SAVING LIVES
CHANGING LIVES

Good nutrition for vulnerable urban populations in the context of COVID-19: WFP Interim Guidance

WFP
World Food Programme

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NOTE

The scope and scale of the COVID-19 pandemic is unprecedented. Nutritionally vulnerable groups are impacted in numerous ways and this guidance begins to unpack what some of these effects are and might be in the future. The guidance should be considered as an interim document to be enhanced as WFP learns more about potential programme adaptations to support good nutrition across different systems in urban areas.

Introduction and Purpose

Coronavirus disease 2019 (COVID-19) has evolved into a global pandemic, and as this note is published, over 15 million individuals have been infected, with over 633,000 deaths globally[1]. The COVID-19 pandemic has highlighted the vulnerabilities of food systems, including several direct and indirect impacts that go beyond the immediate health risks, as well as challenges that many urban populations face in accessing healthy and nutritious diets and ensuring quality nutrition for all family members.

This note describes the pillars and activities that guide WFP Nutrition engagement to support vulnerable urban populations, amid the unique challenges faced in the COVID-19 outbreak and ongoing response of national governments. The note provides a roadmap of key considerations for nutrition analysis and actions across the Health, Food, and Social Protection Systems. By drawing on country experiences, it is intended to be applicable to all WFP regions, but will require adaptation related to the local context to guide concrete actions.

Vulnerability Characteristics of the Urban Context

As the world population has increased, so too has urbanization, with over 55 percent of the global population now residing in urban areas (World Bank)[2]. Across geographies, urban regions exhibit tremendous diversity, but share several defining characteristics. They are highly complex and display a high degree of local and global connectivity and inter-dependence, including to neighbouring rural areas[3]. As urban settings are characterized by a shift from agricultural to non-agricultural livelihoods, rural-urban linkages are a pillar of urban food systems.

While urbanization provides opportunities for improved health and nutrition through increased market availability of diverse foods, the complexity of urban food systems creates unprecedented challenges and vulnerabilities. Crises in urban areas, such as supply chain disruptions and price shocks, disproportionally affect poor populations and those with prior vulnerabilities, as the public services and informal support systems on which they depend may be disrupted. Table 1 presents some of the characteristics of urban areas that increase vulnerabilities to shocks such as COVID-19.

Urban settings are often characterized by the so-called nutrition transition[4], causing an increase in the prevalence of overweight and obesity. Yet this increase often accompanies, rather than replaces, persistent undernutrition, resulting in the double-burden of malnutrition (DBM). One-third of the world's stunted children now live in urban areas, the highest concentration being in the poorest areas. Meanwhile overweight, once considered a problem in high-income countries, is on the rise in low- and middle-income countries (LMICs), particularly in urban areas. The abundant availability of unhealthy, processed foods that are high in sugar, saturated fat and/or salt in urban areas leads to limited micronutrient intake creating a triple-burden of malnutrition[5].

Furthermore, rapid rural-to-urban migration has resulted in overcrowding of informal settlements in slum conditions[6], so called "hidden cities," because they are often not accounted for in official statistics (SOFI 2019). Populations in such informal settlements – estimated at over 800 million globally and constituting 60 percent of the urban population in sub-Saharan Africa[7] – are overlooked by formal Social Protection programmes and live in conditions that exacerbate all forms of malnutrition and disease.

1. These figures continue to rise on a daily basis. Consult the Johns Hopkins coronavirus tracker for up to date figures https://coronavirus.jhu.edu/map.html
2. https://www.worldbank.org/en/topic/urbandevelopment/overview#1
3. The human face of urban food systems https://www.ifpri.org/blog/human-face-urban-food-systems
4. Nutrition transition has emerged as an important concept in health research used to describe shifts in dietary consumption and energy expenditure that coincide with economic, demographic and epidemiological changes at a population level. Singh et al, BMJ June 2020, Mapping the global evidence on nutrition transition: a scoping review protocol https://pubmed.ncbi.nlm.nih.gov/32513879/
5. Triple burden of malnutrition (TBM) refers to the coexistence of undernutrition, overweight and obesity and micronutrient deficiencies
6. UN-HABITAT defines a slum as a group of individuals living under the same roof in an urban area who lack one or more of the following: 1. Durable housing of a permanent nature that protects against extreme climate conditions. 2. Sufficient living space 3. Easy access to safe water 4. Access to adequate sanitation 5. Security of tenure that prevents forced evictions
7. https://unhabitat.org/sites/default/files/2020/04/final_un-habitat_covid-19_response_plan.pdf

Table 1: Select Urban Characteristics that Increase Vulnerabilities in the COVID-19 Crisis

1. **High population density** in urban areas reduces the ability of residents to practice social distancing and increased hygiene requirements put a strain on clean water and sanitation infrastructure.
2. **Informality of settlements,** often with crowded and substandard housing, and homelessness reduce access to services. Unregistered migrants, refugees, and displaced peoples, in particular, lack access to formal and informal social protection systems.
3. **Informal livelihoods**, such as reliance on day labour and a cash economy, limited urban agriculture with low resilience to disruption and lack of social safety nets.
4. **High mobility** within urban centres, between urban and rural regions, and international migration. Movement restrictions and border closures disrupt livelihood opportunities.

Nutritional Vulnerabilities in the context of COVID-19

The rapid spread of COVID-19 and the measures taken to curb the pandemic, have had unprecedented consequences for the livelihoods, food security, and nutrition of the most vulnerable (Table 2). The potential impact is greater in urban settings than in rural areas, where crowded and informal urban settlements, population density, and inadequate water and housing infrastructure facilitate rapid viral transmission[8,9]. Furthermore, the principles advocated by health authorities for reducing transmission - social distancing, handwashing, and protective equipment - are difficult or impossible to follow in such settings. Health systems are being confronted with rapidly increasing demand generated by the COVID-19 outbreak. Disruption of drug supply chains, stigma and fear of attending health facilities, limitations on movement and physical distancing protocols, have compounded and compromised the ability to maintain delivery of essential health services, such as nutrition, maternal and newborn health, sexual reproductive health, mental health and noncommunicable and communicable disease (e.g. HIV, TB and immunization) prevention and management.

COVID-19 and its second-order effects interact with nutritional status in a variety of ways. Overweight and obesity, hypertension, Cardiovascular Disease (CVD), diabetes, and poor nutritional status all weaken the immune system and increase susceptibility to COVID-19 infection, resulting in more adverse outcomes[10]. These conditions are more prevalent in urban areas, although Non-Communicable Diseases (NCDs) may be poorly documented or undiagnosed in informal settlements. The disease is seen to be more severe in those over the age of 60 – also a nutritionally vulnerable group. The COVID-19 crisis poses serious threats to vulnerable populations in terms of lost livelihoods, drying up of income and reduced capacity to meet basic needs all hindered by lockdowns and slowdowns in employment and high levels of job loss. The nature of urban livelihoods brings residents of informal settlements into close contact with others and lockdown measures disrupt livelihoods in the low wage and informal economies, such as those of domestic workers, day labourers, drivers, and food vendors.

Beyond the immediate health impacts and the loss of urban livelihoods, the urban food system[11], with its urban-rural interdependence, is specifically impacted by the COVID-19 crisis. Business closures, mobility restrictions, and lack of available labour may affect the rural-urban supply chains for healthy and nutritious foods. Food environments, where consumers interact with suppliers, will be affected if retail outlets, informal markets, street food vendors, and other points of sale are mandated to close as a mitigation measure.

8. www.socialscienceinaction.org
9. More than 400 million people in urban areas in sub-Saharan Africa, Central and South Asia lack access to handwashing, heightening the risk of the disease spreading rapidly in heavily populated communities. https://www.gavi.org/vaccineswork/how-do-stop-spread-pandemic-slum.
10. See the technical note and guidance "Overweight and obesity in the context of COVID-19" WFP July 2020 for more detail.
11. The High Level Panel of Experts on Food Security and Nutrition of the Committee on World Food Security, report #15 June 2020, "Food security and nutrition: building a global narrative towards 2030", describes the complex interplay between food systems and other sectors and systems. The HLPE report 2017: Nutrition and Food Systems describes the difference between various food systems (traditional/mixed/modern).
    All HLPE reports are available at www.fao.org/cfs/cfs-hlpe

Food purchasing behaviours are significantly impacted by the crisis. Poor populations living in informal settlements or slums typically rely on frequent purchases of small portions of food, as they have neither the economic means to buy in bulk nor the capacity to store perishable nutritious foods. With movement restrictions and store closures, patterns will likely shift even further to cheaper unhealthy, processed foods that are high in sugar, saturated fat and/or salt with a longer shelf life.

The affordability of healthy and nutritious food will also decrease. Healthy and nutritious foods, especially fruits, vegetables and animal products, are more expensive than nutrient-poor alternatives even before the pandemic. As loss of livelihoods and strained supply chains drive up the costs of nutritious foods, urban populations may turn to less diverse diets with the proportion of nutritious foods deceasing at the expense of unhealthy, processed, convenience foods.

Table 2: Select Urban Populations with Increased Vulnerabilities in the COVID-19 Crisis

1. **People suffering from cardio-metabolic disorders and NCDs.** Rates of overweight, obesity, hypertension, CVD, and diabetes are higher in urban areas and may increase the risk of poor outcomes from COVID-19.
2. **People with compromised immune systems;** including people living with HIV and TB. HIV prevalence is often higher in urban areas (girls in towns and cities in southern Africa are markedly more likely to be living with HIV)[12] and overcrowded and poor-quality housing are associated with TB.
3. **Socially marginalized and excluded groups.** The elderly, persons with disabilities: physical, sensory, intellectual and mental[13], and those suffering other mental health impacts from the crisis are particularly vulnerable.
4. **Street children and Orphans and Vulnerable Children (OVC)** lack consistent access to sanitation and health. As schools are closed, this cuts off a vital social protection mechanism.

Support to Urban Nutrition Across Multiple Systems

Reduced access to essential health services, unemployment, supply chains stresses, movement restrictions, decreased affordability, and changes in food consumption behaviours resulting from COVID-19 will all impact the ability to access healthy diets, and the nutrition situation for the most vulnerable urban poor. Experience is showing that the disease itself seems to affect men more severely than women. However, women will disproportionally feel the negative impacts of COVID-19 on their lives and livelihoods with consequent indirect health impacts on the entire household. The challenge for WFP is thus to ensure that urban households have access to adequate, safe, healthy, nutritious and sustainable diets that meet the daily nutritional needs of each household member, despite the unprecedented conditions of the pandemic.

Addressing these challenges to improve nutrition requires an integrated approach across **three key and interrelated systems:** 1) the Health System; 2) the Food System; 3) the Social Protection System.

12. 2014 UNAIDS city report
13. Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others. UN Disability Inclusion Strategy 2019 https://www.un.org/en/content/disabilitystrategy/

The Health System

The COVID-19 response is negatively impacting the ability of the Health System to support the nutritional well-being of vulnerable groups, especially pregnant women and girls, infants and young children, persons living with NCDs and HIV/TB, persons with disabilities and the elderly, among others. This is especially true given the potential of a rapid rise in COVID-19 cases to overburden already resource-constrained health systems. WFP programmes can adopt and support a variety of measures across the health system, to ensure nutrition-related services continue to be delivered and are accessible to the most vulnerable, without further overburdening the already compromised health system.

The following are recommended pillars and activities for analysis and action.

Pillars of Analysis in the Health System to Support Nutrition

- Complete a situational review of secondary data on nutritional status and dietary intake among different target groups in urban areas, starting with DHS type data, Health Information & Monitoring Systems (HIMS) data and any specific sources in the context. Identify marginalised groups and the most vulnerable, particularly those who are unable to access care through the health system.
- Improve data collection and analysis (disaggregated by age, gender, disability) to assess the COVID-19 impact on nutrition status of the most vulnerable.
- Integrate nutrition indicators into the national HIMS system, for example for maternal and child services, HIV/TB treatment services, and services for people with NCDs.
- Whenever relevant, explore the use of SCOPE-CODA for nutrition monitoring.
- Whenever relevant and appropriate, include anthropometric (height and weight) data and nutrition indicators relevant for the most vulnerable population in all health, food and nutrition rapid assessments.
- Advocate for the collection of anthropometric data and metabolic parameters (glucose and insulin levels) for those admitted into health care facilities and those who have tested positive for COVID-19.

Actions in the Health System to Support Nutrition

- Adapt nutrition assessment methods based on the urban context and individual differences, supported by training of staff/volunteers and whenever relevant mothers or caregivers to facilitate community and at-home nutrition monitoring. Support the availability and use of personal protective equipment (PPE) for staff, volunteers and the most vulnerable.
- Leverage existing health facility and community-based platforms (specific prevention and treatment malnutrition programmes, HIV/TB treatment, vaccination) and integrate Social Behaviour Change Communication (SBCC) approaches in order to facilitate individuals, households, groups, and communities to adopt and sustain optimal health and nutrition related practices.
- Engage communities in order to address stigma, fear, rumours, misinformation, discrimination and maintain trust with health care providers. Implement targeted SBCC for health promotion and care seeking, and preventive practices including dietary diversity, the importance of continued breastfeeding during COVID-19 exposure, and taboos or harmful myths around unproven treatments or food restrictions. Ensure that health staff and community health volunteers are trained to support mothers to breastfeed their babies during the pandemic. Use a variety of methods and tools accessible to and understandable by all population groups.
- Strengthen partnership and lines of work with local authorities, NGO's, civil society, private sector and other service providers. Consider the multi-layer and breadth of the decision-making process of municipalities including citizen participation. Leverage existing urban service provision networks and on-going programmes when possible.
- Collaborate with local authorities to advocate for and support actions towards ensuring environmental hygiene services and clean water are available, as these are critical inputs to support good nutrition outcomes.
- For malnutrition treatment and prevention activities, reduce the crowding and frequency of health visits by exploring differentiated service models, including home visits, MUAC screening by mothers and other caregivers, use strong city networks involving community leaders/volunteers/peer groups to reduce burden on health staff for suitable activities, multi-month dispensing of SNF, use of digital devise/smartphone, such as apps or video calls for consultation, assessment, counselling and SBCC.

- Support policy initiatives to enforce compliance with The International Code of Marketing of Breast Milk Substitutes and restrictions on the marketing of unhealthy, nutrient-poor, complementary foods.
- Strengthen and leverage the linkages between the health system and other existing urban infrastructure and services, such as Social Protection System and Education System (i.e. school-based platforms), youth clubs to reach the most vulnerable populations including adolescents and PLHIV and their families for referrals, SBCC around nutrition and COVID-19, nutrition-sensitive in-kind/cash-based programmes.

The Food System

The characteristics of urban food systems - diverse points of sale, supply chains reliant on functioning logistical infrastructure and cold chains, complex rural-urban linkages, high availability of unhealthy processed and low-cost foods – increase vulnerabilities to the immediate and long- term effects of the COVID-19 pandemic. Movement restrictions, border closures and stay-at-home orders may disrupt the supply chain by preventing mobility of farm workers and impeding food transport and the operations of food processors, thus limiting the availability of fresh and nutritious foods in urban markets. Market closures and behaviour changes such as less frequent shopping and bulk purchasing affect the personal food environment and reduce opportunities for obtaining diverse diets. Longer home storage times for fresh products especially if non-refrigerated and exposed to heat, light and air, will reduce their nutrient content. Storage concerns and price increases precipitate a shift in buying behaviour toward processed foods with a longer shelf life, which are often lower in nutritional quality and high in saturated fat, sugar and/or salt.

WFP can implement a variety of Analysis and Action measures across the food system to support improved nutrition in the midst of the crisis response. Additionally, improved City Region Food Systems, an approach which recognizes the linkages between urban, peri-urban and rural areas, will help to achieve better economic, social and environmental conditions in both urban and nearby rural areas (FAO)[14].

Pillars of Analysis in the Food System to Support Nutrition

- WFP's Fill the Nutrient Gap (FNG) can provide vital baseline information about the Food System and the barriers to obtaining good nutrition through healthy diets. In urban localities where an FNG analysis has been completed, the existing analysis should be consulted to understand the pre-crisis context.
- FNG analyses, where available, and VAM monitoring can identify potential upstream impacts of the crisis on nutritious food availability, including disruptions to supply chains for nutrient-dense foods (animal-source foods, fresh fruits and vegetables, fortified foods), closures of retail outlets, shutting down vendors, etc. The supply chains of other nutritious foods, such as fortified rice, flours, oils, and other staples, and Specialized Nutritious Foods (SNFs), should also be characterized.
- Assessments to characterize the post-crisis personal food environments. This may include changes to consumer purchasing behaviours in relation to beliefs around health, nutrition and disease, and other socio-cultural factors.
- Data on price changes of staple and nutrient-dense foods to be gathered by country level authorities or VAM units. Income shock analysis will help to understand effects on overall purchases and not only food purchases and how this impacts nutrition.
- Monitoring and Evaluation should be made nutrition-sensitive, including the possibility of using mVAM for nutrition indicators. Surveys and studies can track and document adaptations including lessons learned and issues raised to add to internal and global learning.

Actions in the Food System to Support Nutrition

- Use data on price increases additional to FNG analysis, identify changes in non-affordability of nutritious diets and prioritize specific actions to reduce barriers to economic access.
- With local authorities and private sector, identify opportunities to leverage improved post-harvest handling and storage to increase the availability and food safety of healthy and nutritious foods during the pandemic.

14. A Vision for City Region Food Systems http://www.fao.org/3/a-i4789e.pdf

- Act with key actors in the food processing and retail sectors, including small and medium enterprises (SMEs) to improve supply and access to nutritious foods on the market to address nutrition needs, barriers and to shape the market and overall system.
- Strengthen rural-urban supply chains to link to peri-urban and rural farmers coops, retail groups, etc to ensure minimal interruptions to the supply of nutritious foods.
- Work with other actors and stakeholders, including national SUN Business Networks (SBN) and other comparable platforms to support: expanded portfolio of nutritious foods produced by local businesses, including local fortification of staple foods; product reformulation (micronutrient fortification; reducing sugar, saturated fat and/or salt); disseminating evidence-based nutrition information; influencing the retail food environment by placing restrictions on marketing of unhealthy foods, high in sugar, saturated fat and/or salt and sugar-sweetened beverages (SSB); and empowering consumers to make informed choices through SBCC and other retail strategies.
- When locally fortified foods are unavailable, work with governments and key stakeholders to facilitate access to and uptake of imported fortified staple foods and SNFs by those at risk for micronutrient deficiencies.
- Leverage cash-based interventions to support the demand for diversified diets and include secondary nutrition outcomes of cash-based transfers (CBT). CBT modalities can also include vouchers for nutritious foods such as fresh foods, animal-source foods, and fortified foods for the general population and specific target groups. Ensure that the transfer value is informed by analyses such as the Cost of the Diet, to maximize the contribution to nutritious diets. Include measures to support access to fresh and fortified nutritious foods on the market, such as the inclusion of SBCC to encourage the consumption of such foods.

The Social Protection System

While many people infected by COVID-19 will be unable to earn a living, the socio-economic fallout from the pandemic and subsequent lockdowns is predicted to be far more devastating than the disease itself, especially in urban areas (WFP). Movement restrictions, immigration bans, closure of public transportation infrastructure, stay-at-home orders, and mandated business closures are potentially catastrophic to the livelihoods of the most vulnerable, affecting their capacity to earn and to access healthy and nutritious foods.

Furthermore, the disease and the mitigation measures exacerbate pre-existing inequalities including for populations that are unregistered, have low access to services, or have pre-existing diseases or overweight. WFP analysis and action can support the capacity of local governments to provide Social Protection and safety net mechanisms, especially CBT and food assistance, to the most vulnerable populations, informal sector workers and those unregistered or unaccounted for in existing programmes.

Pillars of Analysis in the Social Protection System to Support Nutrition

- Draw on existing FNG Analysis if available, as well as VAM data to assess the changes in economic access to nutritious foods, including price fluctuations and incomes, i.e. livelihoods, and social protection systems.
- Analysis should examine the relative price changes of nutritious foods, staple foods and unhealthy, processed foods to ensure that the analysis is nutrition-sensitive.
- Context-specific tools, such as the Cost of the Diet software, can be used to model changes in economic access to healthy diets, especially in contexts where an FNG analysis has been previously conducted.
- Market analysis to inform the value, modality, size and frequency of the transfer for current social protection programmes and any scale-up.
- Nutrition-sensitive M&E should be pursued, including the possibility of using mVAM for nutrition indicators.
- Surveys and studies related to impact of COVID-19 on access and affordability of a nutritious diet as well as on social and economic barriers to access to nutrition and health services. This should include identification of any newly vulnerable populations such as workers in the informal sector.
- Use results of the analyses to inform adaptations in targeting and target groups for social protection transfers and identify risk of exclusion in targeting. Targeting decisions should consider how to make the best use of limited resources compared to the needs, to achieve the greatest impact.

Actions in the Social Protection System to Support Nutrition

- CBT and commodity specific vouchers to be prioritized and made nutrition-sensitive[15]. Transfer values based on analysis of affordability of nutritious diets and paired with nutrition SBCC, outreach and strengthened availability at points of sale will be more effective to ensure access to nutritious foods. "Soft" conditionalities such as participating in nutrition-related activities may be considered.
- CBT to be accompanied by SBCC to discourage recipients from purchasing foods that do not promote good nutrition and health.
- Digital platforms, including mobiles phones to be prioritised for the CBT modality if possible.
- Partner with the local Government, World Bank and other relevant bodies to ensure agreement on the social protection instrument and to ensure that the most vulnerable are reached and no-one is left behind.
- Strengthen food-based social safety net schemes by including fortified staple foods, high-value proteins such as pulses and fortified complementary foods for children age 6 to 23 months.
- Consider multi-sectoral partnerships and linkages (e.g. agriculture or WASH) to (1) see how enhancing the nutrition-sensitive social protection could support those policies (as a conditionality for example) and (2) use as a starting point to identify adjustments in school feeding programmes.
- In the context of school closures, work with governments to support alternative school feeding delivery arrangements that link with existing Social Protection programmes, including CBT or take-home rations. WFP should aim to ensure that take-home rations promote good nutrition and do not include foods high in fat, salt and sugar.
- Advocate for establishing inclusive nutrition social protection schemes, that address the needs of the most vulnerable and marginalised population, including families with children and PLW, persons with disabilities as well as PLHIV, TB clients and their families. The use of multi-purpose CBT should be considered to address income inequalities and access to a nutritious diet, but also to access health or other services (e.g. transport costs).
- Strengthen SBCC as a complementary service around Social Protection. Support the formative research, the development of key communication and information materials, planning for community dialogues and identification of key nutrition-positive behaviours around the use of transfers. Include gender sensitive financial management capacity building among SBCC and training sessions received by recipients of cash assistance in order to support them to achieve their needs.
- Contribute to discussions and decision-making on social protection programming from a nutrition perspective to enhance multisector stakeholder participation in design and implementation arrangements.

SBCC supporting programme objectives across all systems

SBCC strategies are essential as complementary interventions supporting the achievement of programmatic objectives.

Targeted SBCC strategies support individuals, households, groups, and communities to adopt and sustain healthy behaviours and empower consumers to make informed choices resulting in healthier diets.

Across the systems, SBCC can inform and engage populations in order to claim their rights to access services and entitlements.

SBCC strategies can influence food purchase decisions and household consumption and food sharing and reinforce nutrition labelling schemes and other promotional activities enabling healthy food choices by nutritionally vulnerable populations.

Formative research (including consumer insights research) is necessary to define specific target groups and coverage, identify preferred sources of information, trusted channels (including telecommunications and social media platforms), define behavioural objectives and develop targeted SBCC strategies, messages and materials.

15. See WFP Social Protection and Nutrition Note (June 2020). https://newgo.wfp.org/documents/social-protection-and-nutrition-at-a-glance

Programme adaptations: some country examples

This document provides some practical recommendations for nutrition support to the most nutritionally vulnerable populations in urban areas, which could help to react to, mitigate and prevent some of the nutritionally relevant effects of the COVID-19 pandemic.

- The different pillars of analysis and actions across the systems are likely to be refined and enhanced based on the progress of the pandemic and the learning from the different programme adaptations in WFP countries. A number of countries are implementing programmes in urban areas under the COVID-19 planning. These planned or on-going country level processes and experiences will be developed further as they progress and added to this document to enable shared learning across WFP. Examples include:
- Eswatini which is implementing an urban safety net with CBT for PLHIV and OVC.
- In Sudan, WFP initiated preparations for the scale-up of emergency nutrition response for treatment of moderate acute malnutrition (MAM) among children under five as well as pregnant and lactating women. The initial scale-up was planned for Khartoum (approximately 30 health centres).
- In Uganda, WFP is supporting government in offering a protective ration of cereals and beans to all vulnerable individuals including PLHIV, in bigger urban settings.
- Several countries are supporting CBT and opportunities to be nutrition-sensitive can be explored:
    - In southern Africa region WFP's scale-up includes the introduction of large-scale support with CBT for millions of now destitute people in urban areas. Helping to strengthen and expand national social protection systems is a central component.
    - In Colombia, the crisis is particularly affecting the livelihoods of the urban poor, including migrants with precarious, often informal, sources of income. WFPs response includes expanding its operational area to cities such as Bogotá, Cali and Palmira, liaising with the Mayor's Office for beneficiary lists for deduplication and targeting.

Photo credits:

Cover page -WFP/Alice Rahmoun – Republic of Congo, Makélékélé (Brazzaville), 13 May 2020

WFP in Republic of Congo launched food assistance by cash transfers in urban areas (5 boroughs of Brazzaville) in May 2020.

In the Photo (from right to left): Berthe (61) and her younger sister Rephane Bénédice in front of the grocery store when she can buy food thanks to the WFP urban cash transfers.

"My life is difficult. My husband is dead, so I was disregarded (by the community). I'm fighting to feed my children. So I want to thanks WFP for its assistance" says Berthe.

Page 10 - WFP/Alice Rahmoun - a beneficiary waiting for her turn to buy some groceries with WFP urban cash transfers .