

Chhattisgarh

Anganwadi and School-Based Mass Deworming Program



Photo Credit: Evidence Action

National Deworming Day-February 2016

June 2016

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ACRONYMS

ANM:	Auxiliary Nurse Midwife
AWC:	<i>Anganwadi</i> Centre
AWW:	<i>Anganwadi</i> Worker
BMO:	Block Medical Officer
BPM:	Block Program Manager
BRP:	Block Resource Person
CMHO:	Chief Medical and Health Officer
CS:	Civil Surgeon
DC:	District Coordinator (<i>Mitanin</i> Program)
DEO:	District Education Officer
DIO:	District Immunization Officer
DPM:	District Program Manager
DPO:	District Program Officer (WCD)
DWCD:	Department of Women and Child Development
GoI:	Government of India
ICDS:	Integrated Child Development Services
IEC:	Information, Education and Communication
MD:	Mission Director
NHM:	National Health Mission
NDD:	National Deworming Day
PIP:	Program Implementation Plan
RBSK:	Rashtriya Bal Swasthya Karyakarm
WHO:	World Health Organization

Executive Summary

The state of Chhattisgarh dewormed 23,21,789 children between 6-19 years during the Government of India's (GoI) second National Deworming Day (NDD) on February 10, 2016. NDD was implemented in 16 districts¹ out of 27 districts across 27,009 government and government aided schools, 101 private schools (Korba district²) and 28,384 *anganwadi* centers (AWCs) 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). 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 of NDD February 2016 Round in Chhattisgarh

Indicators		Results	% Coverage
Total number of children targeted		25,14,424	
Number of enrolled children (classes 1-12) who were administered albendazole	Government Schools	20,59,963	92%
	Private Schools	17,323	98.5%
Number of out-of-school children (6-19 years) dewormed		2,44,503	92%
Total number of children dewormed (6-19 years)		23,21,789	92%

Source: Report submitted by National Health Mission (NHM) Chhattisgarh to GoI on April 6, 2016. (Annexure A)
All out-of-school children age 6-19 years were catered through *anganwadi* centers in the NDD, as the state had previously dewormed preschool-age (1-5 years) registered and unregistered children through *anganwadi* during the recently concluded *Shishu Sanrakshan Maah (SSM)*³ in the month of November – December 2015.

Building upon the success of first phase of NDD in 2015 in 11 states⁴, the GoI scaled up NDD 2016 across India targeting 27 crore children in 32 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 line with the revised NDD 2016 guidelines, the state engaged private schools during this round. The commitment of Department of Health towards increased coverage led to the inclusion of private schools in one district in the state. 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

¹ in Chhattisgarh 11 districts are endemic districts where Lymphatic Filariasis (LF) treatment with albendazole (along with Diethylcarbamazine citrate) was conducted in December 2015 under National Filaria Control Program (NFCP)

² Inclusion of private school as pilot initiative in one district of Chhattisgarh i.e Korba.

³ In SSM all *anganwadi* registered and unregistered preschool-age children are administered Vitamin A, iron and folic acid tablets, and albendazole tablets.

⁴ Assam, Bihar, Chhattisgarh, Dadra and Nagar Haveli, Haryana, Karnataka, Maharashtra, Madhya Pradesh, Rajasthan, Tamil Nadu, and Tripura

prevalence and intensity of worm infections for all school-age and preschool-age children in the state.

1. Program Background

In India, approximately 22 crore children between the ages of 1 and 14 are at risk of parasitic intestinal worms (known as soil-transmitted helminths or STH). The children at-risk 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 productivity⁵.

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 Center 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"⁶ 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.⁷ The benefits of using such platforms for deworming are immediate. Regular treatment can reduce school absenteeism by 25%.⁸ 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.⁹

⁵ Helminth control in school-age children- A guide for managers of control programmes: WHO, 2011

⁶ <http://www.povertyactionlab.org/publication/deworming-best-buy-development>

⁷ <http://journals.plos.org/plosntds/article?id=10.1371/journal.pntd.0000223#pntd-0000223-g003>

⁸ 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.

⁹ 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

1.2 Deworming Children in India

Deworming children is part of the GoI's school and preschool health programs, such as the Weekly Iron-Folic Acid Supplementation (WIFS) program which provides a weekly dose of Iron Folic Acid (IFA) with biannual deworming for adolescents (10-19 years). 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 the launch of NDD in 2015, only a few states ran effective *anganwadi* and school - based deworming programs with high 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 GoI renewed its focus on deworming by streamlining efforts through a fixed-day *anganwadi* and school – based NDD.

1.3 State Deworming Program History

Prior to NDD, the deworming program in Chhattisgarh was broadly aligned with two pan-state programs: *Shishu Suraksha Maah* (SSM)¹⁰ and *Weekly Iron Folic Supplementation* (WIFS)¹¹. In addition, the National Filariasis Control Program (NFCP) provides community-wide administration of albendazole, the same drug used for deworming, along with diethylcarbamazine citrate (DEC) on an annual basis.

The state has previously administered deworming drugs through these existing programs, but efforts have been disjointed and sporadic. Since the coverage was low in order to reach all at-risk preschool-age and school-age children, a fixed day approach strategy through a comprehensive program like NDD, was necessary to achieve the goal of covering at least 75% of at-risk children. This was facilitated through a Memorandum of Understanding (MoU), which was signed on June 27, 2015 among National Health Mission, Department of Health & Family Welfare, Government of Chhattisgarh and Evidence Action - Deworm the World Initiative wherein Evidence Action provides technical assistance to the state-implemented program.

The state conducted its first NDD round on February 10, 2015 followed by a Mop-up day on February 15, 2016 with a reported coverage of 94%, deworming 9,16,596 lakhs school-age children (10-19 years). On request of the state government, Evidence Action supported the training and monitoring component of this round.

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

¹¹ Under Weekly Iron Folic Supplementation (WIFS) the adolescent girls aged 10-19 years are administered IFA and biannual deworming through the WIFS program, launched in 2013.

1.4 Prevalence Survey

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. Evidence Action, in partnership with National Institute of Epidemiology, National Institute for Cholera and Enteric Diseases – Indian Council of Medical Research, Kolkata (NICED), and GfK Mode, a market research firm conducted a STH prevalence and intensity survey among children studying in classes one to five in government primary schools in the state. The survey was carried out across 40 government schools in 28 blocks of 13 districts covering the three agro-climatic zones of Chhattisgarh, testing a total of 1476 children for worm infections via stool samples. The sampling survey strategy and epidemiological analysis was designed by the National Institute of Epidemiology. Stool samples were analyzed by NICED in field laboratories using the WHO-recommended Kato-Katz method. The preliminary survey report and findings were submitted to the State NHM (**Annexure B**). Based on the data collected, the overall weighted prevalence of any STH in Chhattisgarh was calculated as 72.7%.

The survey data is also taken into account by GoI's appointed National Centre for Disease Control (NCDC), the nodal agency to conduct STH prevalence surveys across the country for formulating evidence based strategy. Based on GoI's recent guidance, dated May 9, 2016) a bi-annual school-based deworming program for school-age children is recommended in the state of Chhattisgarh.

It's recommended that the administration of school-based deworming program and the NFCP be timed six months apart to maximize impact. Prevalence survey also recommends that STH infection levels be surveyed every three years to assess the impact of the school-based deworming program, and to determine whether a change in treatment strategy would be warranted. Lastly, as transmission assessment surveys are an integral tool for the NFCP, Evidence Action also recommends that the state consider integrating assessments of STH prevalence with the lymphatic filariasis transmissions assessment surveys¹². This is recommended by the WHO, and would allow for quick, cost-effective assessment of the impact of school-based deworming and the NFCP on STH prevalence in Chhattisgarh

1.5 Learnings from Chhattisgarh NDD 2015

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 children aged 6-19 years, unlike last year when albendazole was administered to 10-19 years children only. 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 Evidence Action sent out text messages to all district, block officials from all stakeholder departments as well as teachers and AWWs, with reminders of the planned training dates and other key messages about deworming.

¹² Assessing the epidemiology of soil-transmitted helminths during a transmission assessment survey in the Global programme for the elimination of lymphatic filariasis- World Health Organisation 2015

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 territories¹³ 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 union territories (UT's) 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 population¹⁴, increased incentives for *mitanins*, 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, 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.

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

¹⁴ Four categories of target populations were agreed upon, 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.

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 website¹⁵). 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 Chhattisgarh

3.1 Target Beneficiaries

The Government of Chhattisgarh conducted the second round of NDD in 16¹⁶ of 27 districts on February 10, 2016, with a mop-up day on February 15, 2016.

The program targeted children in the age group of 6-19¹⁷, regardless of their enrollment status, at AWCs, government, and government aided schools in 16 districts. Out-of-school children were treated through AWCs. Children enrolled in private schools were also targeted in one (Korba) district of the state during this round, bringing the overall total to 25,14,424 children targeted for deworming.

3.2 Key Stakeholders

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

Department of Health & Family Welfare, Chhattisgarh as 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 *mitanins* in mobilizing out-of-school children.

¹⁵<http://nrhm.gov.in/nrhm-components/rmnch-a/child-health-immunization/national-deworming-day-2016.html>

¹⁶ 11 districts in Chhattisgarh are LF endemic and Albendazole was administered in these districts under the NFCP during November-December 2015

¹⁷ All children aged 1 to 5 years were dewormed under *Shishu Sanrakshan Maah* (SSM) during month of Nov – Dec 2015.

Education and WCD Departments were responsible for providing requisitions of albendazole tablets to NHM based on school enrolment 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. Block level officials from departments of Health, Education and WCD oriented frontline functionaries from education and ICDS on timely submission of standardized coverage reports to the Health Department in standardized formats.

Evidence Action - Deworm the World Initiative, 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 on ground field team during NDD. An external agency hired by Evidence Action conducted the Independent Monitoring of the mass *anganwadi* and school based deworming program. (Details in the report below)

4. Program Implementation

The state implemented NDD in 16 out of 27 districts, including private schools in one (Korba) district. 11 districts endemic for Lymphatic Filariasis (LF) treatment were excluded from NDD as these completed MDA with albendazole in December 2015. State targeted children 6-19 years, as the state had previously dewormed preschool-age (1-5 years) registered and unregistered children through *anganwadi* during the recently concluded SSM in the month of November – December 2015. 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. Key decisions for NDD 2016 were taken under the leadership of Mission Director (MD), NHM including finalizing strategy for including private schools and detailed implementation plans for program components like trainings, drug distribution, and the reporting cascade. 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. Following directives from the MD, NHM, nodal officers for deworming program was appointed in all implementing districts in the state.

To strengthen the inter-sectoral convergence among the stakeholder departments at the district and block level, Principal Secretaries of three stakeholder departments viz. Health, Education and WCD issued joint program directives on January 13 that outlined roles and responsibilities of all stakeholders for the smooth execution of the NDD (Annexure C). NDD

was also discussed as one of the important agenda items in a Video conference held on January 27, 2016, chaired by the Principal Secretary – Health department, where he took stock of preparations on upcoming NDD round from all the participating districts. In addition to monitoring preparedness for NDD in the state, MD, NHM conducted a video conference on February 6, 2016 with chief medical health officers, district program managers.

District Coordination Committee Meeting: Increased engagement and ownership by district administration in the planning and implementation of the deworming program was demonstrated across all target 16 districts as they organized District Coordination Committee meetings¹⁸ between January and February 2016. These meetings reviewed preparations for the program and clarified roles of stakeholders for improved inter-departmental coordination between Departments of Health, Education, WCD, and others stakeholders. Key decisions for program implementation taken were disseminated with the issuance of minutes of the meetings that were circulated in all target 16 districts. DCCM in Korba district had participation of representatives from private schools as well. Evidence Action's field-based district coordinators facilitated and shared critical program updates and relayed information in all of these meetings.

Evidence Action advocated with the Departments of Health, 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 providing space for deworming content in Education department monthly magazine. (Annexure D)

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 the state.

4.2 Program Management

Evidence Action's technical assistance was primarily provided by a four-member state-based team, State Program Manager, two - State Program Coordinators - (M&E) and (Training & Community Mobilization), State Finance & Admin Associate, in addition to field based regional coordinators and short-term hires such as district coordinators placed in all target districts and tele-callers provided technical support to the program. Teams were trained on program strategy and components to build a common understanding to enable effective delivery of outputs.

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 and timely reporting of coverage report.

¹⁸ Out of 16 DCCM, 7 DCCM were conducted in the presence of District collector, and in remaining 9 districts, DCCM were conducted in presence of Additional Collector/SDM/CMHO.

Regional Coordinators: Evidence Action hired two regional coordinators for year-round engagement, with each responsible for 8-10 districts. Regional coordinators provided guidance to district coordinators and support district-level advocacy efforts during the deworming round. As their key role is to provide management and oversight to the district coordinators, they are also in charge of providing prompt remedial action in the field, while guiding district coordinators on advocacy with district officials. In addition, they facilitate organizing of the District Coordination Committee meetings, implementation of the training and distribution cascade, and timely reporting of coverage data. After NDD round now completed, the regional coordinators' efforts are geared towards exploring opportunities at the districts for inclusion of the deworming agenda in platforms where possibilities for synergies exist, including strengthening community mobilization for higher participation in and coverage of the program. 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: 16 district coordinators provided on-the-ground program coordination for three months around the deworming round including specific support to district engaging private schools. They were instrumental in ensuring timely delivery of training 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: Three 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 to 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 corrective measures to be taken. (Figure 1).

Figure 1: Snapshot of the Daily Tracker

Evidence Action Tele-Calling Sheet at District-Training											
District	Date of Calling	Date of training conducted	Training Conducted	Number of Participants	Training Completed	Training completed according to batches	Remarks	Corrective Actions by Evidence Action-DTWI	Flip chart Distribution (AWC)	To Whom	Flip chart Distribution (School)
Sukma	19-01-2016	19-01-2016	Yes	8	Yes	Yes			No		No
Durg	19-01-2016	19-01-2016	Yes	32	Yes	Yes			No		No
Kondagaon	20-01-2016	20-01-2016	Yes	7	Yes	Yes			No		Yes
Balod	23-01-2016	23-01-2016	Yes	22	Yes	Yes			Yes	BMO	Yes
Bastar	21-01-2016	21-01-2016	Yes	21	Yes	Yes			Yes	BMO	Yes
Jashpur	21-01-2016	21-01-2016	Yes	20	Yes	Yes			Yes	BMO	Yes
Korba	21-01-2016	21-01-2016	Yes	40	Yes	Yes			No		Yes
Rajnandgaon	22-01-2016	22-01-2016	Yes	43	Yes	Yes			Yes	BMO	Yes
Pemetara	22-01-2016	22-01-2016	Yes	22	Yes	Yes			Yes	BMO	Yes
Kabirdham	22-01-2016	22-01-2016	Yes	26	Yes	Yes			Yes	BMO	Yes
Janjgir Champa	22-01-2016	22-01-2016	Yes	30	Yes	Yes			Yes	BMO	Yes
Kanker	23-01-2016	23-01-2016	Yes	15	Yes	Yes			Yes	BMO	Yes

4.3 Drug Procurement, Storage, and Transportation

Drug Procurement, Logistics: The drug requirement was determined based on enrolment data at schools across the 16 districts, factoring in a 10% buffer for wastage and spoilage. Evidence Action worked in close coordination with the nodal officer of the deworming program in the health department and the state procurement cell to facilitate availability of deworming drugs across the implementing districts. At the time of planning for finalization of drug requirement, based on the State Drug Management Information System data, the state had approximately 28,95,940 Albendazole (400mg) tablets for the NDD 2016 from existing stock. 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. 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.

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 based on the NDD operational guideline, 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 on alert on deworming day at each block to handle adverse events if reported. 323 mild cases were reported across 16 districts, with no serious adverse events reported (Annexure A)

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 *mitanins* to their role sensitizing the community on the importance of deworming and motivating parents to send their children to schools and AWCs on NDD. As per NDD operational guidelines, the state also provided financial incentives for *mitanins* to motivate them for community mobilisation. Evidence Action also developed all IEC and community mobilization materials that were approved by the GoI 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; *miking*; and wall writings/paintings.

State Level Launch: Evidence Action supported the Department of Health Chhattisgarh, to organize a State level launch event on February 10, 2016 at Raipur district in the presence of Hon'ble Minister of Health – Shri Ajay Chandrakar, and other senior dignitaries, representatives from development partners, media and children. All 16 districts held NDD launch events. These events were led by local district administration and supported by Evidence Action district coordinators. (Annexure E).

Table 2: NDD IEC Campaign Details:

S.N	Activities	Timelines	S.N	Activities	Timelines
1	Flash Ads (Bansal, IBC 24, India News)*	Feb 7-10	5	Newspaper Ad	Feb 10, 14, 15*
2	Radio Spot	Feb 7-10	6	Miking (Block Level)	Feb 3-10
3	Radio Jingle	Feb 7-10	7	Prabhat Pheri	Feb 4-9
4	TV scroll	Feb 7-10	8	Wall paintings/paintings	Jan 20 – Feb 8

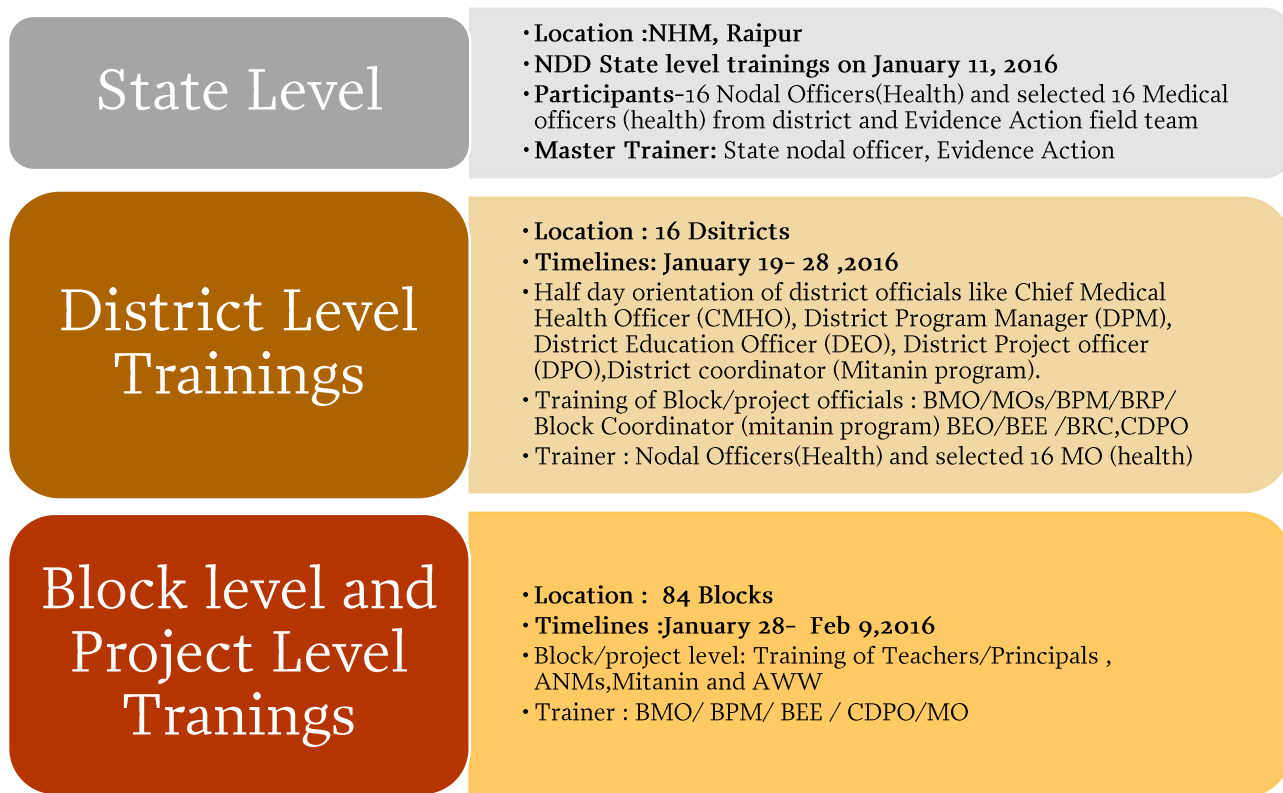
*Evidence Action provided financial support for these activities.

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 state, 16 districts and 84 blocks level between January and February, 2016. The cascade trained nearly 24,356 government school teachers/HM, 89 private school teachers, 26,273 *anganwadi* workers (AWWs), 32,569 *mitanins*. 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* including deworming drugs, banner/poster and handout, reporting forms, to the teachers/AWWs 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 2: Training cascade for NDD February 2016



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, AWWs, and *mitanins* as per state-specific needs. Evidence Action supported the state government in printing the flipcharts and *mitandin* handouts. 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: Along with the master trainers who led the district trainings, Evidence Action conducted training monitoring across all 16 districts and pre- and post-tests to assess

the knowledge gained by participants, in 8 selected districts¹⁹ and 16 blocks²⁰. 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 enabled district officials to take remedial steps during implementation

Training Reinforcement: To reinforce key training messages, Evidence Action sent post-training SMS to various functionaries. Evidence Action adapted the SMS plan uploaded on the national ministry website as per the state’s context and finalized the same with approvals from the government. 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 frontline functionaries. Below is the details on the number of SMSs and IVR messages sent by Evidence Action to functionaries across the various stakeholder departments.

Table 3: Training Reinforcement SMSs and IVR Messages Sent by Evidence Action for NDD Feb 2016

Department	Total SMS Sent	Total IVR Calls Made
Health	2,73,526	25,389
Education	11,58,077	39,226
WCD	3,88,088	15,380

Website Uploads: To access information on deworming, functionaries at state, district and block levels visited Department of Health website to gather information including key training messages, guidelines, training materials, and reporting timelines to reinforce messages and strengthen program operationalization.

¹⁹ The low performing districts were identified on the basis of NDD 2015 process monitoring and coverage validation findings under taken by Evidence Action

²⁰ 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, 2016.
- ✓ State health department, and development partners including Evidence Action, conducted a total of 254 monitoring visits on NDD. Evidence Action shared findings from the field with the MD, NHM on the same day.
- ✓ NDD observed in private schools in one district i.e Korba
- ✓ *Mitanin* were engaged in the field to mobilize out-of-school children to come to the nearest *anganwadi* centres for deworming treatment.
- ✓ Block officials of Departments of Education and Health carried out monitoring visits and tracking along with Evidence Action on National Deworming Day
- ✓ Evidence Action hired and trained an independent monitoring agency to conduct independent monitoring.
- ✓ The state reported dewormed 23,21,789 children out of approximately 25,14,424 children in the target age group.

5. Monitoring and Evaluation

It is imperative that majority children have access to deworming drug and receive benefits for improved health and education outcomes. 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 of the Chhattisgarh NDD program occurs in three ways: (1) process monitoring, (2) coverage reporting and (3) coverage validation. For NDD 2016, an independent monitoring exercise (process monitoring and coverage validation) was conducted on deworming day and mop-up-day, followed by coverage validation from February 20-26, 2016.

5.1 Process Monitoring:

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. 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: A total of 312 monitoring visits (58 visits by state government officials and 254 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 and was submitted to the state health department (Annexure F).

Telephone Monitoring and Cross Verification: 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 3,593 calls were made from January to March 2016, including 232 telephonic calls to district official and 2274 block officials of Health, Education and WCD and 1087 telephonic calls to teachers/AWW in 16 districts. 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 corrective actions around issues such as drug and IEC availability, ensuring adherence to program guidelines and ultimately supporting increased coverage (Annexure G)

5.2 Coverage Reporting:

Coverage reporting provides the numbers 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 in selected schools and *anganwadis*. School teachers/AWW 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/*anganwadis*. Every teacher/ AWW 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/she was administered albendazole on mop-up day. Schools/*anganwadis* were instructed to derive the number of enrolled children dewormed by counting the single and double tick marks in attendance registers. School headmasters were then required 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. Coverage reporting structure and timeline is shown below in Figure 3:

Figure 3: Coverage Reporting Cascade and Timeline

School/Village level reporting Date : February 19, 2016	• Schools/AWC submits filled reporting form to ANM
Sub Center level reporting Date: February 23, 2016	• ANM submit the coverage data at block level (Block Medical Officers-BMOs)
Block level reporting Date: February 29, 2016	• Blocks compile and submit the coverage data to district level (CMHOs/ District nodal officers)
District level reporting Date: March 7, 2016	• Districts compile and submit the coverage data to state level (State nodal officer)
State level reporting Date: March 29, 2016	• State health department aggregate final NDD coverage report and submit to MoHFW

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 *anganwadis* using their respective attendance registers and reporting forms. In each school, one teacher and three students were interviewed. In *anganwadis*, only AWWs 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, 50 blocks were selected from 16 districts that observed deworming by probability proportional to size sampling²¹, followed by random sampling of schools to provide state-wide estimates of indicators. A total of 213 schools and 200 nearby *anganwadis* were visited on NDD and mop-up day. For coverage validation, a total of 329 randomly selected schools and 300 randomly *anganwadis* were visited.

Table 4: 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	16	16	16	16
Total number of blocks	50	50	50	50
Total number of schools	220	213	330	329
Total number of government/government aided schools	200	193	300	299
Total number of private schools covered in one district [#]	20	20	30	30
Total Number of children interviewed in schools*	220	147	990	963
Total number of <i>anganwadis</i>	200	200	300	300

[#] Deworming was observed only in private schools of Korba district

*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

²¹ Probability proportional to size sampling (PPS) selected blocks in Chhattisgarh, 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.

monitoring on NDD and mop-up day, and one each for schools and *anganwadis* for the coverage validation. Questionnaires were designed by Evidence Action and finalized in consultation with the state department of Health. The questionnaires were translated into regional language, and checked to ensure that the languages was concise and easily understandable, before being scripted and loaded onto tablet PCs/mini-laptops for the monitor to administer.

Training of Trainers and Independent Monitors: Through a competitive selection process, Evidence Action hired GfK Mode Pvt. Ltd. to implement the independent monitoring in Chhattisgarh. Evidence Action provided a one-day training to three master trainers from GfK on February 5, 2016 at New Delhi. These master trainers conducted a two day training of 10 supervisors and 120 monitors from February 7-8, 2016 in batches of 50-55 monitors at Raipur. 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 AWWs 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 15% 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 and Program Recommendations

Key findings from the independent monitoring emphasize the importance of strengthening the training cascade and the integrated distribution of drugs and IEC materials at the trainings to ensure all teachers and AWWs are equipped to implement NDD effectively

Training:

Participation at trainings: Independent monitoring data demonstrated that teachers/headmasters from 79% of schools and 78% of AWWs received training for the recent deworming round. Among private schools, 15 out of 20 schools reported attending training on deworming in the previous two months.

Among those who did not attend training, 55% of teacher/headmasters and 33 % of anganwadi workers stated that the location was too far away followed by 31% teacher/headmasters and all the *anganwadi* workers did not know the date/ timings. As training is crucial to equip teachers and AWWs 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 63% schools and 50 % AWWs 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 AWWs 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 Training:

Findings show that only 69% 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 54% headmasters/ principals and 50% AWWs 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 emphasize practices for controlling worm infection.
- Integrated distribution of deworming materials including drugs

Findings from independent monitoring data revealed that only 20% of schools and 18% of *anganwadis* respectively completed integrated distribution²² 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.

²² Integrated distribution of NDD kits including deworming drugs, banner/poster and handout, reporting forms, to the teachers/*anganwadi* workers at the training only.

Table 5: Distribution of NDD Kits Material

Items Received in training	For Schools			For <i>Anganwadi</i>		
	Available (%)	Verified (%)	Received in training (%)	Available (%)	Verified (%)	Received in training (%)
Tablets	97.7	93.3	62.5	88.0	93.2	56.3
Poster/Banner	84.5	96.1	70.0	74.5	96.6	59.7
Handouts/Reporting form	86.5	93.5	65.4	65.5	93.1	54.2
Adverse event reporting form	17.3	78.3	48.6	13.5	85.2	44.4

* *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

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 recommendation:

- 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 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 Sufficiency:

During coverage validation, 90% of schools and *anganwadis* reported to have sufficient drugs for deworming.²³ Moreover, 51% of schools and all the *anganwadis* had surplus drugs after deworming. The drug surplus at the schools and *anganwadis* can be because of 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.

²³ Sufficient drugs is defined here as availability of drugs in accordance with the total number of children enrolled in the school/*anganwadi*.

Source of Information about Recent Round of Deworming:

In order to sensitize the teachers and *anganwadis*, various channels of communication was used in the program, including departmental communication, posters, and banners. Departmental communication was the major source of information for the schools (52%) and *anganwadis* (74%) for deworming (Figure 3). This was followed by training (37%) and SMSs (33%) for schools; radio (55%) and banners (40%) for *anganwadis*. Only 10% of AWWs came to know about deworming through SMS. School teachers were the major source of information to students for deworming (92%). However, 14% of students interviewed were not aware that the medicine given to them was for deworming. With reference to children enrolled in private schools, total 11 of 15 interviewed children were aware that the tablet given to them was for deworming.

Implementation of Deworming:

While 92% of schools and 81% of *anganwadis* reported conducting deworming on either NDD or mop -up day, independent monitors observed ongoing deworming activity in 69% schools and 49% of *anganwadis* respectively. Coverage validation demonstrated that 97% of schools and 92% of *anganwadis* had observed deworming during NDD or mop up day. Out of all enrolled children interviewed on NDD and mop- up day, around 93% 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. With reference to private schools, 24 of the 30 private schools observed during coverage validation reported deworming activities on NDD or mop- up day.

Adverse Events- Knowledge and Management:

Interviews with teachers and AWWs during process monitoring demonstrated a lack of awareness regarding the possible occurrence of adverse events. Only 31% of headmasters/principals and 26% of AWWs acknowledged that adverse events were possible after ingesting albendazole. Of those who knew that adverse events are possible, most of them advocating that mild adverse events should be handled at schools/*anganwadis* while more severe or continued adverse events should be referred to the nearest PHC. During class observations, around 86% of teachers and 87% of AWWs asked children whether they were sick before administering drugs. More than 96% of teachers and 99% AWWs 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/AWW. 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 69% of followed correct recording protocols, whereas around 27% of schools did not adhere to correct recording protocol. As per NDD guidelines, *Mitanins* were required to prepare a list of out-of-school children for submission to AWWs; however, findings suggest that only 57 % *anganwadis* 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 highlights the coverage details from the state including the total coverage of 92% according to government reported figures as well as coverage across various categories

Table 6: State NDD 2016 Coverage Data

Indicators		Results	% Coverage
Total number of children targeted		25,14,424	
Number of enrolled children (classes 1-12) who were administered albendazole on NDD and MUD	Government Schools	20,59,963	92%
	Private Schools	17,323	98.5%
Number of out-of-school children (6-19 years) dewormed on NDD and MUD		2,44,503	92%
Total number of children dewormed (6-19 years)		23,21,789	92%

Substantial district wise variation was observed in NDD coverage reporting.

Evidence Action also advised the state government in finalizing program target figures prior to NDD, allowing for accurate performance measurement across the state. Evidence Action referred to credible data sources including 2011 census data and Annual Status of Educational Report (ASER) for estimation of out-of-school children and advised the state health department in finalizing the target for unregistered preschool-age children. The state defined the final target for out-of-school children, based on Evidence Action's recommendation.

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/AWWs 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 Chhattisgarh only 48% of schools and 15 % of *anganwadis* had copy of the reporting form available after deworming and mop up day. During trainings, school teachers/ headmasters and *anganwadi* workers were instructed to retain a copy of their respective reporting form; however, 22% of headmasters and nine percent of AWWs interviewed during process monitoring were not aware of retaining a copy of the form.

In Chhattisgarh, the state level verification factor for enrolled children was found to be 0.76, indicating that for every 76 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 32% percent inflation of reporting in the state, meaning that reported numbers appear to be approximately 32% higher than the numbers recorded in attendance registers. Similarly, the state level verification factors for out- of- school (6-19 years) children was 0.55 with corresponding inflation rates of 79%. Training was found to increase the accuracy of reporting: trained schools had 24% inflation in reporting, while untrained schools had 58% inflation in reporting.

Around, 99% of the children interviewed during coverage validation reported to have received deworming and 99% reported of them consumed 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 97% of schools did deworming on either of the days and attendance data showed that a maximum of 82% of the enrolled children would have been in attendance across considering the attendance of both the days. Based on deworming implementation status and attendance of enrolled children on deworming and mop-up day and children's interview, maximum 79% (99% children out of 82% present in 97% 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 out-of-school children. This suggests the need to strengthen the role of *mitanins* in mobilising these children and correctly reporting their treatment.
- Coverage reports also reflect a need for greater emphasis on finalizing correct target figures, particularly for out-of-school children for whom coverage percentages have been low. This could be partially because of not setting up accurate target figures prior to NDD. Broadly the targets for all categories were revised after the NDD implementation as all the stakeholder departments agreed on revised figures received from the districts to be considered as final. In future rounds, in case target figures are not available at the state level, districts can be engaged well in advance to finalize their targets.

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

Setting program coverage targets well ahead in time

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) Importance of correct recording, reporting protocols and maintaining correct and complete documentation form for verification purposes
 - 4) Knowledge 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

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 mobilisation

- 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

The second round of deworming in the state demonstrated progress towards expansion of program to include all school age children along with inclusion of private school children. A critical piece of learning derived from this round is the importance of strengthening the training cascade through adequate planning and monitoring, and maximizing its efficiency by using it to distribute all materials and drugs. This is also an established best practice recommended by WHO for all school-based deworming programs for effectiveness, not just in implementation, but also for cost-effectiveness of the program.

Looking to the future, maintaining the program's strong pace will require continued advocacy to ensure that the state commits resources for deworming under its annual Program Implementation Plans. Strengthened planning for the third year of NDD implementation, and wider reach to schools including government, government-aided and private schools, and all preschool age children 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 and new initiatives around 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 Chhattisgarh.

8. Annexures

Annexures:

Annexure 1	Details of Independent Monitoring
Annexure A	NDD 2016 state coverage report
Annexure B	Prevalence Survey Interim Report
Annexure C	NDD 2016 State Joint Directives
Annexure D	Letter to MD to CMHOs regarding implementation of NDD
Annexure E	Community sensitization and awareness
Annexure F	Findings submitted to state NHM on monitoring visits by Evidence Action
Annexure G	Snapshot of compiled calls status in Chhattisgarh by Evidence Action team during NDD 2016

Annexure 1: Analysis for Process Monitoring (School/Anganwadi)

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

Indicators	School N=213		Anganwadi N=200	
	%	N	%	N
Type of School				
Govt./Govt. Aided schools	90.6	193	NA	NA
Private Schools	9.4	20	NA	NA
Respondent of the section			NA	NA
Headmaster/Principal	78.4	167	NA	NA
Vice principal	5.6	12	NA	NA
Nodal Teacher	11.3	24	NA	NA
Any other teacher	4.7	10	NA	NA
Category of school			NA	NA
Primary(1 to 5)			NA	NA
Primary with upper primary(1 to 8)	67.1	143	NA	NA
Primary with upper primary and secondary(1 to 10)	6.1	13	NA	NA
Primary with upper primary secondary and higher secondary(1 to 12)	1.9	4	NA	NA
Upper primary only(6 to 8)	0.9	2	NA	NA
Upper primary with secondary and higher secondary(6 to 12)	16.9	36	NA	NA
upper primary with secondary(6 to 10)	1.4	3	NA	NA
Secondary only (9 to 10)	1.4	3	NA	NA
Secondary with higher secondary(9 to 12)	4.2	9	NA	NA
Higher Secondary only or Jr. college(11 to 12)			NA	NA
Did Anganwadi worker attend training in last 2 months	79.8	180	81.5	163
Did trained teacher provide training to other teachers				
Yes, trained all other teachers	68.2	116	NA	NA
Yes, trained some other teachers	18.2	31	NA	NA
No, did not train other teachers	12.4	21	NA	NA
Don't know /don't remember	1.2	2	NA	NA
Reason for not attending official training				
Location was too far away	54.8	23	33.3	2
Did not know the date/timings	31.0	13	100	6
Busy in other official work	9.5	4	33.3	2

Attended deworming training in the past	4.7	2	33.3	2
Not Necessary	2.3	1	33.3	2
Source of information about recent round of deworming program				
Departmental communication	52.5	112	73.5	142
Television	11.2	24	49.7	96
Radio	6.5	14	55.9	108
Newspaper	11.2	24	45.6	88
Banner	16.9	36	50.7	98
SMS	33.3	71	9.8	19
Training	37.0	79	0	0
Other school/teacher	7.9	17	0	0
Awareness about the ways a child can get worm infection	92.0	196	96	192
Different ways that children can get worm infected				
Having foods without washing hands	52.6	112	83.5	167
Not washing hands after using toilets	80.1	157	80	160
Not using sanitary latrine	54.1	106	50.5	101
Moving in bare feet	57.7	113	53.5	107
Consume vegetables and fruits without washing	56.1	110	50	100
Having long and dirty nails	53.6	105	48.5	97
Receive SMS about the deworming program	69.0	147	60	120
Preference to receive the SMS				
Morning	70.4	150	19.5	39
Afternoon	22.1	47	9.0	18
Evening	12.7	27	11.5	23
Any time	12.2	26	38.0	76
Do not prefer the SMS	22.5	48	23.0	46
Having integrated distribution(Tables, Poster/Banner, handouts/reporting, adverse event reporting form) in training	19.8	40	18.0	36
Visibility over the Deworming Day Poster/Banner is posted				
Clearly posted/ visible to all	89.4	161	80.5	120
Hidden in a room/partially visible.	5.6	10	4.7	7
Not posted/ not visible	5.0	9	14.7	22
Awareness about to whom to submit the completed School/Anganwadi Reporting	61.3	130	85.0	170
Retain a copy of the School/Anganwadi Reporting Form at the school after submitting one copy	77.9	166	91.0	182

Teachers/Anganwadi who think any adverse event can occur after taking the deworming tablets	31.5	67	26.0	52
Possible adverse events could be reported by children after taking the tablets				
Mild abdominal pain	74.6	50	46.1	24
Nausea	52.2	35	32.6	17
Vomiting	74.6	50	53.8	28
Diarrhea	31.3	21	19.2	10
Fatigue	32.8	22	19.2	10
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	81.7	174	54.5	109
Give ORS/ water	40.4	86	35.5	71
Observe the child at least for 2 hours in the school	18.3	39	31.0	62
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	42.3	90	48.9	94
Take the child to the hospital /call doctor to school	59.6	127	57.2	110
Deworming activity going in your school/Anganwadi today				
Yes, getting now	70.4	150	80.5	161
Yes, after few hours	21.1	45	0	0
No, will not administer today	8.5	18	19.5	39

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	97.7	93.3	62.5	88.0	93.2	56.3
Poster/Banner	84.5	96.1	70.0	74.5	96.6	59.7
Handouts/ Reporting form	86.5	93.5	65.4	65.5	93.1	54.2
Adverse event reporting form	17.3	78.3	48.6	13.5	85.2	44.4

Note:-The sample size for items received in schools and *anganwadis* were 213 and 200 respectively

*The denominator for verified is the number of particular item received to schools and *anganwadis*

Table3: Observation of deworming activity in the class/Anganwadi

Indicators	Schools		Anganwadi	
	%	N	%	N
Deworming activity is taking place in the class/Anganwadi	69.0	147	48.5	78
Teachers/Anganwadi worker giving any health education related to deworming				
Yes	91.8	135	87.1	68
No	8.2	12	12.8	10
Could not observe as I reached late				
What are being included by the teacher/Anganwadi worker as a part of health education to children				
Harmful effects of worms	65.2	88	60.3	41
How worms get transmitted	69.6	94	58.8	40
Benefits of deworming	60.0	81	55.9	38
Methods of worm infection prevention	50.4	68	57.4	39
Teacher/ Anganwadi worker were asking the children if they are sick/under medication before giving the tablet	86.4	127	87.2	68
What teacher/ Anganwadi worker did,If there was any sick child in the class room				
Gave Albendazole tablet to the child	7.9	10	2.9	2
Did not give the Albendazole tablet to the child	92.1	117	97.1	66
Students/children are told to chew the tablet before swallowing it	95.9	141	98.7	77
Deworming tablets were distributed by				
Teacher/headmaster	98.6	145	NA	NA
Anganwadi worker	1.3	2	96.2	75
Asha/ANM	0.0	0	2.6	2
Students	0.0	0	1.3	1
Teacher/ Anganwadi worker asking students to take Albendazole tablets in the class/ Anganwadi only	100.0	147	98.7	77
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	92.5	136	82.1	64
Practice followed by teacher ,if the ticking/double ticking protocol was not followed				

Prepare the separate list for dewormed child	27.2	3	71.4	10
Put different symbols	18.1	2	14.2	2
Nothing was done	54.5	6	7.1	1
Others specify			7.1	1
Any child not given the prescribed dose of Albendazole tablet				
Yes, less than the prescribed doze	7.5	11	12.8	10
Yes ,more than the prescribed doze	4.1	6	1.3	1
No, the prescribed doze is being given	88.4	130	85.9	67
Any adverse event observed (nausea, vomiting, stomach-pain diarrhoea, etc.) after taking the tablet	10.2	15	7.7	6

*Deworming activity was observed by monitors in 147 schools and 78 *anganwadis*

Table: 4 Interview with school teacher

Indicators	%	N
Attended any official training for deworming program in the past 2 months	62.4	133
Received training for deworming		
At official level training	70.7	94
By Headmaster/ teacher	29.3	39
Awareness about the ways a child can get worm infection	87.8	187
Different ways that children can get worm infected		
Having foods without washing hands	91.4	171
Not washing hands after using toilets	82.4	154
Not using sanitary latrine	63.1	118
Moving in bare feet	60.4	113
Consume vegetables and fruits without washing	54.0	101
Having long and dirty nails	39.0	73
Others	2.1	4
Awareness about prescribed dose of albendazole		
One	99.5	212
More than one	0.5	1
Teachers who think any adverse event can occur after taking the deworming tablets	38.5	82
Possible adverse events could be reported by children after taking the tablets		
Mild abdominal pain	74.4	61
Nausea	63.4	52

Vomiting	74.4	61
Diarrhea	23.2	19
Fatigue	34.2	28
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	76.1	162
Give ORS/ water	44.1	94
Observe the child at least for 2 hours in the school	44.1	94
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	57.3	122
Take the child to the hospital /call doctor to school	66.7	142
Don't know / don't remember	2.4	5

Note: - Interviews were conducted from 213 school teachers

Table: 5 Interview with school child

Indicators	School	
	%	N
Child got a white tablet in school today	93.3	182
Child was feeling sick before taking the tablet in the school today	5.5	10
Child got tablet by		
By Teacher / headmaster	94.5	172
By ASHA/ANM	1.1	2
By Other student	1.7	3
Other	2.8	5
Child consume tablet	98.9	180
Reason to not consume tablet		
Was feeling sick	50	1
I'm afraid of taking the tablet	50	1
Awareness of child that, how to consume the tablet		
Chewed tablet before swallowing	96.7	176
Swallowed tablet directly	3.3	6
Other, specify		
Awareness of child that, why tablet is provided		
Deworming	85.7	156
Any other answer(unrelated to deworming)	2.2	4
Don't know /don't remember	12.1	22

Child was aware about deworming activity	19.2	5
Source of information about deworming activity		
Teacher / school	91.9	148
Television	7.5	12
Radio	3.1	5
Newspaper	3.1	5
Poster/Banner	16.2	26
Parents/siblings	15.5	25

Note: - Interviews were conducted from 195 school enrolled children

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

Table 1: Findings from School/Anganwadi Coverage Validation data

Indicators	Schools		Anganwadis	
	%	N	%	N
Responses from the headmasters/principals interviewed				
Attended training for Deworming program	78.4	258	75.3	226
For schools that didn't attend training, reasons were				
Location was far away	4.2	3	2.7	2
Was not aware of the date/ timing of training	59.2	42	53.4	39
Busy in other official work	11.3	8	5.5	4
Attended Deworming training in the past	5.6	4	6.9	5
Not necessary	4.2	3	0.0	0
Schools received the followings				
Tablets	97.0	319	92.7	278
Poster	82.4	271	81.7	245
Hand-outs/Reporting form			88.3	265
Adverse event reporting form	87.2	287	21.3	64
Received SMS about Deworming program	63.2	208	50.7	152
Schools/Anganwadis had the sufficient drugs for Deworming	90.3	288	89.9	250
Schools/Anganwadis had surplus storage of drugs after Deworming	90.3	288	100.0	250
Schools/Anganwadis where copy of school reporting form was available after Deworming Day and Mop-Up Day	48.0	154	14.8	41
For schools/Anganwadis that didn't have copy of school reporting form, reasons were				
Did not receive	4.7	8	6.3	15

Submitted to ANM	87.1	148	90.3	214
Unable to locate	2.4	4	0.4	1
Schools/Anganwadi had complete school reporting form	98.1	151	95.4	41
Schools/Anganwadis observed Deworming on Deworming Day or Mop-Up Day	97.6	321	92.7	278
Schools/Anganwadis reported severe adverse event after taking the medicine	5.0	16	1.1	3
Anganwadi having list of out of school children (6-19 years)	NA	NA	57.2	159

Table: 2 School/Anganwadis Coverage Validation Indicators

Indicators	%
Schools where all the classes followed the correct recording protocol	69.7
Schools where one or more of the classes followed the correct recording protocol	72.2
Schools where none of the classes followed the correct reporting protocol	27.3
Schools where one or more of the classes followed other recording protocol	12.4
Schools where no reporting protocol was followed	27.3
State level verification factor	0.76
State inflation rate (which measures the extent to which the recording in school reporting forms exceeds records at schools)	31.5
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)	24.6
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)	58.2
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)	5.6
Attendance on Deworming Day	78.3
Attendance on Mop-up day	70.8
Children who attended on both Deworming Day and Mop-up day	66.3
Maximum attendance of children on Deworming Day and Mop-Up Day according to the CV data	82.4
State level verification factor for out of school children (6-19 years)	0.55
State level inflation for out-of-school children(6-19 years)	79


This was asked to 329 and 301 *anganwadis* covered during coverage validation


Table: 3 Interview of children during Coverage validation

Indicators	%	N
Children received Deworming tablets	99.4	958
Children aware about the Deworming tablets	92.2	884
Children who consumed tablets in front of teacher/headmaster	99.2	950
Children consumed tablet	99.9	957
Way children consumed the tablet	97.1	937

Note:- Three children were interviewed from all those schools(321) who reported to observe deworming during NDD and mop-up day out of total 329 schools visited during coverage validation

Annexure A - National Deworming Day 2016_ Coverage

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 : Chhattisgarh	District: 16 districts covered		Block : B4	
No. of Govt/Govt. Aided schools	27009	No. of Govt/Govt aided schools reporting coverage	26872	
No. of targeted private schools	101	No. of private Schools reporting coverage	101	
No. of Anganwadi Center (AWCs):	28384	No. of AWCs reporting coverage	28322	
No. of ASHAs oriented/trained on NDD (National Deworming Day)		32569		
No. of Govt/Govt aided schools who attended training on NDD		24356		
No. of private schools who attended training on NDD		89		
No. of Anganwadi workers oriented/trained on NDD		26273		
Coverage Details				
		Girls	Boys	Total
Total children out of school		147894	117746	(A) 265640
Total children unregistered in AWCs		NA	NA	(B) 0
Total children registered in AWCs		NA	NA	(C) 0
Total children enrolled in the schools	Govt. school	1113146	1118055	(D) 2231201
	Pvt. school	8265	9318	(E) 17583
Total number of children targeted				(Z)=2514424
No. of enrolled children (class 1-5) who were administered Albendazole on NDD and MUD (Mop Up Day)	Govt.school	481552	484951	1(a) 966503
	Pvt.school	3426	4204	1(b) 7630
No. of enrolled children (class 6-12) who were administered Albendazole on NDD and MUD	Govt.school	548375	545085	2(a) 1093460
	Pvt.school	4726	4967	2(b) 9693
No. of registered children in AWCs (1-5 years) who were administered Albendazole on NDD and MUD		NA	NA	(3) 0
No. of unregistered children (1-5 years) who were administered Albendazole on NDD and MUD		NA	NA	(4) 0
No. of out of school children (6-10 years) who were administered Albendazole on NDD and MUD		27776	23533	(5) 51309
No. of out of school adolescent (10-19 years) who were administered Albendazole on NDD and MUD		111997	81197	(6) 193194
GRAND TOTAL of number of children who were administered Albendazole (T=1a+1b+2a+2b+3+4+5+6)				(T) 2321789
Percent coverage		(T) X 100 / (Z)= 92.34%		
No. of severe adverse events reported from schools and AWCs		0 (323 minor adverse event has happened on NDD & MUD)		
Logistic Details: Block/District/State(tick as applicable)		Govt. schools	Private schools	AWCs
Total no of Albendazole tablets given		2605050	19840	334760
Total no of Albendazole tablets administered		2059963	17323	244503
Stock of Albendazole tablets left		545087	2517	90257
Feedback(if any)				
Name, signature and designation of the official preparing the document:				
Name, signature and designation of the official reviewing the document:		Approved by Mission Director, NHM.		
You may call up the State Office(Dr Khemraj Sonwani/ Phone: 9827872102) for any assistance required				


DD- NRHM

Annexure B – Prevalence Survey Interim Report



राष्ट्रीय जानपदिक रोग विज्ञान संस्थान
NATIONAL INSTITUTE OF EPIDEMIOLOGY
(Indian Council of Medical Research)

Dept. of Health Research, Ministry of Health & Family Welfare, Govt. of India
Tamil Nadu Housing Board
Ayapakkam, Chennai - 600 077, India.



WHO COLLABORATING
CENTRE FOR
LEPROSY RESEARCH
AND EPIDEMIOLOGY

Date: 10 Feb 2016

Dear Sir,

Please find attached the preliminary report of survey conducted by the National Institute of Epidemiology (ICMR), Chennai, in coordination with Evidence Action, to estimate the prevalence of soil transmitted helminths among school children studying in government primary schools in Chhattisgarh.

We will send the full report soon.

Thank you and with regards

Sincerely,

Dr Manoj Murhekar
Scientist G

To,

Dr. Ayyaz F Tamboli
Mission Director - National Health Mission
Raipur, Chhattisgarh

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Director's office : 044 - 2513 6204
Library : 044 - 2513 6408
Fax : 044 - 2582 0355

Prevalence and intensity of soil transmitted helminths, Chhattisgarh, 2015

Background

The WHO estimates that globally about 870 million children are at risk of infection with soil-transmitted helminths (STH) and require treatment with anthelmintics¹, of whom over 241 million are in India. The main STH species in India are roundworm, hookworm, and whipworm. To deal with this significant public health concern, in areas where there has been no prior mass deworming treatment, WHO recommends annual deworming when STH prevalence is between 20% and 50%, and bi-annual treatment when prevalence rates are over 50% (see Table 1). The WHO recommendations are different when the population has received prior mass deworming treatments (Table 2).

An initial prevalence survey, which provides a reliable estimate of extent of STH infection at state level, is recommended to guide the development of school-based control program in the state and subsequently monitor its impact on prevalence and intensity. In school-based deworming programs, administration of anthelmintic to school-age children is done through the existing school infrastructure, because it is simple, safe, cost effective, scalable and provides a platform to reach high-risk populations².

During November-December 2015, the National Institute of Epidemiology (NIE), Chennai, in coordination with Evidence Action, designed a survey to estimate the prevalence and intensity of STH infections in Chhattisgarh. The sampling was based on sentinel sites across the different ecological zones in Chhattisgarh, as recommended by the World Health Organization (WHO). This survey was implemented with support from the Government of Chhattisgarh, the National Institute of Cholera and Enteric Diseases – Indian Council of Medical Research, Kolkata (NICED), GfK Mode, and Evidence Action – Deworm the World Initiative.

Methods

The following issues were considered in designing the survey:

1. The state has 3 agro-climatic zones¹ and 27 districts. The districts in each agro-climatic zone is given in table 3.
2. We calculated the sample of size of 492 (rounded to 500) children per agro-climatic zone considering the prevalence of any STH as 20%, absolute precision=5%, design effect=2. Thus, the total sample size required to estimate the prevalence of STH for the state was 1,500.

¹ Investing to overcome the Global Impact of Neglected Tropical Disease., Third WHO report on Neglected Tropical Disease, 2015

² http://www.who.int/intestinal_worms/resources/en/sti_a_glance.pdf

3. We randomly selected 50% of the districts from each zone (3 each from zone A and C, 7 from Zone B, total 13 districts) from the state.
4. WHO recommends 50 children per school sentinel site. Thus, we required 10 schools from each zone. Assuming a non-response of 20%, we needed 60 children per school. We would thus need to sample 1,800 children from the schools, in order to collect samples from 1,500 children. Nearly 60% the schools in the state had total enrolment of 60 or less, and hence, we considered schools with enrollment of 30 or more for the sampling.
5. From each Zone, 10 schools were selected by population proportional to size. In case the size of selected school was less than 60, we selected one nearby additional school to allow for a total of 60 children to be sampled from the area. This additional school was either in the same village or in the nearby village of the same block.

The parasitological analysis of the stool samples was conducted by trained parasitologists from NICED, Kolkata, in special field laboratories set up in District hospitals around the state. The stool analysis used the WHO-recommended Kato Katz method. Stool samples were collected from households and delivered to field laboratories by GfK Mode. The Government of Chhattisgarh supported the survey by providing access to health facilities for the survey, and access to schools to sample children. After the completion of fieldwork, the data was double entered and analyzed to estimate the state-level prevalence and intensity of STH.

Results

We sampled 1,734 children from 40 schools in Chhattisgarh. From these 1,734 children sampled, we were able to collect and analyze stool samples from 1476 children. Infection with any STH was detected in 1,148 children, for an overall weighted prevalence of 72.7% (95% CI: 69.6-75.7) (Table 4). Any STH prevalence was high (more than 50%) in all agro-climatic zones, as depicted in Figure 1. In all the zones, roundworm was the most common STH infection with a weighted prevalence of 68.3% (95% CI: 65.2-71.4). Hookworm infection was detected in 9.9% (95% CI: 8.4 – 11.4) children surveyed. 1.5% of the children had heavy or moderate intensity roundworm infections, and 0.9% of children had heavy or moderate intensity hookworm infections (Table 5).

Conclusions

The findings of our survey indicated that STH infection is hyper-endemic in most of the districts of Chhattisgarh. A full detailed report will be submitted to the government outlining a detailed analysis of the findings.

Annexure C – Joint Directives

छत्तीसगढ़ शासन
स्वास्थ्य एवं परिवार कल्याण विभाग

:: मंत्रालय ::

महानदी भवन, नया रायपुर- 492002

क्रमांक एफ 1-2/2016/सत्रह/एक
प्रेषक,

नया रायपुर, दिनांक 13 / 01 / 2016

1. सचिव,
छत्तीसगढ़ शासन
स्वास्थ्य एवं परिवार कल्याण विभाग,
2. सचिव,
छत्तीसगढ़ शासन,
महिला एवं बाल विकास विभाग
3. सचिव,
छत्तीसगढ़ शासन,
स्कूल शिक्षा विभाग

प्रेषिती,

1. जिला कलेक्टर
2. मुख्य चिकित्सा एवं स्वास्थ्य अधिकारी,
3. जिला शिक्षा अधिकारी,
4. जिला कार्यक्रम अधिकारी, महिला एवं बाल विकास विभाग,
(बस्तर, बीजापुर, दंतेवाड़ा, कोण्डागांव, कर्वधा कांकेर, कोरिया, कोरबा, नारायणपुर,
राजनांदगांव, सुकमा, जांजगीर-चांपा, बालोद, बेमेतरा, दुर्ग, जशपुर)

विषय:-10 फरवरी 2016 को 6 से 19 वर्षीय बच्चों में कृमिमुक्ति हेतु 16 जिलों में राष्ट्रीय
कृमि मुक्ति दिवस (NDD 2016) का आयोजन किये जाने के संबंध में।

संदर्भ:- भारत सरकार द्वारा जारी पत्र क्र. Z28020/237/2013-CH, दिनांक 11 दिसम्बर
2015।

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बच्चों में कृमि संक्रमण, व्यक्तिगत अस्वच्छता तथा संक्रमित दूषित मिट्टी के संपर्क से संभावित होता है। कृमि संक्रमण से बच्चों की जहाँ एक ओर शारीरिक एवं बौद्धिक विकास बाधित होती है, वहीं दूसरी ओर उनके पोषण स्तर एवं हिमोग्लोबिन स्तर पर भी दुष्प्रभाव पड़ता है। अतः 6 से 19 वर्ष आयु के शालेय तथा शाला अप्रवेशी/शाला त्यागी बच्चों को स्वास्थ्य, शिक्षा, तथा महिला एवं बाल विकास विभाग के संयुक्त प्रयास से राष्ट्रीय कृमिमुक्ति दिवस का आयोजन भारत सरकार के दिशा निर्देशानुसार 10 फरवरी 2016 को राज्य के 16 जिलों के आंगनबाड़ी केन्द्रों एवं शासकीय/अशासकीय अनुदान प्राप्त शालाओं के माध्यम से कृमिनाशन दवाई (एलबेन्डाजोल) का सेवन कराया जाना है। दिनांक 15 फरवरी 2016 को माप-अप दिवस के रूप में छूटे हुए बच्चों को उक्त दवाई का सेवन कराया जाना है। जिससे बच्चों के सम्पूर्ण स्वास्थ्य पोषण स्तर, आयरन स्तर, बौद्धिक विकास स्तर तथा शालाओं में उपस्थिति में सुधार हो सके।

निरंतर..

आपके संयुक्त प्रयास से 0 से 5 वर्ष के बच्चों को राज्य के सभी जिलों में शिशु संरक्षण माह के दौरान कृमि नाशक दवाई एल्बेन्डाजोल दी जा चुकी है।

अतः इस चरण में केवल 6 से 19 वर्ष के बच्चों को कृमि नाशक दवाई एल्बेन्डाजोल दी जावेगी। कार्यक्रम का निजी स्कूलों में विस्तार किये जाने की दिशा में जिला कोरबा के सभी निजी स्कूलों में भी बच्चों को कृमि नाशक दवाई दिया जावेगा।

शेष 11 जिलों में राष्ट्रीय फाईलेरिया दिवस (14 से 16 दिसम्बर 2015) पर 2 से 60 वर्ष के हितग्राहियों को कृमि नाशक दवाई एल्बेन्डाजोल दी जा चुकी है।

राष्ट्रीय कृमिमुक्ति दिवस के आयोजन के संबंध में दिशा निर्देश निम्नानुसार है :-

- राष्ट्रीय कृमिमुक्ति दिवस (National Deworming Day - NDD) का समारोहपूर्वक शुभारंभ विशिष्ट एवं गणमान्य जनप्रतिनिधि/जिला कलेक्टर द्वारा दिनांक 10 फरवरी 2016 को किया जावे।
- कार्यक्रम का क्रियान्वयन स्वास्थ्य, शिक्षा एवं महिला एवं बाल विकास विभाग के समन्वय से किया जायेगा।
- 10 फरवरी 2016 को आयोजित राष्ट्रीय कृमिमुक्ति दिवस एवं मॉप-अप दिवस 15 फरवरी 2016 पर 6 से 19 वर्षीय बच्चों को निम्नानुसार खुराक दी जाए:-

आयु वर्ग	एलबेन्डाजोल की खुराक (400mg)	सेवा प्रदाता
6 से 19 वर्षीय स्कूल में पंजीकृत बच्चे	पूरी 1 गोली (चबाकर पानी के साथ)	शिक्षक
स्कूल नहीं जाने वाले 6 से 19 वर्षीय बच्चे	पूरी 1 गोली (चबाकर पानी के साथ)	आंगनवाड़ी कार्यकर्ता

- दिनांक 10 फरवरी 2015 को समस्त शासकीय/शासकीय अनुदान प्राप्त स्कूलों, निजी स्कूलों एवं आंगनवाड़ी केन्द्रों के माध्यम से 6 से 19 वर्षीय बालक एवं बालिकाओं को कृमिनाशन हेतु एल्बेन्डाजोल (Chewable-400mg) की एक गोली का सेवन स्कूलों में शिक्षक एवं आंगनवाड़ी केन्द्रों में आंगनवाड़ी कार्यकर्ता के द्वारा कराया जावे।
- शाला अप्रवेशी/ शाला त्यागी 6 से 19 वर्षीय बालक एवं बालिकाओं को आंगनवाड़ी केन्द्रों में एल्बेन्डाजोल (Chewable-400mg) की गोली उपरोक्त तालिकानुसार सेवन कराया जाये।
- राज्य, जिला एवं विकासखण्ड स्तर पर मॉनिटरिंग टीम गठित कर गतिविधियों का पर्यवेक्षण किया जावेगा।

निरंतर...

- NDD kit के अंतर्गत निम्न सामग्रियाँ शामिल हैं—
 - a) Tab Albendazole 400 mg
 - b) 1 Poster for per school
 - c) 1 Poster for per Anganwadi centre
 - d) Handout with reporting form:1 per school
 - e) Handout with reporting form: 1 per Anganwadi centre
 - f) Mild adverse event reporting form
 - g) 1 Banner per school and per Anganwadi

स्वास्थ्य विभाग की भूमिका :-

- राष्ट्रीय कृमिमुक्ति दिवस हेतु शासकीय स्कूलों/अशासकीय अनुदान प्राप्त स्कूलों एवं आंगनवाडी केन्द्रों की संख्याओं के आधार पर पोस्टर, शिक्षक एवं आंगनवाडी कार्यकर्ताओं हेतु हैन्ड आउट का मुद्रण राज्य स्तर पर किया जावेगा। विकासखण्ड द्वारा शालाओं एवं आंगनवाडी केन्द्रों की संख्या के मान से बंडलिंग कर उन्मुखीकरण/ प्रशिक्षण के दौरान वितरण किया जाएगा।
- प्रशिक्षण/उन्मुखीकरण के दौरान छूटे हुए शालाओं एवं आंगनवाडी केन्द्रों तक आवश्यक औषधियाँ, मुद्रण सामग्री तथा प्रचार सामग्री पहुंचाने हेतु विकासखण्ड स्तर तक उपलब्ध मोबिलिटी सपोर्ट के तहत वाहन, आर.बी.एस.के. वाहन का उपयोग किया जाये।
- जिला स्तरीय व्यय हेतु भारत सरकार से प्राप्त वित्तीय प्रावधान अनुसार मितानिन मानदेय, प्रचार प्रसार, प्रशिक्षण एवं मॉनिटरिंग हेतु राशि उपलब्ध कारायी जावेगी।
- जिलेवार शासकीय/शासकीय अनुदान प्राप्त स्कूलों में दर्ज बच्चों की संख्या के आधार पर एल्बेण्डाजोल गोलियों CGMSC के क्षेत्रीय स्टोर के द्वारा विकासखण्ड को उपलब्ध करायी जावेगी।
- राष्ट्रीय कृमिमुक्ति दिवस के आयोजन हेतु प्रशिक्षण निम्नानुसार किया जावे :-

क्रं.	प्रशिक्षण स्तर	विवरण (प्रशिक्षार्थी)	निर्धारित समय-सीमा	दायित्व
1	राज्य	जिला नोडल अधिकारी एवं समन्वयक (एविडेन्स एक्शन) शिक्षा तथा महिला एवं बाल विकास के प्रतिनिधि, 102, 108, एवं 104 प्रतिनिधि	15 से 20 जनवरी 2016	राज्य नोडल अधिकारी
2	जिला	तीनों विभागों के जिला स्तरीय प्रभारी अधिकारी एवं विकासखण्ड हेतु मास्टर ट्रेनर	22 से 28 जनवरी 2016	जिला नोडल अधिकारी
3	विकासखण्ड	तीनों विभागों के विकासखण्ड स्तरीय प्रभारी अधिकारी	01 से 05 फरवरी 2016	खण्ड चिकित्सा अधिकारी
		मितानिन/ए.एन.एम. का उन्मुखीकरण	01 से 05 फरवरी 2016	चिकित्सा अधिकारी
4	प्रोजेक्ट /सेक्टर स्तर पर	सुपरवाइजर /आंगनवाडी कार्यकर्ताओं का उन्मुखीकरण	01 से 05 फरवरी 2016	सेक्टर चिकित्सा अधिकारी

निरंतर..

- प्रशिक्षण के दौरान शिक्षको एवं आंगनबाडी कार्यकर्ताओं हेतु मुद्रित हैण्डआउट के साथ ही परफोरेटेड रिपोर्टिंग प्रपत्र उपलब्ध कराया जावे।
- प्रशिक्षण के दौरान गाईड लाइन के अनुसार कार्यक्रमों की जानकारी रिपोर्टिंग प्रपत्रों को भरने की प्रक्रिया तथा दावा सेवन के पश्चात होने वाले विपरीत प्रभावों के प्रबंधन/प्राथमिक उपचार की जानकारी दी जावे।
- प्रत्येक स्कूल एवं आंगनवाडी पर राष्ट्रीय कृमिमुक्ति दिवस एवं मॉप-अप दिवस हेतु एल्बेंडाजोल गोली की पर्याप्त मात्रा में उपलब्धता सुनिश्चित कराया जावे।
- नवीन रिपोर्टिंग प्रणाली अनुसार राष्ट्रीय कृमिमुक्ति दिवस एवं मॉप-अप डे के बाद स्कूलों एवं आंगनवाडी केन्द्रों से समय-सीमा में रिपोर्ट ए.एन.एम. के माध्यम से विकासखण्ड चिकित्सा अधिकारी स्तर पर संकलित किया जावे।
- जिला नोडल अधिकारी के द्वारा राज्य स्तर पर रिपोर्ट समय-सीमा में प्रेषित किया जावे।
- बच्चों में कृमिनाशक की दवाई के साईड इफेक्ट बहुत कम होते हैं। कृमि संक्रमण की अधिकता के कारण कुछ मामूली दुष्प्रभाव जैसे- चक्कर आना, जी मचलना, सरदर्द, उल्टी, दस्त, थकान जैसा अनुभव होने की संभावना हो सकती है। ये कुछ समय में अपने आप ठीक हो जाते हैं।
- प्राथमिक स्वास्थ्य केन्द्रो, सामु.स्वा. केन्द्रो तथा जिला चिकित्सालयों में किसी भी प्रकार की प्रतिकूल घटना का प्रबंधन भी सुनिश्चित किया जाये।
- 108 संजीवनी एम्बुलेंस तथा 102 महतारी एक्सप्रेस सेवा के माध्यम से दवाई सेवन पश्चात विपरीत प्रभाव होने की दशा में रिफरल सेवा सुनिश्चित कराया जावे।
- 104 आरोग्य सेवा के द्वारा कार्यक्रम की प्रारंभिक जानकारी उपलब्ध कराई जावेगी।
- शाला अप्रवेशी/ शाला त्यागी बच्चों को आंगनवाडी केन्द्र पर लाने का दायित्व ग्राम/पारा मितानिन का होगी।

शिक्षा विभाग की भूमिका :-

- शासकीय स्कूलों में 6 से 19 वर्ष के दर्ज बच्चों को उपस्थिति शत प्रतिशत हो इस हेतु प्रधान पाठक/प्राचार्य का दायित्व होगा की बच्चों तथा उनके पालकों को कम से कम एक सप्ताह पूर्व कार्यक्रम की जानकारी दी जावे।
- दवा सेवन के दौरान स्कूलों में स्थान नियत किया जावे तथा शुद्ध पेयजल एवं गिलास की व्यवस्था की जावे।
- बच्चों की संख्या के आधार पर कृमि नाशक दवाई की मात्रा स्थानीय स्वास्थ्य विभाग के समन्वय से पर्याप्त मात्रा में उपलब्धता सुनिश्चित किया जावेगा।
- राष्ट्रीय कृमि मुक्ति दिवस के बैनर का उचित स्थान पर प्रदर्शन किया जावे।
- प्रभारी शिक्षक के द्वारा दवा सेवन की गतिविधि प्रारंभ करने के पूर्व बीमार बच्चों अथवा जिन्हें किसी भी कारण से दवा सेवन नहीं कराया जाना है को पृथक कक्ष में अथवा कतार में बैठाया जावे।
- यह भी सुनिश्चित किया जाए कि बच्चे गोली को चबाकर ही खायें।
- दवा सेवन के पश्चात् उपस्थिति रजिस्टर में बच्चों के नाम के समक्ष गोली खिलाने के बाद ✓ का निशान लगाया जावे।

निरंतर..

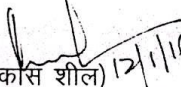
- मॉप-अप दिवस पर छूटे बच्चों को गोली खिलाने के पश्चात उपस्थिति रजिस्टर में ✓✓ का निशान लगाया जावे।
- राष्ट्रीय बाल स्वास्थ्य कार्यक्रम (चिरायु कार्यक्रम) स्वास्थ्य परीक्षण कार्ड के दूसरे पृष्ठ पर एल्बेण्डाजोल की प्रथम अथवा द्वितीय खुराक वाले लाईन पर तिथि अंकित करें।
- प्रतिकूल घटना की सूचना हेतु स्कूल में विकासखण्ड चिकित्सा अधिकारी, ए.एन.एम. सेक्टर चिकित्सा अधिकारी से संपर्क किया जावे।
- प्राथमिक सहायता मिलने के पूर्व किसी भी प्रकार के दुष्प्रभाव की स्थिति में बच्चे को खुले एवं छायादार स्थान पर लिटाया जाये तथा साफ स्वच्छ पेयजल पीने को दिया जाये।
- दवा के प्रतिकूल प्रभाव होने के पश्चात् बच्चों को अस्पताल रिफरल किये जाने की दशा में टोल फ्री नंबर 108 से संजीवनी एम्बुलेंस की सेवा लिया जावे।
- गंभीर प्रतिकूल लक्षण होने पर संपर्क सूची में दर्ज ग्राम की ए.एन.एम./सेक्टर चिकित्सा अधिकारी/बी.एम.ओ. को सूचित किया जाए।
- किसी अन्य जानकारी के संबंध में 104 आरोग्य सेवा के माध्यम से संपर्क किया जावे।
- दिनांक 15 फरवरी 2016 को समस्त शिक्षक/शाला प्रधान द्वारा छूटे हुए बच्चों की सूची अनुसार मॉप अप डे पर एल्बेण्डाजोल गोली का सेवन कराया जाये।
- निधारित प्रपत्र में कार्यक्रम के पश्चात् समय-सीमा अनुसार रिपोर्टिंग किया जावे।

महिला एवं बाल विकास विभाग की भूमिका :-

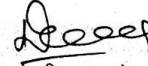
- शाला अप्रवेशी एवं शाला त्यागी 6 से 19 वर्ष को आंगनबाडी केन्द्र में लाने का दायित्व संबंधित मितानिन एवं आंगनबाडी सहायिका की होगी इस हेतु स्थानीय जनप्रतिनिधि या स्वयं सेवी संस्थानों का सहयोग लिया जावे ताकि शत प्रतिशत बच्चों कृमि नाशन दवा का सेवन कराया जा सके।
- परियोजना अधिकारी एवं आंगनबाडी कार्यकर्ता का दायित्व होगा की अपने कार्यक्षेत्र में कार्यक्रम की जानकारी आम जनता एवं बच्चों के पालकों तक पहुंचाने हेतु प्रचार प्रसार सामग्री का प्रदर्शन कम से कम एक सप्ताह पूर्व किया जावे।
- दवा सेवन के दौरान आंगनबाडी में स्थान नियत किया जावे तथा शुद्ध पेयजल एवं गिलास की व्यवस्था की जावे।
- शाला अप्रवाशी तथा शाला त्यागी बच्चों की संख्या के आधार पर कृमि नाशक दवाई की मात्रा स्थानीय स्वास्थ्य विभाग के समन्वय से पर्याप्त मात्रा में उपलब्धता सुनिश्चित किया जावेगा।
- राष्ट्रीय कृमि मुक्ति दिवस के बैनर का उचित स्थान पर प्रदर्शन किया जावे।
- आंगनबाडी कार्यकर्ता के द्वारा दवा सेवन कराने के पूर्व बच्चों अथवा अभिभावकों से किसी भी बीमारी से पीड़ित होने अथवा अन्य दवाई लिये जाने के बारे में अवश्य पूछा जावे।
- यह भी सुनिश्चित किया जाए कि बच्चे गोली को चबाकर ही खायें।

निरंतर..


- दवा सेवन के पश्चात् रजिस्टर/सूची में बच्चों के नाम गोली खिलाने के बाद ✓ का निशान लगाना।
- मॉप-अप दिवस पर छोटे बच्चों को गोली खिलावे तथा रजिस्टर/सूची में ✓✓ का निशान लगाना।
- प्रतिकूल घटना की सूचना आंगनबाड़ी कार्यकर्ता द्वारा विकासखण्ड चिकित्सा अधिकारी, ए.एन.एम.सेक्टर चिकित्सा अधिकारी को दी जावे।
- प्राथमिक सहायता मिलने के पूर्व किसी भी प्रकार के दुष्प्रभाव की स्थिति में बच्चे को खुले एवं छायादार स्थान पर लिटाया जाये तथा साफ स्वच्छ पेयजल पीने को दिया जाये।
- दवा के प्रतिकूल प्रभाव होने के पश्चात् बच्चों को अस्पताल रिफरल किये जाने की दशा में टोल फ्री 108 संजीवनी एम्बुलेंस की सेवा लिया जावे।
- किसी अन्य जानकारी के संबंध में 104 आरोग्य सेवा के माध्यम से संपर्क किया जावे।
- दिनांक 15 तारीख को समस्त आंगनबाड़ी कार्यकर्ता द्वारा छोटे हुए बच्चों की सूची बनाकर मॉप अप डे पर एल्बेण्डाजॉल गोली का सेवन कराया जाये।
- निर्धारित प्रपत्र में कार्यक्रम के पश्चात् निर्धारित तिथि अनुसार रिपोर्टिंग किया जावे।


(विकास शील) 12/11/16
सचिव

छत्तीसगढ़ शासन
स्वास्थ्य एवं परिवार कल्याण


(दिनेश श्रीवास्तव)
सचिव

छत्तीसगढ़ शासन
महिला एवं बाल विकास

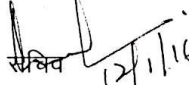

(सुब्रत साहू)
सचिव


छत्तीसगढ़ शासन
स्कूल शिक्षा


पृ0कमांक एफ 1-2/2016/सत्रह/एक
प्रतिलिपि :-

नया रायपुर, दिनांक 13 जनवरी, 2016

1. आयुक्त, स्वास्थ्य सेवायें, छत्तीसगढ़ तृतीय तल इन्द्रावती भवन नया रायपुर,
2. प्रबंध संचालक, सी.जी.एम.एस.सी. गोविन्द सारंग भवन, न्यू राजेन्द्र नगर, रायपुर,
3. संचालक, स्वास्थ्य सेवाएं, छत्तीसगढ़ तृतीयतल इन्द्रावती भवन, नया रायपुर,
4. मिशन संचालक, राष्ट्रीय स्वास्थ्य मिशन, सेक्टर-27, नया रायपुर,
5. संचालक, महिला एवं बाल विकास विभाग, इन्द्रावती भवन, नया रायपुर, छत्तीसगढ़
6. संचालक, स्कूल शिक्षा, इन्द्रावती भवन, नया रायपुर, छत्तीसगढ़,
7. कार्यकारी संचालक, राज्य स्वास्थ्य संसाधन केन्द्र, कालीबाड़ी, रायपुर,
8. राज्य नोडल अधिकारी, संचालनालय, स्वास्थ्य सेवायें, छत्तीसगढ़,
9. राज्य कार्यक्रमप्रबंधक एविडेंस एक्शन छत्तीसगढ़,
की ओर सूचनार्थ एवं आवश्यक कार्यवाही हेतु अग्रेषित।
10. कार्यालयीन प्रति।


सचिव 12/11/16
छत्तीसगढ़ शासन
स्वास्थ्य एवं परिवार कल्याण


सचिव
छत्तीसगढ़ शासन
महिला एवं बाल विकास


सचिव
छत्तीसगढ़ शासन
स्कूल शिक्षा

Annexure D – Letter from MD to CMHO



राष्ट्रीय स्वास्थ्य मिशन, छत्तीसगढ़

चतुर्थ तल, छत्तीसगढ़ गृह निर्माण मंडल व्यायसायिक परिसर, (दक्षिण पूर्व कार्नेर)
सेक्टर -27 नया रायपुर, पिन- 492015 (छत्तीसगढ़)

दूरभाष 0771-2511280, फ़ैक्स 0771-2511285, ई, मेल : office.mdnrm@gamil.com



क्रमांक / एन.एच.एम / NIPI / 2016 (NS-56) 2300 रायपुर दिनांक 06/01/ 2016

प्रति,

मुख्य चिकित्सा एवं स्वास्थ्य अधिकारी,
जिला – बस्तर, बीजापुर, दंतवेड़ा, कोण्डागांव, कर्वधा, कांकर, कोरिया, कोरबा,
नारायणपुर, राजनांदगांव, सुकमा, जांजगीर-चांपा, बालोद, बेमेतरा, दुर्ग, जशपुर

विषय: 10 फरवरी 2016 में 6 से 19 वर्षीय बच्चों में कृमिमुक्ति हेतु 16 जिलों में राष्ट्रीय कृमिमुक्ति दिवस (NDD 2016) का आयोजन किये जाने के संबंध में।

- संदर्भ: 1) राष्ट्रीय कृमिमुक्ति दिवस के संबंध में भारत सरकार द्वारा जारी पत्र क्र. Z-28020/237/2013-CH, दिनांक 16 दिसम्बर 2015।
2) राष्ट्रीय कृमिमुक्ति दिवस के संबंध में भारत सरकार द्वारा जारी वित्तीय दिशा-निर्देश पत्र क्र. Z-28020/237/2013-CH, दिनांक 29 दिसम्बर 2015।

राज्य में राष्ट्रीय कृमिमुक्ति दिवस का आयोजन भारत सरकार के दिशानिर्देशानुसार एक निश्चित दिवस पर (Fix Day Approach) 10 फरवरी 2016 को 16 जिलों के आंगनवाड़ी केन्द्रों एवं शासकीय/शासकीय अनुदान प्राप्त शालाओं के माध्यम से 6 से 19 वर्षीय बच्चों का कृमिनाशक किया जायेगा जिस हेतु भारत सरकार के उक्त संदर्भित पत्र के माध्यम से राष्ट्रीय कृमिमुक्ति दिवस का आयोजन 10 फरवरी 2016 एवं मॉप-अप दिवस 15 फरवरी 2016 तक किये जाने हेतु निर्देशित गया है।

अतः इस चरण में केवल 6 से 19 वर्ष के बच्चों को कृमिनाशक दवाई एल्बेन्डाजाल दी जावेगी। कार्यक्रम का निजी स्कूलों में विस्तार किये जाने की दिशा में जिला कोरबा के सभी निजी स्कूलों में भी बच्चों को कृमिनाशक दवाई दिया जावेगा।

शेष 11 जिलों में राष्ट्रीय फाईलेरिया दिवस (14 से 16 दिसम्बर 2015) पर 2 से 60 वर्ष के हितग्राहीयों को कृमिनाशक दवाई एल्बेन्डाजाल दी जा चुकी है।

1. राष्ट्रीय कृमिमुक्ति दिवस कार्यक्रम :-

राष्ट्रीय कृमिमुक्ति दिवस का उद्देश्य :-समस्त शासकीय/शासकीय अनुदान प्राप्त स्कूलों एवं आंगनवाड़ी केन्द्रों के माध्यम से समस्त 6 से 19 वर्षीय बच्चों को कृमिनाशन हेतु एल्बेन्डाजाल गोली की प्रदायगी सुनिश्चित करना जिससे बच्चों के संपूर्ण स्वास्थ्य-पोषण स्तर, आयरन की कमी की रोकथाम से बौद्धिक विकास तथा शालाओं में उपस्थिति में सुधार हो सके।

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

- राष्ट्रीय कृमिमुक्ति दिवस (National Deworming Day - NDD) का समारोह पूर्वक शुभारंभ विशिष्ट एवं गणमान्य जनप्रतिनिधि/जिला कलेक्टर द्वारा दिनांक 10 फरवरी 2016 को किया जावे।
- कार्यक्रम का क्रियान्वयन स्वास्थ्य, शिक्षा विभाग एवं महिला एवं बाल विकास के समन्वय से किया जायेगा।
- 10 फरवरी 2016 को आयोजित राष्ट्रीय कृमिमुक्ति दिवस एवं मॉप-अप दिवस 15 फरवरी 2016 पर 6 से 19 वर्षीय बच्चों को निम्नानुसार खुराक दी जाए:-

आयु वर्ग	एलबेन्डाजोल की खुराक (400mg)	सेवा प्रदाता
6 से 19 वर्षीय स्कूल में पंजीकृत बच्चे	पूरी 1 गोली (चबाकर पानी के साथ)	शिक्षक
स्कूल नहीं जाने वाले 6 से 19 वर्षीय बच्चे	पूरी 1 गोली (चबाकर पानी के साथ)	आंगनवाडी कार्यकर्ता

- दिनांक 10 फरवरी 2015 को समस्त शासकीय/शासकीय अनुदान प्राप्त स्कूलों, निजी स्कूलों एवं आंगनवाडी केन्द्रों के माध्यम से 6 से 19 वर्षीय बालक एवं बालिकाओं को कृमिनाशन हेतु एलबेन्डाजोल (Chewable-400mg) की एक गोली का सेवन स्कूलों में शिक्षक एवं आंगनवाडी केन्द्रों में आंगनवाडी कार्यकर्ता के द्वारा कराया जावे।
- शाला अप्रवेशी/ शालात्यागी 6 से 19 वर्षीय बालक एवं बालिकाओं को आंगनवाडी केन्द्रों में एलबेन्डाजोल (Chewable-400mg) की गोली उपरोक्त तालिकानुसार सेवन कराया जाये।
- राज्य, जिला एवं विकासखंड स्तर पर मॉनिटरिंग टीम गठित कर गतिविधियों का पर्यवेक्षण किया जावेगा।
- राष्ट्रीय कृमिदिवस के दौरान दवाई सेवन पश्चात होने वाले संभावित विपरित प्रभाव का प्रबंधन हेतु सभी चिकित्सालयों में समुचित व्यवस्था सुनिश्चित किया जावे, तथा इसकी रिपोर्टिंग निर्धारित प्रपत्र में की जावे।
- NDD kit के अंतर्गत निम्न सामग्रियाँ हैं-
 - 1- एलबेन्डाजोल
 - 2- एक पोस्टर प्रति स्कूल
 - 3- एक पोस्टर प्रति आंगनवाडी केन्द्र
 - 4- एक हैण्डआउट एवं रिपोर्टिंग प्रपत्र प्रति स्कूल
 - 5- एक हैण्डआउट एवं रिपोर्टिंग प्रपत्र प्रति आंगनवाडी केन्द्र
 - 6- बैनर प्रति स्कूल और प्रति आंगनवाडी केन्द्र

2. जिले वार एलबेन्डाजोल का वितरण -

जिलों की समस्त शासकीय/शासकीय अनुदान प्राप्त स्कूलों एवं प्राइवेट स्कूल कोरबा जिला में एलबेन्डाजोल का वितरण -

Albendazole distribution plan district wise_Chhattisgarh

Buffer Stock %	10%
Tablets of per strip	10

Govt and Govt aided school					
Sl.No	District	Total Number of Schools	Total Enrollment	Total no of strip (10X10) with additional 10 % buffer stock	Total Albendazole to be Given
1	KORIYA	1376	95158	11144	111440
2	BASTER	2424	148511	17524	175240
3	BIJAPUR	1071	47004	5571	55710
4	DANTEWADA	927	40213	4856	48560
5	KANKER	2313	141134	16646	166460
6	KAWARDHA	1641	165553	19036	190360
7	KONDAGAON	2002	124767	14717	147170
8	KORBA	1968	161655	18758	187580
9	NARAYANPUR	572	28550	3414	34140

Govt and Govt aided school					
Sl.No	District	Total Number of Schools	Total Enrollment	Total no of strip (10X10) with additional 10 % buffer stock	Total Albendazole to be Given
10	RAJNANDGAON	2735	267210	30768	307680
11	SUKMA	948	38344	4610	46100
12	BALOD	1476	152189	17472	174720
13	BEMETARA	1262	184164	20883	208830
14	DURG	1150	195557	22078	220780
15	JANJIR - CHAMPA	2610	284793	32622	326220
16	JASHPUR	2534	156399	18422	184220
Total		27009	2231201	258521	2585210
Private School					
1	KORBA	101	17583	1984	19840
Total		101	17583	1984	19840

- जिलों की आंगनवाड़ी केन्द्रों में एल्बेंडाजॉल का वितरण :

Albendazole bundling plan AWC wise for out of school			
District	No of AWC	Total no of Strip (10X10)	Total no of Albendazole
Bastar	1953	2024	20240
Bijapur	1071	1071	10710
Dantewada	1020	1020	10200
Kanker	2050	2050	20500
Kawardha	1609	1609	16090
Kondagaon	1800	1800	18000
Korba	2560	2560	25600
Koriya	1774	1838	18380
Narayanpur	503	503	5030
Rajnandgaon	2873	2873	28730
Sukma	814	814	8140
Balod	1454	1519	15190
Bemetara	953	1465	14650
Durg	1482	1482	14820
Janjgir -Champa	2176	2176	21760
Jashpur	4292	4292	42920
Total	28384	29096	290960

3. रिपोर्टिंग प्रपत्र :-

राष्ट्रीय कृमिमुक्ति दिवस में उपयोग होने वाले रिपोर्टिंग प्रपत्र निम्न है :

- 1- स्कूल हैण्डआउट एवं रिपोर्टिंग प्रपत्र
- 2- आंगनवाड़ी हैण्डआउट एवं रिपोर्टिंग प्रपत्र
- 3- माईल्ल्ड एवं एडवर्स इवेंट मैनेजमेंट फॉर्म
- 4- मितानिन रिपोर्टिंग फॉर्म
- 5- कॉमन रिपोर्टिंग फॉर्म

जिलेवार रिपोर्टिंग प्रपत्र का वितरण :

S.no	District	No of block	Reporting format for school			Reporting format for AWC			Reporting format for mitanin	Common reporting format (1 per district/per block)
			Total Number of Schools	School handout cum reporting	Mild Adverse event	No of AWW	AWW handout cum reporting	Mild Adverse event		
1	BALOD	5	1476	1476	1476	1454	1454	1454	2284	6
2	BASTER	7	2424	2424	2424	1953	1953	1953	2851	8
3	BEMETARA	4	1262	1262	1262	953	953	953	1874	5
4	BIJAPUR	4	1071	1071	1071	1071	1071	1071	1461	5
5	DANTEWADA	4	927	927	927	1020	1020	1020	1372	5
6	DURG	3	1150	1150	1150	1482	1482	1482	1322	4
7	JANJIR-CHAMPA	9	2610	2610	2610	2176	2176	2176	3749	10
8	JASHPUR	8	2534	2534	2534	4292	4292	4292	3571	9
9	KANKER	7	2313	2313	2313	2050	2050	2050	3260	8
10	KAWARDHA	4	1641	1641	1641	1609	1609	1609	1877	5
11	KONDAGAON	5	2002	2002	2002	1800	1800	1800	2287	6
12	KORBA	5	1968	1968	1968	2560	2560	2560	2821	6
	KORBA(private)	0	101	101	101	0	0	0	0	0
13	KORIYA	5	1376	1376	1376	1774	1774	1774	2473	6
14	NARAYANPUR	2	572	572	572	503	503	503	630	3
15	RAJNANDGAON	9	2735	2735	2735	2873	2873	2873	4327	10
16	SUKMA	3	948	948	948	814	814	814	1190	4
Total		84	27110	27110	27110	28384	28384	28384	37349	100

उपर्युक्त रिपोर्टिंग प्रपत्र को भर कर अपने अधिकारी को जमा करने की तिथि :

- आंगनवाड़ी कार्यकर्ता, मितानिन और स्कूल हेडमास्टर को ए.एन.एम. के पास जमा करने की तिथि 19 फरवरी 2016 है।
- ए.एन.एम. को विकासखंड में जमा करने की तिथि 26 फरवरी 2016 है।
- खंड चिकित्सा अधिकारी को मुख्य चिकित्सा एवं स्वास्थ्य अधिकारी के पास जमा करने की तिथि 10 मार्च 2016 है।
- जिले का नोडल ऑफिसर के पास जमा करने की तिथि 17 मार्च 2016 है।

4. वित्तीय प्रावधान :-

जिला स्तरीय व्यय हेतु भारत सरकार से प्राप्त वित्तीय प्रावधान निम्नानुसार हैं :-

Sr.	District	No. of Block	Media activities for awareness generation @Rs 19000/- per block (B.10.6) *	Mobility support for field level monitoring @ Rs 750/- per block (A.10.8)
1	Balod	5	95000	3750
2	Bastar	7	133000	5250
3	Bemetara	4	76000	3000
4	Bijapur	4	76000	3000
5	Dantewada	4	76000	3000
6	Durg	3	57000	2250
7	JanjgirChampa	9	171000	6750
8	Jashpur	8	152000	6000

Sr.	District	No. of Block	Media activities for awareness generation @Rs 19000/- per block (B.10.6) *	Mobility support for field level monitoring @ Rs 750/- per block (A.10.8)
9	Kanker	7	133000	5250
10	Kawardha	4	76000	3000
11	Kondagaon	5	95000	3750
12	Korba	5	95000	3750
13	Koriya	5	95000	3750
14	Narayanpur	2	38000	1500
15	Rajnandgaon	9	171000	6750
16	Sukma	3	57000	2250
Total		84	1596000	63000

* मिडिया एक्टिविटी – जिला स्तर पर प्रचार-प्रसार के रूप में माईकिंग, दीवार लेखन, लोकल केबल टीवी उद्घाटन समारोह, मिडिया ब्रिफिंग किया जाए।

दवा वितरण हेतु प्रावधानित मानदेय :

राष्ट्रीय कृमिदिवस के दौरान दवा हितग्राहियों को दवा सेवन हेतु आगनवाड़ी/स्कूल में जाने हेतु सहयोग किए जाने वाले मितानिनों को मानदेय की प्रात्रता होगी।

S.No	District	No. of Mitans	Estimated expenditure per Mitanin @Rs 85/- B.1.1.3.5 (other incentive)	Total amount per districts
1	Balod	2284	85	194140
2	Bastar	2851	85	242335
3	Bemetara	1874	85	159290
4	Bijapur	1461	85	124185
5	Dantewada	1372	85	116620
6	Durg	1322	85	112370
7	Janjgir-champa	3749	85	318665
8	Jashpur	3571	85	303535
9	Kanker	3260	85	277100
10	Kawardha	1877	85	159545
11	Kondagoan	2287	85	194395
12	Korba	2821	85	239785
13	Koriya	2473	85	210205
14	Narayanpur	630	85	53550
15	Rajnandgoan	4327	85	367795
16	Sukma	1190	85	101150
Total		37349		3174665

5 . प्रशिक्षण :-

राष्ट्रीय कृमिमुक्ति दिवस के आयोजन हेतु प्रशिक्षण निम्नानुसार किया जावे :-

क्रं.	प्रशिक्षणस्तर	विवरण (प्रशिक्षार्थी)	निर्धारित समय-सीमा	दायित्व
1	राज्य	जिला नोडलअधिकारी एवं किसी भी विकासखंड के एक चिकित्सा अधिकारी,	11 जनवरी 2016	राज्य नोडल अधिकारी

		102, 108 एवं 104 प्रतिनिधि।		
2	जिला	तीनों विभागों के जिला स्तरीय प्रभारी अधिकारी एवं विकासखण्ड हेतु मास्टर ट्रेनर	13 से 18 जनवरी 2016	जिला नोडल अधिकारी
3	विकासखण्ड	तीनों विभागों के विकासखण्ड स्तरीय प्रभारी अधिकारी	22 से 28 जनवरी 2016	खंडचिकित्सा अधिकारी
		मितानिन/ए.एन.एम. का उन्मुखीकरण	22 से 28 जनवरी 2016	चिकित्सा अधिकारी
4	प्रोजेक्ट /सेक्टर स्तरपर	सुपरवाइजर/ आंगनवाडी कार्यकर्ताओं का उन्मुखीकरण	22 से 28 जनवरी 2016	सेक्टर चिकित्सा अधिकारी

प्रशिक्षण हेतु वित्तीय प्रावधान (A.9.11.3) :

Sr.	District	No. of Block	Half day training at PHC/Block level @Rs 100 per participant (A.9.11.3)
1	Balod	5	285700
2	Bastar	7	399980
3	Bemetara	4	228560
4	Bijapur	4	228560
5	Dantewada	4	228560
6	Durg	3	171420
7	JanjgirChampa	9	514260
8	Jashpur	8	457120
9	Kanker	7	399980
10	Kawardha	4	228560
11	Kondagaon	5	285700
12	Korba	5	285700
13	Koriya	5	285700
14	Narayanpur	2	114280
15	Rajnandgaon	9	514260
16	Sukma	3	171420
Total		84	4799760

6. जिलेवार आई.ई.सी. सामाग्री वितरण (B.10.3.5) :

प्रचार-प्रसार सामाग्री मुद्रित किया जायेगा, जिसका वितरण सूची निम्नानुसार है। इन सामाग्रियों का विकासखंड स्तर से स्कूल तथा आंगनवाड़ी केन्द्रों तक उपलब्ध कराने हेतु प्रशिक्षण के दौरान वितरण व्यवस्था सुनिश्चित किया जावे। जिले में दीवार लेखन का कार्य कम से कम 1 से 5 फरवरी के बीच कर लिया जावे। जिससे कि व्यापक प्रचार-प्रसार सुनिश्चित हो सके तथा मितानिनों के माध्यम से 6 से 19 वर्ष के बालक/बालिकाओं वाले घर में कृमिदिवस आयोजन संबंधित जानकारी पहुंचाया जाना सुनिश्चित किया जावे।

District	IEC for School					IEC for AWC				
	Total Number of Schools	Banner	Poster	School Handout	Flip charts	No of AWW	Flip charts	Banner	Poster	AWW Handout
BASTER	2424	2424	2424	2424	7	1953	72	1953	1953	1953
BIJAPUR	1071	1071	1071	1071	4	1071	44	1071	1071	1071
DANTEWADA	927	927	927	927	4	1020	39	1020	1020	1020
KANKER	2313	2313	2313	2313	7	2050	77	2050	2050	2050
KAWARDHA	1641	1641	1641	1641	4	1609	63	1609	1609	1609
KONDAGAON	2002	2002	2002	2002	5	1800	58	1800	1800	1800
KORBA	1968	1968	1968	1968	5	2560	91	2560	2560	2560
KORBA(private)	101	101	101	101	5	0	0	0	0	0

District	IEC for School					IEC for AWC				
	Total Number of Schools	Banner	Poster	School Handout	Flip charts	No of AWW	Flip charts	Banner	Poster	AWW Handout
KORIYA	1376	1376	1376	1376	5	1774	66	1774	1774	1774
NARAYANPUR	572	572	572	572	2	503	15	503	503	503
RAJNANDGAON	2735	2735	2735	2735	9	2873	84	2873	2873	2873
SUKMA	948	948	948	948	3	814	34	814	814	814
BALOD	1476	1476	1476	1476	5	1454	54	1454	1454	1454
BEMETARA	1262	1262	1262	1262	4	953	40	953	953	953
DURG	1150	1150	1150	1150	3	1482	58	1482	1482	1482
JANJIR - CHAMPA	2610	2610	2610	2610	9	2176	80	2176	2176	2176
JASHPUR	2534	2534	2534	2534	8	4292	118	4292	4292	4292
Total	27110	27110	27110	27110	89	28384	993	28384	28384	28384



 मिशन संचालक
 राष्ट्रीय स्वास्थ्य मिशन
 छत्तीसगढ़

क्रमांक/एन.एच.एम/NIPI/2016 (NS-56)/2300

नया रायपुर दिनांक 06/01/2016

प्रतिलिपि :-

1. सचिव, छत्तीसगढ़ शासन, स्वास्थ्य एवं परिवार कल्याण विभाग, मंत्रालय महानदी भवन नया रायपुर छ.ग. को सूचनार्थ।
2. आयुक्त, स्वास्थ्य सेवायें तृतीय तल इन्द्रावती भवन नया रायपुर छ.ग. को सूचनार्थ।
3. संचालक, स्वास्थ्य सेवाएं तृतीय तल इन्द्रावती भवन नया रायपुर छ.ग. को सूचनार्थ।
4. कार्यकारी संचालक, राज्य स्वास्थ्य संसाधन केन्द्र, कालीबाड़ी, रायपुर छ.ग.।
5. संभागीय संयुक्त संचालक, स्वास्थ्य सेवाएं संभाग - समस्त छ.ग.।
6. राज्य वित्त प्रबंधक, राष्ट्रीय स्वास्थ्य मिशन सेक्टर 27 नया रायपुर छ.ग.।
7. उप संचालक (IEC) राष्ट्रीय स्वास्थ्य मिशन सेक्टर 27 नया रायपुर छ.ग.।
8. उप संचालक/राज्य कार्यक्रम अधिकारी NDD तृतीय तल इन्द्रावती भवन नया रायपुर छ.ग. आवश्यक कार्यवाही हेतु।
9. प्रबंधक, 108, 104 एवं 102 रायपुर छ.ग.।
10. राज्य कार्यक्रम प्रबंधक, एविडेन्स एक्शन, रायपुर छ.ग.।
11. कार्यालयीन प्रति।


 मिशन संचालक
 राष्ट्रीय स्वास्थ्य मिशन
 छत्तीसगढ़

कृमि से मुक्ति, बच्चों को शक्ति

क्या आप जानते हैं कि कृमि संक्रमण से बच्चों में:

- बुपोषण और खून में कमी होती है, जिसके कारण हमेशा थकवट रहती है
- संपूर्ण शारीरिक और मानसिक विकास में बाधा आ सकती है

कृमि संक्रमण से बचाव के लिए ध्यान दें

नाखून साफ और अंडे रखें



हमेशा साफ पानी पियें



खाने को ठक कर रखें



साफ पानी में फल व सब्जियाँ धोएँ



जानने वाले साबुन से धोएँ, विशेषकर खाने से पहले और शीच जाने के बाद



जिस परत साफ़ रखें



जूते-चप्पल पहने



खुले में शीच न करें, हमेशा शौचालय का प्रयोग करें





राष्ट्रीय कृमि मुक्ति दिवस



कृमि निवारण की सबसे कृमि संक्रमण में अंतर करती है।
राष्ट्रीय कृमि मुक्ति दिवस पर बहुत सारे बच्चे खुले और संस्कारी संघों में किशोर निवारण करती है।






 **National Deworming Day**
MOP UP DAY
15 February 2016 

Did you know worms can make your child:
anaemic | undernourished | too sick or tired to concentrate or even attend school

Why should all children be dewormed?

- The deworming tablet is safe and effective for all children
- Deworming all children stops worms from spreading
- Deworming helps improve children's overall physical and mental development



Worm Free Children, Healthy Children

Remember - 15 February 2016

Deworming tablet is safe for all children. Children who could not attend school should also be dewormed.

<p style="text-align: center;">Annexure F – Monitoring data submitted by Evidence Action</p>

Snapshot of the findings:

- 1) 92.17 of school and *anganwadi* had sufficient drugs for National Deworming Day
- 1) 86.42% of school and *anganwadi* had school/ *anagnwadi* reporting forms
- 2) 94.78% of school and *anganwadi* were administering deworming drugs on deworming day and mop up day
- 3) Approximately 80% of the teachers/*anganwadi* workers were separating sick children from healthy children for the deworming activity.
- 4) 93.73% of the teachers/*anagnwadi* workers followed the ticking protocol during deworming
- 5) Approximately 50% of the AWW/*mitanin* did NOT prepare a list of out of school who received the drug
- 6) Approximately 56% out of school children received drug in the school/AWC
- 7) 95.04% were given the appropriate dose of albendazole by teacher/AWW
- 8) Supervised administration was conducted in 96% schools/*anganwadi*
- 9) More than 95% of the teachers/*anganwadi* instructed children to chew the tablet
- 10) 81% of teachers/*anganwadi* workers attended official training for deworming

Annexure G – Snapshot of Tele-calling Summary

		Pre Deworming																						
		Drugs						Training						IEC						Pre-deworming calls to schools/anganwadi				
Proposed timeline	Actual timeline	District Level			Block level			District Level			Block level			District Level			Block level			School and Anganwadi				
		15-30 Jan			15 Jan-9 Feb			15-30 Jan			15 Jan-9 Feb			15-30 Jan			15 Jan-9 Feb			School and Anganwadi				
		Officials called	Total no of calls	Officials called	Department	Total no of calls	Officials called	Department	Total no of calls	Officials called	Department	Total no of calls	Officials called	Total no of calls	Officials called	Department	Total no of calls	People called	Department	Total no of calls				
Chhattisgarh	CMHO			BPM	Health	52	BPM	Health		BPM	Health	216	BPM	Health	216	Aw/w	ICDS	21						
				BMO	Health	308	BEO	Education		BMO	Health	185	BMO	Health	185	Teacher/HM-govt	Education	41						
				MO	Health	8	wCD	ICDS		MO	Health	4	MO	Health	4									
				BC	Health	5	Nodal		48	BC	Health	5	BC	Health	5									
				BEE	Health	7				BEE	Health	8	BEE	Health	8									
				BRC	Education	3				BRC	Education	2	BRC	Education	2									
				BEO	Education	10				BEO	Education	10	BEO	Education	10									
				ASHA Coordinator	Health	3				ASHA Coordinator	Health	3	ASHA Coordinator	Health	3									
										Teachers/Principals(private)	Education	27												
										Aw/w	wCD	185												
							336							433							433			62

During Deworming																		
Calls on NDD School and Anganwadi			Calls between NDD and MUD School and Anganwadi			Calls on MUD School and Anganwadi												
People called	Department	Total no of calls	People called	Department	Total no of calls	People called	Department	Total no of calls										
Aw/w	wCD	42	Aw/w	wCD	142	Aw/w	wCD	45										
Teacher/HM-govt	Education	43	Teacher/HM-govt	Education	136	Teacher/HM-govt	Education	102										
Teacher/HM-private	Education	2																
		87			0			0	278			0			0			147

After Deworming											
Coverage reporting											
School/Anganwadi Level			Sector level			Block level			District Level		
15-19 Feb			19-23 Feb			24-29 Feb			29 Feb-7 March		
15-20 Feb			19-23 Feb			24-5 March			29 Feb-7 March		
People called	Department	Total no of calls	Officials called	Department	Total no of calls	Officials called	Department	Total no of calls	Officials called	Department	Total no of calls
ANM	Health	80	ANM	Health	298	BMO	Health	322	Nodal Officer	Health	2
Aw/w	wCD	214				BPM	Health	307	DPM	Health	30
Teacher/HM-govt	Education	143				BEO	Education	4			
						BEE	Health	1			
		80			298			0			634
		0			0			0			363