

COVID-19: IPC TECHNICAL GUIDANCE NOTE

GUIDANCE ON HOW TO BUILD ASSUMPTIONS FOR IPC ACUTE MALNUTRITION PROJECTIONS (CONSIDERING THE COVID-19 PANDEMIC)

This document intends to provide guidance to country IPC Technical Working Groups and/or Nutrition Clusters/Sectors on developing assumptions for IPC Acute Malnutrition (AMN)¹ projections in the context of the COVID-19 pandemic.

This guidance does not include specific assumptions (as assumptions will vary based on the context), but rather provides guiding questions that analysts should consider when developing assumptions for IPC AMN projections. This guidance should be used during the IPC AMN analyses as part of step 6: develop assumptions for future shocks and ongoing conditions. This complements global guidance on assessments and data collection in the context of COVID-19².

In general, acute malnutrition levels are expected to increase³ as a result of the COVID-19 pandemic, especially in nutritionally vulnerable/food insecure areas and where measures have been put in place to slow down the spread of the disease (e.g. physical distancing). Suspension of prevention programmes, such as immunisation campaigns and the reprioritisation of action in the health system to respond to the crisis, is likely to have a detrimental effect on health and nutrition outcomes in the population, especially in children and women. Furthermore, food access is likely to be severely affected, especially for the most vulnerable, who rely on daily incomes and wages. Learnings from the Ebola Virus Disease outbreak in Western Africa also suggested that non-Ebola morbidity and mortality increased after the onset of the outbreak, with reproductive, maternal, and child health services especially affected. The indirect impact on health services is thus likely to be substantial with the COVID-19 pandemic.

Although people with underlying conditions such as high blood pressure, heart problems, and diabetes are much more likely to develop a serious illness and/or die as a result of contracting the coronavirus, the impact of COVID-19 on children with acute malnutrition is less clear. However, given that malnourished children are more vulnerable to infectious diseases, and more likely to die from complications including pneumonia, they may be at increased risk of death and therefore populations with high levels of malnutrition prior to the pandemic are particularly at risk⁴.

The guiding questions in developing assumptions for IPC AMN projection analyses are outlined below using the IPC AMN analytical framework. Analysts should also consider other factors such as the setting (urban or rural), level of restriction (partial or full mobility restrictions), extent of the outbreak (nationwide or localised), status of the outbreak (whether the peak has been reached or not), etc.

- To date, the impact of the virus has been seen more in the urban areas as compared to rural settings (although the impact of the coronavirus is nationwide). Depending on the unit of analysis, the effect of the virus would vary.
- While social distancing measures are nationwide in some countries, others have imposed localised measures to curtail the spread of the coronavirus. Additionally, the intensity of these measures also varies from country to country – from strict mobility restrictions to partial restrictions – which might have varied impacts on the levels of acute malnutrition.
- While some countries may have passed the peak in their transmission, others have not. Additionally, it is unclear if there might be different waves of outbreaks once social distancing measures are relaxed or lifted.

It should be noted that this guidance note should be used in addition to the existing guidance on IPC AMN projections. For example, seasonality of diseases during the projection period should be taken into consideration before the impact of COVID-19 on the projections is considered.

¹Similar guidance has been developed for IPC AFI analyses

²<https://www.nutritioncluster.net/covid-19>

³<https://drive.google.com/file/d/1bKvCZiS1uOPniPONWFBm-fH-EwWtd1WU/view>

⁴<https://www.nutritioncluster.net/sites/nutritioncluster.com/files/2020-04/Joint%20statement%20on%20COVID%2019%20and%20Wasting.pdf>

After considering the local context in light of the different factors as appropriate for their contexts, analysts should identify the most likely scenario for the projection analysis. It may be also useful to produce more than one projection – one for the short-term (e.g. 1-3 months) and another for the long term (such as 3-6 months). It should be noted that whereas the IPC AMN projections are based on the **most likely scenario**, analysts may also develop other scenarios (i.e. worst case scenario, best case scenario, etc.) and inform decision-makers of the evolution of the situation. However, IPC classification maps should only be produced for the most likely scenario. It may also be useful to consider various modelling approaches that are available when predicting the acute malnutrition situation.

GUIDING QUESTIONS

IPC AMN analyses should analyse the likely impact of the virus pandemic on acute malnutrition. Analysts should consider the most likely scenario in the areas of analysis when developing their assumptions. The questions listed below can be considered.

Developing the scenario:

A) Start with the typical characteristics of the projection season. For example:

- a. What are the typical diseases for the season?
- b. What was the coverage of the health and nutrition programmes before the pandemic?
- c. What are the typical non-pandemic related shocks for the projected period? How are these likely to be affected by the pandemic? Are there specific programmes likely to be put in place in response to the pandemic – e.g. Has the protocol to treat malnutrition changed due to COVID-19, are there new measures in place?

B) Start from the macro level (the regional, national/sub-national level)

C) Proceed to the local level/unit of analysis. Identify if there is full or partial mobility restriction in the country/analysis areas. Consider how long the restrictions are likely to be in place. The population movement restrictions may be at the national level or localised and may vary in duration.

Immediate causes:

- What is the level of food consumption among children prior to the pandemic (MDD; MMF; MAD) disaggregated by unit of analysis, again ensuring risks in urban areas are analysed, even if limited data is available given the specific vulnerabilities in this pandemic? Are the food consumption practices mostly related to behaviour, food access, or a combination of both? What are the feeding practices specific to the season of projection, if any (e.g. in some communities, the MMF/ MAD is high during the harvest season)? How likely is the pandemic to affect food consumption among children, especially as the food security situation is expected to get worse? What is the impact of market closures on child food consumption if complementary foods are typically accessed through markets? Note that food consumption may be measured through other indirect indicators, such as mean number of food groups consumed, mean number of meals consumed, etc.
- What are the common childhood illnesses (e.g. based on routine data on diarrhoea, malaria, Acute Respiratory Infection (ARI), measles, etc.) that are typical for the projection period? Are there usual outbreaks during the projection period? How may these diseases and outbreaks be affected by the pandemic? It should be noted that in this context of COVID-19, a decrease in the reporting of cases may be linked to a decrease in the attendance at health facilities, because of concerns from carers who may reduce their use of health services due to concerns of contracting COVID-19, of the mobility restrictions, the closing down of health facilities, etc. Health systems may also be overwhelmed in some areas because of the number of COVID-19 cases.
- What are the typical programme activities to address diseases during the projection period and how are these responses affected by the pandemic? Are there new programmes put in place to mitigate the impact of the pandemic (for example, expanded admission criteria)? Are there specific trainings to health agents or caretakers regarding children's care and feeding practices in the context of COVID-19? What is the impact of COVID-19 on supply chain disruptions for the treatment of wasting?
- The increase in diseases and programme activities and their net impact on acute malnutrition should however be considered carefully – if health facilities and feeding programs are closed and community screening is stopped, more children may become or stay malnourished, but social distancing measures may very likely decrease diseases such as ARIs and thus reduce acute malnutrition prevalence. Therefore, the net effect could be positive rather than negative. Documenting surveillance data trends for common diseases and not just closure of facilities is key to comprehensive analysis.

Underlying causes:

- What is the typical food security situation for the projection season (taking into account the usual and unusual shocks such as locusts, drought, floods, etc.)? How is it affected by the pandemic? Is there an IPC or Cadre Harmonisé Acute Food Insecurity analysis in the country? Check if the impact of COVID-19 has been taken into account or if there is any major change before to refer to the results of the analysis for details.

- Are health services still functioning – are clinics still open? How would this affect the CMAM programme admissions? What is the coverage of routine vaccination programmes and immunisation campaigns, if any, prior to the pandemic? Have the vaccination campaigns been suspended? What is the level of routine immunisation after the pandemic compared to before? Note that the immunisation programme activities should be considered more as a proxy for overall functionality of the health system rather than as a measure of increased risk of specific disease that could possibly impact acute malnutrition.
- If there are movement restrictions, how it is likely to affect health-seeking behaviour and access to CMAM programmes?
- What are the caring and feeding practices prior to the pandemic, and how might they have been changed after? What is the coverage of activities to promote, protect, support and encourage optimal infant and young child feeding (IYCF) practices? How are they likely to be affected by the pandemic?
- What is the typical water and sanitation situation for the projection period? How is it likely to be affected by the pandemic? For example, the access to a sufficient quantity of water.

Basic causes:

- What is the mortality level? Although COVID-19 related mortality is high among the elderly and people with underlying diseases, this may in turn negatively affect child nutrition⁵.
- What are usual/normal shocks in the projection period?
- What is the likely impact of the pandemic on the different capitals⁶ such as social, financial and human resources, and natural capitals? What were the HIV & TB prevalence before the pandemic among adults (as these may directly and negatively affect adults and indirectly children)?
- Effects on programme delivery: will restrictions affect safety net programmes or cash programmes, food distributions (movement restrictions and increased risk of infection created by large gatherings of people), supply chains? Are there options/plans for reprogramming assistance, taking into account the mobility restrictions – e.g. monthly ration instead of weekly distributions?

Data systems and IPC Processes:

As per the IPC Technical Manual Version 3.0, in the absence of current data, the following evidence can be used to conduct an IPC AMN analysis:

- 1) Recent data (data collected within the last 6 months for bimodal areas and 12 months for unimodal); or
- 2) Historical data (2 estimates from the same season of the analysis in the last 5 years); or
- 3) Using the protocols for areas with limited humanitarian access.

Given that the situation is changing rapidly, it is important for the IPC TWGs to provide situation updates whenever needed. The following data and information systems may be used to monitor the situation and update the IPC AMN classifications:

- The GTAM guidelines for nutrition information management, monitoring and surveillance in the context of COVID-19⁷;
- Health Management Information Systems;
- The IPC Acute Food Insecurity classification;
- CMAM admission data – it would be useful to look at the CMAM admission trends between the current analysis period and that of the same period of the previous year (and preferably 2-3 years in the past). It should be noted that admission data are affected by many factors such as supply issues, reporting, availability, access, etc., and that a lower admission does not necessarily mean improvement in the situation.

Additionally,

- Countries should also explore the use of mVAM in collecting data on contributing factors, such as food consumption among children.
- It may also be useful to explore ways in which to gather the MUAC data collected by mothers (i.e. under the mother/family MUAC approach). Although this is currently used for screening and referral in some settings, it may be of use in looking at the trends.
- If possible, the country should strive to have a long validity period for projection analysis (up to 6 months if possible) that can be updated frequently when the situation changes (with set triggers defined at the country level). Note that projections should be updated whenever there is a change in the situation.

⁵<https://www.en-net.org/question/3890.aspx>

⁶<https://unsdg.un.org/resources/policy-brief-impact-covid-19-children>

⁷May also be used as evidence under the areas with limited access