Madhya Pradesh School and *Anganwadi*-Based Mass Deworming Program

Photo Credit: Evidence Action

A Report on Round 2 of State's School and *Anganwadi*-Based Mass Deworming Program

Round Two - Report

May 2016

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ACRONYMS

ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	*Anganwadi* centre
AWW	*Anganwadi* worker
BMO	Block Medical health officer
BPM	Block Programme Manager
BSM	*Bal Suraksha Maah*
CMHO	Chief Medical Health Officer
DIO	District Immunization Officer
DPM	District Program Manager
FAQs	Frequently Asked Questions
GoI	Government of India
ICDS	Integrated Child Development Services
IEC	Information Education Communication
IFA	Iron Folic Acid
M&E	Monitoring and Evaluation
MD	Mission Director
MoHFW	Ministry of Health & Family Welfare
MoU	Memorandum of Understanding
MUD	Mop-up Day
NDD	National Deworming Day
NHM	National Health Mission
NIPI	National Iron Plus Initiative
ORS	Oral Rehydration Salts
RBSK	*Rashtriya Bal Swasthaya Karyakram*
SDMIS	State Drug Management Information System
SMS	Short Message Service
STH	Soil Transmitted Helminths
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WCD	Women Child Development
WIFS	Weekly Iron Folic acid Supplementation
WHO	World Health Organization

Executive Summary

The state of Madhya Pradesh dewormed 1,38,88,604 children between 1-19 years old during the Government of India's second National Deworming Day (NDD) on February 10, 2016. NDD was implemented in 41 districts across 1,21,534 government and government aided schools, 2,718 private and private aided schools[1] and 63,832 *anganwadis* and was followed by a mop-up-day on February 15, 2016. The state's achievement is the outcome of exemplary leadership from the Department of Health and Family Welfare and the joint efforts of the Department of Education, Women and Child Development (WCD) and Department of Tribal Welfare. Evidence Action's Deworm the World Initiative provided key technical support to program implementation, through funding received from the United States Agency for International Development (USAID).

Table 1: Key Achievements from the School and *Anganwadi* - based Deworming Round 2 in Madhya Pradesh

Indicators		Results	% Coverage
Total number of children targeted		1,52,71,305	-
No of enrolled children (classes 1-12) dewormed	Government Schools	76,24,364	90
	Privte Schools	6,97,367	87
Number of registered children dewormed (1 to 5 years) at AWCs		45,26,409	95
Number of unregistered children dewormed (1 to 5 years) at AWCs		2,85,787	71
Number of out-of-school children (6-19 years) dewormed		7,54,677	87
Total number of children dewormed (1-19 years)		1,38,88,604	91

Source: Report submitted by National Health Mission (NHM) MP to GOI dated March 22, 2016 **(Annexure A). NDD 2016 was implemented in 41 out of 51 districts in the state as** 10 districts are Lymphatic Filariasis(LF) endemic and Albendazole was administered in these districts under the National Filaria Control Program (NFCP) districts in the month of December 2015. As the NFCP doesn't cover age 1-2 years, the state took the decision to cover 1-2 years and left out children from 2-19 years from the LF MDA round under NDD. The coverage from the same is reported separately.

Building upon the success of first phase of NDD in 2015 in 11 states[2], including Madhya Pradesh, the Government of India (GoI) scaled up NDD 2016 across India targeting 27 crore children in 30 out of 36 states and Union territories. Evidence Action worked in close association with the GoI's Child Health Division to plan and implement round two of NDD. In the state of Madhya Pradesh, Evidence Action continued comprehensive technical assistance for the successful implementation of NDD, with learnings from previous rounds to guide program planning. In line with the NDD 2016 guidelines revised to call for inclusion of private

[1] In four districts of the state, private schools and centrally affiliated schools also observed NDD- these are Bhopal, Raisen, Sagar and Burhanpur

[2] Assam, Bihar, Chhattisgarh, Dadra and Nagar Haveli, Haryana, Karnataka, Maharashtra, Madhya Pradesh, Rajasthan, Tamil Nadu, and Tripura

schools, the state engaged private private-aided and centrally affiliated schools as a pilot effort in four selected districts. Learnings from this round, especially private school engagement and strategies to reach out-of-school children, will contribute to a sustainable deworming program that aims to reduce the prevalence and intensity of worm infections for all school-age and preschool-age children in the state.

1. Program Background

In India, approximately 22 crores children between the ages of 1 and 14 are at risk of parasitic intestinal worms (known as soil-transmitted helminths or STH). The infected children represent approximately 68% of Indian children in this age group and 28% of all children at-risk for STH infections globally, according to the World Health Organization (WHO). These parasitic infections result from poor sanitation and hygiene conditions, and are easily transmitted among children through contact with contaminated soil. Various studies have documented the widespread and debilitating consequence of chronic worm infections, which cause anaemia and malnutrition among children, affecting their physical and cognitive development. Worm infections contribute to absenteeism and poor performance at school, and in adulthood, diminished work capacity and productivity.[3]

1.1 A Cost-Effective Win for Education: Deworming Through Schools

Evidence from across the globe shows that deworming leads to significant improvement in outcomes related to children's health, education, and long-term well-being. In 2008 and again in 2012, the Copenhagen Consensus Centre identified school-based deworming as one of the most efficient and cost-effective solutions to the current global challenges. School-based deworming is considered a development "best buy"[4] due to its impact on educational and economic outcomes. The existing and extensive infrastructure of schools provides the most efficient way to reach the highest number of children, and teachers, with support from the local health system, can administer treatment with minimal training. Preschool settings are often used to provide children with basic health, education, and nutrition services, making this a natural, sustainable, and inexpensive platform for deworming programs.[5] The benefits of using such platforms for deworming are immediate. Regular treatment can reduce school absenteeism by 25%.[6] Young siblings and others who live nearby treated children but were too young to be dewormed also showed significant gains in cognitive development following mass school-based deworming.[7]

1.2 Deworming Children in India

Deworming children is part of the Government of India's school and preschool health programs, such as the Weekly Iron-Folic Acid Supplementation (WIFS) program which

[3] "Helminth control in school-age children- A guide for managers of control programmes": WHO, 2011

[4] http://www.povertyactionlab.org/publication/deworming-best-buy-development

[5] http://journals.plos.org/plosntds/article?id=10.1371/journal.pntd.0000223#pntd-0000223-g003

[6] Miguel, Edward and Michael Kremer. "Worms: Identifying Impacts On Education And Health In The Presence Of Treatment Externalities," Econometrica, 2004, v72 (1,Jan), 159-217.

[7] Ozier, Owen. "Externalities to Estimate the Long-Term Effects of Early Childhood Deworming." Working Paper, Jun. 2011. http://economics.ozier.com/owen/papers/ozier_early_deworming_20110606a.pdf

provides a weekly dose of Iron Folic Acid (IFA) with biannual deworming for adolescents (10-19 years).[8] National Iron Plus Initiative (NIPI) is a national anaemia control program which offers IFA supplementation and deworming for a wider age group of 1-45 years, including preschool-age children who also receive Vitamin A. Until recently, only a few states ran effective school and preschool (*anganwadi*)-based deworming programs with good coverage. Many had sporadic deworming efforts and low coverage, while in other states no deworming programs existed. Considering this complex environment and the clear need to accelerate treatment for India's children, the Government of India renewed its focus on deworming by streamlining efforts through a fixed-day school and *anganwadi*-based National Deworming Day.

1.3 State Program History

The deworming program in Madhya Pradesh was broadly aligned with two pan-state programs: NIPI[9] and *Bal Suraksha Maah* (BSM).[10] Prior to the launch of NIPI, adolescent girls aged 10-19 years were administered IFA and biannual deworming through the WIFS program, launched in 2013. Since the same stakeholders supported both WIFS and NIPI, the two programs were coupled together. In addition, the National Filaria Control Program (NFCP) provides community-wide administration of albendazole, the same drug used for treatment for STH, along with diethylcarbamazine citrate (DEC) on an annual basis.

The state had been previously administering deworming drugs through these existing programs, but efforts were disjointed and sporadic. Since previous coverage was low, a fixed-day approach through a comprehensive program like NDD was necessary to achieve the WHO goal of treating at least 75% of at-risk children. The fixed day approach was facilitated through a Memorandum of Understanding (MoU) signed on June 11, 2014 between the State Health Society, National Health Mission (NHM), Government of Madhya Pradesh, and Evidence Action wherein Evidence Action provides technical assistance to the state-implemented program.

To develop an appropriate STH treatment strategy, Evidence Action obtained support and approvals from State NHM and Education Department to conduct an STH prevalence and intensity survey among children enrolled in government primary schools. Based on the data collected, the overall weighted prevalence of any STH in Madhya Pradesh was calculated as 12.2%. Based on the findings of the prevalence survey, an annual school-based deworming program for school-age children is recommended in the state. Thus, the government modified the biannual deworming strategy for NIPI and BSM to an annual deworming round, to be covered under the aegis of NDD, under the larger umbrella of the NIPI program. NIPI state and district level committees, include NDD as an agenda item and are leveraged as an effective platform for NDD planning and implementation.

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[8] http://www.nrhmhp.gov.in/sites/default/files/files/Iron%20plus%20initiative%20for%206%20months%20-5%20years.pdf

[9] NIPI launched in 2014, an anaemia control program included a biannual deworming component. The service delivered deworming treatment to children ages 1- 19 years through schools and AWCs while pregnant and lactating women, and women of reproductive age are treated through community-based drug administration

[10] BSM is the state's biannual month-long program to increase overall health status of children under the age of five. BSM was launched in 2001 and offers comprehensive services such as immunization, micronutrient and iron supplementation, and deworming (beginning in 2008) at AWCs.

The state conducted its first NDD round on February 10, 2015 followed by four mop-up-days[11] with a reported coverage of 89%.[12]

1.4 Learnings from Madhya Pradesh NDD 2015 Round:

To enhance program quality and outreach in 2016, the state health department took note of the key findings and recommendations from the previous NDD round. One of the key change this year was the fixed day administration of albendazole to all children aged 1-19 years, unlike last year when preschool-age children were covered under the month long program. The fixed day NDD approach provides an easy, cost-effective way to reach large numbers through leveraging existing channels. Some of the key learnings from the NDD 2015, included the necessity of stronger program planning through timely steering committee meetings, and finalization of drug and IEC plans to strengthen integrated distribution of drugs, training, IEC materials, and reporting forms during block level trainings. In the 2015 round, lack of awareness of training dates was a common reason for non-attendance. As a result, in the 2016 round the Department of Health and Evidence Action sent out text messages to all district, block officials from all stakeholder departments as well as teachers and *anganwadis* workers, with reminders of the planned training dates and other key messages about deworming.

2. About National Deworming Day

Deworming in India reached a key milestone when the national government launched NDD on February 10, 2015. The first phase of NDD targeted all children aged 1-19 years in 11 states/union territories[13] through the network of government and government-aided schools and AWCs, achieving national coverage of 8.9 crore children. After this unprecedented coverage, in November 2015 the Ministry of Health and Family Welfare (MoHFW) announced that NDD would be expanded across all 36 states and UTs from February 2016.

In preparation for the 2016 round, on October 27, 2015, the Child Health Division held a technical review meeting supported by Evidence Action in order to discuss the learnings from NDD 2015. The meeting highlighted lessons learned from participating states and included discussions on coverage data and state-level findings from Evidence Action's independent monitoring and coverage validation. Other key outcomes included standardization of target population[14] using credible data sources like Census, UDISE[15] and ASER[16]; increased incentives

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[11] Mop up day in the state was observed from February 11-14

[12] Report submitted by National Health Mission (NHM) MP to GOI for NDD 2015

[13] Assam, Bihar, Chhattisgarh, Dadra and Nagar Haveli, Delhi, Haryana, Karnataka, Maharashtra, Madhya Pradesh, Rajasthan, Tamil Nadu, and Tripura

[14] Four categories of target populations were agreed, for standard use across all states (e.g., enrolled in government schools, enrolled in private schools, registered in AWCs, or out-of-school/non-registered). This enables comparison of coverage across states.

[15] Unified District Information System for Education (U-DISE) being the only source of data for Educational Planning at Elementary & Secondary level, is implemented at the State in coordination with National University of Educational Planning and Authority (NUEPA), New Delhi since 1997-98. Through U-DISE, annual information on School, Teacher, Children & infrastructure are collected, digitized, analyzed and reported for educational planning and implementation of different activities to fill the gaps in achieving universalization of elementary education.

[16] ASER stands for Annual Status of Education Report. This is an annual survey that aims to provide reliable annual estimates of children's schooling status and basic learning levels for each state and rural district in India. ASER has been conducted every year since 2005 in almost all rural districts of India.

for ASHAs, and consensus around expanding the program to target private schools. With a high enrollment of children in private schools (29% nationally as per Annual Status of Education Report 2014 data), the government is committed to ensuring that those students have access to deworming, and receive benefits for improved health and education outcomes.

A national level orientation was subsequently organized by MoHFW with support from Evidence Action on December 1, 2015, with participation of 31 out of 36 states/UTs. The meeting was used for sharing objectives and strategies and standardizing messages and plans under the revised NDD 2016 operational guidelines for robust implementation in the second round. The MoHFW also held a coordination meeting with joint secretaries from the Ministry of Education and Women and Child Development, Panchayati Raj, and Drinking Water and Sanitation departments, focused on facilitating national-level convergence for effective implementation. Efforts at the national level further cascaded to state and districts via joint directives issued by the secretaries of the ministries of Health, Education, and Women and Child Development to the chief secretaries of all states and UTs emphasizing coordination between stakeholder departments to achieve NDD goals. In addition, the Child Health Division called a meeting of development partners working in child health to garner support for implementation of NDD 2016 in states where the partners have a presence. Evidence Action, UNICEF, and the Micronutrient Initiative attended the meeting and reiterated support for the government's NDD strategy.

As technical assistance partner for NDD, Evidence Action supported the MoHFW to update content and messaging for NDD materials including training and IEC, implementation and financial guidelines, monitoring and reporting forms, and other reference materials included in the resource kit (available on NHM website[17]). These materials enabled simplified, standardized messaging and laid out key information such as objectives, roles and responsibilities of stakeholders, and budgetary allocations for states to finance program implementation.

On February 9, 2016, the Union Minister of Health launched NDD 2016 in Hyderabad, Telangana. The State Minister of Health for Telangana and other senior officials from the national and state government participated in the launch event alongside representatives from development partners and the media. The event received extensive media coverage.

3. NDD 2016 in Madhya Pradesh

3.1 Target Beneficiaries

The program targeted all children between 1-19 years, regardless of their enrollment status, at AWCs, government, and government aided schools in 41 districts. Out-of-school children were treated through AWCs. Children enrolled in private schools were also targeted in four districts of the state during this round, bringing the overall total to 1,52,71,305 children targeted for deworming.

[17] http://nrhm.gov.in/nrhm-components/rmnch-a/child-health-immunization/national-deworming-day-2016.html

3.2 Key Stakeholders

Key stakeholders at the state level included the Health, Education, Tribal and WCD Departments and development partners including Evidence Action. Stakeholders' roles are outlined below.

Health Department- NHM, Madhya Pradesh was the nodal agency, holding key responsibilities such as finalizing target figures and ensuring transportation and distribution of albendazole at all levels. The Department of Health also trained functionaries; disseminated adverse event management protocols; printed and distributed training and Information Education Communication (IEC) materials; distributed reporting and monitoring forms; and provided guidelines and budgetary allocations to districts to support efficient implementation and timely coverage reporting. The department also facilitated involvement of ASHAs in mobilizing out-of-school children and unregistered children.

Education (Rajya Shiksha, Lok Shiksha), Tribal, and WCD Departments were responsible for providing requisitions of albendazole tablets to NHM based on school enrolment figures, anganwadi registration figures, and numbers of out-of-school children targeted at AWCs. The departments were also responsible for ensuring that trainings on drug administration and adverse event management were attended by their respective functionaries, including headmasters, teachers, AWWs, and lady supervisors. The Education department coordinated with private school unions of four pilot districts to engage private school teachers in district and block level trainings. Block level officials from the departments of Health, Education and WCD oriented frontline functionaries from education and Integrated Child Development Services (ICDS) on timely submission of standardized coverage reports to the Health Department.

Evidence Action, funded by USAID for technical support activities, worked closely with all stakeholders to ensure high quality planning and implementation of deworming. Evidence Action provided intensive support for program planning; facilitated information sharing; and worked to adapt NDD training materials, IEC products, and operational guidelines to the state context.Evidence Action also supported the stakeholders for robust program management through telecalling support and onground field team during NDD. An external agency hired by Evidence Action conducted the Independent Monitoring of the mass school and anganwadi based deworming program. (Details in the report below)

4. Program Implementation

The state implemented NDD 2016 in 41 out of 51 districts, including private and centrally affiliated schools in four districts. Ten districts endemic for Lymphatic Filariasis (LF) were excluded from NDD as these completed MDA with albendazole in December 2015. In NDD 2016, in order to ensure maximum children get dewormed, in these ten LF endemic districts, the state included children between 1-2 years, who are not targeted by the LF program, and children between 2-19 years who were not treated through the LF MDA conducted in December 2015. The state has submitted segregated program coverage data from both the programs to the MoHFW, as part of the NDD 2016 coverage report. The implementation of NDD includes several program components detailed below.

4.1 Policy and Advocacy

The Department of Health actively participated in video conferencing and review calls organized by GoI to track the level of preparations for the NDD 2016 round at the state level. The state was included as one of the panel presentations at the NDD 2015 review meeting, to share insights into the program experiences from NDD 2015 round and robust planning for NDD 2016.

Key decisions for NDD 2016 were taken at the state NIPI Advisory committee meeting held on November 23, 2015 under the chairmanship of Principal Secretary, Health, and MD-NHM, with representation from Department of Women and Child Development, Education, and Tribal Welfare Departments. Development partners were also presented by Evidence Action, Micronutrient Initiative, and UNFPA. Key outcomes of the meeting included a finalized strategy for including private and centrally affiliated schools (*Kendriya and Navodaya Vidyalas*) and detailed implementation plans for program components like trainings, drug distribution, and the reporting cascade (Annexure B). Four districts piloted private school engagement, including Bhopal due to geographical proximity to the stakeholder departments, Raisen and Sagar due to their classification as High Priority Districts[18], and Burhanpur due to its political commitment to deworm all children in the district (Annexure Ci,ii,iii). This was in line with the NDD guidance for states to include private schools for at least 10% of implementing districts.

Although in NDD 2015 the state conducted mop up activities across four days, with Evidence Action's continued advocacy and technical assistance the state adopted a fixed mop up day approach in 2016 to better manage adverse events and conduct comprehensive program monitoring. The fixed day approach for NDD and mop up day thus enabled more cost-effective program implementation.

As part of NDD preparations, Evidence Action worked with the state to adapt operational guidelines, define timelines, and clarify roles of concerned stakeholders for program implementation which were disseminated to all stakeholders. To strengthen the inter-sectoral convergence among the stakeholder departments at the district and block level, Mission Director (MD) NHM along with Commissioners of Education and WCD issued joint program directives on December 29 that outlined roles and responsibilities of all stakeholders for the smooth execution of the NDD (Annexure D). In addition to monitoring preparedness for NDD in the state, MD,NHM conducted a video conference on January 28, 2016 with chief medical health officers, district program managers, and civil surgeons. In addition, the state Department of Education directed districts and block officials to facilitate preparations at schools by clarifying responsibilities and sharing important instructions for program implementation. On February 2, 2016 in its monthly departmental video conference with district officials, the Department of Education also tracked the preparations for NDD 2016.

Increased convergence and ownership among district level stakeholders was visible through joint directives issued across 41 districts to block level officials for smooth program implementation (Annexure E). All 41 districts also organized District Coordination Committee

[18] To ensure equitable health care and to bring about sharper improvements in health outcomes, the bottom 25% of the districts in every State according to the ranking of districts based on composite health index have been identified as High Priority Districts (HPDs). (http://pib.nic.in/newsite/PrintRelease.aspx?relid=118620)

meetings (DCCM) as per District Collector's guidance[19], to fill gaps identified in program planning across all levels. Additionally, to track program preparedness, 16 district collectors conducted video conferencing with district and block level officials from January 18-22, 2016. Key decisions for program implementation were disseminated along with meeting minutes that were circulated in 41 districts. Evidence Action's field-based district coordinators facilitated and shared critical program updates and relayed information in all of these meetings. Coordination between the Department of Health and Department of Education also led to joint directives to the selected District Collectors for facilitating private school engagement at all steps, ensuring effective program implementation.

Evidence Action advocated with the Departments of Education and WCD to leverage existing resources for the deworming program in order to maximize program impact. The departments supported initiatives such as uploading deworming-related information to their websites and sending bulk SMS to program functionaries using existing portals.

In line with NDD financial guidelines, Evidence Action worked with the state health department to facilitate timely submission of 2015-16 Program Implementation Plan to the national government. The approval in the Record of Proceedings 2015-16 was assigned for all the activities under NDD including printing of training and IEC materials being approved for 51 districts. Since the state decided to implement NDD in 41 districts and not all 51 districts, the state reappropriated the approved budgets accordingly, for cost-effective implementation of NDD that was later approved under the Supplementary Program Implementation Plans.

4.2 Program Management

Evidence Action's technical assistance was primarily provided by a four-member state-based team, in addition to field-based regional coordinators and short-term hires such as district coordinators and tele-callers. Additional support and guidance was provided by the national team. Regional and district coordinators participated in the aforementioned video conference meeting, along with district officials, and were part of review meetings for program preparations. They collaborated with district and block officials to plan for trainings and other logistics around program implementation.

Regional Coordinators: Evidence Action hired five regional coordinators for year-round engagement, with each responsible for 10-11 districts. They provided program management and oversight to district coordinators, supported information sharing, led prompt remedial action in the field, guided advocacy with district officials, facilitated the training and distribution cascade, and ensured timely reporting of coverage data. After the first round of NDD was completed, their efforts shifted towards exploring opportunities at the districts for synergies with existing work and possible platforms to integrate deworming. The regional coordinators will promote program institutionalization by working with district officials to include deworming in district action plans for the next financial year (2016-2017).

District Coordinators: 43 district coordinators, including 2 additional coordinators for private school districts, provided on-the-ground program coordination for three months around the deworming round. They were instrumental in ensuring timely delivery of training

[19] Out of 41 DCCM, 25 DCCM were conducted in the presence of District collector, and in remaining 16 districts, DCCM were conducted in presence of Additional Collector. Subsequently the district collector of these 16 districts conducted video conferencing with block level officials to review program preparedness.

materials such as flipcharts, and distribution of NDD kits at the trainings for all functionaries. They participated in trainings at district and block levels and escalated any observed gaps to regional coordinators and the state team for appropriate follow-up at the state level. Their role was integral in ensuring high quality of the trainings where pre and post-tests were administered to participants. After the deworming round, they provided rigorous follow-up with block and district-level officials to support timely compilation of coverage reports.

Tele-Callers: Five tele-callers were hired to support the deworming round. Each tele-caller was assigned to work closely with one regional coordinator, as well as the district coordinators within their region. Calls were made at districts, blocks, and schools to obtain updates on drug and IEC availability, training schedules, and status of reports after the deworming round. This dynamic flow of information allowed tele-callers to generate detailed, real-time program updates which were continuously shared with state level officials and enabled any necessary corrective measures to be taken (Figure 1).

Figure 1: Snapshot of the Daily Tracker

Evidence Action Snapshot of NDD 2016 program updates as on 5th Feb 2016

District	Block	Designation of health department officer	Albendazole tablet availability	Albendazole sufficency	Training dates	Number of batches	Trainings conducted For eg. 10/ 12	Training completed and under process	Finalised date for remaining	NDD kit distributed during the training? (Poster, Banner, Handout, Albendazole)	Any Material not available under the NDD kit	Was Flip Chart Used during Training	Number of Participants called for the training	Number of Participants attended the training
Agar	Aagar	BMO	Yes	Sufficient	4-Feb	2	2	Yes	NA	yes	NA	yes	520	403
Agar	Barod	BMO	Yes	Sufficient	2-5 feb	4	2	2	Yes	yes	NA	yes	940	800
Agar	Susner	BPM	Yes	Sufficient	4feb-8feb	5	2	3	Yes	yes	NA	yes	130	123
Agar	Nalkheda	BMO	yes	Sufficient	4,5 feb to 6 feb	6	4	2	Yes	yes	NA	yes	312	245
Alirajpur	Alirajpur	BMO	Yes	Sufficient	29,25 jan	5	5	Yes	NA	yes	NA	yes	794	702
Alirajpur	Bhavra	BPM	Yes	Sufficient	22,28 jan	6	5	1	Yes	yes	NA	yes	418	301
Alirajpur	Jobat	BMO	Yes	Sufficient	28 ,29 jan	8	8	Yes	NA	yes	NA	yes	340	307
Alirajpur	Kathiwada	BMO	Yes	Sufficient	28 to 4 feb	6	5	1	Yes	yes	NA	yes	250	240
Alirajpur	Sondava	BPM	Yes	Insufficient	28 to 5 feb	4	2	2	Yes	yes	NA	yes	763	628
Alirajpur	Udaigarh	BCM	Yes	Sufficient	27,29 Jan	5	5	Yes	NA	yes	NA	yes	207	198
Anuppur	Anuppur	BMO	Yes	Sufficient	3,4,5Feb.	3	2	1	Yes	yes	NA	yes	67	67

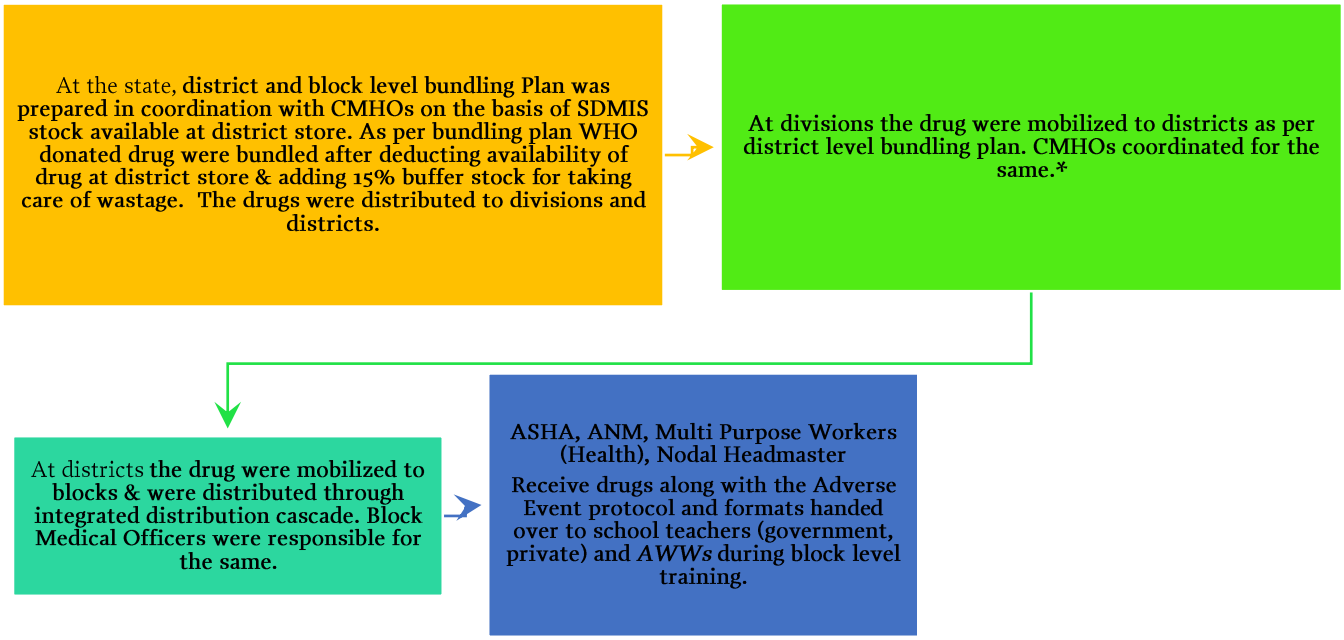
4.3 Drug Procurement, Storage, and Transportation

Drug Procurement, Logistics: The drug requirement was determined based on enrolment data at schools and *anganwadis* across 41 districts, factoring in a 15% buffer for wastage and spoilage. A total of 1,34,00,000 albendazole tablets were received under the WHO global drug donation program in June 2015, intended for distribution to school-age children during the same year, as per the requisition sent in August 2014. Evidence Action supported the state to develop a district and block wise drug distribution plan to ensure all schools and *anganwadis* had sufficient drugs available. Along with the WHO drugs, 92,65,000 tablets were available from the previous year's stocks and were used for this round. The state also undertook drug testing in approved lab facilities before distribution was initiated.

Drug Distribution: As per NDD operational guidelines and established best practices, drug distribution was integrated with the training cascade (as detailed in the training section below), wherein NDD kits were provided to health functionaries at the district level trainings for

onward distribution. The kits included drugs, IEC materials, training handouts, and reporting forms. The district level procurement and distribution cascade is depicted in Figure 2.

Figure 2: Drug procurement and distribution cascade for NDD[20]



Though the drugs reached 13 districts in a timely manner[21], some of the available drugs for NDD were utilized for a maternal health program. In order to fill this gap, additional drugs were mobilized from state to districts to fill the NDD requirement. Evidence Action's district coordinators worked closely with the affected districts to ensure that sufficient drugs were available.

Adverse Event Management: To provide guidance on functionaries' roles and responsibilities in minimizing adverse events, and to handle and report adverse events that did occur, Evidence Action assisted the state health department to prepare a detailed adverse event management protocol that included emergency contact numbers and a briefing on media handling. This was translated in Hindi and shared with district collectors, CMHOs, education and WCD departments, and other stakeholders as appropriate. Additionally, functionaries were trained on adverse event management. A network of ambulance vans was prepared to stay on alert at each block to handle adverse events if reported. 207 mild cases were reported across 41 districts, with no serious adverse events reported (**Annexure A**).

[20] NIPI drug distribution cascade is followed up by the state instead of the NDD drug distribution cascade
[21] Alirajpur, Balaghat, Dindori, Hoshangabad, Jabalpur,Jhabua,Dhar, Narisighpur, Sidhi, Sagar, Sahdol, Barwani, Burhanpur

4.4 Public Awareness and Community Sensitization

Activities designed to increase community awareness of deworming were rolled out based on NDD operational guidelines. Sensitization of children and families helps build trust toward deworming, alleviates worries related to adverse events, and overall leads to greater program uptake. The deworming and mop-up day dates were highlighted in all IEC materials along with other key deworming messages to ensure maximum attendance of the children at the schools and AWCs. Evidence Action supported the state government to develop a plan for orienting ASHAs to their role sensitizing the community on the importance of deworming and motivating parents to send their children to schools and *anganwadi* centres on NDD. Evidence Action also developed all IEC and community mobilization materials that were approved by the Government of India and uploaded on the NHM website. The state adapted and printed the material, including posters and banners for display at schools and AWCs. The community sensitization strategy also included outreach activities such as newspaper advertisements; radio jingles; TV scrolls and spots; *miking*; banners at health, education and WCD offices; and wall writings.

The 30-second radio jingles were run through 17 FM channels and 15 All India Radio (AIR) stations at the state level. 20-second TV scrolls were broadcast over local cable channels and 30-second TV spots were broadcast over 15 local channels with support from Evidence Action. Mass, mid-media, and interpersonal communication activities were included in the IEC campaign, as detailed in table 2. **(Annexure F)**

Table no 2: NDD 2016 IEC campaign details

S.No	Activity	Timeline	Frequency	Channel/Station/Paper/ Location
1	TV Spots *	Feb 8-9	5 times per day	IBC 24, Sadhna, Swaraj News, IND 24, Sahara News, Digi News, Zee News, City News, City Hulchal, India news, Bansal news, News World, E TV News, E TV M.P., City Hulchal Gwalior
2	TV scroll	Feb 1-10	Full day in intervals	Local cable channels
3	Chief Minister's appeal in Newspaper; Newspaper advertisement *	Feb 10-14 Feb 14-15	2 days	Across all English and Hindi newspapers
4	Radio Jingle	Feb 6-10	8-9 times per day	17 FM and 15 AIR channels
5	Wall writing	Feb 1-9	168433 wall writings across 41 districts for all days	In front of CMHO office , Collectorate, District hospital, some school and *anganwadis*

6	Miking	Feb 4-14	Morning and Evening	At districts and blocks close to community reach areas
7	ASHA talk show	Feb 2	One day	AIR- Akashvani
8	Hoarding	Feb 5-15	Approx 123 hoardings	In from of CMHO office , collectorate, public places
9	Rallies	Feb 1- 14	Approx 205 rallies (5 per district) All days in mornings	Conducted by ANMs, ASHAs, Schools children and AWWs

*Evidence Action supported the state for these activities

Block level officials from the three departments oriented the frontline health workers in sector level trainings on community sensitization messages and tasked them to spread the messages through platforms such as morning assembly at schools, parent-teacher meetings, AWCs, and home visits. . In a new initiative for community awareness, an ASHA talk show called *Hello Doctor*[22] included NDD as a topic of discussion on February 2 and was broadcast on radio channels. The state also provided financial incentives for ASHA workers to motivate them for community mobilisation.

The Department of Health reached out to telecom provider Idea for their support to raise public awareness on NDD. This initiative to include the private sector was well received and the provider sent out bulk SMSs on NDD to Idea subscribers (approximately 30,00,000[23]) on February 9 and 15, 2016. Private schools also took initiative to spread awareness on NDD by posting information on their websites. The Health department issued letters to private schools to include deworming during parent teacher meetings and other school activities like 'thought of the day' to create mass awareness. The National Republic Day event was leveraged to spread awareness about the program, with districts flashing NDD messages on the tableaus. Also, local governance was involved in spreading awareness about the program. Evidence Action's field team led discussions on NDD at 64 *Gram sabha* meetings in each of the districts on January 25 and 26, 2016 (Annexure F)

Inaugural Launch Event: The state level launch event was organised at the Sarojini Naidu Higher Secondary school in Bhopal on February 10, inaugurated by the Principal Secretary of Health in the presence of Commissioner, ICDS, Health Commissioner and MD NHM. The state Health Minister, being present in district Dhar during this time, inaugurated the district launch for NDD. District-level launch events were held widely across the state. The events were led by local district administration and supported by Evidence Action district coordinators **(Annexure F).**

[22] Hello Doctor is a monthly talk show wherein the agenda for February included NDD. A wide network consisting of 37 Centres and some Local Radio Stations has reached more than 97% population of MP mostly in rural areas, as listeners access it through short-wave network.

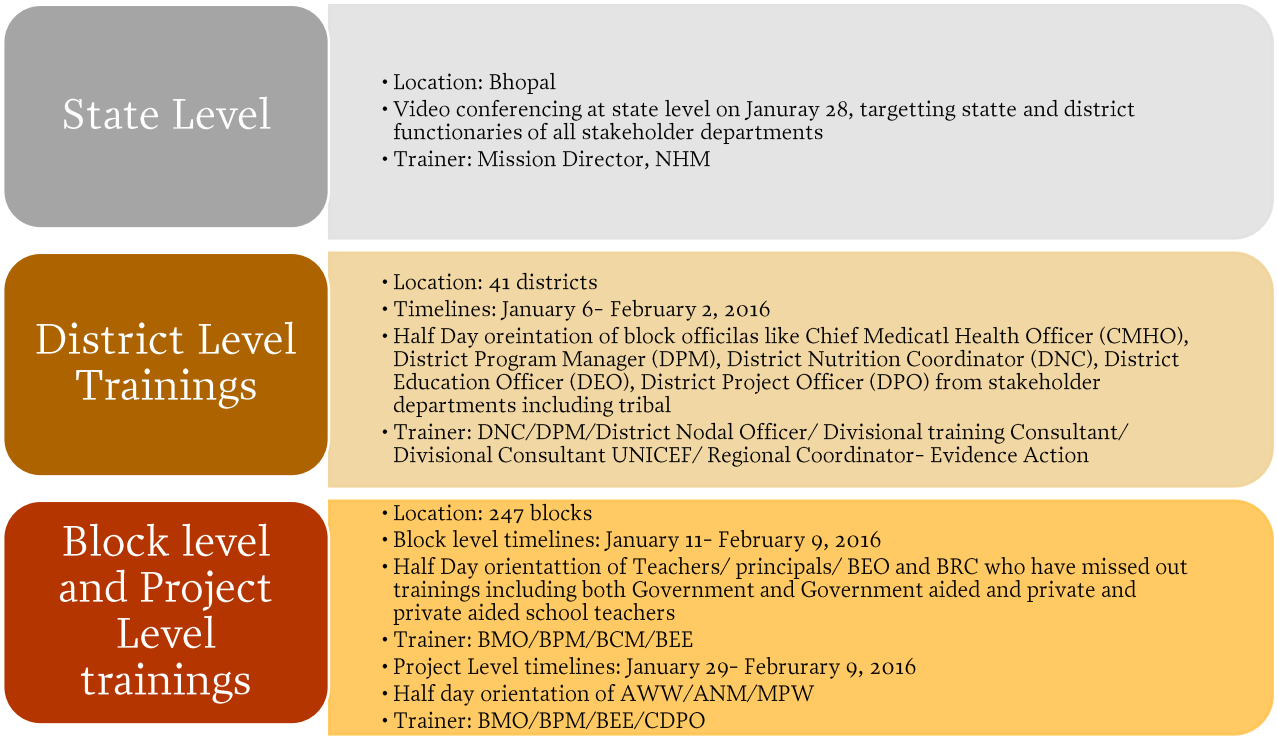
[23] Final figures received from Idea

A press conference was conducted on February 3 in Bhopal under the chairmanship of the Honorable Health Minister and Principal Secretary of Health. It was attended by various senior dignitaries from other stakeholder departments and reflected stakeholders' commitment towards the program. Evidence Action supported in briefing the media representatives about the program's aim and benefits of deworming, resulting in widespread media coverage.

4.5 Training Cascade

As per NDD Operational Guidelines, and the state specific operational plan developed in collaboration between Evidence Action and the NHM, a training cascade was implemented at all districts and blocks between Jan 6 to Feb 9, 2016. The cascade trained 79,197 government and government-aided teachers, 2,058 private school teachers, 55,953 *anganwadi* workers, and 42,396 ASHAs.[24] District and block level officials from all nodal departments implementing the program were also trained. Block level trainings included integrated distribution of drugs and print material (training handouts and IEC). *Integrated distribution* means distribution of *NDD kits i*ncluding deworming drugs, banner/poster and handout, reporting forms, to the teachers/anganwadi workers at the training only. This is a cost effective approach and ensure one point of integration of materials thereby helps ensure greater availability of drugs and other materials at schools and *anganwadis.*

Figure 3: Training cascade followed in Madhya Pradesh during NDD February 2016



[24] NDD coverage report submitted by state to GOI.

Prior to the NDD trainings, officials from divisions, districts, and blocks as well as government and government-aided school teachers and ASHAs, received deworming training under the NIPI program from July to November 2015. Through these trainings functionaries were oriented on the technical knowledge about worms, its impact of health, nutrition and educational status of child, especially anaemia prevent and control. These trainings also includes relevant information on NDD and the roles and responsibilities of functionaries for the NDD. NDD trainings re-emphasizes these technical knowledge as well as include training functionaries on specific action plan as per the NDD timelines.

Training Resources: To assure high quality and standardized messages, Evidence Action worked with stakeholders to contextualize NDD training aids like presentations, flipcharts, leaflets, and handouts for teachers, *anganwadi* workers, and ASHAs as per state-specific needs. Evidence Action supported in drafting the bundling plan as per block requirements, enabling materials to be efficiently transported to all districts before trainings commenced. Evidence Action's district coordinators played a vital role in ensuring the timely completion of tasks in order to ensure availability and distribution of these kits at the block-level trainings.

Training Support: Evidence Action's district coordinators attended and provided supportive supervision to all 41 district trainings. The team monitored trainings across all 41 districts and conducted pre- and post-tests to assess the knowledge gained by participants in 8 selected districts[25] and 16 blocks[26]. Evidence Action also used a monitoring checklist to assess training quality, ensuring that all the components of deworming were covered as per NDD guidelines. Facilitating real-time corrective actions, Evidence Action's state team engaged with the nodal officer and provided up-to-date findings from the field. Timely coordination and information from the field led enabled district officials to take remedial steps during implementation.

SMS*:* To reinforce key training messages, the state departments sent post-training SMS through their existing platforms to various functionaries. Approximately 17,43,780 and 1,80,006 SMS were sent by the State NHM and the Department for Women and Child Development respectively. Additionally, Evidence Action sent 16,35,387 SMS to approximately 2,322 district and block officials; 4,59,196 teachers and headmasters; 1,46,472 ASHAs; 1,6,658 ANMs; and 10,10,739 AWWs. The SMS contained reminders on dates of trainings and NDD, deworming and its benefits, reporting timelines, and instructions for adverse event management. Evidence Action also sent the 30-second NDD radio jingle as an Interactive Voice Response SMS during NDD and mop-up day to 8,75,505 frontline functionaries.

Website Uploads: To access information on deworming, functionaries at state, district and block levels visited their respective departmental website to gather information including key training messages, guidelines, training materials, and reporting timelines to reinforce messages and strengthen program operationalization. Between Feb-March 2016, the total number of hits and downloads was around 5968 from the education portal and 4237 from the ICDS MIS portal (Annexure G).

[25] The low performing districts were identified on the basis of NDD 2015 process monitoring and coverage validation findings under taken by Evidence Action

[26] 2 blocks from each of the 8 selected districts were identified on the basis of preliminary finding from district level training monitoring and pre-post-test during NDD 2016 district level training

Highlights from National Deworming Day 2016

- The program launch was held on February 10, 2016 at state and districts with political commitment and bureaucratic leadership followed by a mop-up-day on February 15 to reach out to children who did not receive treatment on deworming day due to ill health or absenteeism.
- Consultants from MoHFW, Government of India, state health department, and development partners including Evidence Action, conducted a total of 1618 monitoring visits on NDD. Evidence Action shared findings from the field with the MD, NHM on the same day.
- NDD observed in private and centrally affiliated schools of four districts- Bhopal, Raisen and Sagar and Burhanpur
- The state NHM issued a common letter to all district health departments stating feedback observed on deworming day. Additionally, any districts, blocks, schools, or AWCs that had gaps such as insufficient drugs, reporting forms, or IEC materials were directed in how to fill the gaps to enable higher coverage of all children during the mop-up days.
- Evidence Action hired and trained an independent agency to conduct independent monitoring.
- The state government and development partners worked together to facilitate coverage reporting. The state reported dewormed 1,38,88,604 children out of approximately 1,52,71,305 children in the target age group.

5. Monitoring and Evaluation

Evidence Action places great emphasis on understanding the extent to which schools, *anganwadis*, and the health system are prepared to implement mass deworming. This includes assessing the extent to which deworming processes are being followed, and the extent to which coverage has occurred as planned. Monitoring and evaluation are done in three ways: (1) process monitoring, (2) coverage reporting and (3) coverage validation. During Madhya Pradesh's second round of deworming that occurred in 41 districts on February 10, and mop-up day on February 15, an independent monitoring exercise (process monitoring and coverage validation) was conducted, followed by coverage validation from February 20-26, 2016.

5.1 Process Monitoring

Process monitoring assesses the preparedness of schools, *anganwadi*s, and health systems to implement mass deworming and the extent to which they have followed correct processes. Evidence Action assesses the program preparedness during the pre-deworming phase and independent monitors observe the processes on deworming day and mop-up day.

Field Monitoring Visits for Process Monitoring: A total of 1618 monitoring visits (30 visits by state government officials and 1588 visits by Evidence Action's state and field team) were conducted in randomly selected schools and *anganwadis*. As recommended under national guidelines, the team used the NDD monitoring checklist during their visit. Monitors visited 668 *anganwadis*, 885 government- government aided schools and 65 private schools. The NDD monitoring data has been submitted to GOI along with the coverage report (Annexure H)

Telephone Monitoring and Cross Verification for Process Monitoring: Evidence Action tele-callers placed phone calls to track the delivery and availability of training, drug, and IEC materials at the district, block, and school/*anganwadi* levels as deworming day approached.

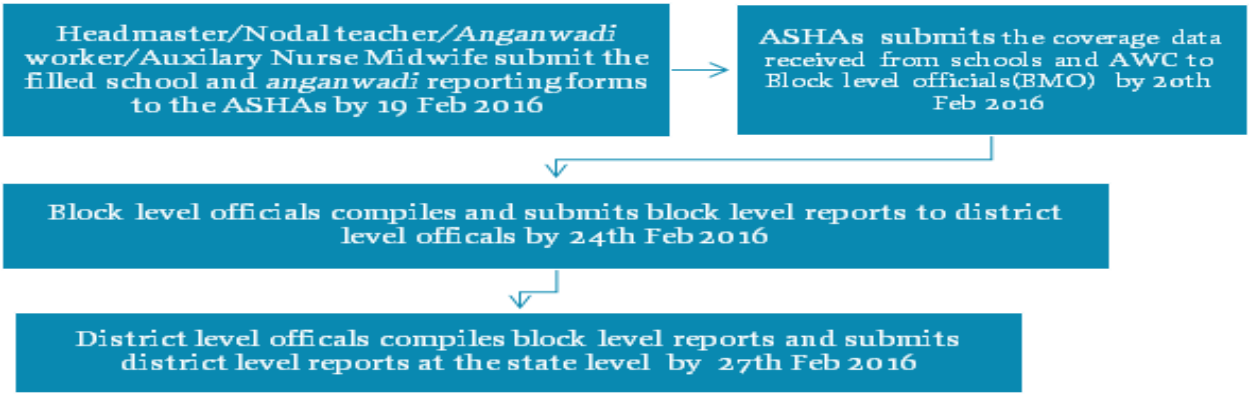
Approximately 11,931 calls were made from January to March 2016, including 2175 calls to health functionaries like ASHA/ANMs, 3,306 calls to government and government-aided schools, 653 calls to private school teachers/principals, 3,646 calls to *anganwadi* workers and schools across 247 blocks in 41 districts. An additional 2151 calls were made to district and block level officials to address gaps identified during block monitoring at each level (Annexure I). Tele-callers used electronic tracking sheets to outline issues identified during calls and monitoring visits. These tracking sheets were shared with the state government to enable the government to take rapid corrective actions as necessary.

With support and inputs provided by short-term hires, Evidence Action's state team held debrief sessions with officials at the state health department to share updates and information from deworming day monitoring visits to schools and *anganwadis*. These updates resulted in issuance of letters to the districts prescribing corrective action around issues such as drug and IEC availability, ensuring adherence to program guidelines and ultimately supporting increased coverage (Annexure J).

5.2 Coverage Reporting

Coverage reporting is the proportion of the target population reached by an intervention (e.g. percentage of school-age children treated on a treatment day) and is a crucial component to measure program performance. With close support from Evidence Action's state and field teams, the Department of Health collected and compiled coverage reports for NDD from schools and *anganwadi*s. School teachers/*anganwadi* workers had been trained on the recording and reporting protocols. These protocols, along with the reporting cascade and timelines, were shared with all districts through the state's directives and intended to improve the accuracy of coverage reports submitted by schools/*anganwadi*s. Every teacher/*anganwadi* worker was required to put a single tick mark (✓) next to a child's name in the attendance register if he/she was administered albendazole on deworming day, and a double-tick mark (✓✓) next to a child's name if he was administered albendazole on mop-up day. Schools/*anganwadis* were supposed to derive the number of enrolled children dewormed by counting the single and double tick marks in attendance registers. School headmasters were then to compile the number of dewormed children as recorded in class registers, fill the school reporting form, and submit it to the designated person in the reporting cascade. The coverage reporting structure and timeline is shown below in Figure 4:

Figure 4: Coverage Reporting Cascade and Timeline



5.3 Coverage Validation

Coverage validation was done within 5-7 days of the mop-up day. During this exercise, monitors checked and verified deworming-related data available in schools and *anganwadi*s using their respective attendance registers and reporting forms. In each school, one teacher and three students were interviewed. In *anganwadis*, only *anganwadi* workers were interviewed. The surveys were conducted with the prior approval of the state government and a permission letter was issued by state Department of Health. Each monitor carried a copy of the authorization letter, produced to the schools and *anganwadis* on request.

Sampling and sample size

Two-stage probability sampling was used to select schools and *anganwadis* for coverage validation on deworming day and mop-up day. First, 121 blocks were selected from all 41 districts by probability proportional to size sampling[27], followed by random sampling of schools to provide state-wide estimates of indicators. A total of 270 schools and 250 nearby *anganwadis* were visited on NDD and mop up day. For coverage validation, a total of 405 randomly selected schools and 375 randomly *anganwadis* were visited.

Table 3: Target and Coverage of Schools and *Anganwadis* during NDD, February 2016 Independent Monitoring

Indicators	Process monitoring		Coverage validation	
	Target	Achieved	Target	Achieved
Total number of districts	41	41	41	41
Total number of blocks	121	121	121	121
Total number of schools	270	277	405	405
Total number of government/government aided schools	250	255	375	383
Total number of private schools	20	22	30	22
Total Number of children interviewed in schools*	270	224	1215	1098
Total number of *anganwadis*	250	238	375	396

***Children were interviewed only where deworming has been conducted on the day of monitor's visit**

Independent monitoring formats

To ensure comprehensive coverage and triangulation of data, four questionnaires were administered- one each for school and *anganwadi* process monitoring on NDD and MUD, and one each for schools and *anganwadis* for the coverage validation. Questionnaires were designed by Evidence Action and finalized in consultation with state Department of Health. The questionnaires were translated into regional language, and checked to ensure that the language

[27] Probability proportional to size sampling (PPS) selected blocks in Madhya Pradesh, according to the number of schools in that block. PPS corrects for unequal selection probabilities in random sampling of unequally sized blocks. Schools were then randomly selected from the selected blocks.

was concise and easily understandable, before being scripted and loaded onto tablet PCs/mini-laptops for the monitor to administer.

Authorization from government

The surveys were conducted with the prior approval of the state government and a permission letter was issued by state Department of Health. Each monitor carried a copy of the authorization letter, produced to the schools and *anganwadis* on request.

Training of trainers and independent monitors

Through a competitive selection process, Evidence Action hired Karvy Insights to implement the independent monitoring in Madhya Pradesh. Evidence Action provided a one-day comprehensive training to three master trainers from Karvy Insights in Bhopal on February 5, 2016. These master trainers conducted a two day training of 140 monitors from February 6-7, 2016 in batches of 45-50 monitors. A total of 160 trainees, including a 10% buffer of monitors and 20 supervisors, were trained over two days to ensure that monitors were equipped with the necessary knowledge on the deworming program. After training, a test was administered to all participants to assess their comprehension and ability to work in the field.

Field Implementation

After training, the selected monitors were sent to their allotted districts. Each monitor was allotted two schools and two *anganwadis* for process monitoring. Subsequently, they were allotted three schools and three *anganwadis* to survey during coverage validation. Monitors were provided a tablet PC, charger, printed questionnaires, and albendazole tablets for demonstration. The details of their allotted schools were shared with them one day before fieldwork commenced to ensure that monitors did not inform local educational authorities ahead of the actual deworming, thus potentially affecting compliance.

In case a school or *anganwadi* was closed on NDD or mop up day it was replaced by the nearest school/*anganwadi*. For coverage validation, however, this strategy was slightly modified: if a school or *anganwadi* was found closed, monitors were asked to cover the next school or *anganwadi* on their list, and return to the first school or *anganwadi* at another time on a subsequent day. If the school or *anganwadi* was non-traceable or closed consistently after making three attempts, a new school was substituted for the old one.

Quality control

Appropriate quality control measures were taken to ensure that data collected was accurate and comprehensive. School headmasters and *anganwadi* workers were asked to sign a participation form and provide an official stamp, verifying that the school or *anganwadi* was actually visited. The agency contacted approximately 20% of schools and *anganwadis* on phone the next day to confirm that they had participated in the monitoring and validation process. In addition, district coordinators visited sampled schools and *anganwadis* to spot check the processes and tele-callers contacted schools and *anganwadis* to verify monitoring visits.

6. Key Findings

The key results from the independent monitoring are provided below, including data from all schools (government and government-aided; centrally affiliated; tribal; and private or private-aided schools) and *anganwadis;* further details are shared in annexure 1.

Training

Participation at trainings: Independent monitoring data demonstrated that teachers/headmasters from 71% of schools and 70% of *anganwadi* workers received training for the recent deworming round. Among private schools, only one out of 22 schools reported attending training on deworming in the previous two months. Out of those who did not attend the training, 32% of all (government, private) school teachers and 35% *anganwadi* workers cited lack of awareness of the date/timing of trainings as the reason for not attending the trainings. As training is crucial to equip teachers and anganwadi workers with the necessary knowledge and drugs for implementing NDD, efforts must be made to increase participation at the trainings. In this direction, for NDD 2016 round, the government and Evidence Action sent out bulk SMSs on reinforcing training schedules and venue information prior to the trainings, along with post training messages on deworming. During independent monitoring, it was found that only 51% schools and 55 % *anganwadis* workers received training reinforcement SMS, which could be the reason for low participation at the trainings during NDD 2016.

Key recommendations:

- Regular updates and strengthening of the database of block level functionaries and teachers/schools and *anganwadi* workers to improve SMS coverage for dissemination of program information to key audiences in a timely manner.
- Advise block level officials to strengthen the communication channels from the block to all schools and *anganwadis* on participation at trainings.

Quality of trainings: Findings show that only 68% of headmasters reported providing training to other teachers after they were trained on deworming. The headmasters/ principals and *anganwadis* also reported incomplete knowledge on the different ways that children can get worm infections; only 35% of these functionaries reported open defecation/not using sanitary latrine as a route of worm transmission

Key Recommendations:

- Improve training sessions with a stronger focus on the importance of sharing training messages at schools so that all teachers are equipped to deworm children in accordance with the protocols.
- Trainings should have greater emphasis on practices for controlling worm infection.

Integrated distribution of deworming materials including drugs: Findings from independent monitoring data revealed that only 31% and 35% of all school and *anganwadis* respectively completed integrated distribution[28] of the NDD kit; however, as reflected in the below table, individual components of the kit were still distributed on a large scale at the trainings.

[28] Integrated distribution of NDD kits including deworming drugs, banner/poster and handout, reporting forms, to the teachers/*anganwadi* workers at the training only.

Table 4: Distribution of IEC material

NDD kit content	For Schools			For *Anganwadi*		
	Received	**Verified***	**Received in training**	**Received**	**Verified***	**Received in training**
Tablets	78.7	88.5	63.8	85.7	86.3	61.8
Poster/Banner	69.3	89.1	68.2	76.9	86.3	65.6
Handouts/ Reporting form	60.3	86.2	71.9	66.4	86.7	68.4
Adverse event reporting form	36.5	86.1	73.3	41.2	84.7	71.4

*The first column shows data on the availability of NDD kit content with the teachers and anganwadis, as reported by them. Availability of items in NDD kit was physically verified by monitors for those schools and *anganwadis* that received these items (Second column) The third column states teachers and anganwadis reporting receipt of NDD kit content at the trainings.

As per the table above, majority of the teachers and anganwadi workers reported receiving most of the NDD kits including tablets, posters/ banners, handouts/reporting forms except adverse event reporting forms which was reported to be available by less than 40% teachers and *anganwadi* workers. Findings suggest a need to strengthen integrated distribution of training, IEC materials, and drugs during block level trainings. While the state planned the bundling process far in advance of the NDD, less than one fourth of schools and *anganwadis* reporting receiving all materials at the trainings.

Key Recommendations:

- Improved bundling and proper distribution is done at all levels down to the blocks, where the ultimate implementers receive materials. This can be done through ensuring clear responsibilities are assigned for bundling at all levels, through state/ district released directive, also necessary supervision at all levels is required for ensuring adequate quantity gets bundled and distributed in a timely manner.

Drug availability at schools and *anganwadis*, was impacted to some extent in the some of the districts due to the drugs being utilised for maternal health program closer to the NDD. Though efforts were made to fill the gap of drugs availability through transportation of drugs from the state, the shortage of time, might have affected the availability of drugs at schools and *anganwadis.*

Key recommendation:

- Improved communication between different programs through release of letter from the health department to districts and blocks for streamlining the drug uptake between programs.

Drug sufficiency: During coverage validation, 96% of the schools and 83% *anganwadis* reported to have sufficient drugs for deworming.[29] Moreover, 56% of schools and 20% of *anganwadis* had surplus drugs after deworming. The drug surplus at the schools and *anganwadis* can be because of the availability of WHO drugs in a sealed jar of 200 tablets which cannot be repackaged because of drug safety protocols, as well as buffer being considered while drug bundling. The drug surplus figures are corroborated with logistics details under state level coverage report as well (**Annexure A**).

Key recommendation:

- Availability of surplus drug at the schools and *anganwadis* after the deworming round is completed, need to be assessed by the state government in terms of making use of available drugs, along with following necessary drug safety protocols.

Source of information about recent round of deworming:

In order to sensitize the teachers and *anganwadis*, various channels of communication was used in the programme, including departmental communication, posters, and banners. Monitoring data revealed that during the recent round of deworming, departmental communication was the major source of information, in other words the maximum number of a medium reported by teachers/headmasters and *anganwadi* workers was 47% of schools and *anganwadis,* followed by training (34% of schools and 27% of *anganwadis*). School teachers were the major source of information to students for deworming (98%). However, 16% of students interviewed were not aware that the medicine given to them was for deworming. With reference to children enrolled in private schools, three out of four interviewed children were aware that the tablet given to them was for deworming.

Implementation of deworming:

While 81% of schools and 85% of *anganwadis* reported conducting deworming on either NDD or Mop up Day, independent monitors observed ongoing deworming activity in 74% of schools and 76% of *anganwadis* respectively. Coverage validation findings highlighted that 90% of schools and 95% of *anganwadis* had observed deworming during NDD or Mop up Day. Out of all enrolled children interviewed on NDD and Mop up Day, around 92% reported to have received a deworming tablet. Prima facie, this suggests that deworming occurred in a large percentage of schools and *anganwadis* on one of the deworming days. However, only 6 of the 22 private schools observed during coverage validation reported deworming activities on NDD or Mop up Day.

Adverse events- knowledge and management:

Interviews with teachers and *anganwadi* workers during process monitoring demonstrated a lack of awareness regarding the possible occurrence of adverse events. Only 28% of headmasters/principals and 22% of *anganwadi* workers acknowledged that adverse events were possible after ingesting albendazole. Of those who knew that adverse events are possible, around 70% were aware of how to manage adverse events. During class observations, around 77% of teachers and 78% of *anganwadi* workers asked children whether they were sick before

[29]Sufficient drugs is defined here as availability of drugs in accordance with the total number of children enrolled in the school.

administering drugs. More than 90% of teachers and *anganwadi* workers ensured that drug administration was well supervised, asking children to chew tablets before swallowing.
Key recommendation:

- Increased focus needs to be given at the trainings on the adverse events that can happen on mass scale program and more importantly, on being equipped to properly manage the adverse events as per the adverse event management protocols.

It was also seen during process monitoring that many schools and *anganwadis* were delaying drug administration to coincide with mid-day meals. As per WHO guidance, there is no need to consume food along with albendazole. Often, children leave school premises right after the mid-day meal, meaning that they do not remain with teachers for two hours post- deworming when any possible adverse events could be properly managed by the trained teacher/ *anganwadi* worker. Thus, training and monitoring functions should provide greater focus on the correct drug administration protocols in future rounds.

Recording protocol:
Coverage validation data demonstrated that 55% of schools and 84% of *anganwadi*s followed correct[30] recording protocols, 25% of schools did not adhere to any recording protocol and remaining 20% schools followed the recording protocol partially[31]. As per NDD guidelines, ASHAs were required to prepare a list of unregistered *anganwadi* children and out-of-school children for submission to *anganwadi* workers; however, findings suggest that less than 40% of *anganwadi*s had a list available.
Key recommendation:

- Increased focus on the importance of correct recording, reporting protocols and maintaining correct and complete documentation at the trainings of frontline functionaries.

6.1 Program Coverage

The following table 5 highlights the coverage details from the state including the total coverage of 91% according to government reported figures as well as coverage across various categories

Table 5: State coverage report for NDD 2016

Indicators		Results	% Coverage
Total number of children targeted		1,52,71,305	-
No of enrolled children (classes 1-12) dewormed	Government Schools	76,24,364	90
	Privte Schools	6,97,367	87

[30]Correct recording protocols refers that all classes/registers of schools and *anganwadis* have single or double ticks.
[31]Not all classes followed the recording protocol.

Number of registered children dewormed (1 to 5 years) at AWCs	45,26,409	95
Number of unregistered children dewormed (1 to 5 years) at AWCs	2,85,787	71
Number of out-of-school children (6-19 years) dewormed	7,54,677	87
Total number of children dewormed (1-19 years)	1,38,88,604	91

Substantial district wise variation was observed in NDD coverage reporting. Twelve out of the total 33 districts reported coverage below the state level with Pratapgarh(68%) having the lowest coverage followed by Sikar (72%) and Bikaner (78%). Further, districts of Baran and Sri Ganganagar reported coverage of more than 95% followed by Sirohi, Dhaulpur and Hanumangarh that reported coverage of 94% in the state. **(Annexure K)**

The following section explores the extent to which the reported coverage figures are likely to be an accurate reflection of the number of children dewormed.

6.2 Coverage validation

In the schools and anganwadis sampled for coverage validation, we calculated state-level verification factors, which are commonly calculated for Neglected Tropical Disease control programs around the world. The verification factor compares the number of ticks in school/anganwadi registers (where teachers/anganwadi workers recorded dewormed children) to the coverage figures in the reporting forms that schools/anganwadis submitted to the state. A verification factor of 1 means the schools reported the exact same figures that as recorded in registers on deworming day. A verification factor less than 1 indicates over-reporting, while a verification factor greater than 1 indicates under-reporting.

Coverage verification factors are estimated on the basis of availability of a copy of reporting forms at schools and *anganwadis.* In Madhya Pradesh only 50% of schools and 47% of *anganwadis* had a copy of the reporting form available after deworming and mop-up day. Although during trainings, teachers/ headmasters and *anganwadi* workers were instructed to retain a copy of their respective reporting form, 24% of headmasters and 18% of the *anganwadi* workers interviewed during process monitoring were not aware of retaining a copy of the form.

In Madhya Pradesh, the state level verification factor for enrolled children was found to be 0.94, indicating that for every 94 enrolled children who were recorded as dewormed in the schools, the school reported that 100 enrolled children had been dewormed. This corresponds to an overall six percent inflation of reporting in the state, meaning that reported numbers appear to be approximately six percent higher than the numbers recorded in attendance registers. Similarly, the state level verification factors for other target groups were 0.90 for *anganwadi* registered children (11% inflation), 0.57 for non-registered children (1-5 years) (74% inflation), and 0.73 for out of school (6-19 years) children (37% inflation). Training was found to increase the accuracy of reporting: trained schools had only one percent inflation in reporting, while untrained schools had 55% inflation in reporting.

Around 98% of the children interviewed during coverage validation reported to have received deworming and 97% reported consuming the tablet under supervised administration in the

school. Further attempts were made to understand the maximum number of enrolled children that could have been dewormed in the state. Coverage validation data demonstrated that 90% of schools did deworming on either of the days and attendance data showed that a maximum of 87% of enrolled children would have been in attendance across both days. Based on deworming implementation status and attendance of enrolled children on deworming and mop-up day and children's interview, maximum 77% (98% children out of 87% present in 90% of schools conducted deworming) children could have been dewormed in the schools of the state.

Key recommendations:

- Correct recording, reporting protocols and the importance of retaining a copy of reporting form for verification purposes, need to be further reinforced at future trainings
- Additionally, greater emphasis need to be made for increasing coverage and accurate reporting of unregistered and out-of-school children. This suggests the need to strengthen the role of ASHAs in mobilising these children and correctly reporting their treatment.

Private school engagement: Since this was the first round for the state to engage private schools in deworming, participation was low and can be increased in the future. In order to broaden the reach of the program, it is critical to include private schools in every aspect of future rounds.

Key recommendations:

- Comprehensive training for teachers and other staff, along with adequate and timely information about the program, may help generate awareness and interest from private schools.
- The continued engagement of District Magistrates will help strengthen the implementation of the program at ground, as reported by the state NDD nodal officers.
- Engaging with private schools has been a largely untapped area for school health programs. However the efforts made during NDD February 2016, and the experiences will guide future strategies for other such initiatives.

Key Recommendations from NDD Feb 2016

Training

- Regular updates and strengthening of the database across program functionaries for sending training reinforcement SMSs.
- Strengthen the communication channels from block to all schools and *anganwadis* on participation at trainings
- Strengthen training component of the program through focusing more on the following:
  1) Importance of sharing training messages by the trained teacher to all other teachers at school
  2)Practices for controlling worm infection
  3) 3) Importance of correct recording, reporting protocols and maintianing correct and complete documentation form for verification purposes
- 4) Knowldege on adverse events that can happen on mass scale program and more importantly, on being equipped to properly manage the adverse events as per the protocols
- Improved bundling and proper distribution is done at all levels down to the blocks, where the ultimate implementers receive materials.

Integrated distribution of NDD kits at trainings

- Strengthening integrated drug distribution through ensuring clear responsibilities are assigned for bundling at all levels, through state/ district released directive. Also, necessary supervision at all levels is required for ensuring adequate quantity gets bundled and distributed in a timely manner.

Community Mobilization

- Greater emphasis need to be made for increasing coverage and accurate reporting of unregistered and out-of-school children. This suggests the need to strengthen the role of ASHAs in mobilizing these children and correctly reporting their treatment.

Private school engagement

- Comprehensive training for teachers and other staff, along with adequate and timely information about the program, may help generate awareness and interest from private schools.
- The continued engagement of District Magistrates will help strengthen the implementation of the program at ground

7. Way Forward

After completing its second round of NDD, including all children aged 1-19 years and private schools in four districts, Madhya Pradesh has laid a strong foundation for extending deworming treatment to all children ages 1-19 in future years. The state has made progress toward institutionalizing deworming by including NDD activities in PIPs, leading the timely finalisation of coverage targets, convening steering committee meetings at state and district levels, and planning ahead for integrated material distribution in trainings. The state's innovation, particularly around community engagement, is a strong example for other states and programs to follow. Strengthened planning for the third year of NDD implementation, and wider reach to schools including government, government-aided and private schools, will pave the way towards higher coverage. Evidence Action will also strengthen the deworming program in line with the above recommendations through close collaboration with government stakeholders, new initiatives around data quality assessments, and SMS-based coverage reporting all under state guidance. Together with the government's commitment and support, all of these efforts will result in improved health, education and productivity for millions of children in Madhya Pradesh.

8. Annexures

Annexure 1	Details of Independent Monitoring
Annexure A	State coverage report
Annexure B	NIPI State Advisory Committee Meeting, November 23, 2015
Annexure C i	Letter for inclusion of private schools in district Bhopal, Sagar
Annexure C ii	Letter for inclusion of private school district Chhattarpur
Annexure C iii	Letter for inclusion of private schools in district Burhanpur
Annexure D	NDD 2016 State Joint Directives issued to districts
Annexure E	NDD 2016 District Joint Directives issued to blocks _Dhar
Annexure F	Public Awareness and Community Sensitization
Annexure G	Snapshot of departmental website uploads
Annexure H	Training Quality Assessment findings
Annexure I	Snapshot of compiled visits, calls status in MP by Evidence Action team during NDD 2016
Annexure J	Letter issued to selected districts for gaps identified in NDD 2016
Annexure K	NDD 2016 District coverage

Annexure-1 Details of Independent Monitoring

Indicators	School		*Anganwadi*	
	Percentage	Number	Percentage	Number
Type of School				
Govt./Govt. Aided schools	92.1	255	NA	NA
Private Schools	7.9	22	NA	NA
Respondent of the section				
Headmaster/Principal	70.0	194	NA	NA
Vice principal	7.6	21	NA	NA
Nodal Teacher	9.0	25	NA	NA
Any other teacher	13.4	37	NA	NA
Category of school				
Primary(1 to 5)	55.2	153	NA	NA
Primary with upper primary(1 to 8)	14.1	39	NA	NA
Primary with upper primary and secondary(1 to 10)	1.1	3	NA	NA
Primary with upper primary secondary and higher secondary(1 to 12)	0.7	2	NA	NA
Upper primary only(6 to 8)	19.5	54	NA	NA
Upper primary with secondary and higher secondary(6 to 12)	1.4	4	NA	NA
upper primary with secondary(6 to 10)	0.4	1	NA	NA
Secondary only (9 to 10)	3.6	10	NA	NA
Secondary with higher secondary(9 to 12)	2.5	7	NA	NA
Higher Secondary only or Jr. college(11 to 12)	1.4	4	NA	NA
Did *Anganwadi* worker attended training in last 2 months	NA	NA	69.7	166
Did any teacher attended training in last 2 months	71.1	197	NA	NA

Did trained teacher provide training to other teachers[1]				
Yes, trained all other teachers	68.5	135	NA	NA
Yes, trained some other teachers	16.2	32	NA	NA
No, did not train other teachers	13.7	27	NA	NA
Don't know /don't remember	1.5	3	NA	NA
Reason for not attending official training				
Location was too far away	5	3	15.9	10
Did not know the date/timings	31.7	19	34.9	22
Busy in other official work	10.0	6	11.1	7
Attended deworming training in the past	16.7	10	11.1	7
Not Necessary	8.3	5	9.5	6
Others*	33.3	20	33.3	21
Source of information about recent round of deworming program				
Departmental communication	47.3	131	46.6	111
Television	7.6	21	6.3	15
Radio	5.4	15	5.9	14
Newspaper	9.4	26	8.0	19
Banner	7.9	22	10.1	24
SMS	13.4	37	11.8	28
Training	34.3	95	26.9	64
Other school/teacher	8.3	23	31.5	75
Others **	15.2	42	9.2	22
Any source of information about deworming	100.0	277	100.0	238
All the sources of information	0	0	0	0
Awareness about the ways a child can get worm infection	78.0	216	NA	NA

Different ways that children can get worm infected				
Having foods without washing hands	84.3	182	79.8	190
Not washing hands after using toilets	69.4	150	65.1	155
Not using sanitary latrine	36.1	78	34.5	82
Moving in bare feet	48.1	104	42.4	101
Consume vegetables and fruits without washing	50.5	109	45.4	108
Having long and dirty nails	36.1	78	30.3	72
Others	9.7	21	15.5	37
Any way a child can get worm infection	100.0	216	100.0	238
Awareness about all the ways a child can get worm infection	0	0	0.4	1
Receive SMS about the deworming program	48.4	134	52.5	125
Preference to receive the SMS				
Morning	17.3	48	16.8	40
Afternoon	10.5	29	10.5	25
Evening	14.8	41	11.8	28
Any time	55.2	153	62.2	148
Do not prefer the SMS	7.6	21	3.4	8
Having integrated distribution (tables, poster/banner, handouts/reporting, adverse event reporting form) in training				
Having received Poster/Banner, handouts/reporting, adverse event reporting form in training	30.96	61	35.54	59
Visibility over the Deworming Day Poster/Banner is posted				
Clearly posted/Visible to all	81.8	157	74.3	136
Hidden in a room/partially visible	6.8	13	12.6	23
Not posted/ not visible	10.9	21	13.1	24

Awareness about to whom to submit the completed School/*Anganwadi* Reporting				
ANM	29.2	81	41.2	98
ASHA	33.2	92	35.3	84
BEO	3.2	9	2.9	7
CRC	5.8	16	2.1	5
Nodal Head Master	4.0	11	0	0
Any other person	5.8	16	7.6	18
Don't know /don't remember	18.8	52	9.7	23
Retain a copy of the School/*Anganwadi* Reporting Form at the school after submitting one copy	76.5	212	82.4	196
Teachers/*Anganwadi* who think any adverse event can occur after taking the deworming tablets	27.8	77	21.8	52
Possible adverse events could be reported by children after taking the tablets				
Mild abdominal pain	72.7	56	80.8	42
Nausea	42.9	33	34.6	18
Vomiting	59.7	46	76.9	40
Diarrhea	15.6	12	5.8	3
Fatigue	19.5	15	21.2	11
Other, specify	11.7	9	7.7	4
Any possible adverse event	100.0	77	100.0	52
All possible adverse event	0	0	1.9	1
Response in case a child complains of mild stomach ache, nausea, vomiting, and diarrhea after taking the tablets,				
Make the child lie down in open and shady place	59.6	165	57.1	136
Give ORS/ water	53.4	148	58.4	139

Observe the child at least for 2 hours in the school	26.0	72	26.5	63
Don't Know	7.6	21	5.5	13
Others	9.7	27	12.2	29
Response in case the child continues to report symptoms of stomach ache, vomiting, diarrhea, etc. even after a few hours				
Call PHC or emergency number	55.2	153	18.5	44
Take the child to the hospital /call doctor to school	64.6	179	71.4	170
Don't know / don't remember	4.3	12	1.3	3
Other, specify	6.9	19	2.1	5
Deworming activity going in your school/*Anganwadi* today				
Yes, getting now	68.6	190	84.5	201
Yes, after few hours	12.3	34	0	0
No, will not administer today	19.1	53	14.3	34

**Others in case of schools included no information regarding the training and no staff being available. In case of anganwadis the reasons cited were - no information being given and no training happening.*
***Others in case of schools included Swasthyakendra, ASHA and a call being received informing about the deworming program. In case of anganwadis the sources were hospitals, ANM, ASHA, other anganwadis and Prathmik swathya kendras.*

Table: 2 Distribution of IEC material

Items Received in training/Percentage	**Schools**			***Anganwadi***		
	Received	**Verified**	**Received in training**	**Received**	**Verified**	**Received in training**
Tablets	78.7	88.5	63.8	85.7	86.3	61.8
Poster/Banner	69.3	89.1	68.2	76.9	86.3	65.6
Handouts/ Reporting form	60.3	86.2	71.9	66.4	86.7	68.4
Adverse event reporting form	36.5	86.1	73.3	41.2	84.7	71.4

Table3: Observation of deworming activity in the class/*Anganwadi*

Indicators	Schools		*Anganwadi*	
	%	Number	%	Number
Deworming activity is taking place in the class/*Anganwadi*	74.1	166	76.1	153
Teachers/*Anganwadi* worker giving any health education related to deworming				
Yes	82.5	137	77.1	118
Could not observe as I reached late	1.2	2	2.0	3
What are being included by the teacher/ *Anganwadi* worker as a part of health education to children				
Harmful effects of worms	67.9	93	65.3	77
How worms get transmitted	61.3	84	56.8	67
Benefits of deworming	55.5	76	50.0	59
Methods of worm infection prevention	42.3	58	38.1	45
Comprehensive health education to children	11.19	31	9.24	22
Teacher/ *Anganwadi* worker were asking the children if they are sick/under medication before giving the tablet	77.1	128	78.4	120
What teacher/ *Anganwadi* worker did ,If there was any sick child in the class room				
Gave Albendazole tablet to the child	19.5	25	10.0	12
Did not give the Albendazole tablet to the child	80.5	103	90.0	108
Students/children are told to chew the tablet before swallowing it	92.8	154	93.5	143
Deworming tablets were distributed by				
Teacher/headmaster	92.2	153	0	0
***Anganwadi* worker**	0	0	81.7	125
Asha/ANM	5.4	9	14.4	22
Students	1.2	2	0	0

Others	1.2	2	2.0	3
Teacher/ *Anganwadi* worker asking students to take Albendazole tablets in the class/ *Anganwadi* only	98.2	163	98.7	151
Teachers/ *Anganwadi* worker following the protocol of putting single tick ✓(deworming day) or double tick ✓✓ (mop-up day) on each child's name/roll no. in the attendance register after giving them the deworming tablet	81.3	135	74.5	114
Practice followed by teacher ,if the ticking/double ticking **Protocol did not followed**				
Prepare the separate list for dewormed child	32.3	10	43.6	17
Put different symbols	6.5	2	5.1	2
Nothing was done	58.1	18	48.7	19
Others specify	0	0	5.1	2
Any child not given the prescribed dose of Albendazole tablet				
Yes, less than the prescribed doze	21.7	36	17.0	26
Yes ,more than the prescribed doze	6.0	10	6.5	10
No, the prescribed doze is being given	72.3	120	76.5	117
Any adverse event observed (nausea, vomiting, stomach-pain diarrohea, etc.) after taking the tablet	16.3	27	11.1	17

Table: 4 Interview with teacher

Indicators	Percentage	Number
Attended any official training for deworming program in the past 2 months	59.6	165
Received training for deworming		
At official level training	75.2	124
By Headmaster/ teacher	21.2	35
Others (specify)'	3.6	6
Awareness about the ways a child can get worm infection	75.8	210
Different ways that children can get worm infected		
Having foods without washing hands	87.1	183
Not washing hands after using toilets	73.8	155
Not using sanitary latrine	38.6	81
Moving in bare feet	51.9	109
Consume vegetables and fruits without washing	54.8	115
Having long and dirty nails	41.4	87
Others	5.2	11
Awareness about prescribed dose of albendazole		
One	90.6	251
More than one	1.1	3
Less than one	8.3	23
Teachers who think any adverse event can occur after taking the deworming tablets	32.1	89
Possible adverse events could be reported by children after taking the tablets		
Mild abdominal pain	84.3	75
Nausea	37.1	33

Vomiting	74.2	66
Diarrhea	22.5	20
Fatigue	29.2	26
Other, specify	2.2	2
In case a child complains of mild stomach ache ,nausea, vomiting, and diarrhea after taking the tablets, Your response should be		
Make the child lie down in open and shady place	62.1	172
Give ORS/ water	53.8	149
Observe the child at least for 2 hours in the school	30.3	84
Don't Know	7.6	21
Others	10.1	28
If the child continues to report symptoms of stomach ache, vomiting, diarrhea, etc. even after a few hours, Your response should be		
Call PHC or emergency number	55.2	153
Take the child to the hospital /call doctor to school	65.3	181

Table: 5 Interview with school children

Indicators	Percentage	Number
Single tick ✓ in front of the name of children present on deworming day		
Yes to every children	68.8	86
Yes, but in few children	13.6	17
No	16.0	20
Other (specify)	1.6	2
There were names which do not have a single tick ✓ on Deworming Day and they also do not have a double tick ✓✓ on Mop-up Day	51.5	51
Reason to not putting single tick ✓on deworming day or double tick ✓✓ on mop-up day in front of the name of all/some children		
They did not get deworming drugs as they were feeling unwell	42.2	38
Teacher did not follow the recording protocol correctly	32.2	29
The parents of those children have refused to get their children dewormed	6.7	6
Children refused to take the drug	8.9	8
Other *	24.4	22
Child got a white tablet in school today	92.4	207
Child was feeling sick before taking the tablet in the school today	6.8	14
Child got tablet		
By Teacher / headmaster	91.8	190
By ASHA/ANM	7.2	15
By Other student	0	0
Other	1.0	2
Child consume tablet	98.1	203
Reason to not consume tablet		
Was feeling sick	25.0	1
I'm afraid of taking the tablet	25.0	1

Parents told me not to have it	25.0	1
Don't have worms so don't need it	0	0
Did not like the taste	0	0
Had difficulty swallowing	0	0
Taking home	25.0	1
Awareness of child that, how to consume the tablet		
Chewed tablet before swallowing	92.8	192
Swallowed tablet directly	6.8	14
Other, specify	0.5	1
Awareness of child that, why tablet is provided		
Deworming	80.7	167
Any other answer(unrelated to deworming)	3.4	7
Don't know /don't remember	15.9	33
Child was aware about deworming activity	7.5	3
Source of information about deworming activity		
Teacher / school	97.6	166
Television	11.8	20
Radio	6.5	11
Newspaper	6.5	11
Poster/Banner	22.9	39
Parents/siblings	5.3	9
Friends/neighbors	1.8	3

**Others include Children being absent and the teachers not being clear about the process*

Annexure 2: Analysis for Coverage Validation (School/*Anganwadi*)

Table:1 Coverage Validation Indicators	School		*Anganwadi*	
Indicators	%	Number	%	Number
Responses from the headmasters/principals/*anganwadi* interviewed:				
Attended training for deworming program	78.8	319	78.5	311
For schools/*anganwadi* that didn't attend training, reasons were:				
Location of training was far away	9.2	7	19.2	14
Was not aware of the date/ timing of training	32.9	25	38.4	28
Busy in other official work	14.5	11	6.8	5
Attended deworming training in the past	5.3	4	8.2	6
Not necessary	5.3	4	5.5	4
Other reasons	39.5	30	30.1	22
Schools/*anganwadis* received the followings				
Tablets	91.4	370	94.7	375
Poster	84.0	340	85.1	337
Handouts/reporting form	74.3	301	76.0	301
Adverse Event Reporting Form	47.7	193	48.7	193
Others	9.6	39	8.1	32
Received SMS about deworming program	50.6	205	54.5	216
Schools/*anganwadis* had the sufficient drugs for deworming	95.8	346	82.8	304
Schools/*anganwadis* where copy of school reporting form was available	50.3	150	47.1	139
For schools/*anganwadis* that didn't have copy of school reporting form, reasons were:				
Did not received	5.4	8	3.2	5
Submitted to ANM	77.0	114	84.6	132

Unable to locate	7.4	11	4.5	7
Others*	10.1	15	7.7	12
Schools/*anganwadis* observed deworming	90.4	366	94.7	375
***Anganwadis* having list of out of school(6-19) children**	NA	NA	30.67	
***Anganwadis* having list of non-registered(1-5) children**	NA	NA	36.8	

**Others in case of schools included that they have already submitted the reporting form. In case of anganwadis others included that they had entered the information on a separate page.*

State level inflation rate among untrained schools (which measures how much coverage reported in reporting forms exceeded school records in registers for schools that were not trained)	55.5
School level inflation rate for schools that followed the correct recording protocol (measures how much coverage reported in reporting forms exceeded school records in registers, for schools that were following recording protocols, i.e., ticking).	-1.6

Table: 2 School Coverage Validation Indicators

Indicators	
Schools where no reporting protocol was followed	25.14
State level verification factor	94.22
State inflation rate (which measures the extent to which the recording in school reporting forms exceeds records at schools)	6.13
Attendance on deworming day	69.29
Attendance on mop-up day	73.15
Children who attended on both Deworming Day and Mop-up day	55.87
Maximum attendance of children on Deworming Day and Mop-Up Day according to the CV data	86.57
Schools had surplus storage of drugs after deworming	55.7
Schools had complete school reporting form	94.7
Schools reported serious adverse event after taking the medicine	6.0
Average number of adverse events reported per school	14.2
Schools where all the classes followed the correct recording protocol	55.5
Schools where one or more of the classes followed the correct recording protocol	60.4
Schools where none of the classes followed the correct reporting protocol	39.6
Schools where one or more of the classes followed other recording protocol	17.8
State level inflation rate among trained schools (which measures how much the coverage reported in reporting forms exceeded school records in registers for schools that received training)	1.1

Table: 3 Interview of children on Coverage validation

Indicators	%
Children received deworming tablets	98.09
Supervised Administration of tablets	95.17
Children consumed tablet	96.99
Reasons for not consuming the tablets	
Feeling sick	0.18
Afraid of taking tablet	0.09
Parents did not allow to consume	0
Not needed as no worm infection	0.18
Did not like the taste	0
Others	0.09
Children aware about the deworming tablets	**89.5**
Way children consumed the tablet	**92.4**

Table: 4 *Anganwadi* Coverage Validation Indicators

Indicators	
Anganwadi **that followed recording protocol**	84.53
State level verification factor for Registered children(1-5 years)	89.95
State level verification factor for non- registered children(1-5 years)	57.61
State level verification factor for out of school children(6-19 years)	73.09
State inflation rate (1-5 years) (which measures the extent to which the recording in school reporting forms exceeds records at schools)	11.17
State inflation rate for non- registered children (1-5 years)	73.58
State inflation rate for out of school children(6-19 years)	36.81
Anganwadi **had surplus storage of drugs after deworming**	19.9

Anganwadi **had complete** ***Anganwadi*** **reporting form**	91.4
Day when ***Anganwadi*** **Observed the Deworming**	
Only deworming day	29.9
Only mop-up day	1.6
Both days	68.0
Others	0.5
Anganwadi **reported severe adverse event after taking the medicine**	8.0
Average **number of adverse events reported per** ***anganwadi***	8.9

National Health Mission

08, Old Jail Road Arera Hills, Bhopal
Madhya Pradesh

No./NIPI/NHM/2016/ 2808

Bhopal, Date 22/03/2016

To,

Dr. Rakesh Kumar
The Joint secretary, Govt. of India,
Ministry of Health & Family Welfare,
Nirman Bhawan, New Delhi

Subject:- Regarding implementation and deworming coverage report of National Deworming Day conducted on 10th February 2016 and mop-up on 15th February 2016.

Ref.:- Your DO letter no. Z-28020/237/2013-CH dated 11/12/2015

****

This is in reference to the implementation of National Deworming Day (NDD) in 41districts of Madhya Pradesh and remaining 10 districts were covered during Dec 2015 under LF-MDA. In compliance with the GoI directives, The NDD was formally inaugurated by Hon. Health Minister in Dhar and by PS (Health) in the state capital. Thus, the event had the desired media attention. Similarly, statewide inaugural events were conducted in 41 districts by divisional commissioners, district collectors, political leaders and officials of Health, ICDS and Education departments too.

The following activities were undertaken in the 41 districts of the State for ensuring maximal coverage in NDD 2016:-

1. Ensured statewide availability of Albendazole chewable tablets for children between 1-19 years. Free supply of 1.34Cr. Albendazole chewable tablets received from WHO.
2. Visibility and Publicity in form of Appeal by Honbl. Chief Minister of Madhya Pradesh in News papers, ASHA live talk show on Akaswani, on National Deworming Day.
3. Press conference chaired by Honbl. Health Minister Madhya Pradesh , broadcasting of radio jingles, Banner, posters, handouts in all govt/govt aided schools and AWCs to all school teachers, AWWs and frontline health functionaries was ascertained.
4. ***As a special initiative, ensured administration of Albendazole in 2718 private's schools of four districts viz Bhopal, Raisen Sagar and Burhanpur during NDD 2016. The coverage for the same was 88% with 20.3 lacs children dewormed.***
5. DO letters from Chief Secretary and Mission Director, NHM were issued to all collectors for reviewing preparedness and actual implementation of the program.
6. Video conference with officials of all allied departments was held on 28th January 2016 to review the preparedness of the event.
7. Joint Directives has been signed by Commissioner RSK, LSS and ICDS and circulated to the districts.
8. NDD Directives and IEC materials have been uploaded on E – repository site of ICDS, Education portal and DISE Booklet.
9. NDD message through IDEA cellular for MP subscriber on 9th and 10th Feb has been also ensured for maximum deworming coverage.
10. Similarly, District Coordination committee meeting (DCCM) and VC has been done in 41 districts in chairmanship of collector. In continuation of this, Joint directive has been signed by collector, CMHO, DEO and DPO at district level.
11. From the stale level, to ensure the effective implementation of NDD, supportive supervision has been done by OIC & SPMUs in their assigned districts.

12. Stringent monitoring and correctives were ensured based on reports of facilitating donor partners like Evidence Action: DtWi, MI, UNICEF, UNFPA and 130 independent monitors appointed by Evidence Action: DtWi including private schools.
13. Vigilant management of 207 minor adverse events reported from schools and AWCs has been ensured.
14. Inclusion of National Deworming Day, in the morning Assembly of schools as "Thought of the day" from 5th to 8th February 2016.

Kindly be apprised that ***there has been a slight change in the freezed denominator from 1.51Cr. to 1.52 Cr. due to inclusion of more number of private schools from the districts in NDD as well as increased number of registered children between 1 to 5 years owed to positioning of new AWCs.***

The state could reach out and render deworming services to approximately1.39 cr children during NDD 2016 thus, achieving and implementation coverage of 91% in 41 districts of the state. The deworming coverage for LF- MDA 10 districts is 93% which includes deworming administration to children 1 to 2 years of age as well as children left out during the LF MDA round.

The detailed report of the same is enclosed herewith in desired format. May also, please like to peruse dossier of photographs & media coverage documenting the successful implementation of NDD activities in the State.

Encl: As above

(Jaishri Kiyawat)
Mission Director,
National Health Mission
Madhya Pradesh

No./Child Health- Nutri/NHM/2016/ **Bhopal, Date:**

Copy to:-

1- Dr. Ajay Khera, DC-Child health & Immunization, MOHFW, Nirman Bhawan, New Delhi.
2- Dr. Sila Deb, DC- CH, MOHFW, Nirman Bhawan, New Delhi.
3- Principal Secretary, Dept. of Health and Family Welfare, GoMP Madhya Pradesh
4- Commissioner Health, Madhya Pradesh
5- Commissioner Rajya Siksha Kendra, Pustak Bhawan- B wing , Bhopal Madhya Pradesh
6- Commissioner ICDS, Vatslaya Bhawan, Madhya Pradesh
7- Commisssioner Lok Shikshan Sanchalnalaya, CPI office , Gautam Nagar, Madhya Pradesh

Mission Director,
National Health Mission
Madhya Pradesh

NATIONAL DEWORMING DAY FEBRUARY 2016
COMMON REPORTING FORMAT (For Block, District and State)

* Please fill in all the details below and write 'NA' wherever it is not applicable.

State: Madhya Pradesh	District: 41 districts covered		Block: 247
No. of Govt/Govt. Aided schools	1,21,534	No. of Govt/Govt aided schools reporting coverage	110596
No. of targeted private schools	2718	No. of private Schools reporting coverage	2365
No. of Anganwadi Centres (AWCs):	63832	No. of AWCs reporting coverage	58725
No. of ASHAs oriented/trained on NDD (National Deworming Day)		42,396	
No. of Govt/Govt aided schools who attended training on NDD		79,197	
No. of Private schools who attended training on NDD		2,058	
No. of Anganwadi workers oriented/trained on NDD		55,953	

Coverage Details

		Girls	Boys	Total
Total children out of school		4,06,034	4,57,868	(A) 8,63,902
Total children unregistered in AWCs		1,88,659	2,12,743	(B) 4,01,402
Total children registered in AWCs		22,38,116	25,23,832	(C) 47,61,948
Total children enrolled in the schools	Govt. school	39,67,442	44,73,923	(D) 84,41,365
	Pvt. school	3,77,263	4,25,425	(E) 8,02,688
Total number of children targeted:				(Z) 1,52,71,305
No. of enrolled children (class 1-5) who were administered Albendazole on NDD and MUD (Mop Up Day)	Govt.school	18,46,071	19,04,033	1(a) 37,50,104
	Pvt.school	1,03,429	1,08,792	1(b) 2,12,221
No. of enrolled children (class 6-12) who were administered Albendazole on NDD and MUD	Govt.school	19,25,710	19,48,550	2(a)38,74,260
	Pvt.school	2,48,006	2,37,140	2(b) 4,85,146
No. of registered children in AWCs (1-5 years) who were administered Albendazole on NDD and MUD		22,22,632	23,03,777	(3) 45,26,409
No. of unregistered children (1-5 years) who were administered Albendazole on NDD and MUD		1,50,759	1,35,028	(4) 2,85,787
No. of out of school children (6-10 years) who were administered Albendazole on NDD and MUD		1,45,459	1,33,110	(5) 2,78,569
No. of out of school adolescent (10-19 years)who were administered Albendazole on NDD and MUD		2,79,705	1,96,403	(6)4,76,108
GRAND TOTAL of number of children who were administered Albendazole (T=1a+1b+2a+2b+3+4+5+6)				(T) 1,38,88,604
Percent coverage		(T) X 100 / (Z)= 1,38,88,604 X 1,52,71,305,= 91%		
No. of severe adverse events reported from schools and AWCs		0 (217 minor adverse events has happened on NDD & MUD)		

Logistic Details: Block/District/State(tick as applicable)	**Govt. schools**	**Private schools**	**AWCs**
Total no of Albendazole tablets given	97,92,917	8,21,018	58,81,622
Total no of Albendazole tablets administered	80,05,582	7,32,235	52,13,616
Stock of Albendazole tablets left	17,87,335	88,783	6,68,006

Feedback (if any): 1- There has been a slight change in freezed denominator from 1.51Cr. to 1.52 cr. due to-
(a) Inclusion of more number of private schools from the districts in NDD and
(b) Increased number of registered children between 1 to 5 years due to positioning of new AWCs.
2- The NDD app was disseminated by MoHFW on 7th March 2016 which left no time for training of frontline functionaries on relevant data entry which has posed a risk for data accuracy.

Name, signature and designation of the official preparing the document: Pragya 18/3/16

Name, signature and designation of the official reviewing the document: 22/3/16 Mission Director National Health Missic Madhya Prad

Contact number of official submitting the report: **Dr. Pragya Tiwari, Mobile No - +91-9425018433**

National Health Mission
Madhya Pradesh
8, Arera Hills, Jail Road, Bhopal – 462004

No. /Child Health- Nutri./ NHN/2015/ **Bhopal, Date:**

Meeting Minutes

State National Iron Plus Initiative Advisory Committee Meeting dated 23.11.2015

National Iron plus Initiative programme is being implemented in the State of Madhya Pradesh since July 2014. NIPI and WIFS are convergent health interventions and hence as per the policy decision of the state, the State Advisory committee of WIFS has been subsumed under the broader program of National Iron plus Initiative (NIPI) program vide GO No. 7050 dated 30th Aug 2014. The first advisory committee meeting for the financial year 2015-16 was held on 19.05.2015. The second meeting for the year was held on 23rd Nov 2015 under the chairmanship of Principal Secretary, Health and Family Welfare, GoMP.

The meeting was attended by the following officials:-

1. **Mrs. Gouri Singh, Principal Secretary, Dept. of Health and Family Welfare, Madhya Pradesh**
2. **Mr. Pankaj Agarwal, Commissioner Health, Madhya Pradesh**
3. **Mrs. Sunita Tripathi, Director Health Services, Madhya Pradesh.**
4. **Dr. Pragya Tiwari, Deputy Director-Child Health Nutrition, NHM, MP**
5. **Dr. Dilip Hedau, Deputy Director, RKSK, NHM, MP.**
6. **Mr. Akshay Shrivastav, Joint Director, WCD, Madhya Pradesh**
7. **Ms. Shashilata Mishra, Assistant Director, SCD, Madhya Pradesh**
8. **Dr. Rekha Patel, Dy. Director, School Education, Madhya Pradesh**
9. **Mr. Deepak Dubey, Deputy Director, IEC, NHM, Bhopal, Madhya Pradesh**
10. **Dr. Tej Ram Jat, State Representative, UNFPA, Madhya Pradesh**
11. **Ms. Ritu Ghosh, State Programme Representative, Micronutrient Initiative, Madhya Pradesh**
12. **Ms. Deepika Sharma, Nutrition Specialist, UNICEF, MP**
13. **Ms. Esha Kalra, Program Manager, Evidence Action-DtWI, New Delhi**
14. **Ms. Roshni Dilbagi, State Programme Manager, Evidence Action-DtWI, MP.**
15. **Ms. Nilofer Sherwani, State Programme Coordinator, Evidence Action-DtWI, MP.**
16. **Ms. Neha Yadav, State Consultant, RBSK, Madhya Pradesh**
17. **Mr. Kamlesh Mishra, Consultant, Adolescent Health, Madhya Pradesh**
18. **Ms. Smita Shende, Consultant RKSK, Madhya Pradesh**
19. **Ms. Archana Shukla , Consultant NIPI/WIFS, Madhya Pradesh.**
20. **Mr. Ashis Mohanty , Data Manager Consultant NIPI/WIFS, Madhya Pradesh.**

The meeting was held in convergence with the allied department including representatives of Dept. of Rajya Shiksha Kendra, Lok Shikshan Sanchalnalaya, Dept. of Scheduled Caste Welfare, Integrated Child Development Scheme (ICDS) and key development partners MI, UNICEF, UNFPA and Evidence action - DtWI. Along with NIPI/WIFS, other convergent health programs viz. Rastriya Kishore Swasthya Karyakarm (RKSK) and Rastriya Bal Swasthya Karyakarm (RBSK) were also reviewed by the chair. DD-CHN/WIFS apprised the committee about the recommendations of previous meeting and action taken thereafter. The achievements, progress and challenges of NIPI and WIFS program for the year 2015-16 was discussed with detailed analysis of procurement status, leads stock availability in the

districts, training status and also block wise analysis of nil reporting and over reporting blocks. She shared the following key achievements of the programme:-

- For the advocacy of the WIFS programme the state has facilitated Media Advocacy Campaign with the support of GoI and UNICEF, which was chaired by Bollywood actress Ms. Priyanka Chopra. Video on WIFS has been developed and uploaded on NHM website by GoI and UNICEF for promotion of IFA Supplementation in adolescents.
- **Madhya Pradesh is the first state in the country which has freezed the denominator (target) of all age groups under NIPI and WIFS programme for the year 2015-16 as per the unified DISE data.**
- According to the freezed denominator, the state will need to ensure IFA supplementation in 71. 88 lacs children between 6 to 60 months, 59.74 lacs children between 5 to 10 yrs of age group and 64.86 lacs adolescents between 10 to 19 years.
- The Weekly IFA supplementation shall be implemented in 82,113 Primary Schools and 70,669 Middle, Higher and Higher Secondary Schools and 92,205 Aganwadi Centres as per directives of WIFS and NIPI program.
- The state has initiated block-wise reporting system from April 2015 and **is field testing the institution wise (schools and AWCs) reporting mechanism and considering development of an interface with HMIS for programmatic ease.**
- Responsibility of report collection has been shifted to the ASHA /urban ASHA for rural and urban report strengthening.
- The state has documented biweekly IFA supplementation coverage of 38% in 6 to 60 month children for quarter 1 (Apr 2015 to Jun 2015) and improvement in quarter 2 (July 2015 to Sep 2015) with 47% coverage. Likewise WIFS junior supplementation coverage in 5 to 10 years is 42% and 55% in Q1 & Q2 respectively.
- WIFS coverage for in-school going adolescents has reported an incremental trend from 43% in Q1 to 61% in quarter 2, however there has been slight decline in WIFS coverage among out of school adolescents girls from 51% in quarter 1 to 43% in quarter 2.
- As per the STH prevalence survey report and policy decision of the state only one annual round of deworming shall be conducted for children between 1-19 years on 10 February 2016 confirming to the National Deworming Day.
- The state has received free drug supply of 1.34 cr. Albendazole chewable tablets from WHO. Hence the state has sufficient quantity to organize NDD in February 2016. It was also apprised that as per MoHFWs directives the state may exclude 10 districts in which LF MDA shall be conducted between 13th to 20th Dec 2015.
- Anemia, IFA supplementation and Deworming component has been included in training curriculum of ICDS and Education to orient teachers and anganwadi workers.

The following salient recommendations/decisions were made by the committee:-

- **NHE sessions shall be taken by RBSK doctors visiting the village to improve the screening and referral of anemia cases. The teachers shall promote awreness generation regarding IFA supplementation in student through inclusion of such topics during assembly discussions, speech and debate topics.**
- **It was concurred by the chair that the NDD 2016 shall be conducted in only 41 districts as rest of the 10 districts (Umaria, Chhattarpur, Tikamgarh, Datia, Panna, Chhindwada, Satna, Damoh Katni and Rewa) shall be covered under Lymphatic filariasis round under MDA. Deworming coverage of these ten MDA districts will be extrapolated and reported in NDD as well.**
- **The scope of NDD shall be expanded in the year 2016 to include 2,276 private, central and municipal schools of Bhopal, Raisen and Sagar on pilot basis.**
- **It is considered under suggestion of ICDS to extend the benefits of incentives to the AWWs for improving out of school coverage to which it was decided by the chair to implement the same in nil reporting blocks for out of schools IFA supplementation.**

- **The committee was appraised by ICDS representative that there are approx. 8 lac children enrolled in 15 SABLA districts where ICDS shall put more emphasis on improving WIFS and NIPI coverage in out of school children or school drop outs.**
- **It was agreed to link biannual Hb estimation of out of school adolescents girls in 15 SABLA districts by ANMs during VHND.**
- **It was agreed by ICDS to include NIPI & WIFS component in the in-service training of AWW.**
- **Both ICDS and education dept. agreed on stringent reporting of adverse events, if any. It was decided that the monthly report of NIPI & WIFS with over reporting and nil reporting block shall be shared with the Education and ICDS department to review the program in their departmental meeting and video conferences.**
- **It was directed by the chair that the state may undertake a rapid assessment for coverage evaluation in few chosen districts through donor support especially by MI & UNICEF support.**
- **UNICEF shall support the state for intensive monitoring of WIFS & NIPI Program and also facilitate the media advocacy campaign for the upscale in entire country.**
- **Micronutrient Initiative shall support in facilitation of trainings on IFA supplementation in 26 support districts and also render support in coverage validation and data accuracy.**
- **DtWI shall support in conduction of NDD 2016.**

Rashtriya Kishor Swasthya Karyakram (RKSK)

RKSK was also reviewed by the chair and following major decisions were taken:-

- **The state shall incorporate 15 SABLA districts of WCD in the upscale plan of next phase so that better convergence with ICDS would result in better off take of the program.**
- **Peer educator selection criteria were discussed and it was observed by the chair that since the PEs didn't have any monetary gains therefore, it is challenging to impose any accountability for implementation of the program.**
- **It was discussed that implementation PE program is very challenging as the adolescent population is floating population and to engage adolescent and tough task so identify the good NGOs for motivating of , one needs different techniques and skills. It is important that the counselors engage in a meaningful dialogue with adolescents. It was observed by the committee members that the high degree of motivation, commitment and supervision is needed from frontline workers and PEs.**
- **The modality of training of PEs and counselors was discussed and PS health emphasized on quality of training.**
- **It was decided to disseminate the Sathiya App and video to all stakeholder depts. and their frontline workers.**
- **Strengthening of AFHC clinics in RKSK districts was mandated and it was directed to increase footfalls in lesser performing clinics and to analyse the client trends in the same.**
- **DD-AH briefed to the committee regarding the envisaged role of AH counselors, steps taken by the cell to increase the footfalls, capacity building initiatives to enhance the counseling skills and efforts to increase the visibility of AH program across 51 districts.**
- **It was directed to hold a follow-up meeting on 28th Nov 15 for further discussion on implementation strengthening and modalities of role out of PE program.**

Rashtriya Bal Swasthya Karyakram (RBSK)

The committee was apprised of the scope, objectives, deliverables and implementation status of the RBSK in the state. The prevalence of various health conditions among screened children was discussed and focus was given on the importance of early detection and treatment of 30 identified health conditions. The role of inter-departmental convergence and coordination was also discussed for better implementation of RBSK. Mobile Health Teams visit schools once in a year and AWCs biannually as per their micro-plan. Advance tour program of the same is shared with the FLWs of the Education and ICDS, however, it is observed that the attendance is very low at AWC & schools.

The following salient recommendations/decisions were made by the committee:-

- **The advance tour program and micro-plan of MHT shall be shared 15-30 days prior to visit with CDPO of ICDS, BEO of Education dept. and Project Officer of Dept. of Tribal Welfare so that preparation may be ensured.**
- **AWW, nodal teachers/principals would ensure maximum attendance of the children on the screening date and be responsible for ensuring proper place, sitting arrangements, privacy and friendly environment for screening.**
- **Referral and transportation of identified children can be made using vehicles under National Ambulance Service Scheme i.e, 108 and Janani Express 102 along with RBSK District Coordinator's vehicle. For tertiary care referrals of identified children the state shall plan for provision of Rs.5000/- or reimbursement of actual fare of transportation of child along with mother and one attendant.**
- **The state shall coordinate for handholding of Project Officer Tribal Welfare for screening of children with Sickle Cell Anemia.**
- **It was directed to issue Joint Directives delineating clear roles responsibilities of FLWs of each department so that better implementation of the scheme may be ensured.**

Approved by PS Health

(Faiz Ahmed Kidwai)
(Mission Director)
NHM Bhopal, MP

Annexure C i- Letter for Inclusion of Private Schools in District Bhopal, Sagar

राष्ट्रीय स्वास्थ्य मिशन

8, क्षेत्रीय ग्रामीण बैंक परिसर, अरेरा हिल्स,
भोपाल, मध्यप्रदेश

क्रमांक/एन.एच.एम/शिशु स्वास्थ्य पोषण/2016/277 भोपाल, दिनांक 06/01/2016

प्रति,

मुख्य चिकित्सा एवं स्वास्थ्य अधिकारी,
जिला भोपाल/रायसेन तथा सागर, मध्यप्रदेश

विषय : राष्ट्रीय कृमिमुक्ति दिवस –2016 के आयोजन में जिले के निजी/प्रायवेट शालाओं को सम्मिलित करने बाबत।
संदर्भ : भारत शासन का संयुक्त हस्ताक्षरित अर्धशासकीय पत्र क्रमांक Z28020/237/2013-CH दिनांक 11/12/2015

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विषयांतर्गत लेख है कि दिनांक 10 फरवरी 2016 को राष्ट्रीय कृमिमुक्ति दिवस एवं 15 फरवरी 2016 को मॉप–अप दिवस का आयोजन किया जाना है। प्रदेश में पायलेट आधार पर भोपाल, रायसेन एवं सागर के निजी/प्रायवेट शालाओं में पंजीकृत बच्चों को इस कृमिनाशन की वृहद साक्ष्य आधारित गतिविधि में सम्मिलित किया जाना है। जिला भोपाल, रायसेन एवं सागर में DISE डेटा अधारित निम्नानुसार निजी शाला एवं पंजीकृत बच्चे है :–

क्र.	जिले का नाम	जिले में कुल निजी शालाओं की संख्या	जिले में पंजीकृत बच्चों की संख्या
1	भोपाल	1435	3,92,997
2	रायसेन	427	1,04,399
3	सागर	710	1,81,767
	कुल योग	2,572	6,79,163

राष्ट्रीय कृमिमुक्ति दिवस 2016 के आयोजन हेतु अंग्रेजी एवं हिन्दी में एक संक्षिप्त कन्सेप्ट नोट/अनुरोध पत्र प्रारूप तैयार कर आपकी ओर प्रेषित है ताकि जिला कलेक्टर के हस्ताक्षर द्वारा सभी निजी शालाओं के प्राचार्यों को उनके शिक्षण माध्यम के अनुरूप उक्त आयोजन के संबंध में सहयोग करने हेतु निर्देशित किया जा सके।

निर्देशित किया जाता है कि तदानुसार शीघ्रातिशीघ्र निजी/प्रायवेट शालाओं के यूनियन प्रतिनिधियों एवं जिला कलेक्टर की अध्यक्षता में बैठक आहूत करे जिसमें जिला शिक्षण अधिकारी को भी सम्मिलित किया जाये। सभी प्रायवेट शालाओं में शिक्षकों का प्रशिक्षण, एल्बेण्डाजोल तथा प्रतिकूल घटना के प्रबंधन के लिये आवश्यक मूलभूत औषधियां, राज्य स्तर से प्रेषित प्रचार–प्रसार सामग्री (फ्लेक्स–बैनर, पोस्टर, शिक्षकों हेतु हैन्डआउट सह रिपोर्टिंग प्रपत्र) उपलब्ध कराना सुनिश्चित करें।

संलग्न : अंग्रेजी एवं हिन्दी में राष्ट्रीय कृमिमुक्ति दिवस हेतु अनुरोध पत्र प्रारूप

ह/
(फैज़ अहमद किदवई)
मिशन संचालक
एन.एच.एम.,मध्यप्रदेश

पृ.क्रमांक/शिशु स्वास्थ्य पोषण/एन.एच.एम/2015/278 भोपाल,दिनांक 06/01/2016

प्रतिलिपिः– सूचनार्थ।

1. प्रमुख सचिव, लोक स्वास्थ्य एवं परिवार कल्याण विभाग, एन.एच.एम.,मध्यप्रदेश।
2. आयुक्त स्वास्थ्य स्वास्थ्य सेवायें, मध्यप्रदेश।
3. संचालक,एन.एच.एम.,मध्यप्रदेश।
4. संभागीय संयुक्त संचालक, स्वास्थ्य सेवायें, भोपाल/सागर, मध्यप्रदेश।
5. कलेक्टर, भोपाल/रायसेन एवं सागर, मध्यप्रदेश।
6. जिला कार्यक्रम प्रबंधक, एन.एच.एम., भोपाल/रायसेन एवं सागर, मध्यप्रदेश की ओर आवश्यक समन्वय हेतु
7. जिला पोषण सलाहकार, भोपाल/रायसेन एवं सागर, मध्यप्रदेश की ओर आवश्यक समन्वय हेतु ।

ह/
मिशन संचालक
एन.एच.एम.,मध्यप्रदेश

राष्ट्रीय कृमिमुक्ति दिवस पर निजी शालाओं को सम्मिलित करने बाबत टीप

राष्ट्रीय कृमिमुक्ति दिवस –2016, लोक स्वास्थ्य एवं परिवार कल्याण मंत्रालय द्वारा निर्देशित गतिविधि :

राष्ट्रीय कृमिमुक्ति दिवस एक स्थाई दिवस रणनीति है जिसके तहत शालाओं एवं आगंवाडी केन्द्रों के माध्यम से 01 से 19 वर्षीय बच्चों का कृमिनाशन किया जायेगा। प्रथम चरण में 11 राज्यो में विगत फरवरी 2015 को हितग्राही आयुवर्ग के लगभग 8.98 करोड़ बच्चों का सफलता पूर्वक कृमिनाशन किया गया। 01 से 14 वर्षीय बच्चों में परजीवी कृमी संक्रमंण की संभावना सबसे प्रबल होती है, जो व्यक्तिगत अस्वच्छता तथा संक्रमित अथवा दूषित मिट्टी/मल के संपर्क मे आने से होती है। **विश्व स्वास्थ्य संगठन द्वारा समस्त शालेय एवं पूर्व शालेय बच्चों का कृमिनाशन किया जाना अनुशंसित है ताकि मिट्टी जनित कृमि संक्रमण से होने वाली वैश्विक रूग्णता में वर्ष 2020 तक वांछित कमी लाई जा सके।** प्रदेश में विगत 10 फरवरी 2015 को लोक स्वास्थ्य एवं परिवार कल्याण विभाग, स्कूल शिक्षा विभाग, एकीकृत बाल विकास सेवायें, महिला बाल विकास विभाग तथा आदिवासी विकास विभाग द्वारा गैर शासकीय संगठन ऐवीडेन्स एक्शन – डीवर्म द वर्ल्ड इनिशिएटिव के सहयोग एवं संयुक्त प्रयास द्वारा लगभग 1.84 करोड़ बच्चों का सफलता पूर्वक कृमिनाशन किया गया।

शिक्षा विभाग के DISE डेटा एवं ASER रिर्पोट (2013–14) में प्रतिवेदन अनुसार प्रदेश के शालाओं में कुल पंजीकृत बच्चों में से लगभग 46% शालेय उम्र के बच्चे निजी एवं केन्द्र सहायित शालाओं में पंजीकृत है। इतनी बड़ी तादाद में निजी शालाओं में पंजीकरण होने से यह अत्यंत महत्वपूर्ण हो जाता है कि शासकीय शाला अधारित स्वास्थ्य एवं शिक्षण कार्यक्रमों की पहुँच इन बच्चों तक पहुँचाई जाये। वैज्ञानिक शोध से यह प्रमाणित है कि स्थाई दिवस पर बड़ी संख्या में कृमिनाशन गतिविधि, जन स्वास्थ्य की दृष्टि से सुरक्षित है एवं इस गतिविधि द्वारा बच्चों की स्वास्थ्य, शैक्षणिक पहुँच एवं परवर्ती वर्षो में आजीविका में वृद्धि हो सकती है। **राष्ट्रीय कृमिमुक्त दिवस के सकारात्मक परिणामों में रक्ताल्पता अथवा एनिमिया में कमी, पोषण स्तर में सुधार, समूचित वज़न वृद्धि, मानक अनुसार शारीरिक एवं मनोवैज्ञानिक विकास, बाल्यकालीन संक्रमणों के लिये प्रतिरोधात्मक क्षमता में बढ़ोत्तरी एवं शालेय उपस्थिती व सीखने की क्षमता में सुधार आदि प्रमुख है।**

वर्ष 2016 में राष्ट्रीय कृमिमुक्ति दिवस के आयोजन प्रदेश के 3 जिले यथा भोपाल, रायसेन एवं सागर के समस्त निजी/प्रायवेट शालाओं में विस्तारित किया जायेगा। मिट्टी जनित कृमि संक्रमण जो कि भारत की एक प्रमुख जन स्वास्थ्य समस्या है कि रोकथाम हेतु आपसे सहयोग एवं प्रतिबद्धता अपेक्षित है। आशा है कि हम आपके सहयोग से बेहतर कार्यक्रम क्रियान्वयन, बेहतर कवरेज एवं अधिकाधिक बच्चों तक गुणवत्तापूर्ण स्वास्थ्य सेवा पहुँचाने में कारगर होंगे।

Note on Inclusion of Private Schools

National Deworming Day – An Initiative of the Ministry of Health and Family Welfare, Government of India:

National Deworming Day (NDD) is a fixed day approach when all children between 1-19 years of age will be targeted to receive treatment for parasitic intestinal worms through the platform of schools and anganwadi centers. The first National Deworming Day implemented in 11 states in February 2015 successfully dewormed 89.8 million children in the age group of 1-19 years. Children between the ages of 1 to 14 are prone to risk of parasitic intestinal worms in India which result from poor sanitation - hygiene conditions and are easily transmitted from child to child through contact with infected soil or oro-faecal contamination. **The World Health Organization (WHO) recommends "Deworming of all school age and pre-school age children", aiming to eliminate global morbidity due to worms (soil-transmitted helminths) in children by 2020.** The Department of Public, Health and Family Welfare, Department of Education, Department of Women and Child Development (ICDS), in facilitation of donor partner agency, Evidence Action-Deworm the World Initiative has successfully implemented mass deworming on a fixed day strategy on 10th February 2015 wherein almost 1.84 crore children between age group of 1-19 years were dewormed in government and government aided schools and anganwadi centers.

As per the DISE data of State Education department and ASER report(Annual Status Of Education Report-2013-14), approximately 46 % of school age children are enrolled in private and centrally affiliated schools, out of total enrolled children at schools in Madhya Pradesh. With such a significant proportion of children attending private schools, it becomes imperative that school-based health and education programs of the Government are extended to reach these children. Rigorous scientific research have shown that mass deworming activity as safe as a public health intervention and documented significant gains from school based deworming program on children's health, access to education and livelihood. The benefits may be cited as **decrease in anemia and improved nutrition levels, optimal growth and weight gain, improved cognition and psycho-physical development, increase resistance to common childhood infections and improved learning ability and school attendance.**

In the year-2016, the scope of National Deworming Day shall be extended to the private schools of three districts viz Bhopal, Raisen and Sagar. You are requested to kindly co-operate towards fulfillment of the commitment towards reducing soil transmitted helminthes, a public health problem in India. We look forward to an improved programme with maximum coverage and high quality service delivery.

राष्ट्रीय स्वास्थ्य मिशन

8 क्षेत्रीय ग्रामीण बैंक परिसर, अरेरा हिल्स,
भोपाल, मध्यप्रदेश

क्रमांक/एन.एच.एम/NIPI/2015/13403 भोपाल, दिनांक 7/12/2015

प्रति,

मुख्य चिकित्सा एवं स्वास्थ्य अधिकारी,
जिला सागर एवं छतरपुर

विषयः— आगामी नेशनल डीर्मिंग डे (10 फरवरी 2016) में प्राईवेट शालाओं एवं केन्द्रीय विद्यालयों को सम्मिलित किये जाने के संबंध में।

संदर्भः— पत्र क्रमांक/एन.एच.एम/NIPI/2015/11732 दिनांक 20.10.2015

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विषयांतर्गत लेख है कि आगामी नेशनल डीर्मिंग डे का आयोजन प्रदेश में 10 फरवरी 2016 को समस्त शासकीय/शासकीय अनुदान प्राप्त शालाओं एवं आंगनवाड़ी केन्द्रों के माध्यम से किया जाना है। भारत सरकार से प्राप्त नेशनल डीर्मिंग डे के दिशा–निर्देश अनुरूप प्राईवेट एवं केन्द्रीय विद्यालयों के बच्चों में कृमिनाशन हेतु एल्बेण्डाजोल गोली की प्रदायगी सुनिश्चित की जानी है इस तारतम्य में पायलट टेस्टिंग के लिये 3 जिलों रायसेन, भोपाल एवं छतरपुर का चिन्हांकन किया गया था जिस हेतु उक्त कार्यालयीन संदर्भित पत्र के माध्यम से इन तीन जिलों को निर्देशित किया गया था।

ज्ञातव्य हो कि 10 जिलों में दिनांक 13 दिसम्बर से 20 दिसम्बर 2015 तक लिम्फेटिक फाईलेरियेसिस जिलों में एम.डी.ए आयोजित किया जाना है जिसमें छतरपुर भी सम्मिलित है। इन 10 जिलों में नेशनल डिवर्मिंग डे का आयोजन माह फरवरी 2016 में नही किया जाएगा।

अतः **छतरपुर के स्थान पर जिला सागर के 710 प्राईवेट एवं केन्द्रीय विद्यालयों को नेशनल डिवर्मिंग डे में सम्मिलित किये जाने हेतु निर्देशित किया जाता है तथा जिला सागर से अपेक्षित है कि प्राईवेट एवं केन्द्रीय विद्यालयों में आगामी नेशनल डिवर्मिंग डे के आयोजन की पूर्व तैयारी सुनिश्चित की जावें।**

(फैज़ अहमद किदवई)
मिशन संचालक
राष्ट्रीय स्वास्थ्य मिशन,म.प्र.

क्रमांक/एन.एच.एम/NIPI/2015/13404 भोपाल, दिनांक 7/12/2015

प्रतिलिपिः— सूचनार्थ आवश्यक कार्यवाही हेतु ।

1. प्रमुख सचिव, लोक स्वास्थ्य एवं परिवार कल्याण विभाग, वल्लभ भवन मध्यप्रदेश।
2. स्वास्थ्य आयुक्त, मध्यप्रदेश।
3. संभागीय संयुक्त संचालक, सागर संभाग स्वास्थ्य सेवायें, मध्यप्रदेश।
4. जिला कार्यक्रम प्रबंधक, जिला सागर एवं छतरपुर, मध्यप्रदेश।
5. जिला पोषण सलाहकार, जिला छतरपुर, मध्यप्रदेश।

मिशन संचालक
राष्ट्रीय स्वास्थ्य मिशन,म.प्र.

Annexure C iii- Letter for Inclusion of Private Schools in district of Burhanpur

राष्ट्रीय स्वास्थ्य मिशन

8, क्षेत्रीय ग्रामीण बैंक परिसर, अरेरा हिल्स,
भोपाल, मध्यप्रदेश

क्रमांक/एन.एच.एम/शिशु स्वास्थ्य पोषण/2016/1300 भोपाल, दिनांक 05/02/2016

प्रति,

मुख्य चिकित्सा एवं स्वास्थ्य अधिकारी,
जिला बुरहानपुर, मध्यप्रदेश

विषय : राष्ट्रीय कृमिमुक्ति दिवस –2016 के आयोजन में जिले के निजी/प्रायवेट शालाओं को सम्मिलित करने बाबत।
संदर्भ : क्रमांक/एन.एच.एम/NIPI/2015/14311, दिनांक 31/12/2015

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विषयांतर्गत लेख है उक्त संदर्भित पत्र के माध्यम से राष्ट्रीय कृमिमुक्ति दिवस–2016 का आयोजन किये जाने हेतु निर्देशित किया गया है जिसके अंतर्गत शासकीय/शासकीय अनुदान प्राप्त शालाओं एवं आंगनवाड़ी केन्द्रों के माध्यम से दिनांक 10 फरवरी 2016 को राष्ट्रीय कृमिमुक्ति दिवस पर 1–19 वर्षीय बच्चों को एल्बेण्डाजोल की मीठी गोली खिलवाई जाना है एवं छुटे हुये बच्चों को 16 फरवरी 2016 मॉप–अप दिवस पर कृमिनाशक गोली की प्रदायगी की जाना है। इसी तारतम्य में राज्य स्तर पर हुये नितिगत निर्णय अनुसार जिले के निजी/प्रायवेट शालाओं में पंजीकृत बच्चों को इस कृमिनाशन की वृहद साक्ष्य आधारित गतिविधि में सम्मिलित किया जाना है। जिला बुरहानपुर में DISE डेटा अनुसार 146 निजी शालाओं में कुल 38,109 बच्चे पंजीकृत है।

उक्त के संबंध में निर्देशित किया जाता है कि :–

- जिला स्तर पर निजी शालाओं में पंजीकृत बच्चों की संख्या के मान से कृमिनाशक गोली का आंकलन कर एवं उपलब्ध औषधि अनुसार इन्डेन्ट एवं वाहन राज्य स्तर पर प्रेषित किया जाये। ज्ञातव्य हो कि राज्य स्तर से 1,73,300 एल्बेण्डाजोल गोलियां (528 Jar of 200 Tablets each) बुरहानपुर को पूर्व में प्रेषित किये गये है।
- शीघ्रातिशीघ्र निजी/प्रायवेट शालाओं के यूनियन प्रतिनिधियों एवं जिला कलेक्टर की अध्यक्षता में बैठक आहूत करे जिसमें जिला शिक्षा अधिकारी को भी सम्मिलित किया जाये।
- फ्लेक्स–बैनर एवं हेन्डआउट सह रिर्पोटिंग प्रपत्र की उपलब्धता एवीडेन्स एक्शन डीवर्म द वर्ल्ड इनिशिएटिव द्वारा दिनांक 07/02/2016 तक उपलब्ध कराई जायेगी। इस हेतु जिले में पदस्थ डीवर्म द वर्ल्ड इनिशिएटिव के प्रतिनिधी से आवश्यक सहयोग प्राप्त करे।
- जिला स्तर पर निजी/पायवेट शालाओं हेतु एन.डी.डी कीट (बैनर, हेन्डआउट सह रिर्पोटिंग प्रपत्र, प्रतिकूल घटना की औषधियां) तैयार कर वितरण दिनांक 08/02/2016 तक सुनिश्चित किया जाये जिससे 10 फरवरी 2016 को निजी/प्रायवेट शालाओं में कृमिनाशक गोली की प्रदायगी सुनिश्चित की जा सके।
- राष्ट्रीय कृमिमुक्ति दिवस 2016 के आयोजन हेतु अंग्रेजी एवं हिन्दी में एक संक्षिप्त कन्सेप्ट नोट/अनुरोध पत्र प्रारूप तैयार कर आपकी ओर प्रेषित है ताकि जिला कलेक्टर के हस्ताक्षर द्वारा सभी निजी शालाओं के प्राचार्यों को उनके शिक्षण माध्यम के अनुरूप उक्त आयोजन के संबंध में सहयोग करने हेतु निर्देशित किया जा सके।

संलग्न : अंग्रेजी एवं हिन्दी में एक संक्षिप्त कन्सेप्ट नोट

ok (जयश्री कियावत)
मिशन संचालक
एन.एच.एम, मध्यप्रदेश

पृ.क्रमांक/शिशु स्वास्थ्य पोषण/एन.एच.एम/2016/1301 भोपाल,दिनांक 05/02/2016

प्रतिलिपि:– सूचनार्थ।

1. प्रमुख सचिव, लोक स्वास्थ्य एवं परिवार कल्याण विभाग, एन.एच.एम.,मध्यप्रदेश।
2. आयुक्त स्वास्थ्य स्वास्थ्य सेवायें, मध्यप्रदेश।
3. संचालक,एन.एच.एम.,मध्यप्रदेश।
4. संभागीय संयुक्त संचालक, स्वास्थ्य सेवायें, इंदौर संभाग इंदौर, मध्यप्रदेश।
5. कलेक्टर, जिला बुरहानपुर, मध्यप्रदेश।
6. जिला कार्यक्रम प्रबंधक, एन.एच.एम., जिला बुरहानपुर, मध्यप्रदेश की ओर आवश्यक समन्वय हेतु।
7. जिला पोषण सलाहकार, जिला बुरहानपुर, मध्यप्रदेश की ओर आवश्यक समन्वय हेतु।

मिशन संचालक
एन.एच.एम.,मध्यप्रदेश

राष्ट्रीय कृमिमुक्ति दिवस पर निजी शालाओं को सम्मिलित करने बाबत टीप

राष्ट्रीय कृमिमुक्ति दिवस –2016, लोक स्वास्थ्य एवं परिवार कल्याण मंत्रालय द्वारा निर्देशित गतिविधि :

राष्ट्रीय कृमिमुक्ति दिवस एक स्थाई दिवस रणनीति है जिसके तहत शालाओं एवं आगंवाडी केन्द्रों के माध्यम से 01 से 19 वर्षीय बच्चों का कृमिनाशन किया जायेगा। प्रथम चरण में 11 राज्यो में विगत फरवरी 2015 को हितग्राही आयुवर्ग के लगभग 8.98 करोड़ बच्चों का सफलता पूर्वक कृमिनाशन किया गया। 01 से 14 वर्षीय बच्चों में परजीवी कृमी संक्रमण की संभावना सबसे प्रबल होती है, जो व्यक्तिगत अस्वच्छता तथा संक्रमित अथवा दूषित मिट्टी/मल के संपर्क मे आने से होती है। **विश्व स्वास्थ्य संगठन द्वारा समस्त शालेय एवं पूर्व शालेय बच्चों का कृमिनाशन किया जाना अनुशंसित है ताकि मिट्टी जनित कृमि संक्रमण से होने वाली वैश्विक रूग्णता में वर्ष 2020 तक वांछित कमी लाई जा सके।** प्रदेश में विगत 10 फरवरी 2015 को लोक स्वास्थ्य एवं परिवार कल्याण विभाग, स्कूल शिक्षा विभाग, एकीकृत बाल विकास सेवायें, महिला बाल विकास विभाग तथा आदिवासी विकास विभाग द्वारा गैर शासकीय संगठन ऐवीडेन्स एक्शन – डीवर्म द वर्ल्ड इनिशिएटिव के सहयोग एवं संयुक्त प्रयास द्वारा लगभग 1.84 करोड़ बच्चों का सफलता पूर्वक कृमिनाशन किया गया।

शिक्षा विभाग के DISE डेटा एवं ASER रिर्पोट (2013–14) में प्रतिवेदन अनुसार प्रदेश के शालाओं में कुल पंजीकृत बच्चों में से लगभग 48% शालेय उम्र के बच्चे निजी एवं केन्द्र सहायित शालाओं में पंजीकृत है। इतनी बड़ी तादाद में निजी शालाओं में पंजीकरण होने से यह अत्यंत महत्वपूर्ण हो जाता है कि शासकीय शाला आधारित स्वास्थ्य एवं शिक्षण कार्यक्रमों की पहुँच इन बच्चों तक पहुँचाई जाये। वैज्ञानिक शोध से यह प्रमाणित है कि स्थाई दिवस पर बड़ी संख्या में कृमिनाशन गतिविधि, जन स्वास्थ्य की दृष्टि से सुरक्षित है एवं इस गतिविधि द्वारा बच्चों की स्वास्थ्य, शैक्षणिक पहुँच एवं परवर्ती वर्षो में आजीविका में वृद्धि हो सकती है। **राष्ट्रीय कृमिमुक्त दिवस के सकारात्मक परिणामों में रक्ताल्पता अथवा एनिमिया में कमी, पोषण स्तर में सुधार, समूचित वज़न वृद्धि, मानक अनुसार शारीरिक एवं मनोवैज्ञानिक विकास, बाल्यकालीन संक्रमणों के लिये प्रतिरोधात्मक क्षमता में बढ़ोत्तरी एवं शालेय उपस्थिती व सीखने की क्षमता में सुधार आदि प्रमुख है।**

वर्ष 2016 में राष्ट्रीय कृमिमुक्ति दिवस के आयोजन प्रदेश के 3 जिले यथा भोपाल, रायसेन एवं सागर के समस्त निजी/प्रायवेट शालाओं में विस्तारित किया जायेगा। मिट्टी जनित कृमि संक्रमण जो कि भारत की एक प्रमुख जन स्वास्थ्य समस्या है कि रोकथाम हेतु आपसे सहयोग एवं प्रतिबद्धता अपेक्षित है। आशा है कि हम आपके सहयोग से बेहतर कार्यक्रम क्रियान्वयन, बेहतर कवरेज एवं अधिकाधिक बच्चों तक गुणवत्तापूर्ण स्वास्थ्य सेवा पहुँचाने में कारगर होंगे।

Note on Inclusion of Private Schools

National Deworming Day – An Initiative of the Ministry of Health and Family Welfare, Government of India:

National Deworming Day (NDD) is a fixed day approach when all children between 1-19 years of age will be targeted to receive treatment for parasitic intestinal worms through the platform of schools and anganwadi centers. The first National Deworming Day implemented in 11 states in February 2015 successfully dewormed 89.8 million children in the age group of 1-19 years. Children between the ages of 1 to 14 are prone to risk of parasitic intestinal worms in India which result from poor sanitation - hygiene conditions and are easily transmitted from child to child through contact with infected soil or oro-faecal contamination. **The World Health Organization (WHO) recommends "Deworming of all school age and pre-school age children", aiming to eliminate global morbidity due to worms (soil-transmitted helminths) in children by 2020.** The Department of Public, Health and Family Welfare, Department of Education, Department of Women and Child Development (ICDS), in facilitation of donor partner agency, Evidence Action-Deworm the World Initiative has successfully implemented mass deworming on a fixed day strategy on 10th February 2015 wherein almost 1.84 crore children between age group of 1-19 years were dewormed in government and government aided schools and anganwadi centers.

As per the DISE data of State Education department and ASER report(Annual Status Of Education Report-2013-14), approximately 46 % of school age children are enrolled in private and centrally affiliated schools, out of total enrolled children at schools in Madhya Pradesh. With such a significant proportion of children attending private schools, it becomes imperative that school-based health and education programs of the Government are extended to reach these children. Rigorous scientific research have shown that mass deworming activity as safe as a public health intervention and documented significant gains from school based deworming program on children's health, access to education and livelihood. The benefits may be cited as **decrease in anemia and improved nutrition levels, optimal growth and weight gain, improved cognition and psycho-physical development, increase resistance to common childhood infections and improved learning ability and school attendance.**

In the year-2016, the scope of National Deworming Day shall be extended to the private schools of three districts viz Bhopal, Raisen and Sagar. You are requested to kindly co-operate towards fulfillment of the commitment towards reducing soil transmitted helminthes, a public health problem in India. We look forward to an improved programme with maximum coverage and high quality service delivery.

महत्वपूर्ण

राष्ट्रीय स्वास्थ्य मिशन

8 क्षेत्रीय ग्रामीण बैंक परिसर, अरेरा हिल्स, भोपाल, मध्यप्रदेश

क्रमांक/एन.एच.एम/NIPI/2015/14227 भोपाल, दिनांक 29/12/2015

प्रति,

1. मुख्य चिकित्सा एवं स्वास्थ्य अधिकारी,
   जिलाः भोपाल, रायसेन, होशंगाबाद, हरदा, बैतूल, सीहोर, विदिशा, राजगढ़, इंदौर, झाबुआ, बड़वानी, बुरहानपुर, धार, अलीराजपुर, खण्डवा, खरगौन, उज्जैन, देवास, नीमच, मंदसौर, रतलाम, शाजापुर, आगर–मालवा, सीधी, सिंगरौली, अनुपपुर, शहडोल, सागर, जबलपुर, बालघाट, सिवनी, मण्डला, डिण्डोरी, नरसिंहपुर, ग्वालियर, गुना, अशोकनगर, भिण्ड, मुरैना, श्योपुर एवं शिवपुरी, मध्यप्रदेश

2. जिला शिक्षा अधिकारी, लोक शिक्षण संचालनालय,
   जिलाः भोपाल, रायसेन, होशंगाबाद, हरदा, बैतूल, सीहोर, विदिशा, राजगढ़, इंदौर, झाबुआ, बड़वानी, बुरहानपुर, धार, अलीराजपुर, खण्डवा, खरगौन, उज्जैन, देवास, नीमच, मंदसौर, रतलाम, शाजापुर, आगर–मालवा, सीधी, सिंगरौली, अनुपपुर, शहडोल, सागर, जबलपुर, बालघाट, सिवनी, मण्डला, डिण्डोरी, नरसिंहपुर, ग्वालियर, गुना, अशोकनगर, भिण्ड, मुरैना, श्योपुर एवं शिवपुरी, मध्यप्रदेश

3. जिला परियोजना समन्वयक, राज्य शिक्षा केन्द्र,
   जिलाः भोपाल, रायसेन, होशंगाबाद, हरदा, बैतूल, सीहोर, विदिशा, राजगढ़, इंदौर, झाबुआ, बड़वानी, बुरहानपुर, धार, अलीराजपुर, खण्डवा, खरगौन, उज्जैन, देवास, नीमच, मंदसौर, रतलाम, शाजापुर, आगर–मालवा, सीधी, सिंगरौली, अनुपपुर, शहडोल, सागर, जबलपुर, बालघाट, सिवनी, मण्डला, डिण्डोरी, नरसिंहपुर, ग्वालियर, गुना, अशोकनगर, भिण्ड, मुरैना, श्योपुर एवं शिवपुरी, मध्यप्रदेश

4. जिला कार्यक्रम अधिकारी, एकीकृत बाल विकास सेवाएं,
   जिलाः भोपाल, रायसेन, होशंगाबाद, हरदा, बैतूल, सीहोर, विदिशा, राजगढ़, इंदौर, झाबुआ, बड़वानी, बुरहानपुर, धार, अलीराजपुर, खण्डवा, खरगौन, उज्जैन, देवास, नीमच, मंदसौर, रतलाम, शाजापुर, आगर–मालवा, सीधी, सिंगरौली, अनुपपुर, शहडोल, सागर, जबलपुर, बालघाट, सिवनी, मण्डला, डिण्डोरी, नरसिंहपुर, ग्वालियर, गुना, अशोकनगर, भिण्ड, मुरैना, श्योपुर एवं शिवपुरी, मध्यप्रदेश

विषयः– 10 फरवरी 2016 को 1 से 19 वर्षीय बच्चों में कृमिनाशन हेतु प्रदेश के 41 जिलों में राष्ट्रीय कृमिमुक्ति दिवस के आयोजन के संबंध में।

संदर्भः– राष्ट्रीय कृमिमुक्ति दिवस के संबंध में भारत सरकार द्वारा जारी पत्र क्र. Z-28020/237/2013-CH, दिनांक 11.12. 2015

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विषयांतर्गत लेख है कि बच्चों में कृमि संक्रमण, व्यक्तिगत अस्वच्छता तथा संक्रमित दूषित मिट्टी के संपर्क से संभावित होता हैं। कृमि संक्रमण से बच्चों की जहाँ एक ओर शारीरिक एवं बौद्धिक विकास बाधित होती है वही दूसरी ओर उनके पोषण स्तर एवं हिमोग्लोबिन स्तर पर भी दुष्प्रभाव पड़ता हैं। अतः 1 से 19 वर्षीय बच्चों का कृमिनाशन करना, विश्व स्वास्थ्य संगठन द्वारा अनुशंसित एक साक्ष्य आधारित सकारात्मक रणनीति है। भारत सरकार के निर्देशानुरूप समस्त राज्यों एवं केन्द्र शासित प्रदेशों में एक साथ दिनांक 10 फरवरी 2016 को राष्ट्रीय कृमिमुक्ति दिवस एवं दिनांक 15 फरवरी 2016 को मॉप–अप दिवस का आयोजन किया जाना है जिसके अंतर्गत शासकीय/शासकीय अनुदान प्राप्त शालाओं, आदिवासी आश्रम शालाओं तथा आंगनवाड़ी केन्द्रों के माध्यम से 1 से 19 वर्षीय समस्त बच्चों का कृमिनाशन किया जाना है। प्रदेश में 41 जिलों में उपरोक्तानुसार कृमिनाशन की कार्यवाही की जायेगी तथा शेष 10 जिलों में माह दिसम्बर 2015 में ही फायलेरिया उन्मूलन कार्यक्रम के अंतर्गत समस्त समुदाय का कृमिनाशन किया जायेगा। प्रदेश के 3 जिले यथा भोपाल, रायसेन तथा सागर में प्रायवेट शालाओं में अध्ययनरत बच्चों को भी इस कार्यक्रम के अंतर्गत सम्मिलित किया जायेगा। राष्ट्रीय कृमिमुक्ति दिवस का उद्देश्य हितग्राही समूह के समस्त बच्चों को एल्बेण्डाजोल चबाने वाली मीठी गोली की प्रदायगी से बच्चों में कृमि नियंत्रण एवं उससे होने वाली आयरन की कमी की रोकथाम करना है ताकि बच्चों का सर्वांगीण बौद्धिक विकास तथा शालाओं में उपस्थिति में सुधार हो सके। कार्यक्रम का क्रियान्वयन स्कूल शिक्षा विभाग, आदिम जाति कल्याण विभाग एवं एकीकृत बाल विकास सेवायें के समन्वय से किया जायेगा।

राष्ट्रीय कृमिमुक्ति दिवस के आयोजन के संबंध में निर्देशित किया जाता है कि :–

- राष्ट्रीय कृमिमुक्ति दिवस (National Deworming Day–NDD-2016) का समारोहपूर्वक शुभारम्भ जन प्रतिनिधि, राजनितिज्ञ अथवा जिला कलेक्टर के द्वारा दिनांक 10 फरवरी 2016 को सुनिश्चित किया जाये।
- उक्त कार्यक्रम के अंतर्गत 1 से 2 वर्षीय बच्चों को आधी गोली चूरा करके तथा 2 से 19 वर्षीय सभी बच्चों को एल्बेण्डाजोल 400 मि.ग्रा. की चबाकर खाने वाली मीठी गोली दिनांक 10 फरवरी 2016 को शालाओं एवं आंगनवाड़ी केन्द्रों में निगरानीबद्ध रूप से खिलाई जाये एवं छुटे हुये बच्चों को दिनांक 15 फरवरी 2016 को मॉप–अप दिवस पर गोली खिलाई जाये।
- इस हेतु जिला स्तर पर स्वास्थ्य विभाग के फेसीलिटेशन से अन्य विभागों को सम्मिलित करते हुये समन्वय समिति गठित की जाये।
- विभिन्न विभागों के समन्वय से आयोजित की जाने वाली राष्ट्रीय कृमिमुक्ति दिवस –2016 में विभिन्न विभागों की निम्नानुसार भूमिका होगी :–

स्वास्थ्य विभाग	शिक्षा विभाग व आदिम जाति कल्याण विभाग	महिला बाल विकास विभाग
1. जिला स्तरीय समन्वय समिति का गठन एवं बैठक का आयोजन। 2. आवश्यक मात्रा में एल्बेण्डाजोल गोली शासकीय शालाओं/आदिवासी आश्रम शालाओं एवं आंगनवाड़ी केन्द्रों तक पहुँचाना। 3. प्रचार–प्रसार सामग्री एवं रिपोर्टिंग प्रपत्रों का मुद्रण एवं वितरण। 4. एन.डी.डी के दौरान किसी भी प्रतिकूल घटना के प्रबंधन हेतु व्यवस्था सुनिश्चित करना। 5. एन.डी.डी के दौरान प्रतिकूल घटना के प्रबंधन हेतु समस्त शासकीय/शासकीय अनुदान प्राप्त शालाओं, आदिवासी आश्रम शालाओं तथा आंगनवाड़ी केन्द्रों पर मूलभूत औषधियों की उपलब्धता, निकटस्थ स्वास्थ्य केन्द्र, चिकित्सक, ए.एन.एम., आशा आदि का संपर्क नम्बर की सूची उपलब्ध करवना, आवश्यकतानुसार आकस्मिक परिवहन व्यवस्था तथा प्रतिकूल घटना प्रबंधन प्रणाली संबंधी सूचना सामग्री का प्रसार करना। 6. समन्वित विभागों के कर्मचारियों का संयुक्त–सीमा अर्द्ध दिवसीय प्रशिक्षण एवं संस्थावार एन.डी.डी. कीट का वितरण। एन.डी.डी. कीट में निम्न सामग्री होगी :– 1. एल्बेण्डाजोल 400 मि.ग्रा. की चबाने वाली गोली 2. प्रतिकूल घटना के प्रबंधन हेतु मूलभूत औषधिया 3. संपर्क नम्बर सूची 4. फ्लेक्स/ बैनर 5. शिक्षक एवं आंगनवाड़ी कार्यकर्ताओं हेतु रिपोर्टिंग प्रपत्र युक्त हेन्डआउट 6. आशा हेतु पेम्पलेट 7. शाला तथा आंगनवाड़ी केन्द्र हेतु एक पोस्टर प्रति संस्था 7. कार्यक्रम की सशक्त निगरानी, रिपोर्ट संकलन एवं सुधारात्मक विश्लेषण।	1. कक्षाओं में इंद्राज बच्चों की संख्या स्वास्थ्य विभाग से सांझा करना ताकि तदानुसार आवश्यक औषधियों की व्यवस्थापन स्वास्थ्य विभाग द्वारा सुनिश्चित की जा सके। 2. अध्यापन शिक्षकों का प्रशिक्षण हेतु नामांकन एवं प्रशिक्षण में भागीदारी सुनिश्चित करना। 3. कक्षा 1 से 12वी के शासकीय शिक्षकों के माध्यम से पंजीकृत समस्त बच्चों को एल्बेण्डाजोल गोली की निगरानीबद्ध प्रदायगी। 4. एन.डी.डी. दिवस तथा मॉप–अप दिवस के दिन अधिकाधिक बच्चों की उपस्थिति सुनिश्चित करना। 5. गोली के सेवन उपरांत बच्चों के पीने हेतु स्वच्छ पेयजल की व्यवस्था। 6. छोटे बच्चों को मीठी गोली के प्रदायगी के समय विशेष ध्यान। 7. राष्ट्रीय कृमिमुक्ति दिवस के संबंध में पालकों को पूर्व सूचना देना। 8. स्वास्थ्य विभाग द्वारा प्रदायित निकटस्थ स्वास्थ्य केन्द्र, चिकित्सक, आशा तथा आकस्मिक परिवहन हेतु वाहन के संपर्क न. का शाला में प्रमुखता से प्रदर्शन। 9. एन.डी.डी. 2016 हेतु प्रदायित प्रसार सामग्री का प्रदर्शन । 10. बच्चों को एन.डी.डी दिवस पर गोली की प्रदायगी उपरांत उपस्थिति पंजी में ✓ का निशान लगाना तथा मॉप–अप दिवस पर गोली का सेवन करने वाले बच्चों के नाम के आगे ✓✓ का निशान लगाना। 11. हितग्राही बच्चों के संबंध में निर्धारित प्रपत्र में रिपोर्ट स्वास्थ्य विभाग से सांझा करना। 12. कार्यक्रम की सशक्त निगरानी, रिपोर्ट संकलन एवं सुधारात्मक विश्लेषण।	1. शाला अप्रवेशी/शाला त्यागी बच्चों की संख्या स्वास्थ्य विभाग से सांझा करना ताकि तदानुसार आवश्यक औषधियों की व्यवस्थापन स्वास्थ्य विभाग द्वारा सुनिश्चित की जा सके। 2. 1 से 2 वर्षीय बच्चों को एल्बेण्डाजोल की आधी गोली तथा 2 से 5 वर्षीय बच्चों को पूरी गोली चम्मच से चूरा करके बच्चों को समक्ष में खिलाना। 3. 5 से 19 वर्षीय समस्त शाला अप्रवेशी/शाला त्यागी बच्चों का आंगनवाड़ी केन्द्र में एकत्रिकरण करना एवं एल्बेण्डाजोल गोली का सेवन सुनिश्चित करना। 4. गोली के सेवन उपरांत बच्चों के पीने हेतु स्वच्छ पेयजल की व्यवस्था। 5. बच्चों को एन.डी.डी दिवस पर गोली की प्रदायगी उपरांत उपस्थिति पंजी में ✓ का निशान लगाना तथा मॉप–अप दिवस पर गोली का सेवन करने वाले बच्चों के नाम के आगे ✓✓ का निशान लगाना। 6. स्वास्थ्य विभाग द्वारा प्रदायित निकटस्थ स्वास्थ्य केन्द्र, चिकित्सक, आशा तथा आकस्मिक परिवहन हेतु वाहन के संपर्क न. का शाला में प्रमुखता से प्रदर्शन। 7. एन.डी.डी. 2016 हेतु प्रदायित प्रसार सामग्री का प्रदर्शन । 8. बच्चों को एन.डी.डी दिवस पर गोली की प्रदायगी उपरांत उपस्थिति पंजी में ✓ का निशान लगाना तथा मॉप–अप दिवस पर गोली का सेवन करने वाले बच्चों के नाम के आगे ✓✓ का निशान लगाना। 9. हितग्राही बच्चों के संबंध में निर्धारित प्रपत्र में रिपोर्ट स्वास्थ्य विभाग से सांझा करना। 10. कार्यक्रम की सशक्त निगरानी, रिपोर्ट संकलन एवं सुधारात्मक विश्लेषण।

राष्ट्रीय कृमिमुक्ति दिवस –2016 के सफल आयोजन हेतु समस्त समन्वित विभाग स्वास्थ्य विभाग को आवश्यक सहयोग प्रदान करें।

संलग्न : भारत सरकार का संयुक्त दिशा–निर्देश

आयुक्त	आयुक्त	आयुक्त	आयुक्त	मिशन संचालक
राज्य शिक्षा केन्द्र मध्यप्रदेश	लोक शिक्षण संचालनालय मध्यप्रदेश	एकीकृत बाल विकास सेवायें मध्यप्रदेश	आदिवासी विकास विभाग मध्यप्रदेश	राष्ट्रीय स्वास्थ्य मिशन मध्यप्रदेश

पृ.क्रमांक/एन.एच.एम/NIPI/2015/ 14228 भोपाल, दिनांक 29/12 /2015

प्रतिलिपिः– आवश्यक कार्यवाही हेतु सूचनार्थ।

1. अतिरिक्त मुख्य सचिव, शिक्षा विभाग, वल्लभ भवन, मध्यप्रदेश।
2. प्रमुख सचिव, लोक स्वास्थ्य एवं परिवार कल्याण विभाग, वल्लभ भवन मध्यप्रदेश।
3. प्रमुख सचिव, एकीकृत बाल विकास सेवायें, वल्लभ भवन, मध्यप्रदेश।
4. स्वास्थ्य आयुक्त, मध्यप्रदेश।
5. समस्त संभागीय आयुक्त, मध्यप्रदेश।
6. समस्त सहायक आयुक्त, आदिवासी विकास विभाग, जिला सागर, जबलपुर, इंदौर, भोपाल, ग्वालियर, शहडोल, धार, अलीराजपुर, झाबुआ, खरगौन, खण्डवा, बड़वानी, बुरहानपुर, बालघाट, मण्डला, डिण्डोरी, सिवनी, श्योपुर, रतलाम, सीधी तथा सिंगरौली, मध्यप्रदेश।
7. समस्त संभागीय संयुक्त संचालक, स्वास्थ्य सेवायें, मध्यप्रदेश।
8. समस्त संभागीय संयुक्त संचालक, एकीकृत बाल विकास सेवायें, मध्यप्रदेश।
9. समस्त संभागीय संयुक्त संचालक, लोक शिक्षण संचालनालय, मध्यप्रदेश।
10. समस्त जिला कलेक्टर, मध्यप्रदेश।
11. राज्य कार्यक्रम अधिकारी, डीवर्म द वर्ल्ड इनिशिएटिव, मध्यप्रदेश की ओर लेख है कि अपने क्षेत्रीय तथा जिला समन्वयकों के माध्यम से शिक्षा, आदिम जाति कल्याण विभाग, महिला एवं बाल विकास विभाग तथा स्वास्थ्य विभाग के मध्य समन्वय स्थापित करें।
12. पोषण विशेषज्ञ, यूनिसेफ, भोपाल।
13. राज्य कार्यक्रम प्रतिनिधि, एम.आई., मध्यप्रदेश।
14. समस्त, जिला शिक्षा अधिकारी, स्कूल शिक्षा विभाग, मध्यप्रदेश।
15. समस्त, जिला कार्यक्रम समन्वयक, राज्य शिक्षा केन्द्र, मध्यप्रदेश।
16. समस्त, जिला कार्यक्रम अधिकारी, एकीकृत बाल विकास सेवायें, मध्यप्रदेश।
17. समस्त, खण्ड चिकित्सा अधिकारी, मध्यप्रदेश।
18. समस्त, संभागीय कार्यक्रम प्रबंधक, आर.सी.एच./एन.एच.एम., मध्यप्रदेश।
19. समस्त, जिला कार्यक्रम प्रबंधक, आर.सी.एच./एन.एच.एम., मध्यप्रदेश।
20. समस्त, जिला पोषण सलाहकार, आर.सी.एच./एन.एच.एम., मध्यप्रदेश।

आयुक्त	आयुक्त	आयुक्त	आयुक्त	मिशन संचालक
राज्य शिक्षा केन्द्र मध्यप्रदेश	लोक शिक्षण संचालनालय मध्यप्रदेश	एकीकृत बाल विकास सेवायें मध्यप्रदेश	आदिवासी विकास विभाग मध्यप्रदेश	राष्ट्रीय स्वास्थ्य मिशन मध्यप्रदेश

Z-28020/237/2013-CH (Pt.III)
GOVERNMENT OF INDIA

New Delhi, dated: 11th December, 2015

B.P. SHARMA
Secretary
M/o Health and Family Welfare

S.C. KHUNTIA
Secretary
D/o School Education & Literacy

V. SOMASUNDARAN
Secretary
M/o Women and Child Development

Dear Chief Secretary,

Soil Transmitted helminths (STH) are significant public health concern for India. Around 68% children of 1-14 years of age (241 million) are estimated to be at risk of parasitic intestinal worm infestation. Evidence has shown detrimental impact of STH infestation on physical growth-anemia, undernutrition and cognitive development as well as school attendance. Periodic deworming can reduce the transmission of STH infections. During 2015, mass deworming was conducted across 11 States as a fixed day strategy to reduce the harm caused by STH on millions of children in India in a cost effective, simple and safe manner. The NDD has resulted in administration of deworming drug to more than 89 million children across these States.

During 2016, Ministry of Health and Family Welfare in collaboration with Ministry of Women and Child Development, Department of School Education and Literacy under Ministry of Human Resource Development, Ministry of Drinking Water and Sanitation and Ministry of Panchayati Raj has decided to conduct annual mass deworming by observing National Deworming Day (NDD) on 10th February, 2016, across the country through schools and anganwadi centres alongwith intensive awareness generation activities focusing benefits of consuming Albendazole and adopting sanitation-hygiene practices.

A detailed NDD toolkit containing Operational framework, monitoring checklists, FAQs and Factsheets is uploaded on NHM website. Concerted efforts from the three departments at the State, District and Block level are required to ensure effective implementation and increased coverage of the program. We seek your support for the same through active participation of the Departments of Health, School Education and Women and Child Development in the upcoming NDD 2016.

The following steps are suggested to strengthen the coordination amongst the three stakeholder departments for the NDD program:

1. All the key stakeholder departments to coordinate with Department of Health in effective rolling out of NDD.

2. Establishment of State and District level coordination committees to be chaired by the Principal Secretary Health and the District Collector respectively.
3. School Education and Women & Child Development departments to provide the Department of Health with the desired numbers of target age group to cover all children 1-19 years age group, so as to ensure adequate procurement and supply of Albendazole tablets is made available for conducting NDD.
4. All the departments will put National Deworming Day as one of the agenda in their periodic meetings to reinforce key messages for the program and facilitate high coverage.
5. Training of functionaries from Education and WCD Departments to be supported by Health Department at State and District level, while block level training of teachers and anganwadi workers to be led by respective departments.
6. State may issue similar joint directive to the districts for effective rolling out of NDD 2016.
7. All stakeholder departments to disseminate the IEC material provided by the Department of Health to the schools, anganwadis and community as appropriate for increasing program awareness and facilitate greater coverage.
8. Officials of all the stakeholder departments are mandated to undertake field visits for monitoring and supportive supervision on the NDD and mop up day.
9. Reporting formats filled by schools and AWCs to be collected by ANMs from schools and anganwadis within the specified timelines.

We are confident that with your support for the NDD program, we will collectively be able to reach out to all the children in the age group 1-19 years and help improve their quality of life with improved health and educational outcomes.

Looking forward to your support in this regard.

With warm regards,

Yours sincerely,

(B.P. Sharma)

Yours sincerely,

S.C. Khuntia 11/12/15

(S.C. Khuntia)

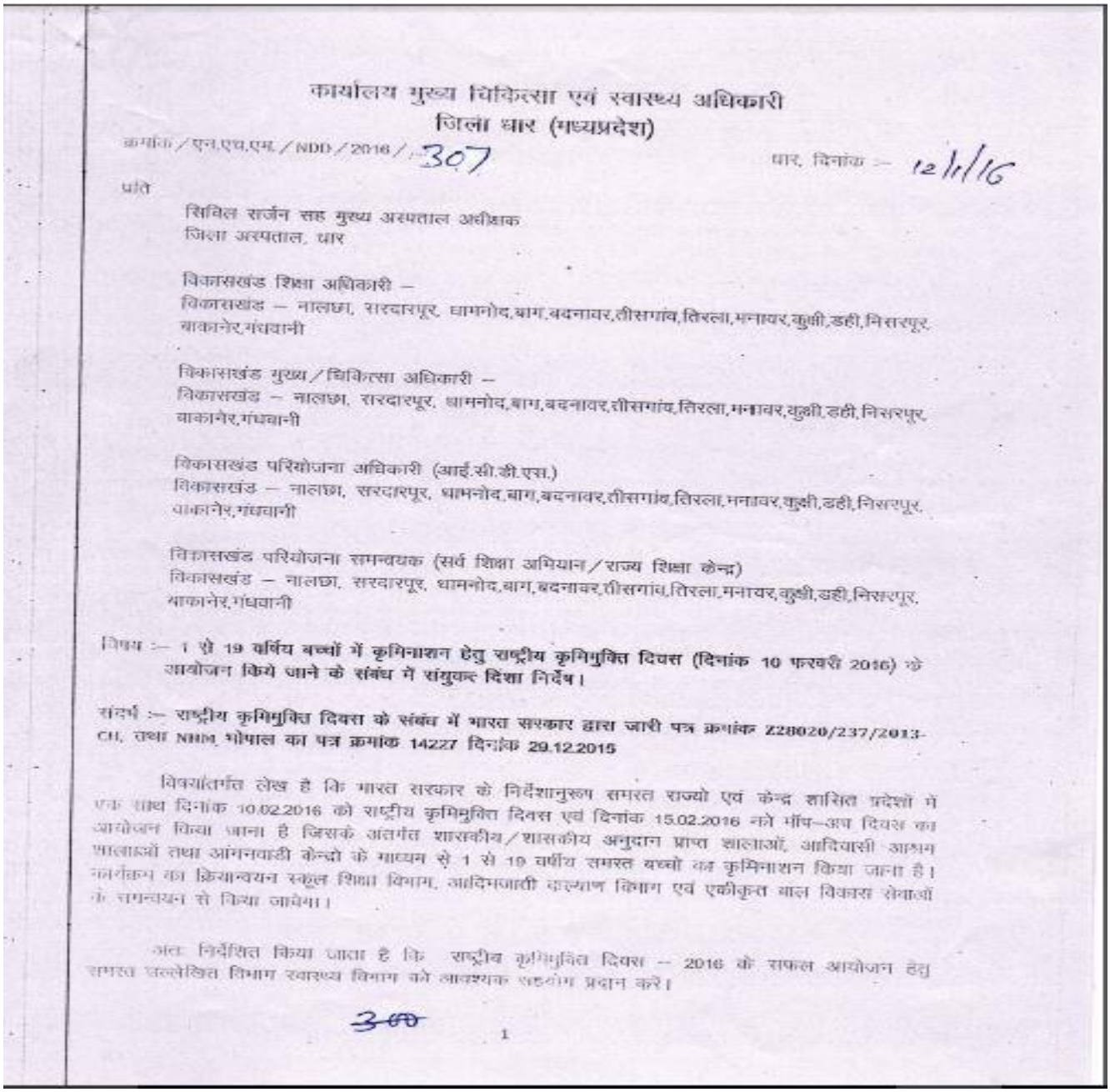
Yours sincerely,

(V. Somasundaran)

To

Chief Secretaries of all States/UTs

Annexure E- NDD 2016 District Joint Directives Issued to Blocks_Dhar



कार्यालय मुख्य चिकित्सा एवं स्वास्थ्य अधिकारी
जिला धार (मध्यप्रदेश)

क्रमांक / एन.एच.एम. / NDD / 2016 / 307 धार, दिनांक :– 12/1/16

प्रति

सिविल सर्जन सह मुख्य अस्पताल अधीक्षक
जिला अस्पताल, धार

विकासखंड शिक्षा अधिकारी –
विकासखंड – नालछा, सरदारपूर, धामनोद, बाग, बदनावर, तीसगांव, तिरला, मनावर, कुक्षी, डही, निसरपूर, बाकानेर, गंधवानी

विकासखंड मुख्य / चिकित्सा अधिकारी –
विकासखंड – नालछा, सरदारपूर, धामनोद, बाग, बदनावर, तीसगांव, तिरला, मनावर, कुक्षी, डही, निसरपूर, बाकानेर, गंधवानी

विकासखंड परियोजना अधिकारी (आई.सी.डी.एस.)
विकासखंड – नालछा, सरदारपूर, धामनोद, बाग, बदनावर, तीसगांव, तिरला, मनावर, कुक्षी, डही, निसरपूर, बाकानेर, गंधवानी

विकासखंड परियोजना समन्वयक (सर्व शिक्षा अभियान / राज्य शिक्षा केन्द्र)
विकासखंड – नालछा, सरदारपूर, धामनोद, बाग, बदनावर, तीसगांव, तिरला, मनावर, कुक्षी, डही, निसरपूर, बाकानेर, गंधवानी

विषय :– **1 से 19 वर्षीय बच्चों में कृमिनाशन हेतु राष्ट्रीय कृमिमुक्ति दिवस (दिनांक 10 फरवरी 2016) के आयोजन किये जाने के संबंध में संयुक्त दिशा निर्देश।**

संदर्भ :– **राष्ट्रीय कृमिमुक्ति दिवस के संबंध में भारत सरकार द्वारा जारी पत्र क्रमांक Z28020/237/2013-CH, तथा NHM, भोपाल का पत्र क्रमांक 14227 दिनांक 29.12.2015**

विषयांतर्गत लेख है कि भारत सरकार के निर्देशानुरूप समस्त राज्यो एवं केन्द्र शासित प्रदेशों में एक साथ दिनांक 10.02.2016 को राष्ट्रीय कृमिमुक्ति दिवस एवं दिनांक 15.02.2016 को मॉप–अप दिवस का आयोजन किया जाना है जिसके अंतर्गत शासकीय / शासकीय अनुदान प्राप्त शालाओं, आदिवासी आश्रम शालाओं तथा आंगनवाडी केन्द्रो के माध्यम से 1 से 19 वर्षीय समस्त बच्चों का कृमिनाशन किया जाना है। कार्यक्रम का क्रियान्वयन स्कूल शिक्षा विभाग, आदिमजाती कल्याण विभाग एवं एकीकृत बाल विकास सेवाओं के समन्वयन से किया जावेगा।

अतः निर्देशित किया जाता है कि राष्ट्रीय कृमिमुक्ति दिवस – 2016 के सफल आयोजन हेतु समस्त उल्लेखित विभाग स्वास्थ्य विभाग को आवश्यक सहयोग प्रदान करें।

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अतः आप संलग्न पत्रों में दिये गये दिशा निर्देशों का पूर्णतः पालन सुनिश्चित करें एवं उक्त कार्यक्रम को संपूर्ण जिले में सफल क्रियान्वयन करें।

संलग्न :- यथोचित पत्र

जिला परियोजना समन्वयक राज्य शिक्षा केन्द्र, धार	जिला शिक्षा अधिकारी जिला – धार	जिला कार्यक्रम अधिकारी म.एवं बा.वि.वि., धार	सहा. आयुक्त जिला कार्यक्रम अधिकारी आदिवासी विकास विभाग जिला– धार	मुख्य चिकित्सा एवं स्वास्थ्य अधिकारी, धार

क्रमांक / एन.एच.एम. / NDD / 2016 / 308 धार दिनांक :- 12/1/16

प्रतिलिपी :–आवश्यक कार्यवाही हेतु सूचनार्थ

1. जिला कलेक्टर, धार
2. संभागीय संयुक्त संचालक स्वास्थ्य सेवाएं, इंदौर
3. संभागीय संयुक्त संचालक, एकीकृत बाल विकास सेवाएं, इन्दौर
4. संभागीय संयुक्त संचालक, लोक शिक्षण संचालनालय, इन्दौर
5. जिला टीकाकरण अधिकारी, धार
6. जिला नि.पी. नोडल अधिकारी, धार
7. जिला कार्यक्रम प्रबंधक, धार
8. जिला पोषण सलाहकार, धार
9. राज्य कार्यक्रम अधिकारी, डीवर्म द वर्ल्ड इनिशिएटिव, भोपाल
10. क्षेत्रीय समन्वयक, डीवर्म द वर्ल्ड इनिशिएटिव, इन्दौर
11. जिला समन्वयक, डीवर्म द वर्ल्ड इनिशिएटिव, धार

जिला परियोजना समन्वयक राज्य शिक्षा केन्द्र, धार	जिला शिक्षा अधिकारी जिला – धार	जिला कार्यक्रम अधिकारी म.एवं बा.वि.वि., धार	सहा. आयुक्त जिला कार्यक्रम अधिकारी आदिवासी विकास विभाग जिला– धार	मुख्य चिकित्सा एवं स्वास्थ्य अधिकारी, धार

Public Awareness and Community Sensitization

Wall paintings at Mandsaur and Vidisha

26th January Rally display on Deworming at Anuppur

तों फरवरी में बच्चों को खिलाएंगे डी-वार्मिंग की गोली

उज्जैन @ पत्रिका

आंगनबाड़ी केंद्रों में एक से दो साल के बच्चे और प्राथमिक व माध्यमिक स्कूलों में 19 साल तक के बच्चों को डी-वार्मिंग की गोली खिलाई जाएगी। राष्ट्रीय स्वास्थ्य मिशन की डायरेक्टर जयश्री किलावत ने वीडियो कॉन्फ्रेंसिंग के माध्यम से उज्जैन समेत सभी जिलों के सीएमएचओ व सेक्टर स्वास्थ्य अधिकारियों को निर्देश दिए हैं। डी-वार्मिंग के लिए विशेष अभियान चलाकर 10 व 15 फरवरी को कार्यक्रम चलाया जाएगा। इससे एक बार छूटने वाले कार्यक्रम के लिए भी संस्था में डी-वार्मिंग की दवा खरीदी जाएगी। एनएचएम की डायरेक्टर ने स्पष्ट कहा कि कोई बच्चा छूटना नहीं चाहिए। हर एक बच्चे का डी-वार्मिंग किया जाना जरूरी है।

मेरी GROW में फ

patrika.com

2 lakh children to be covered on National Deworming Day: Department of Health Ujjain (M.P) took decisions.

नेशनल डी वर्मिंग डे पर बच्चों को खिलाई गई कृमि नाशक

सरोजनी नायडू कन्या शाला में छात्राओं की भागीदारी से हुआ कार्यक्रम

1.52 million children protected by National Deworming Program, In M.P

डेढ करोड से अधिक बच्चों को आज पिलाई जायेगी दवा

Appeal given by Chief Minister for the community mobilization to deworm as many children on National Deworming Day 2016

'1

Launch of NDD, Sarojini Naidu School Higher Secondary , Bhopal

De-worming and its role in sustaining Child health and Nutrition: In conversation with Hon. Health Minister Bhopal (M.P) with 20e media person in the National Deworming Day Press Conference

SMS send by Idea as per of the community Mobilization strategy to mobilize community about administration of Albendazole on National Deworming Day

Live Phone in Program "Hello Doctor" talking about Deworming benefits with Community and Asha for effective implementation of program

Annexure G- Snapshot of Departmental Website Uploads

Departmental Website Upload Snapshot on NDD 2016

Annexure H- Training Quality Assessment Findings

Quality Assurance for Training

To assess the quality of training imparted at all levels and knowledge gain post trainings, training monitoring assessment and pre-post tests were conducted with support from Evidence Action filed based teams. Training quality assessment was conducted across all district level trainings and sampled block level trainings which were attended by district coordinators to ensure that key messages on deworming are shared during training. Pre-post analysis of knowledge gain during district level trainings was conducted across all districts and findings are explained below in the report. Based on the analysis of results for district level pre-post trainings and other criteria like absence of blocks in district level trainings, sampled block level trainings were selected for pre-post assessment.

- Around 60% of respondents were NOT aware about the correct way of administering albendazole for 1-2 years of children.
- Approximately 30% of the participants were NOT aware about the correct recording protocol for National Deworming Day and Mop Up day.
- Approximately 35% of the participants were NOT aware that ASHA is supposed to prepare a list of out of school children before National Deworming Day
- Around 30% were NOT aware about the method of reporting information in school/anganwadi reporting form
- More than 55% of the participants were NOT aware of the submission date of school /anganwadi reporting form to ANM
- Approximately 35% were NOT aware about the date when ANM will submit the Reporting form to Block Nodal officer (BNO)
- Approximately 35% of the participants were NOT aware about the date when District Nodal Officer is supposed to send the reporting form to the State Nodal Officer.

Annexure I- Snapshot of Compiled Visits, Calls Status in MP by evidence Actin team During NDD 2016

Snapshot of compiled visits, calls status in MP by Evidence Action team during NDD 2016

	Pre Deworming																		
	Drugs					Training						IEC					Pre-deworming calls to schools/anganwadi		
Level of call	District Level		Block level			District Level			Block level			District Level		Block level			School and Anganwadi		
Proposed timeline	NA		NA			NA			NA			NA		NA			NA		
Actual timeline	16-Dec		26 Dec - 16 Jan			6 Jan - 16 Jan			18Jan- 6 Feb			8 Jan- 18Jan		8 Jan- 2 Feb			5 Feb-9Feb		
Madhya Pradesh	Officials called	Total no of calls	Officials called	Department	Total no of calls	Officials called	Departm ent	Total no of calls	Officials called	Departm ent	Total no of calls	Officials called	Total no of calls	Officials called	Departm ent	Total no of calls	People called	Department	Total no of calls
	CMHO/ DPM/ DNC	187	BMO/BP M/BCM	Health	431	CMHO/ DPM/ DNC	Health	107	ANM	ICDS	1691	CMHO/ DPM/ DNC	272	BMO/BPM	Health	234	Aww	ICDS	895
			BEO	Education					Teachers/Princip	Education	1459						Teacher/HM-govt	Education	486
			618						AWW	Education	637						Teacher/HM-private	Education	192

	During Deworming								
	Calls on NDD			Calls between NDD and MUD			Calls on MUD		
Level of call	School and Anganwadi			School and Anganwadi			School and Anganwadi		
Proposed timeline									
Actual timeline	10-Feb			11Feb-14Feb			15-Feb		
Madhya Pradesh	People called	Department	Total no of calls	People called	Department	Total no of calls	People called	Departm ent	Total no of calls
	Aww	ICDS	150	Aww	ICDS	995	Aww	ICDS	307
	Teacher/HM-govt	Education	238	Teacher/HM-govt	Education	313	Teacher/HM-govt	Education	219

	After Deworming								
	Coverage reporting								
Level of call	School/Anganwadi Level			Block level			District Level		
Proposed timeline	NA			NA			NA		
Actual timeline	15-26 Feb			21 feb -29 feb			24feb-3 March		
Madhya Pradesh	People called	Department	Total no of calls	Officials called	Department	Total no of calls	Officials called	Department	Total no of calls
	Aww	ICDS	662	BPM/BMO/ BCM	Health	920	CMHO/ DPM/ DNC	Health	67
	Teacher/HM-g	Education	591						
	Teacher/HM-p	Education	172						
	ASHA	Health	484						

Annexure J- Letter Issued to Selected Districts for Gaps Identified in NDD 2016

राष्ट्रीय स्वास्थ्य मिशन

8, क्षेत्रीय ग्रामीण बैंक परिसर, अरेरा हिल्स,
भोपाल, मध्यप्रदेश

क्रमांक/एन.एच.एम/शिशु स्वास्थ्य पोषण/2016/15248 भोपाल, दिनांक 11/02/2016

प्रति,

मुख्य चिकित्सा एवं स्वास्थ्य अधिकारी,
जिला:गुना/झाबुआ/बुरहानपुर/सीहोर/भोपाल/विदिशा/खरगौन/सीधी/इन्दौर/रायसेन/शिवपुरी/हरदा/होशंगाबाद तथा सागर, मध्यप्रदेश।

विषय : राष्ट्रीय कृमिमुक्ति दिवस –2016 के दिनांक 10/02/2016 की स्वतंत्र मॉनीटर द्वारा प्राप्त टीप एवं विसंगतियों पर तत्काल सुधारात्मक कार्यवाही के संबंध में।

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विषयांतर्गत लेख है कि राष्ट्रीय कृमिमुक्ति दिवस का आयोजन प्रदेश के 41 जिलों में शासकीय/शासकीय अनुदान प्राप्त शालाओं एवं आंगनवाड़ी केन्द्रों के माध्यम से दिनांक 10/02/2016 को आयोजित किया गया जिसके अंतर्गत 1–19 वर्षीय बच्चों को कृमि नाशक गोली खिलवाई गई। उक्त जिलों में स्वतंत्र मॉनीटर द्वारा पर्यवेक्षण में निम्न विसंगतियां पाई गई :–

क्र.	जिले का नाम	विकासखण्ड का नाम	राष्ट्रीय कृमिमुक्ति दिवस–2016 में परिलक्षित कमियाँ
1	गुना	राजोगढ़	• आंगनवाड़ी केन्द्र, विजयापुर में कृमिमुक्ति दिवस का आयोजन एल्बेण्डाजोल गोलियों की अनुपलब्धता के कारण नहीं किया गया है।
2	झाबुआ	पेटलावद	• आंगनवाड़ी केन्द्र, भानपुरा एवं धान्दला में रिपोर्टिंग प्रपत्र उपलब्ध नही थे एवं प्रतिकूल घटना का प्रबंधन नहीं होने की वजह से 38 प्रतिकूल घटनाएं हुई।
3	बुरहानपुर	बुरहानपुर	• आंगनवाड़ी केन्द्र क्र.–12 में कृमिमुक्ति दिवस का आयोजन एल्बेण्डाजोल गोलियों की अनुपलब्धता के कारण नही किया गया है एवं रिपोर्टिंग प्रपत्र भी उपलब्ध नहीं थे।
4	खरगौन	कसरावद	• शासकीय प्राथमिक शाला निमरानी में शिक्षको का प्रशिक्षण नहीं हुआ था एवं रिपोर्टिंग प्रपत्र, बैनर, पोस्टर उपलब्ध नहीं कराया गया था। • शासकीय प्राथमिक/माध्यमिक शाला छोटी कसरावद रिपोर्टिंग प्रपत्र, बैनर, पोस्टर उपलब्ध नहीं कराया गया था।
5	सीहोर	बुदनी	• शासकीय हायर सेकण्डरी स्कूल, नांदेर, बुदनी, जौनथाला एवं शाहगंज में कृमिमुक्ति दिवस के आयोजन हेतु रिपोर्टिंग प्रपत्र, पोस्टर एवं बैनर उपलब्ध नहीं कराये गये थे।
		इछावर	• शासकीय हायर सेकण्डरी स्कूल, इछावर में कृमिमुक्ति दिवस के आयोजन हेतु रिपोर्टिंग प्रपत्र, पोस्टर एवं बैनर उपलब्ध नहीं कराये गये थे।
6	भोपाल	फन्दा	• गाँधीनगर आदित्य कॉन्वेंट स्कूल एवं विकास हाई स्कूल, फन्दा शहरी कृमिमुक्ति दिवस का आयोजन एल्बेण्डाजोल गोलियों की अनुपलब्धता के कारण नहीं किया गया है।
7	विदिशा	विदिशा	• शासकीय मिडिल स्कूल मादिपुर, शासकीय प्राथमिक शाला, हिरानी में आशा कार्यकर्ता द्वारा अनुपूरण किया जा रहा था एवं शिक्षक के पास रिपोर्टिंग उपलब्ध नहीं थे। • आंगनवाड़ी केन्द्र, अटारीखेड़ा –152, हिरानी – 18, खारी –17 में रिपोर्टिंग प्रपत्र उपलब्ध नहीं थे।
		गंजबासौदा	• शासकीय उच्चतर माध्यमिक शाला, राजेन्द्र नगर में पंजीकृत बच्चों के अनुसार कृमिनाशक गोलियां उपलब्ध नहीं थी। • शासकीय माध्यमिक शाला, नंदपुरा में रिपोर्टिंग प्रपत्र, बैनर एवं पोस्टर तथा प्रतिकूल घटना हेतु औषधि उपलब्ध नहीं थी।
		पीपलखेड़ा	• आंगनवाड़ी केन्द्र कुँआ खेड़ी–2 में पोस्टर उपलब्ध नहीं थे।
		विदिशा शहरी	• शासकीय प्राथमिक शाला मुजफ्फर पुर में एल्बेन्डाजॉल गोलियाँ उपलब्ध नहीं थी अतः कृमिमुक्ति दिवस का आयोजन नहीं किया गया।
8	सीधी	सेमरिया	• अधिकांश शालाओं में रिपोर्टिंग प्रपत्र उपलब्ध नहीं थे।

8	हरदा	खिरकिया	• शासकीय शालाओं में राष्ट्रीय कृमिमुक्ति दिवस का आयोजन नहीं किया गया। • एल्बेन्डाजॉल गोलियाँ, रिपोर्टिंग प्रपत्र एवं प्रतिकूल घटनाओं हेतु औषधियाँ उपलब्ध नहीं थी।
9	इंदौर	शहरी	• शासकीय प्राथमिक शाला शिवशक्ति नगर में एल्बेन्डाजॉल गोलियाँ, रिपोर्टिंग प्रपत्र एवं प्रतिकूल घटनाओं हेतु औषधियाँ उपलब्ध नहीं थी।
10	रायसेन	शहरी	• आंगनवाड़ी केन्द्र देह गाँव–2, साईनिंग पब्लिक स्कूल रिपोर्टिंग प्रपत्र एवं बैनर /पोस्टर उपलब्ध नहीं थे।
11	सागर	खुरई एवं सागर	• विवेकानन्द विद्या मन्दिर–किमशाला, सरस्वती शिशु मन्दिर किमशाला, आनंद मार्ग हिन्दी मीडियम स्कूल नेहा नगर वार्ड–1, किड्स वैल फेयर फॉउन्डेशन वार्ड–1 में राष्ट्रीय कृमिमुक्ति दिवस का आयोजन नहीं किया गया। एल्बेन्डाजॉल गोलियाँ, रिपोर्टिंग प्रपत्र एवं प्रतिकूल घटनाओं हेतु औषधियाँ उपलब्ध नहीं थी।
12	शिवपुरी	शिवपुरी	• शासकीय माध्यमिक शाला माधीखेड़ा कॉलोनी में शिक्षकों को राष्ट्रीय कृमिमुक्ति दिवस की कोई जानकारी नहीं थी एवं एल्बेन्डाजॉल गोलियाँ, रिपोर्टिंग प्रपत्र एवं प्रतिकूल घटनाओं हेतु औषधियाँ उपलब्ध ना होने के कारण राष्ट्रीय कृमिमुक्ति दिवस का आयोजन नहीं किया गया।
13	होशंगाबाद	एस.पी.एम.वार्ड –22	• शासकीय माध्यमिक शाला एवं होस्टल के शिक्षको का प्रशिक्षण नहीं हुआ था एवं रिपोर्टिंग प्रपत्र, बैनर, पोस्टर एवं प्रतिकूल घटनाओं हेतु औषधियाँ उपलब्ध नहीं करवाई गई थी। • आंगनवाड़ी केन्द्र क्रमांक–1 एस.पी.एम.वार्ड –22 में रिपोर्टिंग प्रपत्र एवं एन. डी.डी. किट उपलब्ध नहीं थे।

उक्त विसंगतियों के संबंध में निर्देशित किया जाता है कि :–

- उक्त पाई गई विसंगतियों पर तत्काल कार्यवाही सुनिश्चित की जाये।
- एल्बेन्डाजॉल गोली के संबंध में भ्रांतियों को दूर करते हुए यह संदेश दे की इसका भोजन के उपरांत या खाली पेट सेवन करने से कोई संबंध नहीं है।
- कृमि नाशक गोली एल्बेन्डाजॉल पूर्णतः सुरक्षित दवा है। जिन बच्चों के पेट में कृमि अधिक होते है उनमें दवा खाने के बाद दवाई के असर से मरे हुए कृमियों के टॉक्सिन से पेट दर्द, उबका आना, उल्टी और चक्कर आदि जैसे तत्कालिक लक्षण होते है। यह सामान्य है जो कि कुछ समय बाद स्वतः ही समाप्त हो जाते है।
- शालाओं एवं आंगनवाड़ी केन्द्रों जहाँ पर राष्ट्रीय कृमिमुक्ति दिवस का आयोजन नहीं किया गया है, उन सभी संस्थाओं पर एल्बेन्डाजॉल गोली की उपलब्धता मॉप–अप दिवस दिनांक 15 फरवरी 2016 से पूर्व सुनिश्चित किया जाये।
- रिपोर्टिंग प्रपत्र की उपलब्धता शाला एवं आंगनवाड़ी केन्द्रों में सुनिश्चित की जाये जिससे समय सीमा में प्रतिवेदन प्राप्त हो सकें।
- किसी भी प्रतिकूल घटना के प्रबंधन हेतु औषधियों की उपलब्धता, संबंधित चिकित्सा अधिकारी/ए.एन.एम. का दूरभाष नंबर का प्रदर्शन अवश्य सुनिश्चित किया जाये।
- किसी भी प्रकार की प्रतिकूल घटना की जानकारी तत्काल राज्य स्तरीय संपर्क नंबर–0755–4092544 अथवा राज्य नोडल अधिकारी डॉ. प्रज्ञा तिवारी को तत्काल दी जाये।

मिशन संचालक द्वारा अनुमोदित

(डॉ. प्रज्ञा तिवारी)
उपसंचालक–शिशु स्वास्थ्य पोषण
एन.एच.एम.,मध्यप्रदेश

पृ.क्रमांक/शिशु स्वास्थ्य पोषण/एन.एच.एम/2016 भोपाल,दिनांक /02/2016

प्रतिलिपिः– सूचनार्थ।

1. प्रमुख सचिव, लोक स्वास्थ्य एवं परिवार कल्याण विभाग, एन.एच.एम.,मध्यप्रदेश।
2. आयुक्त स्वास्थ्य स्वास्थ्य सेवायें, मध्यप्रदेश।
3. संचालक,एन.एच.एम.,मध्यप्रदेश।
4. समस्त संभागीय संयुक्त संचालक, स्वास्थ्य सेवायें, मध्यप्रदेश।
5. जिला कलेक्टर, जिलाः जिलाःगुना/ झाबुआ/ बुरहानपुर/ सीहोर/ भोपाल/ विदिशा/ खरगौन/सीधी/ इन्दौर/रायसेन/शिवपुरी/हरदा/होशंगाबाद तथा सागर, मध्यप्रदेश।
6. राज्य कार्यक्रम अधिकारी डीवर्म द वर्ल्ड इनिशिएटिव मध्यप्रदेश।
7. पोषण विशेषज्ञ, यूनिसेफ मध्यप्रदेश।
8. राज्य कार्यक्रम प्रतिनिधि, माईक्रोन्यूट्रिएन्ट इनिशिएटिव, मध्यप्रदेश।
9. जिला कार्यक्रम प्रबंधक, एन.एच.एम., जिलाः जिलाःगुना/ झाबुआ/ बुरहानपुर/ सीहोर/ भोपाल/ विदिशा/ खरगौन/सीधी/ इन्दौर/रायसेन/शिवपुरी/हरदा/होशंगाबाद तथा सागर, मध्यप्रदेश की ओर आवश्यक कार्यवाही हेतु ।
10. जिला पोषण सलाहकार जिलाः जिलाःगुना/ झाबुआ/ बुरहानपुर/ सीहोर/ भोपाल/ विदिशा/ खरगौन/सीधी/ इन्दौर/रायसेन/शिवपुरी/हरदा/होशंगाबाद तथा सागर, मध्यप्रदेश की ओर आवश्यक कार्यवाही हेतु ।

उपसंचालक–शिशु स्वास्थ्य पोषण
एन.एच.एम.,मध्यप्रदेश

Annexure K: NDD 2016 District Coverage

NDD 2016 District coverage

Sr. No.	District	% Coverage
1	Bhopal	93.24
2	Raisen	96.69
3	Vidisha	89
4	Sehore	91.92
5	Rajgarh	84
6	Hoshangabad	89
7	Harda	79
8	Betul	92.36
9	Indore	96.00
10	Dhar	91.42
11	Jhabua	94.48
12	Alirajpur	92.41
13	Khargone	88
14	Barwani	95.65
15	Burhanpur	91.26
16	Khandwa	97.32
17	Ujjain	104.37
18	Dewas	93.81
19	Shajapur	93.89
20	Ratlam	96.56
21	Neemach	96.34
22	Mandsor	86
23	Agar	92.20
24	Jabalpur	99.44
25	NarsinghPur	90
26	Seoni	99.62
27	Mandla	76
28	Dindori	87
29	Balaghat	92.84
30	Sidhi	82

31	Singrauli	90
32	Shahdol	94.21
33	Anuppur	99.71
34	Sagar	78
35	Gwalior	95.44
36	Morena	82
37	Bhind	86
38	Sheopur	98.30
39	Ashok Nagar	91
40	Guna	99.77
41	Shivpuri	84