ACCOUNTABILITY INITIATIVE

CENTRE FOR POLICY RESEARCH

POLICY NOTE

A Hidden Cost:

The Pandemic's Impact on Nutrition

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Chapters

List of Abbreviations

ASHAs	Accredited Social Health Activists
AMB	Anemia Mukt Bharat
AWCs	Anganwadi Centres
AWWs	Anganwadi Workers
ANC	Ante Natal Care
ANMs	Auxiliary Nurse Midwives
CSS	Centrally Sponsored Scheme
CDPOs	Child Development Project Officers
CAS	Common Application System
GoI	Government of India
GDP	Gross Domestic Product
GNI	Gross National Income
IFA	Iron and Folic Acid
ICDS	Integrated Child Development Services
JSY	Janani Suraksha Yojana
LSs	Lady Supervisors
MWCD	Ministry of Women and Child Department
MoHFW	Ministry of Health and Family Welfare
NHM	National Health Mission
NRC	Nutrition Rehabilitation Centre
PPE	Personal Protective Equipment
POSHAN	PMs Overarching Scheme for Holistic Nourishment
PMMVY	Pradhan Mantri Matru Vandana Yojana
PDS	Public Distribution System
SBCC	Social and Behaviour Change Communication
SNP	Supplementary Nutrition Programme
THR	Take Home Rations
VHSND	Village Health Sanitation and Nutrition Day

Image Source: pixy.org

Chapter 1

Introduction

In India, 68 per cent deaths of children under five are due to malnutrition or 1,935 deaths every day[1]. The onset of the COVID-19 pandemic, subsequent lockdown, and ensuing constraints are likely to exacerbate the distress of those who are malnourished – in particular, pregnant women, young mothers, and children. Estimates suggest that a decline in Gross National Income (GNI) per capita will result in a 14 per cent increase in moderate/severe wasting in children under-5 years of age, and a 22 per cent increase in severe wasting[2]. Combined with disruptions in service provision, COVID-19 could lead to several maternal and child deaths[3].

To avoid losing the momentum gained so far in the battle against malnutrition, public policy should prioritise creating and maintaining robust safety nets for women and children. **This brief provides an overview of the nutrition sector prior to the pandemic, the changes and impact due to the pandemic, and briefly discusses what can be done to get nutrition interventions back on track.**

There are two types of interventions to address fetal and child nutrition and development[4]. **Nutrition-specific interventions** that address immediate determinants and **nutrition-sensitive interventions** that address underlying determinants.

Table 1: Nutrition-Specific and Nutrition-Sensitive Interventions

Nutrition-Specific Interventions	Nutrition-Sensitive Interventions
Adequate food and nutrient intake, complementary feeding, caregiving and parenting practices, and low burden of infectious diseases	Food security; adequate caregiving resources at the maternal, household, and community levels; access to health services; and a safe and hygienic environment

This brief's focus is solely on core nutrition-specific interventions for pregnant women, lactating mothers, and children under six years of age. These address the immediate determinants of fetal and child nutrition and development. Nutrition-sensitive interventions are discussed where relevant.

Image Source: pixabay.com

Chapter 2

Nutrition Sector Prior to the COVID-19 Pandemic

This section provides a brief exposition of India's pre-pandemic nutrition landscape, and covers the government's core nutrition-specific interventions as well as major challenges faced by the sector.

2 (a). An Overview of India's Nutrition Sector

At the Government of India (GoI) level[i], nutrition-specific interventions are delivered primarily through two Centrally Sponsored Schemes (CSSs) -

1. **The Integrated Child Development Services** (ICDS) is GoI's flagship programme aimed at providing basic education, health, and nutrition services for early childhood development. It comes within the Ministry of Women and Child Department (MWCD).

2. The **National Health Mission** (NHM) aims at achieving universal access to healthcare by strengthening health systems, institutions, and capabilities, including a focus on maternal and child health. It comes within the Ministry of Health and Family Welfare (MoHFW).

While these schemes have existed for a long period of time, progress has been slow and variable. In 2016, stunting (low height-for-age) prevalence in India was high (38.4 per cent) and varied considerably across districts (range: 12.4-65.1 per cent), with stunting above 40 per cent in over a third of districts[5]. as per the National Family Health Survey (NFHS)-4 (2015-16). Updated data is available for 22 States and Union Territories (UTs) from NFHS-5 (2019-20)[6]. In 13 out of 22 states for which data is available, stunting among children under five increased, and in 12 out 23 states wasting levels increased. This is concerning.

Recent years have seen an increasing policy focus on nutrition. GoI launched POSHAN (PMs Overarching Scheme for Holistic Nourishment) Abhiyaan[7] in 2017, which aims to holistically reduce the prevalence of malnutrition in India by 2022 using technology including the ICDS Common Application System (ICDS-CAS) a real-time monitoring system and job aid; convergence; capacity building; and behaviour change communication. Simultaneously, GoI launched several other initiatives, such as the Pradhan Mantri Matru Vandana Yojana (PMMVY) – a maternity

[i] States run a number of their own schemes but those are not covered in this brief.

benefit scheme aimed at compensating women for wage loss and promoting health and nutrition seeking behaviour; the Anemia Mukt Bharat (AMB) for addressing the high prevalence of anemia; and a Jan Andolan (people's campaign) for Social and Behaviour Change Communication (SBCC). The launch of these schemes has led to a re-prioritisation of nutrition outcomes, with clear targets being laid out to be achieved by 2022 (Table 2).

Table 2: POSHAN Abhiyaan Targets

Indicator	Targets (by 2022)
Prevent and reduce stunting in children (0- 6 years)	From 38.4% [as per the fourth round of the National Family Health Survey (NFHS-4)] to 25%
Prevent and reduce under-nutrition (underweight prevalence) in children (0-6 years)	By 6 percentage points at a reduction rate of 2% per annum
Reduce the prevalence of Anemia among young children (6-59 months)	By 9 percentage points at a reduction rate of 3% per annum
Reduce the prevalence of Anemia among women and adolescent girls (15-49 years)	By 9 percentage points at a reduction rate of 3% per annum
Reduce Low Birth Weight (LBW)	By 6 percentage points at a reduction rate of 2% per annum

2 (b). Challenges

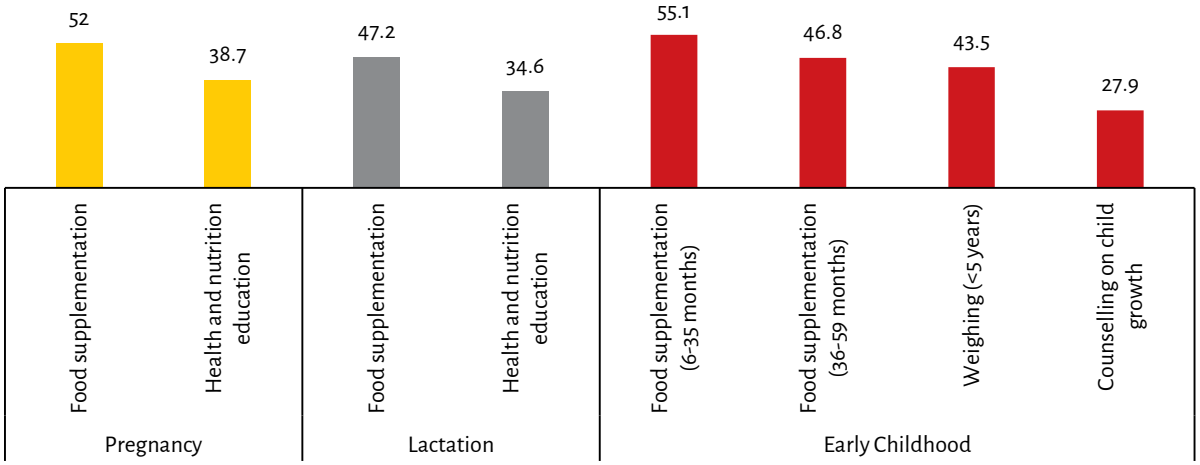
Despite these changes, even prior to the pandemic, the delivery of nutrition-specific interventions was impeded by several challenges. Broadly, they can be classified as three types:

1. Access and equity issues;
2. Bottlenecks in specific interventions, such as the delivery of food supplements; and
3. Lack of an enabling environment for delivery.

Coverage: On average, nationally, no major nutrition specific intervention exceeded 70 per cent even coverage in 2015-16. Coverage of interventions ranged from 65 per cent for Iron and Folic Acid (IFA) during pregnancy and nutrition to just about 50 per cent or less for most other interventions such as food supplements and Ante Natal Care (ANC)[5]. Consequently, most households did not receive all the nutrition interventions. For instance, Menon et al (2019)[8] found that only two of 1,417 households (0.1 per cent) received all 19 nutrition-specific and nutrition sensitive interventions spanning various departments.

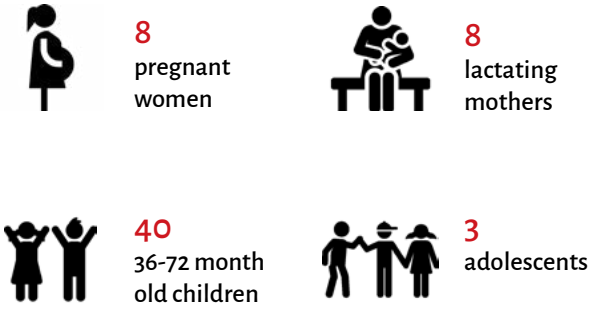
In addition to low coverage across interventions, there are also significant inter-state and inter-district variations in coverage. For instance, the coverage of food supplements ranged from barely 3 per cent in some districts to over 95 per cent in others[9].

Figure 1: Coverage of Core ICDS Interventions in 2015-16



Source: International Food Policy Research Institute. Data Note No. 4. July 2018.
Available online at: http://ebrary.ifpri.org/utils/getfile/collection/p15738coll2/id/132803/filename/133015.pdf.

Inequitable access and exclusion: Exclusion and inequity remain major challenges in nutrition service delivery and are also the focus of the Global Nutrition report for 2020[10]. The overall use of ICDS improved between 2006 and 2016 and reach improved for marginalised groups such as disadvantaged castes and tribes. Yet, the poorest 20 per cent quintiles of the population were still left behind, especially in the largest states that carry the highest burden of undernutrition[11]. Exclusion has been amplified by various state policies as well. For example, despite ICDS being a demand-driven scheme, Anganwadi Centres (AWCs) in Bihar have a cap on the number of people that can be registered. These are shown as follows[12]:



Such rigidity leads to the exclusion of some of those who seek services, despite them meeting all eligibility criteria.

Declining beneficiaries at AWCs: Under the Supplementary Nutrition Programme (SNP), the government provides per child costs for the provision of food supplements to meet the necessary calorific and protein criteria[13]. In 2017, the per day unit cost norms were increased, and currently ₹8 is provided for children under six years of age; ₹9.5 is given for pregnant women and lactating mothers; and ₹12 is provided for severely malnourished children[14]. The number of ICDS beneficiaries receiving supplementary nutrition at AWCs has been decreasing. For instance, between March 2014 and June 2019, the number of children (6 months–6 years) receiving SNP fell by 20 per cent from 849 lakh to 676 lakh. The number of pregnant women and lactating mothers receiving SNP also fell by 18 per cent from 196 lakh to 160 lakh.

The total number of SNP beneficiaries stood at 45 per cent out of the estimated number of beneficiaries in 2019. This decline could be due to both supply side factors including lack of coverage and access, and demand side factors such as household aspirations to seek private services, in line with the perception that government provided services are of poorer quality.

Apart from variable coverage and inequitable access across all nutrition-specific interventions, there are challenges with respect to specific interventions as well.

Quality of food supplements

As per a recent survey, among children aged 6–23 months.

1. 21 per cent had access to minimum dietary diversity[ii],
2. 42 per cent received the minimum meal frequency[iii], and
3. Only 6.4 per cent received a minimum acceptable diet[iv].

Despite this, the quality and quantity of food supplements remains low in several states. Also, experts have argued that requirements for children below and above two years have not been separately examined, and the levels of sugars and proteins in food supplements require re-assessment[15].

Image Source: wikimedia.org

Table 3: Data from the Comprehensive National Nutrition Survey (2016-18)[16]

Indicator	Percentage
Percentage of children aged 6–23 months with minimum acceptable diet	6.4
Percentage of children aged 6–23 months with minimum dietary diversity	21.0
Percentage of children aged 6–23 months with minimum meal frequency	41.9
Percentage of children aged 1–4 years classified as having anemia	40.5
Percentage of children aged 5–9 years classified as having anemia	23.5

[ii] Children received foods from four or more of the following food groups: a. infant formula, milk other than breastmilk, cheese or yogurt or other milk products; b. foods made from grains or roots, including porridge or gruel, fortified baby food; c. vitamin A-rich fruits and vegetables; d. other fruits and vegetables; e. eggs; f. meat, poultry, fish, shellfish, or organ meats; g. beans, peas, lentils, or nuts; h. foods made with oil, fat, ghee, or butter.

[iii] Children aged 6–23 months who received solid, semi-solid or soft foods the minimum number of times or more during the previous day. For girls, 2 meals for aged 6-8 months and 3 meals for 9-23 months; for boys, 4 meals for 6-23 months.

[iv] Breastfed children aged 6–23 months who had at least the minimum dietary diversity and the minimum meal frequency during the previous day and non-breastfed children aged 6–23 months who received at least 2 milk feedings and had at least the minimum dietary diversity (not including milk feeds) and the minimum meal frequency during the previous day.

Supply chains for micronutrients: A study of bottlenecks in the iron and folic acid supply chain in Bihar conducted in 2011 and 2012 found that over 40 per cent of Auxiliary Nurse Midwives (ANMs), responsible for the provision of IFA tablets, reported having no stock[17]. The situation remains similar even today. The recently launched AMB - which provides IFA tablets - has been hampered by disrupted supply chains[18]. For instance, in FY 2019-20, the percentage of stocks available for IFA Syrup for children stood at 52.4 per cent, and tablets for women at 33.2 per cent.

Awareness, enrolment and payments part of maternity benefit cash transfers: Two schemes - namely the Janani Suraksha Yojana (JSY) and the PMMVY - provide dwirect benefit cash transfers to women for meeting conditionalities related to health-seeking behaviors. Several studies, however, have found that low awareness, cumbersome procedures[19], and delayed payments result in women not receiving their entitlements. For instance, a report from 2019 highlighted that a substantial number of payments (28 per cent of all Aadhaar-based payments, amounting to ₹31.29 lakh) were going to different bank accounts than what had been provided by the beneficiaries[20].

Intervention-specific challenges aside, delivery of nutrition-specific interventions is also impacted by human and fiscal resources across the ICDS and health system.

Vacancies and overburdened functionaries: High vacancies have been a perennial issue, especially at mid-manager level in ICDS, and doctors and specialists in NHM. ICDS has three crucial functionaries – Anganwadi Workers (AWWs) who are responsible for activities at AWCs, who are monitored and supervised by Lady Supervisors (LSs), who report to Child Development Project Officers (CDPOs) at the block level. As of June 2019, 29 per cent posts for CDPOs lay vacant, and 30 per cent LS posts were vacant. This translates to an increased workload and challenges faced by AWWs in supportive supervision, resources, and technical knowledge[21].

Similarly, the recent Rural Health Statistics (RHS 2019) found that 24 per cent of sanctioned posts for doctors at Primary Health Centres in rural areas were vacant. For specialists (physicians, surgeons, obstetricians and gynecologists, and pediatricians), 73 per cent of sanctioned posts were vacant at Community Health Centres.

Finances: Budget allocations for nutrition specific interventions has been low. In FY 2019-20, budget allocated for ICDS was only 73 per cent of the funds requested by MWCD[22]. Similarly, for the umbrella NHM, only 78 per cent of projected budgets were allocated[23]. As a consequence, funds for most interventions remain far below required costs. For example, for SNP, allocations in FY 2019-20 were only 44 per cent of required costs.

The situation is exacerbated by low capacity to spend even the funds that are available. Between FY 2016-FY 2018, on average only 60 per cent of funds available under NHM were spent.

Image Source: wikimedia.org

Chapter 3

The Effects of the Pandemic on Nutrition and Health Services

The recent policy focus for nutrition and increased investments are likely to be halted due to the pandemic and ongoing economic slowdown. This section first looks at income decline and health service disruption as the two main reasons because of which the COVID-19 pandemic will impact the nutritional status of children and women. This is followed by a detailed analysis of the impact on nutrition-specific interventions, such as food supplements, immunisations, micronutrient provision, counselling, and maternity benefits.

3 (a). Income decline

Global projections suggest that even fairly short lockdown measures, combined with severe mobility disruptions and comparatively moderate food systems disruptions, result in declines in income. Without any preventive interventions, it is estimated that over 140 million people globally could fall into extreme poverty (measured against the $1.90 poverty line) in 2020 - a 20 per cent increase from present levels[24].

The decline in incomes and consequent increase in poverty is known to have severe consequences on mortality and nutritional outcomes, particularly on wasting (low weight for height)[v]. A global estimate data from 1998-2018 found that a 10 per cent decline in GNI per capita could lead to a 14 per cent increase in moderate or severe wasting in children under-5 years of age, and a 22 per cent increase in severe wasting[2].

The impact of the pandemic on incomes in India is already evident. Unemployment had shot up to over 23 per cent in May 2020, compared to 7-8 per cent before March[25], and earnings reduced for those employed[26]. Projecting the impact of declining Gross Domestic Product (GDP) on wasting suggests that a **potential 9.5 per cent decline in GDP in India 3.946 million children would be newly wasted,** 542,975 mildly wasted; 1.322 million moderately wasted; and 2.081 million severely wasted, with greatly elevated risk of mortality. Given that the GDP contracted by 22.8% from April to June 2020[27], these numbers could be even higher.

[v] In the short term, nutritional gaps often result in the acute weight loss or low weight-for-height z scores (WHZ). Wasting is usually the result of both severe reductions in food intake and recent or repeated episodes of infectious diseases, and the interaction between poor diets and infections. These are all caused during a severe economic downturn.

3 (b). Nutrition and Health System Disruptions

Reductions in the coverage of key services, even in the short-term, can have long-lasting implications on pregnancy, and child health and nutrition outcomes during the critical first two years[28]. A recent Lancet study[3] across 118 countries estimated large increases in maternal and child deaths amongst low and middle income countries. Assuming coverage reductions in key nutrition specific interventions of even 9·8–18·5 per cent, and a wasting increase of 10 per cent, the study projected that over 6 months there would be 2,53,500 additional child deaths and 12,200 additional maternal deaths, across the 118 countries. At the extreme end of the spectrum, reductions in coverage of 39·3–51·9 per cent and an increase in wasting of 50 per cent, over 6 months could lead to 11,57,000 additional child deaths, and 56,700 additional maternal deaths.

In India, government data suggest that while services weren't entirely halted, there was a slowdown in service provision. The lockdown imposed to prevent the spread of COVID-19 affected the delivery of key services. AWCs, the main platform for delivery of core nutrition-specific interventions were shut as people were encouraged to stay home. As of June 2020, AWCs across at least 18 large states remained shut. Further, AWWs, Accredited Social Health Activists (ASHAs), and ANMs had various COVID-19 related responsibilities, such as contact tracing and public awareness generation, and did not have time for their core duties[29]. These factors, coupled with the rise in potential demand from migrants returning to their home states (5-30 million[30]), have clear repercussions on the delivery of specific health and nutrition interventions.

The remaining section looks at the status of and potential concerns in several key services. These are: food supplements, immunisation, care at Nutrition Rehabilitation Centres (NRCs), counselling and check-ups, micronutrient provision, and maternity benefits

Food supplements:

Food security is a big challenge during the pandemic. A survey of 1,694 households in Bihar and Uttar Pradesh in May 2020 found that 32-48 per cent of households faced a shortage of food items in the previous month, and 49-59 per cent of households had to reduce their food intake during the lockdown. This is particularly concerning given differential gender impacts of food shortage. As compared to men, a higher proportion of women in the study reported food shortage and reduced intake[31]. Another survey of 12 states found that many households were reducing the number of food items in a meal and the number of meals in a day[32]. This is supported by reports that rural India was already eating less food and less nutritious food[33].

Several states made food provision, both generally and specifically for ICDS beneficiaries, a priority. Under the Atmanirbhar Bharat Programme[34], the Public Distribution System (PDS) has been mobilised to provide food supplies. Moreover, all large states are providing Take Home Rations (THR) to both women and children[35]. The means of THR delivery has varied across states. For example, at the time of writing this brief, Bihar was giving cash in lieu of THR, and Odisha was delivering THR and dry rations at doorsteps. However, as most AWCs were shut, hot cooked meals for children (3-6 years) were not being served.

The provision of grain alone through PDS does not address the specific nutrition needs of women and children. Hot cooked meals are meant to ensure that the food is consumed by the child, and is not shared among family members. Even with THR, information on coverage is limited thus far, and there is no indication that previous issues of access and coverage across districts (which we have covered in the previous section) have been addressed.

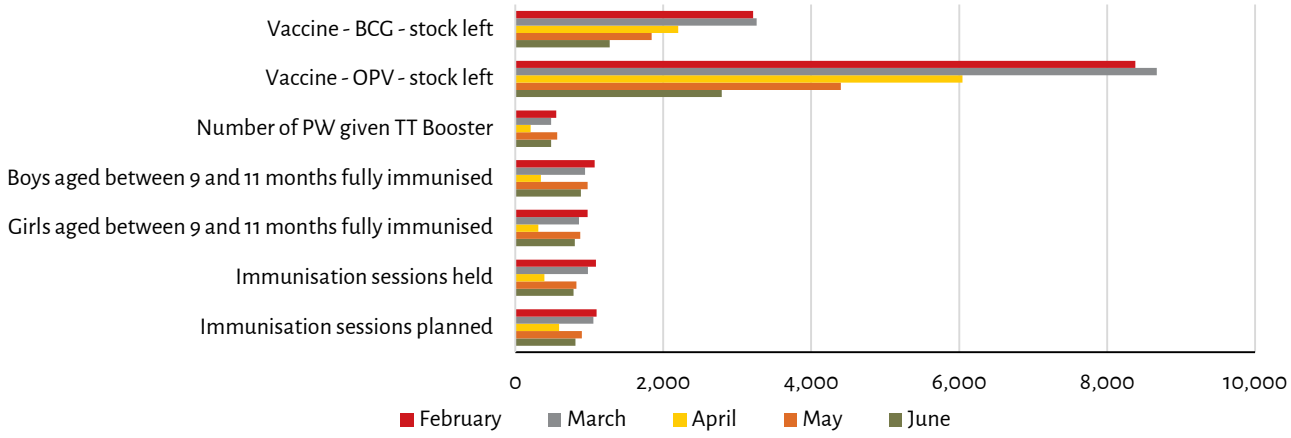
Health Interventions:

Immunisation

Immunisation services were significantly affected during the lockdown, threatening to unwind progress made towards eradicating vaccine preventable diseases. Some immunisations cannot be delayed, and delays can have long lasting effects. A single missed case can lead to a higher chance of the disease spreading in the future, and easily preventable diseases can prove fatal[36].

The number of immunisation sessions planned and held declined significantly in April 2020. As a result, the number of children and pregnant women immunised in April fell by up to 17 lakh. This was a consequence of the lockdown, and fewer immunisation sessions, as sessions are usually held at Village Health Sanitation and Nutrition Days (VHSNDs) every month at AWCs. While these have since recovered, according to some reports, presence in immunisation camps remains low due to fear among parents of their children getting infected with COVID-19.

Figure 2: Immunisation Sessions and Number of Women and Children Immunised (in Thousands)

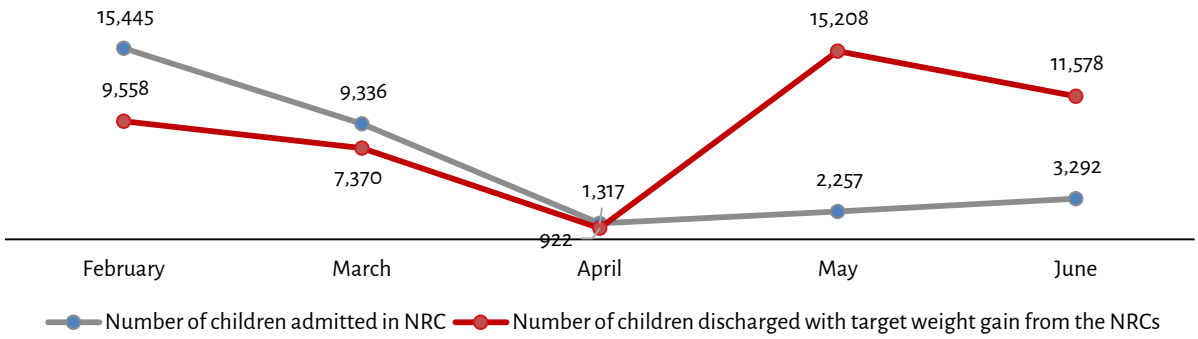


Source: Health Management Information System.
Available online at: https://nrhm-mis.nic.in/hmisreports/frmstandard_reports.aspx.

Nutrition Rehabilitation Centres

The treatment of severely malnourished children can be done at home if the child has no medical complications. If complications exist, treatment at NRCs is required[37]. Treatment at NRCs continued in most states as of June 2020. Gujarat and Chhattisgarh, were two exceptions. As services have resumed, the number of children admitted to NRCs has picked up again.

Figure 3: Children Admitted to NRCs Declined but Services have Resumed



Source: Health Management Information System.
Available online at: https://nrhm-mis.nic.in/hmisreports/frmstandard_reports.aspx.

Counselling and check-ups:

Counselling is a key intervention in increasing healthier practices among people. There are several platforms for counselling which include face-to-face meetings, community sessions, digital messages, and public messages. Among these, conversations at health facilities, VHSNDs and Community-based events reach more people than other platforms[38]. These platforms rely on in-person interaction and can no longer be used due to AWCs being shut[13]. Home visits and the use of television or audio and video calls for the delivery of key messages have continued in most states, as per reports[39]. Uttar Pradesh remained an exception, and counselling services had not resumed as of June.

A key intervention to reduce maternal and infant mortality is regular antenatal care. As per government norms, there should be at least 4 ANC visits[40]. After a dip in provision in April, ANC visits have picked up again but remain below pre-lockdown levels. The disruption of ANC check-ups is likely to have affected both women, and children that were born during this period.

Micronutrient provision:

Micronutrients are crucial for infants and children, who are most vulnerable to micronutrient deficiency, given the high vitamin and mineral intake they need to support their rapid growth and adequate development. Vitamin and mineral deficiencies, particularly of vitamin A, iron, and zinc contribute significantly to morbidity and mortality in children under 5 years of age[41]. Iron deficiencies significantly affect pregnant women and new mothers as well[42], and contribute massively to anemia among women (over 50 per cent are anemic[6]).

While the provision of IFA for pregnant women dipped, it has recovered to pre-lockdown levels to a large extent. The same is not true for lactating mothers, for whom provision has not seen a recovery. For adolescents and children who would normally receive IFA in schools, tablet provision has witnessed a decline since February 2020. The same is true for children whose mothers would receive IFA from the AWC, and for out-of-school children.

For IFA, some states like Madhya Pradesh have issued instructions on providing supplements at home, but given previous coverage issues, it may be difficult to reach each person who requires these supplements. Similar trends hold for other crucial micronutrients like calcium and zinc. This decline could have already had an adverse impact, and continued disruptions in service provision will be detrimental.

Table 4: **Number of Women and Children Provided IFA**

	Number of PW given 180 Iron Folic Acid (IFA) tablets	Number of mothers provided full course of 180 IFA tablets after delivery	Number of children (6-59 months) provided 8-10 doses (1ml) of IFA syrup (Bi weekly)
February	22,73,973	11,05,228	2,23,96,741
March	21,13,233	10,57,332	1,76,95,290
April	12,59,269	7,09,086	1,05,38,462
May	20,54,749	8,25,671	1,28,31,039
June	17,82,912	6,89,121	1,08,36,368

Maternity benefits:

Maternity benefits (PMMVY and JSY) are meant to incentivise health seeking behaviour as well as compensate for wage losses. Despite prior challenges with cash transfers, these have continued in various states, which is encouraging. The main exceptions are Chhattisgarh and Uttar Pradesh which had stopped PMMVY benefits as of June 2020. Research suggests that direct benefit transfers can be an efficient channel during the COVID-19 pandemic to augment incomes due to lower transaction costs, minimal leakages, and its immediate delivery[43].

3 (c). Governance issues due to the COVID-19 pandemic

Frontline Workers:

The cornerstone of ensuring uptake of various interventions is the provision of health and nutrition education. While AWWs, ASHAs, and ANMs continue with immunisation, counselling, and ANC, they are also at the frontline in the fight against COVID-19. They have several tasks, including contact tracing, counselling, monitoring of people who are COVID-19 positive, reporting new cases, etc. FLWs face their own challenges including a lack of Personal Protective Equipment (PPE) in some states, a lack of training, a lack of transport, and families being non-cooperative[28]. In August, FLWs went on strike[44,45], citing inadequate government assistance while fighting COVID-19. The unavailability of FLWs even in the short term may result in a decrease in service provision.

Financing:

The economic impact of the lockdown starkly reduced economic activity, especially in the first quarter of the year. This led to a shortfall in taxes[46] and subsequently, government revenues. State finances are in a precarious position. Some states require a higher amount of money due to a high malnutrition burden. However, states have differing ability to respond to such needs.

States such as Assam, Bihar, Chhattisgarh, Mizoram, Uttarakhand, and West Bengal depend more on GoI fund transfers[47]. Bihar has a high malnutrition burden, and therefore, requires extra support from GoI. New schemes have been put on hold as well. This leaves finances for several interventions, including nutrition-specific ones, in a tight spot. It is possible that expenditures will be low compared to previous years, and this could affect coverage later in the financial year as well.

Image Source: pixabay.com

Chapter 4

What can be done?

There are several immediate steps that must be taken to arrest the decline in coverage and service provision due to the COVID-19 pandemic.

India has 22.17 crore children under 5 years of age, and 3.96 crore pregnant women and lactating mothers, all of whom are at-risk and therefore, providing services requires great care. The **decline in service provision, combined with a fall in incomes, and an increase in medical wasting conditions can lead to increased mortality.** Nutrition services should be delivered while taking precautions (protective equipment, social distancing, etc.) to prevent the spread of COVID-19. Also, while most services have resumed across states after the lifting of the lockdown, restarting all services is necessary, and states would need to be able to have options on how to deliver these services. Furthermore, states must determine ways to register new beneficiaries, given that AWCs are shut.

Even in the absence of opening AWCs, some recommendations are given below (Table 5).

Table 5: **Recommendations to Improve the Provision of Nutrition-Specific Interventions**

Intervention	Recommendation	
Food supplements	Maintaining food security	A lot of services being provided are COVID-19 specific, and these services are being delivered at home. These include counselling on social distancing, or the home delivery of rations. These activities can be combined with nutrition interventions such as counselling and ANC check-ups, the provision of IFA and other drugs, and the distribution of food supplements.
Micronutrients	Restart travel routes and supply chains	
Counselling	Expand use of digital platforms where possible	

Intervention	Recommendation
Maternity benefits	Continue cash transfers as they have found some success[42]. However, the amounts given should be revisited to ease loss of household income.
Immunisation	Continue routine immunisation while taking all precautions[49]. Delayed or missed immunisations should be administered based on WHO guidelines[50].
Breastfeeding	Continue, even if the mother has COVID-19[48].

Apart from these specific interventions, it will be important to strengthen access and coverage. The focus on building an enabling environment of fiscal and human resources will be critical. This includes ensuring FLWs have adequate safety equipment, and providing additional incentive payments or increasing honoraria and salaries.

Expanding coverage is essential given pre-existing vulnerabilities being exacerbated by COVID-19. **This would require budgeting for 100 per cent of the target population.** India should have spent at least ₹58,707 crore in FY 2019-20, across Union government Ministries and State government Departments to fully finance a set of nutrition-specific interventions[51]. Furthermore, all allocations for nutrition-related schemes including the additional funds by the 15th Finance Commission for ICDS[52] should be ring-fenced to ensure all services are adequately provided.

Finally, Initial state-wise trends from 2019-20 show that even as coverage for some interventions like IFA provision improved, outcomes such as anemia stagnated or worsened. This highlights the importance of looking at underlying causes such as loss of incomes and economic decline.

In conclusion, with approximately 75,000 children born every day, it is critical that the nutritional needs of children and women are protected to ensure that gains made prior to the pandemic are sustained and improved upon.

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