

NUTRITION PROGRAMMING: ADJUSTING TO COVID-19



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The purpose of this document

This document outlines adaptations to global nutrition programming during the COVID-19 pandemic. The adaptations offer a greater continuity of critical services when dealing with nutrition-related life-threatening conditions among the most vulnerable populations, while protecting beneficiaries and service providers from contracting COVID-19.

The document summarizes key global recommendations made for community-based management of acute malnutrition (CMAM), infant and young-child feeding practices (IYCF), general food distribution (GFD), community mobilization and sensitization, and nutrition surveys and assessments. The program adjustments are based on guidance from the United Nations International Children Emergency Fund (UNICEF), Global Technical Assistance Mechanism for Nutrition Cluster (GTAM), the World Food Program (WFP), Global Nutrition Clusters, the World Health Organization and others. The document addresses only global guidance and not country-specific guidance. Because guidance is published frequently and existing guidance is updated regularly, this is—by definition—a working document that will be updated frequently as needed to ensure that it reflects the latest thinking.

The audience of this document

The document is intended for those at the forefront of providing nutritional care in humanitarian settings during the COVID-19 pandemic. They would include nutrition coordinators, managers and other nutrition staff at International Medical Corp country offices as well as other relevant stakeholders involved in the design and implementation of nutrition activities.

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Abbreviations

BA	Barrier analysis
BMS	Breast milk substitutes
BSFP	Blanket supplementary feeding program
CHW	Community health workers
CMAM	Community-based management of acute malnutrition
DHSF	Demographic and health survey
GTAM	Global Technical Assistance Mechanism for Nutrition
GFD	General food distribution
ICCM	Integrated community case management
IEC	Information, education and communication
IPC	Infection prevention and control
IYCF	Infant and young-child feeding
KAP	Knowledge, attitude and practice
LNS	Lipid-based nutrient supplements
MAM	Moderate acute malnutrition
MAMI	Management of at-risk mothers and infants under six months
MCG	Mother care group
MICS	Multiple indicator cluster survey
MIYCN	Maternal infant and young-child nutrition
MMS	Multiple micronutrient supplementation
MSG	Mother support group
MUAC	Mid-upper arm circumference
OTP	Outpatient therapeutic program
PLW	Pregnant and lactating women
PWD	People with disabilities
RUSF	Ready-to-use supplementary food
RCCE	Risk communication and community engagement
RUTF	Ready-to-use therapeutic food
SAM	Severe acute malnutrition
SBCC	Social behavior change communication
SC	Stabilization center
SMART	Standardized monitoring and assessment of relief and transition
SQUEAC	Semi-quantitative evaluation of access and coverage
TSFP	Targeted supplementary feeding program
UNICEF	United Nations Children Fund
VAS	Vitamin A supplements
WASH	Water, sanitation and hygiene
WHO	World Health Organization
WHZ	Weight-for-height z-score
WFP	World Food Program

1. General

There are risk-mitigation measures that can be applied in nutrition programming, regardless of modality, target group or objective. They include the following.

- **Minimize infection risk to staff** by using infection prevention and control (IPC) measures as set out by the World Health Organization (WHO). This should include handwashing facilities, soap, hand sanitizer and mandatory handwashing upon arrival for all beneficiaries, staff and volunteers.
- **Minimize physical contact during the handwashing** process with the use of pedal taps, paper towels, and hands-free covered trash bins, in line with recommended guidelines. Ensure regular and safe removal of discarded materials from the handwashing area. Handwashing stations should also have adequate pictorial signage showing how to wash hands. We also recommend that beneficiaries, staff and volunteers use personal protective equipment (PPE).
- **Align and coordinate mitigation plans across all technical specialties** and their programs—including nutrition, women’s and children’s health, food security and others livelihoods—to focus on reaching infants and young children in the context of COVID-19.
- **Ensure the dissemination of guidelines** for providing nutrition services during the COVID-19 pandemic that are in line with national response strategies and plans. Because of fast-changing conditions, these guidelines should be updated on bi-weekly basis.
- Accompany all programming with risk communication and community engagement (RCCE) and/or social-behavior change activities to mitigate the impact of the pandemic on health and nutrition programming.
- **Discuss—and agree upon with national authorities—any deviation from standard wasting treatment protocols** and accompany them with key messaging such issues as maternal, infant and young-child nutrition (MIYCN), good hygiene practices, safe food preparation, and infant and young-child feeding (IYCF) education. Reach out to local community leaders and partners to explain appropriate usage and consumption.
- **Discuss program adaptations with responsible grants officers** to ensure that the donors are aware of the changes, because they may affect important program targets such as caseload or performance indicators. (We do not anticipate problems with this issue, because the changes that we take to protect staff and beneficiaries reduce disease transmission in the process.)
- **Set up screening and triage for COVID-19** at all points of access to the health system, including primary healthcare centers, clinics, hospital emergency units and other locations within the community. Anyone identified with signs of COVID-19 should be promptly isolated and referred to a COVID-19 screening and treatment facility.
- **Limit staff, participant and beneficiary travel.**
- **Avoid any physical contact**, such as shaking hands, hugging or kissing during a welcome greeting (although an elbow “bump” or namaste can be appropriate).
- **Demarcate sitting and standing areas for beneficiaries**, helping them maintain the one-meter requirement for safe physical distancing.
- **Coordinate with MOH/WHO staff in the field to cascade orientation sessions** for nutrition-service providers on COVID-19 related messaging and use of tools.
- **Map COVID-19 isolation and treatment facilities** and nutrition-capacity gap assessment.

2. Community-based Management of Acute Malnutrition (CMAM)

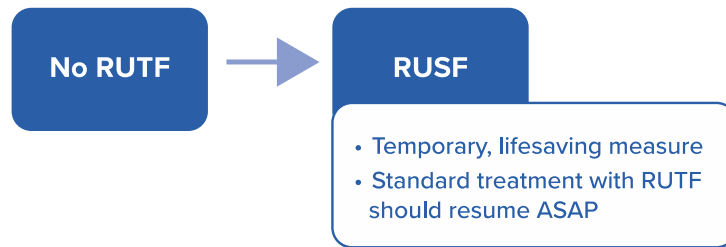
2.1 General

- Although an increase in acute malnutrition is likely due to the impact of COVID-19, this rise may not be accompanied immediately by a jump in CMAM admissions. Several factors could delay admissions, including limited screening capacity, slower-than-normal community mobilization, and the fear and stigma attached to the virus. Depending on local context, however, this should not prevent planning to increase the distribution of specialized nutritious foods, such as fortified flours and medium-quantity lipid-based nutrient supplement (LNS), to all households with children under 5, or pregnant and lactating women.
- Early projections indicate there will likely be increases in wasting that will require strengthened treatment services. The ability to meet this increased demand will depend on several factors, including:
 - the severity of restrictions imposed on the freedom of movement of health workers required to provide the necessary services;
 - the priority that governments and donors give to the treatment of wasting (higher priority could ensure that staff and funding are not redirected away from these activities toward fighting the pandemic directly); and
 - the amount and flexibility of available funding to provide needed supplies, particularly for ready-to-use therapeutic food (RUTF).
- Advocate clearly for the continued support of all ongoing programming, including nutrition programs.
- If resources allow, we recommend distributing hygiene kits to caretakers of children admitted in the CMAM program to ensure that IPC measures can also be implemented at home. This will further reduce the risk of transmissions.

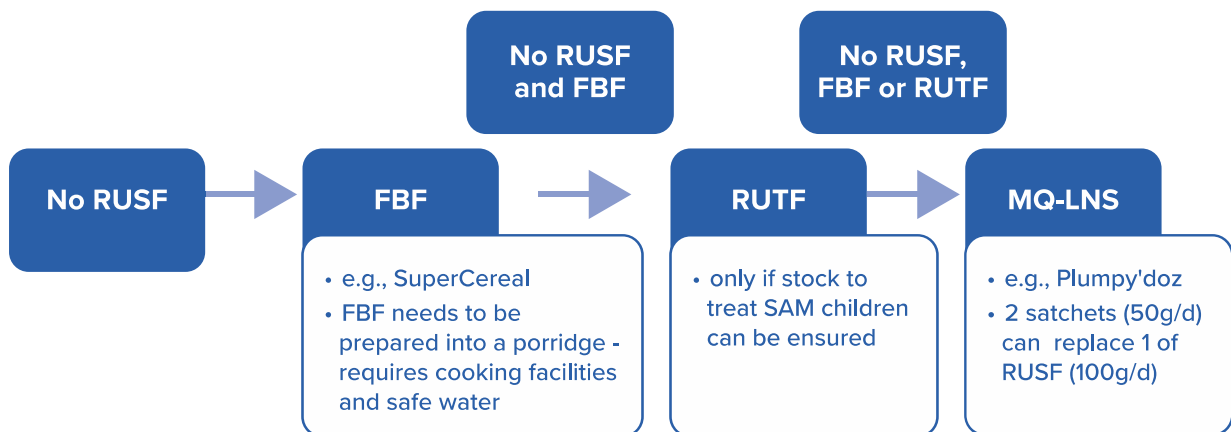
2.2 Pipeline

- Accelerate pre-positioning to assure a minimum buffer stock of two months of essential commodities for nutrition programming. This stock should include formula F100 and F75 milk, ready-to-use foods, fortified blended food, lipid-based nutrient supplements, multiple micronutrient powders and routine medicinal supplies at national and community levels, as well as at health facilities in anticipation of supply-chain disruptions. At present, we are making every effort to ensure an adequate pipeline for specialized nutritious foods, and don't expect large-scale pipeline breaks. However, with systematic closure of borders and airports, and much unknown about the likely duration of the crisis, disruptions are always a risk.
- Adopt the following risk-mitigation measures to assure minimal misuse or loss of food product:
 - Ensure that all staff understand and follow delivery and distribution criteria correctly;
 - Ensure strong supply-chain management; and
 - Intensify communications with beneficiary communities, stressing that supplies are intended and should be used solely for treatment of acute malnutrition.
- Consider including a budget line for buffer stocks of food commodities in newly developed proposals in countries with a high likelihood of supply-chain disruptions. Liaise closely with logistics departments to monitor prospects of on-time arrival for such supplies.
- Raise concerns immediately to relevant stakeholders, such as WFP and UNICEF, if there are expected supply-chain disruptions. In addition, report supply challenges to the nutrition cluster and to donors.

SAM Treatment



MAM Treatment



- In cases of supply-chain breaks, the following substitutions for food commodities in programs for the treatment of severe acute malnutrition (SAM) and moderate acute malnutrition (MAM) can be considered in consultation with the Ministry of Health and the nutrition cluster:
 - In situations where ready-to-use therapeutic food (RUTF) or ready-to-use supplementary food (RUSF) are recommended but are unavailable and cannot be substituted as outlined above, we suggest the “next best alternative” as an exceptional temporary measure—one that gives the child the best chance to meet its energy and nutrient requirements, is age-appropriate, safe and palatable to maximize recovery prospects or, at the very least, prevents deterioration until standard treatment is available.
 - Maximize the child’s nutritional intake from existing sources of local foods. This requires analysis of locally available age-appropriate, safe, nutritious foods, as well as any barriers to access, such as challenges with preparing at home (e.g., knowing how to cook, access to utensils/fuel) or consumption by the child (food preferences or intra-household sharing).
 - Teach the caregiver or family about appropriate local nutritious complementary foods and how to prepare them, using cooking demonstrations and/or recipes.
 - Explore the feasibility of using vouchers, cash transfers or other available sources of funds, coupled with social-behavior change communications and local infant and young-child feeding techniques.
 - Consider prioritizing SAM treatment as a first phase in places where MAM treatment is not currently available.
 - Consider providing high-energy, micronutrient fortified biscuits such as BP5, which are a ready-to-eat compact food often used during the first few days of an emergency. They can be eaten directly or crumbled into safe water and eaten as a porridge by children older than 6 months. (Note: this product is not developed to treat moderate wasting and is not recommended for the treatment of severe acute malnutrition.)
 - Support continued breastfeeding. Infants and young children up to 24 months and beyond should continue to be breastfed.

- Continue to receive systematic routine healthcare information for all children, taking care to respect national IPC measures, including those related to COVID-19.
- Prioritize the treatment of more severe cases of SAM, lowering the admission threshold to mid-upper arm circumference (MUAC) to 110mm or less.
- Reduce the dosage provided. Trials of simplified protocols have used two sachets of RUTF per day for SAM and one sachet per day for MAM. **Caution:** There is currently mixed evidence on treatment outcomes. Therefore, close coordination with ministries of health and the nutrition cluster is needed to implement these adjustments.

2.3 Targeted Supplementary Feeding Program (TSFP) and Outpatient Therapeutic Program (OTP)

- Reduce overcrowding by offering services more frequently. For example, move from one to three outpatient days per week, providing clear information to caregivers about which day they should return. New cases could still be enrolled daily, always adhering to locally recommended IPC measures or by disbursing services to several locations in the community.
- Modify workflow to reduce wait times and crowding.
- Reduce the frequency of follow-up visits. Suggested reduction is to once per month for children and for pregnant and lactating women with uncomplicated severe or moderate acute malnutrition. This reduction should be accompanied by increasing the take-home ration of RUFs and other nutrition commodities. In some countries, biweekly visits for children with SAM are recommended. If all services are temporarily suspended, distribute RUFs and other nutrition commodities for up to eight weeks. Whenever possible, establish links between these households and existing social protection services.
- Use simplified admission criteria, in consultation with ministries of health and nutrition cluster. For example:
 - Make MUAC measurement the only criterion for admission.
 - Use expanded admission criteria; for example, <120mm or <125mm MUAC and/or oedema.
 - Adopt simplified RUF dosage; for example, one RUSF sachet/day for uncomplicated moderate wasting, and two RUTF sachets/day for uncomplicated severe wasting. Current simplified approaches vary in terms of reduced dosage because there is not one standard protocol. Evidence to date is limited because this is an active area of research with trials ongoing. The adequacy of dosage will depend on several considerations, including the age of the child and what protocol is being used. Meeting the demands of moving to a simplified approach depends on factors such as the SAM-to-MAM caseload ratio, whether there was pre-existing MAM treatment availability, whether there is sufficient supply of commodities, as well as the capacity of the health system and partners, and the potential to economize on RUTF where it is in shorter supply and thus could reach more children with treatment.

2.4 Stabilization Centers

- Ensure strict adherence to recommended hygiene and safety measures in stabilization centers, including strict enforcement of staff-sickness policy, use of PPE, screening and triage procedures, proper identification of isolation areas, limiting contact with multiple healthcare workers, and cleaning protocols, including disinfecting scales between measurements.
- Ensure that mothers and caregivers have the ability to prepare their own meals in the center, equipping it with appropriate kitchen facilities to reduce the exposure to COVID-19 from external vendors bringing in food.
- Emphasize that mothers and all others handling infants under six months must maintain high hygiene standards and keep feeding equipment clean, while actively supporting skin-to-skin contact and breastfeeding.

- Maintain at least one meter—and, where possible, two meters—of physical space between beds in stabilization centers.
- Reduce family-member visits to the primary caregiver only. (Multiple caregivers could visit the child if absolutely necessary, but only following discussion with facility staff).
- Whenever possible, separate patient areas for suspected or confirmed COVID-19 cases from non-COVID-19 cases and apply recommended IPC measures.
- Advocate strongly to maintain existing inpatient capacity for SAM cases as a priority lifesaving service if there is pressure to reduce that capacity to make room for additional COVID-19 cases.
- Be aware that recommendations regarding bed spacing in the context of COVID-19 may also impact capacity.
- Isolate any confirmed or suspected COVID 19 cases on separate wards, well-away from other SAM patients. Such cases must be referred to the appropriate or established COVID-19 isolation or treatment facility.

2.5 Community Outreach

- Initiate on-the-job training for community health workers (CHWs) to treat uncomplicated wasting. If feasible, this should include introduction to simplified treatment protocols and approaches. Positive outcomes can result from early admissions and improved discharge outcomes, but they require close supervision of the CHWs, as do incentives, such as financial compensation to motivate trainees.
- Equip CHWs and community health volunteers (CHVs) with “a COVID-19 prevention kit” to address fear and stigma. Such kits—which could include an infra-red thermometer, a small bar of soap and several MUAC tapes—can reassure families that appropriate risk-mitigation measures are in place. Understanding mothers and caregivers and how they relate to CHVs and CHWs is important, as is recognizing that if there is need to change personnel, which should only be done in coordination with relevant authorities. It is also important that CHVs and CHWs monitor their own temperatures daily, and seek immediate medical assistance and stop visiting households if they register a fever. Rumors of CHVs and CHWs working despite high fever can cause panic and fear. Providing the community with accurate feedback on the status of the CHVs and CHWs is key to establishing trust.

2.6 Nutrition Screening for CMAM

- The Family MUAC approach can be used to strengthen the capacity of mothers and caregivers to detect and monitor their children’s nutritional status when using simple, low-literacy/numeracy tools, including mid-upper arm circumference (MUAC) tapes, and promoting the “no-touch” approach. Pictorial guidance can be used as an instructional tool for remote training, or to guide mothers or caregivers on the correct use MUAC tapes. Messaging via television, radio and mobile phones, through community announcements using megaphones or by posting information in key locations are all effective ways to instruct caregivers, to provide reminders to screen their children and to tell them where to go if they find the child to be malnourished.
- A video link is currently in development that would enable a skilled health worker to read a MUAC tape remotely using a mobile phone, tablet or similar device to screen children. This type of screening has yet to undergo trials, but mobile phone technology is already supporting CHW decisionmaking.
 - Mobile health (Mhealth) programs have shown success when used for disease surveillance, supporting CHWs in integrated community case management (ICCM) programs as well as guiding health workers through the process of screening and treating SAM. Mhealth can range from simple SMS messaging to more complex platforms using smartphones or tablets. CHWs have used Mhealth applications in their own work, and as a tool to share information directly with households.

- International Medical Corps' South Sudan country team plans to pilot-test the mobile application AutoAnthro in August 2020. If successful, the application could be offered to our teams in other countries.
- Remote screening can be conducted in areas where family MUAC or regular screening is not feasible. The Global Technical Assistance Mechanism for Nutrition (GTAM) has developed screening questions that can be asked by phone to identify malnourished or at-risk children. The note includes nine screening questions, along with guidance how to interpret the questions.

2.7 Monitoring and Evaluation

- Monitor closely any deviations to national treatment protocols. Standard treatment should start or resume as soon as feasibly possible.
- Monitor program performance indicators very closely. Program modifications and adaptations can influence many of these indicators, including increased lengths of stay, reduced average weight gain, selling of food commodities, increased workload for staff, loss of follow-up, and higher default rates due to reduced frequency of visits and lower admission rates, since MUAC-only admissions miss many children who would have been identified with weight-for-height z-score (WHZ). Review data regularly to determine if adaptations are working as expected or should be modified further.
- Document all program adaptations, carefully citing the specific reasons for each change.

3. Nutrition Treatment of COVID-19

There are currently no separate guidelines for the treatment of COVID-19 and malnutrition. Instead, we are advised to use national and WHO inpatient guidelines for treatment of SAM with medical complications, and follow the IPC guidelines for COVID-19 in all health facilities. It is also important to consider that SAM children with medical complications are immunocompromised, regardless of their COVID-19 infection status. High standards of infection control are always indicated in such cases.

4. Infant and Young-Child Feeding (IYCF) Practices

Programs and services to protect, promote and support optimal IYCF practices should remain a critical component of the programming and response for young children in the context of COVID-19. WHO recommendations on the initiation and continued breastfeeding of infants and young children also apply to mothers with suspected or confirmed COVID-19. Infant and young-child feeding counselling, basic psychosocial support and practical feeding support should be provided to all pregnant women and mothers with infants and young children, whether or not they or their infants and young children have suspected, probable or confirmed COVID-19.

WHO's key recommendations regarding breastfeeding include the following.

- Mothers with suspected or confirmed COVID-19 should be encouraged to initiate breastfeeding or continue to breastfeed.
- Mothers should be counseled that the benefits of breastfeeding substantially outweigh the potential risks of transmission.
- Mother and infant should be allowed to remain together while rooming-in throughout the day and night, and to practice skin-to-skin contact, including kangaroo-mother care, especially immediately after birth and during establishment of breastfeeding, whether they or their infants have suspected or confirmed COVID-19.

Key Messages for Beneficiaries about IYCF

Before preparing or eating food, caregivers should ensure that they practice all recommended hygiene practices, such as handwashing with soap and regular cleaning and disinfecting of food-preparation areas.

In communities where eating from a common bowl or feeding children by hand is common, use the child's own plate and spoon to avoid transmission.

Mothers should prioritize local food. Provide tips on food preparation at home.

Highly processed packaged foods are often less healthy, and contain high amounts of saturated fats, free sugars and/or salt. Provide guidance to families how to read the labels—including the front of pack, the nutrition declaration and the ingredients list—to identify the “better for you” options.

Mothers isolated at home with suspected or confirmed COVID-19 should continue recommended feeding practices, with necessary hygiene precautions during feeding.

Regardless of the feeding mode:

- Mothers should always wash hands with soap and water at critical times, including before and after contact with the infant.
- All surfaces around the home that the mother uses or touches should be routinely cleaned with soap and water.
- If the mother has respiratory symptoms, recommend that she use a face mask, if available, when feeding or caring for the infant. Locally available adaptive face masks can be used as alternatives.
- Mothers with infants should maintain physical distancing of at least one meter from others and avoid touching their eyes, nose and mouth.
- Nursing mothers should be encouraged to continue breastfeeding if the infant or young child becomes sick with suspected, probable or confirmed COVID-19 or any other illness.
- If a mother becomes severely ill with COVID-19 or other health complications to the point where she is unable to care for her infant or continue direct breastfeeding, she should be encouraged to express breastmilk safely to feed the infant, while maintaining appropriate hygiene measures.
- Breast pumps should not be shared among mothers.
- Mothers engaging in artificial feeding should be encouraged to feed the infant or young child from a cup; wash her hands with soap and water before handling cups, bottles, teats or other feeding equipment; and limit the number of caregivers feeding the infant.

In health facilities, infants born to mothers with suspected, probable or confirmed COVID-19 should be fed according to established recommended infant-feeding guidelines, while following necessary respiratory hygiene during feeding.

Special counseling cards developed by UNICEF and USAID for advanced nutrition can be accessed [here](#).

Other program adaptations in the light of COVID-19 should also be considered.

- Provide mothers and infants with skilled breastfeeding support if needed, and enable them to practice skin-to-skin contact and kangaroo-mother care. They should also be allowed to remain together and practice rooming-in throughout the day and night—especially immediately after birth when just beginning breastfeeding—whether or not they or their infants have suspected, probable, or confirmed COVID-19.
- Adhere to the International Code of Marketing of Breast Milk Substitutes (BMS) and subsequent World Health Assembly resolutions (including WHA 69.9 and the associated WHO guidance on ending the inappropriate promotion of foods for infants and young children), in line with the recommendations of IFE Operational Guidance. Collaborate closely with the nutrition cluster to

identify a responsible lead agency that can act against unsolicited BMS donations and other violations.

- Discourage and decline to accept donations, marketing and promotions of unhealthy foods, such as those high in saturated fats, free sugar and/or salt. Thoroughly assess any financial, gift-in-kind or other resources offered by food and beverage companies for their nutritional content, BSM code violations, marketing and credibility.

4.1 Management of At-risk Mothers and Infants (MAMI) under Six Months

In the current context, where weight-for-height (WFH) and weight-for-age (WFA) assessment is not possible, MUAC criteria may also be expanded to infants under six months of age, to monitor growth at home and to identify at-risk babies. A threshold of <110mm may be used for infants zero to six weeks (i.e., before first vaccination) and <115mm for infants aged six weeks to six months¹.

MUAC should only be expanded to this age group when there is a clear, appropriate pathway of care in the community to manage cases identified. A pathway of care requires clinical, feeding and maternal assessment and support (see [MAMI Tool](#)). Feeding-support options include peer support counselors for breastfeeding, IYCF programs, phone counseling and video content (see [Global Media Health Tools](#)). It is unlikely that existing CMAM programs targeting children six months of age and older have the required capacity and skillset to manage at-risk infants under six months. RUTF is not considered suitable for use in infants under six months of age. Inpatient care should generally be reserved for complicated cases, in accordance with national guidelines. Low birthweight infants are at higher risk.

5. Community Sensitization

We need to continue providing information and education for beneficiaries about nutrition, as well as COVID-19 messaging regarding health and hygiene. However, we also need to make sure that this is done in a safe manner, to reduce possible transmission of the virus from beneficiaries to staff or staff to beneficiaries. With this in mind, please consider the following:

- Explore innovative ways to deliver simple, practical and context-specific information on healthy feeding options for young children to support communities and families, using mobile technology, social media, radios, mobile phones, community announcements (through megaphones) and by posting information at essential outlets open to the public, such as supermarkets, food shops) or on TV.
 - Leverage social media, web and mass media platforms to provide important information, clarify misinformation and misconceptions, and support families by providing practical, feasible nutritional solutions for young children when there is limited access to fresh fruits and vegetables.
- Boost the capacity of community health workers to screen and provide key messages on nutrition and COVID-19. If possible, increase the number of CHWs, to ensure that the increased workload remains manageable. Provide appropriate remuneration for CHWs for additional work.
- Limit or cancel household visits unless they are absolutely necessary. If deemed necessary, we suggest targeted visits specifically to provide COVID-19 messaging to vulnerable persons, such as the elderly and those with disabilities. CHWs should maintain a distance of at least one meter from other persons, and wash their hands with soap or use hand sanitizer when available after each visit.

¹ It is important to note there are currently no validated thresholds for MUAC to identify at-risk infants under six months of age. These recommendations are based on research in Africa of MUAC thresholds associated with mortality risk and programming experiences. The thresholds suggested above assume a low risk intervention (i.e., breastfeeding support and implementing integrated management of neonatal and childhood illness.

- Limit or cancel all group sessions unless absolutely necessary. If judged necessary, ensure that there is at least one meter distance between people—this will limit the number of people per session.
- Limit informational materials such as brochures, as they may provide a means to spread infection. Instead, focus more on posters, which can be placed in health facilities, women's centers, child-friendly spaces and other appropriate locations.

Gatherings of individuals who are at higher risk from COVID-19—including older people, people with co-morbidities and people who are immunosuppressed—should be limited to no more than 10 people and be held only if absolutely necessary.

6. Mother Care Groups/Mother Support Groups (MCGs/MSGs)

MSGs/MCGs have a vital role to play in preventing the spread of COVID-19 within communities. They can use their support structures to identify the needs of members and contribute to the COVID-19 response in a coordinated manner. Though it is necessary for MSGs/MCGs to continue their work promoting maternal, infant and young-child nutrition during this pandemic, it is also important that members of such groups remain safe and work in close coordination with Ministry of Health and the nutrition cluster to prevent or reduce community transmission of COVID-19 by:

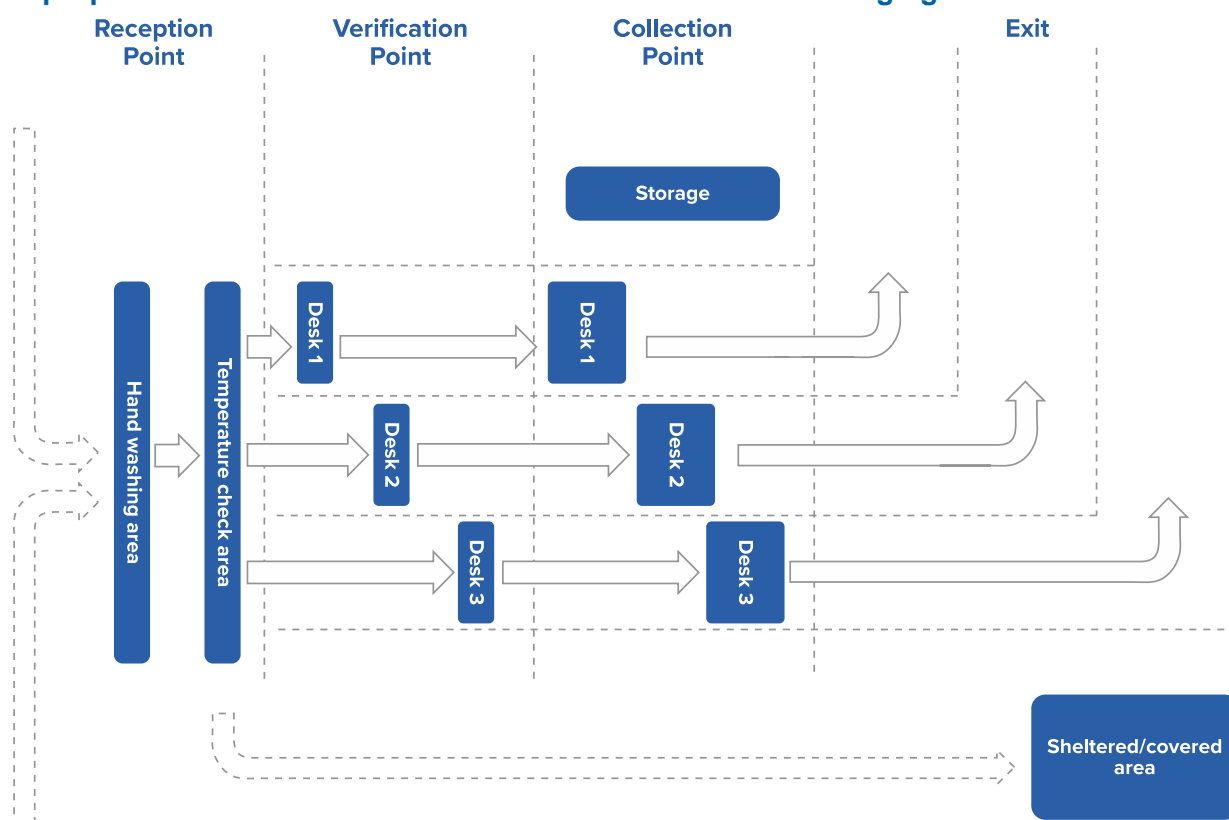
- reducing the frequency of meetings from biweekly to once per month
- organizing meetings in an open space with a maximum of 10 participants, maintaining physical distancing of at least one meter by arranging chairs or mats accordingly (In exceptional circumstances and with close coordination between the Ministry of Health and the nutrition cluster, as many as 12 to 15 members could participate in group sessions)
- avoiding touching, such as shaking hands, hugging or kissing while greeting
- ensuring that meeting sites are equipped with handwashing facilities, including soap or hand sanitizers that are available for use before and after the meeting
- conducting health screening—for example, temperature checks—for participants and their babies before meetings
- adhering to respiratory hygiene, using facial masks if available
- limiting the exchange of informational brochures, leaflets and other materials among meeting attendees, while ensuring that each member receives key messages
- adapting the MSG curriculum to incorporate concerns regarding COVID-19, as well as feeding practices and food myths
- Using social network platforms, such as WhatsApp and Facebook, where available for messaging and awareness raising on nutrition during a pandemic (health workers can establish a social network and add MSG/MCG members under their supervision, using the platform to distribute messages, videos and mobile phone voice messages endorsed by the Ministry of Health or the nutrition cluster on breastfeeding, complementary feeding, food demonstrations, hygiene messages in COVID-19)

7. General Food Distributions or Blanket Supplementary Feeding Program (BSFP)

- Inform all participants that they should not attend the distribution if they feel unwell (fever, cough, shortness of breath) but instead send a family member to collect the ration on their behalf, carrying the appropriate ration card.
- Coordinate closely with the nutrition cluster, community leaders or other relevant community stakeholders to identify vulnerable people who might be eligible to enroll in the general food distribution or BSFP program.
- Increase the number of distribution sites, to limit the numbers attending the site.

- Reduce the distance between the distribution site and the household if beneficiaries need to carry a double ration.
- Establish a reception point, identity verification and collection points, and an exit to channel traffic (see graphic below), and allow for personal space of at least one meter between each beneficiary.
- Organize and clearly mark allocated spaces at the distribution site.
- Inform beneficiaries that they must wash their hands, either with soap and water or in 0.05% chlorine solution as they enter the distribution area. The handwashing area should have adequate supplies of handwashing solution and water, and require minimal manual contact during the handwashing process.
- Ensure that the waiting area is large enough to enable beneficiaries to maintain at least one meter of social distance between each other.
- Organize rations ahead of the scheduled distribution so they can be quickly distributed.
- Provide individual health screenings. If a beneficiary is detected to have a fever or shows flu-like symptoms, direct them to a specified sheltered area for a follow up medical exam by a government-approved healthcare worker, while providing the beneficiary with a mask to cover their nose and mouth.
- Assure beneficiaries who are delayed at health screening areas that they will receive rations regardless of the screening results.
- After health screening/body temperature checks, allocate fast-track lanes for the elderly, pregnant and lactating women, people with disabilities and individuals with pre-existing or chronic underlying conditions, to prioritize them to receive distribution and minimize their exposure to others. Instruct beneficiaries to maintain a distance of at least one meter from each other throughout the distribution process.
- Cordon off (with rope or tape) a radius of at least one meter around the desk at the collection point.

A proposed distribution site in a COVID-19 environment managing the flow of traffic:



8. Micronutrient Supplementation

The COVID-19 pandemic has disrupted food distribution systems in many countries and communities, with already food-insecure areas especially vulnerable. Such disruptions may affect the quality of diets—for example, by reducing the availability of nutritious foods, including fortified foods and those rich in micronutrients. Because such disruptions could impact the nutritional status of women and children, those responsible for providing micronutrient supplements in COVID-19 *must* ensure:

- Context-specific responses, to protect the nutrition of women and children.
- Nutritional support for pregnant and lactating women, infants and young children, including counseling, access to nutrient-dense local food and micronutrient supplements.
- Two to three months' supply of pre-positioned multiple-micronutrient supplements (MMS), in addition to increased amounts of MMS distributed per contact to cover longer periods. This should be done in coordination with MMS pipeline managers in country.
- Maintenance of at least one meter of social distance during distribution or delivery of MMS to beneficiaries.
- Continued delivery of vitamin-A supplements (VAS) through routine health and nutrition services.
- Distribution of VAS to accompany vaccination campaigns, with health workers checking that the distribution site has adequate handwashing facilities, with soap and water or hand sanitizer; that IPC guidelines are maintained as the children and their caretakers move through the vaccination/VAS distribution site; and that every member of the vaccination team is provided with personal protection equipment, including gloves, face masks and non-reusable gowns

9. Training and Supervision

9.1 Trainings

Postpone all non-essential training sessions or organize them remotely. Remote training can be done through such apps as:

- **Commcare.** An estimated 10% of all CHWs in low- and lower-middle-income countries use CommCare, making it the most widely used digital platform for CHWs. CommCare is a data-collection and training tool with specialist services for health programming. A remote health-worker training module is included in the COVID-19 App.
- **Viamo.** Viamo is a mass messaging service that enables large-scale distribution of messages to people through SMS, integrated voice response (IVR) and other channels. The training modules can be delivered by voice, SMS or chatbot to the flip phones that many people already have and use. The training includes quizzes to test the understanding and participation of the trainees. Training can be delivered on a set schedule, or can be accessed on demand by the training participant. Viamo has ready-to-use content that aligns with WHO messaging covering the basics of COVID-19, how to maintain good hygiene and how to maintain social distancing. Specific content can be developed according to users' needs.

[The Community Health Worker Toolkit](#) is an app that uses smartphones as a training tool for CHWs. The CHW logs into the app and the training module appears in a task list. The training begins with an introduction, followed by relevant topics, which are accompanied by visuals. There is an assessment at the end of each module. The CHW cannot complete the task until entering answers correctly. The toolkit tracks completion and provides it to supervisors, who may follow up directly with those needing extra support. Training is also captured in the CHW profile page and refresher quizzes can be sent on a customized schedule.

Videos can be useful training tools. In locations with strong internet access, videos can be shared with CHWs over such apps as WhatsApp. Television can also be used to share these videos. [Global Health Media](#) has a library of videos that can be used to train CHWs.

If in-person training is needed, take into account the following considerations.

- Prioritize training specifically related to COVID-19, or as mandated by the Ministry of Health. If the training is not specifically related to COVID-19, it should incorporate a session dedicated to COVID-19 that should include hand hygiene practices, respiratory hygiene and cough etiquette, appropriate use of PPE, doffing ear looped masks, physical distancing guidelines, cleaning and disinfection practices, COVID-19 symptoms, internal procedures already in place related to COVID-19 (including procedures to be followed when a possible positive case is identified) and guidelines for self-isolation.
- Split the training into different days to reduce the number of people required to attend each session, taking into account budget implications.
- Arrange seating with at least one meter between places. This will likely limit the number of people per training.
- Ensure that soap or hand sanitizer (with at least 60% alcohol) is available to all attendees, and actively encourage people to use it.
- Ensure that everyone maintains at least one meter social distance during informal, unstructured time, such as coffee and lunch breaks.
- Consider conducting a health screening on each person before they enter the training venue.
- Inform all staff and participants that they should not attend the training if they feel unwell, or have a fever, cough or experience shortness of breath. Inform them that if they become unwell during the training, they will be sent to the nearest health facility and that they should avoid shaking hands, hugging or kissing while greeting others, but are free to use the elbow greeting or namaste.
- Ensure that venue staff or members of our team disinfect surfaces that are frequently touched, including chairs, tables, shared desks, doorknobs and electronics such as laptops, projectors or related equipment.
- Open windows and doors to allow for air circulation.
- Limit staff and participant travel.

9.2 Supervision

Where in-person supervision is possible, hold meetings outdoors when possible, with IPC measures in place. Where in-person supervision is not feasible the following options can be considered for remote supervision.

- **Phone calls.** Voice calls can be used to discuss the activities of CHWs and provide program management information, such as new admission and discharge numbers, treatment outcomes, supply stocks of antibiotics and RUTF) and understanding of protocols.
- **Use of phone apps for supervision.** Where smartphones or tablets are available, tools such as supervision checklists can be used through such apps as Kobo Toolkit and Open Data Kit (ODK). Where the network connection is poor, such apps can be used offline and information collected can be uploaded at a later time, when a viable internet connection is available.
- **Use of chat groups (such as WhatsApp).** If well managed to prevent the spread of misinformation, chat groups can be useful for information exchange and motivation.
- **Photos.** Teams based in the field can take photos of key treatment points within nutrition sites and share supply data, reports and supervision checklists used for supervision and program review meetings. Ensure data protection and permission when using this option.

Alternatives to supervision when in-person or remote supervision are unavailable

Where the above types of supervision are not possible—for example, when phones or digital network coverage are unavailable—the following steps could be considered.

- Forecast the CHW's need for supplies based on previous usage and available updated reports, and support prepositioning.
- Use community residents to relay messages in person or via phone if they can reach areas with connectivity.

- Negotiate periodic travel to a location where communication is possible
- Ensure that program objectives and CHW duties are well-understood by the community—radio messaging can be used to support this.
- Promote accountability through mass media and public awareness.
- Leverage radio chat programs with CHWs—including those from other organizations—to foster a sense of camaraderie discuss common challenges and reinforce training.
- If no remote supervision is possible, seek community feedback when restrictions are lifted.

10. Surveys

10.1 General

- Explore phone- or web-based surveys to collect critical nutrition information.
- Identify relevant indicators that have been collected systematically over time and use them as a proxy to monitor the disruption of nutrition services.
- Use innovative approaches, such as mobile technology, to ensure monitoring and tracking of nutrition service delivery, such as SAM admissions.
- Map existing digital platforms and data systems, connectivity and their use across the country to determine which platforms could be easily adapted for remote data collection and reporting of nutrition-related data during the COVID-19 pandemic.
- Initiate discussions with ministries of health, national sector or cluster coordination bodies, or private sector entities (such as mobile network providers) on the use of remote data-collection procedures, such as web- or phone-based surveys, to capture information from communities and caregivers on the monitoring of children's nutritional status and identification of undernourished children.
- Initiate efforts to build the capacity of CHWs to collect data on malnutrition at the community level, using virtual training methods on no-touch assessments, mobile data collection or web-based surveys as examples.
- Initiate discussions on potential options to track the number of undernourished children and other vulnerable-population groups in the context of COVID-19—for example, using mobile technology for interviews or sharing data through SMS.
- Avoid data-collection activities that involve close contact between individuals—such as mass screenings, household visits, population-based surveys or the multiple indicator cluster survey (MICS)—that involve in-person interaction until governments or other authorities deem them safe.
- Continue to participate in existing Nutrition in Emergency fora, Nutrition Cluster meetings, Health and Food Security Cluster meetings, disease surveillance working groups, national health management information systems (HMIS) working groups and national COVID-19 coordination teams, to ensure information needs are well integrated into all processes.
- Consider using other indicators as proxies for required information needs—for example, the most recent program data can be used as proxy indicators on the interruption of key nutrition services and project program needs.

10.2 Without Anthropometric Measurements (KAP, IYCF, BA)

- Ensure physical safe distance of at least one meter between mothers, caregivers, their children and data collectors.
- Consider health screening of each data collector at the beginning of each data collection day, and make sure any data collectors stay at home when presenting any COVID-19 symptoms.

- Ensure data collectors wear masks and gloves when taking measurements. If masks are not being used, then data collectors should cover their mouth and nose with flexed elbow or tissue when coughing or sneezing, and they should dispose of used tissue immediately.
- Interviews should be conducted outside whenever possible.
- Limit crowding during interviews.
- Increase the non-response rate during sample size calculation to account for factors likely to influence that figure.
- Consider reducing the number of data collectors per team to further avoid crowding, especially in camplike settings.
- Train a reserve team of data collectors, in case other data collectors get sick.
- Use more teams and supervisors to shorten data collection periods, in case movement restrictions are announced on short notice.

10.3 With Anthropometric Measurements (SMART, SQUEAC)

Implement the following adaptations in addition to those mentioned above:

- If possible, only measure MUAC and nutritional edema, and avoid measuring weight and height.
- Disinfect frequently touched surfaces and objects. Thoroughly wash the anthropometric equipment with soap for height boards and electronic scales (to avoid the use of Salter scales and hanging pants) if weight and height are absolutely required, and with chlorine for MUAC tapes after every use and between measurements. Guidance to chlorine preparations can be found [here](#).
- Ensure data collectors wear masks and gloves when taking measurements. If masks are not used, then collectors should cover their mouth and nose with flexed elbow or tissue when coughing or sneezing, and they should dispose of used tissue immediately.
- Reconsider the positioning of data collectors when reading measurements (e.g., read the measurement from behind the individual while MUAC measurements are being done to potentially reduce risk of droplet exposure).
- Train data collectors how to practice IPC measures when taking measurements.
- Require data collectors to thoroughly wash their hands (for at least 20 seconds) and disinfect gloves between measurements.
- Request data collectors to consider their task as a training opportunity to show mothers and caregivers how to take their children's MUAC measurements. The MUAC tape can then be given to the mother after measurements to facilitate eventual referrals or general monitoring of their children's nutritional status.

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