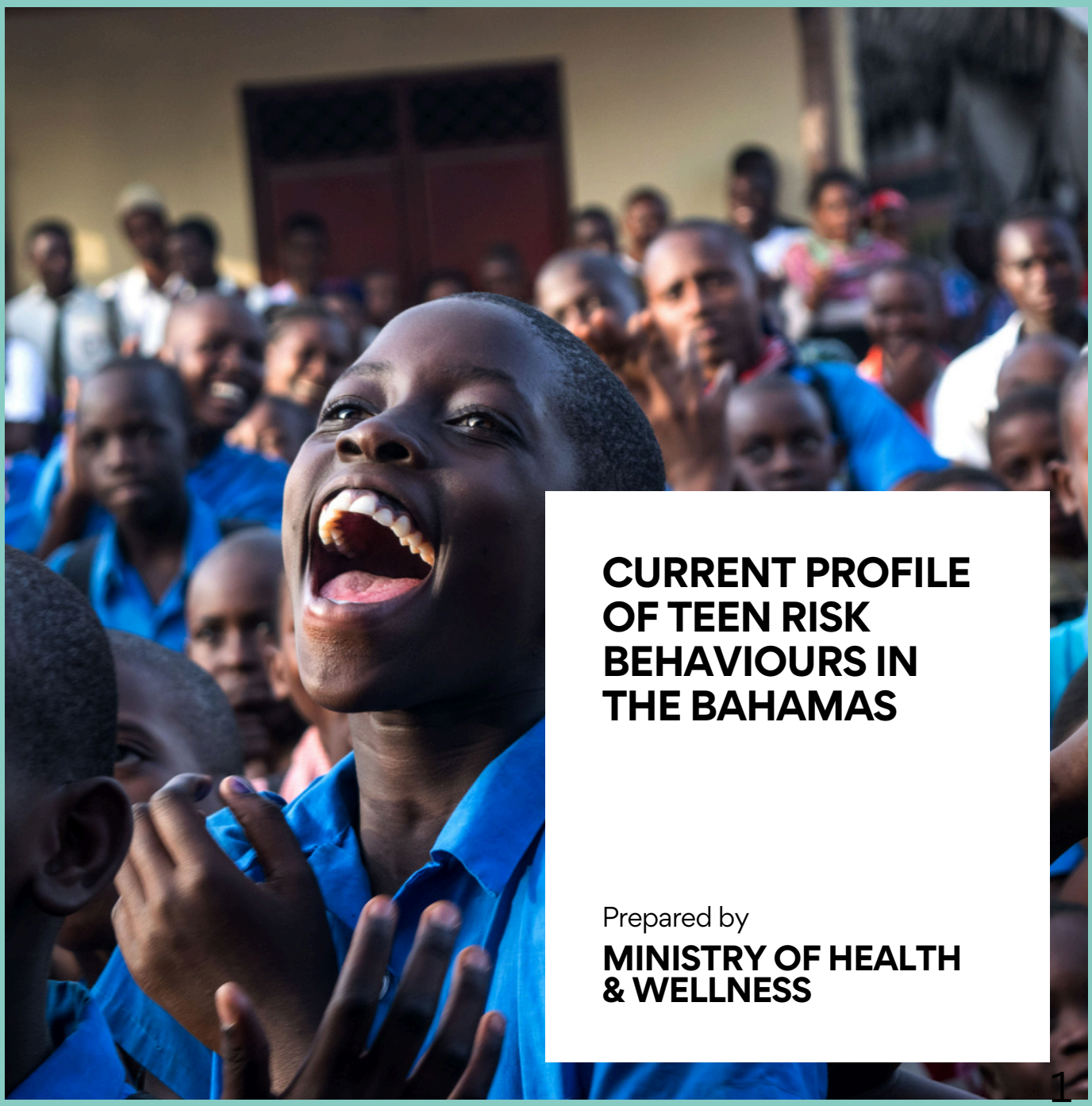
THE BAHAMAS'

GLOBAL SCHOOL HEALTH REPORT 2025



CURRENT PROFILE OF TEEN RISK BEHAVIOURS IN THE BAHAMAS

Prepared by

MINISTRY OF HEALTH & WELLNESS

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PREFACE

Adolescent health is an integral pillar of public health, as it shapes the foundation for well-being throughout life. Nearly 35% of the global burden of diseases originates in adolescence, with over 3,000 adolescents dying every day, mostly due to non-communicable diseases (NCDs), injuries, and other preventable causes.[i]

In The Bahamas, the prevalence of NCDs and their associated risk factors remain high within the general population. Research confirms that behaviours established during childhood and adolescence often persist into adulthood, positioning this critical development stage as a pivotal opportunity for intervention. Adolescence is characterized by rapid physical, emotional and social development as well as by the formation of values, increased autonomy and experimentation – factors that solidify habit, routines and behaviours.

Positive behaviours, such as regular physical activity, healthy eating, effective communication, self-esteem and academic engagement, can lead to lifelong benefits. Conversely, risky behaviours like smoking, alcohol consumption, poor mental health, self-harm or unhealthy dietary patterns initiated during adolescence often transition into adulthood, increasing the risk of chronic diseases and social challenges. Understanding this continuum highlights the importance of targeted interventions during adolescence to promote healthy behaviours and prevent harmful habits from taking root. Targeted interventions which are anchored in current evidence..

To date, The Bahamas has executed three (3) national surveys to comprehensively assess the behaviours and health status of its adolescent (teen) population, establishing meaningful trends. These surveys were conducted in 1998, 2013 and 2023, with the latter two surveys utilizing the WHO Global School Health Survey (GSHS) methodology. The findings contained in this report offer new insights into the health and well-being of Bahamian adolescents. While these findings reveal areas of concern, they also present an opportunity to re-calibrate national policies and systems through comprehensive approaches that promote physical and mental well-being, reduce risky behaviours, and ensure access to adequate education, healthcare, and supportive environments for teens in The Bahams.

This 2025 GSHS report, therefore, serves as a critical tool for shaping the future of The Bahamas' adolescent health policies and interventions. The success of these interventions will be a collective one for policymakers, educators, healthcare providers, researchers, community leaders, and every citizen. Together, we can lay the foundation for a brighter, healthier and more resilient population in The Bahamas.

Dr. Michael R. Darville
Minister
Ministry of Health & Wellness

Dr. Pearl McMillan
Chief Medical Officer
Ministry of Health & Wellness

[i] Abdalmaleki E, Abdi Z, Isfahani SR, Safarpoor S, Haghdoost B, Sazgarnejad S, Ahmadnezhad E. Global school-based student health survey: country profiles and survey results in the eastern Mediterranean region countries. BMC Public Health. 2022 Jan 19;22(1):130.

ABBREVIATIONS

BMI	Body Mass Index
CCAC.	Community Counselling and Assessment Centre
CDC	Centers for Disease Control and Prevention
G.B.	Grand Bahama
GSHS	Global School Health Survey
F.I.	Family Island
F/W.	Fieldwork
LAC	Latin America and the Caribbean
MoETvT.	Ministry of Education and Technology & Vocational Training
MoHW	Ministry of Health & Wellness
NCDs	Non-communicable Diseases
NHI	National Health Insurance
NP	New Providence
OAO	Overweight and Obesity
p	p value
PAHO CO	Pan American Health Organization, Country Office
PAHO WDC	Pan American Health Organization, Washington DC
PTSD	Post-traumatic Stress Disorder
r	Correlation Coefficient
RDI	Recommended Daily Intake
SBP	Standard Benefits Package
SSB	Sugar Sweetened Beverages
STI	Sexually Transmitted Infection
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organizations
$\chi 2$	Chi-square

ACKNOWLEDGEMENTS

The execution of the Bahamas' Global School Health Survey (2023) followed a phased approach, beginning with the conceptual and adaptation stages, transitioning into the fieldwork phase and culminating in the analysis, and reporting and dissemination phases. Each phase relied heavily on collaboration, dedication and the adequacy of needed resources.

To the Minister of Health and Wellness, Dr. Michael R. Darville; Permanent Secretary, Mr. Colin Higgs; and Chief Medical Officer, Dr. Pearl McMillan: Your continued prioritization of surveillance activities like this survey, establishes a strong foundation for understanding and characterizing the nation's health which, in this instance, is specific to the nation's teens.

To the Minister of Education, Mrs. Glenys Hanna-Martin and the Permanent Secretary, Ms. Lorraine Symonette: Your reliable support ensured seamless access to junior and senior high schools throughout the country; and also conveyed your valuing of such national assessments.

To the Pan American Health Organization: The technical assistance and guidance from PAHO WDC and PAHO CO were invaluable. Your financial support for the fieldwork phase enabled the inclusion of more islands in the sampling frame, maximizing the survey's reach and impact.

To school principals, teachers and guidance counsellors from the sampled public and private schools: Your gracious accommodation to our team facilitated smooth and efficient survey execution. Your cooperation was deeply appreciated.

To the students who participated: By being weighed, measured, and by completing the survey, you contributed meaningfully to our understanding of your experiences, concerns, and behaviors. Your participation has deepened our national insights and will help shape future policies tailored to your needs.

To the 38 survey administrators and the 29 survey assistants: Your tenacity brought new vigor to this large-scale undertaking on eight (8) islands.

To the packing team: You sorted, labeled and packed thousands of envelopes with forms, questionnaires and other materials to facilitate the GSHS execution in over 180 classes. This has not been taken for granted.

To the Bahamas National Drug Council support staff and driver: Your follow-up calls to principals and delivery of packages were immensely helpful to a smooth and on-time execution.

To the Coordinating Committee[1] : Your commitment during the adaptation and fieldwork phases anchored this project. Your navigation during these phases were pivotal.

To the locally-based data analysis team[2]: Your work has enriched and deepened the insights on behaviours among teens in The Bahamas.

1 Committee members: Nurse Sheryl Adams (School Health), Dr. Novia Carter-Lookie (BNDC), Daisry Higgs (MoETvT), Benita Adderley (MoETvT), Camelta Barnes (Nutrition Unit), Camille Nairn (HIRU), Indeira Thompson (BDNC), Ashley Farrington (MoHW) and Dr. Cherita Moxey (Committee Chair; and principal author).

2 This team comprised Dr. Pearl McMillan, Glenise Johnson, Camille Nairn, and Dr. Cherita Moxey.

GSHS EXPLAINED

The GSHS is a school-based, self-administered survey conducted primarily among young people aged 13-17 years to measure behavioural risk factors and protective factors related to the leading causes of morbidity and mortality among teens, in ten (10) or more key areas. The GSHS is a rapid, affordable, useful tool and a suitable alternative for surveillance systems; and is a part of the WHO STEPwise approach to health surveillance.[3]

The World Health Organization (WHO) in collaboration with other UN agencies and technical assistance of the Centers for Disease Control and Prevention (CDC) introduced Global School-based Student Health Survey (GSHS) in 2001, with its first implementation in 2003. To-date, it has been implemented in over 99 countries.

The full GSHS survey questionnaire package consists of ten (10) core questionnaire modules, core-expanded questions, and country-specific questions, which are combined to form a country-specific self-administered questionnaire. The 10 core questionnaire modules address the leading causes of morbidity and mortality among teens worldwide, including alcohol abuse, dietary behaviors, drug abuse, hygiene, mental health status and physical activity as well as protective factors, sexual behaviors, tobacco usage, violence, and unintentional injury.

Countries must select at least six of the 10 core modules in their country-specific questionnaire. Thereafter, country-specific questions can be added to the GSHS core questionnaire.

The Bahamas used the mandatory core modules, selected expanded questions and created country-specific questions.

[3] Abdalmaleki E, Abdi Zh, Ahmadnezhad E, et al. A review of the methodology and tools of childhood & adolescence surveillance and prevention of adult non-communicable disease survey (CASPIAN) conducted in Iran. Iran J Epidemiol. 2019;15(3):235–46.

EXECUTIVE SUMMARY

Periodic monitoring of behaviours and experiences that contribute to the leading causes of death and disability among adolescents has been prioritized in The Bahamas for over 20 years. During this period, the country has conducted systematic surveillance among nationally representative samples of public and private junior and senior high school students using an adapted Global School Health Survey (GSHS) instrument. The 2025 Bahamas GSHS Report provides the latest surveillance data and trend analyses on 54 key variables, encompassing individual questions and composite measures.

The 2025 Bahamas GSHS Report offers a comprehensive, multi-year overview of adolescent health and identifies priority focus areas critical to improving their well-being. These areas include sexual behavior, substance use, exposure to violence, mental health challenges, suicidal thoughts and behaviors, and chronic disease risk factors. Consequences of these behaviours and experiences extend beyond health and well-being during adolescence and are related to future opportunities for positive outcomes in adulthood.[4] The survey questions are included in the report's appendix.

KEY FINDINGS AND INSIGHTS

The data trends reveal both progress as well as persistent challenges. Of the fifty-four (54) variables studied, eight (8) are moving in the right direction, three (3) show no change and thirty-five (36) are trending in the wrong direction. Seven variables lack multi-year data points for trend analysis.

In 1988, only (9%) of Bahamian teens were classified as overweight, including those who were obese. Between 1998 and 2013, the prevalence of overweight (including obesity) among teens nearly tripled, rising from 17% to 44.7%. However, from 2013 to 2023, this trend reversed slightly, with a 16.7% decline, bringing the rate down to 40.4%. Despite these changes, the proportion of overweight teens classified as obese (adolescent obesity) has increased tenfold, rising from 2% in 1988 to 7% in 1998, and stabilizing at 21% in both 2013 and 2023. This rate of increase for The Bahamas is significantly higher than the global rate, which has grown fourfold between 1990 and 2022.[5] While there has been a modest decline in overweight rates among both boys and girls, obesity rates, on the other hand, have remained stable. Notwithstanding, the prevalence of overweight (including obesity) among Bahamian teens remains alarmingly high, exceeding Caribbean and Latin America and the Caribbean (LAC) averages. A 2023 UNICEF report identified Bahamian teens as having the highest rates of overweight and obesity within these regions.[6]

[4] Aspy CB et al. School-related assets and youth risk behaviors: alcohol consumption and sexual activity. J Sch Health. 2012;82(1):3-10.
[5] https://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight.
[6] UNICEF. Childhood overweight on the rise, Latin America and the Caribbean. August 2023. https://www.unicef.org/lac/en/reports/childhood-overweight-rise-latin-america-caribbean#downloadpdf

BOX 1: OBESITY HIGHLIGHT

The literature is saturated with irrefutable links between childhood obesity, adolescent (teen) obesity and adult obesity. A 2024 systematic review[ii] concluded that obese children and teens were five times more likely to be obese in adulthood than their non-obese counterparts. The review further revealed that around 55% of obese children become obese in adolescence; around 80% of obese adolescents will stil be obese in adulthood; and around 70% will be obese over age 30. In The Bahamas, 71.6% of adults are overweight. Of this, 43.6% are obese. Recall, adolescent obesity in the country stands at 21%.

Food insecurity significantly impacts adolescent development; and is associated with low diet quality, poor health, and challenges in cognitive and social development. Adolescents facing food shortages are more likely to struggle with behavioral issues, lower educational attainment, school absenteeism, and experiences of bullying. The impact is even more far-reaching, as adolescents experiencing food insecurity are also more prone to feelings of worry and shame, mental health challenges, and heightened vulnerability to unwanted sexual contact, exploitation, early labor market entry, and involvement in the criminal justice system, all of which limit life choices.[7] In The Bahamas, 30.8% of teens currently experience food insecurity—a notable improvement from 43.7% in 1998. However, this figure remains above the 27.5% global average[8] for adolescent food insecurity. In 2019, 33% of all Bahamians faced some level of food insecurity,[9] a rate significantly higher than the global average of 9% but below the 43% average for the English-speaking Caribbean.[10]

Sugar, fat and salt (in excess) have been recognized as nutrients of public health concern. The vast majority of teens (71.7%) consume weekly diets high in fat, salt and added sugars. By contrast, only 5.7% and 10.3% of teens eat the recommended daily intake (RDI) of fruits and vegetables, respectively. These dietary habits are compounded by low physical activity levels, with 83.3% of teens failing to meet the minimum physical activity level. These realities underscore that the nutrition quality of meals consumed by teens and physical activity need laser-focused attention and aggressive policy in-roads.

Given the increasing prevalence of NCDs in the general population, the increase in NCD risk factors among Bahamian adolescents has consequential implications for The Bahamas' ability to achieve and sustainably fund any universal health coverage scheme.

Basic health screenings or preventative health checks among teens are low, while beliefs contributing to vaccine hesitancy are notably high. Among the preventive health behaviors surveyed, only eye examinations show a slight upward trend, albeit marginal.

Sexual behavior trends showed mixed results. More teens abstained from sex in 2023 compared to previous survey cycles, and fewer sexually active teens reported having multiple partners—14.6% in 2023, down from 55.1% in 1998. Despite this progress, risky

[ii] Simmonds M, Llewellyn A, Owen CG, Woolacott N. Predicting adult obesity from childhood obesity: a systematic review and meta-analysis. Obes Rev. 2016 Feb;17(2):95-107. doi: 10.1111/obr.12334. Epub 2015 Dec 23. PMID: 26696565.

[7] Fram MS, Nguyen HT, Frongillo EA. Food Insecurity among Adolescent Students from 95 Countries Is Associated with Diet, Behavior, and Health, and Associations Differ by Student Age and Sex. Curr Dev Nutr. 2022 Feb 15;6(3):nzac024. doi: 10.1093/cdn/nzac024. PMID: 35317415; PMCID: PMC8929982.

[8] Fram MS, Nguyen HT, Frongillo EA. Food Insecurity among Adolescent Students from 95 Countries Is Associated with Diet, Behavior, and Health, and Associations Differ by Student Age and Sex. Curr Dev Nutr. 2022 Feb 15;6(3):nzac024. doi: 10.1093/cdn/nzac024. PMID: 35317415; PMCID: PMC8929982.

[9] Hands for Hunger (2019).

[10] CARICOM. Caribbean Food Security & Livelihoods: Regional Summary Report (April 2024).

behaviors are still too common. Among sexually active teens, there was a concerning gap between teens' knowledge of condom benefits (71.6%) and actual condom usage rate (47.7%) during their last sexual encounter. Also at that time, only 6.8% reported using hormonal birth control to prevent pregnancy. Disturbingly, 56.6% of sexually active teens initiated sexual activity by age 13 or younger, with boys more likely than girls to debut early and have multiple sex partners.

The 2025 GSHS paints an unsettling profile of substance use among teens in The Bahamas. The lifetime smoking prevalence of traditional cigarettes stands at 20.3%, and current prevalence is 11%, underscoring the persistent use of traditional tobacco products in Bahamian society. Globally, however, e-cigarette use is outpacing traditional cigarette consumption among teens, a trend that is mirrored in The Bahamas. Although The Bahamas lacks multi-year data on e-cigarette use among teens, the 2023 GSHS introduces new insights into this emerging product. Notably, while traditional cigarette use remains higher among boys compared to girls, the gender gap has narrowed significantly between 2013 and 2023. In contrast, e-cigarette use is more prevalent among girls (17.6%) than boys (16.4%), with an overall prevalence of 17.2%, meaning nearly 2 in 10 Bahamian teens currently use e-cigarettes.

When compared internationally, the prevalence of e-cigarette use among Bahamian teens rivals global prevalences. For instance, the average e-cigarette prevalence is 18.1% in Europe (2021);[11] 17.4% in the United States (2022);[12] and 14.4% in Canada (2022)[13] Within the Caribbean sub-region, e-cigarette use for Bahamian teens is among the highest, equaling those of Trinidad and Tobago (17.2%) and significantly surpassing Antigua and Barbuda (4%), Jamaica (11.7%), and St. Lucia (11%).[14]

Alcohol consumption is widespread, with 73.9% of teens reporting use (excluding religious sacraments) and 33.6% identifying as current alcohol drinkers. Binge drinking and drunkedness are increasing, especially among girls. These statistics are disconcerting, especially given the survey sampling age was 12 to 18 years; and the national legal drinking age is 18 years.[15] There is a higher proportion of girls than boys engaged in the harmful use of alcohol - binge drinking and intoxication.

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Lifetime illegal drug use is also on the rise, with marijuana at 16.6% and non-prescription opioids at 4.9%. Cocaine use rose from 1% in 1998 to 12% in 2023. Altogether, these are worrying trends. Boys are more likely than girls to use illegal substances. Opinions on access to drugs varied, with 29.3% finding it impossible or very difficult, 11.1% fairly difficult, and 16.5% fairly easy or very easy to access. Forty-three (43%) did not know the easy or difficulty of obtaining illegal drugs.

[11] World Health Organization
[12] CDC
[13] University of Waterloo. Tobacco Use in Teens. https://uwaterloo.ca/tobacco-use-canada/e-cigarette-use-canada/prevalence-e-cigarette-use/e-cigarette-prevalence-age
[14] CDC GTSS Database
[15] Licenses (Liquor and Outdoor Entertainment) Regulations (1998).

Several factors contribute to the perpetuation of violence within societies. Witnessing violence is one of those factors. In 2023, 32.8% of teens reported experiencing or witnessing violence at home, a notable increase from 25% in 1998. Additionally, nearly 30% of teens reported being involved in physical fights, while 27% were physically attacked in the past year. The prevalence of teens carrying weapons climbed from 12.6% (1998) to 18.2% (2023), a 44% increase. Furthermore, almost 8% of teens admit to being a current gang member.

Bullying continues to be a lived experience for far too many teens. Over 1 in 3 teens (38%) report being bullied either on or off school premises, and 15.7% report being cyberbullied. Unacceptably, almost 10% of Bahamian teens have been forced to have sex. An additional 9.6% have been sexually exploited. While more girls are forced to have sex, more boys experience sexual exploitation and, in the relationship context, emotional abuse.

According to the World Health Organization (WHO), suicide ranks among the top three leading causes of death among teens globally and in the LAC region. Overall, the mental health of teens in The Bahamas continues to worsen, with close to 30% of teens always or most times feeling depressed and hopeless, compared to 19.9% in 1998. In addition, teens who always or most times feel lonely have more than doubled, reaching 25.6%. The proportion of teens unable to sleep due to excessive worrying increased from 14.1% in 2013 to 19.6% in 2023.

The proportion of teens seriously contemplating suicide has risen significantly, nearly quadrupling from 6.6% in 1998 to 25.2% in 2023. Currently, 23.1% of Bahamian teens have formulated a suicide plan, and 19.5% have attempted suicide. To put this into perspective, in a typical classroom of 35 students, approximately 9 students have seriously considered suicide, 8 students have created a plan, and 7 students have made a suicide attempt. Self-harm behaviours, without the intent to die, have also surged - almost tripling from 9.5% in 1998 to 26.7% in 2023. Girls are disproportionately affected by suicidality and self-harm behaviours relative to their male counterparts. These troubling trends highlight an urgent need for targeted and gender-sensitive mental health interventions for Bahamian teens, with particular attention to the higher vulnerability among girls.

The data highlights the interconnected nature of bullying, loneliness, worry, and mental health outcomes, with loneliness and worry contributing to, but not solely determining, harmful behaviors.

Although 61.3% of teens know where to access professional mental health help, only 23.4% feel they have someone to confide in about their personal worries and problems. And, 58.4% rarely or never talk to anyone about their challenges, indicating a critical gap between awareness of resources and availability of trusted, accessible support systems. Bridging the gap between professional resources and personal support will be essential to building resilience and improving mental health outcomes for

Bahamian adolescents.

While 60.3% of teens live in a home with their father or a father figure—a term encompassing relatives or parental partners/friends who take on a paternal role—many teens, in increasing proportions, still feel unheard (60.4%) and misunderstood (72.4%) by their parents or guardians. These feelings are more frequently reported by girls than boys.

Parental involvement in academic activities, particularly homework monitoring, has appreciably declined over the years. In 1998, 78.2% of Bahamian teens reported that their parents regularly checked their homework, while only 21.4% said their parents rarely or never did so. By 2023, the percentage of parents routinely monitoring homework had plummeted to 30.5%, with 50.2% of teens indicating their parents rarely or never paid attention to their homework. This decline is more pronounced among girls and becomes increasingly common as teens progress to higher grade levels.

Additionally, 37.2% of teens state that their parents or guardians never or rarely knew what they were doing during their free time. These findings may allude to a widening disconnect between teens and their caregivers.

Across nearly all measures/variables — unhealthy diets, substance use (excluding illegal drugs), bullying, witnessing violence at home, and mental health struggles, as well as suicidal thoughts and behaviors — Bahamian girls face disproportionate burdens, experiencing greater negative impacts. Research by Dr. David Allen concludes that high academic performance is not a sufficient protective factor to mitigate risky behaviour; as supported by students with high GPAs can still exhibit elevated levels of depression and PTSD. This is corroborated by the GSHS findings, which reveal that while girls tend to have higher GPAs, they also report higher incidences of these adverse experiences and behaviors. This deserves a pause.

Adverse Childhood Experiences (ACEs) are well documented as significant risk factors for a wide range of negative outcomes across the lifespan. These outcomes relate to physical health issues, mental health disorders, behavioural issues, lower educational attainment, exposure to violence and intergenerational transmission of violence - among others. While the GSHS is not a formal instrument for measuring ACEs, The Bahamas' adaptation of the survey did incorporate questions addressing key ACE-related factors such as experiences of violence, sexual abuse, lack of parental support, household drug use, hunger, and more.

Research consistently shows a dose-response relationship between ACEs and negative outcomes. Meaning, that as the number of ACEs increases the likelihood of experiencing negative outcomes also rises. Of the ACEs explored in the GSHS, 93.9% of teens in The Bahamas had 1 ACE, 52.3% had 2 ACEs and 13.5% had 3 or more ACEs. These adverse experiences were more prevalent among girls than boys.

KEY POLICY DIRECTIONS

The findings emanating from the GSHS survey warrant urgency and a renewed call to action to safeguard the health and well-being of teens in The Bahamas.

To this end, 64 priority policy directions along 10 broad policy areas are presented for consideration.

While the 10 broad areas are summarized in the graphic below, a more full discussion on these (along with accompanying specific policy directions) are located on page 52 of this Report.

HOW IS THE REPORT ORGANIZED

This report is organized into eight chapters or focus areas:

1. **Academic performance**
2. **Chronic Disease Risks**
3. **Sexual Behaviours**
4. **Substance Use**
5. **Experiencing Violence**
6. **Mental Health & Suicidality**
7. **Support Systems**
8. **Parental Monitoring & Support**

Each chapter provides the most current data for Bahamian teens overall and described by sex, age and grade level. Weighted statistics are presented. Trend data for variables are provided (when available). The trends included in this report are categorized as:

green
(moving in the right direction)

yellow
(no change),

red
(moving in the wrong direction

gray
no multi-year data

For variables with percentage changes less than or equal to one, a no change status will be designated. The baseline year is the earliest year for which data is available. The baseline year will serve as the reference year for directionality. Percentages reflected in the tables are rounded to the nearest whole number.

While the green categories show where teens are being supported to improve their behaviours or reduce their negative experiences, the red and yellow categories show where teens may not be receiving sufficient support from adults, their communities and society at large.

TECHNICAL NOTES

This section describes the methodology for the GSHS Bahamas. Oversight for the planning, coordination, execution of and reporting on the Bahamas' Global School Health Survey (GSHS) resided within the MoHW, led by a Project Coordinator and supported by a Coordinating Committee. The project life extended over 4 phases – conceptual, questionnaire adaptation, fieldwork, and data analysis and reporting.

Sample Selection

A scientific two-stage sample methodology, the common school-based methodology, was used. In the first stage, schools are selected with probability proportional to the number of students in the grades/sections/levels/forms that students aged 13-17 years are most likely to attend. This means that schools with many students aged 13-17 years are more likely to be selected to participate than schools with fewer students aged 13-17 years. The sample was implicitly stratified by school control (public/private) and school level and was drawn from the sampling frame provided and using the sampling parameters approved by the country.

In the second stage, classes were selected randomly among all eligible classes. This means all students in the school had an equal probability of selection, since they were all eligible to be selected, but only eligible once.

A scientifically selected sample such as this one ensures representative results that can be generalized to all students 13-17 in The Bahamas.

Sample Description

Island Level – Eight (8) islands were identified for the sample. These were Abaco, Andros, Berry Island, Eleuthera, Exuma, Grand Bahama, Inagua and New Providence.

School Level – All schools containing Grade 8 - Grade 12 were included in the sampling frame. 36 schools, including public and private, were sampled with probability proportional to enrollment. There may be some schools in the country's enrollment list with very few eligible students. In order to maximize survey efficiency and school

Class Level – Within the selected schools, classes are randomly chosen to participat

	Responsible
Sampling frame	Country
School selection	WHO
Class selection	Country

Weighting

A weight has been associated with each questionnaire to reflect the likelihood of sampling each student and to reduce bias by compensating for differing patterns of non-response. The weight used for estimation is given by:

$W = W1 * W2 * f1 * f2 * f3$

W1=the inverse of the probability of selecting the school;

W2=the inverse of the probability of selecting the classroom within the school;

f1=a school-level nonresponse adjustment factor calculated by school size category (small, medium, large). The factor was calculated in terms of school enrollment instead of number of schools.

f2=a student-level nonresponse adjustment factor calculated by class.

f3=a poststratification adjustment factor calculated by grade.

The weighted results can be used to make important inferences about the priority health risk behaviours and protective factors of all students in Grade 8 - Grade 12 in The Bahamas.

BMI Calculation[16]
BMI classification for adults is different for the BMI classification for adolescents.

The accepted definitions for each weight category follows:

- Underweight: BMI ⩽ 2 standard deviations below the median for BMI by age and sex.
- Overweight: BMI ⩾ 1 standard deviation above the median.
- Obesity: BMI ⩾ 2 standard deviations above the median.

BMI for adolescents is calculated and categorized according to these standard WHO indicators.

Data Analysis
The primary analysis of the data was conducted by the World Health Organization (WHO) to generate basic frequencies. Secondary analysis was subsequently conducted on weighted data by the Ministry of Health & Wellness (MoHW) utilizing statistical software tools such as EPI Info and SPSS to examine composite frequencies, associations and correlations.

T-tests were used to determine pairwise differences between sub-populations. Differences between prevalence estimates are considered statistically significant if the t-test p-value was <0.05.

To identify temporal trends in behaviours from 1998 to 2023, only variables assessed with identically worded questions were examined.

Data Analysis
The primary analysis of the data was conducted by the World Health Organization (WHO) to generate basic frequencies. Secondary analysis was subsequently conducted on weighted data by the Ministry of Health & Wellness (MoHW) utilizing statistical software tools such as EPI Info and SPSS to examine composite frequencies, associations and correlations. T-tests were used to determine pairwise differences between sub-populations. Differences between prevalence estimates are considered statistically significant if the t-test p-value was <0.05.

To identify temporal trends in behaviours from 1998 to 2023, only variables assessed with identically worded questions were examined.

Notes on Survey Cycles
For the 1998 survey, 2,007 students between the ages of 11 to 19 years, in Grades 7 - 11 and across 7 islands participated.

For the 2013 survey, 1,357 students between the ages of 13 to 15 years, in Grades 8 - 10, and across 6 islands participated.

For the 2023 survey, 2,213 students between the ages of 12 to 18 years, in Grades 8 - 12, and across 8 islands participated.

[16] For references see https://www.who.int/publications/m/item/noncommunicable-diseases-global-monitoring-framework-indicator-definitions-and-specifications and https://www.who.int/tools/growth-reference-data-for-5to19-years

RESPONSE RATES

Response rates have been calculated for two sampling levels, as well as the overall response rate.

Overall Resposne Rate

Schools: A total of 97.2% of schools participated in the survey, with 35 out of the 36 sampled schools completing the study.

Students: The student response rate was 82.2%, with 2,213 out of 2,692 sampled students completing the questionnaires. After data editing, 2,211 questionnaires were deemed usable.

Overall Response Rate: The combined response rate was 79.9% (calculated as 97.2% × 82.2%). Response rates exceeding 65% are considered sufficient to generalize findings to the entire population under study.

08
Islands
Abaco, Andros, Berry, Eleuthera, Exuma, Inagua, G.B., and N.P.

35
Public and private schools

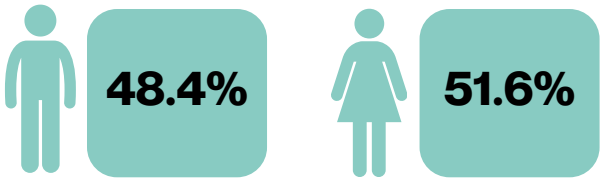
190
Individual Classes

2,213
Public and private students

THE DEMOGRAPHICS

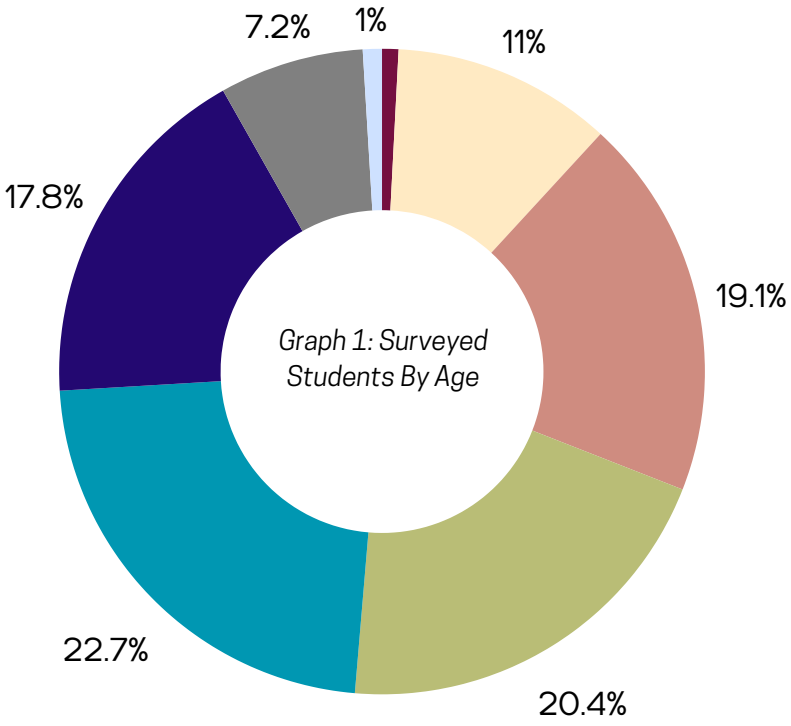
The sample size comprised over 2,000 students in the Bahamian school systems, with a sex, age and grade disaggregation as follows:

Sex Disaggregation



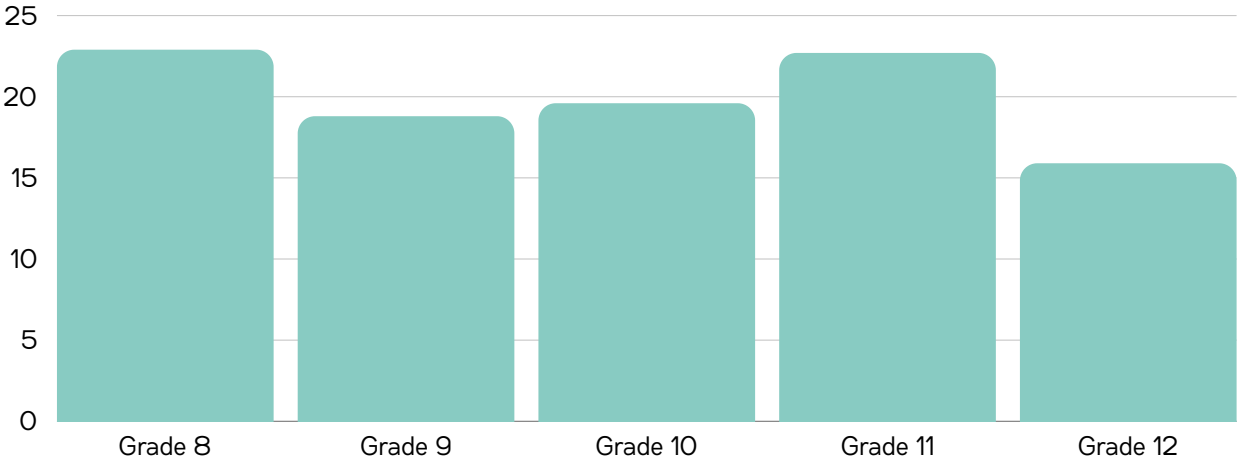
Age Disaggregation

The majority of teens (90.6%) participating were between ages 13- 17 years.



Graph 1: Surveyed Students By Age

Grade Disaggregation



Graph 2: Surveyed Students By Grade

2025

FOCUS AREA 1

ACADEMIC PERFORMANCE

RISK PROFILE

Academic Performance

F;or the purposes of this report, academic performance is categorized as follows:

- below average is defined as GPA less than 2.00,
- average is defined as GPA between 2.00 and 2.99, and
- above average is defined as GPA of 3.00 or higher.

Based on self-reported recall of the most recent report card, the largest proportion of teens (45.2%) identified as having average academic performance. This is compared to 31.6% reporting above-average performance and 12.6% reporting below-average performance. National trends in BJC and BGCSE performance, however, suggest a potential mismatch between students' self-perceptions and actual academic outcomes, given that 51% of national examinations receive grades of D or lower;[16a] and a little over 50% of 12th graders leave school with a high school diploma.

When analyzed by sex, 58.7% of girls reported achieving above-average academic performance, compared to 41.3% of boys. This difference is statistically significant (χ^2, $p<0.001$). However, no statistically significant relationship was found between achieving a GPA of 3.00 or higher and whether parents or guardians monitored homework completion.

A significant association was identified between academic performance (GPA) and marijuana use (χ^2, $p=0.006$). However, no significant relationship was observed between GPA and parental monitoring, alcohol use, or depression.

[16a] MoETvT National Examination Data.

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FOCUS AREA 2

CHRONIC DISEASE

RISK PROFILE

Chronic Disease Risk Behaviours

Diet, food security and physical activity play pivotal roles in shaping mental health, chronic disease risk, and overall well-being, both in the short and long term.[17,18] Research highlights that adolescents often adopt poor dietary habits, including high consumption of ultra-processed foods, inadequate intake of fruits and vegetables, and irregular meal patterns.[19] The widespread use of technology and social media, combined with a decline in structured physical activity, has further entrenched sedentary lifestyles.[20] Together, these factors have led to a sharp decline in physical activity levels among teens, posing significant risks to their health and development.

The Percentage[21] of Teens in The Bahamas Who:	**1998 (Total)**	**2013 (Total)**	**2023 (Total)**	**Trend**
Are underweight	-	3	2	
Are overweight (includes obesity)	17	45	40	
Are obese (subset of overweight)	7	21	21	
Are food insecure	44	-	31	
Meet the RDI for fruits (3 or more per day)	-	14	6	
Meet the RDI for vegetables (2 or more per day)	-	31	10	
Drink sodas (carbonated drinks)	28	69	81	
Drink non-carbonated drinks/SSBs	44	-	83	
Achieve sufficient physical activity	36	15	17	
Live sedentary lifestyles	-	55	72	
Had a hearing test in the last 3 years	45	-	31	
Had their eye tested in the last 2 years	44	-	47	
Had a routine dental check-up in the last 2 years	42	-	42	

Table 1: Modifiable Risk Trends

Body Weight Status

Less than three percent (2.3%) of teens are underweight. By contrast, 40.4% of teens are overweight (boys, 37.5%; girls, 43.1%). Twenty-one percent (21.1%) of overweight teens are obese (boys, 18.9%; girls, 23.1%). This means that more than half of overweight teens fall within the obese category. The overweight prevalence dropped for boys by 4.5% and for girls by 4% since the 2013 survey. But, the sex disaggregated obesity prevalence has remained relatively unchanged between 2013 and 2023.

There is a statistically significant relationship between obese teens and adequate physical activity, with obese teens being less likely to achieve adequate physical activity during any given week ($\chi 2$ $p<0.001$). The strength of the relationship is weak, pointing to factors like diet and diet quality likely being more prominent actors in body weight status among Bahamian teens.

What Are Teens Eating?

Food insecurity among teens has declined over the last 25 years in The Bahamas. In 1998, 43.7% of teens sometimes or always went hungry because of insufficient food in the home, compared to 30.8% in 2023. Though trending down, food insecurity in this demographic is higher than the national average of 25% and the global average for adolescent food insecurity (27.5%).

In 2023, 40.6% of teens rarely or never ate breakfast (boys, 35.3%; girls, 45.7%). The prevalence of skipping breakfast among teens increases with age and is higher among girls across all age groups.

Table 2: Breakfast Eating Patterns, By Sex

Rarely or Never Eat Breakfast	11 - 12 year old	13 - 14 year old	15 - 16 year old	17+
Boys	29.2%	31.2%	38.7%	39.4%
Girls	31.6%	42.6%	50.2%	51.4%

There is a significant association ($\chi 2$ $p<0.001$) between breakfast patterns and unhealthy weight status. That is, 44.7% of teens who rarely or never eat breakfast were overweight. Compared to 37.4% who did eat breakfast.

The recommended daily intake (RDI) of fruit is at least 3 servings daily. When asked to recall their diets in the last week, 31.5% of teens report not having eaten any fruit in those 7-days. Of those that ate fruits, an overwhelming majority (80.9%) eat less than one serving daily; and only 5.7% met the RDI. The recommended daily intake (RDI) of vegetables is at least 2 servings daily. When asked to recall their diets in the last week, 29.6% of teens report not having eaten any vegetables. Of those that ate vegetables, 10.3% met the RDI.

Salt, fat and sugar are considered health-harming when consumed in excess. Eating salty, fatty and sugary foods is commonplace among Bahamian teens.

[17] Institute for Health Metrics and Evaluation (IHME). (2020). Global Burden of Disease Study 2019 Results.
[18] UNICEF. (2019). The State of the World's Children 2019: Children, Food, and Nutrition. New York: UNICEF.
[19] Monteiro, C. A., et al. (2019). Ultra-Processed Foods: Contributions to Obesity and NCD Risk. Public Health Nutrition, 22(1), 176-185.
[20] Aubert, S., et al. (2021). Global Trends in Adolescent Physical Activity Levels. The Lancet Child & Adolescent Health, 5(6), 398-411.
[21] Percentages are rounded to the nearest whole number.

As a composite indicator, 36.4% of Bahamian teens consume foods high in either sugar, salt, or fat two or more times per day.

Compared to 4.3% of teens who consume foods high in sugar, salt and fat two or more times per day. A statistically significant association exists between high body mass indices (BMIs) and frequent consumption of sugary foods. Among teens who consume sugary foods at least twice per day, 33.1% are classified as overweight (χ^2 p=0.005), and 16.6% are classified as obese (χ^2 p=0.043).

What Are Teens Drinking?

The survey examined the consumption of sugar-sweetened beverages (SSBs), including sodas and non-carbonated soft drinks, revealing a high prevalence of SSB consumption among teens in The Bahamas.

Specifically, 80.8% drink sodas, while 83.2% consume non-carbonated soft drinks and juices. In terms of frequency, 15.7% of teens consume at least two sodas daily, and 27.7% have at least two non-carbonated soft drinks or juices per day.

Conversely, fewer than two in ten teens (18.3%) meet the recommended daily water intake. While 26.7% drink between 6 to 8 cups of water daily, the majority (55.1%) consume five cups or less.

A statistically significant association exists between sugary beverage consumption and the intake of sugary, salty, and fatty foods. Specifically, 40.3% of teens who drink sugary beverages also consume sugary foods at least once per day (χ^2 p<0.001), while 49.2% and 43.6% of teens who consume sugary beverages also eat salty and fatty foods, respectively (χ^2 p<0.001). This relationship holds true across all frequencies of sugary beverage consumption.

Interestingly, the data supports the idea that healthier dietary behaviours are often practiced together. Teens who avoid sugary beverages are also less

	Eaten on some but not all days of the week	Eaten two or more times every day of the week
SALTY FOODS/SNACK (chips, hot dogs, hot patties, ramen noodles)	67.6%	23.2%
FATTY FOODS/SNACKS (fried foods, hamburgers, ice-cream)	72.8%	17.4%
SUGARY FOODS/SNACKS (pastries, chocolate bars, cookies, sugary cereals)	74.7%	14.8%

Table 3: Proportional Consumption of Unhealthy Foods

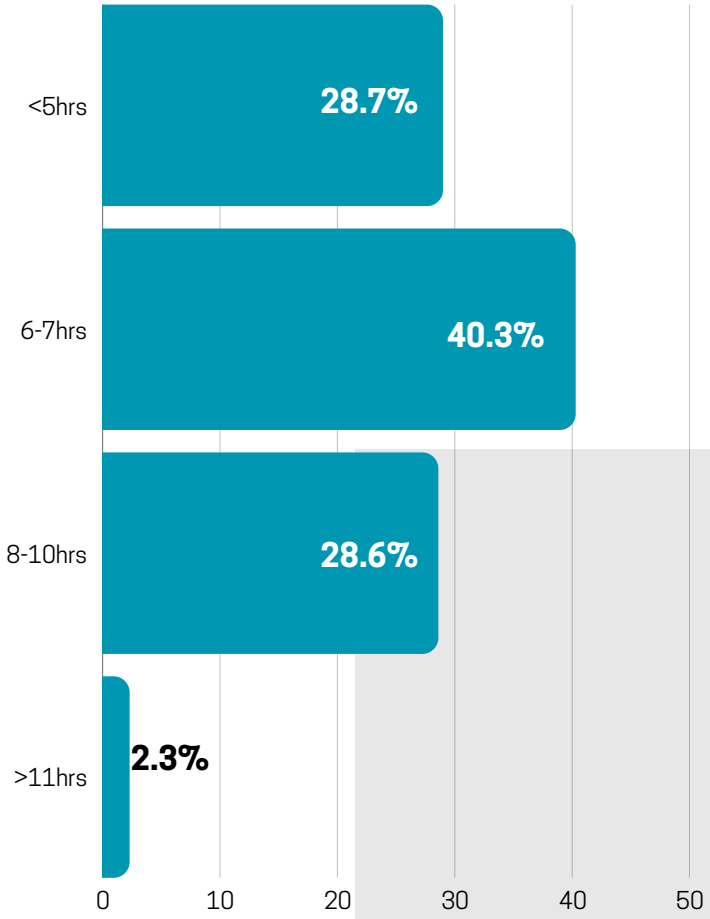
likely to consume foods high in fat (33.9%), salt (21.6%), or sugar (46.5%). These associations are statistically significant (χ^2 $p<0.001$). Further analysis reveals that as the frequency of sugary food consumption increases, so does the likelihood of sugary beverage consumption. Among teens who eat sugary foods four or more times a day, 58.3% also consume sugary beverages, compared to those with lower sugary food intake. This highlights a strong positive relationship between the frequency of sugary food consumption and SSB consumption, suggesting that higher intake of sugary foods is strongly linked to increased consumption of sugary beverages.

Physical Activity and Sleep Pattern Among Teens

A concerning 83.3% of Bahamian teens are not meeting the recommended levels of physical activity. Gender disparities are evident, with a higher percentage of girls reporting insufficient physical activity compared to boys (81.4% of boys and 84.7% of girls). This is slightly higher than the 80% of adolescents across the region who are physically inactive.

Over one-quarter (27.6%) of teens spend 3 to 4 hours daily engaged in sedentary activities, excluding time spent at school, doing homework, or sleeping. Additionally, 44.5% of teens spend 5 or more hours per day in sedentary activities such as watching TV, playing video games, using phones, listening to music, or socializing. Girls are more likely to be sedentary than boys, with 77.3% of girls (95% CI: 73.7 – 80.5) versus 66.7% of boys (95% CI: 63.3 – 69.9) reporting high levels of inactivity. This gender difference is statistically significant. The American Academy of Paediatrics recommends 8 to 10 hours of sleep per night for teens. However, in The Bahamas, only 28.6% of teens are getting the recommended amount of sleep on an average school night.

Graph 3: Amount of Nightly Sleep Among Teens



Preventative Health Checks and Vaccine Perception

The 2023 GSHS highlights gaps in preventive health care within recommended timeframes. It also highlighted gaps in attitudes toward

vaccines among teens. 69% of teens have not had a hearing test in the last 3 years, with negligible difference between boys (68.7%) and girls (69.1%). Over half (52.8%) of teens have not had an eye examination in the last 2 years, with boys (56.5%) being less likely than girls (49.4%) to have had one. A significant proportion (57.8%) of teens have not had a regular dental check-up in the last 2 years. Girls (60%) are slightly less likely than boys (55.6%) to have done so. Alarmingly, 90% of teens have not received the HPV vaccine, with similar rates for boys (89.4%) and girls (90.7%). Only 38.7% of teens believe vaccines are very important to health, with more girls (41.6%) valuing vaccines compared to boys (35.7%). Gender differences are evident in eye exams, dental check-ups, and vaccine attitudes. The low HPV vaccination rates may be indicative of a broader issue of vaccine hesitancy. The findings also show limited value placed on vaccines among teens—especially boys. Both these observations pose consequential challenges to public health initiatives.

2025

FOCUS AREA 3

SEXUAL HEALTH

RISK PROFILE

Sexual Health Behaviours

Adolescence is a critical period of sexual development, where individuals explore independence, relationships and emotions. Early sexual debut (before age 14) is linked to unsafe sexual practices, increasing risks of STIs, unwanted pregnancies, substance use, and psychological distress. Frequent bullying victimization further raises the odds of early sexual initiation and risky behaviours.[23] Unsafe sex practices increase the risk of contracting and transmitting a sexually transmitted infection (STI). Globally, an estimated 1 million sexually transmitted infections (STIs) are acquired every day by young people, making this age group particularly vulnerable to sexual health risks. In addition, adolescent fertility rates (teen pregnancy) remain high. In The Bahamas, teen pregnancy rate has decreased since 2010 to 25.1% (2022). The rate in 2022 was higher than the average rate (11.2%) in its income group, but lower than the LAC average rate (52.2%).[24]

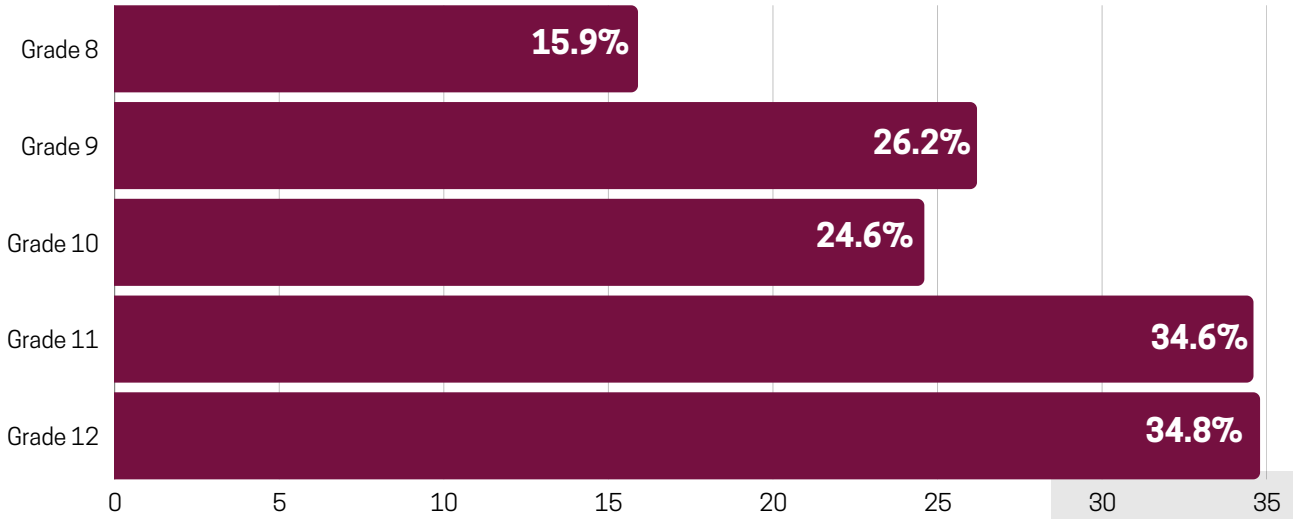
The Percentage of Teens in The Bahamas Who:	1998 (Total)	2013 (Total)	2023 (Total)	Trend
Ever had sex	41	28	28	
Sexually active by age 13 or younger	70	82	57	
Multiple lifetime sexual partners (2 or more)	55	13	15	
Used a condom during last sexual intercourse	73	59	48	
Used effective hormonal birth control	9	-	2	
Were ever diagnosed with an STI	-	-	6	

Table 4: Trends in Sexual Risk Behaviours

[23] Smith L, Grabovac I, Jacob L, López-Sánchez GF, Yang L, Shin JI, Sohn M, Ward PB, McDermott DT, Koyanagi A. Bullying Victimization and Sexual Behavior Among Adolescents Aged 12-15 Years From 53 Countries: A Global Perspective. J Sex Med. 2020 Nov;17(11):2148-2155. doi: 10.1016/j.jsxm.2020.08.007. Epub 2020 Sep 4. PMID: 32896502.
[24] https://genderdata.worldbank.org/en/economies/bahamas-the#:~:text=25%20of%20every%201%2C000%20girls,rate%20in%20its%20income%20group.

Overall, 28.2% of teens in The Bahamas have had sexual intercourse. There was a statistically significant difference between boys 37.7% (95% CI: 32.3 – 43.5), and girls 19.5% (95% CI: 16.2 – 23.3). The percentages of teens who have had sex at least once by grade are reflected in Graph 2.

Graph 4: Proportion of Sexually Debuted Teens By Grade Level



Notably, over half (56.6%) of sexually active teens in The Bahamas reported sexual debut by age 13 or younger, with 7.5% having had their first sexual experience at age 11 or younger. A significant gender gap of nearly 20 percentage points was observed, with 63.8% of boys and 42.1% of girls reporting early sexual debut, indicating that girls tend to delay sexual debut compared to boys. Among sexually debuted teens, the most common reason cited for their first sexual experience was "being in love or carried away by feelings" (12.8%). Not all sexual debut was consensual, 2.1% indicated their sexual debut was was the result of being forced. No association was found between the absence of a father or father figure and early sexual debut ($\chi 2$: 1.29; p=0.256).

Nearly 15% (14.6%) of sexually active teens report having had two or more sexual partners. This behaviour is nearly four times more common among boys (22.3%) than girls (6.3%), a statistically significant difference (boys: 95% CI: 18.8 – 27.3; girls: 95% CI: 4.8 – 8.3). An association was found between having multiple sexual partners and drug use ($\chi 2$ $p<0.001$), though no significant link was identified between multiple sexual partners and alcohol use ($\chi 2$ p=0.078).

While 71.6% of all teens (both sexually active and inactive) believe that condom use helps protect against HIV and other STIs, only 47.7% of sexually active teens used condoms during their most recent sexual encounter.

Additionally, just 1.8% of these teens used hormonal birth control to prevent pregnancy the last time they had sex. The top three methods of contraception reported by sexually active teens were condoms (9%), no method (8.3%), and the withdrawal method (3%).

Among sexually active teens, 5.6% admitted to being diagnosed with an STI.

2025

FOCUS AREA 4

SUBSTANCE USE

RISK PROFILE

Substance Use Behaviours

Substance use and abuse poses dangers to adolescent health. Alcohol is the most commonly used substance among adolescents, largely due to its accessibility. Early onset of alcohol use disrupts brain development, impairing memory, cognitive abilities, and decision-making.[25] Adolescent drinking is critical to address, as habits formed during this period often persist into adulthood, increasing risks of addiction and substance abuse (S.E. Nelson, 2015). The propensity for risky behaviours, specifically substance use, tends to rise during adolescence due to a combination of factors such as accessibility, curiosity and peer pressure.[26]

The Percentage of Teens in The Bahamas Who:	1998 (Total)	2013 (Total)	2023 (Total)	Trend
Ever smoked traditional cigarettes	7	17	20	
Currently smoke traditional cigarettes [27]	5	4	3	
Currently use e-cigarettes	-	-	17	
Have been exposed to secondhand smoke	-	48	46	
Ever drank alcohol (not communion/sacrament)	32	60	74	
Currently drink alcohol	-	-	34	
Ever binged drinked	2	-	12	
Drank so much alcohol and got drunk	-	21	27	
Ever used marijuana	8	10	17	
Ever used uppers, ecstasy or other NM-opioids[28]	-	4	5	
Ever used cocaine	1	-	12	

Table 5: Trends in Substance Use

[25] Tapert, S. Alcohol and the Adolescent Brain: What We've Learned and Where the Data Are Taking Us. Alcohol Research Current Reviews 42(1). 2022. DOI:10.35946/arcr.v42.1.07

[26] Nawi, A. M., Ismail, R., Ibrahim, F., Hassan, M. R., Manaf, M. R. A., Amit, N., Ibrahim, N., & Shafurdin, N. S. (2021). Risk and protective factors of drug abuse among adolescents: a systematic review. BMC Public Health, 21(1). https://doi.org/10.1186/s12889-021-11906-2.

[27] These data points were obtained from the Bahamas' GYTS datasets for 2004, 2013, and 2023.

[28] NM is abbreviation for non-medical

Cigarette Use and Secondhand Smoke Exposure

20.3% of Bahamian teens have smoked traditional cigarettes, with a higher prevalence among boys (22%) compared to girls (18.6%). Among those who have smoked, 74.5% initiated before the age of 14. Electronic cigarette use has become increasingly popular worldwide, and in The Bahamas, 17.2% of teens currently use e-cigarettes, with more girls (17.6%) than boys (16.4%) engaging in this behavior. In contrast, boys outnumber girls when it comes to smoking traditional cigarettes. Secondhand smoke has been definitively established as a harm to health. Of all teens, 46.4% reported being exposed to secondhand smoke from others who were smoking nearby. For more detailed information on tobacco use among Bahamian teens, refer to The Bahamas' Global Youth Tobacco Factsheet (2023).

Alcohol Use

Alcohol consumption is prevalent among Bahamian teens, with 73.9% reporting having consumed alcohol at least once in their lifetime, excluding sips for religious purposes, and most did so before the age of 14. Currently, 33.6% of teens are active drinkers, with girls (35.4%) reporting higher rates than boys (30.9%). Age-related differences are significant, with the 16–17 age group showing a higher prevalence (43%; 95% CI: 37.4–48.8) compared to the 13–15 age group (30.2%; 95% CI: 27.6–32.9).

Regarding frequency, 34.9% of teen drinkers consume two or more alcoholic beverages daily, a pattern more common among girls (36.3%) than boys (32.5%). While no significant associations were found between alcohol consumption and sugary beverages, sugary foods, or fatty foods, a notable link was found between current alcohol use and the consumption of salty foods at least twice weekly ($p=0.017$).

Despite 75% of teens recognizing that excessive alcohol consumption is harmful to health, 12.3% of teen drinkers (boys: 11.3%; girls: 12.2%) reported binge drinking—defined as consuming six or more alcoholic drinks in one sitting. Binge drinking prevalence increased with grade level, though this trend was not statistically significant. Alarmingly, 26.7% of teens reported instances of drinking to the point of intoxication, with girls (29.4%) engaging in this behavior more than boys (23.2%).

Alcohol consumption is linked to negative consequences. Among current drinkers, 22.3% reported getting into trouble at home, school, or work, or engaging in fights due to their drinking, with boys (23.2%) being more affected than girls (20.2%). Teens reported that friends (12.4%), family (10.3%), and store/street vendors (5.2%) were their primary sources of alcohol.

Although the minimum drinking age in The Bahamas is 18 years, 75.7% of teens who drink alcohol were never asked to show identification of proof of age when they sought to purchase alcohol. Notably, girls are less likely than boys to be asked for verification. This gives insight into strategies teens may use to purchase alcohol; aa well as insights into a potential biased enforcement of the law.

Illicit Drugs

Drug use among Bahamian teens is of concern, with 21.8% admitting to having used drugs at some point in their lives. Alarmingly, 54.8% of these teens reported their first drug use occurred at age 13 or younger. The lifetime prevalence of marijuana use is 16.6%, while 10.5% report current use. Boys are more likely to smoke marijuana than girls, with 12% of boys reporting current use compared to 8.1% of girls. The disparity between lifetime and current use suggests that boys are more likely than girls to continue using marijuana after initiation (lifetime use: boys 17.3%, girls 15.3%; current use: boys 12%, girls 8.1%). Despite its usage, 71% of teens believe recreational marijuana use is moderately or very harmful to the body.

The lifetime prevalence of non-medical opioid use (e.g., "uppers" or ecstasy) among teens is 4.9%, with boys (5.3%) using slightly more than girls (3.7%). Cocaine use shows a lifetime prevalence of 12%, with higher rates among boys (13.6%) compared to girls (10.5%).

In terms of being under the influence at school, 13.1% of teens admitted to attending school under the influence of either drugs or alcohol. Interestingly, this behaviour is similarly prevalent among boys (12.9%) and girls (12.6%).

Access to illegal drugs is another concern, with 16.5% of teens reporting that obtaining illegal drugs is either fairly easy or very easy. However, the survey did not explore the specific access modalities. Drug use within the home is also prevalent, with 13.9% of teens indicating they live with someone who uses illegal drugs. This exposure is slightly higher among boys (14.7%) than girls (12.7%).

2025

FOCUS AREA 5

VIOLENCE & INJURY

RISK PROFILE

Injury and Violence

Violence comes in many forms - abuse (physical, emotional and sexual), abandonment and neglect, often observed in the home but also in school settings. A regional UNICEF report (2022) informs that from the age of one, children in Latin America and the Caribbean are at risk of violence at home, in school and on the streets. Due to the rise of technology, cyber-bullying adds to the violence menu and is as equally concerning as the other forms of violence, as it can predispose to other harmful behaviours.

The Percentage [29] of Teens in The Bahamas Who:	**1998 (Total)**	**2013 (Total)**	**2023 (Total)**	**Trend**
Had been in a fight at least once in the last year	14	40	30	
Were physically attacked in the last year	-	30	27	
Were seriously injured in the last year	10	45	50	
Were bullied on and/or off school grounds	-	24	38	
Were cyberbullied	-	-	16	
Carried a weapon recently (last 30 days)	13	-	18	
Are currently in a gang	5	11	8	
Witnessed or experienced violence in the home	25	-	33	
Were ever forced to have sex	8	11	10	
Were ever sexually exploited (among sexually active teens)	-	-	22	

Table 6: Trends in Violence and Injury

[29] Percentages are rounded to the nearest whole number.

Violence and Physical Fights
Physical injuries, including severe traumas such as stabbings and broken bones, are alarmingly common among Bahamian teens. In the 12 months preceding the 2023 GSHS survey, 50.1% of teens reported being seriously injured at least once, with boys outnumbering girls by a ratio of 4 to 1. Among these, 18.6% sustained serious injuries two or three times, while 13.9% were injured four or more times within the same period.

In total, 27% of teens experienced a physical attack in the past year. Boys (31.7%) were more likely than girls (21.7%) to report such incidents, with a male-to-female ratio of 1.5 to 1. Additionally, 29.9% of teens admitted to being involved in a physical fight at least once during the same period, with boys (37.2%) again outpacing girls (22.2%). Among those who fought, 16.6% reported engaging in fights on two or more occasions. Notably, there is a strong association between involvement in physical fights and weapon carrying ($\chi^2 = 178.88$; $p<0.001$).

Weapons and Gang Membership
Weapon carrying is a growing practice, with 18.2% of teens reporting carrying weapons, a behavior significantly more common among boys (26.8%) than girls (9.5%). Furthermore, 7.7% of teens admitted to being gang members, with boys (10.2%) being twice as likely as girls (5.2%) to belong to a gang—a difference that is statistically significant. There is a statistically significant, weak positive relationship ($p<0.01$; $r=0.261$) between gang membership and weapon carrying.

This suggests that teens who are members of a gang are somewhat more likely to carry weapons compared to non-members. This relationship, while not strong, is in line with broader research on gang affiliation and behaviours involving weapons.

These findings underscore the urgent need for targeted interventions to address violence, injury prevention, and gang-related behaviors among Bahamian teens.

Domestic Violence Exposure
A concerning 32.8% of teens have either witnessed or experienced violence in their homes, with this exposure increasing with age and grade level, albeit not reaching statistical significance. However, the difference between sexes is statistically significant, with girls (36.3%) more likely than boys (28.7%) to report such experiences. Witnessing violence at home is strongly associated with engaging in physical fights ($\chi^2 = 12.82$; $p<0.001$).

Sexual Abuse
Sexual abuse generally tends to be underreported. TNearly 10% (9.9%) of Bahamian teens reported being forced to have sex at some point in their lives, with girls nearly twice as likely to experience sexual violence compared to boys (6.6% for boys; 12.9% for girls). Among survivors of sexual abuse, 17.4% were in Junior High (grades 8 and 9), while 31.1% were in Senior High (grades 10 to 12). From an age perspective, those ages16 and 17 (for both boys and girls) reported the highest prevalence.

Sexual Exploitation
Among sexually active teens, 21.8%

admitted to being sexually exploited during their lifetime. This exploitation involved receiving money, a place to stay, food, clothing, shoes, jewelry, bags, or other valuables in exchange for sex. Notably, boys were more likely than girls to experience such exploitation (24% for boys; 19.3% for girls). There is a statistically significant association between early sexual debut and sexual exploitation ($\chi^2 = 6.80$; $p = 0.009$), highlighting the vulnerability of teens who engage in early sexual activity.

Emotional Abuse in Relationships

Bahamian teens are also at risk for emotional abuse in romantic relationships. Approximately 66.5% of teens reported having dated or been in a relationship. Among these, 38.6% experienced controlling or emotionally harmful behaviors from their partner. Boys were slightly more likely to report this experience than girls (40% vs. 36.3%), with no significant differences across age groups.

Bullying

Bahamian teens face bullying across diverse settings, with girls being more frequently targeted than boys. On-campus bullying affects 23.3% of teens, with a higher prevalence among girls (26.5%) compared to boys (19.8%). Off-campus bullying impacts 14.9% of teens, again disproportionately affecting girls (16.6%) over boys (12.6%). In the digital sphere, 15.7% of teens report experiencing cyberbullying, with girls (17.9%) being more affected than boys (12.8%).

The survey highlights several vulnerability factors for bullying across all environments, including being female, younger in age, and in lower grade levels. These findings emphasize the need for targeted anti-bullying initiatives addressing these at-risk groups.

2025

FOCUS AREA 6

MENTAL HEALTH & SUICIDE

RISK PROFILE

Mental Health and Suicidality

Mental health issues and suicidality among teens have emerged as major global public health concerns. Global research consistently shows rising rates of mental health disorders among adolescents, with depression and anxiety being the most common (World Health Organization, 2022). The Global Burden of Disease Study reported that mental health disorders account for a sizable portion of the disease burden among individuals aged 10–19 years. Suicidality, encompassing suicidal thoughts, plans, and attempts, is one of the leading causes of death among adolescents, ranking as the second or third leading cause of mortality in this age group worldwide (Centers for Disease Control and Prevention, 2022).

The UNICEF 2021 Report indicates that an estimated one in seven adolescents aged 10–19 worldwide was living with a diagnosed mental disorder.

The Percentage[30] of Teens in The Bahamas Who:	**1998 (Total)**	**2013 (Total)**	**2023 (Total)**	**Trend**
Most times or always felt hopeless or depressed	20	-	28	
Most times or always felt lonely	-	11	26	
Most times or always were so worried that they couldn't sleep	-	14	20	
Practiced self-harming behaviours without wanting to end their lives	10	-	27	
Seriously considered suicide	7	18	25	
Made a suicide plan	-	16	23	
Attempted suicide	12	14	20	

Table 7: Trends in Mental Health Factors

[30] Percentages are rounded to the nearest whole number.

Social isolation is a known predisposing factor for suicidal behavior and depression. Psychological research emphasizes that platonic relationships can significantly enhance well-being, with the American Academy of Pediatrics noting that young people with friends and close confidants are generally more satisfied with their lives and less prone to depression. While the vast majority (91.1%) of Bahamian teens report having at least one close friend, 1 in 4 (25.6%) admit to feeling lonely most of the time or always. Girls are more likely to experience loneliness, a statistically significant disparity, with 31.1% of girls (95% CI: 28.7–33.6) compared to 19.3% of boys (95% CI: 16.9–21.9) reporting this experience.

Worrying is a common and natural part of adolescence. Excessive worrying, however, can negatively impact mental health. Among Bahamian teens, 19.6% report worrying so much that they are unable to sleep at night, with girls (23.4%, 95% CI: 20.7–26.3) being significantly more affected than boys (14.7%, 95% CI: 12.6–17.1). Furthermore, 8.3% of teens admit to turning to alcohol or drugs when overwhelmed by worry, with prevalence slightly higher among girls (10%) compared to boys (6.1%), although this difference was not statistically significant.

Feelings of depression and hopelessness are prevalent, with over a quarter (28.1%) of teens often or consistently feeling down or disinterested in usual activities. The prevalence among girls (37.9%, 95% CI: 34.9–40.9) is more than double that of boys (17.5%, 95% CI: 15.4–19.8), a statistically significant disparity. Parental support appears to influence depression rates, as data demonstrates a significant association between lower parental support and increased depression (χ^2 $p<0.001$).

Self-harm without suicidal intent affects 26.7% of teens, with girls twice as likely as boys to engage in this behavior (boys: 17.7%, 95% CI: 15.5–20.1; girls: 34.3%, 95% CI: 31.5–37.2). This behavior also varies by age, with 28.7% of teens aged 13–15 (95% CI: 26.3–31.3) and 22.3% of those aged 16–17 (95% CI: 19.1–25.8) reporting self-harm. A significant association between excessive worrying and self-harm is evident (χ^2: 150.12; $p<0.001$).

Suicide-related behaviours span a spectrum from ideation to planning and attempts. In 2023, one-quarter (25.2%) of Bahamian teens seriously contemplated suicide, with girls twice as likely as boys to have these thoughts. Nearly 23.1% of teens reported creating a suicide plan, with prevalence significantly higher among girls (28.9%) than boys (16.2%). Furthermore, 19.5% of teens have attempted suicide, again with girls being more likely than boys to do so. The disparities between sexes in suicidal ideation and planning were statistically significant (see Table). Additionally, an association exists between suicidal behaviors and the use of illicit drugs such as marijuana, opioids, or cocaine (χ^2 $p<0.001$).

Table 8: Suicidality in Boys Versus Girls

	Boys	Girls
Serious Considering	15.6% (95% CI: 13.6 – 17.9)	34% (95%CI: 30.5 – 37.8)
Suicide Planning	16.2% (95% CI: 14.7 – 18.2)	28.9% (95%CI: 25.5 – 32.6)
Suicide Attempt	14.7% (95% CI: 12.2 – 17.7)	23.1% (95% CI: 20.3 – 26.2)

The World Health Organization (WHO) estimates that approximately two-thirds of individuals who contemplate suicide never go on to make an attempt. However, data from the Global School-based Student Health Survey (GSHS) for The Bahamas presents a stark contrast, indicating that nearly equal proportions of teens who seriously consider suicide also attempt it.

In the United States, rising adolescent suicide rates are set against a backdrop of increasing reports of hopelessness, sadness, loneliness, and suicidal ideation. Alarmingly, more than 20% of Black American teens have seriously considered suicide.[31] According to a Centers for Disease Control and Prevention (CDC) report examining mental health trends from 2011 to 2021, 13% of high school girls attempted suicide, and 30% seriously contemplated it.[32]

Key Correlations

Bullying and Mental Health

Secondary analysis revealed a statistically significant, albeit weak, positive relationship between bullying and self-harm ($p<0.01$; $r = 0.204$) as well as between bullying and suicidal behaviors such as ideation ($p<0.01$; $r = 0.187$) and planning ($p<0.01$; $r = 0.126$). These findings suggest that as bullying experiences increase, so do self-harming behaviors and suicide contemplation. However, the weak correlations point to additional factors playing a larger role in predicting these behaviors.

Loneliness and Mental Health

Loneliness emerged as a significant predictor of mental health challenges. A statistically significant, weak positive relationship was observed between loneliness and self-harming behavior ($p<0.01$; $r = 0.280$). A moderate positive

[31] American Psychological Association.
[32] CDC Youth Risk Behavior Survey Data Summary and Trends Report: 2011–2021

correlation ($p<0.01$; $r = 0.468$) was found between loneliness and depression, highlighting a stronger association.

For suicidal behaviors, loneliness showed weak positive correlations with ideation ($p<0.01$; $r = 0.211$) and planning ($p<0.01$; $r = 0.259$). The relationship between loneliness and attempted suicide was slightly stronger ($r = 0.306$), though still moderate. Collectively, these results suggest that within the Bahamian adolescent population, loneliness is more closely associated with depression than with suicide-related behaviors.

Worry and Mental Health

Worry, particularly when chronic or escalating, exacerbates vulnerability to mental health challenges. Analysis revealed weak but consistent associations between worry and self-harm ($p<0.01$; $r = 0.266$), suicidal thoughts ($p<0.01$; $r = 0.295$), plans ($p<0.01$; $r = 0.288$), and attempts ($p<0.01$; $r = 0.257$). Notably, worry demonstrated a stronger relationship with depression ($p<0.01$; $r = 0.384$), indicating that it may act as a precursor to depressive symptoms, which in turn heighten risks of self-harm and suicidal behaviors.

These findings underscore the complex interplay between bullying, loneliness, worry, and mental health outcomes among Bahamian teens. While these factors show statistically significant relationships with harmful behaviors, the strength of these associations suggests that other influences—such as family dynamics, social support, and broader environmental stressors—may play critical roles. Addressing these multifaceted challenges requires holistic interventions targeting both individual and systemic factors.

2025

FOCUS AREA 7

SUPPORT STRUCTURE

RISK PROFILE

Support Systems and Structures

While 61.3% of teens in The Bahamas indicated they knew where to access professional help for issues such as depression, suicidal behavior, experiences of violence, or anger, a much smaller proportion (just 23.4%) felt they had someone to confide in about their worries or difficult problems. Alarmingly, 58.4% of teens reported they were rarely or never able to talk to anyone about such challenges. This disparity highlights a significant gap between knowledge of professional resources and the availability of accessible, trusted personal support systems. Addressing this gap is essential to fostering resilience and improving adolescent mental health outcomes.

Access to and availability of support systems are critical throughout the life course, particularly during adolescence. According to global statistics, adolescents with access to strong family, peer, and community support are significantly more likely to excel academically, maintain better mental health, and avoid risky behaviors. UNICEF (2021) reports that nearly 20% of teens globally face mental health challenges, yet those with supportive environments are more resilient and better equipped to cope. Additionally, access to mentorship programs and social services reduces the likelihood of dropping out of school by up to 30% in vulnerable populations, according to a randomized control trial of the Quantum Opportunities mentoring programme.

Building systems of support for and around teens extend beyond just access to trusted professional help. It embraces parents and guardians as well as trusted relatives, friends, persons in the community, and other individuals as potential supports. Parental involvement in explored in the next section.

2025

FOCUS AREA 8

PARENTAL SUPPORT

RISK PROFILE

Parental Monitoring, Involvement & Support

Parental monitoring refers to the supervision and awareness parents have over their children's activities, behaviors, and peer relationships. Research consistently indicates that effective parental monitoring is associated with:

- Reduced Risk Behaviors: Adolescents whose parents are actively aware of their whereabouts and peer groups are less likely to engage in risky behaviors such as substance use, delinquency, and early sexual activity[33]
- Improved Academic Outcomes: Adolescents who are monitored tend to perform better academically due to structured environments and reduced exposure to distractions[34] .
- Enhanced Emotional Regulation: Parental monitoring fosters a sense of security, enabling children to navigate emotional challenges with greater resilience.

Parental involvement encompasses active participation in a child's education, extracurricular activities, and overall upbringing. Parental support, characterized by emotional availability, encouragement, and unconditional love, forms the backbone of a child's emotional and psychological well-being. Although these are indispensable for fostering healthy, well-rounded children, cultural shifts, technological advancements, and the rise of non-traditional family structures are reshaping how children are raised and supported in their growth and development.

The Percentage of Teens in The Bahamas Who:	**1998 (Total)**	**2013 (Total)**	**2023 (Total)**	**Trend**
Lived with their biological father	53	-	-	
Lived with biological father or father figure	-	-	60	
Had parents who rarely or never paid attention to their school/homework	21	-	50	
Skipped school	22	18	24	
Felt understood by their parents most times or always	37	-	28	
Felt parents listened and were attentive most times or always	51	-	40	
Admitted their parents rarely or never knew what they were really doing in their free time	-	33	36	

Table 9: Trends in Parental Factors

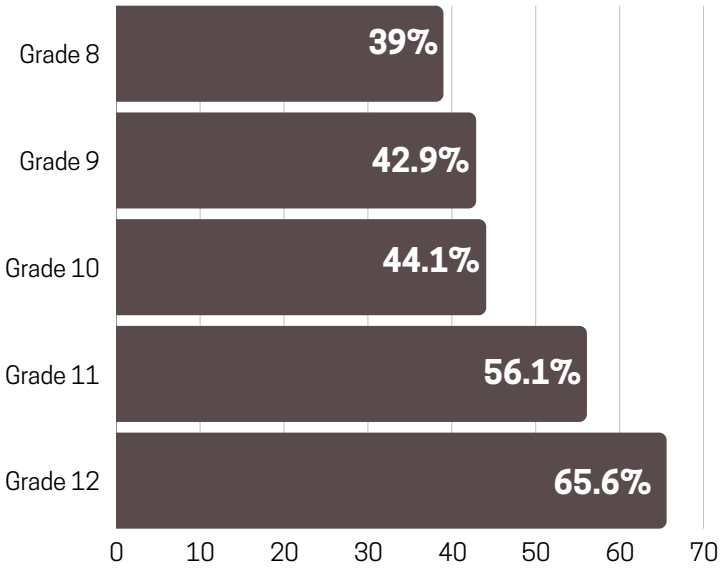
In 2023, 60.3% of Bahamian teens reported living in households with their father or a father figure. More boys (63%) than girls (57.4%) report having this family dynamic. However, there was no significant association between the absence of a father or father figure and the risk of emotional abuse or involvement in physical fights ($\chi 2$: 1.5, p=2.19; $\chi 2$: 0.56, p=0.460).

Regarding emotional support from parents or guardians, 27.6% of teens feel that their parents or guardians mostly or always understand their problems and concerns. In contrast, 54.5% feel their parents rarely or never understand them. A significant gender difference was found, with more girls (57.8%) than boys (51.3%) reporting that they were rarely or never understood by their parents (95% CI: boys 47.9 – 54.6, girls 55.6 – 60.0).

Additionally, 39.6% of teens reported that their parents or guardians listened and were attentive most or all of the time. A significant gender difference was observed here as well, with more boys (44.7%) reporting attentive parenting compared to girls (35.7%) (95% CI: boys 40.8 – 48.6, girls 32.9 – 38.6). However, 65% of teens said their parents were rarely or never attentive, with boys (70.7%) more likely than girls (60.5%) to report this (95% CI: boys 67.9 – 73.4, girls 57.8 – 63.1).

On parental involvement, 30.4% of teens reported that their parents or guardians regularly check to ensure homework is completed. This was more common among boys (34.6%) than girls (26.2%). However, 50.2% of teens said their parents rarely or never checked on homework, with the percentage increasing with higher grade levels.

Graph 2: Percent of Parent Never Checking Homework, By Grade



Regarding school attendance, 24.3% of teens skipped school without permission in the past month, with a higher prevalence among boys (26.2%) compared to girls (21.4%). An association was found between skipping school and carrying weapons ($\chi 2$: 60.5; p<0.001).

In terms of parental monitoring, 37.2% of teens felt their parents or guardians rarely or never knew how they spent their free time. Boys (38.6%) were more likely than girls (35.4%) to report low parental monitoring. Additionally, an association was found between lower parental monitoring and increased sexual activity ($\chi 2$: p<0.001).

Notably, 72% of teens reported that their parents or guardians rarely or never went through their belongings without permission. This may reflect parents

[33] Dishion, T.J., McMahon, R.J. Parental Monitoring and the Prevention of Child and Adolescent Problem Behavior: A Conceptual and Empirical Formulation. Clin Child Fam Psychol Rev 1, 61–75 (1998). https://doi.org/10.1023/A:1021800432380
[34] Wang C, La Salle TP, Do KA, Wu C, Sullivan KE. Does parental involvement matter for students' mental health in middle school? Sch Psychol. 2019 Mar;34(2):222-232. doi: 10.1037/spq0000300. Epub 2018 Dec 27. PMID: 30589313.

respect for their children's privacy; trust in their chidlren; or a high level of open communication between parent and child. However, given the performance of other variables related to parental involvement, parental avoidance or lack of awareness and shifting cultural norms are more likely reasons, which may underscore a larger issue of the disconnect in the parent-child relationship.

On the issue of ridicule or belittlement by parents, 49% of teens reported that their parents never ridiculed them, while 16% said it occurred rarely, and 15.5% said it happened most of the time or always. More boys (70.7%) than girls (60.5%) reported not being subjected to parental ridicule, with this difference being statistically significant.

Key Correlations

Teens who communicate more openly with family or friends about their problems tend to have lower rates of self-harm, depression, and suicidal thoughts or behaviors. These correlations, though weak (r values: -0.076; -0.089; -0.044; -0.055; and -0.06, respectively), are statistically significant and align with existing evidence that communication and emotional support contribute to resilience against mental health challenges. These findings suggest that while communication plays a role, other factors such as the quality, depth, and frequency of these interactions may be influential in shaping mental health outcomes.

Overall, higher levels of parental understanding are associated with fewer mental health challenges among teens. This association was particularly strong for suicidal ideation (r=-0.218), followed by depression (r=-0.195) and self-harm (r=-0.183). Also, the higher the grade level, the more likely parents were to not ensure homework was completed.

THE CONCLUSION

The health and well-being of teens in the Commonwealth of The Bahamas are at risk. This is validated by the profound imbalance in negative versus positive risk trends as discussed in this Report. Specifically, positive trends were found in 8/54 variables, indicating progress. In stark contrast, the overwhelming majority of variables (36/54) are trending negatively. Additionally, teens in The Bahamas are being impacted by adverse childhood experiences (ACEs).

It is not lost that the precursor of teen health is childhood health. The quality and behaviours of childhood can have lasting implications. Studies consistently show that early life plays a crucial role in determining the coevolution of health and socioeconomic status throughout adulthood.[35] Habits formed in childhood - whether healthy or unhealthy - have the potential to migrate into adolescence and from there, into adulthood. Given the state of health and well-being as documented in this report, interventions must be targeted at both the childhood and teenage years.

Shocks to childhood and adolescent health and well-being can be endogenous, or influenced by environmental, family or other factors outside of their control such as the quality of their diets, supportive networks, and policies that protect against the useof alcohol - to name a few.

If no change occurs, if the status quo holds, Bahamian children and teens in The Bahamas are likely to face escalating health risks, and declining mental well-being, potentially leading to increased prevalence of NCD risk factors, substance abuse, and violence. The cumulative impact of these issues—and others—will place significant strain on national healthcare and social systems, potentially resulting in enduring socio-economic challenges.

Based on the Report findings, girls demonstrate more negative and risk behaviours compared to boys, as shown in Table 10. This knowledge provides support for tailoring policies, programmes and interventions for each of the sexes.

Without urgent, targeted, systemic shifts/interventions - that are coordinated and seismic - the gaps in support, parental engagement, and health-promoting behaviours will widen, jeopardizing the future of an entire generation. The proposed policy directions in the next section are a good start.

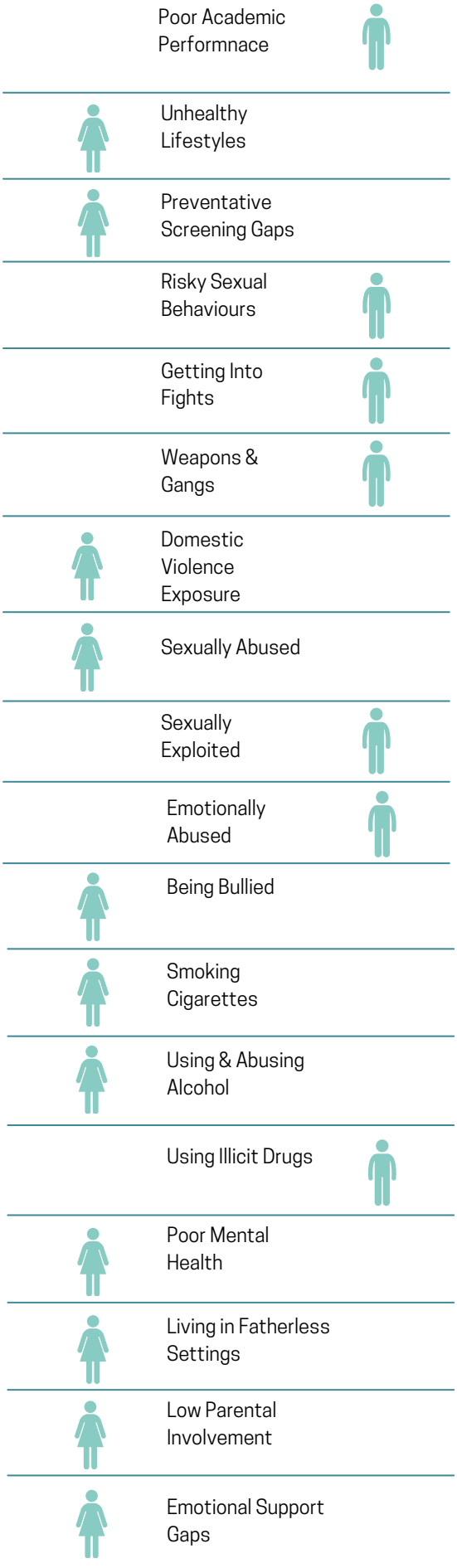
[35] Cutler, D., Lleras-Muney, A and Vogi, T. Socioeconomic Status and Health: Dimensions and Mechanisms. The Oxford Handbook of Health Economics. Chapter 7. p124-163.

Who Has The More

Concerning Profile

In the 11 of 18 listed variables, girls are more vulnerable than boys

Table 10: Summary of Risk Profile By Sex



POLICY DIRECTIONS

To address the challenges highlighted in the GSHS data, the following proposed policy actions aim to tackle the multifaceted issues facing teens living in The Bahamas; and ensure the nation's teens have the support needed to mature into healthy, successful and positively contributing adults. The policy actions involves families, schools, communities, policymakers.

It is believed that, through the integration of the 12 concrete policy areas and 64 policy directions, The Bahamas can better support its youth in navigating the complex challenges of adolescence, promote healthier lifestyles, and ensure that mental health and well-being are prioritized at every level of society.

AREA	POLICY DIRECTION
Mental Health Education and Awareness	Integrate mindfulness, stress management, and emotional regulation techniques into school curricula to better equip students with coping strategies. Implement evidence-based curricula such as MindUp or Social and Emotional Learning (SEL), that equip teens with tools to manage loneliness, depressive thoughts, and other emotional challenges. Scale up and sustain massive national initiatives aimed at raising awareness about the signs of loneliness, depression, and self-harm, particularly targeting students, parents/guardians, and teachers. These initiatives should focus on early detection, intervention, and the destigmatization of mental health issues. Design and execute workshops and campaigns that normalize, in safe spaces, peer discussions on mental health, fostering a supportive environment for sharing. Develop targeted programmes at school and community levels - for teens exhibiting early signs of mental health challenges.

AREA	POLICY DIRECTION
Mental Health Support Programmes	Increase funding for school-based mental health services and youth-friendly counselling services, to improve access. Increase funding for counsellors and psychologists within schools. Incorporate psychological evaluations at Grades 2, 4, 7 and 10 (see Pillar 1 In National Violence Prevention Strategy) Expand the NHI standard benefits package (SBP) to include mental health counselling for teens, as a mechanism for equitable access to mental health services. Accelerate the launch of anonymous helplines and digital platforms to offer teens a convenient, non-discriminatory way to seek help.
Violence Prevention and Intervention	Refer to National Violence Prevention Strategy - 'Rooting Out Violence'. Implement a national anti-bullying policy, with provisions for anti-cyberbullying and school-specific prevention policies. Establish dedicated services for teens who have experienced sexual violence, offering comprehensive medical, psychological, and legal assistance. Re-design the SAFE and SCAN Units, to consider a school-based approach, encouraging greater parental participation. Expand the scope and services of the Adolescent Health Unit to offer a comprehensive suite of services, which can include strengthened referral mechanisms to CCAC. Develop, fund and implement a strategy to attract more male teachers. Equip parents with tools to monitor and guide their children's online activities safely.

AREA	POLICY DIRECTION
Substance Abuse Prevention and Support	Scale-up and sustain school and community-based initiatives to educate teens about the risks of tobacco, alcohol, and drug use. Nationally mandate that any alcohol in homes with minors be secured within a locked cabinet. Enforce regulations on the marketing, sale, and availability of alcohol and intoxicating substances to teens. Penalize parents/guardians for minors found in possession of alcohol. Strengthen enforcement related to the prohibition of the sale of traditional cigarettes to minors (e.g. single stick sales). Amend legislation to ban the sale of e-cigarettes (flavoured and non-flavoured), along with vaping accessories, to minors. Enforce restrictions on online sales of both traditional and e-cigarettes to prevent underage purchases. Mandate anti-vaping education in school curricula. Develop and launch an App to help teens quit vaping and smoking. Strengthen and enforce penalties for vendors violating ID verification for alcohol sales Strengthen zoning laws to restrict the number of liquor licenses in urban centers
Sexual Health Education and Support	Equip parents with resources and training to facilitate discussions about sexual health and safe practices with their teens. Lower the grade level at which sexual education begins in the school system. Increase accessibility to HPV vaccinations through school health services, with parental permission. Design strategies to address promiscuity among boys.

AREA	POLICY DIRECTION
Promoting Healthy Relationships and Preventing Exploitation	Identify and implement healthy relationships curriculum such as the Fourth r Programme (‘r’ being relationship). Implement comprehensive interventions aimed at preventing sexual violence, addressing exploitation, and promoting healthy relationships among Bahamian teens. This includes the development of programs focused on safe dating, consent, and respect in relationships as well as safe and unsafe touch. Teach children to recognize the signs of grooming and sexual exploitation; and how to seek help. Incorporate topics on digital safety, sextortion, and online grooming. Criminalize grooming behaviours. Train teachers and school staff to identify, respond to and report signs of unhealthy relationships and exploitation. Create secure platforms for teens to report exploitation or abuse without fear of retaliation
Lifestyle and Nutrition Initiatives	Enact a Child Nutrition Act to include prohibition of the sale of foods high in fat, sugar, and salt on and around school campuses to promote healthier eating habits, to ensure access not just to foods but to nutritious food. Leverage Apps and digital platforms to promote active lifestyles and healthy eating among tech-savvy teens. Improve access to drinking water on all school campuses. Strengthen school meal programmes with an emphasis on increasing fruit and vegetable consumption, promoting better nutrition among teens. Permeate platforms with tips for healthy nutrition at home.

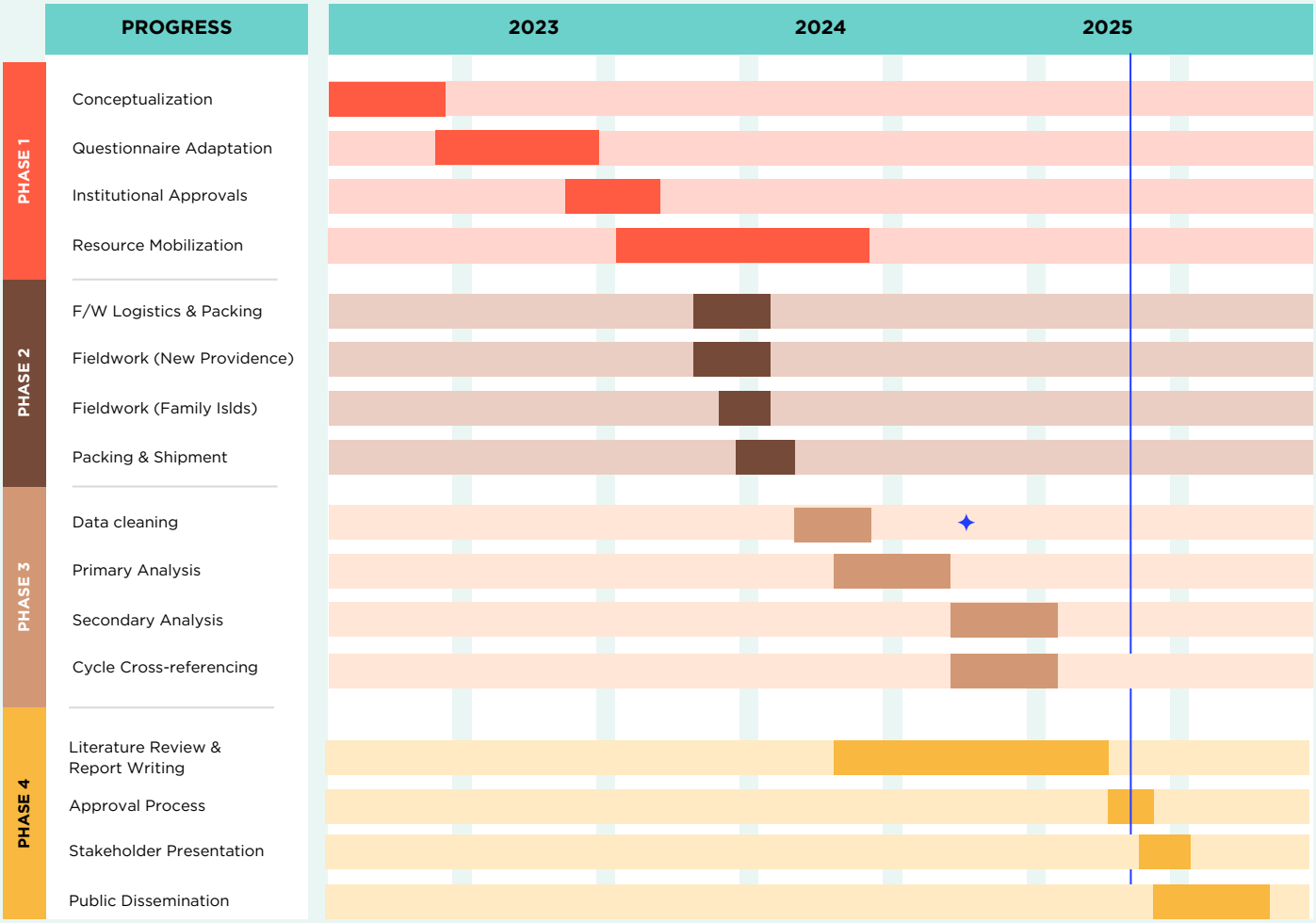
AREA	POLICY DIRECTION
Lifestyle and Nutrition Initiatives (cont'd)	Formally adopt and implement 'The Bahamas School Feeding Manual (2023)' developed in collaboration with Ministries of Education and Health along with FAO. Mandate that at least 90% of physical education curriculum hours be dedicated to actual physical activity, reducing the reliance on classroom-style theory instruction. Expand the health assessments conducted at grade 1, 4, 7 and 10 to ensure at least one eye examination at each assessment grade level; and at least one hearing examination is on file for each student. Expand school dental services. Increase the proportion of teens enrolled in and benefiting from NHI SBP. Advocate for the implementation of active curriculum integration, with the requirement for movement breaks in classes. Require schools to allocate at least 30 minutes daily for physical activity beyond physical education (PE) classes and the time for recess and lunch breaks. Fund non-competitive sporting clubs (like yoga, dance and martial arts) for teens not interested in traditional sports. Partner with local businesses to offer discounts or vouchers for participation in physical activities tracked through wearable devices. Explore the requirement for digital streaming platforms to display activity reminders (e.g., "Get up and move!" after two (2) hours of screen time).

AREA	POLICY DIRECTION
Parental Involvement and Communication	Collaborate with CSOs and FBOs to scale-up and adequately fund family-oriented programmes e.g. the 'Strengthening Families' programme. Develop national workshops and resources aimed at improving parental involvement in and effective communication with their childrens' academic and emotional lives. These should emphasize the importance of open communication and understanding. Build parental/guardian capacity to build strong parent-child relationships, hallmarked by nurturing, encourgaing and communicative existences.
Systematic and Policy Coordination	Develop a National Child Health and Well-Being Policy Develop a National Adolescent Health and Well-Being Policy that is evidence-based, collaborative, and comprehensive. This policy should integrate data-driven insights and input from key stakeholders, including teens, parents, educators, health professionals, and community leaders. It should address the multifaceted needs of adolescents, encompassing mental health, physical health, education, and social well-being, while promoting equity, inclusion, and sustainable interventions tailored to the Bahamian context. Establish a national coordination mechanism for the implementation and monitoring health-related policies specific to children and adolescents, ensuring that interventions are consistent, effective, and well-coordinated across sectors. Re-think the approach to youth health and well-being within the Ministry of Health and its implementing arm, the Department of Public Health, ensuring a holistic, integrated approach to addressing the needs of Bahamian teens. Define and activate referral pathways from school psychologist to advanced interventions.

AREA	POLICY DIRECTION
Systematic and Policy Coordination (cont'd)	Augment conditions for obtaining and maintaining MoETvT registration to require participation of all schools (public and private) in national health surveys.
Research and Knowledge Generation	Prioritize, fund and conduct periodic research to understanding the unique challenges and factors faced by teens, particularly in relation to mental health, bullying, substance abuse, sexual violence and other risky behaviours. Use bivariate analysis to identify additional variables that may influence teen well-being. Encourage research on factors like neighborhood culture/dynamics, peer influence, substance use and socioeconomic status mediate the relationship between key behaviour variables.

BAHAMAS' GSHS

TIMELINE



THE APPENDIX

2023 GSHS BAHAMAS QUESTIONNAIRE

Demographics

1. How old are you?
2. What is your sex?
3. In what grade are you?
4. What range best describes your final GPA in the last school year?

Anthropometric Measures

1. How tall are you without your shoes on?
2. How much do you weigh without your shoes on?

Diet-Related

1. During the past 30 days, how often did you go hungry because there was not enough food in your home?
2. During the past 7 days, how many times did you eat fruit, such as bananas, apples, guava, dilly, papaya, sugar apple, juju, watermelon, mango, or grapes?
3. During the past 7 days, how many times did you eat vegetables, such as cabbage, broccoli, spinach, lettuce, or carrots?
4. During the past 7 days, how many times did you drink a can, bottle, or glass of a carbonated soft drink, such as 7-Up, Coke, Sprite, Goombay, Ginger-Ale, Root Beer, Fruit Champagne, or Fanta? (Do not count diet soft drinks.)
5. During the past 7 days, how many times did you drink a can, bottle, or glass of a sugar-sweetened drink?
6. During the past 7 days, how many times did you eat salty foods or snacks, such as hot dogs, pickled sausage, corn beef, popcorn, ramen noodles, chips (including Cheetos and Cheese Doodles), salted peanuts, or fast food French fries?
7. During the past 7 days, how many times did you eat foods high in fat, such as fried foods, ice cream, pastries, salty sausage, hamburger, or fried chicken?
8. During the past 7 days, how many times did you eat foods high in sugar, such as cookies, cakes, pastries, Frosted Flakes, Fruit Loops, Apple Jacks, guava duff, coconut tart or chocolate bars?
9. During the past 7 days, how many cups of water did you drink each day?
10. During the past 30 days, how often did you eat breakfast?

Injury & Violence

1. During the past 12 months, how many times were you seriously injured?
2. During the past 12 months, what was the most serious injury that happened to you?
3. During the past 12 months, what was the major cause of the most serious injury that happened to you?
4. During the past 12 months, how many times were you physically attacked?
5. During the past 12 months, how many times were you in a physical fight?
6. During the past 12 months, were you bullied on school property?
7. During the past 12 months, were you bullied when you were not on school property?
8. During the past 12 months, were you cyber bullied?
9. Have you ever been physically or verbally forced to have sexual intercourse when you did not want to?
10. During the past 12 months, how many times did someone you were dating or going out with (including your movie or sneaky link) purposely try to control you or emotionally hurt you?
11. Have you ever been given money, a place to stay, food, clothing/shoes, jewelry, bag or something else of value in exchange for sex?
12. Have you ever seen or experienced violence in your home?
13. Are you a member of a gang such as the Mad Ass Gang, Fire and Theft, One Order, Grove Hot Boys, Dirty South Boys, Tiger Nation, Crack Nation, 300, or New YBN?
14. During the past 30 days, on how many days did you carry a weapon, such as a gun, knife, club, brass knuckles, large rings, or a cutlass?
15. Do you know where to get professional help if you are a victim of violence (physical, sexual, or emotional violence); or feel depressed, anxious, or angry?

Mental Health & Suicide

1. How many close friends do you have?
2. During the past 12 months, how often did you feel lonely?
3. During the past 12 months, how often were you so worried about something that you could not sleep at night?
4. During the past 12 months, how often were you so worried about something that you wanted to use alcohol or other drugs to feel better?
5. During the past 12 months, how often did you feel down, depressed, or hopeless or had little interest in your usual activities?
6. During the past 12 months, how many times did you do something to purposely hurt yourself without wanting to die, such as cutting or burning yourself on purpose or taking more of a prescription medicine than was

prescribed?

1. During the past 12 months, did you seriously consider attempting suicide?
2. During the past 12 months, did you make a plan about how you would attempt suicide?
3. During the past 12 months, how many times did you attempt suicide?

Substance Use

1. Have you ever tried or experimented with cigarette smoking, even one or two puffs?
2. How old were you when you first tried smoking a cigarette?
3. During the past 30 days, on how many days did you use electronic cigarettes?
4. During the past 7 days, on how many days did someone smoke in your presence?
5. How old were you when you had your first drink of alcohol other than a few sips?
6. During the past 30 days, on how many days did you have at least one drink containing alcohol?
7. During the past 30 days, on the days you drank alcohol, how many drinks did you usually drink per day?
8. During the past 30 days, what is the largest number of alcoholic drinks you had in a row, that is, within a couple of hours?
9. During the past 30 days, how did you usually get the alcohol you drank?
10. During your life, how many times have you got into trouble at home, work, or school or got into fights, as a result of drinking alcohol?
11. During your life, how many times have you drank so much alcohol that you were really drunk?
12. During the past 30 days, were you asked to show an ID when you tried to buy any type of alcohol?
13. How harmful is drinking too much alcohol to the body?
14. How old were you when you first used drugs?
15. During your life, how many times have you used cannabis (also called marijuana, weed, ganja, dope, and flakka)?
16. During the past 30 days, how many times did you use cannabis (also called marijuana, weed, ganja, dope, and flakka)?
17. How harmful is cannabis (also called marijuana, weed, ganja, dope, and flakka) to the body?
18. During your life, how many times have you used amphetamines or methamphetamines (also called meth, uppers, speed, ecstasy, X, molly, or pop rock candy) for non-medical purposes?

1. During your life, have you ever used cocaine (also called blow, coke, nose candy, or white lady)?
2. How difficult would it be to obtain illegal drugs, such as marijuana, uppers, cocaine, ecstasy, or meth at school?
3. Does anyone that you live with use illegal drugs?
4. During the past 12 months, how many times did you attend school under the influence of either drugs or alcohol?

Sexual Behaviours

1. Have you ever had sexual intercourse?
2. What is the main reason you had sexual intercourse the first time?
3. How old were you when you had sexual intercourse for the first time?
4. During your life, with how many people have you had sexual intercourse?
5. The last time you had sexual intercourse, did you or your partner use a condom?
6. The last time you had sexual intercourse, what one method did you or your partner use to prevent pregnancy?
7. Do condoms protect people against HIV and other sexually transmitted diseases?
8. Have you ever been told by a doctor or nurse that you had a sexually transmitted infection, such as HIV, AIDS, the claps, or gonorrhea?

Physical Activity

1. During the past 7 days, on how many days were you physically active for a total of at least 60 minutes per day?
2. How much time do you spend during a typical or usual day sitting or lying down doing such things as watching television, playing computer games, talking with friends, using your mobile phone, traveling in a motor vehicle, napping, or doing other activities sitting or lying down, such as reading or listening to music?
3. On an average school night, how many hours of sleep do you get?

Home LIfe & Parental Involvement

1. During the past 30 days, on how many days did you miss classes or school without permission?
2. During the past 30 days, how often were you able to talk to someone about difficult problems and worries?
3. During the past 30 days, how often did your parents or guardians understand your problems and worries?
4. During the past 30 days, how often did your parents or guardians check to see if your homework was done?

1. During the past 30 days, how often did your parents or guardians really know what you were doing with your free time?
2. During the past 30 days, how often did your parents or guardians go through your things without your approval?
3. During the past 30 days, how often did your parents or guardians pay attention and listen to you?
4. During the past 30 days, how often did your parents or guardians ridicule you or put you down (for example, by saying you were stupid or useless)?
5. Do you live with your father or someone who acts like a father for you?

General Health & Sreenings

1. During the past 3 years, did you have your hearing tested?
2. During the past 2 years, did you have your eyes tested?
3. During the past 2 years, did you visit the dentist for a regular check-up or exam of your teeth and gums?
4. Have you ever received the HPV vaccine?
5. How important are vaccines for your health?