

ADOLESCENT HEALTH AND WELL-BEING¹



Adolescence is often considered the healthiest period of the lifespan because it is the point of lowest mortality and a time when many attributes of good health are at their highest. At the same time, however, adolescence is also a time of physical, emotional and cognitive development that can be marked by engagement in risky behaviours which can increase one's risk of poor health and death.

BASED upon their stage of brain development, adolescents are more likely to act on impulse, misread or misinterpret social cues and emotions, get into accidents, get involved in fights, and engage in dangerous or risky behaviours. Adolescents are less likely to think before they act or to pause and consider the consequences of their actions, or to change their dangerous and/or inappropriate behaviours. This does not mean that adolescents cannot make good decisions or tell the difference between right and wrong, and it does not mean that adolescents should not be held responsible for their actions.² Rather, it means

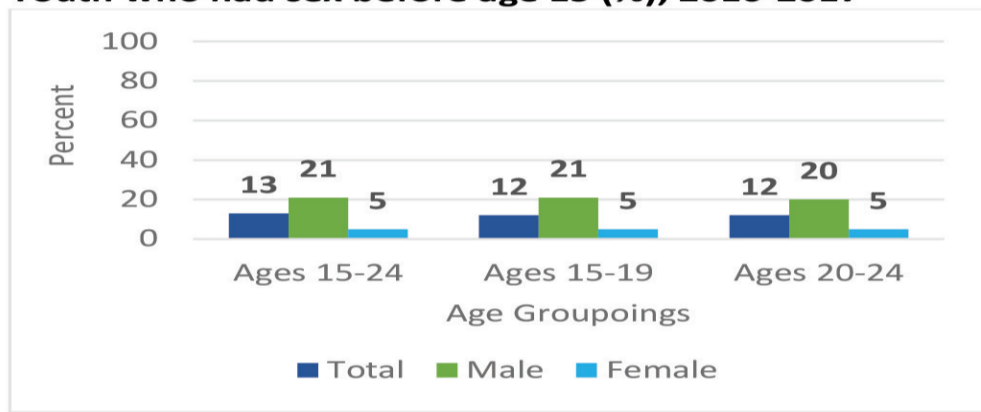
that adolescents are more likely to engage in risky sexual behaviours, to experience early pregnancy and childbirth, and to be exposed to sexually transmitted infections (STIs), including HIV/AIDS. Adolescents are also more likely to engage in alcohol, tobacco and drug use, and to experience mental health issues, including depression, suicide and self-harming behaviours. They are also at-risk of unintentional injuries and violence-related deaths. Given these realities, adolescence is a good time for health services and interventions that aim to promote improved lifelong health and well-being.

SEXUAL BEHAVIOURS

Healthy sexuality is an important part of adolescent development, and parents play an important role in helping young people to develop healthy routines, behaviours and relationships that they can carry into their adult lives. Many adolescents do not understand that risky sexual behaviours can jeopardize their health during these formative years, and can contribute to poor health outcomes in adulthood.³

Data on sexual behaviours of young people in Lesotho are limited and outdated. In 2014, it was estimated that the median age at which women aged 20-24 years had their first sexual intercourse was 18.5 years, and 18.4 years for men aged 20-24 years. In 2016-2017, it was found that 13% of youth aged 15-24 had sex before the age of 15. Boys (21%) were four times more likely than girls (5%) to have sex before the age of 15.

Youth who had sex before age 15 (%), 2016-2017

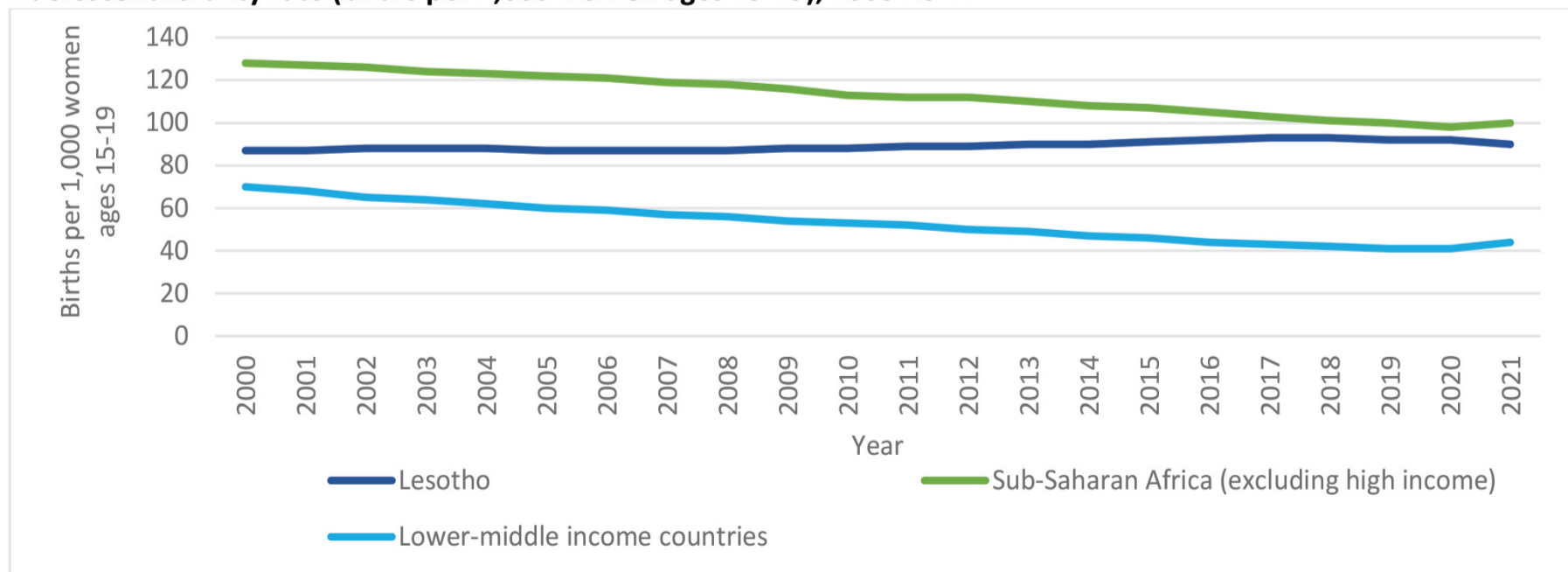


Source: Ministry of Health, Lesotho, Centres for Disease Control and Prevention (CEC) and ICAP at Columbia University (2019). *Lesotho Population-Based HIV Impact Assessment (LePHIA) 2016-2017: Final Report*. Ministry of Health, CDC and ICAP: Maseru, Lesotho, Atlanta, GE & New York, NY, USA

ADOLESCENT FERTILITY/TEENAGE PREGNANCY

Globally, teenage pregnancy continues to be a focus because complications from pregnancy and childbirth are the leading cause of death among adolescent girls. In Lesotho, there has been a 3% increase in the adolescent fertility rate from 87 births per 1,000 in 2000 to 90 births per 1,000 in 2021. In comparison, in sub-Saharan Africa (excluding high income countries), the adolescent birth rate decreased by 22% from 128 births per 1,000 in 2000 to 100 births per 1,000 in 2021. Lesotho also has a higher adolescent fertility rate than the average for lower middle-income countries, which has seen a 37% decrease in adolescent fertility rates from 2000 to 2021.

Adolescent fertility rate (births per 1,000 women ages 15-19), 2000-2021



Source: Retrieved on 23 January 2022 from: [Adolescent fertility rate \(births per 1,000 women ages 15-19\) – Lesotho | Data \(worldbank.org\)](#); [Adolescent fertility rate \(births per 1,000 women ages 15-19\) – Sub-Saharan Africa \(excluding high income\) | Data \(worldbank.org\)](#); [Adolescent fertility rate \(births per 1,000 women ages 15-19\) – Lower middle income | Data \(worldbank.org\)](#).

In 2018, 18% of girls aged 15–19 had a live birth or were pregnant with their first child, and fewer than 1% had a live birth before the age of 15; whereas 12% of women aged 20–24 had a live birth before 18 years of age.⁴

Girls aged 15–19 in rural areas (23%) were more than twice as likely as girls in urban areas (10%) to have had a live birth or were pregnant with their first child. Similarly, females aged 20–24 in rural areas (16%) were more than twice as likely as females in urban areas (7%) to have had a live birth before the age of 18. Girls aged 15–19 in the foothills (37%) were most likely to have had a live birth or were pregnant with their first child, and twice as likely to do so as girls in the Senqu River Valley (18%) and lowlands (15%). Females aged 20–24 in the lowlands (30%) were three times more likely to have had a live birth before the age of 18, compared to females in the lowlands (9%).

Girls aged 15–19 with a primary education or less (32%) were twice as likely as those with a secondary education (16%) to have a live birth or to be pregnant with their first child. Similarly, females aged 20–24 with a primary education or less (26%) were more than twice as likely to have had a live birth before the age of 18 as females with a secondary education (11%).

Poverty is also a strong predictor of early childbearing, as girls aged 15–19 from the poorest households (25%) were four times more likely to have had a live birth or to be pregnant with their first child, compared to girls from the richest households (6%). Also, females aged 20–24 from the poorest households (23%) were six times more likely to have had a live birth before the age of 18 than girls from the richest households (4%) and twice as likely as girls from middle-income households (11%).

Efforts to curb adolescent fertility requires that sexual and reproductive health (SRH) education and services are available to all adolescents and youth; not just those who are victims of sexual and gender-based violence (SGBV) or those infected with HIV/AIDS. The goal should be that adolescents and youth have access to high-quality SRH education and services, including: child sexual abuse prevention and safeguarding education services; comprehensive SRH education and services, including family planning education and services; and quality maternal health care for pregnant teens.

Female teenage pregnancy (%), 2018		
	Girls aged 15-19 who had a live birth or were pregnant with first child	Females aged 20-24 who had a live birth before age 18
Total	18	12
Area		
Urban	10	7
Rural	23	16
Ecological zone		
Lowlands	15	9
Foothills	37	30
Mountains	22	17
Senqu River Valley	18	17
Education		
Primary or less	32	26
Secondary	16	11
Higher	(*)	0
Wealth index		
Poorest	25	23
Middle	21	11
Richest	6	4

(*) Figure based on less than 25 unweighted cases. Source: Lesotho MICS, 2018

Voices of young peoples (10–24 years) – Teenage pregnancy^a

Young people identified teenage pregnancy as a major issue facing young girls. Too often parents do not support their daughters who become pregnant out-of-wedlock at an early age. Some parents kick their daughters out of the home after they discover they are pregnant and other parents pressure their daughters into an early marriage because “they think that sending their child into marriage helps to ease the burden for them.” Some girls who have unwanted pregnancies get illegal abortions, which puts their health and lives at risk (abortion is criminalized in Lesotho).

Teenage pregnancies can often be the result of sexual relations with older men and sex in exchange for money. In Mafeteng, some girls were misled into having sexual relations with older men for money or material gain. Because of poverty, some parents even allowed their daughters to engage in sex for money. In such situations, girls are often unable to ask men to use condoms; placing girls at increased risk of unwanted pregnancies and contracting STIs, including HIV.

Girls also engage in sexual relations because of peer pressure and circumstances in their home environment. Many parents do not talk to their children about sexual and reproductive health (SRH), including the use of contraceptives. Some girls explained, “parents never talk to us [girls] about pregnancy; they only talk to us [girls] when we get pregnant.” Girls explained, “it is too late to talk to girls about SRH after they become pregnant.”

Girls who become pregnant at an early age often feel judged, humiliated and stigmatized, particularly if they do not know who is the father of the child. They are often treated poorly by health workers; as a result, pregnant girls often avoid health clinics and antenatal and postnatal care services, and some girls give birth at home. Even after giving birth, some teenage mothers are hesitant to take their children to health clinics for childhood immunizations, for fear of being judged by health workers.

“Parents do not take as much responsibility to talk to us about issues of sex and prevention of illness and pregnancy; they do not expect us to fall pregnant, but they never talk to us.” (Mafeteng, out-of-school girls, 18–22 years)

“Our self-esteem is so much affected when we get pregnant, we get so ashamed and that makes us hide at home and not be seen pregnant.” (Mokhotlong, In-School Girls, 11–16 years)

“Rape is painful and we are afraid to go to the clinic because we are often asked of where we were, what were we doing and sometimes accused of not being honest about being raped but we slept with that person willingly now we want to waste state resources.” (Mokhotlong, In-School Girls, 11–16 years)

^a Information presented were gathered during consultations with 166 young people in four districts and conducted by the Lesotho Red Cross Society.

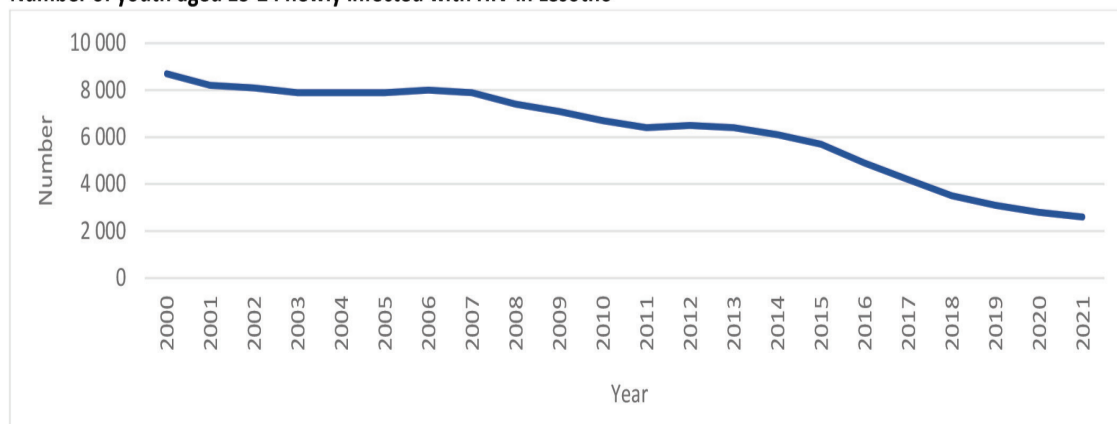
YOUTH EXPOSURE TO AND KNOWLEDGE OF HIV/AIDS PREVENTION

HIV/AIDS is a global public health threat; thus, SDG target 3.3 aims to end the AIDS epidemic by 2030. The UN General Assembly Special Session (UNGASS) on HIV/AIDS called on governments to improve knowledge and skills of young people to protect themselves from HIV because young people represent a growing share of people living with HIV worldwide.

In Lesotho, in 2021, the proportion of females aged 15–24 with HIV was 9% (down from 17% in 2000), which is twice as high as the proportion of males aged 15–24 with HIV (4% in 2021, down from 6% in 2000).⁵ Over the past two decades, there has been an estimated 70% decrease in the number of youths aged 15–24 newly infected with HIV in Lesotho (from an estimated 8,700 in 2000 to 2,600 in 2021).

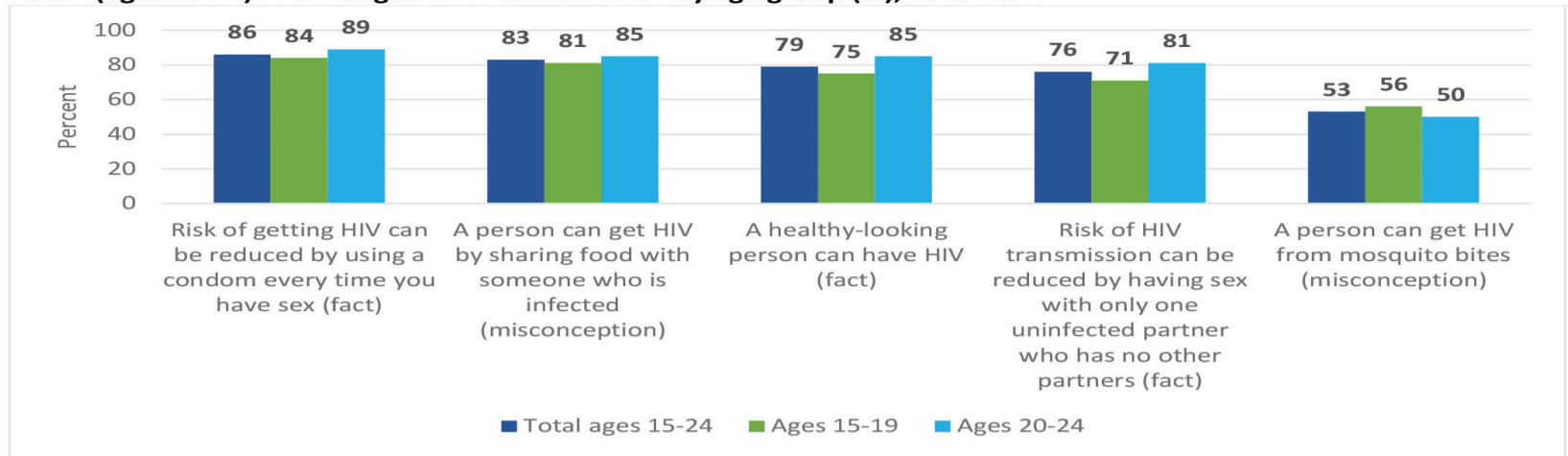
The 2016–2017 Lesotho Population-Based HIV Impact Assessment (LePHIA) found that 86% of youth aged 15–24 knew that the risk of getting HIV can be reduced by using a condom every time you have sex, 79% knew that a healthy-looking person can have HIV, and 76% knew that the risk of HIV transmission can be reduced by having sex with only one uninfected partner who has no other partners. At the same time, a majority of youth had misconceptions of HIV transmission – 83% of youth believed the myth (misperception) that a person can get HIV by sharing food with someone who is infected and 53% believed that a person can get HIV from mosquito’s bites.

Number of youth aged 15–24 newly infected with HIV in Lesotho



Source: Retrieved on 23 January 2023 from: [Children \(ages 0–14\) newly infected with HIV – Lesotho | Data \(worldbank.org\)](#) and [Young people \(ages 15–24\) newly infected with HIV – Lesotho | Data \(worldbank.org\)](#)

Youth (ages 15-24) knowledge of HIV transmission by age group (%), 2016-2017



Source: Ministry of Health, Lesotho, Centres for Disease Control and Prevention (CEC) and ICAP at Columbia University (2019). *Lesotho Population-Based HIV Impact Assessment (LePHIA) 2016-2017: Final Report*. Ministry of Health, CDC and ICAP: Maseru, Lesotho, Atlanta, GE & New York, NY, USA

Voices of young peoples (10-24 years) – Access to SRH education and services^a

Young people from all parts of the country have limited access to SRH education and services; thus, they have limited information about conception, contraceptives and menstruation. As a result, young people tend to believe in myths related contraceptive use. For instance, girls are often told that they will not have children if they use contraceptives at an early age, and boys believe that condoms will make them sick. Boys and men do not like to use condoms because they claim that “sex is different when we do [use a condom].”

Some young men falsely believe that “as men, we cannot be easily affected by some diseases [STIs] because we exercise and we are stronger than women”

(Maseru District, out-of-school boys, 15-24 years). For these reasons, young people, regardless of gender, tend not to use contraceptives, including condoms.

For young people who use contraceptives, access to contraceptives is a challenge, as not all community health clinics provide young people with contraceptives. Young people try to get free contraceptives from mobile health services, but mobile health services are often unreliable as they travel from town-to-town. In Quthing, some young people complained that “condoms are usually placed at the taverns and that is where we [adolescents] are not allowed to go.” In Mafeteng, out-of-school boys pointed out that SRH education and outreach campaigns are being con-

ducted in rural areas, but are no longer conducted in more urban areas and towns.

Since many parents do not discuss contraceptive use with their children and do not like their children using contraceptives, young people tend to hide their use of contraceptives from their parents. Out-of-school girls aged 18-24 in Mokhotlong explained that, “Parents do not talk to us about sexual and reproductive health issues and that puts us in a tight corner when we want to go for contraceptive refills or another injection that we take in secret. And the side effects of contraceptives, like irregular periods make it very hard, because parents can observe and we get in trouble.”

^aInformation presented were gathered during consultations with 166 young people in four districts and conducted by the Lesotho Red Cross Society.

MENSTRUAL HYGIENE

Globally, menstrual hygiene management remains a challenge, and poor access to dignified and functional WASH facilities remains a major barrier for proper menstrual hygiene management for women and girls. In Lesotho, for many women and girls, menstruation is a significant barrier to meaningful participation in school, work and social activities.⁶ In 2021, 13% of females aged 15-49 were unable to take part in school work or social activities due to menstruation and a lack of access to appropriate menstrual hygiene management supplies, inadequate WASH infrastructure and cultural factors, which contributes to feelings of shame and embarrassment, fears of menstrual blood leakage, and menstrual pain and discomfort. Many girls and women, especially in deprived areas, still use pieces of clothing and dirty rags to

manage their menses.⁷

In 2022, a UNFPA-supported study in four districts found that 68% of adolescents aged 10-19 understood what is menstruation. Girls (73%) had more knowledgeable about menstruation than boys (49%), and knowledge was more common among secondary school students (80%) than primary school students (35%). Sources of information about menstruation often includes teachers (50%), friends (41%) and mothers (20%). In fact, 63% of girls aged 10-19 (67% in secondary schools and 48% in primary schools) reported being taught about menstruation in school, and 72% found these classes helpful; only 10% of girls felt embarrassed during these classes (39% of girls in primary school and 6% in secondary schools). In addition, 76% of girls and 64% of boys knew

about menstrual hygiene management.⁸

This study also found that 37% of girls age 10-19 felt that menstruation should be kept secret and 17% believed that you cannot touch a menstruating woman (myth). Rather, the majority of girls understood that you can touch a menstruating woman (74%), you can enter a house when a woman is menstruating (88%), and that women can cook when menstruating (85%). It is notable that 84% of boys aged 10-19 felt they need to know about menstruation and 86% felt that boys should help female family members and friends during menstruation.⁹

Most primary school students (59%) and nearly all secondary school students (91%) reported their schools do not provide sanitary facilities for menstrual hy-

giene management; yet, 92% of girls used disposable pads at schools. In addition, 64% of girls changed their pads at least three times during the day and 24% did so twice a day. The majority of girls aged 10-19 reported that disposal pads were easy to get (82%) and easy to use (83%), thus, 85% preferred using disposable pads.

Only 9% of female students ever missed school because of their menstrual period (11% of female students in urban areas and 7% in rural areas). Among girls who missed school, the main reasons were because they had menstrual pain/cramps (78%), did not have sanitary pads (22%), had a heavy menstruation flow (11%) or feared boys knowing they were menstruating (6%).¹⁰

ALCOHOL AND TOBACCO USE

Alcohol and tobacco use typically begins in adolescence and young adulthood, and is a major risk factor for adverse health and social outcomes, and non-communicable diseases later in life.¹¹ Adolescents are less able to anticipate the negative effects of alcohol and tobacco on their health and well-being, including risks of abusing alcohol and developing addictions.¹²

Lesotho has a national legal minimum age of 21 years for the purchase and consumption of alcoholic beverages, including beer, wine and spirits.¹³ Yet, in 2018, among adolescents aged 15-17 years, 7% of girls and 6% of boys drank alcohol before the age of 15, and 3% of

girls and 4% of boys drank at least one alcoholic drink in the past month. Among adolescents aged 18-19, boys (14%) were twice as likely as girls (7%) to have drunk alcohol in the past month, and among youth ages 20-24 years, boys (31%) were three times more likely than girls (10%) to have drunk alcohol in the past month.¹⁴

Lesotho has a national law that prohibits the sale of tobacco product to minors.¹⁵ In 2018, among adolescents aged 15-17 years, boys (24%) were more than twice as likely as girls (10%) to ever use tobacco products. Among adolescents aged 18-19, boys (39%) four times more likely than girls (9%) to have ever used to-

bacco products, and among youth aged 20-24, males (59%) were four times more likely than females (14%) to have ever used tobacco products, and males (42%) were 14 times more likely than females (3%) to have used tobacco products in the past month. Among males, the use of tobacco products dramatically increases from 15-17 to 20-24 years of age.¹⁶ Among males aged 20-24 years who used tobacco products, 65% smoked fewer than five cigarettes in the past 24 hours, 27% smoked 5-9 cigarettes and 8% smoked 10 or more cigarettes in the past 24 hours.¹⁷

ADOLESCENT NUTRITION AND WEIGHT

Rapid physical growth during adolescence creates a high demand for energy and certain nutrients.¹⁸ Nutrition is a critical factor for appropriate adolescent development and an important element for prevention of disease development, especially for chronic disease. A balanced, varied diet provides adequate calories and nutrition to meet the needs of most adolescents; however, many adolescents live in environments that do not promote optimum nutrition.¹⁹ Nutrition and the adolescent transition are closely related

because eating patterns and behaviours are influenced by many factors, including peer influences, parental modelling, food availability, food costs, food preferences, personal and cultural beliefs, mass media and body image.²⁰

Among adolescents, underweight status has been associated with higher rates of non-communicable diseases, but to a lesser extent than obesity. Underweight status has also been associated with higher rates of asthma, scoliosis, intes-

tinal problems and emotional disorders. The onset of puberty may be delayed in male and female adolescents with a low BMI, and underweight females are more likely to have irregular menstrual periods and infertility. Underweight adolescents who become pregnant may be at increased risk for pregnancy complications and poor foetal and maternal outcomes, including prematurity and low birth weight.²¹ In Lesotho, data related to patterns of underweight and overweight among adolescents and youth are

limited. In 2016, among adolescents aged 10-19, 9% percent of boys and 2% of girls were underweight (down from 19% and 5% respectively in 2000).

Over the past decade, nutrition has been identified as a major global priority and rise in worldwide overweight and obesity has been highlighted. The World Health Assembly declared 2016-2025 as the ‘decade of nutrition’ and set global targets that have

since been integrated into SDG 2, which is focused on ending hunger, achieving food security, improving nutrition and promoting sustainable agriculture.²²

Obesity is a multifaceted chronic condition with several contributing causes, including biological risk factors, socioeconomic status, health literacy and numerous environmental influences. Of particular concern are the increasing rates of overweight and obesity among adolescents, as rates of obesity have increased globally in the past three decades.²³ Major factors contributing to the global rise in obesity are the increase in

cheap, highly processed foods, and increased consumption of energy dense foods that are high in fat and sugars, together with a reduction in the availability of plant-based fibres. There has also been a decline in activity energy expenditures.

With obesity disproportionately affecting adolescents, negative effects of excess fattiness may be particularly salient during this critical period of development. The presentation of chronic cardiometabolic disease symptoms, typically observed in adults, such as hypertension, hyperglycaemia, dyslipidaemia and in-

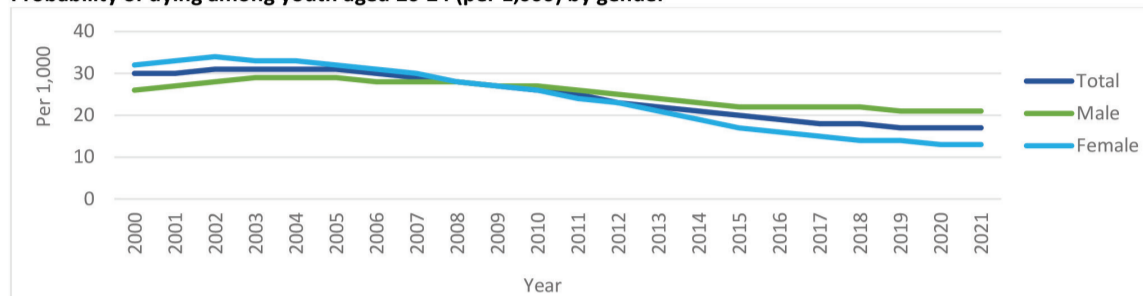
flammation are becoming increasingly common in adolescents with obesity. Obesity also increases the risk for Type 2 diabetes, which is likely to persist into adulthood. Eating patterns formed during adolescence are also frequently carried into adulthood and affect future risk for the development of chronic diseases, such as heart disease, osteoporosis and cancer.²⁴ In addition, there is a dynamic interplay between obesity and psychosocial health, as adolescents with obesity may have increased levels of stress, depressive symptoms and reduced resilience among obese adolescents.

In Lesotho there has been an increase in the proportion of adolescents aged 10-19 who are overweight and obese. The proportion of overweight girls increased threefold from 8% in 2000 to 24% in 2016, and the proportion of obese girls increased from 0% in 2000 to 8% in 2016. Similarly, the proportion of overweight boys increased sixfold from 1% in 2000 to 6% in 2016. In 2016, girls were four times more likely than boys to be overweight, and eight times more likely than boys to be obese. More recent data are not available to track this emerging health risk for adolescents.²⁵

ADOLESCENT AND YOUTH MORTALITY

In Lesotho, adolescent (aged 10-19) mortality rates declined by 3% from 20 deaths per 1,000 live births in 2000 to 14 deaths per live births in 2021; there were no significant gender differences in adolescent mortality rates.²⁶ Little is known about the leading causes of death of adolescents aged 10-19. In 2019, among boys aged 10-14, the leading cause of death was most often communicable diseases (71%), followed by injuries (21%) and non-communicable diseases (7%). Among boys aged 15-19, the leading cause of death was most often injuries (48%) and communicable diseases (41%), followed by non-communicable diseases (11%). In comparison, among girls aged 10-19, the leading cause of death was most often communicable diseases (86%), followed by injuries (10%) and noncommunicable diseases (4%). Among girls aged 15-19, the leading causes of death were most often com-

Probability of dying among youth aged 20-24 (per 1,000) by gender



Source: Retrieved on 24 January 2023 from: [CME Info – Child Mortality Estimates](#)

municable diseases (52%), followed by injuries (22%), communicable diseases (16%) and maternal conditions (9%).

Youth mortality rates declined by 43% from 30 deaths per 1,000 population in 2000 to 17 deaths per 1,000 popula-

tion in 2021. In 2000, the female youth mortality rate was notably higher than the male youth mortality rate; however, in 2008 and 2009, the female and male youth mortality rates converged. Since 2010, the male youth mortality rate has been notably higher than the female

youth mortality rate. While the female youth mortality rate decreased by 59% from 32 per 1,000 in 2000 to 13 per 1,000 in 2021, the male youth mortality rate decreased by only 19% from 26 per 1,000 in 2000 to 21 per 1,000 in 2021.

CONCLUSIONS

The government and development partners would benefit from a much deeper dive into understanding how to build better partnerships for smart planning, problem-solving and innovation to accelerate results for adolescent and youth in the areas of health and well-being. There is a need to: improve access to nutritional foods in adolescent; increase access to SRH education and services for all young people aged 10-24, not just those who are victims of SGBV or those infected with HIV/AIDS; increase access to HIV/AIDS prevention initiatives for young people; reduce teenage pregnancy; and improve mental health and well-being of adolescents who were greatly impacted by the COVID-19 pandemic.

There are notable data gaps, including:

- Data related to adolescent sexual behaviours and contraceptive use are lacking. Timely data related to adolescent's sexual behaviours and contraceptive use, and knowledge, attitudes and practices related to HIV/AIDS are important for HIV prevention initiatives.
- Data related to HIV/AIDS among adolescents and youth, including AIDS-related deaths of adolescents and youth are crucial.
- Data related to adolescent fertility rates are limited in Lesotho. Improving data collection on teenage pregnancy is important to reducing teenage pregnancy and developing programmes and policies that support teenage mothers to continue their education and access employment. Such data are also needed to strengthen much needed social protection and services (e.g., cash transfers, health insurance, child care) to reduce teenage mothers risks of living their lives in poverty, along with their child(ren).
- Data related to adolescent and youth mental health and well-being, including suicidal tendencies are lacking; such data are important given that international research has found that anxiety and depressive disorders have increased among adolescents and youth as a result of stressors and strains related to the COVID-19 pandemic and climate change.
- Data related to nutrition and physical (in)activity among adolescents are lacking; such data are important to better understanding adolescent's health and potential risks of being underweight, overweight and obesity.

For more data and information see: [UNICEF \(2024\). Situation Analysis on Children, Adolescents and Youth in the Kingdom of Lesotho. UNICEF: Maseru: Lesotho.](#)

ENDNOTES

¹This research brief was written by Dr. Robin Haarr, PhD, UNICEF Senior Consultant, and is based upon UNICEF's 2023 Situation Analysis of Children, Adolescents and Youth in the Kingdom of Lesotho.

²American Academy of Child & Adolescent Psychiatry (2016). Teen Brain: Behaviour, Problem-Solving and Decision-Making. Retrieved on 10 September 2021 from: [Teen Brain: Behavior, Problem Solving, and Decision Making \(aacap.org\)](#)

³American Academy of Pediatrics. Adolescent Sexual Health. Retrieved on 10 September 2021 from: [Adolescent Sexual Health \(aap.org\)](#)

⁴This includes only live births and does not include girls who gave birth to a child that did not survive at birth or girls who sought an abortion, although abortions are criminalized in Lesotho.

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²¹Lowe, C.J., J.B. Morton & A.C. Reichelt (2020). Adolescent obesity and dietary decision-making - a brain-health perspective. The Lancet, Vol. 4, Issue 5, pp. 388-396. DOI: [https://doi.org/10.1016/S2352-4642\(19\)30404-3](https://doi.org/10.1016/S2352-4642(19)30404-3)

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²³Ruiz, L.D., M.L. Zuelch, S.M. Dimitratos & R.E. Scherr (2019). Adolescent Obesity: Diet Quality, Psychosocial Health and Cardiometabolic Risk Factor. Nutrients, Vol. 12, No. 1, p. 43.

²⁴Adolescent Nutrition. Pediatric in Review, Vol. 30, No. 12, pp. 494-496. DOI: <https://doi.org/10.1542/pir.30-12-494>

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