PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

48th DIRECTING COUNCIL

60th SESSION OF THE REGIONAL COMMITTEE

Washington, D.C., USA, 29 September- 3 October 2008

Provisional Agenda Item 4.4

CD48/8 (Eng.)
21 August 2008
ORIGINAL: ENGLISH

REGIONAL STRATEGY FOR IMPROVING ADOLESCENT AND YOUTH HEALTH

CONTENTS

Page

Introduction

1. This document proposes a 10-year strategy to engage and respond to the needs of young people aged 10 to 24 of both sexes living in the Americas. It aims to do so by developing and strengthening the health sector's integrated response, with particular attention to the most vulnerable adolescents and youth[1] and to the prevailing disparities in the health status, both among and within the countries of the Region.

2. The Strategy seeks to improve the health of the largest cohort of young people[2] in the history of the Region—representing 24.5% of the total population (232 million) — and to respond to the changing context: demographic transition, globalization, environmental changes, and new communication technologies. In the next decade, Member States will be challenged to promote and protect the health and development of young people in order to ensure that they build social capital and have healthy populations in their most economically productive years and in older ages. This challenge cannot be addressed by the health sector alone; the integration and coordination of actions of all stakeholders is no longer a choice, in order to minimize the duplication of efforts and maximize the impact of investments made.

3. This Strategy is grounded in the preamble of the World Health Organization's Constitution, which states, "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[3] Furthermore, it is consistent with global documents, such as the International Conference on Population and Development (ICPD), the United Nations General Assembly Special Session (UNGASS), the Millennium Development Goals (MDG), and the following UN/Inter-American (OAS) human rights conventions, declarations and recommendations.[4]

---

[1] For example, young people who are disenfranchised, of low socio-economic status, low literacy and/or who have special health needs, including adolescents and youth with severe mental illnesses and disabilities.

[2] The World Health Organization defines adolescents as individuals between the ages of 10 and 19 years old, youth from age 15 to 24 years old and young people from age 10 to 24 years old.

[3] Stated in the World Health Organization Constitution's Preamble and adopted by the International Health Conference, New York, 19 June-22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948. The definition has not been amended since 1948. See also PAHO Directing Council, Technical Document CD47/15 ("Disability: Prevention and Rehabilitation in the Context of the Right to the Highest Attainable Standard of Health and other Related Rights") of 16 August, 2006, 47th Directing Council, pp.10-15. Available at http://www.paho.org/english/gov/cd/CD47-15-e.pdf.

[4] See PAHO Directing Council, Document CD47/15 ("Disability: Prevention and Rehabilitation in the Context of the Right to the Highest Attainable Standard of Health and other Related Rights") of 16 August, 2006, 47th Directing Council, pp.10-15. Available at: http://www.paho.org/english/gov/cd/CD47-15-e.pdf; See the Strategic Plan of PASB 2008-2012, Strategic Objective 7 (Regional Expected Result 7.4.1), 27th Pan American Sanitary Conference, Washington DC, 1-5 October 2007,

UN instruments for the Protection of Human Rights

- Convention on the Rights of the Child;[5]
- Universal Declaration of Human Rights;[6]
- International Covenant on Civil and Political Rights;[7]
- International Covenant on Economic, Social, and Cultural Rights;[8]
- Convention on the Elimination of All Forms of Discrimination against Women;[9]

---

pp.74-78. Available at: http://www.paho.org/english/gov/csp/od328-obj5-8-e.pdf; See resolution CD42.R12 on "Child Health", 42nd Directing Council, PAHO, Washington, D.C., 28 September 2000. Available at: http://www.paho.org/english/gov/cd/cd42_fr-e.pdf.

[5] This instrument entered into force on 2 September 1990 and has been ratified by Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Dominican Republic, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, Uruguay, and Venezuela.

[6] Article 25 of the Universal Declaration of Human Rights states that "…Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing, and medical care, and necessary social services…"

[7] Entered into force on 23 March 1976 and ratified by Argentina, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Dominica, the Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, the United States of America, Uruguay, and Venezuela.

[8] Entered into force on 3 January 1976 and ratified by Argentina, Barbados, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Dominica, the Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, Uruguay, and Venezuela. The United Nations *Committee on Economic, Social, and Cultural Rights* created by this treaty has issued guidelines on the content, scope, and obligations of the Member States to the International Covenant on Economic, Social and Cultural Rights deriving from its Article 12 (*the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*). The Committee established that the right of everyone to the highest attainable standard of health is closely related to and dependent on the exercise of other human rights such as life, non-discrimination, equality, freedom from inhumane or degrading treatment, the right to association, assembly, and movement, food, housing, employment, and education. It refers to children, adolescents and persons with disability as groups whose vulnerability calls for special relatively low-cost programs that offer access to health facilities, goods, and services without discrimination and a safe and supportive environment that ensures the opportunity to participate in decisions affecting their health and to build life skills to acquire appropriate information. For more information see *General Comment 14 of the UN Committee on Economic, Social and Cultural Rights. Available at:* http://daccessdds.un.org/doc/UNDOC/GEN/G00/439/34/PDF/G0043934.pdf?OpenElement

[9] Entered into force in 1979 and has been ratified by Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Dominican Republic, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, Uruguay and Venezuela.

Instruments of the Inter-American System for the Protection of Human Rights

- American Declaration of the Rights and Duties of Man;[10]
- American Convention on Human Rights;[11]
- Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights, or Protocol of San Salvador;[12]
- Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women (Convention "Belém do Pará").[13]

4. The development of this Strategy is the product of a participatory process that involved international experts, strategic partners, and national stakeholders, including young people, and PAHO/WHO country focal points.

Background

5. The commitment of the Pan American Health Organization (PAHO) Secretariat to improve the health and well-being of young people is long standing. Previous mandates on the topic of adolescent and youth heath include: the World Health Assembly resolution on the *Strategy for Child and Adolescent Health and Development* (WHA56.21, 2003),[14] which urges Member States to strengthen and expand efforts to increase the coverage of health services and to promote access to a full range of health promotion and prevention interventions; the WHA resolution *Global Strategy on Reproductive Health* (WHA57.12, 2004),[15] which calls for Member States to reach international goals in reproductive health with particular attention to inequities related to gender and poverty and the risks to which adolescents are exposed; and the Resolution on *Adolescent Health* (CD40.R16)[16] approved by the 40th PAHO Directing Council in 1997,

---

[10] Adopted by the Ninth International Conference of American States, Bogotá, Colombia, 1948. Available at: http://cidh.org/Basicos/English/Basic2.American%20Declaration.htm.

[11] Entered into force on 18 July 1978 and ratified by Argentina, Barbados, Bolivia, Brazil, Chile, Colombia, Costa Rica, Dominica, the Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Trinidad and Tobago, Uruguay, and Venezuela.

[12] Entered into force on 16 November 1999 and ratified by Argentina, Bolivia, Brazil, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Mexico, Panama, Paraguay, Peru, Suriname, and Uruguay.

[13] Entered into force on 5 March 1995 and ratified by Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Colombia, Costa Rica, Chile, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Suriname, Trinidad and Tobago, Uruguay, and Venezuela.

[14] Available at: http://wwww.who.int/gb/ebwha/pdf_files/WHA56/ea56r21.pdf.

[15] Available at: http//www.who.int/gb/ebwha/pdf_files/WHA57/A57_R12-en.pdf.

[16] Available at: http://www.paho.org/English/GOV/CD/ftcd_40.htm.

in which Member States formally recognized the differentiated needs of the youth population and approved a framework and action plan. The PAHO Strategic Plan 2008-2012 and the Health Agenda of the Americas[17] reaffirm the importance of addressing the particular needs of adolescents and youth.

6. An external evaluation of the implementation of the 2001-2007[18] plan of action for Resolution CD40.R16, conducted in 2007, revealed that 22 of 26 responding Member States have established national adolescent health programs, but only 17 of 26 countries had a program with effective functioning.[19] Thirty-one per cent of the surveyed countries rated their program as adequate, 41% as partially adequate, and 18% as inadequate. While this represents clear progress, the response of health systems and services to the needs of young people is often weak and still faces budgetary constraints.

Analysis

7. Many countries[20] in the Region are currently experiencing a demographic "window of opportunity"[21] in which there is a larger proportion of working-age persons relative to the dependent population. The investment in health and education for young people and the alignment of economic policies enable productivity and economic growth. Even in countries where this window has closed, the promotion of health and development of young people is essential to help increase their potential to support the growing dependent population. Furthermore, investment in young people's health is essential to protect investments made in childhood (e.g. significant investments in vaccines and food programs) and secures the health of the future adult population. Most habits detrimental to health are acquired during adolescence and youth and manifest

---

[17] The Strategic Plan of the Pan American Sanitary Bureau for 2008-2012, 27th Pan-American Sanitary Conference, Washington D.C., 1-5 October 2007, can be consulted at http://www.paho.org/spanish/gov/_csp/csp27-od328-s.htm and the Health Agenda of the Americas presented by the Ministers of Health in Panama in June 2007 can be consulted at: http://www.paho.org/Spanish/DD/PIN/Agenda_de_Salud.pdf.

[18] Nirenberg, O. et al. Evaluación Regional Planes de Salud Adolescente 2007 [not yet published]. Available at: http://portal.paho.org/sites/fch/CA/WS/rahs/default.aspx.

[19] A program with effective functioning is defined as one that is at least 2 years old, has a person in charge of the program, has a plan of action that has been implemented in the last year, and has a budget assigned.

[20] The following countries of the Region currently face this type of demographic "window of opportunity" (the year in which this opportunity will end is in parenthesis): Argentina (2035), Bolivia (2045), Brazil (2020), Chile (2015), Colombia (2020), Costa Rica (2020), Cuba (2010), Ecuador (2030), El Salvador (2035), Guatemala (2050), Honduras (2040), México (2020), Nicaragua (2040), Panamá (2020), Paraguay (2050), Peru (2030), Dominican Republic (2025), Uruguay (2020), Venezuela (2025), according to the United Nations publication issued in El Salvador, 2008: Situación y desafíos de la juventud en Iberoamérica. San Salvador: United Nations. Available at: www.pnud.org.sv.

[21] The World Bank. World Development Report 2007: Development and the Next Generation. Washington, D.C.: World Bank, 2006.

themselves as health problems in adulthood (e.g. lung cancer caused by the consumption of tobacco), adding an avoidable financial burden to the health systems.

8. In the Region, in 2003, the mortality rate for 15 to 24 year olds was approximately 130 per 100,000.[22] The main causes of mortality for this age group are external causes, including accidents, homicides, suicides, among others, followed by communicable diseases, including HIV/AIDS, noncommunicable diseases, and complications of pregnancy, childbirth, and the puerperium (see Annex A). Other fundamental health topics that affect young people requiring immediate action are: sexually transmitted infections (STIs), obesity, mental health, tobacco consumption, and substance abuse. The disproportionate impact of these issues on low income, poorly educated, indigenous, migrant, and ethnic minority young people need special consideration.

(a) *Violence* - In 2000 in the Region of the Americas, the homicide rate among 15 to 29 year-old men and women was 68.6 and 6.4 per 100,000, respectively (compared to high income countries in Europe where the homicide rate only reached 1.7 and .7 per 100,000 men and women, respectively). For every youth homicide, there are anywhere from 20 to 40 victims of non-lethal violence in this same age group requiring hospital care.[23] It is estimated that the current number of gang members in Central America is between 30,000 and 285,000, mostly in El Salvador, Guatemala, and Honduras.[24] Additionally, adolescent and young women are four times more likely to be victims of a sexual assault than older women.[25]

(b) *HIV/AIDS/STIs* - In the Caribbean, AIDS is already among the five leading causes of death for young people. In 2004, the estimated percentage of 15 to 24 year-old youth that lived with HIV in the Caribbean was 1.6% (0.9-2.3) in females and 0.7% (0.4-1.5) in males. The figures for Latin America were 0.3% (0.2-0.8) in females and 0.5% in males. Sexually transmitted infections affect one in 20 adolescents a year and the most common infections are chlamydia, gonorrhea, syphilis, and trichomoniasis. In pregnant adolescent girls, sexually transmitted infections increase the risk of delivering premature and low-birth weight infants.

---

[22] Pan American Health Organization. Health in the Americas. 2007. Technical and scientific publication No. 622. Washington, D.C.: PAHO, 2007. (pp.177-181). Available at: http://www.paho.org/HIA/index.html.

[23] Krug, E.G. World Report on Violence and Health. World Health Organization, Geneva. 2002.

[24] Centro de Estudios de Guatemala. Informe especial: Las maras: Amenazas a la Seguridad? Guatemala, 2005. Available at: www.laneta.apc.org/ceg.

[25] Krug, E.G. World Report on Violence and Health. World Health Organization, Geneva. 2002.

Moreover, if left untreated, over the long term, these infections may heighten the risk of cancer and HIV, and may be responsible for half of infertility cases.[26]

(c) *Sexual and Reproductive Health:* Significant advances in gender equity are required to improve young people's sexual and reproductive health. HIV and STIs devastate the population of adolescent girl.[27] Often cultural and social gender norms restrict their access to basic information, prescribe an unequal and more passive role in sexual decision-making, undermine their autonomy, and exposes many of them to sexual coercion. Likewise, traditional expectations related to masculinity are often associated with behaviors that increase the risk of HIV infection among men and adolescent boys. Such behaviors include a high number of sexual partners, use of drugs or alcohol, and refusal to seek medical care for sexually transmitted infections.[28] Thus, the lives and health of adolescent girls can only be improved in parallel with the sensitization of men and adolescent boys. Understanding factors associated with young people's sexual attraction and sexual orientation is key to improve their sexual and reproductive health. In a health survey in the Caribbean, approximately equal percentages (5.0% and 4.5%) of adolescent males and females reported a history of same-sex sexual experience, and more than 10% of adolescents reported being unsure of their sexual orientation (11.7% female and 13.3% male).[29] In many countries of the Region, young people are becoming sexually active at an increasingly young age, with most initiating sexual activity in adolescence. Approximately 50% of 15 to 24 year-old females in some Central American countries had engaged in sexual intercourse by the age of 15;[30] the percentage is even higher in rural areas and among young people with lower levels of education. Nearly 90% of Latin American and Caribbean (LAC) youth reported familiarity with at least one method of contraception, but between 48% and 53% of sexually active youth never used contraception. Among those who had used a contraceptive method,

---

[26] Pan American Health Organization. Health in the Americas. 2007. Technical and scientific publication No. 622. Washington, D.C.: PAHO, 2007. (pg.177-181). Available at: http://www.paho.org/HIA/index.html.

[27] Global Coalition on Women and AIDS (2006). *Keeping the promise: an agenda for action on women and AIDS*. Geneva, UNAIDS.

[28] WHO (2007). Engaging men and boys in changing gender-based inequity in health: evidence from programme interventions. Geneva, World Health Organization.

[29] A portrait of Adolescent Health in the Caribbean, 2000.WHO Collaborating Center on Adolescent Health, University of Minesota, Minneapolis, MN.

[30] United States Centers for Disease Control and Prevention, Division of Reproductive Health; United States Agency for International Development. Reproductive, maternal, and child health in Central America: trends and challenges facing women and children: El Salvador, Guatemala, Honduras, Nicaragua, Atlanta: CDC/USAID; 2005

approximately 40% did not use contraception regularly.[31] For 2006, the unmet need for contraception among young women was 48% in Honduras, 38% in Guatemala, and 36% in Nicaragua.[32]

(d) *Pregnancy:* Obstetric conditions were the most common cause of hospitalization for young women (27%, 31%, and 46% in the Caribbean, Central America and the United States, respectively).[33] Adolescents run a higher risk of adverse pregnancy outcomes and, in comparison with older women, have lower probabilities of completing schooling, risk working in informal jobs, poverty, and their children suffer higher health risks.[34] Half the countries in the Americas have adolescent fertility rates among 15 to 19 year olds higher than 72 per 1,000 women (see Annex B). Twenty percent of the births in the Region were from women younger than 20 years of age, with an estimated 40% of pregnancies being unplanned.[35] In LAC, women below the age of 24 account for 45% (405) of the estimated number of deaths (900) due to unsafe abortions for 2003.[36]

(e) *Malnutrition* - Adolescent obesity in the Region varies between 8% and 22%.[37] In the United States, 17% of adolescents between 12 and 19 years of age are overweight.[38] In Canada, 12% to 20% of young people are overweight, and 3% to 10% are obese. The rates of both overweight and obesity are higher in boys than in girls. In total, approximately 26% of boys and 17% of girls are either

---

[31] Comisión Económica para América Latina y el Caribe. La vulnerabilidad reinterpretada, asimetrías, cruces y fantasmas. Santiago de Chile: CEPAL; 2002.

[32] United States, Guttmacher Institute. Early Childbearing in Nicaragua: A Continuing Challenge. In Brief, 2006 Series, No. 3, 4, and 5 (Honduras, Nicaragua, and Guatemala). Available at: http://www.guttmacher.org/pubs/2006/11/09/rib-Guatemala-en.pdf

[33] Pan American Health Organization. Health in the Americas. 2007. Technical and scientific publication No. 622. Washington, D.C.: PAHO, 2007. (pg.177-181). Available at: http://www.paho.org/HIA/index.html.

[34] Pan American Health Organization. Health in the Americas. 2007. Technical and scientific publication No. 622. Washington, D.C.: PAHO, 2007. (pg.177-181). Available at: http://www.paho.org/HIA/index.html.

[35] Pan American Health Organization. Health in the Americas. 2007. Technical and scientific publication No. 622. Washington, D.C.: PAHO, 2007. (pg.177-181). Available at: http://www.paho.org/HIA/index.html.

[36] World Health Organization (WHO). Unsafe Abortion. Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003, 5a Edición, Ginebra, 2007.

[37] Zwicker C et al. Commitments: Youth Reproductive Health, the World Bank, and the Millenium Development Goals. Washington, D.C.: Global Health Council, 2004. Available at: www.globalhealth.org/images/pdf/commitments.pdf.

[38] MacKay AP, Duran C. Adolescent Health in the United States, 2007. National Center for Health Statistics. 2007.

overweight or obese.[39] Anemia in adolescent women varies from 7% in El Salvador to 30% in Bolivia, and 45% in Haiti.[40]

(f) *Mental health:* The previously described mortality and morbidity among young people is related to the lack of attention to mental health. In 2004 in the United States, suicide was the third leading cause of death among adolescents 13-19 years of age. In addition, many adolescents seriously consider suicide without attempting, or they attempt and do not complete suicide.[41]

(g) *Consumption of Alcohol, Drugs, and Tobacco:* In 2005 in the Caribbean, 40% of adolescent girls and 50% of adolescent boys 12-18 years old had consumed alcohol and 1 in 10 youth 16-18 years old had consumed four or more alcoholic beverages at once.[42] Approximately 1 in 10 adolescents 13-17 years old had used illegal drugs sometime in their lives.[43] In the United States, 1 in 5 students from ninth to twelfth grade reported having used marijuana at least once in the past month.[44] The consumption of tobacco in the past month among adolescents 13-17 years old ranged between 2.2% and 38.7%.[45] In Canada, 5% of young people report first trying smoking when they were aged 11 years or younger, 16% of boys and 18% of girls when they were between 12-14 years old, and 6% when they were 15 years of age or older.[46]

9. By living in the Region with the largest social inequalities, young people are subject to prevailing socioeconomic, territorial, ethnic, and gender inequalities that mold their health and social opportunities. The majority of the primary causes of morbidity and mortality in the Region are associated with the social determinants of health, namely:

---

[39] Healthy settings for young people in Canada. 2008. Public Health Agency of Canada. Available at: http://www.phac-aspc.gc.ca/dca-dea/yjc/.

[40] Chaparro CM, Lutter CK. Anemia among adolescent and young adult women in Latin America and the Caribbean: A cause for concern. Washington, DC PAHO 2008.

[41] MacKay AP, Duran C. Adolescent Health in the United States, 2007. National Center for Health Statistics. 2007.

[42] Pan American Health Organization. Health in the Americas. 2007. Technical and scientific publication No. 622. Washington, D.C.: PAHO, 2007. (pp.177-181). Available at: http://www.paho.org/HIA/index.html.

[43] Organization of American States, Inter-American Drug Abuse Control Commission. Comparative Report on Nationwide School Surveys in Seven Countries: El Salvador, Guatemala, Nicaragua, Panama, Paraguay, Dominican Republic, and Uruguay 2003. Washington, D.C.: OAS/CICAD; 2004.

[44] MacKay AP, Duran C. Adolescent Health in the United States, 2007. National Center for Health Statistics. 2007.

[45] Organization of American States, Inter-American Drug Abuse Control Commission. Comparative Report on Nationwide School Surveys in Seven Countries: El Salvador, Guatemala, Nicaragua, Panama, Paraguay, Dominican Republic, and Uruguay 2003. Washington, DC: OAS/CICAD; 2004.

[46] Healthy Settings for Young People in Canada. 2008. Public Health Agency of Canada. Available at: http://www.phac-aspc.gc.ca/dca-dea/yjc/.

education, income and social class, employment, migration, family, social networks, the environment, among others. In all countries in the Region, the poorest and most excluded are often young people that belong to indigenous, ethnic, and racial minorities, and those that live in female-headed households, and/or in rural communities. Thirty nine per cent of youth live in poverty in LAC.[47] In the United States in 2005, 16% of adolescents 10-17 years old live in households under the poverty line.[48] Adolescents who live in a household with one parent only are substantially more likely to have a family income near or below the poverty line than are adolescents living in a household with two parents.[49] The fertility rate of adolescents living in poverty is three times higher than that of adolescents not living in poverty, they use fewer contraceptive methods, and are more likely to give birth before the age of 20.[50] Education also affects health outcomes and risk behaviors (e.g. pregnancy, STI/HIV/AIDS, the harmful consumption of alcohol and other substances, and the risks of violence). Overall only 38% of 18 year-olds are attending school,[51] however great disparities based on socioeconomic levels, ethnicity, and geographic area exist. For every additional year of schooling fertility rates in adolescents decreases by 5%-10%.[52] Moreover, inequalities in opportunities for education and employment with decent wages are driving high degrees of migration, both in and between countries. This translates in the disintegration of families and communities; unsafe, illegal, and informal employment; trafficking; and in numerous health risks (STI/HIV/AIDS, pregnancy, and violence).

10. Strategic information is critical for informed decision-making. Despite increasingly sophisticated information technology, social and health data on young people is still difficult to obtain, often incomplete, inaccurate or inconsistent in many countries.[53] In the external evaluation of the action plan 2001-2007 of the application of the CD40.R16 resolution, out of 26 countries that responded, 30% have a national surveillance system that includes the issue of adolescent and youth health, and only 27%

---

47 United Nations Development Program, El Salvador, editors. *Situación y desafíos de la juventud en Iberoamérica*. San Salvador: Naciones Unidas, 2008. Available at: www.pnud.org.sv.

48 MacKay AP, Duran C. Adolescent Health in the United States, 2007. National Center for Health Statistics. 2007.

49 MacKay AP, Duran C. Adolescent Health in the United States, 2007. National Center for Health Statistics. 2007.

50 United States, Guttmacher Institute. Early Childbearing in Nicaragua: A Continuing Challenge. In Brief, 2006 Series, No. 3, 4, and 5 (Honduras, Nicaragua, and Guatemala). Available at: http://www.guttmacher.org/pubs/2006/11/09/rib-Guatemala-en.pdf

51 United Nations Development Program, El Salvador, editors. *Situación y desafíos de la juventud en Iberoamérica*. San Salvador: Naciones Unidas, 2008. Available at: www.pnud.org.sv.

52 United Nations Development Program, El Salvador, editors. *Situación y desafíos de la juventud en Iberoamérica*. San Salvador: Naciones Unidas, 2008. Available at: www.pnud.org.sv

53 Panamerican Health Organization. Health in the Americas. 2007. Technical and scientific publication No. 622. Washington, DC: OPS, 2007. (pg.177-181). Available at: http://www.paho.org/HIA/index.html.

monitor and perform an evaluation of their programs.[54] Moreover, stigma remains a barrier causing underreporting of some health issues (e.g. suicide, mental illness, sexual orientation, and sexual abuse). Paucity of data often impedes the identification of groups at particular risk within and among countries or the risk and protective factors for health behaviors and outcomes. Deficient monitoring and evaluation has resulted in the continued implementation of ineffective interventions.

11. In general, policies, programs and services approach adolescent and youth health and development from a vertical and problem-oriented perspective, for example addressing HIV, pregnancy, alcohol consumption, family, and violence as distinct issues. Sources of financing often reinforce this approach, resulting in expensive duplication of efforts and limited impact. Evidence suggests that programs should address interrelated health outcomes, associated behaviors and their common origins to improve impact and reduce expensive duplication of efforts.[55] Contributing to ineffective interventions is the poor use of available scientific evidence and the lack of adolescent and youth participation in the development and implementation processes.

12. Due to lack of adolescent and youth participation, consideration of the specific needs of the target population as determined by age, stage of development, culture, and gender is inadequate. In addition, programs have not capitalized on the pivotal role played by supportive families, schools and communities as protective factors for health and education, as well as their potential to facilitate access to health services and be critical settings for health promotion. It is necessary to identify community and neighborhood strengths and weaknesses through participatory evaluations, to design innovative, comprehensive, and effective youth development programs and health services.

13. Adolescent and youth access to health services also continues to be inadequate in most countries. Many young people encounter legal and financial barriers and unfriendly environments when they use health services, including breaches in confidentiality, judgmental and disapproving attitudes relating to sexual activity and substance use, and discrimination. Additionally, access to health services (including biomedical, mental health, and others) is affected by the financial policies of the health system, geographical barriers, and availability of health personnel. For example, in the United States the large majority of poor and near poor adolescents under the age of 19 are eligible for public coverage, nonetheless, in 2005, one fifth of adolescents in families living in household

[54] Nirenberg, O. et al. Evaluación Regional Planes de Salud Adolescente 2007. Available at: http://portal.paho.org/sites/fch/CA/WS/rahs/default.aspx.

[55] Nirenberg, O. et al. Evaluación Regional Planes de Salud Adolescente 2007. Available at: http://portal.paho.org/sites/fch/CA/WS/rahs/default.aspx.

under the poverty line had no health insurance.[56] Health services should be organized to respond to health needs and wants of young people and their individual and collective expectations. The gap between the supply of health services and the demands of adolescents and youth needs to be closed.[57] Quality health services provide an important opportunity for promotional and preventive health messages along with screening, diagnosis, treatment and care for a range of health issues.

14. The primary health care model demands health care providers to be adequately prepared to respond to the needs of individuals throughout the life cycle.[58] Therefore, they are required to have knowledge of the specific needs of young people and the barriers they face. However, the Region lacks a critical mass of health care providers trained to respond to the needs of young people. Innovative strategies to reach young people and train health providers can help keep abreast of demands for health promotion and prevention services and programs. The increased demands require providers to be knowledgeable about new research and emerging technologies in adolescent and youth health, both in communication (e.g. text messaging, virtual networks) and in health issues (e.g. new findings on brain development, new vaccines—Human Papillomavirus vaccine —and testing and screening methods).

15. Information and communication technology has given many young people increased exposure to mass media, cell phones and the Internet, allowing them to connect with global cultures and revolutionizing social interactions. Those who have access to media are exposed to an array of messages and images, often about unhealthy behaviors, such as the use of tobacco in television programs.[59] However, those same communication technologies can be used as a strategy to improve the health of young people by positively influencing health values, attitudes and beliefs. Another important strategy is targeting pre- or early-adolescence to influence behaviors before they become health-compromising habits.

Proposal

16. The purpose of this Regional Strategy is to contribute to the improvement of the health of young people through the development and strengthening of the integrated

---

[56] MacKay AP, Duran C. Adolescent Health in the United States, 2007. National Center for Health Statistics. 2007.

[57] PAHO. IMAN Servicios: Normas de atención de salud sexual y reproductiva de adolescentes, OPS, Washington DC, 2005.

[58] Pan American Health Organization (PAHO). 2007. Renewing Primary Health Care in the Americas: A position paper of the Pan American Health Organization (PAHO/WHO). Washington, D.C.: PAHO.

[59] Gidwani, P.P et al. Television Viewing and Initiation of Smoking Among Youth. Pediatrics 110(3): 505-508, 2002. Available at:: http://pediatrics.aappublications.org/cgi/content/full/110/3/505.

health sector response and the implementation of adolescent and youth health promotion, prevention, and care programs.

17. The Strategy is assembled with information, evidence and knowledge, and rests on four pillars: primary health care, health promotion, social protection, and the social determinants of health. The Strategy calls for an integration of approaches, programs, and services to tackle health issues of concern and ensure better outcomes. Gender, culture, and youth participation are crosscutting perspectives.

18. Building on the WHO definition of health[60], this Strategy defines a healthy adolescent or youth as someone who fulfils the biological, psychological and social tasks of development with a sense of identity, self-worth and belonging, sees a positive path for the future, is tolerant of change and diversity, and has the competencies to engage as an active member of civil society and the labor force. This manifests in young people as healthy eating habits, engaging in physical activity, mental health and wellness, and a responsible and positive approach to sexuality.

19. This Strategy proposes seven lines of action and promotes their systematic and simultaneous integration to address the primary causes of mortality and morbidity and fundamental adolescent and youth health issues identified in the analysis section: (1) strategic information and innovation; (2) enabling environments and evidence-based policies; (3) integrated and comprehensive health systems and services; (4) human resource capacity building; (5) family, community, and school-based interventions; (6) strategic alliances and collaboration with other sectors; and (7) social communication and media involvement.

20. To support the implementation of these lines of action PAHO, in partnership with the United Nations and other organizations, will use an inter-programmatic approach, work with special emphasis on priority and high impact countries,[61] build networks, and mobilize resources. Specifically, PAHO will provide technical cooperation for the implementation, monitoring, and evaluation of the lines of action, promote advocacy, support the systematization of best practices, create a platform to share lessons learned throughout the Region, and encourage country-to-country cooperation.

---

[60] WHO definition of health: a “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity...” Defined in the preamble to the constitution of the World Health Organization and adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948. The definition has not been amended since 1948.

[61] PAHO has identified as priority countries for technical cooperation: Bolivia, Haiti, Guyana, Honduras, Nicaragua, Guatemala, and high impact countries for adolescent and youth interventions: Brazil, Mexico, Colombia, Argentina, Peru, and Venezuela.

Strategic Lines of Action

21. The strategic lines of action have a duration of 10 years 2008 -2018. Below, the lines of action are described, including concrete objectives, and proposals for action based on evidence and best practices recognized by PAHO. Annex C includes the indicators to monitor and evaluate the achievement of these objectives by strategic line of action and makes note of corresponding strategic objectives and regional expected results from the PAHO Strategic Plan.

Strategic Information and Innovation

22. *Objective.* 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.

23. The collection, analysis, and dissemination of appropriate information will provide essential tools to establish priorities and guide the regional action plan and national programs, including the development of policies, planning, and evaluation of programs.

24. This strategic line of action proposes action to:

(a) Reach consensus on a list of basic indicators that allow for the identification of gaps and inequities in adolescent and youth health. These indicators will be used for the development of a virtual platform with regional data, disaggregated by age, sex, ethnicity and income. The platform could form a regional observatory on adolescent and youth health.

(b) Support the countries to build capacity to: strengthen their national health information systems, develop an Adolescent Health Information System (AIS), and to monitor and evaluate the quality, coverage, and cost of national adolescent and youth health programs, health services, and other interventions, and to align efforts with PAHO and other global work in progress in the topic.[62]

(c) Promote the analysis, synthesis, and dissemination of integrated information from different sources on the state of adolescent and youth health and social determinants at the national and regional levels.

[62] For example, the *Health Metrics Network* (HMN), the PAHO-USAID collaboration for the strengthening of health information systems, and the *Regional Plan of Action for Strengthening of Vital and Health Statistics.*

(d) Support 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.

Enabling Environments and Evidence-based Policies

25. *Objective.* To promote and secure the development of enabling environments and the implementation of effective, comprehensive, sustainable and evidence-based policies on adolescent and youth health.

26. This strategic line of action proposes action to:

(a) Establish public polices that support a better state of health for young people, emphasizing action among the most vulnerable youth and based on WHO and PAHO resolutions and their recommendations.[63] These policies should guarantee specific budget allocation for adolescent and youth health and allow for the follow-up of commitments and ensure accountability.

(b) Develop, implement, and comply with evidence-based policies and programs in a manner consistent with the UN Convention on the Rights of the Child[64] and the previously mentioned UN/OAS human rights instruments.

(c) Advocate for environments that promote health and development among young people, considering social determinants of health and the promotion of health and secure communities, including the health-promoting schools initiative.

---

[63] Framework Convention on Tobacco Control, Global Strategy on Physical Activity and Health, policies to promote enabling environments such as sustainable transportation and urban planning policies (rapid mass transportation systems and alternative transportation, road safety, protection of public spaces) and prevention of obesity (urban agriculture, improve school feeding, guidelines and regulations for food marketing and advertising, physical education programs). Ecoclubs is an example of a program promoting youth involvement with the environment with resulting impact on health promoting behaviors. Other relevant PAHO resolutions include: Regional Strategy to Reduce Maternal Mortality and Morbidity (26 CSP, 2002); Neonatal Health within the Continuum of Maternal, Newborn, and Child Care: Regional Strategy and Plan of Action (CE142/12, 2007); Regional Strategy and Plan of Action on Nutrition in Health and Development, 2006-2015 (CD47/18, 2006); Regional Strategic Plan for HIV/AIDS/STI, 2006-2015, of the Pan American Health Organization (CD46.R15, 2005); Regional Plan of Action on Violence and Health (CD37.R17, 1993).

[64] This instrument entered into force on 2 September 1990 and has been ratified by Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Dominican Republic, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, Uruguay, and Venezuela.

(d) Support the development and revision of current policies and legislation in priority health topics for young people, especially in those that have impact on health service access.

Integrated and Comprehensive Health Systems and Services

27. *Objective*. To facilitate and support strengthening the capacity of the health system to respond to adolescent and youth needs.

28. The effective extension of social protection will be supported. Adolescent and youth health promotion, prevention, and care require primary-level health care services based on quality standards and best practices.[65]

29. This strategic line of action proposes action to:

(a) Implement interventions through the effective Integrated Management of Adolescent Needs (IMAN) model.[66]

(b) Integrate services with referral and counter-referrals between the primary, secondary, and tertiary levels.

(c) Increase access to quality health services with the development of quality standards of care and ensure availability of critical public health supplies.

(d) Develop models of care, including alternative and innovative service provision that can increase access, such as mobile clinics, health services linked to schools, and pharmacies, among others.

(e) Conduct studies on the availability, utilization, and cost of services.

Human Resource Capacity Building

30. *Objective* Support the development and strengthening of human resource training programs in comprehensive adolescent and youth health, especially those in health

---

[65] Pan American Health Organization. Health Agenda of the Americas 2008-2017. Washington DC: PAHO, 2007. Available at: http://www.paho.org/Spanish/DD/PIN/Agenda_de_Salud.pdf.

[66] IMAN follows the Integrated Management of Childhood Illnesses (IMCI) model and includes guidelines for the treatment of diseases in adolescence and youth, with emphasis on prevention and promotion. IMAN seeks to improve the competencies of multidisciplinary professionals in the topic of adolescent and youth health, improve clinical and treatment practices at the family and community levels.

sciences and related fields, in order to develop policies and programs for adolescent and youth health promotion, prevention, and care.

31. Health and service providers (for example school and university teachers, community health *promoters*, among others) are instrumental to improving the health of adolescents and youth, and therefore multidisciplinary teams are required.

32. This strategic line of action proposes action to:

(a) Develop and implement training programs in the health and development of adolescents and youth at the undergraduate and graduate levels and in-service, with the use of new technologies such as e-learning platforms, and including key topics such as the dissemination and clarification of the UN Convention on the Rights of the Child[67] and the previously mentioned UN/OAS human rights instruments with regard to issues such as confidentiality, privacy, informed consent, equal protection of the law and non-discrimination in the context of cultural diversity.[68]

(b) Include the topic of adolescent and youth health in curricula for health and education professionals.

(c) Advocate for the capacity building of primary health care providers using evaluated courses in comprehensive adolescent health supported by PAHO and currently available on diverse e-learning platforms.[69]

---

[67] This instrument entered into force on 2 September 1990 and has been ratified by Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Dominican Republic, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, Uruguay, and Venezuela.

[68] Since 2000 PAHO has been providing technical training to public health officials with the support of UN and OAS organs. To date, PAHO has held 40 training workshops to disseminate the international/regional human rights instruments, recommendations and standards in the context of persons living with HIV/AIDS; persons with mental disorders; persons with disability; older persons; persons exposed to second hand tobacco smoke and the health of indigenous women in the context of their reproductive health, sexuality and nutrition (including women, youth, boys and girls). These training workshops have been held in Argentina, Barbados, Brazil, Canada, Costa Rica, Dominican Republic, Chile, Ecuador, El Salvador, Grenada, Guatemala, Honduras, Nicaragua, Panama, Paraguay, Peru, Saint Lucia, Saint Kitts and Nevis and Uruguay. Approximately 500 public health officials have been trained on the application of provisions related with confidentiality, privacy, equal protection of the law, non-discrimination and other health related human rights.

[69] PAHO supports distance courses in comprehensive adolescent health held through the *Universidad Católica de Chile*, the *Universidad del Estado de Río de Janeiro*, the *Universidad Autónoma de Nuevo León*, and the *Universidad de Buenos Aires*.

(d) Incorporate in available e-learning courses and others current scientific evidence on young people and the topic of monitoring and evaluation of programs.

Family, Community, and School-based Interventions

33. *Objective*. To develop and support adolescent and youth health promotion and prevention programs, with community-based interventions that strengthen families, include schools, and encourage participation.

34. Behavior change in adolescents and youth is influenced by the environment in which they live, study, and work. A favorable family environment is essential to achieve positive health and education results.[70]

35. This strategic line of action proposes action to:

(a) Develop and disseminate evidence-based tools that help strategic actors in interventions that strengthen the family, for example the evaluated PAHO program "Strengthening families with adolescent children with love and limits".

(b) Support community mobilization to change institutional policies and to create communities that are favorable to youth development and health.

(c) Develop tools to promote the meaningful participation and empowerment of adolescents and youth and their communities, starting with the identification of their strengths and weaknesses to effectively contribute to the decision-making process and to the design, and implementation of programs that affect them.

(d) Improve the relationship between the health and education sectors to develop comprehensive programs for adolescents and youth, and to monitor and evaluate their impact.

Strategic Alliances and Collaboration with Other Sectors

36. *Objective* To facilitate dialogue and alliance building between strategic partners, in order to advance the adolescent and youth health agenda and to make sure that strategic partners participate in the establishment of policies and programs for this age group.

---

[70] Roche, K.M., Ahmed, S. Blum, R.W. Enduring consequences of parenting for risk behaviors from adolescence into early adulthood. Soc Sci Med, 66(9), 2008; Resnick, M.D., Harris, L.J., Blum, R.W. The Impact of Caring and Connectedness on Adolescent Health and Well-being. Journal of Paediatrics and Child Health, 29 (s1), 1993.

37. The implementation of adolescent and youth health programs requires concerted action on the part of multiple partners and strategic actors from different sectors. Furthermore, it requires action at various levels of government, from nongovernmental organizations, multilateral organizations, and the local level, among others.

38. This strategic line of action proposes action to:

(a) Develop integrated and coordinated actions between the health sector and with strategic partners at the regional, national, and local levels, for example: government entities (education, judicial system, labor, public security, housing services, environment, among others), private organizations, universities, media, civil society, youth organizations, faith-based organizations, and communities (including teachers, parents, and young people).

(b) Increase and strengthen adolescent and youth interagency programs between and among UN agencies and organs and agencies of the OAS.

(c) Establish mechanisms for south-to-south cooperation and to share best practices and lessons learned in the region.

Social Communication and Media Involvement

39. *Objective*. Support the inclusion of social communication interventions and innovative technologies in National Adolescent and Youth Health Programs.

40. The mass media and new technologies have a significant impact on the health of adolescents and youth. It is essential to work with mass media to promote a positive image of adolescents and youth and to incorporate new technologies in health promotion.

41. This strategic line of action proposes action to:

(a) Promote positive images, values, and behaviors regarding adolescents and youth health.

(b) Strengthen countries to use social communication techniques and new technologies to increase access to health interventions and services.

(c) Support the generation of evidence in this topic, especially in the use of new technologies and their impact on health.

Action by the Directing Council

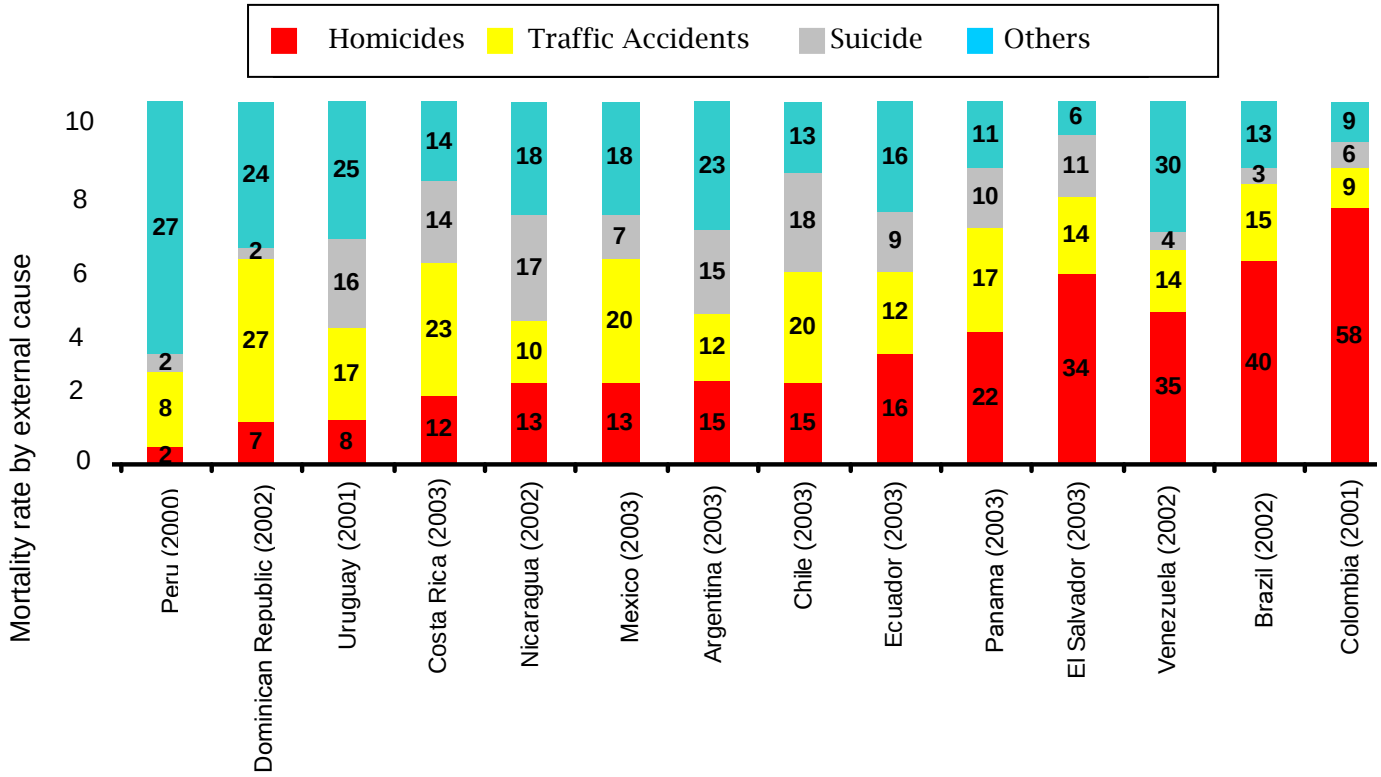
42. The Directing Council is requested to:

(a) Analyze this document, and consider adolescents and youth as a priority and support the strengthening of the health sector response. The Region is experiencing an opportune moment, as 2008 is the Ibero-American Year of Youth, and the focus of discussion at the next Summit of Ibero-American Heads of State and Government (El Salvador, October 2008) will be "youth and development."

(b) Consider the Regional Strategy for Improving Adolescent and Youth Health and adoption of the resolution proposed by the Executive Committee (see Resolution CE142.R16, in Annex E), which will be the basis for the regional plan of action to be submitted for consideration to the 49th Directing Council in 2009.

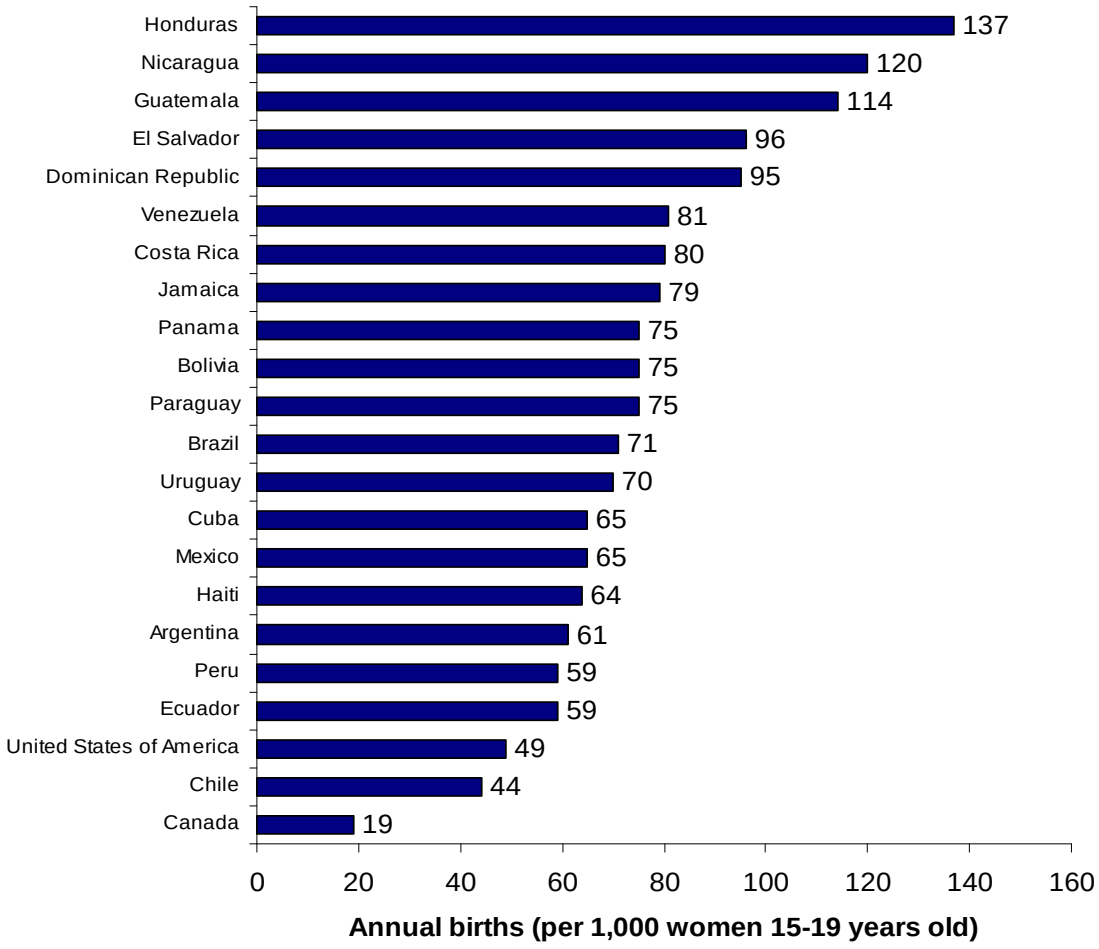
Annexes

External causes of mortality among youth between the ages of 15 and 24 years old, selected countries, around 2003 (per 100,000 inhabitants)



Source: Pan American Health Organization (PAHO), "Statistics on Health in the Americas," 2003 and 2006 editions; and European mortality database (MDB), World Health Organization Regional Office for Europe cited in the United Nations Development Program, El Salvador, editors. *Situación y desafíos de la juventud en Iberoamérica*. San Salvador: Naciones Unidas, 2008. Available at: www.pnud.org.sv.

Age-specific fertility rate for 15-19 year-old adolescents, selected countries, Region of the Americas, 2000-2005



Source: Pan American Health Organization. Health in the Americas. 2007. Available at: http://www.paho.org/HIA/index.html

PURPOSE	***INDICATORS***	
To contribute to the improvement of the health of young people through the development and strengthening of the integrated health sector response and the implementation of adolescent and youth health promotion, prevention, and care programs.	By 2018, priority and high impact countries will have a functional national adolescent and youth health program (defined as one that is at least 2 years old, has a person in charge of the program, has a plan of action that has been implemented in the last year, and has a budget assigned). 100% of the countries by 2018.	

STRATEGIC LINE OF ACTION	***OBJECTIVES***	***INDICATORS***
Strategic line of Action 1: Strategic information and innovation	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. (Strategic objective 3, 4 y 7. Regional expected result 3.3, 4.2, 7.3, 9.3)	By 2012, 75% of the countries will have incorporated agreed upon health indicators on adolescents and youth health, associated risk factors and public health interventions; 95% for the year 2018 ***Measurement*** Number of countries with national information systems that delivers annual information on adolescents and youth data by age. *(Indicator of the strategic objective 1 included in the global monitoring system – GMS)* Number of countries with a national information system that delivers annual information on adolescent and youth health, disaggregated by sex Number of countries with information systems that deliver annual information on adolescent and youth health by socio-economic status and ethnicity.

		Number of countries that analyze data and complete an annual report on the epidemiology, health behavior and interventions for adolescents and youth
Strategic line of Action 2: Enabling environments and evidence-based policies	To promote and secure the development of enabling environments and the implementation of effective, comprehensive, sustainable and evidence-based policies on adolescent and youth health. (Strategic objective 2,3,4, 6 y 7, Regional expected result: 2.2, 3.2, 4.6, 6.4, 6.5, 6.6, 7.4, 7.5, 7.6)	By 2015, priority and high impact countries will have comprehensive policies on young people and their health in effect: 95% of countries in 2018. ***Measurement*** Number of countries with comprehensive adolescence and youth policies with an assigned budget and in effect through an annual plan of action. Number of countries who have revised their health policies and legislation as well as the ones related to accessing health services in the past three years Number of countries who incorporate adolescents and youth to the social protection systems
Strategic line of action 3: Integrated and comprehensive health systems and services	To facilitate and support strengthening the capacity of the health system to respond to adolescent and youth needs. (Strategic objective 4 and 10, Regional expected result 4.1, 4.6, 10.1, 10.4)	By 2012, priority countries will have developed a national adolescent and youth health program and by 2015 these programs will be implemented. By 2015, priority and high impact countries will have 50% of health centers at the district level applying an integrated package of interventions for adolescents and youth (IMAN: Integrated Management of Adolescent Needs). 75% of all countries by 2018

		Measurement Number of districts that deliver the integrated package of health services for adolescents and youth, IMAN, with defined standards Number of adolescents and youth using the district's sentinel health centers
Strategic line of action 4: Human resource capacity building	Support the development and strengthening of human resource training programs in comprehensive adolescent and youth health, especially those in health sciences and related fields, in order to develop policies and programs for adolescent and youth health promotion, prevention, and care. (Strategic objective 4, 7 and 13, Regional expected result 7.4.1, 13.1 and 13.4)	By 2015, all the countries of the Region will have incorporated adolescent health in the curricula of training programs for health and other related professionals. By 2015, 50% of the districts' clinics have at least one provider skilled in adolescent and youth health care and in the applicable international/regional human rights instruments and standards (40-hour course). ***Measurement*** Number of universities that include the subject of adolescent and youth health in the curricula of health science majors Number of clinics with a provider trained in IMAN (40-hour course).

Strategic line of action 5: Family, community and school-based interventions	To develop and support adolescent and youth health promotion and prevention programs, with community-based interventions that strengthen families, include schools, and encourage participation. (Strategic objective 4 and 6, and Regional expected result, 4.6 and 6.1)	By 2012, the priority and high impact countries will have incorporated in their adolescent and youth health promotion and prevention programs, interventions to strengthen families and programs coordinated with schools and communities. 100% of the countries by 2018 ***Measurement*** Number of countries implementing the program "Strengthening Families" or the equivalent. Number of national adolescent and youth health programs that include schools and communities in their program
Strategic line of action 6: **S**trategic alliances and collaboration with other sectors	To facilitate dialogue and alliance building between strategic partners, in order to advance the adolescent and youth health agenda and to make sure that strategic partners participate in the establishment of policies and programs for this age group. (Strategic objective 4, 7 and 15, and Regional expected result 4.6, 7.2 and 15.3)	By 2018, all countries will have an adolescent and youth intersectorial strategic plan with a focus on determinants and equity. ***Measurement*** Number of countries that have an intersectorial strategic plan (defined as a plan which integrates at least 3 key sectors in adolescent health and development)

Strategic line of action 7: Social communication and media involvement	Support the inclusion of social communication interventions and innovative technologies in National Adolescent and Youth Health Programs. (Strategic objective 4 and 15, Regional expected result 4.6 and 15.4)	By 2015, all countries will have incorporated into their national adolescent and youth health programs, social communications interventions and innovative technologies. ***Measurement*** Number of countries with a national adolescent and youth program that include a social communications plan of action

Indicators of impact aligned with the PASB Strategic Plan 2008-2015 to consent with the countries:

Compiled data must be disaggregated by groups of age, sex, socioeconomic levels, race and ethnicity.

1. Annual incident of registered cases of HIV in the adolescent and youth population

2. Mortality rate by HIV in adolescents and youth

3. Prevalence of HIV in pregnant women population from ages 15-24

4. Mortality rate by traffic accidents, homicide and suicide

5. Rate of a specific fertility in adolescents of ages 15-19 and youth of ages 20-24

6. Percentages of birth in adolescent and youth women

7. Reason of maternal mortality by age groups; 10-14, 15-19, and 20-24 years old

8. Percentage of women, adolescent and youth, with an unsatisfied demand of contraceptives

9. Percentage of women, adolescent and youth, that had a unplanned pregnancy

10. Access to contraceptive methods by age groups

11. Average age of the first sexual relationship

12. Percentage of the adolescent population that had sexual relationships in the last 12 months

13. Percentage of young people that used a condom in their first sexual relationship

14. Percentage of young people that had more than one sexual partner in the last 12 months

15. Factors of risk of chronic disease (use of tobacco, physical activity, overweight/obesity)

16. Percentage of adolescents that:

- Smoke cigarettes, one or more in the last 30 days
- Have taken drugs one or more times in their lives
- Have consumed at least one or more alcoholic beverages during the last 30 days
  (Use of alcohol and drugs in adolescents of age 13-15 (GHS) or other to agree)

17. Prevalence of anemia in adolescent and young women

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

CD48/8 (Eng.)
Annex D

ANALYTICAL FORM TO LINK AGENDA ITEM WITH ORGANIZATIONAL AREAS

1. Agenda Item: 4.4	**2. Agenda Title:** Regional Integrated Strategy for Adolescent and Youth Health

3. Responsible Unit: FCH

4. Preparing Officer: Collaborative effort of PAHO Working Group for the development of the Regional Integrated Strategy for Adolescent and Youth Health, UN Agencies, international experts, and other partners.

5. List of collaborating centers and national institutions linked to this Agenda item:

- Ministries of health, Education, Youth, and Social Affairs at the country level
  - Advocates for Youth, USA
  - Associação Brasileira de Adolescência (ASBRA), Brazil
  - Centers for Disease Control and Prevention (CDC), USA
  - Centro de Medicina Reproductiva y Desarrollo Integral del Adolescente CEMERA, Chile
  - Children's National Medical Center, Washington DC, USA
  - Canadian International Development Agency (CIDA)
  - Confederación de Adolescencia y Juventud de Iberoamérica y El Caribe (CODAJIC)
  - Corporation for the Development and Peace of South-Western Colombia (VALLENPAZ)
  - Georgetown University Hospital, USA
  - The Alan Guttmacher Institute, USA
  - Health Canada
  - Instituto de Nutrición y Tecnología de los Alimentos (INTA) Universidad de Chile
  - International Youth Foundation, USA
  - IPAS, Chapel Hill, NC
  - Johns Hopkins Bloomberg School of Public Health, USA
  - Millennium Villages Project (MVP), USA
  - National Institutes of Health (NIH), USA
  - Pathfinder International, USA
  - Pontificia Universidad Católica de Chile
  - Instituto Promundo, Brazil
  - Public Health Agency of Canada
  - Society of Adolescent Health of Canada
  - Sexuality Information and Education Council of the United States (SIECUS), USA
  - The Centre for Health and Social Development (HeSo), Norway
  - The George Washington University Medical Center, USA
  - Universidad Autónoma de Nuevo León (UANL), Mexico
  - Universidade do Estado do Rio de Janeiro, Brazil

- University of Maryland School of Medicine, USA
- United States Agency for International Development (USAID**)**

6. Link between Agenda item and Health Agenda of the Americas:

Agenda Item 4.4 is linked to the principles and values (paragraphs 8-12 copied below) and the Areas of Action described in the Health Agenda of the Americas.

Principles and Values:

8. Acknowledging that the Region is heterogeneous, and that our nations and their populations have different needs and sociocultural approaches to improving health, this Agenda respects and adheres to the following principles and values found in the Health Agenda of the Americas:

9. *Human rights, universality, access, and inclusion.* The constitution of the World Health Organization states that: "enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition...". In order to make this right a reality, the countries should work toward achieving universality, access, integrity, quality and inclusion in health systems that are available for individuals, families, and communities. Health systems should be accountable to citizens for the achievement of these conditions.

10. *Pan American solidarity*. Solidarity, defined as collaboration among the countries of the Americas to advance shared interests and responsibilities in order to attain common targets, is an essential condition to overcome the inequities with regard to health and to enhance Pan American health security during crises, emergencies, and disasters.

11. *Equity in health*. The search for equity in health is manifested in the effort to eliminate all health inequalities that are avoidable, unjust, and remediable among populations or groups. This search should emphasize the essential need for promoting gender equity in health.

12. *Social participation*. The opportunity for all of society to participate in defining and carrying out public health policies and assessing their outcomes is an essential factor in the implementation and success of the Health Agenda.

Areas of Action:

Strengthening the National Health Authority
Tackling Health Determinants
Increasing Social Protection and Access to Quality Health Services
Diminishing Health Inequalities among Countries and Inequities within them
Reducing the Risk and Burden of Disease
Strengthening the Management and Development of Health Workers
Harnessing Knowledge, Science, and Technology

7. Link between Agenda item and Strategic Plan 2008-2012:

SO2: To combat HIV/AIDS, tuberculosis and malaria.

SO4: To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy aging for all individuals.

alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex, which affect health conditions.

SO7: To address the underlying social and economic determinants of health through policies and programs that enhance health equity and integrate

pro-poor, gender-responsive, and human rights-based approaches.

8. Best practices in this area and examples from other countries within AMRO:

Brazil has improved the strategic information system using new technologies and disaggregating information by age. *Sistema Unico de Saúde* (SUS) has expanded access to health services to adolescent and youth.

Costa Rica has a tradition of national adolescent health programs with an integrated approach with good outcomes and coverage with quality information.

Canada applies determinants of health as a framework with emphasis in promotion & prevention, focusing efforts guided by an excellent strategic information system that uses new technologies.

El Salvador has developed a National Adolescent Health Program with human and financial resources allocated from the National budget and is in the process of integrating HIV and sexual and reproductive health services for adolescents.

9. Financial implications of Agenda item:

The team cannot realistically provide the financial implications of this Agenda item without developing the Plan of Action (to be completed in 2009) but a provisional estimate based on previous expenditures is US$ 2,000,000 per annum.

PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

142nd SESSION OF THE EXECUTIVE COMMITTEE

Washington, D.C., USA, 23-27 June 2008

CD48/8 (Eng.)
Annex E

ORIGINAL: ENGLISH

RESOLUTION

CE142.R16

REGIONAL STRATEGY FOR IMPROVING ADOLESCENT AND YOUTH HEALTH

THE 142nd SESSION OF THE EXECUTIVE COMMITTEE,

Having seen the Director's report, *Regional Strategy for Improving Adolescent and Youth Health* (Document CE142/13), based on the PASB Strategic Plan 2008-2012**,**

RESOLVES:

To recommend that the Directing Council adopt a resolution along the following lines:

THE 48th DIRECTING COUNCIL,

Having seen the Director's report *Regional Strategy for Improving Adolescent and Youth Health* (Document CD48/8), based on the PASB Strategic Plan 2008-2012;

Noting the World Health Assembly resolution on the Strategy for Child and Adolescent Health and Development (WHA56.21, 2003), calling on governments to strengthen and expand efforts to strive for full coverage of services, and to promote

access to a full range of health information for adolescents; and Resolution CD40.R16 of the PAHO Directing Council on adolescent health, in which governments formally recognized the differentiated needs of the youth population and approved a framework and action plan;

Recalling the right of adolescents and youth to the enjoyment to the highest attainable standard of health, as set forth in the Constitution of the World Health Organization; the UN Convention on the Rights of the Child and other international and regional human rights instruments;

Understanding that successful passage through adolescence and youth is essential for healthy, engaged and economically well-developed societies**;**

Recognizing that adolescent and youth health is a key aspect of economic and social development in the Americas; that their behaviors and health problems are an important part of the overall disease burden; that the cost associated with the treatment of chronic diseases is high; and that effective prevention and early intervention measures are available;

Considering that the outcomes for adolescent and youth health will be more effective if health promotion, primary health care, social protection, and social determinants are taken into consideration when addressing priority health topics for these populations**;**

Recognizing that PAHO has cooperated with the countries of the Region in establishing conceptual and technical bases and infrastructure for the development of national adolescent and youth health programs and policies; and

Concerned that the specific needs of adolescents and youth have not been adequately addressed and that the achievement of international goals will require additional efforts in adolescent and youth health,

RESOLVES:

1. To endorse the Regional Strategy for Improving Adolescent and Youth Health (Document CD48/8) to effectively and efficiently respond to current and emerging needs in adolescent and youth health with specific consideration of prevailing inequalities in health status, and to strengthen the health system response to develop and implement policies, plans, programs, laws and services for adolescents and young people.

2. To urge Member States to:

(a) promote the collection and use of data on adolescent and youth health disaggregated by age, sex and ethnicity and the use of a gender-based analysis, new technologies (e.g. geographical information systems) and projection models to strengthen the planning, delivery, and monitoring of national plans, policies, programs, laws and interventions related to adolescent and youth health;

(b) strengthen and expand efforts to meet international commitments for adolescent and youth health;

(c) promote and establish enabling environments that foster adolescent and youth health and development;

(d) scale up the coverage of and access to quality health services—including promotion, prevention, effective treatment, and ongoing care—to increase their demand and utilization by adolescents and youth;

(e) support capacity building for policymakers, program managers, and health care providers to develop policies and programs that aim to promote community development and provide effective quality health services addressing the health needs of adolescents and youth and their related determinants of health;

(f) engage adolescents and youth, their families, communities, schools, and other appropriate institutions and organizations in the provision of culturally sensitive and age-appropriate promotion and prevention programs as part of the comprehensive approach to improving the health and well-being of adolescents and youth;

(g) improve coordination within the health sector and with partners in other sectors to ensure that actions and initiatives in adolescent and youth health and development are implemented, minimizing duplication of efforts and maximizing impact of limited resources;

(h) establish partnerships with the media to promote positive images of adolescents and youth which promote appropriate behaviors, social norms and commitment to health issues.

3. To request the Director to:

(a) maintain the Organization's commitment to and support for achieving and sustaining high levels of coverage of evidence-based interventions through the integration of actions by PAHO programmatic areas;

(b) support the establishment and coordination of strategic alliances to improve the health and development of adolescents and youth;

(c) encourage technical cooperation among countries, subregions, international organizations, government entities, private organizations, universities, media, civil society, youth organizations, faith-based organizations, and communities, in activities that promote adolescent and youth health;

(d) establish a time limited technical advisory group for guidance on topics pertinent to adolescent and youth health and development.

(e) develop a plan of action (2010-2018) based on the Regional Strategy for Improving Adolescent and Youth Health (Document CD48/8).

(f) encourage the development of collaborative research initiatives that can provide the evidence base needed to establish and deliver effective and developmentally and age appropriate programs and interventions for adolescents and youth**.**

(Special meeting, 31 July 2008)

PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

48th DIRECTING COUNCIL
60th SESSION OF THE REGIONAL COMMITTEE

Washington, D.C., USA, 29 September- 3 October 2008

CD48/8 (Eng.)
Annex F

Report on the Financial and Administrative Implications for the Secretariat of the Resolutions Proposed for Adoption by the Directing Council

1. Resolution: Regional Integrated Strategy for Improving Adolescent and Youth Health	
2. Linkage to program budget	
Area of work	**Expected result**
SO2 To combat HIV/AIDS, tuberculosis and malaria	RER 2.1 Member States supported through technical cooperation for the prevention of, and treatment, support and care for patients with HIV/AIDS, tuberculosis and malaria, including innovative approaches for increasing coverage of the interventions among poor people, hard-to-reach and vulnerable populations. RER 2.2 Member States supported through technical cooperation to develop and expand gender-sensitive policies and plans for HIV/AIDS, malaria and TB prevention, support, treatment and care.
SO3 To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries	RER 3.1 Member States supported through technical cooperation to increase political, financial and technical commitment to address chronic noncommunicable conditions, mental

	and behavioral disorders, violence, road safety, and disabilities. RER 3.2 Member States supported through technical cooperation for the development and implementation of policies, strategies and regulations regarding chronic noncommunicable conditions, mental and behavioral disorders, violence, road safety, disabilities, and oral diseases. RER 3.3 Member States supported through technical cooperation to improve capacity to collect, analyze, disseminate and use data on the magnitude, causes and consequences of chronic noncommunicable conditions, mental and behavioral disorders, violence, road traffic injuries and disabilities.
SO4 To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy aging for all individuals	RER 4.1 Member States supported through technical cooperation to develop comprehensive policies, plans, and strategies that promote universal access to a continuum of care throughout the life course; to integrate service delivery; and to strengthen coordination with civil society, the private sector and partnerships with UN and Inter-American system agencies and others (e.g. NGOs). RER 4.2 Member States supported through technical cooperation to strengthen national/local capacity to produce new evidence and interventions; and to improve the surveillance and information systems in sexual and reproductive heath, and in maternal, neonatal, child, adolescent and older adult health. RER 4.6 Member States supported through technical cooperation for the implementation of policies and strategies on adolescent health and development.

SO6 To promote health and development, and prevent or reduce risk factors such as use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex, which affect health conditions	RER 6.1 Member States supported through technical cooperation to strengthen their capacity for health promotion across all relevant programs; and to establish effective multisectoral and multidisciplinary collaborations for promoting health and preventing or reducing major risk factors. RER 6.5 Member States supported through technical cooperation to develop evidence-based and ethical policies, strategies, programs and guidelines for preventing and reducing unhealthy diets and physical inactivity, and related problems. RER 6.6 Member States supported through technical cooperation to develop evidence-based and ethical policies, strategies, programs and guidelines for promoting safer sex.
SO7 To address the underlying social and economic determinants of health through policies and programs that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches	RER 7.1 Significance of determinants of health and social policies recognized throughout the Organization and incorporated into normative work and technical cooperation with Member States and other partners. RER 7.4 Ethics- and human rights-based approaches to health promoted within PAHO/WHO and at national, regional and global levels. RER 7.5 Gender and ethnicity analysis and responsive actions incorporated into PAHO/WHO's normative work and Member States supported through technical cooperation for the formulation of gender and ethnic-sensitive policies and programs.
SO10 To improve the organization, management and delivery of health services	RER 10.1 Member States supported through technical cooperation for equitable access to quality health care services, with special emphasis on vulnerable population groups.

3. Financial implications

a) **Total estimated cost for implementation over the lifecycle of the resolution (estimated to the nearest US$ 10,000; including staff and activities):**

This Strategy cannot be addressed by PAHO alone in terms of proposed interventions and budgetary implications; therefore, collaboration with UN agencies and other key stakeholders is essential. Considering that this is a Strategy and that the Plan of Action will be developed in 2009, the estimation of cost for the life cycle of the resolution has been developed based on PAHO's biennial 2006-2007 expenditure. The estimated cost for implementation of the resolution is US$ 4,000,000 per biennium. This includes maintaining current staff, hiring additional staff, and implementing activities at the Regional and national levels.

b) **Estimated cost for the biennium 2008-2009 (estimated to the nearest US$ 10,000; including staff and activities):**

US$ 4,000,000

c) **Of the estimated cost noted in (*b)* what can be subsumed under existing programmed activities?**

US$ 1,000,000 can be subsumed under existing proposed activities (2008).

4. Administrative implications

a) **Implementation locales (indicate the levels of the Organization at which the work will be undertaken and identify the specific regions, where relevant):**

The work will be undertaken at the country level, focusing on priority and impact countries. The Caribbean, Central American, and Andean sub-regions will be prioritized specifically according to the following topics and in accordance with the epidemiological profiles: sexual and reproductive health, violence prevention, NCD prevention, and substance abuse.

b) **Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile):**

Current staff:
Senior Advisor – US$ 160,000 / year
Secretary – US$ 40,000 / year

Additional staffing requirements:

Three subregional coordinators – US$150,000/ year

National level:
Five national professionals (1 per priority country) – US$ 200,000/ year

Total staffing cost per year: US$550,000

c) **Timeframes (indicate broad time frames for the implementation and evaluation):**

2008: Approval of Regional Integrated Strategy for Adolescent and Youth Health
2009: Approval of the Plan of Action for the implementation of the Strategy
2010–2015: Implementation of the Strategy in phases

Phase 1 (2010-2012): 5 countries implement, monitor and evaluate the Strategy to generate lessons learned
Phase 2 (2012-2014): 15 additional countries go to scale with the Strategy
Phase 3 (2014-2016): 15 additional countries go to scale with the Strategy
Phase 4 (2016-2018): 4 additional countries go to scale, emphasis placed on evaluation of implementation in all countries

2018 Final Evaluation of the Strategy