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HUNGER AMIDST THE PANDEMIC

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The COVID-19 pandemic has taken a toll on not just the country's healthcare system, but also on the livelihoods of millions of people across the country. The past few months have set India back on economic, health and developmental targets. While the country's economy will no doubt be back on the track as the health crisis abates and businesses recover, the setbacks on the socio-development front could be more challenging.

From a healthcare perspective, battling a pandemic is a resource-heavy exercise. While these resources are crucial in saving the lives of those infected by COVID-19, it is equally important to take a look at where these resources are coming from. In an all-hands-on-the-deck situation like the pandemic, all healthcare workers, ranging from doctors, nurses to community level ASHA workers have been involved in the screening and management of COVID-19 patients. Understandably, non-essential procedures have been postponed and several non-COVID responsibilities have been put on a backburner. However, these healthcare workers are also critical in the treatment and management of other conditions such as Severe Acute Malnutrition (SAM). Some of their patients may not be able to survive several months of delay in care. According to UNICEF, COVID-related disruption in health and integrated child development services (ICDS) may result in as many as 3,00,000 untimely child deaths, especially in the face of job and income losses that have plagued many families.

Malnutrition has been a challenge for India for many decades. Even during periods of strong economic growth, improvements in the nutrition status of the country's children have been slow. India ranked an abysmal 102 out of 117 countries on the Global Hunger Index 2019. The prevalence of "stunting" in children under the age of five remains as high as 37.9 per cent and that of wasting is 20.8 per cent — both higher than the average for a developing nation.

In the years preceding the pandemic, however, things started improving when Prime Minister Narendra Modi recognised addressing malnutrition as one of the top priorities for achieving universal healthcare in India. The POSHAN Abhiyaan — launched in 2018 — offers a ray of hope across states; other efforts to fight the hunger epidemic have also been undertaken.

While the pandemic may have brought the progress to a standstill, the country cannot afford to lose time in the battle against malnutrition. Luckily, there are successful precedents from Indian states that can be leveraged without adding further burden onto hospitals and healthcare centres that are busy handling COVID-19. One such model that can be scaled up for adoption in other states is Gujarat's Community-based Management of Malnutrition (CMAM).

Typically, only about 10-15 per cent of SAM cases develop complications that require hospitalisation or recuperation at Nutrition Rehabilitation Centres (NRCs). The remaining 80-90 per cent — serious if untreated — can be managed effectively through timely screening, identification, and community-level treatment by ASHA and Anganwadi workers.

In Gujarat, the CMAM programme is being led by the Department of Health and Family. Welfare. After showing success in a few pockets of the state, the programme has been rolled-out across Gujarat. A Centre of Excellence (CoE) was established in the GMERS Medical College and Hospital in Valsad to provide technical support to the state government for the implementation and management of SAM, both at the facility and the community level. At the community level,

children with such deficiencies are provided nutrition-dense food and routine medical care and their families are educated about health and nutrition requirements.

The CoE helps not only in capacity building but also in monitoring, supervision, and validation of the CMAM programme in the state. The CoE and Gujarat's Department of Health and Family Welfare have identified Dharmapur in Valsad district as a model block for intensive monitoring. Here, CMAM processes will be documented with the objective of evaluating implementation and identifying replicable best practices.

A few other states such as Maharashtra, Rajasthan, and Madhya Pradesh have also used the CMAM approach to save thousands of young lives. However, each state's approach differs, and there is immense potential in leveraging and scaling the use of the best practices identified in Gujarat. This could be easily achievable through inter-state collaboration and national guidelines on CMAM.

At a time when a significant portion of the states' resources is being utilised or kept in reserve for managing the COVID-19 pandemic, there is a strong need for states to band together to share best practices, so as to fight the national malnutrition crisis in a more efficient, effective manner.

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