



# National Deworming Day



## Operational Guidelines

Child Health Division  
Ministry of Health and Family Welfare  
Government of India

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**Developed in collaboration with  
Evidence Action - Deworm the World Initiative**

Front Cover Photo Credit: Evidence Action



जगत प्रकाश नड्डा  
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स्वास्थ्य एवं परिवार कल्याण मंत्री  
भारत सरकार  
Minister of Health & Family Welfare  
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## **MESSAGE**

The early years of a child are the most critical and significant. Many initiatives are currently being undertaken by the Government like Polio eradication, National Iron Plus Initiative for combating anaemia, screening of children under Rashtriya Bal Swasthya Karyakarm and improvement of health and sanitation through Swachha Bharat Abiyan. Another key area that needs to be addressed is the risk of parasitic intestinal worm infestation in children.

Making our children completely intestinal worm free is going to be a gradual process. A National Deworming Day will be observed as a part of this initiative. This will help children to reduce the transmission of Soil Transmitted Helminths (STH), thereby improving nutrition level and reducing anaemia in children.

National Deworming Day (NDD) is an initiative to help our children live healthy and help in reducing morbidities. I am confident that if the comprehensive set of actions identified in National Deworming Day Guidelines is fully implemented, children will have improved health outcomes and be able to achieve their potential to the fullest.

I extend my best wishes and fervent support to this new and significant initiative and urge the States/UTs to accelerate their efforts towards successful implementation of this initiative. Let us all come forward to support this initiative and make the National Deworming Day a success.

(JAGAT PRAKASH NADDA)

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# ACRONYMS

ANM	Auxiliary Nurse and Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
AYUSH	Ayurveda, Yoga, Unani, Siddha and Homoeopathy
BCC	Behavior Change Communication
BCM	Block Community Mobilizer
BEO	Block Education Officer
BHM	Block Health Manager
BPHC	Block Primary Health Center
BRP	Block Resource Person
CDPO	Child Development Project Officer
CHC	Community Health Center
CS	Civil Surgeon
DCC	District Coordination Committee
DEO	District Education Officer
DIO	District Immunization Officer
DM	District Magistrate
DPO	District Program Officer
DPM	District Program Manager
Goi	Government of India
ICDS	Integrated Child Development Services
IEC	Information, Education and Communication
MCTS	Mother and Child Tracking System
MUD	Mop Up Day
MO	Medical Officer
MoHFW	Ministry of Health and Family Welfare
NDD	National Deworming Day
NDDCC	National Deworming Day Coordination Committee
NIPI	National Iron Plus Initiative
NNMB	National Nutrition Monitoring Bureau
NHM	National Health Mission
PHC	Primary Health Centre
RBSK	Rashtriya Bal Swasthya Karyakram
RDD	Regional Deputy Director
RPM	Regional Program Manager
SIO	State/UT Immunization Officer
SPM	State/UT Program Manager
STH	Soil Transmitted Helminths
VHND	Village Health and Nutrition Day
VHSNC	Village Health Sanitation and Nutrition Committee
WIFS	Weekly Iron Folic Acid Supplementation
WHO	World Health Organization

# GLOSSARY

**Soil Transmitted Helminths:** Soil-transmitted helminths (STH) is a sub-group within the group of helminth infections. It is caused specifically by those helminths which are transmitted through soil contaminated with faecal matter and are therefore called soil-transmitted helminths. The main species that infect people are the roundworm (*Ascaris lumbricoides*), the whipworm (*Trichuris trichiura*) and the hookworms (*Necator americanus* and *Ancylostoma duodenale*).

**Transmission:** Soil-transmitted helminths are transmitted by eggs that are passed in the faeces of infected people. Adult worms live in the intestine where they produce thousands of eggs each day. In areas that lack adequate sanitation, these eggs contaminate the soil. This can happen in several ways:

- eggs that are attached to vegetables are ingested when the vegetables are not carefully cooked, washed or peeled;
- eggs are ingested from contaminated water sources;
- eggs are ingested by children who play in soil and then put their hands in their mouths without washing them

In addition, hookworm eggs hatch in the soil, releasing larvae that mature into a form that can actively penetrate the skin. People become infected with hookworm primarily by walking barefoot on the contaminated soil. There is no direct person-to-person transmission, or infection from fresh faeces, because eggs passed in faeces need about three weeks to mature in the soil before they become infective. Since these worms do not multiply in the human host, reinfection occurs only as a result of contact with infective stages in the environment.

**Prevalence of any soil-transmitted helminth infection:** The percentage of individuals in a population infected with at least one species of soil-transmitted helminth.

**Intensity of Infections:** The number of helminths infecting an individual. In the case of soil-transmitted helminths, it can be measured directly by counting expelled worms after antihelminthic treatment or indirectly by counting helminth eggs excreted in faeces (expressed as eggs per gram or EPG). Indirect methods are less intrusive, more convenient and more commonly used.

**Endemic:** The constant presence of a disease or infectious agent within a given geographic area; it may also refer to the usual prevalence of a given disease within such area.

**Adverse Event (AE):** Any untoward medical occurrence that may present during treatment with a medicine but that does not necessarily have a causal relationship with this treatment.

**Mass Drug Administration (MDA):** The entire population of an area (example: state, district, block) in given anthelmintic drugs at regular intervals, irrespective of the individual infection status.

**Preschool-age Children:** Children between 1 and 5 years of age.

**School-age Children:** Usually defined as children between 6 and 19 years of age who may or may not be enrolled in school. The exact ages of school enrolment can vary slightly between different States/Union Territories. Because peak prevalence and intensity of soil-transmitted helminth infection occur primarily in school-age children, and because this risk population is easily accessed through schools, deworming activities are implemented through the school system.

**State:** The term 'State' implies both States and Union Territories of India in these guidelines.

**Morbidity:** Detectable and measurable consequences of a disease. Evidence of morbidity due to helminthic diseases may be overt (such as the presence of blood in the urine, anaemia, chronic pain or fatigue) or subtle (such as stunted growth, impeded school or work performance or increased susceptibility to other diseases).

**Strategy to Control STH:** The purpose of control programs is to reduce worm loads and keep them low. Children will become re-infected, but repeated treatment will ensure that, most of the time, they will have fewer worms, and this will improve their chances of growing and learning.

# INTRODUCTION AND RATIONALE

The World Health Organization (WHO) estimates that 241 million children between the ages of 1 and 14 years are at risk of parasitic intestinal worms in India, known as soil-transmitted helminths (STH). These children represent approximately 68% of children in this age-group and approximately 28% of the number of children estimated to be at-risk of STH infections globally.

These parasitic infections result from poor sanitation and hygiene conditions, and are easily transmitted among children through contact with infected soil. The consequences of chronic worm infestation in children are both widespread and debilitating. Worms can cause anaemia and under-nutrition, thereby impairing mental and physical development. Under-nutrition and anaemia in children has been well documented in India: almost 7 in 10 children in the 6-59 months age-group are anaemic, with even higher rates of anaemia in rural areas. Nearly half of children under-five in India are stunted, and approximately 43% are underweight and the prevalence of anaemia in girls and boys of the age group 15-19 years is 56% and 30% respectively<sup>1</sup>. Children with the highest intensity of STH infestation are often too sick or too tired to concentrate at school or attend school at all. Subsequent life outcomes for these children are also considerably impacted due to lower lifetime incomes<sup>2</sup>.

In areas where parasitic worms are endemic, administering safe, effective deworming drugs to children at schools is a development “best buy” due to its impact on educational and economic outcomes and low cost. The evidence shows that mass deworming leads to significant improvement in outcomes related to education, career choice, earnings, and long-term well-being. Rigorous research has shown significant gains from school-based deworming programs on children’s health, access to education and livelihoods<sup>3</sup>.



Photo credit: Evidence Action

In 2009, the Government of India<sup>4</sup> recommended States/UTs to conduct mass deworming based on State-specific STH prevalence. The guidelines also recommend integrating biannual deworming with the Vitamin–A Prophylaxis program for under-five children. Other Government programs launched in recent years like National Iron Plus Initiative (including Weekly Iron and Folic Acid Supplementation for adolescents) mandates biannual deworming for children and adolescents under the age group of 1-19 years.

**Treatment Frequency:** As per WHO<sup>5</sup>, India is endemic for STH. The Government of India is renewing its focus on all components of deworming including mapping of State/UT wise STH prevalence.

Currently, there is insufficient National/Regional level data for estimating the prevalence of worm infestations in India, other than some Statewide prevalence surveys done by external agencies (like Evidence Action - Deworm the World Initiative) in partnership with the State governments (Bihar, Delhi, Madhya Pradesh, Uttar Pradesh and Rajasthan) and National Institute of Cholera and Enteric Diseases (NICED), National Center for Disease Control (NCDC), National Institute of Epidemiology (NIE), All India Institute of Medical Sciences (AIIMS), Post Graduate Institute of Medical Education and Research (PGIMER)-Chandigarh etc. for school-age children. The currently available data from few stand alone studies and independent State surveys shows significant level of STH prevalence. Moreover, none of the current national or sub-national surveys like National Family Health Survey (NFHS), District Level Household Survey (DLHS), Annual Health Survey (AHS), National Nutrition Monitoring Bureau (NNMB) captures this information. In view of the above, the Ministry of Health and Family Welfare MoHFW has initiated STH mapping in areas that do not have comprehensive/recent data which is led by the National Centre for Disease Control, New Delhi in collaboration with regional technical institutes, WHO and Evidence Action.

1 National Family Health Survey - 3; 2005-2006

2 WHO 2012: Eliminating soil-transmitted helminthiasis as a public health problem in children soil-transmitted helminthiasis progress report 2001-2010

3 Deworming-Millennium development Goals, [http://whqlibdoc.who.int/hq/2005/WHO\\_CDS\\_CPE\\_PVC\\_2005.12.pdf](http://whqlibdoc.who.int/hq/2005/WHO_CDS_CPE_PVC_2005.12.pdf)

4 Government of India. MoHFW, Recommendations of the Technical Committee on deworming; 2009 May. Letter No. D.O.No. Z-28020/77/2006-CH(Part)

5 WHO 2010. Soil-transmitted helminthiasis: eliminating soil-transmitted helminthiasis as a public health problem in children: progress report 2001-2010 and strategic plan 2011-2020

The mapping will collect STH prevalence and intensity data to develop statewide estimates of STH infections, and this will guide the decision on the frequency of deworming treatment, as per WHO guidelines. Currently states which have STH prevalence data available can decide the frequency accordingly and other states which do not have the data should continue with one round of deworming.

There is a key gap between existing programs and the coverage needed for STH treatment in India, much of which can be filled by the development of high quality school and anganwadi-based deworming program designed to reach preschool and school-age children at scale. Consistent implementation of a high quality nationally mandated school-and-anganwadi-based deworming program to reach children at scale will dramatically reduce the ill-effects caused by STH on millions of children in India in a cost-effective, simple and safe manner.

The school and anganwadi-based deworming program approach for mass deworming provides an easy way to reach large numbers of target-age group children, through existing infrastructure rather than creating new channels of distribution.

## ABOUT NATIONAL DEWORMING DAY

In February 2015, the MoHFW, Government of India launched the National Deworming Day (NDD) as part of National Health Mission in 11 states/UT, including Assam, Bihar, Chhattisgarh, Dadra and Nagar Haveli, Haryana, Karnataka, Maharashtra, Madhya Pradesh, Rajasthan, Tamil Nadu, and Tripura. The NDD has emerged as the world largest public health campaign for treatment of intestinal parasitic worms. After the unprecedented coverage of NDD with national level coverage of 89 million children, the MoHFW mandated the observation of the NDD at pan-India level from February 2016.

A fixed NDD approach has the potential to ensure maximum coverage with optimal utilization of resources, by leveraging existing programs and infrastructure. A fixed single day approach will:

- Motivate States/UTs to prioritize deworming within current ICDS and school health programs
- Increase public awareness around deworming with standardized campaign messages across the country
- Increase coverage of target beneficiaries (preschool and schoolage children)
- Establish structures to easily track and respond to any cases of adverse events
- Ensure quality and consistency of coverage reporting

With an aim to intensify efforts towards STH control among children in India, the **Ministry of Health and Family Welfare, Government of India has decided to observe NDD on February 10, 2016** in all 36 States/ UTs of the country. The NDD will be followed by a **mop-up day (MUD) on February 15, 2016** with the intent of deworming children who missed the dose on February 10. **All schools and anganwadi centers will be the implementation sites of NDD across the country.**

With high enrolment of children in private schools (29% as per ASER 2014 report), the NDD is committed to reaching out to these children to ensure they too have access to deworming drug and receive benefits for improved health and education outcomes. All States/UT governments are encouraged to include private schools in the planning and implementation of the NDD. Similar IEC and training materials as for government and government aided schools, will be made available to private schools providing deworming treatments. The training and distribution cascade at district, block and levels below will follow the similar channels as for other schools. The respective District Magistrates/ Collectors will lead coordination with the stakeholder departments and Private school associations in the districts for effective implementation of NDD and maximum coverage of children attending private schools.



Photo credit: Esther Haven, Evidence Action

States/UTs that have Lymphatic Filariasis (LF) endemic Districts are encouraged to integrate mass drug administration with anganwadi and school-based mass deworming efforts in order to utilize the resources effectively. States may exclude the identified LF endemic Districts for school and anganwadi-based NDD provided the last round of MDA for LF was conducted in past five months.

Integrated implementation with other school health components like health and hygiene education, mid-day meal etc. should be explored to compliment NDD. Integrated programs contribute to increased coverage and better program outreach.

Long term interventions to minimize STH transmission include improvement in water and sanitation and behaviour change in children of schools and anganwadi centers and community at large through skill-based hygiene education focusing on the use of toilet, encouraging children to wear shoes/chappals; washing hands with soap before eating and after using toilet and clean water supply<sup>6</sup>. All States/UTs are encouraged to identify synergies between NDD and Swacch Bharat Abhiyaan. This could include exploring available platforms and leveraging messages for cross-program strengthening.

## OBJECTIVE OF NATIONAL DEWORMING DAY

The objective of NDD is to deworm all preschool and school-age children between the ages of 1-19 years through the platform of schools and anganwadi centers in order to improve their overall health, nutritional status, access to education and quality of life.

## TARGET BENEFICIARIES

- All children in the age group of 1-19 years.
- The target age group includes:
  - Children enrolled in all government and government-aided schools
  - Children enrolled in private schools
  - Children registered at anganwadi centers
  - Unregistered and out-of-school children in anganwadis and schools, respectively

## KEY STAKEHOLDERS

The Ministry of Health and Family Welfare, Government of India will be the nodal agency for providing all States/UTs with guidelines related to NDD implementation at all levels along with NDD toolkit which will include materials for training, community mobilization and awareness generation, reporting formats and monitoring checklists, guidelines on financial and budgetary provisions and Adverse Event Management protocols. The specific roles and responsibilities of the key stakeholders are defined and not limited to the following.

- **Department of Health and Family Welfare** has the following responsibilities:
  - Lead NDD Coordination Committee meetings at all levels which will have representation from all concerned stakeholders/departments
  - Ensure procurement, transportation and distribution of Albendazole tablets to all schools and anganwadis centers with support from Department of School Education and Literacy and Women and Child Development Department
  - Provision for Master Trainers to further train trainees/functionaries from Education and Women and Child Development Department at the State and District level and provisioning for training of health functionaries (ASHAs, ANMs)

6 WHO, June 2013, Monitoring and Evaluation Guidance for School Health Program: Thematic Indicators.

- Disseminate Adverse Event Management Protocol at all levels starting from State to school and anganwadi centre level
  - Develop and provide financial guidelines and budgets to various levels for effective implementation
  - Develop IEC strategies and materials and provide budgetary allocations for their printing and dissemination
  - Ensure presence of ASHA workers at anganwadi centres on NDD and MUD to support deworming of out-of-school and unregistered children
  - Ensure community mobilization, mobilize beneficiaries especially out-of-school children and adolescents through ASHAs
  - Develop and print reporting formats for implementing departments, i.e. Education and Women and Child Development Department
  - Monitor program progress in the field and ensure timely reporting of coverage data
- **Department of School Education and Literacy** has the following responsibilities:
    - Coordinate with Department of Health and Family Welfare in effective roll-out of NDD in all schools
    - Place requisite indent for Albendazole tablet supply to the Department of Health and Family Welfare based on school enrollment and out-of-school children
    - Train teachers to administer deworming drugs at schools in convergence with Department of Health and Family Welfare and briefing them on possible adverse events and their management
    - Dissemination of IEC material to all schools, including community mobilization through School Management Committees
    - Encourage schools to conduct other community mobilization activities through school assembly, health and sanitation days, interaction with parents and community members
    - Departmental officials to undertake field monitoring visits for assessing program implementation and supportive supervision
    - Report coverage data to the Department of Health and Family Welfare in standardized reporting formats within specified timelines in the cascade
  - **Department of Women and Child Development (Integrated Child Development Services Scheme)** has the following responsibilities:
    - Ensure community mobilization, especially of out-of-school and un-registered children and adolescents through Anganwadi Workers (AWWs)
    - Coordinate with Department of Health and Family Welfare in effective roll-out of NDD
    - Place requisite indent for Albendazole tablet supply to the Department of Health and Family Welfare based on anganwadi centre survey figures of registered and out-of-school school-age children
    - Using the platform of monthly meetings, orient Lady Supervisors (LS) and AWWs to administer deworming drug at anganwadi centre and briefing them on possible adverse events and their management
    - Dissemination of IEC material to all anganwadi centres
    - Departmental officials to undertake field visits for monitoring and supportive supervision
    - Report coverage data to the Department of Health and Family Welfare in standardized formats within specified timelines

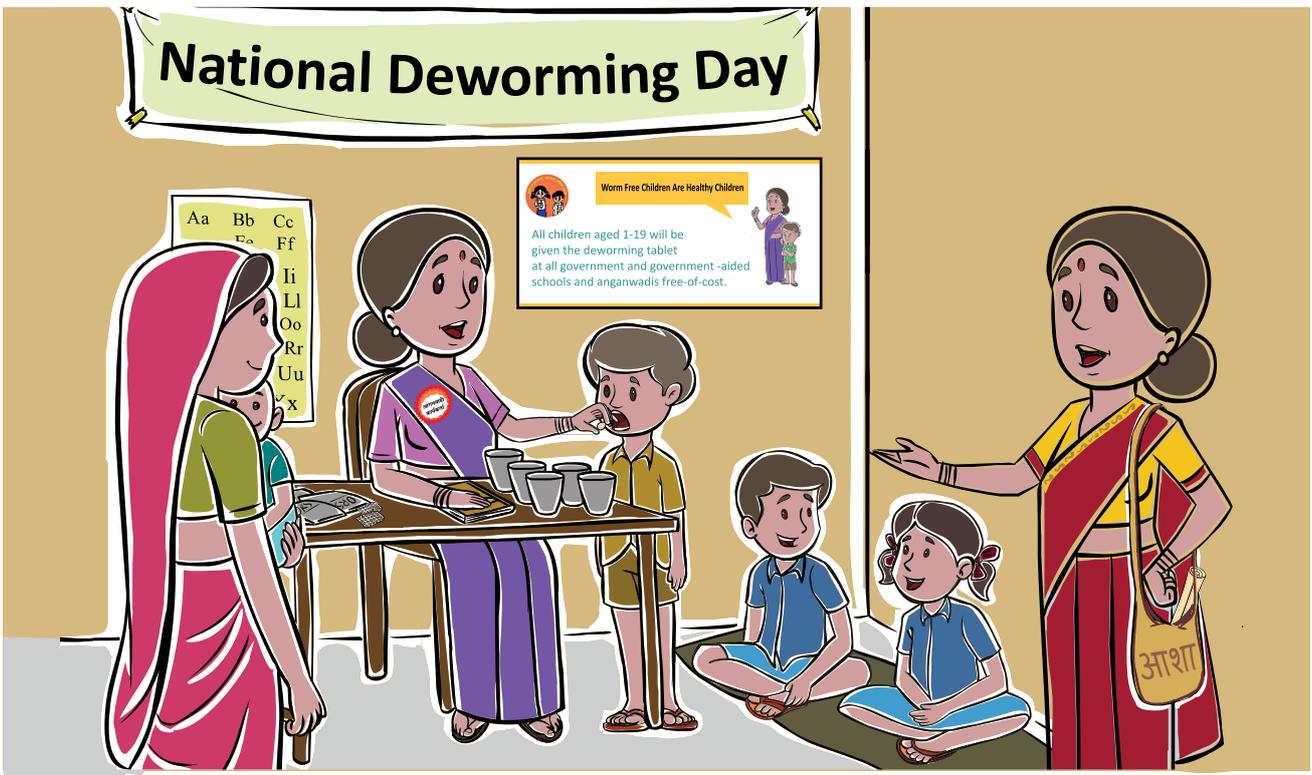
- **Deworm the World Initiative at Evidence Action** is the Technical Assistance partner to MoHFW, Government of India. The specific responsibilities are as follows:
  - Support in development of NDD implementation strategy
  - Design and develop training and reference materials, community mobilization strategies for increased awareness and coverage of target beneficiaries, Monitoring and Evaluation (M&E) systems and reporting formats
  - Conduct coverage validation and independent monitoring
  - Support in analysis of program monitoring and coverage data to inform program improvements
- **Other key stakeholders** are Ministry of Panchayati Raj, Ministry of Tribal Affairs, Ministry of Rural Development, Ministry of Urban Development, Ministry of Drinking Water and Sanitation and Urban Local Bodies (ULBs). Department of Health and Family Welfare shall seek necessary support from all these stakeholder departments for extending deworming program to all preschool and school-age children in all the States/UTs.

## INVOLVEMENT OF DEVELOPMENT PARTNERS UNDER RMNCH+A STRATEGY

- Development partners working at different levels in the country should actively contribute in NDD Coordination Committees at National, State, District and Block level.
- Development partners will actively converge with State and District Health Missions to support them in effective implementation of NDD strategy by engaging the State, District and Block level coordinators of State RMNCH+A Unit (SRU).
- Proposed activities for their engagement are:
  - Facilitating State and District level launch of NDD through State and District Health Mission respectively
  - Ensuring quality implementation of proposed training cascade at all levels and orienting various stakeholders/functionaries at different levels about NDD implementation
  - Contributing to program quality by undertaking monitoring visits to the field on National Deworming Day and Mop-Up Day
  - Supporting State and District Health Mission in development and adaptation of IEC prototypes as per specific language/context requirement
  - Ensuring program implementation in hard to reach and marginalized areas

## NATIONAL DEWORMING DAY: IMPLEMENTATION APPROACH

NDD will be observed on February 10 every year across all 36 States/UTs. This will be followed by a Mop-Up Day on February 15, with the intent of deworming children who were absent or missed taking the Albendazole tablet on NDD. Most of the efforts to ensure high **coverage of children on deworming days occur in advance of the deworming day itself. States will need to plan ahead and initiate the process of preparatory activities as per the timelines.**



# STEPS OF DEWORMING

Effective school and anganwadi-based deworming programs are typically comprised of below mentioned steps.

Figure 2: Steps of deworming



The approach for rolling out the steps of deworming alongside NDD are explained in Preparatory and Implementation activities below.

## PREPARATORY ACTIVITIES

- Establishment of National level, State level and District level Coordination Committees
- Orientation and capacity building of stakeholders and providers
- Procurement of Albendazole tablets and its supply chain management
- Adaptation of the IEC materials shared by Government of India and contextualize as per local needs
- Printing of monitoring and reporting formats
- Conduct community mobilization and awareness activities
- Planning for monitoring activities and developing plan for analyses of monitoring report

## IMPLEMENTATION PLANNING AND PROGRAM MANAGEMENT

Establish NDD Coordination Committee

### National Level Coordination Committee (Constitution and Scope of Work)

The MoHFW is the nodal ministry for implementation of NDD. Other members of the committee will include representatives from Ministry of Human Resource and Development (Department of School Education and Literacy), Ministry of Women and Child Development (ICDS), Ministry of Panchayati Raj, Ministry of Drinking Water and Sanitation and other development partners as appropriate. **A National Level Coordination Committee** under the chairmanship of MoHFW is responsible for policy formulation, technical support, planning of the NDD including the allocation of resources for procurement and supply of Albendazole tablets, providing prototypes of resource material for training, IEC/BCC, establishing monitoring systems and reviewing progress on program preparedness. The Committee will monitor effective implementation of NDD across all 36 States and UTs. A similar structure is to be established at State and District level.

## State level Coordination Committee (Constitution and Scope of Work)

At State level, Deworming Day Coordination Committee be constituted under the Chairmanship of Secretary Health and Mission Director-NHM, Director-ICDS, Director-School Education, Director-PRI, Director – Water and Sanitation, Nodal Officer – LF program, State-level representatives of private school unions in the State and representative from Rural Development, Tribal Welfare, Urban Local Bodies, Urban Development Department including Nodal Officers for Child Health, Adolescent Health, NIPI, IEC Division, ASHA Program, Training Division, Procurement Wing and development partners working in the field of child health and nutrition may be nominated as members. States already having functional coordination committees for programs like WIFS and NIPI may include NDD as an agenda item to these committee meetings. The function of the committee will be to monitor the progress of NDD activities and resolve program related issues and gaps at the State level and provide guidance to Districts for effective implementation.

### The Committee will monitor the following:

- Ensure necessary budgetary provisions are made in State PIPs and supplementary PIPs every year.
- Provide a platform for convergence between Department of Health, Department of Education and Women and Child Development (ICDS) and other departments at State level and guide Districts for the same.
- Formulate strategy for extending deworming program to children attending private schools, residential schools under Tribal Welfare Department, schools under Urban Local Bodies and children of migrant population in certain areas.
- Support Districts in translation to local language and transportation of IEC material, reporting forms, Adverse Event Protocol and training handouts to block-level trainings as appropriate.
- Ensure timely allocation of resources for procurement and transportation of Albendazole tablets to Districts for timely distribution and other resource material during Block-level trainings across all Districts. States must ensure integrated distribution of Albendazole tablets and IEC materials at the training sites
- Ensure issuance of joint directives from the Department of Health, Department of Education, and Department of Women and Child Development (ICDS) at State-level for NDD implementation and interdepartmental convergence at all levels
- Ensure issuance of an advisory note on Adverse Event Management closer to the NDD
- Monitoring and quality assurance of training of Education and ICDS functionaries at District and Block level.
- Coordinate with Districts for provisioning and use of Adverse Event Protocol and IEC materials.
- Monitor status of implementation of NDD through field monitoring visits by State teams/officials.
- Follow up with Districts and Blocks for timely submission of reports and coverage data.

## District Level Coordination Committee (Constitution and Scope of Work)

A District Level Coordination Committee should be led by District Magistrate and Civil Surgeon/CMHOs, District Education Officer (DEO), District ICDS Program Manager (PO-ICDS), representative of private school union at District-level representatives from other departments like District PRI Officer (DPRO), Superintendent Engineer (Dept. Water Supply) etc. and development partners as members. The function of the committee will be to implement and monitor the progress of NDD, resolve programmatic issues and fill gaps at District level and provide guidelines to Blocks for effective implementation.

### The committee will undertake following responsibilities:

- Facilitate inter-departmental convergence and ensure use of community based platforms like VHNDs, VHSNC meetings, Gram Panchayats for community mobilization and mass awareness.
- Ensure implementation of NDD in all schools and anganwadi centers
- Timely printing and transportation of IEC material, reporting forms, Adverse Event Protocol and training handouts for integrated distribution during Block/project-level trainings/orientation sessions.
- Ensure timely and adequate procurement and transportation of Albendazole tablets to Block level training sites for integrated distribution during Block level trainings or as per the plan devised by State for drug delivery.
- Train/orient teachers, principals, AWWs, ANMs and ASHA workers.
- Provide for and use of Adverse Event Management Protocol and community awareness materials.
- Assess implementation status of the NDD through monitoring visits by District teams / officials.
- Ensure timely submission of reports and collation of coverage data.

### Block Level Coordination Committee (Constitution and Scope of Work):

At Block level, Coordination Committee should be constituted under the chairpersonship of Sub-Divisional Magistrate (SDM) / Block Development Officer (BDO) and Block Medical Officer (BMO), Block Education Officer (BEO), Child Development Project Officer (CDPO-ICDS) and representatives from private schools and from other departments like Panchayati Raj (PRI) and Water and Sanitation as members. The Block level committee would ensure effective implementation of NDD and be actively involved in monitoring of intervention during the NDD in schools and anganwadi centers by constituting monitoring teams. The committee will also ensure data flow from schools and anganwadi centers to the District level.

### The committee will undertake following responsibilities:

- Facilitate inter-departmental convergence and ensure use of community based platforms like VHNDs, VHSNC meetings, Gram Panchayats for community mobilization and mass awareness.
- Ensure timely supply of Albendazole, reporting formats, IEC materials etc. to each school and anganwadi centers either for integrated distribution during Block level trainings or as per the plan devised by State for drug delivery.
- Train/orient teachers, principals, AWWs, ANMs and ASHA workers.
- Assess implementation status of the NDD through monitoring visits by Block teams/officials.
- Ensure timely submission of reports and collation of coverage data from schools and anganwadi centers.

# TRAINING AND DISTRIBUTION CASCADE

Orientation and Capacity Building of stakeholders:

Level	Participants	Contents of Orientation / Training*	Latest by dates
<b>National Level</b>	State Program Managers, Nodal Officers for deworming program, Consultants	<ul style="list-style-type: none"> <li>• Technical information on STH and Deworming</li> <li>• Program Management at State level</li> <li>• Program coordination with MoHFW</li> </ul>	December 1, 2015
<b>State Level</b>	RDD, NHM Consultants on nutrition, child health, data and monitoring, SPM, and officials from AYUSH, Education, ICDS, Rural Development, Urban Development, Water and Sanitation, PRI, Tribal Welfare Department and representatives from partner agencies	<ul style="list-style-type: none"> <li>• Technical information on STH and Deworming</li> <li>• Program Management</li> <li>• Adverse Event Management System</li> <li>• Monitoring</li> <li>• Logistics and Supply Chain Management</li> </ul>	December 4-9, 2015
<b>District or Regional Level</b>	CS/CMHOs, RPM, DPM, NHM Consultants, DPO and other officials from Education Department, ICDS and representatives from partner agencies  Orientation: BPO / MOs / BCM / BHM / MO – CHC/ PHC / AYUSH Doctors / BEO/ BRP, CDPO and other officials from Education Department, ICDS and representatives from partner agencies		December 28-31, 2015
<b>Block / PHC Level</b>	<b>Capacity Building:</b> AYUSH team, ANM, ASHA*, school principals/ teachers and ICDS functionaries	<ul style="list-style-type: none"> <li>• Technical orientation on deworming intervention</li> <li>• Drug administration process</li> <li>• Adverse Event Management System</li> <li>• Reporting</li> <li>• Logistics and Supply Chain Management</li> </ul>	January 15, 2016
<b>Project Level</b>	All Lady Supervisors (LS)		
<b>Sector Level</b>	All Anganwadi Workers (AWWs)		

- Template, prototypes, training manual and IEC material will be provided by MoHFW, GoI
- ASHAs will be oriented during their monthly review meetings at Block / cluster level as appropriate (Please refer to the timelines attached as annexure for further details)

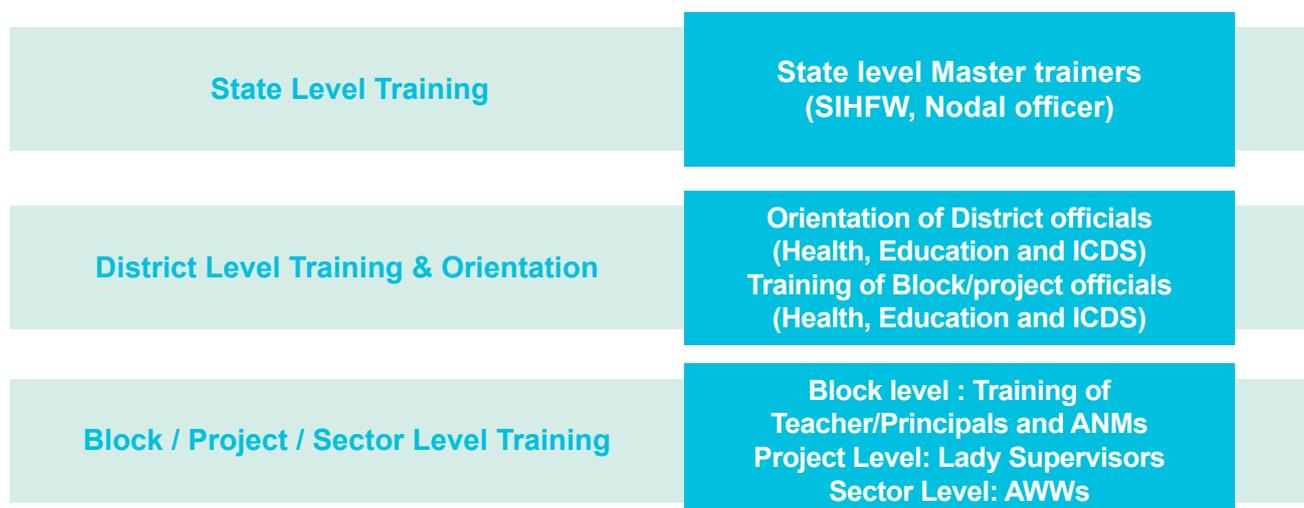
The table above presents an overview of orientation cum capacity building at various levels. At the National level, MoHFW will organise a NDD orientation workshop on 1 December, 2015 for Nodal officers from all 36 States/UTs to orient them on the implementation framework of NDD, related technical aspects and State level program management guidance.

In the State,

- School teachers/principals will be trained to administer Albendazole tablets to school enrolled children in the age group 6-19 years in all schools
- AWWs will be trained to administer Albendazole tablets to preschool-age children in the age group 1-5 years and out-of-school children and adolescents
- ASHAs will be oriented to conduct community mobilization activities.

In order to ensure that the teachers and AWWs are equipped to confidently and safely administer deworming tablets, the Health Department in coordination with Department of Education and WCD will facilitate a training cascade starting at the State level, where a pool of master trainers will be identified through nodal training institutions of State governments like State Institute of Health and Family Welfare (SIHFW) and will be trained on deworming. These master trainers will travel to Districts and train District and Block level personnel (Health, Education and ICDS). The Block level functionaries of Education Department will further train teachers/principals from schools at the Block who will administer/ support Albendazole administration at schools. Similarly the Block/project level functionaries of WCD Department will orient their respective LS in their project level monthly meetings. All trained LS will further train AWWs during their sector level meetings to administer deworming drug. ASHAs will be oriented during their monthly review meetings at Block/cluster level as appropriate for community mobilization and reporting.

Figure 3: Training Cascade



Knowledge about deworming and safe administration practices is disseminated efficiently across many functionaries through this process.

**Orientation Cum Capacity Building:** Functionaries from Health, Education and ICDS across levels will be provided training and resource material to help build skill sets to effectively implement and monitor the program. The resource material will focus on technical aspects of deworming, its health, nutrition and education outcomes like improving school attendance, deworming drug administration process, logistic and supply management of drugs, and actions to be taken in case of any adverse events.

For teacher/principal and AWW level training, emphasis will be on reasons for and benefits of deworming, mobilizing parents to send children for deworming, how to administer Albendazole properly, do's and don'ts of drug administration, management of adverse events if any, and adherence to guidelines for reporting and coverage data submission.

ASHAs will be oriented on her key role in awareness generation on benefits of deworming and mobilizing children, especially out-of-school children to the nearest anganwadi centers on NDD and MUD.

**Training Reinforcement through Bulk SMS:** In order to disseminate training scheduled effectively at all levels of the cascade, Department of Health will make provisions for sending out SMS in bulk to program functionaries of Health, Education and WCD Department in addition to teachers/principals and AWWs. Department of Health will also send SMS to reinforce key messages related to drug administration, training and reporting timelines. States/UTs are encouraged to involve use of MCTS for mass awareness.

- Duration for Orientation/Training Session: Half day session
- Training Material: GoI will provide package of materials and guidelines on its usage for different levels of the cascade. (Soft copy uploaded on the website [www.nrhm.gov.in](http://www.nrhm.gov.in)).
- NDD Kit: A NDD kit for principals/teachers and AWWs will also be distributed during Block level trainings. It will consist of drugs, IEC materials for schools and anganwadi centers, reporting formats(including Adverse Events reporting forms), training handouts which will include adverse event management guidance (to ensure timely availability of materials/ information with the schools/ Anganwadis, training handouts has a perforated school / anganwadi reporting form inbuilt in the handout).
- Integrating Drug Distribution with Trainings: At the terminal level of training cascade, school principals/teachers and AWWs will be provided with NDD kit and also the required quantity of Albendazole 400 mg tablets for conducting NDD and MUD at respective schools and anganwadi centers.

## DRUG PROCUREMENT AND MANAGEMENT

### Determining Drug Requirements:

- State will calculate the need for Albendazole tablets as 1 Albendazole tablet per child along with 10% buffer stock (buffer stock will include spoilage and wastage factor). Thus, a District of average 20 lakh population will require approximately 8.4 lakh Albendazole tablets for one round of deworming in all children in 1-19 years age group. In case sufficient stocks are not available, the District may contact State or undertake decentralized procurement after taking necessary permission from the State.

**The program aims to cover all children in 1-19 age group, which is 42% of the total population of a District/State (8% in the age group of 1-5 years + 12% in the age group 5-10 years + 22% in the age group 10-19 years). Assuming a District of average 20 lakh population, the program will reach out to approximately 8.4 lakh beneficiaries per District.**

### **Estimation of Albendazole tablets (400mg) for one deworming round:**

**(1 x number of children in the age group 1-19 enrolled/registered in government and government-aided schools and anganwadi centers) + (1 x number of children in the age group 1-19 years unregistered and out-of-school children in anganwadi centres) + (1 x number of children in the age group 6-19 years enrolled in private schools) + 10% of total requirement as buffer (for wastage and spoilage)**

- Schools and anganwadi centers will provide the drug requirement to the ANMs of the respective area.
- ANM will collect the indent for both enrolled and out-of-school children and share the school and anganwadi center wise requirement with the Medical Officer-BPHC.
- Procurement of tablets will be ensured by State health department. Supply chain management of tablets till all school and anganwadi centers will be done in coordination with Education and Women and Child Development Department. Supplies will be provided to schools and anganwadis along with a 10% buffer stock for wastage and spoilage.
- The State Health and Family Welfare Department will procure required Albendazole tablets and will supply the stock as per the requirements to the respective District Health Officers.

## Logistic and Supply Chain Management (Drugs and other supplies)

Ensuring sufficient availability of required amount of drugs and supplies is critical to the success of the NDD. In this regard the supplies required are:



Photo credit: Esther Haven, Evidence Action

- Sufficient stock of Albendazole tablets (based on the school and anganwadi enrolment/registration data) with 10% buffer stock for wastage and spoilage.
- The District Civil Surgeon/ Chief Medical Health Officer will ensure transportation of drugs from District to Block (Health Nodal Officer). At the Block level MO-PHC will ensure transfer of drug to the BEO and the Child Development Project Officer (CDPO). BEO and CDPO will further ensure availability of drugs for distribution at the Block level training and project level monthly meeting respectively.
- For schools, final distribution of drugs and NDD kit (IEC material + reporting formats and other relevant materials) shall be made to school principal/teachers at the time of training at Block level.
- For anganwadi centers, subsequent distribution of drugs and NDD kit shall be made to LS during their monthly meetings. LS in turn will do the final distribution of drugs and NDD kit to AWWs in their monthly meeting at sector level.

- Drugs at all levels shall be stored in a cool, dry place. Tablets should be protected from direct sun light.
- Sufficient number of glasses and clean drinking water must be arranged from the kitchen of the school and anganwadi.
- Sufficient stock of reporting forms available for different levels of the cascade.
- Ensuring availability of handouts for principal/teacher and Anganwadi Worker (AWW) that includes guidance on Adverse Event Management Protocol at the school and anganwadi level, including key telephone numbers of officials to be contacted in case of any adverse events.

## COMMUNITY AWARENESS AND MOBILIZATION

- **Awareness Activities:** The role of awareness generation, community sensitization and mobilization efforts are crucial for achieving high coverage. With NDD occurring on the same day across the country, the State Governments will implement locally relevant and contextualized versions of the IEC material and messages from the IEC resource toolkit shared by the MoHFW, Government of India.
- **Key Messages:** The state must ensure that all IEC activities include simple and easy to understand information on the benefits of deworming and the treatment by administering Albendazole at anganwadis and schools to all children. Awareness generation and community mobilization activities aimed to motivate parents to bring their children for treatment to the nearest school or

anganwadi center must be conducted for maximum coverage on NDD. Messaging should include that children who could not be treated on NDD, must be dewormed on MUD.

- **Media Mix:** Each state should select the most appropriate options from the National Government's recommended media mix, which is most effective in the local context. State Governments should use a mix of media, including mass media and mid-media with a combination of print (newspaper, poster, and banners), audio (radio, miking, and announcements), video (TV spot and scrolls, cable TV) channels. In addition, need-based community-centric material with targeted messages such as handbills, wall writings, rallies, street theatre, and community meetings/talks may be explored. A handout for ASHAs focusing on her role and responsibilities towards community mobilization is also available in the resources toolkit. ASHAs will share benefits of deworming and mobilize community members through local platforms such as gram panchayats and VHSNC meetings to ensure greater coverage. They will also play a key role in mobilizing out-of-school children for NDD. School Management Committees and AWWs should actively support the community-based activities in their respective catchment areas.
- **Integrated distribution of IEC material during trainings:** All principals/teachers and AWWs attending Block/sector-level trainings/orientation on NDD implementation will receive necessary IEC material to be used at school and anganwadi centres. The material will consist of poster, banners, handbills and others. The open files of all material prepared at the national level is uploaded on NHM website {[www.nrhm.gov.in](http://www.nrhm.gov.in)} for States to use for translations and local adaptations.
- **Targeted outreach:** Activities for community mobilization will be organized through School Management Committees, prabhat pheris, bal panchayats, and other forums for dissemination of messages on the benefits of deworming. In school sensitization drives, principals will address children during the morning assemblies, through classroom messaging, and reach parents during parent-teacher meetings and other such forums.
- **SMS Connect:** The State/UT health department will send out targeted messages via SMS to concerned functionaries at all levels at optimal frequency to reinforce important program information, including reminders about critical dates. Bulk SMS platforms already available with stakeholder departments will be explored for the same, such as use of Mother and Child Tracking System (MCTS) for mass awareness.
- **Call Centre/Helpline:** State/UT health department may utilize existing helpline numbers for other schemes related to child health to resolve and address queries identified by program functionaries at different levels. States/UTs are encouraged to explore use of existing mechanism like 108/104/ National Ambulance Services.
- **Village Level Mobilization:** ASHAs will conduct village meetings with parents and community members and disseminate information about harmful effects of worm infestation, benefits of deworming, and behavior change practices to reduce re-infection to beneficiaries. Other village based functionaries such as AWW and PRI workers will also be engaged for community mobilization.

**Inter-departmental convergence:** Convergence between the Department of Health and Family Welfare, Department of School Education and Literacy, Department of Women and Child Development (ICDS) and other stakeholders, is critical for high quality implementation of NDD.

The recommended roles and responsibilities of each department to enhance inter-departmental convergence for IEC activities is outlined below.

Department of Health and Family Welfare	Department of School Education and Literacy	Department of Women and Child Development (ICDS)	Other Stakeholders
Develop IEC strategies and materials	Disseminate IEC material to all schools	Disseminate IEC materials to all anganwadi centres	Key departments to seek support from Ministry of Panchayati Raj, Ministry of Tribal Affairs, Ministry of Rural Development, Ministry of Urban Development, Ministry of Drinking Water and Sanitation and Urban Local Bodies to extend NDD program benefits to all children
Provide budget	Ensure appropriate usage, display of IEC materials of schools	Ensuring appropriate usage, display of IEC materials at anganwadi centres	
Mobilize out-of school children (ASHAs)	Provide IEC material and trainings to equip teachers to raise awareness in communities	Provide IEC material and trainings to equip AWWs to raise awareness in communities	
Mobilize out-of-school children (ASHAs)	Build capacity of teachers for adverse event management	Build capacity of AWWs for adverse event management	
Mobilize out-of-school children (ASHAs)	Community mobilisation through School Management Committees, school assemblies, prabhat pheri etc		

**Effective Dissemination and Display of IEC Material:** In order to ensure that the IEC material leads to improved awareness and increased mobilization, it is critical that all material is disseminated and displayed effectively. All print material should be displayed in well-lit, open, and uncluttered areas where maximum footfall of the target audience is expected. Posters should be placed at eye-level and banners/hoardings should be placed at a height where it is not obstructed by trees, poles, buildings etc. IEC such as TV spots, scrolls, and radio spots should be aided during prime time and on channels that are locally relevant. Local community mobilization activities such as rallies, meetings, and street theatres should be held in public areas such as market places at a time when maximum community members can attend/participate.

# IMPLEMENTATION OF NATIONAL DEWORMING DAY

- Drug Administration at the school and anganwadi center
- Adverse Event Management system
- Monitoring and supervision plan
- Recording and reporting process

## Drug Administration at the school and anganwadi center

Table 1: Age specific dose for Albendazole tablets

Age group	Dosage (Albendazole 400 mg tablet)	Administration
1 – 2 years 2 – 19 years	Half tablet Full tablet	<ul style="list-style-type: none"> <li>• Drug administration must be done under supervision by teacher/AWW</li> <li>• During intake, children should chew the tablet and if required should consume some water.</li> <li>• Clean drinking-water should be available at the school/anganwadi centre on deworming day.</li> <li>• For young children the tablet should be broken and crushed (between two spoons) and then administered with water.</li> </ul>

### At school and anganwadi centres on NDD:

- Set up a counter in a clean area with table and chair
- Clean drinking water with glasses (to be arranged from school/anganwadi kitchen)
- Recording and reporting formats (marking must be done on the class attendance register/anganwadi register)
- Phone numbers readily available of the nearest PHC, Medical Officer-Block PHC, ANM for seeking necessary support for managing any adverse events
- Drug administration to children must be under supervision of teachers/principal at school and anganwadi worker at anganwadi centre. Children should not be allowed to take the medicine home

### Drug Administration:

- The teachers will administer the Albendazole tablets to the school enrolled children.
- The AWW will administer Albendazole tablets to the under-five registered and unregistered children, out-of-school children.
- Important: Children who are sick or are on medication on NDD/MUD should not be given the tablet. These children should be advised to take Albendazole tablet upon recovery or after consultation with the medical doctor.
- Teachers, AWWs and ASHAs should ensure that the children properly chew the tablet and if required, should be given clean drinking water.
- Teachers and AWWs should ask the children to wait in the school/anganwadi premises for at least 2 hours after consuming the Albendazole tablet so that in case of any symptoms of adverse events, immediate action may be taken.
- Teachers will record the administration of Albendazole tablets for enrolled children in the class registers, compile, and report the coverage data for the class to the principal.
- Similarly AWWs will record the administration of Albendazole tablets to registered children and out-of-school children in the registers, and then compile and report the coverage data in anganwadi reporting forms. ASHA, while being present at the anganwadi centre, will separately

record the details of out-of-school children as per the standard recording format and will submit it to the ANM (for receiving incentive).

- The principal at the school and the AWW at the anganwadi centre will be responsible for compiling and entering the total number of children dewormed in prescribed reporting formats.
- The ANMs of the area will collect the reports from schools and anganwadis under her area of supervision as per the stipulated timeline.
- All the remaining Albendazole tablets will be stored safely after drug administration. After MUD, schools and anganwadi centres will return the remaining stock of Albendazole tablets to the ANM when she comes to collect the coverage reports.

### Adverse Event Management System

- In case of any reported adverse events, the child should be managed as per protocol. Reporting of any adverse events should be done using Adverse Event standard reporting form (please refer to annexures).
- State health department to adapt Adverse Event protocol in local language and disseminate further to blocks level officials and others for effective adverse event management.
- Schools and anganwadi must have emergency helpline numbers and contact numbers of nearest MO-PHC/ANM (List of contact numbers preferably stuck/fixd on the entrance door or wall).
- The MO-PHC should ensure that the medicines that are mentioned in the Adverse Event Management Protocol (see Annexure) should be available in the health center on Deworming Day and MUD. MO-PHC must ensure functional referral services ready with them for any prompt actions required on NDD and MUD.



Photo credit: Evidence Action

## MONITORING AND SUPERVISION PLAN

Monitoring and supervision are essential management tools which will help ensure that the NDD is being implemented as planned and to assess whether desired results are being achieved. Specific monitoring and supervision guidelines are as follows:

- Designated teams from the MoHFW, GoI will monitor NDD activities by randomly visiting schools and anganwadi centres across all States/UTs.
- Similarly, States/UTs, Districts and Blocks will also designate teams/officials for field monitoring on the NDD and MUD. States/UTs and Districts will be provided with the necessary budget for conducting this activity effectively.
- RBSK Mobile Health Teams and AYUSH doctors at Block level will monitor the implementation of NDD in the field. Each team will visit at least four schools/anganwadis on both NDD and MUD each.
- All monitoring teams and personnel from National, State, District or Block levels, including Development Partners, will use a standardized common format for field-level monitoring of NDD.
- The nodal officer for NDD at the District level will coordinate all monitoring and supervision activities in their respective Districts.
- States should ensure that Districts have prepared micro-plans for NDD monitoring visits and the plan for monitoring visits by States needs to be submitted to child health division at the national level one week before NDD.
- At all State/UTs, District and Block levels, supervisory visits must be based on micro-plans developed.
- States should ensure that Districts have prepared micro-plans for NDD monitoring visits. The plan for monitoring visits by States needs to be submitted to child health division at the national level one week before the NDD round.

- Under RMNCH+A intensification strategy, the lead and partner agencies will monitor the implementation of the NDD efforts through State RMNCH+A units and Block coordinators placed at the 184 High Priority Districts.
- States, Districts and Blocks will use existing mobility mechanisms for monitoring purposes. Additionally separate funds will be provided for hiring vehicles or re-imbursment for refilling of the fuel.(Please refer to the financial guidelines section).
- All monitoring formats used by officials/teams will be submitted to the health department nodal officer at the State level for further compilation, data entry and analysis. States should ensure that every District submits NDD monitoring data to State MIS team along with NDD coverage data.
- The data will be electronically entered and analyzed by the State MIS team and it will submit a report to Child Health Division at the MoHFW along with the coverage reporting. All states should ensure the submission of NDD monitoring report to the child health division at the national level along with NDD coverage data. The Child Health Division at the National level will compile and analyze all the State/UT level reports to assess the performance of NDD implementation across the country. These findings will be shared with all States and program stakeholders to inform them about the status of NDD implementation in this round and areas for program improvement for future rounds.
- Quality Control: State to ensure active quality control measures for checking of samples of Albendazole tablets from the schools and anganwadis to be tested as per the State/UT policy for ensuring the quality.
- Selecting indicators at the outset of the national program is essential for tracking and measuring performance at the State and national level. The key performance indicators for NDD are:

S. No.	Indicator	Level	Target
1	% of States/UTs with budget earmarks in PIPs for spending on activities	National	All States/UTs
2	% of States/UTs that have sufficient drugs available for NDD	National	All States/UTs
3	% of States/UTs adapting national community mobilization materials for NDD to their local populations (e.g. language, messaging) and promoting through at least two mediums/channels (e.g. TV, radio, newspapers)	National	All States/UTs
4	No. and % of States/UTs that have reported coverage data for their state to the National Government by March 29, 2016	National	All States/UTs
5	No. and % of districts that have held District Coordination Meetings about NDD	State/UT	All District in a State/UT
6	No. and % of Government schools reporting data on deworming drugs administered to children	State/UT	All schools in a State/UT
7	No. and % of anganwadis reporting data on deworming drugs administered to children	State/UT	All Anganwadis in a State/UT
8	No. and % children (1-19 years) receiving deworming treatment	State/UT	At least 90 %
9	No. and % of children (1-5 years) receiving deworming treatment	State/UT	At least 90 %
10	No. and % of children (6-19 years) receiving deworming treatment	State/UT	At least 90 %
11	No. and % of districts covering private schools	State/UT	All States
12	No. and % of children (6-19 years) administered deworming drug at private schools	State/UT	All States

# RECORDING AND REPORTING PROCESS

## For schools:

1. Teachers will record the number of enrolled children dewormed in respective class attendance registers. Following is the method of recording the information:
  - For every enrolled student receiving a tablet on NDD, a SINGLE tick mark (✓) will be placed next to the name of the student in the attendance register. At the end of NDD, teachers will count the number of ticks in their attendance registers, and report the number of boys and girls dewormed on NDD in their class to the principal/Nodal teacher.
  - After NDD, teacher will prepare a list of children who have missed the dose due to absence or sickness and put an effort to inform children to be present on MUD for taking the Albendazole tablet.
  - For every enrolled student on MUD, teacher would first check the single tick mark in the front of the name of the student in the class attendance register. In case the tick mark is not there, the child would be administered with the Albendazole tablet. DOUBLE tick marks (✓✓) will be placed next to the names of those students in their class attendance register. At the end of MUD, teachers will count the number of double tick marks in their attendance registers, and report the number of enrolled boys and girls dewormed on MUD in their class to the principal/Nodal teacher.

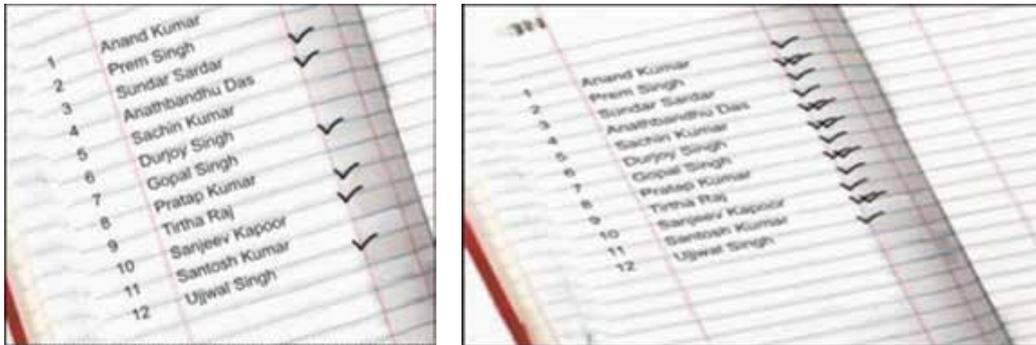


Image: Ticking and double ticking in the attendance a register

2. The principal/nodal teacher will compile the reported class data into the School Reporting Form and submit to ANMs by February 19, 2016. The principal/nodal teacher will prepare two copies of school reporting form, one copy will be submitted to the ANM while the second copy will be kept in the school for record. The coverage data provided in school reporting form should be double checked prior to submission to the ANM and ensure that reported data is correct in all aspects (i.e., accuracy, completeness and timeliness).

## For Anganwadi Centers:

3. AWWs will record the number of registered children dewormed in respective anganwadi centre enrolment registers. Following is the method of recording the information:
  - For every child receiving a tablet on NDD, a **SINGLE** tick mark (✓) will be placed next to the name of the child in the enrolment register. At the end of NDD, the AWW will count the number of ticks in their enrolment registers and report the number of boys and girls dewormed.
  - After NDD, AWW will prepare a list of children who have missed the dose due to absence or sickness and share the list with ASHA. ASHA would then make an effort to inform children to be present on MUD for taking the Albendazole dose.
  - For every child dewormed on MUD, AWW would first check the single tick mark in the front of the name of the child in the enrolment register. In case the tick mark is not there, the child would be administered with the Albendazole tablet. **DOUBLE** tick marks (✓✓) will be placed next to the names of child in their enrolment register. At the end of MUD, the AWW will count up the number of double tick marks in their enrolment registers.

4. AWW will record the numbers of out-of-school children in Anganwadi Reporting Format.
5. ASHA, as per the standard reporting format (see annexures), will also record the details of out-of-school children dewormed on NDD and MUD at the anganwadi centres by recording the name of the child and the name of the father or mother on paper. At the end of both NDD and MUD, ASHA along with the AWW will report to the ANM, the number of out-of-school boys and girls dewormed at the particular anganwadi centre. Since ASHA will be incentivized to mobilize out-of school children, a copy of ASHA standard reporting format shall be retained by the ASHA which shall be duly signed by the ANM.
6. The AWW will compile the data on children dewormed on NDD and MUD through the platform of anganwadi centers in the Anganwadi Reporting Format, and submit to the ANM by February 19, 2016. The AWW will prepare two copies of Anganwadi Reporting Format, one copy will be submitted to the ANM while the second copy will be kept at anganwadi centre for record. The AWW should double check the coverage data provided in Anganwadi Reporting Form prior to submission to the ANM and ensure that reported data is correct in all aspects (i.e., accuracy, completeness and timeliness).

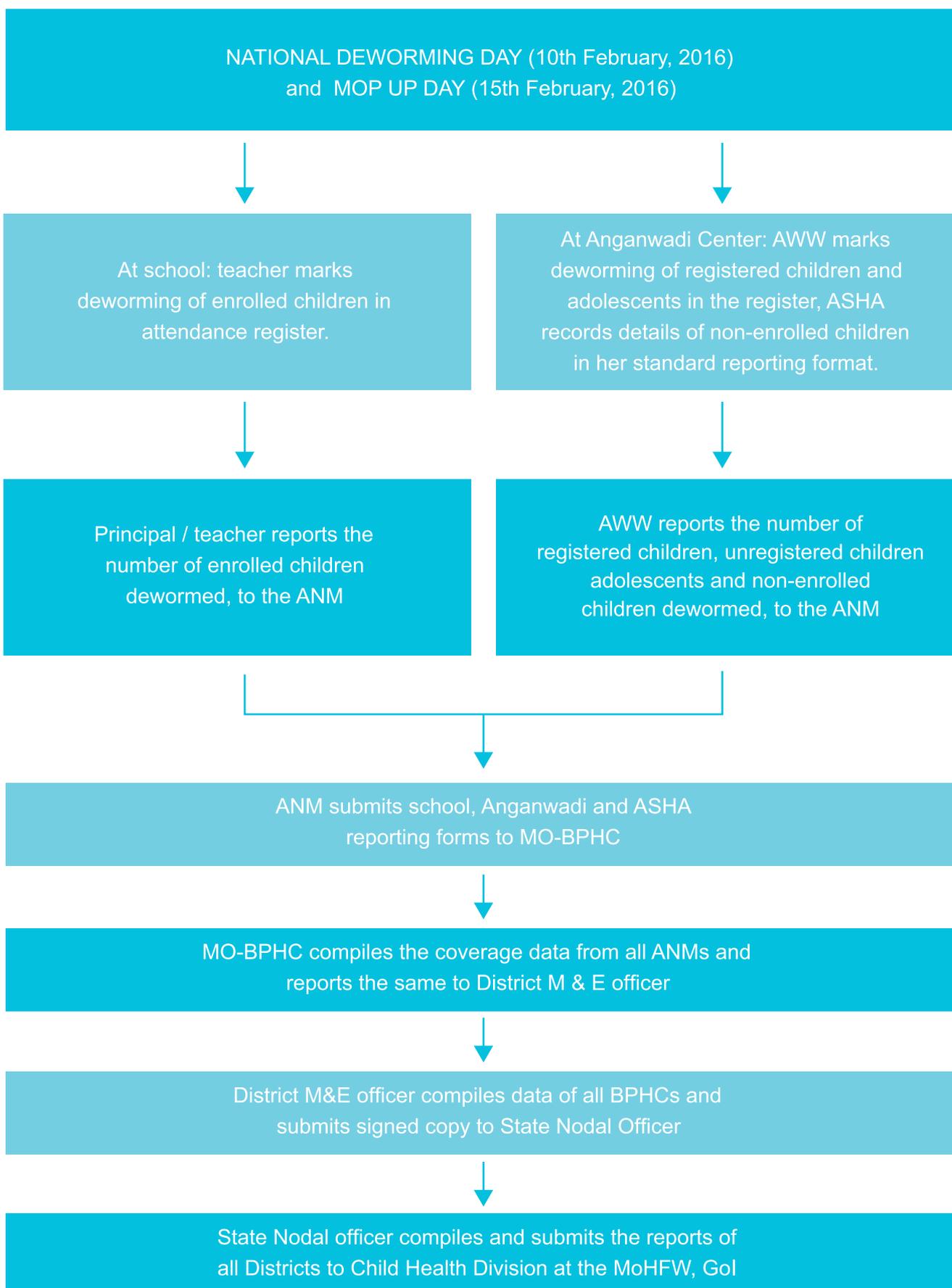
#### For schools and anganwadis after submission of reporting forms to ANM:

1. ANM will ensure to submit all the reporting forms received from the schools and anganwadi centres in her vicinity to the MO-BPHC.
2. Block Medical Officer will compile all the reports received from ANMs in Block level Common Reporting Format and submit them to District M&E officer.
3. The District M&E officer will compile data of all BPHCs in District level Common Reporting Format and submit the duly signed compiled report to the State Nodal Officer under Health Department.
4. The State Nodal officer will compile the reports of all Districts in State level Common Reporting Format and submit the duly signed reports to Child Health Division at the MoHFW.
5. Two officials at Block/District/State level should review the quality of coverage data provided in respective common reporting forms prior to submission to the next level and ensure that reported coverage data is correct in all aspects.

#### Timelines for submission of reporting formats

S No.	Level	Functionary Responsible	Submitted to	Format	Submission date
1	School	Principal	Respective ANM under whose area the school falls in	School Reporting Forms	February 19, 2016
2	Anganwadi Center	AWW	Respective ANM under whose area the anganwadi centre falls in	Anganwadi Reporting Forms	
3	Anganwadi Center	ASHA	Respective ANM under whom ASHA is working	ASHA-Standard Reporting Forms	
4	Sub-center level	ANM	MO-BPHC	All School and Anganwadi Reporting Forms and ASHA Reporting Forms	February 26, 2016
5	Block Level	MO-BPHC	District M&E Officer	Block level Common Reporting Forms and Monitoring Forms	March 10, 2016
6	District Level	District M&E Officer	State Nodal Officer	District level Common Reporting Forms and Monitoring Forms	March 17, 2016
7	State	State Nodal Officer	Child Health, MoHFW	State level Common Reporting Format and Monitoring Forms	March 29, 2016

Figure 5: Flow chart for submission of forms for NDD and MUD.



# Annexure 1

## Reporting Formats: National Deworming Day & Mop-Up Day

### SCHOOL REPORTING FORMAT

\* Please fill in all the details below and do not leave any box unfilled.

State :		District :	
Block :	Sub-center :	Village :	
Name of the school		School DISE Code	
Type of School	Govt./Govt. aided school ( )	Private Schools ( )	
Did someone from the school attend the official NDD training (Yes/No)			
Albendazole Coverage			
	Girls	Boys	Total
Total no. of children enrolled in the school (6-19 years)			(A)
No. of <b>enrolled</b> children (class 1-5) who were administered Albendazole on NDD			(1)
No. of <b>enrolled</b> children (class 1-5) who were administered Albendazole on MUD			(2)
No. of <b>enrolled</b> children (class 6-12) who were administered Albendazole on NDD			(3)
No. of <b>enrolled</b> children (class 6-12) who were administered Albendazole on MUD			(4)
Any others			
GRAND TOTAL of number of children who were administered Albendazole (B = 1+2+3+4)	(B)		
Number of severe adverse events reported from the school (submit adverse event reporting format, as applicable)			
Logistic Details			
Total No. of Albendazole tablets given to the school			
Total No. of Albendazole tablets administered to the children by the school (total of both NDD and MUD)			
Stock of Albendazole tablets left with school			
Name of the Signatory (School Headmaster)			
Signature (School Headmaster)			
Date of Submission of form			
Contact Number of Headmaster:			
You may call up the State Office (Name : ____ / Phone:____) for any assistance required			

### THE PRINCIPAL WILL SUBMIT TO ANM BY FEBRUARY 19, 2016

ANM will submit the School Reporting Form to the Block by February 26, 2016

Note : Principal will prepare two copies of this form. One copy will be submitted to the ANM while the second copy will be kept in the school for records.

## ANGANWADI REPORTING FORMAT

\* Please fill in all the details below and do not leave any box unfilled.

State :		District :	
Block :	Sub-center :	Village :	
Project Name:	Anganwadi Center (AWC):	Anganwadi Code:	
Did Anganwadi Worker receive official training on NDD (Yes/No)?			
Albendazole Coverage			
	Girls	Boys	Total
Total No. of children registered in the AWC			(A)
No. of registered children (1-5 years) who were administered Albendazole on NDD			(1)
No. of registered children (1-5 years) who were administered Albendazole on MUD			(2)
No. of unregistered children (1-5 years) who were administered Albendazole on NDD			(3)
No. of unregistered children (1-5 years) who were administered Albendazole on MUD			(4)
No. of out-of-school children (6-10 years) who were administered Albendazole on NDD			(5)
No. of out-of-school children (6-10 years) who were administered Albendazole on MUD			(6)
No. of out-of-school adolescents (10-19 years) who were administered Albendazole on NDD			(7)
No. of out of school adolescents (10-19 years) who were administered Albendazole on MUD			(8)
GRAND TOTAL of number of children who were administered Albendazole (B = 1+2+3+4+5+6+7+8)	(B)		
Number of severe adverse events reported for the AWC (submit adverse event reporting format, as applicable)			
Logistic Details			
Total No. of Albendazole tablets given to the AWC			
Total No. of Albendazole tablets administered to the children and adolescents by the AWW (total of both NDD and MUD)			
Stock of Albendazole tablets left with AWC			
Name of the Anganwadi Worker		Signature of the Anganwadi Worker	
Phone Number of Anganwadi Worker		Date of Submission of Form	
You may call up the State Office (Name : ____ / Phone:____) for any assistance required			

### THE ANGANWADI WILL SUBMIT TO ANM BY FEBRUARY 19, 2016

ANM will submit the Anganwadi Reporting Form to the Block by February 26, 2016

Note : Anganwadi will prepare two copies of this form. One copy will be submitted to the ANM while the second copy will be kept in the Anganwadi Centre for records.

## ASHA - STANDARD REPORTING FORMAT

\* Please fill in all the details below and do not leave any box unfilled.

State :		District :			
Block :	Sub-center :		Village :		
Project Name:	Anganwadi Centre:		Anganwadi Code:		
Name of ANM:					
Details of unregistered and out-of-school children					
S.No.	Name of the child	Father's Name	Mother's Name	Age (in years)	Dewormed (Yes/No)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
(Name and signature of ASHA)  (Name and Signature of AWW)					
You may call up the State Office (Name : ____ / Phone:____) for any assistance required					

**ASHA TO SUBMIT TO ANM BY FEBRUARY 19, 2016**  
 ANM to submit all ASHA Reporting Forms to MO-BPHC by **February 26, 2016**  
 ASHA will use this copy to mobilize out-of-school children  
 ASHA will share one copy of this form with AWW

## COMMON REPORTING FORMAT (For Block, District, and State)

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

State :	District :	Block:	
No. of Govt./Govt. aided schools#:		No. of Govt./Govt. aided schools reporting coverage	
No. of targeted private schools		No. of private schools reporting coverage	
No. of anganwadi centers (AWCs):		No. of AWCs reporting coverage	
No. of ASHAs oriented/trained on NDD			
No. of Govt./Govt. aided schools who attended training on NDD			
No. of private schools who attended training on NDD			
No. of anganwadi workers oriented/trained for NDD			
Coverage Details			
		Girls	Boys
			Total
Total children out-of school			(A)
Total children unregistered in anganwadis			(B)
Total children registered in anganwadis			(C)
Total children enrolled in the schools	Govt. school		(D)
	Pvt. school		(E)
Total number of children targeted			$Z=(A)+(B)+(C)+(D)+(E)$
<b>No. of enrolled children (classes 1-5) who were administered albendazole on NDD and MUD</b>	Govt. school		(1a)
	Pvt. school		(1b)
<b>No. of enrolled children (classes 6-12) who were administered albendazole on NDD and MUD</b>	Govt. school		(2a)
	Pvt. school		(2b)
No. of registered children in AWCs (1-5 years) who were administered albendazole on NDD and MUD			(3)
No. of unregistered children (1-5 years) who were administered albendazole on NDD and MUD			(4)
No. of out of school children (6-10 years) who were administered Albendazole on NDD and MUD			(5)
No. of out of School adolescent (10-19 years) who were administered albendazole on NDD and MUD			(6)
GRAND TOTAL of number of children who were administered Albendazole ( $T = 1a+ 1b+2a+2b+3+4+5+6$ )			(T)
Percent coverage		$(T) \times 100 / (Z)=$	
No. of severe adverse events reported from schools and anganwadis			
<b>Logistic Details: Block/District/State (tick as applicable)</b>		<b>Govt. schools</b>	<b>Private schools</b>
		<b>Anganwadis</b>	
Total No. of albendazole tablets given			
Total No. of albendazole tablets administered			
Stock of albendazole tablets left			
Feedback (if any) :			
Name, signature, and designation of the official preparing the document			
Name, signature, and designated of the official reviewing the document			
Contact number of official submitting the report			
You may call up the State Office (Name : _____ / Phone: _____) for any assistance required			

# Government schools, Government aided schools and Ashram Shalas in the State.  
SUBMIT TO \_\_\_\_\_ (as per the timelines, see annexure)

## Annexure 2

### Financial Guidelines for National Deworming Day

**State/UT Level:** States/UTs will utilize the funds available under NHM PIP 2015-16 for implementation of National Deworming Day in current financial year. Each of the States/UTs shall be provided with funds for activities to be conducted at the State level as well as the District level.

The table below provides details of expenses to be made at State level:

S.No.	Activity	Estimated Expenditure per State/UT (in INR)
1	Dissemination of IEC: radio jingles, Newspaper appeals and TV spots/scrolls etc. in local language	2,00,000
2	Orientation of District level functionaries (Civil Surgeon, DPM)	To be covered under meeting expenses given to the State
3	Training of Master Trainers of State level	To be covered under the budget for existing training curriculum for FY 2015-16.
4	Supervisory visits from State level on NDD	To be covered under mobility expenses given to the State in the PIP
	Total	2,00,000

**District Level:** Following is a suggestive structure for expenditure for 1 District.

S.No.	Activity	Estimated Expenditure per District (in INR)
1	Albendazole tablets. In a District of average 20 lakh population, one round of Deworming will require approximately 8.40 lakh Albendazole tablets including buffer stock of 10%	8,40,000 (already approved in NHM PIP 2015-16)
2	ASHA incentive of Rs. 100 for mobilizing and ensuring every eligible child (1-19 years out-of-school) is administered Albendazole. In a District there will be approximately 2000 ASHAs	2,00,000
3	Printing of (a) Training material (b) IEC materials: Banners/hordings/Pamphlets (c) Reporting Formats for all levels	1,50,000 1,50,000 20,000
4	Media activities for awareness generation: Cable TV / miking / wall writing / inauguration event and other informative activities as appropriate	1,00,000
5	Half-day orientation meeting at PHC / Block level for approximately 3000 participants# @ Rs. 100 per participants (apart from printing of training materials)	3,00,000
6	Clean glasses for drinking water	To be arranged from the school/anganwadi kitchen
	Total	INR 17,64,000
		~ INR 17.64 lakh per District ~ INR 9.24 lakh per District (excluding cost of Albendazole tablets)

# A District of average 20 lakh population will have approximately 2500 schools (Government + Government aided + Ashram Shales)  
One teacher/principal per school will be oriented along with 500 ANMs = 3000 participants  
(Average number of schools as per Source: DISE, 2013-14)

# Annexure 3

## NATIONAL DEWORMING DAY MONITORING FORM

DATE OF VISIT (Tick the box as applicable):  National Deworming Day (\_\_\_/\_\_\_/2016)

Mop-Up Day (\_\_\_/\_\_\_/2016)

GENERAL INFORMATION							
Name & Mobile No. of Monitoring Officer	Monitoring Site	School / AWC Name	School/ DISE/ AWC Code	State	District	Block	Ward / Village
	1. Government school 2. Private School 3. Anganwadi						

### MONITORING SECTION: Circle the correct option based on your observations and interviews

#### NDD Observations

1. Does the school/AWC have deworming drugs?	1. YES	2. NO
2. Are the drugs available in sufficient quantity to deworm the enrolled as well as out of school/unregistered children?	1. YES	2. NO
3. What is the expiry date of the drugs?		
4. Does the school/AWC have the following provisions for the deworming process? Circle all that apply 1. School/AWC Reporting Form    2. Drinking Water    3. ORS Packets    4. None of these		
5. Are the deworming drugs being administered to children?	1. YES	2. NO
6. If NO, why deworming is not happening at school/Anganwadi?		
7. If YES, who is administering the drugs to the children? Circle all that apply 1. AWW    2. Teacher/ Principal    3. ASHA    4. Other (specify).....		
8. Is the ASHA present at the AWC?	1. YES	2. NO
9. Is the ASHA assisting the AWW in the deworming process?	1. YES	2. NO
10. Is the teacher/AWW separating sick children from healthy children before deworming?	1. YES	2. NO
11. Did the teacher/AWW tick (✓/✓✓) each child's name in the attendance register after giving them the drug?	1. YES	2. NO
12. Did the ASHA / AWW make a list of the out of school/unregistered children who got the drug? 1. YES    2. NO    3. Out-of-school children did not receive drugs at this AWC		
13. Are out of school children getting deworming drug in the school/AWC?	1. YES	2. NO
14. Are teachers giving any health education related to deworming to the students?	1. YES	2. NO
15. Whether children are given appropriate dose (half tablet for 1-2 years/one tablet for 2-19 years) of albendazole by teacher/AWW? 1. Yes    2. No		
16. Are teacher/AWW asking children to take tablets in front of them only?	1. YES	2. NO
17. Whether children are told to chew the tablet before swallowing it?	1. YES	2. NO

#### Training Aspects

18. Have you or any other person from your school/AWW attended official training for deworming in the last two months? 1. Yes    2. No		
19. If YES, did those who attend deworming training provide training to others?	1. YES	2. NO
20. Where did the teacher/AWW receive training? 1. At School    2. At Block training    3. At District training    4. Other (Specify).....		

21. Materials received during training? 1. Tablets 2. Poster/Banner 3. Handouts 4. Reporting form 5. Adverse event reporting form 6. Others (Specify) .....
22. Did you receive any SMS about the NDD? 1. YES 2. NO
<b>Adverse Events</b>
23. According to the teacher/AWW, can the deworming drugs be given to sick children? 1. YES 2. NO
24. Is the teacher/AWW aware of the possibility of adverse events from deworming? 1. YES 2. NO
25. If YES, according to the teacher/AWW, what is the appropriate response in case of adverse events? Circle all that apply. 1. Let the child rest in an open and shaded place 2. Provide clean water to drink 3. Contact the ANM/nearby PHC 4. Others (Specify) .....
26. What possible adverse events could be reported by children after taking the tablets? Circle all that apply. 1. Mild abdominal pain 2. Nausea / vomiting 3. Diarrhea 4. Fatigue 5. Others (Specify) .....
27. Did you witness any severe cases of adverse events in the school/AWC? 1. YES 2. NO
28. Does the school/AWC have phone numbers of the nearest ANM or MO-PHC? 1. YES 2. NO
<b>Community Awareness and IEC Materials</b>
29. Which of the following IEC materials are visible at the school/AWC? Circle all that apply. 1. Poster 2. Banner 3. No IEC materials 4. Others (Specify) .....
30. Which of the following reference documents are available at the school/AWC? Circle all that apply. 1. Teacher Handout 2. AWW Handout 3. Adverse Events Protocol 4. No documents 5. Others (Specify).....
31. Which of the following community mobilization steps have been undertaken by the ASHA before NDD? Circle all that apply. 1. Conducted village meetings with parents 2. Informed parents about harmful effects of worms 3. Informed parents of benefits of deworming 4. Informed parents about behavior change to prevent reinfection 5. Others (Specify).....
32. From where did you get information about the recent round of deworming program? 1. Departmental communication 2. Television 3. Radio Newspaper 4. Banner 5. SMS 6. Training 7. Others (Specify) .....
33. What are the different ways that children can get worm infection? Circle all that apply. 1. Having foods without washing hands 2. Not washing hands after using toilets 3. Not using sanitary toilets 4. Moving in bare feet 5. Consume vegetables and fruits without washing 6. Others (Specify).....
<b>ADDITIONAL COMMENTS: Please write any observations that have not been captured in the preceding sections</b>

## Annexure 4

### National Deworming Day Fact Sheet

#### Soil-Transmitted Helminth Infections and school and anganwadi-based deworming

##### Summary:

- Intestinal worm, or soil transmitted helminths (STH), are among the most common infections worldwide. The World Health Organization (WHO) estimates that 241 million children between the ages of 1 and 14 are at risk of STH infection in India.
- These worms live in human intestines and consume nutrients meant for the human body. They are transmitted by eggs present in human faeces, which contaminate soil in areas where sanitation is poor.
- STH infections can lead to anemia, malnutrition, impaired mental and physical and cognitive development, and reduced school participation. Safe, inexpensive and effective medicines are available to control infection. Regular treatment is a cost-effective method of controlling the public health threat of worms in the absence of improved sanitation.
- MoHFW, Government of India has launched a national school and anganwadi-based program, NDD, through which all children between the ages of 1-19 years will be administered deworming drugs by teachers and AWWs. The WHO recommends school and anganwadi-based deworming as a safe and cost-effective intervention that achieves high coverage of at-risk children.

##### Distribution and prevalence of STH:

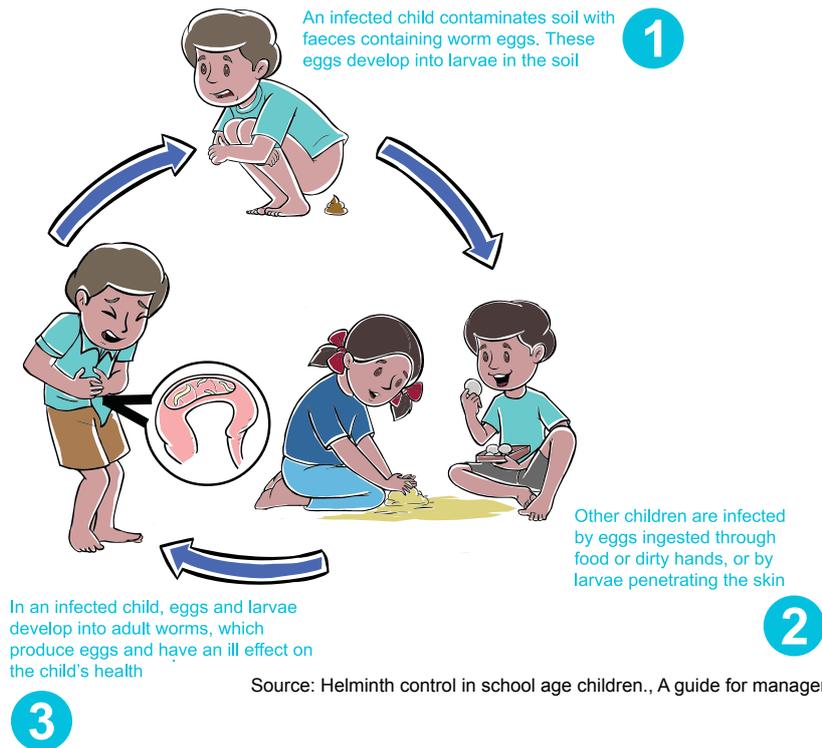
- Global burden: More than 1.5 billion people or 24% of the world's population are infected with STH worldwide. Infections are widely distributed in tropical and subtropical areas, with the greatest numbers occurring in the Sub-Saharan Africa, the America, China and East Asia. Over 600 million school-age children and 270 million preschool-age children are in need of regular treatment and preventive interventions.
- Indian burden: WHO data indicates that STH is a significant public health concern for India, with 241 million children between the ages of 1-14 years predicted to be at risk of STH infections<sup>7</sup>. This represents approximately 68% of children in this age group and approximately 28% of all children estimated to be at risk of STH infections globally. State-wide worm prevalence estimates are not available in all States, although GoI has now renewed its focus to conduct STH prevalence surveys in all States.

##### STH transmission:

- There are three main types of STH that infect people: roundworm (*Ascaris lumbricoides*), whipworm (*Trichuris trichiura*) and hookworms (*Necator americanus* and *Ancylostoma duodenale*).
- Adult worms live in human intestines for food and survival where they produce thousands of eggs each day.
- Infected people who defecate outdoors spread worm eggs in their faeces.
- Subsequently, the eggs contaminate the soil which can spread infection in several ways:
  - Attached to vegetables that are ingested when the vegetables are not carefully washed, peeled, and cooked;
  - Ingested from contaminated water sources;
  - ingested by children who play in soil and then put their hands in their mouth without washing them.

<sup>7</sup> WHO PCT Databank: [http://apps.who.int/neglected\\_diseases/ntddata/sth/sth.html](http://apps.who.int/neglected_diseases/ntddata/sth/sth.html)

Figure 1: STH Transmission Cycle



### Symptoms of infection:

- Regular treatment of at-risk populations will reduce the intensity of infection and protect infected individuals from morbidity.
- The greater the amount of worms in an individual (intensity), the more symptoms the infected individual will have.
- People with light infections usually have no symptoms
- Heavier infections can cause a range of symptoms including diarrhea, abdominal pain, and weakness.
- Loss of appetite.

### Prevention of infection:

Infections can be prevented by taking precautions, including:

- Using sanitary toilets, not defecating outside.
- Hand-washing, particularly before eating and after using toilets.
- Wearing slippers and shoes.
- Washing fruits and vegetables in safe and clean water.
- Properly cooking food.

### Nutritional and health consequences of infection:

STH impairs the nutritional status of the people and infect in multiple ways:

- Worms feed on host tissues, including blood, which leads to anaemia.
- Worms increase mal-absorption of nutrients. In addition, roundworm may compete for vitamin A in the intestine.
- The nutritional impairment caused by STH is recognized to have a significant impact on growth and physical development.

### Benefits of treatment:

Rigorous studies have shown that deworming has a significant impact on the health, education and livelihoods of treated children. Outcomes of deworming can include:

- Decreased anaemia and improved nutrition
- increased growth and weight gain

- Improved cognition, mental and physical development
- increased resistance to other infections
- increased school attendance
- Improvement in children's ability to learn better and be more active in school.
- increased in number of hours worked and wages earned in the long-run in adulthood

Deworming also has important spillover effects, meaning that other members of the community who do not receive treatment benefit, as there are fewer worms in the environment. This is especially important for children who are too young to be treated, but for whom worms can greatly impair cognitive development.

### School and Anganwadi Center-based deworming strategy

- WHO recommends deworming without previous individual diagnosis to all at-risk people living in endemic areas.
- MOHFW has launched the NDD on 10 February, 2015 in selected 11 States/UTs namely Assam, Bihar, Chhattisgarh, Dadra and Nagar Haveli, Haryana, Karnataka, Maharashtra, Madhya Pradesh, Rajasthan, Tamil Nadu and Tripura in the first phase.
- Global experience including Indian has shown that deworming treatment delivered through mass campaigns in schools is a successful strategy as teachers can safely and cost-effectively administer treatment to large numbers of children.
- Deworming treatment is delivered by teachers to school enrolled children and by AWWs to under-five and out-of-school children, with oversight from the health system and support of ASHAs. Children, the community and parents are comfortable with their teachers and AWWs. Teachers and AWWs can easily give deworming tablets to children with basic training and have been successfully deworming children in some States in India and over 30 countries world wide.
- One full tablet of Albendazole (400mg) will be given to all children between the ages of 2-19 years on NDD. Children between 1 – 2 years would receive half a tablet of Albendazole (400mg) after crushing.
- To cover the children who missed the dose due to sickness or absence from school and anganwadi centers will be covered on Mop-Up Day.

### Deworming goals

- Global goal: The WHO global target is to eliminate morbidity due to STH in children by 2020. This goal will be achieved by regularly treating at least 75% of the children in endemic areas (an estimated 873 million)<sup>8</sup>.
- India goal: The objective of NDD in India is to deworm all preschool and school-age children between the ages of 1-19 years through the platform of Government/Government aided and private schools and anganwadi centers in order to improve their overall health, nutritional status, access to education and quality of life.

<sup>8</sup> WHO, Eliminating Soil-transmitted helminthiasis as a public health problem in children, progress report 2001-2010 and strategic plan 2011-2020 (2012)

## Annexure 5

### NDD FREQUENTLY ASKED QUESTIONS (FAQs) AND EVIDENCE BASE

S No.	Questions	Answers
1	How do people become infected with intestinal worms and what are the most common worms?	<p>Soil-transmitted helminths (STH) are transmitted by eggs present in human feces which contaminate soil in areas with poor sanitation and hygiene. Transmission can occur when i) eggs that are attached to vegetables are ingested without being carefully washed, peeled or cooked ii) eggs are ingested from contaminated water sources and iii) eggs are ingested by children who play in contaminated soil<sup>9</sup>. Children typically harbor the highest intensity of infection.</p> <p>The main species of intestinal worms are the roundworm (<i>Ascaris lumbricoides</i>), the whipworm (<i>Trichuris trichiura</i>) and hookworms (<i>Necator americanus</i> and <i>Ancylostoma duodenale</i>).</p>
2	What is the prevalence of STH in India?	<p>WHO data indicates that STH is a significant public health concern for India, with 241 million children between the ages of 1-14 years predicted to be at risk of STH infections<sup>10</sup>.</p> <p>This represents approximately 68% of children in this age group and approximately 28% of all children estimated to be at risk of STH infections globally. State-wide worm prevalence estimates are not available for all States, although Government of India has now renewed its focus to conduct STH prevalence surveys in all States.</p>
3	How is Prevalence Survey of STH conducted?	<p>Prevalence of STH is conducted in the field by collection of stool samples from the school children and analyzed in laboratories for identification of parasitic ova and prevalence and intensity is measured. The sample design selected gives an estimate of the State wide prevalence and intensity of STH in a particular State. The laboratory analysis is conducted by technical institutes having expertise in parasitology and the study design and analysis of data is done by reputed epidemiological institutes.</p>
4	How can we prevent the spread of worm infections?	<p>There are several ways to prevent the spread of worm infections by improving hygiene, including:</p> <ul style="list-style-type: none"> <li>• Washing hands, particularly before eating and after using toilets</li> <li>• Using sanitary latrines</li> <li>• Wearing slippers / shoes</li> <li>• Drinking safe and clean water</li> <li>• Eating properly cooked food</li> <li>• Cover food at all times</li> <li>• Keep nails short and clean</li> <li>• Washing vegetables, fruits and salads in safe and clean water</li> </ul>
5	What is the effect of STH on the nutritional status of children?	<p>Worms impair the nutritional status of people they infect in multiple ways:</p> <ul style="list-style-type: none"> <li>• Worms feed on host tissues, including blood, which leads to a loss of iron and protein and often contributes to anaemia</li> <li>• Worms can increase the malabsorption of nutrients; roundworm may compete for Vitamin A in the intestine</li> <li>• Some worms can cause a loss of appetite, reducing nutritional intake and physical fitness</li> <li>• Some worms can cause diarrhea and dysentery</li> </ul>
6	What are the development and educational consequences of worms in children?	<p>Worms have negative effects on the mental and physical development of children. Children with worms are often underweight and have stunted growth. Heavy infections often make children too sick or too tired to concentrate at or even attend school. Long term, children not treated for worms are shown to earn less as adults.</p>

<sup>9</sup>WHO, Soil-transmitted helminth infections., Fact Sheet Number 266, Updated April 2014, retrieved from <http://www.who.int/mediacentre/factsheets/fs366/en>

<sup>10</sup>WHO PCT Databank: [http://apps.who.int/neglected\\_diseases/ntddata/sth/sth.html](http://apps.who.int/neglected_diseases/ntddata/sth/sth.html)

7	What is the effect of worms on child mortality?	Intestinal worm infections affect child morbidity, not mortality. There is no rigorous evidence that suggests that worms affect child mortality but there is ample evidence that worms fundamentally affect the quality of children's lives and negatively impact their access to health, education and livelihoods.
8	Can Albendazole and iron/folic acid tablets be administered together?	The WHO asserts that periodic deworming can be easily integrated with child health days or vitamin A supplementation programs for preschool-aged children, or integrated with school-based health programs. Additionally, deworming has been / recommended as part of the National Iron + Initiative including Weekly Iron and Folic Acid Supplementation program in India and other school health programs making the combination cost-effective, safe and easy to administer.
9	Can STH be eliminated from a country?	STH have been eliminated from several countries including the U.S. and South Korea, as sanitation conditions improved alongside the delivery of treatments. The WHO recommends mass deworming treatment as a mechanism for controlling the public health threat of worms. A study in Kenya is currently underway that is analyzing the epidemiological requirements, cost-effectiveness and operational feasibility of breaking STH transmission in the absence of improvements in sanitation and findings will be shared broadly.
10	What is the evidence base associated with health impacts and deworming?	Findings from rigorous studies related to health impacts include: <ul style="list-style-type: none"> <li>• Results and data analysis from a systematic review of 14 randomized control trials found that deworming without previous screening marginally improves hemoglobin concentration, which could translate on a public health scale into a 5 to 10% reduction in the prevalence of anaemia (Humphrey J., 2009)</li> <li>• A systematic review found that treatment with anthelmintic in moderate and heavily infected populations resulted in increased hemoglobin (Smith, J.L. et al. 2010)</li> <li>• A randomized control trial found that reduced exposure to worm infections improved cognition for children less than one year of age (Ozier 2011)</li> <li>• A cluster randomized control trial found that the provision of deworming treatment as part of child health services resulted in an increase in weight gain of about 10% above expected weight gain when treatments were given twice a year and about 5% for annual treatment. (Alderman et al. 2006)</li> </ul>
11	What is the evidence base associated with education, livelihoods and deworming?	Findings from rigorous studies related to educational / livelihoods impacts include: <ul style="list-style-type: none"> <li>• A randomized control trial found school-based mass treatment reduced school absenteeism by 25% and was far cheaper than alternative ways of boosting school participation.</li> <li>• A longitudinal study showed that the long term benefits of childhood deworming are substantial; young adults randomly assigned to a deworming program as children work more as adults and earn higher wages (Baird S. et al 2012)</li> <li>• A historical study of hookworm eradication in the Southern United States in the early 1900s found a substantial income and educational gain as a result of the reduction in hookworm infection. (Bleakley 2007)</li> </ul>
12	What is the evidence base for deworming in India?	There are at least two randomized trials in India in the last decade that demonstrate the positive impact of deworming in the country: <ul style="list-style-type: none"> <li>• A health intervention that provided iron, Vitamin A and deworming drugs to Indian preschool children in the slums of Delhi found a significant gain in child weight and school participation compared to intervention with Vitamin A alone. Absenteeism was reduced by one-fifth in the treatment group (Bobonis et al, 2006)</li> <li>• A cluster randomized control trial in preschool children found that the group treated with 4 rounds of Albendazole showed a greater weight gain as compared to the non-treated group (Awasthi S. et al 2008)</li> </ul>

13	What is the WHO's guidance on deworming?	<p>The WHO recommends preventing and controlling STH-related morbidity through the periodic treatment of at-risk populations living in endemic areas, particularly preschool and school-age children and women of childbearing age (including pregnant women in the second and third trimesters and breastfeeding women).</p> <p>The WHO recommends deworming treatment without previous individual diagnosis to all at-risk people living in endemic areas. Treatment should be given once a year when the STH prevalence in the community is over 20% and twice a year when the STH prevalence exceeds 50%<sup>11</sup>. The treatment advice differs for treated and untreated population.</p>
14	What is the deworming treatment to be given to children?	<p>Albendazole is the name of the deworming drug used by the Government of India and is a safe treatment for intestinal worms used across the globe. The recommended dosage for children between the ages of 2 and 19 years is 1 tablet (400 mg) and ½ tablet of Albendazole for children 1-2 years.</p> <p>For young children the tablet should be broken into half and crushed and administered with water. All drugs must be administered under supervision.</p>
15	Does the deworming treatment have side effects?	<p>The deworming treatment has very few side effects. There may be some mild side effects like dizziness, nausea, headache, and vomiting, all likely due to the worms being passed through the child's body. However these side effects disappear after some time.</p> <p>Side effects are usually experienced by children with high infections. If symptoms do not go away within 24 hours, or if they are very severe, the child is probably experiencing something unrelated to the treatment and should be taken to the nearest health facility immediately.</p>

# Annexure 6

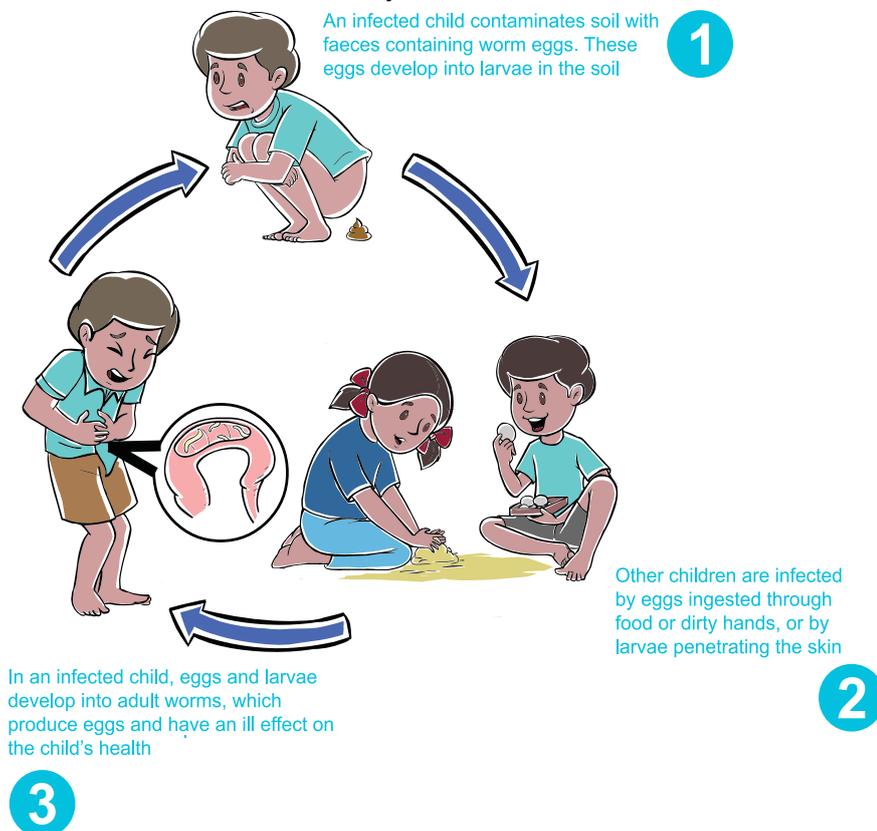
## FAQs for Frontline Health Workers

S No.	Questions	Answers
1	What are intestinal worms?	Worms are parasites, which live in human intestines for food and survival. The worms consume nutrients meant for the human body and cause blood loss, poor nutrition and stunted growth.
2	How do people get infected with worms?	Worm infections result from poor sanitation and hygiene conditions, and are transmitted from contact with infected soil. A schematic of the transmission cycle of soil-transmitted helminths is attached in Annexure I.
3	How to prevent the spread of worm infections?	There are several ways to prevent the spread of worm infections by improving hygiene, including: <ul style="list-style-type: none"> <li>• Washing hand, particularly before eating and after using toilets</li> <li>• Using sanitary latrines</li> <li>• Wearing Slippers</li> <li>• Drinking safe and clean water</li> <li>• Eating properly cooked food</li> <li>• Washing vegetables, fruits and salads in safe clean water.</li> </ul>
4	What are the harms associated with having worms? Why is Deworming children important?	Worm infections interfere with the health, nutrition and education of children. Worms can cause anaemia and malnourishment, which has negative effects on mental and physical development. Malnourished and anaemic children are often underweight and have stunted growth. Children with heavy infections are often too sick or too tired to concentrate at school or attend school at all. A child regularly treated for worms: <ul style="list-style-type: none"> <li>• Grows faster and is healthier</li> <li>• Is more resistant to other infections</li> <li>• Learns better and is more active in school</li> <li>• Attends school more regularly</li> </ul>
5	What is National Deworming Day?	National Deworming Day (NDD) is a day when all children between the ages of 1-19 years can receive treatment for intestinal worms from teachers at government, government-aided, and private schools and by anganwadi workers at anganwadi centers.
6	Why National Deworming Day is observed when there are other programs having a deworming component?	When deworming has been a part of other programs, like National Iron + Initiative including the Weekly Iron and Folic Acid Supplementation Program (WIFS), deworming has occurred inconsistently and not all at-risk children are currently receiving treatment. With NDD as a single fixed day strategy across India, the effort is to maximize the number of children treated.
7	When is National Deworming Day?	For financial year 2015-16, second phase of National Deworming Day will be observed on 10 February, 2016 across all states and UT.
8	Why are teachers and anganwadi workers distributing treatment, as well as health personnel?	Children are comfortable with their teachers, anganwadi workers and the community and parents have a lot of confidence in them. The teachers and anganwadi workers can easily give the deworming drugs to children with basic training. Teachers and anganwadi workers have been successfully deworming children in some States in India and over 30 countries world wide <sup>12</sup> .
9	Why treat all children if some do not appear sick ?	The effects of worms might not be seen immediately, but they can cause long-term harm to children's health, education, and overall well-being. Children can carry worms for a long time and not know they are sick; you will only see that they are doing poorly in school and not growing well. Since the drugs are safe whether or not a child is infected, and the cost of diagnosis is high, it is better to treat every child.

<sup>12</sup> 2010 Global NGO Deworming Inventory Summary Report: Deworming Programs by Country., retrieved from <http://storage.ugal.com/5115/deworming-programs-by-country-2010-3.1.12.pdf>

10	What treatment is to be given to children for intestinal worms?	Albendazole is the name of the deworming drug used by the Government of India. It is a safe treatment for intestinal worms used across the globe. The recommended dosage for children between the ages of 2-19 years is 1 tablet (400 mg) and ½ tablet of Albendazole for children in the 1-2 years age group.  For young children the tablet should be broken and crushed and administered with water. All drugs must be administered under supervision.
11	Does the deworming treatment have side effects?	The deworming treatment has very few side effects in children. There may be some mild side effects like dizziness, nausea, headache, and vomiting, all likely due to the worms being passed through the child's body. These side effects disappear after some time. Side effects are usually experienced by children with high infections. If symptoms do not go away within 24 hours, or if they are very severe, the child is probably experiencing something unrelated to the treatment and should be taken to the nearest health facility immediately.
12	Is it safe for children to consume the deworming tablet without having a meal?	It is fine to take the deworming tablet on an empty stomach.
13	Should the deworming tablet be given to a sick child?	If a child is sick, do not give him or her the deworming treatment. Only children who appear well should be treated.
14	What should the teacher / anganwadi workers do if a child shows a negative reaction / adverse reaction after deworming?	Call the help line as provided to you during the training session. Let the child rest in the shade and drink water. If the symptoms are very severe, it is probably unrelated to the treatment and the child should be taken to the nearest health facility.

### Transmission cycle of soil-transmitted helminths<sup>13</sup>



<sup>13</sup> Helminth control in school age children., A guide for managers of control programs ., 2nd edition ., WHO(2011)

# Annexure 7

Adverse Event Protocol  
NDD – At schools and anganwadi centers

Adverse Event Protocol

## 1. PURPOSE

This document is primarily based on the World Health Organization (WHO) guidelines<sup>14</sup> for assuring drug safety during mass drug administration (MDA).

The deworming drug (Albendazole 400 mg) used in the Government of India's school and anganwadi center – based mass deworming program - NDD - is effective, very safe, and approved by the WHO and the MOHFW of India for treating soil-transmitted helminths in preschool and school-age children. Extensive experience of deworming millions of children worldwide confirms that this drug itself causes only rare, mild and transient side events or adverse drug reactions, and that these reactions are generally related to degeneration of the worms that have been killed. Most of the adverse events observed in school programs occur during initial rounds of implementation of the intervention – a time when children harbor more infections of high intensity. Mild abdominal pain, nausea, vomiting, diarrhea and fatigue are the most commonly reported adverse events in some children with increased worm load, are not serious and do not normally require medical treatment.

An effective Adverse Event Protocol is intended to protect the program, and those who administer the program, by providing clear instructions on the management of adverse events. Although rare, adverse events can and do occur in programs on a large scale in mass drug administration, and all stakeholders should be well-prepared to ensure safety of all children participating in the program.

## 2. DEFINITIONS

An **Adverse Event (AE)** is a medical incident that takes place after a preventive chemotherapy intervention and is suspected to be but is not necessarily caused by the medicines used in the intervention. Some AE, after investigation, may be found to have been caused by the medicine. Such AE will also be referred to as adverse drug reactions or side effects.

A **Severe Adverse Event (SAE)** is fatal, life-threatening, disabling, or incapacitating or that results in hospitalization after drug intake.

**Severe adverse events** can be defined as those that:

- are life-threatening or fatal
- cause or prolong hospital admission
- cause persistent incapacity or disability; or
- concern misuse or dependence on the drug

There are a number of key types of SAEs:

- Those caused by the drugs themselves: e.g., an allergic reaction to the drugs
- Those caused by the parasites degeneration when they are killed: e.g., intestinal blockage
- Those caused by operational issues: e.g., choking
- Those which are coincidental but unrelated: e.g., malaria around the same time as drug administration

## 3. PREPARATORY PHASE FOR MANAGING ADVERSE EVENTS

To effectively deal with any AE or SAE on Deworming Day, a coordinated approach should be established between the Health Department, the Education Department and WCD (ICDS) Department of the respective State Government. The roles and responsibilities of these three primary departments in adverse events management are detailed below.

<sup>14</sup> Assuring safety of preventive chemotherapy interventions for the control of neglected tropical diseases., practical advice for national programme managers on the prevention, detection and management of severe adverse events., WHO (2011)

### 3.1. Health Department:

Health Department Roles and Responsibilities	
WHO	WHAT
State Nodal Officer	<ol style="list-style-type: none"> <li>1. Designate official at state level for overall adverse event management</li> <li>2. Orient the District Civil Surgeon about the flow of information of any AE and SAE</li> <li>3. Adaptation of adverse event protocol in local language and further dissemination to districts and blocks</li> <li>4. Orient District Civil Surgeon about the flow of information of any Adverse Events and distribute reporting form to the District Civil Surgeon (Annexure 7)</li> </ol>
District Civil Surgeon	<ol style="list-style-type: none"> <li>1. Inform and orient the Block Medical Officer about Deworming Day and Mop-Up Day.</li> <li>2. Prepare an Emergency Response Team engaging RBSK and AYUSH doctors and train them to handle any AE or SAE at the Block level</li> <li>3. Ensure that Ambulance Services other mobility support vehicles i.e RBSK are available at Block level</li> <li>4. Distribute the reporting forms and cascade of information diagram to the Block medical officer.</li> <li>5. Circulate list of important phone numbers of the District health officials to every Block Medical Officer (Annexure 7 Section II)</li> </ol>
Block medical officer	<ol style="list-style-type: none"> <li>1. Inform and orient the PHC/CHC/ANMs about Deworming and Mop-Up Day</li> <li>2. Depute doctors to handle calls on the emergency helpline for Deworming Day and Mop Up Day</li> <li>3. Prepare PHCs/CHCs/ANMs to manage an increased number of children presenting with minor, non-specific symptoms</li> <li>4. Ensure ambulance services and other mobility support are on ALERT for handling any SAE cases</li> <li>5. Ensure phone numbers of the PHCs/ANMs are circulated to the Block education department for distribution to the school principals, ICDS-CDPO's Supervisors, anganwadi workers, and ASHAs.</li> </ol>
ANMs	<p>Should be prepared to accompany sick children to health facilities and ensure they receive appropriate medical attention and care. Visit assigned schools in advance if possible and collect information and phone numbers of the school principal. Provide their phone number to the school principal.</p> <p>Share the information collected with the Civil Surgeon. Also share the phone number of the helpline to all the assigned schools</p>

### 3.2 School Education and Literacy Department:

Department Roles and Responsibilities of School Education & Literacy	
WHO	WHAT
State Education nodal officer	<ol style="list-style-type: none"> <li>1. Inform all District education officers about Deworming Day and Mop-Up Day.</li> <li>2. Distribute the reporting form to the District education officer (Annexure I)</li> <li>3. Distribute the locally adapted Adverse event protocol and reporting format to the District education department.</li> </ol>
District Education officer	<ol style="list-style-type: none"> <li>1. Inform and orient the Block education officer about Deworming Day and Mop-Up Day.</li> <li>2. Distribute the reporting form to the District education officer or the “cascade” of information flow to the District Civil Surgeon (Annexure I)</li> </ol>
Block Education officer	<ol style="list-style-type: none"> <li>1. Inform and orient the principal and school teachers about Deworming Day and Mop-Up Day.</li> <li>2. The flow of information or the “cascade” on SAE in the school is to be shared with the department officials and school principals.</li> <li>3. Ensure to circulate important phone numbers of the Block level health officials to the school principal and instruct schools to display the emergency contact numbers in schools before deworming day</li> </ol>
Principals and teachers	<ol style="list-style-type: none"> <li>1. Teachers should inform parents of the children through different forums such as school management committee meetings or parents teachers meeting as appropriate ahead of Deworming Day about the following :               <ol style="list-style-type: none"> <li>a. Deworming and Mop-Up Day</li> <li>b. Benefits of deworming on children’s health and education</li> <li>c. Mild side effects in children may be expected to only children with high worm load. The side effects are usually not serious and would pass by soon.</li> <li>d. Preparations undertaken by the Education and Health Department to manage any AE.</li> <li>e. Build confidence that the child will be taken under observation and care if they show any serious side effects. They will be immediately taken to the nearest health centre.</li> </ol> </li> <li>2. Schools should prepare a shaded open area and keep safe drinking water available for children experiencing any side effects to rest until recovery.</li> </ol>

### 3.3 Education Department:

Women and Child Development (ICDS) Department Roles and Responsibilities	
WHO	WHAT
State Program Officer (ICDS) - Nodal Officer	<ol style="list-style-type: none"> <li>1. Inform all District ICDS officers about Deworming Day and Mop-Up Day.</li> <li>2. Distribute the reporting form to the District ICDS officer (annexure I)</li> <li>3. Distribute the Adverse Event Protocol and reporting format to the District ICDS department.</li> </ol>
District ICDS officer	<ol style="list-style-type: none"> <li>1. Inform and orient the Child Development Block Officer (ICDS- CDPOs) about Deworming Day and Mop-Up Day.</li> <li>2. Distribute the reporting form to the District education officer or the “cascade” of information flow to the District civil surgeon (Annexure I)</li> </ol>
Child Development Block Officer (CDPO) – ICDS	<ol style="list-style-type: none"> <li>1. Inform and orient the ICDS Supervisors and anganwadi workers about Deworming Day and Mop-Up Day.</li> <li>2. The flow of information or the “cascade” on SAE in the anganwadi centers is shared with the department officials and anganwadi workers. (Annexure I)</li> <li>3. Ensure to circulate important phone numbers of the Block level health officials to the ICDS Supervisors, anganwadi workers and instruct anganwadis to display the emergency contact numbers at anganwadi centers before deworming day</li> </ol>

Anganwadi Workers and ASHAs	<ol style="list-style-type: none"> <li>1. AWWs and ASHA should inform parents of the children through different forums such as VHND, VHSNC meetings, Gram Panchayats, home visit etc. about the following : <ol style="list-style-type: none"> <li>a. Deworming and Mop-Up Day.</li> <li>b. Benefits of deworming on children's health and education.</li> <li>c. Mild side effects may be experienced in children with high worm load. The side effects are usually not serious and would subside soon.</li> <li>d. Preparations undertaken by the WCD (ICDS), Education and Health Department to manage any Adverse Event.</li> <li>e. Build confidence that the child will be taken under observation and care if they show any serious side effects. In case of a prolonged adversity the child would be taken immediately to the nearest hospital.</li> </ol> </li> <li>2. AWCs should prepare a shady open area for children experiencing any side effects to rest until recovery.</li> </ol>
ANMs and ASHAs	<p>Should be prepared to accompany sick children to health facilities and ensure they receive appropriate medical attention and care. Visit assigned AWCs in advance if possible and collect information and phone numbers of the AWWs. Give own phone number to the AWWs.</p> <p>Share the information collected with the Civil Surgeon. Also share the phone number of the helpline with all the assigned AWWs.</p>

#### 4. MANAGING ADVERSE EVENTS ON DEWORMING DAY

**On National Deworming Day, school principals, teachers and anganwadi workers should be prepared for any AE or SAE by having read through the Adverse Events Protocol/Guidelines in advance, and ensuring that the protocol and emergency numbers are on hand.** All teachers and AWWs should clearly understand that children who are not well on deworming day should not be given the deworming drug.

The teacher and anganwadi workers MUST administer albendazole tablet under their direct supervision in Schools and Anganwadi on Deworming and Mop-Up Day. The tablet must not be handed over to the child or their family member for consumption later at home.

##### 4.1 Mild Adverse Events

Women and Child Development (ICDS) Department Roles and Responsibilities
<p><b>WHAT ARE THEY?</b> Events such as nausea, mild abdominal pain, vomiting, diarrhea and fatigue may occur among children especially those with high worm infestation. These side effects are transient and usually do not require hospitalization.</p> <p><b>WHAT SHOULD THE TEACHER/PRINCIPAL/AWWs DO WHEN MILD ADVERSE EVENT AT SCHOOL OR ANGANWADI CENTERS HAPPENS?</b></p> <ol style="list-style-type: none"> <li>1. Children with ANY side effects should be taken to an open and shaded place and allowed to lie down and rest. They should be provided with clean drinking water.</li> <li>2. Teachers, AWWs and parents should be prepared for these events and take immediate action in case that they occur.</li> <li>3. Children should remain at school or anganwadi center for at least 2 hours after treatment</li> </ol> <p><b>DO NOT PANIC AND FOLLOW GUIDELINES</b></p>

## 4.2 Severe Adverse Events (SAE)

### Women and Child Development (ICDS) Department Roles and Responsibilities

A **Severe Adverse Event (SAE)** is fatal, life-threatening, disabling, or incapacitating or that results in hospitalization after drug intake.

Choking hazard/asphyxia causes a severe adverse event which needs to be responded to immediately.

1. Separate the affected child from other children and stop deworming activities.
2. Stay calm and communicate that the SAE is likely not due to the deworming drug.
3. School principal should immediately call the Helpline number as per shared details. The school principal should use the information cascade.
4. If ambulance services are available, immediate ALERT the ambulance should be given for transport of the child to the nearest PHC/CHC.
5. The child's parents should be informed immediately.
6. Immediate treatment should be provided to the child by medical/health personnel (See **Annexure 7 Section VI: Guidelines for Emergency Response Team**). Medical treatment for adverse event should only be administered by medical/health personnel.
7. The ANM should inform the Medical officer who should complete an incident report form and submit it to the Civil Surgeon within the same day.
8. Once the reporting form is received, further notification to the next level must be made as per "cascade" of information flow.
9. The Mission Director (NHM) or the designated officer will sign/confirm the report(s), and determine if further investigation is needed and submit the report to the Mission Director immediately. The Mission Director or the designated officer will be the spokesperson to the media.

## 5. MEDIA HANDLING

### MEDIA HANDLING:

The designated officer at state level will be the spokesperson to the media. In all cases, it is important to maintain calm messaging and indicate that the adverse event is very likely not due to deworming medicine.

Before any media contact it is vital to prepare:

- Key messages;
- Answers for the likely and awkward questions;
- List of issues not to respond to (e.g. blaming an individual or speculating on the cause before the investigation is complete) etc.

If the teacher or AWWs is unable to manage Deworming Day after a SAE they should do the following:

1. Principal / AWW should suspend deworming temporarily until the health officials reach the school/AWC and make a decision about how to proceed.
2. Immediately elevate the situation via the information cascade.

## 6. MANAGEMENT OF SAE AFTER DEWORMING DAY

It is possible that an adverse event may occur after deworming day and may still be attributed to the administration of deworming drugs. Teachers, AWWs, parents, health facilities and all health officials and providers, including ANMs must be vigilant for such incidents in their area and elevate immediately through the information cascade. By becoming involved early in any potential SAE, the principals and ANM will reduce the chances that SAEs are incorrectly attributed to deworming drugs and will be able to undertake good and accurate community sensitization ahead of any media coverage.

## RESPONSIBILITIES AFTER DEWORMING DAY

WHO	WHAT
Parents	Should be informed that though mild AEs are expected and severe events are likely to be unrelated to the drugs, they are encouraged to report the incident at the earliest to ANM, ASHA or school principal if they are very worried about the health of their child.
Teachers / AWWs / ASHAs	Should investigate absenteeism more carefully after deworming day and encourage any sick children to seek treatment or inform an ANM if they are worried.
ANMs	To report any case brought into notice to the District Civil Surgeon or Chief Medical Officer through Block Medical Officer or directly as feasible .

## 7. DO'S AND DON'TS FOR SCHOOL AND ANGANWADI TO AVOID ANY SAE:

DO	DON'T
<ul style="list-style-type: none"> <li>Keep telephone numbers for helpline and the nearest health center and / or provider such as ANM and MOIC handy.</li> <li>Always direct the children to CHEW the medicine to avoid choking.</li> <li>Administer the tablet under your direct supervision</li> <li>For younger children at anganwadi, crush the table first and then administer.</li> </ul>	<ul style="list-style-type: none"> <li>Do not administer medicine to a sick child.</li> <li>Do not instruct children to swallow the medicine without chewing first.</li> <li>Do not hand over medicine to parents/ children for consumption at home</li> </ul>

**Information Cascade: If there is any SAE at the school or home the information cascade should be followed:**

SECTION - I
<p>INFORMATION CASCADE</p> <p>Home:</p> <p style="text-align: center;">To fill the reporting form for Adverse Events (Annexure 7 Section IV)</p> <p>Parent → Principal or AWW or ANM → Medical Officer → Medical Officer in Charge → Civil Surgeon → State Program Officer / Nodal Officer → Mission Director (NHM)</p>

SECTION - II

**CONTACT LIST OF DISTRICT MEDICAL OFFICERS**

The form is to be filled by the State Civil Surgeon and given to the State Education Officer for dissemination to schools and AWCs

**STATE HEALTH SOCIETY CONTACT DETAILS**

**District wise Name & Contact No.**

S.No.	District	District medical officer	Mobile No:
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			

SECTION - III

**CONTACT LIST OF BLOCK MEDICAL OFFICERS**

The form is to be filled by the District Medical officer and given to the District Education Officer and District Program Officer (ICDS) for dissemination to schools and AWCs respectively

**DISTRICT STATE HEALTH SOCIETY CONTACT DETAILS**

**Block wise Name & Contact No.**

S.No.	Block	Block Medical Officer	Mobile No.
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			

## SECTION - IV

### MILD ADVERSE EVENT REPORTING FORM

(Event that can be handled at school/AWC level) to be filled up by  
the school principal / AWW / ANM

**Name and Address of Child:**

**School Address:**

**Contact details of parent:**

**Treatment Site:**

**Reported By:**

**Contact Details of the person reporting:**

Drug Name (generic name)	Dose	Brand & Manufacturer	Batch Number

**Date/Time Deworming tablet given**

**Date and Time AE started**

**Action taken to treat AE :**

**Past medical history if any :**

**Nearest Hospital / Health Centre to  
where the child was taken in case  
he/she has not recovered:**

**SECTION - V**

**SEVERE ADVERSE EVENT REPORTING FORM**

From the Hospital / Health Centre

Date of Report:

<b>Patient Name :</b>	<b>Age:</b>	<b>Sex:</b>
<b>Patient Height and Weight:</b>		
<b>Location:</b>	<b>District:</b>	<b>Block:</b>

<b>Pre-existing conditions if any :</b>			
<b>Health status of the child during Deworming:</b>	<b>Good</b>	<b>Poor</b>	<b>Unknown</b>
<b>Other Medicine being taken (concurrently or recently):</b>			

<b>Drug name (generic name):</b>	<b>Batch Number :</b>	<b>Date of treatment:</b>
<b>How many tablets did the child take:</b>	<b>Did the child chew the tablet:</b>	<b>Was this the first time the child took deworming drugs:</b>

<b>Clinical signs and symptoms:</b>	
<b>Date of onset of symptoms</b>	<b>How long after deworming the symptoms showed</b>
<b>Was the patient hospitalised? : Y or N</b>	<b>If Yes : Date of Admission Reason for Admission</b>
<b>Conclusion:</b>	

**Sign and Seal of the Reporting Official**

## SECTION - VI

### EMERGENCY RESPONSE SYSTEM

An Emergency Response System has been put in place by the Health and Family Welfare Department of the State Government to manage any adverse events, mild and/or severe.

In case of any such adverse events, don't panic, as these adverse events are usually very mild in nature and likely to subside soon.

**Step 1.** Make the child lie down on a flat surface and give the child a glass of water to drink. Talk to the child and address all apprehensions.

**Step 2.** The doctor on call will give you some telephonic instructions before his/her arrival. Follow the instructions and wait for arrival of health team.

**Step 3.** Doctor/Paramedical/RBSK team/AYUSH doctors staff arrival at the site. They assess the condition of the child, note down the vitals, and carry the adequate amount of the following medicines:

**Medicine Kit:**

Susp/Tab Domperidonione/Ondasterone  
Susp/Tab Dicyclomine  
ORS Packets  
Susp/Pack Paracetamol

**Step 4.** In case child is very sick, inform District Civil Surgeon and call an ambulance to transport child to the nearest Government Hospital/health facility for further management.

#### Guidelines for Block level Doctors / ANMs on Emergency Response Duty

1. Learn about the location of school and anganwadi centre in your area where deworming will be undertaken. Also collect medicine kit for management of SAE.
2. Visit assigned schools and anganwadi centres in advance if possible and collect information and phone numbers of the school principal and AWWs. Give your phone number to the school principal.
3. Share the information collected with the District Civil Surgeon. Also share the phone number of the helpline to all the assigned schools and anganwadi centres.
4. In case of reporting of any emergency follow the protocols circulated to resolve the issue.

## Annexure 8: Printing Guidelines for IEC and Training Material

All the prototypes can be printed in color and black and white. To print the prototypes in the black and white, go to file > print>printer properties>color>**print in Grayscale**.

### 1. Handouts - Teacher/Anganwadi

Job type: Folder design, colour, front + back, CMYK (4 colour)  
Orientation: Refer to sample print  
Print process: Offset Printing  
Paper type- 70-100 GSM, Maplitho/DO paper  
Final Print size: 24.81" x 11.69" (Custom size) – landscape orientation  
Post processes:

- Creasing
- Perforation

### 2. Flipcharts - Teacher/Anganwadi

Job type: Flipchart, colour, front + back, CMYK (4 colour)  
Orientation: Refer to sample print  
Print process: Offset Printing  
Paper type- 130gsm - 170gsm, uncoated  
Final print size: 16.54" x 23.39" (A2) – portrait  
Post processes:

- Spiral binding
- Cardboard on the back
- Metal eye (rivet) for hanging it from a nail

### 3. ASHA Leaflet

Job type: Colour, front + back, CMYK (4 colour)  
Print process: Offset Printing  
Paper type- 70-100 GSM, Maplitho/DO paper  
Final print size: 8.27" x 11.69" (A4) – portrait  
Post processes:

- None

### 4. Posters (Health Care/Date-Teacher/Anganwadi Worker)

Job type: Colour, one-sided, CMYK (4 colour)  
Print process: Offset Printing  
Paper type- 60- 80 GSM, uncoated  
Final print size: 16.54" x 23.39" (A2) – portrait  
Post processes:

- None

### 5. Banner (Health Care - Teacher/Anganwadi Worker)

Job type: Colour, one-sided, CMYK (4 colour)  
Print process: Offset Printing  
Material – Flex – 250 GSM  
Final print size: 16.54" x 23.39" (A2) – landscape orientation  
Post processes:

- None

## 6. Handbill (2 Variations)

Job type: Colour, front + back, CMYK (4 colour)

Print process: Offset Printing

Paper type- 60-70 GSM, uncoated

Final print size: 8.27" x 11.69" (A4) – portrait

Post processes:

- None

## 7. Mini Checklist

Job type: Colour, front + back, CMYK (4 colour)

Print process: Offset Printing

Paper type- 70-100 GSM, Maplitho/DO paper

Final print size: 8.27" x 11.69" (A4) – portrait

Post processes:

- None

## 8. Banner

Job type: Colour, one-sided, CMYK (4 colour)

Print process: Offset Printing Material – Flex 250 GSM

Final print size: 16.54" x 23.39" (A2) – landscape orientation

## 9. Hording

Job type: Colour, one-sided, CMYK (4 colour)

Print process: Offset Printing Material – Flex - 200 GSM

Final print size: 16 ft" x 20ft" – landscape orientation

## 10. Docket

Job Type: Colour, front + back, CMYK (4 colour)

Pre Press: Make a screen

Print Process: Offset Printing/ Screen Print Paper type-300 GSM Matt

Final print size: A4 folder, white

Post processes:

- Pasting of A4 sheet- if you choose offset
- Creasing: If you choose offset

**National Deworming Day Coordination Committee**  
**Ministry of Health and Family Welfare, Government of India**

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## NOTES





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