INNOVATIONS AND ADAPTATIONS

NUTRITION RESPONSE IN INDIA DURING COVID-19 PANDEMIC

An Anganwadi worker measuring the weight of a child. © UNICEF/UN0390765/Vishwanathan

Stories from India on how nutrition programmes innovated and adapted to the COVID-19 crisis

Developed for #PoshanWeekly poshan@unicef.org
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Foreword

The COVID-19 pandemic of 2020-21 brought unprecedented challenges for nutrition programming in India. The lockdowns, taken as a step to stem the spread of the pandemic, also caused disruptions in the nutrition services. And yet this also became an opportunity for many service providers including frontline workers to innovate and adapt to ensure continuity of critical services for women and children.

This compilation of case studies from different Indian States tells a story of how programmes were adapted in face of the extraordinary situation. Political will, flexibility and decentralized decision making, use of technology were hallmark for these adaptations. Telecommunication and social media found a new use for generating awareness on COVID appropriate behavior, counselling on nutrition, monitoring and reviews, and though the reach of these technologies were limited to only a section of the society, yet they proved to be useful tools. The challenge remains how we reach the media dark areas and to people who do not have access to gadgets.

Development partners came together to assist the Government to monitor health and nutritional services. Various guidelines were issued by the Government at the national and state levels to ensure continuity of services. Various adaptations were made for treating children with severe acute malnutrition in health facilities. Tools were adapted for breastfeeding counselling in the context of COVID-19. Take home rations were delivered at doorsteps.

Some States faced cyclones during the pandemic, putting people at even greater risk of COVID-19 and critical service disruptions. One such story from Odisha shows measures taken by the Government in the face of a double threat. The pandemic caused challenges but also gave hope for a collective response to uncertainty. This compilation is a collection of 15 stories of hope and of the tremendous energy, and commitment of countless officials, volunteers and frontline workers to ensure the delivery of services critical for promotion of health nutrition and prevention of malnutrition.

Many different organizations and individuals working at national, state or district levels have authored these remarkable stories. The purpose is to share details of the approaches used, results achieved and to share details so others could get inspired and also use these in their practices in their daily work.

#PoshanWeekly is an initiative to circulate knowledge materials, tools and other information among various stakeholders. We have received, compiled and now share these stories. The responsibility of each story lies with the authors. The statements in this publication are the views of the author(s) and do not necessarily reflect the policies or the views of UNICEF. Some of the photos were captured pre-COVID-19 hence COVID Appropriate Behaviors are not evident in them. These stories can be shared more widely if credit is given to the authors of the stories. Please send your feedback, suggestions, and new stories to #PoshanWeekly poshan@unicef.org.

A big thanks to all who contributed to these stories, and even more so to all the #NutritionChampions who continue to support and promote COVID-sensitive practices among those families and communities that need it the most.

We wish you happy reading and much inspiration!

Kind Regards,

Arjan de Wagt,

Chief, Nutrition Programme, UNICEF India.
#StopChildMalnutritionIndia

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A child being weighed in an Anganwadi Centre. © UNICEF/UN0389820/Vishwanathan

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Father playing with his daughter in Maharashtra, India. © UNICEF/UNI333178/ Bhardwaj

Involving Fathers in Tele-Counselling for Nutrition and Early Childhood Development ECD: Story from Maharashtra

Contributors: Ms Rubal Agarwal, Commissioner ICDS, Govt of Maharashtra, Rajalakshmi Nair and Dr Aparna Deshpande, UNICEF Mumbai Field Office, Dr Pranali Kothekar, MGMIS, Ms Sharmila Mukherjee, Unicef, Prof (Dr) Subodh Gupta, Mahatma Gandhi Institute of Medical Sciences (MGMIS).

Background

The coronavirus pandemic posed many challenges to the Integrated Child Development Services (ICDS) and the Anganwadi workers. Before the pandemic, when pregnant and lactating mothers visited the Anganwadis, they were introduced to a range of activities that made them aware of the importance of breastfeeding, balanced diet and the importance of the first thousand days after the birth of the baby. Additionally, Anganwadi workers paid regular visits to the households in their catchment area and offered counselling on health and nutrition.

Since the onset of the pandemic, the number of home visits reduced, and communication through social media chats or telephonic conversation became more frequent. Mothers did not assemble in a group at the Anganwadi centres, and their visits to the Anganwadi were for the periodic weight check for their babies. However, Anganwadi workers reached out to community members through regular telephonic calls and WhatsApp groups. Through digital platforms like 'Tarang Suposhit Maharashtracha', an attempt was made to ensure last-mile connectivity.

Response

'Tarang Suposhit Maharashtracha' is a digital platform equipped with facilities like a helpline number, a broadcast call and a WhatsApp chatbot. The helpline number (8080809063) shares answers to questions about breastfeeding, nutrition and childcare. The platform also shares information through photos, videos, short films and recipes for healthy and nutritious dishes. The content from this platform complements the efforts of the Anganwadi workers in reaching out to community members through telephone calls and WhatsApp. However, this outreach has added a new stakeholder in this entire process - the father!

In most families, the fathers have possession of the cell phone, and it remains with them the entire day when they are out for work. Consequently, on most occasions, the message on health and nutrition reached the fathers before it reached anyone else in the family. And these fathers narrated it to the family members in the evening when they were back home after work. The immediate recipients of photos and videos from the digital platform 'Tarang Suposhit Maharashtracha' were the fathers. These circumstances made them an essential ally in combating malnutrition in children. It was observed that fathers attended these calls seriously, participated in conversation with the Anganwadi workers and also called the 'Tarang Suposhit Maharashtracha' helpline number.

"I *now know that my child should only be breastfed for the first six months. Paani pan nahi (not even water)*", says Kishor, an enthusiastic father from a remote village in the Nandurbar district of Maharashtra. It is significant that Kishor, who belongs to a district known for its inaccessibility and other challenges, knows this critical fact, thanks to the videos he accessed through the 'Tarang Suposhit Maharashtracha' platform. He regularly follows the videos, completes the activities mentioned in the video and consults with the Anganwadi worker. Before the pandemic, mothers used to physically attend the meetings in the Anganwadis, and they were the primary point of contact for Anganwadi workers. They used to participate in activities, ate together and shared their problems and solutions among themselves. "*However, one of the positive impacts today is that we can establish a dialogue with the fathers*", says an Anganwadi worker from Nandurbar.

The Anganwadi workers feel happy that now the fathers often ask whether there is an improvement in their child's weight, and critical questions regarding mother's health. "*My child was severely malnourished. My husband received the videos via WhatsApp, and we discussed those messages every day. It was helpful. We followed the instructions, and my child's nutritional status has improved*", says Vidya, a mother, from Nandurbar.

ASHA workers, who often visit households in villages across the state, have observed a major shift in the outlook of the fathers towards health and nutrition. They feel that men earlier felt uncomfortable talking about health or visiting the Anganwadi centres. However, thanks to the information reaching the villages via social media and television, the present-day fathers are more helpful and cooperative. The 'Tarang Suposhit Maharashtracha' digital platform has also helped busting of myths and misconceptions about breastfeeding concerns during COVID. Samadhan Bhuisar, a father from Pandharpur, feels that the platform is informative and easy to understand. Like many other fathers around him, he follows the videos on the platform and follows every recipe. He also makes short

videos of children doing these activities at home and shares them with others in the WhatsApp group. Varha, a village in Ralegaon, Yavatmal, has an 'only fathers' WhatsApp group, and their response to the messages and participation in activities equals that of the mothers! The fathers, Sandip Kulkarni, Sunny Ragde, Kiran Suradkar, Afror Shaikh, Rafique Shah, Amol Raut, Shahid Shaikh, Rajendra Kuber, Pankaj Bhalerao and Yogesh Kathar, are glad to be active participants in the process involving the health and nutrition of the mother and the child.

The Yavatmal district also features a story of Chetan Nehare, who, with the help of Anganwadi workers and ASHA workers, is raising his daughter after the unfortunate demise of his wife during childbirth. He is familiar with the kangaroo-care technique and need for interacting more with his child. He plays with his daughter every day, apart from ensuring a proper diet. His efforts have borne fruit as his daughter is showing a healthy weight gain trajectory and she is no longer malnourished.

Enabling Factors

Poster with Ajjibai mascot

As the initiative was demand-driven, its success depended on program participants being both aware and convinced about the utility of the platform. In this, the support of the government machinery was crucial. 'Tarang Suposhit Maharashtracha' received strong patronage from the government, including the Minister and the Secretary of the Department of Women and Child Development. Take for instance, the broadcast calls (dial 8080809063) that delivered targeted messages to participants such as pregnant women during every trimester or when their children were 6 months old. Thanks to the political support received by the platforms, these calls start with the announcement - “The Minister for Women and Child Development has a message for you.” This increased not only the acceptability of the messages but also lent a personal touch to the calls, leading to high retention levels.

To capture the success stories and identify gaps in the rollout of the initiative, a monitoring dashboard was created. The dashboard displayed the number of program participants registered from each district and block. Enabled by this, many officers took interest in healthy competition to perform better. Many took intensive reviews of the rollout and some even organised massive drives to ensure that every caregiver is aware of the platform. Indeed, many Lady Supervisors successfully onboarded every single program participant on the platform.

The most crucial enablers, however, were the Anganwadi workers. It was through them that caregivers were made aware of the platforms. The platforms were designed in a way not to replace the Anganwadi workers, but to enable them to provide better messaging. For example, the Anganwadi

workers could now simply address the queries of caregivers by referring them to a particular video or a section, ensuring accurate information. During COVID, Anganwadi workers were able to connect and provide counselling even remotely, while maintaining social distance and without risking themselves or any caregiver. More than 50% of the Anganwadi workers in the state have participated in the initiative, with the number being as high as 95% in several blocks and districts. Poster were given to all Anganwadi workers, featuring the Ajjibai mascot and a QR code, scanning which takes caregivers straight to the chatbot.

Challenges

However, there were a few significant challenges in the entire process. Parents across many villages were still scared to travel to the Anganwadis with their children. On many occasions, they missed weighing their children and insisted that they weigh them at home, thus raising concerns about inaccuracies and inconsistencies. Many mothers lost touch with the group meetings, and while they talked to the Anganwadi worker, they hardly interacted with each other. But despite these challenges, Anganwadi workers feel that the 'Tarang Suposhit Maharashtracha' digital platform should continue even after the pandemic and expand its reach among communities. The authentic messages on health and nutrition shared through this platform are helping mothers, adolescent girls, and community members. And more importantly, it has added fathers to the list of stakeholders, thus making it more inclusive.

There were many technological challenges as well. First was ensuring regulatory compliance. The Government of India has placed strict regulations on tele-services including sending SMS or making calls in bulk. Ensuring that these regulations are followed was crucial as non-compliance could result in hefty fines or even termination of services.

Another technological challenge was the availability of smartphones. Many families who did not own a smartphone were unable to access the platforms through WhatsApp. For such families, conventional means were adopted, and an easy-to-use Interactive Voice Response (IVR) helpline was introduced. Parents were able to then call on the number and obtain the desired information by interacting with the helpline through the dial pad. Lastly, connectivity remained a bottleneck, especially in remote tribal regions where telecom operators do not have the financial incentives to provide services.

Key Lessons

The response received from caregivers has helped realise how accessibility to quality information has been a major bottleneck in nutrition programming. 'Tarang Suposhit Maharashtracha' platform has taught us the importance of reaching out to participants in a space in which they are comfortable. For example, on an average, participants engaged with the WhatsApp chatbot for more than 4 minutes, indicating the importance of kindling curiosity among caregivers in a demand-driven system. A feedback survey conducted on the IVR system received more than 85% positive responses about the initiative.

Although 'Tarang Suposhit Maharashtracha' was envisaged with the COVID-19 pandemic in mind, the utility of the platforms to increase the accessibility of information has enabled the digital platforms to

be useful even after the pandemic. Given the continuing high rates of malnutrition, it is imperative that we sustain the platforms even after the pandemic and expand its reach among communities. The authentic messages on health and nutrition shared through this platform are helping mothers, adolescent girls and community members. And more importantly, it has added fathers to the list of stakeholders, thus making it complete and all-inclusive.

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- Rajalaxmi Nayar, Nutrition Specialist, UNICEF, rnair@ unicef.org

Additional Resources

1. https://www.gktoday.in/current-affairs/what-is-tarang-suposhit-maharashtracha/
2. Tarang Suposhit Maharashtracha launch: https://www.youtube.com/watch?v=AhxeOHKAemE

An Anganwadi worker explaining complementary food to mothers. © UNICEF/UN0392554/Kolari

Continuing Supplementary Nutrition Programme for Women and Children during COVID-19 Pandemic in Madhya Pradesh.

Contributors: Ms. Swarnima Shukla Joint Director DWCD, Govt of MP, Dr Sameer M Pawar, Dr Pushpa Awasthy, Dr Tarun Patel, UNICEF Bhopal Field Office.

Background

Continuity of supplementary food for children, pregnant and lactating women was disrupted due to COVID induced lockdown, since March 2020 as Anganwadi centres (AWCs) were closed. Even the Take Home Rations (THR) production units (at divisional level) were closed, and the transportation system was not functional for the period April to June 2020.

Response

The Department of Women and Child Development, Madhya Pradesh took quick action to permit field level functionaries to call for decentralized procurement and distribution of ready to eat recipes in a quantity sufficient for two weeks duration for all children 6 to 72 months of age, pregnant and lactating women. Government of Madhya Pradesh issued order on 17th March 2020 with further revision on 27th March 2020 making provision for alternative recipe options for ready to eat food in absence of THR. Further reinforcements were issued to District Collectors on 4th April 2020.

THR and hot cooked meals (HCM) programmes were de-centralised, and each district was given responsibility of delivering these supplementary nutrition programmes. Districts developed their own food recipes and started procuring food from local women's self-help groups. Thus, the continuity of services was ensured that also generating local employment.

What worked?

- Decentralization of powers for procurement and decision on recipes (with suggestive recipes provided).
- Already existing network of SHGs who were part of 'Sanjha Chulha' initiative, for provision of school mid-day meal and Angandwadi Centres hot cooked meals. Flexibility to utilize services of Self-Help Groups (SHGs) that were already working to serve hot cooked meals.
- Simpler recipes mostly in dry form.
- House to house distribution and flexibility to decide on frequency of distribution depending on the shelf life (weekly or fortnightly).
- Prior experience of the state of providing ready-to-eat food.

Challenge

While decentralization ensured continuity of the supplementary nutrition programme amidst the pandemic situation, ensuring supply appropriate quantity adhering to quality standards posed a huge challenge as different recipes were used in different places and monitoring systems were not fully functional due to COVID restrictions.

Lessons

Swift action to decentralize decision making and production helped to continue the Supplementary Nutrition Programme (SNP) in an uninterrupted manner.

Contact person for further information

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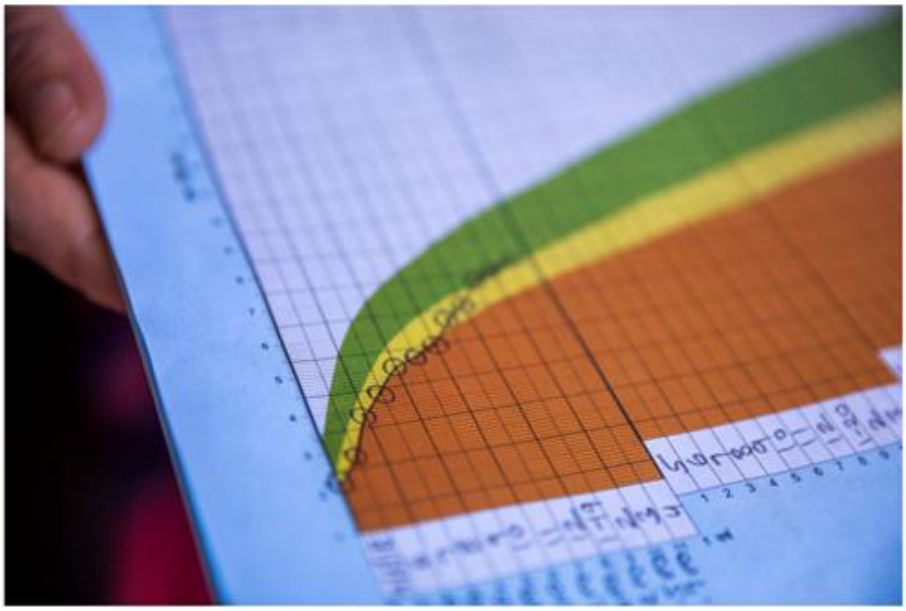
Additional Resources

- For details of Government guidelines on management of hot cooked meals by women SHGs:
  (a) In urban areas: SNP-guideline-and-recipes-2018.pdf (poshancovid19.in)
  (b) In rural areas: SNP-guideline-and-recipes-2018_1.pdf (poshancovid19.in)
- For more Government guidance from Madhya Pradesh, visit Resources – POSHAN COVID-19 (poshancovid19.in)



An Anganwadi worker showcases growth records of a child in Kamla Ganj, Shivpuri. © UNICEF/UNI287546/ Bhardwaj

Continuing Growth Monitoring Children During COVID Pandemic: Story from Madhya Pradesh

Contributors: Ms. Swarnima Shukla Joint Director DWCD MP, Dr. Rajeev Shrivastava Deputy Director NHM MP, Dr Sameer M Pawar, Dr Pushpa Awasthy, Dr Tarun Patel, UNICEF Bhopal Field Office.

Background

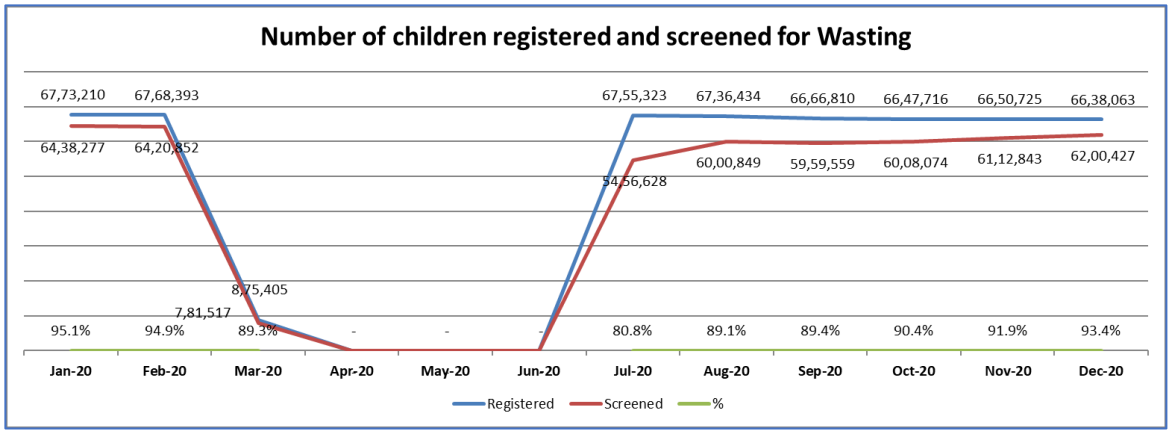
During COVID lockdown in 2020, all Anganwadi centre-based activities, including growth monitoring, came to a halt across the states, including in Madhya Pradesh.

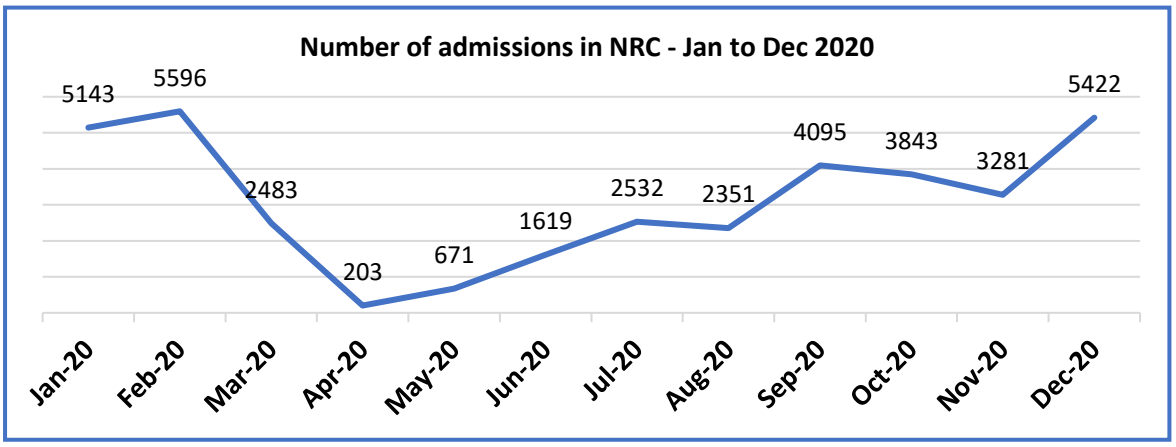
Response

After discussion with Dept of Women and Child Development (DWCD), guidance was issued in April and May 2020 to continue growth monitoring of children below 5 years of age. Govt of MP used a flexible approach to continue growth monitoring amidst COVID-19 pandemic, while avoiding crowding in Anganwadi Centre (AWC), in the following ways:

(a) Calling children in batches of 4-5 children per day to the AWC, or,
(b) Anganwadi worker made home visits and took weight and height measurements, or,
(c) Prioritizing children who were underweight / wasted before lockdown.
(d) Prioritizing children of migrated families, who recently returned to their villages.
(e) Prioritizing children under 2 years of age for growth monitoring.
(f) Identified children with SAM were examined for medical complications at Village Health, Sanitation and Nutrition Day (VHSND) and referred to Nutrition Rehabilitation Centres (NRC) if required.

Home visits were also used to counsel mothers and caregivers on child feeding practices and COVID appropriate behaviours. Simultaneously, National Health Mission (NHM) continued its approach under Dastak Abhiyaan to use MUAC tapes for screening of SAM children during house of house visits by ASHAs. NHM distributed MUAC tapes to 55,000 ASHAs in June 2020 and issued guidance to screen children (6 months to 5 years) using MUAC, during home visits along with administration of IFA and COVID related survey. Guidelines were issued to include families of migrant workers under ICDS. This contributed to a gradual increase in admissions of children with complicated severe acute malnutrition (SAM) in Nutrition Rehabilitation Centres (NRCs) from 203 in April 2020 to 5,422 in December 2020 (up to pre-COVID level) (Data source: DWCD, Govt of MP).





Before COVID, data entry of monthly progress report (MPR) for each AWC was done by a data entry operator at the block level. During lockdown, the time was utilised by the state to integrate MPR reporting into the Department's own supervisory android application (SAMPARK) and it was opened for AWW to enter growth monitoring data directly from the AWC level, reducing the time lag for data entry.

Following the second wave of COVID, a SOP was developed where a verbal questionnaire in local language was prepared to assess the nutritional/health status of children followed by anthropometric

measurement to assess if the child fell under high-risk category, for required actions. Special measures were initiated for treatment of severely underweight children and children discharged from NRCs. The SOP was developed to maintain continuity of growth monitoring anticipating third wave of COVID pandemic.

Result

Growth monitoring picked up again in July 2020 and re-established to pre-COVID levels by September 2020.

What worked?

- Differential and flexible approach to allow field functionaries to conduct growth monitoring in a way that was feasible in local context.
- Clear guidance for following COVID appropriate behaviours.
- Support from Department of Health and Family Welfare (DoHFW) to involve ASHAs for doing growth monitoring.

Challenges and limitation

- Decentralization of decision making by District Crisis Management Committee, during lockdown resulted in priority to contain COVID pandemic over other programmes including growth monitoring.
- During home visits, many families did not allow AWWs to conduct anthropometric measurements / growth monitoring due to fear of COVID.
- Non-availability of Common Application Software (CAS) or Poshan Tracker to record child wise data.
- Coverage could not be ascertained.

Key Lessons

a) Continuity of Growth monitoring is crucial and is possible by adopting a differential and flexible approach

b) Clear Standard Operating Procedure (SOP) developed for use during pandemic situation, but it requires capacity building of frontline workers to use it.

c) Technology could be adopted easily by AWWs to enter monthly data.

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Additional resources

1. MIGRANT-LABOUR-Nutriton-services-COVID-19.pdf (poshancovid19.in) (29.05.2020)
2. For more Government guidance related to Madhya Pradesh, visit Resources – POSHAN COVID-19 (poshancovid19.in)

A newborn being breastfed immediately after birth. © UNICEF/UNI286499/ Bhardwaj

Continuing facility based breastfeeding services during COVID Pandemic: Story from Uttar Pradesh.

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Background

The COVID-19 first and second wave in the State had disrupted the facility-based services with reduced access to government services and mobilisation of existing manpower to support COVID related services. Field learnings pointed to an increase in home deliveries, limited awareness on COVID appropriate breastfeeding behaviours amongst mothers/caregivers, frontline workers, health facility staff and use of formula milk by families for infants. While Health Department was regularly re-enforcing the key messages, aids and tools received from Ministry of Health and Family Welfare, there was a need to go beyond the routine. Towards addressing the misuse of infant formula, better understanding of breastfeeding practices amidst COVID pandemic and to support health facility staff knowledge and skills on appropriate counselling, Child Health Division of National Health Mission, UP jointly with UNICEF and AIIMS, Gorakhpur selected 21 districts with high COVID caseload and visited them on a regular basis to measure the impact of intervention which comprised of on- site support following gap assessment. AIIMS Gorakhpur was selected as they have a trained resource pool which has been supporting NHM in the past on IYCF trainings as well.

Response

The Health Department used the field /health facility pictures on use of formula milk for initiating action and generating response from the districts. The pictures served as an entry point for orienting the medical officers and health staff on Infant Milk Substitutes Act and need for compliance. GOI creatives on breastfeeding in times of COVID were disseminated across the state by the health department. Special communication package comprising of pictorial messages and short videos were created with support of UNICEF and shared with districts for reinforcing breastfeeding messages. NHM also organised online sensitisation meetings for nursing staff from labour room, postnatal wards, Nutrition Rehabilitation Centres and Sick Newborn Care Units so that awareness was across the health facility spectrum and not limited to labour room. The online sensitisations were facilitated by national and state experts to address the practical queries of nursing staff. The Breastfeeding Week and Integrated Diarrhoea Control Fortnight too were used as opportunity for reiterating the importance of breastfeeding. These efforts were made across the state and were led by the Health Department.

More specifically, 53 health facilities (21 District hospitals and 32 block health facilities) were identified and supported continuously for three months (June-August 2021). Work in these facilities focused on assessing the extent of the problem in terms of knowledge, awareness of staff and mothers, breastfeeding practices, use of infant formula and subsequently sensitising and supporting staff on COVID appropriate breastfeeding behaviours / recommendations and direct counselling of mothers on breastfeeding.

Baseline assessment was done during the first visit in June' 21 and end line was done in August 21. Each district level health facility was covered once every month for three months. During each of the monthly visit practices were assessed, staff were sensitised or re-sensitised, feedback shared with facility in-charge along with action points and mothers were counselled and supported. COVID appropriate breastfeeding IEC were shared for further use by the staff.

Result

1600 staff nurses were reached by NHM across the state as part of sensitisation drive.

In 21 districts, 53 health facilities (21 district hospital and 32 block FRUs) were supported; 502 Staff Nurses and ward ancillary staff were sensitised and 1301 mothers of new-borns were directly supported and counselled.

A comparison of baseline and end line report in the 53 health facilities shows the following improvements:

1. Perception of Staff Nurses (SN) that a COVID positive/suspect mother cannot breastfeed declined from 74% to 7%
2. SNs knowledge on expressed breast milk as a feeding option for a COVID positive mother who is unable to breastfeed increased from 19% to 60%. At the time of baseline, majority of staff nurses responded formula milk as a feeding option in such cases.
3. SNs knowledge on COVID vaccination for lactating mother improved from 18% to 75%.

4. No change in the awareness levels of mothers of newborn about the COVID appropriate breastfeeding practices (5% vs. 4%) in the health facility, indicating that improved knowledge levels did not translate into improved awareness amongst the mothers.
5. Considerable decline in the use of formula milk in health facilities was observed i.e., from 40% in June to 13% in August 21.
6. Babies delivered by caesarean section and low birth weight babies were found to be two groups who received formula milk the most throughout the period of monitoring.
7. Staff nurses' capacity on breast milk expression are limited.
8. Early Initiation of Breastfeeding rate improved from 45% (June) to 58% (August).

Enabling factors

- Strong prioritization of the behaviour by NHM and continuous reinforcement across all interaction platforms.
- Dedicated technical support from a trained team (AIIMS, Gorakhpur).
- Regular orientation of the staff in facilities.
- Multiple rounds of follow up and supportive supervision at facility level.
- Advocacy for corrective actions done by sharing monitoring findings and feedback with the state and district officials. The issue was prioritized by the Department and following actions taken in response: (a) Communication from the Health Department was sent to the districts for corrective actions. (b) State level sensitization workshop organized for various district and block health functionaries including facility staff looking after maternal and child services. The action based on the findings also reflected in the agenda of World Breastfeeding Week in August 2021.

Challenges faced

The monitored health facilities registered an improvement in early initiation of breastfeeding rates. However, timely initiation and continuation of breastfeeding was found challenging in three categories of mother-newborn dyad i.e., caesarean section, low birth weight and primigravida (first birth). It was observed that these cases required considerable skills, time and counselling support from the nursing staff. In high caseload facilities, nursing staff often find it challenging to devote dedicated time to mother/caregivers' practices leaving families vulnerable to commercial influence of formula milk. Lack of supervision, low priority and limited skills of the staff all contribute to slow improvement in the breastfeeding rates.

Lessons

Positive reinforcement and regular supportive supervision are critical to ensuring practice and attention to recommended breastfeeding practices in health facilities. While IEC at health facilities is useful source of information, it may not translate into improved practices.

There is a need for:

a) Repeated orientation and skill enhancement of staff nurses especially on the use of expressed breast milk.

b) Stronger monitoring of these practices by involving Chief Medical Superintendent and nurse in-charge is effective.
c) Special focus is needed for supporting breastfeeding for the three vulnerable groups - primigravida (first delivery), caesarean section and low birth weight babies.
d) Strict monitoring of usage of formula milk within health facility especially the sick newborn care unit and KMC.
e) Strengthening the peer support both within the facility as well as in the community is needed so that continuum is maintained.

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- Dr Ravish Sharma, Nutrition Office, UNICEF Lucknow Office ravisharma@unicef.org

Additional resources

- Guidance for use of Human Milk in India in the context of COVID-19, Ver.1.0 (Apr 2020) https://poshancovid19.in/wp-content/uploads/2021/08/Use-of-Human-Milk-in-COVID19-context-in-India.pdf
- Implementation guidance on counselling women to improve breastfeeding practices | Global Breastfeeding Collective
- The Role of Midwives and Nurses in Protecting, Promoting and Supporting Breastfeeding | Global Breastfeeding Collective

Videos for promotion of Breastfeeding:

- Supporting mothers for breastfeeding: https://poshancovid19.in/wp-content/uploads/2021/11/WhatsApp-Video-2021-07-30-at-12.28.54-PM.mp4
- Correct positioning: https://poshancovid19.in/wp-content/uploads/2021/11/WhatsApp-Video-2021-07-30-at-12.31.36-PM.mp4
- Correct attachment: https://poshancovid19.in/wp-content/uploads/2021/11/WhatsApp-Video-2021-07-30-at-12.30.24-PM.mp4
- Precautions to be taken by Covid positive mother while breastfeeding: https://poshancovid19.in/wp-content/uploads/2021/11/WhatsApp-Video-2021-07-30-at-12.28.34-PM.mp4
- Correct procedure for extracting breastmilk: https://poshancovid19.in/wp-content/uploads/2021/11/WhatsApp-Video-2021-07-30-at-12.27.14-PM-3.mp4
- Encouraging mothers to breastfeed post Covid recovery https://poshancovid19.in/wp-content/uploads/2021/11/WhatsApp-Video-2021-07-30-at-12.28.03-PM-1.mp4
- How to extract expressed milk : https://poshancovid19.in/wp-content/uploads/2021/11/WhatsApp-Video-2021-07-30-at-12.31.53-PM.mp4
- If mother is unable to breastfeed: https://poshancovid19.in/wp-content/uploads/2021/11/WhatsApp-Video-2021-07-30-at-12.27.32-PM.mp4
- Pictorial messages on breastfeeding: Breastfeeding-guidelines.pdf (poshancovid19.in)

Fruits and vegetables rich in Vitamin A © UNICEF/UNI71777/Bhandari

SECTION 2

Continuity of Micronutrient Supplementation during COVID-19 Pandemic

An adolescent girl consuming IFA Blue tablet. © UNICEF/UN0390835/Vishwanathan

Ensuring continuity of micronutrient supplementation amidst the pandemic: Nutrition International's experiences

Contributor: Dr Ameet Babre, Nutrition International

Background

India faced the most frightening challenge of the pandemic since the start of the year 2020, its associated challenges like lockdown, travel restrictions, and of course sickness and death impacted all the sectors of the country, due to which more than 31 crores were infected, and more than 4 lakh deaths were observed till September 2021.

The country underwent a complete lockdown starting March 2020 with educational institutions, workplaces, businesses, and markets coming to a halt. After the initial months of complete lockdown in the country, the government of India announced the reinstatement of essential health services which included mother and child health (MCH) delivery. However, with schools and ICDS centers continuing to remain closed, essential nutrition services including WIFS programme (distribution of IFA-Blue) had halted. There were serious disruptions in the regular health service delivery with most of the health workers and infrastructure diverted to cater to the growing needs of the pandemic. Vitamin A supplementation being one of the programs conducted in the form of biannual rounds in Uttar Pradesh (UP) and Madhya Pradesh (MP), it became even more uncertain about how and when the state will be able to conduct them. In this situation, the major threat to the program was ensuring its planning and implementation in concurrence with the COVID protocols. It included revising the current health strategy, ensuring supplies and effective delivery owing to the changed service delivery

platforms, building the capacity of the service providers and informing the community about the changes in service delivery.

In Gujarat, it was observed that the private health sector played a significant role in health service delivery to newborn and young infants. As per NFHS 5, 94.3% of deliveries were institutional deliveries, of which 57% were in private facilities. However, the promotion of IYCF practices such as early initiation of breastfeeding (EIBF) and kangaroo mother care (KMC) which are easily doable have not received much patronage in the private sector.

The pandemic crisis not only impacted the service providers but the community as well. With zero movements due to the imposition of the country-wide lockdown, populations had extremely limited access to key information on nutrition during this period, particularly in rural areas. COVID 19 pandemic had brought an unprecedented challenge in the health sector due to disruption of services and had changed the health and nutrition-seeking behavior of the community.

Response

Advocacy for the program continuity following COVID 19 protocols: Recognizing the importance of nutrition during the pandemic, NI advocated with the state governments in Chhattisgarh, MP, UP, and Gujarat to shift the distribution of IFA blue from schools/community centers to door-to-door services. Based on the advocacy efforts of NI and UNICEF the respective state governments issued guidelines in March 2020 (in Madhya Pradesh), in May 2020 (in Chhattisgarh) and June 2020 (in Uttar Pradesh) to districts/blocks to pull out existing stocks from schools and Anganwadis and redistribute it among the FLWS (ASHA, ANMs, AWWs) to be in turn distributed to adolescents at their homes during visits.

In Uttar Pradesh, Village Health, Sanitation and Nutrition Day (VHSND) being the one community-level platform that experienced the least disruption due to the COVID pandemic, it became the default choice for the implementation of Weekly Iron Folic Acid supplementation (WIFS). In Madhya Pradesh, the Health Department with the support of NI and UNICEF derived a unique strategy to designate ASHA as a key channel for the door-to-door distribution of Iron Folic Acid Supplements among the community.

WIFS intervention: In Madhya Pradesh, the decision the strategy of door-to-door distribution of IFA proved to be critical for continuity of services. First, adolescents started receiving IFA tablets at the convenience of their homes through the FLWS and the piled-up stocks of IFA blues in schools and AWWs were utilized because of the redistribution process. This enabled utilization as well as preventing the expiry of IFA-Blue tablets. NI also advocated for a change in reporting procedures to support the change in delivery platforms in the states. NI supported to development of revised reporting formats that

Anganwadi worker counselling an adolescent girl on IFA supplementation; PC@Ms Aparajita Singh, NI

were subsequently adopted by the Department of Health. With the support of development partners, all FLWs in the states were trained in these modified reporting formats. Throughout this transition of service delivery of IFA blue from schools to homes/community centers, NI supported the transition in the distribution channel with technical inputs, follow up on the stock status, continuous reporting, support in the dissemination of guidelines and reporting formats, and training of officers and front-line workers in the alternate mechanism.

Vitamin A Supplementation (VAS): NI along with UNICEF jointly advocated with the state government for the need to continue vitamin A supplementation even amidst the pandemic while taking due precautions. Though the need for continuation of rounds was rightly accepted by the states, there were apprehensions around how to conduct the rounds while following due COVID 19 precautionary protocols. The same was dealt with through the evidence-based advocacy efforts. The joint systematic planning efforts to ensure supplies to the last mile and revised guidelines for ensuring COVID specific changes in the interventions led to confidence building among all levels of health officials. Each state adopted its unique way of VAS administration. While Chhattisgarh continued to use auto dispensers to dispense Vit A syrup and hence was safe, MP used the measuring spoon provided with VAS bottles to measure the dosage and pour it into spoons carried by beneficiaries to avoid contamination. Similarly, in UP, district administration purchased disposable spoons to administer Vit A syrup. Other than this, FLWs mobilized beneficiaries in a phased manner on VHND days and ensured that social distancing norms were followed at the sites of VAS delivery. This led to the effective conduct of biannual VAS rounds in the states without any disruption.

Supply Chain Strengthening: The pandemic and associated lockdown situation resulted in restricted field movements in the state. In Chhattisgarh, MP and UP with the absence of physical monitoring, NI was instrumental in establishing the tele-calling system to regularly assess the stocks of supplies for IFA blue tablets within districts and blocks during COVID 19. NI field team had reached out to a total of 74 districts and 548 blocks of Chhattisgarh, MP and UP every month to assess the essential stock supplies via telephone since March 2020. The field team also extended monitoring support to ensure that there was steady redistribution of supplies within blocks or facilities in case of any stock-out situation. This resulted in uninterrupted availability of IFA blue tablets among the FLWs, need-based indenting, and delivery of continuous services to the beneficiaries.

In Madhya Pradesh, the Department of Health and Family Welfare managed to ensure the availability of IFA blue tablets to adolescents through door-to-door delivery by health workers. The major factors behind the uninterrupted supply of IFA blue tablets were the timely issuance of procurement and distribution guidelines from the state and districts. Development partners supported the department with the monthly follow-up on the stock status, and guidance to ASHAs to keep one-month buffer stock. NI supported this supply chain mechanism in 26 districts of MP with technical support at the state level. It was one major factor for the maintenance of AMB coverage in Madhya Pradesh during the COVID outbreak. Similarly, NI team from Chhattisgarh also supported the timely redistribution of IFA blue tablets from all the schools to community level to ensure continuity of the WIFS program

The efforts to boost awareness generation activities: In COVID, the use of digital mediums like phones, the internet, and social media platforms increased among the beneficiaries. Nutrition

International supported the Departments of Health and WCD to engage with the community at large for generating awareness on nutrition and nutrition-related service uptake through online training, capacity building of officials/FLWs and developing and sharing BCC materials for awareness generation among community and service providers.

To generate awareness among the community for the revised service delivery strategy for Vitamin A supplementation NI supported NHM in the state of Chhattisgarh, Madhya Pradesh, and Uttar Pradesh with the preparation of creative IEC materials for FLWs and the Community. The prepared IEC had illustrations according to the vitamin A supplementation guidelines issued by the states. In Madhya Pradesh, NHM has surveyed with FLWs to assess the effectiveness of the IEC posters prepared by NI. In the survey among 12,500 FLWs across 52 districts of MP showed that 95% of received and utilized the e-posters developed with the support of NI for VAS.

Digital Poster showing 10 services under DASTAK Abhiyaan

Reorientation of frontline functionaries: The COVID made it difficult to understand the gap of knowledge in the FLWs. In Madhya Pradesh, between July'21 and Aug'21, NI has conducted a total of 4 knowledge assessments covering 50,000 FLWs for the Department of Health and WCD for the DASTAK campaign and World Breastfeeding Day. The knowledge assessment for DASTAK Abhiyaan was conducted after the training to comprehend the technical content retained by the FLWs. The major findings depicted that 97% FLWs had prepared the due list, around 98% FLWs could correctly mention the vitamin A dosages or children age less than 1 year, 96% knew the correct dosage of zinc for children aged 2 months to 6 months and around 88% FLWs knew the correct dosage of IFA syrup to the children aged 6 months to 5 years.

Similarly, in Gujarat, GIFs were developed by NI and shared with the Department of Health. These creative GIFs were focused on the Early Initiation of Breastfeeding and exclusive breastfeeding. During world breastfeeding week, 2020, the Health Department released these GIFs and shared all the communication materials with the districts. These GIFs were widely shared on social media platforms by the Health Department and disseminated across the state for utilization in awareness generation activities.

Summary

COVID 19 has had an unprecedented impact on the nutrition and health care services of the country. At the same time, it was widely acknowledged that nutrition is key to ensuring that immunity is built among population groups and thereby be better prepared to fight out COVID and its impact. NI played a critical role in ensuring that key nutrition services reach populations in these times of distress. In its

programming as well as in providing technical support to the departments at the state, NI has been quick to adopt unique program strategies involving technology and digital mediums for ensuring higher coverages, uninterrupted supplies of stocks, smooth transitioning of the reporting system, capacity building of the frontline workers and officials on adapting to an alternate method of nutrition service delivery, etc. During this period of adapting to innovative ways, there were lessons learned for NI as well. Health systems across states are still in the process of adapting to changes and innovations even as several mediums are transitioning back to previous ways of delivery. This would mean that hybrid models of service delivery would be in place and states would need to be adaptive to the changing needs of the communities. It also means that alternate delivery systems would require further strengthening to be able to reach optimal levels of delivery.

What worked?

Timely advocacy and the early issuance and quick dissemination of guidelines across the state enabled the system to adapt to the rapidly changing situation. The establishment of the alternate delivery system, along with the focus on supply chain, reporting and awareness generation activities with the support of digital platforms and social media altogether have helped the department to ensure program implementation in the states successfully.

Result

The consistent efforts in Chhattisgarh, Madhya Pradesh, and Uttar Pradesh for supply chain strengthening has resulted in a distribution of IFA to adolescents. In Uttar Pradesh, this resulted in improvement in program coverages (in NI-supported 20 districts) from 2% in April 2020 to 35% in June 2021. In Madhya Pradesh, previously NI has suggested including ASHA Sahyogini in the flow of AMB reporting and that has proved an effective enabler to maintain quality of reporting during COVID outbreak. In Madhya Pradesh, the WIFS coverage in 26 NI-focused districts in April'20 dropped to 55% and the system quickly bounced back to 70% WIFS coverage in June'20.

The states of Chhattisgarh, Madhya Pradesh and Uttar Pradesh completed two VAS rounds in the year 2020-21 with coverages of 82%, 86% and 90% respectively in the second semester of VAS round for the year.

Though there were slight dips in the overall coverage, much of the under-five population was covered with VAS during this period.

Challenges

The engagement with the community using a digital medium has also witnessed several challenges such as limited attention span (in case of online training/meetings), loss in transmission of knowledge/information especially during one-way information sharing, and low sensitivity towards health-seeking behavior. The alternate delivery mechanism has although provided iron folic acid supplements to the community at the doorstep, but it has also increased the workload of the front-line workers. In future, the department and development partners together can work towards making the process less challenging for the FLWs.

Contact Details for further information

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Additional resources

Assessment of the Quality of Biannual Vitamin A Supplementation (VAS) through External Monitoring in Uttar Pradesh, Chhattisgarh and Madhya Pradesh, India PowerPoint Presentation (poshancovid19.in)

A child being administered Vitamin A Dose © UNICEF/UN0516859/Panjwani

Harnessing Power of Partnerships for monitoring continuation of the Vitamin A Supplementation to under 5 children during COVID – 19 pandemics in Jharkhand

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Background

With COVID -19 resurging and high death tolls during the second wave, the pandemic reached catastrophic levels in India and Jharkhand. COVID-19 imposed lockdown measures disrupted the delivery of even essential health and nutrition services affecting many.

Month-long Jharkhand Matri Shishu Swasthya Evam Poshan Maah (JMSSPM) round is normally held twice a year (6 months apart) to deliver a basket of six nutrition services namely Vitamin A supplementation, Iron-Folic Acid (IFA) syrup distribution, Infant Young Child Nutrition (IYCN) counselling, anthropometric screening to identify children with severe acute malnutrition (SAM), salt testing for adequacy of Iodine (in 8 endemic districts) and food/recipe demonstration for improving dietary diversity are offered.

While the entire country was grappling to address the calamitous impact of the pandemic, fighting hunger and nutrition crisis, The State of Jharkhand took on its own not to lose on the hard-won progress ensuring Vitamin A supplementation (VAS) for eligible children. WHO recommends VAS for children 9-59 months of age as a low-cost intervention shown to reduce child morbidity and mortality in countries where vitamin A deficiency is a public health problem. The recommended dose for 9–11-month-old children is 100,000 IU, and for children 12-59 months of age it is 200,000 IU. Recent CNNS survey shows that Jharkhand, tops the country with Vitamin A deficiency prevalence at 43 percent among children aged 1 to 5 years. This meant that children were at an even greater need of VAS and thus there was a need for an integrated, comprehensive, and convergent response.

Response

As per NFHS 4 (2015-16), 53 percent children in Jharkhand aged 9-59 months had received Vitamin A dose in past 6 months prior to the survey. When COVID-19 lockdown was announced despite availability of supplies due to the lockdowns and subsequent closure of Anganwadi centres and disruption of Village Health Sanitation and Nutrition Days (VHSNDs) between March to early June 2020, ensuring vitamin A supplementation to eligible children remained a challenge and the planned first round for VAS/JMSSPM could not be held. The State Government strongly felt the need to revamp the strategy to ensure continuity of key essential nutrition services. After ensuring the pre-requisites like quality assurance and logistic arrangements for supply of Vitamin A supplements, Government of Jharkhand issued guidance to initiate a month-long drive-in October 2020. Though most of field activities including Anganwadi services were constrained in October 2020, the Vitamin A supplementation drive was carried out, following COVID related safety measures.

Partnerships ensuring the delivery and supply of VAS: To re-initiate JMSSPM (VAS) drive for joint action, response, and support under the leadership of NHM Jharkhand, all development partners came together. Officials from Department of Women & Child Development and Health and more than 10 development partners joined hands to forge a strategic partnership (non-financial) to strength Vitamin A supplementation in the state. Key partners were Abhivyakti Foundation, Centre for Catalysing Change, The Coalition for Food and Nutrition Security, Ekjut, IPE-Global/WE-Can, Plan International, Piramal Swasthya, Save the Children, World Vision and UNICEF.

Adhering to the state guidelines for delivering Vitamin A to infants and children aged 9–59 months adopting COVID appropriate behaviour; JMSSPM round was conducted in June-July 2021.

Table 1: Number of JMSSPM session sites monitored by different organization

S. N.	Organization	No. of session site monitored
1	Abhivyakti Foundation	76
2	Centre for Catalysing Change (C3)	215
3	Coalition for Food and Nutrition Security (CFNS)	2
4	Ekjut	399
5	ICDS/DWCD and Health/NHM Department	904
6	Piramal Swasthya	165
7	PLAN India	27
8	Save the Children	2
9	IPE-GLOBAL/ WE Can	58
10	World Vision	84
11	UNICEF	113
	Total	**2045**

Methodology for leveraging joint monitoring using technology: Guidelines and supplies were ensured by the State Government however due to COVID imposed measures, disruption in communication; monitoring challenges remained inherent in determining VAS coverage, with pandemic only exacerbating the challenge.

The joint government-development partner alliance thus devised mechanisms for real time monitoring and supportive supervision for the implementation of the 1st round of JMSSPM during 1 June to 30 June 2021, to cover 20 out of 24 districts in the State. To set the ball rolling District level government officials along with the development partners were trained by NHM on JMSSPM expectations, monitoring and reporting tools.

UNICEF supported the State Health Department in developing a Google-form based standard tool and follow-up with partners for data entry and sharing weekly status of monitoring visits. This tool on a Google Form platform helped in easy entry and real time monitoring and supervision. Weekly follow up and update status was being shared with government and partners via WhatsApp group and emails which were further disseminated by NHM to districts for timely corrective actions. Further continuous supportive supervision was provided at the session sites to ensure the supplies as well as to ensure compliance with the COVID appropriate norms.

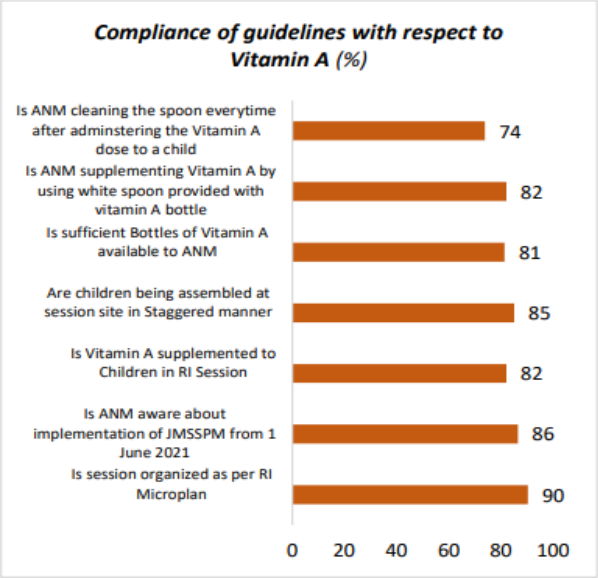
Strengthen Coordination: The alliance resulted in better coordination amongst the state, various departments at the district and block level, development partners working in respective districts and blocks and other key stakeholders that increased the efficacy in coverage and reach of VAS.

Adaptation to the COVID appropriate norms: All the activities under JMSSPM were carried out adhering to COVID-19 appropriate behaviour and protocols, for which availability of soaps, sanitizers

and masks were ensured at the session sites and adherence to social distancing was reinforced. It was also ensured during the monitoring process that only the ANM administered the VAS doses using the marked spoons provided with the bottles, and that the spoons did not touch the lips of the children. Staggering of children was also done to maintain social distancing.

Result

Strengthening Coverage, Reach & Continuity of VAS: Real time monitoring and supportive supervision ensured timely and real time feedback, quick, rational, corrective measures, support and actions as well as delivery of logistic supply on time. Timely and early identification of any shortage in supply of Vitamin A bottles through regular follow up with District health officials/ District Programme Managers (DPMs), on site supervision and checking with inventory ensured good coverage of VAS even in the most vulnerable pockets. This strengthened the delivery system and enhanced accountability.



Weekly monitoring reports helped identify areas with lower coverage and hence Government extended the round till 15 July to maximize the outreach. Joint supervision by Government functionaries and development partners resulted in successful monitoring of 2045 session sites in 6 weeks (from 1 June to 15 July 2021) across 20 districts, even during the second wave. VAS intervention was also monitored for the compliance of necessary precautions to arrest the spread of COVID -19. Coverage report from all the districts were compiled by the government.

With adequate stocks in place, Jharkhand is poised for a second round also in November-December,2021.

Enabling factors

a) Presence and eagerness of development partners who had better reach in respective districts and blocks to reach even the hard-to-reach areas for monitoring.
b) Government initiated processes: Government sent letter addressed to partners seeking joint support along with standard tool. Monitoring tool (see link annexure) was standardized in in Hindi (local language) and was short and required less than 10 minutes to fill in Google Form.
c) Partner were already doing field visits and could layer this additional responsibility of monitoring of session site. Data was entered by all partners in 1 common platform and UNICEF supported in continuous data monitoring, cleaning, generating weekly and final reports.

Challenges

Out of 24 districts, only 21 districts, where 1 or more partners existed, could be monitored. Despite supplies, it was found that in initial weeks, awareness among field staff on JMSSPM round was low. This was alerted to State NHM office and repeated orientations, and reminders were sent to improve awareness and thereby coverage.

Key lessons

One of the key lessons was that joint monitoring through partners using standard tools when facilitated by the State government can result in quick support and timely updates from field. Partnerships are powerful, especially when anchored by the Government. For instance, NHM Jharkhand wrote officially to all partners with the tool, invested in orientation of the partners team and officials at district and block level.

Contact details for further information

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Additional resources

Link to access web recording of the Govt led JMSSPM orientation: https://youtu.be/qaVN1Kd8xdc

Jingles on JMSSPM and Vitamin A in Hindi:
https://poshancovid19.in/wp-content/uploads/2021/11/PRID029030-110515-1.mp3
https://poshancovid19.in/wp-content/uploads/2021/11/PRID029031-110515REV-1.mp3
https://poshancovid19.in/wp-content/uploads/2021/11/REV_NUTRITION-JNGLE-1.mp3

Jingles on JMSSPM and Vitamin A in Nagpuri:
https://poshancovid19.in/wp-content/uploads/2021/11/UNICEF-JINGLE_NAGPURI.mp3

Jingles on JMSSPM and Vitamin A in Ho:
https://poshancovid19.in/wp-content/uploads/2021/11/AUD-20150518-WA0003-1.mp3
https://poshancovid19.in/wp-content/uploads/2021/11/AUD-20150518-WA0002.mp3
https://poshancovid19.in/wp-content/uploads/2021/11/AUD-20150518-WA0001.mp3
https://poshancovid19.in/wp-content/uploads/2021/11/AUD-20150518-WA0000.mp3
https://poshancovid19.in/wp-content/uploads/2021/11/UNICEF-JINGLE_HO.mp3

An ANM conducts a Hb Test of a pregnant woman © UNICEF/UN0390791/Vishwanathan

Beyond Boundaries - How network partners came together to ensure continuity of IFA supplementation services during pandemic: Story from Madhya Pradesh

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Background

With unfolding of COVID-19 pandemic in the state since mid-March 2020, the state of Madhya Pradesh was quick to recognize the importance of maintaining continuity of essential nutrition services and understanding the fact that addressing anaemia will help in boosting immunity hence guidelines for continuity of IFA distribution through home visits by ASHA were issued by end of March 2020 by NHM. District and block officials were sensitized and informed through virtual platforms like Zoom and WhatsApp. However, it was noted that merely releasing guidelines would not be enough to maintain the continuity of essential nutrition services (ENS) and the need for concurrent monitoring and supervision was strongly felt.

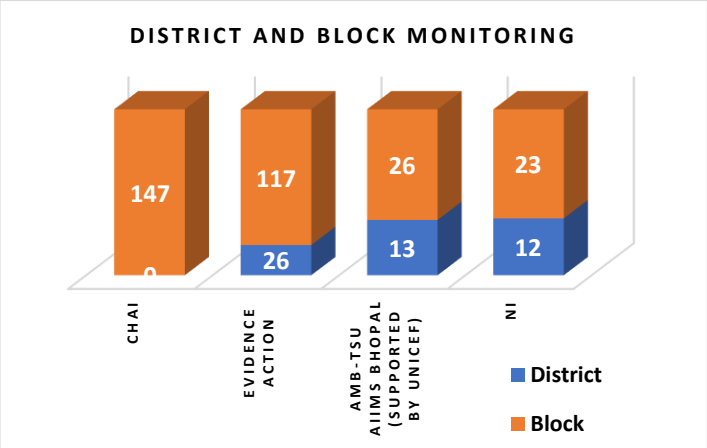
Response

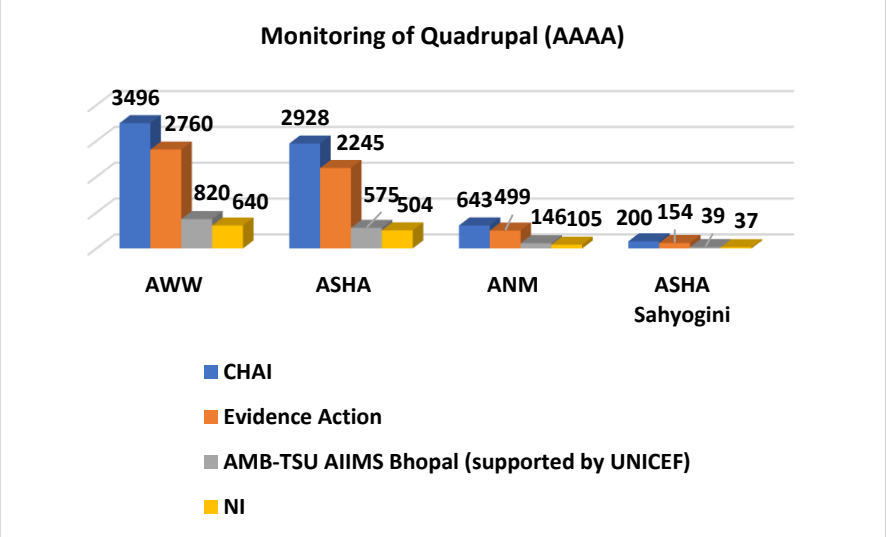
Can we come together to share our resources and boundaries to avoid duplication and get the maximum benefit out of the limited resources available with us? - was the question that was coming in minds of many of the partners while they were supporting the government in implementation and monitoring of micronutrient supplementation programme in their individual capacity. This became

more apparent while remotely monitoring the programme during COVID-19, the district officials shared their concern regarding multiple partners approaching them for the same information. So, the situation was analysed, and it was realized that there is a strong need for sharing, distribution of work and reducing overlap. This led to initiation of joint meetings for planning and monitoring of the programme.

Under the leadership of NHM - Child Health and Nutrition Division and jointly with AMB-Technical Support Unit (TSU) AIIMS team, all the four partners CHAI, NI, EA and UNICEF came together on 11th of May 2020 on a virtual platform (using Zoom) and discussed on the support each partner is providing along with sharing of their geographic presence, HR capacity, mandate, programme areas and expectations. To start with, three areas viz. supply-distribution of IFA commodities, monitoring and review mechanism, were picked up and discussed in detail. During the second round of discussion geographical presence, HR strength, level of presence for each of the partners was mapped. Next was the task of preparing the monitoring plan where all 51 districts and 313 blocks could be covered along with covering field level functionaries of Health and WCD.

AMB monitoring – common tool and joint plan: Field monitors were designated by each of the partners and a plan was developed to cover all the districts, blocks and at least 10% of the field functionaries. Initially, for the first month, all the monitors were asked to try to make 100% calls to district and blocks while 10% successful calls to ANM, ASHA, AWW and ASHA Sahyogini in a month in their respective districts and blocks as finalized in the graph shown below: Tele-calling was the methodology most suitable during this COVID-19 times, and so was chosen by the team.





When it came to monitoring tools, team got stuck as every partner had their own monitoring checklist. So, all the partners shared their monitoring checklists and one of the partners collated and simplified them keeping in mind limitations posed by COVID-19, time required and tele calling method. Again, the team

came together multiple times on Zoom to discuss, finalize and develop a standardized checklist. Using the existing experience of tele calling it was crucial to keep the checklist simple enough to be covered within 15- 20 mins without losing the content. To avoid different interpretation and variety of translation by the monitors, the checklist was translated in Hindi and a one pager was developed as reference document for filling up the checklist and monitoring exercise.

The tool was tested by two of the partners in the field and modified. The team agreed that all the partners will collect the data and share fortnightly with one of the partners (Evidence Action) for collation and analysis and further sharing with NHM and all the partners. It was also discussed that the data will also be shared with AMB-TSU established in AIIMS and all the partners for further detailed analysis and use. The team was open to modify the plan, target and approach after the first round of monitoring depending upon the situation how it evolves.

Next, was the task of bringing everyone to the same page and sharing collective understanding. So, it was important to organize training for the field monitors. On 8th of June 2020, around 155 monitors were oriented on the method and the tool to be used. During training, based on feedback from the monitors, the checklist was further changed and finalized. It took around a month in this whole exercise of planning and preparation. NHM and partners worked closely during this period. Field monitors undertook the remote monitoring to cover 98% of the districts in around 20 days.

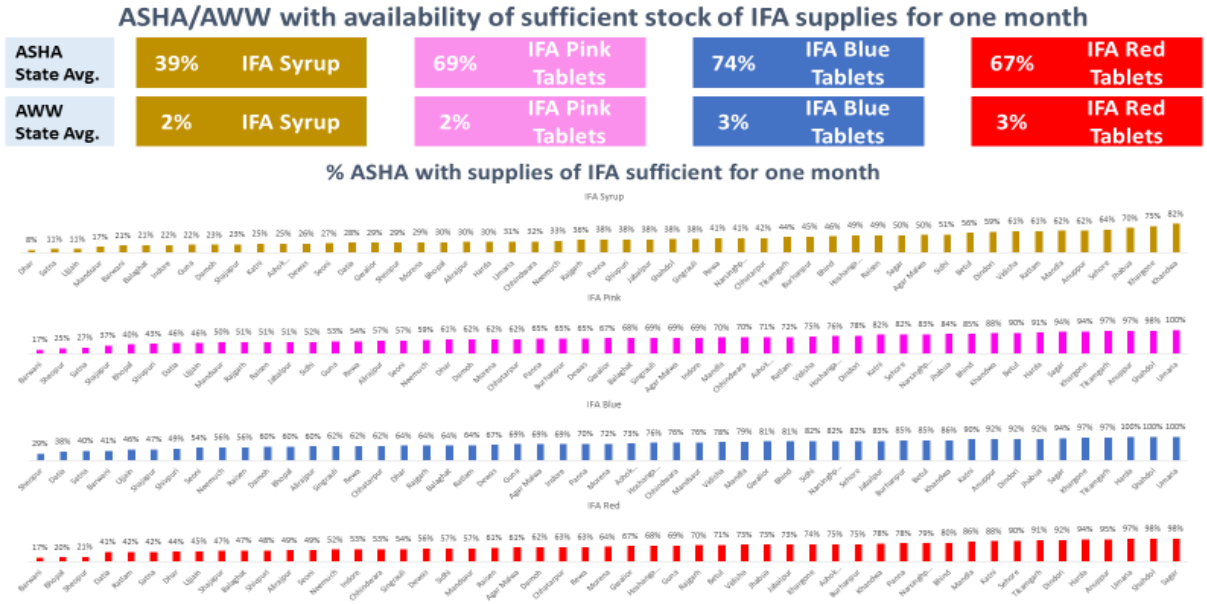
Result

The team shared the first set of monitoring data with Evidence Action (EA) in first week of July 2020. In a period of Around 20 days from 9th to 30th of June, a total of 21,736 calls were made, out of which 12,567 (58%) of the calls were successful with an average of 698 calls per day. The team reached upto ASHA, AWW, ANM, ASHA Sahyogini, block & district level officials across 51 districts. Data was analysed by EA and a debriefing session was held with NHM and partners on 14th of July. This meeting also led to some revision to the monitoring plan and checklist.

The key findings from the monitoring exercise for June 2020 were:

- More than 90% of district, block officials, ANMs and ASHA Sahyoginis had received some guidance on IFA supplementation during COVID-19
- Distribution of IFA syrup was carried out for 2.5 months by 61% of ASHAs and 54% of AWWs, for IFA pink it was by 55% ASHAs and 16% of AWWs and for IFA blue it was 53 and 15% respectively by ASHA and AWW.
- Coverage data/report based on community-based IFA distribution received by 91% of ASHA Sahyoginis, 88% of ANMs, 87% of blocks and 61% of district officials
- Adequate stock of IFA all commodities are available for more than one month at district and block level.
- At the community level, 39% of the ASHA workers have sufficient stock of IFA syrup, this was 69% for IFA pink, 74% for IFA blue and 67% for IFA red.

Graph below captures district wise status:



The findings and action points were discussed with NHM and briefing to all district and block officials by each partner in their respective district was planned. The exercise will be continued and will help in improving availability of IFA stocks and programme implementation in districts where this was initially poor. NHM has used the information and instructed districts to respond appropriately for addressing gaps.

Challenges

During the tele calling one of the main problems was the success rate of the calls which was only 50%, since the numbers provided in the database were not updated or correct. CUG (Close User Group) numbers issued to the frontline functionaries were at times unreachable. Several calls had to be made for collection of the data from FLWs due to their community visits to deliver services at household level.

Data collection from district and block officials was a little challenging at first due to their engagement in COVID-19 work at district level. In a way this joint monitoring exercise paved a way towards better coordination and convergence between the partners in the scenario when resources are shrinking and getting diverted for meeting new challenges posed by COVID-19 and the way it has forced us to modify our style of working. Teleworking is becoming a new normal even in context of monitoring and we have used and continue to use it to the full potential to conduct a situational analysis of AMB programme implementation at the ground level to equip the State Government to take informed decision

Enabling factors

Presence of development partners network in the State, that used to meet regularly even before the pandemic struck helped to quickly discuss and plan out a course of action.

It helped that the partners had good rapport with the National Health Mission and were already supporting the monitoring of Anaemia Mukt Bharat programme. Regular sharing of findings with NHM officials for AMB monitoring during pandemic helped in addressing the gaps in supplies and delivery.

State of Madhya Pradesh used a manual MPR reporting system from quite long. This system is well established and was continued along with online reporting on Health Management Information Systems (HMIS). This system helped during COVID to get report from the field even when online system was not functional. Following is the reporting system used by the state:

ASHA ➡ ASHA Sahyogini ➡ BCM ➡ DCM/DM&E ➡ State Nodal

Lessons

Sharing and working together helped the partners demonstrate successful model of joint monitoring and supporting the state without crossing path and overlapping along with optimal use of limited resources available with each one of the partners. Also, validation of data and information should be clubbed with this model for improved quality of data and reporting.

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Health check-up during pregnancy © UNICEF/UN0390787/Vishwanathan

SECTION 3

Supporting Maternal Nutrition during COVID-19 Pandemic

From Face to Face to Phone-based Data Collection from Swabhimaan Impact Evaluation Sites: Lessons from Bihar, Odisha & Chhattisgarh on Adapting Process Monitoring

Contributors: Bharati Sahu, Monica Shrivastav and Neha Abraham, Consultants, ROSHNI-Centre of Women Collectives led Social Action, Lady Irwin College and Abhishek Saraswat, International Institute for Population Sciences

Background

After the nationwide lockdown was imposed in March 2020, there was a need to understand how the women groups-led actions under the Swabhimaan programme were adapting, how field activities and essential services had been affected, what were the challenges faced by frontline workers and to understand the resilience of community-based institutions to support systems during health emergencies and new areas for capacity building.

Response

370 respondents involved in interventions across five sites; Jalalgarh and Kasba blocks in Bihar, Bastar block in Chhattisgarh and Koraput Sadar, and Pallahara blocks in Odisha were interviewed using tele-monitoring between May-June 2020.

These intervention blocks are also amongst DAY-NRLM's poorest resource blocks where the programme seeks to reach the most vulnerable through the existing Self-Help Groups (SHG) networks.

Interviews were conducted with two kinds of programme implementers using two methods

(a) Telephonic interviews with Community Cadre: *Poshan Sakhis, Kishori Sakhis*, village organisation (VO) functionaries and cluster level federation (CLF) functionaries were involved in various aspects of programme implementation like promoting positive nutrition behaviours, linking beneficiaries to schemes and loans nutri-based livelihoods, organising health and entitlement camps and social drives in the local community

(b) Link-based self-administered questionnaires with programme staff including State Rural Livelihood Mission (SRLM) staff and consultants at block, district and state levels

Block-level Management Information System (MIS) consultants and a team of trained data collectors conducted the interviews based on a bilingual interview schedule. A random, representative sample of village organisations was drawn from each state for round one.

Results

Telemonitoring was a five-week process in each state with > 97% completion rate. Through this process, we were able to reach 370 women's group members. The survey revealed that women collectives were able to prioritize and support needs of at-risk target groups, including anaemic women and adolescent girls because of prior identification. Home visits for nutrition counselling, delivery of antenatal care, and food ration through public distribution system were continued through convergent action with frontline health workers and Panchayati Raj Institutions. At-nutritional risk women and adolescents were supported with nutri-garden development (71%), and linkage to agri-poultry, social protection schemes. Women's collectives led awareness generation (65%), surveillance (60%), hand washing demonstrations (94%), production and distribution of soap, masks, sanitizers (67%) and gap-fill for nutrition and on-the-spot feeding programmes by producing nutrition supplements (21%). Women's groups were able to adapt and support gap-fill for disrupted nutrition services through intensification and leveraging of food, nutrition, health and WASH services and actions already in place through prior training and sensitization. Clear guidelines issued by SRLMs and allied departments supported this.

What worked?

The initial database of respondents included invalid phone numbers. However, we could go past the non-response due to invalid phone numbers, power-cuts and low balance as the block MIS consultants, who are locals, were part of the data collection team. This enabled cross-checking of information and in-person follow-ups, so respondents were reached at later dates or through neighbours and relatives.

Respondents were willing to complete the interview even if it took longer than expected when they were familiar with data collectors.

Data collection was planned around respondents' work at home and in the field, before 8:00 am and after 7:00 pm as all Swabhimaan's intervention sites are in paddy growing areas and data was collected at the peak of the monsoon 'kharif' cropping season. Appointments were also made around husband's availability at homes as few respondents had their own phones.

The questionnaire was developed by adapting indicators that women's group members were familiar with, and this made it easier for respondents to understand telephonically. Data collectors were also trained to listen closely for signs of confusion or hesitation and use these as cues to either probe further or re-explain questions.

Women collectives welcomed the shift to telemonitoring as they felt the process made their efforts on the ground visible. It can thus strengthen their accountability and ownership over interventions. The process allowed accurate, timely information on the status of community-led and systems actions directly from the community. Involvement of SRLM staff in planning this process can enable uptake of telemonitoring, to establish a feedback loop for corrective action and support programme implementation.

Challenges

Low phone ownership amongst women respondents. Most respondents in Bastar didn't have their own phones and the phones were usually with their husbands. Appointments thus had to be made depending on when the husband was at home. In a few cases, certain men were suspicious and insisted on answering on behalf of their wives. In such cases, the background and purpose of data collection were re-explained with an emphasis on why they needed information directly from the women.

Data collectors' gender impacted their ability to reach respondents. It was challenging for male data collectors to speak to respondents who were unknown to them as husbands were suspicious. In such cases the purpose of data collection was reiterated.

Block level MIS consultants collecting data outside of office hours. Most of our intervention sites are rice-growing areas. The onset of monsoon meant that families would leave for their fields by 8:30 am and return at 8:00 pm except for an hour in between for lunch. All interviews had to be scheduled within a limited period between 7:00 am – 8:30 and after 9:00 pm. Data collectors had to work outside conventional office timings. This was a challenge for block-level staff who did not own laptops or computers for data entry and were dependent on computers provided at the block office.

Power cuts and low balance amount. Cases of phones being switched off were surprisingly high, particularly in Bastar. This was unexpected because programme staff and supervisors who were also involved in data collection, had been in regular touch with respondents. We later found that because of continuous power cuts during data collection week many had to travel to neighbouring villages to recharge and switch on their phones. Further, many could not receive calls because the phones did not have sufficient balance and mobile shops were closed. Some also reported not having enough money to top-up their balance regularly because of income lost during the lockdown. We were able to contact most respondents at later dates, and some were also contacted via their neighbours' phones.

Comprehending regional dialects. While all respondents in Bihar understood Hindi, many spoke Surjapuri which has influences of Assamese, Bengali and Maithili, as their first language. Similarly, our respondents in Bastar also spoke either Halbi or Gondi. This made it challenging for the Delhi-based data collectors to understand responses. They were then oriented and prepared to deal with this.

Conducting phone-based interview with adolescent girls: Respondents tend to discontinue the telephone call on facing discomfort and shyness. Enumerators should spend time in building rapport and ensuring privacy of respondent, taking the guardian/ parent into confidence.

Comprehension of response structures in measurement scales: For administration of scale-based tool over phone, statements needed to be repeated (to breakdown the statement and for ease of comprehension). Responses in Yes/No format are easy to capture telephonically. Scales are difficult to explain – vignettes were required for explaining the scale items using anecdotes and situations. For agreement-based scale – one extra question was asked on whether they strongly agreed or disagreed with the statement.

Eliciting and recording responses: Respondents were shy and concerned about correct answers while responding to questions. The responses were also driven by the judgement of the respondent – on what to tell or how to answer. Longer time was needed to 'quantify' answers as per the scales over phone, self-administration, as people tend to answer anecdotally. Anecdotes were useful to understand whether the respondent had understood the focus of the question, but the challenge for the interviewer was to help them arrive at a specific answer. Telephonic interviews miss subtle expressions, non-verbal cues as compared to face-to-face interviews; interviewers rely on change in voice tone. Inter-interviewers bias may also affect the responses within respondents. Interviewer's knowledge of demography, social fabric, impact discernment of responses can impact the quality of data collected. Attempts to probe, triangulate and navigate socially desirable answers was needed.

Key Lessons

Collecting valid phone numbers. In many cases, respondents' phone numbers had either changed or were invalid. Given that numbers change frequently, these must be checked and updated regularly before preparing the master database to ensure the interview process runs smoothly.

Connectivity mapping. This must be done beforehand. In Bihar, two villages- Bareta and Sanjheli- which were in low connectivity areas had to be replaced during the data collection because respondents could not be reached. To deal with this, the possibility of providing respondents with mobile SIM cards for networks that have better connectivity or covering costs of these is being considered. Alternate ways including paper-based data collection from low connectivity areas while adhering to physical distancing norms are also being considered for future.

Timely information shared with respondents. Prior to the interview, all supervisors must inform respondents on the purpose of the interview and the timeframe when they could expect a call. This was part of ethical considerations to ensure respondents were able to understand and provide informed answers. Prior appointments also save time as data collectors could connect and complete interviews in the first attempt.

Contextualising programmatic language. Official terms used for several public goods, services and interventions had to be referred to by colloquially used terms. These were discussed and noted after pre-testing. A glossary of local terms was added to the data collector's manual, to ensure questions were correctly understood.

Paying attention to signs of confusion/ hesitation/ discomfort. While the questionnaire administered was objective, signs of hesitation or confusion from the respondent such as long silences or cross-questions from the respondent, for instance, became cues to either probe further or to move

to a different section. A provision note of these qualitative nuances has been added at the end of each section. As a team, we took note of and discussed these observations during our daily stock-taking meetings.

Addressing requests/ expectations. The team was careful to ensure that data collectors did not raise respondents' expectations. In cases where a few requests were made, it was clarified that information would be passed on to the block level staff as was done earlier during the programme reporting process. The objective and limitations of the data collection process were re-iterated at these times.

Getting data validated by government functionaries. As data collection was being managed by an external knowledge management team, government validation of the data was essential to build ownership over the process monitoring system. This also ensured that data could be used to initiate appropriate corrective actions. Officials and state programme managers from SRLMs were thus actively involved in tool design and finalising the methodology. All factsheets were also validated by the district staff.

Building capacities of block and district level consultants. While data collection for the first round was supported by an external team, consecutive rounds were incrementally handed over to block and district programme staff who normally managed programme MIS. They were thus included in all training sessions. Inclusion of block and district offices also involved more resources in data collection tasks. These staff were also capacitated for the task.

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More information available on www.roshni-cwcsa.co.in/BlogDetail.aspx?BlogID=7

Mother Sonari Wadaka smiles at the camera after bringing two-year-old Sibani back to their village in the Dongria tribal community at Bissam Cuttack, Odisha after medical treatment in an NRC. © UNICEF/UN0428504/India Country Office

SECTION 4

Management and Treatment of Acute Malnutrition among Children during COVID-19 Pandemic

Devamma is all smiles in NRC Chikkabalapur Nutrition Rehabilitation Centre (NRC) Karnataka, India © UNICEF/UNI216281/Edwards

Continuity of Facility based SAM management during COVID in Ballari District of North Karnataka, India

Contributors: Dr. Durgappa, HOD of Paediatrics, VIMS, Ballari, Dr Sridhar, Deputy Director- Nutrition, Health Services, Karnataka, Mr. K. Vishwanath, Senior Nutrition Consultant- IMSAM, UNICEF, Dr. Khyati Tiwari- Nutrition Specialist, UNICEF

Background

Karnataka saw a very high incidence of COVID-19 during the second wave in 2021, with more than 7000 cases being reported daily and total 1,51,566 cases as on 16.6.21 (Source: Media Bulletin Government of Karnataka). Ballari one of the northern Districts of Karnataka, alone reported 96102 total positive cases, 2668 active cases and 1482 deaths on 16th June 21. In response, the district administration decided to convert District and Taluk level Hospitals into COVID wards, through which only COVID infected or suspected cases were admitted in the hospitals.

In Bellari district, the prevalence of wasting among children below 5 years is 22.9% and severe wasting prevalence is 13.6% (NFHS-5). This is higher than the State average of 19.5% wasting and 8.4% severe wasting. Children with severe wasting/severe acute malnutrition (SAM) were severely affected due to the pandemic. There was a need for an alternative management for accessing Nutrition Rehabilitation Centre (NRC) services for SAM children with medical complications.

Innovation

The district administration headed by the Deputy Commissioner had requested UNICEF for technical support to address the above situation. Two rounds of discussions were held followed by capacity building of ICDS and Health staff at State level on screening techniques.

The district administration also decided to try a concept of peripheral NRCs at Taluk (Block) level with coordination of Paediatric Department of Vijayanagar Institute of Medical Sciences (VIMS), Ballari which is taking care of Nutrition Rehabilitation Centre (NRC) at Ballari, With the technical Support of UNICEF, Dept. Of Health & Family Welfare, Department of Women & Child Development from April 2021. The peripheral NRCs could finally start functioning from June 2021.

The salient features of these peripheral NRCs were:

- **Identification of infrastructure for Peripheral NRC** – By Tahasildar, Executive Officer and CDPO of the Block/Taluk.
- **Screening of Children** – ICDS & Health staff were responsible for screening.
- **Transportation of Children**- CDPO, Taluk Health Officer supported by local private schools.
- **Training for preparation of diet and monitoring of NRC**– Provided by district NRC staff including paediatrician, medical officer and diet counsellor, guided by HOD, Paediatrics, Vijayanagar Institute of Medical Sciences (VIMS), Ballari.
- **Funding Support** – Funds were mobilised from District Mining Fund (DMF) and District Health & Family Welfare.
- **Admissions Criteria**: Government of India protocols i.e., MUAC<11.5 cm, Weight for Height (WFH)< -3 SD (Standard Deviation), bilateral pitting oedema were taken for screening SAM children.
- **Beneficiaries**: All children identified with SAM without medical complications were admitted to peripheral NRCs. SAM children with medical complications were referred to District NRCs. Siblings of the children were also allowed to stay along with caregiver.
- **Period of Stay**: 14 days facility-based treatment in identified hostels, now converted to peripheral NRCs.
- **Responsibility of treatment & care**: Medical Officers deputed by Taluk Health Officer (Zila Parishad) supported by Paediatricians of Medical College/NRC and paediatricians identified by district Indian Academy of Paediatrics (IAP) chapter.
- **External Monitors**: Assistant Commissioner of Subdivision, CEO Zila Parishad, Deputy Secretaries of Zila Parishad, District Health & Family Welfare Officer, District RCH Officer, executive officers of taluk, Taluk Health Officer, Tahasildars of concerned taluk, CDPO of the project were entrusted to monitor the functioning of peripheral NRCs.
- **Officers in charge at NRC:** CDPO, Asst. CDPO, selected supervisors & Anganwadi workers of ICDS, Sr. Health Assistants from Dept. of Health, Poshan Abhiyan Co coordinators were made responsible for the peripheral NRCs. Their role was to supervise daily on provision of medicines, food materials, vegetables, preparation of food, adherence to feeding protocols, drinking water, hygiene, bookkeeping, recording of weight gain by child, organizing yoga

classes for mothers, counselling using flip book, orienting on home-based diet, facilitating visits for paediatricians deputed from IAP & Medical Officers from Taluk Health Office (THO).

What worked?

Since students' hostels were converted to peripheral NRCs and had child friendly atmosphere and siblings were also allowed to stay along with caregivers, this arrangement helped the caregivers to access the NRC services, without fear of having to visit a hospital amidst COVID outbreak. The centres were able to provide medical supervision, medicines and supplements, accommodation, a hygienic environment, and food to the occupants.

Apart from care & treatment for children, various activities were designed for mothers such as yoga, counselling on home-based diet, structured play therapy, evening educational videos, physical exercises, advises from expert doctors from IAP, treatment for mothers, which were attractive to the caregivers.

Furthermore, with little opportunity of wage-earning during lockdown, a wage compensation of Rs.275/day (minimum daily wage in Karnataka) for 14 days was looked upon favourably.

Care and treatment, provision of medicines, accommodation, hygiene, water facility, nutritious food and personal security were highlights of the program.

Synergetic action of District Administration, local governance, health and ICDS, private schools, Rural Development and Panchayati Raj, Depts of Revenue, Social Welfare, Zila Parishad Engineering, Transport, and IAP was highly effective in supporting continuity of care for SAM children during the pandemic second wave.

Peripheral NRCs are located at sub taluk level and are put in place to cater acute malnutrition, closer at community level. During lockdown public transportation had come to a halt. Since parents did not have to travel to District Hospital, it helped in accessing the services.

Challenges

Limited funding was available from District Mineral Funds and DHFW due to competing demands during the pandemic. Had to discontinue after 2 batches, as the fund availability was low.

Delayed wage loss compensation payment.

Monitoring from the State was limited due to COVID pandemic.

Result

In Ballari District about 8 blocks /talukas namely Ballari, Sandur Siruguppa, Hosapete, Harapanahalli, HB Halli, Hadagali, Kudligi have started peripheral NRCs.

During phase 1, (which was from 8th June to 25th June 21), 488 children were screened, and 305 children were admitted based on admission criteria. 209 children discharged with weight gain with an increase of 5 % to 15 % weight gain from the admission weight i.e., 68.5% cure rate was achieved. Bed occupancy in the peripheral NRCS was an average of 85% from 8th June 2021 to 25th June 21.

During Phase 2 which was held from 1st July to 15th July 2021, 353 children were screened and 310 were admitted. 238 children gained weight with 76% cured rate. An average of 80% bed occupancy found during the stay.

Key lessons

Caregivers were comfortable in the non-medical child friendly setup for treatment. This also helped in enhancing the length of stay and lower defaulter rates.

Convergent action led by Deputy Commissioner helped to make the alternative arrangement efficiently.

Adequate arrangements for financial resources are required to sustain such initiatives. And hence CMAM emerges as the most relevant, sustainable solution for management of non-complicated SAM and MAM cases closer to home. This needs to become a part of advocacy with state as its both technically appropriate and less resource intensive.

Clear guidelines, delineated roles and responsibilities and SOPs are required for such alternative arrangements.

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A child being treated in a Nutrition Rehabilitation Centre © UNICEF/UNI162420/Biswas

Treatment of Severe Acute Malnourished Children Continues while fighting against COVID-19: A Challenge Accepted by Bansgarh NRC team, Balrampur Purulia District, West Bengal

Authors: Ms. Sulagna Sarkar, Consultant and Dr Farheen Khurshid, Nutrition Specialist, UNICEF Kolkata Field Office

Background

As the coronavirus pandemic struck and India went under lockdown in March 2020, all Nutrition Rehabilitation Centres (NRCs) in West Bengal were gradually closed. It was no different for Purulia district, located in the western corner of the state of West Bengal located in the eastern part of the country. Purulia has the highest burden of childhood wasting among children aged 6-59 months and as per NFHS -5, 7.9% under-five children are Severe Acute Malnourished in Purulia which is higher than the state average (7.1%)

Treatment of children with severe acute malnutrition (SAM) with infections/ clinical complications has been supported by 9 NRCs in the district. In March 2020, all NRCs were closed, and the NRC staff were put on alternative work schedule as they were assigned duty at the COVID monitoring cells in the district. In July 2020, the State decided to reopen all NRCs progressively and by December 2020, 90% of the NRCs were functioning and the bed occupancy started picking up too. In January 2021, NRC teams began conducting outreach sessions while maintaining COVID appropriate behaviour (CAB), for

active case finding. The fear of COVID-19 had created panic among caregivers and families, and it became a humongous task for NRC teams to convince parents to get their children admitted for treatment.

The situation was gradually returning to normal, when the COVID- second wave surged in April 2021 with a sudden increase in the number of COVID-positive cases and also of deaths. Like most other parts of the country, there was panic, fear and anxiety. The mothers and caregivers at the NRC were concerned about themselves and their child's safety and wanted to return to their respective homes.

This time, the NRCs were mandated to remain open during the second wave and admissions continued while maintaining COVID appropriate protocols. However, as the situation became grim with the number of cases in West Bengal increasing, bed occupancies at NRCs also started to decline. Following the Assembly elections in West Bengal, a sudden lockdown was declared which imposed mobility restrictions. Hence though the bed occupancies remained low, children already admitted for treatment were provided the required services

At the Basgarh NRC, the scenario was slightly different. At the time of sudden lockdown there were four (4) children who were already admitted, of whom symptoms of COVID were observed among two children and also among two caregivers. This created panic and caregivers did not want to continue their stay specially those who were not infected. The NRC team members were perplexed and were unable to fathom how to address the situation and reason how the virus could have spread at the NRC.

Soumyasree Rana, Nutritionist of Bansgarh NRC explained, *"We always do the Rapid Antigen Test before admission and admit only those children and caregivers who test negative. During the stay, sometimes visiting family members do not follow proper respiratory hygiene which may be the cause for the sudden spread of corona virus disease among those admitted."*

Response

The NRC had to take some critical decisions on how to manage the infected and non-infected children and the mothers. Several questions had to be reasoned and decisions taken on whether they should continue regular activities or close the NRC. With strict lockdown imposed by the government, plans had to be made to arrange for return of the children to their homes in case the NRC had to be closed. The team discussed the situation with Dr Abir Chanda, Block Medical Officer of Health (BMOH) of Bansgarh Rural Hospital and sought his advice "Close the NRC *Why",* asked the BMOH*, "How can we ask SAM children to return before treating them?"* He continued, *"They are already in a vulnerable state. We have to fight against COVID-19 and win.*" The Bansgarh NRC team was inspired, and they collectively decided that this was the time to take up the challenge, deal with the situation in a planned manner.

The NRCs team swiftly decided to adhere to COVID protocols and continue providing services both for treatment of SAM and recovery from COVID.

- A separate arrangement for non-infected children was made and the playroom was temporarily set up for children and the caregivers who were not infected.
- Daily screening of SAM Children maintaining preventive protocols: The team at NRC screened all the children daily and took anthropometric measurements wearing the PPE Kits, washed hands with soap for at least 20 seconds, sanitized the equipment before and after screening each child.
- Ensuring adherence to COVID preventive protocol within NRC premises:
  1. *The temperature of all staff and non-staff members was checked at the entrance of the NRC.*
  2. *Washing hands for at least 40 seconds with soap after entering the NRC was strictly followed*
  3. *All team members wore PPE Kits during their duty hours.*
  4. *All the mothers were counselled and advised to strictly practice preventive measures like-*
  5. *hand washing at regular intervals and to always wear the mask except while sleeping.*
  6. *To ensure physical distancing, beds were placed two meters apart in the NRC ward.*
  7. *Proper distance was maintained by NRC attendant while serving food. In the feeding room, caregivers with their children maintained at least 3 feet distance with others and refrained from sharing or touching food / utensils of other patients*.
- Discharge: The NRC protocol of discharge criteria of 15% weight gain could not be followed, to decrease the risk of cross infections. Instead, children were discharged after their weight gain reached 5gm / kg / day for three consecutive days.
- Those who had tested COVID positive were discharged only after the Rapid Antigen Test showed they were COVID negative.

A mother of a non-COVID child shared her anxiety when others were COVID positive and later her delight in getting discharged safe with her child on the path of recovery. She stated, "*When some mothers and their children got infected with COVID-19 at the NRC, I was very worried. I didn't want to stay among them. But Didimoni (the nutritionist and attendant) arranged our stay in the playroom which was separate from the ward where the infected patients were staying. I stayed there separately for two more days and then got discharged. Both my child and I are safe. The NRC didimoni (elder sister) took good care of us"*

During discharge, a COVID-19-recovered mother whose child was also infected, was all praise for Bansgarh NRC team and mentioned, "*We got complete care, treatment, medicine and rest during the period we stayed at the NRC, and this would not have been possible at home. I am happy that both my child and I are recovering now, and we can go back to our family without any hesitation*."

The mothers who believed in the NRC team were the ones who gave the team strength to face the situation. The constant support of the BMOH and dedication of Bansgarh NRC team to treat and care for the most vulnerable children, during this challenging time inspired other NRCs in the district to continue providing uninterrupted services.

Challenges faced

- The sudden imposition of lockdown made it difficult for the NRC to take any prior steps, this caused panic and fear amongst caregivers and service providers.

- It was difficult to serve the COVID positive and non-COVID children in the same NRC maintaining all the preventive protocol.
- There was a risk NRC staff also getting infected.
- It was challenging to motivate the family members of non-infected children to continue their stay at the NRC.
- Follow-up after getting discharged from the NRC was difficult.

Result

All 4 children were discharged from NRC after stabilization and weight gain of minimum 5g/body weight/day for 3 consecutive days (the criteria of min 15% weight gain had been waived off in this case). All mothers and children who had tested positive also recovered from COVID.

Name of the child	Age	COVID-19 status	Duration of stay	Admission weight(kg)	Discharge Status	Discharge Weight(kg)
Child A	11m	Mother+ child (-)	21days	6.00	Weight gain & COVID negative	6.90
Child B	21m	Both +	20days	7.80	Weight gain& COVID negative	8.24
Child C	18m	Mother (-) Child +	20days	7.48	Weight gain &COVID negative	8.05
Child D	29m	Both (-)	15days	8.90	Weight gain	9.46

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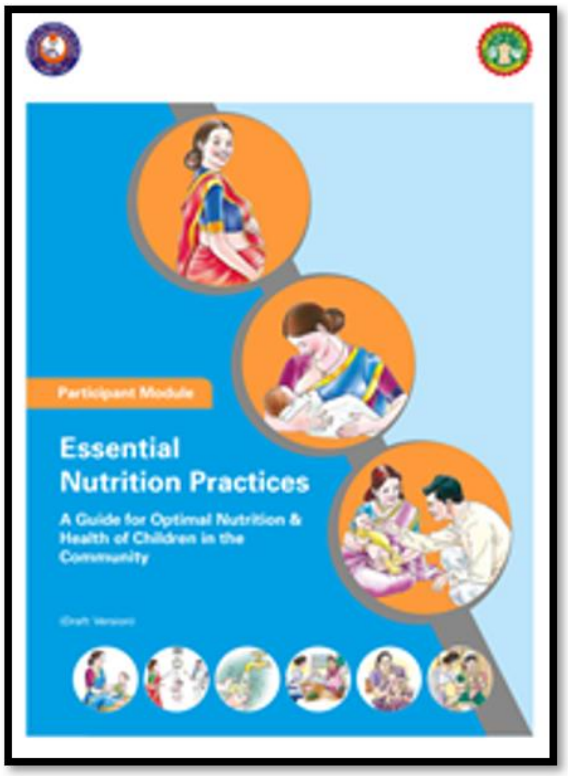

Essential Nutrition Practices Guide

Adapting essential nutrition practices in facility and community-based programmes for management of SAM during Covid-19

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Background

Promotion of essential nutritional practices (ENP) for prevention of childhood wasting is an integral part of management of facility-based management of children with SAM (FSAM) and community-based management of children with SAM (CMAM) programmes. In the backdrop of the COVID-19 pandemic, it became important to modify the ENP guide and counselling cards to incorporate details of COVID-19 and essential components of its prevention besides describing essential nutrition practices for nutrition promotion of children. The counselling tool also helped in building awareness on what is COVID-19, its symptoms and how to prevent its spread besides describing the essential nutrition practices for improving child nutrition.

Response

Counselling cards on Essential Nutrition Practices during COVID-19 Pandemic were developed which was endorsed by Indian Academy of Paediatrics (IAP). This was based on "WHO, UNICEF and USAID Counselling Cards for Infant and Young Child Feeding Recommendations" Infant and Young Child Feeding Recommendations When COVID-19 is Suspected or Confirmed | USAID Advancing Nutrition (attachment 2) and "When COVID-19 is Suspected or Confirmed and Recommended Practice" Booklet, April 2020& MOHFW COVID Guidelines (attachment 3).

The counselling cards were developed in English, Hindi and Odia languages and shared with different States. Different states also translated the cards in the regional languages for local use. This was recognised as counselling tool from India published under "Using the Counselling Package on Infant and Young Child Feeding in the Context of COVID-19" by UNICEF Head Quarters, New York.

Result

Different states such as Odisha, Gujarat, West Bengal, Maharashtra, Rajasthan and Jharkhand are using the counselling cards in the facility and community-based nutrition promotion programmes.

Enabling factors

Child nutrition promotion was focussed by Government of India and State Governments even during the COVID-19 pandemic. NCoESAM, KSCH, New Delhi has been providing technical support in implementing facility and community-based management of acute malnutrition programmes at the national and state levels. The module developed by NCoESAM with endorsement from IAP was acceptable to all the States. The cards could be easily translated in regional languages for local use and was a ready reckoner for frontline functionaries.

Contact details for further information

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Additional Resources

- Infant and Young Child Feeding Recommendations When COVID-19 is Suspected or Confirmed | USAID Advancing Nutrition
- MoHFW, GoI, Guidelines to be followed on detection of suspected or confirmed COVID 19 cases. GuidelinestobefollowedondetectionofsuspectorconfirmedCOVID19case.pdf (mohfw.gov.in).
- Advocacy Brief on SSFP 2020__Final Revised.cdr (coesamnetwork.org)
- Counselling Cards (Hindi) COVID-19 (coesamnetwork.org)

- Counselling Cards (Odia) COVID-19 (coesamnetwork.org)
- Management of childhood wasting in context of Covid Document-2020-06-11-10-19-01.pdf (coesamnetwork.org)
- For more information, please visit: CoE-SAM Network (coesamnetwork.org)

Infotainment on a smartphone © UNICEF/UN0488996/Kolari

SECTION 5

Using Technology for Awareness Generation and Monitoring during COVID-19 Pandemic

Shanta Meena is equipped with a Smart phone to record the data for ICT – Real time monitoring to achieve the target set under the Poshan Abhiyaan. © UNICEF/UN0322021/Kolari

Ensuring continuity of services through remote sensitization and supportive supervision under Dept. of Social Welfare, Assam

Authors: Shri. Bivash Modi, Assam Civil Services, Director Social Welfare and State Project Director, Poshan Abhiyaan Assam, Dr Shweta Sharma, Nutrition Specialist, UNICEF, Guwahati Field Office

Background

Anganwadi centres in Assam remain closed due to the COVID-19 pandemic. Over the last 18 months since April 2020, multiple advisories have been issued by the state government to ensure continuity of essential nutrition services through alternative delivery mechanisms. While numerous online trainings have been organised for district and project officials on different interventions, it has been difficult to ensure sensitisation of all FLWs on continuity of services and recommended nutrition behaviours in context of COVID-19. Field insights showed that COVID-19 and ensuing lockdowns had interrupted supportive supervision and monitoring of service delivery.

The state rolled-out community-based management of severe acute malnutrition (CMAM) programme across 33 districts in 2020-21. While the CMAM state level training was held in February 2021, the trainings for ICDS supervisors and Anganwadi workers was interrupted by the second COVID wave in April 2021. In May 2021, the state introduced light reporting on enrolment under the newly rolled-out CMAM programme, requiring additional handholding support at district and sub-district level.

Response

To address the implementation challenges, a remote sensitisation and supportive supervision mechanism was established by the Department of Social Welfare, Government of Assam. The aim was:

(i) to build capacities of AWWs on service delivery in COVID context; (ii) to intensify supportive supervision and (iii) to streamline reporting on essential nutrition services including MIYCN counselling; growth monitoring; CMAM; IFA supplementation among out-of-school adolescent girls.

The state had conducted numerous state level capacity building sessions. Services prioritised as 'essential services' were in line with the numerous state directives issued in context of COVID. These included monthly growth monitoring and screening for malnutrition; care for children with SAM; weekly Iron and Folic acid supplementation among adolescent girls; and MIYCN counselling for pregnant women, lactating mothers, and mothers of children below 2 years.

To ensure two-way communication and respond to individual context-specific challenges, it was decided to put in place a telephonic outreach system. To carry out the telephonic supportive supervision, a team of 'Mentors for Nutrition' was identified with support from UNICEF Assam and Assam Medical College and Hospital.

As detailed discussion on all the essential nutrition services was difficult to cover in a single call, three rounds of telephonic outreach were planned. Each round of telephonic call aimed to cover key aspects of all essential services with in-depth dialogue on one specific area. For the first round held in June 202; growth monitoring and screening for SAM was the focus.

What worked?

Government led supervision process helped to ensure participation from all relevant stakeholders (supervisors, frontline functionaries) at all stages and higher acceptance of the findings of the surveys. Direct dialogue was held with all CDPOs and Supervisors. Supervisors were asked to sensitise AWWs face-to-face or telephonically. Focus was on strengthening systemic supportive supervision for FLWs. Three phases of supportive supervision were provided to assess the uptake of messages and reinforce the same among different levels of functionaries:

i. The team of mentors reached out to all CDPOs and Supervisors to sensitise them on alternative mechanisms for continuity of essential nutrition services and to provide supportive supervision on service delivery.
ii. Extended team from UNICEF and partners (Tea Associations, Tezpur University, World Vision India) reached out to sample of CDPOs and Supervisors (N=321) to check the receipt of messages provided by mentors
iii. The mentors team reached out to AWWs (N=1200) to assess the uptake of messages from Supervisors to AWWs and supervise service delivery.

Result

1. 131 (99%) CDPOs and 1,975 (89%) supervisors sensitised directly by mentorship team on continuity of essential nutrition services. Of these, 826 (41%) Supervisors reported to the mentors and as per their reports 18,407 (30%) AWWs were sensitised by Supervisors.

2. To assess the knowledge status among supervisors, UNICEF partners and extended teams reached out to 342 supervisors (out of the ones already reached by Mentors Team). The findings helped to understand regarding receipt of information from Mentors team and knowledge retention among Supervisors.
3. 1,206 AWWs were reached by mentorship team to assess the percolation of messages. Findings show more than 90% AWWs received information on continuity of essential nutrition services from AW Supervisor in the month of June/July.
4. Service delivery coverage under growth monitoring, screening for SAM, CMAM services, MIYCN counselling and IFA supplementation among out-of-school girls was reviewed. The exercise helped in understanding the knowledge of ICDS Supervisors and AWWs on alternative mechanisms for service delivery in context of COVID-19. To continue to strengthen the coverage and continuity under growth monitoring, the month of August was declared as 'Massive Growth Monitoring Month' by the Dept of Social Welfare, Assam.
5. The remote sensitisation and supportive supervision exercise served as one of the first efforts to sensitise ICDS supervisors and AWWs on CMAM. Through this exercise for the first-time district level reports on children enrolled under CMAM were received from 33 districts.
6. Two months after the launch of remote supportive supervision was completed, the state has seen a substantial improvement in screening, identification, and management of children with SAM, with NRCs across the state functioning at improved capacity in September 2021.
7. The data from 'round one' has been used to identify priority areas for second round of remote sensitisation and supportive supervision initiated in September 2021.

Challenges

While telephone calls facilitated two-way communication, there were issues with language. To address this, a written note in Assamese/Bengali was shared with all functionaries at the end of the call through mail/WhatsApp for their reference. This helped to ensure standard messages were delivered to all CDPOs and supervisors.

Lessons learnt

Continued engagement with functionaries at sub-district level and FLWs helped both dissemination of key directives as well as understanding the field level challenges. In a fast-evolving situation, with lockdowns being enforced and lifted, the use of telephone allows the state to keep track of the ground level programme status and continue providing handholding support to the frontline workers. The mentorship group continues to respond to technical queries, programme discussion and sharing challenges. In September 2021, the state has initiated the second round of remote supportive supervision to further strengthen coverage, continuity, intensity and quality (C^2IQ) for Nutrition programmes in Assam.

Beyond COVID period

Adaptable supervision and monitoring systems will continue to be relevant in post COVID period. The plan is to continue this mechanism until the end of 2021. Similar remote mechanisms are envisaged to continue engagement with the supervisor level functionaries and frontline workers.

Contact Details

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Additional resources

- Reference note for calling Anganwadi workers: https://poshancovid19.in/wp-content/uploads/2021/11/Note_AWWs.docx
- Reference note for calling Anganwadi supervisors: https://poshancovid19.in/wp-content/uploads/2021/11/Note_Supervisors.docx
- Reference sensitisation note for CDPOs: https://poshancovid19.in/wp-content/uploads/2021/11/Note_for_CDPOs.docx
- For more information on Government circulars, visit Resources – POSHAN COVID-19 (poshancovid19.in)

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Reaching the last mile during COVID-19: virtual tracking of severely malnourished children in Maharashtra

Contributor: Dr Smriti Sharma, Tata Trusts.

Background

The nationwide shutdown in March 2020 was initially planned for 21 days but was extended to multiple months to counter the increasing COVID-19 cases in India. Shutdown of Anganwadi Centres demanded identification of alternative delivery mechanisms especially for the vulnerable children and mothers in tribal areas. To reach the last mile, we present the story of identification and treatment of a SAM child.

Before Intervention

Most SAM children, due to disruption in growth monitoring services had gone unnoticed or unidentified. Children who were moderately undernourished and needed extra services were slipping into severe cases in the absence of timely assessment, counselling, and inability to access supplementary nutrition. a 4-year-old was a SAM child and went unattended to due to hampered services. Govt. of Maharashtra under its ICDS scheme supplies energy dense nutritious food (EDNF) to children suffering from SAM. However, to avail of those services, the beneficiaries themselves need to be aware of the condition of the children or be aware of the services provided. The frontline workers too need to actively identify such cases of severe wasting/ SAM through monthly growth monitoring

sessions and make weight appropriate EDNF available to the child. When either of them fails, the system collapses.

Response

Nevertheless, the pandemic was testing times and each one was trying their best to reach out to the most vulnerable. Reaching out to the beneficiaries at first appeared to be a colossal task, however, leveraging technology by forming WhatsApp groups with frontline workers paved the way.

Trust's field coordinators, through audio/video calls with Anganwadi workers, could access beneficiary contact details from their registers or CAS mobile. Frontline workers were trained and counselled to resume reaching out to children virtually and resume the conduct of Village Health and Sanitation Days with appropriate COVID precautions. While reaching out to mothers and children of the village, the child, who was sick in the past few days, was identified. Anganwadi worker, who had been previously oriented on convergence, along with ASHA and ANM reached out to the child's parents. His anthropometric measurements showed him to be SAM, but he did not show any signs of medical complications. He was registered for availing EDNF as well as additional supplementary nutrition under ICDS. His parents were counselled and counselled for modifying his diet appropriately using local ingredients as well as Take Home Ration (THR). They were also made aware of the services they can avail and the importance of growth measurement.

Result

A month later, the child started recovering and gained weight as well as height. He was now categorized as moderately wasted (MAM). His parents were regularly counselled by Trust's field coordinators using video calling and he is under close watch of Anganwadi worker, ANM, ASHA as well as Sarpanch through the convergence matrix adopted to ensure he becomes normal soon.

Enabling factors

Leveraging technology to reach out helped in accessing the vulnerable families. Anganwadi workers had been provided with smart phones for recording activities and reporting under POSHAN Abhiyaan. These phones came in handy for further installing WhatsApp and creation of groups with mothers, ASHA and ANM for growth monitoring, supervision, early childhood education, homemade dietary recipes, prenatal and antenatal emergencies, and other information dissemination.

Challenges faced

Poor connectivity in some of the hamlets, women who did not have a smartphone had to be reached out through audio calls, or AWW had to visit the households and add on video, ASHA and ANM had to ensure they received both health and nutrition services. Latter was the situation in the index case.

Lesson

Before initiating the exercise and reaching out to frontline workers through WhatsApp, Trust's team took an official district administration approval for virtual interventions. This approval was circulated amongst block and project officials and worked as a game changer with department coming in together to support virtual interventions.

Contact details for further information

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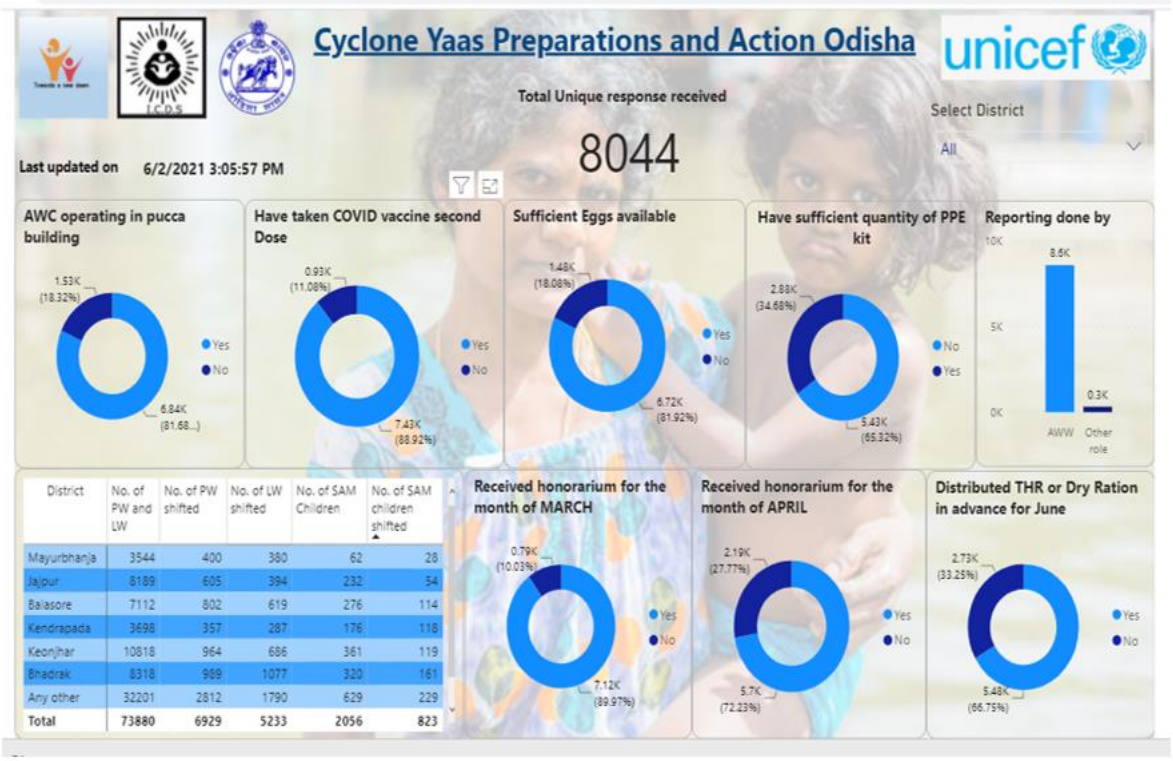
Additional information:

- Project Spotlight implementation strategy and tools (Covid specific strategies on page 42): Project-Spotlight-Implementation-Strategy.pdf (poshancovid19.in)
- For information on Government guidelines etc, visit Resources – POSHAN COVID-19 (poshancovid19.in)



Rapid Pro tool deployed to monitor data collection during cyclone Yaas

Ensuring zero interruption of maternal and child nutrition services during cyclone YAAS and COVID-19 pandemic in Odisha

Contributors: Sourav Bhattacharjee and Robert Johnston, UNICEF and Sonali Sinha, Consultant, Women's Nutrition, DWCD Odisha

Background

Odisha is one of the most disaster-prone states subjected to floods, droughts, and cyclones annually. Nutrition services are essential in Odisha as one in 3 children under-five are stunted and one in 5 are wasted. Natural disasters can lead to nutrition emergencies when supply chains are cut, access to safety nets, health services and potable water is lost. The COVID-19 pandemic delivered economic and health shocks throughout the year. Any natural disaster increases the threat to lives and livelihoods in the at-risk communities.

With experience of handling such disasters in past, the district managers set out to the challenge of ensuring no casualties among vulnerable women and children, no excess transmission of COVID-19 through the emergency response including prevention of hunger and reduced risk of malnutrition after the initial threats.

Response

It was a double threat situation when a cyclone hit the state in the peak of COVID-19. To support the district administration's relief efforts, UNICEF deployed the Rapid Pro tool, a real-time monitoring system to collect data on the numbers and status of pregnant and lactating women and malnourished children along with supplies of Take-Home Ration (THR) and dry ration. The Rapid Pro tool uses a simple chat-based questionnaire in local language to collect data through short message service (SMS) and other communication channels (WhatsApp) to ascertain critical on-ground insights through the collated data and enables its mass-communication with target end-users, including beneficiaries and frontline workers to facilitate quick decisions in times of emergencies.

Anganwadi workers facilitated the assessments of cyclone preparedness in their villages. Automated analysis of the data on dashboards supported immediate actions. The Rapid Pro data informed the strategic planning for distribution of PPE kits, THR, dry rations and safety-net (MAMATA) cash transfers to beneficiaries in the villages and evacuation of inhabitants in the most vulnerable areas.

Pregnant women approaching delivery due dates were relocated to hospitals and shelter homes. The evacuations were managed by Anganwadi workers who were provided latest information and guidance. The Principal Secretary, state and local officials continuously monitored emergency dashboards to ensure full implementation.

Result: Assessment of damage post the Cyclone

On 26th of May 2021, cyclone 'YAAS' hit six northern districts. Immediately following landfall, the Rapid Pro tool revealed that in the six worst affected districts, 57% of beneficiaries received take home ration (THR), and 71% had sufficient eggs for distribution. With a follow-up questionnaire, data was collected on the impact of the cyclone on communities.

Before the introduction of RapidPro, this type of data often took up to a month to reach the state and national level. These delays often meant service cuts and stock-outs reduced the effectiveness of the programmes. Rapid Pro assessments supported not only the preparedness activities and post cyclone assessment for rapid responses. With this attention to detail, Odisha managed to ensure zero casualties among vulnerable populations and a minimum disruption of essential nutrition and health services.

Challenges

Filling in regular responses by the AWWs balancing their work between cyclone preparedness, response and COVID duties required regular follow-up to ensure complete reporting.

Many of the AWWs were overworked, exhausted, and fatigued, so there was a big push required from the department for quick reporting

Rapid Pro is a new tool for many and there were initial mistakes in utilization. As the state faced an emergency, there was no time for detailed capacity building.

Many were scared to report, as they felt that the information might result in disciplinary action against them. Their fears were allayed by constant follow-up by the department functionaries

Contact details for further information

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For additional information:

Rapidpro questions for Aanganwadi workers: AWC-Rapidpro-final.docx (live.com)

Social media use for spreading awareness during Covid-19 © UNICEF/UN0499300/ Bhardwaj

Bridging Gaps between Information, Communication and Nutrition Counselling Using Technology during COVID-19 and beyond: The Gujarat Story

Contributors: Shri K. K. Nirala, IAS, Secretary & Commissioner, Women & Child Development Department, Govt. of Gujarat and Dr Kavita Sharma, Nutrition Specialist, UNICEF Gandhinagar Field Office

Background

When COVID-19 pandemic struck Gujarat in April 2020, the state came to a standstill. Most essential nutrition services were disrupted including the health and nutrition services at field level. The health and ICDS teams at grass root level were reassigned responsibilities for tracing, tracking and treating COVID-19 cases.

The COVID-19 pandemic largely halted the nutrition programs and related services for the high-risk beneficiaries and vulnerable families living in hard to reach tribal, scattered rural and densely populated urban areas. IFA supplementation for children, adolescent girls and pregnant and breastfeeding mothers, maternal, Infant and Young Child Nutrition (MIYCN) messaging and related counselling done at Anganwadi centers, during home visits, group counseling, during Community Based Events (CBEs), and in facility areas like Post Natal Wards, OPDs, Nutrition Rehabilitation Centers (NRCs), Child Malnutrition Treatment Centers (CMTCs) at district, taluka, and at other health facilities, were largely halted due to COVID-19 lockdown.

Response

The Government of Gujarat, UNICFE and other partners worked together in the crisis of COVID-19 to deliver Risk Communication and Community Engagement (RCCE) information on nutrition. Materials were developed and adapted based on the global and national guidelines in the form of posters, leaflets, banners, GIFs for dissemination through social media and at field and facility level.

Guidelines, Frequently Asked Questions (FAQs) and messages on nutrition were developed in context to COVID-19. Educational videos developed by NCEARD and UNICEF, India on various aspects on possibility of coronavirus spread through foods or food packaging and precautions to be taken against the spread of COVID-19, alternatives to fresh foods, nutrition in pregnancy during COIVD-19, general nutrition and lifestyle tips and myths and facts in context to COVID-19.

RCCE materials were shared with Government Departments at state level including the core Departments of Women and Child Development and Health and Family Welfare and with various partners like Banas Dairy and NGOs working with UNICEF to reach the unreached rights holders and vulnerable families and to create awareness on the importance of good MICYN in context of COVID-19 during and after lockdown.

Department of Women and Child Development used social media to disseminate key MIYCN related messages in context to COVID-19 to State, District, Taluka, PHC, Sector and village level groups that were existing or were created during COVID-19 lockdown. These mechanisms help to ensure messaging for the continuing of essential nutrition services and counseling.

UNICEF engaged with Banas Dairy to promote and support in adopting optimal MIYCN behaviors and increasing the reach of essential Nutrition services provided by ICDS and Health through their well-established dairy farmer networks and village level dairy Cooperatives/ milk collection centers. Banas Dairy managing more than 1200 social media groups. During COVID-19, these groups were used to help disseminating nutrition and hygiene related messages, and on continuation of essential services provided by the government.

Partnerships with dairies for nutrition coordinated with DWCD to engage the Gujarat Cooperative Milk Marketing Federation (GCMMF) for reaching the farthest communities with messages on nutrition and ICDS and Health services. This network was used to disseminate messages during lockdown and after.

The Department of Women and Child Development and UNICEF jointly planned and executed SATCOMs sessions on ICDS services and nutrition issues under Umbare Anganwadi – a digital platform to reach out to field level functionaries and last mile stakeholders by virtually celebrating Community Based Events during COVID-19 lockdown and after.

The SATCOM sessions were supported every Tuesday for celebrating CBEs/Mangal Diwas. Sessions on Suposhan Samvad, Baltula Diwas, Annaprasan Diwas and PURNA (Adolescent) Diwas were celebrated with focus on key nutrition messages on maternal nutrition, breastfeeding, complementary feeding, age-appropriate feeding, psychosocial stimulation, positive parenting, growth monitoring and promotion, THR and adolescent nutrition.

During COVID-19 lockdown, the State Management Centre of DWCD monitored the supply of THR to AWCs through a telephone survey to randomly selected registered mobile number. guidelines and questionnaires for data collection were developed. From March to June 2020, the telephone surveys found that 95% of beneficiaries received THR and 85% AWWs were engaged in COVID-19 activities along with health functionaries.

During COVID-19 Lockdown, fortified take home ration was distributed to pregnant and breastfeeding women, children 6 months to 6 years and adolescent girls. Children aged 3 to 6 years were given take home ration (THR) in place of hot cooked meal (HCM) from March to May 2020. From June 2020, they are provided with ready to eat snack - sukhadi (1 kg/child/week) made by AWWs in place of HCM.

Results

In Dahod, Narmada and Banaskantha Districts, RCCE material reached out to total 27,615 persons in 2,615 official social media groups of various Departments namely Health, WCD, District Rural Development Authority, Panchayat, Water and Sanitation Management Organisation (WASMO) of District, Taluka, PHC, Sector and village level.

During COVID-19 unconventional partners such as milk unions reached communities with key nutrition messages on COVID-19. These included all 18 milk unions in Gujarat in collaboration with DWCD.

Tapping this network enabled communications to over 37 lakh members of GCMMF across the state through 18,600 social media groups. Engaging with unconventional partners with a broad community reach helped to amplify reach.

UNICEF has long partnered with Narottam Lalbhai Rural Development Fund – NLRDF to in two tribal blocks of Sabarkantha District in Gujarat. The NLRDF team works intensively in 100 villages of Khedbrahma and Poshina talukas on Maternal, Infant and Young Child Nutrition. During COVID-19 lockdown, the team engaged with high-risk pregnant women, pregnant women, mothers of underweight children and young children. They also disseminated the RCCE material at village level to Sarpanch, Youth Clubs, Dairy, SHG and AWW groups, ICDS and Health groups

SATCOM sessions reached to over 52,000 AWWs and beneficiaries, and more than 5000 people were engaged through live video on social media. To increase the reach of nutrition to messaging, SATCOM sessions were broadcast on Doordarshan channels and circulars by DWCD were sent to GLPC and Dairy cooperatives for distribution. From March 2021 the Department lead organization of SATCOM sessions with programs every Tuesday to celebrate community-based events virtually.

Enabling factors

During COVID-19 pandemic various technologies like social media, SATCOMs, social media, TV channels were used to disseminate key MIYCN messages by government departments, and unconventional partners across Gujarat.

Challenges

Various technologies and mediums were used to disseminate key nutrition messages across Gujarat. Beneficiaries were covered by one or more mediums such as phones with network connectivity, television or community groups in hard-to-reach areas in Gujarat.

One challenge faced in the use of ICDS gateway messaging was one way communication. The needs based or target audience-based messaging was not done. The reach of the different mediums cannot be measured directly as there is no systematic/organized data collection at state level.

Should the intervention continue beyond the pandemic?

Interventions like SATCOM sessions, messages through ICDS gateway, use of social media groups were used during and after the COVID-19 lockdown. The frequency of the use of social media messages and ICDS gateway have increased during celebrations of events like world breastfeeding week, POSHAN Maah. SATCOM sessions are routinely organized by DWCD for celebrating Community based events.

Contact details for further information

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Additional resources

- Poster on new born and infant care during Covid19 (Gujarati): Poster-on-newborn-and-infant-care-during-COVID-19-for-healthworkers-and-parents.pdf (poshancovid19.in)
- Poster on infant nutrition guidelines during Covid (Gujarati): Posters-on-Infant-nutrition-guidelines-during-COVID-19.pdf (poshancovid19.in)
- Poster on maternal nutrition during Covid 19 (Gujarati): Posters-on-Maternal-Nutrition-during-COVID-19.pdf (poshancovid19.in)
- Poster on proper nutrition for women during pregnancy (Gujarati): Pregnant Women_COVID_Q_V12.cdr (poshancovid19.in)
- Parenting during Covid-19 (Gujarati): COVID-19-Parenting-tips.pdf (poshancovid19.in)
- Parenting tips for child's internet usage during Covid 19 (Gujarati): COVID-19-Parenting-tips.pdf (poshancovid19.in)
- Poster on Mother and Baby friendly hospital (Gujarati): Posters-on-Mother-and-Baby-Friendly-Hospitals.pdf (poshancovid19.in)
- Poster on breastfeeding guidelines during Covid 19 (Gujarati): Posters-on-Breastfeeding-Guidelines-during-COVID-19.pdf (poshancovid19.in)
- Poster on handwashing posters (Gujarati): Hand-Washing-Poster-scaled.jpg (1811×2560) (poshancovid19.in)
- Poshan Abhiyaan: Poshan Maah Posters during 2020 (Gujarati): Posters-used-during-POSHAN-Maah-2020-regarding-nutritional-guidance.pdf (poshancovid19.in)
- Poster Childcare guidelines: 12 steps for safe child (Gujarati): Childcare-Guidelines-12-Steps-for-Safe-Chlld.jpg (906×1281) (poshancovid19.in)
- COVID-19 Risk Communication and Community Engagement | UNICEF India
- CBE Module in Hindi: NNM-ILAmodule-03-Planning_CBE_Hindi.pdf (icds-wcd.nic.in)

Abbreviations

AMB	Anemia Mukt Bharat
ANM	Auxiliary nurse midwife
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BCC	Behaviour Change Communication
CAB	Covid Appropriate Behaviour
CAS	Common Application Software
CBE	Community Based Events
CDPO	Community Development Project Officer
CEO	Chief Executive Officer
CMAM	Community Based Management of Acute Malnutrition
COVID-19	Corona virus -19 disease
DAY-NRLM	Deendayal Antyodaya Yojana - National Rural Livelihoods Mission
DMF	District Mineral Fund
DWCD	Department of Women and Child Development
ECD	Early Childhood Development
EDNF	Energy Dense Nutritious Food
EIBF	Early initiation of breastfeeding
ENP	Essential Nutrition Practices
FLW	Frontline Worker
FRU	First Referral Unit
FY	Financial Year
GIF	Graphics Interchange Format
GM	Growth Monitoring
HCM	Hot Cooked Meal

ICDS scheme	Integrated Child Development Services scheme
ICMR	Indian Council of Medical Research
IEC	Information, education and communication
IFA	Iron and Folic Acid
INR	Indian Rupees
IYCF	Infant and Young Child Feeding
JMSSPM	Jharkhand Matri Shishu Swasthya Evam Poshan Maah
KMC	Kangaroo Mother Care
PIP	Project Implementation Plan (NHM)
PRI	Panchayati Raj Institution
MAM	Moderate Acute Malnutrition
MIS	Management Information System
MIYCN	Maternal, infant and young child nutrition
MoHFW	Ministry of Health and Family Welfare
MUAC	Mid Upper Arm Circumference
MTC	Malnutrition Treatment Centre (also called Nutrition Rehabilitation Centre)
NCoE SAM	National Centre of Excellence for Management of SAM.
NCEARD	National Centre of Excellence and Advanced Research on Diets
NGO	Non-Government Organisation
NHM	National Health Mission
NRC	Nutrition Rehabilitation Centre
NFHS	National Family Health Survey
NSS	National Service Scheme
NYK	Nehru Yuva Kendra
POSHAN	Prime Minister's Overarching Scheme for Holistic Nourishment
PPE	Personal Protective Equipment
RCCE	Risk Communication and Community Engagement

RMNCHA	Reproductive, Maternal, Newborn, Child and Adolescent Health
SAM	Severe Acute Malnutrition
SATCOM	Satellite Communication
SHG	Self Help Group
SOP	Standard Operating Procedure
SRLM	State Rural Livelihood Mission
RoP	Record of Proceedings
THR	Take Home Ration
UT	Union Territory
VAS	Vitamin A Supplementation
VHNSD	Village Health, Nutrition and Sanitation Day
WBFW	World Breastfeeding Week
WASH	Water, Sanitation and Hygiene
WIFS	Weekly Iron and Folic Acid Supplementation

Contributors

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