SUN Movement

Monitoring, Evaluation, Accountability, Learning (MEAL) 2016–2020

FOCUS AREA

Adolescent girls and women

Key findings from the SUN Movement MEAL baseline:

- **Overweight and obesity prevalence has increased rapidly among adolescent girls in SUN countries** (2000-2016).
- **Preventing overweight and obesity among adolescent girls is an investment in the future well-being of a nation's women** given the strong correlation in the prevalence of overweight and obesity among adolescent girls and women.
- **Improving women's nutrition will benefit children as well**. High levels of underweight in women are closely related with the highest prevalence of stunting and wasting in children.
- **Nutrition and health interventions targeted to women reach less than half of their intended beneficiaries in low-income SUN countries with the percentage dropping further for women living in very high-humanitarian contexts.** Coverage of nutrition-specific interventions like breastfeeding promotion and iron supplementation in pregnancy is low across all SUN countries.
- **Girls living in low-income and high-humanitarian contexts are highly disadvantaged in all SDG indicators of gender equality**. They are less likely to enroll in secondary school and more likely to get married and have a baby before the age of 18 years. Countries with high adolescent fertility have higher levels of child undernutrition.
- **Women's anaemia levels are higher in SUN countries with low family planning coverage and lower diet quality**, highlighting the multi-factorial causes of anaemia.
- **Young women and adolescent girls aged 15-24 are disproportionately affected by HIV and AIDS compared to men.**

The SUN Movement calls for implementation efforts that explicitly put the well-being of girls and women at the forefront, especially in humanitarian contexts.

Scaling Up NUTRITION
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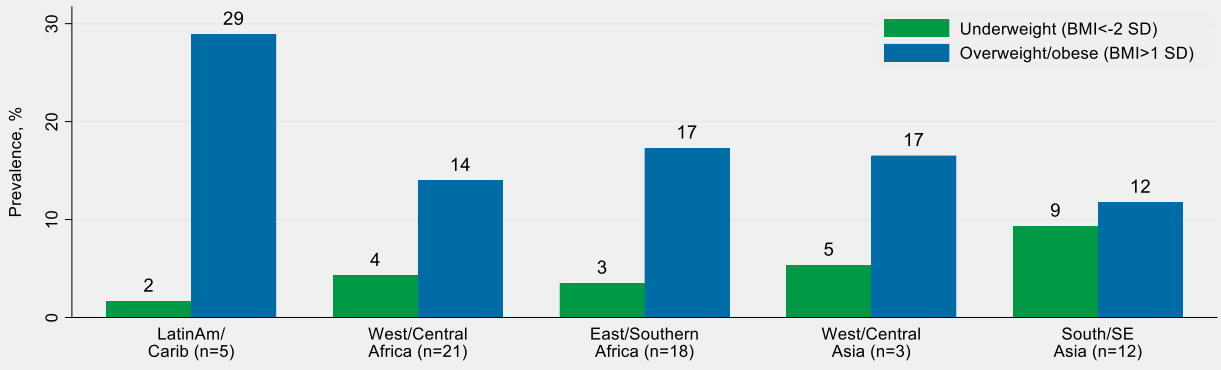
ADOLESCENT GIRLS

Adolescence is a critical period of growth and development with increased nutritional requirements and an opportunity for catch-up growth following childhood deficits. It is also a time when values and lifestyle patterns, such as healthy diet and physical activity, are shaped for life and can lower the risk of overweight and NCDs.[1]

The nutritional status of adolescent girls (10-19 years of age[2]) in SUN countries varies widely across countries from different regions (Figure 1). While about 5% of adolescent girls are considered underweight across the Movement, on average, this is almost double in SUN countries from South and Southeast Asia. Overweight and obesity is a much larger issue in Latin American SUN countries, with nearly one third of adolescent girls affected in these countries, compared to the average of 16% across the SUN Movement.

Figure 1: Prevalence of underweight and overweight/obesity in adolescent girls by region



Source: NCD-RisC estimates for girls 10-19 years of age in 2016

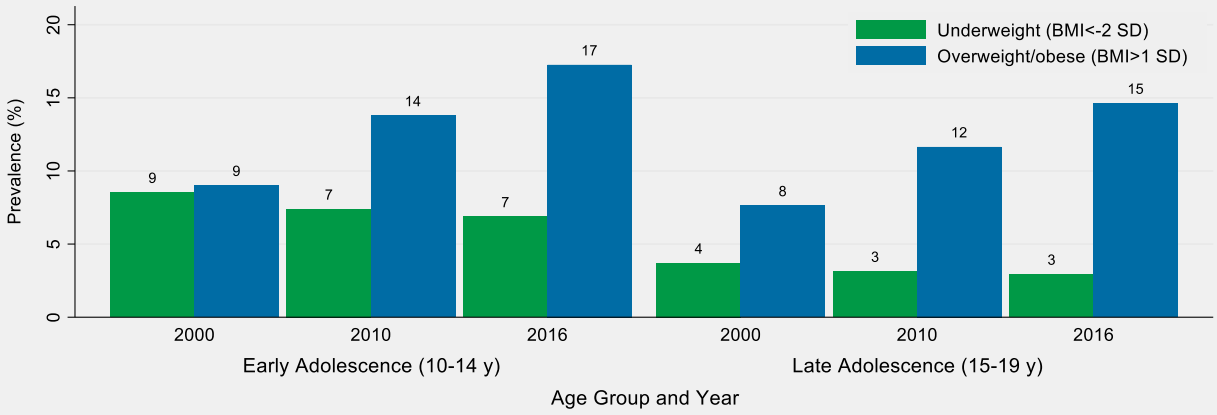
Adolescence is an opportunity to improve individual health trajectories and break intergenerational cycles of malnutrition and poor health.

[1] Akseer N, Al-Gashm S, Mehta S, Mokdad A, Bhutta ZA. Global and regional trends in the nutritional status of young people: a critical and neglected age group. Annals of the New York Academy of Sciences. 2017;1393(1):3-20.

[2] WHO (2017) Global Accelerated Action for the Health of Adolescents (AA-HA!): guidance to support country implementation. Geneva: World Health Organization (WHO/FWC/MCA/17.05).

Between 2000 and 2016, overweight and obesity prevalence has increased rapidly among adolescent girls in SUN countries, while levels of underweight have not changed much (Figure 2).

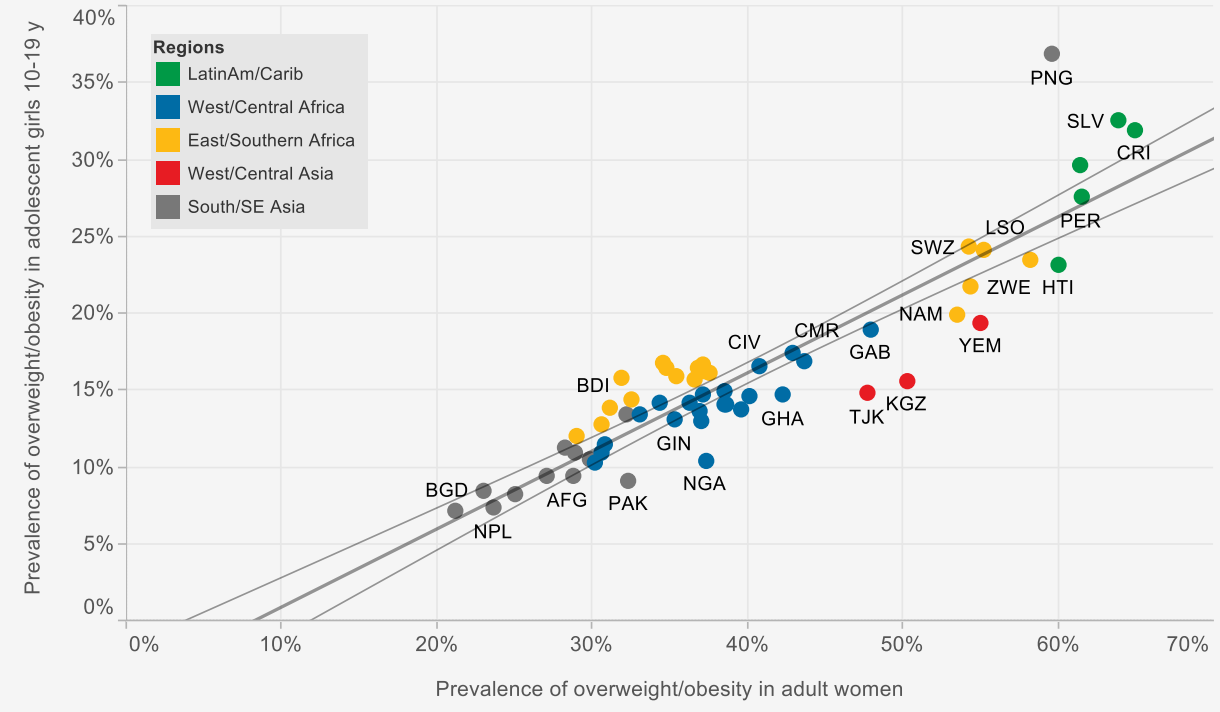
Figure 2: Prevalence of underweight and overweight/obesity in adolescent girls by age group between 2000-2016



Source: NCD-RisC estimates for 59 countries (no data for South Sudan)

Intervening to improve the nutritional status of adolescent girls is an investment in the future well-being of a nation's women. As shown in Figure 3, overweight and obesity among women is highly correlated with prevalence of overweight and obesity in adolescent girls across all SUN countries.

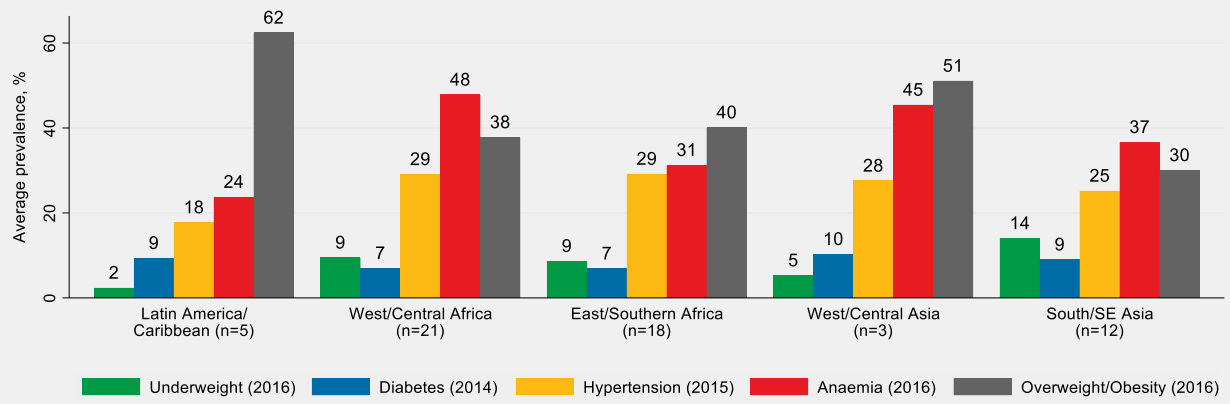
Figure 3: Relationship of overweight in adolescent girls and adult women by country and region



WOMEN

The nutritional status of women in SUN countries shows high levels of anaemia overall and variation in underweight prevalence, with the highest (14%) in South and Southeast Asia (Figure 4). However, prevalence of overweight and obesity is now a much bigger issue and disproportionally affects women compared to men (40% vs. 26%, respectively, in 2016). Overweight and obesity also varies widely across regions, ranging from 30% to 62%. Levels of diabetes among women are similar to the global estimates (8%) with not much regional variation while levels of hypertension in women are higher, on average, in SUN countries (27%) than global estimates (20%), albeit with lower prevalence in Latin America.

Figure 4: Women's nutrition status by SUN country regions



HOW IS WOMEN'S NUTRITIONAL STATUS RELATED TO CHILDREN'S NUTRITIONAL STATUS?

Undernutrition in women is closely associated with undernutrition in young children, as shown in Figure 5. Countries where more than 10% of adult women are underweight also have the highest levels of child stunting and wasting. Similarly, countries with very high levels of overweight and obesity among women also have the highest levels of overweight among children under five years of age (Figure 6).[3]

Figure 5: Prevalence of child malnutrition by prevalence of women's underweight

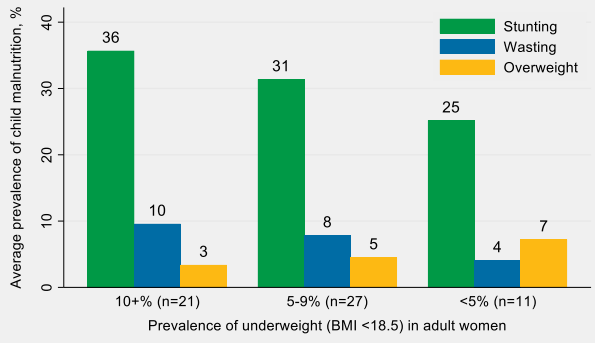
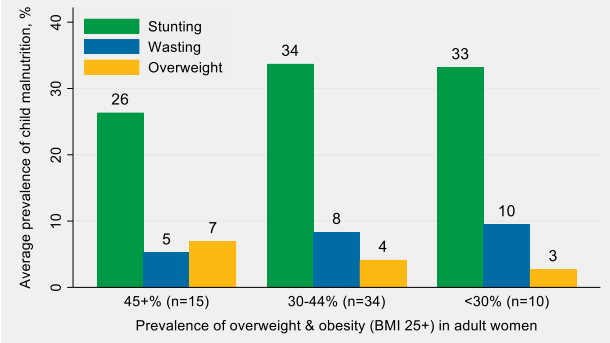


Figure 6: Prevalence of child malnutrition by prevalence of women's overweight/obesity

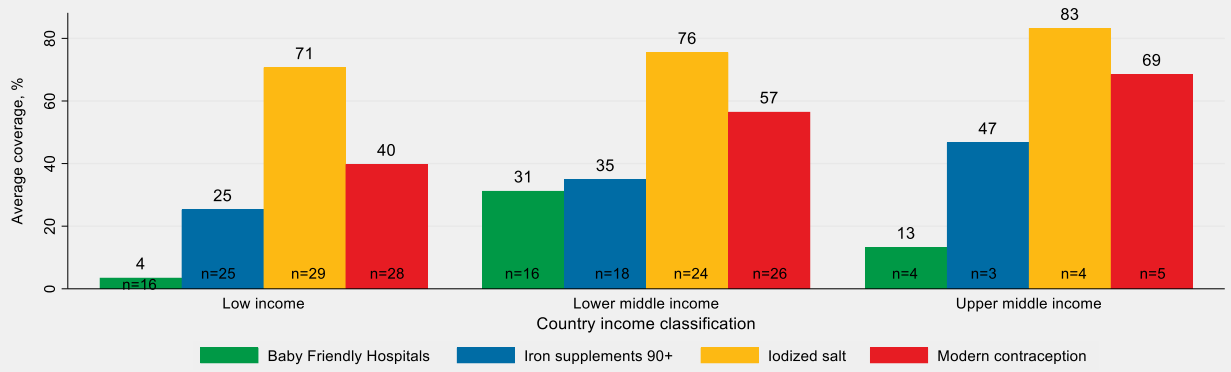


[3] There is no association between diet-related NCD prevalence among women and child nutritional status.

HOW WELL ARE SUN COUNTRIES REACHING WOMEN WITH ESSENTIAL NUTRITION AND HEALTH INTERVENTIONS?

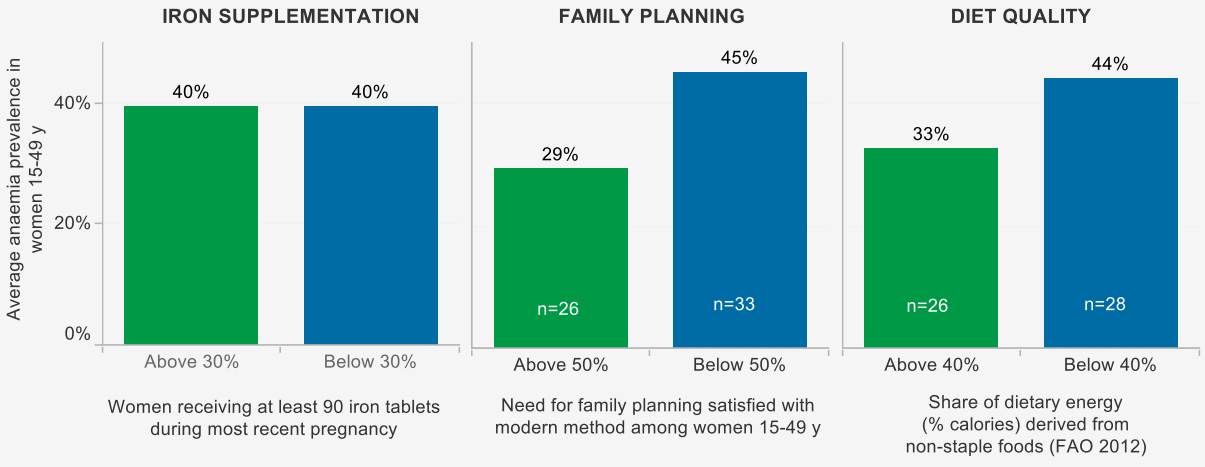
Nutrition and health interventions targeted to women (15-49 years) reach less than half of their intended beneficiaries in low-income SUN countries, except for iodized salt (Figure 7). Average coverage for nutrition-specific interventions like breastfeeding promotion (17% coverage with BFHI) and antenatal iron supplementation (30% coverage with at least 90 tablets) is particularly low across all SUN countries.

Figure 7: Intervention coverage by country income level



Women's anaemia levels are lower in countries with higher family planning coverage but surprisingly not lower in countries with higher iron supplementation coverage during pregnancy (Figure 8). Anaemia among women is also lower in countries where a higher proportion of dietary energy comes from non-staple foods, a proxy indicator of dietary quality.

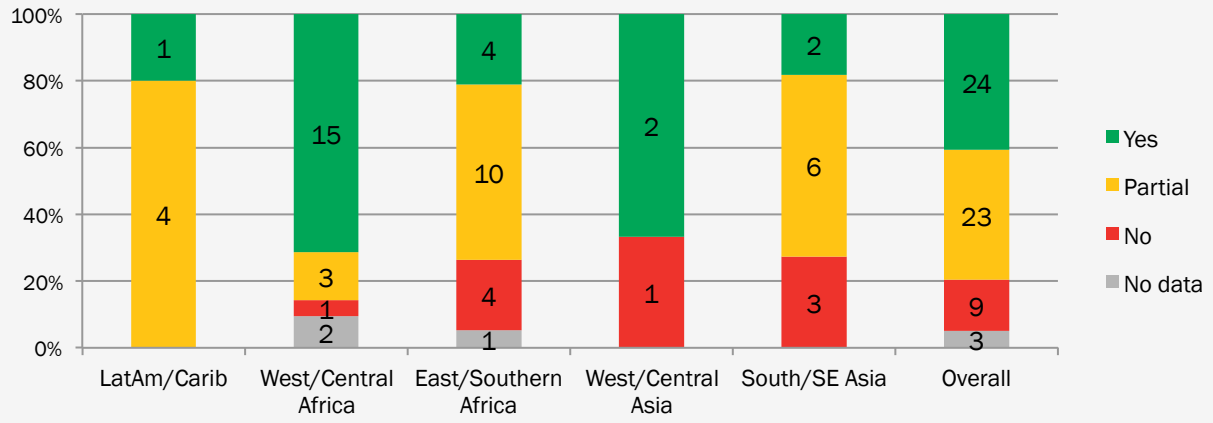
Figure 8: Prevalence of women's anaemia by iron supplementation and family planning coverage and national diet quality



MATERNITY PROTECTION LAWS

Eighty percent of SUN countries have at least partial maternity protection laws in place (Figure 9), an important component for empowering and enabling working mothers to breastfeed and caring for their babies.

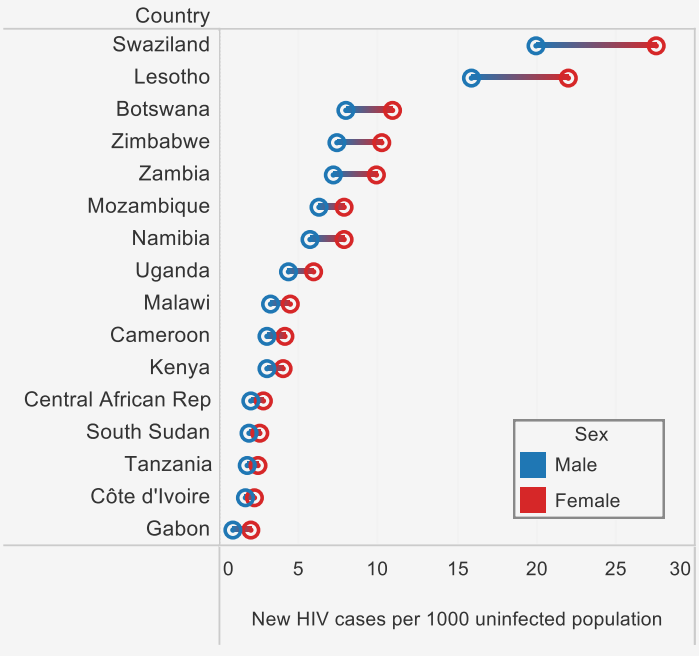
Figure 9: Maternity leave protection status in SUN countries by region



GENDER DIVIDE FOR HIV INFECTION

Young women and adolescent girls aged 15-24 years are disproportionately affected by HIV and AIDS. Globally, in 2015 there were an estimated 2.3 million adolescent girls and young women living with HIV, that constitute 60 per cent of all young people living with HIV.[4] Significant regional differences in the number of new HIV infections among women compared to men are evident globally and in SUN countries, with women in southern sub-Saharan Africa most vulnerable (Figure 10).

Figure 10: Gap in new HIV cases in women vs. men in SUN countries in sub-Saharan Africa (2015)

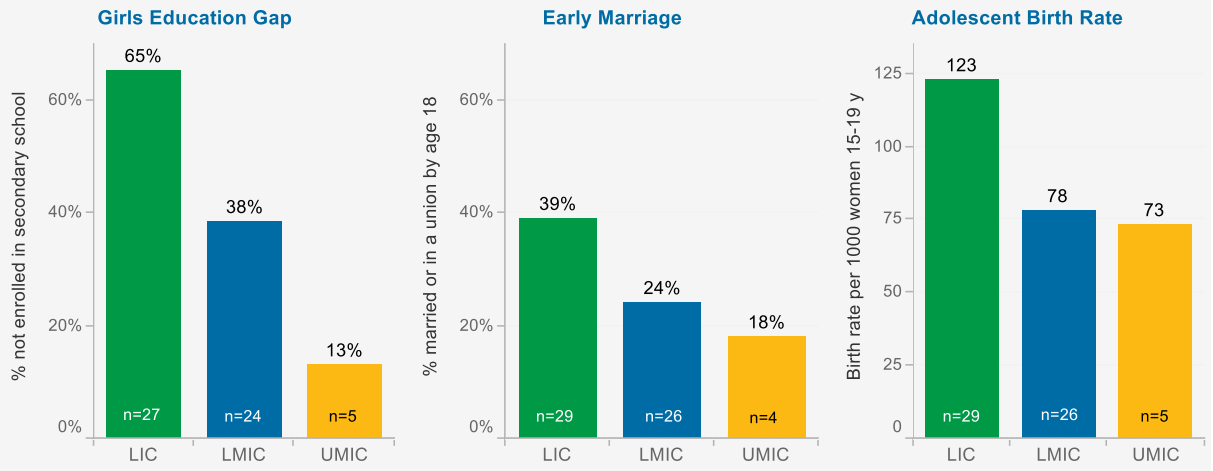


[4] UN Women, Facts and figures: HIV and AIDS. http://www.unwomen.org/en/what-we-do/hiv-and-aids/facts-and-figures

VULNERABILITY FACTORS

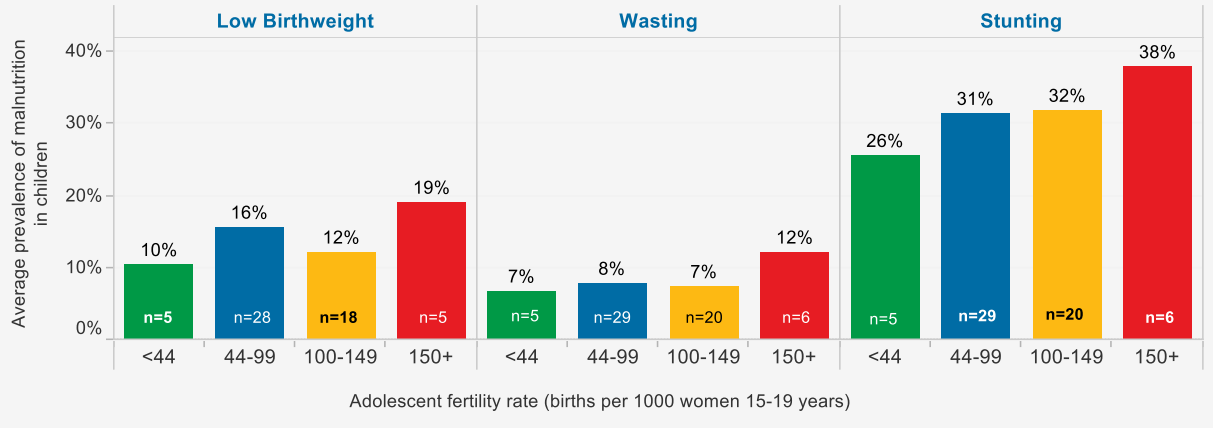
An analysis of SDG indicators of gender equality and health shows the significant disadvantage for girls living in low-income contexts (Figure 11). Girls in low- and lower-middle-income SUN countries are less likely to enroll in secondary school compared with upper-middle-income countries. On average, 32% of girls are married before the age of 18 years in SUN countries, compared to 27% globally. Girls living in low-income countries are over two times more likely to be married by age 18 compared to those in upper-middle-income countries.

Figure 11: Gender equality and empowerment indicators for adolescent girls by country income class



Adolescent birth rates are also much higher in low-income countries (Figure 11), contributing to poor physical growth and health of both these young mothers and their children, perpetuating malnutrition. Figure 12 shows the higher levels of child undernutrition in countries with high and very high adolescent fertility.

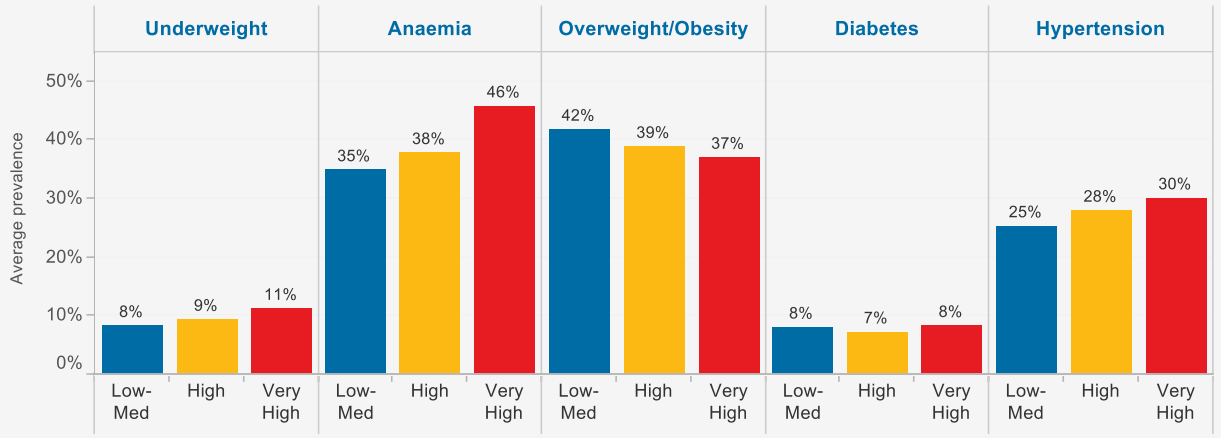
Figure 12: Relationship between adolescent fertility rate and child nutritional status in SUN countries



WOMEN IN COMPLEX HUMANITARIAN CONTEXTS

Women living in very high humanitarian risk contexts are particularly vulnerable, with higher prevalence of underweight and anaemia, as well as hypertension (Figure 13).

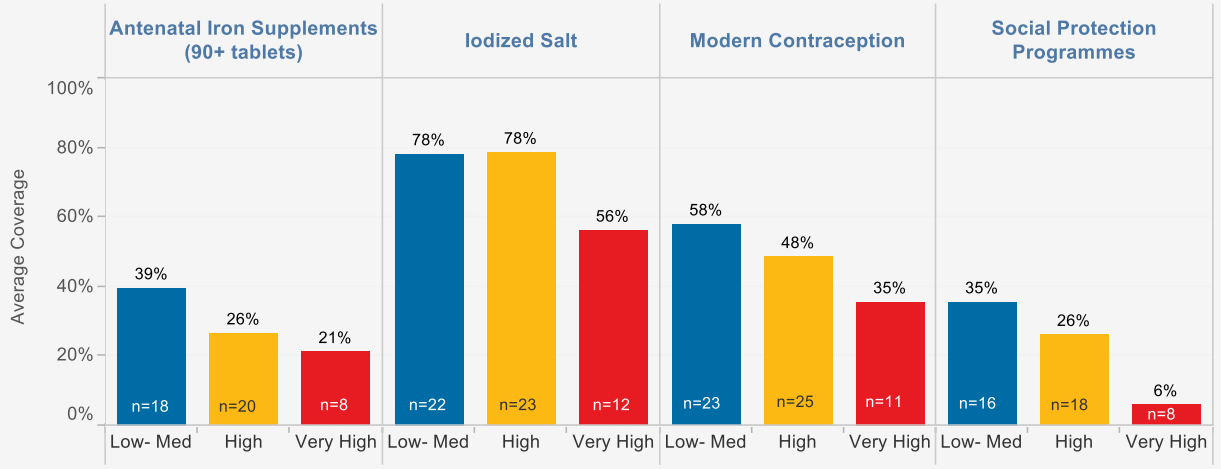
Figure 13: Nutrition status of adult women by country humanitarian risk level



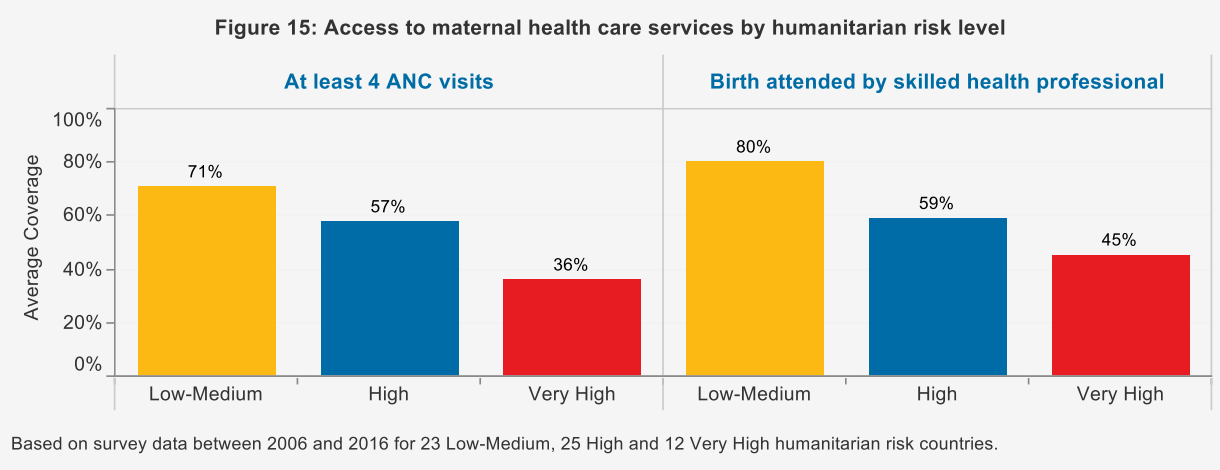
Based on data for 23 Low-Medium, 25 High and 11 Very High humanitarian risk level countries (anaemia data for 12 Very High risk countries).

Access to health and nutrition interventions are much lower for women living in very high humanitarian risk contexts (Figure 14).

Figure 14: Intervention coverage by humanitarian risk level



Access to maternal health care services also decreases with increasing levels of humanitarian risk (Figure 15). Although on average, 58% of women in SUN countries reported at least 4 ANC visits during their most recent pregnancy, only 36% reported this level of access in very high humanitarian risk countries. The proportion of births attended by skilled health personnel was also much lower than average in these contexts, with only 45% of births benefiting from skilled care during delivery compared to the average of 64% for all SUN countries.



Violence against women and girls violates their human rights and hinders development. On the basis of survey data between 2006 and 2016 from 35 SUN countries, 21% of girls and women 15-49 years experienced physical and/or sexual violence at the hands of an intimate partner in the previous 12 months. The level of reported violence against women increases in humanitarian risk contexts, from 16% in low-medium risk countries to 22% in high and 28% in very high humanitarian risk countries.

COUNTRY GENDER PERFORMANCE

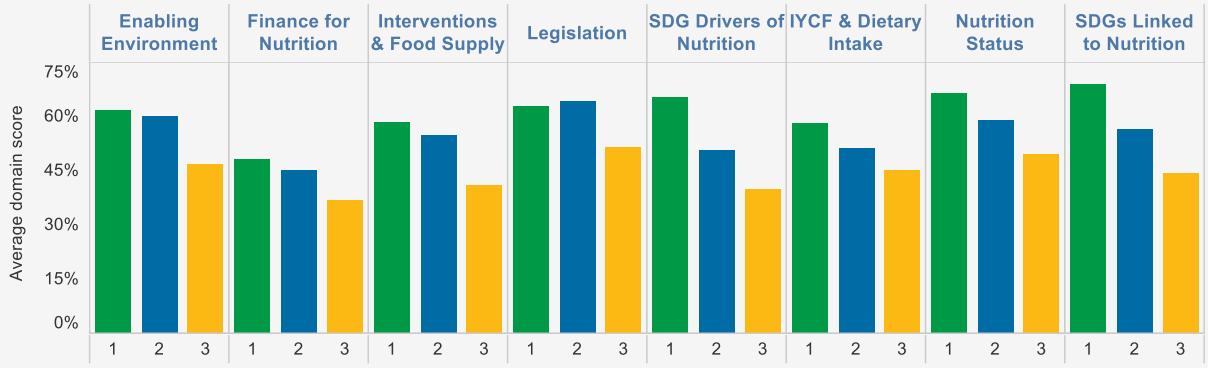
SUN country performance on a set of 14 indicators specific to women was assessed, including 1 on adolescent girls' nutrition status, 6 on women's nutrition status, 4 on interventions, 1 on enacted legislation and 3 on SDGs linked to nutrition. Based on the proportion of these indicators for which a country scored moderate or good (relative to other SUN countries or established cut-offs), countries were classified into three groups, as shown in Table 1.

Table 1: Classification of SUN countries by proportion of gender-specific indicators scored moderate or good

Group 1 >50% moderate or good		Group 2 30-50% moderate or good		Group 3 <30% moderate or good	
Costa Rica	Tajikistan	Haiti	Kyrgyzstan	Central African Republic	Afghanistan
El Salvador					Yemen
Guatemala	Bangladesh	Benin	Nepal	Guinea-Bissau	
Peru	Cambodia	Botswana	Pakistan	Liberia	Papua New Guinea
	Indonesia	Burkina Faso		Madagascar	
Burundi	Lao PDR	Cameroon		Mauritania	
Ethiopia	Myanmar	Chad	Malawi	Mozambique	
Ghana	Philippines	Comoros	Mali	Niger	
Kenya	Sri Lanka	Congo	Nigeria	Sierra Leone	
Lesotho	Viet Nam	Côte d'Ivoire	Senegal	Somalia	
Namibia		DRC	Tanzania	South Sudan	
Rwanda		Gabon	Uganda	Sudan	
Swaziland		Gambia	Zambia		
Togo		Guinea	Zimbabwe		

SUN countries that perform well on MEAL indicators specific to girls and women also tend to perform highest across the MEAL domains (Figure 17). The difference across these gender performance groups is most marked for the domain of SDGs linked to nutrition, even though none of this domain's indicators are considered gender-specific indicators. This supports the idea that women's equality and empowerment is integral to all dimensions of inclusive and sustainable development, including ending malnutrition for all.

Figure 16: MEAL domain performance by country groups defined according to gender-specific indicators



Group 1 (high) n=22, Group 2 (middle) n=24, Group 3 (low) n=14

METHODOLOGY

The SUN Movement's Monitoring, Evaluation, Accountability and Learning (MEAL) system is based on the SUN Movement's Theory of Change and includes 79 key indicators that align with globally-agreed monitoring frameworks and initiatives or are specific to the SUN Movement (e.g. SUN Joint Annual Assessments). A detailed description of the MEAL Framework of Results and Lists of Indicators, including definitions and data sources, is available on the SUN website (http://scalingupnutrition.org/progress-impact/monitoring-evaluation-accountability-learning-meal/).

The results presented in this brief are based on the SUN Movement 2016 MEAL Baseline dataset (March 2018 version). The data analysis process used descriptive statistics (e.g. mean, median) and multi-variate statistical analysis (e.g. ANOVA) to examine the status of countries for various indicators relevant to women and adolescent girls. The associations shown in the figures are descriptive and do not account for potential confounding factors. Although the WHO defines adolescence as the age of 10-19 years, data on girls 10-14 years of age are scarce and this limits our ability to explore their status in SUN countries.

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