

COVID-19 Learning Series

A REPORT OF PRACTITIONERS' EXPERIENCES

Shifts in the number and demographics of people accessing nutrition services in low- and middle-income countries during the COVID-19 pandemic: a qualitative synthesis of key informant interviews



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This document is a part of the ENN COVID-19 Learning Series (www.ennonline.net/C19LearningSeries). This series comprises:

- 1. A survey report** outlining the results of a survey collecting information from ENN's network on topics still underrepresented within the available learning regarding the COVID-19 pandemic and nutrition services in low- and middle-income countries (www.ennonline.net/C19LearningSeries/ScopingSurvey). The results of this survey informed the following work.
- 2. Four case studies and a synthesis document**, focusing on the role of entrepreneurs in supporting nutrition and health services during the pandemic.
 - **Case study 1: Western Stone Enterprise**, a woman-led business that produces peanut paste, sesame paste and other value-added agricultural products in Kenya (www.ennonline.net/C19LearningSeries/CS1).
 - **Case study 2: Adeck Juice Bar**, an all-

natural smoothie bar run by a young entrepreneur in Dar es Salaam, Tanzania (www.ennonline.net/C19LearningSeries/CS2).

- **Case study 3: Sky Brands**, a food processing company specialising in biofortified products in Zimbabwe (www.ennonline.net/C19LearningSeries/CS3).
 - **Case study 4: Solvoz**, an open-access digital procurement platform connecting humanitarian organisations and local suppliers (www.ennonline.net/C19LearningSeries/CS4).
 - **Synthesis report:** a short summary of the key learnings from the four case studies relevant for nutrition practitioners (www.ennonline.net/C19LearningSeries/CS_synthesis).
- 3. A report of practitioners' experiences** of the impact of the COVID-19 pandemic on the number and demographics of people accessing nutrition services in low- and middle-income countries (www.ennonline.net/C19LearningSeries/Practitioner_Survey).





Key messages

This report contains a qualitative synthesis of findings from key informant interviews exploring shifts in the number and demographics of people accessing nutrition services in low- and middle-income countries during the COVID-19 pandemic. We hope these snapshots of different experiences will be interesting and helpful to nutrition practitioners and policy makers wanting to better understand the effects of the COVID-19 pandemic on nutrition services/programmes and their uptake.

1. In many countries, key informants reported a reduction in the provision of nutrition services within the health system due to supply chain disruptions, reduced capacity of health facilities and staff, and a lack of prioritisation of these services following movement and resource restrictions.
2. In many settings, key informants reported a reduction in the utilisation and uptake of nutrition services, which they attributed to several factors, such as fear of infection, the stigmatisation of healthcare staff, heavy police involvement in enforcing government response measures, and communities' reduced trust in the quality of services due to the disruptions described above.
3. The impact of the COVID-19 pandemic on the prevalence of malnutrition is difficult to quantify due to over-stretched health information systems and gaps in the inclusion of nutrition data – challenges which often existed prior to the pandemic. The pandemic has spotlighted these pre-existing gaps; moving forward, it is essential to continue strengthening and investing in these systems to improve learning, nutrition policies and practice.
4. There is little evidence at present of any shifts in the age and sex breakdown of people accessing nutrition services over the course of the pandemic, partially due to a lack of disaggregated data. However, there is evidence of different patterns emerging between rural-urban and socio-economic sub-groups in many contexts.

Background

The COVID-19 pandemic and the response measures implemented to curb increasing infections, such as movement restrictions, curfews and country lockdowns, have disrupted economic, agricultural and health systems, threatening millions of people's access to health and nutrition services and to safe, nutritious and affordable food. Before the COVID-19 pandemic, an estimated 47 million children under five years of age were wasted, with the majority living in Sub-Saharan Africa and South Asia.¹ The Standing Together for Nutrition Consortium estimated that by 2022 the COVID-19 pandemic could result in an additional 9.3 million wasted children under the age of five years.² Furthermore, there have also been predicted increases in stunting, micronutrient deficiencies and overweight.³

Emergency Nutrition Network (ENN) aims to enhance the effectiveness of policy and programming by capturing and exchanging knowledge and experiences, convening actors and networks, and by carrying out

research to build evidence. Given the negative impacts of the COVID-19 pandemic on the systems that are vital for supporting good nutrition, ENN identified a need to develop a COVID-19 Learning Series. To complement, rather than replicate, the large amount of work already done to build knowledge in this area and to ensure that the Learning Series aligned with the needs of people in our network, ENN first developed a survey. This aimed to identify what our network felt were the key learning and information gaps regarding COVID-19 and nutrition services in low- and middle-income countries (LMICs). The report summarising the survey results is available online.⁴ One of the most requested topics to explore within the series was how the COVID-19 pandemic has affected the number and demographics of people (e.g. age/sex profile) accessing nutrition services. Recognising the difficulties in answering this question, ENN decided to collate a snapshot of different service providers' experiences to begin exploring the extent to which the COVID-19 pandemic has affected access to these services.

Objective

A large number of learning materials have been developed regarding the COVID-19 pandemic, but more consideration needs to be given to the learning needs of practitioners. Subsequently, this report aims to describe and understand any shifts in the number and demographics of people accessing nutrition services in LMICs during the COVID-19 pandemic through conducting key informant interviews.

¹ UNICEF, WHO, World Bank Group. Joint malnutrition estimates, 2020 edition. 2020. UNICEF: Geneva. Available at: <https://www.nature.com/articles/s43016-021-00319-4>

² Osendarp S., Akuoku J.K., Black R.E., Headey D., Ruel M., Scott N., Shekar M., Walker N., Flory A., Haddad L., Laborde D. The COVID-19 crisis will exacerbate maternal and child undernutrition and child mortality in low-and middle-income countries. *Nature Food*. 2021;2(7):476–84.

³ Fore H.H., Dongyu Q., Beasley D.M., Ghebreyesus T.A., Child malnutrition and COVID-19: the time to act is now. *The Lancet*. Commentary. 2020;396(10250):517–518.

⁴ Annabel Miller, Philip James, Eilise Brennan, Natalie Sessions, Brenda Akwanyi, Gill Price and Tanya Khara. 2022. COVID-19 Learning Series survey report. Emergency Nutrition Network (ENN): Kidlington, Oxford, UK. Available at: www.enonline.net/C19LearningSeries/ScopingSurvey



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Methods

Between 5th November and 17th December 2021, we interviewed 14 key informants, with 13 interviewed over Zoom and one providing responses by email. We purposively selected key informants from national and regional levels within non-governmental organisations, United Nations agencies, research institutions and government departments. We also adopted a snowballing technique to identify additional interviewees. Appendix 1 provides the list of interviewees and affiliated organisations. Key informants comprised programme managers, researchers, nutrition and public health specialists, statisticians and clinicians. Eight key informants had a regional focus (Africa, South America and South Asia), while six key informants had a country focus (Niger, India and The Gambia). A semi-structured questionnaire guided the interviews with questions shared in advance with interviewees. Verbal consent was secured at the beginning of each interview to record the session and to share the key findings. Specific quotations were reviewed and approved for accuracy by the key informants prior to report finalisation.

Many key informants did not have direct access to data but provided their perspectives and experiences of the impact of the COVID-19 pandemic on the number and demographics of people accessing health and nutrition services. Most key informants voiced their personal opinions, and therefore did not necessarily represent the official viewpoints of their organisations. Key informants also shared existing reports and studies to provide more context.

In this report, we present a qualitative synthesis of our findings. We captured the perspective of a relatively small, though diverse, group of nutrition-service providers. This report does not therefore provide a comprehensive overview of the wide variety of experiences and perspectives on this topic. However, we hope that these snapshots of different experiences will be interesting and will help readers to begin to explore the extent to which the COVID-19 pandemic has affected access to nutrition services in LMICs.

Results

The impact of the COVID-19 pandemic on the number and demographics of people accessing nutrition services and what this means regarding the burden of different forms of malnutrition is complex to unravel and is only in the early days of being quantified (where data exists). A broad range of conversations were had with the key informants on

this topic. The overarching themes that emerged from the interviews described the impact of the COVID-19 pandemic on: (1) the provision of nutrition services; (2) the utilisation of nutrition services; (3) the burden of malnutrition; (4) the demographics of people accessing nutrition services; and (5) the availability of data.

1. Provision of nutrition services

The majority of key informants reported that there was a reduction in the number of people accessing nutrition services due mainly to a reduction in the provision of services during spikes in the COVID-19 pandemic. At the beginning of the pandemic, some countries even experienced a complete closure of nutrition and primary healthcare services.

“ Even now (November 2021) most of eastern India’s services have not been resumed fully. Coverage of services for children and other beneficiaries have still not reached to the pre-COVID level. ”

Dr Rajesh Sinha, National Centre of Excellence (NCoE) for the management of Severe Acute Malnutrition (SAM), India

To maintain access to healthcare while reducing the risk of COVID-19 transmission early on in the pandemic, many national governments designated some services as essential services; these continued to be provided even when government response measures such as lockdowns were in place. However, key informants in South America and South Asia reported that initially some governments did not consider nutrition an essential service, though this position was quickly reversed due to strong advocacy efforts by the nutrition community. Similarly, several key informants from Africa and South America reported that even when nutrition services were available, there was restricted access, as movement restrictions, at least initially, did not make exceptions for people accessing these services.

“ You weren’t allowed to go out of the house, not with your car, not on foot, except for one day per week that was determined by the number on your I.D. card. ”

Caroline Hilari, Independent Consultant, South America

Some of the key informants even mentioned anecdotal reports from individuals in the communities they served detailing how they had been forcefully denied access to services in the early stages of lockdown.

In addition to health service closures, school closures dramatically affected the provision of nutrition services, as service providers often used schools as delivery mechanisms for services, such as iron-folic acid supplementation for adolescent girls and school meal programmes. As a result, service providers started using alternative or adapted delivery mechanisms for nutritional products and services (Box 1). However, implementation of these alternatives varied across contexts.



WFP/SAVED ASIF MAHMUD

“ Even though the central government ministry issued the guidelines of providing doorstep food delivery and other services, access varied across states and communities. ”

Dr Rajesh Sinha, NCoE for management of SAM, India

In many regions, but especially South Asia, respondents reported that strong networks of community healthcare workers have been essential to the successful adaptation and continuation of nutrition services.

“ In some places community health workers would have been given directions to do doorstep services or home visits, but in other places it's just the community health workers being embedded in their communities who decided to do these things themselves. ”

Dr Bindi Borg, UNICEF Regional Office for South Asia (ROSA)



WFP/BORIS HEGGER

For example, in Odisha, India, Anganwadi workers (community-based, front-line healthcare workers in India) continued to provide services under the Supplementary Nutrition Program despite the closure of Anganwadi Centres themselves. This included these workers delivering rations and eggs to households with children three to six years of age in lieu of the morning snack and hot cooked meals normally cooked at Anganwadi centres.⁵

“ Starting from the Anganwadi workers to the healthcare workers to the supervisors, all have tried exceptionally hard. ”

Akshaya Limal, UNICEF/Indian Council of Medical Research, Department of Women and Child Development, Government of Odisha India

Box 1 Vitamin A supplementation in Pakistan and Bangladesh (UNICEF Case Studies)

Two UNICEF case studies (as yet unpublished or in press) documented experiences in Pakistan and Bangladesh in adapting and continuing vitamin A supplementation campaigns during the COVID-19 pandemic.

These two countries implemented a range of adaptations – for example, an increased number of campaign days and locations, the adoption of infection control measures, and extensive training and outreach to ensure campaign days could continue during the pandemic. In Bangladesh, real-time data monitoring and reporting were also implemented using mobile phones, allowing for real-time information and corrective actions, which was critical to the campaign's success. As a result, the campaigns reached 21.5 million children (97% of target) and 31 million children (89% of target) in Bangladesh and Pakistan, respectively.

“ It was surprising [...] at least in those places you have campaigns, where you'd usually have lots of people crowding together and you'd think nobody, not the service providers nor the service users would want to do it, but it was managed very well. I think we could learn a lot from that. ”

Dr Bindi Borg, UNICEF ROSA

Real-time monitoring and reporting of Bangladesh Vitamin-A campaigns are available at: <https://public.tableau.com/app/profile/shammi.shawal/viz/NVACSep-2020/Dashboard1>

⁵ Department of Women and Child Development and Mission Shakti, Government of Odisha. 2021. Annual Activity Report 2020–2021. Department of Women and Child Development: Bhubaneswar, Odisha, India.

The capacity of health facilities and staff was another key challenge in maintaining nutrition services. Health centres that provided nutrition services were often repurposed as COVID-19-only centres, and staff and funding were redeployed and redistributed to prevent and manage the disease.

“ There were months where the inpatient [nutrition] services really came to a halt and personnel on those wards were shifted to other responsibilities. ”

Robert Johnston, UNICEF India

Supply chain disruptions also limited the availability of nutrition commodities across regions. Countries dependent on importing nutrition commodities, such as multiple micronutrient powders, struggled to maintain national stocks. Internal supply chain disruptions also prevented the distribution of nutrition commodities within countries, with centralised distribution systems appearing to be affected more than decentralised systems.

“ Even though we had food items, which were there in the central godowns [warehouses], the distribution of this food was hampered by supply chain disruptions. A study conducted by Nair, D. et al 2021⁶ found that whenever there was a centralised supply system, the effect of supply chain disruptions was greater compared to having a decentralised supply system. An example of a decentralised supply system comes from Self-Help Groups producing nutritionally-dense food items and supplying them as part of the Supplementary Nutrition Program, under the Integrated Child Development Services scheme. ”

Dr Rajesh Sinha, NCoE for management of SAM, India

However, decentralised systems still faced various challenges due to the COVID-19 pandemic.

“ It is important to note, however, that there were challenges even in decentralised supply systems and to respond to these challenges the government needs to resolve funding delays for Anganwadi Workers and Self-Help Groups and develop contingency plans for when there are unexpected food price increases or supply restrictions. ”

Dr Rajesh Sinha, NCoE for management of SAM, India

Though many countries faced restricted access to services, not all countries and services were subjected to the same restrictions and they were not impacted equally. For example, in West Africa, there was a dramatic drop in the coverage of vitamin A supplementation, as healthcare providers were directed to cancel campaign days, while there was minimal documented impact on the functioning of other nutrition services operating out of health facilities. Similarly, there was seemingly relatively little impact on access to health centres and nutrition services in Niger. In complete contrast, there was total quarantine, limiting nutrition services, across most countries in South America.

“ Access to health centres [in Niger] I don't feel was ever hugely impacted. What was more of an issue was a restriction on community group gatherings [...] although that impact was very short-lived before things started to return back to normal. ”

Lucy Lafferty, Concern Worldwide

Overall, the provision of nutrition services has generally increased in most of the countries discussed in this report since the first and second waves of the pandemic; however, the recovery has not been linear as COVID-19

⁶ Nair, D., Gupta, A., Stroming, S., Raj, R., Thompson, W.M., Shukla, K., Nag, D. (2021). Improving Implementation of the Take Home Ration Programme Under ICDS: Findings from Rajasthan and Jharkhand. Project Report. New Delhi: IDinsight. Available at: <https://www.idinsight.org/publication/improving-the-implementation-of-the-take-home-ration-programme-under-icds/>

comes in waves. Key respondents suggested that to maintain access to nutrition services, it is essential to continue to advocate for the importance of nutrition, and to strengthen and build the capacity of existing health systems.

“ Systems that were already strong, things that were already in process and were kept going through COVID-19 [...] aspects such as digitalisation of community health worker training or forms of digitalisation of infant and young child feeding counselling either by phone or radio [...] these procedures that were already in place really shone. ”

Dr Bindi Borg, UNICEF ROSA



WEPI/GLORY NDAKA

“ As much as we are focusing on prevention and management of COVID-19, nutrition is also key, it is a key service we should not forget. ”

Leticia Buluma, Amref Health Africa

2. Utilisation of nutrition services

Even when nutrition and primary healthcare services were available, fewer people were accessing services

during spikes in the COVID-19 pandemic (Box 2), due to a number of social and cultural factors.

Box 2 A brief on nutrition and food insecurity during the COVID-19 pandemic by Alive & Thrive

This brief summarises two separate studies in India and Bangladesh, led by the International Food Policy Research Institute and Alive & Thrive, which assessed the effects of the COVID-19 pandemic on maternal, infant and young child (under two years of age) nutrition services. These studies built on implementation research that was implemented just before the pandemic. In India, 587 mothers of children under two years of age and 313 frontline community healthcare workers were surveyed. In Bangladesh, 40 pregnant women, 387 mothers of children under two years of age and 45 healthcare workers from urban health facilities were surveyed. Between December 2019 and April 2020, there was a decline in the provision of services for mothers and children under two years of age in India. For example, there was a 90% reduction in the number of frontline community healthcare workers that reported providing iron-folic acid supplementation to pregnant women through home visits or Village Health Nutrition Days. Similarly, between February and April 2020, there was a decline in the provision of services in Bangladesh, with a greater decrease in services observed for children under two years of age compared to services for women. By July 2020, the provision of services began to recover but did not reach pre-pandemic levels. The utilisation of services also decreased in India and Bangladesh when restrictions were implemented, with utilisation not recovering to pre-COVID levels for most services after restrictions were lifted. Women/mothers reported that the primary reason for a decrease in demand for services was the lack of transport and the fear of leaving the house.

Available at: <https://www.aliveandthrive.org/en/resources/nutrition-and-food-insecurity-during-the-covid-19-pandemic-the-impact-of-the-pandemic-on-miycn>

“ With every lockdown, there was a change in the number of patients we got [...] once the government declared a lockdown, the mothers tended to keep even the sick children with them at home because they heard there was a lockdown. This was despite it being explicitly stated by the government that lockdown actually shouldn't affect people's visits to the hospital. ”

Dr Babatunde Awokola, Medical Research Centre (MRC) Unit The Gambia at the London School of Hygiene and Tropical Medicine (LSHTM)

All key informants mentioned fear of transmission as a primary factor for the decrease in the number of people utilising health and nutrition services, especially during the initial days of the pandemic.

“ During the last two years, there was a lack of utilisation of health services because people were afraid to visit them. They perceived a high risk to do it. ”

Patricia Dominguez, Nutrition Advisor (independent), Latin America and the Caribbean region

“ The notion that health centres were sort of the centre of most of these [COVID-19] infections was quite prevalent. ”

Abdhalah Ziraba, African Population and Health Research Centre (APHRC)

Communities often avoided health facilities, staff and crowded public transport.

“ It's been an interesting turnaround from what we usually see, usually there's a lack of public transport, leading to overcrowding, now nobody wants to use the transport. ”

Dr Bindi Borg, UNICEF ROSA

Key informants from select countries in Africa also reported that the association between COVID-19, health facilities and healthcare staff also led to the

stigmatisation of healthcare workers, with communities often avoiding contact with them even outside of clinical settings. Moreover, the fear and stigma surrounding health facilities and staff has been compounded in some contexts by false information and reports of heavy police involvement in enforcing government measures, such as movement restrictions and curfew hours, which in itself also decreased the utilisation of services.

“ Because they [the communities] did not want to brush shoulders with law enforcement, what they would do is just stay in their households. ”

Joyce Murerwa, Amref Health Africa

However, it is also important to acknowledge that health facilities struggled to separate COVID-19 and non-COVID-19 patients in many contexts, and did not always have the appropriate personal protective control measures or equipment in place, leading to increased risk of infection. This led to families deprioritising preventive healthcare services, including nutrition services. One key informant felt strongly that this response was proportional to the increased risk of infection, and that nutrition and health practitioners needed to take families' concerns more seriously.

Several key informants reported that due to the disruptions (reported in the section above), the COVID-19 pandemic has negatively impacted some communities' confidence in health and nutrition services, leading to the reduced utilisation of these services. Anecdotally, the COVID-19 pandemic has also affected the quality of services provided due to the redeployment of staff, staff shortages and reduced space in facilities due to the influx of COVID-19 patients.



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3. Changes in the prevalence of trends

The COVID-19 pandemic has negatively affected beneficiaries' access to and utilisation of nutrition services. However, the impact of the COVID-19 pandemic on the burden of malnutrition is more difficult to quantify. The data required to better understand this impact are often sparse due to difficulties in collection and reporting. For example, it was not possible to implement nutrition assessments, such as Standardised Monitoring and Assessment of Relief and Transitions (SMART) surveys, in many contexts, especially during the initial stages of the pandemic. As a result, the available data is often facility-based only (i.e. it only reports trends in numbers accessing services) and thus is unlikely to reflect the level of malnutrition in the community due to all the issues of reduced access to and utilisation of services discussed earlier.

“ We can imagine that if the available data showed that there was no decrease [in new SAM admissions] the trends were probably higher than usual because a lot of health services were closed and there were a lot of difficulties for households and children to access those services. ”

Anne-Céline Delinger,
World Food Programme, West Africa

Data availability and available information on trends varies by context. For example, some settings reported an increase in wasting over the pandemic, often in waves corresponding with lockdown restrictions. However, others reported no differences. Furthermore, there were also anecdotal experiences of improved nutrition outcomes.

4. The demographics of people accessing nutrition services

The COVID-19 Sex Disaggregated Data Tracker has shown that the pandemic has affected men and women differently.⁷ For example, one respondent reported that data from countries tracked by the World Health Organization Regional Office for Africa showed that (excluding South Africa), men received

“ Once lockdown is relaxed, you see large numbers of patients bombarding us, really sick patients, really sick children with weight-for-height z-scores <-4 sometimes [...] then when lockdown comes in again, the numbers drop. ”

Dr Babatunde Awokola, MRC Unit
The Gambia at LSHTM

“ Some caregivers, interviewed in a recent report, said that their children are actually better nourished now because they were not selling their produce from kitchen gardens or small farms; instead, they were feeding it to their children, and their children were doing better compared with how they usually did. ”

Dr Bindi Borg, UNICEF ROSA

There were also possible impacts on overnutrition reported in South Asia and South America due to reduced access to healthy foods and increased screen time for school-age children and adolescents, leading to reduced physical activity and increased exposure to fast food marketing.

It is important to remember that, despite its documented independent effects, COVID-19 can also be viewed as yet another layer of vulnerability added to existing nutrition problems in many contexts. Therefore, it is essential to consider all pre-existing factors and not solely attribute any observed changes in nutrition outcome trends to the pandemic alone.

more COVID vaccinations (54%), were tested more (74%), and comprised more confirmed cases (57%),

⁷ Global Health 50/50, African Population and Health Research Centre, International Centre for Research on Women. 2021. The Sex, Gender and COVID-19 Project. Available at: <https://globalhealth5050.org/the-sex-gender-and-covid-19-project/>

hospitalisations (60%) and deaths (65%) than women. Current work within the Global South A14 project,⁸ which utilises a COVID-19 data hub to support decision making in Kenya and Malawi, showed that sex and gender also played a determining role in the secondary impacts of the pandemic. For example, women were overrepresented in sectors that have been hardest hit by the pandemic, such as the informal sector, health and tourism.

“ It has become clearer that the pandemic is gendered, the impacts are seen in many domains not just health, but economic, social, justice, agriculture, and education domains, among others. ”

Sylvia K. Muyingo, APHRC

However, anecdotally, key informants reported that there was no change in the sex breakdown of beneficiaries accessing nutrition services during the COVID-19 pandemic, although there was a lack of available data to support or refute this observation. This is partially due to the inadequate availability and reporting of sex-disaggregated data for people accessing nutrition services in many contexts, an issue that existed widely pre-pandemic. Key respondents also noted that there was a pre-existing sex differential in the admission of infants and children for wasting services, but could not comment on whether these differences had been reduced or exacerbated during the pandemic.

“ I don't think girls would have less access [to services] than boys – there is no systematic barrier [for one sex]. ”

Caroline Hilari, Independent Consultant, South America

“ All age groups and genders were equally affected because all the caretakers of children under five only sought services that were critical. ”

Joyce Murerwa, Amref Health Africa

One key informant in India observed that older children (above three years of age) had more access to nutrition services than younger children (six months to three years of age) during the COVID-19 pandemic, as community healthcare workers were able to procure



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food rations locally or provide equivalent cash amounts for older children. In comparison, it was difficult to access the fortified take-home rations appropriate for younger children, with these rations often affected by supply chain disruptions.

“ It was difficult to reach younger children, so even our community health workers were focusing more on providing nutritional services to the older children [...] even though the prevalence of malnutrition is high in younger children. ”

Dr Rajesh Sinha, NCoE for management of SAM, India

Overall, there was very little evidence for a change in the age and sex breakdown of people accessing nutrition services. However, socio-economic and rural-urban differences were evident in many contexts. For example, in countries where lockdowns were national rather than localised, rural areas suffered more than urban areas, particularly where journeying to health facilities was already challenging. The lack of transport and/or the fear of crowded public transport during lockdowns meant that populations struggled to reach facilities located farther than walking distances. Health staff also faced difficulties in reaching these populations due to movement restrictions and restrictions on community outreach work. Furthermore, rural areas experienced prolonged knock-on effects, with areas facing difficulties in reopening services due to staffing issues and stock shortages.

⁸ International Development Research Centre. 2021. Harnessing COVID-19 data to support public health and economic decision making in Kenya and Malawi – COVID AI. Available at: <https://www.idrc.ca/en/project/harnessing-covid-19-data-support-public-health-and-economic-decision-making-kenya-and>

“ Even though referrals were being done by the front-line workers or community health workers, because of lack of transportation or lockdown, these children were not being brought to the Nutrition Rehabilitation Centres [inpatient centres for severe wasting], and the bed occupancy was observed to be very low – these admitted children were from the nearby areas only and children from far-flung places were hardly reaching the centres. ”

Dr Rajesh Sinha, NCoE for management of SAM, India

“ A lot of the time healthcare workers assigned to work in rural areas are being pulled into the cities, as vaccination is going a lot faster and there is a lot more demand for healthcare workers in the cities – rural areas have now been quite depleted of health staff. ”

Caroline Hilari, Independent Consultant, South America

Already vulnerable families were also disproportionately affected by the COVID-19 pandemic and faced additional barriers to accessing health and nutrition services. A report by Save the Children found that when comparing “relatively poor” households with households that were “not relatively poor”, 60% of the relatively poor households were struggling to pay for food, compared to 52% of households that were not relatively poor.⁹ For households living on the poverty line, loss of income due to the COVID-19 pandemic meant that families could not afford the out-of-pocket expenditure associated with accessing healthcare services. Furthermore, initiatives such as tele-medicine, which allows for videos or phone appointments between beneficiaries and healthcare providers, discriminated against poorer households, who were less likely to have access to mobile phones or sufficient network coverage.

“ If you have lost your job or if your income has gone down, you will not be able to access care. Therefore, you either seek alternative care, like traditional medicine, or you do not access care at all. ”

Abdhalah Ziraba, APHRC

5. The availability of data

Assessing the impact of the COVID-19 pandemic on the number and demographics of people accessing nutrition services was made more complex due to the impact of the pandemic on data collecting and reporting mechanisms. Regular data collection efforts were suspended in many countries, and national nutrition surveys were put on hold. In settings where data collection was possible, reporting channels were often disrupted, and there were challenges in validating data. Increased urban-to-rural migration due to the pandemic, observed in urban slum settlements in Kenya and anecdotally in other contexts, also added another layer of complexity to data collection efforts.

“ About half of the households [from a longitudinal cohort in urban slum settlements in Kenya] have

had at least one person moving out of the household, going to another household or going back upcountry [...] When the going gets tough in the cities, you don't have accommodation, you don't have food [...] it might be safer for you to go to the rural areas where you have an ancestral home and food produced from your garden. ”

Abdhalah Ziraba, APHRC

⁹ Shah Farrukh. A generation at stake: Protecting India's children from the impact of COVID-19. 2020. Save the Children. Available at: <https://resourcecentre.savethechildren.net/document/generation-stake-protecting-indias-children-impact-covid-19/>



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Furthermore, publicly reporting the prevalence of malnutrition, particularly undernutrition, can be politically sensitive. Subsequently, there were restrictions on data collection efforts and the amount of data permitted to be made publicly available in some contexts. However,

not all countries suffered these restrictions equally and there are some documented examples of adaptations to data collecting and reporting mechanisms which have helped increase the ease of data flow over the pandemic (Box 3).

Box 3 Adaptations to data collecting and reporting mechanisms

- As field visits were restricted, the Government of Odisha in India used Google Forms to collect data from community healthcare workers to validate data reported by supervisors. In addition, telemonitoring (phone calls) with caregivers of Integrated Child Development Services beneficiaries was also used to verify whether beneficiaries were getting nutrition services, such as take-home rations and eggs. Of the 12,000 caregivers contacted between June 2020 and June 2021, 69% received home visits, 95% received take-home rations and 98% received eggs.¹⁰
- UNICEF Nepal developed the Child Family Tracker,¹¹ a national periodic household phone survey used to track the socio-economic impacts of COVID-19 on children and their families, including the impacts on nutrition.
- The Centre of Excellence at the Centre for Technology Alternatives for Rural Areas, Indian Institute of Technology Bombay, and partners developed Poshan COVID-19. The website collated all authenticated information on maternal and child nutrition in the context of COVID-19; this included collating and reporting state-level data every month.
- RapidPro,¹² an open-source software that allows for data collection via text messages, was implemented in Zambia to overcome challenges in collecting routine data due to the COVID-19 pandemic and subsequent government response measures. This system allowed for near real-time screening data and information on ready-to-use therapeutic feeding supplies, which was used to support decision making and response planning.
- Action Against Hunger Bangladesh adapted the SMART survey methodology and operations to continue data collection efforts in Cox's Bazar refugee camps during the COVID-19 pandemic.¹³ Adaptations included reducing the number of indicators and the minimum acceptable precision, conducting community sensitisation, using experienced enumerators, and putting in place personal protective equipment and social distancing measures.

¹⁰ UNICEF. 2021. Odisha adapts to a new nutrition reality in India. Poshan Weekly. Available at: <https://mailchi.mp/2ef1eb225278/odisha-adapts-to-a-new-nutrition-reality-in-india>

¹¹ UNICEF Nepal. 2021. COVID-19 child and family tracker: Findings. Available at: <https://www.unicef.org/nepal/reports/covid-19-child-and-family-tracker-findings>

¹² Nakai Munikwa, Pauline Tsikayi, Desire Rwodzi, Mara Nyawo and Mathieu Joyeux. Use of RapidPro for remote collection of nutrition data during the drought emergency and COVID-19 pandemic in Zimbabwe. Field Exchange 64, January 2021. p67. Available at: www.enonline.net/fex/64/zimbabwecovid19rapidpro

¹³ Md. Lalon Miah, Bijoy Sarker, Jogie Abucejo Agbogon, Brigitte Tonon, Mary Chelang'at Koech and Md. Shahin Emtazur Rahman. Adaptations to SMART surveys in the context of COVID-19 in Cox's Bazar, Bangladesh. Field Exchange 65, May 2021. p60. Available at: www.enonline.net/fex/65/smartsurveyscovid19coxsbazar

Furthermore, there are examples of adaptations to allow the estimation of caseloads of wasted children given the

constraints caused by the pandemic (Box 4).

Box 4 Estimating caseload of wasted children during the COVID-19 pandemic

- Nutrition Cluster partners in Afghanistan undertook a process to calculate wasting caseloads and prioritise geographical areas for services. However, as only a few recent SMART surveys exist in Afghanistan (due to many factors including lack of access to conflict-affected areas) and the Demographic and Health Survey (DHS) did not include anthropometric data, alternative methods had to be found using available data. For example, when calculating combined global acute malnutrition, as recent SMART surveys were unavailable in many provinces, 2015 SMART surveys were used; where these were unavailable, extrapolations were made using data from adjacent provinces. To estimate the likely impact of COVID-19 on wasting caseloads, Nutrition Cluster partners relied on experiences from previous malnutrition crises.¹⁴
- The World Food Programme devised a model to improve estimates of the burden of wasting and to account for food insecurity, seasonal variation and the impact of COVID-19 in six Sahelian countries.¹⁵

In addition to the challenges imposed by the pandemic, key informants reported that the availability and quality of baseline data has also limited nutrition practitioners' ability to assess the impact of the pandemic on nutrition outcomes.

“ We might presume, for example, that anaemia prevalence has gone up because people have had less access to iron supplements during the pandemic. But maybe the provision of iron supplements was weak even pre-pandemic. Without good baseline data we don't know whether the situation got worse or simply remained similar from a low baseline. ”

Caroline Hilari, Independent Consultant, South America

Generally, the COVID-19 pandemic has highlighted the pre-existing gaps in our nutrition information systems. Moving forward, it is essential to continue strengthening and investing in nutrition information systems to improve learning, and to inform nutrition policies and practice.

“ In some weak health systems, it's a norm not to have good data, but in the advent of COVID it has become glaringly obvious to everyone that we need to do better. ”

Dr Babatunde Awokola, MRC Unit The Gambia at LSHTM



WFP/HUGH RUTHERFORD

¹⁴ Beka Teshome Bongassie, Said M. Yaqoob Azimi and Maureen L. Gallagher. Calculating wasting caseloads and geographic prioritisation of nutrition services in the context of limited data in Afghanistan. Field Exchange 65, May 2021. p26. Available at: www.enonline.net/fex/65/peopleinneedafghanistan

¹⁵ Saidou Magagi, Sumra Kureishy, Jessica Bourdairé and Katrien Ghoos. Estimating the burden of wasting during COVID-19 based on empirical experiences in the Sahel. Field Exchange 65, May 2021. p89. Available at: www.enonline.net/fex/65/burdenofwastingcovid19sahel

Conclusion

The impact of the COVID-19 pandemic on the number and demographics of people accessing nutrition services and what this means regarding the burden of different forms of malnutrition is complex to unravel and is only in the early days of being quantified. The pandemic has negatively impacted the provision of nutrition services in many contexts. There are a number of reasons for this, including supply chain disruptions, reduced capacity of health facilities and staff, and a lack of prioritisation of nutrition services following movement and resource restrictions. In many settings, there has been a reduction in the utilisation of nutrition services due to factors such as fear, the stigmatisation of healthcare staff, heavy police involvement in enforcing government response measures, and communities' reduced confidence in the quality of services as a result of the disruptions described.

The impact of the pandemic on the prevalence of malnutrition is difficult to quantify due to incomplete health information systems and restricted use of community-level nutrition assessments such as SMART surveys. Similarly, there is very little evidence as yet for differences in the age and sex profile of people accessing nutrition services over the pandemic, partially due to a lack of disaggregated data collected. However, in many settings, there is evidence of different patterns of uptake from rural-urban and socio-economic sub-groups emerging.

The pandemic has created many challenges. In doing so, it has spotlighted the strength and limitations of existing health, nutrition and information systems.

“ I think definitely COVID-19 has disrupted our routine and way of working and affected the flow of people in and out of our clinic. However, the pandemic has also opened people's eyes and shone a light on things overlooked before, now everyone agrees that we need to focus on and take care of our healthcare system. ”

Dr Bubacarr Susso, MRC Unit The Gambia at LSHTM

“ All the gains that have been made [in health information systems reporting] with COVID-19, I really hope we will be able to keep them, and do better. ”

Dr Babatunde Awokola, MRC Unit The Gambia at LSHTM

The pandemic has created a unique opportunity for change, with numerous innovations already implemented during the pandemic to improve the flow of data. As data (including disaggregated data) is continuously becoming available, in contexts with good baseline data, it may be possible to provide more insights into the impact of the pandemic on the number and demographics of people accessing nutrition services, and therefore in the near future a better understanding of inequalities that may be emerging or are being exacerbated.



DR S. AUSTIN

Appendix

Appendix I: List of participants and organisations represented

Regional perspectives

1. **Abdhalah Ziraba**, APHRC
2. **Anne-Céline Delinger**, World Food Programme, West Africa
3. **Caroline Hilari**, Independent Consultant (former Save the Children), South America
4. **Dr Bindi Borg**, UNICEF ROSA
5. **Joyce Murerwa**, Amref Health Africa
6. **Leticia Buluma**, Amref Health Africa
7. **Patricia Dominguez**, Nutrition Advisor (independent), Latin America and the Caribbean region
8. **Sylvia K. Muyingo**, APHRC

Country perspectives

1. **Akshaya Limal**, UNICEF/Indian Council of Medical Research, Department of Women and Child Development, Government of Odisha India
2. **Dr Rajesh Sinha**, NCoE for management of SAM, Lady Hardinge Medical College and associated Kalawati Saran Children's Hospital, India
3. **Dr Bubacarr Susso**, MRC Unit The Gambia at LSHTM
4. **Dr Babatunde Awokola**, MRC Unit The Gambia at LSHTM
5. **Lucy Lafferty**, Concern Worldwide (formerly in Niger Country Office)
6. **Robert Johnston**, UNICEF India



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