IMPLEMENTATION OF THE REGIONAL STRATEGY AND PLAN OF ACTION ON ADOLESCENT AND YOUTH HEALTH 2010–2018

SUMMARY REPORT

THE HEALTH OF ADOLESCENTS AND YOUTH IN THE AMERICAS

IMPLEMENTATION OF THE REGIONAL STRATEGY AND PLAN OF ACTION ON ADOLESCENT AND YOUTH HEALTH 2010–2018

SUMMARY REPORT

Pan American Health Organization

World Health Organization

REGIONAL OFFICE FOR THE Americas
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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.

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.

This regional report 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.

The report also 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 wellbeing of young people in the Americas.

Based on the lessons learned in the regional response, the report proposes key priorities for action to accelerate progress toward 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 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.

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THE HEALTH OF ADOLESCENTS AND YOUTH IN THE AMERICAS | SUMMARY REPORT
Acknowledgments

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I. Introduction

Currently, the population of young people (10–24 years) in the Americas is the largest in the history of the Region, reaching an estimated 237 million. 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” (1,2). 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 (1,2).

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) (3) and the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030) (4) 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 (5).

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 (6). 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 the 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 document summarizes the regional adolescent and youth health report on the current status of the health of adolescents and youth in the Region and the implementation of the Regional Strategy and the Plan of Action. In addition, the report provides 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 such as the Strategy for Universal Access to Health and Universal Health Coverage (Resolution CD53.R14) adopted by PAHO Member States in 2014 (7), the SDGs (3), and the Global Strategy for Women’s, Children’s and Adolescents’ Health (4).
II. The Current Status of the Health of Adolescents and Youth in the Americas

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 (6). 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, unintended injuries, violence, substance use and mental health, sexual and reproductive health, nutrition and physical activity, chronic diseases, and protective factors. The following paragraphs present a brief status update on the health of adolescents and youth in the Americas, based on these health goals.

Adolescent and youth mortality and morbidity

Each year in the Americas, around 80,000 adolescents (10–19 years) and 150,000 youth (15–24 years) die, with the majority of deaths caused by external, preventable causes (8). Homicide, suicide, and road traffic injuries are the leading causes of death among adolescents and youth in the Region. The data show little variation in adolescent and youth mortality over the 2008–2013 period (Figure 1). Consistently, males die at higher rates, with the highest mortality rates in males aged 15–24 years. Mortality trends are uneven within and between countries. 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 (8).
The leading causes of disability-adjusted life years (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 1). 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.
In Latin America and the Caribbean in 2015, 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 2). Tobacco featured as risk factor number 11 for youth (15–24 years).

Table 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>Male</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).

Table 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>Rank</td>
<td>10-14 years</td>
<td>15-19 years</td>
<td>20-24 years</td>
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<tr>
<td>------</td>
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</tr>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</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).

Mental health

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 Latin American and Caribbean (LAC) countries between 2007 and 2013 provides some insight into suicidal behaviors for subregions of the Americas (9). 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 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 (9).

Substance use

GSHS survey data shows variances between countries in current alcohol use (10). 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 higher percentages of female current drinkers, including Anguilla, Antigua and Barbuda, Argentina, Curacao, Honduras, and Saint Vincent and the Grenadines. 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 (10).

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. With the exception of Argentina, Colombia, and Ecuador, more male students than female students reported recent tobacco use (11).

The use of other psychoactive substances such as marijuana, inhalants, and cocaine, remains relatively low among young people in the Americas. However, available data suggest early initiation of the use of these psychoactive substances, with marijuana as the one most commonly used, and with marked differences between countries. Reported lifetime marijuana use in adolescents aged 13–15 years ranged from 3% in Bolivia to 16% in Anguilla (12). 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% (12).

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. 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.

The rate of early sexual initiation among adolescents differs noticeably among countries and between the sexes. 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 (10), also with consistently higher percentages of male early initiators; in several countries up to twice as many (10). Females with lower levels of education and those from lower wealth quintiles had a lower median age of sexual initiation, as compared with their counterparts with more education or higher income.

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 (13). 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 2) (13). Currently, an estimated 15% of all pregnancies in LAC occur among girls younger than 20 years old (13).

Figure 2: Trends in age-specific fertility rates in Latin America and the Caribbean, 1980-2015

![Figure 2: Trends in age-specific fertility rates in Latin America and the Caribbean, 1980-2015](source: 96)
In the Americas, there are substantial differences in the adolescent fertility rate among subregions, countries, and subgroups in countries. Central America has the highest adolescent fertility rate, followed by South America (13). 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. 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 (14,15).

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%) (16).

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 (17). 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 (18).

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 (19), more females than males in the Caribbean, and more males than females in Latin America. 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 (20). 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 (19).
Human papillomavirus (HPV) vaccine coverage

Cervical cancer is the fourth most frequent cancer in women worldwide. The HPV vaccine protects against common cancer-causing types of human papilloma virus and can significantly reduce the risk of cervical cancer. 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 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.

Overweight, physical activity, and nutrition

In the majority of the countries with GSHS data, more than one in five of the students was overweight, in both males and females, and the level of physical activity among students aged 13–15 years in the LAC countries differs greatly, with consistently more males than females reporting regular physical activity (10). Based on the WHO definition, anemia presents a severe public health problem in adolescents in Haiti, and a moderate public health problem in Guyana (20).

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 protective factors. These include parents’ connection with and regulation of adolescents. 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 (10). In most countries, a slightly higher percentage of girls reported this was the case. A lower percentage of adolescents felt that their parents or guardians understood their problems and worries, ranging from around 25% to slightly over 60% (10).
III. Implementation of the Regional Strategy and Plan of Action on Adolescent and Youth Health, 2010–2018

The vision of the Regional Strategy for Improving Adolescent and Youth Health (4) 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 (6). The Plan of Action proposed seven strategic areas for action:

1. Strategic information and innovation: The capacity of PAHO Member States to generate strategic information was strengthened through the development of various tools and mechanisms, including adolescent health surveys, maintenance of the PAHO mortality database and portal and inclusion of the adolescent (10–19 years) and youth (15–24 years) age categories in the portal, introduction of the Adolescent Information System (SIA), and capacity-building activities. 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.
2. Enabling environments for adolescent and youth health and development using evidence-based policies: Over 90% of countries in the Region have developed adolescent health strategies and plans of action, and many countries developed other governance instruments 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. The lack of budget and human resource allocations in some countries limited the implementing the strategies and plans. In addition, significant legal barriers persist for adolescents seeking access to comprehensive health services, including sexual and reproductive health services.

3. Integrated and comprehensive health systems and services: Based on WHO normative guidance and the Integrated Management of Adolescent Needs (IMAN) model, technical cooperation was provided to countries to define a comprehensive package of adolescent health services, to develop standards for those services, and to establish mechanisms for ongoing monitoring of these quality standards. By 2016, 18 countries reported having a clearly defined comprehensive package of services for adolescents, and 19 reported to WHO having national standards for adolescent health services (21).

4. Human resources capacity-building: Activities under this action area included regional, subregional, and country-level capacity-building workshops on topics related to adolescent health for a range of stakeholders, including adolescent health program managers, health care providers, youth, legislators, human rights advocates, and other stakeholders. Around 600 scholarships were provided to Member States for postgraduate adolescent health training. However, the lack of systematic inclusion of adolescent health content in pre-service curricula and the frequent movement of program managers and service providers make it difficult to achieve and sustain a critical mass of human resources with adequate adolescent health knowledge and competencies.

5. Family, community, and school-based interventions: PAHO introduced several 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 the Strengthening Families Program 10–14 (SFP 10–14) (22) in Latin America under the name Familias Fuertes – Amor y Limites, a program reaching more than 30,000 families annually. However, with
a few exceptions, these interventions were not taken to the scale necessary to achieve significant results. The lack of systematic monitoring and evaluation of initiatives also compromised the ability to determine what works in the context of the Region.

6. Strategic alliances and collaboration with other sectors: 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.

Strategic ongoing partnerships exist among PAHO, UNICEF, The United Nations Population Fund (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.

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 publication of strategic documents, 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.

7. Social communication and media involvement: Key activities under this action area included promotion of and capacity building on the use of digital technology in adolescent health programs, commemoration of advocacy days, such as International Youth Day and International Day of the Girl Child, and consistent inclusion of positive, respectful images of adolescents and youth in all PAHO publications.
IV. The evolving global and regional 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 (SDG), 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! (23), and the Lancet Commission report (5), make a strong case that investing in adolescents and youth is a requirement for development.

Furthermore, there have been a number of new regional commitments and developments that have implications for the health of adolescents and youth, including the regional commitment for universal health coverage and access (7), the Montevideo consensus on population and development (24), the commitment to action of Santiago (25), and the Sustainable Health Agenda for the Americas 2018–2030 (SHAA2030) (26).

The Sustainable Development Goals: The 2030 sustainable development agenda is of unprecedented scope and ambition. 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.” However, there are many linkages between the health goal and other goals and targets. This reflects the fundamental assumption that health is both a major contributor to and a result of sustainable development policies.

The Global Strategy for Women’s, Children’s and Adolescents’ Health: The 2016-2030 Global Strategy on Women’s, Children’s and Adolescents’ Health
builds on the previous Every Woman Every Child Global Strategy on Women’s and Children’s Health (EWEC) (27), but explicitly, and for the first time, includes attention to adolescents. The 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 objective through 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:** Member States at 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”), 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 and the SDGs, 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

**Montevideo consensus on population and development:** Given the importance of sexual and reproductive health for adolescents, the Montevideo consensus on
population and development 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; 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.

The Commitment to Action of Santiago: In 2016, PAHO and other regional partners, including UNICEF, UNFPA, the World Bank, UNAIDS, the United States Agency for International Development (USAID), and the Inter-American Development Bank (IDB) initiated action to roll out in the Americas the Global Strategy for Women’s, Children’s and Adolescents’ Health. 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 (EWEC-LAC). 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. The reflections and recommendations generated by this regional consultative process served as input for a high-level meeting in Santiago, Chile. That event culminated in the Commitment to Action of Santiago, a regional pledge to ensure that every woman, child, and adolescent not only survives, but thrives in a transformative environment.

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. The Agenda sets forth 11 health goals 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.
V. 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 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 “survive, thrive, and transform” from 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. Social determinants such as gender, 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.

**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. 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.
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.

A 2030 adolescent health agenda for the Americas

A future-oriented regional response to the health of adolescents and youth must include the following two core dimensions.

1. **Reducing 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. Reducing the consumption of alcohol among adolescents and youth, including the early introduction of alcohol use.
   c. Promoting and supporting the prevention, timely diagnosis and effective treatment of mental health challenges and diseases in adolescents and youth.
   d. Promoting healthy nutrition and actions to prevent anemia (in particular for youth 10–14 years), and reducing intake of foods with high sugar and fat content.
2. Promoting positive adolescent and youth health and development

This second dimension 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 “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. This includes eliminating persistent barriers to access for adolescents, such as restrictive laws and policies, and resistance based on cultural and religious arguments.

- Implement **evidence-based interventions in schools, families, and communities** for promotion and protection of health and wellness of male and female adolescents and youth, with a focus on the most marginalized and vulnerable groups.

- 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. 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.

- **Empower and engage 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 toward 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, and prevent health risks and conditions into adulthood.

**A rights-based approach:** 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:** It is important for countries to assess health status at subnational levels in order 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. Identifying bottlenecks, and reaching vulnerable and marginalized adolescents will require increased efforts if greater equity is to be achieved.

**Addressing 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 adolescent sexual and reproductive health 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, to involve them more effectively, and to address the excess morbidity and mortality affecting young males in the Region.

**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.

**Research and the use of new technology:** 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.

**Conclusion**

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. The Global Strategy for Women’s, Children’s and Adolescents’ Health, SHAA2030, and tools such as the AA-HA! Framework provide the opportunity for review and updating of the adolescent and youth health programs in the Region, towards a more effective and equity-based response that will ensure that all young people not only survive, but thrive and realize their right to enjoy the highest attainable standard of physical, mental and sexual/reproductive health and well-being.

The full adolescent health report can be accessed through this link: [www.paho.org/adolescent-health-report-2018](http://www.paho.org/adolescent-health-report-2018)
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