowledge regarding STIs, and they experience significant barriers in obtaining STI and SRH services. This can result in going untreated, onward transmission of STIs, and a greater risk for development of long-term and serious complications (118).

II.5: Nutrition and physical activity

Sound nutrition is an essential element of good health in adolescents. It improves school and educational performance, supports a stronger immune system, reduces the risk of disease across the life course, and, in the event of pregnancy, reduces the risk of adverse maternal and neonatal outcomes. The available data on anemia, overweight, and obesity indicate that adolescents in the Americas face the double burden of malnutrition (characterized by micronutrient deficiencies coexisting with overweight, or obesity) (119-120). WHO defines overweight and obesity as abnormal or excessive fat accumulation that may impair health, as measured through an index of weight-for-height or a body mass index (BMI). In children, overweight is defined as (> +1 SD) from the median for BMI for age and
sex, and obesity as greater than plus two standard deviations (> +2 SD) from the median for BMI for age and sex.

In the majority of the countries with GSHS data, more than one in five of the students was overweight, in both males and females (Figure II.31).

**Box II.4: Regional adolescent and youth health goal 6**

Promote nutrition and physical activity

- Reduce the proportion of obese or overweight adolescents aged 13-15 years old
- Increase the proportion of adolescents 13-15 years of age who engage in regular physical activity
- Decrease the prevalence of anemia in adolescent women 10-19 years old

Source: (4).

**Figure II.31: Percentage of students aged 13-15 years who were overweight* in selected countries in Latin America and the Caribbean, 2009-2016**

*Overweight is defined as greater than plus one standard deviation (> +1 SD) from the median for BMI for age and sex.
Some DHS surveys provide data on overweight and obesity in females 15 years of age and older (Figure II.32). In addition, some countries conduct national health and nutrition surveys that also generate this data for different age groups. In these studies, a body mass index (BMI) between 25.0 and 29.9 is defined as overweight, and a BMI greater than or equal to 30.0 as obesity. In the 2012 national health and nutrition survey in Ecuador (121), 24.5% of females in the age group 15-19 years were overweight or obese (BMI greater than or equal to 25.0), and in the 2016 national health and nutrition survey conducted in Mexico (122), 36.3% of females in the age group 12-19 years were overweight or obese.

Figure II.32: Percentage of females aged 15-19 and 20-24 with a body mass index (BMI) greater than or equal to 25, in selected countries of Latin America and the Caribbean, 2008-2015

![Graph showing the percentage of females aged 15-19 and 20-24 with a BMI greater than or equal to 25 in selected countries of Latin America and the Caribbean, 2008-2015.](image)

Sources: (91,123).

Figure II.32 also illustrates the temporal and cumulative dimensions of obesity and overweight. By age 24, the percentage of overweight or obese females has increased significantly in all these countries; in some instances it has doubled.

In the countries with two data points on weight in the GSHS and DHS, the majority show an increase in the percentages of overweight and obese females over time (Table II.7).
Table II.7: Changes in the prevalence of overweight and obesity in young persons aged 13-15, 15-19, and 20-24, in selected countries in Latin America and the Caribbean, 2005-2015

<table>
<thead>
<tr>
<th>Country (year of survey)</th>
<th>Global School-based Health Surveys (GSHS): changes in the prevalence of overweight and obesity in adolescents aged 13-15 years</th>
<th>Demographic Health Survey (DHS): changes in the percentage of overweight and obesity in female adolescents aged 15-19 years</th>
<th>Demographic Health Survey (DHS): changes in the percentage of overweight and obesity in female youth aged 20-24 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guatemala (2009)</td>
<td>Percentage overweight 27.1</td>
<td>Percentage obese 7.5</td>
<td>Haiti (2012)</td>
</tr>
<tr>
<td>Suriname (2015)</td>
<td>Percentage overweight 28.6</td>
<td>Percentage obese 11.6</td>
<td></td>
</tr>
</tbody>
</table>

Sources: (81, 91).
Figure II.33: Percentage of students aged 13-15 years who were physically active at least 60 minutes per day on five days or more during the week\(^a\) before the survey in selected LAC countries, 2009-2016

Source: (81).

\(^a\) For Suriname and Guatemala, the data reflect physical activity on all 7 days before the survey.
Considering the associations between consumption of sugary drinks and fast food, physical exercise, and the risk of noncommunicable diseases (NCDs), the substantial number of young adolescents aged 13-15 who report frequently consuming soda and fast food is a major concern (Figure II.34).

In this context, PAHO has developed a Plan of Action for the Prevention of Obesity in Children and Adolescents (124), to address the rapidly growing obesity epidemic in children and adolescents. Its goals include improving school food and physical activity environments, fiscal policies, and the regulation of food marketing and labeling. The plan also gives attention to gender and equity issues, recognizing girls are often more affected by the obesity epidemic.

Figure II.34: Consumption of carbonated soft drinks and fast food by students aged 13-15 years, 2009-2013

Meanwhile, in 21 countries with data, 10% to 20% of the students indicated that they sometimes went hungry because there was not enough food in the home, which suggests significant levels of food insecurity in the Region. Notably, Jamaica had the highest percentage of students who sometimes went hungry (close to 30%) and also the highest percentage who regularly went hungry (at 10%) (81). These data fully support the conclusion of a double burden of malnutrition in the Region.
Anemia is a global public health problem most often associated with iron deficiency, which is the most widespread nutrient deficiency in the world \((125, 126)\). Anemia is characterized by a reduction in the number of red blood cells and the oxygen-carrying capacity of hemoglobin \((125)\). WHO estimates that half of all anemia cases are caused by iron deficiency, with the remainder caused by other factors. Iron deficiency affects millions of individuals throughout the life course, especially infants and pregnant women, but also young children, adolescents, and women of childbearing age \((127, 128)\).

The health and functional consequences of anemia include: an increased risk of maternal, fetal, and neonatal mortality; poor pregnancy outcomes such as low birthweight and preterm birth; impaired cognitive development, reduced learning capacity, and diminished school performance in children; and decreased productivity in adults \((125)\). Research shows that children under 3 years of age, pregnant and nonpregnant women, and female adolescents are the groups at highest risk \((125)\).

WHO has categorized the public health significance of anemia as follows \((127)\):

- prevalence less than or equal to 4.9%, not a public health problem
- prevalence of 5% to 19.9%, mild public health problem
- prevalence of 20% to 39.9%, moderate public health problem
- prevalence above or equal to 40%, severe public health problem

Based on the WHO definition, anemia presents a severe public health problem in adolescents in Haiti, and a moderate public health problem in Guyana (Table II.8).

### Table II.8: Percentage of adolescent girls aged 10-19 years with any anemia\(^a\) in selected countries of Latin America and the Caribbean, 2009-2015

<table>
<thead>
<tr>
<th>Country (year of survey)</th>
<th>Age group</th>
<th>Percentage with any anemia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argentina (2012)</td>
<td>10-19 years</td>
<td>15.0</td>
</tr>
<tr>
<td>Dominican Republic (2012)</td>
<td>12-14 years</td>
<td>13.4</td>
</tr>
<tr>
<td>Ecuador (2011/13)</td>
<td>15-19 years</td>
<td>14.3</td>
</tr>
<tr>
<td>Guatemala (2014/15)</td>
<td>15-19 years</td>
<td>11.7</td>
</tr>
<tr>
<td>Guyana (2009)</td>
<td>15-19 years</td>
<td>34.1</td>
</tr>
<tr>
<td>Haiti (2012)</td>
<td>15-19 years</td>
<td>55.5</td>
</tr>
<tr>
<td>Honduras (2011/12)</td>
<td>15-19 years</td>
<td>12.5</td>
</tr>
<tr>
<td>Mexico (2012)</td>
<td>12-19 years</td>
<td>7.7</td>
</tr>
<tr>
<td>Peru (2012)</td>
<td>15-19 years</td>
<td>17.2</td>
</tr>
</tbody>
</table>

Sources: \((91, 121, 122)\).

\(^a\) Any anemia defined as \(< 12.0 \text{ g/dl} \) for nonpregnant women and \(< 11.0 \text{ g/dl} \) for pregnant women.
II.6: Chronic diseases

Oral health

Oral health is critical to overall health conditions in Latin America and the Caribbean. Scientific evidence shows that there is a strong interrelationship between oral health and general health, and that poor oral health is associated with a number of public health problems. For example, oral infections are linked with increased risk of cardiovascular disease, diabetes, aspiration pneumonias, and adverse pregnancy outcomes. Particularly in children and adolescents, poor oral health is associated with pain and difficulty eating. Poor oral health can also affect sleep patterns and influence growth and development.

In 2011, the UN Member States recognized the importance of oral health, through the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (129). That document focused on the four most prominent worldwide NCDs and their risk factors. The Member States recognized that renal, oral, and eye diseases pose a major health burden for many countries; that these ailments share common risk factors; and that these diseases can benefit from common responses to NCDs.

Box II.5: Regional adolescent and youth health goal 7

Combat chronic diseases

- Reduce the rate of decayed/missing/filled teeth (DMFT) for 12-year-olds
- Increase coverage of tetanus and diphtheria vaccine among those 10-19 years old

Source: (4).
The rate of decayed, missing, or filled teeth (DMFT) is an important indicator for measuring oral health conditions in countries. At the same time, attention should be given to the broader health implications of oral conditions. These include the associations between oral infections and systemic health; links between oral diseases and chronic diseases; and the onset of cancer of the oral cavity and oropharynx, with its concomitant metastasis. While these aspects are not discussed in this subsection, they should be part of broader discussions on oral health in countries.

Data generated through oral health surveys in selected countries, with PAHO support, documented the status of countries along an oral health continuum, using the DMFT index. The DMFT is calculated on the basis of 32 teeth (i.e., all permanent teeth, including wisdom teeth), and is a unit of measurement that describes the number of caries in a population. In addition, PAHO has developed a typology to identify a country’s oral health profile. It is based on the DMFT index for children at age 12, with three stages of dental caries severity: 1) “emergent,” defined by a DMFT-12 score greater than 5 and the absence of a national salt and water fluoridation program; 2) “growth,” defined by a DMFT-12 score between 3 and 5 and absence of a national salt and water fluoridation program; and 3) “consolidation,” defined by a DMFT-12 score less than 3 and the presence of a national salt and water fluoridation program. The DMFT score facilitates reliable comparisons across countries.

From the 16 countries in the Region that conducted surveys during the 2005-2011 period, 15 were in the “growth” or “consolidation” stage, illustrating the progress made in the in the Americas towards improvement of the oral health of children and adolescents.

In this context, PAHO has been implementing a plan for improving oral health (130). The plan was approved by the PAHO Member States in 2006, and it urges Member States to recognize oral health as a critical aspect of general health. The policies, tools, and training that PAHO has provided to Member States have resulted in significant caries reduction throughout the Region. These improvements can be largely attributed to national preventive programs (including water and salt fluoridation), greater awareness of proper oral hygiene, and better oral health care practices. New, cost-effective approaches, such as fluoridation programs, have also been instrumental in facilitating greater access to oral health services, in particular for vulnerable groups.
Vaccine coverage

WHO recommends that all individuals should receive a total of five doses of a tetanus toxoid vaccine, followed by a booster dose at the beginning of adult life to ensure protection throughout reproductive life, and possibly provide lifelong protection. Because there is evidence that a series of five doses of vaccine provides virtually 100% protection, most countries in the Region have a tetanus vaccination schedule that includes three doses of vaccine in the first year of life, plus two booster doses before 7 years of age (which also strengthen protection against pertussis). In addition, all women of childbearing age without registration of at least five doses of a vaccine containing tetanus toxoid should receive the necessary doses of tetanus vaccine for prevention of neonatal tetanus.

In 2015, 15 countries in the Region reported to PAHO that they had vaccination coverage of 85% or higher with a fifth dose of diphtheria, tetanus, and pertussis vaccine. There is no specific recommendation for vaccination of adolescents with Td in the Region of the Americas. PAHO is continuing to work with all the countries in the Region to assure early protection against tetanus, diphtheria, and pertussis, with a schedule of five doses of DPT vaccine before 7 years of life.

An important addition to the adolescent immunization schedule is the vaccine against human papillomavirus (HPV), the virus that causes cervical cancer. Cervical cancer is caused by the sexually transmitted HPV, which is globally the most common viral infection of the reproductive tract. Almost all sexually active individuals will be infected with HPV at some point in their life, and the peak time for infection is shortly after becoming sexually active. The majority of HPV infections resolve spontaneously and do not cause symptoms or disease. However, persistent infection with specific types of HPV may lead to precancerous lesions that can progress to cervical cancer if left untreated (131).

In spite of the challenges associated with introducing a new vaccine and the many myths around HPV vaccine that create barriers for its uptake, the Region of the Americas has made significant progress in the introduction and expansion of HPV vaccine for adolescents. As of March 2017, at least 29 countries in the Region had introduced public HPV vaccination programs. The majority of these programs target adolescent girls. The countries that provide HPV vaccine for both boys and

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4 Td = tetanus + reduced content diphtheria
girls include Antigua and Barbuda, the Bahamas, Canada, Panama, Puerto Rico, and the United States. Based on country reports to PAHO, by the end of 2016, full-course HPV vaccination coverage according to national guidelines averaged 55% in the Region of the Americas.

II.7: Protective factors

In addition to immediate health outcomes, the Regional Strategy and the Plan of Action on Adolescent and Youth Health have included attention to the risk and protective factors that are important determinants for health and disease in adolescence, in particular health-related behaviors and conditions. These include a focus on parents’ connection with and regulation of adolescents, with the collection of information about how often during the preceding 30 days parents or guardians checked that homework was done, understood their adolescents’ problems and worries, or really knew what the adolescents were doing with their free time.

The percentage of students reporting that their parents really know most of the time or always what they are doing with their free time ranged from a little over 30% in Saint Kitts and Nevis to over 70% in Uruguay. In most countries, a slightly higher percentage of girls reported this was the case (Figure II.35).

Box II.6: Regional adolescent and youth health goal 8

Promote protective factors

- Increase parental knowledge of adolescent activities

*Source: (4).*
A lower percentage of adolescents felt that their parents or guardians understood their problems and worries, ranging from around 25% to slightly over 60% (Figure II.36).

Source: (81).
Conclusions

Part II of the report describes the health status of adolescents and youth, based on the agreed regional set of indicators. The presented data indicates that unfortunately little progress has been made towards improvement of the health status of young people. The adolescent and youth mortality rates have remained fairly constant between 2008 and 2013, with the majority of deaths caused by external, preventable causes. At the country level, the results are mixed. Some countries, such as Bermuda, Grenada, Suriname, and Chile, noted reductions in mortality among males and females across the age range of 10-24 years, while others, such as Brazil, Honduras, and the Dominican Republic, noted increased mortality in all categories.

Of concern is the disproportionate risk of premature mortality among young males due to violence, including interpersonal violence and self-inflicted violence, signaling the need to intensify efforts to reach young males with health programs and services.

Adolescent pregnancy remains unacceptably high, and those most at risk for early initiation of reproduction are poor young people, those living in rural settings, and those from indigenous and Afro-descendant communities.

Mental health challenges and risk factors for premature death and chronic disease across the life course are highly prevalent, and show increasing trends. These include suicidal ideation and attempts, alcohol use, overweight and obesity, and a sedentary lifestyle.

In sum, the data indicate that a significant proportion of young people in the Region continue to face poor health and adopt potentially harmful health-related behaviors. The distribution of these health challenges and risks is frequently related to variations in social determinants such as education level and wealth index quintile, which underlines the importance of pro-equity, multisector actions required to improve the health and wellness of young people in the Region.
Part III

PROGRESS AND CHALLENGES IN THE IMPLEMENTATION OF THE REGIONAL STRATEGY AND PLAN OF ACTION ON ADOLESCENT AND YOUTH HEALTH, 2010-2018
III.1: Introduction

The Pan American Health Organization was established in 1902, and it consists of its Member States and the Secretariat. As stated in its Constitution, PAHO’s purpose is to promote and coordinate efforts of the countries of the Western Hemisphere to combat disease, lengthen life, and promote the physical and mental health of the people (132). Among the important tools used to express and galvanize this collective commitment are resolutions that articulate the commitments, roles, and responsibilities of the Member States and the Secretariat towards specific health goals and issues.

In 2008, PAHO Member States adopted the Regional Strategy for Improving Adolescent and Youth Health (Resolution CD48.R5) (4). The vision of the Regional Strategy is that adolescents and youth in the Region of the Americas lead healthy and productive lives. The overarching goal is to contribute to the improvement of the health of young people, by developing and strengthening an integrated health sector response and implementing effective adolescent and youth health promotion, prevention, and care programs. A year later, in 2009, PAHO Member States adopted the Plan of Action on Adolescent and Youth Health (Resolution CD49.R14), with the aim of operationalizing the Regional Strategy over the 2010-2018 period (4). Both the Regional Strategy and the Plan of Action were innovative in a number of ways. First, they called for intersectoral action based on seven strategic areas that have a crosscutting impact on a range of priority health problems that affect adolescents and youth in the Region (Box III.1). For each strategic area there were clear objectives, indicators, and recommended actions on the interagency, regional, subregional, and country level.

In addition to the seven strategic areas (Box III.1), the Plan of Action proposed eight health goals, with 19 targets (Annex II.A), to help quantify and monitor the initiative’s impact on the regional and country levels (4). Part II of this report provides an overview of the health status of adolescents and youth based on these goals and targets.

The following sections of the report provide an overview of the implementation of the Plan of Action since its approval. Considering the wide scope of the initiative—relating to all areas of PAHO’s technical cooperation, and having multiple levels of
implementation, on regional, subregional, and country levels—this overview does not intend to be exhaustive. Instead, it aims to highlight key actions taken, some by PAHO, and others in coordination with partners such as the United Nations Population Fund (UNFPA), United Nations Children’s Fund (UNICEF), and the World Bank.

Box III.1: Strategic areas for action on adolescent and youth health

1. **Strategic information and innovation**: Strengthen the capacity of the countries to generate, use, and share quality health information on adolescent and youth health and their social determinants, including by disaggregating information by age, sex, ethnicity, and socioeconomic level.

2. **Enabling environments for health and development using evidence-based policies**: Promote and secure the existence of environments that enable adolescent and youth health and development through the implementation of effective, comprehensive, sustainable, evidence-informed policies, including legal frameworks and regulations.

3. **Integrated and comprehensive health systems and services**: Improve comprehensive and integrated quality health systems and services to respond to adolescent and youth needs, with emphasis on primary health care.

4. **Human resources capacity-building**: Support the development and strengthening of human resources training programs in comprehensive adolescent and youth health, especially those in the health sciences and related fields, in order to improve the quality of adolescent and youth health promotion, prevention, and care policies and programs.

5. **Family, community, and school-based interventions**: In alignment with PAHO’s 2009 Family and Community Health concept paper, develop and support adolescent and youth health promotion and prevention programs, incorporating community-based interventions that strengthen families, involve schools, and encourage broad-based participation.

6. **Strategic alliances and collaboration with other sectors**: Facilitate dialogue and alliance-building between strategic partners to advance a regional adolescent and youth health agenda and to ensure that strategic partners participate in the establishment of effective policies and programs for this age group.

7. **Social communication and media involvement**: Support the inclusion of social communication interventions, using traditional media and innovative technologies to promote adolescent and youth health in national adolescent and youth health programs.

Source: (4).
III.2: Strategic information and innovation

The objective of this action area is to strengthen the capacity of the countries to generate quality health information on adolescent and youth health and their social determinants, disaggregating information by age, sex, ethnicity, and socioeconomic level, through:

- reaching consensus on a list of basic indicators that facilitate the identification of gaps and inequities in adolescent and youth health
- building capacity for: a) development of national adolescent health information systems; b) monitoring and evaluation of the quality, coverage, and cost of national adolescent and youth health programs and services; and c) aligning efforts with other relevant work on this topic in PAHO and on the global level
- promoting the analysis, synthesis, and dissemination of integrated information from different data sources on the state of adolescent and youth health and their determinants
- supporting regional and national research on the impact of new and innovative methods to improve the health and development of young people, and to disseminate effective interventions and best practices

The list of indicators included in the Regional Strategy and the Plan of Action for 2010–2018 (4) was generated through a consultative regional process. The indicators were selected based on the following criteria: 1) they represented critical health outcomes or contributing behaviors for adolescents and youth and 2) national-level data were already available or could be generated. The plan called for disaggregated reporting of these indicators by sex, five-year age group brackets, and, where possible, socioeconomic characteristics, ethnic group, and other relevant stratifiers. In addition to creating the indicator list, the following key actions were taken to support the generation and improvement of the quality of health information on adolescent and youth health:

- Maintenance of the PAHO mortality database and publicly accessible portal, and inclusion of the adolescent (10-19 years) and youth (15-24 years) age categories in the portal. The PAHO Health Information and Analysis Unit coordinates the collection, cleaning, standardization, and publication
of mortality data reported by the PAHO Member States. The information is made accessible through the Web-based mortality portal (39). Through this portal, interested persons can access adolescent and youth mortality data disaggregated by sex for their own country and for other countries, as well as regional rates. Mortality reporting by countries tends to lag by two to three years. In addition, some countries have significant percentages of ill-defined mortality cases, which lowers the quality of the mortality rates. The relevant PAHO departments and units provide ongoing technical cooperation to the Member States to improve the quality and timeliness of mortality reporting.

• **Adolescent health surveys.** A significant portion of the data required for monitoring of the mentioned set of indicators is generated through surveys. In partnership with the U.S. Centers for Disease Control and Prevention (CDC) and WHO, the Secretariat provides ongoing support to countries to implement two standardized global adolescent health surveys, the Global School-based Health Survey (GSHS) (81) and the Global Youth Tobacco Survey (GYTS). The GSHS methodology allows for low-cost collection of data on behavioral risk factors and protective factors in 10 key areas among young people aged 13 to 17 years, through a school-based, self-administered survey. Among the topics that countries can include in their survey are sexual behaviors, mental health and substance use, hygiene, dietary behaviors and physical activity, violence and unintentional injury, and protective factors. On average, between 5 and 10 countries from Latin America and the Caribbean (LAC) are supported each year to implement these surveys. Between 2008 and 2014, 23 countries in the Americas completed at least one GSHS, and 3 countries completed two. In addition to these global surveys, support has also been provided to countries to conduct national adolescent and youth health studies. For example, six Overseas Caribbean Territories (OCTs) (Aruba, British Virgin Islands, Cayman Islands, Montserrat, Saint Eustatius, and Sint Maarten) were supported during 2010-2012 to implement school-based adolescent health and sexuality surveys (80).

• **The Adolescent Information System:** The Adolescent Information System (Sistema Informático del Adolescente (SIA)) was developed by the Latin American Center for Perinatology, Women and Reproductive Health (CLAP) in response to the need to improve the quality of adolescent care in health services, by applying an integrated approach (133). The SIA consists of a
basic adolescent medical record form and a follow-up form. These forms are applicable to encounters with professionals from several disciplines, including—but not limited to—medical care, social services, nursing, and psychology. The SIA facilitates a comprehensive assessment of the health and social situation of the adolescent, beyond the primary reason for the encounter. The form includes a range of variables related to personal history, family history, and the physical examination. Beyond its use in individual encounters, analysis of compiled SIA data generates important information of public health significance. Countries that include Argentina, Chile, the Dominican Republic, Ecuador, Guatemala, Honduras, Nicaragua, and Uruguay have adopted the SIA, with varying scopes.

• **The Perinatal Information System**: The Perinatal Information System (SIP) is a standard for perinatal clinical records developed by PAHO/WHO at CLAP. While not specifically geared towards adolescents, SIP can generate data on the perinatal health of adolescents, including on the profile of pregnant adolescents, their care-seeking behavior, and their birth outcomes. This information can inform strategic actions to address these issues.

• **The adolescent health portal**: To improve country access to adolescent health information, PAHO developed an adolescent health portal in 2012. It served as an interactive tool, where PAHO and countries could enter or update their information and also generate graphs, figures, and country profiles. Countries actively used this tool for several years, even though there were challenges in maintaining and regularly updating the country information. The adolescent health portal is currently inactive. Its functions are being incorporated into a new integrated health information platform under construction at PAHO.

• **Capacity-building**: Technical cooperation provides for strengthening of country capacity to generate and use quality information on adolescent and youth health. These efforts have included several sensitization and training workshops, as well as direct support to countries for development of monitoring and evaluation frameworks for their national plans and programs.

• **Research**: In 2009, PAHO commissioned a multicountry study with the aim of generating information on the sexual and reproductive health of indigenous youth. The study was implemented in Bolivia, Ecuador, Guatemala, Nicaragua, and Peru, and resulted in recommendations to sexual and reproductive health services for indigenous youth in these countries (134). In general, while
PAHO’s direct involvement in research has been limited, PAHO continues to have an important role in the formulation of the regional research agenda through the close working relationships with academic institutions. These include the Catholic University of Chile, the Johns Hopkins University, Iowa State University, and the University of the West Indies.

• Inequity analysis: A Promise Renewed for the Americas (APR-LAC) was established in 2013 as an interagency movement that sought to bring more attention to health inequalities affecting women and children in Latin America and the Caribbean, with the Secretariat based at PAHO. Through this area of work, PAHO and its regional partners provided capacity-building and technical support for quantitative and qualitative inequity analysis based on the measurement and monitoring of health inequalities. In 2017, the APR-LAC initiative transitioned to become Every Woman Every Child Latin America and the Caribbean (EWEC-LAC), the regional interagency coordinating mechanism for the Global Strategy for Women’s, Children’s and Adolescents’ Health in Latin America and the Caribbean, for which a primary goal continues to be analyzing and addressing inequities in health.

Overall, the capacity of PAHO Member States to generate strategic information has been strengthened through the development of various tools and mechanisms and through PAHO’s provision of technical support to countries. However, the availability of timely and reliable data on the health of adolescents and youth remains a challenge, and continued efforts are essential. Moving forward, there must be an emphasis on strengthening country capacity to routinely generate national and subnational adolescent and youth health data that is disaggregated by five-year age groups, sex, ethnicity, educational status, wealth quintile, urban/rural, and other relevant variables. Inequity analysis is critical for identifying vulnerable and underserved groups, as well as the factors contributing to their conditions of vulnerability.
III.3: Enabling environments for adolescent and youth health and development using evidence-based policies

The objective of this action area is to promote and secure the development of enabling environments and the implementation of effective, comprehensive, sustainable, evidence-based policies on adolescent and youth health, through:

- establishing public policies that support a better state of health for young people and guarantee specific budget allocations for adolescent and youth health
- developing, implementing, and complying with evidence-based policies and programs in a manner consistent with the UN Convention on the Rights of the Child and other UN and inter-American system human rights instruments
- advocating for environments that promote health and development of young people, considering social determinants of health and the promotion of health and secure communities, including the Healthy Schools Initiative
- supporting the development and/or revision of current policies and legislation on priority health topics for young people, especially those that have impact on health services access

Key interventions implemented under this action area have included:

- Support to Member States to develop and update national adolescent and youth health policies, strategies, and plans: By the end of 2015, 30 out of 35 PAHO Member States (86%) and 7 out of 13 Associate Members and Dutch and British Overseas Territories had established adolescent health objectives in national adolescent health policies, strategies, or plans, either as part of their health plans or in separate adolescent health strategies or plans. In total, 77% of the Member States, Associate Members, and Overseas Territories had established adolescent health objectives (135). Moreover, several countries developed thematic plans and strategies related to specific health issues, such as national adolescent pregnancy prevention plans. A PAHO review of the plans and strategies found that the majority of these strategies and plans focused on adolescents in the age group 15-19 years, with limited attention for
adolescents aged 10-14 years and for youth aged 20-24. Annex III.A provides an overview of national adolescent and youth policies, plans, and strategies reported to PAHO in 2017. Several of these strategies and plans have expired, or are close to expiration, which creates a window of opportunity for updating in line with the SDGs and the Global Strategy for Women’s, Children’s, and Adolescent Health. Annex III.B summarizes information concerning budget allocations for adolescent health activities, reported to WHO by 26 LAC countries during the period 2010-2016. Together, those two annexes show that some countries either lack adolescent health strategies or plans or do not have a dedicated budget for their implementation. Annex III.C reports on the issues for which adolescents are a specific target group in the national policies, strategies, and plans of these 26 countries. Annex III.B and Annex III.C drew from an online dashboard developed by WHO that provides access to all country reports on the global maternal, newborn child, and adolescent policy indicator surveys (136).

• Promote and foster a supportive legal and policy environment for the health of young persons in a manner consistent with the UN Convention on the Rights of the Child and the concluding observations on adolescent health issued by the UN Committee on the Rights of the Child: As the health agency of the inter-American system, PAHO is in a unique position to provide the Inter-American Commission on Human Rights and the UN treaty bodies with technical opinions and relevant information on promoting and protecting young persons’ right to the highest attainable standard of health. Some of the work conducted by PAHO in this area includes strengthening the legislative and judicial branches by using human rights instruments, technical guidelines, and strategic information on the legal capacity of adolescents and adolescent health, including their sexual and reproductive health and rights. This has been done through regional, subregional, and country-level workshops; generation of strategic information (137); and ongoing dialogue. An important strategy has been to foster dialogue on these issues among health care providers, policymakers, decision-makers, judges, legislators, national human rights commissions, ombudspersons, and civil society. These experiences have shown that many of these persons and entities continue to have very limited information about human rights obligations and mechanisms to protect the health and well-being of young people. This
is true for young persons in general, and specifically for those with diverse gender identities, expressions, and sexual orientation, with regard to their access to health services, goods, facilities, and information crucial to making decisions. Information that 26 LAC countries have reported to WHO through the global maternal, newborn child, and adolescent policy indicator surveys (Annex III.D) points to continuing legal barriers for adolescents seeking health services (136).

• **Support the development and revision of national legislation:** In recognition of PAHO’s expertise, countries have been requesting support for developing and reviewing legislation. PAHO has provided that assistance on an ongoing basis, using human rights instruments such as conventions, protocols, declarations, and standards as the basis for review.

According to the available information, the majority of countries in the Region have developed governance documents related to adolescent health, in the form of legislation, policy, strategies, and plans. However, the policies, plans and strategies tend to focus on the age group 15-19 years, with limited attention for adolescents aged 10-14 years, and for youth aged 20-24 years, while this latter age group is also included in the age range of the Regional Strategy. The lack of budget allocations in some countries raises concerns about the feasibility of implementing the strategies and plans. In addition, significant legal barriers persist for adolescents seeking access to comprehensive health services.

### III.4: Integrated and comprehensive health systems and services

The objective of this action area is to bolster the capacity of health care systems to respond to adolescent and youth needs. For this, there must be a focus on strengthening primary-level promotion, prevention, and care services and on supporting the effective extension of social protection through:

• implementing effective interventions utilizing the Integrated Management of Adolescent Needs (IMAN) model
• integrating services with referrals and counter-referrals among the primary, secondary, and tertiary care levels
• increasing access to quality health services by developing minimum standards of care and by ensuring availability of critical public health supplies
• developing models of care, including alternative and innovative service provision (e.g., mobile clinics, health services linked to schools and pharmacies)
• conducting studies on the availability, utilization, and cost of services

Box III.2: The *carné de salud adolescente* (adolescent health card) in Uruguay

The adolescent health card was developed in 2009 by ministerial decree, with technical support from PAHO, and updated in 2017 in a collaborative effort with adolescents, according to the PAHO Uruguay Country Office. The main purpose of the card is to mobilize, empower, and engage adolescents in their health. It contains health records (e.g., vaccinations, growth, weight), provides health tips, and links adolescents with other resources, including websites for additional information and services. Adolescents show the card when accessing health services, and it must also be presented to the school each academic year.

![Carné de Salud Adolescente](image)

*Source: (4).*

Various key activities have been implemented under this action area. Three examples of these efforts are:

• **Expansion and country-level adaptation of the IMAN model:** The IMAN model was introduced by PAHO prior to the current Regional Strategy on adolescent health, as a model for comprehensive adolescent health services. Based on this approach, PAHO and UNFPA developed a module on adolescent sexual and reproductive health (138), and, in 2012, PAHO coordinated the development of a module on adolescents and noncommunicable diseases (139). Various IMAN training workshops were implemented on the regional, subregional, and country level, and the IMAN approach has been widely adopted in the Region, resulting in the incorporation of this approach in national guidelines and manuals of several countries (140).
• Definition of a package and national standards for adolescent health services: Based on WHO normative guidance and the IMAN model, technical cooperation was provided to countries to define a comprehensive package of adolescent health services and to develop standards for those services. The ultimate aim was to improve access for adolescents to quality health services that respond to their specific needs (Annex III.E). WHO’s publication of Global Standards for Quality Health Care Services for Adolescents in 2015 provided a new impetus for countries to develop or update standards for adolescent health services (141).

• Incorporation of adolescents and youth in the regional universal health agenda: In September 2014, PAHO Member States approved the Strategy for Universal Access to Health and Universal Health Coverage (Resolution CD53. R14) (5). In this declaration, Member States resolved to move toward providing universal access to comprehensive, quality, progressively expanded health services that are consistent with health needs, system capacities, and the national context. They also resolved to identify the unmet and differentiated needs of the population, as well as specific needs of groups in conditions of vulnerability. Key pillars of the regional universal health agenda include improving governance and human resource capacity; increasing efficiency and public financing of health; and empowering people and communities. This is to be done through training, active participation, and access to information for community members. This is so that those persons know their rights and responsibilities, and so that they can take an active role in policy-making; in actions to identify and address health inequities and the social determinants of health; and in health promotion and protection. Through inclusion of adolescents and their health needs in the regional and country-level dialogue, structural actions can be promoted so that adolescents and youth have increased, sustainable access to quality health services.

III.5: Human resources capacity-building

The objective of this action area is to support the development and strengthening of comprehensive adolescent and youth health human resources training programs. The priority is to be on health sciences and related fields, but with inclusion of school teachers, community health promoters, and others who can participate in
multidisciplinary teams to respond to the health and development needs of young people. This is to be done through:

• developing and implementing adolescent and youth health and development training programs at the undergraduate and graduate levels, and for in-service professionals, utilizing new technologies such as e-learning platforms

• including the topic of adolescent and youth health in academic curricula for students enrolled in health and/or education programs at the graduate and postgraduate level

• advocating for building the capacity of primary health care providers, using evaluated courses in comprehensive adolescent and youth health that are supported by PAHO and that are currently available on diverse e-learning platforms

• incorporating current scientific evidence on young people, as well as training on program monitoring and evaluation, in available e-learning courses and other virtual platforms

This action area may well have been the most heavily invested area of the Regional Strategy on adolescent and youth health in recent years. The Secretariat has organized more than 40 regional, subregional, and country-level capacity-building workshops on topics related to adolescent health. These have been for a range of stakeholders, including adolescent health program managers, health care providers, youth, legislators, human rights advocates, and other stakeholders. Four key areas of the capacity-building efforts are described below.

Scholarship program for postgraduate adolescent health training

In 2003, PAHO entered into a partnership with the School of Medicine of the Catholic University of Chile for the development of a diploma course on adolescent health. The modular course is offered as postgraduate training through a virtual platform, over a nine-month period. It is open to a wide range of health professionals, including physicians, nurses, mental health specialists, social workers, and others involved in adolescent health programs and services. To facilitate optimal participation of stakeholders in this course, PAHO established a scholarship program, which offers tuition at a discounted price. During 2015-2016, PAHO conducted an evaluation of the scholarship program, in partnership with the Pontifical Catholic University of Chile. The evaluation indicated that PAHO provided 687 scholarships to countries
during the period 2006-2015, including 442 since the adoption of the regional Plan of Action. Candidates were jointly selected by the national authorities and the PAHO country offices. The Dominican Republic (109), Honduras (104), Panama (87), and Nicaragua (71) had the highest number of scholarship recipients (Figure III.1).

Figure III.1: Number of scholarship recipients, per country, for PAHO/Catholic University of Chile post-graduate training course on adolescent health, 2006-2015

Source: Unpublished PAHO analysis.

Just over three-quarters of the scholarship recipients were females. The course participants consisted of general physicians and specialists, psychologists, nurses, and other care providers. At the time of their participation, all the scholarship recipients were involved in adolescent health programs or services, on a managerial level or in direct service delivery.

All the scholarship recipients were invited to participate in an online survey that asked if the course had helped improve their proficiency in adolescent health and development, in general domains and specific competencies as defined by WHO (142). On a scale of 1 (least) to 10 (greatest), the 282 survey respondents rated their improvement in the various competencies as being between 6.7 and 8.2. They gave the highest improvement score to competency 3.5, “provide sexual and reproductive health care” (Table III.1).
Table III.1: Improvement (on a scale of 1 (least) to 10 (greatest)) in adolescent health and development competencies, as rated by scholarship recipients who participated in PAHO/Catholic University of Chile postgraduate adolescent health diploma course

<table>
<thead>
<tr>
<th>Domain/Competency number</th>
<th>Description of domain/competency</th>
<th>Improvement rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1</td>
<td>Demonstrate an understanding of normal adolescent development, its impact on health, and its implications for health care and health promotion</td>
<td>7.4</td>
</tr>
<tr>
<td>1.2</td>
<td>Effectively interact with an adolescent client</td>
<td>7.5</td>
</tr>
<tr>
<td>Domain 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>Apply in clinical practice the laws and policies that affect adolescent health-care provision</td>
<td>7.4</td>
</tr>
<tr>
<td>2.2</td>
<td>Deliver services for adolescents in line with quality standards</td>
<td>7.4</td>
</tr>
<tr>
<td>Domain 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1</td>
<td>Assess normal growth and pubertal development, and manage disorders of growth and puberty</td>
<td>7.2</td>
</tr>
<tr>
<td>3.2</td>
<td>Provide immunizations</td>
<td>7.1</td>
</tr>
<tr>
<td>3.3</td>
<td>Manage common health conditions during adolescence</td>
<td>7.8</td>
</tr>
<tr>
<td>3.4</td>
<td>Assess mental health and manage mental health problems</td>
<td>7.1</td>
</tr>
<tr>
<td>3.5</td>
<td>Provide sexual and reproductive health care</td>
<td>8.2</td>
</tr>
<tr>
<td>3.6</td>
<td>Provide HIV prevention, detection, management, and care services</td>
<td>8.0</td>
</tr>
<tr>
<td>3.7</td>
<td>Promote physical activity</td>
<td>7.7</td>
</tr>
<tr>
<td>3.8</td>
<td>Assess nutritional status and manage nutrition-related disorders</td>
<td>7.4</td>
</tr>
<tr>
<td>3.9</td>
<td>Manage chronic health conditions, including disability</td>
<td>6.7</td>
</tr>
<tr>
<td>3.10</td>
<td>Assess and manage substance use and substance-use disorders</td>
<td>7.2</td>
</tr>
<tr>
<td>3.11</td>
<td>Detect violence and provide first-line support to the victim</td>
<td>7.7</td>
</tr>
<tr>
<td>3.12</td>
<td>Prevent and manage unintended injuries</td>
<td>6.7</td>
</tr>
<tr>
<td>3.13</td>
<td>Detect and manage endemic diseases</td>
<td>7.1</td>
</tr>
</tbody>
</table>

Source: Data from online survey of 282 scholarship recipients.

The evaluation indicates that the scholarship program substantially improved adolescent health core competencies among health care providers in the Region of the Americas.

Inclusion of adolescent content in curricula of training programs for health and related professions

PAHO collaborated with various universities in the Region, including the Rio de Janeiro State University (UERJ) and universities in Argentina, Guatemala, Mexico, and Venezuela, in developing adolescent health content and courses. More recently, in 2015, PAHO entered into a partnership with the University of the West Indies (UWI) for the development of adolescent health training programs at the Faculty of Medical Sciences and the Open Campus.
PAHO Virtual Campus

The Virtual Campus of Public Health is a PAHO technical cooperation tool that provides a range of self-learning and tutored courses that are free to all (143). Several of the courses offered through the Virtual Campus are pertinent to adolescent and youth health, including health and human rights, oral health, gender and health, and tobacco and alcohol use prevention courses. Because of the virtual nature of the platform, it can provide learning opportunities at low cost to all stakeholders who have access to internet.

Training workshops

An integral component of PAHO’s technical cooperation strategy is the regular organization of in-person workshops and training events for regional and country-level stakeholders on specific topics related to adolescent and youth health. In addition, adolescent health training has been provided for other stakeholder groups, including NGOs and youth themselves, in order to facilitate and foster their engagement in dialogue, programs, and services related to the health of adolescents and youth.

There is a high level of turnover of health care providers and program managers in most countries, as well as a lack of regular adolescent-specific training available for health care providers on the country level (Annex III.E). Given that, it is essential to have ongoing investment in pre- and in-service training for health care providers and related professions, policymakers, and other government officials, in order to ensure a critical mass of knowledge and skills to adequately address adolescent and youth health issues.

III.6: Family, community, and school-based interventions

The objective of this action area is to develop and support adolescent and youth health promotion and prevention programs through community-based interventions that strengthen families, involve schools, and encourage broad-based participation, through:
• developing and disseminating evidence-based tools that help strategic actors carry out interventions to strengthen the family
• encouraging community mobilization efforts to modify institutional policies and foster supportive environments for the health and development of young people
• developing tools to promote the empowerment of adolescents and youth and facilitate their meaningful participation in the communities where they live
• strengthening cohesion between the health and education sectors in the development, monitoring, and evaluation of comprehensive programs for adolescents and youth

There is compelling evidence that the health and development of young people are profoundly affected by the relationships they have with parents, peers, their school, and their communities (6, 144, 145). Studies have noted significant associations between low levels of connectedness or emotional attachment with the family, peers, school, and community and increased risk of negative health outcomes and behaviors, such as anxiety, depression, suicide ideation and attempts, unsafe sex, unplanned pregnancy, and substance use (144, 145). In contrast, positive relationships and high levels of connectedness can promote emotional and physical well-being, and protect adolescents from engaging in behaviors that may compromise their health in the short, medium, and long term (6, 144, 145).

In recent years, PAHO has introduced several model approaches and interventions that aim to engage the family, the school, and the community in the promotion and protection of the health and wellness of young people. These activities have included:

• Familias Fuertes – Amor y Límites (Strengthening Families – Love and Limits): In 2000, PAHO entered into a partnership with the Human Sciences Extension and Outreach program of Iowa State University (ISU HSEO) to implement their Strengthening Families Program 10-14 (SFP 10-14) (146) in Latin America. The program is an evidence-based family life skills training curriculum for adolescents and their parents. It is designed to reduce risk-seeking behaviors, delinquency, and alcohol and drug abuse among adolescents; foster positive adolescent-parent relationships; and improve the social competencies and school performance of adolescents. It promotes parental skills and better
communication in families, in order to reduce behavioral risk factors for adolescents. The program consists of seven weekly two-hour sessions with 6 to 12 participating families, led by trained facilitators. In an agreement with ISU HSEO, PAHO translated the package into Spanish and also invested in a review process with Latin American countries, resulting in a version adapted for Latin America, called Familias Fuertes – Amor y Límites (Strong Families – Love and Limits). To date, this program has been introduced in all Latin American countries and implemented with varying scopes. In several countries, including Colombia and Peru (Box III.3), the program has been formally adopted by the national authorities as a core national strategy for the promotion of child and adolescent health. In 2016, PAHO commissioned the Johns Hopkins University to conduct an external evaluation of the implementation and impact of the Familias Fuertes program, to inform continued implementation of this approach in the Region.

Box III.3: Familias Fuertes in Peru

In Peru, implementation of the Familias Fuertes program started in 2005, with training of the first cohort of facilitators. That was followed by the first application of the program in 2007 in nine municipalities of the Lima Metropolitan Area, coordinated by PAHO. In 2008 the program was transferred to the National Commission for Development and Life without Drugs (DEVIDA), through a collaborative agreement. Since then, DEVIDA has been coordinating the implementation of Familias Fuertes, and the program was incorporated in the regular programming and budget of DEVIDA. Currently, Familias Fuertes is being implemented in 23 regions of Peru, through the regional education directorates. The program has continued to expand. DEVIDA has trained 8,338 facilitators nationwide, and has reached more than 120,000 families with this intervention. DEVIDA has also provided support to other countries, including Bolivia, Colombia, Ecuador, and Paraguay, for training of facilitators.

Source: National Commission for Development and Life without Drugs (DEVIDA).

• Health-Promoting Schools: The Health-Promoting Schools Regional Initiative was started in the early 1990s. Supported by PAHO, the OAS, and the United Nations Education, Scientific and Cultural Organization (UNESCO), the Initiative aims to provide a healthy school environment for living, learning, and working. The purpose of the program is to form future generations with the necessary knowledge, abilities, and skills for promoting and caring for their health, the health of their family, and the health of their community. As a result of the Initiative, the majority of the countries in the Region have developed healthy
schools efforts, some with a focus on the preschool level and others at the primary or secondary school level. School-based health promotion activities continue to be implemented and supported in several countries in the Region.

• **Mainstreaming human security in adolescent and youth health plans:** The human security approach addresses the social determinants of health at the local level, seeks the establishment of power-sharing governance for health, and promotes self-reliance and self-determination among individuals and communities (147). In particular, the human security approach addresses the linkages among freedom from fear, freedom from want, and freedom to live in dignity; focuses on the ways in which people experience vulnerability in their daily lives and acknowledge that different threats feed off one another and thus need to be addressed in a comprehensive manner; is people-centered and context-specific; includes all relevant sectors and actors in the planning, decision-making, and implementation processes; focuses on promotion and prevention to the extent possible; and creates synergy between protection and empowerment actions. Mainstreaming the human security approach in adolescent and youth health plans adds value to PAHO’s regional adolescent and youth health agenda by injecting the promotion of individual and community resilience into the process. In particular, it can guide stakeholders to be better prepared in the face of health threats so that they can bounce back more quickly and emerge stronger from these threats at every stage of their development in the spirit of self-reliance and self-determination.

• **Other interventions:** Several other model interventions aimed at improving the health and wellness of adolescents have been launched in recent years, but their implementation has remained limited, often confined to specific time-bound funding. These efforts have included:

  ° **Aventuras inesperadas:** Aventuras inesperadas (Unexpected Adventures) is a peer-driven multimedia program that aims to train peer educators to promote healthy development among their contemporaries. It has been implemented in selected countries. The main principles of this program are that adolescence is a fascinating time, that each change in the body or the soul brings new experiences and new responsibilities, and that, together, these things make adolescence a great adventure.

  ° **Escuelas de fútbol jugados por la salud:** Escuelas de fútbol jugados por la salud (Schools of Soccer Played for Health) is a health promotion program
aimed at males in the age group 8-12 years. Using soccer to promote gender equality and nonviolence, the program has been implemented in 20 countries, supported with funding from the Johan Cruyff Foundation.

- **TEACH-VIP Youth:** This initiative aims to foster alliances between adults and youth for the prevention of youth violence. The intervention consists of a training program for adults and youth to plan, implement, and evaluate programs in their communities to prevent youth violence.

- **Arte, salud y desarrollo:** In recognition of the important role that art can play in promoting health and positive development, PAHO worked in partnership with a network of Latin American artists to organize an international forum titled “Arte, Puente para la Salud y el Desarrollo” (Art, Bridge for Health and Development). The event participants reached agreement on the Declaration of Lima on art, health, and development. Consequently, art and health initiatives were implemented in various countries, at varying scopes.
Youth participation and empowerment

Youth participation and empowerment has been and continues to be a cross-cutting effort in PAHO’s technical cooperation, with special emphasis on empowering adolescent girls. These efforts have included inviting young people to participate in and contribute to strategic meetings and activities targeting young persons, as well as seeking their input on specific topics through surveys, social media activities, and other means. In 2010, PAHO published a strategic document titled “Empowerment of Adolescent Girls: A Key Process for Achieving the Millennium Development Goals.” That publication advocated persuasively for and provided practical recommendations for empowering adolescent girls, as a critical element of sustainable human development (148). In addition, PAHO invested in working with, and empowering indigenous and Afro-descendant youth networks, engaging them in dialogue around their health priorities and challenges. The work with these networks has illustrated the critical importance of meaningful participation of young people in the design and implementation of health interventions.

III.7: Strategic alliances and collaboration with other sectors

The objective of this action area is to facilitate dialogue and alliance-building between strategic partners in order to advance the adolescent and youth health agenda, and to ensure that key actors participate in the development of policies and programs for this age group. This can be done through:

- developing integrated and coordinated actions between the health sector and strategic partners at the regional, national, and local levels, in such areas as education, the judiciary, labor, public security, housing, and the environment
- increasing and strengthening adolescent and youth interagency programs supported by the UN and by entities of the inter-American system
- establishing mechanisms for South-South cooperation and for sharing of best practices and lessons learned in the Region

Key actions taken by PAHO under this action area have included:

- Multisectoral stakeholder engagement: Increasingly, PAHO is engaging a multisectoral group of stakeholders in regional and subregional activities
related to the health of adolescents and youth, in order to provide a platform for intersectoral exchange and articulation. This has been especially true for the education sector and for stakeholders with responsibility for gender mainstreaming, human rights, and social protection.

- **Regional partnerships:** Strategic ongoing partnerships exist among PAHO, UNICEF, UNFPA, the United Nations Office on Drugs and Crime (UNODC), UNESCO, the World Bank, the International Planned Parenthood Federation (IPPF), and other relevant partners and stakeholders to facilitate dialogue, joint action, and alignment of programs and activities. PAHO also works closely with the Council of Ministers of Health of Central America (COMISCA), the Andean Health System - Hipólito Unanue Convention (ORAS - CONHU), and the Caribbean Community (CARICOM) on the implementation of their respective subregional plans for the prevention of adolescent pregnancy and for other areas of adolescent health.

### III.8: Social communication and media involvement

The objective of this action area is to support the inclusion of social communication interventions and innovative technologies in national adolescent and youth health programs, through:

- promoting positive images, values, and behaviors regarding adolescent and youth health
- strengthening the capacity of Member States to use social communication techniques and new technologies effectively to increase access to health interventions and services
- supporting the generation of evidence on this topic, especially in the use of new technologies and their impact on health.

Key activities under this action area include:

- Inclusion and presentation of positive images of adolescents and youth in PAHO publications: PAHO has been consistent and selective in the inclusion of positive, respectful images of adolescents and youth in all publications.
• Promotion of and capacity-building in the use of digital media in adolescent health: PAHO established a collaborative partnership with a California-based NGO, YTH (youth+tech+health), whose main goal is to enhance youth health and wellness through technology. Each year, YTH organizes an international conference for trailblazing technology that advances youth health and wellness. The event brings together innovators in youth advocacy, health, and technology to showcase what works, share ideas and learnings, and launch new collaborations. PAHO and YTH have collaborated in the organization of two regional workshops on the use of digital technology in adolescent health, and also in developing digital health strategies in several countries, including Guatemala and Suriname.

• Commemoration of advocacy days, such as International Youth Day and International Day of the Girl Child: The implementation of targeted outreach events during these occasions provided the opportunity for advocacy and information-sharing on topics related to the health of adolescents and youth.

Conclusion

The information provided in this part of the report highlights significant progress in the regional and country-level adolescent and youth health response. The development of national policies, strategies, and plans, facilitated the articulation and institutionalization of national adolescent and youth health programs in most countries. However, the lack of assignment of human and financial resources limited the implementation of these strategies and plans. Review of the national strategies and plans also indicated limited articulation of approaches to identify and reach subgroups of young people living in conditions of vulnerability.

Several promising interventions were introduced in countries, however, with a few exceptions, these were not taken to the scale necessary to achieve significant results. The lack of systematic monitoring and evaluation (M&E) of initiatives also compromised the ability at regional and country level, to determine what works in the context of the Region. Major investments were made in capacity-building of different cadres of stakeholders in a range of adolescent health topics; however, the lack of M&E and the high turnover of program managers and service providers make it also difficult to assess the long-term results of these investments.
When considering the data presented in Part II, the overall conclusion is that the regional and country-level efforts yielded limited results in terms of improvement of the health status of adolescents and youth, which in turn leads to the conclusion that changes must be made in the regional and country-level responses, to accelerate progress towards improvement of the health and wellness of young people in the Region.

The lessons learned in the past years already point to some of the changes needed. These include: ensuring that adolescent and youth health programs are multisectoral and address the social determinants of health; ensuring that approaches are evidence-based, target the groups in situations of vulnerability from an equity perspective, and are taken to scale; implementing rigorous M&E to inform strategic planning and timely adaptations to improve efficiency and effectiveness of programs and services; and developing new modalities for capacity building that will yield sustainable results.
Part IV

SURVIVE, THRIVE, TRANSFORM: LEAVING NO YOUNG PERSON BEHIND IN THE AMERICAS
IV.1: Introduction

This part of the document presents a forward-looking perspective on adolescent and youth health. It takes into account the lessons learned from the past as well as the evolving global and regional health developments and commitments, and their implications for the construction of a new adolescent and youth health agenda for the Region beyond 2018, when the current Action Plan comes to an end.

IV.2: The evolving nature of the adolescent and youth health agenda

The 2017 progress report on the Every Woman Every Child (EWEC) Global Strategy on Women’s, Children’s and Adolescents’ Health (149) states that until recently, adolescent health was a neglected topic. That report also notes that this has been changing, and has been reinforced with the recognition in the EWEC global strategy and other recent global documents that adolescents occupy a pivotal position in global public health and could play a transformative role within the 2030 Agenda for Sustainable Development (149).

IV.2.1: The global landscape

Major changes have taken place in the global landscape since the adoption of the Regional Strategy and the Plan of Action, including the sun-setting of the Millennium Development Goals and the adoption of the Sustainable Development Goals (SDGs), with a more ambitious and comprehensive agenda. In addition, the new Global Strategy for Women’s, Children’s and Adolescents’ Health puts adolescents and youth at the center of the SDGs, and central to achieving these goals. Further, new scientific and programmatic documents, such as the AAHA! (6) and the Lancet Commission report (3), make a strong case that investing in adolescents and youth is a requirement for development.

The Sustainable Development Goals

The 2030 Sustainable Development Agenda is of unprecedented scope and ambition (1). Poverty eradication, health, education, and food security and
nutrition remain priorities in the SDGs. However, the goals also include a broad range of economic, social, and environmental objectives, offering the prospect of more peaceful and inclusive societies. The 17 goals and 169 targets include one specific goal for health: “Ensure healthy lives and promote well-being for all at all ages.” That goal has 13 targets (see Annex IV.A and Annex IV.B). There are many linkages between the health goal and other goals and targets (see Box IV.1). This reflects the fundamental assumption that health is both a major contributor to and a result of sustainable development policies.

In order to take on the wide range of crosscutting issues included in the SDGs, it will be necessary to achieve greater intersectoral coherence, integration, and coordination of efforts. This in turn will require strengthened local, national, regional, and global partnerships for sustainable development; a commitment to reach across sectors; clear and measurable objectives; and explicit attention to the needs of the most vulnerable and marginalized groups.

The Global Strategy for Women’s, Children’s and Adolescents’ Health

The 2016-2030 Global Strategy on Women’s, Children’s and Adolescents’ Health (2) builds on the previous Global Strategy on Women’s and Children’s Health
strategy focuses on three overarching objectives: 1) survive: end preventable deaths; 2) thrive: ensure health and well-being; and 3) transform: expand enabling environments. The Global Strategy aims to achieve these objectives through a focus on the life course and evidence-based packages of interventions, as well as nine core action areas: 1) country leadership; 2) financing for health; 3) health system resilience; 4) individual potential; 5) community engagement; 6) multisector action; 7) humanitarian and fragile settings; 8) research and innovation; and 9) accountability for results, resources, and rights.

The Global Accelerated Action for the Health of Adolescents (AA-HA!) Framework

The 68th World Health Assembly requested that the WHO Secretariat develop a Global Accelerated Action for the Health of Adolescents Framework (“the Global AA-HA! Framework”) (6), in consultation with youth, Member States, and major partners. The AA-HA! provides guidance to countries on how to plan, implement, and monitor a “survive, thrive, and transform” response to the health needs of adolescents, in line with the Global Strategy for Women’s, Children’s and Adolescents’ Health (2) and the operational framework for that Strategy (151), through:

- involving adolescents and the global health community in shaping its content and in setting a standard by which adolescents can help in holding countries accountable
- communicating evidence-based policies and interventions in health and other sectors for the “survive, thrive, and transform” agenda
- highlighting policies and interventions that address multiple outcomes, risk factors, and determinants and, therefore, give better value for money
- guiding priority-setting in various epidemiological contexts and providing options for implementation based on approaches that have been successfully applied in countries
- proposing tracer indicators for health and other sectors to monitor their performance vis-à-vis adolescent needs

The Committee on the Rights of the Child General comment No. 15

After the PAHO Regional Strategy and the Plan of Action were approved, the Committee on the Rights of the Child (CRC) published its “General comment No.
15 (2013): the right of the child to the enjoyment of the highest attainable standard of health (Article 24)” (152). This comment document does three things:

- highlights the underlying similarities between the scientific basis for a public health approach to adolescent health and a rights-based approach to health during the adolescent years
- outlines the normative content of the right of adolescents to the highest attainable standard of health and their right to facilities for the treatment of illness and rehabilitation in relation to health care services
- describes the legally binding obligations of States that are parties to the CRC with respect to ensuring the full realization of adolescents’ right to health, providing a conceptual framework and recommendations for concrete measures and actions required by States Parties, and non-State actors, to fulfill these obligations, and for developing the regular reports that they prepare for the Committee

The Committee on the Rights of the Child General comment No. 20

In its “General comment No. 20 (2016) on the implementation of the rights of the child during adolescence” (153), the CRC provides guidance to States on the measures necessary to ensure the realization of the rights of children during adolescence. The issues highlighted in that document include:

- the importance of valuing adolescence and its associated characteristics as a positive developmental stage of childhood and the need to promote environments that help them to thrive; explore their emerging identities, beliefs, sexualities, and opportunities; balance risk and safety; build capacity for making free, informed, positive decisions and life choices; and successfully navigate the transition into adulthood
- that parental direction and guidance should be provided in a manner consistent with the evolving capacities of the child, and seeking an appropriate balance between respect for the evolving capacities of adolescents and appropriate levels of protection
- ensuring that all the rights of every adolescent boy and girl are afforded equal respect and protection and that comprehensive and appropriate affirmative action measures are introduced in order to diminish or eliminate conditions that result in direct or indirect discrimination against any group of adolescents on any grounds
• adopting measures that ensure that all adolescents have access, without discrimination, to different forms of media, and that support and promote equal access to digital citizenship, including through the promotion of accessible formats for adolescents with disabilities

• promoting safety of the digital environment through holistic strategies, including digital literacy with regard to online risks and strategies to keep it safe, and strengthen legislation and law enforcement mechanisms to tackle abuse online and fight impunity

• that all measures taken in respect of legislation, policies, and programs focused on adolescents should take into consideration intersecting violations of rights and the compounded negative effects on the adolescents concerned, in particular related to gender stereotypes affecting girls and boys; adolescents living with disabilities; lesbian, gay, bisexual, transgender, and intersex adolescents; and minority and indigenous adolescents

The report of the Lancet Commission on Adolescent Health and Wellbeing

A report published in 2016 by a special Lancet commission presented a series of landmark papers on adolescent health (3). This work brought together the most current evidence and insights from a network of global experts, including academics, policymakers, practitioners, young health advocates, and leading academic institutions representing diverse disciplines. The scholarly fields included public health and medicine, behavioral science, neuroscience, education, law, economics, and political and social science. Box IV.2 presents the key messages of the report.

Box IV.2: Key messages, opportunities, and challenges related to adolescent health, as presented by the 2016 report of the Lancet Commission on Adolescent Health and Wellbeing

Key messages

• Investments in adolescent health and well-being bring a triple dividend of benefits: now, into future adult life, and for the next generation of children.

• Adolescents are biologically, emotionally, and developmentally primed for engagement beyond their families. We must create the opportunities to meaningfully engage with them in all aspects of their lives.
• Inequities, including those linked to poverty and gender, shape all aspects of adolescent health and well-being. Strong multisectoral actions are needed to grow the resources for health and well-being and offer second chances to the most disadvantaged.

• Adolescents and young adults face unprecedented social, economic, and cultural change. We must transform our health, education, family support, and legal systems to keep pace with these changes.

Outstanding opportunities

• Guaranteeing and supporting access to free, quality secondary education for all adolescents presents the single best investment for health and well-being.

• Tackling preventable and treatable adolescent health problems (including infectious diseases, undernutrition, HIV, sexual and reproductive health, injury, and violence) will produce huge social and economic benefits. This is key to bringing a grand global convergence in health in all countries by 2030.

• The most powerful actions for adolescent health and well-being are intersectoral, multilevel, and multicomponent. Information and broadband technologies present an exceptional opportunity for building capacity within sectors and coordinating actions among them.

• Establishing systems for the training, mentoring, and participation of youth health advocates has the potential to transform traditional models of health care delivery to create adolescent-responsive health systems.

Challenges ahead

• Rapid global rises in adolescent health risks for later-life noncommunicable diseases will require an unprecedented extent of coordination across sectors, from the global to the local level.

• Noncommunicable diseases of adolescents (including mental and substance-use disorders, as well as chronic physical illnesses) are becoming the dominant health problems of this age group. Substantial investment in the health care system and approaches to prevention are required.

• Health information systems to support actions in adolescent health remain weak. Greater harmonization and broadening of data collection systems to neglected problems and younger ages will be needed.

• Inequalities in health and well-being are evident in socially and economically marginalized adolescents, including ethnic minorities, refugees, young offenders, indigenous individuals, and LGBT persons. Engagement of adolescents and reconfiguration of service systems to ensure equity of access regardless of sex, ethnic, or socioeconomic status will be essential.

Source: (3).
IV.2.2: The regional landscape

There have been a number of new regional commitments and developments that have implications for the health of adolescents and youth. Some of these were mentioned earlier in this report, including the regional commitment for universal health coverage and access (5), and the Plan of Action for the Prevention of Obesity in Children and Adolescents (124). Various other noteworthy regional products and commitments are highlighted below.

PAHO Strategic Plan for 2014–2019

The Strategic Plan of the Pan American Health Organization 2014-2019 is PAHO’s highest-level planning instrument, as approved by its Governing Bodies (154). The Plan prioritizes health equity, addressing social determinants of health, and Health in All Policies as strategic and cross-cutting approaches. The vision of the Plan goes beyond traditional disease-oriented approaches, and emphasizes health promotion, primary health care, and social protection in health as key tenets to realize healthy living and well-being for all citizens of the Americas.

The Panama Declaration on reducing inequities in reproductive, maternal, and child health

In September 2013, in the Panama Declaration on reducing inequities in reproductive, maternal, and child health (155), the Region renewed its commitment to improving the health of women, newborns, children, and adolescents, by reducing inequities, expanding evidence-based interventions, promoting universal health coverage, establishing regional cooperation mechanisms and partnerships, and mobilizing political will. In a follow-up to that Declaration, regional partners, including PAHO, the UNICEF, the World Bank, the Inter-American Development Bank (IDB), and the U.S. Agency for International Development (USAID) established an interagency collaboration referred to as “A Promise Renewed,” with its Secretariat based at PAHO. Working collaboratively, the agencies took several actions to promote and support inequity analysis, including publishing a health equity report (156) and providing technical cooperation to countries to strengthen their capacity to conduct inequality analysis. Recently, A Promise Renewed transitioned into Every Woman Every Child Latin America and the Caribbean.
Addressing the causes of disparities in health service access and utilization by lesbian, gay, bisexual, and transgender persons

In recognition of the stigma and discrimination in the health sector against LGBT persons and the need to improve access to care and the overall health indicators for these populations, the PAHO Member States adopted the ground-breaking Resolution CD52.R6 in 2013 (157). The resolution urges Member States to: a) promote health services that respect human dignity and health rights, taking into account sexual and gender diversity; b) give priority to promoting equal access to health services in policies, plans, and legislation; and c) collect data about access to health care and health facilities for LGBT populations.

Within the context of this resolution, PAHO coordinated the implementation of an assessment on the health situation and access to care of LGBT persons, the barriers they can face in accessing health care services, and the impact of reduced access for this population (158). The findings are relevant to the situation of LGBT persons from all ages, including adolescents and youth. Key findings included that: 1) many countries that participated in the assessment have antidiscrimination policies in place and laws, policies and protocols tailored to meet the specific needs of LGBT persons, and health-related legislation includes laws that recognize LGBT groups as a population in conditions of vulnerability with unique health needs; however, some countries and territories still have laws that criminalize LGBT persons; 2) the provision of health services tailored to the needs of LGBT persons is heterogeneous in the Region. Most often, the services are offered through the public health system on an undifferentiated basis and are centralized in large urban settings, and stigma and discrimination continue to be major obstacles to access health services for LGBT persons (158).

In September 2017, the results of this assessment were presented to the PAHO Member States, with several recommendations, including the following: 1) Strengthen and/or establish LGBT-sensitive and comprehensive health services grounded in evidence that address the specific health needs of LGBT persons taking into account gender identity and diversity of expression; 2) Improve the training of health care providers so that they are able to address LGBT health needs with gender, diversity, and rights-based approaches that will help to end any form of discrimination; 3) Consider the specific health needs of LGBT persons in the development and/or implementation of health policies and health system
strengthening initiatives as part of the effort to advance toward universal health; 4) Improve efforts to ensure that LGBT persons can enjoy access to and the use of health services without discrimination by including provisions in Member States’ national antidiscrimination laws that explicitly forbid discrimination on the basis of sexual orientation and gender identity; 5) Strengthen health information systems and surveillance mechanisms to generate periodic reports that include LGBT health conditions and barriers to access and include sexual orientation and gender identity items in existing nationally representative health surveys in order to gather data that can be disaggregated by sexual orientation and gender identity (158).

Montevideo consensus on population and development

Given the importance of sexual and reproductive health for adolescents, the Montevideo consensus on population and development (159) was a critical regional commitment made at the first session of the Regional Conference on Population and Development in Latin America and the Caribbean, held in August 2013. This document calls for investing in young people through specific public policies and articulates the regional commitment to effectively implement comprehensive sexuality education from early childhood; provide quality sexual and reproductive
health services for adolescents and young persons that respond to their needs; introduce or strengthen policies and programs to prevent pregnant adolescents and young mothers from dropping out of schools; and eliminate unsafe abortions.

Health in All Policies

While not specifically aimed at adolescent and youth health, the Plan of Action on Health in All Policies, adopted by the PAHO Member States in September 2014 (Resolution CD53/10) (160), provided a framework for ongoing dialogue for and efforts toward multisectoral articulation of health improvement strategies. Such strategies are essential when it comes to the health of adolescents and youth, for example, when it comes to the food industry, efforts to reduce salt, fat and sugar contents, directly impact on the health of adolescents and youth.

Health, human security, and well-being

In 2010, PAHO Member States adopted a resolution titled “Health, Human Security, and Well-being” (CD50.R16) (161). The human security approach is based on fundamental human freedoms, including the right of people to live in freedom and dignity, free from poverty and despair (147, 161). Human security can serve as an overarching philosophy that aims to enhance human freedoms; can inform policy aimed at enabling individuals to fulfill their full potential; and can serve as a tool to guide practitioners in their programming aimed at reducing the sources of vulnerability facing individuals, communities, and institutions. In turn, human security can mitigate the impact of threats to people’s lives, livelihood, and dignity, and can build resilience to future threats (147, 161). The human security approach can contribute to programming related to the health and development of adolescents and youth, including in fashioning comprehensive approaches for reducing youth violence and promoting peace, development, and human rights.

The Commitment to Action of Santiago

In 2016, PAHO initiated action to roll out, in the Americas, the Global Strategy for Women’s, Children’s and Adolescents’ Health, in close partnership with other regional partners, including UNICEF, the United Nations Population Fund (UNFPA), the World Bank, the Joint United Nations Program on AIDS (UNAIDS), USAID, and IDB. Towards this end, an interagency coordinating mechanism was established, officially recognized by the EWEC global movement and named Every Woman
Every Child Latin America and the Caribbean. The main purpose of the mechanism is to serve as a catalyst and to support countries in their efforts towards the goals and objectives of the SDGs and of the Global Strategy, with a focus on reducing health inequalities.

In this context, the interagency group organized several technical meetings and three subregional multisector stakeholder consultations (in the Caribbean, Central America, and South America). The objective was to disseminate the Global Strategy and to have in-depth discussions on its nine action areas during the first half of 2017. The reflections and recommendations generated by this regional consultative process served as input for a high-level meeting convened by Dr. Michelle Bachelet, president of the Republic of Chile and cochair of the High Level Advisory Group of the global EWEC movement. That event culminated in the Commitment to Action of Santiago (162), a regional pledge to ensure that every woman, child, and adolescent not only survives, but thrives in a transformative environment. This is to be done by reducing health inequities, strengthening political will and multisectoral action, prioritizing quality, strengthening cooperation between countries, promoting a research agenda, investing needed resources, building participatory accountability mechanisms, and encouraging appropriate legislative frameworks.

The Sustainable Health Agenda for the Americas 2018-2030 (SHAA2030)

In September 2017, the Ministers and Secretaries of Health of the countries of the Region of the Americas unanimously endorsed the new health agenda for the Region, titled “Sustainable Health Agenda for the Americas 2018-2030: A Call to Action for Health and Well-being in the Region,” as the strategic policy instrument to provide direction and political vision for health development in the Region until 2030 (163).

The Agenda is based on the following principles and values: 1) the right to the enjoyment of the highest attainable standard of health; 2) Pan American solidarity; 3) equity in health; 4) universality; and 5) social inclusion.

SHAA2030 sets forth the following 11 health goals for the Region (163):

- **Goal 1:** Expand equitable access to comprehensive, integrated, quality, people-, family-, and community-centered health services, with an emphasis on health promotion and illness prevention.
Goal 2: Strengthen stewardship and governance of the national health authority, while promoting social participation.

Goal 3: Strengthen the management and development of human resources for health with skills that facilitate a comprehensive approach to health.

Goal 4: Achieve adequate and sustainable health financing with equity and efficiency, and advance toward protection against financial risks for all persons and their families.

Goal 5: Ensure access to essential medicines and vaccines, and to other priority health technologies, according to available scientific evidence and the national context.

Goal 6: Strengthen information systems for health to support the development of evidence-based policies and decision-making.

Goal 7: Develop capacity for the generation, transfer, and use of evidence and knowledge in health, promoting research, innovation, and the use of technology.

Goal 8: Strengthen national and regional capacities to prepare for, prevent, detect, monitor, and respond to disease outbreaks, and emergencies and disasters that affect the health of the population.

Goal 9: Reduce morbidity, disabilities, and mortality from noncommunicable diseases, injuries, violence, and mental health disorders.

Goal 10: Reduce the burden of communicable diseases and eliminate neglected diseases.

Goal 11: Reduce inequality and inequity in health through intersectoral, multisectoral, regional, and subregional approaches to the social and environmental determinants of health.

IV.3: Moving forward with the regional adolescent and youth health agenda

As the current Regional Strategy and Plan of Action on Adolescent and Youth Health are coming to an end, the recent global and regional developments presented in the preceding sections provide a sound basis for reflection and updating of approaches to improve the health and well-being of adolescents and youth in the Americas. There have been achievements and progress in the regional and country
responses to adolescent and youth health, but major obstacles and challenges remain. In trying to apply the three-fold goal of the Global Strategy for Women’s, Children’s and Adolescents’ Health, there are three key challenges, as described below.

**Survive**

Adolescent and youth mortality rates have remained constant or have worsened, with young males dying, on average, four times more frequently than their female counterparts do. Each year more than 150,000 youth aged 15-24 years are dying in the Region. The majority of these deaths are due to preventable causes such as homicide, suicide, and road traffic injuries (Figure IV.1).

Inequality analysis shows that, in addition to gender, such social determinants as wealth quintile, education level, and race/ethnicity influence which groups are most affected by preventable mortality. Risk factors for mortality and morbidity during adolescence and youth, and into adulthood, such as alcohol and drug use, anemia, overweight and obesity, are highly prevalent. Further, there are only a limited number of comprehensive approaches in the Region that address these key risk factors contributing to youth mortality and morbidity, alcohol use, and mental health problems.

**Thrive**

The adolescent fertility rate in Latin America and the Caribbean remains among the highest in the world, with indigenous, rural, poor, and less-educated adolescent girls bearing the heaviest burden of early pregnancy (Figure IV.2). This affects their health and development opportunities across the life course and into the next generation. Nevertheless, adolescents continue to face major legal, policy, health system, and societal barriers to accessing sexual and reproductive services needed to manage their fertility and exercise their sexual and reproductive rights. Attention to the health of adolescents aged 10-14 years remains limited, thus missing the window of opportunity for early intervention and the fostering of positive and protective norms, values, and behaviors. Further, the focus of many programs and interventions remains on risk factors and deficiencies, with limited attention to fostering positive health and development of adolescents and youth.
Figure IV.1: Mortality trends in males and females aged 15-24 years in the Americas, 2008-2013

Adjusted mortality rates (all causes) for youth aged 15-24 in the Americas, by sex, 2008-2013

Data Visualization
Mortality Trends. Ten leading causes of deaths of adolescent and youth in the Americas, by Sex and Age Group (per 100,000 Population), 2000-2014

Figure IV.2: Estimated and projected adolescent fertility rate in the world and selected regions, 1970-2030

Source: (39).
Transform

Many countries have low rates of secondary school completion, and young people in the Region continue to be disproportionately affected by poverty, unemployment, and inadequate access to decent employment. The health of adolescents and youth continues to be compromised by different forms of violence, including acts of aggression, sexual violence, neglect, and physical abuse, as evidenced by the rising homicide rates and the growing trend of pregnancy in girls under 15 years old. Meaningful engagement and participation of young people in efforts to improve their own health and development remain limited and incidental, rather than structural.

Proposed core elements for a 2030 adolescent health agenda for the Americas

To consolidate the gains of recent years and accelerate progress, the regional adolescent and youth health agenda must go beyond “business as usual.” To achieve the level of transformation envisioned by the SDGs and the Global Strategy for Women’s, Children’s and Adolescents’ Health, efforts will need to go outside the comfort zones of current adolescent health programs and address the complex health challenges young people face. These challenges include mental health problems and substance use, violence and suicide, and a range of health-related behaviors and conditions, including overweight and obesity. All of these problems have important implications for adolescent health and for public health across the life course. Fortunately, there is a growing evidence base for effective interventions to be implemented through the health sector and other sectors, to protect and promote optimal health and wellness of adolescents and youth. A future-oriented regional response to the health of adolescents and youth must include the following two core dimensions.

1. Reduction of preventable adolescent and youth morbidity and mortality, their risk factors and determinants, and the risk factors for premature adult mortality

The mortality and burden of disease data indicate that the following areas should be prioritized to reduce adolescent and youth mortality and morbidity:

a. Addressing youth violence and the factors contributing to perpetration or exposure to youth violence.
b. Reduce the consumption of alcohol among adolescents and youth, including the early introduction of alcohol use.

c. Promote and support the prevention, timely diagnosis and effective treatment of mental health challenges and diseases in adolescents and youth.

d. Promote healthy nutrition and actions to prevent anemia (in particular in young adolescents 10-14 years), and reduction of foods with high sugar and fat content.

Addressing the unfinished adolescent and youth mortality and morbidity agenda will require improvement of mortality reporting, as well as conducting additional analysis to better understand the circumstances of the leading causes of adolescent and youth mortality and the most affected groups. Based on this information, strategic actions should be developed and implemented, drawing from the lists of evidence-based interventions proposed by the WHO. Prevention efforts must apply multisector actions to address the underlying factors that contribute to preventable deaths among adolescents and youth.

2. Promotion of positive adolescent and youth health and development

The evidence base on the multiple-layer effects of interventions that apply positive development approaches is in line with longstanding global agreements, such as the Alma Ata Declaration (164), the Ottawa Charter for Health Promotion (165), the PAHO Strategy for Universal Access to Health and Universal Health Coverage (5), the SDGs (1), and the Global Strategy for Women’s, Children’s and Adolescents’ Health (2).

This second element concerns alternatives to traditional approaches that tend to be deficit based or focused on risk factors. Instead, there should be a positive developmental approach to adolescent and youth health that promotes constructive health and development by nurturing affirmative developmental assets. These assets include bonding, resilience, social and emotional and cognitive competence, self-determination, spirituality, self-efficacy, positive identity, and belief in the future. This approach aims to increase adolescents’ resilience and protective factors, and seeks to empower them to participate in a positive way in their own health, the health of their families, and the health of their communities (6). Key elements of these positive development approaches should include:
• Improving the use of the school platform for protection and promotion of the health and wellness of children and adolescents, to include 1) school health policies to promote and protect the health and safety of students; 2) fostering a healthy and safe learning environment; health education within and in addition to the school curriculum, and school-based health services.

• Working with families to maximize the health benefits of supportive and positive parent-child relationships.

• Working with the community to partner in the creation of the conditions for young people to be safe and healthy, and participate in society.

• It is important to note that these two dimensions are not separate, but should rather be seen as inter-related, and parts of a comprehensive approach to achieve the “Survive-Thrive-Transform” adolescent and youth health agenda.

Proposed lines of action

• **Guarantee access for adolescents and youth to integrated and quality health services** that are culturally, ethnically, and linguistically appropriate, with a gender approach, and promote health, prevent diseases, provide care for disease, and offer the necessary short-, medium-, and long-term care (5). This includes eliminating persistent barriers to access for adolescents, such as restricting laws and policies, and resistance based on cultural and religious arguments.

• It is important to note that these efforts should go beyond the typical approach towards adolescent-friendly services (which tend to be small-scale and not sustainable), to the fostering of adolescent and youth-responsive health systems. This implies strengthening the capacity of existing health services to provide appropriate health services to adolescents and youth. Minimum requirements in this context are the development, institutionalization and continuous monitoring of standards for adolescent health services, definition and provision of an appropriate package of services, including SRH services, and training of health care providers in core competencies needed to provide services for adolescents and youth.
• Implement evidence-based interventions in schools, families and communities for promotion and protection of health and wellness of male and female adolescents and youth.

• Efforts are underway for development of a blueprint for strengthening of school health, which will include consensus actions to address the mentioned aspects of school health, including renovation and expansion of school-based health services.

• Continued implementation and monitoring of the Familias Fuertes program, and introduction of other models of family-based programs.

• Articulation and implementation of a strategy for strengthening of positive health and development approaches in the Region.

• Strengthen stakeholder capacity to apply approaches in adolescent and youth health programs and services that will reduce inequities.

• Strengthening of monitoring and evaluation of programs, services and interventions, and sharing of lessons learned and good practices.

• Continue building the regional and country-level capacity for the generation and use of strategic information related to the health and development of adolescents and youth, ideally as an integral part of the national health information system. This should include the generation of information on national and subnational levels, to include the health situation and risks, educational status, literacy, poverty, parental involvement, housing status, employment status, involvement with the justice system, perceived neighborhood safety, victimization of crime, and access to health care. Information on gender, sex, sexual orientation, gender identity, and gender equality should also be included and collected. Data need to be disaggregated based on a range of criteria in addition to age and sex, including socioeconomic status, education, ethnicity, rural/urban residence, and employment. This should include:

• Regular implementation of the Global School-based Health Survey (GSHS) and other surveys that generate data on the health and wellness of adolescents and youth.
• Strengthen stakeholder and capacity and support the measuring of health inequities affecting adolescents and youth.

• Promote and support implementation research to generate new knowledge on what works in the Region and to stimulate innovation.

• **Empowerment and engagement of adolescents and youth as partners and agents of change.** Adolescents and youth can be powerful advocates and activists, and they can play key roles in program design, implementation, and monitoring. While this will clearly continue to be important, there is an ongoing need to be able to demonstrate how this involvement strengthens adolescent and youth health programs, and how young people can be more effectively integrated into national health systems as these systems move towards achieving universal health coverage.

**Cross-cutting themes**

**Application of a life course approach:** the main health challenges faced by adolescents do not take place in isolation, but are interrelated and influenced by what has happened during the first decade of life. Adolescent programs therefore need to link with and build on early child development (ECD) programs, which have changed to place greater emphasis on the relationships and environment of the child and the important role of caretakers and families. This building on ECD programs will require supporting close collaboration between child and adolescent health programs in countries. School health programs could play a critical bridging role in ensuring comprehensive and cohesive health services for children and adolescents across the life course. A life course approach also implies investing in encouraging healthy habits and a healthy environment for adolescents, to foster a healthier life trajectory and prevent health risks and conditions during adulthood.

**Ensuring a rights-based approach:** basing what is done on human rights emphasizes the commitments that Member States have made and the obligations that they have to implement interventions for adolescent survival and development. A rights-based approach provides a framework for national policies and legislation. Also, it stresses the importance of giving adequate attention to issues of equity and the engagement of adolescents, in particular those living in situations of vulnerability. There is a need to better use the existing conventions,
treaties, and other legal instruments to influence the regional and country-level dialogue on the right to health of adolescents. This will require continued advocacy and support for legislative and policy reform based on human rights instruments and obligations, in order to ensure optimal access of adolescents to health information, services, and commodities, including those related to SRH.

Addressing inequities in adolescent and youth health: health inequities are the result of many factors, which are often interrelated. These factors include race, ethnicity, gender, sexual orientation, income level, place of residence, employment, and working conditions. Many health problems depend on social class, educational status, urban vs. rural residence, and ethnicity, particularly among indigenous groups and persons with a disability. It is therefore important for countries to assess indicators at subnational levels, to ensure that progress is made across the various subgroups of the populations of young people. A range of factors, from natural disasters to economic policies, may directly and indirectly affect the health of adolescents and youth. At the same time, subgroups of young people may become invisible in existing data collection systems and in the targeting of interventions. For example, young people with disabilities often remain unseen, with their special needs largely unmet. Identifying bottlenecks and reaching vulnerable and marginalized adolescents will require increased efforts if greater equity is to be achieved.

Tackling gender inequalities, including with more attention to young males: there have been significant efforts in the Region to direct resources to adolescent girls, particularly in the context of ASRH programs, and these need to be strengthened and taken to scale. There is, however, growing awareness of the need to also give adolescent boys adequate attention and to involve them more effectively. We must move beyond the false dichotomy of prioritizing men or women as if there is a competition, since the differential health care needs of both women and men must be met in order to achieve gender equality in health. The relational nature of gender implies that men and women are usually both affected by situations, events, and stressors, albeit in different ways. There is a need, in collaboration with regional partners, to develop and disseminate model interventions for involving men and boys in child and adolescent health.

Intersectoral collaboration: The major causes of mortality and of health challenges among adolescents and youth require interventions outside the health
sector. Among these are road safety guidelines and measures; regulations related to alcohol and tobacco; food and nutrition policies; and protocols for responding to gang violence. Developing intersectoral and multidisciplinary partnerships will be essential, among government ministries (such as education and human development), the private sector, NGOs, community-based organizations, activists, parents, and young people themselves. The fact that this needs to be done is now widely accepted, but how to do it often remains challenging. There should be better documentation and dissemination of success stories, along with information on how success is assessed and achieved. There is an ongoing need to strengthen coordination between the UN and other partners and to facilitate joint support by development partners. This will help avoid competition and confusion, and also maximize the financial and technical resources for the benefit of national programs. Collaboration and exchange between countries to share successful experiences and approaches is also needed. Knowledge management within the Region will continue to be important so that countries can develop, review, and update national adolescent and youth health priorities, strategies, and plans, based on evidence and global and regional normative guidance. To this end, it will be important to document and share promising practices and to facilitate horizontal country-to-country exchanges.

**Research and the use of new technology:** There will always be a need for research on new approaches to improving adolescent health, but much is already known about effective interventions. A challenge for research is to focus less on answering “what” questions and more on addressing “how” questions. Operations research and implementation research will be important to provide real-time feedback during the implementation of adolescent health programs. Such research can help us better understand how effective programs were implemented, how they can be replicated in different contexts and for different target groups, and how they can be taken to scale while maintaining the quality that is required for them to be effective. An important intervention area that will require development and evaluation is the use of interactive media and social media. There is growing awareness of the potential benefits of m-health and e-health for reaching adolescents with information and education, linking them with services, and supporting adherence and follow-up. There is a need to collaborate with other partners to develop and disseminate model interventions for the use of digital media in relation to adolescent health.
Part V
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Adolescent and Youth Health - 2017 Country Profile

**ANGUILLA**

### POPULATION


**Adolescent and Youth Population**

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<th>Male</th>
<th>Female</th>
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<td>542</td>
<td>566</td>
<td>1,108</td>
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<tr>
<td>15-19</td>
<td>634</td>
<td>612</td>
<td>1,246</td>
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<td>10-14</td>
<td>645</td>
<td>613</td>
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<tr>
<td>10-24</td>
<td>1,821</td>
<td>1,791</td>
<td>3,612</td>
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Adolescents and Youth, percentage of total population: **22%**

### ECONOMIC DEVELOPMENT


- GDP per capita (current US$): 21,493.0 (2014)
- GDP growth rate (annual %, const. 2005 prices): 6.0 (2014)
- GDP (million current US$): 311.0 (2014)

### EDUCATION PARTICIPATION


- School enrolment, secondary (%): 96% (2015-2016)

### MORTALITY RATES - Leading Causes of Death, by Age Group and Sex (per 100,000 Population)

**Note:** *If there is no cause of death reported for a specific age group and sex, the corresponding bar with zero value is not being represented.*

#### (10-14 years old)

- **Influenza and Pneumonia:** [Graph 1]
- **N/A. No mortality data reported for the specific age group**

#### (15-19 years old)

- **Handgun fire discharge non intentional:** [Graph 2]
- **Road traffic injuries:** [Graph 3]

#### (20-24 years old)

- **Handgun fire discharge non intentional:** [Graph 4]
- **Road traffic injuries:** [Graph 5]

### MORTALITY TRENDS - Leading Causes of Death, by Sex (per 100,000 Population)

Adolescent and Youth (10-24 years old), 2000-2014

### MENTAL HEALTH

**Source:** 2016 Global School Health Survey (GSHS), WHO.

- Percentage of students who ever seriously considered attempting suicide during the past 12 months
- Students who actually attempted suicide one or more times during the past 12 months
- Students who had no close friends
- Students who missed classes or school without permission 1+ of the past 30 days
- Students whose parents usually understood their problems and worries the past 30 days
- Students whose parents really usually knew what they do with free time the past 30 days

### PROTECTIVE FACTORS

**Source:** 2016 Global School Health Survey (GSHS), WHO.

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**SEXUAL AND REPRODUCTIVE HEALTH**

### Sexual Behavior in Adolescents

#### (13-15 years old)

**Source:** 2016 Global School Health Survey (GSHS), WHO.

- **Students who ever had sexual intercourse:**
  - Male: 15.8%
  - Female: 45.9%
  - Total: 28.3%

- **Among students who ever had sexual intercourse, those that the first time was before age 14 yrs:**
  - Male: 23.6%
  - Female: 71.1%
  - Total: 47.2%

- **Among students who ever had sexual intercourse, those who used a condom the last time:**
  - Male: 71.1%
  - Female: 28.8%
  - Total: 53.7%

#### Prevalence of Sexual Activity among Adolescents

**Source:** 2016 Global School Health Survey (GSHS), WHO.

- **Lever births (15-19):**
  - 1980-1985: 8
  - 1985-1990: 16
  - 1990-1995: 8
  - 1995-2000: 15
  - 2000-2005: 9
  - 2005-2010: 14
  - 2010-2015: 14

**Adolescent fertility rate:**
- 1985-1990: 29.4
- 2000-2005: 15.7
- 2005-2010: 23.6
- 2010-2015: 15.8

#### Risk Factors

**Sources:** GSHS - Global School Health Survey (WHO); GYTS - Global Youth Tobacco Survey (PAHO); OAS - Report on Drug Use in the Americas

#### Alcohol Use

- **Among students who ever drunk alcohol, those that the first drink was before age 14 yrs:**
  - Male: 88.0%
  - Female: 83.2%
  - Total: 85.7%

- **Students who drank at least one drink containing alcohol 1+ of the past 30 days:**
  - Male: 30.2%
  - Female: 30.4%
  - Total: 30.5%

- **Students who drank so much alcohol that they were really drunk 1+ times during their life:**
  - Male: 24.9%
  - Female: 50.7%
  - Total: 42.5%

#### Tobacco Use

- **Students who smoked cigarettes 1+ days during the past 30 days:**
  - Male: 7.7%
  - Female: 4.1%
  - Total: 6.0%

- **Percentage of students who currently used any tobacco product on one or more days during the past 30 days:**
  - Male: 17.4%
  - Female: 9.3%
  - Total: 13.6%

- **Students who reported people smoked in their presence, past 7 days:**
  - Male: 30.4%
  - Female: 19.7%
  - Total: 25.2%

#### Overweight/Obesity/Diet

- **Students who usually drank carbonated soft drinks 1+ times per day the past 30 days:**
  - Male: 54.9%
  - Female: 55.4%
  - Total: 55.2%

#### Physical Activity

- **Students who spent 3+ hours per day doing sitting activities:**
  - Male: 50.3%
  - Female: 67.1%
  - Total: 60.9%

- **Students who went to physical education (PE) class 3+ days weekly in the school year:**
  - Male: 40.2%
  - Female: 45.4%
  - Total: 42.8%

- **Percentage of students who were physically active for a total of at least 60 minutes per day on all 7 days during the past 7 days:**
  - Male: 23.3%
  - Female: 17.4%
  - Total: 20.3%

#### Drug Use

- **Students who used marijuana 1+ times during their life:**
  - Male: 29.0%
  - Female: 12.9%
  - Total: 21.2%

- **Among students who ever used drugs, those that first used drugs before age 14 yrs:**
  - Male: 84.3%
  - Female: 40.7%
  - Total: 43.0%

### Adolescent and Youth Health - 2017 Country Profile

**Anguilla**

**Sexual and Reproductive Health**

**Trends in Adolescent Fertility Rate**


**Risk Factors**

**Alcohol Use**

- **Among students who ever drunk alcohol, those that the first drink was before age 14 yrs:**
  - Male: 88.0%
  - Female: 83.2%
  - Total: 85.7%

- **Students who drank at least one drink containing alcohol 1+ of the past 30 days:**
  - Male: 30.2%
  - Female: 30.4%
  - Total: 30.5%

- **Students who drank so much alcohol that they were really drunk 1+ times during their life:**
  - Male: 24.9%
  - Female: 50.7%
  - Total: 42.5%

**Tobacco Use**

- **Students who smoked cigarettes 1+ days during the past 30 days:**
  - Male: 7.7%
  - Female: 4.1%
  - Total: 6.0%

- **Percentage of students who currently used any tobacco product on one or more days during the past 30 days:**
  - Male: 17.4%
  - Female: 9.3%
  - Total: 13.6%

- **Students who reported people smoked in their presence, past 7 days:**
  - Male: 30.4%
  - Female: 19.7%
  - Total: 25.2%

**Overweight/Obesity/Diet**

- **Students who usually drank carbonated soft drinks 1+ times per day the past 30 days:**
  - Male: 54.9%
  - Female: 55.4%
  - Total: 55.2%

**Physical Activity**

- **Students who spent 3+ hours per day doing sitting activities:**
  - Male: 50.3%
  - Female: 67.1%
  - Total: 60.9%

- **Students who went to physical education (PE) class 3+ days weekly in the school year:**
  - Male: 40.2%
  - Female: 45.4%
  - Total: 42.8%

- **Percentage of students who were physically active for a total of at least 60 minutes per day on all 7 days during the past 7 days:**
  - Male: 23.3%
  - Female: 17.4%
  - Total: 20.3%

**Drug Use**

- **Students who used marijuana 1+ times during their life:**
  - Male: 29.0%
  - Female: 12.9%
  - Total: 21.2%

- **Among students who ever used drugs, those that first used drugs before age 14 yrs:**
  - Male: 84.3%
  - Female: 40.7%
  - Total: 43.0%
Adolescent and Youth Health - 2017 Country Profile

ARGENTINA

POPULATION

Adolescent and Youth Population

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>1,753,654</td>
<td>1,703,095</td>
<td>3,456,749</td>
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<tr>
<td>15-19</td>
<td>1,754,988</td>
<td>1,699,121</td>
<td>3,454,109</td>
</tr>
<tr>
<td>10-14</td>
<td>1,830,758</td>
<td>1,770,409</td>
<td>3,601,167</td>
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<tr>
<td>10-24</td>
<td>5,339,400</td>
<td>5,172,625</td>
<td>10,512,025</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: 24%

ECONOMIC DEVELOPMENT


GDP per capita, PPP (current international $) 874,071.0 (2016) -2.3 (2016)

EDUCATION PARTICIPATION

Net enrollment rate, secondary (%) (2014) 86% 91%

Mortality Rates - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)


Mortality Trends - Four Leading Causes of Death, by Sex (per 100,000 Population)

Mental Health

Source: 2012 Global School Health Survey (GSHS), WHO.

Percentage of students who ever seriously considered attempting suicide during the past 12 months

Protective Factors

Source: 2012 Global School Health Survey (GSHS), WHO.

Students whose parents usually understood their problems and worries the past 30 days

Students whose parents really usually knew what they do with free time the past 30 days

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THE HEALTH OF ADOLESCENTS AND YOUTH IN THE AMERICAS
Adolescent and Youth Health - 2017 Country Profile
ARGENTINA

SEXUAL AND REPRODUCTIVE HEALTH

Trends in Adolescent Fertility Rate
(Births per 1,000 women ages 15-19 years old, 1980-2015)

Sexual Behavior in Adolescents
(age group: 13-15 years old)
Source: 2012 Global School Health Survey (GSHS), WHO.

RISK FACTORS

Sources:
GSHS - Global School Health Survey (WHO)
GYTS - Global Youth Tobacco Survey (PAHO)
OAS - Report on Drug Use in the Americas

Alcohol Use
Among students who ever drank alcohol, those that the first drink was before age 14 yrs
2012 GSHS 78.7% 73.3% 75.9%
Students who drank at least one drink containing alcohol 1+ of the past 30 days
2012 GSHS 49.3% 50.7% 50.0%
Binge drinking among secondary school students
2015 OAS 68.0% 59.1% 63.5%

Tobacco Use
Among students who ever smoked cigarettes, those that first tried cigarettes before age 14 yrs
2012 GSHS 77.0% 74.2% 73.3%
Prevalence of current use of any tobacco product
2012 GYTS 22.3% 25.4% 24.1%
Prevalence of current cigarette smokers
2012 GYTS 17.4% 21.5% 20.6%
Students who reported people smoked in their presence, past 7 days
2012 GSHS 76.9% 74.4% 73.4%

Overweight/Obesity/Diet
Students who usually drank carbonated soft drinks 1+ times per day the past 30 days
2012 GSHS 65.3% 66.4% 65.9%
Students who were overweight (> +1SD from median for BMI for age and sex)
2012 GSHS 35.9% 26.6%
Students who were obese (> +2SD from median for BMI for age and sex)
2012 GSHS 8.3% 3.6% 5.9%

Physical Activity
Students who went to physical education (PE) class 3+ days weekly in the school year
2012 GSHS 28.6% 23.3% 25.5%
Students who spent 3+ hours per day doing sitting activities
2012 GSHS 47.1% 53.4% 50.3%
Students physically active at least 60 minutes daily on 5+ days the past 7 days
2012 GSHS 35.3% 21.9% 28.3%

Drug Use
Among students who ever used drugs, those that first used drugs before age 14 yrs
2012 GSHS 81.8% 82.0%
Prevalence of cocaine use among secondary school students (lifetime)
2015 OAS 6.6% 4.0% 6.8%
Prevalence of marijuana use among secondary school students (lifetime)
2015 OAS 19.3% 9.4% 13.8%
Prevalence of inhalants use among secondary school students (lifetime)
2015 OAS 5.9% 3.3% 4.5%

Violence and Unintentional Injuries
Students seriously injured 1+ times during the past 12 months
2012 GSHS 42.1% 25.2% 33.3%
Students who were in a physical fight 1+ times the past 12 months
2012 GSHS 24.7% 34.3%
Students who were bullied 1+ days during the past 30 days
2012 GSHS 24.8% 24.2% 24.5%
Adolescent and Youth Health - 2017 Country Profile

**Aruba**

### POPULATION

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td>20-24</td>
<td>3,889</td>
<td>3,690</td>
<td>7,579</td>
</tr>
<tr>
<td>15-19</td>
<td>3,787</td>
<td>3,727</td>
<td>7,514</td>
</tr>
<tr>
<td>10-14</td>
<td>3,613</td>
<td>3,493</td>
<td>7,106</td>
</tr>
<tr>
<td>10-24</td>
<td>11,289</td>
<td>10,910</td>
<td>22,199</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: 21%

### ECONOMIC DEVELOPMENT


- **GDP per capita, PPP (current international $)**: 3,671.2 (2011)
- **GDP growth (annual %)**: -5.7 (2009)
- **Net enrollment rate, secondary (%)**: 73% (2011)

### EDUCATION PARTICIPATION


### MORTALITY TRENDS - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)


#### (10-14 years old)

- **N/A**: No mortality data reported for the specific age group
- **Road traffic injuries**: 60
- **Malignant neoplasm of brain**: 12.1

#### (15-19 years old)

- **Road traffic injuries**: 36.0
- **Malignant neoplasm of brain**: 26.7

#### (20-24 years old)

- **Congenital malformations**: 29.7
- **Assault (Homicide)**: 27.7
- **Road traffic injuries**: 27.7

### MORTALITY TRENDS - Four Leading Causes of Death, by Sex (per 100,000 Population)

**Source**: Global School Health Survey (GSHS), WHO.

#### Adolescent and Youth (10-24 years old), 2000-2014

- **Road traffic injuries**: Decrease
- **Assault (Homicide)**: Increase
- **Accidental drowning/submersion**: Increase
- **Intentional self-harm (Suicide)**: Increase

### MENTAL HEALTH

- **Students who ever seriously considered attempting suicide during the past 12 months**
- **Students who actually attempted suicide one or more times during the past 12 months**
- **Students who had no close friends**

### PROTECTIVE FACTORS

- **Students who missed classes or school without permission 1+ of the past 30 days**
- **Students whose parents usually understood their problems and worries the past 30 days**
- **Students whose parents really usually knew what they do with free time the past 30 days**

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Adolescent and Youth Health - 2017 Country Profile

**ARUBA**

### Sexual and Reproductive Health

#### Trends in Adolescent Fertility Rate
**Births per 1,000 women ages 15-19 years old, 1980-2015**


#### Sexual Behavior in Adolescents
**Age group: 13-15 years old**

*Source: Global School Health Survey (GSHS), WHO.*

- Students who ever had sexual intercourse
- Among students who ever had sexual intercourse, those that the first time was before age 14 yrs
- Among students who ever had sexual intercourse, those who used a condom the last time

### Risk Factors

#### Alcohol Use

- Students who drank at least one drink containing alcohol 1+ of the past 30 days
- Binge drinking among secondary school students
- Prevalence of alcohol use among secondary school students (past month)

#### Tobacco Use

- Prevalence of current cigarette smokers
- Prevalence of current use of any tobacco product
- Students who reported people smoked in their presence, past 7 days
- Among students who ever smoked cigarettes, those that first tried cigarettes before age 14 yrs

#### Overweight/Obesity/Diet

- Students who were overweight (> +1SD from median for BMI for age and sex)
- Students who were obese (> +2SD from median for BMI for age and sex)
- Students who usually drank carbonated soft drinks 1+ times per day the past 30 days

#### Physical Activity

- Students physically active at least 60 minutes daily on 5+ days the past 7 days
- Students who spent 3+ hours per day doing sitting activities
- Students who went to physical education (PE) class 3+ days weekly in the school year

#### Drug Use

- Students who used marijuana 1+ times during their life
- Prevalence of marijuana use among secondary school students
- Prevalence of cocaine use among secondary school students
- Prevalence of inhalants use among secondary school students

#### Violence and Unintentional Injuries

- Students seriously injured 1+ times during the past 12 months
- Students who were bullied 1+ days during the past 30 days
- Students who were in a physical fight 1+ times the past 12 months

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Adolescent and Youth Health - 2017 Country Profile
BAHAMS

**SEXUAL AND REPRODUCTIVE HEALTH**

**Trends in Adolescent Fertility Rate**
*(Births per 1,000 women ages 15-19 years old), 1980-2015*

**RISK FACTORS**

**Alcohol Use**

<table>
<thead>
<tr>
<th>Matter</th>
<th>2013 GSHS Male</th>
<th>2013 GSHS Female</th>
<th>2013 GSHS Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Among students who ever drank alcohol, those that the first drink was before age 14 yrs</td>
<td>24.5%</td>
<td>17.3%</td>
<td>21.1%</td>
</tr>
<tr>
<td>Students who drank at least one drink containing alcohol 1+ of the past 30 days</td>
<td>29.7%</td>
<td>27.2%</td>
<td>28.6%</td>
</tr>
<tr>
<td>Binge drinking among secondary school students</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevalence of alcohol use among secondary school students (past year)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Tobacco Use**

<table>
<thead>
<tr>
<th>Matter</th>
<th>2013 GYTS Male</th>
<th>2013 GYTS Female</th>
<th>2013 GYTS Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence of current use of any tobacco product</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Among students who ever smoked cigarettes, those that first tried cigarettes before age 14 yrs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Students who reported people smoked in their presence, past 7 days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevalence of tobacco use among secondary school students (past year)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Overweight/Obesity/Diet**

<table>
<thead>
<tr>
<th>Matter</th>
<th>2013 GSHS Male</th>
<th>2013 GSHS Female</th>
<th>2013 GSHS Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students who usually drank carbonated soft drinks 1+ times per day the past 30 days</td>
<td>67.2%</td>
<td>70.6%</td>
<td>69.0%</td>
</tr>
<tr>
<td>Students who were overweight (&gt; +1SD from median for BMI for age and sex)</td>
<td>42.0%</td>
<td>47.0%</td>
<td>44.7%</td>
</tr>
<tr>
<td>Students who were obese (&gt; +2SD from median for BMI for age and sex)</td>
<td>18.2%</td>
<td>23.6%</td>
<td>21.5%</td>
</tr>
</tbody>
</table>

**Physical Activity**

<table>
<thead>
<tr>
<th>Matter</th>
<th>2013 GSHS Male</th>
<th>2013 GSHS Female</th>
<th>2013 GSHS Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students who went to physical education (PE) class 3+ days weekly in the school year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Students who spent 3+ hours per day doing sitting activities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Students physically active at least 60 minutes daily on all 7 days during the past 7 days</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Drug Use**

<table>
<thead>
<tr>
<th>Matter</th>
<th>2013 GSHS Male</th>
<th>2013 GSHS Female</th>
<th>2013 GSHS Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Among students who ever used drugs, those that first used drugs before age 14 yrs</td>
<td>13.4%</td>
<td>7.6%</td>
<td>10.5%</td>
</tr>
<tr>
<td>Prevalence of cocaine use among secondary school students (lifetime)</td>
<td>9.1%</td>
<td>6.9%</td>
<td>8.5%</td>
</tr>
<tr>
<td>Prevalence of marijuana use among secondary school students (lifetime)</td>
<td>8.3%</td>
<td>8.3%</td>
<td>8.3%</td>
</tr>
<tr>
<td>Prevalence of inhalants use among secondary school students (lifetime)</td>
<td>8.7%</td>
<td>11.3%</td>
<td>10.5%</td>
</tr>
</tbody>
</table>

**Violence and Unintentional Injuries**

<table>
<thead>
<tr>
<th>Matter</th>
<th>2013 GSHS Male</th>
<th>2013 GSHS Female</th>
<th>2013 GSHS Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students who were in a physical fight 1+ times the past 12 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Students who were bullied 1+ days during the past 30 days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Students seriously injured 1+ times during the past 12 months</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Adolescent and Youth Health - 2017 Country Profile**

**Barbados**

**Sexual and Reproductive Health**

**Trends in Adolescent Fertility Rate**
(Births per 1,000 women ages 15-19 years old, 1980-2015)

**Sexual Behavior in Adolescents**
(age group: 13-15 years old)
- Source: 2011 Global School Health Survey (GSHS), WHO.

**Risk Factors**

- Alcohol Use
  - Among students who ever drank alcohol, those that the first drink was before age 14 yrs
  - Students who drank at least one drink containing alcohol 1+ of the past 30 days
  - Binge drinking among secondary school students

- Tobacco Use
  - Prevalence of current use of any tobacco product
  - Students who reported people smoked in their presence, past 7 days
  - Among students who ever smoked cigarettes, those that first tried cigarettes before age 14 yrs

- Overweight/Obesity/Diet
  - Students who usually drank carbonated soft drinks 1+ times per day the past 30 days
  - Students who were overweight (> +1SD from median for BMI for age and sex)
  - Students who were obese (> +2SD from median for BMI for age and sex)

- Physical Activity
  - Students who went to physical education (PE) class 3+ days weekly in the school year
  - Students who spent 3+ hours per day doing sitting activities
  - Students physically active at least 60 minutes daily on 5+ days the past 7 days

- Drug Use
  - Among students who ever used drugs, those that first used drugs before age 14 yrs
  - Prevalence of cocaine use among secondary school students (lifetime)
  - Prevalence of marijuana use among secondary school students (lifetime)
  - Prevalence of inhalants use among secondary school students (lifetime)

- Violence and Unintentional Injuries
  - Students seriously injured 1+ times during the past 12 months
  - Students who were in a physical fight 1+ times the past 12 months
  - Students who were bullied 1+ days during the past 30 days

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Adolescent and Youth Health - 2017 Country Profile

BELIZE

POPULATION


<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
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<tbody>
<tr>
<td>20-24</td>
<td>18,238</td>
<td>18,322</td>
<td>36,560</td>
</tr>
<tr>
<td>15-19</td>
<td>19,446</td>
<td>19,472</td>
<td>38,918</td>
</tr>
<tr>
<td>10-14</td>
<td>19,742</td>
<td>19,418</td>
<td>39,160</td>
</tr>
<tr>
<td>10-24</td>
<td>57,426</td>
<td>57,212</td>
<td>114,638</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: 31%

ECONOMIC DEVELOPMENT


GDP per capita, PPP (2015)

GDP growth (annual %) 3.100.0 (2016) -0.8 (2016)

MORTALITY TRENDS - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)


Note: * If there is no cause of death reported for a specific age group and sex, the corresponding bar with zero value is not being represented.

MORTALITY RATES - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)


EDUCATION PARTICIPATION

Net enrollment rate, secondary (%) (2015)

MENTAL HEALTH

Source: 2011 Global School Health Survey (GSHS), WHO.

Percentage of students who ever seriously considered attempting suicide during the past 12 months

Students who actually attempted suicide one or more times during the past 12 months

Students who had no close friends

PROTECTIVE FACTORS

Source: 2011 Global School Health Survey (GSHS), WHO.

Students who missed classes or school without permission 1+ of the past 30 days

Students whose parents usually understood their problems and worries the past 30 days

Students whose parents really usually knew what they do with free time the past 30 days

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**Belize**

### Sexual and Reproductive Health

#### Trends in Adolescent Fertility Rate

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Belize</td>
<td>46</td>
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<td>70</td>
<td>46</td>
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<tr>
<td>Latin America and the Caribbean</td>
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<tr>
<td>North America</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>World</td>
<td>67.4%</td>
<td>67.5%</td>
<td>67.5%</td>
<td>67.5%</td>
<td>67.5%</td>
<td>67.5%</td>
<td>67.5%</td>
</tr>
</tbody>
</table>


#### Sexual Behavior in Adolescents

<table>
<thead>
<tr>
<th>Age group</th>
<th>13-15 years old</th>
<th>16-19 years old</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students who ever had sexual intercourse</td>
<td>13.5%</td>
<td>32.9%</td>
</tr>
<tr>
<td>Among students who ever had sexual intercourse</td>
<td>23.1%</td>
<td>67.5%</td>
</tr>
<tr>
<td>Among students who ever had sexual intercourse, those who used a condom the last time</td>
<td>67.4%</td>
<td>67.5%</td>
</tr>
</tbody>
</table>

Source: 2011 Global School Health Survey (GSHS), WHO.

### Risk Factors

#### Alcohol Use

- Among students who ever drank alcohol, those that the first drink was before age 14 yrs
  - 2011 GSHS: Male 80.2%, Female 78.0%, Total 79.2%
  - 2011 GSHS: Male 29.4%, Female 26.6%, Total 27.9%

- Students who drank at least one drink containing alcohol 1+ of the past 30 days
  - 2011 GSHS: Male 69.5%, Female 64.9%, Total 67.2%

- Binge drinking among secondary school students
  - 2015 OAS: Male 31.5%, Female 26.5%, Total 29.0%

Source: GSHS - Global School Health Survey (WHO), GYTS - Global Youth Tobacco Survey (PAHO), OAS - Report on Drug Use in the Americas.

#### Tobacco Use

- Prevalence of current use of any tobacco product
  - 2014 GYTS: Male 16.6%, Female 8.2%, Total 12.3%

- Prevalence of current cigarette smokers
  - 2014 GYTS: Male 10.4%, Female 5.4%, Total 7.8%

- Prevalence of tobacco use among secondary school students (past year)
  - 2015 OAS: Male 19.7%, Female 9.3%, Total 14.4%

#### Overweight/Obesity/Diet

- Students who usually drank carbonated soft drinks 1+ times per day the past 30 days
  - 2011 GSHS: Male 67.0%, Female 66.7%, Total 66.9%

- Students who were overweight (> +1SD from median for BMI for age and sex)
  - 2011 GSHS: Male 32.3%, Female 38.1%, Total 35.8%

- Students who were obese (> +2SD from median for BMI for age and sex)
  - 2011 GSHS: Male 12.5%, Female 12.6%, Total 12.5%

#### Physical Activity

- Students who went to physical education (PE) class 3+ days weekly in the school year
  - 2011 GSHS: Male 22.4%, Female 18.8%, Total 20.5%

- Students who spent 3+ hours per day doing sitting activities
  - 2011 GSHS: Male 30.8%, Female 42.7%, Total 36.8%

- Students physically active at least 60 minutes daily on 5+ days the past 7 days
  - 2011 GSHS: Male 32.5%, Female 25.6%, Total 29.0%

#### Drug Use

- Among students who ever used drugs, those that first used drugs before age ...
  - 2011 GSHS: Male 78.0%, Female 77.5%

- Prevalence of cocaine use among secondary school students (lifetime)
  - 2015 OAS: Male 3.8%, Female 2.2%

- Prevalence of marijuana use among secondary school students (lifetime)
  - 2015 OAS: Male 17.1%, Female 24.3%

- Prevalence of inhalants use among secondary school students (lifetime)
  - 2015 OAS: Male 10.5%, Female 9.8%

#### Violence and Unintentional Injuries

- Students seriously injured 1+ times during the past 12 months
  - 2011 GSHS: Male 49.1%, Female 41.1%

- Students who were in a physical fight 1+ times the past 12 months
  - 2011 GSHS: Male 42.7%, Female 36.0%

- Students who were bullied 1+ days during the past 30 days
  - 2011 GSHS: Male 30.3%, Female 31.1%
Adolescent and Youth Health - 2017 Country Profile

**Bermuda**

**Population**

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>2,183</td>
<td>2,132</td>
<td>4,315</td>
</tr>
<tr>
<td>15-19</td>
<td>2,128</td>
<td>2,126</td>
<td>4,254</td>
</tr>
<tr>
<td>10-14</td>
<td>2,122</td>
<td>2,067</td>
<td>4,189</td>
</tr>
<tr>
<td>Total</td>
<td>6,433</td>
<td>6,325</td>
<td>12,758</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: 18%

**Economic Development**

- GDP per capita, PPP (current international $): 3,408.0 (2013)
- GDP growth (annual %): -3.0 (2013)
- Net enrollment rate, secondary (%): (2011)

**Mortality Trends - Leading Causes of Death, by Age Group and Sex (per 100,000 Population)**

- (10-14 years old): N/A. No mortality data reported for the specific age group
- (15-19 years old): Road traffic injuries
- (20-24 years old): Assault (Homicide), Road traffic injuries

**Mental Health**

- Students who ever seriously considered attempting suicide during the past 12 months
- Students who actually attempted suicide one or more times during the past 12 months
- Students who had no close friends

**Protective Factors**

- Students who missed classes or school without permission 1+ of the past 30 days
- Students whose parents usually knew what they do with free time the past 30 days
- Students whose parents usually understood their problems and worries the past 30 days

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### Sexual and Reproductive Health

#### Trends in Adolescent Fertility Rate

(Births per 1,000 women ages 15-19 years old), 1980-2015


#### Sexual Behavior in Adolescents

(age group: 13-15 years old)

- **Source:** Global School Health Survey (GSHS), WHO.

<table>
<thead>
<tr>
<th>Year</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980-1985</td>
<td>67</td>
<td>46</td>
<td>28</td>
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<tr>
<td>2005-2010</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2010-2015</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Risk Factors

**Source:** National School Survey, Ministry of Health and Seniors (MOH), Bermuda, 2015.

*No country data available at: GSHS - Global School Health Survey (WHO); GYTS - Global Youth Tobacco Survey (PAHO); OAS - Report on Drug Use in the Americas*

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students who drank at least one drink containing alcohol 1+ of the past 30 days</td>
<td>4.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Binge drinking among secondary school students</td>
<td>24.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevalence of alcohol use among secondary school students (past month)</td>
<td>66.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Students who were overweight (+1 SD from median for BMI for age and sex)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Students who were obese (+2 SD from median for BMI for age and sex)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Students who usually drank carbonated soft drinks 1+ times per day the past 30 days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Students who used marijuana 1+ times during their life</td>
<td>26.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevalence of marijuana use among secondary school students</td>
<td>67.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevalence of cocaine use among secondary school students</td>
<td>1.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevalence of inhalants use among secondary school students</td>
<td>12.3%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Adolescent and Youth Health - 2017 Country Profile

VENEZUELA, Bolivarian Republic of

### POPULATION


<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>1,382,481</td>
<td>1,352,571</td>
<td>2,735,052</td>
</tr>
<tr>
<td>15-19</td>
<td>1,418,723</td>
<td>1,368,909</td>
<td>2,787,632</td>
</tr>
<tr>
<td>10-14</td>
<td>1,465,290</td>
<td>1,406,990</td>
<td>2,872,280</td>
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<tr>
<td>10-24</td>
<td>4,266,494</td>
<td>4,128,470</td>
<td>8,394,964</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: 27%

### ECONOMIC DEVELOPMENT


- GDP per capita, PPP (current international $): 554,246.4 (2013)
- GDP growth (annual %): 1.3 (2013)

### MORTALITY RATES - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)


#### (10-14 years old)

- Road traffic injuries
- Assault (Homicide)
- Malignant neoplasms, of lymphoid, haematopoietic and related tissue
- Congenital malformations

#### (15-19 years old)

- Road traffic injuries
- Assault (Homicide)
- Malignant neoplasms, of lymphoid, haematopoietic and related tissue
- Congenital malformations

#### (20-24 years old)

- Road traffic injuries
- Assault (Homicide)
- Malignant neoplasms, of lymphoid, haematopoietic and related tissue
- (HIV) diseases

### MORTALITY TRENDS - Four Leading Causes of Death, by Sex (per 100,000 Population)

#### Adolescent and Youth (10-24 years old), 2000-2013

- Assault (Homicide)
- Road traffic injuries
- Accidental drowning/submersion
- Malignant neoplasms, of lymphoid, haematopoietic and related tissue

### MENTAL HEALTH

Source: Global School Health Survey (GSHS), WHO.

- Students who ever seriously considered attempting suicide during the past 12 months
- Students who actually attempted suicide one or more times during the past 12 months
- Students who had no close friends
- Students who missed classes or school without permission 1+ of the past 30 days
- Students whose parents usually understood their problems and worried the past 30 days
- Students whose parents really usually knew what they do with free time the past 30 days

### PROTECTIVE FACTORS

Source: Global School Health Survey (GSHS), WHO.

- Available
- No Data Available
Adolescent and Youth Health - 2017 Country Profile

VENEZUELA, Bolivarian Republic of

SEXUAL AND REPRODUCTIVE HEALTH

### Trends in Adolescent Fertility Rate
(Births per 1,000 women ages 15-19 years old, 1980-2015)

- **Source:** United Nations Population Division.
- **Source:** World Population Prospects: The 2015 Revision.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Venezuela</td>
<td>81.0</td>
<td>76.0</td>
<td>71.0</td>
<td>66.0</td>
<td>61.0</td>
<td>56.0</td>
<td>51.0</td>
</tr>
<tr>
<td>North America</td>
<td>67.0</td>
<td>62.0</td>
<td>57.0</td>
<td>52.0</td>
<td>47.0</td>
<td>42.0</td>
<td>37.0</td>
</tr>
<tr>
<td>Latin America and the Caribbean</td>
<td>46.0</td>
<td>41.0</td>
<td>36.0</td>
<td>31.0</td>
<td>26.0</td>
<td>21.0</td>
<td>16.0</td>
</tr>
<tr>
<td>World</td>
<td>28.0</td>
<td>23.0</td>
<td>18.0</td>
<td>13.0</td>
<td>8.0</td>
<td>3.0</td>
<td>1.0</td>
</tr>
</tbody>
</table>

### Sexual Behavior in Adolescents
(age group: 13-15 years old)

- **Source:** Global School Health Survey (GSHS), WHO.

#### Students who ever had sexual intercourse
No Data Available

#### Among students who ever had sexual intercourse, those that the first time was before age 14 yrs
No Data Available

#### Students who ever had sexual intercourse, those who used a condom the last time
No Data Available

### Risk Factors

#### Alcohol Use

- **Prevalence of alcohol use among secondary school students (past year)**
  - **2015 OAS**
    - **Male:** 31.7%
    - **Female:** 28.7%
    - **Total:** 30.1%

- **Prevalence of alcohol use among secondary school students (past month)**
  - **2015 OAS**
    - **Male:** 19.9%
    - **Female:** 16.2%
    - **Total:** 17.9%

#### Tobacco Use

- **Prevalence of current use of any tobacco product**
  - **2010 GYTS**
    - **Male:** 11.0%
    - **Female:** 7.2%
    - **Total:** 9.4%

- **Prevalence of current cigarette smokers**
  - **2010 GYTS**
    - **Male:** 5.8%
    - **Female:** 5.4%
    - **Total:** 5.6%

- **Prevalence of tobacco use among secondary school students (past year)**
  - **2015 OAS**
    - **Male:** 4.8%
    - **Female:** 4.6%
    - **Total:** 4.7%

#### Overweight/Obesity/Diet

- **Students who were overweight (≥ +1SD from median for BMI for age and sex)**
  - No Data Available

- **Students who were obese (≥ +2SD from median for BMI for age and sex)**
  - No Data Available

- **Students who usually drank carbonated soft drinks 1+ times per day the past 30 days**
  - No Data Available

#### Physical Activity

- **Students physically active at least 60 minutes daily on 5+ days the past 7 days**
  - No Data Available

- **Students who spent 3+ hours per day doing sitting activities**
  - No Data Available

- **Students who went to physical education (PE) class 3+ days weekly in the school year**
  - No Data Available

#### Drug Use

- **Prevalence of cocaine use among secondary school students (lifetime)**
  - **2015 OAS**
    - **Male:** 1.4%
    - **Female:** 1.0%
    - **Total:** 1.1%

- **Prevalence of marijuana use among secondary school students (lifetime)**
  - **2015 OAS**
    - **Male:** 2.6%
    - **Female:** 1.7%
    - **Total:** 2.1%

- **Prevalence of marijuana use among secondary school students (past year)**
  - **2015 OAS**
    - **Male:** 0.5%
    - **Female:** 0.9%
    - **Total:** 0.7%

#### Violence and Unintentional Injuries

- **Students seriously injured 1+ times during the past 12 months**
  - No Data Available

- **Students who were bullied 1+ days during the past 30 days**
  - No Data Available

- **Students who were in a physical fight 1+ times the past 12 months**
  - No Data Available

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Adolescent and Youth Health - 2017 Country Profile
BOLIVIA

POPULATION


<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>506,365</td>
<td>495,387</td>
<td>1,001,752</td>
</tr>
<tr>
<td>15-19</td>
<td>553,809</td>
<td>537,761</td>
<td>1,091,570</td>
</tr>
<tr>
<td>10-14</td>
<td>578,263</td>
<td>559,323</td>
<td>1,137,586</td>
</tr>
<tr>
<td>10-24</td>
<td>1,638,437</td>
<td>1,592,471</td>
<td>3,230,908</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: 30%

ECONOMIC DEVELOPMENT


GDP per capita, PPP (current international $) 78,786.0 (2016)
GDP growth (annual %) 4.0 (2016)
Net enrollment rate, secondary (%) (2015) 77% 78%

MORTALITY RATES - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)


(10-14 years old)

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidental threats to breathing</td>
<td>10.5</td>
<td>10.3</td>
<td>10.4</td>
</tr>
<tr>
<td>Accidental drowning/submersion</td>
<td>5.4</td>
<td>4.8</td>
<td>5.2</td>
</tr>
<tr>
<td>Acute upper respiratory infections (except influenza and pneumonia)</td>
<td>2.9</td>
<td>2.7</td>
<td>2.8</td>
</tr>
<tr>
<td>Congenital malformations</td>
<td>0.4</td>
<td>0.3</td>
<td>0.4</td>
</tr>
<tr>
<td>Septicaemia</td>
<td>0.2</td>
<td>0.2</td>
<td>0.2</td>
</tr>
</tbody>
</table>

(15-19 years old)

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidental threats to breathing</td>
<td>8.5</td>
<td>7.6</td>
<td>8.0</td>
</tr>
<tr>
<td>Accidental drowning/submersion</td>
<td>3.0</td>
<td>2.7</td>
<td>2.9</td>
</tr>
<tr>
<td>Accidental poisoning by and exposure to noxious substances</td>
<td>1.7</td>
<td>1.5</td>
<td>1.6</td>
</tr>
</tbody>
</table>

(20-24 years old)

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidental threats to breathing</td>
<td>9.5</td>
<td>7.6</td>
<td>8.0</td>
</tr>
<tr>
<td>Accidental poisoning by and exposure to noxious substances</td>
<td>6.0</td>
<td>5.6</td>
<td>5.8</td>
</tr>
<tr>
<td>Septicaemia</td>
<td>3.4</td>
<td>3.4</td>
<td>3.4</td>
</tr>
<tr>
<td>Influenza and Pneumonia</td>
<td>1.5</td>
<td>1.5</td>
<td>1.5</td>
</tr>
</tbody>
</table>

MORTALITY TRENDS - Four Leading Causes of Death, by Sex (per 100,000 Population)

Adolescent and Youth (10-24 years old), 1995-2003

MENTAL HEALTH

Source: 2012 Global School Health Survey (GSHS), WHO.

Percentage of students who ever seriously considered attempting suicide during the past 12 months

<table>
<thead>
<tr>
<th>Year</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>11.9</td>
<td>22.0</td>
<td>17.5</td>
</tr>
<tr>
<td>1997</td>
<td>18.3</td>
<td>25.3</td>
<td>22.5</td>
</tr>
<tr>
<td>1999</td>
<td>19.5</td>
<td>24.2</td>
<td>21.9</td>
</tr>
<tr>
<td>2001</td>
<td>19.5</td>
<td>24.2</td>
<td>21.9</td>
</tr>
<tr>
<td>2003</td>
<td>18.2</td>
<td>23.0</td>
<td>20.6</td>
</tr>
</tbody>
</table>

Students who actually attempted suicide one or more times during the past 12 months

<table>
<thead>
<tr>
<th>Year</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>8.2</td>
<td>7.9</td>
<td>8.0</td>
</tr>
<tr>
<td>1997</td>
<td>8.2</td>
<td>7.9</td>
<td>8.0</td>
</tr>
<tr>
<td>1999</td>
<td>8.2</td>
<td>7.9</td>
<td>8.0</td>
</tr>
<tr>
<td>2001</td>
<td>8.2</td>
<td>7.9</td>
<td>8.0</td>
</tr>
<tr>
<td>2003</td>
<td>8.2</td>
<td>7.9</td>
<td>8.0</td>
</tr>
</tbody>
</table>

Students who had no close friends

<table>
<thead>
<tr>
<th>Year</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>30.8</td>
<td>31.3</td>
<td>31.0</td>
</tr>
<tr>
<td>1997</td>
<td>32.5</td>
<td>32.5</td>
<td>32.5</td>
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<tr>
<td>1999</td>
<td>31.3</td>
<td>32.0</td>
<td>31.7</td>
</tr>
<tr>
<td>2001</td>
<td>35.8</td>
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</tr>
<tr>
<td>2003</td>
<td>35.8</td>
<td>39.8</td>
<td>37.7</td>
</tr>
</tbody>
</table>

PROTECTIVE FACTORS

Source: 2012 Global School Health Survey (GSHS), WHO.

Students who missed classes or school without permission 1+ of the past 30 days

<table>
<thead>
<tr>
<th>Year</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>1</td>
<td>2</td>
<td>1.5</td>
</tr>
<tr>
<td>1997</td>
<td>2</td>
<td>3</td>
<td>2.5</td>
</tr>
<tr>
<td>1999</td>
<td>3</td>
<td>4</td>
<td>3.5</td>
</tr>
<tr>
<td>2001</td>
<td>4</td>
<td>5</td>
<td>4.5</td>
</tr>
<tr>
<td>2003</td>
<td>5</td>
<td>6</td>
<td>5.5</td>
</tr>
</tbody>
</table>

Students who usually understood their problems and worries the past 30 days

<table>
<thead>
<tr>
<th>Year</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>11</td>
<td>12</td>
<td>11.5</td>
</tr>
<tr>
<td>1997</td>
<td>11</td>
<td>12</td>
<td>11.5</td>
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<td>2001</td>
<td>11</td>
<td>12</td>
<td>11.5</td>
</tr>
<tr>
<td>2003</td>
<td>11</td>
<td>12</td>
<td>11.5</td>
</tr>
</tbody>
</table>

Students whose parents usually knew what they do with free time the past 30 days

<table>
<thead>
<tr>
<th>Year</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>11.9</td>
<td>22.0</td>
<td>17.5</td>
</tr>
<tr>
<td>1997</td>
<td>18.3</td>
<td>25.3</td>
<td>22.5</td>
</tr>
<tr>
<td>1999</td>
<td>19.5</td>
<td>24.2</td>
<td>21.9</td>
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<tr>
<td>2001</td>
<td>19.5</td>
<td>24.2</td>
<td>21.9</td>
</tr>
<tr>
<td>2003</td>
<td>18.2</td>
<td>23.0</td>
<td>20.6</td>
</tr>
</tbody>
</table>

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Adolescent and Youth Health - 2017 Country Profile

BRAZIL

POPULATION


<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>8,461,108</td>
<td>8,235,819</td>
<td>16,696,927</td>
</tr>
<tr>
<td>15-19</td>
<td>8,927,819</td>
<td>8,626,413</td>
<td>17,554,232</td>
</tr>
<tr>
<td>10-14</td>
<td>8,714,125</td>
<td>8,388,691</td>
<td>17,102,816</td>
</tr>
<tr>
<td>10-24</td>
<td>26,103,052</td>
<td>25,250,923</td>
<td>51,353,975</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: 25%

ECONOMIC DEVELOPMENT


- GDP per capita, PPP (current international $): $3,141,333.0 (2016)
- GDP growth (annual %): -4.0 (2016)

EDUCATION PARTICIPATION

- Net enrollment rate, secondary (%): 80% (2015)

MORTALITY RATES - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)


<table>
<thead>
<tr>
<th>Age Group</th>
<th>(10-14 years old)</th>
<th>(15-19 years old)</th>
<th>(20-24 years old)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Assault (Homicide)</td>
<td>Road traffic injuries</td>
<td>Accidental drowning/submersion</td>
</tr>
<tr>
<td>(10-14 years old)</td>
<td>Assault</td>
<td>0.64</td>
<td>0.81</td>
</tr>
<tr>
<td>(15-19 years old)</td>
<td>Assault</td>
<td>1.90</td>
<td>1.89</td>
</tr>
<tr>
<td>(20-24 years old)</td>
<td>Assault</td>
<td>4.00</td>
<td>3.40</td>
</tr>
</tbody>
</table>

MORTALITY TRENDS - Four Leading Causes of Death, by Sex (per 100,000 Population)

Source: Global School Health Survey (GSHS), WHO.

MENTAL HEALTH

- Students who ever seriously considered attempting suicide during the past 12 months
- Students who actually attempted suicide one or more times during the past 12 months
- Students who had no close friends

PROTECTIVE FACTORS

Source: Global School Health Survey (GSHS), WHO.

- Students who missed classes or school without permission 1+ of the past 30 days
- Students whose parents usually understood their problems and worries the past 30 days

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# Sexual and Reproductive Health

**Trends in Adolescent Fertility Rate**

<table>
<thead>
<tr>
<th>Region</th>
<th>Brazil</th>
<th>North America</th>
<th>World</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980-1985</td>
<td>68</td>
<td>143</td>
<td>100</td>
</tr>
<tr>
<td>1985-1990</td>
<td>67</td>
<td>146</td>
<td>100</td>
</tr>
<tr>
<td>1990-1995</td>
<td>46</td>
<td>130</td>
<td>100</td>
</tr>
<tr>
<td>1995-2000</td>
<td>28</td>
<td>99</td>
<td>100</td>
</tr>
<tr>
<td>2000-2005</td>
<td></td>
<td>77</td>
<td>100</td>
</tr>
<tr>
<td>2005-2010</td>
<td></td>
<td>87</td>
<td>100</td>
</tr>
<tr>
<td>2010-2015</td>
<td></td>
<td>87</td>
<td>100</td>
</tr>
</tbody>
</table>


## Overweight/Obesity/Diet

- **Students who were overweight (> +1SD from median for BMI for age and sex):**
  - Male 2015 (BNS): 15.3%
  - Female 2015 (BNS): 16.5%
  - Total 2015 (BNS): 15.9%

- **Students who were obese (> +2SD from median for BMI for age and sex):**
  - Male 2015 (BNS): 8.3%
  - Female 2015 (BNS): 7.3%
  - Total 2015 (BNS): 7.8%

- **Total percentage of students who were overweight (%):**
  - Male 2015 (BNS): 23.8%
  - Female 2015 (BNS): 23.7%
  - Total 2015 (BNS): 23.7%

## Drug Use

- **Prevalence of marijuana use among secondary school students during the past 30 days (%):**
  - Male 2015 (BNS): 5.8%
  - Female 2015 (BNS): 4.8%

- **Prevalence of cocaine use among secondary school students (lifetime):**
  - Male 2015 OAS: 3.9%
  - Female 2015 OAS: 5.7%

- **Prevalence of marijuana use among secondary school students (lifetime):**
  - Male 2015 OAS: 5.7%
  - Female 2015 OAS: 8.7%

## Alcohol Use

- **Students who drank at least one drink containing alcohol 1+ of the past 30 days:**
  - Male 2015 (BNS): 28.4%
  - Female 2015 (BNS): 30.3%

## Tobacco Use

- **Students who smoked cigarettes 1+ days during the past 30 days:**
  - Male 2015 (BNS): 7.1%
  - Female 2015 (BNS): 6.0%

- **Percentage of students who used any tobacco product during the past 30 days:**
  - Male 2015 (BNS): 7.1%
  - Female 2015 (BNS): 7.3%

- **Students who reported people smoked in their presence, past 7 days:**
  - Male 2015 (BNS): 49.6%
  - Female 2015 (BNS): 51.8%

## Physical Activity

- **Students who went to physical education (PE) class 3+ days weekly in the school year:**
  - Male 2015 (BNS): 4.7%
  - Female 2015 (BNS): 19.7%

- **Students who spent 3+ hours per day doing sitting activities:**
  - Male 2015 (BNS): 51.9%
  - Female 2015 (BNS): 54.0%

## Violence and Unintentional Injuries

- **Students seriously injured 1+ times during the past 12 months:**
  - Male 2015 (BNS): 18.4%
  - Female 2015 (BNS): 15.4%

- **Students who were bullied 1+ days during the past 30 days:**
  - Male 2015 (BNS): 38.7%
  - Female 2015 (BNS): 28.7%

Adolescent and Youth Health - 2017 Country Profile

CANADA

POPULATION


<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>1,265,326</td>
<td>1,211,796</td>
<td>2,477,122</td>
</tr>
<tr>
<td>15-19</td>
<td>1,064,668</td>
<td>1,005,839</td>
<td>2,070,507</td>
</tr>
<tr>
<td>10-14</td>
<td>962,510</td>
<td>912,098</td>
<td>1,874,608</td>
</tr>
<tr>
<td>10-24</td>
<td>3,292,504</td>
<td>3,129,733</td>
<td>6,422,237</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: 18%

ECONOMIC DEVELOPMENT


GDP per capita, PPP (current international $) 1,597,516.5 (2016)
GDP growth (annual%) 1.5 (2016)
Gross enrollment ratio, secondary (%) (2013)

EDUCATION PARTICIPATION

MORTALITY RATES - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)


(10-14 years old)

- Road traffic injuries
- Intentional self-harm (Suicide)
- Congenital malformations
- Malignant neoplasms, of lymphoid, haematopoietic and related tissue

(15-19 years old)

- Road traffic injuries
- Intentional self-harm (Suicide)
- Assault (Homicide)
- Accidental poisoning by exposure to noxious substances

(20-24 years old)

- Road traffic injuries
- Intentional self-harm (Suicide)
- Assault (Homicide)
- Accidental poisoning by exposure to noxious substances

MORTALITY TRENDS - Four Leading Causes of Death, by Sex (per 100,000 Population)

Source: Global School Health Survey (GSHS), WHO.

MENTAL HEALTH

- Students who ever seriously considered attempting suicide during the past 12 months
- Students who actually attempted suicide one or more times during the past 12 months
- Students who had no close friends

PROTECTIVE FACTORS

- Students who missed classes or school without permission 1+ of the past 30 days
- Students whose parents really usually knew what they do with free time the past 30 days
- Students whose parents usually understood their problems and worries the past 30 days

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**Adolescent and Youth Health - 2017 Country Profile**

**CAYMAN ISLANDS**

### POPULATION

**Adolescent and Youth Population**

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>1,826</td>
<td>1,889</td>
<td>3,715</td>
</tr>
<tr>
<td>15-19</td>
<td>1,751</td>
<td>1,746</td>
<td>3,497</td>
</tr>
<tr>
<td>10-14</td>
<td>1,711</td>
<td>1,691</td>
<td>3,402</td>
</tr>
<tr>
<td>10-24</td>
<td>5,288</td>
<td>5,326</td>
<td>10,614</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: **19%**

### ECONOMIC DEVELOPMENT

**GDP per capita, PPP (current international $)**

- **2,823.5** (2011)

**GDP growth (annual %)**

- **5.3** (1994)

**School enrollment, secondary**

- N/A

### MORTALITY RATES - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)


#### (10-14 years old)

- Accidental drowning/submersion: 18.91
- Assault (Homicide): 18.91
- Malignant neoplasm of brain: 18.91

#### (15-19 years old)

- Road traffic injuries: 37.8
- Accidental drowning/submersion: 37.8
- Assault (Homicide): 37.8

#### (20-24 years old)

- Road traffic injuries: 37.8
- Accidental drowning/submersion: 37.8
- Assault (Homicide): 37.8

### MORTALITY TRENDS - Four Leading Causes of Death, by Sex (per 100,000 Population)

**Adolescent and Youth (10-24 years old), 2000-2013**

#### MENTAL HEALTH

**Source:** 2007 Global School Health Survey (GSHS), WHO.

- Percentage of students who ever seriously considered attempting suicide during the past 12 months
  - Male: 13.2
  - Female: 25.5
  - Total: 18.4

- Students who had no close friends
  - Male: 9.2
  - Female: 3.6
  - Total: 6.6

#### PROTECTIVE FACTORS

**Source:** 2007 Global School Health Survey (GSHS), WHO.

- Students who missed classes or school without permission 1+ of the past 30 days
  - Male: 18.4
  - Female: 14.3
  - Total: 18.4

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### Sexual and Reproductive Health

#### Trends in Adolescent Fertility Rate
(Births per 1,000 women ages 15-19 years old, 1980-2015)

<table>
<thead>
<tr>
<th>Year</th>
<th>Latin America and the Caribbean</th>
<th>North America</th>
<th>World</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980-1985</td>
<td>67</td>
<td>46</td>
<td>28</td>
</tr>
<tr>
<td>1985-1990</td>
<td>50</td>
<td>36</td>
<td>21</td>
</tr>
<tr>
<td>1990-1995</td>
<td>40</td>
<td>30</td>
<td>15</td>
</tr>
<tr>
<td>1995-2000</td>
<td>30</td>
<td>21</td>
<td>9</td>
</tr>
<tr>
<td>2000-2005</td>
<td>20</td>
<td>16</td>
<td>6</td>
</tr>
<tr>
<td>2005-2010</td>
<td>10</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>2010-2015</td>
<td>5</td>
<td>5</td>
<td>3</td>
</tr>
</tbody>
</table>

* No Country Data

#### Sources:
- GSHS - Global School Health Survey (WHO)
- GYTS - Global Youth Tobacco Survey (PAHO)
- OAS - Report on Drug Use in the Americas

---

### Risk Factors

#### Alcohol Use

<table>
<thead>
<tr>
<th>Description</th>
<th>2007 GSHS</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students who drank at least one drink containing alcohol 1+ of the past 30 days</td>
<td>41.4%</td>
<td>36.9%</td>
<td>39.4%</td>
<td></td>
</tr>
<tr>
<td>Students who drank so much alcohol that they were really drunk 1+ times during their life</td>
<td>27.7%</td>
<td>27.9%</td>
<td>28.0%</td>
<td></td>
</tr>
<tr>
<td>Students who had a hang-over, missed school or inappropriate behavior one or more times as a result of drinking alcohol during their life</td>
<td>21.2%</td>
<td>18.9%</td>
<td>20.2%</td>
<td></td>
</tr>
</tbody>
</table>

#### Tobacco Use

<table>
<thead>
<tr>
<th>Description</th>
<th>2007 GSHS</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students who smoked cigarettes 1+ days during the past 30 days</td>
<td>13.5%</td>
<td>7.8%</td>
<td>10.9%</td>
<td></td>
</tr>
<tr>
<td>Students who reported people smoked in their presence, past 7 days</td>
<td>54.2%</td>
<td>52.4%</td>
<td>53.2%</td>
<td></td>
</tr>
</tbody>
</table>

#### Overweight/Obesity/Diet

- Students who were overweight (+1SD from median for BMI for age and sex)
- Students who were obese (+2SD from median for BMI for age and sex)
- Students who usually drank carbonated soft drinks 1+ times per day the past 30 days

**No Data Available**

#### Physical Activity

<table>
<thead>
<tr>
<th>Description</th>
<th>2007 GSHS</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of students who were physically active for a total of at least 60 minutes per day on all 7 days during the past 7 days</td>
<td>19.8%</td>
<td>11.7%</td>
<td>16.0%</td>
<td></td>
</tr>
<tr>
<td>Students who spent 3+ hours per day doing sitting activities</td>
<td>51.1%</td>
<td>63.4%</td>
<td>57.0%</td>
<td></td>
</tr>
</tbody>
</table>

#### Drug Use

<table>
<thead>
<tr>
<th>Description</th>
<th>2007 GSHS</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of students who used drugs one or more times during their life</td>
<td>20.3%</td>
<td>10.3%</td>
<td>15.6%</td>
<td></td>
</tr>
</tbody>
</table>

#### Violence and Unintentional Injuries

<table>
<thead>
<tr>
<th>Description</th>
<th>2007 GSHS</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students who were physically attacked one or more times during the past 12 months</td>
<td>41.9%</td>
<td>31.8%</td>
<td>36.9%</td>
<td></td>
</tr>
<tr>
<td>Students who were in a physical fight 1+ times the past 12 months</td>
<td>52.9%</td>
<td>32.2%</td>
<td>42.5%</td>
<td></td>
</tr>
<tr>
<td>Students seriously injured 1+ times during the past 12 months</td>
<td>56.5%</td>
<td>50.2%</td>
<td>53.2%</td>
<td></td>
</tr>
<tr>
<td>Students who were bullied 1+ days during the past 30 days</td>
<td>24.4%</td>
<td>28.2%</td>
<td>26.3%</td>
<td></td>
</tr>
</tbody>
</table>
Adolescent and Youth Health - 2017 Country Profile

Chile

**Population**

**Adolescent and Youth Population**

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>722,599</td>
<td>683,516</td>
<td>1,406,115</td>
</tr>
<tr>
<td>15-19</td>
<td>672,110</td>
<td>639,556</td>
<td>1,311,666</td>
</tr>
<tr>
<td>10-14</td>
<td>631,752</td>
<td>608,220</td>
<td>1,239,972</td>
</tr>
<tr>
<td>10-24</td>
<td>2,026,461</td>
<td>1,931,292</td>
<td>3,957,753</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: 22%

**Economic Development**

<table>
<thead>
<tr>
<th>Country</th>
<th>GDP per capita, PPP (current international $)</th>
<th>GDP growth (annual %)</th>
<th>Net enrollment rate, secondary (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chile</td>
<td>429,122.5 (2016)</td>
<td>1.6 (2016)</td>
<td>90% (2015)</td>
</tr>
</tbody>
</table>

**Mortality Rates - Four Leading Causes of Death, by Age Group and Sex** (per 100,000 Population)

**(10-14 years old)**

<table>
<thead>
<tr>
<th>Cause</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malignant neoplasms, of lymphoid, haematopoietic and related tissue</td>
<td>0.8</td>
<td>0.9</td>
<td>0.8</td>
</tr>
<tr>
<td>Congenital malformations</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Intentional self-harm (Suicide)</td>
<td>1.8</td>
<td>1.6</td>
<td>1.7</td>
</tr>
<tr>
<td>Road traffic injuries</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
</tr>
</tbody>
</table>

**Educaiton Participation**

**Mortality Trends - Four Leading Causes of Death, by Sex** (per 100,000 Population)

**Adolescent and Youth (10-24 years old), 2000-2014**

**Mental Health**

**Protective Factors**

Students who ever seriously considered attempting suicide during the past 12 months

Students who usually understood their problems and worries the past 30 days

Students who had no close friends

Students who missed classes or school without permission 1+ of the past 30 days

Students whose parents usually knew what they do with free time the past 30 days

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Adolescent and Youth Health - 2017 Country Profile

COLOMBIA

POPULATION

Adolescent and Youth Population

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>2,111,524</td>
<td>2,060,112</td>
<td>4,171,636</td>
</tr>
<tr>
<td>15-19</td>
<td>2,063,023</td>
<td>1,988,588</td>
<td>4,051,611</td>
</tr>
<tr>
<td>10-14</td>
<td>2,064,574</td>
<td>1,981,191</td>
<td>4,045,765</td>
</tr>
<tr>
<td>10-24</td>
<td>6,239,121</td>
<td>6,029,891</td>
<td>12,269,012</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: 25%

ECONOMIC DEVELOPMENT

GDP per capita, PPP (current international $) 688,817.3 (2016)
GDP growth (annual %) 2.0 (2016)

EDUCATION PARTICIPATION

Net enrollment rate, secondary (%) (2015)

MORTALITY RATES - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)


MORTALITY TRENDS - Four Leading Causes of Death, by Sex (per 100,000 Population)

Source: Global School Health Survey (GSHS), WHO.

PROTECTIVE FACTORS

Source: Global School Health Survey (GSHS), WHO.

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### Adolescent and Youth Health - 2017 Country Profile

**Colombia**

#### Sexual and Reproductive Health

##### Trends in Adolescent Fertility Rate

(Births per 1,000 women ages 15-19 years old, 1980-2015)


##### Sexual Behavior in Adolescents

(age group: 13-19 years old)

*No data at Global School Health Survey (GSHS), WHO.

#### Risk Factors

##### Alcohol Use

- Prevalence of alcohol use among secondary school students (past year) 2015 OAS
  - Male: 69.8%
  - Female: 69.5%
  - Total: 69.7%
- Prevalence of alcohol use among secondary school students (past month) 2015 OAS
  - Male: 51.2%
  - Female: 49.3%
  - Total: 50.2%

##### Tobacco Use

- Prevalence of tobacco use among secondary school students (past month) 2015 OAS
  - Male: 15.5%
  - Female: 9.8%
  - Total: 12.5%
- Prevalence of tobacco use among secondary school students (past year) 2015 OAS
  - Male: 25.2%
  - Female: 16.7%
  - Total: 20.7%
- Prevalence of tobacco use among secondary school students (lifetime) 2015 OAS
  - Male: 31.7%
  - Female: No Data
  - Total: No Data

##### Overweight/Obesity/Diet

- Percentage of students who were obese (> +1SD from median for BMI for age and sex) (5-17 years old) 2010 ENSIN
  - Male: 13.4%
  - Female: 4.1%

##### Physical Activity

- 60 minutes daily on 5+ days the past 7 days No Data Available

- Students who went to physical education (PE) class 3+ days weekly in the school year
  - Male: No Data
  - Female: No Data
  - Total: No Data

##### Drug Use

- Prevalence of cocaine use among secondary school students (lifetime) 2015 OAS
  - Male: 5.3%
  - Female: 2.9%
  - Total: 4.1%
- Prevalence of marijuana use among secondary school students (lifetime) 2015 OAS
  - Male: 12.1%
  - Female: 7.8%
  - Total: 9.9%
- Prevalence of marijuana use among secondary school students (past year) 2015 OAS
  - Male: 9.0%
  - Female: 5.4%
  - Total: 7.1%
- Prevalence of inhalants use among secondary school students (lifetime) 2015 OAS
  - Male: 3.7%
  - Female: 3.0%
  - Total: 3.3%

##### Violence and Unintentional Injuries

- Percentage of students who were in a physical fight one or more times during the past 12 months (15+ years old) 2015 ECSC
  - Male: 63.3%
  - Female: No Data
  - Total: No Data

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Adolescent and Youth Health - 2017 Country Profile
Costa Rica

POPULATION


<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>209,551</td>
<td>201,747</td>
<td>411,298</td>
</tr>
<tr>
<td>15-19</td>
<td>199,741</td>
<td>191,319</td>
<td>391,060</td>
</tr>
<tr>
<td>10-14</td>
<td>183,796</td>
<td>175,630</td>
<td>359,426</td>
</tr>
<tr>
<td>10-24</td>
<td>593,088</td>
<td>568,696</td>
<td>1,161,784</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: **24%**

ECONOMIC DEVELOPMENT


GDP per capita, PPP (current international $) 80,699.0 (2016)
GDP growth (annual %) 4.0 (2016)

Net enrollment rate, secondary (%) (2015)

MORTALITY RATES - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)


- **(10-14 years old)**
- **(15-19 years old)**
- **(20-24 years old)**

MORTALITY TRENDS - Four Leading Causes of Death, by Sex (per 100,000 Population)

Source: 2009 Global School Health Survey (GSHS), WHO.

MENTAL HEALTH

Source: 2009 Global School Health Survey (GSHS), WHO.

<table>
<thead>
<tr>
<th>Year</th>
<th>Road traffic injuries</th>
<th>Assault (Homicide)</th>
<th>Intentional self-harm (Suicide)</th>
<th>Accidental drowning/submersion</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>12.8</td>
<td>4.0</td>
<td>3.6</td>
<td>7.4</td>
</tr>
<tr>
<td>2002</td>
<td>10.2</td>
<td>4.1</td>
<td>3.6</td>
<td>7.1</td>
</tr>
<tr>
<td>2003</td>
<td>12.8</td>
<td>4.1</td>
<td>3.6</td>
<td>7.1</td>
</tr>
<tr>
<td>2004</td>
<td>10.2</td>
<td>4.1</td>
<td>3.6</td>
<td>7.1</td>
</tr>
<tr>
<td>2005</td>
<td>12.8</td>
<td>4.1</td>
<td>3.6</td>
<td>7.1</td>
</tr>
<tr>
<td>2006</td>
<td>10.2</td>
<td>4.1</td>
<td>3.6</td>
<td>7.1</td>
</tr>
<tr>
<td>2007</td>
<td>12.8</td>
<td>4.1</td>
<td>3.6</td>
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<tr>
<td>2008</td>
<td>10.2</td>
<td>4.1</td>
<td>3.6</td>
<td>7.1</td>
</tr>
<tr>
<td>2009</td>
<td>12.8</td>
<td>4.1</td>
<td>3.6</td>
<td>7.1</td>
</tr>
<tr>
<td>2010</td>
<td>10.2</td>
<td>4.1</td>
<td>3.6</td>
<td>7.1</td>
</tr>
</tbody>
</table>

PROTECTIVE FACTORS

Source: 2009 Global School Health Survey (GSHS), WHO.

<table>
<thead>
<tr>
<th>Year</th>
<th>Students who actually attempted suicide one or more times during the past 12 months</th>
<th>Students who had no close friends</th>
<th>Students who missed classes or school without permission</th>
<th>Students whose parents usually understood their problems and worries</th>
<th>Students whose parents really usually knew what they do with free time the past 30 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>7.5</td>
<td>33.9</td>
<td>34.7</td>
<td>45.2</td>
<td>52.5</td>
</tr>
<tr>
<td>2002</td>
<td>7.9</td>
<td>34.7</td>
<td>45.2</td>
<td>52.5</td>
<td>54.5</td>
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<tr>
<td>2003</td>
<td>7.9</td>
<td>34.7</td>
<td>45.2</td>
<td>52.5</td>
<td>54.5</td>
</tr>
<tr>
<td>2004</td>
<td>7.9</td>
<td>34.7</td>
<td>45.2</td>
<td>52.5</td>
<td>54.5</td>
</tr>
<tr>
<td>2005</td>
<td>7.9</td>
<td>34.7</td>
<td>45.2</td>
<td>52.5</td>
<td>54.5</td>
</tr>
<tr>
<td>2006</td>
<td>7.9</td>
<td>34.7</td>
<td>45.2</td>
<td>52.5</td>
<td>54.5</td>
</tr>
<tr>
<td>2007</td>
<td>7.9</td>
<td>34.7</td>
<td>45.2</td>
<td>52.5</td>
<td>54.5</td>
</tr>
<tr>
<td>2008</td>
<td>7.9</td>
<td>34.7</td>
<td>45.2</td>
<td>52.5</td>
<td>54.5</td>
</tr>
<tr>
<td>2009</td>
<td>7.9</td>
<td>34.7</td>
<td>45.2</td>
<td>52.5</td>
<td>54.5</td>
</tr>
<tr>
<td>2010</td>
<td>7.9</td>
<td>34.7</td>
<td>45.2</td>
<td>52.5</td>
<td>54.5</td>
</tr>
</tbody>
</table>
The Health of Adolescents and Youth in the Americas

**Sexual and Reproductive Health**

**Trends in Adolescent Fertility Rate**
(Births per 1,000 women ages 15-19 years old, 1980-2015)


**Sexual Behavior in Adolescents**
(age group: 13-15 years old)

- Source: 2009 Global School Health Survey (GSHS), WHO.

**Risk Factors**

<table>
<thead>
<tr>
<th>Source</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Students who drank at least one drink containing alcohol 1+ of the past 30 days</td>
<td>23.4%</td>
<td>23.6%</td>
<td>23.6%</td>
</tr>
<tr>
<td>Among students who ever drunk alcohol, those that the first drink was before age 14 yrs</td>
<td>82.9%</td>
<td>76.7%</td>
<td>79.7%</td>
</tr>
<tr>
<td>Students who drank so much alcohol that they were really drunk 1+ times during their life</td>
<td>15.8%</td>
<td>15.6%</td>
<td>15.8%</td>
</tr>
</tbody>
</table>

| Tobacco Use                    |      |        |       |
| Prevalence of current use of any tobacco product 2013 GYTS | 9.7% | 8.1% | 8.9% |
| Prevalence of current cigarette smokers 2013 GYTS | 5.7% | 4.3% | 5.0% |
| Prevalence of tobacco use among secondary school students (past year) 2015 OAS | 14.1% | 8.6% | 11.1% |

| Overweight/Obesity/Diet        |      |        |       |
| Students who usually drank carbonated soft drinks 1+ times per day the past 30 days | 52.6% | 53.4% | 53.0% |
| Students who were overweight (> +1SD from median for BMI for age and sex) | 28.3% | 27.3% | 27.8% |
| Students who were obese (> +2SD from median for BMI for age and sex) | 10.2% | 7.6% | 8.9% |

| Physical Activity              |      |        |       |
| Students who went to physical education (PE) class 3+ days weekly in the school year | 36.5% | 33.4% | 35.9% |
| Students who spent 3+ hours per day doing sitting activities | 40.5% | 47.8% | 44.2% |
| Students physically active at least 60 minutes daily on 5+ days the past 7 days | 35.9% | 19.0% | 27.4% |

| Drug Use                       |      |        |       |
| Prevalence of cocaine use among secondary school students (lifetime) 2015 OAS | 2.0% | 1.0% | 1.4% |
| Prevalence of marijuana use among secondary school students (lifetime) | 21.7% | 11.9% | 16.4% |
| Prevalence of marijuana use among secondary school students (past year) | 14.7% | 7.5% | 10.8% |
| Prevalence of inhalants use among secondary school students (lifetime) | 4.5% | 4.0% | 4.2% |

| Violence and Unintentional Injuries |      |        |       |
| Students seriously injured 1+ times during the past 12 months 2009 GSHS | 29.6% | 14.7% | 22.4% |
| Students who were in a physical fight 1+ times the past 12 months 2009 GSHS | 32.2% | 12.1% | 22.1% |
| Students who were bullied 1+ days during the past 30 days 2009 GSHS | 18.4% | 19.0% | 19.0% |
Adolescent and Youth Health - 2017 Country Profile

CUBA

POPULATION


Adolescent and Youth Population

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>372,190</td>
<td>342,827</td>
<td>715,017</td>
</tr>
<tr>
<td>15-19</td>
<td>353,934</td>
<td>328,552</td>
<td>682,486</td>
</tr>
<tr>
<td>10-14</td>
<td>332,556</td>
<td>311,276</td>
<td>643,832</td>
</tr>
<tr>
<td>10-24</td>
<td>1,058,680</td>
<td>982,655</td>
<td>2,041,335</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: 18%

ECONOMIC DEVELOPMENT


<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cuba</td>
<td>7,602.0</td>
<td>4.0</td>
<td>83%</td>
</tr>
</tbody>
</table>

MORTALITY RATES - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)


MORTALITY TRENDS - Four Leading Causes of Death, by Sex (per 100,000 Population)

Source: Global School Health Survey (GSHS), WHO.

MENTAL HEALTH

PROTECTIVE FACTORS

Students who ever seriously considered attempting suicide during the past 12 months

Students who actually attempted suicide one or more times during the past 12 months

Students who had no close friends

Students who missed classes or school without permission 1+ of the past 30 days

Students who usually understood their problems and worries the past 30 days

Students whose parents really usually knew what they do with free time the past 30 days

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**Adolescent and Youth Health - 2017 Country Profile**

**Cuba**

### Sexual and Reproductive Health

#### Trends in Adolescent Fertility Rate

**Births per 1,000 women ages 15-19 years old, 1980-2015**


#### Sexual Behavior in Adolescents

**Age group: 13-15 years old**

- **Source:** Global School Health Survey (GSHS), WHO.

<table>
<thead>
<tr>
<th>Students who ever had sexual intercourse</th>
<th>Students who ever had sexual intercourse, those that the first time was before age 14 yrs</th>
<th>Students who ever had sexual intercourse, those who used a condom the last time</th>
</tr>
</thead>
<tbody>
<tr>
<td>87</td>
<td>48</td>
<td>28</td>
</tr>
</tbody>
</table>

### Risk Factors

#### Alcohol Use

- **Students who drank at least one drink containing alcohol 1+ of the past 30 days**
- **No Data Available**

#### Tobacco Use

- **Prevalence of current use of any tobacco product**
  - **2010 GYTS**
    - Male: 19.8%
    - Female: 15.0%
    - Total: 17.1%

#### Overweight/Obesity/Diet

- **Students who were overweight (> +1SD from median for BMI for age and sex)**
- **No Data Available**

#### Physical Activity

- **Students physically active at least 60 minutes daily on 5+ days the past 7 days**
- **No Data Available**

#### Drug Use

- **Students who used marijuana 1+ times during their life**
- **No Data Available**

#### Violence and Unintentional Injuries

- **Students seriously injured 1+ times during the past 12 months**
- **No Data Available**

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Adolescent and Youth Health - 2017 Country Profile

Curaçao

**POPULATION**


<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>5,349</td>
<td>5,233</td>
<td>10,582</td>
</tr>
<tr>
<td>15-19</td>
<td>4,859</td>
<td>5,038</td>
<td>9,897</td>
</tr>
<tr>
<td>10-14</td>
<td>4,988</td>
<td>4,811</td>
<td>9,799</td>
</tr>
<tr>
<td>10-24</td>
<td>15,196</td>
<td>15,082</td>
<td>30,278</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: 19%

**ECONOMIC DEVELOPMENT**


- GDP (million current US$): 3,159.0 (2014)
- GDP per capita (current US$): 20,282.7 (2014)

**MORTALITY RATES - Four Leading Causes of Death, by Age Group and Sex** (per 100,000 Population)


Note: *If there is no cause of death reported for a specific age group and sex, the corresponding bar with zero value is not being represented.*

**MORTALITY TRENDS - Four Leading Causes of Death, by Sex** (per 100,000 Population)


**MENTAL HEALTH**

Source: 2015 Global School Health Survey (GSHS), WHO.

**PROTECTIVE FACTORS**

Source: 2015 Global School Health Survey (GSHS), WHO.

- Percentage of students who ever seriously considered attempting suicide during the past 12 months
- Students who actually attempted suicide one or more times during the past 12 months
- Students who had no close friends
- Students who missed classes or school without permission 1+ of the past 30 days
- Students whose parents usually understood their problems and worries the past 30 days
- Students whose parents really usually knew what they do with free time the past 30 days

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**SEXUAL AND REPRODUCTIVE HEALTH**

### Trends in Adolescent Fertility Rate

**Births per 1,000 women ages 15-19 years old, 1980-2015**


### Sexual Behavior in Adolescents

**Age group: 13-15 years old**

Source: 2015 Global School Health Survey (GSHS), WHO.

#### Alcoholic Use

- **Students who drank at least one drink containing alcohol 1+ of the past 30 days**
  - Total: 27.6%
  - Male: 32.4%
  - Female: 22.8%

- **Students who drank so much alcohol that they were really drunk 1+ times during their life**
  - Total: 14.7%
  - Male: 13.9%
  - Female: 13.2%

- **Among students who ever drunk alcohol, those that the first drink was before age 14 yrs**
  - Total: 72.6%
  - Male: 72.0%
  - Female: 72.2%

#### Tobacco Use

- **Students who smoked cigarettes 1+ days during the past 30 days**
  - Total: 7.3%
  - Male: 7.1%
  - Female: 7.2%

- **Students who reported people smoked in their presence, past 7 days**
  - Total: 56.1%
  - Male: 56.2%
  - Female: 56.1%

#### Overweight/Obesity/Diet

- **Students who usually drank carbonated soft drinks 1+ times per day the past 30 days**
  - Total: 62.6%
  - Male: 62.2%
  - Female: 62.4%

#### Physical Activity

- **Students who went to physical education (PE) class 3+ days weekly in the school year**
  - Total: 37.6%
  - Male: 30.9%
  - Female: 38.1%

- **Students who spent 3+ hours per day doing sitting activities**
  - Total: 59.5%
  - Male: 60.0%
  - Female: 59.8%

- **Percentage of students who were physically active for a total of at least 60 minutes per day on all 7 days during the past 7 days**
  - Total: 15.8%
  - Male: 11.5%
  - Female: 7.3%

#### Drug Use

- **Students who used marijuana 1+ times during their life**
  - Total: 7.7%
  - Male: 5.4%
  - Female: 6.5%

#### Violence and Unintentional Injuries

- **Students seriously injured 1+ times during the past 12 months**
  - Total: 29.3%
  - Male: 28.9%
  - Female: 34.1%

- **Students who were in a physical fight 1+ times the past 12 months**
  - Total: 29.4%
  - Male: 26.4%
  - Female: 22.8%

- **Students who were bullied 1+ days during the past 30 days**
  - Total: 27.0%
  - Male: 26.5%
  - Female: 26.9%
### Adolescent and Youth Health - 2017 Country Profile

#### DOMINICA

**POPULATION**


<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>3,271</td>
<td>3,064</td>
<td>6,335</td>
</tr>
<tr>
<td>15-19</td>
<td>2,689</td>
<td>2,554</td>
<td>5,243</td>
</tr>
<tr>
<td>10-14</td>
<td>2,650</td>
<td>2,537</td>
<td>5,187</td>
</tr>
<tr>
<td>10-24</td>
<td>8,610</td>
<td>8,155</td>
<td>16,765</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: 23%

**ECONOMIC DEVELOPMENT**


- GDP per capita, PPP (current international $): 807.1 (2016)
- GDP growth (annual %): 0.9 (2016)
- Net enrollment rate, secondary (%): 86% (2015) 87% (2016)

**MORTALITY RATES - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)**

Source: PAHO Regional Mortality Database, Pan American Health Organization (PAHO/WHO), 2016 Edition. Country latest mortality data available as of 2014. Note: * if there is no cause of death reported for a specific age group and sex, the corresponding bar with zero value is not being represented.

(10-14 years old)
- Road traffic injuries: 36.9
- Epilepsy and status epilepticus: 33.4
- Intentional self-harm (Suicide): 33.4
- Malignant neoplasms, of lymphoid, haematopoietic and related tissue: 33.4
- Benign neoplasms, in situ, uncertain or unknown behaviour: 20.0
- Cardiomyopathy: 36.1
- Influenza and Pneumonia: 36.1

(15-19 years old)
- Road traffic injuries: 36.9
- Epilepsy and status epilepticus: 33.4
- Intentional self-harm (Suicide): 33.4
- Malignant neoplasms, of lymphoid, haematopoietic and related tissue: 33.4
- Benign neoplasms, in situ, uncertain or unknown behaviour: 20.0
- Cardiomyopathy: 36.1
- Influenza and Pneumonia: 36.1

(20-24 years old)
- Road traffic injuries: 36.9
- Epilepsy and status epilepticus: 33.4
- Intentional self-harm (Suicide): 33.4
- Malignant neoplasms, of lymphoid, haematopoietic and related tissue: 33.4
- Benign neoplasms, in situ, uncertain or unknown behaviour: 20.0
- Cardiomyopathy: 36.1
- Influenza and Pneumonia: 36.1

**MORTALITY TRENDS - Four Leading Causes of Death, by Sex (per 100,000 Population)**

**MENTAL HEALTH**

Source: 2009 Global School Health Survey (GSHS), WHO. (13-15 years old)

**PROTECTIVE FACTORS**

Source: 2009 Global School Health Survey (GSHS), WHO. (13-15 years old)

No Data Available

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### Adolescent and Youth Health - 2017 Country Profile

**Dominica**

#### Sexual and Reproductive Health

**Trends in Adolescent Fertility Rate**

<table>
<thead>
<tr>
<th></th>
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<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Latin America and the Caribbean</td>
<td>67</td>
<td>46</td>
<td>28</td>
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<tr>
<td>North America</td>
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<tr>
<td>World</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


#### Sexual Behavior in Adolescents (13-15 years old)

**Students who ever had sexual intercourse**

- Male: 36.9%
- Female: 57.0%
- Total: 48.9%

**Among students who ever had sexual intercourse, those that the first time was before age 14 yrs**

- Male: 60.3%
- Female: 85.1%
- Total: 77.5%

**Among students who ever had sexual intercourse, those who used a condom the last time**

- Male: 63.0%
- Female: 75.5%
- Total: 68.2%

*Source: 2009 Global School Health Survey (GSHS), WHO.*

#### Risk Factors

**Alcohol Use**

- Among students who ever drunk alcohol, those that the first drink was before age 14 yrs
  - Male: 24.0%
  - Female: 40.5%
  - Total: 32.9%

- Students who drank at least one drink containing alcohol 1+ of the past 30 days
  - Male: 49.0%
  - Female: 54.5%
  - Total: 51.8%

- Binge drinking among secondary school students
  - Male: 56.5%
  - Female: 50.1%
  - Total: 53.8%

- Prevalence of alcohol use among secondary school students (past year)
  - Male: 62.3%
  - Female: 55.3%
  - Total: 58.8%

*Source: GSHS - Global School Health Survey (WHO); GYTS - Global Youth Tobacco Survey (PAHO); OAS - Report on Drug Use in the Americas (Group: 13-15 years old).*

**Tobacco Use**

- Prevalence of current use of any tobacco product
  - Male: 36.4%
  - Female: 19.2%
  - Total: 25.3%

- Prevalence of current cigarette smokers
  - Male: 13.9%
  - Female: 11.6%
  - Total: 12.6%

- Prevalence of tobacco use among secondary school students (past year)
  - Male: 17.3%
  - Female: 11.1%
  - Total: 14.4%

- Prevalence of tobacco use among secondary school students (past month)
  - Male: 9.1%
  - Female: 5.4%
  - Total: 7.4%

**Overweight/Obesity/Diet**

- Students who usually drank carbonated soft drinks 1+ times per day the past 30 days
  - Male: 56.3%
  - Female: 55.3%
  - Total: 55.8%

- Students who were overweight (> +1SD from median for BMI for age and sex)
  - Male: 24.0%
  - Female: 25.9%
  - Total: 24.6%

- Students who were obese (> +2SD from median for BMI for age and sex)
  - Male: 8.8%
  - Female: 9.6%
  - Total: 9.1%

**Physical Activity**

- Students who went to physical education (PE) class 3+ days weekly in the school year
  - Male: 25.3%
  - Female: 21.8%
  - Total: 23.9%

- Students physically active at least 60 minutes daily on 5+ days the past 7 days
  - Male: 24.8%
  - Female: 22.6%
  - Total: 23.7%

**Drug Use**

- Among students who ever used drugs, those that first used drugs before age 14 yrs
  - Male: 4.3%
  - Female: 2.6%
  - Total: 3.4%

- Prevalence of cocaine use among secondary school students (lifetime)
  - Male: 1.0%
  - Female: 0.4%
  - Total: 0.6%

- Prevalence of marijuana use among secondary school students (lifetime)
  - Male: 49.5%
  - Female: 24.0%
  - Total: 36.7%

- Prevalence of inhalants use among secondary school students (lifetime)
  - Male: 9.6%
  - Female: 10.8%
  - Total: 10.2%

**Violence and Unintentional Injuries**

- Students seriously injured 1+ times during the past 12 months
  - Male: 49.4%
  - Female: 38.3%
  - Total: 43.1%

- Students who were in a physical fight 1+ times the past 12 months
  - Male: 29.6%
  - Female: 26.7%
  - Total: 27.7%

- Students who were bullied 1+ days during the past 30 days
  - Male: 28.7%
  - Female: 26.0%
  - Total: 27.4%

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Adolescent and Youth Health - 2017 Country Profile

DOMINICAN REPUBLIC

POPULATION


<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>474,763</td>
<td>470,133</td>
<td>944,896</td>
</tr>
<tr>
<td>15-19</td>
<td>493,933</td>
<td>483,884</td>
<td>977,817</td>
</tr>
<tr>
<td>10-14</td>
<td>526,610</td>
<td>510,423</td>
<td>1,037,033</td>
</tr>
<tr>
<td>10-24</td>
<td>1,495,306</td>
<td>1,464,440</td>
<td>2,959,746</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: 28%

ECONOMIC DEVELOPMENT


GDP per capita, PPP (current international $) 161,956.5 (2016)
GDP growth (annual %) 6.6 (2016)

EDUCATION PARTICIPATION

Net enrollment rate, secondary (%) 62% (2015)

MORTALITY RATES - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)


(10-14 years old)

<table>
<thead>
<tr>
<th>Cause</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Road traffic injuries</td>
<td>4.8</td>
<td>4.8</td>
<td>9.6</td>
</tr>
<tr>
<td>Intentional self-harm (Suicide)</td>
<td>4.2</td>
<td>4.2</td>
<td>8.4</td>
</tr>
<tr>
<td>Congenital malformations</td>
<td>1.2</td>
<td>1.2</td>
<td>2.4</td>
</tr>
<tr>
<td>Influenza and Pneumonia</td>
<td>1.6</td>
<td>1.6</td>
<td>3.2</td>
</tr>
</tbody>
</table>

(15-19 years old)

<table>
<thead>
<tr>
<th>Cause</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Road traffic injuries</td>
<td>5.4</td>
<td>5.4</td>
<td>10.8</td>
</tr>
<tr>
<td>Assault (Homicide)</td>
<td>20.0</td>
<td>20.0</td>
<td>40.0</td>
</tr>
<tr>
<td>Congenital malformations</td>
<td>1.2</td>
<td>1.2</td>
<td>2.4</td>
</tr>
<tr>
<td>Influenza and Pneumonia</td>
<td>1.4</td>
<td>1.4</td>
<td>2.8</td>
</tr>
</tbody>
</table>

(20-24 years old)

<table>
<thead>
<tr>
<th>Cause</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Road traffic injuries</td>
<td>6.7</td>
<td>6.7</td>
<td>13.4</td>
</tr>
<tr>
<td>Assault (Homicide)</td>
<td>35.0</td>
<td>35.0</td>
<td>70.0</td>
</tr>
<tr>
<td>Congenital malformations</td>
<td>1.5</td>
<td>1.5</td>
<td>3.0</td>
</tr>
<tr>
<td>Pregnancy, childbirth and the puerperium</td>
<td>1.2</td>
<td>1.2</td>
<td>2.4</td>
</tr>
</tbody>
</table>

MORTALITY TRENDS - Four Leading Causes of Death, by Sex (per 100,000 Population)

Source: PAHO Regional Mortality Database, Pan American Health Organization (PAHO/WHO).

MENTAL HEALTH

Source: Global School Health Survey (GSHS), WHO.

Students who ever seriously considered attempting suicide during the past 12 months

PROTECTIVE FACTORS

Source: Global School Health Survey (GSHS), WHO.

Students who actually attempted suicide one or more times during the past 12 months

Students who missed classes or school without permission 1+ of the past 30 days

Students whose parents really usually knew what they do with free time the past 30 days

Students whose parents usually understood their problems and worries the past 30 days

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Adolescent and Youth Health - 2017 Country Profile

Dominican Republic

SEXUAL AND REPRODUCTIVE HEALTH

Trends in Adolescent Fertility Rate
(Births per 1,000 women ages 15-19 years old, 1980-2015)

Sexual Behavior in Adolescents
(age group: 13-15 years old)
Source: Global School Health Survey (GSHS), WHO.

RISK FACTORS
Sources: GSHS - Global School Health Survey (WHO)          GYTS - Global Youth Tobacco Survey (PAHO)          OAS - Report on Drug Use in the Americas

Alcohol Use
Prevalence of alcohol use among secondary school students (past year)
2015 OAS

- Male: 45.8%
- Female: 50.9%
- Total: 48.6%

Prevalence of alcohol use among secondary school students (past month)
2015 OAS

- Male: 29.9%
- Female: 33.4%
- Total: 31.4%

Tobacco Use
Prevalence of current use of any tobacco product
2011 GYTS

- Male: 28.6%
- Female: 15.8%
- Total: 21.3%

Prevalence of current cigarette smokers
2011 GYTS

- Male: 7.1%
- Female: 6.6%
- Total: 6.6%

Prevalence of tobacco use among secondary school students (past year)
2015 OAS

- Male: 4.3%
- Female: 3.4%
- Total: 3.9%

Overweight/Obesity/Diet
Students who were overweight (> +1SD from median for BMI for age and sex)
No Data Available

Students who were obese (> +2SD from median for BMI for age and sex)
No Data Available

Students who usually drank carbonated soft drinks 1+ times per day the past 30 days
No Data Available

Physical Activity
Students physically active at least 60 minutes daily on 5+ days the past 7 days
No Data Available

Students who spent 3+ hours per day doing sitting activities
No Data Available

Students who went to physical education (PE) class 3+ days weekly in the school year
No Data Available

Drug Use
Prevalence of cocaine use among secondary school students (lifetime)
2015 OAS

- Male: 1.1%
- Female: 0.8%

Prevalence of marijuana use among secondary school students (lifetime)
2015 OAS

- Male: 2.4%
- Female: 1.7%

Prevalence of marijuana use among secondary school students (past year)
2015 OAS

- Male: 1.5%
- Female: 1.0%

Prevalence of inhalants use among secondary school students (lifetime)
2015 OAS

- Male: 1.8%
- Female: 1.1%

Violence and Unintentional Injuries
Students seriously injured 1+ times during the past 12 months
No Data Available

Students who were bullied 1+ days during the past 30 days
No Data Available

Students who were in a physical fight 1+ times the past 12 months
No Data Available
Adolescent and Youth Health - 2017 Country Profile

**Ecuador**

### Population


<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-14</td>
<td>772,409</td>
<td>741,919</td>
<td>1,514,328</td>
</tr>
<tr>
<td>15-19</td>
<td>763,198</td>
<td>737,259</td>
<td>1,500,457</td>
</tr>
<tr>
<td>20-24</td>
<td>2,271,702</td>
<td>2,196,183</td>
<td>4,467,885</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: **27%**

### Economic Development


**GDP per capita, PPP (current international $)**

- 184,924.7 (2016)

**GDP growth (annual %)**

- -1.5 (2016)

**Net enrollment rate, secondary (%)**

- 85% (2015)

**86%**

### Mortality Rates - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)


**Mortality Trends - Four Leading Causes of Death, by Sex (per 100,000 Population)**

**Source:** Global School Health Survey (GSHS), WHO.

### Protective Factors

**Source:** Global School Health Survey (GSHS), WHO.

- Students who missed classes or school without permission 1+ of the past 30 days
- Students whose parents usually understood their problems and worries the past 30 days
- Students who actually attempted suicide one or more times during the past 12 months
- Students who had no close friends
- Students who ever seriously considered attempting suicide during the past 12 months
- Students who had no Data Available

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**The Health of Adolescents and Youth in the Americas**
Adolescent and Youth Health - 2017 Country Profile

Ecuador

SEXUAL AND REPRODUCTIVE HEALTH

Trends in Adolescent Fertility Rate
(Births per 1,000 women ages 15-19 years old), 1980-2015

Sexual Behavior in Adolescents
(age group: 13-15 years old)
- Source: Global School Health Survey (GSHS), WHO.

No Data Available

RISK FACTORS

Sources:
GSHS - Global School Health Survey (WHO)
GYTS - Global Youth Tobacco Survey (PAHO)
OAS - Report on Drug Use in the Americas

Alcohol Use

Binge drinking among secondary school students
2015 OAS
- Male: 34.9%
- Female: 21.3%
- Total: 56.1%

Prevalence of alcohol use among secondary school students (past year)
2015 OAS
- Male: 19.4%
- Female: 17.5%
- Total: 18.5%

Prevalence of alcohol use among secondary school students (past month)
2015 OAS
- Male: 8.1%
- Female: 6.3%
- Total: 7.3%

Tobacco Use

Prevalence of tobacco use among secondary school students (lifetime)
2015 OAS
- Male: 27.8%
- Female: 11.9%
- Total: 18.5%

Prevalence of tobacco use among secondary school students (past year)
2015 OAS
- Male: 5.7%
- Female: 9.0%
- Total: 7.3%

Prevalence of tobacco use among secondary school students (past month)
2015 OAS
- Male: 4.5%
- Female: 1.5%
- Total: 3.0%

Overweight/Obesity/Diet

No Data Available

Physical Activity

No Data Available

Drug Use

Prevalence of cocaine use among secondary school students (lifetime)
2015 OAS
- Male: 3.1%
- Female: 2.2%

Prevalence of marijuana use among secondary school students (lifetime)
2015 OAS
- Male: 9.6%
- Female: 6.7%

Prevalence of marijuana use among secondary school students (past year)
2015 OAS
- Male: 4.1%
- Female: 2.9%

Prevalence of inhalants use among secondary school students (lifetime)
2015 OAS
- Male: 4.0%
- Female: 3.0%

Violence and Unintentional Injuries

No Data Available

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Adolescent and Youth Health - 2017 Country Profile

**EL SALVADOR**

### POPULATION


<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>295,556</td>
<td>312,016</td>
<td>607,572</td>
</tr>
<tr>
<td>15-19</td>
<td>314,466</td>
<td>312,404</td>
<td>626,870</td>
</tr>
<tr>
<td>10-14</td>
<td>292,373</td>
<td>281,714</td>
<td>574,087</td>
</tr>
<tr>
<td>10-24</td>
<td>902,395</td>
<td>906,134</td>
<td>1,808,529</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: **29%**

### ECONOMIC DEVELOPMENT


| GDP per capita, PPP (current international $) | 54,685.6 (2016) | GDP growth (annual %) | 2.4 (2016) |

### MORTALITY RATES - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)


#### (10-14 years old)

- Assault (Homicide)
- Road traffic injuries
- Accidental drowning/submersion
- Intentional self-harm (Suicide)

#### (15-19 years old)

- Assault (Homicide)
- Intentional self-harm (Suicide)
- Accidental drowning/submersion
- Road traffic injuries

#### (20-24 years old)

- Assault (Homicide)
- Road traffic injuries
- Intentional self-harm (Suicide)
- Diseases of the urinary system

### MORTALITY TRENDS - Four Leading Causes of Death, by Sex (per 100,000 Population)

Adolescent and Youth (10-24 years old), 2000-2013

- Assault (Homicide)
- Road traffic injuries
- Intentional self-harm (Suicide)
- Accidental drowning/submersion

### MENTAL HEALTH

Source: 2013 Global School Health Survey (GSHS), WHO.

#### PROTECTIVE FACTORS

Source: 2013 Global School Health Survey (GSHS), WHO.

- Students who actually attempted suicide one or more times during the past 12 months
- Students who had no close friends
- Students who missed classes or school without permission 1+ of the past 30 days
- Students whose parents usually understood their problems and worries the past 30 days
- Students whose parents really usually knew what they do with free time the past 30 days

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**Sexual and Reproductive Health**

**Trends in Adolescent Fertility Rate**
(Births per 1,000 women ages 15-19 years old, 1980-2015)

**Sexual Behavior in Adolescents**
(age group: 13-15 years old)
- Source: 2013 Global School Health Survey (GSHS), WHO.

**Risk Factors**

<table>
<thead>
<tr>
<th>Source</th>
<th>Alcohol Use</th>
<th>Tobacco Use</th>
<th>Overweight/Obesity/Diet</th>
<th>Physical Activity</th>
<th>Drug Use</th>
<th>Violence and Unintentional Injuries</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Students who drank at least one drink containing alcohol 1+ of the past 30 days</td>
<td>Prevalence of current use of any tobacco product 2015 GYTS</td>
<td>Students who usually drank carbonated soft drinks 1+ times per day the past 30 days</td>
<td>Students who went to physical education (PE) class 3+ days weekly in the school year</td>
<td>Prevalence of cocaine use among secondary school students (lifetime) 2015 OAS</td>
<td>Students seriously injured 1+ times during the past 12 months 2013 GSHS</td>
</tr>
<tr>
<td></td>
<td>Students who drank so much alcohol that they were really drunk 1+ times during their life</td>
<td>Prevalence of current cigarette smokers 2015 GYTS</td>
<td>Students who were overweight (&gt; +1SD from median for BMI for age and sex) 2013 GSHS</td>
<td>Students who spent 3+ hours per day doing sitting activities 2013 GSHS</td>
<td>Prevalence of marijuana use among secondary school students (lifetime) 2015 OAS</td>
<td>Students who were in a physical fight 1+ times the past 12 months 2013 GSHS</td>
</tr>
<tr>
<td></td>
<td>Among students who ever drunk alcohol, those that the first drink was before age 14 yrs</td>
<td>Prevalence of tobacco use among secondary school students (past year) 2015 OAS</td>
<td>Students who were obese (&gt; +2SD from median for BMI for age and sex) 2013 GSHS</td>
<td>Students physically active at least 60 minutes daily on all 7 days 2013 GSHS</td>
<td>Prevalence of marijuana use among secondary school students (lifetime) 2015 OAS</td>
<td>Students who were bullied 1+ days during the past 30 days 2013 GSHS</td>
</tr>
</tbody>
</table>

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[www.paho.org](http://www.paho.org)
### Adolescent and Youth Health - 2017 Country Profile

**French Guiana**

#### Sexual and Reproductive Health

**Trends in Adolescent Fertility Rate**

<table>
<thead>
<tr>
<th>Year Range</th>
<th>North America</th>
<th>Latin America and the Caribbean</th>
<th>World</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980-1985</td>
<td>83</td>
<td>67</td>
<td>46</td>
</tr>
<tr>
<td>1985-1990</td>
<td>83</td>
<td>67</td>
<td>46</td>
</tr>
<tr>
<td>1990-1995</td>
<td>83</td>
<td>67</td>
<td>46</td>
</tr>
<tr>
<td>1995-2000</td>
<td>83</td>
<td>67</td>
<td>46</td>
</tr>
<tr>
<td>2000-2005</td>
<td>83</td>
<td>67</td>
<td>46</td>
</tr>
<tr>
<td>2005-2010</td>
<td>83</td>
<td>67</td>
<td>46</td>
</tr>
<tr>
<td>2010-2015</td>
<td>83</td>
<td>67</td>
<td>46</td>
</tr>
</tbody>
</table>

- **French Guiana**
- **North America**
- **Latin America and the Caribbean**
- **World**


#### Sexual Behavior in Adolescents

**Age group:** 13-15 years old

- **Students who ever had sexual intercourse**
- **Among students who ever had sexual intercourse, those that the first time was before age 14 yrs**
- **Among students who ever had sexual intercourse, those who used a condom the last time**

- **No Data Available**

#### Risk Factors

**Sources:**

- **GSHS - Global School Health Survey (WHO)**
- **GYTS - Global Youth Tobacco Survey (PAHO)**
- **OAS - Report on Drug Use in the Americas**

**Alcohol Use**

- Students who drank at least one drink containing alcohol 1+ of the past 30 days
- Binge drinking among secondary school students
- Prevalence of alcohol use among secondary school students (past month)

- **No Data Available**

**Tobacco Use**

- Prevalence of current cigarette smokers
- Prevalence of current use of any tobacco product
- Students who reported people smoked in their presence, past 7 days
- Among students who ever smoked cigarettes, those that first tried cigarettes before age 14 yrs

- **No Data Available**

**Overweight/Obesity/Diet**

- Students who were overweight (> +1SD from median for BMI for age and sex)
- Students who were obese (> +2SD from median for BMI for age and sex)
- Students who usually drank carbonated soft drinks 1+ times per day the past 30 days

- **No Data Available**

**Physical Activity**

- Students physically active at least 60 minutes daily on 5+ days the past 7 days
- Students who spent 3+ hours per day doing sitting activities
- Students who went to physical education (PE) class 3+ days weekly in the school year

- **No Data Available**

**Drug Use**

- Students who used marijuana 1+ times during their life
- Prevalence of marijuana use among secondary school students
- Prevalence of cocaine use among secondary school students
- Prevalence of inhalants use among secondary school students

- **No Data Available**

**Violence and Unintentional Injuries**

- Students seriously injured 1+ times during the past 12 months
- Students who were bullied 1+ days during the past 30 days
- Students who were in a physical fight 1+ times the past 12 months

- **No Data Available**
Adolescent and Youth Health - 2017 Country Profile
GRENADA

**POPULATION**


<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>5,036</td>
<td>4,931</td>
<td>9,967</td>
</tr>
<tr>
<td>15-19</td>
<td>4,826</td>
<td>4,613</td>
<td>9,439</td>
</tr>
<tr>
<td>10-14</td>
<td>4,545</td>
<td>4,314</td>
<td>8,859</td>
</tr>
<tr>
<td>10-24</td>
<td>14,407</td>
<td>13,858</td>
<td>28,265</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: 26%

**ECONOMIC DEVELOPMENT**


GDP per capita, PPP (current international $) 1,494.7 (2016)
GDP growth (annual %) 1.9 (2016)
Net enrollment rate, secondary (%) 83% (2015)

**MORTALITY RATES - Four Leading Causes of Death, by Age Group and Sex** (per 100,000 Population)


Note: * if there is no cause of death reported for a specific age group and sex, the corresponding bar with zero value is not being represented.

**MORTALITY TRENDS - Four Leading Causes of Death, by Sex** (per 100,000 Population)

Adolescent and Youth (10-24 years old), 2000-2015

**MENTAL HEALTH**

Source: 2008 Global School Health Survey (GSHS), WHO.

Students who felt lonely most of the time or always during the past 12 months

<table>
<thead>
<tr>
<th>Year</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>11.6</td>
<td>16.2</td>
<td>14.2</td>
</tr>
<tr>
<td>2004</td>
<td>17.9</td>
<td>24.0</td>
<td>20.7</td>
</tr>
<tr>
<td>2005</td>
<td>17.9</td>
<td>24.0</td>
<td>20.7</td>
</tr>
<tr>
<td>2006</td>
<td>9.4</td>
<td>8.3</td>
<td>8.9</td>
</tr>
<tr>
<td>2007</td>
<td>31.9</td>
<td>22.5</td>
<td>26.6</td>
</tr>
<tr>
<td>2008</td>
<td>44.3</td>
<td>35.3</td>
<td>39.2</td>
</tr>
<tr>
<td>2009</td>
<td>38.0</td>
<td>33.4</td>
<td>35.6</td>
</tr>
</tbody>
</table>

**PROTECTIVE FACTORS**

Source: 2008 Global School Health Survey (GSHS), WHO.

Students who ever seriously considered attempting suicide in the past 12 months

<table>
<thead>
<tr>
<th>Year</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>11.6</td>
<td>16.2</td>
<td>14.2</td>
</tr>
<tr>
<td>2004</td>
<td>17.9</td>
<td>24.0</td>
<td>20.7</td>
</tr>
<tr>
<td>2005</td>
<td>17.9</td>
<td>24.0</td>
<td>20.7</td>
</tr>
<tr>
<td>2006</td>
<td>9.4</td>
<td>8.3</td>
<td>8.9</td>
</tr>
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<td>2007</td>
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<td>22.5</td>
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</tr>
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<td>2008</td>
<td>44.3</td>
<td>35.3</td>
<td>39.2</td>
</tr>
<tr>
<td>2009</td>
<td>38.0</td>
<td>33.4</td>
<td>35.6</td>
</tr>
</tbody>
</table>

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### Adolescent and Youth Health - 2017 Country Profile

**GRENADA**

#### SEXUAL AND REPRODUCTIVE HEALTH

**Trends in Adolescent Fertility Rate**

(Births per 1,000 women ages 15-19 years old), 1980-2015


#### RISK FACTORS

**Sources:**
- GSHS - Global School Health Survey (WHO)
- GYTS - Global Youth Tobacco Survey (PAHO)
- OAS - Report on Drug Use in the Americas

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alcohol Use</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Students who drank at least one drink containing alcohol 1+ of the past 30 days</td>
<td>49.1%</td>
<td>43.0%</td>
<td>46.6%</td>
</tr>
<tr>
<td>Students who drank so much alcohol that they were really drunk 1+ times during their life</td>
<td>33.9%</td>
<td>22.1%</td>
<td>27.4%</td>
</tr>
<tr>
<td>Students who had a hangover, felt sick, got into trouble with family or friends, missed school, or got into fights one or more times as a result of drinking alcohol during their life</td>
<td>19.2%</td>
<td>13.1%</td>
<td>15.7%</td>
</tr>
</tbody>
</table>

| **Tobacco Use** |
| Prevalence of current use of any tobacco product | 2009 GYTS | 24.5% | 16.7% |
| Prevalence of current cigarette smokers | 2009 GYTS | 9.9% | 6.2% |
| Students who reported people smoked in their presence, past 7 days | 2008 GSHS | 60.6% | 60.4% |

| **Overweight/Obesity/Diet** |
| Students who went hungry most of the time or always during the past 30 days because there was not enough food in their home | 2008 GSHS | 7.4% | 6.8% |

| **Physical Activity** |
| Students who spent 3+ hours per day doing sitting activities | 2008 GSHS | 42.6% | 42.9% |
| Percentage of students who were physically active for a total of at least 60 minutes per day on all 7 days during the past 7 days | 2008 GSHS | 18.1% | 13.1% |

| **Drug Use** |
| Percentage of students who used drugs one or more times during their lifetime | 2008 GSHS | 21.9% | 7.8% |
| Prevalence of cocaine use among secondary school students (lifetime) | 2015 OAS | 5.6% | 0.7% |
| Prevalence of marijuana use among secondary school students (lifetime) | 2015 OAS | 24.7% | 15.1% |
| Prevalence of inhalants use among secondary school students (lifetime) | 2015 OAS | 17.8% | 14.2% |

| **Violence and Unintentional Injuries** |
| Percentage of students who were physically attacked one or more times during the past 12 months | 2008 GSHS | 55.2% | 30.0% |
| Students who were in a physical fight 1+ times the past 12 months | 2008 GSHS | 30.0% | 36.2% |
| Students seriously injured 1+ times during the past 12 months | 2008 GSHS | 52.4% | 36.8% |
| Students who were bullied 1+ days during the past 30 days | 2008 GSHS | 26.0% | 26.1% |

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Adolescent and Youth Health - 2017 Country Profile

**GUATEMALA**

**POPULATION**


<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>14,165</td>
<td>12,426</td>
<td>26,591</td>
</tr>
<tr>
<td>15-19</td>
<td>16,076</td>
<td>16,081</td>
<td>32,157</td>
</tr>
<tr>
<td>10-14</td>
<td>18,468</td>
<td>17,756</td>
<td>36,224</td>
</tr>
<tr>
<td>10-24</td>
<td>48,709</td>
<td>46,263</td>
<td>94,972</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: 20%

**ECONOMIC DEVELOPMENT**

| GDP per capita, PPP (current international $) | 7,900 |
| GDP growth (annual %) | N/A |

**EDUCATION PARTICIPATION**

Net school enrollment rate, secondary (%): N/A

**MORTALITY RATES - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)**


**Note:** *If there is no cause of death reported for a specific age group and sex, the corresponding bar with zero value is not being represented.*

**MORTALITY TRENDS - Four Leading Causes of Death, by Sex (per 100,000 Population)**

**MENTAL HEALTH**

Students who ever seriously considered attempting suicide during the past 12 months

Students who actually attempted suicide one or more times during the past 12 months

Students who had no close friends

**PROTECTIVE FACTORS**

Students who missed classes or school without permission 1+ of the past 30 days

Students whose parents really usually knew what they do with free time the past 30 days

Students whose parents usually understood their problems and worries the past 30 days

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Guadeloupe

Sexual and Reproductive Health

Trends in Adolescent Fertility Rate
(Births per 1,000 women ages 15-19 years old), 1980-2015

Sexual Behavior in Adolescents
(age group: 13-15 years old)
Source: Global School Health Survey (GSHS), WHO.

Risk Factors
Sources:
GSHS - Global School Health Survey (WHO)
GYTS - Global Youth Tobacco Survey (PAHO)
OAS - Report on Drug Use in the Americas

Alcohol Use
Students who drank at least one drink containing alcohol 1+ of the past 30 days
Binge drinking among secondary school students
Prevalence of alcohol use among secondary school students (past month)

Tobacco Use
Prevalence of current cigarette smokers
Prevalence of current use of any tobacco product
Students who reported people smoked in their presence, past 7 days
Among students who ever smoked cigarettes, those that first tried cigarettes before age 14 yrs

Overweight/Obesity/Diet
Students who were overweight (> +1SD from median for BMI for age and sex)
Students who were obese (> +2SD from median for BMI for age and sex)
Students who usually drank carbonated soft drinks 1+ times per day the past 30 days

Physical Activity
Students physically active at least 60 minutes daily on 5+ days the past 7 days
Students who spent 3+ hours per day doing sitting activities
Students who went to physical education (PE) class 3+ days weekly in the school year

Drug Use
Students who used marijuana 1+ times during their life
Prevalence of marijuana use among secondary school students
Prevalence of cocaine use among secondary school students
Prevalence of inhalants use among secondary school students

Violence and Unintentional Injuries
Students seriously injured 1+ times during the past 12 months
Students who were bullied 1+ days during the past 30 days
Students who were in a physical fight 1+ times the past 12 months

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Adolescent and Youth Health - 2017 Country Profile

GUATEMALA

POPLATION

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>814,502</td>
<td>810,181</td>
<td>1,624,683</td>
</tr>
<tr>
<td>15-19</td>
<td>921,906</td>
<td>900,963</td>
<td>1,822,869</td>
</tr>
<tr>
<td>10-14</td>
<td>981,777</td>
<td>950,038</td>
<td>1,931,815</td>
</tr>
<tr>
<td>10-24</td>
<td>2,718,185</td>
<td>2,661,183</td>
<td>5,379,367</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: **32%**

ECONOMIC DEVELOPMENT

<table>
<thead>
<tr>
<th>Source</th>
<th>GDP per capita, PPP (current international $)</th>
<th>GDP growth (annual %)</th>
</tr>
</thead>
</table>

EDUCATION PARTICIPATION

<table>
<thead>
<tr>
<th>Source</th>
<th>Net enrollment rate, secondary (%) (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>48%</td>
</tr>
</tbody>
</table>

MORTALITY RATES - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)

**10-14 years old**

- Influenza and Pneumonia: 33.3
- Assault (Homicide): 1.9
- Diseases of the urinary system: 2.0
- Intestinal infectious diseases: 3.8

**15-19 years old**

- Influenza and Pneumonia: 20.4
- Assault (Homicide): 11.8
- Diseases of the urinary system: 12.9
- Intestinal infectious diseases: 5.9

**20-24 years old**

- Influenza and Pneumonia: 12.2
- Assault (Homicide): 12.2
- Diseases of the urinary system: 5.9
- Intestinal infectious diseases: 1.9

MORTALITY TRENDS - Four Leading Causes of Death, by Sex (per 100,000 Population)

**Adolescent and Youth (10-24 years old), 2000-2014**

- Assault (Homicide): Up
- Handgun fire discharge non intentional: Up
- Road traffic injuries: Up
- Intentional self-harm (Suicide): Up

MENTAL HEALTH

Percentage of students who ever seriously considered attempting suicide during the past 12 months: **11.5%**

Students who actually attempted suicide one or more times during the past 12 months: **21.4%**

Percentage of students who did not have any close friends: **12.6%**

PROTECTIVE FACTORS

Students who missed classes or school without permission 1+ of the past 30 days: **19.9%**

Students whose parents really usually knew what they do with free time the past 30 days: **6.7%**

Students whose parents usually understood their problems and worries the past 30 days: **6.4%**

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**Adolescent and Youth Health - 2017 Country Profile**

**Guatemala**

### Sexual and Reproductive Health

#### Trends in Adolescent Fertility Rate

(Births per 1,000 women ages 15-19 years old, 1980-2015)


#### Sexual Behavior in Adolescents

(Age group: 13-15 years old)

- Source: 2015 Global School Health Survey (GSHS), WHO.

#### Risk Factors

**Sources:**

- GSHS - Global School Health Survey (WHO)
- GYTS - Global Youth Tobacco Survey (PAHO)
- OAS - Report on Drug Use in the Americas

#### Alcohol Use

- Students who drank at least one drink containing alcohol 1+ of the past 30 days
- Students who drank so much alcohol that they were really drunk 1+ times during their life

**Tobacco Use**

- Prevalence of current use of any tobacco product
- Prevalence of current cigarette smokers

#### Overweight/Obesity/Diet

- Students who usually drank carbonated soft drinks 1+ times per day the past 30 days
- Students who were overweight (+1SD from median for BMI for age and sex)
- Students who were obese (+2SD from median for BMI for age and sex)

#### Physical Activity

- Students who went to physical education (PE) class 3+ days weekly in the school year
- Students who spent 3+ hours per day doing sitting activities
- Percentage of students who were physically active for a total of at least 60 minutes per day on all 7 days during the past 7 days

#### Drug Use

- Among students who ever used drugs, those that first used drugs before age 14 yrs
- Students who used marijuana 1+ times during their life

#### Violence and Unintentional Injuries

- Students seriously injured 1+ times during the past 12 months
- Students who were in a physical fight 1+ times the past 12 months
- Students who were bullied 1+ days during the past 30 days
Adolescent and Youth Health - 2017 Country Profile

GUYANA

POPULATION


<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>38,594</td>
<td>38,344</td>
<td>76,938</td>
</tr>
<tr>
<td>15-19</td>
<td>47,743</td>
<td>47,381</td>
<td>95,124</td>
</tr>
<tr>
<td>10-14</td>
<td>42,195</td>
<td>42,103</td>
<td>84,298</td>
</tr>
<tr>
<td>10-24</td>
<td>128,532</td>
<td>127,828</td>
<td>256,360</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: 33%

MORTALITY RATES - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)


Note: * If there is no cause of death reported for a specific age group and sex, the corresponding bar with zero value is not being represented.

MORTALITY TRENDS - Four Leading Causes of Death, by Sex (per 100,000 Population)

MENTAL HEALTH

Source: 2010 Global School Health Survey (GSHS), WHO.

<table>
<thead>
<tr>
<th>Percentage of students who ever seriously considered attempting suicide during the past 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
</tr>
<tr>
<td>16.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage of students who had no close friends</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
</tr>
<tr>
<td>9.6</td>
</tr>
</tbody>
</table>

PROTECTIVE FACTORS

Source: 2010 Global School Health Survey (GSHS), WHO.

<table>
<thead>
<tr>
<th>Students who missed classes or school without permission 1+ of the past 30 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
</tr>
<tr>
<td>38.8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Students whose parents usually understood their problems and worries the past 30 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
</tr>
<tr>
<td>39.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Students whose parents really usually knew what they do with free time the past 30 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
</tr>
<tr>
<td>39.1</td>
</tr>
</tbody>
</table>
Adolescent and Youth Health - 2017 Country Profile

**GUYANA**

### Sexual and Reproductive Health

#### Trends in Adolescent Fertility Rate

(Births per 1,000 women ages 15-19 years old, 1980-2015)


#### Sexual Behavior in Adolescents

(Age group: 13-15 years old)

- Source: 2010 Global School Health Survey (GSHS), WHO.

**RISK FACTORS**

- **Sources:** GSHS - Global School Health Survey (WHO), GYTS - Global Youth Tobacco Survey (PAHO), OAS - Report on Drug Use in the Americas.

#### Alcohol Use

- Among students who ever drank alcohol, those that the first drink was before age 14 yrs
- Students who drank at least one drink containing alcohol 1+ of the past 30 days
- Binge drinking among secondary school students

#### Tobacco Use

- Prevalence of current cigarette smokers
- Prevalence of current use of any tobacco product
- Students who ever smoked cigarettes, those that first tried cigarettes before age 14 yrs
- Students who reported people smoked in their presence, past 7 days

#### Overweight/Obesity/Diet

- Students who usually drank carbonated soft drinks 1+ times per day the past 30 days
- Students who were overweight (> +1SD from median for BMI for age and sex)
- Students who were obese (> +2SD from median for BMI for age and sex)

#### Physical Activity

- Among students who ever had sexual intercourse, those that the first time was before age 14 yrs
- Among students who ever had sexual intercourse, those who used a condom the last time
- Students seriously injured 1+ times during the past 12 months
- Students who were in a physical fight 1+ times the past 12 months
- Students who were bullied 1+ days during the past 30 days

#### Drug Use

- Prevalence of cocaine use among secondary school students (lifetime)
- Prevalence of marijuana use among secondary school students (lifetime)
- Prevalence of marijuana use among secondary school students (past year)
- Prevalence of inhalants use among secondary school students (lifetime)

#### Violence and Unintentional Injuries

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Adolescent and Youth Health - 2017 Country Profile
Haiti

POPULATION


<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>523,549</td>
<td>525,753</td>
<td>1,049,302</td>
</tr>
<tr>
<td>15-19</td>
<td>566,626</td>
<td>556,623</td>
<td>1,123,249</td>
</tr>
<tr>
<td>10-14</td>
<td>592,046</td>
<td>575,606</td>
<td>1,167,652</td>
</tr>
<tr>
<td>10-24</td>
<td>1,682,221</td>
<td>1,657,982</td>
<td>3,340,203</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: 31%

ECONOMIC DEVELOPMENT


GDP per capita, PPP (current international $) 19,354.0 (2016)
GDP growth (annual %) 1.0 (2016)

EDUCATION PARTICIPATION

Source: UNICEF Data, USAID. Demographic and Health Survey (DHS), 2012.

Net attendance rate, secondary (%) 33% (2012)

MORTALITY RATES - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)

Note: * if there is no cause of death reported for a specific age group and sex, the corresponding bar with zero value is not being represented.

<table>
<thead>
<tr>
<th>Year</th>
<th>(10-14 years old)</th>
<th>(15-19 years old)</th>
<th>(20-24 years old)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1999</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MORTALITY TRENDS - Four Leading Causes of Death, by Sex (per 100,000 Population)


<table>
<thead>
<tr>
<th>Year</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1999</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MENTAL HEALTH

Source: Global School Health Survey (GSHS), WHO.

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students who ever seriously considered attempting suicide during the past 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Students who actually attempted suicide one or more times during the past 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Students who had no close friends</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PROTECTIVE FACTORS

Source: Global School Health Survey (GSHS), WHO.

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students who missed classes or school without permission 1+ of the past 30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Students whose parents usually understood their problems and worries the past 30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Students whose parents really usually knew what they do with free time the past 30 days</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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THE HEALTH OF ADOLESCENTS AND YOUTH IN THE AMERICAS
Adolescent and Youth Health - 2017 Country Profile

**Haiti**

**SEXUAL AND REPRODUCTIVE HEALTH**

**Trends in Adolescent Fertility Rate**
*(Births per 1,000 women ages 15-19 years old), 1980-2015*


**Sexual Behavior in Adolescents**
*(age group: 13-15 years old)*

- Students who ever had sexual intercourse
- Among students who ever had sexual intercourse, those that the first time was before age 14 yrs
- Among students who ever had sexual intercourse, those who used a condom the last time

**RISK FACTORS**

Sources:
- GSHS - Global School Health Survey (WHO)
- GYTS - Global Youth Tobacco Survey (PAHO)
- OAS - Report on Drug Use in the Americas

**Alcohol Use**

- Binge drinking among secondary school students
- Prevalence of alcohol use among secondary school students (past year)
- Prevalence of alcohol use among secondary school students (past month)

**Tobacco Use**

- Prevalence of tobacco use among secondary school students (lifetime)
- Prevalence of tobacco use among secondary school students (past year)
- Prevalence of tobacco use among secondary school students (past month)

**Overweight/Obesity/Diet**

- Students who were overweight (> +1SD from median for BMI for age and sex)
- Students who were obese (> +2SD from median for BMI for age and sex)
- Students who usually drank carbonated soft drinks 1+ times per day the past 30 days

**Physical Activity**

- Students physically active at least 60 minutes daily on 5+ days the past 7 days
- Students who spent 3+ hours per day doing sitting activities
- Students who went to physical education (PE) class 3+ days weekly in the school year

**Drug Use**

- Prevalence of cocaine use among secondary school students (lifetime)
- Prevalence of marijuana use among secondary school students (lifetime)
- Prevalence of marijuana use among secondary school students (past year)
- Prevalence of inhalants use among secondary school students (lifetime)

**Violence and Unintentional Injuries**

- Students seriously injured 1+ times during the past 12 months
- Students who were bullied 1+ days during the past 30 days
- Students who were in a physical fight 1+ times the past 12 months

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Sexual and Reproductive Health

Honduras

Trends in Adolescent Fertility Rate (Births per 1,000 women ages 15-19 years old, 1980-2015)

<table>
<thead>
<tr>
<th>Year</th>
<th>Honduras</th>
<th>North America</th>
<th>Latin America and the Caribbean</th>
<th>World</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980-1985</td>
<td>150</td>
<td>100</td>
<td>80</td>
<td>60</td>
</tr>
<tr>
<td>1990-1995</td>
<td>100</td>
<td>70</td>
<td>50</td>
<td>40</td>
</tr>
<tr>
<td>2000-2005</td>
<td>50</td>
<td>30</td>
<td>20</td>
<td>15</td>
</tr>
<tr>
<td>2010-2015</td>
<td>0</td>
<td>5</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

Sexual Behavior in Adolescents (age group: 13-15 years old)

Students who had sexual intercourse at least once

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012 GSHS</td>
<td>79.5%</td>
<td>74.9%</td>
<td>77.1%</td>
</tr>
</tbody>
</table>

Students who reported people smoked in their presence, past 7 days

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012 GSHS</td>
<td>12.2%</td>
<td>12.5%</td>
<td>12.7%</td>
</tr>
</tbody>
</table>

Violence and Unintentional Injuries

Students who were bullied 1+ times during the past 30 days

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012 GSHS</td>
<td>31.5%</td>
<td>31.8%</td>
<td>31.6%</td>
</tr>
</tbody>
</table>

Drug Use

Prevalence of cocaine use among secondary school students (lifetime)

<table>
<thead>
<tr>
<th></th>
<th>2015 OAS</th>
<th>2012 GSHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>3.2%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Female</td>
<td>2.1%</td>
<td>2.9%</td>
</tr>
</tbody>
</table>

Prevalence of marijuana use among secondary school students (lifetime)

<table>
<thead>
<tr>
<th></th>
<th>2015 OAS</th>
<th>2012 GSHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>4.5%</td>
<td>5.6%</td>
</tr>
<tr>
<td>Female</td>
<td>1.6%</td>
<td>2.9%</td>
</tr>
</tbody>
</table>

Prevalence of marijuana use among secondary school students (past year)

<table>
<thead>
<tr>
<th></th>
<th>2015 OAS</th>
<th>2012 GSHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>1.7%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Female</td>
<td>0.6%</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

Prevalence of inhalants use among secondary school students (lifetime)

<table>
<thead>
<tr>
<th></th>
<th>2015 OAS</th>
<th>2012 GSHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>1.2%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Female</td>
<td>1.9%</td>
<td>1.9%</td>
</tr>
</tbody>
</table>

Prevalence of inhalants use among secondary school students (past year)

<table>
<thead>
<tr>
<th></th>
<th>2015 OAS</th>
<th>2012 GSHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>1.7%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Female</td>
<td>0.6%</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

Prevalence of tobacco use among secondary school students (past year)

<table>
<thead>
<tr>
<th></th>
<th>2015 OAS</th>
<th>2012 GSHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>12.7%</td>
<td>12.2%</td>
</tr>
<tr>
<td>Female</td>
<td>11.2%</td>
<td>10.7%</td>
</tr>
</tbody>
</table>

Sources:

GSHS - Global School Health Survey (WHO)
GYTS - Global Youth Tobacco Survey (PAHO)
OAS - Report on Drug Use in the Americas

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Adolescent and Youth Health - 2017 Country Profile

JAMAICA

**POPULATION**


<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>134,136</td>
<td>131,260</td>
<td>265,396</td>
</tr>
<tr>
<td>15-19</td>
<td>135,919</td>
<td>129,446</td>
<td>265,365</td>
</tr>
<tr>
<td>10-14</td>
<td>117,573</td>
<td>112,478</td>
<td>230,051</td>
</tr>
<tr>
<td>10-24</td>
<td>387,628</td>
<td>373,184</td>
<td>760,812</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: **27%**

**ECONOMIC DEVELOPMENT**


<table>
<thead>
<tr>
<th>Parameter</th>
<th>Data 2015</th>
<th>Data 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>GDP per capita, PPP (current international $)</td>
<td>25,456.3</td>
<td>25,465.9</td>
</tr>
<tr>
<td>GDP growth (annual %)</td>
<td>1.4</td>
<td>1.4</td>
</tr>
<tr>
<td>Net enrollment rate, secondary (%)</td>
<td>69%</td>
<td>77%</td>
</tr>
</tbody>
</table>

**MORTALITY RATES - Four Leading Causes of Death, by Age Group and Sex** (per 100,000 Population)


Note: * If there is no cause of death reported for a specific age group and sex, the corresponding bar with zero value is not being represented.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-14</td>
<td>72.2</td>
<td>4.5</td>
<td>1.8</td>
</tr>
<tr>
<td>15-19</td>
<td>4.3</td>
<td>0.8</td>
<td>2.2</td>
</tr>
<tr>
<td>20-24</td>
<td>7.5</td>
<td>13.5</td>
<td>22.2</td>
</tr>
</tbody>
</table>

**MORTALITY TRENDS - Four Leading Causes of Death, by Sex** (per 100,000 Population)


**MENTAL HEALTH**

Source: 2017 Global School Health Survey (GSHS), WHO.

<table>
<thead>
<tr>
<th>Percentage of students who ever seriously considered attempting suicide during the past 12 months</th>
<th>Students who actually attempted suicide one or more times during the past 12 months</th>
<th>Students who had no close friends</th>
<th>Students who missed classes or school without permission 1+ of the past 30 days</th>
<th>Students whose parents usually understood their problems and worries the past 30 days</th>
<th>Students whose parents really usually knew what they do with free time the past 30 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.5</td>
<td>4.0</td>
<td>86.1</td>
<td>20.8</td>
<td>10.5</td>
<td>30.2</td>
</tr>
</tbody>
</table>

**PROTECTIVE FACTORS**

Source: 2017 Global School Health Survey (GSHS), WHO.

<table>
<thead>
<tr>
<th>Percentage of students whose parents usually understood their problems and worries the past 30 days</th>
<th>Students who missed classes or school without permission 1+ of the past 30 days</th>
<th>Students whose parents really usually knew what they do with free time the past 30 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>34.1</td>
<td>31.6</td>
<td>37.9</td>
</tr>
</tbody>
</table>

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Adolescent and Youth Health - 2017 Country Profile

JAMAICA

TRENDS IN ADOLESCENT FERTILITY RATE
(Births per 1,000 women ages 15-19 years old, 1980-2015)

Sexual and Reproductive Health

Alcohol Use

Among students who ever drunk alcohol, those that the first drink was before age 14 yrs

2017 GSHS

85.2% 78.7% 82.6%

Tobacco Use

Percentage of students who currently used any tobacco products on one or more days during the past 30 days

2017 GSHS

24.3% 11.4% 17.6%

Overweight/Obesity/Diet

Students who usually drank carbonated soft drinks 1+ times per day the past 30 days

2017 GSHS

73.7% 66.5% 69.9%

Students who went to physical education (PE) class 3+ days weekly in the school year

2017 GSHS

30.5% 20.3% 25.5%

Prevalence of marijuana use among secondary school students (lifetime)

2015 OAS

25.4% 18.0% 21.1%

2017 GSHS

14.8% 14.6% 13.4%

Violence and Unintentional Injuries

Students who were in a physical fight 1+ times the past 12 months

2017 GSHS

44.3% 25.4% 34.5%

Students who were bullied 1+ days during the past 30 days

2017 GSHS

26.3% 24.8% 25.5%
Adolescent and Youth Health - 2017 Country Profile

Martinique

**POPULATION**

Adolescent and Youth Population

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-14</td>
<td>12,451</td>
<td>12,689</td>
<td>25,170</td>
</tr>
<tr>
<td>15-19</td>
<td>12,260</td>
<td>12,260</td>
<td>24,520</td>
</tr>
<tr>
<td>20-24</td>
<td>37,192</td>
<td>25,170</td>
<td>62,362</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: 18%

**ECONOMIC DEVELOPMENT**


GDP per capita, PPP (current international $) N/A

GDP growth (annual %) N/A

Net school enrollment rate, secondary (%) N/A

**MORTALITY RATES - Four Leading Causes of Death, by Age Group and Sex** (per 100,000 Population)


Note: * if there is no cause of death reported for a specific age group and sex, the corresponding bar with zero value is not being represented.

**MORTALITY TRENDS - Four Leading Causes of Death, by Sex** (per 100,000 Population)

Adolescent and Youth (10-24 years old), 2000-2013

**MENTAL HEALTH**

Source: Global School Health Survey (GSHS), WHO.

- Students who had no close friends
- Students who missed classes or school without permission 1+ of the past 30 days
- Students whose parents usually understood their problems and worries the past 30 days
- Students who ever seriously considered attempting suicide during the past 12 months
- Students who actually attempted suicide one or more times during the past 12 months

**PROTECTIVE FACTORS**

Source: Global School Health Survey (GSHS), WHO.

- Students whose parents usually understood their problems and worries the past 30 days

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**Trends in Adolescent Fertility Rate**

(Births per 1,000 women ages 15-19 years old), 1980-2015


**Sexual Behavior in Adolescents**

(age group: 13-15 years old)

- Source: Global School Health Survey (GSHS), WHO.

<table>
<thead>
<tr>
<th>Source</th>
<th>Data Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students who ever had sexual intercourse</td>
<td>No Data Available</td>
</tr>
<tr>
<td>Among students who ever had sexual intercourse, those that the first time was before age 14 yrs</td>
<td>No Data Available</td>
</tr>
<tr>
<td>Among students who ever had sexual intercourse, those who used a condom the last time</td>
<td>No Data Available</td>
</tr>
</tbody>
</table>

**Risk Factors**

- **Sources:** GSHS - Global School Health Survey (WHO), GYTS - Global Youth Tobacco Survey (PAHO), OAS - Report on Drug Use in the Americas

### Alcohol Use

- Students who drank at least one drink containing alcohol 1+ of the past 30 days
- Binge drinking among secondary school students
- Prevalence of alcohol use among secondary school students (past month)

**No Data Available**

### Tobacco Use

- Prevalence of current cigarette smokers
- Prevalence of current use of any tobacco product
- Students who reported people smoked in their presence, past 7 days
- Among students who ever smoked cigarettes, those that first tried cigarettes before age 14 yrs

**No Data Available**

### Overweight/Obesity/Diet

- Students who were overweight (> +1SD from median for BMI for age and sex)
- Students who were obese (> +2SD from median for BMI for age and sex)
- Students who usually drank carbonated soft drinks 1+ times per day the past 30 days

**No Data Available**

### Physical Activity

- Students physically active at least 60 minutes daily on 5+ days the past 7 days
- Students who spent 3+ hours per day doing sitting activities
- Students who went to physical education (PE) class 3+ days weekly in the school year

**No Data Available**

### Drug Use

- Students who used marijuana 1+ times during their life
- Prevalence of marijuana use among secondary school students
- Prevalence of cocaine use among secondary school students
- Prevalence of inhalants use among secondary school students

**No Data Available**

### Violence and Unintentional Injuries

- Students seriously injured 1+ times during the past 12 months
- Students who were bullied 1+ days during the past 30 days
- Students who were in a physical fight 1+ times the past 12 months

**No Data Available**
Adolescent and Youth Health - 2017 Country Profile

MEXICO

POPULATION

Adolescent and Youth Population

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>5,820,837</td>
<td>5,655,125</td>
<td>11,475,962</td>
</tr>
<tr>
<td>15-19</td>
<td>6,049,388</td>
<td>5,869,756</td>
<td>11,919,144</td>
</tr>
<tr>
<td>10-14</td>
<td>5,998,908</td>
<td>5,775,705</td>
<td>11,774,613</td>
</tr>
<tr>
<td>10-24</td>
<td>17,869,133</td>
<td>17,300,586</td>
<td>35,169,719</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: 27%

ECONOMIC DEVELOPMENT

GDP per capita, PPP (current international $) | 2,278,072.0 (2016)  
GDP growth (annual %) | 2.3 (2016)  
Net enrollment rate, secondary (%) | (2012)

MORTALITY RATES - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)

(10-14 years old)

<table>
<thead>
<tr>
<th>Cause</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Road traffic injuries</td>
<td>2.1</td>
<td>3.2</td>
<td>2.6</td>
</tr>
<tr>
<td>Malignant neoplasms, of lymphoid, haematopoietic and related tissue</td>
<td>1.6</td>
<td>1.9</td>
<td>1.7</td>
</tr>
<tr>
<td>Intentional self-harm (Suicide)</td>
<td>0.4</td>
<td>0.4</td>
<td>0.4</td>
</tr>
<tr>
<td>Congenital malformations</td>
<td>0.6</td>
<td>0.6</td>
<td>0.6</td>
</tr>
</tbody>
</table>

(15-19 years old)

<table>
<thead>
<tr>
<th>Cause</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Road traffic injuries</td>
<td>1.3</td>
<td>2.3</td>
<td>1.8</td>
</tr>
<tr>
<td>Malignant neoplasms, of lymphoid, haematopoietic and related tissue</td>
<td>1.6</td>
<td>2.4</td>
<td>2.0</td>
</tr>
<tr>
<td>Intentional self-harm (Suicide)</td>
<td>0.6</td>
<td>0.6</td>
<td>0.6</td>
</tr>
<tr>
<td>Assault (Homicide)</td>
<td>0.4</td>
<td>0.4</td>
<td>0.4</td>
</tr>
</tbody>
</table>

(20-24 years old)

<table>
<thead>
<tr>
<th>Cause</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Road traffic injuries</td>
<td>5.5</td>
<td>5.0</td>
<td>5.2</td>
</tr>
<tr>
<td>Malignant neoplasms, of lymphoid, haematopoietic and related tissue</td>
<td>2.4</td>
<td>2.4</td>
<td>2.4</td>
</tr>
<tr>
<td>Intentional self-harm (Suicide)</td>
<td>0.4</td>
<td>0.4</td>
<td>0.4</td>
</tr>
<tr>
<td>Assault (Homicide)</td>
<td>0.4</td>
<td>0.4</td>
<td>0.4</td>
</tr>
</tbody>
</table>

MORTALITY TRENDS - Four Leading Causes of Death, by Sex (per 100,000 Population)

Mental Health

Source: Global School Health Survey (GSHS), WHO.

Protective Factors

Source: Global School Health Survey (GSHS), WHO.

No Data Available

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MEXICO

SEXUAL AND REPRODUCTIVE HEALTH

Trends in Adolescent Fertility Rate
(Births per 1,000 women ages 15-19 years old, 1980-2015)

Sexual Behavior in Adolescents
(age group: 13-15 years old)
Source: Global School Health Survey (GSHS), WHO.

RISK FACTORS

Sources:
GSHS - Global School Health Survey (WHO)
GYTS - Global Youth Tobacco Survey (PAHO)
OAS - Report on Drug Use in the Americas

Alcohol Use
Students who drank at least one drink containing alcohol 1+ of the past 30 days
Binge drinking among secondary school students
Prevalence of alcohol use among secondary school students (past month)

No Data Available

Tobacco Use
Prevalence of current use of any tobacco product
Prevalence of current cigarette smokers

Overweight/Obesity/Diet
Students who were overweight (> +1SD from median for BMI for age and sex)
Students who were obese (> +2SD from median for BMI for age and sex)
Students who usually drank carbonated soft drinks 1+ times per day the past 30 days

No Data Available

Physical Activity
Students physically active at least 60 minutes daily on 5+ days the past 7 days
Students who spent 3+ hours per day doing sitting activities
Students who went to physical education (PE) class 3+ days weekly in the school year

No Data Available

Drug Use
Students who used marijuana 1+ times during their life
Prevalence of marijuana use among secondary school students
Prevalence of cocaine use among secondary school students
Prevalence of inhalants use among secondary school students

No Data Available

Violence and Unintentional Injuries
Students seriously injured 1+ times during the past 12 months
Students who were bullied 1+ days during the past 30 days
Students who were in a physical fight 1+ times the past 12 months

No Data Available

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Adolescent and Youth Health - 2017 Country Profile

MONTSETRAT

POPULATION


<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>182</td>
<td>167</td>
<td>349</td>
</tr>
<tr>
<td>15-19</td>
<td>423</td>
<td>391</td>
<td>814</td>
</tr>
<tr>
<td>10-14</td>
<td>144</td>
<td>135</td>
<td>279</td>
</tr>
<tr>
<td>10-24</td>
<td>749</td>
<td>693</td>
<td>1,442</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: 27%

ECONOMIC DEVELOPMENT


| GDP per capita, PPP (current international $) | N/A |
| GDP growth (annual %)                        | N/A |

EDUCATION PARTICIPATION

Net school enrollment rate, secondary (%)

MORTALITY RATES - Reported Causes of Death, by Age Group and Sex (per 100,000 Population)


Note: * If there is no cause of death reported for a specific age group and sex, the corresponding bar with zero value is not being represented.

MORTALITY TRENDS - Reported Causes of Death, by Sex (per 100,000 Population)

Adolescent and Youth (10-24 years old), 2000-2012

MENTAL HEALTH

Source: 2008 Global School Health Survey (GSHS), WHO.

<table>
<thead>
<tr>
<th>Percentage of students who felt lonely most of the time or always during the past 12 months</th>
<th>Percentage of students who ever seriously considered attempting suicide during the past 12 months</th>
<th>Students who had no close friends</th>
<th>Students who missed classes or school without permission 1+ of the past 30 days</th>
<th>Students whose parents usually understood their problems and worries the past 30 days</th>
<th>Students whose parents really usually knew what they do with free time the past 30 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.4</td>
<td>10.8</td>
<td>13.0</td>
<td>8.3</td>
<td>11.7</td>
<td>9.9</td>
</tr>
</tbody>
</table>

PROTECTIVE FACTORS

Source: 2008 Global School Health Survey (GSHS), WHO.

<table>
<thead>
<tr>
<th>Percentage of students whose parents allowed them to go to parties or school functions without permission 1+ of the past 30 days</th>
<th>Students who were allowed to go to parties or school functions without permission 1+ of the past 30 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.8</td>
<td>10.8</td>
</tr>
</tbody>
</table>

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**Adolescent and Youth Health - 2017 Country Profile**

**MONTSERRAT**

### Sexual and Reproductive Health

#### Trends in Adolescent Fertility Rate
*(Births per 1,000 women ages 15-19 years old, 1980-2015)*


#### Sexual Behavior in Adolescents
*(age group: 13-15 years old)*

- Students who ever had sexual intercourse
- Among students who ever had sexual intercourse, those that the first time was before age 14 yrs
- Among students who ever had sexual intercourse, those who used a condom the last time

### Risk Factors

**Sources:**
- GSHS - Global School Health Survey (WHO)
- GYTS - Global Youth Tobacco Survey (PAHO)
- OAS - Report on Drug Use in the Americas

#### Alcohol Use

- Students who drank at least one drink containing alcohol 1+ of the past 30 days
- Students who drank so much alcohol that they were really drunk 1+ times during their life

#### Tobacco Use

- Prevalence of current cigarette smokers
- Prevalence of current use of any tobacco product
- Students who reported people smoked in their presence, past 7 days
- Among students who ever smoked cigarettes, those that first tried cigarettes before age 14 yrs

#### Overweight/Obesity/Diet

- Students who were overweight (> +1SD from median for BMI for age and sex)
- Students who were obese (> +2SD from median for BMI for age and sex)
- Students who usually drank carbonated soft drinks 1+ times per day the past 30 days

#### Physical Activity

- Students who spent 3+ hours per day doing sitting activities
- Students physically active at least 60 minutes daily on all 7 days during the past 7 days

#### Drug Use

- Students who used drugs 1+ times during their life

#### Violence and Unintentional Injuries

- Students seriously injured 1+ times during the past 12 months
- Students who were in a physical fight 1+ times the past 12 months
- Students who were bullied 1+ days during the past 30 days

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NICARAGUA

SEXUAL AND REPRODUCTIVE HEALTH

Trends in Adolescent Fertility Rate
(Births per 1,000 women ages 15-19 years old), 1980-2015

Sexual Behavior in Adolescents
(age group: 13-15 years old)
Source: Global School Health Survey (GSHS), WHO.

- Students who ever had sexual intercourse
- Among students who ever had sexual intercourse, those that the first time was before age 14 yrs
- Among students who ever had sexual intercourse, those who used a condom the last time

No Data Available

RISK FACTORS

Sources:
- GSHS - Global School Health Survey (WHO)
- GYTS - Global Youth Tobacco Survey (PAHO)
- OAS - Report on Drug Use in the Americas

Alcohol Use
No Data Available

- Students who drank at least one drink containing alcohol 1+ of the past 30 days
- Binge drinking among secondary school students
- Prevalence of alcohol use among secondary school students (past month)

Tobacco Use

- Prevalence of current use of any tobacco product
  - 2014 GYTS
    - 14.5%
    - 17.6%
    - 20.6%

- Prevalence of current cigarette smokers
  - 2014 GYTS
    - 10.3%
    - 12.2%

Overweight/Obesity/Diet
No Data Available

- Students who were overweight (> +1SD from median for BMI for age and sex)
- Students who were obese (> +2SD from median for BMI for age and sex)
- Students who usually drank carbonated soft drinks 1+ times per day the past 30 days

Physical Activity
No Data Available

- Students physically active at least 60 minutes daily on 5+ days the past 7 days
- Students who spent 3+ hours per day doing sitting activities
- Students who went to physical education (PE) class 3+ days weekly in the school year

Drug Use
No Data Available

- Students who used marijuana 1+ times during their life
- Prevalence of marijuana use among secondary school students
- Prevalence of cocaine use among secondary school students
- Prevalence of inhalants use among secondary school students

Violence and Unintentional Injuries
No Data Available

- Students seriously injured 1+ times during the past 12 months
- Students who were bullied 1+ days during the past 30 days
- Students who were in a physical fight 1+ times the past 12 months

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THE HEALTH OF ADOLESCENTS AND YOUTH IN THE AMERICAS
Adolescent and Youth Health - 2017 Country Profile

**PANAMA**

### POPULATION


<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>165,247</td>
<td>161,055</td>
<td>326,302</td>
</tr>
<tr>
<td>15-19</td>
<td>175,436</td>
<td>169,893</td>
<td>345,329</td>
</tr>
<tr>
<td>10-14</td>
<td>175,688</td>
<td>169,129</td>
<td>344,817</td>
</tr>
<tr>
<td>10-24</td>
<td>516,371</td>
<td>500,077</td>
<td>1,016,448</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: 25%

### ECONOMIC DEVELOPMENT


- GDP per capita, PPP (current international $): 9,284.0 (2016)
- GDP growth (annual %): 5.0 (2016)
- Net enrollment rate, secondary (%): 75% (2012)

### MORTALITY RATES - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)


**10-14 years old**

- Road traffic injuries: 4.0
- Malignant neoplasms, of lymphoid, haematopoietic and related tissue: 1.8
- Congenital malformations: 3.4
- Influenza and Pneumonia: 2.4
- Intentional self-harm (Suicide): 1.7

**15-19 years old**

- Road traffic injuries: 4.5
- Malignant neoplasms, of lymphoid, haematopoietic and related tissue: 3.0
- Assault (Homicide): 1.6
- Intentional self-harm (Suicide): 3.0
- Intentional self-harm (Suicide): 1.2

**20-24 years old**

- Road traffic injuries: 4.0
- Malignant neoplasms, of lymphoid, haematopoietic and related tissue: 5.1
- Assault (Homicide): 1.1
- Intentional self-harm (Suicide): 3.0
- Intentional self-harm (Suicide): 1.9

### MORTALITY TRENDS - Four Leading Causes of Death, by Sex (per 100,000 Population)

Adolescent and Youth (10-24 years old), 2000-2014

- Pregnancy, childbirth and the puerperium
- Road traffic injuries
- Assault (Homicide)
- (HIV) diseases

### MENTAL HEALTH

Source: Global School Health Survey (GSHS), WHO.

- Students who ever seriously considered attempting suicide during the past 12 months
- Students who actually attempted suicide one or more times during the past 12 months
- Students who had no close friends
- Students who missed classes or school without permission 1+ of the past 30 days
- Students whose parents really usually knew what they do with free time the past 30 days
- Students whose parents usually understood their problems and worries the past 30 days

No Data Available

### PROTECTIVE FACTORS

Source: Global School Health Survey (GSHS), WHO.

- Students who actually attended school every day
- Students who had no problems and worries during the past 30 days
- Students who had positive emotional and mental health
- Students who had nopermission 1+ of the past 30 days
- Students whose parents usually understood their problems and worries the past 30 days

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Adolescent and Youth Health - 2017 Country Profile

PARAGUAY

POPULATION


Adolescent and Youth Population

| Age  | Male   | Female  | Total |  
|------|--------|---------|-------|---
| 20-24| 335,077| 322,725 | 657,720
| 15-19| 347,016| 333,652 | 680,668
| 10-14| 333,970| 321,301 | 655,271
| Total | 1,016,063 | 977,678 | 1,993,741

Adolescents and Youth, percentage of total population: 30%

ECONOMIC DEVELOPMENT


GDP per capita, PPP (current international $) | 64,405.0 (2016)
GDP growth (annual %) | 4.0 (2016)
Net enrollment rate, secondary (%) | 67%

MORTALITY RATES - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)


MORTALITY TRENDS - Four Leading Causes of Death, by Sex (per 100,000 Population)

MENTAL HEALTH

Source: 2017 Global School Health Survey (GSHS), WHO.

PROTECTIVE FACTORS

Source: 2017 Global School Health Survey (GSHS), WHO.

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www.paho.org
**SEXUAL AND REPRODUCTIVE HEALTH**

### Trends in Adolescent Fertility Rate

- **Births per 1,000 women ages 15-19 years old,** 1980-2015

![Graph showing trends in adolescent fertility rate](Image)

### Sexual Behavior in Adolescents

- **Age group:** 13-15 years old
- **Source:** 2017 Global School Health Survey (GSHS), WHO.

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students who had sexual intercourse</td>
<td>12.5%</td>
<td>18.5%</td>
<td>25.3%</td>
</tr>
<tr>
<td>Among students who had sexual intercourse, those that the first time was before age 14 yrs</td>
<td>41.9%</td>
<td>39.5%</td>
<td>40.7%</td>
</tr>
<tr>
<td>Among students who had sexual intercourse, those who used a condom the last time</td>
<td>76.0%</td>
<td>72.3%</td>
<td>74.2%</td>
</tr>
</tbody>
</table>

### Risk Factors

**Sources:**
- GSHS - Global School Health Survey (WHO)
- GYTS - Global Youth Tobacco Survey (PAHO)
- OAS - Report on Drug Use in the Americas

#### Alcohol Use

- **Among students who ever drunk alcohol, those that the first drink was before age 14 yrs**
  - 2017 GSHS: 63.1% Male, 60.3% Female, 61.6% Total
  - 2015 OAS: 50.6% Male, 52.4% Female, 51.6% Total

#### Tobacco Use

- **Prevalence of tobacco use among secondary school students (past year)**
  - 2015 OAS: 26.0% Male, 21.1% Female, 23.0% Total
  - 2015 OAS: 17.7% Male, 14.7% Female, 16.2% Total
  - 2014 GYTS: 4.7% Male, 7.6% Female, 6.6% Total
  - 2014 GYTS: 3.9% Male, 3.9% Female, 3.9% Total

#### Overweight/Obesity/Diet

- **Students who usually drank carbonated soft drinks 1+ times per day the past 30 days**
  - 2017 GSHS: 64.5% Male, 59.5% Female, 62.1% Total
  - 2017 GSHS: 25.7% Male, 27.1% Female, 26.4% Total
  - 2017 GSHS: 8.7% Male, 6.2% Female, 7.4% Total

### Physical Activity

- **Students who went to physical education (PE) class 3+ days weekly in the school year**
  - 2017 GSHS: 27.7% Male, 16.5% Female, 21.2% Total
  - 2017 GSHS: 32.1% Male, 35.0% Female, 33.5% Total
  - 2017 GSHS: 23.0% Male, 12.2% Female, 17.4% Total

### Drug Use

- **Prevalence of cocaine use among secondary school students (lifetime)**
  - 2015 OAS: 1.4% Male, 0.6% Female, 1.0% Total
  - 2015 OAS: 6.0% Male, 2.7% Female, 4.4% Total
  - 2015 OAS: 4.6% Male, 1.8% Female, 3.0% Total
  - 2015 OAS: 2.7% Male, 2.8% Female, 2.8% Total

### Violence and Unintentional Injuries

- **Students seriously injured 1+ times during the past 12 months**
  - 2017 GSHS: 26.1% Male, 14.5% Female, 19.8% Total
  - 2017 GSHS: 20.3% Male, 14.6% Female, 16.7% Total
  - 2017 GSHS: 40.6% Male, 30.2% Female, 34.4% Total

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Adolescent and Youth Health - 2017 Country Profile

PERU

SEXUAL AND REPRODUCTIVE HEALTH

Trends in Adolescent Fertility Rate
(Births per 1,000 women ages 15-19 years old), 1980-2015

RISK FACTORS
Sources: GSHS - Global School Health Survey (WHO) GYTS - Global Youth Tobacco Survey (PAHO) OAS - Report on Drug Use in the Americas

Alcohol Use
Prevalence of alcohol use among secondary school students (past month)
2015 OAS 13.1% 10.9% 12.0%
2010 GSHS Among students who ever drunk alcohol, those that the first drink was before age 14 yrs
2010 GSHS 70.2% 62.0% 66.4%
Binge drinking among secondary school students
2015 OAS 25.7% 18.7% 24.4%
Prevalence of alcohol use among secondary school students (past year)
2015 OAS 23.2% 24.4% 24.4%

Tobacco Use
Among students who ever smoked cigarettes, those that first tried cigarettes before age 14 yrs
2010 GSHS 66.5% 65.5% 67.3%
Prevalence of current use of any tobacco product
2014 GYTS Among students who smoked cigarettes 1+ days during the past 30 days
2010 GSHS 10.9% 8.4% 9.7%
Students who smoked cigarettes 1+ days during the past 30 days
2010 GSHS 22.9% 11.3% 17.3%
Students who reported people smoked in their presence, past 7 days
2010 GSHS 58.2% 57.7% 57.7%

Overweight/Obesity/Diet
Students who usually drank carbonated soft drinks 1+ times per day the past 30 days
2010 GSHS 54.0% 53.0% 53.9%
Students who were overweight (+1SD from median for BMI for age and sex)
2010 GSHS 21.8% 18.7% 20.2%
Students who were obese (+2SD from median for BMI for age and sex)
2010 GSHS 3.0% 2.7% 2.9%

Physical Activity
Students who went to physical education (PE) class 3+ days weekly in the school year
2010 GSHS 2.2% 2.5% 2.4%
Students who spent 3+ hours per day doing sitting activities
2010 GSHS 28.4% 28.5% 28.9%
Students physically active at least 60 minutes daily on 5+ days the past 7 days
2010 GSHS 27.0% 22.1% 24.5%

Drug Use
Among Students who ever used drugs, those that first used drugs before age 14 yrs
2010 GSHS 5.7% 1.9% 3.0%
Students who used marijuana 1+ times during their life
2010 GSHS 2.3% 1.3% 1.8%
Prevalence of cocaine use among secondary school students (lifetime)
2015 OAS 6.3% 3.8% 9.0%
Prevalence of marijuana use among secondary school students (lifetime)
2015 OAS 2.9% 2.6% 2.7%
Prevalence of inhalants use among secondary school students (lifetime)
2015 OAS

Violence and Unintentional Injuries
Students seriously injured 1+ times during the past 12 months
2010 GSHS 53.8% 44.2% 48.9%
Students who were in a physical fight 1+ times the past 12 months
2010 GSHS 52.4% 52.4% 52.4%
Students who were bullied 1+ days during the past 30 days
2010 GSHS 46.7% 48.2% 47.4%

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Pan American Health Organization
THE HEALTH OF ADOLESCENTS AND YOUTH IN THE AMERICAS

THE HEALTH OF ADOLESCENTS AND YOUTH IN THE AMERICAS
Adolescent and Youth Health - 2017 Country Profile

PUERTO RICO

POPULATION


Adolescent and Youth Population

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
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<tbody>
<tr>
<td>20-24</td>
<td>140,033</td>
<td>138,443</td>
<td>278,476</td>
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<td>15-19</td>
<td>139,888</td>
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<td>10-14</td>
<td>126,521</td>
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<tr>
<td>10-24</td>
<td>406,442</td>
<td>382,369</td>
<td>788,811</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: 21%

ECONOMIC DEVELOPMENT


GDP per capita, PPP (current international $) 125,842.8 (2013)
GDP growth (annual %) -0.6 (2013)

EDUCATION PARTICIPATION

Net enrollment rate, secondary (%) (2014)
73% 78%

MORTALITY RATES - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)


Note: * if there is no cause of death reported for a specific age group and sex, the corresponding bar with zero value is not being represented.

(10-14 years old)

- Congenital malformations
- Road traffic injuries
- Assault (Homicide)
- Intentional self-harm (Suicide)

(15-19 years old)

- Assault (Homicide)
- Road traffic injuries
- Intentional self-harm (Suicide)
- Accidental drowning/submersion

(20-24 years old)

- Assault (Homicide)
- Road traffic injuries
- Intentional self-harm (Suicide)
- Cerebrovascular diseases

MORTALITY TRENDS - Four Leading Causes of Death, by Sex (per 100,000 Population)

Adolescent and Youth (10-24 years old), 2000-2014

- Assault (Homicide)
- Road traffic injuries
- Intentional self-harm (Suicide)
- Accidental drowning/submersion
- Malignant neoplasms, of lymphoid, haematopoietic and related tissue

MENTAL HEALTH

Source: Global School Health Survey (GSHS), WHO.

- Students who ever seriously considered attempting suicide during the past 12 months
- Students who actually attempted suicide one or more times during the past 12 months
- Students who had no close friends
- Students who missed classes or school without permission 1+ of the past 30 days
- Students whose parents usually understood their problems and worries the past 30 days

PROTECTIVE FACTORS

Source: Global School Health Survey (GSHS), WHO.

- Students whose parents usually knew what they do with free time the past 30 days

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Adolescent and Youth Health - 2017 Country Profile
Puerto Rico

SEXUAL AND REPRODUCTIVE HEALTH

Trends in Adolescent Fertility Rate
(Births per 1,000 women ages 15-19 years old), 1980-2015

Sexual Behavior in Adolescents
(age group: 13-15 years old)
Source: Global School Health Survey (GSHS), WHO.

RISK FACTORS

Sources: GSHS - Global School Health Survey (WHO)  GYTS - Global Youth Tobacco Survey (PAHO)  OAS - Report on Drug Use in the Americas

Alcohol Use
Students who drank at least one drink containing alcohol 1+ of the past 30 days
No Data Available
Binge drinking among secondary school students
Prevalence of alcohol use among secondary school students (past month)

Tobacco Use
Prevalence of current cigarette smokers
No Data Available
Prevalence of current use of any tobacco product
No Data Available
Students who reported people smoked in their presence, past 7 days
Among students who ever smoked cigarettes, those that first tried cigarettes before age 14 yrs

Overweight/Obesity/Diet
Students who were overweight (> +1SD from median for BMI for age and sex)
No Data Available
Students who were obese (> +2SD from median for BMI for age and sex)
No Data Available
Students who usually drank carbonated soft drinks 1+ times per day the past 30 days

Physical Activity
Students physically active at least 60 minutes daily on 5+ days the past 7 days
No Data Available
Students who spent 3+ hours per day doing sitting activities
No Data Available
Students who went to physical education (PE) class 3+ days weekly in the school year

Drug Use
Students who used marijuana 1+ times during their life
No Data Available
Prevalence of marijuana use among secondary school students
Prevalence of cocaine use among secondary school students
Prevalence of inhalants use among secondary school students

Violence and Unintentional Injuries
Students seriously injured 1+ times during the past 12 months
No Data Available
Students who were bullied 1+ days during the past 30 days
No Data Available
Students who were in a physical fight 1+ times the past 12 months

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Adolescent and Youth Health - 2017 Country Profile

SAINT KITTS AND NEVIS

POPULATION


<table>
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<tr>
<th>Age</th>
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<th>Total</th>
</tr>
</thead>
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<tr>
<td>20-24</td>
<td>1,831</td>
<td>1,909</td>
<td>3,740</td>
</tr>
<tr>
<td>15-19</td>
<td>1,936</td>
<td>2,078</td>
<td>4,014</td>
</tr>
<tr>
<td>10-14</td>
<td>1,811</td>
<td>1,825</td>
<td>3,636</td>
</tr>
<tr>
<td>10-24</td>
<td>5,578</td>
<td>5,812</td>
<td>11,390</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: 22%

ECONOMIC DEVELOPMENT


GDP per capita, PPP (current international $) 1,463.0 (2016)
GDP growth (annual %) 3.6 (2016)
Net enrollment rate, secondary (%) 80% (2015)

MORTALITY RATES - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)


Note: * If there is no cause of death reported for a specific age group and sex, the corresponding bar with zero value is not being represented.

(10-14 years old)

Malignant neoplasms, of lymphoid, haematopoetic and related tissue

(15-19 years old)

Assault (Homicide)

(20-24 years old)

Cirrhosis and other diseases of liver

Mental and behavioural disorders due to psychoactive substance use

MORTALITY TRENDS - Four Leading Causes of Death, by Sex (per 100,000 Population)

Adolescent and Youth (10-24 years old), 2000-2012

MENTAL HEALTH

Source: 2011 Global School Health Survey (GSHS)

Percentage of students who ever seriously considered attempting suicide during the past 12 months

Students who actually attempted suicide one or more times during the past 12 months

Students who had no close friends

PROTECTIVE FACTORS

Source: 2011 Global School Health Survey (GSHS)

Students who missed classes or school without permission 1+ of the past 30 days

Students whose parents usually understood their problems and worries the past 30 days

Students whose parents really usually knew what they do with free time the past 30 days

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### Sexual and Reproductive Health

#### Trends in Adolescent Fertility Rate
(Births per 1,000 women ages 15-19 years old, 1980-2015)

- **Source:** United Nations Population Division.
- **World Population Prospects: The 2015 Revision.**

#### Sexual Behavior in Adolescents
(Age group: 13-15 years old)

**Students who ever had sexual intercourse**
- **2011 GSHS:** 18.1%
- **2015 OAS:** 31.7%
- **2015 GYTS:** 48.4%
- **2010 GYTS:** 66.7%

**Among students who ever had sexual intercourse, those that the first time was before age 14 yrs**
- **2015 OAS:** 48.4%
- **2010 GYTS:** 66.7%

**Among students who ever had sexual intercourse, those who used a condom the last time**
- **2011 GSHS:** 50.0%
- **2015 OAS:** 52.5%
- **2015 GYTS:** 60.0%

### Risk Factors

**Sources:**
- GSHS - Global School Health Survey (WHO)
- GYTS - Global Youth Tobacco Survey (PAHO)
- OAS - Report on Drug Use in the Americas

#### Alcohol Use

- **Prevalence of alcohol use among secondary school students (past month)**
  - **2015 OAS:**
    - Male: 27.0%
    - Female: 24.5%
    - Total: 25.9%

- **Binge drinking among secondary school students**
  - **2015 OAS:**
    - Male: 51.3%
    - Female: 47.1%
    - Total: 49.5%

- **Prevalence of alcohol use among secondary school students (past year)**
  - **2015 OAS:**
    - Male: 42.8%
    - Female: 36.1%
    - Total: 44.6%

#### Tobacco Use

- **Prevalence of current use of any tobacco product**
  - **2010 GYTS:**
    - Male: 18.1%
    - Female: 5.0%

- **Prevalence of current cigarette smokers**
  - **2010 GYTS:**
    - Male: 18.1%
    - Female: 5.0%

- **Prevalence of tobacco use among secondary school students (past year)**
  - **2015 OAS:**
    - Male: 10.4%
    - Female: 3.2%

#### Overweight/Obesity/Diet

- **Students who usually drank carbonated soft drinks 1+ times per day the past 30 days**
  - **2011 GSHS:**
    - Male: 63.0%
    - Female: 59.9%
    - Total: 61.6%

- **Students who were overweight (> +1SD from median for BMI for age and sex)**
  - **2011 GSHS:**
    - Male: 32.6%
    - Female: 32.5%
    - Total: 32.5%

- **Students who were obese (> +2SD from median for BMI for age and sex)**
  - **2011 GSHS:**
    - Male: 16.6%
    - Female: 14.4%

#### Physical Activity

- **Students who went to physical education (PE) class 3+ days weekly in the school year**
  - **2011 GSHS:**
    - Male: 25.2%
    - Female: 16.0%
    - Total: 20.6%

- **Students who spent 3+ hours per day doing sitting activities**
  - **2011 GSHS:**
    - Male: 52.4%
    - Female: 58.4%

- **Students physically active at least 60 minutes daily on 5+ days the past 7 days**
  - **2011 GSHS:**
    - Male: 20.4%
    - Female: 26.8%

#### Drug Use

- **Prevalence of cocaine use among secondary school students (lifetime)**
  - **2015 OAS:**
    - Male: 3.4%
    - Female: 2.9%

- **Prevalence of marijuana use among secondary school students (lifetime)**
  - **2015 OAS:**
    - Male: 28.8%
    - Female: 20.0%

- **Prevalence of marijuana use among secondary school students (past year)**
  - **2015 OAS:**
    - Male: 20.2%
    - Female: 12.6%

- **Prevalence of inhalants use among secondary school students (lifetime)**
  - **2015 OAS:**
    - Male: 10.6%
    - Female: 13.7%

#### Violence and Unintentional Injuries

- **Students seriously injured 1+ times during the past 12 months**
  - **2011 GSHS:**
    - Male: 53.8%
    - Female: 41.0%

- **Students who were in a physical fight 1+ times the past 12 months**
  - **2011 GSHS:**
    - Male: 64.2%
    - Female: 34.2%

- **Students who were bullied 1+ days during the past 30 days**
  - **2011 GSHS:**
    - Male: 29.3%
    - Female: 21.9%
**Adolescent and Youth Health - 2017 Country Profile**

**SAINT LUCIA**

### POPULATION


**Adolescent and Youth Population**

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>8,303</td>
<td>8,212</td>
<td>16,515</td>
</tr>
<tr>
<td>15-19</td>
<td>7,837</td>
<td>7,837</td>
<td>15,674</td>
</tr>
<tr>
<td>10-14</td>
<td>7,452</td>
<td>7,340</td>
<td>14,792</td>
</tr>
<tr>
<td>10-24</td>
<td>23,592</td>
<td>23,389</td>
<td>46,981</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: 25%

### ECONOMIC DEVELOPMENT


- **GDP per capita, PPP (current international $)**: $2,055.3 (2016)
- **GDP growth (annual %)**: 0.7 (2016)

### MORTALITY RATES - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)


**Note:** * If there is no cause of death reported for a specific age group and sex, the corresponding bar with zero value is not being represented.

#### (10-14 years old)

- Malignant neoplasms, of lymphoid, haematopoietic and related tissue: 13.3
- Cardiovascular diseases: 13.3
- Musculoskeletal system and connective tissue: 13.3
- Cerebrovascular diseases: 13.2

#### (15-19 years old)

- Malignant neoplasms, of lymphoid, haematopoietic and related tissue: 12.4
- Cardiovascular diseases: 12.4
- Musculoskeletal system and connective tissue: 12.4
- Cerebrovascular diseases: 12.4

#### (20-24 years old)

- Malignant neoplasms, of lymphoid, haematopoietic and related tissue: 12.3
- Cardiovascular diseases: 12.3
- Musculoskeletal system and connective tissue: 12.3
- Cerebrovascular diseases: 12.3

### MORTALITY TRENDS - Four Leading Causes of Death, by Sex (per 100,000 Population)

**Adolescent and Youth (10-24 years old), 2000-2014**

### MENTAL HEALTH

Source: 2007 Global School Health Survey (GSHS), WHO.

- Percentage of students who felt lonely most of the time or always during the past 12 months: 10.7%
- Percentage of students who ever seriously considered attempting suicide during the past 12 months: 17.5%
- Percentage of students who said they had no close friends: 15.6%

### PROTECTIVE FACTORS

Source: 2007 Global School Health Survey (GSHS), WHO.

- Students who missed classes or school without permission 1+ of the past 30 days: 34.8%
- Students whose parents usually understand their problems and worries the past 30 days: 23.5%
- Students whose parents really usually knew what they do with free time the past 30 days: 16.6%
**Sexual and Reproductive Health**

### Adolescent and Youth Health - 2017 Country Profile

**Saint Lucia**

#### Sexual and Reproductive Health

**Trends in Adolescent Fertility Rate**

(Births per 1,000 women ages 15-19 years old, 1980-2015)


**Sexual Behavior in Adolescents**

(age group: 13-15 years old)

- Source: 2007 Global School Health Survey (GSHS), WHO.

#### Risk Factors

**Sources:**

- GSHS - Global School Health Survey (WHO)
- GYTS - Global Youth Tobacco Survey (PAHO)
- OAS - Report on Drug Use in the Americas

### Alcohol Use

- Students who drank at least one drink containing alcohol 1+ of the past 30 days
  - 2007 GSHS: Male 59.2%, Female 52.2%, Total 55.4%
  - 2015 OAS: Male 57.9%, Female 55.4%, Total 56.2%

- Binge drinking among secondary school students
  - 2015 OAS: Male 56.9%, Female 60.0%, Total 58.5%

### Tobacco Use

- Prevalence of current use of any tobacco product
  - 2011 GYTS: Male 24.5%, Female 17.3%, Total 20.1%

- Prevalence of current cigarette smokers
  - 2011 GYTS: Male 13.3%, Female 8.5%, Total 10.7%

- Prevalence of tobacco use among secondary school students (past month)
  - 2015 OAS: Male 5.7%, Female 3.5%, Total 6.9%

- Prevalence of tobacco use among secondary school students (past year)
  - 2015 OAS: Male 8.8%, Female 6.5%, Total 7.6%

### Overweight/Obesity/Diet

- Students who were overweight (> +1SD from median for BMI for age and sex)
- Students who were obese (> +2SD from median for BMI for age and sex)
- Students who usually drank carbonated soft drinks 1+ times per day the past 30 days
- No Data Available

### Physical Activity

- Students physically active at least 60 minutes daily on all 7 days during the past 7 days
  - 2007 GSHS: Male 17.4%, Female 14.0%, Total 15.6%

- Students who spent 3+ hours per day doing sitting activities
  - 2007 GSHS: Male 56.5%, Female 54.0%, Total 55.1%

### Drug Use

- Students who used drugs 1+ times during their life
  - 2007 GSHS: Male 29.7%, Female 15.8%, Total 22.0%

- Prevalence of cocaine use among secondary school students (lifetime)
  - 2015 OAS: Male 4.2%, Female 1.7%, Total 3.0%

- Prevalence of marijuana use among secondary school students (lifetime)
  - 2015 OAS: Male 22.7%, Female 28.8%, Total 25.8%

- Prevalence of inhalants use among secondary school students (lifetime)
  - 2015 OAS: Male 20.8%, Female 20.1%, Total 20.5%

### Violence and Unintentional Injuries

- Students seriously injured 1+ times during the past 12 months
  - 2007 GSHS: Male 55.0%, Female 42.3%, Total 47.8%

- Students who were in a physical fight 1+ times the past 12 months
  - 2007 GSHS: Male 52.4%, Female 31.4%, Total 39.7%

- Students who were bullied 1+ days during the past 30 days
  - 2007 GSHS: Male 25.2%, Female 25.1%, Total 25.1%

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Adolescent and Youth Health - 2017 Country Profile

SAINT VINCIDENT AND THE GRENADINES

POPULATION


<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
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<td>4,817</td>
<td>4,678</td>
<td>9,495</td>
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<tr>
<td>15-19</td>
<td>4,859</td>
<td>4,730</td>
<td>9,589</td>
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<tr>
<td>10-14</td>
<td>4,615</td>
<td>4,512</td>
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<tr>
<td>10-24</td>
<td>14,291</td>
<td>13,920</td>
<td>28,211</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: 26%

ECONOMIC DEVELOPMENT


- GDP per capita, PPP (current international $): 1,272.0 (2016)
- GDP growth (annual %): 3.0 (2016)

EDUCATION PARTICIPATION

- Net enrollment rate, secondary (%): 84%
- Education participation: 87%

MORTALITY RATES - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)


- Note: * If there is no cause of death reported for a specific age group and sex, the corresponding bar with zero value is not being represented.

MORTALITY TRENDS - Four Leading Causes of Death, by Sex (per 100,000 Population)

Adolescent and Youth (10-24 years old), 2000-2015

MENTAL HEALTH

Source: 2007 Global School Health Survey (GSHS), WHO.

- Percentage of students who felt lonely most of the time or always during the past 12 months
- Percentage of students who ever seriously considered attempting suicide during the past 12 months

PROTECTIVE FACTORS

Source: 2007 Global School Health Survey (GSHS), WHO.

- Students who missed classes or school without permission 1+ of the past 30 days
- Students who had no close friends

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**Adolescent and Youth Health - 2017 Country Profile**

**Saint Vincent and the Grenadines**

### Sexual and Reproductive Health

<table>
<thead>
<tr>
<th>Trends in Adolescent Fertility Rate (Births per 1,000 women ages 15-19 years old, 1980-2015)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Sexual Behavior in Adolescents (age group: 13-15 years old)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source: 2007 Global School Health Survey (GSHS), WHO.</td>
</tr>
</tbody>
</table>

### Risk Factors

- **Alcohol Use**
  - Students who drank at least one drink containing alcohol 1+ of the past 30 days: 2007 GSHS 52.6% (Male), 53.5% (Female), 53.2% (Total)
  - Students who drank so much alcohol that they were really drunk 1+ times during their life: 2007 GSHS 40.3% (Male), 30.0% (Female), 35.1% (Total)
  - Binge drinking among secondary school students: 2015 OAS 58.5% (Male), 51.7% (Female), 54.7% (Total)
  - Prevalence of alcohol use among secondary school students (past year): 2015 OAS 60.0% (Male), 57.9% (Female), 58.8% (Total)

- **Tobacco Use**
  - Students who reported people smoked in their presence, past 7 days: 2007 GSHS 69.0% (Male), 65.0% (Female), 67.0% (Total)
  - Prevalence of current use of any tobacco product: 2011 GYTS 14.6% (Male), 19.4% (Female), 16.8% (Total)
  - Prevalence of current cigarette smokers: 2011 GYTS 8.5% (Male), 12.8% (Female), 10.7% (Total)
  - Prevalence of tobacco use among secondary school students (past month): 2015 OAS 5.8% (Male), 5.8% (Female), 5.8% (Total)
  - Prevalence of tobacco use among secondary school students (past year): 2015 OAS 8.2% (Male), 9.4% (Female), 8.7% (Total)

- **Overweight/Obesity/Diet**
  - Students who were overweight (> +1SD from median for BMI for age and sex): No Data Available
  - Students who were obese (> +2SD from median for BMI for age and sex): No Data Available
  - Students who usually drank carbonated soft drinks 1+ times per day the past 30 days: No Data Available

- **Drug Use**
  - Percentage of students who used drugs one or more times during their life: 2007 GSHS 36.9% (Male), 13.4% (Female), 19.9% (Total)
  - Prevalence of cocaine use among secondary school students (lifetime): 2015 OAS 7.7% (Male), 1.6% (Female), 1.2% (Total)
  - Prevalence of marijuana use among secondary school students (lifetime): 2015 OAS 20.9% (Male), 25.7% (Female), 23.3% (Total)
  - Prevalence of inhalants use among secondary school students (lifetime): 2015 OAS 17.6% (Male), 17.3% (Female), 17.5% (Total)

- **Physical Activity**
  - Students who spent 3+ hours per day doing sitting activities: 2007 GSHS 38.2% (Male), 30.3% (Female), 36.3% (Total)
  - Percentage of students who were physically active for a total of at least 60 minutes per day on all 7 days during the past 7 days: 2007 GSHS 15.6% (Male), 11.4% (Female), 13.3% (Total)

- **Violence and Unintentional Injuries**
  - Students seriously injured 1+ times during the past 12 months: 2007 GSHS 52.2% (Male), 44.7% (Female), 48.4% (Total)
  - Students who were in a physical fight 1+ times the past 12 months: 2007 GSHS 55.5% (Male), 46.0% (Female), 49.8% (Total)
  - Students who were bullied 1+ times during the past 30 days: 2007 GSHS 30.7% (Male), 29.4% (Female), 29.9% (Total)

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The Health of Adolescents and Youth in the Americas

**Population**


### Adolescent and Youth Population

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>21,929</td>
<td>21,043</td>
<td>42,972</td>
</tr>
<tr>
<td>15-19</td>
<td>24,403</td>
<td>23,653</td>
<td>48,056</td>
</tr>
<tr>
<td>10-14</td>
<td>24,599</td>
<td>23,978</td>
<td>48,577</td>
</tr>
<tr>
<td>10-24</td>
<td>70,931</td>
<td>68,674</td>
<td>139,605</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: 25%

### Economic Development


- GDP per capita, PPP (current international $) 7,898.9 (2016)
- Net enrollment rate, secondary (%) 56% (2015)

### Mortality Rates - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)


**Note:** * if there is no cause of death reported for a specific age group and sex, the corresponding bar with zero value is not being represented.

**Mortality Trends - Four Leading Causes of Death, by Sex (per 100,000 Population)**

### Mental Health

Source: 2016 Global School Health Survey (GSHS), WHO.

### Protective Factors

Source: 2016 Global School Health Survey (GSHS), WHO.

- Students who missed classes or school without permission 1+ of the past 30 days
- Students whose parents usually understand their problems and worries the past 30 days
- Students whose parents really usually knew what they do with free time the past 30 days
### RISK FACTORS

**Sources:**
- GSHS - Global School Health Survey (WHO)
- GYTS - Global Youth Tobacco Survey (PAHO)
- OAS - Report on Drug Use in the Americas

#### Alcohol Use

- Among students who ever drunk alcohol, those that the first drink was before age 14 yrs
  - 2016 GSHS: **Male** 78.4% **Female** 81.6% **Total** 80.3%
- Students who drank at least one drink containing alcohol 1+ of the past 30 days
  - 2016 GSHS: **Male** 36.6% **Female** 38.5% **Total** 37.5%
- Students who drank so much alcohol that they were really drunk 1+ times during their life
  - 2016 GSHS: **Male** 22.6% **Female** 17.4% **Total** 20.0%
- Binge drinking among secondary school students
  - 2015 OAS: **Male** 68.5% **Female** 64.0% **Total** 66.4%

#### Tobacco Use

- Percentage of students who reported people smoked in their presence on one or more days during the past 7 days
  - 2016 GSHS: **Male** 42.7% **Female** 48.4% **Total** 45.9%
- Students who smoked cigarettes 1+ days during the past 30 days
  - 2016 GSHS: **Male** 12.9% **Female** 10.7% **Total** 11.8%
- Percentage of students who currently used any tobacco product on one or more days during the past 30 days
  - 2016 GYTS: **Male** 13.7% **Female** 14.4% **Total** 14.1%
- Prevalence of tobacco use among secondary school students (past year)
  - 2015 OAS: **Male** 23.6% **Female** 11.0% **Total** 16.6%

#### Overweight/Obesity/Diet

- Students who usually drank carbonated soft drinks 1+ times per day the past 30 days
  - 2016 GSHS: **Male** 79.6% **Female** 78.6% **Total** 79.1%
- Students who were overweight (> +1SD from median for BMI for age and sex)
  - 2016 GSHS: **Male** 28.6% **Female** 29.1% **Total** 28.9%
- Students who were obese (> +2SD from median for BMI for age and sex)
  - 2016 GSHS: **Male** 12.2% **Female** 11.1% **Total** 11.6%

#### Physical Activity

- Percentage of students who were physically active for a total of at least 60 minutes per day on all 7 days during the past 7 days
  - 2016 GSHS: **Male** 21.2% **Female** 16.6% **Total** 18.8%
- Students who went to physical education (PE) class 3+ days weekly in the school year
  - 2016 GSHS: **Male** 29.0% **Female** 20.0% **Total** 21.4%
- Students who spent 3+ hours per day doing sitting activities
  - 2016 GSHS: **Male** 63.8% **Female** 45.1% **Total** 54.5%

#### Drug Use

- Students who used marijuana 1+ times during their life
  - 2016 GSHS: **Male** 4.7% **Female** 3.1% **Total** 3.9%
- Prevalence of cocaine use among secondary school students (lifetime)
  - 2015 OAS: **Male** 1.5% **Female** 0.1% **Total** 0.7%
- Prevalence of marijuana use among secondary school students (lifetime)
  - 2015 OAS: **Male** 12.7% **Female** 12.7% **Total** 12.7%
- Prevalence of inhalants use among secondary school students (lifetime)
  - 2015 OAS: **Male** 0.8% **Female** 5.8% **Total** 7.5%

#### Violence and Unintentional Injuries

- Students who were in a physical fight 1+ times the past 12 months
  - 2016 GSHS: **Male** 27.5% **Female** 14.7% **Total** 20.8%
- Students seriously injured 1+ times during the past 12 months
  - 2016 GSHS: **Male** 25.9% **Female** 24.6% **Total** 25.1%
- Students who were bullied 1+ days during the past 30 days
  - 2016 GSHS: **Male** 24.9% **Female** 29.4% **Total** 27.2%

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Adolescent and Youth Health - 2017 Country Profile
TRINIDAD AND TOBAGO

POPULATION


Adolescent and Youth Population

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>46,761</td>
<td>45,968</td>
<td>92,729</td>
</tr>
<tr>
<td>15-19</td>
<td>43,308</td>
<td>42,290</td>
<td>85,598</td>
</tr>
<tr>
<td>10-14</td>
<td>46,289</td>
<td>45,108</td>
<td>91,397</td>
</tr>
<tr>
<td>10-24</td>
<td>136,358</td>
<td>133,366</td>
<td>269,724</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: 20%

ECONOMIC DEVELOPMENT


MORTALITY RATES - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)


Note: * if there is no cause of death reported for a specific age group and sex, the corresponding bar with zero value is not being represented.

MORTALITY TRENDS - Four Leading Causes of Death, by Sex (per 100,000 Population)

Adolescent and Youth (10-24 years old), 2000-2010

MENTAL HEALTH

Source: 2017 Global School Health Survey (GSHS)

PROTECTIVE FACTORS

Source: 2017 Global School Health Survey (GSHS)

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### RISK FACTORS

**Sources:**
- GSHS - Global School Health Survey (WHO)
- GYTS - Global Youth Tobacco Survey (PAHO)
- OAS - Report on Drug Use in the Americas

#### Alcohol Use

<table>
<thead>
<tr>
<th>Category</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
<th>(95%) CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Among students who ever drank alcohol, those that the first drink was before age 14 yrs</td>
<td>84.9%</td>
<td>80.1%</td>
<td>82.3%</td>
<td></td>
</tr>
<tr>
<td>Students who drank at least one drink containing alcohol 1+ of the past 30 days</td>
<td>27.6%</td>
<td>21.8%</td>
<td>29.8%</td>
<td></td>
</tr>
<tr>
<td>Students who drank so much alcohol that they were really drunk 1+ times during their life</td>
<td>21.9%</td>
<td>18.2%</td>
<td>25.0%</td>
<td></td>
</tr>
<tr>
<td>Binge drinking among secondary school students</td>
<td>40.2%</td>
<td>42.4%</td>
<td>35.7%</td>
<td></td>
</tr>
</tbody>
</table>

#### Tobacco Use

<table>
<thead>
<tr>
<th>Category</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
<th>(95%) CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of students who used any tobacco products on one or more days during the past 30 days</td>
<td>15.8%</td>
<td>8.9%</td>
<td>12.2%</td>
<td></td>
</tr>
<tr>
<td>Students who smoked cigarettes 1+ days during the past 30 days</td>
<td>13.6%</td>
<td>10.5%</td>
<td>10.5%</td>
<td></td>
</tr>
<tr>
<td>Students who reported people smoked in their presence, past 7 days</td>
<td>58.5%</td>
<td>52.6%</td>
<td>55.4%</td>
<td></td>
</tr>
<tr>
<td>Prevalence of tobacco use among secondary school students (past year)</td>
<td>18.3%</td>
<td>10.1%</td>
<td>14.0%</td>
<td></td>
</tr>
</tbody>
</table>

#### Overweight/Obesity/Diet

<table>
<thead>
<tr>
<th>Category</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
<th>(95%) CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students who usually drank carbonated soft drinks 1+ times per day the past 30 days</td>
<td>67.3%</td>
<td>63.3%</td>
<td>55.2%</td>
<td></td>
</tr>
<tr>
<td>Students who were overweight (&gt; +1SD from median for BMI for age and sex)</td>
<td>39.4%</td>
<td>36.1%</td>
<td>32.5%</td>
<td></td>
</tr>
<tr>
<td>Students who were obese (&gt; +2SD from median for BMI for age and sex)</td>
<td>18.5%</td>
<td>17.1%</td>
<td>19.9%</td>
<td></td>
</tr>
</tbody>
</table>

#### Physical Activity

<table>
<thead>
<tr>
<th>Category</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
<th>(95%) CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of students who were physically active for a total of at least 60 minutes per day on all 7 days during the past 7 days</td>
<td>24.5%</td>
<td>20.5%</td>
<td>28.6%</td>
<td></td>
</tr>
<tr>
<td>Students who went to physical education (PE) class 3+ days weekly in the school year</td>
<td>22.2%</td>
<td>21.5%</td>
<td>25.3%</td>
<td></td>
</tr>
<tr>
<td>Students who spent 3+ hours per day doing sitting activities</td>
<td>43.3%</td>
<td>43.4%</td>
<td>44.4%</td>
<td></td>
</tr>
</tbody>
</table>

#### Drug Use

<table>
<thead>
<tr>
<th>Category</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
<th>(95%) CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Among students who ever used drugs, those that first time was before age 14 yrs</td>
<td>77.9%</td>
<td>80.3%</td>
<td>75.5%</td>
<td></td>
</tr>
<tr>
<td>Students who used marijuana 1+ times during their life</td>
<td>13.9%</td>
<td>6.2%</td>
<td>9.7%</td>
<td></td>
</tr>
<tr>
<td>Prevalence of cocaine use among secondary school students (lifetime)</td>
<td>3.5%</td>
<td>2.1%</td>
<td>2.8%</td>
<td></td>
</tr>
<tr>
<td>Prevalence of marijuana use among secondary school students (lifetime)</td>
<td>21.2%</td>
<td>12.4%</td>
<td>18.5%</td>
<td></td>
</tr>
<tr>
<td>Prevalence of inhalants use among secondary school students (lifetime)</td>
<td>15.9%</td>
<td>10.9%</td>
<td>12.9%</td>
<td></td>
</tr>
</tbody>
</table>

#### Violence and Unintentional Injuries

<table>
<thead>
<tr>
<th>Category</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
<th>(95%) CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students who were in a physical fight 1+ times the past 12 months</td>
<td>64.8%</td>
<td>51.3%</td>
<td>71.3%</td>
<td></td>
</tr>
<tr>
<td>Students seriously injured 1+ times during the past 12 months</td>
<td>39.7%</td>
<td>36.4%</td>
<td>43.3%</td>
<td></td>
</tr>
<tr>
<td>Students who were bullied 1+ days during the past 30 days</td>
<td>15.7%</td>
<td>15.7%</td>
<td>15.7%</td>
<td></td>
</tr>
</tbody>
</table>
Adolescent and Youth Health - 2017 Country Profile
TURKS AND CAICOS ISLANDS

POPULATION

Adolescent and Youth Population

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-14</td>
<td>1,735</td>
<td>1,675</td>
<td>3,410</td>
</tr>
<tr>
<td>15-19</td>
<td>1,766</td>
<td>1,760</td>
<td>3,526</td>
</tr>
<tr>
<td>20-24</td>
<td>1,862</td>
<td>1,970</td>
<td>3,832</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: 21%


ECONOMIC DEVELOPMENT

GDP per capita, PPP (current international $)

GDP growth (annual %)

EDUCATION PARTICIPATION

Net school enrollment rate, secondary (%)

MORTALITY RATES - Reported Causes of Death, by Age Group and Sex (per 100,000 Population)


Note: * If there is no cause of death reported for a specific age group and sex, the corresponding bar with zero value is not being represented.

MORTALITY TRENDS - Reported Causes of Death, by Sex (per 100,000 Population)


Mental Health

Source: Global School Health Survey (GSHS), WHO.

Protective Factors

Source: Global School Health Survey (GSHS), WHO.

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Adolescent and Youth Health - 2017 Country Profile
Turks and Caicos Islands

**SEXUAL AND REPRODUCTIVE HEALTH**

**Trends in Adolescent Fertility Rate**
(Births per 1,000 women ages 15-19 years old, 1980-2015)

**Sexual Behavior in Adolescents**
(age group: 13-15 years old)
Source: Global School Health Survey (GSHS), WHO.

- Students who ever had sexual intercourse
- Among students who ever had sexual intercourse, those that the first time was before age 14 yrs
- Among students who ever had sexual intercourse, those who used a condom the last time

**RISK FACTORS**

**Sources:**
- GSHS - Global School Health Survey (WHO)
- GYTS - Global Youth Tobacco Survey (PAHO)
- OAS - Report on Drug Use in the Americas

**Alcohol Use**

- Students who drank at least one drink containing alcohol 1+ of the past 30 days
- Binge drinking among secondary school students
- Prevalence of alcohol use among secondary school students (past month)

**Tobacco Use**

- Prevalence of current cigarette smokers
- Prevalence of current use of any tobacco product
- Students who reported people smoked in their presence, past 7 days
- Among students who ever smoked cigarettes, those that first tried cigarettes before age 14 yrs

**Overweight/Obesity/Diet**

- Students who were overweight (> +1SD from median for BMI for age and sex)
- Students who were obese (> +2SD from median for BMI for age and sex)
- Students who usually drank carbonated soft drinks 1+ times per day the past 30 days

**Physical Activity**

- Students physically active at least 60 minutes daily on 5+ days the past 7 days
- Students who spent 3+ hours per day doing sitting activities
- Students who went to physical education (PE) class 3+ days weekly in the school year

**Drug Use**

- Students who used marijuana 1+ times during their life
- Prevalence of marijuana use among secondary school students
- Prevalence of cocaine use among secondary school students
- Prevalence of inhalants use among secondary school students

**Violence and Unintentional Injuries**

- Students seriously injured 1+ times during the past 12 months
- Students who were bullied 1+ days during the past 30 days
- Students who were in a physical fight 1+ times the past 12 months

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Adolescent and Youth Health - 2017 Country Profile

**UNITED STATES OF AMERICA**

### POPULATION


<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-14</td>
<td>10,627,683</td>
<td>10,207,085</td>
<td>20,834,768</td>
</tr>
<tr>
<td>15-19</td>
<td>10,570,529</td>
<td>10,049,396</td>
<td>20,619,925</td>
</tr>
<tr>
<td>20-24</td>
<td>11,928,066</td>
<td>11,221,876</td>
<td>23,149,942</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: **20%**

### ECONOMIC DEVELOPMENT

**Source:** World Development Indicators (WDIs), The World Bank.

- **GDP per capita, PPP (current international $)**: 18,569,100.0 (2016)
- **GDP growth (annual %)**: 1.6 (2016)
- **Net enrollment rate, secondary (%)**: 89% (2014)

### MORTALITY RATES - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)


#### (10-14 years old)

- **Road traffic injuries**: 1.7
- **Intentional self-harm (Suicide)**: 1.6
- **Assault (Homicide)**: 1.0
- **Congenital malformations**: 1.0

#### (15-19 years old)

- **Road traffic injuries**: 4.2
- **Intentional self-harm (Suicide)**: 4.1
- **Assault (Homicide)**: 1.9
- **Accidental poisoning by exposure to noxious substances**: 1.6

#### (20-24 years old)

- **Road traffic injuries**: 5.0
- **Intentional self-harm (Suicide)**: 2.5
- **Assault (Homicide)**: 3.1
- **Accidental poisoning by exposure to noxious substances**: 1.8

### MORTALITY TRENDS - Four Leading Causes of Death, by Sex (per 100,000 Population)

**Adolescents and Youth (10-24 years old), 2000-2014**

- **Road traffic injuries**
- **Intentional self-harm (Suicide)**
- **Assault (Homicide)**
- **Accidental poisoning by exposure to noxious substances**

### MENTAL HEALTH

**Source:** Global School Health Survey (GSHS), WHO.

- **Students who ever seriously considered attempting suicide during the past 12 months**
- **Students who actually attempted suicide one or more times during the past 12 months**
- **Students who had no close friends**
- **Students who missed classes or school without permission 1+ of the past 30 days**
- **Students whose parents usually understood their problems and worries the past 30 days**
- **Students whose parents really usually knew what they do with free time the past 30 days**

### PROTECTIVE FACTORS

**Source:** Global School Health Survey (GSHS), WHO.

- **No Data Available**

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**Sexual Behavior in Adolescents**

*Age group: 13-15 years old*

Source: Global School Health Survey (GSHS), WHO.

- Students who ever had sexual intercourse: No Data Available
- Among students who ever had sexual intercourse, those that the first time was before age 14 yrs: No Data Available
- Among students who ever had sexual intercourse, those who used a condom the last time: No Data Available

---

**RISK FACTORS**

Sources: YRBS - Youth Risk Behavior Surveillance System (CDC, ONWD, DNPPO), 2015.


*No data available at: GSHS - Global School Health Survey [WHO]; GYTS - Global Youth Tobacco Survey [PAHO]*

**Alcohol Use**

<table>
<thead>
<tr>
<th>Prevalence of alcohol use among secondary school students (past month)</th>
<th>2015 OAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>22.1% Total, 22.8% Male, 22.6% Female</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prevalence of alcohol use among secondary school students (past year)</th>
<th>2015 OAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>38.2% Total, 42.1% Male, 48.7% Female</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Binge drinking among secondary school students</th>
<th>2015 OAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.5% Total, 10.9% Male, 11.9% Female</td>
<td></td>
</tr>
</tbody>
</table>

**Tobacco Use**

<table>
<thead>
<tr>
<th>Prevalence of tobacco use among secondary school students (lifetime)</th>
<th>2015 OAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>22.9% Total, 8.4% Male, 8.0% Female</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prevalence of tobacco use among secondary school students (past month)</th>
<th>2015 OAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.3% Total, 8.0% Male, 7.3% Female</td>
<td></td>
</tr>
</tbody>
</table>

**Overweight/Obesity/Diet**

<table>
<thead>
<tr>
<th>Percent of overweight students in grades 9-12, (BMI ≥85th percentile, on the 2000 CDC growth chart)</th>
<th>2015 YRBSS</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.5% Total, 16.6% Male, 16.0% Female</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percent of obese students in grades 9-12, (BMI ≥95th percentile, on the 2000 CDC growth chart)</th>
<th>2015 YRBSS</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.8% Total, 10.6% Male, 13.9% Female</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percent of students in grades 9-12 who drank regular soda/pap at least one time per day</th>
<th>2015 YRBSS</th>
</tr>
</thead>
<tbody>
<tr>
<td>24.3% Total, 16.4% Male, 20.4% Female</td>
<td></td>
</tr>
</tbody>
</table>

**Physical Activity**

<table>
<thead>
<tr>
<th>Percent of students in grades 9-12 who participate in daily physical education</th>
<th>2015 YRBSS</th>
</tr>
</thead>
<tbody>
<tr>
<td>28.5% Total, 29.8% Male, 28.1% Female</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percent of students in grades 9-12 who achieve 1 hour or more of moderate-and/or vigorous-intensity physical activity daily</th>
<th>2015 YRBSS</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.7% Total, 27.3% Male, 27.7% Female</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percent of students in grades 9-12 watching 3 or more hours of television each school day</th>
<th>2015 YRBSS</th>
</tr>
</thead>
<tbody>
<tr>
<td>24.4% Total, 25.0% Male, 24.7% Female</td>
<td></td>
</tr>
</tbody>
</table>

**Drug Use**

<table>
<thead>
<tr>
<th>Prevalence of cocaine use among secondary school students (lifetime)</th>
<th>2015 OAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2% Male, 2.3% Female</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prevalence of marijuana use among secondary school students (lifetime)</th>
<th>2015 OAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>31.7% Male, 40.4% Female</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prevalence of marijuana use among secondary school students (past year)</th>
<th>2015 OAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>20.0% Male, 25.2% Female</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prevalence of inhalants use among secondary school students (lifetime)</th>
<th>2015 OAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.9% Male, 9.9% Female</td>
<td></td>
</tr>
</tbody>
</table>

**Violence and Unintentional Injuries**

- No Data Available
- Students seriously injured 1+ times during the past 12 months
- Students who were bullied 1+ days during the past 30 days
- Students who were in a physical fight 1+ times the past 12 months
## Adolescent and Youth Population

### Source:

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>133,277</td>
<td>128,603</td>
<td>261,880</td>
</tr>
<tr>
<td>15-19</td>
<td>130,267</td>
<td>125,523</td>
<td>255,790</td>
</tr>
<tr>
<td>10-14</td>
<td>126,636</td>
<td>121,294</td>
<td>247,930</td>
</tr>
<tr>
<td>10-24</td>
<td>390,180</td>
<td>375,420</td>
<td>765,600</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: 22%

## Economic Development

### Source:
World Development Indicators (WDIs), The World Bank, 2016.

| GDP per capita, PPP (current international $) | 74,477.6 (2016) |
| GDP growth (annual %)                       | 1.5 (2016)      |

Net enrollment rate, secondary (%): 73%

## Mortality Rates - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)

### Source:

Note: * If there is no cause of death reported for a specific age group and sex, the corresponding bar with zero value is not being represented.

### (10-14 years old)

- Road traffic injuries: 2.4 (Male), 1.6 (Female), 0 (Total)
- Malignant neoplasms, of lymphoid, haematopoietic and related tissue: 2.3 (Male), 2.3 (Female), 2.3 (Total)
- Epilepsy and status epilepticus: 1.6 (Male), 1.6 (Female), 1.6 (Total)
- Accidental drowning/submersion: 0 (Male), 0 (Female), 0 (Total)
- Intentional self-harm (Suicide): 6.3 (Male), 6.3 (Female), 6.3 (Total)
- Assault (Homicide): 20.4 (Male), 19.6 (Female), 20.0 (Total)
- Handgun fire discharge non intentional: 0 (Male), 0 (Female), 0 (Total)
- Total: 26.4 (Male), 22.4 (Female), 23.4 (Total)

### (15-19 years old)

- Road traffic injuries: 6.3 (Male), 6.3 (Female), 6.3 (Total)
- Malignant neoplasms, of lymphoid, haematopoietic and related tissue: 20.4 (Male), 19.6 (Female), 20.0 (Total)
- Epilepsy and status epilepticus: 3.9 (Male), 3.9 (Female), 3.9 (Total)
- Accidental drowning/submersion: 0 (Male), 0 (Female), 0 (Total)
- Intentional self-harm (Suicide): 6.3 (Male), 6.3 (Female), 6.3 (Total)
- Assault (Homicide): 13.6 (Male), 13.6 (Female), 13.6 (Total)
- Handgun fire discharge non intentional: 0 (Male), 0 (Female), 0 (Total)
- Total: 40.0 (Male), 38.5 (Female), 39.2 (Total)

### (20-24 years old)

- Road traffic injuries: 7.0 (Male), 7.0 (Female), 7.0 (Total)
- Malignant neoplasms, of lymphoid, haematopoietic and related tissue: 23.4 (Male), 23.4 (Female), 23.4 (Total)
- Epilepsy and status epilepticus: 6.8 (Male), 6.8 (Female), 6.8 (Total)
- Accidental drowning/submersion: 0 (Male), 0 (Female), 0 (Total)
- Intentional self-harm (Suicide): 6.8 (Male), 6.8 (Female), 6.8 (Total)
- Assault (Homicide): 10.2 (Male), 10.2 (Female), 10.2 (Total)
- Handgun fire discharge non intentional: 0 (Male), 0 (Female), 0 (Total)
- Total: 40.0 (Male), 38.5 (Female), 39.2 (Total)

## Mortality Trends - Four Leading Causes of Death, by Sex (per 100,000 Population)

### Adolescent and Youth (10-24 years old), 2000-2014

- Road traffic injuries: Male 30.0, Female 20.0, Total 25.0
- Intentional self-harm (Suicide): Male 15.0, Female 10.0, Total 12.5
- Assault (Homicide): Male 5.0, Female 3.5, Total 4.2
- Handgun fire discharge non intentional: Male 0, Female 0, Total 0

## Mental Health

### Source:
2012 Global School Health Survey (GSHS), WHO.

- Percentage of students who ever seriously considered attempting suicide during the past 12 months: Male 6.7%, Female 15.5%, Total 11.4%
- Students who actually attempted suicide one or more times during the past 12 months: Male 7.4%, Female 10.8%, Total 9.2%
- Students who had no close friends: Male 3.3%, Female 2.1%, Total 2.7%
- Students whose parents usually understood their problems and worries: Male 63.9%, Female 61.0%, Total 62.3%
- Students whose parents usually knew what they do with free time the past 30 days: Male 69.4%, Female 74.4%, Total 72.0%

## Protective Factors

### Source:
2012 Global School Health Survey (GSHS), WHO.

- Students who missed classes or school without permission 1+ of the past 30 days: Male 22.3%, Female 23.3%, Total 22.7%
- Students who had no close friends: Male 22.3%, Female 22.7%, Total 22.5%
- Students whose parents usually understood their problems and worries: Male 63.9%, Female 61.0%, Total 62.3%
- Students whose parents usually knew what they do with free time the past 30 days: Male 69.4%, Female 74.4%, Total 72.0%
**SEXUAL AND REPRODUCTIVE HEALTH**

### Trends in Adolescent Fertility Rate

(Births per 1,000 women ages 15-19 years old, 1980-2015)


<table>
<thead>
<tr>
<th>Year</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980-1985</td>
<td>67</td>
<td>69.1%</td>
<td>71.2%</td>
</tr>
<tr>
<td>1985-1990</td>
<td>58</td>
<td>63.4%</td>
<td>66.0%</td>
</tr>
<tr>
<td>1990-1995</td>
<td>46</td>
<td>66.0%</td>
<td>67.2%</td>
</tr>
<tr>
<td>1995-2000</td>
<td>28</td>
<td>62.3%</td>
<td>64.1%</td>
</tr>
<tr>
<td>2000-2005</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2005-2010</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010-2015</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Sexual Behavior in Adolescents

(Age group: 13-15 years old)

Source: 2012 Global School Health Survey (GSHS), WHO.

- **Students who ever had sexual intercourse:**
  - Male: 22.3%
  - Female: 34.0%
  - Total: 27.7%

- **Among students who ever had sexual intercourse, those that the first time was before age 14 yrs:**
  - Male: 31.6%
  - Female: 48.0%
  - Total: 40.8%

- **Among students who ever had sexual intercourse, those who used a condom the last time:**
  - Male: 81.0%
  - Female: 86.8%
  - Total: 84.1%

### Risk Factors

**Alcohol Use**

- Among students who ever drank alcohol, those that the first drink was before age 14 yrs
  - Male: 76.9%
  - Female: 69.1%
  - Total: 72.7%

- Students who drank at least one drink containing alcohol 1+ of the past 30 days
  - Male: 47.2%
  - Female: 35.2%
  - Total: 41.2%

- Binge drinking among secondary school students
  - Male: 71.2%
  - Female: 64.6%
  - Total: 68.0%

- Prevalence of alcohol use among secondary school students (past year)
  - Male: 60.1%
  - Female: 60.4%
  - Total: 60.2%

**Tobacco Use**

- Prevalence of current use of any tobacco product
  - Male: 12.7%
  - Female: 12.5%
  - Total: 12.6%

- Prevalence of current cigarette smokers
  - Male: 7.9%
  - Female: 8.2%
  - Total: 8.0%

- Among students who ever smoked cigarettes, those that first tried cigarettes before age 14 yrs
  - Male: 73.6%
  - Female: 70.3%
  - Total: 71.9%

- Students who reported people smoked in their presence, past 7 days
  - Male: 61.3%
  - Female: 70.0%
  - Total: 66.0%

**Overweight/Obesity/Diet**

- Students who usually drank carbonated soft drinks 1+ times per day the past 30 days
  - Male: 71.2%
  - Female: 67.6%
  - Total: 69.4%

- Students who were overweight (> +2SD from median for BMI for age and sex)
  - Male: 29.7%
  - Female: 25.0%
  - Total: 27.2%

- Students who were obese (> +2SD from median for BMI for age and sex)
  - Male: 8.4%
  - Female: 5.7%
  - Total: 7.0%

**Physical Activity**

- Students who went to physical education (PE) class 3+ days weekly in the school year
  - Male: 36.8%
  - Female: 36.3%
  - Total: 36.6%

- Students who spent 3+ hours per day doing sitting activities
  - Male: 56.1%
  - Female: 60.1%
  - Total: 58.1%

- Students physically active at least 60 minutes daily on 5+ days the past 7 days
  - Male: 42.6%
  - Female: 28.6%
  - Total: 35.6%

**Drug Use**

- Students who used marijuana 1+ times during their life
  - Male: 11.6%
  - Female: 9.8%

- Prevalence of cocaine use among secondary school students (lifetime)
  - Male: 3.7%
  - Female: 2.0%

- Prevalence of marijuana use among secondary school students (lifetime)
  - Male: 22.4%
  - Female: 18.1%

- Prevalence of inhalants use among secondary school students (lifetime)
  - Male: 4.9%
  - Female: 4.2%
Adolescent and Youth Health - 2017 Country Profile

**Virgin Islands (UK)**

### Population

**Adolescent and Youth Population**

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-14</td>
<td>932</td>
<td>1,006</td>
<td>1,938</td>
</tr>
<tr>
<td>15-19</td>
<td>1,056</td>
<td>1,139</td>
<td>2,195</td>
</tr>
<tr>
<td>20-24</td>
<td>1,201</td>
<td>1,317</td>
<td>2,518</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: **19%**

### Economic Development

<table>
<thead>
<tr>
<th>Metric</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>GDP per capita, PPP (current international $)</td>
<td>N/A</td>
</tr>
<tr>
<td>GDP growth (annual %)</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Mortality Rates - Reported Causes of Death, by Age Group and Sex (per 100,000 Population)


**Note:** *If there is no mortality data reported for a specific age group and sex, the corresponding bar with zero value is not being represented.*

#### (10-14 years old)

- HIV diseases
- N/A. No mortality data reported for the specific age group

#### (15-19 years old)

- Road traffic injuries
- 28.89

#### (20-24 years old)

- Assault (Homicide)
- 31.36

### Mortality Trends - Reported Causes of Death, by Sex (per 100,000 Population)

#### Adolescent and Youth (10-24 years old), 2000-2010

- Assault (Homicide)
- Handgun fire discharge non intentional
- Road traffic injuries

### Mental Health

**Source:** 2009 Global School Health Survey (GSHS), WHO.

<table>
<thead>
<tr>
<th>Percentage of students who ever seriously considered attempting suicide during the past 12 months</th>
<th>Students who actually attempted suicide one or more times during the past 12 months</th>
<th>Students who had no close friends</th>
<th>Students who missed classes or school without permission 1+ of the past 30 days</th>
<th>Students whose parents usually understood their problems and worries the past 30 days</th>
<th>Students whose parents really usually knew what they do with free time the past 30 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.1</td>
<td>20.5</td>
<td>15.7</td>
<td>14.9</td>
<td>12.5</td>
<td>9.5</td>
</tr>
<tr>
<td>21.4</td>
<td>16.1</td>
<td>19.2</td>
<td>7.9</td>
<td>8.6</td>
<td>6.5</td>
</tr>
<tr>
<td>38.6</td>
<td>35.0</td>
<td>30.7</td>
<td>38.6</td>
<td>52.8</td>
<td>36.3</td>
</tr>
</tbody>
</table>

### Protective Factors

**Source:** 2009 Global School Health Survey (GSHS), WHO.

<table>
<thead>
<tr>
<th>Percentage of students whose parents really usually knew what they do with free time the past 30 days</th>
<th>Students whose parents usually understood their problems and worries the past 30 days</th>
<th>Students who missed classes or school without permission 1+ of the past 30 days</th>
<th>Students who had no close friends</th>
<th>Students who actually attempted suicide one or more times during the past 12 months</th>
<th>Students who ever seriously considered attempting suicide during the past 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>36.3</td>
<td>38.6</td>
<td>30.7</td>
<td>19.2</td>
<td>14.9</td>
<td>10.1</td>
</tr>
<tr>
<td>52.8</td>
<td>38.6</td>
<td>35.0</td>
<td>7.9</td>
<td>8.6</td>
<td>6.5</td>
</tr>
<tr>
<td>38.6</td>
<td>30.7</td>
<td>38.6</td>
<td>38.6</td>
<td>10.1</td>
<td>21.4</td>
</tr>
</tbody>
</table>

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**SEXUAL AND REPRODUCTIVE HEALTH**

**Trends in Adolescent Fertility Rate**
(Births per 1,000 women ages 15-19 years old, 1980-2015)


**Sexual Behavior in Adolescents**
(age group: 13-15 years old)

Source: 2009 Global School Health Survey (GSHS), WHO.

- **Students who ever had sexual intercourse**
  - Male: 26.0%
  - Female: 35.7%
  - Total: 46.9%

- **Among students who ever had sexual intercourse, those that the first time was before age 14 yrs**
  - Male: 14.0%
  - Female: 23.3%
  - Total: 18.7%

- **Among students who ever had sexual intercourse, those who used a condom the last time**
  - Male: 30.7%
  - Female: 42.3%
  - Total: 36.5%

**RISK FACTORS**

Sources:
- GSHS - Global School Health Survey (WHO)
- GYTS - Global Youth Tobacco Survey (PAHO)
- OAS - Report on Drug Use in the Americas

**Alcohol Use**
- Among students who ever drunk alcohol, those that the first drink was before age 14 yrs
  - Male: 89.1%
  - Female: 64.2%
  - Total: 76.8%
- Students who drank at least one drink containing alcohol 1+ of the past 30 days
  - Male: 30.5%
  - Female: 35.5%
  - Total: 33.0%
- Students who drank so much alcohol that they were really drunk 1+ times during their life
  - Male: 17.7%
  - Female: 20.7%
  - Total: 19.3%

**Tobacco Use**
- Among students who ever smoked cigarettes, those that first tried cigarettes before age 14 yrs
  - Male: 19.2%
  - Female: 22.3%
  - Total: 20.7%
- Students who smoked cigarettes 1+ days during the past 30 days
  - Male: 7.3%
  - Female: 4.3%
  - Total: 5.7%
- Students who reported people smoked in their presence, past 7 days
  - Male: 44.4%
  - Female: 43.2%
  - Total: 43.8%

**Overweight/Obesity/Diet**
- Students who usually drank carbonated soft drinks 1+ times per day the past 30 days
  - Male: 65.0%
  - Female: 63.0%
  - Total: 63.9%
- Students who were overweight (> +1SD from median for BMI for age and sex)
  - Male: 38.2%
  - Female: 37.8%
  - Total: 38.0%
- Students who were obese (> +2SD from median for BMI for age and sex)
  - Male: 17.5%
  - Female: 17.9%
  - Total: 17.7%

**Physical Activity**
- Students who went to physical education (PE) class 3+ days weekly in the school year
  - Male: 28.7%
  - Female: 24.6%
  - Total: 26.3%
- Students who spent 3+ hours per day doing sitting activities
  - Male: 59.2%
  - Female: 64.5%
  - Total: 62.1%
- Students physically active at least 60 minutes daily on 5+ days the past 7 days
  - Male: 33.2%
  - Female: 22.7%
  - Total: 27.8%

**Drug Use**
- Among students who ever used drugs, those that first used drugs before age 14 yrs
  - Male: 81.3%

**Violence and Unintentional Injuries**
- Students seriously injured 1+ times during the past 12 months
  - Male: 51.7%
  - Female: 35.6%
  - Total: 42.9%
- Students who were in a physical fight 1+ times the past 12 months
  - Male: 46.0%
  - Female: 26.3%
  - Total: 35.0%
- Students who were bullied 1+ days during the past 30 days
  - Male: 18.3%
  - Female: 16.5%
  - Total: 17.2%
Adolescent and Youth Health - 2017 Country Profile

Virgin Islands (US)

POPULATION


Adolescent and Youth Population

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>3,507</td>
<td>3,467</td>
<td>6,974</td>
</tr>
<tr>
<td>15-19</td>
<td>3,588</td>
<td>3,283</td>
<td>6,871</td>
</tr>
<tr>
<td>10-14</td>
<td>3,635</td>
<td>3,486</td>
<td>7,121</td>
</tr>
<tr>
<td>10-24</td>
<td>10,730</td>
<td>10,236</td>
<td>20,966</td>
</tr>
</tbody>
</table>

Adolescents and Youth, percentage of total population: 20%

ECONOMIC DEVELOPMENT


GDP per capita, PPP: N/A
GDP growth (annual %): N/A

EDUCATION PARTICIPATION

School enrollment, secondary: N/A

MORTALITY RATES - Four Leading Causes of Death, by Age Group and Sex (per 100,000 Population)


Note: * If there is no cause of death reported for a specific age group and sex, the corresponding bar with zero value is not being represented.

MORTALITY TRENDS - Four Leading Causes of Death, by Sex (per 100,000 Population)

Source: Global School Health Survey (GSHS), WHO.

MENTAL HEALTH

Students who ever seriously considered attempting suicide during the past 12 months

PROTECTIVE FACTORS

Students who actually attempted suicide one or more times during the past 12 months

Students who had no close friends

Students who missed classes or school without permission 1+ of the past 30 days

Students whose parents usually understood their problems and worries the past 30 days

Students whose parents really usually knew what they do with free time the past 30 days

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**SEXUAL AND REPRODUCTIVE HEALTH**

**Trends in Adolescent Fertility Rate**
*(Births per 1,000 women ages 15-19 years old, 1980-2015)*


**Sexual Behavior in Adolescents**
*(age group: 13-15 years old)*

Source: Global School Health Survey (GSHS), WHO.

- Students who ever had sexual intercourse
- Students who used a condom the last time
- Among students who ever had sexual intercourse, those that the first time was before age 14 yrs

**RISK FACTORS**

Sources: YRBSS - Youth Risk Behavior Surveillance System (CDC, ONDIEH/DNPAO), 2015.


* No data available at:
  - GSHS - Global School Health Survey (WHO);
  - GYTS - Global Youth Tobacco Survey (PAHO)

**Alcohol Use**

Students who drank at least one drink containing alcohol 1+ of the past 30 days

Binge drinking among secondary school students

Prevalence of alcohol use among secondary school students (past month)

**Tobacco Use**

Prevalence of current cigarette smokers

Prevalence of current use of any tobacco product

Students who reported people smoked in their presence, past 7 days

Among students who ever smoked cigarettes, those that first tried cigarettes before age 14 yrs

**Overweight/Obesity/Diet**

<table>
<thead>
<tr>
<th></th>
<th>Male 62.9%</th>
<th>Female 64.6%</th>
<th>Total 64.1%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of obese students in grades 9-12 (BMI) ≥95th percentile on the 2000 CDC growth chart</td>
<td>13.9%</td>
<td>12.8%</td>
<td>13.3%</td>
</tr>
<tr>
<td>Percent of overweight students in grades 9-12 (BMI) ≥85th and &lt;95th percentile on the 2000 CDC growth chart</td>
<td>14.9%</td>
<td>15.7%</td>
<td>15.3%</td>
</tr>
</tbody>
</table>

**Physical Activity**

<table>
<thead>
<tr>
<th></th>
<th>Male 35.5%</th>
<th>Female 37.7%</th>
<th>Total 36.8%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of students in grades 9-12 watching 3 or more hours of television each school day</td>
<td>62.9%</td>
<td>64.6%</td>
<td>64.1%</td>
</tr>
<tr>
<td>Percent of students in grades 9-12 who participate in daily physical education</td>
<td>13.9%</td>
<td>12.8%</td>
<td>13.3%</td>
</tr>
</tbody>
</table>

**Drug Use**

Students who used marijuana 1+ times during their life

Prevalence of marijuana use among secondary school students

Prevalence of cocaine use among secondary school students

Prevalence of inhalants use among secondary school students

**Violence and Unintentional Injuries**

Students seriously injured 1+ times during the past 12 months

Students who were bullied 1+ days during the past 30 days

Students who were in a physical fight 1+ times the past 12 months
References


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Annexes

Annex A: The stages of adolescence (PAHO classification)

<table>
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<th>Age</th>
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<th>11</th>
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<th>13</th>
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<th>15</th>
<th>16</th>
<th>17</th>
<th>18</th>
<th>19</th>
<th>20</th>
<th>21</th>
<th>22</th>
<th>23</th>
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<tbody>
<tr>
<td>Girls</td>
<td>Preadolescence</td>
<td>Early adolescence</td>
<td>Middle adolescence</td>
<td>Late adolescence</td>
<td>Youth</td>
<td>Young adulthood</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Boys</td>
<td>Preadolescence</td>
<td>Early adolescence</td>
<td>Middle adolescence</td>
<td>Late adolescence</td>
<td>Youth</td>
<td>Young adulthood</td>
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<td></td>
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</table>

Source: (8, 9).

Annex I.A: Mobile-cellular telephone subscriptions per 100 inhabitants in countries of the Americas, 2000-2016

<table>
<thead>
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<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
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<tbody>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canada</td>
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</tr>
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<td>Anguilla</td>
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<td>Subregion/Country</td>
<td>Number of Facebook users</td>
<td>Facebook penetration (%)</td>
<td></td>
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</tr>
<tr>
<td>-----------------------------------</td>
<td>--------------------------</td>
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<td></td>
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<tr>
<td></td>
<td></td>
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<td></td>
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<tr>
<td><strong>North America</strong></td>
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<td></td>
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<td></td>
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</tr>
<tr>
<td>Canada</td>
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<tr>
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<td></td>
</tr>
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<td>Puerto Rico</td>
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<td>57.1</td>
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<td>Saint Kitts and Nevis</td>
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<td>61.6</td>
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<td>46.9</td>
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<td>53.7</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: (49).

*NA = not available.

Annex I.B: Number of Facebook users and Facebook penetration (percentage) in the Region of the Americas, by country, as of June 2016
### ANNEX II.A: Regional health goals and targets for adolescent and youth health for 2010-2018, under the Regional Strategy and the Plan of Action

#### Goals and targets

**Reduce adolescent and youth mortality**

1.1 Reduce the mortality rate of adolescents and youth ages 10-24

**Reduce unintentional injuries**

2.1 Reduce the mortality rate caused by transport accidents among men 15-24 years of age

**Reduce violence**

3.1 Reduce the suicide rate among those 10-24 years old

3.2 Reduce the homicide rate among men aged 15-24 years

**Reduce substance use and promote mental health**

4.1 Reduce the percentage of adolescents between the ages of 13 and 15 who have consumed one or more alcoholic beverages during the last 30 days

4.2 Reduce past-month use of illicit substances among those 13-15 years old

4.3 Reduce tobacco use among adolescents and youth 15-24 years of age

**Ensure sexual and reproductive health**

5.1 Reduce the percentage of births by mothers 15-19 years old

5.2 Increase the percentage of condom use during last high-risk sex among those 15-24 years old

5.3 Increase contraceptive prevalence among adolescents and youth ages 15-24 years

5.4 Reduce the prevalence of HIV-infected women aged 15-24 years

5.5 Reduce the estimated number of adolescents and youth 15-24 years of age living with HIV

---

### Table: Population by Country and Region

<table>
<thead>
<tr>
<th>Country</th>
<th>Population</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Suriname</strong></td>
<td>260,000</td>
<td>47.1</td>
</tr>
<tr>
<td><strong>Trinidad and Tobago</strong></td>
<td>700,000</td>
<td>51.1</td>
</tr>
<tr>
<td><strong>U.S. Virgin Islands</strong></td>
<td>25,000</td>
<td>70.5</td>
</tr>
<tr>
<td><strong>Central America</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Costa Rica</td>
<td>2,900,000</td>
<td>59.0</td>
</tr>
<tr>
<td>El Salvador</td>
<td>3,100,000</td>
<td>50.3</td>
</tr>
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<td>5,300,000</td>
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</tr>
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</tr>
<tr>
<td>Nicaragua</td>
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<td>30.6</td>
</tr>
<tr>
<td>Panama</td>
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<tr>
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<td>40.7</td>
</tr>
</tbody>
</table>

Source: (48).
5.6 Reduce the specific fertility rate of adolescents aged 15-19 years old (annual number of live births per 1,000 females 15-19)

Promote nutrition and physical activity

6.1 Reduce the proportion of obese or overweight adolescents 13-15 years of age
6.2 Increase the proportion of adolescents 13–15 years of age who engage in regular physical activity
6.3 Decrease the prevalence of anemia in adolescent women (10-19 years old)

Combat chronic diseases

7.1 Reduce the rate of decayed/missing/filled teeth (DMFT) for 12-year-old adolescents
7.2 Increase coverage of tetanus and diphtheria vaccine among those 10-19 years old

Promote protective factors

8.1 Increase parental knowledge of adolescent activities (GSHS)

Source: (4).

Annex II.B: Leading causes of death in adolescents (aged 10-19 years) in the Americas, 2010-2014

Annex II.B1: Leading causes of death in adolescents (aged 10-19 years) in the Americas in 2010 (43 countries reporting), with number of deaths and age-adjusted rates per 100,000, by sex

<table>
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<tr>
<th>Rank</th>
<th>Cause of death</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
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<td></td>
<td></td>
<td>Number</td>
<td>Adjusted rate</td>
<td>Number</td>
</tr>
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<td>1</td>
<td>Assault (homicide)</td>
<td>17,501</td>
<td>22.25</td>
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</tr>
<tr>
<td>2</td>
<td>Road traffic injuries</td>
<td>9,833</td>
<td>12.51</td>
<td>3,734</td>
</tr>
<tr>
<td>3</td>
<td>Intentional self-harm (suicide)</td>
<td>3,928</td>
<td>5.02</td>
<td>1,645</td>
</tr>
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<td>4</td>
<td>Event of undetermined intent</td>
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<td>623</td>
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<td>5</td>
<td>Accidental drowning and submersion</td>
<td>2,519</td>
<td>3.26</td>
<td>474</td>
</tr>
<tr>
<td>6</td>
<td>Malignant neoplasm of lymphoid, hematopoietic and related tissue</td>
<td>1,744</td>
<td>2.24</td>
<td>1,174</td>
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<tr>
<td>7</td>
<td>Congenital malformations, deformations and chromosomal abnormalities</td>
<td>920</td>
<td>1.18</td>
<td>736</td>
</tr>
<tr>
<td>8</td>
<td>Influenza and Pneumonia</td>
<td>931</td>
<td>1.19</td>
<td>651</td>
</tr>
<tr>
<td>9</td>
<td>Accidental poisoning</td>
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<td>1.00</td>
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<td>Diseases of the urinary system</td>
<td>560</td>
<td>0.72</td>
<td>510</td>
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<td>Cerebrovascular diseases</td>
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<td>0.69</td>
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<tr>
<td>12</td>
<td>Malignant neoplasm of brain</td>
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<td>0.59</td>
<td>359</td>
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<tr>
<td>13</td>
<td>Pregnancy, childbirth and the puerperium</td>
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<td>0.00</td>
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<tr>
<td>14</td>
<td>Septicemia</td>
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<td>0.54</td>
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<td>15</td>
<td>Accidental threats to breathing</td>
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<td>0.60</td>
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</tr>
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<td>16</td>
<td>Others</td>
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<td>9,533</td>
</tr>
<tr>
<td>Total</td>
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<td>58,440</td>
<td>74.33</td>
<td>23,667</td>
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</table>

Source: (39).
Annex II.B2: Leading causes of death in adolescents (aged 10-19 years) in the Americas in 2011 (39 countries reporting), with number of deaths and age-adjusted rates per 100,000, by sex

<table>
<thead>
<tr>
<th>Rank</th>
<th>Cause of death</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Adjusted rate</td>
<td>Number</td>
<td>Adjusted rate</td>
</tr>
<tr>
<td>1</td>
<td>Assault (homicide)</td>
<td>17,464</td>
<td>22.21</td>
<td>2,119</td>
</tr>
<tr>
<td>2</td>
<td>Road traffic injuries</td>
<td>10,042</td>
<td>12.80</td>
<td>3,509</td>
</tr>
<tr>
<td>3</td>
<td>Intentional self-harm (suicide)</td>
<td>4,230</td>
<td>5.39</td>
<td>1,910</td>
</tr>
<tr>
<td>4</td>
<td>Event of undetermined intent</td>
<td>3,199</td>
<td>4.32</td>
<td>587</td>
</tr>
<tr>
<td>5</td>
<td>Malignant neoplasm of lymphoid, hematopoietic and related tissue</td>
<td>1,775</td>
<td>2.27</td>
<td>1,280</td>
</tr>
<tr>
<td>6</td>
<td>Accidental drowning and submersion</td>
<td>2,336</td>
<td>3.04</td>
<td>448</td>
</tr>
<tr>
<td>7</td>
<td>Congenital malformations, deformations and chromosomal abnormalities</td>
<td>984</td>
<td>1.27</td>
<td>763</td>
</tr>
<tr>
<td>8</td>
<td>Influenza and Pneumonia</td>
<td>880</td>
<td>1.13</td>
<td>706</td>
</tr>
<tr>
<td>9</td>
<td>Accidental poisoning</td>
<td>778</td>
<td>1.05</td>
<td>373</td>
</tr>
<tr>
<td>10</td>
<td>Diseases of the urinary system</td>
<td>556</td>
<td>0.71</td>
<td>454</td>
</tr>
<tr>
<td>11</td>
<td>Cerebrovascular diseases</td>
<td>499</td>
<td>0.64</td>
<td>382</td>
</tr>
<tr>
<td>12</td>
<td>Pregnancy, childbirth and the puerperium</td>
<td>0</td>
<td>0.00</td>
<td>830</td>
</tr>
<tr>
<td>13</td>
<td>Malignant neoplasm of brain</td>
<td>453</td>
<td>0.59</td>
<td>320</td>
</tr>
<tr>
<td>14</td>
<td>Septicemia</td>
<td>385</td>
<td>0.52</td>
<td>289</td>
</tr>
<tr>
<td>15</td>
<td>Epilepsy and status epileptic</td>
<td>396</td>
<td>0.52</td>
<td>257</td>
</tr>
<tr>
<td>16</td>
<td>Others</td>
<td>14,468</td>
<td></td>
<td>9,130</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>58,445</td>
<td>74.46</td>
<td>23,357</td>
</tr>
</tbody>
</table>

Source: (39).

Annex II.B3: Leading causes of death in adolescents (aged 10-19 years) in the Americas in 2012 (39 countries reporting), with number of deaths and age-adjusted rates per 100,000, by sex

<table>
<thead>
<tr>
<th>Rank</th>
<th>Cause of death</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Adjusted rate</td>
<td>Number</td>
<td>Adjusted rate</td>
</tr>
<tr>
<td>1</td>
<td>Assault (homicide)</td>
<td>18,212</td>
<td>23.83</td>
<td>2,043</td>
</tr>
<tr>
<td>2</td>
<td>Road traffic injuries</td>
<td>10,194</td>
<td>13.35</td>
<td>3,504</td>
</tr>
<tr>
<td>3</td>
<td>Intentional self-harm (suicide)</td>
<td>4,207</td>
<td>5.51</td>
<td>1,757</td>
</tr>
<tr>
<td>4</td>
<td>Event of undetermined intent</td>
<td>3,183</td>
<td>4.38</td>
<td>603</td>
</tr>
<tr>
<td>5</td>
<td>Malignant neoplasm of lymphoid, hematopoietic and related tissue</td>
<td>1,744</td>
<td>2.31</td>
<td>1,123</td>
</tr>
<tr>
<td>6</td>
<td>Accidental drowning and submersion</td>
<td>2,395</td>
<td>3.19</td>
<td>404</td>
</tr>
<tr>
<td>7</td>
<td>Congenital malformations, deformations and chromosomal abnormalities</td>
<td>961</td>
<td>1.27</td>
<td>758</td>
</tr>
<tr>
<td>8</td>
<td>Influenza and Pneumonia</td>
<td>863</td>
<td>1.14</td>
<td>670</td>
</tr>
<tr>
<td>9</td>
<td>Accidental poisoning</td>
<td>707</td>
<td>0.98</td>
<td>312</td>
</tr>
<tr>
<td>10</td>
<td>Diseases of the urinary system</td>
<td>506</td>
<td>0.68</td>
<td>462</td>
</tr>
<tr>
<td>Rank</td>
<td>Cause of death</td>
<td>Males</td>
<td>Females</td>
<td>Total</td>
</tr>
<tr>
<td>------</td>
<td>--------------------------------------------------------------------------------</td>
<td>-------</td>
<td>---------</td>
<td>--------------</td>
</tr>
<tr>
<td></td>
<td>Number</td>
<td>Adjusted rate</td>
<td>Number</td>
<td>Adjusted rate</td>
</tr>
<tr>
<td>1</td>
<td>Assault (homicide)</td>
<td>17,497</td>
<td>23.26</td>
<td>1,872</td>
</tr>
<tr>
<td>2</td>
<td>Road traffic injuries</td>
<td>9,334</td>
<td>12.42</td>
<td>3,158</td>
</tr>
<tr>
<td>3</td>
<td>Intentional self-harm (suicide)</td>
<td>3,937</td>
<td>5.25</td>
<td>1,746</td>
</tr>
<tr>
<td>4</td>
<td>Event of undetermined intent</td>
<td>3,025</td>
<td>4.24</td>
<td>534</td>
</tr>
<tr>
<td>5</td>
<td>Malignant neoplasm of lymphoid, hematopoietic and related tissue</td>
<td>1,634</td>
<td>2.19</td>
<td>1,131</td>
</tr>
<tr>
<td>6</td>
<td>Accidental drowning and submersion</td>
<td>2,220</td>
<td>3.01</td>
<td>393</td>
</tr>
<tr>
<td>7</td>
<td>Congenital malformations, deformations and chromosomal abnormalities</td>
<td>851</td>
<td>1.15</td>
<td>761</td>
</tr>
<tr>
<td>8</td>
<td>Influenza and Pneumonia</td>
<td>914</td>
<td>1.23</td>
<td>671</td>
</tr>
<tr>
<td>9</td>
<td>Accidental poisoning</td>
<td>685</td>
<td>0.94</td>
<td>354</td>
</tr>
<tr>
<td>10</td>
<td>Diseases of the urinary system</td>
<td>447</td>
<td>0.6</td>
<td>459</td>
</tr>
<tr>
<td>11</td>
<td>Cerebrovascular diseases</td>
<td>491</td>
<td>0.66</td>
<td>404</td>
</tr>
<tr>
<td>12</td>
<td>Malignant neoplasm of brain</td>
<td>485</td>
<td>0.65</td>
<td>377</td>
</tr>
<tr>
<td>13</td>
<td>Pregnancy, childbirth and the puerperium</td>
<td>0</td>
<td>0.00</td>
<td>748</td>
</tr>
<tr>
<td>14</td>
<td>Accidental threats to breathing</td>
<td>457</td>
<td>0.64</td>
<td>217</td>
</tr>
<tr>
<td>15</td>
<td>Septicemia</td>
<td>388</td>
<td>0.53</td>
<td>269</td>
</tr>
<tr>
<td>16</td>
<td>Others</td>
<td>13,760</td>
<td>19.76</td>
<td>8,561</td>
</tr>
<tr>
<td>Total</td>
<td>56,125</td>
<td>74.7</td>
<td>21,655</td>
<td>30.12</td>
</tr>
</tbody>
</table>

Source: (39).
Annex II.B5: Leading causes of death in adolescents (aged 10-19 years) in the Americas in 2014 (26 countries reporting), with number of deaths and age-adjusted rates per 100,000, by sex

<table>
<thead>
<tr>
<th>Rank</th>
<th>Cause of death</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Number</td>
<td>Adjusted rate</td>
<td>Number</td>
</tr>
<tr>
<td>1</td>
<td>Assault (homicide)</td>
<td>14,016</td>
<td>21.35</td>
<td>1,548</td>
</tr>
<tr>
<td>2</td>
<td>Road traffic injuries</td>
<td>8,205</td>
<td>12.51</td>
<td>2,629</td>
</tr>
<tr>
<td>3</td>
<td>Intentional self-harm (suicide)</td>
<td>3,675</td>
<td>5.61</td>
<td>1,622</td>
</tr>
<tr>
<td>4</td>
<td>Malignant neoplasm of lymphoid, hematopoietic and related tissue</td>
<td>1,425</td>
<td>2.19</td>
<td>923</td>
</tr>
<tr>
<td>5</td>
<td>Accidental drowning and submersion</td>
<td>1,956</td>
<td>2.99</td>
<td>295</td>
</tr>
<tr>
<td>6</td>
<td>Event of undetermined intent</td>
<td>1,405</td>
<td>2.28</td>
<td>336</td>
</tr>
<tr>
<td>7</td>
<td>Congenital malformations, deformations and chromosomal abnormalities</td>
<td>772</td>
<td>1.18</td>
<td>663</td>
</tr>
<tr>
<td>8</td>
<td>Influenza and Pneumonia</td>
<td>713</td>
<td>1.11</td>
<td>561</td>
</tr>
<tr>
<td>9</td>
<td>Accidental poisoning</td>
<td>711</td>
<td>1.12</td>
<td>325</td>
</tr>
<tr>
<td>10</td>
<td>Malignant neoplasm of brain</td>
<td>437</td>
<td>0.68</td>
<td>301</td>
</tr>
<tr>
<td>11</td>
<td>Cerebrovascular diseases</td>
<td>418</td>
<td>0.64</td>
<td>314</td>
</tr>
<tr>
<td>12</td>
<td>Diseases of the urinary system</td>
<td>372</td>
<td>0.57</td>
<td>359</td>
</tr>
<tr>
<td>13</td>
<td>Accidental threats to breathing</td>
<td>394</td>
<td>0.62</td>
<td>207</td>
</tr>
<tr>
<td>14</td>
<td>Septicemia</td>
<td>314</td>
<td>0.49</td>
<td>263</td>
</tr>
<tr>
<td>15</td>
<td>Pregnancy, childbirth and the puerperium</td>
<td>0</td>
<td>0.00</td>
<td>577</td>
</tr>
<tr>
<td>16</td>
<td>Others</td>
<td>11,731</td>
<td>16.21</td>
<td>7,209</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>46,544</td>
<td>71.02</td>
<td>18,132</td>
</tr>
</tbody>
</table>

Source: (39).

Annex II.C: Leading causes of death in youth (aged 15-24 years) in the Americas, 2010-2014

Annex II.C1: Leading causes of death in youth (aged 15-24 years) in the Americas in 2010 (43 countries reporting), with number of deaths and age-adjusted rates per 100,000, by sex

<table>
<thead>
<tr>
<th>Rank</th>
<th>Cause of death</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Number</td>
<td>Adjusted rate</td>
<td>Number</td>
</tr>
<tr>
<td>1</td>
<td>Assault (homicide)</td>
<td>41,241</td>
<td>53.17</td>
<td>3,765</td>
</tr>
<tr>
<td>2</td>
<td>Road traffic injuries</td>
<td>21,869</td>
<td>28.18</td>
<td>5,885</td>
</tr>
<tr>
<td>3</td>
<td>Intentional self-harm (suicide)</td>
<td>9,031</td>
<td>11.69</td>
<td>2,559</td>
</tr>
<tr>
<td>4</td>
<td>Event of undetermined intent</td>
<td>6,745</td>
<td>8.93</td>
<td>942</td>
</tr>
<tr>
<td>5</td>
<td>Accidental poisoning</td>
<td>2,804</td>
<td>3.71</td>
<td>1,042</td>
</tr>
<tr>
<td>6</td>
<td>Accidental drowning and submersion</td>
<td>3,262</td>
<td>4.27</td>
<td>321</td>
</tr>
<tr>
<td>7</td>
<td>Malignant neoplasm of lymphoid, hematopoietic and related tissue</td>
<td>1,944</td>
<td>2.52</td>
<td>1,261</td>
</tr>
<tr>
<td>8</td>
<td>Influenza and Pneumonia</td>
<td>1,373</td>
<td>1.78</td>
<td>903</td>
</tr>
<tr>
<td>Rank</td>
<td>Cause of death</td>
<td>Males</td>
<td>Females</td>
<td>Total</td>
</tr>
<tr>
<td>------</td>
<td>-------------------------------------------------------------------------------</td>
<td>-------</td>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Number</td>
<td>Number</td>
<td>Number</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adjusted rate</td>
<td>Adjusted rate</td>
<td>Adjusted rate</td>
</tr>
<tr>
<td>1</td>
<td>Assault (homicide)</td>
<td>40,385</td>
<td>52.06</td>
<td>44,042</td>
</tr>
<tr>
<td>2</td>
<td>Road traffic injuries</td>
<td>22,103</td>
<td>28.48</td>
<td>27,757</td>
</tr>
<tr>
<td>3</td>
<td>Intentional self-harm (suicide)</td>
<td>9,543</td>
<td>12.31</td>
<td>12,324</td>
</tr>
<tr>
<td>4</td>
<td>Event of undetermined intent</td>
<td>6,938</td>
<td>9.45</td>
<td>7,835</td>
</tr>
<tr>
<td>5</td>
<td>Accidental poisoning</td>
<td>3,105</td>
<td>4.08</td>
<td>4,207</td>
</tr>
<tr>
<td>6</td>
<td>Accidental drowning and submersion</td>
<td>3,116</td>
<td>4.05</td>
<td>3,457</td>
</tr>
<tr>
<td>7</td>
<td>Malignant neoplasm of lymphoid, hematopoietic and related tissue</td>
<td>1,971</td>
<td>2.55</td>
<td>3,288</td>
</tr>
<tr>
<td>8</td>
<td>Influenza and Pneumonia</td>
<td>1,184</td>
<td>1.55</td>
<td>2,020</td>
</tr>
<tr>
<td>9</td>
<td>Pregnancy, childbirth and the puerperium</td>
<td>0</td>
<td>0.00</td>
<td>1,920</td>
</tr>
<tr>
<td>10</td>
<td>Human immunodeficiency virus (HIV) disease</td>
<td>1,127</td>
<td>1.46</td>
<td>1,727</td>
</tr>
<tr>
<td>11</td>
<td>Diseases of the urinary system</td>
<td>936</td>
<td>1.21</td>
<td>1,654</td>
</tr>
<tr>
<td>12</td>
<td>Congenital malformations, deformations and chromosomal abnormalities</td>
<td>998</td>
<td>1.29</td>
<td>1,661</td>
</tr>
<tr>
<td>13</td>
<td>Cerebrovascular diseases</td>
<td>778</td>
<td>1.01</td>
<td>1,419</td>
</tr>
<tr>
<td>14</td>
<td>Ischemic heart diseases</td>
<td>829</td>
<td>1.08</td>
<td>1,120</td>
</tr>
<tr>
<td>15</td>
<td>Accidental falls</td>
<td>811</td>
<td>1.07</td>
<td>924</td>
</tr>
<tr>
<td>16</td>
<td>Others</td>
<td>23,652</td>
<td></td>
<td>36,668</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12,889</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>117,603</td>
<td>151.52</td>
<td>152,023</td>
</tr>
</tbody>
</table>

Source: (39).
Annex II.C3: Leading causes of death in youth (aged 15-24 years) in the Americas in 2012 (39 countries reporting), with number of deaths and age-adjusted rates per 100,000, by sex

<table>
<thead>
<tr>
<th>Rank</th>
<th>Cause of death</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Adjusted rate</td>
<td>Number</td>
<td>Adjusted rate</td>
</tr>
<tr>
<td>1</td>
<td>Assault (homicide)</td>
<td>41,619</td>
<td>55.14</td>
<td>3,685</td>
</tr>
<tr>
<td>2</td>
<td>Road traffic injuries</td>
<td>22,855</td>
<td>30.25</td>
<td>5,569</td>
</tr>
<tr>
<td>3</td>
<td>Intentional self-harm (suicide)</td>
<td>9,204</td>
<td>12.19</td>
<td>2,691</td>
</tr>
<tr>
<td>4</td>
<td>Event of undetermined intent</td>
<td>7,051</td>
<td>9.80</td>
<td>923</td>
</tr>
<tr>
<td>5</td>
<td>Accidental poisoning</td>
<td>2,925</td>
<td>3.97</td>
<td>993</td>
</tr>
<tr>
<td>6</td>
<td>Accidental drowning and submersion</td>
<td>3,082</td>
<td>4.14</td>
<td>316</td>
</tr>
<tr>
<td>7</td>
<td>Malignant neoplasm of lymphoid, hematopoietic and related tissue</td>
<td>1,908</td>
<td>2.54</td>
<td>1,252</td>
</tr>
<tr>
<td>8</td>
<td>Influenza and Pneumonia</td>
<td>1,183</td>
<td>1.57</td>
<td>845</td>
</tr>
<tr>
<td>9</td>
<td>Pregnancy, childbirth and the puerperium</td>
<td>0</td>
<td>0.00</td>
<td>1,894</td>
</tr>
<tr>
<td>10</td>
<td>Human immunodeficiency virus (HIV) disease</td>
<td>1,144</td>
<td>1.51</td>
<td>577</td>
</tr>
<tr>
<td>11</td>
<td>Diseases of the urinary system</td>
<td>929</td>
<td>1.24</td>
<td>766</td>
</tr>
<tr>
<td>12</td>
<td>Congenital malformations, deformations and chromosomal abnormalities</td>
<td>912</td>
<td>1.21</td>
<td>675</td>
</tr>
<tr>
<td>13</td>
<td>Cerebrovascular diseases</td>
<td>836</td>
<td>1.11</td>
<td>627</td>
</tr>
<tr>
<td>14</td>
<td>Ischemic heart diseases</td>
<td>830</td>
<td>1.12</td>
<td>313</td>
</tr>
<tr>
<td>15</td>
<td>Nonintentional firearm discharge</td>
<td>825</td>
<td>1.15</td>
<td>92</td>
</tr>
<tr>
<td>16</td>
<td>Others</td>
<td>23,514</td>
<td>12,678</td>
<td>36,192</td>
</tr>
<tr>
<td>Total</td>
<td>118,817</td>
<td>157.24</td>
<td>33,896</td>
<td>46.61</td>
</tr>
</tbody>
</table>

Source: (39).

Annex II.C4: Leading causes of death in youth (aged 15-24 years) in the Americas in 2013 (37 countries reporting), with number of deaths and age-adjusted rates per 100,000, by sex

<table>
<thead>
<tr>
<th>Rank</th>
<th>Cause of death</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Adjusted rate</td>
<td>Number</td>
<td>Adjusted rate</td>
</tr>
<tr>
<td>1</td>
<td>Assault (homicide)</td>
<td>39,579</td>
<td>52.98</td>
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<tr>
<td>2</td>
<td>Road traffic injuries</td>
<td>21,382</td>
<td>28.57</td>
<td>5,090</td>
</tr>
<tr>
<td>3</td>
<td>Intentional self-harm (suicide)</td>
<td>8,778</td>
<td>11.75</td>
<td>1,894</td>
</tr>
<tr>
<td>4</td>
<td>Event of undetermined intent</td>
<td>8,778</td>
<td>11.75</td>
<td>1,894</td>
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<tr>
<td>5</td>
<td>Accidental poisoning</td>
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<tr>
<td>6</td>
<td>Malignant neoplasm of lymphoid, hematopoietic and related tissue</td>
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<td>4.12</td>
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<tr>
<td>7</td>
<td>Accidental drowning and submersion</td>
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<td>1,153</td>
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<tr>
<td>8</td>
<td>Influenza and Pneumonia</td>
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<td>3.72</td>
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<tr>
<td>9</td>
<td>Pregnancy, childbirth and the puerperium</td>
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<td>1.71</td>
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<td>Total</td>
<td>118,817</td>
<td>157.24</td>
<td>33,896</td>
<td>46.61</td>
</tr>
<tr>
<td>Rank</td>
<td>Cause of death</td>
<td>Males</td>
<td>Females</td>
<td>Total</td>
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<tr>
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<tr>
<td></td>
<td></td>
<td>Number</td>
<td>Adjusted rate</td>
<td>Number</td>
</tr>
<tr>
<td>1</td>
<td>Assault (homicide)</td>
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<tr>
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<tr>
<td>3</td>
<td>Intentional self-harm (suicide)</td>
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<tr>
<td>7</td>
<td>Accidental drowning and submersion</td>
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<tr>
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<tr>
<td>9</td>
<td>Congenital malformations, deformations and chromosomal abnormalities</td>
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<td>Diseases of the urinary system</td>
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<tr>
<td>11</td>
<td>Pregnancy, childbirth and the puerperium</td>
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<td>0.00</td>
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<tr>
<td>12</td>
<td>Human immunodeficiency virus (HIV) disease</td>
<td>955</td>
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<tr>
<td>13</td>
<td>Ischemic heart diseases</td>
<td>873</td>
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<td>301</td>
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<tr>
<td>14</td>
<td>Cerebrovascular diseases</td>
<td>670</td>
<td>1.02</td>
<td>485</td>
</tr>
<tr>
<td>15</td>
<td>Accidental threats to breathing</td>
<td>630</td>
<td>1.00</td>
<td>227</td>
</tr>
<tr>
<td>16</td>
<td>Others</td>
<td>20,165</td>
<td>10,379</td>
<td>30,544</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>94,077</td>
<td>143.01</td>
<td>27,749</td>
</tr>
</tbody>
</table>

Source: (39).
### Interventions to prevent adolescent suicide

<table>
<thead>
<tr>
<th>Ecological level</th>
<th>Intervention</th>
<th>Further explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structural and environmental</td>
<td>Adoption of national mental health policies</td>
<td>Related to suicide, these should focus on strengthening effective leadership and governance; providing comprehensive, integrated, and responsive services in community-based settings; implementing strategies for prevention; and strengthening information systems, evidence, and research.</td>
</tr>
<tr>
<td></td>
<td>Policies to reduce harmful use of alcohol</td>
<td>Policy options outlined in the 2010 WHO Global Strategy to Reduce the Harmful Use of Alcohol also support suicide prevention, including policies related to drinking-driving countermeasures, reducing the affordability of alcohol, reducing the exposure to all forms of alcohol marketing, reducing the access to purchasing and drinking alcohol.</td>
</tr>
<tr>
<td></td>
<td>Surveillance of suicide and suicide attempts</td>
<td>Sustainable and long-term surveillance of suicide cases and of hospital presentations due to suicide attempts and self-harm provide critical information for prevention, intervention, and treatment.</td>
</tr>
<tr>
<td></td>
<td>Improved access to health care</td>
<td>Adequate, prompt, accessible treatment for mental and substance-use disorders can reduce this risk of suicidal behavior. Implementing health-literacy policies and practices throughout health systems and institutions is also key.</td>
</tr>
<tr>
<td></td>
<td>Restriction of access to means</td>
<td>Restriction includes legislation to limit access to pesticides, firearms, and medications commonly used in suicide, and safer storage and disposal of each, as well as environmental interventions to prevent suicide by jumping.</td>
</tr>
<tr>
<td></td>
<td>Responsible media reporting</td>
<td>Media guidelines should stress: avoidance of detailed descriptions of suicidal acts, sensationalism, or glamorization and oversimplification; use of responsible language; minimizing the prominence of suicide reports; and educating the public about suicide and available treatments.</td>
</tr>
<tr>
<td></td>
<td>Electronic media strategies for service delivery</td>
<td>Online suicide prevention strategies include self-help programs and professionals engaging in chats or therapy with suicidal individuals. Text messaging is an alternative, particularly when the Internet is not accessible.</td>
</tr>
<tr>
<td></td>
<td>Raising awareness about mental health, substance-use disorders, and suicide</td>
<td>Awareness-raising campaigns aim to reduce stigma and promote help-seeking and access to care. Different types of exposure (e.g., television, print media, the Internet, social media, and posters) can reinforce key messages. At the local level, awareness raising can target specific vulnerable populations.</td>
</tr>
<tr>
<td>Community and interpersonal</td>
<td>Interventions for vulnerable groups with a higher risk of suicide</td>
<td>These interventions should be tailored and targeted toward groups that are most at risk of suicide in particular settings. For example, interventions targeting lesbian, gay, bisexual, transgender, and intersex (LGBTI) adolescents should focus on addressing risk factors such as mental disorders, substance abuse, stigma, prejudice, and individual and institutional discrimination.</td>
</tr>
<tr>
<td></td>
<td>Gatekeeper training</td>
<td>For people in a position to identify whether someone may be contemplating suicide (e.g., clinicians or teachers), gatekeeper training develops knowledge, attitudes, and skills for identifying adolescents at risk, determining the level of risk, and referring at-risk adolescents for treatment.</td>
</tr>
<tr>
<td></td>
<td>Crisis helplines</td>
<td>Crisis helplines are public call centers that people can turn to when other social support or professional care is unavailable or not preferred. Helplines can be in place for the wider population or may target certain vulnerable groups, e.g., with peer assistance.</td>
</tr>
</tbody>
</table>
Individual assessment and management of suicidal behaviors

The 2016 WHO mhGAP intervention guide recommends comprehensively assessing everyone presenting with thoughts, plans, or acts of self-harm. The guide advises asking any person over 10 years of age who is experiencing a priority mental, neurological, or substance-use disorder—or chronic pain or acute emotional distress—about his or her thoughts, plans, or acts related to self-harm and suicide.

Assessment and management of mental and substance-use disorders

This involves training primary-health-care workers to recognize depression and other mental and substance-use disorders and to perform detailed evaluations of suicide risk. Training should take place repeatedly over years and should involve the majority of health workers in a country.

Follow-up and community support

Repeated follow-up by health workers for patients discharged after suicide attempts, as well as community support, are low-cost, effective interventions that are easy to implement. Follow-up can include postcards, telephone calls, or brief in-person visits.

Interventions to prevent and mitigate road traffic injuries among adolescents

<table>
<thead>
<tr>
<th>Ecological level</th>
<th>Intervention</th>
<th>Further explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drinking age laws</td>
<td>Raising the legal drinking age to 21 years reduces drinking, driving after drinking, and alcohol-related crashes and injuries among youth.</td>
<td></td>
</tr>
<tr>
<td>Blood alcohol concentration laws</td>
<td>Set a lower permitted blood alcohol concentration limit (0.02 g/dl) for young drivers than recommended for older drivers (≤0.05 g/dl). Enforce blood alcohol concentration limits, e.g., with random breath testing of all drivers at a certain point, or only those who appear to be alcohol impaired. Establish penalties and stiff sanctions for driving under the influence of alcohol.</td>
<td></td>
</tr>
<tr>
<td>Seat-belt laws</td>
<td>Promote seat-belt laws for all vehicle occupants, including in back seats. When laws requiring seat-belt use are enforced, rates of use increase and fatality rates decrease. Although most countries now have such laws, half or more of all vehicles in low-income countries lack properly functioning seat belts.</td>
<td></td>
</tr>
<tr>
<td>Helmet laws</td>
<td>Create mandatory helmet laws for two- and three-wheeled vehicles (including tricycles and others), and enforce them. Establish a required safety standard for helmets that are effective in reducing head injuries.</td>
<td></td>
</tr>
<tr>
<td>Mobile phone laws</td>
<td>There is still little information on the effectiveness of these relatively new driving interventions. However, 142 countries prohibit the use of hand-held phones; 34 prohibit hands-free phones; and 42 prohibit text messaging.</td>
<td></td>
</tr>
<tr>
<td>Speed limits</td>
<td>Roads with high pedestrian, child, or cyclist activity should allow speeds no higher than 30 km/h. Limits should be enforced in such a way that drivers believe there is a high chance of being caught if they speed. According to the best practices, maximum urban speed limits should be set at less than or equal to 50 km/h. Where countries have changed their speed limits, but have taken little action to enforce them, there have been very limited benefits.</td>
<td></td>
</tr>
<tr>
<td>Restriction of young or inexperienced drivers</td>
<td>A graduated licensing system phases in younger driver privileges over time, such as first having an extended learner period involving training and low-risk, supervised driving; then a license with temporary restrictions, and finally a full license.</td>
<td></td>
</tr>
<tr>
<td>Restriction of availability of alcohol</td>
<td>Reducing hours, days, or locations where alcohol can be sold, as well as reducing demand through appropriate taxation and pricing mechanisms, are cost-effective ways to reduce drinking among young people. Ban the sale of alcohol at gas stations and along major highways, as these are risky to any driver, including young drivers.</td>
<td></td>
</tr>
<tr>
<td>Legal disincentives to drive unsafely</td>
<td>Make unsafe behavior less attractive, e.g., give penalty points or take away licenses if people drive while impaired.</td>
<td></td>
</tr>
</tbody>
</table>
### Environmental

| Road design/redesign/traffic calming and safety measures | Examples include infrastructural engineering measures (e.g., speed humps, mini-roundabouts, road narrowing treatments, chicanes, rumble strips, designated pedestrian crossings); visual changes (e.g., road lighting or surface treatment); redistribution of traffic (e.g., one-way streets); promotion of safe public transport, separating pedestrians from other traffic through sidewalks, raised crossings, overpasses, underpasses, refuge islands, and raised medians; improving roadway lighting, including around pedestrian crossings; removing obstacles that block the line of sight between pedestrians and vehicles. |

### Organizational

| Prehospital care | Standardize formal emergency medical services, including equipping vehicles with supplies and devices for children as well as adults. Where no prehospital trauma care system exists: teach interested community members basic first aid techniques; build on existing, informal systems of prehospital care and transport; and initiate emergency services on busy roads and high-frequency crash sites. |
| Hospital care | Improve the organization and planning of trauma care services in an affordable and sustainable way in order to raise the quality and outcome of care. |
| Rehabilitation | Improve services in health care facilities and community-based rehabilitation to minimize the extent of disability after injury, and help adolescents with persistent disability to achieve their highest potential. |

### Community

| Alcohol campaigns | Make drinking and driving less publicly acceptable; alert people to the risk of detection and arrest, and the consequences; and raise public support for enforcement. |
| Speed management | Mass media campaigns linked to other approaches to speed management raise awareness about the dangers of speeding, and gain greater public support for new legislation, stricter enforcement, and stronger penalties. |
| Seat-belt campaigns | Public campaigns about seat-belt laws can target adolescents, to increase awareness and change risk-taking social norms. |
| Helmet campaigns | Educate adolescents about the benefits of wearing helmets on two-wheeled vehicles, by using peer pressure to change youth norms regarding helmet acceptability and to reinforce helmet-wearing laws. |
| Community-based projects | Community projects can employ parents and peers to encourage adolescents to wear seat belts. |

### Individual

| Helmet distribution | Programs that provide helmets at reduced or no cost enable adolescents with little disposable income to use them. Distribution can be taken to scale through the school system. |
| Motorized two-wheeler interventions | Promote use of daytime running lights; reflective or fluorescent clothing; light-colored clothing and helmets; and reflectors on the back of vehicles. |
| Cyclist interventions | Promote front, rear, and wheel reflectors; bicycle lamps; reflective jackets or vests; and helmets. |
| Pedestrian interventions | Promote white or light-colored clothing for visibility; reflective strips on clothing or articles such as backpacks; walking in good lighting; and walking facing oncoming traffic; enacting and enforcing laws on public intoxication; urging pedestrians to abide by road signs and signals, and the rules of the road, to promote a culture of safety. |
## Interventions to prevent youth violence

<table>
<thead>
<tr>
<th>Ecological level</th>
<th>Intervention</th>
<th>Further explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structural</td>
<td>Reduce access to and misuse of firearms</td>
<td>Programs may require new legislation, additional police to supervise implementation, public awareness campaigns, and more elaborate monitoring systems.</td>
</tr>
<tr>
<td></td>
<td>Reduce access to and the harmful use of alcohol</td>
<td>Regulate or ban the marketing of alcohol to adolescents, including advertising, promotions and sponsorships of sports and cultural events; restrict alcohol availability (in public places, schools, sports facilities, large events); reduce days, hours and density of outlets; enforce laws to restrict sales to intoxicated youth with penalties/sanctions to bar owners; reduce demand through taxation and pricing; raise awareness and support for policies; and implement interventions for controlling the harmful use of alcohol.</td>
</tr>
<tr>
<td>Financial incentives to attend school</td>
<td>Money is granted on a per-student or per-family basis, and is tied to 80% or higher school attendance. Grants may cover direct costs (e.g., school fees and supplies) and opportunity costs (e.g., when families lose income from child labor).</td>
<td></td>
</tr>
<tr>
<td>Environmental</td>
<td>Spatial modifications and urban upgrading</td>
<td>For areas with high levels of violence, situational crime prevention includes a security assessment, a stakeholder analysis, and a planning process involving communities, local governments, and housing, transport, and other sectors.</td>
</tr>
<tr>
<td></td>
<td>Poverty deconcentration</td>
<td>These strategies offer vouchers or other incentives for residents of economically impoverished public housing complexes to move to less impoverished neighborhoods.</td>
</tr>
<tr>
<td></td>
<td>Hotspot policing</td>
<td>Police resources are deployed in areas where crime is prevalent. Mapping technology and geographic analysis help identify hotspots based on combined crime statistics, hospital emergency records, vandalism and shoplifting data, and other sources.</td>
</tr>
<tr>
<td>Organizational</td>
<td>Demand- and supply-side interventions for drug control</td>
<td>Drug control may focus on reducing drug demand, drug supply, or both. Most interventions require substantial technical capacity within health services and the police force.</td>
</tr>
<tr>
<td></td>
<td>School-based bullying prevention</td>
<td>Teachers are trained to recognize and explain bullying to students, what to do when it occurs, effective relationship skills, and skills for bystanders. Specialists work with students involved in bullying. School policies and procedures also may be established, and parents may be trained.</td>
</tr>
<tr>
<td>Community</td>
<td>Gang and street violence prevention interventions</td>
<td>This may focus on reducing gang enrollment, helping members leave gangs, and/or suppressing gang activities. Community leaders are engaged to convey a strong message that gang violence is unacceptable. Police involvement, vocational training, and personal development activities may also be included.</td>
</tr>
<tr>
<td></td>
<td>Community- and problem-oriented policing</td>
<td>The systematic use of police-community partnerships and problem-solving techniques identifies and targets underlying problems, to alleviate violence. One necessary precondition is a policing system that is legitimate, accountable, nonrepressive, noncorrupt, and professional. Another precondition is good relations among the police, local government, and the public.</td>
</tr>
<tr>
<td><strong>Interpersonal</strong></td>
<td><strong>Parenting programs</strong></td>
<td>Goals are to promote parental understanding of adolescent development and to strengthen the parents’ ability to assist their children and adolescents in regulating their behavior through non-violent means.</td>
</tr>
<tr>
<td></td>
<td><strong>Home visits</strong></td>
<td>Home visiting programs monitor and support families while there is a high risk of maltreatment (e.g., families living in highly deprived settings).</td>
</tr>
<tr>
<td></td>
<td><strong>Peer mediation</strong></td>
<td>Peer mediators may be nominated by a class and receive 20-25 hours of training on how to mitigate peer conflicts and seek help if needed. Other students may also be trained in conflict resolution skills.</td>
</tr>
<tr>
<td></td>
<td><strong>Dating violence prevention</strong></td>
<td>School-based or after-school participatory activities address the characteristics of caring and abusive relationships; how to develop a support structure of friends; communication skills; and where and how to seek help in case of sexual assault.</td>
</tr>
<tr>
<td><strong>Individual</strong></td>
<td><strong>Life-skills development and social and emotional learning</strong></td>
<td>These age-specific programs help adolescents to understand and manage anger and other emotions, show empathy for others, and establish relationships. They involve 20-150 classroom sessions over several years.</td>
</tr>
<tr>
<td></td>
<td><strong>After-school and other structured leisure time activities</strong></td>
<td>Structured leisure time activities can include cognitive and academic skills development; arts, crafts, cooking, sports, music, dance, and theater; activities related to health and nutrition; and community and parental engagement.</td>
</tr>
<tr>
<td></td>
<td><strong>Academic enrichment</strong></td>
<td>Adolescents are targeted through mass media, after-school lessons, or private tutoring to help them keep up with school requirements and prevent them from dropping out of school.</td>
</tr>
<tr>
<td></td>
<td><strong>Vocational training</strong></td>
<td>Vocational training for at-risk youth can have a meaningful impact on violence prevention if integrated with economic development and job creation. It is important to ensure the capacity of training institutions, available technical equipment, existing cooperation with businesses, and sustainable financing models.</td>
</tr>
<tr>
<td></td>
<td><strong>Mentoring</strong></td>
<td>Volunteer mentors receive training on adolescent development, relationship building, problem solving, communicating, and specific concerns (e.g., alcohol and drug use). A mentor shares knowledge, skills, and perspective to promote an at-risk adolescent’s positive development.</td>
</tr>
<tr>
<td></td>
<td><strong>Therapeutic approaches</strong></td>
<td>Qualified mental health specialists or social workers work with individual adolescents on social skills and behavioral training, anger- and self-control techniques, and cognitive elements (e.g., moral reasoning and perspective-taking to appreciate the negative impacts of violence on victims). Families and social networks of at-risk adolescents may also be targeted.</td>
</tr>
</tbody>
</table>

Source: (6).
Annex II.D2: Evidence-based interventions recommended by the World Health Organization for reducing adolescent tobacco use and exposure

<table>
<thead>
<tr>
<th>Ecological level</th>
<th>Intervention</th>
<th>Further explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structural and environmental</td>
<td>Reduce the affordability of tobacco</td>
<td>Reduce the affordability of tobacco products by increasing tobacco excise taxes.</td>
</tr>
<tr>
<td></td>
<td>Ban tobacco advertising</td>
<td>Enforce comprehensive bans on tobacco advertising, promotion, and sponsorship, including with cross-border advertising, the Internet, and social media. Also actively promote the entertainment media, cinema, and drama as smoke-free.</td>
</tr>
<tr>
<td></td>
<td>Smoke-free environments</td>
<td>Create bylaws ensuring completely smoke-free environments in all schools, recreational areas, indoor workplaces, public places, and public transport.</td>
</tr>
<tr>
<td>Organizational and community</td>
<td>Campaign to raise awareness of the dangers of tobacco</td>
<td>Conduct regular and effective mass-media campaigns to raise awareness of the dangers of tobacco.</td>
</tr>
<tr>
<td></td>
<td>Tobacco prevention within school programs</td>
<td>Integrate tobacco prevention within school policies, skills-based health education, and health services. See Tobacco Use Prevention: An Important Entry Point for the Development of Health-Promoting Schools for age-appropriate knowledge, attitude, and skills-building targets. In no circumstances should these programs be implemented in collaboration with or funded by the tobacco industry.</td>
</tr>
<tr>
<td>Individual and interpersonal</td>
<td>Guidance on stopping tobacco use</td>
<td>Clinicians should encourage all nonsmokers to not start smoking; strongly advise all smokers to stop smoking, and support them in their efforts; and advise individuals who use other forms of tobacco to quit. For more specific guidance, see Toolkit for Delivering the 5A’s and 5R’s Brief Tobacco Interventions in Primary Care.</td>
</tr>
</tbody>
</table>

Source: (6).
Anne II.D3: Evidence-based interventions recommended by the World Health Organization to promote adolescent physical activity and healthy diets

<table>
<thead>
<tr>
<th>Ecological level</th>
<th>Intervention</th>
<th>Further explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structural and environmental</td>
<td>Urban planning policies</td>
<td>Governments should partner with communities, the private sector, and NGOs to develop safe spaces for physical activity and facilities for sports, recreation, and leisure. Active transport policies should ensure that walking, cycling, and other nonmotorized transport are accessible and safe for all.</td>
</tr>
<tr>
<td></td>
<td>School and public facilities</td>
<td>Adequate facilities should be available on school premises, youth workplaces and in public spaces for physical activity during recreational time for adolescents (including those with disabilities), with the provision of gender-friendly spaces where appropriate.</td>
</tr>
<tr>
<td>Organizational and community</td>
<td>Public awareness programs on physical activity</td>
<td>Provide guidance to children and adolescents, their parents, caregivers, teachers, and health professionals on healthy body size, physical activity, sleep behaviors, and appropriate use of screen-based entertainment.</td>
</tr>
<tr>
<td></td>
<td>Physical education curricula in schools</td>
<td>A good physical education curriculum develops abilities and conditioning; provides activity for specific needs to all children; encourages continued sports and physical activity later in life; and provides recreation and relaxation.</td>
</tr>
<tr>
<td></td>
<td>Regular, structured sports activities</td>
<td>Regular, structured sports activities among adolescents strengthen the links among physical activity, sports, and health, and also reduces sedentary behaviors.</td>
</tr>
</tbody>
</table>
| Individual and interpersonal        | Guidance on physical activity for younger adolescents | Clinical guidance for adolescents aged 10-17 years recommends:  
• at least 60 minutes of moderate-intensity to vigorous-intensity physical activity daily  
• amounts of physical activity greater than 60 minutes, for additional health benefits  
• most of the daily physical activity should be aerobic; vigorous-intensity activities should be incorporated, including those that strengthen muscle and bone, at least three times per week |
|                                      | Guidance on physical activity for older adolescents | Clinical guidance for adolescents aged 18-19 years recommends:  
• at least 150 minutes of moderate-intensity aerobic physical activity throughout the week, or at least 75 minutes of vigorous-intensity aerobic physical activity throughout the week (or an equivalent combination of moderate- and vigorous-intensity activity)  
• aerobic activity should be performed in bouts of at least 10 minutes duration  
• for additional health benefits, increase moderate-intensity aerobic physical activity per week, or an equivalent combination of moderate- and vigorous-intensity activity  
• muscle-strengthening activities should be done that involve major muscle groups on two or more days a week |
### Interventions to prevent and mitigate road traffic injuries among adolescents

<table>
<thead>
<tr>
<th>Ecological level</th>
<th>Intervention</th>
<th>Further explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structural and environmental</td>
<td>Nutrient profiles</td>
<td>Develop and use nutrient profiles to identify unhealthy foods and beverages.</td>
</tr>
<tr>
<td></td>
<td>Nutrient labeling system</td>
<td>Implement a standardized global nutrient labeling system; control the use of misleading health and nutrition claims; and implement mandatory front-of-pack labeling.</td>
</tr>
<tr>
<td></td>
<td>Reduce affordability of unhealthy foods and beverages</td>
<td>Tax and increase the pricing of energy-dense, nutrient-poor foods and sugar-sweetened beverages.</td>
</tr>
<tr>
<td></td>
<td>Reduce the impact of marketing of unhealthy foods and beverages</td>
<td>Reduce the impact of marketing of foods and beverages high in sugar, salt, and fat. Establish cooperation between Member States related to cross-border marketing. Implement the WHO set of recommendations on the marketing of foods and nonalcoholic beverages to children.</td>
</tr>
<tr>
<td>Organizational and community</td>
<td>Healthy food environments in schools and other public institutions</td>
<td>Require settings frequented by adolescents (e.g., schools, child care settings, children’s sports facilities and events, and youth workplaces) to create healthy food environments.</td>
</tr>
<tr>
<td></td>
<td>Improved access to healthy food</td>
<td>Improve the availability and affordability of healthy foods in public institutions and settings, particularly in disadvantaged communities.</td>
</tr>
<tr>
<td></td>
<td>Campaigns to raise awareness of adolescent obesity</td>
<td>Campaigns should target policymakers, medical staff, and adults, adolescents, and children in general, promoting capacity-building related to adolescent obesity and its risk factors.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation</td>
<td>Improve services in health care facilities and community-based rehabilitation to minimize the extent of disability after injury, and help adolescents with persistent disability to achieve their highest potential.</td>
</tr>
</tbody>
</table>
| Individual and interpersonal | Guidance on a healthy diet | Clinical dietary guidance for older adolescents (18-19 years) includes:  
- restrict salt to less than 5 g (one teaspoon) per day, reduce it when cooking, and limit processed and fast foods  
- restrict free sugars to less than 10% of total energy intake; a further reduction to below 5% or roughly 25 g (six teaspoons) per day would provide additional health benefits  
- have five servings (400-500 g) of fruits and vegetables per day (one serving is equivalent to one orange, apple, mango, or banana, or three tablespoons of cooked vegetables)  
- limit fatty meat, dairy fat, cooking oil (less than two tablespoons per day); replace palm and coconut oil with olive, soy, corn, rapeseed, or safflower oil; replace other meat with chicken (without skin) |
|                      | Weight management interventions for obese adolescents | Develop and support family-based, multicomponent, lifestyle weight management services for adolescents who are overweight (including nutrition, physical activity, and psychosocial support). These should be delivered by multiprofessional teams as part of universal health coverage. |

Source: (6).
Annex II.E: Suicidal behavior among students ages 13-15 years in countries of English-speaking Caribbean, Southern Cone, Andean area, and Central America

<table>
<thead>
<tr>
<th>English-speaking Caribbean</th>
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<td></td>
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</tr>
<tr>
<td>Percentage of students who ever seriously considered suicide during the 12 months before the survey</td>
<td>20.7</td>
<td>(19.5-21.9)</td>
<td>17.0</td>
<td>(13.9-20.5)</td>
<td>23.9</td>
</tr>
<tr>
<td>Percentage of students who ever made a plan about how they would attempt suicide during the 12 months before the survey</td>
<td>19.9</td>
<td>(18.8-21.1)</td>
<td>15.7</td>
<td>(14.2-17.4)</td>
<td>23.7</td>
</tr>
<tr>
<td>Percentage of students who actually attempted suicide one or more times during the 12 months before the survey</td>
<td>18.0</td>
<td>(15.1-21.4)</td>
<td>16.6</td>
<td>(13.2-20.7)</td>
<td>19.4</td>
</tr>
<tr>
<td>Students who are current drinkers</td>
<td></td>
<td></td>
<td></td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td>Percentage of students who ever seriously considered suicide during the 12 months before the survey</td>
<td>26.4</td>
<td>(24.6-28.3)</td>
<td>21.7</td>
<td>(16.7-27.8)</td>
<td>31.6</td>
</tr>
<tr>
<td>Percentage of students who ever made a plan about how they would attempt suicide during the 12 months before the survey</td>
<td>25.0</td>
<td>(23.4-26.7)</td>
<td>18.3</td>
<td>(15.1-22.1)</td>
<td>32.1</td>
</tr>
<tr>
<td>Percentage of students who actually attempted suicide one or more times during the 12 months before the survey</td>
<td>23.8</td>
<td>(19.3-28.9)</td>
<td>21.7</td>
<td>(14.5-31.3)</td>
<td>26.1</td>
</tr>
<tr>
<td>Students with poor social support</td>
<td></td>
<td></td>
<td></td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td>Percentage of students who ever seriously considered suicide during the 12 months before the survey</td>
<td>57.5</td>
<td>(48.9-65.6)</td>
<td>62.0</td>
<td>(51.6-71.4)</td>
<td>53.9</td>
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<tr>
<td>Percentage of students who ever made a plan about how they would attempt suicide during the 12 months before the survey</td>
<td>43.4</td>
<td>(37.7-49.2)</td>
<td>37.4</td>
<td>(29.2-59.9)</td>
<td>48.2</td>
</tr>
<tr>
<td>Percentage of students who actually attempted suicide one or more times during the 12 months before the survey</td>
<td>47.6</td>
<td>(29.1-66.8)</td>
<td>48.9</td>
<td>(23.7-74.6)</td>
<td>47.5</td>
</tr>
<tr>
<td>Students with strong parental relationships</td>
<td></td>
<td></td>
<td></td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td>Percentage of students who ever seriously considered suicide during the 12 months before the survey</td>
<td>10.2</td>
<td>(7.6-13.6)</td>
<td>6.4</td>
<td>(4.2-9.5)</td>
<td>13.2</td>
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<td>Percentage of students who ever made a plan about how they would attempt suicide during the 12 months before the survey</td>
<td>10.9</td>
<td>(8.7-13.6)</td>
<td>7.9</td>
<td>(4.4-13.8)</td>
<td>13.1</td>
</tr>
<tr>
<td>Percentage of students who actually attempted suicide one or more times during the 12 months before the survey</td>
<td>11.5</td>
<td>(8.6-15.2)</td>
<td>NA&lt;sup&gt;h&lt;/sup&gt;</td>
<td>(8.6-15.2)</td>
<td>15.0</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Southern Cone</th>
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<th></th>
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<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td>Percentage of students who ever seriously considered suicide during the 12 months before the survey</td>
<td>16.5</td>
<td>(14.9-18.3)</td>
<td>10.7</td>
<td>(9.1-12.6)</td>
<td>21.7</td>
</tr>
<tr>
<td>Percentage of students who ever made a plan about how they would attempt suicide during the 12 months before the survey</td>
<td>15.7</td>
<td>(14.2-17.3)</td>
<td>11.3</td>
<td>(9.8-13.0)</td>
<td>19.5</td>
</tr>
<tr>
<td>Percentage of students who actually attempted suicide one or more times during the 12 months before the survey</td>
<td>15.7</td>
<td>(14.4-17.1)</td>
<td>12.5</td>
<td>(10.4-15.0)</td>
<td>18.3</td>
</tr>
<tr>
<td>Students who are current drinkers</td>
<td></td>
<td></td>
<td></td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td>Percentage of students who ever seriously considered suicide during the 12 months before the survey</td>
<td>22.6</td>
<td>(20.4-24.8)</td>
<td>14.0</td>
<td>(11.5-17.0)</td>
<td>30.1</td>
</tr>
<tr>
<td>Percentage of students who ever made a plan about how they would attempt suicide during the 12 months before the survey</td>
<td>21.7</td>
<td>(19.7-23.8)</td>
<td>15.0</td>
<td>(12.3-18.2)</td>
<td>27.3</td>
</tr>
<tr>
<td>Percentage of students who actually attempted suicide one or more times during the 12 months before the survey</td>
<td>20.6</td>
<td>(19.1-22.3)</td>
<td>15.2</td>
<td>(11.9-19.2)</td>
<td>25.2</td>
</tr>
<tr>
<td>Students with poor social support</td>
<td></td>
<td></td>
<td></td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td>Percentage of students who ever seriously considered suicide during the 12 months before the survey</td>
<td>64.4</td>
<td>(50.8-76.1)</td>
<td>60.7</td>
<td>(44.0-75.2)</td>
<td>66.1</td>
</tr>
<tr>
<td>Percentage of students who ever made a plan about how they would attempt suicide during the 12 months before the survey</td>
<td>52.2</td>
<td>(39.1-65.1)</td>
<td>39.4</td>
<td>(26.2-54.2)</td>
<td>60.0</td>
</tr>
<tr>
<td>Percentage of students who actually attempted suicide one or more times during the 12 months before the survey</td>
<td>45.2</td>
<td>(35.9-54.9)</td>
<td>30.9</td>
<td>(24.3-38.4)</td>
<td>54.3</td>
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</table>
### Andean area

<table>
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<th>Males</th>
<th>Females</th>
</tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of students who ever seriously considered suicide during the 12 months before the survey</td>
<td>18.9 (17.1-20.7)</td>
<td>11.4 (9.8-13.1)</td>
<td>26.4 (24.2-28.6)</td>
</tr>
<tr>
<td>Percentage of students who ever made a plan about how they would attempt suicide during the 12 months before the survey</td>
<td>15.4 (13.9-17.1)</td>
<td>9.3 (7.7-11.3)</td>
<td>21.5 (19.6-23.5)</td>
</tr>
<tr>
<td>Percentage of students who actually attempted suicide one or more times during the 12 months before the survey</td>
<td>17.9 (16.4-19.4)</td>
<td>13.0 (11.3-15.0)</td>
<td>22.7 (20.7-24.7)</td>
</tr>
<tr>
<td>Students who are current drinkers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of students who ever seriously considered suicide during the 12 months before the survey</td>
<td>33.2 (28.7-38.1)</td>
<td>20.1 (16.0-24.9)</td>
<td>47.7 (42.3-53.1)</td>
</tr>
<tr>
<td>Percentage of students who ever made a plan about how they would attempt suicide during the 12 months before the survey</td>
<td>27.1 (23.2-31.3)</td>
<td>16.5 (12.7-21.2)</td>
<td>38.6 (33.7-43.7)</td>
</tr>
<tr>
<td>Percentage of students who actually attempted suicide one or more times during the 12 months before the survey</td>
<td>30.6 (26.5-35.0)</td>
<td>20.7 (16.3-25.9)</td>
<td>41.6 (36.5-46.9)</td>
</tr>
<tr>
<td>Students with poor social support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of students who ever seriously considered suicide during the 12 months before the survey</td>
<td>50.1 (42.4-57.8)</td>
<td>38.7 (26.2-52.8)</td>
<td>56.5 (45.0-67.3)</td>
</tr>
<tr>
<td>Percentage of students who ever made a plan about how they would attempt suicide during the 12 months before the survey</td>
<td>41.2 (33.5-49.3)</td>
<td>29.2 (18.9-42.3)</td>
<td>47.9 (36.4-59.6)</td>
</tr>
<tr>
<td>Percentage of students who actually attempted suicide one or more times during the 12 months before the survey</td>
<td>44.5 (37.0-52.2)</td>
<td>41.9 (28.6-56.4)</td>
<td>45.9 (36.7-55.5)</td>
</tr>
</tbody>
</table>

### Central America

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Total</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Percentage of students who ever seriously considered suicide during the 12 months before the survey</td>
<td>14.8 (13.7-16.0)</td>
<td>10.7 (9.3-12.2)</td>
<td>18.9 (17.1-20.9)</td>
</tr>
<tr>
<td>Percentage of students who ever made a plan about how they would attempt suicide during the 12 months before the survey</td>
<td>13.0 (11.9-14.2)</td>
<td>9.0 (7.6-10.7)</td>
<td>16.9 (15.2-18.6)</td>
</tr>
<tr>
<td>Percentage of students who actually attempted suicide one or more times during the 12 months before the survey</td>
<td>13.2 (12.0-14.5)</td>
<td>9.1 (7.8-10.7)</td>
<td>17.1 (15.3-19.0)</td>
</tr>
<tr>
<td>Students who are current drinkers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of students who ever seriously considered suicide during the 12 months before the survey</td>
<td>30.5 (26.7-34.5)</td>
<td>20.3 (16.2-25.0)</td>
<td>40.4 (35.1-46.0)</td>
</tr>
<tr>
<td>Percentage of students who ever made a plan about how they would attempt suicide during the 12 months before the survey</td>
<td>26.9 (23.6-30.6)</td>
<td>17.3 (13.7-21.8)</td>
<td>36.1 (31.4-41.0)</td>
</tr>
<tr>
<td>Percentage of students who actually attempted suicide one or more times during the 12 months before the survey</td>
<td>26.5 (23.0-30.2)</td>
<td>16.1 (12.6-20.4)</td>
<td>36.3 (30.9-42.1)</td>
</tr>
<tr>
<td>Students with poor social support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of students who ever seriously considered suicide during the 12 months before the survey</td>
<td>49.3 (38.6-60.0)</td>
<td>NA</td>
<td>48.3 (34.6-62.2)</td>
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</table>
### Percentage of students who ever made a plan about how they would attempt suicide during the 12 months before the survey

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
<th>95% CI</th>
</tr>
</thead>
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<tr>
<td></td>
<td>41.8</td>
<td>(32.4-51.8)</td>
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<td>NA</td>
<td>(31.2-56.5)</td>
</tr>
<tr>
<td></td>
<td>43.4</td>
<td>(31.2-56.5)</td>
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</table>

### Percentage of students who actually attempted suicide one or more times during the 12 months before the survey

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
<th>95% CI</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>45.4</td>
<td>(35.5-55.6)</td>
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<tr>
<td></td>
<td>43.4</td>
<td>(26.6-62.0)</td>
</tr>
<tr>
<td></td>
<td>46.4</td>
<td>(33.3-60.1)</td>
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</table>

### Students with strong parental relationships

<table>
<thead>
<tr>
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<th>Percentage</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5.8</td>
<td>(4.5-7.4)</td>
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<td>(4.0-7.3)</td>
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<tr>
<td></td>
<td>6.3</td>
<td>(4.2-9.3)</td>
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<table>
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<tr>
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<th>Percentage</th>
<th>95% CI</th>
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</thead>
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<tr>
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<td>4.9</td>
<td>(3.4-7.0)</td>
</tr>
<tr>
<td></td>
<td>6.6</td>
<td>(4.8-9.1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
<th>95% CI</th>
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<td>(5.0-8.0)</td>
</tr>
<tr>
<td></td>
<td>5.7</td>
<td>(4.0-8.2)</td>
</tr>
<tr>
<td></td>
<td>7.1</td>
<td>(5.1-9.8)</td>
</tr>
</tbody>
</table>

**Source:** (79).

a Caribbean countries included in the analysis: Antigua and Barbuda, The Bahamas, Barbados, Cayman Islands, Dominica, Grenada, Guyana, Jamaica, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago.
b Southern Cone countries included in the analysis: Argentina, Chile, Uruguay.
c Andean area countries included in the analysis: Bolivia, Colombia (subnational, capital city only), Ecuador (subnational, capital city only), Peru.
d Central American countries included in the analysis: Belize, Costa Rica, El Salvador, Guatemala, Honduras.
e Current drinker is defined as having at least one drink containing alcohol on one or more of the past 30 days.
f The peer social support construct is composed of four questions related to the respondents’ perceptions of their relationships with their peers: (1) how often the respondent feels lonely, (2) the number of close friends they report, (3) how often other students are kind and helpful, and (4) how often they report being bullied.
g The parental relationship construct is composed of three questions related to respondents’ perceptions of the behavior and attitudes of their parents/guardians, in terms of whether the parents/guardians: (1) checks if homework is complete, (2) understands problems and worries, and (3) really knows what the respondent did in his or her free time.
h NA = not available.
Annex II.F: Number of adolescents aged 10-19 years living with HIV in Latin America and the Caribbean (LAC) in 2015

<table>
<thead>
<tr>
<th>Country</th>
<th>Estimated number</th>
<th>Percentage of total</th>
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</thead>
<tbody>
<tr>
<td>Brazil</td>
<td>28,000</td>
<td>38%</td>
</tr>
<tr>
<td>Haiti</td>
<td>8,400</td>
<td>11%</td>
</tr>
<tr>
<td>Mexico</td>
<td>6,600</td>
<td>9%</td>
</tr>
<tr>
<td>Colombia</td>
<td>5,600</td>
<td>8%</td>
</tr>
<tr>
<td>Venezuela (Bolivian Republic of)</td>
<td>3,800</td>
<td>5%</td>
</tr>
<tr>
<td>Argentina</td>
<td>3,300</td>
<td>4%</td>
</tr>
<tr>
<td>Dominican Republic</td>
<td>3,100</td>
<td>4%</td>
</tr>
<tr>
<td>Guatemala</td>
<td>2,800</td>
<td>4%</td>
</tr>
<tr>
<td>Peru</td>
<td>2,400</td>
<td>3%</td>
</tr>
<tr>
<td>Honduras</td>
<td>1,400</td>
<td>2%</td>
</tr>
<tr>
<td>Jamaica</td>
<td>1,200</td>
<td>2%</td>
</tr>
<tr>
<td>Ecuador</td>
<td>1,100</td>
<td>1%</td>
</tr>
<tr>
<td>Bolivia (Plurinational State of)</td>
<td>1,000</td>
<td>1%</td>
</tr>
<tr>
<td>Chile</td>
<td>&lt; 1,000</td>
<td>1%</td>
</tr>
<tr>
<td>El Salvador</td>
<td>&lt; 1,000</td>
<td>1%</td>
</tr>
<tr>
<td>Guyana</td>
<td>&lt; 1,000</td>
<td>1%</td>
</tr>
<tr>
<td>Panama</td>
<td>&lt; 1,000</td>
<td>1%</td>
</tr>
<tr>
<td>Paraguay</td>
<td>&lt; 1,000</td>
<td>1%</td>
</tr>
<tr>
<td>Nicaragua</td>
<td>&lt; 1,000</td>
<td>1%</td>
</tr>
<tr>
<td>The Bahamas</td>
<td>&lt; 500</td>
<td>&lt; 1%</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>&lt; 500</td>
<td>&lt; 1%</td>
</tr>
<tr>
<td>Trinidad &amp; Tobago</td>
<td>&lt; 500</td>
<td>&lt; 1%</td>
</tr>
<tr>
<td>Uruguay</td>
<td>&lt; 500</td>
<td>&lt; 1%</td>
</tr>
<tr>
<td>Belize</td>
<td>&lt; 200</td>
<td>&lt; 1%</td>
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<tr>
<td>Cuba</td>
<td>&lt; 200</td>
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<td>Suriname</td>
<td>&lt; 200</td>
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</table>

Source: (108)
### Annex III.A. Adolescent and youth health policies, strategies, and plans of countries of Latin America and the Caribbean, as of July 2017

<table>
<thead>
<tr>
<th>Country</th>
<th>Document title</th>
<th>Period covered or year of publication</th>
<th>Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anguilla</td>
<td>National School Health Action Plan and Policy</td>
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<td>Antigua and Barbuda</td>
<td>Antigua and Barbuda Child and Adolescent Health Strategy</td>
<td>2016</td>
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<td>Argentina</td>
<td>Ley 26.061 de Protección Integral de Derechos de Niños, Niñas y Adolescentes</td>
<td>2005</td>
<td><a href="https://www.educ.ar/recursos/118943/ley-nacional-26061-de-proteccion-integral-de-los-derechos-de-ninos-ninas-y-adolescentes">https://www.educ.ar/recursos/118943/ley-nacional-26061-de-proteccion-integral-de-los-derechos-de-ninos-ninas-y-adolescentes</a></td>
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<td></td>
<td>Ley Nº 26.485 de Protección Integral para Prevenir, Sancionar y Erradicar la Violencia contra las Mujeres en los Ámbitos en que Desarrollen sus Relaciones Interpersonales</td>
<td>2009</td>
<td><a href="https://www.oas.org/dil/esp/Ley_de_Proteccion_Integral_de_Mujeres_Argentina.pdf">https://www.oas.org/dil/esp/Ley_de_Proteccion_Integral_de_Mujeres_Argentina.pdf</a></td>
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<td></td>
<td>Ley 27.130 Ley Nacional de Prevención del Suicidio.</td>
<td>2015</td>
<td><a href="http://servicios.infoleg.gob.ar/infolegInternet/anexos/245000-249999/245618/norma.htm">http://servicios.infoleg.gob.ar/infolegInternet/anexos/245000-249999/245618/norma.htm</a></td>
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<td></td>
<td>Embarazos en adolescentes y jóvenes</td>
<td></td>
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<td>Brazil</td>
<td>Diretrizes Nacionales para a Atenção Integral à Saúde de Adolescentes e Jovens na Promoção, Proteção e Recuperação da Saúde</td>
<td>2010</td>
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<td>Country</td>
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<td>----------------------------------------------------------------------------------------</td>
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<td>Brazil</td>
<td>Orientações básicas de atenção integral à saúde de adolescentes nas escolas e unidades básicas de saúde</td>
<td>2013</td>
<td><a href="http://bvsms.saude.gov.br/bvs/publicacoes/orientacao_basica_saude_adolescente.pdf">http://bvsms.saude.gov.br/bvs/publicacoes/orientacao_basica_saude_adolescente.pdf</a></td>
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<tr>
<td>British Virgin Islands</td>
<td>Policy and plan of action on adolescent health</td>
<td>2014/2015</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Family Health Strategy</td>
<td>2012</td>
<td></td>
</tr>
<tr>
<td>Colombia</td>
<td>Estrategia de atención integral a la primera infancia (política de primera infancia de cero a siempre)</td>
<td>2013</td>
<td><a href="http://www.decreoasiempre.gov.co/QuienesSomos/Documents/Fundamentos-politicos-tecnicos-gestion-de-cero-a-siempre.pdf">http://www.decreoasiempre.gov.co/QuienesSomos/Documents/Fundamentos-politicos-tecnicos-gestion-de-cero-a-siempre.pdf</a></td>
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<tr>
<td></td>
<td>Plan de Acción Consejo Interinstitucional de Atención Madre Adolescente</td>
<td>2012-2016</td>
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**The Health of Adolescents and Youth in the Americas**
<table>
<thead>
<tr>
<th>Country</th>
<th>Policy/Plan Description</th>
<th>Years</th>
<th>URL</th>
</tr>
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<tr>
<td>Dominica</td>
<td>Adolescent and Youth Health Policy and Plan of Action</td>
<td>2017-2027</td>
<td>Not yet available</td>
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<tr>
<td>Grenada</td>
<td>National Adolescent Health Policy and Strategic Plan for Grenada</td>
<td>2013</td>
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<tr>
<td></td>
<td>National Sexual and Reproductive Health Policy and Plan</td>
<td>2013</td>
<td></td>
</tr>
<tr>
<td>Guyana</td>
<td>Strategic policy on Reproductive health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Country</td>
<td>Plan/Programme</td>
<td>Year/Period</td>
<td>Reference</td>
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<td>-----------</td>
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<td>Haiti</td>
<td>Protocoles de Prise en charge Santé Jeunes et Adolescents</td>
<td>2017</td>
<td></td>
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<tr>
<td>Jamaica</td>
<td>National Strategic Plan Pre-adolescent and adolescent health and development</td>
<td>2011-2015</td>
<td></td>
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<tr>
<td>Jamaica</td>
<td>Standards and related criteria for adolescent health. A guide for assuring quality health services for adolescents</td>
<td>2014</td>
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</tr>
<tr>
<td>Paraguay</td>
<td>Norma Técnica de atención integral para adolescentes en los Servicios de Salud</td>
<td>2017-2020</td>
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<tr>
<td>Paraguay</td>
<td>Plan estratégico Nacional de Previsión de Embarazo Adolescente no Intencional</td>
<td></td>
<td>Being prepared, as of July 2017</td>
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<tr>
<td>Country</td>
<td>Policy/Strategy</td>
<td>Year</td>
<td>Link</td>
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<td>-------------------------</td>
<td>---------------------------------------------------------------------------------</td>
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<tr>
<td>Saint Kitts and Nevis</td>
<td>Youth Policy</td>
<td>2017</td>
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<td>Saint Lucia</td>
<td>National Child and Adolescent Health Policy and Multi-Sectoral Workplan</td>
<td>2015</td>
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<td>Saint Vincent and the Grenadines</td>
<td>National Adolescent Health and Development Policy</td>
<td>2017</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adolescent Manual</td>
<td>2017</td>
<td></td>
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<td>Adolescent Action Plan</td>
<td>2017</td>
<td></td>
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<td></td>
<td>National Sexual and Reproductive Health and Rights Policy of Suriname</td>
<td>2013-2017</td>
<td></td>
</tr>
<tr>
<td>Trinidad and Tobago</td>
<td>Adolescent Health Policy</td>
<td>2017-2018</td>
<td>Draft Document. Research is currently being conducted and concept paper is being drafted.</td>
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<td></td>
<td>Sexual and Reproductive Health Policy</td>
<td>2017</td>
<td>On-going. Currently being finalized</td>
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<td></td>
<td>Policy On Universal Health Coverage</td>
<td>2017-2018</td>
<td>On-going. Research is currently being conducted and concept paper is being drafted.</td>
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Source: Reported to PAHO by national health authorities, as of 30 July 2017.
Annex III.B: Countries of Latin America and the Caribbean with a budget allocation for adolescent health activities, as reported to the World Health Organization in 2010-2016

<table>
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<th>Country</th>
<th>Budget allocation</th>
<th>Date of reporting</th>
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<td>July 2016</td>
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<td>January 2010</td>
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<td>Bermuda</td>
<td>Yes</td>
<td>February 2014</td>
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<td>Bolivia (Plurinational State of)</td>
<td>No</td>
<td>June 2016</td>
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<tr>
<td>Brazil</td>
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<td>Chile</td>
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<td>Colombia</td>
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<td>June 2016</td>
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<td>Costa Rica</td>
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<td>Cuba</td>
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<td>Dominican Republic</td>
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<tr>
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<td>July 2016</td>
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Annex III.C: Issues for which adolescents are a specific target group in the national policies, strategies, and plans of countries of Latin America and the Caribbean, as reported to the World Health Organization, 2009-2016

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<th>Country</th>
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<th>Sexual and reproductive health and family planning</th>
<th>Interventions to prevent HIV/AIDS</th>
<th>Nutritional intervention</th>
<th>Alcohol use prevention</th>
<th>Tobacco control activities</th>
<th>Mental health</th>
<th>Injury prevention</th>
<th>Violence</th>
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## Anex III.D: Legal and regulatory access for adolescents to selected health services, as reported to the World Health Organization, 2009-2016

<table>
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<tr>
<th>Country</th>
<th>Health services</th>
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<tr>
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<td>Contraceptive services except sterilization</td>
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<tr>
<td></td>
<td>Emergency contraception</td>
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<td>HIV testing and counseling</td>
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<td></td>
<td>Harm reduction interventions for injectable drug users</td>
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</tr>
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<tr>
<td>Bermuda</td>
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<td>Bolivia (Plurinational State of)</td>
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<td>June 2016</td>
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<td>Brazil</td>
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<td>August 2016</td>
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Annex III.E: Existence of a defined package and standards of health services for young people, and systems for regular adolescent-specific training for health providers, as reported to the World Health Organization, 2009-2016

<table>
<thead>
<tr>
<th>Country</th>
<th>Clearly defined comprehensive package of health services for adolescents</th>
<th>National standards for delivery of health services specifically for young people (ages 10-24)</th>
<th>System in place for regular adolescent-specific training for health providers in first-level facilities</th>
<th>Date of reporting</th>
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Annex IV.A: The Sustainable Development Goals (SDGs)

Source: (1).
Annex IV.B: Sustainable Development Goal 3 and targets

Goal 3: Ensure healthy lives and promote well-being for all at all ages

Goal 3 targets:

- By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births
- By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births
- By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
- By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being
- Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
- By 2020, halve the number of global deaths and injuries from road traffic accidents
- By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
- Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
- By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination
- Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate
- Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all
- Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States
- Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks

Source: (1).