Save the Children

INVESTING IN THE NOW AND THE FUTURE

Why governments must commit to adolescent health and nutrition

PHOTO: SACHA MYERS/SAVE THE CHILDREN

Manal*, 18, and her sister Fatima*, 12, with Dr Ma'ab from the Save the Children-supported Emergency Health Unit, after they received their cholera vaccination at a site in Sudan.

The world today is home to 1.2 billion adolescents* – more than one in six people globally is aged between 10 and 19 years.[1] The proportion is higher in some low and middle-income countries and the number of adolescents is expected to rise considerably by 2050. Investing in adolescents' rights has the potential to deliver a triple-dividend – improving their well-being now, enhancing their future life chances, and boosting outcomes for the next generation of children.[2]

Adolescence is a critical window of opportunity but also a challenging period involving rapidly changing needs and capacities. It is also a time when age and gender discrimination can become more acute. Adolescents and their health needs are diverse; while many adolescents have not yet started their reproductive lives, each year, 12 million adolescents aged 15–19 give birth.[5]

Adolescents' rights to health and well-being are central to delivering on key global commitments.

This briefing makes the case for prioritising adolescent health and nutrition, sets out recommendations for implementing a gender-transformative, adolescent-responsive approach, and provides model commitments for advocates, governments and donors.

Front cover: Siti Karlina*, 16, a member of the Coaching for Life programme, demonstrates her skills at a community centre in Jakarta, Indonesia. She says she has gained so much confidence and motivation since joining the programme. Photo: Jiro Ose/ Save the Children

* Adolescence is the transitionary stage between childhood and adulthood that is also shaped by cultural and contextual realities. The World Health Organization defines 'adolescents' as people between the ages of 10 and 19 years. Where the term 'youth' is used in this briefing, it refers to people between the ages of 15 and 24.

Adolescents' rights to health and well-being are central to delivering on key global commitments including Universal Health Coverage and the 2030 Agenda for Sustainable Development. Despite this, adolescent health and nutrition is grossly underfunded and has not been adequately prioritised by donors or governments. Between 2003 and 2015, just 1.6% of global aid for health was allocated to adolescent health,[6] despite adolescents making up 16% of the population. Critically, the areas of health most significant to adolescents-– nutrition, mental health and sexual and reproductive health and rights – face some of the greatest financial and political threats.[7] Before the COVID-19 pandemic, an estimated additional $23.25 billion each year was needed to make progress toward Sustainable Development Goal target 2: zero hunger by 2030.[8] The predicted rise in rates of malnutrition resulting from the pandemic indicate that this will increase.[9]

As the COVID-19 crisis further exacerbates inequalities, improving access to health and nutrition systems that meet the unique needs of adolescents is more important than ever. With less than ten years to deliver on the Sustainable Development Goals, global moments and processes like the Nutrition for Growth (N4G) Year of Action (2021), the Global Financing Facility for Women, Children and Adolescents replenishment, UN Food Systems and Lives in the Balance Summits, Family Planning 2030 and Generation Equality all present critical opportunities for governments and donors, alongside civil society organisations and adolescent and youth advocates, to accelerate progress by placing the rights of adolescents at the heart of health and nutrition policies and services.

Adolescents' right to health and nutrition

The United Nations Convention on the Rights of the Child recognises the right to the highest attainable standard of health including nutrition, family planning information and services, and protection from harmful practices such as female genital mutilation or cutting.[3]

The right to health and nutrition means that all people should have access to services they need, when and where they need them, without suffering financial hardship. For policy-makers this means addressing discriminatory practices and putting the furthest behind first, building services rooted in dignity and equity for all. All states have committed to delivering this right for adolescents under the World Health Organization Constitution or international human rights law.[4]

Jaibelin* attends a temporary learning space in an informal settlement in Colombia.

PHOTO: SAVE THE CHILDREN

Why prioritise adolescent health and nutrition?

Adolescents' health and nutrition needs are not being met. 1.2 million adolescents die each year, mostly from preventable causes.[10] The world has been slow to reduce youth mortality. Between 1990 to 2019, mortality in adolescents and youth aged 15–24 years reduced by just 34% compared to a 59% decline in under-five mortality.[11]

The physical growth, cognitive development and onset of puberty that come with adolescence transform young people's health and nutrition needs. These changes coincide with changing family and social roles determined by social norms, including increased expectations of independence alongside new restrictions, as well as gender-based discrimination and bias that limit personal rights and freedoms. Health and nutrition habits with lifelong consequences are often established during adolescence and social norms begin to crystalise during early adolescence (around ages 10 to 14), making this a critical period for shaping gender-equitable views critical to healthy relationships.[12,13] To ensure positive health and social outcomes, adolescents must be supported to establish good health, nutrition, and social and sexual behaviours.

Health and nutrition habits with lifelong consequences are often established during adolescence.

Leomar*, a Venezuelan migrant boy, doing homework.

PHOTO: MIGUEL ARREATEGUI RODRIGUEZ/SAVE THE CHILDREN

Adolescents face intersecting barriers to health and nutrition services

Stigma and discrimination

Discrimination, based on age, disability, race, class, caste, sexual orientation or gender identity, is at the root of many barriers to accessing health and nutrition services. Taboos around sex mean that many adolescents lack, or have unequal access to, the information they need to make healthy decisions. Adolescents who are discriminated against because of their sexual orientation, gender identity or expression are commonly denied access to information in efforts to police their sexuality. Health and nutrition workers often act as gatekeepers to services and fear of judgement may deter adolescents from seeking services.[14]

Many adolescents lack access to the information they need to make healthy decisions.

Dependence on others

Despite often increasing responsibilities, many adolescents remain dependent on other people, particularly adult family members, to be able to access health and nutrition services. They may need permission, money or transport. Laws may prevent adolescents under 18 years from consenting to services by requiring parental or spousal permission (for girls) or may explicitly prohibit access to sexual and reproductive health products and services, for example.[15] Laws can also create barriers indirectly, by creating fear that seeking services will expose an adolescent as breaking the law, for example where drug use, same-sex relations, transgender identity or expression, safe abortion or selling sex is unlawful. Limits on adolescents' ability to independently access health and nutrition services deny their privacy and mean that the decision to access services ultimately sits with someone else. This is particularly problematic for sensitive or stigmatised services, for example in relation to gender-based violence or safe abortion services. Adolescents with disabilities are also more likely to be excluded from sex education programmes within health and nutrition services.[16]

A lack of services designed specifically for adolescents

Adolescents often fall between services designed for children and those designed for adults. This is particularly significant for services such as family planning or antenatal care, which adolescents may be excluded from due to social assumptions that they are not sexually active, and that they may be stigmatised for.[17] This creates barriers to many of the services that are most critical to adolescents, including mental health, sexual and reproductive health (including maternal health) and nutrition support. It also means that important opportunities to screen for risks, particularly in relation to gender-based violence and self-harm, will be missed. Healthcare staff often lack professional opportunities to reflect on how their own values and biases shape how they treat adolescents, and supervision that supports and holds them accountable for provision of respectful and unbiased care to adolescents. Community health and nutrition outreach programmes can miss adolescents unless they are intentionally included.

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How health and nutrition outcomes differ between adolescent boys and girls

Gender discrimination, sex characteristics and harmful gender norms drive new and sometimes shared risks for girls, boys, non-binary and gender non-conforming adolescents.* Due to a lack of data disaggregated by gender identity, it is not possible to identify the experiences of non-binary, gender non-conforming and transgender adolescents among those presented here. Further research is urgently needed to safely close data gaps and better respond to adolescents' needs.

Sexual and reproductive health and rights

Girls	Boys	Girls and boys
• 80% of new HIV infections among 15–19-year-olds in sub-Saharan Africa are among girls.[18] • Adolescent mothers face higher risks of mortality and morbidity than women aged 20–24 years[19] and are more likely to experience maternal death, still births, neonatal death or deliver babies with low birth weight.[20] • 57% of adolescents have an unmet need for contraception compared with 24% of all women aged 15–49.[21] Adolescents aged 15–17 have the greatest unmet need and 85% of adolescents with an unmet need do not use any method of contraception. • Adolescent girls have the highest risk of curable sexually transmitted infections globally.[22] • One in ten girls in Africa miss school because of their period each year.[23] Misinformation and myths around menstruation leads to stigmatisation of adolescent girls. Lack of access to menstrual hygiene products, shame or taboos can isolate girls from society and cause them to miss school while menstruating.	• In areas with a concentrated HIV epidemic,† a disproportionate number of male adolescents who have sex with men or adolescent boys are living with HIV.	• Adolescents are the only demographic with increasing numbers of deaths from AIDS.[25]

Violence, including harmful practices

Girls	Boys	Girls and boys
• Girls' risk of trauma, death and disability from violence increases throughout adolescence.[26] In most countries, one in five girls aged 15–19 who have ever had a partner has experienced gender-based violence; one in ten globally has experienced rape or other sexual violence.[27] • Around 12 million girls are married each year.[28] • 28 million adolescent girls alive today have experienced female genital mutilation/cutting, most before the age of 14.[29] • For many adolescents, their first sexual intercourse is a result of coercion or violence. The rate is higher among very young adolescents (10–12 years old). One in ten girls under 20 has been a victim of sexual violence.[30]	• Boys are more likely to be murdered than girls.[31]	• Interpersonal violence is among the leading causes of death for adolescent boys and girls.[32]

* 'Non-binary' is an umbrella term for people whose gender identity doesn't sit comfortably with 'male' or 'female'. Non-binary identities are varied and can include people who identify with some aspects of binary identities, while others reject them entirely.

'Gender non-conforming' is a term used to describe people whose gender expression is different from conventional expectations of masculinity and femininity.

These definitions are taken from Save the Children's Sexual Orientation, Gender Identity and Expression Policy.

† Countries are classified as having a 'concentrated' HIV epidemic where the prevalence rate is below 1%. See Boily M-C, Pickles M, Alary M (2015) What really is a concentrated HIV epidemic and what does it mean for West and Central Africa? Insights from mathematical modeling

Leading causes of death

Girls	Boys	Girls and boys
• Maternal mortality due to complications from pregnancy and childbirth (including due to barriers to accessing safe abortion)[33] is the leading cause of death among girls aged 15–19 years.[34]	• Road accidents are the leading cause of death among adolescent boys.[35] The literature suggests this may in part be driven by gender norms that reward risk-taking by boys. Boys also face a higher risk of child labour, including in physically dangerous employment.[36]	• Self-harm is the second leading cause of death for girl and boy adolescents.[37] Many mental health illnesses first present during adolescence – half of all mental health disorders in adulthood start by the age of 14.[38]

Anaemia

Girls	Boys	Girls and boys
• Increased iron requirements for growth during puberty and due to menstruation increases the risk of anaemia. Girls with acute anaemia face twice the risk of dying in childbirth or soon after and globally, rates among women and adolescent girls have risen since 2012.[39,40]	• Boys also suffer from anaemia. One study in India showed that 29% of boys aged 15–19 years were anaemic compared to 54% of girls in the same age group.[41] This can affect physical growth and mental development.	• Anaemia is a global issue faced by adolescents in both high- and low-income countries. Anaemia in adolescence causes reduced resistance to infection, reduced physical and mental capacity, and diminished concentration in work and educational performance.

Nutritional deficiencies

Girls	Boys	Girls and boys
• Adolescent girls have increased nutritional need for animal products, vegetables, nuts, fruits and pulses, which can be expensive. • Pregnant adolescents have higher nutritional needs than pregnant adults due to the demands of their own growth competing with that of their baby. This can result in slowed or stopped growth for girls during pregnancy.[42,43,44] It may also affect the baby and future pregnancies.[45]	• Adolescent boys have increased nutritional needs due to growth. This may coincide with expectations that boys become more financially independent, including through physically demanding work, further raising nutritional needs.	• Adolescents have high nutrient needs for pubertal growth and brain maturation, increasing their risk of malnutrition.

Thinness and obesity

Girls	Boys
• 74 million girls aged 5–19 years suffer from thinness,[46] while girls are also susceptible to obesity through eating energy dense but nutrient poor diets.[47]	• More boys (117 million aged 5–19) suffer from thinness than girls[48] and of obesity (7.8% among 5–19 year olds)[49]

Adolescents have high nutrient needs for pubertal growth and brain maturation, increasing their risk of malnutrition.

Designing services that work for adolescents

Addressing the intersecting barriers that prevent adolescents from accessing health and nutrition services requires fully integrated health and nutrition systems that are *adolescent responsive and gender transformative*.

Adolescent-*friendly* services (defined as being accessible, acceptable, equitable, appropriate and effective for adolescents)[50] typically rely on stand-alone approaches such as separate rooms in clinics for adolescents. Evidence suggests that these measures are not enough to increase uptake, sustain or scale up support to adolescents, or enable adequate monitoring of adolescent health.[51] In Nepal for example, substantial long-term scale-up of adolescent-friendly health facilities has not changed uptake, with just 9.2% of adolescents seeking services from these sites.[52]

In line with the World Health Organization,[53] Save the Children recommends prioritisation of adolescent-*responsive* health and nutrition systems to address the broad range of adolescents' health, nutrition and development needs.

Adolescent-responsive and gender-transformative approaches

An **adolescent-responsive approach** is a systems approach, which integrates adolescent services into each component of the health and nutrition system and adapts policies, procedures and programmes to respond to the unique and diverse needs and preferences of adolescents.[54,55]

A **gender-transformative approach** to adolescent health and nutrition addresses the root causes of gender inequality that adolescents face.

Gender-transformative approaches attempt to promote gender equality by:

- fostering critical examination of inequalities and gender roles, norms and dynamics
- recognising and strengthening positive norms that support equality and an enabling environment
- promoting the relative position of women, girls and marginalised groups and transforming the underlying social structures, policies and broadly held social norms that perpetuate and legitimise gender inequalities.[56]

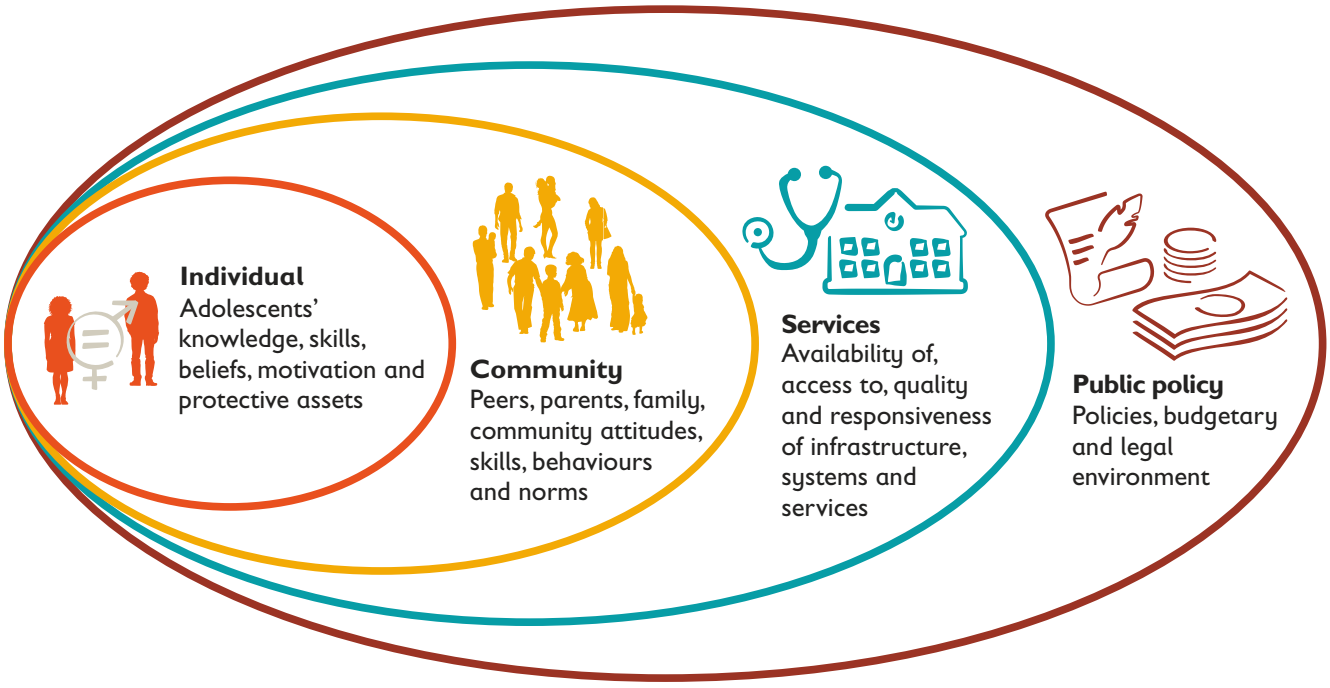
PHOTO: ALI ADAMOU/SAVE THE CHILDREN

Haouaou*, 17, outside her home in Maradi, Niger. She says that one day she wants to be a nurse working in rural areas because most of the nurses there are male and women don't feel comfortable going to see them.

Gender-transformative approaches are typically delivered through engagement with multiple sectors, including education, justice and child protection, and include actions at all levels of society, from the community to law and policy (all levels of the socio-ecological model, see figure below).

Socio-ecological model to guide adolescents' wellbeing interventions

Interventions to promote adolescent wellbeing, including health, nutrition and gender equality, need to address all levels of the socio-ecological model.



Relevant activities to **gender-transformative approaches** include:

- rights awareness-raising
- creation of safe spaces for adolescents to connect with peers
- comprehensive sexuality education
- interventions to ensure financial security
- community engagement for social norm change (including around practices within families that may lead to women and girls eating after men and boys)
- law and policy reform to promote equitable participation in public and household-level decision-making.*

Relevant activities to **adolescent-responsive approaches** include:

- promoting adolescent participation in policy and planning, including opportunities for adolescents to provide feedback working with ministries who are sensitive to adolescent approaches
- health management and information systems (which tracks adolescents served in the health system, including gaps and quality of care)
- developing an adolescent-competent healthcare workforce
- financing UHC for adolescents; maximising adolescent inclusion in prepaid pools, removing out of pocket payments, expanding coverage of adolescent services.

* For examples of gender-transformative programming, see page 5 of Save the Children's catalogue of key resources.

COVID-19 and widening gaps in adolescent health and nutrition systems

Protecting children's health and nutrition and improving child survival require full integration of health and nutrition outcomes. Inequitable, underfunded, weak and dysfunctional health systems mean that children's rights are not being fully realised. Crucial services, such as nutrition and family planning provision and counselling, are often neglected from integrated health care services, missing the opportunity to deliver these vital services through entry points like health facilities, schools, communities, pharmacies and workplaces.

The COVID-19 crisis has severely disrupted health and nutrition services and further increased needs through a 'shadow' pandemic of increasing gender-based violence.[57] Fear of infection has led to decreased demand for services; facilities and outreach services have closed; lockdown restrictions have prevented access; and suspension of community engagement, lack of human resources and income to pay salaries and lack of supplies have threatened to set back decades of hard-won progress.[58]

The COVID-19 crisis has severely disrupted health and nutrition services.

Before the COVID-19 pandemic, almost half the 663 million children enrolled in school lived in areas where coverage of school meals was inadequate. Of these, 251 million were living in countries with significant nutrition deficits.[59] Since COVID-19 struck, 49 countries have reported disruptions to nutrition programmes in schools.[60] In 2020, an estimated 370 million children in 150 countries missed out on school meals due to the crisis.[61,62] In low- and middle-income countries, there has been a 30% reduction in coverage of essential nutrition services, and this is up to 100% where lockdown measures have been imposed.[63] Of particular concern is the setback to anaemia reduction, for which no country is on track to meet the WHO 2025 Nutrition targets. The lack of progress in anaemia reduction is due to the complex and multi-sectoral approach needed. Yet, for every $1 invested in anaemia reduction, there is a $12 return on improved health and productivity.[64] Prior to the pandemic, one in three adolescent girls and women were affected by anaemia,[65] and it has been estimated that the Covid-19 pandemic will cause a further 4.8 million mothers to become anaemic.[66] *

Without urgent action, school closures and the other impacts of the COVID-19 crisis will have lasting impacts. Missing out on school has intergenerational impacts, including poorer health and nutrition outcomes for children in the long term, and for their children.[67] Gender discrimination means that girls are still less likely to be in school than boys and drop-out rates for girls increase during adolescence, often due to child marriage and pregnancy, increasing girls' risk of violence and increased care burdens.[68] Save the Children estimates that as many as 10 million children might never return to school post-pandemic and that most of them will be girls.[69] UNICEF further projects that the crisis could lead to as many as 10 million additional child marriages by 2030, while UNFPA projects severe disruptions to access to contraception, a one-third reduction in progress to end gender-based violence including 2 million additional cases of female genital mutilation/cutting.[70,71] Preventing the worst outcomes of the COVID-19 pandemic for adolescents will require a response that goes beyond treating and preventing the virus to addressing the gender inequality and social norms that sustain it.

* This estimate relates to 15–49-year-olds, so includes older adolescents. Unfortunately no data is available specifically for adolescents.

Core components of an adolescent-responsive and gender-transformative health and nutrition system

To respond to the health and nutrition needs of adolescents, while building back better from COVID-19 and delivering Agenda 2030, governments need to strengthen health and nutrition systems by putting child rights at the centre of their response and recovery efforts, now. Governments must deliver an adolescent-responsive and gender-transformative health and nutrition system, with the following core components.

Systems that support adolescent needs

Policies, laws and programmes across health and nutrition systems must ensure adolescents' needs are met.

- Policies, laws and programmes across health and nutrition systems must ensure adolescents' needs are met through a tailored approach (age-, life- and developmental-stage appropriate) at every level. Policies and guidelines that clearly state all adolescents can access (i) information on their health and well-being (including their sexual and reproductive health) and (ii) support in decision making and treatment from health professionals must be developed and shared widely.
- Health management information systems must be strengthened with sex- and age-disaggregated data collection, combined with intersectional gender analysis, to monitor which services are reaching which adolescents and how access can be improved.[72]
- Adolescents, especially girls, and formal and informal adolescent-, youth-led and feminist civil society organisations must be supported to meaningfully participate in the creation of policies, programmes and campaigns that affect their well-being, and in monitoring their impact.
- Adolescent health and nutrition services and systems should be fully integrated into national health systems and schemes to achieve universal health coverage and to address health systems gaps, access and uptake. For example they should incorporate improved financial protections for adolescents and incentives to scale up adolescent essential health and nutrition services, and should address financial and non-financial barriers to access.[73]

PHOTO: JOSEPH RAOUF/SAVE THE CHILDREN

A Youth in Action graduate from Egypt working in his fishing business. YiA was a six-year learning and livelihood programme in partnership with Mastercard Foundation. It improved the socio-economic status of over 40,000 out-of-school youth, girls and boys aged 12–18 in rural Burkina Faso, Egypt, Ethiopia, Malawi and Uganda.

- Formal and informal education systems should incorporate comprehensive sexuality education to equip adolescents with the knowledge and skills to reduce risky behaviours which could expose them to unplanned pregnancies, HIV and sexually transmitted infections, gender-based violence and a general lack of sexual agency.
- Where essential services are disrupted (including due to the COVID-19 crisis), governments must maximise efforts to protect adolescents from negative impacts, shift entrenched community norms and stigma that prevent adolescents from seeking services and increase coverage levels equitably.

Measures to improve nutrition, including through community entry points

- Approaches to tackle anaemia need to be embedded in gender transformative food systems. Specific at-scale measures should include: deworming,[74] iron and folic acid-containing micronutrient supplementation to complement diets, particularly in nutrient-poor contexts,[75,76] investment in staple food fortification and the control of infections and infectious diseases, especially malaria.*
- Healthy diets for adolescents must be promoted in schools and beyond,[77] through the provision of guidelines for school curricula and restricting the marketing and sale of unhealthy foods and beverages targeted at children and adolescents.[78] Large-scale context-specific, communication and advocacy programmes, led by adolescents, can be effective ways to promote healthy diets and habits, reaching those in and out of school.[79]
- Affordable, safe and nutritious food must be available to all adolescents, including through forward planning to protect food security and livelihoods in times of crisis. Interventions must address food insecurity in a way that increases sustainable and gender-responsive access to nutritious foods, for example through climate-smart agriculture, home/kitchen gardens and improved food processing techniques.
- Nutritious school meals must be provided, including fortified foods and safe drinking water, prioritising areas with nutrient-poor diets, and alternatives should be identified (such as take-home rations or unconditional cash transfers) for adolescents at greatest risk due to suspension of school feeding programmes.
- Community-based health and nutrition interventions must target adolescents (including adolescent mothers) to support healthy eating. Preconception interventions to increase the availability of energy and micronutrients should include multiple micronutrient supplementation or iron and folic acid supplementation, continuing into pregnancy, where relevant.

Affordable, safe and nutritious food must be available to all adolescents.

> **“Adolescents prefer to be reached in places they frequent in convenient times to fit in with their chaotic lifestyles. Programmes requiring adolescent participation should be entertaining and use language owned by adolescents, working with existing adolescent groups, rather than grouping them. Lastly, any programme tailored for the adolescents should build them for the future.”**
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> **Jane Napais Lansika**, SUN Youth Leader, reporting on findings from World Food Programme research in her home country, Kenya.

* School age children are often the population group with the highest levels of malaria infection, but as they are often asymptomatic, it goes untreated, but still causes anaemia, more so than iron deficiency in some contexts.

Information and environments that promote stigma-free access to services

- Service providers must recognise adolescents' need for confidentiality and provide respectful treatment. Where necessary, adolescents must be supported to access health services with a flexibility that promotes maximum access to services without the need for parental authorisation or spousal consent.[80] Efforts must be made to reach adolescents in the community and outside of formal health clinics.
- Frequent on-the-job training should be delivered to equip providers and staff with competencies to provide respectful care supported by social and behavioural change interventions to shift norms that contribute to provider bias.
- Adolescents must be equipped with complete and scientifically accurate information about their bodies and health, including provision of comprehensive sexuality education and provide them with knowledge of health and nutrition services available to them.
- Health and nutrition services must be free at the point of use and efforts are needed to reduce other associated costs, for example, by providing vouchers for transport.

Service providers must recognise adolescents' need for confidentiality and provide respectful treatment.

Measures to address and transform gender inequalities in health and nutrition outcomes

- Skilled antenatal, childbirth and postnatal care and adolescent-responsive services for adolescents must be provided, including confidential spaces within health facilities and support for adolescent parents to care for their children. Social and behaviour change efforts should build community support, increase awareness, and encourage uptake of these services.
- Multisectoral national action plans to address gender-based violence, including child marriage and female genital mutilation or cutting must be funded and implemented. These should include programming to shift gender norms and engagement with communities, including men, boys, traditional leaders, parents and girls.
- Access to comprehensive sexual and reproductive health and rights must be provided. Modern forms of contraception, including long-acting reversible contraceptives, and access to the Human Papillomavirus vaccines, are critical to immediate and long-term health.
- Technical and financial support must be provided to build and sustain local women's rights organisations, girls' networks and LGBTQ+ organisations which deliver and advocate for adolescent health and nutrition services.
- Girls' access to safe, quality education must be supported by reducing costs and barriers, including through free school meals and menstrual hygiene products, removal of bans on pregnant girls attending school, support for girls who have been out of school (including girl mothers) to return, ensuring access to safe, private WASH (water, sanitation and hygiene) and menstrual hygiene management supportive facilities, as well as catch-up classes to support girls to re-enter education following COVID-19 school closures. The most marginalised girls, including refugees, girls with disabilities and those affected by conflict and displacement, should be included in national education systems and in COVID-19 response and recovery programmes.

Girls' access to safe, quality education must be supported.

Model commitments governments can make to deliver on adolescents' right to health and nutrition

Fulfilling adolescents' rights to health and nutrition to meet the 2030 Agenda for Sustainable Development will require ambitious commitments. The following are model commitments governments can make, with the support of donors, at upcoming global pledging moments, and at the national and subnational levels.

- **Partner with adolescents and young people** (particularly girls and other populations affected by gender inequality and other forms of discrimination) and provide financial and technical support to enable them to:
  - develop an adolescent-specific communication strategy that promotes healthy habits, uptake of services and uses gender-transformative and context-specific messaging, and
  - monitor progress and hold governments to account.
- **Develop and track an integrated national strategy or action plan** for adolescent health and nutrition, with adolescents and young people, and use indicators to measure impacts for adolescents, to enable adolescents to hold governments to account.
- **Increase public spending** to strengthen systems and services, train health workers and to provide confidential and quality health and nutrition services for all adolescents.
- **Provide access to healthy diets for adolescents, through school meals** or community programmes.
- **Deliver context-specific, multisectoral and at-scale approaches to reducing anaemia**, which include targeted micronutrient supplementation policies, strategies and programmes, particularly in nutrition-poor settings.[81,82]
- **Integrate health and nutrition services targeting adolescents** into the broader health system, larger essential health programmes and policy plans, including COVID-19 response, other humanitarian response planning and sexual and reproductive, maternal newborn, adolescent and child health plans.
- **Enhance multisectoral collaboration for a 'whole of government' approach** by forging formal partnerships or committees including actors for health systems strengthening, youth social accountability, education, financing, justice, gender equality and civil society.
- **Adopt adolescent health management information systems** to monitor and track performance of the health services, disaggregating key indicators by age and sex at a minimum.[83]

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Names marked with * have been changed to protect identities.

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