was a 50 per cent increase in the number of migrants who reported having spent at least one full day without eating in the previous month, with twice as many women migrants reporting this coping mechanism compared to men (12 per cent versus 21 per cent).[32,35]

The social protection system adapted programmes and policies to address poverty and food and nutrition insecurity in migrants, including providing access to food banks, emergency school meals and cash transfers. Access to the formal labour market was also extended, with new two-year work permits, and migrants were granted access to essential social services, including education.[31-33] While applications for the social protection registry previously required permanent registration, these requirements were eased to allow applicants without fixed addresses and phone numbers in Colombia. Temporary migratory documentation expiration dates were also extended to allow migrants the right to work. In one department at the border with Venezuela, the expanded social protection programme rapidly reached more than 46,000 new beneficiaries with cash assistance.[31] In-kind food baskets were supplied to another 25,000 people for whom cash assistance was not a feasible option.

→ Policy lessons learned

Both South Africa and Colombia demonstrated strong political will in adapting their social protection policies and programmes to support significant numbers of vulnerable people during the pandemic. Leveraging existing systems, South Africa and Colombia provided higher levels of support to existing target groups while also extending assistance to new vulnerable groups based on socioeconomic eligibility. Adaptations included policies and technologies that reduced the barriers to accessing social protection programmes, and a programme to target gender inequities, such as providing supplements to caregivers rather than household heads. Despite implementation setbacks, including the challenge to reaching remote rural populations, the social protection programmes in both countries demonstrated their ability to be adaptive and transformative.

MULTISYSTEM

9. Safeguarding nutrition through multi-systems action in India

India has put in place policy and legislative measures that have brought nutrition and food security to the forefront of the development agenda within a rights-based and inclusive framework. A comprehensive National Nutrition Policy (1993),[36] National Nutrition Strategy (2017),[37] the National Nutrition Mission – POSHAN Abhyaan (2018),[38] and the more recent POSHAN 2.0[39] (which brings together the Integrated Child Development Scheme (ICDS), POSHAN Abhiyaan, the scheme for adolescent girls, and the national creche programme under one umbrella) – are the key reference points for nutrition programmes across the country.

The Government's commitment to nutrition is also reflected in the landmark legislation – the National Food Security Act, 2013[40] – which makes nutrition security a human right in India. With a comprehensive set of national policies and interventions, nutrition in India is addressed through multiple sectors and ministries with separate and committed budgets and a range of programmes that directly or indirectly address malnutrition, food insecurity and poverty.

Nutrition and food security programmes are integrated into India's wide-ranging social protection interventions. While India does not have a comprehensive and articulated social protection policy or strategy, social protection is synonymous with India's long existing poverty reduction strategy and as such, is an integral part of every social sector programme that addresses inclusion and poverty reduction. This means that social protection is embedded into different sectoral ministries targeting vulnerable populations, such as women, children, adolescents and the elderly. Furthermore, social protection measures present through a mix of preventive, promotional and protective interventions and are reflected across sectors like agriculture, education and health. Social protection is delivered primarily as social assistance, both in cash and in-kind. While predominantly led and resourced by central Government, states also contribute.

Nutrition and social protection programmes in India are delivered through multiple sectors led by different ministries. For example, the Ministry of Women and Child Development and the Ministry of Social Welfare are the lead ministries, with their long running flagship schemes such as the ICDS, which supports a large-scale national

Supplementary Nutrition Programme (SNP), as well as the recent POSHAN 2.0 Programme under the National Nutrition Mission. The Ministry of Education and its Mid-Day-Meal (MDM) programme is one of the largest and longest running school meal programmes in the world. The Ministry of Health and Family Welfare implements multiple supplementation and cash transfer schemes with a focus on pregnant and lactating mothers and adolescent girls. The Ministry of Consumer Affairs, Food and Public Distribution has been distributing essential food grains at affordable prices through the Public Distribution Scheme (PDS).

In addition to these national social assistance programmes, poverty reduction and livelihoods support programmes, such as the Mahatma Gandhi National Rural Employment Guarantee Act and the National Rural Livelihood Mission under the Ministry of Rural Development, are in place to provide income support and social protection that is more transformative in nature, with the potential to contribute to sustained positive nutrition outcomes and food security.

Together, these programmes are designed to protect and promote food security and nutrition for the most vulnerable and excluded sections of the population underpinned by the principles of social protection. They aim to reduce inequalities and poverty and are delivered through multiple systems that include health, water and sanitation, education, nutrition, livelihoods, food supplies, etc.

The network of programmes and schemes have an extensive reach to households through a structured delivery mechanism from the state to the district, block and the Gram Panchayats (elected local body at the village level) and are supported by an extensive network of frontline workers – primarily, Anganwadi workers at the childcare centres, Auxiliary Nurses and Midwives at the health centres and Accredited Social Health Activists.[41]

While these efforts have led to improvements in the overall status of food security and nutrition, India is still faced with the challenge of persistent levels of malnutrition among children and pregnant and lactating women, especially in the lowest income quantile.[42,43] A high prevalence of malnourished children and women, micronutrient deficiencies alongside rising trends prevalence of non-communicable diseases, have persisted in the country, even prior to the COVID-19 pandemic.

Safeguarding income, food security and nutrition in the response to the pandemic

In response to the COVID-19 pandemic, the Government of India imposed prolonged restrictive measures that started on 25 March 2020 and were gradually lifted beginning in June 2020. The pandemic caused increased food insecurity and financial burdens and had a spiralling effect on all aspects of life and society. It also increased the risk of nutritional vulnerabilities due to service interruptions, loss of livelihoods, rising food prices and recurrent bouts of economic distress. Several studies collected data on the pandemic's impact on dietary intake among household members and found an overall reduction in meal frequency and quantity. The socioeconomic impacts of COVID-19 measures had a negative impact on household income, food security and child nutrition.[44,45]

The role for expansion of social protection at the forefront of the response strategy

The pandemic adversely affected livelihoods including employment and production and led to significant job losses in small- and medium-scale enterprises. Social protection was considered a necessary measure as a large proportion of India's population earn less than US$3 per day and live close to the national poverty line.[46] Over 90 per cent of India's workforce is in the informal sector, with limited savings or workplace-based social security, including social insurance.[47] More than 9 million migrants who traverse state borders to work annually[48] face an increased risk because social assistance programmes in India are targeted within states, with limited flexibility across states. Hence, the Government of India's response to the COVID-19 pandemic positioned social assistance at the forefront of its strategy from the outset, building on the existing multiple, nationwide social protection schemes, particularly social assistance (food and cash).

Market-driven innovations helped rebuild a disrupted food system

In India, urban and rural food systems tend to be highly fragmented, in part because of the range and diversity of stakeholders in the supply chain. At the outset of the pandemic, food systems were severely disrupted: consumer prices rose, and producer prices fell. Small scale shops and informal street vendors were able to negotiate the challenges of the restrictive measures relatively better than larger, modern retailers. As the pandemic continued, the food system was able to demonstrate some resilience, especially when the Government triggered several initiatives to protect the food system, ranging from large-scale procurement of farm produce (e.g., wheat, milk, fruits, vegetables), to employment guarantees, cash transfers for farmers and

adjusted loan repayment schedules. In addition, the private sector played a key role, including through public-private partnerships and market-driven innovations (e.g., improved use of technology to better match supply with demand).

Disruption and adaptation to enable continuity of essential services in health, education and social protection

While health and nutrition services were immediately affected by the pandemic, the system quickly adapted to ensure continuity of some services. Most frontline workers and health care institutions were repurposed for COVID-19 tracing and treatment at the outset of the pandemic in March 2020, which disrupted the provision of regular health and nutrition services. Pregnant women in particular faced difficulties in accessing health and nutrition services at the community level.

Schools were fully closed for more than six months and partially for nearly 1.5 years,[49] disrupting school-based IFA supplementation and MDM programmes. While the Anganwadi centres remained shut for a larger part of the pandemic, services like the SNP, micronutrient supplementation (IFA and vitamin A), growth monitoring and promotion and infant and young child feeding counselling continued to be provided through home visits by community-based Anganwadi workers.[50] Most states had functioning Nutrition Rehabilitation Centres for the management of children with severe wasting, but access to these centres was challenging.

Children's immunization services continued during the pandemic.[51] Similarly, while school-based IFA supplementation and MDMs were disrupted because of school closures, Accredited Social Health Activists and Auxiliary Nurses and Midwives provided IFA supplementation during home visits. Furthermore, many State governments substituted dry rations, cash payments or a combination of the two in place of the hot prepared food provided through school MDM programmes.[52,53]

Home visits and door-to-door delivery of dry rations combined with antenatal visits throughout the pandemic period continued for pregnant and breastfeeding mothers. While information on coverage of the SNP is not publicly accessible, data from the Anaemia Mukt Bharat dashboard[54] indicates a modest decline in antenatal care services throughout the pandemic period. The proportion of pregnant women registered for antenatal care at the national level were 95 per cent in June 2019, 87 per cent in June 2020 and 85 per cent in June 2021. The percentage of pregnant women receiving four or more antenatal care visits decreased slightly, from 71 per cent in June 2019 to 69 per cent in June 2020. No data are available for June 2021.[51]

Village Health, Sanitation and Nutrition Days were restored to provide essential health services. Many initiatives leveraged cross-platform messaging services to continue delivering nutrition messages and counselling. For example, the State Government of Maharashtra introduced Tarang Suposhit, a digital platform with features like a WhatsApp chatbot, broadcast call and hotline number.[55] The Government of Odisha promoted healthy eating and COVID-19 appropriate behaviour through Tiki Mausi.[56] The Department of Social Welfare in Assam devised a remote sensing and supporting supervision mechanism. The tracking of nutritional status of expectant and nursing mothers and malnourished children in Odisha during the COVID-19 pandemic was also remarkable. In Gujarat, the State Government celebrated community-based events virtually by using a variety of digital channels, including the Umbare Anganwadi digital platform (UNICEF Innovations and Adaptations).[57]

Building on established platforms, a significant expansion to protect the most vulnerable

India's social protection system demonstrated resilience through both horizontal and vertical expansion, with a focus on reaching vulnerable population groups earning less than a dollar per day. The existing large-scale and well-established social assistance and 'safety-net' programme facilitated a rapid expansion during the pandemic. The potential to safeguard nutrition was enhanced given that two important programmes were already in place – the SNP targeting children, pregnant and lactating women and the MDM programme. Furthermore, several cash transfer schemes were in place,[a] which were recognized as potential functional platforms for expansion during the pandemic.

The Ministry of Finance swiftly announced the expansion of social assistance measures in response to the pandemic under the 2020 national Pradhan Mantri Garib Kalyan Yojana (PMGKY) scheme. [59] This entailed expanding (vertically and horizontally) existing social assistance programmes and introducing new initiatives, including[60] the introduction of *the Accelerating India's COVID-19 Social Protection Response Programme*. This new support was funded in two phases – an immediate allocation of US$750 million for the fiscal year 2020 and a second allocation of US$400 million for fiscal year 2021.[61] The first allocation provided cash transfers to 320 million recipients under the PMGKAY (a food security welfare scheme) and additional food rations for about 800 million recipients.

a For example, the Janani Suraksha Yojana (JSY-cash assistance), which had evolved to become a conditional cash transfer scheme for health (2005),[58] and the Prime Minister-KISAN yojana (PMKISAN-minimum income support to farmers).

The first phase was implemented countrywide through the PMGKY scheme, scaling up cash transfers and food benefits using existing national platforms and programmes such as the PDS (800 million beneficiaries)[62] and the Direct Benefit Transfers scheme (900 million beneficiaries).[63] It provided social protection for essential workers involved in COVID-19 relief efforts and benefited vulnerable groups, particularly migrants and informal workers, who faced high risks of exclusion. In the second phase, the social protection package was strengthened through stronger engagement of state governments and additional delivery systems based on local needs, including allocating money to agricultural activities.[64] During the first and second phases, from April to November 2020, almost 300 million tons of foodgrains were distributed monthly to 750 million beneficiaries nationally (94 per cent of the target population), [65] at an estimated cost of about US$15 billion.[66]

Other expansionary efforts included: nearly doubling the entitlements for more than 800 million ration card holders from April to November 2020 through allocating an additional 5 kg of foodgrains per person each month;[67] easing the eligibility criteria for affordable food rations to include migrant workers and other poor families; and targeting employment schemes to migrant workers.

Additionally, many states initiated their own social assistance packages. For example, in Bihar, the PDS was used as a springboard to give ration card holders a one-time transfer of INR 1,000.[68] In Uttar Pradesh and Odisha,[69,70] piggybacking on the extensive network of fair price shops to distribute food grains (in lieu of in-school cooked meals) to participants of the PDS scheme (fair price shop-PDS), essential items kits were distributed through the fair price shops in Delhi and Kerala. Leveraging existing delivery systems helped save crucial time and reduce errors in distribution. Several states made their own relief packages, which enhanced this amount of ration and/or increased the selection of goods covered by PMGKAY.

The Government's unprecedented efforts helped improve food security and post-food subsidy inequity for the most vulnerable. A 2022 International Monetary Fund report found that India's in-kind food transfers during the pandemic's first year played a key role in keeping levels of extreme poverty (income of less than US$1.90) stable during the first year of the pandemic, and even in slightly decreasing post-food subsidy inequality.[46] Additionally, a study in five eastern states found that in 2020, the PMGKAY cash transfer programme mitigated food insecurity; namely, moderate food insecurity decreased by 2.4 per cent and severe food insecurity decreased by around 1 per cent.[64]

Leveraging digitalization for expansion and for women's empowerment

The Government of India swiftly mobilized and scaled up technological advancements that already existed in national social assistance programmes.[71] The presence of the Direct Benefit Transfers was a major contribution, including the development of the National Electronic Fund Management System – a unified payment system that allows payment through the national ID Aadhar number into the accounts of social assistance recipients using biometric identification, including for unskilled workers. A Mobile Monitoring System also enabled real-time updates and decision-making.

In 2020, women owned approximately 6.5 million enterprises in rural India. These enterprises are typically cash-based operations and were particularly vulnerable during the pandemic. The Self-Employed Women's Association, which is India's oldest and largest trade union, responded by teaching its members how to open a digital account and make transactions. For many women merchants, the transition to digital payments was essential in maintaining their businesses during the pandemic. In addition, the transition to digital built a valuable foundation for the future growth of these enterprises by strengthening their financial capacity and giving the owners more time to focus on building their businesses. The Government of India is also implementing digital cash transfers to support women's economic empowerment and improve their individual, family and community resilience. This effort is narrowing both a gender gap and a digital gap by giving women online access to resources, such as credit and bookkeeping, that are useful for family and enterprise finances.

Sustaining and expanding nutrition commitments for the most vulnerable following the pandemic

The Government's budget for nutrition has long been stagnant in India. However, post-COVID-19, the National Nutrition Mission – POSHAN 2.0 – was reconsolidated with Anganwadi Services (an early childhood scheme under the ICDS)[72] into the integrated nutrition support programme 'Saksham Anganwadi and POSHAN 2.0' for women and children,[73,74] and three new programmes were introduced: the Rice Fortification Pilot Project for the distribution of fortified rice in one district in each of the 15 states; the One Nation programme to assist households, particularly migrant workers, to access food rations under the PDS; and the National Millet Mission for incorporating use of millet under the National Food Security Act.[75]

→ Policy lessons learned

Multiple systems supporting nutrition outcomes in India have demonstrated remarkable resilience during the COVID-19 pandemic. In particular, India's existing social protection measures, such as the PDS, played a pivotal role in providing food to households and acted as a safety-net for the poor.

Indian policymakers acted swiftly to reduce the financial impact of the pandemic on family income and consumption. While there were some disruptions in essential health services, these were quickly re-established through adaptations. Schemes like ICDS and the MDM continued to function by adapting innovative approaches, such as the provision of take-home rations and the mobile delivery of essential nutrition supplies. Digital platforms and mobile applications were leveraged to disseminate information, provide updates on COVID-19 and offer guidance on nutrition and health care practices. This integration of technology helped bridge the gap between frontline workers and the populations they served.

The demonstrated absorptive and adaptive capacities and (to a lesser extent) transformative capacities of the multiple systems needed to safeguard nutrition need to be sustained and further strengthened as India continues to face multiple shocks beyond the immediate COVID-19 pandemic. Climate change, lingering socioeconomic consequences, a global cost of living crisis and high inflation are resulting in sustained risks to food security and nutrition, particularly for the poorest and those living in rural areas.

Community capacities, combined with shock-responsive policies and financing commitments – including new financing mechanisms that responded to state-specific socioeconomic profiles and inequalities – were critical in the response. A systems approach that leverages several delivery systems for nutrition, including social assistance (cash and in-kind transfers), informed by inclusiveness (gender, disability, etc.) and shock-responsiveness (climate change and environmental sustainability) and delivered through a Single Social Registry, could be a game-changer in improving the efficiency of programmes in India.

Moving forward there is a need to bring these schemes together to deliver through a single system to increase coverage, improve efficiencies and optimize resources, including ensuring greater convergence of the multiple systems that deliver for nutrition.

Given the size, complexity and diversity of India, a single model of implementation will likely not work; however, a unified framework and approach are critical, illustrating the interconnectedness of systems, combined with a flexible system and some degree of decentralization in implementation.

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