Operational Guidelines on Nutrition Interventions, 2018-19 under Child Health Component

National Health Mission, Assam

Approved
Me

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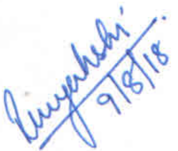
District RoP Approval – 2018-19 (Nutrition)

ASSAM RoP 2018-19		RoP Approvals, 2018-19			Owner of the Activities			State allocation on Fresh RoP approvals	District Allocation on Fresh RoP approvals
FMR	Particulars	Committed Unspent Amount (A)	Approved Budget (B)	Total Approval, 2018-19 (A+B)	At State HQ	At District Level	At Block level		
1.3.1.4	NRCs	0	78	78	Consultant Nutrition + PE - Nutrition	DPM	BPM	17.09	60.91
3.1.1.1.2	ASHA incentive under MAA programme @ Rs 100 per ASHA for quarterly mother's meeting	0	71.9	71.9	SCM+ Nutrition Consultant	DCM	BCM	0	71.9
3.1.1.1.5	Incentive for referral of SAM cases to NRC and for follow up of discharge SAM children from NRCs	0	3.6	3.6	SCM+ Nutrition Consultant	DCM	BCM	0	3.6
3.1.1.1.6	Incentive for National Deworming Day for mobilising out of school children	0	57.52	57.52	SCM+ Nutrition Consultant	DCM	BCM	0	57.52
3.1.1.1.7	Incentive for IDCF for prophylactic distribution of ORS to family with under-five children.	0	36.15	36.15	SCM+ Nutrition Consultant	DCM	BCM	0	36.15
3.1.1.1.8	National Iron Plus Incentive for mobilizing WRA (non pregnant & non-lactating Women 20-49 years)	0	52.36	52.36	SCM+ Nutrition Consultant	DCM	BCM	0	52.36



3.1.1.1.9	National Iron Plus Incentive for mobilizing children and/or ensuring)	0	187.65	187.65	SCM+ Nutrition Consultant	DCM	BCM	0	187.65
6.2.1.5	IFA tablets for non-pregnant & non-lactating women in Reproductive Age (20-49 years)	0	74.13	74.13	DDSM (HQ) & Consultant Nutrition	DDSM + DCM	BCM	74.13	0
6.2.1.6	Albendazole Tablets for non-pregnant & non-lactating women in Reproductive Age (20-49 years)	0	22.81	22.81	DDSM (HQ) & Consultant Nutrition	DDSM + DCM	BCM	22.81	0
6.2.2.3	IFA syrups (with auto dispenser) for children (6-60months)	0	90.56	90.56	DDSM (HQ) & Consultant Nutrition	DDSM + DCM	BCM	90.56	0
6.2.2.4	Albendazole Tablets for children (6-60months)		59.96	59.96	DDSM (HQ) & Consultant Nutrition	DDSM + DCM	BCM	59.96	0
6.2.2.5	IFA tablets (IFA WIFS Junior tablets-pink sugar coated) for children (5-10 yrs)	0	90.7	90.7	DDSM (HQ) & Consultant Nutrition	DDSM+ District Coordinator	BPA/BCM	90.7	0
6.2.2.6	Albendazole Tablets for children (5-10 yrs)		82.52	82.52	DDSM (HQ) & Consultant Nutrition	DDSM+ District Coordinator	BPA/BCM	82.52	0
6.2.2.7	Vitamin A syrup	0	44.65	44.65	DDSM (HQ) & Consultant Nutrition	DDSM + DCM	BCM	44.65	0
6.2.2.8.a	ORS	0	288	288	DDSM (HQ) & Consultant Nutrition	DDSM + DCM	BCM	288.23	-0.23
6.2.2.8.b	Zinc	0	185.23	185.23	DSM DDSM (HQ) & Consultant Nutrition	DDSM + DCM	BCM	185.23	0

6.2.4.1	IFA tablets under WIFS (10-19 yrs)		248.17	248.17	DDSM (HQ) & Consultant Nutrition	District Coordinator	BPA/BCM	248.17	0
6.2.4.2	Albendazole Tablets under WIFS (10-19 yrs)		57.98	57.98	DDSM (HQ) & Consultant Nutrition	District Coordinator	BPA/BCM	57.98	0
9.5.2.2	Management of Diarrhoea & ARI & micronutrient malnutrition (trainings only)	0	40.5	40.5	Consultant Nutrition	DPM	BCM	3.44	37.06
9.5.2.5	Provision for State & District level (Training and Workshops) (Dissemination to be budgeted under IEC; Meetings/ review meetings to be budgeted under PM)	0	26.23	26.23	Consultant Nutrition	DPM, DCM	BCM	1.94	24.29
9.5.2.11	Training on facility based management of Severe Acute Malnutrition (including refreshers)	0	5.03	5.03	Consultant Nutrition + PE Nutrition			5.03	0
9.5.2.18	4 days Trainings on IYCF for MOs, SNs, ANMs of all DPs and SCs (ToT, 4 days IYCF Trainings & 1 day Sensitisation on MAA Program)	0	117.3	117.3	Consultant Nutrition + PE Nutrition	DPM, DCM	BCM	11.16	106.14
9.5.2.19	Orientation on National Deworming Day	0	75.66	75.66	Consultant Nutrition	DPM, DME	BCM	4.71	70.95
9.5.4.9	WIFS trainings (District)	0	15.3	15.3	Consultant Nutrition	DPM, DC	BCM, BPA	0.17	15.13

12.2.2	Printing for Management of Diarrhoea & ARI & micronutrient malnutrition	0	4.17	4.17	SPM1 + Nutrition Consultant	DME		0	4.17
12.2.3	Printing for Micronutrient Supplementation Programme	0	0.74	0.74	SPM1 + Nutrition Consultant	DME		0	0.74
12.2.5	Printing of compliance cards and reporting formats for National Iron Plus Initiative- for 6-59 months age group and for 5-10 years age group	0	116.33	116.33	SPM1 + Nutrition Consultant			116.33	0
12.2.6	Printing of IEC materials and reporting formats etc. for National Deworming Day	0	172.8	172.8	SPM1 + Nutrition Consultant	DME		167.95	4.85
12.2.7	Printing of IEC Materials and monitoring formats for IDCF	0	13.5	13.5	SPM1 + Nutrition Consultant	DME		0.13	13.37
12.2.12	Any other (please specify)	0	37.01	37.01	SPM1 + Nutrition Consultant			0.5	36.51
16.1	Planning Activities	0	132.37	132.37	Consultant Nutrition	DPM, DCM	BCM	30.23	101.14
16.7	Any Other PM Activities	0	37.26	37.26	Consultant Nutrition	DPM, DCM	BCM	31.86	5.4

*Incase of vacancy of any post, I/c of specific programme will be the FMR owner of the programme automatically.

Nutrition Rehabilitation Centre

FMR 1.3.1.4

Guideline for Utilization of Operational Cost of Nutrition Rehabilitation Centre

Severely malnourished children are often die because of lack of specialized treatment practices that are not similar for most children, but suitable for severely malnourished (SAM) children. Nutrition Rehabilitation Centers (NRC) are established in Health Facilities to provide appropriate and facility based case management to children with SAM for all under 5 children.

Guideline for utilization of Operational cost

A. Kitchen supplies: - Every essential food items required for preparing all categories of diet for the admitted SAM children must be available at all the time.

   Supply for making Starter and Catch up Diet:

   - Fresh whole milk/ Dried skimmed milk powder.
   - Puffed rice.
   - Vegetable Oil.
   - Food Similar to those used in home (for teaching /use in transition to home/complementary feed)

B. Pharmacy supplies and consumables (If not supplied in EDL): -

   - Parent health institution where NRC is located should provide all drugs & consumables included in Essential Drug List (EDL) and which are available in the supply.
   - Most essential medicines as per treatment protocol under Facility Based management of SAM children are to be procured when those are not available in the NRC drug kit, at the Health Facility and at District Drug Store. Proper certification for each purchase to be obtained.

      i. Antibiotics: (Ampicillin/Amoxicillin/Benzyl penicillin)
      ii. Co trimoxazole
      iii. Gentamycin
      iv. Metronidazole
      v. Tobramycin eye drops
      vi. ORS
      vii. Electrolyte and minerals
      viii. Potassium chloride
      ix. Magnesium chloride/sulphate
      x. Iron syrup
      xi. Multivitamin
      xii. Folic acid
      xiii. Vitamin A syrup
      xiv. Zinc Sulphate or dispersible Zinc tablets
      xv. Glucose (or sucrose)

xvi. IV fluids (Ringer's lactate solution with 5% glucose; 0.45% (half normal) saline with 5% glucose; 0.9% saline (for soaking eye pads)

- All Consumables required for admitted SAM children for medical and therapeutic dietary treatments which are not available in supply from State or District may be purchased from Operational Cost. e.g.: Cannulas, IV sets, paediatric nasogastric tubes etc.
- Additional Investigation of SAM children which are not available in the Health facility /District Hospital may be arranged from local laboratories using operational cost after due record of tender process. (Mandatory investigations to be performed for all admitted SAM children)
- JSSK fund can also be utilized for expenditure on Drugs and Diagnostics for Infants up to 1 year of age.

C. Wage Compensation and food for mother/caregiver given:

Wage compensation and food for mother /caregiver @ Rs-100/- per mother/caregiver per day is approved for duration of the stay of SAM Child at NRC.

D. Therapeutic food for SAM children @ 50/- per child per day for the duration of the stay at NRC is approved under operational cost.

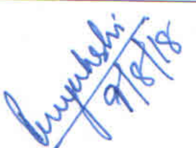
E. Operational Cost is for round the clock functioning of Nutrition Rehabilitation Centre as per standard protocol, Printing activities to be incurred from the same.

F. Operational Cost is approved for maintenance of all equipments, measuring and cooking appliances, making available of linen, laundry, supplies of cleaning agents and tools, kitchen garden etc. Air Conditioner for maintaining ward temperature may be procured from the Hospital Fund or Operational Cost of NRC with approval from state H.Q.

G. Provision of safe drinking water, power backup, internet connectivity, photograph print etc. may be provided either from Operational Cost or contingency.

Recurrent Expenditure Budget Estimate for 10 bedded NRC with 100% Bed Occupancy

Sl no	Item	Annual cost
1	Kitchen Supply	1,80,000
2	Pharmacy Supplies and Consumable	1,80,000
3	Other Cost	3,60,000
4	Wage Compensation	42,000
5	Maintenance of equipments, Linen, Cleaning supplies	18,000
6	Contingency	7,80,000



District wise Fund Break up

Sl no	Name of the District	Fund Approved (L)
1	Baksa	1.8
2	Barpeta	1.7
3	Bongaigaon	2.3
4	Cachar	1.7
5	Chirang	1.2
6	Darrang	6.8
7	Dhemaji	1.2
8	Dhubri(DH)	2.3
9	Dhubri (Mancachar)	0
10	Dibrugarh 1(Moran)	4.5
11	Dibrugarh 2(AMCH)	0
12	Dima Hassao	0
13	Goalpara	6.8
14	Golaghat	3.4
15	Hailakandi	1.7
16	Jorhat	6.8
17	Kamrup M	2.3
18	Kamrup R	0
19	Karbi Anglong	0
20	Karimganj	2.0
21	Kokrajhar	1.7
22	Lakhimpur	1.7
23	Morigaon	2.3
24	Nagaon 1(Raha CHC)	4.5
25	Nagaon 2(samuguri)	0
26	Nagaon 3(Nilbagan MH)	0
27	Nalbari	2.3
28	Sivasagar	0
29	Sonitpur	0
30	Tinsukia	0
31	Udalguri	1.7

Expenditure of the NRC is to be proportionate to bed occupancy.

NRC Protocol:

Following protocols should be maintained without any deviation in all NRCs

Hand washing

1. Working hand washing facilities to be in/ near the ward.
2. Constant hand washing by staff is mandatory each time before handling of food, after handling of patients.
3. Hands washing demonstration with soap to be done for mothers and caregivers.

4. Hands washing by mothers before feeding children to be monitored.

Bedding and laundry

1. Change of bedding to be every day or when soiled/wet.
2. Storing of diapers to be done for proper disposal
3. Soiled towels and rags to be washed immediately.
4. Place for mothers to do laundry to be arranged.
5. Facility for washing and drying cloths to be arranged.

General maintenance

1. Regular swapping of floors to be done. Floor surfaces should be easily cleanable and should minimize the growth of microorganisms.
2. Proper disposal of trash.
3. Protection of ward from insects and rodents. Windows should be covered with mosquito and fly covers.
4. NRC to be open 24X7.
5. **Walls:** As with floors, the ease of cleaning and durability of wall surfaces must be considered.
6. **Water supply:** Unit should have 24 hour uninterrupted running water supply.
7. **Power supply:** Unit should have a 24 hour uninterrupted stabilized power supply.
8. **Lighting:** Should be well lit.
9. **Ventilation:** Should be adequately ventilated, especially for the kitchen area.
10. **Patient area** to house the beds; in NRC adult beds are kept so that the mother can be with the child.
11. **Play and counseling area** with toys; audiovisual equipment like TV , DVD player and IEC material.
12. **Kitchen and food storage** area attached to ward, or partitioned in the ward, with enough space for cooking, feeding and demonstration.
13. **Attached toilet and bathroom facility** for mothers and children along with two separate hand washing areas.

1. **Drainage-** Proper drainage facility should be there for disposal of waste.

Food storage

1. Ingredients and food to be covered and stored at the proper temperature.
2. Discard of leftovers.
3. Discard old food items

Dishwashing

1. Washing of dishes to be done immediately after each meal.
2. Dish washing agents to be used for washing of dishes.

Feeding

1. Correct feeds to be served in correct amounts and at prescribed times, even during nights and weekends.
2. Children to be feed in the presence of mothers and nurses (never left alone to feed).
3. Children to be fed milk with a cup (never a bottle).
4. Food intake (and any vomiting/diarrhoea) to be monitored and recorded correctly after each feed.

Warming

1. The room temperature to be maintained between 25° - 30° C (to the extent possible).
2. Blankets to be provided and children kept covered at night.

Ward environment

1. Surroundings of the ward should be welcoming and cheerful.
2. Mothers to be provided with space for sitting and sleeping.
3. Mothers should be taught/encouraged to be involved in care.

Benchmark Performance

Indicators	Acceptable	Not Acceptable
Recovery Rate	>75%	<50%
Death Rate	<5%	>15%
Defaulter Rate	<15%	>25%
Weight gain(g/kg/d)	>=8g	<8g
Length of stay (weeks)	1-4	<1 and >6

Monitoring

A. Monthly review meeting to be conducted at NRC, which to be attended to by NRC staffs, Nodal Officer,DPM, DCM, Hospital Administrator. Preferably the meeting to be chaired by the Joint Director.

Key points of Discussion

- Review of the previous month
- Involvement of other staffs for identification and mobilization of children with SAM to NRC.

- Areas, which need improvement and immediate attention.
- ASHA payment.
- Bed occupancy.
- Any other relevant issue.

B. Event Management :

- Celebration of any nutrition related day & birth days of inpatients children.
- Regular demonstration on complementary food & power point presentation on complementary food for caregivers & mothers of inpatient children. (Operational cost of NRC to be used).
- Monthly once fix day screening of SAM children referred from community to be done by Dietician/ Nursing staff of NRC along with AWW/ RBSK team/ Local NGO etc.
- Best performing ASHA/AWWs for best referral & follow up to be rewarded (from contingency fund).

Input Indicator

- % of functional beds
- % of HR in place
- % of fund received

Process indicators

- % of staff trained
- % of fund utilization

Output Indicators

- % discharged with 15% weight gain
- Average length of stay
- % children with 4 follow ups (against due list)

Outcome Indicators

- Bed Occupancy Rate
- Recovery Rate
- Referral Rate
- Non-respondent rate
- Defaulter/LAMA Rate
- Case fatality Rate

Impact Indicators

- Infant Mortality Rate
- Under 5 Mortality Rate
- Severe Wasting Rate

Guidelines for utilisation of ASHA Incentive for SAM Case Referral and 4 Follow-up (Details mentioned in ASHA incentive section page 89)

1. Incentives for ASHA to realized , for referral and completion of four follow up after discharged of a child treated for SAM at NRC..
2. ASHA will get 150/- per child after completion of fourth follow up.
3. Payments for ASHA incentives for NRC follow-up must be done through the DBT mode.

*108 & 102 and Institutional National Ambulance Services may be used for Referral of SAM children

NRC SAM CHART

General Information

Name : .... Age (in months) : .... Date of birth (dd/mm/yy) : ...../...../........

Sex : .... SAM No : Hosp. Reg No : ....

Date of Registration (dd/mm/yy): Admission Date : ....../...../........

Address : .... Caste–SC/ST/OBC/General/Otheres

Phone No (Parents/ Any member of family) : Discharge date : ....../...../........

Complaints : .... Discharge from program : ....../...../........

Family Information

Mother's Name : .... Age (yrs) : .... Education : .... Profession : ....

Father's Name : .... Age (yrs) : .... Education : .... Profession : ....

Type of family : Joint/ Nuclear No of family Members................ No of Siblings : ....Average daily family income : ....

Sanitation facility

Water supply (specify) : .... Open defecation/latrine Electricity : Yes/No Refrigerator: Yes/No

Immunization History					
Immunization Status (Please Tick and record the date of giving)				Next (Due) Immunization	
				Date	Vaccines
At birth	BCG	OPV-0	Hep-B_0		
At 6 week	DPT-1	OPV-1	Hep-B_1		
At 10 week	DPT-2	OPV-2	Hep-B_2		
At 14 week	DPT-3	OPV-3	Hep-B_3		
At 9 Months	Measles		Vit-A		
At 16-24 Months	DPT-B	JE-1	Measles-2nd	Vit-A	

History

General History

(INFORMER-Mother/father/Grandmother/other caregver)

Appetie–Good/Poor (Do appetite test if facility available)

Diarrhoea–Yes/No:

Vomiting–Yes/No:

Fever–Yes/No:

Cough–Yes/No:

Lethargy–Yes/No:

Swelling of limbs/body–Yes/No:

Skin Changes –Yes/No:

Urinary complains–Yes/No/Notknown:

Dietary History

Early Initiation of breast Milk Yes/No

Exclusive breast Feeding Yes/No

Complementary feed Yes/No

if yes, age of introduction .... Number of times : ....

Dietary Recall (list all the foods and drinks consumed in 24 hours in addition to breast feeds. Note amount (approx) of each by showing a standard Cups/Katori/Glass)

Time	Fooditems Consumed
Morning (breakfast)	
Mid-morning (Snacks, if any)	
Afternoon (lunch)	
Dinner	
Pre-Sleep (Milk/Snacks/any)	
Midnight (Snacks, if any)	

Examination

General Physical Examination

Weight (g): .... Height/ Lenght (in Cms) : .... MUAC (mm) : .... Visible Severe wasting Yes/No :

Heart Rate (Per minute) : .... Respiratory rate (Per minute) : ....CRT : .... Temperature : .... (Hypothermia(35.C/95F) Fever/> =37.5C/>99. Central 5.F)

Chest indrawing : Yes/No Cyanosis : Yes/No B/L pedal oedema : Yes/No, If yes grade – +/++/+++

Alert : Yes/No Irritable : Yes/No Restless :Yes/No Lethargic Yes/No

If diarrahoea : No dehydration/dehydration present:

Septic shock Yes/No :

Hair Changes : Yes/No, if yes, describe :

Ear discharge : Yes/No, if yes, Pus/water :

Lymphadenopathy : Yes/No if yes, describe :

Skin Changes : Yes/No. If yes describe :

Eye–Signs of Vitamin A : Yes/No. If yes describe :

Mouth (Glossitis/Oralthrush/Angular Stomatis):

Pallor Yes/No if yes describe :

Sytemic Examation

Respiratory System:

Abdominal System :

Cardio-vascular System :

Central nervous System:

Investigations

Hb : .... Total Leukocyte count :

.... PCV : ....

Blood Glucuse : .... Urine R/M :

Blood Culture : Sterile/Growth, if growth describe:

C/s : Sterile/growth; Growth, describe:

Mantoux Test : Any other Investigation (Specify) :

9/8/18

Daily Care Chart:

	Week 1							Week 2							Week 3						
Days in NRC	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Date																					
Weight (gms)																					
Z Score																					
MUAC (mm)																					
Oedema (0/ +/ ++/+++)																					
Diarrhoea/Vomiting																					
Temperature																					
Type of feed																					
NG/Oral																					
Total Numbers of feed per day																					
Volume per feed																					
Amount offered (ml)																					
Amount left in cup (ml)																					
Amount taken by NG, if needed (ml)																					
Estimated amount vomited (ml)																					
Watery diarrhoea (if present, yes)																					
Total volume intake (in 24 hours)																					
Any IV fluids																					
Vit A																					
Vit K																					
Potassium																					
Magnesium																					
Zinc																					
Folic Acid																					
Multivitamins																					
Iron																					
Antibiotics																					
Any other (Specify)																					

Adm.weight:
Discharge weight:

Daily weight chart

Weight (Kg)

Counselling Session in NRC

DATE	DAY	TOPIC	GIVEN BY	REMARK
		General hygiene and sanitation		
		Immunization		
		Nutritional care for young children		
		Causes of malnutrition in children		
		Care of sick children		
		Appropriate cooking methods		
		Use of locally available resources (Kitchen garden)		
		Breast feeding		
		Complementary feeding		
		Demonstration onlocally available resources		
		Care of mother and familly planing		
		Importance of weighing the child and growth Monitoring		
		Follow up and care at home after discharged from NRC		
		Follow up and recap all sessions		
		Other		

REGISTRATION BOOK

Sl. No	SAM No.	Name of Child & Name of care giver/Mother	Referred by (AWW/ASHA/ health worker/others)	Date on Adm / Discharge	Weight Adm / Discharge	MUAC Adm / Discharge (mm)	Length/height Adm / Discharge (cm)	Wt. Z-score Adm / Discharge	Oedema Adm / Discharge
		Name of Child : Name of Care giver/Mother:							
		Name of Child : Name of Care giver/Mother:							
		Name of Child : Name of Care giver/Mother:							
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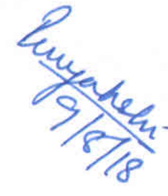


FOLLOW UP-I (At One Week)					FOLLOW UP-II (At Two Weeks, first month)					FOLLOW UP-III (Second Month)					FOLLOW UP-IV (Third Month)					Last Follow Up (Date, Wt., Z-score)	Target Wt. (g) / Target MUAC (mm)	Min. Wt. (g) / Day at Min. Wt.	Disch. Wt (g) / Day of Disch.	Average Wt. Gain (g)	*Exit indicator
DATE	Wt. (g) / MUAC (mm)	LH (cm) / Wt. Z-score	*Oedema	Remark	DATE	Wt. (g) / MUAC (mm)	LH (cm) / Wt. Z-score	*Oedema	Remark	DATE	Wt. (g) / MUAC (mm)	LH (cm) / Wt. Z-score	*Oedema	Remark	DATE	Wt. (g) / MUAC (mm)	LH (cm) / Wt. Z-score	*Oedema	Remark						

*Oedema: 0/+/++/+++

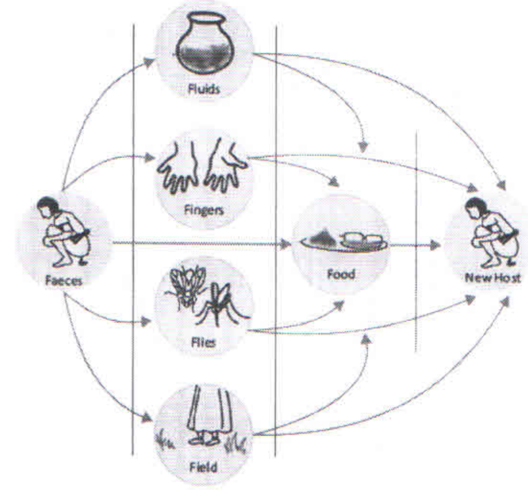
*Exit indicator: Cured/Default/ Medical Transfer/Non-Responders

Intensified Diarrhoea Control fortnight (IDCF)
FMR:9.5.2.2

Diarrhoea is considered when stools have changed from usual patter and are many & watery (more water than fecal matter). It is more common in settings of poor sanitation and hygiene, including a lack of safe drinking water. Most diarrhoea that causes dehydration is due to lose of water with stool.

Type of Diarrhoea	Definition
ACUTE DIARRHOEA	Is an episode of diarrhoea that lasts less than 14 days. Acute watery diarrhoea causes dehydration and contributes to malnutrition. The death of a child with acute diarrhoea is usually due to dehydration.
PERSISTENT DIARRHOEA	If an episode of diarrhoea that lasts for 14 days or more. [Up to 20% of episodes of diarrhoea become persistent, and this often causes nutritional problems and contributes to death in children]
DYSENTERY	Diarrhoea with blood in the stool, with or without mucus. The most common cause of dysentery is *Shigella* bacteria. Amoebic dysentery is not common in young children. A child may have both watery diarrhoea and dysentery.

Diarhoeal infection is majorly transmitted through the of faecal-oral diseases. The adjactent -diagram' illustrates the different routes that the microbes of diarrhoea take from faeces, through the environment, to a new person. For example; microbes in faeces on the ground by a well can get into the water system and be drunk by a child, hands that have not been washed after going to the toilet can carry microbes onto foods, which are then eaten, infecting another child, who gets diarrhoea and spreads more microbes.



IDCF is a set of activities implemented in an intensified manner for prevention and control of deaths due to dehydration due to diarrhoea.

Period of observation of IDCF: 13 days (dates of implementation 28th May to 9th June, 2018)

Goal of IDCF: To attain zero child deaths due to Childhood Diarrhoea

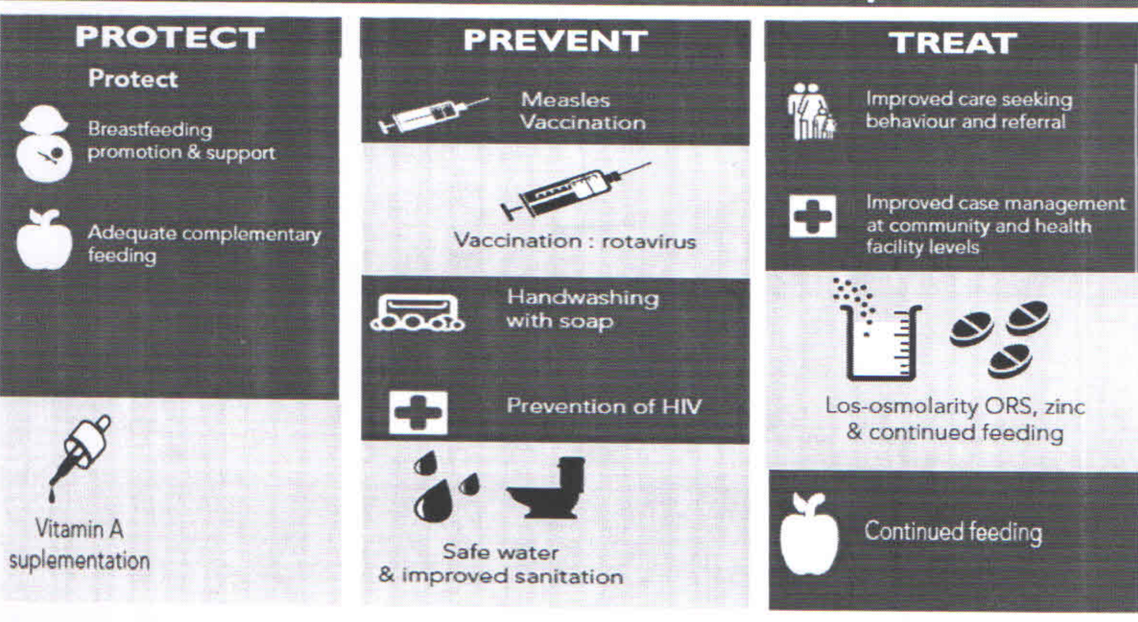
Objectives of IDCF:

- To ensure high coverage of ORS and Zinc use rate in children with diarrhoea
- Inculcation of appropriate behaviour in care givers for diarrhoea prevention and management
- Special focus on high priority area and vulnerable community
- Improvement of awareness on use of ORS and Zinc for child hood diarrhoea

- Strategies:
- Improved availability and use of ORS and Zinc at the community
- Facility level strengthening to manage cases of dehydration
- Enhanced advocacy and communication on prevention and control of diarrhoea through IEC campaign

Target Beneficiaries:

- All U5 children of each household
- U5 children suffering from diarrhoea
- Secondary
- Household members like mothers/ Caregivers
- School Teachers/School going children
- PRI members
- Health and ICDS functionaries
- Private caregivers



Pre campaign Planning

- Activation of steering committee.
- Assessment of availability of ORS and Zinc at all levels of the district
- Stock assessment and indent for ORS and Zinc to the state.
- District drug distribution plan of ORS and Zinc is done as per GoI guideline
- Planning of orientation at district and block.
- IEC plan based on guidelinesfor Launching and community awareness activity
- Plan of printing of IEC materials and other requisite formats

Pre campaign Planning

- Activation of steering committees at state & district level and conduction of the meeting.
- Assessment of availability of ORS and Zinc at all levels of the district
- Stock assessment and indent for ORS and Zinc to the state.
- District drug distribution plan of ORS and Zinc.

- Planning of orientation at district and block.
- IEC plan based on guidelinesfor Launching and community awareness activity
- Plan of printing of IEC materials and other requisite formats

Priority Area:

- Areas with vacant sub-centres: No auxiliary nurse midwife (ANM) posted for more than three months
- Villages/areas with ANMs on long leave or other similar reasons.
- High risk areas (HRAs) with populations living in areas such as:
  - Urban slums with migration
  - Underserved and hard to reach populations (forested and tribal populations, hilly areas etc.).
- Other migrant settlements (fisherman villages, riverine areas with shifting populations)
- Nomadic sites/Brick kilns
- Construction sites
- Orphanage/ Street children
- Areas known for or with diarrhoeal outbreaks, in last two years.
- Areas known for poor sanitation and water supply.
- Small villages, hamlets
- Tea garden population

Community based activities

Activity	Responsibility
➢ Distribution of ORS and demonstration at the household level	ASHA / Link Worker
➢ IPC activities on sanitation and hygiene along with management of Diarrhoea	ANM
➢ Hand washing demonstration in schools	Education department, Health and Family Welfare department & SBM
➢ Service delivery at Urban slum/ Underserved area/ Vulnerable pocket	Mobile Health team / Boat clinics/ MAS

Distribution of ORS and demonstration at the household level

- Distribution of one ORS sachets to each under five children.
- Delivering key messages related to diarrhoea and use of ORS and on the danger signs of diarrhoea.
- Group demonstration on by involving 4-8 households on
  - Steps of preparation of ORS.
  - Importance of hygiene and sanitation.
- Identification and referral of diarrhoeal cases to ANM/ health facilities
- Report all diarrhoeal deaths during the fortnight
- Reporting of the activities at the end of the campaign

IPC activities on sanitation and hygiene along with management of Diarrhoea

- Conduct IDCF meeting in her Sub centre village and VHNDs (as per her existing micro-plan)to disseminate information on prevention & control of diarrhoea, esp. involving care givers of under-five children.
- Imparting Key messages like importance of ORS and Zinc/ Continuing feeding during diarrhoea /Importance of hand washing in control of diarrhoea
- To carry out participatory learning technique on Hygiene and Sanitation.

Hand washing demonstration in schools

- Needs to be carried out in all primary and middle schools.
- Each school should have poster pasted at the hand washing area on steps for effective hand washing.
- After the morning assembly / prayers, message on importance of hand washing should be delivered to all the students.
- Before mid-day-meal, all children should be taught to wash hands following the steps in the poster with water and soap.
- Prabhat pheri or rally by school children on topic of hand-washing to be carried out.

Service delivery at Urban slum/ Underserved area/ Vulnerable pocket

- Urban slum/ Underserved area/ Vulnerable pocket to be covered under NUHM, NULM, Mobile Health team / Boat clinics/ MAS.

Facility based activities:

- Setting up of ORS and Zinc Corner at all health facilities
- Promote standard case management of diarrhoeal cases
- Cleaning of the water tank/ Aqua Guards of the public health facility and over all hygiene and sanitations activity to be undertaken

Setting up of ORS and Zinc Corner at all health facilities

- To be established in OPD/ Paediatric word of the Hospital or in a easily noticeable area of the hospital
- To be established in all Health Institutions i.e.
  - Medical Colleges
  - District Hospital
  - Block CHC / PHC
  - Sub Centre
  - Anganwadi centres
  - Private medical practitioners

- Pasting and display of facility appropriate treatment protocols in the corner to be ensured.
- Prescription of ORS along with Zinc tablet to be done.
- The area of ORS - Zinc Corner should be near a toilet or a washing facility, where mothers can clean the child and wash their hands before feeding them.
- Mothers can sit comfortably while administering ORS to their child.
- The room should be pleasant and well-ventilated.
- The corner should be functional for 24X7 in the hospital
- Ensuring sufficient availability of ORS and Zinc in the ORS and Zinc corner
- Counselling to be done to the mother by using IEC material related to ORS and Zinc
- One litre ORS solution to be made and to be kept in the Corner every day
- Area should be thoroughly and immidiately cleaned if there would be diarrhea or vomiting by the child

Promote standard case management of diarrhoeal cases (IDCF Tool kit is enclosed)

- Training of staffs and Medical Officers on various protocol of Diarrhoea management
  - Plan A : No dehydration
  - Plan B: Some dehydration
  - Plan C : Severe Dehydration
- Display of Protocols in the health institutions
  - Plan A and B in OPD
  - Plan C in wards

Cleaning of the water tank/ Aqua Guards of the public health facility and over all hygiene and sanitations activity to be undertaken

This activity to be carried out in convergence with SBM and PHE department.

Multi Sectoral Involvement

Name of the Department	Roles and Responsibility
➢ Department of Health and Family Welfare	• Over all coordination, planning, monitoring and reporting of the programme
➢ Department of WCD	• Involvement in community distribution of ORS • Monitoring and supervision of the programme • Establishment of ORS and Zinc corner in AWC • Launching of the programme at the district level
➢ Department of Drinking water and sanitation	• Involvement of launching of the programme at the district level • Facilitation of provision of safe drinking water at the schools and AWC
➢ Department of Education	• Involvement of launching of the programme at the district level • Facilitation of school level WASH activity • Arrangement for hand washing demonstration in schools • Arrangement of various competitions among school children
➢ Department of PRI	• Facilitation of District Launching of programme • Facilitation of setting up of ORS and Zinc corner at the AWC • Dissemination of messages of IDCF at the community
➢ IAP/ IMA	• Facilitation of state and district launching programme • Organising sensitisation meeting of private paediatricians, chemists regarding use of ORS and Zinc • Creating awareness about rational use of antibiotics during diarrhea • Facilitation of setting up of ORS and Zinc corner at the private facilities
➢ Development Partners UNICEF	• Technical support for planning and organising workshops • Facilitation of state and district (HPD) launching • Monitoring and supervision of IDCF activity with a special focus in HPDs

Reporting

- Each ASHA shall provide the filled monitoring formats at the end of the IDCF to the ANM (Within first two days of post Fortnight)
- ANM will submit the compiled report to the Block within the next two days of receiving from ASHA.
- The Block DEO will collate the reports and submit it to the district M and E in another 2 days.
- The district M&E will submit the compiled duly signed copy to the State level in another 3 days after receiving from the Block.
- State IDCF reports would be sent to National level.
- (Formats Enclosed)

Set up of ORS – ZINC CORNER

ORS - Zinc Corners are usually meant for childhood diarrhoea with **some dehydration** to be administered ORS under supervision for **4 hours**. Also no-dehydration cases that come directly to facilities could be treated at the ORS – Zinc corners. When there are no diarrhoea cases using the ORS – Zinc corner, the area can be used for treating other problems

Location:

ORS – Zinc corners should be **permanently at health facilities** like like Medical Colleges, District Hospitals, Block health facilities, primary health centres, sub-centres, private paediatrics facilities etc. Earmark a suitable area in the health facility for the corner. A small corner in the OPD or ward or any other suitable area in the health facility is generally enough for this purpose. The space required would depend on the case load. While earmarking such an area it should be ensured that:

- In case of hospital, the area is close to the workplace of the Doctor so that assessment of the child can be carried out frequently.
- The area is near a toilet or a washing facility, where mothers can clean the child and wash their hands before feeding them.
- Mothers can sit comfortably while administering ORS to their child.
- Pleasant and well-ventilated.

Timings:

The ORS – Zinc corners should be **functional during OPD timings and 24 hours in paediatrics ward**. A health worker who is trained in preparation of ORS solution and Zinc solution, should be posted to manage the corner. The corner should be prominently labeled as *"ORS – Zinc Corner for treatment of diarrhoea"*

Materials required for management of ORS – Zinc corner

- One table and two chairs / one bench with a back where the mother can sit comfortably while holding the child should constitute the corner
- Shelves to hold supplies
- Sufficient ORS packets and Zinc tablets with potable drinking water in a clean container, five glasses (200 ml), bowl / cup, soap, waste-backet, one litre vessel, clean spoons and leaflets should be on the table.

Counselling at the ORS – Zinc corners:

- The doctor / staff should counsel the mother in person using MCP card and administration of Zinc for 14 days.
- ORS – Zinc corner is a good place to display informative materials. Banner and poster on ORS – Zinc, hand washing and continued feeding should be displayed at the corner.

Activities:

- At least one litter of ORS solution should be prepared daily after washing hands with soap and water. The solution should be kept at the ORS – Zinc corner. It should be readily available to the mother when required. Replenish the solution whenever required. More than 24 hours prepared solution should be discarded and not be used. After the mother has washed her hands thoroughly with soap and water, provide the ORS solution in bowl / cup or glass with spoon to enable her to administer the solution.
- In case of a diarrheal episode during ORS administration, the child and mother and the area should be thoroughly cleaned. After washing hands again with soap and water the mother should administer ORS.
- If the child vomits, the child and mother and the area should be thoroughly cleaned. After washing hands again with soap and water the mother should administer ORS more slowly.
- In case of no-dehydration diarrhoea,
  - Administer ORS solution at the corner for some time till the child is comfortable.
  - Explain the mother on how to prepare the ORS solution, if possible demonstrate.

- Demonstrate on how to prepare age appropriate Zinc tablet solution in a spoon.
- Administer the first dose of Zinc tablet solution.
- Explain when to administer ORS and Zinc.
- Provide at least one ORS packet and 13 tablets of Zinc to take home.
- Advice on age appropriate feeding during diarrhoea
- Advice when to return

- In case of some-dehydration diarrhoea,
- Administer ORS solution at the corner for 4 hours
- Re-asses the child for status of dehydration.
- In case of no dehydration, follow the above steps for no-dehydration diarrhoea.
- In case of severe-dehydration, the child needs to be admitted for Plan C treatment.

Content for VHSNC meeting to be conducted during IDCF.

ANM should carry out IDCF meeting with VHSNC members in her subcentre village and those villages where her VHND workplan falls in the IDCF weeks. ASHA will mobilize all families with under-five children as well as VHSNC members for the session.

1. ANM should start the session with key message of the IDCF campaign highlighting importance of ORS and Zinc, hand-washing and importance of Sanitation & hygiene in control of childhood diarrhoea.

a. After highlighting importance of hygiene and sanitation, ANM and or ASHA would demonstrate hand-washing with soap and water.

b. ANM will demonstrate preparation of ORS and Zinc, importance of safe water, hand-washing.

c. ANM will communicate on danger signs of diarrhoea.

d. ASHA would distribute ORS to each family with under-five child who are present during the session.

e. If there are cases of diarrhoea then ANM or ASHA will assess the child and provide ORS – Zinc. If child is severely dehydrated then referral will be ensured.

2. PLA technique to be used for advocacy around sanitation & hygiene: PLA (Participatory Learning Approach) techniques should be carried out such as mapping of open defecation areas in and surrounding the village and plan for stopping open defecation should be chalked out, with active participation of VHSNC members and representatives from Department of Drinking Water and Sanitation.

a. The ASHA / ANM will ask the participants to narrate the ailments caused due to water contamination. This could be Diarrhea, Typhoid, Intestinal worms, Abdominal pains, Vomiting etc.

b. The ASHA / ANM will ask participants to say what contaminates the water and food to cause these diseases. A relationship between human faeces, water and the diseases will be established. Focus on how faecal matter slowly recedes into the soil. She will explain how contaminated human faeces get into water and food from open defecation through flies.

c. The ASHA / ANM will ask one of the participant's who had suffered from Diarrhea, about the suffering and cost involved for treatment.

d. A calculation of quantity of faeces will be done. For this The ASHA / ANM will ask the participants the average percentage of households that do not have a toilet.

□ Average percentage of households that do not have toilet X Total population of the village = No. of people defecating in the open.

• No. of people defecating in the open. X 0.3 kg (average faeces excreted per person per day) = Daily quantity of faeces excreted in open (in kg).

• Daily quantity of faeces excreted X 30 days = Monthly quantity of faeces excreted in open (in kg).

• Monthly quantity of faeces excreted per day X 12 months = Annual quantity of faeces excreted in open (in kg).

e. The importance of use of toilet for defecation will be emphasised.

f. A rough map of the village will be drawn on the ground using a stick or stone.

g. Geographical areas within the village and it's vicinity that are used for open defecation (i.e. toilets not used for defecation) will be marked in the map. She will explain how contaminated human faeces get into water and food from open defecation through flies.

h. A plan will be made / updated on construction of toilets in the households of the village.

3. For the above exercise, ASHA may test water from it's source using the field test kit (H2S vials) that is with the gram panchayats. The result of the test is available in 24 hours. The result can be declared during the above exercise.

Process indicators

- % of Trained & Oriented staff at district
- % of Drugs distributed
- % of IEC Materials Distribution
- % of ASHAs oriented/trained
  % of agnanwadi workers oriented/trained
- Preparation of Micro Plan (District/Block/SC)
- % of Fund Released to Blocks
- % of Fund Utilization

IDCF Output Indicators Indicators

- % of villages where ORS was distributed
- %. of children distributed with ORS
- % of children reported with Diarrhoea during IDCF
- % of children with Diarrhoea provided with ORS
- % of children with Diarrhoea provided Zinc for 14 days
- % of children detected with Danger signs and referred by ASHA
- % of villages where VHNSC session on sanitation was conducted giving emphasis on diarrhoea
- % of ORS – Zinc corner established against HI
- % of slums / hard-to-reach areas targeted by MHT
- % of children with Diarrhoea provided with ORS by MHT
- % of children with Diarrhoea provided Zinc for 14 days by MHT

Impact indicator

- IMR
- Under 5 mortality rate
- Diarrhea rate
- Malnutrition rate

Budget Break Up for IDCF 2018

Serial No	Name of the District	Orientation workshop at districct level @ 10 participants per block@ Rs 100/ per participants	Orientation workshop at block level @ 65/ per participants (ASHA/ ASHA supervisor/ ANM/ Urban ASHA/ AYUSH M.Os)	District Steering Committee Meeting	District Launcing	Total Cost (L)
		FMR 9.5.2.2				
1	Baksa	6000	101335	2500	5000	1.14835
2	Barpeta	7000	165425	2500	5000	1.79925
3	Bongaigaon	4000	71500	2500	5000	0.83
4	Cachar	8000	186485	2500	5000	2.01985
5	Chirang	2000	69875	2500	5000	0.79375
6	Darrang	4000	103675	2500	5000	1.15175
7	Dhemaji	5000	75335	2500	5000	0.87835
8	Dhubri	7000	190710	2500	5000	2.0521
9	Dibrugarh	6000	143910	2500	5000	1.5741
10	Dima Hasao	3000	33020	2500	5000	0.4352
11	Goalpara	5000	111540	2500	5000	1.2404
12	Golaghat	5000	110695	2500	5000	1.23195
13	Hailakandi	4000	71110	2500	5000	0.8261
14	Jorhat	7000	125450	2500	5000	1.3995
15	Kamrup M	5000	76505	2500	5000	0.89005
16	Kamrup	12000	189020	2500	5000	2.0852
17	Karbi Anglong	8000	116805	2500	5000	1.32305
18	Karimganj	5000	131495	2500	5000	1.43995
19	Kokrajhar	4000	126035	2500	5000	1.37535
20	Lakhimpur	6000	117455	2500	5000	1.30955
21	Morigaon	3000	93340	2500	5000	1.0384
22	NAGAON	11000	252005	2500	5000	2.70505
23	Nalbari	4000	85995	2500	5000	0.97495
24	Sivasagar	8000	144430	2500	5000	1.5993
25	Sonitpur	7000	209820	2500	5000	2.2432
26	Tinsukia	4000	141765	2500	5000	1.53265
27	Udalguri	3000	105755	2500	5000	1.16255
	Total	153000	3350490	67500	135000	37.0599

Village level plan for IDCF and implementation checklist

(For ANM)

(MOIC to ensure this format is filled for all sub-centres including vacant sub-centres)
Name of the sub-centre:____________ Block: ____________ Name & Mobile no of ANM:__________

ANM visit plan during IDCF

Sub Centre- 1

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14
Village/ urban area														
VHND village (as per routine microplan) (Write Yes /No)														
No. of under 5 children in the village														
Name of ASHA and mobile no														

Sub Centre- 2 (if any)

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14
Village/ urban area														
VHND village (as per routine microplan) (Write Yes /No)														
No. of under 5 children in the village														
Name of ASHA and mobile no														

Sl no	List of vulnerable area to be covered (nomadic/tribal/brick kiln, tea garden etc)
1	
2	
3	
4	

IDCF

Village level plan cum monitoring format for IDCF and implementation checklist

(For ASHA)

District: __________ **Block:** __________ **Village:** ____________ **Total population:** __________ **Families with under 5 children:** _____

ASHA: ______________________________ **Mob. No. :** ______________ **Total under five children:** __________

Listing of children (**to be done before the campaign i.e. 13 – 16 May**)							Home visit (**28 May – 9 June**) to be filled during the campaign				
Sr. No	Father name	Mother name	Child detail				Date of visit	Distribution of ORSwith demonstration **(✓ if yes)**	Does the child suffer from diarrhoea **(✓ if yes)**	ORS &Zinc given to the child with diarrhoea **(✓ if yes)**	Whether danger sign and referred **(✓ if yes)**
			Name	Age	Gender (✓ wherever applicable)						
					M	F					
Total											

Signature of ASHA: ___________

___________ SIgnature of ANM: ________________________

Anuradha 9/8/18

Mobile team plan and reprortingfor IDCF

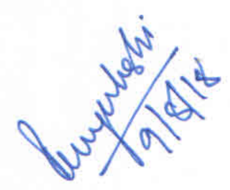
Name of block / municipal area : ________________ Name of Medical Officer I/c of IDCF:________________ Mobile No.: ________________

Plan							Actuals			
Team No	Name of team members	Vehicle No	Mobile No.	Date of planned visit	Place of visit	Estimated under 5 children in the place	Date of visit	No. of children distributed ORS	No of children treated with ORS	No of children treated with Zinc

Signature of Medical Officer I/c of IDCF:

____

District reporting format		
IDCF Report : 28 MAY-09 June 2018		
1	Name of the Ditrict	
2	Name of Nodal Officer Implementing IDCF Email: Phone:	
3	No. of Blocks conducted IDCF 2018/Total No. of Blocks	
4	State launch undertaken as per guideline	
5	No. of ASHAs oriented on IDCF/ Total no of ASHA	
6	No. of ANMs oriented on IDCF/ Total no of ANMs	
7	No. of M.Os oriented on IDCF / Total no of M.Os	
8	No. of Staff Nurses oriented on Diarrhoea management/ No. of Staff Nurses in district	
9	Dates of IDCF observation:	
10	No. of vehicles hired for field supportive supervision	
11	No. of HPDs where supportive supervision was undertaken by DPs/Total no. of HPDs	
12	Total No. of villages in the district	
13	No of villages where ORS was distributed	
14	No of under five children in the villages	
15	No. of children distributed with ORS	
16	No. of children reported with Diarrhoea during IDCF	
17	No. of children with Diarrhoea provided with ORS	
18	No. of children with Diarrhoea provided Zinc for 14 days	
19	No. of children detected with Danger signs and referred by ASHA	
20	No. of villages where VHNSC session on sanitation was conducted	
21	No. of ORS – Zinc corner established (including block / district level)	
22	No. of ORS – Zinc corner established in private medical practitioners	
23	No. of schools where hand-washing demonstration was carried out	
24	Number of health facilities where Plan A was displayed	
25	Number of health facilities where Plan B was displayed	
26	Number of health facilities where Plan B-SAM was displayed	
27	Number of health facilities where Plan C was displayed	
28	Number of health facilities where Plan C-SAM was displayed	
Performance of Mobile Health Team		
29	No. of slums / hard-to-reach areas in the district	
30	No. of mobile teams formed	
31	No. of children received ORS from mobile teams	
32	No. of children with Diarrhoea provided with ORS	
33	No. of children with Diarrhoea provided Zinc for 14 days	
34	No. of one day orientation meeting conducted at PHC	
35	No. of one day orientation meeting held at block level	
36	No. of one day orientation meeting held at district level	



Mothers Absolute Affection

FMR 9.5.2.18

Delayed initiation of breastfeeding followed by inappropriate feeding practices in the new-born leads to undernutrition in infants and children. The 1,000 days between conception and child's second birthday offer a unique window of opportunity to shape healthier and more prosperous future. Infant and Young Child Feeding (IYCF) practices are set of well-known, common and scientific recommendations for appropriate feeding of newborn and children under two years. To improve the breastfeeding and young child feeding practices in the country, the nationwide programme - 'MAA' (Mothers' Absolute Affection) was launched in August 2016. It involves a comprehensive set of activities on protection, promotion and support of breastfeeding and child feeding at community as well as facility levels.

A. Components of MAA

- Building an enabling environment & demand generation through Mass media and Mid media
- Capacity building of community health workers – ASHAs, AWWs & ANMs – on breastfeeding
- Community diagoue – by ASHAs through mother' meetings; & lactation support and interpersonal communication – by skilled ANMs at VHNDs/sub-centres
- Capacity building of auxiliary nurse midwives (ANMs)/nurses doctors on lactation support and managment at facilities
- Role reinforcement on breastfeeding – at all delivery points
- Monitoring and Awards/Recognition.

B. Activities under MAA

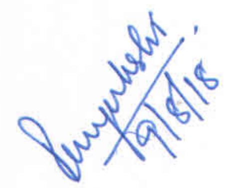
- Sensitization of health service providers on IYCF.
- Capacity building of delivery point staffs and ANMs
- Mothers meeting
- MAA award.

➢ **Sensitization of health service providers on MAA:**

Regular platform of monthly meetings are to be used to sensitized all health service providers.

Participants of the programme will be the all health care providers of the district excluding those who will be trained on 4 days training on IYCF.

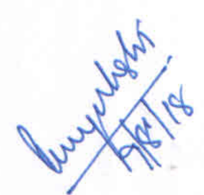
1. The sensitization programme will be of ½ day duration.
2. The Master Trainers of IYCF already trained at state will be the Resource Persons. (List of Master trainers will be communicated from Child Health Cell, NHM, Assam) the meeting preferably to be conducted during district or block level meeting.
3. The District Community Mobilizer (DCM) of the respective district will be responsible for co-coordination and organization of the programme under the supervision of the District Programme Manager (DPM).



4. Training will be as per the module (One Day MAA Sensitization Module) prescribed under MAA Guidelines
5. DCM of the respective district will be responsible for submission of the completion report to the CH section within one week of completion of the training in their respective district with following enclosures-
   a) Detailed participants list. B) Photographs

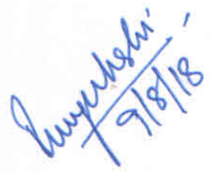
- **Capacity building of delivery point staffs**
  - Participants of the programme will be Paediatricians/O&Gs/MO(MBBS)/CHO/Staff Nurses/ ANMs of Delivery Points. DPs with highest deliveries in the districts to be covered first
  - Aspirational and NNM Districts to include one ICDS Supervisor from total 230 ICDS project across the state additionally as participant. Nomination to be receive from DSWO.TA/DA for ICDS supervisors will be born by their parent department.
  - The 4 days training module on MAA supplied from the State HQ to be used by all participants. The training to be done as per the content and agenda mentioned in the module. 7 days trainers guide already supplied to districts to be distributed among the participants for further reference on the subject.
  - The training period is of 4 days. **The participants should mandatorily attend the whole training for 4 days to complete the training.**
  - The batch size is 30. District wise no. of batches allotted is given below.
  - Two Mid-Level Trainers (MLTs) of MAA in each district will impart the training as Resource Persons (list will be provided by State HQ). Two more trainers from district previously trained on IYCF may be allowed to assist MLTs.
  - The training to be organized in consultation with MLTs by DPMU. DPM of their respective districts will be responsible for overall supervision and completion of the training with the help of DPMU. In case of shortage of MLT any district may approach the nearest district for the same.
  - District level training to be completed within September, 2018..
  - The training to be planned properly in line with the budget provision and full utilization of the budget to be ensured. For this district may do minimum modification in case of batch size but not less than 30.
  - All the required training modules and trainers guide as mentioned above, already been sent to districts from SHQ.
  - The training completion report to the CH section to be submitted within one week of completion of the training in their respective districts with following enclosures-A) Participants list. B) Photographs

NB:- District will inform CH section, NHM, Assam about the dates and venues of the training programme in advance, so that state officials can participate in the training for handholding support.



Training agenda

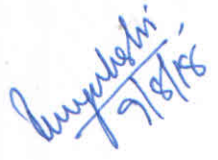
Time	Sessions	Minutes
	Day 1	
9-10am	Registration of participants, introduction of course material	60
10-10.30am	Tea	30
10.30-11.30am	Session 1: Why Optimal Infant and Young Child Feeding	60
11.30-12.30 pm	Session 2 Production and Intake of Breastmilk	60
12.30-1.30 pm	Session 3 Assessing and Observing a Breastfeed	60
1.30-2.30 pm	Lunch	60
2.30-3.30 pm	Session 4 Listening and Learning	60
3.30-4.00pm	Tea	30
4.00-5.00 pm	Session 5 Building Confidence, Giving Support and Checking Understanding	60
5.00-5.30pm	Session 6 Antenatal Preparation and Establishing Community Breastfeeding Support	30
	Day 2	
9.00-10.00am	Session 7 Positioning Baby at the breast	60
10.00-10.30am	Tea	30
10.30-11.15 am	Session 8 Breast conditions	45
11.15-12.00 am	Session 9 Refusal to Breastfeed and Crying	45
12.00-12.30 pm	Session 10 Expression Breastmilk	30
12.30-1.30 pm	Session 11 Not Enough Milk	60
1.30-2.30 pm	Lunch	60
2.30-3.00 pm	Session 12 Breastfeeding Low Birth Weight Babies	30
3.00-5.30 pm	Tea Home visit / visit to anganwadi center / Health Centre *(Listening & learning, confidence building, assessing to breastfed, feeding history, positioning)*	120
	Day 3	
9.00-10.10am	Session 13 Complementary Feeding - Foods to Fill the Nutrient Gap	70
10.10-10.30am	Tea	20
10.30-11.30 am	Session 14 Feeding Techniques and Strategies	60
11.30-1.30 pm	Home visit / visit to anganwadi center / Health Centre *(confidence building, complementary feeding)*	120
1.30-2.30 pm	Lunch	60
2.30-3.15 pm	Session 15 Sustaining Optimal Infant and Young Child Feeding	45
3.15-3.35pm	Session 16 Nutrition of lactating mothers their Health and Fertility	20
3.35-4.00 pm	Tea	30
4.00-4.30pm	Session 17 Breastfeeding by working mothers	30
4.30-5.00 pm	Session 18 Breastfeeding in Special Circumstances	30
	Day 4	
9.00-10.00am	Monitoring Growth	60
10.00-10.30am	Tea	30
10.30-11.30 am	Growth Monitoring Weight &Length/Height	60
11.30-12.30 pm	Growth Monitoring and taking action	60
12.30-1.30 pm	Feedback from trainees	60
1.30- 2.30 pm	Lunch	60
2.30-3.45 pm	Valedictory Function including distribution of Certificate to participants	45



Sl No	Activities	Unit	Unit Cost	Day	Total
1	TA for participants (on actual)	40	200	4	32000
2	Working Lunch, snacks & Tea	50	250	4	50000
3	Training materials for participants & Banner	40	180	1	7200
4	Honorarium for Resource persons	4	600	4	9600
5	TA for Resource persons	4	200	4	3200
6	Venue & LCD projector hiring	1	4000	4	16000
7	Contingency	1	4000	1	4000
Total					**1,22,000**

District wise Batch allocation

Sl no	District	No of batch	Fund approved (L)
1	Baksa	3	3.66
2	Barpeta	4	4.88
3	Bongaigaon	2	2.44
4	Cachar	3	3.66
5	Chirang	3	3.66
6	Darrang	2	2.44
7	Dhemaji	2	2.44
8	Dhubri	4	4.88
9	Dibrugarh	3	3.66
10	Dima Hasao	2	2.44
11	Goalpara	4	4.88
12	Golaghat	3	3.66
13	Hailakandi	2	2.44
14	Jorhat	4	4.88
15	Kamrup Metro	2	2.44
16	Kamrup Rural	5	6.1
17	Karbi Anglong	4	4.88
18	Karimganj	3	3.66
19	Kokrajhar	4	4.88
20	Lakhimpur	3	3.66
21	Morigaon	3	3.66
22	Nagaon	8	9.76
23	Nalbari	2	2.44
24	Sivasagar	3	3.66
25	Sonitpur	4	4.88
26	Tinsukia	3	3.66
27	Udalguri	2	2.44



MAA Training Completion Summery Report

District:

To no of batch:

To no of participants:

Resource Persons:

1
2
3
4

Period of conduction of training:

Block	Name of the Delivery Point	Name of Trainees			
		Doctors	GNM	ANM	Others

Joint Director **DPM**

9/8/18

➢ **Mothers meeting**

1. Total 3 rounds of Mother's meeting to be held by ASHA during till March, 2019 at any suitable place.
2. Multiple meetings may need to conduct to be covered all pregnant and lactating mothers in each round.
3. DCM will be responsible for conduction of the meeting.
4. DCM has to submit the monthly report to the Child Health Section on or before 8th of each month in the following format.
5. DPM will be the Nodal officer for the MAA programme at district and BPM will be the nodal officers at block level All activity and reports related to the programme should be done through the Nodal Officer.

ASHA Incentive

1. ASHA will get Rs 300/ (@Rs 100 per round) as incentive for total 3 rounds of meeting.
2. An eligibility criterion for ASHA incentive @ Rs 100 per round, is to cover 100% pregnant and lactating mothers in one round. (Detail refer ASHA Incentive page 89)

Mother's Meeting Reporting format

1. Name of the district Nodal Officer on MAA
2. Name & Contact no of Person preparing the report
3. Reporting Month
4. Date of Report Submission

Sl No	District	Block	Total No of Lactating mothers	Total No of ANC mothers	Total No of Lactating mothers present in Mothers Meeting	Total No of ANC mothers present in Mothers Meeting	Total no of Rounds completed

DPM

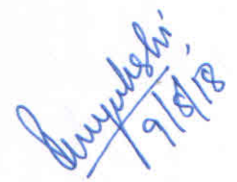
DCM

ANM - MAA reporting format

Name of the SC
Reporting
Month

Name of the District	Name of the block	Number of Mothers' meetings held.	Number and % of Pregnant & lactating mothers who attended mother's meetings.	Number and % of ASHAs having IYCF tool kit

ANM



ASHA - MAA reporting format

Name of the SC
Name of the village
Reporting
Month
Availibility of ASHA tool kit (Yes/ No)

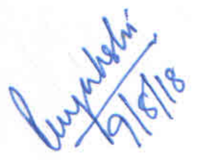
Number of Mothers' meetings held in the reported month

Date of Mothers' meetings held.	Name of the participants	Physiological state of the beneficiary (Pregnant / Lactating)	Number and % of ASHAs having IYCF tool kit

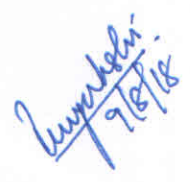
ASHA

List of MAA Mid Level Trainers for 4 days MAA training

List of District Level MLTs trained in 7 Days State Level MAA ToT				
SN	District	Name	Designation	Place of Posting
1	Baksa	Dr.Arjun sharma	MO(MBBS)	Adalbari SD
2		Dr.Himangshu Patuwary	MO(Ayur)	Dighaldenga MPHC
3	Barpeta	Dr.Babul Das	M &HO-I	Nityanandra BPHC
4		Dr.Zahidul Islam	MO(Ayur)	Mandia PHC
5	Darrang	Dr.Ramesh Goswami	MO(MBBS)	O/O of the Jt DHS,Darrang
6		Dr.Nabanita Bora	MO(Ayur)	Kharupetia CHC
7	Dhubri	Dr. Wahedur Rahman	M &HO-I	Dumardaha,MPHC
8		Dr.Asmat ali	MO(Ayur)	Halakuwa CHC
9	Dima Hasao	Dr.Jatin Ch. Das	Sr. MO(Ayur)	Harangajao PHC
10		Dr.L.Changsan	M&HO	Mahur BPHC
11	Goalpara	Dr.B.C. Baishya	Sr. M&HO	Civil Hospital
12		Dr.Kangkan Goswami	MO(Ayur)	Kushdhowa MPHC
13	Karbi Anglong	Dr. B. Verte	MO(MBBS)	Borlangfer MPHC
14		Dr. Bhaskar Jyoti Bharali	MO(AYUSH)	Dhansiri, Manja BPHC
15	Lakhimpur	Dr.Sashi sonowal	MO(AYUSH)	Civil Hospital
16		Dr.Hemanta Bora	M&HO	Boginodi Model Hospital
17	Nagaon	Dr. Azahrul Haq Choudhury	M &HO-I	Hatichung MPHC
18		Dr. Sangita Dhar	MO(AYUSH)	Raha SHC
19	Udalguri	Dr.Madan Basumatary	SDM&HO	Udalguri Civil Hospital
20		Dr.Dhrubajyoti Pathak	M &HO-I	Kajiamati SD
21		Dr.Amulya Das	MO(AYUSH)	Rowpa Model Hospital
22	Chirang	Dr Arshad Anam	MO(Ayur)	Ulubari SHC
23		Dr.Bijit Kr Saikia	MO(MBBS)	Sidli BPHC
24	Cachar	Dr.Atul Chandra Deka	MO(Ayur)	Dholai BPHC
25		Dr.Abdul Latif	MO(Ayur)	Tikol Model Hospital
26	Hailakandi	Dr.Muttakin Hussain Mazumder	M &HO-I	Algapur Model Hospital
27		Dr.Samiul Islam	MO(Ayur)	Algapur BPHC
28	Karimganj	Ms Dhanjita Kalita	Clinical Instructor	GNM Training School
29		Dr.Pallabi Bhattacharjee	M&HO-I	Civil Hospital
30	Bongaigaon	Dr.Mukul Sarma	MO(Ayur)	Mulagaon MPHC
31	Kokrajhar	Dr.Aminul Hoque Balban	MO(Ayur)	Tulshibil SHC
32	Golaghat	Dr.Abhisheck Tirkey	MO(Ayur)	Kaborugaon MPHC
33	Dhemaji	Dr.Mousumi Modhumita Agarwala	M &HO-I	Jonai BPHC
34		Dr.Alakesh Chutia	MO(Ayur)	Gogamukh BPHC
35	Dibrugarh	Dr.Parash Sarma Baruah	M&HO-I	Sassoni CHC
36		Dr.Rotna Prosad Nath	Sr.M&HO(Ayur)	Borborua PHC



37	Jorhat	Dr.Rekha Boruah	Sr.M&HO	Solamara BPHC
38		Dr.Sahabuddin ahmed	MO(Ayur)	Solamara BPHC
39	Kamrup Metro	Dr Monsoon Sharma	Sr.M&HO	Sonapur RFWC ,BPHC
40		Dr Shireen Nesha	MO(Ayur)	Hahara MPHC
41	Kamrup Rural	Dr.Jakaria Mahiuddin	MO(Ayur)	Puranburka MPHC
42		Ms Anjali Baruah	PHNI & Counsellor	Azra FRU
43	Morigaon	Dr Alpana Pegu	M&HO-I	Nakhola Model Hospital,Jagiroad
44		Dr Chandan Sharma	MO(Ayur)	Bhuragaon SHC
45	Nalbari	Dr.Syed Rajib Ahmed	M&HO-I	Dakhin gaon SD
46		Dr.Hirendra Nath Sarma	Sr. MO(Ayur)	Ghograpar BPHC
47	Sivsagar	Dr.Dhruba Lochan Nath	MO(Ayur)	Sapekhati BPHC
48		Dr.Pranami Gogoi	M&HO-I	Desangmukh MPHC
49	Sonitpur	Dr Naresh Sahu	M&HO-I	Itakhola MPHC
50		Dr.Kamaleswar Das	MO(Ayur)	Nagsankar MPHC
51	Tinsukia	Dr.Chandralekha saikia	SDM&HO	Hapjan BPHC
52		Dr.Minakshi Majumdar	MO(AYUR),RBSK	NA-Sadiya BPHC



National Deworming Day (NDD)
FMR 9.5.2.19

Soil Transmitted Helminths (STH) are significant public health concern for Assam. Around 68% children of 1-14 years of age are estimated to be at risk of parasitic intestinal worm infestation in India and . Evidence has shown detrimental impact of STH infestation on physical growth-anaemia, undernutrition and cognitive development as well as school attendance. Periodic deworming can reduce the transmission of STH infections. Ministry of Health & Family Welfare, Government of India, in collaboration with Ministry of Women & Child Development, Department of School Education & Literacy (under Ministry of Human Resource Development), Ministry of Drinking Water and Sanitation and Ministry of Panchayati Raj has decided to conduct annual mass deworming day observing National Deworming Day (NDD). From the year 2015, mass deworming is conducted across 27 districts of Assam as a fixed day strategy to reduce the harm caused by STH on millions of children in a cost effective, simple and safe manner.

Objective:

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.

Strategy:

- Fixed day approach leads to effective mobilization of stakeholders and communities essential for high coverage
- An optimal and cost effective mechanism
- Campaign style messaging to increase awareness across the country
- Support structures in place to easily track and respond to any case of adverse events
- Effective monitoring of program for improving implementation quality
- Leveraging of existing infrastructure rather than creating new channels of service delivery

Targets:

— Children enrolled in all government and government-aided schools

— Children enrolled in central schools

— Children enrolled in private schools

— Children registered at anganwadi centers

— Unregistered and out-of-school children in anganwadis and schools, respectively

— Rag pickers, children working in hotel, restaurants, garages other commercial establishment & children and adolescents living in slum/street through NULM.

— Children and adolescents living in orphanages, children homes, Juvenile Jails and Jails with prisoner mothers.

Doses:

AGE	DOSAGE	ADMINISTRATION
1-2 years	HALF	Crush the half tablet between two spoons, then add safe water to help administer the tablet
2-3 years	FULL	Crush one full tablet between two spoons, then add safe water to help administer the tablet
3-19 years	FULL	• Ask children aged 3-19 to chew the tablet properly. • Albendazole tablets that are not chewed may have significantly lower effectiveness. • Ensure drinking water is available. • Use a spoon to administer one full tablet to the child yourself and do not give it to parents to be taken home.

Steps of implementation

A. District Coordination Committee Meeting and sensitization to be conducted before each NDD round.

i. Meeting to be chaired by the Principal Secry. of Autonomous Council/ Deputy Commissioner cum Member Secy. of DHS.

ii. Members are Jt. Director (DHS), District Nodal Officer for NDD, District Social Welfare Officer, District Elementary Education Officer, Inspector of Schools, Deputy Inspector of Schools DPM (NHM),DMC (SSA), Superintending Engineer (PHE),District Level officials from PHD, Representative from Development Partners (UNICEF/ IAP etc.), DAM, DDM, SDM&HO,District Coordinator, Urban Health Coordinator, BPM, BCM, BDM, BAM, BEE/HE, CDPO/PO (ICDS), IS, DEEO, BEEO (Education Deptt.).

Points to be discussed:

a. Inter Departmental Convergence
b. Availability of drugs
c. IEC activity
d. Trainings at different levels
e. Adverse Event Management Protocol
f. Micro Plan on NDD with special emphasis on hard to reach areas, difficult SC.
g. Plan for deworming of ragpickers, children and adolescents working in hotels, living in Orphanages, Children Homes, Juvenile Jails and Jails with prisoner mothers etc.
h. Involvement of all Government, Private and Central Schools & Colleges.

i. Supervision and Monitoring

j. Reporting on Time

k. Awareness generation on general sanitation and hygiene to prevent worm infestation in coordination with Public Health Department/ Swach Bharat Mission

iii. Orientation NDD to be done by the district Nodal Officer on NDD with other DPMU staffs, who attended State Orientation/ VC on NDD.

iv. The venue for training should have facilities of proper sound and light plus power point presentation.

v. The venue should be large enough to accommodate all participants with toilet and dustbin facilities.

vi. Roles and responsibilities of all departments to explained properly.

vii. Training should include Monitoring and Reporting.

B. Block level sensitization

i. Participants are Ayush Team, MPW, ANM School Principals/ Teachers and ICDS functionaries. (Training of Ayush Team, MPW, ANM to be done during monthly meetings)

ii. Orientation to be done by the block Nodal Officer on NDD with other staffs, who attended District Orientation.

iii. The venue for sensitization should have facilities of proper sound and light plus power point presentation.

iv. The venue should be large enough to accommodate all participants with toilet and dustbin facilities.

v. Reporting formats to be distributed during training.

vi. Refreshment to be serve properly.

C. Project/ Sector level Training

i. ASHA, ASHA Supervisors, Link Workers, LS and AWW to be trained during their respective monthly meetings.

D. Roles and responsibilities

i. District

a. The programme will be under the overall supervision of the district Nodal Officer.

b. Arrangement of coordination committee and orientation to be done by the DME.

c. Community mobilization, Line listing of ASHA, field level implementation of NDD, release of ASHA incentive to be supervised by DCM.

d. Minutes of the meeting to be shared with State H.Q, NHM, Assam.

e. Role and responsibly of all partner departments and respective officials to well defined in district Coordination Committee.

ii. Block

a. The block Nodal Officer would responsible for all activities related to NDD.

b. Arrangement of block level orientation to be done by BCM and BEE (planning, venue fixing, invitation to all participants, specially all teachers, refreshment etc.

c. Drugs and IEC materials to be distributed through Sub Centers/ during sensitization meeting and to be ensured by MPW and HE.

d. RBSK team to be involved in all activities.

iii. Sector

a. Drug distribution by block pharmacist

b. Distribution of IEC materials by MPW and HE.

c. MPW and HE would ensure availability of drugs and IEC materials up to School and AWC.

E. For NDD mobility districts are requested to use the regular mobility fund.

F. Adverse Event Management

- Events such as nausea, mild abdominal pain, vomiting, diarrhoea, and fatigue may occur amongst a few children, especially those who have high worm infection.
- Please do not panic. Follow the adverse event management protocol.
- Any adverse events are temporary and generally can be managed at the school/*anganwadi*.
- Self-limiting symptoms do not require hospitalization
- In case of an adverse event, make the child lie down in an open, shaded area and give the child water to drink.
- Choking is not to be considered a serious adverse event and is a medication error Albendazole is an easily chewable tablet. Still, if the child chokes on a part of the tablet, make the child bend over on your lap and pat the child on the back till the tablet comes out.

- In case of emergency call for any medical assistance. The doctor on call will give you some telephonic instructions before his/her arrival. Follow the instructions and wait for arrival of health team.(For this district needs to an Emergency Response System has to be put in place by the Health and Family Welfare Department at district / block level to manage any adverse events of mild and/or severe nature).

G. Reporting

Level	Functionary Responsible	Submitted to	Format	Submission date
School	Principal	ANM under whom the school falls in	School Reporting Format	To be decided by State
Anganwadi	AWW	ANM under whom the AWC falls in	Anganwadi Reporting Format	
Anganwadi	ASHA	ANM under whom ASHA is working	ASHA –Standard Reporting Format	
Sub-center level	ANM	MO – BHPC	School and Anganwadi ASHA Reporting Formats	
Block-Level	MO-BPHC	District Nodal Officer	Block-level Common Reporting Formats & Monitoring formats; including NDD app reporting	
District-Level	DME	State Nodal Officer	District-level Common Reporting Formats &Monitoring formats including NDD app reporting	

H. Monitoring

A. Preparatory Stage

At this stage the district monitors will ensure the preparation and readiness of the district as well as blocks on below mentioned points-

a. District Steering Committee Meeting.

b. Orientation of School Teachers/AWWs/ASHAs and officials/staff of other departments (Education, WCD, SBM(G), Tea Gardens, Pvt. School Associations).

c. Drug Status and distribution up to Schools and Anganwadi Centres Level.

d. Activation of Emergency Response System.

e. List of beneficiaries with special focus on Slums, street children, J J Homes, Children of prisoners, RSTC etc.

f. Convergence with other departments and their preparation.

g. Reporting Formats and Availability.

h. Fund Allocation to Blocks.

i. District and Block Monitoring Plan for NDD & MUD.

B. Implementation Stage

The districts and blocks will monitor the activities on Deworming Day and Mop Up Dayas per the standard monitoring format. The physical targets for monitoring will be-

a. By Districts-5% of the Schools and AWCs.
b. By Blocks- 10% of the Schools and AWCs.

Roles & Responsibilities of Partner Departments

- **Health & Family Welfare Department**
  - To lead NDD Coordination Committee meetings at all levels.
  - To ensure procurement, transportation and distribution of Albendazole tablets
  - Conduction of Orientation.
  - To disseminate Adverse Event Management Protocol at all levels starting from State to school and Anganwadi centre level.
  - To develop and provide financial guidelines and budgets to various levels for effective implementation.
  - To develop IEC strategies and materials and provide budgetary allocations for their printing and dissemination.
  - To ensure presence of ASHA workers at Anganwadi centres on NDD and MUD to support deworming of out-of-school and unregistered children.
  - To ensure community mobilization, mobilize beneficiaries especially out-of-school children and adolescents through ASHAs.
  - To develop and print reporting formats.
- **Social Welfare Department**
  - To ensure community mobilization, especially of out-of-school and un-registered children and adolescents through Anganwadi Workers (AWWs).
  - To coordinate with Department of Health and Family Welfare in effective roll-out of NDD.
  - To 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 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.

- To report coverage data to the Department of Health and Family Welfare in standardized formats within specified timelines.

- **Education Department**
  - To coordinate with Department of Health and Family Welfare in effective roll-out of NDD in all schools.
  - To place requisite indent for Albendazole tablet supply to the Department of Health and Family Welfare.
  - To train teachers to administer deworming drugs at schools.
  - Dissemination of IEC material to all schools, including community mobilization through School Management Committees.
  - To 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.
  - To report coverage data to the Department of Health and Family Welfare in standardized reporting formats within specified timelines in the cascade.

Process Indicator of NDD

- % of Trained & Oriented staff at district
- % of Drugs distributed
- % of IEC Materials Distribution
- % of ASHAs oriented/trained on NDD
- % of Govt./Govt. aided schools who attended training NDD
- % of private schools who attended training on NDD
- No. of agnanwadi workers oriented/trained for NDD

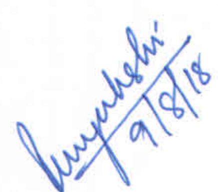
Output Indicators of NDD

- % of enrolled children (classes 1-5) who were administered albendazole on NDD and MUD Govt. School
- % of enrolled children (classes 1-5) who were administered albendazole on NDD and MUD Pvt. School
- % of enrolled children (classes 6-12) who were administered albendazole on NDD and MUD Govt. School

- % of enrolled children (classes 6-12) who were administered albendazole on NDD and MUD Pvt. School
- % of registered children in AWCCs (1-5 years) who were administered albendaxole on NDD and MUD
- % of unregistered children in AWCCs (1-5 years) who were administered albendaxole on NDD and MUD
- % of out of school children (6-10 years) who were administered albendazole on NDD and MUD
- % of severe adverse events reported from schools and anganwadis
- % of Govt./Govt. aided schools
- % of targeted private schools
- % of AWCs

Impact Indicators of NDD

- Malnutrition
- Prevalence of STH



Fund Break Up on National Deworming Day

Serial No	Name of the District	No of Blocks	District level orientation cum convergence meeting @ Rs 10000/-	Total Cost of orientation @ Rs-55/-per participants (In Lakhs)	Total for per round (In Lakhs)	Total for 2 round (In Lakhs)
1	Baksa	6	10000	1.23	1.33	2.664
2	Barpeta	7	10000	1.76	1.86	3.716
3	Bongaigaon	4	10000	0.71	0.81	1.626
4	Cachar	8	10000	1.66	1.76	3.520
5	Chirang	2	10000	0.63	0.73	1.451
6	Darrang	4	10000	0.90	1.00	1.992
7	Dhemaji	5	10000	1.01	1.11	2.213
8	Dhubri	7	10000	1.89	1.99	3.988
9	Dibrugarh	6	10000	1.14	1.24	2.478
10	Dima Hasao	3	10000	0.60	0.70	1.395
11	Goalpara	5	10000	1.19	1.29	2.577
12	Golaghat	5	10000	1.11	1.21	2.419
13	Hailakandi	4	10000	0.97	1.07	2.143
14	Jorhat	7	10000	1.49	1.59	3.185
15	Kamrup M	5	10000	0.57	0.67	1.333
16	Kamrup	12	10000	1.53	1.63	3.269
17	Karbi Anglong	8	10000	1.48	1.58	3.161
18	Karimganj	5	10000	1.36	1.46	2.921
19	Kokrajhar	4	10000	1.14	1.24	2.486
20	Lakhimpur	6	10000	1.55	1.65	3.305
21	Morigaon	3	10000	0.95	1.05	2.110
22	Nagaon	11	10000	2.19	2.29	4.573
23	Nalbari	4	10000	0.93	1.03	2.065
24	Sivasagar	8	10000	1.52	1.62	3.240
25	Sonitpur	7	10000	1.42	1.52	3.038
26	Tinsukia	4	10000	0.95	1.05	2.091
27	Udalguri	3	10000	0.90	1.00	1.992
Total		**153**	**2.25**	**32.77**	**35.47**	**70.949**

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 enrolled children (class 1-5) who were administered Albendazole on NDD			(1)
No. of enrolled children (class 1-5) who were administered Albendazole on MUD			(2)
No. of enrolled children (class 6-12) who were administered Albendazole on NDD			(3)
No. of enrolled 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

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

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

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						

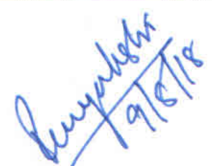
MONITORING SECTION: Circle the correct option based on your observations and interviews

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)...............................



. Materials received during training? 1. Tablets 2. Poster/Banner 3. Handouts 4. Reporting form 5. Adverse event reporting form 6. Others (Specify) ....

. Did you receive any SMS about the NDD? 1. YES 2. NO

Adverse Events

. According to the teacher/AWW, can the deworming drugs be given to sick children? 1. YES 2. NO

. Is the teacher/AWW aware of the possibility of adverse events from deworming? 1. YES 2. NO

. 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) ....

. 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) ....

. Did you witness any severe cases of adverse events in the school/AWC? 1. YES 2. NO

. Does the school/AWC have phone numbers of the nearest ANM or MO-PHC? 1. YES 2. NO

Community Awareness and IEC Materials

. 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) ....

. 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)......................

. 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)................................

. 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) ....

. 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)...........

ADDITIONAL COMMENTS: Please write any observations that have not been captured in the preceding sections

Signature 9/8/18

SECTION - V

SEVERE ADVERSE EVENT REPORTING FORM

From the Hospital / Health Centre

Date of Report:

Patient Name :	Age:	Sex:
Patient Height and Weight:		
Location:	District:	Block:

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

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

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

7/8/18

Sign and Seal of the Reporting Official

Vitamin A Biannual Round
FMR 16.7

Background:

Vitamin A deficiency has been recognized as one of the major preventable public health and nutritional challenge. An estimated 5.7% children in India suffer from eye signs of Vitamin A deficiency. Recent evidence suggested that even mild form of Vitamin A deficiency increases morbidity and mortality among the U-5 children. Under the National Prophylaxis Programme for Prevention of Blindness due to Vitamin A deficiency, there is a provision of administration of Vitamin A on a periodic basis.

Schedule for Administration of Vitamin A:

Vitamin A is stored in body for 6 months, so bi-annual administration ensures adequate Vitamin A supplementation in the body. Administration of Vitamin A to the pre-school children at periodic interval is a simple, effective and most direct intervention strategy. Under the strategy of Biannual supplementation of Vitamin A, the schedule and dose of Vitamin A supplementation is as follows:

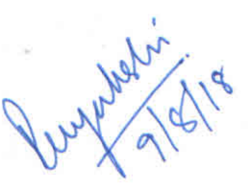
Age	Dose	Remark
Just after 9 completed months	100000 IU 1 ml or inner mark on the measuring spoon (available with Vitamin A bottle)	The contact with the infant during administration of Measles 1st dose is most appropriate for administering 1st dose of Vitamin A
1 - 5 years	200000 IU 2 ml or full measure spoon (available with Vitamin A bottle).	In every 6 months interval thereafter till 5 years.

A child should receive 9 doses of Vitamin A from 9 months to 5 years of age.

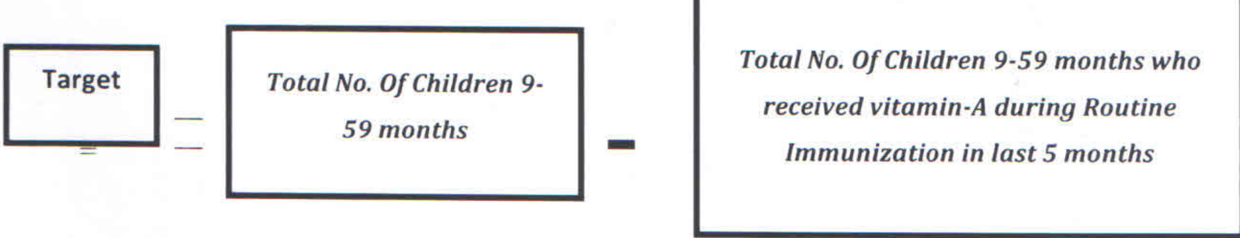
N:B: Date of opening of the Vitamin-A bottles to be mentioned on the carton as well as on the label of the bottle. Once opened, the Vitamin-syrup can be used for 2 months provided it is within the date of expiry.

Activities to be carried out during biannual round for Vitamin A supplementation to 9-59 months of children:

It is observed that in Assam the supplementation of vitamin A is very poor particularly for 2-5 years children. This is the reason why it is proposed to conduct a month long drive on vitamin A supplementation in mission mode to cover all the due, left out, drop out and uncovered children from 1st to 31st May, 2018 and 1st to 30th November, 2018.



1. It is a special vitamin-A drive and intensified activities for vitamin-A supplementation to be carried out during the bi-annual round.
2. The platform of VHND/RI sites, special camps, HI, home visit and others may be used to achieve full coverage on vitamin A supplementation.
3. Children administered vitamin A supplementation in RI in next 5 months from completion of last round to be away from the line list of children to be covered in biannual round.
4. Special emphasis should be on Vitamin-A supplementation to those children who generally do not visit to VHND/RI sites for routine immunization services.
5. Target fixing of beneficiaries/Identification of beneficiaries for the special drive is as mentioned below



6. AWWs and ASHAs should ensure proper line listing & community mobilization for all children who were missed during routine immunization in last five months along with children who are normally due in the month of biannual round. This list to be rechecked by ANM.
7. **Before administration of Vitamin A during Bi-annual round, ANM must ask mother whether child has received Vitamin A during last 5 months.**
8. The Vitamin A administration should be recorded in MCP cards (have place for vitamin A), in the regular tally sheet for VA (it has place for entering 9 doses) and Immunization Master Register. ANMs should check/verify the records of previous administration of vitamin A supplementation in MCP cards and the card to be updated.
9. DSWO need to be informed regarding biannual round of Vitamin A for ensuring participation from ICDS functionaries at all levels.
10. District/ Block level supervisors will ensure proper planning and supervision at VHND/ Immunization site.
11. In case of any adverse events following vitamin A supplementation, the beneficiary should be referred to nearest health institutions and DIO of the district should be informed.

Special Task for the biannual round:

Completions of the following tasks need to be ensured by DIO of the respective districts in coordination with DPMU.

1. Updating/development of micro plan to incorporate missed out centres.
2. Devise strategies to approach vulnerable pockets (flood affected areas, char areas, tea gardens etc.)
3. Identify blocks with poor coverage; discuss shortcomings and how to overcome it.
4. Discuss and plan how to carry out the round with ANMs, ASHA supervisors & ASHAs during sensitization.
5. Districts to ensure distribution of tally sheets, reporting & monitoring formats.
6. Stock assessment to be done and supply of stocks of vitamin A at the sub centre level to be ensured.
7. Dissemination of correct information of age-appropriate dosage of vitamin-A to the ANMs & ASHAs.
8. Preparation of due list of the beneficiaries jointly by ASHAs, AWWs & ANMs in advance.
9. Individual due list to be sent to all beneficiaries. (Prototype will be shared from State H.Q)
10. Ensure weekly reporting from all session sites and compilation at block & subsequently at district level.
11. Interdepartmental convergence: Ensure involvement of the Social Welfare department at all levels during the planning and implementation of the biannual round.

Reporting Mechanism & Flow:

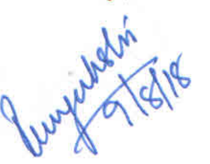
For reporting, the process of reporting of vitamin A supplementation in RI sessions to be followed.

Roles and responsibilities

Entire DPMU & BPMU staffs to be involved in micro planning, implementation, awareness generation along with Jt.DHS, DIO and vitamin A supplementation Nodal Officers in their respective level.

DPM – Overall in charge of the programme
DME – Demand generation through IEC & BCC
DCM/ BCM – Sensitization of ANM, ASHA Supervisor, ASHA & AWW
Community mobilization
Streamlining reporting process at all level
Ensuring drug availably with DDSM/ Block Pharmacist
DDSM/ Block Pharmacist- Indenting and distribution of drugs up to the field level
Ensuring adequate supply of vitamin A
DDM/BDM - Reporting through HMIS.

During Vitamin A administration all MCP cards to be updated and this will be examined with the MCTS report of May, 2018.



Monitoring and Supervision Plan for the Biannual Round: (Monitoring format enclosed in Annexure)

Monitoring and Supervision of the Biannual Round will be undertaken at all levels by the designated monitors. The major purpose of the monitoring will be:

- To monitor the session sites to understand the process of implementation with respect to micro plan, logistics availability, social mobilisation and coverage.
- To provide handholding support for administration of Vitamin A and Deworming at the session sites.
- To ensure timely and complete reporting at all session sites.

Monitoring Team:

S. N.	Level	Supervisors
1	State	SPMU consultants/ UNICEF consultants/ RRC consultants/WCD Consultants
2	District / Zonal	Jt.DHS/ ADCM&HO/ DIO/ DPMU/ Zonal and District RMNCH+A consultants, UNICEF / DSWO
3	Block	SDM&HO/Sector MO/BPM/BCM/ABPM/BDM/CDPO/LHV/ ICDS supervisors/ Health supervisors (Male/ Female)/ BEE/HE

*** Each monitor has to visit minimum 8 individual session sites during the month

Process Indicator of Biannual Vitamin A Round

- % of Drugs distributed
- % of IEC Materials Distribution
- % of ASHAs oriented/trained
- % of Agnanwadi workers oriented/trained
- Preparation of Micro Plan (District/Block/SC)
- % of Fund Released to Blocks
- % of Fund Utilization
- Preparation of Micro Plan-District & Block

Out put Indicators

- % Total No. of children covered
  - 9 to 12 months
  - 1 to 5 years

Impact Indicator

- Vitamin A deficiency rate
- Night blindness prevalence rate

Budget Break up FMR 16.1 (PM activities under Micronutrient Supplementation Programme)

Sl no	District	District level orientation and Microplanning per rounds @ Rs 3000/- per district	Block level orientation, Microplanning & ASHA - ANM Sensitization per rounds @Rs 3000/- per block	Total in Lakhs Per round
1	Baksa	3000.00	18000.00	0.21
2	Barpeta	3000.00	21000.00	0.24
3	Bongaigaon	3000.00	12000.00	0.15
4	Cachar	3000.00	24000.00	0.27
5	Chirang	3000.00	6000.00	0.09
6	Darrang	3000.00	12000.00	0.15
7	Dhemaji	3000.00	15000.00	0.18
8	Dhubri	3000.00	21000.00	0.24
9	Dibrugarh	3000.00	18000.00	0.21
10	Dima Hassao	3000.00	9000.00	0.12
11	Goalpara	3000.00	15000.00	0.18
12	Golaghat	3000.00	15000.00	0.18
13	Hailakandi	3000.00	12000.00	0.15
14	Jorhat	3000.00	21000.00	0.24
15	Kamrup M	3000.00	15000.00	0.18
16	Kamrup R	3000.00	36000.00	0.39
17	Kokrajhar	3000.00	12000.00	0.15
18	Morigaon	3000.00	9000.00	0.12
19	Karbi Anglong	3000.00	24000.00	0.27
20	Karimganj	3000.00	15000.00	0.18
21	Lakhimpur	3000.00	18000.00	0.21
22	Nagaon	3000.00	33000.00	0.36
23	Nalbari	3000.00	12000.00	0.15
24	Sivasagar	3000.00	24000.00	0.27
25	Sonitpur	3000.00	21000.00	0.24
26	Tinsukia	3000.00	12000.00	0.15
27	Udalguri	3000.00	9000.00	0.12
	Total	**0.81**	**4.59**	**5.40**

Session Site Supervision/ Monitoring Checklist
Biannual Round on Vitamin -A Supplementation
During Routine VHND andRoutine Immunization Sessions
..............................,2018

Name of ANM:________________________________ Name of Sub center____________

Name of CHC/PHC:____________________________ District:____________________

Date of Visit: ___/___/___ Time of visit:__________________

Name and designation of Supervisor/Monitor:______________________________________

(Tick all that apply)

1. Session Site Sub Center ☐ Anganwadi Center ☐ Other ☐

2. Is ANM present at site: Yes or No (If ANM is absent, do not fill this format)

3. Others present at Site AWW ☐ ASHA/Link Worker ☐ Mobilizer ☐ ASHA Supervisor ☐ other

4. Is the session site as per micro plan? Yes ☐ No ☐

5. What immunization/ Vitamin -A-related IEC material is displayed at site?

Banner☐ Wall writing☐ Tinplate☐ Poster☐ Other ☐

6. Is Vitamin-A syrup available with the measuring spoon? Yes ☐ No ☐

7. Does ANM/AWW/ASHA/Link Worker have a due list of beneficiaries (9 m. – 5 yrs. old children) for this day? Yes ☐ No ☐

8. Is the Health worker checking previous Vitamin-A administration status of children?

Yes ☐ No ☐

9. Is the health worker/AWW asking the age of the child before Vitamin-A administration?

Yes ☐ No ☐

10. Is Vit A being given with a plastic spoon to beneficiaries receiving measles?

Yes ☐ No ☐ NA ☐

11. How many children have been given Vitamin-A...........

12. Has a Supervisor/MO visited the session site? Yes ☐ No ☐

15. Who informed the mother to come to session site today?

Other Mother ☐ ANM ☐ AWW ☐ ASHA/link worker ☐ other ☐

14. Are the activities in the session site running smoothly? Yes ☐ No ☐

15. Are the clients satisfied with the services provided at the center? Yes ☐ No ☐

*Signature of ANM*____________________ *Signature of the Monitor/ Supervisor*____________

9/8/18

Weekly/ Monthly reporting on Vitamin A coverage at RI Sessions/VHNDs during Biannual Round, May, 2018

f the SC/PHC/District:

k/ th ...	Target Children 9months-12 months			Target Children 1year -5 yrs			Total number of Children (9months-12 months) administered with 1ml of Vit A			Total number of Children (13 months-18 months) administered with 2ml of Vit A			Total number of Children (19 months-24 months) administered with 2ml of Vit A			total number of Children (25 months-30 months) administered with 2ml of Vit A			Total number of Children (31 months-36 months) administered with 2ml of Vit A		
	For 1st dose			For 2nd - 9th doses			1st dose			2nd Dose			3rd dose			4th dose			5th dose		
	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total
ek																					
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k/ th ...	Total number of children (37 months-42 months) administered with 2ml of Vit A			Total number of Children (43 months-48 months) administered with 2ml of Vit A			Total number of Children (49 months-54 months) administered with 2ml of Vit A			Total number of Children (55 months-60 months) administered with 2ml of Vit A			Total number of Children (9months-12 months) administered with 1ml of Vit A			Total number of Children (13 months-60 months) administered with 2ml of Vit A		
	6th dose			7th Dose			8th dose			9th dose			1st dose			2nd - 9th doses		
	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total
ek																		
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Date & signature of SDM&HO/In-charge

Vitamin-A Biannual Round Month of ....

(Tally Sheet for Vitamin A Supplementation)

Name of the Session site:

Category of Session site : Village/Urban/Char/TeaGarden/Hilly

[Tick (√) on the location above]

Name of the sub centre :	**Name of District :**	**Name of ASHA :**
Name of ANM :	**Name of Block :**	**Name of AWW :**
Date of activity :	**Name of ASHA Supervisors :**	

[To put Tick mark (√) on nos against appropriate age group and sex with the administration of Vitamin A dose]

	Dose	Age																										
BOYS	1st Dose	9m-12months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	2nd Dose	13m-18months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	3rd Dose	19m-24months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	4th Dose	25m-30months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	5th Dose	31m-36months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	6th Dose	37m-42months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	7th Dose	43m-48months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	8th Dose	49m-54months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	9th Dose	55m-60months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
GIRLS	1st Dose	9m-12months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	2nd Dose	13m-18months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	3rd Dose	19m-24months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	4th Dose	25m-30months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	5th Dose	31m-36months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	6th Dose	37m-42months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	7th Dose	43m-48months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	8th Dose	49m-54months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	9th Dose	55m-60months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=

signature of ANM

(Tally Sheet for Vitamin A Supplementation)

Name of the Session site:

Category of Session site : Village/Urban/Char/TeaGarden/Hilly

[Tick (√) on the location above]

Name of the sub centre :	Name of District :	Name of ASHA :
Name of ANM :	Name of Block :	Name of AWW :
Date of activity :	Name of ASHA Supervisors	

[To put Tick mark (√) on nos against appropriate age group and sex with the administration of Vitamin A dose]

	Dose	Age																										
BOYS	1st Dose	9m-12months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	2nd Dose	13m-18months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	3rd Dose	19m-24months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	4th Dose	25m-30months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	5th Dose	31m-36months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	6th Dose	37m-42months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	7th Dose	43m-48months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	8th Dose	49m-54months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	9th Dose	55m-60months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
GIRLS	1st Dose	9m-12months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	2nd Dose	13m-18months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	3rd Dose	19m-24months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	4th Dose	25m-30months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	5th Dose	31m-36months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	6th Dose	37m-42months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	7th Dose	43m-48months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	8th Dose	49m-54months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=
	9th Dose	55m-60months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total=

signature of ANM

Month & Year:

Sub-Centre Level Microplanning format for the Vitamin A Supplementation Activity

Name of the Sub-centre:				Month and year of the round: **September 2016**			
Name of the Block PHC:				Total no. of sessions planned for VAS activity:			
Name of the District:							

Sl. No	Name of the Village / VHND Session Site	Whether High Priority Area (Vacant SC/ Areas where last 3 VHND sessions not held / Char Area/ Tea garden/ NA)	Name of ANM conducting the session	Name of the ASHAs	Expected Beneficiaries			Requirement of Vitamin A syrup for the round
					9mo-1yr (A)	1yr-5yrs (B)	Total No. of expected Beneficiaries for the VAS activity (A+B)	No. of Vitamin A syrup bottles (100ml) required
1							0	0
2							0	0
3							0	0
4							0	0
5							0	0
6							0	0
7							0	0
8							0	0
9							0	0
10							0	0
11							0	0
12							0	0
13							0	0
14							0	0
15							0	0
16							0	0
17							0	0
18							0	0
19							0	0
20							0	0
21							0	0
22							0	0
23							0	0
24							0	0
25							0	0
26							0	0
27							0	0
28							0	0
29							0	0
30							0	0
31							0	0
32							0	0
33							0	0
34							0	0
35							0	0
36							0	0
37							0	0
38							0	0
39							0	0
40							0	0
							0	0
TOTAL					**0**	**0**	**0**	**0**

Block Level Microplanning format for the Vitamin A Supplementation Activity

Name of the Block PHC: | Month and year of the round: **September 2016**

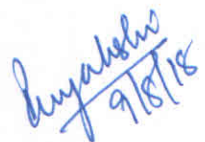
Name of the District: | Total no. of sessions planned for VAS activity:

Sl. No	Name of the Sub-centre	Name of the Village / VHND Session Site	Whether High Priority Area (Vacant SC/ Areas where last 3 VHND sessions not held / Char Area/ Tea garden/ NA)	Name of ANM conducting the session	Name of the ASHAs	Expected Beneficiaries			Requirement of Vitamin A syrup for the round
						9mo-1yr (A)	1yr-5yrs (B)	Total No. of expected Beneficiaries for the VAS activity (A+B)	No. of Vitamin A syrup bottles (100ml) required
1								0	0
2								0	0
3								0	0
4								0	0
5								0	0
6								0	0
7								0	0
8								0	0
9								0	0
10								0	0
11								0	0
12								0	0
13								0	0
14								0	0
15								0	0
16								0	0
17								0	0
18								0	0
19								0	0
20								0	0
21								0	0
22								0	0
23								0	0
24								0	0
25								0	0
26								0	0
27								0	0
28								0	0
29								0	0
30								0	0
TOTAL						**0**	**0**	**0**	**0**

District Level Microplanning format for the Vitamin A Supplementation Activity

Name of the District:

Sl. No	Name of the Blocks	No. of VHND sessions planned for VAS drive	No. of High Priority Areas (Vacant SC/ Areas where last 3 VHND sessions not held / Char Area/ Tea garden/ NA)				Requirement of Vitamin A syrup for the round
				9mo-1yr (A)	1yr-5yrs (B)	Total No. of expected Beneficiaries for the VAS activity (A+B)	No. of Vitamin A syrup bottles (100ml) required
1						0	0
2						0	0
3						0	0
4						0	0
5						0	0
6						0	0
7						0	0
8						0	0
9						0	0
10						0	0
11						0	0
12						0	0
13						0	0
14						0	0
15						0	0
16						0	0
17						0	0
18						0	0
19						0	0
20						0	0
TOTAL				**0**	**0**	**0**	**0**



National Iron Plus Initiative (NIPI)

FMR 9.5.2.5, 9.5.2.9 & 16.1

Anaemia is a clinical condition of lower level of Haemoglobin (< 11 mg/dl) in the blood

The condition may be due to

- Deficiency of iron in the body due to low dietary iron intake.
- Acute or chronic infection which hampers the production of RBC.
- Defective RBC production.
- Increased RBC destruction or blood loss

Adverse Effects of Anaemia

- Reduced physical development
- Reduced cognative development
- Impaired sexual and reproductive development

Prevention of Anaemia through -

- IFA supplementation
- Deworming
- Proper nutritional intake through nutritional awareness.

Activities:

Age group	Intervention/Dose	Regime	Service delivery
6-59 months	1ml of IFA syrup containing 20 mg of elemental iron and 100 mcg of folic acid	Biweekly throughout the period 6–60 months of age and de-worming for children 12 months and above in NDD	Through ASHA by using compliance card
5-10 years (WIFS Junior)	Pink IFA Tablets of 45 mg elemental iron and 400 mcg of folic acid	Weekly throughout the period 5–10 years of age and biannual de-worming in NDD	In school through teachers and for out-ofschool children through Anganwadi centre (AWC) Mobilization by ASHA, compliance card to be used.
10 – 19 years (WIFS)	Blue IFA Tablets of 100 mg elemental iron and 500 mcg of folic acid	Weekly throughout the period 10–19 years of age and biannual de-worming in NDD	In school through teachers and for out-ofschool children through Anganwadi centre (AWC) Mobilization by ASHA, compliance card to be used.
Pregnant & Lactating Mothers	Red IFA Tablets of 100 mg elemental iron and 500 mcg of folic acid	180 tablets during pregnancy and 180 tablets during lactation.	ANM /ASHA, Inclusion in MCP card
Women of reproductive age group	Red IFA Tablets of 100 mg elemental iron and 500 mcg of folic acid	Weekly throughout the reproductive period	Through ASHA home visit

Implementation Planning and Programme Management

The programme will be implemented by department of Health and Family Welfare in convergence with Department of Education and Social Welfare, Assam through the platform of schools and anganwadi centres to prevent anaemia and achieve overall health and nutrition of adolescents. Nodal officers on NIPI to be identified at state, district and block level to look after the overall implementation activities in their jurisdictions.

At the district level, the District NIPI Advisory Committee will be formed with participation from Health and Family Welfare, Education and Social Welfre Departments. The function of the committee will be to monitor the progress of the programme and resolve programmatic issues. The Committee would need to meet every quarter with the participation of Health, Women and Child Development and Education Block officials. Yearly meeting with nodal teachers could be organized to further streamline the implementation of programme. Committee would monitor the following:

- Status of implementation of the programme and timeliness of the submission of monthly reports
- Facilitate convergence and ensure use of community based platform like VHNDs for community mobilization and awareness
- Training
- Timely and adequate supply and distribution of IFA and Albendazole tablets
- Provision and usage of IEC materials

NIPI – 6-59 months

Each baby should get 2 doses of IFA syrup per week at VHND session cite and through ASHA home visit on Wednesday and Saturday. ASHA has to update the compliance card each time. The onset of anaemia in young children is generally after 6 months of age. Before this, iron in breast milk is sufficient to meet the needs of a breastfed child. Iron from breast milk is also in a form that is more easily bio-available to the young child. Thereafter the incidence of anaemia increases from 6–8 months till the child is 1 year old. In India, diets for children in the age group 6–23 months are predominantly plant-based and provide insufficient amounts of micronutrients to meet the recommended nutrient intakes.

For all children aged 6 to 60 months it is proposed that IFA supplement will be administered under the direct supervision of an Accredited Social Health Activist (ASHA) on fixed days on a biweekly basis. The micro plan for reaching out to these children can be worked out at village level. It is recommended that a particular child should receive the supplement on the fixed day (Monday and Thursday), though it can vary for the groups of children depending on the home visits schedule prepared at block/district level. The nutritional status of children should be assessed by MUAC (Mid Upper Arm Circumference less than

11.5 cm) to ensure that IFA syrup is not given to children with Severe Acute Malnutrition (SAM). ASHA would give IFA syrup bottles to mothers for safe storage and to lessen the logistic hurdle of carrying bottles around, but the IFA syrup will be administered under her direct supervision only. During the visits, the ASHA will also advise/inform the caregiver about the following issues:

• Time of administration – half an hour after food if the child has been breastfed (in LBW infants)/fed semisolid/solid food

• Benefits of regular intake of IFA syrup in physical and cognitive development of the child e.g. improvement in well-being, attentiveness in studies and intelligence etc.

• Minor side effects associated with IFA administration such as black discolouration of stools.

• Preservation of IFA bottle – in a cool and dark place, away from reach of children, keeping the lid of the bottle tightly closed each time after administration, etc.

(Note: ASHAs/frontline workers/caregivers should be specifically instructed to administer IFA supplement half an hour after the child has been breastfed (in LBW infants)/fed semisolid/solid food. Details of IFA supplementation will be included in the Mother and Child Protection (MCP) Card.)

NIPI -5-19 years & 10-19 years (WIFS – Junior & WIFS)

Iron deficiency during childhood is often caused by inadequate dietary intake, absorption or utilisation of iron, increased iron requirements during the growth period, or blood loss due to parasitic infections such as malaria and soil-transmitted worm infestations. Adolescents (age 10–19 years) are at high risk of iron deficiency and anaemia due to accelerated increase in requirements for iron, poor dietary intake of iron, high rate of infection and worm infestation as well as the social norm of early marriage and adolescent pregnancy. During this stage the requirement of nutrition and micronutrients is relatively high. Therefore, adolescents, especially girls, particularly those between the ages of 12–15 years, are vulnerable to iron deficiency mainly because requirements are at a peak. Evidence from many countries across the globe suggests that a weekly IFA supplement is as efficacious as daily supplements with a much lower rate of side effects.

The Weekly Iron Folic Acid Supplementation programme is for boys and girls in school (5–19 years) and out of school girls (5–19 years) in urban and rural areas and will be implemented through the platform of Government/Government aided/ municipal schools and AWCs. The strategy involves a "fixed day – Monday" approach for IFA distribution. Teachers and AWWs will supervise the ingestion of the IFA tablet by the beneficiaries.

Guidelines on Orientation Training on Iron Folic Acid Supplementation in School

1. The participants of the orientation training are nodal teachers and MPWs

2. The participants of the training will be those who were not trained previously for WIFS and WIFS Junior. One teacher from each left out school should participate in the orientation training for smooth functioning of the program.
3. The detailed batch load and type of participants are mentioned below

No. of Batches per Block	Batch Size	Total Participants for Two Batches*
2	45	Primary School Teacher (25), Upper Primary School Teacher (25), High Schools Teacher (20), MPW (20)

*no of participants may vary in types but total number will remain same.

4. Trainings to be completed by September, 2018.
5. The orientation training to be conducted at block with proper arrangements of lights and sound system and the venue should be large enough with proper seating arrangements to accommodate the participants comfortably.
6. The orientation training will be of ½ day duration.
7. The orientation is on administration of IFA tablet for school going children in the age group of 5-10 years and 10 – 19 years. Training material will be shared by the Child Health Cell, NHM, Assam.
8. Topics on Deworming as National Deworming Day to be included.
9. DPMU is required to coordinate with District Elementary Education Officer (DEEO), Inspector of Schools (IS) and other concerned departments/ office for ensuring the full participation of teachers and successful completion of the orientation training.
10. The District Nodal Officer on WIFS/ WIFS junior or WIFS Master Trainer in the district will be the trainer/resource person for orientation training of nodal school teachers and MPW.
11. The school teachers should be informed about the Emergency Response System (ERS) during this orientation training.
12. The training programme and reporting to be overseen by DPM of respective district and the District Coordinator-RBSK/RKSK/WIFS of NHM will be responsible for successful completion and proper record keeping and reporting of the orientation training programme.
13. The District Coordinator-RBSK/RKSK/WIFS of NHM will coordinate with block level officials of Education & Social Welfare Departments to conduct the training in collaboration with BPMUs.
14. Proper monitoring to be done by DPMU and dates of training to be informed in advance on wifsassam@gmail.com.

15. The District Coordinator-RBSK/RKSK/WIFS will submit the training completion report to the CH section within one week of completion of the training in their respective districts with following enclosures- A) Detailed participants list B) Photographs
16. State level and district level management team will provide support when and wherever required.

Budget break up on Orientation Training on Iron Folic Acid Supplementation (NIPI)

Serial No	Name of the District	NIPI Training for teachers and others					
		FMR 9.5.2.5		FMR 16.1*		FMR 9.5.4.9	
		Target/	Budget	Target/	Budget	Target/	Budget
1	Baksa	22	2.42				
2	Barpeta	20	2.20				
3	Bongaigaon	4	0.44				
4	Cachar	42	4.62				
5	Chirang	8	0.88				
6	Darrang	20	2.20				
7	Dhemaji	20	2.20				
8	Dhubri	57	6.27				
9	Dibrugarh	30	3.30				
10	Dima Hasao			25	2.783		
11	Goalpara			27	3.01675		
12	Golaghat	15	1.67475				
13	Hailakandi			26	2.90125		
14	Jorhat			13	1.4245		
15	Kamrup M			11	1.1605		
16	Kamrup			66	7.227		
17	Karbi Anglong					4	0.44
18	Karimganj			8	0.91575		
19	Kokrajhar			31	3.44575		
20	Lakhimpur			27	2.97		
21	Morigaon			18	1.969		
22	NAGAON			57	6.2205		
23	Nalbari					3	0.33
24	Sivasagar					36	3.96
25	Sonitpur					44	4.84
26	Tinsukia					36	3.96
27	Udalguri					15	1.65
	Total	238	26.2	309	34.34	138	15.18

*FMR 16.1 (Provision for State & District level (Meetings/ review meetings))

17. Blocks need to maintain proper record of teachers trained previously in the format given below-

Name of the Block	Name of the SC	No. Of Primary School	No. Of Primary School Teachers already Trained	No. Of Upper Primary School	No. Of Upper Primary School Teachers already Trained	No. Of High School	No. Of High School Teachers already Trained

NIPI - Women of Reproductive Age group

Women of reproductive age are at increased risk of anaemia because of chronic iron depletion during the menstrual cycle, inadequate dietary intakes and recurrent infections. Considering the intensity of the problem in the country, intermittent IFA supplementation to all menstruating women would be a cost effective strategy to build up iron stores and prevent anaemia. The following intervention is proposed for them:

• IFA supplementation (100 mg elemental iron and 500 mcg of folic acid) throughout the calendar year, i.e., 52 weeks, each year

• Albendazole (400 mg) tablets for biannual de-worming for helminthic control ASHA to distribute IFA supplements to women in reproductive age group during doorstep distribution of contraceptives.

ASHA has to distribute and ensure compliance of IFA supplementation 1 tablet per week through home visit. ASHA has to distribute 4/5 tablet (no of Mondays in the month) per month for administration by a non pregnant women of reproductive age group on each Monday of the week.

Indicators of NIPI

Process Indicator

- % of Fund Released to Blocks
- % of Training & orientation of ASHAs/AWWs/Anganwadi Supervisors/Teachers
- % of Drugs distribution
- % of IEC Materials Printing & Distribution
- % SCs with available Registers & Reporting Formats

Outcome Indicators NIPI 6-59 months

- % of children consumed 8/10 doses of IFA syrup in the month
- % of children reported adverse effects after consuming IFA syrup
- % of children identified with Moderate / Severe Anaemia
- % of children referred with moderate / severe Anaemia

Outcome Indicators NIPI 5-10 years of WIFS Junior / NIPI 10-19 years or WIFS

- % of children consumed 4/5 IFA (Pink) Tablets in the month
    - In-School
    - Out of School
- % of children identified with Moderate / Severe Anaemia
- % of children referred with moderate / severe Anaemia

- % of children reported adverse effects after consuming IFA tablets

Reporting formats:

ASHA Line list for NIPI (6-59 months)

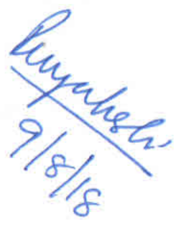
Name of the ASHA | Reporting Month
Name of the Village | Sub Center
Total Population
Total Under 5 Population

Line list

Name of the child	Age	Gender (M/F)	Name of the father	Identification of pallor (Y/N)	Refer (Y/N)	IFA dose administarion (write Y for Yes and N for No)										Total Dose received	Adverse effect if any (Y/N)
						1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th		

Total no of children consumining 8-10 doses of IFA
No of Adverse events reported

Signature of ASHA



ANM Format for NIPI (6-59 months)

Name of the ANM

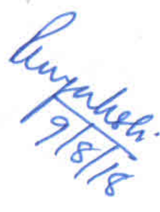
Name of the SC

Total Population

Total Under 5 Population

Name of ASHA	Target beneficiary			Total no of children consumining 8-10 doses of IFA			No of children with pallor			Refferal			Adverse effect reported			IFA bolltle		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	In hand	Required for 2 months	Indent given

Signature of ANM



District/ Block Format for NIPI (6-59 months)

Name of the block/district

Total Population

Total Under 5 Population

Target beneficiary			Total no of children			No of children with pallor			Refferal			Adverse effect reported			IFA bolltle		
Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	In hand	Required for 2 months	Indent given

Signature of BCM/ DCM

Monthly School Reporting Formateekly Iron Folic acid Supplementation (Class VI to XII)

Name of School:	Village/Town/City:	Block :	District:
Type of School: Govt./Govt. Aided/Residential Schools/ Others, specify/......................	Name of the Nodal Teachers/Principal:		
Reporting Month and Year:	Classes in School: (pls tick) $6^{th}/7^{th}/8^{th}/9^{th}/10^{th}/11^{th}/12^{th}$		

I. IFA Consumption	**Girls**	**Boys**	**Total**
Total no. of Students in 6th to 12th Classes	a)	b)	(a+b)
No. of Student in 6th to 12th Classes consuming at least 4 IFA tablets in this month	c)	d)	(c+d)
Coverage %	*c/a x100 =*	*d/b x100=*	*(c+d)/(a+b) x 100 =*
Total number of teachers and other staff consuming at least 4 IFA tablets in this month			
II. Albendazole Tablet Consumption ***(February /August)***	**Girls**	**Boys**	**Total**
No. of Students in 6th to 12th Classes consuming Albendazole tablets	m)	n)	(m+n)
Coverage %	*(m)/(a) x100=*	*(n)/(b)x100 =*	*(m+n)/(a+b)) x 100 =*

III. Students with moderate/severe anaemia **(Based on physical check-up only)**		Girls	Boys	Total
	Identified			
	Referred			

IV. Nutrition and Health Education	
IV a. Number of Nutrition and Health Education sessions planned in the month	
IV b. No. of Nutrition and Health Education sessions conducted	

V. Adverse Effects	
No. of students who experienced adverse effects following IFA consumption	
No. of students referred to health facility for management of adverse effects	

VI. Stock Details	**Opening Stock**	**Stock received in the month** **(if any)**	**Stock Utilized in the month**	**Balance Stock with expiry date**	**Stock needed** **(if any)**
IFA Tablets					
Albendazole Tablets					

Nodal Teacher 1	Nodal Teacher 2	Head Teacher

Puspiehdri 9/8/18

Annexure B

AWC MONTHLY REPORTING FORMAT

Weekly Iron Folic Acid Supplementation for 5 - 10 years

Name of AWC/Village:	**AWC Code**	**Reporting month**
Name of AWW:	**Block/Project:**	**District:**

Total no registered girls at the AWC under WIFS programme

Sl no	Name of girl enrolled under WIFS Programme	Age	Father's name	*Pls. tick* (ü) the if the girl has consumed IFA					Consumption of Albendazole tablets in the month (Y/N)
				1st Week	**2nd Week**	**3rd Week**	**4th Week**	**5th Week**	
				Date:	Date:	Date:	Date:	Date:	
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
No of girls consuming IFA per week									
No of girls experience adverse event			Indentified						
			Referred						
No of girls with moderate/ severe anaemia			Indentified						
			Referred						

Sl no	Tablet	Total no girls consuming	Drug Status							
			Tablet	**Opening Balance**	Stock Received	**Total Stock Available**	**Stock Utilized**	**Closing Balance**	**Expiry Date**	**Stock Required**
1	Atleast 4 IFA tablets in the month		IFA tablets							
2	Albendazole (Frebruary & August)		Albendazole tablets							

Signature of ASHA
Date:

Signature of Anganwadi Worker
Date:

Weekly Iron Folic Acid Supplementation for (AGE GROUP)
Sub Centre Monthly Reporting Format

Name of the SC:			
Sector:	Block		Month & Year:
Target		District	State:

	School	AWC
Total no of institution		
Total no of girls		
Total no of boys		
Total no of girls & boys		
IFA consumption	School	AWC
Total no of girls consuming at least 4 IFA tablets		
Total no of boys consuming at least 4 IFA tablets		
Total no of girls & boys consuming at least 4 IFA tablets		
Total no of teacher/ AWW consuming 4IFA IFA tablets		
Coverage in percentage	School	AWC
Girls consuming at least 4 IFA tablets		
Boys consuming at least 4 IFA tablets		
Total no of girls & boys consuming at least 4 IFA tablets		
Albendazole consumption in February and August	School	AWC
Total no of girls consuming Albendazole tablet		
Total no of boys consuming Albendazole tablet		
Total no of adolecents consuming Albendazole tablet		
Total no of teacher/ AWW consuming Albendazole tablet		
Coverage in percentage	School	AWC
Girls consuming Albendazole		
Boys consuming Albendazole tablet		
Total no of girls & boys consuming Albendazole tablet		

Aneamia		School			AWC
No of adolescents with moderate and severe anaemia (Based on physical chech uponly)		Girls	Boys	Total	Girls
	Identified				
	Referred				

Nutrition and Health Education	School	AWC
Total no of Sessions planned in the month		
Total no of Sessions conducted in the month		

Adverse effects		School			AWC
No of adolescents experienced adverse effect		Girls	Boys	Total	Girls
	Identified				
	Referred				

Drug	Opening stock	Stock received	Utilization	Balance with expiry date	Requirement
IFA					
Albendazole					

Date:

Signature of MPW (M)/ANM

Weekly Iron Folic Acid Supplementation for (AGE GROUP) (Sector Level Monthly Reporting Format)

Name of the PHC/CHC/SDCH/MPHC:		Month & Year:
Block	District	State:
No of total Sub Centres:	No of Sub Centres submitting report:	

Target	School	AWC
Total no of institution		
Total no of girls		
Total no of boys		
Total no of girls & boys		
IFA consumption	School	AWC
Total no of girls consuming at least 4 IFA tablets		
Total no of boys consuming at least 4 IFA tablets		
Total no of adolecents consuming at least 4 IFA tablets		
Total no of teacher/ AWW consuming 4IFA IFA tablets		
Coverage in percentage		
Girls consuming at least 4 IFA tablets		
Boys consuming at least 4 IFA tablets		
Total no of girls & boys consuming at least 4 IFA tablets		
Albendazole consumption in February and August	School	AWC
Total no of girls consuming Albendazole tablet		
Total no of boys consuming Albendazole tablet		
Total no of adolecents consuming Albendazole tablet		
Total no of teacher/ AWW consuming Albendazole tablet		
Coverage in percentage		
Girls consuming Albendazole		
Boys consuming Albendazole tablet		
Total no of girls & boys consuming Albendazole tablet		

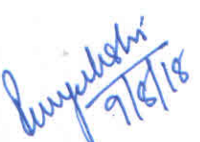
		Girls	Boys	Total	Girls
No of adolescents with moderate and severe anaemia (Based on physical chech uponly)	Identified				
	Referred				
Total no of Sessions planned in the month					
Total no of Sessions conducted in the month					

Adverse effects		School			AWC
		Girls	Boys	Total	Girls
No of adolescents experienced adverse effect	Identified				
	Referred				

Drug	Opening stock	Stock received	Utilization	Balance with expiry date	Requirement
IFA					
Albendazole					

Date:

Signature of ABPM)



Weekly Iron Folic Acid Supplementation for (AGE GROUP) (Block Level Monthly Reporting Format)

Name of the Nodal Officer		Month & Year:	
Block	District	State:	
No of total Sectors:	No of Sectors submitting report		

Target	School	AWC
Total no of institution		
Total no of girls		
Total no of boys		
Total no of girls & boys		
IFA consumption	School	AWC
Total no of girls consuming at least 4 IFA tablets		
Total no of boys consuming at least 4 IFA tablets		
Total no of girls & boys consuming at least 4 IFA tablets		
Total no of teacher/ AWW consuming 4IFA IFA tablets		
Coverage in percentage	School	AWC
Girls consuming at least 4 IFA tablets		
Boys consuming at least 4 IFA tablets		
Adolecents consuming at least 4 IFA tablets		
Albendazole consumption in February and August	School	AWC
Total no of girls consuming Albendazole tablet		
Total no of boys consuming Albendazole tablet		
Total no of girls & boys consuming Albendazole tablet		
Total no of teacher/ AWW consuming Albendazole tablet		
Coverage in percentage	School	AWC
Girls consuming Albendazole		
Boys consuming Albendazole tablet		
Total no of girls & boys consuming Albendazole tablet		

Anaemia		School			AWC
No of adolescents with moderate and severe anaemia (Based on physical chech uponly)		Girls	Boys	Total	Girls
	Identified				
	Referred				

Nutrition and Health Education	School	AWC
Total no of Sessions planned in the month		
Total no of Sessions conducted in the month		

Adverse effects		School			AWC
No of adolescents experienced adverse effect		Girls	Boys	Total	Girls
	Identified				
	Referred				

Drug	Opening stock	Stock received	Utilization	Balance with expiry date	Requirement
IFA					
Albendazole					

Date:

Signature of ABPM)

Weekly Iron Folic Acid Supplementation for (AGE GROUP)	District Level Monthly Reporting Format	
Name of the Nodal Officer	Month & Year:	
District	State:	
No of total Blocks:	No of Blocks submitting report:	
Target	School	AWC
Total no of institution		
Total no of girls		
Total no of boys		
Total no of girls & boys		
IFA consumption	School	AWC
Total no of girls consuming at least 4 IFA tablets		
Total no of boys consuming at least 4 IFA tablets		
Total no of girls & boys consuming at least 4 IFA tablets		
Total no of teacher/ AWW consuming 4IFA IFA tablets		
Coverage in percentage	School	AWC
Girls consuming at least 4 IFA tablets		
Boys consuming at least 4 IFA tablets		
Total no of girls & boys consuming at least 4 IFA tablets		
Albendazole consumption in February and August	School	AWC
Total no of girls consuming Albendazole tablet		
Total no of boys consuming Albendazole tablet		
Total no of girls & boys consuming Albendazole tablet		
Total no of teacher/ AWW consuming Albendazole tablet		
Coverage in percentage	School	AWC
Girls consuming Albendazole		
Boys consuming Albendazole tablet		
Total no of girls & boys consuming Albendazole tablet		

Anaemia		School			AWC
		Girls	Boys	Total	Girls
No of adolescents with moderate and severe anaemia (Based on physical check uponly)	Identified				
	Referred				

Nutrition and Health Education	School	AWC
Total no of Sessions planned in the month		
Total no of Sessions conducted in the month		

Adverse effects		School			AWC
		Girls	Boys	Total	Girls
No of adolescents experienced adverse effect	Identified				
	Referred				

Supply Details			School		AWC
Drug	Opening stock	Stock received	Utilization	Balance with expiry date	Requirement
IFA					
Albendazole					

Date:

Signature of District Nodal Officer

Mission Tejaswee

Mission Tejaswee is a special drive for prevention and awareness on Anaemia. Intensified activities have been carried out since 2015-16 in a campaign mode to increase the IFA supplementation. This year in during 1st to 30th November, 2018 children of age between 6 to 59 months, 5-10 years & 10-19 years out of girls, pregnant & lactating women in all districts and women of reproductive age groups in selected districts are to be covered under Mission Tejaswee..

Activities:

1. **Sensitization:** At Block Level
   I. ASHAs/ASHA Supervisors and AWW to be oriented during the ASHA monthly meeting prior to the implementation.
2. **District & block level convergence cum sensitization meeting:** District and block level officials of Social Welfare department, Sarba Shiksha Abhiyan and Education department to be invited for the convergence meeting. Important points of discussion are
   - Sensitization of frontline workers (especially teachers & AWW) by officials from Health department using monthly meeting platforms of Social Welfare department, Sarba Shiksha Abhiyan and Education department.
   - Innovative group initiatives for smooth and successful implementation of the programme.
   - Logistic management.
   - Awareness generation activities on IFA supplementation and Anaemia.
3. **Micro Planning-** Line listing of target beneficiaries, identification of pockets with poor IFA supplementation coverage, special arrangements for hard to reach areas
4. **Reporting of coverage-**

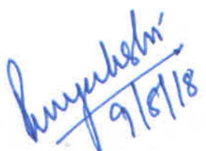
   Reporting to be done using regular reporting formats of NIPI/ WIFS/ WIFS Junior and through HMIS.
5. **Monitoring-** Extensive monitoring plan to be prepared and carried out.
6. **Review** of the programme to be done during District Health Society monthly meeting following the campaign. Minutes of the review meeting to be submitted to the Child Health Cell, NHM, Assam.

Budget break up of Mission Tejaswee

Sl no	District	for district level meeting@ Rs 10000/-	No of school	Health staff & others	No. of participants	Cost @ Rs 100/ participants	Total Approval in Lakhs
1	Baksa	0.1	2313	10	2323	2.32	2.42
2	Barpeta	0.1	3318	10	3328	3.33	3.43
3	Bongaigaon	0.1	1429	10	1439	1.44	1.54
4	Cachar	0.1	3074	10	3084	3.08	3.18
5	Chirang	0.1	1256	10	1266	1.27	1.37
6	Darrang	0.1	1612	10	1622	1.62	1.72
7	Dhemaji	0.1	2152	10	2162	2.16	2.26
8	Dhubri	0.1	4200	10	4210	4.21	4.31
9	Dibrugarh	0.1	2178	10	2188	2.19	2.29
10	Dima Hasao	0.1	1028	10	1038	1.04	1.14
11	Goalpara	0.1	2436	10	2446	2.45	2.55
12	Golaghat	0.1	2048	10	2058	2.06	2.16
13	Hailakandi	0.1	3460	10	3470	3.47	3.57
14	Jorhat	0.1	2708	10	2718	2.72	2.82
15	Kamrup M	0.1	1091	10	1101	1.1	1.2
16	Kamrup	0.1	3046	10	3056	3.06	3.16
17	Karbi Anglong	0.1	2612	10	2622	2.62	2.72
18	Karimganj	0.1	3071	10	3081	3.08	3.18
19	Kokrajhar	0.1	2687	10	2697	2.7	2.8
20	Lakhimpur	0.1	3222	10	3232	3.23	3.33
21	Morigaon	0.1	1866	10	1876	1.88	1.98
22	NAGAON	0.1	4209	10	4219	4.22	4.32
23	Nalbari	0.1	1622	10	1632	1.63	1.73
24	Sivasagar	0.1	2669	10	2679	2.68	2.78
25	Sonitpur	0.1	3063	10	3073	3.07	3.17
26	Tinsukia	0.1	1796	10	1806	1.81	1.91
27	Udalguri	0.1	1728	10	1738	1.74	1.84
	Total	**2.7**	**65894**	**270**	**66164**	**66.16**	**68.86**

Guidelines for preparation of Line Listing and Micro plan

Step 1:	Prepare line listing of pregnant and lactating women as per format "LL-PW" & LW.
	Prepare line listing of Children of the age group 6 to 59 months as per format "LL-CH".
	Prepare line listing of women in reproductive age group as per format "LL-RAW".
	Prepare list of schools
Step 2:	Prepare Sub Centre Microplan as per format "MP-SC" based on the line listings & list of Schools.
	IFA Syrup to be given on every Wednesday and Saturday. And in all schools tablet to be given on Monday.If examination falls supplementation to be done after exam and after food. In case of Monday is a holiday, supplementation to be done on next working day
	Whether High Priority Area (Vacant SC/ Areas where last 3 VHND sessions not held / Char Area/ Tea garden) need to be given highest priority
	PMSMA to be linked to ensure IFA distribution and consumption to PW. Same activity to be through all HI. PW already received IFA to be advocated for IFA consumption.
	Based on line list of lactating women (LW) IFA distribution to be done and LW who already received IFA to be advocated for IFA consumption
	In districts where NIPI for woman of reproductive age group is already implemented ASHA to ensure IFA distribution and consumption.
Step 3:	Prepare Health Block Microplan as per format "MP-BPHC" based on the Sub Centre wise Microplan.
Step 4:	Prepare District Microplan as per format "MP-DIST" based on the Health Block wise Microplan.



LL-PW

Line Listing of Pregnant Women			
District			
Health Block			
Name of the Sub Centre			
Name of the Village/ VHND Site			
Name of the ANM			
Name of the ASHA			
Sl	**Name of the Pregnant Women**	**Husband Name**	**MCTS ID (If available)**

Line Listing of lactating women having children up to 6 months			
District			
Health Block			
Name of the Sub Centre			
Name of the Village/ VHND Site			
Name of the ANM			
Name of the ASHA			
Sl	**Name of the Lactating Women**	**Husband Name**	**MCTS ID (If available)**

Line Listing of Children (6 - 60 months)				
District				
Health Block				
Name of the Sub Centre				
Name of the Village/ VHND Site				
Name of the ANM				
Name of the ASHA				
Sl	**Name of the Child**	**Mother Name**	**Age**	**Sex (M/ F)**

Euryakshi 9/8/18

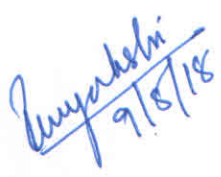
Microplan for Sub Centre (Mission Tejaswee - Anaemia Free Assam)																
District						Block PHC					Sub Centre					
Sl	Name of the Village / VHND Session Site (Both Wednesday and Saturday sessions to be included. IFA Syrup to be given on every wed nes day and Saturday	Whether High Priority Area (*Vacant SC/ Areas where last 3 VHND sessions not held / Char Area/ Tea garden/ NA)*	Name of the ANM	No of the ASHAs	No of schools	Target					Logistic Requirement					
						Number of Pregnant Women	Number of Children (6 - 60 months)	Number of Lactating Woman having child of 6 months	Number of Children (5-10 years)	Number of Children (10 -19 years)	Number of IFA Tablet (Pink Tablet)	Number of IFA Tablet (Blue Tablet)	Number of IFA Tablet (Red Tablet)	No of IFA Syrup bottle (No. of 100 ml Bottle)	Hb Test facility	BP Instrument

Microplan for Block (Mission Tejaswee - Anaemia Free Assam)																
District						Block PHC				No of Sub Centre						
						Target					Logistic Requirement					
Sl	Name of the Village / VHND Session Site (Both Wednesday and Saturday sessions to be included. IFA Syrup to be given on every wed nes day and Saturday	Whether High Priority Area *(Vacant SC/ Areas where last 3 VHND sessions not held / Char Area/ Tea garden/ NA)*	Name of the ANM	No of the ASHAs	No of schools	Number of Pregnant Women	Number of Children (6 - 60 months)	Number of Lactating Woman having child of 6 months	Number of Children (5-10 years)	Number of Children (10 -19 years)	Number of IFA Tablet (Pink Tablet)	Number of IFA Tablet (Blue Tablet)	Number of IFA Tablet (Red Tablet)	No of IFA Syrup bottle (No. of 100 ml Bottle)	Hb Test facility	BP Instrument

Missition Tejaswee PW & LW Reporting format.

Name of the District/ Block/ SC	Target beneficiaries		Covered beneficiaries				No of VHND Session in Mission Tejashwee month	No of PW detected with Hb <7gm/dcl	No of PW referred to FRU
	PW (in 2nd & third trimester)	LW having child up to 6 months	No of PW received IFA tablets	No of PW esured consuption of IFA tablets	No of LW received IFA tablets	No of LW esured consuption of IFA tablets			

For other reporting normal NIPI reporting formats for all age group to used.



ASHA Incentives

One of the key components of the National Rural Health Mission is to provide every village in the country with a trained female community health activist ASHA or Accredited Social Health Activist. Selected from the village itself and accountable to it, the ASHA will be trained to work as an interface between the community and the public health system. Following are the key components of ASHA

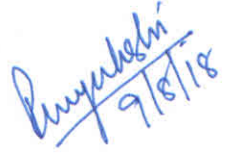
Different ASHA Incentives Under Child Healt & Nutrition Programmes in Assam

FMR	Activity	ASHA incentive
3.1.1.1.2	ASHA incentive under MAA programme @ Rs 100 per ASHA for quarterly mother's meeting	Rs100/- per round of Mother's meeting. Total appvoved Mother's meeting 3 nos per ASHA per year. (1 round means meetining with all eligible beneficiary, hence one or more meetings may need to be conducted in each round.
3.1.1.1.5	Incentive for referral of SAM cases to NRC and for follow up of discharge SAM children from NRCs	Rs 150/- per NRC graduate child for 4 follow up after discharge.
3.1.1.1.6	Incentive for National Deworming Day for mobilising out of school children	ASHA incentive of Rs. 100 for mobilizing and ensuring every eligible child (1-19 years out-ofschool) is administrated Albendazole..
3.1.1.1.7	Incentive for IDCF for prophylactic distribution of ORS to family with under-five children.	Rs 1/- per ORS packet distribution to each under 5 children.
3.1.1.1.8	National Iron Plus Incentive for mobilizing WRA (non pregnant & non-lactating Women 20-49 years)	Ensuring 70% compliance and 100% reporting of WRA (non pregnant & non-lactating Women 20-49 years) Rs100/ per month per ASHA
3.1.1.1.9	National Iron Plus Incentive for mobilizing children and/or ensuring compliance and reporting (6-59 months)	Ensuring compliance and reporting (6-59 months) Rs1/ per month per child

*If any case any district needs additional ASHA Incentive this to be immediately communicated to the State H.Q. after implementation of the programme for approval.

District wise ASHA incentive break up

Serial No	Name of the District	Mothers meeting under MAA 3.1.1.1.2	SAM admission and follow up 3.1.1.1.5	NDD 3.1.1.1.6	IDCF 3.1.1.1.7	NIPI WRA 3.1.1.1.8	NIPI (Under 5) 3.1.1.1.9
1	Baksa	2.10	0.10	1.68	0.90	5.14	5.49
2	Barpeta	3.39	0.18	2.71	2.30	10.85	8.85
3	Bongaigaon	1.67	0.08	1.33	0.93		4.35
4	Cachar	4.11	0.08	3.29	2.05		10.72
5	Chirang	1.61	0.05	1.29	0.54		4.21
6	Darrang	2.17	0.30	1.74	1.24	5.37	5.66
7	Dhemaji	1.68	0.08	1.34	0.81		4.38
8	Dhubri	4.32	0.30	3.46	3.03	7.31	11.28
9	Dibrugarh	2.92	0.23	2.34	1.22		7.63
10	Dima Hasao	0.54	0.30	0.43	0.25		1.40
11	Goalpara	2.42	0.20	1.94	1.40	7.42	6.31
12	Golaghat	2.32	0.08	1.85	1.01		6.05
13	Hailakandi	1.55	0.08	1.24	0.89	9.03	4.05
14	Jorhat	2.85	0.30	2.28	0.91		7.43
15	Kamrup M	1.66	0.08	1.33	0.98		4.33
16	Kamrup	3.91	0.08	3.13	1.54		10.20
17	Karbi Anglong	2.54	0.08	2.03	1.16		6.63
18	Karimganj	2.75	0.15	2.20	1.71		7.18
19	Kokrajhar	2.95	0.08	2.36	0.97		7.67
20	Lakhimpur	2.41	0.15	1.93	1.21		6.29
21	Morigaon	2.05	0.20	1.64	1.32		5.35
22	NAGAON	5.57	0.08	4.46	3.70		14.54
23	Nalbari	1.69	0.08	1.36	0.71		4.42
24	Sivasagar	2.83	0.05	2.26	1.03		7.38
25	Sonitpur	4.39	0.15	3.51	2.12		11.45
26	Tinsukia	3.16	0.05	2.53	1.38		8.26
27	Udalguri	2.35	0.08	1.88	0.83	7.25	6.14
		71.90	3.60	57.52	36.15	52.37	187.65



Budget Break up of printing of Different Child Health & Nutrition Programmes

Sl no	District	IDCF Printing Cost (In lakhs) FMR-12.2.2	Vitamin A Supplementation(In Lakhs) FMR-12.2.3		IEC Training/Materials & Reporting Formats for NDD @Rs-3.2 L per district per round for 2 rounds (In Lakhs) FMR-12.2.6	Printing of IEC materials and Reporting Formats for IDCF (In Lakhs) FMR-12.2.7	Printing of Reporting Formats for SC & ASHA under NIPI(WRA) (In Lakhs) FMR-12.2.12	MAA Printing (In Lakhs) FMR-
		Printing of reporting formats and line list format for ASHAs/ANM Village Plan Formats/SC Reporting Format/Monitoring formats for Blocks	Printing of SC Micro Plan formats/ Tally Sheet/Block monitoring formats Per Round	Total for 2 Rounds				Printing of ANM and ASHA Monthly Reporting format @Rs-1/ per format for 12 months
1	Baksa	0.13	0.013	0.03	6.4	0.5	0.06	0.13104
2	Barpeta	0.20	0.020	0.04	6.4	0.5	0.10	0.21948
3	Bongaigaon	0.09	0.007	0.01	6.4	0.5	0.00	0.09936
4	Cachar	0.23	0.021	0.04	6.4	0.5	0.00	0.25152
5	Chirang	0.08	0.006	0.01	6.4	0.5	0.00	0.09852
6	Darrang	0.13	0.012	0.02	6.4	0.5	0.07	0.13740
7	Dhemaji	0.09	0.009	0.02	6.4	0.5	0.00	0.10128
8	Dhubri	0.23	0.019	0.04	6.4	0.5	0.12	0.26004
9	Dibrugarh	0.17	0.017	0.03	6.4	0.5	0.00	0.18360
10	Dima Hasao	0.04	0.006	0.01	6.4	0.5	0.00	0.04140
11	Goalpara	0.13	0.012	0.02	6.4	0.5	0.07	0.14712
12	Golaghat	0.13	0.012	0.02	6.4	0.5	0.00	0.14472
13	Hailakandi	0.09	0.009	0.02	6.4	0.5	0.05	0.09720
14	Jorhat	0.16	0.013	0.03	6.4	0.5	0.00	0.16908
15	Kamrup(M)	0.18	0.006	0.01	6.4	0.5	0.00	0.09468
16	Kamrup(R)	0.20	0.024	0.05	6.4	0.5	0.00	0.24204
17	Karbi Anglong	0.16	0.014	0.03	6.4	0.5	0.00	0.15288
18	Karimganj	0.16	0.016	0.03	6.4	0.5	0.00	0.17280
19	Kokrajhar	0.15	0.012	0.02	6.4	0.5	0.00	0.17832
20	Lakhimpur	0.19	0.013	0.03	6.4	0.5	0.00	0.17748
21	Morigaon	0.11	0.009	0.02	6.4	0.5	0.00	0.12756
22	Nagaon	0.30	0.028	0.06	6.4	0.5	0.00	0.34272
23	Nalbari	0.10	0.010	0.02	6.4	0.5	0.00	0.10488
24	Sivasagar	0.17	0.018	0.04	6.4	0.5	0.00	0.17700
25	Sonitpur	0.24	0.021	0.04	6.4	0.5	0.00	0.26712
26	Tinsukia	0.17	0.012	0.02	6.4	0.5	0.00	0.18840
27	Udalguri	0.13	0.011	0.02	6.4	0.5	0.07	0.14292