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### STRATEGY AND PLAN OF ACTION ON ADOLESCENT AND YOUTH HEALTH: FINAL REPORT

#### Background

1. In 2008, the 48th Directing Council of the Pan American Health Organization (PAHO) adopted the Regional Strategy for Improving Adolescent and Youth Health (Document CD48/8 and Resolution CD48.R5) (1, 2), and in 2009, the 49th Directing Council approved the Plan of Action on Adolescent and Youth Health 2010-2018 (Document CD49/12 and Resolution CD49.R14) (3, 4). The goal of the Regional Strategy was to improve 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, while the aim of the Plan of Action was to operationalize the Regional Strategy over the period 2010-2018.

2. The purpose of this document is to report to the Governing Bodies on the results obtained with the implementation of the Strategy and Plan of Action and the progress made toward meeting the eight health goals and 19 indicators and impact targets set forth in the Plan of Action. The analysis employed official country data reported to PAHO and the World Health Organization (WHO), global and regional estimates, surveys conducted in countries, and program evaluations. In this report, the term “adolescent” refers to the 10-19 year age group, “youth” to the 15-24 age group, and “young people” to the 10-24 age group.

#### Analysis of Progress Achieved

3. Overall, the Region has made progress in implementing the Strategy and Plan of Action and the seven strategic areas of action proposed in the plan. The progress reflects the work done across Pan American Sanitary Bureau (PASB) departments and programs, as well as collaborative efforts with other regional partners. During the period covered by the Plan of Action, 93% of the Region’s countries and territories developed or updated adolescent and youth health plans and policies that included national adolescent health

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plans and policies, adolescent pregnancy prevention plans, and national health plans with specific adolescent and youth health targets and activities. In 2017, WHO published the document *Global Accelerated Action for the Health of Adolescents (AA-HA! Guidance)* (5) to guide countries in translating the Sustainable Development Goals (SDGs) (6) and *Global Strategy for Women's, Children's, and Adolescents' Health into action* (7). Multidisciplinary teams from 16 countries were trained in the AA-HA! Guidance, and at least eight have already completed or begun developing or updating national adolescent health plans in line with AA-HA!, resulting in a new generation of multisectoral and evidence-informed country plans aligned with the 2030 Agenda for Sustainable Development.

4. The availability and use of adolescent and youth health data was enhanced through stakeholder capacity building, inclusion of the adolescent (10-19 years) and youth (15-24 years) age categories in mortality reporting, and adolescent health surveys and studies: between 2008 and 2017, 27 countries and territories completed at least one Global School-based Student Health Survey (GSHS), and at least seven conducted adolescent health and sexuality surveys. In 2018, PAHO published a regional report on the health of adolescents and youth in the Americas, summarizing the available information on the health goals of the Plan of Action (8). Access to quality health services was expanded through pre-and in-service training of health care providers on a range of adolescent health topics. PAHO collaborated with several universities, including the Catholic University of Chile and the University of the West Indies, to develop adolescent health content and courses for undergraduate and post-graduate training of health care providers and individuals in associated professions. Technical cooperation was provided to Member States for the development and implementation of packages of services and standards for adolescent health services: between 2009 and 2016, 18 countries and territories reported having a clearly defined, comprehensive package of health services for adolescents, and 19 reported having national standards for the delivery of health services specifically for young people.

5. During the period covered by the Plan of Action, several promising school-based, family- and youth-focused interventions were introduced in the Region, including the *Familias Fuertes*, *Aventuras Inesperadas*, and *Escuelas de Futbol* programs. During 2016-2017, PAHO conducted a status analysis of these programs that concluded that most of them had been discontinued or had never been taken to the scale necessary to achieve significant results. Some of the challenges identified in the analysis included dependence on external funding, high implementation costs, and lack of government support. An external evaluation of *Familias Fuertes*, the most widely adopted program in Latin America, which promotes parental skill building and better communication in families to reduce risk behaviors in adolescents, concluded that the countries with the most successful implementation were those where the program had been adopted as a policy and had a dedicated budget and clear coordination and implementation structures. This program reaches more than 140,000 families in Latin America annually. Based on the results of the external evaluation, PAHO has updated the content and guidance for *Familias Fuertes* to further strengthen faithful and sustainable implementation. A major conclusion of the program evaluations was that to be successful, interventions must be easily and

inexpensively replicable with strong government support from the outset. In addition to supporting the Familias Fuertes program, PASB is also compiling and supporting the implementation of a revised package of evidence-based interventions, including a school-based mental health literacy program introduced in the Bahamas, Belize, Cayman Islands, and Jamaica and during 2017-2018.

6. During the reporting period, PAHO continued to promote and support evidence-based road safety strategies, such as actions to strengthen road safety management and improve legislation and enforcement (speed reduction, seat belt use, child restraints, helmets, and penalties for drunk driving); promotion of safer roads and the use of sustainable modes of transportation; policies to protect vulnerable road users; and investment in improving post-crash response and rehabilitation services.

7. In recognition of the important place and significance of digital technology in the daily lives of young people, PAHO supported regional and country-level capacity building in the use of digital media in adolescent health programs, assisting several countries in the development of digital health strategies as part of their adolescent and youth health response. Youth participation and empowerment was mainstreamed in PAHO's technical cooperation, with special emphasis on female adolescents and indigenous and Afro-descendent youth.

8. Mortality analysis was conducted, based on the 24 countries and territories with reported data for 2008 and 2015.<sup>1</sup> Major differences can be observed between countries: among those with mortality data, nine noted an increase in total mortality in the age group 10-24 years (9). Homicides decreased in 11 countries and increased in eight for females and in 11 for males (9). Equity-based analysis conducted in 10 countries with PAHO support showed variations in overall and cause-specific mortality between subgroups within countries when data were analyzed by ethnicity, income level, educational level, and place of residence (10).

9. The adolescent mortality showed similar patterns as those presented above for the age group 10-24 years. On average, 80,000 adolescents died annually between 2008 and 2015, more than half due to homicides, suicides, and road traffic injuries. Notably, mortality from these three external causes remained stable among adolescent females but increased among adolescent males. The homicide rate among males increased from 29.0 in 2008 to 33.8 per 100,000 in 2015, and the suicide rate increased from 5.3 in 2008 to 6.0 per 100,000 in 2015.

10. Adolescence is a critical stage of life for sexual and reproductive health (SRH), due to the rapid physical, hormonal, and emotional changes during puberty and the acquired capacity to reproduce. Global School-based Student Health Survey and Demographic and Health Survey (DHS) data from 20 countries indicate significant levels of early sexual

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<sup>1</sup> Argentina, Aruba, Belize, Bermuda, Brazil, Canada, Chile, Colombia, Cuba, Ecuador, French Guiana, Guadeloupe, Guatemala, Martinique, Mexico, Nicaragua, Panama, Paraguay, Peru, Puerto Rico, St. Vincent and the Grenadines, United States, Uruguay, and US Virgin Islands.

initiation (< 15 years), ranging from 18.9% in El Salvador to 33.5% in Barbados, with consistently higher percentages of male early initiators (11, 12). Meanwhile, Latin America and the Caribbean (LAC) remains the region with the second-highest adolescent fertility rate in the world and the slowest rate of decline (13), with major variations between and within countries. In countries with disaggregated data, indigenous, rural, less-educated, and poor adolescents have fertility rates three to five times higher than the national averages (12, 14, 15). There are, however, some promising signs of progress. Several countries, including Argentina, Colombia, Costa Rica, and Uruguay have noted significant reductions in adolescent fertility rates in recent years. In collaboration with other partners, PAHO is supporting review of the responses in these countries to identify lessons learned that can be replicated in other countries.

11. Pregnancies in girls under 15 are a growing concern in the Region. An estimated 2% of women of reproductive age in LAC had their first delivery before the age of 15. LAC is the only region in the world with an upward trend in very early pregnancies (8), a trend that is closely associated with sexual violence. As reported to Member States in 2018 (16), PAHO also continued implementing the Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women (2015-2025). As indicated in the report, countries made significant progress in their efforts to strengthen the generation of strategic information on violence against women and girls; promote the inclusion of violence against women in national health plans and policies; support the development of national standard operating procedures, protocols, and guidelines for health system response to intimate partner violence; train health professionals and build capacity for provision of comprehensive post-rape care services; and establish multisectoral mechanisms to coordinate action on violence against women that includes ministries of health (16).

12. Any use of alcohol among adolescents is considered harmful, given the impact of alcohol on brain development during adolescence. GSHS data collected since 2008 indicate early introduction of alcohol and significant levels of current alcohol use among adolescents aged 13-15 (17). Marijuana is the most commonly used psychoactive substance among young people after tobacco and alcohol, with marked differences in reported lifetime use among countries. According to global estimates, the proportion of overweight and obese adolescents aged 13-15 in the Americas increased during the reporting period. In addition, adolescents aged 13-15 reported frequent consumption of carbonated soft drinks and fast food, and low levels of regular physical activity (11).

13. The Plan of Action for the Prevention of Obesity in Children and Adolescents (2014-2019) was developed to halt the growing epidemic of obesity in this population. As reported to Member States in 2018 (16), the Region has made progress on a number of related objectives. These include, among others, promotion of healthy dietary practices, including through family-oriented obesity prevention activities; establishment of school feeding programs that promote the consumption of healthy foods and restrict the availability of sugar-sweetened beverages and energy-dense, nutrient-poor products; promotion of physical activity; implementation of regulations to protect children and

adolescents from the impact of marketing of sugar-sweetened beverages, energy-dense nutrient-poor products, and fast foods; and implementation of front-of-package labeling that allows for easy identification of products that are high in sugar, fat, and salt (16).

14. Given the lack of progress in several areas, much remains to be done to ensure that all young people in the Americas not only survive but thrive in an environment that allows them to prosper, reach their full potential, and contribute to their own development and that of their community. Implementation of the Plan of Action generated some important lessons learned:

- a) The implementation of the Strategy and Plan of Action generated broad-based political commitment to improve the health of adolescents and youth. Nevertheless, this commitment did not always translate into increased investment in programs. The insufficient allocation of human and financial resources has limited the implementation of existing policies, strategies, and plans of action, and greater investment in evidence-based programs and approaches is needed to improve results. Recent studies have shown that investment in the health of young people is extremely cost-effective, and the social and economic costs of inaction are many times higher than the required investments over time and across generations.
- b) Adolescent and youth health efforts remain fragmented in Member States and at PASB. They often focus on single risk factors or behaviors rather than applying comprehensive, multisectoral interventions that address multiple outcomes, risk factors, and determinants. Evidence shows that the latter approach is more effective and gives better value for money.
- c) Adolescents continue to face significant legal, policy, health system, and societal barriers to receiving the full range of quality, age-appropriate preventive, promotional, and curative services they need. Where services exist, they may be fragmented and not aligned with the health care needs of young people (e.g. mental health services). Strategies and interventions must take into account the evolving capacities of adolescents and should promote environments that further build their capacity to balance risk and safety and make informed, positive decisions and life choices.
- d) Available data clearly show that poor health outcomes are not evenly distributed across the adolescent and youth population. Nevertheless, efforts to identify and target the most vulnerable groups of young people with evidence-based interventions remain limited.
- e) Although it has been identified as an essential component in the Strategy and other global and regional guidance, consistent and meaningful participation of adolescents in the formulation, design, implementation, and evaluation of actions affecting their own health remains ad hoc and limited. Formal and sustainable mechanisms must be put in place to facilitate and guarantee full engagement of young people, which will help improve the quality of responses adapted to the specific characteristics of this life stage.

15. The table below presents the available information on the impact targets and indicators of the Plan of Action. As several indicators lack baselines or targets, 2008 baselines are constructed or identified where possible, and the available regional or country progress information is summarized. The indicators in the Plan of Action use different age groups and sometimes refer only to males or females and sometimes to both. The progress indicated refers to the specified parameters, with additional information provided, as relevant. The lack of baselines and targets complicates the determination of progress in several indicators.

<b>Goal 1: Reduce adolescent and youth mortality</b>	
<b>Indicator, baseline, and target</b>	<b>Status</b>
<p><b>1.1</b> Reduce the death rate of adolescents and youth (10-24 year olds)</p> <p>Baseline: 90.3 per 100,000 population<sup>2</sup> (2008, 24<sup>3</sup> countries and territories)</p> <p>Target: not available</p>	<p>In 2015, total mortality for young people increased to 92.1 per 100,000 population (9).</p> <p>Among females aged 10-24, total mortality decreased from 45.6 to 44.4 per 100,000, while among males, it increased from 133.6 to 138.1 per 100,000 between 2008 and 2015.</p>

<b>Goal 2: Reduce unintentional injuries</b>	
<b>Indicator, baseline, and target</b>	<b>Status</b>
<p><b>2.1</b> Reduce the death rate caused by road traffic injuries among men (15-24 year olds)</p> <p>Baseline: 34.4 per 100,000 population (2008, 24 countries)<sup>4</sup></p> <p>Target: not available</p>	<p>In 2015, mortality among males aged 15-24 from road traffic injuries fell slightly to 34.1 per 100,000 population (9).</p> <p>Mortality from road traffic injuries among females in this age group fell from 7.9 in 2008 to 6.8 per 100,000 in 2015 (9).</p> <p>Mortality from road traffic injuries among adolescents aged 10-19 fell from 10.8 to 9.8 per 100,000; among female adolescents, from 5.4 to 4.2 per 100,000; and among males, from 16.0 in 2008 to 15.2 per 100,000 in 2015.</p>

<sup>2</sup> The baseline was under construction at the time the Plan of Action was approved. Thus, the baseline was defined based on available data from 2008.

<sup>3</sup> Argentina, Aruba, Belize, Bermuda, Brazil, Canada, Chile, Colombia, Cuba, Ecuador, French Guiana, Guadeloupe, Guatemala, Martinique, Mexico, Nicaragua, Panama, Paraguay, Peru, Puerto Rico, St. Vincent and the Grenadines, United States, Uruguay, and US Virgin Islands.

<sup>4</sup> The baseline was under construction at the time the Plan of Action was approved. Thus, the baseline was defined based on available data from 2008.

<b>Goal 3: Reduce Violence</b>	
<b>Indicator, baseline, and target</b>	<b>Status</b>
<p><b>3.1</b> Reduce suicide rate, (10-24 year olds)</p> <p>Baseline: 5.9 per 100,000 population (2008, 24 countries)<sup>5</sup></p> <p>Target: not available</p>	<p>In 2015, the suicide rate among young people aged 10-24 increased to 6.2 per 100,000 (9).</p> <p>The suicide rate among adolescent males increased from 5.3 to 6.0 per 100,000 and held steady among adolescent females at 3.1 per 100,000 between 2008 and 2015.</p>
<p><b>3.2</b> Reduce homicides rate among men (15-24 year olds)</p> <p>Baseline: 70.5 per 100,000 population (2008, 24 countries)<sup>6</sup></p> <p>Target: not available</p>	<p>In 2015, the homicide rate among males aged 15-24 increased to 75.5 per 100,000 (9).</p> <p>The homicide rate among females aged 15-24 increased from 5.8 to 6.1 per 100,000 between 2008 and 2015 (9).</p> <p>The homicide rate among adolescent males increased from 29.0 to 33.8 per 100,000, and among adolescent females, from 3.3 to 3.5 per 100,000 between 2008 and 2015(9).</p>

<b>Goal 4: Reduce substance use and promote mental health</b>	
<b>Indicator, baseline, and target</b>	<b>Status</b>
<p><b>4.1</b> Reduce the percentage of adolescents between the ages of 13–15 that have consumed one or more alcoholic beverage during the last 30 days</p> <p>Baseline: 36%</p> <p>Target: 20%</p>	<p>Since the plan mentioned only the GSHS as the data source but did not provide details on which and how many countries were included in the regional calculation, PAHO was unable to reconstruct the baseline provided in the Plan of Action or the respective current value.</p> <p>GSHS data from 26 LAC countries in the period 2007-2017 show wide variations among countries in current alcohol consumption, measured as having consumed one or more alcoholic beverages in the past 30 days, with figures ranging from 15.1% in Bolivia (2012) to 55.0% in St. Lucia. In most countries, males reported levels of current alcohol use that were higher or similar to those of females, except for four countries, where females reported levels that were 5 to 10 percentage points higher (British Virgin Islands, Chile, Honduras, Montserrat) (11).</p>

<sup>5</sup> *Ibid.*

<sup>6</sup> *Ibid.*

<b>Goal 4: Reduce substance use and promote mental health</b>	
<b>Indicator, baseline, and target</b>	<b>Status</b>
<p><b>4.2</b> Reduce past-month use of illicit substances (13-15 year olds)</p> <p>Baseline: 10%</p> <p>Target: 5%</p>	<p>Since the plan mentioned only the GSHS as the data source but did not provide details on which illicit substances and how many countries were included in the regional calculation, PAHO was unable to reconstruct the baseline provided in the Plan of Action or the respective current value.</p> <p>While the GSHS does include a question on past-month use of drugs, only a few countries included this question as is or as adapted in past surveys, making the GSHS a limited source for this indicator. Another standardized source of information on substance use among young people is the surveys supported by the Inter-American Observatory on Drugs (OID) of the Inter-American Drug Abuse Control Commission of the Organization of American States (CICAD/OAS). These surveys collect data on substance use among secondary-school students.</p> <p>According to the OAS data, marihuana is the most commonly used psychoactive substance after tobacco and alcohol. Data from 31 countries in the period 2005-2014 show reported past-month marihuana use ranging from 0.41% in El Salvador to 17.96% in Antigua and Barbuda. The other countries with the highest reported proportions of secondary-school students using marihuana were Chile (17.13%), Honduras (14.40%), St. Vincent and the Grenadines (14.11%), Dominica (12.47%), St. Kitts and Nevis (11.61%), St. Lucia (10.71%), Belize (10.64%), and Barbados (10.44%). In most countries, past-month use of marihuana was higher among males (18).</p> <p>Past-month use of cocaine ranged from 0.1% in Suriname to 1.7% in Chile, and past-month use of inhalants ranged from 0.2% in Venezuela to 7.1% in Barbados (18).</p>
<p><b>4.3</b> Reduce tobacco use among adolescents (15-24 year-olds)</p> <p>Baseline: 10%</p> <p>Target: 5%</p>	<p>Since the plan mentioned only the GSHS as the data source but did not provide details on which and how many countries were included in the regional calculation, PAHO was unable to reconstruct the baseline provided in the Plan of Action or the respective current value.</p> <p>According to PAHO estimates, tobacco use among adolescents was 13.1% in 2018 – 13.0% among males and 12.1% among females (17).</p> <p>Current tobacco use among adolescents ranged from 3.1% in Bermuda (2015) to 25.3% in Dominica (2009). Additional countries with the highest reported rates of current tobacco use were Chile (24.5%, 2013) and Argentina (24.1%, 2012) (17).</p>



<b>Goal 5: Ensure sexual and reproductive health</b>	
<b>Indicator, baseline, and target</b>	<b>Status</b>
<p><b>5.1</b> Reduce the percentage of birth by age group of mothers (15-19 year olds)</p> <p>Baseline: 17.5%</p> <p>Target: 15%</p>	<p>The 2005-2010 percentage of births among adolescents aged 15-19 was estimated at 17.2% for LAC and 9.6% for North America (19).</p> <p>For the period 2010-2015, the estimated percentage fell to 15.7% for LAC and to 4.5% for North America (19).</p>
<p><b>5.2</b> Increase the percentage of condom use during last high-risk sex (15-24 year olds)</p> <p>Baseline: not available</p> <p>Target: not available</p>	<p>Surveys that collect information on condom use among youth are not regularly conducted by all countries, making trend assessment difficult.</p> <p>The Multiple Indicator Cluster Survey (MICS) asks about condom use during last sex with a nonmarital, noncohabiting partner in the past 12 months, and DHS asks about condom use during last premarital sex.</p> <p>Of the five countries with DHS data, condom use among females aged 15-19 ranged from 32.2% in Peru to 57.8% in Haiti, and among females aged 20-24, from 31.4% in Peru to 48.5% in the Dominican Republic. Four countries also collected data among males, whose condom use ranged from 60.0% in Haiti to 80.1% in Colombia among males aged 15-19, and from 70.6% in Haiti to 75.2% in Colombia among males aged 20-24 (12).</p> <p>Of the nine countries with MICS data, condom use among females ranged from 42.0% in El Salvador to 79.6% in Cuba (14).</p>
<p><b>5.3</b> Increase contraceptive prevalence among adolescents (15-24 year olds)</p> <p>Baseline: not available</p> <p>Target: not available</p>	<p>According to data collected in 14 countries with DHS and MICS between 2008 and 2015, current use of any modern contraceptive method among adolescents aged 15-19 ranged from 6.1% in Bolivia to 67.0% in Cuba. Countries with contraceptive prevalence of 50% or more were Costa Rica (64.1%), St. Lucia (57.0%), the Dominican Republic (51.7%), and Barbados (51.4%). Apart from Bolivia, the countries with the lowest contraceptive prevalence in adolescents were Guatemala (7.7%), Haiti (8.2%), Peru (10.2%), and Honduras (14.1%) (12, 14).</p> <p>Current use of any modern contraceptive method among females aged 20-24 ranged from 21.9% in Bolivia to 75.5% in Costa Rica. Countries with contraceptive prevalence of 50% or more were Cuba (75.3%), Argentina (58.4%), Colombia (59.8%), the Dominican Republic (56.6%), and Barbados (50.1%). Apart from Bolivia, the countries with the lowest contraceptive prevalence among females in this age group were Haiti (23.2%), Guatemala (26.2%), and St. Lucia (32.0%) (12, 14).</p>

<b>Goal 5: Ensure sexual and reproductive health</b>	
<b>Indicator, baseline, and target</b>	<b>Status</b>
<p><b>5.4</b> Reduce prevalence of HIV-infected pregnant women (15-24 year olds)</p> <p>Baseline: not available Target: not available</p>	<p>When the Plan of Action was drafted, HIV prevalence in pregnant women aged 15-24 was a core indicator in global AIDS monitoring. However, as this is no longer the case, this data is no longer routinely reported and analyzed on a regional and global level.</p>
<p><b>5.5</b> Reduce the estimated number of adolescents and youth (15-24 year olds) living with HIV</p> <p>Baseline: LA – 0.20%, CAR – 0.55%<sup>7</sup> Target: LA – 0.15%, CAR – 0.35%<sup>9</sup></p>	<p>According to modeled UNAIDS estimates, HIV prevalence among youth aged 15-24 in Latin America fell from 0.20% in 2008 to 0.15% in 2017; and in the Caribbean, from 0.55% to 0.45% (20).</p> <p>Among females, HIV prevalence fell from 0.2% in 2008 to 0.1% in 2017 in Latin America; and in the Caribbean, from 0.6% to 0.5% (21).</p> <p>Among males, HIV prevalence held steady at 0.2% between 2008 and 2017 in Latin America, while in the Caribbean, it fell from 0.5% to 0.4% (20).</p>
<p><b>5.6</b> Reduce specific fertility rate of adolescents (15-19 year olds) (defined as the annual number of live births per 1,000 females aged 15-19)</p> <p>Baseline: 75.6 per 1,000 girls Target: 64 per 1,000 girls</p>	<p>In LAC, the adolescent fertility rate fell from 78.7 per 1,000 in 2000-2005 to 66.5 per 1,000 girls in 2010-2015; and in North America, from 40.5 to 28.3 (15, 19).</p> <p>DHS and MICS data collected between 2008 and 2016 in 12 countries indicate that adolescent girls from lower educational and income groups and indigenous girls have 3 to 4 times higher fertility rates on average than their higher-educated, wealthier, and non-indigenous counterparts (12, 14).</p>

<b>Goal 6: Promote Nutrition and Physical Activity</b>	
<b>Indicator, baseline, and target</b>	<b>Status</b>
<p><b>6.1</b> Reduce the proportion of obese or overweight adolescents (13-15 year olds)</p> <p>Baseline: 30%<sup>8</sup> Target: 25%<sup>9</sup></p>	<p>According to WHO estimates, the 2016 prevalence of overweight in adolescents aged 10-19 in the Americas was 31.7 [29.2-34.3] – 32.3 in males and 31.0 in females. The prevalence of obesity was 12.8 [10.8-14.9] – 14.0 in males and 11.5 in females (21).</p> <p>Data from the GSHS conducted in 19 countries between 2008 and 2016 documented percentages of overweight male and female</p>

<sup>7</sup> This baseline was adjusted based on revised estimates published by UNAIDS.

<sup>8</sup> The baseline was under construction at the time the Plan of Action was approved. Thus, the baseline was defined based on available data from 2008.

<sup>9</sup> The target was under construction at the time the Plan of Action was approved. Thus, the target was defined based on available data from 2008.

<b>Goal 6: Promote Nutrition and Physical Activity</b>	
<b>Indicator, baseline, and target</b>	<b>Status</b>
	students aged 13-15 ranging from 15.3% in Guyana to 44.8% in Chile. Apart from Chile, countries with the highest percentages of overweight students included The Bahamas (44.7%), British Virgin Islands (36.9%), Belize (35.8%), St. Kitts and Nevis (32.5%), and Barbados (31.9%) (11).
<p><b>6.2</b> Increase the proportion of adolescents who engage in physical activity (13-15 year olds)</p> <p>Baseline: 13% Target: 30%</p>	<p>According to WHO estimates, the percentage of school-going adolescents aged 11-17 with insufficient physical activity in the Americas was 81.2 [79.6-83.0], 75.3% among males and 87.1% among females in 2010 (21).</p> <p>Data from the GSHS conducted in 19 countries between 2008 and 2016 documented percentages of students aged 13-15 who were physically active at least 60 minutes per day on five days or more during the week before the survey, ranging from 10.9% in Guatemala to 31.8% in Antigua and Barbuda. The other countries with the highest percentages of regular physical activity included Trinidad &amp; Tobago (29.2%), Barbados (29.2%), Belize (29.0%), Uruguay (28.8%), and Argentina (28.3%) (11).</p>
<p><b>6.3</b> Decrease prevalence of anemia in adolescent women (10-19 yearolds)</p> <p>Baseline: 25%-30% Target: 15%-10%</p>	<p>According to global estimates, the prevalence of any anemia in females aged 10-14 in the Region of the Americas was 28.34% in 2008, falling slightly to 26.95% in 2017. The estimated prevalence in the 15-19 age group was 27.28 in 2008, falling to 25.83% in 2017 (22).</p> <p>Country-level data on anemia in adolescent girls remains limited. Survey data from 9 countries reported 7.7% anemia in girls aged 12-19 in Mexico (2012); 11.7% in girls aged 15-19 in Guatemala (2014/15); 12.5% in girls aged 15-19 in Honduras (2011/12); 13.4% in girls aged 12-14 in the Dominican Republic (2012); 14.3% in girls aged 15-19 in Ecuador (2011/13); 15.0% in girls aged 10-19 in Argentina (2012); 17.2% in girls aged 15-19 in Peru (2012); 34.1% in girls aged 15-19 in Guyana (2009); and 55.5% in girls aged 15-19 in Haiti (2012) (8).</p> <p>According to the WHO classifications, anemia is a moderate public health problem in adolescent girls in the Americas (prevalence of 20%-39.9%) and a serious public health problem in Haiti (prevalence greater than or equal to 40%).</p>

<b>Goal 7: Combat Chronic Diseases</b>	
<b>Indicator, baseline, and target</b>	<b>Status</b>
<p><b>7.1</b> Reduce the rate of decayed/missing/filled teeth (DMFT) for 12 year old adolescents</p> <p>Baseline: 5.5 Target: 3.5</p>	<p>According to global estimates, the weighted DMFT in 12-year olds in the Region of the Americas was 2.76 in 2004, 2.35 in 2011, and 2.08 in 2015, making it the region with the second highest estimated DMFT-12 prevalence after the WHO South-East Asia Region (23).</p>
<p><b>7.2</b> Increase coverage of tetanus and diphtheria vaccine (DT) (10-19 year olds)</p> <p>Baseline: 75% Target: 95%</p>	<p>There is no specific recommendation for tetanus and diphtheria vaccination of adolescents in the Region of the Americas, but PAHO is continuing to work with all countries to ensure early protection against these diseases. It should also be noted that by 2017, every country in the Region except Haiti had eliminated neonatal tetanus as a public health problem.</p>

<b>Goal 8: Promote protective factors</b>	
<b>Indicator, baseline, and target</b>	<b>Status</b>
<p><b>8.1</b> Increase parents knowledge of adolescent activities</p> <p>Baseline: 67% Target: 90%</p>	<p>Parental knowledge of adolescent activities was included as a proxy for protective factors that are important determinants of health-related behaviors in adolescents. These include connectedness and nurturing relationships with parents and other adults.</p> <p>Since the plan mentioned only the GSHS as the data source but did not provide details on which and how many countries were included in the regional calculation, PAHO was unable to reconstruct the baseline provided in the Plan of Action or the respective current value.</p> <p>The percentage of adolescents aged 13-15 whose parents or guardians were well-aware of what their children or wards were doing with their free time ranged from 33.8% in St. Kitts and Nevis, to 72.0% in Uruguay. In all countries, the percentages were higher for girls.</p>

### **Action Necessary to Improve the Situation**

16. The SDGs and Global Strategy for Women's, Children's, and Adolescents' Health brought new urgency to the area of adolescent health, highlighting the importance of strategic investment in the health and development of adolescents to meet the SDG targets (5, 6). The AA-HA! and other global guidelines provide evidence-based guidance on how to plan, implement, and monitor a "survive, thrive, and transform" response to the

health needs of adolescents and how to address specific health challenges. Moreover, the Plan of Action for Women's, Children's, and Adolescents' Health 2018-2030, approved by PAHO Member States in 2018 (24), articulates comprehensive and equity-based regional and country-level targets and actions for 2018-2030 to protect the gains already made and close the remaining gaps to ensure healthy lives and promote the well-being of all women, children, and adolescents in the Americas, using a life course approach.

17. Critical activities to accelerate progress in adolescent health include:
- a) Increasing investment in the health of adolescents and youth.
  - b) Developing, updating, and implementing equity-based multisectoral policies and country roadmaps to address the social determinants of adolescent health and reduce health inequities.
  - c) Developing and implementing population-based policies to reduce the availability and consumption of alcohol, tobacco, and sugary beverages among adolescents through, among other things, taxation, the restriction of physical availability, and restrictions on marketing (advertising, sponsorship, and promotions) (25).
  - d) Implementing low-cost, evidence-based interventions in families and communities at scale to improve and promote the mental, physical, sexual, and reproductive health of adolescents, targeting and empowering groups in conditions of vulnerability and implementing the interventions at the scale needed to achieve results while linking these programs with other initiatives (i.e., healthy settings initiatives).
  - e) Expanding the use of the school as an equitable and effective platform for reaching adolescents with health information and services.
  - f) Removing legal, policy, and health system barriers to achieve universal equitable access by adolescents to quality comprehensive health services that meet their needs.
  - g) Establishing specific mechanisms for adolescents to participate in policy-making and policy monitoring processes.
  - h) Increasing country capacity for the generation of reliable information on adolescent health and for the monitoring and systematic analysis of health inequities affecting adolescents.
18. It is important to note that while the new Plan of Action for Women's, Children's, and Adolescents' Health 2018-2030 does not specifically include the 20-24 years age group, continued attention to the specific and unique health issues and needs of this group will be essential for ensuring healthy lives and well-being for these young people as well.

**Action by the Directing Council**

19. The Directing Council is invited to take note of this report and provide any comments it deems pertinent.

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