Remote Integrated Phase Classification during the COVID-19 pandemic: experiences from Madagascar

By Smaila Gnegne, Moussa Moctar, Andrianianja Raonivelock, Desire Rwodzi, Mara Nyawo and Douglas Jayakasekaran

MADAGASCAR

What we know: The Integrated food security Phase Classification (IPC) provides information to decision makers to address food insecurity; COVID-19 related movement restrictions meant that normal IPC methods could not be used.

What this article adds: In May 2020, the Madagascar Ministry of Health, UNICEF and other nutrition partners, together with the IPC Global Support Unit (GSU), leveraged existing technologies to conduct a virtual IPC analysis for acute malnutrition in six drought-prone southern districts in Madagascar. Adaptations made to the IPC methodology for the COVID-19 context featured the inclusion of already trained team members to reduce the length of orientation, utilisation and re-analysis of data collected just prior to lockdown to overcome challenges in data collection and the shifting of meetings from in-person to virtual. A number of assumptions were built into the analysis given the COVID-19 context including the likely negative impact on food systems and access to health services in the post-harvest period. Results of the analysis hypothesised the likely deterioration of the nutrition situation in all six districts beyond August 2020 with two districts being classified as IPC phase 3 or 4. The IPC analysis was largely deemed a success as a result of strong political will and support from nutrition partners and the IPC GSU. However, numerous challenges were noted including a reliance on historical data, a lack of global guidelines on remote facilitation at the time and internet connectivity challenges.

Background

The Integrated food security Phase Classification (IPC) is a widely accepted mechanism for improving food security and nutrition analysis and decision making (http://www.ipcinfo.org/). Originally developed in 2004 in Somalia by the Food and Agriculture Organization’s Food Security and Nutrition Analysis Unit (FSNAU), IPC has evolved over time and currently includes a range of classification scales, namely Acute Food Insecurity (IPC-AFI), Chronic Food Insecurity (IPC-CFI) and Acute Malnutrition (IPC-AMN) with each scale informing specific types of action needed to address food insecurity and malnutrition (IPC, 2019). IPC results inform humanitarian response planning and are the main source of data for the Global Food Crisis Report.1 The IPC-AMN analysis provides decision-makers with key information

to support activities that aim to decrease the prevalence of acute malnutrition. Specifically, it provides guidelines for the classification of areas in terms of the prevalence of global acute malnutrition (GAM) (thresholds for weight-for-height z-score (WHZ) and mid-upper arm circumference (MUAC)), estimations of the numbers of acutely malnourished children (by WHZ, MUAC and/or both), classifications of geographical areas in terms of severity of acute malnutrition and the identification of the key drivers of acute malnutrition.

The general approach for conducting IPC analysis is for stakeholders at national-level to gather primary and secondary data on food security and nutrition, after which they converge to discuss the results, facilitated by and together with technical support from IPC experts. However, this approach has not been feasible in many contexts since the outbreak of the COVID-19 pandemic due to restrictions on travel and gatherings which, at the same time, have resulted in widespread increases in food insecurity due to reduced livelihood activities and household incomes and disrupted supply chains. Four days after Madagascar first reported a case of COVID-19, in March 2020, the country was put on total national lockdown which included a ban on all non-essential activities in the cities of Antananarivo and Toamasina. It was therefore critical to find possible ways to understand the food security and acute malnutrition situation within this novel context.

The 10 southern-most drought-prone districts in the Greater South (Grande Sud) of Madagascar have historically had chronically high levels of both stunting (classified as very high at above 30%) and wasting (GAM levels classified as medium-high nationally at 5-10%, with some districts reaching 10-15%) (MICS, 2018). Given the chronic nature of nutrition vulnerability of populations in the southern parts of Madagascar, the Ministry of Health (MoH) and nutrition partners, including UNICEF, and together with the IPC Global Support Unit (GSU), leveraged existing technologies to conduct a virtual IPC analysis for acute malnutrition (IPC-AMN) for six districts of the Greater South in May 2020 (these six districts out of the 10 districts in the region were selected based on the level of data availability). This article highlights how the IPC-AMN analysis was conducted virtually in order to obtain an understanding of the level of malnutrition in the Greater South region of Madagascar.

The approach
A four-stage approach was followed as described in Figure 1 with each stage described below.

Stage One: Planning
Typically each year, a planning exercise is conducted between country IPC Technical Working Groups (IPC-TWG) and the IPC GSU in order to determine the number and timing of IPC analyses for the year. This planning meeting took place towards the end of 2019 between Madagascar’s IPC-TWG and the Nutrition Cluster, after which it was agreed that an analysis would be conducted in October of 2020. Due to COVID-19, the planning was rapidly adjusted at the request of the Nutrition Cluster and the MoH to enable an analysis of the nutrition situation in districts affected by drought. The virtual methodology was jointly proposed by UNICEF and the IPC GSU and approved by the country IPC-TWG. This was the first time that such an approach had been piloted globally.

Under normal circumstances, IPC analysis usually takes 10 days (including four days of training at the beginning). To shorten the process, previously trained and certified participants were selected to make up the team which reduced the length of the process by four days. This was helpful to ensure that the participants remained motivated and committed during the analysis while using virtual means of communication.

Stage two: Preparation for analysis
A country core group, comprised of one IPC-GSU focal point and four national staff as part of the national IPC-TWG (representatives from MoH, the National Nutrition Office, UNICEF and the National Office of Disaster and Risk Management), prepared relevant tools, data and indicators for analysis. This group met three times virtually using Zoom with technical and financial support from UNICEF. Data was collated on the immediate and underlying causes of malnutrition including population prevalence of key diseases, food security and dietary intake. Survey data for the period February to April 2020 was available for the six selected districts of the Greater South. For three of the six districts, existing data collected just prior to the lockdown was available from a national survey on women’s nutrition and vitamin A coverage from February to March 2020. This data was re-analysed to calculate GAM rates. Data for the remaining three districts was directly available.

Data was projected for May to August 2020 and September to December 2020 based on IPC guidelines (IPC, 2019) using historical data on outcome indicators and trend data on contributing factors derived from the national health management information system (HMIS) and other sources. All projections were informed by assumptions based on the IPC GSU guidance note on developing assumptions for projection analysis in the context of COVID-19 (IPC, 2020). Other indicators were drawn from district-level surveys, food security assessment reports, disease trends provided by the Demographic and Health Information Survey II (DHIS2), coverage survey reports, SMART surveys and Link Nutrition Causal Analysis (Link NCA) surveys conducted over the last three years.

The likely impact of COVID-19 on acute malnutrition was also considered, drawing from the IPC GSU technical guidance (IPC, 2020). Pain points for impact were explored including the likely negative impact on food systems and access to health services in the post-harvest period. The tools, data and indicators were subsequently made available online for the working groups during the analysis.

Composition of analysis team
The virtual IPC-AMN analysis team included 23 participants, comprising 18 locally based partners1 and five external IPC experts including four Cross Country Learning Exchange (CCLE) participants (from the Ministries of Health in Burkina Faso and Niger, UNICEF West and Central Africa Office (WCAFO) and CISS2) and an IPC-GSU focal person based in Rome. The 18 locally based participants formed the group that usually participated in IPC-analyses in-country, however there was more external participation (CCLE participants) in this analysis to support the virtual methodology used. The four CCLE participants shared their experiences

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1 These 18 participants included 10 nutrition and health focal points from districts level government, central MoH and Action Contre la Faim (ACF), four food security focal points from FAO, WFP, three wash and social protection focal points from ACF and CARE International and one disaster risk management focal point.

2 CISS = le Comité permanent inter Etats de lutte contre la sécheresse dans le Sahel (Permanent Inter-state Committee for drought control in the Sahel)
on nutrition indicators and virtual analysis and learned from Madagascar’s experience. Commitment was given from each of the member organisations to fully attend the entire virtual process.

At the start of the virtual sessions, participants were assigned to one of six working groups each focusing on one of the districts, ensuring a spread of technical expertise and organisational affiliation. Each working group was led by a focal person from a different organisation including Action Contre la Faim (ACF), CARE International, the Food and Agriculture Organization (FAO), MoH, the National Nutrition Office under the Prime Minister’s Office (ONN), the National Office of Disaster and Risk Management (BNGRC) and UNICEF. A local country facilitation team was comprised of three experts to oversee the working groups which were comprised of national experts experienced in IPC methodology with extensive knowledge of the local context (from BNGRC, MoH and UNICEF). The IPC-GSU also provided two facilitators from its pool of global and regional experts. At different stages of the analysis, focal persons from each of the six districts were consulted for knowledge of the local context. Support to district-level participants in the form of data bundles was provided to facilitate internet access and participation in online sessions.

### Figure 2 IPC-AMN Madagascar key results, June 2020

**KEY FIGURES**

<table>
<thead>
<tr>
<th></th>
<th>FEBRUARY - DECEMBER 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe Acute Malnutrition (SAM)</td>
<td>19,554</td>
</tr>
<tr>
<td>Moderate Acute Malnutrition (MAM)</td>
<td>100,120</td>
</tr>
<tr>
<td>Global Acute Malnutrition (GAM)</td>
<td>119,674</td>
</tr>
</tbody>
</table>

**Stage three: analysis**

Under normal circumstances, IPC analysis is conducted with a group of three to four persons per district (or unit of analysis). Groups usually travel to one location for the analysis and remain together for the duration of the training and analysis. There is a designated facilitator for each group to assist with technical questions, monitor the progress and act as spokesperson to IPC technical leads and documents are shared via USB flash drives. For the virtual process, a similar process was used but working group sessions were conducted virtually (using Skype and Zoom), administered by BNGRC (supported by the provision of data bundles for each participant) and files were shared using Dropbox. The MoH provided participants with full online access to the country’s HMIS and nutrition-related indicators. UNICEF and the IPC-GSU focal person, as technical leads, created and sent out calendar invitations to participants and meeting reminders 30 minutes prior to each session.

The participants of each working group spent about three to four hours in working sessions on Skype each day. Working groups made their own arrangements with their group facilitator on how to complete assigned activities which typically included two to three IPC-AMN steps per day out of the total eleven IPC-AMN analysis steps (Box 1). The most common arrangement was that participants took turns to take breaks when needed while the other participants continued to work.

There was a one-hour lunch break every day followed by a Zoom plenary session for all the working groups, during which the group’s designated rapporteur presented on the working groups’ deliberations and conclusions for validation within the wider group.

### Figure 3 IPC AMN results maps. The full report can be accessed on the IPC website [here](#).

**Stage four: Wrap-up**

The results of all the group analysis per district were validated in plenary sessions after which they were presented to the national Nutrition Cluster by the chair of the country IPC-TWG for clearance. This was a similar process to a typical IPC analysis, although validation took place online. The analysis team finalised the IPC report according to IPC guidelines and this was then presented virtually to the cluster after which comments and feedback were integrated into the report before submission to the IPC-GSU for review. The final version was then officially released by BNRGC.

**Results**

The results of the Madagascar IPC-AMN analysis estimated GAM prevalence to be between 10.5-16.8%, severe acute malnutrition (SAM) prevalence was estimated to be between 1.6-3.7% and moderate acute malnutrition (MAM) was calculated to be between 9.0-14.4%.

Based on these estimates, it was calculated that 119,674 children 6-59 months of age would need treatment for acute malnutrition between February and December 2020 (Figure 2). Out of these, 16% would need treatment for SAM.

Results estimated that the nutrition situation would likely deteriorate in all six districts beyond August 2020 due to the agricultural lean season and the effects of COVID-19 (Figure 3). Such factors were expected to result in a

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1. Note this is a combined prevalence estimate, i.e., according to weight for height and/or mid-upper arm circumference and/or oedema presence anthropometric indicators.
slight deterioration in four districts (Toliary-II, Ampanihy, Beloha and Tolagnaro) without changing their global classification of IPC Phase 3 – ‘serious’. However, results estimated that Betioky district would likely move into the serious phase category (IPC Phase 3) and Ambatofio district into the ‘critical’ phase (IPC Phase 4) requiring special attention and an urgent and targeted response. Full results are provided in the report.6

Discussion

Key success factors
The IPC-AMN team in Madagascar leveraged existing local opportunities and prevailing political will to organise a virtual IPC-AMN analysis, the first remote IPC acute malnutrition analysis conducted globally. Key success factors were a dynamic and motivated country team, openness, the willingness and participation of national and district level representatives of three key government institutions (the National Nutrition Office, the BNGRC and the MoH) and full sharing of the national HMIS platform. In addition, the IPC team enjoyed a healthy working relationship with the food security, social protection, WASH and health clusters which enabled the sharing of important contextual information. Another key factor was the technical support provided by the IPC GSU and IPC CCLE participants who were able to participate remotely from Niger, Burkina Faso and Rome. Overall, the use of virtual meeting methods enabled the participation of a high calibre of local and international experts that allowed a high-quality process in line with IPC guidelines.

Data collected via a national nutrition survey just prior to the lockdown that included anthropometric data was available and helped form a reliable basis for the baseline IPC projections. While the nutrition assessment was not directly representative of each unit of analysis, it was possible to re-calculate nutrition outcomes per unit of analysis informed by IPC-GSU guidance. This was important as it allowed for the use of recently collected, existing data to ensure a robust and credible analysis. Projections from this analysis have proved to be accurate, as Southern Madagascar is now facing great increases in levels of child wasting across the region.7

Challenges
Organising an IPC-AMN analysis exercise without up-to-date nutrition survey data seemed, at first, to be a daunting task and required additional work to recalibrate available data. The fact that recent data was only available for three districts was problematic and required strong statistical capacity within the country core team to perform appropriate recalculations of all nutrition indicators at district level before the data could be integrated into the analysis. The most recent IPC Technical Manual supported this process.

As this was the first remote IPC-AMN analysis conducted during the pandemic, there were no existing global guidelines to support remote facilitation; the in-country team therefore had to develop their own ways of working. The team faced difficulties coordinating the facilitation of plenary sessions and supervising working groups in a way that would ensure rich discussion and debate between participants. As noted previously, keeping participants engaged and committed for many hours per day was not easy. To overcome this, plenary sessions were limited to just one hour a day and the process was kept to no longer than five hours per day. These challenges were further overcome by ensuring an adequate number of experienced IPC facilitators. Internet connectivity was a noticable challenge throughout which, at times, led to reduced engagement by district-level participants. This was addressed by providing internet bundles to participants which to some extent helped to overcome the issue.

Another challenge was that, at the time of planning the IPC-AMN analysis, there was a limited understanding of the potential impact of COVID-19 on malnutrition estimates and a lack of clarity on how to develop appropriate hypotheses. This was overcome through technical guidance provided by the IPC-GSU focal point, drawing from the latest IPC technical guidance, although there remained many unknowns due to the evolving nature of the pandemic.

Lessons learned
This experience has provided rich learning. Specific lessons learnt include the following:

• Planning and preparation of a virtual IPC analysis requires sufficient time – at least seven days prior to the intended start date. This is more than is typical during a face-to-face analysis and is required to ensure the availability of as much necessary data and information as possible for the working groups to enable them to carry out the analysis in a shorter time frame.
• It is possible, despite the challenges, to use existing available data with re-analysis to the relevant level of unit of analysis. This process, however, requires a high level of technical support for the statistical analysis and additional time to re-calculate nutrition indicators.
• The use of team members previously trained in IPC analysis saves time and ensures quality input for the analysis. If this is not possible, an online training could be carried out to build the capacity of less experienced participants prior to the analysis, however, this would considerably lengthen the time taken for necessary online engagement which should be taken into account.
• Optimising the capabilities of video-conferencing solutions for working group interactions, discussions and plenary presentations kept participants engaged throughout the exercise.

• If there is poor internet connectivity, a virtual IPC analysis may lead to decreased participation of key authorities and partners at decentralised levels. It is, however, vital to include district level participants to ensure inclusion of deeper insights and knowledge of the areas under analysis. Provision of adequate internet bundles can help to support participation of all partners.
• High quality online facilitation is needed to ensure good participation from all group members, in particular ensuring that every participant has a chance to contribute. For this, the use of all the features of the online tools was helpful including screen sharing and the use of breakout rooms with facilitators moving between rooms.

Conclusion
The lessons learnt through this exercise have shown that, with good levels of supervision and with support to facilitate internet connectivity, it is possible to carry out high-quality IPC-AMN analyses remotely in the context of Madagascar. Adapting to carry out this process remotely was critical to ensure the continuity of IPC-AMN analyses in the context of a national lockdown prompted by COVID-19. The results accurately predicted a decline in the nutrition situation and informed a national-level nutrition response. The results of the initial virtual IPC-AMN analysis were presented at UNICEF’s East and Southern Africa regional meeting in June 2020 as a successful example of continuity of activities despite COVID-19 for other countries to learn from and replicate. Since this presentation, another online exercise was carried out in November 2020 in Madagascar and the experience was also replicated in Uganda, Chad, Kenya, Somalia, Burundi and Yemen.8

References

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https://mics.unicef.org/surveys
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RWANDA

What we know: Risk communication and community engagement (RCCE) is essential to ensure the continuity of uptake of nutrition services and optimal infant and young child feeding practices in the context of COVID-19.

What this article adds: In Rwanda, two sub-committees were established within the Nutrition Sector to lead nutrition-related RCCE activities, building on a previous national RCCE strategy developed as part of Ebola preparedness efforts. Nutrition-related RCCE needs were identified through a review of existing data from available government reports and mainstream media and social media reports and in consultation with Nutrition Sector partners through the sub-committees. Related key messages to address myths and misconceptions were subsequently developed. Capacity strengthening and training activities for community health workers leading on RCCE activities were conducted via Zoom, WhatsApp, email and telephonically. Key messages were disseminated through print and electronic media channels as well as via community radio stations. Parliamentarians were also engaged to expand the reach of messages. Measuring the impact of RCCE activities has been challenging although changes in practices were monitored through social media and community-level monitoring systems and the uptake of services was measured through routine indicator tracking. Increases in service uptake were noted and positive behaviour changes were reflected within feedback mechanisms. As a next step, the Government of Rwanda intends to conduct a rapid qualitative and quantitative assessment to further understand the impact of RCCE nutrition-related activities.

Background

At the onset of the COVID-19 outbreak in early March 2020, the Government of Rwanda, with support from UNICEF and other United Nations agencies and development partners, established the National COVID-19 Joint Task Force. The task force, led by the Ministry of Health (MoH) and the Rwanda Biomedical Centre (RBC), was vital to inform the national COVID-19 response and implemented a number of key measures to mitigate and manage the pandemic.

One such measure, following a directive from the MoH, was that nutrition interventions at community-level were instructed to continue. To inform this, clear guidelines were issued by the MoH on nutrition programme adaptations. The guidelines provided a list of nutrition activities and measures to be taken to ensure safe service provision as well as to reduce risks as far as possible to community health workers (CHWs), government and partner staff. These measures enabled the continuity of growth monitoring services including routine screening for malnutrition, the admission and treatment of children suffering from severe acute malnutrition (SAM) and broader maternal, infant and young child nutrition (MIYCN) activities such as counselling on appropriate complementary feeding and exclusive breastfeeding. Maternal nutrition, infant and young child feeding (IYCF) and food safety and hygiene messages were also integrated into the Standard Operating

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The development of a clear RCCE strategy and plan of action was critical to ensure that people had, and continue to have, access to the right information, delivered in the right way and in a timely fashion. RCCE, in the context of COVID-19, aimed to empower people to adopt infection and prevention control (IPC) measures to protect themselves and to avoid the spread of myths and misconceptions about the disease and its effects. This article documents the RCCE activities undertaken by the Government of Rwanda, with support from UNICEF, to address issues related to maternal nutrition and IYCF in the context of COVID-19.

Implementation of a RCCE response to support MIYCN

Location of RCCE coordination

The planning, management and coordination of nutrition-related RCCE activities within the COVID-19 response was led by the MoH in collaboration with Nutrition Sector partners and UNICEF. Two sub-committees were set up, one focusing on nutrition data management and the other, social behaviour change and communication (SBCC).

Development of RCCE strategy and planned activities

Rwanda already had a national RCCE strategy, initially developed as part of Ebola preparedness efforts that included nutrition-related activities and was further developed in light of COVID-19. Support was provided to the MoH by UNICEF’s Communication, Advocacy and Partnerships (CAP) section’s Communication for Development (CAD) programme to ensure that national and community-level nutrition interventions were clearly defined and in line with the East and Southern Africa Regional Office’s RCCE guidance on COVID-19.

Nutrition-related RCCE needs were identified through a review of existing data from available government reports as well as mainstream media and social media reports and in consultation with Nutrition Sector partners through the sub-committees. Assessment methods included virtual meetings and/or telephone conversations with selected government representatives, representatives from other UN agencies, the United States Agency for International Development (USAID) and non-governmental organisations (NGOs) engaged in the Nutrition Sector as well as with CHWs and frontline health workers. This review helped to identify gaps in knowledge, attitudes and perceptions in relation to nutrition and COVID-19. Findings (Box 1) generated a good understanding of the populations at risk and existing communication channels and ultimately informed the objectives of the COVID-19 nutrition-related RCCE activities. As an ongoing assessment of communication needs, government supervision and CHWs’ weekly and monthly reports were adapted to include gathering information on community concerns, feedback and myths and rumours relating to nutrition and COVID-19.

Based on the available evidence, nutrition-related RCCE activities were designed to support the maintenance of healthy diets for pregnant/lactating mothers and children under five years of age, encourage uptake of IPC measures in the context of IYCF, provide information on optimal nutrition including breastfeeding and complementary feeding while practising good respiratory and hand hygiene, support the continuity of growth monitoring and promote nutrition counselling, micronutrient supplementation (including vitamin A and micronutrient powder (MNP)) and SAM management activities while implementing protection precautions.

Capacity strengthening and training

Capacity strengthening and training were essential to ensure the rollout of RCCE activities. Facilitators from the MoH, supported by UNICEF, developed simplified MIYCN digital training materials that were distributed via WhatsApp and email to frontline health and nutrition workers. Remote training sessions, primarily via Zoom, were then held to discuss key learnings from the training material. Training sessions were attended by 47 participants initially and an additional 547 participants when lockdown was lifted in June 2020. Participants included directors of national hospitals, health centre staff, nutritionists working with CHWs, case management staff and IPC teams. These capacity strengthening activities played a critical role in ensuring a high-quality nutrition response during the pandemic, particularly in relation to RCCE activities.

Development of key nutrition messages

MIYCN key messages and information, education and communication (IEC) materials were developed by the SBCC sub-committee in consultation with members of both sub-committees. This process was informed by the results of the needs assessment (Box 1) and feedback on community concerns, myths and rumours around child feeding practices gathered through CHW weekly and monthly reports. Regional and global guidance was also reviewed and adapted including UNICEF and World Health Organization (WHO) MIYCN counselling cards. IEC materials were developed for health workers, essential workers
and CHWs as well as parents/caregivers. Messages were adapted to guide caregivers and parents with intellectual disabilities. Tools were subsequently piloted and refined as needed. The main themes of the final IEC materials are outlined in Box 2.

Testimonials from mothers who had recovered from COVID-19, and who had continued breastfeeding or had given birth to healthy babies, were subsequently featured as community champions through media channels. This helped to address rumours and misinformation.

Channels for communication
The MoH leveraged all existing channels to disseminate key messages including print and electronic media. A total of 11,000 printed posters aimed at health workers were distributed to all 48 district hospitals and 500 health centres, including refugee camps and isolation centres, and 70,000 booklets were distributed to CHWs. Hard copies of IEC materials were distributed in conjunction with existing essential medicine and nutrition commodities. In addition, soft copies of the posters were distributed through WhatsApp and group emails. This was followed up with virtual/telephone briefings through an MoH WhatsApp and email group for all directors of district hospitals, health centres and nutritionists within hospitals. Telephone follow-ups were also made to brief staff in the use and dissemination of the materials.

To ensure information reached those with low connectivity, the MoH also made use of the Internet of Good Things (IoGT) — a UNICEF-led initiative that hosts mobile packaged, public health content information for free even on low-end mobile devices. This was initially aimed at frontline healthcare workers but, in time, content was expanded to the general public. Virtual meetings led by MoH, on platforms such as Zoom and Skype, were also used when disseminating messages to stakeholders.

Mass media communication channels were also used. Bi-weekly nutrition messages were aired on community radio stations with a population coverage of 99%. Additionally, nutrition messages during the COVID-19 pandemic were incorporated into the renowned radio drama, 'Iteore'. Parliamentarians were used to channel information over local radio stations as is described in Box 3. Nutrition messages continue to be disseminated bi-weekly through Radio Rwanda and its five affiliated community-based radios which have a wide and broad population listenership.

Monitoring impact of the RCCE activities
Indicators from Rwanda’s Health Information Management System (HMIS) were used as proxy measures for the effectiveness of the RCCE programme of activities including indicators around participation in growth monitoring, MNP distribution and admissions and treatment for SAM and moderate acute malnutrition (MAM). Social media dashboards were also periodically reviewed by UNICEF to monitor and track mentions, hashtags, notifications and trends to gather information and manage rumours regarding COVID-19 and nutrition. Additional monitoring was conducted through the collection of ad hoc information, for example, monitoring the separation of mothers with COVID-19 from their infants and the cessation of breastfeeding. Supervision reports for CHWs were also collated to explore the extent to which CHWs understood the adapted recommendations. It is planned that rapid qualitative and quantitative assessments will be conducted in the coming months to collect further information on the impact of RCCE activities in relation to changes to the diets of pregnant women, mothers and children during the pandemic as well as aspects such as overall breastfeeding rates and to learn more about communities’ knowledge, attitudes and perceptions regarding MIYCN in the context of COVID-19.

Results
Influence on nutrition indicators
Service uptake was monitored to indicate the influence of RCCE interventions. HMIS routine data on nutrition indicators noted that total SAM admissions increased from 9,200 admissions in April 2020 to 10,022 in February 2021. In the same timeframe, the coverage of growth monitoring services grew from 82% to 87% and the coverage of distribution of MNP to children aged 6-23 months increased from 42% to 44%. While there are many other factors at play and these figures should be read with caution given the challenges of data collection during this time, these findings point to some degree to the success of the RCCE efforts as community members clearly continued to utilise nutrition services during the pandemic.

Changes in practices
Social media and community-level monitoring revealed that mothers reported washing their hands with soap and running water more frequently than prior to the COVID-19 pandemic. A GeoPoll survey for April 2020 indicated that 98% of respondents took measures to protect themselves from exposure to COVID-19 and 37% of respondents prioritised increasing hygiene practices.

Reach of communications targeted to and via health workers
The December 2020 report from the RBC indicated that all frontline staff, including nutritionists, received the posters with nutrition messages that were disseminated. A total of 60,000 CHWs received the booklets and qualitative feedback within the RBC report demonstrated that CHWs were using the booklets within growth monitoring sessions and during household visits. The RBC also reported that, across all 30 districts, 67% of CHWs were confident in conducting MIYCN counselling, growth monitoring sessions and home visits during the COVID-19 pandemic as a result of following social distancing protocols. It was reported that 85% of caregivers of children aged 6-23 months increased from 42% to 44%.

2 https://www.geopoll.com/resources/palladium-rwanda-case-study/
under five years of age were reached with MIYCN messages through non-digital methods. The reports also showed that the use of mobile platforms allowed CHWs, social workers and nutritionists to continue to provide dietary diversity messages and nutrition education to caregivers/parents.

In refugee camps, RCCE activities were monitored on a weekly and monthly basis through reports and participation lists provided by CHWs and partner NGOs. Those lists provided the number of refugees who had attended the RCCE sessions, participated in growth monitoring services and received MNP and children who received treatment for wasting. Reports showed that, by the end of 2020, approximately 8,300 caregivers had received nutrition services including messages on MIYCN best practices in the context of COVID-19. Feedback collection, rumour tracking and complaints were compiled through weekly and monthly reports which would also feed into the abovementioned processes.

Reach of mass media communication
By the end of May 2020, the COVID-19 MIYCN and IPC messages were estimated to have reached over three million people through the medium of radio. Community feedback suggested that most caregivers appreciated the radio talk shows and counselling by CHWs regarding how best to feed infants and young children in the context of COVID-19. It was noted that they understood that poor diets have the potential to exacerbate pre-existing conditions, putting mothers and children at elevated risk of contracting COVID-19. One community member shared, “You know before, we feared that Corona [virus] was like Ebola, but I learnt [through the radio show] that it’s different, we now know how to protect ourselves and the children. The radio programmes are helping us to protect our families, and that makes me feel safe. I learnt that my family, especially young children, need to eat nutritious food every day to provide energy and nutrition to keep them strong”.

Use of Twitter, Facebook and other social media platforms offered numerous opportunities to deliver MIYCN messages to reach target audiences with key information and elicit engagement that related to changes in behaviour. In addition, UNICEF developed a video called ‘You can trust these tips from a UNICEF Nutrition Expert’ which aimed to raise awareness of the importance and benefits of breastfeeding and optimal complementary feeding. The video generated 69.7k views, 70 shares and 2.2k likes on Facebook. Social media, however, also enabled the continued circulation of myths and misconceptions (as discussed below).

Challenges
In spite of strong MIYCN messaging to the contrary, myths and misconceptions around the breastfeeding of infants when a mother was a suspected or confirmed COVID-19 patient resulted in some mothers being separated from their infants for the two-week isolation period. Although no quantitative data was available to understand the degree to which this was happening and the subsequent impact on breastfeeding rates, supervision reports indicated that this was a significant issue which resulted in some mothers being unable to relactate when united with their infants. To mitigate these challenges, sensitisation of frontline health workers was conducted through face-to-face and virtual meetings and printed materials with clear messages were disseminated.

Considerable delays (up to a month) were experienced in approving messages and communication materials for dissemination in both print and digital form. Consistent engagement with stakeholders helped their eventual approval and dissemination. Additional human resource capacities were posted to MoH, with UNICEF support, and contributed to addressing some of the challenges. Two staff members from UNICEF’s CAP section and one staff member from the Nutrition Section were recruited to support additional needs and challenges.

Despite correct messages having been disseminated widely, limited access to resources, such as face masks, other personal protective equipment (PPE), clean running water, soap and alcohol rub, hindered CHWs from providing timely nutrition counselling services which threatened the adoption of the recommended MIYCN practices.

Some radio talk show discussions and social media communications demonstrated that myths and misconceptions around IYC and COVID-19 continued and spread throughout the pandemic. To address this issue, UNICEF has started supporting the Government to partner with agencies such as the Rwanda Red Cross to analyse feedback through existing complaints mechanisms, track rumours and misconceptions and monitor the reach of RCCE activities. Within the partnership with Rwanda Red Cross, for example, data in relation to handwashing practices, the use of masks and broader social distancing and prevailing rumours and myths is collected. This data is used to inform the government response.

Lessons learnt
Establishing a coordination structure through the development of sub-committees, where roles and responsibilities were clearly defined, was an effective way to harmonise nutrition RCCE and ensure the efficient use of resources in the context of COVID-19. The creation of the sub-committees was noted to be effective in bringing together and coordinating a wide range of stakeholders in relation to nutrition RCCE messaging. It further helped to identify potential gaps in the RCCE response, facilitated the sharing of information to enable the development of key messages and appropriate IEC materials and helped to avoid duplication. Identifying supporters/collaborators for RCCE activities on nutrition early on in the response, including other ministries, public institutions and civil society organisations (CSOs), was noted to be a critical element for developing and disseminating harmonised nutrition messages.

Wide dissemination of appropriate evidence-based RCCE nutrition messaging through multiple channels helped to build the capacity of caregivers/parents to protect themselves and their children in light of COVID-19. Adaptation of available regional and global guidance to support message development on nutrition in the context of COVID-19 was seen to be an effective starting point for developing contextualised key nutrition-related RCCE activities.

Due to the country's total lockdown, strengthening the capacity of frontline health workers to improve child nutrition in the country’s hard-to-reach areas and to promote and support appropriate MIYCN in the context of the pandemic was a challenge. This was overcome during the facilitation of remote online training and follow-up.

Given movement restrictions and social distancing requirements, conducting rapid assessments to understand communities’ knowledge, attitudes and perceptions in relation to MIYCN in the context of COVID-19 was not possible. As a result, developing appropriate RCCE content was challenging. The RCCE nutrition needs assessment exercise helped to overcome this gap and enabled the rapid identification of gaps in knowledge, attitudes and perceptions around nutrition. Similar exercises focusing on key areas such as breastfeeding practices could be used to further guide messaging.

Conclusion
As COVID-19 continues to impact the lives of many, adapting appropriate RCCE messages and exploring alternative communication channels is vital to ensure it has an impact on targeted behaviours. More research is needed to explore the critical context-specific factors responsible for improving the diets of women and children and those that may act as barriers for the uptake of nutrition services. As a next step, the Government of Rwanda intends to conduct a rapid qualitative and quantitative assessment to learn more about the communities’ knowledge, attitudes and perceptions regarding MIYCN for children under five years of age in light of COVID-19, how COVID-19 has affected children’s nutrition, communication patterns and channels as well as the impact of the pandemic on nutrition services. Such assessments will help the government to understand the extent to which RCCE messages have impacted on behaviour and to further develop optimal RCCE interventions for nutrition, forming part of the country’s comprehensive COVID-19 response strategy.

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Localising food supply chains during the COVID-19 pandemic: An example from the Philippines, Move Food Initiative

By Natalie Sessions and Christine Jodloman

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This article is based on a series of interviews conducted with the AGREA team as part of the development of a SUN Movement ‘Solutions Brief’. Interviews were conducted with Cherrie Atiliano; CEO, AGREA; Sef Carandang; Move Food Initiative Volunteer/ Gender Specialist, United Nations; Sonia Gonzales, Business Operations Manager, AGREA; Benjamin Jorge Cadag, Agribusiness Manager, AGREA; Caroline de Leon, Mindanao Logistics Officer, AGREA; Mary Ann Reyes, Administration and Finance Manager, AGREA and William Dar, Secretary of the Department of Agriculture, Philippines. The authors are grateful for the support of the SUN Movement Secretariat for identifying this story and for the support in developing and disseminating the broader ‘Solutions Brief’.

PHILIPPINES

What we know: The COVID-19 pandemic and the subsequent country lockdowns have had a large impact on food systems, particularly in relation to supply chains. This has necessitated the strengthening of local supply chains.

What this article adds: In the Philippines, a local non-governmental organisation, AGREA, developed the Move Food Initiative which aimed to move food from farms to consumers and to reduce food waste during the pandemic by using an online fresh food ordering platform and developing ‘rescue kitchens’ which repurposed fresh produce that would otherwise go to waste. While working closely with farmers, AGREA was able to see first-hand some of the problems farmers faced, particularly in the area of post-harvest losses, and have now begun empowering farmers to diversify crops and implement additional measures to reduce post-harvest losses. AGREA has also helped to foster a greater understanding for consumers of where their food comes from.

Background

As a measure to limit the spread of COVID-19 in the Philippines, strict lockdowns, known as community quarantines were imposed in many parts of the country. The strictest of these began on the 16th March 2020 when an enhanced community quarantine (ECQ) effectively shut down most parts of the country, restricting movement except for when essential. In Metropolitan Manila, the quarantine led to challenges in obtaining fresh produce with supermarkets and wet market stalls struggling to meet demand. In other parts of the country, farmers faced challenges in selling their produce, there were logistical problems in transporting produce from farms to cities and, with restaurants closed, Filipino farmers were left with few people to sell their harvest to, leaving fresh produce going to waste.

The Department of Agriculture (DA) mobilised to try to mitigate the effects of the ECQ on agricultural activities including developing a food resilience protocol. A number of mitigation measures were put in place such as developing food passes that enabled trucks carrying food and agricultural products to pass through quarantine checkpoints, increasing efforts to promote urban agriculture through the distribution of seeds and planting materials and developing ‘price freeze’ policies to manage unreasonable and excessive price increases of basic necessities during the ECQ. However, recognising that the DA was not able to act as quickly as it would have liked given the necessary bureaucratic
processes within the government, the DA welcomed public-private partnerships to support agriculture activities during this time.

AGREA was one such partner, led by its CEO, Cherrie Atiñano. AGREA aims to support the empowerment of local farmers by implementing sustainable agricultural practices and creating inclusive agribusiness livelihood programmes. This article explores how AGREA reacted to the challenges brought about by the ECQ and tells the story of AGREA’s Move Food Initiative, an initiative to move food from farms to consumers and to reduce food waste during the pandemic. This article is based on interviews held with the AGREA team in the development of a Solutions Brief which was published jointly by Emergency Nutrition Network (ENN) and the Scaling Up Nutrition (SUN) Movement.

Moving food from farms to the city
Three days after the ECQ was imposed, Atiñano received a call from one of the farmers who AGREA works with who had 15,000 pineapples he had just harvested about 60 kilometres from the capital city. He was unable to transport the fruit to markets given the imposed quarantine. Through its wide network and support system, AGREA was able to source a truck owned by the local municipal government that was able to pass through the stringent checkpoints and transport the pineapples to Metropolitan Manila. By posting on Facebook and again using the networks that AGREA already had, they were able to sell 3,500 pineapples in just three days.

Seeing the success of this initial opportunity, AGREA began receiving more calls from farmers asking for help to move their produce so decided to launch the Move Food Initiative to support this effort.

As with the first call, AGREA relied on Facebook to communicate information about the initiative as this is a social media platform that is widely used in the Philippines. From the very beginning, word spread quickly through the social media platform and people started to respond with offers of help. AGREA’s Facebook page already had a dedicated audience of farmers with whom they had worked for the last five years who were made aware of the initiative and who reached out when they had harvested their produce. This network also included those who were interested in supporting the agricultural sector and who were willing to volunteer when needed. For example, when a call was posted relating to the need for trucks to transport food, one furniture company offered the use of a delivery truck. This was re-purposed for the pick-up and delivery of agricultural produce. Private trucks and cars were offered by friends and acquaintances across farming regions and restaurants that had temporarily closed due to the quarantine were made available to be used as storage depots.

An online fresh food ordering platform, using a simple Google form, was set up to distribute the produce when it arrived in Metropolitan Manila. This included a list of the available fresh produce as well as the amount available and the price. To determine the price, AGREA used the price freezing standards set by the DA to ensure that farmers and consumers were not taken advantage of. Customers were requested to indicate on the form what that they would like to purchase and to share the details of where the food would be delivered to. Given the logistics of delivering to individual consumers, AGREA instead targeted the building of communes, homeowners associations and businesses where food would be delivered to a central point and one volunteer would be responsible for moving food to individual consumers and households. These volunteers, known as ‘movers’, would subsequently set up stalls or mini-markets in building communes (observing strict social distancing measures) to pass produce on to those who had ordered it. Movers were generally well known in their communities and by consumers and hence already had a level of trust for those buying the produce.

Emerging issues
As the initiative progressed, a number of emerging issues were noted that required creative solutions from AGREA.

ECQ restrictions and harvesting challenges
In some areas, only two to three people were allowed to harvest produce at a time as a result of the ECQ. Although no quantitative data was collected, this reportedly led to huge delays in harvesting and subsequent post-harvest losses. To solve this, AGREA spent time advocating with mayors to enable more people to support the harvesting while still adhering to social distancing guidelines. In some areas, as a result of advocacy by AGREA and the DA, these restrictions reportedly reduced and more people were allowed to support in the harvesting of crops.

Financial payments
Paying farmers was another emerging challenge and required flexibility. Typically, AGREA paid farmers in person with cash but the limitations of the ECQ meant that AGREA had to shift from cash payments to bank transfers. Many farmers did not have access to bank accounts and were not able to open one due to not having an Identity Document (ID) so therefore creative ways of sending money had to be found. In some instances, rural banks or the bank accounts of relatives or friends were used or, in areas where there were no ATMs, at times AGREA paid local government officials in central locations and the officials would then distribute the money directly to the farmers. AGREA would subsequently follow up with the farmers to check that they had received the money and if they had distributed it amongst the farming cooperatives as per the agreements.

Working with different communities
As AGREA worked with ever-increasing numbers of farming communities across the country, they realised that ways of working were different in each community. The team had to contextualise the approach based on the farming community involved. For example, an indigenous farming community was identified as needing support to sell raw honey produced on ancestral land. Working with this community required a different
Transportation of food

One challenge of transporting the food using vehicles that were not municipal government vehicles was the negotiation required at quarantine checkpoints. The team had to secure food passes from an Inter-Agency Task Force (a special inter-government taskforce set up in light of COVID-19) which verified that their vehicles were carrying essential food commodities. These passes were often challenging to obtain and required support from local DA officials and government actors who were able to push the processes forward. AGREA had to spend a lot of time utilising local contacts and leveraging strong working relationships built prior to the pandemic to gain the support of government actors to secure the food passes. The DA was instrumental in supporting AGREA in this regard.

As the initiative grew, AGREA began receiving calls from farmers further afield who also needed to move their food. Considering that the Philippines is an archipelago of 7,107 islands, both sea and air transportation were needed along with land transportation. During the ECQ, such transportation also required special permission and came with its own challenges which is why the bulk of transportation was undertaken via land transportation. Sea transportation took time (up to five days) and was subject to weather challenges. Estimating the time that sea transportation would arrive in port was also difficult and meant that members of the AGREA team had to wait at the port for many hours. Air transportation was much quicker (typically only one to two hours). However, the new restrictions within airports meant that once a plane had landed, it took many hours to complete the paperwork and secure the food. These delays were challenging given the need to move fresh produce as quickly as possible to prevent it spoiling. This challenge was also very noticeable when using land transportation as the trucks being used were not made for fresh food conveyance. They were poorly ventilated and lacked proper air conditioning. As such, food orders were prone to spoiling during the journey. Since there was not much that the AGREA team could do to address the challenges in transportation, it became vital that open communication was maintained with consumers so that they too understood the realities and challenges of transportation and were prepared for delays or for when stock was not of a high quality. This helped garner a sense of trust with consumers as they felt that nothing was being hidden from them in the process. Furthermore, when journeys were very long, the DA supported and provided cold storage to keep the food fresh while awaiting delivery in Metropolitan Manila.

Tackling food waste

The biggest emerging issue was that of food spoilage and food waste. In April, it became apparent that a surplus of tomatoes would go to waste if not used. There was also a growing supply of so-called ‘ugly’ foods which consumers were more reluctant to consume as well as a recognition that AGREA was having to throw away food that arrived in Metropolitan Manila already spoiled.

On the other hand, there was the challenge of restaurants being shut and chefs and restaurant workers being out of work. As a result, the Move Food Initiative decided to partner with chefs to develop products made from these oversupplied and misfit foods, naming the initiative the AGREA Rescue Kitchen (ARK). Initially, Pomodoro sauces and tomato jams were developed and this expanded to a broad range of produce including other types of jams, smoothies, soups, salad dressings and many other products depending on what surplus was available. Products were designed to be seasonal (based on what was grown at the time), artisanal (hand-made), intentional (designed out of foods that would otherwise be going to waste) and limited (in supply).

Like many countries, food loss is a major issue in the Philippines. Before the pandemic it was estimated that 30% of produce was lost post-harvest and during the pandemic this rose to almost 60%. This challenge became a priority for the Move Food Initiative. The products produced by the ARK were well received and demand has grown over time. The ARK also donated fresh produce and seasonal products to frontline and other essential workers.

Additional campaigns were developed to limit food going to waste. These included ‘Hero Drives’ where consumers were encouraged to buy fresh produce in bulk for a discount and the ‘Being Crate-ful’ Drive where crates filled with assorted available vegetables were sold to consumers. The ‘Crate-ful’ Drive, launched in August 2020, was the Move Food Initiative’s way of extending gratitude to key workers. Consumers were told that for every crate of fresh and healthy fruit and vegetables purchased, AGREA would set aside a food parcel for selected beneficiaries, particularly jeepney (local bus) drivers and garbage collectors. In just five days, all the fruit crates had sold out, making it possible to deliver food parcels to 84 jeepney drivers and 12 garbage collectors. ‘Donate a vegetable’ campaigns were also developed in which AGREA promised that, for every 300 kg of produce ordered, 15 kg would be donated to kitchens that supplied frontline workers.

Supporting farmers in the ‘new normal’

While working closely with farmers, AGREA was able to see first-hand some of the problems farmers faced particularly in the area of post-harvest losses. Farmers appeared to lack the skills and know-how to reduce these. AGREA built such factors into a brief capacity-building training that was conducted over the telephone and has worked hard to help farmers to better plan their harvests to avoid losses. Creative ideas and practices to prolong the life of food from farmers themselves were also tapped into and shared among other farming communities. One reason for post-harvest losses was the lack of diversity in crop planting – communities tended to produce the same crops that were harvested at the same time leading to a produce surplus. In light of this, AGREA and the DA have started working with farming communities to diversify the produce grown in provinces.

A further realisation that AGREA had was the fact that farmers lacked the skills for and...
understanding of effective pricing models for their produce. Instead, in the past they have tended to rely on middlemen who take a cut of their profits. AGREA has slowly started working with farmers to help them to understand how to cost their produce and how to budget their income so that they are less reliant on taking out loans and working with middlemen in order to keep their farms operational.

**Supporting consumers in the ‘new normal’**

The biggest impact of the quarantine was the realisation by the public of the need to think about how they obtain their food. In an increasingly industrialised world, people have largely lost the connection to people growing their food and the pandemic has offered the opportunity for consumers to engage in a new way going forward. As a result, AGREA has also been promoting ‘grow kits’, urban gardening kits that include seedlings, potting mixes, seedling trays and a grow manual to encourage people to grow things at home, no matter how limited their space is. This is in line with the DA’s ‘Plant, Plant, Plant’ programme that includes the distribution of seeds and planting materials as well as the establishment of community gardens. Home gardening was also promoted during the pandemic as a productive family activity that could be done during the ECQ.

Another lesson from the Move Food Initiative was the need to connect consumers to farmers. During the pandemic, there was a renewed focus on where food was coming from and AGREA was able to educate consumers on the process involved in getting food from farms to their homes. The Move Food Initiative Facebook page facilitated engagement with the wider consumer community and helped to connect farmers and consumers. By sharing farmers’ stories on the platform, consumers were able to get a sense of where their food was coming from, which farmer had produced the fruit and vegetables and what it took to bring produce to the market.

**Building off the successes of the initiative**

The Move Food Initiative was subsequently adapted in light of a series of typhoons that affected the country in October 2020 (Typhoons Quinta, Rolly and Ulysses) to support farmers in the affected communities through a ‘Rise Up and Recover’ drive to support their recovery. One aspect of the drive was the ‘Buto ng Pag-asa’ or Seeds of Hope Initiative, where customers could sponsor a set of seeds that would cover 1,000 square metres of land.

The Move Food Initiative and the broader efforts by the DA have led to greater investments in agriculture by the Government of the Philippines. Amid the pandemic, efforts by the government and partner organisations have focused on localising food supply chains to prevent food waste and also to feed families.

The Move Food Initiative has also been shared widely as a success story in the midst of the pandemic, including through the SUN Movement, to promote the generation of ideas in other countries that are dealing with food waste and struggling to move food during lockdowns.

**Results**

By 1 June 2020, the day the Philippines began lifting quarantine measures, the Move Food Initiative had shipped over 160,000 kg of fruit and vegetables from more than 7,400 farmers to nearly 52,000 families. By the end of November 2020, 191,447 kg of fruit and vegetables had been delivered, 28,122 farmers had been partnered with and fruit and vegetables had been served to 78,177 families and 4,690 frontline workers. Farmers reported stories of how the initiative had impacted their lives such as the very first pineapple farmer who was able to pay back his loans and pay for his child’s school fees. The initiative has been recognised within the DA and further afield with Atilano and AGREA winning numerous international and national awards.

**Lessons Learnt**

Several lessons were learnt during the process of rolling out the Move Food Initiative and were, in part, key to its success. These included:

1. **The need to be creative and agile:** The process of moving food around the country was entirely new to AGREA and the team had to learn as they went along, adapting and adjusting based on the emerging needs. Agility was needed to work differently with different farming communities and creativity was needed in order to overcome some of the challenges.

2. **The importance of leveraging one’s network:** From the beginning, the Move Food Initiative relied on AGREA’s wide network of allies. Across Atilanos and AGREA’s network, volunteers were engaged at both ends of the spectrum. Volunteers dedicated large amounts of personal time to support the initiative and helped to ensure food moved from farm to consumer. Facebook has played a critical role in this mobilisation. From the very beginning, word spread quickly through the social media platform and people started to respond with offers of help.

3. **The need to complement government efforts:** AGREA has always aligned to government goals and objectives and maintains strong communication links with the DA who it kept continuously informed of its plans during the pandemic.

4. **Contextualising the approach:** The Move Food Initiative looked different in each farming community and each consumer community. As such, there was not a logistical blueprint but instead the model was adapted as needed. The ways of working with farmers, the ways of transporting goods and the ways of paying farmers were all adapted based on the unique needs of each farming community. A similar process of contextualising approaches was also noted at the consumer end.

**Conclusion**

While the pandemic has brought unprecedented suffering and challenges across the globe, it has also offered an opportunity to rethink practices and food consumption patterns. The Move Food Initiative is a small-scale example of a response to some of these large challenges. It is farmer-focused, community-based and sustainable. In addition, it provides a model that other countries can adopt, on a bigger scale, for a more sustainable future food system.

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Adapting infant and young child feeding interventions in the context of COVID-19 in Somalia

By Sahra Moalim Ahmed, Bishar Osman Hussein and Emmanuel Barasa

Adaptations were required to the Concern-supported infant and young child feeding (IYCF) programme in Somalia to ensure that caregivers of infants under two years of age continued to access vital IYCF individual and group counselling services, tailored to the COVID-19 context, in a way that minimised the risk of transmission of the virus. Adaptations included the translation and dissemination of key IYCF COVID-19 messages, the training of health workers on IYCF in the COVID-19 context, IPC measures implemented in individual and group counselling sessions, a reduced number of participants at group counselling sessions (and an increase in the number of sessions held and IYCF counsellors per health facility to support this), an increased number of handwashing stations at health facilities and the inclusion of people recovered from COVID-19 into counselling sessions to help to address the stigma and rumours associated with the virus in the community.

Programme data shows that the number of beneficiaries reached during 2020 increased compared to 2019 as a result of the adaptations made. A key challenge was the huge effort required to promote and support many behaviour changes in a short space of time among health staff and beneficiaries and the need for additional funds, made possible by the realignment of budgets and flexible donor funding arrangements.

Background

Somalia is the second most fragile country in the world, with around 69% of the population living below the poverty line. Somalia’s humanitarian situation has worsened in recent years due to the devastating combination of conflict and increasingly erratic weather and climate shocks including drought. Three additional shocks – a desert locust upsurge, extensive flooding and the COVID-19 pandemic – deepened the scale and scope of the humanitarian crisis in 2020, the consequences of which will exacerbate humanitarian needs in 2021. In March 2020, the COVID-19 caseload surged to 7,518 confirmed cases and, by March 2021, stood at 3,284 active cases with 249 confirmed deaths. According to a World Health Organization (WHO) global estimate, 20% of Somalia will suffer from the pandemic’s direct and indirect impacts in 2021. Access to healthcare remains very limited in Somalia due to the scarce availability of skilled health professionals and a dilapidated public health infrastructure, particularly in rural areas, resulting in some of the world’s worst health outcomes.

Child malnutrition remains one of Somalia’s major issues and, in most cases, internally displaced persons (IDPs) are the worst affected. Somalia’s Food Security and Nutrition Analysis Unit (FSNAU) has estimated that approximately 840,000 children under the age of five will be wasted in Somalia in 2021, including 143,000 who will likely be severely wasted (FSNAU, 2021). Concern Worldwide Somalia admissions data reveals a stark increase in admissions of...
is to improve the knowledge and skills of health facilities are directly implemented by Concern where IYCF counselling is integrated within the Concern supports 20 health and nutrition and hygiene practices. Currently, creation through community mobilisation and health and nutrition service delivery through Concern Somalia programme encompasses the health and nutrition component of the programming Concern Somalia IYCF International, 2016). Complementary feeding practices are also often sub-optimal with children introduced to semi-solids, solids and animal milk either too early or too late. Mothers in Somalia also have limited access to information and health facilities are often the only place to access support for optimal IYCF practices (SAF-UK International, 2016).

Concern Somalia IYCF programming

The health and nutrition component of the Concern Somalia programme encompasses health and nutrition service delivery through fixed and mobile services as well as demand creation through community mobilisation and the promotion of positive behaviour changes in health, nutrition and hygiene practices. Currently, Concern supports 20 health and nutrition facilities including one national referral stabilisation centre (14 fixed and six mobile facilities) where IYCF counselling is integrated within the health and nutrition component. Five of these facilities are directly implemented by Concern Worldwide, five through the government health system with strengthening support provided and 10 facilities are implemented by Concern Worldwide partners.

The primary objective of the IYCF activities is to improve the knowledge and skills of health service providers and community health workers (CHWs) so that they will, in turn, be able to provide timely, relevant and quality IYCF counselling support to mothers, caregivers and other key community influencers. The target group for the counselling sessions are mothers/caregivers of children 6–24 months of age and pregnant and lactating women who attend the health facility for community-based management of acute malnutrition services, vaccination, antenatal care, postnatal care or any other health services.

The counselling sessions are conducted by a trained CHW who administers a general screening question to identify issues/challenges related to appropriate infant feeding practices to help to focus counselling on the topic/s presenting a challenge. Subsequent sessions mainly follow up on the advice given to support the resolution of the problem after which the CHW moves on to any other challenges that present. Group counselling sessions are also organised at facility-level on every morning of the outpatient therapeutic programme day. Prior to the COVID-19 pandemic, group counselling involved two female community workers to facilitate a group session with five to 20 caregivers. Female facilitators are used based on the findings of a previous assessment that found that pregnant and lactating women and caregivers were more likely to build a positive and responsive relationship with the facilitator and feel more comfortable discussing their issues (including barriers) with other women (FSNAU, 2016).

Programmatic adaptations in the context of COVID-19

The Concern team faced several challenges at the onset of the COVID-19 crisis to enable these essential IYCF counselling activities to continue. Initially, caregivers did not visit the health facilities as frequently as normal due to the fear of COVID-19 infection and were not comfortable attending the counselling sessions when they did visit. There were also widespread rumours related to breastfeeding and COVID-19 risk that needed to be addressed urgently. Therefore, following the guidance from FMoH and the Somalia Nutrition Cluster, Concern made the following adaptations to the service delivery modality to ensure the continuity and provision of quality IYCF (E) interventions in this new context. The adjustments aimed to allow the counsellors to provide IYCF counselling sessions to targeted beneficiaries to address routine challenges, as well as those that presented as a result of the pandemic, in a way that posed the minimum risk of virus transmission.

Translation and dissemination of WHO/UNICEF key IYCF COVID-19 messages

All the key IYCF messages/recommendations in the context of COVID-19 were translated into the local language and widely disseminated and shared with the health facilities supported by Concern and its partner organisations.

Training of health workers on IYCF in the COVID-19 context

At the initial outbreak of the COVID-19 pandemic March 2020, routine interaction with programme staff and beneficiaries revealed a lot of misconceptions, fear and stigma associated with the disease and its mode of transmission. In order to address these uncertainties and misinformation, a series of trainings were provided to all health facility staff and CHWs on the introduction of COVID-19, infection prevention control (IPC) measures and risk communication and community engagement messages around COVID-19, specifically COVID-19 and IYCF practices. The aim of the training was to ensure that all staff and CHWs were equipped with the appropriate knowledge and skills to reduce the risk of transmission within health facilities, deal with the fear and social stigma prevalent in the community and support optimal IYCF practices in this new context. In total, 181 health staff and CHWs received training across different programme locations. Job aids were also provided to each health facility (such as laminated information, education and communication materials for use during counselling) and additional on-the-job mentoring and support was provided.

Infection prevention control measures implemented during individual counselling

Protocols were put in place to ensure that the IYCF counsellor and caregiver maintained a minimum distance of one metre between them at all times. Counselling took place within a well ventilated room, caregivers and counsellors washed their hands before entering counselling rooms, counsellors and beneficiaries wore face masks throughout counselling and greetings involving physical contact were avoided. These protocols were made clear to all caregivers on arrival.

Reduced number of participants at group counselling sessions

Protocols were also put in place to reduce the number of participants attending support group meetings and group promotion sessions to three

Figure 1

Number of participants reached with counselling sessions per month January 2019 to February 2021

<table>
<thead>
<tr>
<th>Month</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
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<tbody>
<tr>
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<tr>
<td>Feb</td>
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<tr>
<td>Dec</td>
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<td>3124</td>
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</tr>
</tbody>
</table>

Discussion

The quick adaptation of the IYCF programme in Somalia enabled the continuation of essential services in the COVID-19 context and enabled support for caregivers to mitigate the potential negative effects of COVID-19 myths and misconceptions around infant feeding practices. Data shows that, as a result of the adaptations made, particularly the addition of extra staff capacity and the increased frequency of group sessions, more caregivers were reached with IYCF messaging than in the previous pre-COVID-19 year. This has been a positive outcome of the adaptations made. As adaptations were put in place and after initial variations due to infrastructural changes and training, the number of participants at group sessions increased showing that the adaptations were successful which allowed the programme to reach a high number of caregivers. It is too early at this stage to measure the impact of the programme on IYCF practices in the community. However, data shows that cases of acute watery diarrhoea dropped in 2020 compared to 2019 (622 cases recorded April to June 2019 compared to 436 cases April to June 2020) which is likely associated with the adoption of IPC measures in the community and at health facilities.

The adaptations made to the Concern-supported IYCF programme in Somalia were an immense challenge for programme management and staff. Much advocacy was required to bring all staff on board right down to facility-level and to provide the support needed to ensure that necessary adaptations were made and remained in place, even up until now. The necessary changes were not accepted instantly by staff and beneficiaries who were, for example, hesitant as to the need for reduced numbers of participants at the sessions, the increased numbers of sessions and the use of IPC measures. It has taken much effort to continually engage staff and beneficiaries to ensure that the need for these changes is understood and that health staff are equipped with the knowledge and skills needed to implement them. A key lesson learnt, therefore, is that even in the COVID-19 context, behaviour change takes time and requires much effort and constant engagement to be successful.

There were many additional costs associated with the programme adaptations made, for example for the procurement of personal protective equipment, the recruitment of and payment for extra staff members, extra training and mentoring of health staff, translation and printing costs of the adapted IYCF materials and the infrastructural costs associated with providing additional handwashing facilities and triage and counselling spaces. In order to support the extra costs, budgets were realigned, a key enabling factor that was only possible thanks to the flexibility of Concern’s donors.

Support from the government was also an important enabling factor. At national-level, the Somalia FMoH has played a leading role in the coordination of national-level Nutrition Cluster communications and engagement with other key government players. In addition, the FMoH has revitalised the national IYCF technical working group, of which Concern Somalia is a key member, to enable communication, alignment with national and global level recommendations and the sharing of programme adaptations and experiences in the COVID-19 context. This has been an important vehicle for the learning from the experiences described in this article to be shared with other partners engaged in IYCF programming in Somalia and to support similar programme adaptations across the country. Efforts have also been made to align and coordinate COVID-19 mitigation measures across the different sectors, via the nutrition, health, food security, Water, sanitation and hygiene and protection clusters, to enable a harmonised response. This level of coordination has enabled the sharing of IYCF messages in the COVID-19 context to all beneficiaries for greater impact. The Government of Somalia must continue to support these efforts to enable optimal IYCF programming across all sectors moving forward.

Conclusion

Individual and community-level IYCF counselling is critical to support optimal IYCF practices, including the provision of timely support to the carers of newborns to facilitate the early initiation of breastfeeding and exclusive breastfeeding and support to improve the dietary diversity and ongoing breastfeeding of infants aged 6-23 months. The COVID-19 pandemic has uniquely challenged the ability of IYCF counsellors to reach the intended beneficiaries at a time when optimal IYCF practices are challenged by myths and misconceptions around the disease. To address this, rapid adaptations were required to the Concern-supported IYCF programme in Somalia to ensure that caregivers could still be reached with adapted, targeted IYCF-related messages and tailored support in a way that ensured the minimum risk of transmission of the virus. This required additional funds, made possible through the flexibility of donors, to support an unprecedented effort to train and recruit additional staff, make infrastructural changes at health facilities and provide the support needed to beneficiaries. While not without challenges, the increased number of beneficiaries reached during 2020 compared to the previous year is an early indicator of the positive impact of the adaptations made. Learning is still taking place and ongoing efforts to capture the impact of the programme on IYCF practices in the COVID-19 context will provide important lessons in the future.

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Infant and young child feeding in emergencies: Programming adaptation in the context of COVID-19 in Lebanon

By Bayan Ahmad

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IOCC gratefully acknowledge the support of UNICEF for funding the project activities and the salaries of staff and for continuously working on building the capacity of their implementing partners. IOCC also acknowledge the Ministry of Public Health Maternal and Child Health Department, the National Infant and Young Child Feeding Committee and the Nutrition Sector for supporting and facilitating the implementation of the programme.

LEBANON

What we know: During emergencies, promoting adequate infant and young child feeding (IYCF) practices saves lives.

What this article adds: International Orthodox Christian Charities (IOCC) IYCF activities that already targeted both refugees fleeing conflict in Syria and vulnerable Lebanese families were adapted in response to the COVID-19 context. Volunteer educators and lactation specialists were mobilised to scale up awareness raising and one-to-one and group counselling, both remotely and in person with infection prevention control measures in place, and a national hotline was established. IOCC lactation specialists reached more than 11,000 pregnant and lactating women in 2020 with IYCF counselling (versus 3,000 in 2019) and IOCC educators and volunteers reached more than 24,000 caregivers with IYCF education (compared to 1,500 in 2019). IOCC supported the Lebanese government to ensure breastmilk substitutes were only provided according to the national legal framework. Challenges included the lack of internet access for some women, an increase in workload and the need for additional resources. Lessons learned include the need for preparedness plans pre-emergency, the need for sustained support for IYCF programming in Lebanon including investment in community volunteers, lactation specialists and training for health workers, the need to adapt IYCF messages according to prevailing myths and misconceptions and targeting women as well as other household and community decision-makers, the need to invest in the promotion of the national hotline and advocacy to ensure that laws protecting optimal IYCF practices in emergencies are enforced.

Background

Infants, young children and their mothers are vulnerable, particularly during humanitarian emergencies. Improving infant and young child feeding (IYCF) practices1 according to the World Health Organization (WHO) recommendations is key to improving child survival and to promoting healthy growth and development. Rates of optimal IYCF practices in Lebanon are very low. Data shows that only 14.7% of infants less than six months of age are exclusively breastfed (Central Administration of Statistics, 2009) and around 13% of infants aged 6-23 months meet the minimum acceptable diet for complementary feeding (UNICEF, 2016). Field experience reveals that the main barriers to optimal breastfeeding in Lebanon include the lack of both awareness and a supportive environment for breastfeeding.

Ten years into the Syrian crisis, Lebanon remains the country hosting the largest number of refugees per capita. According to United Nations High Commission for Refugees estimates, there were 855,172 registered Syrian refugees dispersed across Lebanon by the end of March 2021.2 The presence of such a large refugee population places enormous strain on the country’s economy, public services and local infrastructure. In addition, during the year 2020, the country went through severe economic challenges, exacerbated by the COVID-19 pandemic and the blast in the port of Beirut on August 4, 2020 that caused more than 200 fatalities and 6,500 injuries. During this succession of crises, ensuring optimal breastfeeding amongst refugees and the host community became an even greater priority given the importance of breastfeeding as a life-saving intervention.

Misconceptions and inadequate IYCF practices are commonly found among both refugees and Lebanese families. Programme staff often report that the introduction of water for thirst and tea for colic, illness or to relax the baby is customary and commonly initiated soon after birth. The early introduction of complementary foods is also customary with mothers commonly starting to give their infants small amounts of food from three to four months of age. Infant formula is also commonly given to infants soon after birth when mothers feel that they are not producing sufficient milk to meet their baby’s needs. Women’s reasons for discontinuing breastfeeding include breast and nipple pain, latch difficulties, sleep deprivation and exhaustion. These difficulties are often compounded by maternal employment, inadequate family support or the lack of professional advice which are known barriers to breastfeeding success.

IYCF programming by International Orthodox Christian Charities in Lebanon

International Orthodox Christian Charities (IOCC) has been actively involved in nutrition-related activities in Lebanon both in schools and communities since 2001. Activities to improve IYCF practices have been prioritised both in normal times and in emergency situations, with specific IYCF-related activities targeted to both refugees fleeing conflict in Syria and vulnerable Lebanese families.

In 2011, a national IYCF programme was established by the Ministry of Public Health (MoPH), with support from IOCC and World Vision, and a sub-committee on IYCF in emergencies (IYCF-E) was created, mainly supported by IOCC. In 2018, the MoPH, with support from UNICEF and IOCC, developed and launched a National Policy on Infant and Young Child Feeding to guide actions to promote optimal IYCF to support the healthy growth and development of infants and young children in the country. The policy defines the responsibilities of the Lebanese government, its partners and all relevant stakeholders in promoting, protecting and supporting IYCF.

IOCC is a member of the IYCF national committee and works through the national IYCF programme to implement IYCF-related activities. Through its UNICEF-funded project launched in 2020, IOCC provides IYCF counselling and support to 10,000 pregnant and lactating women and through its team of community health educators, IOCC conducts education and awareness activities on optimal IYCF practices in all governorates to reach 9,000 caregivers. Mothers with lactation difficulties are referred to IOCC’s pool of qualified and skilled lactation specialists who provide one-on-one counselling. Lactation specialists also provide support to ensure optimal IYCF practices in hospitals, primary healthcare centres and at community level.

1 https://www.who.int/news-room/fact-sheets/detail/infant-and-young-child-feeding
In addition, IOCC monitors and supports hospitals in Lebanon enrolled in the Baby Friendly Hospital Initiative programme through on-the-job coaching and monitoring adherence to the ‘10 steps to successful breastfeeding’, identifying and addressing challenges and supporting them towards certification with the Baby Friendly Hospital label from the MoPH. Other activities include the development of materials on complementary feeding and building the capacity of the healthcare providers working in nurseries to use the breastfeeding cards, as well as the monitoring of violations against the International Code of Marketing of Breast Milk Substitutes (BMS).

During the multi-faceted crisis that occurred in Lebanon, including movement restrictions as a result of COVID-19 imposed from March 2020, IOCC worked to adapt existing programming approaches to ensure that the most vulnerable pregnant and lactating women would be able to access IYCF support. Programmatic adaptations were made in line with the WHO, UNICEF and the Lebanese MoPH guidelines, supported by additional funds reallocated from existing programme budgets. This article outlines the programme adaptations made and lessons learned.

Programmatic adaptations
Promotion of optimal IYCF practices at community level

Initially, IOCC educators provided group education sessions on a daily basis, following a pre-defined curriculum of topics. Caregivers were gathered in one location and sensitised on IYCF topics. In the context of COVID-19, IOCC expanded its team of educators to reach more people and adapted its awareness activities to cover both IYCF and COVID-19. IOCC also mobilised volunteers across the country for a duration of two months to help and support the educators in awareness raising activities.

Based on the materials and guidelines developed at national level, existing educators and volunteers worked to raise awareness of IYCF and COVID-19 within their communities, targeting community members with key messages that aimed to limit the spread of the virus, mitigate its impact and correct misconceptions about IYCF in this context. They provided municipalities with preventive information and guidelines on home isolation, guidance on regular hand washing and hygiene, social distancing, the symptoms of COVID-19, when to seek medical care, how to buy groceries and disinfect them, when to use a face mask and how to use it appropriately as well as myth busters around IYCF/nutrition and COVID-19. Educators and volunteers helped to disseminate key national messages through the distribution of flyers and posters to shops, pharmacies and at household level, as well as through social media (including WhatsApp). They also advocated with local authorities and influencers (mayors, mukhtars and religious leaders) to engage in the dissemination of the key messages. Over two months, the volunteers were able to cover more than 120 of the 1,108 municipalities across the country.

Supporting mothers to practice optimal IYCF

As a response to the COVID-19 pandemic, IOCC lactation specialists began consulting and following up with pregnant and lactating women with either confirmed or suspected COVID-19 infection using the IYCF counselling card that was adapted for COVID-19 by UNICEF (Figure 1).

Box 1 provides an example of the support provided to a breastfeeding mother during COVID-19. Samah, age 35, was unsuccessful in breastfeeding her first two children and was pregnant in her third trimester with her third child when she was diagnosed with COVID-19. Samah was not planning to breastfeed her baby and had heard a lot of myths and misconceptions around the need to avoid breastfeeding during the pandemic and to feed her infant with formula milk as a safer alternative. While still pregnant, Samah was approached by Amal, an IOCC lactation specialist. Amal helped to improve Samah’s knowledge about breastfeeding and build her confidence in her ability to breastfeed. She provided the mother and her partner with information about the benefits of breastfeeding, breastfeeding initiation and positioning, the importance of exclusive breastfeeding and the prevention and treatment of common breastfeeding problems.

Education and counselling sessions were conducted by Amal remotely through WhatsApp and Zoom. Amal also coordinated with the midwife at the hospital to ensure that Samah was supported to initiate breastfeeding within the first hour after her baby was born and that the baby was placed skin-to-skin on her mother’s chest to encourage him to breastfeed more. Amal then followed up closely with Samah through video calls following the birth to observe her breastfeeding and provide support several times before the child was discharged. Samah experienced nipple soreness and bleeding and the physician suggested she use formula supplements, she continued exclusively breastfeeding, adjusting the latch and adopting a good position to overcome the initial difficulties.

Later, when the time came for Samah to return to work, Amal counselled her, giving guidance on how to express and store her breast milk and provided her with a manual pump. Samah said, “We live in a culture where breastfeeding is undervalued and bottle feeding is viewed as the normal and safe way to feed babies, especially during this pandemic. I learned a lot from my experience with Amal. She helped me fix the breastfeeding difficulties I faced and corrected the misconceptions that I had about breastfeeding. She also helped me save money, which was good especially with the worsening economic situation. In addition, online consultations were highly convenient and time savvy; it was easy and fast to communicate with Amal by using WhatsApp. I’m still exclusively breastfeeding my baby. I now in turn raise awareness on breastfeeding and correct misconceptions within my community.”

Protecting IYCF through legislation

Despite the existence of a national law (Law 47/2008) that legislates upon the International Code of Marketing of BMS, IYCF is still undermined, particularly in emergencies. Due to the economic crisis, the COVID-19 pandemic, the heavy refugee burden and, in addition, the blast at the port of Beirut, calls for infant formula donations from the community increased. Several grassroots initiatives and organisations accepted donations and distributed these through a general distribution scheme without having the capacity or knowledge to follow global guidance for humanitarian aid.

IOCC identified the organisations and the formula milk providers involved and contacted them to provide them with legal information to ensure that artificial support was administered in line with the law.4 In addition, as a member of the IYCF national committee, IOCC supported the development of IYCF Standard Operating Procedures (SOPs) to guide and inform national and international agencies on how to ensure appropriate, timely and safe IYCF support for families. IOCC also contributed to the development of an infographics for the SOP to communicate information quickly and clearly, translated

4 The Law recommends that infant formula is strictly targeted to infants who require it and have no viable breastmilk options. https://www.ennonline.net/operationalguidance-v3-2017
this into Arabic and disseminated it across agencies and sectors. IOCC then conducted workshops for organisations and small groups that were providing milk formula distribution to vulnerable families in all Lebanese governorates to inform them about the IYCF SOP, discussing how to provide nutrition support in a way that was in line with the global and international guidance on IYCF-E.

In coordination with the IYCF national committee, IOCC set up a IYCF hotline number to report violations of the BMS Code and to receive referrals for mothers in need of follow-up from lactation specialists. Various channels, including the development of a flyer and social media, were used to promote the hotline to agencies working across different sectors as well as caregivers. Infants and young children less than 24 months of age who were identified as needing support were referred for a full assessment conducted by a lactation specialist and given either skilled IYCF support or artificial feeding support as appropriate.

**Discussion**

The lockdown measures introduced in Lebanon in March 2020 to reduce the spread of COVID-19 resulted in a rapid change in circumstances for pregnant women, new mothers and their infants. Lactation specialists noticed that the changing and uncertain circumstances, the prevalence of misconceptions and myths surrounding breastfeeding and COVID-19, combined with reduced face-to-face support from family, friends and peers negatively affected women’s perceptions and experiences of breastfeeding and their ability to overcome practical challenges. Furthermore, the deterioration of the economic situation and the loss of income associated with the closure of small businesses affected the ability of many families to purchase nutritious foods, altering the economic basis for infant feeding decisions. The prevailing context in Lebanon, where infant formula is regarded as an essential commodity and infant feeding with formula milks is regarded as ‘normative’, also presented extra challenges, driving the soliciting of donations of BMS and feeding equipment for untargeted distribution.

The government, UNICEF and professional health organisations were advised to maintain mother-infant contact and to encourage and support breastfeeding, including when a mother had COVID-19 provided she was well enough and precautions were taken to minimise transmission to her infant during feeding. Global and national guidance was released and IYCF programmes had to adapt quickly in order to provide scaled-up support to protect and promote optimal IYCF in this context.

**Achievements**

As a result of the programme adaptations by IOCC described in this article, between the end of February and the end of December 2020, lactation specialists were able to reach more than 11,000 pregnant and lactating women to provide them with IYCF counselling and support, as compared to around 3,000 in 2019. IOCC educators and volunteers were also able to reach more than 24,000 caregivers (compared to 1,500 in 2019) with education on IYCF especially in the context of COVID-19. This demonstrates a considerable growth in reach at this challenging time, largely driven by the incredible effort of IOCC volunteers and staff, as well as the use of online platforms which enabled many women to be reached swiftly. In terms of the hotline, over 700 calls have been received since its launch in September 2020 with more than 85% of the calls being referred to a lactation specialist. Five violations of the BMS Code were reported through the hotline.

**Challenges**

A major challenge with working remotely was internet access. Some caregivers in rural areas had poor connections while others did not have any connection at all. This limited their ability to engage with some activities.

The programme adaptations described resulted in an increased workload, training needs and logistics within IOCC. Staff were provided with regular additional trainings on infection prevention and control measures to ensure they were able to share key messages and answer common questions on COVID-19. Many more materials were also developed, printed and distributed by IOCC which resulted in staff time and budget implications. To support this, the budget reallocations had to be done in coordination with the donor to support additional activities.

The surge in calls to the IYCF hotline proved challenging during 2020. In response, in 2021, two IYCF monitors were recruited to support the national IYCF hotline and meet the additional surge in needs.

**Lessons learned and recommendations**

Prior to the COVID-19 outbreak, IOCC worked on a preparedness plan that involved identifying resources, determining roles and responsibilities, developing policies and procedures and planning adaptations to programme activities in order to be able to respond promptly and effectively to a pandemic. This meant that the planned programme adaptations could be implemented swiftly after the first case of COVID-19 was confirmed in Lebanon. This kind of preparedness planning is essential in driving an appropriate emergency response. In future, greater alignment and coordination in mitigation plans across sectors (nutrition, health, food security and livelihoods, agriculture, water hygiene and sanitation, social protection and mental health and psychosocial support) is needed to improve the reach and support of all pregnant and lactating women and their infants and maximise opportunities across all services.

Despite the challenges, the merging of online support with in-person support enabled IOCC to reach a large number of pregnant and lactating mothers with essential IYCF support services in a short space of time. However, breastfeeding and complementary feeding practices in Lebanon remain poor. Along with the worsening economic situation and the increased demand for formula milk, programmes and services to protect, promote and support optimal feeding practices should remain a critical component of the programming and response for young children in the context of COVID-19 and more funding for IYCF-E activities is still needed. There is also a need to invest in the training and mobilisation of more community health volunteers to run IYCF-E activities at community level and lactation specialists to provide specialist counselling and support. Building the capacity and strengthening more health facility staff on IYCF-E counselling in the COVID-19 context is also needed to sustain the gains made and further scale up quality IYCF programming.

The understanding of myths and misconceptions related to IYCF and the tailoring of messages accordingly, and the inclusion of key decision-makers within the family structure (fathers, mothers-in-law) and influential members of society (midwives, doctors, dietitians, religious authorities, mayors), in awareness activities were important aspects of the programme. This should be considered by IYCF programmers going forward.

The IYCF hotline number provided another important platform for pregnant and lactating women to access remote support services. The hotline needs to be promoted to reach its full potential. The national IYCF committee, in coordination with the Lebanese government and UNICEF, is preparing a campaign on IYCF that aims to raise awareness on IYCF and promote the IYCF hotline with an official launch planned in June 2021.

IOCC and partner actions to address unethical breaches of the International Code of Marketing of BMS were a critical part of the response. Further advocacy is needed so that Law 47/2008, which aims to protect and promote breastfeeding, and the International Code of Marketing of BMS, are actually enforced in all emergency responses including during and after the COVID-19 pandemic. A legal framework supported by the MoPH is needed to ensure full adherence to the BMS Code to make sure that donations for and the marketing and promotion of formula milk are neither sought nor accepted.

Further recommendations are made for donors, embassies, international organisations, non-government organisations and grassroots organisations in a call for action that was developed by the Nutrition Sector in the response to the Beirut explosion.\(^4\)

**Conclusion**

Adapting IYCF programme activities in the context of COVID-19 and the economic situation in Lebanon proved challenging. Progress has been made but programmes and services to protect, promote and support optimal early and exclusive breastfeeding and age-appropriate and safe complementary foods and feeding practices should remain a critical component of the programming and response for young children in the context of COVID-19. Coordination with other sectors is also needed to focus on reaching and prioritising pregnant and lactating women and infants and young children.

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**References**


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Adaptations to SMART surveys in the context of COVID-19 in Cox’s Bazar, Bangladesh

By Md. Lalan Miah, Bijoy Sarker, Jogie Abucejo Agbogan, Brigitte Tonon, Mary Chelang’at Koch and Md. Shahin Emtazur Rahman

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Funding support was provided by UNHCR, the Bureau of Population, Refugees and Migration, the Directorate–General for European Civil Protection and Humanitarian Aid Operations and the Swedish International Development Cooperation Agency.

What we know: Nutrition programming, including nutrition surveys, has faced significant disruption as a result of the restrictions in movement arising from the COVID-19 pandemic.

What this article adds: Adaptations to the Standardized Monitoring and Assessment of Relief and Transitions (SMART) survey methodology and operations were made in the context of Cox’s Bazar refugee camps in Bangladesh during 2020 to enable data collection to continue in the COVID-19 context. Adaptations included reducing the number of indicators, reducing sample size, addressing myths and fears around COVID-19 through pre-survey community sensitisation; using experienced enumerators to shorten pre-survey training; and use of infection prevention control (IPC) measures by the survey team during the survey. Team members and household members were screened for COVID-19 symptoms regularly and excluded if symptoms were declared. The overall non-responsive rate was very low (5.4%-8.3%) and exclusions due to COVID-19 were low at 1.5%. Adaptations worked to allow the collection of high-quality data. An additional 3 to 5 minutes were required per household to allow for implementation of IPC measures. The experience shows that context-specific adaptations and community sensitisation and mobilisation can enable safe, quality data collection in the COVID-19 context.

Background

Cox’s Bazar nutrition context

Cox’s Bazar (CXB) is a highly disaster-prone coastal district in Bangladesh and one of 20 of Bangladesh’s 64 districts identified as vulnerable with an estimated poverty prevalence rate of 16.6% (Government of Bangladesh, 2017). The CXB district has a host population of 2,290,000 and an additional estimated population of 871,924 refugees residing in 32 makeshift and two registered refugee camps across Ukha and Teknaf (sub-districts) (Government of Bangladesh-UNHCR, 2021). Since the influx of refugees in 2017, the Nutrition Sector in CXB has been providing comprehensive nutrition services to address the underlying causes of malnutrition across all camps targeting children under five years of age, children over five years of age, adolescent girls and pregnant and lactating women. Although the protracted crisis in CXB has stabilised to some extent, the COVID-19 pandemic has had a significant impact, limiting access to services, which has necessitated adaptations to nutrition programmes. Adaptations to community-based management of acute malnutrition (CMAM) programmes in CXB have been outlined in recent Field Exchange articles.1

1 https://www.ennonline.net/fex/63/cmamcxcovid19adaptations and https://www.ennonline.net/fex/63/cxbvitaminasupplementation
Population representative nutrition surveys

Action Against Hunger (ACF) Bangladesh, with the support of ACF France, the ACF Canada SMART team and the ACF UK coverage team, regularly monitor the nutrition and health situations in both refugee camps and host communities. ACF currently leads the implementation of nutrition surveys in CBX and chairs the Nutrition Sector’s Assessment and Information Management Technical Working Group (AIM-TWG). At the national level, ACF is supporting the formation of a National Assessment Technical Working Group. Since 2009, ACF has conducted 85 nutrition surveys in Bangladesh including 60 Standardized Monitoring and Assessment of Relief and Transition (SMART) surveys, six rapid SMART surveys, six Standardized Expanded Nutrition Surveys (SENS), seven coverage assessments (SQUEAC/ SLEAC), three Link Nutrition Causal Analyses (Link NCA) and three health facility assessments. Of these, 54 surveys were conducted in CBX.

SMART surveys by ACF Bangladesh collect data on anthropometry, mortality, morbidity, nutrition supplementation, food assistance, infant and young child feeding practices, food security and livelihoods and Water, sanitation and hygiene (WASH). The data collected informs the formulation of the joint response plan and multi-sector and integrated humanitarian interventions.

Following the release of interim global operational guidance on population level surveys and household level data collection in the COVID-19 context, ACF Bangladesh, in consultation with the Nutrition Sector and government authorities, adapted the methodology for conducting SMART surveys and tested this in refugee camps and host communities in CBX between November 2020 and February 2021. The objective of this article is to capture the experiences and key lessons learned while implementing this interim guidance in three refugee camps to support its further development and implementation in other contexts given that most countries globally have to adapt their surveys due to COVID-19.

Adapting surveys in CBX in the COVID-19 context

Necessary technical, operational, logistical and HR adaptations were made in order to minimise the risk of COVID-19 transmission for the targeted surveyed populations and survey teams during the implementation of three SMART surveys. The assessment method was endorsed by the National Nutrition Services (NNS), the Institute of Public Health Nutrition (IPHN) through the CBX District Civil Surgeon’s Office and the Office of the Refugee Relief and Repatriation Commissioner. All adaptations, outlined below, were comprehensively discussed and agreed in a series of meetings, webinars and email exchanges with AIM-TWG, the Nutrition Sector, NNS, the Civil Surgeon’s Office and the global SMART team at ACF Canada and ACF France headquarters.

Methodology adaptations

The number of indicators collected was reduced to include only those critical for programme decision-making including anthropometric data, a few health indicators and mortality data. Indicators related to food security, anaemia and health aspects, which are usually included, were omitted to simplify the approach and limit the interview time in order to reduce the contact time and minimise the risk of COVID-19 transmission.

For sampling, the precision level was kept at the minimum acceptable level as per the SMART guidance to limit the sample size thereby reducing further non-essential contacts with the population. A relatively higher non-response rate (NRR) was factored in for refugee populations (Makeshift camp: 18%, Nayapara Registered camp: 12% and Kutupalong Registered Camp: 18%) compared to similar past surveys to account for the possible refusal and exclusion of households due to COVID-19 related issues.

Operational adaptations

A number of adaptations were made to survey protocols as advised by global guidance, as follows:

Pre-survey training

- All survey enumerators, team leaders, survey managers and advisors were tested for COVID-19 (using a PCR test) three days prior to training.
- Adequate health and safety measures (use of personal protective equipment (PPE), health screening and maintaining proper physical distancing) were taken during training.
- A special session on the COVID-19 pandemic and necessary infection prevention control (IPC) measures was included in the training.

Survey implementation

- During field implementation, all survey team members were provided with surgical face masks and hand sanitiser. Measurer assistants were also provided with hand gloves to disinfect anthropometric equipment between interviews to avoid skin contact with disinfectant. Each team carried a safety disposal bag for used PPE which was properly disposed of at the end of data collection each day.
- All team members sanitised their hands immediately before entering a household and after completing each household data collection using alcohol-based hand sanitiser with at least 60% alcohol.
- During the interview, the interviewer and respondent maintained a distance of at least one metre (when possible in the confines of household spaces), even if wearing a mask, and the number of persons present during the interview was limited to a maximum of three. Respondents and all children over the age of two years were also given a mask to wear during the interview.
- Anthropometric measurements were mostly taken outside in an open, shaded area with enough space for proper physical distancing and air circulation.
- Anthropometric equipment (weighing scales, height boards and blank wooden boards) were disinfected between each household. New mid-upper arm circumference (MUAC) tapes were used for each household and those previously used were left with each caregiver for use within the Family MUAC approach. Additional time was allocated to each house-hold to ensure safety measures could be carried out.
- Well-functioning vehicles with enough space were hired for the survey teams to ensure social distancing during the field travel and these were disinfected regularly. All drivers were also provided with a face mask and hand sanitiser.

In consultation with the AIM-TWG and government officials, additional measures over and above the global guidelines were also put in place to further reduce the risk of COVID-19 transmission for these specific surveys including those conducted in camps. Those additional adaptations were as follows:

Pre-survey preparations

- The COVID-19 situation was closely monitored and survey fieldwork was only permitted during periods when positive confirmed cases were low (according to the World Health Organization(WHO) Health Sector epidemiological update).
- Because of fear/stigma/mistrust due to COVID-19, extra efforts were made when conducting advocacy and sensitisation with camp leaders and camp-in-charges (government officials) and community mobilisation prior to the start of each survey. Special emphasis was placed on avoiding any confusion, misinformation, rumours and fear in the community, therefore ensuring maximum participation and cooperation both from the camp management and communities.
- While field testing the questionnaire and methodology, special emphasis was given to the team comprehension and appropriate implementation of IPC health and safety procedures (e.g., wearing PPE, ensuring physical distancing, administering COVID-19 screening checklist etc.) as those were introduced for the first time due to the pandemic.
- Coordination took place with the United Nations High Commission for Refugees (UNHCR) health unit to provide the necessary PPE for the survey team to avoid unwanted procurement delays.

Survey team measures

- The assessment mainly used highly experienced measurers (who had previously participated in at least two surveys and had passed the standardisation test in the last 12 months) in order to skip the standardisation test as recommended by the SMART interim guidelines in order to shorten the training period from five to three days to minimise risk.


4 Family MUAC was already implemented within CBX whereby caregivers are trained to screen their own children for wasting using MUAC tapes with self-referral to nutrition centres if severe or moderate wasting is indicated.
The number of survey enumerators was reduced to a minimum of three persons per team (one team leader and lead measurer, one measurer assistant and one interviewer) to limit exposure and allow physical distancing measures.

An additional six team members were trained and kept on standby to recall at any point if a team member showed COVID-19 symptoms, was placed into quarantine or tested positive.

All survey team members were put in a residential hotel with full board and were restricted from going outside and interacting with others during the whole training, field testing and data collection to minimise the risk of infection.

All survey team members monitored their health using a health-screening checklist developed by ACF Bangladesh twice per day (morning and evening) during the survey period. If any individual met any of the conditions outlined in Table 1, they were requested to go into mandatory quarantine and were replaced by a member of the reserve team.

### Participant screening

A standard health-screening checklist for interviewees was developed jointly in consultation with the Nutrition Sector and AIM-TWG members for the inclusion and exclusion of children and/or households. Body temperature was measured using an infrared digital thermometer and questions were asked as described in Table 2. If any household met any of the four conditions as explained in Table 2, the household was excluded from the survey. If any household had multiple eligible children but at least one child without fever or other COVID-19 signs/symptoms and no other family history of COVID-19 infection, these households were included in the survey. Any other household members with a high fever or other signs or symptoms were asked to isolate from the survey team but this was not considered a household exclusion criteria.

#### Data collection and supervision

- Data was collected on tablets (Lenovo Tab) using the Open Data Kit (ODK) application to reduce the time spent entering data and to check for data quality. All teams carried a back-up tablet and hard copies of the questionnaire in the event of tablet failure.
- Survey teams were supervised daily using a supervision checklist with a minimum of one supervisor or survey manager per team on a rotating basis to ensure consistency in data collection across all teams. All data was uploaded and reviewed daily in order to monitor the quantity and quality of the data collected.
- A daily feedback session using a digital platform was held but reduced from 30 to 10 minutes.

#### Findings

All three surveys reached the sufficient number of households and children, well above the minimum requirement as per SMART survey guidelines (90% of clusters and 80% of children) to ensure data quality and representativeness (Table 3).

The overall NRR was very low (5.4 to 8.3%) and much lower than anticipated and used for the sample size calculation (12 to 18%) at the protocol development stage. Table 4 shows the different causes of non-response. This indicates that household exclusion due to COVID-19 exclusion criteria was very low (1.5%) in the Makeshift camp with no exclusions in the other two camps.

Although the original plan was to revisit non-response households for inclusion in the survey, this was not required as all three surveys had achieved adequate samples despite the exclusion of some households. The overall data quality for the three surveys was either “good” (Makeshift camp) or “excellent” (the two registered camps) as per the SMART plausibility score. The overall quality of the survey for the Makeshift camp was high but a penalty was given for a standard deviation (SD) of weight-for-height Z-score (WHZ) (SD value <=0.8; acceptable) which was due to higher homogeneity in that camp.

Although there was no standardisation test used, most enumerators were highly experienced and skilled and therefore a high level of standardisation was assumed which resulted in very few outliers in the data.

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### Table 1 Health screening checklist for survey team

<table>
<thead>
<tr>
<th>Conditions</th>
<th>Morning (Y/N)</th>
<th>Evening (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most common and mild symptoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Did the staff and/or any team member have a high temperature (≥100.4°F/38°C) without a dry cough, tiredness?</td>
<td>(Y)</td>
<td>(Y)</td>
</tr>
<tr>
<td>2. Did the staff and/or any team member have a high temperature (≥100.4°F/38°C) with a dry cough, tiredness?</td>
<td>(Y)</td>
<td>(Y)</td>
</tr>
<tr>
<td>Mild and less common symptoms (treated from home)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Did the staff and/or any team member have a high temperature (≥100.4°F/38°C) without a sore throat, diarrhoea, conjunctivitis, headache, loss of taste or smell, aches and pains?</td>
<td>(Y)</td>
<td>(Y)</td>
</tr>
<tr>
<td>4. Did the staff and/or any team member have a high temperature (≥100.4°F/38°C) with a sore throat, diarrhoea, conjunctivitis, headache, loss of taste or smell, aches and pains?</td>
<td>(Y)</td>
<td>(Y)</td>
</tr>
<tr>
<td>Serious symptoms (take immediate medical attention)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Did the staff and/or any team member have a running nose, sneezing, shortness of breath, chest pain or pressure, loss of speech or movement?</td>
<td>(Y)</td>
<td>(Y)</td>
</tr>
</tbody>
</table>

### Table 2 Health screening checklist for household inclusion/exclusion

<table>
<thead>
<tr>
<th>Conditions</th>
<th>Response (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did eligible children (6-59 months) have a high temperature (≥100.4°F/38°C) and/or other symptoms of COVID-19 (e.g., dry cough, sneezing, shortness of breath, chest pain or pressure, loss of speech or movement etc.)</td>
<td>(Y)</td>
</tr>
<tr>
<td>2. Did anyone in this household test positive for COVID-19 within the past 14 days?</td>
<td>(Y)</td>
</tr>
<tr>
<td>3. Was anyone in this household in close contact with a confirmed COVID-19 positive patient within at least 14 days?</td>
<td>(Y)</td>
</tr>
<tr>
<td>4. Is anyone in this household currently in home or centre quarantine for isolation?</td>
<td>(Y)</td>
</tr>
</tbody>
</table>

### Table 3 Proportion of households and children included in SMART surveys

<table>
<thead>
<tr>
<th>Survey location</th>
<th>Targeted households</th>
<th>Households achieved</th>
<th>Targeted children</th>
<th>Children achieved</th>
<th>Non-response rate (NRR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Makeshift camp</td>
<td>611</td>
<td>578 [94.6%]</td>
<td>492</td>
<td>488 [99.2%]</td>
<td>33 [5.4%]</td>
</tr>
<tr>
<td>Nayapara registered camp</td>
<td>585</td>
<td>552 [94.4%]</td>
<td>362</td>
<td>305 [84.3%]</td>
<td>33 [5.6%]</td>
</tr>
<tr>
<td>Kutupalong registered camp</td>
<td>709</td>
<td>650 [91.7%]</td>
<td>334</td>
<td>346 [103.6%]</td>
<td>59 [8.3%]</td>
</tr>
</tbody>
</table>

### Table 4 Distribution of non-response households by cause

<table>
<thead>
<tr>
<th>Survey area</th>
<th>Absent</th>
<th>Refused</th>
<th>Excluded due to children's high fever</th>
<th>Others*</th>
<th>Total non-response rate (NRR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Makeshift camp</td>
<td>23 [3.8%]</td>
<td>0 [0%]</td>
<td>9 [1.5%]</td>
<td>1 [0.1%]</td>
<td>33 [5.4%]</td>
</tr>
<tr>
<td>Nayapara registered camp</td>
<td>7 [1.2%]</td>
<td>1 [0.2%]</td>
<td>0 [0%]</td>
<td>25 [4.3%]</td>
<td>33 [5.6%]</td>
</tr>
<tr>
<td>Kutupalong registered camp</td>
<td>26 [3.7%]</td>
<td>33 [4.6%]</td>
<td>0 [0%]</td>
<td>0 [0%]</td>
<td>59 [8.3%]</td>
</tr>
</tbody>
</table>
The data collection time of 15 minutes for each household, as recommended by the SMART operational guidelines, was not feasible in this context. A minimum of 20 to 25 minutes was required on average per household with the anthropometry and mortality components. Administration of the health screening checklist, measuring of body temperature, asking/putting on masks for household members and disinfecting equipment added to the time required. There was no refusal related to fear of COVID-19 and health and safety measures were well accepted by community members. Almost all households already had facemasks and other PPE that they were willing to use. However, it was often very challenging to maintain a distance of at least one metre especially in the Makeshift camp due to the very limited space available in and around the households.

All survey team members tested negative for COVID-19 prior to the survey and no one developed other signs/symptoms of COVID-19 or became unwell during the survey implementation.

**Reflections and key lessons learned**

Weighing up the risks and benefits of conducting surveys during the COVID-19 pandemic is important. That was aided in this experience by a thorough series of discussions with Nutrition and Health Sector partners and local health and administration authorities and a constant review of local epidemiological trends around COVID-19. Gaining an understanding of the local context and community perceptions around COVID-19, including stigma, fear and misconceptions, was also important prior to embarking on the survey in this context. This understanding informed community sensitisation prior to the survey and communications during the fieldwork which led to a high level of community compliance with the survey. The selection of locally experienced, skilled enumerators who could understand the context was also important.

There is a high risk that excluding children and households due to high fever will pose a systematic bias by also excluding potentially malnourished children. This could impact the reported malnutrition prevalence and other relevant indicators since there is a general assumption that sick children are more likely to be malnourished. This is unlikely to have affected the results of the three surveys here, given that the exclusion rate was very low, but should be considered as a potential source of bias in SMART surveys in other contexts where COVID-19 rates are higher.

In terms of measures used during the conducting of surveys, several adaptations were made to the interim guidance based on a series of discussions and consultation with the Nutrition Sector, AIM-TWG, NNS, IPHN, the local Civil Surgeon’s Office as well as ACF Canada and France headquarters advisors. Since the COVID-19 crisis was new for everyone and there was a great deal of sensitivity around conducting surveys in this period, a large number of stakeholders were hesitant to embark on the process. A lot of the additional recommendations therefore came from multiple partners, organisations and technical experts which were added to the global guidance particularly for the specific CXB context but which would not necessarily be needed in other settings.

The interim guidelines on SMART surveys recommend the use of both hand gloves and sanitiser for team members. However, using both items proved to be time consuming, resource-heavy and had the potential to create an extra waste management burden at field level. It was therefore decided to only use hand sanitiser (aside from the use of gloves for those cleaning equipment) so as to reduce the resources needed. This appeared to have no negative impact on transmission rates in the context of these three surveys.

Experience from this survey showed that the standard facemask size was difficult to use with children. The recommended 15 minutes allocated for each household was not adequate to complete the anthropometry and mortality components of the survey and apply IPC measures. On the basis of this experience, several recommendations are made to partners who would like to conduct SMART surveys in COVID-19 context, as described in Box 1.

**Conclusion**

Experience from conducting three SMART surveys in the context of COVID-19 in CXB showed context-specific adaptations can enable the proper application of SMART survey guidelines. In this context, community mobilisation that took into account prevailing community COVID-19 myths and concerns prior to the survey enabled a good response rate and IPC measures prevented virus transmission among respondents and survey team members. This enabled the collection of information to inform the nutrition response. It is recommended that surveys continue to be conducted despite the extra efforts and resources needed to minimise the risk of virus transmission.

For more information, please contact Md. Lalon Miah at surveymgr@bd-actionagainsthunger.org

**Box 1 Recommendations to implement SMART surveys in the context of COVID-19**

**Pre-survey preparation**

1. Critically review and monitor the COVID-19 situation in the context before embarking on a decision to conduct a SMART or other population level survey that requires household level data collection.
2. Inform and consult with local authorities (e.g., local government; law enforcement authorities, camp management committees and the Health and Nutrition Sectors) prior to conducting any survey during the COVID-19 pandemic. This is particularly important during the pandemic as internal and in-country rules and regulations may be imposed including movement restrictions due to the pandemic. Consultation with the relevant authorities is critical to gain the necessary approvals and full cooperation to successfully conduct the survey.
3. Use local in-country expertise in technical and management survey aspects wherever possible to ensure both quality data collection and the community’s health and safety in the COVID-19 context.
4. Invest in community mobilisation and advocacy prior to the survey to address rumours and misinformation around COVID-19 in the community.
5. Adequate funding and time should be planned for the proper adaptation of IPC health guidance, the procurement of necessary disinfectant and PPE items and any unforeseen contingency measures required to make the survey as safe as possible in the COVID-19 context.
6. Organisations and the Sector/Cluster should focus on the minimum key indicators required in the survey questionnaire to enable sufficient nutrition situation monitoring and evaluation and decision-making in the context. All additional non-essential indicators should not be included in surveys implemented in the COVID-19 context to reduce exposure time to the survey population and households.
7. Carefully adapt and contextualise the global guidance (e.g., interim global operational guidance on population level surveys and household level data collection in the COVID-19 context) with a group of external experts through a technical committee (e.g., AIM-TWG, Sector/Cluster) to ensure that the guidelines suit the unique context in which they are being applied.
8. The NRR should be carefully estimated during sample size calculations. Child fever prevalence based on a two-week recall period should not be directly used for COVID-19 related NRR for sample size calculations as it may unnecessarily inflate the NNR.

**Survey implementation**

9. Review the allocated time per household based on field testing while taking into consideration extra time for health screening and IPC measures during household visits.
10. Very close monitoring of daily survey field activities by the responsible survey manager is needed to ensure adherence to IPC guidance, data quality, the health and wellbeing of the survey team members and the number of non-responses either due to COVID-19 related rejection or exclusion.
11. Additional survey days (e.g., two to three days) should be planned for during the COVID-19 pandemic to revisit all missed or excluded households either due to high fever or absenteeism. This will minimise the possible high NRR that may happen if many children and/or mothers/caregivers are found with fever on the designated days of data collection.

**References**
