ADVANCING ADOLESCENT NUTRITION: THE KEY TO AFRICA'S FUTURE

JULY 2026

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Foreword

The African Union Commission recognizes adolescent nutrition as a strategic investment priority for Africa's human capital, demographic dividend and long-term development. Adolescents constitute a significant proportion of Africa's population and ensuring that they are healthy and well-nourished is fundamental to achieving sustainable development and realizing the aspirations of the Africa Regional Nutrition Strategy 2026–2035 and Agenda 2063. This report, *Advancing Adolescent Nutrition: The Key to Africa's Future*, provides the evidence base and strategic actions needed to strengthen policies, programmes and investments that improve adolescent nutrition across African Union Member States.

The Africa Regional Nutrition Strategy (ARNS) 2026–2035 identifies adolescent nutrition as a strategic priority for the first time, recognizing adolescence as a critical period for growth, development and the prevention of malnutrition across the life course. While considerable progress has been made in improving maternal and child nutrition, adolescents have historically received limited attention in nutrition policies and programmes. Existing evidence demonstrates that undernutrition, overweight and obesity, micronutrient deficiencies and unhealthy diets continue to affect millions of adolescents across Africa, with consequences for education, health, productivity and future generations. Clear understanding of these challenges is essential to inform effective policy, programme and investment responses.

In line with the ARNS 2026–2035 and the aspirations of Agenda 2063, this report presents the current status of adolescent nutrition in Africa, analyses the multiple determinants of malnutrition, reviews the policy and programmatic landscape, and identifies opportunities for accelerating progress. It highlights the need for coordinated, multisectoral approaches that address the diverse nutritional needs of adolescents and strengthen action across health, education, agriculture, food systems, social protection, water, sanitation and hygiene, gender, and youth development. Such approaches are essential to improving dietary quality, preventing all forms of malnutrition and creating enabling environments for healthy adolescent development.

The ARNS 2026–2035 reaffirms the African Union's commitment to improving nutrition and health outcomes across Member States in accordance with Agenda 2063. This report supports ARNS implementation by consolidating the latest evidence on adolescent nutrition and identifying strategic opportunities to strengthen policies, programmes and investments. By highlighting existing challenges, policy and programme gaps, and opportunities for action, it provides a basis for Member States and partners to prioritize context-specific interventions and integrate adolescent nutrition into national development and sectoral plans.

The primary objective of this report is to equip Member States, Regional Economic Communities, development partners and other stakeholders with a comprehensive evidence base to guide policy development, strategic planning and investment in adolescent nutrition. It seeks to support implementation of evidence-based, context-

specific and multisectoral interventions that respond to the diverse nutritional needs of adolescents across the continent and contribute to improved health, educational attainment, productivity and intergenerational outcomes. This report was developed through a process of comprehensive evidence synthesis, technical review and consultation involving the African Union Commission, technical representatives of Member States and development partners. The work builds on the initial landscaping and presentation of adolescent nutrition data to RECs, as well as guidance from the 14th African Task Force on Food and Nutrition Development (ATFFND) to ensure that adolescents were adequately reflected in the ARNS 2026–2035.

The evidence presented in this report complements the Strategy by providing a more comprehensive review of the adolescent nutrition landscape to inform decision-making and guide action. The African Union Commission will continue to provide leadership in advancing adolescent nutrition by supporting policy dialogue, strengthening partnerships, promoting knowledge sharing, and accountability for implementation of the ARNS 2026–2035. Member States, RECS, development partners, civil society, academia and the private sector each have a critical role in translating the evidence presented in this report into coordinated and sustained action. Strengthening collaboration across sectors and aligning policies, programmes and investments will be essential to achieving meaningful and lasting improvements in adolescent nutrition.

Investing in adolescent nutrition is an investment in Africa's future. Healthy and well-nourished adolescents are better positioned to complete their education, participate productively in society, contribute to economic growth and raise healthier families. Advancing adolescent nutrition therefore requires coordinated, comprehensive and context-specific action, supported by sustained investment and strong partnerships.

Through collective commitment and evidence-based action, Africa can harness the full potential of its young population and advance towards the aspirations of Agenda 2063—the Africa We Want.

AMB. AMMA A. TWUM-AMOAH

COMMISSIONER FOR HEALTH, HUMANITARIAN AFFAIRS AND SOCIAL DEVELOPMENT

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The African Union Commission (AUC), through the Department of Health, Humanitarian Affairs and Social Development, expresses its profound gratitude the individuals and organizations whose dedication, expertise and contributions have been instrumental in the development of the report *Advancing adolescent nutrition: The key to Africa's future.*

The development of this report builds on the initial landscaping and presentation of adolescent nutrition data by Nutrition International (NI) to Regional Economic Communities (RECs) followed by guidance from the Task Force on Food and Nutrition Development (ATFFND) to ensure that adolescent nutrition was adequately reflected in the Africa Regional Nutrition Strategy (ARNS) 2026-2035. Summaries of the evidence presented here informed the adolescent nutrition component of the ARNS 2026-2035. The more comprehensive analysis presented in this report complements the ARNS 2026-2035, by providing additional context and data to guide decision-making, identify gaps in knowledge and inform strategic action on adolescent nutrition across Africa.

The AUC extends sincere appreciation to Arthur Samson and Marion Roche of Nutrition International for their work in writing this report. Special recognition is extended to Gertrude Masautso Kara and Ms. Lucy Murage of the AUC for their technical reviews, comments and strategic guidance, which contributed to strengthening the report and ensuring its relevance to the African Union's nutrition priorities. The AUC also expresses its gratitude to NI's Luke Stover and Chris Lendrum of Nutrition International for their graphic design and editorial support, which contributed to the presentation and accessibility of the report.

This document is intended to provide much needed context and data to guide a clear understanding of the current context of adolescent nutrition in Africa, as well as gaps in that knowledge. Lastly, special thanks go to Nutrition International for the financial support, made possible through a grant from Global Affairs Canada, to support the data analysis and report writing and dissemination. This report shows a shared commitment by AU and NI to ensure that adolescents are meaningfully included within the life course approach to the ARNS, enabling a decade of progress and potential through investments and evidence-based actions.

This collaborative effort reflects the shared commitment of the African Union Commission and Nutrition International to ensuring that adolescents are meaningfully included in the life-course approach underpinning the ARNS 2026–2035. By strengthening the evidence base and identifying opportunities for investment and evidence-based action, the report seeks to support a decade of progress in adolescent nutrition and contribute to improved health, well-being, gender equity, and human capital development across Africa.

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Africa's Adolescent Nutrition Challenge: A Development Imperative
Executive summary
Advancing Adolescent Nutrition: The Key to Africa's Future

Africa's Adolescent Nutrition Challenge: A Development Imperative

Adolescent nutrition is a critical determinant of Africa's human capital, economic development and long-term prosperity. Adolescence (10–19 years) is a period of rapid physical, cognitive and social development, during which adequate nutrition is essential for health, educational attainment, empowerment and future productivity. Investments in adolescent health and nutrition can generate a triple dividend of benefits for adolescents today, throughout their adult lives and for the next generation. Yet adolescent nutrition has historically received limited attention in continental nutrition policies, programmes and investments[i].

Africa is home to approximately 273 million adolescents aged 10–19 years, representing 20% of the global adolescent population. Approximately one in four people in Africa is an adolescent[ii]. This substantial demographic group represents both an opportunity to accelerate progress towards the demographic dividend and a development imperative that requires deliberate policy attention and investment. However, adolescents across the continent face a triple burden of malnutrition, with undernutrition, including thinness and stunting, persisting alongside rising overweight and obesity and widespread micronutrient deficiencies. Anaemia remains a particularly serious public health concern, disproportionately affecting adolescent girls and undermining their health, educational attainment and future opportunities.

The Africa Regional Nutrition Strategy (ARNS) 2026–2035 recognizes adolescent nutrition as a strategic priority, creating an important opportunity to address these challenges within the continental nutrition agenda. This report, *Advancing Adolescent Nutrition: The Key to Africa's Future*, presents evidence on adolescent nutrition status, demographic and gender inequalities, and the policy and programmatic environment across African Union (AU) Member States. It aims to inform decision-making and stimulate coordinated action by Member States, Regional Economic Communities (RECs) and development partners to ensure that adolescents are meaningfully included in nutrition policies, programmes and investments.

Understanding the Drivers of Adolescent Malnutrition

Adolescent nutrition outcomes are shaped by interconnected biological, social, economic, gender and environmental factors. Rapid growth and development increase adolescents' nutritional requirements, while poverty, food insecurity, economic and climate shocks, and humanitarian crises constrain access to adequate and nutritious diets. Poor dietary diversity and limited access to nutrient-dense foods contribute to undernutrition and micronutrient deficiencies, while unhealthy food environments, increased consumption of

energy-dense, nutrient-poor foods and insufficient physical activity contribute to overweight and obesity.

Gender inequalities significantly influence adolescent nutrition and opportunities for healthy development. Differences in access to education, school attendance, health services and economic opportunities affect nutritional outcomes, particularly for adolescent girls. Early marriage, adolescent pregnancy and low contraceptive use contribute to girls' vulnerability, while pregnancy during adolescence increases nutritional demands. Girls who become pregnant often leave school, and those who are out of school face heightened risks of early marriage and adolescent pregnancy. Inadequate sanitation facilities and other barriers to school attendance further undermine access to health and nutrition interventions.

Schools provide an important platform for delivering adolescent nutrition interventions, including nutrition education, school feeding, water, sanitation and hygiene (WASH) services, and weekly iron and folic acid supplementation (WIFAS). However, declining enrolment and attendance as learners progress from primary to secondary education, alongside gender disparities and the exclusion of out-of-school adolescents, limit the reach of these interventions. Addressing adolescent malnutrition therefore requires coordinated action across health, education, food systems, social protection, WASH, gender and youth development.

Approach and Scope of the Report

The report draws on a three-part evidence review covering the 55 AU Member States. First, quantitative data were compiled and analysed across three domains: demographics and gender equity; nutrition and health status; and the enabling environment. The analysis also examined relationships between gender inequalities and nutrition outcomes, with particular attention to anaemia among adolescent girls. Second, a desk review of national policies, commitments, strategies and action plans assessed the extent to which adolescent nutrition is addressed. Third, a literature review examined research and programme experiences to identify lessons and opportunities for strengthening interventions.

Data were compiled and analysed between February 2024 and November 2025. The report was reviewed by the 15th African Task Force on Food and Nutrition Development (ATFFND) in June 2026 and revised to incorporate its recommendations.

The findings are subject to variations in data availability, country coverage and age-group disaggregation. Data on younger adolescents aged 10–14 years and adolescent-specific nutrition outcomes were particularly limited, restricting a comprehensive assessment across the full 10–19-year age range. Differences in country coverage also affect the comparability of indicators. These limitations underscore the need for more comprehensive, age- and sex-disaggregated data to guide policy, programming and accountability.

Evidence on the Status of Adolescent Nutrition in Africa

Demographics, education and gender equality. Adolescents account for between 11.58% of the total population in Cabo Verde and 27.18% in the Central African Republic. While primary school enrolment is generally higher, participation declines considerably at secondary level. Net primary school enrolment ranges from 55.1% in Eritrea to 99.5% in Egypt; lower secondary enrolment ranges from 21.8% in Niger to 99.5% in Namibia; and upper secondary enrolment ranges from 10.0% in Niger to 91.4% in South Africa. School attendance follows a similar pattern, with lower participation at secondary level and notable gender disparities. These gaps reduce opportunities to reach adolescents through school-based nutrition and health programmes. UNESCO data for 2022 indicate that 19.9% of primary, 33.2% of lower secondary and 47.8% of upper secondary school-age children and adolescents in sub-Saharan Africa were out of school[iii].

Overweight and obesity. The prevalence of overweight among adolescent girls aged 15–19 years ranges from 2.5% in Eritrea to 34.7% in Egypt, based on data from 41 countries. Among adolescent boys, prevalence ranges from 0.3% in Rwanda to 7% in Comoros, based on data from 18 countries. Obesity among adolescent girls ranges from 0.2% in Ethiopia to 17.6% in Egypt, based on data from 43 countries. Among adolescent boys, it ranges from 0% in Uganda to 2.5% in South Africa, based on data from 15 countries. Overweight and obesity are generally more prevalent among girls than boys, while adolescents living in urban areas face greater risk[iv],[v]. Poor dietary quality, increased consumption of energy-dense, nutrient-poor foods, sugar-sweetened beverages and fried foods, and insufficient physical activity contribute to these trends.

Undernutrition. Thinness persists in many countries, despite gradual declines in most settings. Among adolescent girls aged 15–19 years, thinness ranges from 0.6% in Egypt to 39.9% in Eritrea, based on data from 36 countries. Among adolescent boys, it ranges from 7% in Seychelles to 59% in Ethiopia. Adolescent boys generally experience higher rates and risks of thinness and stunting than girls. Persistent poverty, food insecurity, economic and climate shocks, humanitarian crises and inadequate access to nutritious diets contribute to undernutrition, alongside the increased nutrient requirements associated with adolescent growth and development[vi].

Anaemia and micronutrient deficiencies. Anaemia remains a major public health concern, particularly among adolescent girls. Of the 38 countries with available data, 35 reported anaemia prevalence above 20% among adolescent girls aged 15–19 years, indicating a public health problem. In 23 countries, prevalence exceeded 40%, indicating a severe public health problem. Available evidence also points to concerns regarding iron, folate, vitamin A and zinc deficiencies, although data on the prevalence of these deficiencies among adolescents remain limited[vii]. The findings underscore the importance of improving prevention, early identification and appropriate management of anaemia and other micronutrient deficiencies.

Why Adolescent Nutrition Requires Greater Policy and Programmatic Attention

Despite the growing recognition of adolescence as a critical stage in the life course, adolescent nutrition was not adequately included in the Africa Regional Nutrition Strategy 2016–2025 and the Continental Nutrition Accountability Scorecard (CNAS)

more than half of the nutrition policies, strategies and plans reviewed for this report included adolescent nutrition in some form, few provided a comprehensive package of evidence-based interventions specifically designed to address adolescents' diverse nutritional needs.

Political commitments have also been limited. Of the 55 AU Member States, 17 had made adolescent-specific or adolescent-inclusive nutrition commitments at the 2021 Nutrition for Growth (N4G) Summit[ix], declining to 13 in 2025. Adolescent-specific commitments included reducing anaemia, overweight and obesity, and increasing coverage of adolescent nutrition interventions. Many adolescent-inclusive commitments focused on reducing anaemia among women of reproductive age, implementing multisectoral nutrition plans, reducing all forms of malnutrition and improving school feeding programmes.

Most adolescent nutrition programmes identified in Africa were implemented as pilot initiatives or at district and regional levels, limiting their reach and potential for sustained impact. Schools were the principal delivery platform, with relatively few programmes targeting out-of-school adolescents. Common interventions included nutrition and health education for girls and boys, WIFAS for adolescent girls, school meals, WASH programmes and interventions to prevent adolescent pregnancy.

Together, these findings highlight the need to move beyond fragmented initiatives towards comprehensive, adequately resourced and scalable approaches that respond to adolescent nutritional needs. The recognition of adolescent nutrition in ARNS 2026–2035 provides an opportunity to strengthen policy commitments, expand effective interventions and improve accountability for results across the continent.

Priority Actions for Accelerating Adolescent Nutrition

The findings call for more deliberate and sustained action to address adolescent nutrition across Africa. Accelerating progress requires stronger policy commitment, evidence-based interventions, gender-responsive approaches, coordinated multisectoral action and sustained investment.

1. Strengthen policy and strategic integration. Adolescent nutrition should be explicitly prioritised in the implementation of ARNS 2026–2035 and reflected in national nutrition policies, strategies and multisectoral action plans. Governments should strengthen policy coherence across nutrition, health, education, food systems and other relevant sectors, ensuring that the specific nutritional needs of adolescents aged 10–19 years are recognised and addressed.

2. Scale up evidence-based adolescent nutrition interventions. Member States should move beyond fragmented and small-scale initiatives towards effective, context-appropriate interventions addressing the multiple forms of malnutrition affecting adolescents. Priorities include preventing and managing anaemia and other micronutrient deficiencies, promoting healthy diets, and preventing undernutrition, overweight and obesity. Nutrition education, WIFAS, school feeding and links with adolescent-responsive

health services should be strengthened in line with national needs and available evidence.

3. Address gender inequalities and reach adolescents facing greater barriers. Policies and programmes should respond to the social, economic and gender-related factors influencing adolescent nutrition, including unequal access to education, health and nutrition services, and nutritious foods. Interventions should recognise differences between girls and boys and across the 10–19-year age range, with particular attention to younger adolescents, out-of-school adolescents, pregnant adolescents and adolescent mothers, as relevant to national contexts. Nutrition action should also be linked with efforts to address early pregnancy, child marriage and barriers to sexual and reproductive health information and services.

4. Strengthen integrated, multisectoral and adolescent-responsive action. Adolescent nutrition cannot be addressed by the health sector alone. Governments should strengthen coordination across health, education, agriculture and food systems, WASH and social protection to create supportive environments for healthy diets, nutrition services and positive health behaviours. Adolescents should be meaningfully considered in the design, delivery and review of interventions, with approaches adapted to their age, circumstances and needs.

5. Strengthen evidence, data and accountability. Member States should improve the routine collection, analysis and use of age- and sex-disaggregated data for adolescents aged 10–19 years, including younger adolescents and those not reached through school-based systems. Adolescent-specific indicators should be integrated into national nutrition monitoring and accountability mechanisms and relevant continental frameworks, including CNAS, to strengthen visibility, track commitments and assess progress. The African Union Commission should provide continental leadership and promote alignment with ARNS 2026–2035, while RECs facilitate regional collaboration and knowledge exchange.

6. Increase financing and strengthen implementation capacity. Governments should give greater priority to adolescent nutrition in resource mobilisation, planning and budgeting, translating commitments into costed multisectoral plans supported by adequate domestic financing and clear institutional responsibilities. Development partners, civil society, academia and other stakeholders should complement national leadership through evidence generation, technical assistance, capacity strengthening and implementation support.

Delivering these priorities requires sustained political commitment and coordinated action at continental, regional and national levels. Stronger institutional capacity, measurable indicators and effective accountability mechanisms should support implementation and help ensure that commitments translate into measurable improvements in adolescent nutrition.

Looking Ahead

Adolescent nutrition is both a public health priority and an investment in Africa's future. The evidence presented in this report demonstrates that undernutrition, overweight and obesity, micronutrient deficiencies and gender inequalities continue to constrain the health, education, empowerment and productive potential of adolescents across the

continent. The recognition of adolescent nutrition as a strategic priority in ARNS 2026–2035 creates an important opportunity to accelerate progress.

Realising this opportunity requires sustained commitment to ensuring that adolescent nutrition is reflected in policies, programmes and investments. Particular attention must be given to adolescent girls, out-of-school adolescents and other underserved groups, while ensuring that interventions respond to the distinct nutritional needs of both girls and boys throughout adolescence.

Investing in adolescent nutrition and education can generate mutually reinforcing benefits for health, learning, empowerment, productivity and intergenerational well-being. By systematically integrating adolescent nutrition into development priorities, AU Member States can unlock the potential of this significant population group and accelerate progress towards the aspirations of Agenda 2063 – *The Africa We Want*.

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Background

Why it is the right time to invest in adolescents in Africa

It is a key moment for action towards improving the nutrition of adolescents in Africa. Africa's Agenda 2063 and the continent's progress on global targets cannot be achieved without investment in adolescent health and nutrition. Adolescents can only have optimal opportunities to learn, earn, grow and lead if they have access to adequate nutrition.

Africa is currently home to approximately 273 million adolescents, the highest population in the continent's history, representing over 20% of the world's total adolescent population. The rate of growth of this population group is quite fast and it is expected to reach 435 million by 2050.[5] This is an opportune time to harness the demographic dividend with investments in adolescent health that have been shown to bring a triple dividend of health and economic benefits for adolescents now, during their future life and into the next generation. Despite this, investments to date have been limited.[1]

The Africa Regional Nutritional Strategy (2016–2025),[1] did not adequately address adolescent nutrition. Consequently, the current Continental Nutrition Accountability Scorecard (CNAS).[2] lacks adolescent indicators. There were no specific indicators in the scorecard related to adolescent nutrition for countries to make progress aligned with the achievement of the 2030 Sustainable Development Goals (SDGs) and World Health Assembly (WHA) targets on anaemia, childhood overweight and low birthweight as it relates to adolescent pregnancy. All of these depend on improvements in the nutrition and health of adolescents.[3,4]

Progress on the Malabo Declaration and Agenda 2063 goals related to health and wellbeing, gender equality and youth empowerment could be accelerated by action in improving adolescent nutrition.[5] As the African Union (AU) embarks on the next Africa Regional Nutrition Strategy (2026–2035) with increased inclusion of adolescent nutrition, it will be essential for Member States to consider potential investments and actions for increasing understanding of the landscape for adolescent nutrition and to undertake an analysis of data to enable potential decision making for improving adolescent nutrition policies and programs.

Why adolescents?

Adolescents in Africa are experiencing a triple burden of malnutrition, with undernutrition, overweight/obesity, and micronutrient deficiencies co-existing in the same populations and geographies.

The World Health Organization (WHO) defines adolescence as the age between 10 and 19 years.[6] It is a unique developmental stage with diverse needs. It is also a transitional stage from childhood to adulthood that is characterized by rapid physical growth, hormonal changes, sexual development and increasing autonomy. Adolescents make up about 16% of the global population, with the majority living in low- and middle-income countries.

Globally, adolescents suffer from various forms of malnutrition, with undernutrition persisting and cases of overweight and obesity rising.[7] The global prevalence of underweight among adolescent girls is estimated at 8%,[8] while anaemia continues to be

an issue of public health concern among adolescents globally, with approximately 30% of adolescent girls being anaemic.[9] A recent study on micronutrient deficiencies from 19 countries shows that more than two thirds of non-pregnant adolescents have iron, zinc or folate deficiency.[10].

Over the last 30 years, the prevalence of overweight girls has doubled.[11] Studies show high, persistent prevalence of anaemia among adolescents and increasing prevalence of overweight and obesity,[12,13,14] with contributing factors of poor dietary intake, insufficient physical activity,[15] and other complex genetic factors and food environments.[16,17]

Similar trends are observed in Africa with rising cases of overweight and obesity among adolescents and persistent anaemia prevalence

Adequate nutrition is necessary for adolescent growth and development

Good nutrition is essential for health and wellbeing, growth and development, educational performance and attainment, and supporting the empowerment of adolescents.

Adolescence is the second fastest growth period after infancy, with adolescents attaining about 20% of their final adult height, 50% of adult weight and an increase in bone mass of up to 40% during this phase.[18] While the brain attains 90% of its size by age six, considerable brain growth and development continue into adolescence, especially the grey and white matter. Adolescence also offers an opportunity for catch-up growth to address deficiencies experienced during childhood.[19] The timing and duration of puberty, which has consequences for the growth and maturation of adolescents, is affected by nutrition. Undernutrition is associated with later onset of menarche, whereas obesity is associated with early sexual maturation.[20,21]

Besides physiological changes, adolescence is also a period of significant change, from dependence on caregivers to having a more active role in decisions, including those related to dietary intake and other determinants of health and nutrition status. This presents an opportunity to cultivate positive dietary behaviour, which has potential long-term benefits — such as prevention of nutrition-related noncommunicable diseases — by fostering healthy food choices and the formation of longer term healthy dietary habits.[22]

Conversely, adolescence can also be a phase with increased risks, as adolescents have greater exposure to marketing, social media, ultra-processed foods (UPFs) and sugar-sweetened beverages. It can also be a phase when physical activity and healthy lifestyle choices are at risk.[23]

Adolescent nutrition is a gender issue

Adolescent girls are disproportionately affected by malnutrition due to biological and gendered social factors. The onset of menstruation increases nutritional needs for iron for girls. Both boys and girls have increased needs for other micronutrients related to growing bone and muscle mass, including calcium, zinc and vitamin D.[24] Unmet iron needs can result in iron-deficiency anaemia among adolescent girls, which negatively affects their growth, immunity and cognitive function. Iron-deficiency anaemia is the leading nutritional deficiency associated with adolescent morbidity and one of the leading causes of years lost due to disability among adolescents.[1,25]

Pregnant adolescents are particularly vulnerable to anaemia because they have dual iron requirements — for their own growth and that of their child — which can perpetuate the intergenerational cycle of malnutrition.[26,27,28,29]

Where are adolescents on the global and continental nutrition agenda?

Despite the high burden of malnutrition among adolescents, global, continental, regional and national strategies and investments in nutrition have largely continued to focus on maternal, newborn and child nutrition, with little emphasis on and inclusion of adolescent nutrition.[30] There is limited attention to adolescent nutrition in the United Nations (UN) Decade of Action on Nutrition (2016–2025) and SDGs, while the recently renewed WHA Global Nutrition targets primarily focus on maternal, infant and young child nutrition. While there is a recommendation for intermittent iron and folic acid supplementation for menstruating women living in settings where the prevalence of anaemia is 20% or above, there is no explicit mention of adolescents. Adolescents were also overlooked in the Africa Regional Nutrition Strategy 2016–2025, with no strategies to address their unique needs.

With a new strategy in the development phase, there is an opportunity to adequately include adolescents. To maintain the gains made in the first two years of life, support catch-up growth following early childhood undernutrition, break the intergenerational cycle of malnutrition and achieve continental, regional and country-specific nutrition targets, it is necessary to include adolescents in nutrition policies, strategies and programs.[31] For instance, to reduce the prevalence of anaemia among women of reproductive age by 50% by 2030, adolescent girls must be targeted, as they contribute significantly to the burden of anaemia among women aged 15–49 years. And while younger adolescents aged 10–14 years are generally underrepresented in the data, they can benefit from anaemia reduction and prevention efforts, and in some contexts, can be more feasibly reached in school-based programs with higher attendance than older adolescent girls.

Recent progress in the global adolescent nutrition policy landscape is encouraging. In 2018, WHO released a guideline on implementing effective actions for improving adolescent nutrition that summarizes evidence-based interventions and policies for adolescent nutrition[32]. In 2021, UNICEF published programming guidance for nutrition in middle childhood and adolescence [33]that provides technical and operational guidance for the design, implementation, and monitoring and evaluation of adolescent nutrition programs. A 2022 series in *The Lancet* [34]further recommended increased emphasis on adolescent nutrition in national policies and programs in view of recent evidence highlighting the critical role of nutrition in adolescent growth and development. The recently published second edition of the *Global Accelerated Action for the Health of Adolescents* [35]provides countries with a framework for the design and implementation of adolescent health programs. It underscores the importance of nutrition in adolescent health and highlights iron-deficiency anaemia as one of the leading causes of morbidity among adolescents.

Despite this progress in global guidance there is limited guidance, policy framework and research on adolescent nutrition in Africa. Data gaps and a lack of awareness of the burden of adolescent malnutrition hinder inclusion of adolescents in nutrition policy and programming.

Aim and purpose of this report

The intention of this report is to draw attention to the state of adolescent nutrition in Africa, and to present data and context to inspire AU Member States and regional communities to act. The report examines health and nutrition status, demographic and gender equity data, and the enabling environment and considers how these factors influence adolescent nutrition in Africa.

An initial draft of the data was used by the Africa Union Commission (AUC) for the development of the Africa Regional Nutrition Strategy 2026–2035. This report was developed in response to recommendation by the 14th Africa Taskforce for Food and Nutrition Development (ATFFND) to better respond to adolescent nutrition. The report seeks to provide Regional Economic Communities (RECs) and AU Member States with information for decision making for adolescent nutrition policy and programming, including the burden of malnutrition and key determinants. In addition, it highlights data gaps, analyzes cross-sectoral connections and provides selected case studies of promising adolescent nutrition programs and nutrition policies that intentionally include adolescents.

Approach to mapping the data on adolescent nutrition

Data mapping and compilation, followed by a desk review, were conducted to assess the current state of adolescent nutrition among Member States.

Data collection followed a three-step process. The first step was collecting country-level quantitative data on adolescent nutrition in the following three domains:

1. Demographic and gender equity data.
2. Nutrition and health data.
3. Enabling environment.

The indicators were selected by Nutrition International's senior experts in adolescent nutrition in consultation with the AUC nutrition experts. The selection was based on WHO guidance on effective actions for adolescent nutrition, the Global Action for Measurement of Adolescent Health (GAMA) list of adolescent health indicators, SDG indicators and WHA Global Nutrition targets. The quantitative data analyses then involved making connections between gender equity gaps and nutrition status data, with a focus on anaemia, a leading cause of morbidity and mortality for adolescent girls.

The second step was a qualitative review of existing policies, commitments, strategies and action plans to assess the enabling environment for adolescent nutrition among each of the 55 AU Member States.

The third step was conducting a literature review on adolescent nutrition in Africa. Data was collected between February 2024 and April to November 2025. Data was updated as new evidence became available.

Demographic and gender equality data collected at the country level included:

- total number of adolescents
- percentage of adolescents as a proportion of the total population
- school completion rates
- school enrollment rates
- school attendance rates
- proportion of the population living below the international poverty line
- adolescent birth rate
- prevalence of child marriage.

Health and nutrition data included:

- prevalence of thinness, overweight and obesity;
- prevalence of anaemia;
- prevalence of micronutrient deficiencies;
- demand for family planning satisfied with modern methods;
- unmet need for contraceptives;

- number of adolescents living with HIV;
- percentage of insufficient physical activity among schoolchildren aged 11–17 years; and
- the proportion of the population that is food insecure.

For the enabling environment, national nutrition policies, strategies and plans were reviewed to assess the inclusion of adolescents. Nutrition for Growth (N4G) commitments were also assessed to evaluate inclusion of adolescents.

Table 1: Sources of data for adolescent nutrition-related indicators in this report

Type of data	Indicator	Source
Demographic data	Total number of adolescents	UN, Department of Economic and Social Affairs, Population Division, World Population Prospects 2024
	Percentage of adolescents as a proportion of total population	UN, Department of Economic and Social Affairs, Population Division, World Population Prospects 2024
	School enrollment, completion and attendance rates	UNESCO Institute for Statistics
	Child marriage	Demographic and Health Surveys, Multiple Indicator Cluster Surveys, AIDS Indicator Surveys (AIS) National Surveys on Violence Against Women, National Population and Family Health Surveys
Health and nutrition status data	Prevalence of obesity, obesity, thinness	Demographic and Health Surveys, Multiple Indicator Cluster Surveys, NCD Risk Factor Collaboration (NCD-Risc), WHO Global Health Observatory
	Prevalence of anaemia	Demographic and Health Surveys, Global Nutrition Report 2024
	Adolescent birth rate	UN, Department of Economic and Social Affairs, Population Division, World Population Prospects 2024
	Demand for family planning satisfied with modern methods and unmet need for contraceptives	Demographic and Health Surveys
	% of insufficient physical activity	Global Status Report on NCDs 2014

	among school-going children (11–17 years)	
	Proportion of population that is food insecure	Food and Agriculture Organization 2023, Suite of Food Security Indicators
	National nutrition policies and strategies	Ministries of Health and Agriculture websites, Food and Agriculture Organization (FAO) website, Scaling Up Nutrition (SUN) website, Global Database on the Implementation of Food and Nutrition Action (GIFNA), Maternal Newborn, Child and Adolescent Health and Aging website, Google search
	Country nutrition commitments	The Nutrition Accountability Framework, N4G website

For the policy review, national nutrition policies, strategies and action plans were retrieved using a simple Google search and from the following websites:

- Global Database on Implementation of Food and Nutrition Action (GIFNA)
- Maternal Newborn, Child and Adolescent Health and Aging
- Food and Agriculture Organization (FAO)
- Scaling Up Nutrition (SUN)
- Ministries of Health and Agriculture

Nutrition commitments were retrieved from the Nutrition Accountability Framework and N4G websites, and analyzed to assess whether they were adolescent inclusive. Policies in English, French and Portuguese were all reviewed. Policies in French and Portuguese were translated to English using machine translators (DeepL Pro and Google Translate). The use of machine translators is supported by recent studies.[36,37] A sample of policies and strategies in French were reviewed by a person proficient in French to validate the accuracy of machine translation. The review showed that machine translation was mostly accurate with minimal inaccuracies related to grammar, which did not affect the quality of the policy review.

A matrix for analysis of policies was developed by senior nutrition experts at Nutrition International in consultation AUC nutrition experts. The matrix placed special focus on checking inclusion of adolescents in strategic objectives or priorities, nutrition interventions and results frameworks to assess whether adolescents were meaningfully included. Two reviewers independently reviewed the policies and provided an assessment. In cases where there were discrepancies, the policy was reviewed again, and a final decision was made.

To complement the review of health and nutrition status and associated determinants — and to identify adolescent nutrition programs and interventions — a literature review was conducted. We searched PubMed and Scopus databases for peer-reviewed literature published between 2000 and 2025 and several websites including WHO, UNICEF and the Global Adolescent Nutrition Network for grey literature. A search strategy was developed and search terms covered adolescents, nutritional status, dietary intake, micronutrient deficiencies, food environments and nutrition interventions across all African countries.

Studies were included if they reported on adolescents aged 10–19 years in Africa and the outcome of interest was: nutrition status (stunting, thinness, underweight, overweight, obesity, iron deficiency and iron-deficiency anaemia); determinants of nutrition (diet, food environment, food insecurity and eating habits); or nutrition interventions and programs.

We excluded studies that: (1) did not include adolescents; (2) combined adolescents with other age groups without presenting disaggregated results; (3) focused exclusively on body image or eating disorders; or (4) were commentaries, protocols, case reports or non-English publications.

The report was reviewed and endorsed by the 15th Africa Taskforce for Food and Nutrition Development of the African Union (ATFFND) in June 2026. The report has been revised to include recommendations of the taskforce.

Strengths and limitations of the review

To the best of our knowledge, this is the first continental review on adolescent nutrition status in Africa covering all 55 AU Member States. It provides a comprehensive analysis of adolescent nutrition status, while also providing an assessment of inclusion of adolescent nutrition in policies, strategies and plans. In addition, a literature review was conducted as part of this work, providing qualitative information on the determinants of adolescent nutrition. The review also includes a review of N4G commitments to assess whether countries have made commitments that are adolescent inclusive.

One limitation of this review is that it relied heavily on online data sources and therefore data that may not be available online was not included; this may include draft surveys and policies that are yet to be published.

Guiding framework for adolescent nutrition data mapping across African Union Member States

HEALTHY AND WELL-NOURISHED ADOLESCENTS

Empowered adolescents with equitable access to good nutrition, growth, development and health

Adolescents have an age- and stage-relevant understanding of their own health, growth and potential to benefit from good nutrition and health practices and access to good nutrition and health, through adequate diet, health practices, including safe recreation/physical activity, and nutrition and health service access.

Health and nutrition status

Healthy BMI • Stunting • Anaemia status • Micronutrient deficiencies • Overweight and obesity, underweight, thinness

ACCESS TO HEALTH AND NUTRITION SERVICES AND PRACTICES

Good nutrition and health practices

- Practice of sufficient physical activity
- Adequate dietary practices*
  - *Food security*

Contributing factors*

- *Environment, food environment and food systems, WASH*

Access to adolescent-responsive health and nutrition services

- Availability of adolescent-responsive/adolescent-friendly health facilities*
- Availability of school health programs*

Contributing factors*

- *Health promoting schools and school environment (including WASH)*

Protection from adolescent pregnancy for adolescent girls

- School enrollment, attendance and completion for girls
- Protection from child marriage
- Access to contraceptives and age- and stage-relevant SRH information and services for adolescent boys and girls

ENABLING ENVIRONMENT AND GOVERNMENT POLICIES

National nutrition policies and strategies

- Inclusion of adolescents in nutrition policies
- Adolescent-responsive policies across relevant sectors (health, education, WASH, social safety nets)
- Inclusion of adolescents in routine data and monitoring*

Investments in adolescent nutrition

- Inclusion of adolescents in country nutrition commitments
- Adolescent nutrition programs*

SOCIAL NORMS AROUND ADOLESCENCE AND GENDER EQUITY

Social norms around adolescence

Prioritization of adolescent nutrition across society: Awareness and importance given to the life stage of adolescence by decision makers, policy makers, communities and families, and an understanding among stakeholders of the potential for adolescence to benefit from improved nutrition and health practices and services in the present and the future.

Gender equity and adolescence

Inequities and gendered social norms impact may affect both boys' and girls' lived experiences and access to good nutrition, dietary practices, physical activity and health practices, protection from risks, access to responsive systems and structures, agency, control over resources and decision making around health and nutrition.

Intersecting social-economic inequities for adolescents

Poverty limits many adolescents from attending or completing education, such as pressures to leave school for wage labor or sibling care, or prohibitive costs or lost opportunity costs for accessing education. Intersecting gender equity barriers for girls exist related to school enrollment and regular attendance, gender-based violence, menstrual health, female-friendly WASH, social norms on valuing female school attendance.

*Indicates a domain that is described in narrative form only and sufficient data was not available to analyze across countries with a defined quantitative indicator.

The analytical framework for this report was informed by: the *UNICEF Conceptual Framework on the Determinants of Maternal and Child Nutrition* (2020); Adolescent Well-being: A Definition and Conceptual Framework (Ross et al., 2020); elements of the *Gender-transformative Framework for Nutrition* (World Vision et al., 2020); and GAMA indicators (WHO, 2024).

Findings

Demographic information

Adolescent population

African countries can reap the benefits of the demographic dividend, which is defined by the UN as economic growth that occurs when there are more working-age people (aged 15–64 years) than non-working people (under 14 and over 65).

Adolescents constitute a substantial proportion of the population in Africa and present significant opportunities for economic growth, especially when investments are made to improve their health and wellbeing. Adolescents aged 10–19 years make up between 11.58% (Cape Verde) and 27.18% (Central African Republic) of the total population in Africa. The proportion of adolescents aged 15–19 years ranges between 6% (Seychelles) to 13% (South Sudan), while younger adolescents (aged 10–14 years) make up between 5% (Mauritius) to 15% (Central African Republic) of the total population. See Appendix 1 for more information.

Education

Good health and nutrition provide an essential foundation for academic success, as healthy and well-nourished adolescents learn better. Schools serve as important partners and platforms for the delivery of health and nutrition services, and they can also provide protection for adolescents.

As a result, out-of-school adolescents miss out on these critical health and nutrition services, perpetuating health inequity among adolescents who may be in vulnerable contexts. Evidence shows that out-of-school adolescent girls are at risk of adolescent marriages and pregnancies, which ultimately affects their health and nutrition status and lack of economic empowerment, perpetuating cycles of poverty.[38,39] In contrast, studies show that in-school adolescents are more likely to utilize healthcare services, be physically active, have used a condom during the last intercourse, know their HIV status and wash their hands compared to their out-of-school counterparts.[40] In addition, school-based interventions such as school meals have been shown to be associated with increased school enrollment and attendance rates (9% and 8%, respectively). [41] Deworming and micronutrient supplementation can result in students attending school for 2.5 additional years in places where anaemia and worm infections are prevalent.[42]

Investing in both adolescent nutrition and education has the potential to be mutually beneficial for both education and nutrition outcomes. Generally, data shows higher enrollment rates in primary schools compared to secondary schools. Data from UNESCO Institute of Statistics shows that net primary school enrollment rates range from 55.1% in Eritrea to 99.5% in Egypt.[6] However, there is a significant drop in enrollment rates in secondary school, with net lower secondary school enrollments rates ranging from 21.8% (Niger) to 99.5% (Namibia) and net upper secondary school enrollment rates ranging from 10% (Niger) to 91.4% (South Africa).

There are variations in enrollment rates among girls compared to boys, with significant differences observed in both lower and upper secondary schools. For instance, net lower secondary school enrollment is significantly lower among girls compared to boys in Guinea, Guinea Bissau, Malawi and Mauritius and higher in Gambia and the Republic of the Congo. Similarly, upper secondary school enrollment is significantly lower among girls compared to boys in Benin, Chad, Eritrea, Guinea, Malawi, the Republic of the Congo and Togo, and higher in the Gambia, Lesotho, Mauritius, Seychelles and South Africa (see Appendix 2). Primary school net attendance rates are highly variable and range from 26.2% (Somalia) to 98.4% (South Africa), reflecting the diversity of contexts.

Similar to school enrollment, there is a drop in attendance from primary to secondary school, with differences across countries. Net school attendance for lower secondary school ranges from 32.9% (Niger) to 97.5% (Gabon). Net school attendance for upper secondary school ranges from 18.1% (Niger) to 89.8% (Gabon). There are variations in attendance rates among boys and girls in both lower and upper secondary schools, with significant differences in upper secondary schools. Out of 38 countries with data, 31 have higher school attendance among boys compared to girls (see Appendix 3). The rates of attendance will have implications for the feasibility of reaching adolescent boys and girls through school-based programs, with differing implications across school levels for those aged 10 to 19 years.

Health and nutrition status

Prevalence and trends of thinness and stunting

WHO defines thinness as low body mass index (BMI) for age (BMI for age <-2 standard deviations), while stunting is defined as low height for age (height-for-age <-2 standard deviations).[43] Thinness reflects acute nutrition deprivation, while stunting indicates chronic nutrient deprivation. Adolescents who are thin or stunted face impaired immune function, reduced bone density and physical performance, and an increased risk of noncommunicable diseases later in life. Beyond physical health, undernutrition during adolescence negatively affects cognitive development, concentration and school performance, which in turn limits educational attainment and future economic productivity.[44] For adolescent girls, undernutrition can have lifelong consequences for health and wellbeing, as well as potential intergenerational effects, increasing the risk of low birthweight, preterm birth and neonatal mortality among their future children.[45] Ultimately, undernutrition undermines the ability of adolescents to live healthy lives and reach their full potential.

Undernutrition among adolescents in Africa occurs in the context of persistent poverty, economic and climate shocks, and protracted humanitarian crises, all of which reduce food production, affordability and consistent access to nutritious diets and health and social services. Other drivers of undernutrition include biological factors, such as increased nutrient needs during adolescence due to rapid growth and development, and adolescent pregnancy among girls.

Demographic and Health Surveys (DHS) provide thinness data for adolescents aged 15–19 years, while data on adolescents aged 10–14 years is typically lacking in most national surveys. Prevalence of thinness among adolescent girls (aged 15–19 years) ranges from 0.6% in Egypt to 39.9% in Eritrea (data from 36 countries), while prevalence of thinness among adolescent boys (aged 15–19 years) ranges from 7% in Seychelles to 59% in Ethiopia (data from 20 countries).

A review of published literature between 2016 and 2025 shows high rates of adolescent stunting. In Ethiopia, reported stunting ranged from 6.4% to 47.4%, while in Nigeria, a systematic review found that stunting ranged from 0.4% to 41.6%. Similar studies showed stunting ranged from 7.5% to 19.8% in Sudan, from 3.1% in urban settings to 64.5 % in rural settings in Tanzania and from 9.6% to 18.4% in South Africa. Studies also showed stunting rates of 12.75% in Morocco and 13.5% in Zimbabwe, and one study in Ghana reported a stunting prevalence of 26.5% among girls.

Studies from Burkina Faso, Ethiopia, Ghana, Nigeria, South Africa, Tanzania and Uganda indicate that adolescent boys have higher rates and greater risk of stunting and thinness compared to adolescent girls.[9,46,47,48,49] For instance, a study conducted in eight countries in sub-Saharan Africa showed that female sex was associated with a lower risk of being underweight (pooled PR 0.66; 95% CI: 0.57–0.77) and stunted (pooled PR 0.63; 95% CI: 0.55–0.71), but a higher risk of being overweight (pooled PR 1.60; 95% CI: 1.26–2.06). This is consistent with DHS data (shown in Figure 1), which shows higher prevalence of thinness among boys compared to girls. More research is needed to understand the drivers of these disparities and their implications.

Generally, adolescents from households with low wealth indices exhibit higher rates of stunting, thinness and underweight.[50,51,52,53] Maternal education is also an independent predictor of undernutrition among adolescent girls.[54] Several studies document higher rates of stunting and thinness among adolescents in rural areas compared to urban areas. Two meta-analyses of undernutrition among adolescents in Ethiopia — along with studies from Côte D'Ivoire, Nigeria and a regional analysis of East African adolescent girls — found that rural residence was a significant predictor of adolescent stunting.[55 56,57,58,59] However, adolescents living in low-income households in urban areas are also at risk of undernutrition.[60, 61]

Generally, adolescent thinness is declining in nearly most countries, albeit at a slow pace. Conflicts and acute shocks may arise and are not necessarily reflected in surveys. Data from the WHO Global Health Observatory shows a slow declining trend over the last two decades in almost all countries except in Mozambique, Nigeria and Tanzania (where it is increasing) and in Niger (where the prevalence has stayed the same). However, only four countries have experienced reduction in prevalence of thinness greater than 5 percentage points: South Africa (9 percentage points), Sierra Leone (5 percentage points), Democratic Republic of the Congo (5 percentage points) and Ethiopia (5 percentage points).

Prevalence and trends of overweight and obesity

Overweight and obesity in children and adolescents aged 5–19 years are defined by the WHO as BMI greater than 1 and 2 standard deviations from the WHO Growth Reference median, respectively.[62] Overweight and obesity resulting from an unhealthy diet and inadequate physical activity poses risks for future health, including noncommunicable diseases such as diabetes, hypertension, coronary heart disease, stroke and certain cancers.[63] For the first time in history, the number of school-age children and adolescents globally living with overweight or obesity now exceeds those who are underweight.[64] Data from the WHO Global Health Observatory shows that in 2022, the prevalence of adolescent overweight has surpassed thinness in most African countries. Only 10 countries with available data (Burkina Faso, Burundi, Chad, Eritrea, Ethiopia, Madagascar, Niger, Nigeria, Senegal and Tanzania) record higher rates of thinness compared to overweight.

This shift has frequently been linked to changes in diet and lifestyle. Food systems and environments in Africa have transformed over the last two decades, and the availability, promotion and consumption of fast foods, UPFs and beverages have increased.[65] These foods are typically high in calories, sugar, sodium and saturated fat and low in essential micronutrients. UPFs are designed to be hyper-palatable, leading to excessive energy intake, which contributes to overweight and obesity. UPF corporations are increasingly preying on adolescents in Africa through targeted marketing strategies that make UPFs attractive, addictive and convenient for these populations. The intake of fruits, vegetables and animal-source foods have simultaneously declined with this nutrition transition.[66] Combined with sedentary lifestyles, these factors contribute to an emerging crisis of adolescent overweight and obesity and the development of related chronic health complications during adolescence and into adulthood, including Type 2 diabetes, cardiovascular disease and hypertension.

Data from DHS shows that the prevalence of overweight among adolescent girls (aged 15–19 years) ranges from 2.5% in Eritrea to highly a concerning 34.7% in Egypt (data from 41 countries), while the prevalence of overweight among adolescent boys (aged 15–19 years) ranges from 0.3% in Rwanda to 7% in Comoros (data from 18 countries). Obesity among adolescent girls (aged 15–19 years) ranges from 0.2% in Ethiopia to 17.6% in Egypt (data from 43 countries), while among adolescent boys, obesity ranges from 0% in Uganda to 2.5% in South Africa (data from 15 countries).

A review of published literature shows that rates of overweight and obesity vary by gender, age and place of residence. One study in South Africa documented an alarming overweight prevalence of 57% among rural black adolescents.[67] The prevalence of overweight and obesity is consistently higher among adolescent girls compared to boys (Figure 2). Behaviours promoting obesity and overweight are often higher among girls compared to boys, including consumption of snacks, less engagement in physical activity and detrimental body image perceptions.[68,69] Some researchers hypothesize that lower rates of physical activity among girls may be relatively more important than other factors

in explaining the disparities between male and female obesity, because physical activity is highly gendered in several African countries.[70] Gender norms and inequality across many African countries restrict girls' participation and presence in activities outside the home, and girls may share more of the domestic workload. Even in the absence of gender norms specific to exercise, recreation, sports and physical activity, fears of gender-based violence and the lack of female-friendly physical activity programs and urban spaces prevent girls' participation and lead to low levels of physical activity.[71] Adolescents living in urban areas are also at higher risk of overweight and obesity due to greater access to fast foods and ultra-processed snacks and to having a more sedentary lifestyle.[7,8]

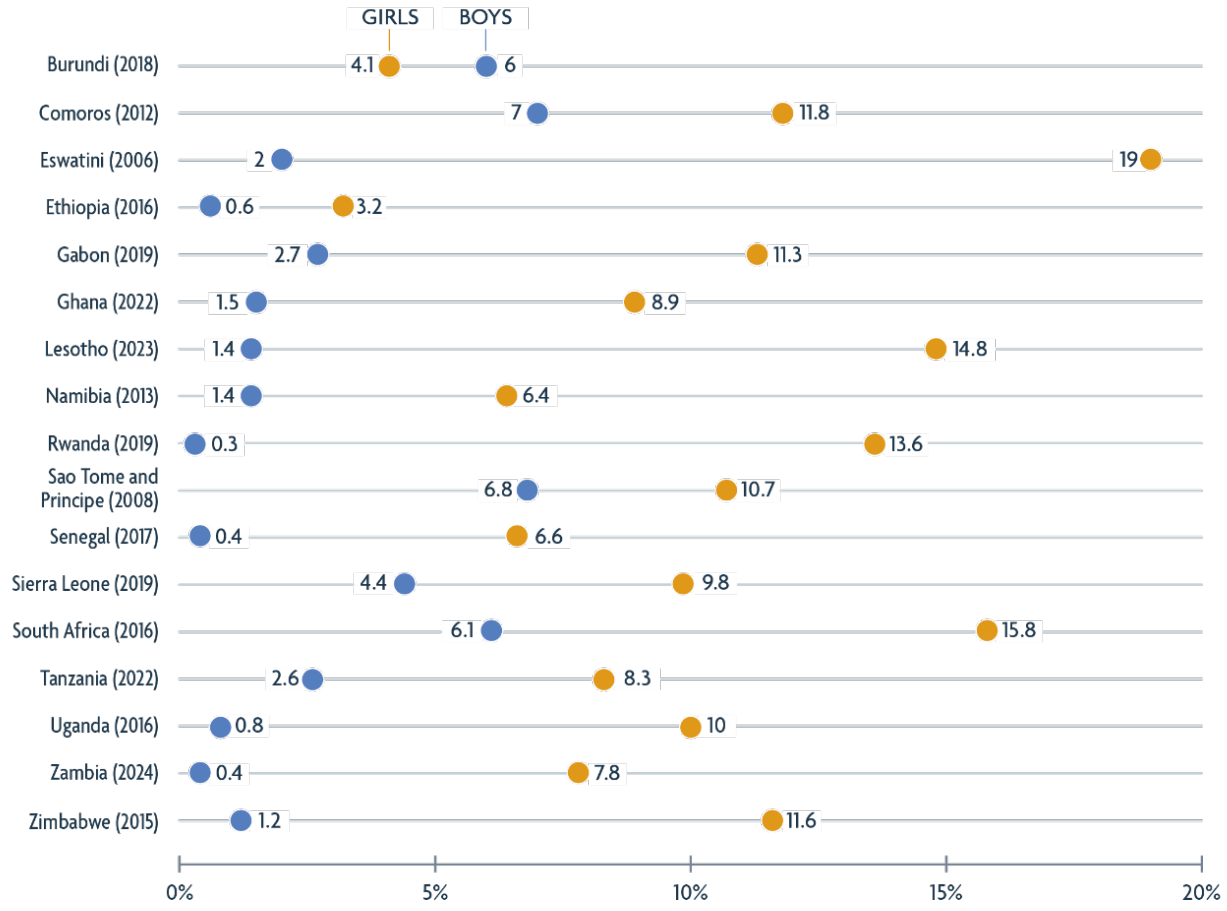
Adolescent overweight has risen sharply between 2000 and 2022 in every African country where data is available (see Appendix 9). Most countries have experienced increases of more than 5 percentage points. Some of the highest increases in prevalence of overweight were recorded in Seychelles (18 percentage points), Mauritius (18 percentage points), Mauritania (12 percentage points), South Africa (12 percentage points), Algeria (12 percentage points) and Liberia (11 percentage points). Similarly, obesity has increased in every country, with Seychelles (12 percentage points), Mauritius (9 percentage points), Algeria (7 percentage points), Liberia (7 percentage points), South Africa (7 percentage points) and Mauritania (7 percentage points) recording the most increases (see Appendix 10).

Figure 1: Comparison of thinness between adolescent boys and girls in AU Member States



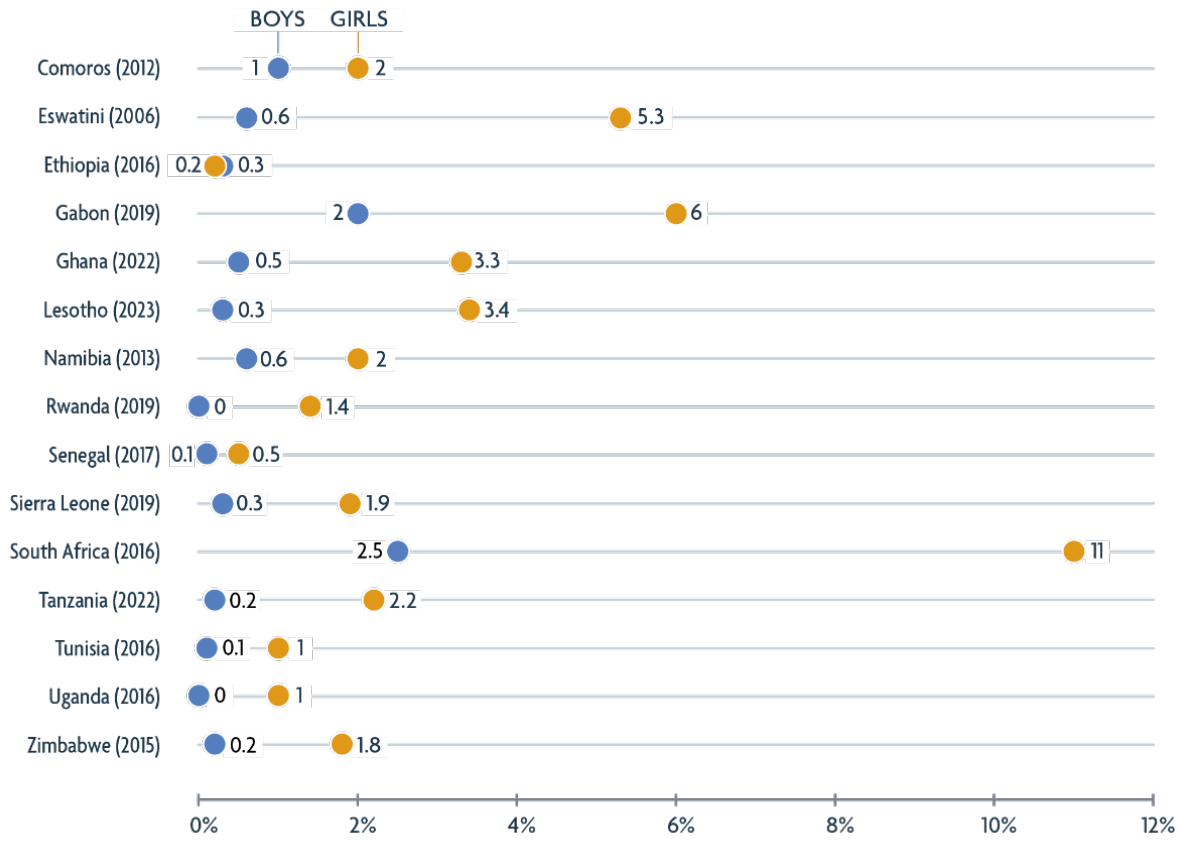
Source: Demographic Health Surveys

Figure 2: Comparison of overweight between adolescent boys and girls in AU Member States



Source: Demographic Health Surveys

Figure 3: Comparison in obesity between adolescent boys and girls among AU Member States



Source: Demographic Health Surveys

Anaemia

Anaemia is a public health problem in many contexts, affecting children, menstruating adolescent girls and women, and pregnant and postpartum women. The causes of anaemia are multifactorial and can be nutritional and non-nutritional. Direct risk factors include nutritional deficiencies, infections, gynaecological and obstetric conditions and inherited red blood cell disorders. Iron deficiency is the most common cause of anaemia, estimated to account for half of all cases of anaemia. The risk of iron-deficiency anaemia is high among adolescents (aged 10–19 years) due to factors such as increased demand for iron, inadequate intake from dietary sources, parasitic infections, blood loss during menstruation and lower iron stores.[37] Iron-deficiency anaemia is a leading contributor for adolescent disability-adjusted life years (DALYs) lost for adolescent girls (aged 10–14 and 15–19 years) and adolescent boys (aged 10–14 years).[72] Additionally, it is the third greatest global risk factor in adolescent boys aged 15–19 years.

In adolescents, iron-deficiency anaemia negatively affects physical capacity and work performance, educational outcomes and immunity.[73] In pregnancy, anaemia is associated with fetal morbidity and mortality, as well as perinatal risks for mothers and neonates.[74,75] WHO considers anaemia prevalence above 20% to be a moderate public health concern, and above 40% a severe public health concern.[76]

Anaemia prevalence data among adolescents aged 10–14 years is lacking in most national surveys, with DHS only providing data for adolescents aged 15–19 years. Data from DHS, however, does show prevalence of anaemia among adolescent girls aged 15–19 years is highest in Gabon (72%). Rwanda has the lowest prevalence (15%). Of the 38 countries with available data, 35 countries have a prevalence of anaemia among adolescent girls aged 15–19 years that is greater than 20%. Over half (23) of the countries have a prevalence greater than 40%, indicating that anaemia is a serious concern among adolescent girls in Africa.

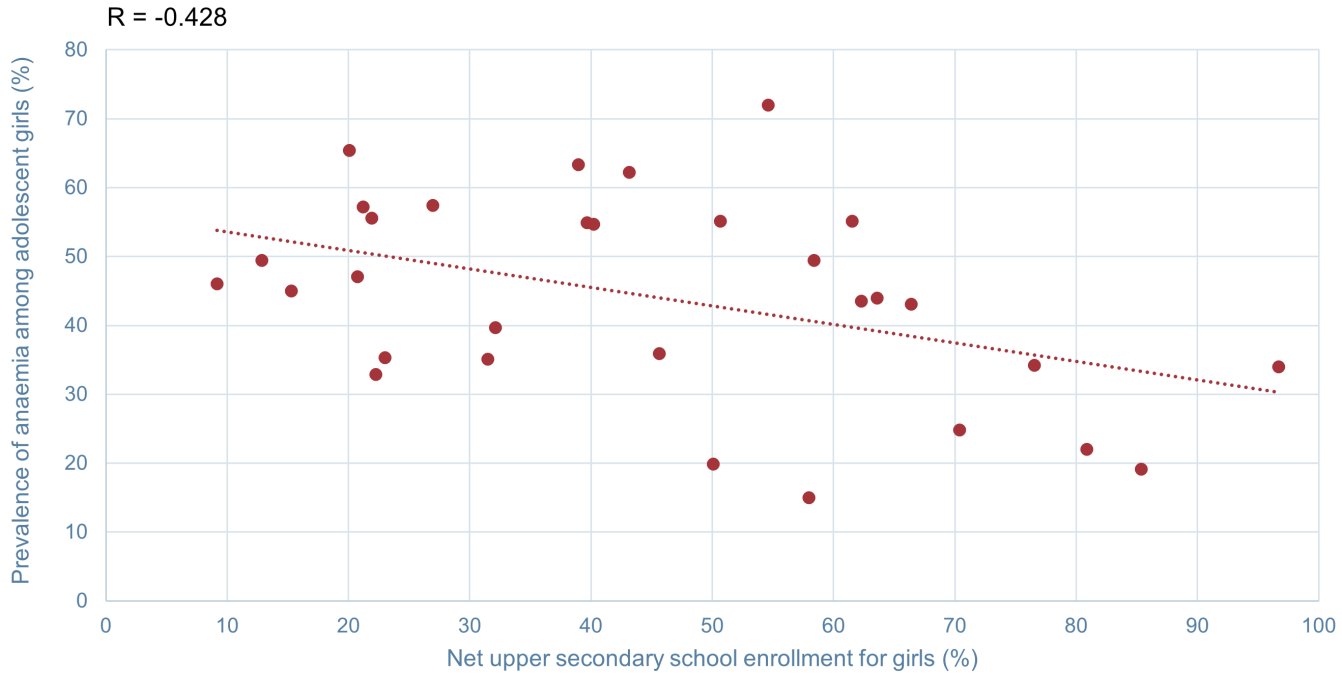
The prevalence of anaemia among adolescent boys aged 15–19 years is also high. Of the 21 countries with available data, prevalence of anaemia among adolescent boys is highest in Senegal (47.9%) and lowest in Eswatini (16.3%). However, the prevalence of anaemia is higher among adolescent girls compared to adolescent boys, as would be expected due to the biological and social vulnerability of adolescent girls. In cases where anaemia is high in boys, it seems to decrease into adulthood, whereas it persists or increases for adult women.

Figure 4: Prevalence of anaemia among adolescents in AU Member States



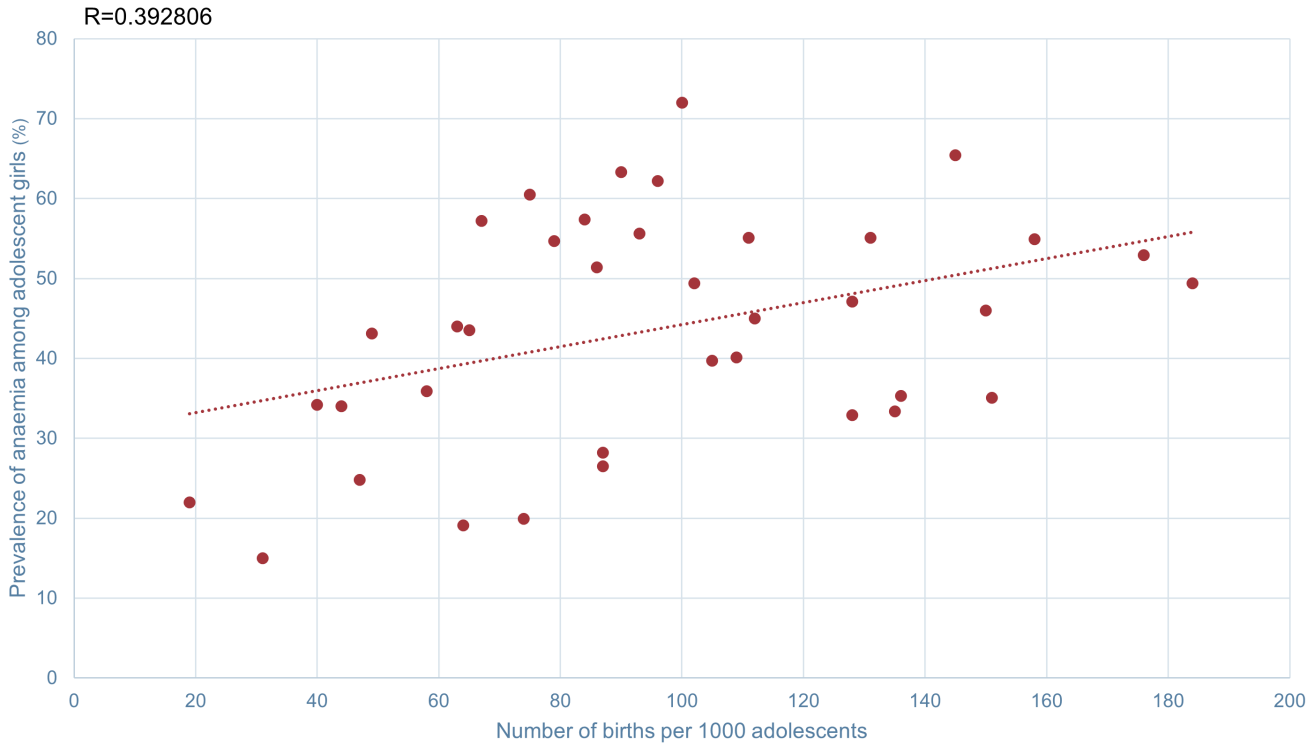
Source: Demographic Health Surveys

Figure 5: Correlation between upper secondary school enrollment and prevalence of anaemia among adolescent girls in Africa



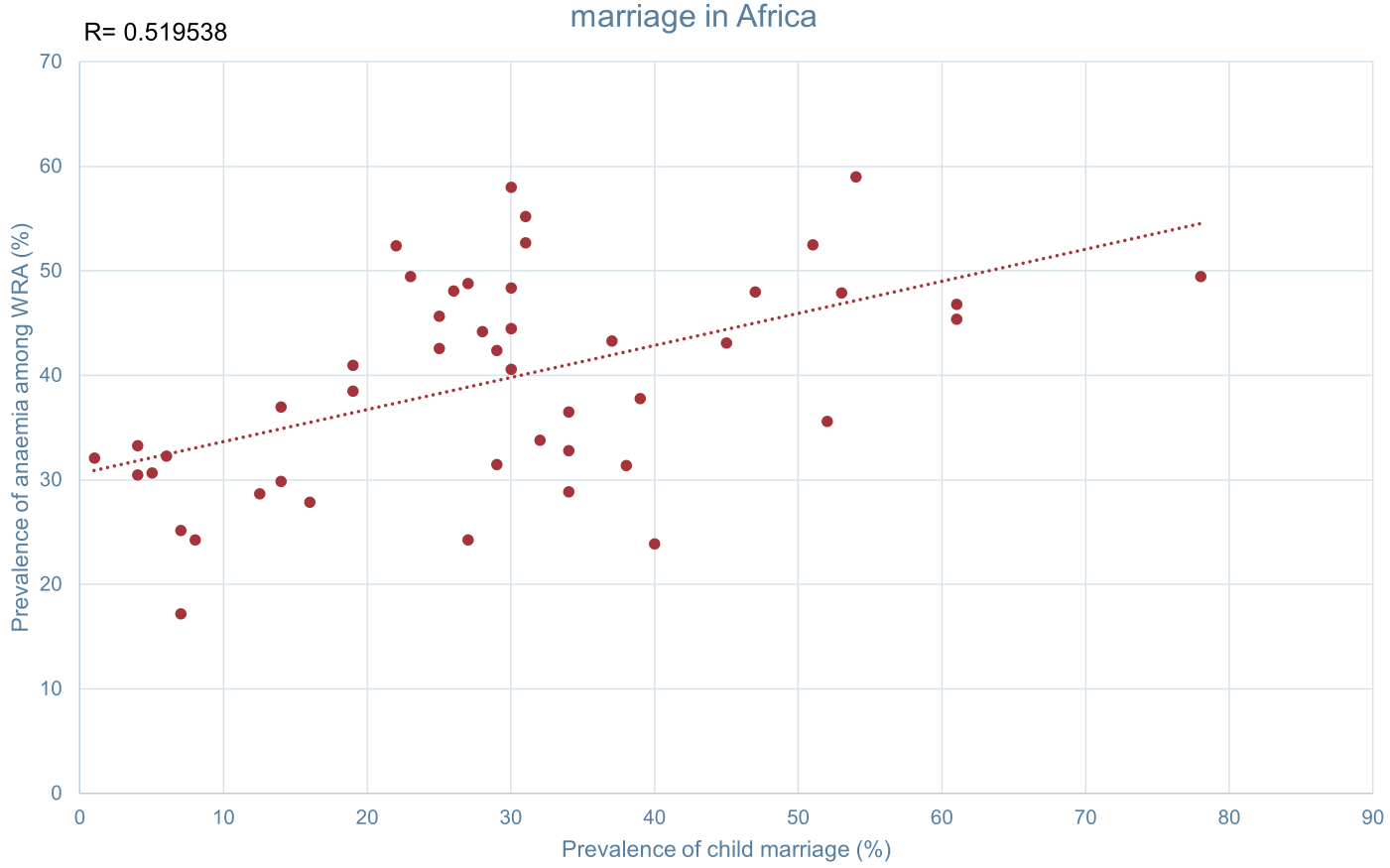
Countries with higher female secondary school enrollment have less adolescent anaemia. There is a moderate negative correlation between the prevalence of anaemia among adolescents and school enrollment.

Figure 6: Correlation between prevalence of anaemia among adolescent girls (15-19) years and adolescent birth rate in Africa



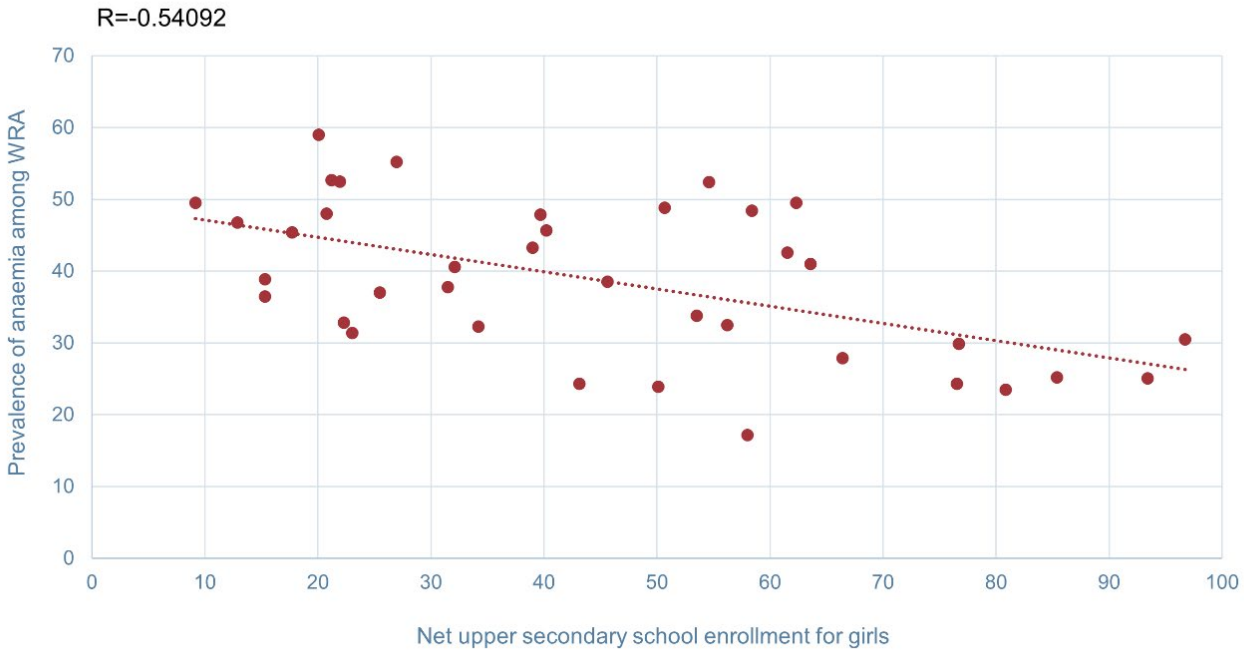
Countries with higher rates of adolescent pregnancies tend to have higher levels of adolescent anaemia. There is a positive, albeit weak, relationship between prevalence of anaemia and adolescent birthrate.

Figure 7: Correlation between prevalence of anaemia among WRA and child marriage in Africa



Countries with higher levels of child marriage see higher rates of anaemia in females aged 15–49 years. There is a moderate positive relationship between the prevalence of anaemia among women of reproductive age and the prevalence of child marriage. The prevalence of anaemia increases as the prevalence of child marriage increases.

Figure 8: Correlation between anaemia prevalence in WRA and girls' upper secondary school enrollment



There is a moderate negative relationship between the prevalence of anaemia among women of reproductive age and upper secondary school enrollment for girls. Anaemia prevalence decreases as net upper secondary school enrollment increases.

Table 2:Nutrition status of Adolescents(15-19 years) by different Africa Regions

	Prevalence of Anaemia (%)		Prevalence of Thinness (%)		Prevalence of Overweight (%)		Prevalence of Obesity (%)	
	Male	Female	Male	Female	Male	Female	Male	Female
Eastern Africa	18.2-39.9	15.0-45.0	7.0-59	4-39.9	0.3-7.0	2.5-13.6	0.0-1.0	0.2-2.0
Northern Africa	_	24.8-63.3	_	0.6-15.6	_	9.3-34.9	_	0.6-12.0
Central Africa	17.9-45.9	35.9-72.0	14.0-22.5	10.2-26.2	2.7-6.0	4.1-15.8	_	0.2-3.1
Southern Africa	16.3-39.9	19.1-72	6.7-26.7	9.0-30.7	2.0-6.1	4.1-15.8	0.2-2.5	0.2-11.0
Western Africa	27.1-47.9	34.2-65.4	9.0-51.4	10.4-34.5	0.4-4.4	3.8-12.1	0.1-1.0	0.5-3.8

Micronutrient deficiencies

Micronutrients are vitamins and minerals that are required in very small amounts in the body. Despite this, they play a critical role in health, and micronutrient deficiencies can cause serious health problems. Important micronutrients include iron, zinc, iodine, folate, vitamin A and vitamin B12.

Iron deficiency is a leading cause of anaemia, while vitamin A deficiency can lead to vision impairment, affect growth and reproduction, and weaken immunity. Iodine deficiency is associated with iodine deficiency disorders such as goiter and irreversible neurodevelopmental impairment. Zinc is a component of several enzymes and plays an important role in growth. Folate deficiency prior to pregnancy is associated with a higher risk of neural tube defect-affected pregnancies.

There is inadequate data on the prevalence of micronutrient deficiencies among adolescents in most African countries. Available data on micronutrient deficiencies from 11 countries does show a high prevalence of folate deficiency among adolescent girls aged 15–19 years in Liberia (84.2%), Ghana (57.3%) and Senegal (50.6%).[i] It also shows that the prevalence of zinc deficiency is high among adolescent girls in Cameroon (93.1%), Senegal (67.3%) and Malawi (61.1%), and that the prevalence of iron deficiency is high in Senegal (47.4%), Somalia (44.8%) and Gambia (36.7%).

[i] The 11 countries are: Cameroon, Ethiopia, Gambia, Ghana, Kenya, Liberia, Malawi, Mozambique, Senegal, Sierra Leone and Somalia.

Table 3: Micronutrient deficiencies among adolescent girls aged 15–19 years, Africa

Country (Year)	Region	Iron deficiency	Zinc deficiency	Folate deficiency	Vitamin B12 deficiency	Vitamin A deficiency
Cameroon (2009)	Central		93.1%			
Ethiopia (2015)	Eastern	10%	31.8%	14.7%	13.6%	
Kenya (2011)	Eastern	15.6%		31.5%	47.7%	
Somalia (2019)	Eastern	44.8%				
Malawi (2016)	Southern	14.4%	61%	2.9%	11%	55.7%
Mozambique (2002)	Southern					10%
Ghana (2017)	Southern	20.9%		57.3%	8.4%	
Gambia (2018)	Western	36.7%				
Liberia (2011)	Western	28.8%				
Senegal (2018)	Western	47.4%	67.3%	50.6%		2.4%
Republic of Sierra Leone (2013)	Western	10.3%		84.2%		

Source: World Health Organization. (n.d.). *Vitamin and mineral information system (VMNIS) micronutrients database*. World Health Organization. https://www.who.int/teams/nutrition-and-food-safety/databases/vitamin-and-mineral-nutrition-information-system/data

Underlying and immediate risk factors and determinants for malnutrition

Dietary intake

Healthy diets are important determinants of the nutrition and health status of adolescents. WHO defines a healthy diet as one capable of protecting an individual against all forms of malnutrition and noncommunicable diseases, such as diabetes, hypertension, cancer and stroke. A healthy diet provides adequate energy, protein, vitamins and minerals obtained through the consumption of foods such as fruits, vegetables, legumes, nuts and whole grains.[42] A healthy diet and good eating practices during adolescence can contribute to potential catch-up growth and can reduce the risk of noncommunicable diseases in adulthood.[77]

Adolescent dietary habits and behaviours are influenced by several factors, including the psychological, socio-cultural and economic environment.[78,79] Aggressive marketing by food manufacturers continues to expose adolescents to unhealthy foods. They consume greater amounts of cheap, energy-dense and nutrient-poor foods that are high in sugar, sodium and fat (including fast food and UPFs). Many adolescents lack access to affordable fresh fruits and vegetables, and they may not have the nutritional knowledge, skills or control of resources to buy and prepare foods needed for a healthy diet.[80,81,82,83,84]

Several studies show poor quality dietary intake among adolescents in Africa. A study on diet intake and quality among school-going adolescents (aged 15–19 years) in Burkina Faso, Ethiopia, Sudan and Tanzania found that the consumption of fruits, vegetables, nuts and seeds was low, while the consumption of lower, nutrient-dense refined grains was high. This is consistent with results of a study in Senegal that showed poor dietary intake among adolescents.[85] Another study on diet quality among school-aged children and adolescents in Zanzibar showed poor diets largely characterized by low animal-sourced foods and high intake of fried foods and sweetened beverages.[86]

In Ghana, one study showed that while only about 49% of school-going adolescents sampled regularly consumed fruits and vegetables, 90% of them regularly consumed toffees/sweets and 93% regularly consumed soft drinks. Furthermore, 57% never had breakfast before going to school.[87] In addition, a study on dietary intake among adolescent girls in low- and middle-income countries showed inadequate intake of fruits and vegetables, with almost half (47%) of adolescent girls in Africa skipping breakfast.[88]

Food insecurity

Food insecurity is the state of being unable to access sufficient, safe, nutritious and culturally valued food. Adolescents are vulnerable to food insecurity as they are less likely to be shielded compared to young and school-aged children, and this has a profound impact on their health and nutrition status.[89] It is associated with increased risk of stunting and underweight among children and adolescents, thinness among adolescent girls and poor dietary quality.[11,90,91,92] Africa is largely food insecure, with the latest estimates from the Food and Agriculture Organization (FAO) indicating that 36.7% of the total population

is moderately food insecure, 22.2% is severely food insecure and 58.9% is either moderately or severely food insecure.[93] Shocks from the COVID-19 pandemic and the war in Ukraine, coupled with the impact of climate change, have negatively impacted the food system, further worsening the food security situation.

Household measures of food insecurity do not capture the specific experiences of adolescents; therefore, further research is needed to understand food security situation of adolescents in Africa. The global, school-based student health survey provides data on food insecurity for school-going adolescents, but data is either lacking or outdated for most countries. Although the evidence base remains limited, available published studies point to a high prevalence of food insecurity among adolescents. A study in Kenya showed a 36% prevalence of household food insecurity among adolescents.[94] Another study on temporal trends in food insecurity among school-going adolescents across 31 countries in Africa, Asia and the Americas showed a high prevalence of severe food insecurity in Benin in 2009 (19%) and the Seychelles in 2007 (16.6%).[95]

Physical activity

WHO recommends at least 60 minutes of moderate to vigorous physical activity daily for children and adolescents. That level of activity confers the following benefits: improved physical fitness (cardiorespiratory and muscular fitness), cardiometabolic health (blood pressure, dyslipidemia, glucose and insulin resistance), bone health, cognitive outcomes (academic performance and executive function), mental health (reduced symptoms of depression) and reduced adiposity.[96]

Sedentary lifestyles among adolescents are now common in Africa, especially in urban settings. The popularity of indoor leisure activities and screen time (television, smartphones and gaming) among adolescents, poorly planned urban developments and a lack of safe outdoor spaces are contributing to disengagement in physical activity among adolescents.[97] While the global status report on noncommunicable diseases provides data on physical activity among adolescents aged 11–17 years, data is missing for most African countries.[98] Available data from 21 countries shows insufficient physical activity among adolescents, with all of the countries having prevalence of insufficient physical activity above 70%. This is consistent with several studies that highlight low levels of physical activity among adolescents, particularly for adolescent girls and adolescents living in urban environments.[99,100,12] Low levels of physical activity coupled with high calorie intake are contributors to overweight and obesity.

The food environment

The food environment encompasses the physical, economic, policy and sociocultural conditions that shape what foods people can access, afford and consume. Food

environments in parts of the world that have transitioned to overweight and obesity as the major nutritional challenges have been described as obesogenic, as they are characterized by widespread availability of UPFs, aggressive marketing of unhealthy foods, and persistent financial and structural barriers to healthy eating. Despite the small number of studies conducted on food environments in Africa, emerging evidence points to similar trends. Food environments that adolescents find themselves in, such as the school food environment, seem to be conducive to overweight and obesity. Across African settings, adolescents report that their school and neighbourhood food environments are dominated by informal vendors, kiosks, canteens, tuck shops and convenience shops selling deep-fried snacks, sweets and sugar-sweetened beverages, with few affordable options for fruits or vegetables.[101,102,103,104]

These food outlets tend to be most pervasive in low-income urban areas, with a sample of low-income neighbourhoods in Ghana and Kenya finding that 70.5% of food outlets were informal vendors.[105] Policies regulating what can be sold in or around schools are often weak or not enforced, allowing unhealthy foods to remain the default option. Adolescents in Addis Ababa and Cape Coast described concerns about food hygiene, safety and affordability of the food outlets located closest to them.[106,107] For adolescents, who typically have limited time, transportation options and pocket money, the easiest choice is therefore purchasing packaged foods. Although it is unclear how much influence the food environment has on overweight and obesity rates among adolescents in Africa, evidence from high-income countries suggests that the food environment is certainly a driver of obesogenic behaviours among adolescents.

Social cultural and behavioural determinants

Adolescence is a period marked by increasing autonomy, during which young people begin making more independent decisions about food. As adolescents gain greater agency in daily life, their food choices increasingly reflect their own preferences, knowledge and social goals.

While autonomy can support positive decision making, limited research from Africa shows that modern food environments and structural barriers influence adolescents to develop unhealthy food preferences and choices. Qualitative studies show adolescents have strong preferences for fast food, packaged foods and other UPFs and beverages. UPFs are hyper-palatable and marketed in ways that appeal to adolescents.

Social and economic pressures also underlie these preferences. Adolescents are more susceptible to peer pressure, and this also influences their food choices. Eating is a significant social activity during adolescence; food can be a way to strengthen social bonds and, in some cases, gain social acceptance among adolescents. Packaged foods were seen as more socially acceptable among adolescent girls in a study in Botswana, and they noted that they were mocked for choosing healthier options when friends bought pies and sugary drinks.[108] Adolescents also perceive packaged and convenience foods as more affordable, safer in terms of food hygiene and better suited to their busy academic lifestyles.[99,100] Adolescents in several qualitative studies described the vendors

and markets selling produce and healthier foods as unsafe and dirty, and processed foods as reliable in quality and safety.

In many contexts, adolescents are knowledgeable and acutely aware of nutrition and the risks associated with overweight and obesity, but this knowledge does not always result in the practice of healthier behaviours. Studies across Côte d'Ivoire, South Africa and Tanzania show that adolescents can identify the components of a balanced diet and recognize obesity-related health risks, yet they face structural barriers that constrain healthier choices.[109,110,111] Beyond these structural barriers, the factors that motivate adolescent dietary behaviours are complex and diverse across settings, and the desire to be healthy often competes with preferences for convenience, social acceptability and other influences.[112]

Adolescents also indicate a desire to take part in physical activity but face cultural and structural barriers to doing so. In multiple qualitative studies, girls in particular report restrictions linked to gender norms, expectations to stay indoors, limited encouragement to join sports, lack of organized opportunities and judgment for activities perceived as "unfeminine."[108,113] Safety concerns such as violence, harassment and lack of safe spaces also hinder adolescent physical activity.

Adolescent pregnancy

Adolescent pregnancy is the occurrence of pregnancy between the ages of 13 and 19 years.[114] It results in major inequities in health, nutrition status and overall well-being for adolescent girls in both the short and long term. Pregnancy compounds the risks of malnutrition for both adolescent girls and their children, and it negatively impacts linear growth of adolescent girls and increases their risk of anaemia.[39] While the adolescent is pregnant, she has little opportunity for linear growth, as the body favours the developing fetus/baby. Lower stature can also be a risk to neonatal outcomes for subsequent pregnancies.

The prevalence of adolescent pregnancy in Africa is estimated to be 30%. Countries in West Africa have the highest prevalence (33%) of adolescent pregnancy, while those in North Africa has the lowest prevalence (26%).[115] Despite a global decline in adolescent birth rates, Africa continues to experience adolescent birth rates that are twice the global average.[5] Adolescent birth rates range between four births per 1,000 adolescents (Tunisia) and 184 births per 1,000 adolescents (Central Africa Republic). Central Africa has high adolescent birth rates with Cameroon (105 births per 1,000), Central Africa Republic (184 births per 1,000), Chad (139 births per 1,000), Democratic Republic of the Congo (109 births per 1,000), Republic of the Congo (111 births per 1,000), Equatorial Guinea (176 births per 1,000) and Gabon (100 births per 1,000) all having adolescent birth rates above 100 births per 1,000 adolescents. Northern Africa has the lowest birth rates with Algeria (100 births per 1,000), Egypt (47 births per 1,000), Libya (11 births per 1,000), Mauritania (90 births per 1,000), Morocco (23 births per 1,000) and Tunisia (4 births per 1,000).[116]

One of WHO's effective actions for improving adolescent nutrition is the prevention of adolescent pregnancies. Interventions include increasing the use of contraception among adolescents at risk of unintended pregnancy, reducing marriage before the age of 18 years, reducing pregnancy before the age of 20 years and reducing coerced sex among adolescents.[42]

Early marriages

Early marriage poses a risk to adolescent health and nutrition, as married adolescents are more likely to get pregnant compared to non-married adolescents.[115] Marriage may also be expected of adolescents who become pregnant. Married adolescents are less likely to use contraceptives compared to non-married adolescents.[117]

Adolescent pregnancy is one of the risk factors for adolescent malnutrition, as it compounds the risks of malnutrition for both adolescent girls and their children.[42] Available data from DHS and Multiple Indicator Cluster Surveys (MICS) from 2010 to 2022 shows the prevalence of early marriages (girls married by the age of 18 years) ranges between 1% in Tunisia and 78% in Niger. Some of the countries with the highest prevalences of child marriages include Niger (78%), Central African Republic (61%), Chad (61%), Mali (54%), Mozambique (53%), South Sudan (52%) and Burkina Faso (51%).

Contraceptive use

Access to contraceptives is one of the most effective strategies to prevent unintended pregnancies among adolescents. It can also support the delay of pregnancy among married adolescents. Adolescent pregnancies have a profound effect on nutrition status of adolescent girls.[39,118,119]

The use of contraceptive methods for preventing unintended pregnancies is linked to positive maternal nutritional outcomes through several mechanisms, such as lengthening inter-pregnancy intervals, reducing parity, changing menstruation, delaying age of first pregnancy, and increasing income and empowerment.[120] A recent study on the prevalence of contraceptive use among sexually active adolescents in 25 countries in Africa found the overall prevalence to be 25.4%. The rates range from 4% in Chad to 60.5% in Namibia. Contraceptive use was found to be lower than 10% in Chad, Gambia (8.2%), Niger (7.2%) and Nigeria (5.4%). More than 50% of adolescent girls in Lesotho (53.6%), South Africa (59.8%) and Namibia (60.5%) made use of contraceptives.[117]

Enabling environment for adolescent nutrition

Inclusion of adolescents in policy

This review found that 45 out of the 55 AU Member States had a nutrition policy, strategy or plan. Forty-two of these policies were reviewed for inclusion of adolescents. Three of the policies found were not reviewed as they were over 25 years old.

The review found that 25 out of the 42 policies reviewed included adolescents in at least one of the following: priority areas and objectives, results areas, outcomes and

interventions. Sixteen out of 42 policies had adolescent-specific nutrition interventions. Adolescent nutrition interventions included in the policies were: nutrition assessment, counselling and support, nutrition education, management of acute malnutrition, promotion of fortified and biofortified foods, and iron and folic acid supplementation.

The review shows that while more than half of the policies reviewed included adolescent nutrition in one way or another, there were generally no comprehensive strategies specifically targeting adolescents with a full suite of evidence-based adolescent nutrition interventions. Appendix 13 shows the assessment of national nutrition policies, strategies and plans for adolescent inclusion. Table 3 highlights examples of countries with policies, strategies and plans that have meaningfully included adolescents.

Table 4: Examples of policies where adolescents have been well included

Policy document	Adolescent inclusion
Nigeria National Multisectoral Plan of Action for Food and Nutrition (2021–2025)	Adolescents included in targets. Adolescent-specific targets include: • arrest the emerging increase in obesity prevalence in adolescents and adults by 2025 • support distribution of iron folate supplements to adolescents (boys and girls) in schools and communities (25% coverage)
Ethiopia National Food and Nutrition Strategy 2021	Adolescent nutrition included in Strategic Direction 4.6: To improve the nutrition status of adolescents 10–19 years with various strategic initiatives targeting adolescents: • Strategic initiative 4.6.1: Provide nutritional assessments and counselling services for adolescents at all contact points • Strategic initiative 4.6.2: Promote good nutrition behaviour and prevent harmful nutrition practices • Strategic Initiative 4.6.3: Prevent and mitigate macro- and micronutrient deficiencies in adolescents • Strategic Initiative 4.6.4: Ensure access to reproductive health information and services for boys and girls • Strategic Initiative 4.6.5: Develop and enforce minimum standards on nutrition and health services for adolescents in special situations • Strategic Initiative 4.6.6: Support adolescent empowerment • Strategic Initiative 4.6.7: Promote implementation of school health and nutrition programs to improve the nutrition status of school children
Tanzania National Multisectoral Nutrition	Interventions for school-age children (5–9 years) and adolescents (10–19 years)

Action Plan (2021/22–2025/26)	Nutrition-specific interventions • promotion of diversified diet • promotion of locally available foods, fortified foods and biofortified varieties • provision of school meals using diversified and fortified foods • nutrition assessment, education and counseling support • management of acute malnutrition • promotion of healthy lifestyles Nutrition-sensitive interventions • sexual and reproductive health education • HIV testing, care and support • deworming • promotion of hygiene and improved sanitation practices • promotion of completion of secondary education • prevention of gender-based violence
Malawi National Multi-Sector Nutrition Strategic Plan 2018–2022	Strategic Objective 1: Prevent undernutrition with emphasis on children under five, adolescent girls, school-going children, pregnant and lactating women, people living with HIV (PLHIV) and other vulnerable groups • Strategy 3 of Objective 1 focuses on intensifying the prevention and control of micronutrient deficiencies, with one of the activities being to develop micronutrient supplementation guidelines for school-aged children and adolescents • Strategy 9 of Strategic Objective 1 focuses on promoting school feeding and school health and nutrition programs Strategic Objective 2: Enhance gender equality, equity, protection, participation, and empowerment of adolescent, women, and children for improved nutrition • Strategy 3 of this strategic objective focuses on promoting improved nutrition for adolescents
Kenya National Nutrition Action Plan 2018–2022	Adolescents included in key results areas (KRA) **KRA 2**: Nutrition of older children and adolescents promoted Strategies include: • formulate/review policies, develop guidelines and advocate for the nutrition of older children and adolescents

	• facilitate participation of adolescents in policies, strategies and plans that affect them • build capacity among stakeholders on healthy diets and physical activity, sensitize communities and increase diversity of food production in kitchen gardens • promote consumption and marketing healthy foods for older children and adolescents • establish collaboration with stakeholders and sensitize them to promote good nutrition in older children and adolescents
Senegal Plan Strategique Multisectoriel de la Nutrition du Senegal 2018–2022	Adolescents included in strategic objectives and interventions Strategic objectives • reduction in prevalence of anaemia among adolescent girls by 25% • reduction in prevalence of obesity among adolescents by 5% Interventions • iron/folic acid supplementation in schools, particularly for adolescent girls

Nutrition commitments

Nutrition commitments are intended to be specific, measurable, accountable, realistic and time-bound (SMART) pledges made by governments and other stakeholders during the N4G Summit, which is held every four years. While these commitments are voluntary, they help to foster accountability towards achieving global nutrition targets. They also reflect nutrition priorities for different governments.

While nutrition commitments can be broad, this review focused on adolescent-specific and adolescent-inclusive commitments. For this review, an adolescent-specific commitment is defined as a commitment that particularly targets adolescents aged 10–19 years. An adolescent-inclusive commitment is defined as a commitment that targets a population group of which adolescents, or a subset of adolescents are part, such as women aged 15–49 years and school-aged children.

Out of the 55 African countries, only 17 had either an adolescent-specific commitment or an adolescent-inclusive commitment in 2021.This number declined to 13 in 2025, although several countries made multiple commitments. Adolescent-specific commitments included improving adolescent nutrition status (a reduction in the prevalence of anaemia and reduction in overweight and obesity) and increasing coverage of adolescent nutrition interventions. Most adolescent-inclusive commitments involved a reduction in the prevalence of anaemia among women aged 15–49 years. Other

adolescent-inclusive commitments include the implementation of multisectoral strategic plans, reducing all forms of malnutrition and improving school feeding programs.

Table 5: N4G adolescent-specific commitments, 2021

Rwanda (N4G 2021)	Reduce prevalence of anaemia among adolescent girls from 14.7% in 2020 to 10% by 2030
Sao Tome and Principe (N4G 2021)	By 2030, reduce anaemia rates to less than 10% in adolescents
Senegal (N4G 2021)	Increase coverage of nutrition-related interventions for adolescent girls to 50%

Table 6: N4G adolescent-inclusive commitments, 2021

Burkina Faso (N4G 2021)	Increase the dietary diversity score among women of childbearing age who receive a minimum number of food groups from 16.5% in 2021 to 26% by 2024
Burundi (N4G 2021)	Reduce anaemia in women of reproductive age
Chad (N4G 2021)	Reduce by at least 50% anaemia among in women aged 15–49 years
Democratic Republic of the Congo (N4G 2021)	Reduce prevalence of anaemia among women of reproductive age (15–49 years) to less than 30% by 2030
Gambia (N4G 2021)	Decrease the prevalence of anaemia in women of reproductive age (15–49 years) from 44.3% in 2021 to 30% in 2030
Ghana (N4G 2021)	Reduction in prevalence of anaemia in women of reproductive age from 21% to 14% by 2025
Guinea (N4G 2021)	Reduce anaemia in women of reproductive age from 45% to 27% by 2030
Kenya (N4G 2021)	Implement school meals and nutrition policy
Namibia (N4G 2021)	Implement school feeding program in targeted schools
Somalia (N4G 2021)	Endorse a national school feeding policy by 2022
Tanzania (N4G2021)	Reduce the prevalence of anaemia among women (15–49 years) from 28.8% to 23% by 2026.
Togo (N4G 2021)	Reduce the prevalence of anaemia among women aged 15–49 from 52% to 40% between 2019 and 2030. Expand the provision of community meals in schools by tripling the number of schools with school canteens and tripling the number of beneficiary learners to 300,000
Uganda (N4G 2021)	Reduce the prevalence of anaemia in women of reproductive age from 32% to 19%
Zimbabwe (N4G 2021)	Reduce the prevalence of iron-deficiency anaemia among women of childbearing age (15–49 years) from 27% to 13% by 2025

Table 7: N4G adolescent-specific commitments, 2025

Botswana (N4G 2025)	Reduce the prevalence of overweight and obesity among adolescents from 8.5% to less than 5% through promotion of healthy eating habits, regular physical activity, healthy lifestyles and roll-out of national dietary guidelines
Mauritius (N4G 2025)	Reduce the prevalence of nutritional anaemia in female adolescents aged 12–19 by 2030 through school health programs and iron/folic acid supplementation
Senegal (N4G 2025)	Senegal commits to achieving coverage of at least 50% of adolescents receiving iron/folic acid supplementation and nutrition education by 2030
	Increase coverage of adolescent nutrition services to at least 50%
Togo (N4G 2025)	The National Agency for Grassroots Development Support, Togo, commits to guaranteeing community meals to 23.5% of Togolese schoolchildren, including extending the school canteen program to secondary schools to improve nutritional status of adolescent girls

Table 8: N4G adolescent-inclusive commitments, 2025

Botswana (N4G 2025)	Ensure that 80% of school meals include organic nutrient-dense foods (such as fruits, vegetables, eggs, legumes, green mealies or watermelons) by 2030
	By 2030, the Government of Botswana commits to reducing the prevalence of micronutrient deficiencies among the vulnerable groups such as iron deficiency in women of reproductive age from 32.5% to 15%
Egypt (N4G 2025)	The Government of Egypt commits to reducing anaemia among women of reproductive age through a multi-stakeholder approach, with special focus on adolescent girls and pregnant and breastfeeding women
Eswatini (N4G 2025)	By 2030, the government of Eswatini is committed to reducing all forms of malnutrition by 30% of the current prevalence among women of reproductive age, children under five years, adolescent girls and the elderly
Ethiopia (N4G 2025)	The Government of Ethiopia commits to reducing the prevalence of anaemia among women of reproductive age group from 20% to 13% by 2030
	The Government of Ethiopia commits to increasing diet diversity among women of reproductive age from 7% to 50% by 2030
Gambia (N4G 2025)	Reduce anaemia in women 15–49 years from 44.3% in 2020 to 30% in 2030
Guinea (N4G 2025)	Committed to reducing the prevalence of anaemia among women of reproductive age from 46% in 2024 to 30% in 2028 by increasing awareness among pregnant women about taking iron folic acid, organizing mass distribution campaigns of supplements to adolescent girls in school and non-school settings, and intensifying the promotion of the consumption of local iron-rich food

	By 2028, the Ministry of Pre-University Education and Literacy, with the support of the ministries involved and the World Food Programme, is committed to strengthening the school canteen strategy so that children and young people in school benefit from a balanced meal in schools by increasing the coverage of schools with school canteens and carrying out an evaluation of the strategy
Liberia (N4G 2025)	By 2030, the Government of Liberia, through the Ministry of Finance and Development Planning to allocate domestic financing for nutrition, is committed to investing about 5% of the annual national budget for implementing the Multi-Sectoral Nutrition Costed Strategic Plan across the country by 2030, and to scaling up nutrition-specific and -sensitive interventions by 50%, including adolescent nutrition programs
Mali (N4G 2025)	Particular attention should be paid to women, girls and adolescent girls because of their vulnerability to poverty, hunger and malnutrition, but also because they are sources of change for the reduction of poverty, hunger and malnutrition
Senegal (N4G 2025)	Extend school canteen coverage to 50%
	By 2029, reduce the rate of anaemia among women of reproductive age from 46.7% (2019) to 20%
Siera Leone (N4G 2025)	Expand family planning access and choice, increasing the modern contraceptive prevalence rate (mCPR) among all women of reproductive age to at least 32% by 2027 to contribute to reductions in anaemia and childhood stunting and wasting
Togo (N4G 2025)	By 2030, the Ministry of Health and Public Hygiene, with the support of its partners, is committed to improving the coverage of iron supplementation programs targeting pregnant women and to developing awareness on good eating practices to reduce the prevalence of anaemia in women of childbearing age
	By 2030, the National Agency for Grassroots Development Support (ANADEB), with the support of its partners, is committed to guaranteeing community meals to 23.5% of Togolese schoolchildren
	By 2030, improve the coverage of iron supplementation programs targeting pregnant women and develop awareness on good eating practices to reduce the prevalence of anaemia in women of childbearing age
Uganda (N4G 2025)	Reduce the prevalence of anaemia in women of reproductive age from 25% to 19%
	This commitment aims to increase fortified maize flour production by small-scale millers to combat anaemia in women of reproductive age

Case studies

Senegal: A case of adolescent-inclusive global commitments

The government of Senegal has demonstrated strong commitment to adolescent nutrition, including adolescents in its commitments for both the 2021 and 2025 N4G

Summits. In 2021, the government committed to increase coverage of nutrition-related interventions for adolescent girls to 50%. It followed that up in 2025 by committing to achieve coverage of at least 50% of adolescents receiving iron/folic acid supplementation and nutrition education by 2030, in addition to increasing coverage of adolescent nutrition services to at least 50%.

The Senegalese government also has the Multisectoral Nutrition Strategic Plan (PSMN) and the Reproductive, Maternal, Child and Adolescent Health and Nutrition Strategic Plan for 2024–2028. In these two strategic plans, the following key priorities emerge for adolescent nutrition and health:

1. Reduce the prevalence of anemia among vulnerable groups (children under 5, pregnant women and adolescents) to less than 40%.
2. Strengthening the provision of integrated services adapted to the needs of adolescents and young people according to standards, considering the gender dimension (including disability).

Between 2019 and 2025, the government's adolescent nutrition program — supported by Nutrition International — reached nine out of the 14 regions of the country (Dakar, Thies, Kaolack, Saint-Louis, Ziguinchor, Kolda, Sedhiou, Fatick and Diourbel) with a coverage of 2,214 out of 14,325 schools. Annual reach of WIFAS to adolescent girls was estimated at 255,000 (approximately 13% of adolescent girls in Senegal) as the program expansion continues, bringing the country closer to its N4G commitments. Reaching the goals to reduce anaemia among the priority groups, including adolescents, will require additional investments and expansion of evidence-based actions.

Ethiopia: Policies promoting an enabling environment for adolescent nutrition

Ethiopia has a robust enabling environment for improving adolescent nutrition. The National Food and Nutrition Strategy 2021–2030 is adolescent inclusive, with adolescents the focus of Strategic Direction 4.6, which aims to improve the nutrition status of adolescents aged 10–19 years. Interventions and actions within the Strategy include:

- provision of nutritional assessments and counselling services for adolescents at all contact points;
- promotion of good nutrition behaviour and prevention of harmful nutrition practices;
- prevention and mitigation of macro- and micronutrient deficiencies in adolescents, including through supplementation;
- ensuring access to reproductive health information and services for boys and girls;
- development and enforcement of minimum standards on nutrition and health services for adolescents in special situations; and
- adolescent empowerment and implementation of school health and nutrition programs.

The 2023 Adolescent Nutrition Implementation guideline acts as a road map for stakeholders across a range of sectors to engage in nutrition-specific and nutrition-sensitive interventions targeting adolescents, including WIFAS for anaemia reduction.

In 2025, Ethiopia updated its national Essential Medicines List (EML) to include the WHO-recommended formulation of WIFAS for adolescents. This formulation, which contains 60mg elemental iron and 2.8mg folic acid has been proven to reduce anaemia and neural tube defect pregnancies among adolescent girls. Adding a commodity to the EML implies a country should have the product in sufficient quality and quantity for the population at risk. Its inclusion into the national EML is the first step towards improving supply availability. one local pharmaceutical company has already started manufacturing this new formulation. Increased local availability has the potential to drive down the unit cost, ensuring many more adolescent girls have access.

In addition to a robust enabling environment, Ethiopia has also demonstrated action towards implementation of adolescent nutrition programs. Through collaboration with partners, including Nutrition International and UNICEF, the government of Ethiopia implements adolescent nutrition program; WIFAS for in-school adolescent girls is one of the interventions. The program expanded to 100 districts in 2025, reaching about 600,000 adolescent girls annually. Through adolescent-responsive policies, strategies, commitments and programs, Ethiopia is making good steps towards improving the health and nutrition status of adolescents.

Conclusions and way forward

Africa has a unique opportunity to fuel a demographic dividend, with the largest population of adolescent cohort in continental history; yet adolescent malnutrition is holding back girls and boys.

This report presents qualitative and quantitative national data relevant to adolescent nutrition in Africa for 55 AU Member States across three domains: 1) demographic and gender equity data; 2) nutrition and health data; and 3) enabling environment. A literature

review highlighted additional subnational data, program examples and experiences of adolescents in Africa.

In compiling and analyzing data across sources, the evidence highlights an evolving burden of malnutrition with diversity within states, and regional economic communities, with many countries facing a triple burden of malnutrition which includes persistent undernutrition, rapidly increasing overweight and obesity and widespread anaemia and micronutrient deficiencies.

These challenges for boys and girls stem from inadequate access to health and nutrition services, poor diet quality, and lack of access to physical activity. Malnutrition is driven by interconnected structural determinants: widespread food insecurity, unhealthy food environments, poverty, economic vulnerability and lack of adolescent responsive systems and services and increasing sedentary lifestyles.

Gender inequities exist. Adolescent girls are at greater risk of anaemia and lost opportunities related to economic empowerment and academic achievement, and they also uniquely suffer the consequences of adolescent pregnancies. In contexts where overweight and obesity are a concern, girls are generally at greater risk, often with lower access to and practice of physical activity. Increasing the burden of noncommunicable diseases and undermining long-term human capital development. In contrast, rates of underweight tend to be higher for adolescent boys.

Anaemia is higher in countries with low female school secondary school enrollment and greater adolescent pregnancies. Adolescent malnutrition is an issue that impacts across society, and action across education, social safety net and health sectors will be essential for progress.

This report is limited to primarily summary level national data, and adolescents are a diverse demographic with many lived experiences that are not reflected in the numbers. Qualitative work included has highlighted adolescent perspectives. Adolescent-inclusive approaches are needed for youth-centred change.

Systems need to work for adolescents. Health systems, food systems, education systems, water and sanitation systems, and social protection systems must be strengthened to respond intentionally to the nutritional needs of diverse adolescents, with consideration for gender equity and inclusion. Making systems accountable to adolescents and meaningfully engaging adolescents is essential.

Accelerating improvements in adolescent nutrition will require prioritization and inclusion of adolescents in policies. While some countries meaningfully include adolescents in national nutrition strategies, most do not. Several countries are making commitments related to adolescent nutrition, although there is a decline in the number of countries that made commitments in 2025 compared to 2021. In addition to prioritization and inclusion of adolescents in policies, investments and evidence-informed actions are needed to reach these goals.

There is a need for more data throughout adolescence (10–19 years) for both boys and girls, especially for younger adolescents (10–14 years), to enhance decision making and track progress. While GAMA aims to fill a gap for an adolescent-specific standard set of recommended indicators to be collected routinely within government systems, there are gaps in data availability, and adolescents are not sufficiently included in surveys at the country level. Inclusion of adolescent-specific targets within accountability frameworks and strategies — and the disaggregation of data — are much needed to show specific progress for adolescents within global and regional targets such as the WHA anaemia targets for females aged 15–49 years.

Key Priority Actions:

- **Prioritize meaningful inclusion** of adolescent nutrition within national, regional and continental strategies and multisectoral action plans
- **Invest** in evidence based and context informed actions to improve adolescent nutrition for adolescents
- **Promote equity in nutrition for adolescent girls** to reduce burden of anaemia, protect girls from adolescent pregnancy, and equitably increase access to health and nutrition services, and enable healthy practices.
- **Address the sexual and reproductive health needs of adolescent girls to improve their health and nutrition outcomes.**
- **Strengthen systems to be adolescent responsive** across relevant sectors: health, education, social protection, and WASH.
- **Include** adolescent-specific targets and indicators within health and nutrition accountability frameworks and strategies at country, regional and continental level, such as CNAS
- **Address the increasing influence of food industry and marketing of unhealthy foods to adolescents**.

Actions and investments to improve adolescent nutrition in Africa do not need to wait for more data. Global adolescent-specific evidence-based guidelines, strong adolescent-inclusive policies, national strategies and commitments, proven program practices and country examples already provide models for accelerating progress in adolescent nutrition.

As Africa embarks on the journey of developing a new 10-year continental Africa Regional Nutrition Strategy, a key opportunity for accelerating improvements for adolescent nutrition is emerging, and progress on the Malabo Declaration and Agenda 2063 are dependent on meaningful adolescent inclusion.

Adolescents are an integral part of families and communities, and they are Africa's future economic engine, leaders and parents. Investments in the health and nutrition of the adolescents of today protects and fuels a demographic dividend offering an opportunity to accelerate progress towards Africa's Agenda 2063.

Annex 1. Proportion of the population that are adolescents

Country	10–14 years	15–19 years	10–19 years
Algeria	9.71	7.81	17.52
Angola	12.82	10.6	23.42
Benin	12.31	10.63	22.94
Botswana	9.79	9.73	19.52
Burkina Faso	13.3	11.41	24.71
Burundi	14.23	11.5	25.73
Cameroon	12.24	10.8	23.04
Cape Verde	9.43	9.14	11.58
Central African Republic	14.93	12.26	27.18
Chad	12.84	10.89	23.73
Comoros	11.44	10.08	21.52
Côte d'Ivoire	12.35	10.65	23.01
Democratic Republic of Congo	12.7	10.42	20.37
Djibouti	9.68	9.85	24.55
Egypt	10.73	9.23	19.95
Equatorial Guinea	11.27	9.55	20.82
Eritrea	12.51	12.04	24.55
Eswatini	10.85	10.41	21.26
Ethiopia	11.52	11.08	22.61
Gabon	11.06	9.31	20.37
Gambia	12.83	11.03	23.86
Ghana	11.45	10.18	21.62
Guinea	12.25	10.85	23.1
Guinea Bissau	12.27	10.9	23.17
Kenya	12.14	11.51	23.66
Lesotho	11.44	10.31	21.76
Liberia	12.55	11.42	23.97
Libya	9.56	9.17	18.73
Madagascar	11.77	10.66	22.43
Malawi	12.94	11.87	24.81
Mali	13.48	11.35	24.83
Mauritania	12.75	10.86	23.6
Mauritius	5.33	6.72	12.05
Morocco	8.82	8.38	17.2
Mozambique	13.07	10.88	23.95
Namibia	10.95	9.37	20.32
Niger	13.5	11.34	24.84

Nigeria	12.81	11.2	24.01
Republic of the Congo	12.92	10.64	23.56
Rwanda	11.51	11.17	22.68
Sao Tome and Principe	12.18	11.63	23.81
Senegal	12.13	11.08	23.2
Seychelles	6.47	6.19	12.67
Sierra Leone	11.95	10.9	22.85
Somalia	12.61	10.77	23.38
South Africa	8.3	8.37	16.67
South Sudan	13.96	12.68	26.64
Sudan	11.91	10.78	22.69
Tanzania	12.23	10.9	23.13
Togo	12.12	10.6	22.72
Tunisia	8.48	7.2	24.66
Uganda	13.05	11.61	24.66
Zambia	12.72	11.27	23.99
Zimbabwe	13.59	11.35	24.94

Source: United Nations Department of Economic and Social Affairs, Population Division. (2024). *World population prospects*. United Nations. https://population.un.org/wpp/

Annex 2. Net school enrollment rate

Country	Primary			Lower secondary			Upper secondary		
	Male	Female	Both	Male	Female	Both	Male	Female	Both
Algeria	N/A	N/A	99.02	97.49	96.9	97.2	78.8	NA	83.9
Angola	NA	NA	NA	NA	NA	NA	79.89	NA	NA
Benin	97.52	91.57	94.58	57.8	52.5	55.2	34.48	26.94	30.7
Botswana	88.93	90.96	89.93	82.7	89.4	86	57.47	56.21	56.8
Burkina Faso	57.53	58.69	58.1	42.7	49.7	46	24.4	21.92	26.7
Burundi	80.76	83.47	82.11	56.7	60.3	59.1	37.8	45.63	41.7
Cameroon	96.11	86.68	95.59	54.6	50.7	52.71	37.46	32.1	34.79
Cape Verde	89.22	89.04	89.13	82.7	82.7	82.66	70.83	76.54	69.2
Central African Republic	94.49	75.07	84.86	51.6	34.89	43	21.45	12.88	17.21
Chad	82.62	69.45	76.13	47.7	34.6	41.2	31.29	17.7	24.59
Comoros	79.97	75.53	77.78	86	88.1	87.1	49.6	53.5	51.5
Côte d'Ivoire	97.9	94.38	96.15	54.5	33.3	54.5	47.01	43.15	45.11
Congo	83.8	84.16	83.98	47.4	67.9	69.4	61.01	50.68	58.44
Djibouti	NA	NA	NA	52.3	45.2	55.3	37.43	34.2	35.83
Egypt	99.41	99.68	99.54	94.8	94.8	94.8	74.22	70.4	72.39
Eritrea	57.95	52.24	55.12	63.9	54.9	59.4	48.65	25.48	45.22
Eswatini	90.69	88.34	89.52	NA	NA	NA	NA	NA	NA
Ethiopia	79.31	88.85	76.85	50.7	50.1	50.4	50.7	50.1	32.87
Gabon	71.42	71.65	71.53	63.2	65.44	64.3	51.8	54.6	63.2
Gambia	71.81	81.63	76.67	72.3	88.7	80.4	46.9	62.3	54.5
Ghana	80.92	80.56	88.66	91.7	90.7	91.2	67.7	63.6	65.7
Guinea	86.56	76.31	81.51	52.59	41.1	47.1	30.8	20.75	26.7
Guinea Bissau	NA	NA	NA	52.5	41.1	NA	NA	NA	NA
Lesotho	73.27	73.36	73.32	79.8	86.6	83.3	59.25	66.4	62.84
Liberia	61.4	63.3	62.34	59.1	60.5	68.1	59.9	61.55	60.76
Madagascar	94.29	99.22	96.73	63.8	65.4	64.6	31.42	31.5	31.46
Malawi	NA	NA	97.76	76.9	65.4	64.6	37.11	23.03	29.96
Mali	70.68	53	67.47	47.4	41.4	44.7	27.12	20.08	26.3
Mauritania	67.85	71.07	69.44	65.7	68.2	66.9	37.38	38.97	38.19
Mauritius	97.87	98.66	98.26	94.5	68.2	66.9	72.94	80.86	76.84
Morocco	97.93	98.33	99.29	96.8	91.4	95.5	77.68	76.69	77.24
Mozambique	98.27	95.4	98.97	60.8	56.5	42.2	44.86	39.69	42.2
Namibia	NA	NA	99.37	98.6	98.7	99.5	89.98	85.37	87.64

Niger		63.9	60.27	62.11	29.8	26.3	28.1	10.83	9.17	10.01
Rwanda		98.74	98.15	99.51	85.4	92.5	88.9	54.32	57.98	56.15
Sao Tome and Principe		95.59	92.74	94.17	NA	NA	NA	NA	NA	NA
Senegal		67.47	79.49	73.41	34.4	42.1	38.2	16.87	21.19	19.01
Seychelles		97.71	96.6	97.17	94.3	97.6	95.9	80.23	93.4	86.6
Sierra Leone		NA	NA	97.27	75.5	79.4	77.4	57.93	58.4	58.23
South Africa		87.02	89.86	88.42	92.36	97.8	95	86.22	96.7	91.4
Sudan		68.51	63.68	66.13	71.4	68.8	70.1	17.66	15.3	16.4
Tanzania		81.1	86.18	83.62	47.81	51.1	49.4	17.66	15.3	16.4
Togo		99.48	98.26	99.23	83.7	79.2	81.5	52.31	40.21	46.33
Tunisia		97.73	98.41	98.06	NA	NA	NA	NA	NA	NA
Uganda		87.36	89.56	88.46	51.57	50.5	51.06	26.94	22.28	24.6
Zambia		84.52	86.59	85.55	NA	NA	NA	NA	NA	NA
Zimbabwe		86.45	86.42	94.41	NA	NA	85.27	NA	NA	NA

Source: UNESCO (2026). *UNESCO Institute for Statistics homepage*. UNESCO. https://www.uis.unesco.org/en

Annex 3. Net school attendance rates

Country	Primary			Lower secondary			Upper secondary		
	Male	Female	Both	Male	Female	Both	Male	Female	Both
Algeria	98.1	98.1	98.1	95.92	95.7	95.81	72.42	82.35	77.19
Benin	77.65	73.19	75.47	63.69	57.11	60.46	44.33	33.99	39.14
Burkina Faso	65.2	65.29	65.24	55.64	61.74	58.79	44.82	40.37	42.53
Burundi	82.16	82.36	82.26	72.55	74.99	73.76	52.09	52.74	52.43
Cameroon	85.97	81.92	83.96	85.62	79.74	82.64	70.13	55.53	62.47
Central African Republic	76.85	70.19	73.63	82.06	69.97	76.08	67.58	36.87	51.53
Chad	45.6	40.32	42.99	52.67	41.76	47.3	45.73	26.16	36.13
Comoros	87.43	91.28	89.32	85.69	89.74	87.7	71.51	78.31	74.86
Côte d'Ivoire	79.76	79.48	79.62	67.33	61.84	64.47	54.3	45.18	49.61
Democratic Republic of the Congo	NA	77.65	78.38	84.23	82.29	83.26	76.14	66.72	71.23
Djibouti	80.83	75.84	78.43	87.92	82.33	85.18	69.49	68.34	68.91
Eswatini	95.19	95.88	95.53	94.02	93.05	93.54	85.09	80.57	82.98
Ethiopia	70.14	71.35	70.75	69.01	71.22	70.16	53.87	45.85	50.14
Gabon	94.15	95.27	94.7	96.67	98.2	97.47	89.79	89.74	89.76
Gambia	78.03	84.86	81.52	73.81	81.01	77.48	56.93	62.99	60.26
Ghana	91.11	94.01	91.62	90.01	90.59	90.3	77.06	74.06	75.62
Guinea	68.59	63.27	65.94	61.23	45.95	53.25	50.99	26.78	37.5
Kenya	94.93	95.36	95.14	95.57	95.99	95.79	87.82	87.65	87.74
Lesotho	96.33	97.94	97.15	80.8	90.89	NA	54.63	70.51	62.27
Liberia	78.74	82.52	80.64	85.5	86.1	85.81	81.56	77.62	79.79
Madagascar	75.56	80.42	77.97	60.86	66.75	62.1	32.64	29.05	30.9
Malawi	93.3	90.05	94.18	89.01	89.03	89.02	68.97	63.09	66.22
Mali	58.03	54.94	56.5	49.84	40.75	45.58	36.75	25.23	30.66
Mauritania	54.06	56.77	55.4	58.27	61.15	59.78	42.84	39.21	40.8
Mozambique	71.9	73.78	72.84	67.83	67.52	67.68	52.81	39.45	46.33
Niger	58.09	52.78	55.36	36.5	29.2	32.88	22.95	14.52	18.1
Nigeria	72.78	73.91	74.37	75.97	74.19	76.67	66.78	64.61	65.71
Rwanda	NA	NA	94.84	87.2	87.8	87.51	58.39	54.37	56.34

Sao Tome and Principe	96.06	97.03	96.53	91.35	95.77	93.52	81.03	84.33	82.71
Senegal	60.16	62.34	61.3	57.15	63.25	60.29	46.5	43.94	45.17
Sierra Leone	88.2	91.99	90.06	79.66	87.93	85.94	75.88	69.44	72.68
Somalia	26.99	25.42	26.21	48.69	42.93	45.84	49.22	42.83	45.81
South Africa	98.62	98.24	98.43	96.93	95.81	96.35	73.46	68.41	70.98
Tanzania	82.75	87.45	83.86	59.96	61.51	60.71	24.04	15.02	19.05
Togo	92.4	91.22	91.82	90.03	85.65	87.86	79.73	59.82	70.45
Tunisia	96.88	96.96	96.92	88.26	90.12	92.6	67.22	83.17	72.91
Zambia	81.97	86.77	84.4	80.69	72.6	76.53	55.41	38.45	46.7
Zimbabwe	94.16	95.53	94.84	72.55	76.22	74.32	33.68	21.68	27.93

Source: UNESCO (2026). *UNESCO Institute for Statistics homepage*. UNESCO. https://www.uis.unesco.org/en

Annex 4. Adolescent birth rate per 1,000 adolescents

Country	**10–14 years**	**15–19 years**	**Year**
Algeria	0	10	2017
Angola	11	163	2014
Benin	2	84	2019
Botswana	0	50	2019
Burkina Faso	1	93	2020
Burundi	1	58	2015
Cameroon	2	105	2020
Cape Verde	0	40	2020
Central African Republic	8	184	2018
Chad	4	139	2018
Comoros	NA	74	2017
Côte d'Ivoire	2	96	2020
Democratic Republic of the Congo	3	109	2016
Djibouti	0	21	
Egypt	1	47	2019
Equatorial Guinea	NA	176	2010
Eswatini	1	87	2013
Ethiopia	1	74	2018
Gabon	3	100	2019
Gambia	1	65	2018
Ghana	2	63	2021

Guinea	3	128	2020
Guinea Bissau	2	84	2017
Kenya	1	44	2020
Lesotho	0	49	2020
Liberia	6	131	2021
Libya		11	2013
Madagascar	7	151	2018
Malawi	2	136	2018
Mali	5	145	2020
Mauritania	6	90	2019
Mauritius	1	19	2022
Morocco	0	23	2018
Mozambique	7	158	2021
Namibia	4	64	2016
Niger	3	150	2020
Nigeria	2	75	2020
Republic of the Congo	4	111	2015
Rwanda	0	31	2021
Sao Tome and Principe	0	86	2018
Senegal	4	67	2019
Seychelles	1	46	2022
Sierra Leone	4	102	2018
Somalia	1	116	2017
South Africa	1	44	2019
Sudan	2	87	2013
Tanzania	1	112	2020
Togo	3	79	2016
Tunisia	0	4	2021
Uganda	1	128	2018
Zambia	3	135	2017
Zimbabwe	1	87	2021

Source: UN Department of Economic and Social Affairs. (March 2024). *SDG indicators database.* https://unstats.un.org/sdgs/dataportal/

Annex 5. Prevalence of child marriage (%)

Country	Married by age 15	Married by age 18	Source
Algeria	0	4	MICS 2018
Angola	8	30	DHS 2015
Burkina Faso	9	51	EMDS 2015
Burundi	3	19	DHS 2016
Cameroon	11	30	DHS 2018
Cape Verde	2	8	DHS 2018
Central African Republic	26	61	MICS 2018
Chad	24	61	MICS 2019
Comoros	10	32	DHS 2012
Côte d'Ivoire	7	27	MICS 2016
Democratic Republic of the Congo	8	29	MICS 2017
Djibouti	1	6	EVFF 2019
Egypt	2	17	DHS 2014
Equatorial Guinea	9	30	DHS 2011
Eritrea	13	14	EPHS 2010
Eswatini	1	5	MICS 2014
Ethiopia	14	40	DHS 2016
Gabon	6	22	DHS 2012
Gambia	6	23	DHS 2019
Ghana	5	19	MICS 2017
Guinea	17	47	DHS 2018
Guinea Bissau	8	26	MICS 2018
Kenya	2.2	12.5	DHS 2022
Lesotho	1	16	MICS 2018
Liberia	6	25	DHS 2019
Madagascar	13	39	DHS 2021
Malawi	8	38	MICS 2019
Mali	16	54	DHS 2018
Mauritania	16	37	DHS 2019-2021
Morocco	1	14	ENSPF 2018
Mozambique	17	53	AIS 2015
Namibia	2	7	DHS 2013
Niger	28	78	DHS 2012
Nigeria	18	30	MICS 2021
Republic of the Congo	7	27	MICS 2014
Rwanda	0	7	DHS 2014

Sao Tome and Principe	5	28	MICS 2019
Senegal	9	31	DHS 2019
Sierra Leone	9	30	DHS 2019
Somalia	8	45	MICS 2006
South Africa	1	4	DHS 2016
South Sudan	9	52	SHHS-2 2010
Sudan	12	34	MICS 2014
Togo	6	25	MICS 2017
Tunisia	0	1	MICS 2018
Uganda	7	34	DHS 2018
Zambia	5	29	DHS 2018
Zimbabwe	5	34	MICS 2019

Annex 6. Demand for family planning satisfied with modern methods among adolescents aged 15–19 years (%)

Country	Proportion of the demand for family planning satisfied with modern methods	Data source
Angola	14.9	DHS 2024
Benin	13.2	DHS 2017/2018
Burkina Faso	51.4	DHS 2021
Burundi	54.6	DHS 2015
Cameroon	24.1	DHS 2018
Central African Republic	4.9	DHS 1994
Chad	8.9	DHS 2014
Comoros	20.1	DHS 2012
Côte d'Ivoire	26.9	DHS 2021
Democratic Republic of the Congo	12.6	DHS 2013
Egypt	63.9	DHS 2014
Eritrea	3.6	DHS 2002
Eswatini	63.5	DHS 2006
Ethiopia	60.7	DHS 2016
Gabon	29.3	DHS 2019
Gambia	13	DHS 2019
Ghana	41.4	DHS 2022
Guinea	33.6	DHS 2018
Kenya	59.4	DHS 2022
Lesotho	55	DHS 2014
Liberia	16.3	DHS 2019
Madagascar	67.9	DHS2021
Malawi	62.2	DHS 2015
Mali	30.5	DHS 2018
Mauritania	21.6	DHS 2019
Morocco	73.6	DHS 2004
Mozambique	29.8	DHS 2022
Namibia	46.7	DHS 2013
Niger	29.4	DHS 2012
Nigeria	15	DHS 2018
Republic of the Congo	37.1	DHS 2007
Rwanda	87.4	DHS 2019
Sao Tome and Principe	30.4	DHS 2008
Senegal	24.6	DHS 2019
Sierra Leone	33.8	DHS 2019

South Africa	60.9	DHS 2016
Tanzania	37.2	DHS 2022
Togo	15.3	DHS 2013
Uganda	39.5	DHS 2016
Zambia	63.3	DHS 2018
Zimbabwe	76.8	DHS 2015

Source: DHS Stat Compiler

Annex 7. Trends in thinness among adolescents aged 10–19 years, 2000–2022

Country	2000	2005	2010	2016	2022
Algeria	4.8 [2.4–8.4]	4.5 [2.2–7.7]	4.3 [2.2–7.1]	4.1 [2.1–6.8]	4.0 [1.6–7.4]
Angola	10.6 [5.8–16.1]	9.6 [5.3–14.6]	8.7 [4.9–13.2]	7.9 [4.3–12.5]	7.4 [3.3–13.2]
Benin	9.0 [5.1–14.0]	8.0 [4.7–12.5]	7.3 [4.4–11.1]	6.8 [4.0–10.4]	6.6 [3.2–11.3]
Botswana	13.8 [8.7–19.2]	12.8 [8.4–17.7]	11.9 [8.2–16.3]	11.2 [7.5–15.3]	10.5 [5.7–16.4]
Burkina Faso	14.1 [10.7–17.9]	13.2 [10.1–16.6]	12.8 [9.8–16.0]	12.9 [10.0–16.1]	13.4 [9.4–17.8]
Burundi	10.7 [5.8–17.1]	9.9 [5.4–16.0]	9.4 [5.2–15.1]	9.4 [5.3–15.0]	9.4 [4.7–15.8]
Cape Verde	11.5 [6.5–17.6]	10.6 [6.1–16.1]	9.9 [5.8–14.8]	9.6 [5.8–14.1]	9.7 [5.3–15.1]
Cameroon	7.1 [4.9–9.7]	6.2 [4.3–8.5]	5.6 [3.7–8.0]	5.3 [3.1–8.3]	5.3 [2.2–10.0]
Central African Republic	11.9 [5.8–19.5]	10.9 [5.3–18.0]	10.0 [4.8–16.8]	9.3 [4.1–16.2]	8.7 [3.2–16.9]
Chad	12.5 [7.0–19.2]	11.6 [6.6–17.9]	10.9 [6.4–16.9]	10.6 [6.1–16.5]	10.6 [5.4–17.8]
Comoros	9.3 [4.5–15.4]	8.5 [4.1–14.4]	7.9 [3.9–13.5]	7.4 [3.5–12.8]	7.2 [2.8–13.7]
Côte d'Ivoire	8.8 [5.8–12.3]	8.0 [5.3–11.2]	7.5 [4.8–10.5]	7.5 [4.5–11.3]	7.7 [3.8–13.2]
Democratic Republic of the Congo	13.1 [9.4–17.0]	11.8 [8.6–15.3]	10.3 [7.4–13.6]	8.7 [5.6–12.5]	7.4 [3.5–12.7]
Equatorial Guinea	12.1 [5.7–19.8]	11.0 [5.1–18.5]	10.0 [4.6–17.0]	9.3 [4.1–16.6]	8.8 [3.3–16.9]
Eritrea	17.5 [12.9–22.4]	16.5 [12.4–21.1]	15.6 [11.3–20.4]	14.5 [9.6–20.2]	13.5 [7.2–21.4]
Eswatini	5.3 [3.5–7.6]	4.6 [3.2–6.3]	4.2 [2.9–5.6]	4.1 [2.6–6.1]	4.3 [2.0–7.4]
Ethiopia	23.4 [19.2–27.5]	22.7 [19.3–26.1]	21.7 [19.3–24.1]	19.9 [18.0–21.8]	18.0 [13.7–22.5]
Gabon	9.0 [5.0–13.9]	7.9 [4.6–12.2]	7.1 [4.2–11.0]	6.6 [3.7–10.8]	6.4 [3.0–11.7]
Gambia	12.4 [7.0–19.0]	11.5 [6.6–17.9]	11.1 [6.4–16.9]	11.0 [6.6–17.0]	11.3 [6.3–18.5]
Ghana	8.7 [5.8–12.2]	7.8 [5.5–10.7]	7.4 [5.6–9.4]	7.4 [6.2–8.7]	7.8 [5.6–10.2]

Guinea	10.2 [6.5–14.8]	9.4 [6.1–13.5]	8.8 [5.8–12.6]	8.6 [5.5–12.6]	8.9 [4.7–14.4]
Guinea-Bissau	10.4 [5.3–16.9]	9.5 [4.8–15.6]	8.9 [4.5–14.7]	8.5 [4.1–14.4]	8.5 [3.4–15.5]
Kenya	12.7 [8.5–17.4]	11.8 [8.2–15.7]	11.1 [8.2–14.4]	10.4 [8.2–12.7]	9.7 [7.6–12.1]
Lesotho	8.2 [5.4–11.3]	7.3 [5.1–9.7]	6.6 [5.1–8.4]	6.2 [4.4–8.2]	6.0 [3.1–9.7]
Liberia	8.3 [5.4–11.8]	7.4 [5.0–10.3]	6.8 [4.9–9.1]	6.6 [4.7–8.9]	6.7 [4.0–10.0]
Madagascar	10.7 [5.9–17.0]	10.0 [5.6–16.0]	9.3 [5.3–15.1]	8.8 [4.9–14.4]	8.4 [4.3–15.0]
Malawi	5.4 [3.5–7.7]	4.8 [3.2–6.6]	4.3 [3.1–5.8]	4.1 [2.7–5.7]	4.0 [2.0–6.8]
Mali	13.5 [10.0–17.3]	12.5 [9.3–16.0]	11.9 [8.8–15.1]	11.5 [8.0–15.5]	11.2 [6.2–17.2]
Mauritania	14.1 [9.1–19.8]	13.0 [8.4–18.2]	11.9 [7.7–16.8]	11.3 [7.0–16.4]	11.0 [5.6–18.0]
Mauritius	13.9 [10.0–18.4]	12.4 [9.4–15.8]	11.3 [9.1–13.7]	10.6 [8.9–12.6]	9.9 [7.0–13.4]
Mozambique	4.6 [2.8–6.8]	4.2 [2.8–6.1]	4.3 [3.0–5.9]	4.7 [3.3–6.3]	5.5 [3.2–8.5]
Namibia	14.4 [9.7–19.7]	13.4 [9.3–18.0]	12.1 [8.5–16.3]	11.1 [7.2–16.0]	10.5 [5.5–17.2]
Niger	17.9 [13.5–22.4]	17.3 [13.4–21.4]	17.0 [13.5–20.9]	17.3 [13.6–21.2]	17.9 [13.0–23.0]
Nigeria	14.4 [10.7–18.2]	13.6 [10.6–16.7]	13.5 [11.0–16.1]	14.4 [11.6–17.3]	15.8 [11.2–21.0]
Republic of the Congo	11.3 [7.8–-15.3]	10.5 [7.0–-14.5]	9.7 [6.3–-13.9]	9.1 [5.4–-13.7]	8.6 [4.0–-14.9]
Rwanda	9.5 [6.8–12.5]	8.4 [6.4–10.7]	7.7 [6.2–9.4]	6.9 [5.4–8.7]	6.3 [3.9–9.2]
Sao Tome and Principe	6.6 [4.0–9.8]	5.8 [3.7–8.3]	5.2 [3.4–7.4]	5.1 [3.0–7.5]	5.1 [2.4–8.8]
Senegal	18.9 [14.7–23.3]	18.3 [14.8–22.1]	18.0 [14.9–21.2]	17.8 [13.8–22.0]	17.7 [11.2–24.7]
Seychelles	7.0 [6.1–7.8]	6.4 [5.8–7.2]	6.2 [5.5–7.0]	6.1 [5.4–6.8]	5.7 [4.6–6.8]
Sierra Leone	9.2 [6.1–12.9]	8.0 [5.4–10.9]	6.6 [4.8–8.7]	5.0 [3.8–6.4]	3.8 [2.3–5.6]
South Africa	12.6 [11.2–14.1]	8.2 [7.4–9.1]	5.5 [4.9–6.1]	4.2 [3.6–4.8]	3.6 [2.4–5.2]
South Sudan	10.0 [5.0–16.5]	9.4 [4.7–15.7]	8.7 [4.2–14.5]	8.3 [3.9–14.3]	8.0 [3.1–14.9]
Togo	9.1 [5.9–13.0]	8.0 [5.5–11.2]	7.2 [5.0–9.8]	6.5 [4.3–9.2]	6.0 [3.3–9.6]

Uganda	7.9 [5.8–10.2]	7.2 [5.6–8.9]	6.9 [5.7–8.3]	7.0 [5.7–8.5]	7.4 [5.0–10.4]
United Republic of Tanzania	9.3 [5.7–13.5]	8.6 [5.5–12.4]	8.3 [5.6–11.6]	8.7 [6.0–12.0]	9.4 [5.6–14.2]
Zambia	7.7 [4.4–12.0]	6.9 [4.0–10.7]	6.2 [3.6–9.4]	5.5 [3.2–8.4]	5.0 [2.4–8.6]
Zimbabwe	9.2 [6.5–12.4]	8.6 [6.3–11.2]	8.0 [6.3–9.9]	7.1 [5.3–8.9]	6.5 [3.7–9.9]

Source: World Health Organization. (November 2025). *The global health observatory*. World Health Organization. https://www.who.int/data/gho

Annex 8. Prevalence of thinness, overweight and obesity among adolescents, 15–19 years (%)

	Thinness		Overweight		Obesity		Sources
Country	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	
Angola	5.3	NA	NA	NA	1.8	NA	DHS 2024
Benin	20.5	NA	5.9	NA	0.9	NA	DHS 2017–2018
Burkina Faso	20.8	NA	6.9	NA	1.3	NA	DHS 2021
Burundi	22.9	NA	4.1	6	0.2	NA	DHS 2016/2017
Cameroon	10.2	NA	15.2	NA	3.1	NA	DHS 2018
Central African Republic	15.2	NA	3.2	6	0.8	NA	DHS 1994/1995
Chad	26.2	NA	4.2	NA	0.5	NA	DHS 2014/2015
Comoros	13	NA	11.8	7	2	1	DHS 2012
Côte d'Ivoire	14.4	NA	12.1	NA	3.8	NA	DHS 2021
Democratic Republic of the Congo	20.8	14	6.2	NA	1.4	NA	DHS 2013
Egypt	0.6	NA	34.7	NA	17.6	NA	DHS 2014
Eritrea	39.9	NA	2.5	NA	0.4	NA	DHS 2002
Eswatini	7	15.8	19	2	5.3	0.6	DHS 2006
Ethiopia	23	59	6.0	0.6	0.2	0.3	DHS 2024/2016
Gabon	21.2	22.5	11.3	2.7	6	2	DHS 2019
Gambia	27.6	NA	9.6	NA	2.7	NA	DHS 2019
Ghana	19.2	36.5	8.9	1.5	3.3	0.5	DHS 2022
Guinea	15.6	NA	9.1	NA	1.9	NA	DHS 2018
Kenya	18	43	9.7	NA	1.6	NA	DHS 2022
Lesotho	9	36.7	14.8	1.4	3.4	0.3	DHS 2023/2024
Liberia	10.4	10	8.5	NA	0.9	NA	DHS 2019
Madagascar	25.5	NA	3.2	NA	0.3	NA	DHS 2021
Malawi	9.8	NA	8.6	NA	1.1	NA	DHS 2024
Mali	18.1	NA	11.5	NA	2.5	NA	DHS 2018
Mauritania	15.6	NA	19.6	NA	8.7	NA	DHS 2019-2021
Morocco	14.9	NA	9.3	NA	1.6	NA	DHS 2003
Mozambique	12.8	NA	9.5	NA	1.4	NA	DHS 2022/2023
Namibia	26.7	50.3	6.4	1.4	2	0.6	DHS 2013

Niger	30.5	NA	5.2	NA	1.0	NA	DHS 2024
Nigeria	31.5	NA	4.3	NA	0.7	NA	DHS 2024
Republic of the Congo	25.2	NA	5.4	NA	0.5	NA	DHS 2011
Rwanda	10.5	35.2	13.6	0.3	1.4	0	DHS 2019/20
Sao Tome and Principe	13.8	16.2	10.7	6.8	2.1	NA	DHS2008/2009
Senegal	34.5	51.4	6.6	0.4	0.5	0.1	DHS 2017
Sierra Leone	13.95	22.3	9.85	4.4	1.9	0.3	DHS 2019
South Africa	6.7	20.7	15.8	6.1	11	2.5	DHS 2016
Tanzania	18	33.9	8.3	2.6	2.2	0.2	DHS 2022
Togo	11.8	26.3	9.2	NA	1.4	NA	DHS 2013
Tunisia	NA	NA	NA	NA	1	0.1	DHS 2016
Uganda	12.6	26.3	10	0.8	1	0	DHS 2016
Zambia	14.8	9.0	9.0	0.4	1.0	NA	DHS 2024
Zimbabwe	12.5	30.7	11.6	1.2	1.8	0.2	DHS 2015

Source: World Health Organization. (November 2025). *The global health observatory.* World Health Organization. https://www.who.int/data/gho

Annex 9. Trends in overweight among adolescents, 10–19 years, 2000–2022

Country	2000	2005	2010	2016	2022
Algeria	20.1 [14.7–26.2]	22.7 [17.2–28.6]	24.8 [19.7–30.2]	28.0 [22.7–33.7]	32.2 [24.5–40.4]
Angola	5.3 [3.1–8.1]	6.6 [4.2–9.5]	7.9 [5.3–11.0]	9.6 [6.4–13.4]	12.2 [7.0–18.6]
Benin	6.0 [4.4–8.2]	7.6 [5.8–10.0]	9.1 [7.1–11.7]	10.5 [8.0–13.7]	12.6 [8.4–18.0]
Botswana	6.2 [3.8–9.2]	7.9 [5.2–11.0]	9.6 [7.0–12.7]	11.9 [8.6–15.8]	15.3 [9.6–22.4]
Burkina Faso	2.6 [1.9–3.4]	3.2 [2.5–4.1]	3.9 [3.1–4.9]	4.9 [3.9–6.1]	6.5 [4.8–8.6]
Burundi	4.0 [2.5–6.0]	4.6 [3.1–6.6]	5.1 [3.6–7.3]	5.7 [3.8–8.6]	6.8 [3.7–11.7]
Cape Verde	6.0 [3.5–9.3]	7.4 [4.6–10.9]	8.7 [5.7–12.2]	10.1 [7.0–13.9]	12.4 [8.1–17.7]
Cameroon	9.8 [8.1–11.7]	11.6 [9.8–13.4]	12.9 [10.9–15.1]	14.5 [11.7–17.7]	16.9 [12.3–22.6]
Central African Republic	6.0 [3.2–9.8]	7.6 [4.3–12.0]	9.2 [5.4–14.2]	11.3 [6.6–17.3]	14.4 [7.5–23.1]
Chad	4.5 [2.7–7.0]	5.5 [3.5–8.4]	6.5 [4.3–9.7]	7.6 [4.9–11.5]	9.6 [5.3–15.8]
Comoros	6.8 [4.6–9.4]	7.9 [5.8–10.6]	9.0 [6.8–11.6]	10.5 [7.7–14.0]	12.7 [7.9–18.7]
Congo	4.8 [3.7–6.0]	6.0 [4.7–7.6]	7.1 [5.4–9.2]	8.5 [5.8–12.2]	11.0 [6.0–17.5]
Côte d'Ivoire	8.5 [6.7–10.5]	10.2 [8.3–12.4]	11.6 [9.4–14.1]	13.1 [10.2–16.6]	15.5 [11.1–21.3]

Democratic Republic of the Congo	4.4 [3.2–5.9]	5.9 [4.5–7.4]	7.6 [6.0–9.5]	10.2 [7.6–13.4]	13.8 [8.8–20.1]
Equatorial Guinea	6.0 [3.2–9.7]	7.5 [4.3–11.7]	9.2 [5.4–13.9]	11.3 [6.6–17.4]	14.4 [7.6–23.4]
Eritrea	4.7 [3.1–6.8]	5.6 [3.8–7.9]	6.6 [4.3–9.3]	7.9 [4.9–11.7]	9.9 [5.3–15.9]
Eswatini	10.9 [8.6–13.5]	13.0 [10.9–15.2]	14.6 [12.6–16.8]	16.3 [13.3–19.5]	18.8 [13.4–24.9]
Ethiopia	1.7 [1.3–2.3]	2.1 [1.6–2.6]	2.5 [2.1–3.0]	3.3 [2.8–3.8]	4.6 [3.1–6.4]
Gabon	8.2 [5.7–11.2]	10.3 [7.6–13.4]	12.2 [9.5–15.4]	14.3 [10.8–18.5]	17.1 [11.8–23.9]
Gambia	5.4 [3.4–8.1]	6.7 [4.5–9.6]	7.9 [5.6–11.1]	9.3 [6.7–13.1]	11.7 [7.7–17.5]
Ghana	6.2 [4.8–8.0]	7.7 [6.3–9.4]	9.2 [7.9–10.7]	11.4 [10.3–12.5]	14.5 [12.1–17.0]
Guinea	4.9 [3.5–6.7]	6.1 [4.6–7.9]	7.3 [5.7–9.2]	8.9 [6.8–11.6]	11.6 [7.8–16.6]
Guinea-Bissau	5.3 [3.5–7.7]	6.5 [4.5–9.1]	7.7 [5.5–10.8]	9.3 [6.2–13.4]	11.7 [6.7–18.6]
Kenya	5.7 [4.3–7.4]	6.9 [5.6–8.5]	7.9 [6.7–9.4]	8.8 [7.6–10.1]	9.2 [7.6–10.9]
Lesotho	9.2 [7.2–11.2]	10.4 [8.7–12.1]	11.0 [9.6–12.6]	11.7 [9.6–14.1]	12.9 [8.8–17.4]
Liberia	4.6 [3.2–6.2]	5.5 [4.2–7.1]	6.8 [5.5–8.2]	9.4 [7.7–11.3]	15.9 [12.1–20.4]
Madagascar	2.4 [1.4–3.9]	2.9 [1.8–4.7]	3.5 [2.1–5.5]	4.4 [2.6–7.2]	6.0 [3.1–10.7]
Malawi	4.1 [3.2–5.1]	4.8 [4.0–5.7]	5.5 [4.6–6.4]	6.6 [5.4–8.0]	8.3 [5.7–11.4]

Mali	5.3 [4.0–7.0]	7.2 [5.6–9.1]	9.1 [7.3–11.3]	11.5 [8.8–14.6]	14.7 [10.0–20.7]
Mauritania	9.0 [6.3–12.2]	11.5 [8.5–14.8]	14.0 [10.8–17.4]	17.1 [13.5–21.2]	21.3 [16.1–27.8]
Mauritius	11.2 [8.3–14.4]	15.4 [12.6–18.6]	19.4 [17.0–21.9]	23.9 [21.7–26.2]	29.0 [24.6–33.6]
Mozambique	6.4 [5.0–7.8]	7.1 [5.9–8.6]	7.6 [6.4–9.0]	8.1 [6.5–9.7]	8.7 [6.0–11.9]
Namibia	5.2 [3.6–7.2]	6.7 [4.9–8.9]	8.2 [6.2–10.7]	10.2 [7.2–14.0]	13.2 [7.8–19.7]
Niger	3.6 [2.4–5.2]	4.6 [3.2–6.3]	5.6 [4.1–7.6]	7.0 [5.1–9.4]	9.2 [6.2–13.0]
Nigeria	4.2 [3.2–5.4]	5.2 [4.3–6.2]	6.0 [5.1–7.0]	6.9 [5.6–8.4]	8.5 [5.7–12.0]
Republic of the Congo	4.8 [3.7–6.0]	6.0 [4.7–7.6]			
Rwanda	5.1 [4.2–6.3]	6.0 [5.1–7.1]	6.9 [5.9–7.9]	8.1 [7.0–9.3]	9.8 [7.7–12.2]
Sao Tome and Principe	8.4 [6.0–11.1]	10.4 [8.0–13.0]	11.8 [9.5–14.3]	12.8 [9.8–16.1]	14.0 [9.3–19.6]
Senegal	3.6 [2.5–4.8]	4.3 [3.3–5.4]	4.9 [3.8–6.1]	5.9 [4.2–7.9]	7.7 [4.5–12.1]
Seychelles	15.6 [14.6–16.7]	19.9 [18.9–21.0]	23.1 [21.9–24.4]	27.6 [26.3–28.9]	34.3 [32.0–36.6]
Sierra Leone	8.2 [6.0–10.7]	9.6 [7.6–11.9]	10.2 [8.5–12.1]	10.5 [8.9–12.2]	11.4 [8.8–14.3]
South Africa	9.7 [8.8–10.6]	16.1 [15.0–17.1]	21.3 [20.2–22.3]	22.0 [20.7–23.2]	21.8 [18.8–25.0]
South Sudan	6.0 [3.3–9.5]	7.1 [4.2–10.8]	8.2 [5.1–12.1]	9.9 [6.0–14.6]	12.4 [6.9–19.5]

Togo	6.8 [4.7–9.3]	8.2 [6.2–10.6]	9.3 [7.4–11.4]	10.0 [7.8–12.4]	10.9 [7.6–14.8]
Uganda	5.4 [4.3–6.7]	6.0 [5.0–7.0]	6.3 [5.5–7.3]	7.0 [6.0–8.2]	9.7 [7.0–12.8]
United Republic of Tanzania	4.4 [3.2–5.8]	5.0 [4.0–6.3]	5.7 [4.7–6.9]	6.4 [5.1–7.8]	7.6 [5.2–10.5]
Zambia	4.8 [3.5–6.5]	5.9 [4.4–7.7]	7.2 [5.6–9.2]	9.3 [7.2–11.9]	12.5 [8.5–17.3]
Zimbabwe	7.1 [5.8–8.5]	7.7 [6.5–9.1]	8.1 [6.9–9.4]	8.8 [7.3–10.5]	9.9 [6.9–13.5]

Source: World Health Organization. (November 2025). *The global health observatory.* World Health Organization. https://www.who.int/data/gho

Annex 10. Trends in obesity among adolescents, 10–19 years, 2000–2022

Country	2000	2005	2010	2016	2022
Algeria	6.8 [3.3–11.6]	8.4 [4.5–13.2]	9.7 [5.9–14.4]	11.9 [7.8–16.8]	14.7 [8.5–22.5]
Angola	1.0 [0.3–2.3]	1.4 [0.5–3.0]	1.8 [0.7–3.6]	2.5 [1.0–5.0]	3.9 [1.1–8.7]
Benin	1.2 [0.6–2.5]	1.8 [0.9–3.3]	2.4 [1.4–4.2]	3.1 [1.7–5.5]	4.4 [1.7–9.2]
Botswana	1.6 [0.6–3.2]	2.2 [0.9–4.0]	2.9 [1.4–4.9]	3.9 [2.0–6.6]	5.7 [2.2–11.4]
Burkina Faso	0.3 [0.1–0.5]	0.4 [0.2–0.7]	0.5 [0.3–0.8]	0.7 [0.4–1.1]	1.0 [0.5–1.9]
Burundi	0.5 [0.1–1.2]	0.6 [0.2–1.5]	0.8 [0.3–1.9]	1.1 [0.4–2.8]	1.7 [0.3–5.0]
Cape Verde	1.1 [0.3–2.6]	1.5 [0.5–3.3]	2.0 [0.7–3.9]	2.5 [1.0–4.7]	3.6 [1.4–7.1]
Cameroon	1.0 [0.6–1.5]	1.4 [0.9–2.0]	1.7 [1.1–2.5]	2.3 [1.4–3.8]	3.6 [1.7–7.3]
Central African Republic	1.2 [0.3–3.1]	1.7 [0.5–4.1]	2.3 [0.6–5.1]	3.1 [0.8–7.0]	4.6 [1.0–11.2]
Chad	0.7 [0.2–1.8]	1.0 [0.3–2.4]	1.3 [0.4–3.0]	1.7 [0.6–4.3]	2.6 [0.6–7.2]
Comoros	1.0 [0.4–2.0]	1.4 [0.6–2.6]	1.8 [0.9–3.1]	2.4 [1.1–4.4]	3.5 [1.1–7.7]
Côte d'Ivoire	1.3 [0.7–2.3]	1.9 [1.1–3.1]	2.4 [1.4–4.0]	3.2 [1.7–5.7]	4.6 [2.1–9.2]
Democratic Republic of the Congo	0.9 [0.5–1.6]	1.3 [0.7–2.1]	1.8 [1.0–2.8]	2.4 [1.2–4.4]	3.7 [1.2–8.2]
Equatorial Guinea	1.2 [0.3–3.2]	1.7 [0.4–4.1]	2.2 [0.6–5.3]	3.1 [0.8–7.2]	4.6 [1.0–11.5]
Eritrea	0.7 [0.2–1.5]	1.0 [0.3–2.0]	1.3 [0.4–2.6]	1.8 [0.5–3.9]	2.7 [0.6–6.6]

Eswatini	1.9 [1.0–3.2]	2.7 [1.7–4.0]	3.4 [2.3–4.8]	4.4 [2.7–6.7]	6.0 [2.7–11.0]
Ethiopia	0.2 [0.1–0.5]	0.3 [0.2–0.6]	0.4 [0.3–0.6]	0.6 [0.4–0.8]	0.9 [0.4–1.8]
Gabon	1.2 [0.5–2.5]	1.8 [0.9–3.1]	2.4 [1.3–4.0]	3.3 [1.9–5.8]	5.1 [2.4–10.0]
Gambia	1.1 [0.4–2.4]	1.5 [0.6–3.0]	1.9 [0.9–3.7]	2.5 [1.3–5.0]	3.6 [1.4–8.4]
Ghana	1.1 [0.6–1.9]	1.5 [1.0–2.3]	2.0 [1.4–2.7]	2.6 [2.1–3.3]	4.0 [2.7–5.6]
Guinea	0.6 [0.3–1.3]	0.9 [0.4–1.7]	1.2 [0.6–2.1]	1.7 [0.9–3.2]	2.8 [1.1–6.2]
Guinea-Bissau	0.8 [0.3–1.9]	1.2 [0.5–2.5]	1.6 [0.7–3.3]	2.1 [0.8–4.8]	3.3 [0.9–8.4]
Kenya	0.7 [0.3–1.4]	1.0 [0.6–1.8]	1.4 [0.9–2.1]	1.6 [1.1–2.2]	1.8 [1.1–2.6]
Lesotho	1.5 [0.8–2.5]	2.0 [1.3–2.9]	2.4 [1.7–3.3]	3.0 [1.8–4.4]	3.9 [1.6–7.1]
Liberia	0.5 [0.2–0.9]	0.7 [0.4–1.3]	1.2 [0.7–1.9]	2.8 [1.8–4.2]	8.1 [4.9–12.2]
Madagascar	0.3 [0.1–0.9]	0.4 [0.1–1.3]	0.6 [0.1–1.7]	0.9 [0.2–2.5]	1.5 [0.3–4.8]
Malawi	0.4 [0.2–0.8]	0.6 [0.4–0.9]	0.8 [0.5–1.1]	1.1 [0.6–1.6]	1.6 [0.6–3.1]
Mali	1.1 [0.6–2.0]	1.7 [1.0–2.7]	2.3 [1.4–3.5]	3.0 [1.7–5.1]	4.3 [1.8–8.6]
Mauritania	2.3 [1.0–4.1]	3.2 [1.7–5.3]	4.2 [2.4–6.5]	5.4 [3.3–8.2]	7.4 [4.1–12.8]
Mauritius	3.0 [1.6–5.1]	4.6 [3.0–6.6]	6.4 [4.9–8.1]	8.9 [7.3–10.5]	12.2 [8.6–16.3]
Mozambique	0.7 [0.4–1.0]	0.8 [0.5–1.2]	0.9 [0.6–1.4]	1.0 [0.6–1.6]	1.3 [0.5–2.5]
Namibia	1.0 [0.5–1.9]	1.5 [0.8–2.4]	1.9 [1.1–3.1]	2.6 [1.2–4.8]	4.0 [1.2–9.3]

Niger	0.6 [0.2–1.2]	0.9 [0.4–1.6]	1.2 [0.5–2.2]	1.7 [0.8–3.1]	2.8 [1.1–5.6]
Nigeria	0.8 [0.4–1.3]	1.1 [0.7–1.6]	1.5 [1.1–2.0]	2.0 [1.3–2.8]	3.0 [1.3–5.5]
Republic of the Congo	0.6 [0.3–1.0]	0.8 [0.4–1.5]	1.1 [0.6–2.2]	1.7 [0.6–3.8]	2.8 [0.6–7.5]
Rwanda	0.3 [0.2–0.6]	0.5 [0.3–0.7]	0.6 [0.4–0.9]	0.8 [0.5–1.2]	1.2 [0.6–2.2]
Sao Tome and Principe	1.6 [0.7–2.9]	2.2 [1.2–3.7]	2.6 [1.5–4.1]	2.8 [1.4–4.7]	3.3 [1.1–6.8]
Senegal	0.5 [0.2–0.9]	0.7 [0.3–1.1]	0.8 [0.5–1.4]	1.1 [0.5–2.1]	1.9 [0.5–4.4]
Seychelles	5.6 [4.9–6.3]	8.0 [7.2–8.8]	10.0 [9.0–11.1]	12.9 [11.9–14.0]	17.9 [15.8–20.1]
Sierra Leone	1.4 [0.7–2.5]	1.8 [1.0–2.8]	1.9 [1.2–2.8]	1.8 [1.2–2.6]	2.0 [1.1–3.4]
South Africa	2.6 [2.1–3.1]	5.2 [4.5–5.9]	7.3 [6.6–8.1]	7.4 [6.5–8.3]	7.2 [5.1–9.6]
South Sudan	1.1 [0.3–2.8]	1.6 [0.5–3.6]	2.1 [0.7–4.6]	3.1 [1.0–6.5]	4.7 [1.3–10.5]
Togo	0.9 [0.4–1.8]	1.3 [0.6–2.3]	1.5 [0.8–2.5]	1.8 [1.0–3.0]	2.3 [0.9–4.6]
Uganda	0.4 [0.2–0.6]	0.5 [0.3–0.8]	0.7 [0.4–0.9]	1.1 [0.7–1.6]	3.1 [1.4–5.5]
United Republic of Tanzania	0.4 [0.2–0.7]	0.5 [0.3–0.9]	0.7 [0.4–1.1]	0.9 [0.6–1.5]	1.5 [0.6–3.0]
Zambia	0.6 [0.3–1.4]	0.9 [0.5–1.8]	1.4 [0.8–2.5]	2.4 [1.4–3.9]	4.3 [1.9–7.9]
Zimbabwe	0.7 [0.4–1.2]	1.0 [0.6–1.5]	1.2 [0.8–1.7]	1.4 [0.9–2.1]	1.9 [0.8–3.7]

Source: World Health Organization. (November 2025). *The global health observatory.* World Health Organization. https://www.who.int/data/gho

Annex 11. Prevalence of insufficient physical activity among adolescents in AU Member States, 11–17 years, 2010 estimates

Country	Female	Male	Both
Algeria	92.4	75.9	84.6
Angola	NA	NA	NA
Benin	76.8	72.8	74.1
Botswana	88.7	87.3	88.1
Burkina Faso	NA	NA	NA
Burundi	NA	NA	NA
Cameroon	NA	NA	NA
Cape Verde	NA	NA	NA
Central African Republic	NA	NA	NA
Chad	NA	NA	NA
Comoros	NA	NA	NA
Côte d'Ivoire	85.4	72.6	79.3
Democratic Republic of the Congo	NA	NA	NA
Djibouti	89.1	81.3	84.6
Egypt	92.9	80.6	87.3
Equatorial Guinea	NA	NA	NA
Eritrea	NA	NA	NA
Eswatini	NA	NA	NA
Ethiopia	NA	NA	NA
Gabon	NA	NA	NA
Gambia	NA	NA	NA
Ghana	88.3	87.5	87.9
Guinea	NA	NA	NA
Guinea Bissau	NA	NA	NA
Kenya	NA	85.7	87.4
Lesotho	NA	NA	NA
Liberia	NA	NA	NA
Libya	88.2	78.2	84
Madagascar	NA	NA	NA
Malawi	NA	NA	NA
Mali	NA	NA	NA
Mauritania	92.3	83.1	88
Mauritius	86.8	74.2	81.1
Morocco	89.4	84.2	86.6
Mozambique	NA	NA	NA

Namibia	86.8	85	86
Niger	NA	NA	NA
Nigeria	NA	NA	NA
Republic of the Congo	NA	NA	NA
Rwanda	NA	NA	NA
Sao Tome and Principe	NA	NA	NA
Senegal	93.6	85.6	89.2
Seychelles	86.8	76.6	82.1
Sierra Leone	NA	NA	NA
Somalia	NA	NA	NA
South Africa	NA	NA	NA
South Sudan	NA	NA	NA
Sudan	92.3	91.2	91.9
Tanzania	84.9	75.5	80.4
Togo	NA	NA	NA
Tunisia	88.2	74.1	81.4
Uganda	86.6	84.7	85.6
Zambia	88.8	91.5	90.1
Zimbabwe	88.6	85.5	87.2

Source: World Health Organization. (2014). *Global status report on noncommunicable diseases 2014*. World Health Organization. https://www.who.int/publications/i/item/9789241564854

Annex 12. Prevalence of anaemia among adolescents, 15–19 years (%)

Country	Female	Male	Source
Benin	57.4		DHS 2017/2018
Burkina Faso	55.6	43.7	DHS 2021
Burundi	35.9	17.9	DHS 2010
Cameroon	39.7		DHS 2018
Cape Verde	34.2		DHS 2020
Côte d'Ivoire	62.2	42.8	DHS 2011/2012
Democratic Republic of the Congo	40.5	37	DHS 2024
Egypt	24.8		DHS 2014
Equatorial Guinea	52.9	33.3	DHS 2011
Eswatini	28.2	15.6	DHS 2006/2007
Ethiopia	19.9	18.2	DHS 2016
Gabon	72	45.9	DHS 2019/2021
Gambia	43.5		DHS 2019/2020
Ghana	44		DHS 2022
Guinea	47.1	36.5	DHS 2012
Lesotho	43.1	31.1	DHS 2023/2024
Liberia	55.1		DHS 2019/2020
Madagascar	27.8	39.9	DHS 2008/2009
Malawi	42.3	35.3	DHS 2024/2016
Mali	53.8	27.1	DHS 2024/2018
Mauritania	63.3		DHS 2019/2021
Mozambique	54.4		DHS 2022/2023
Namibia	19.1	18.4	DHS 2013
Niger	46	42.8	DHS 2012
Nigeria	42.2		DHS 2024
Republic of the Congo	55.1		DHS 2011/2012
Rwanda	14.7		DHS 2019/2020
Sao Tome and Principe	51.4	39.9	DHS 2008/2009
Senegal	57.2	47.9	DHS 2017
Sierra Leone	49.4	45.8	DHS 2019
South Africa	34	17.2	DHS 2016
Tanzania	45		DHS 2022
Togo	54.7	34.7	DHS 2013/2014
Uganda	32.9	26	DHS 2016
Zambia	47.2	NA	DHS 2024
Zimbabwe	26.5	20.4	DHS 2015

Annex 13. Inclusion of adolescents in nutrition policy

Country	Policy/strategic plan	Meaningful inclusion? (yes or no)	Reason
Benin	National Food and Nutrition Policy 2023–2033	Yes	• School nutrition is part of nutrition interventions • Promotion of adolescent girls' nutrition included
Burkina Faso	National Multisectoral Policy of Nutrition 2020–2029	Yes	**Adolescents included in Strategic Objective 2.2** Reduce the prevalence of anaemia among pregnant women, adolescents, children **2.2.1** Adolescents supplemented with iron and folic acid **2.2.2** Adolescent girls are dewormed
Burundi	Burundi Strategie de Nutrition 2019	No	Adolescents mentioned as part of the population but no adolescent specific strategies and interventions
Cameroon	Politique Nationale d' alimentation et de nutrition	No	Adolescents not meaningfully included
Chad	Politique Nationale de Nutrition et D'alimentation 2014–2025 – Tchad	No	There's a strategic objective on promoting nutrition in schools but no direct focus on adolescent nutrition
Comoros	National Nutrition and Food Policy of the Union of the Comoros (PNNA 2018–2025)	No	Adolescents are mentioned as part of the population groups but there are no specific strategies or interventions targeting them

Côte D'Ivoire	Plan National Multisectoriel de Nutrition 2016—2020	Yes	**Adolescents included in Outcome 1.2** Deworming and iron and folic acid supplementation of adolescents and others
Democratic Republic of the Congo	National Strategic Multisectoral Nutrition Plan for the DRC (PNSMN 2023–2030)	Yes	Adolescents included in Objectives and Interventions **Objective** 4.1: Reduce adolescent obesity to less than 8.5% **Interventions**: Promote consumption of iron and folic acid for adolescents
Djibouti	Stratégie Nationale de prévention des différentes formes de la malnutrition à Djibouti	Yes	Adolescent girls are mentioned as part of the target groups for the policy Interventions targeting adolescents, such as nutrition education, micronutrient supplementation and deworming
Ethiopia	National Food and Nutrition Strategy	Yes	Adolescent nutrition included in Strategic Direction 4.6 to improve the nutrition status of adolescents (10–19 years) with various strategic initiatives targeting adolescents
Gabon	National Policy Food Safety and Nutrition 2017–2025	Yes	Adolescents included in Strategic Priority 2 Improve nutrition of **adolescents** and women of childbearing age, and implement nutrition interventions in schools
Ghana	National Nutrition Policy for Ghana 2013–2017	Yes	One of the policy measures is to prevent and control micronutrient deficiencies through weekly iron supplementation among adolescent girls and women of childbearing age

Guinea	PSNMN 2019 2024 Republique de Guinee	Yes	Adolescents included in strategic objectives **Strategic Objective 3.1.7**: Improved knowledge about prevention and treatment of obesity in children and adolescents **Strategic Objective 5.2.4** Strengthen the nutritional status of adolescent girls through better nutrition education
Kenya	Kenya National Nutrition Action Plan 2018–2022	Yes	Adolescents included in Key Result Area 2: Nutrition of older children and adolescents Reduce prevalence of anaemia in adolescent girls
Lesotho	Lesotho Food and Nutrition Policy 2016–2025	Yes	One of the policy objectives is to provide optimal nutrition to adolescents
Liberia	National Nutrition Policy 2019–2024	Yes	Adolescents included in Objectives 6.1.a Improve coverage of infant and young child feeding interventions including adolescent nutrition 6.2.f Reach adolescent girls during pre-conception through school-linked interventions 6.9 Nutrition for school-age children and adolescents 6.12 Improve nutritional outcomes of poor children and adolescents through social services
Madagascar	Plan National D'Action Pour La Nutrition 2012–2015	Yes	Adolescents included in Interventions Intervention 4: Promoting nutrition among adolescent girls Intervention 5: Nutrition education in schools Intervention 7:

			Micronutrient supplementation (iron and folic acid, multiple micronutrient supplementation, vitamin A) for pregnant and breastfeeding women, adolescent girls (15–24), children
Malawi	National Multi-Sector Nutrition Strategic Plan 2018–2022	Yes	Adolescent nutrition included as one of the priority areas (promotion of adolescent nutrition and WIFAS included in strategic objectives)
Mali	Multisectoral Nutrition Action Plan 2021–2025	No	Adolescents are mentioned in strategic objectives and guiding principles but no strategies or interventions targeting adolescents
Mauritania	Multi-sector strategic nutrition plan 2016–2025	No	Mention of adolescents in strategy but no specific strategies and interventions targeting adolescents
Mauritius	National Plan of Action for Nutrition 2016–2020	Yes	Adolescent nutrition issues meaningfully included (one of the objectives is to reduce nutritional anaemia in adolescent girls aged 12–19 years); adolescents are also a target group for school feeding program
Morocco	The National Nutrition Strategy 2011–2019	No	Adolescents not included except promoting nutrition in schools
Mozambique	Multisectoral Action Plan for the Reduction of Chronic Undernutrition in Mozambique 2011–2015 (2020)	Yes	One of the strategic objectives is to improve adolescent nutrition Anaemia reduction and nutrition education among adolescents' key results
Namibia	Multisectoral Nutrition Implementation plan, results frameworks and Implementation plan results framework & dashboard of indicators 2012/13–2015/16	No	Adolescent nutrition is not meaningfully included; only mentioned as part of the school feeding program

Niger	Polique Nationale de Securité Nutritionnelle au Niger (2016–2025)	Yes	Adolescents included in commitments and strategic directions **Commitment 2:** Optimal nutrition for adolescents, specifically teen girls **Strategic Direction 2.2:** Teen health before/during/after pregnancy **Strategic Direction 2.4:** Strengthening reproductive health among adolescents **Commitment 3:** Availability and consumption of diverse foods among adolescents, among other groups **Strategic Direction 6.4**: Ensure teen girls' and boys' knowledge of nutrition during pregnancy
Nigeria	National Multi-sectoral Plan of Action for Food and Nutrition	Yes	Adolescents included in targets to arrest the emerging increase in obesity prevalence in adolescents and adults by 2025 Support distribution of iron and folate supplements to adolescents (boys and girls) in schools and communities (25% coverage)
Republic of the Congo	Strategic Framework to Combat Malnutrition in Congo 2025	No	There is a goal related to expanding school canteens; however, only primary schools are a target, thus it does not include adolescents
Rwanda	National Food and Nutrition Policy 2013–2018	No	School feeding is an objective, but no mention of adolescent nutrition
Senegal	Plan Strategique Multisectoriel de la nutrition du Senegal 2018–2022	Yes	Adolescents included in strategic objectives and interventions Strategic Objectives Reduction in prevalence of anaemia among adolescent girls by 25%

			Reduction in prevalence of obesity among adolescents by 5% Interventions Iron and folic acid supplementation in schools, particularly for adolescent girls
Seychelles	Food and Nutrition Policy 2013	Yes	One of the objectives is to promote appropriate nutrition for school children and adolescents One of the interventions is to institutionalize routine assessment and monitoring of nutritional status of adolescents and other groups and create awareness of healthy diets
Sierra Leone	Multisector Strategic Plan to Reduce Malnutrition in Sierra Leone – 2019–2025	No	Adolescents mentioned in key strategic directions as part of the target populations but no specific strategies or interventions targeting adolescents
South Africa	National Policy in Food and Nutrition Security 2013	No	School feeding is mentioned, but there is no indication that this would target adolescents
Sudan	National Nutrition Strategic Plan 2014–2025	No	No specific strategies or interventions targeting adolescents
Tanzania	National Multisectoral Nutrition Action Plan (2021/22–2025/26)	Yes	Adolescents included in strategic outcomes, key interventions and outcome indicators
Togo	Plan Strategique National D'Alimentation et de Nutrition 2012-2015	No	Adolescents not meaningfully included
Uganda	Nutrition Action Plan 2 (2020/2021–2024/2025)	Yes	Adolescents included mentioned in Strategy 1.1 and 1.2 **Strategy 1.1:** Promote optimal maternal, infant, young child and adolescent nutrition

			practices in stable and emergency situations **Strategy 1.2**: Promote optimal micronutrient intake among children, adolescent girls and women of reproductive age in stable and emergency situations Adolescents included in primary outcomes Reduced proportion of overweight adolescents from 10% to 6% Proportion of obesity in adolescent girls maintained at 1%
Zambia	National Food and Nutrition Policy	No	There is mention of adolescents in policy but no specific strategies or interventions targeting adolescents, except support for appropriate feeding practices for school children and adolescents
Zimbabwe	National Nutrition Strategy 2014–2018	Yes	Adolescent nutrition included in key result areas and outcome indicators Key Result Area Increase to 50% by 2018 coverage of health and nutrition services for adolescents Coverage of health and community nutrition services for school children increased to 50% by 2018 Outcome indicators Proportion of school-age children (5–12yrs) with obesity Proportion of **adolescents** with obesity (15–19 years) Proportion of **adolescents** underweight (15–19 years) Proportion of school-going children (6–14 years) with iodine deficiency

			Proportion of school age children (6–14 years) with anaemia

Annex 14. Definition of indicators

Adolescent birthrate: Number of live births to female adolescents per 1,000 female adolescents.

Adolescent pregnancy: The occurrence of pregnancy between the ages of 13 and 19 years.

Anaemia: Proportion of adolescents (10–19 years) who have a haemoglobin level below the relevant WHO threshold.

Child marriage: Proportion of girls married by the age of 18 years.

Contraceptive use: Proportion of adolescents (10–19 years) who used any modern method of contraception the last time they had sexual intercourse.

Food environment: The physical, economic, policy and sociocultural conditions that shape what foods people can access, afford and consume.

Food insecurity: Proportion of adolescents (10–19 years) who went hungry most of the time or always during the past 30 days because there was not enough food in their home.

Micronutrient deficiency: Inadequate amount of essential vitamins and minerals that are required in small amounts by the body for proper growth and development

Net school attendance rates: Total number of students of the official age group for primary education who are attending school at any level of education, expressed as a percentage of the corresponding population.

Net school enrollment rates: The ratio of children of official school age who are enrolled in school to the population of the corresponding official school age.

Nutrition commitment: Specific, measurable, accountable, realistic and time-bound (SMART) pledges made by governments and other stakeholders.

Obesity: Proportion of adolescents (10–19 years) whose body mass index (BMI) was ≥+2 standard deviation from the median BMI, according to WHO growth reference standards for respective age and sex.

Overweight: Proportion of adolescents (10–19 years) whose body mass index (BMI) was ≥+ 1 standard deviation from the median BMI, according to WHO growth reference standards for respective age and sex.

Physical activity: Proportion of adolescents (10–19 years) who accumulated an average of at least 60 minutes of moderate-to-vigorous intensity physical activity per day during the past seven days

Thinness: Proportion of adolescents (10–19 years) whose body mass index (BMI) was <–2 SDs from the median BMI, according to WHO growth reference standards for the respective age and sex.

Annex 15. Sources of data

Indicator	Source of data
Demographic data and gender equality data	
Adolescent population	UN, Department of Economic and Social Affairs, Population Division, World Population Prospects 2024
Adolescent birthrate	UN Department of Economic and Social Affairs (SDG Indicator Database)
Child marriage	Demographic and Health Survey, Multiple Indicator Cluster Surveys
Demand for family planning satisfied with modern methods	Demographic Health Surveys
School enrollment	UNESCO Institute of Statistics
School attendance	UNESCO Institute of Statistics
Health and nutrition status	
Thinness, overweight and obesity	Demographic and Health Surveys, Multiple Indicator Cluster Surveys, NCD Risk Factor Collaboration (NCD-Risc), WHO Global Health Observatory
Anaemia	Demographic and Health Surveys (DHS)
Micronutrient deficiencies	World Health Organization, Vitamin and Mineral Information System (VMNIS) Micronutrients database
Physical activity	Global Status report on NCDs 2014
Enabling environment	
National nutrition policies and strategies	Ministries of Health and Agriculture websites, Food and Agriculture Organization (FAO) website, Scaling Up Nutrition (SUN) website, Global Database on the Implementation of Food and Nutrition Action (GIFNA), Maternal Newborn, Child and Adolescent Health and Aging Website, Google search
Nutrition Commitments	The Nutrition Accountability Framework, Nutrition for Growth Website

End notes

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