Continuing Community based care of children with Acute Malnutrition during COVID-19 Outbreak

This note is conceptualized by Development Partners working in the field of Integrated Management of Severe Acute Malnutrition (IM-SAM) in India

17th June 2020

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Background

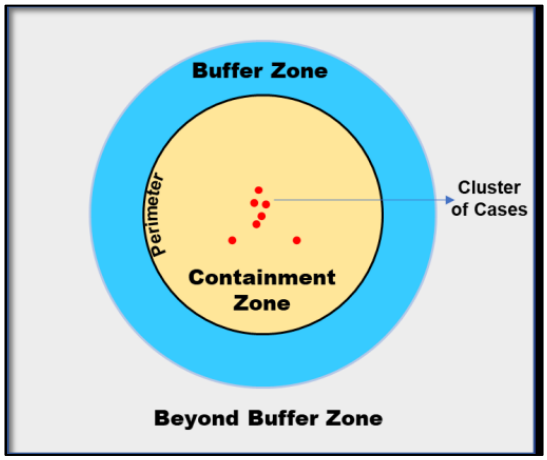
Humanitarian needs provoked by the COVID-19 pandemic are enormous. Health-care systems are overwhelmed, and this severely constrains their ability to provide optimal care to children; especially those who are malnourished. Although children are currently less likely to die directly from COVID-19, the potential disruptions of health systems and decreased access to food security and nutrition can cause significant increase in child mortality. According to the recent estimates[1], with the best possible scenario and subsequent changes in coverage of essential health and nutrition services due to COVID-19, India could see an additional sixty thousand child deaths (it can be around three lakhs under the worst possible scenario) in next six months.

Regardless of the level of the mobility restriction across different states, action is urgently needed to ensure the continuity of services for the management of child wasting. This guidance note heavily draws from different global and national guidance documents[2,3,4] and will be adjusted based on updated guidance released by Government of India – Ministry of Home Affairs regarding lockdown policies, Ministry of Health and Family Welfare and Ministry of Women and Child Development regarding provision of nutrition services related to growth monitoring and promotion, home visits, counseling, and other relevant service provisions in the context of COVID-19.

Current Situation and Guidelines

As per MHA order dated 15th April 2020[5], all health services are expected to remain functional, even during the lockdown stage. In addition, Anganwadi centers are expected to operate for distribution of food items and nutrition once in 15 days at the doorstep of beneficiaries.

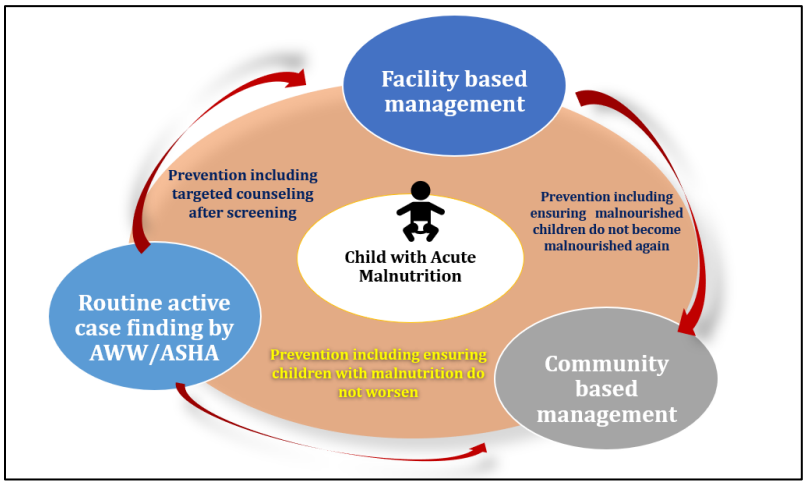
Districts/Sub-Division/Municipal Corporation/Ward or any other appropriate administrative units are categorized into **Green Zone** (No active COVID-19 cases) or **Red & Orange Zone** (Active COVID-19 cases). Areas where COVID-19 cases are reported have been classified as **Containment zone** and surrounding areas with risk for COVID-19 spread are termed as **buffer zone.** For the purpose of this guidance, services have been bifurcated into 1) Containment and Buffer Zone and 2) Areas beyond Buffer Zone and Green Zone.



[1] https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(20)30239-4/fulltext
[2] https://www.ennonline.net/attachments/3360/Wasting-Programming-COVID19-Brief-1-(Draft)_27-March_v1_For-distribution.pdf
[3] Technical cum Operational Guidance, Health, Nutrition and WASH in COVID-19; Save the Children India, Version 1 (6th April 2020)
[4] https://www.ennonline.net/attachments/3414/Nutrition-Information-COVID19-Brief-1_0_14-April.pdf
[5] https://www.mha.gov.in/sites/default/files/MHA%20order%20dt%2015.04.2020%2C%20with%20Revised%20Consolidated%20Guidelines_compressed%20%283%29.pdf

It is pertinent that during the COVID-19 outbreak, essential life-saving nutrition services are continued. MoHFW (vide letter dated 14th April 2020) released a 'Guidance Note'[6] on continuation of essential services including guidance related to the management of children with SAM with medical complications. Further, MoHFW has also released a Guidance Note on the Provision of Reproductive, Maternal, Newborn, Child, Adolescent Health Plus Nutrition (RMNCAH+N) services during and post COVID 19 pandemic.[7]

Management of Wasting – the three Component



A comprehensive approach to manage children with Acute Malnutrition puts the child with SAM at the center and envisages the following key components:

1. Active Case Finding
2. Facility based care for children with SAM with medical complications
3. Community based care for children with SAM without medical complications

1. Active Case Finding:

While recognizing the risk of COVID-19 being transmitted during anthropometric measurements and other forms of data collection, active case finding should continue where possible while exploring innovative approaches to collect vital information (detailed later in the document) while respecting IPC measures and provide adequate and timely information for response planning. This may be undertaken during fortnightly home visits of AWWs or ASHAs when THR is being distributed or during outreach sessions – such as Village Health Sanitation Nutrition Days (VHSNDs), or Growth Monitoring and Promotion (GMP) sessions when those are still initiated.

Any child identified with danger signs or severe medical complications (as per IMNCI protocols) would be referred to an appropriate facility for medical management. Many frontline workers in different states have already been oriented on IMNCI protocols and danger signs.

The options of tools available for growth monitoring and promotion are highlighted in the table below, along with the advantages and disadvantages of use in times of COVID (Table 1). While acknowledging the position of Government of India Ministry of Women and Child Development regarding the involvement of Anganwadi Workers in growth monitoring through weight and height assessments only, this interim guidance recognizes the challenges in the field to safely conduct weight and height assessment while keeping necessary social distancing measures, and thus, discusses the alternative approach of using

[6] https://www.mohfw.gov.in/pdf/EssentialservicesduringCOVID19updated0411201.pdf
[7] https://www.mohfw.gov.in/pdf/GuidanceNoteonProvisionofessentialRMNCAHNServices24052020.pdf

Family MUAC – given the Global guidance for the same and if Government decides to explore alternative method for assessment.

Table 1: Advantage and disadvantage of growth monitoring of children using the available tools in COVID context

No	Growth Monitoring tool	Advantages	Disadvantages
1	Height measurement scale (Stadiometer / Infantometer)	• Allows the identification of SAM as per WFH criteria • Would identify majority of the children with SAM • Aligned with guidance under POSHAN Abhiyaan pre-COVID • Made up of plastic / metal – disinfection possible • Health workers already trained on height measurement • Includes infants under six months	• Risk of COVID transmission high; unless proper disinfection practices of measurement scale are followed between two measurements – difficult to ensure compliance • Difficult to carry while visiting homes
2	Weight measurement scale	• Allows identification of SAM as per WFH criteria • Would identify children with growth faltering • Aligned with guidance under POSHAN Abhiyaan pre-COVID • Bathroom scale could allow measuring weight with no touch • Health workers already trained on weight measurements • Includes infants under six months	• Salter scale use would have high risk of COVID transmission unless proper disinfection practices are followed – difficult to ensure compliance • Disinfection of the sling bag (comes with Salter weighing scale) between two consecutive measurements, or one sling bag per child - is unfeasible. • Although bulky, can be carried to home
3	MUAC tape	• Simple tool • Easy to interpret by colour • Same cut-off for all 6-59 months children • Can be adapted for use by family under supervision of frontline worker • Identifies the youngest and most at risk • Can be easily carried and used during home visit	• Not suitable for infants below 6 months • Needs disinfection between measurements or one MUAC tape per family • Frequent use of alcohol for disinfection may damage the tape easily. • If used by Family – then needs frontline worker time and adequate supplies • Not part of existing POSHAN Abhiyaan

No	Growth Monitoring tool	Advantages	Disadvantages
			• Requires pre-training of frontline workers and families/caregivers
4	Assessment of Edema	• Easy to perform, even during home visit • Can be performed by family under guidance of frontline worker	• Implies touch assessment and risk of infection • Can be easily missed during assessment
5	Assessment of Visible Severe Wasting	• Easy to perform during home visit • Is completely touch free • Part of IMNCI recommendations • Includes infants under six months	• Subjective criteria that still requires confirmation with anthropometric measurements • Concurrence with other criteria not tested
6	Structured questionnaire - to caretaker/mother regarding perception of child's worsening condition	• Rough guide • Is completely touch-free • Could be conducted remotely • Includes infants under six months	• Subjective criteria that still requires confirmation with anthropometric measurements • Reliability untested • Will need confirmation

Identification of children with Acute malnutrition can be done at the time of home visit or during outreach session.

Home visits

In containment zones and buffer zones, during home visits, AWWs or ASHAs should ask specific questions regarding the status of the child and progress over the last month. They could also assess the child for signs of visible severe wasting and other danger signs as per IMNCI package. A guidance on identification of children with SAM during active case finding is detailed in annexure 1.

In case, the responses indicate worsening of nutritional status, the ANM should be contacted and child may be referred for medical assessment. ASHA workers to counsel families to take the SAM child to NRCs for treatment. Child would be discharged immediately after treatment of complications and return of appetite or as per the NRCs state guidelines in COVID time. The follow up of discharged children would be undertaken telephonically. Ensure mobility support for travel to NRCs as families amid the risk of COVID are fearful of taking the child themselves to the facility.

House to house growth monitoring of children

If there are symptoms related to COVID – Fever, Cough or difficulty in breathing then appropriate referral procedures need to be communicated (immediately inform the nearest health center or call State Helpline Number or Ministry of Health & Family Welfare, Government of India 24x7 helpline 011-2397 8046, 1075 or respective ASHA/ANM)[8]. 104 service, Ambulance drivers trained in safety measures including use of PPE kit-protection gears etc. and cleaning of ambulances.

[8] https://www.mohfw.gov.in/pdf/3Pocketbookof5_Covid19_27March.pdf

Figure 1: Precautions for frontline functionaries during home visit

Outreach Session

These could be held as Village Health Sanitation Nutrition Days or as Growth Monitoring Promotion Sessions. Conduction of these sessions would follow the MoHFW and MoWCD guidance. The principles that are to be followed for the conduction of outreach sessions in specific risk category areas are detailed below.

Containment and Buffer Zone:

- Outreach sessions such as VHSNDs or GMPs should not be organized.
- Services to children who are SAM with medical complications should be provided in the nearest NRC.
- Proper referral arrangement should be ensured. Routine follow-up through teleconsultation should be provided.
- House to house visit conducted by Health Workers/COVID warriors for COVID purpose should be utilized to enquire about services required for children and linkages to the required service should be provided.
- COVID warriors may be trained, if required.

Beyond Buffer Zone and Green Zone:

- Modified VHSND/UHSND should be organized.
- Other health services should be continued as per existing guidelines

Modified VHSND/UHSND/Outreach Sessions:

To maintain physical distancing and reduce waiting time, VHSND/UHSND/Outreach session should be modified so as the number beneficiaries attending sessions are limited.

Sessions may be reorganized as follows:

A. Staggered Approach: To avoid crowding at VHSND/UHSND/Outreach, a staggered approach needs to be practiced. For each session, divide all beneficiaries into hourly slots so that 5-10 beneficiaries are allocated per hour. A voucher system may be adopted to streamline this if required. Alternate session sites may be identified in case of space constraints to maintain social distancing.

B. Break-up Session: One village session is divided into two sessions to reduce crowding if staggered approach does not suffice. For detail guidance on conducting modified outreach session for GMP or VHSNDs - please refer annexure – 2.

2. Facility based care for children with SAM with medical complications [9]

During and post COVID -19 pandemic, facility-based management of SAM is an essential service under RMNCHA+N.

- In containment & Buffer Zone, the following non-negotiable services to be provided for management of children with SAM at the facility.
  - During period of restriction, new admissions may be allowed only in Nutritional Rehabilitation Centres (NRC), where adequate supervisory and medical staff continue to be available.
  - Proper referral arrangement should be ensured. SAM children with medical complications to be referred to nearby health facility (PHC/CHC) for medical management. For secondary care, the PHC/CHC – Medical Officer may refer children who are SAM with medical complications to the DH/Medical College.
  - Previously admitted children who are stable and entered rehabilitation phase may be discharged early with appropriate feeding advice, and provided oral antibiotics, supplements except Potassium Chloride (Potklor) and Magnesium.
  - For children who cannot be discharged, appropriate infection protocols to be maintained.
  - List of SAM children (discharged from NRC) to be shared with Anganwadi centres for prioritizing post-discharge home-based delivery of Take- Home Ration.
  - House to house visit conducted by Health Workers/COVID warriors for COVID purpose should be utilized to enquire about services required for children and linkages to the required service should be provided.
  - Routine Follow up to be done telephonically and only children with medical complications to be called for physical follow up.
  -
- Beyond buffer zone and Green Zone, management of sick SAM children should be continued as per existing guideline.


NRC follow-up

[9] https://www.mohfw.gov.in/pdf/EssentialservicesduringCOVID19updated0411201.pdf

3. Community based care for children with SAM without medical complications

Given the COVID-19 outbreak and extended lockdown, regular Growth Monitoring for children below 5 years has been disrupted. Consequently, no children with Severe Acute Malnutrition have been identified in last few months. However, guidance from the MHA and MOHFW suggest continuing essential services like provision of ICDS THR, prioritized home visits, medical check-up (who requires), referral and remote follow-up. Many State Governments have also issued guidance on community-based management of SAM in COVID context. Services related to CMAM would be delivered as per area categorization and as per State Government guidance. Community based care for children with SAM programme is a package of services. In the COVID-19 pandemic, delivery of each services needs to be adjusted in the present context. The table below presents the essential services under Community based care for children with SAM without medical complications and suggested adjustments.

Initiation of complementary feeding during home visit

Table 2: package of services under Community based care for children with SAM and suggested adjustments

Package of services	Adjustment in the context of COVID
 - **Monthly screening**	To be initiated as per the area categorization. Please refer the active screening section for details.
 - **Assessment of Medical complications**	Medical checkup is encouraged in case of any visible sign of illness (vomiting, fever, diarrhea, respiratory distress etc.), lack of appetite, lethargy. Immediate checkup by ASHA/ ANM is suggested.
 - **Medicines** - **Prophylactic Deworming** - **Preventive IFA & Biannual Vitamin A**	Prophylactic Deworming, IFA supplementation and Vitamin A oil to be administered as per the MOHFW Continuation of essential RMNCAH+N guideline Other medicines / antibiotics to be continued as per protocol suggested by ANM / Medical Officers
 - **Food** - **(ICDS Take Home Ration / other food)**	As per the guidance from the state, provision for additional appropriate foods - Take-Home Ration / other food used for community-based management of SAM should be continued. To ensure food security in the family, please ensure access of food supplied by PDS. Fortnightly or monthly portions may be given instead of weekly.
 **Interpersonal counselling**	Interpersonal counselling to be continued maintaining social distance. Telephonic counselling is encouraged. WhatsApp group can be used for sharing counselling messages. Counselling can also be carried out at the time of THR distribution and Home visit.
 - Regular monitoring of growth	Weekly / Fortnightly growth monitoring can be replaced by monthly weighing. Please follow the State growth monitoring protocol.
 - Referral for medical complication	Referral services to be continued on priority as per the MOHFW Continuation of essential RMNCAH+N guideline

Field Observations – community based programme in COVID-19 pandemic:

The section above highlights the technical aspect of the management of children with acute malnutrition. Besides the technical aspect, management of acute malnutrition largely depends on supply chain management, skill of the frontline workers, availability and accessibility of services and community mobilization. The section below highlights glimpses from the field that have been gathered during the time of covid-19 pandemic. Field experiences will help to comprehend the challenges in the field and plan program accordingly. We acknowledge the rapid evolving situation in the field with a huge interstate variation. Bottlenecks identified a week ago may no longer be relevant now. Yet, could be a reality in the other pocket of the country.

Distribution of Take-Home Ration by ICDS worker

✸ Distribution of Take-Home Ration ✸

- Distribution of take-home ration and ready to eat food for malnourished children are in place but there are many remote/hard to reach areas that are left out because of the topography, engagement of AWW in COVID management etc.
- THR is being distributed by the AWWs, however limited/no counselling about the feeding practices is going to the family.
- The THR is being distributed regularly in almost all the states. Dry ration is being distrusted instead of hot cooked meal in some states like Rajasthan that contains 3kg wheat 1kg pulse.
- The supply of THR is almost consist in the states where SHGs are involved in preparation and distribution of THR.

✸ Identification of children with SAM and management ✸

- Due to lack of screening, nutritional status of children is not known and hence the requirements of malnourished children are not being met.
- In some states, AWWs are taking individual interest to measure the children (Weight) to after they realize that child is getting physically weak and providing additional care and visits to the family.

- Children of reverse migrants are also on the verge of malnutrition so there is a need to link them to ICDS programme as well as re-initiate screening.
- IEC may play a vital role and the focus is to be made on how to identify the malnourished children.
- Screening of SAM children is kept on halt.
- The NRC is opened but hardly any child with SAM is referred there, as AWW is unable to determine the nutritional status (wasting level) of children in the absence of measuring equipment.
- There is no BCC taking place regarding management and follow-up of children with SAM.
- Lack of referral to NRCs. NRCs are open but people are scared of going to the hospital due to the fear of COVID and also due to lack of proper transport services.

✸ Required support to the Anganwadi workers ✸

- AWWs are working hard but their supervisors/ line managers are not available for necessary guidance and hence this needs to be looked at the system level.
- All AWWs are not equipped with all three-protective supply-masks, gloves and sanitizers.
- PRI has given facemask to frontline workers.

✸ Village Health Sanitation and Nutrition day (VHSND) in the field ✸

- VHSNDs are not happening hence all essential services for children through outreach have almost disrupted.
- VHSND has become operational but not in its totality. Only ANC check-up and immunization are being conducted. Beneficiaries are made to leave VHSND site as soon as their check-up is done.
- The VHSND is shifted to Sub-Center hence it is challenging for mothers to travel longer distance where habitation is scattered.
- In some cases, ANM along with AWW and ASHA is going to homes of beneficiaries who are in due list but did not turn up to VHSND site (Chhattisgarh).

✸ Availability of food and access to social safety nets ✸

- Poor families with malnourished children are facing problems in the procurement of food from markets due to the lockdown.
- Most of the children who are affected by this pandemic are from tribal communities, socially excluded communities and agriculture labourers families.
- Nutri-gardens that were promoted under CMAM in MP has been advantageous in reducing the burden of food insecurity in the current time.
- Majority of the beneficiaries don't have bank account, and those who have bank account, they are not operational. Therefore, transferring cash against MDM/HCM in beneficiaries account is a challenge.
- Awareness, follow-up, and information are disseminated through WhatsApp and provision of primary medical services are being done through unqualified medical professionals.

Annexure 1

Guidance on identification of children with SAM during Active Case Finding:

Prior to the outbreak of COVID-19, children with SAM were identified by the Anganwadi workers during the monthly growth monitoring. However, in the present context, to avoid transmission of COVID-19, low or no touch assessment is recommended globally.

During this crisis, when service delivery platforms became disrupted or non-functional, nutritional assessment could involve the following approaches:

- Screening questions administered remotely or during home visits
- Assessment of child for signs of visible severe wasting
- Involvement of mother or family members for assessment of nutritional status of children using simple MUAC tape / MUAC bracelet as an alternative approach for identification of Severe Acute Malnutrition.

Growth monitoring of young infants during home visit

Remote screening questionnaire

Nine screening questions are suggested. It is recommended that where three of the screening criteria for risk are met, this should prompt advice to the caregiver to access a health/nutrition service. The exception are questions 3, 4 and 5 which should prompt immediate advice to access urgent medical attention.[10]

Table 3: Questionnaire for remote screening and suggested interpretations

No	Screening Question	Aid to interpret answers
1	How old are your children?	Children under 2 years are more at risk. However irrespective of age of the child, if they are 0-59 months, please continue with the screening questions.
2	Are you worried about the health of your child/any of your children?	If a mother or primary caregiver is concerned about her child, this is an important alert to a problem and helps to interpret the responses to the rest of the questions.
3	**Is your child unusually sleepy, not feeling well, vomiting everything, or had any loss of consciousness or seizures?**	These are IMCI danger signs that are an immediate alert for a caregiver to seek urgent medical attention. IF ANSWER IS YES -> ADVISE TO IMMEDIATELY GO TO A HEALTH FACILITY
4	**If your child is currently sick or has a fever, has it been going on for more than 7 days?**	A child who is or has been very recently sick is at greater risk. If the child is currently sick and the caregiver is worried about the child, advise that s/he access health services. If a child has been sick for more than 7 days then should be referred to a health facility. IF ANSWER IS YES -> ADVISE TO IMMEDIATELY GO TO A HEALTH FACILITY
5	**Do you think your child is too thin or is becoming thinner than before?**	A child who has recently lost weight or has faltered in growth is at increased risk IF ANSWER IS YES -> ADVISE TO IMMEDIATELY GO TO A HEALTH FACILITY
6	Is your child still feeding or eating normally? If answer is no, has this been for 2 days or more?	Poor appetite for food puts a child at increased risk of wasting and can indicate a child who is sick. IF CHILD HAS NOT BEEN EATING NORMALLY FOR MORE THAN 2 DAYS -> ADVISE TO IMMEDIATELY GO TO A HEALTH FACILITY

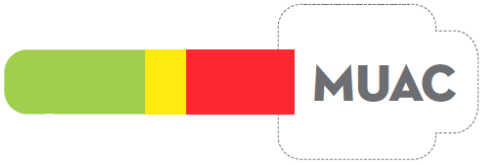
[10] https://www.nutritioncluster.net/Resources_Wasting_COVID-19_Programme_Adaptations_Information_Note_2

No	Screening Question	Aid to interpret answers
7	If the child is under 2: Have you ever breastfed your child?	A child not breastfeeding is at higher risk, especially if under 1 year of age. If not breastfed aged under six months of age, requires immediate further investigation to assess how this infant is being fed.
8	If no longer breastfeeding, when and why did you stop?	It is important to identify children who have stopped breastfeeding due to reduced appetite/ willingness or inability to breastfeed.
9	Does your family struggle to have enough food every day for the entire household?	If a family is struggling to have enough food, this will compromise food intake of the children.
10	Has your child previously been identified as malnourished or admitted to a nutrition treatment programme?	A child who previously was wasted is at higher risk.

The screening questions can be administered by any of the frontline workers during home visits or remotely. Based on the responses, the frontline worker can refer the child to a health facility, prioritize for a detailed assessment or link to available services.

Screening through MUAC

Shifting to MUAC by mother or family member for identification of SAM will not only reduce the exposure of children with multiple contacts but also help to encourage the caregivers to detect acute malnutrition at the earliest. Multiple studies showed that minimally trained mothers could classify their children by MUAC color-coded class with minimum errors. The mother should be guided to perform MUAC assessment under the observation of the health worker – who demonstrates the process to perform MUAC assessment on a dummy or doll. Frontline workers would need to be trained on this component.



MUAC measurement by a frontline worker

Table 4: Analysis of strength and weakness of family MUAC models for identification of children with Severe Acute Malnutrition in the context of COVID-19

Model	Suitable for	Strengths	Weaknesses
Identification of SAM by mother and family members using MUAC tapes	➢ Situations where community health workers (CHWs) exist but have a high workload ➢ Situations where distances between households make it difficult for Frontline functionaries to conduct regular house-to-house screening of children ➢ Situations where weight and height measurements are not possible or recommended ➢ Situations where mass gathering is avoided, mobility is controlled and services under existing Government platform are disrupted	➢ Puts the mother / family at the centre of screening, therefore encourages early identification of nutritionally vulnerable infants and children who are acutely malnourished. ➢ More regular screening because the mother is always in contact with the child, and accuracy of MUAC measurement may increase with repeated use. ➢ Reduce the exposure of multiple contacts and infection (in the context of COVID). ➢ Early detection will help to initiate management for severe acute malnutrition early and developing the risk of complications can be averted. ➢ If all mothers within the catchment area are trained, the approach can greatly improve the coverage of Community based SAM management programme. ➢ Economic and easy to use	➢ It requires sourcing large quantities of MUAC tapes. ➢ The approach needs an initial capacity building of mothers/ family members and may require initial handholding support by the Frontline functionaries, who themselves need to be properly trained ➢ Mothers' MUAC measurements might not be accurate without quality training and routine follow up. However, colour coded classification can ease the process of interpretation. ➢ Supervisory visits or telephonic follow-up is required to take timely action. ➢ In India, use of MUAC not generalized in many states

Family MUAC is an early screening tool for identification of malnutrition. Mothers or caregivers will only identify the level of malnutrition by following the colour band of the tape but also be able to seek treatment in time. Family will be sensitized on interpretation of each colour and suggested actions by the frontline functionaries.

Table 5: Interpretation of colour coded MUAC tape and recommended action for family members

Color of MUAC tape	Interpretation	Recommended action for the family members
RED	Child is severely thin and can quickly become ill	• Ensure the tape is not too tight. • Repeat the MUAC measurement to reassure. • Immediately (within 2 days) contact respective AWW/ASHA/ ANM for guidance
YELLOW	Child is moderately thin	• Ensure the tape is not too tight or too loose. • Feed the child – ICDS THR, available family food more frequently in adequate amount. • Report the findings to the AWW/ ASHA when they come for THR distribution and or home visit. • AWW/ASHA will provide counselling • Repeat measurement in 7 days, if worsens (RED) immediately (within 2 days) contact AWW/ ASHA/ANM for guidance
GREEN	Child is NOT thin	• Continue to care and feed the child as practiced before. • Check MUAC every two weeks and watch for changes.

Implementation of Family MUAC in the community:

How to sensitize?

- Demonstration on usage of colour coded MUAC tapes and interpretation of each colour. Mother or care giver will measure MUAC under the supervision of Frontline functionaries.
- Using short demonstration videos is an effective way to reach mothers and caretakers with messages during training sessions.
- WhatsApp videos
- Post orientation, frontline workers will follow-up with the families telephonically and during THR distribution the worker will request the mother/caregiver to measure MUAC of children in front of her, which will help to identify and address incorrect measurements.

When (to provide training to the mothers / care givers)?

- During the time of THR distribution by the AWWs
- During the time of home visits by ASHA
- At the time of discharge from NRC (mothers / caregivers to be trained)

Whom to prioritize?

For provision of MUAC tapes, the following household will be prioritized. The households having

- children under two years of age (and above 6 months)
- children who were identified as severely underweight / moderately underweight (as per weight for age classification criteria)

And /or

- children who had Severe Acute Malnutrition and Moderate acute Malnutrition (as per weight for height classification criteria)

And / or,

- children who discharged from the Nutrition Rehabilitation Center in last 3 months

And/ or,

- Children defaulted from the CMAM programme.

And, children from migrated families and other vulnerable groups

What would be the modality for procurement of MUAC tapes?

- Printing at the local level (as per the standard specifications)

What is the role of social media?

- Screening related messages can be broadcast via radio ads, SMS, social media
- Key messages need to be as simple and clear as possible in the local language.

Reporting:

For reporting, interchanging contact details (mobile number) between family members and ASHA/AWW is a prerequisite. Reporting on MUAC measurement findings can be done in the following ways:

a) **Remote data collection:** Responsible frontline functionaries will contact the family (those who were not covered during home visit / remotely located families/ families have previously identified SUW/MUW/SAM/MAM children) telephonically to collect information on MUAC measurement. Collected information to be shared with the respective ANM / ICDS supervisors/NRC nutritionist for monthly compilation.

b) **Data collection during home visit:** Responsible frontline functionaries - AWW/ASHA (families having previously identified severely/ moderately underweight children and or SAM / MAM children can be prioritized/ other criteria for prioritization can be used) will collect information on MUAC measurement during home visit / THR distribution. If required (for those children categorized as RED) cross-checking of MUAC measurement can be done for immediate referral and relevant advice.

c) **Reporting by the family to the responsible Frontline functionaries:** Families can be instructed to share their observation telephonically or through WhatsApp to the responsible Frontline functionaries.

Monitoring and Follow-up:

Follow-up activities are important to ensure mothers successfully understand the screening techniques and that screening occurs routinely and regularly. AWW/ ASHA can conduct checks in randomly selected households during home visits / door-to-door THR distributions.

In case, procurement of MUAC tapes for mothers take longer, then Anganwadi worker / ASHA workers should initiate prioritize screening in their catchment area. However, disinfecting the tape (using alcohol / soap water solution) between two measurements is non-negotiable, along with other measures for infection prevention, including regular handwashing, use of recommended personal protection equipment and social distancing. Use of alcohol is likely to fade the colour and marking of the MUAC tape faster. In that case, a greater number of tapes are required for each functionary.

The aim of the proposed case finding approach is that wherever childhood malnutrition is prevalent, all families soon will be familiar with these techniques and empowered to screen their own children. Given the potential for mother/caregiver MUAC screening to improve community case detection, early care-seeking behaviors and acute malnutrition treatment coverage will not only help to reduce the load of hospitalization significantly but also catalyze progress in reducing malnutrition related child mortality and morbidity. MUAC screening during an emergency will help inform the nutrition and food security related response measures.

Annexure : 2

Guidance for conducting modified outreach session for GMP or VHSNDs:

Sessions should be continued/re-started as per district categorization mentioned above. Blocks/districts/states should start their planned session as per micro plan or GMP schedule.

Some suggested modalities to implement VHSND and GMP sessions are as below:

1) Session day, location, frequency and timings

- The Outreach session should be organized on the 'Same Day or Days of the Month' and at the 'Same Location' as per micro-plan. Any modification in 'Day' or 'Session Site' should be informed to the beneficiaries.
- Usually the Anganwadi Center is the designated location for outreach session. However, in case of space constraints to maintain social/physical distancing and lack of adequate provision for hand washing with soap and water, another site may need to be identified. Schools, Panchayat Ghar, etc. may be explored as alternate sites.
- In areas with migration of laborers back to their home and this would be an ideal opportunity to provide services those under-privileged community. Number of sessions needed would depend on the load of such cases.
- Flexibility of the timings and duration need to be considered as per local needs.

2) Staggered Approach

- To avoid crowding at outreach session, a staggered approach needs to be practiced. In a day, total cases accessing the session should not exceed 25-30 beneficiaries
- The health worker should prepare a due list including new beneficiaries (newly born and newly migrated). For each session (rural, urban or mobile session), the beneficiaries need to be divided as per 'Due List' into hourly slots.
- The number of beneficiaries to be mobilized for each hour will be dependent on the space available at the session site along with seating arrangement and other provisions to maintain social distancing of at least 1-meter distance between two beneficiaries
- The segregation of beneficiaries into hourly slots should be done at least 2 days before the upcoming session and the same segregation methodology should be finalized for next session before the end of current session if COVID-19 related conditions persist.

VHND session maintaining social distancing

- Based on beneficiaries in the due list, the timing of session may be extended to reduce overcrowding.
- If number of beneficiaries are high additional session may be planned as required and inform beneficiaries about the next session date and location. For example, if there are 28 beneficiaries due on the given session day, a group of 4 beneficences should be created for each hour and session may be extended for 7 hours or extended to an additional day as feasible.
- If any of the frontline workers is suffering from flu like symptoms (fever, cough or shortness of breath), the individual should not participate in the outreach session and should update the line manager and take necessary steps as per the guidelines.
- Supervision and monitoring should be strong and ICDS lady supervisors should monitor as per the session plan. The VHSNC members should be informed and should actively participate to facilitate mobilization and logistics. Prior communication to be provided to the beneficiaries if the AWW is unwell and the responsibility can be taken by nearest AWW or ASHAs.

3) Beneficiary Mobilization:

- Based on the agreed hourly slot, ASHA, AWW and MAS member should mobilize the beneficiaries/family of beneficiaries by phone at least one day prior to the session to inform them about their time and request them to follow the time slot to create a healthy and safe session environment. Only if additionally required, the ASHA and AWW may visit houses of due beneficiaries.
- Request for only one caregiver to accompany with the beneficiary to avoid overcrowding and maintain effective social distancing.
- Advice beneficiaries and family members to wear cloth mask while coming to the session site.

- The 3As can modify the time slot of a beneficiary if parents or caregivers are not available at the allocated time slot.
- Any child, caregiver and/or pregnant woman suffering from flu like symptoms (fever, cough or shortness of breath) should be asked not to come to the session site and seek services as per existing guidelines related to COVID-19. The services need to be provided to such families at their doorstep.

4) Session Site:

- Frontline workers should practice standard hygiene practices and should wash hands with soap and water for at least 20 seconds before start of session and sanitize hands with an alcohol-based sanitizer before and after interacting with every beneficiary. Availability of sanitizer is essential with each frontline worker, which may be supplied or procured from untied funds.
- Lady supervisors should be responsible to supervise the sessions over phone or by visiting the site.
- The frontline worker should wear a triple layered surgical mask. Disposable masks are never to be reused. (Used mask should be considered as potentially infected). Mask to be disposed safely.
- ANM, ASHA and AWW should practice respiratory etiquettes and avoid touching their eyes, nose and mouth and should practice respiratory hygiene by coughing or sneezing into a bent elbow or tissue, then immediately disposing of the tissue.
- All caregivers should be advised to use homemade cloth mask during their visit to the session site.
- Additional volunteers (VHSNC/village support group like School teachers, SHG members, PRI members, VHSNC members, Youth Club etc.) should be made available to manage seating arrangement for the pregnant women and care givers.
- The staff must be trained on screening of children, caregivers or pregnant mothers for flu like symptoms (fever, cough, difficulty in breathing etc.) and if found symptomatic, should be guided to seek appropriate treatment as per guidelines.
- Adequate arrangement for soap and water should be made at session site. Every caregiver should be encouraged to wash his or her hands with soap and water before approaching for the service.
- Equipment such as weighing scale, thermometer, infant-meter, stadiometer etc., should be adequately sanitized immediately after use, with prescribed disinfectants (70% Alcohol based rub).
- While conducting tests (pregnancy, Uristix, etc.) involving body fluids, necessary infection prevention measures should be undertaken.

5) Waiting Area, Group Counselling and COVID-19 Related Awareness Generation

- The waiting area should follow social distancing protocol and the ASHA and AWW should ensure that beneficiaries and caregivers maintain the same.
- This waiting period to be used for group counselling and can be conducted by one of the ASHAs or AWWs. Provide key preventive messages related to COVID-19, demonstrate correct handwashing technique and discuss about other topics like nutrition of pregnant and lactating women, breastfeeding etc.
- COVID-19 related IEC material in local languages could be made available for caregivers in the waiting area.

6) Information, Education and Communication

- The focus should be on prevention of COVID-19 and other diseases like diarrhea, pneumonia etc. by
    - Handwashing with soap and water for 40 seconds
    - Social distancing
    - Cough and sneeze etiquettes. Avoid touching your eyes, nose, mouth
    - Cover mouth and nose with clean cloth or mask
- ASHA, AWW, Swatchagraahis and Aapda Mitra should be roped in to deliver the messages. They may also forward the messages on WhatsApp to beneficiaries, especially women and adolescents who have smart phones.

After the session:

- After all the beneficiaries are vacated the site, the site should be sanitized properly (tables, chairs, weighing machine and other equipment used during the session) by frontline workers and helpers. Youth club members and other community members could play important role here.
- Gloves and masks should be properly disposed as per the guideline of COVID-19.
- All the biomedical wastes should be taken back or disposed as per routine biomedical waste guidelines.
- All data recording and reporting procedures to be followed as usual.

Capacity building of front-line health workers:

In-person trainings, which congregate groups of people, should be temporarily suspended when they are not compliant with social/physical distancing recommendations. Existing digital health platforms may be leveraged for training, information access, and dialogue with the communities who seek services. Such platforms may help refer families to appropriate sources of health information or other social services.

Capacity building can be done through, info kits, FAQs and small video clips. Small video clips can be designed and circulated for easy understanding.

- ✓ Holding an ideal outreach with social distancing, handwashing and other precautionary measures in place.
- ✓ Protocols for identification of children with SAM in the context of COVID
- ✓ Importance of maintaining hand hygiene while conducting the session
- ✓ Importance of maintaining social distancing at outreach session during COVID outbreak

Supportive Supervision of outreach session:

States need to strengthen the supportive supervisory mechanism for outreach sessions and to include monitoring of practices associated with social distancing and other guidelines. Data from Supportive Supervision should be used for local action and monitoring progress.

- ✓ The Gram Pradhan (Head of village) should be informed in advance about the outreach programmes by the frontline workers to avail his/her support in community mobilization and logistic support.
- ✓ Lady supervisors, CDPOs, ASHA coordinators, VHSNC members, Lady Health Visitors should be involved in supporting the frontline workers. In addition, Swachhagrahis may also be involved.
- ✓ Roles and responsibilities should be clearly spelled out for VHSNC members, Swachhagrahis, etc.
- ✓ Lady supervisors should ensure that in her sector or cluster all the sessions are taking place as per plan. She should make visit to all the centers or should be in touch through phone.
- ✓ CDPOs and ICDS LS should ensure that all AWWs should have sanitizers, surgical masks, disinfectants for measurement instruments, etc.
- ✓ LS should have a clear micro plan/information about the outreach programme in her sector and they should make random joint visits with LHV to the outreach site/AWC
- ✓ The local NGOs/CBOs may also be allowed to provide supportive supervision support during outreach programme.