



COVID-19 and the Risks to the Nutritional outcomes of Children and Women in Eastern and Southern Africa

A Joint Call to Protect the Nutritional Status of the Most Vulnerable Women and Children across Eastern and Southern Africa from the effects of COVID-19 July 22, 2020

1. Background

COVID-19 is affecting every country in the world, with a confirmed caseload of 15 million and a death toll of more than 617,254¹. The necessary efforts to control the virus and stem the rate of infection have resulted in major economic losses for countries and significantly increased levels of poverty.

COVID-19 arrives at a time of unprecedented global need, with a record 168 million people already requiring humanitarian assistance at the beginning of this year. The latest edition² of the *State of Food Security and Nutrition in the World*, estimates that almost 690 million people went hungry in 2019 – up by 10 million from 2018, and by nearly 60 million in five years. Based on the global economic outlooks of the COVID-19 pandemic, the report suggests that the number of undernourished people could increase by an additional 83 to 132 million. High costs and low affordability also mean billions cannot eat healthy balanced diets that are age appropriate. According to the most recent estimates³ of maternal and child malnutrition, 154 million women of reproductive age are underweight, 144 million of children under 5 suffer from stunting, and 47 million of children under 5 suffer from wasting. The hungry are most numerous in Asia but in percentage terms, Africa is the hardest hit region and becoming more so, with 19.1 percent of its people undernourished.⁴, with high **burdens of malnutrition in its multiple forms including stunting, wasting, and micronutrient deficiencies**. On current trends, by 2030, Africa will be home to more than half of the world’s chronically hungry.

Eastern and Southern Africa (ESA) continues to be the region most affected by HIV globally with approximately 20.7 million people living with HIV (PLHIV)⁵ with women and adolescent girls most affected by the epidemic. During emergencies such as the COVID-19 pandemic, HIV-related risks and vulnerabilities may be increased due to the loss of livelihoods; disruption of health services, family and social networks. Worsening of food and nutrition security may also undermine effective treatment outcomes for this population group⁶.¹ The region also hosts 4.6 million refugees, asylum seekers and 8.1 million internally displaced person (IDPs) as a result of on-going conflicts, insecurity

¹ WHO Coronavirus Disease (COVID-19) Dashboard

² Published on July 13th, 2020

³ Joint Malnutrition Estimates, UNICEF/WHO / World Bank 2020,

⁴ This is more than double the rate in Asia (8.3 percent) and in Latin America and the Caribbean (7.4 percent).

⁵ UNAIDS data 2019

⁶ Further, PLHIV with compromised immune systems are highly susceptible to co-infection and face significantly increased risks of undernutrition

and climatic shocks. They are heavily dependent on humanitarian food assistance to meet their minimum food and nutrition needs, but funding shortfalls have forced serious ration cuts in food assistance to refugee populations in the region, including in Djibouti, Ethiopia, Kenya, South Sudan, Tanzania, and Uganda. The food ration cuts of 10-30% of the recommended 2100 kcal/p/d is affecting over 3.2 million or (72%) of total refugee population in the region.

2. Impacts of COVID-19 on Nutritional Outcomes

According to the 2020 Joint Malnutrition Estimates, released prior to the pandemic, there are currently more **than 26 million stunted children**, and an estimated **10.7 million wasted** children including 2.6 million severely wasted children in the 21 countries of Eastern and Southern Africa.

While the effects of COVID-19 on malnutrition are not yet fully known, it is anticipated that the biggest toll on the most vulnerable will not come from the pathology of COVID-19 itself, but from the collateral impact on food production and access, provision of health services and changes in practices and behaviour. At global level, scenarios developed by UNICEF indicate that the impact of COVID-19 on nutrition could lead to an increase in wasting by about 15% (7 million children) over the first 12 months of the pandemic, with higher increases in Africa (20-25%) over the remainder of 2020 and into 2021⁷. The direct and collateral effect of COVID-19 on vulnerable communities, particularly those in fragile and conflict-affected states, is likely to be devastating. A recently published model from Johns Hopkins University shows that the potential impact of disruption to health services may have devastating effects on child and maternal mortality with an **increase in wasting rates between 10 and 50%**.⁸

Possible pathways leading to increase of undernutrition through the impact of COVID-19:

Reduced access to health and nutrition services: While children and adolescents are less directly affected by COVID-19 related complications and mortality, they are the most vulnerable when essential health services become less available due to health systems being overwhelmed or when health systems exclusively focus on the needed COVID-19 response. Countries in ESA have put in place early measures to contain the pandemic, with varying degrees of success, but overall managing to reduce the initial impact of COVID-19 relative to other regions in the world. Cuts, lockdown measures and diverted funds will have a dramatic impact on health and nutritional status, particularly of women and young children, who are more likely to suffer and die from common diseases such as malaria, diarrhoea, and measles. At the same time, some containment measures have impacted the utilization of essential services negatively: across the region admissions for treatment of severely wasted children are generally below 2019 admissions for Jan-May (esp. in Kenya – 40 percent reduction, South Sudan – 24 percent reduction, Malawi and Somalia – 5 percent reduction), however up to 10 percent higher admission trends are being reported in Angola, Malawi, Ethiopia and Eritrea compared to the same time last year. Almost all countries are off track for semester 1 Vitamin A Supplementation (VAS)⁹.

Increased food insecurity: Prior to the COVID-19 pandemic, food insecurity in the ESA region was already alarmingly high, with **over 45 million food insecure people (IPC Phase 3+)** across the 21 ESA countries. Key drivers of this food insecurity include climatic shocks (drought, flooding), economic challenges/high food prices, outbreak of livestock pest and diseases, conflict/insecurity, and population displacements¹⁰; Looking forward to the upcoming 2020 agricultural season, the ongoing desert locust outbreak has already increased concerns about further food security deteriorations.

⁷ UNICEF GLOBAL COVID-19 Situation Report No.8 11–24 June 2020

⁸ Early estimates of the indirect effects of the coronavirus pandemic on maternal and child mortality in low- and middle-income countries

⁹ UNICEF ESARO Nutrition Database

¹⁰ The region hosts 4.6 million refugees, asylum seekers and 8.1 million internally displaced person (IDPs) as a result of on-going conflicts, insecurity and climatic shocks. They are heavily dependent on humanitarian food assistance to meet their minimum food and nutrition needs, but funding shortfalls have forced serious ration cuts in food assistance to refugee populations in the region, including in Djibouti, Ethiopia, Kenya, South Sudan, Tanzania, and Uganda. The food ration cuts of 10-30% of the recommended 2100 kcal/p/d is affecting over 3.2 million or (72%) of total refugee population in the region.

Risks to Infant and Young Child Feeding practices: Countries are also increasingly reporting violations of the International Code of Marketing of Breastmilk Substitutes (BMS) in relation to the COVID-19 response and access to affordable quality nutritious foods for complementary feeding remains severely threatened due to the loss of livelihoods and incomes for the most vulnerable households.

Resources for nutrition programming: Finally, while national governments and the international community have provided an impressive amount of resources to the COVID-19 response, specific funding to increase the scale up of quality nutrition services and especially for pre-positioning of key nutrition supplies have not been forthcoming as expected.

3. Call to Action:

Therefore, given these high levels of nutritional vulnerability, and the risks to lives and nutrition outcomes for women and children, we request National Governments, the Development Community, UN and Civil Society partners in the nutrition sector across the 21 countries of Eastern and Southern Africa, to take urgent action to protect the nutritional status of the most vulnerable families and individuals through undertaking the following actions:

1. **Ensure inclusion of key preventive and curative nutrition actions in national response plans on COVID-19**
 - **Adopt an effective and holistic approach to nutrition**, addressing both preventive and curative actions for women and children at scale as an essential service for continuity in all national COVID-19 response plans.
 - **Expand safe access to and coverage of high-impact preventive nutrition interventions** that target children under age five, adolescent girls and women of reproductive age including Vitamin A supplementation, IFAS during pregnancy and Infant and Young Child Feeding (IYCF) counselling.
 - **Increase linkage to other sectoral measures** such as food security, and social protection, encouraging safe modalities such as cash transfers for those vulnerable households that are facing increasing food insecurity. Consider the nutritional needs of school aged children who are missing school meals
 - Ensure **delivery of key nutrition services is monitored** to identify areas and populations that may be affected to allow for reorientation and programme correction.
 - Ensure the **inclusion of nutrition indicators into food security and livelihoods assessments** where feasible even when remote, to assess impacts of household food insecurity on dietary quality and meal frequency of young children and inform response.
 - **Adopt innovative solutions**, such as remote training, counselling and monitoring, to enhance access to quality nutrition care, particularly for those harder to reach.
2. **Ensure adequate resourcing for the scale up of key nutrition actions**
 - **Ensure the nutrition sector is adequately resourced** both in terms of funding for staffing, supplies, expansion of programme adaptations, capacity development, and adequate protective equipment for the safe delivery of preventive and treatment services at facility and community level. Ensure to procure essential supplies early, preposition and strengthen supply chains to avoid pipeline breaks and stockouts.
3. **Scale up promotion and protection of the key recommendations for infant feeding in the context of COVID-19**
 - **National guidance and policies should promote breastfeeding for all infants** born to mothers with suspected, probable, or confirmed COVID-19 while applying the necessary hygiene precautions.

- **Guidance and policies should also support symptomatic mothers who are breastfeeding or practicing skin-to-skin contact or Kangaroo Mother Care (KMC)** to practice respiratory hygiene, including during feeding (for example, if the mother has respiratory symptoms, it is recommended to use a face mask when near a child, if possible), perform hand hygiene before and after contact with the child, and routinely clean and disinfect surfaces with which the symptomatic mother has been in contact.
- **Breastfeeding counselling, basic psychosocial support, and practical feeding support should be provided to all pregnant women** and mothers with infants and young children, whether they or their infants and young children have suspected, probable or confirmed COVID-19.
- National guidance and policies **should ensure that mothers and infants be enabled to practice skin-to-skin contact, kangaroo mother care and to remain together** and to practice rooming-in throughout the day and night, especially immediately after birth during establishment of breastfeeding, whether they or their infants have suspected, probable, or confirmed COVID-19.
- **Government and partners should increase the monitoring and reporting of CODE violations** including increasing awareness of health worker and carers as to the increased risks of using formula in place of breastfeeding in all times but especially in the time of this pandemic. Donations of breastmilk substitutes (BMS), complementary foods and feeding equipment, including bottles and teats, should not be sought or accepted for targeted for blanket distribution.
- **Guidance and policies should include support for caregivers and health workers on the importance of healthy diets during complementary feeding¹¹** and safe food preparation/ handling to reduce risk of transmission of COVID-19 including strategies to increase access to nutritious foods for food insecure populations.

4. **Adopt context-specific programme adaptations where necessary that reduce the risk of transmission and enable early identification and referral of wasted children as well as access to treatment for those who need it**

- Adoption of **family led MUAC** for early case identification and referral;
- **MUAC-only admission** where weight and height measurements are not feasible
- For food insecure areas where MUAC only may miss certain vulnerable children consider **expanding admission cut-off for MUAC and or provision of a protective** ration for under 2 years; expanding to under five where feasible.
- **Reduction of frequency of follow-up visits** to the health facility (consider larger take-home rations of ready to use therapeutic or supplementary foods), where applicable and possible.

5. **Ensure food systems support access to affordable nutritious food for the most vulnerable women and children throughout the year**

- **National government with the support from partners, need to** look throughout the food system to address the factors that are driving up the cost of nutritious foods. This means supporting food producers – especially small-scale local producers, to get nutritious foods to markets at low cost, making sure people have access to these food markets, and making food supply chains work for vulnerable people; from small-scale producers to the billions of consumers whose income is simply insufficient to afford healthy diets.
- Promote **household demand creation of affordable nutritious** food through nutrition messaging and social behaviour change activities, particularly in households with pregnant and lactating women and children 6-24 months.

¹¹ Improving Young Children's Diets During the Complementary Feeding Period, Programming Guidance, UNICEF, Feb 2020. <https://www.unscn.org/en/news-events/recent-news?idnews=2030>