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Statement submitted by International Planned Parenthood Federation, a non-governmental organization in general consultative status with the Economic and Social Council[2]

The Secretary-General has received the following statement, which is being circulated in accordance with paragraphs 36 and 37 of Economic and Social Council resolution 1996/31.

[1] E/CN.9/2020/1.
[2] The present statement is issued without formal editing.

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Statement

1. About International Planned Parenthood Federation

As a locally owned and globally connected federation, leading service provider and advocate of sexual and reproductive health and rights, the International Planned Parenthood Federation (IPPF) works through Member Associations and Collaborating Partners in 166 countries to empower women, adolescents and girls, and young people, the most marginalized and in the most vulnerable situations have access life-saving services and program, and live with dignity. IPPF has had general consultative status with the Economic and Social Council since 1973.

2. Introduction

Nutrition is an essential part of maternal child health and sexual and reproductive health (SRH) services for adolescents and young people. Sexual and reproductive health and rights (SRHR) and nutrition are both critical issues that play important roles in the lives of girls and adolescents, which can have deep impacts on their development and future. As recognized in Agenda 2030 target 2.2, adolescent girls' nutrition is of particular importance, as this represents a critical stage of physical and mental development. Unfortunately, due to gender discrimination, stereotypes, and harmful social and cultural norms, girls and adolescent girls are the most likely to be denied both their sexual and reproductive health and rights and adequate nutrition, which have compounding and mutually reinforcing consequences for their lives. As such, they have an urgent need to access youth friendly sexual and reproductive health services, information and education, as well as adequate nutrition.[3] To meet these needs, integrated services are necessary to address both the root causes of gender inequality, stereotypes and discrimination, and access to integrated sexual and reproductive health and nutrition education, information and services for adolescents, without third-party consent barriers.

3. Women, adolescent and girls' nutrition and sexual and reproductive health and rights

Patriarchal norms have long been used to control women's, adolescents' and girls' lives, sexuality and agency. Stigma and gender stereotypes dictate how women are expected to behave in both the private and public spheres, including specific forms of deprivation that lead to unmet nutritional and sexual and reproductive health needs and rights.

At a time in their life cycle when they have higher iron needs, girls often face steep barriers to accessing the nutrition they require, including gender discrimination and social and cultural norms, which mean that girls eat last and least.[4] Women and girls are twice as likely to suffer from malnutrition as men and boys, and adolescent girls are most at risk.[3] Anaemia impacts 300 million adolescent girls and is one of the most off-track global health targets, despite the fact that we know iron and folic acid reduce anaemia and disability.[3] Malnutrition and knock-on effects like anaemia and stigmatization of menstruation can make learning difficult, impacting girls' ability to learn in schools, obtain an education, obtain decent employment and participate actively in their communities.[3] Undernutrition is strongly associated with shorter

[3] Nutrition International, *3 reasons why integrating nutrition and family planning is a game changer* (July 2017), https://www.nutritionintl.org/2017/07/3-reasons-integrating-nutrition-family-planning-game-changer/.

[4] Nutrition International, *Bringing nutrition and sexual and reproductive health together for women and girls* (Oct. 2019), https://www.nutritionintl.org/2019/10/bringing-nutrition-and-sexual-and-reproductive-health-together-for-women-and-girls/.

adult height, less schooling, reduced economic activity, and – for women – lower offspring birthweight.[5] These violations impact negatively on their right to life, right to health, food, education, and right to freedom of expression.[6] Compounding these facts are the well-known gender dimensions and feminization of poverty, in which women and girls experience poverty at disproportionate rates to men and boys, and patriarchal systems of oppression keep them trapped in a vicious cycle of poverty across generations.

Numerous laws and practices legitimize efforts to control women's sexual and reproductive behaviour.[7] This is especially true for adolescent girls, leading to the denial of care and major barriers to accessing services, including third party consent requirements, which mandate that parents, guardians, spouses or others must give their consent for services, because a women's own consent is not valued or considered sufficiently valid. Other practices based on gender discrimination, such as *cheupadi*, now a punishable act in some countries, involves isolating and confining women during their menstruation period, depriving them of the right to move freely and access basic needs and services, including adequate nutrition.[8]

Discriminatory attitudes towards sex outside of marriage and the restricted social autonomy of women and young girls can reduce their ability to access sexual health and HIV services. Comprehensive sexuality education and youth-friendly sexual and reproductive health services, including integrated nutrition information and education, without third-party consent requirements, are critical tools to empower and education girls so they can to make informed decisions, protect themselves from sexually transmitted infections, and to understand their rights, consent and how to report sexual abuse.

Additionally, young people who are or are perceived to be LGBTI have often been excluded and ostracized often face abuse and rejection from their families, and therefore face high rates of poverty, homelessness and food insecurity as a result. Studies undertaken in several countries suggest that rates of poverty, homelessness and food insecurity are higher among LGBT individuals than in the wider community.[9] Furthermore, research has documented high rates of disordered eating for lesbian, gay, bisexual and transgender youth linked to enacted stigma (the higher rates of harassment and discrimination sexual minority youth experience).[10]

SRH services and the exercise of sexual and reproductive rights also have a major impact on nutrition and wellbeing of women and girls living with HIV/AIDS.[3]

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[5] C. G. Victoria et al, *Maternal and child undernutrition: consequences for adult health and human capital*, The Lancet, 371 (9609): 302–302 (2008), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)61692-4/fulltext.

[6] Office of the High Commissioner of Human Rights, Open consultation on Youth & Human Rights, Joint submission by The YP Foundation, Queer Alliance, Network for Adolescents and Youth of Africa, Centre for Youth Empowerment and Civil Education, CHOICE for Youth and Sexuality, January 2018, available at https://www.ohchr.org/Documents/Issues/Youth/ChoiceYouthSexuality.docx.

[7] Report of the Working Group on the issue of discrimination against women in law and in practice, *Women deprived of liberty* (May 2019), A/HRC/41/33, para 33, available at https://documents-dds-ny.un.org/doc/UNDOC/GEN/G19/139/27/PDF/G1913927.pdf?OpenElement.

[8] Ibid, para 29.

[9] Report of the Office of the United Nations High Commissioner for Human Rights, *Discrimination and violence against individuals based on their sexual orientation and gender identity*, A/HRC/29/23 (May 2015), https://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session29/Documents/A_HRC_29_23_en.doc, para 42.

[10] Watson, Ryan J et al. "Disordered eating behaviors among transgender youth: Probability profiles from risk and protective factors." The International journal of eating disorders vol. 50, 5 (2017): 515–522, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5754211/.

Globally, 1.8 million children under age 15 are living with HIV/AIDS,[11] who often are at increased risk of malnutrition. Chronic infections, including HIV/AIDS, can lead to poor growth and may reduce appetite, food intake, and nutrient absorption at a time when the body needs good nutrition the most to fight the infection. The result is a further weakened immune system that is ill equipped to fight the virus and infections like tuberculosis. Many children living with HIV suffer from severe acute malnutrition, a life-threatening condition.[11] Adolescent girls and young women are disproportionally affected by HIV, with young women 10–24 years old twice as likely to acquire HIV as young men the same age.[12] In eastern and southern Africa in 2017, 79 per cent of new HIV infections among 10–19-year-olds were girls,[13] which is mainly due to vulnerabilities created by unequal cultural, social and economic status.

Strengthening nutrition services within SRH services will go a long way in addressing the SRH needs of women and girls and promoting healthy reproductive lifestyles. In order to address this need, IPPF Member Association Reproductive Health Association of Cambodia includes anaemia and nutrition as part of their SRH service delivery package in their workplace service delivery.[14] Nutrition is essential for women and girls, and more so during pregnancy and lactation. During pregnancy, a critical period in terms of nutritional needs for both the pregnant woman and the fetus, a women's agency to make her own diet and nutrition decisions can often be robbed by spouses, family members, and others who dictate what and how much she can eat. This can endanger the health of the girl or women, and violates her rights, as well as endangering the pregnancy and newborn. Malnutrition during pregnancy, especially high-risk adolescent pregnancies, can lead to low birthweight and stunting and increase the risk of death for both women and newborns.[3]

IPPF Member Associations can provide good practices to learn from to address these issues. In Myanmar, Myanmar Maternal and Child Welfare Association (MMCWA) provides nutrition education, counselling and free nutrition supplements (vitamins, iron, folic acid and foods such as eggs and iodized salts) during antenatal and postnatal care visits at their clinics, as well as through mobile clinics. For childcare, they have growth monitoring programs for children up to 5 years of age, a community nutrition center, and village foodbank program. In collaboration with Ministry of Education and Ministry of Health, they provide mobile health education programs for youth at the government schools, covering sexual and reproductive health knowledge on physical and psychological changes in adolescents, HIV/AIDS, narcotic and drug abuse, nutrition and injuries. They also have regular nutrition promotion activities during world breastfeeding week and nutrition weeks, such as a healthy mom and baby contest, cooking competition, and other engaging activities.[15]

4. Recommendations

In order to address the needs of women, adolescents and girls and guarantee their rights, the harmful patriarchal gender norms that discriminate against them must be eliminated through revising laws and policies which discriminate on the basis of gender in law or in practice, norms-changing educational campaigns, and gender-transformative social, legal, political, financial and other policies.

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[11] UNICEF, *Nutrition: HIV and nutrition* (Aug. 2016), https://www.unicef.org/nutrition/index_HIV.html.

[12] Avert, *Women and Girls, HIV and AIDS* (last updated Oct. 2019), https://www.avert.org/professionals/hiv-social-issues/key-affected-populations/women.

[13] UNAIDS, *Women and HIV: A Spotlight on Adolescent Girls and Young Women* (2019) p. 3, available at https://www.unaids.org/sites/default/files/media_asset/2019_women-and-hiv_en.pdf.

[14] https://cambodia.unfpa.org/sites/default/files/pub-pdf/SRHRofGarmentFactoryWorkerLiteratureReview_2.pdf.

[15] http://www.mmcwa-myanmar.org/unicef.

Future success requires increased political will and engagement of young people, including young women and girls in the formulation and implementation of policies and programs, along with increased investments to deliver at scale evidence-based, age appropriate comprehensive sexuality education, health services that are youth-friendly and approachable and not judgmental, safe spaces programs, especially for vulnerable girls, adolescents and young women, and programs that engage families and communities.[16] Stronger policy-making and programming also requires expanding the evidence on adolescent health and rights for both younger and older adolescents, boys and girls, and relating to a range of key health matters affecting adolescents.[16]

Critical nutrition interventions among adolescents in relation to reproductive health include 1) nutrition-specific interventions, such as iron or iron and folic acid (IFA) supplementation and improving dietary intake through dietary diversification or fortification, and balanced energy and protein (BEP) supplementation; 2) nutrition-sensitive interventions, including Comprehensive Sexuality Education in and out of school to encourage lifelong healthy behaviours; 3) delaying age at marriage through education and empowerment interventions; and 4) delaying age at first pregnancy through the provision of quality SRH services including contraceptive services and safe abortion.

[16] Santhya, K. G., & Jejeebhoy, S. J. (2015). Sexual and reproductive health and rights of adolescent girls: Evidence from low-and middle-income countries. Global public health, 10 (2), 189–221, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4318087/.