



Community based
programme for children
below 5 years of age
with severe acute
malnutrition in India

Progress so far and
lessons learned

2020





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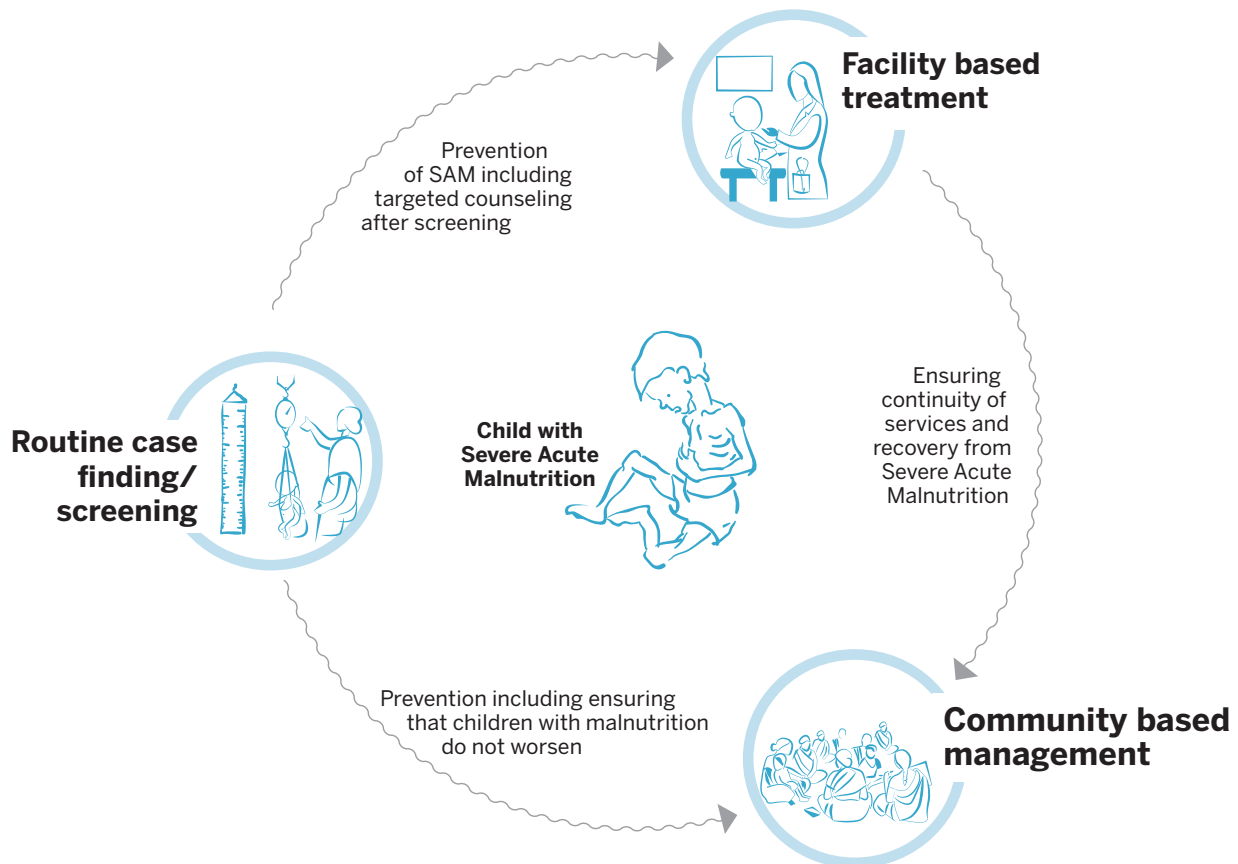
Background

Community based programme for children below five years of age with Severe Acute Malnutrition (SAM) is based on the principle that if acute malnutrition is identified in the early stages, treatment can be provided at community level and medical complications in these children will be averted. Key to the success of the approach is timely detection and admission into a treatment programme before the metabolic and immunological aspects become marked and require inpatient treatment.

Government of India has set up Nutrition Rehabilitation Centres (NRCs) in inpatient health facilities across the country for treatment of children with SAM and

medical complication. However, only an estimated 10-15% of children with SAM are medically complicated and require inpatient treatment. Evidence shows that the remainder (85-90% of children with SAM) can be treated at community level.¹

Community-based care is linked with facility-based care; children developing medical complications are referred to the nearest Nutrition Rehabilitation Centre for clinical management of SAM, while those discharged from NRCs are enrolled into the community-based programme for continuation of care and nutrition rehabilitation. Effective management of SAM must be based on the basic principle of 'Continuum of Care' from the home

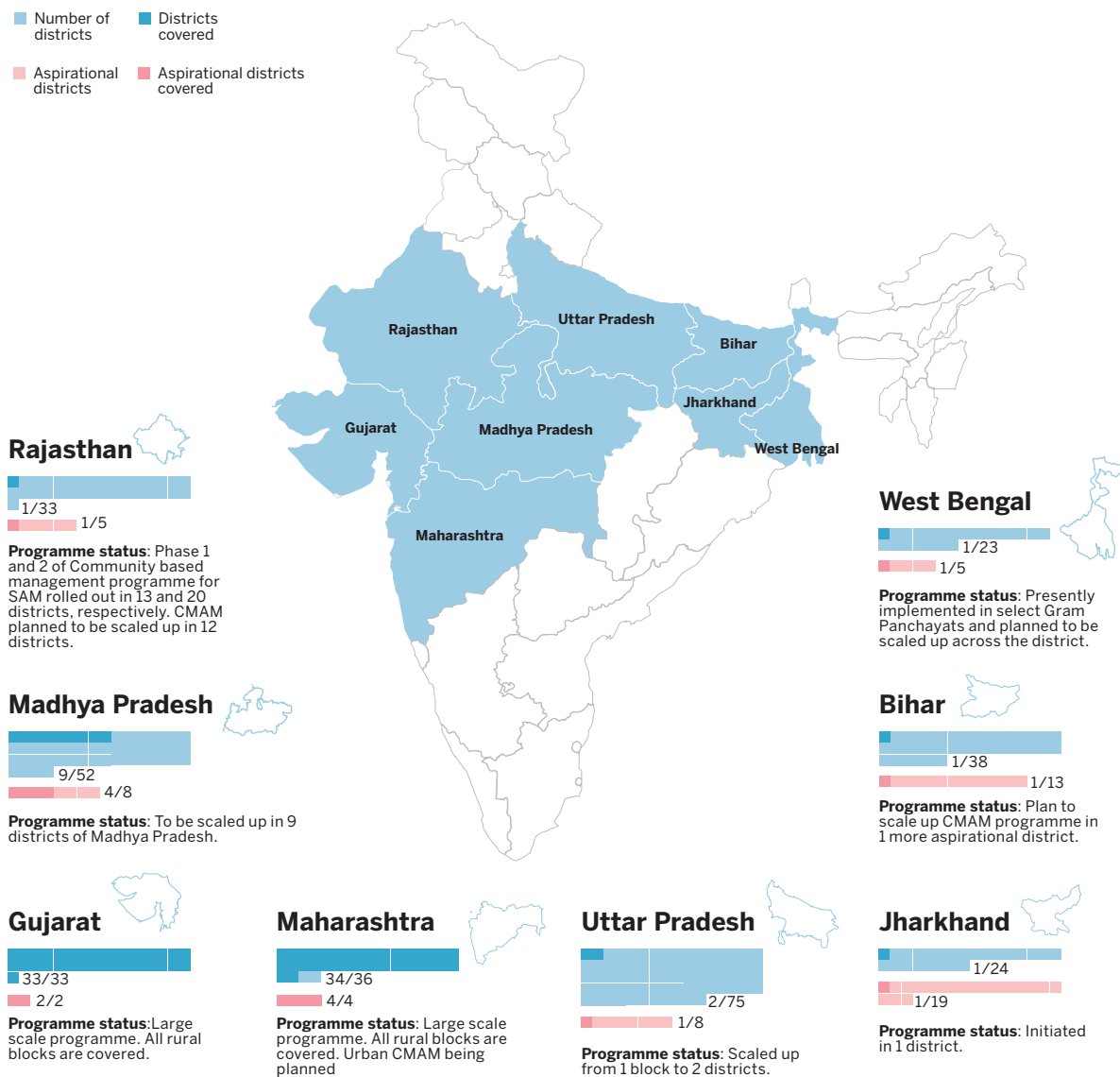


¹ Community based management of severe acute malnutrition: A joint statement by the World Health Organization, The World Food Programme, the United Nations System Standing Committee on Nutrition and the United Nations Children's Fund. Available: http://apps.who.int/iris/bitstream/10665/44295/1/9789280641479_eng.pdf?ua=1

Progress so far (Upto December 2019)

State wise update on roll out of community based programme for children with Severe Acute Malnutrition

Figure 1: Community based care for children with SAM - status of implementation





and community to the health centre / health facility and back again.

Since the launch of the POSHAN Abhiyaan by the Hon'ble Prime Minister in 2018, there is an unprecedented momentum and interest from states as well as many districts to implement comprehensive programme for identification and treatment of children with SAM, and to explore opportunities for strengthening elements of SAM care within the existing Government programme. While states are waiting for the National guidance to be issued by the Ministry of Women and Child Development on community based management of children with SAM, they are using state funds for rolling out the community based programme in selected geographic area or across the state.

Since March 2020, due to COVID-19 pandemic, regular ICDS and Health-services have been severely constrained. Optimal care for children, especially those who are malnourished has been disrupted. With COVID-19 outbreak, massive disruptions in continuity of food availability and livelihood are anticipated. The situation may increase the overall SAM burden in the country. The urgent need of this hour is to bring SAM management under the fold of essential health and nutrition services and to ensure continuity of services for the management of child wasting.

The section below highlights state wise status of community based programme for management of SAM cases in 12 states where UNICEF has presence:



Between September 2017 and December 2018, a Community based Management of Acute Malnutrition (CMAM) pilot was implemented in Khutpani block of West Singhbhum district, as per WHO standards under the leadership and technical oversight of Jharkhand State Nutrition Mission. A total of 7,987 children under five years of age were screened for SAM out of a target of 10,857 (74%). Around 4% children (n=319) were identified as SAM and 95% of identified cases were enrolled in the CMAM programme. Children who had

medical complications or a loss of appetite were referred to facility-based care in a Malnutrition Treatment Centre (MTC). At the end of 16 weeks of the programme, out of 303 children discharged, 152 children (50%) were cured, 56 children (18%) defaulted, 90 children (30%) were non-responders, death reported in 5 children (2%). Out of total non-responder cases, 64 children (21% of total) were reported to be partially cured (reached MAM status).

During the intervention period, there was a one-month Anganwadi strike which resulted in a gap in continuity of services being offered under the programme. This led to low motivation levels of Anganwadi Workers and THR stock outs which may have led to the high defaulter rates. Nevertheless, the pilot provided invaluable experience, which is being documented in terms of programme experience as well as a cost effectiveness study taking both a provider and societal perspective is being documented.

The State Government has established Centre of Excellence for management of children with SAM both at community and facility at Rajendra Institute of Medical Sciences, Ranchi. The State Government also constituted Technical Advisory Group (TAG) to develop CMAM strategy for the state. The TAG includes members from State Centre of Excellence, National Centre of Excellence for SAM management – Kalawati Saran Children's Hospital, UNICEF and other development partners. The TAG reviewed the findings from the Khutpani CMAM pilot as well as CMAM programme experiences from other pilot programmes implemented by other development partners – MSF (Doctors without Borders), Save the Children and World Vision. Based on the recommendation from the TAG, a committee has been formed to draft the CMAM operational guidelines for the State.

Based on the learnings from the CMAM pilots, CMAM programme is being rolled out across the West Singhbhum district jointly by the Department of Women and Child Development, and Department of Health, Medical Education and Family Welfare. State specific guideline on community based programme for management of children with SAM is under development. The state CoE will be involved in the capacity building of frontline functionaries, monitoring and mentoring of the programme.



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Gujarat

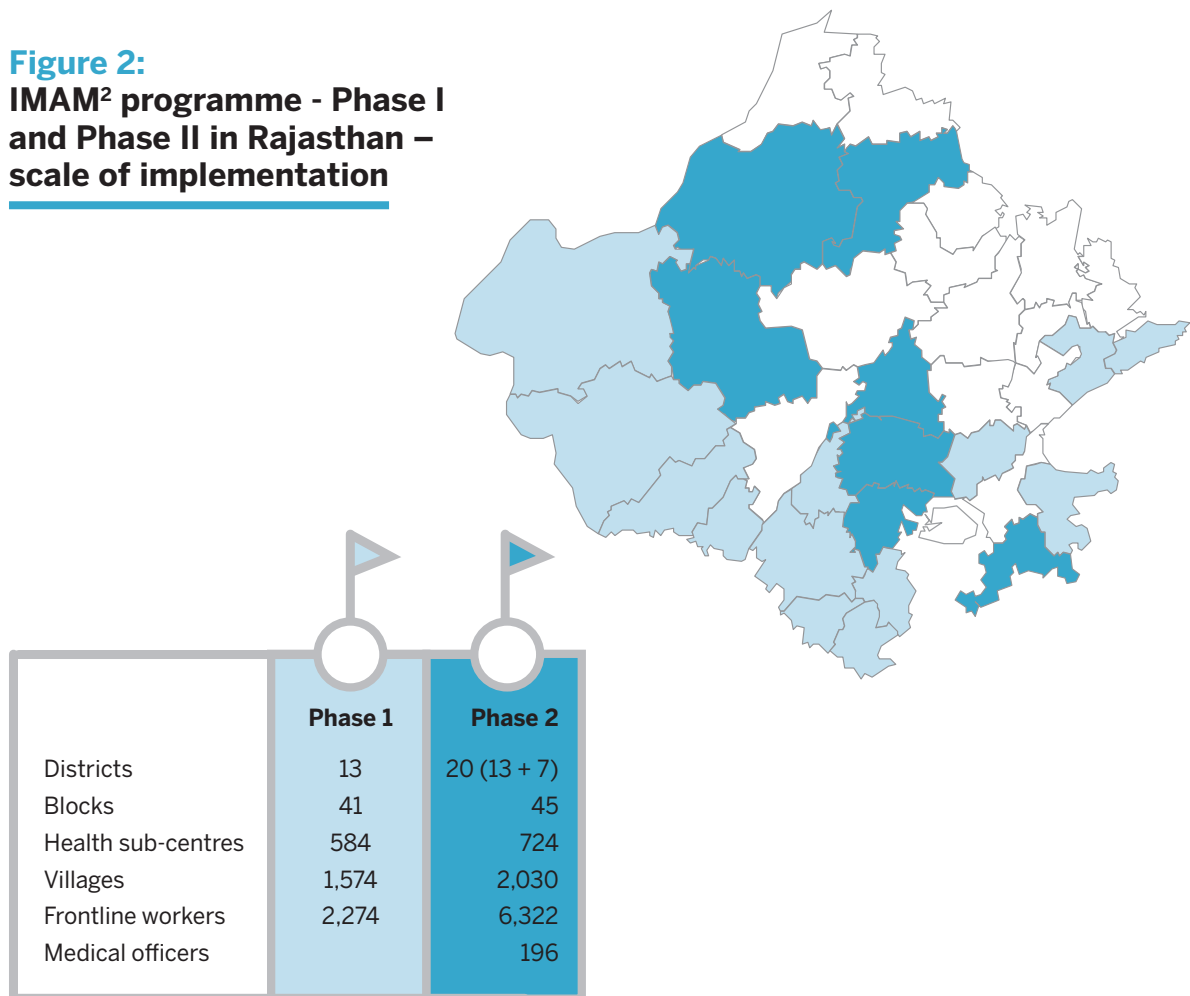
The CMAM programme is operational across the state, led by the Department of Health and Family Welfare, Government of Gujarat. State Government funds are used for implementing all the components of the CMAM programme. For extending technical support to the Government of Gujarat to strengthen SAM management (both CMAM and F-SAM) programme across the state, a Centre of Excellence (CoE) was established in GMERS Medical College and Hospital Valsad, Gujarat. The CoE is involved in capacity building, monitoring, strengthening supportive supervision and validation activities to

CMAM programme. In concurrence with the Department of Health and Family Welfare and State Centre of Excellence, Dharampur block of Valsad district has been selected for intensive monitoring, documentation of CMAM implementation processes, identification of good practices and evaluation of CMAM.

Rajasthan

The State Government of Rajasthan had implemented community-based management of SAM programme in two phases in selected geographical areas. The CMAM programme was called Integrated Management of Acute

Figure 2:
IMAM² programme - Phase I and Phase II in Rajasthan – scale of implementation



2 IMAM – Integrated Management of Acute Malnutrition



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Malnutrition (IMAM) in the State. The programme was led by the Department of Medical, Health and Family Welfare, in convergence with other Government departments and with support from development partners. The first and second phase of IMAM was rolled out in 2015-16 and in 2018-19 respectively in convergence with Government departments and development partners.

Two Regional Centres of Excellence, Dr. S.N. Medical College Umaid Hospital, Jodhpur, Rajasthan and Ravindra Nath Tagore Medical College, Udaipur have been established to provide technical support to the State Government in SAM management. The CoE team undertook supportive supervision of Nutrition Rehabilitation Centres, capacity building of frontline functionaries and health personnel on community based management of SAM, concurrent monitoring and mentoring in the selected blocks to ensure quality of the programme. Phase I was implemented in 41 blocks of 13 districts. Around 9,640 children with SAM were treated at the community level and more than 80% children recovered. Phase II of the programme was implemented in 45 blocks across 20 districts of Rajasthan. The programme treated 10,630 children with SAM and

achieved 70% cure rate, with 17% non-responders, 12% defaulters and death reported in 11 children (0.1%).

Findings, experience and learnings from Phase I and II were disseminated by the State Government with multi-stakeholders' involvement where multiple states participated and shared their learnings and experiences. Detailed report of IMAM programme and monitoring findings are available.

Government of Rajasthan is planning to implement a comprehensive programme at community level for children with SAM in 12 blocks of 12 districts (out of 12 districts ICDS CAS rolled out in 9 districts) which will be led by the Department of Women and Child Development. A joint guideline by both the Department of Health and Women and Child Development is under development.

Uttar Pradesh

A community-based care programme for children with SAM was piloted in Naraini block of Banda district, using



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existing Government programmes and community platforms. The programme had two key objectives: demonstrate an integrated system-driven model for prevention and care of SAM using a community-based approach; establish an effective system for early identification, referral and inpatient treatment of children suffering from SAM. To date, the community based programme has completed two phases; phase one was from December 2017 to May 2018 and the second between July and December 2018. The pilot was implemented in one block of Banda district in convergence with the Department of Health & Family Welfare and the Department of Women and Child Development, with technical support from National Centre of Excellence, Kalawati Saran Children's Hospital and UNICEF.

Combined results for phase one and two of the pilot showed that out of 11,286 under five children, 10,282 children (91%) were screened for identification of acute malnutrition. Out of these, 148 (1.4%) were identified as SAM. On discharge from community based programme, 38% of children were cured 8% defaulted, 3% died. More than 50% (n=77) of children were discharged as non-responders, of them 36 children showed partial

improvement (reached MAM status). A detailed report of phase one and two is available. This report outlines the protocol, strengths, challenges and how the lessons learned were used to improve service delivery. Based on these experiences the district administration has scaled up the community based care programme for children with SAM across Banda district.

A similar programme has also been initiated subsequently in Chitrakoot district—an aspirational district. Programme has been initiated in select 100 AWCs across four (out of five) blocks of Chitrakoot. Special AWC-based sessions for children with SAM & MAM are held focusing on building caregivers' capacities on augmenting local food and ICDS THR through demonstration and counselling.

Maharashtra



The Community based Management for children with SAM (CMAM) programme has been scaled up to 34 rural and tribal districts of Maharashtra. In 2018, the state

used alternate food – Amylase Rich Flour for managing children with SAM. Since January 2019, the state started using locally prepared Energy Dense Therapeutic Food for management of SAM at community level.

In Maharashtra, children with SAM are managed at 3 levels—SAM children with complications at Nutrition Rehabilitation Centre, children with mild to moderate medical complications at Community Treatment Centre (CTC) and children with SAM without complication are managed at Village Child Development Centres (VCDC). VCDCs are operationalized at select Anganwadi Centres amongst a cluster of a few AWC in the village and have better access and facilities for managing children with SAM. Weight and Height of all children are measured at AWCs on a select day of each month and classified as SAM / MAM / Normal by the Anganwadi worker. Confirmation of nutritional status of each child is done by Medical Officer / Health Worker Male / LHV / ANM through second level of screening on VHSND. Identified SAM children with medical complications are referred to CTC / NRC and SAM cases without any medical complication are admitted to VCDC. Children with SAM admitted to VCDC are treated as per the Government

approved medical and nutrition protocols.

Reported data from the state showed that in 2019 from January to September, total 27,522 children with SAM were managed under CMAM programme.

Government of Maharashtra has decided to roll out CMAM programme for urban children with SAM as well. The state has Centre of Excellence in Wadia Hospital with Department of Paediatrics to provide technical assistance to the State Government for management of SAM at facility and community.

Madhya Pradesh

In Madhya Pradesh, a community-based care for children with SAM programme is implemented in nine districts, where training of field functionaries has been completed. Two districts have initiated enrollment of identified children with SAM in CMAM programme and reporting on their progress. The state has a Centre of Excellence in AIIMS, Bhopal. Departments of Pediatrics

Figure 3:
CMAM reporting app developed by the State CoE - AIIMS, Bhopal

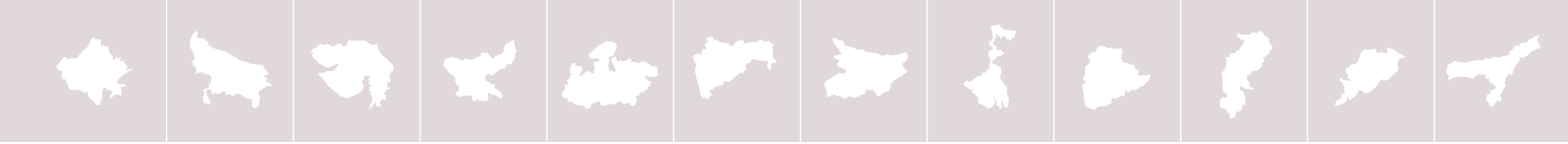


CMAM App log-in

Startup page after login

List of registered children for weekly services (Session/ Clinics) entry

Data can be synced automatically as well as manually



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and Community and Family Medicine are involved in strengthening the facility and community based programme for management of SAM respectively.

The CoE is involved in providing technical support to the State Government on the SAM management issues, capacity building of field level functionaries, monitoring, supportive supervision and validation activities to strengthen SAM management programme. In concurrence with the Department of Women and Child Development and State Centre of Excellence (AIIMS Bhopal), Babai block of Hoshangabad has been selected for intensive monitoring, documentation of CMAM implementation processes, identification of good practices and evaluation of CMAM. AIIMS, Bhopal also facilitated development of a CMAM mobile application for capturing real time data. The application is integrated with state ICDS supportive supervision app- 'SAMPARK' and is hosted on ICDS MIS website / database. The progress of the programme is being reviewed to improve coverage, strengthen implementation and quality.



Since February 2019 community-based care for children with SAM has been initiated in Krityanand Nagar block of Purnea district. In the first phase, activity was initiated in 43 AWCs which was later expanded to 55 more AWCs. Out of total 14,587 children in the target area of 98 AWCs, 11,138 (76%) were screened for weight for height. Of these, 519 (4.6%) were found to be MAM & 113 (1%) were SAM. Of the total identified children with SAM, 11 children were referred to Nutrition Rehabilitation Centre, remaining 102 (90%) children with SAM and without any medical complication enrolled in CMAM programme. Two NRC graduates, of the eleven children referred to NRC, enrolled in CMAM programme and continued until discharge from CMAM. Of these, 74 have completed 16 weeks of treatment and remaining children are under treatment. Out of 74, 21 (28%) children reached the discharge criteria of cured (weight for height \geq -2SD), 34 (46%) discharged children improved from severe to moderate acute malnutrition (SAM to MAM), 17 (23%) were non-responders (children who remained SAM at the time of discharge) and 2 (3%)

were defaulters.

State Government has also approved implementation of CMAM in one block (Dumra) of Sitamarhi district (NITI aspirational district) in Bihar using POSHAN Abhiyaan innovation fund, with technical support of Dr Rajendra Prasad Central Agricultural University (DRPCA) PUSA, UNICEF & State Centre of Excellence. Out of 150 AWCs approved under the project, activity has been initiated in 53 AWCs in first phase. Trainings were initiated in November 2019 and implementation will be initiated from January 2020.

Recently, under the POSHAN Abhiyaan activities, the State Government has approved the formation of State Technical Committee for nutrition comprising of Department of Health, Department of Social Welfare, State Centre of Excellence and other Medical, Nutrition and Agriculture colleges, SRLM and Development partners.



Care for children with SAM programme is initiated in one block of Purulia district. The model of Comprehensive Nutrition Care Programme (CNCP) is being implemented in a phased manner. The programme is being implemented jointly by Department of Women and Child Development and Department of Health and Family Welfare. Department of Health has involved Nutritionists of NRCs in screening of children for identification of SAM cases. Medical check up of identified SAM cases are performed by Medical Officers followed by recommendation of medicines and referral (if needed).

First phase started in select villages of Jhalda I block. Based on the experience of phase I of the small scale programme, geographic coverage will be expanded across the block and district. From the State Government, Centre of Excellence-College of Medicine Sagore Dutta Medical College has been approved in West Bengal to support the quality roll out of Facility and Community based programme for SAM management. The team of National CoE - Kalawati Saran Children's Hospital are involved in



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the capacity building of the State CoE team on facility and community-based management of SAM. The nutrition OPD at the CoE became functional in December 2019 where screening of children for identification of SAM and counseling of care givers has initiated.

Telangana

Care for SAM children at the community level has been initiated in two districts of Telangana—Asifabad and Gadwal by Department of Women Development and Child Welfare with the support from National Institute of Nutrition, Hyderabad and UNICEF. National Institute of Nutrition has taken the initiative to modify the nutrient density of existing ICDS THR – ‘Balamrutham’. Using State Government fund, the modified ICDS THR ‘Balamrutham

plus’ is produced by the Telangana Foods for community based programme (SSFP) targeted to children with SAM. Training for the front line functionaries in two districts has been completed. The state has created a Technical Advisory Group to provide guidance to the State Government on CMAM programme implementation and to suggest possible scale up strategy.

Chhattisgarh

Department of Women and Child Development is in the process of developing operational guideline and communication materials for comprehensive community-based management of children with SAM. The CMAM programme is planned to be implemented in Manpur block of Rajnandgaon district and Narayanpur

block of Narayanpur district. State Centre of Excellence (CoE) AIIMs Raipur has been operationalized to support the roll out of F-SAM and CMAM in the State. Involvement of CoE in CMAM will be an opportunity for systematic monitoring and supportive supervision. State Government has committed to upscale this initiative in all the aspirational districts in the coming months.



Dialogue has been initiated with senior Government Officials of Department of Women and Child Development and Mission Shakti (DW&CD&MS), Department of Health and Family Welfare (DH&FW), and Tribal Affairs Department (TAD) to initiate community-based care programme for children with SAM in Koraput and Nabrangpur districts. This is as part of the 'Strategy for Odisha's Pathway to Accelerated Nutrition' (SOPAN).



Under the umbrella of POSHAN Abhiyaan, in December 2019, district administration Dibrugarh hosted a

consultation on Community-based Programme for Severe Acute Malnutrition (CP-SAM) to initiate a pilot in Lahowal block, Dibrugarh. The development of this initiative has been led by Department of Social Welfare at state and District administration Dibrugarh with technical support from UNICEF. As part of this initiative, children identified as Severe Acute Malnutrition (SAM), with no accompanying medical complications, would receive care and counselling at community level. The enrollment into and discharge from the programme would be done at health sub-centres. Nutrition and health counselling, anthropometric assessments, provision of two meals (one hot cooked meal and one THR meal) along with micronutrients would be provided to all enrolled children through Anganwadi centres for 12 weeks. This is the first attempt at community-based care for children with severe acute malnutrition in the state of Assam. The district level training of master trainers is proposed in March 2020. The pool of master trainers includes the district POSHAN team, NRC staff, MOs, ICDS Supervisors, ASHA supervisors, Faculty from Medical College and one coordinator from tea association. In addition to this, the state is also planning to utilize the opportunity of innovations under POSHAN Abhiyaan to scale-up CP-SAM to five districts with high prevalence of severe wasting.

Table 1: Community based management programme for under 5 - children with SAM - Programme status - at a glance

States	Geographical coverage and aspirational district covered	Screening criteria	Screening done by	Admission criteria	Food used	Remarks/Scale up plan
Programme in place						
Bihar	1 block in 1 district	All U5 children screened for SAM (Weight for Height)	Anganwadi Worker	WHZ <-3SD	ICDS THR	The SAM care programme will be scaled up in Sitamarhi district (NITI Aspirational district) using POSHAN Abhiyaan Innovation plan.
Gujarat	33 districts	All U5 children screened for SAM (Weight for Height and / or MUAC)	ANM/Fe-male Health Supervisor	WHZ <-3SD and / or MUAC <115 mm	EDNS	Operational across the state by the Department of H&FW.
Maha-rashtra	34 / 36 districts (except 2 municipality areas)	All U5 children screened for SAM (Weight for Height)	Anganwadi Worker	WHZ <-3SD	EDNF	Similar programme to be scaled up in Municipal Corporation areas.
Madhya Pradesh	4 districts – Hoshangabad, Khandwa, Burhanpur, Chhattarpur	All U5 children screened for SAM (Weight for Height)	Anganwadi Worker	WHZ <-3SD	ICDS THR	Scale up plan – in place. The existing model of SAM care will be scaled up in 9 districts of M.P.
Uttar Pradesh	2 districts – Banda and Chitrakoot	Two steps screening. All U5 children screened as per Weight for Age. Thereafter, all identified underweight children screened for Weight for Height to identify children with SAM and MAM.	Anganwadi Worker	WHZ <-3SD	Aug-mented ICDS THR	In 2018, the care for SAM programme – ‘Bal Poshan Satra’ was operational in 1 block of Banda district. In 2019, it has been scaled up across the district. Similar initiative started in 4 blocks of Chitrakoot district.
West Bengal	1 block of 1 district (Jhalda I in Purulia District)	2 steps screening - weighing of all U5 children and classified as underweight as per WFA criteria. Thereafter, severely underweight children screened for identification of MAM and SAM cases (Weight for Height and / or MUAC is measured)	Weight for Age – by AWW and Weight for Height by NRC Nutritionist	WHZ <-2SD and/or MUAC <125 mm	Hot cooked meal	State has a plan to scale up the programme across the district (Purulia) – process initiated

CMAM Programme - planned and yet to be rolled out						
States	Geographical coverage and aspirational district covered	Screening criteria	Screening done by	Admission criteria	Food used	Remarks/Scale up plan
Rajasthan	12 blocks of 12 districts	All U5 children in the intervention area screened for SAM (Weight for Height and MUAC)	Anganwadi workers	WHZ <-3SD and/or MUAC <115 mm	ICDS THR	State Government has decided to scale up the CMAM programme in 12 blocks of 12 districts of Rajasthan which will be led by DWCD in convergence with DHFW.
Telangana	2 districts – Asifabad, Gadwal	Weight for Height	Anganwadi teachers	WHZ <-3SD	Balamrutham plus – developed by NIN and to be produced by Telangana Foods.	Training of frontline functionaries initiated. Screening and enrollment will be started soon. Balamrutham plus – order placed. State level Technical Advisory Group for CMAM (SSFP) – Formed.
Chhattisgarh	2 blocks in 2 districts – Manpur block of Rajnandgaon district and Narayanpur block of Narayanpur district	Weight for Height	Anganwadi workers	WHZ <-3SD	Yet to be decided	Planning meeting held with DWCD and Health, Government of Chhattisgarh
Jharkhand	1 district - West Singhbhum	Weight for Height	Anganwadi Worker	WHZ <-3SD	Yet to be decided	Guideline under development
Odisha	2 districts – Koraput and Nabarangpur	Yet to be decided				Guideline under development
Assam	1 district – Dibrugarh	Yet to be decided				Discussions with the State Government initiated

Lessons learned



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1. Community engagement

Community mobilisation is an essential component of CMAM programmes, for both inpatient and outpatient services. Mobilisation is about engaging the community

and sensitising them on the programme, sharing information on what is malnutrition, how can it be treated and where it can be treated. If caregivers are not aware of the importance of following the treatment

protocol, they may not ensure that their children do so. This will likely result in limited results for the child and so caregivers will not see the benefit of attending services in the future, creating a negative cycle. This is done using a participatory approach which should follow these steps:

- a. **Community assessment:** A good understanding of the community is required which can come from a community assessment. This enables an analysis of community structures – community actors, areas of influence, communication channels and the allocation of decision making powers. In addition, it will enable a good understanding of how malnutrition is perceived in these communities so that any materials can adopt the same language and target any community concerns or caring practices that contribute to the development of malnutrition. Through this, it is possible to identify which community members can be engaged to sensitise on the programme that will (a) obtain their buy-in and (b) encourage other community members to attend screening and, if required, treatment. This can be done in a light touch way if resources are limited.
- b. **Sensitisation of the community:** The sensitisation strategy should be developed based on the findings of the assessment – actors targeted and materials used clearly defined.
- c. **Screening:** Regular screening of all children below 5 years of age is essential to ensure that episodes of SAM are identified and treated early which will minimise the risk of the child developing medical complications and therefore requiring inpatient care which is costlier and causes greater disruption to family life. Screening should ideally happen every month for all children within the catchment area.

Barriers identified from ongoing programme:

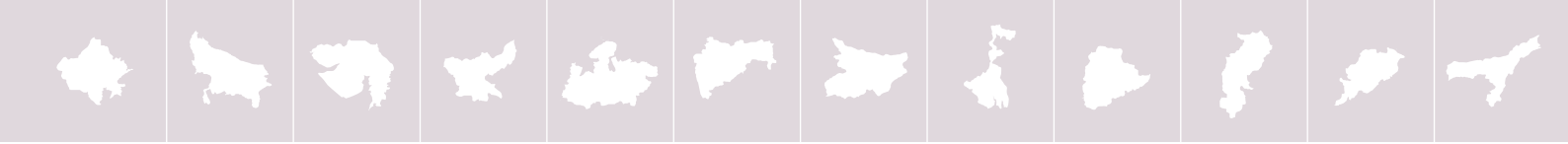
- ⚠ Although community mobilisation strategies are developed, activities are rarely implemented as planned due to a lack of convergence between Government departments, with proposed actors engaged by other activities.
- ⚠ All activities are to be discussed and agreed across

all departments during programme planning stages

- ⚠ List of children developed by Anganwadi Workers are often used to identify children that need to be screened, yet they are often not complete which means not all children are screened. As a result, children that live in more remote and hard to reach areas of the block can be excluded from routine screening.
- ⚠ Regular updating of due lists developed by AWWs every 6 months is essential.
- ⚠ Screening equipment is often faulty and therefore unusable.
 - ⚠ Solutions need to be found to fix faulty equipment if it cannot be replaced
- ⚠ AWW and ANM's weight and height measurements are of poor quality, leading to inaccurate classification of children's nutrition status. Weight and height measurements are inaccurate. As height measurements are new to many, it will take time to build their skills. At times block and district-level staff that are training and supervising frontline workers often don't have the skills to train FLWs effectively.
 - ⚠ Initial training for frontline workers and block and district level staff on screening needs to include practical sessions followed by refresher trainings at regular intervals.
 - ⚠ AWWs require close supervision (on-the-job training) post-training so they can develop their skills sufficiently.

2. Programme implementation

- a. **Enrolment:** Once children have been identified as SAM, they need to be immediately enrolled into a treatment programme as their nutritional status can deteriorate rapidly. However, some programmes have delayed enrolment for months due to a lack of sufficient programme supplies.
 - ⚠ Ensure children that are identified as SAM are enrolled into care within one week of identification. If



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this is not possible, close monitoring and rapid referral to inpatient care is required as a safety net, although this is a last resort approach.

b. Nutrition: The nutritional content of therapeutic food used varies across the states, with a range of products from ready-to-use food that meet WHO recommended standards to recipes using existing ICDS THR provisions. Nutrition institutes are working with some State Governments to develop local alternatives. For children to reach the discharge weight, they need to consume the recommended dose as per the

state protocol although often this does not happen. This is one factor that increases the length of stay.

- ✦ Studies are required to better understand the reasons for poor consumption.
- ✦ Counselling of caregivers each week during follow up sessions on the importance of consumption needs to be reinforced.
- ✦ States should leverage the nutrition expertise of nutrition institutes to develop foods that are ap-



appropriate to treat SAM as per global protocols.

c. Counselling: On enrollment and at each weekly follow up visit, the AWW/ANM should counsel the caregiver on the child's condition, advise them on any danger signs to look out for and listen to any concerns the caregiver may have. As all children come on the same day for treatment within a short time period, it is challenging for the AWW/ANM to find time to do this.

- ✘ Consider staggering children's arrival at the AWC/VHSND across a few hours so the workload could be an option to explore.
- ✘ Consider providing treatment across multiple days in the week so children do not all come on the same day.

d. Human resources

✘ **Vacancies:** Many areas where services have been implemented, blocks or AWCs which have the lowest number of frontline worker vacancies have been chosen to ensure high quality service delivery. However, in the case of scale up, vacancies will become a challenge.

- ✘ Fill/advocate to fill frontline worker vacancies

✘ **Quality of care:** Low level of skill in implementing protocols, particularly in initial months of implementation.

- ✘ Training needs to include theory and practical sessions
- ✘ The intensity of supervision visits by Lady Supervisors, Medical Officers, block and district staff needs to be high in initial months to reinforce the frontline workers' skills.
- ✘ Programmes require 6 months to be able to start to function sufficiently and achieve good outcomes
- ✘ In the context of COVID, it is imperative to focus on maintaining social distancing and promoting infection prevention control practices and behaviors during service delivery.

✘ **Workload and motivation:** This community-based programme adds additional work on to the existing workload of AWWs, ASHA and ANMs. Frontline workers often have multiple programmes to manage and additional work can lead to a drop-in motivation if the workload is perceived as too high.

✘ **Supervision:** Particularly in the first few months of implementation, but also regularly thereafter, close supervision of frontline workers is essential to ensure that they have the skills and the confidence to deliver services as planned. Supervision mechanisms are often weak with irregular and insubstantial visits from supervisors (Lady Supervisors/Medical Officers) or block and district staff. The supervisory mechanism is essential, both to ensure a high quality of care and frontline worker motivation.

✘ Lady supervisors should be responsible to supervise the sessions over phone or by visiting the site.

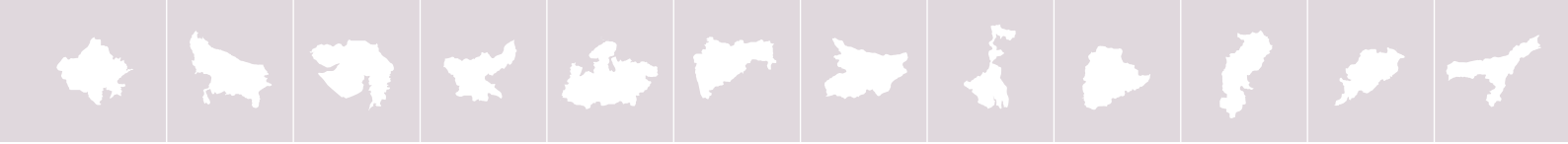
✘ Regular supervision visits are required with the Centre of Excellence monitoring the quality and frequency of visits, as well as conducting additional visits.

e. Linkage with inpatient care: Transfers between inpatient and outpatient services are often not timely enough or effective. Some caregivers refuse to attend inpatient services or it is not known whether those that are referred actually reach inpatient services as required. Equally, it is not known whether those that are discharged from inpatient care receive the remainder of their care in the outpatient component.

✘ Soft-skills on counselling need to be developed for AWWs and ANMs so they can successfully counsel caregivers on the importance of attending inpatient care.

✘ A referral slip should be given to caregivers when referred to inpatient care (or when leaving inpatient care to go to outpatient) which they can give to the MTC on arrival to ensure successful referral.

✘ Transport from the community/AWC/VHSND is required to transfer children to inpatient care. If ambulances are not available, community-led solutions



can be sought which will often be a sustainable approach (Panchyat members can be involved for arrangement of vehicles from community to facility).

f. Post-discharge follow-up and linkage to ICDS SNP:

On discharge from the programme, children should be linked with SNP services from the AWC as per existing ICDS Government guidelines. This should be straightforward as AWWs who deliver ICDS SNP also manage SAM treatment care. In addition, children should have monthly check ups for 6 months to monitor their nutritional status. Any child that relapses to SAM should be readmitted into the treatment programme. Often less than 50% of children are receiving ICDS SNP service on discharge from SAM treatment and only 20% of children are attending all 6 follow up sessions.

- ✘ Emphasis on the full continuum of care, with ICDS seen as a component of CMAM, should be made in training, followed up by Lady Supervisors during supervision visits.

Suggestions for preparation of CMAM session sites in context of COVID:

- ✘ Frontline workers should follow standard hygiene practices and should wash hands with soap and water for at least 40 seconds before start of session and sanitize hands with an alcohol-based sanitizer before and after interacting with every mother and child.
- ✘ The frontline worker should wear a triple layered surgical mask.
- ✘ All service providers (AWW, AWH, ANM, ASHA) should practice respiratory etiquettes by coughing or sneezing into a bent elbow or tissue, then immediately disposing off the tissue.
- ✘ Try to avoid touching the eyes, nose and mouth.
- ✘ Only one caregiver to accompany with a child to the session site.
- ✘ Maintaining social distancing at the session site is critical. Therefore, to avoid overcrowding visits of children with SAM to CMAM site can be scheduled

in staggered approach.

- ✘ All care givers should be advised to use homemade cloth mask during their visit to the session site.
- ✘ Adequate arrangement for soap and water should be made available at session site. Every caregiver should be encouraged to wash their hands with soap and water before approaching for the service.
- ✘ Equipment such as weighing scale, thermometer, infant-meter, stadiometer etc., should be adequately sanitized immediately after use and in between two measurements, with prescribed disinfectants.
- ✘ Please follow State Guidelines for detail guidance.

3. Reporting:

Programmes aim to have accurate child-wise reporting by frontline workers, timely sharing of data with block and district level and regular data analysis to course correct implementation activities. Within the Health and ICDS system reporting can be a challenge, although with CMAM it is more challenging as it requires the AWW to keep accurate records of a child's condition over multiple weeks. Programmes have found AWWs and ANMs have poor reporting skills and data is often delayed in reaching the block and district levels.

- ✘ Ensure time spent during frontline worker and block and district level training on reporting, with practical sessions on how to complete reporting formats
- ✘ Supervision visits should include time spent on reporting alongside implementation support
- ✘ Monthly analysis of CMAM outcomes at the block/district level should be undertaken to identify poor performing areas. Centre of Excellence should support data analysis.

4. Centres of Excellence

Programme monitoring and technical support: This model of providing technical support is an excellent approach to sustainably support the Government in implementation. State Governments partner with a local medical



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college, or institute of repute—involving preferably their Community Medicine and or Pediatric departments. The National Centre of Excellence (Kalawati Saran Children’s Hospital, New Delhi) also provides support to State Centre of Excellence in capacity building and to the State Governments in the absence of state-level CoEs. CoEs conduct monitoring activities of implementation to assess the quality of service delivery. To date, monitoring activities have been very complex with a large amount of data collected which has been challenging to analyze sufficiently to use for programme improvement.

- ❖ During the CMAM planning stages, identify the state-level CoE
- ❖ CoE monitoring data collection activities should be streamlined with data used to direct efforts for

programme improvement

- ❖ CoE staff can provide supervision support to frontline workers and block and district staff which will improve their skills and improve motivation

5. Convergence

As this programme intersects across Ministries and Departments, convergence is essential, which needs to start at the planning stages.

- ❖ Ensure all relevant departments are involved from the start of planning stage
- ❖ An active District administration can follow up on actions to resolve implementation barriers in monthly meetings.

What data reveals?

Table 2: Number of under 5 children screened and proportion of children identified as SAM

State ³	Estimated target of children U5 years/month ⁴	Q1 January - March 19		Q2 April - June 19		Q3 July - Sep 19		Q4 (Oct - Dec 19)		Percent of children identified as SAM			
		Number of children screened	Number of children identified as SAM	Number of children screened	Number of children identified as SAM	Number of children screened	Number of children identified as SAM	Number of children screened	Number of children identified as SAM	Q1	Q2	Q3	Q4
Andhra Pradesh	24,02,212	21,27,834	45,015	22,89,651	42,393	26,91,261	34,208	28,87,507	34,382	2.1	1.9	1.3	1.2
Bihar	1,40,07,807	9,43,679	38,973	8,58,627	33,969	24,34,455	1,00,293	24,25,960	98,350	4.1	4.0	4.1	4.1
Chhattisgarh	26,86,731	18,71,982	1,09,873	18,71,982	1,09,873	0	0	0	0	5.9	5.9	NA	NA
Gujarat	57,51,007	NO DATA	NO DATA	NO DATA	NO DATA	21,54,570	1,09,795	10,78,431	82,523	NA	NA	5.1	7.7
Jharkhand	40,33,796	2,06,241	18,155	1,61,060	18,474	4,05,950	10,499	4,66,249	11,170	8.8	11.5	2.6	2.4
Karnataka	62,01,985	37,31,727	26,220	38,00,775	22,921	29,67,367	9,627	36,64,965	20,531	0.7	0.6	0.3	0.6
Madhya Pradesh	73,91,141	56,77,893	5,516	1,88,47,107	3,51,179	1,92,39,349	3,34,999	1,92,48,260	2,88,021	0.1	1.9	1.7	1.5
Maharashtra	79,19,760	1,25,631	3,687	18,49,294	36,320	76,43,776	1,55,707	1,23,71,906	2,10,583	2.9	2.0	2.0	1.7
Rajasthan	54,34,532	8,637	386	1,320	399	0	0	1,07,056	2,745	4.5	30.2	NA	2.6
Telangana	31,56,048	6,09,557	39,645	10,86,643	1,05,404	10,23,042	70,566	11,18,274	60,630	6.5	9.7	6.9	5.4
Uttar Pradesh	2,47,51,826	1,31,139	1,325	1,16,176	2,840	8,680	230	1,59,346	8,492	1.0	2.4	2.6	5.3
West Bengal	67,67,060	198	46	101	16	27,477	5,390	759	168	23.2	15.8	19.6	22.1
IN 12 STATES	90 Million	15.4 Million	0.3 Million	30.7 Million	0.7 Million	38.5 Million	0.8 Million	43.5 Million	0.8 Million	1.9	2.3	2.2	1.9

Data sources:

Andhra Pradesh: Department of Women Development and Child Welfare, ICDS MIS (NHTS) **Bihar:** Department of Social Welfare, ICDS - CAS **Chhattisgarh:** Department of Women and Child Development **Gujarat:** Department of Health & Family Welfare, report from TECHO plus **Jharkhand:** ICDS CAS, Department of Women and Child Development, Jharkhand, Number of districts reporting under ICDS CAS: 7 out of 24 **Karnataka:** Department of Health & Family Welfare MIS **Madhya Pradesh:** Department of Women and Child Development, ICDS - Monthly report **Maharashtra:** Department of Women and Child Development, ICDS - Monthly report and for Quarter 3 - ICDS CAS **Rajasthan:** Data was collected by the district team (Sirohi) of TATA TRUSTS and shared with UNICEF state office **Telangana:** Department of Women Development and Child Welfare, ICDS MIS (NHTS) **Uttar Pradesh:** Reported data from CMAM programme in Banda and Chitrakoot district **West Bengal:** Quarter 1 and 2 - data from 1 GP of Purulia where CMAM is operational and in Q3 - from DH&FW (SUW) children were screened for WZL/H and MUAC by the nutritionists of NRCs)

³ Odisha and Assam – screening of under 5 children for identification of acute malnutrition is yet to be initiated

⁴ State level Under 5 population targets sourced from Anaemia Mukth Bharat dashboard

For the quarterly screening coverage calculation, the denominator is U5 population times with 3 (months) and numerator is cumulative number of children screened in 1st, 2nd and 3rd month of the quarter.



$$\% \text{ children screened in a quarter} = \frac{\text{Number of children screened in the reporting quarter}}{\text{Total number of children (U5) eligible for screening in the reporting quarter}} \times 100$$

For the calculation of percent children identified as SAM =

$$\% \text{ of U5 children identified as SAM} = \frac{\text{(No. of U5 children identified SAM)}}{\text{(No. of children screened in the reporting quarter)}} \times 100$$

Under POSHAN Abhiyaan mandate, each child below 5 years of age should be measured for weight, length/height every month. In many states, monthly screening has been initiated at AWC and screening coverage is reported either through ICDS MIS or ICDS CAS. The screening coverage has gone up to 16% in quarter 4 (October – December 2019) compared to 5% in quarter 1 (January – March 2019).

Gradually a greater number of children have been reaching out by the Frontline Workers for monthly

screening. Compared to previous two quarters, higher number of children were identified as SAM in third and fourth quarters. However, the proportion of children identified with SAM is significantly lower than the recent state level data of CNNS (2016-18) on prevalence of severe wasting.

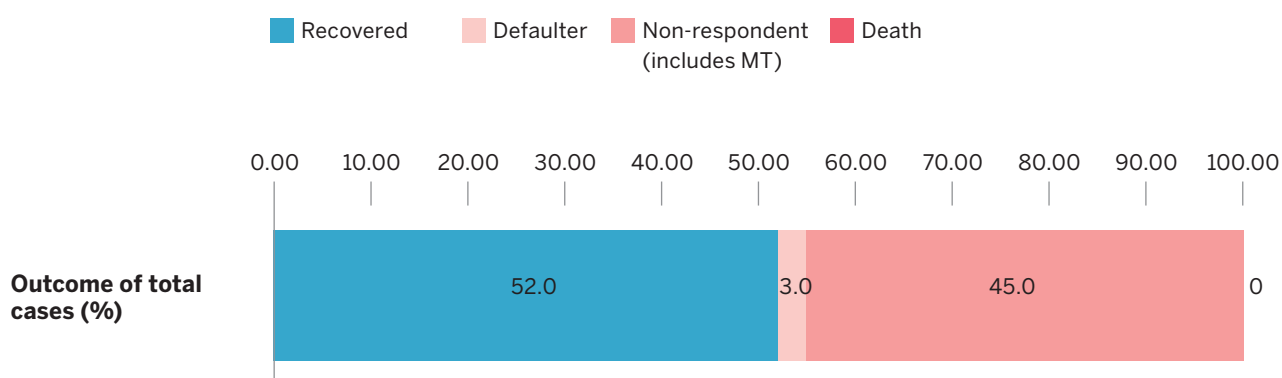
Data trend shows that, with improved screening coverage, frontline workers can identify higher number of children with SAM. Hence, it is crucial to reach out all under 5 children for screening and early detection of wasting. It is expected that the renewed focus of POSHAN Abhiyaan on growth monitoring will increase coverage of screening. Nevertheless, availability of anthropometric tools across the states, quality of weight and height/length measurement by the Frontline workers are challenges and need to be streamlined. It is necessary to ensure that community health workers have the capacity (equipment, skills, time and motivation) to add this responsibility to their roles and increase community demand for services.

Table 3: Outcome of ongoing CMAM programme in 6 states January to December 2019⁵

	Bihar	Rajasthan	Maharashtra	Uttar Pradesh	Madhya Pradesh	West Bengal	Gujarat	Total
	January - December 2019						Sep - Dec 2019	
No. of children admitted to CMAM (n)	146	399	37,999	4,352	474	273	493	44,136
Discharge (n)	81	136	29,087	3,094	64	109	554	33,125
Recovered (n)	25	54	16,230	541	11	35	247	17,143
Defaulter (n)	11	15	967	89	11	6	9	1,108
Non-respondent (includes MT) (n)	45	67	11,889	2,462	42	66	298	14,869
Death (n)	0	0	1	2	0	2	0	5

⁵ Data source: Reported data from programme

'Non-respondent' also include those children who were partially cured (Nutritional status shifted from SAM to MAM but not normal) in the programme.



A total of 44,136 children were enrolled in CMAM programme across the 7 states. Out of total number of children admitted 75% children (n = 33,125) were discharged from the programme. Almost 52% (n =

17,143) of children recovered within the treatment period. Protocol for management of children with SAM at community level varies across the states.



Abbreviations and Acronyms

Abbreviation	Full name
ANM	Auxiliary Nurse Midwifery
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
AWC	Anganwadi Centre
CAS	Common Application Software
CMAM	Community Based Management of Acute Malnutrition
CoE	Centre of Excellence
CTC	Community Treatment Centre
CNCP	Comprehensive Nutrition Care Programme
DHFW	Department of Health and Family Welfare
DWCD	Department of Women and Child Development
FSAM	Facility Based Management of Severe Acute Malnutrition
ICDS	Integrated Child Development Services
IMAM	Integrated management of Acute Malnutrition
KSCH	Kalawati Saran Children's Hospital
LHV	Lady Health Visitor
MAM	Moderate Acute malnutrition
MSF	Médecins Sans Frontières
MTC	Malnutrition Treatment Centre
NCoE	National Centre of Excellence
NIN	National Institute of Nutrition
NRC	Nutrition Rehabilitation Centre
POSHAN	Prime Minister's Overarching Scheme for Holistic Nutrition
SAM	Severe Acute Malnutrition
SSFP	Supervised Supplementary Feeding Programme
TAG	Technical Advisory Group
TAD	Tribal Affairs Department
TWG	Technical Working Group
THR	Take Home Ration
UNICEF	United Nations Children's Fund
VCDC	Village Child Development Centres
VHSND	Village Health Sanitation and Nutrition Day
WHO	World Health Organization
WHZ	Weight for Height Z score



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Chhattisgarh	Department of Health and Family Welfare and Medical Education, Government of Chhattisgarh Department of Women and Child Development, Government of Chhattisgarh State Centre of Excellence for management of Severe Acute Malnutrition, All India Institute of Medical Sciences, Raipur, Chhattisgarh
Gujarat	Department of Health and Family Welfare, Government of Gujarat Department of Women and Child Development, Government of Gujarat GMERS Medical College and Hospital Valsad, Gujarat
Jharkhand	State Nutrition Mission, Government of Jharkhand Department of Women, Child Development & Social Security, Government of Jharkhand Department of Health, Medical Education and Family Welfare, Government of Jharkhand State Centre of Excellence for management of Severe Acute Malnutrition, Rajendra Institute of Medical Sciences, Ranchi, Jharkhand
Madhya Pradesh	Department of Women and Child Development, Government of Madhya Pradesh, Department of Health and Family Welfare, Government of Madhya Pradesh State Centre of Excellence for management of Severe Acute Malnutrition, All India Institute of Medical Sciences, Bhopal, Madhya Pradesh
Maharashtra	Department of Women and Child Development, Government of Maharashtra Department of Health and Family Welfare, Government of Maharashtra
Odisha	Department of Women and Child Development and Mission Shakti, Government of Odisha Department of Health and Family Welfare, Government of Odisha
Rajasthan	Department of Medical, Health and Family Welfare, Government of Rajasthan Department of Women and Child Development, Government of Rajasthan Rabindra Nath Tagore Medical College, Udaipur, Rajasthan Dr. S.N. Medical College Umaid Hospital, Jodhpur, Rajasthan
Telangana	Department of Women Development and Child Welfare, Government of Telangana Department of Health and Family Welfare, Government of Telangana National Institute of Nutrition, Hyderabad
Uttar Pradesh	Department of Health and Family Welfare, Government of Uttar Pradesh Department of Women and Child Development, Government of Uttar Pradesh
West Bengal	Department of Health and Family Welfare, Government of West Bengal Department of Women and Child Development and Social Welfare, West Bengal College of Medicine and Sagore Dutta Hospital, Kolkata, West Bengal

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