REGIONAL GUIDE
AMRO REGION

AMWHO

2026 AMWHO INTERNATIONAL CONFERENCE

Global Child and Adolescent Health: Protecting the Next Generation in a Time of Crisis

Introduction

The Pan American Health Organization (PAHO), the World Health Organization's (WHO) Regional Office for the Americas, comprises 35 member countries and 4 associate members, spanning North, Central, and South America, as well as the Caribbean.[1] Home to over one billion people, this region is defined by its striking cultural, economic, and political diversity. These variations have produced wide disparities in health outcomes, particularly for children and adolescents, as the region struggles with inequities across healthcare, nutrition, and preventative services.

Fig. 1 A map of the nations and territories included in the AMRO region of the WHO.[2]

PAHO was established in 1902 in Washington, D.C., making it the oldest international public health agency in the world.[3] Since its founding, PAHO has guided milestones in disease prevention, including the regional eradication of smallpox in 1971 and the elimination of polio in 1994 - two landmark achievements that demonstrated the strength of cooperation in health across the Americas.[4] However, progress has slowed in recent years.

Introduction

According to PAHO's 2024 Immunization in the Americas report, vaccination coverage for key childhood vaccines has declined to levels not seen since the 1990s.[5] More than 1.4 million children in the region did not receive their basic vaccines in 2024, placing them at risk for diseases such as measles and diphtheria.[5]

Economic instability and political injustice have weakened healthcare infrastructure in several Latin American countries, resulting in reduced vaccination coverage, shortages of medical supplies, and migration of healthcare professionals.[6] For example, Venezuela's economic collapse has caused significant medicine shortages, while Haiti's limited government resources limit the delivery of essential services, especially in rural regions, and all of these were further disrupted due to COVID-19.[7,8]

Despite these setbacks, the region has shown resilience through joint efforts to restore vaccination programs and rebuild public trust in health institutions. PAHO has been working with countries in the region, along with the United Nations Children's Fund (UNICEF), to support post-pandemic catch-up campaigns targeting unvaccinated children between 2020 and 2022.[9] These efforts reflect the theme of this year's conference, "Global Child and Adolescent Health: Protecting the Next Generation in a Time of Crisis," by emphasizing that collaboration and data-driven policy are central to safeguarding youth health in the Americas.

Subtheme 1: Vaccine Uptake and Infectious Disease Management

For over 40 years, the Expanded Program on Immunization (EPI) and the National Immunization Programs in some countries have made the region a leader in protecting children from vaccine-preventable diseases (VPDs), such as polio, rubella, smallpox, congenital rubella syndrome, measles, and neonatal tetanus.[10] Yet, in recent years, vaccine uptake has declined across multiple AMRO countries due to improper training, political instability, and inequitable access to healthcare.[5] According to WHO and UNICEF, childhood immunization coverage stalled, causing 2.7 million more children to be unvaccinated or undervaccinated compared to before COVID in 2023.[11] As a result, diseases that were once eliminated, such as measles and diphtheria, have reemerged in parts of the region. This decline corresponds with the re-emergence of diseases that were once said to be eliminated, such as measles, diphtheria, and rubella, showing how political and social factors directly influence disease control.[11]

These issues are visible in countries affected by crisis and migration. Millions of people fleeing Venezuela's political and economic turmoil have contributed to the spread across neighboring countries, while Caribbean islands struggle to maintain systems needed for vaccine prevention.[12,13] Structural barriers, such as unreliable electricity, geographic isolation, and underfunded health systems, add to the challenge.[13]

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COVID-19 exacerbated these problems by diverting resources from regular immunizations, leading to outbreaks of previously controlled diseases.[11]

CASE STUDY 1: MEASLES RESURGENCE IN CANADA

For decades, Canada was regarded as a leader in measles control, having eliminated endemic transmission in 1998 through high routine childhood immunization coverage and strong disease surveillance systems.[14] However, following the COVID-19 pandemic, disruptions to routine healthcare services and declining vaccine uptake reversed years of progress, placing children and adolescents at increased risk for vaccine-preventable diseases.[15]

National and provincial data show that childhood vaccination coverage for measles declined after 2020, falling below the 95% threshold required to maintain herd immunity.[16] These immunity gaps were particularly pronounced among young children who missed scheduled vaccinations during pandemic-related service interruptions.[17] As a result, infants too young to be fully vaccinated, as well as school-aged children and adolescents with incomplete immunization histories, became increasingly vulnerable to infection.[17]

The measles resurgence began in late 2024, when imported cases led to sustained community transmission across multiple provinces.[18]

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By 2025, Canada had reported more than 5,000 confirmed and probable measles cases, the majority occurring among unvaccinated or under-vaccinated individuals, including children and adolescents.[19] The outbreak had severe consequences for pediatric populations, including the deaths of two premature infants exposed to measles in utero, highlighting the disproportionate risk faced by infants who rely on community immunity for protection.[19]

Because measles transmission persisted for more than 12 consecutive months, PAHO determined that Canada no longer met the criteria for measles elimination, formally revoking the country's elimination status in November 2025.[18,20] This loss also contributed to the AMRO region losing its measles-free designation, underscoring how declines in childhood vaccine uptake in a single country can have regional public health consequences.[20]

In response, the Public Health Agency of Canada worked in coordination with provincial and territorial health authorities to implement outbreak control measures focused on protecting children and adolescents.[21] These efforts included enhanced measles surveillance, expanded contact tracing, and temporary exclusion of unvaccinated children from schools and childcare settings following exposure.[21]

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Provinces also launched catch-up immunization campaigns through public health clinics, pharmacies, mobile vaccination units, and community programs, while following national guidance to offer early measles vaccination to infants aged 6–11 months in outbreak-affected areas.[18]

Public health messaging emphasized that measles is highly contagious but preventable, and urged families to verify vaccination records and ensure that children receive all recommended doses. Despite these interventions, PAHO noted that emergency outbreak responses cannot replace strong, equitable, and sustained routine immunization systems.[22] Canada's experience demonstrates that even well-resourced health systems remain vulnerable when childhood vaccine uptake declines, reinforcing the need for long-term investment in prevention to protect child and adolescent health during times of crisis.

CASE STUDY 2: COVID-19 VACCINE BARRIERS IN HAITI

Haiti's COVID-19 vaccine rollout illustrates how fragile systems can delay protection for children and adolescents during a crisis. In July 2021, Haiti became the last country in the Americas to receive COVID-19 vaccines, initiating its rollout months after neighboring countries and limiting early population-level protection.[23]

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Even after vaccines arrived, uptake and coverage remained low, restricting indirect protection for children who rely on adult and community immunity and delaying opportunities to vaccinate adolescents.[23] Low coverage meant that households with children faced prolonged exposure risk, especially in multigenerational living settings common throughout the country.[23]

A clear equity issue emerged regarding eligibility timelines for children and adolescents. While nearly all countries in the Americas expanded COVID-19 vaccine eligibility to adolescents by mid-2022, Haiti lagged behind, delaying access for youth during a critical period when schools were reopening, and transmission risk remained high.[24,25] This delay further widened disparities between Haitian adolescents and their regional peers.

Multiple structural barriers contributed to these challenges, including limited health service delivery capacity, uneven geographic access to clinics, shortages of trained health workers, and persistent distrust in public institutions.[26,27] These barriers reduced both vaccine availability and demand, making it challenging to reach caregivers and adolescents through traditional facility-based vaccination strategies.[27]

To address low uptake, public health authorities, with international support, implemented community-based outreach and social mobilization strategies designed to improve vaccine confidence and access.[24,29]

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These efforts emphasized local engagement, risk communication, and outreach to caregivers, recognizing that trust-building was essential for increasing vaccination among families with children and adolescents.[24,29]

Haiti's experience also reflected broader regional inequities in vaccine access during the COVID-19 pandemic, highlighting the importance of pooled procurement mechanisms and international coordination to support countries with limited fiscal and logistical capacity. Emergency vaccine deliveries helped narrow supply gaps but did not fully overcome delivery and uptake challenges.

Overall, Haiti's COVID-19 vaccination experience underscores a critical lesson for child and adolescent health in the Americas: when routine health systems are weak, emergency vaccination efforts may arrive late and scale slowly, leaving young populations unprotected for extended periods. Strengthening immunization systems, improving community trust, and ensuring early inclusion of children and adolescents in vaccination strategies remain essential for protecting youth during future public health crises.

Subtheme 2: Mental Health and Violence Exposure

Across the AMRO region, mental health has quickly become one of the most urgent child and adolescent health challenges, with rates of psychological distress, trauma, and violence exposure having risen sharply across the region.[30] Throughout the last decade, stressors such as political instability, economic inequality, community violence, the COVID-19 pandemic, and more have increased the risk of anxiety, depression, and post-traumatic stress among adolescents. According to PAHO, almost one in five adolescents in Latin America reports symptoms of a mental disorder, and is the third leading cause of death among individuals aged 10-19 in the AMRO region is suicide.[31] Despite the prevalence of mental health disorders within this region, countries continue to allocate small portions of their health budgets to such conditions, and the majority of the population has limited access to resources and services for treatment options.[32] This statistic emphasizes how social and structural forces, such as organized crime and displacement, shape mental health outcomes as profoundly as biological factors do.

The impact of mental health burden and violence exposure is especially prevalent in countries affected by crisis, migration, and armed violence. Millions of children and adolescents in the AMRO region have experienced chronic stress, family separation, or exposure to conflict, as they flee economic collapses or gang-related threats.[33]

Subtheme 2: Mental Health and Violence Exposure

Caribbean nations, including Guyana, Trinidad and Tobago,and Suriname, face some of the highest adolescent suicide rates across the globe, while rural areas across Honduras, Colombia, and Brazil face limited access to appropriate and culturally aligned mental health services.[34] Various systemic and structural barriers exist, such as shortages of trained professionals, underfunded support systems in schools, and preexisting stigma; each contributes to hindering early intervention to mental health issues and exposure to violence.[35] These vulnerabilities were exacerbated by the COVID-19 pandemic because of schooling disruptions, an increase in domestic violence, and the isolation of the youth from different protective social networks, which only worsens the mental health crisis present across this region. [36]

CASE STUDY 1: VIOLENCE AND MENTAL HEALTH IN COLOMBIA

Violence is experienced by children and adolescents across the country of Colombia, affecting both their physical and mental health. According to the U.S. Department of Labor Bureau of International Labor Affairs, violence faced by youth and adolescents comes in the form of “commercial sexual exploitation, trafficking in persons for further labor exploitation and servitude, and recruitment of children for use in armed conflict, among other forms of violence.”[37]

Subtheme 2: Mental Health and Violence Exposure

Specifically, around 200,000 children are sexually abused each year, and more than 35,000 are forced into commercial sexual exploitation. Furthermore, girls are noted to be more exposed to sexual violence than boys.[37]

Physical violence is said to be more common among males, while girls experience higher rates of emotional violence. There was a 50% increase in violations against children in recruitment and use by non-state armed groups for armed conflict, leading to the displacement of children and families.[37] These, and other forms of violence experienced by youth and adolescents across Colombia, have detrimental effects on their mental health, as seen by the prevalence of illnesses and issues such as Post Traumatic Stress Disorder (PTSD), substance abuse, emotional problems, suicidal thoughts, and behavioural problems.[38]

Such disorders also have social consequences, exemplifying how violence and mental health issues impede many aspects of the lives of Colombian youth and adolescents. Lower educational attainment, social marginalisation, and inadequate access to basic needs are examples of the effects of mental health on the social lives of children and adolescents.[38] Thus, it becomes evident that the intersectionality of consequences of mental health disorders, stemming from experienced violence within the country, has severe effects on the mental health of children and adolescents in Colombia.

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Specifically, in Medellin, Colombia, “41% of Medellin’s inhabitants have witnessed a homicide, 75% have witnessed an aggressive incident, and 40% have been victims of other types of violent incidents.”[39] After examining neighborhood violence exposure and depression, it was reported that 8.9% of the children and youth of Medellin show or describe experiencing depressive symptoms.[39] Again, such symptoms can lead to the experience of further difficulties in other areas of the youth’s lives, specifically in education, social interactions, and access to basic needs.

Specific prevention and interventions for both violence and mental health disorders exist in Colombia currently. For example, community organizations and schools implement strategies of a collective and psychosocial nature to address the mental health of children and adolescents.[40] Efforts by the state include clinical options, but they are limited in terms of resources, accessibility, and continuity.[40] To address these issues more completely, it is necessary to implement better coordination in efforts between the school system, the state, and international organizations, so that the strategies to improve child and adolescent mental health and decrease violence are both effective and reach the target recipients.

Subtheme 2: Mental Health and Violence Exposure

CASE STUDY 2: EXPOSURE TO VIOLENCE AND EFFECTS ON MENTAL HEALTH IN BRAZIL

The experience of violence is the horrific reality of children and adolescents across Brazil, which significantly affects their mental health, development, and overall well-being. Children and adolescents in Brazil are exposed to various forms and types of violence, including, but not limited to, community violence, domestic abuse, sexual violence, and indirect exposure to homicides.[41] Exposure occurs cumulatively for both children and adolescents, which exacerbates vulnerability to psychological and long-term mental health risks.[42]

There is a strong association between exposure to violence during childhood and a wide range of mental health disorders in Brazilian children and adolescents. It is indicated by evidence from population-based studies that childhood trauma, such as witnessing violent crime, physical abuse, and neglect, accounts for a significant amount of mental health disorders in late adolescents.[42] Those who are exposed to violence in childhood are reported to be more likely to experience mental health issues, such as anxiety disorders, depression, conduct disorders, and substance abuse issues when compared to their non-exposed counterparts.[42]

There are also noted differences by gender in patterns of violence exposure and mental health effects.

Subtheme 2: Mental Health and Violence Exposure

A study identified that boys are more likely to experience direct physical and community violence, while girls are more likely to experience higher exposure to sexual and emotional violence.[43] That being said, both physical and community violence and sexual and emotional violence are strongly associated with internalizing orders, such as depression, anxiety, and suicidal thoughts.[43] Specifically, in São Paulo, both exposure to violent events and lower socioeconomic status were associated with a higher prevalence of internalizing and externalizing psychiatric disorders among twelve-year-olds across the country.[44] This evidence and research highlight how violence and inequality intersect to shape mental health outcomes among Brazilian youth and adolescents.

Urban settings with high crime rates exemplify particularly strong mental health consequences of violence. In Rio de Janeiro and surrounding cities, studies identified that adolescents living in neighborhoods reporting frequent lethal and non-lethal violence experience significantly higher chances of developing common mental health disorders.[43] In a similar manner, research from São Gonçalo identified that around 7.8% of adolescents showed symptoms of post-traumatic stress disorder (PTSD), with major contributors to the issues being community and family violence.[40] These mental health disorders - PTSD, depression, and others - can interfere with adolescents' and children' s performance in school, social relationships, and access to basic services.[43]

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Current interventions, such as school-based initiatives, community outreach, and services within the Unified Health System, are being implemented across Brazil as efforts towards prevention and intervention.[43] However, access to such services and the consistency and cultural appropriation thereof remain limited, specifically in low-income and high-violence areas of Brazil.[43] A need for broader and more intersectional approaches is necessary to effectively combat the violence and mental health crises taking place in Brazil currently.

Subtheme 3: Nutrition, Physical Activity, and Noncommunicable Diseases

Research has proven that across the AMRO region, noncommunicable diseases (NCDs) are the leading cause of death, and this is largely driven by controllable factors, such as unhealthy diets, a lack of physical activity, and other lifestyle choices.[45] In the United States, the Physical Activity Alliance, a national coalition attempting to advance youth participation in physical activity, graded the overall physical activity for children and youth a D-, with only 20-28% of six to seventeen-year-olds meeting the recommended hour of daily physical activity.[46] In addition to this, more than 20% of Latin American children between the ages of zero and nineteen are overweight and obese, but also face the double burden of undernutrition simultaneously. This is resulting from the normalization of diets that are composed of energy-dense, nutrient-poor foods and the tendency to lead sedentary lifestyles, as well as socioeconomic conditions, urbanization, retail foods, and public transportation.[47]

Along with this comes the concern of NCDs that result from malnutrition and the lack of physical activity, such as diabetes, cardiovascular diseases, and various forms of cancer. It is noted that across the AMRO region, starting in childhood and manifesting in adolescence and adulthood, noncommunicable diseases threaten the health and livelihoods of the youth and adolescents.[48] Many adult diseases can be traced back to behaviors and lifestyles adopted in youth, which emphasizes the need for prevention and interventions through education and policy.[48]

Subtheme 3: Nutrition, Physical Activity, and Noncommunicable Diseases

CASE STUDY 1: NCDS, NUTRITION, AND PHYSICAL ACTIVITY IN MEXICO

It has been identified that 65.5% of Mexican youth and adolescents do not meet physical activity recommendations, such as those of physical activity, sleep, active play, active transportation, and sedentary behavior.[49] In the 2022 Mexican Report Card of physical activity, low grades were assigned to the country in all areas except for sleep, suggesting that movement behaviors do not meet the recommended level among children and adolescents, with a specific emphasis among girls. Furthermore, there are limited opportunities that exist for movement behaviors to be engaged in by the youth and adolescents.[49] A study evaluating the associations between diet and physical activity with body fat in adolescents in Mexico identifies that the adoption of unhealthy lifestyles, marked by inadequate diet and minimal physical activity, are large contributor to obesity and cardiometabolic risk.[50] Their findings indicated that adolescents who consumed more total fat, specifically saturated fats, tended to have higher levels of body fat, adolescents who engaged in more high-intensity physical activity tended to have lower body fat, and eating more fruits and vegetables appeared to be linked with healthier body fat levels.[50]

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An additional study reported that such lifestyles and the engagement in minimal physical activities and poor diets increase the risk of Mexican youth and adolescents developing NCDs in their adulthood. Insulin resistance, high systolic blood pressure, and overweight/obesity were the most prevalent variables found within the youth and adolescents that indicate the potential risk and prevalence of NCDs in their future.[51] Within the country, the likelihood and prevalence of these variables differed by socioeconomic status and marginalization index; higher glucose levels were associated with higher socioeconomic status and a better lipid profile, and lower glucose levels were associated with higher marginalization.[51] In order to combat potential NCDs and encourage healthier lifestyles, it is necessary that there are prevention and strategies for combating the current normalized lifestyle and diet among Mexican youth and adolescents.

In Mexico, many solutions are being implemented or exist that aim to reduce diseases and promote healthy lifestyles among the youth and adolescents. For example, The National Strategy for Prevention and Control of Overweight, Obesity, and Diabetes aims "[to consolidate the] culture that facilitates the adoption of lifestyles that maintain people's health; to detect timely the universe of cases of overweight, obesity, and diabetes to guarantee their proper management; and to generate a platform allowing trained human resources and inputs to make effective access to health services."[52]

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Similarly, other organizations encourage healthy environments for children to implement more physical activity and improved diets. Additional organizations want to provide proper, nutritious meals to children in schools and to students and implement education that includes and incorporates physical activity.[52] Thus, it is evident that such preventions and interventions are necessary to combat the threat of NCDs in Mexican youth and adolescents due to insufficient nutrition and low levels of physical activity.

CASE STUDY 2: NUTRITION, PHYSICAL ACTIVITY, AND NCDS IN CHILE

Chile's child and adolescent NCD risk has risen along with an increase in overweight and obesity among student populations. Using the database repository of the Epidemiology Department of the Chilean Ministry of Health, the prevalence of overweight and obesity is about 78% of the Chilean population. There are about 21,977 deaths from NCD every year in Chile, which makes up about 31.6% of major NCD deaths and about 20.4% of all 2018 deaths.[53] These patterns in childhood are linked to a higher lifetime risk of NCDs such as type 2 diabetes and cardiovascular disease, reinforcing PAHO's framing that NCDs in the Americas are behind early-life risk exposures.[54]

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A major driver of this trend is the high availability and consumption of ultra-processed foods and sugary drinks among children, which increases caloric intake while reducing diet quality. Chile's policy context reflects this risk environment: researchers describe how food and drinks high in calories, sugars, sodium, and saturated fat are widespread and targeted by Chile's national warning-label policy.[55] At the same time, physical inactivity remains a challenge for Chilean youth, limiting protective behaviors that would reduce obesity and cardiometabolic risk.[56]

Chile's 2022 national "Report Card" on physical activity for children and adolescents reported low overall grades, with only 37% of youth, ages 5-17, achieving 60 minutes of physical activity on at least 4 days per week, highlighting insufficient movement among children and adolescents.[56,57] WHO also tracks insufficient physical activity among school-going adolescents, ages 11-17, as a core NCD risk factor, reinforcing the relevance of adolescent inactivity for long-term chronic disease prevention.[58]

In response to rising childhood obesity and diet-related NCD risk, Chile implemented Law 20.606, Food Labeling and Advertising, establishing mandatory front-of-package warning and related marketing restrictions designed to shift children's food environments.[59] Chile's Ministry of Health operationalized this law through national labeling guidance and implementation materials tied to Law 20.606 requirements.[59,60]

Subtheme 3: Nutrition, Physical Activity, and Noncommunicable Diseases

Independent evaluations show measurable consumer and purchasing changes after implementation, including a 23.7% decline in purchases of high sugar-sweetened beverages following the policy's launch.[60] Chile's Ministry of Health also put together national evaluations of Law 20.606, showing evidence on labeling, marketing, and related outcomes relevant to child health protections.[61]

Because the policy aims to restrict harmful food marketing to children, it is often cited in global child-health policy resources as a prominent example of protecting children from unhealthy food promotion. Taken together, Chile's experience shows that regulations such as warning labels, limits on child-directed marketing, and school food environment protections can change purchasing patterns, but continued gains in child and adolescent NCD prevention also need sustained physical activity promotion and equity-focused implementation.

Conclusion

Across the AMRO region, the case studies presented show how child and adolescent health is shaped by structural conditions, policy choices, and system resilience during times of crisis. Declines in vaccine uptake, rising exposure to violence and mental health stressors, and increasing risk of poor nutrition and physical inactivity highlight that health threats rarely exist alone and can reinforce one another across the life course. Experiences from Canada, Haiti, Colombia, Brazil, Mexico, and Chile are examples that show that while the region has a history of public health achievement, progress can be reversed when routine systems are disrupted or inequities exist. At the same time, these cases show the potential of coordinated regional action, evidence-based policy, and community-centered interventions to protect children and adolescents. Strengthening prevention, rebuilding trust, and investing in health systems are essential to protecting the next generation and advancing health equity across the Americas.

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