Evidence Action

Independent Monitoring and Coverage Validation of Schools and *Anganwadis* based mass deworming program in Madhya Pradesh – February 2016

REPORT

July, 2016

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1. EXECUTIVE SUMMARY

The World Health Organization (WHO) estimates that more than 1.5 billion or 24% of world's population is infected with soil-transmitted helminth (STH) infections worldwide. Over 270 million preschool-age and over 600 million school-age children live in areas of intensive worm transmission, and face physical, nutritive and cognitive impairment as a result of preventable STH infection. In 2001, WHO developed a strategy to control worm infection and recommended periodic mass deworming for all people living in endemic areas.[1]

India has an estimated 220 million children living with STH infection- almost one quarter of the global burden. In order to combat the high prevalence of STH, the Government of India launched National Deworming Day (NDD) program as a part of National Health Mission in February, 2015 to deworm all children between 1-19 years of age. The program aims supervised administration of albendazole tablets to all children in preschool and school-age, in *anganwadis* and schools, including unregistered (1-5 years) and out-of-school (6-19 years) children, in *anganwadis*. The first round of NDD in Madhya Pradesh was observed in all 41 districts of the state on **February 10, 2016** followed by mop-up day (MUD) on **February 15, 2016**. Evidence Action-Deworm the World Initiative, as the technical assistance partner, coordinated and facilitated planning and implementation of the deworming round in the state.

Evidence Action engaged an independent research agency to provide process monitoring on both deworming day and mop-up day (MUD) to assess the preparedness of *anganwadis* and schools to implement mass deworming program, followed by coverage validation to evaluate accuracy of the reporting data and coverage estimates post deworming. Due approvals for the survey obtained from Department of Health & Family Welfare, Government of Madhya Pradesh.

On National Deworming Day and mop-up day (MUD), 125 monitors visited 277 randomly selected government, government aided, and private schools, and 250 *anganwadis* to observe the ongoing deworming activity. Coverage validation was undertaken in February 20-26, 2016 during which 125 monitors visited 405 randomly selected government, government aided, and private schools and 375 *anganwadis* to verify their reported treatment figures. Findings from independent monitoring highlighted that around 90% of schools and 95% of *anganwadis* observed deworming on NDD and MUD. Approximately 96% of schools and 83% *anganwadis* reported to receive sufficient drugs for deworming. Around 69% of schools and 77% of *anganwadis* received program posters and banners. However, integrated distribution of NDD kits[2] was relatively low for both schools (31%) and *anganwadis* (36%). 76% of schools and *anganwadis* received training for the recent round of deworming. The corresponding figure for attending training in private schools was very low, with only one of 22 teachers in private

[1] WHO: Soil-transmitted helminth infections. *www.who.int/mediacentre/factsheets/fs366/en/*

[2] Integrated distribution of NDD kits including deworming drugs, banner/poster and handout-reporting forms and provided to schools and AWC during the trainings at block or PHC level.

schools reported to have received training on deworming in the last two months. Awareness of the causes of worm infection, possible adverse events, and adverse event protocols was high among teachers and *anganwadi* workers.

High compliance with procedures and protocols was observed across the schools and *anganwadis* in the state. All school principals, teachers and *anganwadi* workers were able to accurately mention at least one of the symptoms of adverse events. Although the basic knowledge of processes for management of adverse events was good, very few teachers and *anganwadi* workers had awareness of adverse event reporting protocols. Cases of any adverse events were reported in around 16% of the schools and 11% of the *anganwadis*.

Coverage validation data revealed that around 55% of schools and 85% of *anganwadis* followed correct protocols for recording the number of children dewormed. However, around 25% of schools did not adhere to any recording protocol. A substantial proportion of *anganwadi* workers did not have a list of unregistered preschool-age children (37%). Perhaps in line with substantial compliance with recording protocols, coverage validation data for school enrolled children exhibited a low level of overall inflation (6%; verification factor of 0.94) of treatment figures. Nevertheless, interviews indicated that 98% of all enrolled children received a deworming tablet.

The monitoring exercise conducted during Madhya Pradesh's second round of NDD also highlights opportunities to strengthen future rounds. As training is a critical component of the program, quality and coverage of the program can be improved in future rounds by ensuring timely communication of training dates to schools and *anganwadis*. Improved attendance of school teachers in trainings would enable effective implementation of the program in the schools. The database of functionaries across all stakeholder departments needs to be regularly updated and strengthened to ensure information dissemination on the program is reaching the key audience in a timely manner to allow for action as needed. Efforts are also required to ensure that those teachers who attend training also impart adequate training to other teachers in the school. Further, efforts are needed to strengthen the integrated distribution of deworming kits in the training. Integrated distribution would enable more widespread use of IEC materials for community mobilization and awareness, potentially improving the reach of the program. In addition, tracking the distribution cascade to identify and fill gaps in a timely manner will likely improve the availability of IEC materials. Enhanced engagement of ASHAs and AWWs is also critical for the success of program. Utilizing incentives approved by the national government for ASHA workers will provide motivation to these workers to mobilize out-of-school children. Moreover, as most of the *anganwadi* centers did not have a list of out-of-school and unregistered 1-5 years children, efforts are required to proactively engage ASHAs to prepare the list of all unregistered children in the community. Schools and *anganwadis* should be encouraged to retain a copy of school and *anganwadi* reporting forms after submission.

2. MONITORING AND EVALUATION

2.1 Study Background

Understanding program reach and quality is a key component of a successful deworming intervention. In order to fulfill this need, Evidence Action worked intensively with Government of Madhya Pradesh's health and education departments to assess the quality of program planning and implementation with an ultimate focus on developing recommendations for improvements in future rounds. The preparedness of schools, *anganwadis* and health systems to undertake deworming; adherence to the prescribed deworming processes; and ensuring accurate coverage reporting are key components of the supervision process. Three processes of monitoring and evaluation are included in each deworming program round: (1) process monitoring, (2) coverage reporting and (3) coverage validation.

2.2 Process Monitoring, Coverage Reporting, and Coverage Validation

Process Monitoring assesses the preparedness of schools, *anganwadis*, and health systems to implement mass deworming and the extent to which they have followed correct processes to ensure a high quality deworming program. Evidence Action assessed program preparedness during the pre-deworming phase and selected independent monitors who observed the processes on deworming day and mop-up day. Evidence Action conducted process monitoring in two ways: a) telephone monitoring and cross verification and b) physical verification by visiting schools and training venues.

Coverage Reporting assesses the estimated number of program beneficiaries, and is a crucial component to measure success. With close support from Evidence Action's state and field teams, the Department of Health collected and compiled the coverage report for NDD within the established reporting timelines. School teachers and *anganwadi* workers had been trained on the recording and reporting protocols. These protocols, along with the reporting cascade and timelines (refer to Figure A below), were shared with all districts through the state's directives. In order to improve the accuracy of coverage reporting by the schools and *anganwadi*s, every participating school and *anganwadi* was instructed to follow a recording protocol for deworming. Every teacher and *anganwadi* worker was required to put a single tick mark (✓) next to a child's name in the attendance register if they received albendazole on deworming day, and a double-tick mark (✓✓) if received on mop-up day. These tick marks are the basis for the numbers reported by every school and *anganwadi*. Schools and *anganwadi*s provided the number of enrolled/registered children dewormed by counting the single and double tick marks in the registers. Headmasters and *anganwadi* workers compiled the number of dewormed children from attendance registers, filled out the summary reporting format, and submitted it to the next level.

Figure A: Reporting cascade and timelines for Schools

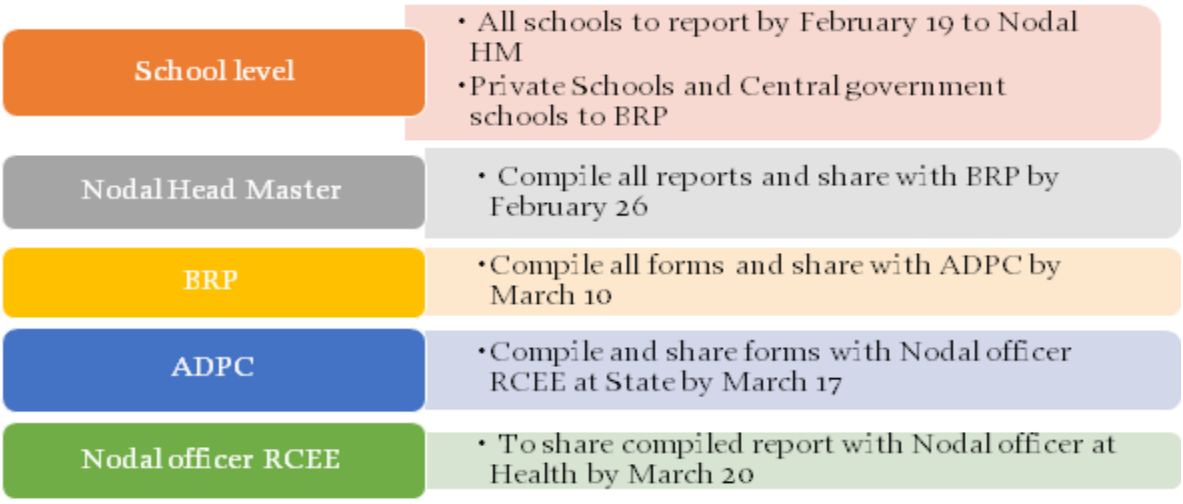
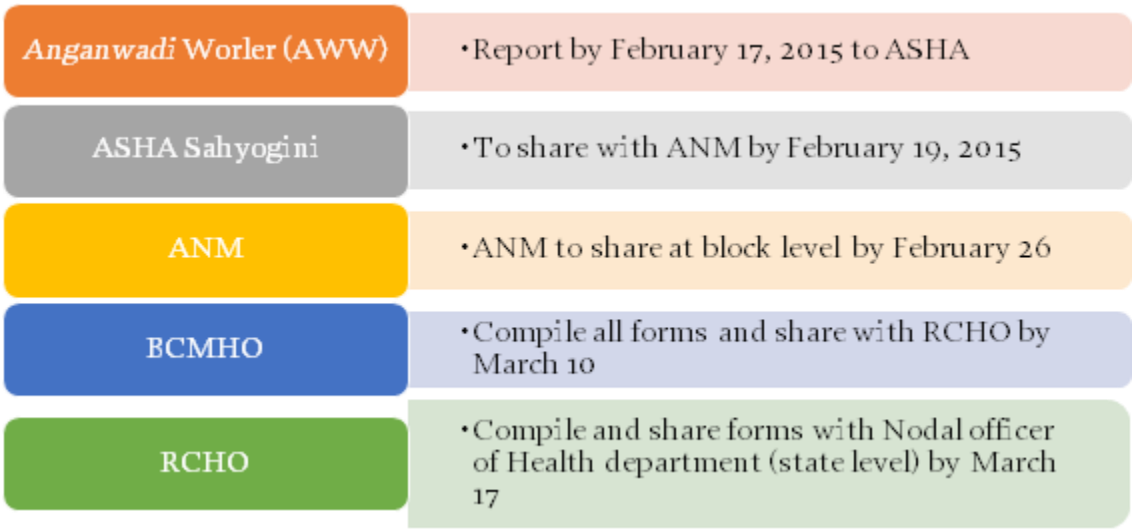


Figure B: Reporting cascade and timelines for *Anganwadis*



Coverage Validation is an ex-post check of the accuracy of the reporting data and coverage estimates. Coverage validation data was gathered through interviews with headmasters and three students (in three different randomly selected classes) in each school, and by checking all class registers and reporting forms. These activities provided a framework to validate coverage reported by schools and to calculate the level of inaccuracy in the data by comparing the ticks with numbers reported in school reporting forms.

2.3 Sampling and Sample Size

Through a competitive selection process, Evidence Action hired an experienced independent research agency, Karvy Insights Limited, to implement monitoring across 121 blocks in all 41 districts of the state. A two-stage probability sampling procedure was adopted to select schools for process monitoring and schools and *anganwadis* for coverage validation (Table A). For process monitoring, *anganwadis* near sampled schools were selected. Process monitoring was carried out on two days: NDD (February 10, 2016) and mop-up day (February 15, 2016). On each day, monitors aimed to visit 135 randomly selected government/government aided schools and 125 nearby *anganwadis* to observe deworming. Coverage validation was undertaken during February 20-26, 2016 during which monitors targeted to visit 405 randomly selected government/government aided schools, and 375 *anganwadis* to verify the reported coverage numbers. Additionally five monitors visited 20 private schools on National Deworming day and mop-up day, and 30 private schools during coverage validation.

Process information was collected to check for adequacy of drug supplies and awareness materials; assess whether teachers had received training; and check knowledge of adverse event management and reporting protocols. During coverage validation monitors collected information by interviewing school headmaster/teacher, *anganwadi* workers, checking attendance registers, and interviewing three children from each school.

Table A: Target and Coverage of schools and *anganwadis* during Independent monitoring

Indicators	Process monitoring		Coverage validation	
	Target	Achieved	Target	Achieved
Total number of districts	41	41	41	41
Total number of Blocks	125	125	125	125
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	250	375	375

2.4 Independent Monitoring Formats

To ensure comprehensive coverage and triangulation of data, four formats were administered - one each for process monitoring at schools and *anganwadis* on NDD and mop-up day, and one each for schools and *anganwadi*s for coverage validation. Evidence Action designed and finalized formats in consultation with Department of Health, Government of Madhya Pradesh. The formats were translated into the regional language, checked to ensure that the language was concise and easily understandable, and loaded onto tablet PCs. Using these four standard formats, monitors collected information on training, availability and use of IEC material, availability and submission of reporting forms, and frequency and management of adverse events.

2.5 Authorization from Government

The surveys were conducted with prior approval of the state government. An approval letter was issued by Department of Health, Government of Madhya Pradesh. Each monitor carried copies of the letter explaining the process of monitoring and coverage validation, and requesting participation from school and *anganwadi* staff.

2.6 Training of Trainers and Independent Monitors

A two-phase training program was organized at the state level. In the first phase, representatives from Evidence Action provided a one-day comprehensive training 10 master trainers of Karvy Insights in Bhopal on **February 5, 2016.** These master trainers conducted a two day training of 140 monitors during February 6-7, 2016 in batches of 45-50 monitors. A total of 160 trainees, including 10% buffer monitors and 20 supervisors were trained over two days.

The training included discussions on the deworming initiative, importance of independent monitoring, and monitoring formats. Afterward, all relevant formats were shared. Monitors received a demonstration of Tablet PC and were briefed on computer assisted personal interview (CAPI) administration process and troubleshooting. Upon completion of these modules, each monitor used the tablet to complete at least one practice session in the presence of trainers. During this period, trainers replied to any queries, and a live demonstration was conducted after the practice session. At the end of the training, all participants were tested on their degree of comprehension and ability to work in the field.

2.7 Field Implementation

Each monitor was allotted two schools and two *anganwadi*s for process monitoring. Subsequently, they were allotted three schools and three *anganwadi*s to survey for coverage validation. Monitors were provided a tablet device, charger, printed copy of monitoring formats, and albendazole tablets for demonstration. The details of sample schools were shared with them one day before fieldwork commenced to ensure that monitors do not inform local educational authorities ahead of their visit, thus potentially affecting compliance.

For process monitoring monitors were instructed to visit schools first and then a nearby *anganwadi*. In most cases, however, schools administered albendazole tablets only after the mid-day meal, so monitors were instructed to revisit those schools around noon after collecting information from *anganwadis*. For coverage validation, however, the strategy was slightly modified; if a school was closed or non-traceable, monitors were asked to cover the next school on their list, and return to the first school at another time on a subsequent day. If the school was non-traceable or closed consistently after attempting three visits, a new school was substituted for the old one.

Monitors' attendance and compliance with protocols were assessed by the supervisors. The monitors completed both formats by 4:00 pm, and then reported to their supervisors. Data was synced to the main server after completion of work, and assessed and scrutinized for comprehensiveness.

2.8 Quality Control

Appropriate quality control measures were taken to ensure data collected was accurate and comprehensive. Approximately 20% of schools and *anganwadis* were contacted over the phone on the next day to confirm that they had participated in monitoring and validation. In addition, district coordinators visited sampled schools to spot check the monitoring processes and tele-callers contacted schools and *anganwadis* to verify monitoring visits. In all cases, school and *anganwadi* staff were asked to sign a participation form and provide an official stamp, verifying that the school or *anganwadi* was actually visited. The data synced to tablets was vetted as quickly as possible to ensure comprehensiveness, and errors were subsequently addressed by follow up visits or calls.

3. KEY FINDINGS

Key results from independent monitoring are provided below, with further details shared in annexures.

3.1 Training

For effective implementation of NDD, teachers and *anganwadi* workers are trained prior to the deworming day. Independent monitoring data demonstrated that 76% of teachers/ headmasters from schools and *anganwadi* workers received training for the deworming round[3] **(Figure 1).** Among those who did not attend training, the majority of teachers (32%) and *anganwadi* workers (35%) cited unawareness about the date and time of training as the main reason. **(Annexure 1 – Table 1).**

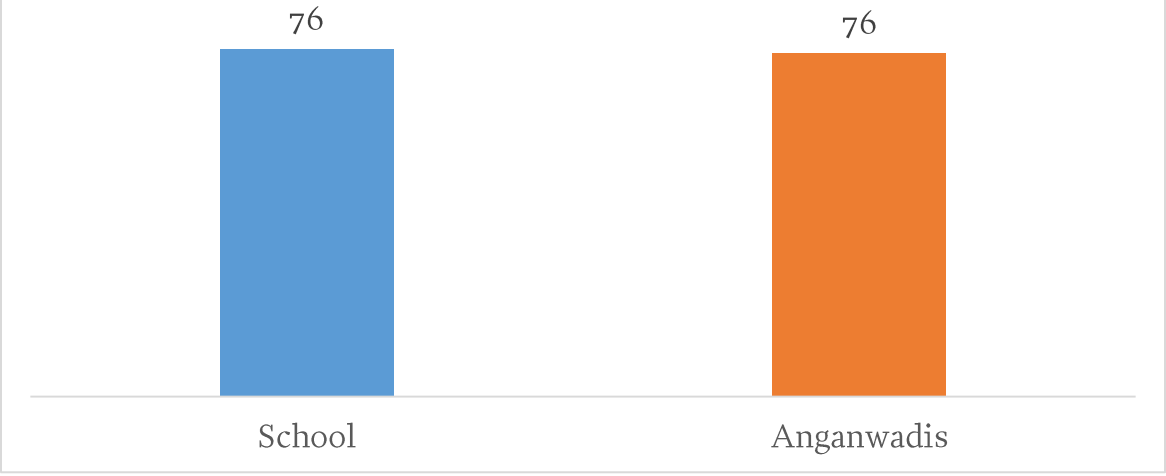
One of the 22 sampled private schools reported to have received training on deworming in the last two months. Among these teachers, unawareness about training date and time, busy with

[3] Findings from both process monitoring and coverage validation were grouped together for this indicator.

other official work, and attended deworming training in past were reasons for not attending the training. Only two of the 22 private schools teachers believed any adverse events can occur after taking the tablets. Further monitoring observed only 3 schools of the 22; out of which any case of adverse event recorded in 1 school.

Approximately 48% of schools and 52% of *anganwadis* reported that they did not receive an SMS about deworming schedule **(Annexure 1 – Table 1)**. Similarly, 21 out of 22 private schools did not receive SMS about deworming round. Additionally, in schools where a headmaster/teacher attended training, 69% provided training to other teachers in the school **(Annexure 1 – Table 1)**.

Figure 1: Attended training for National Deworming Day



3.2 Integrated Distribution of Deworming Materials Including Drugs

As per NDD guidelines, there should be an integrated distribution process, providing all necessary IEC and training materials along with deworming tablets to schools and *anganwadi* centers at Block level training.[4] Despite the well-defined NDD kit and integrated distribution cascade, findings from independent monitoring demonstrate that only 31% of schools and 27% of *anganwadis* in the state had integrated distribution of deworming materials, highlighting large distribution of deworming materials outside the cascade **(Annexure 1 – Table 1)**.

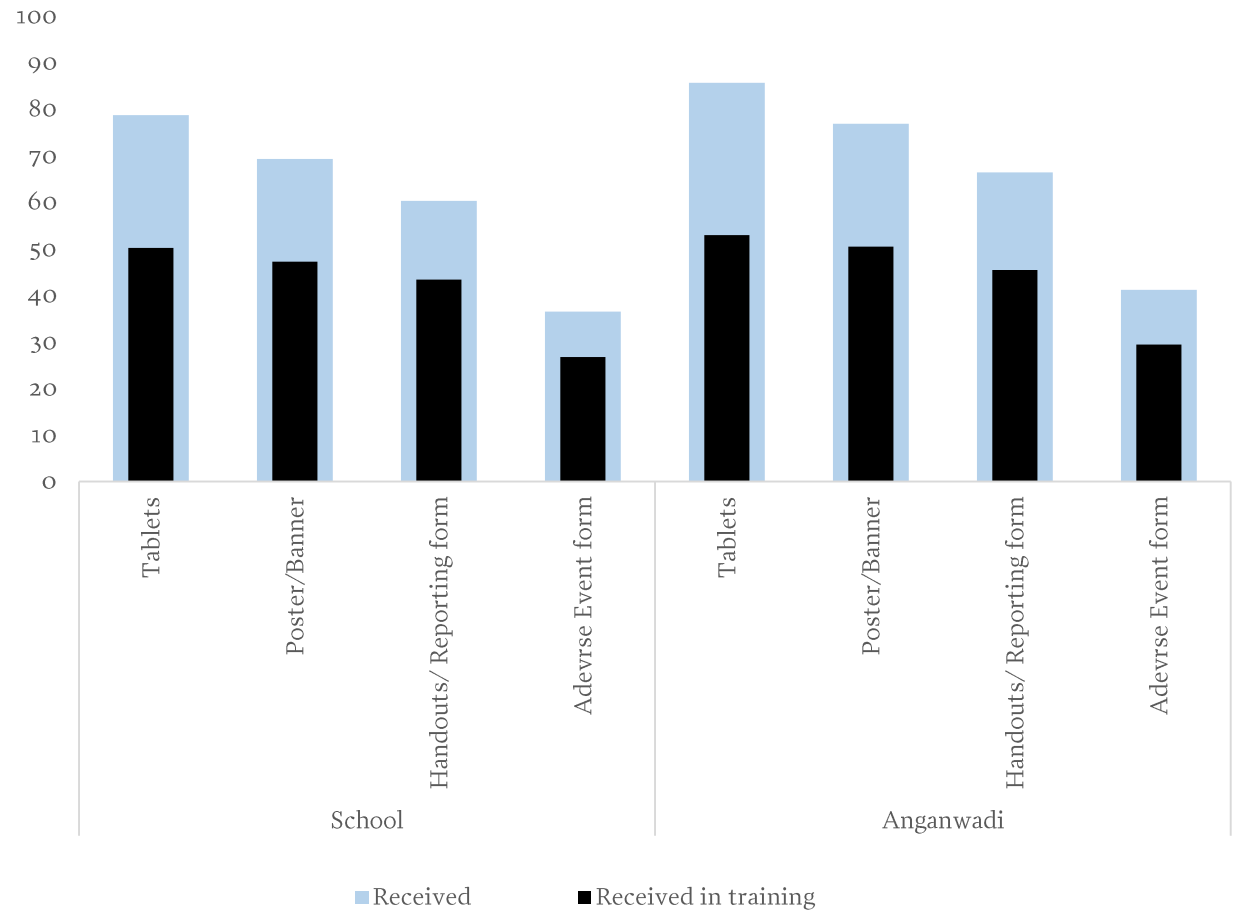
Around 79% of schools and 86% of *anganwadis* received tablets for deworming; however, 50% of schools and 53% of *anganwadis* had received these tablets during training **(Figure 2 & Annexure 1 – Table 2)**. Moreover, 96% of schools and 83% of *anganwadis* reported to have received sufficient drugs for deworming **(Annexure 2 – Table 1)**. 69% of schools and 77% of

[4] 'National Deworming Day, operational Guidelines 2016,Ministry of Health and Family Welfare, Government of India http://nrhm.gov.in/images/pdf/NDD-2016/Guidelines/Draft_NDD_2016_Operational_Guidelines.pdf

anganwadis received poster/banners whereas around 47% of schools and 50% of *anganwadis* received banner/posters in training **(Figure 2 & Annexure 1 – Table 2).** About 60% of schools and 66% of *anganwadis* received handouts/reporting forms and 43% of schools and 45% of *anganwadis* received them in the training. Moreover, 37% schools and 41% *anganwadis* received adverse event reporting forms **(Figure 2 & Annexure 1 – Table 1).**

Only two of the 22 private schools covered during process monitoring reported to receive tablets. During coverage validation six of the 22 private schools reported to have received sufficient quantity of deworming tablets.

Figure 2: Items received during deworming



3.3 Source of Information about Recent Round of Deworming

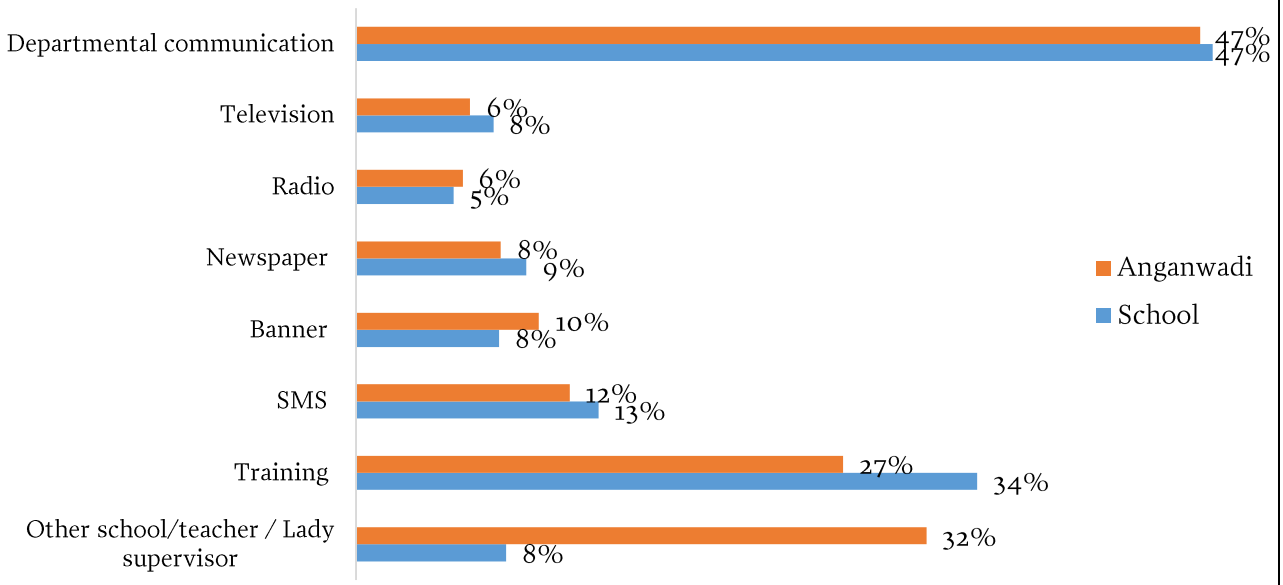
Departmental communication was the major source[5] of information for the schools and *anganwadis* (47%) for deworming **(Figure 3).** This was followed by training (34%) and SMS

[5] Major source of information is the maximum number of a medium reported by school teachers/headmaster and *anganwadi* workers

(13%) for schools, and other workers (32%) and SMS (12%) for *anganwadis* **(Figure 3 & Annexure 1 – Table 1).** Departmental communication was also the primary source of information for five of 22 private schools.

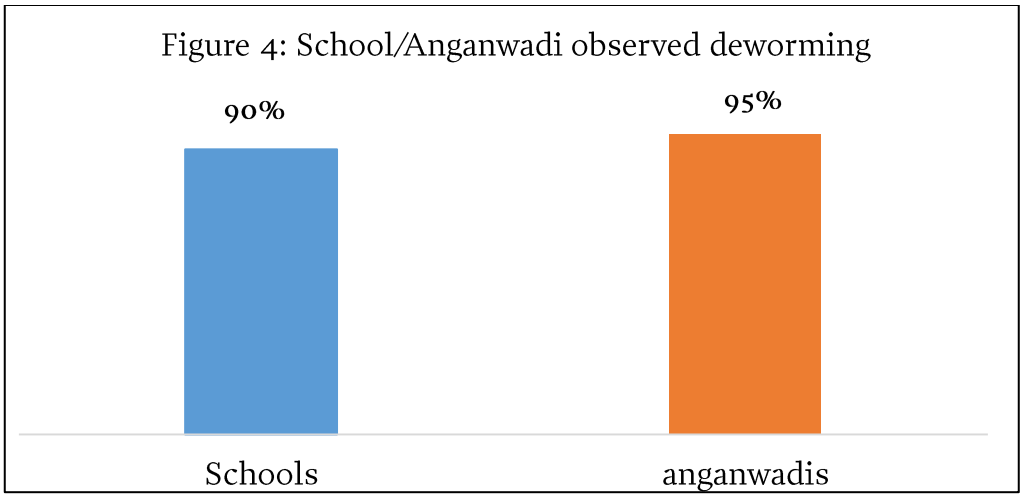
Most children reported their primary source of information about deworming to be verbal instructions and explanation from their teacher (98%), followed by the banner/poster (23%), and television (12%) **(Annexure 1 – Table 5).**

Figure 3: Source of information about recent round of deworming



3.4 Implementation of Deworming

Independent monitoring data depicted that around 81% of schools and 85% of *anganwadis* reported to conduct deworming on the day of visit; however, monitors observed ongoing deworming activity in 74% of schools and 76% of *anganwadis* respectively **(Annexure 1 – Table 1 & 3).** Further, coverage validation demonstrated that 90% of schools and 95% of *anganwadis* had dewormed children during deworming or mop-up day **(Figure 4 & Annexure 2– Table 1).** Out of total enrolled children who were interviewed on deworming day and mop-up day, around 92% reported receiving a tablet on one of these days. Prima facie, this suggests that deworming occurred in a large proportion of schools and *anganwadis* on one of the deworming days **(Annexure 1 – Table 5).** Six of the 22 monitored private schools observed deworming on both NDD and mop-up day.

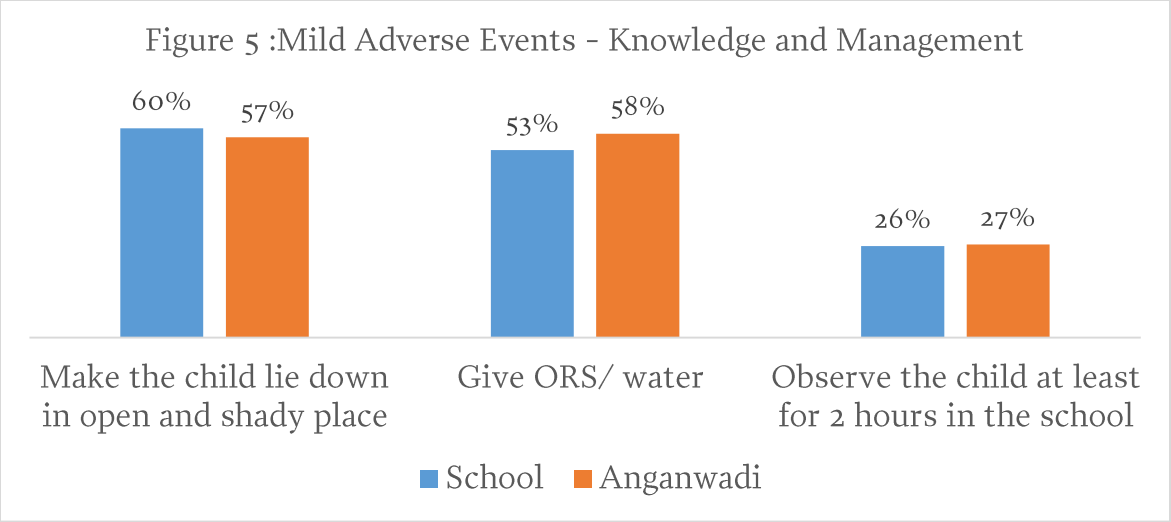


3.5 Adverse Events - Knowledge and Management

Interviews with headmasters and teachers revealed substantial awareness regarding potential adverse events, and understanding of appropriate protocols to follow in case of such events. Around 77% of schools and 78% of *anganwadi* workers asked children if they were sick before administering tablets, and 81% of schools and 90% of *anganwadi* workers did not administer tablets to a sick child **(Annexure 1 – Table 3)**. Abdominal pain was listed as a symptom by 72% of principals and 81% of *anganwadi* workers followed by vomiting which was listed by 60% of principals and 77% of *anganwadi* staff, nausea listed by 43% of schools and 35% of *anganwadis*. Fewer school staff (20%) and *anganwadi* workers (21%) recognized fatigue as a symptom **(Annexure 1 – Table 1)**. Further, 60% of school teachers and 57% of *anganwadi* workers knew to have a child lie down in an open, shady place in case of any symptoms and 53% of schools and 58% of *anganwadis* knew to give ORS/water in case of adverse event **(Figure 5)**. Further, 55% of schools and 19% of *anganwadis* reported the need to call a PHC doctor if symptoms persisted **(Annexure 1 – Table 1)**.

The high proportion of teachers and *anganwadi* workers who listed adverse event symptoms, and describe response protocols, suggest that schools and *anganwadis* have substantial awareness about the processes to be followed. Almost all interviewed teachers listed at least one symptom and one measure to be followed in case of an adverse event. Around 16% of schools and 11% of *anganwadis* reported any case of mild adverse event **(Annexure 1 – Table 3)**.

Only one private schools aware of the potential adverse events, listed abdominal pain, vomiting and diarrhea as symptoms. And only one case of adverse event was observed in private schools.



3.6 Recording Protocol

Coverage validation data **(Annexure 2 – Tables 2 & 4)** demonstrated that 55% of schools and 85% of *anganwadi*s followed correct recording protocols, while 45% percent of schools did not adhere to the protocols. Of these non-adhering schools, 25% did not follow any recording protocol **(Annexure 2 – Table 2)**. During training, teachers and *anganwadi* workers were instructed to retain a copy of school/*anganwadi* reporting forms; 77% of schools and 82% of *anganwadi* workers interviewed during process monitoring were aware of this requirement **(Annexure 1 – Table 1)**. During coverage validation, reporting forms were available in 50% of schools and 47% of *anganwadis*. Further, as per NDD guidelines, ASHAs were required to prepare a list of the children not attending schools and *anganwadis* and submit it to *anganwadi* workers to increase coverage of these children; however, findings suggest that only 37% of *anganwadi*s had lists of unregistered (1-5 years) children **(Annexure 1 – Table 1)**. Overall, 94% of schools had completed the school reporting forms **(Annexure 2 – Table 2)**.

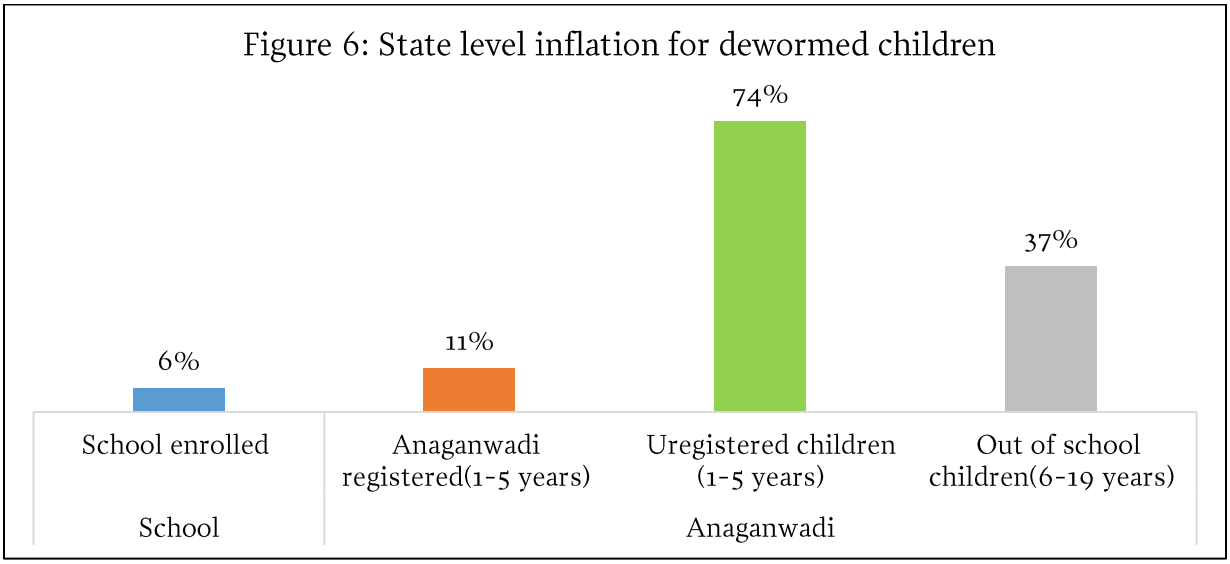
3.7 Coverage Validation

In schools and *anganwadis* sampled for coverage validation, state-level verification factors were calculated. Verification factors are common indicators for Neglected Tropical Disease control programs around the world. The verification factor compares the aggregated number of ticks in school/*anganwadi* registers (indicating that children were dewormed) to the coverage reported by schools/*anganwadis* in reporting forms submitted to the state. A verification factor of 1 means the schools reported the exact same figures that they recorded on deworming day. A verification factor less than 1 indicates over-reporting, while a verification factor greater than 1 indicates under-reporting. Thus, the verification factor was estimated on the basis of availability of a copy of reporting forms at schools and *anganwadis*.

As mentioned in the previous section, 50% of schools and 47% of *anganwadis* had a copy of the reporting form available after deworming and mop-up day. The state level verification

factor for enrolled children was 0.94, indicating that for every 94 enrolled children who were recorded as dewormed in schools, the school reported that 100 enrolled children had been dewormed **(Figure 6 & Annexure 2 – Table 2)**. This corresponds to an overall 6% inflation of reporting in the state, meaning that reported numbers appear to be approximately 6% higher than the numbers recorded in attendance registers. Similarly, the state level verification factors for *anganwadi* registered children, non-registered (1-5 years) and out-of-school (6-19 years) children were 0.89, 0.57 and 0.73 with corresponding inflation of 11%, 74%, and 37% respectively **(Figure 6 & Annexure 3 – Table 2)**. Training was found to increase the accuracy of reporting. As a result, inflation was observed to be very low among trained schools too: trained schools had 9% inflation in reporting, while untrained schools had 20% inflation in reporting **(Annexure 2 – Table 2)**.

Figure 6: State level inflation for dewormed children



Further, attempts were made to understand the maximum number of enrolled children that could have been dewormed. Coverage validation demonstrated that 90% of schools did deworming on either of the days and attendance data showed that 95% of the total school enrolled children were in attendance **(Annexure 2 – Table 2)**. Moreover, 98% of children interviewed during coverage validation reported to have received a deworming tablet and consumed it under the supervised administration in schools **(Annexure 2 – Table 3)**. Based on deworming implementation status and attendance of enrolled children on deworming and mop-up day and children's interview, maximum 87% (100% children out of 90% present in 97% of schools conducted deworming) children could have been dewormed in the state.

4. RECOMMENDATIONS

Since the program follows a fixed-day approach and engages multiple stakeholders, it is critical that all program components are aligned with each other for successful program implementation and to prevent gaps and delays. Of particular importance are IEC, training, drug logistics, and adverse event management related preparedness. Following are the key recommendations for program improvements that emerged from this exercise.

1. The preparatory activities leading up to NDD 2016 were conducted under a compressed time schedule. In forthcoming rounds, all stakeholder engagement for planning and preparations should be initiated in advance as per the operations plan.

2. In coordination with all the stakeholder departments, consensus on fixing target population would be helpful to assess the extent of coverage and expanding reach to children not attending schools and *anganwadis.*

3. Training is a critical component of the program. Findings about training attendance suggest that quality and coverage can be improved in future rounds by ensuring that sessions are planned earlier and that greater emphasis is placed on communicating training dates. Better attendance at trainings may also be used to capture contact details, improving the ability of the deworming program to reach out to the ultimate implementers of the program. Improving attendance at trainings will likely benefit the distribution cascade as well, since drugs and materials are intended to be distributed at the time of training.

4. As substantial proportion of school headmasters and *anganwadi* workers did not receive deworming related SMS during NDD, the contact database of functionaries across all stakeholder department needs to be regularly updated and strengthened to ensure comprehensive information dissemination and reaching concern officials/functionaries in a timely manner.

5. Findings suggest a need for greater focus on integrated distribution to ensure that sufficient drugs and other materials reach schools before deworming day. This requires efficient planning for the integrated training and distribution cascade to ensure that it works effectively.

6. Intensive efforts towards generating community awareness and mobilizing children to achieve high coverage will be critical for program success. For instance, parents and siblings may be targeted with specific community mobilization activities to increase coverage of out-of-school children. More engagement of ASHAs and AWWs should be encouraged, since they conduct community meetings, mobilize children, and conduct health education activities. Providing ASHAs with incentives, as approved by the national government, will motivate them to conduct activities for community engagement. Further, as most of the *anganwadi* centers did not have the list of out-of-school and non-registered children, efforts are required to proactively engage ASHAs to prepare these lists in their communities.

7. Coverage validation data, as well as differences in reporting between trained and untrained schools, suggest that a greater emphasis on recording protocols will improve the quality of coverage data in the future rounds.

5. WAY FORWARD

Program monitoring has given useful insights for increasing scale and coverage in future rounds. As the program has achieved significant coverage for enrolled children in schools,

moving forward the strategies will focus on increasing coverage of unregistered and out-of-school children. In this second round of NDD, Madhya Pradesh covered private schools in four districts on a pilot basis and the findings from independent monitoring reveal poor performance. Efforts are required to scale the NDD to cover all private schools in all districts in the state and emphasis should be given on timely communication on deworming related information to these schools. Efforts will be directed on encouraging schools and *anganwadis* to follow standard recording protocols for recording dewormed children to improve the accuracy of coverage data.

ANNEXURE 1

Table: 1 Interview with headmaster/headmistress/principal and *Anganwadi* workers

Indicators	School		Anganwadi	
	%	N	N	%
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		
Did teacher/ *Anganwadi* worker attended training in last 2 months	71.1	197	69.7	166
Did trained teacher provide training to other teachers				
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
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 and Lady Supervisor	8.3	23	31.5	75
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
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	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(CRC)/Anganwadi Reporting(ANM)	29.2	81	41.2	98
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
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

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

Table: 2 Integrated Distribution of Drugs and IEC material

Items Received in training	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**

Note:-The sample size for items received in schools and *anganwadis* were 263 and 250 respectively

*The denominator for verified is the number of particular item received

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

Indicators	School (145)*		Anganwadi(171)*	
	%	N	%	N
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
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
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
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

*Deworming activity was observed by monitors in 145 schools and 171 *anganwadis*

Table: 4 Interview with school teacher

Indicators	%	N
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
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
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
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 child

Indicators	%	N
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		
By Teacher / headmaster	91.8	190
By ASHA/ANM	7.2	15
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
Taking home	25.0	1
Other, specify		
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

ANNEXURE 2

Table 1: Findings from School/*Anganwadi* Coverage Validation data

Table:1 Coverage Validation Indicators	School		*Anganwadi*	
Indicators	%	N	%	N
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* observed deworming	90.4	366	94.7	375

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
***Anganwadis* having list of out of school(6-19) children**	NA	NA	30.67	115
***Anganwadis* having list of non-registered(1-5) children**	NA	NA	36.8	138

Table: 2 School Coverage Validation Indicators

Indicators	%
Schools where all the classes followed the correct recording protocol	55.4
Schools where one or more of the classes followed the correct recording protocol	60.3
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	17.2
Schools where no reporting protocol was followed	25.1
State level verification factor	0.94
State inflation rate (which measures the extent to which the recording in school reporting forms exceeds records at schools)	6.0%
Attendance on Deworming Day	69.2
Attendance on mop-up day	73.1
Children who attended on both Deworming Day and mop-up day	55.8
Maximum attendance of children on Deworming Day and mop-Up Day according to the CV data	86.5
Schools had surplus storage of drugs after deworming	58.1%
Schools had complete school reporting form	94.4%

Schools reported serious adverse event after taking the medicine	6.0%
Average number of adverse events reported per school	14.1
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%
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)	55.4%
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).	-0.01%

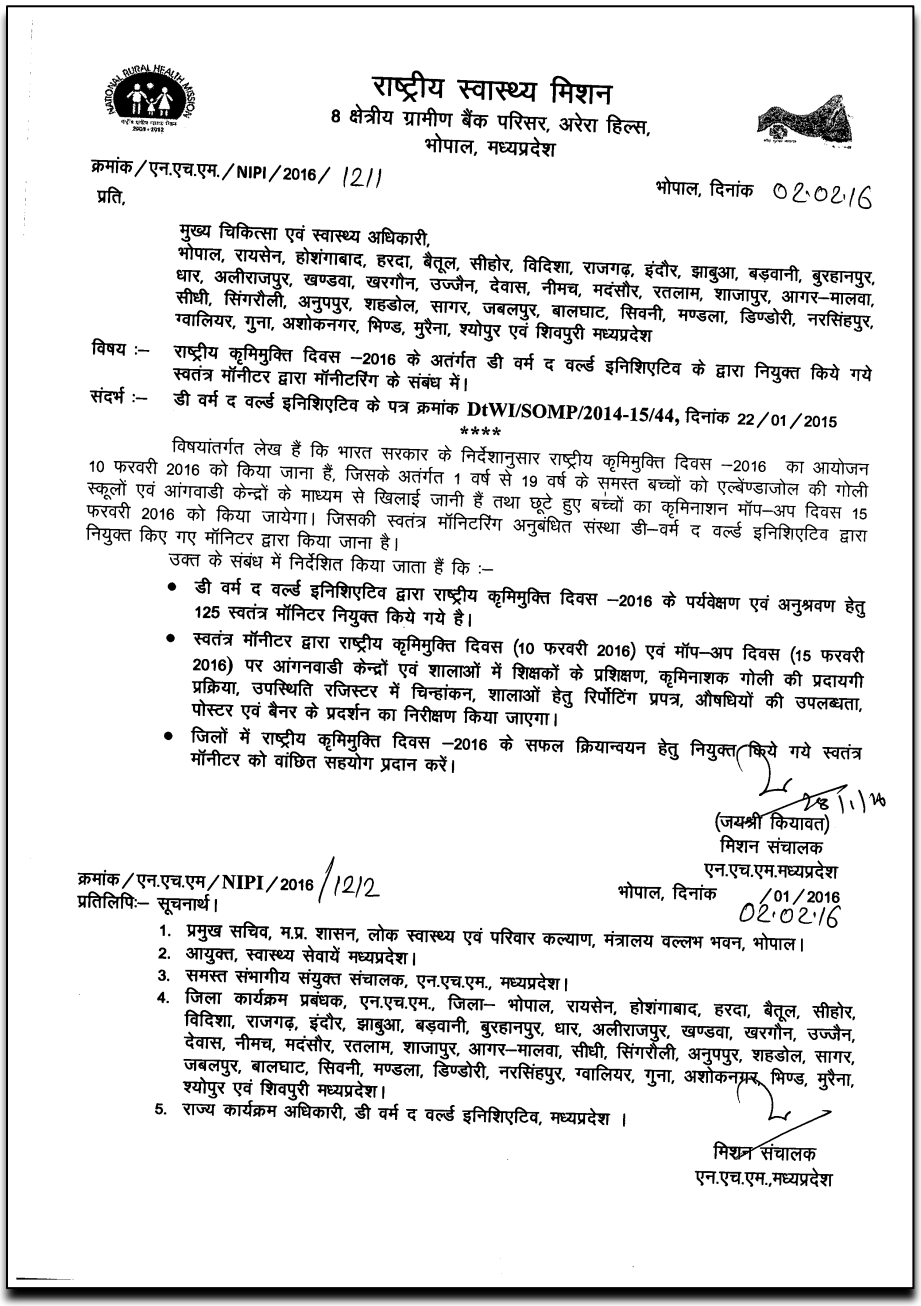
Table: 3 Interview of children during Coverage validation

Indicators	%
Children received Deworming tablets	98.0
Supervised Administration of tablets	95.1
Children consumed tablet	96.9
Way child consumed the tablet	
Chewed tablet before swallowing	90.7
Swallowed tablet directly	9.3

Table: 4 *Anganwadi* Coverage Validation Indicators

Indicators	%
***Anganwadi* that followed recording protocol**	84.5
State level verification factor for Registered children(1-5 years)	0.89
State level verification factor for non- registered children(1-5 years)	0.57
State level verification factor for out of school children(6-19 years)	0.73
State inflation rate (1-5 years)	11.1
State inflation rate for non- registered children (1-5 years)	73.5
State inflation rate for out of school children(6-19 years)	36.8

Annexure 3: Authorization letter from the Government



राष्ट्रीय स्वास्थ्य मिशन

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

क्रमांक/एन.एच.एम./NIPI/2016/ 1211

भोपाल, दिनांक 02.02.16

प्रति,

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

विषय :– राष्ट्रीय कृमिमुक्ति दिवस –2016 के अतंर्गत डी वर्म द वर्ल्ड इनिशिएटिव के द्वारा नियुक्त किये गये स्वतंत्र मॉनीटर द्वारा मॉनीटरिंग के संबंध में।

संदर्भ :– डी वर्म द वर्ल्ड इनिशिएटिव के पत्र क्रमांक **DtWI/SOMP/2014-15/44,** दिनांक 22/01/2015

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विषयांतर्गत लेख हैं कि भारत सरकार के निर्देशानुसार राष्ट्रीय कृमिमुक्ति दिवस –2016 का आयोजन 10 फरवरी 2016 को किया जाना हैं, जिसके अतंर्गत 1 वर्ष से 19 वर्ष के समस्त बच्चों को एल्बेण्डाजोल की गोली स्कूलों एवं आंगवाडी केन्द्रों के माध्यम से खिलाई जानी हैं तथा छूटे हुए बच्चों का कृमिनाशन मॉप–अप दिवस 15 फरवरी 2016 को किया जायेगा। जिसकी स्वतंत्र मॉनिटरिंग अनुबंधित संस्था डी–वर्म द वर्ल्ड इनिशिएटिव द्वारा नियुक्त किए गए मॉनिटर द्वारा किया जाना है।

उक्त के संबंध में निर्देशित किया जाता हैं कि :–

- डी वर्म द वर्ल्ड इनिशिएटिव द्वारा राष्ट्रीय कृमिमुक्ति दिवस –2016 के पर्यवेक्षण एवं अनुश्रवण हेतु 125 स्वतंत्र मॉनिटर नियुक्त किये गये है।
- स्वतंत्र मॉनीटर द्वारा राष्ट्रीय कृमिमुक्ति दिवस (10 फरवरी 2016) एवं मॉप–अप दिवस (15 फरवरी 2016) पर आंगनवाडी केन्द्रों एवं शालाओं में शिक्षकों के प्रशिक्षण, कृमिनाशक गोली की प्रदायगी प्रक्रिया, उपस्थिति रजिस्टर में चिन्हांकन, शालाओं हेतु रिर्पोटिंग प्रपत्र, औषधियों की उपलब्धता, पोस्टर एवं बैनर के प्रदर्शन का निरीक्षण किया जाएगा।
- जिलों में राष्ट्रीय कृमिमुक्ति दिवस –2016 के सफल क्रियान्वयन हेतु नियुक्त किये गये स्वतंत्र मॉनीटर को वांछित सहयोग प्रदान करें।

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

क्रमांक/एन.एच.एम/NIPI/2016/1212

भोपाल, दिनांक 02.02.16/01/2016

प्रतिलिपिः– सूचनार्थ।

1. प्रमुख सचिव, म.प्र. शासन, लोक स्वास्थ्य एवं परिवार कल्याण, मंत्रालय वल्लभ भवन, भोपाल।
2. आयुक्त, स्वास्थ्य सेवायें मध्यप्रदेश।
3. समस्त संभागीय संयुक्त संचालक, एन.एच.एम., मध्यप्रदेश।
4. जिला कार्यक्रम प्रबंधक, एन.एच.एम., जिला– भोपाल, रायसेन, होशंगाबाद, हरदा, बैतूल, सीहोर, विदिशा, राजगढ़, इंदौर, झाबुआ, बड़वानी, बुरहानपुर, धार, अलीराजपुर, खण्डवा, खरगौन, उज्जैन, देवास, नीमच, मदंसौर, रतलाम, शाजापुर, आगर–मालवा, सीधी, सिंगरौली, अनुपपुर, शहडोल, सागर, जबलपुर, बालघाट, सिवनी, मण्डला, डिण्डोरी, नरसिंहपुर, ग्वालियर, गुना, अशोकनगर, भिण्ड, मुरैना, श्योपुर एवं शिवपुरी मध्यप्रदेश।
5. राज्य कार्यक्रम अधिकारी, डी वर्म द वर्ल्ड इनिशिएटिव, मध्यप्रदेश ।

मिशन संचालक
एन.एच.एम.,मध्यप्रदेश

संचालनालय एकीकृत बाल विकास सेवा, म.प्र.

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क्रमांक / आई.सी.डी.एस / मूल्यांकन / 2015–16 / 355 भोपाल, दिनांक 01 / 02 / 2016

प्रति,

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

विषय–राष्ट्रीय कृमि मुक्ति दिवस–2016 के अंतर्गत डी वर्म द वर्ल्ड इनिशिएटिव के द्वारा नियुक्त किये गये स्वतंत्र मॉनीटर द्वारा मॉनीटरिंग के संबंध में।

संदर्भ–डी वर्म द वर्ल्ड इनिशिएटिव के पत्र क्रमांक Dt WI/SOMP/2015-16/45, दिनांक 22 / 01 / 2016

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विषयांतर्गत भारत सरकार के निर्देशानुसार राष्ट्रीय कृमिमुक्ति दिवस–2016 का आयोजन 10 फरवरी 2016 को किया जाना है, जिसके अंतर्गत 1 वर्ष से 19 वर्ष के समस्त बच्चों को एल्बेण्डाजोल की गोली स्कूलों एवं आंगनवाड़ी केन्द्रों के माध्यम से खिलाई जानी है तथा छूटे हुए बच्चों का कृमिनाशनगॉप–अपदिवस 15 फरवरी 2016 को किया जायेगा। जिसकी स्वतंत्र मॉनिटरिंग अनुबंधित संस्था डी–वर्म द वर्ल्ड इनिशिएटिव द्वारा नियुक्त किए गए मॉनिटर द्वारा किया जाना है।

कार्यक्रम के सफल आयोजन हेतु निर्देशित किया जाता है कि स्वतंत्र मॉनीटर द्वारा राष्ट्रीय कृमिमुक्ति दिवस (10 फरवरी 2016) एवं गॉप–अप दिवस (15 फरवरी 2016) पर आंगनवाड़ी केन्द्रों के प्रशिक्षण, कृमि नाशक गोली की प्रदायगी प्रक्रिया, उपस्थिति रजिस्टर में चिन्हांकन, शालाओं हेतु रिपोर्टिंग प्रपत्र, औषधियों की उपलब्धता, पोस्टर एवं बैनर के प्रदर्शन का निरीक्षण किया जाएगा। डी वर्म द वर्ल्ड इनिशिएटिव द्वारा राष्ट्रीय कृमिमुक्ति दिवस–2016 के पर्यवेक्षण एवं अनुश्रवण हेतु 125 स्वतंत्र मॉनिटर नियुक्त किये गये है।

कृपया जिलों में राष्ट्रीय कृमिमुक्ति दिवस–2016 के सफल क्रियान्वयन हेतु नियुक्त किये गये स्वतंत्र मॉनिटर को वांछित सहयोग प्रदान करें।

Mdwidh.

(महेन्द्र द्विवेदी)
संयुक्त संचालक
एकीकृत बाल विकास सेवा,
मध्यप्रदेश

लोक शिक्षण संचालनालय, मध्यप्रदेश
गौतम नगर, भोपाल — 462023

क्र./विद्या/ई/2016/313 भोपाल, दिनांक /02/2016

प्रति,

1. संभागीय संयुक्त संचालक
   सागरत संभाग (म.प्र.)
2. जिला शिक्षा अधिकारी
   समस्त जिले (म.प्र.)

विषय :— राष्ट्रीय कृमिमुक्ति दिवस —2016 के अंतर्गत डी वर्म द वर्ल्ड इनिशिएटिव के द्वारा नियुक्त किये गये स्वतंत्र मॉनीटर द्वारा मॉनीटरिंग के संबंध में।

संदर्भ :— डी वर्म द वर्ल्ड इनिशिएटिव के पत्र क्रमांक DtWI/SOMP/2015 16/46, दिनांक 22/01/2016

विषयांतर्गत लेख हैं कि भारत सरकार के निर्देशानुसार राष्ट्रीय कृमिमुक्ति दिवस —2016 का आयोजन 10 फरवरी 2016 को किया जाना हैं, जिसके अंतर्गत 1 वर्ष से 19 वर्ष के समस्त बच्चों को एल्बेण्डाजोल की गोली स्कूलों एवं आंगवाडी केन्द्रों के माध्यम से खिलाई जानी हैं तथा छूटे हुए बच्चों का कृमिनाशन मॉप—अप दिवस 15 फरवरी 2016 को किया जायेगा। जिसकी स्वतंत्र मॉनिटरिंग अनुबंधित संस्था डी—वर्म द वर्ल्ड इनिशिएटिव द्वारा नियुक्त किए गए मॉनिटर द्वारा किया जाना है।

उक्त के संबंध में निर्देशित किया जाता हैं कि :—

- डी वर्म द वर्ल्ड इनिशिएटिव द्वारा राष्ट्रीय कृमिमुक्ति दिवस —2016 के पर्यवेक्षण एव अनुश्रवण हेतु 125 स्वतंत्र मॉनिटर नियुक्त किये गये है।
- स्वतंत्र मॉनीटर द्वारा राष्ट्रीय कृमिमुक्ति दिवस (10 फरवरी 2016) एवं मॉप—अप दिवस (15 फरवरी 2016) पर स्कूलों के प्रशिक्षण, कृमिनाशक गोली की प्रदायगी प्रक्रिया, उपस्थिति रजिस्टर में चिन्हांकन, शालाओं हेतु रिपोर्टिंग प्रपत्र, औषधियों की उपलब्धता, पोस्टर एव बैनर के प्रदर्शन का निरीक्षण किया जाएगा।
- जिलों में राष्ट्रीय कृमिमुक्ति दिवस —2016 के सफल क्रियान्वयन हेतु नियुक्त किये गये स्वतंत्र मॉनीटर को वांछित सहयोग प्रदान करें।

(पीरेन्द्र चतुर्वेदी)
संयुक्त संचालक
लोक शिक्षण संचालनालय

प्रतिलिपि :—

पृ. क्र./विद्या/ई/2016/314 भोपाल, दिनांक /02/2016

1. स्टाफ आफिसर, प्रमुख सचिव, मध्यप्रदेश शान, लोक स्वास्थ्य एवं परिवार कल्याण मंत्रालय वल्लभ भवन भोपाल।
2. मिशन संचालक, राष्ट्रीय स्वास्थ्य मिशन की ओर आपके संदर्भित पत्र के तारतम्य में सूचनार्थ।
3. राज्य कार्यक्रम अधिकारी डी वर्म द वर्ल्ड इनिशिएटिव, मध्यप्रदेश।

संयुक्त संचालक
लोक शिक्षण संचालनालय