Evidence Action

Deworm the World Initiative

Independent Monitoring of National Deworming Day in Haryana February, 2018

REPORT

June 2018

Coverage Validation

Following every round of National Deworming Day (NDD), Evidence Action conducts a coverage validation exercise post-NDD through an independent survey agency, to assess the planning, implementation and quality of the program with an objective of identifying gaps and suggesting recommendations to improve future NDD rounds. Coverage validation is an ex-post check of the accuracy of the reporting data and coverage estimates to verify government-reported treatment figures. The fieldwork for coverage validation in Haryana was conducted May 7-11, 2018.

This extract is a summary of the broad findings from the survey conducted in the state.

Survey Methodology

Using a two stage probability sampling procedure, Evidence Action selected 502 schools (government schools=350 and private schools=152) and 506 *anganwadis* for coverage validation across all 22 districts of Haryana. Through a competitive review process, Evidence Action hired an independent survey agency to conduct coverage validation activities with approvals from the state government. Evidence Action designed and finalized survey tools for coverage validation; two separate tools each for schools and *anganwadis*.

Implementation

Prior to the survey, Evidence Action conducted a comprehensive training of master trainers who further conducted a two-days training of 100 surveyors and 20 supervisors. The training included an orientation on NDD, the importance of coverage validation, details of the monitoring formats including CAPI practices, survey protocols and practical sessions. Each surveyor was allotted five schools and five *anganwadis* for coverage validation. Surveyors were provided with a tablet computer with the latest CAPI version downloaded, battery charger, printed copy of formats as backup, and albendazole tablets for demonstration during data collection. The details of sampled schools were shared with surveyors one day before the commencement of fieldwork to ensure that surveyors did not contact schools and *anganwadis* in advance, as this could cause bias in the results.

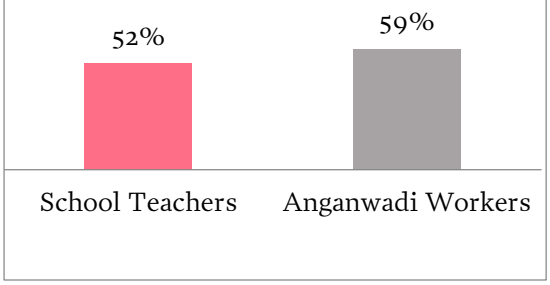
Appropriate quality assurance measures were taken to ensure that the data collected was accurate, consistent and authenticated. For example, school and *anganwadi* workers (AWWs) were asked to sign a participation form with an official stamp to authenticate surveyor visits to schools or *anganwadis*. Further, photographs of schools and *anganwadis* were also collected to authenticate the location of the interview. Evidence Action reviewed all data sets and shared feedback with the agency for any inconsistencies observed and ensured timely corrective actions. All analysis was performed using STATA and Microsoft Excel.

KEY FINDINGS

Training

Prior to each NDD round, teachers and *anganwadi* workers are trained on NDD related processes and protocols to facilitate effective NDD implementation. While all teachers and *anganwadi* workers are mandated to attend training for every round of NDD, irrespective of whether they had attended training in earlier rounds. Fifty-two percent of teachers and 59% AWWs visited by the surveyors had attended training for the February 2018 NDD round. The training attendance among private school teachers was also low (48%). Among those who did not attend training, 53% of all teachers and 48% of AWWs reported the lack of information about NDD training as the main reason for not attending. Only 56% percent of teachers provided training to other teachers at their schools. Forty-four percent of all teachers (46% of government and 38% of private school teachers) and 39% of AWWs reported that they did not receive an SMS about NDD. Absence of an updated contact database of mobile numbers is largely responsible for the sub-optimal delivery of SMS to teachers and AWWs.

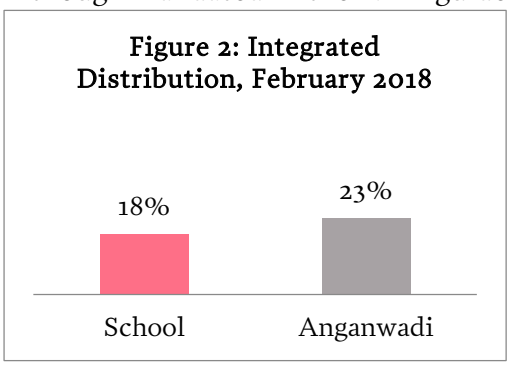
Figure 1: Attended training for National Deworming Day, February 2018



Integrated Distribution of NDD Materials Including Drugs at Trainings

Although mandated in the NDD guidelines, integrated distribution of the NDD materials kit was low for both schools (18%) and *anganwadis* (23%). Lower participation of teachers and *anganwadi* workers at trainings could have contributed to the low integrated distribution of the NDD kit. Around 93% of schools and 89% of *anganwadis* received deworming tablets, 67% ofschools and 70% *anganwadis* received posters/banners, and more than 50% of schools (55%) and *anganwadis* (52%) received handouts/reporting forms (Annex-Table CV3). Around 93% of schools and 86% of *anganwadis* reported having received sufficient drugs for deworming (Annex-Table CV2).

Figure 2: Integrated Distribution, February 2018



Among the sampled private schools, 85% received deworming tablets and among those, 90% reported having received a sufficient quantity. Fifty-six percent of private schools covered during coverage validation received posters/banners and 46% received handouts/reporting forms. (Annex-Table CV9)

Source of Information about the Recent Round of NDD

Other teachers/*AWWs* were the most reported source of information in schools (45%) and *anganwadis* (56%) on NDD. Around, 20% of schools and 22% of *anganwadis* reported receiving information via training. Another source of information was SMS, which was reported by 29% of schools and 19% of *anganwadis*. Radio was the least reported sources of information for the current round of NDD by both teachers and *anganwadi* workers. The Gram Pradhan/PRI was reported as source of information by six percent of teachers and eight percent of *anganwadi* workers (Annex-Table CV1).

NDD Implementation

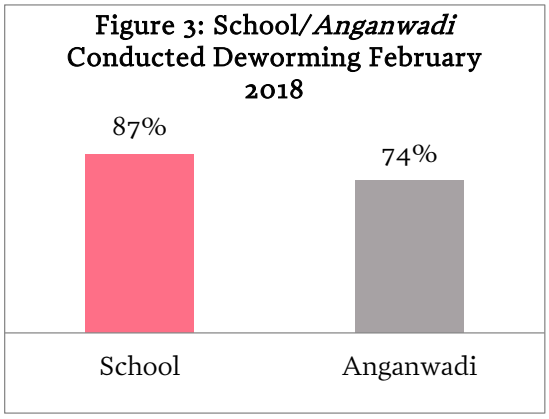


Figure 3: School/*Anganwadi* Conducted Deworming February 2018

Monitoring data of the February 2018 NDD round found that around 87% of schools and 74% of *anganwadis* dewormed children on either NDD or mop-up day. Around 77% of private schools conducted deworming activities, considerably lower than government schools (92%). The majority of schools (76%) and *anganwadi*s (74%) did not conduct deworming activities as they did not have any information about NDD or mop-up day.

Adverse Events – Knowledge and Management

Interviews with headmasters/teachers, and AWWs reveals a high degree of awareness regarding potential adverse events due to deworming and a high level of understanding of the appropriate protocols to follow in case of such events. Mild abdominal pain was listed as a side effect by 68% of teachers and 76% of AWWs followed by vomiting (as reported by 66% of teachers/ headmasters and 76% of AWWs).

About 82% of teachers and 76% of AWWs knew to make a child lie down in an open and shaded place in case of an adverse event. Representatives from 32% of schools and 34% of *anganwadi*s recalled that during adverse events a child should be given ORS or water. Approximately 70% of teachers and 60% of *anganwadi*s workers could also recall that they would need to call a Primary Health Centre (PHC) doctor if symptoms persisted.

Recording Protocol

As per coverage validation data, only 15% of schools and 26% of *anganwadis* followed correct recording protocols (single and double ticks). Around six percent of schools and 13% of *anganwadis* followed partial protocols (marking down different symbols or making a list of dewormed children), whereas 79% of schools and 61% of *anganwadis* did not follow any recording protocol (Annex CV7).

As recommended in NDD guidelines, teachers and AWWs were supposed to retain a copy of reporting forms; whereas only nine percent of headmasters who were interviewed and three percent of AWWs had a copy of the reporting form available with them.

Accredited Social Health Activists (ASHAs) are required to prepare a list of out-of-school children and children not registered in *anganwadis* and submit it to AWWs. However, only 17% of *anganwadis* had received lists of unregistered children (1-5 years) whereas

20% had received lists of out-of-school children (6-19 years) (Annex CV5). Only 11% of ASHA workers who were available at the *anganwadis* at the time of surveyors visit reported receiving an incentive for the last round of NDD. On the positive note, 95% of ASHAs conducted meetings with parents to inform them about NDD.

Coverage Validation

Coverage validation provides an opportunity to assess the accuracy of reported data and verify government-reported treatment figures. Verification factors[1] are common indicators to measure the accuracy of reported treatment values for Neglected Tropical Disease control programs[2].

The state-level verification factor for school enrolled children was 0.25, indicating that on an average, for every 100 dewormed children reported by the school, only twenty-five were verified either through single/double tick or through any other available documents at the schools. Similarly, overall state-level verification factor for children dewormed at *anganwadis* was 1.10, indicating that on an average, for every 100 dewormed children reported by the *anganwadi,* one hundred and ten children were verified through available documents. (Annex CV7). However, category-wise verification factors for registered (1-5 years), unregistered (1-5 years) and out-of-school (6-19 years) children were 1.04, 1.74 and 1.24 respectively for *anganwadis* (Annex CV7). The data suggests underreporting of coverage figures particularly for unregistered and out-of-school children in *anganwadis*, therefore, highlighting a need for proper record keeping. Further, interview of children suggests that majority of the children present at schools on NDD or mop-up day received (96%) and consumed (100%) the albendazole tablet on either NDD or mop-up day, based on children's interviews.

Against the state government reported 97% coverage in schools and 94% coverage for 1-5 years registered children in *anganwadis*, attempts were made to understand the maximum number of children that could have been dewormed at schools and *anganwadis* through coverage validation data. The NDD treatment coverage in schools was estimated considering the maximum attendance of children on NDD dates. Coverage validation data showed that 87% schools conducted deworming on either NDD or mop-up day (Annex-Table CV5), a maximum of 97% of children were in attendance (Annex-Table CV7), 96% of children received an albendazole tablet, and around 100% of children reported to consume the tablet under supervision (Annex-Table CV8). Considering these factors, 76%[3](0.87*0.97*0.96*1.00) of enrolled children could have been dewormed at schools.

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[1]A verification factor of 1 means of the schools reported the exact same figures that they recorded on deworming day. A verification factor less than 1 indicators over-reporting, while a verification factor greater than 1 indicates under reporting.

[2]WHO (2013), Data quality assessment tools for Neglected Tropical Disease: Guideline for implementation December 2013.

[3]This was estimated on the basis of NDD implementation status (87%), maximum attendance on NDD and mop-up day (97%), children received albendazole (96%) and supervised drug

Since interviews of children are not conducted at *anganwadis*, the verification factor of 1-5 years registered children from coverage validation data is applied to government reported coverage data for the same category. It was estimated that around 98% (0.94*1.04) of registered children (1-5 years) in *anganwadis* could have been dewormed. The calculation of verification factors is based on only those schools and *anganwadis* where a copy of the reporting form was available for verification. Therefore, adjusted coverage in *anganwadis* based on verification factor needs to be interpreted with caution.

RECOMMENDATIONS

The following are the key recommendation for program improvements that emerged from the coverage validation exercise:

1. Trainings form an important component for the effective implementation of the program and attendance of the *anganwadis* and the school teachers is very crucial for the program. Efforts are needed to increase the participation of the stakeholders in the trainings. Block trainings should be planned and communicated to teachers/*anganwadis* in advance and tracked and monitored by the respective departments at the district and block levels. Delays or rescheduling should be avoided by means of effective planning and coordination between the stakeholder departments.

2. Integrated distribution was also seen to be a weak component which needs to be strengthened and focused on during the coming round. Trainings should further focus on ensuring an effective and robustly planned integrated distribution of drugs and IEC materials at training sessions in order to mitigate the current gap in distribution.

3. As the state continues to target private schools and focus on increasing their engagement, it is critical that private schools and their representatives are further engaged to participate in state coordination and district-level coordination committee meetings.

4. SMS delivery continues to bean important platform for the dissemination of NDD related information to the stakeholder departments. Hence, the availability of updated database needs to be prioritized for better dissemination of the NDD related information to all stakeholders.

5. ASHA engagement forms a crucial point for the effective coverage of out-of-school and unregistered children. As seen from the coverage validation survey of this round, the percentage of *anganwadis* that had a list of out-of-school and unregistered children was low. Hence improved engagement of ASHAs with better coordination at the district/block level with ASHAs is important to train ASHAs on NDD forms and reporting requirements.

6. While adherence to correct recording protocol has been found to be limited at both schools and *anganwadis,* the state should ensure that the state devotes a training

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administration (100%). In absence of children's interview in anganwadis, the Government reported coverage was adjusted by implying state-level verification factor.

session to proper recording and reporting protocols. Additional practical sessions should be organized during training for better retention. The same can also be strengthened through reinforcement SMSs sent out to teachers/headmasters after training sessions. Since the availability of a copy of the reporting form directly affects the evaluation of reported coverage data, A standard copy of reporting formats (as attached along with the training handout) should be made available to minimize the issue of unavailability. This should also be reiterated at the trainings of teachers and *anganwadi* workers.

7. To achieve higher NDD coverage, teachers and ASHAs should be mobilized to place an emphasis on achieving maximum attendance of children at schools on NDD and mop-up day and high level of participation of schools in NDD program. More specifically, efforts must be made to mobilize participation of private schools in NDD program.

Annexure-1

Table A: Sample description including number of Schools and *Anganwadis* covered during Coverage Validation[4]

Sample Details	Number
Total number of districts in the state	22
Total number of NDD districts in the state	22
Number of districts covered during coverage validation	22
Number of trained surveyors deployed during coverage validation	100
Number of blocks in the state	119
Number of blocks in NDD districts	119
Number of blocks[5] covered during coverage validation	100
Total number of schools covered[6] during coverage validation	502
• Number of government schools covered	350
• Number of private schools covered	152
Total number of *anganwadis* covered[7]during coverage validation	506

Table CV1: Training, awareness and source of information about National Deworming Day among respondents (teacher/headmaster/*anganwadi* worker) February, 2018

Indicators[8]	School			Anganwadi		
	Denominator	Numerator	%	Denominator	Numerator	%
Attended training for current round of NDD	502	259	52	506	297	59

[4]Coverage validation in the state was conducted during May 07-11, 2018.

[5]These are sampled blocks selected from U-DISE data, 2014-15.

[6]These are the actual schools covered during Coverage Validation visits. Numbers given in subsequent tables (numerator and denominator) are weighted. The weights are used in order to generalize the findings at state level.

[7]These are the actual *anganwadis* covered during Coverage Validation visits. Numbers given in subsequent tables (numerator and denominator) are weighted. The weights are used in order to generalize the findings at state level.

[8]Weighted percentages and numbers are presented against each indicator in all the coverage validation tables.

Ever attended training for NDD[9]	502	287	57	506	321	63
Never attended training for NDD	502	215	43	506	185	37
Reasons for not attending official training						
Location was too far away	243	14	6	209	17	8
Did not know the date/timings/venue	243	130	53	209	101	48
Busy in other official/personal work	243	30	12	209	20	9
Not necessary because already attended deworming training in past	243	28	11	209	24	12
Do not feel the need	243	21	8	209	3	1
No incentives/no financial support	243	8	3	209	9	4
Others	243	74	30	209	71	34
Trained teacher provided training to						
All other teachers	259	145	56	Not Applicable		
Few teachers	259	64	25	Not Applicable		
No (himself/herself only teacher)	259	32	12	Not Applicable		
No, did not train other teachers	259	18	7	Not Applicable		
Source of information about current NDD round (Multiple Response)						
Television	502	108	22	506	100	20
Radio	502	37	7	506	27	5

[9] Includes those teachers and *anganwadi* workers who attended training either for NDD February 2018 or attended tanning in past.

Newspaper	502	82	16	506	65	13
Banner	502	78	16	506	78	16
SMS	502	143	29	506	96	19
Other school/teacher/*anganwadi* worker	502	224	45	506	282	56
WhatsApp message	502	62	12	506	20	4
Training	502	99	20	506	109	22
Gram Pradhan	502	31	6	506	43	8
Others	502	111	22	506	117	23
Receive SMS for current NDD round	502	220	44	506	196	39
Probable reasons for not receiving SMS						
Changed Mobile number	282	105	37	310	105	34
Other family members use this number	282	36	13	310	49	16
Number not registered to receive such messages	282	102	36	310	93	30
Others[10]	282	39	14	310	63	20

Table CV2: Awareness about NDD among teachers/headmasters and *anganwadi* workers, February 2018

Indicators	School			Anganwadi		
	Denominator	Numerator	%	Denominator	Numerator	%
Awareness about the ways a child can get worm infection	502	449	90	506	454	90

[10]Mostly includes Poor Network/ low internet connectivity.

Different ways a child can get worm infection (Multiple Response)						
Not using sanitary latrine	449	203	45	454	188	42
Having unclean surroundings	449	278	62	454	302	67
Consume vegetables and fruits without washing	449	326	73	454	281	62
Having uncovered food and drinking dirty water	449	300	67	454	287	63
Having long and dirty nails	449	258	58	454	240	53
Moving in bare feet	449	207	46	454	187	41
Having food without washing hands	449	219	49	454	202	44
Not washing hands after using toilets	449	124	28	454	116	26
Awareness about all the possible ways a child can get a worm infection[11]	449	28	6	454	26	6
Awareness about correct dose and right way of administration of albendazole tablet						
1-2 years of children (Crush the half tablet between two spoons and administer with water)	Not Applicable			506	309	61
2-3 years of children (Crush one full tablet between	Not Applicable			506	87	17

[11]Includes those who were aware that a child can get worm infection if she/he does not use sanitary latrine, have unclean surroundings, consume vegetable and fruits without washing, have uncovered food and drinking dirty water, have long and dirty nails, moves in bare fee, have food without washing hands and not washing hands after using toilets.

two spoons, and administer with water)						
3-5 years of children (one full tablet and child chewed the tablet properly)	Not Applicable			506	469	93
6-19 years of children (one full tablet and child chewed the tablet properly)	502	489	97	506	494	98
Awareness about non-administration of albendazole tablet to sick child						
Will administer albendazole tablet to sick child	502	84	17	506	83	16
Will not administer albendazole tablet to sick child	502	181	36	506	158	31
Awareness about consuming albendazole tablet						
Chew the tablet	502	480	96	506	470	93
Swallow the tablet directly	502	22	4	506	36	7
Awareness about consuming albendazole in school/*anganwadi*	502	482	96	506	490	97
Sufficient quantity of albendazole tablets[12]	465	430	92	451	388	86

[12] This indicator is based on the sample that received albendazole tablet.

TableCV3: Integrated distribution of albendazole tablets and IEC materials, February 2018

Indicators	Schools			*Anganwadi*		
	Denominator	Numerator	%	Denominator	Numerator	%
Items received by school teacher and anganwadi worker						
Albendazole tablet	502	465	93	506	451	89
Poster/banner	502	338	67	506	354	70
Handouts/ reporting form	502	275	55	506	262	52
Adverse event reporting form	502	49	10	506	58	11
Received all materials	502	43	9	506	47	9
Items verified during Independent Monitoring						
Albendazole tablet	465	272	59	451	249	55
Poster/banner	338	204	60	354	209	59
Handouts/ reporting form	275	95	34	262	75	29
Adverse event reporting form	49	15	31	58	15	27
Received all materials	43	15	34	47	11	24
No of school teachers/anganwadi worker attended training and received items during training						
Albendazole tablet	250	205	82	278	234	84
Poster/banner	210	161	77	240	196	81
Handouts/ reporting form	153	100	65	185	127	69
Adverse event reporting form	34	19	57	50	22	45
Received all materials	30	18	59	42	16	39
Integrated Distribution of albendazole tablet IEC and training materials[13]	502	92	18	506	116	23

[13] Integrated distribution of NDD kits includes albendazole, banner/poster and handout/reporting form provided to schools and AWC during the trainings.

Table CV4: Awareness about Adverse events and Its Management, February 2018

Indicators	Schools			Anganwadi		
	Denominator	Numerator	%	Denominator	Numerator	%
Opinion of occurrence of an adverse event after administering albendazole tablet	502	99	20	506	89	18
Awareness about possible adverse events (Multiple Response)						
Mild abdominal pain	99	67	68	89	67	76
Nausea	99	59	60	89	54	61
Vomiting	99	65	66	89	68	76
Diarrhea	99	29	29	89	28	31
Fatigue	99	21	21	89	16	18
All possible adverse event[14]	99	8	8	89	8	9
Awareness about mild adverse event management						
Make the child lie down in open and shade/shaded place	502	410	82	506	383	76
Give ORS/water	502	162	32	506	172	34
Observe the child at least for 2 hours in the school	502	128	26	506	115	23
Don't know/don't remember	502	34	7	506	75	15
Awareness about severe adverse event management						
Call PHC or emergency number	502	351	70	506	301	60
Take the child to the hospital /call doctor to school	502	300	60	506	310	61

[14]Includes those who are aware that a mild abdominal pain and nausea and vomiting and diarrhea and fatigue can be reported by a child after taking albendazole tablet.

Don't know/don't remember	502	7	1	506	26	5

Table CV5: Findings from School and *Anganwadi* Coverage Validation Data, February 2018

Indicators	Schools			Anganwadis		
	Denominator	Numerator	%	Denominator	Numerator	%
Percentage of schools/*anganwadis* Conducted deworming[15]	502	438	87	506	372	74
Percentage of government schools conducted deworming	341	313	92	Not Applicable		
Percentage of private schools conducted deworming	161	125	77	Not Applicable		
Percentage of School and *anganwadis* administered albendazole on day of - (Multiple Response)						
a. National Deworming Day	438	390	89	372	310	83
b. Mop-Up Day	438	285	65	372	247	66
c. Between NDD and Mop-Up Day	438	99	23	372	78	21
d. Both days (NDD and Mop-Up day)	438	274	64	372	230	62

[15]Schools and anganwadis that conducted deworming on NDD or mop-up day.

Reasons for not conducting deworming						
a. No information	64	49	76	134	99	74
b. Drugs not received	64	6	10	134	15	12
c. Apprehension of adverse events	64	3	4	134	2	2
d. Others[16]	64	6	10	134	17	13
Percentage of schools and *anganwadis* left over with Albendazole tablet after deworming	465	155	33	451	187	42
Number of albendazole tablets left after deworming						
a. Less than 50 tablets	155	129	83	187	159	85
b. 50-100 tablets	155	16	10	187	23	12
c. More than 100 tablets	155	11	7	187	5	3
Copy of filled-in reporting form was available for verification	438	39	9	372	9	3
Copy of filled-in reporting form was available for verification in Government Schools	313	31	10	Not Applicable		
Copy of filled-in reporting form was available for verification in Private Schools	125	8	7	Not Applicable		
Reasons for non-availability of copy of reporting form						

[16] Other includes mainly strike of anganwadi worker and no incentives for deworming.

a. Did not received	392	81	21	350	57	16
b. Submitted to ANM	392	256	65	350	245	70
c. Unable to locate	392	34	9	350	35	10
d. Other	392	22	6	350	12	4
Anganwadis having list of unregistered children (Aged 1-5 years)	Not Applicable			372	63	17
Anganwadis having list of out-of-school children (Aged 6-19 years)	Not Applicable			372	76	20

Table CV6: Selected indicators based on ASHA's interview at *Anganwadi* Centre, Coverage Validation Data

Sr. No.	Indicators	Anganwadis		
		Denominator	Numerator	%
1	ASHA[17] conducted meetings with parents to inform about NDD	186	176	95
2	ASHA prepared list of unregistered and out-of-school children	186	105	56
3	ASHA shared the list of unregistered and out-of-school children with *anganwadis* teacher[18]	105	63	61
4	ASHA administered albendazole to children	186	175	94
5	ASHA received incentive for NDD August 2017 round	186	20	11

[17] Surveyors were instructed to call ASHA at *anganwadi* centers during coverage validation and collect relevant information. Surveyors could only cover those ASHA's who were able to join for interview because it was not mandatory for ASHA's to attend.

[18]Based on sub-sample who reported to prepare the said list.

Table CV7: Recording protocol, verification factor and school's attendance

Indicators	Schools			Anganwadis		
	Denominator	Numerator	%	Denominator	Numerator	%
Followed correct[19] recording protocol	438	64	15	372	98	26
Followed correct recording protocol in Government Schools	313	45	14	Not Applicable		
Followed correct recording protocol in Private Schools	125	19	15	Not Applicable		
Followed partial[20] recording protocol	438	27	7	372	49	13
Followed no[21] recording protocol[12]	438	346	78	372	226	61
State-level verification factor[22] (Children enrolled)	8161	2058	25	334	368	110
a. Children registered with *anganwadis*	Not Applicable			253	264	104
b. Children unregistered with *anganwadis* (Aged 1-5)	Not Applicable			8	14	174
c. Out-of-school children (Aged 6-19)	Not Applicable			73	91	124
Attendance on previous day of NDD (Children enrolled)	127712	112950	88	Not Applicable		

[19]Correct recording protocol includes schools/*anganwadis* where all the classes/registers put single tick (✓) on NDD and double tick (✓✓) on mop-up day to record the information of dewormed children.

[20]Partial recording protocol includes schools/*anganwadis* where all the classes/registers did not follow correct protocol, put different symbols and prepared separate list to record the information of dewormed children.

[21]No protocol includes all those schools/*anganwadis* where none of the classes/registers followed any protocol to record the information of dewormed children.

[22]Ratio of recounted value of the dewormed children to the reported value. This calculation is based on only those schools (n=39) and *anganwadis* (n=9) where deworming was conducted and copy of reporting form was available for verification.

Attendance on NDD (Children enrolled)	127712	109088	85	Not Applicable
Attendance on mop-up day (Children enrolled)	127712	112904	88	Not Applicable
Children who attended on both NDD and mop-up day (Children enrolled)	127712	97552	76	Not Applicable
Maximum attendance of children on Deworming Day and mop-up day[23](Children enrolled)	127712	124440	97	Not Applicable
Estimated NDD coverage[24'25]	76			98
Estimated NDD coverage for Government School	81			Not Applicable
Estimated NDD coverage for Private School	66			Not Applicable

Table CV8: Description on children (6-19 years) interviewed in the schools (n=438) during coverage validation

Indicators	Denominator	Numerator	%
Children received Albendazole tablets	1314	1260	96
Children aware about the Albendazole tablets	1260	1144	91
Source of information about deworming among children (Multiple response)			
a. Teacher/school	1144	1124	98
b. Television	1144	82	7
c. Radio	1144	31	3
d. Newspaper	1144	49	4

[23]Maximum attendance refers to the total attendance of children who were exclusively present in school either on NDD or mop-up day and children who attended school on both days.

[24]This was estimated on the basis of NDD implementation status, attendance on NDD and mop-up day, whether child received albendazole and its supervised administration. Since no child interview is conducted at anganwadis; this has not been estimated for anganwadis.

[25]This was estimated by implying state-level verification factor on government reported coverage for 1-5 years registered children in AWC.

e. Poster/Banner	1144	115	10
f. Parents/siblings	1144	61	5
g. Friends/neighbors	1144	8	1
Children aware about the worm infection	1144	929	81
Children awareness about different ways a child can get worm infection (Multiple response)			
a. Not using sanitary latrine	965	352	37
b. Having unclean surroundings	965	480	50
c. Consume vegetables and fruits without washing	965	527	55
d. Having uncovered food and drinking dirty water	965	543	56
e. Having long and dirty nails	965	495	51
f. Moving in bare feet	965	314	33
g. Having food without washing hands	965	374	39
h. Not washing hands after using toilets	965	220	23
Children consumed Albendazole tablet	1260	1257	100
Way children consumed the tablet			
a. Chew the tablet	1257	1212	96
b. Swallow tablet directly	1257	45	4
Supervised administration of tablets	1257	1182	94
Reasons for not consuming Albendazole tablet			
a. Feeling sick	3	2	67
b. Afraid of taking the tablet	3	1	33
c. Parents told me not to have it	3	-	-
d. Do not have worms so don't need it	3	-	-
e. Did not like the taste	3	-	-