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2021

UJAS (National CSO Coalition)

Bihar Chapter

Access to Primary Health and Nutrition Services during COVID-19 Lockdown in Bihar

Conducted By

UJAS (National Coalition of Civil Society Organisations) - Bihar Chapter

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Key Findings – Highlights of the Study

- **Immunization:** 34% of children under one year missed their immunization. 55% of the Auxiliary Nurse Midwives (ANMs) reported that child immunization sessions were either not held or irregularly held during these two months. Similar findings for pregnant women immunization where 49% ANMs reported that immunization sessions could not be organised regularly for pregnant women.
- **Institutional Delivery:** Owing to lockdown, 11% deliveries happened at home while 23% took place in private facilities.
- **Service Delivery:** The study shows that little over half of the patients were provided free medicines during delivery in the government health facility. 20% of respondents said that they had to get tests done outside the health facility and 25% respondents said that they did not get free ambulance service to take the expected mother to government health facility.
- **Heath Service Seeking Behaviour:** The survey data revealed that only 11% patients visited a government health facility to seek treatment in case they fell ill. 50% of the respondents said that they went to an unqualified Rural Medical Practitioner (RMP) to seek treatment. Some of the reasons behind this were non-functional government health facilities, fear of pandemic, and unavailability of transport.
- **Nutrition Service Delivery:** 53% of the respondents with children between 7 to 36 months and 22% of respondents with children between 3 to 6 years said they did not receive any Take Home Ration (THR) during lockdown period. Main reasons cited by respondents for not receiving the THR were due to lockdown (34%) as Anganwadi Centres were closed and movement was grossly restricted during this period. Three-fourth of the respondents informed that egg/soya *bari* or milk powder—the source of protein in diet—was not provided to children during the lockdown period.

Chapter 1: Introduction

Bihar, one of the backward states in India, faces many socio-economic challenges. The state's economy is not in good condition and it ranks high in the list of states measured on multidimensional poverty index. Poor performing economy has made the underprivileged section of Bihar to suffer from an incompetent healthcare system, education system, and employment policy over the years. The major challenge faced by the people in Bihar now is related to health and nutrition. Child malnutrition is one of the important public health problems in this northern state. According to the National Family Health Survey (NFHS) 2015–2016, 48.3% of children are stunted, 20.8% are wasted, and 43.9% are underweight. The prevalence of anaemia among children between 6 months to 5 years of age, is also significant at 63.5% (NFHS 2015-16, Bihar). Bihar also tops the list for number of deaths of children less than five years due to malnutrition.

2020 changed lives of people worldwide. The onslaught of the COVID-19 pandemic led to calling of a nation-wide lockdown. The spread of coronavirus was rapid, and it soon spread from urban to rural areas in India. Bihar was already struggling with its chronic resource constraints and limited healthcare capacity, the pandemic pushed the state in a critical state. The pandemic created a huge pressure on the entire health service department for providing treatment and services to patients suffering from either communicable or non-communicable diseases including COVID-19, where the department itself was also fighting for their safety.

The study highlights the background about the services at public health service delivery points during the lockdown period due to COVID-19 in Bihar. The document also makes a comparative analysis for the regular health programmes like immunization, TB treatment, outreach services of ASHA & ANM, Family Planning, and Out Patient Department (OPD) during two periods of time i.e. April-June 2019 and April-June 2020.

It was in this backdrop that the Bihar State Coalition of UJAS[1] conducted a rapid survey on status of primary health and nutrition services during COVID-19 times. The survey focused on non-COVID diseases, routine and emergency health services, and status of malnutrition, Severe Acute Malnutrition (SAM) children and hunger.

A task group was formed among the Bihar State Coalition, nominated by the members themselves. The task group comprised:

1. CHARM (Jan Swasthya Abhiyan (JSA))
2. BVHA
3. Koshish (Right to Food (RTF))
4. Oxfam India (Secretariat, UJAS)

This task group was primarily responsible for planning and rolling out of the complete assessment. The task group members through collective discussion, decided the following objectives of this assessment:

- To record the overall status of services provided to the people accessing primary health and nutrition services (with focus on maternal and child health services, communicable disease like TB, non-communicable disease like diabetes, hypertension, heart disease, cancer, dialysis etc) other than Covid-infected people and the functionality of health facilities during the COVID-19 pandemic.
- To understand the quality of services provided to patients approaching government facilities during the COVID-19 pandemic and the services provided by the government health facilities.

[1] The National Coalition of Civil Society Organisations (CSOs) known as UJAS is spread across 15 states in India with a collective outreach of about 325 organisations. This coalition as a collective platform intends to act as a knowledge sharing resource body and furthering to deepen the health, nutrition and women's economic empowerment outcomes of government flagship programmes like NRLM, NHM, ICDS. UJAS as a national coalition emphasizes its work particularly in context with the vulnerable and marginalised communities like Dalits, Muslims and Adivasis. Oxfam India is the Secretariat of this National Coalition.

Chapter 2: Methodology

The study was designed to understand the status of primary health and nutrition service delivery and accessibility of these services by the community during the lockdown months of April and May 2020.

The survey was conducted with primary health and nutrition service providers and community people. The survey prioritised access and availability of services for non-Covid diseases, routine and emergency health services, and status of malnutrition, SAM children and hunger management.

For the interviews of service providers at the government facilities, several detailed structured questionnaires were developed. Grassroots organisations that are members of JSA, RTF and BVHA were identified for data collection.

The investigators / monitoring officials from grassroots organisations were also provided online training on survey tools.

The data after analysis, indicated the following:

1. Necessity of health services in the community for other than coronavirus infection during COVID-19 pandemic.
2. Trend of health seeking behaviour of people from different community during the pandemic.

1. Sample

The survey was conducted in 18 districts under all the nine divisional commissionaires of Bihar. The districts identified are:

Sl. No.	Name of District	Sl. No.	Name of District
1	Patna	10	Samastipur
2	Nalanda	11	Saharsa
3	Gaya	12	Supaul
4	Nawada	13	Kishanganj
5	East Champaran	14	Bhagalpur
6	Vaishali	15	Banka
7	Siwan	16	Munger
8	Gopalganj	17	Lakhisarai
9	Darbhanga	18	Araria

In each of these districts 2 blocks were selected to cover the facilities of health and nutrition service providers. The total universe of the study was:

Total Sample Universe:	Numbers:
Primary Health Centres (PHC):	36
Health Sub Centres (HSC)/Health and Wellness clinics:	72
Anganwadi Centres (AWC):	144
ASHA workers:	144
Beneficiaries:	144

Nutrition Resource Centres (NRCs):	18

2. Sampling

Multistage sampling was done. The 18 districts which were spread over nine administrative divisions were selected purposefully. One of the reasons behind selecting the districts for the study was that in all these districts JSA, RTF and BVHA members were present. During this pandemic situation, the operational areas of the organisations of UJAS Coalition conducting this study was the primary criteria for sample selection. Conducting the study in other locations would have been difficult for the field surveyors as well as the respondents. The sample size was selected randomly:

Block PHCs	2 in each district
Block Manager	1 in each district
ANMs	2 in each district
ASHAs	2 in each district
Anganwadi Workers	2 in each district
Community members	4 from two HSCs in each block PHC
Online Questionnaire for different levels of service providers/duty bearers	388
NRC	1 in each district

For administering the questionnaire on community members, five different categories of respondents were selected. They were families with:

i) Pregnant women

ii) Child below one year

iii) Child between 7 months to 36 months

iv) Child between 3 to 6 years

v) Any sick person in the family during April-May 2020.

For NRC, the questionnaire was administered to Nutrition Counsellor/Staff Nurse/ANM.

3. Tools and Techniques

Online structured questionnaire was used for the current study. It was administered on Block Health Managers (PHC), ANMs (HSC/HWC), AWW (AWC), ASHA and community members (pregnant women and mothers of children aged 6 months to 6 years), Managers (NRC). The questionnaire was also administered in 1 NRC, 2 PHC, 4 HSC and 4 AWC for assessment of quality of services provided by them to beneficiaries in 18 districts for the study. Online Google forms were used to prepare the questionnaire for six different types of respondents. Among them, five forms were for duty bearers and one for the community.

The interviews with duty bearers were conducted based on secondary data source, whereas the interviews of the beneficiaries were based on recall of the patients/caregivers. Proper consent was taken prior to data collection. Observations, field notes, online structured questionnaires, mobile phones were used as techniques for data collection.

4. Data Collection

A one-day online training workshop was organised on Google Meet for the investigators on each of the six forms. The feedback and questions were addressed in detail after training on each form. Prior to final data collection, field-testing of the questionnaire was also conducted. The final data collection was done during the months of July and August 2020.

Data quality assurance was also taken care through logic check, spot check (date time and location stamp in each submitted form) and back check (responses other than options were checked).

Data accuracy "confidence interval" was supposed to be about 95% due to fixed responses except exceptional cases for which "other response" have been captured exactly as answered by the respondents.

- Relative precision was presumed to be ±20% to ±10% (for different FLWs to Community level respondents)
- Type-I error or α was taken as 0.05.
- Type-II error or β was considered as 0.2 (power=0.8)
- Using these assumptions, the estimated sample size turned out to be 396. Considering a design effect (due to Covid-19 lockdown) of 2% to 5% non-response, the required sample size was inflated to 338.

5. Data Analysis

Different Software packages like online Google forms, MS excel, and Statistical Package for Social Sciences (SPSS) were used for data collection and data analysis. Simple statistical techniques such as frequency, cross tabulation, and percentage have been used for quantitative analysis of data/information with GUI representation through graphs and tables. The field notes and observations were also utilised by the study team during data analysis as supporting evidence.

Chapter 3: Results & Findings of the study

As one deadly disease spreads throughout the world, immunization efforts must continue to prevent outbreaks of other diseases says WHO.

A detailed discussion about the results and findings of this assessment done across 18 districts of Bihar on the status of primary health and nutrition delivery services during the lockdown months of April and May, 2020, is addressed in this chapter. This complete

discussion with the data analyses is divided into 4 sections:

I. Status of primary health services
II. Status of primary nutrition services at Anganwadi Centre
III. Access to food during lockdown period
IV. Situation of frontline workers during lockdown

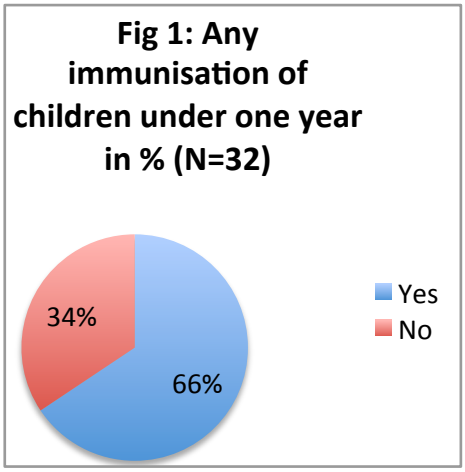
These sections are discussed below along with their various intersections to understand the complete scenario.

I. Status of Primary Health Services

Immunization

Immunization is an essential component of health services and needs to be continued to protect children and pregnant mothers from Vaccine Preventable Diseases (VPDs). [Immunization Services during and post COVID-19 Outbreak, M/o Health and Family Welfare, GoI]. Immunization is one of the most cost-effective public health interventions to date, avoiding an estimated two to three million deaths every year [UNICEF, Immunization, July 2019].

The study intended to evaluate the status of immunization and growth monitoring services of the children in Bihar during the lockdown period April and May 2020 due to COVID-19 pandemic. Based on replies from members of the community, it is evident that more than one-third children under one year of age missed their immunization and nearly half of the children's growth was not monitored during lockdown period of COVID-19.



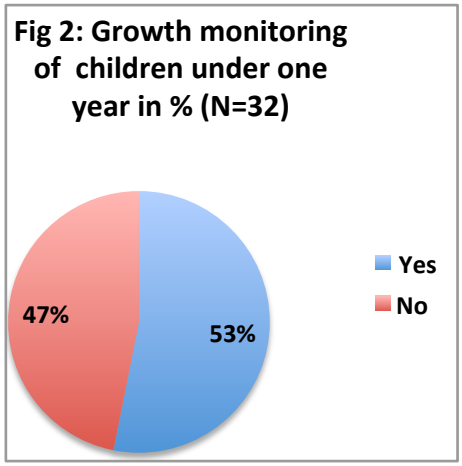
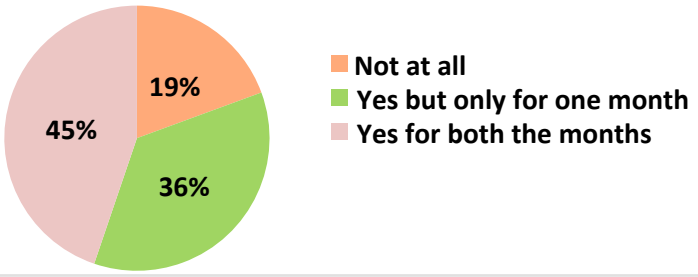
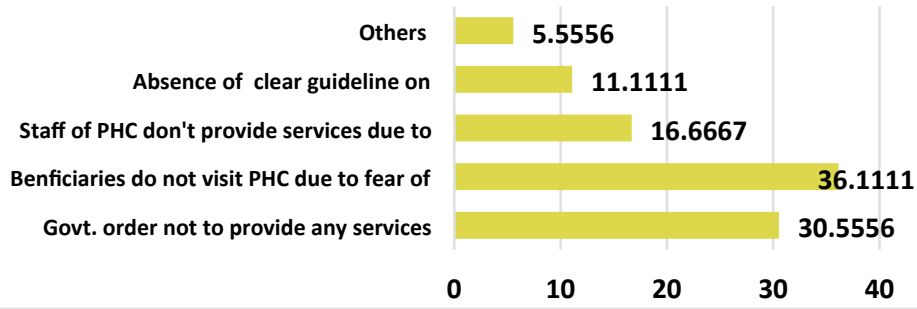


Fig 3: Immunization session held (N=67)



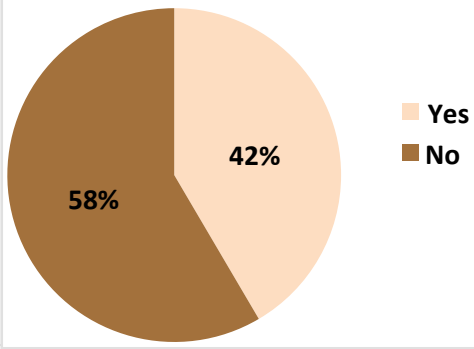
ANMs were enquired about the regularity of immunization sessions during April-May 2020 lockdown. Less than half of the ANMs (45%) informed that immunization sessions were held regularly as per the schedule. However, the majority (55%) was divided in their response with responding that either no immunization session was held (19%) or were irregularly held (36%) during lockdown.

Fig 4: Reasons for not organising sessions of Child Immunization (N=36)



According to the ANMs, majority of the community members did not visit health facility (PHC) due to fear of COVID-19 pandemic. In addition, there was lack of clarity regarding the government orders about providing services, which was followed by fear among the PHC staff members for providing services. Absence of clear guidelines on immunization also contributed for the decline in immunization session. All these together led to the substantial fall in immunization services for the children.

Fig 5: Due List prepared for Child Immunization (N=65)

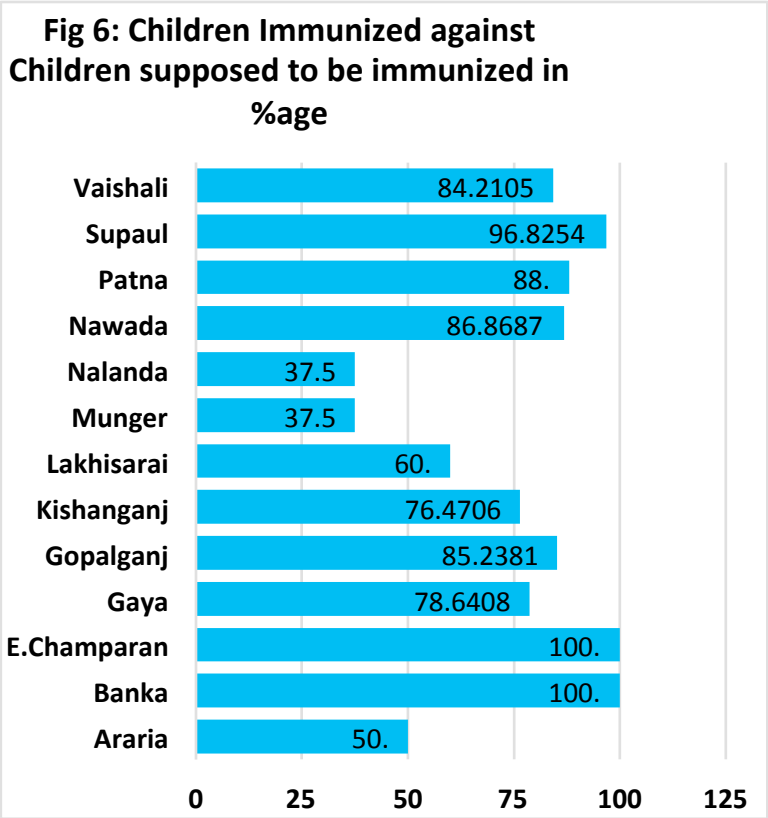


At the same time, there was also shortfall in preparation of due list for immunization. When ANMs were enquired about preparation of due list for immunization of children, majority of them (58%) said that no due list was prepared. Only about less

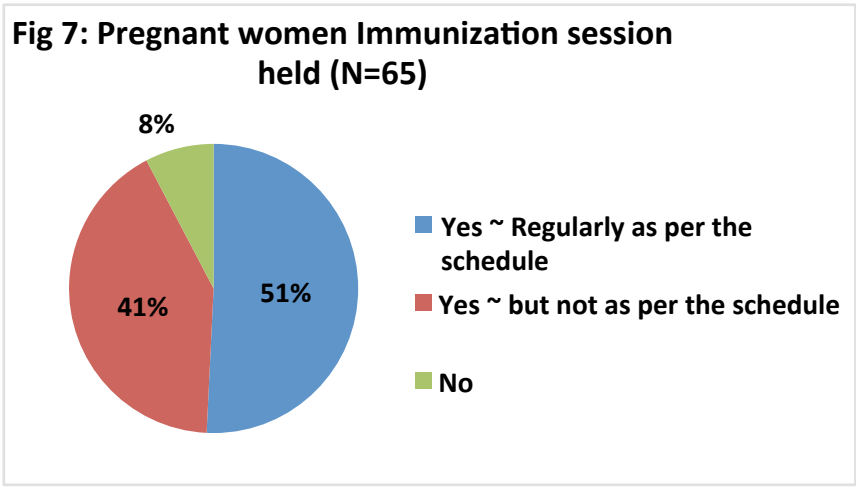
than half the ANMs (42%) confirmed that they had prepared the due list.

Analysis of the data reveals that only 73% of children were immunized against the total number of children that were supposed to be immunized as per the due list in Bihar during April-May 2020.

A district-wise segregation of the lapse in child immunization coverage gives a more compact idea. There is extreme variation in coverage with two districts covering only 38% child immunization targets while Banka and East Champaran districts reported to have completed cent percent coverage.

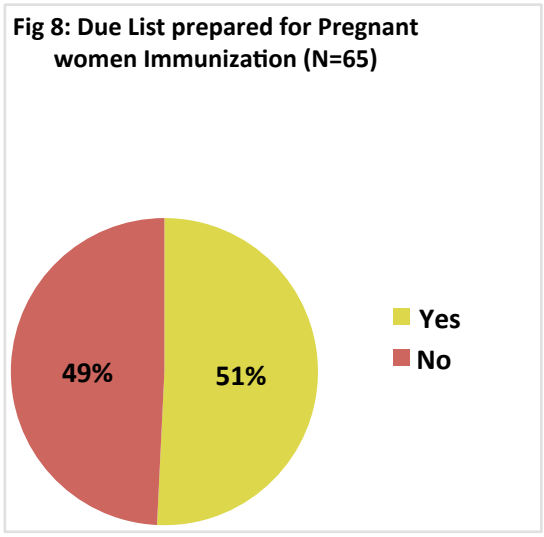


There is lapse in almost all the districts depicting the immunization coverage shortage and indicating the horrific future outcomes of this shortfall for the children.



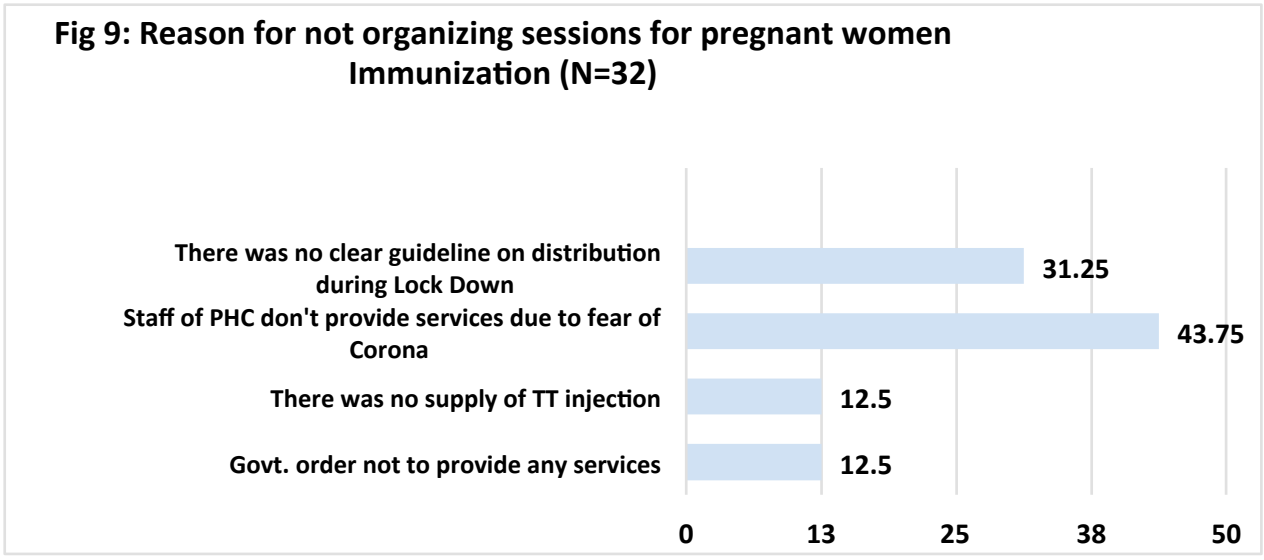
The shortfall for immunization of pregnant women was also more or less similar like the children. 41% of the sessions were irregular and 8% were cancelled which

totals to 49% of the sessions being irregular or not held for pregnant women. The situation is grim, to say the least.



51% of ANMs confirmed that due list was prepared for immunization of pregnant women during April-May 2020 COVID-19 pandemic. Rest of 49% ANMs said that no due list could be prepared for immunization of pregnant women during that time.

After analysing the data, it became evident that only 409 pregnant women (45%) were immunized as against 919 pregnant women who were supposed to be immunized as per the due list. This implies a massive 55% of the pregnant women missed their immunization sessions which are extremely vital during pregnancy. Even for the remaining 45%, the above data, clearly shows that whatever sessions held were also majorly irregular indicating the faltering of time gaps between the immunization doses for these women.



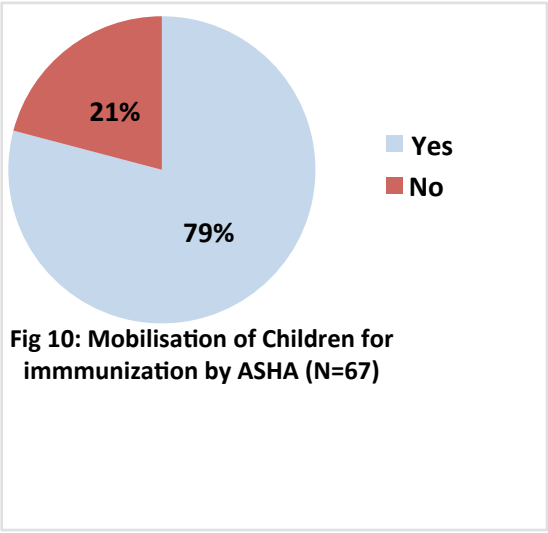
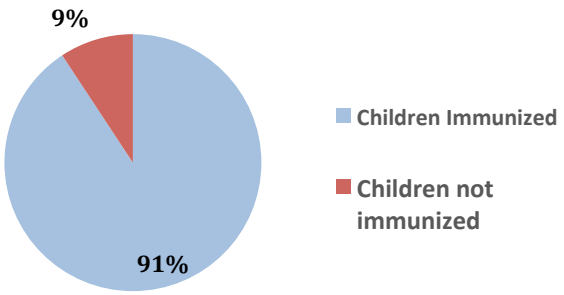


Fig 10: Mobilisation of Children for immmunization by ASHA (N=67)

Expectedly, the reasons for not organising immunization sessions for pregnant women are similar as that for the children. The data analysis reveals that fear of coronavirus pandemic among the staff of PHC was the most important cause (44%) for not providing immunization services to pregnant women. The absence of clear guideline from the government was another important reason (31%) for not holding immunization sessions. Non-supply of TT injections and lack of clarity regarding government's order to provide any services were other reasons for not conducting these sessions.

ASHA workers played a commendable job during this pandemic. 79% ASHAs confirmed that they facilitated mobilisation of children in their catchment area during April-May 2020 lockdown.

Fig 11: Child immunization by Target



ASHA workers reported that 91% of the children i.e. 1008 children got immunized out of 1111. Similar results were said to be achieved for pregnant women mobilisation by the ASHAs during this period.

This extreme contradiction of information between ANM, ASHA and AWWs show that there was major mismanagement of data keeping regarding immunization

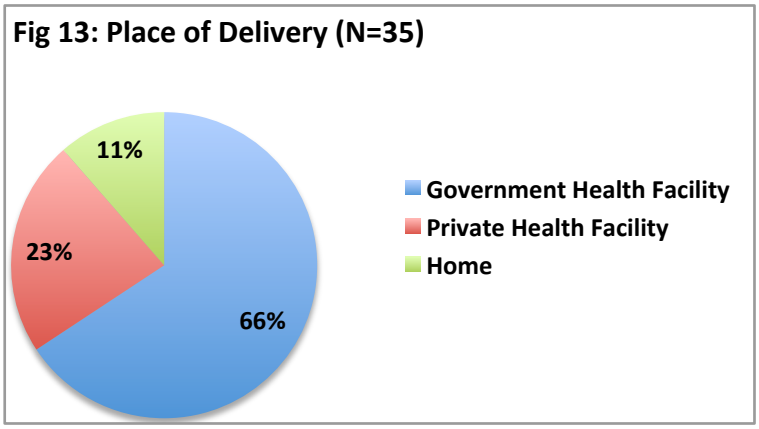
According to ANMs 73% of children were immunized against the due list, ASHAs are telling 91% children have been against the targeted children to be immunized, and AWWs are claiming that regular immunization sessions were held in only in 45% AWC!!!

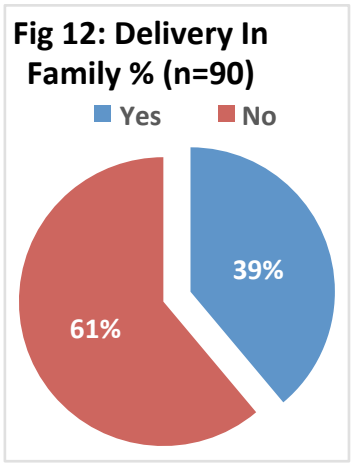
sessions for both children and pregnant women during this period. At the end of the day, it is the children and the women who were the victims of this confusion and mismanagement.

Maternal Health Services

Out of a sample size of 90 women, 39% responded that they had a delivery during the lockdown period. However, even during the lockdown period, 89% of the deliveries happened in institutions. Out of the total deliveries, 66% responded that baby was delivered in a government health facility.

23% deliveries were at private health facility, and the remaining 11% were delivered at home. The data was further analysed to discover the reason for not visiting the government health facility.

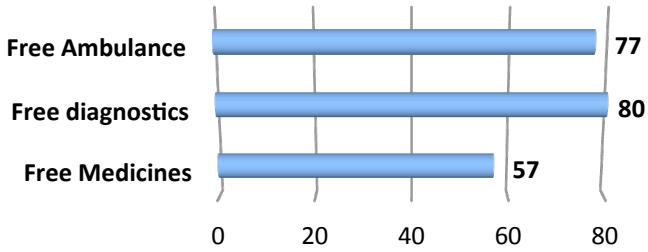




Majority of them revealed that they had first visited the government health facility for delivery but were either refused admission or were referred to other health facility, owing to which they were forced to go to the private health facility. Other reasons for not visiting the government health facility for delivery of child included non-functional government health facility or lack of transport. During the period of lockdown, which was an unprecedented blow to people's lives and health and with means of sustenance reduced to a bare minimal, having compelled to go to a private health facility goes on to create further burden on the already burdened shoulder of the rural mass.

Not only for delivery, but pregnant women also faced lot of gaps in accessing other government services. There was major disruption in availability of medicines, diagnostic services and ambulance facilities. All these services are supposed to be provided free of charge at the government health facilities and the lockdown period witnessed major disruption of these services. The study shows that 43% of the pregnant women did not receive free medicines during delivery in the government health facility. 20% said that they had to get diagnosis done outside the health facility and 23% respondents said that they did not get free ambulance service to take the expectant mother to government health facility. Lapse in receiving ambulance services also led to rise in home delivery figures during this time.

Fig 14: Free services availed at government health facility during delivery in % (N=23)



Home visits were very challenging for the frontline workers during the study period. 52% of the ANMs responded in affirmative when they were asked whether they made home visits for post-natal care of critical cases. Remaining (48%) said that either they did not go for home visits or were irregular in their home visits, which indicates the lack of care the women and new-borns received during their post-natal period.

Fig 16: Home visits for Post Natal Care (N=67)

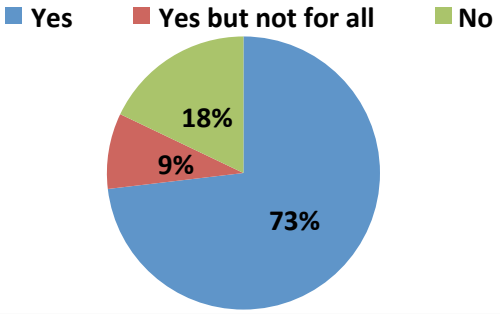
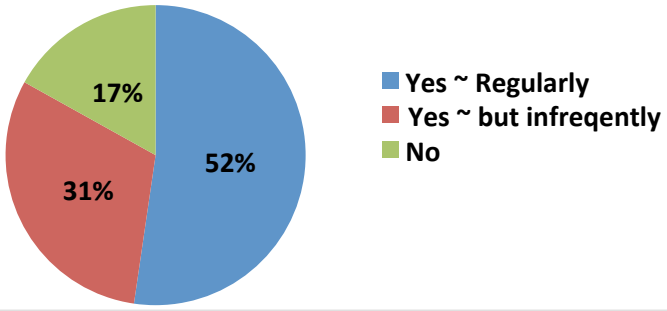
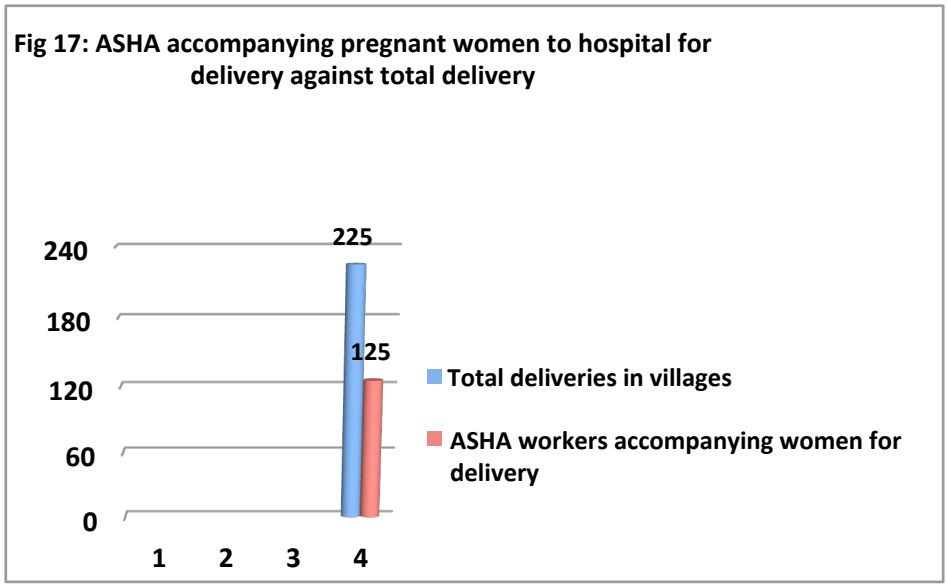


Fig 15: Home visit for PNC of critical cases (N=65)



Similarly, more than one-fourth (27%) of ASHAs responded that their visits could not be made to all women and children going through post-natal period.



According to ASHAs the main reasons (six out of every 10 ASHA) for not undertaking PNC visits was either the women did not want them to visit their home during COVID-19 pandemic or they themselves were afraid of visiting their home due to fear of the virus.

ASHAs get incentives for accompanying pregnant women for delivery. This ensures safety of the pregnant woman and the to-be born child and at the same time gives incentive to the ASHA. However, the pandemic led to a change in this too. Data shows that only 56% women were accompanied by ASHAs to a health facility for delivery.

More than half of the ASHAs (56%) told that they did not accompany pregnant women due to fear of COVID-19 pandemic. Another important reason cited by ASHAs for not accompanying pregnant women to health facility were lack of transportation facilities and fear among beneficiaries due to pandemic.

Access to Government Health Facility in case of any illness

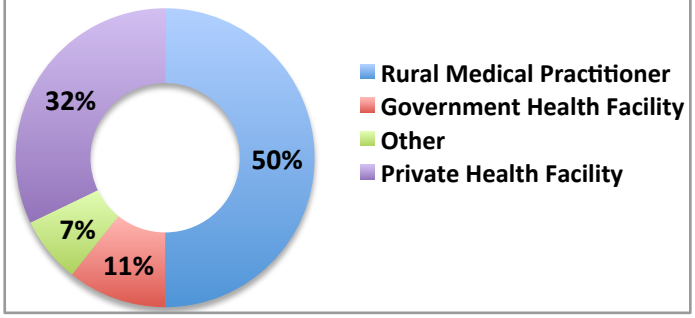
COVID-19 pandemic has dramatically changed how outdoor patient care was delivered in health care facilities in Bihar. The lockdown affected transportation, access to health care facilities, availability of medicines and consumables as well as outdoor patient and services for patients who were hospitalised. The maintenance of essential healthcare services for outdoor

patient during the aftermath of COVID-19 pandemic is a major public health challenge. It was observed that the provisions of essential outpatient health care service were disrupted in a significant proportion at PHCs, CHCs and District Hospitals across the state.

As per HMIS, NHM, the total number of OPD at public health facilities came down from 18410389 (Apr-Jun 2019) to 62, 28,993 (Apr-Jun 2020).

OPD	Apr-Jun 2020-21	Apr-Jun 2019-20
OPD (Ayush + Allopathic) (Number)	62,28,993	1,84,10,389
OPD (Patient Visit) (HMIS-SHSB)	743831	2450805

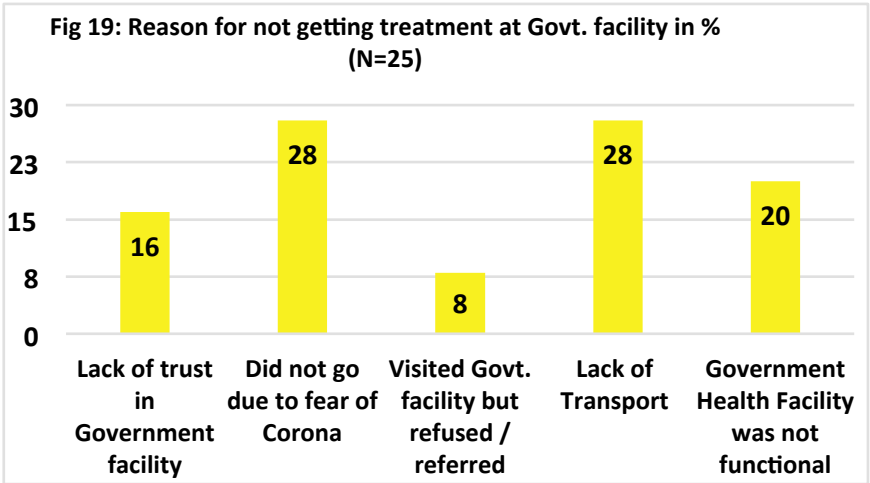
Fig 18:Patients seeking treatment by type of facility in % (N=28)



The survey data also reveals that only 11% visited a government health facility to seek treatment in cases when they fell ill. Half of the respondents said that they went to rural medical practitioner to seek treatment; whereas one-third respondents chose a private health facility to get treatment in case of illness.

When probed further for the reason for not visiting a government health facility in

Fig 19: Reason for not getting treatment at Govt. facility in % (N=25)



case of any illness, more than one-fourth of respondents (28%) said that they did not visit due to fear of coronavirus and another 28% attributed it to lack of transport facility. Other major reasons for not going to a government health facility were non-functional government health facility and they were denied treatment at the health facility and were referred to other facility.

The complete lockdown during the two months created severe obstacles in accessing even primary health care services. People were left almost without any options, and even though the primary health centres were open, accessing them in the absence of any means of local transport became impossible.

TB Control Programme

Global health emergencies, like Severe Acute Respiratory Syndrome (SARS) and Ebola virus disease, negatively impacted TB care. [Global HIV and TB, Centre for Diseases Control and Prevention], these challenges often resulted in disruption of TB health care services, delayed diagnosis and treatment and increased morbidity and mortality for patients with TB. In Bihar, during pandemic, it was essential to reach out to those who were suffering from TB, create awareness and facilitate their easy access to the public health system during the lockdown period.

Though COVID-19 has strained the health infrastructure across India, Bihar appears to be one of the worst affected. Over 70% of the staff meant for tuberculosis control and testing were reassigned to COVID-19 duty. This has led to a massive decrease in TB notifications in Bihar this year. According to public records, on the Nikshay dashboard as many as 63,617 cases have been notified in Bihar this year (35,740 in government hospitals and 27,877 in private institutions). In the same period last year (January-September), 91,836 TB cases were notified in Bihar (58,413 in the government sector and 33,423 in the private). Overall, India has reported a 60% decline in TB notifications due to the Covid-induced lockdown. [The Print, Kairvy Grewal, September 2020]

Nearly half of the ASHAs surveyed were also DOTs provider for the treatment of TB. The data shows that 20% TB patients did not receive anti-tuberculosis drugs provided under the DOTs regimen.

Family Planning

COVID-19 pandemic has caused tremendous disturbance to health systems in the state of Bihar, disrupting access to family planning information and services too. Despite this disruption, the need for family planning remains the same. Family planning plays a critical role in the densely populated country.

As health systems shift to prevent and treat people with COVID-19, it is essential they also protect access to family planning services. The number of live births may be higher, since access to abortion services have been impacted during the lockdown period. Many women who ended up with an unintended pregnancy may be forced to carry their pregnancy to term, since they may not have been able to access abortion care. "The overall adverse impact on Family Programme in 2020 is estimated to be between (-)15% and (-)23% in terms of couple years of protection compared to 2019" [Foundation for Reproductive Health Services India].

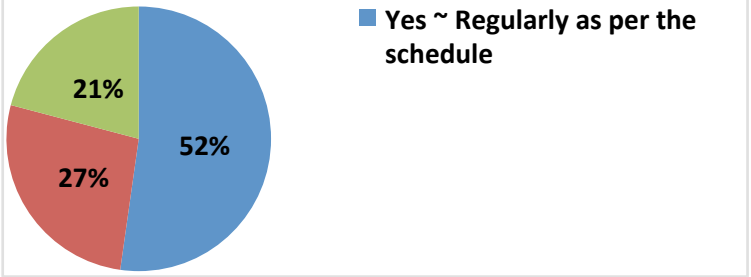
An unintended fallout of the nationwide lockdown since 25 March has been the inability of millions of women to access the services of family planning in Bihar. In April-June 2019, as per the Health Management Information System (HMIS), 37434 total sterilizations conducted, 82656 IUCD insertions done in public facilities, 2.31 lakh combined oral pills distributed and 42,201 beneficiaries of first dose of injectable contraceptive services were provided by the public sector. However, in the same period in 2020, a decline is observed for the family planning services. It is noticed that total sterilizations conducted have declined to 3820, IUCD Insertions (public facilities) to 46163, combined oral pills distribution to 1.92 lakh and first dose of injectable contraceptive were given to 15,595 beneficiaries during April-June 2020.

Family Planning	**Apr-Jun 2020-21**	**Apr-Jun 2019-20**

Total Sterilisation Conducted	3,820	37,434
IUCD Insertions done (public facilities)	46,163	82,656
Total PP IUCD Insertions done	29,866	36,414
Combined Oral Pills distributed	1,92,006	2,31,380
Emergency pills distributed	54,923	55,465
Condom pieces distributed	17,40,257	21,12,108
Number of beneficiaries given 1st dose of Injectable	15,595	42,201
Pregnancy testing kits used	1,55,555	2,25,680

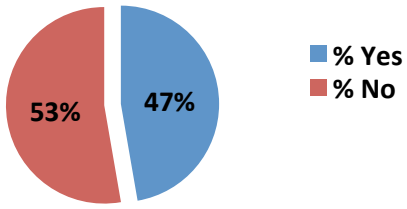
(Source: Bihar HMIS Data, 2019-20, 2020-21)

Fig 20: Distribution of Contraceptives (N=67)



During the study, ASHAs were asked about distribution of contraceptives during the lockdown period. 27% ASHAs said that it was distributed irregularly and more than one-fifth (21%) told that contraceptives were not distributed at all in their catchment area during aforesaid period totaling to almost half (48%) of the ASHAs reporting about lapses in contraceptive distribution.

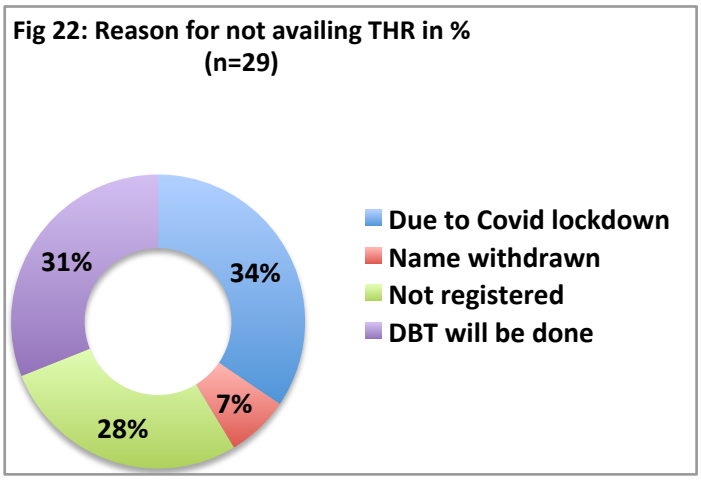
Fig 21: Did the mother Receive THR on regular basis in % (n=55)

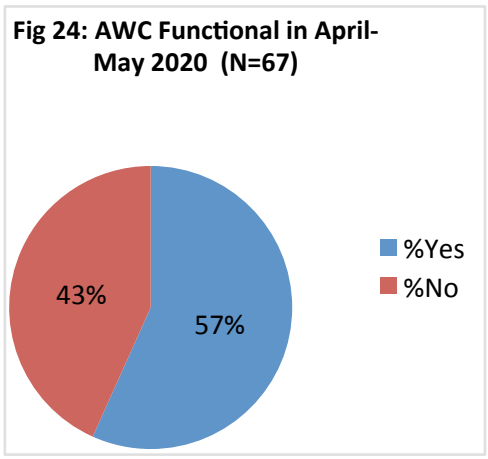


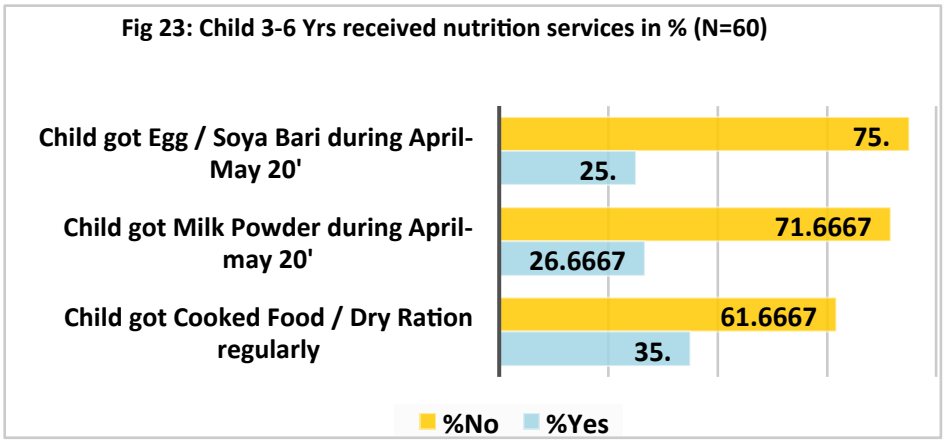
II. Status of Primary Nutrition services at Anganwadi Centre

The respondents with children between 7 to 36 months were asked whether they received Take Home Ration (THR) during lockdown period of April and May 2020. Majority of the respondents (53%) said they did not receive any THR during lockdown period.

Main reasons cited by respondents for not receiving THR were due to lockdown (34%) as Anganwadi Centres were closed and movement was very restricted during this period. Nearly one-third respondents (31%) attributed it to a supposedly cash transfers (DBT) which they had heard will be done in coming months. The data also reveals that more than one-fourth of children (28%) were not registered at the Anganwadi Centres. Thus, making universalization of ICDS services in Bihar, a huge challenge that Bihar is facing.

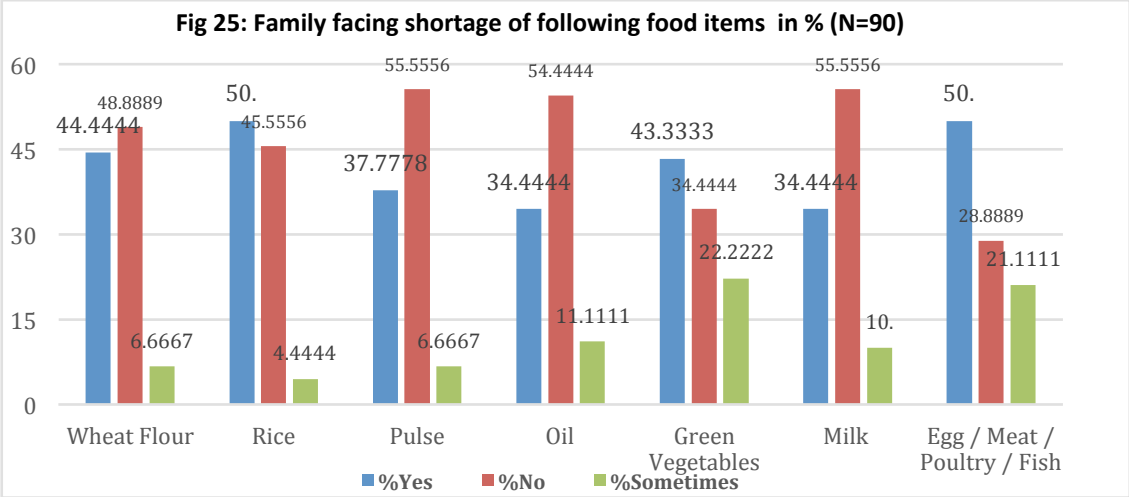






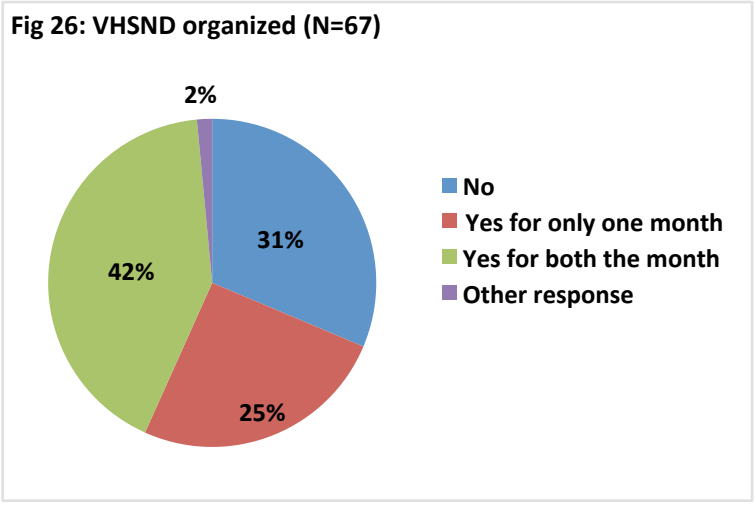
Nearly two-thirds of the respondents (62%) who had children between 3 to 6 years of age in the family informed that they neither received cooked food or dry ration during the lockdown period for their children. Nearly three-fourth of the respondents said that egg/soya *bari* or milk powder—the source of protein in diet—was not provided to children during the lockdown period. Decline in nutritional supplements from AWC was

also due to non-functioning of the centre. The data depicts that 43% of AWC were non-functional during the lockdown period of April-May 2020.



The survey also enquired about the status of food crisis faced by the families during this period. It was revealed that there was severe food crisis with almost 60% of the families reporting a dearth of basic food ingredients on a regular basis during this period. With even the AWCs, not supplying the promised THR, milk powder or other food items added with the food crisis suffered by the families during this period, it is not difficult to imagine the pathetic condition of the children, especially the malnourished ones during this period.

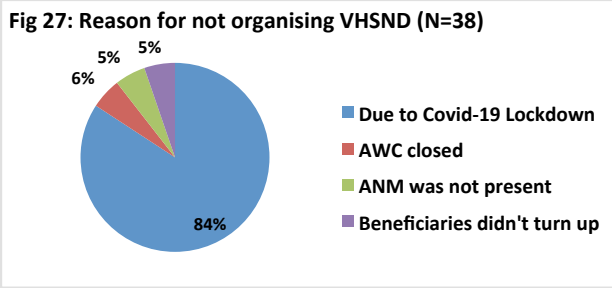
Village Health Sanitation Nutrition Day (VHSND) sessions at Anganwadi Centres



In nearly one-third (31%) of AWCs, no session of VHSND were held during April-May 2020. Whereas VHSNDs were organised for both the months in 42% of AWC, it was held only for one month in 25% of AWC. The data clearly depicts the

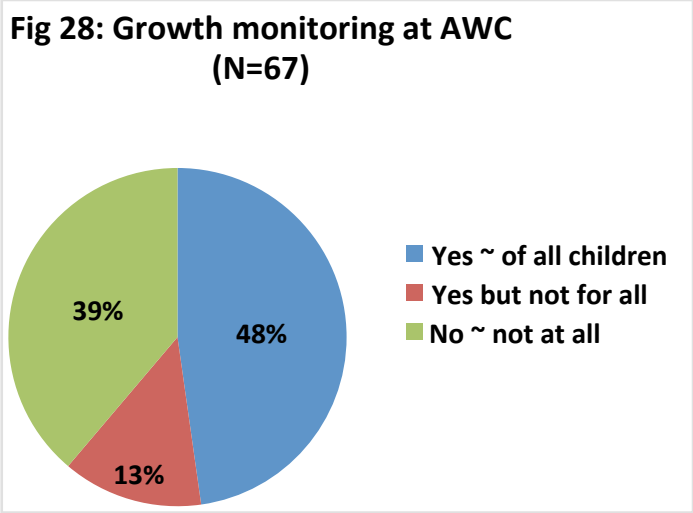
lacklustre condition of the primary health and nutrition service delivery system during these months.

Overwhelming majority of AWWs (84%) said that VHSND was not organised due to COVID-19 lockdown. Other reasons for not holding VHSND sessions were absence of ANMs, beneficiaries or AWC was closed or else the community members did not come.



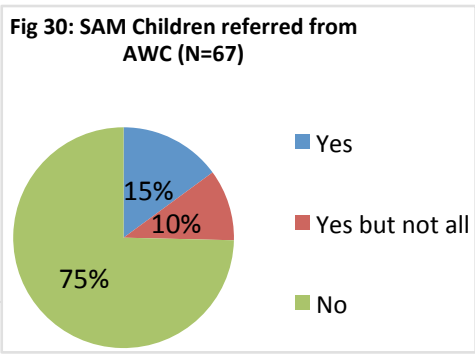
Growth Monitoring of children

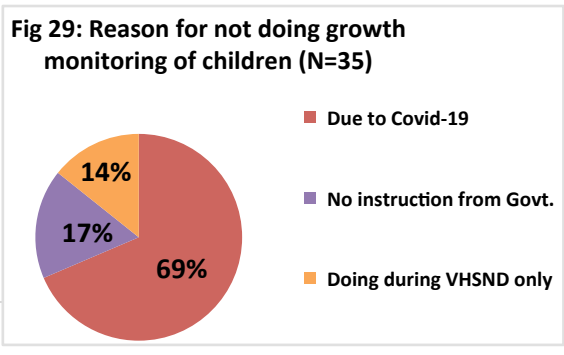
Growth monitoring was not carried out at two-fifths (39%) of AWCs for any children during April-May 2020. Another 13% of the centres reported irregularity in conducting taking the total to 52% of the AWCs not doing any growth monitoring of the children. The long-term consequences of this neglect and lapse for a state like Bihar with high child malnutrition is deadly, to say the least.



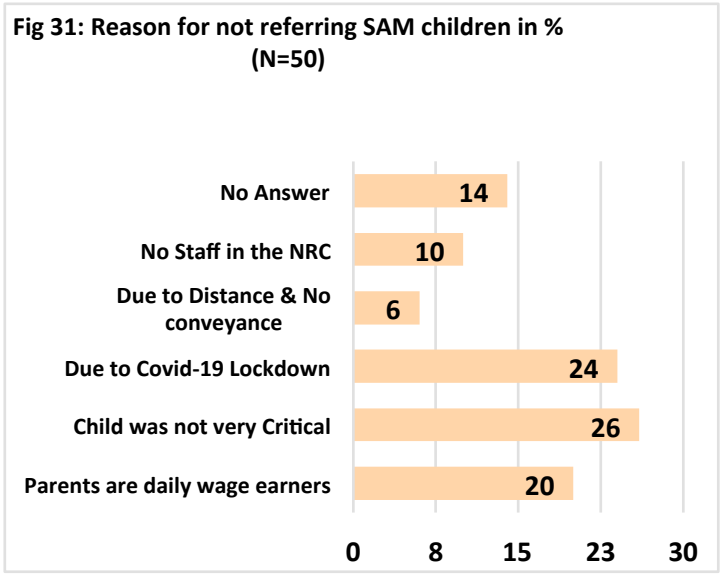
The pandemic was the foremost reason of not doing the growth monitoring in AWC (69%). Other reasons included absence of clear-cut guidelines from the government (17%) and doing it only during VHSNDs (14%).

Severely Acute Malnourished (SAM) children

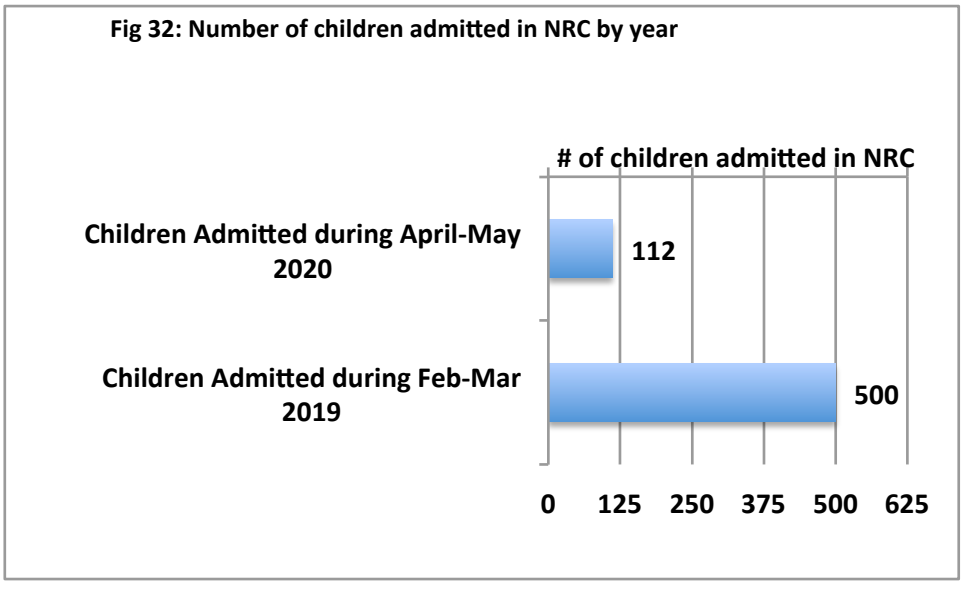




No Severely Acute Malnourished (SAM) child was referred from (75%) AWC to higher centres (PHC/DH/NRC) in April-May 2020 during lockdown imposed due to COVID-19 pandemic. The total number of children referred from remaining one-fourth AWCs was 164, of which 105 were referred to PHC, 31 to DH and 28 children to NRC.



According to one-fourth of the AWW (26%) the child was not critical enough to be referred to PHC/DH/NRC. Another one-fourth AWW (24%) cited lockdown due to Covid-19 as reason for not referring SAM children. Other important reasons told by AWW for not referring SAM children were that parents were daily wage earners and did not want to lose on their wages, understaffed NRC and absence of conveyance. There was no response from 14% of respondents.



The data depicts that there was a sharp fall of 78% in admission of SAM children in NRCs in April-May 2020 as compared to February-March 2019. Only 112 children were admitted in 16 NRCs during lockdown period of COVID-19 in April-May 2020 as compared to 500 children in Feb-Mar 2019. However, data does not depict that there has been any significant reduction in

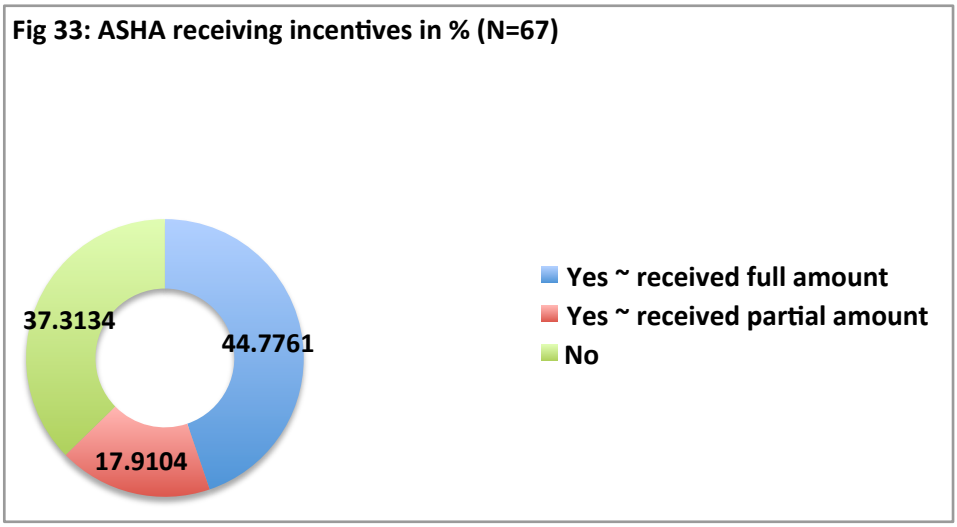
child malnutrition during this period. Thereby, the only reason for this seep fall is obviously attributed to the pandemic induced lockdown which completely left the rural populace without any access to primary health and nutrition services.

Interestingly some of the NRCs were even converted into quarantine centres during April-May 2020 for admitting suspected/confirmed cases of COVID-19 cases.

III. Situation of Frontline workers during lockdown

Bihar has been using its large workforce of ASHAs towards its public outreach efforts during the pandemic. As the country remains in lockdown, with citizens restrained from stepping outside their homes, a large army of ASHAs has been making its way towards many tasks pivoted around the pandemic control such as conducting door to door surveys, conducting awareness campaigns among people, overseeing the movement of migrants, sensitisation for social distancing etc. ASHAs have been assigned several tasks during the pandemic. Additionally, they were supposed to trace the contacts of COVID-19 patients. They also have to find out if the travel history of any person who has travelled outside or has come from somewhere recently.

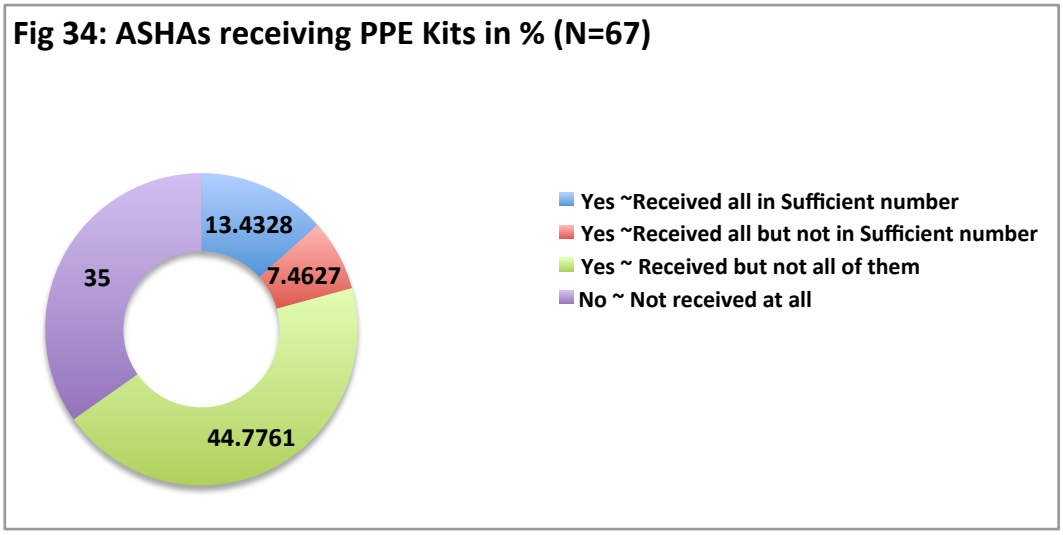
Fig 33: ASHA receiving incentives in % (N=67)



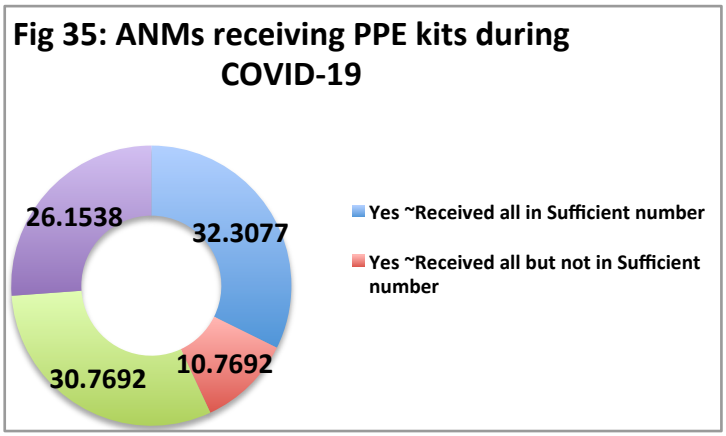
However despite putting in tremendous level of efforts and working absolutely at the grassroots level with minimal support, a basic recognition of their work—their remuneration—has been delayed. Approximately four out of every ten ASHA

(37%) informed that they did not receive their incentive for the period of April-May 2020 during COVID-19 pandemic. Roughly, two ASHAs out of every ten ASHAs (18%) informed that they have only received partial payment of incentives. The frontline cadre like ASHAs has put in huge efforts during these trying times of public health emergency. Delaying their meagre remuneration gives a huge blow to their motivation of work.

There was also gap in the safety support provided to ASHAs. The data depicts that more than one-third of ASHAs (35%) were working in the field



without PPE kits during April-May 2020 COVID-19 pandemic. Most of those who received PPE kits either did not receive all components of PPE Kits (45%) (gloves, mask, body suit and sanitiser) or were insufficient in number (7%).



A similar situation was also for the ANMs. Data reveals that less than one-third of ANMs (32%) received all components of PPE kits (gloves, mask, body suit and sanitiser) during Covid-19 pandemic in the months of April-May 2019. Another one-third (31%) said they received some of the components of PPE kit, for the remaining one-third some said

that although they received PPE kits but not in sufficient number or they did not receive PPE kits at all.

Chapter 4: Conclusion & Recommendation

The study across 18 districts of Bihar to assess the impact of lockdown on primary health and nutrition services came out with several debilitating concerns, which have been presented in Chapter 3. The following conclusions can be drawn:

- The COVID-19 pandemic and response are having profound impacts on people, leading to numerous health care challenges, a looming economic recession and humanitarian crises.
- Preventive, promotive, and curative services were severely disrupted during the lockdown period of COVID-19 pandemic in Bihar.
- There was alarming decline in the number of children and pregnant women receiving vaccines due to disruptions in delivery and uptake of immunization services caused by pandemic.
- There was significant decrease in maternal and child health services like Ante-natal check-up, Post-natal care, institutionalised delivery of pregnant women, and growth monitoring of children.
- An unintended nationwide lockdown created a challenge for the women to access the services of family planning in Bihar.
- The lockdown affected transportation, access to health care facilities and availability of medicines and consumables leading to major disruptions to outpatient and inpatient services.
- TB notification saw a massive decline in Bihar due to reassignment of duties of TB control and testing to COVID-19.
- Supply of PPE kits to Frontline health workers like ANMs and ASHAs was grossly inadequate.
- The nutrition status of children faced big challenges during lockdown due to disruption of regular Take Home Ration and serving cooked food to children. Non-functioning of many NRCs during pandemic has further worsened the problem for SAM children.

- Food security and food diversity has emerged as a big issue during lockdown period due to interruption in Public Distribution System. Even the distribution of free ration by the government during lockdown was patchy.
- COVID-19 pandemic and resulting lockdowns, economic and food security, and fear and uncertainty caused devastating impact on people's mental health.

Recommendations

- Primary health & nutrition outreach services should not be closed under any circumstances. The health and nutritional implications of this closure will be far-reaching on the population.

- In case of pandemic like COVID-19, staggered timing approach could be followed, so that for ICDS centres children can attend the centres either on rotational basis or on shifts. This will ensure that the children are within the nutritional safety net as well as receiving early childhood care. This also will have a ripple effect in ensuring reduction of child trafficking and children migrating out for work.

- In case of health camps like VHNDs, similar staggered timing approach and rotational shifts need to be planned so that crowding can be avoided yet at the same time primary health services can be extended to the community.

- In situations where there is dearth of food rations, linkages can be established with the PDS system or the local SHG groups to develop community kitchens or kitchen gardens which can be of help in times of food crisis or ration shortage.

- Since the pandemic has resulted in a lot of disruptions of primary services, with severe exclusions, it's imperative that the health workers immediately prepare a list of women and children on priority basis, and start rolling out the immunization programmes, reproductive care, childcare, adolescent care, and family planning services.

- Last but not the least, the system needs to do an internal assessment of why there had been disruption in supply of food rations to children and women during the lockdown period despite government orders. This internal assessment might help in identifying the exact gap areas in efficient rolling out of service delivery.